CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

November 6, 1992 / Vol. 41 / No. 44

MMWR
MORBIDITY AND MORTALITY WEEKLY REPORT

CDC: the Nation's Prevention Agency

On October 27, 1992, CDC's name was changed to the Centers for Disease Control and Prevention (with "CDC" still to be used as the acronym). This change was enacted by Congress, as part of the Preventive Health Amendments of 1992, to recognize CDC's leadership role in the prevention of disease, injury, and disability. In enacting this change, Congress also specified that the agency continue to use the acronym "CDC" because of its recognition within the public health community and among the public.

CDC's new name reflects the evolution of its mission since 1946 as an agency that provides science-based assistance to state and local health departments in the control and prevention of disease, injury, and disability. In 1946, the Communicable Disease Center was created from the Office of Malaria Control in War Areas, an agency that had been established in 1942 to limit the impact of malaria and other mosquitoborne diseases on U.S. military personnel training in the southeastern United States (*1,2*). The change in name in 1946 reflected an assignment of responsibility for assisting states with the control of a broader range of communicable diseases.

In 1970, CDC was renamed the Center for Disease Control to reflect responsibilities for noncommunicable disease problems. The scope of mission expanded rapidly to include programs in areas such as occupational and environmental health, family planning and reproductive health, and chronic diseases. A major reorganization of CDC in 1980, and its renaming to the Centers for Disease Control, emphasized the importance of health promotion and education in the agency's mission. During the 1980s, CDC redoubled efforts to reduce the impact of smoking-related diseases, injuries, and other problems, while facing the new challenge of the human immunodeficiency virus/acquired immunodeficiency syndrome epidemic. Recent milestones in CDC's evolution include the creation of centers for chronic disease prevention and health promotion and for injury prevention and control. The National Center for Health Statistics has also recently joined CDC. These changes underscore CDC's commitment to the prevention of disease, injury, and disability.

Reported by: Office of the Director, and Office of the Director, Epidemiology Program Office, CDC.

References

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National Diabetes Month, 1992

November is National Diabetes Month. During this month, nationwide educational activities are planned to increase the public's awareness of diabetes. Articles in this issue of *MMWR* focus on the incidence of treatment for end-stage renal disease attributed to diabetes mellitus in the United States and Colorado and hospitalizations for diabetic ketoacidosis in Washington state. Additional information is available from the American Diabetes Association, National Center, 1600 Duke Street, Alexandria, VA 22314; telephone (800) 232-3472 ([800] ADA-DISC).

Current Trends

Incidence of Treatment for End-Stage Renal Disease Attributed to Diabetes Mellitus — United States, 1980–1989

End-stage renal disease (ESRD) is defined as renal insufficiency requiring dialysis or kidney transplantation for survival. In the United States, diabetes mellitus is the major cause of ESRD (*1*). This report summarizes trends during the 1980s in the incidence of treatment for ESRD attributable to diabetes mellitus (ESRD-DM).*

Because 90% of ESRD treatment in the United States is reimbursed by Medicare's ESRD program, Medicare's medical information system has been used for surveillance of ESRD-DM (*2,3*). Incidence is defined as the initiation of treatment for ESRD-DM.† Estimates of the number of persons with diabetes were derived from CDC's National Health Interview Survey (NHIS) and were used in the calculation of rates (*3*). Because of limitations in the sample size of the NHIS, race-specific analysis in this report is presented only for blacks and whites. Rates were age-adjusted by the direct method (*4*) using the estimated 1980 population of persons with diabetes as the standard.

From 1980 through 1989, new cases of ESRD-DM increased from 2220 to 13,332. Similarly, the age-adjusted incidence of ESRD-DM increased more than fivefold, from 38.4 to 202.0 per 100,000 persons with diabetes. Although the incidence varied inversely with age, age differences narrowed during the decade because incidence increased at a greater rate among the older age groups (Figure 1). Incidence among persons with diabetes increased threefold among those aged <45 years but increased 12-fold among those aged ≥75 years.

*These data are part of an ongoing national diabetes surveillance system that provides estimates of the prevalence and incidence of diabetes and its complications. A copy of the most recent surveillance report is available from the Division of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC, Mailstop K-10, 4770 Buford Highway, NE, Atlanta, GA 30341-3724.

†Incidence data were provided by the Bureau of Data Management and Strategy, Health Care Financing Administration, from Medicare's ESRD program management and medical information system.

End-Stage Renal Disease — Continued

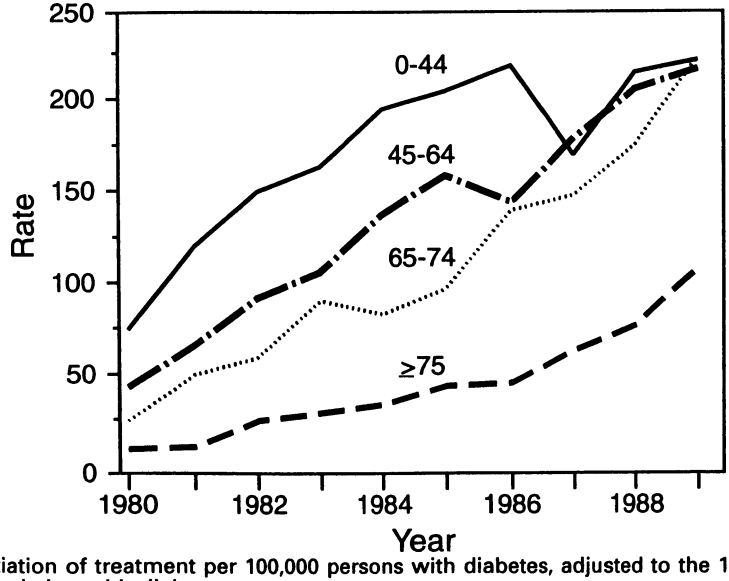
The age-adjusted incidence of ESRD-DM was greater for blacks with diabetes than for whites with diabetes and highest for black females with diabetes (Figure 2). In 1989, the age-adjusted ESRD-DM incidence for black males was 1.4 times that for white males (284.6 versus 201.3 per 100,000 persons with diabetes), and the ESRD-DM incidence for black females was 2.3 times that for white females (352.8 versus 150.8 per 100,000 persons with diabetes). Among whites with diabetes, the incidence was greater in males than females. Among blacks with diabetes, during 1985–1986, the incidence in black females began to exceed that in black males. The rate of increase in ESRD-DM incidence was similar for blacks and whites but was higher for females than for males (approximately fivefold versus fourfold increase).

Reported by: Div of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: The dramatic increase in occurrence of ESRD-DM during the 1980s may have reflected increases both in the incidence and in the treatment of this problem. Use of treatment may be influenced not only by availability but also by changes in the definition of eligibility for treatment (*3*). In addition, because Medicare does not reimburse approximately 10% of ESRD treatment and does not include as incident cases those persons who are neither candidates for treatment nor who choose not to be treated (*3*), the number of cases may be underreported.

Age-specific differences in incidence of ESRD-DM decreased during the decade because of greater increases in rates among older age groups. Because ESRD cases attributed to noninsulin-dependent diabetes mellitus (NIDDM) are more frequent in

FIGURE 1. Age-adjusted incidence* of end-stage renal disease attributed to diabetes mellitus, among persons with diabetes, by age group (years) — United States, 1980–1989



*Initiation of treatment per 100,000 persons with diabetes, adjusted to the 1980 U.S. standard population with diabetes.

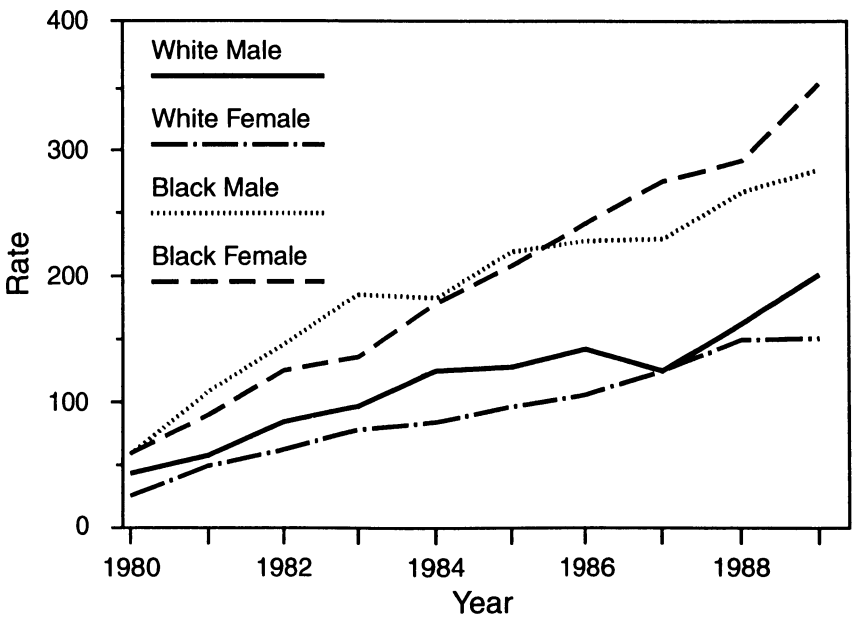
End-Stage Renal Disease — Continued

older age groups, the increased incidence in these age groups suggests that ESRD-DM associated with NIDDM is increasing (*5*).

The findings in this report indicate that the incidence of ESRD-DM was higher among blacks than whites. Rates for the incidence of ESRD and ESRD-DM among other minority groups are also higher than for whites (*6*). Factors accounting for these differences may include greater severity of diabetes, higher prevalence of hypertension, higher prevalence of uncontrolled diabetes and hypertension, and lack of access to preventive care and treatment (*3,6,7*).

Three levels of prevention efforts may help reduce the incidence of ESRD-DM. The first is the primary prevention of NIDDM (*5*), which accounts for 90%–95% of all incident cases of diabetes. Effective interventions using dietary and physical activity strategies are needed for persons in minority groups and others who may be at high risk for the development of NIDDM (*5*). The second level is the prevention of diabetic nephropathy, which is the precursor to ESRD-DM. Although strategies for preventing diabetic nephropathy are not well established (*8,9*), the efficacy of controlling hyperglycemia as a means for preventing diabetic nephropathy is being assessed by the National Institute of Diabetes and Digestive and Kidney Diseases in its Diabetes Control and Complications Trial (*10*). The third level of prevention efforts is to slow the progression of diabetic nephropathy to ESRD-DM. These efforts should focus on detecting early markers of renal disease and offering at-risk persons intensive interventions, which include 1) controlling hypertension, 2) limiting protein intake, 3) controlling hyperglycemia, 4) promptly treating urinary tract infections, and 5) iden-

FIGURE 2. Age-adjusted incidence* of end-stage renal disease attributed to diabetes mellitus, among persons with diabetes, by race and sex — United States, 1980–1989



*Initiation of treatment per 100,000 persons with diabetes, adjusted to the 1980 U.S. standard population with diabetes.

End-Stage Renal Disease — Continued

tifying and eliminating barriers to preventive care and treatment (e.g., financial, geographic, and cultural barriers) (*6–9*).

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Hospitalizations for Diabetic Ketoacidosis — Washington State, 1987–1989

Diabetic ketoacidosis (DKA) is an acute metabolic complication of diabetes mellitus that can be life threatening. Although DKA is often preventable (*1–3*), approximately 84,000 DKA-associated hospitalizations and 1800 DKA-associated deaths occurred in the United States during 1988 (*4*). The Washington Department of Health (WDH) monitors DKA-associated hospitalizations to assist its chronic disease programs in preventing DKA-associated hospitalizations and deaths. This report summarizes surveillance of DKA hospitalizations among Washington state residents from 1987 through 1989.

The analysis included all hospitalizations* in Washington except those from Veterans Administration, military, and psychiatric facilities. The hospitalizations included any patient for whom DKA (*International Classification of Diseases, Ninth Revision, Clinical Modification* [ICD-9-CM], diagnosis code 250.1) was recorded on state hospital discharge records. Estimates of the number of persons with diabetes were calculated by applying 1988 estimates of diabetes prevalence from CDC's National Health Interview Survey to Washington population estimates for 1987–1989.

During 1987–1989, 4377 DKA-associated hospitalizations occurred among Washington residents. Although the statewide DKA-associated hospitalization incidence rate for the 3-year period was 12.5 per 1000 persons with diabetes, rates by county of residence ranged from 7.3 to 27.9 per 1000.

*Includes multiple admissions for some patients.

Diabetic Ketoacidosis — Continued

Rates also varied by age and sex. Rates were higher for younger persons; persons aged 0–44 years accounted for 72% of all admissions for DKA. Within this age group, rates were substantially higher for females (61.2 per 1000) than for males (42.5 per 1000) (Figure 1).

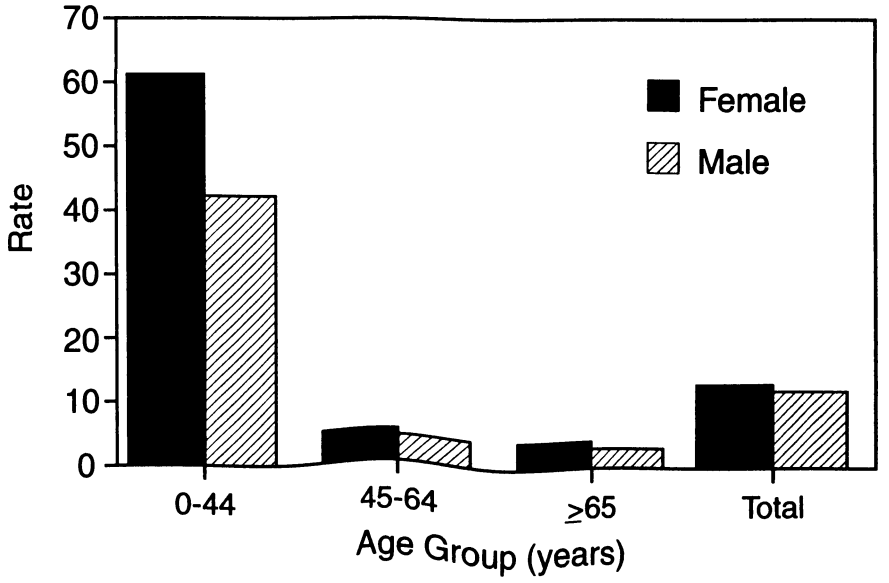
More than one third (36%) of DKA-associated hospitalizations occurred among persons who had at least one other admission for DKA during the 3-year period; persons aged <45 years accounted for nearly half (45%) of these repeat admissions.

Persons with diabetes who were hospitalized for DKA were more likely to receive Medicaid (27%) than were persons with diabetes hospitalized for all causes, including DKA (10%). Younger persons (i.e., those aged <45 years) and persons with repeat admissions were also more likely to receive Medicaid. Thirty-three percent of persons aged <45 years and 30% of persons who had repeat admissions used Medicaid to cover the cost of hospitalization. In contrast, only 10% of those aged ≥45 years and 15% of persons admitted only once during the 3-year period received Medicaid.

Reported by: C Shaw, MPH, Washington Dept of Health. Div of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: Manifestations of DKA include acute or subacute alteration of mental state, fatigue, weight loss, blurred vision, thirst, excessive urination, enuresis, abdominal pain, nausea, and vomiting. DKA may occur in persons with insulin-dependent diabetes mellitus (IDDM) who have new onset of disease, who do not take insulin, or who do not increase their insulin dosage during illness. Among persons with noninsulin-dependent diabetes mellitus (NIDDM), DKA may be associated with severe acute stress (e.g., pneumonia or myocardial infarction).

FIGURE 1. Rates* of diabetic ketoacidosis-associated hospitalizations,† by age group and sex — Washington State, 1987–1989



*Per 1000 persons with diabetes.
†Includes multiple admissions for some patients.

Diabetic Ketoacidosis — Continued

Basic considerations for prevention of DKA are for both patients and health-care providers to 1) recognize that certain persons with diabetes (e.g., those with psychosocial or major emotional problems, adolescents, and those with physical illnesses) may have difficulty adhering to a prescribed program of insulin therapy and dietary control, 2) recognize indicators of inappropriate therapy, and 3) be knowledgeable about proper techniques for monitoring and management of diabetes (*3*). Although all persons with diabetes should be taught to monitor their blood glucose levels, those at increased risk for DKA should receive intensified instruction that emphasizes the importance of such monitoring. In addition, persons with diabetes should monitor ketones in their urine when their blood glucose level is 240 mg/dL or higher and/or acute illness develops (*3*). Persons with diabetes should understand the importance of contacting their health-care providers immediately if their blood glucose level remains higher than 240 mg/dL, ketonuria develops, or symptoms of illness persist. Persons with diabetes should use guidelines for self-care (*5*); health-care providers should use guidelines for the clinical management of DKA (*6*).

In addition to treating an episode of DKA, health-care providers should analyze antecedent or precipitating circumstances and take measures to prevent further episodes. The analysis should include assessment of the patient's self-care practices, precipitating illnesses, stressful life events, and behavioral or emotional problems. Referral to endocrinologists, psychosocial specialists, or both may be appropriate for patients having particular difficulty in management of IDDM (*3*).

Public health strategies may also assist in preventing the occurrence of DKA-associated hospitalizations and deaths. For example, state and county surveillance data, such as those developed by the WDH, assist public health practitioners and health-care providers in directing services toward populations with the greatest need. Ensuring availability of preventive diabetes education and access to health care are also important factors in reducing the burden associated with DKA.

The Washington Diabetes Control Program (WDCP) provides educational materials and technical assistance to community health centers and hospitals. The analysis in this report indicates that such resources can be directed toward counties in which rates of DKA are high and especially toward younger persons (i.e., those aged <45 years) and Medicaid recipients with diabetes. As a result of this analysis, the WDCP and the state Medicaid office are exploring a pilot project to target Medicaid beneficiaries hospitalized with DKA for intensive education and follow-up by chronic disease case managers.

References

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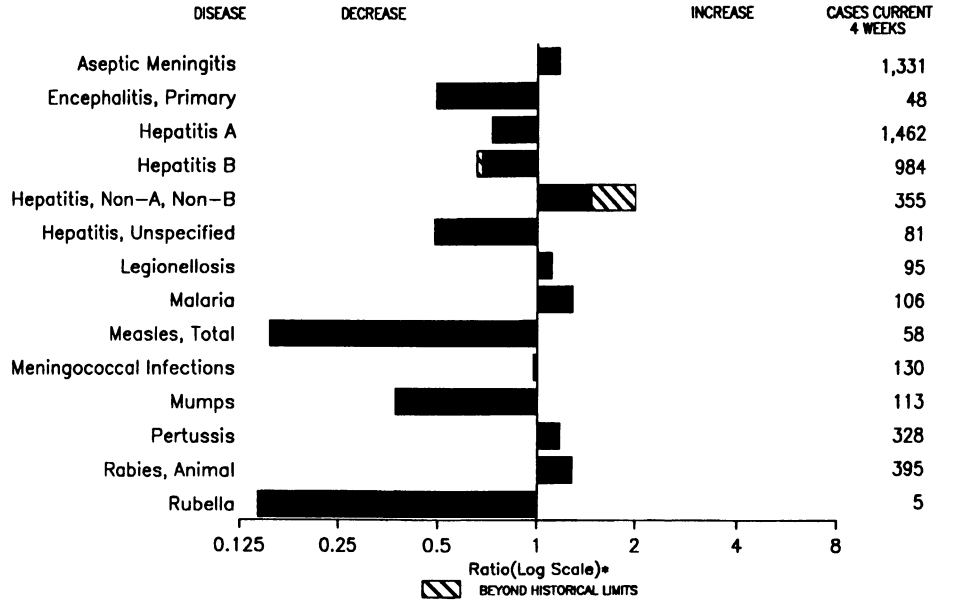
FIGURE I. Notifiable disease reports, comparison of 4-week totals ending October 31, 1992, with historical data — United States



*Ratio of current 4-week total to 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 31, 1992 (44nd Week)

	Cum. 1992		Cum. 1992
AIDS*	39,229	Measles: imported	118
Anthrax	1	indigenous	2,036
Botulism: Foodborne	16	Plague	11
Infant	44	Poliomyelitis, Paralytic†	-
Other	1	Psittacosis	79
Brucellosis	75	Rabies, human	-
Cholera	97	Syphilis, primary & secondary	28,150
Congenital rubella syndrome	8	Syphilis, congenital, age < 1 year§	1,639
Diphtheria	4	Tetanus	27
Encephalitis, post-infectious	98	Toxic shock syndrome	201
Gonorrhea	402,989	Trichinosis	23
Haemophilus influenzae (invasive disease)	1,101	Tuberculosis	18,580
Hansen Disease	130	Tularemia	141
Leptospirosis	38	Typhoid fever	333
Lyme Disease	6,502	Typhus fever, tickborne (RMSF)	420

*Updated monthly; last update October 31, 1992.
†Four cases of suspected poliomyelitis have been reported in 1992; 6 of the 9 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.
§Reports through second quarter 1992.

TABLE II. Cases of selected notifiable diseases, United States, weeks ending October 31, 1992, and November 2, 1991 (44th 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	39,229	9,157	558	98	402,989	507,887	17,391	13,122	5,931	625	1,094	6,502
NEW ENGLAND	1,447	341	24	-	8,662	12,239	507	487	90	21	45	1,431
Maine	44	36	3	-	76	139	28	19	6	-	2	5
N.H.	36	24	3	-	92	174	31	32	20	1	7	35
Vt.	23	21	5	-	23	49	11	12	11	-	2	6
Mass.	722	148	10	-	3,130	5,259	247	393	47	20	24	211
R.I.	84	112	3	-	575	1,061	130	18	6	-	10	261
Conn.	538	-	-	-	4,766	5,557	60	13	-	-	-	913
MID. ATLANTIC	10,273	749	22	7	39,599	60,328	1,331	1,656	304	19	289	3,716
Upstate N.Y.	1,304	389	-	-	8,589	11,017	286	419	182	9	108	2,259
N.Y. City	6,024	127	4	1	15,302	23,438	608	315	5	-	6	16
N.J.	1,805	-	-	-	1,240	9,712	206	422	87	-	34	536
Pa.	1,140	233	18	6	14,468	16,161	231	500	30	10	141	905
E.N. CENTRAL	3,477	1,475	142	28	77,860	94,414	2,404	1,983	1,165	34	294	130
Ohio	659	412	47	2	23,608	29,891	370	201	78	4	135	56
Ind.	342	195	11	11	7,692	9,606	705	672	554	13	37	30
Ill.	1,662	361	59	6	24,937	28,101	523	246	83	6	25	17
Mich.	623	476	22	9	18,237	20,363	130	504	378	11	66	27
Wis.	191	31	3	-	3,386	6,453	676	360	72	-	31	-
W.N. CENTRAL	1,110	496	36	6	20,231	25,102	2,297	571	246	32	69	298
Minn.	188	75	15	-	2,566	2,615	650	66	20	2	6	149
Iowa	78	80	-	3	1,331	1,714	47	31	5	4	16	26
Mo.	613	219	8	-	12,022	15,296	948	381	189	24	25	95
N. Dak.	8	1	3	-	52	70	102	1	4	1	2	1
S. Dak.	8	9	1	1	149	308	198	5	-	-	-	1
Nebr.	52	26	4	2	8	1,524	231	32	15	1	15	9
Kans.	163	86	5	-	4,103	3,575	121	55	13	-	5	17
S. ATLANTIC	8,687	1,455	142	43	123,695	150,116	1,116	2,165	819	112	165	558
Del.	112	51	6	-	1,514	2,459	50	183	170	1	23	191
Md.	1,115	185	13	-	13,747	16,845	197	336	32	9	31	154
D.C.	621	25	1	-	5,223	7,795	14	73	278	-	13	2
Va.	541	231	31	12	13,568	15,382	101	158	31	47	18	100
W. Va.	44	34	63	-	727	1,077	7	46	2	24	-	12
N.C.	590	184	24	-	21,140	30,482	101	371	78	-	34	69
S.C.	259	23	-	-	8,985	12,477	21	47	1	1	16	2
Ga.	1,144	187	2	-	34,709	33,307	162	257	102	-	7	3
Fla.	4,261	535	2	31	24,082	30,292	463	694	125	30	23	25
E.S. CENTRAL	1,204	457	21	-	41,007	52,566	278	1,120	1,659	2	54	57
Ky.	187	163	13	-	4,061	5,135	92	83	3	-	25	20
Tenn.	386	105	4	-	12,393	17,790	106	917	1,640	-	23	28
Ala.	416	119	3	-	14,648	17,423	46	116	15	1	6	9
Miss.	215	70	1	-	9,905	12,218	34	4	1	1	-	-
W.S. CENTRAL	3,753	1,054	53	5	44,568	57,091	1,703	1,580	139	143	21	105
Ark.	244	13	7	-	6,043	6,619	111	72	7	4	1	15
La.	633	58	8	1	12,438	13,173	190	154	70	3	4	5
Okla.	219	-	3	2	4,729	5,993	165	166	37	5	9	25
Tex.	2,657	983	35	2	21,358	31,306	1,237	1,188	25	131	7	60
MOUNTAIN	1,140	345	27	5	10,344	10,349	2,496	626	243	54	81	15
Mont.	18	11	1	1	102	84	81	32	27	1	9	-
Idaho	31	22	-	-	97	134	75	72	-	1	4	2
Wyo.	4	5	2	-	48	82	12	12	47	-	1	5
Colo.	354	105	9	1	3,681	2,894	677	94	80	23	17	-
N. Mex.	97	47	4	1	803	879	268	171	24	8	2	2
Ariz.	333	98	6	1	3,621	3,843	996	145	24	14	26	-
Utah	109	15	3	1	285	276	299	15	27	7	2	6
Nev.	194	42	2	-	1,707	2,157	88	85	14	-	20	-
PACIFIC	8,138	2,785	91	4	37,023	45,682	5,259	2,934	1,266	208	76	192
Wash.	458	-	1	-	3,133	4,023	677	295	131	8	12	13
Oreg.	257	-	-	-	1,411	1,739	387	233	65	9	1	-
Calif.	7,289	2,688	84	3	31,453	38,548	3,979	2,373	871	181	62	178
Alaska	13	16	6	-	577	743	62	16	4	1	-	-
Hawaii	121	81	-	1	449	629	154	17	195	9	1	1
Guam	-	2	-	-	50	27	5	1	-	6	-	1
P.R.	1,478	151	1	-	192	461	38	361	162	17	1	-
V.I.	9	-	-	-	86	324	4	7	-	-	-	-
Amer. Samoa	-	-	-	-	40	51	1	1	-	-	-	-
C.N.M.I.	-	-	-	-	67	75	3	-	-	-	-	-

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

*Updated monthly; last update October 31, 1992.

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending October 31, 1992, and November 2, 1991 (44th 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	837	8	2,036	-	118	9,015	1,807	21	2,105	101	2,310	2,303	-	148	1,302
NEW ENGLAND	41	-	56	-	13	84	115	-	16	5	203	262	-	6	4
Maine	1	-	-	-	4	7	9	-	-	-	11	54	-	1	-
N.H.	3	-	15	-	-	-	5	-	3	5	48	18	-	-	1
Vt.	-	-	-	-	-	5	7	-	1	-	8	4	-	-	-
Mass.	22	-	16	-	5	37	44	-	3	-	96	160	-	-	2
R.I.	5	-	23	-	-	4	12	-	1	-	3	-	-	4	-
Conn.	10	-	2	-	4	31	38	-	8	-	37	26	-	1	1
MID. ATLANTIC	234	-	180	-	15	4,648	221	3	151	2	217	221	-	17	565
Upstate N.Y.	35	-	81	-	5	401	99	3	62	2	94	121	-	11	539
N.Y. City	127	-	42	-	8	1,750	21	-	12	-	9	27	-	-	2
N.J.	45	-	52	-	1	1,034	39	-	11	-	31	15	-	3	2
Pa.	27	-	5	-	1	1,463	62	-	66	-	83	58	-	3	22
E.N. CENTRAL	53	-	40	-	14	96	288	2	284	17	384	389	-	8	320
Ohio	10	-	-	-	6	11	68	2	99	17	99	92	-	-	283
Ind.	12	-	20	-	-	6	46	-	10	-	39	74	-	-	3
Ill.	15	-	9	-	4	27	76	-	89	-	30	70	-	8	8
Mich.	13	-	11	-	2	43	79	-	71	-	9	37	-	-	25
Wis.	3	-	-	-	2	9	19	-	15	-	207	116	-	-	1
W.N. CENTRAL	36	2	8	-	8	59	86	5	72	-	196	187	-	8	18
Minn.	16	2	7	-	5	27	17	5	24	-	32	75	-	-	6
Iowa	2	-	-	-	3	17	8	-	11	-	7	20	-	3	6
Mo.	11	-	-	-	-	1	28	-	29	-	93	64	-	1	5
N. Dak.	1	-	-	-	-	-	1	-	2	-	14	4	-	-	1
S. Dak.	1	-	-	-	-	-	1	-	-	-	14	4	-	-	-
Nebr.	1	-	-	-	-	1	15	-	4	-	13	9	-	-	-
Kans.	4	-	1	-	-	13	16	-	2	-	23	11	-	4	-
S. ATLANTIC	172	2	124	-	12	515	334	5	747	2	149	222	-	21	9
Del.	5	-	3	-	-	21	2	-	8	-	7	-	-	-	-
Md.	53	-	10	-	7	176	33	1	70	1	30	50	-	6	1
D.C.	10	-	-	-	-	-	3	-	5	-	1	1	-	1	1
Va.	36	-	11	-	4	30	50	-	49	-	10	24	-	-	-
W. Va.	2	-	-	-	-	-	16	1	26	-	9	9	-	1	-
N.C.	12	-	24	-	-	44	76	-	192	-	36	38	-	-	2
S.C.	1	U	29	U	-	13	22	U	51	U	10	13	U	7	-
Ga.	12	-	2	-	1	15	48	-	70	-	14	42	-	-	-
Fla.	41	2	45	-	-	216	84	3	276	1	32	45	-	6	5
E.S. CENTRAL	18	3	449	-	18	28	119	-	57	-	31	88	-	1	100
Ky.	1	3	448	-	2	23	38	-	-	-	1	-	-	-	-
Tenn.	12	-	-	-	-	3	34	-	15	-	9	36	-	1	100
Ala.	4	-	-	-	-	2	36	-	13	-	18	48	-	-	-
Miss.	1	-	1	-	16	-	11	-	29	-	3	4	-	-	-
W.S. CENTRAL	27	-	1,049	-	5	199	131	-	356	54	109	138	-	-	7
Ark.	3	-	-	-	-	5	16	-	9	-	18	12	-	-	1
La.	1	-	-	-	-	-	27	-	22	-	9	16	-	-	-
Okla.	5	-	11	-	-	-	14	-	17	-	28	39	-	-	-
Tex.	18	-	1,038	-	5	194	74	-	308	54	54	71	-	-	6
MOUNTAIN	27	-	25	-	7	1,255	84	2	133	9	350	299	-	9	30
Mont.	-	-	-	-	-	-	14	-	2	-	7	4	-	-	3
Idaho	1	-	-	-	-	450	8	-	3	-	38	27	-	1	-
Wyo.	-	-	1	-	-	3	2	-	-	-	-	3	-	-	-
Colo.	7	-	21	-	6	7	17	2	22	8	57	125	-	2	3
N. Mex.	4	-	1	-	1	98	8	N	N	1	97	39	-	-	4
Ariz.	9	-	2	-	-	454	19	-	72	-	114	62	-	2	2
Utah	4	-	-	-	-	224	4	-	22	-	35	37	-	2	11
Nev.	2	-	-	-	-	19	12	-	12	-	2	2	-	2	7
PACIFIC	229	1	105	-	26	2,131	429	4	289	12	671	497	-	78	249
Wash.	16	-	-	-	11	61	69	-	12	-	192	131	-	8	8
Oreg.	13	-	3	-	1	91	62	N	N	-	40	64	-	3	3
Calif.	187	1	60	-	3	1,944	284	3	252	7	403	229	-	44	227
Alaska	1	-	8	-	1	5	8	-	3	-	14	13	-	-	1
Hawaii	12	-	34	-	10	30	6	1	22	5	22	60	-	23	10
Guam	2	U	10	U	-	-	1	U	11	U	-	-	U	3	-
P.R.	-	-	411	-	-	94	3	-	1	-	11	54	-	-	1
V.I.	-	U	-	U	-	2	-	U	20	U	-	-	U	-	-
Amer. Samoa	-	U	-	U	-	24	-	U	-	U	6	-	U	-	-
C.N.M.I.	-	U	1	U	1	-	-	U	-	U	1	-	U	-	-

*For measles only, imported cases include 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 October 31, 1992, and November 2, 1991 (44th 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	28,150	35,577	201	18,580	19,302	141	333	420	6,542
NEW ENGLAND	598	877	14	446	569	1	27	7	739
Maine	2	3	1	19	33	-	-	-	-
N.H.	70	12	6	16	5	-	1	-	9
Vt.	1	2	-	6	9	-	-	-	22
Mass.	282	415	5	241	306	1	17	3	27
R.I.	35	45	2	42	75	-	-	2	-
Conn.	208	400	-	122	141	-	9	2	681
MID. ATLANTIC	3,611	6,101	24	3,931	4,487	1	88	45	1,806
Upstate N.Y.	266	563	9	344	372	-	12	15	1,220
N.Y. City	2,132	3,109	-	2,540	2,765	-	37	6	16
N.J.	105	1,027	-	483	751	1	25	13	281
Pa.	1,108	1,402	15	564	599	-	14	11	289
E.N. CENTRAL	4,298	4,300	54	1,912	1,902	1	36	30	142
Ohio	705	569	15	284	300	-	6	16	13
Ind.	259	158	11	161	193	-	1	6	19
Ill.	1,923	2,013	8	985	977	1	25	2	36
Mich.	826	1,026	20	413	347	-	3	3	15
Wis.	585	534	-	69	85	-	1	3	59
W.N. CENTRAL	1,274	729	36	435	436	53	6	31	956
Minn.	85	60	7	120	86	-	2	-	150
Iowa	43	63	7	33	55	-	1	3	160
Mo.	983	465	8	195	192	38	2	22	29
N. Dak.	1	1	2	6	7	-	-	-	138
S. Dak.	-	1	-	19	30	11	-	1	113
Nebr.	1	15	4	20	16	2	1	-	12
Kans.	161	124	8	42	50	2	-	5	354
S. ATLANTIC	7,777	10,427	21	3,587	3,637	5	31	129	1,545
Del.	182	150	3	42	29	-	-	13	178
Md.	546	832	2	325	334	1	7	15	458
D.C.	332	619	-	91	161	-	1	1	16
Va.	623	783	3	304	282	2	2	21	308
W. Va.	17	26	1	78	60	-	1	5	41
N.C.	2,110	1,700	3	443	460	1	-	57	43
S.C.	1,022	1,318	1	331	353	-	2	7	146
Ga.	1,513	2,576	4	748	726	1	2	7	312
Fla.	1,432	2,423	4	1,225	1,232	-	16	3	43
E.S. CENTRAL	3,607	3,888	3	1,165	1,326	9	5	61	172
Ky.	145	91	-	329	295	2	1	6	57
Tenn.	953	1,251	3	286	439	7	-	52	41
Ala.	1,258	1,469	-	345	332	-	1	3	73
Miss.	1,251	1,077	-	205	260	-	3	-	1
W.S. CENTRAL	5,242	6,404	2	2,261	2,292	38	15	100	622
Ark.	702	578	-	187	195	25	1	19	40
La.	2,213	2,375	-	155	175	2	1	-	8
Okla.	348	175	1	129	146	11	-	80	283
Tex.	1,979	3,276	1	1,790	1,776	-	13	1	291
MOUNTAIN	296	503	15	477	523	27	5	11	231
Mont.	7	6	1	-	6	12	-	3	22
Idaho	1	4	1	21	9	-	1	1	7
Wyo.	3	8	-	-	5	1	-	4	81
Colo.	48	78	6	52	70	4	2	-	24
N. Mex.	38	28	1	64	63	6	1	1	9
Ariz.	151	320	2	218	270	-	-	-	65
Utah	7	6	4	61	40	2	-	1	6
Nev.	41	53	-	61	60	2	1	1	17
PACIFIC	1,447	2,348	32	4,366	4,130	6	120	6	329
Wash.	71	166	2	263	256	2	8	-	-
Oreg.	41	78	1	115	106	-	2	3	2
Calif.	1,322	2,093	29	3,722	3,539	2	103	3	314
Alaska	5	4	-	43	57	2	-	-	13
Hawaii	8	7	-	223	172	-	7	-	-
Guam	3	1	-	58	8	-	3	-	-
P.R.	290	366	-	200	203	-	1	-	41
V.I.	58	88	-	3	3	-	-	-	-
Amer. Samoa	-	-	-	-	3	-	1	-	-
C.N.M.I.	6	5	-	50	18	-	1	-	-

U: Unavailable

TABLE III. Deaths in 121 U.S. cities,* week ending October 31, 1992 (44th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	634	443	108	51	17	15	57
Boston, Mass.	176	106	39	17	5	9	17
Bridgeport, Conn.	51	41	8	2	-	-	7
Cambridge, Mass.	26	22	3	1	-	-	6
Fall River, Mass.	27	21	3	3	-	-	1
Hartford, Conn.	40	25	6	4	4	1	-
Lowell, Mass.	22	18	3	1	-	-	2
Lynn, Mass.	9	7	-	1	1	-	1
New Bedford, Mass.	31	26	3	1	1	-	1
New Haven, Conn.	45	29	7	6	3	-	3
Providence, R.I.	46	32	7	7	-	-	2
Somerville, Mass.	9	5	3	1	-	-	-
Springfield, Mass.	43	29	9	2	2	1	2
Waterbury, Conn.	40	30	5	3	-	2	2
Worcester, Mass.	69	52	12	2	1	2	13
MID. ATLANTIC	2,781	1,770	561	309	63	77	111
Albany, N.Y.	37	25	8	1	1	2	5
Allentown, Pa.	9	8	-	1	-	-	-
Buffalo, N.Y.	98	71	18	4	3	2	1
Camden, N.J.	35	23	8	4	-	-	-
Elizabeth, N.J.	24	20	3	1	-	-	-
Erie, Pa.§	50	38	7	2	-	3	4
Jersey City, N.J.	49	34	9	3	2	1	2
New York City, N.Y.	1,562	959	318	205	32	48	44
Newark, N.J.	127	50	38	27	5	6	8
Paterson, N.J.	19	11	2	3	2	1	-
Philadelphia, Pa.	399	259	86	32	15	7	17
Pittsburgh, Pa.§	79	60	12	6	-	1	7
Reading, Pa.	15	8	4	3	-	-	3
Rochester, N.Y.	119	92	17	7	1	2	10
Schenectady, N.Y.	U	U	U	U	U	U	U
Scranton, Pa.§	20	14	5	-	-	1	3
Syracuse, N.Y.	84	60	18	4	1	1	2
Trenton, N.J.	38	26	3	6	1	2	5
Utica, N.Y.	17	12	5	-	-	-	-
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	2,004	1,246	384	204	115	54	122
Akron, Ohio	67	46	11	3	6	1	-
Canton, Ohio	38	30	5	3	-	-	5
Chicago, Ill.	517	207	134	89	74	13	18
Cincinnati, Ohio	133	88	26	13	2	4	14
Cleveland, Ohio	148	97	27	14	7	3	4
Columbus, Ohio	169	113	27	18	6	5	8
Dayton, Ohio	104	74	22	4	4	-	9
Detroit, Mich.	U	U	U	U	U	U	U
Evansville, Ind.	45	30	13	1	1	-	3
Fort Wayne, Ind.	65	47	11	3	3	1	5
Gary, Ind.	24	11	8	4	-	1	-
Grand Rapids, Mich.	46	31	8	2	2	3	8
Indianapolis, Ind.	227	152	37	25	2	11	12
Madison, Wis.	72	52	12	3	3	2	3
Milwaukee, Wis.	152	115	23	8	2	4	18
Peoria, Ill.	49	36	5	5	-	3	7
Rockford, Ill.	43	30	3	5	1	3	3
South Bend, Ind.	41	34	4	2	1	-	3
Toledo, Ohio	U	U	U	U	U	U	U
Youngstown, Ohio	64	53	8	2	1	-	2
W.N. CENTRAL	999	724	158	72	23	21	57
Des Moines, Iowa	71	58	9	4	-	-	4
Duluth, Minn.	26	19	6	1	-	-	-
Kansas City, Kans.	67	52	11	3	1	-	3
Kansas City, Mo.	124	88	29	3	3	1	7
Lincoln, Nebr.	28	23	4	-	1	-	-
Minneapolis, Minn.	258	183	36	24	6	9	21
Omaha, Nebr.	95	74	12	4	3	2	4
St. Louis, Mo.	134	99	17	9	4	5	8
St. Paul, Minn.	58	41	11	3	3	-	3
Wichita, Kans.	138	87	23	21	2	4	7

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
S. ATLANTIC	1,411	851	276	178	41	63	63
Atlanta, Ga.	192	108	39	29	10	6	6
Baltimore, Md.	207	147	24	25	4	7	13
Charlotte, N.C.	113	69	31	6	4	3	3
Jacksonville, Fla.	112	71	17	18	4	2	9
Miami, Fla.	157	91	25	33	4	3	2
Norfolk, Va.	44	23	12	5	1	3	1
Richmond, Va.	66	44	14	6	1	1	3
Savannah, Ga.	71	43	13	8	3	4	7
St. Petersburg, Fla.	52	36	8	2	3	3	-
Tampa, Fla.	133	95	29	9	-	-	15
Washington, D.C.	245	109	62	35	7	31	4
Wilmington, Del.	19	15	2	2	-	-	-
E.S. CENTRAL	755	488	156	67	31	13	57
Birmingham, Ala.	122	72	25	13	5	7	5
Chattanooga, Tenn.	58	42	9	4	2	1	4
Knoxville, Tenn.	94	68	17	7	2	-	8
Lexington, Ky.	66	45	15	5	1	-	12
Memphis, Tenn.	169	105	35	14	13	2	7
Mobile, Ala.	66	40	15	7	3	1	5
Montgomery, Ala.	48	34	8	2	3	1	4
Nashville, Tenn.	132	82	32	15	2	1	12
W.S. CENTRAL	1,029	642	222	99	34	30	32
Austin, Tex.	47	27	14	5	1	-	1
Baton Rouge, La.	51	33	10	5	3	-	2
Corpus Christi, Tex.	44	36	5	1	-	2	3
Dallas, Tex.	178	105	41	21	4	7	3
El Paso, Tex.	51	31	11	3	1	5	5
Ft. Worth, Tex.	114	71	23	11	5	4	5
Houston, Tex.	U	U	U	U	U	U	U
Little Rock, Ark.	68	40	16	8	2	2	-
New Orleans, La.	153	89	30	19	10	3	-
San Antonio, Tex.	210	132	50	18	6	4	9
Shreveport, La.	17	11	6	-	-	-	1
Tulsa, Okla.	96	67	16	8	2	3	3
MOUNTAIN	609	422	105	47	19	16	47
Albuquerque, N.M.	94	71	12	8	2	1	3
Colo. Springs, Colo.	41	28	4	3	4	2	3
Denver, Colo.	U	U	U	U	U	U	U
Las Vegas, Nev.	110	69	25	12	4	-	8
Ogden, Utah	32	23	7	-	1	1	2
Phoenix, Ariz.	113	70	25	8	2	8	18
Pueblo, Colo.	21	15	5	1	-	-	-
Salt Lake City, Utah	82	60	7	10	3	2	6
Tucson, Ariz.	116	86	20	5	3	2	7
PACIFIC	1,358	908	247	129	50	24	88
Berkeley, Calif.	21	13	4	4	-	-	4
Fresno, Calif.	88	56	15	5	9	3	6
Glendale, Calif.	U	U	U	U	U	U	U
Honolulu, Hawaii	U	U	U	U	U	U	U
Long Beach, Calif.	91	50	24	11	6	-	7
Los Angeles, Calif.	U	U	U	U	U	U	U
Pasadena, Calif.	32	19	7	1	4	1	1
Portland, Oreg.	108	80	17	9	-	2	5
Sacramento, Calif.	171	110	31	15	11	4	16
San Diego, Calif.	173	113	34	19	2	5	16
San Francisco, Calif.	150	93	28	23	6	-	1
San Jose, Calif.	162	107	35	14	5	1	12
Santa Cruz, Calif.	28	24	2	1	-	1	2
Seattle, Wash.	173	123	25	19	2	4	6
Spokane, Wash.	59	47	9	1	-	2	5
Tacoma, Wash.	102	73	16	7	5	1	7
TOTAL	11,580¶	7,494	2,217	1,156	393	313	634

*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.

Incidence of Treatment for End-Stage Renal Disease Attributed to Diabetes Mellitus, by Race/Ethnicity — Colorado, 1982–1989

Diabetes mellitus (DM) is the principal known cause of end-stage renal disease (ESRD) (i.e., renal insufficiency requiring kidney dialysis or transplantation for survival) and accounts for one third of all incident cases of treated ESRD in the United States (*1*). Rates for initiating diabetes-related ESRD (ESRD-DM) treatment have been characterized for blacks and whites but have not been well characterized for Hispanics (*2–5*). To describe ESRD-DM treatment by race/ethnicity in Colorado for improved program planning for intervention services, the Colorado Diabetes Surveillance Project of the Colorado Department of Health investigated differences in the rates of initiating ESRD-DM treatment for non-Hispanic white, Hispanic, and black Colorado residents with diabetes. This report describes trends in the incidence of ESRD-DM treatment by race/ethnicity among persons with diabetes in Colorado from 1982 through 1989.

Data regarding the treatment of persons with diabetes-related ESRD were obtained from the Intermountain End-Stage Renal Disease Network (ImESRDN).* ImESRDN collects demographic, etiologic, and other information for all patients undergoing renal replacement therapy (i.e., dialysis or kidney transplantation), regardless of their payment source, in Colorado and five other states in the Rocky Mountain region. Incident cases were defined as Colorado residents with diabetes who had a primary diagnosis of diabetic nephropathy and for whom renal replacement therapy was initiated during 1982–1989. The number of persons with diabetes in the state was estimated by applying national age-, sex-, and race/ethnicity-specific diabetes prevalence rates to Colorado population estimates for 1982–1989 (*6*). ESRD-DM treatment rates were age-adjusted using the estimated 1980 U.S. population with diabetes divided into four age groups: 0–44 years, 45–64 years, 65–74 years, and ≥75 years (*7*).

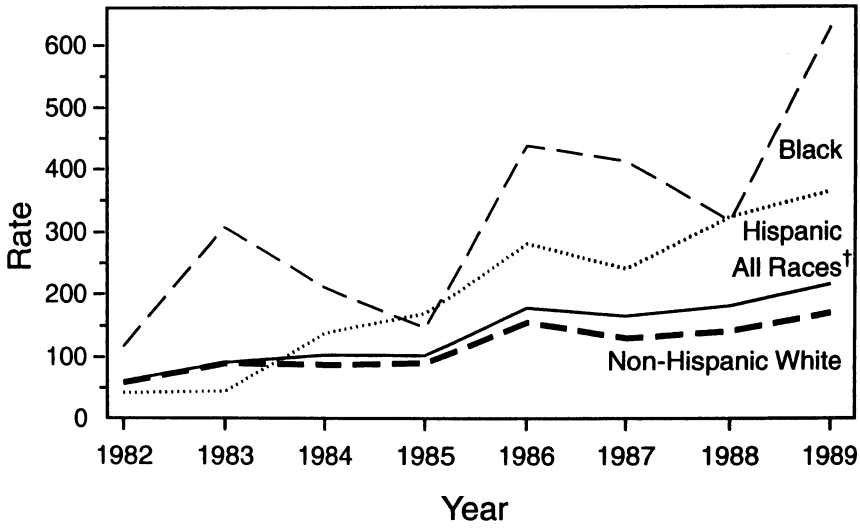
From 1982 through 1989, 874 Colorado residents began ESRD-DM treatment; of these, 562 (64%) were non-Hispanic white; 191 (22%), Hispanic; 80 (9%), black; and 41 (5%), persons of other races. In comparison, 78% of the estimated Colorado population with diabetes were non-Hispanic white, 17% were Hispanic, 4% were black, and 1% were persons of other races (*6*).

From 1982 through 1989, the age-adjusted incidence rate for ESRD-DM treatment more than tripled, increasing from 61 to 216 per 100,000 persons with diabetes (Figure 1). The greatest increase in rates was for Hispanics (770%), compared with blacks (440%) and non-Hispanic whites (190%). For persons with diabetes, the 8-year average annual age-adjusted rates for blacks and Hispanics were 2.8 and 1.8 times, respectively, that for non-Hispanic whites. For Hispanics and blacks, the overall age-adjusted incidence of treated ESRD-DM was greater for females than for males; for non-Hispanic whites, however, the overall incidence was higher for males than females. For non-Hispanic whites, the 8-year average annual rate for treated ESRD-DM was highest in the 0–44 age group (263 per 100,000 persons with diabetes) and decreased with age (Figure 2). However, for Hispanics, rates increased with age and were highest for per-

*ImESRDN is one of 18 organizations or networks contracted by the federal Health Care Financing Administration to collect data on all patients undergoing treatment for ESRD and to conduct quality assurance activities related to the care of ESRD patients.

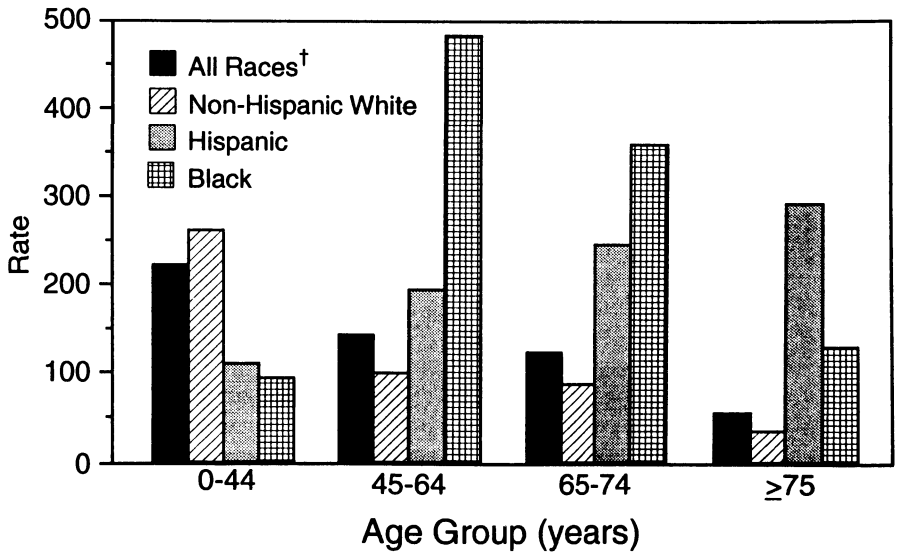
ESRD—Colorado — Continued

FIGURE 1. Age-adjusted incidence rate* of diabetes-related end-stage renal disease treatment, by race and ethnicity — Colorado, 1982–1989



*Per 100,000 population with diabetes, adjusted to the 1980 U.S. standard population with diabetes.
†Includes persons from all racial/ethnic groups.

FIGURE 2. Age-specific average annual incidence rate* of diabetes-related end-stage renal disease treatment, by race and ethnicity — Colorado, 1982–1989



*Per 100,000 population with diabetes.
†Includes persons from all racial/ethnic groups.

ESRD—Colorado — Continued

sons aged ≥75 years (293 per 100,000 persons with diabetes). For blacks, the highest age-specific incidence rate of ESRD-DM was for persons aged 45–64 years (483 per 100,000 persons with diabetes).

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Editorial Note: The findings in this report indicate that rates of initiation of treatment for ESRD-DM in Colorado are consistent with national patterns for blacks and whites (*7*). In many cases, this variability is likely related to environmental factors rather than genetic differences (*8*). However, data regarding ESRD treatment among Hispanics are limited.

In Colorado, Hispanics (primarily of Mexican and American Indian descent) are 13% of the total population and comprise the largest minority group. A previous report indicated that in Texas the incidence rate for ESRD-DM treatment for U.S. residents of Mexican descent was six times greater and the rate for blacks was four times greater than that for non-Hispanic whites in the general population (*5*). However, in Colorado, overall incidence rates of treated ESRD-DM for Hispanics were intermediate to those for blacks and non-Hispanic whites among persons with diabetes; this pattern persisted when total population rates were calculated (age-adjusted incidence rate ratios of 4.6 and 3.7 for blacks and Hispanics, respectively, when compared with non-Hispanic whites) (*6*). Potential explanations for these race/ethnicity differences may include variations in ESRD biologic risk factors, variations in the availability of ESRD treatment or in access to preventive care and ESRD services, changes in ESRD reporting practices, or a combination of these or other factors.

Two national health objectives for the year 2000 are to reduce the rate of initiating ESRD-DM treatment from 1.5 to 1.4 per 1000 persons with diabetes and from 2.2 to 2.0 per 1000 blacks with diabetes (objectives 17.10 and 17.10a) (*9*). Surveillance data indicate, however, that during the 1980s the rates for persons with diabetes increased annually in Colorado and throughout the United States (*7*).

The development of public health strategies to delay and prevent the development of ESRD-DM (*10*) will require the continued monitoring of trends in initiation of ESRD treatment. The ImESRDN is one potential monitoring system for assessing the effectiveness of proposed prevention strategies. These data may be useful in tracking national health objectives related to ESRD-DM and in developing prevention strategies for ESRD-DM, particularly among minority populations. Colorado has used these findings to develop a Diabetes State Plan for the Year 2000 and will use these data to monitor trends and direct interventions associated with diabetes-related ESRD treatment.

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9. 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.
10. CDC. Incidence of treatment for end-stage renal disease attributed to diabetes mellitus—United States, 1980–1989. MMWR 1992;41:834–7.

Notices to Readers

Office Visits for Diabetes

A new report presenting national estimates pertaining to diabetes-related office visits has been released by CDC's National Center for Health Statistics (NCHS). The report, based on data collected by the National Ambulatory Medical Care Survey conducted annually by NCHS, presents data on the patient, physician, and visit characteristics for a sample of office visits resulting in a diagnosis of diabetes mellitus.

Copies of the report, *Office Visits for Diabetes Mellitus: United States, 1989* (*1*), can be ordered by contacting the Scientific and Technical Information Branch, Division of Data Services, NCHS, CDC, Room 1064, 6525 Belcrest Road, Hyattsville, MD 20782; telephone (301) 436-8500.

Reference

1. NCHS. Office visits for diabetes mellitus: United States, 1989. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, CDC, 1992. (Advance data no. 211).

New Data From 1989 Revised Birth Certificate

A recent report presents information on selected new items from the revised "U.S. Standard Certificate of Live Birth." CDC's National Center for Health Statistics (NCHS) now makes available data on medical and lifestyle risk factors of pregnancy and birth, obstetric procedures performed, method of delivery, abnormal conditions and congenital anomalies of the infant, Hispanic origin of parents, and expanded data on birth attendant and place of delivery. The medical and health data now available for mothers and infants greatly expand the scope of information available on pregnancy outcome.

Copies of the report, *Advance Report of New Data from the 1989 Birth Certificate* (*1*), can be ordered by contacting the Scientific and Technical Information Branch, Di-

Notices to Readers — Continued

vision of Data Services, NCHS, CDC, Room 1064, 6525 Belcrest Road, Hyattsville, MD 20782; telephone (301) 436-8500.

Reference

1. NCHS. Advance report of new data from the 1989 birth certificate. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, 1992; DHHS publication no. (PHS)92-1120. (Vital and health statistics; vol 40, no. 12S).

Prevalence of Major Digestive Disorders

The 1989 National Health Interview Survey included digestive disorders as a current health topic. The questionnaire was developed by CDC's National Center for Health Statistics (NCHS), in collaboration with the National Institute of Diabetes and Digestive and Kidney Diseases. Respondents were asked the details (i.e., timing of onset, treatment, and medical diagnosis) about specific digestive conditions; location and severity of pain; information on normative bowel habits; and common bowel complaints.

Copies of the report, *The Prevalence of Major Digestive Disorders and Bowel Symptoms, 1989* (*1*), can be ordered by contacting the Scientific and Technical Information Branch, Division of Data Services, NCHS, CDC, Room 1064, 6525 Belcrest Road, Hyattsville, MD 20782; telephone (301) 436-8500.

Reference

1. NCHS. The prevalence of major digestive disorders and bowel symptoms, 1989. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, CDC, 1992. (Advance data no. 212).

Using Chronic Disease Data: A Handbook for Public Health Practitioners

CDC's National Center for Chronic Disease Prevention and Health Promotion, Office of Surveillance and Analysis, has released *Using Chronic Disease Data: A Handbook for Public Health Practitioners (1)*. The handbook, which discusses the use of mortality, hospitalization, and behavioral risk factor data, is designed to help state and local health agencies locate and analyze data about chronic diseases. Examples in the handbook show how data drawn from multiple sources have been used to support public health action. Special aids include guidelines for the visual presentation of data, an age-adjustment spreadsheet on disk, a directory of contacts for different types of data, and samples of selected legislation. Copies are available free by calling (404) 488-5269.

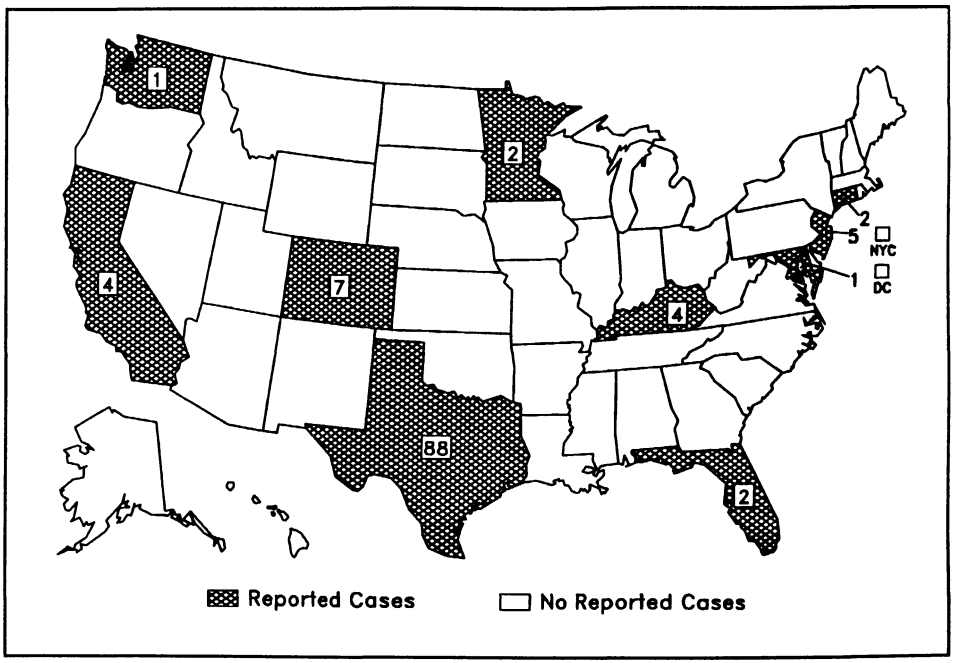
Reference

1. CDC. Using chronic disease data: a handbook for public health practitioners. Atlanta: US Department of Health and Human Services, Public Health Service, 1992.

Addendum: Vol. 41, No. 26

In the article, "Congenital Rubella Syndrome Among the Amish—Pennsylvania, 1991–1992," the following name should be added to the credits on page 475: B Kleger, DrPH, Bur of Laboratories, Pennsylvania Dept of Health.

Reported cases of measles, by state — United States, weeks 40–44, 1992



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The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) 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 and Prevention, Atlanta, GA 30333; telephone (404) 332-4555.

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HHS Publication No. (CDC) 93-8017