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Current Trends

Years of Potential Life Lost Before Ages 65 and 85 – United States, 1989–1990

Years of potential life lost (YPLL) is a public health measure that reflects the impact of deaths occurring in years preceding a conventional cut-off year of age, usually 65 years. YPLL is calculated using final mortality data from CDC's National Center for Health Statistics (NCHS) (*1*) for the most recent year available and provisional mortality data (i.e., a 10% sample of deaths) (*2*) for the following year. This report summarizes final YPLL data for 1989 and provisional YPLL data for 1990.

In the United States during 1989, 12,339,045 years of potential life were lost before age 65 (YPLL-65) (Table 1), a total consistent with 1989 provisional data (12,370,499) (*4*). Provisional data for 1990 indicate that there were 12,083,228 YPLL-65, a 2.1% decline from 1989 (*1,2*; NCHS unpublished data, 1992).

As in the preceding 10 years, unintentional injuries were the leading cause of YPLL-65 in 1990, accounting for 17.8% of all YPLL-65, followed by malignant neoplasms (15.2%), intentional injuries (homicide and suicide) (12.6%), diseases of the heart (11.2%), congenital anomalies (5.3%), and human immunodeficiency virus (HIV) infection (5.3%). The remaining listed causes of death accounted for less than 15% of total YPLL-65.

From 1989 to 1990, YPLL-65 decreased for nine causes of death and increased for four (Table 1). The largest percentage increases in YPLL-65 were for HIV infection (9.9%) and intentional injuries (8.4%); the largest percentage decreases were for prematurity (14.8%), pneumonia and influenza (10.2%), chronic liver disease and cirrhosis (8.9%), and unintentional injuries (3.9%).

For 1990, the causes of death ranked differently when YPLL was calculated to age 85 years (YPLL-85). Neoplasms ranked highest (23.5% of all YPLL-85), followed by diseases of the heart (21.6%), unintentional injuries (10.6%), intentional injuries (7.5%), cerebrovascular diseases (3.7%), and HIV infection (3.6%). The remaining listed diseases combined contributed less than 14% of YPLL-85.

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Years of Potential Life Lost — Continued

Editorial Note: Crude death rates (Table 1) weight all deaths equally (i.e., the rates provide an estimate of the proportion of a population that dies during a specific period). In comparison, YPLL emphasizes deaths at early ages in two ways: 1) by not including deaths occurring at ages beyond the cut-off, and 2) by giving greater computational weight to deaths among younger persons. YPLL is calculated by multiplying the number of deaths that have occurred in an age category by the difference between the cut-off age and the mid-year of the age category; the weighted products in each age category are then added. In 1989, deaths occurring among persons aged <65 years accounted for 28.5% of U.S. deaths; deaths occurring among persons aged <85 years accounted for 78.7% of U.S. deaths. Differences between the rankings of causes of death by YPLL-65 and YPLL-85 reflect relative differences in rates of death at different ages.

The concept of YPLL, first used by CDC in 1982, was employed to indicate premature mortality and preventability (*5*). YPLL-65 emphasizes causes of death among younger persons, some of which may be prevented by known interventions (e.g., smoking cessation, early prenatal care, responsible sexual behavior, and use of safety belts). Although the concept of YPLL has been instrumental in directing

TABLE 1. Years of potential life lost (YPLL) before age 65* and death rates†, by cause of death — United States, 1989 (final) and 1990 (provisional)

Cause of death (ICD-9§ codes)	YPLL for persons dying in 1989	YPLL for persons dying in 1990	Cause-specific crude death rate, 1990¶
All causes (total)	**12,339,045**	**12,083,228**	**861.9**
Unintentional injuries (E800–E949)	2,235,335	2,147,094	37.3
Malignant neoplasms (140–208)	1,832,039	1,839,900	201.7
Suicide/Homicide (E950–E978)	1,402,524	1,520,780	22.5
Diseases of the heart (390–398, 402, 404–429)	1,411,399	1,349,027	289.0
Congenital anomalies (740–759)	660,346	644,651	5.3
Human immunodeficiency virus (HIV) infection (042–044)	585,992	644,245**	9.6
Prematurity (765, 769)††	487,749	415,638	2.5
Sudden infant death syndrome (798)	363,393	347,713	2.2
Cerebrovascular disease (430–438)	237,898	244,366	57.9
Chronic liver disease and cirrhosis (571)	233,472	212,707	10.2
Pneumonia/Influenza (480–487)	184,382	165,534	31.3
Diabetes mellitus (250)	145,501	143,250	19.5
Chronic obstructive pulmonary disease (490–496)	135,507	127,464	35.5

*For details of calculation, see reference *3*.
†Per 100,000 population.
§*International Classification of Diseases, Ninth Revision.*
¶Cause-specific death rates reported by CDC's National Center for Health Statistics are compiled from a 10% sample of all deaths.
**Aggregated age categories disaggregated by application of 1989 age-specific HIV mortality data.
††Category derived from disorders relating to short gestation and respiratory distress syndrome.

Years of Potential Life Lost — Continued

attention toward certain preventable conditions (e.g., unintentional injury), the precise nature of the relations among YPLL-65, premature mortality, and preventability has not been established.

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Update: Influenza Activity — United States and Worldwide, and Composition of the 1992–93 Influenza Vaccine

During the 11 influenza seasons from 1977 through 1988, more than 10,000 excess deaths attributed to pneumonia and influenza (P&I) were reported during each of seven seasons, and approximately 45,000 deaths were reported during each of two seasons (CDC, unpublished data, 1992). The most important strategy for preventing influenza-associated morbidity and mortality is vaccination of persons in high-risk groups with vaccine closely matched to circulating strains. In collaboration with state and local health departments, CDC conducts surveillance to monitor influenza activity and to detect antigenic changes in the circulating strains of influenza virus. This report summarizes surveillance for influenza in the United States and worldwide during the 1991–92 season and describes the composition of the 1992–93 influenza vaccine.

United States

During the 1991–92 influenza season, substantial influenza activity began in October and peaked from December 1 through January 18 when 11–20 states reported widespread activity* each week. From January 19 through March 21, activity steadily declined; for the week ending March 21, no states reported widespread activity, and three states reported regional activity.

Before mid-December, outbreaks were reported primarily in schools; subsequently, outbreaks were reported in schools, nursing homes, and other institutional settings. Based on data from death certificates provided by CDC's 121 U.S. Cities Mortality Surveillance System, excess mortality was associated with P&I. The proportion of deaths attributable to P&I exceeded the epidemic threshold for 7 consecutive weeks (from the weeks ending December 28 through February 8) and peaked at 7.9% of all deaths during the week ending January 18.

*Levels of activity are: 1) *sporadic*—sporadically occurring influenza-like illness (ILI) or culture-confirmed influenza, with no outbreaks detected; 2) *regional*—outbreaks of ILI or culture-confirmed influenza in counties having a combined population of less than 50% of the state's population; 3) *widespread*—outbreaks of ILI or culture-confirmed influenza in counties having a combined population of 50% or more of the state's total population.

Influenza Activity — Continued

Of the 5861 influenza virus isolates reported to CDC, more than 99% were influenza A. Of the influenza A virus isolates subtyped, 81% were influenza A(H3N2), and 19% were influenza A(H1N1). As of April 10, 179 (99%) of the 180 influenza A(H3N2) viruses characterized at CDC resembled A/Beijing/353/89, the A(H3N2) component included in the 1991–92 influenza vaccine. Influenza A(H1N1) viruses were isolated most frequently in the mid-Atlantic and South Atlantic regions and accounted for 30% and 52% of influenza A isolates, respectively. Influenza A(H1N1) viruses were characterized by moderate antigenic heterogeneity.

Worldwide

Influenza activity worldwide occurred at moderate levels during the 1991–92 influenza season. Although most activity was associated with influenza A(H3N2), influenza A(H1N1) viruses were isolated in 17 countries; influenza B viruses were isolated rarely. Most countries reported that influenza activity began in December and peaked in late January or early February.

In Europe, influenza A(H3N2) virus was the predominant isolate in the Commonwealth of Independent States, Czechoslovakia, Denmark, Finland, France, Greece, Hungary, Italy, the Netherlands, Norway, Portugal, Romania, Spain, Sweden, Switzerland, and the United Kingdom; in some of these countries, it was associated with localized outbreaks. In Asia, outbreaks of influenza A(H3N2) were reported in Japan, Korea, and the People's Republic of China.

Although influenza A(H1N1) viruses were isolated less frequently worldwide, Belgium and Japan reported that A(H1N1) viruses constituted the majority of isolates and were isolated from outbreaks. France, Germany, the Netherlands, and the United Kingdom reported that approximately 20% of the influenza A viruses isolated were A(H1N1). In these countries, the proportion of influenza A(H1N1) viruses isolated increased during the latter part of the season as influenza A(H3N2) activity declined. Bulgaria, Canada, the Commonwealth of Independent States, Croatia, Finland, Norway, Spain, Switzerland, and Yugoslavia reported only sporadic cases of influenza A(H1N1).

Outbreaks caused by influenza B viruses were reported in Greece, Korea, the People's Republic of China, Taiwan, Tunisia, and Yugoslavia. Sporadic cases were reported from Canada, the Commonwealth of Independent States, Finland, France, Norway, Poland, Sweden, the United Kingdom, and the United States.

Composition of the 1992-93 Influenza Vaccine

For the 1992–93 influenza season, the Food and Drug Administration (FDA) Vaccines and Related Biologicals Advisory Committee (VRBAC) has recommended that the trivalent influenza vaccine contain A/Texas/36/91-like(H1N1), A/Beijing/353/89-like(H3N2), and B/Panama/45/90-like viruses. This recommendation was based on the antigenic analyses of recent isolates and studies of the antibody response of persons previously vaccinated with the 1991–92 influenza vaccine.

Antigenic analyses of influenza A(H1N1) isolates from North America and Europe indicate that antigenic heterogeneity exists among recent isolates (*1,2*). Approximately 40% of isolates, represented by the A/Texas/36/91 strain, exhibit drift from the A/Taiwan/1/86 vaccine strain. Antibody induced by the A/Taiwan/1/86 vaccine component reacted at lower titers with the A/Texas/36/91 virus and other representative 1991–92 A(H1N1) viruses than with A/Taiwan/1/86 in several vaccine studies (Table 1). Therefore, the VRBAC recommended changing the influenza A(H1N1) vaccine component to an A/Texas/36/91-like strain for the 1992–93 vaccine.

Influenza Activity — Continued

Although some antigenic heterogeneity exists among influenza A(H3N2) isolates, most viruses isolated throughout the world were antigenically related to the A/Beijing/353/89 vaccine strain (*2*). Antibody induced by this vaccine component reacted similarly with recent isolates, such as the A/Washington/15/91 virus, in serum from all age groups, and postvaccination geometric mean titers (GMTs) of antibody to the recent isolates were approximately 50%–100% of those to the vaccine virus. Thus, the World Health Organization and the VRBAC recommended retaining the A/Beijing/353/89 vaccine strain.

Two distinct strains of influenza B virus, related to either the B/Victoria/2/87 or the B/Yamagata/16/88 and B/Panama/45/90 reference strains, have cocirculated in the world since 1988. Since October 1991, only two strains related to the B/Victoria/2/87 reference strain have been identified worldwide. Although relatively few influenza B viruses related to the B/Yamagata/16/88 and B/Panama/45/90 reference strains have been isolated, antigenic heterogeneity has been observed among them. Postvaccination serum specimens obtained from vaccinees of all age groups reacted well with the vaccine virus B/Panama/45/90, and except for serum from the youngest children, also reacted well with B/Victoria/2/87. In all age groups, the postvaccination GMTs to recent influenza B isolates were approximately 50%–100% of those for the vaccine virus. Therefore, for the 1992–93 vaccine, the VRBAC recommended retaining the B/Panama/45/90 vaccine strain.

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TABLE 1. Hemagglutination-inhibition antibody responses to the A/Taiwan/1/86 (H1N1) component of the 1991–92 trivalent influenza vaccine*

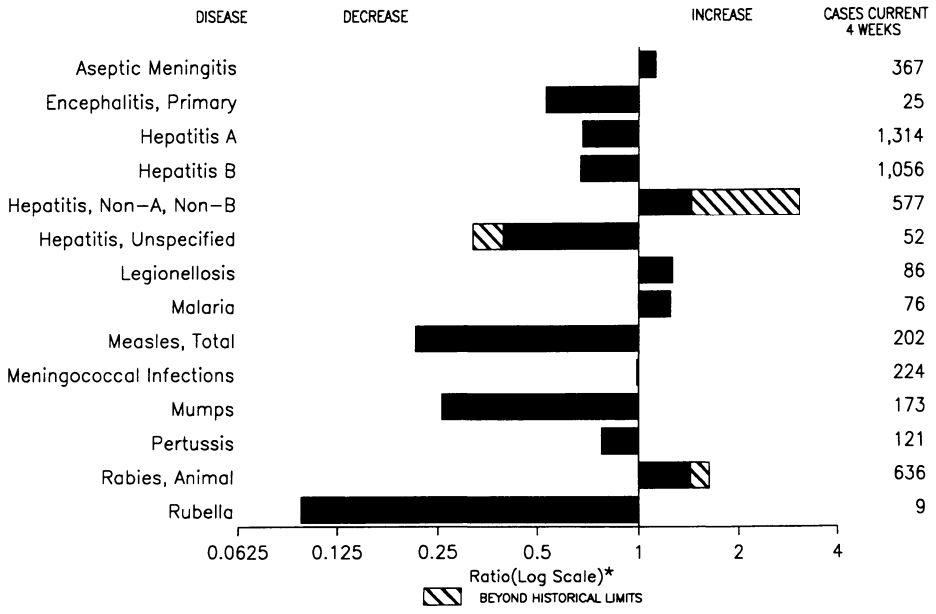
Age group (yrs)	No. persons	Virus strain	Prevaccination GMT†	Postvaccination GMT
0–4 unprimed	18	A/Taiwan/1/86	7	78
		A/Victoria/36/88	6	47
		A/Texas/36/91	6	28
0–4 primed	19	A/Taiwan/1/86	14	93
		A/Victoria 36/88	12	52
		A/Texas/36/91	8	21
College-aged adults	25	A/Taiwan/1/86	103	151
		A/Victoria/36/88	70	97
		A/Texas/36/91	25	36
Elderly (mean age 83.5)	64	A/Taiwan/1/86	21	46
		A/Victoria/36/88	14	27
		A/Texas/36/91	11	17

*Volunteers received trivalent influenza vaccine containing 15 μg each of A/Taiwan/1/86, A/Beijing/353/89, and B/Panama/45/90.

†Geometric mean titer.

Sources of serum: University of Colorado; National Institute of Biological Standards and Control; Goodwin House, Inc., Alexandria, Virginia.

FIGURE I. Notifiable disease reports, comparison of 4-week totals ending May 2, 1992, 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 May 2, 1992 (18th Week)

	Cum. 1992		Cum. 1992
AIDS*	16,200	Measles: imported	59
Anthrax	-	indigenous	688
Botulism: Foodborne	7	Plague	-
Infant	19	Poliomyelitis, Paralytic†	-
Other	-	Psittacosis	22
Brucellosis	7	Rabies, human	-
Cholera	26	Syphilis, primary & secondary	11,931
Congenital rubella syndrome	4	Syphilis, congenital, age < 1 year	-
Diphtheria	2	Tetanus	5
Encephalitis, post-infectious	38	Toxic shock syndrome	87
Gonorrhea	164,894	Trichinosis	12
Haemophilus influenzae (invasive disease)	604	Tuberculosis	6,440
Hansen Disease	43	Tularemia	20
Leptospirosis	10	Typhoid fever	110
Lyme Disease	1,282	Typhus fever, tickborne (RMSF)	51

*Updated monthly; last update May 2, 1992
†Nine suspected cases of poliomyelitis have been reported in 1991; 4 of the 8 suspected cases in 1990 were confirmed, and all were vaccine associated.

TABLE II. Cases of selected notifiable diseases, United States, weeks ending May 2, 1992, and May 4, 1991 (18th Week)

Reporting Area	AIDS*	Aseptic Meningitis	Encephalitis		Gonorrhea		Hepatitis (Viral), by type				Legionellosis	Lyme Disease
			Primary	Post-infectious			A	B	NA,NB	Unspecified		
	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1991	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992
UNITED STATES	16,200	1,584	173	38	164,894	196,945	6,252	5,016	1,641	219	446	1,282
NEW ENGLAND	562	103	13	-	3,553	5,150	234	213	25	13	36	90
Maine	18	10	-	-	35	42	28	12	3	-	2	-
N.H.	19	4	2	-	-	123	16	18	9	-	3	5
Vt.	8	4	1	-	9	16	2	5	2	-	2	1
Mass.	313	36	7	-	1,333	2,184	108	149	8	13	19	30
R.I.	32	49	3	-	288	400	55	16	3	-	10	33
Conn.	172	-	-	-	1,888	2,385	25	13	-	-	-	21
MID. ATLANTIC	3,733	191	10	5	16,169	24,927	507	690	145	12	140	970
Upstate N.Y.	558	84	-	-	2,454	4,316	134	171	85	6	58	649
N.Y. City	1,942	24	2	1	5,714	10,041	164	82	3	-	2	-
N.J.	742	4	-	-	2,422	3,678	68	172	42	-	22	79
Pa.	491	79	8	4	5,579	6,892	141	265	15	6	58	242
E.N. CENTRAL	1,515	237	51	5	26,562	38,103	742	647	87	11	89	27
Ohio	287	71	22	-	9,541	11,765	169	100	43	-	45	19
Ind.	154	20	4	-	2,872	3,770	234	160	2	3	4	4
Ill.	619	49	10	2	9,185	11,220	143	54	12	2	4	2
Mich.	364	93	14	3	3,947	8,904	54	217	7	6	26	2
Wis.	91	4	1	-	1,017	2,444	142	116	23	-	10	-
W.N. CENTRAL	498	98	4	4	8,650	9,174	707	277	138	7	22	37
Minn.	88	7	1	-	1,003	948	219	18	6	2	1	1
Iowa	28	20	-	2	620	646	19	13	1	1	4	6
Mo.	264	37	-	-	5,004	5,542	173	211	126	4	6	25
N. Dak.	1	1	-	-	25	27	31	1	-	-	1	2
S. Dak.	3	3	-	1	67	128	152	2	-	-	-	-
Nebr.	18	9	1	1	4	664	54	12	-	-	9	1
Kans.	96	21	2	-	1,927	1,219	59	20	5	-	1	2
S. ATLANTIC	3,885	354	30	16	59,760	58,228	397	879	133	34	60	71
Del.	38	10	4	-	567	785	11	78	-	1	10	31
Md.	474	46	7	-	5,375	6,017	84	142	15	6	9	6
D.C.	330	7	-	-	2,700	3,553	7	40	-	-	7	-
Va.	205	63	6	6	6,612	5,579	36	70	12	14	6	19
W. Va.	24	1	1	-	303	424	4	22	-	5	-	1
N.C.	174	40	9	-	8,845	10,942	28	134	35	-	10	5
S.C.	145	6	-	-	3,880	4,308	9	21	-	-	12	-
Ga.	504	36	1	-	18,071	14,939	41	107	38	-	-	1
Fla.	1,991	145	2	10	13,407	11,681	177	265	33	8	6	8
E.S. CENTRAL	532	74	6	-	15,332	17,164	105	391	568	1	20	13
Ky.	62	32	4	-	1,589	1,860	24	29	-	-	10	4
Tenn.	157	18	1	-	4,882	6,634	49	316	564	-	8	9
Ala.	215	16	-	-	4,833	4,109	19	44	4	1	2	-
Miss.	98	8	1	-	4,028	4,561	13	2	-	-	-	-
W.S. CENTRAL	1,525	125	15	3	16,123	22,242	533	565	23	42	6	15
Ark.	79	8	7	-	3,103	2,321	34	37	5	3	-	1
La.	267	8	-	-	2,073	5,075	31	53	-	1	-	-
Okla.	100	-	1	2	1,612	2,182	76	88	14	2	2	6
Tex.	1,079	109	7	1	9,335	12,664	392	387	4	36	4	8
MOUNTAIN	462	48	8	1	3,693	3,980	906	217	72	26	34	1
Mont.	5	-	1	-	34	28	28	18	13	-	5	-
Idaho	7	5	-	-	47	57	20	24	1	-	3	-
Wyo.	3	-	-	-	18	42	1	2	5	-	1	-
Colo.	174	15	4	1	1,311	1,096	263	41	25	14	4	-
N. Mex.	43	6	2	-	301	353	66	47	4	6	2	-
Ariz.	120	15	1	-	1,261	1,518	436	42	10	2	11	-
Utah	40	-	-	-	65	123	64	3	8	4	1	1
Nev.	70	7	-	-	656	763	28	40	6	-	7	-
PACIFIC	3,488	354	36	4	15,052	17,977	2,121	1,137	450	73	39	58
Wash.	174	-	-	-	1,350	1,617	202	97	44	4	3	2
Oreg.	105	-	-	-	513	677	139	100	21	6	-	-
Calif.	3,142	313	33	3	12,748	15,237	1,694	933	383	62	35	56
Alaska	8	2	3	-	261	249	12	4	2	1	-	-
Hawaii	59	39	-	1	180	197	74	3	-	-	1	-
Guam	-	-	-	-	37	-	5	2	-	2	-	1
P.R.	498	51	-	-	61	216	9	115	5	4	1	-
V.I.	2	-	-	-	40	222	5	4	-	-	-	-
Amer. Samoa	-	-	-	-	13	20	-	1	-	-	-	-
C.N.M.I.	-	-	-	-	28	2	-	-	-	-	-	-

N: Not notifiable U: Unavailable C.N.M.I.: Commonwealth of the Northern Mariana Islands
*Updated monthly; last update May 2, 1992

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending May 2, 1992, and May 4, 1991 (18th Week)

Reporting Area	Malaria	Measles (Rubeola)					Menin-gococcal Infections	Mumps		Pertussis			Rubella		
		Indigenous		Imported*		Total									
	Cum. 1992	1992	Cum. 1992	1992	Cum. 1992	Cum. 1991	Cum. 1992	1992	Cum. 1992	1992	Cum. 1992	Cum. 1991	1992	Cum. 1992	Cum. 1991
UNITED STATES	257	135	688	4	59	4,864	903	39	984	45	440	734	-	57	604
NEW ENGLAND	12	-	3	-	5	18	55	-	1	-	40	95	-	4	1
Maine	-	-	-	-	-	-	5	-	-	-	2	4	-	-	-
N.H.	2	-	1	-	-	-	4	-	-	-	15	12	-	-	1
Vt.	-	-	-	-	-	5	1	-	-	-	-	3	-	-	-
Mass.	5	-	2	-	3	7	22	-	1	-	19	68	-	-	-
R.I.	2	-	-	-	-	-	-	-	-	-	-	-	-	4	-
Conn.	3	-	-	-	2	6	23	-	-	-	4	8	-	-	-
MID. ATLANTIC	76	35	124	-	6	3,104	90	6	73	3	53	80	-	10	242
Upstate N.Y.	11	35	39	-	1	164	41	-	29	-	18	47	-	6	228
N.Y. City	37	-	26	-	1	900	9	4	8	2	4	-	-	-	-
N.J.	16	-	58	-	1	752	17	-	14	-	9	7	-	4	-
Pa.	12	-	1	-	3	1,288	23	2	22	1	22	26	-	-	14
E.N. CENTRAL	12	-	10	2	6	55	123	7	117	2	32	152	-	5	162
Ohio	1	-	2	2†	3	1	31	3	46	2	14	56	-	-	147
Ind.	3	U	8	U	-	-	13	U	4	U	8	27	U	-	1
Ill.	2	-	-	-	2	24	37	-	31	-	3	32	-	5	3
Mich.	5	-	-	-	-	25	35	4	34	-	1	20	-	-	11
Wis.	1	-	-	-	1	5	7	-	2	-	6	17	-	-	-
W.N. CENTRAL	13	-	5	-	-	27	42	3	29	-	32	58	-	3	8
Minn.	5	-	3	-	-	5	6	-	5	-	13	21	-	-	4
Iowa	2	-	-	-	-	15	5	-	5	-	1	5	-	-	3
Mo.	3	-	1	-	-	-	15	3	13	-	13	20	-	-	1
N. Dak.	-	-	-	-	-	-	-	-	2	-	2	1	-	-	-
S. Dak.	1	-	-	-	-	-	1	-	-	-	1	1	-	-	-
Nebr.	-	-	-	-	-	-	5	-	2	-	2	4	-	-	-
Kans.	2	-	1	-	-	7	10	-	2	-	-	6	-	3	-
S. ATLANTIC	52	1	93	-	5	276	155	12	425	-	57	37	-	3	4
Del.	3	-	2	-	-	19	2	1	2	-	-	-	-	-	-
Md.	15	-	1	-	4	115	16	1	37	-	14	6	-	-	1
D.C.	3	-	-	-	-	-	-	-	2	-	-	-	-	1	1
Va.	12	-	5	-	1	21	23	-	20	-	4	5	-	-	-
W. Va.	-	-	-	-	-	-	12	-	15	-	3	6	-	-	-
N.C.	6	1	21	-	-	1	28	-	82	-	13	7	-	-	-
S.C.	-	-	29	-	-	12	12	1	46	-	9	-	-	-	-
Ga.	2	-	-	-	-	-	22	-	24	-	4	6	-	-	-
Fla.	11	-	35	-	-	108	40	9	197	-	10	7	-	2	2
E.S. CENTRAL	4	83	327	-	17	1	61	-	27	-	9	19	-	3	83
Ky.	-	83	325	-	-	-	24	-	-	-	-	-	-	-	-
Tenn.	1	-	-	-	1	1	15	-	12	-	7	9	-	3	83
Ala.	3	-	-	-	-	-	20	-	4	-	2	10	-	-	-
Miss.	-	-	2	-	16	-	2	-	11	-	-	-	-	-	-
W.S. CENTRAL	2	-	62	-	-	5	69	5	139	1	14	17	-	-	1
Ark.	-	-	-	-	-	5	10	-	4	1	8	-	-	-	1
La.	-	-	-	-	-	-	11	-	12	-	-	7	-	-	-
Okla.	2	-	-	-	-	-	7	-	4	-	6	10	-	-	-
Tex.	-	-	62	-	-	-	41	5	119	-	-	-	-	-	-
MOUNTAIN	10	-	1	-	4	293	51	2	62	28	79	100	-	1	2
Mont.	-	-	-	-	-	-	11	-	-	-	-	-	-	-	-
Idaho	-	-	-	-	-	2	7	-	2	-	13	15	-	1	-
Wyo.	-	-	1	-	-	-	2	-	-	-	-	3	-	-	-
Colo.	5	-	-	-	4	2	8	-	4	-	19	50	-	-	-
N. Mex.	2	-	-	-	-	91	3	N	N	1	14	14	-	-	1
Ariz.	3	-	-	-	-	182	10	2	39	27	27	8	-	-	-
Utah	-	-	-	-	-	6	4	-	13	-	5	10	-	-	-
Nev.	-	-	-	-	-	10	6	-	4	-	1	-	-	-	1
PACIFIC	76	16	63	2	16	1,085	257	4	111	11	124	176	-	28	101
Wash.	6	-	-	-	7	4	33	-	6	3	33	45	-	-	-
Oreg.	7	1	3	1†	1	26	41	N	N	2	12	30	-	1	1
Calif.	58	-	37	-	6	1,052	174	4	102	6	74	67	-	27	98
Alaska	1	-	8	-	1	1	6	-	-	-	-	9	-	-	-
Hawaii	4	15	15	1†	1	2	3	-	3	-	5	25	-	-	2
Guam	1	-	7	-	3	-	-	-	5	-	-	-	-	-	-
P.R.	-	-	5	-	-	27	3	1	1	-	8	12	-	-	-
V.I.	-	U	-	U	-	2	-	U	10	U	-	-	U	-	-
Amer. Samoa	-	-	-	-	-	24	-	-	-	-	6	-	-	-	-
C.N.M.I.	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-

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

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending May 2, 1992, and May 4, 1991 (18th Week)

Reporting Area	Syphilis (Primary & Secondary)		Toxic-shock Syndrome	Tuberculosis		Tula-remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1992	Cum. 1991	Cum. 1992	Cum. 1992	Cum. 1991	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992
UNITED STATES	11,931	14,859	87	6,440	6,848	20	110	51	2,702
NEW ENGLAND	215	400	8	114	185	-	10	2	253
Maine	-	-	-	23	16	-	-	-	-
N.H.	-	10	5	-	-	-	-	-	1
Vt.	1	1	-	2	1	-	-	-	-
Mass.	98	198	2	52	97	-	7	1	2
R.I.	15	16	1	10	18	-	-	1	-
Conn.	101	175	-	27	53	-	3	-	250
MID. ATLANTIC	1,813	2,506	11	1,537	1,560	-	33	1	850
Upstate N.Y.	120	103	4	80	111	-	5	-	509
N.Y. City	950	1,292	-	976	937	-	12	-	-
N.J.	237	430	-	243	292	-	12	-	249
Pa.	506	681	7	238	220	-	4	1	92
E.N. CENTRAL	1,426	1,692	23	623	779	-	12	5	37
Ohio	242	222	8	112	115	-	2	4	1
Ind.	80	39	2	58	55	-	-	-	2
Ill.	648	822	3	364	422	-	9	-	8
Mich.	239	428	10	57	152	-	1	-	4
Wis.	217	181	-	32	35	-	-	1	22
W.N. CENTRAL	487	268	12	130	191	5	1	1	517
Minn.	32	26	2	29	33	-	-	-	118
Iowa	12	22	3	12	26	-	-	-	68
Mo.	376	162	1	56	80	4	1	1	3
N. Dak.	1	-	1	2	4	-	-	-	41
S. Dak.	-	1	-	9	13	-	-	-	28
Nebr.	1	7	3	2	6	1	-	-	2
Kans.	65	50	2	20	29	-	-	-	257
S. ATLANTIC	3,459	4,511	10	1,273	1,203	3	10	13	542
Del.	75	56	2	11	10	-	-	-	93
Md.	265	371	1	84	111	2	1	-	176
D.C.	159	291	-	48	72	-	1	-	5
Va.	268	385	1	98	99	1	-	-	93
W. Va.	6	10	-	22	34	-	1	-	15
N.C.	828	654	3	181	131	-	-	11	2
S.C.	447	545	1	120	139	-	1	-	42
Ga.	736	1,078	1	292	253	-	-	-	111
Fla.	675	1,121	1	417	354	-	6	2	5
E.S. CENTRAL	1,693	1,559	-	335	504	5	2	1	52
Ky.	47	29	-	133	119	1	-	1	30
Tenn.	435	578	-	7	152	4	-	-	-
Ala.	727	561	-	144	122	-	-	-	22
Miss.	484	391	-	51	111	-	2	-	-
W.S. CENTRAL	2,201	2,654	1	564	681	6	1	26	210
Ark.	353	179	-	41	64	3	-	6	15
La.	873	833	-	27	49	-	-	-	-
Okla.	87	57	-	32	42	3	-	20	119
Tex.	888	1,585	1	464	526	-	1	-	76
MOUNTAIN	155	203	7	197	162	1	2	1	52
Mont.	2	1	-	-	-	-	-	-	6
Idaho	1	3	1	11	2	-	1	-	-
Wyo.	1	1	-	-	2	-	-	-	20
Colo.	19	25	2	16	6	-	1	-	-
N. Mex.	17	13	-	26	9	1	-	-	2
Ariz.	75	156	2	99	91	-	-	-	23
Utah	2	4	2	23	25	-	-	1	1
Nev.	38	-	-	22	27	-	-	-	-
PACIFIC	482	1,066	15	1,667	1,583	-	39	1	189
Wash.	32	59	-	109	105	-	2	-	-
Oreg.	21	28	-	33	34	-	-	-	-
Calif.	419	973	15	1,428	1,371	-	36	1	179
Alaska	1	3	-	17	26	-	-	-	10
Hawaii	9	3	-	80	47	-	1	-	-
Guam	2	-	-	34	-	-	1	-	-
P.R.	89	162	-	55	71	-	-	-	17
V.I.	20	42	-	2	1	-	-	-	-
Amer. Samoa	-	-	-	-	2	-	-	-	-
C.N.M.I.	4	-	-	12	4	-	1	-	-

U: Unavailable

TABLE III. Deaths in 121 U.S. cities,* week ending May 2, 1992 (18th Week)

Reporting Area	All Causes, By Age (Years)						P&I†
	All Ages	≥65	45-64	25-44	1-24	<1	Total
NEW ENGLAND	632	441	108	48	11	24	54
Boston, Mass.	164	108	26	17	3	10	14
Bridgeport, Conn.	49	38	7	4	-	-	2
Cambridge, Mass.	20	17	1	2	-	-	3
Fall River, Mass.	17	15	2	-	-	-	-
Hartford, Conn.	71	39	17	11	-	4	2
Lowell, Mass.	24	17	5	1	-	1	2
Lynn, Mass.	18	13	5	-	-	-	2
New Bedford, Mass.	21	14	6	1	-	-	2
New Haven, Conn.	55	36	10	4	5	-	3
Providence, R.I.	45	37	5	1	2	-	7
Somerville, Mass.	4	4	-	-	-	-	-
Springfield, Mass.	46	35	9	2	-	-	2
Waterbury, Conn.	31	20	9	1	-	1	3
Worcester, Mass.	67	48	6	4	1	8	12
MID. ATLANTIC	2,412	1,586	438	269	62	57	127
Albany, N.Y.	44	34	6	1	2	1	3
Allentown, Pa.	17	16	1	-	-	-	1
Buffalo, N.Y.	100	71	20	5	3	1	4
Camden, N.J.	30	20	5	4	-	1	4
Elizabeth, N.J.	11	7	2	1	-	1	-
Erie, Pa.§	40	34	4	2	-	-	2
Jersey City, N.J.	54	27	10	13	1	3	-
New York City, N.Y.	1,291	814	243	170	33	31	54
Newark, N.J.	54	18	17	12	3	4	3
Paterson, N.J.	20	7	7	4	2	-	-
Philadelphia, Pa.	295	185	59	34	8	9	21
Pittsburgh, Pa.§	81	58	14	5	3	1	4
Reading, Pa.	16	13	3	-	-	-	4
Rochester, N.Y.	124	94	15	8	4	3	11
Schenectady, N.Y.	29	25	4	-	-	-	1
Scranton, Pa.§	26	19	4	3	-	-	1
Syracuse, N.Y.	103	85	13	4	1	-	6
Trenton, N.J.	29	22	4	1	-	2	4
Utica, N.Y.	20	18	2	-	-	-	3
Yonkers, N.Y.	28	19	5	2	2	-	1
E.N. CENTRAL	2,216	1,302	420	254	155	85	109
Akron, Ohio	70	52	9	3	1	5	-
Canton, Ohio	29	20	5	4	-	-	4
Chicago, Ill.	648	240	134	147	109	18	20
Cincinnati, Ohio	118	80	21	5	5	7	13
Cleveland, Ohio	122	77	28	8	4	5	-
Columbus, Ohio	171	110	40	8	8	5	11
Dayton, Ohio	92	70	15	6	1	-	7
Detroit, Mich.	210	111	50	27	8	14	4
Evansville, Ind.	49	42	4	-	1	2	-
Fort Wayne, Ind.	55	43	7	2	-	3	6
Gary, Ind.	12	7	2	1	1	1	-
Grand Rapids, Mich.	51	34	10	4	-	3	6
Indianapolis, Ind.	161	110	24	14	5	8	8
Madison, Wis.	31	17	7	5	-	2	2
Milwaukee, Wis.	133	101	17	4	4	7	10
Peoria, Ill.	63	45	10	1	5	2	4
Rockford, Ill.	37	26	8	2	1	-	5
South Bend, Ind.	37	26	8	3	-	-	2
Toledo, Ohio	82	56	14	8	1	3	5
Youngstown, Ohio	45	35	7	2	1	-	2
W.N. CENTRAL	781	554	141	54	20	12	35
Des Moines, Iowa	85	61	16	7	1	-	5
Duluth, Minn.	44	38	4	1	1	-	2
Kansas City, Kans.	40	30	7	2	1	-	-
Kansas City, Mo.	86	54	18	10	3	1	5
Lincoln, Nebr.	38	30	5	1	1	1	1
Minneapolis, Minn.	155	104	34	15	2	-	11
Omaha, Nebr.	95	68	16	6	1	4	3
St. Louis, Mo.	127	86	23	7	7	4	3
St. Paul, Minn.	60	46	8	3	2	1	4
Wichita, Kans.	51	37	10	2	1	1	1

Reporting Area	All Causes, By Age (Years)						P&I†
	All Ages	≥65	45-64	25-44	1-24	<1	Total
S. ATLANTIC	1,337	837	265	137	46	52	82
Atlanta, Ga.	222	126	47	28	7	14	8
Baltimore, Md.	208	126	46	26	7	3	22
Charlotte, N.C.	114	74	17	10	5	8	6
Jacksonville, Fla.	116	68	28	10	6	4	10
Miami, Fla.	103	60	26	10	4	3	-
Norfolk, Va.	66	44	11	4	5	2	3
Richmond, Va.	70	45	8	9	2	6	4
Savannah, Ga.	47	30	9	2	1	5	1
St. Petersburg, Fla.	64	51	5	6	2	-	-
Tampa, Fla.	165	112	32	15	3	3	21
Washington, D.C.	141	82	34	17	4	4	5
Wilmington, Del.	21	19	2	-	-	-	2
E.S. CENTRAL	898	603	173	74	31	17	64
Birmingham, Ala.	114	74	20	12	5	3	3
Chattanooga, Tenn.	98	73	14	8	3	-	6
Knoxville, Tenn.	96	70	20	4	1	1	12
Louisville, Ky.	116	74	27	10	4	1	7
Memphis, Tenn.	214	143	39	21	8	3	16
Mobile, Ala.	72	49	8	6	5	4	7
Montgomery, Ala.	45	28	12	2	2	1	1
Nashville, Tenn.	143	92	33	11	3	4	12
W.S. CENTRAL	1,537	962	338	139	53	45	104
Austin, Tex.	57	39	6	5	3	4	4
Baton Rouge, La.	33	21	6	5	1	-	4
Corpus Christi, Tex.	42	27	9	3	2	1	2
Dallas, Tex.	200	111	51	21	6	11	2
El Paso, Tex.	88	57	15	6	5	5	8
Ft. Worth, Tex.	95	59	15	11	7	3	8
Houston. Tex.	417	250	95	53	10	9	48
Little Rock, Ark.	76	42	21	4	3	6	3
New Orleans, La.	145	85	45	12	2	1	-
San Antonio, Tex.	228	162	40	13	9	4	10
Shreveport, La.	57	35	19	2	1	-	8
Tulsa, Okla.	99	74	16	4	4	1	7
MOUNTAIN	807	526	156	79	29	16	44
Albuquerque, N.M.	86	55	16	10	4	1	3
Colo. Springs, Colo.	38	17	15	2	2	2	5
Denver, Colo.	100	60	16	16	6	2	8
Las Vegas, Nev.	183	112	47	16	3	4	8
Ogden, Utah	21	17	1	2	1	-	-
Phoenix, Ariz.	149	97	25	17	5	5	13
Pueblo, Colo.	29	20	5	3	1	-	1
Salt Lake City, Utah	82	57	15	4	5	1	1
Tucson, Ariz.	119	91	16	9	2	1	5
PACIFIC	1,409	952	253	128	42	33	92
Berkeley, Calif.	23	17	4	2	-	-	1
Fresno, Calif.	102	59	21	11	5	6	10
Glendale, Calif.	U	U	U	U	U	U	U
Honolulu, Hawaii	64	40	14	6	3	1	4
Long Beach, Calif.	73	51	10	7	4	1	12
Los Angeles, Calif.	U	U	U	U	U	U	U
Pasadena, Calif.	29	19	2	4	2	2	2
Portland, Oreg.	136	101	16	11	3	5	6
Sacramento, Calif.	156	105	36	11	2	2	12
San Diego, Calif.	179	119	38	17	4	1	21
San Francisco, Calif.	156	89	29	28	4	5	1
San Jose, Calif.	162	106	30	14	5	7	10
Santa Cruz, Calif.	37	27	4	-	4	2	3
Seattle, Wash.	145	108	23	10	4	-	3
Spokane, Wash.	61	48	10	3	-	-	3
Tacoma, Wash.	86	63	16	4	2	1	4
TOTAL	12,029¶	7,763	2,292	1,182	449	341	711

*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

Influenza Activity — Continued

department epidemiologists and state public health laboratory directors. Div of Virology, Center for Biologics Evaluation and Research, Food and Drug Administration. Epidemiology Activity and WHO Collaborating Center for Influenza, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases, CDC.

Editorial Note: Strains to be included in the influenza vaccine for the United States are selected from late January through March each year to meet the production schedule required for the manufacture, quality control, and distribution of more than 30 million doses of vaccine before the next influenza season. Specific recommendations for the use of the newly constituted influenza vaccine will be made by the Immunization Practices Advisory Committee of the Public Health Service and published in the *MMWR Recommendations and Reports* dated May 15, 1992.

References

1. CDC. Update: influenza activity—United States, 1991–92 season. MMWR 1992;41:63–5.
2. World Health Organization. Recommended composition of influenza virus vaccines for use in the 1992–1993 season. Wkly Epidemiol Rec 1992;9:57–60.

Progress in Chronic Disease Prevention

Increased Cholesterol Awareness in Urban and Rural Areas — Missouri, 1988–1991

Elevated serum cholesterol is a risk factor for coronary heart disease (CHD) (*1,2*). From 1983 through 1990, the percentage of persons who had their cholesterol measured—a first step in reducing risk for CHD from serum cholesterol—increased nationwide (*3*). Changes in patterns had not been monitored specifically in rural areas, where access to medical care and other socioeconomic barriers may hinder receipt and use of cholesterol screening (*4,5*). To monitor trends in cholesterol awareness and other risk factors for cardiovascular disease among persons who live in rural and urban settings in Missouri, Washington University and the Missouri Department of Health (MDH) analyzed 1988–1991 Behavioral Risk Factor Surveillance System (BRFSS) data for Missouri (*6*).

For the BRFSS, participating state health departments use random-digit–dialed telephone surveys of residents ≥18 years of age to collect survey data. Each year from 1988 through 1991, the MDH interviewed approximately 1500 Missouri residents. Since 1988, the BRFSS has included county codes; for this analysis, the sample was subdivided by county code into three categories: 1) core cities (i.e., county of St. Louis city for St. Louis and Jackson County for Kansas City [19% of the sample]), 2) other metropolitan areas (i.e., counties within metropolitan statistical areas [MSAs] that do not include the counties of the core cities [48%]), and 3) rural areas (i.e., all counties not included in MSAs [33%]). The percentage of respondents who finished high school was 74% in rural areas, 83% in core cities, and 88% in other MSAs; from 1988 to 1991, the percentages of respondents who finished high school for the three geographic areas remained relatively constant.

The proportion of all respondents from Missouri who reported never having had their cholesterol measured declined consistently from 47% (range: 43%–54%) during 1988 to 30% (range: 20%–32%) during 1991 (Table 1). In addition, the percentage of persons not knowing whether their cholesterol had ever been measured declined in all three areas from 4%–6% during 1988 to 1%–3% during 1991. The combined

Cholesterol Awareness — Continued

proportion of those who had never had their cholesterol measured or did not know whether their cholesterol had ever been measured declined 53% in core areas, 45% in rural areas, and 31% in other MSAs (Table 1). Other risk factors examined (i.e., high blood pressure, smoking, obesity, and sedentary lifestyle) fluctuated over time and across categories.

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Editorial Note: Serum cholesterol measurement identifies persons who need treatment for high serum cholesterol and provides health-care providers the opportunity to recommend lifestyle changes to patients to reduce their risk for CHD (*7*). A national health objective for the year 2000 is to increase to at least 75% the proportion of adults who have had their cholesterol measured within the preceding 5 years (objective 15.14) (*7*). The findings in this report, which document a decline in the proportion of adults in Missouri who reported never having had their cholesterol measured, is consistent with previous reports (*3*). In addition, despite possible barriers to information and access to health care, the gap that existed in 1988 between rural areas and MSAs other than the core cities in the proportion of persons who had had their cholesterol measured was closed substantially by 1991.

This analysis has at least two limitations. First, the findings do not indicate whether an increase in awareness was associated with lower levels of serum cholesterol among respondents. Second, the study could not assess whether physicians responded to public health messages by testing their patients, as suggested by a national survey (*3*), or whether patients themselves requested serum cholesterol measurements, possibly after receiving public health messages.

TABLE 1. Percentage of persons who never had cholesterol measured or don't know if cholesterol had been measured, by geographic category — Missouri Behavioral Risk Factor Surveillance System, 1988–1991

	1988		1989		1990		1991	
Category	**%**	**(95% CI*)**	**%**	**(95% CI)**	**%**	**(95% CI)**	**%**	**(95% CI)**
Cholesterol never measured								
Rural areas†	54	(±4.8)	45	(±4.4)	40	(±4.3)	32	(±4.8)
Core cities§	43	(±5.6)	42	(±6.0)	29	(±5.3)	20	(±4.7)
Other metropolitan areas¶	44	(±3.9)	46	(±3.5)	35	(±3.5)	32	(±3.4)
State total	**47**	**(±2.6)**	**45**	**(±2.5)**	**36**	**(±2.4)**	**30**	**(±2.3)**
Don't know if cholesterol measured								
Rural areas†	6	(±2.2)	3	(±1.5)	3	(±1.5)	1	(±0.8)
Core cities§	6	(±2.7)	2	(±2.4)	4	(±2.3)	3	(±2.0)
Other metropolitan areas¶	4	(±1.5)	4	(±1.0)	2	(±1.0)	1	(±0.7)
State total	**5**	**(±1.2)**	**3**	**(±0.9)**	**2**	**(±0.7)**	**1**	**(±0.5)**

*Confidence interval.
†All counties not included in metropolitan statistical areas (MSAs); 33% of sample.
§The sample was subdivided by county code into core cities (e.g., county of St. Louis city for St. Louis and Jackson County for Kansas City); 19% of sample.
¶Counties within MSAs, not including counties of core cities; 48% of sample.

Cholesterol Awareness — Continued

Transmission of public health messages through the media, however, is an important adjunct in increasing cholesterol awareness across geographic regions (*7*). Even though the proportion of persons in the United States who have had their cholesterol level measured has increased, in 1988, only 17% of persons aged ≥18 years knew their cholesterol level (*7*). Although findings in this report indicate a substantial proportion of persons in Missouri have had their cholesterol measured, approximately 30% of the adult state population across all three geographic regions had not had their cholesterol measured. Therefore, the MDH can use this data to develop targeted cholesterol awareness messages to these persons. In addition, the MDH may refine its message to the larger percentage of persons who have had their cholesterol measured to encourage them to learn their cholesterol count and to understand the importance of the cholesterol count in cardiovascular health. Missouri and other states are increasingly using data sets such as BRFSS to monitor trends in risk factors and target public health messages to persons in high-risk groups (*8*). For example, the MDH can use these data on cholesterol awareness to guide efforts in rural cardiovascular disease-control coalitions.

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Notices to Readers

Change in the Reporting of AIDS Cases

As of May 2, 1992, the acquired immunodeficiency syndrome (AIDS) case reports in *MMWR*'s tables of selected notifiable diseases will be updated monthly rather than weekly. Because state and local health departments forward AIDS case reports to CDC on a monthly basis, this change will ensure that the data in *MMWR* are consistent with these reporting practices and should facilitate use of these data to monitor trends in the human immunodeficiency virus (HIV)/AIDS epidemic. A footnote providing the date of the last update will accompany the tables.

For more detailed statistics on AIDS, a quarterly HIV/AIDS surveillance report is available from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone (800) 485-5231.

Notices to Readers — Continued

International Course on Applied Epidemiology

The ninth annual International Course on Applied Epidemiology will be held in Annecy, France, September 7–26, 1992; this course is cosponsored by the Institute for the Development of Applied Epidemiology (IDEA), the National School of Public Health in Rennes, France, and CDC. The course emphasizes applied epidemiology in public health practice, and the curriculum includes interactive exercises, as well as lectures and a field survey. Participants must be fluent in both French and English.

Applications are due May 31, 1992. Additional information about the course is available from: Secretariat General de l'IDEA, 1-3 Boulevard Poincare, 92430 Marnes-La-Coquette, France; telephone 33-1-47 95 08 87; fax 33-1-47 95 08 88.

International Conference on Child Day Care Health

CDC and 14 other organizations will cosponsor a conference, "International Child Day Care Health: Science, Prevention, and Practice," in Atlanta June 15–17, 1992.

Scientific sessions are scheduled on the following topics: diarrheal diseases; children with special needs; infectious hepatitis; economics and child day care; epidemiology of injuries; surveillance by health departments; health promotion issues; infectious diseases—epidemiology and pathogens; infectious diseases—measuring and reducing risks; economics and demographics; injury in child day care; environmental health; health promotion opportunities and evaluation; regulation for improving health; the human immunodeficiency virus-infected child; health education; respiratory infections; developmental outcomes; vaccine-preventable diseases; occupational health of providers; injury prevention; environmental quality; care of mildly ill children; methodologic and ethical research issues; invasive bacterial disease; prevention of developmental disabilities; cytomegalovirus transmission; international perspectives; technology to prevent injuries; and American Public Health Association/American Academy of Pediatrics National Health and Safety Guidelines.

Preregistration (cost: $40) and additional information is available from Lisa Townsend, PACE Enterprises, Inc.; telephone (404) 633-8610; fax (404) 633-8745.

Availability of Varicella Vaccine for Children with Acute Lymphocytic Leukemia

An investigational, live, attenuated varicella vaccine is available free of charge through Merck Research Laboratories to any physician requesting it for certain pediatric patients (aged 12 months to 17 years) with acute lymphocytic leukemia (ALL). Patients must meet specified criteria, including no clinical history of varicella and continuous remission for at least 12 months.

Varicella vaccine is being provided to this group of patients for use through a study protocol to monitor and evaluate safety. An Investigational New Drug application for the vaccine has been filed with the Food and Drug Administration.

Previous experience with this vaccine has shown it to be immunogenic in children with ALL (*1*). The most common reaction to the vaccine is a mild (fewer than 100 lesions) varicelli-form rash, occurring in approximately 40% of vaccinees (*2*).

Notices to Readers — Continued

The physician must provide information outlined in the protocol, and the protocol and consent form for the study must be approved by the institution's Investigational Review Board. Additional information about eligibility criteria and vaccine administration is available from Dr. Jo White, Merck Research Laboratories, telephone (215) 834-2554.

Reported by: Div of Immunization, National Center for Prevention Svcs, CDC.

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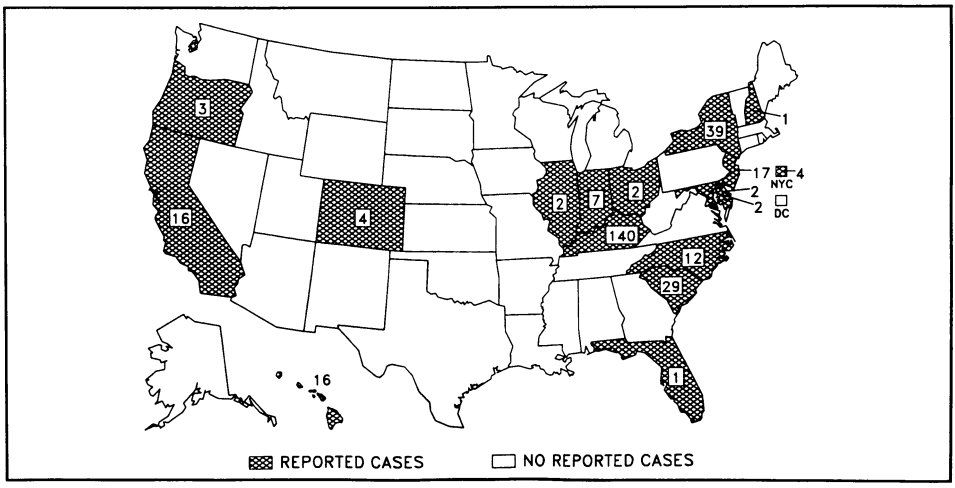
Reported cases of measles, by state — United States, weeks 13–17, 1992



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.

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