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Current Trends

Recommendations for Assisting in the Prevention of Perinatal Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus and Acquired Immunodeficiency Syndrome

The information and recommendations in this document are intended to assist health-care providers and state and local health departments in developing procedures to prevent perinatal transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the virus that causes acquired immunodeficiency syndrome (AIDS).

This document contains recommendations for providing counselling and, when indicated, testing for antibody to HTLV-III/LAV for women who are at increased risk of acquiring the virus and who are either pregnant or may become pregnant. It is important that these women know they are at risk, as well as know and understand their HTLV-III/LAV-antibody status, so they can make informed decisions to help prevent perinatally acquired HTLV-III/LAV.

Through counselling, uninfected women can learn how to avoid becoming infected, and infected women can choose to delay pregnancy until more is known about perinatal transmission of the virus. If already pregnant, infected women can be provided information for managing the pregnancy and caring for the child.

Currently available data indicate that most pediatric HTLV-III/LAV infections and AIDS are acquired perinatally from infected women, but additional studies are needed to better quantify the risk of transmission from an infected pregnant woman to the fetus or newborn.

The recommendations below pertain to women. However, men who are HTLV-III/LAV-antibody positive should also be counselled regarding the risks of sexual and perinatal transmission, so they can refer for counselling and testing their sex partners who may be pregnant or considering pregnancy.

BACKGROUND

Pediatric AIDS Cases due to Perinatal Transmission. As of December 1, 1985, 217 (1%) of the 15,172 AIDS cases reported to CDC occurred among children under 13 years of age. Sixty percent of these children are known to have died. These 217 cases represent only the more severe manifestations of HTLV-III/LAV infection. Less severe manifestations, often described as AIDS-related complex (ARC), are not reported to CDC, so the number of children with clinically significant illness attributable to HTLV-III/LAV infection is greater than the reported cases of pediatric AIDS. In addition, a number of infected children are probably asymptomatic.

HTLV-III/LAV — Continued

Of the 217 reported pediatric AIDS patients, 165 (76%) have as their only known risk factor a mother belonging to a group with increased prevalence of HTLV-III/LAV infection. An additional 18% of the pediatric cases are attributable to transfusions of blood or blood products, while risk factor information is missing or incomplete on the remaining 6%. Of the 217 children with AIDS, 48% had mothers who were intravenous (IV) drug abusers; 17% had mothers who were born in Haiti; and 10% had mothers who were sex partners of either IV drug abusers or bisexual men.

Of the patients with perinatally acquired AIDS, 45% resided in New York City, while Florida and New Jersey accounted for an additional 32%.

Mechanisms of Perinatal Transmission. It is believed that HTLV-III/LAV is transmitted from infected women to their fetuses or offspring during pregnancy, during labor and delivery, or perhaps shortly after birth. Transmission of the virus during pregnancy or labor and delivery is demonstrated by two reported AIDS cases occurring in children who had no contact with their infected mothers after birth. One was delivered by Cesarean section (*1,2*).

Transmission of the virus after birth has been implicated in one case of HTLV-III/LAV infection in a child born to a mother reported to have acquired the infection from a postpartum blood transfusion. Since she breastfed the child for 6 weeks, the authors suggested breastfeeding as the possible mode of transmission (*3*). Recently, HTLV-III/LAV has been isolated from the breast milk of infected women (*4*).

Risk of Perinatal Transmission from Infected Mothers. The rate of perinatal transmission of HTLV-III/LAV from infected pregnant women is unknown; however, available data suggest a high rate. In one study of 20 infants born to infected mothers who had already delivered one infant with AIDS, 13 (65%) had serologic and/or clinical evidence of infection with HTLV-III/LAV several months after birth (*5,6*). Since these women were selected on the basis of having previously transmitted HTLV-III/LAV perinatally, this study may overestimate the average risk of transmission for all infected pregnant women.

Perinatal transmission from an infected mother to her newborn is not inevitable. Of three children born to women who became infected with HTLV-III/LAV by artificial insemination from an infected donor, all were in good health and negative for antibody to the virus more than 1 year after birth (*7*). Another child, born to a woman who was already pregnant at the time of AIDS diagnosis and was demonstrated to be viremic, was seronegative, culture negative, and healthy at birth and at 4 months of age (*8*). In a retrospective study evaluating nine children under 5 years of age whose mothers were later diagnosed with AIDS, two (22%) had antibody to HTLV-III/LAV (*9*). The infection status of these women during pregnancy was unknown.

In these studies, the rate of transmission ranged from 0% (0/3) to 65% (13/20). Additional studies are needed to better define the rate of transmission and variables associated with it.

Risk of Illness among Infected Pregnant Women. Pregnancy is associated with suppression of cell-mediated immunity and increased susceptibility to some infections (*10*). The T-helper to T-suppressor ratio is decreased during normal pregnancy, being lowest in the third trimester, and returns to normal approximately 3 months postpartum (*10*). It is not known whether pregnancy increases an infected woman's risk of developing AIDS or ARC, but one study suggests it does (*6*). Fifteen infected women who were well at time of delivery were followed an average of 30 months after the births of their children. Five (33%) subsequently developed AIDS; seven (47%) developed AIDS-related conditions; and only three (20%) remained asymptomatic. These results may not apply to all infected pregnant women, but they do suggest an increased likelihood of developing disease when an HTLV-III/LAV infection occurs in association with pregnancy.

HTLV-III/LAV – Continued

Prevalence of HTLV-III/LAV Infection. Counselling and testing for antibody to HTLV-III/LAV, when indicated, to reduce perinatal transmission of AIDS will be most beneficial in populations of women with increased prevalence of the virus (Table 1). These include: women who have used drugs intravenously for nonmedical purposes; women who were born in countries where heterosexual transmission is thought to play a major role (*11,12*); women who have engaged in prostitution; and women who are or have been sex partners of men who abuse IV drugs, are bisexual, have hemophilia, were born in countries where heterosexual transmission is thought to play a major role (*11,12*), or have evidence of HTLV-III/LAV infection.

The prevalence of antibody to HTLV-III/LAV in U.S. populations of men and women ranges from less than 0.01% in female blood donors to as high as 74% in men with hemophilia (*13-15*). Among heterosexual IV drug abusers, the prevalence of HTLV-III/LAV infection ranges from 2% to 59% in various geographic areas (*16,17*). Seroprevalence among the heterosexual partners of persons at increased risk for AIDS varies from 10% in female partners of asymptomatic, seropositive hemophilia patients to 71% in the female partners of men with AIDS or ARC (*18-20*). Among prostitutes, the HTLV-III/LAV antibody prevalence varies from 5% to 40%, depending on geographic area, with most of the women with positive tests relating histories of IV drug abuse (*21*). Among female blood donors in Atlanta, Georgia, who

TABLE 1. Prevalence of HTLV-III/LAV antibody in heterosexual populations — United States

Populations	Location	No. tested	Prevalence (%)
Intravenous drug abusers (*16,17*)	New York City	274	59
	NJ* < 5 miles from NYC†	204	56
	NJ 5-10 miles from NYC	124	43
	NJ > 100 miles from NYC	55	2
	San Francisco	53	9
Persons with hemophilia (*13,14*)			
Factor VIII concentrate recipients		234	74
Factor IX concentrate recipients		36	39
Cryoprecipitate only recipients		15	40
Female prostitutes (*21*)	Seattle, Washington	92	5
	Miami, Florida	25	40
Female sex partners of men with AIDS or ARC		7	71
(two separate studies) (*19,20*)		42	47
Female sex partners of men with asymptomatic HTLV-III/LAV infection (*18*)		21	10
Haitians (*12*)	New York City	97	4
	Miami, Florida	129	8
Female blood donors (*15*)	Atlanta, Georgia	28,354	0.01

*New Jersey.

†New York City.

HTLV-III/LAV — Continued

denied belonging to high-risk groups, 0.01% had repeatedly reactive enzyme-linked immunosorbent assays (ELISAs) followed by reactive Western blot tests (*15*).

Commercially available tests to detect antibody to HTLV-III/LAV are ELISAs using antigens derived from whole disrupted HTLV-III/LAV. When the ELISA is reactive on initial testing, it is standard procedure to repeat the test on the same specimen. Repeatedly reactive tests are highly sensitive and specific for antibody to HTLV-III/LAV. However, when the ELISA is used to screen populations in which the prevalence of infection is very low (such as blood donors or women not in high-risk groups), the proportion of repeatedly reactive results that are falsely positive will be higher. For that reason, an additional test, such as a Western blot, is recommended following repeatedly reactive ELISA results, especially in low-prevalence populations. In populations with high prevalence of infection (e.g. homosexual men or IV drug abusers), most repeatedly reactive ELISAs are reactive by Western blot or another test. For example, among 109 IV drug abusers whose sera were repeatedly reactive by ELISA, over 85% were reactive by Western blot (*22*). In contrast, in a low-prevalence population of 69 female blood donors whose sera were repeatedly reactive by ELISA, only 5% were reactive by Western blot (*15*).

Due to the seriousness of the implications of HTLV-III/LAV-antibody reactivity, it is recommended that repeatedly reactive ELISAs be followed by an additional test, such as the Western blot. Women with sera repeatedly reactive by ELISA and reactive by Western blot should have a thorough medical evaluation. HTLV-III/LAV has been isolated from a single specimen in 67%-95% of persons with specific antibody (*23,24*). Because infection has been demonstrated in asymptomatic persons, the presence of specific antibody should be considered presumptive evidence of current infection and infectiousness.

RECOMMENDATIONS

Women Who Should be Offered Counselling and Testing. *Counselling services and testing for antibody to HTLV-III/LAV should be offered to pregnant women and women who may become pregnant in the following groups*: (1) those who have evidence of HTLV-III/LAV infection; (2) those who have used drugs intravenously for nonmedical purposes; (3) those who were born in countries where heterosexual transmission is thought to play a major role (*11,12*); (4) those who have engaged in prostitution; (5) those who are or have been sex partners of: IV drug abusers, bisexual men, men with hemophilia, men who were born in countries where heterosexual transmission is thought to play a major role (*11,12*), or men who otherwise have evidence of HTLV-III/LAV infection. If data become available to show that HTLV-III/LAV-antibody prevalence is increased in other groups or settings, counselling and testing programs should be extended to include them. Routine counselling and testing of women who are not included in the above-mentioned groups is not recommended due to low prevalence of infection and concern about interpretation of test results in a low-prevalence population. However if a woman requests it, the service should be provided in accordance with these recommendations.

Settings for Offering Counselling and Testing. Counselling and testing for antibody to HTLV-III/LAV to prevent perinatal transmission is recommended in the setting of any medical service in which women at increased risk are commonly encountered. These include services for treating IV drug abuse (i.e., detoxification and methadone maintenance), comprehensive hemophilia treatment centers, sexually transmitted disease clinics, and clinics that serve female prostitutes. In addition, services related to reproduction, such as family planning and infertility services, gynecologic, premarital, or preconceptual examinations, and prenatal and

HTLV-III/LAV – Continued

obstetric services should also consider offering counselling and testing if high-risk women are seen at these facilities. Testing for antibody to HTLV-III/LAV should be performed with the woman's consent after counselling is provided regarding risk factors for infection, the interpretation of test results, the risks of transmission, and the possible increased likelihood of disease among women infected with HTLV-III/LAV in association with pregnancy. The counselling and testing must be conducted in an environment in which confidentiality can be assured. In settings where confidential counselling and testing cannot be assured, information should be provided and referrals made to appropriate facilities.

Frequency of Testing. Detectable antibodies to HTLV-III/LAV may not develop until 2-4 months after exposure. This, and whether the woman is continuously exposed, should be taken into account when considering the need for, and frequency of, repeat testing. High-risk women should be offered counselling and testing before they become pregnant. During pregnancy, counselling and testing should be offered as soon as the woman is known to be pregnant. If the initial test is negative, repeat testing may be indicated near delivery to aid in the clinical management of the pregnant woman and newborn. If this final test is negative and the mother's risk of exposure no longer exists, she may safely consider breastfeeding the child, and management of the child need not include the same concerns that would be appropriate if the woman had had a positive test or if she were at high risk and had not been tested at all.

Counselling Women with Positive Results. Women with virologic or serologic evidence of HTLV-III/LAV infection should be counselled regarding their own risk of AIDS and the risk of perinatal and sexual transmission of HTLV-III/LAV. Infected women should be counselled to refer their sex partners for counselling and testing. If the partners of these women are not infected, both members of the couple should be counselled on how they may modify their sexual practices to reduce the risk of HTLV-III/LAV transmission to the uninfected partner. In addition, the couple should be told not to donate blood, organs, or sperm and should be discouraged from using IV drugs and advised against sharing needles and syringes. When seeking medical or dental care for intercurrent illness, they should inform those responsible for their care of their positive antibody status so appropriate evaluation can be undertaken. Recommendations for providing information and advice to individuals infected with HTLV-III/LAV have been published (*25*).

Infected women should be advised to consider delaying pregnancy until more is known about perinatal transmission of the virus. Pregnant infected women may require additional medical and social support services due to an enhanced risk of opportunistic infections and psychosocial difficulties during and after pregnancy. Obstetric-care providers should be alert to signs and symptoms of HTLV-III/LAV and related opportunistic infections in these pregnant women and to the need for specialized medical care.

HTLV-III/LAV-infected women should be advised against breastfeeding to avoid postnatal transmission to a child who may not yet be infected. The child should receive follow-up pediatric evaluations to determine whether he/she has HTLV-III/LAV infection, and to diagnose and treat promptly any diseases that may be secondary to HTLV-III/LAV infection. Recommendations for educating and providing foster care for infected children have been published (*26*).

Counselling Women with Negative Test Results. A negative ELISA for HTLV-III/LAV antibody in women who have no clinical or laboratory evidence of HTLV-III/LAV infection is evidence that they have probably not been infected. However, uninfected women who have sex

HTLV-III/LAV – Continued

partners with evidence of HTLV-III/LAV infection or with an increased risk of becoming infected should be informed that sexual intercourse increases their risk of infection. These women should be informed of the risks associated with pregnancy if they become infected and advised to consider delaying pregnancy until more is known about perinatal transmission of the virus or until they are no longer considered to be at risk for acquiring the virus. In addition to preventing pregnancy, the consistent and proper use of condoms can offer some protection against HTLV-III/LAV infection.

High-risk women, even if seronegative, should be told not to donate blood or organs. To decrease their risk of becoming infected, IV drug abusers should be encouraged to seek treatment for their drug abuse. Persons counselling IV drug abusers should know that IV drug abuse is often strongly ingrained and compulsive. Despite educational efforts and encouragement for treatment, some addicts will continue to abuse drugs or relapse after treatment. If drug abuse continues, they should be advised not to share needles or syringes and to use only sterile equipment.

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

Disease	48th Week Ending			Cumulative, 48th Week Ending		
	Nov. 30, 1985	Dec. 1, 1984	Median 1980-1984	Nov. 30, 1985	Dec. 1 1984	Median 1980-1984
Acquired Immunodeficiency Syndrome (AIDS)	111	138	N	7,316	3,911	N
Aseptic meningitis	158	227	222	9,467	7,655	8,954
Encephalitis: Primary (arthropod-borne & unspec.)	7	22	23	1,173	1,098	1,430
Post-infectious	1	3	2	109	106	83
Gonorrhea: Civilian	10,908	15,535	16,913	775,020	777,626	882,338
Military	125	240	263	16,719	19,545	24,044
Hepatitis: Type A	497	455	476	21,040	19,907	21,145
Type B	505	550	486	24,188	23,993	20,172
Non A, Non B	58	80	N	3,721	3,520	N
Unspecified	105	103	168	5,286	4,746	7,986
Legionellosis	16	17	N	615	641	N
Leprosy	4	7	7	332	217	217
Malaria	12	10	21	935	921	985
Measles: Total*	14	15	15	2,628	2,516	2,516
Indigenous	14	12	N	2,191	2,222	N
Imported	-	3	N	437	294	N
Meningococcal infections: Total	38	55	49	2,165	2,461	2,508
Civilian	38	55	49	2,161	2,457	2,493
Military	-	-	-	4	4	14
Mumps	39	67	81	2,655	2,722	4,267
Pertussis	55	36	36	3,039	2,150	1,624
Rubella (German measles)	3	11	21	590	707	1,966
Syphilis (Primary & Secondary): Civilian	320	511	521	23,485	25,709	28,595
Military	3	3	5	132	271	351
Toxic Shock syndrome	6	5	N	324	436	N
Tuberculosis	320	499	515	19,621	19,558	23,485
Tularemia	2	4	4	156	276	260
Typhoid fever	6	4	8	350	345	428
Typhus fever, tick-borne (RMSF)	4	9	5	675	821	1,087
Rabies, animal	58	90	90	4,896	5,009	5,831

TABLE II. Notifiable diseases of low frequency, United States

	Cum 1985		Cum 1985
Anthrax	-	Leptospirosis	33
Botulism: Foodborne (Alaska 8)	51	Plague	16
Infant (Idaho 1)	60	Poliomyelitis: Total	5
Other	1	Paralytic	5
Brucellosis	125	Psittacosis (Ariz. 1)	102
Cholera	3	Rabies, human	1
Congenital rubella syndrome	-	Tetanus (Pa. 1)	67
Congenital syphilis, ages < 1 year	149	Trichinosis (Upstate N.Y. 1)	56
Diphtheria	2	Typhus fever, flea-borne (endemic, murine)	25

*There were no cases of internationally imported measles reported for this week.

TABLE III. Cases of specified notifiable diseases, United States, weeks ending November 30, 1985 and December 1, 1984 (48th 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	7,316	158	1,173	109	775,020	777,626	497	505	58	105	16	332
NEW ENGLAND	251	13	33	-	20,879	21,022	12	25	1	6	-	7
Maine	11	-	-	-	1,067	927	-	-	-	-	-	-
N.H.	3	-	7	-	523	682	-	-	-	-	-	-
Vt.	2	-	-	-	307	356	-	-	-	-	-	-
Mass.	149	6	18	-	8,636	8,924	11	12	1	5	-	7
R.I.	12	-	-	-	1,724	1,531	-	3	-	-	-	-
Conn.	74	7	8	-	8,622	8,602	1	10	-	1	-	-
MID ATLANTIC	2,801	22	144	11	117,363	104,459	44	47	4	3	-	36
Upstate N.Y.	300	12	45	4	16,772	16,753	34	18	2	1	-	1
N.Y. City	1,925	1	16	-	56,466	40,502	-	-	-	-	-	31
N.J.	415	-	28	-	17,856	18,596	4	20	2	1	-	-
Pa.	161	9	55	7	26,269	28,608	6	9	-	1	-	4
E.N. CENTRAL	333	17	342	20	107,001	110,884	17	43	4	5	2	21
Ohio	52	12	139	4	29,345	28,815	9	24	1	-	2	3
Ind.	24	2	66	2	11,479	12,011	3	6	-	2	-	-
Ill.	177	-	53	8	25,109	25,950	1	1	-	-	-	16
Mich.	56	3	63	-	30,751	31,929	4	12	3	3	-	2
Wis.	24	-	21	6	10,317	12,179	-	-	-	-	-	-
W.N. CENTRAL	106	7	75	4	38,249	38,164	9	15	1	1	-	2
Minn.	35	2	36	1	5,649	5,748	3	7	1	-	-	1
Iowa	12	2	28	-	4,114	4,197	-	3	-	1	-	-
Mo.	43	2	-	-	18,473	18,446	-	4	-	-	-	1
N. Dak.	1	-	-	1	254	362	-	-	-	-	-	-
S. Dak.	1	-	-	-	736	920	5	-	-	-	-	-
Nebr.	3	-	5	-	3,258	2,759	-	-	-	-	-	-
Kans.	11	1	6	2	5,765	5,732	1	1	-	-	-	-
S. ATLANTIC	1,157	30	134	44	172,409	196,517	29	83	12	2	2	8
Del.	10	1	8	-	4,125	3,748	3	-	-	-	-	-
Md.	132	4	28	1	27,216	22,237	-	10	2	-	-	1
D.C.	165	-	-	-	14,663	14,088	-	7	-	-	-	-
Va.	94	10	27	7	17,866	18,569	2	11	1	-	-	-
W. Va.	6	-	38	-	2,419	2,483	-	-	-	-	2	-
N.C.	59	5	27	1	33,800	31,770	3	6	2	-	-	2
S.C.	27	1	6	-	20,199	20,023	2	5	-	-	-	-
Ga.	171	-	-	-	-	36,655	5	20	2	-	-	1
Fla.	493	9	-	35	52,121	46,944	14	24	5	2	-	4
E.S. CENTRAL	66	15	37	4	70,881	70,673	3	39	2	2	1	-
Ky.	17	4	17	-	8,111	8,396	1	3	-	-	-	-
Tenn.	16	3	6	-	27,279	28,276	-	18	1	2	-	-
Ala.	26	8	11	4	21,251	21,302	2	12	1	-	1	-
Miss.	7	-	3	-	14,240	12,699	-	6	-	-	-	-
W.S. CENTRAL	519	18	137	2	102,509	104,676	64	47	3	33	4	31
Ark.	10	-	7	1	9,670	9,575	1	4	1	1	-	1
La.	86	-	9	-	19,579	22,803	-	-	-	-	-	7
Okla.	16	2	24	1	11,547	11,579	4	3	-	3	2	-
Tex.	407	16	97	-	61,713	60,719	59	40	2	29	2	23
MOUNTAIN	137	6	57	6	25,958	25,526	76	41	7	11	3	9
Mont.	1	-	-	-	751	965	1	-	-	1	-	-
Idaho	1	-	-	-	895	1,195	2	-	1	-	-	-
Wyo.	-	-	1	-	593	674	-	1	-	-	1	-
Colo.	45	1	23	2	7,553	7,317	15	10	2	4	-	2
N. Mex.	13	3	3	-	2,879	3,070	7	6	-	-	-	-
Ariz.	52	1	17	-	7,911	7,167	37	12	4	6	-	1
Utah	13	1	10	4	1,260	1,204	9	4	-	-	2	4
Nev.	12	-	3	-	4,116	3,934	5	8	-	-	-	2
PACIFIC	1,946	30	214	18	119,771	105,705	243	165	24	42	4	218
Wash.	108	1	13	1	9,127	8,331	18	13	7	1	-	37
Oreg.	30	-	1	-	5,950	6,109	50	16	3	-	-	4
Calif.	1,787	28	160	17	100,250	86,827	165	135	14	41	4	156
Alaska	3	-	40	-	2,871	2,655	-	1	-	-	-	-
Hawaii	18	1	-	-	1,573	1,783	10	-	-	-	-	21
Guam	1	U	-	-	161	221	U	U	U	U	U	3
P.R.	88	2	7	2	2,912	3,098	1	13	-	1	-	2
V.I.	2	U	-	-	369	487	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 November 30, 1985 and December 1, 1984 (48th 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	935	14	2,191	-	437	2,516	2,165	39	2,655	55	3,039	2,150	3	590	707
NEW ENGLAND	53	-	38	-	88	106	105	5	64	1	205	71	-	12	19
Maine	4	-	-	-	1	-	4	-	6	-	10	4	-	-	1
N.H.	5	-	-	-	-	36	15	-	11	-	112	17	-	2	1
Vt.	1	-	-	-	-	7	10	-	3	-	3	23	-	-	-
Mass.	25	-	34	-	84	49	21	4	21	1	47	19	-	6	16
R.I.	6	-	-	-	-	-	17	-	15	-	22	4	-	-	-
Conn.	12	-	4	-	3	14	38	1	8	-	11	4	-	4	1
MID ATLANTIC	150	-	193	-	38	173	381	6	313	3	240	191	-	226	226
Upstate N.Y.	49	-	72	-	13	52	152	5	166	2	115	103	-	18	99
N.Y. City	59	-	67	-	12	109	65	-	33	-	27	16	-	185	103
N.J.	18	-	17	-	10	7	59	-	48	-	11	13	-	9	23
Pa.	24	-	37	-	3	5	105	1	66	1	87	59	-	14	1
E.N. CENTRAL	60	-	443	-	90	697	375	5	916	8	712	490	-	34	100
Ohio	11	-	-	-	54	9	117	-	277	4	117	75	-	-	2
Ind.	4	-	55	-	2	3	49	-	37	-	201	231	-	1	5
Ill.	21	-	293	-	10	181	84	2	203	-	56	27	-	16	63
Mich.	18	-	37	-	23	464	97	3	313	1	48	31	-	16	22
Wis.	6	-	58	-	1	40	28	-	86	3	290	126	-	1	8
W.N. CENTRAL	33	-	2	-	10	58	107	1	84	4	233	124	-	19	39
Minn.	16	-	-	-	6	47	27	-	1	-	117	16	-	2	4
Iowa	2	-	-	-	-	-	10	1	17	-	31	13	-	1	1
Mo.	5	-	1	-	2	6	42	-	15	1	31	20	-	7	-
N. Dak.	2	-	-	-	2	-	5	-	4	-	10	-	-	2	3
S. Dak.	1	-	-	-	-	-	3	-	-	1	5	9	-	-	-
Nebr.	1	-	-	-	-	-	9	-	3	2	10	12	-	-	-
Kans.	6	-	1	-	-	5	11	-	44	-	29	54	-	7	31
S. ATLANTIC	106	8	289	-	30	66	417	3	263	20	399	217	-	56	28
Del.	-	-	-	-	-	-	11	-	1	-	2	2	-	2	2
Md.	26	-	106	-	9	22	56	-	33	16	173	61	-	6	1
D.C.	8	-	9	-	1	8	7	-	-	-	1	-	-	-	-
Va.	20	-	21	-	7	5	51	-	47	2	21	19	-	2	1
W. Va.	2	-	31	-	2	-	8	1	73	-	4	11	-	9	-
N.C.	9	-	9	-	-	1	56	-	19	1	34	35	-	1	-
S.C.	-	-	-	-	3	1	34	-	11	-	2	2	-	3	-
Ga.	10	-	8	-	-	2	75	-	28	-	93	17	-	4	2
Fla.	31	8	105	-	8	27	119	2	51	1	69	70	-	29	22
E.S. CENTRAL	11	-	-	-	7	6	96	-	30	3	67	14	-	3	12
Ky.	4	-	-	-	5	1	9	-	8	-	8	2	-	3	6
Tenn.	-	-	-	-	1	2	37	-	18	1	26	7	-	-	-
Ala.	6	-	-	-	-	3	26	-	1	2	26	1	-	-	3
Miss.	1	-	-	-	1	-	24	-	3	-	7	4	-	-	3
W.S. CENTRAL	93	4	425	-	15	621	185	8	302	9	527	334	2	41	66
Ark.	3	-	-	-	-	8	19	-	7	-	14	22	-	1	3
La.	1	-	42	-	-	8	25	-	2	-	17	10	-	-	-
Okla.	7	-	-	-	1	8	33	N	N	-	160	243	-	1	-
Tex.	82	4	383	-	14	597	108	8	293	9	336	59	2	39	63
MOUNTAIN	52	2	499	-	51	145	97	7	241	2	215	122	-	5	22
Mont.	-	-	122	-	17	-	11	-	12	-	9	19	-	-	-
Idaho	3	-	126	-	18	23	5	-	9	1	9	7	-	1	1
Wyo.	1	-	5	-	-	-	6	-	2	-	1	6	-	-	3
Colo.	15	2	8	-	7	6	25	1	26	1	90	45	-	-	2
N. Mex.	15	-	1	-	5	88	13	N	N	-	13	12	-	2	1
Ariz.	11	-	237	-	4	1	22	6	121	-	40	24	-	1	4
Utah	2	-	-	-	-	27	9	-	6	-	53	7	-	-	7
Nev.	5	-	-	-	-	-	6	-	65	-	-	2	-	1	4
PACIFIC	377	-	302	-	108	644	402	4	442	5	441	587	1	194	195
Wash.	23	-	90	-	39	154	66	-	35	2	82	322	-	14	1
Oreg.	14	-	4	-	1	-	35	N	N	1	50	30	-	2	2
Calif.	321	-	190	-	63	327	280	4	379	2	262	157	1	135	185
Alaska	2	-	-	-	-	-	9	-	9	-	30	3	-	1	1
Hawaii	17	-	18	-	5	163	12	-	19	-	17	75	-	42	6
Guam	1	U	10	U	1	90	-	U	6	U	-	-	U	2	4
P.R.	-	-	67	-	-	212	14	3	155	2	15	1	-	27	20
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 November 30, 1985 and December 1, 1984 (48th 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	23,485	25,709	6	19,621	19,558	156	350	675 +4	4,896
NEW ENGLAND	547	493	-	663	585	4	14	9	20
Maine	15	10	-	44	30	-	-	-	-
N.H.	38	14	-	20	27	-	1	1	1
Vt.	5	1	-	8	7	-	-	-	1
Mass.	270	277	-	391	319	4	10	6	11
R.I.	17	22	-	50	48	-	-	1	-
Conn.	202	169	-	150	154	-	3	1	7
MID ATLANTIC	3,322	3,455	-	3,499	3,563	2	53	37	591
Upstate N.Y.	244	305	-	600	542	-	14	9	139
N.Y. City	2,004	2,064	-	1,715	1,480	1	27	5	-
N.J.	643	610	-	476	787	1	11	4	39
Pa.	431	476	-	708	754	-	1	19	413
E.N. CENTRAL	908	1,264	-	2,408	2,555	3	43	39 + -	170
Ohio	135	218	-	410	455	-	11	23	28
Ind.	75	126	-	309	315	-	3	5	23
Ill.	414	502	-	1,046	1,065	2	19	9	38
Mich.	224	346	-	509	572	-	8	2	25
Wis.	60	72	-	134	148	1	2	-	56
W.N. CENTRAL	222	334	1	562	595	48	13	42	867
Minn.	42	86	-	120	105	1	6	-	175
Iowa	18	11	1	53	62	-	3	1	142
Mo.	126	170	-	269	295	31	3	7	48
N. Dak.	2	9	-	9	13	-	-	1	128
S. Dak.	6	1	-	31	22	8	-	2	294
Nebr.	6	15	-	12	30	2	1	4	34
Kans.	22	42	-	68	68	6	-	27	46
S. ATLANTIC	5,778	7,514	2	4,033	4,079	6	42	320 +2	1,234
Del.	36	19	-	41	52	1	-	3	1
Md.	416	444	-	362	374	-	11	26	626
D.C.	306	316	-	141	161	-	-	-	-
Va.	282	388	-	406	400	1	3	25	169
W. Va.	25	20	-	102	127	-	1	2	28
N.C.	631	799	1	539	616	4	4	133 2	12
S.C.	743	718	-	489	497	-	3	71	59
Ga.	-	1,311	1	677	637	-	3	48	196
Fla.	3,339	3,499	-	1,276	1,215	-	17	12	143
E.S. CENTRAL	2,039	1,852	-	1,694	1,836	9	5	77 +1	233
Ky.	65	92	-	414	436	-	1	15	34
Tenn.	592	480	-	502	532	7	2	33 1	72
Ala.	611	625	-	499	536	1	2	15	120
Miss.	771	655	-	279	332	1	-	14	7
W.S. CENTRAL	5,673	6,278	1	2,485	2,315	61	32	134 +1	809
Ark.	308	200	-	286	263	36	-	16	136
La.	1,008	1,098	-	352	337	-	1	4	19
Okla.	178	197	-	236	221	19	2	90	103
Tex.	4,179	4,783	1	1,611	1,494	6	29	24 1	551
MOUNTAIN	714	627	-	526	530	15	13	14	437
Mont.	6	3	-	46	17	4	-	6	223
Idaho	7	23	-	25	28	-	-	-	10
Wyo.	13	7	-	7	4	-	-	4	33
Colo.	201	169	-	82	66	• 2	5	2	25
N. Mex.	121	88	-	83	100	2	4	-	12
Ariz.	297	227	-	230	243	4	3	-	119
Utah	9	18	-	17	35	3	1	-	4
Nev.	60	92	-	36	37	-	-	2	11
PACIFIC	4,282	3,892	2	3,751	3,500	8	135	3	535
Wash.	97	141	-	214	184	-	1	-	4
Oreg.	100	106	-	124	141	1	5	-	4
Calif.	4,014	3,566	2	3,141	2,901	4	123	3	524
Alaska	4	6	-	95	74	3	2	-	3
Hawaii	67	73	-	177	200	-	4	-	-
Guam	2	-	U	35	50	-	3	-	-
P.R.	813	733	-	330	359	-	4	-	34
V.I.	3	11	U	1	4	-	52	-	-
Pac. Trust Terr.	13	-	U	16	-	-	-	-	-

U: Unavailable

TABLE IV. Deaths in 121 U.S. cities,* week ending November 30, 1985 (48th Week)

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	489	352	89	28	6	14	48
Boston, Mass.	95	48	30	9	3	5	11
Bridgeport, Conn.	40	29	9	-	1	1	2
Cambridge, Mass.	23	17	3	3	-	-	2
Fall River, Mass.	17	16	-	1	-	-	-
Hartford, Conn.	44	30	9	2	2	1	2
Lowell, Mass.	27	19	7	1	-	-	1
Lynn, Mass.	16	13	3	-	-	-	4
New Bedford, Mass.	20	14	3	2	-	1	3
New Haven, Conn. §	37	35	1	-	-	1	2
Providence, R.I.	47	39	2	4	-	2	6
Somerville, Mass.	2	1	1	-	-	-	-
Springfield, Mass.	41	30	8	2	-	1	7
Waterbury, Conn.	30	22	5	3	-	-	6
Worcester, Mass.	50	39	8	1	..	2	2
MID ATLANTIC	2,309	1,541	488	185	51	44	99
Albany, N.Y.	64	46	13	1	3	1	2
Allentown, Pa.	17	15	2	-	-	-	-
Buffalo, N.Y.	108	74	25	6	-	3	9
Camden, N.J.	28	21	7	-	-	-	1
Elizabeth, N.J.	18	16	2	-	-	-	1
Erie, Pa.†	37	27	9	1	-	-	2
Jersey City, N.J.	40	21	12	6	-	1	-
N.Y. City, N.Y.	1,203	789	234	132	27	21	51
Newark, N.J.	15	8	5	2	-	-	3
Paterson, N.J.	31	14	11	3	-	3	1
Philadelphia, Pa.	297	197	69	14	9	8	13
Pittsburgh, Pa.†	61	40	13	4	4	-	2
Reading, Pa.	33	25	7	-	-	1	2
Rochester, N.Y.	111	74	26	7	4	-	5
Schenectady, N.Y.	38	29	6	1	..	2	1
Scranton, Pa.†	23	17	6	-	..	-	-
Syracuse, N.Y.	100	69	22	4	3	2	1
Trenton, N.J.	27	18	7	-	-	2	-
Utica, N.Y.	27	18	7	1	1	..	3
Yonkers, N.Y.	31	23	5	3	-	-	2
E.N. CENTRAL	1,952	1,383	307	115	66	80	86
Akron, Ohio	31	23	6	1	-	1	1
Canton, Ohio	44	29	10	3	1	1	4
Chicago, Ill.§	553	462	11	26	16	37	16
Cincinnati, Ohio	127	77	32	10	3	5	7
Cleveland, Ohio	157	87	43	13	4	10	4
Columbus, Ohio	132	81	32	12	5	2	7
Dayton, Ohio	83	58	20	2	3	-	2
Detroit, Mich.	155	107	24	14	9	1	1
Evansville, Ind.	35	26	6	1	2	-	2
Fort Wayne, Ind.	26	17	4	2	2	1	1
Gary, Ind.	9	6	1	2	-	-	-
Grand Rapids, Mich.	63	42	15	2	3	1	4
Indianapolis, Ind.	150	89	35	10	7	9	2
Madison, Wis.	35	27	2	3	1	2	4
Milwaukee, Wis.	89	67	12	2	3	5	4
Peoria, Ill.	33	30	3	-	-	-	3
Rockford, Ill.	28	19	4	1	1	3	6
South Bend, Ind.	30	23	5	2	-	-	5
Toledo, Ohio	103	66	26	7	3	1	11
Youngstown, Ohio	69	47	16	2	3	1	2
W.N. CENTRAL	577	397	100	34	24	21	33
Des Moines, Iowa	48	32	10	2	2	2	6
Duluth, Minn.	9	7	1	-	1	-	-
Kansas City, Kans.	37	20	6	4	3	3	4
Kansas City, Mo.	116	85	23	6	1	1	2
Lincoln, Nebr.	28	17	7	3	-	1	1
Minneapolis, Minn.	61	40	4	4	8	5	2
Omaha, Nebr.	59	42	11	2	2	2	4
St. Louis, Mo.	133	100	22	3	2	6	10
St. Paul, Minn.	42	27	9	4	1	1	1
Wichita, Kans.	44	27	7	6	4	-	3
S. ATLANTIC	1,173	713	272	88	35	65	46
Atlanta, Ga.	109	58	31	9	7	4	-
Baltimore, Md.	259	155	50	24	10	20	12
Charlotte, N.C.	74	42	21	6	2	3	6
Jacksonville, Fla.	60	42	15	1	-	2	2
Miami, Fla.	145	89	39	11	2	4	-
Norfolk, Va.	47	24	8	3	4	8	6
Richmond, Va.	59	38	13	4	2	2	4
Savannah, Ga.	51	37	12	1	-	1	3
St. Petersburg, Fla.	91	66	14	5	1	5	4
Tampa, Fla.	57	35	10	6	1	5	3
Washington, D.C.	194	107	53	17	6	11	5
Wilmington, Del.	27	20	6	1	..	..	1
E.S. CENTRAL	613	383	138	30	24	38	37
Birmingham, Ala.	122	71	31	7	6	7	4
Chattanooga, Tenn.	57	45	10	1	1	..	5
Knoxville, Tenn.	75	53	16	3	2	1	3
Louisville, Ky.	101	66	29	3	2	1	12
Memphis, Tenn.	123	70	22	5	4	22	7
Mobile, Ala.	45	28	8	2	5	2	2
Montgomery, Ala.	21	12	6	2	1	..	..
Nashville, Tenn.	69	38	16	7	3	5	4
W.S. CENTRAL	960	559	232	95	40	34	45
Austin, Tex.	41	25	6	3	2	5	3
Baton Rouge, La.	37	21	8	3	2	3	2
Corpus Christi, Tex.	44	25	10	7	1	1	3
Dallas, Tex.	114	61	27	19	5	2	7
El Paso, Tex.	36	25	8	1	1	1	..
Fort Worth, Tex.	78	40	19	8	8	3	4
Houston, Tex.	291	159	82	27	10	13	4
Little Rock, Ark.	22	14	4	3	..	1	4
New Orleans, La.	77	48	20	7	2	..	1
San Antonio, Tex.	120	70	28	13	6	3	9
Shreveport, La.	48	36	10	1	1	..	5
Tulsa, Okla.	52	35	10	3	2	2	3
MOUNTAIN	565	374	107	50	20	14	40
Albuquerque, N.Mex.	71	45	16	6	1	3	5
Colo. Springs, Colo.	26	18	6	1	..	1	6
Denver, Colo.	92	71	14	6	1	..	7
Las Vegas, Nev.	87	45	26	11	4	1	8
Ogden, Utah	20	12	3	4	1	..	2
Phoenix, Ariz.	89	57	16	8	4	4	4
Pueblo, Colo.	24	19	2	3	-	..	1
Salt Lake City, Utah	54	35	7	7	3	2	..
Tucson, Ariz.	102	72	17	4	6	3	7
PACIFIC	1,719	1,127	317	146	55	66	107
Berkeley, Calif.	23	16	4	3	..	..	2
Fresno, Calif.	90	59	19	7	1	4	10
Glendale, Calif.	15	11	3	-	-	1	1
Honolulu, Hawaii	57	39	13	2	1	2	8
Long Beach, Calif.	89	53	15	9	4	8	14
Los Angeles, Calif.	379	247	67	40	13	6	6
Oakland, Calif.	74	53	12	6	-	3	4
Pasadena, Calif.	14	9	1	-	1	3	..
Portland, Oreg.	136	104	17	8	4	3	8
Sacramento, Calif.	146	95	35	11	2	3	14
San Diego, Calif.	148	95	30	10	4	7	11
San Francisco, Calif.	167	98	35	24	5	5	4
San Jose, Calif.	167	106	33	11	7	10	13
Seattle, Wash.	121	75	20	10	9	7	4
Spokane, Wash.	53	41	6	2	2	2	7
Tacoma, Wash.	40	26	7	3	2	2	1
TOTAL	10,357††	6,829	2,050	771	321	376	541

* 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.

HTLV-III/LAV – Continued

Additional Considerations. These recommendations will be revised as additional information becomes available. It is recognized that provision of the recommended professional counselling, HTLV-III/LAV-antibody testing and associated specialized medical services will take time to implement and may stress available resources, particularly in public facilities, which are most greatly affected. Health-care providers, social-service personnel, and others involved in educating and caring for HTLV-III/LAV-infected persons should be aware of the potential for social isolation and should be sensitive to the need for confidentiality. They should be familiar with federal and state laws, regulations, and policies that protect the confidentiality of clinical data and test results. Each institution should assure that specific mechanisms are in place to protect the confidentiality of all records and to prevent the misuse of information. Anonymous testing would not be appropriate if it prevents adequate counselling and medical follow-up evaluation.

Hospital precautions for managing infected women and infants should be patterned after those for caring for patients with HTLV-III/LAV infection (*27,28*). Additional recommendations will follow.

DEVELOPMENT OF THESE RECOMMENDATIONS

The information and recommendations contained in this document were developed and compiled by CDC and the U.S. Public Health Service in consultation with individuals representing: the Conference of State and Territorial Epidemiologists, the Association of State and Territorial Health Officials, the American Public Health Association, the United States Conference of Local Health Officers, the American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the Planned Parenthood Federation of America, the American Venereal Disease Association, the Division of Maternal and Child Health of the Health Resources and Services Administration, the National Institute on Drug Abuse of the Alcohol, Drug Abuse, and Mental Health Administration, the National Hemophilia Foundation, the Haitian Medical Association, the American Bar Foundation, and the Kennedy Institute of Ethics at Georgetown University. The consultants also included representatives of the departments of health of the areas with the largest number of perinatally transmitted pediatric AIDS cases: New York City, Florida, and New Jersey. These recommendations may not reflect the views of all individual consultants or the organizations they represented.

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Epidemiologic Notes and Reports

Mucuna pruriens-Associated Pruritus — New Jersey

On October 6, 1985, a Paterson, New Jersey, Fire Department ambulance responded to a call reporting two people with severe pruritus. On arrival, the two emergency medical technicians (EMTs) found a Spanish-speaking couple living above a beauty salon who described

Pruritus – Continued

severe itching, which they attributed to "voodoo beans" found in their beds. They displayed several fuzzy bean pods. Soon after their arrival, the EMTs developed pruritus. All four individuals went to an emergency room complaining of itching and skin discomfort. On examination, both members of the couple had erythematous macular rashes on their extremities and bodies; the EMTs had rashes on their arms. There were no respiratory problems. Because of the unknown etiology of the symptoms, two were given epinephrine injections; the others received antihistamines and topical steroid cream. Symptoms resolved within 1-2 hours of treatment. The admitting nurse, who put an arm around one patient, developed a pruritic erythematous area on her inner forearm approximately 20 minutes later. This resolved an hour after washing her skin with soap and water. A policeman who went to the apartment and a worker who collected trash outside the following day also developed itching and received similar emergency-room treatment. Patrons and employees of the shop below and neighbors of the couple had no similar symptoms over the 2-day period.

An industrial hygienist with the local health department went to the site in complete protective gear to look for possible chemical contamination from the beauty salon. Visual inspection and screens for ionizable organic vapors were negative, but he retrieved another bean pod. The botanical samples were sent to Rutgers University, where the plant was identified as *Mucuna pruriens*. Recommended decontamination procedures for the apartment included steam cleaning of all fabrics and rugs, HEPA Vac cleaning of floors and countertops, and destruction of any fabrics that could not be cleaned.

Reported by D Fairbrothers, MD, E Kirby, MD, Rutgers University, New Brunswick, Barnert Memorial Hospital Center, Paterson, RM Lester, PC Wegmann, Paterson Div of Health, F Marshall, WE Parkin, DVM, State Epidemiologist, New Jersey Dept of Health; Div of Field Svcs, Epidemiology Program Office, CDC.

Editorial Note: *Mucuna pruriens*, a legume known from Medieval Latin botanical works with the Latin synonym *Stizolobium pruriens* (*1*), was first described in the English literature in 1804. The plant is variously called cowitch, cowhage (derived from the Hindu name, "kiwach" or "bad rubbing"), kaunch, and pica-pica (*2*); the common names are not specific. It grows wild in the tropics, including India, and tropical islands, including the Bahamas (*3,4*); its range may extend to southern Florida.

Each 10- to 13-cm fruiting pod bears approximately 5,000 barbed, easily detachable spicules measuring 2 mm by 20 μm that cause dermatitis through an inflammatory response, presumably an immediate hypersensitivity reaction. Hairs from dried pods, as in herbarium specimens, remain potent (*5*). The spicules have been sold commercially as itching powder and, at least through 1950, as an oral vermifuge (*1,6*).

In 1955, studies showed that introduction of one spicule through the epidermis with friction or pressure led to a burning itch lasting up to 30 minutes (*1*). Spicules could be removed from the skin by washing or by applying an adhesive tape. Mucunain, a protein with endopeptidase and dipeptidase activity, was identified as the active pruritic agent. The protein was extractable only from spicules using aqueous solutions and could be inactivated by autoclaving, changing the pH, or using a similar denaturing process that did not change the spicule structure. Further investigations confirmed the biochemical nature of the pruritic agent, identified as a thermolabile protein of molecular weight 40,000 (*7*).

Emergency-room personnel should be alert to the possibility that members of some subcultures in this country may be exposed to *Mucuna pruriens*. Pods and contaminated fabrics should be handled with caution. Symptoms resolve spontaneously within several hours, but antihistaminic therapy appears to be effective for faster resolution.

Pruritus – Continued

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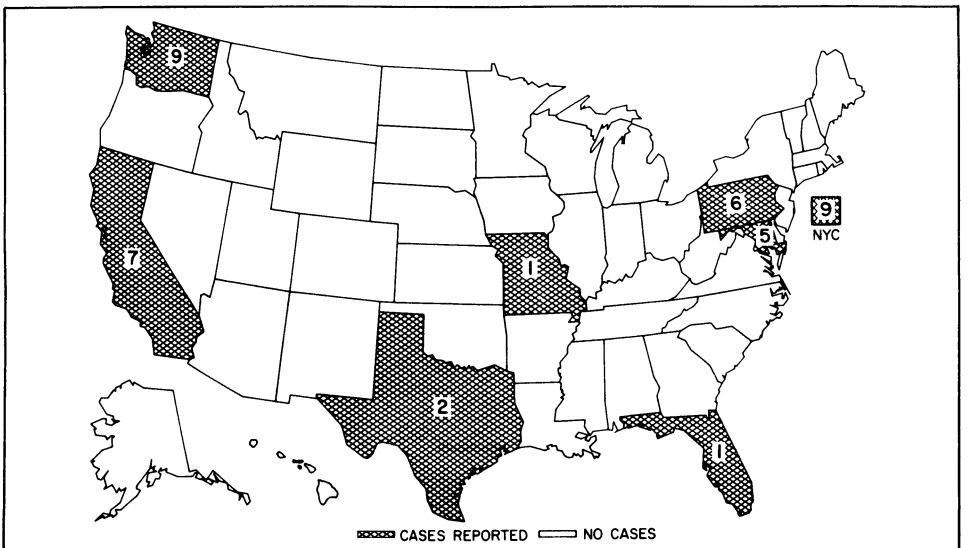
Influenza Outbreaks — Alaska

Alaska state health officials reported outbreaks of influenza-like illness in most areas of the state during the last 2 weeks of November. Although physicians have noted cases in adults, most cases have been reported in schoolchildren. Absentee rates in excess of 20% have been reported in schools located near Anchorage, Fairbanks, and Juneau in association with increased influenza-like illness among students.

Preliminary laboratory testing identified six type A(H3N2) influenza viruses in specimens collected from patients in Anchorage and Fairbanks, where sporadic influenza was reported from late September to mid-October. Laboratory identification of viral isolates from the recent outbreaks is pending.

Reported by D Ritter, L Curtin, Northern Regional Laboratory, JP Middaugh, MD, State Epidemiologist, Div of Public Health, Alaska Dept of Health and Social Svcs; Div of Field Svcs, Epidemiology Program Office, Influenza Br, Div of Viral Diseases, Center for Infectious Diseases, CDC.

FIGURE I. Reported measles cases — United States, weeks 44-47, 1985



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The data in this report are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the succeeding Friday.

The editor welcomes accounts of interesting cases, outbreaks, environmental hazards, or other public health problems of current interest to health officials. Such reports and any other matters pertaining to editorial or other textual considerations should be addressed to: ATTN: Editor, *Morbidity and Mortality Weekly Report*, Centers for Disease Control, Atlanta, Georgia 30333.

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