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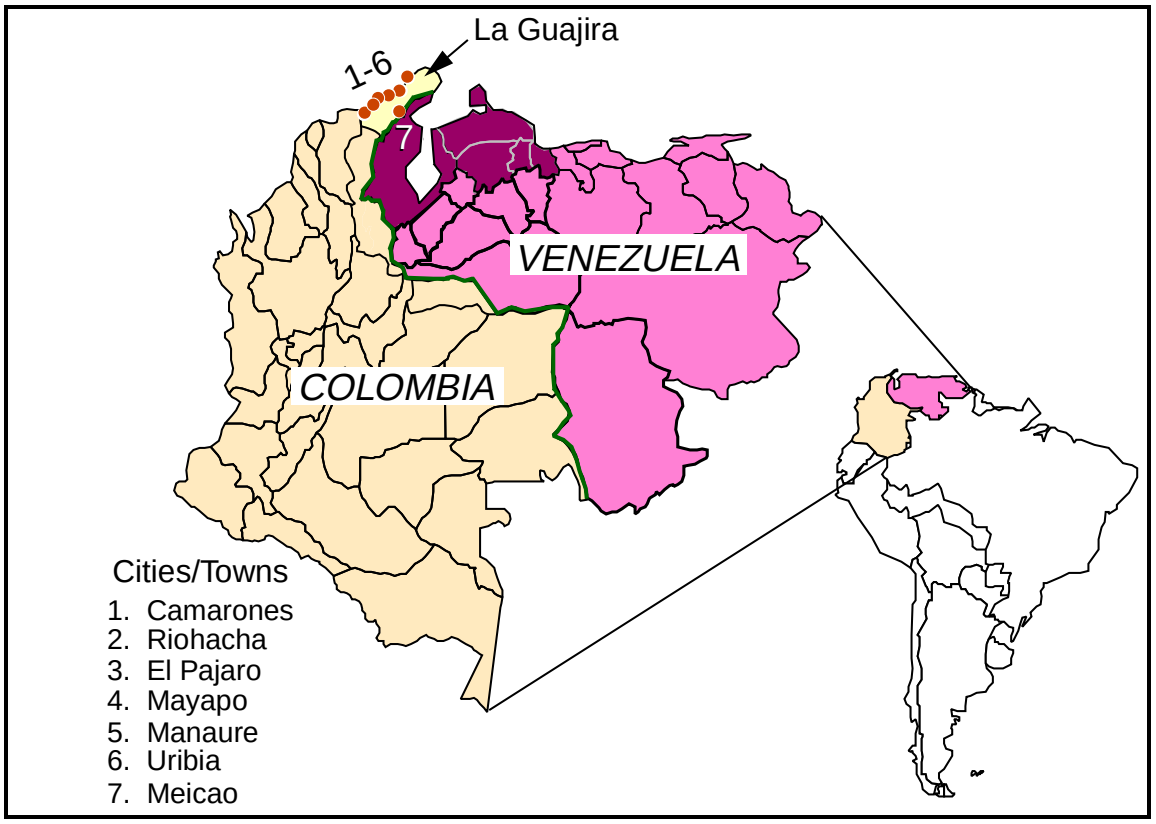
## Venezuelan Equine Encephalitis — Colombia, 1995

An outbreak of Venezuelan equine encephalitis (VEE) that began in northwestern Venezuela in April 1995 has spread westward to the Guajira peninsula and to Colombia (Figure 1), resulting in an estimated minimum of 13,000 cases in humans and an undetermined number of equine deaths. Governments of both countries have initiated efforts to control the spread of this outbreak by quarantining and vaccinating equines and applying insecticides. This report summarizes the ongoing investigation of the outbreak in Colombia.

**FIGURE 1. Location of outbreak of Venezuelan equine encephalitis — Colombia, April 1–October 1, 1995**



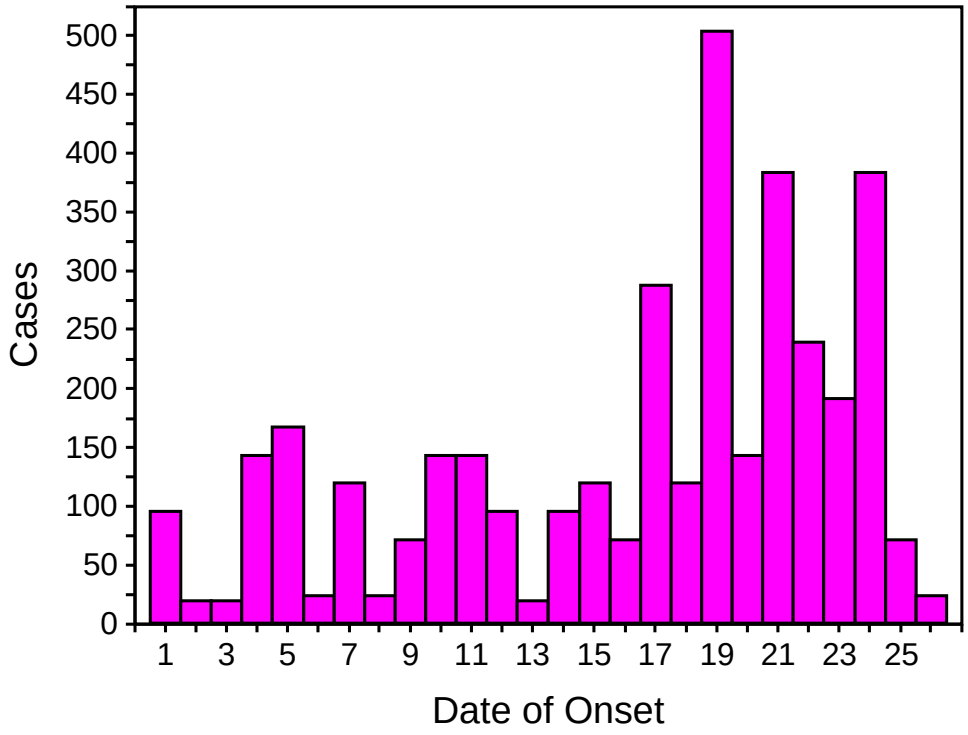
*Venezuelan Equine Encephalitis — Continued*

During the first week of September, rural health clinics in the towns of Mayapo, Manaure, and El Pajaro in the municipality of Manaure in La Guajira state reported an increased number of patients seeking care for acute febrile illnesses characterized by intense headache, muscle pain, prostration, and vomiting. Illness in some patients was complicated by convulsions and other neurologic symptoms.

As of September 28, a total of 8320 persons with acute febrile illness compatible with VEE had been treated at public hospitals and clinics in La Guajira, and large outbreaks had been reported from the towns of Manaure, Riohacha, El Pajaro, Mayapo, Uribia, and Meicao. Based on a random survey of 250 residents of Manaure, a recent history of acute illness compatible with VEE was present in 57% of respondents (Figure 2); 4% reported associated convulsions, and one person died (case-fatality rate=0.7%). All age groups were equally affected. In Manaure, the epidemic peaked on September 19, and malathion spraying was initiated on September 21.

In Riohacha, the state capitol, hospital visits for acute febrile illness increased steadily in September, reaching 143 visits on September 24 with no evidence of a decline. A similar pattern occurred in Uribia. Based on interviews and physical examinations of 23 inpatients at local hospitals on September 27–28, prominent manifestations included fever (100%); convulsions (98%); headache (56%); photophobia (56%); myalgias (56%); and chills, vomiting, and diarrhea (48% each). Ten associated deaths were reported statewide. Unidentified viral isolates have been recovered from four of 18 human blood samples submitted to the Colombian National Institute of Health.

**FIGURE 2. Number of Venezuelan equine encephalitis cases estimated from a random household survey (n=250), by date of onset — Manaure,* Colombia, September 1–26, 1995**




*Population 6283.

*Venezuelan Equine Encephalitis — Continued*

Because of a prolonged rainy season (the heaviest in 20 years in La Guajira), mosquito abundance has increased dramatically. *Aedes aegypti* house indices increased in August to 70% in Manaure and to 22% in Riohacha. Entomologic surveys in Manaure detected large numbers of *Psorophora confinnis* and *Ae. taeniorhynchus* breeding in estuarine waters in the town's vicinity. The equine population in La Guajira consists of approximately 70,000 unvaccinated horses, donkeys, and mules owned by native Wayuu people, who constitute approximately 35% of the inhabitants of Riohacha. Control measures instituted by the government of Colombia include vaccination of equines in La Guajira, restriction of equine movement from and within the state, large-scale application of insecticides, public education and community mobilization campaigns to eradicate mosquito breeding sites, issuance of guidelines on case-management and referral, and surveillance of humans and equines.

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**Editorial Note:** Major epizootics and concurrent epidemics of VEE have occurred periodically in northern areas of South America, resulting in hundreds of thousands of human and equine cases. The current epidemic is the largest in the region since 1962–1971, when outbreaks affected Colombia, Ecuador, Peru, Venezuela, all the countries of Central America (except Panama), Mexico, and Texas (*1,2*). No major outbreaks had been recognized since the outbreak that occurred on La Guajira peninsula in 1973, suggesting that epizootic viral strains (subtypes IAB and IC) had become extinct. However, based on recent molecular phylogenetic studies, these strains may have evolved from enzootic ID strains maintained in silent cycles of rodent-mosquito transmission. This hypothesis predicts that strains with epidemic and epizootic potential will continue to emerge periodically from enzootic reservoirs (*1,3,4*). Partial nucleotide sequencing and antigenic analysis of three human isolates from the current epidemic indicates they are related to the IC epizootic strain of VEE virus isolated during a large outbreak in Venezuela and Colombia during 1962–1964 (S. Weaver, University of Texas, and R. Ricco-Hesse, Yale University, personal communications, 1995) and to a strain isolated from a mosquito pool in Venezuela in 1983 (*1*).

Although conditions leading to the emergence of VEE epidemics have not been clearly defined, previous outbreaks also were associated with heavy rains and flooding in arid rural areas, especially during the dry season. During epidemics and epizootics, VEE virus is transmitted rapidly among equines and from equines to humans by a variety of mosquito species. Horses are the principal amplifying hosts in epidemic transmission because they develop and sustain high levels of viremia and attract large numbers of biting mosquitoes. Cases among humans generally occur 2 weeks after epizootic infections in horses, and epidemic transmission ceases after susceptible horses have been either infected or vaccinated. Because the total number of horses and other equines in South America has declined since the last major outbreaks in 1971, the current outbreak suggests a possible role of human and other animal infections in sustaining the epidemic cycle. VEE virus levels in human blood

*Venezuelan Equine Encephalitis — Continued*

are sufficiently high to infect mosquitoes, and virus has been isolated from the pharynx of ill persons, indicating the virus could be transmitted between humans by mosquitoes or by close direct contact (*5*).

The clinical features of cases in the current outbreaks are consistent with those reported in previous VEE epidemics in which neurologic symptoms developed in 4% of cases, primarily among children and the elderly (*6*). VEE infections during pregnancy may result in fetal infection and malformations. VEE outbreaks have the potential for substantial social impact: for example, during the 1967 outbreak in Colombia, an estimated 220,000 human cases immobilized villages and local clinics (*7*).

The Pan American Health Organization coordinates a surveillance system for equine encephalitis in the Americas and is assisting countries of Latin America and the Caribbean in strengthening their diagnostic capacity. Equine vaccination with the live attenuated TC-83 vaccine provides rapid immunity and, when combined with restriction of equine movements, may limit the spread of epizootics and prevent their emergence (*1*).

No commercially licensed human VEE vaccine is available. Persons who cannot defer travel to these areas should use insect repellents, stay in air-conditioned or well-screened accommodations when possible, and wear long-sleeved shirts and long pants. The incubation period for VEE is 2–5 days. Health-care providers who suspect VEE in ill returned travelers can refer clinical specimens through state health departments to CDC for diagnosis.

*References*

1. Weaver SC, Belew LA, Rico-Hesse R. Phylogenetic analysis of alphaviruses in the Venezuelan equine encephalitis complex and identification of the source of epizootic viruses. Virology 1992; 191:282–90.
2. Walton TE, Grayson MA. Venezuelan equine encephalomyelitis. In: Monath TP, ed. The arboviruses: epidemiology and ecology. Boca Raton, Florida: CRC Press, 1989;203–32.
3. Ricco-Hesse R, Weaver SC, deSiger J, Medina G, Salas RA. Emergence of a new epidemic/epizootic Venezuelan equine encephalitis virus in South America. Proc Natl Acad Sci U S A 1995;92:5278–81.
4. Kinney RM, Tsuchiya KR, Sneider JM, Trent DW. Genetic evidence that epizootic Venezuelan equine encephalitis (VEE) viruses may have evolved from enzootic VEE subtype I-D virus. Virology 1992;191:579–80.
5. Bowen GS, Calisher CH. Virological and serological studies of Venezuelan equine encephalomyelitis in humans. J Clin Microbiol 1976;4:22–7.
6. Briceno-Rossi AL. Rural epidemic encephalitis in Venezuela caused by a group A arbovirus (VEE). Prog Med Virol 1967;9:176–203.
7. Sanmartin C, Mackenzie RB, Trapido H, et al. Equine encephalitis in Colombia, 1967. Bol Oficina Sanit Panam 1973;74:108–37.

## Outbreak of Gastrointestinal Illness Associated with Consumption of Seaweed — Hawaii, 1994

Seaweed is frequently served as a side dish at meals in the Pacific Islands and is a common component in the diet of many persons living in the Pacific Rim. Seaweed is often harvested at beaches, gathered in nearshore waters, or purchased at local markets. It is served either raw or cooked and is commonly prepared with salt and/or other

*Seaweed-Related Illness — Continued*

spices and herbs (e.g., chili pepper, ginger, and garlic). Previous reports have documented a toxic illness associated with seaweed harvested in some locations in the Pacific (*1,2*). This report summarizes the investigation of an outbreak of acute gastrointestinal illness associated with consumption of seaweed during a picnic in Hawaii in September 1994.

On September 9, 1994, a 60-year-old woman contacted the Maui County Health Department (MCHD) to report a burning sensation in her mouth and throat that occurred 15 minutes after she tasted a seaweed ("ogo") preparation. The woman had received the seaweed from a friend on September 1 and had prepared the seaweed on September 2 by washing it, then boiling it in water for 1–2 minutes, and finally mixing it with vinegar, sugar, soy sauce, and sliced cucumbers. The seaweed mixture then was refrigerated. Approximately 4 hours after preparation, she tasted the mixture and, 15 minutes later, had onset of a sore throat and mouth, and headache. She was examined by a physician on September 3; a throat culture obtained during the visit was negative.

MCHD determined that the seaweed from which the woman's portion had come was to be served at a picnic on September 5 on the island of Hawaii. When contacted by the Hawaii County Health Department, some picnic attendees reported having had onset of nausea and diarrhea soon after eating at the picnic.

To assess the role of different foods as risk factors for illness, the Hawaii Department of Health (HDOH) surveyed all 13 picnic attendees. A questionnaire was administered by telephone to the attendees regarding menu items consumed, onset of illness, and symptoms. Menu items included poi, two types of fish (mamo and awe), beef stew, ogo (seaweed), salmon salad, steak, rice, tuna salad, chips, crackers, beer, soda, and water. A case was defined as onset of a burning sensation in the mouth or throat or two or more of the following symptoms: vomiting, diarrhea, nausea, or lethargy within 2 hours after eating food items from the picnic.

The seaweed had been prepared on September 4 by washing, removing debris, and cooking in boiling water. It was then mixed with codfish, vinegar, onion, soy sauce, and chili peppers. The woman who had prepared the seaweed and her husband had tasted it soon after preparation, and both noted a burning sensation in their throats that lasted for 4 hours. They attributed the burning sensation to an excessive amount of chili peppers. Before preparation, the seaweed had been stored in previously unused plastic bags and refrigerated.

Of the 13 persons who attended the picnic, eight were aged ≥18 years. Illness in seven (54%) attendees met the case definition, and onset occurred 15–90 minutes after eating the meal. All seven ill persons were adults, and five were males. Symptoms included diarrhea (71%), nausea (71%), vomiting (60%), and a burning sensation (57%), and the mean duration of gastrointestinal symptoms was 22 hours. None of the ill persons were examined by a physician.

The only foods statistically associated with risk for illness were seaweed (illness in seven of seven who consumed versus none of six who did not [relative risk (RR)= undefined]) and salmon salad (RR=undefined). Two of the seven persons who had consumed seaweed had eaten less than one serving (i.e., one serving spoon) and experienced only a burning sensation in the mouth and throat; in comparison, the five persons who ate one or more servings experienced gastrointestinal illness.

*Seaweed-Related Illness — Continued*

A leftover sample of the seaweed served at the picnic and another sample harvested from the same site were examined at the University of Hawaii for species identification and toxicity studies. The seaweed was identified as *Gracilaria coronopifolia*. It was rinsed thoroughly with fresh water and extracted with acetone. The toxicity of the crude extract was assessed by intraperitoneal injection into mice; the mice were observed for symptoms of toxicity. Manifestations of toxicity in the mice included diarrhea at lower dosages and death within 15 minutes at the most concentrated dosages. The compound that induced the most extreme signs of toxicity in the mice was isolated using high-performance liquid chromatography; however, the isolate was not identified.

Bacterial organisms were identified microscopically both on the surface and in the seaweed. These bacteria were cultured or isolated using 2% NaCl Heart Infusion Agar (DIFCO,* Detroit, Michigan). Colonies of two different species of *Pseudomonas* and *Vibrio* grew on the culture media. Each culture was then extracted, and the extracted fraction was subjected to the mouse-toxicity test. Mice injected with the extracted fraction from these bacteria exhibited transient weakness but no other signs of toxicity.

The seaweed had been harvested from a site in a bay on a northeast-facing shore in Maui County in water at a depth of 3–5 feet. Two fresh-water streams flow into the bay, and discharge from storm drains pours into one of the streams. In addition, the tides carry tree branches and other debris into the bay. The State Wastewater Management Division of the Hawaii Department of Health collects water samples from this area on a monthly basis but had not documented increased levels of fecal coliforms or any other potential pollutants during the period before the seaweed was harvested. There was no evidence the seaweed had been exposed to pesticides.

HDOH has notified physicians throughout the state about the potential for seaweed-induced toxicity and has requested that physicians report any cases to HDOH. Seaweed samples will be collected from the same site from which the original samples were obtained for toxin surveillance.

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**Editorial Note:** The investigation of this outbreak in Hawaii indicated that consumption of seaweed was associated with acute illness in picnic attendees. In addition to the epidemiologic findings, this conclusion was supported by the isolation of toxin that caused both similar illness and more severe illness in mice. The toxin most likely was elaborated by the seaweed itself or by a coexistent microorganism and probably was heat resistant because both samples of seaweed were boiled before consumption.

Although this outbreak was the first reported episode of seaweed-related illness in Hawaii, this problem has been reported previously in other areas in the Pacific Rim. For example, in 1991, a total of 13 persons became ill, and three of them died after eating seaweed harvested in Guam (*3*); the seaweed species was identified as *Gracilaria tsudai*, and manifestations included gastrointestinal illness, fever, wheezing, muscle fasciculations, and hypotension. In 1992, three persons had onset of illness after

*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.

*Seaweed-Related Illness — Continued*

eating seaweed harvested on a beach in California (*4*); the seaweed species implicated in that episode was *Grasilariopsis lemanaeformis*. In 1993, two persons became ill, and one of them died after eating *Gracilaria verrucosa* seaweed in Japan (*1*). In the episodes in both Guam and California, the implicated seaweed previously had not been known to develop toxicity.

Although the mechanism of development of toxicity in seaweed has not been clearly determined, findings of previous studies suggest that some species of seaweed may become toxic at the end of their reproductive cycle, and thereby exhibit a seasonal variation in toxin production (*2*). Other suggested mechanisms are that stress from over-harvesting may cause seaweed to begin elaborating toxin as a method of protection (*5*) and that environmental changes and increased pollution promote colonization of toxin-producing bacteria.

State and local health departments should inform persons who may eat seaweed that seaweed consumption can be associated with illness and that varieties previously consumed with safety may undergo changes that increase their potential for causing illness. Episodes of seaweed-related illness should be reported promptly to state and local health departments.

*References*

1. Noguchi T, Matsui T, Miyazawa K. Poisoning by the red alga 'Ogonori' (*Gracilaria verrucosa*) on the Nojima Coast, Yokohama, Kanagawa Prefecture, Japan. Toxicon 1994;32:1533–8.
2. Yasumoto T. Guam seaweed poisoning: biochemistry of the *Grasilaria* toxin. Micronesica 1993;26:53–7.
3. Haddock R. Guam seaweed poisoning: food histories. Micron 1993;26:35–8.
4. Snyder B. Seaweed suspect in poisoning of Livermore family. Oakland Tribune, Nov 2, 1992: 1(col 1).
5. Meyer KD, Paul V. Intraplant variation in secondary metabolite concentration in three species of Caulerpa (Chlorophyta: Caulerpales) and its effects on herbivorous fishes. Marine Ecology Progress Series 1992;82:249–57.

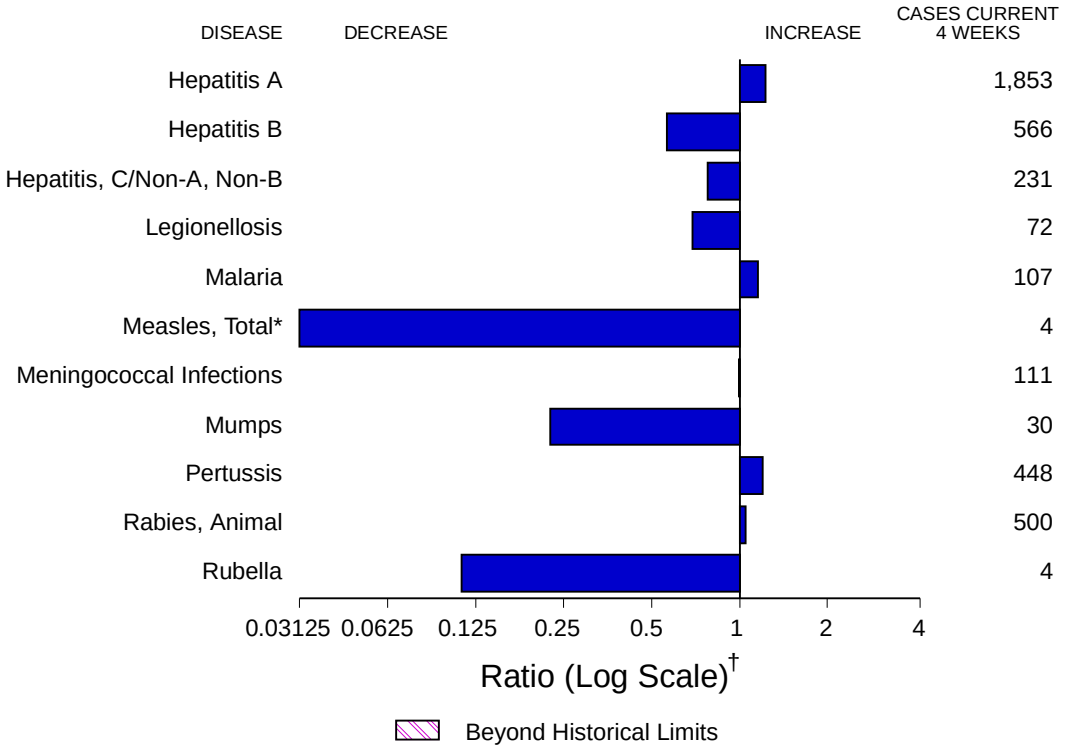
## Acute Lower Respiratory Tract Illness in Illicit Drug Users — South Carolina, 1995

On July 31, 1995, the South Carolina Department of Health and Environmental Control was notified of a cluster of five patients with acute, severe lower respiratory illnesses among previously healthy residents of a small rural community in Berkeley County (1990 population: 128,776). All five patients were users of illicit drugs. This report summarizes the preliminary findings of an investigation initiated to describe the clinical features and epidemiology of this syndrome and to determine an etiology.

Based on information about the five cases obtained from interviews with the patients and reviews of records, a case was defined as an unexplained acute, severe respiratory illness in a previously healthy person aged <65 years characterized by shortness of breath and/or pleuritic pain with onset of symptoms during July 15–31. One additional case was identified by contacting local physicians, intensive-care units, and pulmonary and infectious disease specialists. No cases of similar acute respiratory illness were noted in household contacts of patients.

*(Continued on page 733)*

**FIGURE I. Notifiable disease reports, comparison of 4-week totals ending September 30, 1995, with historical data — United States**




*The large apparent decrease in the number of reported cases of measles (total) reflects dramatic fluctuations in the historical baseline.

†Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

**TABLE I. Summary — cases of specified notifiable diseases, United States, cumulative, week ending September 30, 1995 (39th Week)**

| | Cum. 1995 | | Cum. 1995 |
|---|---|---|---|
| Anthrax | - | Psittacosis | 50 |
| Brucellosis | 69 | Rabies, human | 1 |
| Cholera | 13 | Rocky Mountain Spotted Fever | 444 |
| Congenital rubella syndrome | 4 | Syphilis, congenital, age < 1 year† | 280 |
| Diphtheria | - | Tetanus | 22 |
| *Haemophilus influenzae** | 875 | Toxic shock syndrome | 140 |
| Hansen Disease | 101 | Trichinosis | 24 |
| Plague | 6 | Typhoid fever | 236 |
| Poliomyelitis, Paralytic | - | | |

*Of 856 cases of known age, 204 (24%) were reported among children less than 5 years of age.
†Updated quarterly from reports to the Division of STD Prevention, National Center for Prevention Services. This total through second quarter 1995.
-: no reported cases

# TABLE II. Cases of selected notifiable diseases, United States, weeks ending September 30, 1995, and October 1, 1994 (39th Week)

| Reporting Area | AIDS* | Gonorrhea | | Hepatitis (Viral), by type | | | | | | Legionellosis | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | A | | B | | C/NA,NB | | | |
| | Cum. 1995 | Cum. 1995 | Cum. 1994 | Cum. 1995 | Cum. 1994 | Cum. 1995 | Cum. 1994 | Cum. 1995 | Cum. 1994 | Cum. 1995 | Cum. 1994 |
| UNITED STATES | 54,704 | 257,118 | 302,033 | 20,137 | 18,077 | 7,289 | 8,571 | 3,173 | 3,124 | 924 | 1,176 |
| NEW ENGLAND | 2,653 | 4,313 | 6,340 | 211 | 223 | 163 | 259 | 89 | 116 | 23 | 58 |
| Maine | 81 | 63 | 66 | 23 | 20 | 7 | 11 | - | - | 5 | 4 |
| N.H. | 77 | 89 | 82 | 8 | 16 | 18 | 20 | 12 | 9 | 1 | - |
| Vt. | 30 | 46 | 23 | 5 | 8 | 1 | 6 | 1 | 12 | - | - |
| Mass. | 1,137 | 2,140 | 2,368 | 88 | 83 | 63 | 150 | 71 | 75 | 14 | 38 |
| R.I. | 192 | 400 | 355 | 25 | 19 | 8 | 6 | 5 | 20 | 3 | 16 |
| Conn. | 1,136 | 1,575 | 3,446 | 62 | 77 | 66 | 66 | - | - | N | N |
| MID. ATLANTIC | 14,696 | 25,277 | 34,101 | 1,186 | 1,278 | 909 | 1,113 | 311 | 362 | 146 | 181 |
| Upstate N.Y. | 1,736 | 3,846 | 8,044 | 314 | 438 | 296 | 293 | 167 | 174 | 39 | 44 |
| N.Y. City | 7,624 | 8,598 | 12,893 | 566 | 483 | 279 | 249 | 1 | 1 | 3 | 5 |
| N.J. | 3,575 | 3,256 | 3,922 | 140 | 228 | 190 | 287 | 108 | 157 | 21 | 34 |
| Pa. | 1,761 | 9,577 | 9,242 | 166 | 129 | 144 | 284 | 35 | 30 | 83 | 98 |
| E.N. CENTRAL | 4,122 | 56,160 | 60,894 | 2,188 | 1,793 | 709 | 882 | 210 | 261 | 247 | 338 |
| Ohio | 852 | 16,430 | 16,437 | 1,425 | 652 | 85 | 129 | 8 | 18 | 124 | 159 |
| Ind. | 429 | 6,182 | 6,511 | 132 | 297 | 179 | 161 | 6 | 8 | 59 | 36 |
| Ill. | 1,736 | 15,964 | 18,586 | 217 | 450 | 94 | 230 | 33 | 71 | 13 | 31 |
| Mich. | 825 | 13,285 | 13,541 | 279 | 215 | 310 | 287 | 163 | 164 | 24 | 59 |
| Wis. | 280 | 4,299 | 5,819 | 135 | 179 | 41 | 75 | - | - | 27 | 53 |
| W.N. CENTRAL | 1,266 | 14,719 | 16,922 | 1,417 | 910 | 454 | 499 | 95 | 69 | 90 | 79 |
| Minn. | 285 | 2,133 | 2,463 | 144 | 168 | 44 | 46 | 2 | 14 | 5 | 2 |
| Iowa | 71 | 1,151 | 1,094 | 50 | 47 | 33 | 24 | 11 | 9 | 17 | 28 |
| Mo. | 564 | 8,493 | 9,341 | 1,014 | 464 | 316 | 374 | 55 | 18 | 44 | 26 |
| N. Dak. | 6 | 20 | 32 | 23 | 5 | 4 | - | 8 | 1 | 4 | 4 |
| S. Dak. | 15 | 127 | 166 | 49 | 31 | 2 | 2 | 1 | - | 3 | 1 |
| Nebr. | 84 | 697 | 1,030 | 34 | 104 | 22 | 24 | 6 | 11 | 10 | 13 |
| Kans. | 241 | 2,098 | 2,796 | 103 | 91 | 33 | 29 | 12 | 16 | 7 | 5 |
| S. ATLANTIC | 14,155 | 75,291 | 80,057 | 938 | 936 | 1,043 | 1,568 | 251 | 335 | 167 | 285 |
| Del. | 241 | 1,670 | 1,451 | 7 | 21 | 2 | 12 | 1 | 1 | 2 | 31 |
| Md. | 2,250 | 7,471 | 14,100 | 166 | 136 | 198 | 261 | 4 | 17 | 27 | 65 |
| D.C. | 827 | 3,483 | 5,411 | 19 | 17 | 15 | 40 | - | 1 | 4 | 6 |
| Va. | 1,082 | 7,962 | 9,983 | 159 | 133 | 89 | 101 | 14 | 20 | 15 | 6 |
| W. Va. | 86 | 507 | 603 | 17 | 15 | 41 | 31 | 43 | 24 | 4 | 3 |
| N.C. | 816 | 18,048 | 20,525 | 88 | 100 | 224 | 216 | 46 | 50 | 31 | 19 |
| S.C. | 766 | 9,333 | 9,929 | 38 | 31 | 37 | 25 | 17 | 7 | 29 | 12 |
| Ga. | 1,784 | 11,257 | U | 55 | 26 | 63 | 516 | 15 | 171 | 23 | 100 |
| Fla. | 6,303 | 15,560 | 18,055 | 389 | 457 | 374 | 366 | 111 | 44 | 32 | 43 |
| E.S. CENTRAL | 1,763 | 31,492 | 35,469 | 1,193 | 474 | 624 | 887 | 753 | 716 | 43 | 71 |
| Ky. | 221 | 3,684 | 3,736 | 32 | 124 | 52 | 66 | 22 | 23 | 10 | 8 |
| Tenn. | 709 | 10,215 | 11,460 | 956 | 212 | 488 | 761 | 729 | 678 | 24 | 36 |
| Ala. | 484 | 12,798 | 12,079 | 69 | 77 | 84 | 60 | 2 | 15 | 6 | 12 |
| Miss. | 349 | 4,795 | 8,194 | 136 | 61 | - | - | - | - | 3 | 15 |
| W.S. CENTRAL | 4,691 | 23,326 | 36,232 | 3,018 | 2,340 | 1,245 | 957 | 508 | 249 | 12 | 35 |
| Ark. | 209 | 2,350 | 5,075 | 343 | 151 | 36 | 22 | 4 | 7 | 1 | 6 |
| La. | 785 | 8,475 | 9,072 | 94 | 120 | 152 | 133 | 132 | 139 | 2 | 12 |
| Okla. | 206 | 1,496 | 3,696 | 661 | 228 | 376 | 105 | 323 | 46 | 3 | 11 |
| Tex. | 3,491 | 11,005 | 18,389 | 1,920 | 1,841 | 681 | 697 | 49 | 57 | 6 | 6 |
| MOUNTAIN | 1,716 | 6,563 | 7,566 | 3,006 | 3,535 | 586 | 503 | 341 | 348 | 88 | 73 |
| Mont. | 17 | 55 | 71 | 100 | 18 | 19 | 18 | 12 | 10 | 4 | 14 |
| Idaho | 38 | 93 | 68 | 244 | 266 | 64 | 67 | 41 | 64 | 2 | 1 |
| Wyo. | 12 | 42 | 66 | 90 | 23 | 16 | 21 | 137 | 128 | 8 | 4 |
| Colo. | 523 | 2,176 | 2,632 | 409 | 388 | 93 | 78 | 54 | 58 | 33 | 15 |
| N. Mex. | 137 | 763 | 760 | 620 | 857 | 223 | 161 | 39 | 43 | 4 | 3 |
| Ariz. | 545 | 2,522 | 2,474 | 869 | 1,395 | 90 | 53 | 35 | 17 | 9 | 9 |
| Utah | 112 | 131 | 195 | 555 | 404 | 54 | 60 | 9 | 15 | 13 | 6 |
| Nev. | 332 | 781 | 1,300 | 119 | 184 | 27 | 45 | 14 | 13 | 15 | 21 |
| PACIFIC | 9,642 | 19,977 | 24,452 | 6,980 | 6,588 | 1,556 | 1,903 | 615 | 668 | 108 | 56 |
| Wash. | 717 | 1,957 | 2,214 | 593 | 850 | 137 | 177 | 152 | 193 | 20 | 10 |
| Oreg. | 347 | 224 | 764 | 1,486 | 764 | 62 | 117 | 29 | 32 | - | - |
| Calif. | 8,328 | 16,821 | 20,224 | 4,738 | 4,758 | 1,335 | 1,573 | 395 | 438 | 83 | 44 |
| Alaska | 60 | 544 | 695 | 40 | 176 | 9 | 12 | 1 | - | - | - |
| Hawaii | 190 | 431 | 555 | 123 | 40 | 13 | 24 | 38 | 5 | 5 | 2 |
| Guam | - | 58 | 97 | 2 | 22 | 1 | 4 | - | - | 1 | 1 |
| P.R. | 1,925 | 446 | 382 | 81 | 47 | 452 | 270 | 177 | 133 | - | - |
| V.I. | 27 | 6 | 25 | - | 3 | 2 | 7 | - | 1 | - | - |
| Amer. Samoa | - | 19 | 25 | 6 | 8 | - | - | - | - | - | - |
| C.N.M.I. | - | 23 | 41 | 15 | 6 | 7 | 1 | - | - | - | - |

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

*Updated monthly to the Division of HIV/AIDS Prevention, National Center for Prevention Services, last update September 28, 1995.

## TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending September 30, 1995, and October 1, 1994 (39th Week)

| Reporting Area | Lyme Disease | | Malaria | | Measles (Rubeola) | | | | | | Meningococcal Infections | | Mumps | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Indigenous | | Imported* | | Total | | | | | |
| | Cum. 1995 | Cum. 1994 | Cum. 1995 | Cum. 1994 | 1995 | Cum. 1995 | 1995 | Cum. 1995 | Cum. 1995 | Cum. 1994 | Cum. 1995 | Cum. 1994 | Cum. 1995 | Cum. 1994 |
| UNITED STATES | 6,197 | 9,264 | 883 | 807 | - | 241 | 1 | 24 | 265 | 860 | 2,275 | 2,083 | 603 | 1,097 |
| NEW ENGLAND | 1,559 | 2,185 | 37 | 59 | - | 6 | 1 | 2 | 8 | 27 | 104 | 100 | 10 | 19 |
| Maine | 16 | 18 | 5 | 4 | - | - | - | - | - | 5 | 8 | 19 | 4 | 3 |
| N.H. | 19 | 22 | 1 | 3 | - | - | - | - | - | 1 | 19 | 8 | 1 | 4 |
| Vt. | 8 | 14 | 1 | 3 | - | - | - | - | - | 3 | 8 | 2 | - | - |
| Mass. | 141 | 145 | 12 | 27 | - | 1 | - | 1 | 2 | 7 | 37 | 44 | 2 | 3 |
| R.I. | 279 | 312 | 4 | 7 | - | 5 | - | - | 5 | 7 | - | - | 1 | 2 |
| Conn. | 1,096 | 1,674 | 14 | 15 | - | - | 1 | 1 | 1 | 4 | 32 | 27 | 2 | 7 |
| MID. ATLANTIC | 3,750 | 5,549 | 236 | 160 | - | 7 | - | 5 | 12 | 212 | 269 | 223 | 93 | 93 |
| Upstate N.Y. | 1,904 | 3,560 | 52 | 43 | - | 1 | - | - | 1 | 17 | 82 | 73 | 24 | 27 |
| N.Y. City | 153 | 14 | 117 | 58 | - | 2 | - | 3 | 5 | 14 | 35 | 28 | 13 | 7 |
| N.J. | 770 | 1,074 | 50 | 35 | - | 4 | - | 2 | 6 | 173 | 74 | 49 | 12 | 13 |
| Pa. | 923 | 901 | 17 | 24 | - | - | - | - | - | 8 | 78 | 73 | 44 | 46 |
| E.N. CENTRAL | 64 | 463 | 83 | 88 | - | 7 | - | 3 | 10 | 102 | 315 | 307 | 104 | 186 |
| Ohio | 42 | 32 | 9 | 14 | - | 1 | - | - | 1 | 17 | 92 | 88 | 33 | 50 |
| Ind. | 14 | 15 | 14 | 12 | - | - | - | - | - | 1 | 59 | 40 | 4 | 7 |
| Ill. | 3 | 23 | 32 | 40 | - | - | - | 2 | 2 | 56 | 71 | 99 | 31 | 84 |
| Mich. | 5 | 5 | 15 | 19 | - | 4 | - | 1 | 5 | 25 | 56 | 46 | 36 | 35 |
| Wis. | - | 388 | 13 | 3 | - | 2 | - | - | 2 | 3 | 37 | 34 | - | 10 |
| W.N. CENTRAL | 180 | 214 | 19 | 35 | - | 2 | - | - | 2 | 170 | 149 | 134 | 30 | 56 |
| Minn. | 117 | 106 | 4 | 11 | - | - | - | - | - | - | 24 | 12 | 2 | 4 |
| Iowa | 10 | 13 | 1 | 5 | - | - | - | - | - | 7 | 26 | 18 | - | 13 |
| Mo. | 34 | 84 | 6 | 11 | - | 1 | - | - | 1 | 160 | 61 | 65 | 22 | 34 |
| N. Dak. | - | - | 1 | 1 | - | - | - | - | - | - | 1 | 1 | 1 | 4 |
| S. Dak. | - | - | 2 | - | - | - | - | - | - | - | 5 | 8 | - | - |
| Nebr. | 1 | 3 | 3 | 4 | - | - | - | - | - | 2 | 12 | 10 | 4 | 1 |
| Kans. | 18 | 8 | 2 | 3 | - | 1 | - | - | 1 | 1 | 20 | 20 | 1 | - |
| S. ATLANTIC | 431 | 648 | 187 | 162 | - | 10 | - | 1 | 11 | 62 | 409 | 305 | 88 | 157 |
| Del. | 7 | 101 | 1 | 3 | - | - | - | - | - | - | 6 | 5 | - | - |
| Md. | 267 | 209 | 52 | 57 | - | - | - | 1 | 1 | 4 | 30 | 26 | 20 | 44 |
| D.C. | 1 | 6 | 15 | 12 | - | - | - | - | - | - | 3 | 4 | - | - |
| Va. | 47 | 116 | 41 | 23 | - | - | - | - | - | 3 | 51 | 55 | 20 | 38 |
| W. Va. | 22 | 17 | 2 | - | - | - | - | - | - | 37 | 8 | 12 | - | 3 |
| N.C. | 47 | 69 | 15 | 9 | - | - | - | - | - | 3 | 64 | 42 | 16 | 35 |
| S.C. | 16 | 7 | 1 | 4 | - | - | - | - | - | - | 53 | 21 | 9 | 7 |
| Ga. | 12 | 109 | 22 | 29 | - | 2 | - | - | 2 | 3 | 80 | 66 | 8 | 8 |
| Fla. | 12 | 14 | 38 | 25 | - | 8 | - | - | 8 | 12 | 114 | 74 | 15 | 22 |
| E.S. CENTRAL | 40 | 37 | 20 | 29 | - | - | - | - | - | 28 | 144 | 148 | 13 | 18 |
| Ky. | 8 | 21 | 2 | 10 | - | - | - | - | - | - | 46 | 33 | - | - |
| Tenn. | 20 | 10 | 7 | 9 | - | - | - | - | - | 28 | 37 | 28 | - | 6 |
| Ala. | 7 | 6 | 8 | 9 | - | - | - | - | - | - | 32 | 57 | 4 | 5 |
| Miss. | 5 | - | 3 | 1 | - | - | - | - | - | - | 29 | 30 | 9 | 7 |
| W.S. CENTRAL | 84 | 97 | 39 | 36 | - | 21 | - | 3 | 24 | 16 | 281 | 247 | 39 | 196 |
| Ark. | 5 | 8 | 3 | 3 | - | 2 | - | - | 2 | 1 | 22 | 38 | 3 | 5 |
| La. | 4 | 1 | 4 | 6 | - | 17 | - | 1 | 18 | 1 | 39 | 31 | 9 | 23 |
| Okla. | 36 | 54 | 1 | 4 | U | - | U | - | - | - | 26 | 24 | - | 23 |
| Tex. | 39 | 34 | 31 | 23 | - | 2 | - | 2 | 4 | 14 | 194 | 154 | 27 | 145 |
| MOUNTAIN | 7 | 12 | 46 | 25 | - | 67 | - | 1 | 68 | 163 | 158 | 140 | 24 | 132 |
| Mont. | - | - | 3 | - | - | - | - | - | - | - | 2 | 6 | 1 | - |
| Idaho | - | 3 | 1 | 2 | - | - | - | - | - | - | 7 | 15 | 3 | 7 |
| Wyo. | 3 | 3 | - | 1 | - | - | - | - | - | - | 7 | 6 | - | 2 |
| Colo. | - | 1 | 22 | 11 | - | 26 | - | - | 26 | 19 | 42 | 27 | 1 | 3 |
| N. Mex. | 1 | 3 | 4 | 3 | - | 30 | - | 1 | 31 | - | 31 | 13 | N | N |
| Ariz. | - | - | 7 | 2 | - | 10 | - | - | 10 | 1 | 48 | 48 | 2 | 94 |
| Utah | 1 | 1 | 5 | 4 | - | - | - | - | - | 134 | 14 | 18 | 11 | 14 |
| Nev. | 2 | 1 | 4 | 2 | - | 1 | - | - | 1 | 9 | 7 | 7 | 6 | 12 |
| PACIFIC | 82 | 59 | 216 | 213 | - | 121 | - | 9 | 130 | 80 | 446 | 479 | 202 | 240 |
| Wash. | 10 | 1 | 16 | 23 | - | 16 | - | 4 | 20 | 3 | 73 | 75 | 10 | 14 |
| Oreg. | 4 | 6 | 9 | 14 | - | - | - | 1 | 1 | 2 | 70 | 106 | N | N |
| Calif. | 68 | 52 | 179 | 162 | - | 105 | - | 3 | 108 | 61 | 291 | 291 | 174 | 207 |
| Alaska | - | - | 2 | 2 | - | - | - | - | - | 10 | 8 | 2 | 13 | 3 |
| Hawaii | - | - | 10 | 12 | - | - | - | 1 | 1 | 4 | 4 | 5 | 5 | 16 |
| Guam | - | - | - | - | U | - | U | - | - | 228 | 3 | - | 3 | 6 |
| P.R. | - | - | 1 | 4 | - | 11 | - | - | 11 | 11 | 23 | 6 | 2 | 2 |
| V.I. | - | - | - | - | U | - | U | - | - | - | - | - | 2 | 4 |
| Amer. Samoa | - | - | - | - | U | - | U | - | - | - | - | - | - | 2 |
| C.N.M.I. | - | - | 1 | 1 | U | - | U | - | - | 29 | - | - | - | 2 |

*For imported measles, cases include only those resulting from importation from other countries.
N: Not notifiable U: Unavailable -: no reported cases

## TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending September 30, 1995, and October 1, 1994 (39th Week)

| Reporting Area | Pertussis | | | Rubella | | | Syphilis (Primary & Secondary) | | Tuberculosis | | Rabies, Animal | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1995 | Cum. 1995 | Cum. 1994 | 1995 | Cum. 1995 | Cum. 1994 | Cum. 1995 | Cum. 1994 | Cum. 1995 | Cum. 1994 | Cum. 1995 | Cum. 1994 |
| UNITED STATES | 90 | 2,849 | 2,924 | 1 | 117 | 208 | 11,213 | 16,003 | 14,466 | 16,433 | 5,298 | 5,764 |
| NEW ENGLAND | 22 | 379 | 341 | - | 34 | 128 | 139 | 169 | 380 | 379 | 1,195 | 1,415 |
| Maine | 1 | 27 | 15 | - | 1 | - | 2 | 4 | 12 | 23 | 39 | - |
| N.H. | 3 | 31 | 66 | - | 1 | - | 1 | 4 | 15 | 13 | 120 | 118 |
| Vt. | - | 59 | 38 | - | - | - | - | - | 3 | 6 | 141 | 107 |
| Mass. | 8 | 238 | 190 | - | 7 | 124 | 46 | 73 | 208 | 194 | 360 | 541 |
| R.I. | - | 2 | 5 | - | - | 2 | 3 | 12 | 38 | 35 | 260 | 40 |
| Conn. | 10 | 22 | 27 | - | 25 | 2 | 87 | 76 | 104 | 108 | 275 | 609 |
| MID. ATLANTIC | 12 | 250 | 458 | - | 12 | 6 | 626 | 1,070 | 3,011 | 3,356 | 995 | 1,529 |
| Upstate N.Y. | 9 | 126 | 191 | - | 4 | 5 | 43 | 143 | 368 | 424 | 367 | 1,136 |
| N.Y. City | - | 21 | 84 | - | 7 | - | 287 | 471 | 1,600 | 1,944 | - | - |
| N.J. | - | 13 | 12 | - | 1 | 1 | 129 | 172 | 573 | 577 | 275 | 214 |
| Pa. | 3 | 90 | 171 | - | - | - | 167 | 284 | 470 | 411 | 353 | 179 |
| E.N. CENTRAL | 10 | 270 | 432 | - | 4 | 9 | 1,981 | 2,377 | 1,442 | 1,564 | 68 | 52 |
| Ohio | 3 | 111 | 116 | - | - | - | 664 | 905 | 201 | 261 | 10 | 4 |
| Ind. | 1 | 19 | 47 | - | - | - | 214 | 194 | 176 | 142 | 12 | 12 |
| Ill. | 4 | 67 | 89 | - | 1 | 1 | 743 | 802 | 711 | 777 | 3 | 17 |
| Mich. | 2 | 61 | 47 | - | 3 | 8 | 228 | 229 | 299 | 338 | 35 | 11 |
| Wis. | - | 12 | 133 | - | - | - | 132 | 247 | 55 | 46 | 8 | 8 |
| W.N. CENTRAL | - | 180 | 132 | - | - | 2 | 596 | 935 | 438 | 432 | 265 | 167 |
| Minn. | - | 88 | 51 | - | - | - | 34 | 37 | 100 | 97 | 19 | 14 |
| Iowa | - | - | 9 | - | - | - | 37 | 49 | 48 | 44 | 90 | 68 |
| Mo. | - | 43 | 35 | - | - | 2 | 490 | 796 | 166 | 194 | 19 | 18 |
| N. Dak. | - | 8 | 4 | - | - | - | - | 1 | 3 | 8 | 24 | 10 |
| S. Dak. | - | 11 | 15 | - | - | - | - | 1 | 20 | 21 | 72 | 29 |
| Nebr. | - | 8 | 8 | - | - | - | 9 | 11 | 20 | 16 | 5 | - |
| Kans. | - | 22 | 10 | - | - | - | 26 | 40 | 81 | 52 | 36 | 28 |
| S. ATLANTIC | 28 | 276 | 257 | - | 26 | 15 | 2,864 | 4,172 | 2,503 | 2,975 | 1,625 | 1,533 |
| Del. | - | 10 | 2 | - | - | - | 11 | 22 | 42 | 32 | 74 | 44 |
| Md. | 1 | 28 | 58 | - | - | - | 137 | 229 | 241 | 240 | 265 | 419 |
| D.C. | - | 5 | 7 | - | - | - | 84 | 172 | 82 | 95 | 11 | 2 |
| Va. | - | 15 | 30 | - | - | - | 476 | 614 | 167 | 255 | 320 | 313 |
| W. Va. | - | - | 4 | - | - | - | 9 | 8 | 56 | 61 | 94 | 61 |
| N.C. | 26 | 110 | 58 | - | 1 | - | 862 | 1,292 | 333 | 366 | 366 | 130 |
| S.C. | - | 20 | 12 | - | 1 | - | 456 | 622 | 234 | 287 | 100 | 142 |
| Ga. | - | 24 | 24 | - | 1 | 2 | 544 | 635 | 323 | 526 | 204 | 296 |
| Fla. | 1 | 64 | 62 | - | 23 | 13 | 285 | 578 | 1,025 | 1,113 | 191 | 126 |
| E.S. CENTRAL | - | 253 | 119 | - | - | - | 2,908 | 2,917 | 1,133 | 1,148 | 222 | 156 |
| Ky. | - | 11 | 58 | - | - | - | 156 | 156 | 232 | 242 | 23 | 19 |
| Tenn. | - | 204 | 18 | - | - | - | 658 | 796 | 294 | 378 | 72 | 34 |
| Ala. | - | 35 | 31 | - | - | - | 507 | 522 | 319 | 314 | 118 | 99 |
| Miss. | - | 3 | 12 | N | N | N | 1,587 | 1,443 | 288 | 214 | 9 | 4 |
| W.S. CENTRAL | 4 | 227 | 151 | - | 7 | 13 | 1,426 | 3,465 | 1,743 | 2,079 | 527 | 517 |
| Ark. | - | 28 | 22 | - | - | - | 82 | 388 | 113 | 204 | 21 | 25 |
| La. | 2 | 15 | 10 | - | - | - | 774 | 1,346 | 6 | 11 | 25 | 55 |
| Okla. | U | 14 | 22 | U | - | 4 | 54 | 123 | 146 | 193 | 31 | 30 |
| Tex. | 2 | 170 | 97 | - | 7 | 9 | 516 | 1,608 | 1,478 | 1,671 | 450 | 407 |
| MOUNTAIN | 13 | 421 | 377 | - | 5 | 5 | 201 | 206 | 464 | 421 | 145 | 123 |
| Mont. | - | 3 | 6 | - | - | - | 4 | 3 | 10 | 9 | 41 | 15 |
| Idaho | 1 | 81 | 44 | - | - | - | - | 1 | 12 | 11 | 3 | 3 |
| Wyo. | - | 1 | - | - | 1 | - | 4 | - | 2 | 7 | 22 | 17 |
| Colo. | 9 | 77 | 185 | - | - | - | 95 | 107 | 37 | 51 | 9 | 11 |
| N. Mex. | 3 | 86 | 20 | - | - | - | 33 | 18 | 64 | 43 | 5 | 6 |
| Ariz. | - | 149 | 97 | - | 3 | - | 33 | 39 | 234 | 168 | 45 | 51 |
| Utah | - | 19 | 23 | - | 1 | 4 | 4 | 10 | 24 | 38 | 14 | 12 |
| Nev. | - | 5 | 2 | - | - | 1 | 28 | 28 | 81 | 94 | 6 | 8 |
| PACIFIC | 1 | 593 | 657 | 1 | 29 | 30 | 472 | 692 | 3,352 | 4,079 | 256 | 272 |
| Wash. | - | 206 | 91 | - | 2 | - | 11 | 29 | 181 | 207 | 5 | 15 |
| Oreg. | 1 | 27 | 86 | - | 1 | 4 | 7 | 30 | 33 | 90 | - | 9 |
| Calif. | - | 319 | 465 | 1 | 23 | 22 | 453 | 627 | 2,951 | 3,543 | 247 | 215 |
| Alaska | - | - | - | - | - | - | 1 | 3 | 59 | 51 | 4 | 33 |
| Hawaii | - | 41 | 15 | - | 3 | 4 | - | 3 | 128 | 188 | - | - |
| Guam | U | - | 2 | U | - | 1 | 5 | 3 | 35 | 62 | - | - |
| P.R. | - | 12 | 2 | - | - | - | 231 | 242 | 165 | 150 | 44 | 67 |
| V.I. | U | - | - | U | - | - | 2 | 25 | - | - | - | - |
| Amer. Samoa | U | - | 1 | U | - | - | - | 1 | 3 | 4 | - | - |
| C.N.M.I. | U | - | - | U | - | - | 4 | 1 | 13 | 25 | - | - |

U: Unavailable -: no reported cases

# TABLE III. Deaths in 121 U.S. cities,* week ending September 30, 1995 (39th Week)

| Reporting Area | All Causes, By Age (Years) | | | | | | P&I† Total |
|---|---|---|---|---|---|---|---|
| | All Ages | ≥65 | 45-64 | 25-44 | 1-24 | <1 | |
| NEW ENGLAND | 569 | 389 | 94 | 58 | 13 | 15 | 31 |
| Boston, Mass. | 141 | 84 | 33 | 15 | 4 | 5 | 7 |
| Bridgeport, Conn. | 32 | 17 | 5 | 5 | 3 | 2 | - |
| Cambridge, Mass. | 19 | 15 | 1 | 2 | - | 1 | 1 |
| Fall River, Mass. | 25 | 18 | 7 | - | - | - | - |
| Hartford, Conn. | 46 | 31 | 7 | 6 | 2 | - | 3 |
| Lowell, Mass. | 23 | 18 | 3 | 2 | - | - | 1 |
| Lynn, Mass. | 19 | 15 | 3 | 1 | - | - | - |
| New Bedford, Mass. | 28 | 21 | 3 | 2 | - | 2 | 1 |
| New Haven, Conn. | 29 | 19 | 5 | 2 | 2 | 1 | - |
| Providence, R.I. | 54 | 36 | 9 | 7 | 1 | 1 | 5 |
| Somerville, Mass. | 5 | 5 | - | - | - | - | - |
| Springfield, Mass. | 49 | 36 | 4 | 8 | - | 1 | 6 |
| Waterbury, Conn. | 42 | 34 | 4 | 3 | - | 1 | 3 |
| Worcester, Mass. | 57 | 40 | 10 | 5 | 1 | 1 | 4 |
| MID. ATLANTIC | 2,426 | 1,629 | 410 | 302 | 49 | 36 | 124 |
| Albany, N.Y. | 52 | 43 | 4 | 3 | 1 | 1 | 4 |
| Allentown, Pa. | 21 | 15 | 6 | - | - | - | 1 |
| Buffalo, N.Y. | 113 | 80 | 16 | 13 | 4 | - | 4 |
| Camden, N.J. | 28 | 17 | 4 | 6 | 1 | - | 2 |
| Elizabeth, N.J. | 21 | 16 | 4 | 1 | - | - | 1 |
| Erie, Pa.§ | 42 | 35 | 3 | 3 | 1 | - | 2 |
| Jersey City, N.J. | 31 | 17 | 12 | 1 | 1 | - | - |
| New York City, N.Y. | 1,243 | 808 | 212 | 185 | 24 | 14 | 49 |
| Newark, N.J. | 59 | 28 | 16 | 13 | 2 | - | 2 |
| Paterson, N.J. | U | U | U | U | U | U | U |
| Philadelphia, Pa. | 398 | 257 | 71 | 48 | 8 | 14 | 20 |
| Pittsburgh, Pa.§ | 84 | 64 | 15 | 1 | 2 | 2 | 6 |
| Reading, Pa. | 15 | 11 | 4 | - | - | - | 2 |
| Rochester, N.Y. | 116 | 89 | 13 | 8 | 5 | 1 | 15 |
| Schenectady, N.Y. | 17 | 15 | 2 | - | - | - | 1 |
| Scranton, Pa.§ | 23 | 18 | 2 | 3 | - | - | - |
| Syracuse, N.Y. | 79 | 59 | 12 | 5 | - | 3 | 5 |
| Trenton, N.J. | 36 | 20 | 5 | 11 | - | - | 4 |
| Utica, N.Y. | 23 | 16 | 7 | - | - | - | 2 |
| Yonkers, N.Y. | 25 | 21 | 2 | 1 | - | 1 | 4 |
| E.N. CENTRAL | 2,306 | 1,486 | 457 | 213 | 66 | 66 | 124 |
| Akron, Ohio | 36 | 23 | 9 | 2 | 1 | 1 | - |
| Canton, Ohio | 44 | 33 | 9 | 2 | - | - | 1 |
| Chicago, Ill. | 495 | 267 | 106 | 76 | 22 | 22 | 21 |
| Cincinnati, Ohio | 192 | 132 | 32 | 20 | 3 | 5 | 10 |
| Cleveland, Ohio | 153 | 93 | 32 | 15 | 7 | 6 | 3 |
| Columbus, Ohio | 184 | 117 | 49 | 11 | 4 | 3 | 20 |
| Dayton, Ohio | 126 | 91 | 27 | 3 | 3 | 2 | 8 |
| Detroit, Mich. | 227 | 129 | 55 | 27 | 10 | 6 | 7 |
| Evansville, Ind. | 45 | 31 | 10 | 1 | 1 | 2 | 2 |
| Fort Wayne, Ind. | 62 | 41 | 5 | - | - | - | - |
| Gary, Ind. | 8 | 6 | 2 | - | - | - | - |
| Grand Rapids, Mich. | 52 | 39 | 10 | 1 | 1 | 1 | 2 |
| Indianapolis, Ind. | 242 | 160 | 44 | 22 | 5 | 11 | 12 |
| Madison, Wis. | 55 | 43 | 7 | 3 | - | 2 | 2 |
| Milwaukee, Wis. | 119 | 93 | 12 | 12 | 1 | 1 | 12 |
| Peoria, Ill. | 39 | 21 | 12 | 2 | 2 | 2 | 3 |
| Rockford, Ill. | 47 | 30 | 8 | 8 | 1 | - | 9 |
| South Bend, Ind. | 37 | 32 | 2 | 1 | 2 | - | 5 |
| Toledo, Ohio | 84 | 58 | 16 | 7 | 1 | 2 | 6 |
| Youngstown, Ohio | 59 | 47 | 10 | - | 2 | - | 1 |
| W.N. CENTRAL | 733 | 519 | 105 | 59 | 25 | 12 | 36 |
| Des Moines, Iowa | 52 | 32 | 15 | 4 | 1 | - | 4 |
| Duluth, Minn. | 38 | 31 | 3 | 4 | - | - | 1 |
| Kansas City, Kans. | 30 | 24 | 1 | 3 | 2 | - | - |
| Kansas City, Mo. | 107 | 60 | 16 | 10 | 5 | 3 | 6 |
| Lincoln, Nebr. | 33 | 27 | 4 | 1 | - | 1 | 2 |
| Minneapolis, Minn. | 140 | 106 | 19 | 8 | 3 | 4 | 13 |
| Omaha, Nebr. | 83 | 61 | 12 | 7 | 3 | - | 5 |
| St. Louis, Mo. | 115 | 82 | 15 | 12 | 6 | - | 2 |
| St. Paul, Minn. | 52 | 46 | 2 | 2 | - | 2 | 2 |
| Wichita, Kans. | 83 | 50 | 18 | 8 | 5 | 2 | 1 |

| Reporting Area | All Causes, By Age (Years) | | | | | | P&I† Total |
|---|---|---|---|---|---|---|---|
| | All Ages | ≥65 | 45-64 | 25-44 | 1-24 | <1 | |
| S. ATLANTIC | 1,394 | 841 | 301 | 180 | 43 | 29 | 70 |
| Atlanta, Ga. | 178 | 104 | 38 | 24 | 6 | 6 | 6 |
| Baltimore, Md. | 280 | 157 | 59 | 51 | 6 | 7 | 25 |
| Charlotte, N.C. | 88 | 55 | 16 | 14 | 2 | 1 | 1 |
| Jacksonville, Fla. | 121 | 76 | 25 | 17 | 3 | - | 5 |
| Miami, Fla. | 135 | 79 | 35 | 17 | 2 | 2 | 1 |
| Norfolk, Va. | 35 | 24 | 4 | 3 | 1 | 3 | 2 |
| Richmond, Va. | 89 | 57 | 22 | 3 | 3 | 4 | 2 |
| Savannah, Ga. | 62 | 46 | 13 | - | 3 | - | 6 |
| St. Petersburg, Fla. | 51 | 38 | 7 | 4 | 1 | 1 | 3 |
| Tampa, Fla. | 156 | 107 | 29 | 10 | 6 | 4 | 14 |
| Washington, D.C. | 192 | 92 | 53 | 36 | 10 | 1 | 5 |
| Wilmington, Del. | 7 | 6 | - | 1 | - | - | - |
| E.S. CENTRAL | 815 | 532 | 168 | 72 | 25 | 17 | 55 |
| Birmingham, Ala. | 139 | 79 | 31 | 20 | 6 | 2 | 4 |
| Chattanooga, Tenn. | 77 | 53 | 19 | 2 | 1 | 2 | 5 |
| Knoxville, Tenn. | 70 | 39 | 20 | 7 | 3 | 1 | 7 |
| Lexington, Ky. | 86 | 54 | 24 | 2 | 2 | 4 | 6 |
| Memphis, Tenn. | 189 | 126 | 34 | 19 | 5 | 5 | 15 |
| Mobile, Ala. | 107 | 83 | 17 | 6 | 1 | - | 5 |
| Montgomery, Ala. | 41 | 31 | 6 | 3 | 1 | - | 3 |
| Nashville, Tenn. | 106 | 67 | 17 | 13 | 6 | 3 | 10 |
| W.S. CENTRAL | 1,345 | 853 | 293 | 141 | 25 | 33 | 86 |
| Austin, Tex. | 70 | 51 | 8 | 10 | - | 1 | 2 |
| Baton Rouge, La. | 46 | 34 | 6 | 6 | - | - | 3 |
| Corpus Christi, Tex. | 49 | 32 | 12 | 2 | 1 | 2 | 6 |
| Dallas, Tex. | 188 | 106 | 42 | 25 | 9 | 6 | 5 |
| El Paso, Tex. | 82 | 52 | 22 | 4 | 2 | 2 | 7 |
| Ft. Worth, Tex. | 95 | 63 | 12 | 17 | 2 | 1 | 9 |
| Houston, Tex. | 378 | 243 | 87 | 38 | 5 | 5 | 29 |
| Little Rock, Ark. | 66 | 39 | 18 | 5 | 1 | 3 | 5 |
| New Orleans, La. | 83 | 46 | 22 | 10 | 2 | 3 | - |
| San Antonio, Tex. | 172 | 115 | 39 | 13 | 2 | 3 | 14 |
| Shreveport, La. | 32 | 21 | 5 | 4 | - | 2 | 5 |
| Tulsa, Okla. | 84 | 51 | 20 | 7 | 1 | 5 | 1 |
| MOUNTAIN | 815 | 528 | 165 | 76 | 30 | 14 | 47 |
| Albuquerque, N.M. | 130 | 87 | 26 | 10 | 5 | 2 | 2 |
| Colo. Springs, Colo. | 48 | 29 | 9 | 8 | 1 | 1 | 3 |
| Denver, Colo. | 111 | 71 | 24 | 14 | - | 2 | 11 |
| Las Vegas, Nev. | 138 | 89 | 36 | 10 | 2 | 1 | 8 |
| Ogden, Utah | 21 | 17 | - | 3 | - | 1 | 2 |
| Phoenix, Ariz. | 139 | 84 | 26 | 15 | 10 | 2 | 7 |
| Pueblo, Colo. | 30 | 21 | 5 | 4 | - | - | 2 |
| Salt Lake City, Utah | 78 | 44 | 23 | 3 | 6 | 2 | 7 |
| Tucson, Ariz. | 120 | 86 | 16 | 9 | 6 | 3 | 5 |
| PACIFIC | 1,624 | 1,057 | 314 | 164 | 49 | 39 | 127 |
| Berkeley, Calif. | 18 | 9 | 3 | 6 | - | - | - |
| Fresno, Calif. | 90 | 51 | 23 | 5 | 3 | 8 | 5 |
| Glendale, Calif. | 14 | 12 | 2 | - | - | - | - |
| Honolulu, Hawaii | 79 | 60 | 8 | 9 | 1 | 1 | 17 |
| Long Beach, Calif. | 81 | 48 | 14 | 12 | 1 | 6 | 11 |
| Los Angeles, Calif. | 239 | 143 | 49 | 31 | 15 | - | 11 |
| Pasadena, Calif. | 24 | 16 | 7 | 1 | - | - | 6 |
| Portland, Oreg. | 124 | 80 | 28 | 6 | 6 | 4 | 6 |
| Sacramento, Calif. | 187 | 111 | 49 | 18 | 4 | 5 | 18 |
| San Diego, Calif. | 149 | 105 | 25 | 11 | 5 | 3 | 15 |
| San Francisco, Calif. | 154 | 89 | 38 | 22 | 3 | 2 | 10 |
| San Jose, Calif. | 163 | 113 | 22 | 16 | 5 | 7 | 14 |
| Santa Cruz, Calif. | 20 | 10 | 5 | 4 | 1 | - | - |
| Seattle, Wash. | 142 | 105 | 20 | 13 | 3 | 1 | 7 |
| Spokane, Wash. | 43 | 31 | 6 | 5 | 1 | - | 5 |
| Tacoma, Wash. | 97 | 74 | 15 | 5 | 1 | 2 | 2 |
| TOTAL | 12,027¶ | 7,834 | 2,307 | 1,265 | 325 | 261 | 700 |

*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 -: no reported cases

*Lower Respiratory Tract Illness — Continued*

Five of the six case-patients were male; patients ranged in age from 30 to 37 years. Five resided in Berkeley County and one in adjacent Charleston County. All had onset of symptoms during July 19–23 and reportedly had recently used illicit drugs. Five had been hospitalized. Predominant clinical features included nonproductive cough, fever (maximum: 103 F [39.4 C]), pleuritic chest pain, and progressively severe shortness of breath. Laboratory findings included a polymorphonuclear leukocytosis (range: 9100 $mm^3$–23,600 $mm^3$) in all six patients and severe hypoxia ($PO_2$ range: 49–81) in five. All patients had bibasilar or diffuse pulmonary infiltrates on chest radiographs. Of the five patients who were hospitalized, three developed respiratory failure within 1–4 days of admission and within 7–10 days of onset of symptoms; two died.

Diagnostic studies included sputum gram stain and cultures, blood cultures, serologic tests, and pathologic examination of tissue obtained by open lung biopsy or postmortem. These tests were negative for common bacterial pathogens and for *Mycoplasma* sp*, Chlamydia* sp, *Legionella* sp, *Pneumocystis carinii*, *Mycobacterium tuberculosis*, human immunodeficiency virus, respiratory syncytial virus, cytomegalovirus, adenoviruses, Epstein-Barr virus, and influenza virus. Fungal cultures of sputum from the two deceased patients and open lung biopsy from another were positive for molds believed to be contaminants; final identification is pending. Histopathologic analysis of lung tissue from the two deceased patients indicated diffuse alveolar damage with microemboli and minimal inflammatory cell infiltrate. Tissue from the open lung biopsy of the third patient indicated severe organizing fibrinous pneumonia with bronchiolitis obliterans and diffuse alveolar damage. Analyses of blood (five patients) and lung tissue (three patients) specimens and of samples taken from drug paraphernalia (i.e., homemade "pipes" of one patient) were negative for potential toxins.

Although interviews with patients, relatives, and acquaintances suggested several potential exposures (e.g., rodents and herbicides), the only exposure common to all patients was nonparenteral use of drugs during the week before onset of symptoms. Five reported use of crack cocaine and one reported smoking marijuana. Several of the patients were acquainted; however, investigation has not detected a single event attended by all the patients or a common source for the crack cocaine. The ongoing investigation includes following up all possible drug-related contacts of the patients and continued surveillance.

*Reported by: L Lettau, MD, S Miller, MD, D Handshoe, MD, J Chambers, MD, Trident Health District, Charleston; L Bell, MD, E Brenner, MD, J Gibson, MD, State Epidemiologist, South Carolina Dept of Health and Environmental Control. Div of Environmental Health and Hazard Effects, National Center for Environmental Health; Div of Field Epidemiology, Epidemiology Program Office, CDC.*

**Editorial Note:** The clinical features of the cluster of cases of acute lower respiratory illness in South Carolina are similar to those reported previously in crack cocaine users who have sustained inhalational injuries. These cases have been characterized by a variety of clinical syndromes including pulmonary edema, interstitial pneumonitis, obliterative bronchitis, and pulmonary hemorrhage (*1–6*). However, the cluster of cases in South Carolina is the first known outbreak of acute, severe respiratory tract illnesses associated with crack cocaine. Potential explanations for the cases in South Carolina include an idiosyncratic reaction to crack cocaine or the effects of a contaminant or adulterant introduced during the preparation or smoking of the crack.

*Lower Respiratory Tract Illness — Continued*

The temporal and geographic clustering of the cases and the similarity of their clinical features suggest a common exposure to a unique yet unidentified toxin or microbiologic agent associated with inhalational drug abuse. Cases of similar severe illnesses should be reported to the Division of Disease Control, South Carolina Department of Health and Environmental Control, telephone (803) 737-4165.

*References*

1. Ettinger NA, Albin RJ. A review of the respiratory effects of smoking cocaine. Am J Med 1989; 87:664–8.
2. Meisels IS, Like J. The pulmonary effects of free-base cocaine: a review. Cleve Clin J Med 1993;60:325–9.
3. Haim DY, Lippmann ML, Goldberg SK, Walkenstein MD. The pulmonary complications of crack cocaine: a comprehensive review. Chest 1995;107:233–40.
4. Forrester JM, Steele AW, Waldron JA, Parsons PE. Crack lung: an acute pulmonary syndrome with a spectrum of clinical and histopathologic findings. Am Rev Respir Dis 1990;142:462–7.
5. O'Donnell AE, Mappin FG, Sebo TJ, Tazelaar H. Interstitial pneumonitis associated with "crack" cocaine abuse. Chest 1991;100:1155–7.
6. Patel RC, Dutta D, Schonfeld SA. Free-base cocaine use associated with bronchiolitis obliterans organizing pneumonia. Ann Intern Med 1987;107:186–7.

## Patterns of Homicide — Cali, Colombia, 1993–1994

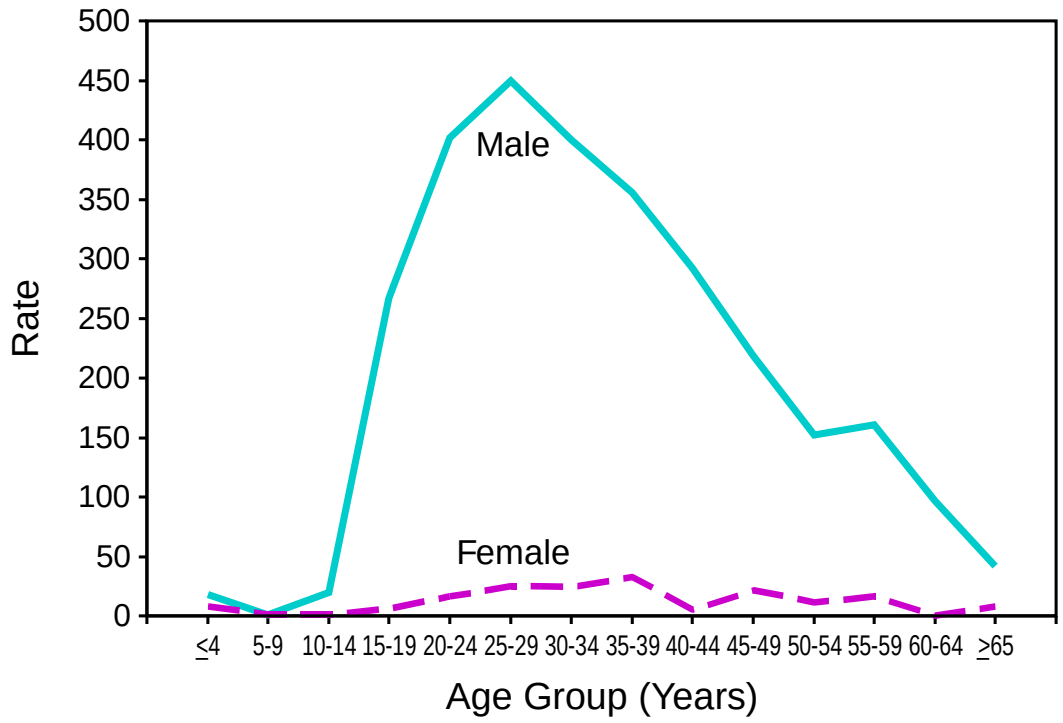
In Colombia, as in the United States, homicide occurs disproportionately among urban residents (*1,2*). Homicide rates in the city of Cali, Colombia (1994 population: 1,776,436), increased fivefold from 1985 through 1992, reaching levels of 100 per 100,000 persons. Because of this increase, in 1992 the city of Cali established the Development, Security, and Peace Program (DESEPAZ) to implement a series of strategies to prevent violence and improve security among the residents of Cali. An important element of this program was the establishment of a surveillance system to enable characterization of patterns and determinants of homicide to provide information to decision makers for formulating policies and programs. This report summarizes findings from this system for January 1993–May 1994.

Data about homicide are collected daily and reviewed weekly by a committee with representatives from the police department, the public health service, the district attorney's office, the ombudsman's office, the National Institute of Legal Medicine and Forensic Sciences, and the department of transportation, under the coordination of an epidemiologist assigned by the mayor's office (*3*). The list of cases is developed by comparing reports from the different sources represented on the committee. Tabulation and mapping of homicides are distributed weekly to the participating groups and to the news media.

In 1993, a total of 1829 homicides occurred in Cali, representing a crude rate of 104 homicides per 100,000 residents. In 1994, a total of 866 homicides occurred during January–May, compared with 625 for the same 5-month period in 1993. In 1993, age group-specific rates were highest among men aged 25–29 years (450 per 100,000) (Figure 1). Overall, the risk for homicide among males was 16-fold higher than that among females (209 per 100,000 and 13 per 100,000, respectively).

*Homicide — Continued*

**FIGURE 1. Rate* of homicide, by age group and sex — Cali, Colombia, 1993**




*Per 100,000 population.

Homicides were clustered in specific areas of the city: more than one half (54%) occurred in 59 neighborhoods in which 37% of the population resided. Homicide rates varied inversely with the socioeconomic status of the neighborhood of residence of victims and was greatest in three areas: an inner-city location near downtown Cali (rate: 254 per 100,000), a large area of immigrant settlements on the east side (rate: 245 per 100,000), and an area on the west side of the city (rate: 167 per 100,000). In most (89%) cases, homicides occurred in the same neighborhood in which the victim resided.

Of the 2695 total homicides during January 1993–May 1994, for 2461 (91%) no suspect was charged with the murder. For 641 (24%) of all homicides, the suspected perpetrator was identified as a "hit man" (i.e., a hired assassin) (458 [71%]), gang member (91 [14%]), or a relative/acquaintance (62 [10%]). The circumstance was determined for 835 (31%) homicides; of these, the most frequently cited categories were assaults (309 [37%]) and brawls (261 [31%]). Most (2544 [94%]) homicides occurred in streets or other public places; 6% occurred in homes or other residential settings. A total of 2134 (79%) homicides were committed using firearms. During 1994, blood alcohol concentration (BAC) was determined for 98% of the decedents; the BAC was >0.15 g/dL in 23% of the persons.

Homicides occurred more commonly (43%) during weekend days (Friday, Saturday, and Sunday)—especially during weekends coinciding with biweekly paydays. The hour of death was known for 2631 homicides; of these, 51% occurred between 9 p.m. and 6 a.m.

*Homicide — Continued*

*Reported by: V Espitia, MS, Office for the Epidemiology of Violence, Municipality of Cali; R Guerrero, MD, Pan American Health Organization, Cali, Colombia. A Concha, MD, National Center for Injury Surveillance and Research; C Sanchez, MD, VM Cardenas, MD, Colombian Field Epidemiology Training Program, National Institute of Health. Div of Violence Prevention, National Center for Injury Prevention and Control, CDC.*

**Editorial Note:** The data summarized in this report are from the first population-based homicide surveillance system established in Latin America. These findings are being used to develop and evaluate the policies and programs of DESEPAZ, which include efforts to enhance public security by enforcing state and city regulations and using the Mayor's office to issue decrees and laws that further enhance security (*4*). For example, in response to the relation between homicide and alcohol use, the mayor restricted the hours during which alcoholic beverages could be sold. Similarly, the high proportion of homicides committed with guns prompted institution of prohibitions on carrying guns in public during high-risk weekends, holidays, and election days. In addition, the city initiated efforts to educate members of the community through the news media, schools, and families about resolving conflicts without violence.

To address homicide in areas of the city where the risk has been highest and the socioeconomic status of residents lowest, social and economic development projects are being implemented to provide housing, primary health care, and job opportunities for residents, especially persons in high-risk groups (e.g., prostitutes, street children, and members of youth gangs). Other actions include improving the quality of the relationship between the police and the community, the modernization of the judicial system, and the promotion and protection of human rights. The homicide surveillance data are being used to evaluate the impact of these policies and programs on homicide rates.

Violence is a problem that affects urban areas throughout the Americas. In 1991, the average homicide rate for the 15 largest cities in Colombia (excluding Medellin [rate: 435 per 100,000]) was 61 per 100,000 (*1*). In comparison, in the United States in 1991, the crude homicide rate was 32 per 100,000 for cities with populations ≥1 million (*2*). The Pan American Health Organization with assistance from CDC and other organizations is working to promote the application of public health surveillance, analysis, and evaluation methods to assist countries in this region in reducing the problem.

*References*

1. Gaitan Daza F, Diaz Moreno J. The violence in Colombia: some basic explanations. In: Concha Eastman A, Carrion F, Cobo G, eds. Cities and violence in Latin America. Urban management series, vol 2. Quito, Ecuador: United Nations Urban Management Program, Regional Office for Latin America and the Caribbean, 1994:75–97.
2. US Department of Justice. Crime in the United States, 1991. Washington, DC: US Department of Justice, Federal Bureau of Investigation, 1992.
3. Eugenia Espitia V, Guerrero Velasco R, Concha Eastman A. Homicide surveillance in Cali, January to December of 1993: the application of epidemiology to public administration. In: Concha Eastman A, Carrion F, Cobo G, eds. Cities and violence in Latin America. Urban management series, vol 2. Quito, Ecuador: United Nations Urban Management Program, Regional Office for Latin America and the Caribbean, 1994:155–66.
4. Guerrero Velasco R, Concha Eastman A, Alvarez A, Cobo G, de Roux G, Alzate S. Development, Security, and Peace Program (DESEPAZ): strategies of the Cali mayor's office for addressing the insecurity and the violence. In: Concha Eastman A, Carrion F, Cobo G, eds. Cities and

*Homicide — Continued*

Violence in Latin America. Urban management series, vol 2. Quito, Ecuador: United Nations Urban Management Program, Regional Office for Latin America and the Caribbean, 1994: 119–53.

## *Notice to Readers*

### National Surveillance for Infectious Diseases, 1995

On October 13, CDC will release the annual *Summary of Notifiable Diseases, United States, 1994* (*1* ). A notifiable disease traditionally has been considered to be a condition for which regular, frequent, and timely information about individual cases is necessary for the prevention and control of the disease. During 1994, a total of 49 infectious diseases were considered notifiable at the national level and were reported to CDC; 41 were reported weekly, and eight were reported monthly.

During November 30–December 2, 1994, the Council of State and Territorial Epidemiologists (CSTE) and CDC held a conference to review the status of national infectious disease surveillance. At this conference, 10 diseases were proposed for deletion from the list of nationally notifiable diseases: amebiasis, aseptic meningitis, primary encephalitis (except for arboviral encephalitis), postinfectious encephalitis, granuloma inguinale, unspecified hepatitis, leptospirosis, lymphogranuloma venereum, rheumatic fever, and tularemia. In addition, nine diseases were proposed for addition to the list during 1995: genital *Chlamydia trachomatis* infections, coccidioidomycosis (for regional surveillance), cryptosporidiosis, hantavirus disease, (postdiarrheal) hemolytic uremic syndrome, pediatric infection with human immunodeficiency virus, invasive group A streptococcal infections, streptococcal toxic-shock syndrome, and drug-resistant *Streptococcus pneumoniae* invasive disease. These changes were approved by a vote of the full membership of CSTE in March 1995. However, these conditions are currently not reportable in all states, and the mechanism for reporting may not involve clinicians or consist of weekly reports of individual cases (i.e., traditional notification methods); rather, some may be reported directly by laboratories or in summary form on a monthly basis.

As of October 1, 1995, 52 infectious diseases were designated as notifiable at the national level (Table 1).

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

**Editorial Note:** In 1878, Congress authorized the U.S. Marine Hospital Service (the precursor to the Public Health Service [PHS]) to collect morbidity reports on cholera, smallpox, plague, and yellow fever from U.S. consuls overseas; this information was used to implement quarantine measures to prevent the introduction and spread of these diseases into the United States. In 1879, Congress approved appropriations explicitly for the collection and publication of reports of these notifiable diseases. The authority for weekly reporting and publication was expanded by Congress in 1893 to include information from states and municipal authorities. To increase the uniformity of the data, Congress enacted a law in 1902 directing the Surgeon General to provide forms for the collection and compilation of data and for the publication of reports at the national level.

*Surveillance for Infectious Diseases — Continued*

**TABLE 1. Infectious diseases designated as notifiable at the national level* — United States, 1995**

| | | |
|---|---|---|
| Acquired immunodeficiency syndrome | *Haemophilus influenzae*, invasive disease | Rabies, human |
| Anthrax | Hansen disease (Leprosy) | Rocky Mountain spotted fever |
| Botulism† | Hantavirus disease† | Rubella |
| Brucellosis | Hepatitis A | Salmonellosis† |
| Chancroid† | Hepatitis B | Shigellosis† |
| *Chlamydia trachomatis*, genital infections† | Hepatitis, C/non-A, non-B | Streptococcal disease, invasive, Group A† |
| Cholera | HIV infection, pediatric† | *Streptococcus pneumoniae*, drug-resistant† |
| Coccidioidomycosis† | Legionellosis | Streptococcal toxic-shock syndrome† |
| Congenital rubella syndrome | Leprosy | Syphilis |
| Congenital syphilis | Lyme disease | Tetanus |
| Cryptosporidiosis† | Malaria | Toxic-shock syndrome |
| Diphtheria | Measles | Trichinosis |
| Encephalitis, California† | Meningococcal disease | Tuberculosis |
| Encephalitis, eastern equine† | Mumps | Typhoid fever |
| Encephalitis, St. Louis† | Pertussis | Yellow fever† |
| Encephalitis, western equine† | Plague | |
| *Escherichia coli* O157:H7† | Poliomyelitis | |
| Gonorrhea | Psittacosis | |
| | Rabies, animal | |

*Although varicella is not a nationally notifiable disease, the Council of State and Territorial Epidemiologists recommends reporting of cases of this disease to CDC.
†Not currently published in the weekly tables.

In 1912, state and territorial health authorities—in conjunction with PHS—recommended immediate telegraphic reporting of five infectious diseases and monthly reporting by letter of 10 additional diseases. The first annual summary of *The Notifiable Diseases* in 1912 included reports of 10 diseases from 19 states, the District of Columbia, and Hawaii. By 1928, all states, the District of Columbia, Hawaii, and Puerto Rico were participating in national reporting of nearly 30 specified conditions. At their meeting in 1950, the State and Territorial Health Officers authorized a conference of state and territorial epidemiologists whose purpose was to determine which diseases should be reported to PHS. In 1961, CDC assumed responsibility for the collection and publication of data on nationally notifiable diseases.

The list of nationally notifiable diseases is revised periodically. Diseases may be added to the list as new pathogens emerge and deleted as their incidence declines. Public health officials at state health departments and CDC collaborate in determining which diseases should be nationally notifiable; CSTE, in conjunction with CDC, makes recommendations annually for additions and deletions to the list of nationally notifiable diseases. However, reporting of nationally notifiable diseases to CDC by the states is voluntary. Reporting is currently mandated (by state legislation or regulation) only at the state level. Therefore, the list of diseases that are considered notifiable varies slightly by state. All states generally report the internationally quarantinable diseases (i.e., cholera, plague, and yellow fever) in compliance with the World Health Organization's International Health Regulations.

The *Summary of Notifiable Diseases, United States, 1994* contains summary tables of the official statistics for the reported occurrence of nationally notifiable diseases during 1994. Data are presented in tables by month, geographic location, and patient

*Surveillance for Infectious Diseases — Continued*

age and race/ethnicity and in maps and graphs for many conditions. New features included in this year's annual summary include written highlights of important developments in the reported occurrences of selected nonnotifiable diseases, data from the Public Health Laboratory Information System, and short statements under each map or graph that underscore their important public health messages. Tables presenting historical notifiable disease data since 1945 and a table on deaths associated with specific notifiable diseases reported to CDC's National Center for Health Statistics also are included.

*Reference*

1. CDC. Summary of notifiable diseases, United States, 1994. MMWR 1995;43(no. 53).

## 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 reported through the National Electronic Telecommunications System for Surveillance (NETSS).

**Number of reported cases of diseases preventable by routine childhood vaccination — United States, August 1994 and 1994–1995***

| Disease | No. cases, August 1995 | Total cases January–August 1994 | Total cases January–August 1995 | No. cases among children aged <5 years† January–August 1994 | No. cases among children aged <5 years† January–August 1995 |
|---|---|---|---|---|---|
| Congenital rubella syndrome (CRS) | 0 | **2** | **4** | 2 | 4 |
| Diphtheria | 0 | **2** | **0** | 1 | 0 |
| *Haemophilus influenzae*§ | 71 | **763** | **798** | 215 | 185 |
| Hepatitis B¶ | 746 | **7486** | **6491** | 78 | 54 |
| Measles | 16 | **833** | **255** | 197 | 92 |
| Mumps | 33 | **992** | **554** | 157 | 108 |
| Pertussis | 506 | **2454** | **2241** | 1454 | 1,301 |
| Poliomyelitis, paralytic** | 0 | **1** | **0** | 0 | 0 |
| Rubella | 15 | **202** | **113** | 22 | 16 |
| Tetanus | 5 | **22** | **18** | 0 | 1 |

*Data for 1994 and 1995 are provisional.

†For 1994 and 1995, age data were available for ≥92% cases.

§Invasive disease; *H. influenzae* serotype is not routinely reported through the National Electronic Telecommunications System for Surveillance. Of 185 cases among children aged <5 years, serotype was reported for 49 cases, and of those, 28 were type b, the only serotype of *H. influenzae* preventable by vaccination.

¶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 July 1994 has been confirmed; this case was vaccine-associated. An additional six suspected cases are under investigation. In 1993, three of 10 suspected cases were confirmed; two of the confirmed cases 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.

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