

M M M M R

MORBIDITY AND MORTALITY WEEKLY REPORT

Current Trends

- 237 Tuberculosis among Hispanics in the United States — 1980
 Perspectives in Disease Prevention and Health Promotion
- 240 Unintentional and Intentional Injuries — United States

Current Trends

Tuberculosis among Hispanics in the United States — 1980

In 1980, 46 states, New York City, and Washington, D.C., reported 3,099 cases of tuberculosis among Hispanic persons; this figure represents 12.6% of the 24,662 cases in these areas that year. Four states did not submit data on Hispanic ethnicity.

Relatively more Hispanic than other patients were in younger age groups. Forty-nine percent of the Hispanic patients were <35 years of age, compared with 25% of other tuberculosis patients from these areas. The overall case rate calculated for Hispanics (23.2/100,000 population) was twice that for other persons (11.7/100,000). Among persons <35 years of age, the age-specific incidence of tuberculosis among Hispanics ranged from 2.7 to 4.2 times that for other persons (Table 1). About 62% of the Hispanic patients were males, a sex distribution comparable with that for other persons in these areas. The proportion of pulmonary cases among Hispanics and other persons did not differ significantly—85% and 86%, respectively.

Most of the Hispanic patients were concentrated in a few areas: California and Texas accounted for 42% and 26%, respectively, of the total (Table 2). Twenty-seven states and

TABLE 1. Tuberculosis case rates* by age and ethnicity, United States,† 1980

Age (in years)	Hispanics	Other	Relative Risk
0-4	13.3	4.9	2.7
5-9	7.5	2.1	3.6
10-14	4.0	1.3	3.1
15-19	10.7	2.7	4.0
20-24	26.7	6.3	4.2
25-34	28.2	8.9	3.2
35-44	26.3	13.2	2.0
45-54	37.1	18.0	2.1
55-64	49.2	19.9	2.5
>65	65.8	30.6	2.2
Total	23.2	11.7	2.0

*Cases/100,000 population.

†Data for New Jersey, New York, Ohio, and Virginia not available.

Tuberculosis — Continued

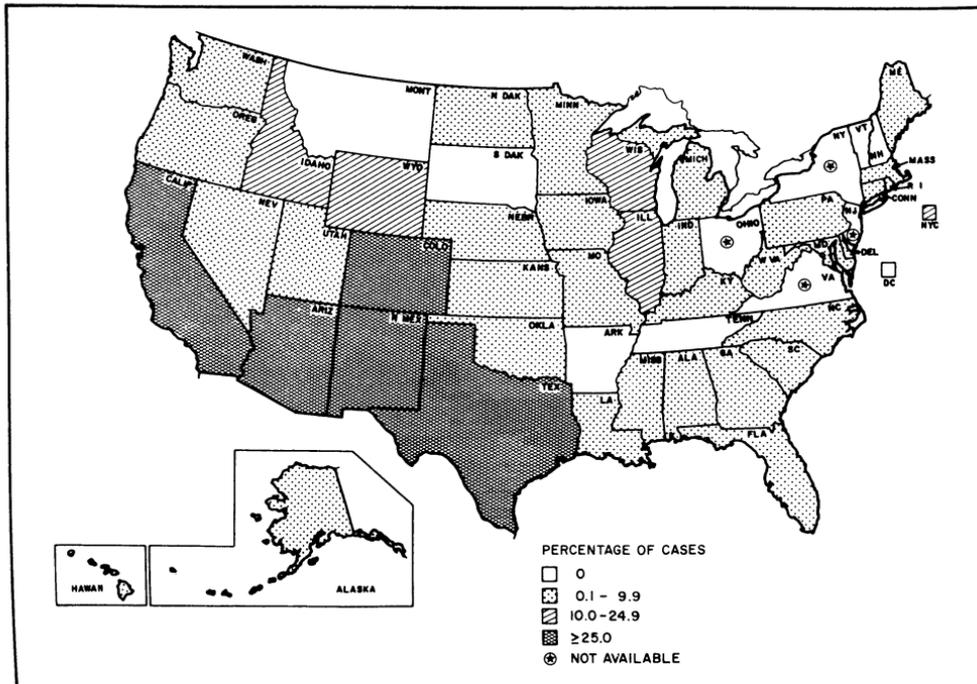
Washington, D.C., each reported 5 or fewer Hispanic patients with tuberculosis. In each of 5 southwestern states, Hispanic patients comprised over 25% of reported cases (Figure 1).

The tuberculosis case rate was higher for Hispanic persons living in cities with populations of 250,000 or more (25.4/100,000) than for Hispanic persons living elsewhere (20.6/100,000). Several cities reported a large number of cases among Hispanics (Los Angeles, 340; New York, 260; Houston, 135; Chicago, 112; San Antonio, 85; Miami, 78; El

TABLE 2. Hispanic persons with tuberculosis by state, United States, 1980

State	Number	Percentage
California	1,304	42.1
Texas	794	25.6
New York City	260	8.4
Illinois	149	4.8
Florida	115	3.7
Arizona	94	3.0
All others	383	12.4
Total	3,099	100.0

FIGURE 1. Percentage of each state's reported tuberculosis patients of Hispanic ethnicity, United States, 1980



Tuberculosis — Continued

Paso, 71; San Jose, 61; and San Diego, 54). Hispanic patients accounted for almost four-fifths of the reported cases in El Paso and almost two-thirds of the reported cases in San Antonio and Albuquerque.

Additional information on Hispanic patients was available from 10 states (Connecticut, Illinois, Indiana, Maine, Mississippi, Nevada, Oklahoma, South Carolina, Washington, and Wisconsin) and 3 large cities (Miami-Dade County, New York, and St. Louis). Of the totals reported for these areas, 569 (10.1%) of the 5,635 patients were Hispanic (ranging from 19% in Dade County to < 1% in Mississippi, South Carolina, St. Louis, and Washington, D.C.). The place of origin for 305 (53.6%) of the Hispanic patients from these areas was outside the 50 states and Washington, D.C. Forty-three percent of the 260 patients for whom the year of arrival in the United States was known arrived after 1975.

Reported by the Tuberculosis Control Div, Center for Prevention Svcs, CDC.

Editorial Note: Information about the Hispanic ethnicity of patients with tuberculosis was collected for the first time in 1980. Data on race and ethnicity were collected in separate questions so that race-specific and ethnicity-specific rates could be calculated. Alternative methods of data collection that use, among others, the categories of "white, not Hispanic," "black, not Hispanic," and "Hispanic," do not permit calculation of race-specific rates.

The categorization of persons by ethnic group or race is difficult because precise boundaries for categories are difficult to define and are cumbersome. For the tuberculosis patients reported in 1980, states were requested to use the following guidelines:

Hispanics are persons of Spanish origin, descent, or culture, regardless of race. Most persons of Mexican, Puerto Rican, Cuban, and Central or South American culture or origin are Hispanic; however, persons of Portuguese culture or origin are not, and persons from Brazil, Guyana, Surinam, Trinidad and Tobago may not be. When in doubt, the category that most closely reflects the individual's recognition in his/her community should be used for counting purposes.

This definition is consistent with federal guidelines concerning the collection of data on Hispanic persons and approximates the suggested definition of "Spanish Origin" used by the Bureau of the Census (1).

It has been suggested that these definitions are not appropriate because they include some European groups (e.g., Spaniards) and exclude some American groups (e.g., Brazilians); a different category, such as "Latin American," might be more appropriate for epidemiologic studies and other purposes (2). Nevertheless, the definition above permits a reasonably accurate estimate of the rates of disease among "Hispanic" persons. The data indicate that Hispanics presently are and likely will remain, for at least several decades, at significantly higher risk of having tuberculosis than most other persons in the United States.

References

1. United States. Bureau of the Census. 1980 census of population and housing, United States summary. Final population and housing unit counts. (Advance Reports PHC80-V-1) Washington, D.C.: Bureau of the Census, U. S. Department of Commerce, April 1981; p3.
2. Hayes-Bautista DE. Identifying "hispanic" populations: the influence of research methodology upon public policy. *Am J Pubic Health* 1980;70:353-6.

Notice to Readers

The following article is part of a continuing series planned to accompany Table V, which appears once a month in the MMWR. These articles, to be published under the heading "Perspectives in Disease Prevention and Health Promotion," will explore different aspects of preventable problems that can lead to morbidity and premature death.

Perspectives in Disease Prevention and Health Promotion

Unintentional and Intentional Injuries — United States

Injuries rank as the fourth leading cause of death in the United States, exceeded only by heart diseases, malignant neoplasms, and cerebrovascular diseases. In terms of years of life lost prematurely, however, injuries rank first (1). In the United States alone in 1980, there were over 70 million injuries and 150,000 unintentional and intentional injury-related deaths.

(Continued on page 246)

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

DISEASE	18th WEEK ENDING			CUMULATIVE, FIRST 18 WEEKS		
	May 8 1982	May 9 1981	MEDIAN 1977-1981	May 8 1982	May 9 1981	MEDIAN 1977-1981
Aseptic meningitis	82	91	56	1,334	1,173	848
Brucellosis	4	7	3	41	44	52
Encephalitis: Primary (arthropod-borne & unspec.)	16	18	13	259	240	213
Post-infectious	2	3	3	21	32	61
Gonorrhea: Civilian	17,262	19,815	19,815	312,122	335,835	324,066
Military	344	527	551	8,899	9,891	9,260
Hepatitis: Type A	439	490	536	7,693	8,718	9,767
Type B	446	418	326	6,922	6,658	5,534
Non A, Non B	58	N	N	702	N	N
Unspecified	151	237	200	3,122	3,674	3,483
Legionellosis	5	N	N	118	N	N
Leprosy	9	2	2	66	75	55
Malaria	19	53	14	258	450	168
Measles (rubeola)	38	176	731	496	1,229	6,893
Meningococcal infections: Total	73	78	55	1,270	1,683	1,188
Civilian	73	78	55	1,266	1,678	1,176
Military	—	—	—	4	5	9
Mumps	241	96	304	2,685	1,880	6,998
Pertussis	17	20	24	376	362	368
Rubella (German measles)	196	87	697	1,088	1,033	6,185
Syphilis (Primary & Secondary): Civilian	603	528	442	11,440	10,370	8,347
Military	5	2	6	142	123	106
Tuberculosis	532	454	576	8,611	8,734	9,227
Tularemia	4	4	3	33	39	37
Typhoid fever	3	5	6	128	157	135
Typhus fever, tick-borne (RMSF)	20	32	11	61	84	41
Rabies, animal	149	166	114	2,023	2,551	1,527

TABLE II. Notifiable diseases of low frequency, United States

	CUM. 1982		CUM. 1982
Anthrax	—	Poliomyelitis: Total	1
Botulism (Calif. 1)	22	Paralytic	1
Cholera	—	Psittacosis	32
Congenital rubella syndrome	3	Rabies, human	—
Diphtheria	—	Tetanus (Ala. 2, Tex. 1)	20
Leptospirosis	20	Trichinosis (Mass. 3, N.J. 1)	42
Plague	2	Typhus fever, flea-borne (endemic, murine)	5

N: Not notifiable

TABLE III. Cases of specified notifiable diseases, United States, weeks ending
May 8, 1982 and May 9, 1981 (18th week)

REPORTING AREA	ASEPTIC MENINGITIS		BRUCELLA LOSIS		ENCEPHALITIS		GONORRHEA (Civilian)		HEPATITIS (Viral), by type				LEGIONELLOSIS	LEPROSY
	1982	CUM. 1982	CUM. 1982	CUM. 1982	Primary	Post-infectious	CUM. 1982	CUM. 1981	A	B	NA,NB	Unspecified	1982	CUM. 1982
UNITED STATES	82	+1	259	21	312,122	335,835	439	446	58	151	5	66		
NEW ENGLAND	1	-	12	3	7,469	8,167	14	18	-	1	2	1		
Maine	-	-	-	-	343	409	4	1	-	-	-	-		
N.H.	-	-	-	-	212	290	1	-	-	-	-	-		
Vt.	-	-	-	-	158	138	1	-	-	-	-	-		
Mass.	-	-	4	-	3,346	3,392	5	7	-	1	-	-		
R.I.	-	-	-	-	528	410	2	1	-	-	-	-		
Conn.	1	-	8	3	2,982	3,528	1	9	-	-	-	1		1
MID. ATLANTIC	13	-	40	3	38,542	39,300	40	86	13	16	-	-		4
Upstate N.Y.	4	-	15	-	6,283	6,278	8	24	4	3	-	-		1
N.Y. City	2	-	8	-	16,073	16,102	19	38	-	6	-	-		1
N.J.	5	-	9	-	7,000	7,933	13	22	9	7	-	-		1
Pa.	2	-	8	3	9,186	8,987	U	U	U	U	-	-		1
E.N. CENTRAL	5	-	50	6	42,642	52,852	51	70	3	13	-	-		-
Ohio	2	-	16	4	12,700	18,469	14	13	1	1	-	-		-
Ind.	-	-	12	2	5,158	4,549	19	32	2	8	-	-		-
Ill.	2	-	-	-	9,999	14,495	2	7	-	1	-	-		-
Mich.	-	-	20	-	10,617	10,792	14	17	-	3	-	-		-
Wis.	1	-	2	-	4,268	4,547	2	1	-	-	-	-		-
W.N. CENTRAL	4	4	14	1	14,943	15,621	17	9	2	5	1	-		-
Minn.	3	-	1	1	2,285	2,494	8	1	-	1	-	-		-
Iowa	-	1	8	-	1,623	1,635	-	3	-	1	-	-		-
Mo.	1	1	3	-	6,783	7,050	5	1	-	1	-	-		-
N. Dak.	-	-	-	-	212	213	-	-	-	-	-	-		-
S. Dak.	-	-	-	-	422	446	1	-	-	-	-	-		-
Nebr.	-	-	1	-	953	1,230	1	3	1	3	1	-		-
Kans.	-	2	1	-	2,665	2,553	2	1	1	-	-	-		-
S. ATLANTIC	11	13	34	4	77,611	82,853	49	80	5	18	2	4		
Del.	-	-	-	-	1,277	1,225	2	1	1	3	-	-		-
Md.	-	-	10	-	10,388	9,013	14	15	1	2	1	2		2
D.C.	-	-	-	-	4,266	5,320	-	3	-	-	-	-		-
Va.	-	4	9	-	7,010	7,590	6	4	-	-	-	-		-
W. Va.	-	-	-	-	942	1,257	3	-	-	-	-	-		-
N.C.	2	-	3	1	13,264	12,814	5	9	-	1	-	-		-
S.C.	-	2	-	-	7,970	7,972	8	6	-	2	-	-		-
Ga.	-	1	-	-	9,483	16,465	3	29	1	3	-	-		-
Fla.	9	6	12	3	23,011	21,197	8	13	2	7	1	2		2
E.S. CENTRAL	10	5	14	1	26,600	27,786	20	40	6	6	-	-		-
Ky.	2	-	-	-	3,608	3,588	4	7	-	5	-	-		-
Tenn.	2	3	9	-	10,045	10,158	14	21	3	-	-	-		-
Ala.	6	1	4	1	8,147	8,908	1	10	3	1	-	-		-
Miss.	-	1	1	-	4,800	5,132	1	2	-	-	-	-		-
W.S. CENTRAL	9	10	28	-	43,845	44,886	97	23	3	60	-	-		8
Ark.	-	3	1	-	3,694	3,079	4	2	1	4	-	-		-
La.	3	2	4	-	7,830	7,116	12	8	-	10	-	-		-
Okla.	2	3	9	-	4,826	4,602	27	5	2	9	-	-		-
Tex.	4	2	14	-	27,495	30,089	54	8	-	37	-	-		8
MOUNTAIN	1	-	14	1	11,426	13,285	41	13	3	4	-	-		1
Mont.	-	-	-	-	476	492	-	1	-	-	-	-		-
Idaho	-	-	-	-	533	534	2	1	-	-	-	-		1
Wyo.	-	-	-	-	309	293	6	2	-	-	-	-		-
Colo.	-	-	4	1	3,027	3,504	12	2	2	1	-	-		-
N. Mex.	-	-	-	-	1,408	1,450	10	-	-	-	-	-		-
Ariz.	1	-	6	-	3,151	4,182	2	4	-	-	-	-		-
Utah	-	-	-	-	523	622	2	1	1	3	-	-		-
Nev.	-	-	4	-	1,999	2,208	7	2	-	-	-	-		-
PACIFIC	28	9	53	2	49,044	51,085	110	107	23	28	-	-		48
Wash.	1	-	5	-	4,060	4,411	7	5	-	2	-	-		4
Oreg.	-	-	1	-	2,721	3,498	11	4	-	1	-	-		-
Calif.	17	8	43	2	40,202	40,813	90	98	23	25	-	-		25
Alaska	-	1	3	-	1,217	1,333	-	-	-	-	-	-		1
Hawaii	10	-	1	-	844	1,030	2	-	-	-	-	-		18
Guam	U	-	-	-	19	49	U	U	U	U	U	U		-
P.R.	-	-	1	-	1,027	1,116	5	1	-	6	U	U		-
V.I.	U	-	-	-	60	45	U	U	U	U	U	U		-
Pac. Trust Terr.	U	-	-	-	36	146	U	U	U	U	U	U		1

N: Not notifiable

U: Unavailable

TABLE III (Cont.'d). Cases of specified notifiable diseases, United States, weeks ending
May 8, 1982 and May 9, 1981 (18th 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	19	258	38	496	1,229	73	1,270	241	2,685	17	196	1,088	1,033
NEW ENGLAND	1	19	-	7	39	8	71	3	132	2	2	10	79
Maine	-	-	-	-	3	-	2	2	27	-	-	-	31
N.H.	-	1	-	1	5	-	10	-	12	-	-	8	31
Vt.	-	-	-	2	2	-	4	-	4	-	-	-	-
Mass.	-	13	-	2	23	4	20	1	69	1	1	1	11
R.I.	-	1	-	-	-	-	9	-	10	1	1	1	-
Conn.	1	4	-	2	6	4	26	-	10	-	-	-	6
MID. ATLANTIC	4	29	1	33	383	15	208	10	175	3	6	64	125
Upstate N.Y.	2	6	-	15	174	2	52	2	35	3	1	31	52
N.Y. City	1	11	1	16	29	3	41	3	31	-	4	20	30
N.J.	1	8	-	-	37	1	47	3	30	-	1	13	39
Pa.	-	4	-	2	143	9	68	2	79	-	-	-	4
E.N. CENTRAL	-	17	-	31	59	6	153	150	1,583	3	5	99	233
Ohio	-	5	-	-	15	6	63	125	1,173	-	-	-	-
Ind.	-	1	-	1	3	-	13	-	25	1	2	18	76
Ill.	-	1	-	15	15	-	35	10	100	2	3	26	58
Mich.	-	9	-	15	25	-	31	15	214	-	-	38	29
Wis.	-	1	-	-	1	-	11	-	71	-	-	17	70
W.N. CENTRAL	-	7	-	2	4	3	51	39	194	2	2	26	55
Minn.	-	-	-	-	1	3	12	34	112	1	2	5	7
Iowa	-	3	-	-	1	-	5	2	23	-	-	-	-
Mo.	-	1	-	2	-	-	17	-	13	-	-	15	2
N. Dak.	-	-	-	-	-	-	4	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	1	-	1	-	-	1	-
Nebr.	-	2	-	-	1	-	4	-	-	-	-	-	1
Kans.	-	1	-	-	1	-	8	3	45	1	-	5	45
S. ATLANTIC	4	44	2	29	263	13	259	7	162	2	4	33	89
Del.	-	-	-	-	-	-	-	-	3	-	-	-	-
Md.	-	6	-	2	1	3	14	1	13	-	3	14	1
D.C.	-	3	-	1	1	-	1	-	-	-	-	-	-
Va.	-	16	-	14	3	-	26	1	23	-	-	10	3
W. Va.	1	1	-	1	7	-	7	1	72	-	-	1	16
N.C.	-	-	-	-	3	4	42	1	6	1	-	-	4
S.C.	1	3	-	-	-	1	32	-	9	-	-	1	6
Ga.	2	6	-	-	84	1	63	2	6	1	1	2	21
Fla.	-	9	2	11	164	4	74	1	30	-	-	5	38
E.S. CENTRAL	-	1	-	5	-	7	84	-	25	1	3	34	19
Ky.	-	1	-	1	-	2	13	-	9	1	3	19	12
Tenn.	-	-	-	4	-	2	33	-	9	-	-	-	7
Ala.	-	-	-	-	-	3	34	-	4	-	-	-	-
Miss.	-	-	-	-	-	-	4	-	3	-	-	15	-
W.S. CENTRAL	6	19	4	15	280	4	159	13	104	-	3	62	67
Ark.	-	1	-	-	-	-	8	-	5	-	-	-	-
La.	1	3	-	-	-	1	25	-	3	-	-	-	9
Okla.	2	2	-	-	5	2	12	-	2	-	-	6	-
Tex.	3	13	4	15	275	1	114	13	96	-	3	60	58
MOUNTAIN	-	6	-	-	19	3	76	2	40	2	5	31	53
Mont.	-	-	-	-	-	-	4	-	3	-	-	3	1
Idaho	-	-	-	-	-	-	5	-	2	-	-	-	2
Wyo.	-	-	-	-	-	-	4	-	2	-	-	5	1
Colo.	-	4	-	-	5	2	29	-	7	2	1	2	27
N. Mex.	-	1	-	-	3	1	11	-	-	-	-	2	3
Ariz.	-	1	-	-	3	-	14	1	14	-	2	7	11
Utah	-	-	-	-	-	-	6	1	10	-	2	10	3
Nev.	-	-	-	-	9	-	3	-	2	-	-	2	5
PACIFIC	4	116	31	374	182	14	209	17	270	2	166	729	313
Wash.	-	6	1	16	1	1	23	3	43	-	-	19	45
Oreg.	-	3	-	-	1	7	45	-	-	-	-	3	35
Calif.	4	105	30	356	178	4	129	14	219	2	166	699	229
Alaska	-	-	-	-	-	2	9	-	6	-	-	1	-
Hawaii	-	2	-	2	2	-	3	-	2	-	-	7	4
Guam	U	2	U	1	5	U	-	U	1	U	U	1	-
P.R.	-	4	8	59	143	-	3	1	26	-	-	4	3
V.I.	U	-	U	-	6	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
May 8, 1982 and May 9, 1981 (18th week)

REPORTING AREA	SYPHILIS (Civilian) (Primary & Secondary)		TUBERCULOSIS		TULA- REMIA	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	11,440	10,370	532	8,611	33	3	128	20	61	2,023
NEW ENGLAND	215	230	6	231	-	-	11	-	-	5
Maine	1	1	-	17	-	-	-	-	-	5
N.H.	-	9	-	9	-	-	-	-	-	-
Vt.	-	13	-	6	-	-	2	-	-	-
Mass.	150	140	6	161	-	-	8	-	-	-
R.I.	12	16	-	8	-	-	-	-	-	-
Conn.	52	51	-	30	-	-	1	-	-	-
MID. ATLANTIC	1,542	1,598	77	1,436	2	1	16	-	-	40
Upstate N.Y.	151	145	15	257	2	-	2	-	-	20
N.Y. City	944	991	29	552	-	-	11	-	-	-
N.J.	182	197	14	272	-	1	3	-	-	1
Pa.	265	265	19	355	-	-	-	-	-	19
E.N. CENTRAL	644	734	69	1,339	-	-	13	-	-	237
Ohio	110	90	12	240	-	-	6	-	-	33
Ind.	79	65	4	175	-	-	-	-	-	40
Ill.	297	410	50	531	-	-	3	-	-	101
Mich.	121	133	3	319	-	-	4	-	-	1
Wis.	37	36	-	74	-	-	-	-	-	62
W.N. CENTRAL	222	186	25	273	7	-	3	2	3	463
Minn.	37	69	4	47	-	-	-	-	-	76
Iowa	11	9	6	41	1	-	1	-	-	147
Mo.	136	91	9	124	5	-	-	-	1	54
N. Dak.	4	3	1	6	-	-	-	-	-	46
S. Dak.	-	2	1	7	-	-	-	-	-	34
Nebr.	8	3	3	12	-	-	-	-	-	50
Kans.	26	9	1	36	1	-	1	2	2	56
S. ATLANTIC	3,116	2,725	99	1,694	6	1	18	7	24	322
Del.	7	7	-	18	-	-	-	-	-	-
Md.	180	215	11	207	1	1	6	-	7	16
D.C.	201	241	4	63	-	-	-	-	-	-
Va.	217	265	6	188	1	-	2	-	-	155
W. Va.	8	7	6	46	-	-	-	-	-	16
N.C.	225	205	25	277	-	-	-	4	9	12
S.C.	147	191	9	164	3	-	2	3	7	21
Ga.	662	688	-	234	-	-	-	-	1	79
Fla.	1,469	906	38	497	1	-	6	-	-	23
E.S. CENTRAL	826	681	50	783	4	1	11	1	6	246
Ky.	61	29	15	222	-	-	-	-	-	42
Tenn.	224	273	9	260	4	-	2	1	2	170
Ala.	292	180	19	225	-	-	7	-	3	34
Miss.	269	199	7	76	-	1	2	-	1	-
W.S. CENTRAL	2,886	2,474	89	950	8	-	8	9	26	416
Ark.	80	48	3	91	5	-	1	1	3	58
La.	631	553	32	178	1	-	-	-	-	11
Okla.	63	66	10	139	2	-	2	8	15	90
Tex.	2,112	1,807	44	542	-	-	5	-	8	257
MOUNTAIN	288	251	12	256	3	-	5	1	1	47
Mont.	1	8	-	18	-	-	-	-	-	21
Idaho	16	2	1	11	1	-	-	1	1	-
Wyo.	9	3	-	2	1	-	-	-	-	2
Colo.	85	79	-	31	-	-	1	-	-	-
N. Mex.	61	53	3	47	-	-	-	-	3	5
Ariz.	64	51	5	105	-	-	3	-	-	19
Utah	10	7	1	14	1	-	1	-	-	-
Nev.	42	48	2	28	-	-	-	-	-	-
PACIFIC	1,701	1,491	105	1,649	3	-	43	-	1	247
Wash.	53	58	7	96	1	-	2	-	-	-
Oreg.	49	33	4	61	-	-	1	-	-	-
Calif.	1,551	1,365	82	1,358	2	-	39	-	1	180
Alaska	6	4	-	18	-	-	-	-	-	67
Hawaii	42	31	12	116	-	-	1	-	-	-
Guam	-	-	U	2	-	U	-	U	-	-
P.R.	204	255	1	107	-	-	1	-	-	17
V.I.	-	4	U	1	-	U	-	U	-	-
Pac. Trust Terr.	-	-	U	19	-	U	-	U	-	-

U: Unavailable

TABLE IV. Deaths in 121 U.S. cities,* week ending
May 8, 1982 (18th week)

REPORTING AREA	ALL CAUSES, BY AGE (YEARS)						P&I** TOTAL	REPORTING AREA	ALL CAUSES, BY AGE (YEARS)						P&I** TOTAL
	ALL AGES	>65	45-64	25-44	1-24	<1			ALL AGES	>65	45-64	25-44	1-24	<1	
NEW ENGLAND	650	425	168	31	13	13	52	S. ATLANTIC	1,164	691	303	98	32	35	48
Boston, Mass.	193	117	53	12	4	7	24	Atlanta, Ga.	125	82	27	9	5	2	3
Bridgeport, Conn.	37	26	9	1	1	1	1	Baltimore, Md.	219	130	58	21	3	7	6
Cambridge, Mass.	22	16	5	1	1	1	1	Charlotte, N.C.	66	37	17	5	2	3	4
Fall River, Mass.	32	20	9	1	1	1	1	Jacksonville, Fla.	88	47	30	3	5	3	2
Hartford, Conn.	56	34	16	5	1	1	1	Miami, Fla.	110	57	31	11	2	9	3
Lowell, Mass.	35	24	9	1	1	1	3	Norfolk, Va.	63	40	14	3	2	4	3
Lynn, Mass.	15	9	4	2	1	1	2	Richmond, Va.	84	48	26	8	2	6	6
New Bedford, Mass.	28	21	7	1	1	1	1	Savannah, Ga.	57	31	19	5	2	1	5
New Haven, Conn.	42	30	9	2	1	1	1	St. Petersburg, Fla.	84	69	11	3	1	1	4
Providence, R.I.	55	42	10	2	1	1	6	Tampa, Fla.	56	36	11	4	2	2	3
Somerville, Mass.	8	5	3	1	1	1	2	Washington, D.C.	150	77	44	19	5	3	4
Springfield, Mass.	41	24	12	1	1	3	5	Wilmington, Del.	62	37	15	7	3	1	5
Waterbury, Conn.	36	23	9	2	2	2	2								
Worcester, Mass.	50	34	13	1	1	1	1								
								E.S. CENTRAL	705	421	189	45	23	26	34
MID. ATLANTIC	2,823	1,829	645	180	75	94	111	Birmingham, Ala.	106	68	27	6	5	1	2
Albany, N.Y.	53	27	12	5	2	7	1	Chattanooga, Tenn.	46	27	9	4	1	4	8
Allentown, Pa.	13	11	2	1	1	1	2	Knoxville, Tenn.	61	40	15	3	2	1	1
Buffalo, N.Y.	150	97	41	8	2	2	9	Louisville, Ky.	125	78	36	8	1	2	11
Camden, N.J.	34	23	9	1	2	1	1	Memphis, Tenn.	178	101	47	10	10	6	10
Elizabeth, N.J.	30	26	4	2	1	1	1	Mobile, Ala.	25	14	7	3	1	1	1
Erie, Pa.	50	39	6	2	3	1	3	Montgomery, Ala.	58	33	14	5	1	1	1
Jersey City, N.J.	48	33	10	2	2	1	1	Nashville, Tenn.	106	60	34	6	4	2	6
N.Y. City, N.Y.	1,444	928	343	107	37	29	46								
Newark, N.J.	66	29	20	9	6	2	5	W.S. CENTRAL	1,538	868	372	163	59	76	39
Paterson, N.J.	34	21	5	1	1	6	5	Austin, Tex.	66	44	15	2	3	2	2
Philadelphia, Pa.	442	269	108	31	3	31	12	Baton Rouge, La.	57	34	13	7	1	2	2
Reading, Pa.	67	46	13	1	3	4	3	Corpus Christi, Tex.	39	23	7	5	2	2	1
Rochester, N.Y.	45	40	3	1	2	1	6	Dallas, Tex.	190	111	52	14	7	6	4
Schenectady, N.Y.	119	83	17	7	5	7	10	El Paso, Tex.	48	29	12	2	2	3	2
Scranton, Pa.	28	21	6	1	1	1	1	Fort Worth, Tex.	96	56	24	12	4	1	3
Syracuse, N.Y.	25	14	7	1	3	1	1	Houston, Tex.	410	215	102	53	20	20	6
Trenton, N.J.	84	56	20	3	1	4	1	Little Rock, Ark.	60	43	13	2	1	1	3
Utica, N.Y.	41	29	10	1	1	1	1	New Orleans, La.	205	99	40	44	3	19	1
Yonkers, N.Y.	28	20	5	2	1	1	4	San Antonio, Tex.	184	106	51	10	8	9	11
	22	17	4	1	1	1	4	Shreveport, La.	83	46	25	4	4	4	1
								Tulsa, Okla.	100	62	18	8	4	8	4
E.N. CENTRAL	2,240	1,404	533	146	66	91	67	MOUNTAIN	671	404	140	66	38	22	17
Akron, Ohio	62	47	11	1	1	2	1	Albuquerque, N. Mex.	109	46	22	23	16	1	2
Canton, Ohio	54	31	20	3	1	2	2	Colo. Springs, Colo.	31	24	3	1	1	1	5
Chicago, Ill.	482	290	111	39	15	27	8	Denver, Colo.	117	73	26	12	4	2	1
Cincinnati, Ohio	184	120	42	10	4	8	12	Las Vegas, Nev.	65	29	20	10	3	3	1
Cleveland, Ohio	161	88	41	15	6	11	5	Ogden, Utah	23	17	5	1	1	1	1
Columbus, Ohio	92	60	17	4	5	6	2	Phoenix, Ariz.	166	110	29	12	7	8	2
Dayton, Ohio	107	64	29	5	4	5	2	Pueblo, Colo.	18	15	2	1	1	1	1
Detroit, Mich.	278	162	65	29	10	12	4	Salt Lake City, Utah	51	28	14	3	1	5	2
Evansville, Ind.	50	29	15	2	4	1	1	Tucson, Ariz.	91	62	19	6	2	2	3
Fort Wayne, Ind.	49	29	12	3	3	2	2								
Gary, Ind.	16	5	6	2	3	1	1								
Grand Rapids, Mich.	51	37	7	4	1	3	3								
Indianapolis, Ind.	169	104	43	11	3	8	2	PACIFIC	1,561	1,014	353	104	31	58	82
Madison, Wis.	53	34	13	3	2	1	8	Berkeley, Calif.	20	16	3	1	1	1	1
Milwaukee, Wis.	125	93	24	4	3	1	4	Fresno, Calif.	57	40	10	4	1	2	3
Peoria, Ill.	41	26	11	1	1	3	4	Glendale, Calif.	17	13	2	2	1	1	1
Rockford, Ill.	36	22	12	2	1	3	3	Honolulu, Hawaii	47	28	15	1	1	2	1
South Bend, Ind.	56	39	14	1	2	1	3	Long Beach, Calif.	100	73	20	2	1	5	5
Toledo, Ohio	88	66	19	2	1	1	2	Los Angeles, Calif.	404	252	84	41	12	14	19
Youngstown, Ohio	86	58	21	6	1	1	1	Oakland, Calif.	68	44	14	6	1	4	1
								Pasadena, Calif.	26	13	10	2	1	1	3
								Portland, Ore.	109	65	29	6	2	7	5
W.N. CENTRAL	762	526	160	30	21	25	26	Sacramento, Calif.	75	43	19	6	2	5	5
Des Moines, Iowa	76	52	14	3	5	2	3	San Diego, Calif.	115	80	27	3	4	1	11
Duluth, Minn.	26	19	4	2	1	2	2	San Francisco, Calif.	148	84	46	14	1	4	6
Kansas City, Kans.	37	23	6	7	1	1	2	San Jose, Calif.	148	104	32	8	4	1	14
Kansas City, Mo.	109	73	24	5	2	5	8	Seattle, Wash.	137	96	25	6	1	9	3
Lincoln, Neb.	38	31	7	1	1	1	1	Spokane, Wash.	64	46	11	1	3	3	4
Minneapolis, Minn.	91	66	20	1	2	3	2	Tacoma, Wash.	26	17	6	1	1	2	1
Omaha, Neb.	76	53	15	4	2	2	1								
St. Louis, Mo.	168	108	46	5	5	4	2								
St. Paul, Minn.	67	49	8	2	2	6	2								
Wichita, Kans.	74	52	16	2	2	2	4	TOTAL	12,114^{††}	7,582	2,863	863	358	440	476

*Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

**Pneumonia and influenza

†Because of changes in reporting methods in these 4 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

††Total includes unknown ages.

*Injuries — Continued***TABLE V. Years of potential life lost, deaths, and death rates, by cause of death, and estimated number of physician contacts, by principal diagnosis, United States**

Cause of morbidity or mortality (Ninth Revision ICD, 1975)	Years of potential life lost before age 65 by persons dying in 1980 ¹	Estimated mortality December 1981		Estimated number of physician contacts December 1981 ⁴
		Number ²	Annual Rate/100,000 ³	
ALL CAUSES (TOTAL)	10,006,060	168,820	863.1	84,586,000
Accidents and adverse effects (E800-E807, E810-E825, E826-E949)	2,684,850	8,230	42.1	4,610,000
Malignant neoplasms (140-208)	1,804,120	34,270	175.2	1,403,000
Diseases of heart (390-398, 402, 404-429)	1,636,510	65,960	337.2	4,956,000
Suicides, homicides (E950-E978)	1,401,880	4,110	21.0	—
Chronic liver disease and cirrhosis (571)	301,070	2,250	11.5	86,000
Cerebrovascular diseases (430-438)	280,430	14,530	74.3	57,000
Pneumonia and influenza (480-487)	124,830	4,170	21.3	1,067,000
Diabetes mellitus (250)	117,340	3,090	15.8	2,312,000
Chronic obstructive pulmonary diseases and allied conditions (490-496)	110,530	4,930	25.2	2,025,000
Prenatal care ⁵				1,911,000
Infant mortality ⁵		3,600	11.6 /1000 live births	

¹Years of potential life lost for persons between 1 year and 65 years old at the time of death are derived from the number of deaths in each age category as reported by the National Center for Health Statistics, *Monthly Vital Statistics Report* (MVSR), Vol. 29, No. 13, September 17, 1981, multiplied by the difference between 65 years and the age at the mid-point of each category. As a measure of mortality, "Years of potential life lost" underestimates the importance of diseases that contribute to death without being the underlying cause of death.

²The number of deaths is estimated by CDC by multiplying the estimated annual mortality rates (MVSR Vol. 31, No. 1, April 16, 1982, pp. 8-9) and the provisional U.S. population in that month (MVSR Vol. 30, No. 12, March 18, 1982, p.1) and dividing by the days in the month as a proportion of the days in the year.

³Annual mortality rates are estimated by NCHS (MVSR Vol. 31, No. 1, April 16, 1982, pp. 8-9), using the underlying cause of death from a systematic sample of 10% of death certificates received in state vital statistics offices during the month and the provisional population of those states included in the sample for that month.

⁴IMS America *National Disease and Therapeutic Index* (NDTI), Monthly Report, December, 1981, Section III. This estimate comprises the number of office, hospital, and nursing home visits and telephone calls prompted by each medical condition based on a stratified random sample of office-based physicians (2,100) who record all private patient contacts for 2 consecutive days each quarter.

⁵"Prenatal care" (NDTI) and "Infant mortality" (MVSR Vol. 30, No. 12, March 18, 1982, p.1) are included in the table because "Years of potential life lost" does not reflect deaths of children < 1 year.

Injuries — Continued

Motor-vehicle deaths account for nearly 35% of all injury-related deaths; homicides and suicides account for over 30%; and burns, falls, and drownings account for nearly 18% (2).

The societal cost of injuries is high—estimated at more than \$83 billion per year (2); yet relatively little effort has been devoted to the prevention of injuries. This imbalance is, in part, the result of a widespread misunderstanding of injury causation. Often, cause is characterized by the term "accident," which connotes chance or fate, while actually many injuries, like diseases, can be prevented. Also, epidemiologic analyses of injuries describing the relationship of host, agent, and environmental variables may provide useful information about injury prevention. However, education-oriented intervention strategies directed at host variables such as risk-taking behavior and alcohol and drug use typically have had little effect on injury rates. Automatic or "passive" protection is gaining recognition as the major focus of prevention efforts because it requires no individual action by those protected and has considerable potential for preventing injury morbidity and mortality. Ten interrelated strategies that can help prevent injuries have recently been summarized (3,4) (Table 3).

Listed below are 3 injury-control measures designed to eliminate or modify potentially injurious environmental factors that have been associated with substantial decreases in morbidity and mortality.

1. Since the introduction in 1972 of childproof caps on aspirin and other medication containers, there has been a substantial reduction in childhood poisonings. In the period 1971-1977, deaths attributable to ingestion of analgesics and antipyretics decreased 41% for all age groups (5).

TABLE 3. Basic strategies to reduce injuries and deaths*

Strategies	Examples
1) Prevent the marshalling of potentially injurious agents†	Reduce speed limits, the height of diving boards, and the height of high chairs
or	
2) Reduce the amount of the agent	
3) Prevent inappropriate release of the agent	Apply nonslip surfaces to bathtubs
4) Modify release of the agent	Use seatbelts to decelerate occupants; use flame-retardant fabrics
5) Separate host from potentially injurious agent by time or space	Lock up guns and harmful substances
or	
6) Separate them with physical barriers	
7) Modify surfaces and basic structures	Use passive restraint systems; use pots and pans with non-heat-conducting handles
8) Increase resistance to injury	Participate in a physical-conditioning program
9) Improve emergency responses	Apply first aid rapidly
10) Improve medical care and rehabilitation	Train emergency and paramedical personnel

*Source: Baker SP, Dietz PE. Injury prevention. In: Healthy people. The Surgeon's General's Report on Health Promotion and Disease Prevention, background papers. Washington, D.C.: U.S. Department of Health, Education, and Welfare, 1979; Haddon W, Jr, Baker SP. Injury control. In: Clark DW, MacMahon B, eds. Preventive and community medicine. Boston: Little, Brown, 1981.

†The agent of injury is defined here as the abnormal transfer of energy.

Injuries – Continued

2. In New York City, there was a substantial reduction in the incidence of childhood injuries and deaths due to falls after the health department provided free, easily installed window guards to families with young children living in high-risk areas. Between 1973, when the program began, and 1975, the number of falls reported declined 50%, and the number of deaths due to falls decreased 35% (6).

3. In Honolulu, where legislation requires protective fencing around public and private pools, childhood drowning fatalities associated with swimming pools occur substantially less frequently than in cities without such legislation. Total population studies of swimming pool fatalities have been done in Honolulu and in Brisbane, Australia, a city that does not have a law requiring fencing but is similar to Honolulu in size, pool-to-house ratio, climate, and life style (7). The fatality rate for swimming-pool drownings in Honolulu is 0.9/100,000 population, compared with a rate of 2.6/100,000 in Brisbane, Australia.

Two other areas in which control measures are likely to decrease injuries include tap-water scalds and childhood automobile injuries. Each year 4,000 persons require extended hospital care for tap-water scalds. Although it is still too early to measure the outcome, many cities are actively involved in programs to prevent these injuries. Tap-water-scald injuries can be virtually eliminated by limiting water-heater temperature to no more than 120 F (48.9 C) (8).

Recognizing that automobile child-restraint devices, when properly used, can be up to 90% effective in reducing fatalities and serious injuries, 10 states have passed child-restraint laws. At least 20 more states have such bills pending.

These examples of injury-control methods have several common elements (5). 1) The injury pattern is fairly obvious and consistent so that it can be defined through data-collection methods currently available. 2) The countermeasure consists of modifying the environment to eliminate the hazard or reduce it demonstrably. 3) The need for behavior change on the part of the potential victim is minimal. 4) The countermeasure and its cost are accepted by the public or are sufficiently minor to be of little significance. 5) The cost and ease of introducing the countermeasure is acceptable to manufacturers or others responsible for it. 6) The injury-producing product or environment is susceptible to relatively rapid modification or replacement.

Reported by Environmental Health Svcs Div, Center for Environmental Health, CDC.

Editorial Note: A 1981 survey of state and territorial health departments conducted by the National Environmental Health Association identified only 12 state health departments that maintain injury-control programs. Expansion of the field of injury control requires the involvement of voluntary and private organizations, as well as federal, state, and local governments, and the commitment of health professionals—physicians, nurses, epidemiologists, and public health officials—all of whom can be leaders in advocating and implementing injury-control programs.

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.

*Injuries — Continued**References*

1. CDC. Introduction to Table V. Premature deaths, monthly mortality, and monthly physician contacts—United States. MMWR 1982;31:109-10.
2. National Safety Council. Accident facts, 1981 Edition. Chicago:National Safety Council, 1981.
3. Baker SP, Dietz PE. Injury prevention. In: Healthy people. The Surgeon's General's Report on Health Promotion and Disease Prevention, background papers. Washington, D.C.: U.S. Department of Health, Education, and Welfare, 1979.
4. Haddon W, Jr, Baker SP. Injury control. In: Clark DW, MacMahon B, eds. Preventive and community medicine. Boston: Little, Brown, 1981.
5. Planek, W. A continuing social problem, accident analysis and prevention. Accident Analysis and Prevention 1982;14:107-20.
6. Spiegel CN, Lindaman FC. Children can't fly: a program to prevent childhood morbidity and mortality from window falls. Am J Public Health 1977;67:1143-7.
7. Pearn, JH, Wong RY, Brown J, Ching Y-C, Bart R, Hammar S. Drowning and near drowning involving children: a five-year total population study from the city and county of Honolulu. Am J Public Health 1979;69:450-4.
8. Katcher, ML. Scald burns from hot tap water. JAMA 1981;246:1219-22.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE / CENTERS FOR DISEASE CONTROL
 ATLANTA, GEORGIA 30333
OFFICIAL BUSINESS

Postage and Fees Paid
 U.S. Department of HHS
 HHS 396



Director, Centers for Disease Control
 William H. Foege, M.D.
 Director, Epidemiology Program Office
 Phillip S. Brachman, M.D.
 Editor
 Michael B. Gregg, M.D.
 Mathematical Statistician
 Keewhan Choi, Ph.D.

S 6HCRH3MCDJ73 8129
 JOSEPH MC DADE PHD
 LEGIONNAIRE ACTIVITY
 LEPROSY & RICKETTSIAL BR
 VIROLOGY DIV, CID
 7-85

111

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Current Trends

- 265 National Surveillance of Cocaine Use and Related Health Consequences
- 275 Licensure of Yomesan
- Epidemiologic Notes and Reports
- 274 Inadvertent BCG Administration — Tennessee, Michigan

Current Trends

National Surveillance of Cocaine Use and Related Health Consequences

A recent report on extensive surveillance of cocaine use and related health consequences compiled by the National Institute on Drug Abuse (NIDA) of the U.S. Public Health Service is discussed below.

An initial report from the early 1970s stated that little cost to society attributed to cocaine use had been verified in the United States (1). This pattern of low cost was believed to reflect the route of administration most commonly used, i.e., sniffing or "snorting," and an estimated low prevalence of chronic use. However, use of cocaine has increased substantially in the United States since that time. A more recent report indicates that almost 10 million people over the age of 11 years reported having used cocaine during the year preceding the survey, and almost half of these had used cocaine during the month before the survey (2). Two-thirds of these self-reported cocaine users were between the ages of 18 and 25 years. Overall, the number of people in the United States reporting cocaine use in 1979 was more than double that in 1977 (3). Additional survey data from 1975 through 1981 show a similar trend for graduating high school seniors (4). There was a substantial increase in the number of these students who reported having used cocaine both during the year and the month preceding the survey, i.e., from 5.6% to 12.4% and from 1.9% to 5.8%, respectively.

The recent marked increase in the prevalence of cocaine use is also reflected in health consequences associated with use. Figure 1 shows data on morbidity and mortality associated with cocaine use reported to the Drug Abuse Warning Network (DAWN)* (5) and the rate of

*DAWN is a morbidity- and mortality-information system, funded by NIDA, in which data are collected from a non-random sample of more than 800 hospitals located in 26 major metropolitan areas in the continental United States and in a national panel of hospitals outside these areas, and from medical examiners/coroners located in the 26 major metropolitan areas.

TABLE 1. Number of cocaine-related emergency-room cases reported to DAWN, by age and sex, January 1977-November 1981, United States

Age in years	Male		Female		Total	
	No.	%	No.	%	No.	%
< 20	772	8.5	683	15.8	1,455	10.8
20-29	4,969	54.5	2,637	61.1	7,606	56.6
30-39	2,594	28.4	809	18.8	3,403	25.3
≥ 40	737	8.1	156	3.6	893	6.7
Not recorded	51	0.5	29	0.7	80	0.6
Total	9,123	100.0	4,314	100.0	13,437	100.0

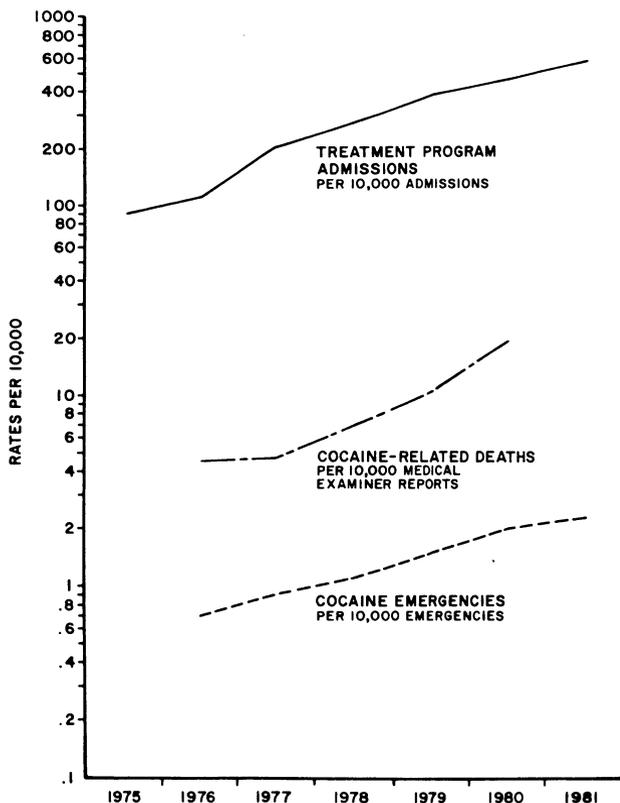
Cocaine Use — Continued

treatment-program admissions for problems related to cocaine use reported to the Client-Oriented Data Acquisition Process (CODAP)† (6). As the figure shows, there was a more than 3-fold increase in the rate of cocaine-related emergencies/10,000 emergencies (from 0.7 to 2.3) and the rate of cocaine-related deaths/10,000 medical-examiner reports (from 4.5 to 19.1) between 1976 and 1980-1981. At the same time, the percentage of cocaine-related treatment-program admissions increased more than 6-fold in the period 1975-1981.

Males associated with reported non-fatal cocaine-related emergencies outnumber females by more than 2 to 1 (Table 1), a ratio that is consistent with prevalence estimates for current use of cocaine. The prevalence ratio for cocaine use is 7 to 1 for whites compared with all

†CODAP was a drug-abuse treatment-program information system, operated by NIDA, through 1981, in which data were collected for persons admitted to all federally funded treatment programs in the United States.

FIGURE 1. Rates of emergencies, deaths, and treatment program admissions associated with primary cocaine use, DAWN and CODAP, United States, 1975-1981*



*Preliminary data for treatment program admissions in 1981.

Source: National Institute on Drug Abuse Statistical Series D, U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration. Drug Abuse Warning Network, DECHIST 1981 Tape, National Institute on Drug Abuse, U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration.

Cocaine Use — Continued

other races; the emergency cases for which race/ethnicity is recorded are about equally distributed between whites and others (Table 2). Clear age differences exist, however, in both sex and race categories, with females being younger than males and whites being younger than blacks.

Despite regional variability in cocaine-related morbidity rates, almost all metropolitan areas reporting to DAWN have shown substantial increases in the period 1976-1981 (Table 3). Although a portion of the increase may have resulted from improved reporting—

TABLE 2. Number of cocaine-related emergency-room cases reported to DAWN, by age and race, January 1977-November 1981, United States

Age in years	White		Black		Other		Not recorded		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
<20	891	15.5	311	6.0	62	9.7	191	10.4	1,455	10.8
20-29	3,516	61.3	2,716	52.1	355	55.6	1,019	55.3	7,606	56.6
30-39	1,121	19.5	1,633	31.3	165	25.9	484	26.3	3,403	25.3
≥40	187	3.3	529	10.1	53	8.3	124	6.7	893	6.7
Not recorded	24	0.4	29	0.5	3	0.5	24	1.3	80	0.6
Total	5,739	100.0	5,218	100.0	638	100.0	1,842	100.0	13,437	100.0

TABLE 3. Rate of non-fatal cocaine-related emergencies reported to DAWN/100,000 emergencies, by metropolitan area, 1976-1981, United States

Metropolitan area	1976	1981
San Francisco	1.5	9.3
New York	2.1	9.0
Miami	5.9	6.3
Denver	0.4	3.4
Washington, D.C.	0.3	3.1
Seattle	0.9	2.6
San Diego	1.0	2.2
Los Angeles	0.3	2.1
Atlanta	0.4	1.8
Phoenix	2.0	1.8
Boston	0.3	1.7
Chicago	0.5	1.6
Detroit	0.5	1.6
New Orleans	0.1	1.6
Baltimore	0.5	1.4
Cleveland	0.2	1.3
Kansas City	0.3	1.2
Buffalo	0.3	1.0
Minneapolis	0.4	0.8
Philadelphia	0.2	0.7
Oklahoma City	0.0	0.6
Indianapolis	0.2	0.5
St. Louis	0.0	0.4
Norfolk	0.3	0.4
Dallas	0.1	0.3
San Antonio	0.0	0.2
All other facilities in DAWN	0.1	0.6
National total	0.7	2.3

Cocaine Use — Continued

which may reflect a greater awareness among emergency-room staff of the potential implications of cocaine use—much of the increase is due to actual increased prevalence, including use of cocaine in combination with other substances. For example, 6% of all cocaine-related emergencies reported to DAWN in 1980 were reported in combination with the use of other substances, including alcohol.

Data on treatment support the conclusion that changes have occurred in patterns of cocaine use. Table 4 shows changes indicating increases in smoking and intravenous use in the period 1977-1980. Both these routes of administration result in more immediate and direct absorption of the drug and produce a quicker and more intense euphoria, while, at the same time, substantially increasing the possibility of acute toxic reaction.

Reported by NJ Kozel, MS, RA Crider, PhD, EH Adams, MS, Div of Data and Information Development, National Institute on Drug Abuse, US Public Health Svc, Dept of Health and Human Svcs.

(Continued on page 273)

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

DISEASE	20th WEEK ENDING			CUMULATIVE, FIRST 20 WEEKS		
	May 22 1982	May 23 1981	MEDIAN 1977-1981	May 22 1982	May 23 1981	MEDIAN 1977-1981
Aseptic meningitis	59	88	64	1,479	1,351	965
Brucellosis	1	—	6	43	49	62
Encephalitis: Primary (arthropod-borne & unspec.)	9	17	12	285	268	236
Post-infectious	2	4	7	26	37	74
Gonorrhea: Civilian	15,513	20,021	19,246	345,000	374,302	362,024
Military	532	552	552	10,245	11,130	10,451
Hepatitis: Type A	330	506	554	8,510	9,732	10,910
Type B	431	387	290	7,781	7,452	6,227
Non A, Non B	49	N	N	795	N	N
Unspecified	168	217	213	3,456	4,199	3,867
Legionellosis	13	N	N	134	N	N
Leprosy	4	5	4	73	83	61
Malaria	29	10	17	303	490	194
Measles (rubeola)	31	140	843	591	1,530	8,546
Meningococcal infections: Total	55	51	51	1,396	1,803	1,286
Civilian	55	51	51	1,392	1,798	1,274
Military	—	—	—	4	5	10
Mumps	150	100	353	2,976	2,072	7,774
Pertussis	20	13	20	406	390	409
Rubella(German measles)	130	45	724	1,293	1,166	7,526
Syphilis (Primary & Secondary): Civilian	570	636	427	12,512	11,559	9,220
Military	6	5	5	155	136	117
Tuberculosis	554	503	582	9,662	9,853	10,270
Tularemia	3	8	3	40	54	41
Typhoid fever	7	9	8	138	174	146
Typhus fever, tick-borne (RMSF)	32	29	33	110	157	106
Rabies, animal	128	154	111	2,283	2,864	1,763

TABLE II. Notifiable diseases of low frequency, United States

	CUM. 1982		CUM. 1982
Anthrax	—	Poliomyelitis: Total	1
Botulism(NYC 1, Hawaii 1)	27	Paralytic	1
Cholera	—	Paittacosis(N.J. 3, Wash. 2, Calif. 1)	39
Congenital rubella syndrome	5	Rabies, human	—
Diphtheria	—	Tetanus(S.C. 1, Ala. 1, Texas 2, N. Mex. 1)	26
Leptospirosis(Maine 1, Texas 1)	24	Trichinosis(N.J. 1, Ohio 1, Tenn. 1)	46
Plague	3	Typhus fever, flea-borne (endemic, murine)(Texas 2)	7

N: Not notifiable

TABLE III. Cases of specified notifiable diseases, United States, weeks ending
May 22, 1982 and May 23, 1981 (20th week)

REPORTING AREA	ASEPTIC MENIN- GITIS	BRUCEL- LOSIS	ENCEPHALITIS		GONORRHEA (Civilian)		HEPATITIS (Viral), by type				LEGIONEL- LOSIS	LEPROSY
			Primary	Post-in- fectious			A	B	NA, NB	Unspecified		
			CUM. 1982	CUM. 1982	CUM. 1982	CUM. 1981	1982	1982	1982	1982		
UNITED STATES	59	43	285	26	345,000	374,302	330	431	49	168	13	73
NEW ENGLAND	-	-	14	4	8,476	9,223	8	25	4	14	2	1
Maine	-	-	-	-	376	465	-	5	-	-	-	-
N.H.	-	-	-	-	233	325	1	-	-	-	-	-
Vt.	-	-	-	-	179	157	-	-	-	-	-	-
Mass.	-	-	4	-	3,968	3,795	3	9	-	11	-	-
R.I.	-	-	-	-	573	458	3	7	2	1	-	-
Conn.	-	-	10	4	3,147	4,019	1	4	1	2	2	1
MID. ATLANTIC	6	-	42	5	42,673	44,206	26	63	-	13	-	4
Upstate N.Y.	1	-	15	1	6,923	7,095	6	14	-	3	-	1
N.Y. City	1	-	9	-	17,938	18,358	12	20	-	5	-	1
N.J.	-	-	10	-	7,659	8,699	8	29	-	5	-	-
Pa.	4	-	8	4	10,153	10,064	U	U	U	U	-	1
E.N. CENTRAL	5	-	57	6	46,884	58,934	47	49	-	5	10	-
Ohio	1	-	17	4	14,293	20,632	15	18	-	-	10	-
Ind.	1	-	14	2	5,483	5,278	7	3	-	2	-	-
Ill.	-	-	-	-	10,419	16,075	8	8	-	1	-	-
Mich.	1	-	24	-	11,975	11,928	12	20	-	2	-	-
Wis.	2	-	2	-	4,714	5,021	5	-	-	-	-	-
W.N. CENTRAL	1	4	15	2	16,655	17,395	5	7	4	6	-	-
Minn.	1	-	1	1	2,527	2,796	2	5	2	1	-	-
Iowa	-	1	8	1	1,822	1,781	2	-	1	1	-	-
Mo.	-	1	4	-	7,560	7,907	1	1	1	4	-	-
N. Dak.	-	-	-	-	234	237	-	-	-	-	-	-
S. Dak.	-	-	-	-	479	506	-	1	-	-	-	-
Nebr.	-	-	1	-	1,047	1,355	-	-	-	-	-	-
Kans.	-	2	1	-	2,986	2,813	-	-	-	-	-	-
S. ATLANTIC	16	12	39	5	84,143	91,600	44	97	9	27	-	5
Del.	-	-	-	-	1,408	1,371	1	1	-	1	-	-
Md.	-	-	10	-	11,511	9,991	2	14	3	3	-	2
D.C.	2	-	-	-	4,784	5,813	2	10	-	-	-	-
Va.	-	3	9	-	7,840	8,364	1	6	-	1	-	1
W. Va.	-	-	-	-	1,049	1,376	3	1	-	-	-	-
N.C.	3	-	4	1	14,790	14,339	3	12	-	2	-	-
S.C.	1	2	-	-	8,658	8,675	9	16	2	1	-	-
Ga.	2	1	-	-	9,483	18,314	4	17	-	3	-	-
Fla.	8	6	16	4	24,620	23,357	19	20	4	16	-	2
E.S. CENTRAL	4	5	15	1	29,798	30,510	5	22	1	4	-	-
Ky.	-	-	-	-	3,919	3,853	-	3	-	-	-	-
Tenn.	2	3	9	-	11,467	11,526	4	12	-	3	-	-
Ala.	1	1	5	1	9,052	9,454	-	7	1	1	-	-
Miss.	1	1	1	-	5,360	5,677	1	-	-	-	-	-
W.S. CENTRAL	8	12	31	-	50,106	49,865	59	44	-	49	1	8
Ark.	-	3	1	-	4,150	3,450	3	5	-	2	-	-
La.	2	2	4	-	9,073	7,966	9	4	-	3	-	-
Okla.	-	3	9	-	5,361	5,143	2	8	-	5	1	-
Tex.	6	4	17	-	31,522	33,306	45	27	-	39	-	8
MOUNTAIN	-	-	14	1	12,613	14,858	40	19	6	12	-	2
Mont.	-	-	-	-	504	515	-	-	-	-	-	-
Idaho	-	-	-	-	596	630	2	-	-	-	-	1
Wyo.	-	-	-	-	338	331	3	-	1	-	-	-
Colo.	-	-	4	1	3,283	3,985	5	7	-	2	-	-
N. Mex.	-	-	-	-	1,569	1,662	10	-	3	-	-	-
Ariz.	-	-	6	-	3,514	4,595	13	2	2	3	-	-
Utah	-	-	-	-	565	698	3	2	-	3	-	1
Nev.	-	-	4	-	2,244	2,442	4	8	-	4	-	-
PACIFIC	19	10	58	2	53,652	57,711	96	105	25	38	-	53
Wash.	-	-	5	-	4,385	4,987	5	10	2	1	-	5
Oreg.	-	-	1	-	2,956	3,839	6	3	-	1	-	-
Calif.	14	9	48	2	44,046	46,310	76	85	23	35	-	28
Alaska	-	1	3	-	1,335	1,479	2	4	-	-	-	1
Hawaii	5	-	1	-	930	1,096	7	3	-	1	-	19
Guam	U	-	-	-	33	55	U	U	U	U	U	-
P.R.	-	-	1	-	1,133	1,268	2	7	-	5	-	-
V.I.	U	-	-	-	60	48	U	U	U	U	U	-
Pac. Trust Terr.	U	-	-	-	36	158	U	U	U	U	U	1

N: Not notifiable

U: Unavailable

TABLE III (Cont.'d). Cases of specified notifiable diseases, United States, weeks ending May 22, 1982 and May 23, 1981 (20th 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	29	303	31	591	1,530	55	1,396	150	2,976	20	130	1,293	1,166
NEW ENGLAND	1	20	-	7	62	3	80	6	140	2	1	10	95
Maine	-	-	-	-	5	-	2	3	32	1	-	-	32
N.H.	-	-	-	1	6	-	11	-	12	-	-	8	38
Vt.	-	-	-	2	2	-	4	-	4	-	-	-	-
Mass.	1	15	-	2	43	1	22	2	70	-	-	-	15
R.I.	-	1	-	-	-	1	11	-	10	1	-	1	-
Conn.	-	4	-	2	6	1	30	1	12	-	1	1	10
MID. ATLANTIC	4	35	7	48	470	13	243	2	201	2	3	70	134
Upstate N.Y.	2	8	2	25	180	2	60	-	36	-	-	33	53
N.Y. City	1	14	2	18	38	1	47	1	32	2	3	24	36
N.J.	1	9	2	2	43	4	52	-	30	-	-	13	41
Pa.	-	4	1	3	209	6	84	1	103	-	-	-	4
E.N. CENTRAL	2	20	-	31	68	6	167	77	1,708	4	14	115	262
Ohio	1	6	-	-	15	-	68	64	1,264	-	-	-	-
Ind.	-	1	-	1	6	-	13	-	25	-	-	18	91
Ill.	-	1	-	15	20	5	41	5	110	4	14	42	62
Mich.	1	10	-	15	26	1	34	8	238	-	-	38	31
Wis.	-	2	-	-	1	-	11	-	71	-	-	17	78
W.N. CENTRAL	1	9	17	19	4	4	57	27	263	3	18	45	69
Minn.	-	-	-	-	1	-	12	18	155	-	-	5	7
Iowa	-	3	-	-	1	-	5	-	24	2	-	-	1
Mo.	1	3	-	2	-	-	18	-	13	-	18	34	2
N. Dak.	-	-	-	-	-	1	5	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	2	3	-	1	1	-	1	-
Nebr.	-	2	-	-	1	-	4	-	-	-	-	-	1
Kans.	-	1	17	17	1	1	10	9	70	-	-	5	58
S. ATLANTIC	2	47	-	31	280	10	284	6	176	3	9	43	101
Del.	-	-	-	-	-	-	-	-	3	-	-	-	-
Md.	-	6	-	2	1	-	17	2	15	-	8	22	1
D.C.	-	3	-	1	1	1	2	-	-	-	-	-	-
Va.	-	16	-	14	3	2	30	1	28	-	-	8	3
W. Va.	-	2	-	1	7	-	7	1	73	-	-	1	17
N.C.	-	-	-	-	3	4	52	-	7	2	1	1	4
S.C.	-	3	-	-	-	1	33	1	10	1	-	1	6
Ga.	2	8	-	-	91	1	65	-	7	-	-	3	26
Fla.	-	9	-	13	174	1	78	1	33	-	-	7	44
E.S. CENTRAL	-	1	-	6	-	3	90	1	27	1	1	35	20
Ky.	-	1	-	1	-	1	14	-	9	-	1	20	12
Tenn.	-	-	-	4	-	-	35	1	11	-	-	-	8
Ala.	-	-	-	-	-	2	36	-	4	-	-	-	-
Miss.	-	-	-	1	-	-	5	-	3	1	-	15	-
W.S. CENTRAL	3	26	2	16	426	7	171	6	117	1	4	69	83
Ark.	-	3	-	-	-	-	8	-	6	-	-	-	2
La.	-	3	-	-	-	4	29	-	3	1	-	-	9
Okla.	1	3	-	-	5	-	14	-	-	-	-	2	-
Tex.	2	17	2	16	421	3	120	6	108	-	4	67	72
MOUNTAIN	-	6	-	-	24	-	78	8	49	-	7	38	58
Mont.	-	-	-	-	-	-	4	-	3	-	-	3	3
Idaho	-	-	-	-	1	-	6	-	2	-	-	-	2
Wyo.	-	-	-	-	-	-	4	-	2	-	-	5	1
Colo.	-	4	-	-	5	-	30	-	7	-	-	2	28
N. Mex.	-	1	-	-	5	-	11	-	-	-	-	2	4
Ariz.	-	1	-	-	3	-	14	8	22	-	-	7	11
Utah	-	-	-	-	-	-	6	-	11	-	2	12	3
Nev.	-	-	-	-	10	-	3	-	2	-	5	7	6
PACIFIC	16	139	5	433	196	9	226	17	295	4	73	668	344
Wash.	1	7	5	23	1	1	24	4	47	2	-	22	46
Oreg.	-	4	-	-	1	-	45	-	-	-	-	3	37
Calif.	15	126	-	408	192	8	145	11	236	2	73	835	256
Alaska	-	-	-	-	-	-	9	-	6	-	-	1	-
Hawaii	-	2	-	2	2	-	3	2	6	-	-	7	5
Guam	U	1	U	-	6	U	1	U	1	U	U	1	1
P.R.	-	4	-	61	156	1	4	4	30	-	-	4	3
V.I.	U	-	U	-	6	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 May 22, 1982 and May 23, 1981 (20th week)

REPORTING AREA	SYPHILIS (Civilian) (Primary & Secondary)		TUBERCULOSIS		TULA- REMIA	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	12,512	11,559	554	9,662	40	7	138	32	110	2,283
NEW ENGLAND	233	248	14	262	-	-	11	1	1	17
Maine	1	1	1	21	-	-	-	-	-	16
N.H.	-	9	-	9	-	-	-	-	-	-
Vt.	-	13	-	6	-	-	2	-	-	-
Mass.	165	156	7	176	-	-	8	-	-	-
R.I.	12	16	-	9	-	-	-	1	1	-
Conn.	55	53	6	41	-	-	1	-	-	1
MID. ATLANTIC	1,729	1,786	72	1,581	3	1	18	-	-	49
Upstate N.Y.	173	153	3	283	3	-	2	-	-	27
N.Y. City	1,052	1,108	28	605	-	1	13	-	-	-
N.J.	216	229	22	304	-	-	3	-	-	1
Pa.	288	291	19	389	-	-	-	-	-	21
E.N. CENTRAL	683	819	86	1,494	-	-	13	4	4	252
Ohio	133	108	8	255	-	-	6	4	4	37
Ind.	83	73	17	196	-	-	-	-	-	42
Ill.	297	461	40	604	-	-	3	-	-	105
Mich.	126	139	17	358	-	-	4	-	-	1
Wis.	44	38	4	81	-	-	-	-	-	67
W.N. CENTRAL	243	213	25	308	7	-	3	-	3	507
Minn.	42	78	3	50	-	-	-	-	-	82
Iowa	11	9	-	41	1	-	1	-	-	160
Mo.	152	105	16	147	5	-	1	-	1	55
N. Dak.	4	5	-	6	-	-	-	-	-	51
S. Dak.	-	2	-	10	-	-	-	-	-	34
Nebr.	8	3	1	13	-	-	-	-	-	56
Kans.	26	11	5	41	1	-	1	-	2	69
S. ATLANTIC	3,436	3,013	103	1,917	6	2	20	19	60	366
Del.	7	7	3	21	-	-	-	-	-	-
Md.	200	237	20	239	1	-	6	2	10	19
D.C.	221	264	3	74	-	-	-	-	-	-
Va.	241	285	7	207	1	-	2	-	2	179
W. Va.	8	9	-	49	-	-	-	1	1	20
N.C.	244	230	15	315	-	-	-	9	27	13
S.C.	158	210	8	184	3	-	2	7	19	23
Ga.	724	773	24	277	-	-	-	-	1	85
Fla.	1,633	998	23	551	1	2	8	-	-	27
E.S. CENTRAL	896	763	58	882	5	-	11	3	9	273
Ky.	49	35	12	241	-	-	-	-	-	48
Tenn.	244	305	17	293	4	-	2	3	5	187
Ala.	317	198	17	260	-	-	7	-	3	38
Miss.	286	225	12	88	1	-	2	-	1	-
W.S. CENTRAL	3,146	2,791	78	1,105	12	2	9	4	30	491
Ark.	86	55	5	106	7	-	1	3	3	68
La.	685	627	12	199	1	-	-	-	-	14
Okla.	69	70	19	158	4	-	2	1	16	101
Tex.	2,306	2,039	42	642	-	2	7	2	11	308
MOUNTAIN	317	272	24	293	4	-	6	1	2	63
Mont.	1	8	6	24	-	-	-	-	-	27
Idaho	17	3	2	13	1	-	-	-	1	1
Wyo.	10	4	-	2	1	-	-	1	1	3
Colo.	91	90	-	31	-	-	2	-	-	-
N. Mex.	64	60	4	53	-	-	-	-	-	8
Ariz.	76	51	9	121	-	-	3	-	-	23
Utah	11	8	-	15	2	-	1	-	-	-
Nev.	47	48	3	34	-	-	-	-	-	1
PACIFIC	1,829	1,654	94	1,820	3	2	47	-	1	265
Wash.	53	63	6	109	1	-	2	-	-	-
Oreg.	52	37	2	66	-	-	1	-	-	-
Calif.	1,671	1,518	76	1,487	2	2	43	-	1	197
Alaska	6	5	-	18	-	-	-	-	-	68
Hawaii	47	31	10	140	-	-	1	-	-	-
Guam	1	-	U	2	-	U	-	U	-	-
P.R.	239	278	-	124	-	-	1	-	-	20
V.I.	-	4	U	1	-	U	-	U	-	-
Pac. Trust Terr.	-	-	U	19	-	U	-	U	-	-

U: Unavailable

TABLE IV. Deaths in 121 U.S. cities,* week ending
May 22, 1982 (20th week)

REPORTING AREA	ALL CAUSES, BY AGE (YEARS)						P & I**	TOTAL	REPORTING AREA	ALL CAUSES, BY AGE (YEARS)						P & I**	TOTAL
	ALL AGES	≥65	45-64	25-44	1-24	<1				ALL AGES	≥65	45-64	25-44	1-24	<1		
NEW ENGLAND	628	415	144	30	12	27	43	S. ATLANTIC	1,143	701	253	73	30	43	45		
Boston, Mass.	174	100	44	10	7	13	13	Atlanta, Ga.	156	100	42	7	7	-	-		
Bridgeport, Conn.	41	22	13	3	-	3	3	Baltimore, Md.	194	108	51	21	6	8	4		
Cambridge, Mass.	14	10	4	-	-	-	2	Charlotte, N.C.	83	42	34	2	1	4	4		
Fall River, Mass.	26	20	5	1	-	-	-	Jacksonville, Fla.	108	72	23	3	6	4	2		
Hartford, Conn.	39	22	12	2	3	-	3	Miami, Fla.	81	52	18	3	3	5	2		
Lowell, Mass.	31	22	7	2	-	-	-	Norfolk, Va.	58	35	11	7	-	5	8		
Lynn, Mass.	28	24	3	1	-	-	-	Richmond, Va.	82	51	24	4	-	3	8		
New Bedford, Mass.	31	24	6	1	-	-	1	Savannah, Ga.	51	33	9	7	1	1	3		
New Haven, Conn.	38	26	9	1	1	1	1	St. Petersburg, Fla.	91	71	17	1	-	2	4		
Providence, R.I.	64	44	12	4	1	3	8	Tampa, Fla.	66	38	23	4	-	1	6		
Somerville, Mass.	11	8	3	-	-	-	-	Washington, D.C.	139	77	32	13	4	10	1		
Springfield, Mass.	39	23	7	5	-	4	5	Wilmington, Del.	34	22	9	1	2	-	3		
Waterbury, Conn.	36	27	8	-	-	1	2										
Worcester, Mass.	56	43	11	-	-	2	5										
MID. ATLANTIC	2,465	1,622	552	168	66	57	106	E.S. CENTRAL	731	415	215	47	24	30	37		
Albany, N.Y.	58	40	12	6	-	-	-	Birmingham, Ala.	124	64	46	8	3	3	3		
Allentown, Pa.	18	16	2	-	-	-	-	Chattanooga, Tenn.	43	32	7	2	-	2	5		
Buffalo, N.Y.	100	66	21	6	3	4	6	Knoxville, Tenn.	55	40	9	1	3	2	-		
Camden, N.J.	51	32	12	2	1	4	-	Louisville, Ky.	95	56	29	4	4	2	3		
Elizabeth, N.J.	25	23	-	2	-	-	4	Memphis, Tenn.	182	91	61	13	5	12	11		
Erie, Pa.†	45	33	10	-	2	-	3	Mobile, Ala.	69	35	15	8	4	3	6		
Jersey City, N.J.	47	31	12	2	-	2	-	Montgomery, Ala.	32	15	10	2	2	3	1		
N.Y. City, N.Y.	1,386	909	297	118	31	31	47	Nashville, Tenn.	131	82	34	9	3	3	8		
Newark, N.J.	50	19	17	6	5	3	8										
Paterson, N.J.	27	11	10	1	4	1	-	W.S. CENTRAL	1,224	694	256	106	64	64	52		
Philadelphia, Pa.†	178	103	51	14	8	2	11	Austin, Tex.	57	41	8	5	1	2	4		
Pittsburgh, Pa.†	66	40	22	2	2	-	3	Baton Rouge, La.	20	13	4	1	-	2	1		
Reading, Pa.	43	33	9	-	1	-	2	Corpus Christi, Tex.	44	27	10	4	2	1	1		
Rochester, N.Y.	136	100	26	1	3	6	9	Dallas, Tex.	180	105	45	19	5	6	4		
Schenectady, N.Y.	28	20	4	2	2	-	-	El Paso, Tex.	53	24	14	3	7	5	8		
Scranton, Pa.†	26	20	5	-	1	-	-	Fort Worth, Tex.	96	65	19	5	2	5	7		
Syracuse, N.Y.	93	57	26	5	2	3	4	Houston, Tex.	274	121	76	39	23	15	2		
Trenton, N.J.	28	20	8	-	-	-	-	Little Rock, Ark.	66	39	19	3	3	2	3		
Utica, N.Y.	26	23	3	-	-	-	2	New Orleans, La.	140	75	38	8	5	14	1		
Yonkers, N.Y.	34	26	5	1	1	1	7	San Antonio, Tex.	163	106	26	15	10	6	13		
								Shreveport, La.	53	28	19	1	3	2	4		
								Tulsa, Okla.	78	50	18	3	3	4	4		
E.N. CENTRAL	2,276	1,416	530	174	91	65	67	MOUNTAIN	652	382	169	47	33	21	32		
Akron, Ohio	72	45	17	5	4	1	-	Albuquerque, N. Mex.	95	52	27	11	4	1	9		
Canton, Ohio	33	24	5	1	3	-	1	Colo. Springs, Colo.	31	19	9	-	2	1	3		
Chicago, Ill.	446	270	109	43	19	5	15	Denver, Colo.	136	87	32	11	1	5	4		
Cincinnati, Ohio	115	71	25	10	1	8	9	Las Vegas, Nev.	55	32	15	4	4	-	1		
Cleveland, Ohio	158	87	43	11	2	15	2	Ogden, Utah	23	14	5	1	3	-	5		
Columbus, Ohio	139	73	31	11	15	9	6	Phoenix, Ariz.	148	90	36	8	9	5	3		
Dayton, Ohio	119	78	31	8	1	1	-	Pueblo, Colo.	28	12	10	5	1	-	3		
Detroit, Mich.	289	170	72	30	11	6	6	Salt Lake City, Utah	48	23	9	4	4	8	1		
Evansville, Ind.	39	30	6	2	1	-	1	Tucson, Ariz.	88	53	26	3	5	1	3		
Fort Wayne, Ind.	83	60	15	4	3	1	7										
Gary, Ind.	15	9	4	-	2	-	-										
Grand Rapids, Mich.	58	45	7	3	2	1	1	PACIFIC	1,785	1,152	391	123	67	51	76		
Indianapolis, Ind.	211	118	57	21	10	5	3	Berkeley, Calif.	15	10	3	1	1	-	1		
Madison, Wis.	23	15	6	-	1	1	2	Fresno, Calif.	80	47	19	7	5	2	2		
Milwaukee, Wis.	151	100	34	8	4	5	1	Glendale, Calif.	26	23	2	-	1	-	1		
Peoria, Ill.	34	20	9	3	1	1	-	Honolulu, Hawaii	61	35	16	7	-	3	2		
Rockford, Ill.	35	25	7	1	1	1	4	Long Beach, Calif.	96	56	21	4	3	2	4		
South Bend, Ind.	51	41	5	5	-	-	3	Los Angeles, Calif.	533	350	106	38	25	13	16		
Toledo, Ohio	134	93	26	3	8	4	6	Oakland, Calif.	59	34	14	6	3	2	5		
Youngstown, Ohio	71	42	21	5	2	1	-	Pasadena, Calif.	22	15	5	1	1	-	2		
								Portland, Ore.	116	80	19	6	3	8	7		
								Sacramento, Calif.	68	29	25	8	3	3	-		
W.N. CENTRAL	765	500	152	37	28	48	19	San Diego, Calif.	116	82	20	8	2	4	12		
Des Moines, Iowa	60	45	11	1	-	3	-	San Francisco, Calif.	162	99	41	14	5	3	4		
Duluth, Minn.	44	31	8	3	1	1	1	San Jose, Calif.	181	112	44	16	5	4	14		
Kansas City, Kans.	27	19	4	3	-	1	-	Seattle, Wash.	140	89	36	6	6	3	2		
Kansas City, Mo.	110	59	26	8	6	11	-	Spokane, Wash.	65	46	11	1	4	3	1		
Lincoln, Nebr.	38	28	8	-	1	1	1	Tacoma, Wash.	45	35	9	-	-	1	3		
Minneapolis, Minn.	74	44	19	4	2	5	-										
Omaha, Nebr.	102	67	20	4	5	6	-										
St. Louis, Mo.	177	107	36	8	11	15	12										
St. Paul, Minn.	66	58	6	1	-	1	3										
Wichita, Kans.	67	42	14	5	2	4	2										
TOTAL	11,669 ^{††}	7,297	2,742	805	415	406	477										

*Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

**Pneumonia and influenza

†Because of changes in reporting methods in these 4 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

††Total includes unknown ages.

Cocaine Use — Continued

Editorial Note: Cocaine is an alkaloid derived from the leaves of the coca shrub (*Erythroxylon Coca*). The U.S. Pharmacopeia compound consists of white, orderless crystals or crystalline powder having a purity of 100% (± 1). Its current medical application is limited to topical use for anesthesia of the ear, nose, and throat, and for bronchoscopy.

Illegally distributed cocaine is often adulterated with a variety of substances including procaine, lidocaine, and amphetamines, as well as sugars, such as mannitol and lactose. The dangers involved in cocaine use include consequences of both acute and chronic use. Acute toxicity, similar to that caused by amphetamines, is characterized by nervousness, dizziness, blurred vision, and tremors, and may lead to convulsions, cardiac arrhythmias, and respiratory arrest. Chronic use is associated with ulceration and perforation of the nasal septum, weight loss, insomnia, anxiety, paranoia, formication, and hallucination.

The increased prevalence of cocaine use and of the health consequences associated with that use may be based on increasing availability and changes in the patterns of use. The U.S. Department of Justice estimated that between 40 and 48 metric tons of cocaine hydrochloride were imported into the United States in 1980, an increase of more than 50% over the previous year (7). In addition, changes in the route of administration of the drug from inhaling or "snorting" to freebasing (processing the cocaine into a pure form by removing the hydrochloride base and then smoking the freebase) and to intravenous use may be causing adverse health consequences.

References

1. Marihuana and Drug Abuse Commission. Drug use in America: problem in perspective, second report of the National Commission on Marihuana and Drug Abuse. Washington, D.C.: National Institute on Drug Abuse, March 1973. Public Health Service.
2. Fishburne PM. National survey on drug abuse: main findings 1979. Rockville, Md.: Office of Medical and Professional Affairs, National Institute on Drug Abuse, 1980, Public Health Service.
3. Abelson, HI. National survey on drug abuse, 1977: a nationwide study—youth, young adults and older people. Washington, D.C.: National Institute on Drug Abuse, 1979. Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service.
4. Johnston LD, Bachman JG, O'Malley TM. Student drug use in America, 1975-1981. Washington, D.C.: National Institute on Drug Abuse, 1981. Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service.
5. Drug Abuse Warning Network. 1976-1981 data (tape-SRVCD 48). Washington, D.C.: National Institute on Drug Abuse, December 1981. Public Health Service.
6. Division of Scientific and Program Information. Client-oriented data acquisition process. Rockville, Md.: National Institute on Drug Abuse, 1980. Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service.
7. National Narcotics Intelligence Consumers Committee. The supply of drugs to the U.S. illicit market from foreign and domestic sources in 1981 (with projections through 1984). Washington, D.C.: 1982. Drug Enforcement Administration, Department of Justice.

TABLE 4. Cocaine users admitted to federally funded drug-abuse programs, 1977-1980, United States

Route of administration	1977		1980	
	No.	%	No.	%
Inhalation	2,333	69	6,906	61
Intravenous	812	24	3,510	31
Oral	169	5	453	4
Smoking	34	1	340	3
Intramuscular	34	1	113	1
Total	3,382	100	11,322	100

Epidemiologic Notes and Reports

Inadvertent BCG Administration — Tennessee, Michigan

In October 1981, 49 employees of a Tennessee hospital, scheduled to receive tuberculin skin tests as part of their institution's tuberculosis-surveillance program, were inadvertently given *Bacillus of Calmette and Guérin* (BCG) instead of purified protein derivative of tuberculin (PPD). Of those vaccinated, 47 subsequently developed the expected local reaction to BCG at the site of vaccination on the forearm; 1 employee had no local reaction, and 1 experienced a local reaction and axillary lymphadenopathy. All these reactions resolved spontaneously. Approximately 10 weeks after receiving BCG, 20 of the 49 employees returned voluntarily for testing with 5 tuberculin units (TU) of PPD; 18 of the 20 (90%) developed "significant" tuberculin reactions (≥ 10 mm in diameter).

During the same month, BCG was also given instead of PPD to 63 residents and 37 employees of a Michigan nursing home. The 3 employees who either were known tuberculin reactors or had a past history of tuberculosis developed large, erythematous reactions at the inoculation site within 2 days of receiving the BCG; 2 of the 3 also noted low-grade fever that lasted for several days. Five days after the BCG was given, the vaccinated residents and other vaccinated staff were tuberculin tested. Six employees whose tuberculin tests had been negative in the past had "significant" reactions. Of the 63 residents, 3 had "significant" reactions; 2 of these 3 had a record of having had negative tuberculin tests in the past. Several weeks later, 3 patients and 1 staff member were given isoniazid (INH) for a short period because of slowly healing ulcers at the site of inoculation. The medication was discontinued after the lesions were examined by a consultant who found them to be typical lesions developed by persons given BCG.

Reported by HR Anderson, MD, Div of Tuberculosis Control, RH Hutcheson, Jr, MD, State Epidemiologist, Tennessee State Dept of Health; W Thar, MD, MPH, Mid-Michigan District Health Dept, NB Keon, Div of Disease Surveillance, NS Hayner, MD, MPH, State Epidemiologist, Michigan Dept of Health; Tuberculosis Control Div, Center for Prevention Svcs, CDC.

Editorial Note: In the United States, tuberculosis-control programs for employees, patients, or residents in health-care facilities should be based on measures to prevent the transmission of tuberculosis and on a program of tuberculin testing of employees at periodic intervals to detect any recently acquired infections (1-3).

In the episodes described, 0.1 ml of BCG vaccine was inadvertently given instead of the same dose of PPD. Ulceration at the site of BCG administration is common and usually heals spontaneously after several weeks. Axillary lymphadenopathy may also occur. Resolution is usually spontaneous, but occasionally treatment is required. Most strains of BCG are sensitive to antituberculosis drugs. Disseminated BCG infection is uncommon, and usually occurs only among immunologically abnormal hosts.

Inservice education programs can help maintain an awareness of tuberculosis among health-care personnel, and can help clarify the distinction between BCG (a tuberculosis vaccine) and PPD (a tuberculin skin-test antigen). These episodes, along with previous instances in which diphtheria-pertussis-tetanus (DPT) and PPD solutions have been inadvertently substituted for one another (4), also reemphasize the need for personnel to read labels on drugs and biologics carefully before such materials are used.

References

1. CDC. Guidelines for prevention of TB transmission in hospitals. Atlanta: Center for Disease Control, 1979. (HEW publication no. [CDC] 79-8371).

BCG Administration — Continued

2. Stead WW. Tuberculosis among elderly persons: an outbreak in a nursing home. *Ann Intern Med* 1981;94:606-10.
3. American Thoracic Society Executive Committee. The tuberculin skin test. *Am Rev Respir Dis* 1981;124:356-63.
4. Graham DR, Dan BB, Bertagnoli P, Dixon RE. Cutaneous inflammation caused by inadvertent intradermal administration of DTP instead of PPD. *Am J Public Health* 1981;71:1040-3.

*Current Trends***Licensure of Yomesan***

Miles Pharmaceuticals has been licensed by the Food and Drug Administration (FDA) to manufacture and distribute Niclocide (Yomesan)[†] in the United States for treatment for humans with cestodiasis (tapeworm infections). Drug requests should be directed to local Miles representatives or to: Miles Pharmaceuticals, 400 Morgan Lane, West Haven, CT 06516. Telephone: 800-243-4153 (toll free) or 203-934-9221.

The Parasitic Disease Drug Service (PDDS) of CDC will continue to distribute 13 other drugs to physicians requesting them (Table 5). After the requesting physician provides information about the infection, specific laboratory data, and limited patient data (name, age, sex, and weight), CDC will release these drugs to all licensed physicians in the United States who agree to register as Clinical Investigators by completing FDA Form FD-1573. Included in each shipment is a packet containing 1) a drug protocol outlining indications/contraindications, dosages, routes and frequency of administration, expected adverse reactions, and toxicity; 2) a patient consent form (available in English, Spanish, Cambodian, Lao, Muong [Hmoob],

*Use of trade names is for identification only and does not imply endorsement by the Public Health Service or the U.S. Department of Health and Human Services.

[†]Formerly distributed in the United States by the Parasitic Disease Drug Service (PDDS) as niclosamide (Yomesan).

TABLE 5. Drugs carried by the Parasitic Disease Service

Investigational new drugs	Indications
Bayer 205 (Suramin)	African trypanosomiasis, onchocerciasis
Bayer 2502 (Lampit)	American trypanosomiasis
Bithionol, N.F.	Paragonimiasis, <i>Fasciola hepatica</i>
Dehydroemetine	Amebiasis
Diloxanide furoate (Furamide)	Amebiasis
Melarsoprol (Mel B)	African trypanosomiasis
Metrifonate (Bilarcil)	Schistosomiasis
Niridazole (Ambilhar)	Dracunculiasis, schistosomiasis
Pentamidine isethionate (Lomidine)	Pneumocystosis, African trypanosomiasis
Sodium antimony dimercaptosuccinate (Astiban)	Schistosomiasis
Sodium antimony gluconate (Pentostam)	Leishmaniasis
Commercially licensed, but difficult-to-obtain drugs	
Chloroquine (parenteral)	Malaria
Quinine (parenteral)	Malaria

Yomesan — Continued

and Vietnamese); and 3) a 1-page patient report form that asks the physician to report all side effects of therapy and record the drug's effectiveness (cure/noncure), as demonstrated by the appropriate laboratory parameters.

Requests for drugs from PDDS should be directed to: Centers for Disease Control, Parasitic Disease Drug Service, 1600 Clifton Road, Bldg. 6, Room 161, Atlanta, GA 30333. Telephone: (Day) 404-329-3670, 8:00 AM to 4:30 PM, Monday through Friday; (night, weekend, or holiday) 404-329-2888, For Emergency Calls *Only*.

Reported by Parasitic Diseases Div, Center for Infectious Diseases, CDC.

The Morbidity and Mortality Weekly Report, circulation 108,000, 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.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE / CENTERS FOR DISEASE CONTROL
ATLANTA, GEORGIA 30333
OFFICIAL BUSINESS

Director, Centers for Disease Control
William H. Foege, M.D.
Director, Epidemiology Program Office
Philip S. Brachman, M.D.
Editor
Michael B. Gregg, M.D.
Mathematical Statistician
Keewhan Choi, Ph.D.

Postage and Fees Paid
U.S. Department of HHS
HHS 396



S 6HCRH3MCDJ73 8129
JOSEPH MC DADE PHD
LEGIONNAIRE ACTIVITY
LEPROSY & RICKETTSIAL BR
VIROLOGY DIV, CID
7-85

111