CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

August 2, 1985 / Vol. 34 / No. 30

Epidemiologic Notes and Reports

Plasmodium vivax Infection among Tourists to Puerto Vallarta, and Acapulco, Mexico, — New Mexico, Texas

New Mexico. On January 17, 1985, a husband and wife from Santa Fe, New Mexico, flew to Puerto Vallarta, Mexico. They stayed at a beachfront resort hotel within the city limits of Puerto Vallarta for 4 days, after which they returned to the United States. On January 31, within a 12-hour period, the couple had onset of an illness characterized by fever, chills, drenching sweats, malaise, and headache. On February 2, when the wife sought medical attention, she had a fever of 38.9 C (102 F) and a mild tachycardia. Blood smears examined on the wife on February 3 and on the husband on February 4 revealed *Plasmodium vivax*. Both were successfully treated with chloroquine and primaquine. Interviews with the patients revealed no risk factors for acquiring malaria other than their recent vacation in Puerto Vallarta. Neither patient had traveled outside the United States in the past 5 years; neither had a history of blood transfusion or intravenous drug use. The couple did not leave the hotel grounds during their stay in Puerto Vallarta other than to travel to and from the airport. They had eaten their evening meal outdoors at the hotel on two occasions and had slept in a room with unscreened open windows. Both stated that they had been bitten by mosquitoes on multiple occasions.

Texas. On May 31, 1985, nine members of a family from San Antonio, Texas, flew to Acapulco, Mexico. They stayed in a rented villa situated on a cliff overlooking Acapulco Bay in a resort area 12 miles from the center of the city, where they remained until they returned to the United States on June 5. Between June 5 and June 17, six of the nine family members experienced febrile illnesses. On June 16, the first family member who became ill was diagnosed as having malaria after blood smears revealed *P. vivax*. Subsequently, blood smears on the other five ill family members also demonstrated *P. vivax*. All six were successfully treated with chloroquine and primaquine. Two of the three who have remained well have had negative blood smears. None of the family members had traveled outside the United States in the previous 5 years; none had any history of blood transfusion or intravenous drug use. The family had not left the villa other than to travel to and from downtown Acapulco and the airport. They ate their evening meals on an unscreened porch at the villa, where they experienced frequent mosquito bites.

Subsequently, CDC has been notified of four additional unrelated Texas residents who were infected by *P. vivax* during May and June in the same resort area as the family described above.

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Plasmodium vivax *Infection — Continued*

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Editorial Note: Transmission of *P. vivax* is reported to occur in the rural areas of both Jalisco and Guerrero, the states in which Puerto Vallarta and Acapulco are located (*1*). Current CDC recommendations indicate that there is no risk of malaria in major tourist resorts along the Pacific and Gulf of Mexico coasts (*2*), and the National Malaria Service of Mexico has not received any reports of malaria in Mexican or foreign tourists to these areas. However, these cases among U.S. travelers suggest that malaria can be transmitted in such areas, albeit rarely, and should be considered as a possible cause of a febrile illness in persons who have recently returned from resort vacations in Pacific coastal areas of Mexico.

While chemoprophylaxis is not recommended for travelers to these areas, physicians who advise patients before travel to Mexico should emphasize the importance of measures to reduce contact with mosquitoes during evening and nighttime hours, such as remaining in well-screened areas when possible, wearing protective clothes that cover most of the body, and using insect repellent on exposed areas of skin.

References

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Outbreak of Phototoxic Dermatitis from Limes — Maryland

On August 8, 1984, the Office of Disease Control and Epidemiology, Maryland Department of Health and Mental Hygiene, was notified by a nurse at a day camp in Owings Mills, Maryland, of a rash illness reported among 12 children during the previous week. The rash, confined to the dorsa of the hands and extensor and flexor surfaces of the forearms and in the form of blotches, speckles, and streaks, was macular, hyperpigmented, and nonpruritic. No other signs or symptoms were noted. Dermatologists diagnosed the rash as a phototoxic contact dermatitis. Investigation disclosed that limes used in an art class to make pomander balls were incriminated as the cause of the rash.

All children and counselors at the day camp were examined for evidence of the characteristic rash. A case was defined as a day-camp member with the rash noted by the examiner between August 8 and August 14. Ninety-seven (16%) of 622 children and seven (7%) of 104 counselors were affected. None of the 57 adult staff members reported a rash. Analysis of rash in children and counselors by sex and race showed no disproportionate representation. Since most children were too young to remember a date of onset, parents of children with rash were telephoned and asked for the date they first discovered the rash (Figure 1). Of the 82 (85%) mothers contacted, 23 (28%) had not noticed the rash or had thought it was dirt.

Several activities involving work with hands were investigated. Five activities that involved more than two-thirds (65) of affected children were significantly associated with illness ($p \leq 0.004$). These activities were making wallpaper, pomanders, tissue wine-paper cups, and burlap covers and participating in a nature scavenger hunt. However, when controlling for each of the other four activities, only exposure to making pomanders in arts and crafts class was significantly associated with illness ($p \leq 0.03$). Of the 17 counselors who had helped children make the pomanders, seven had the rash ($p < 0.001$), whereas none of the 34 counselors who were not exposed to the pomanders had the rash ($p < 0.001$). The pomanders were made from July 23 to July 27 by camp units A and B (approximately 60 children

Dermatitis – Continued

per unit) and by some members of units D and H on July 31. Discovery of the rash for most cases correlates with the time of exposure (Figure 1).

In making pomanders, the children received one lime each during class, poked several holes in it with scissors, filled the holes with cloves, sprinkled cinnamon over the lime, and placed the product in cloth later tied with a pipecleaner. During the process, oil glands in the lime skin probably ruptured, releasing chemicals in the oil known to cause phototoxicity on exposure to the sun (*1-5*).

The limes were purchased from a supermarket, part of a nationwide chain, that purchases its limes from Florida. After harvesting the limes, the processors wash off any insecticides (all water-soluble) and later coat the limes with an inert vegetable wax. Environmental and botanical survey of the camp did not reveal other chemicals or plants with phototoxic potential with which camp members may have come into contact.

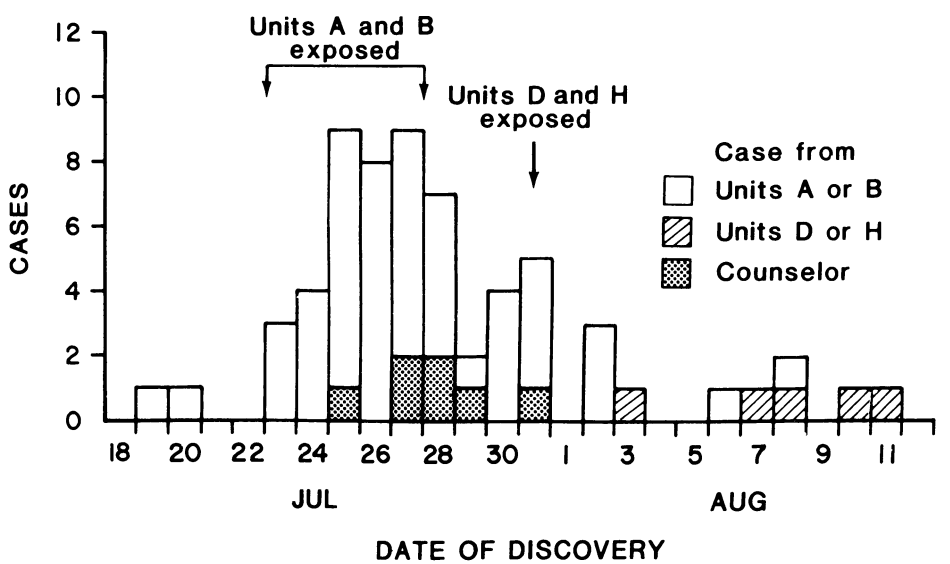
Reported by E Israel, MD, State Epidemiologist, Maryland State Dept of Health and Mental Hygiene; Div of Field Svcs, Epidemiology Program Office, Chronic Diseases Div, Center for Environmental Health, CDC.

Editorial Note: Photosensitivity of the skin refers to an abnormal reaction of the skin to light. This abnormal reaction results from exposure to certain therapeutic or chemical agents. Exposure may occur when the offending agent is either ingested or applied topically. The reaction occurs only after an exposed individual is subjected to ultraviolet or visible light. In most cases, the offending agents do not act as contact irritants by themselves; they are harmless to skin in the absence of exposure to light.

Photosensitivity reactions are classified as either photoallergic or phototoxic. Photoallergy involves the immune system. The offending agent, acting as a hapten, absorbs radiation, becomes activated, and reacts with protein(s) within the skin to form an antigen(s). This photoantigen is immunologically processed and manifests itself as an ordinary delayed hypersensitivity response. The patient with photoallergy has eczematous or papulovesicular eruptions.

In contrast to photoallergy, phototoxicity does not involve the immune system. Most often, phototoxic reactions can be produced in an individual if he or she is exposed to both an appropriate concentration of the offending agent and sufficient light energy of the correct

FIGURE 1. Cases of rash illness in a day camp, by date of discovery and by unit — Owings Mills, Maryland, July-August 1984



Dermatitis — Continued

wavelength. The patient with phototoxicity has an exaggerated sunburn reaction, with or without vesicles, edema, and hyperpigmentation. The reaction occurs within 5-18 hours after the patient is exposed to light; it is most intense 36-72 hours after exposure.

Furocoumarins are heterocyclic aromatic compounds naturally found in the skin of citrus fruits, including limes. Psoralen, a compound resembling the naturally occurring furocoumarins, has been shown to produce photosensitivity reactions.

In all cases of photosensitivity, rapid diagnosis and identification of the offending agent are fundamental in effecting control. In photoallergy, cross-sensitization to closely related photoantigens can occur: the patient should be alerted to this possibility. In phototoxicity, the severity of symptoms depends on the concentration of exposures, and a variety of clinical presentations may be observed within an exposed group. Further measures call for eliminating, or at least reducing, exposure to the offending agent. Exposure to sunlight should be minimized, sunscreens should be used, and patient education should be emphasized.

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Acute Poisoning Following Exposure to an Agricultural Insecticide — California

In 1984, 1,156 workers were documented to have had possible pesticide-related illnesses in California. Twenty of the 274 workers exposed to field residues had systemic reactions, one of which was related to exposure to Phosdrin® (mevinphos), an organophosphate insecticide (*1*). Although only one systemic reaction to mevinphos was reported among California field workers for each of the years 1982-1984, a 1981 incident involved over 30 workers and is reported below.

At 7 a.m. on April 23, 1981, 44 farm workers entered a field in the Salinas Valley of California to harvest a crop of iceberg lettuce. By 9 a.m., several workers experienced dizziness, visual disturbances, headache, nausea, and eye irritation. At 11 a.m., a field supervisor reported that, at 5 a.m. the same morning, despite a cancellation order sent the previous day, the field had been sprayed with mevinphos.

Thirty-one field workers and three agricultural officials who had been inspecting the harvested lettuce were seen at a local hospital for evaluation and treatment. Tests for plasma cholinesterase were performed. Two workers were hospitalized for observation and treatment of respiratory difficulties. Two others had plasma cholinesterase levels below the lower limit of normal. The remaining workers disrobed, were "hosed down" with water, and after redressing, were instructed to wash their clothes when they got home; none was advised against returning to work the following day.

The next day, several workers were unable to return to work because of continuing symptoms. A union representative arranged for further examinations at a second hospital; 29 workers were examined and tested for cholinesterase activity. One was hospitalized because of bradycardia.

Investigators from the National Institute for Occupational Safety and Health (NIOSH), in

Agricultural Insecticide Poisoning – Continued

collaboration with investigators from the second hospital, conducted an investigation beginning April 24 during the acute phase of this episode (*2*). They interviewed the 29 workers who reported symptoms and signs, including eye irritation (76%), headache (48%), visual disturbances (48%), dizziness (41%), nausea (38%), fatigue (28%), chest pain or shortness of breath (21%), skin irritation (17%), fasciculation of the eyelids (10%), fasciculation of muscles in the arm (7%), excessive sweating (7%), and diarrhea (7%). Twenty-two (76%) of the workers reported three or more symptoms or signs.

Levels of plasma cholinesterase and red blood cell (RBC) cholinesterase were determined for all 29 workers on April 24; no result was below the lower limit of normal. When the workers returned 6 days later for follow-up examinations, tests for cholinesterase were again performed. The mean plasma cholinesterase level for the group had increased by 5 Michel units; 2 weeks later, when 26 workers were tested a third time, the mean plasma cholinesterase level had increased by another 14 Michel units. These increases were found to be statistically significant.

Periodic examinations over the next 12 weeks also included tests for cholinesterase. For 27 workers, followed for at least 8 weeks each, investigators attempted to estimate presumptive "baseline" levels of plasma- and RBC-cholinesterase levels by averaging the results of the previous two tests. Comparing these derived "baseline" levels retrospectively with the values determined during the acute phase of the episode, it was possible to estimate an average depression of cholinesterase activity. The average depression for plasma cholinesterase was 15.6%, and for RBC cholinesterase, 5.6%. These estimated depressions were presumed to be caused by the exposure to mevinphos. For both plasma cholinesterase and RBC cholinesterase, the estimated depression was greater among workers reporting four or more signs or symptoms than among those reporting fewer than four, but this difference was not statistically significant. Cholinesterase activity appeared to return to the estimated "baseline" levels within 2 weeks after the exposure to mevinphos.

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Editorial Note: Organophosphates inhibit the enzyme, cholinesterase; toxic effects from exposure to organophosphates are believed due to a consequent increase of the neurotransmitter, acetylcholine, in the nervous system. The antidotes are atropine and Propopan®, which block the effect of acetylcholine (*3*). Humans have two cholinesterases, RBC cholinesterase (or "true cholinesterase") and plasma cholinesterase (or "pseudocholinesterase"), which are generated in the liver.

Symptoms following moderate exposure to organophosphates include headache, dizziness, weakness, nausea and vomiting, fasciculations of eyelids and skin, blurred vision (due to pupillary constriction), and sweating. More severe exposures may cause abdominal cramps, muscular tremors, hypotension, bradycardia, dyspnea, and, ultimately, death from respiratory paralysis (*4*). The chronic health effects of exposure to the organophosphate residues have not been fully investigated (*5,6*), but are currently under study by NIOSH (*7*).

Acute poisoning due to organophosphate insecticides is diagnosed by a history of exposure and the appearance of typical signs and symptoms; the diagnosis is assisted by a favorable response to a test dose of atropine. Poisoning is confirmed by laboratory tests that demonstrate a depression (usually 25% or more) in cholinesterase activity. Because plasma cholinesterase is generated in the liver and may be affected by any factor that alters normal liver function, it is considered more labile than RBC cholinesterase. Hence, RBC cholinesterase, which measures the same enzyme that is active in nerve tissue, is the preferred index of toxic effects. During recovery from a toxic inhibition of cholinesterase, RBC cholinesterase is regenerated more slowly than plasma cholinesterase (*8*).

Agricultural Insecticide Poisoning – Continued

The prevalence of signs and symptoms among the 29 workers studied was not recorded beyond the day after exposure to mevinphos. These workers may have intensified their exposure by redonning clothing contaminated with pesticide residue. The pattern of increasing postexposure cholinesterase values seen among these workers suggests that they experienced significant depressions of cholinesterase soon after exposure, despite acute-phase test results within the normal range. In turn, this suggests that, in the absence of previously measured baseline values for cholinesterase, the results of tests after possible toxic exposures must be interpreted with caution. Exposures to organophosphates can produce significant toxicity even though laboratory results of postexposure tests fall within the normal range. Thus, when workers with possible exposure to organophosphates present with symptoms, such as those described, and do not have previously established baseline values for cholinesterase activity, test results in the low or middle portion of the range of laboratory normal values should not rule out the presence of significant toxicity. Preexposure baseline levels should be established for each worker expected to be frequently exposed to organophosphates or their residues.

The rate of decrease in cholinesterase levels is thought to correlate more directly with

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

Disease	30th Week Ending			Cumulative, 30th Week Ending		
	July 27, 1985	July 28, 1984	Median 1980-1984	July 27, 1985	July 28, 1984	Median 1980-1984
Acquired Immunodeficiency Syndrome (AIDS)	194	107	N	4,308	2,287	N
Aseptic meningitis	240	185	264	2,971	2,864	3,201
Encephalitis: Primary (arthropod-borne & unspec.)	13	28	34	518	512	570
Post-infectious	1	1	1	76	80	58
Gonorrhea: Civilian	18,713	16,905	20,049	470,023	462,861	540,998
Military	363	474	474	10,279	12,070	15,423
Hepatitis: Type A	409	415	435	12,171	11,817	12,727
Type B	449	484	437	14,382	14,276	12,047
Non A, Non B	67	76	N	2,325	2,179	N
Unspecified	98	97	170	3,236	2,755	4,874
Legionellosis	15	5	N	323	324	N
Leprosy	2	2	2	203	131	131
Malaria	37	27	29	518	487	584
Measles: Total*	22	36	36	2,095	2,098	2,098
Indigenous	21	24	N	1,716	1,858	N
Imported	1	12	N	379	240	N
Meningococcal infections: Total	42	36	36	1,552	1,833	1,833
Civilian	42	36	36	1,549	1,830	1,830
Military	-	-	-	3	3	12
Mumps	24	22	39	2,007	2,026	2,965
Pertussis	47	33	44	964	1,142	757
Rubella (German measles)	24	24	33	443	471	1,604
Syphilis (Primary & Secondary): Civilian	648	622	621	14,489	15,935	17,153
Military	2	15	10	97	203	227
Toxic Shock syndrome	10	12	N	221	292	N
Tuberculosis	518	450	511	12,055	12,080	14,512
Tularemia	4	22	8	73	167	128
Typhoid fever	18	10	9	182	178	221
Typhus fever, tick-borne (RMSF)	19	40	59	331	465	632
Rabies, animal	121	93	126	2,926	2,893	3,718

TABLE II. Notifiable diseases of low frequency, United States

	Cum. 1985		Cum. 1985
Anthrax	-	Leptospirosis (Fla. 4)	18
Botulism: Foodborne	22	Plague	7
Infant (Calif. 1)	29	Poliomyelitis: Total	3
Other	-	Paralytic	3
Brucellosis (Fla. 1)	64	Psittacosis (Fla. 2)	68
Cholera	2	Rabies, human	-
Congenital rubella syndrome	-	Tetanus (Pa. 1, Mo. 1, N.C.1)	32
Congenital syphilis, ages < 1 year	90	Trichinosis	47
Diphtheria	1	Typhus fever, flea-borne (endemic, murine)	6

*One of the 22 reported cases for this week was 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 July 27, 1985 and July 28, 1984 (30th 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	4,308	240	518	76	470,023	462,861	409	449	67	98	15	203
NEW ENGLAND	148	13	14	-	13,499	12,939	7	22	1	9	-	4
Maine	6	-	-	-	600	527	1	1	-	-	-	-
N.H.	-	-	4	-	308	390	-	-	-	-	-	-
Vt.	1	5	-	-	170	217	-	-	-	-	-	-
Mass.	89	4	9	-	5,139	5,225	4	12	-	9	-	4
R.I.	7	3	-	-	1,038	875	-	4	-	-	-	-
Conn.	45	1	1	-	6,244	5,705	2	5	1	-	-	-
MID ATLANTIC	1,691	21	73	5	72,108	63,215	36	58	8	3	-	15
Upstate N.Y.	204	16	25	4	9,387	9,292	6	8	-	1	-	-
N.Y. City	1,135	5	7	-	36,785	26,636	3	5	-	1	-	15
N.J.	249	-	18	-	10,971	10,612	9	23	5	1	-	-
Pa.	103	-	23	1	14,965	16,675	18	22	3	-	-	-
E.N. CENTRAL	189	38	112	15	66,245	64,497	13	34	3	5	6	20
Ohio	34	19	45	4	16,727	16,638	5	5	-	1	2	2
Ind.	13	8	16	2	7,065	7,566	1	2	-	2	-	-
Ill.	94	1	14	6	17,801	14,786	1	5	2	-	-	16
Mich.	32	10	30	-	18,479	18,309	6	22	1	2	4	2
Wis.	16	-	7	3	6,173	7,198	-	-	-	-	-	-
W.N. CENTRAL	49	28	33	3	22,854	22,285	13	17	4	2	2	-
Minn.	12	6	15	1	3,288	3,296	1	2	1	-	-	-
Iowa	7	3	10	-	2,480	2,448	-	2	-	-	1	-
Mo.	22	12	-	-	10,911	10,763	5	12	3	2	-	-
N. Dak.	-	-	-	1	152	219	-	-	-	-	-	-
S. Dak.	-	1	-	-	422	553	4	-	-	-	1	-
Nebr.	3	-	3	-	1,999	1,515	3	-	-	-	-	-
Kans.	5	6	5	1	3,602	3,491	-	1	-	-	-	-
S. ATLANTIC	673	57	62	26	102,712	117,629	48	96	17	15	5	5
Del.	7	4	1	-	2,305	2,078	3	-	-	-	-	-
Md.	74	3	16	1	16,468	13,427	-	18	1	1	-	1
D.C.	87	1	-	-	8,546	8,431	-	1	1	-	-	-
Va.	45	11	15	4	10,638	11,133	2	8	3	1	-	-
W. Va.	4	2	7	-	1,428	1,417	4	-	-	-	-	-
N.C.	32	6	20	-	19,588	18,750	2	14	-	2	5	2
S.C.	7	-	3	-	12,637	11,548	1	9	-	-	-	-
Ga.	105	12	-	-	-	22,337	1	15	4	2	-	1
Fla.	312	18	-	21	31,102	28,508	35	31	8	9	-	1
E.S. CENTRAL	44	10	23	4	40,707	39,852	6	31	1	1	-	-
Ky.	12	-	8	-	4,650	4,896	6	4	-	-	-	-
Tenn.	14	1	4	-	16,197	16,554	-	16	1	1	-	-
Ala.	16	5	9	4	12,661	12,610	-	10	-	-	-	-
Miss.	2	4	2	-	7,199	5,792	-	1	-	-	-	-
W.S. CENTRAL	313	16	65	2	63,245	63,133	29	18	4	10	2	15
Ark.	4	-	1	1	6,128	5,772	3	-	-	-	-	1
La.	54	-	3	-	12,758	14,240	1	1	-	-	-	1
Okla.	7	3	17	1	6,645	6,849	8	5	1	2	-	-
Tex.	248	13	44	-	37,714	36,272	17	12	3	8	2	13
MOUNTAIN	67	7	24	5	15,152	14,802	66	43	9	12	-	5
Mont.	-	-	-	-	423	635	-	-	-	-	-	-
Idaho	-	1	-	-	479	740	3	-	-	-	-	-
Wyo.	-	-	1	-	371	420	1	3	-	-	-	-
Colo.	25	1	6	1	4,623	4,242	11	14	5	4	-	1
N. Mex.	7	-	3	-	1,760	1,693	21	3	-	1	-	-
Ariz.	24	5	4	-	4,401	4,009	23	18	3	7	-	1
Utah	8	-	7	4	644	725	3	1	-	-	-	2
Nev.	3	-	3	-	2,451	2,338	4	4	1	-	-	1
PACIFIC	1,134	50	112	16	73,501	64,509	191	130	20	41	-	139
Wash.	67	2	11	-	5,032	4,641	15	13	1	1	-	31
Oreg.	15	-	-	-	3,528	3,613	35	12	2	1	-	2
Calif.	1,032	48	98	16	62,186	53,596	139	101	17	39	-	92
Alaska	2	-	3	-	1,729	1,573	1	1	-	-	-	-
Hawaii	18	-	-	-	1,026	1,086	1	3	-	-	-	14
Guam	-	U	-	-	73	150	U	U	U	U	U	1
P.R.	51	1	4	2	2,030	1,944	1	17	1	1	-	2
V.I.	2	U	-	-	279	303	U	U	U	U	U	-
Pac. Trust Terr.	-	U	-	-	146	-	U	U	U	U	U	20

N: Not notifiable U: Unavailable

TABLE III. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending July 27, 1985 and July 28, 1984 (30th 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	518	21	1,716	1	379	2,098	1,552	24	2,007	47	964	1,142	24	443	471
NEW ENGLAND	26	-	33	-	86	102	69	-	41	2	52	30	1	10	18
Maine	3	-	-	-	-	-	2	-	6	-	2	1	-	-	1
N.H.	4	-	-	-	-	36	8	-	7	1	24	6	-	2	1
Vt.	-	-	-	-	-	6	9	-	2	-	2	14	-	-	-
Mass.	12	-	29	-	83	47	12	-	13	1	10	7	-	6	16
R.I.	2	-	-	-	-	-	13	-	8	-	8	1	-	-	-
Conn.	5	-	4	-	3	13	25	-	5	-	6	1	1	2	-
MID ATLANTIC	83	6	155	-	26	132	261	-	216	2	67	100	19	182	162
Upstate N.Y.	26	-	71	-	10	31	107	-	123	-	30	56	-	17	95
N.Y. City	29	6	47	-	7	90	43	-	14	-	9	3	19	144	49
N.J.	10	-	14	-	9	7	39	-	27	-	3	7	-	9	17
Pa.	18	-	23	-	-	4	72	-	52	2	25	34	-	12	1
E.N. CENTRAL	24	5	343	-	125	651	274	1	762	5	112	297	-	20	76
Ohio	6	-	-	-	43	8	91	-	232	4	26	52	-	-	2
Ind.	3	-	48	-	1	3	37	-	33	-	11	195	-	-	2
Ill.	2	5	204	-	66	161	60	-	150	1	17	19	-	5	46
Mich.	11	-	37	-	15	446	58	1	281	-	22	17	-	14	18
Wis.	2	-	54	-	-	33	28	-	66	-	36	14	-	1	8
W.N. CENTRAL	16	-	1	-	8	9	84	-	63	5	76	86	-	19	29
Minn.	6	-	-	-	4	3	21	-	1	-	19	9	-	2	2
Iowa	1	-	-	-	-	-	7	-	9	1	5	5	-	1	1
Mo.	4	-	-	-	2	2	34	-	11	4	16	15	-	7	-
N. Dak.	1	-	-	-	2	-	3	-	2	-	9	-	-	2	3
S. Dak.	1	-	-	-	-	-	2	-	-	-	1	6	-	-	-
Nebr.	1	-	-	-	-	-	7	-	2	-	4	2	-	-	-
Kans.	2	-	1	-	-	4	10	-	38	-	22	49	-	7	23
S. ATLANTIC	67	5	217	-	6	40	304	14	188	10	212	118	-	49	21
Del.	-	-	-	-	-	-	7	-	1	-	-	2	-	1	-
Md.	16	5	56	-	4	16	42	-	26	1	90	28	-	3	1
D.C.	4	-	2	-	1	8	6	-	-	1	1	-	-	-	-
Va.	14	-	21	-	1	4	40	-	31	-	5	16	-	2	-
W. Va.	1	-	31	-	-	-	8	-	55	-	1	8	-	11	-
N.C.	7	-	9	-	-	-	42	-	11	2	12	17	-	-	-
S.C.	-	-	-	-	-	1	30	-	7	-	-	2	-	3	-
Ga.	5	-	8	-	-	-	52	14	28	6	65	10	-	4	2
Fla.	20	-	90	-	-	11	77	-	29	-	38	35	-	25	18
E.S. CENTRAL	8	-	-	-	1	3	74	1	18	1	17	6	-	2	9
Ky.	2	-	-	-	-	1	5	-	4	-	3	1	-	2	3
Tenn.	-	-	-	-	-	2	29	1	12	-	5	2	-	-	-
Ala.	5	-	-	-	-	-	24	-	-	-	6	-	-	-	3
Miss.	1	-	-	-	1	-	16	-	2	1	3	3	-	-	3
W.S. CENTRAL	47	3	364	-	9	478	130	1	210	-	143	234	-	28	6
Ark.	-	-	-	-	-	6	12	-	4	-	10	14	-	1	3
La.	1	3	42	-	-	-	22	-	2	-	8	4	-	-	-
Okla.	2	-	-	-	1	8	25	N	N	-	74	207	-	1	-
Tex.	44	-	322	-	8	464	71	1	204	-	51	9	-	26	3
MOUNTAIN	29	1	448	-	43	139	66	2	199	14	68	79	-	4	15
Mont.	-	-	122	-	17	-	5	-	7	-	4	17	-	-	-
Idaho	1	1	120	-	18	23	2	1	9	2	2	3	-	1	1
Wyo.	1	-	-	-	-	-	5	-	2	-	-	3	-	-	2
Colo.	8	-	-	-	6	1	19	-	16	7	29	28	-	-	2
N. Mex.	10	-	1	-	2	88	8	N	N	1	6	5	-	2	-
Ariz.	5	-	205	-	-	-	18	-	97	4	18	15	-	1	-
Utah	2	-	-	-	-	27	7	1	6	-	9	6	-	-	7
Nev.	2	-	-	-	-	-	2	-	62	-	-	2	-	-	3
PACIFIC	218	1	155	1	75	544	290	5	310	8	217	192	4	129	135
Wash.	17	-	9	-	32	124	52	-	28	8	35	42	-	11	1
Oreg.	11	-	3	-	-	-	26	N	N	-	21	11	-	2	1
Calif.	173	1	130	1 †	38	286	201	5	266	-	135	69	3	74	129
Alaska	2	-	-	-	-	-	7	-	4	-	23	1	-	1	1
Hawaii	15	-	13	-	5	134	4	-	12	-	3	69	1	41	3
Guam	1	U	10	U	-	90	-	U	4	U	-	-	U	1	4
P.R.	-	-	48	-	-	3	10	3	116	1	7	-	1	23	6
V.I.	-	U	4	U	6	-	-	U	3	U	-	-	U	-	-
Pac. Trust Terr.	-	U	-	U	-	-	-	U	3	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 July 27, 1985 and July 28, 1984 (30th Week)

Reporting Area	Syphilis (Civilian) (Primary & Secondary)		Toxic-shock Syndrome	Tuberculosis		Tula-remia	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	14,489	15,935	10	12,055	12,080	73	182	331 +22	2,926
NEW ENGLAND	301	304	-	403	341	1	6	3	9
Maine	9	3	-	29	18	-	-	-	-
N.H.	6	8	-	11	20	-	-	-	1
Vt.	3	1	-	4	6	-	-	-	-
Mass.	161	179	-	248	183	1	5	3	5
R.I.	7	11	-	32	28	-	-	-	-
Conn.	115	102	-	79	86	-	1	-	3
MID ATLANTIC	1,981	2,183	-	2,240	2,197	1	29	7	248
Upstate N.Y.	140	178	-	369	359	-	8	4	60
N.Y. City	1,231	1,344	-	1,127	901	1	15	1	-
N.J.	393	394	-	304	474	-	5	-	24
Pa.	217	267	-	440	463	-	1	2	164
E.N. CENTRAL	654	727	1	1,487	1,593	-	17	30 +6	97
Ohio	88	143	-	276	306	-	3	23 3	21
Ind.	61	83	-	180	178	-	3	2	14
Ill.	340	239	-	635	674	-	4	3 3	15
Mich.	127	217	1	311	334	-	5	2	14
Wis.	38	45	-	85	101	-	2	-	33
W.N. CENTRAL	135	235	-	318	361	24	8	25 +2	546
Minn.	28	69	-	63	59	1	5	-	111
Iowa	15	10	-	42	40	-	1	-	102
Mo.	68	120	-	149	178	18	1	1	23
N. Dak.	2	5	-	3	8	-	-	1	82
S. Dak.	4	-	-	18	15	4	-	2	170
Nebr.	5	10	-	11	18	1	1	2	26
Kans.	13	21	-	32	43	-	-	19 2	32
S. ATLANTIC	3,614	4,744	-	2,433	2,501	6	19	147 +9	781
Del.	20	13	-	24	29	1	-	1	-
Md.	220	295	-	219	255	-	5	12 1	395
D.C.	201	183	-	101	95	-	-	-	-
Va.	173	240	-	220	244	1	3	15	105
W. Va.	9	12	-	65	81	-	-	1	18
N.C.	391	473	-	307	390	4	2	57 2	4
S.C.	448	433	-	316	304	-	-	43 4	45
Ga.	-	807	-	397	356	-	1	13 1	120
Fla.	2,152	2,288	-	784	747	-	8	5 1	94
E.S. CENTRAL	1,237	1,081	-	1,078	1,111	3	4	35 +5	144
Ky.	36	59	-	241	258	-	1	1	21
Tenn.	349	292	-	317	354	3	1	20 2	29
Ala.	391	341	-	332	334	-	2	7 1	91
Miss.	461	389	-	188	165	-	-	7 2	3
W.S. CENTRAL	3,537	3,883	2	1,460	1,389	21	11	69	542
Ark.	187	120	-	157	154	8	-	11 1	89
La.	614	697	-	195	182	-	-	-	12
Okla.	97	134	2	158	138	9	-	49 -1	66
Tex.	2,639	2,932	-	950	915	4	11	9	375
MOUNTAIN	419	361	5	328	307	13	7	13	238
Mont.	2	2	-	46	14	4	-	6	114
Idaho	3	14	-	15	19	-	-	1	6
Wyo.	7	6	-	5	-	-	-	4	12
Colo.	100	83	-	40	31	2	4	1	13
N. Mex.	73	48	-	60	58	2	2	-	5
Ariz.	208	137	3	134	142	3	1	-	85
Utah	5	12	2	6	28	2	-	-	-
Nev.	21	59	-	22	15	-	-	1	3
PACIFIC	2,611	2,417	2	2,308	2,280	4	81	2	321
Wash.	64	83	-	131	118	-	-	-	4
Oreg.	50	70	1	79	90	1	-	-	1
Calif.	2,452	2,214	1	1,919	1,905	1	78	2	313
Alaska	2	3	-	67	43	2	-	-	3
Hawaii	43	47	-	112	124	-	3	-	-
Guam	2	-	U	16	32	-	-	-	-
P.R.	450	482	-	198	242	-	1	-	24
V.I.	1	8	U	1	3	-	52	-	-
Pac. Trust Terr.	13	-	U	16	-	-	-	-	-

U: Unavailable

TABLE IV. Deaths in 121 U.S. cities,* week ending July 27, 1985 (30th Week)

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	639	398	162	39	13	27	50
Boston, Mass.	172	90	43	13	8	18	21
Bridgeport, Conn.	35	22	9	2	1	1	2
Cambridge, Mass. §	28	28	-	-	-	-	2
Fall River, Mass.	25	19	5	1	-	-	-
Hartford, Conn.	61	39	19	2	-	1	2
Lowell, Mass.	23	16	4	2	1	-	3
Lynn, Mass.	21	17	4	-	-	-	-
New Bedford, Mass.	29	17	8	3	1	-	2
New Haven, Conn.	45	25	13	4	-	3	3
Providence, R.I.	60	32	26	1	-	1	6
Somerville, Mass.	2	2	-	-	-	-	-
Springfield, Mass.	48	28	10	8	-	2	3
Waterbury, Conn.	24	15	7	2	-	-	1
Worcester, Mass.	66	48	14	1	2	1	5
MID ATLANTIC	2,443	1,575	503	236	66	62	99
Albany, N.Y.	61	38	14	3	3	3	-
Allentown, Pa.	16	13	2	1	-	-	-
Buffalo, N.Y.	78	52	15	6	2	3	4
Camden, N.J.	37	25	7	1	1	3	1
Elizabeth, N.J.	20	14	3	2	-	1	-
Erie, Pa.†	35	23	8	4	-	-	1
Jersey City, N.J.	49	34	10	4	-	1	3
N.Y. City, N.Y.	1,351	828	298	165	39	21	51
Newark, N.J.	63	30	11	9	3	10	3
Paterson, N.J.	31	15	8	5	1	2	-
Philadelphia, Pa.	291	199	60	16	7	9	9
Pittsburgh, Pa.†	61	36	17	3	2	3	2
Reading, Pa.	32	25	4	3	-	-	7
Rochester, N.Y.	107	83	14	3	5	2	6
Schenectady, N.Y.	30	25	2	2	1	-	2
Scranton, Pa.†	30	20	6	1	-	3	1
Syracuse, N.Y.	70	49	13	4	2	1	1
Trenton, N.J.	43	32	7	4	-	-	7
Utica, N.Y.	14	11	3	-	-	-	-
Yonkers, N.Y.	24	23	1	-	-	-	1
E.N. CENTRAL	2,319	1,541	458	144	77	98	84
Akron, Ohio	69	46	17	2	1	3	3
Canton, Ohio	34	27	3	3	1	-	2
Chicago, Ill.§	553	462	11	26	16	37	16
Cincinnati, Ohio	171	103	46	9	6	7	15
Cleveland, Ohio	147	86	47	10	2	2	-
Columbus, Ohio	177	97	47	11	8	14	3
Dayton, Ohio	119	73	35	8	1	2	3
Detroit, Mich.	272	138	77	36	13	8	7
Evansville, Ind.	56	43	10	-	-	3	2
Fort Wayne, Ind.	68	40	15	4	5	4	4
Gary, Ind.	11	4	4	2	1	-	-
Grand Rapids, Mich.	36	25	5	2	2	2	2
Indianapolis, Ind.	155	92	43	6	7	7	-
Madison, Wis.	37	27	6	2	2	-	6
Milwaukee, Wis.	139	89	42	4	1	3	8
Peoria, Ill.	49	32	7	8	1	1	3
Rockford, Ill.	39	23	10	3	3	-	1
South Bend, Ind.	35	27	4	2	1	1	3
Toledo, Ohio	101	70	17	6	5	3	5
Youngstown, Ohio	51	37	12	-	1	1	1
W.N. CENTRAL	697	483	129	31	29	25	20
Des Moines, Iowa	65	43	14	2	3	3	1
Duluth, Minn.	22	14	6	2	-	-	-
Kansas City, Kans.	31	24	4	2	1	-	1
Kansas City, Mo.	116	76	23	4	6	7	2
Lincoln, Nebr.	40	25	14	1	-	-	1
Minneapolis, Minn.	68	50	9	3	4	2	2
Omaha, Nebr.	88	58	21	4	2	3	6
St. Louis, Mo.	114	87	12	5	4	6	1
St. Paul, Minn.	74	56	9	3	4	2	1
Wichita, Kans.	79	50	17	5	5	2	5

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
S. ATLANTIC	1,213	721	314	103	29	46	56
Atlanta, Ga.	156	94	42	15	2	3	5
Baltimore, Md.	273	148	89	25	3	8	8
Charlotte, N.C.	72	50	13	6	1	2	7
Jacksonville, Fla.	71	46	15	7	2	1	3
Miami, Fla.	59	46	9	3	1	-	1
Norfolk, Va.	75	49	16	4	2	4	4
Richmond, Va.	63	40	10	5	4	4	3
Savannah, Ga.	45	22	10	6	3	4	5
St. Petersburg, Fla.	92	75	10	4	2	1	5
Tampa, Fla.	48	26	12	5	2	3	3
Washington, D.C.	240	110	84	23	7	16	11
Wilmington, Del.	19	15	4	-	-	-	1
E.S. CENTRAL	823	494	212	65	27	25	33
Birmingham, Ala.	136	83	29	12	7	5	5
Chattanooga, Tenn.	50	32	12	3	2	1	2
Knoxville, Tenn.	89	53	25	7	3	1	2
Louisville, Ky.	121	80	30	7	2	2	5
Memphis, Tenn.	197	118	52	16	4	7	11
Mobile, Ala.	78	37	29	7	3	2	3
Montgomery, Ala.	54	37	11	4	2	-	3
Nashville, Tenn.	98	54	24	9	4	7	2
W.S. CENTRAL	1,242	810	208	107	62	55	50
Austin, Tex.	52	31	8	3	7	3	3
Baton Rouge, La.	46	20	8	12	3	3	-
Corpus Christi, Tex.	11	6	2	2	-	1	-
Dallas, Tex.	209	121	46	23	9	10	7
El Paso, Tex.	49	28	9	5	4	3	3
Fort Worth, Tex.	101	54	24	14	5	4	4
Houston, Tex. §	283	247	2	8	16	10	6
Little Rock, Ark.	47	27	10	1	4	5	2
New Orleans, La.	139	85	29	14	5	6	-
San Antonio, Tex.	166	107	36	13	5	5	11
Shreveport, La.	60	37	13	5	-	5	6
Tulsa, Okla.	79	47	21	7	4	-	8
MOUNTAIN	653	401	142	68	24	18	34
Albuquerque, N.Mex.	95	52	19	18	3	3	6
Colo. Springs, Colo.	34	21	4	7	2	-	1
Denver, Colo.	109	72	22	12	2	1	10
Las Vegas, Nev.	78	41	22	9	3	3	7
Ogden, Utah	34	23	7	-	2	2	3
Phoenix, Ariz.	149	93	36	13	3	4	1
Pueblo, Colo.	15	10	4	-	1	-	-
Salt Lake City, Utah	43	26	9	1	6	1	-
Tucson, Ariz.	96	63	19	8	2	4	6
PACIFIC	1,945	1,259	377	175	71	55	127
Berkeley, Calif.	18	14	1	1	1	1	-
Fresno, Calif.	63	47	8	2	5	1	5
Glendale, Calif.	27	27	-	-	-	-	1
Honolulu, Hawaii	69	43	17	5	3	1	3
Long Beach, Calif.	99	70	16	8	2	3	12
Los Angeles, Calif.	619	380	138	61	19	13	24
Oakland, Calif.	64	40	9	4	6	5	3
Pasadena, Calif.	10	6	2	-	-	2	3
Portland, Oreg.	127	80	28	12	4	3	16
Sacramento, Calif.	133	88	25	9	6	5	9
San Diego, Calif.	122	80	25	15	1	1	15
San Francisco, Calif.	146	74	36	25	1	10	7
San Jose, Calif.	152	97	30	14	8	3	13
Seattle, Wash.	160	115	18	16	8	3	5
Spokane, Wash.	42	32	6	1	2	1	1
Tacoma, Wash.	94	66	18	2	5	3	10
TOTAL	11,974††	7,682	2,505	968	398	411	553

*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 3 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.

Agricultural Insecticide Poisoning — Continued

symptoms than is the amount of the depression. Because moderate exposure on a continuing basis produces a cumulative effect, continuous moderate exposures may cause the cholinesterase level to gradually fall; a sudden, unexplained onset of symptoms may occur when the cholinesterase level falls below a "threshold" in the worker. Thus, symptomatic workers, and those with a demonstrated depression of cholinesterase activity, are at increased risk if they continue to work in jobs exposing them to cholinesterase inhibitors before they have fully recovered (*9*). State health officials have estimated that as few as 1% of the residue-induced illnesses among California field workers are reported (*5*).

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International Notes

Update: Acquired Immunodeficiency Syndrome — Europe

As of March 31, 1985, 940 cases of acquired immunodeficiency syndrome (AIDS) have been reported to the World Health Organization (WHO) Collaborating Centre on AIDS (Table 1). One hundred seventy-eight new cases were reported by the 17 countries corresponding with the Centre since December 31, 1984 (*1*), an average increase of 14 cases per week.

The greatest increases in the number of cases were observed in: France—47 new cases (three to four per week); United Kingdom—32 (two to three/week); and the Federal Republic of Germany—27 (two to three/week). In four countries (Belgium, Netherlands, Spain, and Switzerland), an increase of one case/week was noted; for the other 10 countries, zero to eight new cases were reported from January through March.

AIDS cases per million population were calculated from 1983 population data (Institut National d'Etudes Demographiques, [INED], Paris). The highest rates were noted in Denmark—8.0; Switzerland—7.9; and France—5.6. These rates are low compared to the U.S. rate of 40.9 (April 1, 1985). The situation in Belgium is special, since 77% of the cases originate from Africa.

A total of 468 deaths were reported for the 940 cases (case-fatality rate: 50%). Fifty-two percent of the AIDS patients diagnosed 1 year ago and 86% of those diagnosed 3 years ago have died (Figure 2). Six hundred three patients (64%) presented with one or more opportunistic infections; 188 (20%) had Kaposi's sarcoma (KS) alone; and 143 (15%) had opportunistic

AIDS – Continued

infections with KS (Table 2). The category "Other" (six cases) includes three cases of progressive multifocal leukoencephalopathy (France—two; Denmark—one); two cases of isolated cerebral lymphoma (Switzerland and United Kingdom—one each), and one isolated Burkitt lymphoma of the brain (Federal Republic of Germany). The highest case-fatality rate (65%) was noted for patients with both opportunistic infection and KS. The case-fatality rate for opportunistic infection alone was 54%, and for KS alone, 24%.

Males accounted for 92% of the cases (Table 3). The male to female ratio was 11:1, compared with 15:1 for the United States. Forty-five percent of cases occurred in the 30- to 39-year age group.

Cases were geographically distributed as follows (Table 4):

European*: 756 cases (80% of total). Seven hundred twenty-five patients were living in Europe before the onset of the first symptoms, and 31 (4%) were living overseas (Zaire—10; United States—nine; Haiti—two; and one each in Bermuda, Burundi, Congo, Gabon, Ghana, Nicaragua, South Africa, Togo, and Venezuela). The country of residence was not specified for one patient.

Caribbean: 32 cases (3%). Thirty patients were living in Europe before the onset of the first symptoms: 26 Haitians diagnosed in France and one in Belgium; one Dominican and one Jamaican were living in the United Kingdom; one of unspecified origin was living in Switzerland. Two other Haitians diagnosed in France were living in Haiti.

African: 124 cases (13%). These cases were diagnosed in seven European countries and originated from 18 African countries. Sixty-five percent were from Zaire, and 10%, from the Congo. Among the remaining 16 countries, the number of cases varied from one to four. Two

*The word European refers to the patients originating from one of the 32 countries belonging to the WHO European region.

TABLE 1. Reported acquired immunodeficiency syndrome cases and estimated rates per million population—17 European countries

Country	Oct. 1983*	Oct. 1984	Dec. 1984	Mar. 1985	Rates†
Austria	7	-	13	13	1.7
Belgium	38	-	65	81	8.2
Czechoslovakia	0	0	0	0	0.0
Denmark	13	31	34	41	8.0
Finland	-	4	5	5	1.0
France	94	221	260	307	5.6
Federal Republic of Germany	42	110§	135	162	2.6
Greece	-	2§	6	7	0.7
Iceland	0	0	0	0	0.0
Italy	3	10	14	22	0.4
Netherlands	12	26	42	52	3.6
Norway	-	4	5	8	2.0
Poland	0	0	0	0	0.0
Spain	6	18	18	29	0.8
Sweden	4	12	16	22	2.7
Switzerland	17	33	41	51	7.9
United Kingdom	24	88	108	140	2.5
Total	**253**	**559**	**762**	**940**	**2.4**

*These data were reported at the First European Meeting on AIDS held in Aarhus, Demark, October, 1983.

†Based on 1983 populations, INED, Paris.

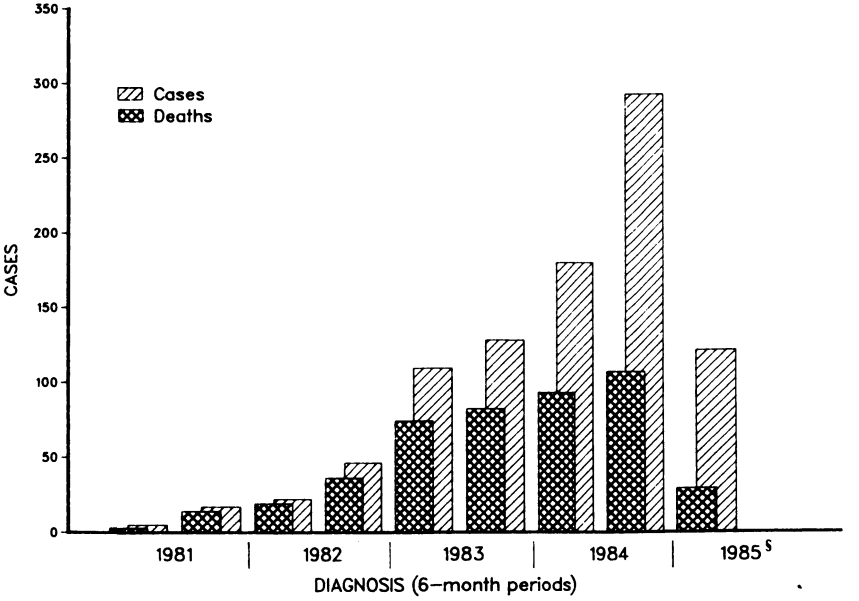
§Data of July 15, 1984.

AIDS — Continued

patients were of unknown origin. Sixty-seven patients (54%) were living in Europe before the onset of the first symptoms. Fifty-five resided in Africa, and one, in the United States; the country of residence was unknown in one case.

Other origins: 28 cases (3%). Most of these patients originated from the American continent: United States—18; Canada—one; two each from Argentina and Brazil; and one each from Nicaragua, Peru, and South America (country unknown). One patient originated from Australia, and, one, from Pakistan. Twelve of these patients were not living in Europe before the onset of the first symptoms (United States—nine; Africa—one; unknown—two).

FIGURE 2. Acquired immunodeficiency syndrome cases and number of deaths, by 6-month period of diagnosis — 17 European countries,* January 1, 1981-March 31, 1985†



*Austria, Belgium, Czechoslovakia, Denmark, Finland, France, Federal Republic of Germany, Greece, Iceland, Italy, Netherlands, Norway, Poland, Spain, Sweden, Switzerland, and United Kingdom.

†Before 1981, 19 cases, including 11 deaths, were reported.

§January-March 1985.

TABLE 2. Acquired immunodeficiency syndrome cases and number of deaths, by disease category — 17 European countries,* through March 31, 1985

Disease category	Cases (%)	Deaths (%)
Opportunistic infection	603 (64.1)	324 (53.7)
Kaposi's sarcoma	188 (20.0)	46 (24.4)
Opportunistic infection and Kaposi's sarcoma	143 (15.2)	93 (65.0)
Other	6 (0.6)	5 (83.3)
Unknown	0 (0.0)	0 (0.0)
Total	**940 (100.0)**	**468 (49.8)**

*Austria, Belgium, Czechoslovakia, Denmark, Finland, France, Federal Republic of Germany, Greece, Iceland, Italy, Netherlands, Norway, Poland, Spain, Sweden, Switzerland, and United Kingdom.

AIDS — Continued

Among the 756 European AIDS patients, 627 (83%) were homosexual or bisexual. Twenty-five patients (3%) were drug abusers, and 10 (1%), both homosexual and drug abusers (Table 4); these 35 cases were diagnosed in: Federal Republic of Germany—11; Spain—10; France and Italy—five each; Austria—two; and Switzerland and United Kingdom—one each.

Twenty-seven (3%) were hemophilia patients diagnosed in: Federal Republic of Germany—11; Spain—six; United Kingdom—four; France—three; and one each in Austria, Greece, and Sweden. One German hemophilia patient was reported as being both homosexual and a drug abuser.

For 11 patients (1%), the only risk factor found was blood transfusion. These cases were diagnosed in: France—seven; Belgium—two; and Netherlands and United Kingdom—one each. Four of these 11 patients had received blood transfusions overseas: one diagnosed in the Netherlands had undergone surgery in the United States; one diagnosed in France had re-

TABLE 3. Acquired immunodeficiency syndrome cases, by age group and sex — 17 European countries, through March 31, 1985

Age group	Males	Females	Sex ratio	Total No. (%)
0-11 mos.	5	5	1:1	10 (1.1)
1-4 yrs.	0	0		
5-9 yrs.	2	0		2 (0.2)
10-14 yrs.	2	0		2 (0.2)
15-19 yrs.	4	0		4 (0.4)
20-29 yrs.	142	37	4:1	179 (19.0)
30-39 yrs.	399	22	18:1	421 (44.8)
40-49 yrs.	226	9	25:1	235 (25.0)
50-59 yrs.	57	5	11:1	62 (6.6)
≥ 60 yrs.	14	1	14:1	15 (1.6)
Unknown	10	0		10 (1.1)
Total	**861**	**79**	**11:1**	**940 (100.0)**

TABLE 4. Acquired immunodeficiency syndrome cases, by patient risk group and geographic origin — 17 European countries, through March 31, 1985

Patient risk groups	Nationality				Total
	European	Caribbean	African	Other	
1. Male homosexual or bisexual	627	4	9	21	**661**
2. Intravenous drug abuser	25	-	-	-	**25**
3. Hemophilia patient	27	-	-	1	**28**
4. Transfusion recipient (without other risk factors)	11	-	5	-	**16**
5. 1- and 2-associated	10	-	-	2	**12**
6. No known risk factor					
male	33	20	67	2	**122**
female	18	7	32	-	**57**
7. Unknown	5	1	11	2	**19**
Total	**756**	**32**	**124**	**28**	**940**

AIDS — Continued

ceived blood transfusions in Haiti and Martinique; and two diagnosed in Belgium had received transfusions in Zaire.

For 51 patients (5%), no risk factor was found, and the information was not obtained in five cases.

The AIDS epidemic continues to spread in Europe. The distribution of patients by age, sex, and geographic origin is the same as in the previous reports. Homosexuals are still the major risk group, but cases among intravenous drug abusers have now been reported in seven countries.

AIDS cases related to the use of clotting factor or to blood transfusions are also increasing. Cases among hemophilia patients have been reported in seven European countries. In some of these countries, hemophilia patients account for a high percentage of the total number of AIDS cases reported at a national level: Spain—21% (six of 29 cases); Greece—14% (1/7); Austria—8% (1/13); Federal Republic of Germany—7% (11/162); Sweden—5% (1/22); United Kingdom—3% (4/140); and France—1% (3/307). Among the hemophiliac population of these countries, AIDS cases vary from one to three per thousand. All seven countries have imported blood products from the United States in the past few years.

Two countries have reported cases among recipients of blood collected through the respective national blood banks (France—seven; United Kingdom—one). This indicates that, in European countries in which an AIDS focus is developing, the use of local blood products is not sufficient to ensure the safety of transfusions. Other measures recognized by the WHO Collaborating Centre on AIDS that can be taken to improve safety are: (1) preferential use, when possible, of cryoprecipitates rather than concentrates of factor VIII; (2) use of heat-treated products; (3) selection of blood donors according to identified risk groups; and (4) screening anti-lymphadenopathy-associated virus/human T-lymphotropic virus type III (LAV/HTLV-III)-carrier blood donors.

Finally, it is important to note that AIDS cases related to transfusion of blood or blood components are mainly the consequence of the dissemination of the AIDS virus in the general population. The transmission of LAV/HTLV-III by sexual contact is, at present, the principal route of dissemination. Health education programs (information on subjects in exposed populations, training health-care workers with respect to problems created by AIDS) are essential to set up public health strategies. These strategies must be selected by each country depending on the respective epidemiologic characteristics, sociocultural conditions and the available resources.

Editorial Note: As of March 31, 1985, 17 countries were participating in the surveillance of AIDS in Europe by reporting their respective data to the Centre, which uses the CDC case definition. One source per country, recognized by the respective national health authorities, provides the information. The national data are noted on standard tables; therefore, each source is responsible for the quality of the data provided.

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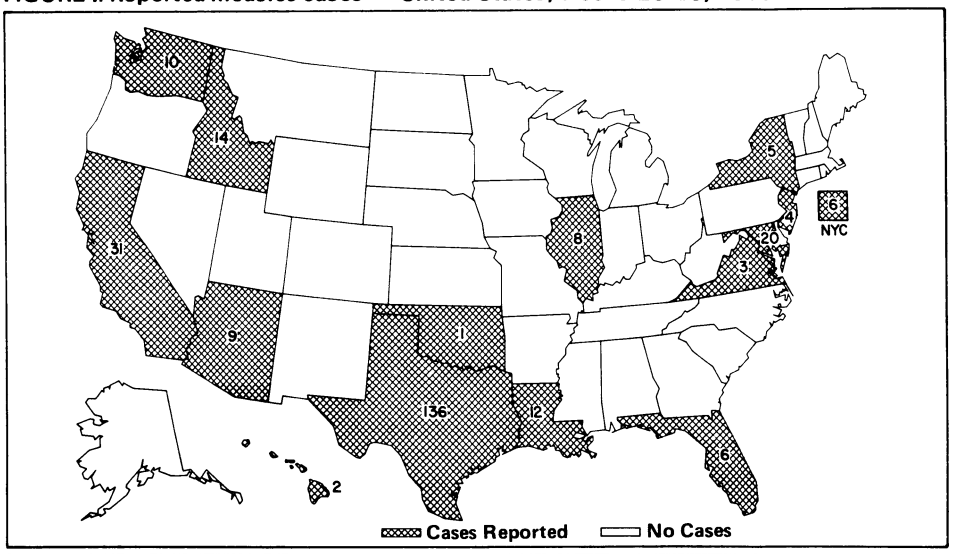
Reference

1. WHO. Acquired immune deficiency syndrome (AIDS). Report on the situation in Europe as of 31 December 1984. Weekly Epidemiological Record 1985;60:85-92.

FIGURE I. Reported measles cases — United States, weeks 26-29, 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.

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