CENTERS FOR DISEASE CONTROL

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MORBIDITY AND MORTALITY WEEKLY REPORT

Current Trends

Toy Safety — United States, 1983

The U.S. Consumer Product Safety Commission (CPSC) estimated that, in 1983, 594,100 toy-related injuries to children under 15 years of age were treated in U.S. hospital emergency rooms (Table 1); 16 children died (Table 2). Most injuries occurred from impacts with toys (falling on, tripping over, or hit by). Choking from ingestion of small toys or parts of toys was the second most frequently reported incident. Half the deaths involved children who choked on balloons, rode tricycles into pools, or were struck by motor vehicles while riding tricycles.

These incidents often involved children who may have been too young to use the toys—such as balloons, crayons, marbles, small building toy pieces, and stuffed crib toys—as they were intended. Parts of the toys were ingested, or pieces were broken or bitten off and put into the nose, ear, or mouth. Small riding toys and rocking horses were involved in tip-over and falling incidents and sometimes resulted in head/face injuries to children in the 1-year age group. Toys with cords, including play phones that entangled some very young children, kites with metallic twine that contacted power lines and caused electrocution or burns, and electric or battery-powered toys that overheated, melted, and resulted in fires caused other toy-related injuries in 1983.

Editorial Note: CPSC has mandatory safety standards for electric toys, bicycles, pacifiers, and infant rattles, toys with sharp points and edges, lead paint in toys, and small parts in toys. Approximately 150,000 different toys are on the market, and toy manufacturers are responsibile for assuring that products meet these standards. Many manufacturers have extensive testing programs. Although CPSC does some testing to check for compliance and to follow up on consumer complaints, it does not approve or endorse toys for safety.

During 1983, CPSC investigated consumer and trade complaints and reports of injuries and deaths by conducting inspections of toy manufacturers, importers, and distributors and

TABLE 1. Estimated injuries among children under 15 years old treated in hospital emergency rooms — United States, 1983

Cause of injury	No. injuries
Toys	118,000*
Bicycles	387,300
Sleds	16,600
Skates	61,900
Skateboards	10,300
Total	**594,100**

*Data for 1983 indicate that injuries decreased slightly from 1982.

Toy Safety — Continued

by collecting samples of suspected unsafe toys. CPSC determines the appropriate corrective action based on the severity of the hazard presented by the subject toy, which may include: correcting the violation in future production, ceasing distribution, recalling from retail stores, and recalling from consumers.

Approximately 39 toys and 11 other children's articles were recalled between October 1, 1983, and September 30, 1984. Several infant rattles were recalled because they presented a choking hazard. Manufacturers are responsible for notifying retailers when a product is recalled and should be removed from shelves; banned or recalled toys are removed from shelves.

The Toy Manufacturers of America (TMA) has a Voluntary Product Standard that establishes safety requirements and tests. This standard is currently being revised to cover additional safety requirements. Manufacturers have extensive testing programs, both to assure compliance with federal and voluntary standards and to conduct actual "play testing" of toys by children.

CPSC and TMA recommend the following guidelines for selecting and using safe toys:

1. Toys should be selected to suit the age, skills, abilities, and interests of the individual child. There are age recommendations on many toy packages, which sometimes reflect safety concerns, in addition to aiding in selection of stimulating, educational toys.
2. If supervision is required, "ground rules" for play should be set.
3. Instructions should be clear to parents and, when appropriate, to the child.
4. Toys should be sturdily constructed. Soft toys for young children should be well made, with eyes, noses, and other small parts tightly secured.
5. For infants and toddlers, small parts that children can put in their mouths and long strings or cords that can cause strangulation should be avoided.
6. Toys that shoot or propel objects that can injure eyes or become lodged in the throat should be avoided.
7. Arrows or darts should have soft cork tips, rubber suction cups, or other protective tips. Tips should be securely attached to their shafts and should be examined periodically to ensure the protective tips remain secured.
8. Electric toys with heating elements are recommended only for children over 8 years of age and only with adult supervision.
9. The surroundings in which toys will be used should be considered, as should sufficiency of toy storage and play space, and whether young children will be exposed to toys designed for older children.

CPSC has a toll-free telephone number ([800] 638-2772) that consumers and others can call to ask questions, request information, or file complaints.

Reported by U.S. Consumer Product Safety Commission, Washington, D.C.

TABLE 2. Reported fatalities associated with toys and other children's products — United States, 1983

Toy/Other	No. fatalities	Nature of injury leading to death
Balloons	5	Choking
Tricycles	3	Hit by auto (1); rode into pool/spa (2)
Small toy (soldier)	1	Choking
Small part (knob on child's jewelry box)	1	Choking
Building toy piece	1	Aspiration
Toy whip	1	Hanging from tree
Doll-making kit	1	Plastic face over child's mouth
Unnamed toy	1	Struck head falling
Beach ball	1	Drowned while playing
Toy chest (homemade)	1	Neck compression

Temporal Patterns of Motor-Vehicle-Related Fatalities Associated with Young Drinking Drivers — United States, 1983

Analysis of data from the Fatal Accident Reporting System (FARS) reveals that there were 37,971 reported fatal motor-vehicle incidents in 1983, resulting in 42,584 fatalities. Alcohol was an important contributing factor in 17,847 (42%) of these deaths. Of the 54,649 drivers involved in these incidents, 16,483 (30%) had positive blood-alcohol concentration test results or were judged by the investigating officers to be alcohol-involved. Thirty-three percent (17,764) of all drivers in fatal motor-vehicle incidents were between the ages of 16 years and 24 years. Thirty-eight percent (6,833) of the drivers from this age group were alcohol-involved, compared to 26% for all other ages. In 1983, incidents involving young drinking drivers claimed 7,784 lives, of which 3,992 (51%) were the young drivers themselves.*

Several studies have indicated that motor-vehicle-associated deaths involving young drinking drivers are not uniformly distributed temporally (*2-4*). For example, more fatalities occur during nighttime rather than daytime and on weekends rather than weekdays. Analysis of 1983 FARS data for youth-related alcohol-involved fatalities supports and expands these findings. Temporal patterns of fatalities were investigated by quarter, month, day of week and time of day, and holiday period. Examination of the frequency of fatalities by quarter shows that the third quarter (July-September) accounts for the largest proportion of fatalities, followed by the second, fourth, and first quarters (Table 3).

An examination of monthly totals for alcohol-involved young driver-related fatalities reveals a more detailed picture of the quarterly pattern. January has the fewest fatalities for the

*There are several limitations related to these findings. One is that blood-alcohol information is available for fewer than half the drivers reported in the FARS (*1*); also, these data do not allow consideration of other risk factors, such as miles driven by young drivers, compared with other drivers, or average number of occupants per car, by driver age.

TABLE 3. Motor-vehicle-related fatalities associated with young drinking drivers, by quarter and month — United States, 1983

Quarter and month	Fatalities No. (%)
First	1,527 (19.6)
January	465 (6.0)
February	490 (6.3)
March	572 (7.3)
Second	2,089 (26.9)
April	658 (8.5)
May	738 (9.5)
June	693 (8.9)
Third	2,360 (30.3)
July	821 (10.5)
August	806 (10.4)
September	733 (9.4)
Fourth	1,808 (23.2)
October	724 (9.3)
November	583 (7.5)
December	501 (6.4)
Total	**7,784 (100.0)**

Motor-Vehicle-Related Fatalities – Continued

year. From January through May, the frequency of fatalities rises steadily, followed by a slight drop in June. Fatalities peak in July and August, then decline from September through December.

Temporal patterns of fatalities associated with young drinking drivers also vary depending on the day of the week and the time of day of the incident (Figure 1). Approximately 67% of all such deaths occur on Friday, Saturday, or Sunday. Seventy percent of all such deaths occur between 8 p.m. and 4 a.m. When these two factors are considered simultaneously, 48% of all such deaths occur between 8 p.m. and 4 a.m. on the weekend.

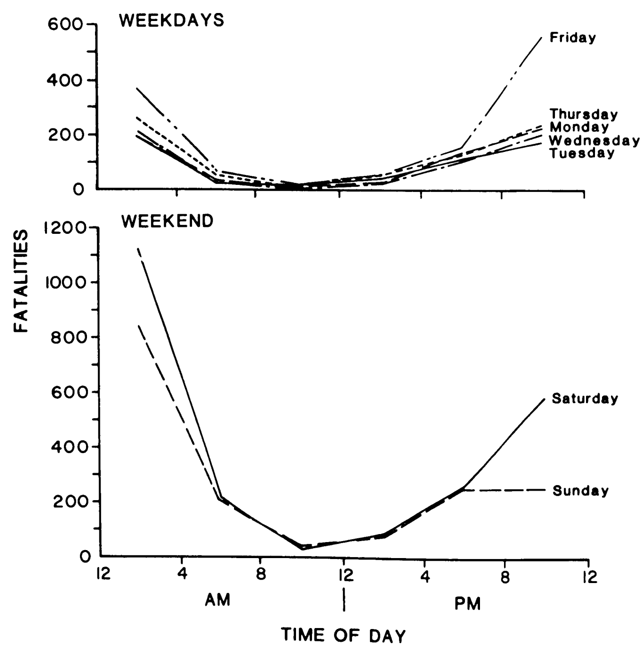
The number of persons killed in motor-vehicle incidents involving young drinking drivers for the major holiday periods (*5,6*), Memorial Day, Independence Day, and Labor Day accounts for 65% of all holiday fatalities (Figure 2). The numbers of fatalities for these holidays were greater than those for similar quarterly nonholiday days of the week and times of day, while fewer young drinking driver-related fatalities occurred for the New Year's, Thanksgiving, and Christmas holiday periods.

Reported by T Zobeck, PhD, MB Grigson, Alcohol Epidemiologic Data System, CSR, Incorporated, J Noble, H Malin, MA, Div of Biometry and Epidemiology, National Institute on Alcohol Abuse and Alcoholism, Washington, DC; Epidemiologic Studies Br, Div of Surveillance and Epidemiologic Studies, Epidemiology Program Office, Special Studies Br, Chronic Diseases Div, Center for Environmental Health, CDC.

Editorial Note: Many fatal motor-vehicle-related injuries are associated with young drivers, particularly those who are alcohol-involved. Nonetheless, although alcohol use is clearly a risk factor for fatal vehicular injuries among young persons, the increased risk of incurring such injuries when drinking is not limited to young drivers.

The prevention of alcohol-associated motor-vehicle deaths and injuries has been a subject of scientific scrutiny (*7*). Research indicates that drunk-driving laws can have an effect in reducing fatality rates only when there is sustained public perception of a significant possibili-

FIGURE 1. Temporal patterns of fatalities associated with young drinking drivers, by day of week and time of day — United States, 1983



Motor-Vehicle-Related Fatalities — Continued

ty of arrest and conviction with severe penalty matched by a significant and sustained increase in the number of arrests and convictions.

Other proven methods in reducing motor-vehicle fatalities and injuries associated with younger drivers include raising the legal age for the consumption and purchase of alcohol, raising the age of motor-vehicle licensure, and instituting a well-enforced curfew system to restrict night driving.

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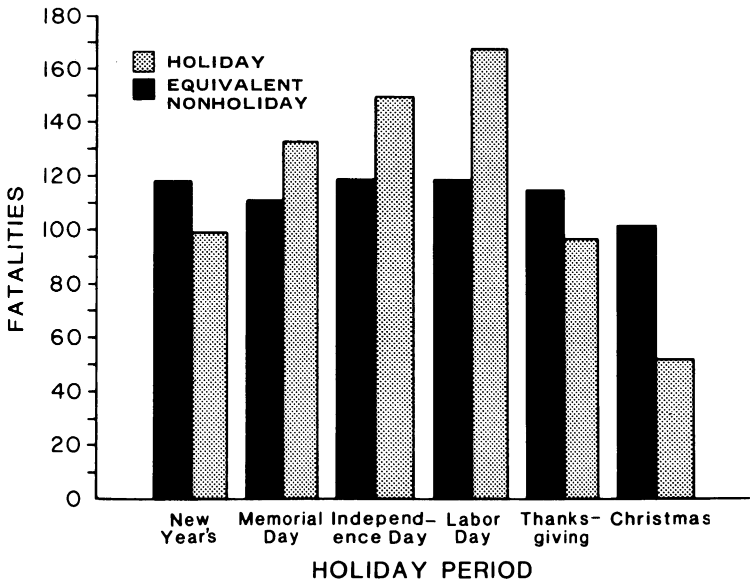
FIGURE 2. Motor-vehicle-associated fatalities involving young drinking drivers, by holiday* and equivalent nonholiday† periods — United States, 1983



*The complete holiday period was defined according to the National Safety Council (*5*) as lasting from 6 p.m. Friday to 12 midnight Monday, except for Thanksgiving, which was from 6 p.m. Wednesday to 12 midnight Sunday, and the New Year's holiday period. The complete New Year's holiday period was defined as lasting from 12:01 a.m. January 1, 1983, through 12 midnight January 2, 1983, and from 6 p.m., December 30, 1983, through 12 midnight, December 31, 1983.

†The number of nonholiday fatalities for all equivalent periods (same quarter of year, day of week, and time of day as was found in the corresponding holiday period) was divided by the number of nonholiday equivalent periods. These were added to obtain the mean number of fatalities for the complete nonholiday equivalent period.

Epidemiologic Notes and Reports

Measles — Hawaii

Between May 5, and June 29, 1984, 106 cases of measles were reported on the island of Kauai, Hawaii (Figure 3). All met the clinical case definition* for measles; 25 cases were serologically confirmed.† Four distinct generations of illness were identified 10-12 days apart. The second generation (May 17-28) was the largest, with 35 (33%) cases. No source was identified. Seven children (7%) of the 106 patients were hospitalized secondary to measles. Three were hospitalized for diarrhea and dehydration, and four, for evaluation.

The single largest group of cases, 52 (49%), occurred among children under 5 years of age, including 36 (34%) under 16 months of age (Table 4). Persons 15-19 years of age were the next largest group, accounting for 27 (25%) cases. Forty-five (42%) of the cases occurred among school-aged children (5-19 years). Although more than two-thirds of the first generation occurred among school-aged children (15/22), the second generation occurred mainly in

*Cases meeting the CDC measles case definition defined as: (1) generalized maculopapular rash for 3 days or more; (2) fever of 38.3 C (101 F) or higher, if measured; and (3) cough, coryza, or conjunctivitis.
†Either by a fourfold rise between acute and convalescent measles titers or a measles-specific immunoglobulin M.

(Continued on page 707)

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

Disease	50th Week Ending			Cumulative, 50th Week Ending		
	Dec. 15, 1984	Dec. 17, 1983	Median 1979-1983	Dec. 15, 1984	Dec. 17, 1983	Median 1979-1983
Acquired Immunodeficiency Syndrome (AIDS)*	135	49	N	4,203	2,012	N
Aseptic meningitis	134	209	170	7,852	12,167	9,265
Encephalitis: Primary (arthropod-borne & unspec.)	21	19	19	1,131	1,778	1,478
Post-infectious	1	4	4	82	91	91
Gonorrhea: Civilian	19,453	18,664	20,495	806,245	869,203	964,060
Military	253	428	601	19,605	23,154	25,893
Hepatitis: Type A	458	379	596	20,668	20,522	24,581
Type B	685	571	463	25,054	23,130	20,088
Non A, Non B	75	66	N	3,590	3,292	N
Unspecified	124	121	206	5,238	6,951	10,089
Legionellosis	13	19	N	628	734	N
Leprosy	4	7	5	226	233	227
Malaria	10	9	16	946	769	1,011
Measles: Total**	13	11	42	2,524	1,442	2,946
Indigenous	13	10	N	2,232	1,139	N
Imported	-	1	N	292	304	N
Meningococcal infections: Total	46	36	46	2,564	2,600	2,600
Civilian	46	35	46	2,559	2,584	2,584
Military	-	1	-	5	16	16
Mumps	68	139	139	2,807	3,237	5,146
Pertussis	14	67	40	2,081	2,270	1,610
Rubella (German measles)	7	12	25	729	938	2,255
Syphilis (Primary & Secondary): Civilian	591	612	612	26,519	31,000	30,023
Military	4	8	7	275	375	357
Toxic Shock syndrome	6	14	N	446	416	N
Tuberculosis	599	601	616	20,758	22,663	26,125
Tularemia	5	4	9	284	289	250
Typhoid fever	7	8	8	358	446	486
Typhus fever, tick-borne (RMSF)	3	3	7	848	1,095	1,095
Rabies, animal	46	49	61	5,089	5,719	5,990

TABLE II. Notifiable diseases of low frequency, United States

	Cum. 1984		Cum. 1984
Anthrax	1	Plague	31
Botulism: Foodborne	19	Poliomyelitis: Total	4
Infant (Calif. 1)	90	Paralytic	4
Other	6	Psittacosis (Mich. 1)	87
Brucellosis (Tex. 1)	119	Rabies, human	3
Cholera	1	Tetanus	64
Congenital rubella syndrome	4	Trichinosis	61
Diphtheria	1	Typhus fever, flea-borne (endemic, murine) (Tex. 1)	36
Leptospirosis	30		

*The 1983 reports which appear in this table were collected before AIDS became a notifiable condition.
**There were no cases of internationally imported measles reported for this week.

TABLE III. Cases of specified notifiable diseases, United States, weeks ending December 15, 1984 and December 17, 1983 (50th Week)

Reporting Area	AIDS	Aseptic Menin-gitis	Encephalitis		Gonorrhea (Civilian)		Hepatitis (Viral), by type				Legionel-losis	Leprosy
			Primary	Post-in-fectious			A	B	NA,NB	Unspeci-fied		
	Cum. 1984	1984	Cum. 1984	Cum. 1984	Cum. 1984	Cum. 1983	1984	1984	1984	1984	1984	Cum. 1984
UNITED STATES	4,203	134	1,131	82	806,245	869,203	458	685	75	124	13	226
NEW ENGLAND	144	-	47	3	22,241	22,931	5	46	4	14	-	11
Maine	-	-	-	-	979	1,084	1	2	-	-	-	-
N.H.	3	-	7	-	701	712	-	3	-	-	-	-
Vt.	1	-	5	-	370	425	-	1	-	-	-	-
Mass.	80	-	21	-	9,473	10,026	1	26	1	13	-	6
R.I.	6	-	-	-	1,586	1,245	-	3	-	-	-	4
Conn.	54	-	14	3	9,132	9,439	3	11	3	1	-	1
MID ATLANTIC	1,852	25	125	9	108,235	112,515	62	180	1	17	1	36
Upstate N.Y.	157	6	41	7	17,459	18,158	8	17	-	2	-	3
N.Y. City	1,344	1	11	-	41,962	45,252	40	111	-	9	1	31
N.J.	262	5	28	-	19,178	20,937	5	17	1	3	-	-
Pa.	89	13	45	2	29,636	28,168	9	35	-	3	-	2
E.N. CENTRAL	183	19	328	18	116,524	124,229	18	46	1	3	2	7
Ohio	20	6	105	9	30,816	31,972	4	19	1	1	-	3
Ind.	25	1	82	-	12,271	11,954	2	9	-	-	-	-
Ill.	98	2	37	6	27,367	35,689	3	-	-	-	-	2
Mich.	30	10	67	-	33,371	33,380	9	18	-	2	2	2
Wis.	10	-	37	3	12,699	11,234	-	-	-	-	-	-
W.N. CENTRAL	41	5	99	3	40,178	40,913	7	19	3	-	1	4
Minn.	11	-	46	-	6,009	5,706	-	-	-	-	-	2
Iowa	2	2	32	-	4,409	4,433	2	6	-	-	-	1
Mo.	23	3	11	-	19,218	20,064	-	8	2	-	-	1
N. Dak.	-	-	-	-	385	428	-	-	-	-	-	-
S. Dak.	-	-	2	1	963	1,020	4	2	-	-	-	-
Nebr.	3	-	1	-	2,978	2,685	-	1	-	-	1	-
Kans.	2	-	7	2	6,216	6,577	1	2	1	-	-	-
S. ATLANTIC	540	34	173	17	196,574	225,574	39	114	27	10	6	14
Del.	5	1	1	-	3,905	4,130	4	1	-	-	1	-
Md.	51	4	33	-	23,353	28,870	-	9	2	2	1	1
D.C.	83	2	-	-	14,634	15,344	-	1	1	-	-	1
Va.	38	9	31	5	19,411	20,548	17	32	10	2	1	4
W. Va.	5	-	40	-	2,642	2,541	-	2	-	-	-	-
N.C.	14	4	33	7	33,186	34,522	1	18	2	-	1	-
S.C.	8	2	5	-	20,960	20,619	2	10	1	-	-	-
Ga.	56	2	2	2	28,722	47,441	2	11	2	-	1	1
Fla.	280	10	28	3	49,761	51,559	13	30	9	6	1	7
E.S. CENTRAL	25	6	53	8	73,176	73,031	10	36	4	6	-	-
Ky.	10	-	13	-	8,632	8,627	6	-	-	2	-	-
Tenn.	6	-	17	1	29,532	29,905	3	21	-	2	-	-
Ala.	6	5	20	6	22,109	22,529	-	13	4	2	-	-
Miss.	3	1	3	1	12,903	11,970	1	2	-	-	-	-
W.S. CENTRAL	290	12	107	4	109,265	121,161	77	43	3	32	1	24
Ark.	1	-	-	2	9,743	9,631	7	2	-	4	-	1
La.	44	-	12	-	23,835	23,405	1	4	1	3	-	1
Okla.	9	2	19	1	12,050	13,850	7	9	-	5	-	-
Tex.	236	10	76	1	63,637	74,275	62	28	2	20	1	22
MOUNTAIN	71	8	34	11	26,770	27,634	52	53	7	13	1	8
Mont.	-	-	-	-	1,016	1,193	2	1	1	-	-	-
Idaho	-	-	-	-	1,250	1,236	-	-	-	-	-	-
Wyo.	1	-	-	-	712	725	-	-	-	-	-	-
Colo.	36	2	12	-	7,666	7,715	10	6	1	5	-	-
N. Mex.	2	-	-	-	3,190	3,416	5	18	-	2	-	-
Ariz.	19	2	12	3	7,605	7,857	9	15	3	5	-	6
Utah	7	3	10	8	1,253	1,323	14	8	2	1	1	1
Nev.	6	1	-	-	4,078	4,169	12	5	-	-	-	1
PACIFIC	1,057	25	165	9	113,282	121,215	188	148	25	29	1	122
Wash.	54	1	9	-	8,446	9,495	7	2	2	-	-	8
Oreg.	14	-	-	-	6,403	6,438	19	11	4	2	-	2
Calif.	975	20	152	9	93,753	99,994	162	131	19	27	1	92
Alaska	2	-	-	-	2,792	3,046	-	1	-	-	-	-
Hawaii	12	4	4	-	1,888	2,242	-	3	-	-	-	20
Guam	-	U	-	-	103	130	U	U	U	U	U	-
P.R.	69	2	3	2	3,180	2,615	2	24	-	-	-	5
V.I.	-	U	-	-	427	316	U	U	U	U	U	-
Pac. Trust Terr.	-	U	-	-	-	-	U	U	U	U	U	-

N: Not notifiable U: Unavailable

TABLE III. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending December 15, 1984 and December 17, 1983 (50th Week)

Reporting Area	Malaria	Measles (Rubeola)					Meningococcal Infections	Mumps		Pertussis			Rubella		
		Indigenous		Imported *		Total									
	Cum. 1984	1984	Cum. 1984	1984	Cum. 1984	Cum. 1983	Cum. 1984	1984	Cum. 1984	1984	Cum. 1984	Cum. 1983	1984	Cum. 1984	Cum. 1983
UNITED STATES	946	13	2,232	-	292	1,442	2,564	68	2,807	14	2,081	2,270	7	729	938
NEW ENGLAND	47	-	94	-	12	21	174	2	95	2	70	73	1	22	19
Maine	-	-	-	-	-	-	1	-	29	-	4	5	-	1	-
N.H.	-	-	33	-	3	3	11	1	20	-	14	10	-	1	5
Vt.	7	-	2	-	5	-	30	-	5	-	23	8	-	-	5
Mass.	26	-	49	-	-	9	70	1	21	2	21	38	1	19	7
R.I.	4	-	-	-	-	-	18	-	11	-	4	5	-	-	-
Conn.	10	-	10	-	4	9	44	-	9	-	4	7	-	1	2
MID ATLANTIC	143	-	135	-	44	119	439	17	330	-	195	384	1	231	145
Upstate N.Y.	28	-	42	-	14	18	139	3	99	-	108	118	-	99	30
N.Y. City	48	-	89	-	20	71	87	5	35	-	16	56	1	105	86
N.J.	37	-	4	-	3	27	86	-	138	-	13	20	-	23	3
Pa.	30	-	-	-	7	3	127	9	58	-	58	190	-	4	26
E.N. CENTRAL	84	-	617	-	75	717	411	25	1,081	3	463	502	2	98	138
Ohio	20	-	3	-	6	87	136	12	505	3	79	151	-	2	2
Ind.	4	-	2	-	1	406	51	2	76	-	241	60	-	5	27
Ill.	28	-	179	-	1	216	88	4	191	-	26	175	2	61	61
Mich.	17	-	411	-	54	7	85	7	194	-	31	42	-	22	19
Wis.	15	-	22	-	13	1	51	-	115	-	86	74	-	8	29
W.N. CENTRAL	24	-	49	-	9	8	163	-	108	1	127	178	-	39	43
Minn.	7	-	44	-	3	1	35	-	7	-	16	48	-	4	9
Iowa	2	-	-	-	-	-	23	-	25	-	14	9	-	1	-
Mo.	8	-	5	-	1	1	52	-	10	-	20	23	-	-	-
N. Dak.	1	-	-	-	-	-	2	-	2	-	-	3	-	3	-
S. Dak.	1	-	-	-	-	-	6	-	-	-	9	8	-	-	-
Nebr.	3	-	-	-	-	-	13	-	4	-	13	4	-	-	-
Kans.	2	-	-	-	5	6	32	-	60	1	55	83	-	31	34
S. ATLANTIC	129	-	19	-	33	206	528	6	204	4	172	266	1	29	102
Del.	4	-	-	-	-	-	4	-	3	-	2	5	-	2	-
Md.	31	-	8	-	14	11	40	1	42	-	13	34	-	1	3
D.C.	1	-	-	-	5	-	8	-	-	-	-	-	-	-	-
Va.	35	-	1	-	4	23	67	1	19	-	15	50	-	1	2
W. Va.	1	-	-	-	-	-	5	2	41	-	11	9	-	-	-
N.C.	12	-	-	-	1	1	85	-	22	1	37	31	-	-	10
S.C.	2	-	-	-	-	4	57	-	5	-	1	14	-	-	1
Ga.	15	-	1	-	1	8	101	-	22	-	18	70	-	2	16
Fla.	28	-	9	-	8	159	161	2	50	3	75	53	1	23	70
E.S. CENTRAL	11	-	1	-	5	27	141	-	55	-	14	33	-	20	19
Ky.	2	-	1	-	-	1	50	-	11	-	2	14	-	14	18
Tenn.	2	-	-	-	2	-	40	-	17	-	7	8	-	-	-
Ala.	7	-	-	-	3	5	34	-	6	-	1	5	-	3	1
Miss.	-	-	-	-	-	21	17	-	21	-	4	6	-	3	-
W.S. CENTRAL	84	-	596	-	25	79	288	4	183	-	329	451	-	68	120
Ark.	-	-	8	-	-	13	49	-	8	-	19	26	-	3	-
La.	9	-	8	-	-	29	57	-	-	-	10	12	-	-	10
Okla.	10	-	-	-	8	1	28	N	N	-	241	330	-	-	-
Tex.	65	-	580	-	17	36	154	4	175	-	59	83	-	65	110
MOUNTAIN	28	-	113	-	32	34	85	5	263	-	122	232	-	22	37
Mont.	2	-	-	-	-	4	2	1	11	-	19	2	-	-	3
Idaho	2	-	-	-	23	10	10	-	10	-	7	16	-	1	8
Wyo.	-	-	-	-	-	1	3	-	2	-	6	6	-	3	9
Colo.	7	-	-	-	6	3	30	-	28	-	45	134	-	2	1
N. Mex.	1	-	88	-	-	-	8	N	N	-	12	13	-	1	-
Ariz.	11	-	-	-	1	1	17	3	194	-	24	29	-	4	8
Utah	5	-	25	-	2	15	9	-	11	-	7	31	-	7	7
Nev.	-	-	-	-	-	-	6	1	7	-	2	1	-	4	1
PACIFIC	396	13	608	-	57	231	335	9	488	4	589	151	2	200	315
Wash.	20	13	157	-	15	35	53	1	53	-	321	20	-	2	9
Oreg.	14	-	-	-	-	10	49	N	N	-	30	10	-	2	14
Calif.	357	-	292	-	38	182	224	8	397	4	161	114	2	189	290
Alaska	-	-	-	-	-	2	8	-	14	-	1	4	-	1	1
Hawaii	5	-	159	-	4	2	1	-	24	-	76	3	-	6	1
Guam	1	U	83	U	2	2	1	U	5	U	-	-	U	2	-
P.R.	4	25	235	-	-	96	7	1	173	-	1	14	-	20	8
V.I.	-	U	-	U	-	5	-	U	5	U	-	-	U	-	2
Pac. Trust Terr.	-	U	-	U	-	-	-	U	-	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 15, 1984 and December 17, 1983 (50th Week)

Reporting Area	Syphilis (Civilian) (Primary & Secondary)		Toxic-shock Syndrome	Tuberculosis		Tula-remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1984	Cum. 1983	1984	Cum. 1984	Cum. 1983	Cum. 1984	Cum. 1984	Cum. 1984	Cum. 1984
UNITED STATES	26,519	31,000	6	20,758	22,663	284	358	848	5,089
NEW ENGLAND	516	655	1	633	693	7	21	6	48
Maine	10	19	-	36	35	-	-	-	13
N.H.	14	22	-	27	36	-	-	-	16
Vt.	1	3	-	8	11	-	-	-	-
Mass.	284	426	1	343	375	7	17	4	11
R.I.	22	23	-	55	62	-	-	-	-
Conn.	185	162	-	164	174	-	4	2	8
MID ATLANTIC	3,553	4,124	-	3,802	4,042	3	56	27	535
Upstate N.Y.	276	393	-	592	631	-	12	10	124
N.Y. City	2,145	2,378	-	1,576	1,640	2	18	3	-
N.J.	640	799	-	813	831	1	18	3	37
Pa.	492	554	-	821	940	-	8	11	374
E.N. CENTRAL	1,352	1,642	-	2,690	3,061	10	59	53	211
Ohio	228	441	-	489	487	2	7	28	27
Ind.	143	141	-	342	359	-	12	7	21
Ill.	558	731	-	1,109	1,311	8	23	15	74
Mich.	349	236	-	600	754	-	8	3	21
Wis.	74	93	-	150	150	-	9	-	68
W.N. CENTRAL	345	376	-	621	719	83	10	53	746
Minn.	87	144	-	111	152	1	3	1	94
Iowa	11	23	-	66	65	-	-	6	148
Mo.	179	142	-	304	358	45	5	18	67
N. Dak.	9	2	-	13	8	-	-	-	140
S. Dak.	1	11	-	23	37	34	-	5	203
Nebr.	15	15	-	30	25	-	-	5	44
Kans.	43	39	-	74	74	3	2	18	50
S. ATLANTIC	7,567	8,406	1	4,385	4,522	8	41	395	1,505
Del.	20	43	-	56	66	-	-	1	6
Md.	470	506	-	424	361	1	2	28	846
D.C.	330	374	-	174	189	1	6	-	-
Va.	402	545	-	449	488	1	8	50	206
W. Va.	20	25	-	127	132	-	-	7	40
N.C.	830	853	1	680	714	1	1	176	25
S.C.	754	558	-	542	438	-	1	80	59
Ga.	1,059	1,498	-	662	753	4	9	48	183
Fla.	3,682	4,004	-	1,271	1,381	-	14	5	140
E.S. CENTRAL	1,973	2,109	-	1,957	2,022	7	10	94	249
Ky.	95	171	-	487	498	1	2	19	53
Tenn.	534	578	-	562	622	5	2	49	78
Ala.	647	803	-	558	510	-	2	15	118
Miss.	697	557	-	350	392	1	4	11	-
W.S. CENTRAL	6,514	7,898	3	2,420	2,813	117	24	201	979
Ark.	191	187	-	279	346	83	-	28	101
La.	1,149	1,608	-	337	433	7	2	4	57
Okla.	206	194	-	230	266	19	4	119	101
Tex.	4,968	5,909	3	1,574	1,768	8	18	50	720
MOUNTAIN	648	631	1	567	625	36	13	13	279
Mont.	3	7	-	28	42	3	1	8	124
Idaho	23	7	-	28	32	8	-	1	11
Wyo.	4	12	-	5	12	1	-	3	27
Colo.	180	146	-	72	93	8	5	1	39
N. Mex.	91	172	-	109	108	3	3	-	11
Ariz.	235	162	1	251	251	4	3	-	45
Utah	18	22	-	35	41	4	-	-	6
Nev.	94	103	-	39	46	5	1	-	16
PACIFIC	4,051	5,159	-	3,683	4,166	13	124	6	537
Wash.	138	192	-	189	230	3	3	2	3
Oreg.	114	140	-	145	177	2	2	1	1
Calif.	3,716	4,735	-	3,067	3,455	8	110	2	525
Alaska	6	14	-	75	73	-	1	1	8
Hawaii	77	78	-	207	231	-	8	-	-
Guam	-	-	U	5	9	-	-	-	-
P.R.	753	879	-	388	455	-	5	-	62
V.I.	11	19	U	3	2	-	3	-	-
Pac. Trust Terr.	-	-	U	-	-	-	-	-	-

U: Unavailable

TABLE IV. Deaths in 121 U.S. cities,* week ending December 15, 1984 (50th Week Ending)

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	688	498	131	23	14	22	49
Boston, Mass.	185	114	49	9	5	8	15
Bridgeport, Conn.	44	35	8	1	-	-	-
Cambridge, Mass.	34	24	7	2	1	-	1
Fall River, Mass.	24	24	-	-	-	-	1
Hartford, Conn.	60	48	8	2	-	2	2
Lowell, Mass.	26	19	6	1	-	-	3
Lynn, Mass.	18	14	3	1	-	-	-
New Bedford, Mass.	30	23	5	2	-	-	3
New Haven, Conn.	44	30	7	3	-	4	4
Providence, R.I.	73	46	23	1	2	1	8
Somerville, Mass.	9	6	2	-	1	-	1
Springfield, Mass.	48	41	4	1	1	1	3
Waterbury, Conn.	26	24	1	-	1	-	2
Worcester, Mass.	67	50	8	-	3	6	6
MID. ATLANTIC	2,794	1,881	607	186	73	47	125
Albany, N.Y.	56	36	10	3	-	7	1
Allentown, Pa.	16	9	5	2	-	-	-
Buffalo, N.Y.	141	100	35	4	2	-	6
Camden, N.J.	45	30	10	4	-	1	1
Elizabeth, N.J.	33	24	9	-	-	-	-
Erie, Pa.†	37	26	10	-	-	1	3
Jersey City, N.J.	49	29	11	5	3	1	2
N.Y. City, N.Y.	1,462	976	305	111	45	25	68
Newark, N.J.	74	30	21	14	5	4	3
Paterson, N.J.	29	18	7	3	1	-	-
Philadelphia, Pa.†	366	247	81	23	11	4	19
Pittsburgh, Pa.†	82	59	19	2	1	1	3
Reading, Pa.	32	27	5	-	-	-	1
Rochester, N.Y.	119	86	26	5	2	-	13
Schenectady, N.Y.	37	29	6	-	1	1	1
Scranton, Pa.†	28	25	3	-	-	-	-
Syracuse, N.Y.	94	66	23	2	1	2	1
Trenton, N.J.	49	31	13	4	1	-	-
Utica, N.Y.	13	7	4	2	-	-	-
Yonkers, N.Y.	32	26	4	2	-	-	3
E.N. CENTRAL	2,237	1,588	400	102	58	80	90
Akron, Ohio	43	28	7	2	1	5	-
Canton, Ohio	32	23	7	1	1	-	2
Chicago, Ill. §	459	415	5	7	11	12	11
Cincinnati, Ohio	169	106	45	8	4	6	15
Cleveland, Ohio	143	81	38	11	4	9	5
Columbus, Ohio	128	75	26	12	5	10	5
Dayton, Ohio	114	77	24	5	4	4	1
Detroit, Mich.	264	157	65	27	6	9	11
Evansville, Ind.	48	37	9	-	-	2	2
Fort Wayne, Ind.	66	47	13	1	3	2	4
Gary, Ind.	11	6	1	2	1	1	-
Grand Rapids, Mich.	56	42	11	2	1	-	1
Indianapolis, Ind.	156	110	32	2	3	9	3
Madison, Wis.	36	26	6	2	2	-	3
Milwaukee, Wis.	164	113	35	6	5	5	4
Peoria, Ill.	60	34	21	2	-	3	4
Rockford, Ill.	40	30	4	2	2	2	6
South Bend, Ind.	54	35	15	3	1	-	2
Toledo, Ohio	117	83	26	4	3	1	9
Youngstown, Ohio	77	63	10	3	1	-	2
W.N. CENTRAL	786	505	180	44	25	32	50
Des Moines, Iowa	63	40	18	2	1	2	8
Duluth, Minn.	29	18	7	1	-	3	1
Kansas City, Kans.	48	31	12	2	3	-	3
Kansas City, Mo.	124	81	32	5	3	3	9
Lincoln, Nebr.	36	23	9	1	1	2	3
Minneapolis, Minn.	94	65	10	9	4	6	4
Omaha, Nebr.	102	61	27	4	4	6	8
St. Louis, Mo.	163	102	39	12	4	6	6
St. Paul, Minn.	51	37	9	2	2	1	-
Wichita, Kans.	76	47	17	6	3	3	8
S. ATLANTIC	1,234	796	259	101	32	42	65
Atlanta, Ga.	121	76	28	9	4	4	3
Baltimore, Md.	223	146	47	12	11	7	10
Charlotte, N.C.	84	50	20	9	1	3	8
Jacksonville, Fla.	131	77	26	20	2	6	7
Miami, Fla.	132	77	30	15	3	7	1
Norfolk, Va.	57	34	16	3	1	3	2
Richmond, Va.	82	49	24	7	2	-	7
Savannah, Ga.	65	44	14	5	1	1	6
St. Petersburg, Fla.	147	117	21	4	1	4	10
Tampa, Fla.	83	54	13	5	2	6	5
Washington, D.C.	39	30	4	4	1	-	3
Wilmington, Del.	70	42	16	8	3	1	3
E.S. CENTRAL	763	479	189	45	24	26	44
Birmingham, Ala.	130	76	31	10	5	8	1
Chattanooga, Tenn.	64	48	13	2	-	1	10
Knoxville, Tenn.	66	45	16	1	1	3	3
Louisville, Ky.	108	71	27	6	1	3	8
Memphis, Tenn.	91	48	30	7	3	3	2
Mobile, Ala.	92	60	20	6	4	2	8
Montgomery, Ala.	48	29	11	2	3	3	1
Nashville, Tenn.	164	102	41	11	7	3	11
W.S. CENTRAL	1,349	839	295	105	47	63	63
Austin, Tex.	63	38	10	10	1	4	4
Baton Rouge, La.	22	14	5	1	1	1	2
Corpus Christi, Tex.	44	30	9	1	1	3	-
Dallas, Tex.	215	136	43	14	10	12	15
El Paso, Tex.	73	44	13	6	3	7	5
Fort Worth, Tex.	88	64	15	5	1	3	7
Houston, Tex.	300	166	78	33	14	9	3
Little Rock, Ark.	71	38	18	7	2	6	9
New Orleans, La.	124	82	28	10	4	-	2
San Antonio, Tex.	173	110	33	11	5	14	9
Shreveport, La.	58	34	18	4	2	-	-
Tulsa, Okla.	118	83	25	3	3	4	7
MOUNTAIN	746	498	143	53	27	25	40
Albuquerque, N.Mex.	74	48	15	7	2	2	5
Colo. Springs, Colo.	44	26	11	4	1	2	5
Denver, Colo.	140	97	30	4	3	6	4
Las Vegas, Nev.	86	58	17	8	3	-	4
Ogden, Utah	24	17	4	1	-	2	2
Phoenix, Ariz.	183	117	39	7	9	11	8
Pueblo, Colo.	23	16	2	4	1	-	1
Salt Lake City, Utah	57	36	10	8	2	1	-
Tucson, Ariz.	115	83	15	10	6	1	11
PACIFIC	1,820	1,241	374	117	32	52	96
Berkeley, Calif.	24	17	6	1	-	-	1
Fresno, Calif.	74	53	15	2	2	2	5
Glendale, Calif.	39	35	4	-	-	-	2
Honolulu, Hawaii	78	49	21	5	1	2	2
Long Beach, Calif.	80	68	9	3	-	-	2
Los Angeles, Calif.	397	263	81	28	11	10	15
Oakland, Calif.	67	45	18	1	1	2	3
Pasadena, Calif.	39	30	5	2	2	-	2
Portland, Oreg.	131	93	24	8	2	4	5
Sacramento, Calif.	160	96	45	9	2	8	14
San Diego, Calif.	145	85	36	15	1	8	18
San Francisco, Calif.	162	116	27	16	2	1	2
San Jose, Calif.	165	106	38	10	4	7	14
Seattle, Wash.	170	116	35	9	3	7	4
Spokane, Wash.	54	39	7	6	1	1	5
Tacoma, Wash.	35	30	3	2	-	-	2
TOTAL	12,417††	8,325	2,578	776	332	389	622

* 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.

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

Cause of morbidity or mortality (Ninth Revision ICD, 1975)	Years of potential life lost before age 65 by persons dying in 1982*†	Estimated mortality July 1984		Estimated number of physician contacts July 1984*¶
		Number*§	Annual Rate/100,000*§	
ALL CAUSES (TOTAL)	9,429,000	163,990	817.8	114,800,000
Accidents and adverse effects (E800-E949)	2,367,000	8,780	43.8	6,700,000
Malignant neoplasms (140-208)	1,809,000	38,800	193.5	2,600,000
Diseases of heart (390-398, 402, 404-429)	1,566,000	60,340	300.9	6,400,000
Suicides, homicides (E950-E978)	1,314,000	4,430	22.1	–
Cerebrovascular diseases (430-438)	256,000	11,870	59.2	900,000
Chronic liver disease and cirrhosis (571)	252,000	1,880	9.4	100,000
Pneumonia and influenza (480-487)	118,000	3,550	17.7	600,000
Chronic obstructive pulmonary diseases and allied conditions (490-496)	114,000	5,130	25.6	900,000
Diabetes mellitus (250)	106,000	2,630	13.1	3,900,000
Prenatal care*				3,000,000
Infant mortality*††		3,200	9.8 /1,000 live births	

*For details of calculation, see footnotes for Table V, *MMWR* 1984;33:2.

†Years of potential life lost for persons between 1 year and 65 years old at the time of death are derived from the number of deaths in each age category as reported by the National Center for Health Statistics, *Monthly Vital Statistics Report* (MVSR), Vol. 31, No. 13, October 5, 1983.

§National Center for Health Statistics, *Monthly Vital Statistics Report* (MVSR), Vol. 33, No. 8, November 15, 1984, pp. 8-9.

¶IMS America *National Disease and Therapeutic Index* (NDTI), Monthly Report, July 1984, Section III.

††MVSR Vol. 33, No. 7, October 22, 1984, p. 1.

Measles — Continued

preschool-aged children 0-4 years of age (25/35). Further investigation revealed that 16 (46%) of the 35 second-generation cases were among infants 15 months of age or younger,§ compared to two (9%) of 22 cases in the first generation. High school stuaents accounted for 34 (75%) of the school-aged patients. Seven additional cases occurred at four elementary schools.

Of the 106 cases, 48 (45%) were considered preventable¶ (Table 5). Thirty-two of these patients had no record of measles vaccination or prior physician-diagnosed natural disease,

§Measles vaccination is normally recommended at 15 months of age.

¶A measles case is considered preventable if illness occurs in a U.S. citizen: (1) at least 16 months of age; (2) born after 1956; (3) lacking adequate evidence of immunity to measles; (4) without a medical contraindication to receiving vaccine; and (5) with no religious or philosophical exemption under state law.

Measles — Continued

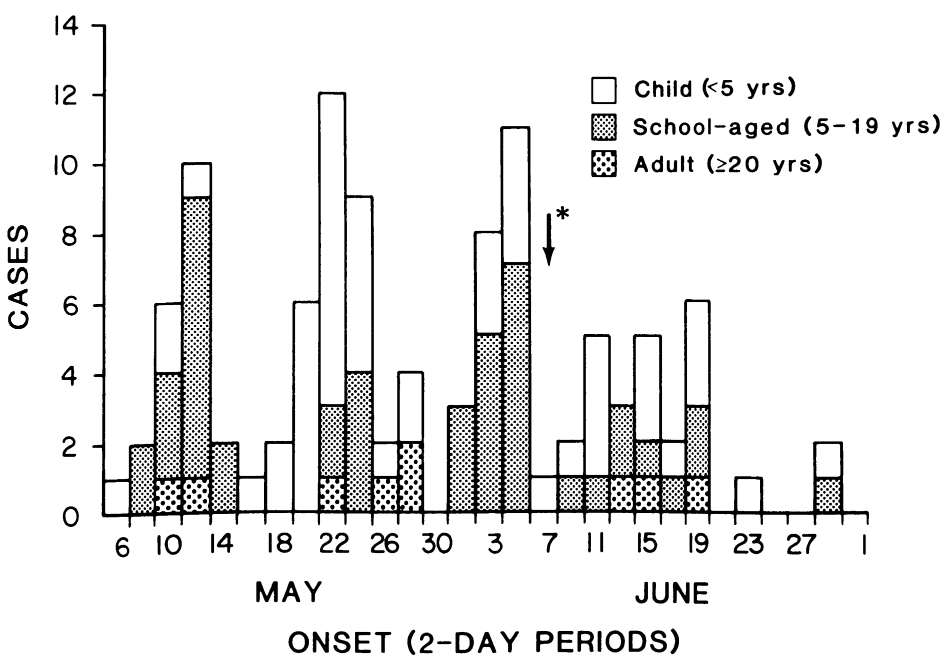
and 16 had been vaccinated at under 12 months of age. Thirty-six of the 58 nonpreventable cases** (62%) occurred among children 15 months of age or younger, most of whom were too young for routine vaccination. Eighteen (31%) of the nonpreventable cases had been immunized appropriately.†† The remaining four measles patients were 28 years of age or older—too old for routine vaccination. Of the 45 school-aged patients, 16 (35%) were vaccinated at 12 months of age or under; 12 (27%) were unvaccinated. Thus, non-immune schoolchildren accounted for 58% (28/48) of all preventable measles cases.

Sixteen persons who subsequently developed measles had visited a doctor's office in May and June at the same time a patient with known or suspected measles was being seen in the office; one additional person was seen within 45 minutes after a patient with known measles left the office. All such visits occurred 8-14 days before onset of rash. Sixteen of the cases were in children; one was in a parent of one of these children. Mothers of four recalled face-to-face contact in the waiting room between their children and another child with rash. In 12 cases, for which exact times were available, the exposed person had been in the office with the measles patient for 20-90 minutes. No other possible sources of measles exposure were identified for these 17 cases. Interviews with parents revealed that, of the 16 children involved in office transmission, two were in the office primarily for measles-mumps-rubella vac-

**A case is considered nonpreventable if illness occurs in a person: (1) under 16 months of age; (2) born before 1957; (3) with adequate evidence of immunity; (4) with a medical contraindication to receiving vaccine; or (5) a religious or philosophical exemption under state law.

††Persons can be considered immune to measles only if they have documentation of: (1) physician-diagnosed measles; (2) laboratory evidence of measles immunity; or (3) adequate immunization with live measles vaccine on or after the first birthday.

FIGURE 3. Measles cases, by date of rash onset — Kauai, Hawaii, May 5-June 29, 1984



*Age of vaccination lowered to 6 months. Recommendations on office isolation procedures.

Measles — Continued

cine, and four, for routine examination; four accompanied an ill relative; and seven were ill themselves. Transmission in physicians' offices was most important in infecting young preschool-aged children. Such transmission accounted for 36% of cases among children 15 months of age and under and 31% of cases among children under 5 years of age.

Interviews with office staff revealed that procedures for isolating sick children from well children in the office were not well implemented. In many cases, parents brought in their children complaining of high fever and rash without appointments and either had to wait in or pass through a common waiting room.

On June 6, because of increasing evidence that up to one-third of all measles cases were occurring among children under 15 months of age, measles vaccination recommendations were extended to children as young as 6 months of age for the duration of the outbreak. On June 7, to limit measles transmission in private offices, the Hawaii Department of Health recommended that health professionals: (1) screen patients requesting appointments by asking if symptoms of rash and fever were present. If possible, such patients should then be seen in separate facilities or at the end of the day after all other patients had left; (2) keep suspected measles patients in respiratory isolation in separate rooms with face masks to limit spread of the virus; they should be given priority and seen as soon as possible.

Although measles cases continued to be reported in June and July, the last case of suspected intraoffice transmission occurred on June 7. With the implementation of isolation precautions and continued vaccination of susceptible children and adults, reports of measles cases began to decline after the third generation (Figure 3).

To define other populations at risk for disease, an island-wide school and day-care center

TABLE 4. Age distribution of measles cases — Kauai, Hawaii, May and June 1984

Age	No. cases (%)
≤ 15 mos.	36 (34.0)
16 mos.-4 yrs.	16 (15.1)
5-9 yrs.	5 (4.7)
10-14 yrs.	13 (12.3)
15-19 yrs.	27 (25.5)
20-24 yrs.	2 (1.9)
25-27 yrs.	3 (2.8)
≥ 28 yrs.	4 (3.8)
Total	**106 (100.0)**

TABLE 5. Preventability of measles cases and number believed associated with physician's office, by age — Kauai, Hawaii, May and June 1984

Age	Preventable cases	Nonpreventable cases	Doctor's office as probable source
≤ 15 mos.	—	36	13
16 mos.-4 yrs.	15	1	3
5-9 yrs.	1	4	—
10-14 yrs.	7	6	—
15-19 yrs.	20	7	—
20-24 yrs.	2	—	—
25-27 yrs.	3	—	—
≥ 28 yrs.	—	4	1
Total	**48**	**58**	**17**

Measles — Continued
health record review was done. A student was considered susceptible to or at high risk for measles if there was no record of receipt of live measles vaccine on or after the first birthday and no record of physician-diagnosed measles. Using this definition, 47% (1,864/3,986) of high school students and 22% (2,200/5,100) of elementary, private, and parochial school students were considered susceptible. Those students were asked to provide proof of previous adequate vaccination or be vaccinated in school-based clinics, held in all three high schools before graduation and end of school or in public clinics. Over 1,000 students were vaccinated at the high school clinics. Approximately 400 persons were vaccinated in 13 public clinics held between June 7 and June 15 for the general public and elementary and private schools.

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Editorial Note: Over the last 5 years, Hawaii has made significant progress towards measles elimination. The last major cluster of measles cases occurred in 1979, when 68 cases were reported. Fewer than seven cases had been reported annually in Hawaii since 1980. The present outbreak confirms that measles can occur in populations essentially free of disease for long periods. The source of this outbreak was not determined.

Hawaii's immunization law, enacted in 1974, covers only new school enterers and has been vigorously enforced only since about 1976. In this outbreak, susceptible schoolchildren made up 62% (28/45) of all school-aged measles patients. The predominance of high school students among the school-aged patients may, in part, reflect a higher susceptibility rate among the age group that was too old to be affected by the law. Only the year of vaccination was required for the school record. Considerable numbers of susceptibles were identified, because many students had records of vaccination in the year of, or the year following, birth, making determination of who was vaccinated on or after the first birthday impossible. Vigorous enforcement of comprehensive school laws covering all students from kindergarten through grade 12 has been demonstrated to be the most effective means of reducing measles incidence rates (*1*).

This outbreak is also important because of the large number of preschool-aged children who acquired measles. Of the 52 preschool-aged children with measles, 69% were under 16 months of age and their cases, therefore, were nonpreventable. However, 15 children in the preschool-aged group simply had not been vaccinated, and their measles could have been prevented (Table 5).

This investigation suggests that transmission in physicians' offices played a major role in perpetuating the outbreak, particularly among children too young for routine vaccination. Intraoffice transmission can occur both when droplet nuclei are aerosolized by coughing children and by direct physical contact between children. Measles outbreaks in medical offices, airports, and other settings have been propagated by susceptible persons inhaling measles-containing droplet nuclei left by infected persons (*2-4*). Transmission in medical offices has been documented to have occurred up to 75 minutes after an infectious person has left the office (*5*). The opportunity for intraoffice transmission by both direct contact and airborne routes was present on Kauai.

In situations where exposure has already occurred, susceptible persons who had face-to-face contact with a measles patient may benefit from immune globulin prophylaxis, if it is given within 6 days of exposure. Measles vaccination may provide protection if it is given within 72 hours of exposure. Prophylaxis is not generally offered to persons who have not had face-to-face contact but were in the office with the patient or arrived after the patient departed. The rarity of reports of transmission in doctors' offices suggests that airborne transmission is uncommon. Denominator data that would have defined the actual risk of mea-

Measles — Continued

sles for patients in a physician's office in this outbreak are lacking. However, should future outbreaks document substantial hazards for all susceptible patients who are in a medical office at the same time as a transmitting patient, prophylaxis for all contacts might be indicated.

Hawaii is a major international transit point. Tourists, businessmen, and refugees from countries where measles is endemic present a largely uncontrollable source of measles introduction into the Hawaiian Islands and the mainland. An immunized population continues to be the primary means of protection against the spread of measles in the United States. Continued vaccination of preschoolers and enactment and enforcement of school vaccination laws for children in kindergarten through grade 12, as well as vaccination efforts for college students, will continue to increase the level of immunity in the population, greatly limit the spread of measles introduced, and eventually eliminate measles from the United States.

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Current Trends

Influenza Activity — United States

Influenza viruses have recently been isolated from sporadic cases identified in California, New York, Texas, and Wisconsin. Type A(H3N2) influenza was isolated from a 38-year-old-man and his 14-year-old daughter in San Diego, California; from 7- and 2-year-old children on Long Island, New York; and from an 8-year-old girl and a 24-year-old college student in Milwaukee, Wisconsin. Type A(H1N1) influenza virus was isolated from a schoolchild in Houston, Texas. All became ill during the last half of November or December. None had a history of recent travel. Previously this season, type A(H3N2) and type B isolates had been identified in Nevada and Texas (*1,2*). No laboratory-confirmed influenza outbreaks have been documented in the United States this season.

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Combined Issues of *MMWR*

The December 28, 1984, issue of *MMWR* will not be published. The next issue will be Volume 33, Numbers 51 and 52, dated January 4, 1985, and will include the tables on specified notifiable diseases and deaths in 121 U.S. cities for the weeks ending December 22 and December 29.

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