CENTER FOR DISEASE CONTROL



MORBIDITY AND MORTALITY WEEKLY REPORT

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- ACIP Recommendation 510 Poliomyelitis Revention

## NOV 7 1979

International Notes

# Diphtheria in Indochinese Refugees from Thailand RY

At the Lumphini refugee transit center in Bangkok, Thailand, a 2-year-old girl developed clinical evidence of diphtheria and was hospitalized on October 20. She had arrived by bus the night before from Leoi Camp in northern Thailand, where in the preceding month a child had died with pharyngitis and fever of unknown cause. On October 22, the flow of refugees into Lumphini Center was stopped, and active surveillance for diphtheria was initiated at both the camp and the center and among refugees arriving into the United States from Lumphini.

Among 96 refugees who arrived in Los Angeles on October 26, 7 were found to have pyrexia and pharyngitis without pharyngeal exudate or pseudomembrane and were cultured for *Corynebacterium diphtheriae*. One was culture positive: a 32-year-old man, with no known prior diphtheria immunization, who along with 5 well family members traveled to Denver to join his sponsor family before the culture results were available. Biotyping and toxigenicity testing of his isolate are not complete. Among 29 refugees who arrived in Honolulu on October 29, one, a 1-year-old Cambodian boy, had possible signs of diphtheria. The boy was transferred to Tripler Air Force Medical Center for evaluation. Cultures of the boy and 3 family contacts are pending. Culture or clinical evidence of diphtheria was not identified in refugees from 5 other flights arriving in the United States through October 29.

Reported by S Fannin, MD, Los Angeles County Health Dept; J Chin, MD, State Epidemiologist, California Dept of Health Services; RS Hopkins, MD State Epidemiologist, Colorado State Dept of Health; K Wells, MD, USPHS Outpatient Clinic, Honolulu; NH Wiebenga, MD, State Epidemiologist, Hawaii State Dept of Health; Quarantine Div, Field Services Div, and Special Pathogens Br, Bacterial Diseases Div, Bur of Epidemiology, CDC.

Editorial Note: Evidence of diphtheria in refugees at Lumphini Center and possibly at Leoi Camp has prompted several control measures. Attempts have been increased to initiate diphtheria immunization of all persons at the Lumphini Center and other transit camps. The goal is to immunize all refugees at least twice, including once on arrival at a camp and once 3 weeks later. A waiting period of at least 1 week is planned between the second toxoid immunization and departure from Thailand. Until the immunization program is fully implemented and shown to be effective, refugees scheduled to leave Bangkok will be screened within 24 hours of departure for clinical evidence of diphtheria. Those with pyrexia and pharyngitis, exudative pharyngitis, or pseudomembranes will be detained, cultured, and, if indicated, treated for diphtheria. Upon arrival in the United States, refugees will again be screened for evidence of diphtheria. Any persons suspected to have the disease will be cultured and isolated pending results of culture.

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

<u>Recommendation of the Immunization</u> Practices Advisory Committee (ACIP)

## **Poliomyelitis Prevention**

This revised ACIP recommendation on poliomyelitis prevention addresses issues important in poliomyelitis control in the United States today. Specifically, situations that constitute increased risk are defined, and alternatives for protection are outlined. Recommendations for immunization of adults are presented, clarifying the role of Inactivated Polio Vaccine in immunizing adults. These recommendations also address the problems of interrupted immunization schedules and completion of primary immunization. Oral Polio Vaccine remains the vaccine of choice for primary immunization of children.

## INTRODUCTION

Poliovirus vaccines, used widely since 1955, have dramatically reduced the incidence of poliomyelitis in the United States. The annual number of reported cases of paralytic disease declined from more than 18,000 in 1954 to less than 20 in 1973-1978. The risk of poliomyelitis is generally very small in the United States today, but epidemics are certain to occur if the immunity of the population is not maintained by immunizing children beginning in the first year of life.

The proportion of the U.S. population fully immunized against poliomyelitis appears to have declined in recent years. The United States Immunization Survey in 1978 indicated that only 60% of 1- to 4-year-old children had completed primary vaccination against poliomyelitis. Rates for infants and young children in disadvantaged urban and rural areas were even lower. Recent intensive immunization efforts have reversed this downward trend, but clearly there remain many unimmunized (or incompletely immunized) children.

Laboratory surveillance of enteroviruses shows that the circulation of wild polioviruses has diminished markedly. Inapparent infection with wild strains no longer contributes significantly to establishing or maintaining immunity, making universal vaccination of infants and children even more important.

### **POLIOVIRUS VACCINES**

Two types of poliovirus vaccines are currently licensed in the United States: Oral Polio Vaccine (OPV)\* and Inactivated Polio Vaccine (IPV).†

## Oral Polio Vaccine (OPV)

Since it was licensed in the United States in 1963, trivalent OPV, the live attenuated vaccine combining all 3 strains of poliovirus, has almost totally supplanted the individual monovalent OPV antigens used in the early 1960s. Full primary vaccination with OPV will produce long-lasting immunity to all 3 poliovirus types in more than 95% of recipients. Most recipients are protected after a single dose.

OPV consistently induces intestinal immunity that provides resistance to reinfection with polioviruses. Administration of OPV may interfere with simultaneous infection by wild polioviruses, a property which is of special value in epidemic-control campaigns. In rare instances (once in approximately 3 million doses distributed) OPV has been associated with paralytic disease in vaccine recipients or their close contacts. In the 10-year

<sup>\*</sup>Official name: Poliovirus Vaccine, Live, Oral, Trivalent.

<sup>†</sup>Official name: Poliomyelitis Vaccine.

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## Poliomyelitis Prevention - Continued

Period 1969-1978, approximately 242 million doses of OPV were distributed, and 76 cases of paralysis associated with vaccine were reported. Eighteen cases of paralysis occurred in otherwise healthy vaccine recipients, 47 cases in healthy close contacts of vaccine recipients, and 11 cases in persons (recipients or contacts) with immune deficiency conditions.

## Inactivated Polio Vaccine (IPV)

Licensed in 1955, IPV has been extensively used in this country and many other parts of the world. It is given by subcutaneous injection. Where extensively used, IPV has brought about a great reduction in paralytic poliomyelitis cases. Approximately 428 million doses have been administered in the United States, mostly before 1962. Although IPV has not been widely used in this country for more than a decade, a Canadian product licensed for use in the United States is now available.

It is generally accepted that primary vaccination with 4 doses of IPV produces immunity to all 3 poliovirus types in more than 95% of recipients. Additional experience with the currently available, more potent, IPV product is necessary to establish whether the duration of immunity is comparable to that induced by OPV. Experience in other countries forms the basis for the present recommendations on booster doses.

There is considerable evidence from epidemiologic studies that immunizing with IPV diminishes circulation of wild poliovirus in the community, although it is known that persons vaccinated with IPV can subsequently be infected with, and become intestinal carriers of, either wild strains or attenuated vaccine virus strains. No paralytic reactions to IPV are known to have occurred since the 1955 cluster of poliomyelitis cases caused by vaccine that contained live polioviruses that had escaped inactivation. Serious adverse reactions are not anticipated with the current IPV product.

## **ROUTINE IMMUNIZATION**

## Rationale for Choice of Vaccine

Although IPV and OPV are both effective in preventing poliomyelitis, OPV is the vaccine of choice for primary immunization of children in the United States when the benefits and risks for the entire population are considered. OPV is preferred because it induces intestinal immunity, is simple to administer, is well accepted by patients, results in immunization of some contacts of vaccinated persons, and has a record of having essentially eliminated disease associated with wild polioviruses in this country. The choice of OPV as the preferred polio vaccine in the United States has also been made by the Committee on Infectious Diseases of the American Academy of Pediatrics (1) and a special expert committee of the Institute of Medicine, National Academy of Sciences (2).

Some poliomyelitis experts contend that greater use of IPV in the United States for routine vaccination would provide continued control of naturally occurring poliovirus infections and simultaneously reduce the problem of OPV-associated disease. They argue that there is no substantial evidence that OPV and currently available IPV differ in their ability to protect individuals from disease. They question the public health significance of higher levels of gastrointestinal immunity achieved with OPV. Finally, they question whether the transmission of vaccine virus to close contacts contributes substantially to the level of immunity achieved in the community.

Some countries prevent poliomyelitis successfully with IPV. However, because of many differences between these countries and the United States, particularly with respect to risks of exposure to wild polioviruses and the ability to achieve and maintain very high vaccination rates in the population, their experiences with IPV may not be directly

## Poliomyelitis Prevention - Continued

applicable here. Based on current achievements in the United States with other vaccines, it is doubtful that a sufficient number of persons would regularly receive vaccination with IPV to sustain the present level of poliomyelitis protection in the community and to prevent recurrence of outbreaks.

Prospective vaccinees or their parents should be made aware of the polio vaccines available and the reasons why recommendations are made for giving specific vaccines at particular ages and under certain circumstances. Furthermore, the benefits and risks of the vaccines for individuals and the community should be stated so that vaccination is carried out among persons who are fully informed.

#### **RECOMMENDATIONS FOR INFANTS, CHILDREN, AND ADOLESCENTS**

## **Primary Immunization**

**OPV:** For infants, children, and adolescents (up to the 18th birthday) the primary series of OPV consists of 3 doses. In infancy the primary series is integrated with DTP vaccination, and the first dose is commonly given at 6-12 weeks of age. At all ages the first 2 doses should be separated by at least 6, and preferably 8, weeks. The third dose is given at least 6 weeks, and preferably 8-12 months, after the second dose.

(Continued on page 517)

	43rd Wi	EK ENDING		CUMU	LATIVE, FIRST 4	WEEKS
DISEASE	October 27, 1979	October 28, 1978*	MEDIAN 1974-1978**	October 27, 1979	October 28, 1978*	MEDIAN 1974-1978*
Aseptic meningitis	254	199	113	6,640	5,329	3,32
Brucellosis	1	3	2	135	146	18
Chickenpox	762	997	1.104	174,414	127,708	127,70
Diphtheria	-		-	64	63	128
Encephalitis: Primary (arthropod borne & unspec.)	27	28	34	842	1,009	1,009
Post infectious	3	1	3	187	198	215
Hepatitis, Viral: Type B	273	308	268	11,956	12,412	12.404
Туре А	479	670	670	24,263	24.123	27,923
Type unspecified	234	20 3	178	8,828	6,954	6,819
Malaria	24	17	6	616	624	39
Measles (rubeola)	60	125	155	12,506	24,670	24.54
Meningococcal infections: Total	26	35	25	2,137	2,018	1,29
Civilian	26	35	25	2,125	1,994	1,27
Military	-			12	24	24
Mumps	106	133	371	11,844	14,170	34,114
Pertussis	18	27	27	1,118	1,745	1.424
Rubella (German measles)	51	90	90	10,990	17,265	15,321
Tetanus		1	3	58	69	69
Tuberculosis +	539	557	622	23,114	24,024	25,185
Tularemia	3	2	2	170	107	113
Typhoid fever	5	19	10	412	433	350
Typhus fever, tick borne (Rky. Mt. spotted)	16	12	12	978	1,002	641
Venereal diseases:	and the first state					
Gonorrhea: Civilian	21,335	22,696	21,871	826,597	837,055	836.412
Military	395	533	511	22,675	21,446	22,40
Syphilis, primary & secondary: Civilian	607	555	475	20,602	17,791	17,791
Military	10	5	5	255	251	261
Rabies in animals	81	80	44	4,191	2,658	2.508

TABLE I. Summary - cases of specified notifiable diseases, United States

TABLE II. Notifiable diseases of low frequency, United States										
The second se	CUM. 1979		CUM. 1979							
Anthrax		Poliomyelitis: Total	25							
Botulism †(Ky 1)	24	Paralytic	21							
Cholera	1	Psittacosis (Colo. 1)	83							
Congenital rubella syndrome	39	Rabies in man	3							
Leprosy †(Fla. 1)	146	Trichinosis	128							
Leptospirosis (Texas 1)	41	Typhus fever, flea-borne (endemic, murine)	52							
Plague	10	· , ,	-							

\*Delayed reports received for calendar year 1978 are used to update last year's weekly and cumulative totals.

\*\*Medians for gonorrhea and syphilis are based on data for 1976 1978.

The following delayed reports will be reflected in next week's cumulative totals: Botulism: Ky, +2; Leprosy: S.C. +1, Pac.Tr.Terr. +1

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REPORTING AREA	ASEPTIC	BRU-	0000755		100		ENCEPHALI	TIS	HEPATI	TIS (VIRA	L), BY TYPE			
	MENIN- GITIS	CEL- LOSIS	POX	DIPHTHERIA		Pr	imary	Post-in- fectious	8	A	Unspecified	MAI	LARIA	
	1979	1979	1979	1979	CUM. 1979	1979	1978*	1979	1979	1979	1979	1979	CUM. 1979	
INITED STATES	254	1	762	-	64	27	28	3	273	479	234	24	614	
EW ENGLAND	4	-	139	-		2	-		8	11	12	1	39	
	-	-	32	-	-	-	-	-	-	3	1		3	
₩.H. /t.		-	21	-	-		-	-	1	-	2	-	1	
Mass.	-	-	-	-	-	-	-	-	-	2	-	-	-	
R.I.	1	2	45			2		-	2	2 4	7	-	11	
Conn.†	3	-	14 27		-	-		-	4	-	2	ī	15	
WID, ATLANTIC	48		28		-	3	4		22	20	10	12	84	
N.Y. City	8	-	13				1	-	3	8	1	12	13	
N.J.	6 16	-	11 NN			ī.	1	-	4 15	4 8	4 5		39	
Pa.t	18	-	4	-	-	ż	2	-	NA	NA	NĂ	-	18	
E.N. CENTRAL	38	-	288		2	-	10	-	26	60	5	1	47	
Ohio Ind. t	NA	NA	NA	NA	-	NA	2		NA	NA	NA	NA	12	
III.	-	-	24	-	1	-	1	-	9	3	1	-	1	
Mich.	33	1.1	24 111	1.2	-		3		5 10	26	4	ī	20	
Wia,	3	2	129	1	ĩ	Ξ	-	-	2	5	-	-	2	
W.N. CENTRAL	9	-	82	-	1	2	1	-	13	18	27	2	21	
lowa t	-	-	-	-	-	-			3	9	-	1	8	
Mo	7	-	46	-		2	1	-	1	1	2	-	2	
N. Dak.	6	-	18		1		2	-	9	4	17	-	3	
a Dak	-	-	5	-		-	-	-				-	1	
Nebr. Kans.	1	2	-		-	-	-	-	-	1	-	ī	2	
S. ATLANTIC	2		13		-	-	-	-		3				
	29	-	77	-	1	5	2	2	69	67	27	2	71	
Md.	-	2	3	2		- 2	-	-	2 8	5	4	1	12	
D.C. Va.t	-	-	-	-	-	-			-	ĩ			6	
W.Va.t	10	-	3	-	1	1	1	2	13	7	4	1	22	
	4		52	-	-	1		-	1	6	1	-	2	
S.C.	8	-	NN	-	1.1	2	1	-	7 9	9 1	3	- 2	6	
Ga, Fla	1	2.	5	- 2	- 2.			-		1	-	-	2	
	6	-	14		-	1	-	2	29	38	14	1	19	
E.S. CENTRAL	32	1	2	-	-	7	5	-	34	34	6	2	11	
Tenn	1	-	2	-	-	-	-		-	-	-	-		
Ala	14	1	NN	-	-	3	1	-	25	18	2	-		
Miss.	11 6	-		2.	1	22	4	12	6 3	10	4	-2	3	
W.S. CENTRAL	23	-	60	-	-	7	3	_	22	58	53	2	35	
Ark.	2	-	-	-	-	-	1	-	-	6	5	-		
Okla.	4	-	NN	-	-	1			3	12	3		5	
Tex.	7 10		60	- 1		1 5	2		9 10	37	6 39	-2	6 28	
MOUNTAIN														
	9	Ξ	31		1	1			6	77	43	12	17	
Idaho	-	-	20	-	- 2	-		1.2	-	1		- 2	-	
Wya. Colo	-	-	-	-	-	-	-			-	-		1	
N. Mex	8	-	6	-		1	-		1	8	1	-	7	
Aris	1	2	3	1	-		1.1	- 2	4	12 34	31	1	1	
Utah	-	-	NN 1		1	12	- 2	- 2 -	- 2	2	7		2	
Nev.	-	-	î	-	-	-	-	-	- 1	15	4	I	1	
PACIFIC	64		55	-	59		3	1	73	134	51	14	287	
Orea	4	-	51		56	- G -			6	29	6	-	12	
Galif +	2	-	1	-	-	-	1	12	8	9	1	1	12	
Alaska	53	-	-	5	3	121	3	1	56	95	43	10	258	
riawaii †	1 4	-	1 2		-	- 2			3	1	1	3	5	
0														
Guam t P.R.	NA	NA	NA	NA	-	NA	-	-	NA	NA	NA	NA	-	
VI	14	-	21	-	-	-	-	-	2	5	2	-	2	
Pac. Trues Ton &	NA	NA.	NA	NA	2	NA	- 2	2	NA	NA	NA	NA	0.12	
NN: Not notifiable.														

TABLE III. Cases of specified notifiable diseases, United States, weeks ending October 27, 1979 and October 28, 1978 (43rd week)

Ni: Not notifiable. NA: Not available. Delayed reports received for 1978 are not shown below but are used to update last year's weekly and cumulative totals. The second s <sup>1</sup> The following delayed reports received for 1978 are not shown below but are used to update last years weekly and communication to the following delayed reports will be reflected in next week's cumulative totals: Asep, meng.: Pa. -2, Ind. +9; Chickenpox: Iowa +20, Calif. +5, Guam +9, Pac. T. Tar. +34; Enceph.: Pa. -1, Ind. +4, W.Va. -1; Hep. B: Conn. -1, Minn. +1, Va. -1; Hep. A: Minn. +2, N.C. -1, Hawaii -1, Guam +1; Hep. unsp.: Iowa -1, Va. -1; N.C. -1, Pac.Tr.Terr. +6; Malaria: Minn, +1.

	N	AEASLES (RI	JBEOLA)	MENIN	GOCOCCAL I TOTAL	NFECTIONS		MUMPS	PERTUSSIS	RUBELLA		TETANU
REPORTING AREA	1979	CUM. 1979	CUM. 1978*	1979	CUM. 1979	CUM. 1978*	1979	CUM. 1979	1979	1979	CUM. 1979	CUM. 1979
UNITED STATES	60	12,506	24,670	26	2,137	2,018	106	11,844	18	51	10,990	58
NEW ENGLAND		288	1,988	1	113	110	18	489		1	1,420	5
Maine		17	1,316		7	7	10	183	I		61	1
N.H.	-	32	55	-	13	9	-	5	-	-	125	-
Vt.	2	119	33	-	7	2	-	2	-	1	398	-
Mass.	-	14	248		34	44	6	60	-	_	487	3
R.I. Conn.	24	102	8 328	1	8 44	17 31	1	42 190	- 2	1	93 256 -	1
MID. ATLANTIC	3	1,506	2,200	5	340	313	1	1,152	2	1	1,950	82
Upstate N.Y.	-	621	1,406	1	114	101	1	166	2	_	1,091	4
N.Y. City N.J.	3	782	362		84	72	1	565		1	325	ī
Pa.	- 2	46	358	2	64	62 78	ŝ	295		-	265	ī
E.N. CENTRAL	12	3, 266	11,019	3	222	283	34	5,058	5	16	2,559	4
Ohio	NA	282	487	-	78	74	NA	1,801	NĂ	ŇĂ	140	3
Ind.	2	216	200		42	46	5	300		4	745	-
111.	-	1,441	1,120	-	20	90	6	894	1	-	187	-
Mich.	5	836	7,736	3	65	62	16	928	4	7	1,218	1
Wis.	5	491	1,476	-	17	11	7	1,135		5	269	-
W.N. CENTRAL	21	1,779	402	4	64	79	8	683		11	482	2
Minn.	-	1.218	40	3	14	21	2	20		-	41	1.
lowa	-	16	57	-	11	10	-	234	-	-	52	ī
Mo.	6	420	12	-	29	31	112	195		4	65	i
N. Dak.		21	198	-	1	3	- 21	27	-	-	8	-
S. Dak.	15	2 35	5		2	Э	- 2	÷	-		202	-
Nebr. Kans.	-	67	90	1	7	11	6	218	-	7	109	-
& ATLANTIC	9	1,926	5,284	5	521	479	13	625	1	3	1,237	11
Del.	-	1	7	-	3	2	8	53	-	- 21	5	-
Md.	-	16	52	-	46	34	-	166	-		28	1
D.C.	-		48	-	2	2	-	2			1	ī
Va.†	-	276	2,830	2	76	58	1	87 104	111	1	203 108	-
W. Va. N.C.		57 113	1,058 121	1	81	13	1	77	1.1	1	530	3
S.C.†	1	169	199	-	59	32	-	3	-	-	64	-
Ga.	6	494	34	-	77	53	_	7		-	11	-
Fla.	2	800	935	2	169	190	3	126	1	1	287	6
E.S. CENTRAL	2	214	1,423	2	160	159	9	1,383		- <u>-</u>	302	8
Ky.		37	119	-	33	30	6	1,139	-	-	68	1
Tenn.	2	68	958	-	44	41	2	103		-	96	5
Ala.	-	85	101	-	38	47	1	24		-	44	2
Miss.		24	245	2	45	41	-	117	-	-	92	
W.S. CENTRAL	2	932	1,154	2	328	281	3	1,361	3	6	252	16
Ark.	-	9	16		27	22	-	481	-		7	3
La.	-	250	343	1.2	118	116	-	34	_	1	30 23	-
Okla.† Tex.	2	22 651	14 781	1	32 151	16 127	3	844	3	1 4	192	9
MOUNTAIN	1	326	260	_	86	49	3	294		5	534	-
Mont	-	57	106	-	10	4		10	-	ĩ	70	•
idaho t	-	18	1	-	7	4		9	-	÷ _	204	5
Wyo.	-	36	-	-	1	-	-		-	-	-	
Colo.		68	38	-	5	3	2	93		-	66	-
N. Mex.	-	39		-	6	12	1	13	-	-	11 143	-
Ariz.	ī	77	51	2	36	15	- D	59 96		2	38	-
Utah Nev.		19 12	44 20	-	12	6 5	12	14		-	2	-
PACIFIC	10	2,269	940	4	303	265	11	799	7	8	2,254	4
Wash.	2	1,135	219	2	54	44	2	201	2	-	188	-
Oreg.	-	61	148	1	24	29	-	94	* -	-	109	4
Calif.	8	988	563	1	209	181	8	386	5	8	1,929	-
Alaska	-	17	1	-	6	8	1	12	10 <u>+</u>		4	-
Hawaii †	-	<b>68</b>	9	-	10	3	2	106	-	-	24	1.20
Guar	NA	11	25			1	NA		NA	NA	4	-
Guam P.R. †	NA 6	363	270	1	1	7	NA 9	11 572	-		38	10
V.I.	-	4	6	-	3	i		20		-	-	-
Pac. Trust Terr. †	NA	9	619		ĩ	3	NA	34	NA	NA	1	

## TABLE III (Cont.'d). Cases of specified notifiable diseases, United States, weeks ending October 27, 1979, and October 28, 1978 (43rd week)

NA: Not available. \*Delayed reports received for 1978 are not shown below but are used to update last year's weekly and cumulative totals.

t The following delayed reports will be reflected in next week's cumulative totals: Measles: Va. -1, Hawaii -1, P.R. +1; Men. inf.: Idaho +1; Mumps: Pac<sup>TT</sup> Terr. +6; Pertussis: S.C. +5, Okla. +18, Pac.Tr.Terr. +3; Rubella: Hawaii -5.

#### MMWR

REPORTING AREA		TUBERCULOSIS		TVP	HOID	TYPHUS	FEVER		VENERE	AL DISEASES (	ivilian)			RABIES	
	1081	i udenculuais					VER	(Tick-b (RM:	orne) SF)	- IN - C	GONORRHEA		SY	PHILIS (Pri.	& Sec.)
	1979	CUM. 1979	CUM. 1979	1979	CUM. 1979	1979	CUM. 1979	1979	CUM. 1979	CUM. 1978*	1979	CUM. 1979	CUM. 1978*	CUM. 1979	
UNITED STATES	539	23,114	170	5	412	16	978	21,335	826,597	837,055	607	20,602	17,791	4,191	
NEW ENGLAND	16	659	з	1	18	- E.	9	658	20,470	21,465	9	407	486	45	
Maine	-	50	-	-	1			34	1,432	1,753	-	10	8	28	
N.H.	1	16	-	-	-	-	-	21	756	963	-	18	5		
Vt. Mass.	3	29		-		-	1	17	504	518	-	1	3		
R.I.	6	343 57	3	-	10		4	250	8,132	9,447	5	225	300		
Conn.	6	164		ī	2 5		4	38 298	1,645	1,537 7,227	4	16 137	20 150		
MID. ATLANTIC	74	3,603	1	-	67	1	44	2,303	89,800	90,172	95	3,092	2, 335	67	
Upstate N.Y.	11	648	1		13		27	627	15,722	15,165	7	223	163	47	
N.Y. Cityt N.J.	36	1,352	-	-	29	-	1	867	34,411	34,191	65	2,089	1,620		
Pa.	11	664 939	-	-	16	ī	5 11	172	15,851	16,963	16	410	287		
			1.1.	- 10	-			637	23,816	23,853					
E.N. CENTRAL Ohio	93	3,405	-	-	27	-	58	3,112	128,483	129,573	49	2,594	2,023	374	
Ind.t	NA 14	598 436		NA	3	NA	21	230	34,728	33,350 13,417	NA 2	506 179	368		
114.	53	1,374		_	8		31	1,817	40,934	41,285	40	1,461	1,284		
Mich.	21	838	-	-	12		3	770	30,320	30,062	5	378	1,20		
Wis. †	5	159	-	-	4	-	ĩ	295	11,866	11,459	2	70	55		
W.N. CENTRAL	12	780	24	3	20		53	1,122	41,079	42,388	8	267	368		
minn,	2	121	÷	-	4	-	2	181	6,767	7,209	2	73	135	142	
lowa Mo,		59	1	1	5	-	14	148	4,919	4,654	-	28	30	159	
N. Dak.	5	422	20	2	8	-	25	590	17,726	18,733	3	123	117		
S. Dak.t	2	18		-	-	-	-	9	692	744	-	2	3		
Nebr.	12	46	2		1		4	35 76	1,375	1,453	-	2	12		
Kans. t	3	22 92	1 -		2		a	83	2,919 6,681	3,076 6,519	3	34	68		
S ATLANTIC	1 20	5,211	11	-	41	4	559	5,204	199,977	204,169	136	4,870	4,719	589	
Del.	1	46	- 12	-			3	88	3, 322	2,861	-	24	10	Carried -	
Md. D.C.	11	663	-	-	7		75	907	24,649	26,287	4	311	363	37	
Va.	10	249	2	-	1	-	2	377	13,211	13,683	7	373	360		
W. Va.	9	619	2	-	4	1	91	587	19,179	19,634	18	399	399		
N.C.t	6	199	-	-	4		9	62	2,742	2,810	11	45	24		
S.C. †	18	821	ī	_	2	1	217	736	28,880 18,412	28,918 20,083	- 11	380	240		
Ga,	27	824	6		2	- 1 A -	81	1,104	37,956	39,331	33	1,365	1.166		
Fla.	27	1,390	-		18	1	8	1.061	51,626	50,562	56	1,726	1,657		
E.S. CENTRAL	53	2,107	14	-	21	5	132	2,004	70,590	71,075	43	1,375	933	284	
Ky. Tenn,	8	544	2		7	-	19	194	9,403	9,411	3	138	126		
Ala.	13	609	12	-	3	2	75	651	25,426	26,234	14	580	309		
Miss.	22	504	11-1		8	2	19	842	20,956	20,261	6	250	162		
	10	450	-	-	3	1	19	317	14,805	15,169	20	407	336	• 1	
W.S. CENTRAL Ark. t	60	2,778	71	-	71	6	102	2,666	106,104	112,690	120	3,783	2,843	1,561	
La	3	240	45	-	5	- 2	22	237	8,303	8,408	3	132	60		
Okla.	7	553	5	-	5	-	3	604	18,906	18,245	46	971	601		
Tex.	11 39	311	14	-	61	6	61 16	292 1,533	10,516 68,379	10,664	2 69	2,604	2,096		
MOUNTAIN											1				
mont.t	18	697	38		25	-	16	819	33,295	31,928	19	415	363		
Idaho	-	32	9		1	_	5	23 15	1,630	1,317	111	25	13		
Wyo.	12	13	1		1	-	-	10	957	783	-	8			
Colo.	4	1.03	12	-	14	-	4	271	8,852	8,822	4	81	103		
N. Max. Ariz.	4	119	4	-	4	-	i	88	4,079	4,611	4	75	76	39	
Utah	8	346	-	-	3	-	-	225	9,297	8,199	9	123	81		
Nev.	1	27 50	10	12	-2	-	1	53 134	1,701 5,304	1,735 4,639	1	91	12		
PACIFIC	11			1.1		100					1.0				
**ash	93	3,874	8	1	122	-	5	3,447	136,799	133,595	128	3,799	3,721	306	
Oren.	15	231	5	1	7	-	-	227	12,041	11,102	NA	166	213		
Calif.	17	168		-	2	-	-	264	8,562	9,184	1 22	148	138		
Alaska	53	3,141	3		104	- 2	5	2,797	109,364	106,786	123	3,383 21	3,322		
Hawaii	8	63 271	-	-	2 7	-	-	59	4,210 2,622	4,138 2,385	1	81	38		
Guard															
Guam t P.R.	NA	50	-	NA	-	NA	-	NA	82	123	NA	1		-	
V.I.	6	256	-	- 1	5	111 51	-	29	1,827	1,850	17	479	411	20	
Pac. Trutt Tons +		4	-	-	1		-	1	135	166		7	15	-	
NA: Not available	NA	29		NA		NA		NA	344	382	NA	1	-		

## TABLE III (Cont.'d). Cases of specified notifiable diseases, United States, weeks ending October 27, 1979 and October 28, 1978 (43rd week)

NAT. Not available. "Delayed reports received for 1978 are not shown below but are used to update last year's weekly and cumulative totals. "Delayed reports received for 1978 are not shown below but are used to update last year's weekly and cumulative totals. The second s Many del reports received for 1978 are not shown below but are used to update last year's weekly and compliance loters. The following delayed reports will be reflected in next week's cumulative totals: TB: Kans. -1, N.C. -6, S.C. -1, Guam +3, Pac.Tr.Terr. +3; Tularemia: Mont. +5; GC: NYC +988 civ., Ind. +389 civ., Wis. +6 civ., S.Dak. -1, Guam +6 civ. +8 mil., Pac.Tr.Terr. +26 civ.; Syphilis: Ind. +6, Ark. -1.

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## TABLE IV. Deaths in 121 U.S. cities,\* week ending October 27, 1979 (43rd week)

		ALL CAUSE	S, BY AGE	(YEARS)		1.1	122/4/2010/04/1	ALL CAUSES, BY AGE (YEARS)						
REPORTING AREA	ALL	>85	45-64	25-44	<1	P & I** Total	REPORTING AREA	ALL AGES	>65	45-64	25-44	<1	P&I** TOTAI	
NEW ENGLAND	692	462	149	35	21	37	S. ATLANTIC	1, 103	669	301	61	37	40	
Boston, Mass.	190	103	52	14	12	11	Atlanta, Ga.	143	88	36	6	5		
Bridgeport, Conn.	46	31	13	1		1	Baltimore, Md.	107	59	35	7	3	1	
Cambridge, Mass. Fall River, Mass.	31 28	24 20	4	3	-	3	Charlotta, N.C. Jacksonville, Fla.	46 124	25 76	14 29	3 12	1		
Hartford, Conn.	55	37	9	5	1	3	Miami, Fla.	124	75	39	2	6		
Lowell, Mass.	40	25	9	2	î.	2	Norfolk, Va.	56	31	19	2	4	- 2	
Lynn, Mass.	18	14	4	_	-	-	Richmond, Va.	86	49	22	11	2		
New Bedford, Mass.	19	16	2	1	-	1	Savannah, Ga	43	28	11	1	2		
New Haven, Conn. Providence, R.I.	51	33	.9	6	2		St. Petersburg, Fla. Tampa, Fla.	61 84	46 52	10 22	1 5	3		
Somerville, Mass.	62	38	17	3	1	7	Washington, D.C.	180	111	48	9	7		
Springfield, Mass.	36	27	6	1.1	2	2	Wilmington, Del.	49	29	16	ź	1		
Waterbury, Conn.	38	29	6	10 m - 1	-	3	1.64 1.11							
Worcester, Mass.	69	57	10	1941	1	4				10			30	
							E.S. CENTRAL	730	419	220	45	12	34	
MID. ATLANTIC	7. 5.75	1,629	598	140	82	112	Birmingham, Ala. Chattanooga, Tenn.	106	55 37	34 20	3	2	-	
Albany, N.Y.	2, 521	29	18	2	4	112	Knoxville, Tenn.	36	21	13	-	- 1	1	
Allentown, Pa.	21	18	3	-			Louisville, Ky.	108	55	38	11	1	8	
Buffalo, N.Y.	138	86	39	8	2	8	Memphis, Tenn.	194	127	50	6	1		
Camden, N.J.	41	22	10	6	3	1	Mobile, Ala.	80	41	20	8	3	15	
Elizabeth, N.J.	27	16	8	3		2	Montgomery, Ala.	40	25	10	2	2	1	
Erie, Pa.† Jersey City, N.J.	56 48	37	14	3	1	4	Nashville, Tenn.	105	58	35	6	3		
Newark, N.J.	48	37	13 13	6	9	2								
N.Y. City, N.Y. 11	1,273	831	287	ลดี	35	49	W.S. CENTRAL	1, 203	695	336	91	34	2	
Paterson, N.J.	33	22	5	1	5	2	Austin, Tex.	61	41	14	5	-	3	
Philadelphia, Pa. †	318	194	76	19	16	17	Baton Rouga, La.	57	34	16	1	2	2	
Pittsburgh, Pa. 1	66	44	19	1	1	1	Corpus Christi, Tax.	32	22	7 59	2	1		
Reading, Pa. Rochester, N.Y.	24	19	5	-	2	3	Dallas, Tex.	196	101 28	15	21 2	3	2	
Schenectady, N.Y.	111	81	23 8	1 2		11	El Paso, Tex. Fort Worth, Tex.	93	55	28	5	î	2	
Scranton, Pa.1	30	25	5	-	-	4	Houston, Tex.	207	110	63	17	6	2	
Syracuse, N.Y.	90	53	29	3	3	- 1 H	Little Rock, Ark.	64	41	11	4	2	2	
Trenton, N.J.	52	39	12	1000	1	2	New Orleans, La.	116	59	36	10	10	3	
Utics, N.Y. Yonkers, N.Y.	29	23	5	1	-	2	San Antonio, Tex.	168	104	47	7	6	ĩ	
TORKERS, IN. T.	26	19	6	1	97	2	Shreveport, La. Tuisa, Okia.	106	63	29	10	1	3	
E.N. CENTRAL	2,340	1,379	600	150	102	57	Contra de la contr							
Akron, Ohio	107	71	19	8	- 4	-	MOUNTAIN	561	336	141	34	24	21	
Canton, Ohio	42	30	9		1	1	Albuquerque, N. Mex.	47 31	27	12	3	2	3	
Chicago, III.	547 169	291 100	153 40	50 11	32 10	9	Colo. Springs, Colo. Denver, Colo.	102	65	26	4	4	1	
Cincinnati, Ohio Cleveland, Ohio	163	\$3	55	- 6	3	2	Las Vegas, Nev.	59	33	19	6	-	3	
Columbus, Ohio	139	80	35	8	9	2	Ogden, Utah	19	10	6	2	-	1	
Dayton, Ohio	110	73	24	4	4	2	Phoenix, Ariz.	126	81	28	6	7	1	
Detroit, Mich.	263	144	80	17	9	9	Pueblo, Colo.	30	18	8	2	6	2	
Evansville, Ind.	39 49	24	8 11	4 5	2	17	Salt Lake City, Utah	67 80	37	14 23	5	3	-	
Fort Wayne, Ind. Gary, Ind.	16	27	8	2	- 1	1	Tucson, Ariz.	00	70	23		1		
Grand Rapids, Mich.	43	33	4	2	2	1								
Indianapolis, Ind.	151	83	42	12	5	2	PACIFIC		1,037	351	102	72	48	
Madison, Wis.	53	27	14	3	6	7	Berkeley, Calif.	11	9	2	-	-		
Milwaukee, Wis.	162	107	39	5	4	3	Fresno, Calif.	46	22	12	1	9	1	
Peoria, III.	26	15	6	7	1	3	Glendale, Calif.	19	17	14	6	1	2	
Rockford, III. South Bend, Ind.	43 36	28	8	4	2		Honolulu, Hawaii	86	52	24	6	3	2	
Toledo, Ohio	125	84	22	6	5	5	Los Angeles, Calif.	462	319	72	32	13	16	
Youngstown, Ohio	57	36	16	3	ĩ	-	Oakland, Calif.	91	49	27	9	3	-	
110 2							Pasadena, Calif.	24	20	2	1	1	-	
							Portland, Oreg.	110	77	22	1	5	3	
W.N. CENTRAL Des Moines, Iowa	733	469	156	45 5	31	33 2	Sacramento, Calif.	74	41	22	10	8	-	
Duluth, Minn.	23	19	11 2	1	1	3	San Francisco, Calif.	155	90	44	10	5	3	
Kansas City, Kans.	29	14	10	3	1	3	San Jose, Calif.	128	87	23	4	4	3	
Kansas City, Mo.	107	71	20	8	5	3	Seattle, Wash.	147	93	33	11	10	6	
Lincoln, Nebr.	25	20	4	-	1	3	Spokane, Wash.	41	27	11	2	1	2	
Minneapolis, Minn.	103	62	20	9	8	3	Tacoma, Wash.	49	29	11	5	4	1	
Omaha, Nebr.	70	46	12	3	7	3								
Ce Louis Mo			20	2	6		1						409	
St. Louis, Mo. St. Paul, Minn.	60	38	16	2	-	2	TOTAL	11,507	7.095	2.852	703	415	40-	

\*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

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

tt(NYC) Data not available. Figures are estimates based on average percent of regional totals.

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## Poliomyelitis Prevention - Continued

IPV: The primary series consists of 4 doses of vaccine; volume and route of injection are specified by the manufacturer. In infancy, the primary schedule is usually integrated with DTP vaccination, as with OPV. Three doses can be given at 4- to 8-week intervals; the fourth dose should follow 6-12 months after the third.

All children should complete primary immunization with OPV or IPV before entering school.

## Supplementary Immunization

**OPV:** Before school entry, all children who previously received primary immunization with OPV (3 doses) in early childhood should be given a fourth dose. This additional dose will increase the likelihood of complete immunity in the small percentage of children who have not previously developed serum antibodies to all 3 types of polioviruses. The need for supplementary doses after the 4 basic doses of OPV has not been established, but children considered to be at increased risk of exposure to poliovirus (as noted below under **RECOMMENDATIONS FOR ADULTS**) may be given a single additional dose of OPV.

IPV: Before entering school, all children who previously received primary immunization with IPV (4 doses) in early childhood should be given at least 1 dose of OPV or 1 additional dose of IPV. Use of a primary series of OPV would eliminate the need for subsequent booster doses of IPV. Children who received primary immunization with IPV should obtain a booster dose of IPV every 5 years until the age of 18 years, unless a primary series of OPV is given. The need for supplementary doses after the 5 basic doses of the currently available IPV product has not been firmly established. Further experience may lead to alteration of this recommendation.

## Children Incompletely Immunized

The preadolescent years are a good time to re-evaluate polio vaccination status and to complete the immunization of those who are inadequately protected.

OPV: To help assure seroconversion to all 3 serotypes of poliovirus, completion of the primary series of 3 doses of OPV is recommended. Time intervals between doses longer than those recommended for routine primary immunization do not necessitate additional doses of vaccine. Individuals who received only 1 dose of each of the monovalent OPVs in the past should receive 2 doses of trivalent OPV at least 6 weeks apart. One dose of each monovalent OPV (poliovirus types 1, 2, and 3) is at least equivalent to 1 dose of trivalent OPV.

IPV: Regulations for vaccine licensure adopted since 1968 require a higher potency IPV than was previously manufactured. Four doses of IPV administered after 1968 are considered a complete primary series. As with OPV, time intervals between doses longer than those recommended for routine primary immunization do not necessitate additional doses.

Incompletely immunized children who are at increased risk of exposure to poliovirus (as noted below under **RECOMMENDATIONS FOR ADULTS**) should be given the remaining required doses or, if time is a limiting factor, at least a single dose of OPV.

## **RECOMMENDATIONS FOR ADULTS**

Routine primary polio vaccination of adults (those past the 18th birthday) residing in the United States is not necessary. Most adults are already immune and have a very small risk of exposure to poliomyelitis. Immunization is recommended for certain adults

### Poliomyelitis Prevention - Continued

- who are at greater risk of exposure to poliovirus than the general population, including:
  - 1. travelers to areas or countries where poliomyelitis is epidemic or endemic;
  - members of communities or specific population groups with disease caused by wild poliovirus;
  - 3. laboratory workers handling specimens which may contain polioviruses;
  - health care workers in close contact with patients who may be excreting polioviruses.

For individuals in the above categories, polio vaccination is recommended, as detailed below.

## **Unvaccinated Adults**

For adults at increased risk of exposure to poliomyelitis, primary immunization with IPV is recommended whenever this is feasible. IPV is preferred because the risk of vaccineassociated paralysis following OPV is slightly higher in adults than in children. Three doses should be given at intervals of 1-2 months; a fourth dose should follow 6-12 months after the third.

In circumstances where time will not allow at least 3 doses of IPV to be given before protection is required, the following alternatives are recommended:

- If less than 8, but more than 4, weeks are available before protection is needed, 2 doses of IPV should be given at least 4 weeks apart.
- If less than 4 weeks are available before protection is needed, a single dose of OPV is recommended.

In both instances the remaining doses of vaccine should be given later, at the recommended intervals, if the person remains at increased risk.

#### **Incompletely Immunized Adults**

Adults who are at increased risk of exposure to poliomyelitis and who have previously received less than a full primary course of OPV or IPV should be given the remaining required doses of either vaccine, regardless of the interval since the last dose.

## Adults Previously Given a Complete Primary Course of OPV or IPV

Adults who are at increased risk of exposure to poliomyelitis and who have previously completed a primary course of OPV may be given another dose of OPV. The need for further supplementary doses has not been established. Those adults who previously completed a primary course of IPV may be given a dose of either IPV or OPV. If IPV is used exclusively, additional doses may be given every 5 years, but their need also has not been established.

## **Recommendations for Unvaccinated Parents of Children to be Given OPV**

Unvaccinated parents of infants who are to be given OPV are at a very small risk of developing OPV-associated paralysis. Therefore, when OPV strains are to be introduced into a household with adults who have never received any polio vaccine, some health care personnel may elect to give these adults at least 2 doses of IPV a month apart-if not the full primary series—before the children receive OPV. Vaccination of the children must be assured and not unduly delayed by this process—the primary concern is immunization of the child.

## PRECAUTIONS AND CONTRAINDICATIONS

## Pregnancy

Although there is no convincing evidence documenting adverse effects of either OPV or IPV on the developing fetus or pregnant woman, it is prudent on theoretical grounds

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## Poliomyelitis Prevention - Continued

to avoid vaccinating pregnant women. However, if immediate protection against poliomyelitis is needed, OPV is recommended.

## Immunodeficiency

Patients with immune deficiency diseases, such as combined immunodeficiency, hypogammaglobulinemia and agammaglobulinemia, should not be given OPV because of their substantially increased risk of vaccine-associated disease. Furthermore, patients with altered immune states due to diseases such as leukemia, lymphoma, or generalized malignancy, or with immune systems compromised by therapy with corticosteroids, alkylating drugs, antimetabolites, or radiation should not receive OPV because of the theoretical risk of paralytic disease. OPV should not be used for immunizing immunodeficient patients and their household contacts; IPV is recommended. Although a protective immune response to IPV in the immunodeficient patient cannot be assured, the vaccine is safe and some protection may result from its administration. If OPV is inadvertently administered to a household-type contact of an immunodeficient patient, close contact between the patient and the recipients of OPV should be avoided for at least 2-3 weeks after vaccination. Because of the possibility of immunodeficiency in other children born to a family in which there has been 1 such case, OPV should not be given to a member of a household in which there is a family history of immunodeficiency until the immune status of the recipient and other children in the family is documented.

## **ADVERSE REACTIONS**

### OPV

In rare instances, administration of OPV has been associated with paralysis in healthy recipients and their contacts. Other than efforts to identify persons with immune deficiency conditions, no procedures are currently available for identifying persons likely to experience such adverse reactions. Although the risk of vaccine-associated paralysis is extremely small for vaccinees and their susceptible close personal contacts, they should be informed of this risk.

## IPV

No serious side effects of currently available IPV have been documented. Since IPV <sup>Contains</sup> trace amounts of streptomycin and neomycin, there is a possibility of hyper-<sup>sensitivity</sup> reactions in individuals sensitive to these antibiotics.

## CASE INVESTIGATION AND EPIDEMIC CONTROL

The occurrence of a single case of poliomyelitis should prompt an immediate epidemiologic investigation, including an active search for other cases. If evidence implicates wild poliovirus and there is a possibility of transmission, a vaccination plan designed to contain spread should be developed. If evidence implicates vaccine-derived poliovirus, no vaccination plan need be developed, as no outbreaks associated with vaccine virus have been

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## Poliomyelitis Prevention - Continued

documented to date. Within an epidemic area, OPV should be provided for all persons over 6 weeks of age who have not been completely immunized or whose immunization status is unknown, with the exceptions noted above under **Immunodeficiency**.

#### References

- American Academy of Pediatrics: Report of the Committee on Infectious Diseases. 18th ed. Evanston, Illinois, AAP, 1977
- Nightingale E: Recommendations for a national policy on poliomyelitis vaccination. N Engl J Med 297:249-253, 1977

#### SELECTED BIBLIOGRAPHY

CDC: Neurotropic Diseases Surveillance: Poliomyelitis Summary 1974-1976. Issued October 1977 CDC: Poliomyelitis – United States, 1978-1979. MMWR 28:483-484, 1979

Hardy GE, Hopkins CC, Linneman CC Jr, et al: Trivalent oral poliovirus vaccine: A comparison of two infant immunization schedules. Pediatrics 45:444-448, 1970

Krugman S, Katz SL: Childhood immunization procedures. JAMA 237:2228-2230, 1977

Nightingale E: Recommendations for a national policy on poliomyelitis vaccination. N Engl J Med 297:249-253, 1977

Salk J, Salk D: Control of influenza and poliomyelitis with killed virus vaccines. Science 195: 834-847, 1977

Sanders DY, Cramblett HG: Antibody titers to polioviruses in patients ten years after immunization with Sabin vaccine. J Pediatr 84:406-408, 1974

Schonberger LB, McGowan JE, Gregg MB: Vaccine-associated poliomyelitis in the United States, 1961-1972. Am J Epidemiol 104:202-211, 1976

The relation between acute persisting spinal paralysis and poliomyelitis vaccine (oral): Results of a WHO enquiry. Bull WHO 53:319-331, 1976

Replaces previous recommendation on poliomyelitis, published in MMWR 26:329-330, 335-336, 1977.

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