CENTERS FOR DISEASE CONTROL

March 8, 1985 / Vol. 34 / No. 9

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Perspectives in Disease Prevention and Health Promotion

Update: Childhood Poisonings — United States

Deaths from unintentional ingestion of potentially poisonous substances among children under 5 years of age have decreased from a high of 456 in 1959 to a low of 57 in 1981 (*1,2*). Mortality data, however, underestimate the magnitude and public health impact of the childhood poisoning problem (Table 1). Data from the National Hospital Discharge Survey (NHDS), conducted by the National Center for Health Statistics (NCHS), show that, for each year between 1979 and 1982, an estimated 20,000 children under 5 years of age were hospitalized in the United States for ingestion of potentially toxic substances. Therefore, for each child death from unintentional poisoning, approximately 300 children were hospitalized. Medicinal substances accounted for 45% of the hospitalizations, and nonmedicinal substances accounted for the remainder. Of the medicinals, aspirin and other analgesics accounted for the most hospitalizations (11.8%). Of the nonmedicinals, products containing lead accounted for an additional 11.7% of hospitalizations.

The number of children hospitalized for unintentional ingestions also underestimates the public health impact of childhood poisonings. The U.S. Consumer Product Safety Commission (CPSC) estimates from its National Electronic Injury Surveillance System (NEISS) that, in

TABLE 1. Summary of recent assessments of annual cases and rates of poisoning among children under 5 years of age — United States

Outcome	Number	Rate*	Source
Death	57	0.3	NCHS: 1981 mortality data
Hospitalization	20,000	122.3	NCHS: NHDS average for 1979-1982
Emergency-room visit	110,000	672.9	CPSC: NEISS, 1983
Poison-control center call	1,400,000	8,563.6	Association of Poison Control Centers, 1983

*Per 100,000 children ages 0-4 years in 1980.

Childhood Poisonings – Continued

1983, over 110,000 children under 5 years of age were treated in hospital emergency rooms for ingesting potentially toxic substances (*3*). Thus, for each child hospitalized for unintentional poisoning, an estimated six to eight children are treated in emergency rooms and released. The American Association of Poison Control Centers estimates from poison-control reports about 1.4 million childhood poison exposures in 1983; 91% of these occurred in the home (*4*). For each child treated in an emergency room for poisoning, about 13 other poison exposures to children are reported to poison-control centers. It is unlikely that even these high figures reflect all poisonings. Many poisonings are not reported to poison-control centers because they are either treated in a physician's office or not treated at all.

Reported by Southeastern Regional Office, US Consumer Product Safety Commission, Atlanta, Georgia; Chronic Diseases Div, Center for Environmental Health, CDC.

Editorial Note: March 17-23, 1985, marks the 24th annual Poison Prevention Week. It is sponsored by the Poison Prevention Week Council (PPWC), a coalition of 31 national organizations representing industry, consumer groups, health professionals, government, and the media. Its purpose is to reduce unintentional poisoning among children by alerting Americans to this preventable problem.

The Poison Prevention Packaging Act (PPPA) of 1970 requires that certain potentially hazardous drugs and household products be sold in child-resistant containers. Currently, 15 product categories are covered by the PPPA, including controlled drugs, turpentine, some petroleum distillates, and prescription drugs. Since the PPPA was implemented, reported incidents of children ingesting regulated products have markedly declined. The PPPA is credited with preventing an estimated 86,000 ingestions between 1974 and 1981 (*5*). Data from a CPSC study indicate that, for regulated products, rates for emergency-room visits for ingestion by children under 5 years of age declined from 5.7/1,000 children under 5 years of age in 1973 to 3.4/1,000 in 1978. For unregulated products, the rate increased from 1.8/1,000 to 1.9/1,000 during the same period (*6*).

Although unintentional ingestions and deaths among children have declined considerably since PPPA was enacted, the childhood poisoning problem persists. Possible causes include failure to correctly use child-resistant packaging, improper storage of poisonous substances, ignorance of proper emergency procedures when ingestion occurs, and failure of some pharmacies to dispense prescription drugs in child-resistant containers. A recent survey of pharmacies in one area determined that nearly one-third did not dispense prescription drugs in child-resistant containers (*7*).

The PPWC and its member organizations advocate a broad-based approach to preventing childhood poisoning. This approach will be enhanced as better information about the circumstances surrounding the poisoning events become available. This information should provide clues for further environmental interventions.

References

1. National Office of Vital Statistics, National Center for Health Statistics. Vital statistics of the United States, 1959. Vol II. Mortality statistics for the United States and each state. Washington, D.C.: U.S. Department of Health, Education, and Welfare, Public Health Service, 1961.
2. Division of Vital Statistics, National Center for Health Statistics. Unpublished data, 1981.
3. CDC. Poisoning among young children—United States. MMWR 1984;33:129-31.
4. Veltri JC, Litovitz TL. 1983 annual report of the American Association of Poison Control Centers national data collection system. Am J Emer Med 1984;2:420-43.
5. National Safety Council. Accident facts, 1982. Chicago: National Safety Council, 1982.
6. Walton WW. An evaluation of the Poison Prevention Packaging Act. Pediatrics 1982;69:363-70.
7. New York State Attorney General's Office. Investigation of pharmacies' compliance with the Poison Prevention Packaging Act, 1984. New York: New York State Attorney General's Office, 1984.

International Notes

Epidemic Meningococcal Disease: Recommendations for Travelers to Nepal

During the first 6 months of 1983, an epidemic of serogroup A meningococcal meningitis, resulting in 875 cases and 95 deaths, occurred in the Kathmandu valley of Nepal. The overall annual attack rate was 103 cases per 100,000 population; the case-fatality ratio was 11%. The highest age-specific attack rate (223/100,000) was for children under 1 year of age; 83% of the cases occurred among persons under 25 years of age. The epidemic peaked in May and ended in June, coincident with the onset of the rainy season. No vaccination efforts were undertaken.

During December 1983 and January 1984, three times as many cases occurred in Kathmandu as in the same period a year previously; a mass vaccination campaign was initiated February 8, 1984. The target population included persons 1-24 years of age living in the Kathmandu valley. Three hundred thirty thousand doses of bivalent A/C meningococcal vaccine were given, achieving approximately 65% coverage of the target population. A dramatic decline in the number of meningitis cases occurred coincident with the initiation of the mass vaccination campaign.

Surveillance in 1985 indicates that meningococcal meningitis is occurring at a much lower rate than in 1984. However, meningococcal disease among hikers is now being recognized. Between January 1984 and January 1985, two culture-confirmed and four clinically suspected cases of meningococcal disease have been documented among tourists from western countries traveling in Nepal. Three of these occurred between January and April 1984, and three occurred between November 1984 and January 1985. Patients' ages ranged from 16 years to 40 years (mean 27 years). Five patients had evidence of meningococcemia; the other had meningitis alone. Two (33%) died. All became ill during or shortly after hiking outside Kathmandu. The patients' countries of origin were the United States (three patients), Australia (two), and Switzerland (one).

Reported by Div of Bacterial Diseases, Center for Infectious Diseases, Div of Immunization, Div of Quarantine, Center for Prevention Services, CDC.

Editorial Note: Epidemic meningococcal disease has not been reported previously in Nepal, and, except for Mongolia and Vietnam, has been reported in no other Asian country (*1,2*). Large epidemics of group A meningococcal disease have occurred primarily in the "meningitis belt" of Africa, which consists of the semiarid Sahelian zone south of the Sahara (*3*). In Africa, epidemics have been cyclic, occurring every 10-12 years and lasting 2-3 years. The epidemics occur during the dry season and stop when the rains begin. The seasonal pattern of disease seen in Nepal is similar to that observed in Africa, although Nepal's dry season is cold rather than hot.

Meningococcal polysaccharide vaccines have been used to control epidemics in the past (*4-6*). In the immunization campaign in the Kathmandu valley, the target population was selected to cover the age group in which 75% of the cases were occurring. Although at high risk, children under 1 year of age were not vaccinated because the vaccine is poorly immunogenic in that age group.

Based on the 1983 tourist statistics, approximately 105,000 non-Asian tourists visit Nepal each year. Thus, the attack rate for such tourists during the past year was 6/100,000. Based on the number of hiking permits issued (32,298), the attack rate for hikers was 19/100,000. By comparison, the annual incidence of meningococcal disease in this age group in the United

Meningococcal Disease — Continued

States is approximately 0.3/100,000 (7). The relative increase in risk is even more striking when the average length of stay for tourists in Nepal (11 days) is taken into account, since the attack rate for the disease in the United States for 11 days would be only .009/100,000. Because of the risk of meningococcal disease among hikers, CDC recommends that tourists planning to hike in Nepal receive meningococcal vaccine. Although all cases of meningococcal disease to date have occurred in hikers, it is prudent for other travelers to Nepal to receive the vaccine also.

The serogroup A meningococcal vaccine has a clinical efficacy of 85%-95% for at least 1 year, with protection achieved 1-2 weeks after vaccination. Adverse reactions are limited to local erythema or soreness. There are two formulations of meningococcal vaccine currently available in the United States: the bivalent A-C vaccine and the quadrivalent A,C,Y,W-135 vaccine. Either formulation will give protection against serogroup A meningococcal disease; the bivalent vaccine is less expensive. The sole distributor of these vaccines in the United States is Squibb. The vaccine can be obtained through a pharmacy by contacting a Squibb regional distribution center or by calling Squibb at (800) 822-2463. Because meningococcal vaccine is inactivated, it can be administered simultaneously, if necessary, with other live or

(Continued on page 125)

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

Disease	9th Week Ending			Cumulative, 9th Week Ending		
	Mar. 2, 1985	Mar. 3, 1984	Median 1980-1984	Mar. 2, 1985	Mar. 3, 1984	Median 1980-1984
Acquired Immunodeficiency Syndrome (AIDS)	98	73	N	973	581	N
Aseptic meningitis	34	74	74	565	747	729
Encephalitis: Primary (arthropod-borne & unspec.)	14	17	12	123	128	135
Post-infectious	1	-	2	16	8	10
Gonorrhea: Civilian	12,663	14,211	17,965	132,332	141,505	162,798
Military	761	290	564	3,179	3,418	4,708
Hepatitis: Type A	389	474	528	3,371	3,539	4,062
Type B	432	488	426	3,888	3,994	3,209
Non A, Non B	85	66	N	631	582	N
Unspecified	95	72	169	700	729	1,437
Legionellosis	10	8	N	85	68	N
Leprosy	19	7	5	58	38	38
Malaria	10	16	16	103	99	121
Measles: Total*	64	59	70	156	340	340
Indigenous	52	57	N	111	275	N
Imported	12	2	N	45	65	N
Meningococcal infections: Total	64	94	83	504	572	572
Civilian	64	94	81	504	572	570
Military	-	-	-	-	-	3
Mumps	85	96	126	564	608	926
Pertussis	24	43	23	173	299	186
Rubella (German measles)	7	17	54	36	84	314
Syphilis (Primary & Secondary): Civilian	467	468	568	4,220	4,942	5,274
Military	3	5	10	27	57	76
Toxic Shock syndrome	8	10	N	63	74	N
Tuberculosis	432	321	490	2,875	3,105	3,871
Tularemia	1	5	3	19	11	15
Typhoid fever	1	4	7	39	55	65
Typhus fever, tick-borne (RMSF)	-	3	1	4	10	10
Rabies, animal	71	86	93	677	687	810

TABLE II. Notifiable diseases of low frequency, United States

	Cum 1985		Cum 1985
Anthrax	-	Plague	-
Botulism: Foodborne	1	Poliomyelitis: Total	1
Infant	8	Paralytic	1
Other	-	Psittacosis (Vt. 1, Upstate N.Y. 1, Ohio 1)	21
Brucellosis (Upstate N.Y. 1, Tex. 1)	12	Rabies, human	-
Cholera	-	Tetanus (N.C. 1, Ky. 1, Hawaii 1)	8
Congenital rubella syndrome	-	Trichinosis	6
Diphtheria	-	Typhus fever, flea-borne (endemic, murine)	2
Leptospirosis	4		

*Twelve of the 64 reported cases for this week were imported from a foreign country or can be directly traceable to a known internationally imported case within two generations.

TABLE III. Cases of specified notifiable diseases, United States, weeks ending March 2, 1985 and March 3, 1984 (9th Week)

Reporting Area	AIDS	Aseptic Meningitis	Encephalitis		Gonorrhea (Civilian)		Hepatitis (Viral), by type				Legionellosis	Leprosy
			Primary	Post-infectious			A	B	NA,NB	Unspecified		
	Cum 1985	1985	Cum 1985	Cum 1985	Cum 1985	Cum 1984	1985	1985	1985	1985	1985	Cum 1985
UNITED STATES	973	34	123	16	132,332	141,505	389	432	85	95	10	58
NEW ENGLAND	29	-	2	-	4,150	4,642	4	33	5	13	5	-
Maine	1	-	-	-	180	178	-	-	1	-	-	-
N H	-	-	1	-	90	107	-	-	1	-	-	-
Vt	-	-	-	-	40	66	-	1	1	1	1	-
Mass	19	-	1	-	1,534	1,753	4	18	-	10	4	-
R I	1	-	-	-	326	281	-	3	-	-	-	-
Conn	8	-	-	-	1,980	2,257	-	11	2	2	-	-
MID ATLANTIC	404	3	9	-	19,310	18,082	25	70	7	6	-	5
Upstate N Y	48	1	4	-	2,545	2,807	7	9	1	1	-	-
N Y City	261	1	-	-	8,844	7,856	4	4	-	3	-	5
N J	64	1	3	-	3,480	2,548	8	37	3	1	-	-
Pa	31	-	2	-	4,441	4,871	6	20	3	1	-	-
E N CENTRAL	57	9	37	2	19,563	20,081	12	46	9	6	3	1
Ohio	15	2	12	1	4,881	4,833	6	25	2	3	3	1
Ind	3	3	9	-	1,940	2,281	2	6	2	2	-	-
Ill	24	-	1	-	6,039	5,220	1	2	-	-	-	-
Mich	11	4	13	-	5,566	5,600	3	13	5	1	-	-
Wis	4	-	2	1	1,137	2,147	-	-	-	-	-	-
W N CENTRAL	11	1	8	1	6,932	6,418	18	13	-	1	1	-
Minn	3	-	3	1	1,020	914	4	-	-	-	-	-
Iowa	2	1	5	-	770	776	1	4	-	-	-	-
Mo	4	-	-	-	3,177	2,860	2	8	-	1	-	-
N Dak	-	-	-	-	46	82	-	-	-	-	-	-
S Dak	-	-	-	-	136	220	10	-	-	-	-	-
Nebr	-	-	-	-	645	435	1	1	-	-	1	-
Kans	2	-	-	-	1,138	1,131	-	-	-	-	-	-
S ATLANTIC	137	7	17	8	28,314	36,119	30	90	18	7	-	-
Del	1	-	1	-	568	604	1	2	1	-	-	-
Md	16	-	5	-	4,195	4,791	1	7	-	-	-	-
D C	20	-	-	-	2,425	2,679	-	4	-	-	-	-
Va	7	-	1	3	2,888	3,502	1	3	1	-	-	-
W Va	1	-	1	-	345	391	-	2	-	-	-	-
N C	6	1	8	-	5,828	5,795	1	13	2	1	-	-
S C	1	-	1	-	3,818	3,273	1	10	1	-	-	-
Ga	20	2	-	-	-	7,083	1	14	1	-	-	-
Fla	65	4	-	5	8,247	8,001	24	35	12	6	-	-
E S CENTRAL	9	2	5	3	11,489	12,096	12	18	1	3	-	-
Ky	4	2	1	-	1,313	1,493	7	5	-	-	-	-
Tenn	-	-	3	-	4,573	4,829	2	11	1	3	-	-
Ala	4	-	1	3	3,356	4,001	3	-	-	-	-	-
Miss	1	-	-	-	2,247	1,773	-	2	-	-	-	-
W S CENTRAL	40	6	10	-	19,592	19,404	64	30	5	29	-	7
Ark	-	-	-	-	1,914	1,626	-	-	-	-	-	-
La	1	-	-	-	4,099	4,657	1	4	-	2	-	-
Okla	1	1	5	-	2,002	2,148	1	-	2	1	-	-
Tex	38	5	5	-	11,577	10,973	62	26	3	26	-	7
MOUNTAIN	17	1	5	1	4,321	4,294	65	33	8	6	-	-
Mont	-	-	-	-	133	226	1	1	1	-	-	-
Idaho	-	-	-	-	140	191	10	-	2	-	-	-
Wyo	-	U	-	-	107	116	U	U	U	U	U	-
Colo	5	-	2	-	1,233	1,088	5	8	3	4	-	-
N Mex	3	-	-	-	529	553	16	3	-	1	-	-
Ariz	6	-	-	-	1,306	1,144	16	15	2	1	-	-
Utah	-	-	3	1	181	241	4	1	-	-	-	-
Nev	3	1	-	-	692	735	13	5	-	-	-	-
PACIFIC	269	5	30	1	18,661	20,369	159	99	32	24	1	45
Wash	17	1	2	-	1,329	1,402	7	1	3	1	-	7
Oreg	8	-	-	-	1,125	1,176	23	5	6	-	-	1
Calif	241	3	28	1	15,448	16,956	127	91	23	22	1	34
Alaska	-	-	-	-	463	521	-	-	-	-	-	-
Hawaii	3	1	-	-	296	314	2	2	-	1	-	3
Guam	-	U	-	-	-	54	U	U	U	U	U	-
P R	18	1	1	-	724	583	8	13	-	8	-	2
V I	-	U	-	-	57	73	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 March 2, 1985 and March 3, 1984 (9th Week)

Reporting Area	Malaria	Measles (Rubeola)					Menin-gococcal Infections	Mumps		Pertussis			Rubella		
		Indigenous		Imported *		Total									
	Cum. 1985	1985	Cum 1985	1985	Cum. 1985	Cum. 1984	Cum. 1985	1985	Cum. 1985	1985	Cum 1985	Cum. 1984	1985	Cum 1985	Cum 1984
UNITED STATES	103	52	111	12	45	340	504	85	564	24	173	299	7	36	84
NEW ENGLAND	4	-	-	-	-	-	26	2	14	-	6	10	-	2	5
Maine	-	-	-	-	-	-	1	-	1	-	2	-	-	-	1
N.H.	-	-	-	-	-	-	-	-	-	-	-	2	-	1	-
Vt.	-	-	-	-	-	-	4	2	2	-	1	4	-	-	-
Mass.	2	-	-	-	-	-	7	-	9	-	2	3	-	1	4
R.I.	-	-	-	-	-	-	6	-	1	-	1	1	-	-	-
Conn.	2	-	-	-	-	-	8	-	1	-	-	-	-	-	-
MID ATLANTIC	14	6	6	-	2	6	62	8	72	5	34	18	2	8	1
Upstate N.Y.	7	2	2	-	1	-	20	1	46	3	13	10	-	1	-
N.Y. City	3	4	4	-	1	5	8	5	8	2	7	-	2	6	-
N.J.	-	-	-	-	-	1	20	2	7	-	-	-	-	1	1
Pa.	4	-	-	-	-	-	14	-	11	-	14	8	-	-	-
E.N. CENTRAL	5	6	29	12 †	12	222	95	44	273	3	31	82	-	6	16
Ohio	1	-	-	12 †	12	2	35	4	53	-	8	15	-	-	-
Ind.	-	-	-	-	-	1	16	1	9	-	11	47	-	-	-
Ill.	-	-	2	-	-	46	8	23	47	1	2	8	-	-	12
Mich.	4	6	17	-	-	173	25	16	137	2	4	5	-	6	2
Wis.	-	-	10	-	-	-	11	-	27	-	6	7	-	-	2
W.N. CENTRAL	1	-	-	-	-	-	26	-	9	1	13	57	-	1	8
Minn.	-	-	-	-	-	-	7	-	-	1	7	2	-	-	-
Iowa	-	-	-	-	-	-	4	-	2	-	1	3	-	-	-
Mo.	1	-	-	-	-	-	14	-	5	-	3	10	-	-	-
N. Dak.	-	-	-	-	-	-	-	-	-	-	2	-	-	-	1
S. Dak.	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-
Nebr.	-	-	-	-	-	-	-	-	-	-	-	2	-	-	-
Kans.	-	-	-	-	-	-	-	-	2	-	-	40	-	1	7
S. ATLANTIC	15	-	1	-	2	4	102	9	44	7	30	35	-	1	9
Del.	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-
Md.	2	-	-	-	1	-	9	1	6	3	6	1	-	-	-
D.C.	3	-	-	-	1	-	4	-	-	-	-	-	-	-	-
Va.	3	-	-	-	-	1	13	-	6	-	1	6	-	-	-
W. Va.	1	-	-	-	-	-	3	6	16	-	-	3	-	-	-
N.C.	1	-	-	-	-	-	16	-	3	-	6	13	-	-	-
S.C.	-	-	-	-	-	-	10	-	1	-	-	1	-	1	-
Ga.	1	-	-	-	-	-	18	-	2	3	6	4	-	-	1
Fla.	4	-	1	-	-	3	28	2	10	1	11	7	-	-	8
E.S. CENTRAL	2	-	-	-	-	2	23	2	5	-	3	2	-	1	-
Ky.	-	-	-	-	-	-	2	-	-	-	1	1	-	1	-
Tenn.	-	-	-	-	-	2	10	2	4	-	1	1	-	-	-
Ala.	2	-	-	-	-	-	9	-	-	-	1	-	-	-	-
Miss.	-	-	-	-	-	-	2	-	1	-	-	-	-	-	-
W.S. CENTRAL	4	2	2	-	-	39	43	12	45	-	9	35	3	4	4
Ark.	-	-	-	-	-	-	5	-	1	-	5	9	-	1	1
La.	-	-	-	-	-	-	4	-	-	-	-	1	-	-	-
Okla.	-	-	-	-	-	-	8	N	N	-	4	18	-	-	-
Tex.	4	2	2	-	-	39	26	12	44	-	-	7	3	3	3
MOUNTAIN	3	34	59	-	16	43	32	6	47	2	8	31	-	1	3
Mont.	-	34	59	-	16	-	3	1	3	-	-	16	-	-	-
Idaho	-	-	-	-	-	-	-	1	3	-	-	1	-	-	1
Wyo.	-	U	-	U	-	-	1	U	-	U	-	-	U	-	-
Colo.	1	-	-	-	-	-	7	1	9	1	3	11	-	-	-
N. Mex.	2	-	-	-	-	21	4	N	N	-	1	2	-	-	-
Ariz.	-	-	-	-	-	-	11	3	27	1	2	-	-	1	-
Utah	-	-	-	-	-	22	4	-	2	-	2	1	-	-	2
Nev.	-	-	-	-	-	-	2	-	3	-	-	-	-	-	-
PACIFIC	55	4	14	-	13	24	95	2	55	6	39	29	2	12	38
Wash.	5	-	-	-	-	5	12	-	2	-	3	6	-	-	-
Oreg.	2	-	-	-	-	-	11	N	N	1	5	4	1	1	-
Calif.	40	4	12	-	11	17	72	2	46	5	29	13	-	10	37
Alaska	1	-	-	-	-	-	-	-	1	-	-	-	-	-	-
Hawaii	7	-	2	-	2	2	-	-	6	-	2	6	1	1	1
Guam	-	U	-	U	-	34	-	U	-	U	-	-	U	-	1
P.R.	-	-	27	-	-	-	2	4	30	-	1	-	-	4	1
V.I.	-	U	-	U	6	-	-	U	3	U	-	-	U	-	-
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 March 2, 1985 and March 3, 1984 (9th Week)

Reporting Area	Syphilis (Civilian) (Primary & Secondary)		Toxic-shock Syndrome	Tuberculosis		Tularemia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1985	Cum. 1984	1985	Cum. 1985	Cum. 1984	Cum. 1985	Cum. 1985	Cum. 1985	Cum. 1985
UNITED STATES	4,220	4,942	8	2,875	3,105	19	39	4	677
NEW ENGLAND	93	106	-	103	90	-	3	-	-
Maine	3	1	-	5	4	-	-	-	-
N H	-	-	-	-	8	-	-	-	-
Vt	-	-	-	-	2	-	-	-	-
Mass	50	65	-	66	43	-	2	-	-
R I	2	5	-	13	11	-	-	-	-
Conn	38	35	-	19	22	-	1	-	-
MID ATLANTIC	561	670	-	595	582	1	5	-	86
Upstate N Y	29	56	-	78	97	-	3	-	16
N Y City	371	372	-	343	234	1	-	-	-
N J	107	135	-	36	109	-	1	-	-
Pa	54	107	-	138	142	-	1	-	70
E N CENTRAL	223	221	4	375	400	-	2	-	6
Ohio	16	37	1	75	97	-	1	-	1
Ind	17	34	-	44	43	-	1	-	-
Ill	126	94	-	165	146	-	-	-	2
Mich	53	39	3	74	92	-	-	-	-
Wis	11	17	-	17	22	-	-	-	3
W N CENTRAL	54	80	2	72	74	6	2	-	96
Minn	18	15	2	11	10	-	2	-	13
Iowa	9	8	-	14	11	-	-	-	35
Mo	15	46	-	28	31	5	-	-	6
N Dak	-	-	-	-	3	-	-	-	10
S Dak	3	-	-	4	1	-	-	-	26
Nebr	1	3	-	5	8	1	-	-	6
Kans	8	8	-	10	10	-	-	-	-
S ATLANTIC	1,080	1,525	-	578	732	4	7	2	218
Del	6	4	-	5	10	-	-	-	-
Md	82	72	-	71	78	-	1	-	138
D C	55	55	-	28	19	-	-	-	-
Va	56	80	-	27	55	-	1	-	21
W Va	1	7	-	13	25	-	-	-	-
N C	128	161	-	62	136	4	-	1	-
S C	137	150	-	80	96	-	-	1	6
Ga	-	259	-	81	85	-	-	-	31
Fla	615	737	-	211	228	-	5	-	22
E S CENTRAL	393	345	-	233	285	1	1	2	34
Ky	13	17	-	44	74	-	-	-	3
Tenn	87	79	-	63	89	1	-	1	3
Ala	140	120	-	97	102	-	1	1	28
Miss	153	129	-	29	20	-	-	-	-
W S CENTRAL	1,051	1,161	-	289	254	2	2	-	111
Ark	64	48	-	19	11	-	-	-	11
La	187	245	-	58	40	-	-	-	3
Okla	35	29	-	36	32	2	-	-	13
Tex	765	839	-	176	171	-	2	-	84
MOUNTAIN	144	107	1	43	56	3	-	-	67
Mont	1	-	-	5	2	-	-	-	32
Idaho	2	5	-	1	3	-	-	-	-
Wyo	3	1	U	1	-	-	-	-	2
Colo	31	20	-	-	6	-	-	-	-
N Mex	18	12	-	7	15	1	-	-	1
Ariz	81	45	1	24	24	-	-	-	32
Utah	1	4	-	2	5	2	-	-	-
Nev	7	20	-	3	1	-	-	-	-
PACIFIC	621	727	1	587	632	2	17	-	59
Wash	12	31	1	16	32	-	-	-	-
Oreg	20	22	-	20	27	1	-	-	-
Calif	579	656	-	479	515	1	17	-	59
Alaska	-	1	-	38	17	-	-	-	-
Hawaii	10	17	-	34	41	-	-	-	-
Guam	-	-	U	-	4	-	-	-	-
P R	165	170	-	51	29	-	1	-	2
V I	-	5	U	-	1	-	-	-	-
Pac. Trust Terr	-	-	U	-	-	-	-	-	-

U Unavailable

TABLE IV. Deaths in 121 U.S. cities,* week ending March 2, 1985 (9th Week)

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	789	603	116	38	14	18	90
Boston, Mass.	189	125	38	11	7	8	33
Bridgeport, Conn.	46	37	6	2	-	1	4
Cambridge, Mass.	34	27	5	1	-	1	6
Fall River, Mass.	35	31	3	1	-	-	1
Hartford, Conn.	50	41	4	3	-	2	2
Lowell, Mass.	45	37	7	-	-	1	4
Lynn, Mass.	34	24	7	3	-	-	3
New Bedford, Mass.	26	20	5	-	1	-	3
New Haven, Conn.	46	32	6	2	5	1	3
Providence, R.I.	109	84	17	8	-	-	13
Somerville, Mass.	12	9	3	-	-	-	1
Springfield, Mass.	48	40	5	2	1	-	5
Waterbury, Conn.	37	32	4	1	-	-	1
Worcester, Mass.	78	64	6	4	-	4	11
MID. ATLANTIC	2,989	1,960	628	260	74	65	190
Albany, N.Y.	59	43	12	2	1	1	4
Allentown, Pa.	20	15	5	-	-	-	-
Buffalo, N.Y.	149	109	22	14	2	2	20
Camden, N.J.	56	38	10	4	3	1	-
Elizabeth, N.J.	29	21	7	-	-	1	3
Erie, Pa.†	52	42	7	1	1	1	10
Jersey City, N.J.	70	55	6	6	-	3	1
N.Y. City, N.Y.	1,549	976	343	159	43	28	80
Newark, N.J.	77	35	20	10	3	7	4
Paterson, N.J.	33	20	6	4	2	1	2
Philadelphia, Pa.†	421	262	93	40	10	16	31
Pittsburgh, Pa.†	73	48	19	4	-	2	3
Reading, Pa.	40	32	6	2	-	-	6
Rochester, N.Y.	101	77	17	4	2	1	11
Schenectady, N.Y.	35	27	6	-	2	-	-
Scranton, Pa.†	35	28	6	-	-	1	2
Syracuse, N.Y.	84	58	20	4	2	-	5
Trenton, N.J.	46	29	13	3	1	-	3
Utica, N.Y.	27	21	3	2	1	-	2
Yonkers, N.Y.	33	24	7	1	1	-	3
E.N. CENTRAL	2,447	1,781	395	129	64	77	143
Akron, Ohio	71	50	15	2	4	-	4
Canton, Ohio	54	38	13	2	1	-	3
Chicago, Ill. §	556	463	11	27	16	38	16
Cincinnati, Ohio	127	95	17	6	6	3	19
Cleveland, Ohio	178	112	49	11	2	4	7
Columbus, Ohio	110	75	23	5	5	2	12
Dayton, Ohio	124	78	34	6	3	3	10
Detroit, Mich.	291	196	56	25	9	5	8
Evansville, Ind.	61	42	12	3	2	2	3
Fort Wayne, Ind.	51	36	12	1	1	1	3
Gary, Ind.	23	16	5	1	1	-	1
Grand Rapids, Mich.	70	52	9	5	2	2	9
Indianapolis, Ind.	171	124	38	2	5	2	4
Madison, Wis.	43	33	5	2	-	3	4
Milwaukee, Wis.	141	102	24	10	3	2	9
Peoria, Ill.	51	37	8	3	1	2	5
Rockford, Ill.	47	34	11	1	-	1	10
South Bend, Ind.	51	39	9	1	1	1	5
Toledo, Ohio	150	107	28	9	2	4	10
Youngstown, Ohio	77	52	16	7	-	2	1
W.N. CENTRAL	929	709	150	42	14	14	85
Des Moines, Iowa	94	61	26	5	-	2	15
Duluth, Minn.	28	24	2	1	1	-	1
Kansas City, Kans.	35	26	3	4	2	-	2
Kansas City, Mo.	147	102	34	8	1	2	10
Lincoln, Nebr.	42	39	2	-	1	-	5
Minneapolis, Minn.	95	76	12	1	3	3	4
Omaha, Nebr.	131	100	24	3	3	1	16
St. Louis, Mo.	168	129	23	11	2	3	9
St. Paul, Minn.	86	71	10	5	-	-	4
Wichita, Kans.	103	81	14	4	1	3	19

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
S. ATLANTIC	1,537	981	370	111	39	32	115
Atlanta, Ga.	209	134	53	18	3	1	14
Baltimore, Md.	243	161	54	16	5	7	13
Charlotte, N.C.	68	45	17	4	1	1	9
Jacksonville, Fla.	144	86	39	9	4	6	15
Miami, Fla.	138	77	40	15	3	3	5
Norfolk, Va.	65	46	13	2	3	1	6
Richmond, Va.	106	65	31	4	3	3	18
Savannah, Ga.	65	42	13	6	4	-	12
St. Petersburg, Fla.	124	109	9	5	-	1	7
Tampa, Fla.	71	43	16	2	7	3	5
Washington, D.C.	277	152	79	30	6	6	10
Wilmington, Del.	27	21	6	-	-	-	1
E.S. CENTRAL	995	645	221	57	28	44	62
Birmingham, Ala.	136	88	29	7	3	9	6
Chattanooga, Tenn.	72	43	22	3	2	2	4
Knoxville, Tenn.	111	84	20	4	2	1	12
Louisville, Ky.	127	80	36	8	2	1	2
Memphis, Tenn.	225	132	50	14	10	19	18
Mobile, Ala.	82	53	18	6	3	2	10
Montgomery, Ala.	79	52	18	2	3	4	2
Nashville, Tenn.	163	113	28	13	3	6	8
W.S. CENTRAL	1,366	894	281	86	56	49	88
Austin, Tex.	70	46	10	6	4	4	8
Baton Rouge, La.	74	51	15	3	1	4	2
Corpus Christi, Tex.	35	26	9	-	-	-	3
Dallas, Tex.	219	131	49	15	15	9	13
El Paso, Tex.	75	43	26	4	2	-	5
Fort Worth, Tex.	120	74	25	11	2	8	11
Houston, Tex. §	168	141	2	7	9	9	7
Little Rock, Ark.	83	53	16	5	4	5	8
New Orleans, La.	141	79	45	13	3	1	-
San Antonio, Tex.	224	141	50	15	11	7	20
Shreveport, La.	36	27	9	-	-	-	2
Tulsa, Okla.	121	82	25	7	5	2	9
MOUNTAIN	718	468	152	51	23	24	58
Albuquerque, N.Mex.	86	52	16	10	5	3	14
Colo. Springs, Colo.	39	27	8	3	-	1	6
Denver, Colo.	146	90	32	10	7	7	2
Las Vegas, Nev.	95	55	30	6	3	1	12
Ogden, Utah	23	17	3	3	-	-	2
Phoenix, Ariz.	157	100	32	12	4	9	6
Pueblo, Colo.	18	13	5	-	-	-	2
Salt Lake City, Utah	42	28	8	3	-	3	1
Tucson, Ariz.	112	86	18	4	4	-	13
PACIFIC	2,492	1,722	485	158	57	56	204
Berkeley, Calif.	22	15	5	1	-	1	-
Fresno, Calif.	72	48	14	5	1	4	16
Glendale, Calif.	52	37	9	1	3	1	4
Honolulu, Hawaii	91	72	14	3	1	1	12
Long Beach, Calif.	123	82	29	7	1	4	10
Los Angeles, Calif.	701	464	148	52	18	6	26
Oakland, Calif.	94	66	16	6	2	4	10
Pasadena, Calif.	49	39	8	2	-	-	1
Portland, Oreg.	160	121	27	5	1	6	12
Sacramento, Calif.	144	98	30	7	7	2	19
San Diego, Calif.	222	138	45	25	5	9	29
San Francisco, Calif.	184	129	35	13	3	4	8
San Jose, Calif.	199	142	31	12	9	5	24
Seattle, Wash.	223	155	45	14	3	6	11
Spokane, Wash.	56	41	13	2	-	-	12
Tacoma, Wash.	100	75	16	3	3	3	10
TOTAL	14,262††	9,763	2,798	932	369	379	1,035

* 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.

Meningococcal Disease — Continued

inactivated vaccines needed for foreign travel. Immunoglobulin, if needed, should not interfere with the immune response.

Because immunity is not achieved until 1-2 weeks postvaccination, CDC recommends that tourists be vaccinated before departure. However, vaccine is available in Nepal at the Epidemiology Division, Department of Health Services, Teku, Kathmandu. Questions concerning meningococcal disease in Nepal and recommendations for vaccination should be addressed to the Respiratory and Special Pathogens Epidemiology Branch, Division of Bacterial Diseases, Center for Infectious Diseases, CDC, telephone (404) 329-3687.

References

1. Jamba G, Bytchenko B, Causse G, et al. Immunization during a cerebrospinal meningitis epidemic in the Mongolian People's Republic, 1974-75. Bull WHO 1979;57:943-6.
2. Oberti J, Hoi NT, Caravano R, Tan CM, Roux J. Etude d'une épidémie de méningococcie au Viet Nam (provinces du sud). Bull WHO 1981;59:585-90.
3. Galazka A. Meningococcal disease and its control with meningococcal polysaccharide vaccines. Bull WHO 1982;60:1-7.
4. Bosmans E, Vimont-Vicary P, Andre FE, Crooy PJ, Roelants P, Vandepitte J. Protective efficacy of a bivalent (A+C) meningococcal vaccine during a cerebrospinal meningitis epidemic in Rwanda. Ann Soc Belg Med Trop 1980;60:297-306.
5. Peltola H. Group A meningococcal polysaccharide vaccine and course of the group A meningococcal epidemic in Finland. Scand J Infect Dis 1978;10:41-4.
6. Greenwood BM, Wali SS. Control of meningococcal infection in the African meningitis belt by selective vaccination. Lancet 1980;I:729-32.
7. Band JD, Chamberland ME, Platt T, Weaver RE, Thornsberry C, Fraser DW. Trends in meningococcal disease in the United States, 1975-1980. J Infect Dis 1983;148:754-8.

Epidemiologic Notes and Reports

Pseudo-outbreak of Intestinal Amebiasis — California

In October 1983, the Los Angeles County (California) Department of Health Services was notified by a local medical laboratory of a large increase in the laboratory's diagnoses of intestinal amebiasis (*Entamoeba histolytica* infection). Thirty-eight cases were identified from August to October. The laboratory staff estimated that, before August, they had diagnosed approximately one *E. histolytica* infection per month.

A preliminary investigation failed to identify a common source of the infection. There had been no increase in the number of specimens examined, and although the laboratory served several health facilities, there was no clustering of cases in particular facilities. Finally, most patients did not belong to groups recognized to be at high risk for acquiring amebiasis (such as male homosexuals, tourists to or immigrants from developing countries, or institutionalized persons). The most common complaint of patients was gastrointestinal symptoms, and most improved after treatment with metronidazole. A review of amebiasis diagnoses from other laboratories in Los Angeles County did not reveal other instances of increased reporting.

To evaluate the accuracy of *E. histolytica* diagnoses, 71 slides from the 38 patients were reexamined by the University of California at Los Angeles Clinical Laboratory or the California Department of Health Services' Public Health Laboratory. Only four slides from two (5.3%) patients were found to contain *E. histolytica*. Of specimens from the 36 patients found not to

Intestinal Amebiasis — Continued

have *E. histolytica*, 34 contained polymorphonuclear neutrophils and/or macrophages, and two contained nonpathogenic protozoa.

The laboratory reporting the increase follows approved procedures for the collection and examination of stools for protozoa. Permanent slides are prepared from fecal material preserved in polyvinyl alcohol and stained by the Gomori-trichrome method (*1*). One technician was responsible for reading parasitology slides and had performed that job for the preceding 4 years. The technician's supervisor reviewed all positive slides. The only change in procedure that had been recently introduced was the assignment of a different person to the preparation of the initial smears. This person prepared slides that were "less dense," and the slides were "easier to read."

Reported by L Garcia, MT, University of California at Los Angeles Medical Laboratory, F Sorvillo, MPH, M Epstein, MD, K Mori, B Agee, MD, R Barnes, PhD, Los Angeles County Dept of Health Svcs, J Chin, MD, State Epidemiologist, California Dept of Health Svcs; Protozoal Diseases Br, Div of Parasitic Diseases, Center for Infectious Diseases, Laboratory Program Office, CDC.

Editorial Note: This pseudo-outbreak of intestinal amebiasis serves as a reminder that identification of *E. histolytica* is difficult. Although *E. histolytica* can be confused with other intestinal protozoa, a more common problem is that leukocytes or macrophages in stool specimens are identified as *E. histolytica* (*2*). In 1981, the College of American Pathologists (CAP) conducted a proficiency survey using a stool specimen, which contained many leukocytes, from a patient with inflammatory bowel disease (*3*). None of 15 referee laboratories but 100 (16.7%) of 599 participating laboratories reported one or more intestinal protozoa, most commonly *E. histolytica*. Similarly, as shown in a report of seven suspected outbreaks of amebiasis in the United States between 1971 and 1974, three laboratories might have mistakenly diagnosed amebiasis in as many as 1,200 patients a year for 20 years (*2*).

A summary of proficiency surveys for parasites conducted by the CAP from 1973 to 1977 showed that *E. histolytica* infections are also often overlooked (*4*). Twenty-seven percent of participating laboratories overlooked trophozoites, and 37% overlooked cysts of *E. histolytica* in stool specimens.

Results of CDC's Proficiency Testing Program in Parasitology closely paralleled those reported by the CAP. In 1982, CDC conducted a parasitology proficiency testing survey using a stool specimen that contained no parasites and numerous leukocytes. None of the 17 reference or referee laboratories reported the presence of intestinal parasites; however, 74 (14.0%) of the 528 participant laboratories incorrectly reported one or more intestinal parasites, most commonly *E. histolytica* cysts. A summary of CDC proficiency testing surveys in parasitology from 1973-1977 also demonstrated that *E. histolytica* is often overlooked. Twenty-nine percent of participating laboratories overlooked *E. histolytica* trophozites, and 33% overlooked *E. histolytica* cysts in stool specimens .

To avoid errors when attempting to diagnose parasitic diseases, physicians should identify laboratories in their areas whose staffs are experienced in diagnostic parasitology and who participate in and score well on proficiency testing for parasitic diseases.

References

1. Garcia LS, Ash LR. Diagnostic parasitology clinical laboratory manual. St. Louis, Missouri: CV Mosby, 1975:16-7.
2. Krogstad DJ, Spencer HC Jr, Healy GR, Gleason NN, Sexton DJ, Herron CA. Amebiasis: epidemiologic studies in the United States, 1971-1974. Ann Intern Med 1978;88:89-97.
3. College of American Pathologists. Special parasitology survey (critique specimen P-12), 1981.
4. Smith JW. Identification of fecal parasites in the special parasitology survey of the College of American Pathologists. Am J Clin Pathol 1979;72:371-3.

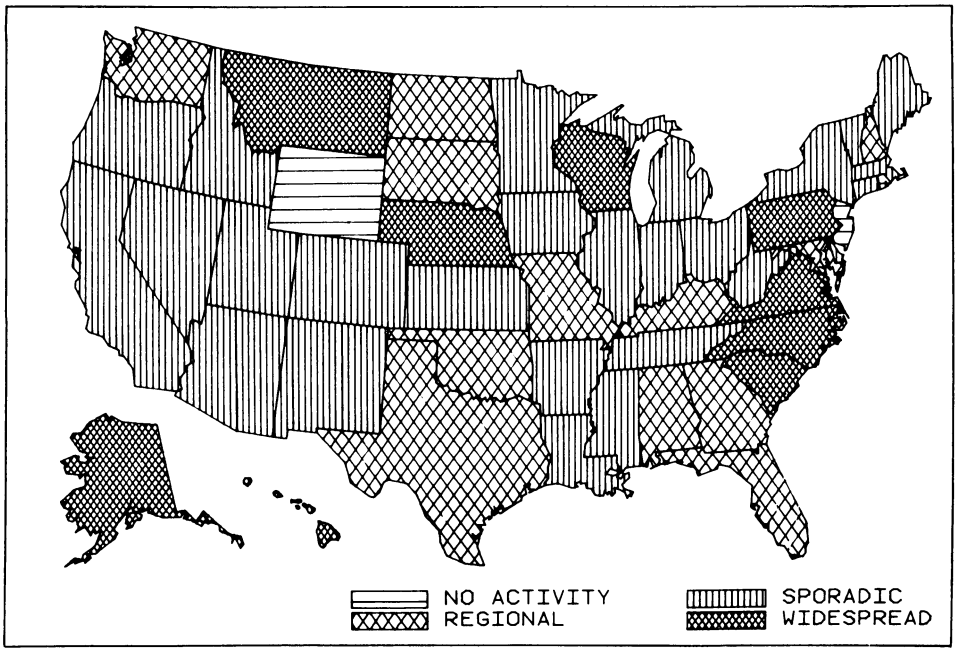
Update: Influenza Activity — United States

Recent data from leading indicators show static or declining levels of influenza activity. The average number of cases of influenza-like illness reported by family physicians for the reporting week ending February 20, 1985, was 8.2, continuing the trend since the apparent peak of 11.2 cases for the reporting week ending January 30. The preliminary total of influenza virus isolates reported for the week ending February 22 was 197, a decrease from the approximately 250 isolates reported for each of the preceding 3 weeks. A total of 21 states indicated the occurrence of widespread or regional outbreaks of influenza-like illness for the week ending March 2, compared with the 26 states that indicated similar levels for the preceding week (Figure 1).

Of total deaths reported from 121 cities for the week ending March 2, 7.3% were associated with pneumonia or influenza (P&I), unchanged from the preceding week. Changes in numbers of P&I deaths typically lag behind morbidity indices.

Reported by Participating physicians of the American Academy of Family Physicians; State and Territorial Epidemiologists; State Laboratory Directors; Other collaborating laboratories; Statistical Svcs Br, Div of Surveillance and Epidemiologic Studies, Epidemiology Program Office, Influenza Br, Div of Viral Diseases, Center for Infectious Diseases, CDC.

FIGURE 1. Influenza morbidity reported by state — United States, week ending March 2, 1985.



The *Morbidity and Mortality Weekly Report* is prepared by the Centers for Disease Control, Atlanta, Georgia, and available on a paid subscription basis from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, (202) 783-3238.

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.

☆U.S. Government Printing Office: 1985-746-149/10042 Region IV

HHS Publication No. (CDC) 85-8017