CENTERS FOR DISEASE CONTROL

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International Notes

Yaws and Yellow Fever Project — Ghana

In January 1981, the government of Ghana and 4 major donors (USAID, WHO, UNICEF, EEC*) began a project to interrupt the precipitous increase in the prevalence of yaws and to contain the spread of yellow fever in that country. The project is intended to support the Ghanaian government's overall goal of providing the most effective health care at the most reasonable cost to the greatest number of people.

By the end of 1981, participants in the project had examined 803,437 Ghanaians (total population about 11 million) for yaws and had treated 544,469 of these persons (yaws patients and their contacts), each with a single injection of long-acting penicillin. In the project, 292,037 children were vaccinated against yellow fever, 55,791 against measles, 120,793 against tuberculosis, and 125,715 women of childbearing age were vaccinated against tetanus. In the areas surveyed, coverage of the target population with penicillin treatment and yellow fever vaccine slightly exceeded the project objective of 80%. The anti-yaws strategy included the use of mobile teams and the assurance that fixed health facilities received regular supplies of penicillin for treating patients and their contacts. However, mainly because of shortfalls in gasoline supplies, the mobile teams were only able to carry out their field activities on about 43% of the intended days of operation.

In the surveyed villages of heavily affected Ashanti, Eastern and Central Regions, the prevalence of persons with active yaws was reduced by the end of 1981 to 53/100,000 population from the 1980 level of 703/100,000.

Reported by Dr EG Beausoleil, Director of Medical Svcs, Dr Yaw Aboagye-Attah, Deputy Director of Medical Svcs (PH), Dr VK Agadzi, Chief, Epidemiology Div, FK Kofi, Chief Technical Officer, Ghanaian Ministry of Health; International Health Program Office, CDC.

Editorial Note: This timely project demonstrates the feasibility of halting the resurgence of yaws in Ghana, where the numbers of cases of that disease reported each year increased almost 10-fold between 1969 and 1979 (*1,2*). Moreover, this was accomplished while persons in the same villages were being vaccinated against other important infectious agents. In recent years several other countries, particularly in West Africa, reported large numbers of cases of yaws and/or endemic, non-venereal syphilis (*1*). It is hoped that the impact of this project and the methods used in it will stimulate other countries with similar public health problems to reconsider what might be accomplished in their own epidemiologic situations. Two of Ghana's neighbors, Togo and Ivory Coast, have already decided to intensify their efforts to combat yaws. The emergence of chloroquine-resistant malaria, isoniazid-resistant tuberculosis, and now dapsone-resistant leprosy (*3*) illustrate the risks of not acting promptly

*USAID (United States Agency for International Development), WHO (World Health Organization), UNICEF (United Nations Children's Emergency Fund), EEC (European Economic Community).

Yaws and Yellow Fever — Continued

and vigorously to make maximal use of inexpensive, effective, and simple chemotherapy against an endemic disease.

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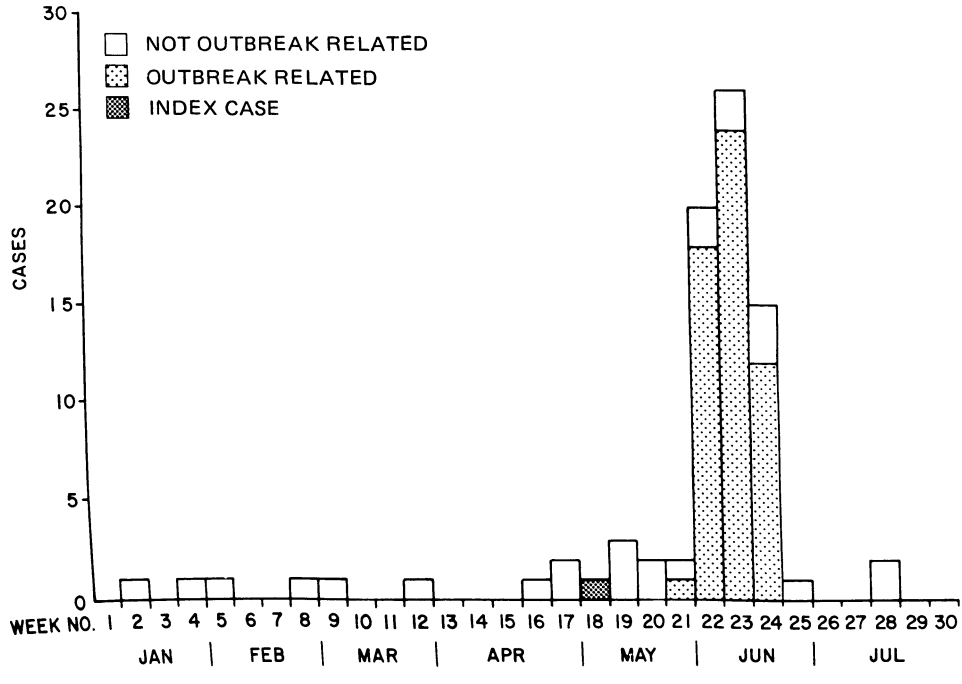
Epidemiologic Notes and Reports

Outbreak of Food-borne Hepatitis A — New Jersey

An increase in the number of hepatitis cases in Monmouth County, New Jersey, was reported to the New Jersey Department of Health on June 15, 1981. Investigation by state and local area health departments revealed that 56 cases of hepatitis had occurred during the first 3 weeks of June in an area of Monmouth County where the usual average is 3-4 cases/month. Patients for whom appropriate laboratory tests had been done were confirmed to have hepatitis A.

Detailed food histories revealed that, within the appropriate incubation period for hepatitis A, 55 of the 56 patients had eaten at a Mexican style restaurant (Figure 1). Interviews of a control group matched for age, sex, and neighborhood of residence, showed that 10% of the

FIGURE 1. Hepatitis A cases, by week of onset, Monmouth County, New Jersey, 1981



Food-borne Hepatitis – Continued

controls ate food from this restaurant over a time period comparable with that for 98% of the patients. The restaurant agreed to close voluntarily pending further investigation.

Of the patients whose illness was related to the Mexican restaurant, 71% were male, 68% were between the ages of 15 and 29 years, and 4 were children under 15 years. A case-control study using 46 non-ill patrons revealed that patients were more likely to have eaten nachos, beans, and jalapeno peppers. Both beans and jalapeno peppers were used in preparing nachos.

Ten individuals including the 2 owners worked in the restaurant; all handled food at one time or another. Interviews on June 18 revealed that 1 employee who frequently ate food from the restaurant was ill with hepatitis at the time of the interview. Another employee had symptoms compatible with hepatitis on May 9. He had worked all day May 9, but felt too ill to work thereafter; the diagnosis of hepatitis A was confirmed for him on May 16. This employee prepared food—including grating cheese, shredding lettuce, and occasionally cutting meat—measured portions of meat, beans, jalapeno peppers, onions, cheeses, and lettuce into shells, and served the customers.

Because a food handler was recently ill with hepatitis and because the restaurant was implicated in the spread of hepatitis, immune globulin was offered to all individuals who ate in the restaurant from June 5 until it closed. A total of 1,430 people were immunized at a 2-day clinic held June 19 and 20.

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Editorial Note: Hepatitis A virus (HAV) can be transmitted by food contaminated with feces from an infected food handler. If acute hepatitis A has been confirmed in a food handler by testing for IgM-specific HAV antibody, immunoglobulin prophylaxis (IG, gamma globulin) may be considered for patrons, depending on the probability of transmission of infectious virus and the probability of successful intervention in transmission by using IG. However, few food handlers actually appear to transmit disease via food, and IG prophylaxis of patrons is seldom warranted. Although for the past few years approximately 1,000 food handlers with non-B hepatitis have been reported annually to CDC, an average of 4 outbreaks of food-borne hepatitis A have been reported each year.

Transmission of HAV is affected by the amount of virus excreted by the food handler, the type of food handled, and the food handler's hygiene practices. Because the amount of virus excreted peaks 7-10 days before onset of symptoms and declines rapidly thereafter (*1*), food-borne outbreaks of hepatitis commonly originate from foods prepared before the food handler has clinical symptoms (*2,3*). As in this outbreak, most reported outbreaks have been traced to symptomatic rather than asymptomatic excreters. Uncooked foods have most frequently been associated with food-borne hepatitis because normal cooking temperatures inactivate HAV (*4*). However, cooked foods that were handled after cooling and foods that were contaminated and then cooked with insufficiently high internal temperature to inactivate HAV have also been implicated (*2,5*). Although poor hygiene practices among food handlers increase the chance of transmission of virus, outbreaks have occurred even when food handlers' personal hygiene practices were described as "acceptable" and "generally good" (*3*). Hygiene practices should be assessed by interviewing the ill food handler, coworkers, and employer. If deficiencies occurred and the ill food handler did not wear gloves, prophylaxis may be considered for patrons who ate implicated food items during the appropriate time period. Successful intervention in disease transmission depends on identifying persons at risk

Food-borne Hepatitis — Continued

and administering IG within 2 weeks after exposure (*6*).

Other employees who have been regularly exposed to the index case are at risk of acquiring infection. If they do become infected, they may serve as additional sources of infection for future food consumers. These employees should be extremely conscientious in their hygiene practices, and those who handle high-risk foods should be given IG. Screening of coworkers for elevated liver enzymes or antibodies to HAV does not appear justified because the enzymes are not specific for hepatitis A, and both enzymes and antibodies appear after most virus excretion has occurred.

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TABLE I. Summary — cases of specified notifiable diseases, United States

DISEASE	12th WEEK ENDING			CUMULATIVE, FIRST 12 WEEKS		
	March 27 1982	March 28 1981	MEDIAN 1977-1981	March 27 1982	March 28 1981	MEDIAN 1977-1981
Aseptic meningitis	67	94	53	877	791	582
Brucellosis	5	3	4	20	16	39
Encephalitis: Primary (arthropod-borne & unspec.)	20	21	12	160	175	138
Post-infectious	2	–	3	9	17	36
Gonorrhea: Civilian	16,384	17,103	16,914	211,561	221,455	218,491
Military	389	730	471	6,114	6,746	6,428
Hepatitis: Type A	369	582	582	5,107	5,780	6,332
Type B	400	439	318	4,296	4,260	3,571
Non A, Non B	31	N	N	388	N	N
Unspecified	169	221	221	2,106	2,445	2,372
Legionellosis	7	N	N	57	N	N
Leprosy	2	2	2	31	48	34
Malaria	13	16	9	156	277	111
Measles (rubeola)	17	74	683	183	613	3,501
Meningococcal infections: Total	69	88	70	767	1,207	794
Civilian	69	88	68	763	1,205	785
Military	–	–	2	4	2	9
Mumps	225	127	571	1,447	1,295	4,503
Pertussis	18	22	22	221	234	243
Rubella(German measles)	57	67	529	710	591	2,874
Syphilis (Primary & Secondary): Civilian	737	591	452	7,768	7,059	5,613
Military	1	13	5	86	96	73
Tuberculosis	422	563	565	5,462	5,553	5,904
Tularemia	1	4	2	17	24	21
Typhoid fever	7	9	9	85	100	91
Typhus fever, tick-borne (RMSF)	1	–	–	18	12	12
Rabies, animal	118	199	84	1,078	1,426	727

TABLE II. Notifiable diseases of low frequency, United States

	CUM. 1982		CUM. 1982
Anthrax	–	Poliomyelitis: Total	1
Botulism (Calif. 1)	17	Paralytic	1
Cholera	1	Psittacosis (Mass. 2; Mo. 1; Wash. 1)	17
Congenital rubella syndrome (Mich. 1)	1	Rabies, human	–
Diphtheria	–	Tetanus	9
Leptospirosis	12	Trichinosis (N.H. 1)	26
Plague	2	Typhus fever, flea-borne (endemic, murine)	3

N: Not notifiable

TABLE III. Cases of specified notifiable diseases, United States, weeks ending March 27, 1982 and March 28, 1981 (12th week)

REPORTING AREA	ASEPTIC MENINGITIS	BRUCELLOSIS	ENCEPHALITIS		GONORRHEA (Civilian)		HEPATITIS (Viral), by type				LEGIONELLOSIS	LEPROSY
			Primary	Post-infectious			A	B	NA,NB	Unspecified		
	1982	CUM. 1982	CUM. 1982	CUM. 1982	CUM. 1982	CUM. 1981	1982	1982	1982	1982	1982	CUM. 1982
UNITED STATES	67	20	160	9	211,561	221,455	369	400	31	169	7	31
NEW ENGLAND	1	–	8	3	4,825	5,597	8	22	1	14	2	1
Maine	–	–	–	–	234	280	2	–	–	–	–	–
N.H.	–	–	–	–	152	212	–	1	1	2	–	–
Vt.	–	–	–	–	104	95	1	1	–	–	–	–
Mass.	1	–	3	–	2,243	2,264	5	8	–	12	–	–
R.I.	–	–	–	–	371	262	–	2	–	–	–	–
Conn.	–	–	5	3	1,721	2,484	–	10	–	–	2	1
MID. ATLANTIC	14	–	21	1	26,031	25,314	50	69	2	20	1	2
Upstate N.Y.	4	–	10	–	4,208	3,933	5	12	–	5	–	–
N.Y. City	5	–	4	–	11,273	10,075	28	36	–	7	–	–
N.J.	5	–	4	–	4,531	5,152	17	21	2	8	1	1
Pa.	–	–	3	1	6,019	6,154	U	U	U	U	–	1
E.N. CENTRAL	3	–	36	2	27,157	36,267	54	60	3	12	2	–
Ohio	3	–	12	–	8,597	12,691	24	29	1	9	1	–
Ind.	–	–	10	2	3,758	2,910	10	7	1	2	–	–
Ill.	–	–	–	–	4,536	10,035	11	12	1	–	–	–
Mich.	–	–	12	–	7,442	7,583	8	10	–	1	1	–
Wis.	–	–	2	–	2,824	3,048	1	2	–	–	–	–
W.N. CENTRAL	5	2	11	–	9,799	10,620	10	11	1	1	1	–
Minn.	2	–	–	–	1,488	1,709	5	3	1	–	–	–
Iowa	2	1	6	–	1,104	1,067	1	3	–	–	–	–
Mo.	1	1	3	–	4,399	4,761	1	1	–	1	1	–
N. Dak.	–	–	–	–	124	136	–	–	–	–	–	–
S. Dak.	–	–	–	–	292	291	–	1	–	–	–	–
Nebr.	–	–	1	–	607	819	–	–	–	–	–	–
Kans.	–	–	1	–	1,785	1,837	3	3	–	–	–	–
S. ATLANTIC	8	6	19	1	54,935	55,431	36	79	6	19	–	1
Del.	–	–	–	–	848	885	2	–	–	3	–	–
Md.	–	–	9	–	7,372	5,832	2	11	1	–	–	–
D.C.	–	–	–	–	2,730	3,644	–	–	–	–	–	–
Va.	2	4	6	–	4,652	5,214	2	13	2	2	–	–
W. Va.	–	–	–	–	625	796	3	2	–	1	–	–
N.C.	3	–	1	–	9,057	9,150	4	4	–	1	–	–
S.C.	–	1	–	–	5,140	4,975	7	8	–	2	–	–
Ga.	–	–	–	–	8,818	10,835	6	14	–	4	–	–
Fla.	3	1	3	1	15,693	14,100	10	27	3	6	–	1
E.S. CENTRAL	6	3	10	1	17,780	18,077	19	15	1	1	–	–
Ky.	–	–	–	–	2,414	2,377	5	3	–	–	–	–
Tenn.	–	1	7	–	6,758	6,757	8	5	1	–	–	–
Ala.	4	1	2	1	5,362	5,748	2	5	–	1	–	–
Miss.	2	1	1	–	3,246	3,195	4	2	–	–	–	–
W.S. CENTRAL	6	3	12	–	30,312	30,548	104	43	2	66	–	–
Ark.	–	2	–	–	2,512	1,990	6	3	1	2	–	–
La.	4	–	1	–	5,420	4,663	22	7	1	3	–	–
Okla.	–	1	5	–	3,203	3,127	17	3	–	4	–	–
Tex.	2	–	6	–	19,177	20,768	59	30	–	57	–	–
MOUNTAIN	7	–	7	1	7,931	8,938	24	29	3	15	–	–
Mont.	–	–	–	–	338	323	2	–	–	–	–	–
Idaho	–	–	–	–	306	328	–	2	–	–	–	–
Wyo.	–	–	–	–	224	200	1	–	–	1	–	–
Colo.	–	–	1	1	2,105	2,327	8	1	–	1	–	–
N. Mex.	–	–	–	–	993	1,063	3	3	–	–	–	–
Ariz.	–	–	2	–	2,176	2,907	1	2	–	–	–	–
Utah	1	–	–	–	338	425	–	1	1	5	–	–
Nev.	6	–	4	–	1,451	1,365	9	20	2	8	–	–
PACIFIC	17	6	36	–	32,791	30,663	64	72	12	21	1	27
Wash.	2	–	3	–	2,781	2,952	4	8	3	–	1	2
Oreg.	–	–	–	–	1,876	2,397	4	3	2	2	–	–
Calif.	8	5	31	–	26,734	23,756	56	57	7	19	–	18
Alaska	–	1	2	–	827	864	–	–	–	–	–	–
Hawaii	7	–	–	–	573	694	–	4	–	–	–	7
Guam	U	–	–	–	5	37	U	U	U	U	U	–
P.R.	–	–	1	–	669	762	1	2	–	2	–	–
V.I.	U	–	–	–	51	14	U	U	U	U	U	–
Pac. Trust Terr.	U	–	–	–	36	113	U	U	U	U	U	1

N: Not notifiable U: Unavailable

TABLE III (Cont.'d). Cases of specified notifiable diseases, United States, weeks ending March 27, 1982 and March 28, 1981 (12th week)

REPORTING AREA	MALARIA		MEASLES (RUBEOLA)			MENINGOCOCCAL INFECTIONS (Total)		MUMPS		PERTUSSIS	RUBELLA		
	1982	CUM. 1982	1982	CUM. 1982	CUM. 1981	1982	CUM. 1982	1982	CUM. 1982	1982	1982	CUM. 1982	CUM. 1981
UNITED STATES	13	156	17	183	613	69	767	225	1,447	18	57	710	591
NEW ENGLAND	1	11	–	4	25	5	39	8	79	1	2	13	55
Maine	–	–	–	–	2	–	2	–	20	–	–	–	31
N.H.	–	1	–	–	3	1	8	–	8	–	–	9	18
Vt.	–	–	–	2	1	–	3	–	4	–	–	–	–
Mass.	1	7	–	–	15	2	8	7	31	1	2	4	3
R.I.	–	1	–	–	–	1	5	–	7	–	–	–	–
Conn.	–	2	–	2	4	1	13	1	9	–	–	–	3
MID. ATLANTIC	2	13	1	28	210	9	112	5	85	4	3	31	69
Upstate N.Y.	–	2	1	15	143	2	30	1	21	1	1	18	30
N.Y. City	–	4	–	11	17	2	20	2	16	1	–	10	14
N.J.	1	4	–	–	14	2	29	1	18	1	2	3	23
Pa.	1	3	–	2	36	3	33	1	30	1	–	–	2
E.N. CENTRAL	1	12	1	11	40	6	79	181	831	3	4	57	129
Ohio	1	2	–	–	13	5	32	151	569	–	–	–	–
Ind.	–	1	–	1	3	–	6	–	17	–	–	8	46
Ill.	–	–	–	2	6	–	14	6	38	1	3	16	32
Mich.	–	8	1	8	18	–	21	19	136	–	1	18	18
Wis.	–	1	–	–	–	1	6	5	71	2	–	15	33
W.N. CENTRAL	–	4	–	–	4	5	33	6	57	1	2	16	32
Minn.	–	–	–	–	1	1	9	–	3	–	–	1	6
Iowa	–	1	–	–	1	1	4	1	15	–	–	–	–
Mo.	–	1	–	–	–	1	11	1	10	–	–	9	–
N. Dak.	–	–	–	–	–	1	4	–	–	–	–	–	–
S. Dak.	–	–	–	–	–	1	1	–	–	–	–	1	–
Nebr.	–	1	–	–	1	–	1	–	–	–	–	–	1
Kans.	–	1	–	–	1	–	3	4	29	1	2	5	25
S. ATLANTIC	4	29	–	16	185	14	169	6	120	5	–	18	59
Del.	–	–	–	–	–	–	–	–	3	–	–	–	–
Md.	–	5	–	1	1	–	6	3	10	–	–	4	–
D.C.	–	3	–	1	1	1	1	–	–	–	–	–	–
Va.	3	12	–	9	3	2	15	1	16	–	–	8	1
W. Va.	–	–	–	1	7	–	5	1	58	–	–	1	14
N.C.	–	–	–	–	–	1	27	–	4	1	–	–	2
S.C.	–	2	–	–	–	2	21	–	5	1	–	1	4
Ga.	–	2	–	–	70	7	52	–	2	3	–	1	17
Fla.	1	5	–	4	103	1	42	1	22	–	–	3	21
E.S. CENTRAL	–	–	–	4	–	8	53	–	17	1	3	11	14
Ky.	–	–	–	1	–	1	3	–	7	–	3	11	9
Tenn.	–	–	–	3	–	–	23	–	6	1	–	–	5
Ala.	–	–	–	–	–	6	25	–	2	–	–	–	–
Miss.	–	–	–	–	–	1	2	–	2	–	–	–	–
W.S. CENTRAL	1	5	3	24	28	11	109	3	53	–	3	40	36
Ark.	–	–	–	–	–	–	8	–	3	–	–	–	–
La.	1	1	–	–	–	5	17	–	–	–	–	–	4
Okla.	–	–	–	–	3	1	9	–	–	–	–	1	–
Tex.	–	4	3	24	25	5	75	3	50	–	3	39	32
MOUNTAIN	–	3	–	–	8	4	48	2	28	1	3	14	23
Mont.	–	–	–	–	–	–	4	1	3	–	–	–	1
Idaho	–	–	–	–	–	1	4	–	2	1	–	–	2
Wyo.	–	–	–	–	–	–	4	1	2	–	–	4	1
Colo.	–	2	–	–	–	–	18	–	5	–	–	1	14
N. Mex.	–	–	–	–	–	–	7	–	–	–	–	1	1
Ariz.	–	1	–	–	1	1	5	–	8	–	–	1	1
Utah	–	–	–	–	–	2	3	–	6	–	2	5	2
Nev.	–	–	–	–	7	–	3	–	2	–	1	2	1
PACIFIC	4	79	12	96	113	7	125	14	177	2	37	510	174
Wash.	1	7	–	14	1	1	13	5	33	1	–	14	35
Oreg.	–	2	–	–	–	1	24	–	–	–	–	2	20
Calif.	3	69	12	81	112	4	81	8	139	1	36	491	119
Alaska	–	–	–	–	–	1	5	1	4	–	–	1	–
Hawaii	–	1	–	1	–	–	2	–	1	–	1	2	–
Guam	U	–	U	–	3	U	–	U	1	U	U	1	–
P.R.	–	2	7	39	77	1	3	–	12	–	1	3	–
V.I.	U	–	U	–	3	U	–	U	–	U	U	–	–
Pac. Trust Terr.	U	–	U	–	–	U	–	U	–	U	U	–	1

U: Unavailable

TABLE III (Cont.'d). Cases of specified notifiable diseases, United States, weeks ending March 27, 1982 and March 28, 1981 (12th week)

REPORTING AREA	SYPHILIS (Civilian) (Primary & Secondary)		TUBERCULOSIS		TULAREMIA	TYPHOID FEVER		TYPHUS FEVER (Tick-borne) (RMSF)		RABIES, Animal
	CUM. 1982	CUM. 1981	1982	CUM. 1982	CUM. 1982	1982	CUM. 1982	1982	CUM. 1982	CUM. 1982
UNITED STATES	7,768	7,059	422	5,462	17	7	85	1	18	1,078
NEW ENGLAND	154	163	8	144	–	–	10	–	–	5
Maine	–	1	1	11	–	–	–	–	–	5
N.H.	–	7	–	6	–	–	–	–	–	–
Vt.	–	5	–	5	–	–	2	–	–	–
Mass.	107	95	5	90	–	–	7	–	–	–
R.I.	10	12	–	16	–	–	–	–	–	–
Conn.	37	43	2	16	–	–	1	–	–	–
MID. ATLANTIC	1,039	1,063	69	925	1	1	6	–	–	11
Upstate N.Y.	99	99	7	160	1	–	1	–	–	6
N.Y. City	651	664	44	357	–	1	5	–	–	–
N.J.	122	122	4	170	–	–	–	–	–	1
Pa.	167	178	14	238	–	–	–	–	–	4
E.N. CENTRAL	369	483	39	826	–	2	7	–	–	118
Ohio	78	69	10	153	–	2	4	–	–	14
Ind.	61	30	13	119	–	–	–	–	–	18
Ill.	132	282	16	327	–	–	1	–	–	44
Mich.	70	76	–	178	–	–	2	–	–	–
Wis.	28	26	–	49	–	–	–	–	–	42
W.N. CENTRAL	152	130	16	160	6	–	3	–	1	286
Minn.	23	44	1	30	–	–	–	–	–	57
Iowa	7	8	3	25	–	–	1	–	–	94
Mo.	94	67	9	64	5	–	1	–	1	34
N. Dak.	3	1	1	3	–	–	–	–	–	35
S. Dak.	–	–	–	3	–	–	–	–	–	12
Nebr.	4	3	1	6	–	–	–	–	–	25
Kans.	21	7	1	29	1	–	1	–	–	29
S. ATLANTIC	2,181	1,819	83	1,123	5	–	11	1	12	174
Del.	5	3	–	11	–	–	–	–	–	–
Md.	128	140	6	144	1	–	3	–	7	13
D.C.	142	158	4	43	–	–	–	–	–	–
Va.	155	175	7	101	1	–	2	–	–	87
W. Va.	6	4	1	29	–	–	2	–	–	7
N.C.	176	133	10	181	–	–	–	1	4	–
S.C.	108	130	12	107	3	–	2	–	1	12
Ga.	452	479	19	190	–	–	–	–	–	46
Fla.	1,009	597	24	317	–	–	2	–	–	9
E.S. CENTRAL	599	485	37	482	1	1	8	–	3	118
Ky.	29	20	7	118	–	–	–	–	–	21
Tenn.	161	188	14	175	1	–	2	–	–	79
Ala.	206	134	9	149	–	1	6	–	3	18
Miss.	203	143	7	40	–	–	–	–	–	–
W.S. CENTRAL	1,968	1,699	73	553	2	–	3	–	1	185
Ark.	48	31	5	52	1	–	–	–	–	25
La.	410	373	13	103	–	–	–	–	–	4
Okla.	37	44	4	91	1	–	2	–	–	49
Tex.	1,473	1,251	51	307	–	–	1	–	1	107
MOUNTAIN	224	194	18	149	1	1	5	–	–	19
Mont.	1	8	–	11	–	–	–	–	–	9
Idaho	14	2	1	7	–	–	–	–	–	–
Wyo.	9	2	–	3	–	–	–	–	–	1
Colo.	71	62	–	17	–	1	1	–	–	–
N. Mex.	44	39	8	31	–	–	–	–	–	3
Ariz.	44	44	9	59	–	–	3	–	–	6
Utah	5	3	–	6	1	–	1	–	–	–
Nev.	36	34	–	15	–	–	–	–	–	–
PACIFIC	1,082	1,023	79	1,100	1	2	32	–	1	162
Wash.	24	37	4	65	1	–	–	–	–	–
Oreg.	35	22	2	41	–	–	1	–	–	–
Calif.	992	936	67	919	–	2	30	–	1	116
Alaska	6	4	–	13	–	–	–	–	–	46
Hawaii	25	24	6	62	–	–	1	–	–	–
Guam	–	–	U	2	–	U	–	U	–	–
P.R.	138	164	–	30	–	–	–	–	–	11
V.I.	–	–	U	1	–	U	–	U	–	–
Pac. Trust Terr.	–	–	U	19	–	U	–	U	–	–

U: Unavailable

Urban Rat Control — Continued

TABLE 1. Status of target-area blocks in Urban Rat-Control Programs, fourth quarter, fiscal year 1981 (July 1-September 30) — *Continued*

Program Community	Target-area blocks				Environmentally improved blocks*	
	Total	In attack phase	In maintenance phase		New this quarter	Cumulative
			<12 months	≥12 months		
REGION IV	4,228	1,483	1,924	357	304	7,863
Mobile	71	38	33	0	52	669
Tuscaloosa	295	74	197	24	49	49
Miami	1,606	520	728	135	83	1,103
Pensacola	267	100	167	0	87	322
Atlanta, Ga.‡	728	337	129	21	0	0
DeKalb Co. Ga	335	88	153	94	0	405
Lexington	194	35	159	0	33	123
Louisville	480	179	256	45	0	770
Memphis	252	112	102	38	0	564
Previously funded programs						3,858
REGION V	4,875	1,475	1,913	367	366	5,508
Chicago	490	212	257	21	0	10
Peoria	249	20	84	145	75	75
Indianapolis	351	166	185	0	0	417
Benton Harbor	87	13	74	0	32	103
Detroit	1,210	159	61	0	0	706
Highland Park	148	61	87	0	72	72
Saginaw	355	50	175	0	108	108
Washtenaw Co.-Ypsilanti	264	85	144	35	0	0
Wayne Co.-Ecorse	193	88	91	14	0	0
Akron	194	88	70	36	60	670
Barberton	122	3	107	12	7	175
Cincinnati	124	39	83	2	11	188
Cleveland	312	182	130	0	1	735
Columbus	282	75	143	64	0	283
Toledo	149	22	127	0	0	189
Youngstown	210	103	69	38	0	10
Milwaukee	135	109	26	0	0	0
Previously funded programs						1,767
REGION VI	1,399	646	435	192	300	7,009
Little Rock	349	81	175	93	53	53
Pine Bluff	175	76	99	0	43	233
New Orleans	301	214	29	58	169	3,139
Houston	574	275	132	41	35	2,326
Previously funded programs						1,258
REGION VII	582	226	269	87	147	4,286
Kansas City, Mo.	124	54	70	0	0	747
St. Louis	244	111	77	56	77	1,168
Omaha	214	61	122	31	70	734
Previously funded programs						1,637
REGION IX	511	186	221	104	0	1,726
Los Angeles	130	9	52	69	0	435
Oakland	187	96	83	8	0	279
San Francisco	194	81	86	27	0	341
Previously funded programs						671
Region X						830
Previously funded programs						830
Total	19,272	7,533	7,090	2,324	2,014	41,815

*Contiguous blocks where maintenance has been achieved and sustained for a minimum of 12 months. These blocks are no longer part of the approved project target area.

†Northwestern Pennsylvania Vector Control Association. Serves Lackawanna and Luzerne counties and the cities of Nanticoke, Wilkes-Barre, and Hazleton.

‡Target-area blocks are confined to public housing projects.

International Notes

Smallpox Vaccination

Following the global eradication of smallpox, the Thirty-Fourth World Health Assembly of the World Health Organization (WHO) by resolution amended the International Health Regulations to remove smallpox from the diseases subject to the Regulations, effective January 1, 1982 (*1*).

According to WHO, the collaboration of national health administrations in withdrawing the requirement for smallpox vaccination certificates has been very positive. All the countries of the world except Chad, in Africa, have advised WHO that an International Certificate of Vaccination against Smallpox is no longer required from any traveler. However, WHO reports that some local authorities in Democratic Kampuchea may require proof of vaccination. Because of the risk of complications of vaccination to both vaccinees and their contacts, physicians should give travelers to any country in which a certificate may be required a signed statement that vaccination is medically contraindicated. Smallpox vaccination should not be given for international travel.

Reported by the Quarantine Div, Center for Prevention Svcs, and International Health Program Office, CDC.

Editorial Note: The change in the International Health Regulations removes smallpox from the list of internationally quarantinable diseases and eliminates the legal basis for requirement of smallpox vaccination of international travelers.

A new revision of the International Certificates of Vaccination from which the smallpox vaccination certificate has been deleted will be available in the next several months.

In the United States, smallpox vaccination of civilians is recommended only if they are laboratory workers directly in contact with smallpox or other closely related orthopox viruses (*2*).

In 1981, the California Board of Medical Quality Assurance revoked the medical license of a physician who administered smallpox vaccine to a 53-year old man with chronic lymphocytic leukemia in an atternpt to treat recurrent herpes labialis (*3*). The patient developed severe vaccinia necrosum. The California board stayed the revocation of the physician's medical license and placed him on probation for 5 years.

Smallpox vaccine is ineffective in the treatment of any disease.

References

1. WHO. Smallpox vaccination certificates. Wkly Epidem Rec 1981;56:305.
2. ACIP. Smallpox vaccine. MMWR 1980;29:417-20.
3. California Department of Health Services. Inappropriate smallpox vaccination for recurrent herpes simplex—medical license revoked. California Morbidity 1981, November 20:45.

The Morbidity and Mortality Weekly Report, circulation 106,000, is published by the Centers for Disease Control, Atlanta, Georgia. The data in this report are provisional, based on weekly telegraphs 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 succeeding Friday.

The editor welcomes accounts on interesting cases, outbreaks, environmental hazards, or other public health problems of current interest to health officials. Send reports to: Attn: Editor, Morbidity and Mortality Weekly Report, Centers for Disease Control, Atlanta, Georgia 30333.

Send mailing list additions, deletions and address changes to: Attn: Distribution Services, Management Analysis and Services Office, 1-SB-419, Centers for Disease Control, Atlanta, Georgia 30333. When requesting changes be sure to give your former address, including zip code and mailing list code number, or send an old address label.

Current Trends

Influenza Update — United States

Three type A(H3N2) virus isolates associated with sporadic cases of influenza have been reported from the U.S. Air Force School of Aerospace Medicine in San Antonio, Texas. These isolates were collected on March 3 from an enlisted servicewoman at Eglin Air Force Base in Florida and on March 8 and 9 from 2 young children with influenza at Brooks Air Force Base in Texas. North Carolina has reported its first influenza virus isolates for the season, both type B, collected during the second week of March from 2 children. At the time of the isolations, increased school absenteeism associated with influenza-like illness was noted in western North Carolina by health authorites. The first type A(H1N1) isolates reported from Michigan this season were obtained in early March from 2 adults with sporadic influenza cases.

Reported by Epidemiology Division, U.S. Air Force School of Aerospace Medicine, Brooks Air Force Base, San Antonio, C Webb, Jr, MD, State Epidemiologist, Texas State Dept of Health; R Gunn, MD, State Epidemiologist, Florida State Dept of Health and Rehabilitative Svcs; S Neshiem, MD, P Boland, MD, Murphy, K Kleeman, PhD, M Hines, DVM, State Epidemiologist, North Carolina State Dept of Human Resources; A Monto, MD, University of Michigan, Ann Arbor, G Anderson, DVM, W Hall, MD, N Hayner, MD, State Epidemiologist, Michigan Dept of Public Health; Field Svcs Div, Epidemiology Program Office, Influenza Br, Center for Infectious Diseases, CDC.

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