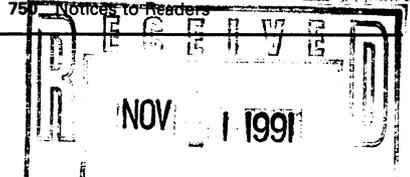


M M W R

MORBIDITY AND MORTALITY WEEKLY REPORT

- 737 Lower Extremity Amputations Among Persons with Diabetes — Washington, 1988
- 739 Sensitivity of Death Certificate Data for Monitoring Diabetes Mortality — Diabetic Eye Disease Follow-Up Study, 1985–1990
- 741 Body-Weight Perceptions and Selected Weight-Management Goals and Practices of High School Students — United States, 1990



Progress in Chronic Disease Prevention

National Diabetes Month, 1991

November is National Diabetes Month. During this month, nationwide educational activities are planned to increase the public's awareness of diabetes. Additional information is available from the American Diabetes Association, National Center, 1600 Duke Street, Alexandria, VA 22314; telephone (800) 232-3472 ((800) ADA-DISC).

Lower Extremity Amputations Among Persons with Diabetes Mellitus — Washington, 1988

Diabetes mellitus is the leading cause of lower extremity amputations (LEAs) in the United States, accounting for approximately 50% of all nontraumatic LEAs (1). To assist public health programs in preventing diabetes-related LEAs in Washington state, the diabetes-control program of the Washington Department of Health characterizes LEAs. This report summarizes an analysis of the incidence of LEAs during 1988 among Washington residents with and without diabetes.

The analysis included all hospitalizations in Washington in 1988 except hospitalizations from Veterans Administration, military, and psychiatric facilities. The criterion for LEA classification was any *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) procedural code of 84.10–84.19 recorded on state hospital discharge records; cases of traumatic amputation (ICD-9-CM diagnostic codes 800–995.89) were deleted from the analysis. The criterion for diabetes classification was any ICD-9-CM diagnostic code of 250.0–250.9 listed among the discharge diagnoses. Estimates of the number of persons with diabetes were calculated by applying National Health Interview Survey diabetes prevalence rates for 1988 to Washington population estimates for 1988. The population-attributable risk

Lower Extremity Amputations – Continued

(PAR)—the proportion of all new nontraumatic amputations associated with diabetes—was calculated using a standard formula (2).

In 1988, 1087 residents of Washington had nontraumatic LEAs; 543 (50%) of these persons had diabetes. Although the overall rate of LEA among persons with diabetes was 5.1 per 1000 persons (95% confidence interval [CI]=4.7–5.5), county-specific rates varied substantially, ranging from 1.6 per 1000 (95% CI=0.5–2.7) to 11.7 per 1000 (95% CI=6.8–16.6).

The incidence rate of LEA for persons with diabetes was substantially higher for males (5.3 per 1000 [95% CI=4.7–5.9]) than for females (3.6 per 1000 [95% CI=3.1–4.1]). Compared with females without diabetes, the risk for LEA was greatest for females aged <45 years (relative risk [RR]=218.1; 95% CI=123.6–384.7) and lowest for females aged ≥75 years (RR=6.0; 95% CI=4.5–8.1) (Table 1).*

Among persons with diabetes, the rate of LEA was more than 40 times that for persons without diabetes. Based on PAR calculations for males and females, depending on age, 38%–66% and 30%–69% of all nontraumatic LEAs, respectively, were directly attributed to diabetes.

Reported by: FA Connell, MD, Univ of Washington, Seattle; C Shaw, MPH, J Will, PhD, Washington Dept of Health, Div of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: The clinical and pathologic changes that necessitate LEA in persons with diabetes are related to several problems, including peripheral neuropathy, peripheral vascular disease, and infection (3). For example, peripheral neuropathy may result in loss of sensation in the feet and the development of foot deformities; these deformities, in turn, can cause pressure points that may ulcerate. Inadequate blood supply and infection may then result in osteomyelitis and gangrene that necessitate LEA.

Based on national surveillance data, in 1987 there were approximately 56,000 LEAs among persons with diabetes in the United States—a hospital discharge rate of 8.2 per 1000 persons with diabetes (4). One of the national health objectives for the year 2000 is to reduce this rate to 4.9 per 1000 persons with diabetes (5). The risk for LEA within the population with diabetes increases by age and by the duration of diabetes. Therefore, to achieve the national objective, clinicians must promptly identify persons

*The risk for LEA among persons with diabetes appears greatest for those aged <45 years because few persons without diabetes account for nontraumatic LEA in that age group. When the risk is calculated only for persons with diabetes, the risk increases with age.

TABLE 1. Relative risk (RR)* for nontraumatic amputations among persons with diabetes, by age and sex – Washington state, 1988

Age (yrs)	Male		Female	
	RR	(95% CI [†])	RR	(95% CI)
≤44	84.9	(48.6–148.4)	218.1	(123.6–384.7)
45–64	35.5	(25.5– 49.5)	43.1	(26.5– 70.1)
65–74	15.3	(11.1– 21.1)	16.2	(10.9– 24.1)
≥75	7.1	(5.3– 9.5)	6.0	(4.5– 8.1)
Total	48.0	(40.6– 56.7)	39.2	(32.4– 47.5)

*Based on a comparison with persons without diabetes.

[†]Confidence interval.

Lower Extremity Amputations – Continued

who are at increased risk, take measures to both treat and prevent foot ulcers, and prevent the recurrence of foot ulcers (6).

In the United States, an estimated 44%–85% of LEAs among persons with diabetes can be prevented with improved foot-care programs (7). This will require clinicians to provide patients with information about proper foot care and the need for daily foot inspection as well as intensified collaboration among medical and public health practitioners. For example, CDC has provided recommendations for identifying when patients' feet are at increased risk, preventing and treating foot ulcers, halting the recurrence of foot ulcers, and educating patients and their families about proper foot care (8).

State and county surveillance data, such as those developed by the Washington Department of Health, will assist public health practitioners and health-care providers in directing services to the populations with greatest need and track progress toward the year 2000 objective. By using this approach, 44%–85% of all diabetes-related LEAs in the United States may be prevented (7); for example, in Washington approximately 240–460 LEAs could be prevented each year with appropriate targeting of improved foot-care programs. The Washington State Diabetes Control Program provides community health centers and hospitals with educational materials and technical assistance to prevent diabetes-related LEAs; based on the analysis in this report, such resources can be targeted especially toward counties that have high rates of diabetes-related LEAs.

References

1. Most RS, Sinnock P. The epidemiology of lower extremity amputations in diabetic individuals. *Diabetes Care* 1983;6:87–91.
2. Kleinbaum DG, Kupper LL, Morgenstern H. *Epidemiologic research: principles and quantitative methods*. 1st ed. Belmont, California: Lifetime Learning Publications, 1982.
3. Palumbo PJ, Melton LJ. Peripheral vascular disease and diabetes. Chapter XV. In: Harris M, ed. *Diabetes in America*. Washington, DC: US Department of Health and Human Services, Public Health Service, National Institutes of Health, 1985; NIH publication no. 85-1468.
4. CDC. *Diabetes surveillance, 1980–1987*. Atlanta: US Department of Health and Human Services, Public Health Service, 1990.
5. Public Health Service. *Healthy people 2000: national health promotion and disease prevention objectives—full report, with commentary*. Washington, DC: US Department of Health and Human Services, Public Health Service, 1991; DHHS publication no. (PHS)91-50212.
6. Levin ME, O'Neal LW, eds. *The diabetic foot*. 4th ed. St. Louis: CV Mosby, 1988.
7. Bild DE, Selby JV, Sinnock P, Browner WS, Braverman P, Showstack JA. Lower extremity amputation in people with diabetes: epidemiology and prevention. *Diabetes Care* 1989;12: 24–31.
8. CDC. *The prevention and treatment of complications of diabetes mellitus: guide for primary care practitioners*. Atlanta: US Department of Health and Human Services, Public Health Service, 1991.

**Sensitivity of Death Certificate Data
for Monitoring Diabetes Mortality –
Diabetic Eye Disease Follow-Up Study, 1985–1990**

Although death certificates are a primary source of data for characterizing mortality patterns in the United States, the underreporting of diabetes as a cause of death limit the use of death certificates for monitoring diabetes mortality (1). To determine whether diabetes was underreported on the death certificates of patients

Diabetes Mortality – Continued

with known diabetic eye disease, CDC analyzed data from death certificates for persons identified as deceased by the Diabetic Eye Disease Follow-Up Study (DEFUS).*

DEFUS was designed to determine adherence to recommended eye-treatment protocols and to measure changes in visual acuity among participants who were first evaluated from 1985 through 1987 in diabetes-control programs (DCPs). A stratified probability sample (n = 569) was selected from persons with diabetes who had been 1) identified at high risk[†] for blindness and 2) screened for or diagnosed with eye disease by DCPs in Colorado, Florida, Maryland, and Minnesota.

For this analysis, during September 1989–December 1990, DCP staff attempted to interview and obtain medical record information for the 569 persons in the sample from the four states; vital records in the four states were searched for those patients who had died or were lost to follow-up. CDC's National Center for Health Statistics coded the death certificates by the underlying causes of death according to the *International Classification of Diseases, Ninth Revision*.

Of the 569 persons, 74 (13%) had died during 1985–1990 (Table 1). Of these, CDC was able to obtain death certificates for 59 (80%) patients (15 death certificates were unavailable at the time of the analysis). Overall, cardiovascular disease, particularly heart disease, was the most common underlying cause of death (28 [48%] deaths). Diabetes was mentioned as either the underlying or contributory cause on 28 (48%) of the 59 death certificates and listed as the underlying cause on 10 (36%) of these 28. The proportion of death certificates listing diabetes as a contributory cause of death was statistically greater ($p < 0.01$; 1-sided Fisher exact test) if cardiovascular disease was given as the underlying cause of death than if other causes were given (50%

*Seventy percent of the study's population (95% confidence interval = 64%–76%) was diagnosed with eye disease (i.e., nonproliferative diabetic retinopathy, preproliferative diabetic retinopathy, proliferative diabetic retinopathy, diabetic maculopathy, cataracts, or glaucoma) at or within 1 year of evaluation by a diabetes-control program.

[†]Considered at high risk were postpubertal persons who had not received an eye examination in the past 12 months and who had either type II diabetes or type I diabetes for 5 or more years.

TABLE 1. Reported deaths among persons known to have diabetes* and frequency with which diabetes was reported on death certificates – selected states, 1989–1990

State	Sample Size	Known deceased		Death certificates obtained		
		No.	% of state sample	No.	Frequency of any mention [†] of diabetes (%)	Median age at death (yrs)
Colorado	155	20	12.9	18	44.4	67
Florida	162	20 [§]	12.3	15 [§]	46.7	67
Maryland	228	32	14.0	24	45.8	66
Minnesota	24	2	8.3	2	100.0	35
Aggregate	569	74	13.0	59	47.5	67

*From a stratified probability sample derived from persons identified by the Diabetic Eye Disease Follow-Up Study who were interviewed or for whom a death certificate was available.

[†]As either an underlying or contributory cause.

[§]Includes one patient for whom interview data were obtained.

Diabetes Mortality – Continued

versus 19%, respectively). The frequency of any mention of diabetes was 53% for whites, 50% for Hispanics, and 33% for blacks.

Reported by: S Michael, Colorado Dept of Health. S Gard, Florida Dept of Health and Rehabilitative Svcs. E Schurman, Maryland Dept of Health and Mental Hygiene. D Kurth, Weiner Memorial Medical Center, Marshall, Minnesota. Div of Data Processing, Div of Epidemiology and Health Promotion, National Center for Health Statistics; Div of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: When compared with studies of diabetes-related mortality in the general population, diabetes appears to be recorded more often on the death certificates of persons from the DEDFUS sample (48% versus 40%) (2–4). Nonetheless, the findings in this report indicate that even though DEDFUS patients were known to have diabetes, diabetes was substantially underreported in the DEDFUS sample. This underreporting limits the use of death certificates for monitoring diabetes mortality, even for persons with a recognized complication of diabetes. Factors associated with underreporting of diabetes-related mortality include the specific underlying cause of death (2,5) and the duration of the disease (6).

To plan and implement public health programs for control of diabetes, national and state health officials need to be able to measure accurately the magnitude of the disease burden. Therefore, physicians and other medical personnel are urged to record diabetes on death certificates, when appropriate, to assist in public health surveillance for and efforts to better characterize this disease. Additional efforts will be necessary to determine factors affecting the recording of diabetes on death certificates.

References

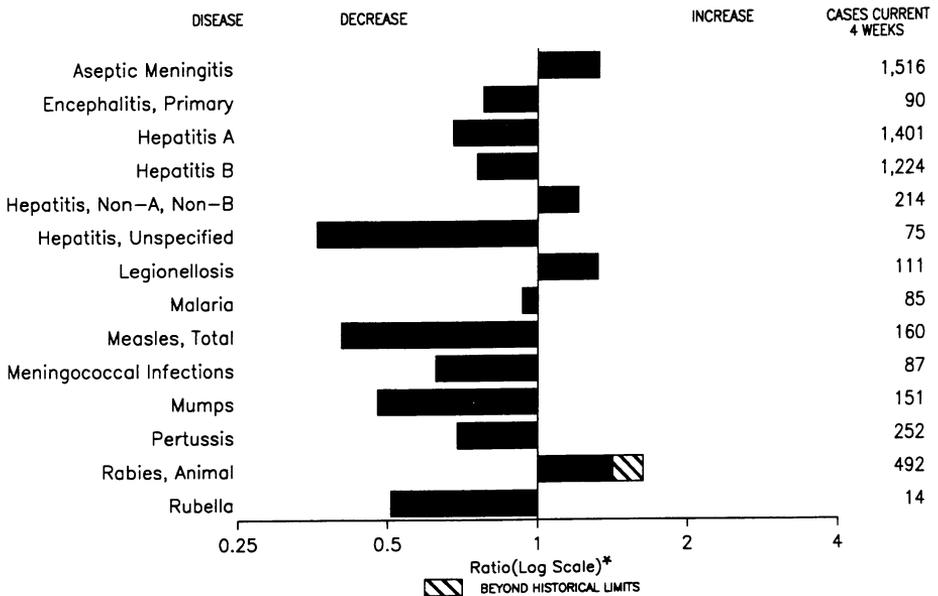
1. CDC. Diabetes surveillance, 1980–1987. Atlanta: US Department of Health and Human Services, Public Health Service, 1990.
2. Ochi JW, Melton LJ, Palumbo PJ, Chu CP. A population-based study of diabetes mortality. *Diabetes Care* 1985;8:224–9.
3. Palumbo PJ, Elveback LR, Chu C, Connolly DC, Kurland LT. Diabetes mellitus: incidence, prevalence, survivorship, and causes of death in Rochester, Minnesota, 1945–1970. *Diabetes* 1976;25:566–73.
4. Brousseau JD. Occurrence of diabetes among decedents in North Dakota. *Diabetes Care* 1987;10:542–3.
5. Fuller JH, Elford J, Goldblatt P, Adelstein AM. Diabetes mortality: new light on an underestimated public health problem. *Diabetologia* 1983;24:336–41.
6. O'Sullivan JB, Mahan CM. Mortality related to diabetes and blood glucose levels in a community study. *Am J Epidemiol* 1982;116:678–84.

*Health Objectives for the Nation***Body-Weight Perceptions and Selected Weight-Management Goals and Practices of High School Students – United States, 1990**

Among adults, overweight is associated with elevated serum cholesterol levels, elevated blood pressure, and noninsulin-dependent diabetes and is an independent risk factor for coronary heart disease (1). Youth who are overweight and remain overweight as adults may increase their risk for certain chronic diseases in adulthood (1). However, overemphasis on thinness during adolescence may contribute to potentially harmful weight-management practices and eating disorders such as

(Continued on page 747)

FIGURE I. Notifiable disease reports, comparison of 4-week totals ending October 26, 1991, with historical data — United States



*Ratio of current 4-week total to the mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary — cases of specified notifiable diseases, United States, cumulative, week ending October 26, 1991 (43rd Week)

	Cum. 1991		Cum. 1991
AIDS	35,807	Measles: imported	198
Anthrax	-	indigenous	8,623
Botulism: Foodborne	17	Plague	8
Infant	62	Poliomyelitis, Paralytic*	-
Other	6	Psittacosis	70
Brucellosis	69	Rabies, human	3
Cholera	21	Syphilis, primary & secondary	34,308
Congenital rubella syndrome	17	Syphilis, congenital, age < 1 year†	1,535
Diphtheria	2	Tetanus	41
Encephalitis, post-infectious	66	Toxic shock syndrome	241
Gonorrhea	488,748	Trichinosis	61
<i>Haemophilus influenzae</i> (invasive disease)	2,295	Tuberculosis	18,598
Hansen Disease	115	Tularemia	169
Leptospirosis	48	Typhoid fever	375
Lyme Disease	7,594	Typhus fever, tickborne (RMSF)	587

*Four suspected cases of poliomyelitis have been reported in 1991; none of the 8 suspected cases in 1990 have been confirmed to date. Five of the 13 suspected cases in 1989 were confirmed and all were vaccine associated.

†Includes updates for first two quarters of 1991.

TABLE II. Cases of selected notifiable diseases, United States, weeks ending October 26, 1991, and October 27, 1990 (43rd Week)

Reporting Area	AIDS	Aseptic Meningitis	Encephalitis		Gonorrhea		Hepatitis (Viral), by type				Legionellosis	Lyme Disease
			Primary	Post-infectious			A	B	NA,NB	Unspecified		
			Cum. 1991	Cum. 1991	Cum. 1991	Cum. 1991	Cum. 1991	Cum. 1991	Cum. 1991	Cum. 1991		
UNITED STATES	35,807	12,096	786	66	488,748	561,861	19,273	13,810	2,501	995	1,003	7,594
NEW ENGLAND	1,475	1,368	28	1	12,114	15,330	478	683	58	26	68	1,338
Maine	51	144	3	-	132	181	18	18	2	-	2	-
N.H.	36	161	5	-	167	228	30	29	7	-	8	35
Vt.	17	221	5	-	45	46	23	15	7	1	4	7
Mass.	799	455	12	1	5,158	6,410	226	473	29	22	49	246
R.I.	78	380	1	-	1,061	1,005	88	22	11	3	5	120
Conn.	494	7	2	-	5,551	7,460	93	126	2	-	-	930
MID. ATLANTIC	9,442	2,352	59	11	57,532	73,333	1,950	1,341	298	18	283	4,638
Upstate N.Y.	1,303	1,188	31	7	11,126	12,109	744	496	167	10	96	3,053
N.Y. City	5,242	331	1	-	21,008	29,995	691	213	8	-	48	-
N.J.	1,980	-	-	-	9,639	12,460	221	317	80	-	29	754
Pa.	917	833	27	4	15,759	18,769	294	315	43	8	110	831
E.N. CENTRAL	2,499	2,357	231	7	91,134	109,179	2,489	1,594	390	59	203	274
Ohio	476	896	81	2	28,489	33,223	325	347	153	19	98	143
Ind.	231	170	21	1	9,856	9,419	328	178	1	1	17	10
Ill.	1,203	400	74	4	27,887	33,799	1,051	238	62	7	18	21
Mich.	417	776	50	-	19,420	25,325	248	519	114	32	39	100
Wis.	172	115	5	-	5,482	7,413	537	312	60	-	31	-
W.N. CENTRAL	1,000	607	57	7	24,303	28,969	1,954	602	252	23	55	287
Minn.	200	120	35	-	2,592	3,520	353	67	11	2	12	78
Iowa	84	138	-	4	1,612	1,974	47	38	9	4	11	18
Mo.	576	238	12	3	14,941	17,395	531	403	222	12	14	171
N. Dak.	4	9	2	-	49	116	38	4	4	1	1	1
S. Dak.	3	11	4	-	303	254	722	7	1	-	3	1
Nebr.	45	25	2	-	1,474	1,564	185	35	1	-	9	-
Kans.	88	66	2	-	3,332	4,146	78	48	4	4	5	18
S. ATLANTIC	8,531	2,163	153	29	146,609	159,083	1,524	2,909	315	198	160	594
Del.	67	64	2	-	2,416	2,685	7	43	5	2	2	54
Md.	805	268	22	1	16,317	19,620	242	329	44	14	34	244
D.C.	572	66	2	-	7,636	10,924	66	128	1	1	7	2
Va.	599	380	38	3	15,316	15,360	155	185	25	128	13	128
W. Va.	49	39	27	-	1,042	1,118	20	56	2	14	2	38
N.C.	475	301	29	-	29,870	24,536	150	466	103	-	19	73
S.C.	277	40	-	-	12,092	12,663	37	588	16	3	33	10
Ga.	1,161	283	9	2	32,209	34,283	196	447	59	-	15	27
Fla.	4,526	722	24	23	29,711	37,894	651	667	60	36	35	18
E.S. CENTRAL	845	727	37	-	46,853	48,487	212	1,156	334	3	49	97
Ky.	132	177	12	-	5,018	5,432	51	150	7	2	17	40
Tenn.	283	208	17	-	16,664	15,232	116	854	301	-	17	43
Ala.	255	272	8	-	13,263	15,880	35	141	22	1	14	14
Miss.	175	70	-	-	11,908	11,943	10	11	4	-	1	-
W.S. CENTRAL	3,454	1,185	103	4	56,030	61,212	2,564	1,808	109	196	41	72
Ark.	164	58	32	-	6,613	7,278	234	107	3	6	7	27
La.	570	118	16	-	12,848	11,521	112	265	6	8	7	3
Okla.	161	4	8	3	5,854	5,335	242	171	44	16	17	31
Tex.	2,559	1,005	47	1	30,715	37,078	1,976	1,265	56	166	10	11
MOUNTAIN	1,040	230	17	2	9,901	11,769	3,001	833	163	130	70	17
Mont.	25	18	1	-	82	172	74	63	4	5	5	-
Idaho	20	-	-	-	130	120	78	65	3	1	3	2
Wyo.	15	-	-	-	83	146	102	11	3	-	-	8
Colo.	374	90	7	1	2,725	3,442	519	121	81	24	14	-
N. Mex.	95	20	-	-	848	1,032	735	197	15	29	3	-
Ariz.	216	54	9	1	3,726	4,457	954	147	18	56	27	-
Utah	84	16	-	-	266	324	251	64	14	14	7	1
Nev.	211	32	-	-	2,041	2,076	288	165	25	1	11	6
PACIFIC	7,521	1,107	101	5	44,272	54,499	5,101	2,884	582	342	74	277
Wash.	456	-	8	1	3,773	4,740	456	372	123	19	8	3
Oreg.	229	-	-	-	1,702	2,115	336	254	108	8	2	-
Calif.	6,683	1,018	91	4	37,437	46,115	4,179	2,186	334	314	62	274
Alaska	18	45	2	-	741	996	87	32	13	1	-	-
Hawaii	135	44	-	-	619	533	43	40	4	-	2	-
Guam	2	-	-	-	-	246	-	-	-	-	-	-
P.R.	1,487	212	2	3	457	637	115	412	153	44	-	-
V.I.	14	-	-	-	309	380	1	9	-	-	-	-
Amer. Samoa	-	-	-	-	-	73	-	-	-	-	-	-
C.N.M.I.	-	-	-	-	-	165	-	-	-	-	-	-

N: Not notifiable

U: Unavailable

C.N.M.I.: Commonwealth of the Northern Mariana Islands

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending October 26, 1991, and October 27, 1990 (43rd Week)

Reporting Area	Malaria		Measles (Rubeola)				Meningococcal Infections	Mumps		Pertussis			Rubella		
	Cum. 1991	Indigenous		Imported*		Total 1990		1991	Cum. 1991	1991	Cum. 1991	Cum. 1990	1991	Cum. 1991	Cum. 1990
		1991	Cum. 1991	1991	Cum. 1991										
UNITED STATES	989	82	8,623	5	198	23,961	1,676	41	3,277	37	2,179	3,552	5	1,283	1,029
NEW ENGLAND	64	-	62	-	17	292	133	-	25	6	250	357	-	4	8
Maine	1	-	7	-	-	30	11	-	1	52	16	-	-	1	1
N.H.	2	-	-	-	-	9	13	-	4	18	51	-	1	1	1
Vt.	4	-	5	-	-	1	14	-	4	4	7	-	-	-	-
Mass.	30	-	26	-	11	29	75	-	1	5	153	252	-	2	2
R.I.	7	-	3	-	1	30	1	-	4	-	-	6	-	-	1
Conn.	20	-	21	-	5	193	19	-	12	-	23	25	-	1	3
MID. ATLANTIC	178	26	4,481	-	7	1,523	182	5	254	5	177	476	-	561	11
Upstate N.Y.	44	-	334	-	4	318	93	1	92	4	118	309	-	539	10
N.Y. City	72	25	1,750	-	-	443	13	-	-	-	7	-	-	-	-
N.J.	48	-	858	-	2	377	37	-	58	-	1	35	-	-	-
Pa.	14	1	1,539	-	1	385	39	4	104	1	51	132	-	22	1
E.N. CENTRAL	78	3	75	5	20	3,538	276	7	331	5	357	915	-	317	162
Ohio	19	3	4	5 ¹	7	539	85	2	81	-	100	198	-	283	131
Ind.	3	-	1	-	5	418	28	-	8	5	69	124	-	2	-
Ill.	28	-	25	-	1	1,356	78	-	120	-	55	341	-	6	19
Mich.	25	-	43	-	-	473	62	5	99	-	37	74	-	25	9
Wis.	3	-	2	-	7	752	23	-	23	-	96	178	-	1	3
W.N. CENTRAL	34	-	39	-	16	860	96	3	108	3	174	190	-	18	40
Minn.	11	-	12	-	15	374	20	-	20	-	69	37	-	6	34
Iowa	6	-	17	-	-	26	13	-	20	-	20	18	-	6	4
Mo.	7	-	-	-	1	101	32	1	33	2	58	103	-	5	-
N. Dak.	1	-	-	-	-	-	1	-	2	-	3	3	-	1	1
S. Dak.	2	-	-	-	-	23	2	1	2	-	4	1	-	-	-
Nebr.	1	-	1	-	-	106	6	-	6	-	9	7	-	-	1
Kans.	6	-	9	-	-	230	22	1	25	1	11	21	-	-	-
S. ATLANTIC	205	4	481	-	23	1,295	302	13	1,161	1	216	286	1	9	20
Del.	2	-	21	-	-	11	2	-	6	-	-	8	-	-	-
Md.	55	-	173	-	3	212	31	7	226	-	54	61	-	1	2
D.C.	13	-	-	-	-	22	13	-	23	-	1	14	-	1	1
Va.	47	-	25	-	5	86	31	-	53	-	18	18	-	-	-
W. Va.	3	-	-	-	-	6	13	3	25	-	9	28	-	-	-
N.C.	13	-	40	-	4	30	51	1	239	-	34	72	-	2	-
S.C.	10	-	13	-	-	4	29	-	358	-	12	5	-	-	-
Ga.	18	-	10	-	5	358	60	-	40	-	42	32	-	-	-
Fla.	44	4	199	-	6	566	72	2	191	1	46	48	1	5	15
E.S. CENTRAL	20	20	30	-	3	199	107	4	170	1	90	143	-	100	4
Ky.	2	20	23	-	1	43	37	-	-	-	-	-	-	-	1
Tenn.	11	-	6	-	1	104	36	3	138	-	38	71	-	100	3
Ala.	7	-	1	-	1	25	32	1	12	1	50	64	-	-	-
Miss.	-	-	-	-	-	27	2	-	20	-	2	8	-	-	-
W.S. CENTRAL	64	-	186	-	14	4,274	121	4	300	1	138	183	-	7	66
Ark.	9	-	-	-	5	48	20	-	43	-	9	21	-	1	3
La.	17	-	-	-	-	10	32	-	29	-	16	30	-	-	-
Okla.	7	-	-	-	-	174	13	-	15	1	39	52	-	-	1
Tex.	31	-	186	-	9	4,042	56	4	213	-	74	80	-	6	62
MOUNTAIN	42	26	1,228	-	19	935	63	-	273	9	299	282	1	25	109
Mont.	1	-	-	-	-	1	10	-	-	-	4	35	-	-	14
Idaho	3	1	444	-	2	26	7	-	8	-	27	52	-	-	49
Wyo.	-	U	1	U	2	15	1	U	4	U	3	-	U	-	-
Colo.	11	-	1	-	5	138	12	-	127	3	122	93	-	2	4
N. Mex.	6	-	117	-	5	93	8	N	N	1	42	18	1	3	-
Ariz.	15	25	427	-	-	303	19	-	108	5	62	49	-	2	32
Utah	5	-	220	-	4	128	-	-	13	-	37	31	-	11	2
Nev.	1	-	18	-	1	231	6	-	13	-	2	4	-	7	8
PACIFIC	304	3	2,041	-	79	11,045	396	5	655	6	478	720	3	242	609
Wash.	21	-	46	-	15	254	53	-	166	1	127	195	-	8	-
Oreg.	11	-	52	-	38	212	50	N	N	-	64	90	-	4	74
Calif.	268	2	1,933	-	14	10,465	282	5	452	4	220	351	3	224	520
Alaska	-	-	2	-	3	80	9	-	12	-	13	7	-	1	-
Hawaii	4	1	8	-	9	34	2	-	25	1	54	77	-	5	15
Guam	-	U	-	U	-	1	-	U	-	U	-	1	U	-	-
P.R.	1	-	93	-	1	1,657	18	-	10	-	50	11	-	1	-
V.I.	2	U	-	U	2	24	-	U	9	U	-	-	U	-	-
Amer. Samoa	-	U	-	U	-	566	-	U	-	U	-	-	U	-	-
C.N.M.I.	-	U	-	U	-	8	-	U	-	U	-	4	U	-	-

*For measles only, imported cases includes both out-of-state and international importations.

N: Not notifiable U: Unavailable ¹International ⁵Out-of-state

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending October 26, 1991, and October 27, 1990 (43rd Week)

Reporting Area	Syphilis (Primary & Secondary)		Toxic- shock Syndrome	Tuberculosis		Tula- remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1991	Cum. 1990	Cum. 1991	Cum. 1991	Cum. 1990	Cum. 1991	Cum. 1991	Cum. 1991	Cum. 1991
UNITED STATES	34,308	40,714	241	18,598	19,196	169	375	587	5,409
NEW ENGLAND	858	1,401	13	534	470	5	32	9	98
Maine	1	7	4	33	18	-	1	-	-
N.H.	12	47	2	5	3	-	1	-	2
Vt.	2	1	-	8	8	-	-	-	-
Mass.	405	562	7	283	243	5	27	8	14
R.I.	45	19	-	69	61	-	-	-	-
Conn.	393	765	-	136	137	-	3	1	82
MID. ATLANTIC	5,834	7,791	37	4,280	4,590	2	89	23	1,870
Upstate N.Y.	118	742	18	275	323	1	17	12	731
N.Y. City	3,292	3,714	2	2,669	2,873	-	50	1	-
N.J.	1,064	1,247	-	749	789	1	16	6	845
Pa.	1,360	2,088	19	587	605	-	6	4	294
E.N. CENTRAL	4,169	2,925	47	1,865	1,873	7	30	41	159
Ohio	543	443	21	288	329	1	3	24	18
Ind.	148	79	-	188	177	-	-	10	26
Ill.	2,003	1,235	15	958	950	4	10	4	34
Mich.	1,025	832	11	346	350	2	12	3	33
Wis.	450	336	-	85	67	-	5	-	48
W.N. CENTRAL	670	440	37	427	500	48	6	36	730
Minn.	59	77	8	86	97	1	2	-	262
Iowa	62	66	7	55	50	-	-	1	145
Mo.	446	230	12	189	253	38	1	24	19
N. Dak.	-	1	-	6	17	-	-	-	82
S. Dak.	1	2	1	29	12	5	-	1	154
Nebr.	12	14	1	15	16	1	3	5	16
Kans.	90	50	8	47	55	3	-	5	52
S. ATLANTIC	10,054	13,058	23	3,530	3,557	4	65	271	1,269
Del.	144	156	1	28	33	-	-	-	147
Md.	814	994	1	320	274	-	10	27	476
D.C.	614	951	1	154	132	-	2	-	15
Va.	741	791	5	276	319	-	9	18	217
W. Va.	26	18	-	60	61	-	1	4	47
N.C.	1,653	1,478	10	462	481	1	4	149	19
S.C.	1,286	887	2	344	401	1	4	35	92
Ga.	2,447	3,300	-	692	588	1	5	35	228
Fla.	2,329	4,483	3	1,194	1,268	1	30	3	28
E.S. CENTRAL	3,728	3,775	9	1,244	1,376	19	2	93	138
Ky.	89	86	4	289	314	4	2	25	40
Tenn.	1,256	1,580	5	389	372	14	-	52	29
Ala.	1,331	1,140	-	310	417	1	-	16	69
Miss.	1,052	969	-	256	273	-	-	-	-
W.S. CENTRAL	6,216	7,057	14	2,257	2,287	51	25	103	519
Ark.	578	447	3	190	285	38	-	26	39
La.	2,290	2,262	-	197	251	-	5	-	5
Okla.	167	213	4	143	169	12	3	75	151
Tex.	3,181	4,135	7	1,727	1,582	1	17	2	324
MOUNTAIN	502	742	30	498	464	28	12	8	223
Mont.	6	-	1	6	22	9	-	6	38
Idaho	4	6	-	8	10	-	-	-	7
Wyo.	9	3	-	4	5	1	-	-	66
Colo.	66	44	5	57	42	9	2	2	77
N. Mex.	28	40	7	58	86	2	2	-	25
Ariz.	303	531	5	262	206	2	7	-	5
Utah	6	17	12	40	37	5	-	-	43
Nev.	80	101	-	63	56	-	1	-	18
PACIFIC	2,277	3,525	30	3,963	4,079	5	114	3	403
Wash.	139	330	4	250	226	2	6	2	1
Oreg.	74	118	-	106	104	2	5	1	5
Calif.	2,053	3,042	26	3,398	3,549	1	95	-	393
Alaska	4	17	-	49	52	-	-	-	3
Hawaii	7	18	-	160	148	-	8	-	1
Guam	-	2	-	-	36	-	-	-	-
P.R.	349	291	-	203	95	-	9	-	-
V.I.	85	12	-	2	4	-	-	-	54
Amer. Samoa	-	-	-	-	15	-	-	-	-
C.N.M.I.	-	3	-	-	48	-	-	-	-

U: Unavailable

TABLE III. Deaths in 121 U.S. cities,* week ending
October 26, 1991 (43rd Week)

Reporting Area	All Causes, By Age (Years)						P&I†	Total	Reporting Area	All Causes, By Age (Years)						P&I†	Total
	All Ages	≥65	45-64	25-44	1-24	<1				All Ages	≥65	45-64	25-44	1-24	<1		
NEW ENGLAND	570	400	110	38	10	12	36	S. ATLANTIC	1,358	818	293	167	43	37	80		
Boston, Mass.	140	88	28	17	5	2	11	Atlanta, Ga.	159	95	37	25	1	1	5		
Bridgeport, Conn.	36	23	11	-	1	1	1	Baltimore, Md.	187	122	41	22	2	-	18		
Cambridge, Mass.	27	21	4	2	-	-	6	Charlotte, N.C.	96	52	26	12	3	3	3		
Fall River, Mass.	19	14	4	1	-	-	-	Jacksonville, Fla.	112	64	18	22	4	4	15		
Hartford, Conn.	69	41	18	7	1	2	-	Miami, Fla.	88	49	23	11	4	1	-		
Lowell, Mass.	16	12	3	1	-	-	2	Norfolk, Va.	47	33	6	5	2	1	2		
Lynn, Mass.	19	17	2	-	-	-	3	Richmond, Va.	97	53	21	9	3	11	4		
New Bedford, Mass.	22	17	4	-	1	-	-	Savannah, Ga.	78	50	14	5	5	4	8		
New Haven, Conn.	35	30	3	2	-	-	2	St. Petersburg, Fla.	57	40	10	3	2	2	1		
Providence, R.I.	36	26	7	2	1	-	-	Tampa, Fla.	162	118	29	7	3	5	16		
Somerville, Mass.	4	3	1	-	-	-	-	Washington, D.C.	257	130	63	45	14	5	8		
Springfield, Mass.	58	45	9	2	1	1	2	Wilmington, Del.	18	12	5	1	-	-	-		
Waterbury, Conn.	24	19	4	1	-	-	1	E.S. CENTRAL	742	490	155	55	22	20	54		
Worcester, Mass.	65	44	12	3	-	6	8	Birmingham, Ala.	110	70	23	12	1	4	5		
MID. ATLANTIC	3,212	2,055	611	398	68	79	156	Chattanooga, Tenn.	65	53	9	2	-	1	5		
Albany, N.Y.	50	33	8	5	3	1	3	Knoxville, Tenn.	60	43	15	1	1	-	7		
Allentown, Pa.	26	23	3	-	-	-	-	Louisville, Ky.	85	54	16	7	8	-	5		
Buffalo, N.Y.	100	78	10	8	1	3	6	Memphis, Tenn.	130	76	31	13	5	13	13		
Camden, N.J.	39	17	12	5	2	3	-	Mobile, Ala.	108	79	22	6	1	-	9		
Elizabeth, N.J.	41	27	9	5	-	-	-	Montgomery, Ala.	49	34	8	2	-	5	3		
Erie, Pa.§	32	22	5	1	2	2	1	Nashville, Tenn.	135	81	31	12	6	5	7		
Jersey City, N.J.	118	74	24	13	2	5	4	W.S. CENTRAL	1,459	882	295	175	68	39	92		
New York City, N.Y.	1,855	1,165	351	266	39	34	75	Austin, Tex.	74	46	16	8	4	-	4		
Newark, N.J.	66	24	22	13	1	6	4	Baton Rouge, La.	52	30	11	6	3	2	-		
Paterson, N.J.	32	22	5	4	-	1	4	Corpus Christi, Tex.	37	18	11	5	-	3	1		
Philadelphia, Pa.	405	248	83	44	13	16	15	Dallas, Tex.	221	132	49	24	10	6	6		
Pittsburgh, Pa.§	83	56	17	6	1	3	8	El Paso, Tex.	65	41	9	7	2	6	4		
Reading, Pa.	32	22	7	2	1	-	9	Ft. Worth, Tex.	109	78	18	8	3	2	7		
Rochester, N.Y.	126	92	22	9	1	2	8	Houston, Tex.	372	197	85	58	21	11	41		
Schenectady, N.Y.	21	17	3	1	-	-	2	Little Rock, Ark.	51	36	8	4	1	2	5		
Scranton, Pa.§	33	25	7	1	-	-	6	New Orleans, La.	115	67	21	19	7	1	-		
Syracuse, N.Y.	69	48	11	6	2	2	3	San Antonio, Tex.	182	109	34	24	12	3	7		
Trout, N.J.	32	21	8	2	-	1	3	Shreveport, La.	79	58	13	6	2	-	11		
Utica, N.Y.	29	21	3	5	-	-	1	Tulsa, Okla.	102	70	20	6	3	3	6		
Yonkers, N.Y.	23	20	1	2	-	-	4	MOUNTAIN	827	535	163	71	27	29	36		
E.N. CENTRAL	2,084	1,302	410	208	107	57	112	Albuquerque, N.M.	93	55	21	6	8	3	3		
Akron, Ohio	78	44	16	8	5	5	-	Colorado Springs, Colo.	33	15	7	8	3	-	5		
Canton, Ohio	30	15	8	6	1	-	4	Denver, Colo.	123	73	29	13	2	6	9		
Chicago, Ill.	298	122	64	63	41	8	15	Las Vegas, Nev.	174	111	40	13	4	4	6		
Cincinnati, Ohio	131	82	29	8	5	7	12	Ogden, Utah	24	19	5	-	-	-	1		
Cleveland, Ohio	163	102	37	17	4	3	2	Phoenix, Ariz.	190	118	30	20	9	13	4		
Columbus, Ohio	167	112	30	17	6	2	5	Pueblo, Colo.	31	24	6	-	1	-	-		
Dayton, Ohio	101	74	16	7	4	-	8	Salt Lake City, Utah	42	26	8	7	-	1	2		
Detroit, Mich.	233	145	45	26	13	4	4	Tucson, Ariz.	117	94	17	4	-	2	6		
Evansville, Ind.	53	30	15	3	2	3	2	PACIFIC	1,376	900	256	139	31	46	98		
Fort Wayne, Ind.	59	43	10	4	-	2	3	Berkeley, Calif.	26	18	6	2	-	-	-		
Gary, Ind.	18	7	6	2	3	-	-	Fresno, Calif.	81	56	15	5	3	1	12		
Grand Rapids, Mich.	68	49	13	4	1	1	10	Glendale, Calif.	U	U	U	U	U	U	U		
Indianapolis, Ind.	219	150	34	21	7	7	16	Honolulu, Hawaii	92	61	23	5	-	3	10		
Madison, Wis.	51	30	9	6	3	3	3	Long Beach, Calif.	93	59	15	9	5	5	15		
Milwaukee, Wis.	116	80	28	4	2	2	6	Los Angeles, Calif.	U	U	U	U	U	U	U		
Peoria, Ill.	50	35	11	-	1	3	2	Oakland, Calif.	U	U	U	U	U	U	U		
Rockford, Ill.	44	27	10	3	1	3	5	Pasadena, Calif.	35	26	4	3	-	2	4		
South Bend, Ind.	49	42	5	1	1	-	6	Portland, Ore.	125	95	20	5	3	2	4		
Toledo, Ohio	103	69	20	4	7	3	7	Sacramento, Calif.	150	102	25	16	2	5	13		
Youngstown, Ohio	53	44	4	4	-	1	2	San Diego, Calif.	189	104	38	23	7	16	16		
W.N. CENTRAL	863	629	123	66	26	19	41	San Francisco, Calif.	159	90	30	34	2	1	2		
Des Moines, Iowa	72	63	2	1	5	1	5	San Jose, Calif.	176	114	38	15	3	6	11		
Duluth, Minn.	34	24	7	2	1	-	4	Seattle, Wash.	129	88	20	13	4	4	2		
Kansas City, Kans.	30	21	6	2	1	-	-	Spokane, Wash.	50	37	8	5	-	-	6		
Kansas City, Mo.	117	79	18	13	1	6	5	Tacoma, Wash.	71	50	14	4	2	1	3		
Lincoln, Nebr.	29	22	4	2	-	1	2	TOTAL	12,491†	8,011	2,416	1,317	402	338	705		
Minneapolis, Minn.	218	160	33	19	4	2	14										
Omaha, Nebr.	79	59	13	4	3	-	2										
St. Louis, Mo.	156	106	24	14	5	7	2										
St. Paul, Minn.	74	55	8	5	4	2	6										
Wichita, Kans.	54	40	8	4	2	-	1										

*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.

U: Unavailable

Weight Perceptions and Management – Continued

anorexia nervosa and bulimia nervosa (2,3). This report presents self-reported body-weight perceptions and selected weight-management goals and practices among high school students in the United States.

The national school-based Youth Risk Behavior Survey (YRBS) is a component of CDC's Youth Risk Behavior Surveillance System, which periodically measures the prevalence of priority health-risk behaviors among youth through comparable national, state, and local surveys (4). A three-stage sample design was used to obtain a representative sample of 11,631 students in grades 9–12 in the 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands. To obtain body-weight perceptions, students were asked, "Do you think of yourself as too thin (underweight), about the right weight, or too fat (overweight)?" Weight-management goals of students were determined from responses to the question, "Which of the following are you doing about your weight: not trying to do anything about weight, trying to lose weight, trying to keep from gaining more weight, or trying to gain more weight?" Students were asked four separate questions about their weight-management practices: "During the past 7 days, how many times did you [take a diet pill, vomit on purpose, or exercise] to try to lose weight or to keep from gaining weight?" and "During the past 7 days, how many meals did you skip to try to lose weight or to keep from gaining weight?"

Male students were significantly more likely to consider themselves either the right weight (68.8%) or underweight (16.5%) than were female students (58.5% and 7.2%, respectively) (Table 1). Among both male and female students, black students were significantly less likely to consider themselves overweight than were white and Hispanic students.

Overall, female students were significantly more likely to report currently trying to lose weight (43.6%) than were male students (15.3%) (Table 2). Moreover, 27.4% of female students who considered themselves the right weight reported currently trying to lose weight. Female students were significantly more likely than male students to report having exercised, skipped meals, taken diet pills, or induced vomiting for weight management during the 7 days preceding the survey or ever (Table 2).

Reported by: Div of Adolescent and School Health and Div of Nutrition, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: Overweight, inappropriate weight-management practices, and eating disorders among adolescents are important public health concerns in the United

TABLE 1. Body-weight perceptions of high school students, by race/ethnicity and gender – United States, Youth Risk Behavior Survey, 1990*

Race/ Ethnicity	Female			Male		
	Underweight % (95% CI) [†]	Right weight % (95% CI)	Overweight % (95% CI)	Underweight % (95% CI)	Right weight % (95% CI)	Overweight % (95% CI)
White	5.4 (±0.9)	58.0 (±2.6)	36.7 (±2.1)	15.6 (±1.4)	68.6 (±2.3)	15.8 (±1.8)
Black	12.7 (±3.0)	62.0 (±5.0)	25.3 (±4.3)	19.8 (±3.9)	72.5 (±4.4)	7.8 (±2.0)
Hispanic	10.5 (±3.8)	53.0 (±5.7)	36.5 (±4.7)	18.5 (±2.8)	66.6 (±2.5)	14.8 (±2.8)
Total	7.2 (±0.7)	58.5 (±2.0)	34.3 (±1.7)	16.5 (±1.1)	68.8 (±1.8)	14.7 (±1.4)

*Unweighted sample size = 11,631 students.

[†]Confidence interval.

Weight Perceptions and Management – Continued

States (1,2,5). Consequently, national health objectives for the year 2000 are to “reduce overweight to a prevalence of no more than 15 percent among adolescents aged 12 through 19” (objective 2.3) (6), and to “increase to at least 50 percent the proportion of overweight people aged 12 and older who have adopted sound dietary practices combined with regular physical activity to attain an appropriate body weight” (objective 2.7) (6). Because height and weight are not measured, the YRBS cannot directly monitor these two objectives. However, data about self-reported body-weight perceptions and weight-management goals and practices provide important information to plan programs to help students maintain a healthy body weight through appropriate weight-management skills.

Race- and ethnicity-specific differences in perceptions of overweight described in this report are consistent with previous findings (7) that showed white and Hispanic females perceive themselves to be overweight more often than black females. Previous studies (5) also have indicated that normal-weight adolescent females often consider themselves to be overweight and use inappropriate weight-reducing methods. In addition, harmful weight-loss practices and negative attitudes about body size have been reported among girls as young as 9 years of age (8).

Serious long-term adverse health consequences may result from unhealthy weight-loss behaviors among youth. For example, nutritional self-deprivation by and recurrent weight fluctuations in children and adolescents may increase the likelihood of weight gain and obesity in adulthood (8). In addition, unhealthy weight-loss behaviors may be associated with nutritional deficiencies, decreases in growth velocity, and delays of pubertal and psychosocial development (8).

National health objectives for the year 2000 that address these issues include plans for sound school breakfast and lunch menus, nutrition education, and appropriate physical activity. To encourage nutritionally sound eating habits, school breakfast and lunch programs should offer menus that are consistent with the nutrition principles in the *Dietary Guidelines for Americans* (objective 2.17) (6). Nutrition education should be provided from preschool through 12th grade, preferably as part of quality school health education (objective 2.19) (6). In addition, daily school physical education (objective 1.8) (6) should help young persons develop a healthy body weight through physical activity.

The high prevalence of body weight dissatisfaction and the potentially harmful weight-loss practices among female students described in this report underscore the potential influences of social norms that equate thinness with attractiveness and social approval. To ensure appropriate weight-management practices among adolescents, educational programs about assessment and maintenance of healthy body weight should involve families; teachers; school administrators, nurses, and counselors; public health officials; pediatricians; and family physicians. This goal also can be addressed through family-based adolescent obesity programs (9) that support body weight acceptance and the adoption of healthy dietary and physical activity patterns.

References

1. Public Health Service. The Surgeon General's report on nutrition and health. Washington, DC: US Department of Health and Human Services, Public Health Service, 1988; DHHS publication no. (PHS)88-50210.
2. Shisslak CM, Crago M, Neal ME. Prevention of eating disorders among adolescents. *American Journal of Health Promotion* 1990;5:100-6.

TABLE 2. Selected weight-management goals and practices among high school students, by gender and by body-weight perception – United States, Youth Risk Behavior Survey, 1990*

Category	Female								Male							
	Underweight		Right weight		Overweight		Total		Underweight		Right Weight		Overweight		Total	
	%	(95% CI [†])	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Goals																
Not trying to do anything about weight	27.6	(±8.4)	34.0	(±2.6)	4.4	(±1.0)	23.4	(±2.0)	20.5	(±4.5)	55.9	(±2.9)	12.2	(±2.6)	43.6	(±2.5)
Trying to lose weight	3.6	(±2.9)	27.4	(±2.9)	79.6	(±2.0)	43.6	(±2.5)	1.2	(±0.9)	7.6	(±1.0)	66.9	(±3.2)	15.3	(±1.4)
Trying to keep from gaining more weight	3.2	(±2.3)	35.4	(±2.3)	15.8	(±1.7)	26.3	(±1.6)	2.8	(±2.0)	17.4	(±1.7)	19.0	(±2.9)	15.1	(±1.6)
Trying to gain more weight	65.6	(±8.4)	3.2	(±1.1)	0.2	(±0.2)	6.6	(±1.3)	75.5	(±5.4)	19.2	(±2.5)	2.0	(±1.5)	26.0	(±2.5)
Practices[‡]																
<i>Exercise</i>																
Past 7 days	10.2	(±3.7)	46.5	(±3.3)	67.5	(±3.7)	51.0	(±2.9)	5.9	(±2.2)	26.7	(±2.4)	70.1	(±4.9)	29.6	(±1.8)
Ever [†]	26.5	(±7.9)	77.1	(±2.5)	94.8	(±2.2)	79.5	(±2.2)	12.9	(±2.4)	41.6	(±2.4)	90.9	(±2.7)	44.1	(±1.8)
<i>Diet pills</i>																
Past 7 days	1.6	(±1.8)	2.0	(±0.8)	6.4	(±1.8)	3.5	(±0.8)	1.2	(±0.8)	1.0	(±0.4)	5.0	(±2.4)	1.6	(±0.6)
Ever [†]	3.8	(±2.4)	14.7	(±2.2)	34.3	(±4.1)	20.6	(±2.4)	3.1	(±1.4)	3.8	(±1.2)	14.4	(±3.5)	5.3	(±1.2)
<i>Vomiting</i>																
Past 7 days	2.0	(±2.0)	1.4	(±0.6)	5.5	(±1.2)	2.8	(±0.6)	2.0	(±1.8)	0.8	(±0.4)	3.4	(±1.8)	1.4	(±0.4)
Ever [†]	4.9	(±2.5)	9.4	(±1.6)	23.3	(±2.4)	13.8	(±1.2)	4.3	(±2.2)	2.5	(±1.0)	7.9	(±2.7)	3.6	(±1.0)
<i>Skipping meals past 7 days**</i>																
	13.3	(±4.9)	39.6	(±2.4)	72.5	(±2.9)	49.0	(±2.0)	7.0	(±2.5)	13.3	(±1.8)	54.3	(±5.7)	18.4	(±2.0)

*Unweighted sample size = 11,631 students.

[†]Confidence interval.[‡]Categories not mutually exclusive.[†]Includes number of times in past 7 days plus response category "have done this but not in the past 7 days."

**Question did not include "ever" response category.

Weight Perceptions and Management – Continued

3. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th ed. Washington, DC: American Psychiatric Association, 1987.
4. Kolbe LJ. An epidemiological surveillance system to monitor the prevalence of youth behaviors that most affect health. *Health Education* 1990;21:44–8.
5. Feldman W, Feldman E, Goodman JT. Culture versus biology: children's attitudes toward thinness and fatness. *Pediatrics* 1988;81:190–4.
6. Public Health Service. Healthy people 2000: national health promotion and disease prevention objectives—full report, with commentary. Washington, DC: US Department of Health and Human Services, Public Health Service, 1991; DHHS publication no. (PHS)91-50212.
7. Dawson DA. Ethnic differences in female overweight: data from the 1985 National Health Interview Survey. *Am J Public Health* 1988;78:1326–9.
8. Mellin LM. Responding to disordered eating in children and adolescents. *Nutrition News* 1988;51:5–7.
9. Epstein LH, Valoski A, Wing RR, McCurley J. Ten-year follow-up of behavioral family-based treatment of obese children. *JAMA* 1990;265:2519–23.

*Notices to Readers***ATSDR Training Sessions:
Association Between Illness and Environmental Exposures**

Health-care professionals increasingly must diagnose and treat illnesses caused by exposure to hazardous substances. On November 9 and 10, the Agency for Toxic Substances and Disease Registry will sponsor a training program to inform health professionals about using health assessments to determine the adverse health implications of hazardous exposures. The course is designed for physicians, nurses, and other public health professionals such as epidemiologists, toxicologists, and sanitarians.

The training program will include a 1-day general session to discuss the basic components of the health-assessment process and a 1-day advanced session to address specific case studies of environmental exposure. Participants will receive a syllabus containing instructional material.

The program will be held at the American Public Health Association (APHA) meeting in Atlanta. Applicants may register through the Continuing Education Program, APHA, 1015 15th Street, NW, Washington, DC 20005; telephone (202) 789-5622; fax (202) 789-5661.

**International Conference on Child Day Care Health:
Science, Prevention, and Practice**

On June 15–17, 1992, CDC will sponsor a conference entitled “International Conference on Child Day Care Health: Science, Prevention, and Practice” in Atlanta. The objective of the conference is to provide structured and informal opportunities to exchange information, skills, knowledge, and experiences related to child day care health. Presentations and discussion will focus on three major themes: child day care health, meeting the needs of children and care-givers, and translating science into practice. Topics for the scientific sessions will include infectious diseases; injuries

Notices to Readers – Continued

and hazards; health promotion; children with special needs and disabilities; environmental health; developmental and psychologic aspects; occupational health; impact of regulations, standards, accreditation, and training; and economics. The deadline for abstracts is January 15, 1992. Additional information is available from Lillian Glickman at Pace Enterprises, Inc., telephone (404) 633-8610 or fax (404) 633-8745.

Publication of Report on Exposure to Alcoholism in the Family

CDC's National Center for Health Statistics (NCHS) has released a report presenting data on exposure to alcoholism in the family. The study, a collaborative project between NCHS's National Health Interview Survey and the National Institute on Alcohol Abuse and Alcoholism, provides new data on this public health problem.

The report, *Exposure to Alcoholism in the Family: United States, 1988 (1)*, is available free of charge from the Scientific and Technical Information Branch, NCHS, CDC, Room 1064, 6525 Belcrest Road, Hyattsville, MD 20782; telephone (301) 436-8500.

Reference

1. NCHS. Exposure to alcoholism in the family: United States, 1988. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, CDC, 1991. (Advance data no. 205).

Publication of Annual Vital Statistics Summary Report

CDC's National Center for Health Statistics (NCHS) has released provisional data on the number and rate of births, marriages, divorces, and deaths for 1990. Monthly estimates and rates are included for each vital event.

The report presents statistics on the expectation of life, major causes of death, deaths by human immunodeficiency virus infection, and infant mortality. Data by state of occurrence are shown for birth, marriage, divorce, death, and infant death.

The report, *Annual Summary of Births, Marriages, Divorces, and Deaths: United States, 1990 (1)*, is available free of charge from the Scientific and Technical Information Branch, NCHS, CDC, Room 1064, 6525 Belcrest Road, Hyattsville, MD 20782; telephone (301) 436-8500.

Reference

1. NCHS. Annual summary of births, marriages, divorces, and deaths: United States, 1990. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, CDC, 1991. (Monthly vital statistics report; vol 39, no. 13).

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

The data in the weekly *MMWR* 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. Inquiries about the *MMWR* Series, including material to be considered for publication, should be directed to: Editor, *MMWR* Series, Mailstop C-08, Centers for Disease Control, Atlanta, GA 30333; telephone (404) 332-4555.

Director, Centers for Disease Control
William L. Roper, M.D., M.P.H.
Director, Epidemiology Program Office
Stephen B. Thacker, M.D., M.Sc.

Editor, *MMWR* Series
Richard A. Goodman, M.D., M.P.H.
Managing Editor, *MMWR* (Weekly)
Karen L. Foster, M.A.

☆U.S. Government Printing Office: 1992-631-123/42040 Region IV

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control
Atlanta, Georgia 30333

Official Business
Penalty for Private Use \$300

FIRST-CLASS MAIL
POSTAGE & FEES PAID
PHS/CDC
Permit No. G-284

S *HC A54CDCL23 9137
CDC INFORMATION CENTER
IRMO
1-4105 C04

X

HHS Publication No. (CDC) 92-8017

Redistribution using permit imprint is illegal.