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Perspectives in Disease Prevention and Health Promotion

Alcohol-Related Traffic Fatalities during Christmas and New Year Holidays — United States, 1978-1984

Analyses of data from the Fatal Accident Reporting System (FARS) for 1978-1984 reveal that alcohol-related traffic deaths tend to be higher during the Christmas and New Year holiday periods* than during the year as a whole. Three sets of comparisons were made for the 7 years of data: the absolute number of alcohol-related traffic deaths, the percentage of alcohol-related deaths, and the number of alcohol-related deaths per 24 hours occurring during the two holiday periods and the 12-month periods. A death was considered alcohol-related if at least one driver had a positive blood-alcohol concentration test result† (*1*) or if the investigating officer judged that alcohol was involved.

During the years 1978-1984, the total number of alcohol-related traffic deaths ranged from 17,861 to 21,114 per year. Over these 7 years, both the number of traffic deaths per 24 hours and the proportion of alcohol-related traffic deaths were generally higher for the two holiday periods than for the year as a whole. Both the total number of traffic deaths and the number of alcohol-related traffic deaths per 24 hours for the holidays and the 12-month periods declined from 1980 to 1983. In 1984, the number of alcohol-related traffic deaths increased for both the two holiday periods and the 12-month period; in addition, the proportion

*The holiday periods were defined according to the National Safety Council. For 1979, 1982, and 1984, the holiday periods were 102 hours long; for the remaining years, the holiday periods were 78 hours long.
†Blood alcohol information is available for fewer than half the drivers reported in the FARS.

TABLE 1. Total and alcohol-related traffic deaths per 24 hours, for each 12-month period and the Christmas and New Year holidays — United States, 1978-1984

	12-months			Christmas			New Year		
Year	Total	Alcohol-related	(%)	Total	Alcohol-related	(%)	Total	Alcohol-related	(%)
1978	135	50	(37)	180	81	(45)	146	67	(46)
1979	137	56	(41)	211	97	(46)	148	77	(52)
1980	138	58	(42)	148	68	(46)	145	71	(49)
1981	133	57	(43)	135	62	(46)	140	67	(48)
1982	119	51	(43)	137	63	(46)	113	60	(53)
1983	117	49	(42)	107	45	(42)	106	55	(52)
1984	121	51	(42)	145	77	(53)	114	48	(42)

Traffic Fatalities — Continued

of alcohol-related traffic deaths increased during the Christmas holiday period but not the New Year.

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Editorial Note: The proportion of all traffic deaths that are alcohol-related is generally higher during the holidays than at other times (*2*). Data collected by Iowa, for example, show that the alcohol involvement rate for 1978 through 1983 was 50%-60% for the New Year holiday period and over 60% for the Christmas holiday. In contrast, during 1983, 49% of all Iowa traffic fatalities were alcohol-related (*3*).

The National Institute on Alcohol Abuse and Alcoholism and the National Highway Traffic Safety Administration are collaborating in a public and private, state and federal prevention effort centered around this year's "National Drunk and Drugged Driving Awareness Week," December 15-21, 1985. They have prepared public service announcements for television and radio that will be available for state and local use during the holidays. A similar effort in Maryland has previously been successful in preventing alcohol-related traffic fatalities (*4*).

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Adolescent Sex Offenders — Vermont, 1984

To determine the extent and characteristics of sex offenses committed by adolescents in Vermont, the Vermont Department of Health conducted a survey of caseworkers at the Departments of Social and Rehabilitation Services (the statewide child-protection agency) and Corrections (*1*). The survey collected information on 161 persons, including all those aged 19 or younger who were known by caseworkers in 1984 and were identified as having committed sex offenses. Neither conviction for a sex offense nor adjudication as a delinquent was required for case inclusion. Data were not available to ascertain how representative this subset of sex offenders was of all actual adolescent sex offenders.

Over 92% of the offenders were males, with a median age of 15 years. Median age of female offenders was 13 years. Victims ranged in age from 2 years to 60 years (median 7 years). Offenders victimized persons younger than themselves in 91% of cases. More than two-thirds of the victims were aged 9 years or younger, and nearly half were aged 6 years or younger. Twenty-eight percent of the victims were males. Male offenders victimized females in over 77% of their offenses; female offenders victimized males in 92% of their offenses.

Categorization by type of sex offense was based on invasiveness of the offense. For each offender, the most serious offense known to have been committed was classified. Categories included penetration, oral-genital acts, fondling, and noncontact offenses. The most serious offense classification, penetration, was also the most common (60% of cases). Of these, 53% were penile penetration. As age of offender increased, penetration offenses accounted for a larger proportion of the most serious reported offenses (Figure 1). Of the penetration offenses reported in this study, the largest proportion were committed against the youngest victims.

Ninety-one percent of all known offenses occurred between individuals who were family

Sex Offenders — Continued

members, friends, or acquaintances. Twenty percent occurred between immediate family members; 20%, between extended family members; 51%, between friends or acquaintances; and 9%, between strangers. The most frequent family relationships were brother (offender)/sister (victim), step-brother (offender)/step-sister (victim), and cousins. More penetration offenses occurred against friends/acquaintances than against strangers or family members. However, penetration offenses represented a higher proportion of known offenses against immediate family members than against those in any other relationship category (Figure 2).

The method of coercion was known in 81% of the cases. Nearly 8% of those involved weapon use, and another 5% involved a weapon threat. Physical force was used in 26%, and threatened in 4%. Verbal threats were made in the remaining 57%. Three-quarters of the offenses occurred in a home, most often that of the victim.

Twenty-nine percent of the offenders were either adjudicated delinquent or convicted for a sexual offense. More than 25% of the offenders received no type of treatment; less than 12% received specialized treatment for sex offenses.

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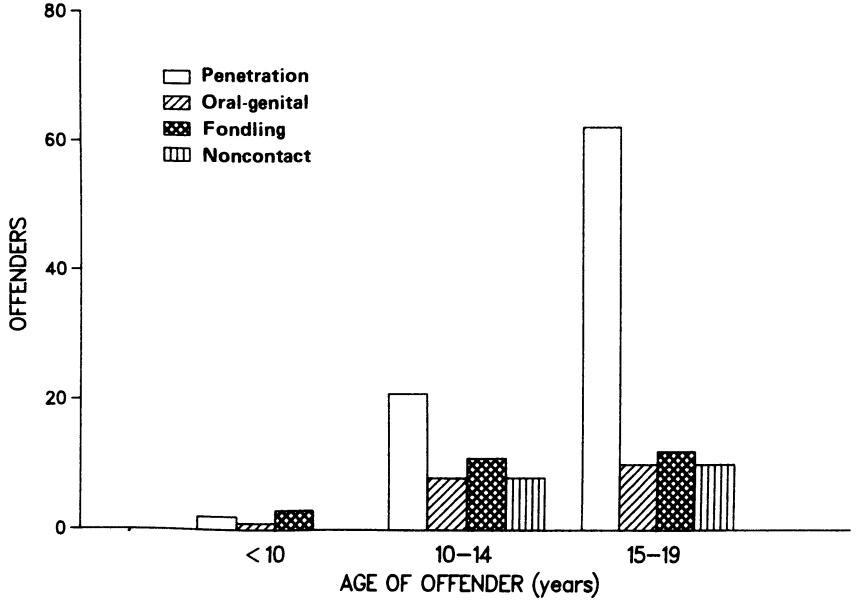
Editorial Note: This study of adolescent sex offenders emphasizes the increasing awareness in the public health community that violence is a serious public health problem and that nonfatal interpersonal violence has far-reaching consequences in terms of morbidity and quality of life. Sexual violence is one type of interpersonal violence that markedly diminishes the quality of life and warrants further attention. While not all sexual offenses involve the threat or use of physical force, they frequently include exploitation by virtue of such things as the relationship between victim and offender or the age difference between them.

Although sexual abuse has traditionally been a focus of criminal justice and is a relatively new public health area, the Vermont Department of Health initiated this study with the cooperation of the Vermont Departments of Corrections and Social and Rehabilitation Services.

FIGURE 1. Number of sex offenders, by age and offense category — Vermont, 1984

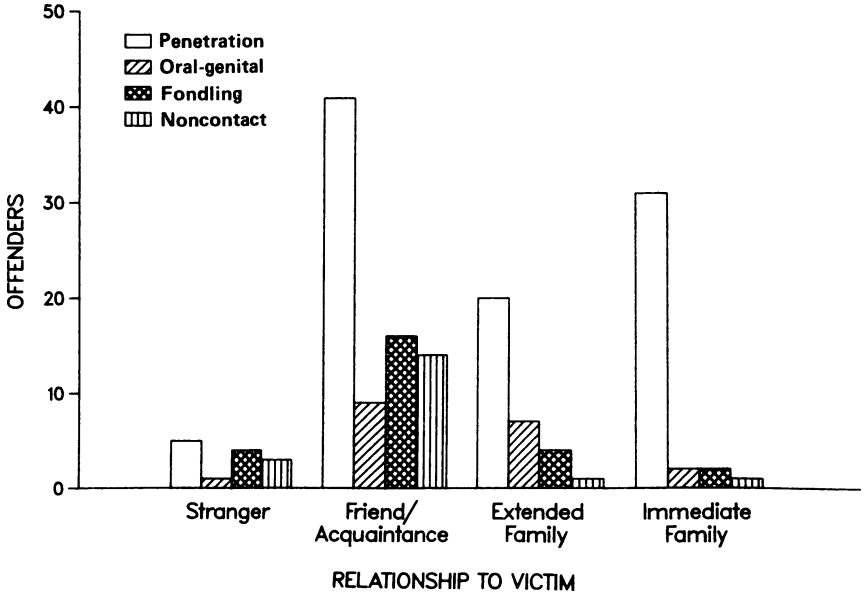


Sex Offenders — Continued

The findings suggest that productive research and prevention efforts might be developed around another relatively new focus for public health—the concentration on perpetrators of abusive behaviors, rather than the traditional concentration on victims. In the past, public health personnel have placed greater emphasis on morbidity and mortality of victims than on information about perpetrators of interpersonal injury. However, research using data sources with perpetrator information may be extremely valuable in developing prevention and intervention strategies. Access to such information can often be facilitated by cooperation with criminal justice and social service agencies.

It should be emphasized that the reported findings in Vermont describe only known adolescent sex offenders, and more specifically, only those known to caseworkers. The same bias affects data from other sources. These studies generally focus on victims rather than offenders, and they are considered to constitute only a small portion of child sex abuse (estimated between 5% and 25%) (*2*). For example, state child-protection agencies have provided the American Humane Association with national data on sexual abuse to children. Police statistics also underestimate the actual volume of sex offenses, because many such victimizations are never reported to police. Nevertheless, descriptions of the known Vermont adolescent sex offenders are consistent with findings from studies of child sex-abuse victims, which found disproportionate perpetration by men (*2,3*). Studies of child sex-abuse victims have also shown that about one-fourth of victimizations occur to children younger than 8 years of age (*2*). Reports of abusive behaviors by sex offenders of all ages differ somewhat from the Vermont findings for adolescent sex offenders. Fondling or groping constitutes the largest reported abuse category (*2*), whereas penetration was most frequently reported in Vermont. Consistent with the Vermont study, American Humane Association research indicates that the children and/or their families know the offenders in 75% of child sex-abuse cases (*3*). Each of these studies may reflect biases such that more information is learned about certain offenders and their offenses than about others. For example, troubled families may be more likely to be in contact with caseworkers; thus sex abuse in such families may be more likely to be known to a caseworker.

FIGURE 2. Number of sex offenders, by relationship to victim — Vermont, 1984



Sex Offenders — Continued

The Vermont report suggests that a multidisciplinary, interagency, coordinated effort is needed to develop a comprehensive statewide strategy for preventing sexual assault. The report notes that, at present, few adolescent sex offenders are charged or convicted, and few receive specialized treatment for sex offenses.

The report also suggests that early intervention with offenders may be effective in preventing child sex abuse. Although a variety of intervention strategies and treatment approaches for offenders have been developed, there has been virtually no evaluation of them (*2*). Adolescent sex offenders are thought by some to be more treatable than adult sex offenders (*4*), but it is also believed that effectiveness depends on specialized assessment and treatment for sex offenses. While more than 225 adolescent sex offender treatment programs and services exist nationwide (*1*), none exist in Vermont. Without specialized treatment resources available, appropriate identification, assessment, and referral are less likely to occur; hence, the pervasiveness of the adolescent sex offender problem is likely to be greatly underestimated.

One study of incarcerated sex offenders found that 80% of the offenders reported being victims of sex abuse as children (*5*). Victim treatment may serve prevention goals by blocking the cycle of repetitive sexual victimization. However, while this is plausible, better studies utilizing well-selected control groups are needed to determine whether sex abusers of children are more likely than nonabusers to have been abuse victims themselves (*6*). Since all abused children do not become abusers, the ways in which victimization interacts with other factors to produce abusers needs to be determined (*6*).

Since many adult sex offenders began committing offenses during adolescence, intervention during the adolescent years might prevent the continuation of the behavior into the adult years. While there is not yet any clear evidence that the early identification/treatment strategy is effective, further examination of this possibility may make an important public health contribution.

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Current Trends

Update: Influenza Activity — United States

Alaska: Alaska reported widespread outbreaks of influenza-like illness for the weeks ending November 30, and December 7, 1985, and was the only state to report outbreaks for either week. Sixteen viruses isolated from patients involved in ongoing outbreaks throughout the state have been preliminarily identified as influenza type A(H3N2).

Hawaii: Influenza type A(H1N1) virus was isolated from a 7-year-old boy on the island of Oahu who had onset of illness around November 20; no further cases have been detected.

New York: Influenza type A(H3N2) virus was isolated from an 11-year-old Rochester boy

Influenza — Continued

with influenza-like illness. This case, with onset in mid-November, was the only one associated with influenza virus, although the laboratory has identified respiratory syncytial virus from several recent cases of febrile respiratory illness in children.

Texas: Influenza type B virus was isolated from a 40-year-old Houston man with typical influenza-like illness. The man had onset of illness November 14; no further cases have been detected.

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Editorial Note: The reports above document the current circulation in the United States of the three major types of influenza virus that have caused outbreaks in recent seasons. Available influenza vaccines include components representing each of these influenza types. Despite

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

Disease	49th Week Ending			Cumulative, 49th Week Ending		
	Dec. 7, 1985	Dec. 8, 1984	Median 1980-1984	Dec. 7, 1985	Dec. 8, 1984	Median 1980-1984
Acquired Immunodeficiency Syndrome (AIDS)	221	110	N	7,538	4,021	N
Aseptic meningitis	187	142	158	9,653	7,797	9,108
Encephalitis: Primary (arthropod-borne & unspec.)	14	29	24	1,188	1,127	1,454
Post-infectious	2	-	2	111	106	87
Gonorrhea: Civilian	14,650	17,957	19,145	792,489	795,583	901,143
Military	192	443	522	16,932	19,988	24,623
Hepatitis: Type A	519	454	565	21,602	20,361	21,746
Type B	518	554	535	24,707	24,547	20,707
Non A, Non B	72	70	N	3,794	3,590	N
Unspecified	112	111	192	5,394	4,857	8,178
Legionellosis	11	7	N	626	648	N
Leprosy	2	6	5	334	223	223
Malaria	22	28	19	956	949	1,002
Measles: Total*	13	14	14	2,682	2,530	2,530
Indigenous	11	13	N	2,238	2,235	N
Imported	2	1	N	444	295	N
Meningococcal infections: Total	69	56	56	2,240	2,517	2,564
Civilian	69	56	56	2,236	2,513	2,549
Military	-	-	-	4	4	14
Mumps	57	58	131	2,720	2,780	4,413
Pertussis	54	29	29	3,115	2,179	1,663
Rubella (German measles)	2	9	33	593	716	2,008
Syphilis (Primary & Secondary): Civilian	353	565	600	23,943	26,274	29,271
Military	-	2	4	132	273	355
Toxic Shock syndrome	4	11	N	328	447	N
Tuberculosis	507	552	529	20,127	20,110	24,038
Tularemia	2	-	4	159	276	264
Typhoid fever	9	12	10	357	357	438
Typhus fever, tick-borne (RMSF)	8	4	4	685	825	1,092
Rabies, animal	105	82	93	5,031	5,091	5,930

TABLE II. Notifiable diseases of low frequency, United States

	Cum. 1985		Cum. 1985
Anthrax	-	Leptospirosis	33
Botulism: Foodborne	51	Plague	16
Infant	60	Poliomyelitis: Total	5
Other	1	Paralytic	5
Brucellosis (Mass. 1, Ala. 1, Calif. 1)	128	Psittacosis (Wash. 1)	103
Cholera	3	Rabies, human	1
Congenital rubella syndrome	-	Tetanus (Tex. 1)	68
Congenital syphilis, ages < 1 year	149	Trichinosis	56
Diphtheria	2	Typhus fever, flea-borne (endemic, murine)	25

*Two of the 13 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 December 7, 1985 and December 8, 1984 (49th 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	7,538	187	1,188	111	792,489	795,583	519	518	72	112	11	334
NEW ENGLAND	259	10	34	-	21,396	21,492	9	36	3	5	-	7
Maine	11	-	-	-	1,085	959	-	3	-	-	-	-
N.H.	3	-	7	-	531	693	-	-	-	-	-	-
Vt.	2	3	-	-	320	363	1	2	-	-	-	-
Mass.	156	5	19	-	8,918	9,201	4	18	1	5	-	7
R.I.	12	-	-	-	1,769	1,552	-	2	-	-	-	-
Conn.	75	2	8	-	8,773	8,724	4	11	2	-	-	-
MID ATLANTIC	2,913	56	147	11	120,370	106,552	47	50	10	11	-	36
Upstate N.Y.	301	17	47	4	17,007	17,199	16	10	4	3	-	1
N.Y. City	2,033	8	16	-	58,145	41,202	1	2	-	-	-	31
N.J.	418	16	29	-	18,360	19,050	5	7	1	7	-	-
Pa.	161	15	55	7	26,858	29,101	25	31	5	1	-	4
E.N. CENTRAL	336	16	345	20	109,065	113,619	21	44	3	5	2	21
Ohio	53	7	140	4	29,629	29,282	9	17	1	2	1	3
Ind.	25	4	68	2	12,186	12,149	7	15	1	3	-	-
Ill.	177	-	53	8	25,293	26,911	1	-	-	-	-	16
Mich.	57	5	63	-	31,466	32,768	4	12	1	-	1	2
Wis.	24	-	21	6	10,491	12,509	-	-	-	-	-	-
W.N. CENTRAL	117	5	77	4	39,374	39,371	32	14	6	3	3	2
Minn.	38	1	36	1	5,778	5,880	9	-	1	2	2	1
Iowa	13	2	29	-	4,173	4,307	-	-	1	-	-	-
Mo.	47	-	-	-	19,153	18,922	2	9	-	-	-	1
N. Dak.	1	-	1	1	262	372	-	-	-	-	-	-
S. Dak.	1	-	-	-	747	944	19	-	1	-	1	-
Nebr.	6	1	5	-	3,340	2,855	2	3	-	1	-	-
Kans.	11	1	6	2	5,921	6,091	-	2	3	-	-	-
S. ATLANTIC	1,170	51	135	46	175,696	201,064	38	109	12	10	5	8
Del.	10	8	8	-	4,210	3,846	1	-	-	-	-	-
Md.	137	5	28	1	27,646	22,790	2	12	6	1	-	1
D.C.	167	1	-	-	14,912	14,352	-	1	-	-	-	-
Va.	99	8	27	8	18,118	19,128	2	3	-	4	2	-
W. Va.	6	1	38	-	2,452	2,549	-	4	1	-	-	-
N.C.	60	10	28	1	34,465	32,456	2	17	2	-	3	2
S.C.	27	2	6	-	20,528	20,537	1	8	-	-	-	-
Ga.	171	2	-	-	-	37,540	3	22	-	1	-	1
Fla.	493	14	-	36	53,365	47,866	27	42	3	4	-	4
E.S. CENTRAL	66	9	38	4	72,189	71,789	8	40	1	1	-	-
Ky.	17	-	17	-	8,111	8,511	3	13	-	-	-	-
Tenn.	16	6	6	-	27,787	28,926	-	18	-	-	-	-
Ala.	26	3	11	4	21,702	21,575	1	1	-	-	-	-
Miss.	7	-	4	-	14,589	12,777	4	8	1	1	-	-
W.S. CENTRAL	529	16	140	2	104,970	107,416	71	60	5	28	1	32
Ark.	10	-	7	1	9,886	9,815	2	2	-	2	-	1
La.	91	7	10	-	19,859	23,269	4	5	1	-	-	7
Okla.	16	2	25	1	11,731	11,817	7	4	2	-	1	-
Tex.	412	7	98	-	63,494	62,515	58	49	2	26	-	24
MOUNTAIN	144	4	57	6	26,626	26,157	42	33	9	5	-	9
Mont.	1	-	-	-	768	971	6	1	-	-	-	-
Idaho	2	-	-	-	929	1,207	8	2	-	-	-	-
Wyo.	-	-	1	-	593	700	-	1	-	1	-	-
Colo.	45	2	23	2	7,715	7,466	1	2	1	1	-	2
N. Mex	14	1	3	-	2,933	3,114	9	9	2	-	-	-
Ariz.	52	-	17	-	8,129	7,472	14	16	6	3	-	1
Utah	17	-	10	4	1,282	1,227	1	-	-	-	-	4
Nev.	13	1	3	-	4,277	4,000	3	2	-	-	-	2
PACIFIC	2,004	20	215	18	122,803	108,123	251	132	23	44	-	219
Wash.	109	1	14	1	9,246	8,446	31	16	2	2	-	37
Oreg.	30	-	1	-	6,041	6,274	53	7	1	1	-	4
Calif.	1,835	18	160	17	102,956	88,812	167	108	20	41	-	156
Alaska	3	-	40	-	2,966	2,728	-	-	-	-	-	-
Hawaii	27	1	-	-	1,594	1,863	-	1	-	-	-	22
Guam	1	U	-	-	161	222	U	U	U	U	U	3
P.R.	88	6	7	2	2,967	3,166	-	14	1	4	-	2
V.I.	2	-	-	-	382	493	-	-	-	-	-	-
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 December 7, 1985 and December 8, 1984 (49th 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	956	11	2,238	2	444	2,530	2,240	57	2,720	54	3,115	2,179	2	593	716
NEW ENGLAND	54	-	38	-	88	106	109	1	65	2	207	72	-	12	19
Maine	4	-	-	-	1	-	6	-	6	-	10	4	-	-	1
N.H.	5	-	-	-	-	36	15	-	11	-	112	17	-	2	1
Vt.	2	-	-	-	-	7	10	-	3	-	3	23	-	-	-
Mass.	25	-	34	-	84	49	21	1	22	2	49	20	-	6	16
R.I.	6	-	-	-	-	-	17	-	15	-	22	4	-	-	-
Conn.	12	-	4	-	3	14	40	-	8	-	11	4	-	4	1
MID ATLANTIC	153	-	193	-	38	177	396	10	323	5	245	195	-	226	228
Upstate N.Y.	50	-	72	-	13	56	156	5	171	4	119	107	-	18	99
N.Y. City	61	-	67	-	12	109	70	-	33	-	27	16	-	185	104
N.J.	18	-	17	-	10	7	62	1	49	-	11	13	-	9	24
Pa.	24	-	37	-	3	5	108	4	70	1	88	59	-	14	1
E.N. CENTRAL	60	-	448	-	90	697	387	15	939	-	733	503	-	35	101
Ohio	11	-	5	-	54	9	126	8	285	-	117	75	-	-	2
Ind.	4	-	55	-	2	3	51	-	37	-	201	241	-	1	5
Ill.	21	-	293	-	10	181	84	4	211	-	56	27	-	17	64
Mich.	18	-	37	-	23	464	98	3	316	-	48	31	-	16	22
Wis.	6	-	58	-	1	40	28	-	90	-	311	129	-	1	8
W.N. CENTRAL	34	-	2	-	10	58	114	-	84	13	246	127	-	19	39
Minn.	17	-	-	-	6	47	27	-	1	10	127	16	-	2	4
Iowa	2	-	-	-	-	-	10	-	17	2	33	14	-	1	1
Mo.	5	-	1	-	2	6	44	-	15	1	32	20	-	7	-
N. Dak.	2	-	-	-	2	-	5	-	4	-	10	-	-	2	3
S. Dak.	1	-	-	-	-	-	5	-	-	-	5	9	-	-	-
Nebr.	1	-	-	-	-	-	10	-	3	-	10	14	-	-	-
Kans.	6	-	1	-	-	5	13	-	44	-	29	54	-	7	31
S. ATLANTIC	107	-	308	-	32	67	427	11	274	9	409	221	2	58	29
Del.	-	-	-	-	-	-	11	-	1	-	2	2	-	2	2
Md.	25	-	106	-	9	22	57	3	36	1	174	61	-	6	1
D.C.	8	-	28	-	3	8	8	-	-	-	1	-	-	-	-
Va.	21	-	21	-	7	5	52	1	48	-	21	19	-	2	1
W. Va.	2	-	31	-	2	-	9	2	75	-	4	11	-	9	-
N.C.	9	-	9	-	-	1	58	-	19	1	35	36	-	1	-
S.C.	-	-	-	-	3	1	34	-	11	-	2	2	-	3	-
Ga.	10	-	8	-	-	2	77	2	30	6	99	18	2	6	2
Fla.	32	-	105	-	8	28	121	3	54	1	71	72	-	29	23
E.S. CENTRAL	11	-	-	-	7	6	98	-	30	2	69	14	-	3	12
Ky.	4	-	-	-	5	1	9	-	8	-	8	2	-	3	6
Tenn.	-	-	-	-	1	2	39	-	18	1	27	7	-	-	-
Ala.	6	-	-	-	-	3	26	-	1	1	27	1	-	-	3
Miss.	1	-	-	-	1	-	24	-	3	-	7	4	-	-	3
W.S. CENTRAL	95	10	435	2	17	621	194	10	312	15	542	336	-	41	68
Ark.	3	-	-	-	-	8	19	-	7	-	14	22	-	1	3
La.	2	-	42	-	-	8	25	-	2	-	17	10	-	-	-
Okla.	7	-	-	-	1	8	34	N	N	-	160	245	-	1	-
Tex.	83	10	393	2 †	16	597	116	10	303	15	351	59	-	39	65
MOUNTAIN	57	-	496	-	54	145	98	2	243	2	217	122	-	5	22
Mont.	-	-	122	-	17	-	11	-	12	-	9	19	-	-	-
Idaho	3	-	126	-	18	23	5	-	9	-	9	7	-	1	1
Wyo.	1	-	5	-	-	-	6	-	2	-	1	6	-	-	3
Colo.	20	-	8	-	7	6	25	-	26	1	91	45	-	-	2
N. Mex.	15	-	1	-	5	88	13	N	N	1	14	12	-	2	1
Ariz.	11	-	234	-	7	1	23	2	123	-	40	24	-	1	4
Utah	2	-	-	-	-	27	9	-	6	-	53	7	-	-	7
Nev.	5	-	-	-	-	-	6	-	65	-	-	2	-	1	4
PACIFIC	385	1	318	-	108	653	417	8	450	6	447	589	-	194	198
Wash.	27	-	105	-	39	160	71	-	35	3	85	323	-	14	2
Oreg.	14	-	4	-	1	-	38	N	N	-	50	30	-	2	2
Calif.	325	1	191	-	63	330	287	8	387	3	265	157	-	135	187
Alaska	2	-	-	-	-	-	9	-	9	-	30	3	-	1	1
Hawaii	17	-	18	-	5	163	12	-	19	-	17	76	-	42	6
Guam	1	U	10	U	1	91	-	U	6	U	-	-	U	2	4
P.R.	-	-	67	-	-	226	15	1	156	1	16	1	-	27	20
V.I.	-	-	4	-	6	-	-	-	4	-	-	-	-	-	-
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 December 7, 1985 and December 8, 1984 (49th 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	23,943	26,274	4	20,127	20,110	159	357	685	5,031
NEW ENGLAND	558	507	-	671	604	4	14	9	20
Maine	16	10	-	44	33	-	-	-	-
N.H.	40	14	-	20	27	-	1	1	1
Vt.	5	1	-	8	7	-	-	-	1
Mass.	275	287	-	397	330	4	10	6	11
R.I.	17	22	-	50	48	-	-	1	-
Conn.	205	173	-	152	159	-	3	1	7
MID ATLANTIC	3,365	3,519	-	3,555	3,680	2	59	38	610
Upstate N.Y.	252	312	-	609	555	-	14	9	143
N.Y. City	2,030	2,099	-	1,749	1,532	1	33	5	-
N.J.	643	625	-	476	801	1	11	4	39
Pa.	440	483	-	721	792	-	1	20	428
E.N. CENTRAL	928	1,323	-	2,473	2,611	3	43	39	170
Ohio	140	226	-	426	467	-	11	23	28
Ind.	78	140	-	318	329	-	3	5	23
Ill.	414	538	-	1,078	1,083	2	19	9	38
Mich.	236	347	-	516	583	-	8	2	25
Wis.	60	72	-	135	149	1	2	-	56
W.N. CENTRAL	224	340	-	575	602	49	13	42	927
Minn.	44	87	-	121	108	1	6	-	191
Iowa	18	11	-	56	62	-	3	1	147
Mo.	126	174	-	277	297	31	3	7	49
N. Dak.	2	9	-	9	14	-	-	1	134
S. Dak.	6	1	-	31	22	8	-	2	321
Nebr.	6	15	-	13	30	2	1	4	35
Kans.	22	43	-	68	69	7	-	27	50
S. ATLANTIC	5,865	7,658	-	4,165	4,212	6	43	328	1,252
Del.	36	20	-	41	55	1	-	3	1
Md.	432	458	-	383	394	-	11	26	637
D.C.	318	316	-	146	169	-	-	-	-
Va.	286	395	-	416	430	1	3	26	172
W. Va.	26	20	-	105	127	-	1	2	29
N.C.	637	820	-	554	635	4	4	140	12
S.C.	768	735	-	497	502	-	3	71	60
Ga.	-	1,334	-	712	654	-	3	48	198
Fla.	3,362	3,560	-	1,311	1,246	-	18	12	143
E.S. CENTRAL	2,069	1,910	1	1,742	1,894	10	5	77	238
Ky.	65	92	1	428	454	1	1	15	37
Tenn.	606	489	-	525	545	7	2	33	72
Ala.	627	636	-	507	549	1	2	15	122
Miss.	771	693	-	282	346	1	-	14	7
W.S. CENTRAL	5,840	6,420	-	2,550	2,371	62	32	135	831
Ark.	314	204	-	293	271	37	-	16	141
La.	1,023	1,125	-	369	337	-	2	4	20
Okla.	180	203	-	236	223	19	2	91	107
Tex.	4,323	4,888	-	1,652	1,540	6	28	24	563
MOUNTAIN	731	634	1	541	542	15	13	14	439
Mont.	6	3	-	46	17	4	-	6	226
Idaho	7	23	1	25	28	-	-	-	10
Wyo.	13	7	-	7	4	-	-	4	32
Colo.	206	171	-	84	66	2	5	2	25
N. Mex.	121	88	-	83	103	2	4	-	12
Ariz.	307	232	-	239	252	4	3	-	119
Utah	11	18	-	21	35	3	1	-	4
Nev.	60	92	-	36	37	-	-	2	11
PACIFIC	4,363	3,963	2	3,855	3,594	8	135	3	544
Wash.	97	144	1	214	189	-	1	-	4
Oreg.	103	110	-	128	143	1	5	-	4
Calif.	4,092	3,628	1	3,237	2,982	4	123	3	533
Alaska	4	6	-	95	74	3	2	-	3
Hawaii	67	75	-	181	206	-	4	-	-
Guam	2	-	U	35	50	-	3	-	-
P.R.	833	749	-	333	380	-	4	-	36
V.I.	3	11	-	1	4	-	52	-	-
Pac. Trust Terr.	13	-	U	16	-	-	-	-	-

U: Unavailable

TABLE IV. Deaths in 121 U.S. cities,* week ending December 7, 1985 (49th Week)

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	865	645	142	36	12	30	76
Boston, Mass.	244	168	46	13	1	16	26
Bridgeport, Conn.	66	47	12	1	3	3	3
Cambridge, Mass.	38	26	11	1	-	-	5
Fall River, Mass.	40	32	7	1	-	-	1
Hartford, Conn.	62	46	11	4	1	-	2
Lowell, Mass.	31	24	6	-	1	-	4
Lynn, Mass.	18	15	1	2	-	-	2
New Bedford, Mass.	46	34	9	3	-	-	3
New Haven, Conn.	30	16	9	3	2	-	1
Providence, R.I.	105	88	6	4	1	6	16
Somerville, Mass.	14	11	2	1	-	-	1
Springfield, Mass.	54	44	7	1	2	-	6
Waterbury, Conn.	45	36	6	-	-	3	4
Worcester, Mass.	72	58	9	2	1	2	2
MID ATLANTIC	2,980	1,976	625	254	58	67	152
Albany, N.Y.	56	41	10	3	-	2	2
Allentown, Pa.	15	11	4	-	-	-	-
Buffalo, N.Y.	98	66	23	6	-	3	4
Camden, N.J.	40	25	13	2	-	-	1
Elizabeth, N.J.	33	26	6	1	-	-	3
Erie, Pa †	49	38	9	-	1	1	5
Jersey City, N.J.	45	31	9	2	-	3	1
N.Y. City, N.Y.	1,652	1,063	347	173	34	35	74
Newark, N.J.	111	50	32	20	5	4	9
Paterson, N.J.	38	23	11	2	2	-	-
Philadelphia, Pa.	406	268	93	26	7	12	15
Pittsburgh, Pa.†	83	64	15	-	2	2	4
Reading, Pa.	25	19	3	3	-	-	4
Rochester, N.Y.	114	83	19	7	2	3	15
Schenectady, N.Y.	38	31	6	1	-	-	3
Scranton, Pa.†	29	23	5	1	-	-	3
Syracuse, N.Y.	67	51	9	1	4	2	3
Trenton, N.J.	27	21	4	2	-	-	2
Utica, N.Y.	29	23	4	1	1	-	2
Yonkers, N.Y.	25	19	3	3	-	-	2
E.N. CENTRAL	2,514	1,760	429	159	65	100	122
Akron, Ohio	75	49	15	5	3	3	5
Canton, Ohio	63	47	14	-	-	2	10
Chicago, Ill.§	553	462	11	26	16	37	16
Cincinnati, Ohio	165	104	40	10	2	9	18
Cleveland, Ohio	159	98	45	10	3	3	1
Columbus, Ohio	123	66	34	15	6	2	1
Dayton, Ohio	141	96	30	9	3	3	8
Detroit, Mich.	367	218	78	38	17	16	17
Evansville, Ind.	50	36	9	3	1	1	1
Fort Wayne, Ind.	68	51	11	2	-	4	1
Gary, Ind.	14	8	4	2	-	-	-
Grand Rapids, Mich.	38	29	4	3	-	2	2
Indianapolis, Ind.	174	120	36	8	6	4	6
Madison, Wis.	27	19	7	-	-	1	5
Milwaukee, Wis.	175	130	26	13	1	5	11
Peoria, Ill.	65	48	12	1	1	3	10
Rockford, Ill.	49	31	12	5	1	-	4
South Bend, Ind.	58	43	11	3	1	-	1
Toledo, Ohio	93	66	19	4	3	1	3
Youngstown, Ohio	57	39	11	2	1	4	2
W.N. CENTRAL	805	574	144	43	21	23	48
Des Moines, Iowa	47	33	9	4	-	1	7
Duluth, Minn.	35	24	5	3	-	3	2
Kansas City, Kans.	37	25	6	6	-	-	-
Kansas City, Mo.	109	76	25	6	1	1	10
Lincoln, Nebr.	45	32	10	-	3	-	3
Minneapolis, Minn.	87	61	17	1	3	5	3
Omaha, Nebr.	123	85	20	11	2	5	10
St. Louis, Mo.	174	129	26	4	7	8	4
St. Paul, Minn.	60	46	8	4	2	-	3
Wichita, Kans.	88	63	18	4	3	-	6

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
S. ATLANTIC	1,203	733	279	107	33	51	53
Atlanta, Ga.	142	86	32	16	7	1	5
Baltimore, Md.	185	105	43	23	8	6	3
Charlotte, N.C.	77	53	18	4	1	1	1
Jacksonville, Fla.	155	93	38	13	4	7	5
Miami, Fla.	103	63	27	9	2	2	1
Norfolk, Va.	56	32	12	4	1	7	7
Richmond, Va.	93	55	25	6	2	5	6
Savannah, Ga.	49	32	9	3	1	4	3
St. Petersburg, Fla.	94	76	12	4	1	1	9
Tampa, Fla.	69	42	15	7	2	3	7
Washington, D.C.	158	83	41	17	3	14	6
Wilmington, Del.	22	13	7	1	1	-	-
E.S. CENTRAL	682	440	166	39	16	21	39
Birmingham, Ala.	119	72	30	7	2	8	3
Chattanooga, Tenn.	54	37	13	2	-	2	3
Knoxville, Tenn.	75	54	14	4	2	1	3
Louisville, Ky.	82	56	16	7	-	3	4
Memphis, Tenn.	133	90	35	3	4	1	9
Mobile, Ala.	53	37	14	-	-	2	6
Montgomery, Ala.	29	15	6	4	2	2	-
Nashville, Tenn.	137	79	38	12	6	2	11
W.S. CENTRAL	1,537	1,017	308	98	63	51	77
Austin, Tex.	64	39	13	5	2	5	4
Baton Rouge, La.	28	20	6	-	-	2	2
Corpus Christi, Tex.	67	43	13	8	1	2	4
Dallas, Tex.	225	128	58	23	9	7	8
El Paso, Tex.	78	38	26	5	6	3	5
Fort Worth, Tex.	94	52	30	6	2	4	10
Houston, Tex. §	323	291	3	6	14	9	5
Little Rock, Ark.	109	70	28	4	3	4	5
New Orleans, La.	182	112	42	21	7	-	3
San Antonio, Tex.	214	127	50	11	14	12	18
Shreveport, La.	59	38	16	2	1	2	6
Tulsa, Okla.	94	59	23	7	4	1	7
MOUNTAIN	743	474	161	48	25	35	43
Albuquerque, N.Mex.	102	72	14	11	4	1	10
Colo. Springs, Colo.	53	42	7	2	1	1	7
Denver, Colo.	129	72	25	9	9	14	3
Las Vegas, Nev.	100	64	24	8	2	2	8
Ogden, Utah	23	18	1	1	1	2	3
Phoenix, Ariz.	151	84	47	9	4	7	1
Pueblo, Colo.	21	14	6	1	-	-	1
Salt Lake City, Utah	49	30	8	3	2	6	1
Tucson, Ariz.	115	78	29	4	2	2	9
PACIFIC	1,927	1,319	342	156	53	50	128
Berkeley, Calif.	17	14	-	1	1	1	2
Fresno, Calif.	86	59	14	6	1	6	13
Glendale, Calif.	21	17	2	-	2	-	-
Honolulu, Hawaii	83	49	18	9	2	5	5
Long Beach, Calif.	46	34	7	2	2	1	5
Los Angeles, Calif.	592	397	111	57	17	3	19
Oakland, Calif.	69	46	8	4	4	7	8
Pasadena, Calif.	27	18	5	3	-	1	-
Portland, Oreg.	107	76	21	7	3	-	10
Sacramento, Calif.	142	111	19	5	1	6	22
San Diego, Calif.	164	102	39	10	6	7	14
San Francisco, Calif.	162	105	26	23	4	4	5
San Jose, Calif.	175	112	39	18	2	4	11
Seattle, Wash.	118	83	18	9	4	4	6
Spokane, Wash.	39	37	1	-	1	-	6
Tacoma, Wash.	79	59	14	2	3	1	2
TOTAL	13,256††	8,938	2,596	940	346	428	738

* 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.

Influenza – Continued

the occurrence of type A(H3N2) outbreaks in Alaska, it is not possible to predict which influenza virus type will be most active in the continental United States during the coming season or the level of activity that may occur. Health-care personnel should continue efforts to vaccinate persons in high-risk groups who have not yet received the 1985-1986 immunization and continue their contingency planning for deploying the available antiviral agent, amantadine, in the event that outbreaks of type A influenza occur among their high-risk patients. Particular attention should be given to the revised amantadine dosage recommendations (100 mg/day) for persons aged 65 years and older (*1*).

Reference

1. ACIP. Prevention and control of influenza. MMWR 1985;34:261-8, 273-5.

Epidemiologic Notes and Reports

Bacteriologic Conversion of Sputum among Tuberculosis Patients — United States

By the end of May 1985, information was available from 44 state health departments, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands on bacteriologic conversion of sputum from positive to negative for 12,637 tuberculosis patients. All patients had begun treatment in 1983 for pulmonary tuberculosis and represented 73% of the total sputum-positive pulmonary tuberculosis cases reported during that year. Within 3 months of starting treatment, 54% had negative sputum.

Within 6 months of beginning therapy, 10% of the patients had moved or died. Of the remaining 11,410, 75% had converted to sputum negative; 18% had no follow-up sputum examination; 3% were lost to follow-up; and 4% were known to be sputum positive (Table 2). Fifteen state and territorial possessions reported that more than 90% of their patients had negative sputum within 6 months; four states reported that less than half of their patients were known to be sputum negative within 6 months (Table 3).

During 1972-1983, the percentage of patients known to have converted to negative

TABLE 2. Bacteriologic conversion of 12,637 sputum-positive patients — United States, 1983

Situation	No.	(%)
Observation discontinued	1,227*	(9.7)
Patients observed for 6 mos.	11,410	(90.3)
Lost to follow-up	332	(2.9)†
No follow-up examination	2,071	(18.2)†
Known positive sputum	453	(4.0)†
Sputum converted in 6 mos.	8,554	(75.0)†

*Consists of 812 patients who died and 415 patients who moved.

†Percentage of patients observed for 6 months.

Tuberculosis — Continued

sputum within 6 months of treatment decreased from 88% to 75%. Patients for whom no sputum results were available 6 months after initiation of treatment increased from 6% to 18%. The percentage known to have had positive sputum after 6 months of starting therapy has remained nearly constant at 4% during the 12-year period. From 1972 to 1981, the percentage of patients lost to follow-up increased from 2% to 4%, but has since dropped to 3% (Figure 3).

Reported by Div of Tuberculosis Control, Center for Prevention Svcs, CDC.

Editorial Note: Examination of the sputum of patients with pulmonary tuberculosis at 2- to 4-week intervals until conversion occurs is important for several reasons. It provides objective evidence of the patient's response to therapy. A delayed or absent response may result from patient noncompliance, drug-resistant organisms, prescription error, immunosuppression, or malabsorption of drugs. Failure to detect these problems early, and to adjust the chemotherapy regimen accordingly, may lead to treatment failure and potential transmission of tubercle bacilli to others in the community. Results can also be used to estimate the level of patient infectivity, which permits decisions concerning hospital isolation procedures, the need for supervised therapy, and the investigation and management of patient contacts (*1,2*).

Periodic bacteriologic examinations are necessary for establishing the length of therapy for patients. CDC and the American Thoracic Society currently recommend that the patient receive isoniazid (INH) and rifampin (RIF) for at least 6 months *beyond the time of conversion* (the time of the first negative sputum results, after which there are no subsequent positive sputa) or a minimum of 9 months total therapy, whichever is longer (*3*). An appropriate and a minimum length of treatment can be calculated for those patients for whom the date of conversion is known.

TABLE 3. Bacteriologic conversion of sputum from tuberculosis patients, by state or territory — United States, 1983

State	Patients with positive sputum*	Converted in 6 mos.		Did not convert in 6 mos.		
		No.	(%)	Positive 6th mo.	No. sputum 6th mo.	Lost
Alabama†	375	366	(97.6)	8	1	0
Alaska	32	27	(84.4)	0	5	0
Arizona§	31	28	(90.3)	0	3	0
Arkansas	¶	¶	¶	¶	¶	¶
California§	847	611	(72.1)	47	166	23
Colorado§	46	46	(100.0)	0	0	0
Connecticut	91	42	(46.2)	1	46	2
Delaware	¶	¶	¶	¶	¶	¶
District of Columbia	115	91	(79.1)	1	20	3
Florida†	908	809	(89.1)	36	45	18
Georgia†	494	446	(90.3)	37	7	4
Guam	23	21	(91.3)	1	0	1
Hawaii†	97	88	(90.7)	4	4	1
Idaho	¶	¶	¶	¶	¶	¶
Illinois§	841	513	(61.0)	39	179	110
Indiana§	54	32	(59.3)	0	22	0
Iowa	34	29	(85.3)	1	3	1
Kansas†	56	56	(100.0)	0	0	0
Kentucky†	335	313	(93.4)	9	12	1
Louisiana†	394	261	(66.2)	11	106	16
Maine	15	14	(93.3)	0	1	0
Maryland†	206	174	(84.5)	7	24	1
Massachusetts§	96	49	(51.0)	8	38	1
Michigan§	71	54	(76.1)	0	17	0
Minnesota†	74	53	(71.6)	0	21	0

Tuberculosis — Continued

TABLE 3. Bacteriologic conversion of sputum from tuberculosis patients, by state or territory — United States, 1983 (Continued)

State	Patients with positive sputum*	Converted in 6 mos.		Did not convert in 6 mos.		
		No.	(%)	Positive 6th mo.	No. sputum 6th mo.	Lost
Mississippi	266	235	(88.3)	12	17	2
Missouri†	244	155	(63.5)	7	73	9
Montana	¶	¶	¶	¶	¶	¶
Nebraska†	20	16	(80.0)	4	0	0
Nevada†	25	15	(60.0)	3	5	2
New Hampshire	3	0	(0.0)	0	3	0
New Jersey†	283	203	(71.7)	8	61	11
New Mexico†	59	54	(91.5)	0	5	0
New York§	1,110	630	(56.8)	54	369	57
North Carolina	421	305	(72.4)	13	59	44
North Dakota	8	7	(87.5)	0	1	0
Ohio†	341	76	(22.3)	3	262	0
Oklahoma†	183	130	(71.0)	9	42	2
Oregon†	99	76	(76.8)	2	21	0
Pennsylvania†	499	429	(86.0)	14	55	1
Puerto Rico	256	138	(53.9)	41	72	5
Rhode Island	¶	¶	¶	¶	¶	¶
South Carolina	267	227	(85.0)	6	33	1
South Dakota	28	27	(96.4)	1	0	0
Tennessee†	394	349	(88.6)	13	32	0
Texas†	1,159	939	(81.0)	32	178	10
Utah	29	28	(96.6)	0	0	1
Vermont	3	3	(100.0)	0	0	0
Virgin Islands	3	3	(100.0)	0	0	0
Virginia§	217	203	(93.5)	14	0	0
Washington†	107	95	(88.8)	2	5	5
West Virginia	75	58	(77.3)	5	12	0
Wisconsin†	76	30	(39.5)	0	46	0
Wyoming	¶	¶	¶	¶	¶	¶
Total	**11,410**	**8,554**	**(75.0)**	**453**	**2,071**	**332**

*Observed for 6 months.

†Represents data from more than one reporting area.

§Data for less than entire state or for less than entire year.

¶No data available.

Among patients with uncomplicated pulmonary tuberculosis treated with INH- and RIF-containing regimens, virtually 100% become sputum negative within 6 months if they follow prescribed treatment regimens (*4*). Because the data reported here include patients treated with regimens other than INH and RIF, as well as patients with drug-resistant organisms or immune-compromising conditions, an overall national conversion rate of 100% within 6 months is not a realistic goal. However, a goal of 95% sputum conversion within 6 months is realistic and was achieved by seven states and territorial possessions in 1983.

The downward trend in the percentage of patients known to have become sputum negative from 1972 through 1983 was accompanied by an increase in the percentage of patients lost to follow-up and for whom no sputum results were available. The number of patients from whom no sputum result was available includes patients the attending physician presumed had converted, but from whom no specimen was obtained to document sputum negativity. Data from four metropolitan-area health departments indicate that some nonhealth

Tuberculosis — Continued

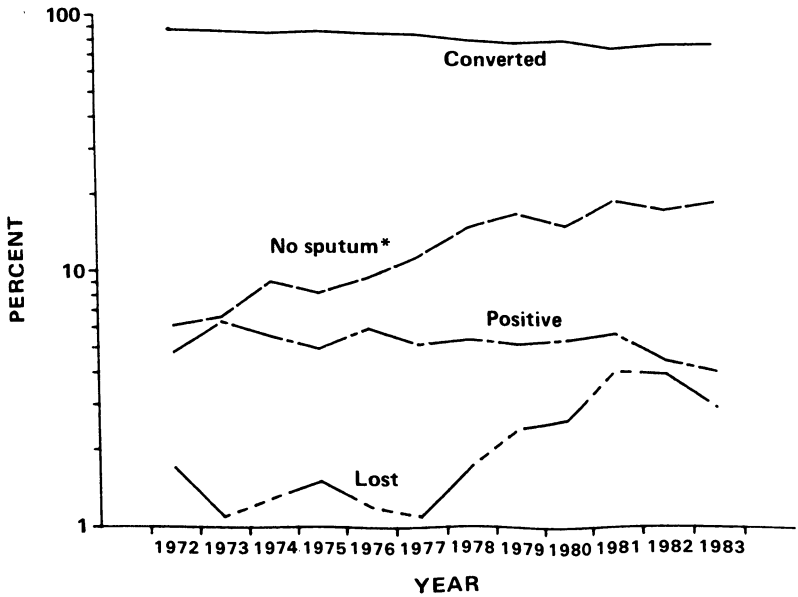
department health-care providers either do not routinely obtain sputum specimens to monitor the patient's response to therapy or do not report bacteriologic results to the health department.

Early in the course of treatment, patients with pulmonary tuberculosis should have sputum examinations performed every 2-4 weeks, until sputum negativity on two consecutive cultures is documented. Subsequently, it is not necessary to collect more specimens unless signs and/or symptoms suggest treatment failure or relapse. Without documenting that sputum cultures have become negative, neither the clinician nor the health department can verify a patient's noninfectious status.

References

1. CDC. Guidelines for prevention of TB transmission in hospitals. Atlanta, Georgia: U.S. Department of Health, Education, and Welfare, Public Health Service, 1982; HEW publication no. (CDC) 82-8371.
2. American Thoracic Society/CDC. Control of tuberculosis. Am Rev Respir Dis 1983;128:336-42.
3. American Thoracic Society/CDC. Treatment of tuberculosis and other mycobacterial diseases. Am Rev Respir Dis 1983;127:790-6.
4. Fox W. The chemotherapy of pulmonary tuberculosis: a review. Chest 1979;76:785-96.

FIGURE 3. Status of sputum-positive patients after 6 months of chemotherapy — United States, 1972-1983



*Sputum examination not done or not reported.

Notice to Readers

Seventh National Lesbian/Gay Health Conference; Fourth National AIDS Forum

The Seventh National Lesbian/Gay Health Conference and Fourth National AIDS Forum will be held March 13-16, 1986, at George Washington University, Washington, D.C., sponsored by the National Lesbian and Gay Health Foundation, Inc.; CDC; the National Institute of Allergy and Infectious Diseases, the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, the National Institute of Mental Health, National Institutes of Health; Alcohol, Drug Abuse, and Mental Health Administration; George Washington University Medical School; the Center for Interdisciplinary Studies of Immunology at Georgetown University; Addiction Recovery Corporation; the Washington, D.C., AIDS Task Force; and the Whitman-Walker Clinic, Washington, D.C.

The purpose of the meeting is to discuss developments in health-care delivery to lesbians and homosexual men; discussions will include acquired immunodeficiency syndrome (AIDS), addiction, and general lesbian and homosexual health concerns. Scientific papers and workshop proposals are now being solicited. For further information and future announcements, contact: NLGHF Conference, P.O. Box 65472, Washington, D.C., 20035; telephone (202) 797-3708.

Availability of Revised Nosocomial Guidelines

The following revised *CDC Guidelines for the Prevention and Control of Nosocomial Infections* are now available for purchase from the National Technical Information Service:

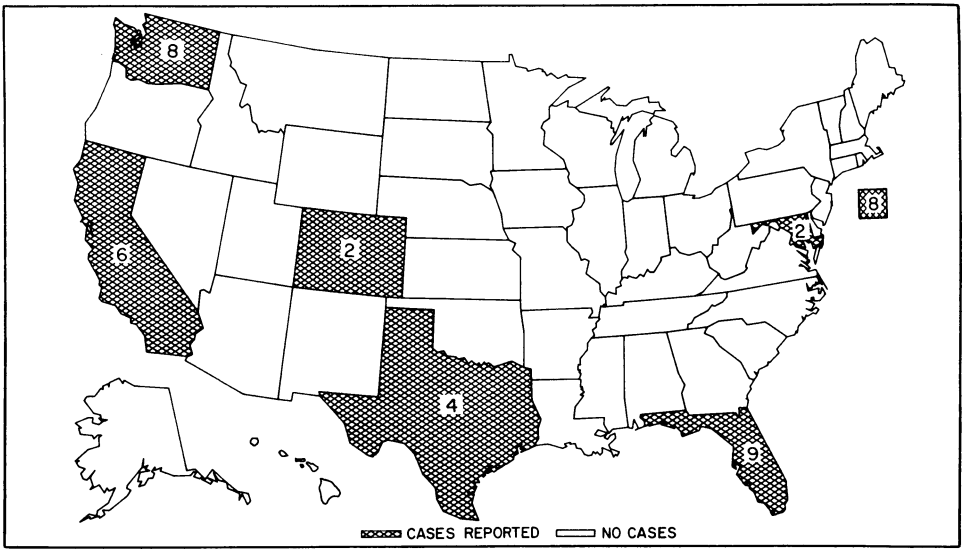
CDC Guideline for Handwashing and Hospital Environmental Control, 1985	Stock No. PB85-923404 Price: Domestic $7.00* Foreign $14.00†
CDC Guideline for Prevention of Surgical Wound Infections, 1985	Stock No. PB85-923403 Price: Domestic $7.00* Foreign $14.00†

These publications should be ordered by stock number, and check or money order sent to: National Technical Information Service, U.S. Department of Commerce, 5285 Port Royal Road, Springfield, Virginia 22161; Telephone: (703) 487-4650.

*Add $3.00 for shipping and handling per total domestic order.

†Add $4.00 for shipping and handling per total foreign order.

FIGURE I. Reported measles cases — United States, weeks 45-48, 1985



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

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

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

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