

# MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

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## Emerging Infectious Diseases

### **Hemorrhage and Shock Associated with Invasive Pneumococcal Infection in Healthy Infants and Children — New Mexico, 1993–1994**

From December 1993 through May 1994, four previously healthy children (including two infants) in New Mexico developed a severe illness characterized by septic shock and hemorrhage into the skin or internal organs. An investigation subsequently implicated *Streptococcus pneumoniae* as the cause of illness. The two infants attended the same child care center (CCC) and died 6 weeks apart. This report describes the syndrome, an investigation of potential transmission in the CCC, and prevention measures.

#### **Case Investigations**

On December 10, 1993, the New Mexico Department of Health (NMDH) received a report of a previously healthy 4-month-old girl (patient 1) who died from septic shock with petechiae and hemorrhage into the adrenal glands, heart, and diaphragm. Blood and tissue cultures were negative. However, because her clinical presentation suggested meningococemia, a prophylactic regimen of rifampin was prescribed for infants, toddlers, and staff at the CCC she attended. On February 9, 1994, a 7-month-old infant (patient 2) who attended the same CCC died from septic shock, purpura, and Waterhouse-Friderichsen syndrome. Gram-positive cocci were detected on a smear of the patient's blood buffy coat, and a latex agglutination test on cerebrospinal fluid (CSF) indicated infection with *S. pneumoniae* as the cause of death; pneumococcal infection was confirmed by polymerase chain reaction (PCR), using primers for the pneumococcal autolysin gene on autopsy tissue, and by counterimmunoelectrophoresis (CIE) of CSF (serogroup 19). Analysis of autopsy tissue from patient 1, using the same PCR assay, suggested that she also had died from pneumococcal infection.

On February 17 and May 13, 1994, NMDH received reports of two other previously healthy children in whom septic shock and purpura fulminans had been diagnosed but who resided in different communities and who did not attend the CCC. Both children (aged 22 months and 4 years) were critically ill but fully recovered. Routine cultures were negative for both patients, but *S. pneumoniae* (serogroups 14 and 12, respectively) was detected by CIE of CSF from each child.

*Invasive Pneumococcal Infection — Continued***CCC Investigation**

After determining the specific cause of death for the two infants, NMDH evaluated potential transmission of pneumococcal disease in the CCC. At the time of the investigation (February 9–March 25), 75 children aged 6 weeks–10 years were enrolled in the CCC, and 17 persons were employees there. CCC attendees were divided into classrooms by age: the infant group (age <1 year) had infrequent contact with the toddler group (age 1–2 years) and no contact with the older children. Staff rotated between the classrooms. The CCC staff routinely adhered to infection-control procedures that were consistent with state and federal guidelines, including handwashing after diaper changes and exclusion of infants and children with potentially infectious illnesses (1).

To characterize the number and type of illnesses occurring among attendees aged  $\leq 2$  years during the 2-week periods preceding the two infants' deaths, NMDH conducted a self-administered survey of CCC staff and parents of CCC attendees. Parents were asked if their children had symptoms including cough, fever, and conjunctivitis or if a physician had told them their child had otitis media, pneumonia, or sinusitis—illnesses suggestive of pneumococcal infection. Six of the nine members of the infant group (excluding patients 1 and 2) and four of eight in the toddler group had had illnesses suggestive of pneumococcal infection during November 26–December 10, 1993. Otitis media was diagnosed by a physician for the six ill infants and three of the four ill toddlers; one of the ill toddlers had had purulent conjunctivitis. During January 25–February 8, 1994, illnesses suggestive of pneumococcal infection were diagnosed in five of the nine infants (four with otitis media and one with otitis media and pneumonia) and two of the eight toddlers (one with otitis media and one with otitis media and purulent conjunctivitis).

To assess the prevalence of pneumococcal carriage, on February 11, nasopharyngeal samples were obtained from CCC staff and from children in the infant and toddler groups. Of the 38 persons from whom swabs were obtained, pneumococci were isolated from six children and two staff (serogroup 19 in two infants and one toddler).

To prevent additional cases among children and staff at the CCC, NMDH and CDC, in consultation with University of New Mexico clinicians, recommended pneumococcal polysaccharide vaccine for all children aged  $\geq 2$  years and for all staff. Because the vaccine is poorly immunogenic in children aged <2 years, health officials recommended those children receive one dose of benzathene penicillin administered intramuscularly with a repeat dose 1 month later.

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**Editorial Note:** *S. pneumoniae* is the most common cause of invasive bacterial disease in the United States (2). The findings in New Mexico indicate that systemic pneumococcal infection in previously healthy children may be complicated by the rapid onset of septic shock accompanied by hemorrhage into the skin or other organs. Overwhelming sepsis with hemorrhagic complications has been well documented in persons who are asplenic and in adults with underlying medical conditions (3,4).

*Invasive Pneumococcal Infection — Continued*

However, reports of hemorrhage and shock associated with pneumococcal septicemia in previously healthy children have been limited and have included cases in a previously healthy 13-month-old who developed fatal Waterhouse-Friderichsen syndrome (5); two children with purpura fulminans (6); and two children with pneumococcal septicemia, shock, and hemorrhagic complications (7).

Because CSF, blood, and tissue cultures were negative, determining the etiology of the four cases in New Mexico required use of alternative diagnostic methods. Latex agglutination testing is performed on CSF specimens of some patients with suspected bacterial meningitis. CIE, a technique not commonly used, is highly specific for most pneumococcal serogroups when used on CSF specimens, but its sensitivity may be lower than that of other methods (8). The validity of PCR using primers for the pneumococcal autolysin gene on autopsy tissue has not been evaluated (9).

Although the most common pneumococcal diseases in persons in CCCs include otitis media and sinusitis, transmission of invasive pneumococcal disease in this setting has been reported previously (10). The report of the two deaths among children who attended the New Mexico CCC underscores the need to improve prevention of pneumococcal disease transmission in CCCs. However, until a vaccine effective in children aged <2 years is developed and licensed, substantial morbidity from pneumococcal infections among children in CCCs will probably continue to occur.

The incidence of hemorrhage and shock as a complication of pneumococcal infection in healthy children is unknown. Identification of *S. pneumoniae* as the etiology of infection in a child with this presentation is difficult when cultures are negative and other diagnostic tests are not performed. CDC recommends the following case definition to facilitate further study and reporting of this illness: septic shock, hemorrhage into the skin (petechiae or purpura) or Waterhouse-Friderichsen syndrome, and evidence of pneumococcal infection in an otherwise healthy person. Evidence of pneumococcal infection may include isolation of pneumococci from sterile body fluids or detection of pneumococci by nonculture methods. If CSF or autopsy tissues are available and routine diagnostic tests are negative, CDC can assist with detection or characterization of pneumococci. Physicians and other health-care providers are encouraged to report patients with this clinical presentation to CDC through their state health departments.

*References*

1. American Public Health Association/American Academy of Pediatrics. Caring for our children—national health and safety performance standards: guidelines for out-of-home child care programs. Washington, DC: American Public Health Association/American Academy of Pediatrics, 1992.
2. Wenger JD, Hightower AW, Facklam RR, Gaventa S, Broome CV, and the Bacterial Meningitis Study Group. Bacterial meningitis in the United States, 1986: report of a multistate surveillance study. *J Infect Dis* 1990;162:1316–23.
3. Hautekeete ML, Berneman ZN, Bieger R, et al. Purpura fulminans in pneumococcal sepsis. *Arch Intern Med* 1986;146:497–9.
4. Johansen K, Hansen ST. Symmetrical peripheral gangrene (purpura fulminans) complicating pneumococcal sepsis. *Am J Surg* 1993;165:642–5.
5. Ryan CA, Wenman W, Henningsen C, Tse S. Fatal childhood pneumococcal Waterhouse-Friderichsen syndrome. *Pediatr Infect Dis J* 1993;12:250–1.
6. Cohen JR, Lackner R, Keller A, Douglas B. The surgical implications of purpura fulminans. *Ann Vasc Surg* 1990;4:276–9.
7. Floret D, Andre S. Fulminating pneumococcal septicemia in children. *Pediatric* 1985;40:475–80.

*Invasive Pneumococcal Infection — Continued*

8. Ballard TL, Roe MH, Wheeler RC, Todd JK, Glode MP. Comparison of three latex agglutination kits and counterimmunoelectrophoresis for the detection of bacterial antigens in a pediatric population. *Pediatr Infect Dis J* 1987;6:630-4.
9. Rudolph KM, Parkinson AJ, Black CM, Mayer LW. Evaluation of polymerase chain reaction for diagnosis of pneumococcal pneumonia. *J Clin Microbiol* 1993;31:2661-6.
10. Cherian T, Steinhoff MC, Harrison LH, Rohn D, McDougal LK, Dick J. A cluster of invasive pneumococcal disease in young children in child care. *JAMA* 1994;271:695-7.

Current Trends**Asthma — United States, 1982-1992**

Asthma is characterized by variable airflow obstruction with airway hyperresponsiveness; prominent clinical manifestations include wheezing and shortness of breath. During the 1980s, the prevalence of and mortality associated with asthma increased in the United States and other countries (1,2). To describe national trends in disease burden for asthma in the United States, CDC analyzed data for 1982-1992 (the most recent year for which data are available) for deaths, hospital discharges, and self-reported morbidity. This report summarizes the findings of the analysis.

This analysis used data maintained by CDC, including the multiple-cause-of-death file, the National Hospital Discharge Survey, and the National Health Interview Survey. For asthma deaths, the underlying cause was listed as *International Classification of Diseases, Ninth Revision, Clinical Modification*, code 493. Because of the limited accuracy of diagnosing asthma in persons aged >35 years (3), this analysis presents overall age-adjusted rates and rates for persons aged 5-34 years. Race-specific analyses were restricted to blacks and whites because numbers for other races were too small to enable calculation of stable estimates.

From 1982 through 1991\*, the overall annual age-adjusted death rate<sup>†</sup> for asthma increased 40% and steadily, from 13.4 per 1 million population (3154 deaths) to 18.8 per 1 million (5106 deaths). During this period, the rate increased 59% for females (from 15.4 to 24.6) and 34% for males (from 11.7 to 15.7). For persons aged 5-34 years, the rate increased 42%, from 3.4 (401 deaths) to 4.9 (569 deaths) (Figure 1). The annual death rate was consistently higher for blacks than for whites. During this period, the rate increased 41% for females (from 3.6 to 4.6) and 43% for males (from 3.7 to 5.3).

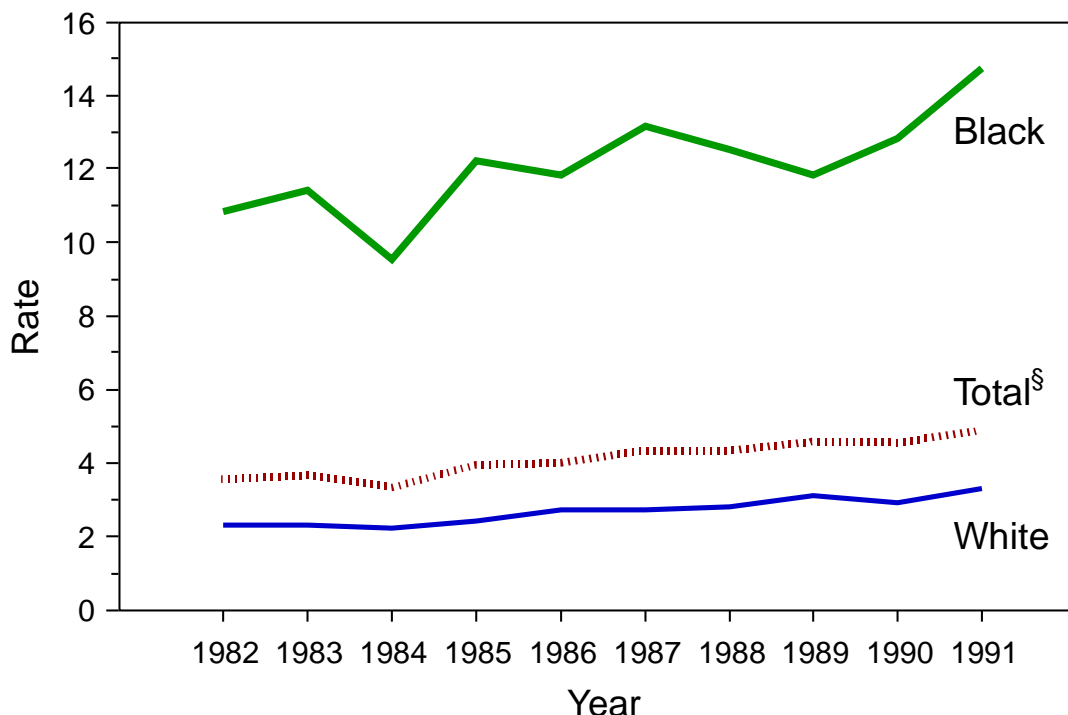
The overall annual age-adjusted hospital discharge rate for asthma as the primary diagnosis decreased slightly from 18.4 per 10,000 in 1982 to 17.9 per 10,000 in 1992. For persons aged 5-34 years, the rate was constant in both years (12.8 per 10,000); rates for females were consistently higher than for males, and rates for blacks were consistently higher than for whites.

From 1982 through 1992, the overall annual age-adjusted prevalence rate of self-reported asthma increased 42%, from 34.7 per 1000 to 49.4 per 1000. For persons aged 5-34 years, the rate increased 52%, from 34.6 to 52.6 (Figure 2). The rate for males increased by 29% (from 39.7 to 51.4) and for females increased 82% (from 29.4 to 53.6).

\*Mortality data were not available for 1992.

<sup>†</sup>Intercensal population estimates were used to calculate age-adjusted rates standardized to the 1980 U.S. population.

Asthma — Continued

**FIGURE 1. Age-adjusted death rate\* for asthma as the underlying cause of death for persons aged 5–34 years, by race† and year — United States, 1982–1991**

\*Per one million persons, standardized to the 1980 U.S. population.

†Data are presented only for black and white races because numbers for other races were too small to enable calculation of stable estimates.

§Includes persons from all racial/ethnic groups for whom data are available and persons for whom race/ethnicity was unknown.

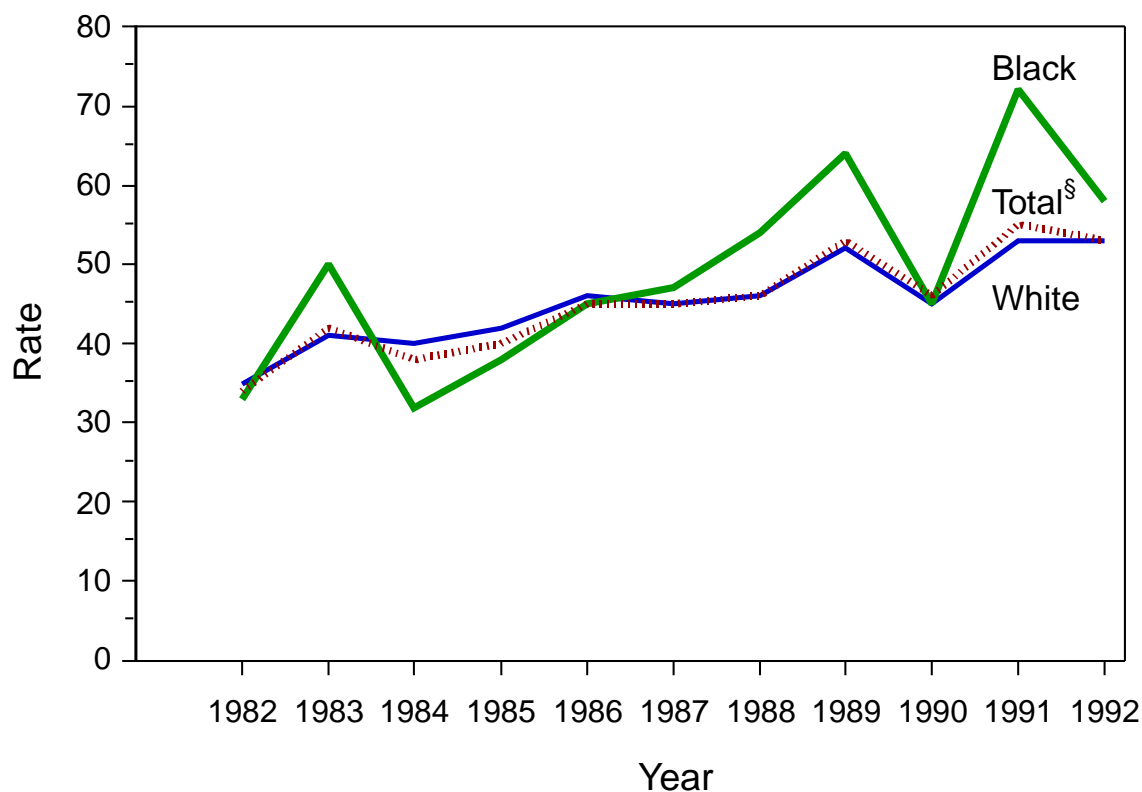
Source: CDC's National Center for Health Statistics multiple cause-of-death data.

Reported by: Air Pollution and Respiratory Health Br, Div of Environmental Hazards and Health Effects, National Center for Environmental Health, CDC.

**Editorial Note:** Three national health objectives for the year 2000 include decreasing disability and hospitalizations for asthma and increasing education about asthma (objectives 11.1, 17.4, and 17.14) (4). Although hospitalization rates for asthma were stable during 1982–1992, both prevalence and death rates increased during this period. Potential explanations for the stable hospitalization rates for asthma, despite the increased prevalence of self-reported disease, include improved outpatient treatment and, because of billing practices, classification of cases of asthma under other diagnostic categories. Prominent racial differences in asthma death rates and hospitalization rates indicate the need for further investigation of potential explanations (e.g., access to appropriate health care and socioeconomic factors).

Although the specific etiology of asthma is unknown, this problem may be associated with familial, infectious, allergenic, environmental, socioeconomic, and psychosocial factors. For example, in 1991, an estimated 6.4 million (63%) of the 10.3 million persons with asthma in the United States resided in areas where at least one National Ambient Air Quality Standard was exceeded (5). Factors associated with risk for death

## Asthma — Continued

**FIGURE 2. Age-adjusted prevalence rate\* of self-reported asthma for persons aged 5–34 years, by race† and year — United States, 1982–1992**

\*Per 1000 persons, standardized to the 1980 U.S. population.

†Data were presented only for black and white races because numbers for other races were too small to enable calculation of stable estimates.

§Includes persons from all racial/ethnic groups for whom data are available and persons for whom race/ethnicity was unknown.

Source: National Health Interview Surveys.

among persons with asthma include medication overuse (6), substance abuse (7), and cigarette smoking (8).

Morbidity and mortality associated with asthma may be affected by patient compliance, patient education, and medical management. In particular, a high proportion of asthma morbidity and mortality may be preventable through patient recognition and aggressive medical management. In 1989, the National Asthma Education Project was implemented to increase awareness about asthma and to improve effective control of asthma by providing physicians and patients with updated treatment information. This program has developed educational materials for patients and physicians about the treatment of asthma during pregnancy, for physicians about educating patients about asthma, and for educators about adding or improving awareness about asthma in schools. Additional information about these or other asthma materials are available from the National Heart, Lung, and Blood Institute Information Center, telephone (301) 251-1222.

*Asthma — Continued**References*

1. Weiss KB, Wagener DK. Changing patterns of asthma mortality: identifying target populations at high risk. *JAMA* 1990;264:1683–7.
2. Woolcock AJ. Worldwide differences in asthma prevalence and mortality: why is asthma mortality so low in the USA? *Chest* 1986;90(suppl):40S–45S.
3. Sears MR, Rea HH, de Boer G, et al. Accuracy of certification of deaths due to asthma: a national study. *Am J Epidemiol* 1986;124:1004–11.
4. Public Health Service. Healthy people 2000: national health promotion and disease prevention objectives—full report, with commentary. Washington, DC: US Department of Health and Human Services, Public Health Service, 1991; DHHS publication no. (PHS)91-50212.
5. CDC. Populations at risk from air pollution—United States, 1991. *MMWR* 1993;42:301–4.
6. Ernst P, Habbick B, Suissa S, et al. Is the association between inhaled beta-agonist use and life-threatening asthma because of confounding by severity? *Am Rev Respir Dis* 1993;148:75–9.
7. Greenberger PA, Miller TP, Lifschultz B. Circumstances surrounding deaths from asthma in Cook County (Chicago) Illinois. *Allergy Proc* 1993;14:321–6.
8. Marquette CH, Saulnier F, Leroy O, et al. Long-term prognosis of near-fatal asthma: a 6-year follow-up study of 145 asthmatic patients who underwent mechanical ventilation for a near-fatal attack of asthma. *Am Rev Respir Dis* 1992;146:76–81.

*Current Trends***Changes in Notifiable Diseases Data Presentation**

The next issue of *MMWR* (dated January 13, 1995 [volume 44, number 1]), will incorporate modifications to Tables I and II, Cases of Notifiable Diseases, United States. The purposes of these modifications are to improve the usefulness of notifiable diseases data (1,2) and to respond to changing priorities in notifiable disease surveillance. This report describes the rationale for data dissemination in Table I and Table II.

**Table I**

Table I will present the cumulative number of cases of low-frequency diseases (in general,  $\leq 500$  cases per year) reported for the current year. In addition, Table I will present the reported number of cases of congenital syphilis, which currently is updated quarterly, and *Haemophilus influenzae*, for which serotype-specific information about the vaccine-preventable subgroup (serotype b) often is not reported. Data that will be deleted from Table I, but that will continue to be published in Table II, include the number of reported cases of acquired immunodeficiency syndrome (AIDS), gonorrhea, Lyme disease, measles, syphilis (primary and secondary), and tuberculosis. Publication of reports of cases of botulism will be discontinued in *MMWR* (weekly) but will be included in the *Annual Summary of Notifiable Diseases*.

Diseases proposed for deletion from the national notifiable diseases list by the Council of State and Territorial Epidemiologists (CSTE) at its National Surveillance Conference (November 30–December 2, 1994) include aseptic meningitis, primary encephalitis (except for arboviral encephalitis), postinfectious encephalitis, unspecified hepatitis, leptospirosis, and tularemia. These diseases had been published weekly; they will continue to be published in Table I until deletion is formally approved by CSTE.

*Notifiable Diseases Data — Continued***Table II**

Table II will present high-frequency diseases (in general, >500 cases per year) or selected diseases targeted by the national Childhood Immunization Initiative for elimination of indigenous transmission in the United States (3). Cumulative totals for both the current and immediately preceding years will be presented by state or territory. Table II also will present the number of cases of measles, pertussis, and rubella reported during the previous week. Reports of cases of imported measles previously included out-of-state cases but now will include only the number of cases believed to have resulted from importation from other countries. The category indigenous measles cases will include all other measles cases reported by the state or territory. Publication of reports of cases of three diseases—tickborne typhus fever (Rocky Mountain spotted fever), toxic shock syndrome, and typhoid fever—will be discontinued in Table II but will be included in Table I.

*Reported by: Council of State and Territorial Epidemiologists. Div of Surveillance and Epidemiology, Epidemiology Program Office, CDC.*

**Editorial Note:** National notifiable diseases data presented weekly in *MMWR* generally are transmitted through the National Electronic Telecommunications System for Surveillance (NETSS) (4); the exception is data on AIDS cases, which are transmitted through the human immunodeficiency virus/AIDS reporting system.

A key determinant for the changes in the table formats was the importance of listing the distribution of cases by state or region for high-frequency diseases and diseases targeted for national elimination. As a basis for comparison, cumulative totals for both current and past year (when available) will be presented for the diseases listed in Table II. The decision to change the classification of imported measles cases will facilitate tracking of cases imported from other countries. Weekly publication of NETSS data on botulism cases was not believed to be either timely or useful because an emergency botulism antitoxin surveillance system is already in place.

Although deletions and additions to the national notifiable diseases list generally are made during CSTE's annual meeting in the spring, the recent national surveillance conference focused on changes to the list. During that meeting, proposals also were tentatively approved for adding diseases to national public health surveillance, including genital chlamydia infections, coccidioidomycosis (recommended for regional surveillance), cryptosporidiosis, hantavirus infection, hemolytic uremic syndrome, invasive group A streptococcal infections, and drug-resistant *Streptococcus pneumoniae*. These additions have not yet been formally approved by CSTE.

*References*

1. CDC. Update: changes in notifiable disease surveillance data—United States, 1992–1993. *MMWR* 1993;42:824–6.
2. CDC. National notifiable diseases reporting—United States, 1994. *MMWR* 1994;43:800–1.
3. CDC. Reported vaccine-preventable diseases—United States, 1993, and the Childhood Immunization Initiative. *MMWR* 1994;43:57–60.
4. CDC. National Electronic Telecommunications System for Surveillance—United States, 1990–1991. *MMWR* 1991;40:502–3.



### Current Trends

#### **Lack of Evidence for Wild Poliovirus Circulation — United States, 1993**

Following the isolation of wild poliovirus type 3 during January–February 1993 among members of a religious community objecting to vaccination in Alberta, Canada, surveillance for poliomyelitis was enhanced among related communities in the United States (1). In addition, during May–July 1993, a series of surveys was conducted in seven states (Iowa, Missouri, New York, Ohio, Pennsylvania, Washington, and Wisconsin) to determine whether wild poliovirus was circulating or had circulated recently among members of these religious communities residing in the states. This report summarizes the results of these surveys.

The isolation of wild poliovirus in Canada and the efforts to enhance surveillance in the United States followed a polio outbreak in the Netherlands during September 1992–February 1993 (2–4). The outbreak was attributed to wild poliovirus type 3 and resulted in 71 cases of polio among members of a religious community objecting to vaccination. A virtually identical genotype of wild poliovirus type 3 was subsequently isolated from stool samples collected from members of related religious groups in Alberta during January–February 1993 (3) and again from samples collected in April 1993; however, this genotype was not isolated from samples collected in June 1993 (P. Duclos, Laboratory Center for Disease Control, Ottawa, Canada, personal communication, November 1994). Based on nucleotide sequence studies, the poliovirus detected in the Netherlands and Canada most likely originated in India (4).

In response to the importation of poliovirus type 3 into the Western Hemisphere, measures taken by state health departments in the United States during April 1993 included 1) intensified efforts to vaccinate persons in religious communities that usually object to vaccination; 2) enhanced surveillance to identify medical conditions possibly caused by poliovirus (i.e., aseptic meningitis and acute paralysis); and 3) the initiation of a series of serologic, stool, and/or environmental surveys in Iowa, Missouri, New York, Ohio, Pennsylvania, Washington, and Wisconsin. The purpose of these surveys was to determine whether poliovirus type 3 was circulating currently or had circulated at any time since 1980 among unvaccinated members of these religious communities.

No cases of aseptic meningitis or acute paralysis have been detected among members of the religious communities since April 1993. Members of these religious communities were enrolled for the serologic, stool, and environmental surveys; poliovirus was not isolated (or detected) in the 122 stool specimens collected from members of 73 families in five states (Iowa, Missouri, Ohio, Pennsylvania, and Washington). A total of 123 serum specimens from persons in four states (Missouri, Ohio, Pennsylvania, and Washington) were tested for neutralizing poliovirus antibody; antibody to poliovirus types 1, 2, or 3 were detected in 40%, 92%, and 26% of specimens, respectively. However, poliovirus type 3 was not detected in any of the 40 children from Ohio and Pennsylvania who were unvaccinated and born after 1979. Based on the serologic surveys, poliovirus type 3 had not circulated in these communities since 1980.

*Wild Poliovirus Circulation — Continued*

A total of 12 sewage and latrine waste specimens was collected during June and July 1993 from Iowa, Missouri, New York, Pennsylvania, and Wisconsin and was examined by polymerase chain reaction; wild poliovirus was not detected in these samples.

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**Editorial Note:** Wild poliovirus infection has not been documented among persons in the United States since 1986, when wild poliovirus type 1 was isolated from a person with imported paralytic polio. The last indigenous cases of polio in the United States occurred in 1979 (5), and the last imported case in which wild poliovirus was not isolated was reported in 1993\*.

Polio can be prevented by vaccination. All children and all previously unvaccinated adults should receive a primary series of at least three doses of oral poliovirus vaccine (OPV) or inactivated poliovirus vaccine. For children, the standard recommended 4-dose series of OPV comprises doses at ages 2, 4, and 6 months and 4–6 years (6).

The findings in this report suggest that poliovirus type 3, which caused both the outbreak in the Netherlands during 1992–93 (4) and the “silent” transmission in Canada during 1993 (3), was not imported into the United States. Despite these findings, members of religious groups that object to vaccination and suboptimally vaccinated preschool-aged children who reside in urban areas may be susceptible to polio. If poliovirus is introduced into these unvaccinated groups, the number of persons who are susceptible may support virus circulation. Some members of groups usually opposed to vaccination will accept vaccination if offered.

On September 29, 1994, the International Commission for the Certification of Polio Eradication concluded that wild poliovirus transmission had been interrupted in the Western Hemisphere (7). However, the commission recognized that the region will remain at risk for poliovirus importation until polio is eradicated globally (8). The importations into the Netherlands and Canada underscore the efficiency by which poliovirus can be transported across borders and continents (3,9,10). Unvaccinated persons in groups objecting to vaccination is the primary group in the United States in which transient circulation of imported poliovirus may occur. To ensure that poliovirus transmission cannot be sustained in the United States, poliovirus vaccination coverage should be increased to 90% in all areas.

*References*

1. CDC. Poliomyelitis—Netherlands, 1992. *MMWR* 1992;41:775–8.
2. CDC. Update: poliomyelitis outbreak—Netherlands, 1992. *MMWR* 1992;41:917–9.

\*This imported case occurred in a 2-year-old child who had onset of paralysis on December 15, 1993, in Nigeria and was brought for tertiary hospital care to New York 2 weeks later; no poliovirus was isolated from this child.

*Wild Poliovirus Circulation — Continued*

3. CDC. Isolation of wild poliovirus type 3 among members of a religious community objecting to vaccination—Alberta, Canada, 1993. *MMWR* 1993;42:337–9.
4. Oostvogel PM, van Wijngaarden JK, van der Avoort HG, et al. Poliomyelitis outbreak in an unvaccinated community in The Netherlands, 1992–93. *Lancet* 1994;344:665–70.
5. Strebel PM, Sutter RW, Cochi SL, et al. Epidemiology of poliomyelitis in the United States one decade after the last reported case of indigenous wild virus-associated disease. *Clin Infect Dis* 1992;14:568–79.
6. CDC. General recommendations on immunizations: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR* 1994;43(no. RR-1).
7. CDC. Certification of poliomyelitis eradication—the Americas, 1994. *MMWR* 1994;43:720–2.
8. Pan American Health Organization. Americas certified polio free. *EPI Newsletter* 1994;16:2–3.
9. Rico-Hesse R, Pallansch MA, Nottay BK, Kew OM. Geographic distribution of wild poliovirus type 1 genotypes. *Virology* 1987;160:311–22.
10. Kew OM, Pallansch MA, Nottay BK, Rico-Hesse R, De L, Yang CF. Genotypic relationship among wild polioviruses from different regions of the world. In: Brinton MA, Heinz FX, eds. *New aspects of positive-strand RNA viruses*. Washington, DC: American Society for Microbiology 1990;52:357–65.

*Notice to Readers***Recommended Childhood Immunization Schedule —  
United States, January 1995**

Since the 1960s, the two groups that historically have developed vaccine guidelines for the United States have been the Advisory Committee on Immunization Practices (ACIP) and the Committee on Infectious Diseases of the American Academy of Pediatrics (AAP). During 1994, these organizations participated in a working group that included representatives from the American Academy of Family Physicians to develop one vaccination schedule that would accommodate the current ACIP and AAP recommendations and ensure the earliest administration of vaccines. The recommended childhood immunization schedule (Table 1) has been endorsed by these groups and becomes effective January 1995.

In the first year of life, three doses each of diphtheria and tetanus toxoids and pertussis vaccine (DTP), *Haemophilus influenzae* type b (Hib) vaccine, and oral poliovirus vaccine (OPV) are recommended to be administered at ages 2, 4, and 6 months; however, the third dose of OPV may be administered through age 18 months, and for children who receive *Haemophilus* b conjugate vaccine (Meningococcal Protein Conjugate) (PRP-OMP) at ages 2 and 4 months, a dose at age 6 months is not required. For hepatitis B vaccine, the first dose is recommended at birth (but can be given up to age 2 months), the second at age 2 months (age 1–4 months is acceptable, provided at least 1 month has elapsed since receipt of the first dose), and the third at age 6–18 months. Vaccines recommended at age 12–15 months can be administered simultaneously during one visit or during two separate visits. The second dose of measles, mumps, and rubella vaccine (MMR) may be given at entry to kindergarten or middle school. Diphtheria and tetanus toxoids (Td) is recommended at age 11–12 years but may be given through age 14–16 years. When this vaccine is given at age 11–12 years, health-care providers can ensure that the child has received a second dose of MMR.

*Reported by: Advisory Committee on Immunization Practices. American Academy of Pediatrics. American Academy of Family Physicians. National Immunization Program, CDC.*

Notice to Readers — Continued

**TABLE 1. Recommended childhood immunization schedule\* — United States, January 1995**

Vaccine	Birth	2 Months	4 Months	6 Months	12 <sup>†</sup> Months	15 Months	18 Months	4 - 6 Years	11-12 Years	14-16 Years
Hepatitis B <sup>§</sup>	HB-1	HB-2	HB-3							
Diphtheria, Tetanus, Pertussis <sup>¶</sup>		DTP	DTP	DTP	DTP or DTaP at ≥15 months			DTP or DTaP	Td	
<i>H. influenzae</i> type b <sup>**</sup>		Hib	Hib	Hib	Hib					
Poliovirus		OPV	OPV	OPV				OPV		
Measles, Mumps, Rubella <sup>††</sup>				MMR				MMR	or	MMR

\*Recommended vaccines are listed under the routinely recommended ages. Shaded bars indicate range of acceptable ages for vaccination.

<sup>†</sup>Vaccines recommended in the second year of life (i.e., 12–15 months of age) may be given at either one or two visits.

<sup>§</sup>Infants born to hepatitis B surface antigen (HBsAg)-negative mothers should receive the second dose of hepatitis B vaccine between 1 and 4 months of age, provided at least 1 month has elapsed since receipt of the first dose. The third dose is recommended between 6 and 18 months of age. Infants born to HBsAg-positive mothers should receive immunoprophylaxis for hepatitis B with 0.5 ml Hepatitis B Immune Globulin (HBIG) within 12 hours of birth, and 0.5 ml of either Merck Sharpe & Dohme (West Point, Pennsylvania) vaccine (Recombivax HB<sup>®</sup>) or of SmithKline Beecham (Philadelphia) vaccine (Engerix-B<sup>®</sup>) at a separate site. In these infants, the second dose of vaccine is recommended at 1 month of age and the third dose at 6 months of age. All pregnant women should be screened for HBsAg during an early prenatal visit.

<sup>¶</sup>The fourth dose of diphtheria and tetanus toxoids and pertussis vaccine (DTP) may be administered as early as 12 months of age, provided at least 6 months have elapsed since the third dose of DTP. Combined DTP-Hib products may be used when these two vaccines are administered simultaneously. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP) is licensed for use for the fourth and/or fifth dose of DTP in children aged ≥15 months and may be preferred for these doses in children in this age group.

<sup>\*\*</sup>Three *H. influenzae* type b conjugate vaccines are available for use in infants: 1) oligosaccharide conjugate Hib vaccine (HbOC) (HibTITER<sup>®</sup>, manufactured by Praxis Biologics, Inc. [West Henrietta, New York], and distributed by Lederle-Praxis Biologics, [Wayne, New Jersey]); 2) polyribosylribitol phosphate-tetanus toxoid conjugate (PRP-T) (ActHIB<sup>™</sup>, manufactured by Pasteur Mérieux Sérums & Vaccins, S.A. (Lyon, France), and distributed by Connaught Laboratories, Inc. [Swiftwater, Pennsylvania], and OmniHIB<sup>™</sup>, manufactured by Pasteur Mérieux Sérums & Vaccins, S.A., and distributed by SmithKline Beecham); and 3) *Haemophilus* b conjugate vaccine (Meningococcal Protein Conjugate) (PRP-OMP) (PedvaxHIB<sup>®</sup>, manufactured by Merck Sharp & Dohme). Children who have received PRP-OMP at 2 and 4 months of age do not require a dose at 6 months of age. After the primary infant Hib conjugate vaccine series is completed, any licensed Hib conjugate vaccine may be used as a booster dose at age 12–15 months.

<sup>††</sup>The second dose of measles-mumps-rubella vaccine should be administered EITHER at 4–6 years of age OR at 11–12 years of age.

Source: Advisory Committee on Immunization Practices, American Academy of Pediatrics, and American Academy of Family Physicians.

### Monthly Immunization Table

To track progress toward achieving the goals of the Childhood Immunization Initiative (CII), CDC publishes monthly a tabular summary of the number of cases of all diseases preventable by routine childhood vaccination reported during the previous month and year-to-date (provisional data). In addition, the table compares provisional data with final data for the previous year and highlights the number of reported cases among children aged <5 years, who are the primary focus of CII. Data in the table are derived from CDC's National Notifiable Diseases Surveillance System.

#### Number of reported cases of diseases preventable by routine childhood vaccination — United States, November 1994 and 1993–1994\*

Disease	No. cases, November 1994	Total cases January–November		No. cases among children aged <5 years†	
		1993	1994	1993	1994
Congenital rubella syndrome (CRS)	2	5	6	4	5
Diphtheria	0	0	1	0	1
<i>Haemophilus influenzae</i> §	69	1,222	1,031	379	266
Hepatitis B¶	817	11,469	10,399	120	106
Measles	3	300	876	114	211
Mumps	97	1,484	1,212	245	198
Pertussis	258	5,689	3,198	3,398	1,708
Poliomyelitis, paralytic**	0	3	1	1	1
Rubella	2	175	211	31	21
Tetanus	1	39	34	0	0

\* Data for 1993 are final and for 1994, are provisional.

† For 1993 and 1994, age data were available for 90% or more cases, except for 1993 age data for CRS, which were available for 80% of cases.

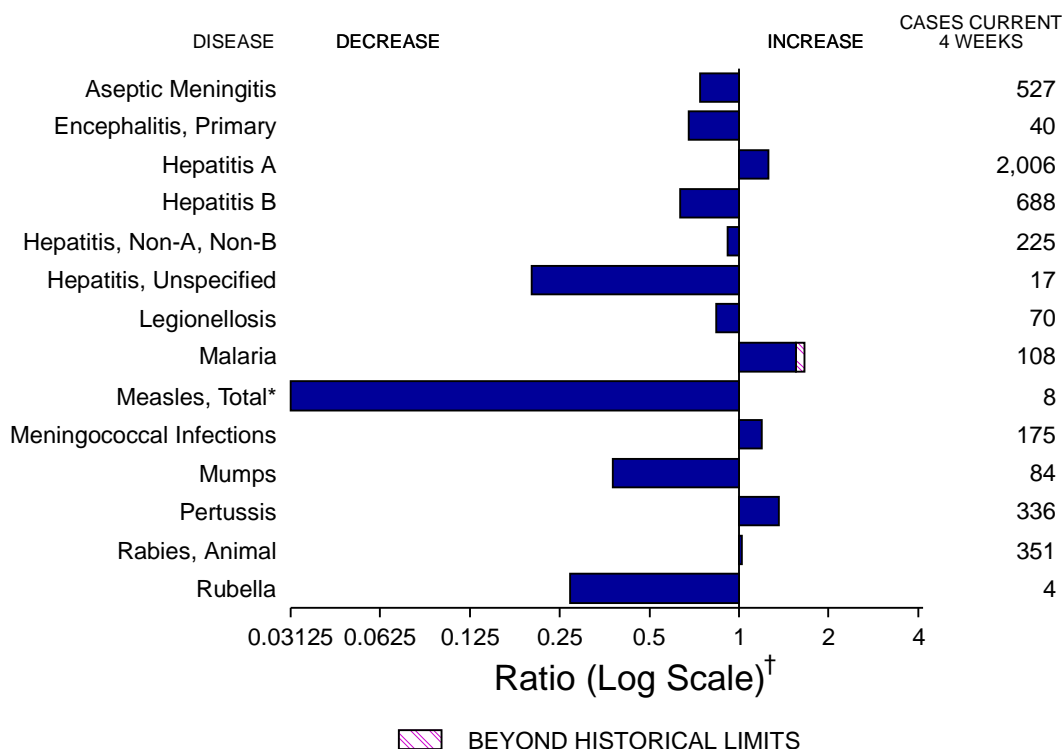
§ Invasive disease; *H. influenzae* serotype is not routinely reported to the National Notifiable Diseases Surveillance System.

¶ Because most hepatitis B virus infections among infants and children aged <5 years are asymptomatic (although likely to become chronic), acute disease surveillance does not reflect the incidence of this problem in this age group or the effectiveness of hepatitis B vaccination in infants.

\*\* One case with onset in 1994 has been confirmed; this case is vaccine-associated. An additional six suspected cases are under investigation. In 1993, three of 10 suspected cases were confirmed; two of the confirmed cases of 1993 were vaccine-associated, and one was imported. The imported case occurred in a 2-year-old Nigerian child brought to the United States for care of his paralytic illness; no poliovirus was isolated from the child.

#### Erratum: Vol. 43, No. 46

In the article "Update: Influenza Activity—United States, 1994–95 Season," an error appeared on page 848. In the first sentence of the second paragraph, *Minnesota*, not Michigan, should have been listed among the states that reported sporadic isolates of influenza type A(H3N2) during July–September 1994.

**FIGURE I. Notifiable disease reports, comparison of 4-week totals ending December 24, 1994, with historical data — United States**

\*The large apparent decrease in the number of reported cases of measles (total) reflect dramatic fluctuations in the historical baseline. (Ratios (log scale) for week 51 measles (total) is 0.03125).

<sup>†</sup>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 December 24, 1994 (51st Week)**

	Cum. 1994		Cum. 1994
AIDS*	72,888	Measles: imported	186
Anthrax	-	indigenous	696
Botulism: Foodborne	58	Plague	14
Infant	74	Poliomyelitis, Paralytic <sup>§</sup>	1
Other	7	Psittacosis	40
Brucellosis	93	Rabies, human	2
Cholera	31	Syphilis, primary & secondary	19,783
Congenital rubella syndrome	6	Syphilis, congenital, age < 1 year <sup>¶</sup>	1,123
Diphtheria	1	Tetanus	36
Encephalitis, post-infectious	107	Toxic shock syndrome	180
Gonorrhea	388,234	Trichinosis	35
<i>Haemophilus influenzae</i> (invasive disease) <sup>†</sup>	1,113	Tuberculosis	21,694
Hansen Disease	111	Tularemia	85
Leptospirosis	34	Typhoid fever	405
Lyme Disease	11,144	Typhus fever, tickborne (RMSF)	437

\*Updated monthly to the Division of HIV/AIDS, National Center for Infectious Diseases; last update November 29, 1994.

<sup>†</sup>Of 1047 cases of known age, 301 (29%) were reported among children less than 5 years of age.

<sup>§</sup>This case was vaccine-associated. The remaining 6 suspected cases with onset in 1994 have not yet been confirmed.

<sup>¶</sup>Total reported to the Division of Sexually Transmitted Diseases and HIV Prevention, National Center for Prevention Services, through second quarter 1994.







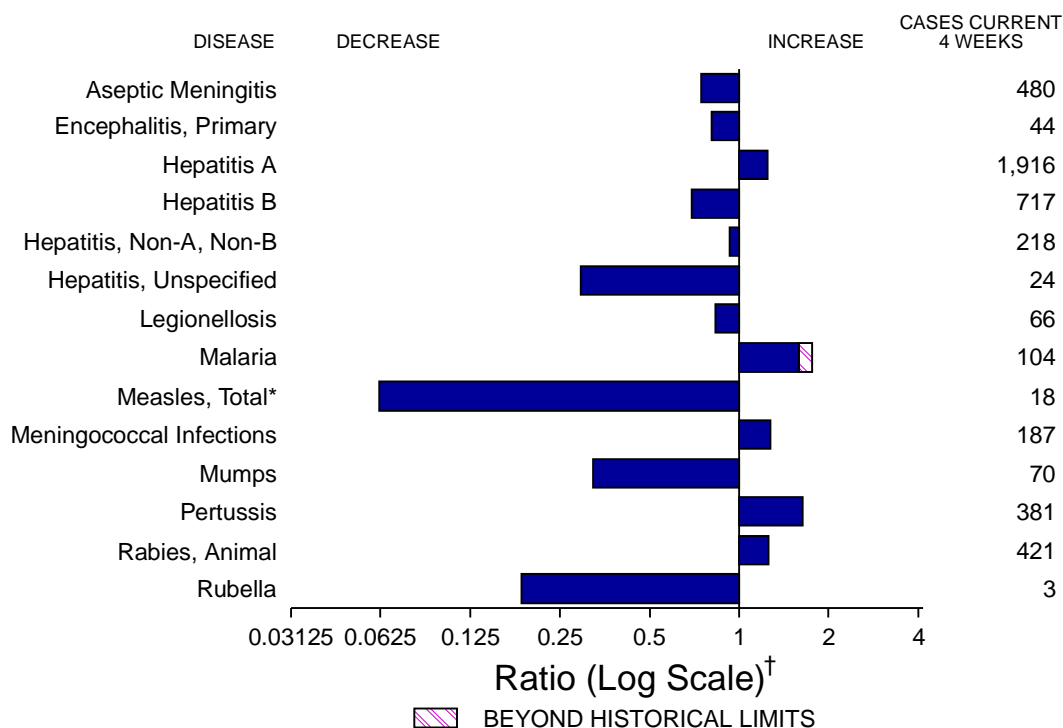
**TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending December 24, 1994, and December 25, 1993 (51st Week)**

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	19,783	25,710	180	21,694	22,632	85	405	437	7,171
NEW ENGLAND	215	348	4	515	534	1	22	15	1,846
Maine	4	8	1	27	25	-	-	-	-
N.H.	4	25	-	16	17	-	-	-	212
Vt.	-	1	1	10	7	-	-	-	140
Mass.	90	122	2	268	305	1	18	7	717
R.I.	16	15	-	52	58	-	1	-	44
Conn.	101	177	-	142	122	-	3	8	733
MID. ATLANTIC	1,352	2,353	28	4,311	4,916	2	110	18	1,825
Upstate N.Y.	161	245	15	502	678	1	12	6	1,306
N.Y. City	562	1,183	-	2,509	2,830	1	72	1	-
N.J.	234	303	-	800	813	-	20	4	272
Pa.	395	622	13	500	595	-	6	7	247
E.N. CENTRAL	2,756	4,160	40	2,118	2,309	8	73	44	66
Ohio	1,106	1,170	11	334	303	1	7	27	4
Ind.	255	360	2	191	219	2	7	5	13
Ill.	812	1,604	12	1,081	1,234	3	46	10	19
Mich.	278	543	15	447	459	1	6	2	14
Wis.	305	483	-	65	94	1	7	-	16
W.N. CENTRAL	1,147	1,592	26	566	506	39	1	39	214
Minn.	55	56	1	126	80	1	-	-	17
Iowa	71	64	8	62	59	-	-	1	85
Mo.	957	1,342	7	245	243	25	1	20	26
N. Dak.	-	4	1	8	7	1	-	-	12
S. Dak.	1	2	-	25	14	2	-	13	39
Nebr.	11	10	4	19	23	3	-	1	-
Kans.	52	114	5	81	80	7	-	4	35
S. ATLANTIC	5,295	6,394	8	3,956	4,511	2	48	207	1,947
Del.	27	91	-	40	47	-	1	-	41
Md.	323	356	-	333	392	1	14	24	508
D.C.	213	325	-	108	160	-	1	-	3
Va.	788	644	1	292	444	-	8	19	421
W. Va.	9	12	-	79	75	-	-	2	80
N.C.	1,620	1,893	1	551	577	-	-	82	172
S.C.	798	909	-	376	394	-	-	20	173
Ga.	790	1,052	1	672	741	1	2	55	361
Fla.	727	1,112	5	1,505	1,681	-	22	5	188
E.S. CENTRAL	3,849	4,058	6	1,379	1,610	2	4	47	220
Ky.	214	331	2	327	375	2	1	9	26
Tenn.	1,009	1,156	3	401	508	-	3	29	71
Ala.	621	861	1	429	487	-	-	2	123
Miss.	2,005	1,710	-	222	240	-	-	7	-
W.S. CENTRAL	4,235	5,382	2	2,964	2,651	17	16	53	644
Ark.	465	549	-	277	185	16	-	11	25
La.	1,635	2,517	-	193	357	-	3	-	69
Okla.	111	277	2	239	166	1	3	35	42
Tex.	2,024	2,039	-	2,255	1,943	-	10	7	508
MOUNTAIN	233	251	13	521	565	9	12	14	135
Mont.	4	1	-	9	13	3	-	4	22
Idaho	2	-	3	12	12	-	-	-	3
Wyo.	2	13	-	9	6	-	-	2	19
Colo.	128	87	6	21	108	1	3	4	15
N. Mex.	19	24	-	65	59	1	1	2	8
Ariz.	39	95	2	229	236	-	3	1	45
Utah	8	11	2	55	30	2	2	-	13
Nev.	31	20	-	121	101	2	3	1	10
PACIFIC	701	1,172	53	5,364	5,030	5	119	-	274
Wash.	32	55	3	253	260	-	4	-	-
Oreg.	21	40	-	90	-	2	5	-	12
Calif.	641	1,061	46	4,709	4,467	2	105	-	232
Alaska	4	8	-	63	56	1	-	-	30
Hawaii	3	8	4	249	247	-	5	-	-
Guam	10	3	-	170	65	-	1	-	-
P.R.	298	486	-	159	213	-	-	-	61
V.I.	28	42	-	-	2	-	-	-	-
Amer. Samoa	1	-	-	4	4	-	1	-	-
C.N.M.I.	2	7	-	35	41	-	1	-	-

U: Unavailable



**FIGURE I. Notifiable disease reports, comparison of 4-week totals ending December 31, 1994, with historical data — United States**



\*The large apparent decrease in the number of reported cases of measles (total) reflect dramatic fluctuations in the historical baseline. (Ratios (log scale) for week 52 measles (total) is 0.06170).

†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 December 31, 1994 (52nd Week)**

	Cum. 1994		Cum. 1994
AIDS*	78,126	Measles: imported	188
Anthrax	-	indigenous	707
Botulism: Foodborne	59	Plague	14
Infant	76	Poliomyelitis, Paralytic <sup>§</sup>	1
Other	7	Psittacosis	41
Brucellosis	95	Rabies, human	5
Cholera	39	Syphilis, primary & secondary	20,183
Congenital rubella syndrome	6	Syphilis, congenital, age < 1 year <sup>¶</sup>	1,123
Diphtheria	1	Tetanus	29
Encephalitis, post-infectious	107	Toxic shock syndrome	183
Gonorrhea	400,592	Trichinosis	35
<i>Haemophilus influenzae</i> (invasive disease) <sup>†</sup>	1,126	Tuberculosis	22,152
Hansen Disease	111	Tularemia	85
Leptospirosis	35	Typhoid fever	410
Lyme Disease	11,424	Typhus fever, tickborne (RMSF)	441

\*Updated monthly to the Division of HIV/AIDS, National Center for Infectious Diseases; last update December 31, 1994.

†Of 1055 cases of known age, 301 (29%) were reported among children less than 5 years of age.

§This case was vaccine-associated. The remaining 6 suspected cases with onset in 1994 have not yet been confirmed.

¶Total reported to the Division of Sexually Transmitted Diseases and HIV Prevention, National Center for Prevention Services, through second quarter 1994.



**TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending December 31, 1994, and January 1, 1994 (52nd Week)**

Reporting Area	Malaria	Measles (Rubeola)					Menin- gococcal Infections	Mumps		Pertussis			Rubella		
		Indigenous		Imported*		Total		1994	Cum. 1994	1994	Cum. 1994	Cum. 1993	1994	Cum. 1994	Cum. 1993
		Cum. 1994	1994	Cum. 1994	1994	Cum. 1994									
UNITED STATES	1,065	10	707	-	188	312	2,638	9	1,322	105	3,590	6,586	1	209	192
NEW ENGLAND	79	-	14	-	14	63	142	-	26	36	515	834	-	131	10
Maine	6	-	1	-	4	1	23	-	3	3	21	20	-	-	1
N.H.	3	-	1	-	-	2	7	-	4	-	84	168	-	-	-
Vt.	3	-	2	-	1	31	5	-	-	-	45	122	-	-	-
Mass.	34	-	2	-	6	18	61	-	3	31	316	408	-	125	9
R.I.	10	-	4	-	3	2	-	-	4	-	7	14	-	3	-
Conn.	23	-	4	-	-	9	46	-	12	2	42	102	-	3	-
MID. ATLANTIC	229	-	172	-	35	41	264	-	113	9	655	991	-	8	59
Upstate N.Y.	58	-	12	-	15	11	101	-	32	1	233	373	-	6	17
N.Y. City	86	-	11	-	4	19	11	-	16	-	209	116	-	1	22
N.J.	54	-	144	-	12	11	57	-	7	-	11	85	-	1	15
Pa.	31	-	5	-	4	-	95	-	58	8	202	417	-	-	5
E.N. CENTRAL	107	-	59	-	44	31	425	2	263	18	435	1,627	-	12	8
Ohio	20	-	15	-	2	9	121	2	77	4	162	523	-	-	1
Ind.	15	-	-	-	1	1	87	-	7	12	78	178	-	-	3
Ill.	39	-	17	-	39	9	123	-	106	-	95	434	-	3	1
Mich.	31	-	24	-	2	6	59	-	59	2	50	116	-	9	2
Wis.	2	-	3	-	-	6	35	-	14	-	50	376	-	-	1
W.N. CENTRAL	45	-	126	-	44	3	179	1	68	5	230	626	-	2	1
Minn.	14	-	-	-	-	-	19	-	5	-	100	393	-	-	-
Iowa	5	-	6	-	1	-	20	-	16	-	23	38	-	-	-
Mo.	13	-	118	-	42	1	87	1	41	-	47	144	-	2	1
N. Dak.	1	-	-	-	-	-	1	-	5	-	5	5	-	-	-
S. Dak.	-	-	-	-	-	-	9	-	-	-	26	8	-	-	-
Nebr.	5	-	1	-	1	-	13	-	1	-	11	14	-	-	-
Kans.	7	-	1	-	-	2	30	-	-	5	18	24	-	-	-
S. ATLANTIC	213	-	60	-	8	33	436	4	205	1	359	673	-	11	7
Del.	3	-	-	-	-	-	5	-	-	-	3	11	-	-	-
Md.	86	-	3	-	2	4	37	1	67	-	75	133	-	-	3
D.C.	15	-	-	-	-	-	7	-	-	-	11	14	-	-	-
Va.	37	-	1	-	2	4	66	1	47	-	36	75	-	-	-
W. Va.	-	-	36	-	-	-	14	2	5	1	6	8	-	-	-
N.C.	12	-	2	-	1	1	57	-	36	-	140	199	-	-	-
S.C.	5	-	-	-	-	-	35	-	8	-	14	73	-	-	-
Ga.	26	-	3	-	-	-	69	-	9	-	27	56	-	2	-
Fla.	29	-	15	-	3	24	146	-	33	-	47	104	-	9	4
E.S. CENTRAL	32	-	28	-	-	1	160	-	27	-	123	297	-	-	1
Ky.	12	-	-	-	-	-	43	-	-	-	59	38	-	-	1
Tenn.	10	-	28	-	-	-	40	-	8	-	22	183	-	-	-
Ala.	9	-	-	-	-	1	77	-	12	-	35	65	-	-	-
Miss.	1	-	-	-	-	-	-	-	7	-	7	11	-	-	-
W.S. CENTRAL	76	-	11	-	8	11	344	-	184	4	77	239	-	4	24
Ark.	3	-	-	-	1	-	45	-	5	-	27	18	-	-	-
La.	10	-	-	-	1	1	40	-	35	-	12	14	-	-	1
Okla.	7	-	-	-	-	-	38	-	23	4	36	86	-	4	1
Tex.	56	-	11	-	6	10	221	-	121	-	2	121	-	-	22
MOUNTAIN	40	2	157	-	20	7	170	-	156	27	521	464	-	5	12
Mont.	-	-	-	-	-	-	6	-	-	-	11	11	-	-	-
Idaho	2	-	1	-	-	-	17	-	10	11	172	101	-	-	2
Wyo.	1	-	-	-	-	-	9	-	3	-	-	2	-	-	-
Colo.	19	-	17	-	3	3	40	-	3	-	125	187	-	-	3
N. Mex.	3	2	2	-	-	-	17	N	N	-	36	43	-	-	-
Ariz.	9	-	5	-	4	3	50	-	95	16	148	70	-	-	2
Utah	4	-	132	-	2	-	19	-	26	-	26	45	-	4	4
Nev.	2	-	-	-	11	1	12	-	18	-	3	5	-	1	1
PACIFIC	244	8	80	-	15	122	518	2	280	5	675	835	1	36	70
Wash.	16	-	-	-	-	-	35	-	9	2	37	91	-	-	-
Oreg.	14	-	-	-	2	4	107	N	N	-	43	106	-	3	-
Calif.	197	-	56	-	9	96	361	1	248	3	573	619	1	28	41
Alaska	2	-	16	-	-	2	5	-	4	-	1	5	-	1	1
Hawaii	15	8	8	-	4	20	10	1	19	-	21	14	-	4	28
Guam	4	U	211	U	-	25	1	U	7	U	2	-	U	1	-
P.R.	3	-	13	-	-	356	15	-	2	-	2	11	-	-	-
V.I.	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-
Amer. Samoa	-	U	-	U	-	-	-	U	1	U	2	2	U	-	-
C.N.M.I.	1	U	26	U	-	93	-	U	2	U	-	1	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 December 31, 1994, and January 1, 1994 (52nd 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	20,183	26,470	183	22,152	24,324	85	410	441	7,347
NEW ENGLAND	215	351	4	528	619	1	22	15	1,958
Maine	4	8	1	34	28	-	-	-	-
N.H.	4	25	-	16	26	-	-	-	212
Vt.	-	1	1	10	7	-	-	-	143
Mass.	90	123	2	272	370	1	18	7	730
R.I.	16	16	-	54	64	-	1	-	129
Conn.	101	178	-	142	124	-	3	8	744
MID. ATLANTIC	1,390	2,823	29	4,469	5,248	2	113	19	1,839
Upstate N.Y.	169	258	15	528	717	1	12	7	1,312
N.Y. City	583	1,210	-	2,509	3,003	1	72	1	-
N.J.	234	328	-	820	921	-	23	4	275
Pa.	404	1,027	14	612	607	-	6	7	252
E.N. CENTRAL	2,858	4,210	40	2,163	2,404	8	73	39	66
Ohio	1,157	1,209	11	345	309	1	7	22	4
Ind.	259	362	2	193	248	2	7	5	13
Ill.	845	1,604	12	1,108	1,281	3	46	10	19
Mich.	291	551	15	447	463	1	6	2	14
Wis.	306	484	-	70	103	1	7	-	16
W.N. CENTRAL	1,170	1,612	26	578	540	39	1	39	220
Minn.	55	59	1	130	96	1	-	-	17
Iowa	71	64	8	66	59	-	-	1	91
Mo.	980	1,354	7	245	256	25	1	20	26
N. Dak.	-	4	1	8	7	1	-	-	12
S. Dak.	1	2	-	27	16	2	-	13	39
Nebr.	11	10	4	19	23	3	-	1	-
Kans.	52	119	5	83	83	7	-	4	35
S. ATLANTIC	5,397	6,495	8	3,992	5,191	2	50	215	1,982
Del.	27	94	-	40	66	-	1	-	41
Md.	334	365	-	348	401	1	14	25	520
D.C.	214	326	-	112	160	-	1	-	3
Va.	816	663	1	292	456	-	9	19	428
W. Va.	9	12	-	79	75	-	-	2	82
N.C.	1,640	1,903	1	567	594	-	1	88	177
S.C.	804	924	-	377	398	-	-	20	177
Ga.	808	1,081	1	672	753	1	2	56	366
Fla.	745	1,127	5	1,505	2,288	-	22	5	188
E.S. CENTRAL	3,897	4,071	6	1,392	1,708	2	4	47	223
Ky.	216	331	2	332	405	2	1	9	26
Tenn.	1,018	1,156	3	401	555	-	3	29	71
Ala.	631	861	1	433	487	-	-	2	126
Miss.	2,032	1,723	-	226	261	-	-	7	-
W.S. CENTRAL	4,303	5,479	2	3,014	2,844	17	16	53	645
Ark.	465	558	-	258	189	16	-	11	25
La.	1,653	2,598	-	193	357	-	3	-	69
Okla.	111	284	2	264	208	1	3	35	43
Tex.	2,074	2,039	-	2,299	2,090	-	10	7	508
MOUNTAIN	249	256	13	600	605	9	12	14	135
Mont.	4	1	-	24	22	3	-	4	22
Idaho	2	-	3	13	12	-	-	-	3
Wyo.	3	13	-	12	6	-	-	2	19
Colo.	129	90	6	21	108	1	3	4	15
N. Mex.	21	26	-	78	74	1	1	2	8
Ariz.	50	95	2	257	238	-	3	1	45
Utah	9	11	2	55	44	2	2	-	13
Nev.	31	20	-	140	101	2	3	1	10
PACIFIC	704	1,173	55	5,416	5,165	5	119	-	279
Wash.	35	56	3	266	275	-	4	-	-
Oreg.	21	40	-	90	-	2	5	-	12
Calif.	641	1,061	48	4,744	4,583	2	105	-	237
Alaska	4	8	-	63	56	1	-	-	30
Hawaii	3	8	4	253	251	-	5	-	-
Guam	11	4	-	170	84	-	1	-	-
P.R.	300	491	-	159	213	-	-	-	61
V.I.	28	42	-	-	2	-	-	-	-
Amer. Samoa	1	-	-	4	4	-	1	-	-
C.N.M.I.	2	7	-	36	47	-	1	-	-

U: Unavailable



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