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Progress in Chronic Disease Prevention

Trends in Diabetes Mellitus Mortality

In 1985, diabetes mellitus (DM) was the seventh leading cause of death in the United States (*1*) and the 13th leading cause of years of potential life lost (YPLL) before age 65 (*2*), accounting for 128,229 (1.1%) of all YPLL. However, because these statistics are based on underlying cause of death, they understate the overall impact of DM on mortality. Specifically, diabetes is selected as the underlying cause on approximately one quarter of the death certificates on which it appears in any field (see Figure 1 on p. 779) (*3*) and is recorded on only about half of the certificates for persons who have the disease at the time of death (*3*). Thus, DM contributes to a much larger number of deaths than it directly causes.

National mortality rates for 1970–1985 were analyzed to evaluate trends for diabetes as an underlying cause of death and for total DM-related mortality.* National Center for Health Statistics (NCHS) numbers of resident DM deaths (eighth and ninth revision *International Classification of Diseases* [ICD] rubric 250) were used for numerators. (The comparability ratio for the revision from ICD-8 to ICD-9 for ICD rubric 250 is 0.9991 [CI 0.98–1.02] [*4*]; because the ratio is near unity, no adjustment for comparability was made.) Numbers of deaths for which DM was listed anywhere on the death certificate were used to compute total DM-related mortality rates. The rates were age-adjusted by the direct method, using the estimated U.S. resident population in 1980 as the standard.

Mortality rates based on the U.S. resident population provide one measure of the public health impact of DM. To determine diabetic persons' risks of dying from their disease, mortality rates were also calculated for the U.S. population known to have DM. The DM prevalence estimates from 1976, 1980, and 1984 (*5*) (available from the National Health Interview Survey) were multiplied by the corresponding estimated U.S. resident population (*6,7*) to estimate the number of persons known to have DM for these years. This latter estimate served as the denominator in calculating mortality rates for persons known to have DM.

*The underlying cause of death is selected according to standard criteria (including order) that determine which cause or contributing factor listed on the death certificate takes precedence over others that may be listed. Mortality statistics are usually based on underlying cause of death. However, multiple cause of death data available from NCHS allows for mortality statistics based on all mentions of a condition on death certificates.

Diabetes Mellitus — Continued

From 1970 through 1985, age-adjusted rates declined for both DM as an underlying cause of death (Figure 1) and total DM-related mortality (Figure 2). The greatest decline occurred between 1970 and 1979, when the average annual decrease in rates for DM as an underlying cause of death was 3.7% (Figure 1) and for total DM-related mortality, 3.0% (Figure 2); between 1979 and 1985, the average annual changes in rates were –0.2% (Figure 1) and +0.4% (Figure 2). Crude rates also declined for both methods of coding DM mortality during 1970–1985.

For 1980–1985, average age-specific mortality rates for DM, both underlying cause and total DM-related, increased with age (Figure 3). Nearly all DM deaths occurred after age 44. For all age groups after age 44, total DM-related mortality rates were 3.3 to 4.2 times higher than those for DM as an underlying cause of death.

Race-specific age-adjusted rates for total DM-related deaths (U.S. residents used as denominator) were highest for blacks (Figure 4). From 1970 to 1979, rates for all four race/sex groups declined. Between 1979 and 1985, however, rates for white males, black males, and black females increased annually an average of 0.6%, 2.1%, and 1.6%, respectively; rates for white females did not change.

In contrast to the results for mortality rates among U.S. residents (Figure 4), the highest rates of total DM-related mortality for persons known to have diabetes occurred for white males (Figure 5). Although rates for all four race/sex groups decreased during the period, they increased slightly for white males after 1980.

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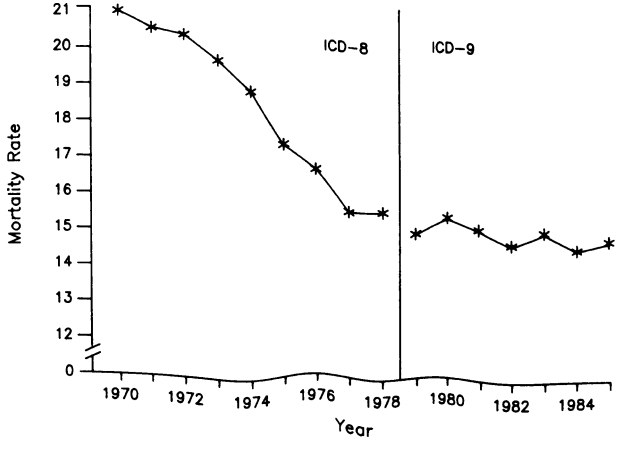
Editorial Note: Analyses of national death certificate data indicate that age-adjusted mortality rates for DM have decreased from 1970 to 1985 and that most of the decrease occurred between 1970 and 1979. These analyses (Figure 3) also demonstrate that rates based on underlying cause of death, the usual measure of DM mortality, reflected only about one quarter of the deaths to which DM may have contributed.

The decline in DM-associated mortality may reflect 1) changes in the death certification process, e.g., persons who complete death certificates may be less likely to list diabetes where it would be selected as the underlying or contributory cause of

FIGURE 1. Age-adjusted mortality rates per 100,000 residents for diabetes mellitus coded as the underlying cause of death — United States, 1970–1985



Diabetes Mellitus — Continued

death, and 2) improved treatment for DM and DM-related conditions from 1970 to 1985, resulting in longer survival for persons with diabetes (*8*).

Age-specific mortality rates indicate that DM mortality increases with age and may reflect the prevalence of diabetes in older populations (*9*). For example, in 1980, 40% of all persons with known diabetes were aged ≥65 years; 84% were aged ≥45 years.

Analyses of trends among race/sex groups for total DM-related mortality indicate that among U.S. residents, blacks have the highest mortality rates, possibly reflecting a greater prevalence of diabetes among blacks. Among persons known to have diabetes, white males have higher mortality rates than blacks. Further investigation of these patterns should address the effect of sampling variability and confounding (e.g., age).

FIGURE 2. Age-adjusted mortality rates per 100,000 residents for total diabetes mellitus-related deaths — United States, 1970–1985

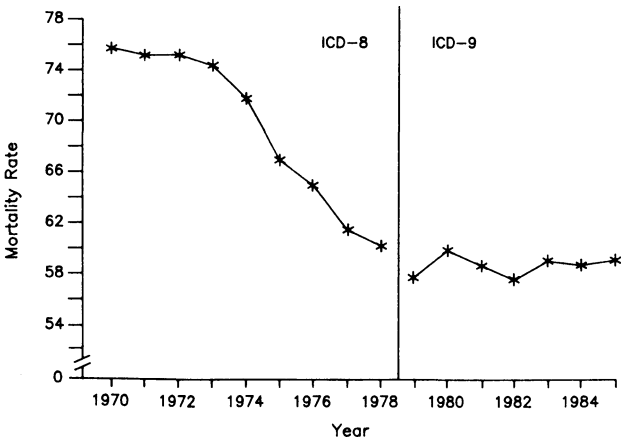
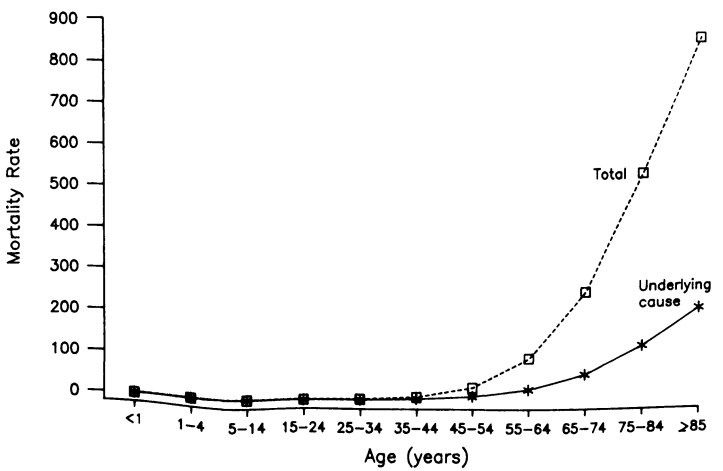


FIGURE 3. Average age-specific mortality rates per 100,000 residents for diabetes mellitus coded as the underlying cause of death and for total diabetes mellitus-related deaths — United States, 1980–1985



Diabetes Mellitus — Continued

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FIGURE 4. Age-adjusted mortality rates per 100,000 residents for total diabetes mellitus-related deaths, by race and sex — United States, 1970–1985

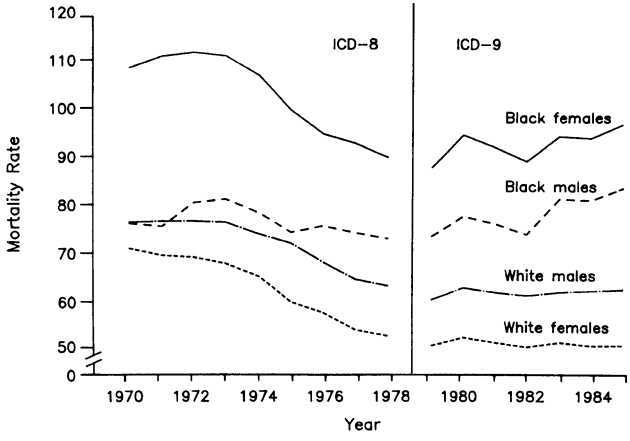
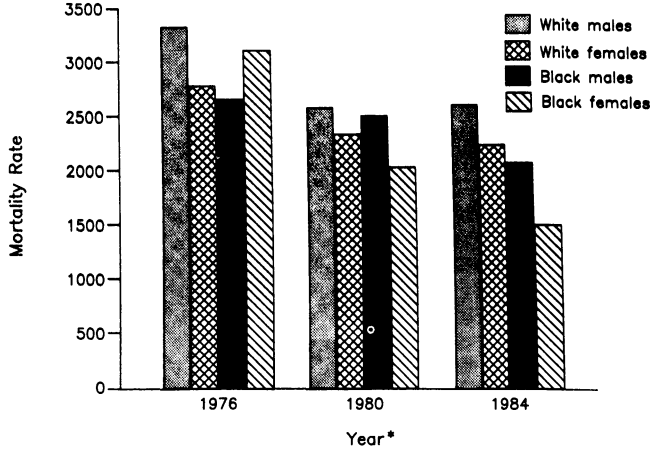


FIGURE 5. Age-adjusted mortality rates per 100,000 residents with known diabetes for total diabetes mellitus-related deaths, by race and sex — United States, 1976, 1980, 1984



*In 1979, ICD-9 was implemented.

Diabetes Mellitus — Continued

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Current Trends

Operational Criteria for Determining Suicide

Suicide is the eighth leading cause of death among Americans (*1*). In 1986, suicide accounted for 30,904 deaths and for 939,104 years of potential life lost before age 65. In the United States, a coroner or medical examiner usually determines whether a death is a suicide and records that decision on the death certificate. Laws guiding these decisions vary by state and sometimes by county, and guidelines for certification decisions may be inconsistent and vague.

No explicit criteria exist to assist in determining whether a death is a suicide. Therefore, several factors, e.g., uncertainty about what evidence is necessary and pressures from families or communities, may influence a coroner or medical examiner not to certify a specific death as a suicide. Because the extent to which suicides are underreported or misclassified is unknown, it has not been possible to estimate precisely the number of suicides (*2–6*), identify risk factors, or plan and evaluate preventive interventions.

To address these problems, a working group representing coroners, medical examiners, statisticians, and public health agencies* developed operational criteria to assist coroners and medical examiners in determining suicide (*7*). Following are the working group's findings.

CRITERIA FOR DETERMINING SUICIDE

Self-Inflicted: There is evidence that death was self-inflicted. This may be determined by pathologic (autopsy), toxicologic, investigatory, and psychologic evidence and by statements of the decedent or witnesses.

Intent: There is evidence (explicit and/or implicit) that, at the time of injury, the decedent intended to kill himself/herself or wished to die and that the decedent understood the probable consequences of his/her actions. This evidence may include:

*The working group comprised representatives from the American Academy of Forensic Sciences, American Association of Suicidology, Association of Vital Records and Health Statistics, International Association of Coroners and Medical Examiners, National Association of Counties, National Association of Medical Examiners, National Center for Health Statistics, and CDC.

Suicide — Continued

1. Explicit verbal or nonverbal expression of intent to kill self;
2. Implicit or indirect evidence of intent to die, such as
   - preparations for death inappropriate to or unexpected in the context of the decedent's life,
   - expression of farewell or the desire to die or an acknowledgment of impending death,
   - expression of hopelessness,
   - expression of great emotional or physical pain or distress,
   - effort to procure or learn about means of death or to rehearse fatal behavior,
   - precautions to avoid rescue,
   - evidence that decedent recognized high potential lethality of means of death,
   - previous suicide attempt,
   - previous suicide threat,
   - stressful events or significant losses (actual or threatened), or
   - serious depression or mental disorder.

(Continued on page 779)

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

Disease	50th Week Ending			Cumulative, 50th Week Ending		
	Dec. 17, 1988	Dec. 19, 1987	Median 1983-1987	Dec. 17, 1988	Dec. 19, 1987	Median 1983-1987
Acquired Immunodeficiency Syndrome (AIDS)	310	U*	176	29,146	20,446	7,653
Aseptic meningitis	131	143	179	6,620	10,804	10,576
Encephalitis: Primary (arthropod-borne & unspec)	17	20	20	751	1,254	1,254
Post-infectious	2	5	3	114	102	102
Gonorrhea: Civilian	11,879	12,154	17,502	666,573	735,369	853,899
Military	244	371	371	11,225	15,602	19,805
Hepatitis: Type A	643	513	466	25,476	23,865	22,043
Type B	456	545	545	21,777	24,542	24,805
Non A, Non B	36	67	67	2,402	2,841	3,379
Unspecified	57	49	116	2,289	2,972	4,973
Legionellosis	29	20	15	955	912	734
Leprosy	2	15	7	172	205	233
Malaria	8	59	10	945	894	959
Measles: Total†	39	8	11	2,865	3,575	2,726
Indigenous	38	8	10	2,543	3,153	2,290
Imported	1	-	2	322	422	308
Meningococcal infections	36	61	47	2,654	2,789	2,564
Mumps	84	175	139	4,504	12,233	3,237
Pertussis	74	44	44	2,857	2,425	2,425
Rubella (German measles)	5	1	4	210	333	605
Syphilis (Primary & Secondary): Civilian	807	612	612	38,865	33,964	26,896
Military	3	8	8	151	159	163
Toxic Shock syndrome	3	3	4	329	320	353
Tuberculosis	449	615	597	20,432	20,880	20,880
Tularemia	4	2	4	174	189	189
Typhoid Fever	3	11	8	370	346	364
Typhus fever, tick-borne (RMSF)	2	7	3	609	595	740
Rabies, animal	41	45	70	4,109	4,461	5,179

TABLE II. Notifiable diseases of low frequency, United States

	Cum. 1988		Cum. 1988
Anthrax	-	Leptospirosis (Hawaii 7)	51
Botulism: Foodborne	26	Plague	14
Infant (Pa. 1, Ohio 1)	36	Poliomyelitis, Paralytic	1
Other (Ohio 2)	6	Psittacosis (Md. 1)	93
Brucellosis (Mich. 1, Ala. 1, Tex. 1, Calif. 1)	74	Rabies, human	-
Cholera	7	Tetanus	48
Congenital rubella syndrome	4	Trichinosis (Upstate N.Y. 1, Ariz. 1, Calif. 1)	44
Congenital syphilis, ages < 1 year	426		
Diphtheria (Ga. 1)	1		

*Because AIDS cases are not received weekly from all reporting areas, comparison of weekly figures may be misleading.
†One of the 39 reported cases for this week was imported from a foreign country or can be directly traceable to a known internationally imported case within two generations.

TABLE III. Cases of specified notifiable diseases, United States, weeks ending December 17, 1988 and December 19, 1987 (50th Week)

Reporting Area	AIDS	Aseptic Meningitis	Encephalitis		Gonorrhea (Civilian)		Hepatitis (Viral), by type				Legionellosis	Leprosy
			Primary	Post-infectious			A	B	NA,NB	Unspecified		
	Cum. 1988	Cum. 1988	Cum. 1988	Cum. 1988	Cum. 1988	Cum. 1987	Cum. 1988	Cum. 1988	Cum. 1988	Cum. 1988	Cum. 1988	Cum. 1988
UNITED STATES	29,146	6,620	751	114	666,573	735,369	25,476	21,777	2,402	2,289	955	172
NEW ENGLAND	1,265	401	30	4	21,185	22,821	832	1,186	113	90	53	15
Maine	27	21	3	-	384	676	18	57	5	2	4	-
N.H.	38	40	1	3	267	392	45	69	11	4	5	-
Vt.	10	29	9	-	111	208	16	55	7	4	5	-
Mass.	711	160	9	1	7,246	8,006	380	687	71	61	36	14
R.I.	83	94	-	-	1,955	2,062	84	82	11	4	3	1
Conn.	396	57	8	-	11,222	11,477	289	236	8	15	-	-
MID. ATLANTIC	9,710	725	54	4	104,643	116,011	1,935	3,112	184	321	211	8
Upstate N.Y.	1,304	384	35	1	15,565	16,950	727	743	72	20	80	-
N.Y. City	5,254	140	8	3	42,750	62,031	362	1,303	19	240	45	7
N.J.	2,340	61	11	-	15,310	15,882	437	703	62	44	40	1
Pa.	812	140	-	-	31,018	21,148	409	363	31	17	46	-
E.N. CENTRAL	2,082	1,114	202	13	113,217	112,691	1,712	2,292	216	128	246	8
Ohio	468	430	63	3	25,279	25,309	318	533	39	20	96	-
Ind.	80	99	28	-	8,672	9,020	157	349	19	31	27	-
Ill.	972	134	47	10	34,245	32,253	621	496	76	35	21	7
Mich.	457	402	47	-	36,132	36,296	390	641	56	39	61	-
Wis.	105	49	17	-	8,889	9,813	226	273	26	3	41	1
W.N. CENTRAL	708	261	60	12	28,714	29,656	1,370	1,004	101	36	74	1
Minn.	156	30	18	4	3,805	4,342	105	137	24	4	4	-
Iowa	39	36	9	3	2,150	2,925	49	82	13	3	18	-
Mo.	364	108	1	-	16,736	15,909	798	580	44	18	23	-
N. Dak.	4	7	4	-	182	276	9	14	3	6	1	-
S. Dak.	7	18	5	2	462	596	29	6	3	-	14	-
Nebr.	45	13	13	2	1,416	1,917	46	41	2	-	5	-
Kans.	93	49	10	1	3,963	3,691	334	144	12	5	9	1
S. ATLANTIC	5,137	1,421	104	41	187,565	192,438	2,373	4,541	370	343	144	1
Del.	63	44	3	-	2,961	3,273	47	136	8	4	16	-
Md.	552	202	11	3	19,509	22,232	287	691	40	28	22	1
D.C.	475	21	1	1	14,072	12,757	18	47	4	1	1	-
Va.	343	205	32	4	13,820	14,045	356	312	73	227	11	-
W. Va.	20	37	22	-	1,293	1,354	15	69	5	4	-	-
N.C.	274	166	21	-	26,665	29,257	377	815	91	-	31	-
S.C.	171	21	-	1	15,064	14,192	40	518	12	6	27	-
Ga.	763	164	1	2	35,632	34,345	596	659	15	7	23	-
Fla.	2,476	561	13	30	58,549	60,983	637	1,294	122	66	13	-
E.S. CENTRAL	739	457	63	8	52,865	55,259	728	1,399	176	14	48	2
Ky.	92	158	22	1	5,359	5,566	471	270	62	2	20	-
Tenn.	324	53	16	-	18,543	19,386	164	646	41	-	8	-
Ala.	199	186	25	2	15,840	17,276	56	346	62	10	14	2
Miss.	124	60	-	5	13,123	13,031	37	137	11	2	6	-
W.S. CENTRAL	2,374	816	88	3	71,938	83,124	3,234	2,057	207	552	38	40
Ark.	80	17	6	-	7,105	9,300	341	113	10	17	6	-
La.	358	120	24	1	14,216	13,194	163	380	25	17	7	8
Okla.	127	77	8	-	6,793	8,958	484	180	42	36	17	-
Tex.	1,809	602	50	2	43,824	51,672	2,246	1,384	130	482	8	32
MOUNTAIN	845	235	29	4	14,270	19,064	3,382	1,552	245	175	48	1
Mont.	16	5	-	-	393	545	44	54	10	4	2	-
Idaho	11	3	-	-	315	652	128	110	9	4	2	-
Wyo.	6	2	-	-	195	407	5	12	3	-	3	-
Colo.	299	75	3	-	3,126	4,344	231	191	64	80	8	1
N. Mex.	59	24	3	1	1,406	2,063	536	225	20	1	4	-
Ariz.	273	84	14	1	5,235	6,471	1,910	598	78	57	20	-
Utah	61	25	4	2	519	633	300	132	39	20	4	-
Nev.	120	17	5	-	3,081	3,949	228	230	22	9	5	-
PACIFIC	6,286	1,190	121	25	72,176	104,305	9,910	4,634	790	630	93	96
Wash.	362	-	7	4	6,765	8,584	2,283	861	196	74	24	7
Oreg.	175	-	-	-	3,128	3,792	1,356	569	91	22	5	1
Calif.	5,626	1,055	108	21	60,694	89,517	5,668	3,097	490	516	61	73
Alaska	19	25	4	-	1,025	1,618	591	56	8	13	-	1
Hawaii	104	110	2	-	564	794	12	51	5	5	3	14
Guam	1	-	-	-	143	181	9	13	-	2	1	5
P.R.	1,230	79	4	1	1,288	1,862	53	251	41	41	-	3
V.I.	32	-	-	-	422	282	1	7	2	-	-	-
Amer. Samoa	-	-	-	-	77	82	7	2	-	5	-	2
C.N.M.I.	-	-	-	-	52	-	1	3	-	5	-	1

N: Not notifiable U: Unavailable C.N.M.I.: Commonwealth of the Northern Mariana Islands

TABLE III. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending December 17, 1988 and December 19, 1987 (50th Week)

Reporting Area	Malaria	Measles (Rubeola)					Menin-gococcal Infections	Mumps		Pertussis			Rubella		
		Indigenous		Imported*		Total									
	Cum. 1988	1988	Cum. 1988	1988	Cum. 1988	Cum. 1987	Cum. 1988	1988	Cum. 1988	1988	Cum. 1988	Cum. 1987	1988	Cum. 1988	Cum. 1987
UNITED STATES	945	38	2,543	1	322	3,575	2,654	84	4,504	74	2,857	2,425	5	210	333
NEW ENGLAND	73	-	83	-	54	282	231	1	129	-	176	171	-	9	2
Maine	3	-	7	-	-	3	10	-	-	-	24	34	-	-	1
N.H.	3	-	67	-	44	163	24	-	106	-	47	43	-	5	-
Vt.	5	-	-	-	-	26	18	1	6	-	5	4	-	-	-
Mass.	36	-	2	-	2	66	101	-	7	-	80	54	-	3	1
R.I.	7	-	-	-	-	2	21	-	-	-	17	5	-	1	-
Conn.	19	-	7	-	8	22	57	-	10	-	23	31	-	-	-
MID. ATLANTIC	165	1	912	-	50	588	292	6	360	2	302	298	1	15	12
Upstate N.Y.	41	1	20	-	18	43	138	-	99	1	207	165	-	2	10
N.Y. City	89	-	46	-	6	466	68	3	104	-	9	19	-	7	1
N.J.	11	-	317	-	12	39	63	-	57	-	17	22	1	4	1
Pa.	24	-	529	-	14	40	23	3	100	1	69	92	-	2	-
E.N. CENTRAL	50	-	141	-	108	389	376	13	895	2	258	265	-	31	42
Ohio	11	-	2	-	83	5	142	-	130	-	49	74	-	1	-
Ind.	4	-	57	-	-	-	30	4	82	-	74	20	-	-	-
Ill.	3	-	56	-	16	209	75	7	322	1	46	18	-	26	31
Mich.	23	-	26	-	5	29	88	1	225	1	38	51	-	4	9
Wis.	9	-	-	-	4	146	41	1	136	-	51	102	-	-	2
W.N. CENTRAL	18	-	11	-	3	230	97	9	253	-	142	145	-	2	2
Minn.	6	-	10	-	1	39	21	-	-	-	63	14	-	-	-
Iowa	2	-	-	-	1	-	-	-	36	-	34	58	-	-	1
Mo.	6	-	1	-	1	189	37	-	42	-	22	39	-	-	-
N. Dak.	-	-	-	-	-	1	1	-	-	-	11	15	-	-	-
S. Dak.	-	-	-	-	-	-	5	-	1	-	5	3	-	-	-
Nebr.	1	-	-	-	-	-	12	-	11	-	-	1	-	-	-
Kans.	3	-	-	-	-	1	21	9	163	-	7	15	-	2	1
S. ATLANTIC	123	-	415	-	22	177	451	21	748	3	253	311	-	18	19
Del.	1	-	-	-	-	32	2	-	1	-	7	5	-	-	2
Md.	22	-	12	-	5	10	54	10	175	2	48	19	-	1	3
D.C.	12	-	-	-	-	1	10	3	285	-	1	-	-	-	1
Va.	20	-	237	-	2	1	55	3	139	-	24	55	-	11	1
W. Va.	3	-	6	-	-	-	8	-	19	-	10	39	-	-	-
N.C.	16	-	-	-	5	6	67	-	51	1	67	122	-	1	1
S.C.	10	-	-	-	-	2	37	2	8	-	1	-	-	-	-
Ga.	6	-	-	-	-	10	70	-	32	-	37	23	-	2	2
Fla.	33	-	160	-	10	115	148	3	38	-	58	48	-	3	9
E.S. CENTRAL	21	-	69	-	-	8	245	3	449	3	105	48	-	2	3
Ky.	1	-	35	-	-	-	57	-	213	1	13	2	-	-	2
Tenn.	-	-	-	-	-	-	131	2	217	1	30	15	-	2	1
Ala.	10	-	-	-	-	4	41	1	16	1	58	24	-	-	-
Miss.	10	-	34	-	-	4	16	N	N	-	4	7	-	-	-
W.S. CENTRAL	83	-	20	-	4	448	180	10	871	3	239	312	-	24	12
Ark.	4	-	-	-	1	-	21	2	138	3	38	13	-	4	2
La.	12	-	-	-	-	-	49	-	315	-	20	50	-	-	-
Okla.	10	-	8	-	-	4	23	-	197	-	62	171	-	1	6
Tex.	57	-	12	-	3	444	87	8	221	-	119	78	-	19	4
MOUNTAIN	44	13	160	1	34	497	81	6	220	58	870	224	-	6	25
Mont.	5	13	48	-	31	128	2	-	2	2	4	7	-	-	8
Idaho	2	-	-	-	1	-	8	-	7	1	335	80	-	-	1
Wyo.	-	-	-	-	-	2	-	3	7	-	2	5	-	-	1
Colo.	15	-	112	-	1	9	20	-	33	6	35	69	-	2	-
N. Mex.	3	-	-	-	-	318	13	N	N	-	53	13	-	-	-
Ariz.	13	-	-	-	-	36	21	2	143	49	413	38	-	-	5
Utah	4	-	-	1†	1	1	15	-	7	-	27	12	-	3	10
Nev.	2	-	-	-	-	3	2	1	21	-	1	-	-	1	-
PACIFIC	368	24	732	-	47	956	701	15	579	3	512	651	4	103	216
Wash.	25	-	7	-	-	47	66	2	62	1	115	98	-	-	2
Oreg.	16	-	6	-	2	103	45	N	N	-	50	83	-	-	2
Calif.	313	24	715	-	37	801	565	13	475	2	280	228	4	75	140
Alaska	3	-	1	-	-	1	8	-	13	-	7	6	-	-	2
Hawaii	11	-	3	-	8	4	17	-	18	-	60	236	-	28	70
Guam	-	-	-	-	1	2	-	-	3	-	-	-	-	1	1
P.R.	2	-	231	-	-	771	12	-	10	-	15	20	-	3	3
V.I.	-	-	-	-	-	-	-	-	34	-	-	-	-	-	1
Amer. Samoa	-	-	-	-	-	1	3	-	4	-	-	-	-	-	-
C.N.M.I.	1	-	-	-	-	-	1	-	2	-	-	-	-	-	-

*For measles only, imported cases includes both out-of-state and international importations.
N: Not notifiable U: Unavailable †International §Out-of-state

TABLE III. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending December 17, 1988 and December 19, 1987 (50th Week)

Reporting Area	Syphilis (Civilian) (Primary & Secondary)		Toxic-shock Syndrome	Tuberculosis		Tula-remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1988	Cum. 1987	Cum. 1988	Cum. 1988	Cum. 1987	Cum. 1988	Cum. 1988	Cum. 1988	Cum. 1988
UNITED STATES	38,865	33,964	329	20,432	20,880	174	370	609	4,109
NEW ENGLAND	1,168	629	24	526	641	4	37	12	15
Maine	12	1	4	29	28	-	-	-	1
N.H.	7	3	5	11	18	-	-	-	5
Vt.	3	4	2	6	16	-	1	-	-
Mass.	426	297	10	302	358	3	21	7	-
R.I.	33	12	-	39	61	-	7	2	-
Conn.	687	312	3	139	160	1	8	3	9
MID. ATLANTIC	9,105	6,260	48	4,228	3,868	-	73	19	479
Upstate N.Y.	598	255	22	531	504	-	15	11	44
N.Y. City	6,180	4,647	6	2,306	1,931	-	45	6	-
N.J.	980	697	3	726	694	-	11	-	15
Pa.	1,347	661	17	665	739	-	2	2	420
E.N. CENTRAL	1,146	836	47	2,255	2,315	1	34	34	144
Ohio	108	105	31	424	431	-	7	22	5
Ind.	51	57	1	243	250	-	2	2	29
Ill.	520	421	2	999	1,037	-	19	7	31
Mich.	433	194	13	490	504	1	4	2	35
Wis.	34	59	-	99	93	-	2	1	44
W.N. CENTRAL	259	177	45	504	583	78	6	93	456
Minn.	18	23	6	85	115	3	4	2	128
Iowa	26	27	7	58	39	-	-	-	13
Mo.	153	79	11	241	314	48	2	57	22
N. Dak.	1	1	3	15	13	1	-	-	105
S. Dak.	-	11	5	33	24	16	-	7	129
Nebr.	28	16	4	16	25	3	-	1	21
Kans.	33	20	9	56	53	7	-	26	38
S. ATLANTIC	13,939	11,613	21	4,384	4,464	7	42	199	1,419
Del.	100	67	2	42	39	2	-	1	57
Md.	693	610	3	418	387	2	3	22	317
D.C.	693	399	-	174	152	-	2	-	13
Va.	420	312	-	392	413	2	12	17	349
W. Va.	37	13	-	68	98	-	1	2	98
N.C.	811	702	9	525	600	-	2	107	8
S.C.	714	668	4	470	451	-	-	23	123
Ga.	2,498	1,621	-	723	807	1	8	24	290
Fla.	7,973	7,221	3	1,572	1,517	-	14	3	164
E.S. CENTRAL	2,030	1,836	24	1,678	1,874	11	3	92	287
Ky.	65	27	10	354	413	5	1	30	118
Tenn.	895	730	11	513	601	5	-	39	69
Ala.	567	484	2	501	529	-	1	11	93
Miss.	503	595	1	310	331	1	1	12	7
W.S. CENTRAL	4,318	4,284	34	2,598	2,412	54	8	144	528
Ark.	247	251	2	302	289	35	-	31	86
La.	848	775	-	311	312	-	4	2	11
Okla.	139	175	11	235	233	16	-	93	35
Tex.	3,084	3,083	21	1,750	1,578	3	4	18	396
MOUNTAIN	801	670	35	561	617	11	11	12	359
Mont.	3	9	-	31	18	-	1	6	202
Idaho	4	6	5	22	30	-	-	2	11
Wyo.	1	3	-	5	2	2	-	3	38
Colo.	105	123	3	74	150	5	3	1	28
N. Mex.	47	54	2	91	98	2	1	-	11
Ariz.	163	284	16	248	261	1	6	-	44
Utah	17	25	9	29	25	1	-	-	9
Nev.	461	166	-	61	33	-	-	-	16
PACIFIC	6,099	7,659	51	3,698	4,106	8	156	4	422
Wash.	228	165	9	226	243	1	13	1	-
Oreg.	301	290	1	150	128	1	7	1	-
Calif.	5,527	7,182	40	3,113	3,483	4	130	2	395
Alaska	15	4	-	49	61	2	1	-	27
Hawaii	28	18	1	160	191	-	5	-	-
Guam	3	2	-	31	26	-	-	-	-
P.R.	661	854	-	249	303	-	5	-	72
V.I.	2	10	-	6	2	-	-	-	-
Amer. Samoa	-	-	-	5	11	-	1	-	-
C.N.M.I.	1	-	-	25	-	-	-	-	-

U: Unavailable

TABLE IV. Deaths in 121 U.S. cities,* week ending December 17, 1988 (50th Week)

Reporting Area	All Causes, By Age (Years)						P&I**
	All Ages	≥65	45-64	25-44	1-24	<1	Total
NEW ENGLAND	722	500	136	58	15	12	58
Boston, Mass.	179	116	42	13	6	2	24
Bridgeport, Conn.	43	27	12	3	1	-	2
Cambridge, Mass.	19	15	3	1	-	-	1
Fall River, Mass.	36	25	8	3	-	-	1
Hartford, Conn.	63	40	13	6	2	2	4
Lowell, Mass.	39	25	6	7	-	1	2
Lynn, Mass.	18	14	2	2	-	-	-
New Bedford, Mass.	32	24	6	1	1	-	3
New Haven, Conn.	51	33	9	3	3	3	-
Providence, R.I.§	58	45	10	3	-	-	2
Somerville, Mass.	14	11	2	1	-	-	-
Springfield, Mass.	60	42	11	6	1	-	6
Waterbury, Conn.	47	33	4	7	1	1	4
Worcester, Mass.	63	50	8	2	-	3	9
MID. ATLANTIC	2,599	1,708	533	229	58	70	130
Albany, N.Y.	65	39	16	7	1	2	3
Allentown, Pa.	19	17	2	-	-	-	2
Buffalo, N.Y.	120	78	29	8	2	2	7
Camden, N.J.	38	23	9	4	1	1	1
Elizabeth, N.J.	27	19	4	-	-	4	1
Erie, Pa.†	47	35	10	-	1	1	3
Jersey City, N.J.	62	38	18	5	-	1	2
N.Y. City, N.Y.	1,461	941	295	158	36	31	61
Newark, N.J.	67	37	15	8	4	3	3
Paterson, N.J.	37	25	3	6	1	2	7
Philadelphia, Pa.	194	132	40	8	6	8	12
Pittsburgh, Pa.†	77	47	22	4	1	3	2
Reading, Pa.	25	19	3	1	1	1	5
Rochester, N.Y.	102	73	20	5	-	4	7
Schenectady, N.Y.	32	26	3	2	1	-	1
Scranton, Pa.†	37	28	5	2	1	1	-
Syracuse, N.Y.	92	63	18	6	1	4	10
Trenton, N.J.	50	29	15	4	1	1	-
Utica, N.Y.	27	24	1	1	-	1	1
Yonkers, N.Y.	20	15	5	-	-	-	2
E.N. CENTRAL	2,448	1,617	492	181	75	83	120
Akron, Ohio	56	41	11	1	3	-	2
Canton, Ohio	30	23	6	1	-	-	3
Chicago Ill§	564	362	125	45	10	22	16
Cincinnati, Ohio	162	111	30	9	3	9	20
Cleveland, Ohio	154	91	36	20	2	5	9
Columbus, Ohio	122	71	26	12	7	6	1
Dayton, Ohio	140	100	27	9	1	3	7
Detroit, Mich.	273	172	54	30	8	9	10
Evansville, Ind.	86	74	10	-	2	-	7
Fort Wayne, Ind.	48	37	2	5	3	1	3
Gary, Ind.	72	29	25	13	2	3	6
Grand Rapids, Mich.	82	59	10	1	6	6	3
Indianapolis, Ind.	171	100	46	15	5	5	5
Madison, Wis.	46	30	9	1	3	3	5
Milwaukee, Wis.	125	88	21	6	5	5	6
Peoria, Ill.	45	33	5	3	1	3	3
Rockford, Ill.	53	36	12	1	3	1	1
South Bend, Ind.	50	33	14	1	2	-	6
Toledo, Ohio	111	81	16	4	8	2	7
Youngstown, Ohio	58	46	7	4	1	-	-
W.N. CENTRAL	791	561	141	45	23	21	31
Des Moines, Iowa	63	48	10	4	1	-	-
Duluth, Minn.	26	20	5	-	-	1	-
Kansas City, Kans.	32	20	9	2	1	-	-
Kansas City, Mo.	110	77	19	9	3	2	11
Lincoln, Nebr.	28	23	3	-	2	-	3
Minneapolis, Minn.	192	138	30	11	5	8	7
Omaha, Nebr.	87	59	17	4	3	4	6
St. Louis, Mo.	142	95	29	11	4	3	-
St. Paul, Minn.	51	37	8	2	2	2	2
Wichita, Kans.§	60	44	11	2	2	1	2

Reporting Area	All Causes, By Age (Years)						P&I**
	All Ages	≥65	45-64	25-44	1-24	<1	Total
S. ATLANTIC	1,362	826	300	117	60	57	72
Atlanta, Ga.	184	108	38	21	8	9	8
Baltimore, Md.	312	208	67	21	8	8	14
Charlotte, N.C.	92	56	17	8	7	4	10
Jacksonville, Fla.	102	56	30	5	7	3	3
Miami, Fla.	159	81	42	15	13	8	-
Norfolk, Va.	70	41	14	8	2	5	10
Richmond, Va.	77	49	16	5	3	4	9
Savannah, Ga.	50	34	9	5	-	2	5
St. Petersburg, Fla.	78	63	9	1	1	4	6
Tampa, Fla.	84	47	17	11	4	4	4
Washington, D.C.	127	63	36	15	7	6	3
Wilmington, Del.	27	20	5	2	-	-	-
E.S. CENTRAL	904	600	184	63	27	30	50
Birmingham, Ala.	126	79	27	6	4	10	-
Chattanooga, Tenn.	85	58	16	8	2	1	4
Knoxville, Tenn.	96	67	17	8	3	1	8
Louisville, Ky.	148	87	32	14	5	10	5
Memphis, Tenn.	177	118	40	12	7	-	19
Mobile, Ala.	72	49	17	2	2	2	-
Montgomery, Ala.	58	45	8	2	1	2	4
Nashville, Tenn.	142	97	27	11	3	4	10
W.S. CENTRAL	1,853	1,137	423	189	64	40	68
Austin, Tex.	57	36	11	6	-	4	3
Baton Rouge, La.	44	27	10	3	1	3	1
Corpus Christi, Tex.§	48	37	10	1	-	-	1
Dallas, Tex.	216	123	49	27	12	5	7
El Paso, Tex.	68	48	13	3	2	2	1
Fort Worth, Tex	96	55	20	13	7	1	7
Houston Tex§	734	436	169	89	24	16	18
Little Rock, Ark.	72	45	18	3	4	2	7
New Orleans, La.	166	103	40	17	3	3	-
San Antonio, Tex.	191	117	53	13	6	2	8
Shreveport, La.	40	23	11	4	2	-	4
Tulsa, Okla.	121	87	19	10	3	2	11
MOUNTAIN	687	436	146	60	16	29	29
Albuquerque, N. Mex:	81	52	15	7	4	3	2
Colo. Springs, Colo.	34	19	8	5	1	1	3
Denver, Colo.	139	81	33	17	3	5	2
Las Vegas, Nev.	105	64	31	4	1	5	6
Ogden, Utah	24	18	3	-	1	2	2
Phoenix, Ariz.	150	92	27	17	5	9	8
Pueblo, Colo.	19	14	2	2	-	1	1
Salt Lake City, Utah	41	31	7	2	-	1	-
Tucson, Ariz.	94	65	20	6	1	2	5
PACIFIC	1,995	1,321	389	179	50	49	115
Berkeley, Calif.	15	9	5	1	-	-	-
Fresno, Calif.	95	57	23	10	3	2	9
Glendale, Calif.	26	20	4	2	-	-	2
Honolulu, Hawaii	64	50	10	3	1	-	4
Long Beach, Calif.	91	70	10	8	1	2	20
Los Angeles Calif.	560	340	131	58	15	11	17
Oakland, Calif.§	71	48	12	7	1	3	3
Pasadena, Calif.	35	25	6	4	-	-	2
Portland, Oreg.	140	103	21	5	7	4	5
Sacramento, Calif.	149	91	37	11	5	5	11
San Diego, Calif.	140	88	26	18	1	5	8
San Francisco, Calif.	163	103	29	21	6	4	5
San Jose, Calif.	193	136	34	14	3	6	19
Seattle, Wash.	155	114	22	11	5	3	3
Spokane, Wash.	56	39	9	2	2	4	5
Tacoma, Wash.	42	28	10	4	-	-	2
TOTAL	13,361††	8,706	2,744	1,121	388	391	673

*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 available 4 weeks.

Suicide — Continued

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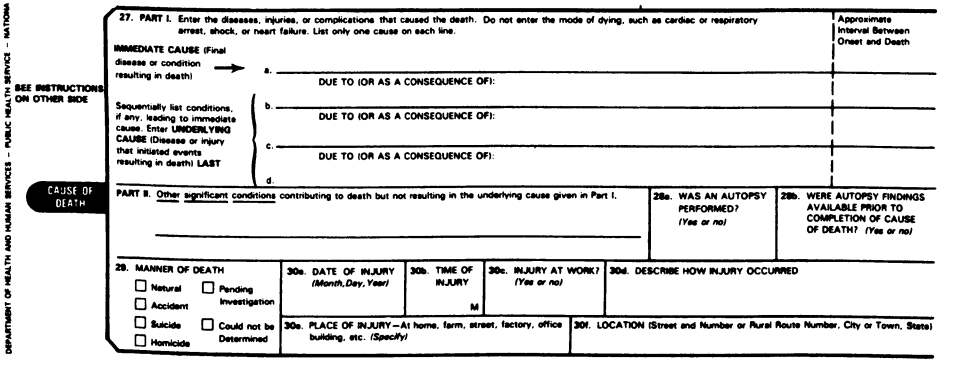
Editorial Note: For each death certificate filed in the United States, the certifier must indicate, in addition to the cause of death, the manner of death as "natural," "accident," "suicide," "homicide," or "could not be determined" (Figure 1) (*8*). For suspected suicide or homicide, state laws usually require a medical examiner or coroner to complete the death certificate. Because suicide is particularly subject to inaccurate determination, the incidence of suicide may be underestimated by 10%–50% (*2–6*).

Death certificates are the primary data source for U.S. mortality statistics, and public health priorities are influenced considerably by the perceived magnitude of problems. Thus, underreporting of suicide can affect research, prevention, and intervention efforts regarding this problem. More accurate reporting may improve understanding of the risk factors for suicide and lead to more effective prevention strategies.

The validity and reliability of certifications of suicide are decreased for several reasons (*9–11*). The determination of suicide requires that the death be established as both self-inflicted and intentional. For most certifiers, establishing intentionality is the most difficult criterion. A coroner or medical examiner who suspects suicide may be reluctant to impose social stigma, guilt, and loss of insurance benefits on the victim's family. Since many certifiers lack explicit criteria for assessing suicidal intent, they might search for a narrower range of evidence concerning intent (*10*). Thus, a certifier might conclude that a death was not a suicide because information proving intent was not collected. However, absence of evidence of intent is not evidence of absence of intent.

Some certifiers require a suicide note to certify a death as suicide. Yet, only about one third of persons who commit suicide leave such notes (*11*). Forensic science experts also differ on the proper certification of deaths for psychotic, very young, or alcohol- or drug-intoxicated persons (*12–17*).

FIGURE 1. Cause of Death section of U.S. Standard Certificate of Death



Suicide — Continued

The new operational criteria for determining suicide should improve reporting by helping to standardize the information collected and incorporated into the manner of death determination. The certifier is more likely to identify a suicide correctly when the case file contains objective information regarding intent to die.

Suggestions or inquiries regarding the criteria should be addressed to Operational Criteria for Determination of Suicide Working Group, c/o Division of Injury Epidemiology and Control, Center for Environmental Health and Injury Control, CDC.

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Hypothermia Prevention

From 1976 through 1985, 7450 deaths were caused by exposure to cold* in the United States (Figure 1). Of health effects associated with cold exposure, hypothermia—defined as a core body temperature of ≤35 C (≤95 F)—is the most commonly fatal syndrome. Persons ≥60 years of age are particularly susceptible to hypothermia and account for more than half of all deaths (*1*). Younger persons subjected to

*Deaths attributed to excessive cold (ICD code E901) were analyzed using mortality data tapes for 1976–1985 from the National Center for Health Statistics.

Hypothermia – Continued

overwhelming cold stress are also vulnerable (*2*). Although deaths attributable to hypothermia occur infrequently in children, infants <1 year of age are at relatively high risk. Rates of death from hypothermia are generally higher in males than in females, but these differences are less substantial in children and the elderly (*3*).

Persons with hypothyroidism are at increased risk for hypothermia (*4*). In addition, a variety of drugs, principally sedative-hypnotics, may predispose users to hypothermia; ethanol and neuroleptic medications particularly increase susceptibility to cold (*2*).

As the body temperature of a cold-exposed person decreases, impaired consciousness, confusion, or disorientation may occur. Because mental status is altered, a mildly hypothermic person may fail to take appropriate corrective measures to lessen exposure. In response to the decline in core temperature, vasoconstriction (causing pallor) and shivering occur. However, shivering decreases markedly in severe hypothermia because thermoregulation becomes impaired. Severely hypothermic persons lose consciousness and develop shallow respirations. Ventricular fibrillation and death may follow (*2*).

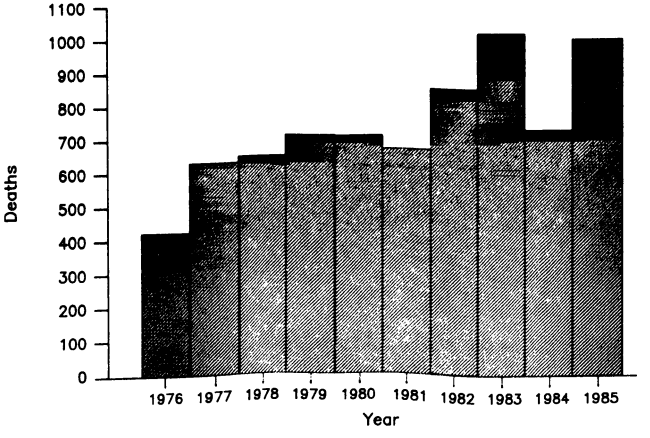
Reported by: Health Studies Br, Div of Environmental Hazards and Health Effects, Center for Environmental Health and Injury Control, CDC.

Editorial Note: This preliminary study of mortality data suggests a trend toward increased incidence of hypothermia. Although age-adjusted rates are required to properly evaluate the hypothesis that mortality due to effects of cold is increasing, the crude numbers of deaths (Figure 1) strongly suggest such a trend.

Hypothermia prevention programs should focus on persons particularly susceptible to hypothermia and those likely to be subjected to unusual cold stress. Persons caring for the elderly should be alerted to hypothermia's symptoms and signs, and elderly persons living alone should be visited frequently. Since adequate caloric intake is important in preventing hypothermia, programs designed to improve nutrition in the elderly may also be helpful. Programs that ensure home heating for the elderly may also help prevent hypothermia.

Younger persons likely to be subjected to cold stress (e.g., skiers and hikers) should be educated concerning the need for adequate clothing and the importance of

FIGURE 1. Deaths attributable to excessive cold exposure – United States, 1976–1985



Hypothermia — Continued

abstaining from alcohol use during prolonged cold exposure. Shelter should be offered to homeless persons who would otherwise sleep outdoors on cold winter nights.

Persons using medications (particularly neuroleptic medications) that are likely to increase susceptibility to the cold should be advised by their physicians regarding their increased vulnerability to cold stress.

References

1. Kilbourne EM. Illness due to thermal extremes. In: Last JM, ed. Maxcy-Rosenau public health and preventive medicine. 12th ed. Norwalk, Connecticut: Appleton-Century-Crofts, 1986: 711–4.
2. Collins KJ. Hypothermia: the facts. New York: Oxford University Press, 1983.
3. CDC. Hypothermia-associated deaths—United States, 1968–1980. MMWR 1985;34:753–4.
4. Forester CF. Coma in myxedema: report of a case and review of the world literature. Arch Intern Med 1963;111:734–43.

Notices to Readers

Fourth National Environmental Health Conference

On June 20–23, 1989, the Center for Environmental Health and Injury Control, CDC; the Agency for Toxic Substances and Disease Registry (ATSDR); and the Association of State and Territorial Health Officials will cosponsor the Fourth National Environmental Health Conference. The conference will be held in San Antonio, Texas, and is directed toward federal, state, and local health and environment officials, physicians, and the environmental community.

The theme of the 1989 conference is "Environmental Issues: Today's Challenge for the Future." The conference will address environmental problems that have the greatest importance to public health, review topical scientific findings, and discuss prevention strategies. Plenary sessions will cover radon; medical, municipal, and hazardous waste; air pollution; lead in the environment; and dioxin. Twenty workshops will be held on topics of interest to states, academic institutions, and federal agencies, including health assessments at National Priority List (NPL) and Resource Conservation and Recovery Act (RCRA) sites, emergency responding, radiation, birth defects, risk communication, and indoor air pollution and respiratory disease.

For further information, call CDC at (404) 488-4700 or (404) 488-4682 or ATSDR at (404) 488-4881.

Combined Issues of *MMWR*

The December 30, 1988, issue of *MMWR* will not be published. The next issue will be Volume 37, Numbers 51 and 52, dated January 6, 1989, and will include the tables on notifiable diseases and deaths for the weeks ending December 24 and December 31.

Current Trends

Update: Influenza – United States, 1988–89 Season

The table below provides a summary of surveillance measures of influenza activity in the United States for the weeks ending November 26 and December 3, 10, and 17. These numbers are provisional and may change if additional cases are reported. Final 1987 data for the last report week listed are also included.

	Report week ending				
	1988				1987
Reports	**Nov 26**	**Dec 3**	**Dec 10**	**Dec 17**	**Dec 19**
No. states/territories reporting influenza or influenza-like illness*					
Sporadic activity	18	19	20	24	**21**
Regional activity	0	0	0	2†	**3**
Widespread activity	0	0	0	0	**0**
Cumulative no. states/territories reporting culture-confirmed influenza infection§					
Influenza A(H3N2)	1	2	3	3	**6**
Influenza A(H1N1)	0	0	1	2	**0**
Influenza B	4	4	6	11	**2**
Sentinel physician reports of patients with influenza-like illness, expressed as percentage of total no. patients seen¶	3.5%	3.7%	4.0%	–	**4.3%**

*Reported by state and territorial epidemiologists. Three levels of activity are defined: 1) Sporadic–sporadically occurring cases of influenza-like illness or culture-confirmed influenza, with no outbreaks detected; 2) Regional–outbreaks of influenza-like illness or culture-confirmed influenza in counties having a combined population <50% of the state's total population; 3) Widespread–outbreaks of influenza-like illness or culture-confirmed influenza in counties having a combined population ≥50% of the state's total population.

†Nebraska and California each reported an outbeak of influenza type B in an elementary school this week.

§Reported by WHO Collaborating Laboratories or other U.S. laboratories. Influenza A(H3N2) has been reported from the District of Columbia, New York, and Hawaii. Influenza B has been reported from Arizona, California, Florida, Michigan, Nebraska, New York, Ohio, Oklahoma, Oregon, Tennessee, and Texas. Influenza A(H1N1) has been reported from Hawaii and Wisconsin. A previously reported case of influenza A from Maryland (*1*) was identified by fluorescent antibody test and has not been confirmed.

¶Because reporting from sentinel physicians for the week ending December 17 is incomplete, this estimate is not included in this update.

Reported by: Participating state and territorial epidemiologists and state laboratory directors. WHO Collaborating Laboratories. Sentinel Physicians of the American Academy of Family Physicians. Influenza Research Center, Baylor College of Medicine, Houston, Texas. Div of Surveillance and Epidemiologic Studies, Epidemiology Program Office; WHO Collaborating Center for Influenza, Influenza Br, and Epidemiology Office, Div of Viral Diseases, Center for Infectious Diseases, CDC.

Reference

1. CDC. Update: influenza–United States, 1988–89 season. MMWR 1988;37:721–2,727.

Erratum: Vol. 37, No. 49

p. 762 In Table IV, the deaths from pneumonia and influenza (P&I) in New York City for the week ending December 10, 1988 (49th week), should have read 66 instead of 255. The total P&I deaths for the Mid-Atlantic region and Total (121 cities) should have read 149 instead of 338 and 694 instead of 883, respectively.

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: Editor, *Morbidity and Mortality Weekly Report*, Centers for Disease Control, Atlanta, Georgia 30333.

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