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Alcohol-Related Highway Fatalities among Young Drivers — United States

In 1981, 49,268 highway accident deaths involving 62,666 drivers occurred in the United States; young drivers (ages 16 to 24 years), constituting 17% of the U.S. population, were involved in accidents resulting in 48% of the fatalities.* A total of 21,431 young drivers accounted for crashes resulting in 23,690 fatalities, and 9,834 of these drivers themselves were killed.

Analysis of 1981 data from the Fatal Accident Reporting System (FARS)† shows that alcohol played an important role in fatal highway accidents involving young drivers. In 1981, 4,738 young drivers under the influence of alcohol were killed, and 9,310 persons died in accidents involving these young drivers.

Of the 21,431 young drivers involved in accidents, 8,222 had positive blood alcohol content (BAC) tests or were judged by investigating officers to have alcohol involvement; 4,738 were killed, for a case fatality rate of 58%. The remaining 13,209 were untested or had negative BAC; 5,096 of these were killed, for a case fatality rate of 39 per 100 young drivers with negative or unknown BAC. Thus, young drivers with known alcohol involvement were 49% more likely to be killed than those with zero or unknown alcohol involvement.

For single vehicle accidents, there was a steady, inverse relationship between age and involvement in fatal accidents, regardless of alcohol use (Table 1). Young drivers accounted for 41% of the 25,095 fatal single vehicle accidents, compared with 11% for drivers 55 years or older. Young drivers were involved in nearly 45% of alcohol-related single vehicle accidents, compared with 5.5% for drivers 55 and older. A total of 7,158 fatal, alcohol-related, single vehicle accidents occurred in 1981. A comparison of BAC by driver age for single vehicle accidents shows a greater fraction of young than older drivers with low BAC, (Figure 1).

The overall crude death rate in 1981 was 43.2/100,00 for highway accidents attributable to young people aged 16-24 years, compared with 31.9 for those 25-29 years, 23.7 for 30-34 years, 19.5 for 35-44 years, and 17.9 for those 45 years and older. No crude death rates were computed for drinking driver fatalities, because no reliable way exists for estimating the number of drinking drivers on the road at any given time.

The overall crude death rate attributable to highway traffic fatalities has been relatively stable over the 5-year period 1977-1981. Minor fluctuations in crude rates have occurred for all ages; for most age groups the trend has been slightly downward since 1978-1979 (Table 2). The most noteworthy aspect has been the extreme variablilty between ages in any given year. In 1981, the crude death rate for 16-year-olds was 28.7/100,00 and for 17-, 18-, and

*U.S. Department of Commerce, Bureau of the Census, 1970 and 1980 Census of Population.

†Department of Transportation, National Highway Traffic Safety Administration, 1977-1981 data tapes.

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19-year-olds, 40.5, 50,9, and 51.8, respectively. Only after age 35 did the rate decrease below the overall crude rate. This pattern has occurred in all 5 data years, with the crude death rate for 16-24 year olds exceeding the overall rate by more than 2 to 1 in each year.

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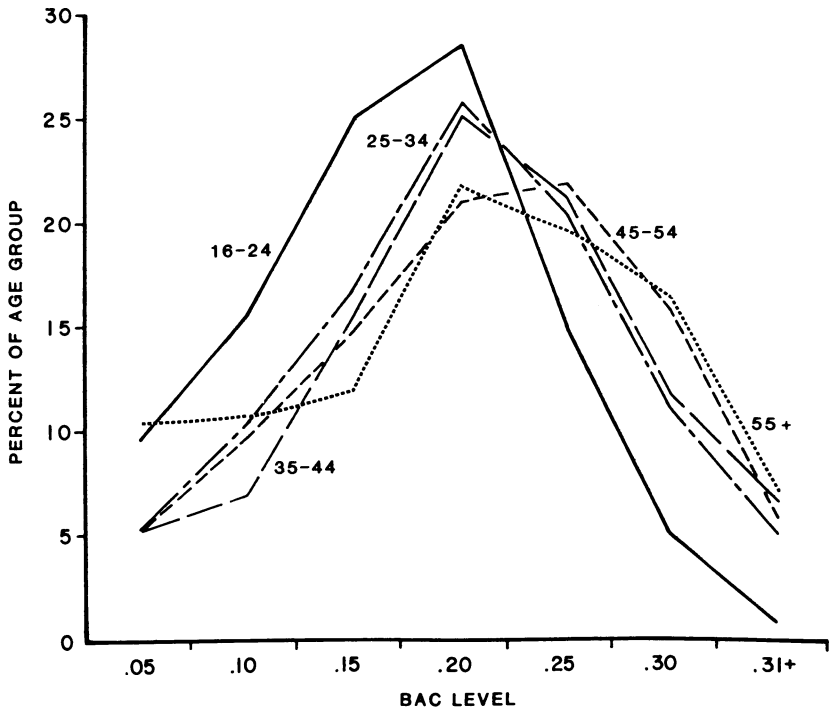
Editorial Note: Because testing for BAC is not uniform for all states and police jurisdictions, actual overall alcohol involvement in highway traffic fatalities may be underestimated. In

TABLE 1. Fatal single vehicle accidents, age of driver, and alcohol involvement — United States, 1981

Age group	% United States population	Single vehicle accidents	% Total	Number with alcohol	% in age group with alcohol	% alcohol-involved accidents
16-24	16.5	10,295	41.0	3,190	31.0	44.6
25-34	16.8	6,977	27.8	2,193	31.4	30.6
35-44	11.5	3,165	12.6	902	28.5	12.6
45-54	9.9	2,002	8.0	476	23.8	6.6
55+	21.1	2,656	10.6	397	14.9	5.5
Totals		25,095	100.0	7,158	28.5	100.0

FIGURE 1. Percentage blood alcohol concentration (BAC), by age group — United States, 1981



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addition, traffic deaths are only tabulated if they occur within 30 calendar days of the highway traffic accident; thus, deaths are also undercounted. Nevertheless, alcohol-related motor vehicle crashes are the leading cause of death in the 16-24-year age group.

These data, and an awareness of the tragic health and social consequences of the use of alcohol by youth, have led the Department of Health and Human Services to emphasize the need for a combined effort by adults and young people against youth alcohol abuse and to announce an Initiative on Teenage Alcohol Abuse. The Secretarial Initiative, designed to increase public awareness of the seriousness of the problem and to mobilize public and private action, includes the following major activities.

1. A Secretarial Conference for Youth on Drinking and Driving, co-sponsored by the Departments of Education, Transportation, and Agriculture, will be held in Chevy Chase, Maryland, March 26-28, 1983, for young people working to combat drinking and driving. Teenagers across the country will be invited to share experiences on implementing programs in their local communities to reduce alcohol- and drug-related traffic fatalities.
2. A series of 10 regional conferences on prevention and early intervention, held across the country for school personnel, parent groups, and alcohol and drug abuse program personnel, has resulted in a prevention guide, "Prevention Plus: Involving Schools, Parents, and the Community in Alcohol and Drug Education," which will be printed early in 1983.
3. Beginning the summer of 1983, a series of 1-day regional conferences will be held to help communities assess the need for and design comprehensive treatment services for youth.
4. Agencies within the Department of Health and Human Services have been asked to identify activities in research, education, and prevention designed to curb teenage alcohol abuse. In

TABLE 2. Crude death rates* for highway accident fatalities by age groups and by single years of age, 16-24 — United States, 1977-1981

	Crude Death Rates Year				
Age	1977	1978	1979	1980	1981
Overall	22.1	23.1	23.2	22.6	21.6
16	34.3	34.6	36.8	34.1	28.7
17	44.6	46.6	45.3	43.5	40.5
18	55.4	57.5	58.9	57.7	50.9
19	54.1	57.7	57.5	56.2	51.8
20	51.6	52.2	51.8	50.0	46.9
21	49.4	52.2	51.5	49.6	45.8
22	46.2	49.4	47.4	48.1	44.2
23	40.9	44.3	42.5	44.4	41.3
24	36.2	37.3	40.8	39.3	38.5
16-19	47.0	49.0	49.6	47.9	43.1
20-24	45.0	47.2	46.9	46.3	43.4
16-24	45.9	48.0	48.1	47.0	43.2
25-29	28.8	31.5	32.7	32.1	31.9
30-34	21.7	23.7	24.4	24.3	23.7
35-44	18.6	20.0	20.6	19.8	19.5
45+	19.3	19.3	18.9	19.1	17.9

*Per 100,000 population

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addition, the Department will be involved in the "National Drunk and Drugged Driving Awareness Week," December 12-18, 1982.

5. Communication has been established with the World Health Organization to develop a collaborative relationship on the issue.
6. Studies to examine the medical and developmental consequences of youth alcohol consumption are being undertaken.

Selected Bibliography

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2. Malin HJ, Munch NE, Archer LD. A National surveillance system for alcoholism and alcohol abuse. In: Proceedings of the 32nd International Congress on Alcoholism and Drug Dependence. Congress held Warsaw, Poland, 1978.

Epidemiologic Notes and Reports

Update on Acquired Immune Deficiency Syndrome (AIDS) among Patients with Hemophilia A

In July 1982, three heterosexual hemophilia A patients, who had developed *Pneumocystis carinii* pneumonia and other opportunistic infections, were reported (*1*). Each had in vitro evidence of lymphopenia and two patients who were specifically tested had evidence of T-lymphocyte abnormalities. All three have since died. In the intervening 4 months, four additional heterosexual hemophilia A patients have developed one or more opportunistic infections accompanied by in-vitro evidence of cellular immune deficiency; these four AIDS cases and one highly suspect case are presented below. Data from inquiries about the patients' sexual activities, drug usage, travel, and residence provide no suggestion that disease could have been acquired through contact with each other, with homosexuals, with illicit drug abusers, or with Haitian immigrants—groups at increased risk for AIDS compared with the general U.S. population. All these patients have received Factor VIII concentrates, and all but one have also received other blood components.

Case 1: A 55-year-old severe hemophiliac from Alabama developed anorexia and progressive weight loss beginning in September 1981. He had developed adult-onset diabetes mellitus in 1973, which had required insulin therapy since 1978. He had had acute hepatitis (type unknown) in 1975. In March 1982, he was hospitalized for herpes zoster and a 17-kg weight loss. Hepatosplenomegaly was noted. The absolute lymphocyte count was 450/mm^3. Liver enzymes were elevated; antibodies to hepatitis B core and surface antigens were present. A liver biopsy showed changes consistent with persistent hepatitis. Evaluation for an occult malignancy was negative. The zoster resolved following 5 days of adenosine arabinoside therapy.

In early June, he was readmitted with fever and respiratory symptoms. Chest x-ray showed bibasilar infiltrates. No causative organism was identified, but clinical improvement occurred coincident with administration of broad spectrum antibiotics. Laboratory studies as an outpatient documented transient thrombocytopenia (63,000/mm^3) and persistent inversion of his T-helper/T-suppressor ratio (T_H/T_S =0.2). He was readmitted for the third time in early September with fever, chills and nonproductive cough. His cumulative weight loss was

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now 47 kg. Chest x-ray demonstrated bilateral pneumonia, and open lung biopsy showed infection with *P. carinii*. He responded to sulfamethoxazole/trimethoprim (SMZ/TMP). His T-cell defects persist.

Case 2: A 10-year-old severe hemophiliac from Pennsylvania had been treated with Factor VIII concentrate on a home care program. He had never required blood transfusion. He had been remarkably healthy until September 1982 when he experienced intermittent episodes of fever and vomiting. Approximately 2 weeks later, he also developed persistent anorexia, fatigue, sore throat, and nonproductive cough. On October 20, he was admitted to a hospital with a temperature of 38.4 C (101.2 F) and a respiratory rate of 60/min. Physical examination revealed cervical adenopathy but no splenomegaly. The absolute number of circulating lymphocytes was low (580/mm^3) and the T-helper/T-suppressor ratio was markedly reduced (T_H/T_S = 0.1). His platelet count was 171,000/mm^3. Serum levels of IgG, IgA, and IgM were markedly elevated. Chest x-rays showed bilateral pnuemonia and an open lung biopsy revealed massive infiltration with *P. carinii* and *Cryptococcus neoformans*. Intravenous SMZ/TMP and amphotericin B have led to marked clinical improvement, but the T-cell abnormalities persist.

Case 3: A 49-year-old patient from Ohio with mild hemophilia had been treated relatively infrequently with Factor VIII concentrate. During the summer of 1982, he noted dysphagia and a weight loss of approximately 7 kg. In October, he was treated for cellulitis of the right hand. Two weeks later, he was observed by a close relative to be dyspneic. He was admitted in November with progressive dyspnea and diaphoresis. Chest x-rays suggested diffuse pneumonitis. His WBC count was 11,000/mm^3 with 9% lymphocytes (absolute lymphocyte number 990/mm^3). The T_H/T_S ratio was 0.25. Open lung biopsy revealed *P. carinii*. The patient was treated with SMZ/TMP for 6 days with no improvement, and pentamidine isethionate was added. Virus cultures of sputum and chest tube drainage revealed herpes simplex virus. He died on November 22.

Case 4: A 52-year-old severe hemophiliac from Missouri was admitted to a hospital in April 1982 with fever, lymphadenopathy, and abdominal pain. Persistently low numbers of circulating lymphocytes were noted (480/mm^3). Granulomata were seen on histopathologic examination of a bone marrow aspirate. Cultures were positive for *Histoplasma capsulatum*. The patient improved after therapy with amphotericin B. During the following summer and early fall, he developed fever, increased weight loss, and difficulty thinking. On readmission in early November, he had esophageal candidiasis. Laboratory tests showed profound leukopenia and lymphopenia. A brain scan showed a left frontal mass, which was found to be an organizing hematoma at the time of craniotomy. A chest x-ray showed "fluffy" pulmonary infiltrates. Therapy with SMZ/TMP was begun. Exploratory laparotomy revealed no malignancy. A splenectomy was performed. Biopsies of liver, spleen, and lymph node tissues were negative for *H capsulatum* granulomata. The lymphoid tissue including the spleen showed an absence of lymphocytes. His total WBC declined to 400/mm^3 and the T_H/T_S cell ratio was 0.1. He died shortly thereafter.

Suspect Case: Described below is an additional highly suspect case that does not meet the strict criteria defining AIDS. A 7-year-old severe hemophiliac from Los Angeles had mild mediastinal adenopathy on chest x-ray in September 1981. In March 1982, he developed a spontaneous subdural hematoma requiring surgical evacuation. In July, he developed parotitis. In August, he developed pharyngitis and an associated anterior and posterior cervical adenopathy, which has not resolved. In late September, he developed herpes zoster over the right thigh and buttock, and oral candidiasis . Chest x-rays revealed an increase of the mediastinal adenopathy and the appearance of new perihilar infiltrates. In late October, enlarge-

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ment of the cervical nodes led to a lymph node biopsy. Architectural features of the node were grossly altered, with depletion of lymphocytes. Heterophile tests were negative. IgG, IgA, and IgM levels were all elevated. He has a marked reduction in T-helper cells and a T_H/T_S ratio equal to 0.4. Recent progressive adenoid enlargement has caused significant upper airway obstruction and resultant sleep apnea.

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Editorial Note: These additional cases of AIDS among hemophilia A patients share several features with the three previously reported cases. All but one are severe hemophiliacs, requiring large amounts of Factor VIII concentrate. None had experienced prior opportunistic infections. All have been profoundly lymphopenic (< 1000 lymphocytes/mm^3) and have had irreversible deficiencies in T-lymphocytes. Clinical improvement of opportunistic infections with medical therapy has been short lived. Two of the five have died.

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

Disease	48th Week Ending			Cumulative, First 48 Weeks		
	December 4, 1982	December 5, 1981	Median 1977-1981	December 4, 1982	December 5, 1981	Median 1977-1981
Aseptic meningitis	216	125	127	8,506	8,931	7,262
Brucellosis	1	3	3	147	163	167
Encephalitis: Primary (arthropod-borne & unspec.)	38	17	20	1,347	1,393	1,113
Post-infectious	-	3	3	56	86	202
Gonorrhea: Civilian	16,795	17,956	19,839	881,075	923,109	923,923
Military	289	770	461	23,944	25,597	24,753
Hepatitis: Type A	470	518	556	20,940	23,303	26,940
Type B	431	487	340	19,870	19,050	15,066
Non A, Non B	56	N	N	2,162	N	N
Unspecified	173	230	222	8,135	9,988	9,613
Legionellosis	13	N	N	503	N	N
Leprosy	2	11	7	186	233	160
Malaria	23	21	21	965	1,279	725
Measles (rubeola)	4	35	112	1,583	2,891	13,255
Meningococcal infections: Total	42	64	49	2,705	3,229	2,385
Civilian	42	63	49	2,692	3,216	2,365
Military	-	1	-	13	13	18
Mumps	111	182	243	4,855	4,266	12,833
Pertussis	55	19	34	1,608	1,135	1,568
Rubella (German measles)	19	29	89	2,189	1,966	11,304
Syphilis (Primary & Secondary): Civilian	563	598	515	30,265	28,595	23,032
Military	2	5	6	405	351	290
Tuberculosis	576	533	596	23,690	25,101	25,261
Tularemia	4	9	4	234	260	178
Typhoid fever	3	8	12	368	530	488
Typhus fever, tick-borne (RMSF)	4	5	5	966	1,160	1,109
Rabies, animal	116	108	77	5,736	6,730	4,672

TABLE II. Notifiable diseases of low frequency, United States

	Cum. 1982		Cum. 1982
Anthrax	-	Poliomyelitis: Total	7
Botulism (Calif. 1)	76	Paralytic (Ind. 1, Wash. 1)	7
Cholera	-	Psittacosis	113
Congenital rubella syndrome	6	Rabies, human	-
Diphtheria	3	Tetanus	74
Leptospirosis	67	Trichinosis (N.J. 1)	82
Plague	18	Typhus fever, flea-borne (endemic, murine) (Tex. 1)	40

TABLE III. Cases of specified notifiable diseases, United States, weeks ending December 4, 1982 and December 5, 1981 (48th 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	216	147	1,347	56	881,075	923,109	470	431	56	173	13	186
NEW ENGLAND	5	3	52	6	21,409	22,370	11	26	2	14	3	2
Maine	-	-	-	-	1,119	1,204	1	1	-	-	1	-
N.H.	-	-	8	-	693	832	2	1	-	-	-	-
Vt.	1	-	-	-	394	409	-	1	1	-	-	-
Mass.	1	-	22	-	9,530	9,433	3	4	1	13	-	-
R.I.	3	-	-	1	1,422	1,367	3	3	-	-	-	-
Conn.	-	3	22	5	8,251	9,125	2	16	-	1	2	2
MID. ATLANTIC	33	3	140	14	111,880	111,362	75	118	6	18	-	9
Upstate N.Y.	16	3	59	3	18,705	19,636	9	13	4	8	-	1
N.Y. City	2	-	19	-	46,115	45,328	9	58	-	3	-	6
N.J.	8	-	23	-	20,085	20,914	25	21	2	6	-	1
Pa.	7	-	39	11	26,975	25,484	32	26	-	1	-	1
E.N. CENTRAL	15	4	337	12	124,134	137,043	37	28	3	1	1	10
Ohio	10	1	133	5	33,239	42,808	16	11	1	-	-	-
Ind.	2	-	91	3	15,369	11,402	1	1	-	-	-	-
Ill.	-	2	15	2	33,886	39,914	6	5	2	1	-	8
Mich.	3	1	69	-	30,426	30,331	14	11	-	-	1	-
Wis.	-	-	29	2	11,214	12,588	-	-	-	-	-	2
W.N. CENTRAL	10	17	98	4	41,506	44,546	7	10	2	-	1	7
Minn.	-	1	27	1	6,008	6,911	1	3	1	-	-	4
Iowa	2	5	52	1	4,440	4,936	-	2	-	-	-	-
Mo.	5	4	8	-	19,653	20,734	4	4	1	-	-	1
N. Dak.	-	1	-	-	540	560	-	-	-	-	-	-
S. Dak.	-	1	-	1	1,068	1,187	-	-	-	-	-	1
Nebr.	2	2	6	-	2,448	3,341	2	1	-	-	1	1
Kans.	1	3	5	1	7,349	6,877	-	-	-	-	-	-
S. ATLANTIC	58	28	193	8	231,477	227,379	47	77	13	20	2	11
Del.	-	-	-	-	3,837	3,651	1	5	-	-	-	-
Md.	1	-	25	-	28,793	27,123	12	21	4	2	1	4
D.C.	-	-	-	-	14,038	12,982	1	-	-	3	-	-
Va.	5	10	40	1	18,668	20,857	4	8	4	3	-	1
W. Va.	-	-	16	-	2,587	3,363	1	2	-	-	-	-
N.C.	13	-	29	1	36,492	35,162	2	7	-	4	-	-
S.C.	1	2	2	-	22,432	22,096	4	9	-	1	-	-
Ga.	1	3	14	-	45,887	47,236	3	3	-	-	-	1
Fla.	37	13	67	6	58,743	54,909	19	22	5	7	1	5
E.S. CENTRAL	10	12	66	3	76,328	77,072	20	22	4	1	-	-
Ky.	-	-	1	-	10,262	9,662	5	1	-	1	-	-
Tenn.	5	7	30	-	30,000	29,302	9	11	3	-	-	-
Ala.	4	4	19	3	22,433	23,091	4	7	1	-	-	-
Miss.	1	1	16	-	13,633	15,017	2	3	-	-	-	-
W.S. CENTRAL	23	45	211	1	121,809	121,568	80	34	5	66	2	27
Ark.	-	7	19	-	9,923	9,280	3	5	-	18	2	-
La.	1	8	27	-	22,660	21,575	1	-	-	-	-	-
Okla.	2	8	38	-	13,363	13,348	17	6	5	6	-	-
Tex.	20	22	127	1	75,863	77,365	59	23	-	42	-	27
MOUNTAIN	6	4	55	2	29,702	36,449	52	15	3	18	3	2
Mont.	-	3	-	-	1,251	1,331	3	-	-	-	-	-
Idaho	-	1	-	-	1,413	1,603	1	-	-	-	-	1
Wyo.	-	-	1	-	893	955	2	-	-	1	-	-
Colo.	3	-	19	1	7,960	9,771	12	4	2	2	-	-
N. Mex.	1	-	1	-	4,077	4,142	4	-	1	-	1	-
Ariz.	-	-	11	-	7,731	10,763	16	8	-	12	1	-
Utah	2	-	18	1	1,458	1,809	14	3	-	-	1	1
Nev.	-	-	5	-	4,919	6,075	-	-	-	3	-	-
PACIFIC	56	31	195	6	122,830	145,320	141	101	18	35	1	118
Wash.	1	1	13	-	10,587	12,146	12	4	1	-	1	9
Oreg.	1	-	4	-	7,350	8,578	10	4	-	1	-	1
Calif.	35	29	162	6	99,320	118,022	119	92	16	34	-	76
Alaska	-	1	10	-	3,184	3,756	-	-	-	-	-	1
Hawaii	19	-	6	-	2,389	2,818	-	1	1	-	-	31
Guam	U	-	-	1	107	111	U	U	U	U	U	1
P.R.	-	-	1	3	2,336	3,028	13	3	-	2	-	3
V.I.	-	-	-	-	228	244	-	-	-	-	-	-
Pac. Trust Terr.	U	-	-	-	388	419	U	U	U	U	U	44

N: Not notifiable U: Unavailable

TABLE III. (Cont.'d). Cases of specified notifiable diseases, United States, weeks ending December 4, 1982 and December 5, 1981 (48th 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	23	965	4	1,583	2,891	42	2,705	111	4,855	55	19	2,189	1,966
NEW ENGLAND	1	50	-	16	85	1	147	2	190	-	-	21	120
Maine	-	-	-	-	5	-	10	-	43	-	-	-	33
N.H.	-	2	-	3	8	-	18	-	18	-	-	11	51
Vt.	-	-	-	2	3	-	11	-	7	-	-	-	-
Mass.	-	28	-	5	59	-	41	1	82	-	-	4	23
R.I.	-	3	-	-	-	-	16	-	17	-	-	1	-
Conn.	1	17	-	6	10	1	51	1	23	-	-	5	13
MID. ATLANTIC	8	165	1	167	954	11	490	11	328	41	3	107	229
Upstate N.Y.	2	31	-	113	221	3	168	3	91	17	2	52	114
N.Y. City	5	66	-	43	103	-	93	-	47	-	-	35	55
N.J.	-	31	-	6	58	4	101	-	52	-	-	18	47
Pa.	1	37	1	5	572	4	128	8	138	24	1	2	13
E.N. CENTRAL	1	85	-	77	90	4	351	70	2,442	5	3	196	416
Ohio	-	13	-	1	20	2	123	62	1,699	-	2	4	3
Ind.	1	4	-	2	9	-	36	1	44	-	-	29	137
Ill.	-	36	-	24	25	2	91	1	202	3	1	73	113
Mich.	-	26	-	50	33	-	78	5	376	2	-	49	40
Wis.	-	6	-	-	3	-	23	1	121	-	-	41	123
W.N. CENTRAL	-	31	-	49	10	2	138	8	625	1	2	62	80
Minn.	-	4	-	-	3	-	32	2	456	-	1	7	8
Iowa	-	8	-	-	1	-	12	2	53	-	-	-	4
Mo.	-	10	-	2	1	1	41	-	20	1	-	38	2
N. Dak.	-	2	-	-	-	-	6	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	8	-	1	-	-	1	-
Nebr.	-	4	-	3	4	-	14	-	1	-	-	-	1
Kans.	-	3	-	44	1	1	25	4	94	-	1	16	65
S. ATLANTIC	-	127	-	168	482	9	565	8	292	4	2	95	144
Del.	-	4	-	-	-	-	1	-	12	2	-	1	1
Md.	-	20	-	4	5	1	41	2	32	-	-	34	1
D.C.	-	4	-	1	1	1	5	-	-	-	-	-	-
Va.	-	39	-	14	9	1	68	-	39	-	-	13	6
W. Va.	-	7	-	3	9	-	10	4	102	1	-	3	22
N.C.	-	8	-	1	3	2	110	-	20	-	-	2	5
S.C.	-	4	-	-	2	3	69	-	17	-	-	1	8
Ga.	-	16	-	-	111	-	109	2	24	-	-	17	39
Fla.	-	25	-	145	342	1	152	-	46	1	2	24	62
E.S. CENTRAL	1	10	-	9	6	2	162	1	64	-	-	47	40
Ky.	-	5	-	1	2	-	25	-	20	-	-	29	26
Tenn.	-	-	-	6	2	1	71	-	25	-	-	2	13
Ala.	1	2	-	2	2	1	53	1	10	-	-	-	1
Miss.	-	3	-	-	-	-	13	-	9	-	-	16	-
W.S. CENTRAL	1	65	3	173	874	5	313	2	229	1	-	120	185
Ark.	1	5	-	-	23	1	16	-	7	-	-	1	7
La.	-	5	3	14	4	-	63	-	6	-	-	1	9
Okla.	-	8	-	30	6	1	31	-	-	-	-	3	3
Tex.	-	47	-	129	841	3	203	2	216	1	-	115	166
MOUNTAIN	-	30	-	28	38	-	116	4	112	3	1	83	96
Mont.	-	1	-	-	-	-	7	1	6	-	1	6	3
Idaho	-	2	-	-	1	-	7	-	4	-	-	7	4
Wyo.	-	-	-	1	1	-	5	-	2	1	-	7	12
Colo.	-	12	-	7	11	-	48	-	18	1	-	6	30
N. Mex.	-	3	-	-	8	-	15	-	-	1	-	6	5
Ariz.	-	8	-	17	7	-	21	3	54	-	-	16	22
Utah	-	4	-	3	-	-	11	-	20	-	-	23	9
Nev.	-	-	-	-	10	-	2	-	8	-	-	12	11
PACIFIC	11	402	-	896	352	8	423	5	573	-	8	1,458	656
Wash.	-	24	-	42	3	-	49	-	79	-	1	41	93
Oreg.	1	15	-	24	5	1	76	-	-	-	-	6	53
Calif.	10	355	-	824	337	7	283	4	461	-	7	1,397	494
Alaska	-	1	-	1	-	-	11	-	12	-	-	5	1
Hawaii	-	7	-	5	7	-	4	1	21	-	-	9	15
Guam	U	1	U	6	6	U	2	U	5	U	U	2	3
P.R.	-	4	2	136	301	-	8	8	98	1	-	12	5
V.I.	-	-	-	-	24	-	-	-	3	-	-	2	1
Pac. Trust Terr.	U	-	U	1	1	U	5	U	6	U	U	-	1

U: Unavailable

TABLE III. (Cont.'d). Cases of specified notifiable diseases, United States, weeks ending December 4, 1982 and December 5, 1981 (48th 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	30,265	28,595	576	23,690	234	3	368	4	966	5,736
NEW ENGLAND	555	538	34	687	7	-	18	-	11	42
Maine	7	5	-	53	-	-	-	-	-	26
N.H.	5	16	4	30	-	-	-	-	1	1
Vt.	4	17	-	10	-	-	2	-	-	2
Mass.	373	342	25	437	7	-	14	-	6	7
R.I.	24	33	3	31	-	-	-	-	2	-
Conn.	142	125	2	126	-	-	2	-	2	6
MID. ATLANTIC	4,046	4,102	61	3,984	7	2	66	-	45	196
Upstate N.Y.	401	422	10	679	7	2	11	-	16	108
N.Y. City	2,411	2,416	20	1,528	-	-	35	-	3	-
N.J.	589	577	11	776	-	-	12	-	14	17
Pa.	645	687	20	1,001	-	-	8	-	12	71
E.N. CENTRAL	1,730	2,173	75	3,586	1	1	35	1	85	570
Ohio	291	299	11	577	-	-	12	1	77	79
Ind.	192	275	8	433	-	-	2	-	2	72
Ill.	880	1,165	36	1,569	-	-	7	-	6	292
Mich.	274	348	12	804	-	1	11	-	-	6
Wis.	93	86	8	203	1	-	3	-	-	121
W.N. CENTRAL	513	632	18	705	38	-	16	-	34	1,145
Minn.	132	183	7	133	-	-	8	-	-	196
Iowa	32	29	2	71	3	-	1	-	4	374
Mo.	275	363	8	336	25	-	4	-	13	117
N. Dak.	7	11	-	15	-	-	-	-	-	93
S. Dak.	2	2	-	30	1	-	-	-	4	101
Nebr.	14	10	-	29	4	-	2	-	2	122
Kans.	51	34	1	91	5	-	1	-	11	142
S. ATLANTIC	8,315	7,590	138	4,918	13	-	45	1	516	1,199
Del.	24	13	3	45	-	-	-	-	-	2
Md.	455	542	24	575	1	-	10	1	50	75
D.C.	459	613	2	237	-	-	-	-	-	-
Va.	567	650	37	570	5	-	4	-	73	676
W. Va.	30	27	2	142	-	-	4	-	8	48
N.C.	676	605	20	724	-	-	3	-	222	65
S.C.	527	523	13	479	6	-	3	-	106	65
Ga.	1,730	1,836	11	784	-	-	-	-	51	200
Fla.	3,847	2,781	26	1,362	1	-	21	-	6	68
E.S. CENTRAL	2,089	1,869	39	2,142	8	-	20	-	96	622
Ky.	126	98	16	566	-	-	4	-	1	125
Tenn.	595	657	7	695	6	-	4	-	59	347
Ala.	778	558	11	585	-	-	9	-	17	143
Miss.	590	556	5	296	2	-	3	-	19	7
W.S. CENTRAL	7,995	6,880	104	2,888	118	-	39	2	159	1,115
Ark.	210	151	11	338	72	-	8	-	22	152
La.	1,727	1,569	13	447	3	-	3	-	2	31
Okla.	177	165	14	316	33	-	3	-	76	188
Tex.	5,881	4,995	66	1,787	10	-	25	2	59	744
MOUNTAIN	766	707	9	656	32	-	14	-	14	270
Mont.	5	11	-	39	5	-	-	-	5	88
Idaho	25	18	1	29	1	-	-	-	4	11
Wyo.	16	17	-	6	5	-	-	-	1	21
Colo.	213	217	-	90	7	-	3	-	1	48
N. Mex.	181	125	2	110	3	-	-	-	1	23
Ariz.	207	170	4	276	-	-	8	-	-	57
Utah	21	27	2	43	11	-	2	-	-	18
Nev.	98	122	-	63	-	-	1	-	2	4
PACIFIC	4,256	4,104	98	4,124	10	-	115	-	6	577
Wash.	146	180	13	262	1	-	7	-	-	8
Oreg.	107	111	2	179	2	-	4	-	1	5
Calif.	3,883	3,731	82	3,358	6	-	100	-	5	481
Alaska	15	12	-	80	1	-	1	-	-	83
Hawaii	105	70	1	245	-	-	3	-	-	-
Guam	1	-	U	38	-	U	-	U	-	-
P.R.	724	593	2	431	-	-	3	-	-	48
V.I.	24	16	-	1	-	-	-	-	-	-
Pac. Trust Terr.	-	-	U	114	-	U	1	U	-	-

U: Unavailable

TABLE IV. Deaths in 121 U.S. cities,* week ending December 4, 1982 (48th week)

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	733	498	163	29	15	28	43
Boston, Mass.	188	115	50	7	6	10	19
Bridgeport, Conn.	43	34	5	2	-	2	2
Cambridge, Mass.	31	22	8	1	-	-	2
Fall River, Mass.	39	30	7	1	1	-	1
Hartford, Conn.	66	43	13	6	1	3	2
Lowell, Mass.	32	22	7	-	1	2	1
Lynn, Mass.	31	26	3	1	-	1	-
New Bedford, Mass.	31	26	3	-	1	1	2
New Haven, Conn.	59	38	15	1	3	2	1
Providence, R.I.	76	53	19	-	1	3	5
Somerville, Mass.	13	12	1	-	-	-	-
Springfield, Mass.	34	22	8	2	-	2	1
Waterbury, Conn.	38	21	14	3	-	-	3
Worcester, Mass.	52	34	10	5	1	2	4
MID. ATLANTIC	2,682	1,782	603	187	56	54	89
Albany, N.Y.	44	29	7	1	2	5	1
Allentown, Pa.	20	17	2	1	-	-	-
Buffalo, N.Y.	130	78	36	9	3	4	5
Camden, N.J.	49	27	11	5	1	5	2
Elizabeth, N.J.	39	34	3	1	-	1	2
Erie, Pa.†	39	29	7	1	2	-	2
Jersey City, N.J.	59	33	20	4	2	-	-
N.Y. City, N.Y.	1,521	1,002	339	123	33	24	45
Newark, N.J.	72	40	20	10	-	2	6
Paterson, N.J.	37	30	5	1	1	-	2
Philadelphia, Pa.†	156	94	43	10	5	4	5
Pittsburgh, Pa.†	100	61	30	6	1	2	3
Reading, Pa.	36	28	6	1	1	-	3
Rochester, N.Y.	124	87	25	7	1	4	7
Schenectady, N.Y.	34	27	6	-	-	1	1
Scranton, Pa.†	22	15	7	-	-	-	3
Syracuse, N.Y.	97	73	18	2	3	1	1
Trenton, N.J.	38	29	8	1	-	-	-
Utica, N.Y.	29	23	4	-	1	1	-
Yonkers, N.Y.	36	26	6	4	-	-	1
E.N. CENTRAL	2,457	1,555	553	189	71	89	72
Akron, Ohio	85	62	12	6	1	4	-
Canton, Ohio	42	30	3	4	4	1	2
Chicago, Ill	511	288	129	52	14	28	15
Cincinnati, Ohio	189	136	38	8	-	7	15
Cleveland, Ohio	168	89	48	15	5	11	3
Columbus, Ohio	89	50	23	9	2	5	1
Dayton, Ohio	143	91	35	9	2	6	2
Detroit, Mich.	274	165	59	36	10	4	7
Evansville, Ind.	61	31	19	7	4	-	-
Fort Wayne, Ind.	66	43	13	4	5	1	1
Gary, Ind.	14	10	2	1	-	1	-
Grand Rapids, Mich.	77	49	18	2	4	4	1
Indianapolis, Ind.	187	126	42	10	2	7	5
Madison, Wis.	30	22	3	4	1	-	2
Milwaukee, Wis.	184	140	32	5	5	2	7
Peoria, Ill.	30	21	7	-	1	1	3
Rockford, Ill.	66	48	12	2	3	1	3
South Bend, Ind.	68	44	16	4	3	1	2
Toledo, Ohio §	107	67	31	5	1	3	2
Youngstown, Ohio	66	43	11	6	4	2	1
W.N. CENTRAL	784	518	165	50	28	23	41
Des Moines, Iowa	67	47	13	4	2	1	10
Duluth, Minn.	22	17	3	1	1	-	1
Kansas City, Kans.	40	23	7	4	2	4	1
Kansas City, Mo.	121	72	38	4	6	1	6
Lincoln, Nebr.	36	26	5	3	2	-	1
Minneapolis, Minn.	101	62	23	7	3	6	2
Omaha, Nebr.	88	58	19	6	3	2	4
St. Louis, Mo.	169	106	38	11	7	7	7
St. Paul, Minn.	54	41	6	4	2	1	2
Wichita, Kans.	86	66	13	6	-	1	7

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
S. ATLANTIC	1,439	874	358	93	45	67	51
Atlanta, Ga.	151	97	31	11	5	7	2
Baltimore, Md.	234	136	64	18	8	8	7
Charlotte, N.C.	82	46	24	4	4	4	3
Jacksonville, Fla.	136	83	39	5	4	3	5
Miami, Fla.	164	95	44	12	4	9	3
Norfolk, Va.	49	20	15	7	5	2	3
Richmond, Va.	87	49	23	7	2	6	5
Savannah, Ga.	43	29	7	3	3	1	1
St. Petersburg, Fla.	115	95	16	1	-	3	4
Tampa, Fla.	107	68	22	3	3	11	9
Washington, D.C.	215	122	57	19	5	12	3
Wilmington, Del.	56	34	16	3	2	1	6
E.S. CENTRAL	732	480	169	41	26	16	29
Birmingham, Ala.	120	73	33	9	5	-	2
Chattanooga, Tenn.	68	48	8	7	4	1	5
Knoxville, Tenn.	51	37	6	2	4	2	3
Louisville, Ky.	136	85	36	4	5	6	4
Memphis, Tenn.	154	102	42	6	3	1	9
Mobile, Ala.	55	32	13	7	2	1	2
Montgomery, Ala.	37	25	6	1	2	3	3
Nashville, Tenn.	111	78	25	5	1	2	1
W.S. CENTRAL	1,654	949	421	134	73	76	55
Austin, Tex.	74	45	20	6	2	1	5
Baton Rouge, La.	40	23	9	4	3	1	-
Corpus Christi, Tex.	28	20	6	-	-	2	-
Dallas, Tex.	223	131	58	10	17	7	5
El Paso, Tex.	62	40	13	4	2	3	3
Fort Worth, Tex.	80	53	20	4	2	1	4
Houston, Tex.	522	263	149	59	25	26	16
Little Rock, Ark.	86	49	30	3	2	2	8
New Orleans, La.	149	83	42	12	6	6	-
San Antonio, Tex.	238	145	42	22	10	19	10
Shreveport, La.	47	31	10	3	-	3	-
Tulsa, Okla.	105	66	22	7	4	5	4
MOUNTAIN	714	439	168	55	25	27	24
Albuquerque, N.Mex.	94	55	26	6	4	3	4
Colo. Springs, Colo.	50	34	11	4	1	-	5
Denver, Colo.	130	86	26	6	7	5	4
Las Vegas, Nev.	88	40	30	9	5	4	3
Ogden, Utah	30	21	5	2	-	2	-
Phoenix, Ariz.	167	98	40	18	6	5	2
Pueblo, Colo.	28	22	3	2	-	1	-
Salt Lake City, Utah	49	35	8	1	-	5	1
Tucson, Ariz.	78	48	19	7	2	2	5
PACIFIC	1,681	1,113	370	103	46	48	100
Berkeley, Calif.	17	12	5	-	-	-	1
Fresno, Calif.	96	70	18	3	2	3	6
Glendale, Calif.	18	11	6	1	-	-	1
Honolulu, Hawaii	96	51	29	7	6	3	13
Long Beach, Calif.	78	52	13	7	1	5	2
Los Angeles, Calif.	332	214	77	22	11	7	14
Oakland, Calif.	75	50	14	6	4	1	5
Pasadena, Calif.	38	29	3	2	2	2	5
Portland, Oreg.	117	89	18	4	5	1	5
Sacramento, Calif.	73	36	25	6	2	4	3
San Diego, Calif.	176	118	43	9	3	3	11
San Francisco, Calif.	163	100	39	16	2	6	5
San Jose, Calif.	167	107	40	9	4	7	18
Seattle, Wash.	135	103	19	7	2	4	6
Spokane, Wash.	49	34	11	2	2	-	1
Tacoma, Wash.	51	37	10	2	-	2	4
TOTAL	12,876††	8,208	2,970	881	385	428	504

* 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.

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 July 1982		Estimated number of physician contacts July 1982[4]
		Number[2]	Annual Rate/100,000[3]	
ALL CAUSES (TOTAL)	10,006,060	164,690	837.6	91,599,000
Accidents and adverse effects (E800-E807, E810-E825, E826-E949)	2,684,850	8,990	45.7	5,374,000
Malignant neoplasms (140-208)	1,804,120	37,100	188.7	2,101,000
Diseases of heart (390-398, 402, 404-429)	1,636,510	61,720	313.9	5,256,000
Suicides, homicides (E950-E978)	1,401,880	4,210	21.4	—
Chronic liver disease and cirrhosis (571)	301,070	2,240	11.4	159,000
Cerebrovascular diseases (430-438)	280,430	12,860	65.4	646,000
Pneumonia and influenza[5] (480-487)	124,830	3,850	19.6	572,000
Diabetes mellitus (250)	117,340	2,670	13.6	2,597,000
Chronic obstructive pulmonary diseases and allied conditions (490-496)	110,530	4,950	25.2	900,000
Prenatal care[6]				2,137,000
Infant mortality[6]		3,300	10.0 /1,000 live births	

[1]Years 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 midpoint 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.

[2]The number of deaths is estimated by CDC by multiplying the estimated annual mortality rates (MVSR Vol. 31, No. 8, November 15, 1982, pp. 8-9) and the provisional U.S. population in that month (MVSR Vol. 31, No. 7, October 7, 1982, p.1) and dividing by the days in the month as a proportion of the days in the year.

[3]Annual mortality rates are estimated by NCHS (MVSR Vol. 31, No. 8, November 15, 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.

[4]IMS America *National Disease and Therapeutic Index* (NDTI), Monthly Report, July 1982, 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]Data for "infectious diseases and their sequelae" as a cause of death and physician visits comparable to other multiple-code categories (e.g., "malignant neoplasms") are not presently available.

[6]"Prenatal care" (NDTI) and "Infant mortality" (MVSR Vol. 31, No. 7, October 7, 1982, p.1) are included in the table because "Years of potential life lost" does not reflect deaths of children <1 year.

Acquired Immune Deficiency Syndrome — Continued

In most instances, these patients have been the first AIDS cases in their cities, states, or regions. They have had no known common medications, occupations, habits, types of pets, or any uniform antecedent history of personal or family illnesses with immunological relevance.

Although complete information is not available on brands and lot numbers for the Factor VIII concentrate used by these additional five patients during the past few years, efforts to collect and compare these data with information obtained from the earlier three cases are under way. No common lot number has been found among the lots of Factor VIII given to the five patients from whom such information is currently available.

These additional cases provide important perspectives on AIDS in U.S. hemophiliacs. Two of the patients described here are 10 years of age or less, and children with hemophilia must now be considered at risk for the disease. In addition, the number of cases continues to increase, and the illness may pose a significant risk for patients with hemophilia.

The National Hemophilia Foundation and CDC are now conducting a national survey of hemophilia treatment centers to estimate the prevalence of AIDS-associated diseases during the past 5 years and to provide active surveillance of AIDS among patients with hemophilia.

Physicians are encouraged to continue to report AIDS-suspect diseases among hemophilia patients to the CDC through local and state health departments.

Reference

1. CDC. *Pneumocystis carinii* pneumonia among persons with hemophilia A. MMWR 1982; 31:365-7.

Possible Transfusion-Associated Acquired Immune Deficiency Syndrome (AIDS) — California

CDC has received a report of a 20-month old infant from the San Francisco area who developed unexplained cellular immunodeficiency and opportunistic infection. This occurred after multiple transfusions, including a transfusion of platelets derived from the blood of a male subsequently found to have the acquired immune deficiency syndrome (AIDS).

The infant, a white male, was delivered by caesarian section on March 3, 1981. The estimated duration of pregnancy was 33 weeks; and the infant weighed 2850 g. The mother was known to have developed Rh sensitization during her first pregnancy, and amniocentesis done during this, her second, pregnancy showed the fetus had erythroblastosis fetalis. The infant had asphyxia at birth and required endotracheal intubation. Because of hyperbilirubinemia, six double-volume exchange transfusions were given over a 4-day period. During the 1-month hospitalization following birth, the infant received blood products, including whole blood, packed red blood cells, and platelets from 19 donors. All blood products were irradiated.

After discharge in April 1981, the infant appeared well, although hepatosplenomegaly was noted at age 4 months. At 7 months, he was hospitalized for treatment of severe otitis media. Oral candidiasis developed following antibiotic therapy and persisted. At 9 months of age, he developed anorexia, vomiting, and then jaundice. Transaminase levels were elevated, and serologic tests for hepatitis A and B viruses and cytomegalovirus were negative; non-A non-B hepatitis was diagnosed.

Transfusion-Associated Acquired Immune Deficiency Syndrome — Continued

At 14 months of age, the infant developed neutropenia and an autoimmune hemolytic anemia and thrombocytopenia. Immunologic studies showed elevated serum concentrations of IgG, IgA, and IgM, decreased numbers of T-lymphocytes, and impaired T-cell function in vitro. Following these studies, he was begun on systemic corticosteroid therapy for his hematologic disease. Three months later, a bone marrow sample, taken before steroid therapy began, was positive for *Mycobacterium avium-intracellulare*. Cultures of urine and gastric aspirate, taken while the infant received steroids, also grew *M. avium-intracellulare*. The infant is now receiving chemotherapy for his mycobacterial infection. He continues to have thrombocytopenia.

The parents and brother of the infant are in good health. The parents are heterosexual non-Haitians and do not have a history of intravenous drug abuse. The infant had no known personal contact with an AIDS patient.

Investigation of the blood products received by the infant during his first month of life has revealed that one of the 19 donors was subsequently reported to have AIDS. The donor, a 48-year-old white male resident of San Francisco, was in apparently good health when he donated blood on March 10, 1981. Platelets derived from this blood were given to the infant on March 11. Eight months later, the donor complained of fatigue and decreased appetite. On examination, he had right axillary lymphadenopathy, and cotton-wool spots were seen in the retina of the left eye. During the next month, December 1981, he developed fever and severe tachypnea and was hospitalized with biopsy-proven *Pneumocystis carinii* pneumonia.

Although he improved on antimicrobial therapy and was discharged after a 1-month hospitalization, immunologic studies done in March 1982 showed severe cellular immune dysfunction typical of AIDS. In April 1982, he developed fever and oral candidiasis, and began to lose weight. A second hospitalization, beginning in June 1982, was complicated by *Salmonella* sepsis, perianal herpes simplex virus infection, encephalitis of unknown etiology, and disseminated cytomegalovirus infection. He died in August 1982.

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Editorial Note: The etiology of AIDS remains unknown, but its reported occurrence among homosexual men, intravenous drug abusers, and persons with hemophilia A (*1*) suggests it may be caused by an infectious agent transmitted sexually or through exposure to blood or blood products. If the infant's illness described in this report is AIDS, its occurrence following receipt of blood products from a known AIDS case adds support to the infectious-agent hypothesis.

Several features of the infant's illness resemble those seen among adults with AIDS. Hypergammaglobulinemia with T-cell depletion and dysfunction are not typical of any of the well-characterized congenital immunodeficiency syndromes (*2*), but are similar to abnormalities described in AIDS (*3*). Disseminated *M. avium-intracellulare* infection, seen in this infant, is a reported manifestation of AIDS (*4*). Autoimmune thrombocytopenia, also seen in this infant, has been described among several homosexual men with immune dysfunction typical of AIDS (*5*). Nonetheless, since there is no definitive laboratory test for AIDS, any interpretation of this infant's illness must be made with caution.

If the platelet transfusion contained an etiologic agent for AIDS, one must assume that the agent can be present in the blood of a donor before onset of symptomatic illness and that the incubation period for such illness can be relatively long. This model for AIDS transmission is

Transfusion-Associated Acquired Immune Deficiency Syndrome — Continued

consistent with findings described in an investigation of a cluster of sexually related AIDS cases among homosexual men in southern California (*6*).

Of the 788 definite AIDS cases among adults reported thus far to CDC, 42 (5.3%) belong to no known risk group (i.e., they are not known to be homosexually active men, intravenous drug abusers, Haitians, or hemophiliacs). Two cases received blood products within 2 years of the onset of their illnesses and are currently under investigation.

This report and continuing reports of AIDS among persons with hemophilia A (*7*) raise serious questions about the possible transmission of AIDS through blood and blood products. The Assistant Secretary for Health is convening an advisory committee to address these questions.

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Update: Influenza Virus A(H3N2) Isolations — United States

Three additional states, Pennsylvania, Tennessee, and Washington, as well as upstate New York, have reported influenza virus type A(H3N2) isolations. The isolates were collected from patients who had onset of influenza from mid to late November in Pittsburgh, Pennsylvania (1 case), Nashville, Tennessee (2 cases), and Skagit County, Washington (2 cases). The isolate from upstate New York was obtained from a 16-year-old female who had visited in Ottawa, Canada, for approximately 2 days, when she had onset of influenza on November 19. She returned to her home in Rochester, New York, on November 21, and a specimen was collected for virus testing on November 22.

Isolations of H3N2 influenza virus had earlier been reported from Alaska, New York City, Oregon, and Virginia (*1*). Alaska has widespread outbreaks of influenza, and 33 isolates of influenza virus, all H3N2, have now been identified. Isolates from other locations have been associated with sporadic cases of influenza rather than outbreaks.

Reported by D Ritter, J Middaugh, MD, State Epidemiologist, Alaska Dept of Health and Social Svcs; P Wright, MD, Vanderbilt University, R Hutcheson, MD, State Epidemiologist, Tennessee State Dept of Public Health; J Sarandria, Allegheny County Health Dept, M Richards, MD, C Hayes, MD, State Epidemiologist, Pennsylvania State Dept of Health; S Mills, J Allard, PhD, State Epidemiologist, Washington State Dept of Social and Health Svcs; R Dolin, MD, R Betts, MD, C Hall, MD, Univ of Rochester, D

Influenza — Continued

Morse, MD, R Rothenberg, MD, State Epidemiologist, New York State Dept of Health; Influenza Br, Center for Infectious Diseases, CDC.

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International Notes

Outbreak of *Salmonella oranienburg* Infection — Norway

From November 1981 to September 1982, 126 bacteriologically confirmed cases of *Salmonella oranienburg* infection were reported through the national reporting system of infectious diseases. Nearly all the infections were contracted in Norway.

S. oranienburg infections are usually rare in Norway; the average number recorded from 1975 to 1980 was less than four per year. Practically all these cases were contracted abroad by children less than 1 year of age coming from east Asian countries. The current outbreak has spread throughout most parts of Norway, clustering in the southeastern, central, and southwestern sections. Only six of 18 counties reported no cases. Only a few cases were reported from the two largest cities, Oslo and Bergen.

The number of cases recorded per week and per month was fairly constant throughout the period. The age distribution shows that approximately 85% of patients were more than 25 years of age (Table 3). Approximately 1/4-1/2 of the patients reported have been hospitalized, some with septicemia.

Since June-July this year, health authorities, in cooperation with the Food Control Laboratories, have strengthened their efforts to trace the sources of the outbreak. On August 27, the Food Control Laboratory in Trøndelag succeeded in isolating *S. oranienburg* from a home-made cured meat product in a household where a female had *S. oranienburg* infection. When the different ingredients used in preparing this meat product were examined, *S. oranienburg* was isolated from a pepper box. This pepper had been bought in a nearby store belonging to a nation-wide food distribution firm. Eventually, the same laboratory succeeded in isolating *S. oranienburg* from six unopened pepper boxes and pepper bags obtained from different households with *S. oranienburg* cases and from different stores belonging to the food chain. The contaminated black pepper seems to be restricted to two different consignments imported from Brazil via the Federal Republic of Germany in April and August 1981.

TABLE 3. Age-distribution of *Salmonella oranienburg*-infected patients — Norway, January-September 1982

Age (yrs)	Number of cases	Population	Incidence/100,000
<1	4	263,512	1.5
1-4	3		
5-14	4	648,975	0.6
15-24	9	621,323	1.5
25-54	46	1,479,398	3.1
55-64	27	467,644	5.8
≥65	28	598,048	4.7
Total	121	4,078,900	3.0

Salmonella oranienburg — Continued

Other brands of pepper from other importers have been extensively examined but have failed to reveal any positive *Salmonella* isolates. Further studies are in progress to clarify how the pepper contamination could have occurred.

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The editor welcomes accounts of interesting cases, outbreaks, environmental hazards, or other public health problems of current interest to health officials. Such reports and any other matters pertaining to editorial or other textual considerations should be addressed to: ATTN: Editor, *Morbidity and Mortality Weekly Report,* Centers for Disease Control, Atlanta, Georgia 30333.

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