## Epidemiologic Notes and Reports

## Farm-Tractor Associated Deaths - Georgia

From 1971 to 1981, a study to characterize Georgia deaths associated with farm-tractor accidents was undertaken as a basis for developing preventive recommendations. For each death certificate listing a farm-tractor accident as the cause or contributing cause of death, information was abstracted concerning the characteristics of the victim and the accident.

Two hundred two tractor-associated fatalities occurred in Georgia during the study period; $198(98 \%)$ of the victims were male; $166(82 \%)$ were white, and $30(15 \%)$ were black. Accidents occurred during all months-but predominantly in March, April, July, and August-and throughout the day, with a peak between 4 and 5 p.m. All deaths involved persons living in rural areas. Accidents occurred in 103 of Georgia's 159 counties, but were concentrated in the mountainous and hilly northern counties (Figure 1). Most accidents happened on farms; 18 occurred on roads.

The majority of deaths occurred among older men. Data from the U.S. Census and the Department of Agriculture permitted estimation of fatality rates for Georgia males. Based on figures for the subpopulation of male farm residents, the crude annual fatality rate was 23.6/100,000 (Table 1). Farming was listed as the primary occupation for 82 persons; other listings included construction, manufacturing, common laborer, military, sales, mechanic, student, and retired.

A variety of events resulted in fatal injury: 153 persons ( $76 \%$ ) were fatally injured when the tractors overturned; 28 were run over; and six drowned when their tractors fell into a stream or lake. Eighty-three percent of fatalities were attributed to crushing chest injury; other causes of death were external hemorrhage, strangulation or asphyxia, and drowning.
Reported by JD Smith, DL Rogers, RK Sikes, DVM, State Epidemiologist, Georgia Dept of Human Resources; Div of Field Svcs, Epidemiology Program Office, CDC.
Editorial Note: This study suggests that farm-tractor associated deaths are more likely to occur during the planting and harvesting seasons and during late afternoon hours, that acci-
TABLE 1. Annual fatality rate* for deaths associated with farm-tractor accidents Georgia, 1971-1981

| Age group | Number of deaths | Mortality rate* |
| :--- | :---: | :---: |
| $<20$ | 21 | 6.7 |
| $20-39$ | 32 | 22.3 |
| $40-59$ | 65 | 27.6 |
| $\geqslant 60$ | 80 | 54.1 |
| Total | 198 | 23.6 |

'Deaths/100,000 male farm residents.

Farm-Tractor Deaths - Continued
dents are more prevalent in north Georgia, and that older males are the most common victims. Although the total number of persons using tractors on farms is unknown, the higher incidence in north Georgia may result from an increased likelihood of tractors overturning on hilly terrain, and the higher fatality rates among older men may be due to physiologic impairment or other age-related factors. A preliminary review of 16 fatal farm-tractor accidents in 1982 indicates that most accidents involved tractors over 10 years old with small horsepower (20-40 hp) that were not equipped with roll-over protection structures.

The large proportion of fatalities associated with rollovers implies the need for improved measures to protect the users when tractors overturn. Such measures are commercially available and include different types of roll bars or protective cabs; however, current safety standards require the use of roll-over protection structures only in limited circumstances and do not apply to farm owners or their families. The increased risk of fatality among older men may indicate that educational efforts can be directed at specific groups. Deaths represent the most extreme consequence of tractor accidents, and a much greater number of serious and disabling injuries probably occur. Improved use of protective measures should prevent both morbidity and mortality due to farm accidents.

FIGURE 1. Farm-tractor associated deaths, by region - Georgia, 1971-1981


## Reducing Exposures to Airborne Lead in Indoor Firing Ranges - United States

Between 1980 and 1982, the National Institute for Occupational Safety and Health (NIOSH) completed nine evaluations of exposures to lead in indoor firing ranges (1). Results show that exposure of shooters to airborne lead is greatly reduced by replacing traditional lead bullets with nylon-clad, copper-jacketed, or zinc ammunition.

Investigators conducted studies in municipal, state, and federal government firing ranges in Alabama, Georgia, Missouri, Nebraska, Ohio, Vermont, and Washington, D.C. Personal breathing-zone air samples were obtained to measure lead exposure of 90 persons firing weapons during qualifying tests with .38 caliber revolvers. The samples were analyzed for lead by atomic absorption spectrophotometry (2).

When shooters were firing lead bullets, their mean lead exposure was $110 \mu \mathrm{~g} / \mathrm{m}^{3}$, calculated as an 8-hour time-weighted average (TWA). Forty-two ( $89 \%$ ) of 47 exposures exceeded the Occupational Safety and Health Administration (OSHA) standard (3) for occupational exposure to lead ( $50 \mu \mathrm{~g} / \mathrm{m}^{3}$ as an 8-hour TWA) (Table 2). When nylon-clad, zinc, and copper-jacketed bullets were being fired, the mean exposures to airborne lead were 41, 22, and $10 \mu \mathrm{~g} / \mathrm{m}^{3}$, respectively, calculated as 8 -hour TWAs. While these alternate types of ammunition were being fired, three ( $7 \%$ ) of the 43 samples studied exceeded the OSHA standard for occupational exposure to lead.
Reported by Hazard Evaluations and Technical Assistance Br, Div of Surveillance, Hazard Evaluations, and Field Studies, NIOSH, CDC.
Editorial Note: There are an estimated 16,000-18,000 indoor firing ranges in the United States (4) and an estimated 1,178,000 people employed in law enforcement (5). Hence, alternatives that reduce exposures to airborne lead in indoor firing ranges have important implications for the health and safety of these workers. Several previous studies have documented the occupational hazard of exposure to lead in indoor firing ranges, particularly among range masters and instructors ( 6,7 ). Major sources of such exposures are lead bullets (from which airborne particles are released during firing) and primers containing lead styphnate (a highly explosive compound used to initiate the combustion of gunpowder in the cartridge).

These exposures may be reduced by limiting the time a shooter or other person spends in the range and/or by improving the range's ventilation. In 1975, NIOSH developed criteria for the design and ventilation of indoor firing ranges (8). However, they are difficult to implement, particularly as "retrofits" of existing ranges, and high-efficiency ventilation is costly to install and operate. Also, while the criteria, when implemented, were sufficient to result in lead exposures below the then-current OSHA standard of $200 \mu \mathrm{~g} / \mathrm{m}^{3}$, their ability to produce levels meeting the current standard is less certain.

TABLE 2. Comparison of the concentrations of airborne lead in personal breathing zones of shooters firing various types of bullets - United States

| Bullet type | Number of <br> firing ranges | Number of <br> air samples | Mean sampling <br> time $(\mathbf{m i n})$. | Airborne lead <br> levels $\left(\boldsymbol{\mu g} / \mathbf{m}^{\mathbf{3}}\right)$ <br> Mean <br> Range | Mean 8-Hour time- <br> weighted average <br> exposure $\left(\boldsymbol{\mu g} / \mathbf{m}^{\mathbf{3}}\right)$ |  |
| :--- | :---: | :---: | :---: | :---: | :--- | :---: |
| Lead | 6 | 47 | 25 | 3,000 | ND*-33,000 | 110 |
| Nylon-clad | 2 | 10 | 29 | 740 | $400-1,200$ | 41 |
| Zinc | 4 | 22 | 36 | 150 | ND-580 | 22 |
| Copper-jacketed | 3 | 11 | 20 | 300 | ND-580 | 10 |

[^0]
## Exposures to Airborne Lead - Continued

These circumstances have prompted the search for more utilitarian control technologies. Substitution of a less toxic substance for a hazardous one has been found to be an efficient and effective primary preventive measure in occupational safety and health. Results of previous laboratory investigations showed that substituting unleaded materials for lead bullets and primers could reduce lead emissions from those sources $(9,10)$. The present study documents the efficacy of this substitution under conditions of actual use.

There are disadvantages to the use of alternate bullets that must be considered; they include the increased cost of clad or jacketed bullets (although this cost in the long run may be less than that of operating a high-efficiency ventilation system) and possible safety hazards caused by the propensity of zinc bullets to "bounce back" from the bullet traps in some ranges.

## References

1. National Institute for Occupational Safety and Health. Health hazard evaluation and technical assistance report nos.: HETA 80-000-011; HETA 80-079-753; HETA 80-072-755; HETA 81-010-890; HETA 81-019-846; HETA 81-470-1040; HETA 81-303-947; HETA 82-380-1219; and HETA 82-195-1200. Cincinnati, Ohio: National Institute for Occupational Safety and Health, 1980-1982.
(Continued on page 489)
TABLE I. Summary-cases specified notifiable diseases, United States

| Disease | 37 th Week Ending |  |  | Cumulative, 37th Week Ending |  |  |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: |
|  | $\begin{array}{\|c\|} \hline \text { September } 17, \\ 1983 \\ \hline \end{array}$ | September 18, 1982 | $\begin{gathered} \text { Median } \\ 1978-1982 \\ \hline \end{gathered}$ | $\begin{array}{\|c} \text { September } 17 \\ 1983 \\ \hline \end{array}$ | $\begin{array}{\|c} \text { September } 18 \\ 1982 \\ \hline \end{array}$ | $\begin{gathered} \text { Median } \\ 1978-1982 \end{gathered}$ |
| Aseptic meningitis | 508 | 400 | 400 | 7,070 | 5,707 | 4.819 |
| Encephalitis: Primary (arthropod-bome \& unspec.) Post-infectious | 76 3 | 80 | 67 3 | 1.070 61 | 988 | 802 |
| Gonorrhea: Civilian | 17,126 | 19,941 | 20,955 | 629,184 | 675,728 | 700,978 |
| Military | 524 | 621 | 525 | 17,165 | 19,229 | 19,590 |
| Hepatitis: Type A | 358 | 518 | 518 | 15,000 | 15,866 | 19,674 |
| Type B | 393 | 430 | 353 | 16,082 | 15,148 | 12,346 |
| Non A, Non B | 50 | 47 | N | 2,372 | 1,645 | N |
| Unspecified | 160 | 178 | 179 | 5,486 | 6,068 | 7.139 |
| Legionellosis | 9 | 20 | N | 493 | 413 | N |
| Leprosy | 5 | 4 | 2 | 177 | 148 | 133 |
| Malaria | 14 | 35 | 19 | 560 | 785 | 785 |
| Measles : Total* | 9 | 8 | 39 | 1,229 | 1,221 | 12,052 |
| Indigenous | 9 | N | N $N$ | 1.020 | N $N$ | N |
| imported | 31 | ${ }_{N}^{N}$ | ${ }^{\mathbf{N}}$ | 209 | ${ }_{2}{ }^{\text {N }}$ | ${ }^{\text {N }}$ |
| Meningococcal infections: Total | 31 31 | 45 | 30 | 2,080 | 2,257 | 1.990 |
| Civilian <br> Military | 31 | 44 1 | 30 | 2,065 15 | 2,244 13 | 1,976 14 |
| Mumps Military | 19 | 53 | 53 | 2,455 | 4,261 | 7.113 |
| Pertussis | 29 | 37 | 41 | 1,598 | 1,069 | 1,069 |
| Rubelia (German measles) | 4 | 21 | 29 | 779 | 2,002 | 3,264 |
|  | 656 | 752 | 549 | 22,730 | 23,357 | 18,719 |
| Military | 6 8 | 14 $N$ | 9 $N$ | 287 | 309 | 227 |
| Toxic-shock syndrome Tuberculosis | r 8 | N 507 | N 507 | 16,510 | ${ }_{17,836}$ | 19,100 |
| Tularemia | 3 | 6 | 6 | 233 | 177 | 153 |
| Typhoid fever | 11 | 11 | 11 | 288 | 284 | 348 |
| Typhus fever, tick-borne (RMSF) | 40 | 27 | 23 | 1.027 | 827 | 874 |
| Rabies, animal | 115 | 137 | 109 | 4,302 | 4,588 | 4,588 |

TABLE II. Notifiable diseases of low frequency, United States

|  | Cum. 1983 |  | Cum. 1983 |
| :---: | :---: | :---: | :---: |
| Anthrax |  | Plague | 34 |
| Botulism: Foodborne (Ariz. 1) | 14 | Poliomyelitis: Total | 4 |
| Infant (N.C. 1, Utah 1, Calif. 1) | 45 | Paralytic | 4 |
| Other |  | Psittacosis (Calif. 2) | 91 |
| Brucellosis (Va. 1, Fla. 1, Tex. 3) | 146 | Rabies, human | 2 |
| Cholera | 1 | Tetanus (N.C. 1) | 53 |
| Congenital rubella syndrome (Calif. 1) | 17 | Trichinosis | 26 |
| Diphtheria Leptospirosis (Mo.1) | 1 36 | Typhus fever, flea-bome (endemic, murine) | 40 |

- There were no cases of internationally imported measies reported for this week.

TABLE III. Cases of specified notifiable diseases, United States, weeks ending
September 17, 1983 and September 18, 1982 (37th week)

| Reporting Area | Aseptic Meningitis | Encephalitis |  | Gonorrhea (Civilian) |  | Hepatitis (Viral), by type |  |  |  | Legionellosis | Leprosy | Malaria |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
|  |  | Primary | Post-infectious |  |  | A | B | NA,NB | Unspecified |  |  |  |
|  | 1983 | $\begin{aligned} & \text { Cum. } \\ & 1983 \end{aligned}$ | $\begin{aligned} & \text { Cum. } \\ & 1983 \end{aligned}$ | $\begin{aligned} & \text { Cum. } \\ & 1983 \end{aligned}$ | $\begin{aligned} & \text { Cum. } \\ & 1982 \end{aligned}$ | 1983 | 1983 | 1983 | 1983 | 1983 | $\begin{aligned} & \text { Cum. } \\ & 1983 \end{aligned}$ | $\begin{aligned} & \text { Cum. } \\ & 1983 \end{aligned}$ |
| UNITED STATES | 508 | 1,070 | 61 | 629,184 | 675,728 | 358 | 393 | 50 | 160 | 9 | 177 | 560 |
| NEW ENGLAND | 13 | 43 | - | 15,978 | 16,178 | 5 | 17 | 1 | 8 | 2 | 3 | 26 |
| Maine | 2 | - | - | 798 | 822 | - | 1 | 1 | - | - |  | 1 |
| N.H. | 2 | 5 | - | 520 | 559 | 1 | - | - | - | - | 2 | - |
| V t. | - | 1 | - | 316 | 305 | 2 | 1 | - | - | - | - |  |
| Mass. | 3 | 20 | - | 6,859 | 7.275 | 1 | 8 | - | 8 | - |  | 12 |
| R.I. | - | 1 | - | 894 | 1.097 | - | 2 | - | - | 2 | - | 3 |
| Conn. | 6 | 16 | - | 6,591 | 6,120 | 1 | 5 | - | - | - | 1 | 9 |
| MID ATLANTIC | 54 | 91 | 5 | 79.813 | 83,407 | 46 | 70 | 1 | 20 | 1 | 24 | 77 |
| Upstate N.Y. | 14 | 20 | - | 12,510 | 13,635 | 1 | 16 | - | 2 | - | - | 22 |
| N. Y City | 8 | 10 | - | 32,021 | 34,245 | 18 | 4 | - | 1 | 1 | 23 | 21 |
| N.J. | - | 16 | - | 15.054 | 15,398 | 17 | 25 | 1 | 14 | - | - | 22 |
| Pa . | 32 | 45 | 5 | 20.228 | 20.129 | 10 | 25 | - | 3 | - | 1 | 12 |
| EN CENTRAL | 108 | 364 | 20 | 88,170 | 97.079 | 20 | 34 | 4 | 12 | 1 | 5 | 43 |
| Ohio | 22 | 109 | 9 | 23,531 | 26,520 | 2 | 6 | 2 | 4 | - | 1 | 6 |
| Ind | 40 | 143 | 1 | 9,170 | 11,199 | 4 | 12 | 1 | 7 | - | - | 2 |
| III. | 5 | 17 | 7 | 22,900 | 27.602 | 2 | 7 | 1 | - | 1 | 2 | 16 |
| Mich | 41 | 68 | - | 24.512 | 23,082 | 12 | 9 | - | 1 | - | 2 | 14 |
| Wis | - | 27 | 3 | 8.057 | 8,676 | - | - | - | - | - | - | 5 |
| W.N. CENTRAL | 78 | 83 | 8 | 29,375 | 31,854 | 14 | 29 | 3 | 3 | - | 6 | 21 |
| Minn. | - | 19 | 1 | 4,182 | 4,570 | 9 | 1 | 1 | - | - | 4 | 6 |
| lowa | 18 | 46 | - | 3,293 | 3.358 | - | 1 | 1 | - | - | - | 3 |
| Mo | 51 | 14 | - | 14,004 | 15,174 | 3 | 27 | 1 | 2 | - | 1 | 2 |
| N Dak | - | - | - | 310 | 420 | - | - | - | - | - | - | 2 |
| S. Dak | - | - | 2 | 778 | 870 | - | - | - | - | - | - | 1 |
| Nebr. | $\square$ | 3 | - | 1.927 | 1.944 | 1 | - | - | - | - | - | 1 |
| Kans. | 9 | 1 | 5 | 4,881 | 5,518 | 1 | - | - | 1 | - | 1 | 6 |
| S ATLANTIC | 112 | 155 | 15 | 163,733 | 177,346 | 39 | 105 | 10 | 21 | 2 | 9 | 85 |
| Del | 10 | - | - | 2,946 | 2,834 | 1 | 3 | - | - | - | - | 1 |
| Md | 10 | 18 | - | 20,873 | 22,039 | 2 | 16 | 1 | 2 | - | 1 | 14 |
| D.C | 2 | 7 | - | 11,210 | 10,174 | - | 4 | - | 1 | - | - | 13 |
| Va | 18 | 37 | 2 | 14,629 | 13,910 | 4 | 11 | 5 | 3 | - | 1 | 16 |
| W Va. | 4 | 26 | - | 1,764 | 2,008 | 2 | 2 | - | - | - | - | 1 |
| N.C. | 40 | 32 | - | 25,201 | 28,011 | 1 | 16 | - | 3 | - | - | 3 |
| S.C | 5 | 3 | - | 15,390 | 17,222 | 4 | 20 | 1 | 1 | 1 | - | 5 |
| Ga. | 8 | 6 | 1 | 32.574 | 35,192 | 3 | 7 | 1 | 1 | - | 1 | 8 |
| Fla. | 25 | 33 | 12 | 39,146 | 45,956 | 22 | 26 | 2 | 10 | 1 | 6 | 24 |
| E. S CENTRAL | 30 | 48 | 1 | 52,876 | 58,459 | 16 | 22 | 3 | 2 | 2 | - | 7 |
| Ky | 14 | 9 | - | 6,260 | 7.873 | 11 | 3 | - | 1 | - | - | - |
| Tenn | 9 | 13 | - | 21.826 | 22,957 | 2 | 8 | 1 | 1 | $\overline{-}$ | - | 5 |
| Ala | 5 | 22 | - | 16,184 | 17.345 | 3 | 9 | 2 | - | 2 | - | 5 |
| Miss. | 2 | 4 | 1 | 8,606 | 10,284 | - | 2 | - | - | - | - | 2 |
| W.S CENTRAL | 31 | 123 | 2 | 90,192 | 93.219 | 92 | 46 | 2 | 62 | - | 22 | 52 |
| Ark | 1 | 6 | - | 6,961 | 7,720 | 2 | 1 | - | 6 | - | - | 1 |
| La. | 1 | 16 | $\bar{\square}$ | 17.698 | 16,628 | 13 | 8 | $\overline{-}$ | 3 | - | 1 | 8 |
| Okla | 9 | 25 | 1 | 10,423 | 10.261 | 12 | 6 | 2 | 3 | - | - | 10 |
| Tex | 20 | 76 | 1 | 55,110 | 58,610 | 65 | 31 | - | 50 | - | 21 | 33 |
| MOUNTAIN | 23 | 46 | 4 | 20.148 | 22,833 | 41 | 11 | 5 | 7 | 1 | 12 | 23 |
| Mont. | 2 | 2 | - | 840 | 942 | 1 | 1 | - | - | - | - | , |
| Idaho | - | 1 | - | 850 | 1.111 | 3 | - | - | - | - | - | 2 |
| Wyo | - | 2 | - | 529 | 670 | 1 | 4 | 2 | 1 | - | 2 | 1 |
| Colo. | 13 | 23 | - | 5,664 | 6,144 | 5 | 4 | 2 | 1 | - | 2 | 8 |
| N. Mex | 1 | 1 | - | 2,501 | 3,011 | 2 | 1 | 2 | 1 | $\overline{-}$ | - | 5 |
| Ariz | 2 | 8 | 4 | 5.695 | 5,960 | 13 | 1 | 1 | 2 | 1 | 9 | 4 |
| Utah | 2 | 9 | - | 955 | 1.104 | 10 | 3 |  | 2 | - | 1 | 3 |
| Nev . | 5 | - | - | 3.114 | 3.891 | 6 | 1 | - | - | - | - | - |
| PACIFIC | 59 | 117 | 6 | 88,899 | 95,353 | 85 | 59 | 21 | 25 | - | 96 | 226 |
| Wash | 10 | 12 | 1 | 6,774 | 7.997 | 6 | 8 | 2 | 2 | - | 15 | 10 |
| Oreg. | $3{ }^{-}$ | $9{ }^{-}$ | 2 | 4,782 | 5,524 | 20 | 5 | 4 | - | - | 1 | 8 |
| Calif. | 36 | 98 | 3 | 73,217 | 77.586 | 58 | 45 | 15 | 23 | - | 56 | 207 |
| Alaska | 5 | 7 | - | 2,365 | 2,397 | - | 1 | - | - | - | $\stackrel{-}{-}$ | - |
| Hawaii | 8 | 7 | - | 1.761 | 1,849 | 1 | - | - | - | - | 24 | 1 |
| Guam | U | - | - | 87 | 106 | U | U | U | U | U | - | 2 |
| P.R. | 5 | - | 1 | 1,827. | 1.988 | 5 | 17 | - | 10 | - | - | 2 |
| V. 1 | - | - | - | 188 | 200 | - | - | - | - | - | - | - |
| Pac. Trust Terr. | U | - | - | - | 338 | U | U | U | U | U | - | - |

N Not notifiable

TABLE III. (Cont.'d). Cases of specified notifiable diseases, United States, weeks ending September 17, 1983 and September 18, 1982 ( 37 th week)


TABLE III. (Cont.'d). Cases of specified notifiable diseases, United States, weeks ending September 17, 1983 and September 18, 1982 (37th week)

| Reporting Area | Syphilis (Civilian) (Primary \& Secondary) |  | Toxicshock Syndrome <br> 1983 | Tuberculosis |  | Tularemia <br> Cum. <br> 1983 | Typhoid <br> Fever <br> Cum. <br> 1983 | Typhus Fever <br> (Tick-borne) <br> (RMSF) <br> Cum. <br> 1983 | Rabies, <br> Animal <br> Cum. <br> 1983 |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
|  | $\begin{aligned} & \text { Cum. } \\ & 1983 \end{aligned}$ | $\begin{aligned} & \text { Cum. } \\ & 1982 \end{aligned}$ |  | 1983 | $\begin{aligned} & \text { Cum. } \\ & 1983 \end{aligned}$ |  |  |  |  |
| UNITED STATES | 22,730 | 23,357 | 8 | 505 | 16.510 | 233 | 288 | 1,027 | 4,302 |
| NEW ENGLAND | 475 | 402 | - | 4 | 467 | 4 | 11 | 6 | 23 |
| Maine | 15 | 4 | - | - | 27 | - | - | - | 6 |
| N.H. | 17 | 4 | - | - | 30 | - | - | 1 | 2 |
| V t. | 1 | 2 | - | - | 9 | - | - |  | 1 |
| Mass. | 295 | 265 | - | - | 250 | 3 | 9 | 2 | 9 |
| R.I. | 16 | 19 | - | - | 31 | 1 | - | - | - |
| Conn. | 131 | 108 | - | 4 | 120 | - | 2 | 3 | 5 |
| MID ATLANTIC | 2.869 | 3,195 | - | 117 | 2,950 | 1 | 49 | 24 | 201 |
| Upstate N.Y. | 202 | 343 | - | 40 | 499 | 1 | 7 | 6 | 68 |
| N.Y. City | 1.725 | 1,900 | - | 28 | 1,161 | - | 16 | 1 | - |
| N.J. | 561 | 434 | - | 16 | 632 | - | 20 | 8 | 22 |
| Pa . | 381 | 518 | - | 33 | 658 | - | 6 | 9 | 111 |
| E.N. CENTRAL | 1,143 | 1,430 | - | 78 | 2,199 | 2 | 46 | 70 | 394 |
| Ohio | 316 | 222 | - | 12 | 343 | - | 12 | 43 | 51 |
| Ind. | 89 | 143 | - | 17 | 246 | - | 3 | 6 | 28 |
| III. | 509 | 782 | - | 44 | 958 | 1 | 22 | 14 | 208 |
| Mich. | 165 | 215 | - | - | 537 | 1 | 9 | 6 | 12 |
| Wis. | 64 | 68 | - | 5 | 115 | - | - | 1 | 95 |
| W.N. CENTRAL | 273 | 398 | 1 | 21 | 509 | 70 | 9 | 51 | 637 |
| Minn. | 108 | 85 | - | - | 104 | - | 2 | - | 106 |
| lowa | 15 | 22 | 1 | 5 | 46 | 5 | - | ${ }^{-}$ | 159 |
| Mo. | 102 | 235 | - | 13 | 248 | 53 | 6 | 25 | 88 |
| N. Dak. | 2 | 7 | - | - | 6 | - | - | 1 | 62 |
| S. Dak. | 11 | 1 | - | - | 32 | 4 | - | 5 | 96 |
| Nebr. | 11 | 11 | - | - | 20 | 6 | - | 3 | 58 |
| Kans. | 24 | 37 | - | 3 | 53 | 7 | 1 | 17 | 68 |
| S. ATLANTIC | 6,130 | 6,306 | - | 97 | 3,373 | 13 | 43 | 427 | 1,431 |
| Del. | 25 | 16 | - | 6 | 32 | - | - | 4 | 5 |
| Md. | 375 | 348 | - | 8 | 276 | 5 | 7 | 37 | 596 |
| D.C. | 276 | 342 | - | 5 | 135 | - | 3 | 5 | 1 |
| Va . | 419 | 431 | - | - | 345 | 1 | 10 | 57 | 507 |
| W. Va. | 19 | 21 | - | 9 | 106 | - | 2 | 11 | 101 |
| N.C. | 580 | 503 | - | 14 | 498 | 6 | 3 | 176 | 19 |
| S.C. | 391 | 373 | - | 9 | 305 | - | 1 | 73 | 22 |
| Ga. | 1.118 | 1,317 | - | 20 | 630 | 1 | 2 | 65 | 159 |
| Fla. | 2,927 | 2,955 | - | 26 | 1,046 | - | 15 | 4 | 21 |
| E.S. CENTRAL | 1,572 | 1,618 | 1 | 32 | 1.474 | 17 | 7 | 93 | 297 |
| Ky. | 103 | 86 | 1 | 8 | 362 | 1 | 3 | 19 | 68 |
| Tenn. | 435 | 444 | - | 6 | 453 | 11 | 1 | 47 | 166 |
| Ala. | 627 | 603 | - | 7 | 381 | - | 1 | 22 | 63 |
| Miss. | 407 | 485 | - | 11 | 278 | 5 | 2 | 5 | - |
| W.S. CENTRAL | 5.977 | 6,083 | 1 | 64 | 1,981 | 99 | 40 | 342 | 826 |
| Ark. | 143 | 151 | - | 4 | 227 | 61 | 2 | 36 | 136 |
| La. | 1,246 | 1,392 | - | 13 | 266 | 3 | 3 | 1 | 21 |
| Okla. | 152 | 128 | 1 | 11 | 183 | 27 | 2 | 218 | 87 |
| Tex. | 4,436 | 4,412 | - | 36 | 1,305 | 8 | 33 | 87 | 582 |
| MOUNTAIN | 474 | 578 | 1 | 13 | 438 | 22 | 10 | 12 | 180 |
| Mont. | 7 | 3 | - | - | 34 | 5 | 1 | 6 | 66 |
| Idaho | 6 | 24 | - | - | 23 | 2 | - | 2 | 10 |
| Wyo. | 10 | 15 | 1 |  | 10 | 4 | $\overline{-}$ | 2 | 11 |
| Colo. | 118 | 162 | 1 | 2 | 56 | 3 | 1 | - | 18 |
| N. Mex. | 128 | 142 | - | 1 | 86 | 3 | 1 | - | 7 |
| Ariz. | 119 | 121 | - | 7 | 181 | 1 | 5 | - | 33 |
| Utah | 18 | 16 | - | 3 | 30 | 3 | 1 | 1 | 6 |
| Nev . | 68 | 95 | - | - | 18 | 1 | 1 | 1 | 29 |
| PACIFIC | 3.817 | 3,347 | 4 | 79 | 3.119 | 5 | 73 | 2 | 313 |
| Wash. | 127 | 117 | - | 11 | 177 | 2 | 3 | - | 2 |
| Oreg. | 102 | 82 | - | 5 | 129 | 2 | 3 | - | 1 |
| Calif. | 3.527 | 3,059 | 4 | 53 | 2,597 | 1 | 65 | 2 | 295 |
| Alaska | 10 | 9 | - | - | 42 | - | - | - | 15 |
| Hawaii | 51 | 80 | - | 10 | 174 | - | 2 | - | - |
| Guam | - | 1 | U | U | 4 | - | - | - | - |
| P.R. | 648 | 500 | - | 9 | 347 | - | - | - | 40 |
| V.I. | 16 | 25 | - | - | 2 | - | - | - | - |
| Pac. Trust Terr. | - | - | U | U | - | - | - | - | - |

TABLE IV. Deaths in 121 U.S. cities,* week ending
September 17, 1983 (37th week)

| Reporting Area | All Causes, By Age (Years) |  |  |  |  |  | P\&1"• <br> Total | Reporting Area | All Causes, By Age (Years) |  |  |  |  |  | P\&1•• <br> Total |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
|  | $\begin{gathered} \text { All } \\ \text { Ages } \end{gathered}$ | $\geqslant 65$ | 45-64 | 25-44 | 1-24 | <1 |  |  | $\begin{gathered} \text { All } \\ \text { Ages } \end{gathered}$ | $\geqslant 65$ | 45-64 | 25-44 | 1-24 | <1 |  |
| NEW ENGLAND | 693 | 464 | 146 | 47 | 19 | 17 | 48 | S. ATLANTIC | 1,195 | 733 | 267 | 94 | 41 | 57 | 38 |
| Boston, Mass. | 194 | 116 | 45 | 15 | 7 | 11 | 20 | Atlanta, Ga. | 140 | 82 | 34 | 10 | 6 | 8 | 4 |
| Bridgeport, Conn. | 64 | 40 | 18 | 4 | 2 | - | 4 | Baltimore, Md. | 180 | 105 | 47 | 16 | 3 | 9 | 5 |
| Cambridge, Mass. | 20 | 17 | 2 | 1 | - | - | 5 | Charlotte, N.C. | 63 | 40 | 16 | 3 | 2 | 2 | 2 |
| Fall River, Mass. | 29 | 25 | 3 | 1 | - | - | - | Jacksonville, Fla. § | 87 | 76 | 1 | 1 | 4 | 2 | 4 |
| Hartford, Conn. | 62 | 40 | 14 | 5 | 1 | 2 | - | Miami, Fla. | 153 | 97 | 38 | 8 | 2 | 8 | 2 |
| Lowell, Mass. | 27 | 20 | 7 | - | - | - | 1 | Norfolk, Va. | 45 | 26 | 10 | 5 | 2 | 2 | 2 |
| Lynn, Mass. | 20 | 16 | 3 | 1 | - | - | 1 | Richmond, Va. | 82 | 44 | 26 | 9 | 3 | - | 7 |
| New Bedford, Mass. | s. 10 | 8 | 1 | 1 | - | - | - | Savannah, Ga. | 26 | 14 | 9 | 1 | 1 | 1 | 7 |
| New Haven, Conn. | 70 | 41 | 18 | 8 | 2 | 1 | 2 | St. Petersburg, Fla. | 99 | 82 | 7 | 6 | 3 | 1 | 5 |
| Providence, R.I. | 57 | 41 | 10 | 3 | 1 | 2 | 5 | Tampa, Fla. | 77 | 46 | 16 | 6 | 4 | 5 | 3 |
| Somerville, Mass. | 5 | 3 | 1 | 3 | 1 | - | - | Washington, D.C. | 221 | 109 | 55 | 28 | 10 | 19 | 3 |
| Springfield, Mass. | 48 | 33 | 9 | 3 | 2 | 1 | 5 | Wilmington, Del. | 22 | 12 | 8 | 1 | 1 | 19 | 3 |
| Waterbury, Conn. | 32 | 21 | 9 | 1 | 1 | - | 2 | Wilmington. Del. |  |  |  |  |  |  |  |
| Worcester, Mass. | 55 | 43 | 6 | 4 | 2 | - | 3 | E.S CENTRAL | 688 | 425 | 153 | 54 | 23 | 33 | 26 |
|  |  |  |  |  |  |  |  | Birmingham, Ala. | 94 | 54 | 22 | 7 | 4 | 7 |  |
| MID ATLANTIC Albany, N Y. | 2,445 56 | 1.649 39 | 499 | 177 | 58 | 62 | 93 | Chattanooga, Tenn. | 49 | 32 | 12 | 1 | 3 | 1 | 2 |
| Albany, N.Y. | 56 | 39 | 7 | 4 | 3 | 3 | - | Knoxville, Tenn. | 47 | 38 | 7 | 1 | 1 | - | 2 |
| Allentown, Pa. | 20 125 | 15 | 3 | 2 | 2 | 2 | 11 | Louisville, Ky. | 111 | 51 | 34 | 14 | 8 | 4 | 7 |
| Buffalo, N.Y. | 125 | 95 | 20 | 6 | 2 | 2 | 11 | Memphis, Tenn. | 180 | 110 | 36 | 17 | 6 | 11 | 5 |
| Camden, N.J. Elizabeth, N.J. | 42 | 26 | 7 | 6 | - | 3 | 1 | Mobile, Ala | 50 | 36 | 10 | 2 | 1 | 1 | 3 |
| Elizabeth, N.J. | 26 | 18 | 6 | 2 | - | - | 1 | Montgomery, Ala. | 55 | 40 | 6 | 4 | - | 5 | 2 |
| Erie, Pa.t | 42 | 30 | 8 | 3 | - | 1 | 2 | Nashville, Tenn. | 102 | 64 | 26 | 8 | - | 4 | 5 |
| Jersey City, N.J. | 5 | 36 | 11 | 6 | $3{ }^{-}$ | 2 | 1 | Nashvile, Tem. |  |  |  |  |  |  |  |
| N.Y. City, N.Y. | 1,403 | 925 | 290 | 113 | 38 | 37 | 43 | W.S CENTRAL | 1,298 | 778 | 292 | 98 | 68 | 61 | 39 |
| Newark, N.J. | 49 | 25 | 17 | 6 | - | 1 | 3 | Austin, Tex. | 55 | 43 | 6 | 3 | 2 | 1 | 1 |
| Paterson, N.J. | 26 | 18 | 6 | 5 | 2 | 5 | 1 | Baton Rouge, La | 47 | 26 | 12 | 8 | 1 | - | 3 |
| Philadelphia, Pa. $\dagger$ | 198 | 125 | 48 | 15 | 5 | 5 | 8 | Corpus Christi, Tex | 50 | 32 | 9 | 3 | 3 | 3 |  |
| Pittsburgh, Pa.t | 61 | 38 | 14 | 4 | 2 | 3 | 1 | Dallas, Tex. | 229 | 133 | 66 | 12 | 9 | 9 | 2 |
| Reading, Pa. | 33 | 25 | 2 | 5 | 1 | - | 2 | El Paso. Tex. | 61 | 33 | 17 | 3 | 5 | 2 | 2 |
| Rochester, N. Y. | 112 29 | 85 | 23 | 2 | 1 | 1 | 9 | Fort Worth, Tex | 100 | 51 | 29 | 10 | 6 | 4 | 6 |
| Schenectady, N.Y. | 29 | 22 | 6 | - | 1 | - |  | Houston, Tex. | 204 | 103 | 55 | 24 | 11 | 11 | 5 |
| Scranton, Pa. ${ }^{\text {S }}$ | 24 | 18 | 6 | - | - | - | 2 | Little Rock, Ark. | 65 | 43 | 16 | 4 | 1 | 1 | 7 |
| Syracuse, N.Y. | 67 39 | 48 | 13 | 2 | 2 | 2 | 1 | New Orleans, La. | 163 | 94 | 32 | 12 | 7 | 18 |  |
| Trenton, N.J. | 39 17 | 34 11 | 4 | 1 | 1 |  | 3 | San Antonio. Tex. | 197 | 130 | 35 | 13 | 13 | 6 | 8 |
| Yonkers, N.Y | 21 | 16 | 4 | - | 1 | 1 | 4 | Shreveport, La | 40 | 29 | 5 | - | 3 | 3 | - |
| EN. CENTRAL | 2,254 | 1,403 | 563 | 147 | 71 | 70 | 58 | MOUNTAIN | 662 | 445 | 145 | 46 | 11 | 15 | 22 |
| Akron, Ohio | 74 | 57 | 14 | - | 2 | 1 | - | Albuquerque, N. Mex | 75 | 53 | 15 | 2 | 3 | 2 |  |
| Canton, Ohio | 41 | 29 | 11 | 1 | - |  | 4 | Colo. Springs, Colo. | 34 | 24 | 6 | 2 | 1 | 1 | 6 |
| Chicago, III | 488 | 295 | 123 | 46 | 18 | 6 | 12 | Denver, Colo. | 109 | 76 | 23 | 9 | 1 | 1 | 1 |
| Cincinnati, Ohio | 135 | 92 | 36 | 3 | 1 | 3 | 10 | Las Vegas, Nev. | 93 | 47 | 28 | 17 | 1 | 1 | 2 |
| Cleveland, Ohio | 158 | 95 | 45 | 8 | 4 | 6 | 2 | Ogden, Utah | 21 | 18 | 1 | 17 | 1 | 1 |  |
| Columbus, Ohio | 135 | 74 | 34 | 11 | 6 | 10 | 2 | Phoenix, Ariz. | 153 | 110 | 32 | 6 | 2 | 3 |  |
| Dayton, Ohio | 122 | 78 | 34 | 4 | 1 | 5 | 1 | Pueblo, Colo. | 19 | 16 | 3 | - | - | . | 1 |
| Detroit, Mich. | 287 | 148 | 75 | 35 | 17 | 12 | 2 | Salt Lake City, Utah | 51 | 30 | 8 | 5 | 2 | 6 |  |
| Evansville, Ind | 43 | 32 | 11 | - | - | , | 2 | Tucson, Ariz. | 107 | 71 | 29 | 5 | 1 | 1 | 11 |
| Fort Wayne, Ind. | 65 | 41 | 18 | 2 | 2 | 2 | 3 |  |  |  |  |  |  |  |  |
| Gary, Ind. | 12 | 6 | 5 | 1 | 2 | 4 | - | PACIFIC | 2,082 | 1,388 | 418 | 145 | 61 | 69 | 118 |
| Grand Rapids. Mich. | . 66 | 45 | 12 | 3 | 2 | 4 | 1 | Berkeley, Calif. | 2,082 | 1, 12 | 2 | 2 | 61 | 69 | 118 |
| Indianapolis, Ind. | 163 | 94 | 42 | 12 | 4 | 11 | 1 | Fresno, Calif. | 78 | 45 | 16 | 6 | 4 | 7 | 5 |
| Madison, Wis. | 51 | 37 | 11 | 1 | 2 | - | 4 | Glendale, Calif. | 46 | 29 | 12 | 1 | 4 | 7 | 1 |
| Milwaukee, Wis. | 128 | 87 | 33 | 3 | 2 | 3 | 2 | Honolulu. Hawaii | 57 | 38 | 11 | 3 | 2 | 3 | 5 |
| Peoria, III. | 61 | 40 | 12 | 1 | 3 | 5 | 6 | Long Beach, Calif. | 53 | 31 | 17 | 1 | 2 | 2 | 3 |
| Rockford, III. | 45 | 31 | 9 | 2 | 1 | 2 | 2 | Los Angeles, Calif | 712 | 473 | 143 | 61 | 19 | 15 | 33 |
| South Bend, Ind. | 32 | 23 | 5 | 4 | - | - | 2 | Oakland, Calif. | 61 | 40 | 15 | 4 | 1 | 15 | 3 3 |
| Toledo, Ohio | 88 | 63 | 18 | 5 | 2 |  | 1 | Pasadena, Calif. | 38 | 30 | 1 | 3 | 1. | 4 | 3 |
| Youngstown, Ohio | 60 | 36 | 15 | 5 | 4 | - | 1 | Portland, Oreg. | 131 | 91 | 25 | 5 | 5 | 4 5 | 3 9 |
|  |  |  |  |  |  |  |  | Sacramento, Calif. | 80 | 45 | 22 | 5 | 3 | 5 | 5 |
| W.N. CENTRAL Des Moines, ${ }^{\text {lowa }}$ | 826 96 | 550 | 180 21 | 37 3 | 25 4 | 30 | 35 | San Diego, Calif. | 173 | 114 | 28 | 14 | 7 | 10 | 19 |
| Duluth, Minn. | 32 | 25 | 6 | 1 | 4 | 1 | 8 | San Francisco. Calif | 195 | 133 | 39 | 14 | 4 | 5 | 4 |
| Kansas City, Kans. | 31 | 14 | 11 |  | 4 | 2 | - | Seattle, Wash. | 179 | 109 | 39 | 12 5 | 5 | 4 | 18 |
| Kansas City, Mo. | 135 | 86 | 37 | 5 | - | 3 | 3 | Spokane, VJash. | +54 | 109 39 | 39 7 | 5 5 | 4 | 4 | 5 |
| Lincoln, Nebr. | 36 | 30 | 5 | 1 | - | - | 4 | Tacoma, Wash. | 48 | 30 | 12 | 4 | 1 | 2 |  |
| Minneapolis, Minn. | 103 | 63 | 26 | 6 | 5 | 3 | 2 |  | 48 | 30 | 12 | 4 |  | 2 |  |
| Omaha, Nebr. | 89 172 | 64 112 | 18 | 2 | 2 | 3 | 4 | TOTAL | $12,143^{\text {tt }}$ | 7,835 | 2.663 | 845 | 377 | 414 | 477 |
| St. Louis, Mo. | 172 | 112 | 36 | 10 | 6 | 8 | 4 |  |  |  |  |  |  |  | 47 |
| St. Paul, Minn. | 58 | 44 | 6 | 5 | - | 3 | 2 |  |  |  |  |  |  |  |  |
| Wichita, Kans. | 74 | 45 | 14 | 4 | 4 | 7 | 8 |  |  |  |  |  |  |  |  |

[^1]
## Exposures to Airborne Lead - Continued

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## Patient-Source Scabies among Hospital Personnel - Pennsylvania

In early January 1982, a 60-year-old woman with severe diabetes mellitus and multiple end-organ complications was admitted to a Pennsylvania hospital with bacterial sepsis and shock; she had previously been a custodial nursing home patient. The patient died 5 days after admission. During her hospitalization, she was comatose and required total nursing care, including repeated physical contact by the floor nursing and support staffs. On admission, the patient had an excoriated, crusted rash covering her entire body that had been present for many weeks; retrospectively, it was believed to be crusted or Norweigan scabies. No other patients requiring extensive care contact had dermatologic problems on this unit during the same period.

Approximately 3 weeks after the patient's death, unit staff members began to report to the employee-health service with itching and red, scaly, skin lesions primarily on the anterior trunk and volar side of the arms. Epidemiologic investigation revealed that all the ill individuals had had frequent, close contact with the deceased. Staff members at risk of physical contact were identified, and on examination, 10 had skin rashes clinically compatable with scabies. Some of these individuals had already been treated with a scabicide by their private physicians. All had onset of rash about 2 weeks after the death of the index patient; the remaining 20 at-risk individuals without rash had considerably fewer intense physical contacts with her. There were no cleaning or food service personnel or orderlies, transporters, or other nonnursing-care staff in either the skin-rash or at-risk groups.

All individuals with rash were examined. Four had been previously treated, and their lesions were resolving. Five had lesions suitable for scrapings to detect mites; three of these had positive scrapings.

All 10 individuals were treated with lindane lotion and noted prompt relief of symptoms and resolution of rash. Surveillance over the next 8 weeks identified one possibly late primary case with the same clinical features as the original 10 and one suspected secondary case

Scabies - Continued
with hand-dominant localization. Both patients were treated by private physicians, with immediate symptom resolution.

After a year of total follow-up, no additional cases were reported.
Reported by SJ Pancoast, MD, JJ Kishel, Mercy Hospital, Scranton, Pennsylvania; Div of Vector-Borne Viral Diseases, Center for Infectious Diseases, CDC.
Editorial Note: Each patient in this outbreak had a rash distribution that included mainly the anterior trunk, upper legs, and volar arms. Classic hand involvement was conspicuously absent. The predominance of trunk and arm distribution reflects the mode of probable acquisition (body contact acquired by lifting and positioning the index patient). All affected staff members had repeated, close body contact without protective outerwear, frequently with bare arms and forearms. The lack of hand involvement can be partly attributed to frequent post-patient handwashing.

In many custodial, close-confinement situations with disabled patients, scabies is an endemic problem. When skin-rash outbreaks are reported among hospital personnel, even with an atypical distribution of skin lesions as in this case, scabies should be considered. The usual mode of transmission in such instances may be predominantly body-to-body contact.

All persons admitted to patient-care institutions should be examined for skin lesions. Those positive for scabies should be managed as having an infectious disease and isolated until cured to prevent spread among staff and other patients. This includes the use of gloves and, if indicated, gowns, while actually in contact with suspected or positive cases.

## International Notes

## Post-Smallpox Eradication Surveillance

In conformity with the 1980 recommendations of the Thirty-third World Health Assembly for post-smallpox eradication surveillance, the World Health Organization (WHO) is continuing to coordinate and participate in the investigation of suspected smallpox cases throughout the world.

Since January 1979, 143 reports of suspected smallpox have been received from 58 countries - 15 of them during the last 12 months. These reports were investigated by national health authorities or joint national/WHO teams, and when required, specimens were collected and tested by a WHO collaborating center for laboratory confirmation of diagnosis. Results of the investigation of 142 reports (one is still under investigation) showed that none was smallpox; they were actually misdiagnosed cases of chickenpox, measles, or diseases other than smallpox. These results further augment confidence in the absence of smallpox worldwide.

## NIGERIA

The results of investigation of an outbreak of fever and rash disease reported by the press as smallpox are presented below. This is one example of a smallpox report that received international attention and was clarified through the joint efforts of WHO and the government concerned.

On November 19, 1982, a Nigerian newspaper published an article describing an outbreak of suspected smallpox with more than 17 cases that occurred in Onitsha prison in Anambra

Post-Smallpox Eradication - Continued
State. On November 23, the National WHO Program Coordinator in Lagos, Nigeria, brought this report to the attention of the national health authorities. By the middle of December 1982, the outbreak had already been investigated by a medical officer in Onitsha and a diagnosis of chickenpox made.

Meanwhile, the outbreak continued, and the report received international attention. In December, WHO was asked by scientists from the Federal Republic of Germany and the United States to clarify this report. At the request of the Smallpox Eradication Unit, WHO, the national health authorities further investigated the outbreak and collected specimens that were dispatched for testing at a WHO collaborating laboratory. The results of these investigations follow:

During January 23-26, 1983, a team from the Federal Epidemiological Division of the Ministry of Health headed by the Principal Health Superintendent with the participation of medical personnel of the Onitsha local government area visited the prison to investigate the outbreak, and confirmed the diagnosis of chickenpox.

The first cases occurred at the beginning of November, and by November 19, they totaled 20. From the outset, the outbreak was monitored by the Medical Officer of Health responsible for the Onitsha local government area. By November 30, there were 79 cases, and by December 14, 120 cases of chickenpox had been recorded. When the team from the Federal Epidemiological Division arrived at the end of January to carry out the investigation, the outbreak was still continuing, and four cases in the acute stage of the disease were noted.

Results of clinical examination showed that the distribution of rash, the stage of its development, the absence of lesions on the palms and soles, and other signs conformed with a diagnosis of chickenpox. Nevertheless, skin lesion specimens were taken from two of the patients, and some convalescent serum specimens were also collected from other persons. All these specimens were promptly sent to the WHO Collaborating Center for Poxvirus Diagnosis and Research at the Centers for Disease Control (CDC), Atlanta, Georgia, and the laboratory results were made available within a few days. The laboratory examination revealed herpes varicella particles in skin lesion specimens, thus confirming the clinical diagnosis of chickenpox. The results of the investigation were communicated to those persons in the Federal Republic of Germany and the United States who had requested WHO to clarify this report.
INDIA
At the beginning of June 1983, a daily newspaper in Patna (Bihar, India) published a photograph of a young girl with facial skin lesions. The case was diagnosed as chickenpox by local physicians. However, the newspaper caption read, "Smallpox, the dreaded disease, which was supposedly eradicated from Asia, has struck again in Patna." The photograph and comments were later reprinted in newspapers in other Indian States, as well as abroad. The report created concern, and WHO was asked by the members of the media whether or not the report was correct.

The Union Ministry of Health (New Delhi) sent officials with smallpox experience from the National Institute of Communicable Disease (New Delhi) to carry out an independent "on-the-spot" investigation. The patient, a 12-year-old girl, was located and examined. She had a scar indicating a successful vaccination against smallpox. Clinical and epidemiologic examination confirmed the diagnosis of chickenpox. Further skin samples were collected and sent to the National Smallpox Reference Laboratory, Delhi, and to the WHO Collaborating Center at CDC. No viruses belonging to the orthopoxvirus group were identified by these laboratory examinations.
Reported by WHO Weekly Epidemiological Record, 1983:58;226-7.

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The data in this report are provisional, based on weekly reports 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 of interesting cases, outbreaks, environmental hazards, or other public health problems of current interest to health officials. Such reports and any other mat ters pertaining to editorial or other textual considerations should be addressed to: ATTN: Editor, Monidity and Mortality Weekly Report, Centers for Disease Control, Atlanta, Georgia 30333.

| Director, Centers for Disease Control | Editor |  |
| :---: | :---: | :---: |
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[^0]:    *None detected (below sampling and analytical limit of detection)

[^1]:    - 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
    $\dagger$ 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.
    $\dagger$ Total includes unknown ages.
    § Data not available. Figures are estimates based on average of past 4 weeks.

