# Update: Human Plague—India, 1994

*MMWR 1994;43:761-762*

FROM August 26 through October 18, 1994, a total of 693 suspected bubonic or pneumonic plague cases with positive test results for antibodies to *Yersinia pestis* were reported by India to the World Health Organization (WHO). Cases were reported from five states (Maharashtra [488 cases], Gujarat [77 cases], Karnataka [46 cases], Uttar Pradesh [10 cases], and Madhya Pradesh [4 cases]) and from the federal district of New Delhi (68 cases). Nationwide, 56 fatal plague cases have been reported; no deaths have been reported since October 11.

As of October 19, WHO considered the outbreak to be under control because few new suspected cases had been reported. In addition, WHO continues to recommend no restrictions for travelers visiting India. However, travelers to the city of Surat, Gujarat, or the Beed district, Maharashtra—areas where plague transmission may be ongoing—are advised to seek medical attention for any illness that begins within 6 days of departure.

As of October 19, no imported plague cases had been detected in persons in other countries. No plague cases had been reported in U.S. residents in India.

Reported by: World Health Organization, Geneva. Div of Quarantine, National Center for Prevention Svcs; Bacterial Zoonoses Br, Div of Vector-Borne Infectious Diseases, National Center for Infectious Diseases, CDC.

**CDC Editorial Note:** The reliability of reported data about the plague outbreaks in India is unknown, and criteria for clinical and laboratory confirmation of cases have not been described. However, the most recent data suggest that transmission has been more geographically limited than previously reported.[1,2] Studies have been initiated to accurately assess the extent of the outbreaks, their relation to persistent foci of transmission, and the clinical spectrum and epidemiologic features of the illness, including the incidence of person-to-person transmission.

Travelers to India and other plague-endemic countries continue to be at low risk for infection with *Y. pestis*. As of October 19, health officials had identified and evaluated 12 airline passengers who had arrived from India with febrile or other illnesses and who disembarked in the United States. Using similar surveillance protocols, health officials have evaluated 40 travelers in Canada (B. Gushulak, Laboratory Center for Disease Control, Ottawa, personal communication, October 18, 1994) and 27 in the United Kingdom (J. Watson, Public Health Laboratory Service Communicable Disease Surveillance Center, London, personal communication, October 18, 1994); none have been diagnosed with plague.

Suspected human plague cases in international travelers should be reported through state and local health departments to CDC's Division of Quarantine, National Center for Prevention Services, telephone (404) 639-8107 or (404) 639-2888 (nights, Sundays, and holidays).

**References**

1. CDC. Human plague—India, 1994. MMWR 1994;43:689-91.
2. CDC. Update: human plague—India, 1994. MMWR 1994;43:722-3.

# Adult Blood Lead Epidemiology and Surveillance

CDC's National Institute for Occupational Safety and Health (NIOSH) Adult Blood Lead Epidemiology and Surveillance program (ABLES) monitors elevated blood lead levels (BLLs) in adults in the United States. Blood lead data from laboratory reports are transmitted to state-based lead surveillance programs and are compiled by NIOSH for quarterly reporting.[1]

The cumulative number of BLL reports for the first and second quarters of 1994 increased 29% over those of the same period for 1993. This finding is consistent with a previous ABLES report describing the increasing number of reports of elevated BLL cases among U.S. workers during 1992-1993.[2]

Reports of elevated BLLs represent new, ongoing, or recurrent exposures and illustrate the extent and ongoing nature of elevated BLLs in workers in lead-using industries. Factors that help explain the increase in reports include increased testing of workers in construction trades,[3] improved case ascertainment by state-based surveillance programs, and increased numbers of participating states. Finally, during this quarter, the number of persons reported apparently exceeded the number of reports in one reporting category (25-39 ug/dL) because one large industrialized state reports only numbers of persons on a quarterly basis and compiles overall numbers of reports only annually.

Reported by: NH Chowdhury, MBBS, Alabama Dept of Public Health. C Fowler, MS, Arizona Dept of Health Svcs. FJ Mycroft, PhD, Occupational Health Br, California State Dept of Health Svcs. BC Jung, MPH, Connecticut Dept of Public Health and Addiction Svcs. M Lehnherr, Occupational Disease Registry, Div of Epidemiologic Studies, Illinois Dept of Public Health. R Gergely, Iowa Dept of Public Health. E Keyvan-Larijani, MD, Lead Poisoning Prevention Program, Maryland Dept of the Environment. R Rabin, MSPH, Div of Occupational Hygiene, Massachusetts Dept of Labor and Industries. A Carr, MBA, Bur of Child and Family Svcs, Michigan Dept of Public Health. D Solet, PhD, Div of Public Health Svcs, New Hampshire State Dept of Health and Human Svcs. B Gerwel, MD, Occupational Disease Prevention Project, New Jersey State Dept of Health. R Stone, PhD, New York State Dept of Health. S Randolph, MSN, North Carolina Dept of Environment, Health, and Natural Resources. E Rhoades, MD, Oklahoma State Dept of Health. M Barnett, MS, State Health Div, Oregon Dept of Human Resources. J Gostin, MS, Occupational Health Program, Div of Environmental Health, Pennsylvania Dept of Health. R Marino, MD, Div of Health Hazard Evaluations, South Carolina Dept of Health and Environmental Control. D Perrotta, PhD, Bur of Epidemiology, Texas Dept of Health. D Beaudoin, MD, Bur of Epidemiology, Utah Dept of Health. L