INTERNATIONAL NOTES

FOLLOW-UP ON SMALLPOX — Yugoslavia

Since March 24, 1972, the World Health Organization (WHO) has reported 140 cases of smallpox with 20 deaths in Yugoslavia (MMWR, Vol. 21, No. 12). Vaccination campaigns are being conducted in Kosovo Province and in Belgrade, the two primary foci of the epidemic, as well as in other areas of eastern Yugoslavia that have had cases traced to these foci. As in previous outbreaks of smallpox in Europe, a significant number of cases in Yugoslavia are occurring in hospitals.

One case has been exported from Yugoslavia to Hannover, Germany. This case occurred in a Yugoslavian who traveled from Kosovo to Hannover and had onset of symptoms on March 21. German authorities have 600 contacts of this man. Health departments are following these travelers for signs or symptoms suggestive of smallpox. Information from WHO indicates that persons who were in Belgrade between March 20 and 30 are at highest risk. If persons contract smallpox during exposure in that period, they will have onset of symptoms in the first 2 weeks of April.

(Reported by the Smallpox Eradication Program, CDC.)

Editorial Note

The spread of smallpox in hospitals again points up the importance of vaccinating all medical and hospital personnel against this disease (MMWR, Vol. 20, No. 38).

| TABLE I. CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES |
| (Cumulative totals include revised and delayed reports through previous weeks) |
| DISEASE | 13th WEEK ENDED | MEDIAN 1967-1971 | CUMULATIVE, FIRST 13 WEEKS |
| Aseptic meningitis | 31 | 32 | 26 | 423 | 656 | 359 |
| Brucellosis | 6 | 4 | 5 | 28 | 26 | 27 |
| Chickenpox | 3,908 | | 4 | 4 | 41,553 | 35 |
| Encephalitis, primary | 1 | 4 | 26 | 51 | 38 |
| Encephalitis, primary: | | | | | | |
| Arthropod-borne & unspecified | 15 | 1 | 19 | 189 | 268 | 259 |
| Encephalitis, post-infectious | 6 | 3 | 9 | 60 | 79 | 98 |
| Hepatitis, serum (Hepatitis B) | 161 | 158 | 116 | 2,422 | 2,122 | 1,300 |
| Hepatitis, infectious (Hepatitis A) | 1,196 | 1,149 | 900 | 14,485 | 15,832 | 11,898 |
| Malaria | 25 | 50 | 56 | 392 | 960 | 606 |
| Measles (rubeola) | 1,147 | 2,806 | 1,598 | 10,197 | 26,528 | 14,726 |
| Meningococcal infections, total | 28 | 61 | 64 | 459 | 855 | 885 |
| Civilian | 27 | 52 | 57 | 440 | 730 | 804 |
| Military | 1 | 9 | 11 | 19 | 125 | 92 |
| Mumps | 2,185 | 4,209 | | 27,573 | 46,685 | --- |
| Rubella (German measles) | 954 | 1,997 | 1,980 | 8,739 | 15,479 | 2,073 |
| Tetanus | 3 | | | 21 | 17 | 24 |
| Tuberculosis, new active | 666 | | | | | --- |
| Tularemia | 2 | 2 | 2 | 27 | 25 | 24 |
| Typhoid fever | 6 | 5 | 5 | 64 | 64 | 57 |
| Typhus, tick-borne (Rky. Mt. spotted fever) | 1 | 1 | 12 | 5 | 4 |
| Venereal Diseases† | 14,011 | 10,338 | | 166,522 | 134,394 | --- |
| Gonorrhea | 537 | 368 | | 5,703 | 4,784 | --- |
| Syphilis, primary and secondary | 107 | 113 | 101 | 994 | 1,095 | 966 |

| TABLE II. NOTIFIABLE DISEASES OF LOW FREQUENCY |
| | Cum. |
| Poliomyelitis, total | 5 |
| Paralytic | 5 |
| Pneumococcal: Conn.-2 | 8 |
| Rabies in man | 1 |
| Trichinosis: Ups. N.Y.-2, Ohio-1, Pa-1 | 23 |
| Typhus, murine | 5 |

†Numbers for 1971 are estimated from quarterly reports to the Venereal Disease Branch, CDC.
Epidemiologic Notes and Reports
Botulism — California

On Dec. 16, 1971, a 30-year-old Korean physician and his 30-year-old wife in Los Angeles, California, had onset of diplopia and generalized muscular weakness. They were admitted the next day to a local hospital, where botulism was diagnosed. Both patients were treated with botulinum antitoxin and penicillin, and the woman required a tracheostomy. They recovered within 1 week. Their 2-month-old asymptomatic baby who was being breast fed was also given antitoxin.

On December 15, both patients had eaten home-prepared "Tam Puk Chang," a Korean dish consisting mainly of fermented soy beans. They did not notice anything abnormal about the food, which had been prepared approximately 2 weeks earlier by the woman. She apparently neglected to follow the recipe, for she failed to add a large amount of salt prior to the fermentation process and to boil the preparation immediately before serving it. Laboratory tests of the remaining fermented bean preparation were positive for type B botulism at the Los Angeles County Health Department Laboratories.

(Reported by Allen W. Mathies, M.D., head physician, Pediatrics-Communicable Disease, Joshua H. Ritchie, M.D., chief resident, Communicable Disease Service, Los Angeles County-University of Southern California Medical Center; Ichiro Kamei, M.D., Chief, Acute Communicable Disease Control Division, Robert A. Murray, Epidemiology Analyst, Richard Barnes, Ph.D., Director, Bureau of Public Health Laboratories, County of Los Angeles Health Department; John R. Philp, M.D., Health Officer, Orange County; and an EIS Officer.)

International Notes
Cholera — Worldwide

As of March 24, 1972, a total of 20 countries had reported cholera to the World Health Organization; seven of these are in Asia, and 13 are in Africa. Table 1 shows the countries that are infected with the disease as well as all countries that have reported cholera since 1970 (1). Yemen is the only new country that has reported cholera since Jan.

(Reported by the Bacterial Diseases Branch, Epidemiology Program, and the Foreign Quarantine Program, CDC.)

Reference

Table I
Countries Reporting Cholera — 1970-1972

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<th>Infected</th>
<th>Previously Infected in 1970-1972</th>
<th>Imported Cases Only</th>
<th>Geographic Area</th>
<th>Infected</th>
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Coxsackie B Virus Infections — United Kingdom, 1971

In 1971, a total of 1,269 infections due to Coxsackie B viruses were reported in the United Kingdom, with serotypes B2 and B5 accounting for 34% and 29%, respectively, of the total (Table 2). These two serotypes have not been isolated in such numbers since 1967 in the case of B2 and 1965 in the case of B5.

Serotypes B2 through B5 vary in incidence from year to year, and outbreaks of each type tend to occur every 3-6 years. Type 1, however, does not seem to share this periodicity, although an epidemic due to this virus occurred in 1971. Type B6 is rarely isolated, compared with the other serotypes.

The number of isolations of Coxsackie B5 virus began to increase in June and reached a peak at the end of August. Since then, the number of isolations slowly decreased but has not as yet reached the usual baseline. An increased summer incidence has been a feature of all infections with the Coxsackie B group of viruses.

Infections with Coxsackie B5 virus were reported from all parts of the British Isles, but most commonly from laboratories in the south of England. Minor epidemics of the
Table 2
Coxsackie B Virus Infections
United Kingdom – 1965-1971

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<th>B3</th>
<th>B4</th>
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<td>46</td>
<td>110</td>
<td>47</td>
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<td>129</td>
<td>58</td>
<td>189</td>
<td>30</td>
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<td>138</td>
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<tr>
<td>1970</td>
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<td>198</td>
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<td>49</td>
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<td>1971</td>
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<td>431</td>
<td>176</td>
<td>161</td>
<td>364</td>
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<td>1,269</td>
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<tr>
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<td>1,486</td>
<td>1,141</td>
<td>786</td>
<td>1,854</td>
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disease seemed to occur in some areas; for example, 26 of 32 isolations reported from one laboratory occurred in an 8-week period in the summer. All ten infections reported from another laboratory occurred in a 4-week period in July and August.

Eleven small outbreaks were reported. Most of these were within single families; three were in nurseries.

The age and sex distribution and the clinical features of the 364 infections due to B5 are shown in Table 3. The greatest incidence was in infants under 1 year of age. Children were affected more often than adults; only 5% of the proven infections occurred in adults more than 45 years old. To some extent, this distribution may reflect a greater tendency to investigate children than adults. There were more infections reported in male than in female children.

The most common clinical manifestations in children were respiratory tract infection (23%), meningoencephalitis (22%), and gastrointestinal (13%). Malaise, headache, and aching limbs were reported in 15% of the cases, and 7% of the isolations were from asymptomatic persons. A clinical diagnosis of whooping cough was made in two children: one was a 5-year-old boy who had symptoms for 2 weeks, and one was a 2-month-old baby.

Meningitis was the most common clinical manifestation in adults and occurred in 40% of the cases reported; respiratory illness was the main feature in 27%. On the other hand, gastrointestinal symptoms were much less commonly reported in adults than in children.

Bornholm disease was diagnosed in 11 patients, seven of whom were children. Five adult patients had pericarditis, and a 6-month-old baby experienced myocarditis from which he recovered.

Three cases were fatal. One was in a 2-week-old infant with generalized infection, and the other two were in adults, one with myocarditis and the other with encephalitis.

(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, Feb. 12, 1972.)

Table 3
Coxsackie B5 Infections, by Age and Clinical Category
United Kingdom – 1971

<table>
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<tr>
<th>Age (Years)</th>
<th>Respiratory</th>
<th>Gastro-Intestinal</th>
<th>Central Nervous System</th>
<th>General</th>
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<td>46</td>
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<td>1-4</td>
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<td>8</td>
<td>12</td>
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<td>10</td>
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<td>80</td>
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<td>5-9</td>
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<td>12</td>
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<td>50</td>
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CURRENT TRENDS
NEW IMPORT RESTRICTIONS ON PSITTACINE BIRDS – United States

Effective March 10, 1972, the United States Department of Agriculture (USDA) promulgated regulations which placed new import restrictions on psittacine birds (parrots, macaws, and other birds of the Order Psittaciformes). The new USDA regulations are directed primarily towards preventing the introduction of exotic strains of Newcastle Disease. They superimpose additional requirements on existing Public Health Service regulations concerning the importation of these birds to guard against psittacosis.

The USDA requires that all entering or returning psittacine birds, including personal pets, undergo isolation and approved medication for 45 days at a facility located overseas and approved by the USDA. In addition, it requires a 30-day post-entry isolation period in the United States in approved facilities. Ports of entry for incoming birds are now restricted to Honolulu, Los Angeles, Miami, New York, and Seattle. Birds from Mexico may also enter at San Ysidro, California, and from Canada at Buffalo, New York, or Detroit, Michigan.

Pending revision of Public Health Service psittacine regulations, inquiries concerning procedures for importing psittacine birds should be directed to: Deputy Administrator, Veterinary Services, Animal and Plant Health Service, U.S. Department of Agriculture, Washington, D.C. 20250.

(Reported by the Foreign Quarantine Program, CDC.)
TABLE III. CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES FOR WEEKS ENDING APRIL 1, 1972 AND APRIL 3, 1971 (13th WEEK)

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<th>CHICKENPOX</th>
<th>DIPHTHERIA Cum. 1972</th>
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*Delayed reports: Hepatitis, infectious: W. Va. 2
Morbidity and Mortality Weekly Report

TABLE III. CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES
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*Delayed reports: Measles: Me delete 38, Mass. delete 6, Ariz. delete 5, Utah delete 1

Meningococcal infections: Ala. 1, Wash. delete 6

Rubeella: Utah 1
### TABLE III. CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES

FOR WEEKS ENDING APRIL 1, 1972 AND APRIL 3, 1971 (13TH WEEK) – Continued

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*Delayed reports: Tuberculosis: Ohio delete 1, N.C. delete 2, Tenn. 29
Syphilis: Ohio 1
RMSF: Ala. 1
TABLE IV. DEATHS IN 122 UNITED STATES CITIES FOR WEEK ENDING APRIL 1, 1972

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

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</table>

Las Vegas, Nev.*               | 26         | 13                 | 3            |            |                    |             |                  |

*Mortality data are being collected from Las Vegas, Nev., for possible inclusion in this table, however, for statistical reasons, these data will be listed only and not included in the total, expected number, or cumulative total, until 5 years of data are collected.

†Delay report for week ending March 25, 1972

*Estimate based on average percent of divisional total
In September 1971, the Surgeon General of the Public Health Service recommended that routine smallpox vaccination be discontinued in the United States (MMWR, Vol. 20, No. 38). In the past 6 months, a significant reduction has occurred in the amount of smallpox vaccine distributed (Figure 1). A reduction has also been noted in the number of Vaccinia Immune Globulin (VIG) requests for the prophylaxis or treatment of smallpox vaccination complications (Figure 2). This suggests a 75% reduction in the number of smallpox vaccinations given in the United States.

Only four states still have both a mandatory smallpox requirement for school entrance and a State Health Department policy supporting routine vaccinations. (Reported by the Smallpox Eradication Program, CDC.)