CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

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

Current Trends

Education and Foster Care of Children Infected with Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus

The information and recommendations contained in this document were developed and compiled by CDC in consultation with individuals appointed by their organizations to represent the Conference of State and Territorial Epidemiologists, the Association of State and Territorial Health Officers, the National Association of County Health Officers, the Division of Maternal and Child Health (Health Resources and Services Administration), the National Association for Elementary School Principals, the National Association of State School Nurse Consultants, the National Congress of Parents and Teachers, and the Children's Aid Society. The consultants also included the mother of a child with acquired immunodeficiency syndrome (AIDS), a legal advisor to a state education department, and several pediatricians who are experts in the field of pediatric AIDS. This document is made available to assist state and local health and education departments in developing guidelines for their particular situations and locations.

These recommendations apply to all children known to be infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV). This includes children with AIDS as defined for reporting purposes (Table 1); children who are diagnosed by their physicians as having an illness due to infection with HTLV-III/LAV but who do not meet the case definition; and children who are asymptomatic but have virologic or serologic evidence of infection with HTLV-III/LAV. These recommendations do not apply to siblings of infected children unless they are also infected.

BACKGROUND

The Scope of the Problem. As of August 20, 1985, 183 of the 12,599 reported cases of AIDS in the United States were among children under 18 years of age. This number is expected to double in the next year. Children with AIDS have been reported from 23 states, the District of Columbia, and Puerto Rico, with 75% residing in New York, California, Florida, and New Jersey.

The 183 AIDS patients reported to CDC represent only the most severe form of HTLV-III/LAV infection, i.e., those children who develop opportunistic infections or malignancies (Table 1). As in adults with HTLV-III/LAV infection, many infected children may have milder illness or may be asymptomatic.

Legal Issues. Among the legal issues to be considered in forming guidelines for the education and foster care of HTLV-III/LAV-infected children are the civil rights aspects of public

HTLV-III/LAV — Continued

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

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

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

The diseases accepted as sufficiently indicative of underlying cellular immunodeficiency are the same as those used in defining AIDS in adults. In the absence of these opportunistic diseases, a histologically confirmed diagnosis of chronic lymphoid interstitial pneumonitis will be considered indicative of AIDS unless test(s) for HTLV-III/LAV are negative. Congenital infections, e.g., toxoplasmosis or herpes simplex virus infection in the first month after birth or cytomegalovirus infection in the first 6 months after birth must be exluded.

Specific conditions that must be excluded in a child are:

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

school attendance, the protections for handicapped children under 20 U.S.C. 1401 et seq. and 29 U.S.C. 794, the confidentiality of a student's school record under state laws and under 20 U.S.C. 1232g, and employee right-to-know statutes for public employees in some states.

Confidentiality Issues. The diagnosis of AIDS or associated illnesses evokes much fear from others in contact with the patient and may evoke suspicion of life styles that may not be acceptable to some persons. Parents of HTLV-III/LAV-infected children should be aware of the potential for social isolation should the child's condition become known to others in the care or educational setting. School, day-care, and social service personnel and others involved in educating and caring for these children should be sensitive to the need for confidentiality and the right to privacy in these cases.

ASSESSMENT OF RISKS

Risk Factors for Acquiring HTLV-III/LAV Infection and Transmission. In adults and adolescents, HLTV-III/LAV is transmitted primarily through sexual contact (homosexual or heterosexual) and through parenteral exposure to infected blood or blood products. HTLV-III/LAV has been isolated from blood, semen, saliva, and tears but transmission has not been documented from saliva and tears. Adults at increased risk for acquiring HTLV-III/LAV include homosexual/bisexual men, intravenous drug abusers, persons transfused with contaminated blood or blood products, and sexual contacts of persons with HTLV-III/LAV infection or in groups at increased risk for infection.

The majority of infected children acquire the virus from their infected mothers in the perinatal period (*1-4*). In utero or intrapartum transmission are likely, and one child reported from Australia apparently acquired the virus postnatally, possibly from ingestion of breast milk (*5*). Children may also become infected through transfusion of blood or blood products that contain the virus. Seventy percent of the pediatric cases reported to CDC occurred among children whose parent had AIDS or was a member of a group at increased risk of acquiring HTLV-III/LAV infection; 20% of the cases occurred among children who had received blood or blood products; and for 10%, investigations are incomplete.

HTLV-III/LAV — Continued

Risk of Transmission in the School, Day-Care or Foster-Care Setting. None of the identified cases of HTLV-III/LAV infection in the United States are known to have been transmitted in the school, day-care, or foster-care setting or through other casual person-to-person contact. Other than the sexual partners of HTLV-III/LAV-infected patients and infants born to infected mothers, none of the family members of the over 12,000 AIDS patients reported to CDC have been reported to have AIDS. Six studies of family members of patients with HTLV-III/LAV infection have failed to demonstrate HTLV-III/LAV transmission to adults who were not sexual contacts of the infected patients or to older children who were not likely at risk from perinatal transmission (*6-11*).

Based on current evidence, casual person-to-person contact as would occur among schoolchildren appears to pose no risk. However, studies of the risk of transmission through contact between younger children and neurologically handicapped children who lack control of their body secretions are very limited. Based on experience with other communicable diseases, a theoretical potential for transmission would be greatest among these children. It should be emphasized that any theoretical transmission would most likely involve exposure of open skin lesions or mucous membranes to blood and possibly other body fluids of an infected person.

Risks to the Child with HTLV-III/LAV Infection. HTLV-III/LAV infection may result in immunodeficiency. Such children may have a greater risk of encountering infectious agents in a school or day-care setting than at home. Foster homes with multiple children may also increase the risk. In addition, younger children and neurologically handicapped children who may display behaviors such as mouthing of toys would be expected to be at greater risk for acquiring infections. Immunodepressed children are also at greater risk of suffering severe complications from such infections as chickenpox, cytomegalovirus, tuberculosis, herpes simplex, and measles. Assessment of the risk to the immunodepressed child is best made by the child's physician who is aware of the child's immune status. The risk of acquiring some infections, such as chickenpox, may be reduced by prompt use of specific immune globulin following a known exposure.

RECOMMENDATIONS

1. Decisions regarding the type of educational and care setting for HTLV-III/LAV-infected children should be based on the behavior, neurologic development, and physical condition of the child and the expected type of interaction with others in that setting. These decisions are best made using the team approach including the child's physician, public health personnel, the child's parent or guardian, and personnel associated with the proposed care or educational setting. In each case, risks and benefits to both the infected child and to others in the setting should be weighed.
2. For most infected school-aged children, the benefits of an unrestricted setting would outweigh the risks of their acquiring potentially harmful infections in the setting and the apparent nonexistent risk of transmission of HTLV-III/LAV. These children should be allowed to attend school and after-school day-care and to be placed in a foster home in an unrestricted setting.
3. For the infected preschool-aged child and for some neurologically handicapped children who lack control of their body secretions or who display behavior, such as biting, and those children who have uncoverable, oozing lesions, a more restricted environment is advisable until more is known about transmission in these settings. Children infected with HTLV-III/LAV should be cared for and educated in settings that minimize exposure of other children to blood or body fluids.

HTLV-III/LAV — Continued

4. Care involving exposure to the infected child's body fluids and excrement, such as feeding and diaper changing, should be performed by persons who are aware of the child's HTLV-III/LAV infection and the modes of possible transmission. In any setting involving an HTLV-III/LAV-infected person, good handwashing after exposure to blood and body fluids and before caring for another child should be observed, and gloves should be worn if open lesions are present on the caretaker's hands. Any open lesions on the infected person should also be covered.
5. Because other infections in addition to HTLV-III/LAV can be present in blood or body fluids, all schools and day-care facilities, regardless of whether children with HTLV-III/LAV infection are attending, should adopt routine procedures for handling blood or body fluids. Soiled surfaces should be promptly cleaned with disinfectants, such as household bleach (diluted 1 part bleach to 10 parts water). Disposable towels or tissues should be used whenever possible, and mops should be rinsed in the disinfectant. Those who are cleaning should avoid exposure of open skin lesions or mucous membranes to the blood or body fluids.
6. The hygienic practices of children with HTLV-III/LAV infection may improve as the child matures. Alternatively, the hygienic practices may deteriorate if the child's condition worsens. Evaluation to assess the need for a restricted environment should be performed regularly.
7. Physicians caring for children born to mothers with AIDS or at increased risk of acquiring HTLV-III/LAV infection should consider testing the children for evidence of HTLV-III/LAV infection for medical reasons. For example, vaccination of infected children with live virus vaccines, such as the measles-mumps-rubella vaccine (MMR), may be hazardous. These children also need to be followed closely for problems with growth and development and given prompt and aggressive therapy for infections and exposure to potentially lethal infections, such as varicella. In the event that an antiviral agent or other therapy for HTLV-III/LAV infection becomes available, these children should be considered for such therapy. Knowledge that a child is infected will allow parents and other caretakers to take precautions when exposed to the blood and body fluids of the child.
8. Adoption and foster-care agencies should consider adding HTLV-III/LAV screening to their routine medical evaluations of children at increased risk of infection before placement in the foster or adoptive home, since these parents must make decisions regarding the medical care of the child and must consider the possible social and psychological effects on their families.
9. Mandatory screening as a condition for school entry is not warranted based on available data.
10. Persons involved in the care and education of HTLV-III/LAV-infected children should respect the child's right to privacy, including maintaining confidential records. The number of personnel who are aware of the child's condition should be kept at a minimum needed to assure proper care of the child and to detect situations where the potential for transmission may increase (e.g., bleeding injury).
11. All educational and public health departments, regardless of whether HTLV-III/LAV-infected children are involved, are strongly encouraged to inform parents, children, and educators regarding HTLV-III/LAV and its transmission. Such education would greatly assist efforts to provide the best care and education for infected children while minimizing the risk of transmission to others.

HTLV-III/LAV — Continued

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Perspectives in Disease Prevention and Health Promotion

Status of the 1990 Physical Fitness and Exercise Objectives

Eleven of the U.S. Public Health Service's 1990 Objectives for the Nation concern physical fitness and exercise (*1*). When the objectives were developed in 1980, less baseline information was available for physical fitness and exercise than for most other areas. During the ensuing 5 years, considerable progress has been made toward clarifying the relationship between physical activity and health and in collecting previously unavailable information about the activity levels of children and adults. Several of the objectives are likely to be achieved by 1990 (Table 2). Nevertheless, much remains to be learned and most segments of society would benefit from increased levels of physical activity. The following is a brief summary of the current status of the 1990 objectives on physical fitness and exercise.

HEALTH EFFECTS

The established beneficial effects of physical activity on health include reduced risk of coronary heart disease (CHD), desirable weight control, and reduced symptoms of anxiety and mild to moderate depression (*2-4*). Beneficial effects on the prevention and control of hypertension, diabetes, osteoporosis, and certain psychiatric and psychologic conditions appear likely but are less firmly established (*2,4*). The temporarily increased risk of sudden death during vigorous physical activity is outweighed by the overall reduced risk of CHD from habitual vigorous activity (*2*). Information about the incidence of musculoskeletal injuries and other possible adverse effects is not available (*5*).

Physical Fitness — Continued

TABLE 2. Current status and projected likelihood of achieving the 1990 physical fitness and exercise objectives

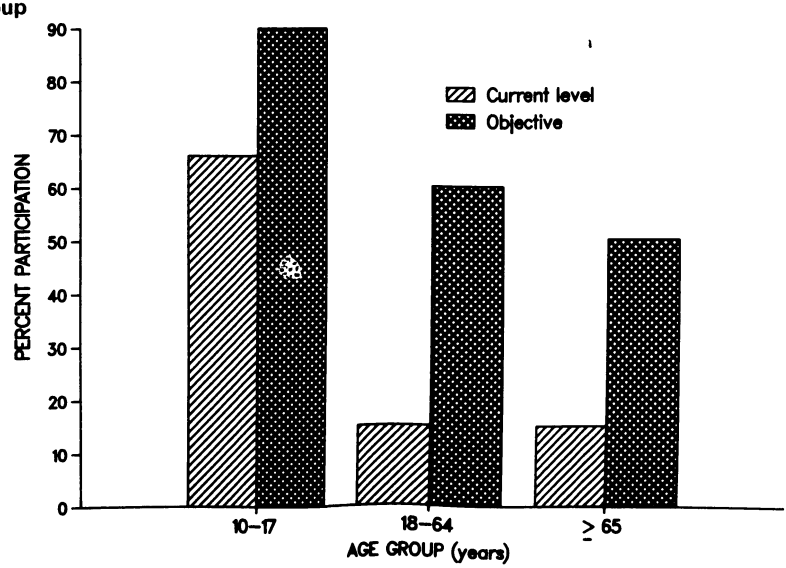
General category	Objective	Best estimate of current status	Likelihood of achievement by 1990
Health effects:	By 1990, data should be available with which to evaluate the short- and long-term health effects of participation in programs of appropriate physical activity.	Data vary with specific health effect.	Not a quantifiable objective; progress will be made; questions will remain.
Prevalence of appropriate physical activity practices:	By 1990, the proportion of children and adolescents 10-17 years old participating regularly in appropriate physical activities, particularly cardiorespiratory fitness programs, that can be carried into adulthood, should be greater than 90%.	66% (no trend data)	Poor
	By 1990, the proportion of adults 18-65 years old participating regularly in vigorous physical exercise should be greater than 60%.	10%-20% (no trend data)	Poor
	By 1990, 50% of adults 65 years old and older should be engaging in appropriate physical activity, e.g., regular walking, swimming, or other aerobic activity.	10-20% (no trend data)	Poor
	By 1990, data should be available for (1) regular monitoring of national trends and patterns of participation in physical activity; (2) these should include participation in public recreation programs in community facilities.	(1) Baseline data are available (2) Data not available	(1) Good (2) Unknown
Public and professional awareness:	By 1990, the proportion of adults who can accurately identify the variety and duration of exercise thought to promote most effectively cardiovascular fitness should be greater than 70%.	70% duration and frequency (local surveys) 50% intensity (local and national surveys)	Good
	By 1990, the proportion of primary-care physicians who include a careful exercise history as part of their initial examination of new patients should be greater than 50%.	47% (two state surveys)	Good

Physical Fitness — Continued

TABLE 2. Current status and projected likelihood of achieving the 1990 physical fitness and exercise objectives (Continued)

General category	Objective	Best estimate of current status	Likelihood of achievement by 1990
Worksite fitness programs:	By 1990, the proportion of employees of companies and institutions with more than 500 employees offering employer-sponsored fitness programs should be greater than 25%.	Data not available	Unknown
	By 1990, data should be available to evaluate the effects of participation in programs of physical fitness on job performance and health-care costs.	Data not available	Unknown
Children and adolescents:	By 1990, the proportion of children and adolescents 10-17 years old participating in daily school physical education programs should be greater than 60%.	36% (stable over 10 years)	Poor
	By 1990, (1) a methodology for systematically assessing the physical fitness of children should be established; (2) at least 70% of children and adolescents 10-17 years old should be participating in such an assessment.	(1) Three methods available (2) Data not available	(1) Achieved (2) Unknown

FIGURE 1. Current prevalence and 1990 objective of appropriate physical activity, by age group



Physical Fitness — Continued

PREVALENCE OF APPROPRIATE PHYSICAL ACTIVITY PRACTICES

Three of the objectives on physical fitness and exercise pertain to the prevalence of participation in appropriate physical activities of specific age groups. For the 1990 objectives, appropriate physical activity is defined as that which produces moderate to high levels of cardiorespiratory fitness and, therefore, has the following four characteristics: (1) rhythmic contraction of large muscle groups; (2) intensity that requires 60% or more of maximal aerobic capacity; (3) frequency of three or more sessions per week; and (4) duration of 20 minutes or more per session. For children, appropriate activity is also required to be able to be continued into adulthood (e.g., requires only one or two persons to do the activity).

Few of the surveys of the activity patterns of persons in the United States have obtained information compatible with this definition. None of the definitions of physical activity used in past surveys are similar enough to each other to allow comparison of results (*6*). National polls and data from selected population groups suggest the amount of time spent by adults in vigorous leisure-time activity has increased in the past 10-20 years (*6, 7*), but the data do not allow a quantitative estimate of the increase.

(Continued on page 529)

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

Disease	34th Week Ending			Cumulative, 34th Week Ending		
	Aug. 24, 1985	Aug. 25, 1984	Median 1980-1984	Aug. 24, 1985	Aug. 25, 1984	Median 1980-1984
Acquired Immunodeficiency Syndrome (AIDS)	135	82	N	4,975	2,604	N
Aseptic meningitis	355	306	361	4,390	4,076	4,596
Encephalitis: Primary (arthropod-borne & unspec.)	29	33	43	626	643	748
Post-infectious	2	1	1	85	84	65
Gonorrhea: Civilian	16,964	19,290	19,290	539,642	533,798	618,549
Military	424	431	431	11,879	14,032	17,582
Hepatitis: Type A	422	396	429	14,029	13,466	14,488
Type B	490	477	440	16,494	16,392	13,879
Non A, Non B	82	75	N	2,655	2,481	N
Unspecified	108	106	149	3,704	3,184	5,586
Legionellosis	11	9	N	379	368	N
Leprosy	7	-	2	246	146	146
Malaria	19	19	21	642	592	701
Measles: Total*	30	18	17	2,310	2,215	2,215
Indigenous	27	14	N	1,889	1,961	N
Imported	3	4	N	421	254	N
Meningococcal infections: Total	34	25	30	1,665	1,964	1,964
Civilian	34	25	30	1,662	1,960	1,960
Military	-	-	-	3	4	12
Mumps	21	28	28	2,108	2,145	3,134
Pertussis	139	35	50	1,432	1,342	1,024
Rubella (German measles)	12	6	11	488	500	1,705
Syphilis (Primary & Secondary): Civilian	490	562	603	16,473	18,088	19,654
Military	1	5	6	100	221	240
Toxic Shock syndrome	6	3	N	249	324	N
Tuberculosis	419	385	528	13,724	13,675	16,430
Tularemia	5	7	7	101	213	156
Typhoid fever	6	6	13	217	212	257
Typhus fever, tick-borne (RMSF)	21	25	38	445	595	846
Rabies, animal	108	118	149	3,384	3,454	4,206

TABLE II. Notifiable diseases of low frequency, United States

	Cum. 1985		Cum. 1985
Anthrax	-	Leptospirosis	20
Botulism: Foodborne	33	Plague	10
Infant	32	Poliomyelitis: Total	3
Other	1	Paralytic	3
Brucellosis (Tex. 3, Calif. 2)	84	Psittacosis (Colo. 3)	77
Cholera	3	Rabies, human	-
Congenital rubella syndrome	-	Tetanus (Ohio 1)	40
Congenital syphilis, ages < 1 year	111	Trichinosis	48
Diphtheria	1	Typhus fever, flea-borne (endemic, murine) (Tex. 1)	12

*Two of the 30 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 August 24, 1985 and August 25, 1984 (34th 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	4,975	355	626	85	539,642	533,798	422	490	82	108	11	246
NEW ENGLAND	181	23	17	-	15,042	14,815	6	25	3	21	-	5
Maine	7	-	-	-	727	622	-	-	-	-	-	-
N.H.	-	3	4	-	376	442	1	1	1	-	-	-
Vt.	1	-	-	-	205	238	-	-	-	-	-	-
Mass.	108	11	12	-	5,749	6,099	1	16	1	21	-	5
R.I.	9	4	-	-	1,193	1,019	-	-	-	-	-	-
Conn.	56	5	1	-	6,792	6,395	4	8	1	-	-	-
MID ATLANTIC	2,018	81	92	6	82,762	72,699	9	41	3	1	-	22
Upstate N.Y.	240	19	30	4	11,054	10,868	4	22	2	-	-	1
N.Y. City	1,373	8	11	-	41,576	30,375	2	-	-	1	-	21
N.J.	287	54	23	-	12,467	12,177	3	19	1	-	-	-
Pa.	118	-	28	2	17,665	19,279	-	-	-	-	-	-
E.N. CENTRAL	215	52	145	18	76,449	74,101	15	38	2	6	3	21
Ohio	40	15	56	4	19,586	19,463	11	10	1	-	1	3
Ind.	13	16	26	2	7,704	8,213	-	4	-	1	-	-
Ill.	109	1	14	7	20,385	16,723	1	10	-	2	-	16
Mich.	37	20	34	-	21,425	21,422	3	13	1	3	2	2
Wis.	16	-	15	5	7,349	8,280	-	1	-	-	-	-
W.N. CENTRAL	57	12	42	3	26,432	25,918	17	22	5	5	1	-
Minn.	16	1	20	1	3,867	3,865	-	6	3	-	-	-
Iowa	8	2	12	-	2,855	2,823	1	1	-	1	1	-
Mo.	24	4	-	-	12,753	12,574	1	8	-	3	-	-
N. Dak.	-	-	-	1	177	250	-	-	-	-	-	-
S. Dak.	-	1	-	-	491	615	3	-	-	-	-	-
Nebr.	3	-	5	-	2,256	1,803	10	4	-	1	-	-
Kans.	6	4	5	1	4,033	3,988	2	3	2	-	-	-
S. ATLANTIC	742	54	75	30	116,608	135,721	44	91	15	5	4	5
Del.	9	4	4	-	2,691	2,460	-	-	-	-	3	-
Md.	97	14	16	1	19,010	15,570	-	17	2	2	-	1
D.C.	95	-	-	-	9,867	9,731	1	1	-	-	-	-
Va.	52	4	17	4	12,201	12,826	2	4	1	1	-	-
W. Va.	5	3	16	-	1,644	1,650	3	-	1	-	-	-
N.C.	35	7	19	-	22,046	21,766	4	12	3	-	-	2
S.C.	6	2	3	-	14,025	13,782	-	8	-	-	-	-
Ga.	121	8	-	-	-	24,930	3	13	-	-	-	1
Fla.	322	12	-	25	35,124	33,006	31	36	8	2	1	1
E.S. CENTRAL	44	49	23	4	48,286	46,458	5	29	2	-	-	-
Ky.	12	15	8	-	5,446	5,611	4	14	1	-	-	-
Tenn.	14	2	4	-	18,471	19,454	-	5	1	-	-	-
Ala.	16	32	9	4	14,761	14,622	1	6	-	-	-	-
Miss.	2	-	2	-	9,608	6,771	-	4	-	-	-	-
W.S. CENTRAL	356	43	84	2	72,510	73,407	50	36	10	17	1	17
Ark.	5	-	3	1	7,025	6,741	-	-	-	-	-	1
La.	62	1	3	-	14,903	16,329	-	6	-	-	-	1
Okla.	8	2	19	1	7,725	7,899	7	2	-	1	-	-
Tex.	281	40	59	-	42,857	42,438	43	28	10	16	1	15
MOUNTAIN	73	10	26	5	17,732	17,157	70	57	16	11	1	5
Mont.	-	-	-	-	496	735	3	2	-	1	-	-
Idaho	-	-	-	-	541	858	2	-	-	-	-	-
Wyo.	-	1	1	-	418	485	-	-	-	-	-	-
Colo.	25	3	6	1	5,230	4,952	9	7	1	5	-	1
N. Mex.	7	-	3	-	2,035	1,979	3	7	-	1	-	-
Ariz.	26	2	5	-	5,205	4,584	45	36	14	4	1	1
Utah	12	4	8	4	762	842	2	2	-	-	-	2
Nev.	3	-	3	-	3,045	2,722	6	3	1	-	-	1
PACIFIC	1,289	31	122	17	83,821	73,522	206	151	26	42	1	171
Wash.	78	-	13	-	5,922	5,534	3	4	-	-	-	33
Oreg.	16	-	1	-	4,144	4,206	57	15	4	-	-	3
Calif.	1,175	29	105	17	70,673	60,719	145	124	22	42	1	116
Alaska	2	-	3	-	1,894	1,832	-	2	-	-	-	-
Hawaii	18	2	-	-	1,188	1,231	1	6	-	-	-	19
Guam	-	U	-	-	81	162	U	U	U	U	U	1
P.R.	53	5	4	2	2,262	2,253	3	3	-	3	-	2
V.I.	2	U	-	-	312	366	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 August 24, 1985 and August 25, 1984 (34th 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	642	27	1,889	3	421	2,215	1,665	21	2,108	139	1,432	1,342	12	488	500
NEW ENGLAND	35	-	36	-	87	104	73	-	42	5	80	36	-	12	18
Maine	4	-	-	-	1	-	2	-	6	-	2	1	-	-	1
N.H.	4	-	-	-	-	36	11	-	7	2	31	6	-	2	1
Vt.	1	-	-	-	-	7	9	-	2	-	3	17	-	-	-
Mass.	18	-	32	-	83	48	12	-	14	3	25	10	-	6	16
R.I.	2	-	-	-	-	-	13	-	8	-	12	1	-	-	-
Conn.	6	-	4	-	3	13	26	-	5	-	7	1	-	4	-
MID ATLANTIC	100	1	167	-	28	142	290	1	220	9	89	110	1	205	175
Upstate N.Y.	31	-	71	-	10	31	113	-	125	3	46	62	-	17	98
N.Y. City	36	-	52	-	8	100	49	-	14	-	9	5	1	166	59
N.J.	13	-	16	-	10	7	44	-	28	-	3	7	-	9	17
Pa.	20	1	28	-	-	4	84	1	53	6	31	36	-	13	1
E.N. CENTRAL	30	2	356	-	134	665	287	3	796	64	239	360	-	21	79
Ohio	6	-	-	-	49	9	95	-	237	-	32	57	-	-	2
Ind.	3	-	49	-	2	3	38	-	36	59	70	220	-	1	2
Ill.	5	2	214	-	66	162	64	-	164	3	20	23	-	5	48
Mich.	12	-	37	-	17	455	62	3	286	1	30	21	-	14	19
Wis.	4	-	56	-	-	36	28	-	73	1	87	39	-	1	8
W.N. CENTRAL	23	-	1	-	10	10	85	1	64	-	96	105	-	19	31
Minn.	10	-	-	-	6	3	22	-	1	-	31	12	-	2	2
Iowa	1	-	-	-	-	-	7	1	10	-	5	9	-	1	1
Mo.	4	-	-	-	2	3	34	-	11	-	23	16	-	7	-
N. Dak.	1	-	-	-	2	-	3	-	2	-	9	-	-	2	3
S. Dak.	1	-	-	-	-	-	2	-	-	-	1	7	-	-	-
Nebr.	1	-	-	-	-	-	7	-	2	-	4	11	-	-	-
Kans.	5	-	1	-	-	4	10	-	38	-	23	50	-	7	25
S. ATLANTIC	83	3	256	2	13	47	323	1	198	3	276	156	1	54	22
Del.	-	-	-	-	-	-	8	-	1	-	-	2	-	1	-
Md.	20	-	84	-	4	20	43	-	27	-	123	48	-	6	1
D.C.	4	-	5	-	1	8	6	-	-	-	1	-	-	-	-
Va.	18	-	21	1†	4	5	40	1	37	-	8	17	-	2	-
W. Va.	2	-	33	-	-	-	8	-	56	-	2	10	-	9	-
N.C.	8	-	9	-	-	-	43	-	11	2	17	21	-	-	-
S.C.	-	-	-	-	1	1	32	-	7	-	1	2	-	3	-
Ga.	6	-	8	-	-	-	53	-	28	1	77	14	-	4	2
Fla.	25	3	96	1†	3	13	90	-	31	-	47	42	1	29	19
E.S. CENTRAL	8	-	-	-	3	3	77	-	23	1	18	11	-	2	9
Ky.	2	-	-	-	2	1	6	-	8	-	3	1	-	2	3
Tenn.	-	-	-	-	-	2	31	-	13	1	6	6	-	-	-
Ala.	5	-	-	-	-	-	24	-	-	-	6	-	-	-	3
Miss.	1	-	-	-	1	-	16	-	2	-	3	4	-	-	3
W.S. CENTRAL	58	4	410	-	13	508	143	1	225	38	234	247	3	32	6
Ark.	-	-	-	-	-	8	13	-	4	-	12	15	-	1	3
La.	1	-	42	-	-	-	22	-	2	-	10	4	-	-	-
Okla.	2	-	-	-	1	8	27	N	N	1	105	213	-	1	-
Tex.	55	4	368	-	12	492	81	1	219	37	107	15	3	30	3
MOUNTAIN	33	5	487	-	49	144	70	1	202	9	110	92	-	5	17
Mont.	-	-	122	-	17	-	5	1	8	2	7	19	-	-	-
Idaho	1	-	126	-	18	23	2	-	9	-	3	7	-	1	1
Wyo.	1	-	-	-	-	-	6	-	2	-	-	3	-	-	2
Colo.	11	3	6	-	7	6	19	-	16	-	31	32	-	-	2
N. Mex.	10	-	1	-	3	88	8	N	N	-	12	6	-	2	-
Ariz.	5	2	232	-	4	-	18	-	99	3	27	17	-	1	1
Utah	2	-	-	-	-	27	7	-	6	4	30	6	-	-	7
Nev.	3	-	-	-	-	-	5	-	62	-	-	2	-	1	4
PACIFIC	272	12	176	1	84	592	317	13	338	10	290	225	7	138	143
Wash.	18	-	9	-	32	139	55	-	29	2	52	60	-	11	1
Oreg.	12	-	3	-	-	-	29	N	N	-	29	14	-	2	1
Calif.	225	12	150	1§	47	296	222	11	287	6	168	81	7	82	137
Alaska	2	-	-	-	-	-	7	1	7	1	29	1	-	1	1
Hawaii	15	-	14	-	5	157	4	1	15	1	12	69	-	42	3
Guam	1	U	10	U	-	90	-	U	4	U	-	-	U	1	4
P.R.	-	-	50	-	-	4	10	1	124	1	10	-	-	25	7
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 August 24, 1985 and August 25, 1984 (34th 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	16,473	18,088	6	13,724	13,675	101	217	445	3,384
NEW ENGLAND	351	340	-	464	393	3	8	5	17
Maine	9	4	-	34	19	-	-	-	-
N.H.	9	11	-	12	23	-	-	1	1
Vt.	5	1	-	4	7	-	-	-	-
Mass.	175	199	-	277	212	3	7	4	9
R.I.	12	13	-	35	29	-	-	-	-
Conn.	141	112	-	102	103	-	1	-	7
MID ATLANTIC	2,293	2,466	-	2,526	2,514	1	33	15	310
Upstate N.Y.	161	205	-	438	405	-	9	9	77
N.Y. City	1,425	1,516	-	1,225	1,003	1	16	2	-
N.J.	447	438	-	350	557	-	7	2	33
Pa.	260	307	-	513	549	-	1	2	200
E.N. CENTRAL	719	856	-	1,700	1,804	1	24	37	124
Ohio	100	162	-	306	346	-	5	27	23
Ind.	65	88	-	206	199	-	3	2	17
Ill.	362	292	-	742	749	1	9	6	21
Mich.	148	265	-	340	396	-	5	2	19
Wis.	44	49	-	106	114	-	2	-	44
W.N. CENTRAL	153	267	2	372	425	30	10	32	636
Minn.	31	72	2	80	73	1	6	1	127
Iowa	17	11	-	43	45	-	2	-	112
Mo.	76	135	-	176	214	19	1	2	29
N. Dak.	2	9	-	6	10	-	-	1	94
S. Dak.	5	-	-	18	15	6	-	2	211
Nebr.	6	11	-	11	22	2	1	2	28
Kans.	16	29	-	38	46	2	-	24	35
S. ATLANTIC	4,204	5,379	2	2,755	2,828	6	23	212	885
Del.	25	13	-	27	36	1	-	1	-
Md.	285	339	1	258	282	-	8	19	453
D.C.	234	216	-	105	108	-	-	-	-
Va.	195	265	-	245	284	1	3	16	112
W. Va.	15	13	-	74	91	-	-	1	20
N.C.	434	548	1	368	431	4	2	80	5
S.C.	539	498	-	340	342	-	-	65	51
Ga.	-	915	-	454	408	-	2	25	133
Fla.	2,477	2,572	-	884	846	-	8	5	111
E.S. CENTRAL	1,323	1,206	-	1,200	1,273	5	4	44	163
Ky.	42	63	-	270	302	-	1	3	25
Tenn.	398	335	-	359	393	4	1	24	29
Ala.	422	419	-	364	378	1	2	10	105
Miss.	461	389	-	207	200	-	-	7	4
W.S. CENTRAL	3,985	4,415	-	1,676	1,574	36	17	83	596
Ark.	212	143	-	175	171	18	-	12	100
La.	686	780	-	222	207	-	-	1	12
Okla.	116	141	-	176	157	13	-	61	79
Tex.	2,971	3,351	-	1,103	1,039	5	17	9	405
MOUNTAIN	453	399	2	356	355	13	10	14	286
Mont.	3	2	-	46	14	4	-	6	131
Idaho	4	16	1	15	23	-	-	-	8
Wyo.	7	7	-	5	-	-	-	4	16
Colo.	112	102	-	42	39	2	4	2	15
N. Mex.	81	51	-	65	66	2	4	-	6
Ariz.	219	145	1	151	168	3	2	-	103
Utah	6	12	-	10	30	2	-	-	2
Nev.	21	64	-	22	15	-	-	2	5
PACIFIC	2,992	2,760	-	2,675	2,509	6	88	3	367
Wash.	73	106	-	156	123	-	-	-	4
Oreg.	60	76	-	85	104	1	-	-	3
Calif.	2,810	2,523	-	2,241	2,096	3	84	3	357
Alaska	2	3	-	69	45	2	-	-	3
Hawaii	47	52	-	124	141	-	4	-	-
Guam	2	-	U	19	37	-	-	-	-
P.R.	536	537	-	233	254	-	1	-	28
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 August 24, 1985 (34th Week)

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	586	415	114	27	17	13	46
Boston, Mass.	131	81	34	7	6	3	17
Bridgeport, Conn.	42	31	8	3	-	-	2
Cambridge, Mass.	33	28	4	-	-	1	6
Fall River, Mass.	13	8	3	1	-	1	-
Hartford, Conn.	55	40	7	6	1	1	4
Lowell, Mass.	26	18	5	2	1	-	1
Lynn, Mass.	19	16	3	-	-	-	-
New Bedford, Mass.	24	21	2	1	-	-	2
New Haven, Conn.	47	28	10	4	3	2	-
Providence, R.I.	75	56	14	-	2	3	4
Somerville, Mass.	8	8	-	-	-	-	-
Springfield, Mass.	40	24	12	-	2	2	7
Waterbury, Conn.	24	17	5	2	-	-	3
Worcester, Mass.	49	39	7	1	2	-	-
MID ATLANTIC	2,557	1,637	560	248	65	46	107
Albany, N.Y.	42	30	5	3	3	1	1
Allentown, Pa.	16	10	6	-	-	-	-
Buffalo, N.Y.	118	79	21	8	9	1	9
Camden, N.J.	48	33	7	6	2	-	1
Elizabeth, N.J.	24	20	2	2	-	-	-
Erie, Pa.†	31	17	11	2	1	-	-
Jersey City, N.J.	74	44	24	6	-	-	1
N.Y. City, N.Y.	1,349	854	287	155	24	29	47
Newark, N.J.	60	32	12	9	4	3	2
Paterson, N.J.	36	22	9	2	-	3	4
Philadelphia, Pa.	301	186	72	28	10	5	18
Pittsburgh, Pa.†	68	47	17	2	1	1	4
Reading, Pa.	33	22	8	1	2	-	4
Rochester, N.Y.	114	74	29	7	2	1	8
Schenectady, N.Y.	37	26	9	2	-	-	2
Scranton, Pa.†	31	23	5	1	2	-	3
Syracuse, N.Y.	90	61	18	6	3	2	-
Trenton, N.J.	37	25	8	3	1	-	-
Utica, N.Y.	24	17	5	2	-	-	-
Yonkers, N.Y.	24	15	5	3	1	-	3
E.N. CENTRAL	2,108	1,462	377	123	60	85	79
Akron, Ohio	61	35	20	4	-	2	-
Canton, Ohio	32	19	11	-	1	1	2
Chicago, Ill.§	553	462	11	26	16	37	16
Cincinnati, Ohio	125	85	27	6	3	4	8
Cleveland, Ohio	118	71	26	9	8	4	2
Columbus, Ohio	87	57	20	5	2	3	6
Dayton, Ohio	117	81	26	6	2	2	3
Detroit, Mich.	249	134	68	28	13	6	6
Evansville, Ind.	45	33	8	2	2	-	-
Fort Wayne, Ind.	42	26	13	1	2	-	1
Gary, Ind.	15	6	5	3	1	-	-
Grand Rapids, Mich.	64	47	12	1	2	2	7
Indianapolis, Ind.	169	98	43	13	6	9	3
Madison, Wis.	29	18	8	1	-	2	5
Milwaukee, Wis.	143	100	27	7	-	9	8
Peoria, Ill.	41	27	8	3	1	2	4
Rockford, Ill.	27	21	3	3	-	-	2
South Bend, Ind.	39	34	3	1	-	1	2
Toledo, Ohio	104	78	21	3	1	1	4
Youngstown, Ohio	48	30	17	1	-	-	-
W.N. CENTRAL	661	453	128	35	24	21	27
Des Moines, Iowa	65	53	7	2	-	3	2
Duluth, Minn.	25	20	3	-	1	1	-
Kansas City, Kans.	32	19	8	2	2	1	4
Kansas City, Mo.	135	89	32	8	4	2	5
Lincoln, Nebr.	29	23	4	-	2	-	2
Minneapolis, Minn.	73	45	14	6	6	2	2
Omaha, Nebr.	79	53	13	5	3	5	4
St. Louis, Mo.	123	77	27	9	5	5	4
St. Paul, Minn.	44	33	9	2	-	-	1
Wichita, Kans.	56	41	11	1	1	2	3

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
S. ATLANTIC	1,199	722	292	95	42	47	46
Atlanta, Ga.	133	81	30	16	5	1	8
Baltimore, Md.	192	119	53	10	2	8	6
Charlotte, N.C.	64	35	12	8	5	4	4
Jacksonville, Fla.	96	70	16	4	2	4	4
Miami, Fla.	113	60	29	12	10	2	-
Norfolk, Va.	45	35	6	2	-	2	2
Richmond, Va.	85	48	27	5	2	3	6
Savannah, Ga.	44	27	15	-	2	-	4
St. Petersburg, Fla.	102	73	22	3	2	2	8
Tampa, Fla.	68	35	16	8	2	6	2
Washington, D.C.	247	132	63	27	10	15	2
Wilmington, Del.	10	7	3	-	-	-	-
E.S. CENTRAL	789	498	190	56	26	18	23
Birmingham, Ala.	122	74	29	12	3	4	3
Chattanooga, Tenn.	53	38	11	2	1	1	2
Knoxville, Tenn.	57	33	13	8	3	-	4
Louisville, Ky.	155	105	40	5	1	4	4
Memphis, Tenn.	207	135	41	19	10	1	8
Mobile, Ala.	50	29	14	-	5	2	-
Montgomery, Ala.	40	24	11	3	2	-	1
Nashville, Tenn.	105	60	31	7	1	6	1
W.S. CENTRAL	1,240	812	218	102	62	46	45
Austin, Tex.	52	34	8	5	4	1	7
Baton Rouge, La.	25	16	7	-	1	1	2
Corpus Christi, Tex.	45	25	10	3	3	4	-
Dallas, Tex.	172	90	48	23	7	4	3
El Paso, Tex.	73	43	12	10	5	3	-
Fort Worth, Tex.	83	47	14	10	4	8	7
Houston, Tex. §	283	242	2	9	19	11	4
Little Rock, Ark.	70	40	20	7	1	2	5
New Orleans, La.	106	61	27	9	4	5	-
San Antonio, Tex.	167	104	33	13	11	6	8
Shreveport, La.	54	34	14	4	1	1	1
Tulsa, Okla.	110	76	23	9	2	-	8
MOUNTAIN	580	340	125	57	26	29	28
Albuquerque, N.Mex.	71	37	15	8	5	5	4
Colo. Springs, Colo.	29	23	1	3	2	-	7
Denver, Colo.	107	55	23	15	5	9	2
Las Vegas, Nev.	77	44	20	6	4	1	4
Ogden, Utah	21	9	5	4	2	1	-
Phoenix, Ariz.	126	85	23	8	3	7	2
Pueblo, Colo.	27	17	8	1	1	-	7
Salt Lake City, Utah	44	21	10	7	-	6	1
Tucson, Ariz.	78	49	20	5	4	-	1
PACIFIC	1,907	1,240	374	168	64	55	104
Berkeley, Calif.	18	14	1	2	1	-	1
Fresno, Calif.	55	36	10	5	2	2	6
Glendale, Calif.	21	18	2	-	1	-	1
Honolulu, Hawaii	63	38	14	5	4	2	5
Long Beach, Calif.	70	46	16	5	1	2	6
Los Angeles, Calif.	605	397	114	58	19	11	21
Oakland, Calif.	66	43	10	7	1	5	8
Pasadena, Calif.	31	22	7	1	1	-	5
Portland, Oreg.	120	77	29	8	4	2	3
Sacramento, Calif.	145	92	30	11	8	4	8
San Diego, Calif.	146	93	28	15	3	7	9
San Francisco, Calif.	167	112	30	22	1	2	9
San Jose, Calif.	134	82	33	7	6	6	6
Seattle, Wash.	149	96	32	11	5	5	3
Spokane, Wash.	47	25	8	5	5	4	7
Tacoma, Wash.	70	49	10	6	2	3	6
TOTAL	11,627††	7,579	2,378	911	386	360	505

*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.

Physical Fitness — Continued

The prevalence estimates from sources using a definition of appropriate physical activity suggested in the 1990 objectives are shown in Figure 1. The estimate for children and adolescents is adapted from the National Children and Youth Fitness Survey (*8*), the estimates for adults are based primarily on unpublished data from 16 states that participated in the 1984 CDC-State Behavioral Risk Factor Surveillance System.

The fourth objective in this area concerns the level of participation in public programs and trends in the pattern of physical activity. No information is available about the use of public facilities. Most surveys show the most commonly reported leisure-time physical activities by adults are walking, swimming, calisthenics, bicycling, and jogging or running. Variation in definition of participation precludes any assessment of national trends in the absolute or relative frequencies of these activities.

AWARENESS

Unpublished data from surveys conducted in a Dallas, Texas, suburb and in Los Angeles, California, indicate that over 70% of adults know that vigorous physical activity needs to be done three or more times per week and maintained for 20 minutes or more per session to promote cardiovascular fitness. Fifty-nine percent to 90% of the time, respondents to the Los Angeles survey and to the Perrier survey (*9*) correctly identified specific activities that are vigorous enough (e.g., running, swimming); only 10%-58% of the time did they correctly identify activities that are not vigorous enough (e.g., baseball, bowling, golf).

Surveys of physicians in Massachusetts and Maryland indicated that just under 50% of primary-care physicians routinely inquire about their patient's exercise practices (*10,11*). Whether the inquiries include questions about the frequency, duration, and intensity of the exercise, as suggested by the 1990 objectives, is unknown.

WORKSITE FITNESS PROGRAMS

A great deal has been written about worksite fitness programs. However, data are currently not available to describe the prevalence of programs because: (1) existing studies have been limited to particular states or industries; (2) different definitions of fitness or exercise programs have been used; (3) existing studies were not based on representative samples or have had very low response rates; and (4) the studies focused on the company or organization, not on individual worksites.

Similarly, data are not available to determine the effects of participation in fitness programs on job performance and health-care costs.

CHILDREN AND ADOLESCENTS

Overall, approximately 36% of children and adolescents, ages 10-17 years, participate in daily physical education programs (*12*). This is essentially unchanged since 1974 and well below the 1990 objective of 60%.

Methods of determining the fitness of children and adolescents are available, and surveys have been conducted. It is not known how many participate in such tests annually.

Reported by President's Council on Physical Fitness and Sports; Behavioral Epidemiology and Evaluation Br, Div of Health Education, Center for Health Promotion and Education, CDC.

Editorial Note: The 1990 objectives consist of 223 discrete objectives in 15 broad areas, such as Family Planning, Toxic Agent Control, and Smoking Control (*1*). They were developed in 1980 through the combined efforts of over 500 representatives of the public and private sectors and are useful national guidelines in need of periodic evaluation, rather than rigid obligations. If achieved, the health status of the people of the United States would be appreciably improved (*1*).

Physical Fitness — Continued

Even though several of the objectives in the area of physical fitness and exercise are not likely to be achieved, considerable progress has been made. Research on the various health effects of physical activity has progressed, but more is needed. Surveys by the National Center for Health Statistics, projects sponsored by the Office of Disease Prevention and Health Promotion, and CDC will provide valuable information about the prevalence and trends of certain physical activity patterns. Promotional efforts by the President's Council on Physical Fitness and Sports and a variety of public and private agencies are likely to favorably influence the knowledge, attitudes, and practices of U.S. citizens with respect to the benefits of appropriate physical activity.

A few particularly noteworthy issues deserve comment. First, many important questions remain about the salubrious effect of physical activity on CHD. Several careful observational studies of the association between activity and CHD document that the risk of CHD is reduced among more active persons (*13-18*). Evidence suggests that this is not entirely due to the selection of a more active life style by those who are intrinsically less susceptible to CHD (*2*). In fact, the reduction in risk appears to be relatively greater for persons who are obese or have hypertension (*19*). Nevertheless, several important areas need more research. More information is needed about the dose-response effect of physical activity on CHD, the effects on CHD of beginning a more active life style in the middle or later years, and the factors that affect the risk of sudden death during exercise. These and other research needs are listed elsewhere (*2*). Resolution of these issues would provide better and safer recommendations about how to reduce the risk of CHD through physical activity.

A second and related issue concerns the type and intensity of physical activity appropriate for inclusion in national objectives, such as the 1990 Objectives for Physical Fitness and Exercise. The definition of appropriate physical activity set forth by the 1990 objectives is rigorous, and only 10%-20% of the adult population is presently meeting it. Persons who achieve the level recommended by the 1990 objectives probably attain the maximum reduction in CHD risk available through physical activity. However, less vigorous activity also appears to be helpful. In fact, the relative reduction in risk of CHD appears to be greatest as those with the least physically active life style become just a little more active (*20*). Additionally, some of the health benefits to be achieved through activity do not seem to require vigorous physical activity. Osteoporosis appears to be retarded simply by being in an upright posture (e.g. standing, walking); weight control may be more related to overall energy expenditure regardless of intensity; and activities of daily living may be best maintained among the elderly through exercise designed to promote flexibility and strength. Therefore, future objectives should encourage regular physical activity regardless of intensity. Some physical activity three or more times per week for 20 or more minutes per session, regardless of intensity, is likely to provide important public health benefits.

Finally, to the extent that data are available, participation in a regular physical activity program appears to be more common among persons of higher socioeconomic status (SES) (*6*). Special efforts need to be made to overcome the barriers to increased physical activity among those of lower SES to ensure that the benefits are shared by all segments of society.

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Physical Fitness — Continued

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International Notes

Influenza — Southern Hemisphere, Asia, the Tropics, March-August 1985

Worldwide influenza surveillance from March to August 1985 indicates circulation of influenza virus types A(H3N2), A(H1N1), and B (Table 3). Type A(H3N2) viruses have been isolated most frequently, followed by type B. Influenza type A(H3N2) has often been associated with outbreak activity. Type A(H1N1) viruses have been isolated least frequently, often in association with sporadic cases.

Reported by Virus Disease Unit, World Health Organization, Geneva, Switzerland; WHO Collaborating Center for Influenza, Influenza Br, Div of Viral Diseases, Center for Infectious Diseases, CDC.

Influenza — Continued

Editorial Note: Influenza generally occurs from about April through September in the Southern Hemisphere and often throughout the year in the tropics. Surveillance in these regions may, therefore, identify strains that subsequently appear in the Northern Hemisphere. During the 1984-1985 influenza season, the United States and several other countries in the Northern Hemisphere experienced extensive influenza A(H3N2) activity. It appears that the present activity in the world results from continual spread of those strains, rather than from emergence of a new variant of type A(H3N2) virus. Preliminary laboratory comparisons of viruses from around the world support this view.

TABLE 3. Reported influenza virus isolates — Southern Hemisphere, Asia, the Tropics, March-August 1985

Country	Virus	Period of isolation
Australia	A(H3N2)	June-August
	A(H1N1)	July
	B	May-July
Brazil	A(H3N2)	April-May
Chile	A(H3N2)	May-June
China	A(H3N2)	May-June
	A(H1N1)	May-June
	B	March
Equador	A(H3N2)	March-April
Guatemala	A(H3N2)	March-April
Hong Kong	A(H3N2)	April-June
India	A(H3N2)	March-April
Indonesia	A(H3N2)	March-May
	B	March-May
Jamaica	A(H3N2)	April-May
Korea	A(H3N2)	March
Malaysia	A(H3N2)	April-May
New Zealand	A(H3N2)	April-August
Panama	A(H3N2)	July
South Africa	A(H3N2)	May-July
	A(H1N1)	May-July
	B	July
Singapore	A(H3N2)	March-April
	A(H1N1)	March-June
	B	March-June
Taiwan	B	May-June
Thailand	A(H3N2)	May-June
Uruguay	A	July

Current Trends

Recommendations for Preventing Possible Transmission of Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus from Tears

Human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the etiologic agent of acquired immunodeficiency syndrome (AIDS), has been found in various body fluids, including blood, semen, and saliva. Recently, scientists at the National Institutes of Health isolated the virus from the tears of an AIDS patient (*1*). The patient, a 33-year-old woman with a history of *Pneumocystis carinii* pneumonia and disseminated *Mycobacterium avium-intracellulare* infection, had no ocular complaints, and her eye examination was normal. Of the tear samples obtained from six other patients with AIDS or related conditions, three showed equivocal culture results, and three were culture-negative.

The following precautions are judged suitable to prevent spread of HTLV-III/LAV and other microbial pathogens that might be present in tears. They do not apply to the procedures used by individuals in caring for their own lenses, since the concern is the possible virus transmission between individuals.

1. Health-care professionals performing eye examinations or other procedures involving contact with tears should wash their hands immediately after a procedure and between patients. Handwashing alone should be sufficient, but when practical and convenient, disposable gloves may be worn. The use of gloves is advisable when there are cuts, scratches, or dermatologic lesions on the hands. Use of other protective measures, such as masks, goggles, or gowns, is *not* indicated.
2. Instruments that come into direct contact with external surfaces of the eye should be wiped clean and then disinfected by: (a) a 5- to 10-minute exposure to a fresh solution of 3% hydrogen peroxide; or (b) a fresh solution containing 5,000 parts per million (mg/L) free available chlorine—a 1/10 dilution of common household bleach (sodium hypochlorite); or (c) 70% ethanol; or (d) 70% isopropanol. The device should be thoroughly rinsed in tap water and dried before reuse.
3. Contact lenses used in trial fittings should be disinfected between each fitting by one of the following regimens:
   a. Disinfection of trial hard lenses with a commercially available hydrogen peroxide contact lens disinfecting system currently approved for soft contact lenses. (Other hydrogen peroxide preparations may contain preservatives that could discolor the lenses.) Alternatively, most trial hard lenses can be treated with the standard heat disinfection regimen used for soft lenses (78-80 C [172-176 F] for 10 minutes). Practitioners should check with hard lens suppliers to ascertain which lenses can be safely heat-treated.
   b. Rigid gas permeable (RGP) trial fitting lenses can be disinfected using the above hydrogen peroxide disinfection system. RGP lenses may warp if they are heat-disinfected.
   c. Soft trial fitting lenses can be disinfected using the same hydrogen peroxide system. Some soft lenses have also been approved for heat disinfection.

   Other than hydrogen peroxide, the chemical disinfectants used in standard contact lens solutions have not yet been tested for their activity against HTLV-III/LAV. Until other disinfectants are shown to be suitable for disinfecting HTLV-III/LAV, contact lenses used in the eyes of patients suspected or known to be infected with HTLV-III/LAV are most safely handled by hydrogen peroxide disinfection.

HTLV-III/LAV — Continued

The above recommendations are based on data from studies conducted at the National Institutes of Health and CDC on disinfection/inactivation of HTLV-III/LAV virus (*2-4*). Additional information regarding general hospital and laboratory precautions have been previously published (*5-9*).

Reported by the U.S. Food and Drug Administration; National Institutes of Health; Centers for Disease Control.

Editorial Note: All secretions and excretions of an infected person may contain lymphocytes, host cells for HTLV-III/LAV; therefore, thorough study of these fluids might be expected to sometimes yield this virus. Despite positive cultures from a variety of body fluids of infected persons, however, spread from infected persons to household contacts who have no other identifiable risks for infection has not been documented. Furthermore, there is no evidence to date that HTLV-III/LAV has been transmitted through contact with the tears of infected individuals or through medical instruments used to examine AIDS patients.

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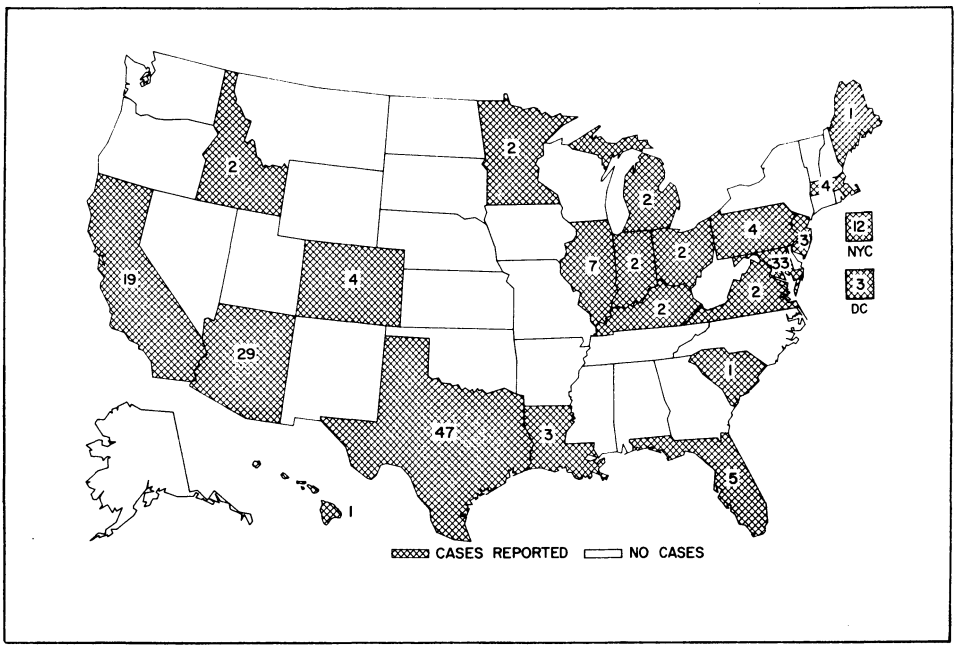
Erratum: Vol. 34, No. 33

p. 515. In the article, "Cutaneous Leishmaniasis—Ohio," the telephone number in the last sentence of the third paragraph of the Editorial Note should be: (404) 329-3670.

FIGURE I. Reported measles cases — United States, weeks 30-33, 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: 1985-746-149/21014 Region IV

HHS Publication No. (CDC) 85-8017