Poliomyelitis Eradication — Continued

India, Indonesia, Myanmar, Nepal, Sri Lanka, and Thailand) of the 10 countries of SEAR, six of these seven countries plan to have conducted NIDs by February 1996. Despite this progress, member countries of SEAR reported 4373 polio cases in 1994, accounting for 58% of the global total. This region and sub-Saharan Africa are the two persistent and major reservoirs of polio worldwide (*2*).

Worldwide eradication of wild poliovirus requires the implementation of NIDs and the establishment and maintenance of strong AFP surveillance systems in polio-endemic countries (*5*). In the Americas, eradication of wild poliovirus was accomplished primarily by targeting NIDs to children aged <5 years in polio-endemic countries during the low season of transmission (*1*). Rapid mass vaccination of children with OPV effectively interrupts community transmission of wild poliovirus (*6*). Further progress in SEAR is contingent on the identification of sufficient resources—in addition to those provided by international organizations such as WHO, the United Nations Children's Fund (UNICEF), and Rotary International—to implement NIDs. In India, upcoming Pulse Polio Immunization Days will be restricted to children aged <3 years because of financial and operational constraints to including additional birth cohorts of approximately 25 million children each. Because recent surveillance data suggest that 8%–9% of reported polio cases occur in children aged 3 years, inclusion of these children in future NIDs will be critical. Because most polio cases in the world are reported from SEAR, the ability of member countries in the region to strengthen integrated AFP and virologic surveillance will be critical to the success of the global polio eradication initiative (*7*).

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

CDC's National Institute for Occupational Safety and Health (NIOSH) Adult Blood Lead Epidemiology and Surveillance program (ABLES) monitors elevated blood lead levels (BLLs) among adults in the United States (*1*). Twenty-three states, representing 64% of the U.S. population, report BLL surveillance results to ABLES. This report presents data from ABLES for the second quarter, 1995.

Adult Blood Lead Epidemiology — Continued

Based on the total U.S. population, the 26,832 reports (*2*) of adults with BLLs ≥25 μg/dL reported to ABLES in 1994 represents approximately 42,000 reports throughout the United States, and the 12,137 persons on whom these reports were made represents approximately 19,000 persons.

During April–June 1995, ABLES received 5870 reports of BLLs ≥25 μg/dL, a decrease of 7% from the 6314 reports for the same period in 1994 (Table 1). Compared with the second quarter, 1994, reports for 1995 decreased 4% for BLLs 25–39 μg/dL, 17% for BLLs 40–49 μg/dL, and 21% for BLLs 50–59 μg/dL; reports increased 4% for BLLs ≥60 μg/dL. During January–June 1995, cumulative reports of BLLs ≥25 μg/dL increased 1% over reports for the same period in 1994 (Table 1). Cumulative reports increased for BLLs 25–39 μg/dL but decreased for all higher levels. Although there was some variation in the second quarter of 1995, the trend of increasing reports at the lower reporting levels and decreasing reports at the higher levels is consistent with the data for 1994 (*2*).

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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,* second quarter, 1995

Reported BLL (μg/dL)	Second quarter 1995		Cumulative reports, 1995	Cumulative reports, 1994¶	% change 1994–1995
	No. reports†	No. persons§			
25–39	4,393	3,476	9,307	8,659	+ 7%
40–49	1,152	817	2,349	2,754	–15%
50–59	208	136	453	540	–16%
≥60	117	68	199	229	–13%
Total	**5,870**	**4,497**	**12,308**	**12,182**	**+ 1%**

* 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 Michigan are missing; second quarter 1994 data are 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 Michigan are missing; second quarter 1994 data are used as an estimate.

¶ Data for the second quarter of 1994 are corrected (*3*) from data published earlier (*4*) and include data for Maine, which were not previously included.

Adult Blood Lead Epidemiology — Continued

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Editorial Note: Reporting of adults with elevated BLLs reflects monitoring practices by employers. 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, and 3) interstate differences in worker BLL testing by lead-using industries.

The data presented in this report document the persistence of work-related lead exposures as an occupational health problem in the United States. ABLES can further enhance surveillance for this preventable condition by expanding the number of participating states, reducing variability in reporting, and distinguishing between new and recurring elevated BLLs in adults.

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MORBIDITY AND MORTALITY WEEKLY REPORT

Outbreak of Salmonellosis Associated With Beef Jerky — New Mexico, 1995

In February 1995, the New Mexico Department of Health (NMDOH) was notified of cases of salmonellosis in two persons who had eaten beef jerky. An investigation by the New Mexico Environment Department determined that these cases were associated with beef jerky processed at a local plant. An investigation by NMDOH identified 91 additional cases. This report summarizes the investigation of this outbreak.

On January 26, 1995, two men presented to the emergency department of a local hospital after onset of diarrhea and abdominal cramps. On January 24, the men had purchased and consumed carne seca, a locally produced beef jerky. Cultures of leftover beef jerky and stool obtained from one patient grew *Salmonella*. On February 7, NMDOH identified both isolates as *Salmonella* serotype Montevideo.

NMDOH initiated efforts to determine whether other cases of salmonellosis associated with beef jerky had occurred. On February 8, NMDOH issued a news release advising the public not to eat the implicated brand of beef jerky and to contact the local health department if illness had occurred after eating the product. Cases also were identified through a review of NMDOH records for isolates matching those identified in jerky samples. A confirmed case of beef jerky-related salmonellosis was defined as isolation of *Salmonella* from a stool sample obtained from a person who had consumed the implicated jerky. A probable case was defined as onset of diarrhea, abdominal cramps, vomiting, and/or nausea in a person who had consumed the implicated jerky.

Illness in 93 persons met the probable or confirmed case definitions. Ill persons reported purchasing the jerky at the local processing plant and eating the jerky during January 21–February 7; onset of symptoms occurred during January 22–February 11 (Figure 1). Incubation periods for most (89%) persons were ≤3 days. The median age of ill persons was 22 years (range: 2–65 years); 56 (60%) were male. Symptoms of the 93 persons included diarrhea (93%), bloody diarrhea (13%), abdominal cramps (87%), headache (74%), fever (61%), vomiting (43%), and chills (40%). The median duration of illness was 7 days (range: 1–40 days). Five persons (5.4%) were hospitalized.

Of the 93 cases, 40 were culture-confirmed. From the stool samples of these 40 ill persons, three *Salmonella* serotypes were isolated: *Salmonella* Typhimurium (31 persons), *Salmonella* Montevideo (12), and *Salmonella* Kentucky (11). Stool samples from 12 persons yielded two serotypes, and the sample from one patient contained