

Poliomyelitis Eradication — Continued

provided to achieve progress in the polio eradication initiative in EUR has been provided by an international coalition consisting of WHO; United Nations Children's Fund (UNICEF); and other partner agencies including Rotary International, US Agency for International Development, CDC, and the governments of Canada, Denmark, France, Germany, Italy, Japan, Luxembourg, the Netherlands, Norway, Switzerland, and the United Kingdom and the European Commission Humanitarian Office.

References

1. CDC. Update: mass vaccination with oral poliovirus vaccine—Asia and Europe, 1996. *MMWR* 1996;45:911–4.
2. CDC. Progress toward global eradication of poliomyelitis, 1996. *MMWR* 1997;46:579–84.
3. CDC. Status of the global laboratory network for poliomyelitis eradication, 1994–1996. *MMWR* 1997;46:692–4.
4. CDC. Poliomyelitis outbreak—Albania, 1996. *MMWR* 1996;45:819–20.
5. Oblapenko G, Sutter RW. Status of poliomyelitis eradication in Europe and the Central Asian Republics of the Former Soviet Union. *J Infect Dis* 1997;175:S76–S81.
6. Kew OM, Mulders MN, Lipskaya GJ, da Silva EE, Pallansch MA. Molecular epidemiology of poliovirus. *Semin Virol* 1995;6:401–14.
7. CDC. Progress toward poliomyelitis eradication—Eastern Mediterranean Region, 1996–1997. *MMWR* 1997;46:793–7.
8. Sutter RW, Chudaiberdiev YK, Vaphakulov SH, Tursunova D, Oblapenko G, Iskandarov TI. A large outbreak of poliomyelitis following temporary cessation of vaccination in Samarkand, Uzbekistan, 1993–1994. *J Infect Dis* 1997;175:S82–S85.

Adult Blood Lead Epidemiology and Surveillance — United States, Second Quarter, 1997

CDC's National Institute for Occupational Safety and Health (NIOSH) Adult Blood Lead Epidemiology and Surveillance (ABLES) program monitors laboratory-reported elevated blood lead levels (BLLs) among adults in the United States. During 1997, a total of 27 states reported surveillance data to ABLES.* In this report, ABLES data for the first and second quarters of 1997 are presented and compared with the first and second quarters of 1996.

During April–June 1996 and 1997, reports of BLLs ≥ 25 $\mu\text{g}/\text{dL}$ by the same 27 states increased by 5%, from 5867 to 6157, respectively (1).[†] This quarterly increase follows an increase of 13% during the first quarter of 1997 (2). The combined increase for the first two quarters of 1997 is 9% (Table 1); in comparison, the long-term trend had been decreasing during 1993–1996 (2–4) as had the overall number of reported BLLs ≥ 25 $\mu\text{g}/\text{dL}$ among adults in the United States (5).

*Alabama, Arizona, California, Connecticut, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Vermont, Washington, Wisconsin, and Wyoming.

[†]To compare the number of reports for a constant roster of 27 states in 1997 and 1996, first and second quarters 1997 data for New Mexico, Rhode Island, and Wyoming were added to the previously reported totals for the first and second quarter of 1996, and first and second quarters 1996 data for Illinois (which discontinued reporting at the end of 1996) were subtracted from the previously reported totals for the first and second quarters of 1996 (1). Adjustments were made to compare 28 states in the first quarter report for 1997 (2), but a roster of 27 states has been adopted for the remainder of 1997.

ABLES — Continued

TABLE 1. Number of reports of elevated blood lead levels (BLLs) among adults, number of persons with elevated BLLs, and percentage change in number of reports — 27 states,* second quarter, 1997

Reported BLL ($\mu\text{g/dL}$)	Second quarter, 1997		Cumulative reports, 1996 [§]	Cumulative reports, 1997 [¶]	% Change from second quarter, 1996 to 1997
	No. reports	No. persons [†]			
25–39	4,928	3,566	8,835	9,866	12%
40–49	933	652	1,947	1,897	–3%
50–59	189	136	415	403	–3%
≥60	107	76	196	215	10%
Total	6,157	4,430	11,393	12,381	9%

* Alabama, Arizona, California, Connecticut, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Vermont, Washington, Wisconsin, and Wyoming. Data from New Hampshire were missing; 1996 data were used as an estimate.

[†] Individual reports for persons are categorized according to the highest reported BLL for the person during the given quarter. The number of persons reported in Michigan is an estimate based on the number of reports received.

[§] To compare the number of reports for a constant roster of 27 states in 1997 and 1996, first and second quarter 1997 data for New Mexico, Rhode Island, and Wyoming were added to the previously reported totals for the first and second quarters of 1996, and first and second quarters 1996 data for Illinois (which discontinued reporting at the end of 1996) were subtracted from the previously reported totals for the first and second quarter of 1996 (1).

[¶] To compare a constant roster of 27 states, first quarter 1996 data for Illinois, used as an estimate, were subtracted from the previously reported totals for the first quarter of 1997 (2).

Reported by: JP Lofgren, MD, Alabama Dept of Public Health. K Schaller, Arizona Dept of Health Svcs. S Payne, MA, Occupational Lead Poisoning Prevention Program, California Dept of Health Svcs. BC Jung, MPH, Div of Environmental Epidemiology and Occupational Health, Connecticut Dept of Public Health. R Gergely, Iowa Dept of Public Health. A Hawkes, MD, Occupational Health Program, Bur of Health, Maine Dept of Human Svcs. E Keyvan-Larjani, MD, Lead Poisoning Prevention Program, Maryland Dept of Health and Mental Hygiene. R Rabin, MSPH, Div of Occupational Safety, Massachusetts Dept of Labor and Workforce Development. M Scoblic, MN, Michigan Dept of Public Health. M Falken, PhD, Minnesota Dept of Health. L Thistle-Elliott, MEd, 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 and Senior Svcs. R Prophet, PhD, New Mexico Dept of Health. R Stone, PhD, New York State Dept of Health. S Randolph, MSN, North Carolina Dept of Environment, Health, and Natural Resources. A Migliozi, MSN, Bur of Health Risk Reduction, Ohio Dept of Health. E Rhoades, MD, Oklahoma State Dept of Health. A Sandoval, MS, State Health Div, Oregon Dept of Human Resources. J Gostin, MS, Occupational Health Program, Div of Environmental Health, Pennsylvania Dept of Health. M Stoeckel, MPH, Rhode Island Dept of Health. A Gardner-Hillian, Div of Health Hazard Evaluations, South Carolina Dept of Health and Environmental Control. P Schnitzer, PhD, Bur of Epidemiology, Texas Dept of Health. W Ball, PhD, Bur of Epidemiology, Utah Dept of Health. L Toof, Div of Epidemiology and Health Promotion, Vermont Dept of Health. J Kaufman, MD, Washington Dept of Health. J Tierney, Wisconsin Dept of Health and Family Svcs. T Kietz, Wyoming Dept of Health. Div of Surveillance, Hazard Evaluations, and Field Studies, National Institute for Occupational Safety and Health, CDC.

Editorial Note: The increase in the number of reports of elevated BLLs for the first two quarters of 1997 suggests the possible ending of the long-term decline in the overall number of detected cases of elevated BLLs among adults reported during 1993–1996 (4). Factors related to this increase might include 1) improved efforts of the

ABLES — Continued

participating states and lead-using industries within them to identify lead-exposed workers; 2) improved compliance with Occupational Safety and Health Administration requirements for blood lead monitoring; 3) increased occupational exposures to lead; and/or 4) an increase in the size of the workforce in lead-using industries. However, this trend also might reflect normal variations in nationwide reporting totals that result from changes in staffing and funding in state-based surveillance programs and interstate differences in worker BLL testing by lead-using industries. Continued surveillance is required before this two-quarter increase can be confirmed as a reversal of the previous long-term decrease.

The findings in this report document the continuing hazard of lead exposures as an occupational health problem in the United States. ABLES seeks to 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.

References

1. CDC. Adult blood lead epidemiology and surveillance—United States, second quarter, 1996. MMWR 1996;45:919–20.
2. CDC. Adult blood lead epidemiology and surveillance—United States, first quarter 1997, and annual 1996. MMWR 1997;46:643–7.
3. CDC. Adult blood lead epidemiology and surveillance—United States, fourth quarter, 1996. MMWR 1997;46:358–60,367.
4. CDC. Adult blood lead epidemiology and surveillance—United States, third quarter, 1996. MMWR 1997;46:105–7.
5. CDC. Update: blood lead levels—United States, 1991–1994. MMWR 1997;46:141–6.

*Notice to Readers***Satellite Broadcast on Managing Occupational Exposures to HIV**

Putting the Pieces Together: Managing Occupational Exposures to HIV, a live satellite broadcast, will be held Thursday, January 15, 1998, from 1 p.m. to 3:30 p.m. eastern standard time. Cosponsors are CDC and the Public Health Training Network. This course is designed for physicians, nurses, occupational-health professionals, infection-control professionals, pharmacists, laboratorians, hospital administrators, and others who developed policies on or managed occupational exposures to HIV.

This course will provide an overview and update of the "PHS Statement on Management of Occupational Exposures to HIV and Recommendations for Chemoprophylaxis after Exposure." Experts will identify and discuss the components necessary to incorporate the PHS recommendations in policies on management of occupational exposures to HIV. Viewers will be able to submit questions during the program. Continuing education credits will be offered.

Additional information is available through CDC's fax information system, telephone (888) 232-3299 ([888] CDC-FAXX), by requesting document number 130013.



MORBIDITY AND MORTALITY WEEKLY REPORT

- 985 Knowledge About Causes of Peptic Ulcer Disease — United States, March–April 1997
- 987 Childhood Pedestrian Deaths During Halloween — United States, 1975–1996
- 990 Smallpox Surveillance — Worldwide
- 994 Progress Toward Poliomyelitis Eradication — Europe and Central Asian Republics, 1991–September 1997
- 1000 Adult Blood Lead Epidemiology and Surveillance — United States, Second Quarter, 1997
- 1002 Notices to Readers

Knowledge About Causes of Peptic Ulcer Disease — United States, March–April 1997

An estimated 25 million persons in the United States have had peptic ulcer disease (PUD) during their lifetimes (1). A high proportion (at least 90%) of PUD cases are caused by infection with *Helicobacter pylori*—an association first reported in 1983 (2,3). However, in 1995, most (72%) of the general public was unaware of this association (4). To increase awareness among the general public and health-care providers about the relation between *H. pylori* infection and PUD, CDC, in collaboration with other federal agencies, academic institutions, and partners from private industry, has developed an awareness and education campaign. The campaign is being initiated during October 19–25, 1997, in conjunction with National Infection Control Week. In preparation for the education campaign, during early 1997 a population-based survey was conducted to provide more current estimates of knowledge about the causes of PUD. This report summarizes the survey findings and describes the campaign; the findings indicate that only 27% of the general public is aware of the association between *H. pylori* infection and PUD.

Questions about the causes of PUD were included as part of the Health Styles Supplemental Survey, which was administered during March–April 1997 (5). Questionnaires were mailed to a representative sample of 3064 U.S. adults aged ≥18 years; of these, 2512 (82%) persons completed the questionnaire. Respondents read statements about the causes of PUD and were asked whether they agreed or disagreed with each statement; therefore, respondents could identify more than one cause. To compensate for differential nonresponse rates in various demographic categories, data were weighted to the 1992 distribution of the U.S. population by age, sex, race/ethnicity, income level, and region.

Approximately 60% (95% confidence interval [CI]=58%–62%) of respondents believed that ulcers were caused by too much stress; 17% (95% CI=16%–18%), that eating spicy foods caused ulcers; and 27% (95% CI=25%–29%), that a bacterial infection caused ulcers. The belief that stress was the most likely cause was highest among persons aged 18–24 years (78% [95% CI=65%–81%]) and among persons with annual household incomes of <\$15,000 (65% [95% CI=60%–70%]). Similarly, the belief that spicy food was the most common cause of ulcers was highest among persons aged 18–24 years (33% [95% CI=18%–48%]) and among persons with annual household incomes of <\$15,000 (26% [95% CI=22%–30%]). The proportion of respondents who

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format and on a paid subscription basis for paper copy. To receive an electronic copy on Friday of each week, send an e-mail message to listserv@listserv.cdc.gov. The body content should read *SUBscribe mmwr-toc*. Electronic copy also is available from CDC's World-Wide Web server at <http://www.cdc.gov/> or from CDC's file transfer protocol server at <ftp.cdc.gov>. To subscribe for paper copy, contact Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone (202) 512-1800.

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Address inquiries about the *MMWR* Series, including material to be considered for publication, to: Editor, *MMWR* Series, Mailstop C-08, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone (888) 232-3228.

All material in the *MMWR* Series is in the public domain and may be used and reprinted without permission; citation as to source, however, is appreciated.

Director, Centers for Disease Control
and Prevention
David Satcher, M.D., Ph.D.
Deputy Director, Centers for Disease Control
and Prevention
Claire V. Broome, M.D.
Director, Epidemiology Program Office
Stephen B. Thacker, M.D., M.Sc.

Editor, *MMWR* Series
Richard A. Goodman, M.D., M.P.H.
Managing Editor, *MMWR* (weekly)
Karen L. Foster, M.A.
Writers-Editors, *MMWR* (weekly)
David C. Johnson
Darlene D. Rumph Person
Teresa F. Rutledge
Caran R. Wilbanks

☆ U.S. Government Printing Office: 1998-633-228/67034 Region IV
