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Morbidity and Mortality

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WEEKLY REPORT

Week Ending August 19, 1967

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE — PUBLIC HEALTH SERVICE

BUREAU OF DISEASE PREVENTION AND ENVIRONMENTAL CONTROL

EPIDEMIOLOGIC NOTES AND REPORTS

IMPORTED MALARIA – New York City

A case of malaria due to *Plasmodium falciparum* was reported from New York City on August 17, 1967. The 24-year-old female patient had returned on August 6, 1967, from a trip around the world. On August 11 she developed fever, headache, malaise, nausea and vomiting, followed by chills on August 13. She was treated with antibiotics until admitted to the hospital on August 16. On admission she was in a stupor and had a temperature of 107°F. Malaria was then suspected and *P. falciparum* organisms were detected in the peripheral blood. Antimalarial treatment was promptly initiated.

CONTENTS

The patient had toured the globe with 46 other persons, none of whom had used malaria chemprophylaxis enroute. Their itinerary included stops in Japan, Taiwan, Hong Kong, Singapore, Thailand, India, Pakistan, Iran, Turkey, and Greece. Since the other group members also could have been infected with malaria while overseas, the

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CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES

(Cumulative totals include revised and delayed reports through previous weeks)

DISEASE	33rd WEEK ENDED		MEDIAN	CUMULATIVE, FIRST 33 WEEKS		
	AUGUST 19, 1967	AUGUST 20, 1966	1962 - 1966	1967	1966	MEDIAN 1962 - 1966
Aseptic meningitis	107	142	88	1,386	1,327	1,114
Brucellosis	7	11	10	170	149	233
Diphtheria	3	4	4	65	112	153
Encephalitis, primary:						
Arthropod-borne & unspecified	43	120	- - -	923	1,000	- - -
Encephalitis, post-infectious	10	8	- - -	593	550	- - -
Hepatitis, serum	46	33	643	1,344	877	25,367
Hepatitis, infectious	683	610		24,216	20,691	
Malaria	20	15	3	1,232	218	56
Measles (rubeola)	230	694	919	57,075	187,674	355,346
Meningococcal infections, total	23	32	26	1,602	2,600	1,858
Civilian	21	28	- - -	1,491	2,332	- - -
Military	2	4	- - -	111	268	- - -
Poliomyelitis, total	2	2	2	22	61	65
Paralytic	2	2	2	19	57	57
Rubella (German measles)	253	229	- - -	39,289	40,917	- - -
Streptococcal sore throat & scarlet fever	4,477	3,838	3,193	310,222	294,323	272,741
Tetanus	7	5	5	140	105	159
Tularemia	4	7	10	113	109	185
Typhoid fever	6	11	11	248	227	250
Typhus, tick-borne (Rky. Mt. spotted fever)	14	6	13	192	168	158
Rabies in animals	86	92	81	2,903	2,771	2,771

NOTIFIABLE DISEASES OF LOW FREQUENCY

	Cum.		Cum.
Anthrax:	2	Rabies in man:	2
Botulism:	2	Rubella, Congenital Syndrome:	4
Leptospirosis: Utah-1	25	Trichinosis:	45
Plague:	2	Typhus, murine: Tex.-1	29
Psittacosis:	31	Polio, Unsp.	3

RECOMMENDATION OF THE PUBLIC HEALTH SERVICE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES

The Public Health Service Advisory Committee on Immunization Practices meeting on May 26, 1967, issued the following recommendation on poliomyelitis vaccines, a revision of the initial recommendation which was released as a supplement to the Poliomyelitis Surveillance Unit Report #285, September 1964.

POLIOMYELITIS VACCINES

Introduction

Widespread use of poliovirus vaccines has resulted in the virtual elimination of paralytic poliomyelitis in the United States. To insure continued freedom from the disease, it is necessary to pursue regular immunization of all children from early infancy.

Following the introduction of poliovirus vaccine in 1955, paralytic poliomyelitis declined from 18,308 cases in 1954 to a low of 61 cases in 1965. A national survey in September 1966, showed that 70 percent of all children 1-4 years of age had received at least three doses of oral poliovirus vaccine (OPV)*, inactivated poliovirus vaccine (IPV)**, or both. Approximately 90 percent of all children 5 years old and older had been adequately vaccinated.

Nevertheless, low immunization rates can still be found in some population groups, both urban and rural. In 1966, 108 cases of paralytic poliomyelitis were reported in the United States and Puerto Rico, reversing the downward national trend. The majority of the 1966 cases occurred in unimmunized children less than 5 years of age in south Texas. These cases illustrate the possibility of outbreaks where incomplete immunization exists.

With widespread use of poliovirus vaccine, laboratory surveillance of enteroviruses indicates that circulation of wild polioviruses has diminished markedly. It can be assumed that inapparent infections with wild strains will no longer contribute significantly to maintaining immunity in the general population. Therefore, it is essential not only to continue active immunization programs for infants and children but also to make special efforts to raise the low immunization rates existing in certain segments of the population. Identification of population groups requiring special immunization programs should be undertaken through surveys, both of immunization history and serologic status.

Poliovirus Vaccines

From the introduction of IPV in 1955 until the live attenuated vaccines became widely used in 1962, more than 400 million doses of IPV were distributed in the United States. Primary immunization with IPV plus regular booster doses provided a high degree of protection against paralytic disease.

Monovalent OPV, types 1, 2, and 3, have been widely used in the United States since 1961-62. Trivalent OPV was introduced in 1963.

OPV is more widely used than IPV in this country because it is easier to administer and produces an immune response which, without regular booster doses, appears to be similar to immunity induced by natural poliovirus infection. Trivalent OPV has largely replaced the monovalent forms because of simplicity of scheduling and record-keeping.

A primary series of trivalent OPV, consisting of three adequately spaced doses, will produce an immune response to all poliovirus types in well over 90 percent of the recipients. Using the immunization schedule recommended in this report, possible interference with immunity produced by wild enteroviruses is minimized. Immunization may, therefore, begin in any season.

For community protection during an epidemic, it is better to immunize against the prevalent poliovirus type. For this purpose, type-specific monovalent OPV is preferable to trivalent OPV.

Very rarely, cases of paralytic poliomyelitis have occurred in recipients of OPV or their close contacts within 30 days of vaccine feeding. Careful analysis indicates a ratio of no more than one case of "vaccine-associated" paralytic disease for every three million doses of OPV administered.

Vaccine Usage

Oral Poliovirus Vaccine (OPV)

Primary Immunization

Trivalent OPV

Infants: The three-dose immunization series should be started at 6 to 12 weeks of age, simultaneously with the first DTP inoculation. The second dose should be given no less than 6 and preferably 8 weeks later. The third dose is an integral part of primary immunization and should be administered 8 to 12 months after the second dose.

Children and Adolescents: In children and adolescents through the level of high school, the primary series should consist of three doses, the first two doses given 6 to 8 weeks apart, and the third, 8 to 12 months after the second. If circumstances do not allow for the optimal interval between the second and third doses, the third may be given as early as 6 weeks after the second.

Adults: Routine poliomyelitis immunization for adults residing in the continental United States is not currently necessary because of the extreme unlikelihood of exposure. However, any unimmunized adult who may be at

*The official names of the products in use are: 1) Poliovirus Vaccine, Live, Oral, Type 1; 2) Poliovirus Vaccine, Live, Oral, Type 2; 3) Poliovirus Vaccine, Live, Oral, Type 3; 4) Poliovirus Vaccine, Live, Oral, Trivalent.

**The official name of the product in use is: Poliomyelitis Vaccine.

increased risk by virtue of contact with a known case or travel to epidemic or endemic areas should receive trivalent OPV according to the schedule outlined for children and adolescents. Persons employed in hospitals, medical laboratories, and sanitation facilities might also be considered as having an increased risk, especially if poliomyelitis is occurring in the area.

Pregnancy of itself is not an indication for vaccine administration, nor is it a contraindication when immunization is required.

Monovalent OPV

An alternative immunization procedure for infants, children, and adolescents is to give the separate monovalent OPV types at intervals of 6 to 8 weeks. The recommended sequence of types is 2, 1, 3. A fourth OPV dose, but of trivalent vaccine, should be given 8 to 12 months after the third dose of monovalent OPV. The special role of monovalent OPV in epidemic control is discussed below.

Follow-up Doses

School Entrance

On entering elementary school, all children who have completed the primary OPV series should be given a single follow-up dose of trivalent OPV. All others should complete the primary series.

Routine "Boosters"

On the basis of current information, there is no indication for regular or routine "booster" doses of OPV.

Increased Risk

A single dose of trivalent OPV may be administered to anyone who has completed the full primary series described above and has an increased risk of exposure by virtue of contact with a known outbreak, travel to epidemic or endemic areas, or occupation. However, the need for such an additional dose has not been established. If there is uncertainty about the adequacy of previous immunization, a single dose of trivalent OPV should be given.

Inactivated Poliovirus Vaccine (IPV)

Primary Immunization

All Ages: Four parenteral doses should be given, three at approximately monthly intervals and the fourth, a reinforcing dose, 6 to 12 months after the third. This schedule may be integrated with DTP immunization beginning at 6 to 12 weeks of age.

Booster Immunization

Single booster doses every 2 to 3 years have been recommended to insure adequate levels of antibody. The need for IPV boosters could be obviated by a full course of OPV. For individuals at particular risk as described previously, at least one dose of trivalent OPV, and preferably a full primary series, is recommended.

Epidemic Control*

For operational purposes in the United States, an "epidemic" of poliomyelitis is now defined as two or more cases caused by the same type virus during a 4-week period in a circumscribed population such as that of a city, county, or metropolitan area. An epidemic of poliomyelitis can be controlled by an emergency monovalent OPV immunization program. As soon as possible, the type of poliovirus responsible should be determined and the epidemic area defined. Within the epidemic area, all persons over 6 weeks of age who are not completely immunized or whose immunization status is uncertain should promptly receive one dose of type-specific monovalent OPV.

Simultaneous Administration of Live Virus Vaccines

Data on simultaneous administration of live virus vaccines are not sufficient to develop comprehensive recommendations, but there are obvious practical advantages to combining vaccines, and investigations are underway which should help to define optimal practices. When combined administration is indicated, available data do not suggest that undesirable responses will result. The following comment presents current attitudes toward scheduling vaccination with three major live virus vaccines – polio, measles, and smallpox.

It has been generally recommended that immunizations with live virus vaccines be separated by at least one month whenever possible. The rationale for this recommendation is the theory that superimposed reactions and diminished antibody responses might result if two or more live virus vaccines were given simultaneously. Ideally, the initial doses of oral poliovirus vaccine should have been given before a child reaches one year, the age for giving live attenuated measles virus vaccine. Administration of polio and measles antigens should be separated by at least one month. It is likewise desirable to separate measles and smallpox vaccinations by one or more months because both of these antigens may produce febrile reactions.

When, however, immunization program effectiveness is hindered or when the threat of concurrent exposures exists, the relevant live virus vaccines should be given at the same time. Observations do not indicate that this will cause a significant increase in adverse reactions or depressed antibody responses to either antigen.

*For epidemic control, monovalent OPV types 1 and 3 are available from the National Communicable Disease Center on request of the State Health Department.

CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES

FOR WEEKS ENDED

AUGUST 19, 1967 AND AUGUST 20, 1966 (33rd WEEK)

AREA	ASEPTIC MENINGITIS		BRUCELLOSIS	DIPHTHERIA	ENCEPHALITIS			HEPATITIS			
					Primary including unsp. cases		Post-Infectious	Serum		Infectious	
	1967	1966	1967	1967	1967	1966	1967	1967	1966	1967	1966
UNITED STATES...	107	142	7	3	43	120	10	46	33	683	610
NEW ENGLAND.....	2	9	-	-	6	3	-	1	-	12	22
Maine.....	-	-	-	-	-	-	-	-	-	1	3
New Hampshire.....	-	-	-	-	-	-	-	-	-	-	-
Vermont.....	-	-	-	-	-	-	-	-	-	1	-
Massachusetts.....	1	8	-	-	6	2	-	-	-	-	2
Rhode Island.....	1	-	-	-	-	1	-	1	-	3	3
Connecticut.....	-	1	-	-	-	-	-	-	-	7	14
MIDDLE ATLANTIC.....	9	6	1	-	4	9	1	12	16	95	66
New York City.....	3	4	-	-	2	2	-	10	13	35	16
New York, Up-State.	3	-	-	-	-	1	1	-	-	25	19
New Jersey.....	2	-	1	-	1	5	-	2	2	13	9
Pennsylvania.....	1	2	-	-	1	1	-	-	1	22	22
EAST NORTH CENTRAL...	29	8	5	-	15	15	-	5	3	128	151
Ohio.....	11	1	-	-	12	10	-	1	1	27	27
Indiana.....	1	1	-	-	2	-	-	-	-	9	6
Illinois.....	15	5	5	-	-	1	-	2	1	46	50
Michigan.....	1	1	-	-	-	3	-	2	1	38	66
Wisconsin.....	1	-	-	-	1	1	-	-	-	8	2
WEST NORTH CENTRAL...	3	1	1	-	3	2	4	-	-	37	28
Minnesota.....	2	1	-	-	-	-	2	-	-	2	5
Iowa.....	1	-	1	-	-	-	2	-	-	5	11
Missouri.....	-	-	-	-	2	-	-	-	-	26	11
North Dakota.....	-	-	-	-	-	2	-	-	-	3	-
South Dakota.....	-	-	-	-	-	-	-	-	-	-	1
Nebraska.....	-	-	-	-	1	-	-	-	-	1	-
Kansas.....	-	-	-	-	-	-	-	-	-	-	-
SOUTH ATLANTIC.....	11	24	-	2	4	6	-	1	2	95	54
Delaware.....	-	-	-	-	-	-	-	-	-	1	1
Maryland.....	9	-	-	-	1	-	-	1	1	20	14
Dist. of Columbia..	-	1	-	-	-	-	-	-	-	2	-
Virginia.....	-	2	-	-	2	3	-	-	-	15	7
West Virginia.....	-	15	-	-	-	-	-	-	-	3	5
North Carolina.....	-	-	-	-	1	-	-	-	-	4	8
South Carolina.....	-	-	-	-	-	-	-	-	1	4	1
Georgia.....	-	-	-	1	-	-	-	-	-	39	7
Florida.....	2	6	-	1	-	3	-	-	-	7	11
EAST SOUTH CENTRAL...	12	12	-	1	-	4	-	-	-	45	39
Kentucky.....	-	1	-	-	-	-	-	-	-	19	9
Tennessee.....	8	2	-	-	-	1	-	-	-	16	17
Alabama.....	4	5	-	1	-	-	-	-	-	3	6
Mississippi.....	-	4	-	-	-	3	-	-	-	7	7
WEST SOUTH CENTRAL...	4	39	-	-	2	72	1	2	2	72	61
Arkansas.....	-	-	-	-	1	-	-	-	-	1	4
Louisiana.....	1	4	-	-	1	4	1	2	-	16	18
Oklahoma.....	-	-	-	-	-	9	-	-	-	7	1
Texas.....	3	35	-	-	-	59	-	-	2	48	38
MOUNTAIN.....	1	-	-	-	-	4	-	-	-	23	25
Montana.....	-	-	-	-	-	-	-	-	-	2	2
Idaho.....	-	-	-	-	-	3	-	-	-	1	1
Wyoming.....	-	-	-	-	-	-	-	-	-	-	1
Colorado.....	1	-	-	-	-	1	-	-	-	12	2
New Mexico.....	-	-	-	-	-	-	-	-	-	5	8
Arizona.....	-	-	-	-	-	-	-	-	-	3	8
Utah.....	-	-	-	-	-	-	-	-	-	-	3
Nevada.....	-	-	-	-	-	-	-	-	-	-	-
PACIFIC.....	36	43	-	-	9	5	4	25	10	176	164
Washington.....	3	1	-	-	3	-	-	3	-	24	17
Oregon.....	-	-	-	-	-	2	-	1	-	10	24
California.....	28	42	-	-	6	3	4	20	10	142	119
Alaska.....	-	-	-	-	-	-	-	-	-	-	3
Hawaii.....	5	-	-	-	-	-	-	1	-	-	1
Puerto Rico	-	-	-	-	-	-	-	-	-	17	21

CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES

FOR WEEKS ENDED

AUGUST 19, 1967 AND AUGUST 20, 1966 (33rd WEEK) - CONTINUED

AREA	MALARIA	MEASLES (Rubeola)			MENINGOCOCCAL INFECTIONS, TOTAL			POLIOMYELITIS			RUBELLA
			Cumulative			Cumulative		Total	Paralytic		
	1967	1967	1967	1966	1967	1967	1966	1967	1967	Cum. 1967	1967
UNITED STATES...	20	230	57,075	187,674	23	1,602	2,600	2	2	19	253
NEW ENGLAND.....	-	8	838	2,230	2	67	113	-	-	-	19
Maine.....	-	-	234	194	-	3	9	-	-	-	2
New Hampshire.....	-	-	74	79	-	2	9	-	-	-	-
Vermont.....	-	-	42	225	-	1	4	-	-	-	-
Massachusetts.....	-	7	337	773	-	32	44	-	-	-	2
Rhode Island.....	-	-	62	72	-	4	12	-	-	-	3
Connecticut.....	-	1	89	887	2	25	35	-	-	-	12
MIDDLE ATLANTIC.....	2	21	2,225	17,925	5	261	307	-	-	5	27
New York City.....	2	9	445	8,247	-	46	43	-	-	1	13
New York, Up-State.	-	11	568	2,508	4	65	87	-	-	1	13
New Jersey.....	-	1	481	1,844	1	92	91	-	-	-	-
Pennsylvania.....	-	-	731	5,326	-	58	86	-	-	3	1
EAST NORTH CENTRAL...	-	40	5,277	68,161	5	223	399	1	1	1	58
Ohio.....	-	6	1,136	6,326	3	74	108	-	-	-	8
Indiana.....	-	-	587	5,646	-	30	69	-	-	-	14
Illinois.....	-	7	934	11,317	-	52	76	-	-	-	7
Michigan.....	-	4	906	14,183	1	51	105	1	1	1	3
Wisconsin.....	-	23	1,714	30,689	1	16	41	-	-	-	26
WEST NORTH CENTRAL...	1	14	2,823	8,661	1	68	140	1	1	3	2
Minnesota.....	-	-	120	1,639	-	16	33	-	-	-	1
Iowa.....	-	1	745	5,303	-	13	22	-	-	1	1
Missouri.....	-	-	332	529	1	14	54	-	-	-	-
North Dakota.....	1	12	857	1,075	-	1	9	-	-	-	-
South Dakota.....	-	-	52	40	-	6	4	-	-	-	-
Nebraska.....	-	1	624	75	-	12	8	-	-	-	-
Kansas.....	-	-	93	NN	-	6	10	1	1	2	-
SOUTH ATLANTIC.....	1	17	6,807	15,009	1	304	443	-	-	2	17
Delaware.....	-	-	43	256	-	6	4	-	-	-	-
Maryland.....	1	-	149	2,095	1	38	46	-	-	1	-
Dist. of Columbia..	-	-	22	381	-	10	11	-	-	-	-
Virginia.....	-	4	2,171	2,108	-	37	53	-	-	-	3
West Virginia.....	-	6	1,368	5,158	-	21	20	-	-	-	2
North Carolina.....	-	5	847	462	-	66	110	-	-	1	-
South Carolina.....	-	-	507	654	-	29	47	-	-	-	2
Georgia.....	-	-	32	233	-	44	63	-	-	-	-
Florida.....	-	2	1,668	3,662	-	53	89	-	-	-	10
EAST SOUTH CENTRAL...	6	22	5,126	19,559	1	124	224	-	-	1	75
Kentucky.....	6	2	1,318	4,693	-	34	82	-	-	-	58
Tennessee.....	-	12	1,825	12,194	1	52	73	-	-	-	16
Alabama.....	-	5	1,321	1,673	-	25	49	-	-	-	1
Mississippi.....	-	3	662	999	-	13	20	-	-	1	-
WEST SOUTH CENTRAL...	3	75	17,177	24,084	3	215	365	-	-	7	-
Arkansas.....	-	-	1,404	966	-	28	33	-	-	-	-
Louisiana.....	2	-	151	98	2	85	137	-	-	-	-
Oklahoma.....	1	22	3,347	474	-	16	18	-	-	1	-
Texas.....	-	53	12,275	22,546	1	86	177	-	-	6	-
MOUNTAIN.....	-	16	4,594	11,810	-	27	81	-	-	-	8
Montana.....	-	4	281	1,802	-	-	4	-	-	-	1
Idaho.....	-	2	377	1,542	-	1	5	-	-	-	-
Wyoming.....	-	-	180	145	-	1	6	-	-	-	-
Colorado.....	-	4	1,543	1,276	-	12	42	-	-	-	5
New Mexico.....	-	-	576	1,118	-	3	10	-	-	-	-
Arizona.....	-	3	1,008	5,264	-	4	10	-	-	-	2
Utah.....	-	3	360	620	-	4	-	-	-	-	-
Nevada.....	-	-	269	43	-	2	4	-	-	-	-
PACIFIC.....	7	17	12,208	20,235	5	313	528	-	-	-	47
Washington.....	-	3	5,417	3,478	1	28	37	-	-	-	7
Oregon.....	-	3	1,566	1,701	-	25	33	-	-	-	11
California.....	4	11	4,930	14,459	4	247	439	-	-	-	23
Alaska.....	-	-	133	467	-	9	15	-	-	-	5
Hawaii.....	3	-	162	130	-	4	4	-	-	-	1
Puerto Rico.....	1	12	2,099	2,599	-	12	10	-	-	-	-

CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES
FOR WEEKS ENDED
AUGUST 19, 1967 AND AUGUST 20, 1966 (33rd WEEK) - CONTINUED

AREA	STREPTOCOCCAL SORE THROAT & SCARLET FEVER	TETANUS		TULAREMIA		TYPHOID		TYPHUS FEVER TICK-BORNE (Rky. Mt. Spotted)		RABIES IN ANIMALS	
	1967	1967	Cum. 1967	1967	Cum. 1967	1967	Cum. 1967	1967	Cum. 1967	1967	Cum. 1967
UNITED STATES...	4,477	7	140	4	113	6	248	14	192	86	2,903
NEW ENGLAND.....	524	-	2	1	1	-	3	-	1	2	73
Maine.....	13	-	-	-	-	-	-	-	-	-	16
New Hampshire.....	-	-	-	-	-	-	-	-	-	-	37
Vermont.....	16	-	-	-	-	-	-	-	-	2	17
Massachusetts.....	63	-	1	1	1	-	2	-	1	-	2
Rhode Island.....	39	-	-	-	-	-	-	-	-	-	1
Connecticut.....	393	-	1	-	-	-	1	-	-	-	-
MIDDLE ATLANTIC.....	159	-	11	-	-	-	21	-	18	1	60
New York City.....	3	-	5	-	-	-	10	-	-	-	-
New York, Up-State.	150	-	1	-	-	-	7	-	4	1	50
New Jersey.....	NN	-	1	-	-	-	2	-	7	-	-
Pennsylvania.....	6	-	4	-	-	-	2	-	7	-	10
EAST NORTH CENTRAL...	342	1	16	1	11	2	21	1	18	8	296
Ohio.....	14	-	4	-	-	1	5	1	10	3	102
Indiana.....	97	1	3	-	2	1	7	-	1	1	64
Illinois.....	86	-	7	1	9	-	2	-	7	2	59
Michigan.....	109	-	2	-	-	-	6	-	-	-	23
Wisconsin.....	36	-	-	-	-	-	1	-	-	2	48
WEST NORTH CENTRAL...	285	-	10	-	19	-	14	-	2	27	696
Minnesota.....	-	-	3	-	-	-	1	-	-	7	133
Iowa.....	57	-	1	-	1	-	2	-	-	2	89
Missouri.....	4	-	5	-	7	-	7	-	1	5	128
North Dakota.....	82	-	-	-	-	-	-	-	-	6	128
South Dakota.....	26	-	1	-	2	-	-	-	-	1	92
Nebraska.....	26	-	-	-	-	-	3	-	1	3	43
Kansas.....	90	-	-	-	9	-	1	-	-	3	83
SOUTH ATLANTIC.....	619	1	33	-	9	-	32	4	85	7	378
Delaware.....	1	-	-	-	-	-	-	-	-	-	-
Maryland.....	110	-	-	-	-	-	2	1	16	-	1
Dist. of Columbia..	7	-	1	-	-	-	1	-	-	-	-
Virginia.....	90	1	7	-	-	-	3	1	19	2	176
West Virginia.....	187	-	1	-	2	-	1	-	1	-	54
North Carolina.....	6	-	6	-	-	-	3	1	36	-	3
South Carolina.....	12	-	1	-	2	-	7	-	4	-	-
Georgia.....	7	-	3	-	4	-	8	1	9	4	90
Florida.....	199	-	14	-	1	-	7	-	-	1	54
EAST SOUTH CENTRAL...	916	-	22	-	8	2	41	5	36	10	546
Kentucky.....	103	-	3	-	1	1	17	2	13	5	128
Tennessee.....	636	-	8	-	5	-	7	3	17	5	379
Alabama.....	130	-	8	-	-	-	9	-	6	-	37
Mississippi.....	47	-	3	-	2	1	8	-	-	-	2
WEST SOUTH CENTRAL...	490	4	30	2	54	1	30	3	17	22	607
Arkansas.....	-	-	5	1	32	-	7	3	6	2	83
Louisiana.....	1	-	3	1	4	1	13	-	-	4	54
Oklahoma.....	42	-	1	-	14	-	6	-	7	13	207
Texas.....	447	4	21	-	4	-	4	-	4	3	263
MOUNTAIN.....	671	-	-	-	7	-	16	-	8	2	91
Montana.....	12	-	-	-	1	-	1	-	-	-	-
Idaho.....	81	-	-	-	-	-	-	-	-	-	-
Wyoming.....	5	-	-	-	2	-	-	-	-	-	5
Colorado.....	427	-	-	-	1	-	11	-	8	-	10
New Mexico.....	59	-	-	-	-	-	1	-	-	2	28
Arizona.....	19	-	-	-	-	-	3	-	-	-	43
Utah.....	68	-	-	-	3	-	-	-	-	-	2
Nevada.....	-	-	-	-	-	-	-	-	-	-	3
PACIFIC.....	471	1	16	-	4	1	70	1	7	7	156
Washington.....	75	-	-	-	2	-	1	-	1	-	1
Oregon.....	31	-	1	-	-	-	-	1	1	-	2
California.....	340	1	13	-	2	1	66	-	5	7	153
Alaska.....	21	-	-	-	-	-	-	-	-	-	-
Hawaii.....	4	-	2	-	-	-	3	-	-	-	-
Puerto Rico.....	3	-	10	-	-	-	4	-	-	-	26

Week No. 33

DEATHS IN 122 UNITED STATES CITIES FOR WEEK ENDED AUGUST 19, 1967

(By place of occurrence and week of filing certificate. Excludes fetal deaths)

Area	All Causes		Pneumonia and Influenza	Under 1 year
	All Ages	65 years and over	All Ages	All Causes
NEW ENGLAND:	633	371	21	29
Boston, Mass.	211	108	8	12
Bridgeport, Conn.	44	24	3	2
Cambridge, Mass.	26	20	-	-
Fall River, Mass.	21	13	1	-
Hartford, Conn.	52	27	1	5
Lowell, Mass.	22	16	4	-
Lynn, Mass.	14	10	-	1
New Bedford, Mass.	25	17	-	1
New Haven, Conn.	51	29	1	2
Providence, R. I.	58	33	2	2
Somerville, Mass.	13	11	-	-
Springfield, Mass.	31	24	1	-
Waterbury, Conn.	25	15	-	1
Worcester, Mass.	40	24	-	3
MIDDLE ATLANTIC:	2,963	1,668	85	153
Albany, N. Y.	42	26	-	1
Allentown, Pa.	37	23	1	-
Buffalo, N. Y.	130	78	3	4
Camden, N. J.	42	32	3	4
Elizabeth, N. J.	33	17	-	4
Erie, Pa.	40	23	-	1
Jersey City, N. J.	67	35	1	6
Newark, N. J.	83	43	1	5
New York City, N. Y.	1,471	808	46	86
Paterson, N. J.	38	22	4	3
Philadelphia, Pa.	419	233	4	26
Pittsburgh, Pa.	185	100	3	3
Reading, Pa.	43	26	-	-
Rochester, N. Y.	83	42	7	3
Schenectady, N. Y.	24	18	1	-
Scranton, Pa.	47	30	4	1
Syracuse, N. Y.	73	40	3	3
Trenton, N. J.	44	28	1	1
Utica, N. Y.	30	20	2	1
Yonkers, N. Y.	32	24	1	1
EAST NORTH CENTRAL:	2,312	1,266	48	120
Akron, Ohio	62	38	-	6
Canton, Ohio	36	19	2	1
Chicago, Ill.	674	355	19	36
Cincinnati, Ohio	160	86	5	10
Cleveland, Ohio	191	106	2	4
Columbus, Ohio	125	66	1	7
Dayton, Ohio	75	43	2	7
Detroit, Mich.	271	147	4	8
Evansville, Ind.	38	30	1	-
Flint, Mich.	46	29	-	4
Fort Wayne, Ind.	34	22	2	-
Gary, Ind*	30	14	1	2
Grand Rapids, Mich.	41	29	-	2
Indianapolis, Ind.	143	63	-	14
Madison, Wis.	29	15	-	2
Milwaukee, Wis.	105	65	4	4
Peoria, Ill.	43	16	-	5
Rockford, Ill.	30	19	3	4
South Bend, Ind.	39	27	1	-
Toledo, Ohio	77	42	1	2
Youngstown, Ohio	63	35	-	2
WEST NORTH CENTRAL:	807	480	21	29
Des Moines, Iowa	63	32	-	2
Duluth, Minn.	31	16	-	2
Kansas City, Kans.	42	22	5	2
Kansas City, Mo.	125	77	2	6
Lincoln, Nebr.	25	17	-	-
Minneapolis, Minn.	114	66	-	6
Omaha, Nebr.	71	44	1	1
St. Louis, Mo.	217	130	7	6
St. Paul, Minn.	62	41	1	4
Wichita, Kans.	57	35	5	-

Area	All Causes		Pneumonia and Influenza	Under 1 year
	All Ages	65 years and over	All Ages	All Causes
SOUTH ATLANTIC:	1,035	513	36	58
Atlanta, Ga.	142	65	4	6
Baltimore, Md.	226	112	7	18
Charlotte, N. C.	45	18	3	3
Jacksonville, Fla.	51	25	1	3
Miami, Fla.	88	46	-	6
Norfolk, Va.	51	26	4	2
Richmond, Va.	74	35	-	3
Savannah, Ga.	37	21	4	6
St. Petersburg, Fla.	53	44	5	-
Tampa, Fla.	57	33	5	3
Washington, D. C.	171	66	2	7
Wilmington, Del.	40	22	1	1
EAST SOUTH CENTRAL:	540	269	31	27
Birmingham, Ala.	97	54	4	2
Chattanooga, Tenn.	33	16	-	2
Knoxville, Tenn.	23	11	2	3
Louisville, Ky.	132	65	15	6
Memphis, Tenn.	94	46	4	4
Mobile, Ala.	37	14	1	5
Montgomery, Ala.	37	18	3	1
Nashville, Tenn.	87	45	2	4
WEST SOUTH CENTRAL:	1,085	569	37	58
Austin, Tex.	34	18	5	2
Baton Rouge, La.	27	15	2	-
Corpus Christi, Tex.	20	12	-	1
Dallas, Tex.	155	71	4	8
El Paso, Tex.	29	14	5	3
Fort Worth, Tex.	72	46	2	6
Houston, Tex.	189	85	1	9
Little Rock, Ark.	54	29	1	1
New Orleans, La.	175	83	4	8
Oklahoma City, Okla.	66	37	-	4
San Antonio, Tex.	101	58	1	8
Shreveport, La.	86	52	6	4
Tulsa, Okla.	77	49	6	4
MOUNTAIN:	362	214	16	21
Albuquerque, N. Mex.	30	13	2	-
Colorado Springs, Colo.	21	12	1	-
Denver, Colo.	116	67	2	16
Ogden, Utah	18	12	-	-
Phoenix, Ariz.	83	46	6	3
Pueblo, Colo.	9	7	1	1
Salt Lake City, Utah	47	32	2	-
Tucson, Ariz.	38	25	2	1
PACIFIC:	1,479	913	34	77
Berkeley, Calif.	16	13	1	-
Fresno, Calif.	50	31	1	4
Glendale, Calif.	24	18	-	1
Honolulu, Hawaii	55	26	-	7
Long Beach, Calif.	50	37	2	2
Los Angeles, Calif.	477	290	12	27
Oakland, Calif.	76	44	1	6
Pasadena, Calif.	32	22	-	-
Portland, Oreg.	114	77	2	5
Sacramento, Calif.	65	41	-	2
San Diego, Calif.	72	38	2	8
San Francisco, Calif.	170	98	4	6
San Jose, Calif.	35	20	2	2
Seattle, Wash.	138	84	6	5
Spokane, Wash.	67	48	-	-
Tacoma, Wash*	38	26	1	2
Total	11,216	6,263	329	572

Cumulative Totals
including reported corrections for previous weeks

All Causes, All Ages ----------409,908
All Causes, Age 65 and over----------234,225
Pneumonia and Influenza, All Ages---------- 14,704
All Causes, Under 1 Year of Age---------- 20,798

*Estimate - based on average percent of divisional total.

IMPORTED MALARIA – New York City

(Continued from front page)

epidemiologists in the 10 states in which they reside were contacted and requested to inform the travellers of the occurrence of malaria in one of their travel companions. They were successful in notifying within 24 hours all but one of the 46 travellers of their potential exposure. One traveller was contacted while vacationing on a beach and one individual was located in a hospital where she was being treated for diabetes. The final member of the tour was located 3 days after the information had been received at the NCDC. None of the travellers have experienced symptoms suggestive of malaria to date.

(Reported by Dr. B. H. Kean, Professor of Tropical Medicine, Cornell University; Dr. Tibor Fodor, Chief, Division of Epidemiology, and Dr. Howard B. Shookoff, Chief, Division of Tropical Diseases, both of the New York City Health Department; DHEW Region II, New York City; and the Malaria Surveillance Unit, Epidemiology Program, NCDC.)

HUMAN EXPOSURE TO A RABID BAT – Rhode Island

The first rabid bat found in Rhode Island was reported by the Rhode Island Department of Health Laboratories on June 12, 1967. An 11-year-old boy was bitten on June 10 when he attempted to pet the "sleeping" bat. The child was immediately taken to a hospital where the single puncture wound on the right thumb was cleansed with benzalkonium chloride and a booster dose of tetanus toxoid was administered. The bat was caught in a shoebox later that day; in a short time it died and was buried in the backyard.

On Monday, June 12, an alert local dog officer investigated the incident. The bat was unburied and brought to the Rhode Island Department of Health Laboratories where it was tentatively identified as a little brown bat *(Myotis lucifugus)*. Examination of the brain with Seller's stain yielded equivocal results but direct fluorescent microscopy identified rabies virus. Subsequently, the diagnosis was confirmed in Rhode Island using intracerebrally inoculated mice and at the National Communicable Disease Center by fluorescent antibody technique.

Within 2 hours after the diagnosis was made, prophylactic treatment was begun. Since completion of a full regimen of treatment, the child has, to date, remained well.

Prior to this report, Rhode Island was the only state of the 48 states of the U.S. mainland that had never reported a rabid bat.

(Reported by Joseph E. Cannon, M.D., Director of Health, Rhode Island Department of Health.)

THE MORBIDITY AND MORTALITY WEEKLY REPORT, WITH A CIRCULATION OF 17,000, IS PUBLISHED AT THE NATIONAL COMMUNICABLE DISEASE CENTER, ATLANTA, GEORGIA.

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THE EDITOR
MORBIDITY AND MORTALITY WEEKLY REPORT
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NOTE: THE DATA IN THIS REPORT ARE PROVISIONAL AND ARE BASED ON WEEKLY TELEGRAMS TO THE NCDC BY THE INDIVIDUAL STATE HEALTH DEPARTMENTS. THE REPORTING WEEK CONCLUDES ON SATURDAY; COMPILED DATA ON A NATIONAL BASIS ARE RELEASED ON THE SUCCEEDING FRIDAY.

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