

Colorado (n=12), New Jersey (n=12), Kansas (n=nine), North Carolina (n=two), California (n=one), Delaware (n=one), Montana (n=one), Rhode Island (n=one), South Carolina (n=one), Vermont (n=one), West Virginia (n=one), and Wyoming (n=one) (Figure). Among the 3,378 patients for whom data were available, the median age was 55 years (range: 1.5 months–99 years); 1,802 (54%) were male, and the dates of illness onset ranged from June 10 to November 4. A total of 201 human deaths have been reported. The median age of decedents was 78 years (range: 24–99 years); 121 (60%) deaths were among men. In addition, 7,715 dead crows and 6,275 other dead birds with WNV infection were reported from 42 states and the District of Columbia; 9,051 WNV infections in mammals (9,038 equines, three canines, and 10 other species) have been reported from 38 states (Alabama, Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, Wisconsin, and Wyoming). During 2002, WNV seroconversions have been reported in 366 sentinel chicken flocks from Florida, Iowa, Nebraska, North Carolina, Pennsylvania, Texas, and New York City; 4,943 WNV-positive mosquito pools have been reported from 28 states (Alabama, Arkansas, Connecticut, Delaware, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma,

Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Vermont, and Virginia), New York City, and the District of Columbia.

Additional information about WNV activity is available from CDC at <http://www.cdc.gov/ncidod/dvbid/westnile/index.htm> and http://www.cindi.usgs.gov/hazard/event/west_nile/west_nile.html.

Notice to Readers

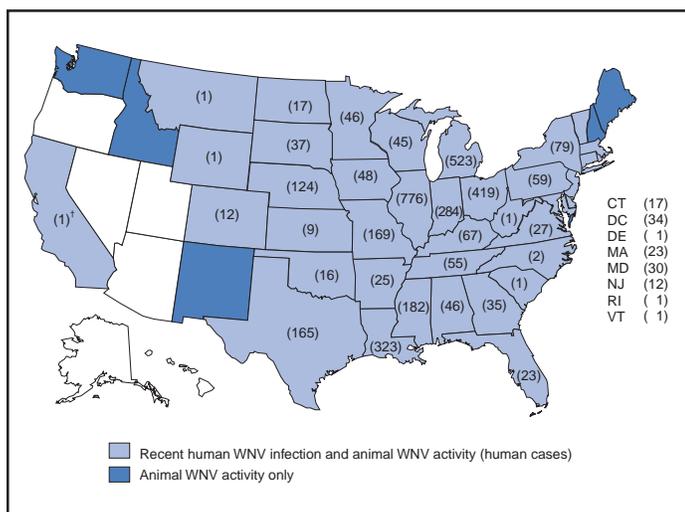
Occupational Health Indicators for Tracking Work-Related Health Effects and Their Determinants

Experts in various fields of public health have developed proposed indicators to enhance public health surveillance. These indicators have been published in *Indicators for Chronic Disease Surveillance, June 2000*; *State Injury Indicator Report January 2002*; and *Draft Environmental Public Health Indicators, August 2002*. The indicators are measures of health or factors associated with health in specified populations.

The Council of State and Territorial Epidemiologists (CSTE) Occupational Health Surveillance Work Group, a subcommittee of the Environmental/Occupational/Injury Committee, completed a set of proposed occupational health indicators that can be used by states to track work-related adverse health effects and their determinants. Occupational health indicators provide information about a population's health status with respect to workplace factors that can influence health. These proposed indicators include measures of health endpoints (e.g., work-related disease or injury) and measures of workplace factors associated with health (e.g., workplace exposures, hazards, and interventions). These indicators serve as a guide for states about the minimal level of occupational health surveillance activity. The indicators are intended to bring consistency to time-trend analyses and comparisons of occupational health status among states and to inform program and policy development at the national, state, and local levels to protect worker safety and health.

The occupational health indicators were developed, with support from the National Institute for Occupational Safety and Health (NIOSH), by the workgroup, which included representatives of state labor and health agencies, CSTE, and NIOSH. These indicators represent the consensus view of state and NIOSH representatives and are intended as an advisory to the states. The implementation of these indicators will depend on the availability of fiscal resources and epidemiologic capacity. During the next year, California, Maine, Massachusetts, Michigan, New York, and Washington will pilot the occupational health indicators to assess the data

FIGURE. Areas reporting West Nile virus (WNV) activity — United States, 2002*



* As of 9:30 a.m. Mountain Standard Time, November 26, 2002.

† California has reported human WNV activity only.

availability and the resources involved in implementing the indicators and to refine recommendations for standard data collection and presentation.

Additional information about the proposed occupational health indicators and publications from the CSTE Occupational Health Surveillance Workgroup are available at <http://www.cste.org/occupationalhealth.htm>.

Notice to Readers

2003 CDC and ATSDR Symposium on Statistical Methods

The Ninth Biennial Symposium on Statistical Methods sponsored by CDC and the Agency for Toxic Substances and Disease Registry will be held January 28–29, 2003, in Atlanta, Georgia, at the Crown Plaza Ravinia. A short course, “Modeling and Analysis Using Monte Carlo Methods,” will be offered January 27, along with the symposium. Presentations will include applications of study designs that have improved public health decision-making, alternate study designs and implications for public health decision-making processes, decision-making algorithms and related software applications and development, and statistics and policymaking in the face of uncertainty. The symposium and course are open to the public, and there is no charge to attend. Registration and additional information about the symposium are available from CDC at <http://www.cdc.gov/od/ads/sag>.

Notice to Readers

Publication of “Health, United States, 2002 with Chartbook on Trends in the Health of Americans”

CDC has published *Health, United States, 2002 with Chartbook on Trends in the Health of Americans*, the 26th edition of the annual report on the nation’s health. This report includes 147 trend tables organized around four broad subject areas: health status and determinants, health-care use, health-care resources, and health-care expenditures. Disparities in health by race/ethnicity and socioeconomic status are presented in several tables.

This year’s report includes *Chartbook on Trends in the Health of Americans*. The chartbook assesses the nation’s health by presenting trends and current information on selected determinants and measures of health status. Determinants of health include demographic factors, health insurance coverage, health behaviors, and preventive health care, and measures of health status focus on trends in mortality and limitations of activity caused by chronic health conditions. During the 20th

century, the health of persons in the United States improved substantially, reflecting the influence of healthier lifestyles, greater use of preventive care, public health efforts, and Maine, Maine, advances in medicine. Despite these health gains, disparities in health and health care among segments of the U.S. population persist.

This report is available at <http://www.cdc.gov/nchs/hus.htm>. Additional information is available from the National Center for Health Statistics, telephone 301-458-4636 or at nchsquery@cdc.gov. Print copies can be purchased from the Government Printing Office, telephone 202-512-1800, or at <http://bookstore.gpo.gov/index.html>.

Notice to Readers

World AIDS Day, December 1, 2002

“Live and Let Live” is the theme designated by the Joint United Nations Program on Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) for this year’s World AIDS Day, December 1, 2002. This year’s theme highlights the challenges that stigma and discrimination pose to the success of prevention, treatment, and care programs for persons living with HIV/AIDS.

AIDS continues to be a stigmatizing health issue for infected persons (1). Discrimination against persons with infectious diseases is not new (2), and after 20 years of HIV and AIDS public education, 18.7% of respondents in a 2000 survey reported some level of agreement with the statement, “People who get AIDS through sex or drug use have gotten what they deserve,” a proxy measure for stigma (3). One fourth of these respondents also reported misinformed opinions on modes of HIV transmission (3).

At the end of 2001, an estimated 362,827 persons in the United States (4) and 40 million persons worldwide were living with HIV/AIDS (5). Worldwide in 2001, three million persons died of AIDS and 14 million children lost one or both parents to AIDS (5). Overcoming stigma and discrimination against persons with AIDS remains a challenge to effective public health prevention and education programs.

Information about domestic HIV infection and AIDS is available from CDC’s National Prevention Information Network at <http://www.cdcnpin.org> and from CDC’s National Center for HIV, STD, and TB Prevention at <http://www.cdc.gov/nchstp/od/nchstp.html>. Additional information is available at 800-342-2437 or in Spanish at 800-344-7432. Information on the global pandemic is available from the Joint United Nations Program on AIDS at <http://www.unaids.org>.



MMWR™

Morbidity and Mortality Weekly Report

Weekly

November 29, 2002 / Vol. 51 / No. 47

Hepatic Toxicity Possibly Associated with Kava-Containing Products — United States, Germany, and Switzerland, 1999–2002

Since 1999, health-care professionals in Germany, Switzerland, and the United States have reported the occurrence of severe hepatic toxicity possibly associated with the consumption of products containing kava (i.e., kava kava or *Piper methysticum*). A total of 11 patients who used kava products had liver failure and underwent subsequent liver transplantation (1–7). On March 25, 2002, in response to five such case reports (four in Europe and one in the United States), the Food and Drug Administration (FDA) issued a consumer advisory (8) and subsequently completed an investigation already underway of a similar U.S. case. This report presents the investigation of the two U.S. cases of liver failure associated with kava-containing dietary supplement products and summarizes the European cases. FDA continues to advise consumers and health-care providers about the potential risk associated with the use of kava-containing products.

Case Reports

Case 1. In May 2001, a previously healthy woman aged 45 years reported the onset of nausea and weakness approximately 8 weeks after beginning use of a kava-containing dietary supplement that listed on the package label, “Kava kava extract (root), standardized to 30% kavalactones (75 mg), hops (strobiles), German chamomile (flower head), passion flower (flower and fruit), gelatin, and natural vegetable fiber.” The patient reported taking one tablet twice daily, which was less than the package label recommendation of one tablet three times daily. The patient reported no concomitant medication or dietary supplement use and rare alcohol ingestion (one to two drinks a year). The patient was initially prescribed rabeprazole for acid reflux symptoms, and this drug was taken for 4 days. In addition, the patient discontinued use of the kava-containing supplement. Several days later, the patient was hospitalized with jaundice and hepatitis. Liver biopsy

demonstrated subfulminant hepatic necrosis. Autoimmune and infectious hepatitis tests were negative. Liver transplantation was performed in July 2001, and the patient resumed daily activities following recovery from the procedure.

Case 2. In December 2000, a previously healthy girl aged 14 years reported the onset of nausea, vomiting, decreased appetite, weight loss, and fatigue. One week later, the patient had scleral icterus and was hospitalized with acute hepatitis. During late August to mid-December 2000, the patient reportedly used two kava-containing products. One product was taken intermittently in accordance with package directions (two capsules once daily). The patient estimated that she used the product on approximately 44 days during this period. The patient reported taking the second product in accordance with package directions (two capsules once daily) for 7 consecutive days at the beginning of the 4-month period. Because the product labels were unavailable, other product ingredients were unknown. The patient reported no use of alcohol or medications other than occasional ibuprofen. At the time of hospitalization, the patient’s liver-function tests were markedly abnormal (alanine aminotransferase: 4,076 U/L, aspartate aminotransferase: 3,355 U/L, gamma-glutamyltransferase: 148 U/L, total bilirubin: 16.2 mg/dL, ammonia: 17 mg/dL, and prothrombin time: 29.4 seconds) (5). Tests for human immunodeficiency virus (HIV),

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