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THE PLACE OF MENTAL HYGIENE IN A FEDERAL HEALTH PROGRAM[1]

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In discussing the place of mental hygiene in a Federal health program it is well to consider the subject from the viewpoint of its professional content, and to clarify, perhaps, the relationship such content may bear to practical and abiding results. Brief mention will therefore be made of the material with which mental hygiene is expected to deal.

For many years, the term "mental hygiene" was limited largely in application to what today are classified as the psychoses, the behavior of such patients leading to legal commitment and compulsory segregation for the protection of both the patient and the community. It is this step that is implied by the word "insanity", a term that has no other meaning in medical terminology. In addition to the psychoses, it is now recognized that there is an even larger field of mental illness in which the question of compulsory segregation of the patient or that of insanity does not arise. This group comprises what is known as the "psychoneuroses." Its size and importance as a cause of invalidism and as a problem in national health can best be gaged from the fact that approximately 4 in every 10 persons applying for medical advice in public clinics and dispensaries are invalided because of mental illness of this type. Moreover, it is also recognized that physical disease often has a psychic or mental component associated with it.

The psychoses and psychoneuroses do not complete the total disorders with which mental hygiene is called upon to deal. To them must be added mental deficiency, or feeblemindedness, as it is more often called, and also a variable proportion of behavior problems now included under the headings of dependency, delinquency, and crime. But there is still an additional group of large size, consisting of behavior problems of children and of older persons not ordinarily included with the psychoneuroses, but which are the outcome of faulty habits and misunderstandings in dealing with environmental relationships. Such behavior problems, if uncorrected, may be the forerunners of

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crystallized faulty mental adjustments in later life or adaptations that are contrary to customary behavior prescribed by society.

There are many who believe that "mental hygiene" has reached that stage in its development when it is desirable to resurvey its fundamental values and also the security of the foundations upon which it rests. Such a survey may be approached through six broad avenues of interest, including, first, that concerned with the recognition and with the early and adequate treatment of the mentally ill; second, with investigations into the nature and underlying causes of such illness; third, with the training of personnel for undertaking the duties involved in this particular field; fourth, with the adoption of measures to render less threatening a possible increase in the number of the mentally ill; fifth, with a more satisfactory solution of the economic problems associated with mental illness; and, sixth, with measures for uprooting community sources of mental invalidism, disease, and defect.

THE PROBLEM OF ADEQUATE TREATMENT FOR THE MENTALLY ILL

In approaching the task of evaluating the adequacy of facilities for the treatment of the mentally ill of a given community or of a political jurisdiction, it must be appreciated, first, that any betterment in the social organization and moral obligations of a self-governing people does not spring from the mind of any one person, but evolves from the congregate opinions and wishes of generations in community groups. Most changes in these fields have been based upon a framework of tradition and community principles. These have been flavored, perhaps, by a dash of the spirit of the times, which enthusiastically awakened a public consciousness through emphasizing the humane aspects of a particular social situation. This awakening of public consciousness has ofttimes either not been aware of, or has not taken into account the basic need for, accurate and scientific knowledge in meeting various phases of the problems involved.

For example, in London, where, about the middle of the sixteenth century, the first abiding steps were taken to meet the situation affecting public relief, those seeking aid were divided into three broad groups: First, were the poor children, provided for at Christ's Hospital, a policy that has served to influence a traditional background toward the evolution of all those diversified and by no means uniform public policies for the welfare of children; second, were the sick and helpless persons, provided for at St. Thomas' Hospital, or given a license to beg, that early policy traditionally influencing those later and varied policies toward that particular group of the population; and third, were the sturdy and able-bodied vagabonds, who were gathered together at Bridewell, and for whom occupations were provided, and the "insane", who were cared for at Bethlehem Hospital.

The latter for a time was considered as a separate institution, but its separate administration existed for a short time only, as early reports show that Bridewell and Bethlehem Hospitals were administered by the same group of persons. The influence of these early policies, especially toward the "criminal" and the "insane", still bears its mark upon public outlook, since these principles, adopted in the Old World, followed the colonists to America as part of their social philosophy.

Early progress in this country in the matter of attempting to meet the needs of special groups who constituted special social problems, was stimulated by philanthropies or by appeals to the humane instincts, without recourse to special knowledge of the particular problem involved. With the march of time, however, much has been accomplished for "the child", for "the sick", for "the poor" and for "the bad." History has clearly shown, however, that wherever there are groups of "children", "physically sick persons", "bad men and women" or "poor people", there one finds degrees of mental ill health demanding attention and disproportionate to that of an average general population. Moreover, every policy that has been set up to deal with these particular situations has been complicated by a mental health administration problem which is not being met in a logical or uniform manner. The accessibility of these particular groups of the population for study and investigation makes possible the establishment of a more or less accurate endemic index of mental ill health, leading eventually to a mental health administration policy based upon where and when such illness occurs.

It is true that public sentiment toward these groups of the population has become more charitable with the passage of time; nevertheless, there is a paradoxical attitude of "public mind" toward them, fluctuating between sentimental sympathy on the one hand and condemnation on the other hand.

This paradox is further illustrated by the fact that, for the first time in history, a wider interest is now being shown in disorders of the mind by the lay public; failures and unconventional behavior and conduct are being interpreted, not in terms of institutional provisions, but in terms of personality factors having behind them mental implications. Moreover, workers in the mental health fields are being called upon for a greater and greater responsibility and function to the community. Home, school, and other relationship problems are being referred; demands are being made by educational and health services, by industry, by general hospitals, by vocational and child guidance agencies, and by courts and penal and correctional institutions and those ministering to dependency, for services that demand an organized and concerted public policy to meet the needs of the mentally ill.

On the other hand, this demand for wider service is inconsistent with the facilities and means now available for the early recognition, amelioration, treatment, and care of adverse mental states, or for relieving persons in the incipient stages of mental ill health. Rapid growths in population, coupled with the necessity for securing immediate institutional provisions for those making the strongest appeal, have resulted in the development of piecemeal facilities and policies, without regard to an adequately balanced program. Such piecemeal growths have met some of the community's needs and left other, and perhaps equally important, needs unprovided for. In consequence, every stage in the evolution of public facilities and public policies for the mentally ill may be found somewhere represented in the United States today.

The recognition, treatment, and care of mental illness implies a knowledge of these diseases; and whereas the present status of medical knowledge makes possible the interpretations of departures in social adaptations and adjustments, not in terms of institutional facilities alone but in terms of individual needs and requirements, that knowledge does not always enter into the formulation or administration of public policies toward the mentally ill of American communities.

As an illustration of the potential needs in this field, it is sufficient to point out that only a very few States or local jurisdictions have seen fit to place their mental health administrative problems under the immediate banner and guidance of persons with medical training. In fact, in the majority of instances where central administrative control agencies have been established, the executive functions in mental health administration have been assumed largely by lay representatives, without regard for the executive and administrative functions which modern medicine may or can assume. While it is true that no State legislature has kept pace with the needs of the mentally ill, nevertheless in those States where mental health administration is directed by medically trained persons, the facilities and public policies for that group of the population stand far ahead of those jurisdictions where domiciliary facilities alone represent the assumed total of a community's obligation and responsibility toward mental disease and disorders.

Mental health administration in the United States is comparable to that of public health administration of 80 years ago. It is apparent also that the effectual fulfillment of any mental health administration program for a given community or political jurisdiction involves the development of a department, a division, or a special agency charged specifically with carrying it into effect, and the appointment of a competent, reliable, and experienced physician, with such necessary deputies and assistants as may be required, for the responsible execution of the aims and objectives of such a program.

The content and execution of a mental health administration program embraces the formulation of policies respecting the qualifications and training of medical and technical personnel, both special and general, that are required to meet the problems of mental illness; the enforcement of regulations governing the qualifications and appointment of medical commissions for the detection and certification of mental diseases and defects; those governing the operation of community facilities for the early diagnosis, treatment, and care of persons with mental diseases or mental defects, and for inebriates and problem children; those governing the rendering of expert testimony in alleged mental cases; those governing the mental examination of offenders against the law and the disposition of mentally disordered and mentally defective delinquents; those governing the formulation and supervision of measures and policies concerned with the treatment, care, disposition, and general supervision of mentally disordered members of the population, including regulations governing a system of interchange of mental patients with jurisdictions having responsibility for their care; with the development and supervision of facilities and agencies for out-patient and in-patient treatment when needed; and the community supervision of mentally disordered persons when necessary, including the insane, the mentally defective, the epileptic, and problem situations manifesting symptoms of mental ill health; and last, but not least, with taking stock of the material with which mental health administration is called upon to deal, so that comparisons may be made from time to time of the conditions under which mental diseases are found and when they occur, and including an analysis of the omissions and commissions attributed to a given public policy.

The time has arrived when a national health agency must take cognizance of the need for greater uniformity in mental health administration. It is evident that an agency such as the United States Public Health Service must eventually assume a more permanent and active role in this particular field by serving as a depository for the collection and dissemination of information on matters pertaining to mental health administration, by making studies and investigations of the prevalence and needs of the mentally ill, and by making available to the States and political subdivisions thereof a consultant service, to the end that more adequate facilities and uniform measures may be adopted for the early recognition and treatment of mental ill health.

On the other hand, an analysis of the activities of the Federal Government in the field of mental health administration shows a lack of uniformity in the evolution of policies or facilities hardly comparable with that of local governments where greater unity of local opinions and customs in these matters is more likely to crystallize

into law or regulation. Of the 10 executive departments of the Federal Government, 8 have functions directly and intimately concerned with the problem of mental diseases and mental disorders. Several independent establishments also have similar interests. It must be appreciated, however, that the Federal Government, as a whole, involves an intricate maze of activities and interests. Lack of uniformity in the field of mental health administration as it affects the wards and beneficiaries of the Federal Government is but a part of this intricate maze; and since there are but a few to champion the rights of these mentally ill, medical and scientific opinion concerning these matters has sometimes been subservient to expediency. There is need, however, for better coordination and greater uniformity in administrative policies respecting these matters as they affect the various departments of the Federal Government. The Public Health Service may serve as the coordinating medical agency to bring about greater uniformity in this particular governmental activity.

THE NATURE AND CAUSES OF MENTAL ILLNESS

In many instances the exact nature of certain forms of mental illness is unknown, their exact cause is often vaguely understood, and definite knowledge as to where, when, and under what conditions they occur leaves much to be desired. This also holds true for many physical diseases, however.

Nevertheless, the exact nature of certain types of mental diseases or disorders is known, and their causes, conditions under which they arise, and their treatment or amelioration are fairly well understood. General paralysis of the insane is one example of the latter situation. The amount of work and study necessary to bring the knowledge of this disease to its present state represents diligent application and study of a widely diversified professional group, extending over a period of a little more than 130 years.

The present knowledge of the nature of mental diseases, despite its shortcomings, is based upon a background of scientific inquiry and traditional attack under the banner of medicine. If one believes that the behavior and conduct of an individual and the adjustment of his body to his environment are all intricately bound up with that complicated maze of neurological function which associates, correlates, and synchronizes the various activities of the organs of the body and of the conscious mental life, then psychobiology and mental health must enter into every aspect of human activity.

This broad conception of the scope of mental hygiene or mental health at once becomes a challenge for all those interests and activities embraced by the field of human relationships. A determination of the more exact nature and causes of mental diseases is a special challenge to medicine and biology; whereas the conservation of men-

tal health and the prevention of mental illness are not only a special challenge to medicine and biology, but are also a particular challenge to statesmanship and the legal profession, and to sociology and education in their broader aspects.

It is apparent that a comprehensive national health program must take into account the need for research and investigation into the nature and causes of mental ill health, and a more accurate determination of where, when, and under what conditions such diseases arise. The United States Public Health Service, because of its access to clinical material, it being charged by law with the care and treatment of a widely diversified group of beneficiaries or wards of the Government; and because of its wide scope of interests and activities in the field of biologic research, it is potentially fitted as a nuclear agency for carrying on studies of this character.

There is nothing new in such a proposal, since whole-time research supported by public funds in terms of careers is already effective. Moreover, there is no danger that, through supported medical research by public funds, universities or even privately endowed agencies will lose the particular kind of scientific leadership and power of inspiration which it is essential they retain. Owing to their very nature, universities and privately endowed foundations can offer only limited opportunities in scientific research to the ablest and most enterprising students and workers. Furthermore, the more numerous the extra-academic and stabilized opportunities in the field of research, the greater will be the number of able men and women willing to try for careers of distinction, for the promotion of science for science's sake, and for a patriotic service to their country.

The scientific future of any country or organization cannot be determined alone by the attractiveness of formal teaching, but must afford the best and more promising young workers, since they represent the seeding of the scientific world, an opportunity for a living contact with the highest type of ability and research achievement. The Public Health Service may offer opportunities to men and women, selected for their achievement and promise, for sharing in the responsibility for the scientific future of public and mental health; for fundamental advances toward a better understanding of the nature and causes of certain types of ill health; and for paving the way for applying the results of such research studies to the definite objective of preventing specific illnesses or disease.

In approaching the subject of research into the nature and causes of mental diseases and disorders, it must be appreciated that man is a biological complex, synchronized and functioning as a unit, and that the sum total of scientific knowledge concerning man has progressed with amazing rapidity. The knowledge of the nature and causes of ill health, to say naught of treatment, have been revolutionized in the

past generation. One need but mention the advances made in the realm of comparative anatomy, in neuro-physiology, in biochemistry, in biophysics, in endocrinology, immunology and allergy, and the psychobiologic component of ill health to appreciate the need for correlating research in the basic medical sciences and the social sciences with a comprehensive program of mental health.

There are men well qualified to direct and conduct certain specific research projects, whose happiness and efficiency in research are contingent upon the associations of an academic life. It is desirable, therefore, in the interest of advancing the sum total of knowledge, to utilize those facilities available in American universities to the fullest extent possible by grants in aid to those who, through achievement, are able to carry on definite research projects. Such grants, however, should be coordinated with the various problems relating to the nature and causes of mental ill health, and to where, when, and under what conditions mental diseases and disorders occur. Corollary to such a proposal is the granting of fellowships to those qualified to undertake research projects of this nature under the general provisions establishing the National Institute of Health of the Public Health Service.

It is apparent that some agency must eventually correlate and evaluate research projects being undertaken in this particular field in order that those engaged therein may be in a better position to concentrate their efforts in directions best suited to accomplish results. A national health agency may justifiably not only assume the conduct of research studies in the field of mental health as they relate to the application of preventive measures and the promotion of positive good mental health, but it may serve also as a depository for the collection and dissemination of information on various research projects undertaken by various other agencies, and act to stimulate such agencies for research in this particular field through its correlating and coordinating efforts.

TRAINING OF PERSONNEL

The present cooperative endeavors for arranging a medical curriculum to meet eventual needs must be maintained between those, on the one hand, interested in problems affecting the health of the general public, and those, on the other hand, who are concerned with medical education. Similar endeavors are essential in relation to the curricula for the training of technical and other personnel whose tasks and interests relate to public and mental health.

Agencies interested in mental health should give endorsement to that immediate problem of the American Board of Psychiatry and Neurology, concerned with the establishment of minimum standards for qualifying specialists in these fields, so that the general public and other groups, such as those requiring trained personnel, may

possess guides for choosing specially trained people for those special tasks involved in a comprehensive mental health program.

A comprehensive mental health program, as it relates to the Federal Government, involves only indirectly the question of medical education, excepting insofar as the need arises for recruiting competently trained personnel or the training of such of its employees as may be required for carrying out the essential features of its particular work.

MEASURES FOR CONTROL

Measures necessary for the control of mental disease in an effort to minimize the threat of a possible increase, involve those applicable to an individual, on the one hand, and to the population mass, on the other hand. The first category may include such measures as birth control, human sterilization, institutional segregation, and community supervision, about which there are wide differences of opinion and no concerted or uniform policy. These measures demand further study and investigation before fundamental and scientific principles can be evolved and practical and uniform measures proposed.

The second category may include such measures as the control of foreign immigration and the interstate migration of mentally disordered persons. The first contribution of the Public Health Service to mental health had its inception in 1875, when, by a decision of the Supreme Court, all State laws relating to foreign immigration were declared unconstitutional and the authority for the regulation of foreign immigration was vested in the Federal Government. It was not until 1882, however, that the first Federal immigration law was enacted. Several changes have taken place in this law, a significant one in 1891, since which year the medical examination of arriving aliens has been conducted by the Public Health Service.

Our changing immigration policy inaugurated by the per centum limit plan of restriction provided in 1924 for a system of consular inspection of prospective immigrants in countries of origin. This was by no means a new proposal, for the first bill providing for such a scheme was introduced in Congress in 1838. Since 1925, however, a system has been applied, in connection with the application of immigration visas, for the Public Health Service medically to examine prospective immigrants in countries of their origin.

Throughout the more than 40 years' experience of the Service in immigration work sincere efforts have been made to bring about greater perfection in the recognition of mental defects and diseases among immigrants. The culmination of these efforts is reflected in part by the recent authorization for the establishment of more adequate facilities for the conduct of this phase of immigration work, notably a modern psychiatric pavilion at Ellis Island, N. Y.

THE ECONOMIC PROBLEM

To date there has been no very satisfactory solution of the economic problems associated with mental illness. This requires further study and investigation, with special reference to the adequacy of facilities and measures to meet the needs of the mentally ill of a given population.

There is evident need, however, for greater uniformity in the matter of interchanging mentally disordered persons between jurisdictions having responsibility for their care. It is possible that a national health agency may be of assistance in these matters by serving as a depository for the collection, correlation, and dissemination of information on the subject, to the end that a more satisfactory economic solution may be found.

UPROOTING COMMUNITY SOURCES OF MENTAL ILLNESS

It would hardly seem necessary to justify the responsibility for mental health or mental hygiene as belonging in the field of the medical profession. One obvious reason for this statement is that the diagnosis and recognition of the nature and causes of mental ill health are the foundations upon which the whole superstructure of mental health or mental hygiene must be built. The prevention of ill health and the promotion of positive health implies a knowledge of ill health. In the ultimate analysis, however, mental health is only an aspect of what is termed "public health."

As public health workers, your interest in the prevention of mental illness will carry you into the field of, first, those mental disorders or conditions associated with structural changes in the brain or conditions which interfere with its nutrition; second, those diseases or disorders associated with faulty mental adjustment, often classed as the "functional case" or psychogenic disorders; and, third, that group characterized by abnormal personal make-up. The time has arrived, however, when some agency such as that of the Public Health Service must undertake studies and investigations by practical demonstrations as to how our present knowledge of mental hygiene may be integrated with that of a regularly constituted local health organization. Those mental disorders involving exogeneous poisons and infections are mass phenomena of disease demanding mass control and the application of preventive measures embracing those broad public health policies of which mental hygiene is but a part. Reference may be made, also, to such situations as those involving alcohol, drugs, industrial hazards, venereal diseases, infections involving the central nervous system primarily, nutritional situations, child and maternal welfare, and other adult problems, all carrying with them a mental health factor that must be met eventually through the

regularly constituted health agency amplified in its organization and outlook to meet these special health factors.

Without going further into this interesting and important phase of a mental health program, it is desirable to point out that, during the course of this discussion a distinction has been implied between the prevention of ill health and the promotion of positive good health. These are not distinctly separate fields, but have been treated in this manner merely to give them emphasis. Medicine has the major responsibility in the prevention of illness and, through this function, should exert a direct influence on the promotion or conservation of good mental health. Perhaps a direct responsibility for the promotion of positive mental health rests in educators. Other groups are also concerned, including law, psychology, and sociology in its broadest aspects.

It is not possible to practice medicine satisfactorily today, whether it be remedial or preventive medicine, without realizing that man represents a component unit of organs and functions acted upon and reacting to conditions under which he lives. Much of the behavior of man, including many symptoms of ill health, is a direct reaction to his social environment. If physicians are to undertake full responsibilities, then it is essential that they take cognizance of the forces at work in their community. Mass study of such forces is a function peculiar to epidemiology and sociology. Problems being encountered by the modern demand made in the practice of preventive medicine are increasingly seeking for solution, an absorption of the methods and technique of sociology. Sociology and epidemiology, in their broadest sense, have some contributions to make for the promotion and conservation of mental health.

If it is true that the promotion of positive mental health is partly a matter of training and habits, then it is apparent that the responsibility of education in its broadest implication is of great importance. This statement carries greater significance when it is realized that education means far more than the acquisition of knowledge. The educator, including parents, should be concerned with the development of what is called normal habits, the term "normal" being used as indicating behavior bringing successful adaptation to social environments. The public health physician, correlating his interests with those of educators, is probably more concerned with avoiding and remedying abnormal habits. The interrelation between preventive medicine and education becomes at once apparent.

The mental health interests of a regularly constituted local health agency, therefore, leads to inquiries correlating with those of education methods and with measures for the correction of adverse situations in that particular field, with those of jurisprudence, and with those of a sociological and epidemiological character involving recreation, use of

leisure time, housing, working conditions, and many other questions of similar import affecting the social environment.

CONCLUSIONS

In closing this discussion on the place of mental hygiene in the Federal health program, reference may be made to the need for greater uniformity in mental health administration in the United States. This may be encouraged by a national health agency becoming a depository for the collection and dissemination of information upon matters pertaining to mental health administration, by making studies and investigations of the prevalence and needs of the mentally ill, and by making available to the States and political subdivisions thereof a consultant service, to the end that more adequate facilities and uniform measures may be adopted for the early recognition and treatment of mental ill health. There is need also for better coordination and greater uniformity in administrative policies respecting these matters as they affect the various departments of the Federal Government, and the Public Health Service may serve as the coordinating medical agency to bring about greater uniformity in this particular governmental activity.

Furthermore, a national health agency may justifiably not only assume the conduct of research studies in the field of mental health as they relate to the application of preventive measures and the promotion of positive good mental health, but it may serve also as a depository for the collection and dissemination of information on various research projects undertaken by various other agencies for research in this particular field, through its correlating and coordinating efforts.

A comprehensive mental health program as it relates to the Federal Government involves only indirectly the question of medical education, excepting insofar as the need arises for recruiting competently trained personnel or the training of such of its employees as may be required for carrying out the essential features of its particular work.

Measures necessary for the control of mental disease, in an effort to minimize the threat of a possible increase, involve those applicable to an individual on the one hand and to the population mass on the other hand. Further studies and observations are necessary before developing a concerted and uniform policy with reference to birth control, human sterilization, institutional segregation, and community supervision. Since authority for the regulation of foreign immigration is vested in the Federal Government, it is necessary, in accordance with law, that the Public Health Service continue the medical functions associated with the examination and exclusion of mentally unfit immigrants.

There is need for greater uniformity in the matter of interchanging mentally disordered persons between jurisdictions having responsibility for their care, and it is possible that a national health agency may be of assistance in these matters by serving as a depository for the collection, correlation, and dissemination of information on that subject, to the end that a more satisfactory economic solution may be found.

There is overwhelming evidence that the responsibility for mental health or mental hygiene belongs in the field of the medical profession, since the diagnosis and recognition of the nature and causes of mental ill health are the foundations upon which the whole superstructure of mental health or mental hygiene must be built.

Measures for uprooting community sources of mental illness must eventually be integrated with the interests of a regularly constituted local health agency and correlated with those of education methods and with measures for the correction of adverse situations in that particular field, with those of jurisprudence, and with those of a sociological and epidemiological character.

DEATHS DURING WEEK ENDED FEBRUARY 1, 1936

[From the Weekly Health Index, issued by the Bureau of the Census, Department of Commerce]

	Week ended Feb. 1, 1936	Corresponding week, 1935
Data from 86 large cities of the United States:		
Total deaths	9,468	9,092
Deaths per 1,000 population, annual basis	13.2	12.7
Deaths under 1 year of age	575	627
Deaths under 1 year of age per 1,000 estimated live births	52	57
Deaths per 1,000 population, annual basis, first 5 weeks of year	13.4	13.1
Data from industrial insurance companies:		
Policies in force	67,819,150	67,211,803
Number of death claims	13,775	14,497
Death claims per 1,000 policies in force, annual rate	10.6	11.2
Death claims per 1,000 policies, first 5 weeks of year, annual rate	10.5	11.1

PREVALENCE OF DISEASE

No health department, State or local, can effectively prevent or control disease without knowledge of when, where, and under what conditions cases are occurring

UNITED STATES

CURRENT WEEKLY STATE REPORTS

These reports are preliminary, and the figures are subject to change when later returns are received by the State health officers

Reports for Weeks Ended February 8, 1936, and February 9, 1935

Cases of certain communicable diseases reported by telegraph by State health officers for weeks ended Feb. 8, 1936, and Feb. 9, 1935

Division and State	Diphtheria		Influenza		Measles		Meningococcus meningitis	
	Week ended Feb. 8, 1936	Week ended Feb. 9, 1935	Week ended Feb. 8, 1936	Week ended Feb. 9, 1935	Week ended Feb. 8, 1936	Week ended Feb. 9, 1935	Week ended Feb. 8, 1936	Week ended Feb. 9, 1935
New England States:								
Maine	2	2	3	1	424	238	2	0
New Hampshire					18	4	0	0
Vermont		1			191	4	0	0
Massachusetts	3	10			435	612	2	0
Rhode Island	1			5	99	26	0	0
Connecticut [1]	1	6	4	9	124	617	1	1
Middle Atlantic States:								
New York	54	23	[2] 60	[2] 38	1,408	1,313	14	4
New Jersey	11	11	11	30	61	219	4	1
Pennsylvania	46	45			283	2,541	6	6
East North Central States:								
Ohio	27	60	20	40	181	516	7	7
Indiana	43	33	52	111	32	628	6	4
Illinois	36	59	43	72	30	2,101	15	13
Michigan	9	6	3	6	42	501	7	0
Wisconsin	4	1	56	187	81	1,279	2	0
West North Central States:								
Minnesota	4	12		41	120	2,135	2	1
Iowa	6	11	6	214	11	1,023	2	0
Missouri	22	25	184	396	17	457	8	0
North Dakota	2	5	3	33	1	152	0	0
South Dakota	5	2			4	74	1	0
Nebraska	2	7	5	20	51	520	1	5
Kansas	11	11	68	61	16	1,139	5	2
South Atlantic States:								
Delaware		4			74		0	0
Maryland [3]	5	8	7	180	112	59	11	4
District of Columbia	12	18	1	7	7	11	4	2
Virginia	22	24			37	930	11	2
West Virginia	17	23	151	371	2	529	2	11
North Carolina [1]	23	23	67	198	28	778	2	4
South Carolina [1]	2	3	1,009	1,022	10	17	2	0
Georgia [1]	10	4	490	535			0	0
Florida	9	3	4	80	2	36	0	0

See footnotes at end of table.

Cases of certain communicable diseases reported by telegraph by State health officers for weeks ended Feb. 8, 1936, and Feb. 9, 1935—Continued

Division and State	Diphtheria		Influenza		Measles		Meningococcus meningitis	
	Week ended Feb. 8, 1936	Week ended Feb. 9, 1935	Week ended Feb. 8, 1936	Week ended Feb. 9, 1935	Week ended Feb. 8, 1936	Week ended Feb. 9, 1935	Week ended Feb. 8, 1936	Week ended Feb. 9, 1935
East South Central States:								
Kentucky	9	23	101	383	70	666	11	5
Tennessee	10	17	176	351	29	18	6	6
Alabama [1]	12	21	334	2,392	25	256	0	1
Mississippi [3]	8	8	----	----	----	----	0	1
West South Central States:								
Arkansas	12	2	166	31	2	13	0	5
Louisiana	13	46	31	63	96	71	0	0
Oklahoma [4]	9	12	285	279	1	59	7	2
Texas [1]	48	56	491	901	126	123	9	2
Mountain States:								
Montana	6	2	6	503	20	223	1	1
Idaho	----	----	8	1	50	74	1	1
Wyoming	1	----	----	----	5	210	0	1
Colorado	3	3	----	----	34	586	1	0
New Mexico	7	5	2	80	9	20	0	1
Arizona	4	1	175	214	13	10	0	1
Utah [3]	----	----	----	----	4	10	0	0
Pacific States:								
Washington	1	----	----	33	182	107	2	3
Oregon	5	----	33	181	616	81	1	1
California	46	54	522	461	1,336	282	9	6
Total	583	690	4,577	9,530	6,519	21,268	165	104
First 6 weeks of year	4,268	4,792	17,503	54,192	31,671	95,006	1,011	539

Division and State	Poliomyelitis		Scarlet fever		Smallpox		Typhoid fever	
	Week ended Feb. 8, 1936	Week ended Feb. 9, 1935	Week ended Feb. 8, 1936	Week ended Feb. 9, 1935	Week ended Feb. 8, 1936	Week ended Feb. 9, 1935	Week ended Feb. 8, 1936	Week ended Feb. 9, 1935
New England States:								
Maine	0	1	47	18	0	0	0	2
New Hampshire	0	0	6	10	0	0	0	0
Vermont	2	0	16	17	0	0	0	0
Massachusetts	0	0	250	169	0	0	0	1
Rhode Island	0	0	30	12	0	0	1	0
Connecticut [1]	0	0	69	49	0	0	2	0
Middle Atlantic States:								
New York	1	3	955	699	0	0	7	5
New Jersey	0	0	276	138	0	0	1	1
Pennsylvania	2	1	452	647	0	0	4	9
East North Central States:								
Ohio	0	0	304	867	3	2	3	4
Indiana	0	0	355	269	0	1	2	1
Illinois	0	1	756	954	12	2	2	9
Michigan	1	0	250	319	1	0	4	6
Wisconsin	0	0	646	627	11	35	4	3
West North Central States:								
Minnesota	0	0	315	122	12	2	1	1
Iowa	0	0	182	101	25	2	5	2
Missouri	4	2	145	119	17	4	0	5
North Dakota	0	0	86	----	2	0	1	0
South Dakota	0	0	30	10	14	2	0	2
Nebraska	0	0	188	39	53	27	0	0
Kansas	1	0	209	108	10	3	0	0
South Atlantic States:								
Delaware	0	0	7	22	0	0	0	0
Maryland [3]	0	0	73	97	0	0	1	4
District of Columbia	1	0	30	25	0	0	0	2
Virginia	0	0	40	78	0	0	8	3
West Virginia	1	2	42	157	0	0	2	1
North Carolina [1]	0	1	28	26	0	0	4	0
South Carolina [1]	0	0	3	10	0	0	0	4
Georgia [1]	0	0	19	3	0	0	1	2
Florida	0	0	8	16	0	0	3	0

See footnotes at end of table.

Cases of certain communicable diseases reported by telegraph by State health officers for weeks ended Feb. 8, 1936, and Feb. 9, 1935—Continued

Division and State	Poliomyelitis		Scarlet fever		Smallpox		Typhoid fever	
	Week ended Feb. 8, 1936	Week ended Feb. 9, 1935	Week ended Feb. 8, 1936	Week ended Feb. 9, 1935	Week ended Feb. 8, 1936	Week ended Feb. 9, 1935	Week ended Feb. 8, 1936	Week ended Feb. 9, 1935
East South Central States:								
Kentucky	0	0	39	61	0	0	5	4
Tennessee	0	1	37	26	0	1	3	3
Alabama [1]	1	1	22	15	2	0	1	0
Mississippi [3]	0	0	11	21	0	0	1	3
West South Central States:								
Arkansas	0	0	18	15	0	3	1	1
Louisiana	0	1	15	25	0	0	2	15
Oklahoma [4]	1	0	21	32	2	1	2	5
Texas [1]	0	1	52	79	0	93	2	16
Mountain States:								
Montana	0	0	126	15	11	9	4	0
Idaho	0	0	75	10	2	0	2	0
Wyoming	0	0	101	19	5	12	0	0
Colorado	0	0	238	291	23	0	1	1
New Mexico	0	0	47	18	0	1	1	1
Arizona	0	0	22	35	0	0	0	2
Utah [3]	0	0	133	85	0	0	0	0
Pacific States:								
Washington	0	0	86	51	12	34	2	2
Oregon	1	0	45	59	2	2	0	0
California	2	8	421	227	0	5	2	4
Total	18	23	7,326	6,812	219	241	85	124
First 6 weeks of year	112	166	43,097	37,913	1,245	1,193	630	880

[1] Typhus fever, week ended Feb. 8, 1936, 14 cases, as follows: Connecticut, 1; North Carolina, 1; South Carolina, 4; Georgia, 2; Alabama, 3; Texas, 3.
[2] New York City only.
[3] Week ended earlier than Saturday.
[4] Exclusive of Oklahoma City and Tulsa.

SUMMARY OF MONTHLY REPORTS FROM STATES

The following summary of cases reported monthly by States is published weekly and covers only those States from which reports are received during the current week:

State	Meningococcus meningitis	Diphtheria	Influenza	Malaria	Measles	Pellagra	Poliomyelitis	Scarlet fever	Smallpox	Typhoid fever
October 1935										
New Hampshire	-------	3	-------	-------	-------	-------	6	16	0	0
South Dakota	4	26	4	1	31	-------	6	150	40	9
Tennessee	11	282	45	250	3	27	3	344	0	84
November 1935										
North Carolina	5	347	33	-------	60	22	18	309	3	34
Wisconsin	4	14	170	-------	242	-------	5	1,470	36	11
December 1935										
Hawaii Territory	1	3	4,073	-------	-------	-------	0	1	0	5
Wisconsin	9	10	268	-------	364	-------	1	2,155	57	6
January 1936										
Arkansas	18	52	395	75	16	25	0	76	6	10
Connecticut	9	14	66	-------	374	-------	0	265	0	5
Delaware	1	6	1	-------	636	-------	0	64	0	2
Indiana	13	177	199	-------	231	-------	3	1,345	16	3
Missouri	16	143	902	11	99	1	3	1,032	19	10
New Mexico	6	13	19	2	13	-------	2	234	1	18
North Carolina	16	116	69	-------	75	30	4	172	2	14

October 1935

	Cases
South Dakota:	
Chickenpox	65
Mumps	64
Ophthalmia neonatorum	1
Trachoma	2
Undulant fever	1
Whooping cough	24
Tennessee:	
Chickenpox	16
Dysentery (amoebic)	1
Dysentery (unspecified)	7
Epidemic encephalitis	2
German measles	1
Impetigo contagiosa	3
Mumps	14
Ophthalmia neonatorum	2
Paratyphoid fever	3
Scabies	10
Septic sore throat	8
Tetanus	4
Tularaemia	1
Typhus fever	1
Vincent's infection	5
Whooping cough	105

November 1935

North Carolina:	
Chickenpox	308
German measles	14
Ophthalmia neonatorum	2
Paratyphoid fever	1
Septic sore throat	8
Typhus fever	4
Undulant fever	5
Whooping cough	130
Wisconsin:	
Chickenpox	3,371
Dysentery (amoebic)	1
Mumps	2,473
Ophthalmia neonatorum	3
Trachoma	1
Tularaemia	3
Undulant fever	13
Whooping cough	813

December 1935

Hawaii Territory:	
Chickenpox	16
Dysentery (amoebic)	1
Leprosy	5
Mumps	6
Paratyphoid fever	2
Typhus fever	2
Whooping cough	36
Wisconsin:	
Chickenpox	4,410
Dysentery (amoebic)	2
Epidemic encephalitis	5
German measles	112
Mumps	4,225
Septic sore throat	23
Tularaemia	5
Undulant fever	6
Whooping cough	852

January 1936

Anthrax:	
Delaware	1
Chickenpox:	
Arkansas	101
Connecticut	791
Delaware	94
Indiana	491
Missouri	451
New Mexico	179
North Carolina	607
Conjunctivitis:	
Connecticut	12
Dysentery:	
Connecticut (bacillary)	4
Missouri	5
New Mexico (amoebic)	2
New Mexico (unspecified)	1
Epidemic encephalitis:	
Connecticut	1
Indiana	1
Missouri	1
Food poisoning:	
New Mexico	7
German measles:	
Connecticut	445
Delaware	1
New Mexico	2
North Carolina	93

January 1936—Continued

	Cases
Mumps:	
Arkansas	306
Connecticut	466
Delaware	60
Indiana	379
Missouri	711
New Mexico	434
Ophthalmia neonatorum:	
North Carolina	2
Paratyphoid fever:	
Connecticut	2
Puerperal septicemia:	
New Mexico	6
Rabies in animals:	
Indiana	32
Missouri	7
Rocky Mountain spotted fever:	
North Carolina	1
Scabies:	
Delaware	1
Septic sore throat:	
Connecticut	11
Missouri	83
New Mexico	9
North Carolina	7
Trachoma:	
Arkansas	9
Connecticut	1
Missouri	20
Trichinosis:	
Connecticut	1
Tularaemia:	
Missouri	7
New Mexico	1
North Carolina	2
Undulant fever:	
Connecticut	4
Missouri	2
Whooping cough:	
Arkansas	36
Connecticut	282
Delaware	84
Indiana	139
Missouri	92
New Mexico	99
North Carolina	88

WEEKLY REPORTS FROM CITIES

City reports for week ended Feb. 1, 1936

This table summarizes the reports received weekly from a selected list of 140 cities for the purpose of showing a cross section of the current urban incidence of the communicable diseases listed in the table. Weekly reports are received from about 700 cities, from which the data are tabulated and filed for reference.

State and city	Diphtheria cases	Influenza cases	Influenza deaths	Measles cases	Pneumonia deaths	Scarlet fever cases	Smallpox cases	Tuberculosis deaths	Typhoid fever cases	Whooping cough cases	Deaths, all causes
Maine:											
Portland	0	------	0	2	1	3	0	0	0	6	26
New Hampshire:											
Concord	0	------	0	0	1	2	0	0	0	0	11
Manchester	0	------	0	1	2	1	0	0	0	0	13
Nashua	0	------	------	3	3	0	0	------	0	0	------
Vermont:											
Barre	0	------	0	0	0	0	0	1	0	0	8
Burlington	0	------	0	0	0	4	0	0	0	0	10
Rutland	0	------	0	2	0	1	0	0	0	0	5
Massachusetts:											
Boston	4	------	1	127	33	55	0	8	1	14	270
Fall River	0	------	1	0	6	7	0	0	0	0	37
Springfield	0	------	0	1	3	6	0	1	0	5	44
Worcester	0	------	0	0	5	10	0	5	0	5	56
Rhode Island:											
Pawtucket	0	------	0	0	0	1	0	0	0	0	16
Providence	0	------	0	11	4	5	0	2	0	2	60
Connecticut:											
Bridgeport	0	------	0	0	2	2	0	1	1	0	37
Hartford	0	------	0	2	9	3	0	0	0	3	51
New Haven	0	2	1	0	3	1	0	1	0	16	43

City reports for week ended Feb. 1, 1936—Continued

State and city	Diphtheria cases	Influenza		Measles cases	Pneumonia deaths	Scarlet fever cases	Smallpox cases	Tuberculosis deaths	Typhoid fever cases	Whooping cough cases	Deaths, all causes
		Cases	Deaths								
New York:											
Buffalo	0	------	2	19	18	62	0	5	0	9	165
New York	28	17	4	549	183	300	0	89	3	83	1,665
Rochester	1	------	0	0	6	2	0	1	1	6	82
Syracuse	0	------	0	17	6	18	0	1	0	17	47
New Jersey:											
Camden	0	------	0	3	2	13	0	3	0	7	40
Newark	0	1	0	5	11	90	0	10	0	19	111
Trenton	0	------	0	0	8	2	0	6	0	17	53
Pennsylvania:											
Philadelphia	4	2	1	235	35	77	0	21	2	59	486
Pittsburgh	6	2	4	18	32	100	0	7	0	16	196
Reading	0	------	0	1	4	6	0	1	0	4	39
Scranton	1	------	--------	8	------	7	0	-------	0	1	--------
Ohio:											
Cincinnati	3	------	0	3	19	10	0	13	0	10	188
Cleveland	5	40	2	47	16	39	0	9	1	57	202
Columbus	5	3	3	1	9	19	0	4	0	2	105
Toledo	1	------	0	13	5	5	0	5	0	7	90
Indiana:											
Anderson	4	------	0	0	0	2	1	0	0	0	--------
Fort Wayne	1	------	0	0	3	10	0	0	0	1	33
Indianapolis	3	------	0	1	23	29	0	9	0	16	126
Muncie	0	------	0	0	3	0	0	0	0	0	10
South Bend	0	------	0	0	4	1	0	1	0	1	23
Terre Haute	0	------	0	0	0	1	0	0	0	0	25
Illinois:											
Alton	0	------	0	0	0	0	0	0	0	0	11
Chicago	14	7	7	14	43	210	0	39	0	230	785
Elgin	0	------	0	1	0	0	0	0	0	0	10
Springfield	0	------	0	0	4	7	0	1	0	0	31
Michigan:											
Detroit	6	3	0	8	42	68	0	19	0	148	306
Flint	3	------	0	1	7	10	0	0	0	4	27
Grand Rapids	0	------	0	3	5	11	0	1	0	8	38
Wisconsin:											
Kenosha	0	------	1	0	0	6	0	1	0	4	10
Milwaukee	0	2	2	1	4	66	0	2	1	97	119
Racine	0	------	0	2	1	18	0	0	0	2	19
Superior	0	------	0	0	1	12	0	0	0	0	10
Minnesota:											
Duluth	0	------	0	2	0	2	0	0	0	7	17
Minneapolis	2	------	1	68	6	124	0	0	1	6	111
St. Paul	0	------	0	46	6	42	0	1	0	4	62
Iowa:											
Cedar Rapids	0	------	--------	0	-------	2	0	-------	1	1	--------
Davenport	0	------	--------	0	-------	11	0	-------	0	0	--------
Des Moines	1	------	--------	0	-------	3	1	-------	0	0	29
Sioux City	0	------	--------	2	-------	6	17	-------	0	0	--------
Waterloo	1	------	--------	2	-------	4	0	-------	0	0	--------
Missouri:											
Kansas City	1	------	1	1	25	37	0	5	1	1	84
St. Joseph	1	------	0	0	11	5	0	2	0	0	37
St. Louis	8	2	--------	3	22	37	0	10	1	3	237
North Dakota:											
Fargo	2	------	0	0	1	13	0	0	0	1	6
Grand Forks	0	------	--------	0	-------	0	1	-------	0	1	--------
Minot	0	------	0	0	0	9	0	0	0	0	2
South Dakota:											
Aberdeen	0	------	--------	0	-------	0	0	-------	0	0	--------
Nebraska:											
Omaha	0	------	1	5	11	76	3	1	0	1	59
Kansas:											
Lawrence	0	------	0	0	0	1	0	0	0	0	--------
Topeka	0	------	2	0	5	21	0	1	0	0	40
Wichita	1	------	0	1	7	22	0	1	0	1	38
Delaware:											
Wilmington	1	------	0	1	4	2	0	3	0	7	35
Maryland:											
Baltimore	3	6	0	17	24	24	0	9	2	30	224
Cumberland	1	------	0	0	0	1	0	0	0	0	15
Frederick	0	------	0	0	2	0	0	0	0	0	4
District of Columbia:											
Washington	19	4	3	6	24	16	0	10	1	7	206
Virginia:											
Lynchburg	0	------	0	8	2	1	0	0	0	9	11
Norfolk	2	------	0	0	4	2	0	3	0	1	34
Richmond	0	------	1	0	13	9	0	2	1	1	76
Roanoke	1	------	0	0	1	2	0	1	0	0	17

City reports for week ended Feb. 1, 1936—Continued

State and city	Diphtheria cases	Influenza		Measles cases	Pneumonia deaths	Scarlet fever cases	Smallpox cases	Tuberculosis deaths	Typhoid fever cases	Whooping cough cases	Deaths, all causes
		Cases	Deaths								
West Virginia:											
Charleston	0	-----	0	0	3	1	0	0	0	0	24
Huntington	1	-----	-----	0	-----	1	0	-----	0	0	-----
Wheeling	1	-----	1	1	1	0	0	0	0	1	25
North Carolina:											
Gastonia	0	1	0	0	0	0	0	0	0	0	7
Raleigh	0	-----	0	0	3	2	0	1	0	6	15
Wilmington	0	-----	0	0	0	0	0	0	0	0	5
Winston-Salem	1	1	0	29	7	3	0	0	0	0	19
South Carolina:											
Charleston	0	99	1	1	4	4	0	0	1	3	28
Columbia	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----
Florence	0	-----	0	0	2	0	0	0	0	0	17
Greenville	0	-----	0	12	1	0	0	1	0	0	22
Georgia:											
Atlanta	6	21	1	0	7	14	0	5	0	0	96
Brunswick	1	1	1	0	4	0	0	0	0	0	9
Savannah	0	31	0	0	6	3	0	4	0	2	39
Florida:											
Miami	2	2	0	0	2	7	0	3	0	3	50
Tampa	0	-----	0	0	1	2	0	2	0	0	30
Kentucky:											
Ashland	1	-----	-----	0	-----	0	0	-----	0	0	-----
Covington	2	-----	0	0	2	3	0	2	0	2	21
Lexington	0	-----	0	0	5	0	0	2	0	0	25
Louisville	1	7	0	0	18	21	0	6	0	8	84
Tennessee:											
Knoxville	1	13	1	0	5	0	0	0	0	0	14
Memphis	0	-----	0	0	9	3	0	6	0	3	99
Nashville	0	-----	1	0	3	4	0	0	0	0	59
Alabama:											
Birmingham	2	10	2	0	15	4	0	2	0	1	80
Mobile	1	2	0	0	4	1	0	0	0	0	25
Montgomery	0	2	-----	0	-----	0	0	-----	0	0	-----
Arkansas:											
Fort Smith	0	-----	-----	0	-----	0	0	-----	0	0	-----
Little Rock	6	-----	1	6	13	1	0	3	0	0	17
Louisiana:											
Lake Charles	1	-----	0	0	0	0	0	0	0	0	2
New Orleans	4	5	2	11	21	5	0	10	0	4	187
Shreveport	1	-----	0	12	13	4	0	3	0	0	44
Texas:											
Dallas	4	4	4	8	9	15	0	4	0	3	70
Fort Worth	4	-----	1	0	2	6	0	1	0	0	37
Galveston	2	-----	0	2	3	1	0	2	0	0	19
Houston	6	-----	2	2	10	5	0	10	0	1	95
San Antonio	1	1	1	0	15	1	0	5	0	0	59
Montana:											
Billings	1	-----	0	0	2	7	0	0	0	4	7
Great Falls	1	-----	0	1	0	3	0	0	0	6	7
Helena	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----
Missoula	0	-----	0	0	4	19	0	0	0	1	13
Idaho:											
Boise	0	-----	0	0	1	6	0	0	0	0	9
Colorado:											
Colorado Springs	0	-----	1	2	0	8	3	0	0	1	17
Denver	4	-----	1	5	12	23	0	2	0	11	83
Pueblo	0	-----	0	2	4	16	0	0	0	0	17
New Mexico:											
Albuquerque	3	-----	1	1	4	19	0	6	0	2	23
Utah:											
Salt Lake City	2	-----	0	0	1	35	0	1	0	6	40
Nevada:											
Reno	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----
Washington:											
Seattle	0	-----	4	29	7	31	0	4	1	4	84
Spokane	0	1	1	4	3	6	0	1	0	1	29
Tacoma	0	-----	0	2	3	7	0	0	0	3	33
Oregon:											
Portland	0	-----	1	233	5	7	0	5	0	7	74
Salem	0	-----	-----	1	-----	2	0	-----	0	0	-----
California:											
Los Angeles	5	31	0	144	22	79	0	17	1	16	367
Sacramento	1	-----	1	5	1	18	3	2	1	3	38
San Francisco	0	23	1	286	12	79	1	11	1	22	184

City reports for week ended Feb. 1, 1936—Continued

State and city	Meningococcus meningitis		Poliomyelitis cases
	Cases	Deaths	
Massachusetts:			
Boston	1	1	0
Springfield	1	1	0
Rhode Island:			
Providence	1	0	1
New York:			
Buffalo	0	1	0
New York	19	7	0
Rochester	1	0	0
New Jersey:			
Newark	1	0	0
Pennsylvania:			
Philadelphia	1	0	0
Pittsburgh	1	0	0
Ohio:			
Cincinnati	3	3	0
Cleveland	3	1	0
Columbus	0	1	0
Toledo	1	0	0
Indiana:			
Indianapolis	0	1	0
Illinois:			
Chicago	6	3	0
Springfield	1	2	0
Michigan:			
Detroit	2	1	0
Minnesota:			
Minneapolis	3	0	0
St. Paul	1	0	0
Iowa:			
Des Moines	1	0	0
Missouri:			
Kansas City	1	0	0
St. Joseph	2	1	0
St. Louis	3	0	0
Kansas:			
Wichita	0	0	1
Maryland:			
Baltimore	12	4	0
District of Columbia:			
Washington	4	2	0
North Carolina:			
Raleigh	1	1	0
South Carolina:			
Charleston	1	0	0
Georgia:			
Atlanta	1	0	0
Kentucky:			
Louisville	1	0	0
Tennessee:			
Knoxville	1	1	0
Memphis	2	0	0
Nashville	1	2	0
Alabama:			
Birmingham	0	0	1
Louisiana:			
Shreveport	0	1	0
Texas:			
Dallas	1	0	0
Galveston	0	1	0
Houston	2	2	0
Colorado:			
Denver	1	0	0
Oregon:			
Portland	0	1	0
California:			
Los Angeles	2	0	0
Sacramento	2	1	0
San Francisco	0	1	0

Pellagra.—Cases: Savannah 4; Birmingham 2.
Typhus fever.—Cases: Baltimore 1; Savannah 1.

FOREIGN AND INSULAR

CANADA

Provinces—Communicable diseases—2 weeks ended January 25, 1936.—During the 2 weeks ended January 25, 1936, cases of certain communicable diseases were reported by the Department of Pensions and National Health of Canada as follows:

Disease	Prince Edward Island	Nova Scotia	New Brunswick	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Total
Cerebrospinal meningitis				5	2		1		1	9
Chicken pox		21		473	935	108	71	20	210	1,838
Diphtheria		12	6	40	18	11	2	11		100
Dysentery				1	1	1				3
Erysipelas		2		8	5	8	1	8	7	39
Influenza		3			57	64	10		41	175
Lethargic encephalitis				1	2	1			8	12
Measles	6	90	6	1,162	3,233	579	1,055	64	643	6,838
Mumps		6	2		1,047	127	442	23	485	2,132
Paratyphoid fever					7					7
Pneumonia	1				42				11	54
Poliomyelitis								3		3
Scarlet fever		15	12	189	650	92	33	165	65	1,221
Smallpox									2	2
Trachoma							1		2	3
Tuberculosis	2	15	9	81	97	31	1	3	35	274
Typhoid fever			1	28	5	1	1	1		37
Undulant fever				2	11		1	1		15
Whooping cough	6	35	24	125	525	18	68	21	58	880

ITALY

Communicable diseases—4 weeks ended November 10, 1935.—During the 4 weeks ended November 10, 1935, cases of certain communicable diseases were reported in Italy as follows:

Disease	Oct. 14–20		Oct. 21–27		Oct. 28–Nov. 3		Nov. 4–10	
	Cases	Communes affected	Cases	Communes affected	Cases	Communes affected	Cases	Communes affected
Anthrax	30	25	26	25	35	25	39	38
Cerebrospinal meningitis	6	6	2	2	3	3	10	9
Chicken pox	108	62	131	65	126	67	159	89
Diphtheria and croup	530	286	632	301	591	292	718	351
Dysentery	16	14	18	15	4	3	19	12
Hookworm disease	29	6	12	9	8	7	7	6
Lethargic encephalitis	2	2	2	2	2	2	1	1
Measles	636	145	780	164	799	166	937	189
Paratyphoid fever	111	75	111	83	106	79	95	66
Poliomyelitis	33	23	23	19	25	18	30	21
Puerperal fever	30	28	46	42	40	38	43	38
Rabies					1	1		
Scarlet fever	488	182	608	205	546	210	685	229
Typhoid fever	850	407	875	438	667	371	820	426
Undulant fever	16	13	20	18	24	22	28	23
Whooping cough	132	55	179	61	144	48	197	66

CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER

NOTE.—A table giving current information of the world prevalence of quarantinable diseases appeared in the PUBLIC HEALTH REPORTS for January 31, 1936, pages 122-137. A similar cumulative table will appear in the PUBLIC HEALTH REPORTS to be issued February 28, 1936, and thereafter, at least for the time being, in the issue published on the last Friday of each month.

Plague

India—Bombay.—During the week ended January 25, 1936, 1 imported case of plague was reported in Bombay, India.

Yellow Fever

Brazil.—Yellow fever has been reported in Brazil as follows: Itauna, Bahia State, December 21, 1935, to January 5, 1936, 2 cases, 2 deaths; Campo Grande, Matto Grosso State, January 13, 1936, 1 case, 1 death; Minas Geraes State, Santa Rita de Cassia, January 12, 1936, 1 case, 1 death; Santa Cruz das Areias, January 14, 1936, 1 case, 1 death; Altinopolis, January 15, 1936, 1 case, 1 death.