CENTERS FOR DISEASE CONTROL

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MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Trichinosis — Maine, Alaska

In 1985, the following outbreaks of trichinosis were reported from Maine and Alaska.

Maine. On October 10, 1985, two cases of trichinosis were reported to the Maine Bureau of Health. The patients had consumed pork from a sow purchased from a local farm. Because members of several families had consumed pork or viscera from the pig, the cases were investigated to determine the extent of the outbreak. A survey was undertaken seeking a history of symptoms commonly seen with trichinosis (fever, myalgias, periorbital edema, and malaise) in individuals known to have consumed the implicated pork. Blood was collected from each individual for eosinophil count and *Trichinella* serology. A case was defined as an individual with a history of ingesting the implicated pork and with signs and symptoms compatible with trichinosis and either (1) an elevated eosinophil count (total eosinophil count of greater than 450 or a differential greater than 5% on the white blood cell count) or (2) serologic proof of trichinosis infection (bentonite flocculation titers [BF] $\geq$ 1:5).

Nineteen individuals consumed pork from the implicated pig. Follow-up could not be obtained on three. Two (18%) of the 11 individuals submitting convalescent sera, both with symptoms and elevated eosinophil counts, had titers of 1:10 or greater. Sera drawn during the acute phase on these two patients tested negative. Five (31%) persons met the case definition, with eosinophilia and at least one of the following symptoms: fever (two [40%] individuals), periorbital edema (two [40%]), myalgias (two [40%]), malaise (two [40%]), diarrhea (two [40%]), and maculopapular rash (one [20%]), including both those with positive serologies.

Patients' ages ranged from 25 years to 49 years (mean 35 years). Four (80%) were male. Since all but one individual consumed the implicated pork on more than one occasion, the incubation period could not be determined. All five patients denied consuming the pork raw or undercooked; three were involved in butchering the pig; two were hospitalized and received thiabendazole. The patient with the maculopapular rash received corticosteroids and benadryl. All five patients recovered.

Meat samples from the implicated pig were examined by the Animal Parasitology Institute, U.S. Department of Agriculture (USDA). Analysis by tissue digestion revealed greater than 300 trichinae larva/gram. Investigation by the Maine Bureau of Health of the farm where the pig had been purchased revealed that the farmer fed the pigs garbage (reportedly boiled) and that the environment was conducive to the proliferation of rats. The three remaining pigs at the farm had serologic evidence of trichinosis on testing by USDA. Because approximately 25 suckling pigs were reportedly sold from the farm, a press release was issued November 5 alerting area residents to the problem and asking persons who felt they may have been exposed to noncommercial pork to call the Bureau of Health. To date, no calls have been received, but surveillance is continuing.

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Alaska. On March 15, 1985, a private physician reported a case of trichinosis to the Alaska Department of Health and Social Services. Because the patient and 15 other individuals had consumed grizzly bear meat at a birthday party in January 1985, an investigation was initiated similar to the one in Maine.

Follow-up information was obtained from 14 (88%) of the 16 individuals who attended the birthday party and three others who consumed some of the meat either before or after the party. Fourteen (82%) of the 17 had elevated eosinophil counts ranging from 3% to 63%. Of these, nine had the following symptoms suggestive of trichinosis: myalgias (six [67%]), diarrhea (four [44%]), rash (three [33%]), fever (three [33%]), and periorbital edema (one [11%]). BF testing of sera drawn from the 17 individuals 3 months after consumption of the bear meat was negative, except for the index patient who had a titer of 1:20.

The nine patients with eosinophilia and symptoms ranged from 3 years to 35 years of age (mean 22 years). Five (56%) of the patients were female. The incubation period ranged from 10 days to 61 days.

The implicated bear meat had been frozen for approximately 3 weeks before the party. The frozen meat was cut into bite-sized pieces and reportedly cooked in a soup with vegetables for 1-2 hours. No samples of the meat were available for examination or for verification of cooking status.

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Editorial Note: Although the incidence of trichinosis has decreased markedly from 300 to 400 cases reported annually in the late 1940s (*1*) to a mean of 88 cases reported annually over the past 5 years, trichinosis remains a public health problem in the United States. The outbreaks presented here highlight interesting aspects of the epidemiology and control of trichinosis. A large number of the cases reported each year occur in the New England and Middle Atlantic states, a finding that has been associated with the high concentration of ethnic groups in those regions whose culinary preferences include raw pork (*1*). In addition, recent studies suggest that swine from these regions may be more highly infected than those of other regions. Surveys of selected slaughterhouses in the New England and Middle Atlantic states found infection rates of 0.73% and 0.58%, respectively (*2,3*), surpassing the estimated national average rate of 0.1% (*4*). These findings were attributed to certain swine-management practices (garbage feeding, rat infestation [*5*], and cannibalism) by small and/or part-time hog producers common to these regions. In light of the culinary preferences of the resident ethnic groups of these areas, the relative importance of these findings needs further investigation.

This is the fifth outbreak of trichinosis reported from Alaska since 1975 (*6*). Two outbreaks have involved walrus meat; one, black bear meat; and two, including the one reported here, grizzly bear meat. Epidemiologic and experimental studies suggest that the arctic strain of *T. spiralis* may be more resistant to cold than those found in pork. According to USDA recommendations, *T. spiralis* in pork is rendered nonviable if held at -15 C (5 F) (temperatures achievable in noncommercial refrigerators) for 20 days. However, polar bear meat, stored at -18 C (0 F) for up to 24 months remained infective for mice (*7,8*), and an outbreak of trichinosis resulted from the consumption of bear meat frozen for 81 days at -18 C (0 F) (*9*). Since control of trichinosis, in part, has relied upon the widespread use of commercial and home freezing (*1*), this difference between strains is of clinical importance and needs to be

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emphasized through public health education to potential consumers of wild animal meat. However, adequate cooking at 77 C (170 F)—well above the thermal death point of the parasite—remains the best safeguard against trichinosis.

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International Notes

Update: Acquired Immunodeficiency Syndrome — Europe

As of September 30, 1985, 1,573 cases of acquired immunodeficiency syndrome (AIDS) were reported to the World Health Organization (WHO) European Collaborating Centre on AIDS by the 21 countries corresponding with the Centre (Table 1). The new cases represent an average increase of 27 cases per week. Of the 1,573 patients, 792 are reported to have died (case-fatality rate: 50%) (Table 2, Figure 1).

The greatest increases in numbers of cases were observed in: the Federal Republic of Germany—75 (five to six per week); France—74 new cases (five to six per week); the United Kingdom—49 (three to four per week); and Italy—40 (three per week). In each of four countries (Belgium, Netherlands, Spain, and Switzerland), an increase of one to two cases per week was noted. Five countries (Czechoslovakia, Hungary, Iceland, Poland, the Union of Soviet Socialist Republics) had not reported any cases.

AIDS cases per million population were calculated using 1985 population estimates (Institut National d'Etudes Démographiques, Paris). The highest rates were noted in: Switzerland—11.8; Denmark—11.2; and France—8.5. These rates are low compared to the U.S. rate of 60.0 (*1*).

DISTRIBUTION BY DISEASE CATEGORY AND PATIENT SEX

A total of 1,025 patients (65%) presented with one or more opportunistic infections; 309 (20%) had Kaposi's sarcoma (KS) alone; and 212 (13%) had opportunistic infections with KS. The category "Other" (27 cases) includes four cases of progressive multifocal leukoencephalopathy (France—three; Denmark—one), six cases of isolated cerebral lymphoma (the United Kingdom—two; France—three, Switzerland—one), three cases of isolated Burkitt lymphomas of the brain (Denmark—one; the Federal Republic of Germany—two); 10 cases of B-cell non-Hodgkin's lymphomas (the Federal Republic of Germany—four; the Netherlands—three); and

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Luxembourg, Norway, and Switzerland—one each); and four unknown (Sweden). The highest case-fatality rate (59%) was noted for patients with both KS and opportunistic infections. The case-fatality rate for opportunistic infections alone was 56%; for KS alone, 25%.

Males accounted for 92% of the cases (Table 3). The male:female ratio was 11:1. Forty-two percent of cases occurred in the 30- to 39-year age group. Thirty-six pediatric cases (children under 15 years old) have been reported in 10 European countries. Twenty-four (67%) children either had parents with AIDS or parents in a group at high risk for AIDS; for 10 pediatric patients (five with hemophilia and five with blood transfusions), transmission was linked to contaminated blood or blood products. In two of the pediatric patients, no risk factor was reported.

DISTRIBUTION BY GEOGRAPHIC ORIGIN

Total cases were distributed geographically and by risk group as follows (Table 4):

Europeans* (1,330 cases [85% of total]). A total of 1,288 (97%) patients were living in Europe before onset of the first symptoms; 42 (3%) were living in non-European countries: United States—13; Zaire—12; Haiti—three; and one each in Bermuda, Brazil, Burundi, Congo, Gabon, Ghana, Malaysia, Morocco, Nicaragua, South Africa, Togo, and Venezuela; the country of residence was not specified for two patients.

Of the 1,330 European patients, 1,031 (78%) were homosexual or bisexual. Ninety (7%)

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

TABLE 1. Reported acquired immunodeficiency syndrome cases and estimated rates per million population — 21 European countries, October 1, 1984-September 30, 1985

Country	Oct. 1984	March 1985	June 1985	Sept. 1985	Rates*
Austria	-	13	18	23	3.1
Belgium	-	81	99	118	11.9
Czechoslovakia	0	0	0	0	0.0
Denmark	31	41	48	57	11.2
Federal Republic of Germany	110	162	220	295	4.8
Finland	4	5	6	10	2.0
France	221	307	392	466	8.5
Greece	2	7	9	10	1.0
Hungary	-	-	-	0	0.0
Iceland	0	0	0	0	0.0
Italy	10	22	52	92	1.6
Luxembourg	-	-	1	3	7.5
Netherlands	26	52	66	83	5.7
Norway	4	8	11	14	3.3
Poland	0	0	0	0	0.0
Spain	18	29	38	63	1.6
Sweden	12	22	27	36	4.3
Switzerland	33	51	63	77	11.8
United Kingdom	88	140	176	225	4.0
Union of Soviet Socialist Republics	-	-	-	0	0.0
Yugoslavia	-	-	-	1	-
Total	**559**	**940**	**1,226**	**1,573**	-

*Per million population based on 1985 populations.

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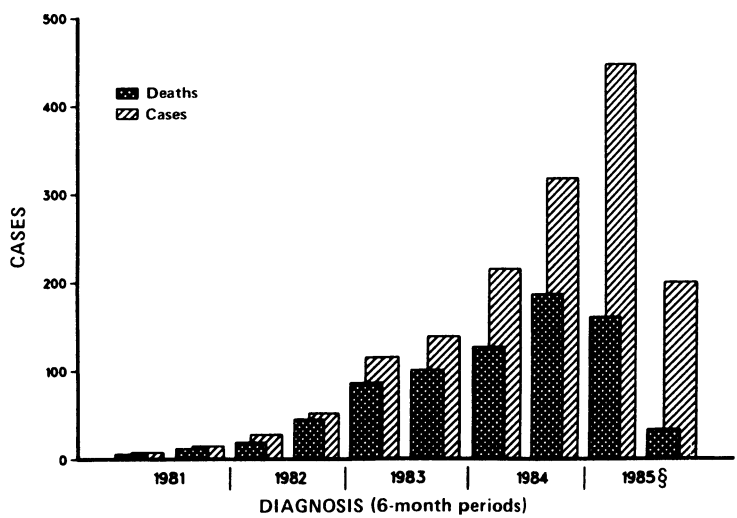
patients were IV drug abusers, and 21 (2%), both homosexual and IV drug abusers. These 111 cases were diagnosed in: Italy—45; Spain—26, the Federal Republic of Germany—14; France—11; Switzerland—seven; Austria—four; the United Kingdom—three; and Sweden—one. Fifty-two (4%) of the reported patients had hemophilia and were diagnosed in: the Federal Republic of Germany—21; Spain—12; the United Kingdom—nine; France—three; Sweden—two; and one each in Austria, Denmark, Greece, Italy, and Norway. One German patient with hemophilia was reported as being homosexual and an IV drug abuser. Thirty (2%) patients, for whom the only risk factor found was blood transfusion, were

TABLE 2. Acquired immunodeficiency syndrome cases and number of deaths, by disease category — 21 European countries,* through September 30, 1985

Disease category	Cases	(%)	Deaths	(%)
Opportunistic infection	1,025	(65)	575	(56)
Kaposi's sarcoma	309	(20)	77	(25)
Opportunistic infection and Kaposi's sarcoma	212	(13)	126	(59)
Other	27	(2)	14	(52)
Total	**1,573**	**(100)**	**792**	**(50)**

*Austria, Belgium, Czechoslovakia, Denmark, Finland, France, the Federal Republic of Germany, Greece, Hungary, Iceland, Italy, Luxembourg, the Netherlands, Norway, Poland, Spain, Sweden, Switzerland, the United Kingdom, the Union of Soviet Socialist Republics, and Yugoslavia.

FIGURE 1. Acquired immunodeficiency syndrome cases and deaths, by 6-month period of diagnosis — 21 European countries,* January 1, 1981-September 30, 1985†



*Austria, Belgium, Czechoslovakia, Denmark, the Federal Republic of Germany, Finland, France, Greece, Hungary, Iceland, Italy, Luxembourg, the Netherlands, Norway, Poland, Spain, Sweden, Switzerland, the United Kingdom, the Union of Soviet Socialist Republics, and Yugoslavia.

†Before 1981, 21 cases, including 11 deaths, were reported. In addition, 23 cases (10 deaths) with unknown dates of diagnosis were also reported.

§January-September 1985.

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diagnosed in: France—15; Belgium, the Netherlands, and the United Kingdom—four each; the Federal Republic of Germany—two; and Italy—one. Among these 30 cases, five had received blood transfusions outside Europe: one diagnosed in the Netherlands had undergone heart surgery in the United States; one diagnosed in France had received blood transfusions in Haiti and Martinique; and two diagnosed in Belgium had received transfusions in Zaire. One child diagnosed in the United Kingdom had received a blood transfusion in the United States. For 90 patients (7%), no risk factor was found (male:female ratio 2:1). Risk-factor information was not obtained for 16 patients.

Caribbeans (39 [2%]). Thirty-seven patients were living in Europe before the onset of the first symptoms: 32 Haitians were diagnosed in France; one, in Belgium; and one, in Switzerland; one Dominican and one Jamaican were living in the United Kingdom; one patient of unspecified origin was living in Switzerland. Two Haitian patients diagnosed in France were living in Haiti.

Of the Caribbean patients, four were homosexual, and no risk factors were identified for 34 (male:female ratio 3:1). Risk-factor information was not obtained in one case.

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

Disease	3rd Week Ending			Cumulative, 3rd Week Ending		
	Jan. 18, 1986	Jan. 19, 1985	Median 1981-1985	Jan. 18, 1986	Jan. 19, 1985	Median 1981-1985
Acquired Immunodeficiency Syndrome (AIDS)	155	124	N	658	277	N
Aseptic meningitis	44	79	91	192	206	264
Encephalitis: Primary (arthropod-borne & unspec.)	8	15	18	33	36	44
Post-infectious	-	1	2	-	6	4
Gonorrhea: Civilian	13,050	15,696	18,989	38,922	41,396	55,168
Military	157	291	458	586	859	1,475
Hepatitis: Type A	250	382	382	799	928	1,011
Type B	278	421	421	942	1,042	1,042
Non A, Non B	29	71	N	122	181	N
Unspecified	31	83	145	163	204	362
Legionellosis	2	5	N	21	26	N
Leprosy	-	4	3	13	9	9
Malaria	8	7	14	21	20	33
Measles: Total*	4	10	10	31	25	25
Indigenous	4	5	N	29	15	N
Imported	-	5	N	2	10	N
Meningococcal infections: Total	39	48	62	128	113	155
Civilian	39	48	60	127	113	148
Military	-	-	-	1	-	-
Mumps	25	49	82	81	126	192
Pertussis	28	16	14	77	55	45
Rubella (German measles)	-	5	6	6	14	30
Syphilis (Primary & Secondary): Civilian	316	378	591	956	1,064	1,718
Military	3	1	7	9	10	23
Toxic Shock syndrome	2	5	N	11	18	N
Tuberculosis	209	304	349	583	679	912
Tularemia	1	1	1	4	8	3
Typhoid fever	1	1	4	7	6	19
Typhus fever, tick-borne (RMSF)	-	-	-	2	1	4
Rabies, animal	57	73	81	185	195	237

TABLE II. Notifiable diseases of low frequency, United States

	Cum 1986		Cum 1986
Anthrax	-	Leptospirosis	5
Botulism: Foodborne	-	Plague	-
Infant	2	Poliomyelitis, Paralytic	-
Other	-	Psittacosis (Pa. 1)	1
Brucellosis (S. Dak. 1)	2	Rabies, human	-
Cholera	-	Tetanus (S.C. 1)	2
Congenital rubella syndrome	1	Trichinosis (Mass. 4)	4
Congenital syphilis, ages < 1 year	-	Typhus fever, flea-borne (endemic, murine)	-
Diphtheria	-		

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

TABLE III. Cases of specified notifiable diseases, United States, weeks ending January 18, 1986 and January 19, 1985 (3rd Week)

Reporting Area	AIDS	Aseptic Meningitis	Encephalitis		Gonorrhea (Civilian)		Hepatitis (Viral), by type				Legionellosis	Leprosy
			Primary	Post-infectious			A	B	NA,NB	Unspecified		
	Cum. 1986	1986	Cum. 1986	Cum. 1986	Cum. 1986	Cum. 1985	1986	1986	1986	1986	1986	Cum. 1986
UNITED STATES	658	44	33	-	38,922	41,396	250	278	29	31	2	13
NEW ENGLAND	17	5	-	-	895	1,550	13	38	2	9	-	-
Maine	-	-	-	-	50	61	-	4	-	-	-	-
N.H.	1	-	-	-	21	32	5	-	-	-	-	-
Vt.	1	-	-	-	8	13	1	2	-	-	-	-
Mass.	9	4	-	-	379	526	6	29	1	9	-	-
R.I.	2	-	-	-	70	125	-	3	1	-	-	-
Conn.	4	1	-	-	367	793	1	-	-	-	-	-
MID ATLANTIC	253	12	5	-	5,962	5,064	21	35	5	2	-	-
Upstate N.Y.	19	5	3	-	634	105	14	11	1	1	-	-
N.Y. City	156	U	1	-	3,102	2,319	U	U	U	U	U	-
N.J.	48	3	-	-	676	566	-	-	-	-	-	-
Pa.	30	4	1	-	1,550	2,074	7	24	4	1	-	-
E.N. CENTRAL	30	7	9	-	5,689	4,961	12	16	2	1	-	-
Ohio	22	-	5	-	2,008	1,995	6	7	-	1	-	-
Ind.	4	U	-	-	565	384	U	U	U	U	U	-
Ill.	-	-	-	-	860	854	-	-	-	-	-	-
Mich.	4	7	4	-	1,813	1,653	6	9	2	-	-	-
Wis.	-	-	-	-	443	75	-	-	-	-	-	-
W.N. CENTRAL	22	1	-	-	2,092	2,520	7	20	2	-	1	-
Minn.	12	-	-	-	372	360	1	-	-	-	-	-
Iowa	2	-	-	-	236	236	-	-	-	-	-	-
Mo.	4	-	-	-	906	1,148	3	19	1	-	-	-
N. Dak.	1	-	-	-	30	17	1	-	-	-	-	-
S. Dak.	-	-	-	-	40	56	1	-	-	-	1	-
Nebr.	1	-	-	-	112	286	-	-	-	-	-	-
Kans.	2	1	-	-	396	417	1	1	1	-	-	-
S. ATLANTIC	74	8	9	-	8,676	9,191	22	62	5	2	1	-
Del.	4	-	2	-	188	183	2	3	-	-	-	-
Md.	14	1	5	-	1,171	1,407	4	13	1	1	1	-
D.C.	17	-	-	-	837	716	-	1	-	-	-	-
Va.	5	1	-	-	1,015	1,115	1	1	1	-	-	-
W. Va.	-	-	-	-	131	161	2	2	-	-	-	-
N.C.	5	1	2	-	1,480	1,741	3	18	3	1	-	-
S.C.	5	-	-	-	1,186	1,335	-	1	-	-	-	-
Ga.	-	1	-	-	-	-	1	11	-	-	-	-
Fla.	24	4	-	-	2,668	2,533	9	12	-	-	-	-
E.S. CENTRAL	16	4	5	-	3,469	3,958	2	34	1	1	-	-
Ky.	5	-	1	-	370	392	-	3	-	-	-	-
Tenn.	9	2	-	-	1,410	1,636	2	15	-	1	-	-
Ala.	-	2	4	-	810	1,209	-	16	1	-	-	-
Miss.	2	-	-	-	879	721	-	-	-	-	-	-
W.S. CENTRAL	59	-	-	-	5,838	6,468	11	4	-	1	-	-
Ark.	5	-	-	-	504	600	-	2	-	-	-	-
La.	10	-	-	-	995	1,451	-	-	-	-	-	-
Okla.	2	-	-	-	707	700	1	1	-	-	-	-
Tex.	42	-	-	-	3,632	3,717	10	1	-	1	-	-
MOUNTAIN	9	7	1	-	1,391	1,585	63	41	9	14	-	-
Mont.	-	-	-	-	41	49	1	2	-	2	-	-
Idaho	1	1	-	-	11	36	4	-	-	-	-	-
Wyo.	1	U	-	-	18	34	U	U	U	U	U	-
Colo.	1	3	-	-	389	471	3	5	1	6	-	-
N. Mex.	-	-	-	-	151	186	7	5	-	-	-	-
Ariz.	1	2	1	-	476	474	43	21	7	5	-	-
Utah	1	1	-	-	64	71	2	6	1	1	-	-
Nev.	4	-	-	-	241	264	3	2	-	-	-	-
PACIFIC	178	-	4	-	4,910	6,099	99	28	3	1	-	13
Wash.	7	-	-	-	282	408	7	13	-	1	-	-
Oreg.	2	-	-	-	220	382	91	13	3	-	-	-
Calif.	166	U	3	-	4,167	5,084	U	U	U	U	U	13
Alaska	-	-	1	-	148	137	1	-	-	-	-	-
Hawaii	3	-	-	-	93	88	-	2	-	-	-	-
Guam	-	U	-	-	-	6	U	U	U	U	U	-
P.R.	-	3	-	-	100	137	2	8	-	-	-	-
V.I.	-	-	-	-	8	23	-	-	-	-	-	-
Pac. Trust Terr.	-	U	-	-	-	-	U	U	U	U	U	-
Amer. Samoa	-	U	-	-	-	-	U	U	U	U	U	-

N: Not notifiable U: Unavailable

TABLE III. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending January 18, 1986 and January 19, 1985 (3rd Week)

Reporting Area	Malaria	Measles (Rubeola)					Menin-gococcal Infections	Mumps		Pertussis			Rubella		
		Indigenous		Imported *		Total									
	Cum. 1986	1986	Cum. 1986	1986	Cum. 1986	Cum. 1985	Cum. 1986	1986	Cum. 1986	1986	Cum. 1986	Cum. 1985	1986	Cum. 1986	Cum. 1985
UNITED STATES	21	4	29	-	2	25	128	25	81	28	77	55	-	6	14
NEW ENGLAND	-	-	-	-	-	-	10	-	2	1	5	1	-	-	2
Maine	-	-	-	-	-	-	3	-	-	-	1	-	-	-	-
N.H.	-	-	-	-	-	-	-	-	1	-	2	-	-	-	1
Vt.	-	-	-	-	-	-	4	-	-	-	-	1	-	-	-
Mass.	-	-	-	-	-	-	1	-	-	1	2	-	-	-	1
R.I.	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-
Conn.	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-
MID ATLANTIC	4	1	1	-	1	-	20	1	6	6	20	6	-	1	4
Upstate N.Y.	-	1	1	-	1	-	3	1	3	6	14	2	-	1	-
N.Y. City	1	U	-	U	-	-	8	U	-	U	-	4	U	-	3
N.J.	2	-	-	-	-	-	2	-	2	-	-	-	-	-	1
Pa.	1	-	-	-	-	-	7	-	1	-	6	-	-	-	-
E.N. CENTRAL	-	-	-	-	-	13	12	12	38	8	9	21	-	-	-
Ohio	-	-	-	-	-	-	7	9	9	7	7	3	-	-	-
Ind.	-	U	-	U	-	-	1	U	-	U	-	8	U	-	-
Ill.	-	-	-	-	-	1	-	-	23	-	-	-	-	-	-
Mich.	-	-	-	-	-	-	4	3	6	1	1	-	-	-	-
Wis.	-	-	-	-	-	12	-	-	-	-	1	10	-	-	-
W.N. CENTRAL	-	2	22	-	-	-	7	3	8	1	9	3	-	-	2
Minn.	-	-	-	-	-	-	-	-	-	-	5	1	-	-	-
Iowa	-	-	-	-	-	-	2	2	3	1	2	-	-	-	-
Mo.	-	-	-	-	-	-	4	-	1	-	-	-	-	-	-
N. Dak.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Nebr.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Kans.	-	2	22	-	-	-	1	1	4	-	2	1	-	-	2
S. ATLANTIC	6	-	-	-	-	-	24	4	13	6	11	4	-	-	1
Del.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Md.	1	-	-	-	-	-	2	-	-	4	4	1	-	-	-
D.C.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Va.	4	-	-	-	-	-	1	-	3	-	2	-	-	-	-
W. Va.	-	-	-	-	-	-	-	2	7	-	-	-	-	-	-
N.C.	1	-	-	-	-	-	5	1	1	2	4	2	-	-	-
S.C.	-	-	-	-	-	-	7	-	1	-	1	-	-	-	1
Ga.	-	-	-	-	-	-	3	1	1	-	-	-	-	-	-
Fla.	-	-	-	-	-	-	6	-	-	-	-	1	-	-	-
E.S. CENTRAL	1	-	-	-	-	-	14	-	2	1	4	1	-	1	1
Ky.	1	-	-	-	-	-	8	-	2	-	1	-	-	1	1
Tenn.	-	-	-	-	-	-	1	-	-	-	1	1	-	-	-
Ala.	-	-	-	-	-	-	5	-	-	1	2	-	-	-	-
Miss.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
W.S. CENTRAL	-	-	-	-	-	-	3	1	1	-	-	4	-	-	-
Ark.	-	-	-	-	-	-	-	-	-	-	-	3	-	-	-
La.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Okla.	-	-	-	-	-	-	2	N	N	-	-	1	-	-	-
Tex.	-	-	-	-	-	-	1	1	1	-	-	-	-	-	-
MOUNTAIN	-	1	1	-	-	5	11	4	7	5	9	1	-	-	-
Mont.	-	-	-	-	-	5	2	-	-	-	-	-	-	-	-
Idaho	-	-	-	-	-	-	-	-	-	2	2	-	-	-	-
Wyo.	-	U	-	U	-	-	-	U	-	U	-	-	U	-	-
Colo.	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-
N. Mex.	-	1	1	-	-	-	2	N	N	2	3	1	-	-	-
Ariz.	-	-	-	-	-	-	4	4	6	1	3	-	-	-	-
Utah	-	-	-	-	-	-	1	-	1	-	-	-	-	-	-
Nev.	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-
PACIFIC	10	-	5	-	1	7	27	-	4	-	10	14	-	4	4
Wash.	-	-	-	-	-	1	7	-	-	-	5	-	-	-	-
Oreg.	1	-	-	-	-	-	5	N	N	-	-	-	-	-	-
Calif.	9	U	5	U	1	6	13	U	4	U	5	14	U	4	4
Alaska	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-
Hawaii	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Guam	-	U	-	U	-	7	-	U	-	U	-	-	U	-	-
P.R.	-	-	-	-	-	12	-	1	2	1	1	-	-	-	-
V.I.	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-
Pac. Trust Terr.	-	U	-	U	-	-	-	U	-	U	-	-	U	-	-
Amer. Samoa	-	U	-	U	-	-	-	U	-	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 January 18, 1986 and January 19, 1985 (3rd Week)

Reporting Area	Syphilis (Civilian) (Primary & Secondary)		Toxic-shock Syndrome	Tuberculosis		Tula-remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1986	Cum. 1985	1986	Cum. 1986	Cum. 1985	Cum. 1986	Cum. 1986	Cum. 1986	Cum. 1986
UNITED STATES	956	1,064	2	583	679	4	7	2	185
NEW ENGLAND	37	25	-	19	19	-	1	1	-
Maine	1	1	-	6	1	-	-	-	-
N.H.	1	-	-	-	3	-	-	-	-
Vt.	1	-	-	1	-	-	-	-	-
Mass.	20	13	-	4	12	-	1	1	-
R.I.	1	-	-	-	-	-	-	-	-
Conn.	13	11	-	8	3	-	-	-	-
MID ATLANTIC	117	148	-	103	180	-	1	-	21
Upstate N.Y.	11	7	-	24	14	-	-	-	3
N.Y. City	57	94	U	33	116	-	1	-	-
N.J.	34	35	-	23	8	-	-	-	-
Pa.	15	12	-	23	42	-	-	-	18
E.N. CENTRAL	17	36	-	91	70	-	2	-	5
Ohio	4	6	-	9	21	-	-	-	-
Ind.	8	5	U	-	10	-	-	-	-
Ill.	-	13	-	59	38	-	-	-	-
Mich.	4	9	-	17	-	-	2	-	2
Wis.	1	3	-	6	1	-	-	-	3
W.N. CENTRAL	16	12	1	15	12	3	-	-	11
Minn.	2	2	-	1	-	-	-	-	-
Iowa	3	2	1	-	7	1	-	-	6
Mo.	9	6	-	6	-	2	-	-	1
N. Dak.	2	-	-	1	1	-	-	-	4
S. Dak.	-	-	-	-	1	-	-	-	-
Nebr.	-	1	-	-	-	-	-	-	-
Kans.	-	1	-	7	3	-	-	-	-
S. ATLANTIC	250	257	1	141	118	-	-	-	32
Del.	1	3	-	-	1	-	-	-	-
Md.	28	27	-	7	7	-	-	-	20
D.C.	16	6	-	10	8	-	-	-	-
Va.	27	20	1	4	-	-	-	-	1
W. Va.	1	-	-	1	9	-	-	-	1
N.C.	28	41	-	26	7	-	-	-	-
S.C.	50	46	-	30	27	-	-	-	2
Ga.	-	-	-	11	11	-	-	-	8
Fla.	99	114	-	52	48	-	-	-	-
E.S. CENTRAL	79	88	-	73	60	1	-	1	15
Ky.	4	5	-	16	15	1	-	-	-
Tenn.	48	20	-	14	16	-	-	-	9
Ala.	27	32	-	43	29	-	-	1	6
Miss.	-	31	-	-	-	-	-	-	-
W.S. CENTRAL	253	213	-	29	47	-	-	-	19
Ark.	10	13	-	9	-	-	-	-	2
La.	47	56	-	6	26	-	-	-	-
Okla.	5	4	-	6	5	-	-	-	3
Tex.	191	140	-	8	16	-	-	-	14
MOUNTAIN	32	53	-	11	9	-	1	-	68
Mont.	-	-	-	-	2	-	-	-	34
Idaho	1	1	-	-	-	-	-	-	-
Wyo.	-	-	U	-	-	-	-	-	26
Colo.	18	11	-	-	-	-	-	-	-
N. Mex.	-	-	-	2	-	-	-	-	1
Ariz.	11	41	-	5	5	-	-	-	7
Utah	2	-	-	-	-	-	1	-	-
Nev.	-	-	-	4	2	-	-	-	-
PACIFIC	155	232	-	101	164	-	2	-	14
Wash.	-	6	-	10	4	-	-	-	-
Oreg.	6	11	-	5	2	-	-	-	-
Calif.	144	209	U	82	152	-	1	-	14
Alaska	-	-	-	-	-	-	-	-	-
Hawaii	5	6	-	4	6	-	1	-	-
Guam	-	-	U	-	2	-	-	-	-
P.R.	34	25	-	11	8	-	-	-	3
V.I.	-	-	-	-	-	-	-	-	-
Pac. Trust Terr.	-	-	U	-	-	-	-	-	-
Amer. Samoa	-	-	U	-	-	-	-	-	-

U: Unavailable

TABLE IV. Deaths in 121 U.S. cities,* week ending January 18, 1986 (3rd Week)

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	711	507	143	38	11	12	76
Boston, Mass.	173	112	37	17	5	2	25
Bridgeport, Conn.	58	43	10	2	1	2	5
Cambridge, Mass.	25	19	4	2	-	-	3
Fall River, Mass.	34	27	7	-	-	-	2
Hartford, Conn.	70	46	16	3	1	4	4
Lowell, Mass.	28	18	7	2	1	-	-
Lynn, Mass.	20	14	5	1	-	-	1
New Bedford, Mass.	30	27	3	-	-	-	4
New Haven, Conn.	39	28	9	1	-	1	-
Providence, R.I.	78	55	18	4	-	1	10
Somerville, Mass.	11	7	3	-	-	1	1
Springfield, Mass.	49	34	9	2	3	1	6
Waterbury, Conn.	36	33	1	2	-	-	10
Worcester, Mass.	60	44	14	2	-	-	5
MID ATLANTIC	3,113	2,546	338	108	60	60	192
Albany, N.Y.	51	30	15	4	1	1	2
Allentown, Pa.§	20	20	-	-	-	-	-
Buffalo, N.Y.	142	110	24	5	1	1	12
Camden, N.J.	35	23	9	2	-	1	-
Elizabeth, N.J.	34	25	8	-	1	-	3
Erie, Pa.†	49	39	6	4	-	-	4
Jersey City, N.J.	52	41	4	5	2	-	1
N.Y. City, N.Y.§	1,527	1,435	12	17	34	29	74
Newark, N.J.	53	27	9	11	4	2	3
Paterson, N.J.	28	16	7	2	2	1	6
Philadelphia, Pa.	587	397	142	28	10	10	43
Pittsburgh, Pa.†	54	32	16	3	1	2	3
Reading, Pa.	41	36	4	1	-	-	4
Rochester, N.Y.	132	94	17	14	2	5	18
Schenectady, N.Y.	31	23	6	1	-	1	1
Scranton, Pa.†	34	28	6	-	-	-	3
Syracuse, N.Y.	104	71	23	3	2	5	6
Trenton, N.J.	78	54	18	6	-	-	2
Utica, N.Y.	31	21	7	2	-	1	-
Yonkers, N.Y.	30	24	5	-	-	1	7
E.N. CENTRAL	2,494	1,754	419	134	64	122	114
Akron, Ohio	80	58	14	4	3	1	1
Canton, Ohio	39	31	6	2	-	-	5
Chicago, Ill.§	553	462	11	26	16	37	16
Cincinnati, Ohio	140	93	35	5	4	3	4
Cleveland, Ohio	177	99	57	12	4	5	3
Columbus, Ohio	124	74	33	7	2	8	6
Dayton, Ohio	133	84	36	5	3	5	8
Detroit, Mich.	304	187	59	37	8	13	7
Evansville, Ind.	58	38	10	6	1	3	3
Fort Wayne, Ind.	82	60	11	4	4	3	6
Gary, Ind.	23	14	6	2	-	1	-
Grand Rapids, Mich.	60	46	9	1	1	3	6
Indianapolis, Ind.	163	89	46	8	5	15	4
Madison, Wis.	48	33	9	1	3	2	7
Milwaukee, Wis.	154	112	29	2	1	10	3
Peoria, Ill.	53	41	4	4	2	2	10
Rockford, Ill.	49	39	5	1	-	4	9
South Bend, Ind.	44	33	6	1	3	1	4
Toledo, Ohio	150	119	20	2	3	6	9
Youngstown, Ohio	60	42	13	4	1	-	3
W.N. CENTRAL	865	632	150	42	19	22	43
Des Moines, Iowa	91	69	17	3	1	1	6
Duluth, Minn.	34	21	9	2	1	1	2
Kansas City, Kans.	32	20	10	-	1	1	1
Kansas City, Mo.	123	89	21	8	1	4	7
Lincoln, Nebr.	45	37	6	1	-	1	2
Minneapolis, Minn.	98	69	16	7	3	3	2
Omaha, Nebr.	113	75	21	8	6	3	9
St. Louis, Mo.	169	132	23	9	2	3	5
St. Paul, Minn.	71	56	12	-	2	1	3
Wichita, Kans.	89	64	15	4	2	4	6
S. ATLANTIC	1,554	956	366	129	50	49	68
Atlanta, Ga.	218	123	61	21	8	5	5
Baltimore, Md.	248	159	51	19	7	12	4
Charlotte, N.C.	70	43	17	5	3	2	2
Jacksonville, Fla.	162	104	36	9	8	5	10
Miami, Fla.	114	62	35	13	3	1	1
Norfolk, Va.	72	47	17	5	1	2	6
Richmond, Va.	99	59	24	8	3	5	10
Savannah, Ga.	54	35	11	3	2	3	3
St. Petersburg, Fla.	136	115	15	2	3	1	12
Tampa, Fla.	66	44	10	5	2	2	10
Washington, D.C.	284	146	84	35	7	11	5
Wilmington, Del.	31	19	5	4	3	-	-
E.S. CENTRAL	944	640	190	65	22	27	46
Birmingham, Ala.	174	113	41	14	4	2	4
Chattanooga, Tenn.	73	54	12	1	2	4	4
Knoxville, Tenn.	128	86	23	9	7	3	4
Louisville, Ky.	146	105	29	7	1	4	7
Memphis, Tenn.	142	91	33	11	4	3	8
Mobile, Ala.	71	50	8	8	2	3	5
Montgomery, Ala.	57	38	14	2	1	2	3
Nashville, Tenn.	153	103	30	13	1	6	11
W.S. CENTRAL	1,452	1,018	241	86	54	51	78
Austin, Tex.	69	45	13	4	2	5	11
Baton Rouge, La.	73	60	4	3	3	3	3
Corpus Christi, Tex.	63	39	18	3	1	2	3
Dallas, Tex.	230	133	52	20	12	13	6
El Paso, Tex.	93	55	22	6	4	5	5
Fort Worth, Tex.	135	98	22	7	6	2	7
Houston, Tex.	255	233	2	5	8	7	5
Little Rock, Ark.	61	40	13	4	3	1	7
New Orleans, La.	87	52	21	9	3	2	1
San Antonio, Tex.	217	138	45	14	10	9	16
Shreveport, La.	25	16	3	4	-	2	2
Tulsa, Okla.	144	109	26	7	2	-	12
MOUNTAIN	718	496	131	46	22	23	50
Albuquerque, N.Mex.	105	70	19	8	4	4	6
Colo. Springs, Colo.	41	29	7	4	-	1	9
Denver, Colo.	114	79	16	10	5	4	4
Las Vegas, Nev.	86	59	21	3	2	1	4
Ogden, Utah	21	17	3	-	-	1	2
Phoenix, Ariz.	130	83	22	10	7	8	3
Pueblo, Colo.	21	15	4	2	-	-	4
Salt Lake City, Utah	60	40	11	6	2	1	1
Tucson, Ariz.	140	104	28	3	2	3	17
PACIFIC	2,044	1,520	296	108	55	58	167
Berkele, Calif.	25	20	2	2	-	1	-
Fresno, Calif.	71	51	13	2	2	3	14
Glendale, Calif. §	22	22	-	-	-	-	2
Honolulu, Hawaii	75	52	12	6	2	3	5
Long Beach, Calif.	74	50	18	1	4	1	13
Los Angeles, Calif. §	486	457	3	-	17	3	16
Oakland, Calif.	78	48	19	6	2	3	6
Pasadena, Calif.	33	20	8	1	1	3	3
Portland, Oreg.	167	115	33	10	5	4	12
Sacramento, Calif.	143	96	30	6	4	7	20
San Diego, Calif.	209	150	32	18	4	5	26
San Francisco, Calif.	188	113	36	27	3	9	8
San Jose, Calif.	192	121	40	15	6	9	25
Seattle, Wash.	172	124	33	10	3	2	10
Spokane, Wash.	46	35	5	2	2	2	6
Tacoma, Wash.	63	46	12	2	-	3	1
	††						
TOTAL	13,895	10,069	2,274	756	357	424	834

* 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.

AIDS – Continued

Africans (157 [10%]). These persons were diagnosed in eight European countries and originated from 22 African countries (63% from Zaire and 10% from the Congo). Among the remaining 20 countries, the number of cases varied from one to five. Eighty-six patients (55%) were living in Europe before onset of the first symptoms. Sixty-six resided in Africa, and one, in the United States. Two patients from Zaire and one each from Burundi and Rwanda were living in other parts of the world.

Of the 157 Africans, 11 were homosexuals; five had received blood transfusions; and one was both homosexual and an IV drug abuser. No risk factors were identified for 124 (male: female ratio 2:1); and for 16, information was not obtained.

Other origins (47 cases [3%]). Most of these patients originated from the American continents: the United States—23; Argentina—four; Brazil—three; and one each from Canada,

TABLE 3. Acquired immunodeficiency syndrome cases, by age group and sex — 21 European countries, through September 30, 1985

Age group	Males	Females	Total No.	Total (%)
0-11 mos.	6	8	**14**	**(0.9)**
1-4 yrs.	9	6	**15**	**(1.0)**
5-9 yrs.	3	1	**4**	**(0.3)**
10-14 yrs.	3	0	**3**	**(0.2)**
15-19 yrs.	8	0	**8**	**(0.5)**
20-29 yrs.	277	57	**334**	**(21.2)**
30-39 yrs.	622	36	**658**	**(41.8)**
40-49 yrs.	375	12	**387**	**(24.6)**
50-59 yrs.	103	9	**112**	**(7.1)**
≥ 60 yrs.	21	4	**25**	**(1.6)**
Unknown	13	0	**13**	**(0.8)**
Total	**1,440**	**133**	**1,573**	**(100.0)**

TABLE 4. Acquired immunodeficiency syndrome cases, by patient risk group and geographic origin — 21 European countries, through September 30, 1985

Patient risk group	Origin: Europe	Origin: Caribbean Islands	Origin: Africa	Origin: Other	Total No.	Total (%)
1. Male homosexual or bisexual	1,031	4	11	39	**1,085**	**(69)**
2. IV drug abuser	90	-	-	-	**90**	**(6)**
3. Hemophilia patient	52	-	-	1	**53**	**(3)**
4. Transfusion recipient (without other risk factors)	30	-	5	-	**35**	**(2)**
5. 1- and 2-associated	21	-	1	2	**24**	**(2)**
6. No known risk factor						
Male	59	24	81	3	**167**	**(11)**
Female	31	10	43	-	**84**	**(5)**
7. Unknown	16	1	16	2	**35**	**(2)**
Total	**1,330 (85%)**	**39 (2%)**	**157 (10%)**	**47 (3%)**	**1,573**	**(100)**

AIDS – Continued

Chili, Nicaragua, Peru, and Uruguay. One patient each originated from Australia, Egypt, Lebanon, New Zealand, Pakistan, Thailand, and Turkey; the origins of four were unknown. Fourteen of these patients were not living in Europe before the onset of the first symptoms (the United States—10; Canada and Africa—one each; unknown—two).

Among the 47 patients, 39 were homosexual; two were both homosexual and IV drug abusers (one Canadian diagnosed in the United Kingdom and one American diagnosed in Spain). One American diagnosed in Sweden had hemophilia. Two did not present any risk factors. Information was not obtained in three cases.

DISTRIBUTION BY RISK GROUP

It is not possible to compare precisely the situations in the various European countries because of differences that may exist in the methods of data collection. Furthermore, in countries where AIDS is still rare, distribution may be modified with the increase in number of cases. However, some observations can be made:

Male homosexuals. AIDS patients belonging to this risk group accounted for 60%-100% of the total number of cases in 12 of 16 countries. In four other countries (Belgium, Greece, Italy, and Spain), male homosexuals accounted for fewer than 50% of cases.

IV drug abusers. The spread of AIDS in Europe has been particularly marked in this group. In October 1984, IV drug abusers represented only 2% of the total number of European cases and were reported by three countries. By September 30, 1985, they represented 8% of all European cases and were reported by nine countries, a significant increase ($p < 0.001$). Italy and Spain together accounted for 63% of the IV drug abusers with AIDS in Europe. Forty-five (49%) of the 92 Italian patients and 23 (37%) of the 63 Spanish patients were members of this risk group.

Cases related to transfusion of blood and blood products. Ten countries have reported AIDS among hemophilia patients, and six have reported cases among blood transfusion recipients.

Patients not belonging to any of the above risk groups. This group contributed the second largest number of cases. In four countries (Belgium, France, Greece, and Switzerland), a high proportion of patients originated from regions where most AIDS patients have not belonged to any of the above risk groups but where heterosexual transmission is thought to be a major factor. In Belgium, 72% of the patients originated from equatorial Africa; in France, 11% originated from the same region, and 8% from Haiti; in Switzerland, 12% originated from equatorial Africa).

REVIEW OF PUBLIC HEALTH MEASURES RELATED TO BLOOD DONORS

A questionnaire on public health measures related to blood transfusion was sent to the 21 European countries corresponding with the Centre and to Portugal. Except for the Union of Soviet Socialist Republics, all the countries answered this questionnaire.

Systematic screening of blood donors for lymphadenopathy-associated virus/human T-lymphotropic virus type III (LAV/HTLV-III) antibodies became effective in 16 of 21 countries between June and November 1985. In 13 countries, the screening is compulsory. In three others (Italy, the Netherlands, and Sweden), this screening is recommended rather than compulsory, but the public health authorities of these countries consider that the recommendation is followed and all blood donations are tested.

The test used in these countries is the enzyme-linked immunosorbent assay (ELISA). The follow-up tests used are mainly a second ELISA with an immunoblot (Western blot) or immunofluorescence test. Portugal is the only country that does not yet use a follow-up test. The follow-up test is recommended in six countries (Denmark, Greece, Italy, the Netherlands, Sweden, and Switzerland). In the other nine countries, the follow-up test is compulsory.

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Among the 16 countries that have taken measures related to blood donors, only Portugal has organized a national register of seropositive blood donors for whom confidentiality has been ensured. A national register is under consideration in Norway.

Specialized consultations for the follow-up of seropositive subjects are organized or are being organized in 11 of 16 countries (Austria, Belgium, Denmark, the Federal Republic of Germany, France, Italy, Luxembourg, Norway, Sweden, Switzerland, and the United Kingdom). In Finland, seropositive subjects are followed up by their usual physicians. Specialized consultations are under consideration in four countries (Greece, Hungary, the Netherlands, Portugal).

Information for seropositive subjects is systematic in five of 16 countries (Denmark, Finland, Greece, the Netherlands, and Switzerland) and recommended in 10 countries (Austria, Belgium, the Federal Republic of Germany, France, Hungary, Italy, Luxembourg, Norway, Sweden, and the United Kingdom). No official recommendation concerning information to seropositive subjects has been made in Portugal. Systematic screening of blood donors is under consideration in five countries (Czechoslovakia, Iceland, Poland, Spain, and Yugoslavia).

Eighteen countries have a national reference center for confirmation. Luxembourg is, and Iceland will be, using a reference center in a neighboring country. Portugal has not made a decision on this subject yet.

Measures to exclude donors at risk have been taken in all the countries except Czechoslovakia, Finland, and Portugal. These measures were initiated in 1983 for seven countries (Belgium, Denmark, France, the Netherlands, Norway, Sweden, and the United Kingdom); in 1984 for Luxembourg; in 1985 for Austria, Greece, Iceland, Italy, Poland, Spain, and Yugoslavia. No date was given for Hungary.

EDITORIAL COMMENTS BY THE WHO CENTRE

Prevention of AIDS transmission through blood transfusion is now effective in most European countries due to systematic screening for LAV/HTLV-III antibodies in blood donors. Even in countries where no cases of AIDS have been officially reported, the establishment of screening programs is being studied; in Hungary, screening is already compulsory.

As in the United States, male homosexuals account for the highest percentage of the total number of cases (69%). The distribution by risk group shows a marked increase in cases among drug abusers, accounting for 2% of 421 European cases by July 1984, and 8% of the 1,573 cases reported by September 1985. Over 40% of the cases in Italy and Spain occurred in this group. Several 1985 studies in various European countries showed a high frequency (20%-50%) of serologic markers of infection with LAV/HTLV-III in IV drug abusers, indicating that the spread of the infection has been rapid in this population. Information campaigns that are being set up should emphasize this aspect of the spread of AIDS.

Surveillance of AIDS in Europe was set up progressively in 1982; case-fatality rates obtained before 1982 cannot be included in the present surveillance data because of an unknown proportion of patients lost to follow-up.

The Centre uses the CDC case definition. One source per country, recognized by the respective national health authorities, provides the information. The national data are noted on standard tables, and each source is responsible for the quality of the data provided. Hungary, the Union of Soviet Socialist Republics, and Yugoslavia now also collaborate with the Centre.

The number of cases diagnosed between January and September 1985 must be considered as provisional because of the time required for reports to reach national surveillance centers.

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Institute of Biomedical Sciences, Tampere, Finland; Direction Générale de la Santé, Paris, France; Robert Koch Institute, West Berlin, Federal Republic of Germany; Ministry of Health, Athens, Greece; National Institute of Hygiene, Budapest, Hungary; General Direction of Public Health, Reykjavik, Iceland; Instituto Superiore di Sanita, Rome, Italy; Ministère de la Santé, Luxembourg, Luxembourg; Staatstoezicht op de Volksgezondheid, Leidfehendam, Netherlands; National Institute of Public Health, Oslo, Norway; National Institute of Hygiene, Warsaw, Poland; Ministerio de Sanidad y Consumo, Madrid, Spain; National Bacteriological Laboratory, Stockholm, Sweden; Office Federale de la Santé Publique, Berne, Switzerland; Communicable Disease Surveillance Centre, London, United Kingdom; Ministry of Public Health, Moscow, Union of Soviet Socialist Republics; Federal Institute of Public Health, Belgrade, Yugoslavia.

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1. CDC. AIDS weekly surveillance report. September 30, 1985.

Current Trends

Update: Influenza Activity — United States — and the Role of Rapid Virus Typing in Improving Amantadine Use

Between December 30, 1985, and January 13, 1986, 27 (36%) of 74 elderly residents in a San Joaquin County, California, nursing home developed influenza-like illnesses.* Influenza virus type B was isolated from two of the five ill residents tested. This is the first report of a nursing-home outbreak this season associated with type B virus; an earlier report described outbreaks associated with type A(H3N2) virus in health-care facilities for elderly patients in New York (*1*).

Nine additional states have reported their first influenza virus isolations for the season. Type B virus has been reported from Alabama, Florida, Idaho, Louisiana, Missouri, New Jersey, and Oregon; type A(H3N2) virus has been reported from New Mexico and Oklahoma. In New York and Nevada, where type A(H3N2) virus had been reported previously this season, type B virus was also reported. The season's first influenza virus isolates have also been reported from sporadic cases in New York City; type A(H3N2) viruses have been isolated from residents of Brooklyn and the Bronx.

Tallies of patients† with influenza-like illnesses seen by sentinel physicians nationwide increased from an average of 6.1 for the reporting week ending January 1, 1986, to an average of 8.4 for the week ending January 8. Similar increases have been observed in recent seasons concurrently with the spread of influenza outbreaks.

The percentages of deaths from the 121 cities that were associated with pneumonia and influenza were 5.7% and 6.0% for the weeks ending January 11 and January 18, compared with the range of 4.9%-5.4% for the 4 preceding weeks.

Reported by State and Territorial Epidemiologists; State Laboratory Directors; W Owings, MD, Centreville, Alabama; D Pates, MD, Rupert, Idaho; J Clark, M Earling, MD, Sunrise Hospital, R Weisner, MD, Las Vegas, Nevada; K Bromberg, MD, Kings County Hospital, I Spigland, MD, Montefiore Hospital, New York City, S Lipson, PhD, K Szabo, MD, Virus Laboratory, Naussau County, New York; participating physicians of the American Academy of Family Physicians; Statistical Svcs Br, Div of Surveillance and Epidemiologic

*Fever of 37.7 C (100 F) or higher and one or more respiratory symptoms. Approximately 20% of the 100 staff also had febrile respiratory illnesses slightly before or during the outbreak among residents.

†Cases reported by those members of the American Academy of Family Physicians Research Panel who serve as sentinel physicians for influenza.

Influenza — Continued

Studies, Div of Field Svcs, Epidemiology Program Office, WHO Collaborating Center for Influenza, Influenza Br, Div of Viral Diseases, Center for Infectious Diseases, CDC.

Editorial Note: The antiviral drug, amantadine hydrochloride, is highly effective in preventing illness caused by influenza type A viruses and has been recommended by the Immunization Practices Advisory Committee (ACIP) as an adjunct to vaccination in the control of influenza A infections (*2*). Amantadine is not effective against influenza type B viruses or other respiratory pathogens. Although amantadine seldom causes serious side effects in healthy, younger adults, it is more likely to cause troublesome side effects in older persons. When the normal adult dose of 200 mg daily has been reduced to 100 mg in individuals 65 years of age or older, as recommended by the ACIP, the incidence and severity of side effects has decreased substantially; however, particularly for older individuals, it is undesirable to administer amantadine over the several weeks required to prevent possible spread or reintroduction of influenza A viruses once the first evidence for an outbreak is detected, if the outbreak is actually due to influenza B or another respiratory pathogen.

The ability to rapidly diagnose influenza A infections would provide greater confidence in the use of amantadine for early treatment and prophylaxis of such cases, particularly when both type A and B influenza viruses are circulating. Nasopharyngeal specimens properly collected from residents and/or staff members within the first 1-3 days of illness before administration of amantadine can be tested using fluorescent microscopy and recently developed monclonal antibody reagents (*3,4*) to determine within 1 day whether or not influenza type A viruses are responsible for the outbreak. An alternative strategy would be to administer amantadine for 3 days to high-risk patients of an institution when an outbreak is beginning, and at the same time, obtain rapid virus culture confirmation by detecting antigen synthesized within 72 hours of inoculation of cell culture (*5*). In such a case, amantadine could be discontinued if either the outbreak continued to spread to amantadine-treated individuals and/or the laboratory diagnosis identified influenza B rather than influenza A viruses. Confirmation of influenza A infection would justify continued use of amantadine until risk of infection was over. Influenza A- and B-specific reagents for rapid virus typing have been distributed by CDC to all state health departments and other collaborating laboratories before the influenza season, although not all such laboratories may have established the diagnostic procedures referred to above.

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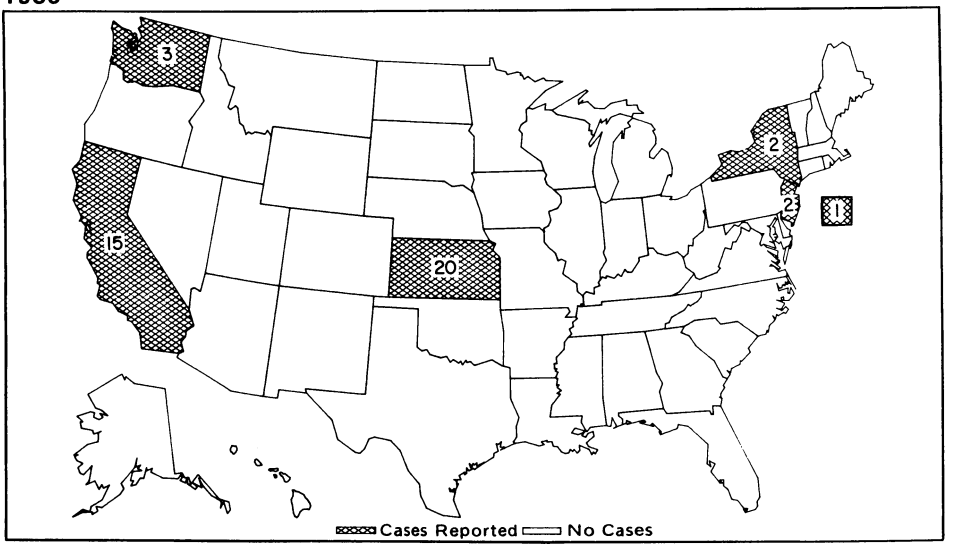
FIGURE I. Reported measles cases — United States, weeks 51-52, 1985 — week 2, 1986



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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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