CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

March 14, 1986 / Vol. 35 / No. 10

Perspectives in Disease Prevention and Health Promotion

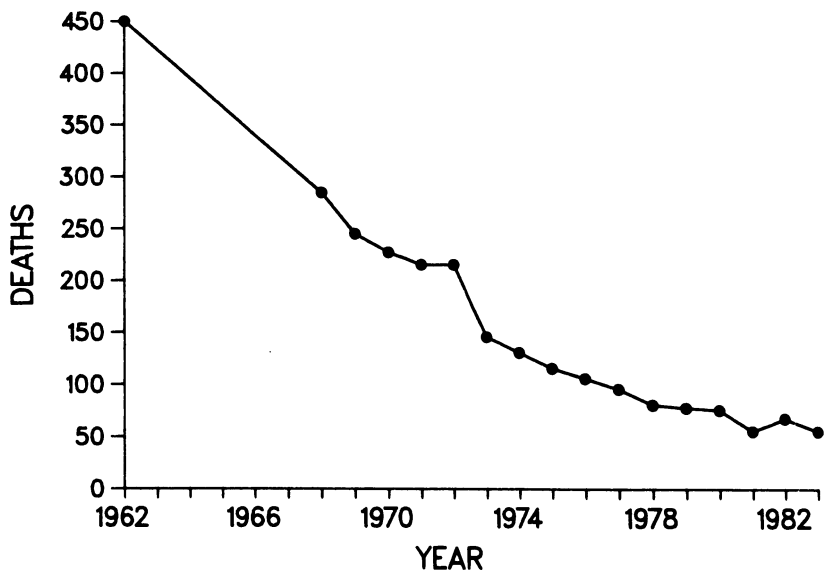
National Poison Prevention Week: 25th Anniversary Observance

The number of poison-related deaths among children under 5 years of age decreased from approximately 450 in 1961 to 55 in 1983, an 88% decline (Figure 1) (*1,2*). This decrease is due in part to increased awareness concerning poisons, facilitated in 1961 by the passage of Public Law 87-319 (75 Stat. 681), which designated the third week of March as National Poison Prevention Week (NPPW). March 16-22, 1986, marks the 25th anniversary of NPPW.

BACKGROUND

Early Awareness of the Poison Problem. In 1927, Congress passed the Caustic Poisons Act, which applied to approximately 12 acids and alkalies used in household products. The Act required a warning on packages of household lye used to make soap. Each year, both the

FIGURE 1. Deaths among children under 5 years of age involving household chemicals and medicines — United States, 1962-1983



Poison Prevention Week — Continued

chemical's resemblance to sugar and its users' carelessness in storing the lye caused thousands of young children to suffer chemical burns; some were fatal.

The Act was widely complied with and required minimal enforcement. However, as new products increased, the number of unintentional ingestions increased, so that by the 1950s, physicians considered poisonings by common household chemicals and medicines the leading cause of injuries to children under 5 years of age (*3*). The U.S. Public Health Service (PHS) National Health Survey estimated that each year 500,000 unintentional ingestions of toxic and potentially toxic substances occurred among young children; many pediatricians and public health officials estimated the figure at one million (*1*). Death certificates from states attributed almost 500 fatalities per year among children under 5 years of age to ingestion of drugs and household products (*1*). Therefore, the American Academy of Pediatrics' Committee on Accident Prevention recommended the establishment of poison control centers. The first center opened in Chicago, Illinois, in 1953.

In 1957, under the auspices of PHS, the National Clearinghouse for Poison Control Centers was established to collect data from poison control centers and provide them with diagnostic and therapeutic information on the many household products involved in childhood poisonings. In 1958, the American Association of Poison Control Centers was created to provide a professional membership society that offered guidance to its members and produced and disseminated poisoning-prevention materials.

Creation of NPPW. In the 1950s, a Missouri pharmacist, Homer A. George, became concerned about conflicting or nonexistent antidotes for some medicines and chemicals sold in his practice. He perceived a need for greater public awareness of means to prevent childhood poisonings. In 1958, he convinced his town's mayor to proclaim a Poison Prevention Week, then persuaded Missouri's governor to proclaim a statewide Poison Prevention Week. Eventually, Homer George convinced his congressional representative to introduce national legislation. With assistance from the American College of Apothecaries, the American Pharmaceutical Association, and PHS, the enabling legislation was guided through the 86th Congress and signed into law by President John F. Kennedy on September 16, 1961. To coordinate the first NPPW, the American Pharmaceutical Association and PHS sponsored a meeting in Washington, D.C., that was attended by 21 professional, industrial, and service organizations and federal agencies. That meeting established what is now called the Poison Prevention Week Council (PPWC). The first NPPW was observed March 18-24, 1962.

EFFECTS OF NPPW

By 1966, almost every state had some poisoning-prevention activity, including distribution of poisoning-prevention publications, governors' proclamations, and public service announcements. In 1970, Congress passed the Poison Prevention Packaging Act, which required child-resistant packaging for many products. While poisoning deaths had begun declining during the 1960s, this Act had a major effect on poisonings (*4*). By 1973, poisoning deaths among children under 5 years of age had declined 50% since the first NPPW. This was attributed in large part to increased public awareness of poisoning-prevention measures (*1*) and to the Poison Prevention Packaging Act. In 1986, 33 years after the opening of the first U.S. poison control center, there are over 300 such centers nationwide.

Over the past 25 years, the PPWC has dealt with issues that included:

1. **First Aid Measures**. The PPWC recommends that a poison control center, hospital, or physician be called as soon as possible after ingestion.

2. **Different Statistics**. Although there are several sources of data about childhood poisonings (*5*), mortality data collected by the National Center for Health Statistics have been considered the most reliable, because all states are required to report deaths to NCHS.

3. **Adult Poisonings**. While NPPW focuses on children, the elderly are also at risk of being poisoned.

Poison Prevention Week — Continued

Editorial Note: NPPW is sponsored by the PPWC, a coalition of 34 national organizations* representing industry, consumer groups, health professionals, government, and the media. PPWC members are continuously involved in projects to reduce unintentional poisonings among young children (*4-6*).

This year, as many as 130,000 children under 5 years of age will ingest poisons. The PPWC and the U.S. Consumer Product Safety Commission (CPSC) recommend the following precautions to reduce the risk:

1. Household products and medicines should be kept out of reach and out of sight of children, preferably in a locked cabinet or closet. When leaving the room even briefly, containers of such products should be moved to a safe place.
2. Medicines should be stored separately from other household products and kept in their original containers—never in cups or soft-drink bottles.
3. All products should be properly labeled, and the label should be read before use.
4. A light should be turned on when giving or taking medicine.
5. Since children tend to imitate adults, adults should avoid taking medications in their presence. Medicine should not be drunk from the bottle.
6. Medicines should be referred to by their correct names. They are not candies.
7. Medicine cabinets should be cleaned out periodically. Old medicines should be discarded by flushing them down the drain, rinsing the container with water, and discarding it.
8. Household substances in child-resistant packaging should be used. Prescription medicines should be contained in safety packaging. Safety features should be carefully resecured after using.

To avoid poisonings among elderly persons, PPWC and CPSC recommend the following:

1. Always read the label and follow instructions when taking medicine.
2. Turn on a light at night when taking medicine.
3. Never mix medicines and alcohol, and never take more than the prescribed amount of medicine.
4. Do not "borrow" a friend's medicine or take old medicines.
5. Inform the physician what other medicines are being taken to avoid the risk of adverse drug interactions.

Additional information on NPPW is available from the Secretary, PPWC, P.O. Box 1543, Washington, D.C. 20013; telephone (301) 492-6580. Additional information on poisoning prevention is available from CPSC's toll-free hotline, (800) 638-2772.

Reported by Poison Prevention Week Council, Consumer Product Safety Commission, Washington, D.C.; Office of the Director, Epidemiology Program Office, CDC.

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*Members of the PPWC are: American Academy of Clinical Toxicology; American Academy of Pediatrics; American Association of Poison Control Centers; American Association of Retired Persons; American College of Emergency Physicians; American Dental Association; American Hospital Association; American Medical Association; American Nurses' Association; American Petroleum Institute; American Pharmaceutical Association; American Public Health Association; American Red Cross; American Society of Hospital Pharmacists; Boy Scouts of America; Chemical Specialties Manufacturers Association, Inc.; Closure Manufacturers Association; Cosmetic, Toiletry, and Fragrance Association, Inc.; Council For Responsible Nutrition; Council on Family Health; Girl Scouts of the United States of America; National Agricultural Chemicals Association; National Association of Broadcasters; National Association of Chain Drug Stores; National Association of Retail Druggists; National Paint and Coatings Association; National Safety Council; Pharmaceutical Manufacturers Association; Soap and Detergent Association; The Proprietary Association; U.S. Consumer Product Safety Commission; U.S. Department of Agriculture—Extension Service; U.S. Department of Health and Human Services—Food and Drug Administration, Bureau of Drugs; and U.S. Environmental Protection Agency.

Poison Prevention Week — Continued

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Current Trends

Additional Recommendations to Reduce Sexual and Drug Abuse-Related Transmission of Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus

BACKGROUND

Human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the virus that causes acquired immunodeficiency syndrome (AIDS), is transmitted through sexual contact, parenteral exposure to infected blood or blood components, and perinatally from mother to fetus or neonate. In the United States, over 73% of adult AIDS patients are homosexual or bisexual men; 11% of these males also had a history of intravenous (IV) drug abuse. Seventeen percent of all adult AIDS patients were heterosexual men or women who abused IV drugs (*1,2*). The prevalence of HTLV-III/LAV antibody is high in certain risk groups in the United States (*3,4*).

Since a large proportion of seropositive asymptomatic persons have been shown to be viremic (*5*), all seropositive individuals, whether symptomatic or not, must be presumed capable of transmitting this infection. A repeatedly reactive serologic test for HTLV-III/LAV has important medical, as well as public health, implications for the individual and his/her health-care provider. The purpose of these recommendations is to suggest ways to facilitate identification of seropositive asymptomatic persons, both for medical evaluation and for counseling to prevent transmission.

Previous U.S. Public Health Service recommendations pertaining to sexual, IV drug abuse, and perinatal transmission of HTLV-III/LAV have been published (*6-8*). Reduction of sexual and IV transmission of HTLV-III/LAV should be enhanced by using available serologic tests to give asymptomatic, infected individuals in high-risk groups the opportunity to know their status so they can take appropriate steps to prevent the further transmission of this virus.

Since the objective of these additional recommendations is to help interrupt transmission by encouraging testing and counseling among persons in high-risk groups, careful attention must be paid to maintaining confidentiality and to protecting records from any unauthorized disclosure. The ability of health departments to assure confidentiality—and the public confidence in that ability—are crucial to efforts to increase the number of persons requesting such testing and counseling. Without appropriate confidentiality protection, anonymous testing should be considered. Persons tested anonymously would still be offered medical evaluation and counseling.

PERSONS AT INCREASED RISK OF HTLV-III/LAV INFECTION

Persons at increased risk of HTLV-III/LAV infection include: (1) homosexual and bisexual men; (2) present or past IV drug abusers; (3) persons with clinical or laboratory evidence of infection, such as those with signs or symptoms compatible with AIDS or AIDS-related complex (ARC); (4) persons born in countries where heterosexual transmission is thought to play

HTLV-III/LAV — Continued

a major role*; (5) male or female prostitutes and their sex partners; (6) sex partners of infected persons or persons at increased risk; (7) all persons with hemophilia who have received clotting-factor products; and (8) newborn infants of high-risk or infected mothers.

RECOMMENDATIONS

1. Community health education programs should be aimed at members of high-risk groups to: (a) increase knowledge of AIDS; (b) facilitate behavioral changes to reduce risks of HTLV-III/LAV infection; and (c) encourage voluntary testing and counseling.
2. Counseling and voluntary serologic testing for HTLV-III/LAV should be routinely offered to all persons at increased risk when they present to health-care settings. Such facilities include, but are not limited to, sexually transmitted disease clinics, clinics for treating parenteral drug abusers, and clinics for examining prostitutes.
   a. Persons with a repeatedly reactive test result (see section on Test Interpretation) should receive a thorough medical evaluation, which may include history, physical examination, and appropriate laboratory studies.
   b. High-risk persons with a negative test result should be counseled to reduce their risk of becoming infected by:
      (1) Reducing the number of sex partners. A stable, mutually monogamous relationship with an uninfected person eliminates any new risk of sexually transmitted HTLV-III/LAV infection.
      (2) Protecting themselves during sexual activity with any possibly infected person by taking appropriate precautions to prevent contact with the person's blood, semen, urine, feces, saliva, cervical secretions, or vaginal secretions. Although the efficacy of condoms in preventing infections with HTLV-III/LAV is still under study, consistent use of condoms should reduce transmission of HTLV-III/LAV by preventing exposure to semen and infected lymphocytes (*9,10*).
      (3) For IV drug abusers, enrolling or continuing in programs to eliminate abuse of IV substances. Needles, other apparatus, and drugs must never be shared.
   c. Infected persons should be counseled to prevent the further transmission of HTLV-III/LAV by:
      (1) Informing prospective sex partners of his/her infection with HTLV-III/LAV, so they can take appropriate precautions. Clearly, abstention from sexual activity with another person is one option that would eliminate any risk of sexually transmitted HTLV-III/LAV infection.
      (2) Protecting a partner during any sexual activity by taking appropriate precautions to prevent that individual from coming into contact with the infected person's blood, semen, urine, feces, saliva, cervical secretions, or vaginal secretions. Although the efficacy of using condoms to prevent infections with HTLV-III/LAV is still under study, consistent use of condoms should reduce transmission of HTLV-III/LAV by preventing exposure to semen and infected lymphocytes (*9,10*).
      (3) Informing previous sex partners and any persons with whom needles were shared of their potential exposure to HTLV-III/LAV and encouraging them to seek counseling/testing.
      (4) For IV drug abusers, enrolling or continuing in programs to eliminate abuse of IV substances. Needles, other apparatus, and drugs must never be shared.
      (5) Not sharing toothbrushes, razors, or other items that could become contaminated with blood.
      (6) Refraining from donating blood, plasma, body organs, other tissue, or semen.

*e.g., Haiti, Central African countries.

HTLV-III/LAV — Continued

(7) Avoiding pregnancy until more is known about the risks of transmitting HTLV-III/LAV from mother to fetus or newborn (*8*).

(8) Cleaning and disinfecting surfaces on which blood or other body fluids have spilled, in accordance with previous recommendations (*2*).

(9) Informing physicians, dentists, and other appropriate health professionals of his/her antibody status when seeking medical care so that the patient can be appropriately evaluated.

3. Infected patients should be encouraged to refer sex partners or persons with whom they have shared needles to their health-care provider for evaluation and/or testing. If patients prefer, trained health department professionals should be made available to assist in notifying their partners and counseling them regarding evaluation and/or testing.
4. Persons with a negative test result should be counseled regarding their need for continued evaluation to monitor their infection status if they continue high-risk behavior (*8*).
5. State and local health officials should evaluate the implications of requiring the reporting of repeatedly reactive HTLV-III/LAV antibody test results to the state health department.
6. State or local action is appropriate on public health grounds to regulate or close establishments where there is evidence that they facilitate high-risk behaviors, such as anonymous sexual contacts and/or intercourse with multiple partners or IV drug abuse (e.g., bathhouses, houses of prostitution, "shooting galleries").

TEST INTERPRETATION

Commercially available tests to detect antibody to HTLV-III/LAV are enzyme-linked immunosorbant assays (ELISAs) using antigens derived from disrupted HTLV-III/LAV. When the ELISA is reactive on initial testing, it is standard procedure to repeat the test on the same specimen. Repeatedly reactive tests are highly sensitive and specific for HTLV-III/LAV antibody. However, since falsely positive tests occur, and the implications of a positive test are serious, additional more specific tests (e.g., Western blot, immunofluorescent assay, etc.) are recommended following repeatedly reactive ELISA results, especially in low-prevalence populations. If additional more specific test results are not readily available, persons in high-risk groups with strong repeatedly reactive ELISA results can be counseled before any additional test results are received regarding their probable infection status, their need for medical follow-up, and ways to reduce further transmission of HTLV-III/LAV.

OTHER CONSIDERATIONS

State or local policies governing informing and counseling sex partners and those who share needles with persons who are HTLV-III/LAV-antibody positive will vary, depending on state and local statutes that authorize such actions. Accomplishing the objective of interrupting transmission by encouraging testing and counseling among persons in high-risk groups will depend heavily on health officials paying careful attention to maintaining confidentiality and protecting records from unauthorized disclosure.

The public health effectiveness of various approaches to counseling, sex-partner referral, and laboratory testing will require careful monitoring. The feasibility and efficacy of each of these measures should be evaluated by state and local health departments to best utilize available resources.

Developed by Center for Prevention Svcs and Center for Infectious Diseases, CDC, in consultation with persons from numerous other organizations and groups.

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HTLV-III/LAV — Continued

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Report of the Recommendations of the 1985 DES Task Force of the U.S. Department of Health and Human Services

In 1978, the U.S. Department of Health, Education, and Welfare set up a DES (diethylstilbestrol [a synthetic estrogen]) Task Force to review all aspects of the DES question and to develop recommendations regarding health issues of DES and research gaps that exist. In 1985, a second DES Task Force of the U.S. Department of Health and Human Services (DHHS) was convened to review recent studies showing a possible increased risk of breast cancer among women given DES during pregnancy and a possible excess of precancerous abnormalities of the cervix and vagina among women exposed to DES in utero (*1*).

BREAST CANCER

Since 1978, results of four investigations relevant to this issue have been published (*2-5*). Two of these studies were randomized clinical trials reporting the long-term follow-up results of the use of DES during pregnancy. In one, 80 diabetic women received hormonal treatment, and 76 diabetic women received placebos. After 29 years of follow-up, four cases of breast cancer had occurred among the exposed women, and none, among the unexposed women (*2*). In another study, 10 cases of breast cancer were found among 319 DES-exposed women, and nine, among 331 unexposed women, suggesting there was no excess risk. Exposure occurred in the early 1950s.

Two observational follow-up studies of women treated with DES during pregnancy have also been reported recently (*4,5*). In these studies, the overall relative risk of breast cancer among the exposed women ranged from 1.2 to 1.5. One study noted that there was no increased risk in the first 20 years of follow-up but that the relative risk rose to 1.6 during the 20-29 years after exposure and to 2.5 for those followed 30 years or more (*5*).

The 1985 Task Force concluded that:

1. These levels of excess risk are difficult to evaluate, since it is difficult to rule out various sources of bias that could be responsible for such excesses.
2. In the two observational studies, the interpretation involves assessing whether the excess risks are due to the drug itself or to the indications for the use of the drug. Data from two recent studies suggest that spontaneous abortion before a first birth is a risk factor for the development of breast cancer (*6, 7*). In the observational studies, a primary indication of DES use was previous spontaneous abortion. The Task Force felt it would be useful to analyze the data on risk according to frequency of spontaneous

DES Task Force — Continued

abortion before a first live birth. Unless or until such analyses can be done and evaluated, it was felt that separating a drug effect from an effect related to the indication for drug use remains an open issue.

3. In all these studies, it is possibile that DES-exposed mothers are more likely to have had more intensive medical attention and, therefore, higher rates of breast cancer diagnosis. This could take the form of earlier diagnosis or an excess of cases or both.
4. The 1985 DES Task Force concluded that women who used DES during their pregnancies may subsequently experience an increased risk of breast cancer. However, a causal relationship is still unproven, and the observed level of excess risk is similar to that for a number of other breast cancer risk factors. (See Editorial Note below.)

SQUAMOUS CELL ABNORMALITIES OF THE UTERINE CERVIX IN DES-EXPOSED DAUGHTERS

In 1974, the National Cancer Institute began a multi-institutional cooperative research study, the National Cooperative Diethylstilbestrol Adenosis Project (DESAD Project). The DESAD Project was a large collaborative study involving four groups of DES-exposed persons and having a complex study design.

(Continued on page 161)

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

Disease	10th Week Ending			Cumulative, 10th Week Ending		
	Mar. 8, 1986	Mar. 9, 1985	Median 1981-1985	Mar. 8, 1986	Mar 9, 1985	Median 1981-1985
Acquired Immunodeficiency Syndrome (AIDS)	200	109	N	2,129	1,082	N
Aseptic meningitis	90	70	68	807	658	797
Encephalitis: Primary (arthropod-borne & unspec.)	14	25	18	152	160	160
Post-infectious	-	4	1	8	23	14
Gonorrhea: Civilian	13,449	15,381	16,500	148,195	147,923	175,513
Military	382	471	471	2,918	3,697	4,918
Hepatitis: Type A	433	457	457	4,317	3,942	4,411
Type B	517	541	454	4,413	4,521	4,209
Non A, Non B	70	109	N	553	770	N
Unspecified	114	153	153	1,026	869	1,334
Legionellosis	8	20	N	98	130	N
Leprosy	7	23	6	46	86	44
Malaria	23	16	16	125	127	127
Measles: Total*	56	65	65	508	239	239
Indigenous	49	56	N	487	187	N
Imported	7	9	N	21	52	N
Meningococcal infections: Total	82	80	89	621	602	657
Civilian	82	79	88	620	601	657
Military	-	1	1	1	1	2
Mumps	48	98	114	502	682	809
Pertussis	46	31	30	381	259	240
Rubella (German measles)	7	14	23	79	51	183
Syphilis (Primary & Secondary): Civilian	418	423	540	4,537	4,670	5,814
Military	5	-	2	38	29	78
Toxic Shock syndrome	7	10	N	50	81	N
Tuberculosis	390	507	502	3,367	3,380	3,917
Tularemia	3	1	2	13	21	18
Typhoid fever	7	2	7	40	43	67
Typhus fever, tick-borne (RMSF)	-	1	1	8	5	10
Rabies, animal	73	68	108	760	749	863

TABLE II. Notifiable diseases of low frequency, United States

	Cum 1986		Cum 1986
Anthrax	-	Leptospirosis	10
Botulism: Foodborne	3	Plague	-
Infant (Calif. 1, Hawaii 1)	11	Poliomyelitis, Paralytic	-
Other	-	Psittacosis	10
Brucellosis (Calif. 2)	9	Rabies, human	-
Cholera	-	Tetanus	6
Congenital rubella syndrome	1	Trichinosis	7
Congenital syphilis, ages < 1 year	-	Typhus fever, flea-borne (endemic, murine)	1
Diphtheria	-		

*Six of the 56 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 March 8, 1986 and March 9, 1985 (10th 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	2,129	90	152	8	148,195	147,923	433	517	70	114	8	46
NEW ENGLAND	109	4	7	-	3,460	4,815	7	47	4	11	-	1
Maine	4	-	-	-	167	198	-	2	-	-	-	-
N.H.	3	-	2	-	106	102	-	-	-	-	-	-
Vt.	1	-	2	-	58	45	-	-	-	-	-	-
Mass.	62	3	2	-	1,417	1,795	7	40	4	11	-	1
R.I.	9	-	-	-	327	363	-	-	-	-	-	-
Conn.	30	1	1	-	1,385	2,312	-	5	-	-	-	-
MID ATLANTIC	761	16	26	-	25,035	20,606	26	37	3	31	-	5
Upstate N.Y.	51	6	8	-	3,045	2,738	15	6	1	-	-	-
N.Y. City	490	7	8	-	14,322	9,194	4	3	-	30	-	5
N.J.	152	-	2	-	2,943	3,990	4	15	2	-	-	-
Pa.	68	3	8	-	4,725	4,684	3	13	-	1	-	-
E.N. CENTRAL	118	12	30	1	19,639	21,563	23	49	6	4	4	3
Ohio	29	3	10	1	5,305	5,148	15	25	1	2	3	-
Ind.	16	2	2	-	3,334	2,176	3	2	2	2	-	-
Ill.	42	4	3	-	2,831	6,676	3	4	2	-	-	2
Mich.	28	3	14	-	6,783	6,194	2	18	1	-	1	1
Wis.	3	-	1	-	1,386	1,369	-	-	-	-	-	-
W.N. CENTRAL	49	6	1	1	7,244	7,832	30	18	2	-	1	1
Minn.	24	-	-	-	1,029	1,239	2	5	-	-	-	1
Iowa	3	1	1	-	711	824	-	2	-	-	-	-
Mo.	13	4	-	-	3,401	3,552	4	10	2	-	-	-
N. Dak.	2	-	-	-	77	59	-	-	-	-	-	-
S. Dak.	1	1	-	-	126	144	24	-	-	-	-	-
Nebr.	3	-	-	-	528	668	-	1	-	-	1	-
Kans.	3	-	-	1	1,372	1,346	-	-	-	-	-	-
S. ATLANTIC	244	13	28	6	32,458	31,368	31	99	10	8	1	-
Del.	7	-	2	-	660	645	-	1	1	-	-	-
Md.	31	3	8	-	4,739	4,773	4	13	-	-	-	-
D.C.	21	-	-	-	2,914	2,719	-	5	-	-	-	-
Va.	38	2	12	-	3,502	3,500	4	15	2	1	-	-
W. Va.	-	-	1	-	453	404	-	5	-	-	-	-
N.C.	18	2	4	-	5,910	6,271	1	21	1	1	1	-
S.C.	13	-	-	-	3,593	3,933	-	13	-	1	-	-
Ga.	21	3	-	-	-	-	5	7	-	-	-	-
Fla.	95	3	1	6	10,687	9,123	17	19	6	5	-	-
E.S. CENTRAL	26	5	12	-	13,362	13,087	3	34	4	1	-	-
Ky.	7	-	6	-	1,569	1,449	1	8	1	-	-	-
Tenn.	12	2	1	-	5,277	5,124	-	8	3	-	-	-
Ala.	3	2	5	-	3,579	4,035	1	13	-	-	-	-
Miss.	4	1	-	-	2,937	2,479	1	5	-	1	-	-
W.S. CENTRAL	205	10	8	-	19,715	21,627	69	44	8	19	-	4
Ark.	7	-	-	-	1,790	2,178	5	1	-	-	-	-
La.	30	1	1	-	3,528	4,519	1	2	1	-	-	-
Okla.	2	1	1	-	2,304	2,183	9	4	1	-	-	-
Tex.	166	8	6	-	12,093	12,747	54	37	6	19	-	4
MOUNTAIN	66	5	10	-	4,781	4,818	44	50	9	13	-	5
Mont.	-	-	-	-	123	151	-	-	-	-	-	-
Idaho	1	-	-	-	169	167	2	-	-	1	-	-
Wyo.	2	-	2	-	114	143	1	-	-	-	-	-
Colo.	34	2	2	-	1,312	1,398	1	11	-	6	-	2
N. Mex.	4	1	-	-	521	590	4	3	1	-	-	-
Ariz.	14	2	4	-	1,271	1,402	21	24	6	4	-	1
Utah	5	-	1	-	223	213	7	8	1	2	-	-
Nev.	6	-	1	-	1,048	754	8	4	1	-	-	2
PACIFIC	551	19	30	-	22,501	22,207	200	139	24	27	2	27
Wash.	21	-	2	-	1,719	1,730	7	11	-	-	-	5
Oreg.	10	-	-	-	861	1,309	41	11	3	1	-	-
Calif.	507	18	26	-	19,001	18,320	152	116	21	26	2	21
Alaska	4	1	2	-	662	508	-	1	-	-	-	-
Hawaii	9	-	-	-	258	340	-	-	-	-	-	1
Guam	-	-	-	-	1	28	-	1	-	-	-	-
P.R.	16	-	2	-	453	810	-	2	-	-	-	-
V.I.	-	-	-	-	43	76	-	-	-	-	-	-
Pac. Trust Terr.	-	-	-	-	4	146	8	-	-	-	-	-
Amer. Samoa	-	-	-	-	7	-	2	-	-	-	-	-

N: Not notifiable U: Unavailable

TABLE III. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending March 8, 1986 and March 9, 1985 (10th 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	125	49	487	7	21	239	621	48	502	46	381	259	7	79	51
NEW ENGLAND	7	1	9	-	-	-	45	1	8	-	24	13	-	-	3
Maine	-	-	-	-	-	-	10	-	-	-	2	2	-	-	-
N.H.	-	-	-	-	-	-	2	-	4	-	7	7	-	-	1
Vt.	1	-	-	-	-	-	7	-	-	-	1	1	-	-	-
Mass.	3	1	9	-	-	-	8	-	-	-	8	2	-	-	2
R.I.	1	-	-	-	-	-	3	-	3	-	1	1	-	-	-
Conn.	2	-	-	-	-	-	15	1	1	-	5	-	-	-	-
MID ATLANTIC	18	2	181	1	3	10	112	4	34	3	57	44	2	19	9
Upstate N.Y.	-	1	1	-	2	4	28	1	10	2	38	22	2	14	2
N.Y. City	7	1	17	1†	1	6	28	-	1	-	5	7	-	5	6
N.J.	2	-	163	-	-	-	18	-	12	-	-	1	-	-	1
Pa.	9	-	-	-	-	-	38	3	11	1	14	14	-	-	-
E.N. CENTRAL	4	3	40	-	-	78	76	18	235	9	85	50	-	1	5
Ohio	1	-	-	-	-	11	36	2	38	7	45	8	-	-	-
Ind.	-	-	-	-	-	-	9	4	12	-	9	11	-	-	-
Ill.	2	3	21	-	-	4	16	9	129	-	2	9	-	-	-
Mich.	1	-	-	-	-	32	15	2	32	2	11	5	-	-	4
Wis.	-	-	19	-	-	31	-	1	24	-	18	17	-	1	1
W.N. CENTRAL	3	2	51	-	-	-	28	2	18	3	22	25	-	2	6
Minn.	1	-	-	-	-	-	7	-	1	-	11	10	-	-	-
Iowa	1	-	-	-	-	-	4	-	5	2	4	1	-	-	-
Mo.	1	-	-	-	-	-	13	1	4	1	3	5	-	1	-
N. Dak.	-	-	-	-	-	-	-	-	1	-	1	3	-	-	-
S. Dak.	-	-	-	-	-	-	-	1	1	-	-	-	-	-	-
Nebr.	-	-	-	-	-	-	2	-	-	-	-	1	-	-	-
Kans.	-	2	51	-	-	-	2	-	6	-	3	5	-	1	6
S. ATLANTIC	18	19	73	-	1	7	129	3	48	7	74	50	-	5	4
Del.	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-
Md.	3	3	4	-	-	1	15	-	3	2	18	13	-	-	1
D.C.	-	-	-	-	-	1	2	-	-	-	-	-	-	-	-
Va.	6	-	-	-	-	3	21	1	6	-	6	1	-	-	-
W. Va.	-	-	-	-	-	-	2	2	19	1	2	-	-	-	-
N.C.	2	-	-	-	-	-	16	-	4	1	12	6	-	-	-
S.C.	-	15	58	-	-	-	20	-	4	-	2	-	-	-	2
Ga.	2	1	1	-	-	-	13	-	3	3	29	18	-	-	-
Fla.	5	-	10	-	1	2	39	-	9	-	5	12	-	5	1
E.S. CENTRAL	2	-	-	-	-	-	32	-	5	-	11	3	-	1	1
Ky.	2	-	-	-	-	-	6	-	2	-	1	1	-	1	1
Tenn.	-	-	-	-	-	-	14	-	1	-	2	1	-	-	-
Ala.	-	-	-	-	-	-	10	-	1	-	8	1	-	-	-
Miss.	-	-	-	-	-	-	2	-	1	-	-	-	-	-	-
W.S. CENTRAL	5	10	36	1	5	2	37	6	37	3	18	14	2	12	4
Ark.	-	-	21	-	-	-	2	-	2	-	-	7	-	-	1
La.	1	-	-	-	-	-	4	-	-	1	2	-	-	-	-
Okla.	1	-	-	-	-	-	7	N	N	2	16	7	-	-	-
Tex.	3	10	15	1†	5	2	24	6	35	-	-	-	2	12	3
MOUNTAIN	4	1	33	1	5	96	29	4	58	19	52	13	-	-	1
Mont.	-	-	-	1§	1	96	4	-	2	-	-	1	-	-	-
Idaho	-	-	-	-	-	-	1	-	2	6	13	-	-	-	-
Wyo.	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-
Colo.	1	-	-	-	2	-	5	-	4	3	12	5	-	-	-
N. Mex.	-	-	13	-	2	-	4	N	N	1	7	2	-	-	-
Ariz.	2	1	20	-	-	-	9	4	46	9	19	2	-	-	1
Utah	-	-	-	-	-	-	2	-	1	-	1	3	-	-	-
Nev.	1	-	-	-	-	-	2	-	3	-	-	-	-	-	-
PACIFIC	64	11	64	4	7	46	133	10	59	2	38	47	3	39	18
Wash.	5	2	20	2†	3	1	20	-	4	2	16	5	-	-	-
Oreg.	7	-	-	1†	2	-	12	N	N	-	2	5	-	-	1
Calif.	52	8	38	1†	2	41	96	9	49	-	17	35	3	39	15
Alaska	-	-	-	-	-	-	5	-	2	-	1	-	-	-	-
Hawaii	-	1	6	-	-	4	-	1	4	-	2	2	-	-	2
Guam	-	1	1	-	-	10	-	-	1	-	-	-	1	1	1
P.R.	1	-	-	-	-	35	1	-	11	-	2	1	-	-	4
V.I.	-	-	-	-	-	9	-	-	3	-	-	-	-	-	-
Pac. Trust Terr.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

*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 March 8, 1986 and March 9, 1985 (10th 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	4,537	4,670	7	3,367	3,380	13	40	8	760
NEW ENGLAND	110	102	1	104	117	-	1	1	-
Maine	7	3	1	12	9	-	-	-	-
N.H.	5	3	-	3	6	-	-	-	-
Vt.	4	-	-	6	-	-	-	-	-
Mass.	58	53	-	50	66	-	1	1	-
R.I.	5	2	-	5	16	-	-	-	-
Conn.	31	41	-	28	20	-	-	-	-
MID ATLANTIC	657	617	-	627	666	-	4	-	89
Upstate N.Y.	31	29	-	94	88	-	1	-	12
N.Y. City	366	417	-	300	380	-	3	-	-
N.J.	137	117	-	126	48	-	-	-	-
Pa.	123	54	-	107	150	-	-	-	77
E.N. CENTRAL	102	230	-	472	441	-	3	-	9
Ohio	17	16	-	73	82	-	-	-	-
Ind.	25	17	-	53	50	-	-	-	2
Ill.	18	126	-	209	209	-	-	-	1
Mich.	27	60	-	109	78	-	3	-	2
Wis.	15	11	-	28	22	-	-	-	4
W.N. CENTRAL	51	58	-	83	89	4	2	-	92
Minn.	8	18	-	17	16	-	1	-	-
Iowa	4	10	-	11	16	1	-	-	24
Mo.	25	18	-	43	36	3	1	-	9
N. Dak.	2	-	-	3	2	-	-	-	34
S. Dak.	-	3	-	2	5	-	-	-	25
Nebr.	7	1	-	3	4	-	-	-	-
Kans.	5	8	-	4	10	-	-	-	-
S. ATLANTIC	1,163	1,180	-	674	669	3	3	3	181
Del.	8	9	-	6	8	-	-	-	-
Md.	84	99	-	45	60	1	-	-	116
D.C.	77	57	-	30	31	-	-	-	-
Va.	98	61	-	50	43	1	-	-	24
W. Va.	3	1	-	25	17	-	-	-	5
N.C.	115	142	-	106	72	-	2	2	-
S.C.	148	153	-	84	95	-	-	1	5
Ga.	-	-	-	79	99	1	-	-	25
Fla.	630	658	-	249	244	-	1	-	6
E.S. CENTRAL	320	415	-	309	288	3	-	2	33
Ky.	21	13	-	76	63	2	-	1	8
Tenn.	150	95	-	91	81	1	-	-	14
Ala.	105	154	-	116	110	-	-	1	11
Miss.	44	153	-	26	34	-	-	-	-
W.S. CENTRAL	1,049	1,167	-	416	344	3	1	2	78
Ark.	47	64	-	36	22	2	-	-	13
La.	173	214	-	107	58	-	-	-	2
Okla.	33	40	-	41	40	1	-	-	7
Tex.	796	849	-	232	224	-	1	2	56
MOUNTAIN	137	159	3	69	50	-	2	-	155
Mont.	3	1	-	2	5	-	-	-	62
Idaho	1	2	-	4	1	-	-	-	-
Wyo.	-	4	-	-	1	-	-	-	64
Colo.	38	38	1	-	3	-	-	-	-
N. Mex.	17	17	-	19	8	-	-	-	2
Ariz.	59	88	1	33	27	-	1	-	27
Utah	4	2	1	1	2	-	1	-	-
Nev.	15	7	-	10	3	-	-	-	-
PACIFIC	948	742	3	613	716	-	24	-	123
Wash.	16	27	-	34	29	-	2	-	-
Oreg.	22	22	-	28	23	-	-	-	-
Calif.	900	681	3	503	590	-	20	-	120
Alaska	-	-	-	12	37	-	-	-	3
Hawaii	10	12	-	36	37	-	2	-	-
Guam	-	2	-	-	5	-	-	-	-
P.R.	167	188	-	55	56	-	-	-	6
V.I.	-	-	-	-	1	-	-	-	-
Pac. Trust Terr.	-	13	-	3	16	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-

NO change

U: Unavailable

TABLE IV. Deaths in 121 U.S. cities,* week ending March 8, 1986 (10th Week)

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	759	566	133	44	4	12	80
Boston, Mass.	214	139	52	17	2	4	33
Bridgeport, Conn.	52	42	4	6	-	-	4
Cambridge, Mass.	36	31	5	-	-	-	5
Fall River, Mass.	39	33	3	3	-	-	3
Hartford, Conn.	25	15	7	2	-	1	3
Lowell, Mass.	19	15	4	-	-	-	1
Lynn, Mass.	29	24	4	1	-	-	2
New Bedford, Mass.	28	23	4	1	-	-	2
New Haven, Conn.	62	45	8	6	2	1	4
Providence, R.I.	89	66	17	4	-	2	7
Somerville, Mass.	11	10	1	-	-	-	1
Springfield, Mass.	47	33	10	1	-	3	5
Waterbury, Conn.	38	33	4	1	-	-	4
Worcester, Mass.	70	57	10	2	-	1	6
MID ATLANTIC	3,167	2,644	273	126	57	66	187
Albany, N.Y.	72	48	11	6	4	3	1
Allentown, Pa.	11	10	1	-	-	-	-
Buffalo, N.Y.	136	96	26	9	1	4	14
Camden, N.J.	44	33	5	3	-	3	-
Elizabeth, N.J.	30	24	5	1	-	-	-
Erie, Pa.†	45	35	8	1	1	-	5
Jersey City, N.J.	86	63	14	9	-	-	2
N.Y. City, N.Y. §	1,713	1,611	12	22	34	34	79
Newark, N.J.	79	50	13	11	1	3	7
Paterson, N.J.	46	35	9	1	1	-	5
Philadelphia, Pa.	409	267	85	36	8	13	28
Pittsburgh, Pa.†	93	66	18	7	-	2	5
Reading, Pa.	43	38	4	1	-	-	5
Rochester, N.Y.	149	111	26	4	4	4	14
Schenectady, N.Y.	31	28	2	1	-	-	1
Scranton, Pa.†	31	25	5	1	-	-	5
Syracuse, N.Y.	53	41	7	3	2	-	4
Trenton, N.J.	30	19	7	4	-	-	4
Utica, N.Y.	36	24	10	2	-	-	3
Yonkers, N.Y.	30	20	5	4	1	-	5
E.N. CENTRAL	2,574	1,819	448	144	61	101	140
Akron, Ohio	77	53	14	4	1	5	4
Canton, Ohio	62	40	19	1	-	2	8
Chicago, Ill.§	553	462	11	26	16	37	16
Cincinnati, Ohio	165	116	35	8	4	2	21
Cleveland, Ohio	166	96	47	12	5	6	2
Columbus, Ohio	169	109	39	11	2	8	2
Dayton, Ohio	114	80	25	7	1	1	3
Detroit, Mich.	302	184	59	32	13	14	15
Evansville, Ind.	51	40	10	-	-	1	3
Fort Wayne, Ind.	56	42	12	2	-	-	4
Gary, Ind.	18	12	4	1	1	-	-
Grand Rapids, Mich	97	72	9	9	2	5	15
Indianapolis, Ind.	193	124	52	5	6	6	6
Madison, Wis.	47	32	9	1	2	3	5
Milwaukee, Wis.	161	111	38	7	2	3	11
Peoria, Ill.	39	26	10	2	1	-	3
Rockford, Ill.	51	34	9	6	1	1	2
South Bend, Ind.	58	38	11	5	2	2	5
Toledo, Ohio	125	88	26	5	2	4	9
Youngstown, Ohio	70	60	9	-	-	1	6
W.N. CENTRAL	802	566	151	43	17	24	56
Des Moines, Iowa	80	65	9	4	1	1	11
Duluth, Minn.	40	28	8	2	1	1	5
Kansas City, Kans.	46	24	18	1	-	3	1
Kansas City, Mo.	117	86	20	6	3	2	6
Lincoln, Nebr.	37	23	9	2	2	1	2
Minneapolis, Minn.	89	63	15	4	4	3	6
Omaha, Nebr.	80	61	12	4	3	-	11
St. Louis, Mo.	165	121	23	11	3	6	6
St. Paul, Minn.	69	49	13	2	-	5	1
Wichita, Kans.	79	46	24	7	-	2	7
S. ATLANTIC	1,654	1,043	377	136	50	48	87
Atlanta, Ga.	178	118	38	17	1	4	10
Baltimore, Md.	420	259	110	31	10	10	13
Charlotte, N.C.	65	31	20	12	-	2	3
Jacksonville, Fla.	130	90	26	8	4	2	8
Miami, Fla.	160	81	44	21	6	8	2
Norfolk, Va.	66	38	20	3	5	-	7
Richmond, Va.	87	52	22	4	4	5	7
Savannah, Ga.	55	42	9	3	-	1	5
St. Petersburg, Fla.	155	134	13	4	1	3	12
Tampa, Fla.	99	55	29	3	9	3	6
Washington, D.C.	204	116	40	30	9	9	11
Wilmington, Del.	35	27	6	-	1	1	3
E.S. CENTRAL	833	542	182	54	26	29	57
Birmingham, Ala.	142	90	35	10	4	3	5
Chattanooga, Tenn.	54	41	8	1	2	2	9
Knoxville, Tenn.	58	40	11	3	3	1	6
Louisville, Ky.	106	65	24	8	2	7	8
Memphis, Tenn.	221	153	46	14	6	2	10
Mobile, Ala.	96	64	23	2	4	3	10
Montgomery, Ala.	42	25	11	3	-	3	1
Nashville, Tenn.	114	64	24	13	5	8	8
W.S. CENTRAL	1,380	937	266	78	57	42	66
Austin, Tex.	55	31	17	3	2	2	3
Baton Rouge, La.	60	39	12	7	2	-	5
Corpus Christi, Tex.	32	21	6	2	2	1	-
Dallas, Tex.	189	116	37	18	13	5	8
El Paso, Tex.	59	37	14	3	4	1	4
Fort Worth, Tex.	107	62	30	8	5	2	10
Houston, Tex. §	319	283	6	6	12	12	5
Little Rock, Ark.	74	48	19	4	1	2	5
New Orleans, La.	153	98	40	10	3	2	3
San Antonio, Tex.	195	112	53	13	8	9	14
Shreveport, La.	33	25	7	-	-	1	1
Tulsa, Okla.	104	65	25	4	5	5	8
MOUNTAIN	760	511	159	61	17	11	39
Albuquerque, N.Mex.	104	76	15	7	4	1	-
Colo. Springs, Colo.	50	34	6	6	2	2	9
Denver, Colo.	143	104	24	8	5	2	5
Las Vegas, Nev.	99	64	29	3	1	2	6
Ogden, Utah	25	16	6	2	-	1	2
Phoenix, Ariz.	171	104	43	20	3	1	5
Pueblo, Colo.	32	25	6	1	-	-	4
Salt Lake City, Utah	45	27	12	4	-	2	-
Tucson, Ariz.	91	61	18	10	2	-	8
PACIFIC	2,143	1,415	394	200	77	46	140
Berkeley, Calif.	34	20	5	5	-	4	2
Fresno, Calif.	54	42	7	3	-	2	9
Glendale, Calif.	37	31	4	1	1	-	3
Honolulu, Hawaii	74	42	23	2	3	4	9
Long Beach, Calif.	119	80	21	14	3	1	25
Los Angeles, Calif.	686	438	125	74	30	8	29
Oakland, Calif.	79	52	15	8	2	2	6
Pasadena, Calif. §	29	29	-	-	-	-	1
Portland, Oreg.	133	95	21	7	6	4	3
Sacramento, Calif.	175	113	37	16	4	5	11
San Diego, Calif.	165	101	38	13	7	6	18
San Francisco, Calif.	138	83	24	22	6	3	2
San Jose, Calif.	177	116	40	11	7	3	13
Seattle, Wash.	147	105	20	18	4	-	4
Spokane, Wash.	60	40	11	2	3	4	4
Tacoma, Wash.	36	28	3	4	1	-	1
TOTAL	14,072††	10,043	2,383	886	366	379	852

* 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.

DES Task Force – Continued

The 1978 DES Task Force concluded that, in the uterine cervix, the risks for squamous cell cancer were the same in unexposed and exposed daughters, i.e., there was no reliable scientific evidence to indicate that a risk of squamous cell cancer was associated with DES exposure in utero. This conclusion was based primarily on clinical evaluations and on the results from the initial screening examination of DES-exposed daughters in the DESAD Project.

A recent study that has reopened the issue of cervical abnormalities is a report from the DESAD Project summarizing the cytologic and pathologic abnormalities of the cervix and vagina noted during the first 7 years of follow-up of DES-exposed daughters (*8*). One subset of 744 women was identified from reviews of obstetrical records as exposed in utero to DES and was matched with another subset of 744 women who had not been exposed to DES. Over 7 years of screening, the incidence rate of mild, moderate, and severe dysplasia and of carcinoma in situ of the uterine cervix was substantially higher in the exposed women than in the unexposed (15.7, compared with 7.9 cases per 1,000 persons per year of follow-up) (*8*). The 1985 Task Force reviewed this report (*8*) and concluded that a relationship between DES exposure in utero and the risk of subsequently developing squamous cell cancer is not proven but needs further study.

The following considerations were thought to be important in interpreting the reported new finding of an increase in dysplasia among DES-exposed daughters (*8*):

1. While dysplasia is recognized as a potential risk for the development of squamous cell carcinoma, it does not always progress into carcinoma.
2. There was no difference between the matched cohorts of exposed and unexposed women in regard to a history of a prior diagnosis of dysplasia or in the prevalence of dysplasia at the initial examination. The nearly twofold difference in incidence rate for any degree of dysplasia, in the presence of essentially similar prevalence rates for the two groups (as noted in the 1978 DES Task Force Report), needs to be addressed.
3. There is an unexplained difference between the exposed and unexposed daughters in the frequency of a history of genital herpes: 11.8% of 703 DES-exposed and only 6.3% of 695 unexposed. This raises the possibility that the increased frequency of dysplasia in the DES-exposed daughters could be related to this higher frequency of a history of genital herpes infection in that group, rather than to the DES exposure. However, there is also the possibility that DES might be related to increased herpetic infection through long-term postnatal immunosuppression or through some other mechanism.
4. The possibility of an ascertainment bias also needs to be evaluated, since the likelihood that a woman would be biopsied is greater if the area of metaplasia (associated with DES exposure) is larger.

RECOMMENDATION

The Task Force recommended that physicians continue attempts to notify women for whom they had prescribed DES and that DHHS continue to support and encourage research on the possible adverse effects of DES. The Task Force outlined specific areas for further study.

In addition, the Task Force recommended continued dissemination of information to all physicians and DES-exposed mothers and offspring and continued implementation of recommendations for the surveillance of DES-exposed mothers, daughters, and sons. Recommendations for screening DES mothers for breast cancer are the same as those for other women. Details of screening DES-exposed daughters for cervical and vaginal lesions are given in the DES Task Force Report. Copies of the full report can be obtained by contacting: DES, Office of Cancer Communication, Building 31, National Cancer Institute, Bethesda, Maryland 20892; telephone (800) 4-CANCER.

Reported by the 1985 DES Task Force, US Dept of Health and Human Svcs.

DES Task Force — Continued

Editorial Note: Previously reported risk factors for breast cancer include a family history of breast cancer, nulliparity, late age at first birth of a child, prior atypical proliferative disease of the breast, certain ethnic characteristics, high socioeconomic status, early menarche, late menopause, high-fat diet, pregnancies of less than 4-5 months' duration, irregular menstrual cycles, obesity, and lack of exercise (*9-11*).

Similarly, there are multiple risk factors for cervical cancers. Among those reported are early sexual activity (especially with multiple partners), infections with genital herpes and human papilloma virus, multiple sex partners of the male mate, multiparity, and high chronic alcohol intake (12).

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Epidemiologic Notes and Reports

Respiratory Syncytial Virus — Oklahoma

From November 1985 through the end of January 1986, an unusually large number of respiratory illnesses due to respiratory syncytial virus (RSV) occurred in Oklahoma.

Oklahoma Children's Memorial Hospital (OCMH), a 239-bed teaching hospital, serves Oklahoma City and is a tertiary referral center for central and western Oklahoma. From November 1985 through January 1986, more bronchiolitis was diagnosed each month among patients visiting the OCMH emergency room (ER) than in any month of the previous two winters (Figure 2). While the median age of patients during this 3-month epidemic season (5 months,

RSV — Continued

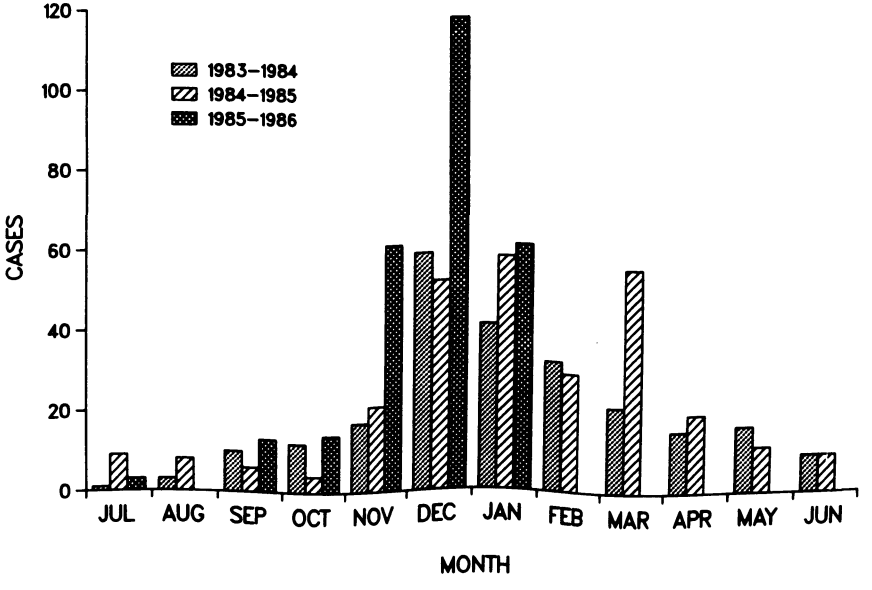
range 18 days to 70 months) was similar to that seen in the previous 2 years, the sex distribution (51% female) differed in that the usual predominance of males (59% for the November 1984-March 1985 season, 67% for the January 1984-March 1984 season) was not seen. In December, the peak month of the outbreak, more than twice as many patients were hospitalized for bronchiolitis than in any month during the previous 5 years.

RSV was identified in 66 (53.2%) of 124 nasopharyngeal aspirates submitted from hospitalized patients in December for viral culture or fluorescent antibody tests. This was the largest number of positive tests and the highest rate of RSV positivity for any month since the virology laboratory began testing for RSV in 1981. For patients hospitalized at OCMH for bronchiolitis through December 10 of this epidemic period, 39 (84.8%) of 46 of those who submitted nasopharyngeal aspirates for testing had RSV infection. Twenty-five (67.6%) of 37 patients with pneumonia had RSV infection. Although the number of patients seen with RSV-related illness increased, indicators of the severity were similar to those seen in previous years. For example, of 238 patients seen in the OCMH ER for bronchiolitis from November 1, 1985, through January 31, 1986, 57 (23.9%) were admitted to the hospital, compared with 36 (16.7%) of 215 and 37 (24.2%) of 153 for the two previous seasons, respectively. Likewise, the rate of admission to the intensive-care unit for patients with laboratory-confirmed RSV illnesses was 8.8/100 ER visits for bronchiolitis, compared with 8.4/100 for the previous season (November 1984-March 1985). Two deaths at OCMH were attributed to RSV during this season; one such death occurred during the previous year.

Reports of increased rates of bronchiolitis from physicians and hospitals in areas of Oklahoma relative to previous years indicate that the RSV epidemic is not limited to Oklahoma City.

Reported by W Pryor, MD, M Marks, MD, P Rettig, MD, J Waner, PhD, J Steumky, MD, D Conrad, MD, J Christensen, MD, W Chapman, MD, S Bullard, MD, J Hayes, MD, P Hines, MD, M Rock, MD, H Shalaby,

FIGURE 2. Patients with bronchiolitis seen at emergency room, — Oklahoma Children's Medical Center Hospital, 1983-1986



RSV – Continued

PhD, S Todd, N Whitehurst, L Wall, Oklahoma Children's Memorial Hospital, Oklahoma City, C Wood, J Dudly, Immunization Div, G Istre, MD, State Epidemiologist, Oklahoma State Dept of Health; Div of Field Svcs, Epidemiology Program Office, Respiratory and Enterovirus Br, Div of Viral Diseases, Center for Infectious Diseases, CDC.

Editorial Note: RSV infection, the most common cause of bronchiolitis among infants, occurs in seasonal epidemics that usually peak in the winter months. For the last 10 years, data from seven to 16 U.S. university virus laboratories show the average initial outbreak month (the first month with 8% or more of the year's total isolates) has been December or January; the peak outbreak month, January or February; and the duration of the outbreak, 2-4 months. Several studies have shown that the number of RSV-associated illnesses varies from year to year (*1,2*). The Oklahoma outbreak, plus reports from other (university) laboratories, suggest that the number of RSV-associated illnesses has increased in several locations this year. Data from these laboratories also suggest RSV activity occurred earlier than usual this season, with the average initial outbreak month being November rather than December. The number of RSV isolates reported has increased through January in all reporting regions except the South Atlantic, where the number of RSV isolates peaked in December.

RSV is the major cause of acute, lower respiratory illness among infants and young children worldwide. It is estimated that nearly 50% of children under 1 year of age are infected with RSV during an epidemic, and between one in 50 and one in 200 of these are hospitalized (*3*). Among children hospitalized with RSV, mortality rates between 0.5% and 5.6% have been reported (*4-7*), consistent with the two of 57 (3.5%) reported in this outbreak. Of particular concern during RSV outbreaks is the potential for nosocomial spread to infants and children at greatest risk for severe disease, such as those with compromised cardiac, pulmonary, or immune systems. A mortality rate as high as 37% has been reported among hospitalized children with cardiac abnormalities who became infected with RSV (*7*). Nosocomial RSV has also been associated with nearly a twofold increase in the duration of hospitalization (*8*).

Recommendations for the control of RSV spread in hospitals include strict attention to good hand-washing practices and the use of gowns when contact with respiratory secretions of RSV-infected patients is likely. RSV-infected patients should be in private rooms or cohorted with other patients likely to be infected with RSV (*9,10*).

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International Notes

Agranulocytosis Associated with the Use of Amodiaquine for Malaria Prophylaxis

Seven cases of agranulocytosis associated with the use of amodiaquine (Camoquine®) among British travelers have recently been reported (*1*). Sixteen additional cases of agranulocytosis from Western Europe associated with the use of amodiaquine have recently been reported to the drug manufacturer, and two U.S. cases have been reported to CDC. Twenty-three of these 25 cases occurred in 1985 or 1986, and seven are reported to have been fatal. Among 20 cases for which the duration of amodiaquine prophylaxis is known, usage ranged from 3 weeks to 24 weeks. In all but four of the 25 cases, amodiaquine was used at the appropriate dosage (adults 400 mg base per week) for prophylaxis. Fourteen of the patients are known to have used another antimalarial drug concurrently for prophylaxis; weekly pyrimethamine-sulfadoxine (Fansidar®) was used in five cases, and daily proguanil (Paludrine®), in nine cases.

Reported by Malaria Br, Div of Parasitic Diseases, Center for Infectious Diseases, Div of Quarantine, Center for Prevention Svcs, CDC.

Editorial Note: Amodiaquine, a 4-aminoquinoline similar to chloroquine in structure and activity, has been used as both an antimalarial and an anti-inflammatory agent for more than 30 years. Only rarely has amodiaquine been associated with agranulocytosis: of 13 reports published between 1955 and 1985, only three were associated with the use of amodiaquine at recommended dosages for malaria prophylaxis in the absence of the use of other drugs known to have similar toxicity (*2,3*).

The reason for the discrepancy between the previous and recent experiences with amodiaquine is not clear. While previously used largely for treating malaria in endemic areas, amodiaquine has been increasingly recommended for chemoprophylaxis in nonimmune visitors to endemic areas (*4,5*). It is not known whether bone-marrow toxicity is more likely to occur when the drug is used on a routine weekly basis for prophylaxis or when used in combination with other antimalarials, such as Fansidar® or Paludrine®. Agranulocytosis has been associated with the use of Fansidar® alone (*6*), but has not been reported when Paludrine® has been used alone.

Alternatively, the recent increase in the number of agranulocytosis cases might be explained by an increase in the number of persons using amodiaquine for malaria prophylaxis. Although amodiaquine is not marketed in the United States, information provided by the manufacturer indicates that the number of Europeans using amodiaquine for malaria prophylaxis may have increased in 1985. In the United Kingdom, amodiaquine became available in March 1985 after a 10-year hiatus in marketing; in Switzerland, a threefold increase in amodiaquine sales was noted from 1984 to 1985.

In April 1985, CDC revised its recommendations for preventing malaria in travelers, because of severe cutaneous reactions associated with the use of Fansidar®, and recommended amodiaquine use for malaria prophylaxis could be considered as an alternative for longer-term travelers at risk of acquiring chloroquine-resistant *Plasmodium falciparum* (CRPF) (*7*). This recommendation was based on studies showing amodiaquine was somewhat more effective than chloroquine in treating CRPF infections (*8*) and, therefore, might provide more protection than chloroquine when used as weekly prophylaxis in areas where CRPF transmission occurs. Similarly, the World Health Organization recently suggested the use of amodiaquine as an alternative to chloroquine and recommended that it be used in combination with Paludrine® or Maloprim® (dapsone-pyrimethamine) for travel to certain areas (*4*).

It is now apparent that any possible prophylactic advantage that amodiaquine may afford

Agranulocytosis — Continued

is not justified by the possible risk of agranulocytosis associated with the use of the drug. CDC, therefore, no longer recommends that amodiaquine be used for prophylaxis. Otherwise, previous recommendations for the prevention of malaria in travelers remain valid (*5, 7*).

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Current Trends

Update: Influenza Activity — United States

Reports of influenza activity from family physicians, state health departments, and collaborating diagnostic laboratories indicate that U.S. influenza activity is at elevated but declining levels.

Reports of influenza-like cases from the practices of sentinel physicians* for the week ending February 26 averaged 10.4, a decrease from the average of 11.2 reported for the preceding week (Figure 3). Outbreaks of influenza-like illness were reported by 14 states and the District of Columbia for the week ending March 8, a decrease from the 25 states that reported outbreaks the preceding week. Seven states indicated widespread outbreaks; seven states and the District of Columbia indicated regional outbreaks.

Isolates of type B influenza virus have now been reported from every state, and type A(H3N2) influenza viruses, from 31 states during the 1985-1986 influenza season. Incomplete totals for the week ending March 1 include 130 type B and 35 type A(H3N2) isolates; 187 type B and 47 type A(H3N2) viruses were reported for the week ending February 22. Overall, 1,714 influenza virus isolates, including 78.5% type B viruses and 21.5% type A(H3N2) viruses have been reported this season.

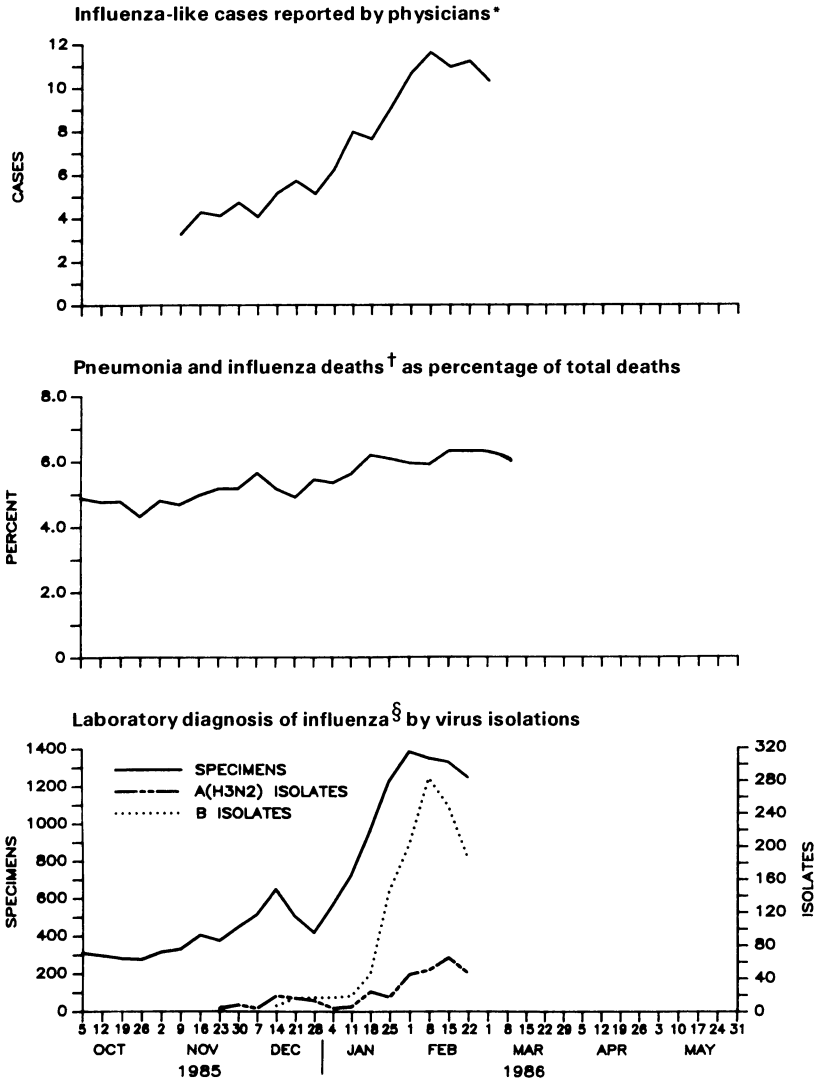
The percentage of pneumonia and influenza (P&I) deaths reported from the 121 U.S. cities for the week ending March 8 was 6.1%, compared with 6.3% for the preceding week. This is the ninth consecutive week that the P&I percentage has exceeded the statistical limit expected in the absence of influenza outbreaks nationwide.

Reported by State and Territorial Epidemiologists; State Laboratory Directors; Statistical Svcs Br, Div of Surveillance and Epidemiologic Studies, Div of Field Svcs, Epidemiology Program Office, WHO Collaborating Center for Influenza, Influenza Br, Div of Viral Diseases, Center for Infectious Diseases, CDC.

*Cases reported by those members of the American Academy of Family Physicians research panel who serve as sentinel physicians for influenza.

Influenza — Continued

FIGURE 3. Indicators of influenza activity, by week — United States, 1985-1986

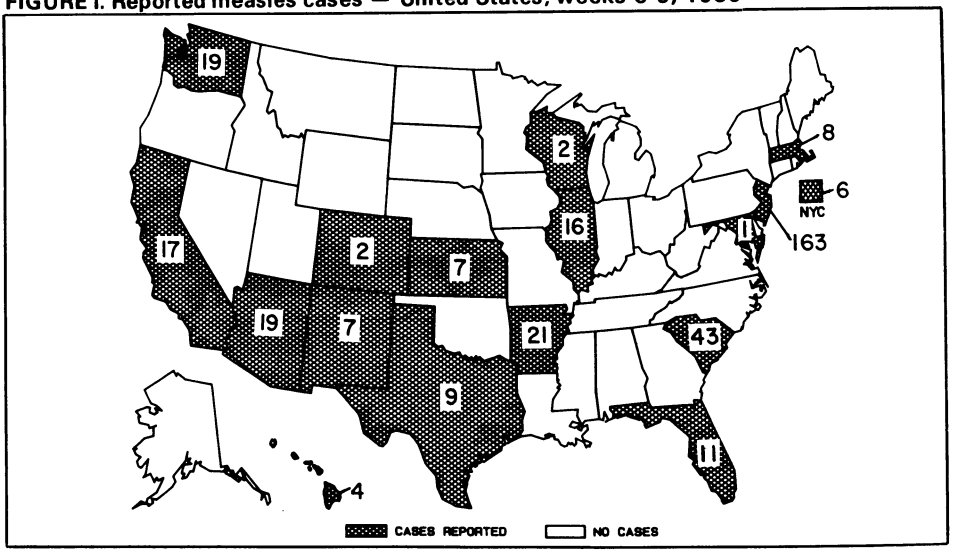


*Reported to CDC by approximately 125 physician members of the American Academy of Family Physicians. A case was defined as a patient with fever 37.8 C (100F) or greater and at least cough or sore throat.

†Reported to CDC from 121 cities in the United States. Pneumonia and influenza deaths include all deaths where pneumonia is listed as a primary or underlying cause or where influenza is listed on the death certificate.

§Reported to CDC by WHO Collaborating Laboratories (including military sources).

FIGURE I. Reported measles cases — United States, weeks 6-9, 1986



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

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

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

☆U.S. Government Printing Office: 1986-746-149/21045 Region IV

HHS Publication No. (CI