Death Certification — Continued

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Editorial Note: Based on a meeting of experts cosponsored by CDC and the National Committee on Vital and Health Statistics in 1991, recommendations were developed for more accurate and consistent completion of DCs in physician-education programs (*4*). In particular, the recommendations suggested that, because most physicians are likely to certify only a small number of deaths, educational efforts should be aimed at physicians and institutions most likely to be pronouncing and certifying deaths. The findings in Fulton County characterize physicians and institutions involved in certifying deaths in a defined geographic area and may assist in the design of educational programs to increase the accuracy and completeness of DCs. In particular, these findings indicate that death-certification education efforts may be most effective if they are hospital based and targeted to all hospitals to reach appropriate PP certifiers and focus on the certification of inpatient deaths from natural causes. Because results from this study indicate that MECs certified nearly 20% of all deaths, education efforts for MECs could improve the accuracy and completeness of a substantial proportion of DCs.

Hospital-based efforts could include 1) training in death certification and registration before permanent or resident physician privileges are granted; 2) requiring physicians who certify the cause of death to complete approved training within a specified time after their first death certification; and 3) training a designated group of physicians to certify all deaths in the institution in consultation with the attending physician and after review of the medical record and other documents (*5*).

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Current Trends

Adult Blood Lead Epidemiology and Surveillance — United States, Second Quarter, 1993

Quarterly surveillance data from state-based Adult Blood Lead Epidemiology and Surveillance (ABLES) programs are reported for the second quarter of 1993. Previous quarterly summaries included multiple reports for persons received during the quarter (e.g., reflecting follow-up or repeat blood specimens). Counts of persons now exclude such multiple reports and report the highest blood lead level (BLL) obtained

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during the reporting period. These data provide a better estimate of the number of persons with elevated BLLs in the system and assist with targeted prevention efforts.

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TABLE 1. Reports of elevated blood lead levels (BLLs) in adults — 20 states,* second quarter, 1993

Reported BLL (μg/dL)	Second quarter, 1993		Cumulative reports, 1993†	Cumulative reports, 1992§
	No. reports	No. persons		
25-39	4,053	1,975	19,332	15,279
40-49	1,061	442	5,349	4,288
50-59	257	120	1,346	1,289
≥60	161	77	746	585
Total	**5,532**	**2,614**	**26,773**	**21,441**

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

† Cumulative totals for 1993 reflect first-quarter data from 16 states (Alabama, Connecticut, Illinois, Iowa, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, Oregon, South Carolina, Texas, Utah, Vermont, and Wisconsin) and second-quarter data from 20 states.

§ Cumulative totals for 1992 reflect first- and second-quarter data from 12 states (Alabama, California, Connecticut, Illinois, Iowa, Maryland, Massachusetts, New Jersey, New York, Oregon, Texas, and Wisconsin).

Notice to Readers

Update: Polio Eradication — the Americas, 1993

On September 7, 1993, the Pan American Health Organization (PAHO) announced that 2 years have elapsed since the occurrence of the last case of poliomyelitis associated with wild poliovirus isolation in the Americas (Peru, August 1991). This achievement is a milestone in the global eradication of poliomyelitis. The only

CDC
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September 10, 1993 / Vol. 42 / No. 35

MMWR
MORBIDITY AND MORTALITY WEEKLY REPORT

Effectiveness in Disease and Injury Prevention

Public Health Focus: Physical Activity and the Prevention of Coronary Heart Disease

Coronary heart disease (CHD) is the leading cause of mortality in the United States: each year, CHD is newly diagnosed in approximately 1.5 million persons and accounts for an estimated $47 billion in direct and indirect health-care costs (*1*). Multiple risk factors associated with CHD include genetic susceptibility, elevated serum cholesterol, low levels of high-density lipoprotein cholesterol, cigarette smoking, uncontrolled hypertension, obesity, diabetes mellitus, and physical inactivity (*2*). This report summarizes information about the potential efficacy and cost-effectiveness of physical activity promotion as a strategy for preventing CHD.

Efficacy and Attributable Risk

Mild to moderate levels of physical activity (e.g., walking, gardening, yardwork, and dancing) can help prevent CHD. In 1987, a review of 43 epidemiologic studies concluded that moderate to vigorous physical activity reduces risk for CHD (*3*). Two thirds of the studies documented a substantial inverse relation between physical activity and risk for CHD. In addition, the risk for CHD was increased nearly twofold for persons who were physically inactive (relative risk=1.9; 95% confidence interval=1.4–2.5), a level comparable to the relative risks associated with increased systolic blood pressure (2.1), cigarette smoking (2.5), and elevated serum cholesterol (2.4) (*4*). A subsequent meta-analysis (*5*) and results from other longitudinal studies (*6*) support the role of physical inactivity as a strong and independent risk factor for CHD.

Based on a national survey in 1985, 56% of men and 61% of women in the United States either never or irregularly engaged in physical activity (*7*). Specifically, 25% of men and 30% of women reported no leisure-time physical activity during the preceding month, and an additional 31% of men and women reported irregular physical activity. Of the 36% of men and 32% of women who were regularly active during leisure time, 8% of the men and 7% of the women reported participating in vigorous and intense activity (*7*).

An estimate of the population-attributable risk for CHD mortality associated with physical inactivity among a selected group of men from 1977 through 1985 was