CENTERS FOR DISEASE CONTROL March 21, 1986 / Vol. 35 / No. 11

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Perspectives in Disease Prevention and Health Promotion

Premature Mortality due to Sudden Infant Death Syndrome

Sudden infant death syndrome (SIDS) ranked as the seventh leading cause of years of potential life lost before age 65 (YPLL) in 1984. It accounted for 314,000 (2.4%) YPLL of the total YPLL in that year (see Table V, page 179). In 1984, SIDS accounted for 12.4% of all YPLL from deaths among infants.

Data presented below are from the National Center for Health Statistics (NCHS) Mortality Detail tapes. The latest year for which these tapes are available is 1982. Deaths were attributed to SIDS if the underlying cause of death was classified as category 798.0 in *The International Classification of Diseases, 9th Revision* (ICD-9), and age at death was under 1 year.

In 1979, 340,496 YPLL were attributed to SIDS; in 1980, 355,395; in 1981, 341,528; and in 1982, 340,431. The average YPLL due to SIDS for this 4-year period was 344,462. During this same period, the race- and sex-specific YPLL was 144,319 for white males; 89,752 for white females; 55,873 for black males; 44,424 for black females; 5,644 for other males; and 4,451 for other females. The male:female YPLL ratio for white infants was 1.6:1, compared with 1.3:1 for black and other infants..

YPLL is directly dependent on the number of births in any given group. The average annual YPLL per 1,000 live births is 97.2 for white males; 63.9 for white females; 187.7 for black males; 153.6 for black females; 86.6 for other males; and 72.7 for other females.

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Editorial Note: SIDS is defined as the unexpected death of a previously healthy infant between 2 weeks and 1 year of age, unexplained after a complete autopsy examination (*1*). SIDS usually occurs during the first 6 months of life. The concept and definition of a sudden infant death syndrome were formalized in 1969, and SIDS was not specified as a cause of death until ICD-9 came into use in 1979. Therefore, comparison of YPLL due to SIDS cannot be carried out using vital records for years before 1979.

SIDS is usually a diagnosis of exclusion, theoretically dependent on the performance of a post-mortem examination. Since 1979, the autopsy rate for SIDS in the NCHS Mortality Detail tapes has exceeded 80%. This compares with an autopsy rate of approximately 40% for non-SIDS infant deaths. The higher autopsy rate for SIDS may result from legal requirements in some areas. It is important to note that the death certificate may be completed before the results of the autopsy are available.

SIDS – Continued

From 1979 to 1982, the YPLL due to SIDS has ranged from 340,000 to 355,000, and the rate of death due to SIDS/1,000 live births ranged from 1.4 to 1.5. This compares with worldwide rates of 0.6/1,000 to 3.0/1,000. In 1980, NCHS recorded the highest U.S. rate of SIDS deaths. This followed the National Institute of Child Health and Human Development SIDS Cooperative Epidemiological Study, which finished interviewing parents in 1980. This may represent increased case finding stimulated by this study.

The etiology of SIDS is unclear, although there are several established risk factors (*1*). Current theories implicate an abnormality of the autonomic regulation of respiratory and/or cardiovascular function. Whether this is due to genetic or environmental factors, or is prenatal or postnatal in origin, is unknown. Risk factors include sociodemographic and pregnancy-related variables. Siblings of SIDS victims have a tenfold increased risk of SIDS. Blacks and Native Americans have a rate of SIDS two to three times that of whites (*2*). Preterm and low-birthweight infants, as well as products of multiple gestations, are also at increased risk of SIDS. In many studies, SIDS appears to be seasonal, with increased rates in the winter months (November-March), raising the speculation that respiratory infections may potentiate whatever underlying predisposition may exist.

Prevention of SIDS is hindered by lack of knowledge of the etiology and lack of understanding of which infants are at particularly high risk. Some survivors of episodes of infant apnea ("near misses") and some siblings of SIDS victims are currently being treated with home apnea monitoring and various pharmacologic therapies. The efficacy of these interventions has not been formally evaluated in a randomized clinical trial. In addition, the number of deaths that are potentially preventable using these interventions represents only a small portion of total SIDS deaths. Laboratory research on SIDS is needed to identify high-risk infants and to develop effective prevention measures.

References

1. Peterson DR. Evolution of the epidemiology of sudden infant death syndrome. Epidemiologic Rev 1980;2:97-112.
2. Adams MM. The descriptive epidemiology of sudden infant deaths among natives and whites in Alaska. Am J Epidemiol 1985;122:637-43.

Recommendations of the Immunization Practices Advisory Committee (ACIP)

Update: Prevention of *Haemophilus influenzae* Type b Disease

Haemophilus influenzae *type b (Hib) is the most common cause of bacterial meningitis in the United States. It also causes other serious invasive illnesses, including epiglottitis, sepsis, cellulitis, septic arthritis, osteomyelitis, pericarditis, and pneumonia. By 5 years of age, one of every 200 children in the United States will have had a systemic infection due to Hib. A polysaccharide vaccine against systemic Hib disease was licensed in the United States in April 1985. Information on the vaccine and Immunization Practices Advisory Committee (ACIP) guidelines for its use should be consulted* (1). *The purpose of this statement is to update these recommendations and to provide guidelines for the prevention of secondary cases of Hib disease.*

Haemophilus influenzae — *Continued*

CHEMOPROPHYLAXIS

Risk of Secondary Disease. Secondary disease, defined as illness within 1-60 days following contact with a child who has Hib disease, accounts for less than 5% of all invasive Hib disease. However, six studies of household contacts of Hib patients found a secondary attack rate of 0.3% in the month following disease onset in the index patient, which is about 600-fold higher than the age-adjusted risk in the general population (*2-7*). Among these studies, the attack rate among household contacts varied markedly with age: 4% for children under 2 years of age; 2% for children 2-3 years of age; 0.1% for children 4-5 years of age; and 0% for those over 6 years of age (*2-7*). Among these household contacts, 64% of secondary cases occurred within the first week (excluding the first 24 hours) of disease onset in the index patient; 20%, during the second week; and 16%, during the third and fourth weeks.

The risk of secondary disease among children who were exposed to a primary case in day-care and who did not receive rifampin prophylaxis has been examined in four studies. A national collaborative study that calculated secondary attack rates for household and day-care classroom contacts found that one (1%) of 91 children under 4 years of age in day-care acquired disease in the month following the index patient, compared with three (2%) of 125 household contacts under 4 years of age (*2*). A multicenter study in Seattle-King County, Washington; Oklahoma; and Atlanta, Georgia, found that the risk of secondary Hib disease among day-care classroom contacts was age-dependent; 10 (3%) cases occurred among the 376 contacts 0-23 months old, whereas none of the 379 classroom contacts older than 23 months of age acquired secondary disease (*8*). No cases occurred among children who attended day-care for fewer than 25 hours per week. In this study, classroom contacts were defined as children who spent more than half their day-care time in the same classroom as a child with primary Hib disease in the week before disease onset of the primary case. The overall risk for classroom contacts was 0.7% (10/1,388), 20 times higher than the risk for other children in the center (0.04% [2/5,639]). Thirty-three percent of the secondary cases occurred within 3 weeks of onset of the index case; 13%, between days 21 and 40; and 53%, between days 41 and 60. Meningitis and other systemic Hib infections were equally likely to result in secondary cases.

Two prospective studies have examined the risk of subsequent Hib disease in day-care facilities. In Dallas County, Texas, follow-up for 60 days of classroom contacts revealed no cases of secondary disease in 361 children under 2 years old, and a secondary attack rate of 0.5% (1/213) in those 2-3 years of age (*9*). Other cases of Hib disease occurred but could not be classified as secondary cases because these children enrolled in the day-care facility after the index patient became ill. Since it is known that rates of asymptomatic transmission are elevated in day-care classrooms with children with Hib disease, some of these cases may have been associated with the index case.

A similar surveillance study was conducted in Minnesota. No cases of secondary Hib disease were found among 370 day-care contacts under 2 years of age; 263 (71%) were classroom contacts. These were defined as children who spent more than 8 hours in the same classroom as the primary case in the week before the patient with primary disease became ill. Similarly, secondary cases were not seen in 716 children 2-3 years of age, of whom 421 (59%) were classroom contacts (*10*).

The disparities in the risk of day-care-associated secondary Hib disease in Minnesota; Dallas County, Texas; and the two multicenter studies remain unexplained. Possible reasons include differences among the several study areas in day-care characteristics, such as

Haemophilus influenzae — *Continued*

classroom size and age distribution of children, which might affect intensity and duration of contact. There may be further unrecognized differences in epidemiologic factors or invasiveness of prevalent Hib strains.

Efficacy of Rifampin Prophylaxis. Most children at risk of secondary disease are too young to respond to the Hib polysaccharide vaccine. Therefore, the main preventive measure presently available is rifampin administration. Currently available data from several studies indicate rifampin in a dosage of 20 mg/kg per dose once daily (maximum daily dose 600 mg) for 4 days eradicated Hib carriage in 95% or more of contacts of primary cases, including children in day-care facilities (*11-13*). In a randomized placebo controlled trial, rifampin in the currently recommended dosage administered to all household and day-care classroom contacts, including adults, significantly decreased secondary Hib disease among household and day-care contacts (none of 303 rifampin-treated contacts under 4 years of age had secondary disease, compared with four of 216 placebo-treated contacts under 4 years of age [$p = 0.03$]) (*2*); the number of cases was insufficient to evaluate efficacy in the household or day-care setting alone. However, the collaborative study of day-care centers cited above found that among classroom contacts of Hib patients, children aged 0-23 months who received rifampin prophylaxis were significantly less likely to develop secondary disease than children who did not take rifampin (none of 232, compared with 10 [3%] of 376 [$p < 0.02$]) (*8*). Secondary disease did not develop in day-care classes in which over 75% of the class received rifampin. However, rifampin prophylaxis is unlikely to be 100% effective, and a day-care center in which rifampin prophylaxis failed to prevent subsequent disease has been reported (*14*).

Implementation of Chemoprophylaxis. Rifampin is available in 150-mg and 300-mg capsules. For those unable to swallow capsules, rifampin may be mixed with several teaspoons of applesauce immediately before administration, resulting in acceptable serum and salivary levels (*15*). Although there has been more experience with the applesauce mixture, a suspension of rifampin may also be freshly prepared in United States Pharmacopeia syrup; the preparation should be vigorously shaken before use. Side effects of rifampin in the recommended dose include nausea, vomiting, diarrhea, headache, or dizziness, which occurred among 20% of those taking rifampin and 11% of placebo recipients. No serious reactions occurred (*2*). Those taking rifampin (including parents and day-care staff) should be informed that orange discoloration of urine, discoloration of soft contact lenses, and decreased effectiveness of oral contraceptives can occur.

In implementing chemoprophylaxis in day-care centers, it is important to ensure that all classroom contacts receive rifampin during the same period. Some local and state health departments have facilitated the timely implementation of chemoprophylaxis by coordinating rifampin administration following consultation with private physicians or by providing information to parents of day-care contacts.

VACCINE

Effect of Haemophilus b Polysaccharide Vaccine on Nasopharyngeal Carriage. Limited data are available on the effect of the Haemophilus b polysaccharide vaccine on nasopharyngeal carriage of the organism. By analogy to carriage studies after serogroups A and C meningococcal polysaccharide vaccination, some reduction in acquisition of carriage may occur shortly after immunization, but no long-term effect has been noted (*16-18*).

Use of Haemophilus b Polysaccharide Vaccine in Children with Preceding Hib Disease. Studies have shown that the development of anticapsular antibodies following invasive Hib dis-

Haemophilus influenzae — *Continued*

ease is largely age-dependent. A study of acute and convalescent sera from 125 patients with meningitis, septicemia, or epiglottitis due to Hib determined that, among those who acquired disease when they were younger than 18 months, 41 (85%) of 48 failed to develop an adequate antibody response, in contrast to 18 (23%) of 77 of those older than 18 months (*19*). Cases have been reported in which children who do not mount an antibody response after an invasive episode of Hib have developed a second systemic infection with the organism (*20*).

RECOMMENDATIONS

The primary strategy for preventing Hib disease is immunization. Children should be vaccinated at 24 months of age. Those at high risk for Hib disease, including children attending day-care, may be given the vaccine at 18 months of age. ACIP guidelines for use of the vaccine should be consulted (*1*). This update addresses chemoprophylaxis (recommendations 1-7) and additional vaccine issues (recommendations 8 and 9).

Chemoprophylaxis. Although unexplained disparities in available data prevent a precise estimate of the magnitude of risk among day-care contacts, it is likely that the increased risk of disease observed among young household contacts is also present among day-care classroom contacts under 2 years of age. Since rifampin prophylaxis is effective in preventing subsequent cases in this high-risk group, the ACIP recommends that:

1. Contacts of all ages who develop symptoms suggestive of invasive Hib disease, such as fever or headache, be evaluated promptly by a physician.
2. In any household in which a case of invasive Hib disease has occurred and in which another child under 4 years of age resides, all members of the household, including adults, should receive rifampin according to the following regimen: rifampin in a dosage of 20 mg/kg per dose once daily (maximal daily dose 600 mg) for 4 days; the dose for neonates (under 1 month of age) is 10 mg/kg once daily for 4 days.
3. In day-care classrooms in which a case of Hib disease has occurred and in which another child under 2 years of age has been exposed, all parents should be notified (preferably in writing) regarding the occurrence of the case and the possibility of increased risk to their children. They should be informed about the symptoms and the need for prompt medical evaluation if symptoms occur. They should also be notified of the availability of rifampin prophylaxis. Although the data on which to base recommendations are not optimal, and some authorities disagree, the consensus of the ACIP is as follows: In a day-care classroom in which a case of systemic Hib disease has occurred, and in which one or more children under 2 years old have been exposed, strong consideration should be given to administering rifampin prophylaxis to all children and staff in the classroom, regardless of age.
4. Rifampin should not be used in pregnant women, as its effect on the fetus has not been established, and it is teratogenic in laboratory animals.
5. Chemoprophylaxis should be instituted as rapidly as possible. If more than 14 days have passed since the last contact with the index patient, the benefit of chemoprophylaxis is likely to be decreased.
6. All children convalescing from systemic Hib disease who are anticipated to resume close contact with other young children, at home or in day-care, should receive rifampin immediately after completing treatment for their illness. Therapy for systemic disease does not reliably eradicate respiratory carriage of Hib, and some physicians may wish to give rifampin to all index patients.

Haemophilus influenzae – *Continued*

7. In day-care classrooms in which children are to receive chemoprophylaxis, children who have received the Haemophilus b polysaccharide vaccine should also receive rifampin. Although these children are felt to be at decreased risk for disease, the vaccine probably does not affect carriage of the organism, which they may pass on to susceptible classmates.
8. Children who have had invasive Hib disease when they were under 24 months of age should still receive the vaccine according to previous recommendations, since most children under 24 months of age fail to mount an immune response to the clinical disease.
9. Satisfactory response to the vaccine is not consistent among children 18-23 months of age, and most authorities believe that these children should be revaccinated. Although data on the precise timing of this second dose are not currently available, it would be reasonable to reimmunize 2-12 months after the initial dose but not before 24 months of age. Previous immunization does not change the immune response or adverse reaction to a subsequent dose of the vaccine (*21*).

(Continued on page 179)

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

Disease	11th Week Ending			Cumulative, 11th Week Ending		
	Mar. 15, 1986	Mar. 16, 1985	Median 1981-1985	Mar. 15, 1986	Mar. 16, 1985	Median 1981-1985
Acquired Immunodeficiency Syndrome (AIDS)	327	56	N	2,455	1,138	N
Aseptic meningitis	86	91	77	894	749	874
Encephalitis: Primary (arthropod-borne & unspec.)	23	24	22	175	184	178
Post-infectious	2	3	2	10	26	16
Gonorrhea: Civilian	15,360	15,154	16,906	163,747	163,077	192,513
Military	350	335	342	3,268	4,032	5,248
Hepatitis: Type A	441	440	470	4,761	4,382	4,886
Type B	498	505	490	4,922	5,026	4,750
Non A, Non B	73	95	N	629	865	N
Unspecified	108	173	173	1,134	1,042	1,495
Legionellosis	7	12	N	106	142	N
Leprosy	11	2	3	57	88	47
Malaria	12	13	13	137	140	140
Measles: Total*	217	43	68	733	282	289
Indigenous	214	34	N	701	221	N
Imported	3	9	N	32	61	N
Meningococcal infections: Total	67	81	81	688	683	726
Civilian	67	81	81	687	682	726
Military	-	-	-	1	1	2
Mumps	35	98	112	550	780	921
Pertussis	30	38	31	420	297	271
Rubella (German measles)	11	19	41	92	70	224
Syphilis (Primary & Secondary): Civilian	461	379	586	4,998	5,049	6,464
Military	6	5	5	44	34	84
Toxic Shock syndrome	7	5	N	57	86	N
Tuberculosis	451	410	434	3,839	3,790	4,351
Tularemia	2	1	-	15	22	18
Typhoid fever	5	1	5	46	44	72
Typhus fever, tick-borne (RMSF)	-	1	1	8	6	10
Rabies, animal	81	88	112	867	837	975

TABLE II. Notifiable diseases of low frequency, United States

	Cum 1986		Cum 1986
Anthrax	-	Leptospirosis	10
Botulism: Foodborne	3	Plague	-
Infant (Calif. 1)	12	Poliomyelitis, Paralytic	-
Other	-	Psittacosis (Colo. 1, Hawaii 1)	12
Brucellosis (Calif. 2)	11	Rabies, human	-
Cholera	-	Tetanus (Ga. 1)	7
Congenital rubella syndrome	1	Trichinosis	7
Congenital syphilis, ages < 1 year	-	Typhus fever, flea-borne (endemic, murine)	1
Diphtheria	-		

*Three of the 217 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 15, 1986 and March 16, 1985 (11th 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	2,455	86	175	10	163,747	163,077	441	498	73	108	7	57
NEW ENGLAND	112	5	7	-	3,815	5,231	14	45	5	6	1	1
Maine	4	1	-	-	184	215	1	5	-	-	1	-
N.H.	3	1	2	-	113	119	4	2	1	-	-	-
Vt.	2	1	2	-	62	48	3	1	-	-	-	-
Mass.	62	-	2	-	1,583	1,880	2	24	2	5	-	1
R.I.	9	1	-	-	337	406	-	4	1	1	-	-
Conn.	32	1	1	-	1,536	2,563	4	9	1	-	-	-
MID ATLANTIC	885	18	32	-	27,731	21,929	21	59	7	25	-	5
Upstate N.Y.	93	10	12	-	3,378	3,220	11	43	4	1	-	-
N.Y. City	571	2	7	-	15,907	9,194	1	1	1	21	-	5
N.J.	153	5	2	-	3,246	4,682	9	15	2	3	-	-
Pa.	68	1	11	-	5,200	4,833	-	-	-	-	-	-
E.N. CENTRAL	121	10	31	2	21,689	24,054	16	21	6	2	-	3
Ohio	30	2	10	2	6,169	6,050	6	7	-	1	-	-
Ind.	16	4	2	-	3,475	2,211	1	4	1	-	-	-
Ill.	42	2	3	-	3,009	7,364	8	4	1	-	-	2
Mich.	28	2	15	-	7,471	6,817	1	6	4	1	-	1
Wis.	5	-	1	-	1,565	1,612	-	-	-	-	-	-
W.N. CENTRAL	53	4	3	1	7,680	8,540	8	9	-	-	3	1
Minn.	26	1	1	-	1,074	1,326	2	3	-	-	-	1
Iowa	4	-	2	-	770	920	-	1	-	-	1	-
Mo.	13	3	-	-	3,676	3,895	3	2	-	-	2	-
N. Dak.	2	-	-	-	82	68	-	-	-	-	-	-
S. Dak.	1	-	-	-	139	155	3	-	-	-	-	-
Nebr.	3	-	-	-	567	730	-	3	-	-	-	-
Kans.	4	-	-	1	1,372	1,446	-	-	-	-	-	-
S. ATLANTIC	345	9	31	6	35,770	35,265	44	75	6	8	1	-
Del.	7	-	3	-	728	719	3	2	1	-	-	-
Md.	31	1	9	-	5,037	5,485	2	15	1	2	-	-
D.C.	59	-	-	-	3,168	2,968	-	1	-	-	-	-
Va.	42	1	12	-	3,719	3,756	15	11	2	-	-	-
W. Va.	1	-	2	-	485	443	-	7	-	-	-	-
N.C.	20	-	4	-	6,858	7,117	1	8	1	1	1	-
S.C.	14	-	-	-	3,971	4,470	-	7	1	-	-	-
Ga.	21	1	-	-	-	-	4	13	-	-	-	-
Fla.	150	6	1	6	11,804	10,307	19	11	-	5	-	-
E.S. CENTRAL	26	13	15	-	14,806	14,339	14	46	4	1	1	-
Ky.	7	1	6	-	1,721	1,579	-	3	-	-	-	-
Tenn.	12	3	1	-	5,900	5,639	13	13	3	1	-	-
Ala.	3	9	8	-	4,022	4,396	1	22	1	-	1	-
Miss.	4	-	-	-	3,163	2,725	-	8	-	-	-	-
W.S. CENTRAL	207	7	11	-	21,763	23,448	64	56	6	15	1	5
Ark.	7	-	-	-	1,974	2,274	4	2	-	-	-	-
La.	31	1	1	-	3,812	5,003	-	11	-	1	-	-
Okla.	2	1	3	-	2,493	2,308	3	4	2	-	-	-
Tex.	167	5	7	-	13,484	13,863	57	39	4	14	1	5
MOUNTAIN	70	3	10	1	5,520	5,355	32	32	4	7	-	7
Mont.	-	1	-	1	132	170	-	-	-	-	-	-
Idaho	1	-	-	-	183	181	2	3	-	-	-	-
Wyo.	2	-	2	-	123	148	1	-	-	-	-	-
Colo.	35	1	2	-	1,456	1,554	3	2	-	4	-	3
N. Mex.	4	-	-	-	596	654	5	2	-	-	-	-
Ariz.	17	-	4	-	1,601	1,589	15	17	4	3	-	2
Utah	5	-	1	-	236	230	3	5	-	-	-	-
Nev.	6	1	1	-	1,193	829	3	3	-	-	-	2
PACIFIC	636	17	35	-	24,973	24,916	228	155	35	44	-	35
Wash.	21	1	2	-	1,908	1,892	14	17	5	-	-	5
Oreg.	14	-	-	-	932	1,407	20	11	4	-	-	-
Calif.	585	14	31	-	21,127	20,628	192	121	26	44	-	29
Alaska	7	-	2	-	724	612	1	6	-	-	-	-
Hawaii	9	2	-	-	282	377	1	-	-	-	-	1
Guam	-	-	-	-	7	33	-	1	-	1	-	-
P.R.	22	3	2	-	489	830	3	2	-	-	-	-
V.I.	-	-	-	-	47	86	-	-	-	-	-	-
Pac. Trust Terr.	-	-	-	-	12	146	13	-	-	-	-	-
Amer. Samoa	-	-	-	-	8	-	1	2	-	-	-	-

N: Not notifiable U: Unavailable

TABLE III. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending March 15, 1986 and March 16, 1985 (11th 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	137	214	701	3	32	282	688	35	550	30	420	297	11	92	70
NEW ENGLAND	8	-	9	-	-	3	52	1	9	2	26	13	-	-	4
Maine	-	-	-	-	-	-	11	-	-	-	2	2	-	-	-
N.H.	-	-	-	-	-	-	3	-	4	-	7	7	-	-	2
Vt.	1	-	-	-	-	-	7	-	-	-	1	1	-	-	-
Mass.	3	-	9	-	-	3	9	-	-	-	8	2	-	-	2
R.I.	1	-	-	-	-	-	4	1	4	-	1	1	-	-	-
Conn.	3	-	-	-	-	-	18	-	1	2	7	-	-	-	-
MID. ATLANTIC	21	182	363	-	3	17	123	9	43	2	59	47	1	21	14
Upstate N.Y.	1	-	1	-	2	7	33	6	16	1	39	25	-	14	5
N.Y. City	7	11	28	-	1	8	32	-	1	-	5	7	-	5	6
N.J.	2	171	334	-	-	2	18	1	13	-	-	1	1	2	3
Pa.	11	-	-	-	-	-	40	2	13	1	15	14	-	-	-
E.N. CENTRAL	4	-	48	-	-	83	85	7	255	7	100	57	-	1	6
Ohio	1	-	-	-	-	11	39	2	40	7	52	13	-	-	-
Ind.	-	-	-	-	-	-	9	-	12	-	9	11	-	-	-
Ill.	2	-	21	-	-	4	20	-	129	-	8	9	-	-	-
Mich.	1	-	-	-	-	34	17	5	37	-	11	5	-	-	5
Wis.	-	-	27	-	-	34	-	-	37	-	20	19	-	1	1
W.N. CENTRAL	3	4	55	-	-	2	30	2	20	-	23	27	-	2	6
Minn.	1	-	-	-	-	-	7	-	1	-	11	10	-	-	-
Iowa	1	-	-	-	-	-	4	-	5	-	4	1	-	-	-
Mo.	1	-	-	-	-	2	14	2	6	-	3	6	-	1	-
N. Dak.	-	-	-	-	-	-	-	-	1	-	2	4	-	-	-
S. Dak.	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-
Nebr.	-	-	-	-	-	-	3	-	-	-	-	1	-	-	-
Kans.	-	4	55	-	-	-	2	-	6	-	3	5	-	1	6
S. ATLANTIC	19	21	93	-	2	9	144	3	51	11	85	56	1	6	8
Del.	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-
Md.	3	-	4	-	-	1	18	-	3	-	18	16	-	-	1
D.C.	-	-	-	-	-	1	2	-	-	-	-	-	-	-	-
Va.	6	-	-	-	-	5	29	-	6	2	8	1	-	-	-
W. Va.	-	-	-	-	-	-	2	1	20	-	2	-	-	-	-
N.C.	2	-	-	-	-	-	16	-	4	-	12	6	-	-	-
S.C.	-	20	78	-	-	-	22	-	4	-	2	-	-	-	2
Ga.	2	-	-	-	1	-	15	1	4	9	38	19	-	-	4
Fla.	6	1	11	-	1	2	39	1	10	-	5	14	1	6	1
E.S. CENTRAL	4	-	-	-	-	-	35	-	5	-	11	3	-	1	1
Ky.	2	-	-	-	-	-	6	-	2	-	1	1	-	1	1
Tenn.	-	-	-	-	-	-	15	-	1	-	2	1	-	-	-
Ala.	2	-	-	-	-	-	12	-	1	-	8	1	-	-	-
Miss.	-	-	-	-	-	-	2	-	1	-	-	-	-	-	-
W.S. CENTRAL	5	-	30	1	12	2	41	4	41	-	18	19	4	17	10
Ark.	-	-	21	-	-	-	2	1	3	-	-	7	-	-	1
La.	1	-	-	-	-	-	4	-	-	-	2	-	-	-	-
Okla.	1	-	-	-	-	-	8	N	N	-	16	12	-	-	-
Tex.	3	-	9	1 †	12	2	27	3	38	-	-	-	4	17	9
MOUNTAIN	5	1	34	-	5	113	31	2	60	6	58	16	-	-	1
Mont.	-	-	-	-	1	113	4	-	2	-	-	2	-	-	-
Idaho	1	-	-	-	-	-	1	-	2	-	13	-	-	-	-
Wyo.	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-
Colo.	1	-	-	-	2	-	6	-	4	-	12	7	-	-	-
N. Mex.	-	-	13	-	2	-	4	N	N	1	8	2	-	-	-
Ariz.	2	1	21	-	-	-	9	2	48	-	19	2	-	-	1
Utah	-	-	-	-	-	-	3	-	1	5	6	3	-	-	-
Nev.	1	-	-	-	-	-	2	-	3	-	-	-	-	-	-
PACIFIC	68	6	69	2	10	53	147	7	66	2	40	59	5	44	20
Wash.	5	-	19	2 †	6	1	21	-	4	1	17	9	-	-	-
Oreg.	7	-	-	-	2	-	13	N	N	-	2	5	-	-	1
Calif.	56	2	40	-	2	46	108	6	55	1	18	42	5	44	17
Alaska	-	-	-	-	-	-	5	-	2	-	1	1	-	-	-
Hawaii	-	4	10	-	-	6	-	1	5	-	2	2	-	-	2
Guam	1	-	1	-	-	10	-	-	1	-	-	-	-	1	1
P.R.	1	-	-	-	-	38	1	-	11	-	2	1	-	-	4
V.I.	-	-	-	-	-	9	-	2	5	-	-	-	-	-	-
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 15, 1986 and March 16, 1985 (11th 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	4,998	5,049	7	3,839	3,790	15	46	8	867
NEW ENGLAND	116	116	-	109	133	-	2	1	-
Maine	7	3	-	12	11	-	-	-	-
N.H.	6	3	-	3	6	-	-	-	-
Vt.	4	-	-	6	-	-	-	-	-
Mass.	61	62	-	51	77	-	1	1	-
R.I.	5	4	-	5	16	-	-	-	-
Conn.	33	44	-	32	23	-	1	-	-
MID ATLANTIC	734	633	1	757	744	-	4	-	102
Upstate N.Y.	38	31	-	108	95	-	1	-	13
N.Y. City	421	417	1	376	411	-	3	-	-
N.J.	145	131	-	138	51	-	-	-	-
Pa.	130	54	-	135	187	-	-	-	89
E.N. CENTRAL	128	246	-	529	480	-	4	-	12
Ohio	28	25	-	79	89	-	-	-	1
Ind.	26	17	-	61	55	-	-	-	3
Ill.	29	132	-	230	223	-	-	-	2
Mich.	30	60	-	127	89	-	3	-	2
Wis.	15	12	-	32	24	-	1	-	4
W.N. CENTRAL	57	65	-	94	102	5	3	-	106
Minn.	8	19	-	20	19	-	1	-	9
Iowa	4	11	-	11	17	1	-	-	28
Mo.	30	21	-	46	43	4	2	-	10
N. Dak.	2	-	-	3	2	-	-	-	34
S. Dak.	-	4	-	2	5	-	-	-	25
Nebr.	8	1	-	3	4	-	-	-	-
Kans.	5	9	-	9	12	-	-	-	-
S. ATLANTIC	1,284	1,299	2	745	751	3	4	3	239
Del.	10	12	-	7	8	-	-	-	-
Md.	98	107	-	45	71	1	-	-	156
D.C.	81	69	-	33	34	-	-	-	-
Va.	108	71	2	57	50	1	-	-	36
W. Va.	3	2	-	30	18	-	-	-	6
N.C.	129	150	-	115	79	-	2	2	-
S.C.	157	171	-	97	103	-	-	1	6
Ga.	-	-	-	88	115	1	-	-	29
Fla.	698	717	-	273	273	-	2	-	6
E.S. CENTRAL	354	456	-	360	326	3	-	2	34
Ky.	23	16	-	89	71	2	-	1	9
Tenn.	164	120	-	102	90	1	-	-	14
Ala.	123	167	-	127	122	-	-	1	11
Miss.	44	153	-	42	43	-	-	-	-
W.S. CENTRAL	1,143	1,240	4	457	370	3	1	2	84
Ark.	51	69	-	48	29	2	-	-	17
La.	189	229	-	107	58	-	-	-	3
Okla.	37	43	4	41	50	1	-	-	8
Tex.	866	899	-	261	233	-	1	2	56
MOUNTAIN	145	171	-	81	68	-	2	-	162
Mont.	3	1	-	5	5	-	-	-	64
Idaho	1	2	-	4	2	-	-	-	-
Wyo.	-	4	-	-	1	-	-	-	66
Colo.	44	41	-	1	3	-	-	-	-
N. Mex.	17	17	-	19	14	-	-	-	2
Ariz.	61	97	-	38	36	-	1	-	30
Utah	4	2	-	4	2	-	1	-	-
Nev.	15	7	-	10	5	-	-	-	-
PACIFIC	1,037	823	-	707	816	1	26	-	128
Wash.	16	29	-	45	36	-	2	-	-
Oreg.	25	24	-	29	24	-	-	-	-
Calif.	986	754	-	583	679	-	22	-	125
Alaska	-	-	-	12	37	1	-	-	3
Hawaii	10	16	-	38	40	-	2	-	-
Guam	1	2	-	-	6	-	-	-	-
P.R.	179	196	-	58	61	-	-	-	7
V.I.	-	-	-	-	1	-	-	-	-
Pac. Trust Terr.	-	13	-	3	16	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-

U: Unavailable

TABLE IV. Deaths in 121 U.S. cities,* week ending March 15, 1986 (11th Week)

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	791	556	161	33	21	20	94
Boston, Mass.	180	116	44	12	3	5	34
Bridgeport, Conn.	54	34	13	2	1	4	4
Cambridge, Mass.	26	24	2	-	-	-	3
Fall River, Mass.	24	20	4	-	-	-	-
Hartford, Conn.	115	83	22	5	3	2	11
Lowell, Mass.	32	27	3	1	1	-	3
Lynn, Mass.	23	16	7	-	-	-	2
New Bedford, Mass.	28	19	5	3	1	-	1
New Haven, Conn.	56	37	12	5	1	1	4
Providence, R.I.	72	51	14	2	1	4	8
Somerville, Mass.	10	7	3	-	-	-	1
Springfield, Mass.	52	38	6	2	3	3	6
Waterbury, Conn.	44	31	10	-	3	-	9
Worcester, Mass.	75	53	16	1	4	1	8
MID ATLANTIC	2,772	1,920	511	207	66	66	177
Albany, N.Y.	54	40	10	1	1	2	2
Allentown, Pa.	20	17	2	1	-	-	1
Buffalo, N.Y.	104	78	19	6	-	1	11
Camden, N.J.	49	33	11	3	-	2	1
Elizabeth, N.J.	25	20	3	2	-	-	-
Erie, Pa.†	48	35	8	2	2	1	6
Jersey City, N.J.	41	24	9	5	1	2	4
N.Y. City, N.Y.	1,396	924	257	142	37	36	80
Newark, N.J.	102	58	20	10	9	4	5
Paterson, N.J.	35	23	8	1	1	2	6
Philadelphia, Pa.	302	209	64	17	6	6	14
Pittsburgh, Pa.†	102	75	21	2	1	3	7
Reading, Pa.	39	33	3	-	-	3	1
Rochester, N.Y.	144	111	26	4	3	-	15
Schenectady, N.Y.	36	29	6	-	1	-	-
Scranton, Pa.†	38	32	4	1	1	-	2
Syracuse, N.Y.	148	110	28	5	3	1	11
Trenton, N.J.	27	19	4	1	-	3	1
Utica, N.Y.	30	25	4	1	-	-	4
Yonkers, N.Y.	32	25	4	3	-	-	6
E.N. CENTRAL	2,571	1,803	463	147	65	92	156
Akron, Ohio	61	40	10	5	4	2	3
Canton, Ohio	33	24	7	1	-	1	6
Chicago, Ill.§	553	462	11	26	16	37	16
Cincinnati, Ohio	161	103	43	7	5	3	17
Cleveland, Ohio	197	125	52	14	3	3	10
Columbus, Ohio	128	86	28	12	1	1	3
Dayton, Ohio	148	100	41	4	3	-	10
Detroit, Mich.	312	184	80	30	9	9	13
Evansville, Ind.	49	34	11	2	1	1	2
Fort Wayne, Ind.	69	41	13	4	1	10	4
Gary, Ind.	18	13	2	2	-	1	-
Grand Rapids, Mich.	108	77	14	4	6	7	15
Indianapolis, Ind.	222	138	57	15	5	7	4
Madison, Wis.	37	19	9	6	2	1	6
Milwaukee, Wis.	149	116	22	3	4	4	6
Peoria, Ill.	35	23	9	2	-	1	5
Rockford, Ill.	38	25	9	2	2	-	4
South Bend, Ind.	69	52	11	2	-	4	11
Toledo, Ohio	108	78	21	6	3	-	16
Youngstown, Ohio	76	63	13	-	-	-	5
W.N. CENTRAL	726	531	118	32	27	18	54
Des Moines, Iowa	35	29	4	1	-	1	4
Duluth, Minn.	29	27	-	1	-	1	3
Kansas City, Kans.	38	24	9	2	3	-	1
Kansas City, Mo.	110	76	23	3	4	4	8
Lincoln, Nebr.	32	27	4	-	-	1	3
Minneapolis, Minn.	67	46	14	4	2	1	5
Omaha, Nebr.	95	65	17	4	6	3	9
St. Louis, Mo.	167	125	17	15	7	3	4
St. Paul, Minn.	75	60	10	-	1	4	9
Wichita, Kans.	78	52	20	2	4	-	8
S. ATLANTIC	1,390	902	290	110	31	54	87
Atlanta, Ga.	185	117	34	25	8	1	7
Baltimore, Md.	229	152	51	18	1	7	7
Charlotte, N.C.	69	47	15	4	1	2	2
Jacksonville, Fla.	132	82	32	4	6	7	11
Miami, Fla.	111	61	31	14	2	3	3
Norfolk, Va.	80	43	20	9	-	8	7
Richmond, Va.	93	63	18	5	2	5	10
Savannah, Ga.	72	53	10	4	2	3	8
St. Petersburg, Fla.	119	102	13	1	-	3	11
Tampa, Fla.	87	52	19	5	2	7	8
Washington, D.C.	179	102	44	19	6	8	13
Wilmington, Del.	34	28	3	2	1	-	-
E.S. CENTRAL	755	473	190	45	27	19	41
Birmingham, Ala.	137	84	34	7	7	5	7
Chattanooga, Tenn.	56	41	12	2	-	1	4
Knoxville, Tenn.	106	73	21	6	4	2	7
Louisville, Ky.	93	52	34	6	-	1	3
Memphis, Tenn.	94	60	26	4	3	1	6
Mobile, Ala.	73	42	16	8	3	3	7
Montgomery, Ala.	60	39	9	3	6	3	1
Nashville, Tenn.	136	82	38	9	4	3	6
W.S. CENTRAL	1,423	983	243	92	58	46	71
Austin, Tex.	53	38	6	5	2	2	3
Baton Rouge, La.	47	28	12	5	2	-	1
Corpus Christi, Tex.	52	34	10	6	1	1	3
Dallas, Tex.	216	116	58	28	11	3	9
El Paso, Tex.	79	53	16	3	2	5	5
Fort Worth, Tex.	89	61	16	5	4	3	6
Houston, Tex. §	314	282	6	5	10	11	5
Little Rock, Ark.	95	60	18	7	4	5	10
New Orleans, La.	137	88	30	12	1	6	2
San Antonio, Tex.	185	122	35	10	12	6	17
Shreveport, La.	58	34	15	3	4	2	5
Tulsa, Okla.	98	67	21	3	5	2	5
MOUNTAIN	742	483	148	69	20	22	45
Albuquerque, N.Mex.	105	66	17	12	8	2	8
Colo. Springs, Colo.	38	27	4	4	1	2	5
Denver, Colo.	137	86	35	10	1	5	8
Las Vegas, Nev.	90	57	18	12	2	1	1
Ogden, Utah	17	12	3	1	-	1	2
Phoenix, Ariz.	180	115	36	18	5	6	7
Pueblo, Colo.	26	20	2	4	-	-	3
Salt Lake City, Utah	35	17	12	3	2	1	-
Tucson, Ariz.	114	83	21	5	1	4	11
PACIFIC	1,791	1,182	377	128	50	44	123
Berkeley, Calif.	12	9	2	1	-	-	-
Fresno, Calif.	82	60	12	4	1	5	8
Glendale, Calif.	15	11	4	-	-	-	1
Honolulu, Hawaii	68	50	10	5	1	2	3
Long Beach, Calif.	96	67	22	3	-	4	22
Los Angeles, Calif.	384	233	91	37	11	4	14
Oakland, Calif.	66	44	14	5	2	1	3
Pasadena, Calif.	45	28	9	4	3	1	3
Portland, Oreg.	122	81	27	7	3	4	9
Sacramento, Calif.	136	85	25	13	8	5	16
San Diego, Calif.	166	114	31	10	5	6	19
San Francisco, Calif.	163	98	37	20	5	1	6
San Jose, Calif.	177	111	49	11	1	5	11
Seattle, Wash.	150	108	24	8	9	1	4
Spokane, Wash.	60	46	11	-	1	2	3
Tacoma, Wash.	49	37	9	-	-	3	1
TOTAL	12,961††	8,833	2,501	863	365	381	848

* 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.

Table V. Estimated years of potential life lost before age 65 and cause-specific mortality, by cause of death — United States, 1984

Cause of mortality (Ninth Revision ICD)	Years of potential life lost by persons dying in 1984*	Cause-specific mortality† (rate/100,000)
ALL CAUSES (Total)	11,761,000	866.7
Unintentional injuries§ (E800-E949)	2,308,000	40.1
Malignant neoplasms (140-208)	1,803,000	191.6
Diseases of the heart (390-398, 402, 404-429)	1,563,000	324.4
Suicide, homicide (E950-E978)	1,247,000	20.6
Congenital anomalies (740-759)	684,000	5.6
Prematurity¶ (765, 769)	470,000	3.5
Sudden infant death syndrome (798)	**314,000**	**2.4**
Cerebrovascular diseases (430-438)	266,000	65.6
Chronic liver diseases and cirrhosis (571)	233,000	11.3
Pneumonia and influenza (480-487)	163,000	25.0
Chronic obstructive pulmonary diseases (490-496)	123,000	29.8
Diabetes mellitus (250)	119,000	15.6

*For details of calculation, see footnotes for Table V, *MMWR* 1986;35:27.

†Cause-specific mortality rates as reported in the MVSR are compiled from a 10% sample of all deaths.

§Equivalent to accidents and adverse effects.

¶Category derived from disorders relating to short gestation and respiratory distress syndrome.

Haemophilus influenzae — *Continued*

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Current Trends

Poliomyelitis — United States, 1975-1984

In September 1985, CDC-selected consultants individually reviewed clinical, laboratory, and epidemiologic data on 150 suspected cases of poliomyelitis reported to CDC from 1975-1984. CDC's Division of Immunization, Center for Prevention Services, and Division of Virology, Center for Infectious Diseases, had tentatively determined that 121 cases met the

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case definition for paralytic poliomyelitis.* Overall, 118 cases were accepted by the consultants as cases and classified according to an epidemiologic classification system established in 1975 that provides "epidemic," "endemic," "imported," and "immune-deficient" categories (Table 1).

Compared to the average of 15,822 cases per year during 1951-1955, the period directly preceding the widespread availability and use of polio vaccines, U.S. cases averaged 15 per year during 1975-1979 and declined to nine per year during 1980-1984. Of the total 118 cases for 1975-1984, 10 (8%) were epidemic cases, i.e., were epidemiologically linked with another case(s), all from a 1979 epidemic caused by a wild type 1 poliovirus; 12 (10%) were imported cases among U.S. citizens with illness onset before or after return to the United States; and 11 (9%) were cases occurring among persons with primary immunodeficiencies. One of these latter cases, which occurred in 1981 in a nontraveler, was the last case of endemic, wild-virus poliomyelitis in the United States. The remaining 85 (72%) cases were endemic, i.e., were not epidemiologically linked to another case(s); 71 (60%) were epidemiologically associated with vaccine usage. Of the 71 vaccine-associated cases, 30 (42%) oc-

*Since 1969, the CDC definition of a case of paralytic poliomyelitis has been a patient with paralysis clinically and epidemiologically compatible with poliomyelitis who, at 60 days after onset of symptoms, has a residual neurologic deficit, has died, or for whom no information is available on neurologic residua.

TABLE 1. Epidemiologic classification of reported poliomyelitis cases, by year — United States, 1975-1984

Category	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	10-year Sub-total	10-year Total
Epidemic												**10**
No OPV	0	0	0	0	10*	0	0	0	0	0	10	
OPV received	0	0	0	0	0	0	0	0	0	0	0	
Endemic												**85**
Not vaccine-associated	3	1	4	2	1	1	0	1	0	1	14	
OPV recipient	0	2	3	3	6	2†	1	3	7	3	30	
OPV contact											41	
(Household)	3§	3	6¶	1	4	1	3	3	3	1	(28)	
(Nonhousehold)	0	0	5¶	1	1	1	2	2	1	0	(13)	
Imported	4**	2	2	1	0	2	0	0	0	1	12	**12**
Immune-deficient	3	2	0	0	0	2	1††	1	1	1	11	**11**
Total	**13**	**10**	**20**	**8**	**22**	**9**	**7**	**10**	**12**	**7**		**118**

*Outbreak among Amish caused by type 1 poliovirus.

†One patient received OPV on same day as twin and had onset 38 days later.

§One patient had poliovirus type 3 and ECHO 9 isolated from stool.

¶One patient with severe persistent paralysis had coxsackie B1 isolated from pharynx; however, clinical findings met CDC case definition of paralytic poliomyelitis.

**One patient had onset 2 months before returning to the United States.

††Wild type poliovirus isolated (source unknown).

Poliomyelitis — Continued

curred among vaccine recipients, and 41 (58%), among contacts of vaccine recipients. Fourteen (40%) of the endemic cases were not epidemiologically associated with vaccine; however, five had virus isolates characterized definitively as vaccine-related.

Reported by Surveillance, Investigations, and Research Br, Div of Immunization, Center for Prevention Svcs, Div of Viral Diseases, Center for Infectious Diseases, CDC.

Editorial Note: Continuing transmission of wild virus-caused paralytic poliomyelitis has been eliminated in the United States using the currently recommended immunization policy of the Immunization Practices Advisory Committee (ACIP), which relies primarily on oral polio vaccine (OPV) use for the primary immunization series (*1*). From 1980 to 1984, only three of 45 cases (two imported and one immune-deficient) were documented as wild by strain characterization of poliovirus isolates. A third imported case was presumed epidemiologically to be caused by a wild poliovirus. Otherwise, the rare cases of reported paralytic poliomyelitis in the United States have been vaccine-associated.

The risk of vaccine-associated paralytic poliomyelitis, based on 85 cases occurring in immunologically normal recipients and contacts and the distribution of an estimated 274.1 million doses of OPV during 1973-1984, is one case per 3.22 million doses of OPV distributed.

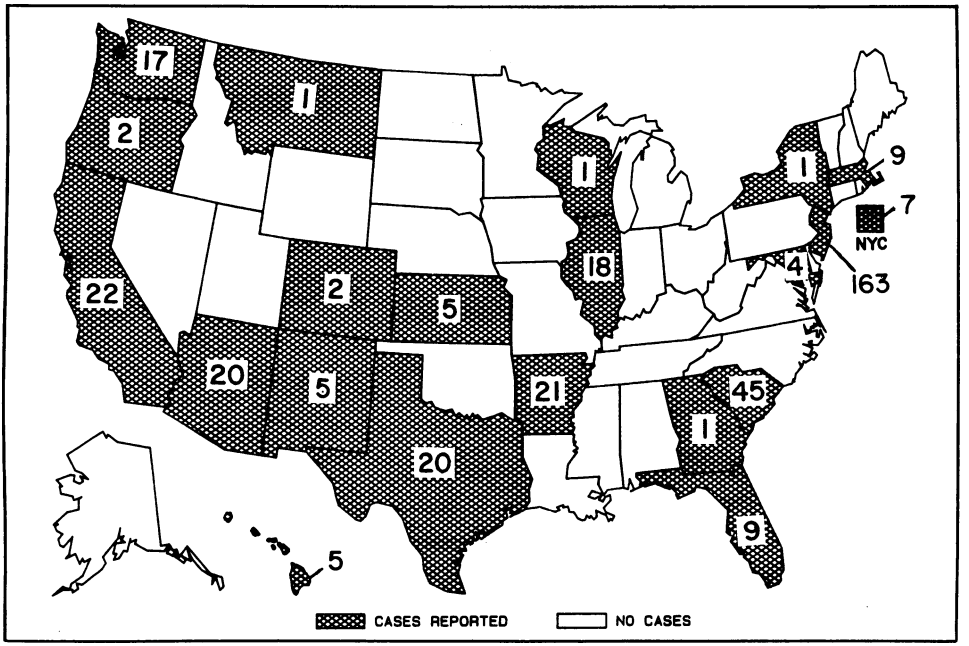
When all 104 vaccine-associated cases (85 among immunologically normal recipients and contacts; 13 among immune-deficient recipients and contacts; and six others, patients from whom a vaccine-like virus was isolated) from this same period are included, the overall vaccine-associated risk is one case per 2.64 million doses of OPV distributed.

At the October 24-25, 1985, meeting of the ACIP, issues concerning polio vaccines and current polio vaccination policy in the United States were reviewed. Discussion included live polio vaccine and both the currently available inactivated polio vaccine (IPV) and a more potent IPV not currently available in the United States. The issues discussed included seroconversion, intestinal immunity, duration of immunity, replication of poliovirus in the intestine, safety, immunization coverage, seroprevalence, the current epidemiology of poliomyelitis in the United States, and the estimated likelihood of wild poliovirus introduction. In light of the data reviewed, the ACIP concluded that no change in the basic U.S. approach to poliomyelitis (primary reliance on OPV with selected use of IPV [*1*]) is warranted currently but that the subject should be reviewed on a continuing basis.

Reference

1. ACIP. Poliomyelitis prevention. MMWR 1982;31:22-6, 31-4.

FIGURE I. Reported measles cases — United States, weeks 7-10, 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: 1986-746-149/21046 Region IV

HHS Publication No. (CDC) 86-8017