

MORBIDITY AND MORTALITY WEEKLY REPORT

- 597 Motor Vehicle-Related Burn Injuries Massachusetts
- 600 Shigellosis United States, 1984
- 602 Tetanus United States, 1982-1984

Perspectives in Disease Prevention and Health Promotion

Motor Vehicle-Related Burn Injuries — Massachusetts

To assess the importance of motor vehicles in causing persons to be hospitalized with burns, data were analyzed for Massachusetts residents burned in Massachusetts between July 1, 1978, and June 30, 1979, and treated as hospital inpatients in any of the 240 acute-care hospitals participating in the New England Regional Burn Program (NERBP).*

Of the 1,237 persons hospitalized for burns, 127 (10%) were hospitalized for motor vehicle-related burns. The incidence rate for these persons was 2.3 burns per 100,000 person-years. The rate varied considerably by age and sex (Table 1). The burn rate for males was approximately nine times that for females, accounting for 13% of all males hospitalized with burns in Massachusetts during the study period. For each sex, individuals 15-24 years old experienced the highest burn rates and accounted for half of all persons with vehicle-related burns.

Flame burns, associated with gasoline from carburetors, and scald burns from radiators were the most common types of injury, accounting for 35% and 32%, respectively, of all reported burns (Table 2). Burns from contact with hot tail pipes or engine surfaces accounted for an additional 14%, and 15% of burns were caused by vehicle crashes.

The average length of hospital stay for the 127 hospitalized burn patients was 12.9 days

Age	Rate*								
(years)	Male	Female	Total						
< 10	0.3	0.3	0.3						
10-14	2.2	0.0	1.1						
15-24	11.0	1.3	6.1						
25-34	6.4	0.7	3.5						
35-44	3.5	0.3	1.9						
45-64	2.3	0.2	1.2						
≥ 65	0.4	0.0	0.1						
All ages	4.4	0.5	2.3						

TABLE 1. Motor vehicle-related burn incidence rates, by age and sex of resident inpatients — Massachusetts, July 1, 1978,-June 30, 1979

*Number of burns per 100,000 person-years.

^{*}The NERBP was one of six projects within the National Burn Demonstration Project established under contractual agreements with the Division of Emergency Medical Services of the U.S. Department of Health and Human Services.

Burn Injuries – Continued

(11.9 days for males; 21.2 days for females) (Table 2). Burns associated with vehicle crashes had the longest average stays, attributable in part to the need for medical treatment of other injuries sustained during the crash.

A strong seasonal variation in the incidence of vehicle-related burns was evident, with the estimated peak occurring in mid-July (Figure 1). Thirty-six percent of all vehicle-related burns occurred in June or July, and 61% occurred during the 4 months of May through August.

Reported by AM Rossignol, ScD, JA Locke, MPH, CM Boyle, MPH, JF Burke, MD, Dept of Civil Engineering, Tufts University, Medford, Massachusetts; Div of Injury Epidemiology and Control, Center for Environmental Health, CDC.

TABLE 2. Type of burn and average length of hospital stay for residents with motorvehicle-related burns, by sex — Massachusetts, July 1, 1978,-June 30, 1979

		S	ex			
	-	Male	F	emale		Total
Type of burn	No. burns	Average hospital stay (days)	No. burns	Average hospital stay (days)	No. burns	Average hospital stay (days)
Scald	39	6.9	2	10.0	41	6.9
Chemical	5	3.2	0	_	5	3.2
Contact	12	9.2	6	19.3	18	12.6
Flame						
Non-moving vehicle	43	12.1	1	20.0	44	12.3
Moving vehicle	15	30.3	4	29.8	19	30.2
All types	114	11.9	13	21.2	127	12.9

FIGURE 1. Residents hospitalized with motor vehicle-related burns, by month of occurrence — Massachusetts, July 1, 1978,-June 30, 1979 (presented as an annual curve)



YEAR (seasonal pattern)

MMWR

Burn Injuries – Continued

Editorial Note: October 6-12 is Fire Prevention Week,[†] an appropriate time to consider the importance of fire- and burn-related injuries and the effectiveness of prevention efforts. Fires and burns, which cause about 6,000 deaths per year, are the fourth most common cause of death from unintentional injury, surpassed only by motor vehicle crashes, falls, and drownings. Over a million burn injuries each year require medical attention or restriction of activity. Each year, 90,000 patients are admitted to hospitals, and patients with burns require over a million days of hospital care — an average of 12 days of hospital care per admission. Severely burned patients may need skin grafting and frequently suffer disability, disfigurement, and emotional distress (1).

House fires account for approximately 75% of all deaths from fires and burns (2). Most deaths result from the toxic byproducts of combustion (1). Fatality rates are highest among young children and the elderly, who have difficulty escaping fires and reduced likelihood of survival after burn injuries. Cigarettes are the leading cause of fatal residential fires. High blood alcohol concentrations are found in about 50% of adults who die in house fires (2).

The U.S. Department of Health and Human Services has included reducing burn injuries in its 1990 objectives for the nation: (1) by 1990, residential fire deaths should be reduced to no more than 4,500 per year (between 1978 and 1982, annual residential fire deaths decreased by 900 per year); and (2) by 1990, at least 75% of residential units should have a properly placed and functioning smoke detector (smoke detector installation increased from 50% in 1980 to 67% in 1982) (2).

Many preventive measures have been recommended to save lives and to decrease injuries caused by fires and burns. Smoke detectors (alarms) provide an early warning of fire. Several studies have suggested that smoke detectors reduce the risk of death from fires (3,4); protection is increased if sprinkler systems are also used (4). More effort is needed to ensure that smoke detectors are not only installed but are also functioning properly, especially among groups at highest risk of death from fires. Enactment and enforcement of fire extinguisher codes and building construction codes have also prevented fire deaths (4).

Because up to two-thirds of persons dying in house fires are unable to escape, residents need to know exit routes and to have a well-prepared escape plan (4,5). Fire drills are an important component of preparation. Other prevention strategies may include increasing the self-extinguishing capacity of cigarettes (estimated to cause about half of fatal house fires); use of matches that burn at lower temperatures and self-extinguish when dropped; and use of flame-retardant fabrics and designs to prevent clothing and upholstery fires (4, 6-8).

Instruction in fire-related emergencies and first aid should also help to prevent further injury once an incident has occurred. For example, use of the "drop and roll" technique for extinguishing burning clothing should be taught. The importance of cooling a burn with cold water—not butter—to stop skin damage and reduce pain should be emphasized (9).

The Massachusetts study of motor vehicle-related burns illustrates another aspect of preventing fire and burn-related injuries and mortality by demonstrating how local or regional inquiry can target problem areas for effective safety programs. Motor vehicle-related burns have rarely been studied in the past. The findings here show that male teenagers and young adults are at high risk for burns from carburetor gasoline fires and for scalds from radiator fluids, especially during the summer months. Such data will enable prevention efforts to be targeted more efficiently.

Some strategies to prevent motor vehicle-related burns, such as installing radiator safety caps, have been implemented. Teaching the hazards of "carburetor priming" and other potential areas of injury during drivers' education, automotive-repair classes, or testing for new drivers' licenses has been proposed.

[†]The theme of Fire Prevention Week is "Fire Drills Save Lives."

Burn Injuries — Continued References

- 1. Baker SP, O'Neill B, Karpf RS. The injury fact book. Lexington, Massachusetts: Lexington Books, 1984.
- U.S. Department of Health and Human Services. Promoting health/preventing disease: objectives for the nation. Washington, D.C.: U.S. Department of Health and Human Services, Public Health Service, 1980:45-9.
- 3. McLoughlin E, Marchone M, Hanger L, German PS, Baker SP. Smoke detector legislation: its effect on owner-occupied homes. Am J Public Health 1985;8:858-62.
- Smith GS, Falk H, Coleman P. Unintentional injuries: intervention strategies and their potential for reducing human losses. A position paper for the Carter Center "closing the gap" project. Atlanta, Georgia: Emory University, 1984.
- 5. Baker SP, Dietz PE. Injury prevention. In: Healthy people, the Surgeon General's report on health promotion and disease prevention background papers. Washington, D.C.: U.S. Department of Health, Education, and Welfare, 1979.
- Feck G, Baptiste MS, Tate CL, Jr. An epidemiologic study of burn injuries and strategies for prevention. Atlanta, Georgia: U.S. Department of Health, Education, and Welfare, Public Health Service, Centers for Disease Control, January 1978.
- 7. Mierley MC, Baker SP. Fatal house fires in an urban population. JAMA 1983;249:1466-8.
- Teret JD, Baker SP, Trinkoff AM, DeFrancesco S. Report of the national conference on injury control, May 18-19, 1981. Atlanta, Georgia: Centers for Disease Control, 1981.
- 9. U.S. Consumer Product Safety Commission. What you should know about home fire safety. Washington, D.C.: U.S. Consumer Product Safety Commission, 1979.

Current Trends

Shigellosis - United States, 1984

In 1984, 12,790 *Shigella* isolates from humans were reported to CDC. This is a 14.4% decrease from the 14,946 isolates reported in 1983. The number of isolates continues to be less than the 15,334 reported during the peak year, 1978 (Figure 2).

Shigella serotypes were reported for 12,179 of the 12,790 isolates. The most frequently isolated serotype, *S. sonnei*, comprised 64.4% of all isolates serotyped (Table 3). *S. flexneri* 1a accounted for 14.1% of all *S. flexneri* subtyped; 1b, 2.6%; 2a, 28.1%; 3a, 24.3%; and 6, 13.3%.

The number of reported isolates in every serotype decreased, compared with the numbers reported in 1983 (Table 3). *S. sonnei* decreased 15.3%; *S. flexneri*, 10.8%; *S. boydii*, 6.5%; and *S. dysenteriae*, 3.2%. The decreases were not confined to one state or region.





600

Vol. 34/No. 39

Shigellosis - Continued

The age-specific rate of reported isolates per 100,000 population was highest for 2-yearold children, lower for older children, and lowest for adults. The age-specific rate for 20- to 29year-olds was slightly higher than the rates for the older children and the remaining age groups (Figure 3). In addition, in the 20- to 29-year-age group, a slightly higher rate was reported for females than for males. Rates of reported isolates by patient sex were similar for the remaining age groups.

Since some populations have higher rates than others, data were tabulated separately for patients residing in certain institutions (e.g. nursing homes, facilities for the mentally ill, and other resident-care centers) and on American Indian reservations. Only 2,416 (18.9%) of the reports included data on residence at the time of onset of illness. Of those specified, 22 (0.9%) lived in institutions, and 67 (2.8%), on Indian reservations. Fifteen (68.2%) of the reported isolates from residents of institutions were *S. sonnei*, and five (22.7%) were *S. flexneri*. Twenty-four (36.4%) of the reported isolates from Indian reservation residents were *S. sonnei*, and 42 (63.6%) were *S. flexneri*. For other known residences, *S. sonnei* accounted for 1,634 (71.7%); *S. flexneri*, for 587 (25.8%); *S. boydii*, for 34 (1.5%); and *S. dysenteriae*, for 24 (1.1%).

TABLE 3. Shigella serotypes isolated from humans - United States, 1984

	No. isolate	es reported	Isolates serotyped	Decrease
Serotype	1983	1984	in 1984 (%)	from 1983 (%)
S. sonnei	9,267	7,847	64.4	15.3
S. flexneri	4,222	3,765	30.9	10.8
S. boydii	415	388	3.2	6.5
S. dysenteria	185	179	1.5	3.2

FIGURE 3. Rate of reported Shigella isolates, by age of patient — United States,* 1984



*Age data unavailable for California.

Shigellosis - Continued

Reported by Statistical Svcs Activity, Enteric Diseases Br, Div of Bacterial Diseases, Center for Infectious Diseases, CDC.

Editorial Note: This report is based on CDC's *Shigella* Surveillance Activity, a passive laboratory-based system that receives reports from the 50 states and the District of Columbia. These reports do not distinguish between clinical or subclinical infections or between chronic or convalescent carriers.

Tetanus — United States, 1982-1984

From 1982 through 1984, 253 U.S. cases of tetanus were reported to the *MMWR* (88 in 1982, 91 in 1983, and 74 in 1984). Forty states and the District of Columbia reported at least one case; 19 states reported cases in all 3 years. The 10 states reporting no cases are located in the western and northeastern United States (Figure 4). The average annual incidence rate for 1982-1984 was 0.036 cases per 100,000 total population, compared to

(Continued on page 607)

	3	9th Week Endin	9	Cumulative, 39th Week Ending			
Disease	Sept. 28, 1985	Sept. 29, 1984	Median 1980-1984	Sept. 28, 1985	Sept. 29, 1984	Median 1980-1984	
Acquired Immunodeficiency Syndrome (AIDS)	196	127	N	5 802	2 067	N	
Asentic meningitis	419	200	3/3	5,602	5,007	6 4 4 5	
Encenhalitist Primary (arthropod-borne	415	200	343	0,017	5,045	0,445	
& unspec)	35	35	65	914	901	1 000	
Post-infectious	1	20	05	014	001	1,035	
Gonorrhea: Civilian	116 379	19 242	19 606	626 222	621 944	716 900	
Military	337	189	436	12 725	16 242	20 20 7	
	536	505	499	16,755	16,243	16 940	
Type B	591	583	403	19,220	10,000	16,049	
Non A Non B	96	74	NI	2 0 7 5	2 704	10,070	
Unspecified	131	135	178	4 254	2,754	6 5 1 9	
legionellosis	16	19	N N	4,254	3,709	0,516	
eprosy	4	13	7	277	451	176	
Malaria	15	16	20	756	714	920	
Measles: Total*	28	15	23	2 4 9 9	2 2 2 2 0	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
Indigenous	25	10	2.5 N	2,403	2,330	2,330	
Imported	23	5	N	2,033	2,004	IN N	
Maningoogoal infectiones Total	32	36	26	1 909	2 1 0 9	2 1 0 9	
Civilian	32	36	36	1,000	2,100	2,100	
Military	52	30	30	1,000	2,104	2,104	
Mumos	28	26	45	2 2 2 2	2 207	2 264	
Portuguin	73	01	40	2,200	2,20/	3,304	
Pubella (Carman manalas)	, 5	51	55	2,004	1,033	1,2/3	
Supplie (Briman & Secondary)), Civilian	659	714	607	10 020	20.076	22 901	
Syphilis (Frimary & Secondary); Civilian	033	/14	007	19,039	20,976	22,091	
Towie Check average	2	11	O NI	260	230	200	
Tubacularia	412	450	E 4 0	15 920	15 005	10 000	
Tuberculosis	412	405	549	10,039	15,905	10,900	
		5	10	123	241	205	
Typhola rever	16	15	24	203	204	1 0 1 9	
iypnus rever, tick-borne (MMSF)	100	10	127	2000	/26	1,018	
Rabies, animal	100	135	127	3,980	4,093	4,838	

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

TABLE II. Notifiable diseases of low frequency, United States

Anthrax Botulism: Foodborne (Ariz. 1) 3 Infant (Wash. 1, Calif. 2) 4 Other Brucellosis (Ark. 1, Tex. 2, Calif. 2) 10 Cholera Congenital rubella syndrome Congenital syndris, ages < 1 year 1	39 46 1 05 3	Leptospirosis Plague Poliomyelitis: Total Paralytic Psittacosis Rabies, human Tetanus Trichinosis	28 11 4 84 - 48 50

Three of the 28 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.

		Aseptic	Encer	ohalitis	Con		н	epatitis (V	'iral), by ty	pe		
Reporting Area	AIDS	Menin- gitis	Primary	Post-in- fectious	Gon (Cir	vilian)	A	в	NA,NB	Unspeci- fied	losis	Leprosy
	Cum. 1985	1985	Cum. 1985	Cum. 1985	Cum. 1985	Cum. 1984	1985	1985	1985	1985	1985	Cum. 1985
UNITED STATES	5,802	419	814	99	626,232	621,844	536	591	96	131	16	277
NEW ENGLAND	202	38	22	-	16,990	17,120	8	34	1	3	5	6
Maine N.H	9	1	- 5	-	851 419	731 516	-	1	-	-	- 1	-
Vt.	1	2	-	-	253	286	-	-	-	-	-	-
Mass. R I	124	22	15	-	6,658 1 380	7,203	6	24	-	3	4	6
Conn.	58	2	2	-	7,429	7,211	2	7	1	-	-	-
MID ATLANTIC	2,296	89	106	11	94,468	84,184	27	36	. 7	2	-	29
Upstate N.Y.	264	40	33	4	13,029	13,130	21	17	4	-	-	1
N.J.	349	49	25	-	14,612	14,117	5	18	3	-	-	20
Pa	126	U	36	7	20,094	22,640	U	U	U	U	U	3
E.N. CENTRAL	247	93	205	20	88,854	87,244	25	64	10	7	1	21
Ind	43	39	85 44	4	23,059	22,801	11	18	2	2		3
III.	125	-	14	8	22,119	19,707	ž	2	1	2	-	16
Mich. Wis	42 18	44	44 18	6	25,363 8.621	25,392 9.524	7	24	1	2	-	2
	73	21	62	3	30 796	30.528	85	13	3	1	1	1
Minn.	21	4	28	1	4,598	4,623	56	3	-	-	-	-
lowa	9	3	23	•	3,300	3,338	-	-	-	1	-	-
N. Dak	32		-	1	206	282	4	-	-	-		-
S. Dak	1	1	-	-	590	702	19	1	1	-		-
Nebr. Kans.	2 8	2	5 6	1	2,525 4,661	2,172 4,745	1 5	1	-	-	1	-
S ATLANTIC	890	71	97	36	137 904	158 119	45	115	22	8	6	7
Del.	10	4	5		3,280	2,934	-	-		-	1	-
Md.	104	11	20	1	22,135	18,319	-	5	4	2	-	1
Va.	73	15	22	5	14,376	14,973	1	10	2	-	1	-
W. Va.	5	2	22	-	1,959	1,965	-	3	1	-	2	-
N.C.	44	11	24		26,914	25,860	3	19 17	3	1	1	2
Ga	134	8	-	-		28,722	10	20	3	1	-	1
Fla.	380	17	-	30	41,085	38,000	29	41	8	4	1	3
E.S. CENTRAL	50	30	25	4	56,436	55,089	9	41	2	-	-	-
Ky. Tenn	13	5	6		21,475	22,671	4	14	2	-	-	-
Ala	19	14	9	4	17,067	17,191	-	4	-	-	-	-
Miss.	3	4	2	-	11,408	8,572	4	12	-	-	-	-
W.S. CENTRAL	417	29	103	2	83,789	84,910	69	45	6	33	1	17
La.	71	5	3		16,156	18,820	2	1	-	3		i
Okla.	13	3	23	1	9,253	9,278	8	4	1	1	1	
lex.	328	20	74	-	50,217	49,047	53	36	4	29	-	15
MOUNTAIN	100	10	32	6	20,530	20,385	64	41	8	9	1	7
Idaho	-	-		-	657	982	4	-	1	-		-
Wyo.		-	1	-	476	567		1	:	2	-	-
Colo. N. Mex	45	5	6 3	2	6,059 2 387	5,828	8	5	1	5	-	2
Ariz.	26	i	9	-	6,005	5,582	31	21	4	1	1	1
Utah Nev	12	1	10	4	941 3 429	986 3 231	5 15	6	2	2	-	3
BACIFIC	1 5 9 7		160	17	00,405	04.265	204	200	~	-	-	
Wash.	80	38	13	-	90,405 7,205	6,467	204	202	37	68	1	189
Oreg.	23		1		4,846	4,934	54	10	3	2	-	3
Calif. Alaska	1,403	35	127	17	80,811	69,301 2 1 1 1	140	180	31	64	1	134
Hawaii	18	1	-	-	1,354	1,452	7	2	-	-	-	19
Guam	1	U	-	-	119	185	U	U	U	υ	υ	3
F.R. VI	65 2	1	5	2	2,467	2,605	;	9	-	6	-	2
Pac. Trust Terr.	-	Ū	-	-	146	-	ΰ	Ū	Ū	Ū	Ū	20

TABLE III. Cases of specified notifiable diseases, United States, weeks ending September 28, 1985 and September 29, 1984 (39th Week)

N: Not notifiable

T		Measles (Rubeola)			Menin-	·				T					
Paparting Area	Malaria	Indig	enous	Impo	rted *	Total	gococcal	Mur	mps		Pertussis			Rubella	
Reporting Area	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	756	25	2,059	3	430	2,338	1,808	28	2,288	73	2,064	1,833	5	556	612
NEW ENGLAND Maine	41 4	-	38	-	88 1	105	83 3	1	53 6	2	111	48		12	18
N.H.	4	-	-	-	-	36	14	-	9	-	39	7		2	i
Mass.	19	-	34	-		7	10	-	2	-	3	20	-	-	.:
R.I.	3	-		-	- 04	40	13		15	2	3/	13	-	6	16
Conn.	10	-	4	-	3	14	29	-	7	-	7	4	-	4	-
MID ATLANTIC	122	3	172	3	37	151	326	4	254	6	128	148	2	218	215
Upstate N.Y.	41	-	71		13	36	125	-	134	1	60	83	-	17	99
N.J.	45	3	58	3 '	11	103	58	2	32	3	19	7	2	178	98
Pa.	22	U	26	Ū	3	5	49 94	Ű	34 54	Ŭ	42	47	Ū	9 14	17
E.N. CENTRAL	39	-	434	-	89	691	314	5	844	12	440	443	-	29	84
Ind.	4	-	55	-	54	9	104	2	251	12	76	68	-	-	2
III.	6	-	286	-	9	179	71	2	184	-	135	225	-	12	5
Mich.	15	-	37	-	23	461	71	-	290	-	41	28	-	15	20
WIS.	6	-	56	-	1	39	28	-	82	-	159	99	-	1	8
WIN. CENTRAL	27	-	1	-	10	46	91	1	70	7	150	111	-	19	35
lowa	2	-		-	6	38	23	-	1	5	77	12	-	2	4
Mo.	5	-	-	-	2	3	35		11	i	27	18		7	1
N. Dak.	2	-	-	-	2	-	4	-	3	-	9	-	-	2	3
S. Dak. Nebr	1	-	-	-	-	-	3	-	-	-	2	8	-	-	-
Kans.	5	-	1	-	-	5	11	-	2 40	-	4 24	11 52	-	7	27
	91	1	270	-	30	51	350	3	213	11	319	186	1	55	23
Md.	22	1	96	-	-		8	-	1	2	1	2	-	1	-
D.C.	- 5		9	-	1	20	49		28	5	131	57	-	6	1
Va.	19	-	21	-	7	5	43	-	42	-	14	19	-	2	
vv. va. N.C.	2	-	31	-	2	-	8	1	59		4	11	-	9	-
S.C.	-	-	9		3	- 1	46	1	13	2	23	32	1	1	-
Ga.	7	-	8	-	-	i	58	-	28	1	86	14	-	3	- 2
Fla.	28	-	96	-	8	16	98	-	35	3	57	49	-	29	20
E.S. CENTRAL	9	-	-	-	7	6	82	-	27	-	42	13		3	۹
Ky. Tenn	3	-	-	-	5	1	8	-	8	-	8	1	-	3 3	3 3
Ala.	5	-	-		1	2	32	-	15	-	19	7	-	-	-
Miss.	ĩ	-	-	-	1	-	17	-	3	-	4	1	-	-	3
W.S. CENTRAL	72	2	416	-	15	533	150	6	243	12	325	285	1	33	54
La.	1	-	42	-		8	14	-	6	2	14	18	-	1	3
Okla.	3	-	-	-	1	8	28	Ň	Ň	i	131	237	-	1	-
Tex.	66	2	374	-	14	509	85	6	235	8	168	24	1	31	51
MOUNTAIN	42	4	496	-	51	145	76	-	213	11	169	105	-	5	21
Mont.	- 2	-	122	-	17	-	5	-	9	1	9	19	-	-	-
Wyo.	1	4	120	-	18	23	2	-	9	-	5	7	-	1	1
Colo.	12	-	6	-	7	6	21	-	18	3	65	34	-	-	2
N. Mex.	14	-	1	-	5	88	8	N	Ň	-	12	8	-	2	1
Ariz. Litah	8	-	237	-	4	1	19	-	106	6	33	22	-	1	4
Nev.	3	-	-	-	-	- 27	9 6	-	6 63	1	45	7 2	-	1	7
PACIFIC	313	15	232	-	103	610	336	8	371	12	380	494	1	182	153
Wash.	23	-	31	-	39	140	59	-	31	7	67	282		14	1
Oreg. Calif	12	16	170	-	1		30	N	N		40	25	-	1	2
Alaska	201	- 13	1/9	-	58	307	234	5	314	5	227	114	1	124	145
Hawaii	15	-	18	-	5	163	4	3	18	-	17	72	-	42	4
Guam	1	υ	10	U	1	90	-	U	5	U	-	-	U	2	4
r.n. VI	-	-	63	-	-	14	12	5	138	-	10	1	-	25	9
Pac. Trust Terr.	-	Ū	-	U	-	-	-	Ū	3	- U	-	-		-	-
									-	-	-	-	0	-	

TABLE III. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending September 28, 1985 and September 29, 1984 (39th Week)

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

N: Not notifiable U: Unavailable [†]International [§]O

ΤΑΒΙ	LE III. (Co So	ont'd.) Ca eptember	eses of spec 28, 1985	cified not and Sept	ifiable dis ember 29	eases, Uni), 1984 (3	ted States 9th Weel	, weeks end c)	ding
Reporting Area	Syphilis (Primary &	(Civilian) Secondạry)	Toxic- shock Syndrome	Tube	culosis	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	19,039	20,976	2	15,839	15,905	123	263	580 🕈	1 5 3,980
NEW ENGLAND	440	383	-	524	475	3	11	7	19
Maine	13	4	-	38	21	-	-	-	-
N.H.	35	12	-	15	25	-	-	1	1
Vt.	5	1	-	5	7	-	-	-	-
Mass.	217	220	-	315	262	3	8	5	11
R.I.	14	16	-	38	37	-	-	1	-
Conn.	156	130	-	113	123	-	3	-	7
MID ATLANTIC	2.628	2.840	-	2,889	2 880	2	40	31+	395
Linstate N Y	200	243	-	517	454	-	10	9	91
N Y City	1.589	1.752	-	1.403	1.160	1	22	41	
N.I	527	490	-	383	643	i		4	35

N.H.	35	12	-	15	25	-	-	1	1
Vt.	217	220	-	215	262	- 3	- 8	5	11
RI	14	16	-	38	37	-	-	1	-
Conn.	156	130	-	113	123	-	3	-	7
	2 6 2 0	2.040		2 000	2 000	2	40	ar +1	205
MID ATLANTIC	2,628	2,840	-	2,889	2,880	2	40	9	395
NY City	1.589	1.752	-	1.403	1.160	1	22	41	-
N.J.	527	490	-	383	643	i		4	35
Pa.	312	355	U	586	623	-	1	14	269
5 N. 05N75 N.	770	080		1 000	2.060	2	21	40	147
E.N. CENTRAL	114	185	-	345	380	2	7	28	27
Ind	71	103	-	241	249	-	3	4	21
111.	381	327	-	844	855	1	13	6	28
Mich.	162	305	-	418	446	-	6	2	21
Wis.	50	60	-	112	130	1	2	-	50
W N CENTRAL	172	287	-	440	490	35	11	38 + I	727
Minn.	35	78	-	94	78	1	6	-	150
lowa	17	11	-	46	50		2	1	128
Mo.	90	147	-	214	247	22	2	4	38
N. Dak.	2	9	-	22	19	- 7	-	2	237
S. Dak. Nobr	5	11	-	11	27	2	1	3	30
Kans.	17	31	-	46	59	3		27	39
S. ATLANTIC	4,847	6,169	-	3,194	3,334	6	29	2// 40	1,044
Del.	29	387	-	28	45		10	26	526
NIA. DC	261	245	-	123	140	-	-	-	-
Va.	224	316	-	287	343	1	3	18	139
W. Va.	18	14	-	83	104	-	-	1	22
N.C.	518	628	-	404	478	4	3	119 5	11
S.C.	621	586	-	396	397	-	1	36 1	58
Ga. Fla	2.848	2,920		1.051	997	-	10	6	136
	_,								
E.S. CENTRAL	1,669	1,486	1	1,396	1,471	7	4	59 * 2	200
Ky.	54	78	1	336	348	5	1	281	27
Ienn. Ala	402	474	-	400	446	1	2	13	113
Miss.	663	535	-	239	230	i	-	9 2	5
							•••	2 2	070
W.S. CENTRAL	4,579	5,146	-	2,010	1,870	4/	23	14	110
Ark.	244	928	-	207	261	27	-	21	16
Ca. Okla	138	165	_	194	175	15	2	81 2	86
Tex.	3,384	3,886	-	1,306	1,233	5	21	14	458
MOUNTAIN	662	472		417	121	14	11	14	335
MOUNTAIN	553	4/2	-	417	434	4		6	156
Idaho	6	20	_	20	24	-	-	-	9
Wyo.	8	7	-	5	-	-	-	4	16
Colo.	137	125	-	49	52	2	4	2	21
N. Mex.	106	63	-	73	85	2	4	-	11
Ariz.	248	162	-	186	197	4	3	-	110
Utan	37	75	-	26	28	-	-	2	8
	<u>.</u>							_	
PACIFIC	3,373	3,213	1	3,009	2,891	7	103	3	443
Wash.	80	120	1	191	145	-	1	-	4
Oreg. Calif	3 164	2.948	-	2 505	2 413	4	98	3	432
Alaska	2	5	-	72	51	2	-	-	3
Hawaii	52	58	-	143	166	-	4	-	-
6	2			20	41			_	-
Guam	616	615		288	285	-	2	-	31
V.I.	3	8		1	200	-	52	-	-
Pac. Trust Terr.	13	-	U	16	-	-		-	-

U. Unavailable

TABLE IV. Deaths in 121 U.S. cities,* week ending September 28, 1985 (39th Week)

		All Caus	es, By A	ge (Yea	rs)					All Cau	ses, By A	Age (Yea	rs)		
Reporting Area	All Ages	≥65	45-64	25-44	1-24	4 < 1	P&I** Total	Reporting Area	All Ages	≥65	45-64	25-44	1-24	<1	Total
NEW ENGLAND	667	466	139	31	11	20	43	S. ATLANTIC	1,268	788	286	107	46	41	55
Boston, Mass.	164	110	37	7	4	6	12	Atlanta, Ga.	142	75	35	24	6	2	5
Bridgeport, Conn.	54	39	9	4	1	1	Ē	Baltimore, Md.	264	1/4	51	24	10	3	9
Fall River Mass	35	26	11	1	1	-	5	Lacksonville Fla	130	80	26	12	6	6	6
Hartford, Conn.	64	43	16	i	1	3	4	Miami, Fla.	114	70	34	7	2	1	3
Lowell, Mass.	25	18	3	1	1	2	1	Norfolk, Va.	35	16	13	2	1	3	6
Lynn, Mass.	14	12	2	-	-	-	-	Richmond, Va.	84	52	20	4	6	2	8
New Bedford, Mas	s. 26	17	11	3	-	1	2	Savannah, Ga.	/1	40	25	2	1	2	1
Providence R1	67	30 47	17	3		2	3	Tampa Fla	60	40	14	2	ż	2	2
Somerville, Mass.	9	7	2	-	-	-		Washington, D.C.	182	100	41	15	11	15	1
Springfield, Mass.	29	18	8	2	1	-	1	Wilmington, Del.	22	14	2	6	-	-	1
Waterbury, Conn.	39	30	6	1	1	1	6		745	400		40		10	
Worcester, Mass.	52	40	6	2	-	4	7	E.S. CENTRAL	/45	489	182	43	15	16	34
MID ATLANTIC	2 690	2 1 3 3	305	108	65	79	112	Birriningnam, Ala.	. 69	48	16	3	4	2	4
Albany, N.Y.	55	31	13	4	1	6		Knoxville Tenn	65	44	15	4	2	-	. 3
Allentown, Pa.	17	14	3	-	-	-	-	Louisville, Ky.	136	79	46	8	1	2	. 8
Buffalo, N.Y.	124	81	28	8	3	4	10	Memphis, Tenn.	155	106	33	10	3	3	9
Camden, N.J.	39	24	10	2	1	2	3	Mobile, Ala.	89	66	17	3	2	1	. 4
Elizabeth, N.J. Frie Pat	22	23	6	3	2	-	-	Montgomery, Ala.	51	30	10	2	2	3	1 2
Jersey City, N.J.	64	49	6	5	1	3	-	reastraile, renn.	0,	50	24	5	-	-	- 3
N.Y. City, N.Y. §	1,356	1,280	6	16	32	22	46	W.S. CENTRAL	1,537	902	363	145	64	63	65
Newark, N.J.	73	45	14	9	3	2	6	Austin, Tex.	65	34	17	7	5	2	: 5
Paterson, N.J.	32	20	6	2		4	1	Baton Rouge, La.	47	21	15	5	1	5	6
Pittsburgh Pa t	76	250	102	34	13	20	18	Corpus Christi, Tex	161	37	1/	3	2	5	
Reading, Pa.	26	20	4	-	2	2	2	El Paso Tex	53	38	44	15	8	4	. 9
Rochester, N.Y.	121	76	32	8	2	3	10	Fort Worth, Tex.	99	61	23	7	3	5	6 6
Schenectady, N.Y.	31	22	7	1	-	1	1	Houston, Tex.	508	273	115	70	30	20) 1 <u>3</u>
Scranton, Pa.†	28	21	5	-	2	-	2	Little Rock, Ark.	59	36	13	2	1	7	4
Trenton N I	27	45	23	1	3		1	New Orleans, La.	154	98	40	8	4	4	
Utica, N.Y.	22	19	2	ì	-	-	1	San Antonio, Tex.	200	23	40	20	8		14
Yonkers, N.Y.	41	34	3	4	-	-	5	Tulsa, Okla	96	64	25	3	2	2	2
E.N. CENTRAL	2,251	1,565	374	127	72	112	94	MOUNTAIN	543	328	130	46	19	20	25
Akron, Uhio	61	39	11	6	1	4	-	Albuquerque, N.Me	x. 69	36	17	5	6	5	i <u>1</u>
	35	24	11	2	1		2	Colo. Springs, Colo	100	27	11	1	1	1	. 5
Cincinnati, Ohio	171	94	40	20	10	20	10	Las Venas Nev	65	38	17	9		1) 3 4
Cleveland, Ohio	176	118	40	9	4	5	3	Ogden, Utah	29	21	4	2	2		. 2
Columbus, Ohio	120	73	22	9	8	8	10	Phoenix, Ariz.	108	55	30	13	7	3	
Dayton, Ohio	95	59	27	6	3		2	Pueblo, Colo.	21	15	4	1	-	1	2
Evansville Ind	238	153	49	18	6	12	7	Salt Lake City, Utal	1 38 72	25	11	1	-	1	2
Fort Wayne, Ind.	39	29	3	4	3	2	2	TUCSON, ANZ.	12	51	14	5	2	2	. 0
Gary, Ind.	13	4	4	2	3	-	2	PACIFIC	1,870	1,192	387	181	52	54	83
Grand Rapids, Mic	h. 64	47	10	4	-	3	4	Berkeley, Calif.	24	16	2	2	2	2	1
Indianapolis, Ind.	182	111	42	12	7	10	1	Fresno, Calif.	68	45	15	5	1	2	7
Milwaukee Wis	41	21	15	1	2	2	1	Glendale, Calif.	28	40	11	-	3	-	
Peoria III.	41	33	5	3	1	2	2	Long Reach Calif	76	41	23	5	2	5	5
Rockford, III.	47	34	8	5	-	-	1	Los Angeles, Calif.	576	363	122	64	19	4	15
South Bend, Ind.	45	35	5	4	1	-	6	Oakland, Calif.	67	38	19	4	1	5	1
Toledo, Ohio	97	72	17	2	4	2	8	Pasadena, Calif.	10	9	1	÷		-	:
Youngstown, Uhio	59	41	12	5	1	-	1	Portland, Oreg.	130	94	24	5	-	6	4
W N CENTRAL	750	515	135	44	28	29	21	Sacramento, Calif.	152	98	29	17	6	2	10
Des Moines, Iowa	73	44	19	8	1	1	2	San Francisco. Cali	f. 147	80	30	28	4	5	4
Duluth, Minn.	29	24	2	2	1	-	ĩ	San Jose, Calif.	158	95	36	19	3	5	12
Kansas City, Kans.	40	22	11	3	2	2	1	Seattle, Wash	148	97	29	14	5	3	3
Kansas City, Mo.	113	78	22	6	5	2	2	Spokane, Wash	41	31	2	2	1	4	4
Lincoln, Nebr.	38	28	11	10	7	-	2	Tacoma, Wash.	U U U	+ 30	9			-	~
Omaba Nebr	89	64	13	2	2	с 8	2	τοτοι	12,321	8,378	2,301	832	372	433	533
St. Louis. Mo.	144	107	19	7	5	6	-								
St. Paul, Minn.	65	44	14	4	2	1	2								
Wichita, Kans.	68	46	16	1	2	3	4								

*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.

t†Total includes unknown ages.

§ Data not available. Figures are estimates based on average of past 4 weeks

MMWR

Tetanus – Continued

0.39/100,000 in 1947, when national reporting began. The estimated average annual agespecific incidence rates progressively increased by age group, with a sevenfold increase from the 5- to 19-year to 20- to 29-year age group and a ninefold increase from the 20- to 29-year to 60 years and older age group (Table 4).

Case report forms for 234 (92%) patients with onset during these years provided information on demographic characteristics, immunization history, circumstances of injury or other medical condition, and tetanus prophylaxis used in wound management. Extrapolating from 229 patients for whom race was known, the estimated average annual incidence rate for whites was 0.033/100,000 (177 cases); for blacks, 0.059/100,000 (45 cases); and for all other races, 0.040/100,000 (seven cases).

FIGURE 4. Average annual incidence rates * and total cases of tetanus, by state - United States, 1982-1984



*Per 100,000 total population using July 1, 1982, population estimate.

TABLE 4	Average	annual	crude	incidence	rates	of reported	tetanus	cases,*	' by age g	jroup
— United	States,	1982-1	984							

Age (years)	Rates
0-4	0.012
5-19	0.002
20-29	0.014
30-39	0.024
40-49	0.029
50-59	0.047
≥ 60	0.132

*Determined from extrapolating the age distribution of 244 cases in patients with known age to the entire 253 cases reported to *MMWR* and using July 1, 1982, population estimates as denominators.

Tetanus -- Continued

One hundred fifty-nine (71%) of the 224 patients with known ages were 50 years of age or older; six (3%) were 1 month to 19 years of age; and 56 (25%) were 20-49 years of age (Table 5). Three cases of neonatal tetanus were reported (Texas—two; California—one); two of the mothers had no history of prior immunization, and the third had no history of completing primary immunization. All three infants survived. The remainder of this report covers 231 cases of tetanus that occurred among individuals ages 1 month and older.

The case-fatality rate was 26% (52% for patients 60 years of age and older and 13% for those under age 60). No deaths occurred among patients under 30 years of age.

Eleven (5%) of the 231 patients had received at least a primary series of tetanus toxoid* before onset (Table 6). Of these, three received their third dose of tetanus toxoid as part of wound prophylaxis, and three had not received a dose within the preceding 10 years. Two hundred fifteen patients (93%) had received fewer than two doses of toxoid before onset of illness or had received an unknown number of doses.

*Primary immunization against tetanus consists of three doses of tetanus toxoid assuming at least 1 month between doses 1 and 2 and at least 6 months between doses 2 and 3 (1).

Age (years)	No.	(%)
0-4	5*	(2.2)
5-19	4	(1.8)
20-29	16	(7.1)
30-39	21	(9.4)
40-49	19	(8.5)
50-59	27	(12.1)
60-69	49	(21.9)
70-79	51	(22.8)
≥ 80	32	(14.3)
Subtotal	224	(100.1)
Unknown	10	
Total	234	

TABLE 5. Age distribution of tetanus patients reported with supplementary information - United States, 1982-1984

*Includes three cases in neonates.

TABLE 6. Immunization status in reported non-neonatal tetanus cases — United States, 1982-1984

Immunization status	No.	(%)
0 dose	56	(24.2)
1 dose	37	(16.0)
2 doses	5	(2.2)
3 doses	5*	(2.2)
≥4 doses	6	(2.6)
Unknown no. of doses	53	(22.9)
Unknown status	69	(29.9)
Total	231	(100.0)

*Includes three patients who received dose 3 as part of wound management.

MMWR

Tetanus – Continued

Tetanus occurred after an identified acute injury in 166 cases (72%). The most frequently reported acute injuries were puncture wounds (37%) and lacerations (35%). Injuries incurred indoors accounted for 41% of acute wounds; gardening and other outdoor injuries, for 39%; animal-associated injuries and major trauma, for 4% each; and other and unknown circumstances, for 12%. The median incubation period for the 142 tetanus patients with known interval between acute injury and onset was 8 days. One hundred thirty-one (92%) had an incubation period of 14 days or less. For 18 (13%) patients, the interval between wound and onset was reported to be 3 days or less. Tetanus toxoid was given as prophylaxis in wound management to 42 patients (25%) with acute wounds; two patients also received tetanus immune globulin (TIG). Of the 42 patients, 34 (81%) received prophylaxis within 3 days of the injury.

Fifty-six patients had acute wounds severe enough to require debridement after injury but before onset of tetanus. Based on the current recommendations of the Immunization Practices Advisory Committee (ACIP) for wound management (Table 7) (1), 55 of these patients were candidates for both Tetanus and Diphtheria Toxoids (Td) and TIG; none received TIG, and 22 (40%) received Td in the course of wound management. One patient was a candidate for Td only but did not receive tetanus toxoid.

Forty-eight cases (21%) were associated with chronic wounds or underlying medical conditions, such as skin ulcers, abscesses, or gangrene; a history of parenteral drug abuse was the only associated medical condition reported for five (2%) patients. A known acute injury, a chronic wound, or any other preexisting medical condition was not reported for 17 (7%) patients.

Reported by Div of Immunization, Center for Prevention Svcs, CDC.

Editorial Note: Following a steady decline in the average annual crude incidence rate of tetanus between 1947 and 1976, the rate has not changed substantially (Figure 5). The decline results both from immunization and careful wound management, since naturally acquired immunity against tetanus is undocumented in the United States. However, tetanus is a continuing health burden and has a high case-fatality ratio, primarily among the unimmunized and inadequately immunized. Approximately 95% of patients reported with tetanus during 1982-1984 had not received a primary series of tetanus toxoid. Vaccination with a primary series of three doses of tetanus toxoid and booster doses every 10 years is highly effective in

History of adsorbed tetanus toxoid	Clean, minor wounds		All other wounds [†]	
	τd§	TIG	τd [§] τις	
Unknown or < three doses	Yes	No	Yes Yes	
≥ three doses ¶	No**	Νο	No ^{††} No	

TABLE 7. Summary guide to tetanus prophylaxis in routine wound management — United States, 1985*

*ACIP. Diphtheria, tetanus and pertussis: guidelines for vaccine prophylaxis and other preventive measures. MMWR 1985;34:405-14, 419-26.

[†]Such as, but not limited to, wounds contaminated with dirt, feces, soil, saliva, etc.; puncture wounds; avulsions; and wounds resulting from missiles, crushing, burns, and frostbite.

[§]For children less than 7 years old; DTP (DT, if pertussis vaccine is contraindicated) is preferred to tetanus toxoid alone. For persons 7 years old and older, Td is preferred to tetanus toxoid alone.

[¶] If only three doses of *fluid* toxoid have been received, then a fourth dose of toxoid, preferably an adsorbed toxoid, should be given.

**Yes, if more than 10 years since last dose.

^{+†}Yes, if more than 5 years since last dose. (More frequent boosters are not needed and can accentuate side effects.)

Tetanus - Continued

preventing tetanus (2). Single-antigen tetanus toxoid is not recommended for use in routine immunization or in general wound management. The recommended preparation for individuals 7 years of age and older is Tetanus and Diphtheria Toxoids Adsorbed (For Adult Use) (Td). The recommended preparation for children before the seventh birthday is Diphtheria and Tetanus Toxoids and Pertussis Vaccine (DTP); Diphtheria and Tetanus Toxoids (For Pediatric Use) (DT) is recommended for children before the seventh birthday for whom pertussis antigen is contraindicated (1).

Tetanus cases are most frequently associated with acute wounds; most of these patients did not receive tetanus prophylaxis following the wound. It is uncertain what proportion of patients sought care for their wounds. Among tetanus patients in whom the associated wound was debrided, health-care contact did not result in the use of recommended Td/TIG. Underprophylaxis may have occurred in other tetanus patients who sought care (8). Primary immunization and routine maintenance of an up-to-date immunization status is necessary to prevent tetanus that is not associated with acute wounds or that occurs in persons who do not seek medical care for their wounds. Routine use of tetanus toxoid-containing preparations would also eliminate the need for, or simplify, tetanus prophylaxis in wound management for a given individual.

The relative absence of tetanus among persons 5-19 years of age reflects the success of the U.S. childhood vaccination program. Forty-seven states and the District of Columbia require primary immunization against tetanus for entry into school. Annual nationwide surveys indicate over 95% of children entering school since 1980 had received a primary series of tetanus immunizations. However, immunity levels in older populations are lower. In particular, serosurveys done since 1977 indicated that 49%-66% of persons 60 years of age or older lacked protective levels of circulating antitoxin antibody against tetanus (*3-5*). Expanded efforts to ensure that vaccination against tetanus is up-to-date in individuals of all ages could





*National reporting began.

MMWR

Tetanus – Continued

reduce further the remaining burden of tetanus in the United States. Efforts need to be directed primarily towards older adults, especially those 50 years of age and older who account for over 70% of current cases. One method to ensure adequate protection is to routinely provide booster doses of Td at mid-decade ages, i.e., 15 years, 25 years, 35 years, etc. Td is the only universally recommended immunization for individuals of all ages. As with tetanus, a substantial proportion of the remaining morbidity and mortality from other vaccine-preventable diseases now occurs among older adolescents and adults. The ACIP and the American College of Physicians have published recommendations for immunization of adults (6, 7). All persons providing health care to older adolescents and adults should review the immunization status of patients and provide tetanus and diphtheria toxoids and, when indicated, measles, rubella, influenza, pneumococcal, and hepatitis B vaccines to persons found to be inadequately immunized.

References

- 1. ACIP. Diphtheria, tetanus, and pertussis: guidelines for vaccine prophylaxis and other preventive measures. MMWR 1985;34:405-14, 419-26.
- 2. Edsall G. Specific prophylaxis of tetanus. JAMA 1959;171:417-27.
- Ruben FL, Nagel J, Fireman P. Antitoxin responses in the elderly to tetanus-diphtheria (TD) immunization. Am J Epidemiol 1978;108:145-9.
- Crossley K, Irvine P, Warren JB, Lee BK, Mead K. Tetanus and diphtheria immunity in urban Minnesota adults. JAMA 1979;242:2298-3000.
- 5. Weiss BP, Strassburg MA, Feeley JC. Tetanus and diphtheria immunity in an elderly population in Los Angeles County. Am J Public Health 1983;73:802-4.
- 6. ACIP. Adult immunization. MMWR 1985;33:1S-68S.
- 7. Committee on Immunization, American College of Physicians. Guide for adult immunization. Philadelphia, Pennsylvania: American College of Physicians, 1985.
- 8. Brand DA, Acampora D, Gottlieb LD, Glancy KE, Frazier WH. Adequacy of antitetanus prophylaxis in six hospital emergency rooms. N Engl J Med 1983;309:636-40.





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.

Director, Centers for Disease ControlEditor Pro TemJames O. Mason, M.D., Dr.P.H.Janet B. Arrowsmith, M.D.Director, Epidemiology Program OfficeAssistant EditorCarl W. Tyler, Jr., M.D.Karen L. Foster, M.A.

DU.S. Government Printing Office: 1985-746-149/21019 Region IV

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service Centers for Disease Control Atlanta GA 30333

Official Business Penalty for Private Use \$300



Postage and Fees Paid U.S. Dept. of H.H.S. HHS 396

Х

S #HCRH NEWV75 8129 DR VERNE F NEWHOUSE VIRCLOGY DIVISION CID 7-814