CDC
CENTERS FOR DISEASE CONTROL

August 14, 1992 / Vol. 41 / No. 32

MMWR
MORBIDITY AND MORTALITY WEEKLY REPORT

Current Trends

Testing for HIV in the Public and Private Sectors — Oregon, 1988–1991

Counseling and testing persons for human immunodeficiency virus (HIV) infection is a key component of the public health strategy for reducing transmission of HIV in the United States (*1,2*). In 1991, the federal government allocated $100 million to state and local health agencies to provide counseling and testing programs in public clinics for at-risk persons, including persons who may not otherwise use public health services. However, the relative contribution of HIV-testing in public clinics to HIV testing in the private sector is unknown. To compare HIV testing in Oregon public clinics to overall HIV testing, the Health Division (HD) of the Oregon Department of Human Resources, in cooperation with CDC, reviewed data collected from September 1, 1988, through August 31, 1991, on public and private HIV testing in Oregon. This report summarizes findings for HIV testing rates and assesses the importance of publicly funded testing in identifying HIV-seropositive persons.

Oregon law requires that all blood samples to be tested for HIV antibody be accompanied by certification that informed consent was obtained from the person being tested. The certification form, completed by the health-care provider, includes general demographic information about the person tested, reason for testing, previous HIV test results (if any), and the specimen collection date; the patient's name is not reported. Because HIV testing certificates do not include names, the data represent tests and not individual persons. Licensed laboratories (both public and private sector) are required to forward this information, along with test results, to the Oregon HD. For a specimen to be considered positive for HIV, enzyme immunoassay (EIA)-positive results must be confirmed by Western blot or immunofluorescent assay.

During the 3-year period, 125,159 HIV tests were reported to the Oregon HD. The annual number of reported tests increased steadily from 34,525 in 1989 (12 per 1000 residents) to 50,351 in 1991 (18 per 1000) (Table 1). Testing rates varied by persons' age, race/ethnicity, and place of residence. The highest testing rate was for persons

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aged 20–29 years (31 per 1000 state residents); testing rates were higher for blacks (40 per 1000) and Hispanics (28 per 1000) than for whites (13 per 1000). Testing was more common for residents of Oregon's Portland metropolitan area counties (17 per 1000) than for residents of other urban (12 per 1000) or rural (9 per 1000) counties.

In Oregon, publicly funded testing is done at 57 sites, primarily in county health departments. During the study period, 46,259 (37%) tests were publicly funded, and 78,900 (63%) were privately funded (Table 1). The proportion of all tests that were

TABLE 1. Number and percentage of HIV-antibody tests and newly positive HIV-antibody tests, by public and private test sites and by sex, age group, race/ethnicity, residence, and reason for testing — Oregon, September 1, 1988–August 31, 1991

	All HIV tests					Newly positive HIV tests				
	Public sector		Private sector			Public sector		Private sector		
Category	No.	(%)	No.	(%)	Total	No.	(%)	No.	(%)	Total
Period										
9/88–8/89	11,127	(32)	23,398	(68)	**34,525**	213	(41)	310	(59)	**523**
9/89–8/90	15,089	(37)	25,194	(63)	**40,283**	271	(37)	461	(63)	**732**
9/90–8/91	20,043	(40)	30,308	(60)	**50,351**	455	(56)	350	(44)	**805**
Sex										
Male	23,127	(39)	36,697	(61)	**59,824**	849	(48)	920	(52)	**1,769**
Female	22,505	(38)	37,102	(62)	**59,607**	69	(41)	98	(59)	**167**
Unknown	627		5,101		**5,728**	21		103		**124**
Age group (yrs)										
<13	168	(11)	1,314	(89)	**1,482**	2	(10)	18	(90)	**20**
13–19	5,125	(44)	6,537	(56)	**11,662**	11	(38)	18	(62)	**29**
20–29	17,499	(44)	22,223	(56)	**39,722**	362	(56)	285	(44)	**647**
30–39	14,528	(40)	21,463	(60)	**35,991**	384	(50)	383	(50)	**767**
40–49	6,306	(35)	11,867	(65)	**18,173**	136	(38)	225	(62)	**361**
≥50	2,048	(19)	8,639	(81)	**10,687**	29	(22)	102	(78)	**131**
Unknown	585		6,857		**7,442**	15		90		**105**
Race/Ethnicity										
White	38,072	(39)	59,004	(61)	**97,076**	771	(47)	867	(53)	**1,638**
Black	3,104	(56)	2,412	(44)	**5,516**	66	(55)	54	(45)	**120**
Hispanic	2,377	(25)	7,105	(75)	**9,482**	45	(54)	38	(46)	**83**
Other	1,565	(38)	2,551	(62)	**4,116**	28	(56)	22	(44)	**50**
Unknown	1,141		7,828		**8,969**	29		140		**169**
Residence										
Portland	23,077	(38)	38,031	(62)	**61,108**	671	(47)	763	(53)	**1,434**
Other urban	15,993	(39)	24,751	(61)	**40,744**	182	(48)	199	(52)	**381**
Rural	5,912	(37)	9,969	(63)	**15,881**	60	(46)	71	(54)	**131**
non-Oregon	727	(20)	2,978	(80)	**3,705**	11	(22)	39	(78)	**50**
Unknown	550		3,171		**3,721**	15		49		**64**
Reason for test										
Symptomatic	568	(10)	5,060	(90)	**5,628**	83	(15)	482	(85)	**565**
Asymptomatic*	45,318	(46)	53,098	(54)	**98,416**	855	(65)	470	(35)	**1,325**
Third party†	373	(3)	14,374	(97)	**14,747**	1	(3)	33	(97)	**34**
Unknown	0		6,368		**6,368**	0		136		**136**
Total	**46,259**	**(37)**	**78,900**	**(63)**	**125,159**	**939**	**(46)**	**1,121**	**(54)**	**2,060**

*Persons who initiated testing of their own accord.

†Asymptomatic persons referred by a third party (e.g., an insurance company).

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publicly funded increased from 32% in 1989 to 40% in 1991. Of persons tested, those aged 13–39 years were more likely to be tested at publicly funded test sites (43%) than were those aged <13 years or ≥40 years (28%). Blacks were more likely to be tested at publicly funded sites (56%) than were whites (39%) or Hispanics (25%).

Test providers classified persons being tested as 1) symptomatic; 2) asymptomatic and initiating testing of their own accord, or 3) asymptomatic and being referred by a third party (e.g., an insurance company). A minority of tests from symptomatic persons (10%) and third-party referred (3%) were performed at public sites. However, nearly half (46%) of tests from asymptomatic persons were performed at public sites.

Overall, 2667 (2%) tests were positive for HIV antibody. Newly diagnosed HIV infections were defined as positive tests for persons who had no history of a positive HIV-antibody test (i.e., persons who were tested for the first time or who had a previously negative test, or those for whom no previous testing history was available). Of positive HIV tests, 2060 (77%) represented newly diagnosed infections. Of tests for which age, sex, race/ethnicity, and place of residence of the person were reported, most newly diagnosed infections were among persons aged 20–49 years (91%), men (91%), whites (87%), and persons from the Portland metropolitan area (72%).

Rates of newly diagnosed infections varied by demographic characteristics: 1769 (3.0%) tests among males were newly positive, compared with 167 (0.3%) among females. The highest rate by age group was among persons aged 30–49 years (2.1%), followed by those aged 20–29 years (1.6%), and those aged ≥50 years (1.2%). Rates also varied by race/ethnicity: 2.2% of tests among blacks were newly positive, 1.7% among whites, and 0.9% among Hispanics. Tests from the Portland metropolitan area were more likely to be newly positive (2.3%) than were those from other urban (0.9%) or rural areas (0.8%).

Samples submitted by the public and private sectors each accounted for approximately half of the newly diagnosed HIV infections (Table 1). The overall rate of newly diagnosed HIV infections was greater for the public (2.0%) than private (1.4%) sector. Of all tests for which reason for testing was known, most (69%) newly diagnosed HIV infections were among asymptomatic persons who self-initiated testing, 29% of new diagnoses were among symptomatic persons, and 2% were among third-party referrals. Of all tests representing newly diagnosed HIV infections among asymptomatic persons who self-initiated testing, 65% were performed in the public sector. Fewer newly diagnosed HIV infections among symptomatic persons and third-party referrals were diagnosed through public-sector testing (15% and 3%, respectively).

Reported by: K Hedberg, MD, R Klockner, D Fleming, MD, State Epidemiologist, State Health Div, Oregon Dept of Human Resources. Div of Field Epidemiology, Epidemiology Program Office, CDC.

Editorial Note: The findings in this report indicate that from 1988 through 1991, nearly half of newly diagnosed HIV infections in Oregon were diagnosed through public-sector testing. In addition, the overall rate of HIV testing and the proportion of tests conducted in the public sector increased during this time.

Asymptomatic persons who are unaware of their HIV infection are an important target group for prevention programs aimed at reducing transmission of HIV through counseling and testing; however, unlike symptomatic persons, asymptomatic persons may need to be convinced through various education efforts to seek testing. In Oregon, public clinics performed only 37% of all tests but diagnosed nearly two thirds

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(65%) of new HIV infections among asymptomatic persons who self-initiated testing. Asymptomatic persons seeking testing at public clinics were twice as likely to have a newly diagnosed HIV infection as asymptomatic persons seeking testing in private clinics. These findings suggest that the cumulative impact of community education, case-finding, and outreach programs have been effective in encouraging high-risk, asymptomatic persons to be counseled and tested at public clinics. These findings also suggest that, in Oregon, publicly funded HIV counseling and testing is increasingly important in identifying persons with undetected HIV infection.

References

1. CDC. Publicly funded HIV counseling and testing—United States, 1990. MMWR 1991;40:666–9,675.
2. Francis DP, Anderson RE, Gorman ME, et al. Targeting AIDS prevention and treatment toward HIV-1 infected persons. JAMA 1989;262:2572–6.

Misclassification of Infant Deaths — Alaska, 1990–1991

In June 1991, the Alaska Section of Vital Statistics reported that nine deaths of Alaskan Native infants occurred in seven villages in southwestern Alaska from January 1990 through June 1991. In comparison, seven Alaskan Native infant deaths occurred in these villages during 1986–1989. Two of the deaths during 1990–1991 had been attributed to acute viral myocarditis (*International Classification of Diseases, Ninth Revision* [ICD-9], code 422.9) and three to viral or unspecified pneumonitis (ICD-9 codes 480.9 and 486), while from 1985 through 1989, one infant death in these villages had been attributed to either of these causes. An examination of the clinical histories of these nine infants by the Alaska Division of Public Health (ADPH) suggested some of the diagnoses might be inaccurate. This report summarizes an investigation by the ADPH to assess the accuracy of the immediate cause of death recorded on the death certificates for the nine infants.

The nine infants who died ranged in age from 26 days to 8 months and were unrelated. Six had been found dead by caretakers, two died while receiving care at the regional hospital, and one had a respiratory arrest at a village clinic after presenting with cyanosis and periodic apnea. For eight of the infants, a pathologist determined cause of death after postmortem examination; no autopsy was performed on the ninth infant, and cause of death was determined by a physician familiar with the case history.

The ADPH formed an infant death review team consisting of a medical epidemiologist, pediatricians, a consulting pediatric pathologist, other physicians, and public health nurses who reviewed clinical records and pathologic specimens for each death. For two of the infants, there was no information about the scene of death and limited clinical information.

The review team offered a consensus cause of death for each infant. This was compared to the cause of death listed on the death certificate for each of the nine infants (Table 1). The review team reported that for the two infants with acute viral myocarditis listed as the cause of death on the death certificate, the cause was sudden infant death syndrome (SIDS) for one and unknown for the other (Table 1). Similarly, for two infants with pneumonitis listed as cause of death on the death certificate, the review team reported the cause as SIDS for one and unknown for the other. Overall,

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five deaths had been inappropriately attributed to myocarditis or pneumonitis and at least two were due to SIDS. Both deaths that had been attributed on the death certificates to SIDS were considered accurate by the review team (Table 1) (*1*).

Reported by: JP Middaugh, MD, State Epidemiologist, Alaska Dept of Health and Social Svcs. Div of Field Epidemiology, Epidemiology Program Office, CDC.

Editorial Note: The findings of this investigation revealed that the cause of death listed on the death certificates for five of the nine infants was inaccurate. In particular, the underdiagnosis of SIDS indicated in this investigation suggests the possibility that the SIDS rate for Alaska (2.7 per 1000 live births) (*2,3*)—approximately twice the overall rate for the United States (U.S. rate: 1.4 per 1000 live births [CDC, unpublished data, 1979–1988])—may be higher than previously considered.

A variety of determinants may influence the accuracy and quality of data derived from death certificates. These include 1) differences in the interpretation of the causes of death by those entering this information on death certificates (e.g., understanding definitions of underlying, intermediate, and immediate cause of death), 2) incomplete clinical and laboratory information available at the time death certificates are completed, 3) variations in coding the underlying cause of death, and 4) the level of training and experience of those determining cause of death (*4,5*). Misclassification of cause of death on death certificates may bias epidemiologic studies, misdirect prevention efforts and services, and prompt inappropriate action within the justice system.

Although reports have suggested that use of autopsy information will improve the accuracy of vital statistics data (*4–7*), findings from this investigation indicate that autopsies alone may not improve the accuracy of such data for infant deaths. The findings in this report suggest that infant death review teams may improve the accuracy of causes of death for infants (*8*). Since this investigation, the ADPH, in cooperation with the Alaska Area Native Health Service, plans to investigate and review all infant deaths that occur in Alaska. An infant death review committee similar to the one assembled to conduct this investigation in Alaska should be considered in other locales to periodically review infant deaths, including parental interviews and death scene investigations, to improve cause-of-death reporting for infants (*8*).

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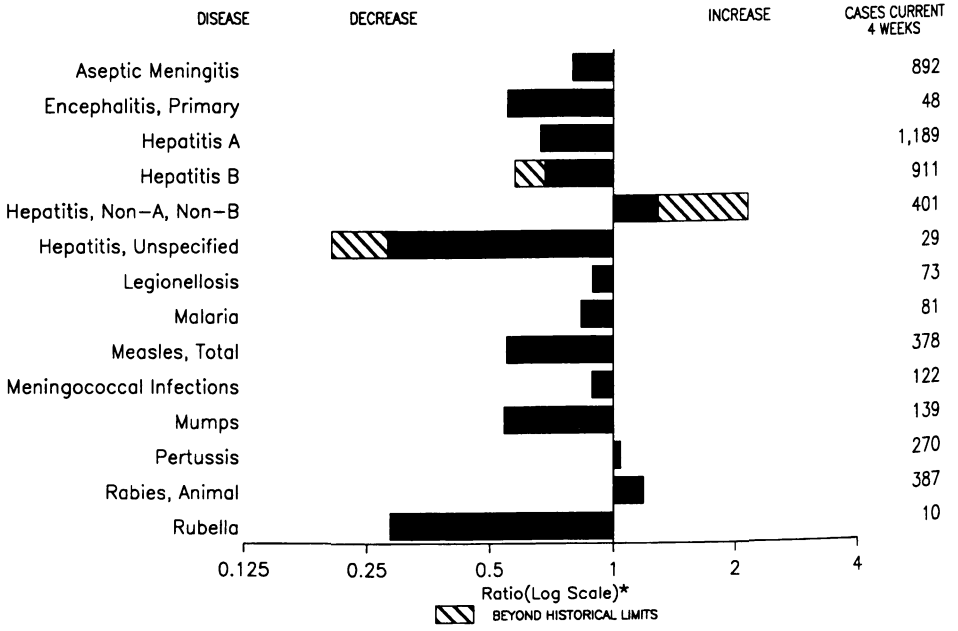
TABLE 1. Age at death, death certificate cause of death, and consensus cause of death for nine infants — Alaska, 1990–1991

Infant age at death	Death certificate cause of death	Consensus cause of death
26 days	Acute pneumonitis	Acute bronchopneumonia
1 month	Acute viral pneumonitis	Unknown
1 month	Acute viral myocarditis	Unknown
2 months	SIDS*	SIDS
3 months	Viral bronchiolitis/pneumonitis	SIDS
6 months	SIDS	SIDS
6 months†	Meningitis/sepsis	Meningitis/sepsis due to *Streptococcus pneumoniae*
6 months	Sepsis due to viral pneumonitis/myocarditis	Sepsis due to *Haemophilus influenzae* type b
8 months	Acute viral myocarditis	SIDS

*Sudden infant death syndrome.
†No autopsy performed.

FIGURE I. Notifiable disease reports, comparison of 4-week totals ending August 8, 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 August 8, 1992 (32nd Week)

	Cum. 1992		Cum. 1992
AIDS*	27,377	Measles: imported	98
Anthrax	-	indigenous	1,574
Botulism: Foodborne	10	Plague	3
Infant	32	Poliomyelitis, Paralytic[§]	-
Other	2	Psittacosis	55
Brucellosis	45	Rabies, human	-
Cholera[†]	92	Syphilis, primary & secondary	20,885
Congenital rubella syndrome	7	Syphilis, congenital, age < 1 year[¶]	697
Diphtheria	3	Tetanus	10
Encephalitis, post-infectious	87	Toxic shock syndrome	149
Gonorrhea	296,150	Trichinosis	17
Haemophilus influenzae (invasive disease)	922	Tuberculosis	13,353
Hansen Disease	114	Tularemia	92
Leptospirosis	19	Typhoid fever	199
Lyme Disease	3,732	Typhus fever, tickborne (RMSF)	228

*Updated monthly; last update August 1, 1992.
†Delayed reports from California.
§Two cases of suspected poliomyelitis have been reported in 1992; six of the nine suspected cases with onset in 1991 were confirmed and 5 of the 8 suspected cases with onset in 1990 were confirmed; all were vaccine associated.
¶Updates for first quarter 1992.

TABLE II. Cases of selected notifiable diseases, United States, weeks ending August 8, 1992, and August 10, 1991 (32nd Week)

Reporting Area	AIDS*	Aseptic Menin-gitis	Encephalitis		Gonorrhea		Hepatitis (Viral), by type				Legionel-losis	Lyme Disease
			Primary	Post-in-fectious			A	B	NA,NB	Unspeci-fied		
	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	27,377	4,073	334	87	296,150	358,306	11,921	9,517	4,476	407	765	3,732
NEW ENGLAND	906	171	20	-	6,278	8,762	350	357	50	16	37	827
Maine	35	14	2	-	51	105	23	21	5	-	1	4
N.H.	30	9	2	-	91	154	25	24	12	1	3	22
Vt.	13	8	3	-	15	32	5	10	9	-	2	3
Mass.	492	78	10	-	2,280	3,816	176	272	21	15	21	90
R.I.	67	62	3	-	457	716	83	17	3	-	10	130
Conn.	269	-	-	-	3,384	3,939	38	13	-	-	-	578
MID. ATLANTIC	6,806	419	16	8	30,859	43,134	909	1,239	228	14	221	2,118
Upstate N.Y.	752	200	-	-	5,988	7,539	218	302	137	7	87	1,321
N.Y. City	3,901	81	4	1	10,148	16,548	349	222	4	-	3	8
N.J.	1,362	-	-	-	4,528	7,258	148	311	67	-	27	319
Pa.	791	138	12	7	10,195	11,789	194	404	20	7	104	470
E.N. CENTRAL	2,520	564	87	26	55,827	66,351	1,717	1,436	806	24	177	72
Ohio	454	156	25	2	16,443	20,348	272	142	59	4	79	34
Ind.	262	86	9	11	5,257	6,673	512	493	390	8	21	24
Ill.	1,155	123	32	6	18,519	19,656	315	156	42	4	12	6
Mich.	500	190	19	7	13,279	14,989	88	374	268	8	41	8
Wis.	149	9	2	-	2,329	4,685	530	271	47	-	24	-
W.N. CENTRAL	762	225	19	6	13,165	17,638	1,414	387	164	21	49	176
Minn.	138	24	3	-	1,706	1,720	423	45	13	2	3	68
Iowa	54	30	-	3	963	1,253	23	25	5	2	14	14
Mo.	387	97	8	-	7,256	10,753	503	253	125	15	17	71
N. Dak.	8	1	1	-	39	44	73	1	3	1	1	1
S. Dak.	6	7	-	1	110	211	182	3	-	-	-	1
Nebr.	34	10	2	2	8	1,151	111	15	7	1	12	10
Kans.	135	56	5	-	3,083	2,506	99	45	11	-	2	11
S. ATLANTIC	6,452	761	69	35	92,900	108,996	733	1,570	613	58	110	274
Del.	79	31	6	-	1,077	1,593	25	149	131	1	16	112
Md.	757	94	11	-	9,390	11,026	141	233	23	5	20	62
D.C.	423	14	1	-	4,145	5,935	13	52	233	-	7	2
Va.	392	114	21	9	10,441	10,584	61	108	25	20	10	52
W. Va.	34	10	6	-	577	749	5	36	1	12	-	4
N.C.	436	100	20	-	15,355	22,052	65	276	60	-	20	22
S.C.	221	7	-	-	6,879	8,829	17	34	-	1	16	1
Ga.	842	95	2	-	28,070	26,233	97	175	58	-	5	2
Fla.	3,268	296	2	26	16,966	21,995	309	507	82	19	16	17
E.S. CENTRAL	860	240	12	-	28,253	35,034	180	808	1,369	2	42	45
Ky.	128	76	7	-	2,936	3,666	49	47	3	-	18	14
Tenn.	265	56	2	-	8,785	12,443	81	673	1,354	-	18	24
Ala.	313	67	2	-	9,457	10,246	29	85	11	1	6	7
Miss.	154	41	1	-	7,075	8,679	21	3	1	1	-	-
W.S. CENTRAL	2,566	541	35	4	33,416	39,825	1,151	1,224	81	95	13	80
Ark.	127	7	7	-	4,641	4,859	53	49	7	4	-	10
La.	466	39	3	1	9,471	9,490	97	112	35	2	1	4
Okla.	147	-	3	2	3,214	4,164	126	119	23	3	7	21
Tex.	1,826	495	22	1	16,090	21,312	875	944	16	86	5	45
MOUNTAIN	788	146	13	4	7,345	7,610	1,744	432	162	33	58	8
Mont.	14	2	1	1	63	66	53	25	26	-	9	-
Idaho	19	19	-	-	65	85	37	56	-	-	4	2
Wyo.	2	-	1	-	33	59	3	2	10	-	1	1
Colo.	264	49	6	1	2,764	2,231	493	68	60	17	10	-
N. Mex.	66	10	3	1	548	678	180	118	15	7	2	4
Ariz.	254	45	1	-	2,543	2,812	729	90	20	4	18	-
Utah	54	2	1	1	158	202	194	10	19	5	2	1
Nev.	115	19	-	-	1,171	1,477	55	63	12	-	12	-
PACIFIC	5,717	1,006	63	4	28,107	30,956	3,723	2,064	1,003	144	58	132
Wash.	314	-	1	-	2,312	2,784	464	208	88	7	8	6
Oreg.	161	-	-	-	1,037	1,250	219	179	50	8	-	-
Calif.	5,146	943	59	3	24,031	25,988	2,870	1,657	699	121	49	125
Alaska	11	9	3	-	445	473	33	8	2	1	-	-
Hawaii	85	54	-	1	282	461	137	12	164	7	1	1
Guam	-	2	-	-	48	5	5	1	-	6	-	1
P.R.	877	120	1	-	123	386	28	280	125	16	1	-
V.I.	2	-	-	-	67	265	2	6	-	-	-	-
Amer. Samoa	-	-	-	-	26	29	1	1	-	-	-	-
C.N.M.I.	-	-	-	-	51	48	1	-	-	-	-	-

N: Not notifiable U: Unavailable C.N.M.I.: Commonwealth of the Northern Mariana Islands
*Updated monthly; last update August 1, 1992.

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending August 8, 1992, and August 10, 1991 (32nd 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	532	138	1,574	1	98	8,168	1,446	74	1,758	75	1,144	1,444	2	124	1076
NEW ENGLAND	29	-	51	-	7	65	90	-	11	9	101	208	-	6	4
Maine	-	-	2	-	-	2	8	-	-	-	4	46	-	1	-
N.H.	3	-	15	-	-	-	5	-	3	-	27	17	-	-	1
Vt.	-	-	-	-	-	5	4	-	-	-	2	3	-	-	-
Mass.	15	-	11	-	3	32	37	-	2	5	45	123	-	-	2
R.I.	4	-	23	-	-	2	1	-	-	-	-	-	-	4	-
Conn.	7	-	-	-	4	24	35	-	6	4	23	19	-	1	1
MID. ATLANTIC	148	-	175	-	12	4,484	166	2	120	2	100	141	-	16	563
Upstate N.Y.	21	-	79	-	3	383	81	2	50	1	29	80	-	11	537
N.Y. City	82	-	42	-	8	1,625	14	-	21	-	15	19	-	-	2
N.J.	24	-	49	-	1	1,020	25	-	9	-	16	10	-	2	2
Pa.	21	-	5	-	-	1,456	46	-	40	1	40	32	-	3	22
E.N. CENTRAL	34	-	23	-	13	78	221	-	229	2	93	287	-	7	176
Ohio	6	-	-	-	6	3	57	-	82	-	32	75	-	-	147
Ind.	9	-	20	-	-	2	34	-	7	-	17	50	-	-	2
Ill.	9	-	1	-	4	25	57	-	75	-	13	55	-	7	6
Mich.	8	-	2	-	2	39	57	-	57	2	8	24	-	-	20
Wis.	2	-	-	-	1	9	16	-	8	-	23	83	-	-	1
W.N. CENTRAL	27	-	6	-	8	40	65	-	60	3	100	108	-	4	16
Minn.	13	-	5	-	5	10	9	-	19	-	32	47	-	-	6
Iowa	2	-	-	-	3	15	7	-	10	-	3	12	-	-	5
Mo.	8	-	-	-	-	1	20	-	23	1	36	33	-	-	5
N. Dak.	-	-	-	-	-	-	1	-	2	-	10	2	-	-	-
S. Dak.	1	-	-	-	-	-	1	-	-	-	5	3	-	-	-
Nebr.	-	-	-	-	-	1	13	-	4	-	8	5	-	-	-
Kans.	3	-	1	-	-	13	14	-	2	2	6	6	-	4	-
S. ATLANTIC	100	1	118	-	11	440	264	56	679	12	96	144	1	15	7
Del.	5	-	3	-	-	21	2	-	4	-	3	-	-	-	-
Md.	27	-	9	-	7	173	26	-	60	-	16	33	1	6	1
D.C.	7	-	-	-	-	-	3	-	5	-	1	-	-	1	1
Va.	23	-	10	-	4	28	38	-	38	-	6	16	-	-	-
W. Va.	1	-	-	-	-	-	14	-	22	2	6	8	-	1	-
N.C.	8	-	25	-	-	39	61	55	181	8	21	22	-	-	2
S.C.	-	-	29	-	-	12	18	1	48	1	11	9	-	2	-
Ga.	5	-	-	-	-	14	38	-	56	-	8	24	-	-	-
Fla.	24	1	42	-	-	153	64	-	265	1	24	32	-	5	3
E.S. CENTRAL	13	-	445	-	17	2	91	3	44	-	19	45	-	1	100
Ky.	1	-	444	-	1	1	28	-	-	-	-	-	-	-	-
Tenn.	8	-	-	-	-	1	27	1	14	-	5	16	-	1	100
Ala.	4	-	-	-	-	-	27	2	10	-	13	25	-	-	-
Miss.	-	-	1	-	16	-	9	-	20	-	1	4	-	-	-
W.S. CENTRAL	18	131	646	-	-	159	105	7	296	2	38	40	-	-	5
Ark.	-	-	-	-	-	5	10	-	6	-	10	4	-	-	1
La.	1	-	-	-	-	-	24	1	17	-	2	10	-	-	-
Okla.	5	-	11	-	-	-	13	-	15	2	26	20	-	-	-
Tex.	12	131	635	-	-	154	58	6	258	-	-	6	-	-	4
MOUNTAIN	18	6	12	-	8	963	74	-	100	10	221	150	-	5	6
Mont.	-	-	-	-	-	-	13	-	2	-	3	2	-	-	-
Idaho	-	-	-	-	-	398	8	-	3	1	24	21	-	1	-
Wyo.	-	-	1	-	-	3	2	-	-	-	-	3	-	-	1
Colo.	5	6	9	-	7	5	14	-	14	-	25	80	-	-	1
N. Mex.	2	-	-	-	1	98	8	N	N	9	53	16	-	-	-
Ariz.	8	-	2	-	-	312	16	-	56	-	91	8	-	2	-
Utah	2	-	-	-	-	129	4	-	18	-	24	18	-	1	4
Nev.	1	-	-	-	-	18	9	-	7	-	1	2	-	1	-
PACIFIC	145	-	98	1	22	1,937	370	6	219	35	376	321	1	70	199
Wash.	8	-	-	-	10	61	55	-	9	8	106	84	-	6	8
Oreg.	10	-	4	-	1	68	51	N	N	1	22	41	-	2	2
Calif.	119	-	54	1†	3	1,785	253	1	191	25	229	145	1	41	181
Alaska	1	-	8	-	1	3	6	-	1	1	5	12	-	-	1
Hawaii	7	-	32	-	7	20	5	5	18	-	14	39	-	21	7
Guam	1	U	10	U	-	-	-	U	8	U	-	-	U	1	-
P.R.	-	-	293	-	-	92	3	-	1	-	8	32	-	-	1
V.I.	-	-	-	-	-	2	-	-	17	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	24	-	-	-	-	6	-	-	-	-
C.N.M.I.	-	U	1	U	1	-	-	U	-	U	1	-	U	-	-

*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 August 8, 1992, and August 10, 1991 (32nd 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	20,885	25,683	149	13,353	13,582	92	199	228	4,910
NEW ENGLAND	413	680	10	246	364	1	22	7	463
Maine	2	-	-	17	27	-	-	-	-
N.H.	38	12	6	3	5	-	1	-	1
Vt.	1	1	-	3	4	-	-	-	18
Mass.	198	322	3	106	179	1	13	3	5
R.I.	21	37	1	34	33	-	-	2	-
Conn.	153	308	-	83	116	-	8	2	439
MID. ATLANTIC	3,140	4,603	19	3,120	3,178	-	53	17	1,487
Upstate N.Y.	199	414	8	214	298	-	7	6	816
N.Y. City	1,712	2,294	-	1,951	1,942	-	23	3	-
N.J.	399	790	-	555	521	-	16	4	460
Pa.	830	1,105	11	400	417	-	7	4	211
E.N. CENTRAL	3,081	2,994	40	1,337	1,363	1	22	22	82
Ohio	474	400	12	202	196	-	3	12	8
Ind.	169	94	9	101	112	-	1	4	10
Ill.	1,412	1,393	5	686	721	1	15	2	13
Mich.	622	770	14	296	271	-	2	1	8
Wis.	404	337	-	52	63	-	1	3	43
W.N. CENTRAL	730	440	26	308	322	38	3	19	801
Minn.	51	45	5	74	61	-	1	-	121
Iowa	31	40	5	23	47	-	1	-	138
Mo.	553	307	5	149	138	28	1	17	9
N. Dak.	1	1	1	2	6	-	-	-	106
S. Dak.	-	1	-	15	24	8	-	1	95
Nebr.	1	11	3	13	11	1	-	-	8
Kans.	93	35	7	32	35	1	-	1	324
S. ATLANTIC	5,792	7,614	14	2,468	2,559	4	16	56	1,100
Del.	136	97	3	25	17	-	-	4	137
Md.	417	615	2	178	237	1	4	7	324
D.C.	265	478	-	79	118	-	1	1	13
Va.	442	586	1	169	221	2	1	4	190
W. Va.	11	20	1	58	42	-	1	3	24
N.C.	1,491	1,182	3	323	339	1	-	25	18
S.C.	785	938	1	249	248	-	1	5	95
Ga.	1,170	1,871	1	546	522	-	-	5	229
Fla.	1,075	1,827	2	841	815	-	8	2	70
E.S. CENTRAL	2,637	2,790	1	886	913	5	3	39	93
Ky.	89	53	-	236	219	1	-	5	50
Tenn.	709	942	1	245	257	4	-	31	-
Ala.	993	1,019	-	238	242	-	-	3	43
Miss.	846	776	-	167	195	-	3	-	-
W.S. CENTRAL	3,766	4,557	1	1,434	1,570	21	6	58	487
Ark.	505	386	-	106	141	13	-	8	25
La.	1,561	1,552	-	108	140	-	-	-	5
Okla.	177	111	-	95	106	8	-	50	233
Tex.	1,523	2,508	1	1,125	1,183	-	6	-	224
MOUNTAIN	234	352	13	350	375	20	2	6	102
Mont.	7	6	1	-	6	10	-	3	12
Idaho	1	3	1	14	4	-	1	1	-
Wyo.	1	5	-	-	3	2	-	-	23
Colo.	34	56	4	29	35	3	1	-	9
N. Mex.	27	21	2	47	49	5	-	1	5
Ariz.	117	225	2	166	203	-	-	-	49
Utah	6	5	3	52	30	-	-	1	1
Nev.	41	31	-	42	45	-	-	-	3
PACIFIC	1,092	1,653	25	3,204	2,938	2	72	4	295
Wash.	49	115	-	187	185	-	4	-	-
Oreg.	26	49	1	80	69	-	-	1	2
Calif.	1,008	1,481	24	2,757	2,515	1	65	3	280
Alaska	4	4	-	33	46	1	-	-	13
Hawaii	5	4	-	147	123	-	3	-	-
Guam	2	-	-	34	6	-	3	-	-
P.R.	195	291	-	135	141	-	1	-	31
V.I.	43	75	-	3	2	-	-	-	-
Amer. Samoa	-	-	-	-	2	-	1	-	-
C.N.M.I.	5	2	-	38	8	-	1	-	-

U: Unavailable

TABLE III. Deaths in 121 U.S. cities,* week ending August 8, 1992 (32nd Week)

Reporting Area	All Causes, By Age (Years)						P&I†
	All Ages	≥65	45-64	25-44	1-24	<1	Total
NEW ENGLAND	492	344	78	41	13	16	41
Boston, Mass.	151	88	32	19	5	7	22
Bridgeport, Conn.	31	23	3	3	1	1	-
Cambridge, Mass.	18	14	3	1	-	-	3
Fall River, Mass.	18	13	5	-	-	-	-
Hartford, Conn.	35	26	6	2	-	1	-
Lowell, Mass.	19	16	3	-	-	-	1
Lynn, Mass.	18	16	2	-	-	-	2
New Bedford, Mass.	19	14	1	3	1	-	1
New Haven, Conn.	42	26	8	3	1	4	5
Providence, R.I.	23	19	2	1	1	-	-
Somerville, Mass.	9	6	1	1	1	-	-
Springfield, Mass.	41	25	6	7	2	1	2
Waterbury, Conn.	23	18	2	1	1	1	1
Worcester, Mass.	45	40	4	-	-	1	4
MID. ATLANTIC	2,692	1,719	558	304	62	49	128
Albany, N.Y.	62	39	17	2	-	4	2
Allentown, Pa.	14	10	2	2	-	-	1
Buffalo, N.Y.	101	68	20	9	1	3	3
Camden, N.J.	35	17	10	6	1	1	2
Elizabeth, N.J.	20	15	3	1	-	1	-
Erie, Pa.§	57	41	12	-	4	-	3
Jersey City, N.J.	44	31	4	2	-	7	1
New York City, N.Y.	1,424	872	299	205	31	17	57
Newark, N.J.	56	25	20	8	-	3	5
Paterson, N.J.	30	21	5	4	-	-	-
Philadelphia, Pa.	392	261	84	30	11	6	27
Pittsburgh, Pa.§	53	38	10	4	1	-	4
Reading, Pa.	21	15	3	2	1	-	2
Rochester, N.Y.	118	81	24	8	3	2	4
Schenectady, N.Y.	27	18	5	1	3	-	-
Scranton, Pa.§	22	21	1	-	-	-	1
Syracuse, N.Y.	120	81	23	8	5	3	7
Trenton, N.J.	40	24	8	6	-	2	4
Utica, N.Y.	17	15	2	-	-	-	-
Yonkers, N.Y.	39	26	6	6	1	-	5
E.N. CENTRAL	1,974	1,231	385	212	94	52	83
Akron, Ohio	43	34	5	2	1	1	2
Canton, Ohio	34	21	9	3	1	-	1
Chicago, Ill.	410	138	100	111	54	7	9
Cincinnati, Ohio	116	81	23	6	3	3	11
Cleveland, Ohio	135	88	30	9	5	3	3
Columbus, Ohio	145	98	34	9	3	1	7
Dayton, Ohio	94	68	15	8	2	1	4
Detroit, Mich.	215	130	41	22	9	13	7
Evansville, Ind.	46	38	4	3	-	1	1
Fort Wayne, Ind.	58	41	9	2	6	-	6
Gary, Ind.	20	13	4	3	-	-	-
Grand Rapids, Mich.	64	50	6	2	2	4	8
Indianapolis, Ind.	159	114	27	11	2	5	9
Madison, Wis.	31	22	8	1	-	-	1
Milwaukee, Wis.	118	84	23	4	2	5	6
Peoria, Ill.	39	27	10	-	1	1	3
Rockford, Ill.	37	26	6	3	1	1	1
South Bend, Ind.	43	30	7	3	1	2	1
Toledo, Ohio	102	79	13	7	1	2	2
Youngstown, Ohio	65	49	11	3	-	2	1
W.N. CENTRAL	736	537	105	46	29	19	35
Des Moines, Iowa	71	55	7	5	2	2	6
Duluth, Minn.	29	24	4	1	-	-	-
Kansas City, Kans.	29	22	5	-	1	1	-
Kansas City, Mo.	112	71	19	11	4	7	6
Lincoln, Nebr.	28	21	4	3	-	-	-
Minneapolis, Minn.	155	113	31	7	3	1	13
Omaha, Nebr.	91	72	10	6	3	-	5
St. Louis, Mo.	116	80	17	6	9	4	-
St. Paul, Minn.	53	41	5	1	3	3	3
Wichita, Kans.	52	38	3	6	4	1	2
S. ATLANTIC	1,271	763	270	139	54	45	58
Atlanta, Ga.	123	62	32	21	7	1	7
Baltimore, Md.	253	146	51	31	14	11	15
Charlotte, N.C.	76	49	19	1	2	5	4
Jacksonville, Fla.	116	81	23	5	5	2	3
Miami, Fla.	101	63	25	6	4	3	1
Norfolk, Va.	56	41	5	7	2	1	6
Richmond, Va.	67	34	12	14	4	3	3
Savannah, Ga.	33	20	7	2	2	2	3
St. Petersburg, Fla.	48	37	5	2	1	3	-
Tampa, Fla.	141	94	28	11	2	6	7
Washington, D.C.	237	121	59	38	11	8	9
Wilmington, Del.	20	15	4	1	-	-	-
E.S. CENTRAL	697	467	126	50	22	32	46
Birmingham, Ala.	115	74	24	7	2	8	4
Chattanooga, Tenn.	75	59	7	5	2	2	4
Knoxville, Tenn.	48	33	11	2	2	-	4
Lexington, Ky.	70	47	13	7	1	2	8
Memphis, Tenn.	160	100	35	11	5	9	15
Mobile, Ala.	67	46	6	9	2	4	4
Montgomery, Ala.	39	23	6	3	3	4	1
Nashville, Tenn.	123	85	24	6	5	3	6
W.S. CENTRAL	1,254	746	279	142	52	35	62
Austin, Tex.	51	34	9	6	2	-	6
Baton Rouge, La.	47	30	10	7	-	-	2
Corpus Christi, Tex.	58	38	10	4	5	1	-
Dallas, Tex.	224	130	43	28	13	10	4
El Paso, Tex.	65	32	21	8	3	1	5
Ft. Worth, Tex.	75	48	12	5	2	8	2
Houston, Tex.	316	178	63	55	12	8	26
Little Rock, Ark.	70	44	19	5	2	-	5
New Orleans, La.	40	21	10	7	1	1	-
San Antonio, Tex.	178	113	46	6	9	4	5
Shreveport, La.	55	32	16	5	1	1	3
Tulsa, Okla.	75	46	20	6	2	1	4
MOUNTAIN	753	522	122	71	21	17	48
Albuquerque, N.M.	76	45	15	13	2	1	1
Colo. Springs, Colo.	43	30	7	4	2	-	4
Denver, Colo.	86	57	16	10	1	2	3
Las Vegas, Nev.	131	86	27	14	2	2	6
Ogden, Utah	21	19	2	-	-	-	3
Phoenix, Ariz.	153	106	20	10	7	10	18
Pueblo, Colo.	24	20	4	-	-	-	1
Salt Lake City, Utah	83	61	9	9	4	-	5
Tucson, Ariz.	136	98	22	11	3	2	7
PACIFIC	1,728	1,142	284	201	57	41	87
Berkeley, Calif.	21	12	4	3	-	2	2
Fresno, Calif.	66	43	13	5	3	2	7
Glendale, Calif.	15	14	1	-	-	-	2
Honolulu, Hawaii	76	56	12	6	-	2	7
Long Beach, Calif.	91	69	8	9	1	4	9
Los Angeles, Calif.	408	242	76	54	26	10	11
Pasadena, Calif.	30	24	2	3	-	1	5
Portland, Oreg.	136	99	19	12	5	1	5
Sacramento, Calif.	169	108	35	15	4	4	16
San Diego, Calif.	128	80	17	21	6	4	8
San Francisco, Calif.	142	89	21	30	1	1	-
San Jose, Calif.	146	102	22	13	4	5	10
Santa Cruz, Calif.	29	21	4	4	-	-	-
Seattle, Wash.	138	98	25	13	2	-	1
Spokane, Wash.	48	35	4	7	1	1	-
Tacoma, Wash.	85	50	21	6	4	4	4
TOTAL	11,597¶	7,471	2,207	1,206	404	306	588

*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

Infant Deaths — Continued

References
1. Willinger M, James LS, Catz C. Defining the sudden infant death syndrome (SIDS): deliberations of an expert panel convened by the National Institute of Child Health and Human Development. Pediatr Pathol 1991;11:677–84.
2. Adams MM. The descriptive epidemiology of sudden infant deaths among natives and whites in Alaska. Am J Epidemiol 1985;122:637–43.
3. Fleshman JK, Peterson DR. The sudden infant death syndrome among Alaska Natives. Am J Epidemiol 1977;105:555–8.
4. Ruzicka LT, Lopez AD. The use of cause-of-death statistics for health situation assessment: national and international experiences. World Health Stat Q 1990;43:249–58.
5. Kircher T. The autopsy and vital statistics. Hum Pathol 1990;21:166–73.
6. NCHS. Annotated bibliography of cause-of-death validation studies: 1958–1980—data evaluation and methods research. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, CDC, 1982. (Vital and health statistics; series 2, no. 89).
7. Engel LW, Strauchen JA, Chiazze L, Heid M. Accuracy of death certification in an autopsied population with specific attention to malignant neoplasms and vascular diseases. Am J Epidemiol 1980;111:99–112.
8. Durfee MJ, Gellert GA, Tilton-Durfee D. Origins and clinical relevance of child death review teams. JAMA 1992;267:3172–5.

Ectopic Pregnancy — United States, 1988–1989

Although the number and rate of ectopic pregnancies in the United States increased from 1970 through 1987, they stabilized from 1987 through 1989 (*1*). This report presents data regarding the number and rate of ectopic pregnancies and ectopic pregnancy-related deaths in the United States from 1988 through 1989 and compares those data with information reported since 1970.

Data were obtained from the National Hospital Discharge Survey (NHDS), conducted by CDC's National Center for Health Statistics (NCHS). Information on deaths was obtained from death certificate data compiled by NCHS. Estimates of hospitalization for ectopic pregnancy are rounded to the nearest 100.

During 1989, an estimated 88,400 (95% confidence interval [CI] = 70,600–106,100) U.S. women were hospitalized for ectopic pregnancy, a 10% increase over the 1988 estimate of 80,700 (95% CI = 67,200–94,200) but approximating the estimate for 1987. From 1970 (when surveillance of ectopic pregnancy began) through 1989, the rate of ectopic pregnancies per 1000 reported pregnancies* increased almost fourfold, from 4.5 to 16.1 (Table 1). Similarly, the rate of ectopic pregnancies per 1000 live births increased almost fivefold, from 4.8 to 22.0, while the rate per 10,000 reproductive-aged women (aged 15–44 years) increased more than threefold, from 4.2 to 15.5 (Table 1).

From 1988 through 1989, the highest rate of ectopic pregnancy occurred for women aged ≥30 years, the same as in previous years (*1*). The rate for black and other minority women was 32% higher than that for white women. When rates were calculated by geographic region, the highest rate of ectopic pregnancy occurred in the South†, the same as reported during 1985–1987 (*1,2*); the lowest rate occurred in the Midwest.

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*Includes live-born infants, legally induced abortions, and ectopic pregnancies.

†Regions defined by the Bureau of the Census.

Ectopic Pregnancy — Continued

Although the risk for death associated with ectopic pregnancy decreased from 1970 through 1987 (Figure 1), slight increases occurred in 1988 and 1989. From 1970 through 1989, the case-fatality rate decreased 90%, from 35.5 to 3.8 deaths per 10,000 ectopic pregnancies.

In 1988, 44 women died from complications of ectopic pregnancy[§] — 14 more than reported in 1987 (*1*) (case-fatality rate: 5.4 deaths per 10,000 ectopic pregnancies). In 1989, 34 deaths occurred as a result of ectopic pregnancy complications (case-fatality rate: 3.8 deaths per 10,000 ectopic pregnancies).

For black women and women in other minority groups, the risk for death from ectopic pregnancy was more than three times that for white women in 1988 and almost five times the risk in 1989. The racial disparity during 1988 and 1989 increased from figures reported in 1986 and 1987 and was similar to figures reported from 1983 through 1985 (*2*)—when fourfold higher rates occurred among black women and women in other minority groups (Figure 1).

Reported by: Pregnancy and Infant Health Br, Div of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: In the United States, complications from ectopic pregnancy are the leading cause of pregnancy-related death during the first trimester (*3,4*). Factors

[§]Ectopic pregnancy mortality data were obtained from death certificate data compiled by NCHS.

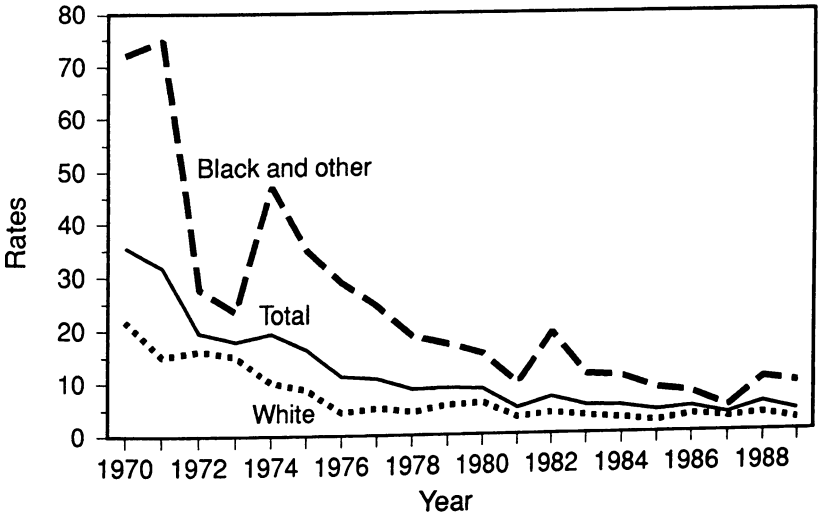
TABLE 1. Number and rates of ectopic pregnancy, by year — United States, 1970–1989

Year	No.*	Rate		
		Reported pregnancies[†]	Live births[§]	Reproductive-aged women[¶]
1970	17,800	4.5	4.8	4.2
1971	19,300	4.8	5.4	4.4
1972	24,500	6.3	7.5	5.5
1973	25,600	6.8	8.2	5.6
1974	26,400	6.7	8.4	5.7
1975	30,500	7.6	9.8	6.5
1976	34,600	8.3	11.0	7.2
1977	40,700	9.2	12.3	8.3
1978	42,400	9.4	12.8	8.5
1979	49,900	10.4	14.3	9.9
1980	52,200	10.5	14.5	9.9
1981	68,000	13.6	18.7	12.7
1982	61,800	12.3	17.0	11.5
1983	69,600	14.0	19.2	12.6
1984	75,400	14.9	20.6	13.6
1985	78,400	15.2	20.9	14.0
1986	73,700	14.3	19.7	12.8
1987	88,000	16.8	23.1	15.3
1988	80,700	15.1	20.7	14.4
1989	88,400	16.1	22.0	15.5
Total	**1,047,900**	**11.3**	**14.8**	**10.3**

*Estimated from the National Hospital Discharge Survey conducted by CDC's National Center for Health Statistics; rounded to the nearest 100.
[†]Per 1000 reported pregnancies.
[§]Per 1000 live births.
[¶]Per 10,000 women aged 15–44 years.

Ectopic Pregnancy — Continued

FIGURE 1. Ectopic pregnancy death rates*, by race — United States, 1970–1989



*Per 10,000 ectopic pregnancies.

accounting for the decreased occurrence of ectopic pregnancy in 1988 include heightened awareness of ectopic pregnancy among health-care providers and patients, earlier diagnosis, and more frequent use of conservative ambulatory therapy (*5–8*). In addition, this decrease may also reflect changes in the NHDS sampling frame implemented in 1988. However, variability of the data, as indicated by wide confidence intervals, does not permit meaningful conclusions about changes in the estimates of ectopic pregnancies for 1988 and 1989.

The increase in case-fatality rates in 1988 resulted from the simultaneous increase in the number of deaths reported and the decrease in the estimated number of women hospitalized with ectopic pregnancy. Although the race-specific risk for death associated with ectopic pregnancy requires further assessment, all rates employing race-specific estimates must be interpreted cautiously because race was unreported for almost 10% of ectopic pregnancy cases during the time interval of the report.

CDC is analyzing data from a case-control study that will increase knowledge about risk factors for ectopic pregnancies among a predominantly black population. In addition, CDC will be analyzing data from the National Prospective Maternal Mortality Surveillance System, initiated in 1987, to assess deaths due to complications of ectopic pregnancy during 1987–1990.

References

1. Nederlof KP, Lawson HW, Saftlas AF, Atrash HK, Finch EL. Ectopic pregnancy surveillance, United States, 1970–1987. In: CDC surveillance summaries, December 1990. MMWR 1990; 39(no. SS-4):9–17.
2. Lawson HW, Atrash HK, Saftlas AF, Finch EL. Ectopic pregnancy surveillance, United States, 1970–1986. In: CDC surveillance summaries, September 1989. MMWR 1989;38(no. SS-2): 1–10.
3. Leach R, Ory S. Management of ectopic pregnancy. Am Fam Physician 1990;41:1215–22.
4. Ory S. New options for diagnosis and treatment of ectopic pregnancy. JAMA 1992;267:534–7.
5. Vermesh M. Conservative management of ectopic gestation. Fertil Steril 1989;51:559–67.

Ectopic Pregnancy — Continued

6. Stovall G, Ling F, Buster J. Outpatient chemotherapy of unruptured ectopic pregnancy. Fertil Steril 1989;51:435–8.
7. Garcia A, Aubert J, Sama J, Josimovich J. Expectant management of presumed ectopic pregnancy. Fertil Steril 1987;48:395–400.
8. Stabile I, Grudzinskas JG. Ectopic pregnancy: a review of incidence, etiology and diagnostic aspects. Obstet Gynecol Surv 1990;45:335–47.

Notices to Readers

First International Latex Conference

CDC and the Food and Drug Administration (FDA) will cosponsor the first International Latex Conference November 5–7, 1992, in Baltimore. The conference will provide an opportunity for health-care professionals, scientists, industry, and regulatory agencies to present data and exchange information about the issues of hypersensitivity reaction to latex medical devices. The program will include speakers, oral and poster presentations, and a panel discussion. Topics will include latex chemistry, clinical studies, protein quantification and identification, epidemiology of latex hypersensitivity, diagnostic testing methods, prevention strategies, and approaches of manufacturers and producers.

Additional information is available from the FDA International Latex Conference, in care of Crosspaths Management Systems, Inc., Two Wisconsin Circle, Suite 660, Chevy Chase, MD 20815; telephone (800) 5CPATHS ([800] 527-2847).

Training Courses for Hospital Epidemiologists

CDC, the Society for Hospital Epidemiology of America, and the American Hospital Association (AHA), will cosponsor two training courses for hospital epidemiologists. One is scheduled for September 17–20, 1992, in Atlanta; the other, November 19–22, 1992, in Park City, Utah.

The courses, intended for infectious disease fellows and new hospital epidemiologists, will emphasize hands-on exercises in which participants work in small groups to detect, investigate, and control epidemiologic problems encountered in the hospital setting. These working sessions are supplemented with lectures and seminars covering fundamental aspects of hospital epidemiology.

Course information is available from Gina Pugliese, AHA, 840 North Lake Shore Drive, Chicago, IL 60611; telephone (312) 280-6404; fax (312) 280-6228.

Announcement of Meeting About Revising the AIDS Surveillance Case Definition

On September 2, 1992, CDC will hold an open meeting in Atlanta to review information on illnesses that have been suggested for addition to the acquired immunodeficiency syndrome (AIDS) surveillance case definition. Data relevant to expansion of the AIDS surveillance case definition and to public health reporting and surveillance will be heard. Information from this meeting will be considered by CDC

Notices to Readers — Continued

in completing the proposed expansion of the surveillance case definition, which was made available for public comment on November 15, 1991.

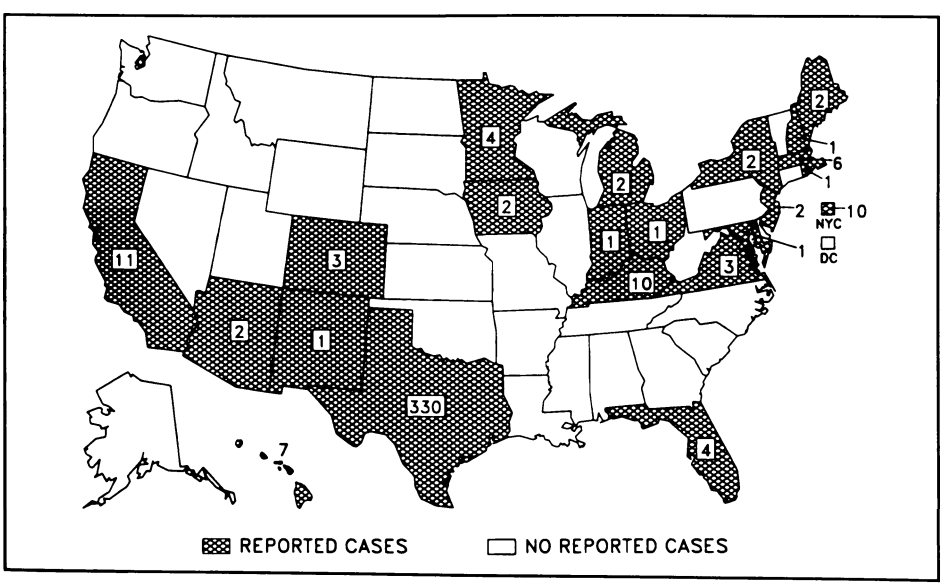
Additional information is available from PACE Enterprises, Inc., 17 Executive Park Drive, Suite 200, Atlanta, GA 30329; telephone: (404) 633-8610; fax (404) 633-8745.

Errata: Vol 41. No. 30

In the article "Arboviral Disease—United States, 1991," in the first paragraph on page 545, the first sentence should read "During 1991, state and local health departments reported *128* cases of human arboviral encephalitis to CDC." In the second paragraph on page 545, the third sentence should read "Additional sporadic SLE cases were confirmed from Arkansas (three), California (three), Florida (one), Louisiana (one), *North Dakota (one)*, Texas (two) and Washington (one)." In the second paragraph on page 546, the fourth sentence should read "Six additional human cases occurred in Georgia (two), Michigan (two), Louisiana (one) and *Rhode Island (one)*."

On page 555, in Table 1 of the article "Trends in Ischemic Heart Disease Mortality—United States, 1980–1988," the age-adjusted death rate in 1980 for men in Indiana should read *839.3*.

Reported cases of measles, by state — United States, weeks 26–31, 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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