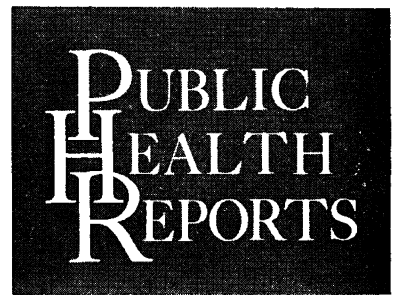


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**GOLDSTEIN, HYMAN (Public Health Service), GOLDBERG, IRVING D., FRAZIER, TODD M., and DAVIS, GEORGE E.: Cigarette Smoking and Prematurity. *Public Health Reports, Vol. 79, July 1964, pp. 553-560.***

Most of the comparatively few controlled studies to determine whether a history of smoking by a gravida, or pregnant woman, increases the risk of having a premature birth have been retrospective in approach, where smoking histories have been obtained post partum. However, all the evidence, whether obtained from retrospective or prospective studies, points to an association between smoking and prematurity. The association tends to retard fetal growth but not by shortening gestation as a result of earlier onset of labor. Most studies appear to indicate a direct correlation between the prematurity rate and the amount smoked. In any explanation of the observed association between smoking and prematurity, one must look for possible third

factors or for a multiplicity of causes related both to smoking habits and reduced birth weight. Possibly the smoking gravida population, in whole or in part, is to some degree self-selected. The argument for causation can be tested by comparing outcomes for women who are motivated to stop smoking during pregnancy with the outcomes for a similar population not so motivated. A major difficulty to be surmounted is devising an effective method of getting women to discontinue smoking. Another difficulty, the development of an objective indicator of smoking, has already been overcome by the perfection of a test to detect a substance in urine, acetonitrile, which is quantitatively correlated with the amount smoked.

**FREITAG, JULIA L. (New York State Department of Health): Treatment of chronic typhoid carriers by cholecystectomy. *Public Health Reports, Vol. 79, July 1964, pp. 567-570.***

Release of typhoid carriers in New York State no longer requires submission of duodenal specimens. This modification was based primarily on the findings that: (a) gallbladder carriers consistently excrete typhoid bacilli in their stools, (b) if cured by cholecystectomy, carriers convert to consistently negative stools, and (c) no carrier would have been released prematurely if examination of

duodenal specimens had been omitted.

From 1945 through 1963, 54 chronic typhoid carriers underwent cholecystectomy. Of 34 for whom determination of postoperative status was possible, 30 were considered cured. Ninety-seven percent of the preoperative fecal specimens submitted were positive for *Salmonella typhosa*.

**BROWN, GORDON C. (School of Public Health, University of Michigan), VOLK, V. K., GOTTSCHALL, RUSSELL Y., KENDRICK, PEARL L., and ANDERSON, H. D.: Responses of infants to DTP-P vaccine used in nine injection schedules. *Public Health Reports, Vol. 79, July 1964, pp. 585-602.***

A comparison of primary and secondary responses of 373 infants to the individual components of DTP-Polio vaccine revealed that if poliomyelitis immunization is started too early failures may be expected and the risk of disease following exposure will exist during the interval between the primary series and the "booster" injection. Even after the booster, more than one-fifth of all the infants studied could have been considered susceptible to poliomyelitis.

Fifty percent of the infants failed to respond to primary stimulation with types 1 and 2 poliomyelitis and 39 percent to type 3: 30, 25, and 20 percent respectively failed to respond to the three types after booster.

The diphtheria and tetanus antibody responses were generally high in all

groups of infants following both primary and secondary inoculation and were considered far in excess of the levels usually required for protection. The pertussis component of the vaccine was of relatively low potency; 35 percent of the infants failed to respond to primary stimulation and 21 percent failed after the booster.

The majority of vaccine failures occurred in infants with high titers of maternal antibody at the time of first injection. This suppression of active immunization occurred most frequently in children started at the age of 3 or 4 months and was most noticeable in the response to poliomyelitis components of the vaccine. Infants aged 5 months or older showed the best response.

*The nature of a paper, not its importance or significance, determines whether a synopsis is printed. See "Information for Contributors" on next page.*

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