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Perspectives in Disease Prevention and Health Promotion

Smoking and Cardiovascular Disease

The U.S. Department of Health and Human Services' (DHHS) 1983 report on the health consequences of smoking reviews the evidence associating smoking with coronary heart disease (CHD) and other forms of cardiovascular disease (CVD). It concludes that cigarette smoking is a major cause of CHD for both men and women and should be considered the most important of the known modifiable risk factors for CHD (*1*).

The report estimates that up to 30% of deaths from CHD can be attributed to cigarette smoking; approximately the same percentage of cancer deaths have been attributed to smoking. However, because there are more CHD deaths in the United States than cancer deaths (565,000, compared with 416,000 in 1980), estimates of cigarette smoking-related CHD deaths (170,000) are higher than estimates of cigarette smoking-related cancer deaths (125,000).

Atherosclerosis, the main underlying process of CVD, is characterized by the accumulation of lipid in the intima of large elastic arteries (aorta) and medium-sized muscular arteries (coronary, femoral, carotid, and others). Autopsy studies have demonstrated a significant positive relationship between smoking and atherosclerosis. The evidence is most striking for atherosclerosis of the aorta, but a significant positive relationship exists with lesions of the coronary arteries.

Coronary Heart Disease

Prospective mortality studies involving over 20 million person years of observation reveal that smokers have a 70% greater CHD death rate than nonsmokers. Heavy smokers (those who smoke two or more packs per day) have an almost 200% greater CHD mortality rate than nonsmokers.

Cigarette smoking increases the risk of developing CHD, and this effect is independent of the other major risk factors for CHD. However, smoking interacts with the other major risk factors (elevated serum cholesterol and hypertension) to substantially increase the CHD risk beyond the sum of the independent components (Figure 1). Each factor contributes about the same order of magnitude of risk for CHD. When one factor is present, the risk approximately doubles; with two factors, the risk is fourfold greater; and when all three are present, the CHD risk is eightfold greater than when none of the three factors are present.

Cigarette smokers experience a twofold to fourfold greater risk for sudden cardiac death than do nonsmokers. This risk is dose-related when measured by the number of cigarettes smoked per day.

A synergistic relationship between oral contraceptive use and cigarette smoking exists for myocardial infarction. Women who use both have a 10-times higher risk than women who use neither.

Smoking and Cardiovascular Disease — Continued

A substantial benefit of smoking cessation in reducing the risk of CHD can be detected within a few years of cessation. Ten years after cessation, the CHD risk of an ex-smoker approaches that of a person who has never smoked.

Cerebrovascular Disease

An association between smoking and cerebrovascular disease has been found in numerous prospective mortality studies. This relationship is stronger in younger age groups. The increased risk of cerebrovascular disease from smoking appears to decrease rapidly after cessation.

The combination of smoking and oral contraceptives is associated with marked increase of risk in women for one particular type of cerebrovascular disease—subarachnoid hemorrhage.

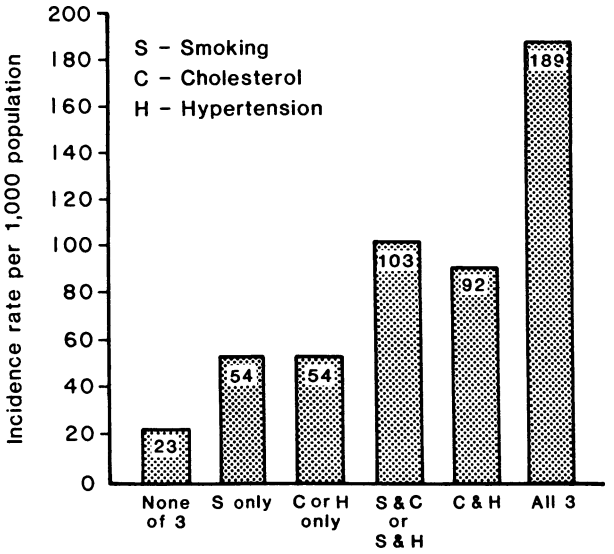
Other Forms of Vascular Disease

Smoking is the major modifiable risk factor for atherosclerotic peripheral vascular disease. Smoking cessation is important in the clinical management of patients with peripheral vascular disease, as it is with other forms of CVD. Mortality due to rupture of abdominal aortic aneurysms is more common among smokers than among nonsmokers.

Intervention Studies

The 1983 DHHS report notes that one of the elements supporting the judgment of causality in the smoking-CHD relationship is the effect of smoking cessation: smokers reduce their excess risks when they stop smoking. The report describes numerous intervention programs and trials in this country and abroad, concluding that the effectiveness of the interventions increases when multiple methods such as individual counseling, group sessions, and media campaigns are appropriately combined with proper reinforcement and follow-up.

FIGURE 1. Interaction of major risk factors* on incidence of first major coronary event†



*Hypercholesterolemia (C)—≥ 250 mg/dh; elevated blood pressure (H)—diastolic pressure ≥ 90 mm Hg; cigarette smoking (S)—any current use of cigarettes at entry.

†A nonfatal or fatal myocardial infarction or sudden death from CHD.

Source: National Pooling Project Study

Smoking and Cardiovascular Disease – Continued

Reported by the Office on Smoking and Health, Public Health Svc; Behavioral Epidemiology and Evaluation Br, Div of Health Education, Center for Health Promotion and Education, CDC.

Editorial Note: The DHHS report on smoking and cardiovascular disease (*1*) summarizes evidence on the association of smoking and several forms of CVD, especially the well-established relationship between smoking and CHD. The report adds additional support to the statement in the 1979 Surgeon General's Report on Health Promotion and Disease Prevention that "Cigarette smoking is clearly the largest single preventable cause of illness and premature death in the United States" (*2*).

Progress has been made in reducing the proportion of adults who regularly smoke in the United States from 43% in 1966 to 33% in 1980. Risk-factor prevalence surveys in 1982 indicate a range of 23%-37% among participating states (*3-5*).

It has been estimated that, from 1964 to 1978, more than 200,000 premature, smoking-related deaths were avoided because persons had either not started smoking or had given up smoking cigarettes (*6*). Nevertheless, with over 300,000 premature, smoking-related deaths every year, additional efforts to prevent cigarette smoking and to promote smoking cessation are essential.

References

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Recommendations of the Immunization Practices Advisory Committee (ACIP)

Yellow Fever Vaccine

*These revised Immunization Practices Advisory Committee (ACIP) recommendations on yellow fever vaccine update the previous recommendations (*MMWR *1978:27:268-70). Changes have been made to clarify (1) the risks of acquiring yellow fever associated with travel to endemic areas; (2) the precautions necessary for immunization of special groups (infants, pregnant women); (3) procedures for immunization of persons with histories of possible egg allergy; and (4) simultaneous administration of other vaccines.*

INTRODUCTION

Yellow fever presently occurs only in Africa and South America. Two forms of yellow fever—urban and jungle—are epidemiologically distinguishable. Clinically and etiologically, they are identical (*1,2*).

Urban yellow fever is an epidemic viral disease of humans transmitted from infected to susceptible persons by a vector, the *Aedes aegypti* mosquito. In areas where *Ae. aegypti* has been eliminated or suppressed, urban yellow fever has disappeared; eradication of *Ae. aegypti* in a number of countries, notably Panama, Brazil, Ecuador, Peru, Bolivia, Paraguay,

Yellow Fever Vaccine — Continued

Uruguay, and Argentina, achieved in the early 1900s, led to the disappearance of urban yellow fever. The last *Ae. aegypti*-borne yellow fever epidemic occurred in Trinidad in 1954. However, periodic reinfestations of some countries have occurred in recent years, and other countries remain infested, including areas of Venezuela, Colombia, and Guiana, which border on the enzootic zone for jungle yellow fever. In West Africa, *Ae. aegypti*-transmitted epidemics continue to occur at frequent intervals and involve human populations in both towns and rural villages (*3*).

Jungle yellow fever is an enzootic viral disease transmitted among nonhuman primate hosts by a variety of mosquito vectors. It is currently observed only in forest-savannah zones of tropical Africa and in forested areas of South America, but occasionally extends into parts of Central America and the island of Trinidad. In South America, approximately 200-400 cases are recognized annually, mainly among persons with occupational exposures in forested areas; the disease is, however, believed to be greatly underreported. In Africa, epidemics involving forest mosquito vectors affect tens of thousands of persons at intervals of a few years, but few cases are officially reported. The disease may sometimes not be detected in an area for some years and then reappear. Delineation of affected areas depends on surveillance of animal reservoirs and vectors, accurate diagnosis, and prompt reporting of all cases. The jungle yellow fever cycle may be active but unrecognized in forested areas of countries within the yellow fever endemic zone (Figure 2).

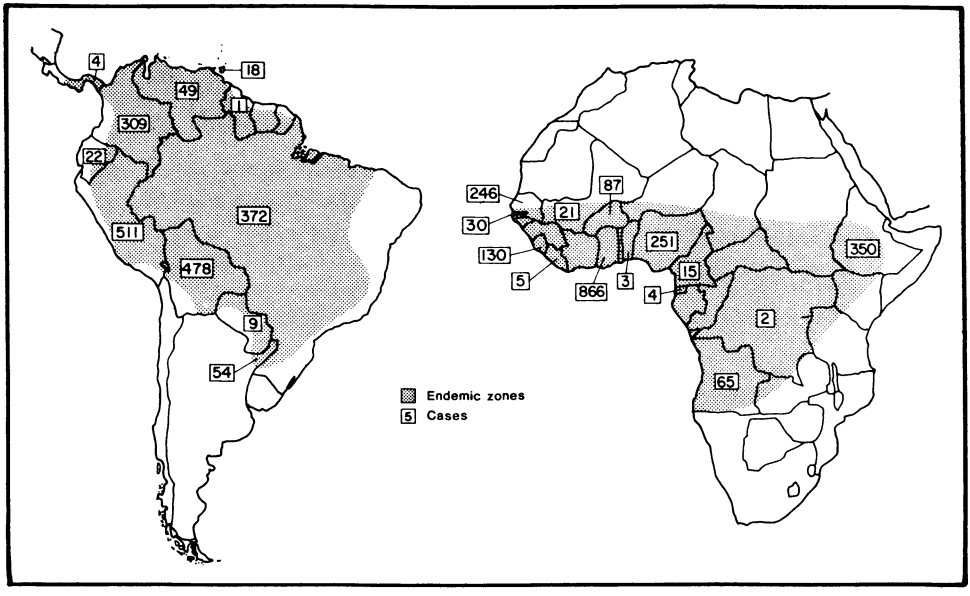
Urban yellow fever can be prevented by eradicating *Ae. aegypti* mosquitoes or by suppressing their numbers to the point that they no longer perpetuate infection. At the present time, jungle yellow fever can most effectively be prevented in humans by immunization.

YELLOW FEVER VACCINE

Yellow fever vaccine* is a live, attenuated virus preparation made from the 17D yellow fever virus strain (*4*). The 17D vaccine has proven to be extremely safe and effective (*5*). The

*Official name: Yellow Fever Vaccine.

FIGURE 2. Yellow fever endemic zones in Americas and Africa and number of yellow fever cases reported to World Health Organization, 1965-1980



Yellow Fever Vaccine – Continued

17D strain is grown in chick embryo inoculated with a seed virus of a fixed-passage level. The vaccine is freeze-dried supernate of centrifuged embryo homogenate, packaged in one-dose and five-dose vials for domestic use.

Vaccine should be stored at temperatures between 5 C (41 F) and -30 C (-22 F)—preferably frozen, below 0 C (32 F)—until it is reconsitituted by the addition of diluent sterile, physiologic saline supplied by the manufacturer. Multiple dose vials of reconstituted vaccine should be held at 5 C-10 C (41 F-50 F); unused vaccine should be discarded within 1 hour after reconstitution.

VACCINE USAGE

A. Persons living or traveling in endemic areas:

1. Persons 6 months of age or older traveling or living in areas where yellow fever infection exists—currently parts of Africa and South America—should be vaccinated. (These are listed in the "Bi-Weekly Summary of Countries with Areas Infected with Quarantinable Diseases" available in state and local health departments. Information on known or probable infected areas is also available from the World Health Organization [WHO] and Pan American Health Organization offices or the Division of Vector-Borne Viral Diseases, Center for Infectious Diseases, CDC, Fort Collins, Colorado.)

   Vaccination is also recommended for travel outside the urban areas of countries in the yellow fever endemic zone (Figure 1). It should be emphasized that the actual areas of yellow fever virus activity far exceed the infected zones officially reported and that, in recent years, fatal cases of yellow fever have occurred in unvaccinated tourists (*6*).
2. Infants under 6 months of age and pregnant women should be considered for vaccination if traveling to high-risk areas when travel cannot be postponed and a high level of prevention against mosquito exposures is not feasible.
3. Laboratory personnel who might be exposed to virulent yellow fever virus should also be vaccinated.

B. Vaccination for international travel: For purposes of international travel, yellow fever vaccines produced by different manufacturers worldwide must be approved by WHO and administered at an approved Yellow Fever Vaccination Center. State and territorial health departments have the authority to designate nonfederal vaccination centers; these can be identified by contacting state or local health departments. Vaccinees should have an International Certificate of Vaccination filled in, signed, and validated with the center's stamp where the vaccine is given.

Vaccination for international travel may be required under circumstances other than those specified herein. Some countries in Africa require evidence of vaccination from all entering travelers. Some countries may waive the requirements for travelers coming from noninfected areas and staying less than 2 weeks. These requirements may change, so all travelers should seek current information from health departments. Travel agencies, international airlines, and/or shipping lines should also have up-to-date information.

Some countries require an individual, even if only in transit, to have a valid International Certificate of Vaccination if he or she has been in countries either known or thought to harbor yellow fever virus. Such requirements may be strictly enforced, particularly for persons traveling from Africa or South America to Asia.

C. Primary immunization: For persons of all ages, a single subcutaneous injection of 0.5 ml of reconstituted vaccine is used.

D. Booster doses: Yellow fever immunity following vaccination with 17D strain virus persists for more than 10 years (*7-9*); the International Health Regulations do not require vaccination more often than every 10 years.

Yellow Fever Vaccine — Continued

REACTIONS

Reactions to 17D yellow fever vaccine are generally mild. Two percent to 5% of vaccinees have mild headaches, myalgia, low-grade fevers, or other minor symptoms 5-10 days after vaccination. Fewer than 0.2% curtail regular activities. Immediate hypersensitivity reactions, characterized by rash, urticaria, and/or asthma, are extremely uncommon (incidence less than 1/1,000,000) and occur principally in persons with histories of egg allergy. Although more than 34 million doses of vaccines have been distributed, only two cases of encephalitis temporally associated with vaccinations have been reported in the United States; in one fatal case, 17D virus was isolated from the brain.

PRECAUTIONS AND CONTRAINDICATIONS

A. Age: Infants under 6 months of age are theoretically more susceptible to serious adverse reactions (encephalitis) than older children.

B. Pregnancy: Although specific information is not available concerning adverse effects of yellow fever vaccine on the developing fetus, it is prudent on theoretical grounds to avoid vaccinating pregnant women and to postpone travel to areas where yellow fever is present until after delivery. If international travel requirements constitute the only reason to vaccinate a pregnant woman, rather than an increased risk of infection, efforts should be made

(Continued on page 687)

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

Disease	52nd Week Ending			Cumulative, 52nd Week Ending		
	December 31, 1983	January 1, 1983	Median 1978-1982	December 31, 1983	January 1, 1983	Median 1978-1982
Aseptic meningitis	108	209	163	11,740	9,733	8,505
Encephalitis: Primary (arthropod-borne & unspec.)	18	72	23	1,705	1,634	1,198
Post-infectious	-	3	3	70	82	214
Gonorrhea: Civilian	11,259	14,292	14,292	889,902	955,324	999,638
Military	202	404	404	23,571	25,550	26,477
Hepatitis: Type A	219	782	780	21,571	23,364	28,393
Type B	310	737	586	22,708	22,326	18,479
Non A, Non B	32	86	N	3,332	2,544	N
Unspecified	95	243	255	7,569	8,743	10,666
Legionellosis	6	48	N	704	689	N
Leprosy	2	8	6	234	238	220
Malaria	7	22	22	764	1,041	1,041
Measles: Total*	-	48	55	1,436	1,728	13,385
Indigenous	-	N	N	1,136	N	N
Imported	-	N	N	300	N	N
Meningococcal infections: Total	34	86	80	2,687	3,037	2,715
Civilian	34	85	80	2,671	3,022	2,696
Military	-	1	1	16	15	19
Mumps	46	102	239	3,285	5,310	8,449
Pertussis	45	118	32	2,258	1,882	1,660
Rubella (German measles)	9	27	32	953	2,308	3,819
Syphilis (Primary & Secondary): Civilian	450	459	441	32,038	32,746	27,259
Military	6	5	5	384	429	322
Toxic-shock syndrome	9	N	N	391	N	N
Tuberculosis	281	681	800	23,422	25,796	27,524
Tularemia	5	16	6	316	271	235
Typhoid fever	2	27	7	438	420	517
Typhus fever, tick-borne (RMSF)	1	11	11	1,126	971	1,066
Rabies, animal	21	113	85	5,732	6,171	6,171

TABLE II. Notifiable diseases of low frequency, United States

	Cum 1983		Cum. 1983
Anthrax	-	Plague (Colo. 1)	39
Botulism: Foodborne	20	Poliomyelitis: Total	8
Infant	70	Paralytic	8
Other	3	Psittacosis	118
Brucellosis (Iowa 1)	183	Rabies, human	2
Cholera	1	Tetanus (Minn. 1)	75
Congenital rubella syndrome	20	Trichinosis (Mo. 1)	33
Diphtheria	5	Typhus fever, flea-borne (endemic, murine)	47
Leptospirosis (Fla. 1)	46		

*There were no cases of internationally imported measles reported for this week.

TABLE III. Cases of specified notifiable diseases, United States, weeks ending December 31, 1983 and January 1, 1983 (52nd week)

Reporting Area	Aseptic Meningitis	Encephalitis		Gonorrhea (Civilian)		Hepatitis (Viral), by type				Legionellosis	Leprosy	Malaria
		Primary	Post-infectious			A	B	NA,NB	Unspecified			
	1983	Cum. 1983	Cum. 1983	Cum. 1983	Cum. 1982	1983	1983	1983	1983	1983	Cum. 1983	Cum. 1983
UNITED STATES	108	1,705	70	889,902	955,324	219	310	32	95	6	234	764
NEW ENGLAND	3	61	-	24,243	23,129	10	21	2	21	-	3	38
Maine	-	-	-	1,119	1,224	-	-	1	-	-	-	1
N.H.	-	5	-	716	756	1	1	1	1	-	1	2
Vt.	-	1	-	441	420	-	-	-	-	-	-	1
Mass.	-	28	-	10,256	10,368	8	11	-	19	-	-	18
R.I.	1	1	-	1,273	1,572	-	1	-	-	-	1	4
Conn.	2	26	-	10,438	8,789	1	8	-	1	-	1	12
MID ATLANTIC	14	139	8	117,089	122,298	36	75	8	6	-	27	110
Upstate N.Y.	3	36	1	19,131	20,592	6	8	2	-	-	-	32
N.Y. City	8	14	-	46,854	49,798	10	22	-	2	-	26	28
N.J.	-	19	1	21,859	22,306	10	19	3	3	-	-	28
Pa.	3	70	6	29,245	29,602	10	26	3	1	-	1	22
E.N. CENTRAL	14	594	20	123,495	137,987	20	47	4	7	1	6	55
Ohio	6	198	9	32,816	35,760	6	9	1	1	-	1	10
Ind.	2	185	1	12,763	16,703	-	2	-	1	-	-	7
Ill.	-	17	7	32,283	40,612	1	4	-	1	1	2	18
Mich.	6	127	-	34,106	32,850	13	32	3	4	-	3	15
Wis.	-	67	3	11,527	12,062	-	-	-	-	-	-	5
W.N. CENTRAL	6	170	10	41,270	44,790	35	12	2	-	1	6	32
Minn.	2	70	1	5,811	6,467	1	5	1	-	-	4	11
Iowa	-	58	-	4,620	4,868	-	-	-	-	-	-	4
Mo.	2	30	-	19,850	21,266	3	4	1	-	1	1	5
N. Dak.	-	4	-	437	566	-	-	-	-	-	-	2
S. Dak.	-	1	2	1,037	1,122	30	1	-	-	-	-	1
Nebr.	1	5	-	2,768	2,651	1	2	-	-	-	-	3
Kans.	1	2	7	6,747	7,850	-	-	-	-	-	1	6
S. ATLANTIC	34	237	16	233,477	248,162	17	56	2	9	1	13	124
Del.	2	1	-	4,274	4,168	-	-	-	-	-	-	1
Md.	3	23	-	29,976	31,369	2	8	-	1	-	1	21
D.C.	-	-	-	15,891	15,167	-	-	-	-	-	-	16
Va.	1	61	2	21,119	19,869	1	4	1	-	1	1	31
W. Va.	-	48	-	2,607	2,788	1	3	-	-	-	-	3
N.C.	9	47	-	35,785	39,668	4	10	-	4	-	2	7
S.C.	2	5	-	21,231	23,999	-	3	-	-	-	-	5
Ga.	3	9	2	49,761	48,336	1	10	-	-	-	1	10
Fla.	14	43	12	52,833	62,798	8	18	1	4	-	8	30
E.S. CENTRAL	11	70	2	74,283	82,375	12	38	5	4	-	-	14
Ky.	5	17	-	8,851	11,027	4	2	1	1	-	-	2
Tenn.	2	19	-	30,433	32,510	2	5	-	1	-	-	-
Ala.	4	25	-	22,624	24,401	5	31	4	2	-	-	7
Miss.	-	9	2	12,375	14,437	1	-	-	-	-	-	5
W.S. CENTRAL	11	174	2	124,663	130,598	47	30	-	44	-	36	66
Ark.	-	14	-	9,752	10,323	1	3	-	3	-	-	1
La.	2	22	-	23,664	24,178	3	11	-	1	-	1	8
Okla.	1	31	1	14,284	14,529	5	4	-	1	-	-	9
Tex.	8	107	1	76,963	81,568	38	12	-	39	-	35	48
MOUNTAIN	3	80	4	28,289	32,095	22	15	4	3	3	15	29
Mont.	-	2	-	1,221	1,337	-	-	-	-	-	-	-
Idaho	1	1	-	1,287	1,524	2	1	2	-	-	-	2
Wyo.	-	2	-	740	959	1	3	-	-	-	-	1
Colo.	2	49	-	7,961	8,655	8	5	1	1	3	3	10
N. Mex.	-	2	-	3,515	4,379	4	2	1	-	-	-	5
Ariz.	U	11	4	7,857	8,339	U	U	U	U	U	10	8
Utah	-	12	-	1,364	1,584	3	1	-	2	-	2	3
Nev.	-	1	-	4,344	5,318	4	3	-	-	-	-	-
PACIFIC	12	180	8	123,093	133,890	20	16	5	1	-	128	296
Wash.	2	13	1	9,495	11,381	4	10	2	1	-	16	17
Oreg.	-	-	4	6,643	7,818	16	4	3	-	-	1	12
Calif.	U	158	3	101,441	108,636	U	U	U	U	U	76	265
Alaska	-	-	-	3,213	3,449	-	-	-	-	-	-	-
Hawaii	10	9	-	2,301	2,606	-	2	-	-	-	35	2
Guam	U	-	-	114	137	U	U	U	U	U	2	2
P.R.	-	1	1	2,854	2,548	10	15	-	12	-	-	3
V.I.	-	-	-	303	287	-	-	-	-	-	-	-
Pac. Trust Terr.	U	-	-	-	388	U	U	U	U	U	-	-

U: Unavailable

TABLE III. (Cont.'d). Cases of specified notifiable diseases, United States, weeks ending December 31, 1983 and January 1, 1983 (52nd week)

Reporting Area	Measles (Rubeola)					Menin-gococcal Infections	Mumps			Pertussis			Rubella		
	Indigenous		Imported*		Total										
	1983	Cum. 1983	1983	Cum. 1983	Cum. 1982	Cum. 1983	1983	Cum. 1983	Cum. 1982	1983	Cum. 1983	Cum. 1982	1983	Cum. 1983	Cum. 1982
UNITED STATES	-	1,136	-	300	1,728	2,687	46	3,285	5,310	45	2,258	1,882	9	953	2,308
NEW ENGLAND	-	5	-	16	15	152	-	130	190	-	73	66	-	20	22
Maine	-	-	-	-	-	10	-	22	43	-	5	4	-	-	-
N.H.	-	-	-	3	3	7	-	27	18	-	10	12	-	5	13
Vt.	-	-	-	-	2	11	-	15	7	-	8	2	-	5	-
Mass.	-	4	-	5	4	48	-	29	75	-	38	32	-	8	2
R.I.	-	-	-	-	-	13	-	16	18	-	5	11	-	-	1
Conn.	-	1	-	8	6	63	-	21	29	-	7	5	-	2	6
MID ATLANTIC	-	75	-	44	174	448	9	381	365	25	415	605	1	148	111
Upstate N.Y.	-	5	-	13	112	144	1	110	100	1	120	322	-	32	55
N.Y. City	-	44	-	27	49	77	1	42	48	-	53	52	1	87	36
N.J.	-	26	-	1	6	78	5	144	57	-	20	26	-	3	18
Pa.	-	-	-	3	7	149	2	85	160	24	222	205	-	26	2
E.N. CENTRAL	-	649	-	59	90	503	11	1,439	2,682	10	499	362	3	139	224
Ohio	-	72	-	16	1	150	-	591	1,775	3	158	98	-	2	4
Ind.	-	402	-	4	2	56	-	56	50	3	63	25	-	27	31
Ill.	-	173	-	33	24	144	2	170	315	-	161	164	2	59	87
Mich.	-	2	-	5	63	89	9	528	410	4	46	34	1	21	55
Wis.	-	-	-	1	-	64	-	94	132	-	71	41	-	30	47
W.N. CENTRAL	-	1	-	7	49	141	4	176	652	-	143	83	-	44	66
Minn.	-	1	-	-	-	28	-	30	455	-	49	34	-	9	7
Iowa	-	-	-	-	-	20	1	45	65	-	9	9	-	-	-
Mo.	-	-	-	1	2	55	1	20	13	-	18	17	-	-	38
N. Dak.	-	-	-	-	-	4	-	1	-	-	3	-	-	-	-
S. Dak.	-	-	-	-	-	4	-	-	1	-	8	6	-	-	1
Nebr.	-	-	-	-	3	5	-	4	1	-	2	1	-	-	-
Kans.	-	-	-	6	44	25	2	76	117	-	54	16	-	35	20
S. ATLANTIC	-	173	-	31	271	548	18	249	332	2	248	301	1	100	102
Del.	-	-	-	-	-	11	-	9	13	-	5	9	-	-	1
Md.	-	6	-	4	5	55	1	45	34	-	20	76	-	2	34
D.C.	-	-	-	-	1	11	-	-	-	-	-	-	-	-	-
Va.	-	10	-	13	14	80	-	37	44	1	51	29	1	3	12
W. Va.	-	-	-	-	3	3	-	62	124	-	9	15	-	-	3
N.C.	-	-	-	1	2	106	17	31	23	-	31	54	-	10	2
S.C.	-	-	-	4	-	52	-	14	18	-	14	16	-	1	-
Ga.	-	8	-	-	-	90	-	51	30	-	65	43	-	13	18
Fla.	-	149	-	9	246	140	N	-	46	1	53	59	-	71	32
E.S. CENTRAL	-	3	-	24	14	155	-	59	67	-	34	54	-	19	49
Ky.	-	-	-	1	1	31	-	21	22	-	14	7	-	18	31
Tenn.	-	-	-	-	6	52	-	32	25	-	9	26	-	-	2
Ala.	-	1	-	4	2	50	-	2	10	-	5	5	-	1	-
Miss.	-	2	-	19	5	22	-	4	10	-	6	16	-	-	16
W.S. CENTRAL	-	44	-	35	173	279	1	224	269	7	468	114	3	126	130
Ark.	-	5	-	8	-	24	-	3	9	1	27	6	-	-	2
La.	-	4	-	25	16	52	-	1	6	-	12	24	-	10	1
Okla.	-	1	-	-	30	37	N	-	-	4	339	9	-	-	3
Tex.	-	34	-	2	127	166	1	220	254	2	90	75	3	116	124
MOUNTAIN	-	22	-	18	29	122	2	187	130	1	227	91	1	40	106
Mont.	-	-	-	4	-	30	-	7	8	-	2	1	1	7	7
Idaho	-	-	-	10	-	9	1	9	5	-	15	12	-	8	7
Wyo.	-	-	-	-	1	2	-	4	2	-	6	4	-	8	8
Colo.	-	-	-	3	8	38	1	54	22	1	138	35	-	1	6
N. Mex.	-	-	-	-	-	7	N	-	-	-	14	8	-	-	6
Ariz.	U	-	U	1	17	23	U	93	63	U	29	27	U	8	29
Utah	-	22	-	-	3	12	-	15	22	-	22	4	-	7	31
Nev.	-	-	-	-	-	1	-	5	8	-	1	-	-	1	12
PACIFIC	-	164	-	66	913	339	1	440	623	-	151	206	-	317	1,498
Wash.	-	2	-	33	43	50	1	55	102	-	20	36	-	9	58
Oreg.	-	8	-	2	17	60	N	-	-	-	9	27	-	14	10
Calif.	U	153	U	29	847	218	U	349	484	U	115	115	U	292	1,416
Alaska	-	-	-	2	1	4	-	16	16	-	4	-	-	1	5
Hawaii	-	1	-	-	5	7	-	20	21	-	3	28	-	1	9
Guam	U	1	U	1	9	1	U	1	5	U	-	-	U	-	2
P.R.	-	94	-	-	221	11	6	151	104	-	14	22	-	8	15
V.I.	-	-	-	5	3	-	-	-	4	-	-	-	-	2	2
Pac. Trust Terr.	U	-	U	-	1	-	U	-	6	U	-	-	U	-	-

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

N: Not notifiable U: Unavailable †International §Out-of-state

TABLE III. (Cont.'d). Cases of specified notifiable diseases, United States, weeks ending December 31, 1983 and January 1, 1983 (52nd 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	32,038	32,746	9	281	23,422	316	438	1,126 -6	5,732
NEW ENGLAND	695	610	-	16	720	4	20	7 -1	37
Maine	19	8	-	1	37	-	-	-	9
N.H.	27	5	-	1	35	-	-	1	5
Vt.	4	8	-	1	13	-	-	-	2
Mass.	443	410	-	5	391	3	15	3 -1	14
R.I.	22	27	-	4	66	1	1	-	1
Conn.	180	152	-	4	178	-	4	3	6
MID ATLANTIC	4,256	4,454	2	71	4,254	1	76	28	271
Upstate N.Y.	392	477	-	10	710	1	11	7	79
N.Y. City	2,461	2,593	-	34	1,701	-	27	2	-
N.J.	825	666	-	17	859	-	31	8	24
Pa.	578	718	2	10	984	-	7	11	168
E.N. CENTRAL	1,622	1,947	1	37	3,175	4	62	69	473
Ohio	446	333	-	8	520	-	18	27	60
Ind.	151	199	-	7	382	-	4	16	30
Ill.	695	1,013	-	-	1,321	1	28	17	241
Mich.	236	299	1	13	785	1	10	7	21
Wis.	94	103	-	9	167	2	2	2	121
W.N. CENTRAL	386	558	1	21	735	97	13	56	818
Minn.	149	145	-	4	156	-	2	-	143
Iowa	22	34	-	-	65	-	-	-	201
Mo.	147	296	1	8	358	68	9	27	96
N. Dak.	2	7	-	1	9	1	-	1	87
S. Dak.	11	6	-	8	45	10	-	5	144
Nebr.	15	16	-	-	25	8	-	3	65
Kans.	40	54	-	-	77	10	2	20	82
S. ATLANTIC	8,837	8,925	1	81	4,739	12	53	472 -1	2,088
Del.	43	25	-	-	63	-	-	4	5
Md.	577	498	-	3	373	3	5	37 -1	797
D.C.	379	477	-	8	199	-	3	-	141
Va.	567	624	-	-	499	1	16	59	625
W. Va.	26	31	-	3	135	-	2	12	114
N.C.	916	724	-	-	738	7	4	206	26
S.C.	580	564	-	5	443	-	2	80	36
Ga.	1,548	1,828	-	17	832	1	2	68	215
Fla.	4,201	4,154	1	45	1,457	-	19	6	129
E.S. CENTRAL	2,135	2,258	-	16	2,059	23	10	108	357
Ky.	176	133	-	-	507	1	3	24	83
Tenn.	583	655	-	6	634	17	2	49	189
Ala.	813	835	-	6	523	-	2	24	85
Miss.	563	635	-	4	395	5	3	11	-
W.S. CENTRAL	8,218	8,590	-	18	2,846	121	65	370 -6	1,001
Ark.	187	217	-	8	356	70	4	42	160
La.	1,679	1,845	-	10	446	7	4	1	34
Okla.	196	191	-	-	276	33	3	227 -6	108
Tex.	6,156	6,337	-	-	1,768	11	54	100	699
MOUNTAIN	655	831	2	16	633	45	23	14	233
Mont.	7	5	-	-	42	6	1	6	68
Idaho	10	25	2	-	29	2	1	3	16
Wyo.	12	16	-	-	13	8	-	2	12
Colo.	156	230	-	9	98	15	1	-	32
N. Mex.	181	197	-	2	116	4	2	-	15
Ariz.	162	221	U	U	253	1	16	1	36
Utah	23	24	-	5	43	8	1	1	11
Nev.	104	113	-	-	39	1	1	1	43
PACIFIC	5,234	4,573	2	5	4,261	9	116	2	454
Wash.	186	172	-	-	230	2	5	-	2
Oreg.	146	113	2	3	182	3	4	-	1
Calif.	4,810	4,162	U	U	3,540	3	104	2	433
Alaska	14	18	-	-	73	1	-	-	18
Hawaii	78	108	-	2	236	-	3	-	-
Guam	-	1	U	U	5	-	-	-	-
P.R.	928	784	-	-	455	-	1	-	49
V.I.	19	31	-	-	2	-	1	-	-
Pac. Trust Terr.	-	-	U	U	-	-	-	-	-

U: Unavailable

TABLE IV. Deaths in 121 U.S. cities,* week ending December 31, 1983 (52nd week)

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	719	504	148	35	19	13	60
Boston, Mass.	188	120	42	14	7	5	20
Bridgeport, Conn.	40	26	8	2	3	1	2
Cambridge, Mass.	32	23	7	1	1	-	2
Fall River, Mass.	42	36	5	1	-	-	-
Hartford, Conn.	69	51	12	4	-	2	6
Lowell, Mass.	21	13	6	2	-	-	-
Lynn, Mass.	20	13	6	1	-	-	3
New Bedford, Mass.	29	21	6	-	1	1	2
New Haven, Conn.	37	25	7	2	2	1	3
Providence, R.I.	72	54	17	1	-	-	6
Somerville, Mass.	10	9	1	-	-	-	-
Springfield, Mass.	44	31	5	2	4	2	3
Waterbury, Conn.	35	25	8	1	1	-	4
Worcester, Mass.	80	57	18	4	-	1	9
MID. ATLANTIC	2,658	2,164	251	96	58	65	115
Albany, N.Y.	54	39	10	1	2	2	5
Allentown, Pa.	20	15	5	-	-	-	-
Buffalo, N.Y.	134	94	29	7	-	4	14
Camden, N.J.	25	11	13	1	-	-	1
Elizabeth, N.J.	33	26	7	-	-	-	1
Erie, Pa.†	32	25	3	3	-	1	2
Jersey City, N.J.	58	37	15	3	1	2	2
N.Y. City, N.Y.§	1,481	1,360	11	20	35	31	50
Newark, N.J.	45	18	12	11	1	3	2
Paterson, N.J.	35	27	5	2	1	-	-
Philadelphia, Pa.†	278	179	59	27	5	8	15
Pittsburgh, Pa.†	56	36	13	4	1	2	4
Reading, Pa.	37	25	7	3	2	-	3
Rochester, N.Y.	120	85	22	4	5	4	6
Schenectady, N.Y.	34	27	4	1	1	1	1
Scranton, Pa.†	30	22	8	-	-	-	2
Syracuse, N.Y.	86	65	9	5	4	3	3
Trenton, N.J.	52	34	13	2	-	3	1
Utica, N.Y.	21	18	2	-	-	1	2
Yonkers, N.Y.	27	21	4	2	-	-	1
E.N. CENTRAL	2,309	1,516	505	136	68	84	84
Akron, Ohio	66	53	11	-	1	1	-
Canton, Ohio	46	30	13	3	-	-	6
Chicago, Ill.	638	386	137	45	25	45	14
Cincinnati, Ohio	120	84	20	11	2	3	11
Cleveland, Ohio	179	109	46	15	5	4	3
Columbus, Ohio	131	85	29	8	4	5	9
Dayton, Ohio	110	83	21	2	2	2	-
Detroit, Mich.	198	118	51	16	7	6	1
Evansville, Ind.	32	22	8	2	-	-	1
Fort Wayne, Ind.	47	27	17	1	1	1	-
Gary, Ind.	19	9	7	2	1	-	1
Grand Rapids, Mich.	82	67	12	-	2	1	4
Indianapolis, Ind.	142	78	38	10	12	4	3
Madison, Wis.	27	21	2	3	-	1	5
Milwaukee, Wis.	141	96	32	7	1	5	3
Peoria, Ill. §	45	41	-	2	-	2	5
Rockford, Ill.	49	36	10	1	1	1	5
South Bend, Ind.	64	45	14	3	2	-	5
Toledo, Ohio	106	80	18	3	2	3	8
Youngstown, Ohio	67	46	19	2	-	-	-
W.N. CENTRAL	688	456	155	34	28	14	32
Des Moines, Iowa	59	40	12	3	2	2	4
Duluth, Minn.	11	6	3	1	1	-	1
Kansas City, Kans.	25	16	6	1	2	-	1
Kansas City, Mo.	114	72	32	6	3	-	4
Lincoln, Nebr.	37	27	7	3	-	-	3
Minneapolis, Minn.	68	43	13	8	1	3	3
Omaha, Nebr.	81	57	19	1	1	3	6
St. Louis, Mo.	154	104	28	9	9	4	2
St. Paul, Minn.	75	52	17	1	5	-	-
Wichita, Kans.	64	39	18	1	4	2	8

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
S. ATLANTIC	1,124	744	221	66	37	53	42
Atlanta, Ga.	115	73	27	9	3	3	5
Baltimore, Md.	186	111	38	12	6	19	6
Charlotte, N.C.	67	33	19	9	6	-	3
Jacksonville, Fla.	73	43	19	7	1	3	2
Miami, Fla.	156	88	44	10	4	10	2
Norfolk, Va.	48	31	12	2	-	3	1
Richmond, Va.	64	43	14	3	3	1	7
Savannah, Ga.	45	27	13	3	-	2	6
St. Petersburg, Fla.	104	85	10	3	3	3	5
Tampa, Fla.	89	61	14	3	7	4	3
Washington, D.C.	145	128	1	4	4	5	2
Wilmington, Del.	32	21	10	1	-	-	-
E.S. CENTRAL	622	394	159	30	21	18	38
Birmingham, Ala.	83	48	24	3	2	6	1
Chattanooga, Tenn.	41	23	12	1	3	2	2
Knoxville, Tenn.	37	24	9	1	1	2	5
Louisville, Ky.	98	61	25	3	6	3	11
Memphis, Tenn.	157	113	31	10	3	-	10
Mobile, Ala.	52	36	12	1	1	2	5
Montgomery, Ala.	45	27	9	4	2	3	-
Nashville, Tenn.	109	62	37	7	3	-	4
W.S. CENTRAL	1,025	599	254	88	43	41	41
Austin, Tex.	45	28	9	4	1	3	4
Baton Rouge, La.	35	21	10	4	-	-	1
Corpus Christi, Tex.	30	22	6	-	-	2	-
Dallas, Tex.	175	88	50	21	11	5	8
El Paso, Tex.	57	32	11	8	3	3	-
Fort Worth, Tex.	65	39	16	3	2	5	2
Houston, Tex.	121	54	41	7	9	10	2
Little Rock, Ark.	52	39	7	5	-	1	3
New Orleans, La.	191	110	48	23	8	2	-
San Antonio, Tex.	109	70	22	5	5	7	11
Shreveport, La.	48	35	9	3	1	-	2
Tulsa, Okla.	97	61	25	5	3	3	8
MOUNTAIN	676	448	144	40	20	23	39
Albuquerque, N.Mex.	93	56	21	4	4	7	11
Colo. Springs, Colo.	39	27	10	-	-	2	6
Denver, Colo.	123	85	18	12	4	4	4
Las Vegas, Nev.	80	49	21	8	1	1	3
Ogden, Utah	28	18	7	2	1	-	4
Phoenix, Ariz.	162	107	39	7	6	3	3
Pueblo, Colo.	12	9	2	-	1	-	2
Salt Lake City, Utah	37	27	4	1	1	4	-
Tucson, Ariz.	102	70	22	6	2	2	6
PACIFIC	1,354	888	290	92	36	47	71
Berkeley, Calif.	22	17	1	2	-	2	-
Fresno, Calif.	65	35	18	3	5	4	6
Glendale, Calif.	11	8	2	1	-	-	-
Honolulu, Hawaii	59	38	15	5	1	-	3
Long Beach, Calif.	86	56	16	6	4	4	3
Los Angeles, Calif.	234	147	46	27	11	2	9
Oakland, Calif.	73	51	12	6	1	3	5
Pasadena, Calif.	30	18	7	1	1	3	2
Portland, Oreg.	105	73	22	3	1	6	5
Sacramento, Calif.	60	39	12	5	2	2	2
San Diego, Calif.	134	73	46	6	3	6	7
San Francisco, Calif.	138	102	24	9	-	3	5
San Jose, Calif.	136	88	31	8	4	5	12
Seattle, Wash.	105	80	18	5	2	-	4
Spokane, Wash.	57	36	16	1	-	4	6
Tacoma, Wash.	39	27	4	4	1	3	2
TOTAL	11,175††	7,713	2,127	617	330	358	522

* 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.

Yellow Fever Vaccine — Continued

to obtain a waiver letter from the traveler's physician (see below). Pregnant women who must travel to areas where the risk of yellow fever is high should be vaccinated. It is believed that under these circumstances, the small theoretical risk for mother and fetus from vaccination is far outweighed by the risk of yellow fever infection.

C. **Altered immune states**: Infection with yellow fever vaccine virus poses a theoretical risk to patients with leukemia, lymphoma, or generalized malignancy or to those whose immunologic responses are suppressed by corticosteroids, alkylating drugs, antimetabolites, or radiation. Short-term (less than 2 weeks) corticosteroid therapy or intra-articular, bursal, or tendon injections with corticosteroids should not be immunosuppressive and constitute no increased hazard to recipients of yellow fever vaccine.

D. **Hypersensitivity**: Live yellow fever vaccine is produced in chick embryos and should not be given to persons clearly hypersensitive to eggs; generally, persons who are able to eat eggs or egg products may receive the vaccine.

If international travel regulations are the only reason to vaccinate a patient hypersensitive to eggs, efforts should be made to obtain a waiver. A physician's letter clearly stating the contraindication to vaccination has been acceptable to some governments. (Ideally, it should be written on letterhead stationery and bear the stamp used by health departments and official immunization centers to validate the International Certificates of Vaccination.) Under these conditions, it is also useful for the traveler to obtain specific and authoritative advice from the country or countries he or she plans to visit. Their embassies or consulates may be contacted. Subsequent waiver of requirements should be documented by appropriate letters.

If vaccination of an individual with a questionable history of egg hypersensitivity is considered essential because of a high risk of exposure, an intradermal test dose may be administered under close medical supervision. Specific directions for skin testing are found in the package insert.

SIMULTANEOUS ADMINISTRATION OF OTHER VACCINES

Determination of whether to administer yellow fever vaccine and other immunobiologics simultaneously should be made on the basis of convenience to the traveler in completing the desired immunizations before travel and on information regarding possible interference. The following will help guide these decisions.

Studies have shown that the serologic response to yellow fever vaccine is not inhibited by administration of certain other vaccines concurrently or at various intervals of a few days to 1 month. Measles, smallpox, and yellow fever vaccines have been administered in combination with full efficacy of each of the components; Bacillus Calmette Guérin (BCG) and yellow fever vaccines have been administered simultaneously without interference. Additionally, severity of reactions to vaccination was not amplified by concurrent administration of yellow fever and other live virus vaccines (*10*). If live virus vaccines are not given concurrently, 4 weeks should be allowed to elapse between sequential vaccinations.

Other studies have indicated that persons given yellow fever and cholera vaccines simultaneously or 1-3 weeks apart showed reduced antibody responses to both vaccines (*11,12*). When feasible, cholera and yellow fever vaccines should be administered at a minimal interval of 3 weeks, unless time constraints preclude this. If the vaccines cannot be administered at least 3 weeks apart, they should be given simultaneously. There are no data on possible interference between yellow fever and typhoid, paratyphoid, typhus, hepatitis B, plague, rabies, or Japanese encephalitis vaccines.

A recently completed prospective study of persons given yellow fever vaccine and 5 cc of commercially available immune globulin revealed no alteration of the immunologic response to yellow fever vaccine when compared to controls (*13*).

Yellow Fever Vaccine — Continued

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Current Trends

Update: Acquired Immunodeficiency Syndrome (AIDS) — United States

As of December 19, 1983, physicians and health departments in the United States have reported a total of 3,000 patients who meet the surveillance definition for acquired immunodeficiency syndrome (AIDS) (*1*). Of these patients, 51% were reported to have had *Pneumocystis carinii* pneumonia (PCP) without Kaposi's sarcoma (KS); 26%, KS without PCP; 7%, both KS and PCP; and 16%, opportunistic infections without either KS or PCP. A total of 1,283 (43%) of reported patients are known to have died; the proportion of patients with KS alone who have died (23%) is less than half that of other AIDS patients (50%). Of the 3,000 patients, 90% have been between 20 and 49 years old. Fifty-nine percent of the cases have occurred among whites, 26% among blacks, and 14% among persons of Hispanic origin. Women account for 7% of the cases.

AIDS was first reported in the spring of 1981 (*2,3*), although patients with diagnoses meeting the surveillance definition for AIDS were, in retrospect, seen earlier (Figure 3). Half the 3,000 reported AIDS patients have been diagnosed since February 1983.

Cases have been reported from 42 states, the District of Columbia, and Puerto Rico (Figure 4). Eighty-one percent of the patients were residents of New York, California, Florida,

AIDS — Continued

or New Jersey at the time of their onsets of illness. Within these states, most cases have been reported among residents of large cities. The standard metropolitan statistical areas that have reported the greatest number of cases include: New York City (42% of all AIDS patients), San Francisco (12%), Los Angeles (8%), Miami (4%), and Newark (3%).

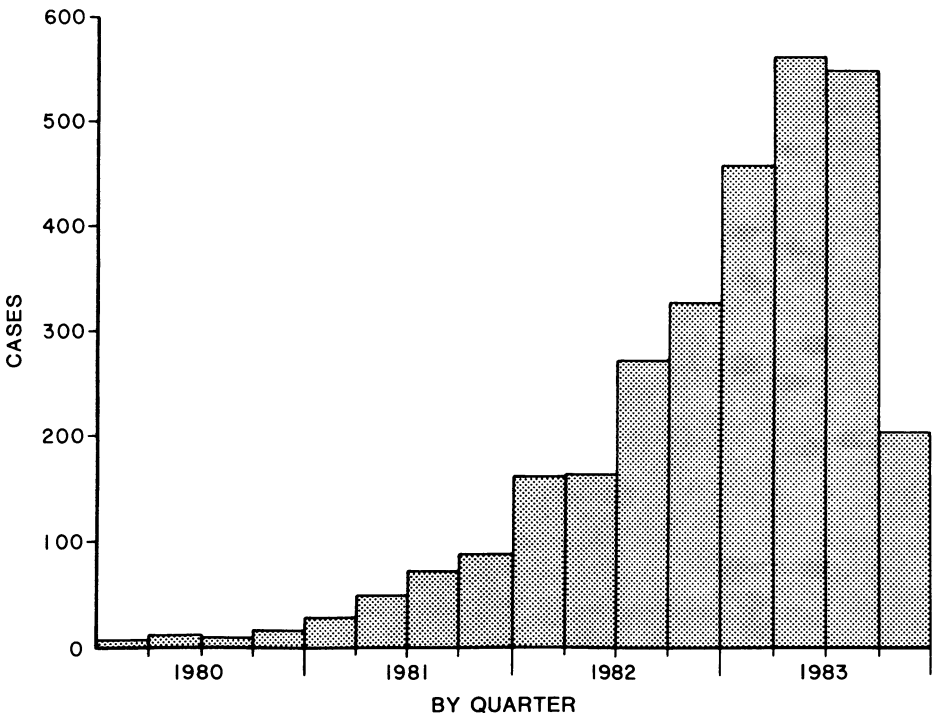
Groups at highest risk of acquiring AIDS continue to be homosexual and bisexual men (71% of cases) and intravenous drug abusers (17%); 12% of patients have other or unknown risk factors. These include persons born in Haiti and now living in the United States (5% of total cases), patients with hemophilia (1%), heterosexual contacts of persons at increased risk for acquiring AIDS (1%), and recipients of blood transfusions (1%).

The 31 patients with "transfusion-associated" AIDS include 18 men and 13 women who have no other known risk factor for AIDS and were transfused with blood or blood components within 5 years of their onsets of illness. These patients received transfusions between April 1978 and May 1983. Twelve are known to have died.

Not included in the 3,000 case reports are 42 children under the age of 5 years who meet a provisional case definition for pediatric AIDS (Table 1). All had life-threatening opportunistic infections; two also had KS (*4*). Twenty-nine (69%) are known to have died.

Twenty-nine of the children came from families in which one or both parents had a history of intravenous drug abuse (17 children) or were born in Haiti (12 children). Three of the 29 children, including one previously reported (*5*), have had a parent (two mothers, one father) with AIDS. Of the other 13 children, seven had transfusions with blood or blood components

FIGURE 3. Acquired immunodeficiency syndrome (AIDS) cases, by quarter of diagnosis — United States, first quarter 1980 through December 19, 1983*



*Excludes 15 cases diagnosed before 1980 and 7 cases for which date of diagnosis was not reported.

AIDS – Continued

before their onsets of illness. One of these children received a platelet transfusion from a man who died of AIDS (*6*).

Reported by State and Territorial Epidemiologists; AIDS Activity, Center for Infectious Diseases, CDC.

Editorial Note: Although the rate of increase of diagnosed AIDS cases appears lower for the last half of 1983 than previously, trends in reported AIDS incidence must be interpreted cautiously. For example, several months often elapse between the diagnosis of an AIDS patient and the receipt of the case report at CDC; the number of reported cases lags behind the true incidence of disease. Also, during the past year, AIDS reporting has been decentralized, so that most cases are reported to state and local health departments, which forward reports to CDC. Final interpretation of trends in AIDS incidence for the last half of 1983 will, therefore, require several more months.

Because children are subject to a variety of congenital immunodeficiencies, confirmation of AIDS diagnoses in children is more complex than in adults. Laboratory testing to exclude congenital conditions is required. In future surveillance summaries, CDC will give the number of children reported to meet the provisional case definition for pediatric AIDS.

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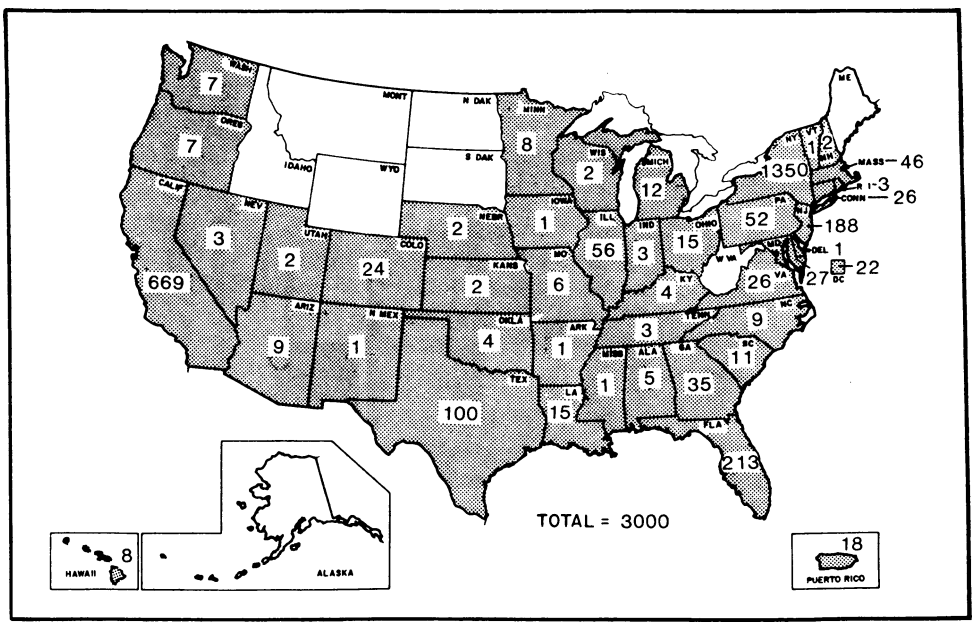
FIGURE 4. Acquired immunodeficiency syndrome (AIDS) cases reported to CDC, by state—United States, as of December 19, 1983



AIDS — Continued

TABLE 1. Provisional case definition for acquired immunodeficiency syndrome (AIDS) in children

For the limited purposes of epidemiologic surveillance, CDC defines a case of pediatric acquired immunodeficiency syndrome (AIDS) as a child who has had:

1. a reliably diagnosed disease at least moderately indicative of underlying cellular immunodeficiency and
2. no known cause of underlying cellular immunodeficiency or any other reduced resistance reported to be associated with that disease.

The diseases accepted as sufficiently indicative of underlying cellular immunodeficiency are the same as those used in defining AIDS in adults (*1*) with the exclusion of congenital infections, e.g., toxoplasmosis or herpes simplex virus infection in the first month after birth or cytomegalovirus infection in the first 6 months after birth.

Specific conditions that must be excluded in a child are:

1. Primary immunodeficiency diseases—severe combined immunodeficiency, DiGeorge syndrome, Wiskott-Aldrich syndrome, ataxia-telangiectasia, graft versus host disease, neutropenia, neutrophil function abnormality, agammaglobulinemia, or hypogammaglobulinemia with raised IgM.*
2. Secondary immunodeficiency associated with immunosuppressive therapy, lymphoreticular malignancy, or starvation.

*Immunodeficiency. WHO Technical Report Series 1978;630:28-31.

Respiratory Virus Surveillance — United States, 1983

Since September 1983, CDC has collected reports of noninfluenza respiratory virus isolations from certain state and university virology laboratories. The viruses reported include respiratory syncytical virus (RSV), parainfluenza virus types 1-4, and rhinoviruses. Reports received through December 19 show: (1) increasing numbers of RSV isolates beginning in November in the South Atlantic, West South Central, and Mountain regions and appearance of a few RSV isolates in the New England, East South Central, and Pacific regions during this same time period; (2) parainfluenza type 1 isolates occurring in the New England, Mid-Atlantic, East North Central, West North Central, South Atlantic, West South Central, and Mountain regions, with peak numbers of isolates in October. The largest numbers of isolates were reported from the Mid-Atlantic and Mountain regions; 42/310 and 40/147, respectively, of the respiratory specimens tested were positive for parainfluenza type 1. Smaller numbers of parainfluenza types 2 and 3 and rhinovirus isolates were reported during this time period.

Reported by LL Minnich, MS, CG Ray, MD, Arizona Health Science Center, Tucson; C Brandt, PhD, HW Kim, MD, Children's Hospital National Medical Center, District of Columbia; L Pierik, K McIntosh, MD, The Children's Hospital, Boston, Massachusetts; CB Hall, MD, University of Rochester Medical Center, Rochester, New York; M Kervina, MS, E Sannella, MS, PF Wright, MD, Vanderbilt University School of Medicine, Nashville, Tennessee; L Corey, MD, Children's Orthopedic Hospital, Seattle, Washington; Respective State Virus Laboratory Directors; Div of Viral Diseases, Center for Infectious Diseases, CDC.

Editorial Note: The purpose of this respiratory surveillance program is to identify the timing and locations of outbreaks of noninfluenza respiratory viruses in the United States. Initially, the program will focus on RSV and the parainfluenza viruses. RSV causes yearly outbreaks sometime between late fall and early spring; parainfluenza types 1 and 2 cause periodic outbreaks, often every other year in the fall; and parainfluenza type 3 is likely to be isolated throughout the year, with periodic outbreaks also occurring.

Notice to Readers

Cumulative 1983 Totals for Tables I, II, and III

The cumulative totals printed in this issue for week 52 are the 1983 provisional totals pending publication of the 1983 *Annual Summary*. Please note that data from the states of Arizona and California are unavailable for week 52. An updated table of 1983 provisional totals, including data from these states, will be available on request.

Erratum: Vol. 32, No. 50

p. 649. In the article, "Alcohol-Related Deaths—United States, 1968-1978," the first sentence should read: "According to mortality data from the National Center for Health Statistics, from 1968 through 1978, 21,221,893 people died." The number given, 11,806,737, was the number of males who died during this period.

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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 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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