Tuberculosis Outbreak — Continued

cilities should conduct regular employee TB screening clinics (graded by occupational risk category) that closely monitor tuberculin skin test conversions; such clinics can assist in surveillance for nosocomial transmission of TB.

References

1. Kent JH. The epidemiology of multidrug-resistant tuberculosis in the United States. Med Clin North Am 1993;77:1391–409.
2. CDC. Nosocomial transmission of multidrug-resistant tuberculosis among HIV-infected persons—Florida and New York, 1988–1991. MMWR 1991;40:585–91.
3. CDC. Guidelines for preventing the transmission of *Mycobacterium tuberculosis* in health-care facilities, 1994. MMWR 1994;43(no. RR-13).

Adult Blood Lead Epidemiology and Surveillance — United States, Fourth Quarter, 1995

CDC's National Institute for Occupational Safety and Health Adult Blood Lead Epidemiology and Surveillance program (ABLES) monitors elevated blood lead levels (BLLs) among adults in the United States (*1*). This report presents ABLES data for the fourth quarter of 1995.

During October–December 1995, the 6553 reports of BLLs ≥25 μg/dL represented a 4% decrease from the 6821 reports for the fourth quarter of 1994, which now include previously unpublished data for Maine (*2*). Compared with the fourth quarter of 1994, reports for the same period of 1995 increased 1% at the 25–39 μg/dL level; reports decreased 15% at the 40–49 μg/dL level, 27% at the 50–59 μg/dL level, and 10% at the ≥60 μg/dL level. For 1995, cumulative reports of BLLs ≥25 μg/dL decreased 10% from reports for 1994 (Table 1). The cumulative number of reports decreased at each reporting level.

TABLE 1. Number of reports of elevated blood lead levels (BLLs) among adults, number of adults with elevated BLLs, and percentage change in number of reports — 23 states,* fourth quarter, 1995

Reported BLL (μg/dL)	Fourth quarter, 1995		Cumulative reports, 1995		Cumulative reports, 1994		% Change from 1994 to 1995
	No. reports†	No. persons§	No.	(%)	No.	(%)	
25–39	5,034	3,720	18,492	(76)	19,420	(72)	– 5%
40–49	1,192	801	4,482	(18)	5,821	(22)	–23%
50–59	225	153	885	(4)	1,132	(4)	–22%
≥60	102	65	412	(2)	459	(2)	–10%
Total	**6,553**	**4,739**	**24,271**	**(100)**	**26,832**	**(100)**	**–10%**

* Alabama, Arizona, California, Connecticut, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Utah, Vermont, Washington, and Wisconsin.

† Data for Alabama and South Carolina were missing; fourth quarter 1994 data were used as an estimate.

§ Individual reports are categorized according to the highest reported BLL for the person during the given quarter. Pennsylvania provides the number of reports but not the number of persons; the number of persons for Pennsylvania in this table are estimates based on the proportions from the other 22 states combined and the number of reports received from Pennsylvania. Data for Alabama and South Carolina were missing; third quarter 1994 data were used as an estimate.

Adult Blood Lead Epidemiology and Surveillance — Continued

Compared with 1994, the increase in the number of reports at the highest reporting level (≥60 μg/dL) in the second and third quarters of 1995 (*3*) did not continue into the fourth quarter; the number of BLL reports during the fourth quarter in this category declined from 114 to 102 (*2*). The percentage of all reported BLLs at the ≥60 μg/dL level was 3% in 1992 (*4*) and remained at 2% in 1993 (*2*), 1994 (*5*) and 1995 (Table 1).

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Editorial Note: Variation in national quarterly reporting totals may result from 1) changes in the number of participating states, 2) timing of receipt of laboratory BLL reports by state-based surveillance programs, 3) changes in staffing and funding of state-based surveillance programs, and 4) interstate differences in worker BLL testing by lead-using industries. Variation from these sources reduces the capability to confidently identify trends in the actual data reported.

The findings in this report document the continuing hazard of work-related lead exposures as an occupational health problem in the United States. ABLES enhances surveillance for this preventable condition by expanding the number of participating states, reducing variability in reporting, and distinguishing between new and recurring elevated BLLs among adults.

References

1. CDC. Surveillance of elevated blood lead levels among adults—United States, 1992. MMWR 1992;41:285–8.
2. CDC. Adult Blood Lead Epidemiology and Surveillance—United States, fourth quarter, 1994. MMWR 1995;44:286–7.
3. CDC. Adult Blood Lead Epidemiology and Surveillance—United States, third quarter, 1995. MMWR 1996;45:170–1.
4. CDC. Adult Blood Lead Epidemiology and Surveillance—United States, fourth quarter, 1992. MMWR 1993;42:254.
5. CDC. Adult Blood Lead Epidemiology and Surveillance—United States, 1994 and first quarter, 1995. MMWR 1995;44:515–7.

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MORBIDITY AND MORTALITY WEEKLY REPORT

Tick Paralysis — Washington, 1995

Tick paralysis (tick toxicosis)—one of the eight most common tickborne diseases in the United States (*1*)—is an acute, ascending, flaccid motor paralysis that can be confused with Guillain-Barré syndrome, botulism, and myasthenia gravis. This report summarizes the results of the investigation of a case of tick paralysis in Washington.

On April 10, 1995, a 2-year-old girl who resided in Asotin County, Washington, was taken to the emergency department of a regional hospital because of a 2-day history of unsteady gait, difficulty standing, and reluctance to walk. Other than a recent history of cough, she had been healthy and had not been injured. On physical examination, she was afebrile, alert, and active but could stand only briefly before requiring assistance. Cranial nerve function was intact. However, she exhibited marked extremity and mild truncal ataxia, and deep tendon reflexes were absent. She was admitted with a tentative diagnosis of either Guillain-Barré syndrome or postinfectious polyradiculopathy.

Within several hours of hospitalization, she had onset of drooling and tachypnea. A nurse incidentally detected an engorged tick on the girl's hairline by an ear and removed the tick. Within 7 hours after tick removal, tachypnea subsided and reflexes were present but diminished. The patient recovered fully and was discharged on April 11. The tick species was not identified.

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Editorial Note: Tick paralysis occurs worldwide and is caused by the introduction of a neurotoxin elaborated into humans during attachment of and feeding by the female of several tick species. In North America, tick paralysis occurs most commonly in the Rocky Mountain and northwestern regions of the United States and in western Canada. Most cases have been reported among girls aged <10 years during April–June, when nymphs and mature wood ticks are most prevalent (*2*). Although tick paralysis is a reportable disease in Washington, surveillance is passive, and only 10 cases were reported during 1987–1995.

In the United States, this disease is associated with *Dermacentor andersoni* (Rocky Mountain wood tick), *D. variabilis* (American dog tick), *Amblyomma americanum* (Lone Star tick), *A. maculatum*, *Ixodes scapularis* (black-legged tick), and *I. pacificus*