Adenovirus Respiratory Disease — Continued

of the vaccines will probably be exhausted in 1999, at which time large ARD outbreaks in military settings are expected, primarily in winter months (*9*). This outbreak underscores that adenoviruses can cause outbreaks of ARD among young adults, persons living in crowded conditions, and military recruits.

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

CDC's National Institute for Occupational Safety and Health Adult Blood Lead Epidemiology and Surveillance program (ABLES) 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.* This report presents ABLES data through the fourth quarter for 1997 and compares the data for each quarter of 1997 with data reported for the corresponding quarter of 1996; preliminary totals for the fourth quarter 1997 reports suggest that the overall number of persons with BLLs ≥25 μg/dL were similar for 1996 and 1997.

Beginning with this report, the focus is on the number of persons with elevated BLLs (prevalence); previous ABLES reports focused primarily on the number of laboratory reports of elevated BLLs (there are often multiple laboratory reports for the same person, representing repeat or follow-up testing of the person). The number of new cases of elevated BLLs (incidence) will continue to be reported as cumulative annual data, which accompanies the succeeding year's first quarter report.

*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.

Adult Blood Lead Epidemiology — Continued

States in the ABLES program mandate that laboratories report elevated BLLs for adults to the state health departments or another designee. The minimum BLL required to be reported varies among the states; the ABLES definition of an elevated BLL is ≥25 μg/dL. ABLES follow-back procedures have been previously described (*1*).

During October–December 1996 and 1997, the number of persons with BLLs ≥25 μg/dL reported by the same 27 participating states decreased 5%, from 4229 (*2*) to 4010.[†] This quarterly decrease in the number of persons with BLLs ≥25 μg/dL follows no change from 1996 when compared with 1997 in the third quarter (from 3747 to 3748), a decrease of 6% in second quarter (from 4421 to 4148), and a 10% increase in first quarter (from 4198 to 4598) (Figure 1). A similar quarterly pattern was observed for the number of persons with BLLs ≥50 μg/dL (the level designated by the Occupational Safety and Health Administration [OSHA] for medical removal from the workplace [*3*])—decreases of 6% in the fourth quarter (from 250 to 236), 12% in the third quarter (from 214 to 188), and 20% in the second quarter (from 245 to 197), and an increase of 14% in the first quarter (from 194 to 222).

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Editorial Note: Beginning with this report, the ABLES program will report the prevalence of persons with elevated BLLs, rather than the number of laboratory reports of elevated BLLs. Prevalence is a more accurate measure of the burden of elevated BLLs among adults. ABLES continues to collect and analyze data about the number of laboratory reports for use in following persons with persistently high BLLs and for use as a measure of compliance with OSHA testing requirements.[§]

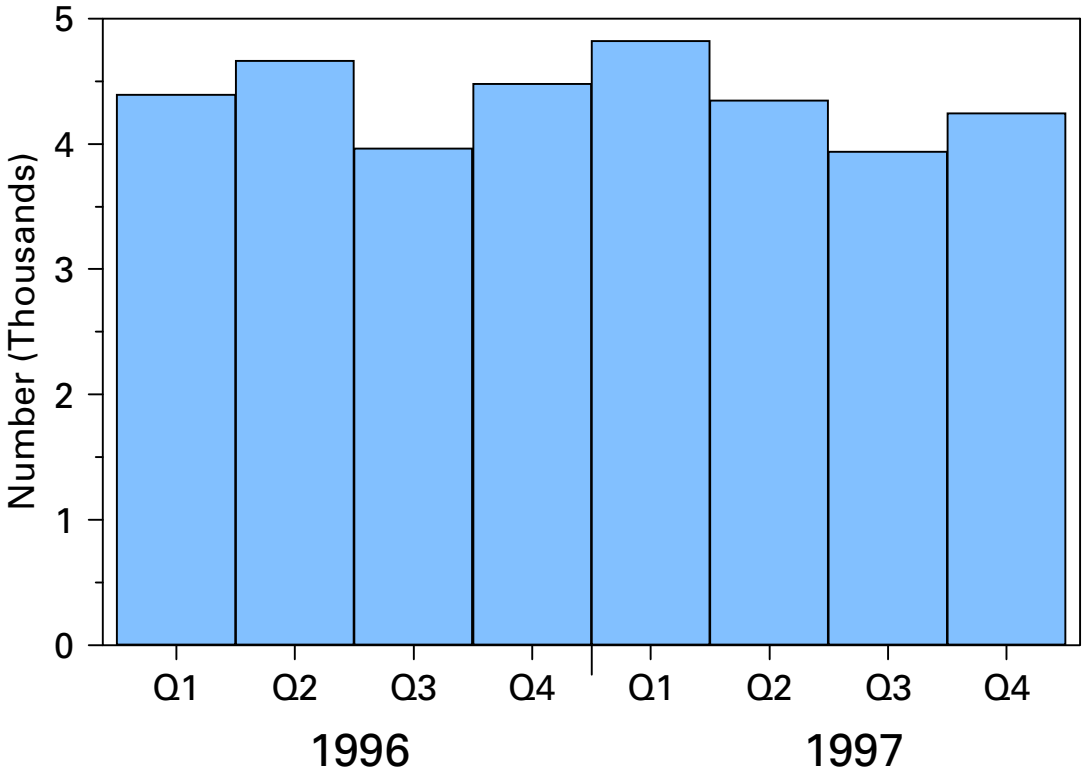
The number of persons with elevated BLLs is not directly comparable with previously reported numbers of laboratory reports. However, trends in these two forms of data are similar, and the general pattern in the number of persons with elevated

[†] To compare the number of persons for a constant roster of 27 states in 1997 and 1996, data for 1997 for New Mexico, Rhode Island, and Wyoming were added to previously reported totals for 1996 (*1*). In addition, 1996 data for Illinois, which no longer reports, were subtracted from previously reported totals for 1996 (*1*). Alabama and Ohio have updated their reports for 1996, and these updated data are now incorporated.

[§] The number of laboratory reports for the fourth quarter of 1997 was 5421, compared with 5874 in 1996.

Adult Blood Lead Epidemiology — Continued

FIGURE 1. Number of persons* with blood lead levels (BLLs) ≥25 µg/dL, by quarter — 27 states,† 1996–1997



*Persons are categorized according to the highest reported BLL for the person during the given quarter.

†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 persons for a constant roster of 27 states in 1997 and 1996, 1997 data for New Mexico, Rhode Island, and Wyoming were added to previously reported totals for 1996 (*1*). In addition, 1996 data for Illinois, which no longer reports, were subtracted from the previously reported totals for 1996. Alabama and Ohio have updated their reports for 1996 and these updated data are now incorporated.

BLLs over the four quarters of 1997 suggests a continuation of the long-term declines observed for laboratory reports since 1993 (*2,4,5*). This decline detected in the last three quarters of 1997, when compared to the same period of 1996, may reflect decreased occupational exposures to lead through improved controls implemented by employers. Alternatively, the decreases might also reflect 1) decreased efforts of the various participating states, and lead-using industries within them, to identify lead-exposed workers; 2) a reduction in the size of the workforce in lead-using industries; and/or 3) a change in reporting laws or in compliance with these laws. Quarterly increases and decreases also might represent normal fluctuations in case reporting, which may result from changes in staffing and funding in state-based surveillance

Adult Blood Lead Epidemiology — Continued

programs, interstate differences in worker BLL testing by lead-using industries, or random variation.

The findings in this report document the continuing hazard of lead exposures as an occupational health problem in the United States. ABLES enhances surveillance for this preventable condition by expanding the number of participating states, exploring ways to increase the usefulness of reporting, and alerting the public to potential new sources of lead exposure.

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Notice to Readers

CDC's National Profile of Local Boards of Health, September 1997

During 1995–1996, CDC, in collaboration with the National Association of Local Boards of Health (NALBOH), conducted the National Survey of Local Boards of Health (*1*). The survey was designed to characterize the nation's local boards of health (LBOHs) and learn more about their needs, concerns, and capacities. Data were collected in five areas: 1) demographic characteristics of LBOHs and the areas they represent, 2) telecommunications capability/infrastructure, 3) roles, responsibilities, and authorities, 4) composition and structure, and 5) concerns and needs.

An LBOH was defined as any officially constituted local body that establishes general public health policies for a local jurisdiction or that provides advice about the development of such policies to those responsible for policy development. Surveys were completed by 1391 (44%) of 3186 LBOHs.

The survey found that, although 70% of respondents reported having access to a computer, only 31% used e-mail and only 18% used Internet e-mail. Most (80%) LBOHs reported performing multiple functions. More than half reported performing a combination of advisory, governing, and policy-making functions, and 70% reported that they recommended public health policy; proposed, adopted, and enforced public health regulations; and recommended health department budgets and priorities.

Approximately 70% of respondents reported needing training, information, or technical assistance in establishing community health priorities, identifying funding sources, conducting state and local health reform activities and community health assessments, and working with managed care organizations.

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MORBIDITY AND MORTALITY WEEKLY REPORT

Foodborne Outbreak of Cryptosporidiosis — Spokane, Washington, 1997

On December 29, 1997, the Spokane Regional Health District received reports of acute gastroenteritis among members of a group attending a dinner banquet catered by a Spokane restaurant on December 18. The illness was characterized by a prolonged (3–9 days) incubation period and diarrhea, which led public health officials to suspect a parasitic cause of the illness. Eight of 10 stool specimens obtained from ill banquet attendees were positive for *Cryptosporidium* using both modified acid-fast and auramine-rhodamine staining of concentrated specimens. This report summarizes the epidemiologic investigation of the outbreak, which suggests that foodborne transmission occurred through a contaminated ingredient in multiple menu items.

In a retrospective cohort study, a case was defined as diarrhea or abdominal cramping in a banquet attendee with onset within 10 days after the banquet. Of the 62 attendees, 54 (87%) had illnesses meeting the case definition; they became ill a median of 6 days (range: 3–9 days) after the banquet. Symptoms included diarrhea (98%), fever/chills (61%), headache (59%), body ache (54%), abdominal cramps (50%), nausea (28%), and vomiting (11%). Based on information from initial interviews, the median length of illness was 5 days (range: 1–13 days), but subsequently several persons reported that they had symptoms intermittently for a month or longer. Two persons were hospitalized, and six others sought health care for their illness.

The banquet buffet included 18 separate food and beverage items; seven items contained uncooked produce. No single food was significantly associated with illness. When menu items that contained green onions were combined, foods containing uncooked green onions (au gratin potatoes, romaine salad, and pasta salad) were reportedly eaten by all 51 case-patients who could recall and by three of four persons who were not ill and could recall (undefined relative risk, p=0.07).

The banquet food items were prepared or served by 15 food workers. Stool specimens were available from 14 food workers within 3–4 weeks of the banquet; specimens from two tested positive for *Cryptosporidium*. One of the two food workers was symptomatic at the same time as banquet attendees; the other was asymptomatic. A stool specimen from another food worker was not available for testing until 5 weeks after the outbreak and was negative; he reported that he worked for 2 days in December while experiencing diarrhea but he could not remember the dates of his illness. All

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