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MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Pertussis — Maryland, 1982

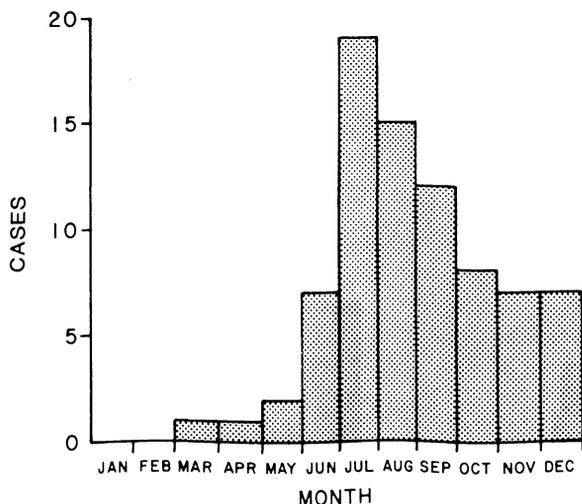
During 1982, 79 cases of pertussis were reported to the Maryland Department of Health and Mental Hygiene (1), a marked increase from the one to 18 cases reported annually during the previous 10 years. All cases were investigated. Thirty-five cases were from Baltimore city, and 44 were from 14 of the state's 23 counties. The first patient reported to have pertussis had onset in March. The number of cases peaked in July and August and decreased gradually through December (Figure 1).

Of the 79 reported cases, 32 occurred in males and 47 in females. Ages ranged from 7 weeks to 23 years. Sixty patients (76%) were less than 1 year of age (a pertussis incidence rate in Maryland of 0.22/1,000 children less than 1 year old), and forty-six (58%) were under 6 months of age (Figure 2).

Fifty-seven percent of all patients and 68% of patients less than 1 year old were hospitalized. The average duration of hospitalization was 8.6 days. Whoop was reported in 32 (41%) patients, episodes of apnea in 17 (22%), and pneumonia in 12 (15%), of whom 11 were under 1 year of age. Two (3%) of the 79 children, both infants, developed seizures; one of these (1/79) also developed an encephalopathy. No deaths occurred.

Forty-four cases (56%) were laboratory confirmed, 29 (37%) by direct fluorescent antibody (DFA) technique, four (5%) by culture, and 11 (14%) by both DFA and culture. The remaining

FIGURE 1. Pertussis cases, by month — Maryland, 1982



Pertussis — Continued

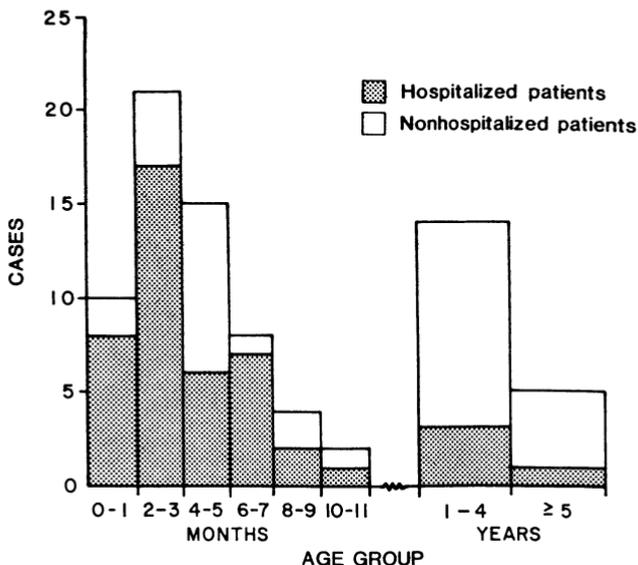
thirty-five (44%) reported cases were diagnosed on clinical grounds alone. Twenty-three (52%) of the 44 hospitalized patients had laboratory-confirmed cases. Twenty-three (32%) of the 71 patients for whom laboratory specimens were submitted received antibiotics before the specimens were obtained; only seven (30%) of these were DFA- and/or culture-positive. By contrast, of the 48 patients whose specimens were taken before antibiotic administration, 35 (73%) were DFA- and/or culture-positive ($p < 0.01$). For two patients, information on when antibiotics were begun was unavailable.

Of the 33 patients 6 months of age or older, 20 (61%) had received fewer than three doses of pertussis vaccine; these episodes may have been prevented by vaccination. Twenty-six (33%) of all patients were non-compliant with the age-recommended diphtheria-tetanus-pertussis (DTP) dosage schedule for the following reasons: illness at the time of scheduled vaccination—13 (50%), prematurity—three (12%), religious belief—three (12%), fear of vaccine effects—three (12%), and other—four (15%).

The household of each reported patient was investigated. In 72 completed household investigations, 236 household members were identified, of whom 74 (31%) were less than 10 years old. Immunization records were available for 64 (86%) of these children. Prior receipt of three or more doses of DTP vaccine was verified for 54 (84%). Four secondary cases were identified among all household contacts, one in an unimmunized child aged 4 years, two in children aged 20 months and 3 years with documentation of three or more doses of DTP, and one in an adult with an undocumented history of three doses of DTP as a child. Pertussis was laboratory-confirmed in the three secondary cases in children or in the primary case within their households. Although the numbers were small, the calculated clinical vaccine efficacy in household contacts 0-9 years of age in Maryland was 89%.

The increase in pertussis activity in 1982 was confirmed by reviews of hospital admissions and laboratory specimen submissions for 1981 and 1982. A survey of admissions for pertussis or pertussis-like syndromes to six major hospitals in the Baltimore metropolitan area revealed that, in 1981, only four children were admitted for pertussis—one with laboratory confirmation of disease. In contrast, in 1982, 25 children were hospitalized with

FIGURE 2. Age distribution and hospitalization of patients with pertussis — Maryland, 1982



Pertussis — Continued

pertussis—10 with laboratory confirmation. The Maryland State Laboratory received 161 specimens from patients with clinical pertussis for examination in 1981; three were DFA- or culture-positive. In 1982, the same laboratory, using the same procedures and personnel, received 324 specimens; 31 were DFA- or culture-positive. Many of the specimens submitted in 1982 were from contacts of patients.

While completion rates for DTP immunization were high at school entry (96%) in 1980 and 1981 in Maryland (2), completion rates in the preschool population may be considerably lower. In one comprehensive child-care clinic in Baltimore city, only 67 (69%) of the 97 infants 7.5-9.5 months of age on December 17, 1982, had received three doses of DTP vaccine.

Following a television presentation on pertussis vaccine side effects, DTP vaccine sales by one pharmaceutical company to the private medical sector in Maryland decreased 45% in April 1982, compared to average monthly sales for the preceding 3 months. Concomitantly, DT/Td* sales to the private medical sector increased 160%. Although DTP sales returned to normal during the following 2 months, DT/Td sales continued at 100% above the average of the first 3 months of 1982 through at least June 1982, the last month for which data are available. Following recognition of the increase in pertussis in Maryland, some private providers began to request pertussis single antigen vaccine from the state health department.

Reported by Local health depts, FYC Lin, MD, M Johnson, RE Longenecker, E Israel, MD, State Epidemiologist, Maryland State Dept of Health and Mental Hygiene; Div of Immunization, Center for Prevention Svcs, CDC.

Editorial Note: Despite high immunization levels of 96% for at least three doses of DTP vaccine in children entering school, Maryland experienced a marked increase in pertussis cases in 1982. Over 50% of pertussis patients were hospitalized for more than 1 week each; 18% of patients less than 1 year old developed pneumonia. Maryland's experience, as well as that of the United States from 1979 to 1981 (7), clearly indicates that pertussis remains a serious illness in young children.

Sixty-one percent of Maryland pertussis patients 6 months of age or older had not received three doses of DTP vaccine and can be considered as having had potentially vaccine-preventable cases (3). Three doses of pertussis vaccine generally provide a clinical vaccine efficacy between 63% and 94% (4-8). Furthermore, vaccine recipients who do develop disease have been shown to have decreased severity of illness, compared to that in patients who do not receive vaccine (4, 7, 9).

Age-specific immunization coverage of younger children, particularly those between 6 and 11 months of age, is not available nationwide. In Tennessee, where immunization status was obtained in 98% of a sample of 2-year old children, 91% had received three doses of DTP (10). In Hawaii, 68% of a younger cohort, aged 14 months, attending public health clinics had received three doses of DTP, which is comparable to the Baltimore clinic's experience of 69% in children 7.5-9.5 months of age (11).

Prevention measures against pertussis must stress full immunization of children at the earliest age possible. By ensuring the administration of three doses of DTP by 6 months of age, a fourth dose approximately 1 year later and a booster dose between 4 and 6 years of age, as recommended by the Immunization Practices Advisory Committee (ACIP) (3), the maximum obtainable age-appropriate, vaccine-induced protection can be ensured for children 6 months to 7 years old, thus both reducing the occurrence of pertussis in this age group and decreasing the exposure risk to pertussis organisms of infants less than 6 months of age.

Minor illnesses without fever, such as mild upper respiratory infections, should not cause postponement of vaccinations. However, scheduled DTP vaccination should be postponed for the duration of a severe febrile illness. In such instances, the health care provider should

*Diphtheria and tetanus toxoid adsorbed (for pediatric use) (DT)/tetanus and diphtheria toxoid adsorbed (for adult use) (Td).

Pertussis — Continued

reschedule the child for DTP immunization at the earliest time possible and provide followup to assure the child returns for the missed dose.

The percentage of organism recovery is highest when specimens are obtained during the initial 3 weeks of illness and before antibiotics are instituted. Present laboratory procedures for *Bordetella pertussis* confirmation consist of culture and DFA techniques. Properly obtained and processed cultures can be more sensitive than DFA results; in addition, positive culture results are highly specific. Under favorable hospital conditions in which direct plating of the specimen is done, culture confirmation has been obtained in 87% of cases (12).

References

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

Disease	23rd Week Ending			Cumulative, 23rd Week Ending		
	June 11, 1983	June 12, 1982	Median 1978-1982	June 11, 1983	June 12, 1982	Median 1978-1982
Aseptic meningitis	145	139	82	1,890	1,845	1,450
Encephalitis: Primary (arthropod-borne & unsp.)	17	17	17	366	390	282
Post-infectious	-	4	5	35	38	88
Gonorrhea: Civilian	15,944	19,939	19,561	383,617	411,233	412,210
Military	445	694	674	10,590	12,349	12,103
Hepatitis: Type A	387	359	497	9,952	9,782	11,848
Type B	428	383	357	9,730	9,117	7,227
Non A, Non B	54	55	N	1,460	988	N
Unspecified	177	165	197	3,478	3,706	4,413
Legionellosis	13	6	N	320	203	N
Leprosy	7	2	3	117	85	77
Malaria	14	36	26	293	408	408
Measles: Total	57	66	570	915	758	9,488
Indigenous	47	N	N	752	N	N
Imported*	10	N	N	163	N	N
Meningococcal infections: Total	69	80	56	1,522	1,628	1,465
Civilian	69	80	56	1,507	1,621	1,455
Military	-	-	-	15	7	10
Mumps	106	77	213	1,930	3,472	6,046
Pertussis	19	17	17	738	480	480
Rubella (German measles)	95	83	99	611	1,491	2,570
Syphilis (Primary & Secondary): Civilian	563	525	456	14,035	14,470	11,333
Military	6	2	6	206	170	144
Toxic-shock syndrome	5	N	N	187	N	N
Tuberculosis	543	602	602	9,865	11,087	11,558
Tularemia	12	11	7	89	64	64
Typhoid fever	3	10	9	148	165	191
Typhus fever, tick-borne (RMSF)	26	57	57	184	249	223
Rabies, animal	110	117	117	2,815	2,710	2,710

TABLE II. Notifiable diseases of low frequency, United States

	Cum. 1983		Cum. 1983
Anthrax	-	Plague (Ariz. 2)	7
Botulism: Foodborne	9	Poliomyelitis: Total	1
Infant (Conn. 1)	30	Paralytic	1
Other	-	Psittacosis (N.Y. City 1, Minn. 15)	53
Brucellosis (Ohio 1, Miss. 1, Tex. 1)	60	Rabies, human	2
Cholera	-	Tetanus (Md. 1, Ga. 2, Fla. 1, Ala. 1, Ark. 1)	28
Congenital rubella syndrome (Calif. 1)	10	Trichinosis	17
Diphtheria	-	Typhus fever, flea-borne (endemic, murine)	13
Leptospirosis (Mo. 1)	13		

*Ten of the 57 reported cases for this week were imported from a foreign country or can be directly traceable to a known internationally imported case within two generations.

TABLE III. Cases of specified notifiable diseases, United States, weeks ending
June 11, 1983 and June 12, 1982 (23rd week)

Reporting Area	Aseptic Mening- itis	Encephalitis		Gonorrhea (Civilian)		Hepatitis (Viral), by type				Legionel- losis	Leprosy	Malaria
		Primary	Post-in- fectious			A	B	NA,NB	Unspeci- fied			
		1983	Cum. 1983	Cum. 1983	Cum. 1983	Cum. 1982	1983	1983	1983	1983	1983	Cum. 1983
UNITED STATES	145	366	35	383,617	411,233	387	428	54	177	13	117	293
NEW ENGLAND	4	16	-	9,826	9,758	8	18	1	12	1	3	12
Maine	-	-	-	517	443	-	2	1	-	-	-	-
N.H.	-	1	-	276	340	-	-	-	-	-	2	-
Vt.	-	1	-	177	196	-	-	-	-	-	-	1
Mass.	3	8	-	4,316	4,526	4	4	-	8	1	-	4
R.I.	1	-	-	569	661	1	1	-	-	-	-	2
Conn.	-	6	-	3,971	3,592	3	11	-	4	-	1	5
MID ATLANTIC	24	50	3	49,254	49,606	72	86	4	20	3	18	42
Upstate N.Y.	4	13	-	7,166	7,852	7	17	-	1	-	-	13
N.Y. City	6	7	-	20,421	21,083	42	18	-	6	3	17	13
N.J.	4	12	-	9,536	8,884	4	20	1	9	-	-	13
Pa.	10	18	3	12,131	11,787	19	31	3	4	-	1	3
E.N. CENTRAL	13	65	8	50,961	58,652	27	33	6	11	7	4	13
Ohio	4	26	5	13,989	16,317	6	10	-	2	6	1	2
Ind.	4	8	1	6,235	6,416	7	10	3	5	-	-	-
Ill.	-	-	-	11,469	16,856	1	1	-	-	-	2	2
Mich.	5	27	-	14,539	13,706	13	12	3	4	1	1	8
Wis.	-	4	2	4,729	5,357	-	-	-	-	-	-	1
W.N. CENTRAL	1	42	4	18,025	19,128	9	18	2	5	-	3	13
Minn.	-	18	1	2,566	2,849	1	4	1	-	-	2	4
Iowa	-	18	-	2,072	2,059	-	2	-	-	-	-	2
Mo.	-	2	-	8,612	8,777	1	11	1	4	-	-	2
N. Dak.	-	-	-	172	267	-	-	-	-	-	-	1
S. Dak.	-	-	1	504	538	6	-	-	-	-	-	-
Nebr.	-	3	-	1,087	1,217	-	-	-	1	-	-	1
Kans.	1	1	2	3,012	3,421	1	1	-	-	-	1	3
S. ATLANTIC	21	61	12	99,155	106,518	34	95	9	5	-	6	41
Del.	-	-	-	1,807	1,620	1	1	-	-	-	-	-
Md.	2	11	-	12,558	13,300	2	14	4	2	-	1	6
D.C.	-	-	-	6,827	5,604	-	1	-	-	-	-	4
Va.	2	18	1	8,290	9,066	5	8	1	2	-	-	6
W. Va.	2	-	-	1,031	1,184	1	1	1	-	-	-	1
N.C.	7	16	-	14,282	16,730	1	14	-	1	-	-	1
S.C.	2	2	-	9,365	10,060	5	16	1	-	-	-	5
Ga.	-	3	-	21,469	20,509	2	15	-	-	-	1	4
Fla.	6	11	11	23,526	28,445	17	25	2	-	-	4	14
E.S. CENTRAL	7	13	-	32,354	34,736	18	17	1	-	-	-	3
Ky.	3	-	-	3,862	4,647	13	-	-	-	-	-	-
Tenn.	-	1	-	13,037	13,271	1	11	1	-	-	-	-
Ala.	3	12	-	10,076	10,670	3	3	-	-	-	-	1
Miss.	1	-	-	5,379	6,148	1	3	-	-	-	-	2
W.S. CENTRAL	41	37	1	54,897	57,103	69	43	-	74	-	13	35
Ark.	1	4	-	4,090	4,755	1	-	-	5	-	-	1
La.	1	3	-	10,249	10,008	6	6	-	5	-	1	4
Okla.	16	10	1	6,421	6,187	4	7	-	1	-	-	8
Tex.	23	20	-	34,137	36,153	58	30	-	63	-	12	22
MOUNTAIN	4	21	3	11,929	14,255	31	17	7	10	1	11	15
Mont.	-	-	-	508	597	-	-	-	2	1	-	5
Idaho	-	-	-	553	674	1	-	-	-	-	-	2
Wyo.	-	2	-	311	398	-	1	-	-	-	-	1
Colo.	2	10	-	3,337	3,792	8	1	-	2	-	2	5
N. Mex.	-	1	-	1,444	1,784	1	1	-	-	-	-	3
Ariz.	1	1	3	3,312	3,951	16	11	7	5	-	9	3
Utah	1	7	-	588	655	3	2	-	-	-	-	1
Nev.	-	-	-	1,876	2,404	2	1	-	1	-	-	-
PACIFIC	30	61	4	57,216	61,477	119	101	24	40	1	59	119
Wash.	-	4	1	4,130	5,053	7	6	5	1	-	7	2
Oreg.	-	-	1	2,903	3,405	20	4	1	3	1	1	4
Calif.	19	53	2	47,576	50,380	89	91	17	35	-	35	113
Alaska	-	-	-	1,439	1,556	2	-	-	-	-	-	-
Hawaii	11	4	-	1,168	1,083	1	-	1	1	-	16	-
Guam	U	-	-	65	62	U	U	U	U	U	-	2
P.R.	-	-	1	1,324	1,295	-	5	-	5	U	-	1
V.I.	U	-	-	113	100	U	U	U	U	U	-	-
Pac. Trust Terr.	U	-	-	-	204	U	U	U	U	U	-	-

N: Not notifiable

U: Unavailable

TABLE III. (Cont.'d). Cases of specified notifiable diseases, United States, weeks ending June 11, 1983 and June 12, 1982 (23rd week)

Reporting Area	Measles (Rubeola)					Meningo- coccal Infections	Mumps			Pertussis			Rubella		
	Indigenous		Imported*		Total		1983	Cum. 1983	Cum. 1982	1983	Cum. 1983	Cum. 1982	1983	Cum. 1983	Cum. 1982
	1983	Cum. 1983	1983	Cum. 1983	Cum. 1982										
UNITED STATES	47	752	10	163	758	1,522	106	1,930	3,472	19	738	480	95	611	1,491
NEW ENGLAND	-	2	-	8	9	75	4	76	137	3	24	29	-	8	11
Maine	-	-	-	-	-	7	1	15	32	-	3	-	-	-	-
N.H.	-	-	-	1	1	2	1	15	13	2	4	4	-	2	8
Vt.	-	-	-	-	2	3	1	9	5	-	3	1	-	3	-
Mass.	-	2	-	-	2	27	-	17	63	1	15	10	-	3	-
R.I.	-	-	-	-	-	6	-	9	12	-	2	9	-	-	1
Conn.	-	-	-	7	4	30	1	11	12	-	2	2	-	-	2
MID ATLANTIC	13	24	2	19	107	251	4	139	223	4	216	78	76	115	76
Upstate N.Y.	-	-	2†	6	79	84	3	54	45	3	65	48	1	19	37
N.Y. City	13	24	-	9	20	40	1	11	34	1	27	16	75	82	26
N.J.	-	-	-	1	4	38	-	26	32	-	11	7	-	3	13
Pa.	-	-	-	3	4	89	-	48	112	-	113	7	-	1	-
E.N. CENTRAL	27	450	-	51	43	254	75	981	1,976	1	170	144	2	82	139
Ohio	21	34	-	13	-	91	60	491	1,455	1	57	33	-	1	-
Ind.	-	325	-	-	2	29	1	23	33	-	14	11	1	15	24
Ill.	6	91	-	33	16	64	-	106	148	-	77	69	-	37	50
Mich.	-	-	-	5	25	52	14	306	265	-	11	8	1	13	42
Wis.	-	-	-	-	-	18	-	55	75	-	11	23	-	16	23
W.N. CENTRAL	-	2	-	-	31	91	4	125	384	1	51	24	-	33	51
Minn.	-	-	-	-	-	13	3	20	276	-	19	8	-	5	2
Iowa	-	-	-	-	-	10	-	35	29	-	5	3	-	-	-
Mo.	-	2	-	-	2	47	1	20	7	-	8	7	-	4	38
N. Dak.	-	-	-	-	-	2	-	-	-	-	1	-	-	-	-
S. Dak.	-	-	-	-	-	4	-	-	1	-	2	3	-	-	1
Nebr.	-	-	-	-	-	1	-	2	-	-	-	1	-	-	-
Kans.	-	-	-	-	29	14	-	48	71	1	16	2	-	24	10
S. ATLANTIC	5	149	-	23	33	326	5	119	201	6	99	53	1	67	57
Del.	-	-	-	-	-	-	-	5	6	-	-	3	-	-	1
Md.	-	-	-	4	2	36	2	23	20	-	8	2	-	1	31
D.C.	-	-	-	-	1	4	-	-	-	-	-	1	-	-	-
Va.	1	11	-	11	14	44	-	20	30	1	38	8	-	1	8
W. Va.	-	-	-	-	2	3	2	25	79	1	4	3	-	-	1
N.C.	-	-	-	-	-	65	-	4	9	-	5	8	-	6	1
S.C.	-	-	-	4	-	37	-	6	11	1	7	6	-	-	1
Ga.	-	6	-	-	-	53	1	36	9	1	24	9	-	10	4
Fla.	4	132	-	4	14	84	-	-	37	2	13	13	1	49	10
E.S. CENTRAL	-	-	-	5	5	93	1	35	28	-	6	14	-	8	37
Ky.	-	-	-	1	1	19	1	15	9	-	2	2	-	7	21
Tenn.	-	-	-	-	4	34	-	17	11	-	2	5	-	-	-
Ala.	-	-	-	4	-	26	-	-	5	-	1	-	-	1	-
Miss.	-	-	-	-	-	14	-	3	3	-	1	7	-	-	16
W.S. CENTRAL	-	34	-	8	32	9	171	4	138	132	1	76	27	3	86
Ark.	-	-	-	11	-	13	-	2	6	-	3	2	-	-	-
La.	-	-	-	8†	20	29	-	-	3	-	2	2	-	9	-
Okla.	-	1	-	-	-	20	-	-	-	-	42	3	-	-	3
Tex.	-	33	-	1	9	109	4	136	123	1	29	20	3	77	62
MOUNTAIN	-	-	-	2	5	55	1	84	57	2	69	27	2	19	53
Mont.	-	-	-	-	-	5	-	2	3	-	1	-	-	3	4
Idaho	-	-	-	-	-	5	-	5	3	-	2	2	2	7	2
Wyo.	-	-	-	-	-	1	-	-	2	-	4	1	-	1	5
Colo.	-	-	-	2	5	24	-	10	13	1	43	7	-	-	5
N. Mex.	-	-	-	-	-	5	-	-	-	-	5	4	-	-	5
Ariz.	-	-	-	-	-	9	1	58	23	-	9	12	-	4	7
Utah	-	-	-	-	-	6	-	6	11	1	5	1	-	3	16
Nev.	-	-	-	-	-	-	-	3	2	-	-	-	-	1	9
PACIFIC	2	91	-	23	516	206	8	233	334	1	27	84	11	193	1,002
Wash.	-	1	-	3	24	28	2	34	57	-	2	14	-	6	30
Oreg.	-	5	-	2	-	33	-	-	-	-	5	20	2	11	3
Calif.	2	84	-	18	488	139	5	177	265	1	20	50	9	176	962
Alaska	-	-	-	-	1	-	-	9	6	-	-	-	-	-	1
Hawaii	-	1	-	-	3	6	1	13	6	-	-	-	-	-	6
Guam	U	-	U	1	5	1	U	-	3	U	-	-	U	-	2
P.R.	-	77	-	-	65	8	7	94	39	-	7	12	-	3	4
V.I.	U	-	U	5	-	-	U	-	-	U	-	-	U	1	-
Pac. Trust Terr.	U	-	U	-	-	-	U	-	1	U	-	-	U	-	-

*For measles only, imported cases includes both out-of-state and international importations.

U: Unavailable

† International

§ Out-of-state

TABLE III. (Cont.'d). Cases of specified notifiable diseases, United States, weeks ending
June 11, 1983 and June 12, 1982 (23rd week)

Reporting Area	Syphilis (Civilian) (Primary & Secondary)		Toxic- shock Syndrome	Tuberculosis		Tula- remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1983	Cum. 1982	1983	1983	Cum. 1983	Cum. 1983	Cum. 1983	Cum. 1983	Cum. 1983
UNITED STATES	14,035	14,470	5	543	9,865	89	148	184	2,815
NEW ENGLAND	307	252	1	8	262	-	6	1	8
Maine	8	1	-	-	17	-	-	-	2
N.H.	9	2	1	1	23	-	-	-	1
Vt.	2	1	-	-	2	-	-	-	-
Mass.	190	175	-	6	137	-	6	1	2
R.I.	10	12	-	-	20	-	-	-	-
Conn.	88	61	-	1	63	-	-	-	3
MID ATLANTIC	1,764	1,977	-	74	1,778	-	29	1	83
Upstate N.Y.	89	232	-	12	292	-	4	-	34
N.Y. City	1,061	1,173	-	31	739	-	14	1	-
N.J.	360	249	-	31	373	-	9	-	1
Pa.	254	323	-	-	374	-	2	-	48
E.N. CENTRAL	651	905	1	76	1,294	1	23	16	228
Ohio	201	136	-	6	199	-	6	8	28
Ind.	71	93	-	-	91	-	1	-	17
Ill.	248	498	-	37	584	-	9	3	125
Mich.	96	128	1	27	351	1	7	3	2
Wis.	35	50	-	6	69	-	-	2	56
W.N. CENTRAL	171	279	-	11	315	26	7	11	424
Minn.	73	54	-	5	61	-	1	-	84
Iowa	5	14	-	-	27	-	-	-	109
Mo.	59	167	-	3	167	20	1	7	51
N. Dak.	1	4	-	-	3	-	-	1	33
S. Dak.	8	-	-	1	22	-	-	2	70
Nebr.	11	8	-	-	8	2	-	-	37
Kans.	14	32	-	2	27	4	5	1	40
S. ATLANTIC	3,706	3,951	1	94	1,965	13	20	63	982
Del.	17	8	-	1	15	-	-	-	1
Md.	235	224	-	13	158	5	4	6	405
D.C.	157	243	-	2	78	-	-	-	1
Va.	253	278	-	8	193	1	4	13	361
W. Va.	12	14	1	3	71	-	2	4	70
N.C.	350	278	-	11	264	6	1	17	8
S.C.	232	195	-	12	178	-	1	11	14
Ga.	702	815	-	15	392	1	1	11	105
Fla.	1,748	1,896	-	29	616	-	7	1	17
E.S. CENTRAL	966	1,003	-	52	940	7	2	11	231
Ky.	57	55	-	14	241	-	-	1	49
Tenn.	273	269	-	13	280	5	1	6	151
Ala.	390	353	-	12	239	-	-	3	31
Miss.	246	326	-	13	180	2	1	1	-
W.S. CENTRAL	3,721	3,628	-	106	1,133	37	13	77	594
Ark.	93	94	-	5	120	26	2	10	103
La.	779	783	-	16	174	2	3	-	16
Okla.	106	77	-	1	126	8	-	50	62
Tex.	2,743	2,674	-	84	713	1	8	17	413
MOUNTAIN	324	363	-	10	265	2	7	3	92
Mont.	5	3	-	-	22	-	1	1	66
Idaho	6	18	-	-	13	1	-	1	-
Wyo.	6	10	-	1	5	-	-	-	1
Colo.	76	102	-	3	25	-	1	-	-
N. Mex.	104	77	-	-	49	1	-	-	4
Ariz.	74	87	-	5	119	-	3	-	21
Utah	10	11	-	-	22	-	1	-	-
Nev.	43	55	-	1	10	-	1	-	-
PACIFIC	2,425	2,112	2	112	1,913	3	41	1	173
Wash.	71	71	-	4	97	2	2	-	1
Oreg.	47	57	1	2	83	-	-	-	-
Calif.	2,270	1,920	1	104	1,589	1	38	1	165
Alaska	7	7	-	-	25	-	-	-	7
Hawaii	30	57	-	2	119	-	1	-	-
Guam	-	1	U	U	2	-	-	-	-
P.R.	400	273	-	-	182	-	-	-	25
V.I.	8	7	U	U	1	-	-	-	-
Pac. Trust Terr.	-	-	U	U	-	-	-	-	-

U: Unavailable

TABLE IV. Deaths in 121 U.S. cities,* week ending
June 11, 1983 (23rd 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	610	430	134	15	14	17	37	S. ATLANTIC	1,227	779	278	90	39	41	56
Boston, Mass.	170	110	44	4	6	6	14	Atlanta, Ga.	145	91	32	13	8	1	5
Bridgeport, Conn.	44	32	10	-	1	1	1	Baltimore, Md.	130	80	31	7	4	1	1
Cambridge, Mass.	25	23	2	-	-	-	-	Charlotte, N.C.	48	29	13	2	1	3	1
Fall River, Mass.	18	14	4	-	-	-	-	Jacksonville, Fla.	93	47	28	9	2	7	4
Hartford, Conn.	47	31	11	2	1	2	-	Miami, Fla.	225	144	53	19	5	4	9
Lowell, Mass.	30	21	7	1	1	-	1	Norfolk, Va.	55	30	13	4	5	3	2
Lynn, Mass.	17	13	4	-	-	-	-	Richmond, Va.	86	61	18	7	-	-	-
New Bedford, Mass.	26	18	6	1	-	1	1	Savannah, Ga.	46	25	10	4	3	4	3
New Haven, Conn.	46	34	5	4	1	2	2	St. Petersburg, Fla.	74	61	8	1	-	4	6
Providence, R.I.	63	46	12	1	-	4	4	Tampa, Fla.	87	63	17	4	-	3	6
Somerville, Mass.	6	5	1	-	-	-	-	Washington, D.C.	185	120	40	15	8	2	8
Springfield, Mass.	41	25	14	2	-	-	6	Wilmington, Del.	53	28	15	5	3	2	2
Waterbury, Conn.	29	23	4	-	2	-	2	E.S. CENTRAL	688	442	165	30	26	25	42
Worcester, Mass.	48	35	10	-	2	1	4	Birmingham, Ala.	117	76	29	3	6	3	4
MID ATLANTIC	2,343	1,542	496	179	66	59	99	Chattanooga, Tenn.	59	40	10	5	1	3	3
Albany, N.Y.	54	33	14	4	1	2	1	Knoxville, Tenn.	44	31	10	1	1	1	-
Allentown, Pa.	20	15	5	-	-	-	-	Louisville, Ky.	108	76	22	3	3	4	14
Buffalo, N.Y.	133	88	28	3	8	6	11	Memphis, Tenn.	130	80	26	7	9	8	8
Camden, N.J.	47	33	8	3	2	1	1	Mobile, Ala.	66	42	17	4	3	-	2
Elizabeth, N.J.	26	19	7	-	-	-	3	Montgomery, Ala.	36	23	10	-	1	2	-
Erie, Pa.†	55	42	8	3	1	1	3	Nashville, Tenn.	128	74	41	7	2	4	11
Jersey City, N.J.	37	28	5	1	1	2	2	W.S. CENTRAL	1,293	720	339	113	71	50	57
N.Y. City, N.Y.	1,397	896	290	134	40	37	46	Austin, Tex.	48	32	8	4	4	-	3
Newark, N.J. §	65	60	-	1	2	1	6	Baton Rouge, La.	51	35	8	5	2	1	5
Paterson, N.J.	25	13	9	1	2	-	1	Corpus Christi, Tex.	46	34	7	2	-	3	-
Philadelphia, Pa. †	94	59	24	5	2	4	7	Dallas, Tex.	217	110	64	22	12	9	4
Pittsburgh, Pa. †	55	28	21	3	1	2	3	El Paso, Tex.	69	33	20	9	5	2	4
Reading, Pa.	25	18	5	2	-	-	2	Fort Worth, Tex.	74	49	16	3	3	3	6
Rochester, N.Y.	94	63	23	6	1	1	7	Houston, Tex.	260	120	78	28	26	8	6
Schenectady, N.Y.	21	16	2	3	-	-	-	Little Rock, Ark.	92	63	19	6	1	3	6
Scranton, Pa. †	24	16	8	-	-	-	-	New Orleans, La.	137	66	45	11	4	11	-
Syracuse, N.Y.	91	58	23	6	2	2	1	San Antonio, Tex.	160	92	40	13	10	5	11
Trenton, N.J.	35	25	7	1	2	-	-	Shreveport, La.	44	28	8	6	-	2	3
Utica, N.Y.	20	13	7	-	-	-	4	Tulsa, Okla.	95	58	26	4	4	3	9
Yonkers, N.Y.	25	19	2	3	1	-	1	MOUNTAIN	621	365	139	59	36	22	15
E.N. CENTRAL	2,257	1,464	538	129	68	58	78	Albuquerque, N.Mex.	75	39	21	8	5	2	2
Akron, Ohio	61	41	13	5	1	1	-	Colo. Springs, Colo.	34	27	4	2	1	-	4
Canton, Ohio	40	29	9	2	-	-	3	Denver, Colo.	114	64	24	8	10	8	2
Chicago, Ill.	536	329	155	30	13	9	13	Las Vegas, Nev.	87	29	25	22	9	2	2
Cincinnati, Ohio	184	126	48	4	5	1	20	Ogden, Utah	20	14	6	-	-	-	1
Cleveland, Ohio	146	95	36	8	3	4	-	Phoenix, Ariz.	133	91	29	6	4	3	2
Columbus, Ohio	130	80	25	13	4	8	7	Pueblo, Colo.	29	20	5	2	2	-	-
Dayton, Ohio	104	65	28	3	4	4	1	Salt Lake City, Utah	50	31	6	6	2	5	-
Detroit, Mich.	279	157	79	26	14	3	3	Tucson, Ariz.	79	50	19	5	3	2	2
Evansville, Ind.	30	24	6	-	-	-	-	PACIFIC	1,970	1,322	376	145	73	51	103
Fort Wayne, Ind.	60	44	8	3	2	3	4	Berkeley, Calif.	26	19	6	1	-	-	-
Gary, Ind.	11	7	4	-	-	-	-	Fresno, Calif.	85	61	16	4	2	2	8
Grand Rapids, Mich.	66	43	13	2	4	4	2	Glendale, Calif.	33	27	5	-	-	1	2
Indianapolis, Ind.	165	104	34	13	7	7	3	Honolulu, Hawaii	36	22	11	1	1	1	6
Madison, Wis.	40	25	12	1	2	-	4	Long Beach, Calif.	90	65	19	6	-	-	4
Milwaukee, Wis.	140	104	24	4	3	5	7	Los Angeles, Calif.	588	369	117	58	30	14	18
Peoria, Ill.	41	26	8	3	2	2	3	Oakland, Calif.	89	60	21	5	2	1	5
Rockford, Ill.	40	32	3	3	-	2	3	Pasadena, Calif.	35	25	6	2	2	-	2
South Bend, Ind.	45	32	10	2	1	-	-	Portland, Ore.	136	94	20	10	6	6	7
Toledo, Ohio	91	66	17	4	1	3	4	Sacramento, Calif.	74	46	16	4	4	3	11
Youngstown, Ohio	48	35	6	3	2	2	1	San Diego, Calif.	167	112	31	12	9	1	18
W.N. CENTRAL	775	525	156	40	18	35	43	San Francisco, Calif.	181	129	28	16	2	6	4
Des Moines, Iowa	77	45	22	5	1	4	7	San Jose, Calif.	135	90	25	7	6	7	10
Duluth, Minn.	34	25	5	-	2	2	2	Seattle, Wash.	159	115	27	10	4	3	3
Kansas City, Kans.	29	16	9	2	1	1	-	Spokane, Wash.	63	40	13	5	3	2	1
Kansas City, Mo.	108	79	22	4	1	1	5	Tacoma, Wash.	73	48	15	4	2	4	4
Lincoln, Nebr.	28	20	6	1	-	1	1	TOTAL	11,784 ^{††}	7,589	2,621	800	411	358	530
Minneapolis, Minn.	80	55	12	7	3	3	5								
Omaha, Nebr.	85	55	19	6	1	4	6								
St. Louis, Mo.	186	128	33	10	7	8	7								
St. Paul, Minn.	62	46	10	2	2	2	3								
Wichita, Kans.	86	56	18	3	-	9	7								

* 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

§ Data not available. Figures are estimates based on average of past 4 weeks.

Pertussis — Continued

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Niacin Intoxication from Pumpnickel Bagels — New York

On April 27, 1983, 14 (20%) of 69 persons attending a brunch had acute onset of rash, pruritis, and sensation of warmth. The illness was of relatively short duration, with an incubation period of approximately 30 minutes after consumption of one or more pumpnickel bagels served at the brunch. Of 25 persons who ate the bagels, 14 (56%) became ill, whereas none of the 44 persons who did not eat pumpnickel bagels became ill. The bagels had been produced at a local bagel factory from a batch of dough originally prepared on April 23.

A review of reports from the hospital emergency room serving the area revealed that an emergency-room visit was made by one person with similar symptoms on April 24 and by two other persons on April 27. All three had eaten pumpnickel bagels made from the same batch of dough.

Because the pumpnickel bagels were very light in color, the ingredients were suspected. Investigation revealed that, in an attempt to enrich the pumpnickel flour, a large quantity of niacin had been added, apparently from an improperly labeled container. Laboratory studies revealed 60 times the normal level of niacin in the pumpnickel flour. On the basis of these data, each bagel contained approximately 190 mg of niacin; the recommended dietary allowance for niacin is 6.6 mg/1000 calories or about 13 mg/day for the average adult (1). Measures have been taken to assure proper labeling of all ingredient containers in the bagel factory.

Reported by J Campana, S Redmond, MD, JL Nitzkin, MD, Monroe County Health Dept, C Reiffler, MD, Student Health Svcs, University of Rochester, K Martin, MD, Emergency Dept, The Genesee Hospital, Rochester, D Eiseman, New York State Dept of Agriculture and Markets, J Guzewich, R Rothenberg, MD, State Epidemiologist, New York State Dept of Health; Div of Field Svcs, Epidemiology Program Office, Epidemiology Br, Div of Nutrition, Center for Health Promotion and Education, CDC.

Editorial Note: Acute ingestion of excessive amounts of niacin (nicotinic acid, one of the B-complex vitamins), such as in this instance, can produce an acute syndrome of cutaneous vasodilation of the face and trunk, pruritus and sensation of heat (2). Gastrointestinal distress has also been noted. Although alarming, these symptoms usually resolve spontaneously over several hours without sequelae. Outbreaks of this syndrome have previously been reported in association with inappropriate food additive use (3) or with mislabeled food ingredient containers (4). An unusual color of the implicated food was also noted in the latter outbreak.

Excessive, chronic use of high doses of niacin, which may occur in persons taking large amounts of vitamins, has been related to the occurrence of hepatitis (5).

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Current Trends

Condyloma Acuminatum — United States, 1966-1981

From 1966 to 1981, the estimated number of consultations* for condyloma acuminata (genital and venereal warts) with office-based, private physicians in the United States increased 459%. CDC analysis of data on condylomata collected by the National Disease and Therapeutic Index (NDTI)[†] shows that the number of consultations rose from 169,000 in 1966 to 946,000 in 1981 (Figure 3). By comparison, in 1981, the number of consultations with private physicians for genital herpes was 295,000; thus, in that year genital and venerealwarts accounted for more than three times as many consultations with private physicians as genital herpes.

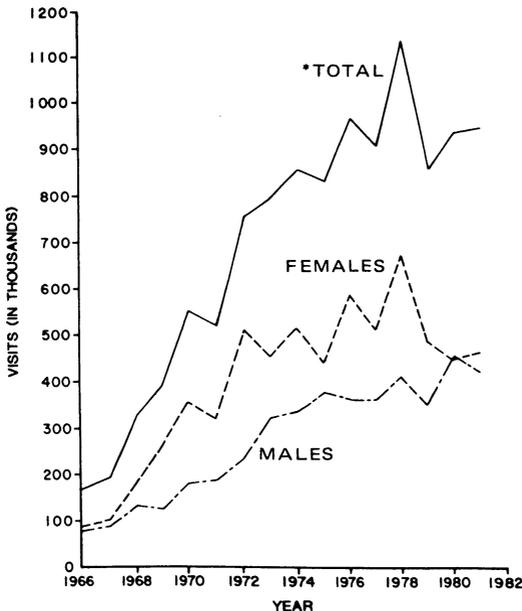
From 1966 to 1978, the number of consultations for condyloma acuminata increased 398% for males and 684% for females. Although the number of visits or calls declined slightly in 1978-1981, this may have been due in part to sampling error. For example, at the 95% confidence level, the associated relative sampling error in the NDTI survey for 900,000 consultations is 22% (range 703,000-1,096,000).

In 1978, the year when consultations for the disease peaked, 62% of all visits and calls were made by females. Except in 1980, more consultations were with females than males during all these years.

*Included are all consultations between patients and sample physicians in an office, hospital, or nursing home or in the form of a house call or telephone conversation.

[†]The NDTI survey is a national, stratified random sample of patient consultations with physicians in fee-for-service, office-based practice in the continental United States.

FIGURE 3. Number of visits to private physicians for treatment of genital warts, by year — United States, 1966-1981



* Includes visits by patients with gender not stated.

Source: National Disease Therapeutic Index, IMS, Inc. Ambler, Pa.

Condyloma Acuminata – Continued

Females and males consulted different specialists. Over half the females (54.4%) visited or called obstetrician-gynecologists. For males, the largest percentage (24.4%) of consultations was with dermatologists; general practitioners, internists, and urologists also handled a sizeable percentage (Table 1).

As with other sexually transmitted diseases (STDs), young adults comprised the group most frequently consulting physicians for genital warts. In 1981, more than 65% of such consultations were with persons aged 15-29 years. The highest risk group was the 20- to 24-year age group (33% of total), followed by the 25- to-29-year group (23%). The mode was 23 years.

Reported by Evaluation and Statistical Svcs Br, Operational Research Br, Div of Venereal Disease Control, Center for Prevention Svcs, CDC.

Editorial Note: *Condyloma acuminata* are Papillomavirus-induced soft, pink growths that appear singly or in clusters in moist areas around the genitalia and rectum. This disease is one of the most common STDs in the United States. Morbidity and complications associated with it can be severe. One study has shown a positive epidemiologic association between genital warts and cervical carcinoma (2).

Because the NDTI survey does not include visits to public health, hospital outpatient, or military medical facilities, it is impossible to estimate the total number of consultations in the United States for genital warts. The data collected do indicate, however, the relative importance of various STDs among persons visiting private practitioners.

A limited study by CDC of visits to public clinics for STDs supports the NDTI findings that visits for genital warts may surpass those for genital herpes in this country (1). For males attending public STD clinics, 4.3 cases of venereal warts were diagnosed for every 100 visits, compared with 3.4 cases of genital herpes and 24.0 cases of gonorrhea. For every 100 visits by females, 4.0 cases of venereal warts were diagnosed, compared with 2.1 cases of genital herpes and 23.5 cases of gonorrhea.

Unlike the more publicized STDs, such as gonorrhea, syphilis, genital herpes, and genital chlamydia infections, relatively little is known about the epidemiology, microbiology, and complications of genital warts. Although they tend to recur, no specific treatment is available to prevent further episodes. Small condyloma acuminata usually result in dyspareunia and rectal pain, while large condylomata can cause tenesmus and may result in transmission to neonates during childbirth. Such neonatal transmission is thought to cause childhood laryngeal papillomatosis (3). Additional studies are needed to better define the epidemiologic relationship between condyloma acuminata and genital malignancies.

The NDTI data show an increased number of consultations for condyloma acuminata during the 1970s. The rate of increase in consultations for genital warts is particularly notable

TABLE 1. Number of consultations for genital warts by physician specialty – United States, 1981

Physician specialty	Males		Females		Total	
	No.	%	No.	%	Visits*	%
General practitioners	75,210	17.9	41,350	8.9	136,010	14.4
OB/GYN	7,130	1.7	252,000	54.4	273,160	28.9
Dermatologists	102,360	24.4	52,740	11.4	167,980	17.8
General surgeons	39,340	9.4	32,600	7.0	71,940	7.6
Internists	64,020	15.3	7,340	1.6	71,360	7.5
Urologists	44,280	10.6	13,430	2.9	64,230	6.8
Other	87,070	20.8	63,760	13.8	161,590	17.1
Total	419,410		463,220		946,270	

*Includes visits by patients with gender not stated.

Condyloma Acuminata – Continued

because visits to physicians for all reasons did not increase after 1972, while visits for genital warts continued to rise until 1978. As with some other STDs, this overall increase may be partially due to changing social and demographic factors, including changes in marriage and family institutions, shift in the age pyramid as a result of the "baby-boom," increased urbanization of the American population, and changes in casual and non-marital sexual behavior (4).

Diagnostic and therapeutic practices have lowered the incidence of STDs for which laboratory tests can detect asymptomatic or incubating infection and which readily respond to therapy (e.g., syphilis and gonorrhea); however, they have had little influence on the incidence of genital warts. At present, no laboratory tests exist to detect incubating condyloma acuminata; moreover, therapy can be difficult, prolonged, and only marginally efficacious (5). These are areas in which research is needed.

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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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