

# Morbidity and Mortality



U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE  
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INTERNATIONAL NOTES  
SMALLPOX - Worldwide

At the end of October 1974, the number of reported smallpox-infected areas was the smallest ever recorded, and under the impact of intensive campaigns in each of the remaining endemic countries, cases and outbreaks in the infected areas are rapidly decreasing. The endemic areas of Asia are now almost wholly confined to limited areas of eastern India and northern Bangladesh. In Pakistan, no cases whatsoever have been detected in the country in the past 2 weeks despite an intensive search by program personnel and the offer of 100 rupees to anyone who reports an outbreak. In Nepal, no cases with onsets of illness more recent than September 27 have been found. In India, 6,650 of the cases detected since September 1 (97%) have occurred in only 3

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states (Assam, Bihar, and Uttar Pradesh) of the country's 30 states and union territories; in Bangladesh, 78% of the remain-

TABLE I. CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES  
(Cumulative totals include revised and delayed reports through previous weeks)

DISEASE	WEEK ENDING		MEDIAN 1969-1973	CUMULATIVE, FIRST 46 WEEKS		
	November 16, 1974	November 17, 1973		1974	1973	MEDIAN 1969-1973
Aseptic meningitis	75	93	93	2,822	4,303	4,303
Brucellosis	2	1	3	161	165	172
Chickenpox	1,689	1,446	---	107,428	151,048	---
Diphtheria	3	6	7	209	167	167
Encephalitis:						
Primary: Arthropod-borne and unspecified	66	47	29	950	1,398	1,368
Post-Infectious	2	4	4	227	252	274
Hepatitis, Viral:						
Type B	253	156	169	8,737	7,166	7,168
Type A	886	1,047	1,143	37,082	45,685	48,668
Type unspecified	169			7,336		
Malaria	6	2	30	234	223	2,686
Measles (rubeola)	124	169	303	20,922	25,299	28,674
Meningococcal infections, total	47	17	20	1,201	1,214	1,994
Civilian	47	17	20	1,173	1,188	1,783
Military	---	---	1	28	26	211
Mumps	945	1,070	1,697	49,235	61,834	76,984
Pertussis	51	---	---	1,536	---	---
Rubella (German measles)	164	161	303	11,115	27,064	41,393
Tetanus	3	3	4	86	82	106
Tuberculosis, new active	549	570	---	26,945	27,671	---
Tularemia	1	4	4	130	148	138
Typhoid fever	9	14	7	381	602	338
Typhus, tick-borne (Rky. Mt. spotted fever)	7	4	2	742	621	437
Veneral Diseases:						
Gonorrhea	19,129	17,383	---	810,943	755,134	---
Syphilis, primary and secondary	523	498	---	22,211	22,072	---
Rabies in animals	56	47	53	2,618	3,051	3,051

TABLE II. NOTIFIABLE DISEASES OF LOW FREQUENCY

	Cum.		Cum.
Anthrax:	2	Poliomyelitis, total:	5
Botulism:	16	Paralytic:	5
Congenital rubella syndrome: Wash. 1	45	Psittacosis: *	150
Leprosy:	87	Rabies in man:	---
Leptospirosis: Conn. 1	41	Trichinosis: * Calif. 1	85
Plague:	6	Typhus, murine: Calif. 1	23

\*Delayed reports: Psittacosis: Calif. 1  
Trichinosis: N.J. 5

**SMALLPOX – Continued**

ing outbreaks are in 2 of the 19 districts; and in Ethiopia, all but 22 cases found in the past 7 weeks have occurred in 2 of the country's 14 provinces.

For the still infected areas, it is felt that the number of remaining active outbreaks best reflects the status of the problem. An active outbreak is defined as a village or municipal ward which has experienced 1 or more cases of smallpox in the preceding 4 weeks and so must be kept under close surveillance by program epidemiologists. Such data are now reported weekly throughout the endemic Asian countries. As of mid-October, there were 1,110 active foci in all of Asia, a decrease of 88% from the 9,511 known to have been present at the end of May. Of the 442 districts in India, Pakistan, and Bangladesh, 350 (79%) harbor no known active outbreaks, and an additional 63 (14%) have less than 10 outbreaks and so appear to be near to interrupting transmission. "Problem" districts, i.e., those now harboring 10 or more active outbreaks, are only 29 in number or 7% of the total districts in these countries. The average number of cases in each focus is now less than 5, and more than one-third are single case outbreaks. The number of new outbreaks detected each week in Asia has decreased from 1,420 in May to 120 in mid-October. The number is now sufficiently few so that a reward has been posted and widely advertised throughout

Asia to be paid to anyone reporting a previously undetected outbreak. The widespread response to this incentive has been such that it is believed that few outbreaks are now escaping detection.

The status of smallpox in Ethiopia is also encouraging; only 193 cases having been discovered in the past 7 weeks. Except for a single focus in the southeastern desert area of Hararge Province (now believed to be contained), all known foci are limited to remote villages in mountainous areas of "awrajas" in the Provinces of Begemdir and Gojjam. A helicopter-supported search and containment program that commenced November 10 undoubtedly will reveal some additional foci, but these are expected to be comparatively few in number.

Although a great deal of work remains and unexpected difficulties could occur, program officers in each of the endemic countries now foresee the possibility that the last known outbreaks might be contained within the next few months. However, intensive active search programs for cases will be required in the following 6 months to assure that no remote foci have been missed, and then to confirm this, a special surveillance program will be established for a full 2-year period after the last case is detected.

(Reported by the World Health Organization: Weekly Epidemiological Record 49(44):365-369, 1 Nov 1974.)

#### EPIDEMIOLOGIC NOTES AND REPORTS MIXED FILARIAL INFECTION – California

On August 1, 1974, an 11-year-old boy was seen at the Palo Alto (California) Medical Clinic for a routine physical examination. He was born in Ogbomoso, West Nigeria, and had lived there until November 1973 when he and his family moved to Menlo Park, California. With the exception of this move he had never traveled out of the environs of Ogbomoso.

Although he was well at the time of examination, the patient had experienced recurrent chills, fever, nausea, vomiting, and anemia since 1968. Each episode had been treated with unknown antimalarial drugs with abatement of symptoms. He had taken pyrimethamine once a week for malaria prophylaxis for nearly 2 years, discontinuing its use when he moved to California. In 1971 he required an unknown number of transfusions for anemia.

The physical examination on August 1 was normal. Because of the history of recurrent fevers, blood was obtained for malaria detection. Although no *Plasmodium* organisms were seen, 2 types of microfilaria were observed (1-5 per thin smear). The majority were consistent with *Acanthocheilonema perstans*; the remainder appeared to be *Wuchereria bancrofti*. This finding was confirmed at Stanford University Medical Center. Subsequently, the patient was treated with diethylcarbamazine for 14 days; blood obtained at 10 pm on the fourteenth day of treatment revealed no organisms. The remainder of the patient's family are currently being evaluated for filariasis.

(Reported by John E. Swartzberg, M.D., Fellow, and Jack S. Remington, M.D., Chief, Allergy Immunology, and Infectious Diseases Section, Department of Medicine, Stanford University; W. Elwyn Turner, M.D., Health Officer, Santa Clara County, California; James Chin, M.D., Chief, Infectious Dis-

eases Section, California State Department of Health; and the Parasitic Diseases Branch, Parasitic Disease and Veterinary Public Health Division, CDC.)

**Editorial Note**

*W. bancrofti* and *A. (Dipetalonema) perstans* are common filarial parasites of man. *A. perstans* is found in tropical Africa and South America and is transmitted by the bite of midges (*Culicoides*). Adult worms may be found in the mesentery, perirenal, and retroperitoneal spaces, pericardium, pleura, and occasionally in subcutaneous cysts. Infection with this organism is generally considered to be asymptomatic in endemic populations, although a high incidence of allergic symptoms have been reported in studies with Caucasian missionaries (1). Its microfilariae manifest no periodicity and thus may be found in the blood day or night. A high prevalence of *A. perstans* microfilaremia may be found in populations throughout much of Africa, most frequently in those living in banana-growing areas.

The distribution of *W. bancrofti* is more cosmopolitan, extending throughout the world's tropics. Species of *W. bancrofti* in Africa manifest nocturnal periodicity unlike those found in southeast Asia. Nocturnal periodic bancroftian filariasis is spread by a variety of mosquito vectors, including *Anopheles*, *Culex*, *Aedes*, and *Mansonia* species.

To find microfilariae, blood must be obtained at night. The best time is between 10 pm and midnight (2). Acute infection may cause a severe lymphadenitis and lymphangitis, eventuating in lymphedema, hydrocele, and elephantiasis in the chronic stage.

Mixed filarial infections are not common. Prevalence studies revealed a 1% incidence of mixed microfilaremia (with

*A. perstans* and *Mansonella ozzardi*) among aboriginal Indians in Guyana (3) and 0.07% (for *W. bancrofti* and *Brugia malayi*) in residents of the Philippines (4).

References

1. Adolph PE, Kagan IG, McQuay RM: Diagnosis and treatment of *Acanthocheilonema perstans* filariasis. *Am J Trop Med Hyg* 11:76-88, 1962

2. Kessel JF: Filarial infections of man. *Am Zool* 5:79-84, 1965  
 3. Orihel TC: Infections with *Dipetalonema perstans* and *Mansonella ozzardi* in the aboriginal Indians of Guyana. *Am J Trop Med Hyg* 16:628-635, 1967  
 4. Cabrera DP, Tamondong CT: Filariasis—Studies in Mindanao, Republic of the Philippines: The third endemic focus for Malayan filariasis. *Acta Med Philip* 6:102-31, 1970

HEPATITIS IN NAVY RECRUITS – California

Between September 24 and October 6, 1974, 94 clinical cases of hepatitis A developed in recruits undergoing basic training at the Naval Training Center, San Diego, California. The first hospitalized case was admitted on October 4, and on October 6, a screening program to detect subclinical hepatitis cases was initiated. A total of 5,422 recruits were screened, and those having (1) an SGOT greater than 3 times normal or (2) an elevated SGOT on 2 separate occasions and a positive test for bile in the urine were hospitalized for diagnostic evaluation. In this manner, a total of 41 suspect asymptomatic cases were identified, of whom 19 were subsequently confirmed as having asymptomatic, anicteric hepatitis. Also, in the course of the screening process, 19 additional symptomatic recruits were identified, for a total of 113 clinical cases (Figure 1). All 132 cases were tested for the hepatitis B surface antigen (HBsAg) and were negative.

The temporal clustering of cases suggested a common source outbreak, and an investigation to identify the source was initiated. The ill recruits were found to be from different barracks and different companies and to have received their vaccinations at different times. Routine water samples from the camp's 2 galleys showed no evidence of contamination.

However, further investigation revealed that all but 2 of the ill recruits had arrived at the Naval Training Center before August 31 and that all but 3 of the symptomatic cases had eaten at 1 dining hall during the first 2 weeks of September. Of 2,781 recruits who ate at this dining hall, the overall attack rate was 46.3/1,000, while the attack rate for 2,639 recruits who ate at the second dining hall was 0.7/1,000. Results obtained from administering a food preference questionnaire to 112 patients and 346 well recruits on October 12 were as follows: For 10 of the total 78 food items surveyed, the patients' and controls' preferences were significantly different ( $p \leq 0.01$ ). These items were tossed salad, cottage cheese, cucumbers, sliced tomatoes, French dressing, thousand island dressing, grapefruit, plums, nectarines, and oranges. (The last 4 items may not have been available in the dining hall during the first 2 weeks of September but were nonetheless included on the questionnaire.)

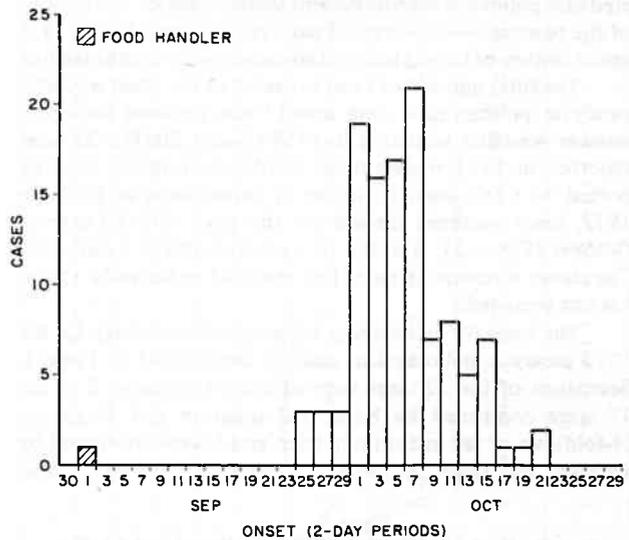
On October 7, 1974, investigators learned that a food handler, who had worked in the implicated dining hall on September 3 and 5, had become ill on September 1 and was subsequently hospitalized on September 9 with HBsAg-negative hepatitis (Figure 1). While preparing food on September 3 and 5 he had experienced symptoms of diarrhea, nausea, and vomiting. He reported that his routine duties included preparing sliced tomatoes, tossed salad, cole slaw, and sliced

cantalope, and placing glazed cherries on cottage cheese—all without gloves. Thus, while 1 specific food was not definitely incriminated, the results of the questionnaire supported the evidence that a combination of foods was the vehicle of infection—most likely the uncooked items known to have been handled by the suspect index case.

During the training period, several recruits, who subsequently developed hepatitis A, had been involved in food handling at the 2 main galleys at the Naval Training Center immediately prior to the onset of their illness. To reduce the possibility of a second wave of cases, 21,000 doses of immune serum globulin were given to all Naval personnel who had eaten at the dining halls in question.

(Reported by LCDR Richard R. Hooper, M.D., M.P.H., Epidemiologist, and Capt. Stephen J. Kendra, M.D., M.P.H., Officer-in-Charge, Navy Environmental and Preventive Medicine Unit No. 5; CDR James Quinn, M.D., Regional Health Care Coordinator, CDR Will Harrison, M.D., Head, Infectious Disease Division, and LCDR John Routenberg, M.D., Gastroenterology Clinic, Navy Regional Medical Center, San Diego; and LCDR Charles Juels, M.D., M.P.H., Resident, University of California, Berkeley, School of Public Health, and Infectious Disease Section, California State Health Department.)

Figure 1  
 HEPATITIS A CASES BY DATE OF ONSET  
 NAVAL TRAINING CENTER, SAN DIEGO, CALIFORNIA  
 SEPTEMBER-OCTOBER 1974



**SURVEILLANCE SUMMARY**  
**POLIOMYELITIS – United States, 1972**

Twenty-two cases of paralytic poliomyelitis with 3 deaths were reported in the United States in 1972. This represents an increase of 3 cases from the corrected total of 19 cases reported for 1971. The cases were scattered among 14 states. Connecticut and New York with 4 cases each, and Texas with 3 cases, were the only states to report more than 1 case. Seventeen (78%) of the 22 cases were in persons 19 years of age or younger, and 5 (23%) were in preschool age children. Type 1 poliovirus was implicated in 64% of the cases and in 74% of those cases in which an etiology was determined.

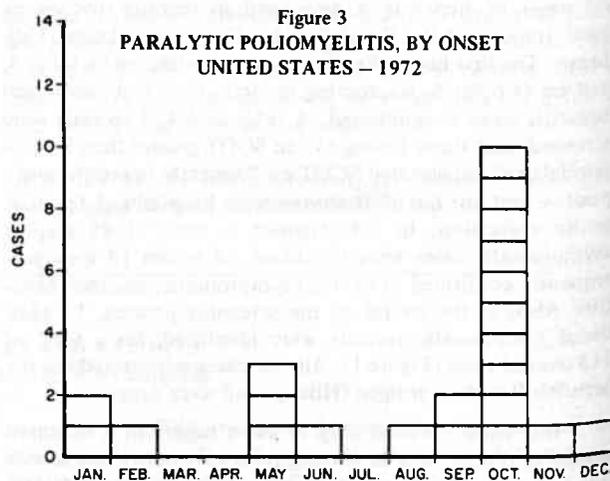
Four of the 22 reported cases were "recipient vaccine-associated" and 6 were "contact vaccine-associated." Two additional cases of paralytic poliomyelitis were reported for 1971 and were both "contact vaccine-associated," increasing the 1971 total to 19 cases, 10 of which were "contact vaccine-associated." This is the highest annual number of "contact vaccine-associated" cases reported to CDC since live, attenuated oral poliovirus vaccine became widely used in 1962. None of the persons who contracted paralytic poliomyelitis in 1972 gave a history of having received adequate polio immunization.

The total number of cases included in the "best available paralytic poliomyelitis case count" has declined since this number was first tabulated in 1958 (Figure 2). The 22 cases reported in 1972 represent the third lowest annual total reported to CDC since initiation of surveillance in 1955. In 1972, cases occurred throughout the year, with 10 cases in October (Figure 3); 8 of the 10 were clustered in 1 outbreak. The classic summer-fall peak, last observed in the early 1960s, has not persisted.

The basis for establishing a type-specific etiology for the 1972 paralytic poliomyelitis cases is summarized in Table 1. Seventeen of the 22 cases were of known etiology; 2 of the 17 were confirmed by both viral isolation and diagnostic (4-fold) rise or fall in antibody titer, and 5 were confirmed by serologic test alone. Although the presence of an enterovirus

in the alimentary tract does not constitute proof of an etiologic role, isolation of poliovirus from throat washings or stool specimens in the context of compatible illness and absence of evidence for another etiology has been accepted by the respective states as adequate documentation of etiology and is indicated as the probable agent in 9 cases. In 1 case, the diagnosis of type 1 paralytic poliomyelitis was based on clinical and epidemiologic criteria alone.

Comparison of "etiologic" poliovirus types for 1966-1972 (the only years for which this method of definition has been used) shows that in 1972 type 1 poliovirus increased from the lowest level of 26% in 1971 to 64%, the second highest percentage since 1966. However, for the first time in 7 years, type 2 poliovirus was not implicated as the etiologic agent in any of the reported cases.



**Table 1**  
**Paralytic Poliomyelitis Cases by Designation**  
**of Known "Etiologic" Poliovirus Type, 1972\***

Basis of Confirmation	Poliovirus			Total
	Type 1	Type 2	Type 3	
Viral isolation and diagnostic serologic test	0	0	2	2
Serologic test (only)	4	0	1	5
Viral isolation (only)	9	0	0	9
Diagnosis made on clinical and epidemiologic basis only	1	0	0	1
<b>Total</b>	<b>14</b>	<b>0</b>	<b>3</b>	<b>17</b>

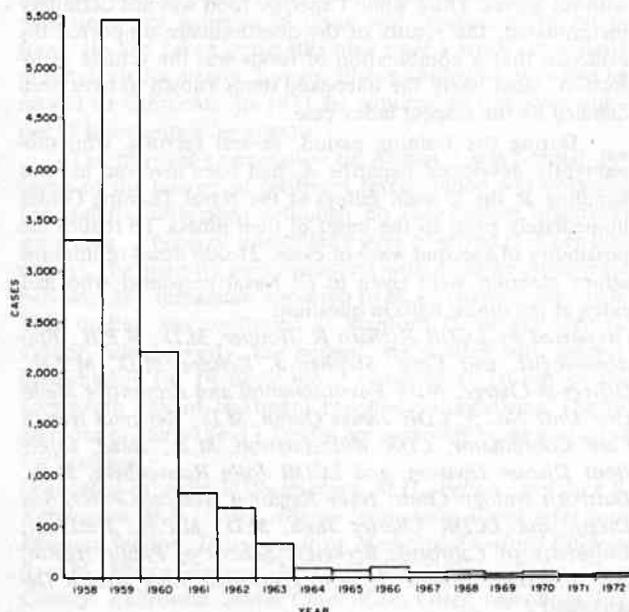
\*Excludes 4 vaccine-associated cases with multiple isolates or serologic changes

(Reported by the Viral Examination Branch, Enteric Virology Branch, Virology Division, Bureau of Laboratories, and the Viral Diseases Division, Bureau of Epidemiology, CDC.)

A copy of the report from which these data were derived is available on request from

Center for Disease Control  
Attn: Neurotropic Diseases  
Viral Diseases Division  
Bureau of Epidemiology  
Atlanta, Georgia 30333

**Figure 2**  
**"BEST AVAILABLE PARALYTIC POLIOMYELITIS CASE**  
**COUNT," BY YEAR – UNITED STATES, 1958-1972**



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**TABLE III. CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES  
FOR WEEKS ENDING NOVEMBER 16, 1974 AND NOVEMBER 17, 1973 (46th WEEK)**

AREA	ASEPTIC MENIN- GITIS	BRUCEL- LOSIS	CHICKEN- POX	DIPHThERIA		ENCEPHALITIS			HEPATITIS, VIRAL			MALARIA	
						Primary: Arthropod- borne and Unspecified		Post In- fectious	Type B	Type A	Type Unspecified		
						1974	1973	1974	1974	1974	1974		
<b>UNITED STATES</b> .....	<b>75</b>	<b>2</b>	<b>1,689</b>	<b>3</b>	<b>209</b>	<b>66</b>	<b>47</b>	<b>2</b>	<b>253</b>	<b>886</b>	<b>169</b>	<b>6</b>	<b>234</b>
<b>NEW ENGLAND</b> .....	-	-	92	-	-	-	-	-	5	19	9	1	9
Maine *	-	-	8	-	-	-	-	-	-	-	-	-	-
New Hampshire	-	-	-	-	-	-	-	-	2	2	-	1	1
Vermont	-	-	20	-	-	-	-	-	-	-	-	-	-
Massachusetts	-	-	35	-	-	-	-	-	2	3	9	-	2
Rhode Island	-	-	5	-	-	-	-	-	1	8	-	-	3
Connecticut	-	-	24	-	-	-	-	-	-	6	-	-	3
<b>MIDDLE ATLANTIC</b> .....	5	-	58	-	1	2	1	-	19	73	17	4	45
Upstate New York	2	-	16	-	-	1	-	-	5	28	2	-	16
New York City	-	-	41	-	-	1	-	-	5	13	-	2	16
New Jersey	2	-	NN	-	-	-	-	-	7	16	14	2	7
Pennsylvania	1	-	1	-	1	-	1	-	2	16	1	-	6
<b>EAST NORTH CENTRAL</b> .....	3	-	695	-	2	4	8	-	63	123	42	-	19
Ohio	-	-	103	-	1	-	3	-	9	41	-	-	6
Indiana	-	-	64	-	-	-	-	-	1	-	23	-	-
Illinois	1	-	-	-	1	-	3	-	37	29	16	-	2
Michigan	2	-	285	-	-	2	2	-	11	46	3	-	10
Wisconsin	-	-	243	-	-	2	-	-	5	7	-	-	1
<b>WEST NORTH CENTRAL</b> .....	2	-	274	-	-	3	18	-	24	61	20	-	7
Minnesota	1	-	1	-	-	-	-	-	13	11	-	-	2
Iowa	-	-	231	-	-	-	-	-	3	10	6	-	3
Missouri *	-	-	-	-	-	-	17	-	7	10	5	-	1
North Dakota	-	-	25	-	-	-	-	-	-	6	-	-	-
South Dakota	-	-	-	-	-	-	-	-	-	7	-	-	1
Nebraska	-	-	3	-	-	-	1	-	1	1	1	-	-
Kansas	1	-	14	-	-	3	-	-	-	16	8	-	-
<b>SOUTH ATLANTIC</b> .....	8	-	98	-	1	2	7	1	17	96	14	-	35
Delaware	-	-	4	-	-	-	-	-	1	-	-	-	1
Maryland	1	-	13	-	-	-	3	-	5	12	3	-	6
District of Columbia	-	-	1	-	-	-	-	-	-	-	-	-	5
Virginia	2	-	8	-	-	-	-	1	4	6	8	-	7
West Virginia	2	-	70	-	-	-	-	-	-	3	-	-	2
North Carolina *	1	-	NN	-	1	-	1	-	3	12	-	-	4
South Carolina	1	-	2	-	-	-	-	-	1	9	3	-	1
Georgia	-	-	-	-	-	-	-	-	-	22	-	-	1
Florida	1	-	-	-	-	2	3	-	3	32	-	-	8
<b>EAST SOUTH CENTRAL</b> .....	13	-	76	-	-	49	7	1	21	88	1	-	9
Kentucky	-	-	57	-	-	-	-	-	1	9	-	-	5
Tennessee	11	-	NN	-	-	46	4	-	17	53	-	-	1
Alabama	-	-	18	-	-	-	2	-	1	10	1	-	-
Mississippi	2	-	1	-	-	3	1	1	2	16	-	-	3
<b>WEST SOUTH CENTRAL</b> .....	11	2	202	-	9	-	2	-	24	120	18	1	17
Arkansas *	-	-	6	-	-	-	-	-	2	4	1	-	1
Louisiana	4	-	NN	-	-	-	-	-	1	9	5	-	1
Oklahoma	2	1	30	-	-	-	2	-	14	33	5	-	6
Texas	5	1	166	-	9	-	-	-	7	74	7	1	9
<b>MOUNTAIN</b> .....	-	-	61	-	34	-	-	-	7	60	22	-	12
Montana	-	-	47	-	-	-	-	-	-	18	-	-	-
Idaho	-	-	-	-	-	-	-	-	-	3	6	-	-
Wyoming	-	-	-	-	-	-	-	-	-	6	-	-	-
Colorado	-	-	14	-	3	-	-	-	4	3	3	-	5
New Mexico	-	-	-	-	13	-	-	-	2	14	8	-	3
Arizona	-	-	-	-	18	-	-	-	1	8	4	-	2
Utah	-	-	-	-	-	-	-	-	-	3	1	-	1
Nevada	-	-	-	-	-	-	-	-	-	5	-	-	1
<b>PACIFIC</b> .....	33	-	133	3	162	6	4	-	73	246	26	-	81
Washington	5	-	122	3	151	5	-	-	10	19	9	-	-
Oregon	1	-	2	-	-	-	-	-	4	15	1	-	2
California *	13	-	-	-	7	1	3	-	59	122	16	-	75
Alaska	-	-	5	-	4	-	-	-	-	87	-	-	-
Hawaii	14	-	4	-	-	-	1	-	-	3	-	-	4
Guam *	-	-	-	-	-	-	-	-	-	-	-	-	2
Puerto Rico	-	-	6	-	1	-	-	-	-	-	15	-	1
Virgin Islands	---	---	---	---	---	---	---	---	---	---	---	---	3

\*Delayed reports: Aseptic meningitis: Calif. 21  
 Brucellosis: Ark. 1  
 Chickenpox: Me. 7, Calif. 20, Guam 29  
 Encephalitis, post infectious: Calif. 1

Hepatitis B: Mo. 1, Calif. 47  
 Hepatitis A: Me. 3, N.C. delete 2, Calif. 117, Guam 35  
 Hepatitis unspecified: Me. 2, N.C. delete 1, Calif. 17, Guam 22  
 Malaria: Calif. 1

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TABLE III. CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES  
FOR WEEKS ENDING NOVEMBER 16, 1974 AND NOVEMBER 17, 1973 (46th WEEK) - Continued

AREA	MEASLES (Rubeola)			MENINGOCOCCAL INFECTIONS. TOTAL			MUMPS		PERTUSSIS	RUBELLA		TETANUS
	1974	Cumulative		1974	Cumulative		1974	Cum. 1974	1974	1974	Cum. 1974	Cum. 1974
		1974	1973		1974	1973						
UNITED STATES	124	20,922	25,299	47	1,201	1,214	945	49,235	51	164	11,115	86
NEW ENGLAND	3	952	7,487	2	68	50	40	6,284	6	10	1,152	1
Maine *	-	43	69	-	2	1	1	836	-	-	286	-
New Hampshire *	-	211	920	-	10	7	-	296	5	-	22	1
Vermont *	-	56	120	-	12	3	-	17	-	-	41	-
Massachusetts	2	401	3,945	-	17	13	23	1,058	1	3	362	-
Rhode Island *	-	61	620	-	9	3	15	2,534	-	1	20	-
Connecticut	1	180	1,813	2	18	23	1	1,543	-	6	421	-
MIDDLE ATLANTIC	21	8,214	2,623	1	177	169	46	3,850	8	3	1,134	7
Upstate New York	3	967	818	1	64	60	9	946	5	1	261	2
New York City	1	616	928	-	40	36	17	718	2	-	159	1
New Jersey	16	5,662	497	-	48	40	9	699	1	2	459	2
Pennsylvania *	1	969	380	-	25	33	11	1,487	-	-	255	2
EAST NORTH CENTRAL	66	8,168	8,814	12	152	166	355	14,286	19	34	3,654	10
Ohio	4	3,059	294	9	63	71	58	3,274	-	-	520	2
Indiana	6	271	681	-	15	5	35	1,099	-	4	624	-
Illinois	14	2,097	2,111	-	10	27	39	1,325	9	8	606	3
Michigan	36	2,156	4,451	3	47	47	123	5,994	3	15	1,309	4
Wisconsin	6	585	1,277	-	17	16	100	2,594	7	7	595	1
WEST NORTH CENTRAL	7	711	456	5	90	90	42	3,082	-	2	230	13
Minnesota	-	85	22	1	31	12	-	44	-	-	13	2
Iowa	-	134	279	1	15	21	23	1,856	-	-	15	1
Missouri	-	265	53	1	21	34	4	416	-	2	43	4
North Dakota	2	33	67	-	3	3	9	78	-	-	18	3
South Dakota	-	27	2	-	3	4	-	2	-	-	26	-
Nebraska	1	3	6	-	3	7	-	88	-	-	6	-
Kansas	4	164	27	2	14	9	6	598	-	-	109	3
SOUTH ATLANTIC	4	584	1,272	13	234	206	94	5,888	-	33	1,306	23
Delaware	-	15	10	-	5	2	3	102	-	-	30	-
Maryland	-	24	13	-	23	27	13	133	-	-	5	1
District of Columbia	-	3	8	-	1	4	-	50	-	-	4	-
Virginia	-	38	422	-	39	41	28	664	-	2	52	3
West Virginia	-	218	222	1	8	6	28	3,082	-	3	306	1
North Carolina	-	5	4	1	46	42	NN	NN	-	-	55	4
South Carolina	3	57	66	3	21	13	6	134	-	26	663	4
Georgia	-	4	152	-	8	23	-	1	-	-	3	1
Florida	1	220	375	8	83	48	16	1,722	-	2	188	9
EAST SOUTH CENTRAL	2	283	629	2	114	113	75	5,922	4	18	638	6
Kentucky	2	196	393	1	44	40	27	2,349	-	1	217	-
Tennessee	-	56	165	-	50	44	38	2,630	3	16	339	2
Alabama	-	18	13	1	12	16	7	563	-	1	63	1
Mississippi	-	13	58	-	8	13	3	380	1	-	19	3
WEST SOUTH CENTRAL	4	231	725	8	204	187	121	3,664	5	22	482	10
Arkansas	-	7	72	-	13	13	4	144	1	-	26	-
Louisiana	-	13	87	-	53	44	20	254	-	12	111	3
Oklahoma	-	29	60	2	21	32	4	399	2	-	57	3
Texas	4	182	506	6	117	98	93	2,867	2	10	288	4
MOUNTAIN	1	759	932	1	39	35	13	1,170	6	3	425	1
Montana	-	373	211	-	1	7	-	178	5	-	68	-
Idaho	-	52	256	-	2	4	-	158	-	-	14	-
Wyoming	-	1	81	-	3	1	-	10	-	-	-	-
Colorado	-	36	107	-	9	11	12	572	-	-	160	-
New Mexico	-	61	128	-	3	3	-	179	-	1	125	-
Arizona	-	20	19	1	8	5	-	-	-	-	1	1
Utah	-	16	129	-	9	2	-	67	1	2	24	-
Nevada	1	200	1	-	4	2	1	6	-	-	33	-
PACIFIC	16	1,020	2,361	3	123	198	159	5,089	3	39	2,094	15
Washington	-	72	1,043	1	16	20	77	1,766	-	7	410	1
Oregon	-	-	460	-	14	16	8	821	-	2	232	2
California *	16	882	773	2	86	154	68	2,280	3	30	1,435	11
Alaska	-	-	65	-	4	8	1	149	-	-	-	-
Hawaii	-	66	20	-	3	-	5	73	-	-	17	1
Guam *	-	17	52	-	2	-	-	370	-	-	6	-
Puerto Rico	2	661	1,957	-	6	8	17	1,169	-	1	33	4
Virgin Islands	---	29	7	---	-	-	---	35	---	---	-	1

\*Delayed reports: Measles: N.H. 1, Vt. delete 1, R.I. 2, Calif. 8  
Meningococcal infection: Vt. 10, Penn. delete 1,  
Calif. 1, Guam 1  
Mumps: Me. 1, N.H. 6, Calif. 29, Guam 8

Pertussis: N.H. 2, Calif. 5  
Rubella: Vt. 2, Calif. 2

TABLE III. CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES  
FOR WEEKS ENDING NOVEMBER 16, 1974 AND NOVEMBER 17, 1973 (46th WEEK) - Continued

AREA	TUBERCULOSIS (New Active)		TULA- REMIA	TYPHOID FEVER		TYPHUS-FEVER TICK-BORNE (Rky. Mt. spotted fever)		VENEREAL DISEASES						RABIES IN ANIMALS
	1974	Cum. 1974		Cum. 1974	1974	Cum. 1974	1974	Cum. 1974	GONORRHEA		SYPHILIS (Pri. & Sec.)		Cum. 1974	
			1974						Cumulative		1974	Cumulative		
									1974	1973		1974		1973
UNITED STATES	549	26,945	130	9	381	7	742	19,129	810,943	755,134	523	22,211	22,072	2,618
NEW ENGLAND	9	1,068	-	2	21	-	8	444	21,324	18,970	18	448	589	25
Maine	-	81	-	-	1	-	-	38	1,821	1,228	-	40	22	3
New Hampshire *	-	25	-	-	1	-	-	21	732	717	2	13	10	3
Vermont *	-	23	-	-	1	-	-	16	585	315	-	2	21	1
Massachusetts	4	579	-	2	14	-	6	178	9,497	8,057	4	180	266	4
Rhode Island	3	97	-	-	2	-	2	59	1,943	1,918	-	18	15	4
Connecticut	2	263	-	-	2	-	-	132	6,746	6,735	12	195	255	10
MIDDLE ATLANTIC	68	4,879	2	3	64	-	66	2,204	96,876	104,181	79	4,697	4,893	77
Upstate New York *	11	716	2	-	14	-	27	414	18,465	18,071	3	437	345	34
New York City	32	1,877	-	-	33	-	3	1,008	41,561	46,838	43	2,702	2,934	-
New Jersey	8	890	-	1	11	-	4	176	13,418	15,386	21	757	887	25
Pennsylvania	17	1,396	-	2	6	-	32	606	23,432	23,886	12	801	727	18
EAST NORTH CENTRAL	90	3,731	6	-	38	-	26	2,825	128,528	115,848	45	1,921	2,026	190
Ohio *	24	985	-	-	6	-	17	844	34,311	28,284	3	297	242	26
Indiana	5	540	-	-	5	-	1	93	12,156	10,647	2	164	262	14
Illinois	38	1,080	3	-	15	-	6	998	41,279	40,049	38	999	1,028	45
Michigan	20	1,014	-	-	10	-	2	567	28,196	27,328	2	369	426	5
Wisconsin	3	112	3	-	2	-	-	323	12,586	9,540	-	92	68	100
WEST NORTH CENTRAL	52	1,046	20	-	10	-	17	742	41,963	38,123	14	564	343	697
Minnesota	7	162	-	-	4	-	-	86	9,190	7,614	3	73	91	237
Iowa	6	115	-	-	2	-	1	15	5,283	4,476	-	34	54	116
Missouri	31	503	17	-	2	-	9	358	13,943	12,903	6	370	159	38
North Dakota	-	30	-	-	-	-	-	26	667	632	-	3	2	101
South Dakota	-	51	3	-	-	-	2	36	2,012	1,928	-	2	5	134
Nebraska *	1	43	-	-	-	-	-	66	3,649	4,360	-	12	10	5
Kansas	7	142	-	-	2	-	5	155	7,219	6,210	5	70	22	66
SOUTH ATLANTIC	103	5,688	10	-	52	2	410	5,619	206,103	183,395	142	7,027	6,478	364
Delaware	4	92	-	-	-	-	10	113	2,771	2,680	1	77	82	1
Maryland	6	731	1	-	8	-	48	547	21,821	16,215	5	686	640	26
District of Columbia	7	327	-	-	1	-	-	257	14,557	15,853	16	596	755	-
Virginia	18	703	4	-	3	2	135	352	18,479	18,015	11	687	732	96
West Virginia	5	266	-	-	13	-	5	42	2,348	2,699	-	17	21	31
North Carolina	16	848	3	-	3	-	107	539	28,044	26,867	3	852	576	38
South Carolina	7	520	-	-	5	-	55	547	20,854	19,127	16	727	1,037	6
Georgia	18	850	2	-	3	-	48	1,811	42,794	35,696	16	787	881	128
Florida	22	1,351	-	-	16	-	2	1,411	54,435	46,243	74	2,598	1,754	38
EAST SOUTH CENTRAL	43	2,373	13	-	52	1	111	1,532	67,375	61,130	25	1,152	1,228	218
Kentucky	11	508	3	-	18	1	20	233	8,371	7,341	5	252	328	130
Tennessee	8	744	6	-	25	-	65	679	26,894	23,774	3	424	418	52
Alabama	15	710	2	-	4	-	10	350	18,459	17,346	12	232	176	33
Mississippi	9	411	2	-	5	-	16	270	13,651	12,669	5	244	306	3
WEST SOUTH CENTRAL	60	3,128	59	-	25	4	94	2,471	106,758	97,873	48	2,054	2,390	539
Arkansas	7	369	31	-	4	2	13	157	10,325	11,169	1	89	122	68
Louisiana	1	439	3	-	8	-	1	381	21,223	20,703	9	530	734	24
Oklahoma *	5	275	18	-	2	2	63	205	9,806	8,853	3	130	154	148
Texas	47	2,045	7	-	11	-	17	1,728	65,404	57,148	35	1,305	1,380	299
MOUNTAIN	21	860	12	1	18	-	7	619	30,749	25,818	8	519	547	163
Montana	11	70	-	-	-	-	1	41	1,685	1,477	3	6	4	7
Idaho	-	32	-	-	-	-	1	14	1,579	1,835	1	12	10	-
Wyoming	1	19	6	-	3	-	1	18	662	459	-	9	29	11
Colorado	-	161	-	-	-	-	1	140	8,549	6,981	1	126	187	27
New Mexico	7	178	2	-	4	-	2	133	4,749	4,626	-	81	101	73
Arizona *	2	311	-	1	8	-	-	146	8,556	7,170	1	190	141	44
Utah	-	36	4	-	-	-	1	31	1,853	1,482	-	14	13	1
Nevada	-	53	-	-	3	-	-	96	3,116	1,788	2	81	62	-
PACIFIC	103	4,172	8	3	101	-	3	2,673	111,267	109,796	144	3,829	3,578	345
Washington	-	291	-	-	13	-	1	284	10,576	10,611	-	80	137	-
Oregon	3	180	2	-	1	-	2	143	10,078	9,567	2	94	54	6
California *	89	3,288	6	3	83	-	-	2,131	85,744	85,077	142	3,610	3,305	328
Alaska	-	82	-	-	2	-	-	61	2,670	2,511	-	16	16	11
Hawaii	11	331	-	-	2	-	-	54	2,199	2,030	-	29	66	-
Guam *	-	30	-	-	1	-	-	-	284	388	-	3	5	-
Puerto Rico	7	476	-	-	4	-	-	59	2,911	3,748	10	781	645	50
Virgin Islands	---	3	-	---	-	---	-	---	273	207	---	43	29	-

\*Delayed reports: Tuberculosis: Ariz. delete 6, Calif. 58, Guam 2  
 Typhoid: Vt. 1, Calif. 2, Guam 1  
 RMSF: Okla. delete 2

Gonorrhea: N.H. 11, Neb. 1, Calif. 1980, Guam 39  
 Syphilis: Upstate N.Y. 9, Ohio delete 1, Neb. 2,  
 Calif. 45  
 Rabies: Calif. 5

TABLE IV. DEATHS IN 121 UNITED STATES CITIES FOR WEEK ENDING NOVEMBER 16, 1974

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

Area	All Causes					Pneumonia and Influenza All Ages	Area	All Causes					Pneumonia and Influenza All Ages
	All Ages	65 years and over	45-64 years	25-44 years	Under 1 year			All Ages	65 years and over	45-64 years	25-44 years	Under 1 year	
NEW ENGLAND	670	415	168	39	22	32	SOUTH ATLANTIC	1,359	739	399	114	46	35
Boston, Mass.	194	113	48	13	9	9	Atlanta, Ga.	120	64	33	10	6	-
Bridgeport, Conn.	39	25	12	1	1	1	Baltimore, Md.	203	108	57	21	8	1
Cambridge, Mass.	25	22	-	3	-	1	Charlotte, N. C.	55	32	15	2	3	-
Fall River, Mass.	29	16	8	3	-	1	Jacksonville, Fla.	69	34	25	3	5	1
Hartford, Conn.	35	19	11	3	1	5	Miami, Fla.	156	94	46	11	1	4
Lowell, Mass.	24	18	4	1	-	1	Norfolk, Va.	62	37	15	6	3	2
Lynn, Mass.	20	13	7	-	-	-	Richmond, Va.	98	48	40	8	-	7
New Bedford, Mass.	27	21	4	-	1	2	Savannah, Ga.	51	31	17	2	-	4
New Haven, Conn.	63	29	21	5	4	-	St. Petersburg, Fla.	82	67	13	1	-	4
Providence, R. I.	62	33	23	2	3	6	Tampa, Fla.	69	42	18	1	4	4
Somerville, Mass.	12	9	2	1	-	-	Washington, D. C.	357	163	112	44	15	6
Springfield, Mass.	45	32	9	1	2	1	Wilmington, Del.	37	19	8	5	1	2
Waterbury, Conn.	44	25	12	6	-	1							
Worcester, Mass.	51	40	7	-	1	4	EAST SOUTH CENTRAL	681	406	169	52	34	28
MIDDLE ATLANTIC	2,769	1,689	728	167	74	116	Birmingham, Ala.	100	61	22	6	9	-
Albany, N. Y.	47	28	10	8	-	3	Chattanooga, Tenn.	46	31	9	3	2	1
Allentown, Pa.	30	22	5	-	2	1	Knoxville, Tenn.	37	26	9	1	1	2
Buffalo, N. Y.	126	73	32	6	8	8	Louisville, Ky.	114	67	36	6	3	11
Camden, N. J.	37	25	10	-	2	-	Memphis, Tenn.	139	74	32	18	7	2
Elizabeth, N. J.	22	9	12	-	1	-	Mobile, Ala.	82	41	20	10	8	1
Erie, Pa.	25	11	12	1	-	4	Montgomery, Ala.	45	27	10	3	3	2
Jersey City, N. J.	53	34	8	4	7	1	Nashville, Tenn.	118	79	31	5	1	9
Newark, N. J.	80	43	21	6	4	3	WEST SOUTH CENTRAL	1,224	685	325	85	67	27
New York City, N. Y. †	1,457	889	376	97	33	50	Austin, Tex.	68	38	18	4	3	2
Paterson, N. J.	26	11	9	3	2	5	Baton Rouge, La.	42	26	9	3	1	3
Philadelphia, Pa.	292	170	79	21	7	4	Corpus Christi, Tex.	39	27	8	1	1	-
Pittsburgh, Pa.	171	106	52	7	2	17	Dallas, Tex.	186	95	55	17	13	-
Reading, Pa.	34	24	9	1	-	3	El Paso, Tex.	66	35	16	5	7	5
Rochester, N. Y.	128	82	33	6	2	5	Fort Worth, Tex.	69	45	19	4	1	1
Schenectady, N. Y.	21	14	6	-	-	-	Houston, Tex.	261	137	66	20	14	3
Scranton, Pa.	35	25	5	1	1	-	Little Rock, Ark.	61	22	24	3	9	3
Syracuse, N. Y.	90	48	32	4	3	-	New Orleans, La.	157	95	42	8	9	2
Trenton, N. J.	33	23	8	2	-	4	San Antonio, Tex.	156	93	33	14	7	3
Utica, N. Y.	29	25	3	-	-	3	Shreveport, La.	48	29	13	5	-	1
Yonkers, N. Y.	33	27	6	-	-	5	Tulsa, Okla.	71	43	22	1	2	4
EAST NORTH CENTRAL	2,342	1,337	644	161	115	52	MOUNTAIN	573	298	165	40	35	18
Akron, Ohio	84	58	19	3	3	-	Albuquerque, N. Mex.	68	32	18	12	2	4
Canton, Ohio	40	17	16	3	-	-	Colorado Springs, Colo.	31	17	10	1	1	4
Chicago, Ill.	597	335	175	44	25	12	Denver, Colo.	153	76	48	5	15	2
Cincinnati, Ohio	138	87	32	10	5	2	Las Vegas, Nev.	16	-	8	5	2	-
Cleveland, Ohio	199	117	61	13	1	3	Ogden, Utah	22	17	5	-	-	2
Columbus, Ohio	135	65	33	11	18	1	Phoenix, Ariz.	153	79	45	9	7	3
Dayton, Ohio	88	44	30	6	5	-	Pueblo, Colo.	24	15	5	2	1	2
Detroit, Mich.	303	159	77	30	23	5	Salt Lake City, Utah	47	29	9	3	3	1
Evansville, Ind.	56	36	19	-	-	2	Tucson, Ariz.	59	33	17	3	4	-
Fort Wayne, Ind.	39	24	10	2	3	4	PACIFIC	1,511	975	334	97	33	50
Gary, Ind.	20	5	8	3	1	2	Berkeley, Calif.	19	10	5	-	-	-
Grand Rapids, Mich.	65	49	9	5	1	6	Fresno, Calif.	64	43	12	4	3	2
Indianapolis, Ind.	171	87	53	11	11	1	Glendale, Calif.	21	14	6	1	-	-
Madison, Wis.	35	20	8	-	2	5	Honolulu, Hawaii	63	41	14	4	2	-
Milwaukee, Wis.	120	75	31	5	7	1	Long Beach, Calif.	102	70	22	6	1	3
Peoria, Ill.	27	17	8	-	2	1	Los Angeles, Calif.	378	237	77	32	12	11
Rockford, Ill.	31	23	4	-	2	3	Oakland, Calif.	80	51	13	9	1	4
South Bend, Ind.	31	20	9	2	-	2	Pasadena, Calif.	32	26	3	1	-	-
Toledo, Ohio	98	53	32	8	4	1	Portland, Oreg.	132	77	35	9	4	6
Youngstown, Ohio	65	46	10	5	2	1	Sacramento, Calif.	53	31	11	9	2	2
WEST NORTH CENTRAL	770	491	185	39	30	27	San Diego, Calif.	91	58	25	1	-	2
Des Moines, Iowa	57	37	14	2	3	2	San Francisco, Calif.	169	111	42	9	1	6
Duluth, Minn.	8	6	1	-	1	2	San Jose, Calif.	59	44	7	1	3	1
Kansas City, Kans.	29	14	8	4	2	1	Seattle, Wash.	173	112	45	7	3	6
Kansas City, Mo.	118	73	30	8	2	-	Spokane, Wash.	42	25	10	3	1	5
Lincoln, Nebr.	28	20	5	2	1	1	Tacoma, Wash.	33	25	7	1	-	2
Minneapolis, Minn.	106	69	26	3	4	2							
Omaha, Nebr.	79	47	23	2	3	1	Total	11,899	7,035	3,117	794	456	385
St. Louis, Mo.	212	133	55	11	9	10	Expected Number	12,313	7,360	3,277	806	407	410
St. Paul, Minn.	74	52	14	2	2	1							
Wichita, Kans.	59	40	9	5	3	7							

†Delayed report for week ending November 9, 1974

CURRENT TRENDS

PRIMARY AND SECONDARY SYPHILIS  
United States, September 1974 (Provisional Data)

In September 1974, reported cases of primary and secondary syphilis numbered 2,192, up 6.5% from the number reported in September 1973 (provisional data). During the first 9 months of calendar year 1974, cases numbered 19,024, representing a small increase (1.4%) over the number reported in the same time period in the previous year. These increases are referable to a relatively small

number of program areas. For example, 4 project areas accounted for 20% of the total cases reported between January and September and 67.7% of the increases reported in that period.

(Reported by the Venereal Disease Control Division, Bureau of State Services, CDC.)

SUMMARY OF REPORTED CASES OF INFECTIOUS SYPHILIS

CASES OF PRIMARY AND SECONDARY SYPHILIS: By Reporting Areas, September 1974 and September 1973 - Provisional Data

Reporting Area	Sept.		Calendar Year Cumulative Jan. - Sept.		Reporting Area	Sept.		Calendar Year Cumulative Jan. - Sept.	
	1974	1973	1974	1973		1974	1973	1974	1973
Connecticut	12	19	138	191	Arkansas	6	5	77	106
Maine	7	1	30	21	Louisiana	49	78	472	626
Massachusetts	41	35	471	562	New Mexico	9	1	64	56
New Hampshire	0	1	7	7	Oklahoma	14	15	99	134
Rhode Island	4	4	13	17	Texas	141	164	1,052	1,190
Vermont	0	3	1	16	DHEW REGION VI TOTAL	219	263	1,764	2,112
DHEW REGION I TOTAL	64	63	660	814	Iowa	8	8	34	42
New Jersey	72	72	661	755	Kansas	8	2	54	16
New York (Excl. NYC)	54	29	399	300	Missouri	44	39	326	118
New York City	249	227	2,333	2,539	Nebraska	1	1	10	10
DHEW REGION II TOTAL	375	328	3,393	3,594	DHEW REGION VII TOTAL	61	50	424	186
Delaware	10	6	65	72	Colorado	12	9	99	153
District of Columbia	55	74	484	599	Montana	0	0	2	2
Maryland (Excl. Baltimore)	13	21	182	197	North Dakota	2	1	6	2
Baltimore	46	39	380	448	South Dakota	0	1	2	5
Pennsylvania (Excl. Philadelphia)	22	16	172	196	Utah	2	1	10	12
Philadelphia	49	53	506	382	Wyoming	0	0	2	3
Virginia	46	82	588	581	DHEW REGION VIII TOTAL	16	12	121	177
West Virginia	2	1	14	14	Arizona	31	23	199	133
DHEW REGION III TOTAL	243	292	2,391	2,489	California (Excl. LA and SF)	129	91	913	878
Alabama	28	13	182	137	Los Angeles*	146	135	1,411	1,357
Florida	243	161	2,116	1,448	San Francisco*	97	60	662	440
Georgia (Excl. Atlanta)	56	62	516	597	Hawaii	0	4	22	42
Atlanta*	51	41	371	423	Nevada	4	8	47	53
Kentucky	27	18	220	265	DHEW REGION IX TOTAL	407	321	3,254	2,903
Mississippi	22	26	185	264	Alaska	1	3	4	13
North Carolina	72	54	701	467	Idaho	0	0	9	9
South Carolina	62	78	537	558	Oregon	9	2	72	34
Tennessee	29	54	359	339	Washington	14	19	95	121
DHEW REGION IV TOTAL	590	507	5,187	4,498	DHEW REGION X TOTAL	24	24	180	177
Illinois (Excl. Chicago)	29	17	201	148	UNITED STATES TOTAL	2,192	2,059	19,024	18,760
Chicago	68	84	628	715	Puerto Rico	76	63	672	576
Indiana (Excl. Indianapolis)	7	15	94	155	Virgin Islands	0	4	20	25
Indianapolis*	3	7	37	64	U.S. Including Territories	2,268	2,126	19,716	19,361
Michigan	39	43	322	380					
Minnesota	4	3	60	75					
Ohio	36	26	227	212					
Wisconsin	7	4	81	61					
DHEW REGION V TOTAL	193	199	1,650	1,810					

\*County Data

Note: Cumulative totals include revised and delayed reports through previous months.  
Source: CDC 9,98 CDC, VD Control Division, Atlanta, Ga. 30333

EPIDEMIOLOGIC NOTES AND REPORTS  
GIARDIASIS - Utah

From September 5 to 17, 1974, 54 members of a Brigham Young University (BYU) sociology class camped in the Uintah Mountains of Utah. During their last week or after their return to Provo, 34 of 52 campers contacted developed diarrhea or loose, frequent stools of at least 3-5 days' duration (clinical attack rate 65%). Distribution of symptomatic cases by date of onset is shown in Figure 4, and frequency of symptoms is shown in Table 2. Symptoms lasted from 3 to

41 days, with a mean of 13 days and a median of 11 days. No campers were hospitalized. All had had normal physical examinations before the trip.

The Center for Health and Environmental Studies at BYU examined stools from 42 campers; 26 (62%) contained *Giardia lamblia* trophozoites or cysts. Twenty-two (79%) of 28 symptomatic campers tested had positive stools, while 4 (29%) of 14 asymptomatic campers tested had positive stools.

## GIARDIASIS - Continued

Figure 4  
GIARDIASIS CASES IN 34 SYMPTOMATIC CAMPERS  
BY DATE OF ONSET  
BRIGHAM YOUNG UNIVERSITY - SEPTEMBER 1974

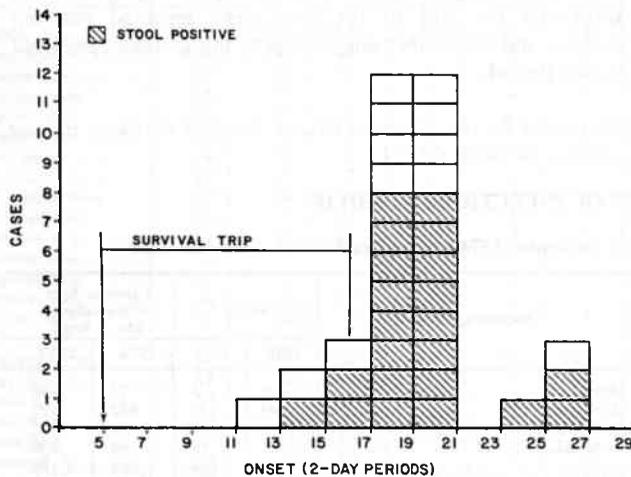


Table 2  
Frequency of Symptoms in 34 Ill Campers  
Brigham Young University - September 1974

Symptom	Percent with Symptom
Bloating, belching, or flatulence	97
Diarrhea or frequent, loose stools	85
Nausea	79
Weight loss	56
Abdominal cramps	44
Loss of appetite	41
Vomiting	24
Fever	0

Including both symptomatic and asymptomatic cases, the overall attack rate was 75%. One asymptomatic member who was negative for *Giardia* had *Endolimax nana* cysts in his stool. Stool specimens from 6 campers were tested for *Shigella* and *Salmonella* and were negative. At least 34 campers, 28 of whom were symptomatic, have been treated with quinacrine hydrochloride; 3 of the 28 have had clinical relapses.

Stool specimens were subsequently obtained from 55 other students at BYU before they went on similar survival trips; 1 (1.8%) contained *Giardia*.

Epidemiologic investigation revealed that the group, after

3 days of backpacking, set up camp at an altitude of 8,000 feet near a stream. They obtained all their drinking water from this source; it was neither halogenated nor boiled. The campers noted several active beaver ponds in the drainage area and saw grazing sheep and 1 shepherd, but no other humans. Food consisted of indigenous flora and some store-bought food. Human wastes were deposited at least 100 yards from the stream. Samples of stream water had 42 colonies of *Escherichia coli* per 100 ml; this is not an atypical coliform count for surface water in mountain streams in Utah (1).

Analysis of questionnaires from 52 members (96%) did not show a significant difference in attack rates when data were stratified by age, sex, home residence, history of recent foreign travel, or amount of water consumed during the trip. (Reported by Percy Hawkes, Missionary Parasite Study, Vernon J. Tipton, Ph.D., Director, Center for Health and Environmental Studies, and Cloyd C. Hofheins, M.D., Director, Health Center, Brigham Young University; Craig R. Nichols, Epidemiologist, Merlin A. Smith, M.S., Chief, Environmental Microbiology, Bureau of Laboratories, and Taira Fukushima, M.D., M.P.H., Director, Bureau of Disease Prevention, Utah State Division of Health; and an EIS Officer.)

## Editorial Note

Sporadic single cases or small clusters of giardiasis in people with no history of foreign travel but with recent exposure to untreated mountain or pond water have been noted in Utah and other Rocky Mountain states recently (2, 3). This is the largest known outbreak to occur where the only source appears to be mountain streams. Human fecal contamination from the shepherd, group members, or other unknown sources is possible. However, *Giardia* species have been found in many wild and domestic animals (4). They are said to be host-specific, but extensive studies have not been done (5, 6). A wild or grazing animal at high altitudes may be an alternate host to man.

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## SHIGELLOSIS ASSOCIATED WITH SWIMMING IN THE MISSISSIPPI RIVER - Iowa

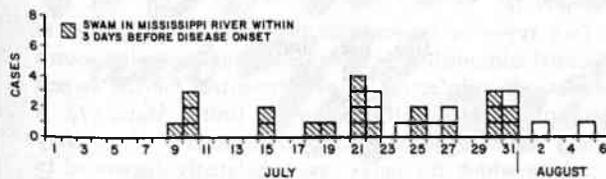
Thirty-nine culture-positive cases of shigellosis occurring in 29 families between July 9 and August 5, 1974, were reported to the City and County Health Departments, Dubuque, Iowa, by August 30. Symptoms included diarrhea (100%), accompanied by fever (95%), abdominal pain (79%), chills (51%), headache (51%), vomiting (49%), and blood in stools (23%). Thirty-seven persons (95%) consulted a physician, 16 (41%) were hospitalized, and 1 underwent surgery for acute appendicitis. All isolates were *Shigella sonnei*.

Investigation revealed that 21 (72%) of the initial cases in each family had swum in a 5-mile portion of the Mississippi River about 6-11 miles south of Dubuque within 3 days be-

fore disease onset; 10 of these 21 persons swam at the same spot, a small beach near a camping park 10 miles south of Dubuque. The median age of all swimmers was 5 years and of the other initial cases, 12.5 years. Only 2 cases, both swimmers, had shared food or had personal contact; only 2 of the 10 swimmers from the park beach had consumed food or water while there. Swimming exposures and disease onsets for the 29 initial cases occurred over a 28-day period (Figure 5). Comparison of these cases with a neighbor-matched control group showed a statistically significant correlation ( $p < .0000001$ ) between swimming and illness.

A retrospective telephone survey of 60 family groups

Figure 5  
29 INITIAL SHIGELLOSIS CASES BY DATE OF ONSET  
DUBUQUE, IOWA – JULY 9-AUGUST 5, 1974



who had camped at the park showed a statistically significant association between diarrheal illness and swimming at the beach near the park ( $p < .0001$ ) but no association with drinking water from the well or consuming food prepared at a park restaurant. The attack rate among all swimmers was 13%; among those swimmers who remembered getting river water in their mouths it was 21%. The attack rate for swimmers less than 20 years old (16%) was more than twice that for swimmers over 20 (6%).

*S. sonnei* isolates from the 21 swimmers were examined for antibiogram and colicin type. Isolates from 6 were resistant to tetracycline, streptomycin, carbenicillin, and ampicillin, sensitive to 8 other antibiotics tested, and colicin untypable. Isolates from 12 were resistant to tetracycline, streptomycin, and sulfathiazole and were colicin type 9. Isolates from 2 were resistant only to sulfathiazole and were colicin type 9. The antibiogram and colicin type of the isolate from 1 swimmer were unknown.

Water samples were obtained from a 5-mile stretch of river between the Dubuque sewage treatment plant and the swimming area on August 2, 5, 7, 13, and 20. Mean fecal coliform counts were 17,500 organisms per 100 ml in the swimming area near the park and 6,500 organisms per 100 ml 5 miles upstream just below the outfall of the Dubuque sewage treatment plant. *S. sonnei*, with the same antibiogram and colicin type as the isolates from 6 cases (resistant to tetracycline, streptomycin, carbenicillin, and ampicillin, colicin untypable), was isolated at the Mercy Medical Center Laboratory in Dubuque from a sample of water obtained at the swimming area on September 4. Several possible sources of river contamination were found, but the specific source of shigella contamination could not be identified.

A ban was posted on swimming and waterskiing in the involved area on August 2, and no cases directly attributable to river contact in that area occurred after the ban was announced. Investigations were initiated to further identify and correct sources of river contamination.

(Reported by John Schaefer, and Ray Ann Moriarity, Bacteriology Laboratories, Mercy Medical Center; Mary Gleason

Kline, Frances Kringle, Glenann Slade, Mary Jane Toner, Mary Unsen, Public Health Nurses, and Arthur J. Roth, Jr., M.P.H., City Health Administrator, Dubuque City Health Department; David Kunkel, Sanitarian, and Isabel Hagge, Public Health Nurse, Dubuque County Health Department; Kenneth K. Hazlet, M.D., Director, Dubuque City and County Health Departments; Kim Deppe, Public Health Nurse, Jackson County Health Department; Franklin P. Koontz, Ph.D., Assistant Director, William J. Hausler, Ph.D., Director, Iowa State Hygienic Laboratories; Kenneth Choquette, Director, Health Engineering Section, William Permar, Robert Olsen, Frank Thompson, and Charles A. Herron, M.D., State Epidemiologist, Iowa State Department of Health; and an EIS Officer.)

#### Editorial Note

Epidemiologic data strongly implicated swimming in the Mississippi River as the vehicle of transmission of shigellosis for 21 of the 29 initial cases in this study. Other infectious diseases associated with swimming in polluted natural waters include hepatitis (MMWR, Vol. 20, No. 26), typhoid fever (1), dermatitis (MMWR, Vol. 18, No. 41), primary amebic meningoencephalitis (MMWR, Vol. 20, No. 24), and leptospirosis (2). An outbreak of shigellosis in 1969 in Medford, Oregon, was traced to 8 index patients, 2 to 6 years old, who had used a wading pool grossly contaminated with fecal coliforms (MMWR, Vol. 18, No. 46); however, shigellae were not cultured from the pool, and epidemiologic data could not further implicate the pool as the source.

In this outbreak, fecal coliform counts where the children swam greatly exceeded the recommended federal standards of 200 per 100 ml of water used for swimming and other recreational purposes (3). The small number of swallowed shigellae necessary to cause disease ( $10^1$ - $10^2$  shigella organisms, compared to  $10^5$  salmonellae or  $10^8$  *Vibrio cholerae*) suggest that this organism may pose a significant risk to swimmers in polluted waters (4).

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#### INTERNATIONAL NOTES

##### SALMONELLA CROSS-INFECTION IN A HOSPITAL – United Kingdom

A patient was admitted to a maternity hospital where she had a normal delivery of a female child. As the hospital was short of accommodation, mother and child were transferred to a cottage hospital after 3 days. Four days later it was noted that the baby was failing to thrive. A loose stool was sent for laboratory examination, and the child was transferred the next day to a third hospital, under the care of a pediatrician. *Salmonella indiana* was isolated from the stool and also subsequently from the mother who admitted that she

had had diarrhea for several days before entering the hospital; the source of infection may well have been uncooked sausage meat, which the mother regarded as a delicacy and had eaten recently. Within the maternity ward of the cottage hospital there were 7 other mothers and their babies; *S. indiana* was isolated from 2 of the babies and 1 of the mothers and also from 2 nurses who were mainly employed with adult patients but also helped care for the babies. One of these nurses had helped to feed the infected infants; she also washed their

**SALMONELLOSIS – Continued**

diapers in a sink after which they were boiled in an electric boiler. One adult patient in another ward of the cottage hospital, a 37-year-old man with carcinomatosis, was also infected with this salmonella and is likely to have acquired it by direct or indirect contact with 1 of the nurses. Only the babies had loose stools; the 2 mothers, 2 nurses, and the adult patient were symptomless. No salmonellae were isolated from fecal specimens from 12 domestics, 17 other nursing and ancillary staff, and 7 other male and 14 female adult patients. There was no spread in the Maternity Unit where the first baby had been delivered.

The cottage hospital was closed to new admissions while the staff and patients were investigated for salmonellosis. As many patients as possible were sent home. The 2 nurses who were carriers were not allowed to return to duty until they had had 3 consecutive negative fecal examinations, and the adult patient who was an excreter was transferred to the isolation unit of a district general hospital. Advice was given on personal and environmental hygiene, and it was recommended (1) that nurses use gloves when handling diapers, (2) that disposable diapers and bedpans are preferable and that if nondisposable diapers are used they should be boiled first before being washed in a sink, and (3) that in small hospitals with inadequate facilities or staff shortages, consideration should be given to the use of commercially prepared baby-feeds. A hand-wash basin was supplied to the kitchen and a disinfectant provided for hand-washing in the wards as an additional safeguard.

(From notes based on reports to the Public Health Laboratory

Service from Public Health and Hospital Laboratories in the United Kingdom and Republic of Ireland, published in the British Medical Journal. October 12, 1974.)

**Editorial Note**

Two types of transmission patterns are recognized in nosocomial salmonellosis—cross-infection and common source outbreaks. Cross-infections have accounted for the largest number of reported outbreaks in the United States (1). A recurrent theme in nosocomial salmonellosis is the nursery outbreak in which the index case is belatedly discovered to have been delivered from a mother with a recent or current history of diarrhea. The likelihood of such an occurrence could be greatly diminished if a question on recent gastrointestinal illness were a routine part of every obstetrical admission history. If the mother has had diarrhea recently or if she is currently having diarrhea, isolation precautions appropriate for enteric infections should be extended to mother and child until cultures have ruled out enteric pathogens. Infants with diarrhea of suspected infectious etiology should also be isolated pending culture results. If outbreaks do occur, it may be necessary to close the ward to admissions or to apply cohorting of both patients and personnel so that well and ill infants are separated and attendants caring for patients with diarrhea do not come into contact with newly admitted or uninfected patients. Recognizing and correcting environmental problems, as in the outbreak reported here, are also important in the control and prevention of outbreaks.

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