CENTER FOR DISEASE CONTROL

Morbidity and Mortality

Vol. 24, No. 35

WEEKLY REPORT

For Week Ending August 30, 1975

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE

DATE OF RELEASE: SEPTEMBER 5, 1975 – ATLANTA, GEORGIA 30333

EPIDEMIOLOGIC NOTES AND REPORTS
NEONATAL HYPERBILIRUBINEMIA
New Jersey, Wyoming

Investigations of 2 epidemics of idiopathic neonatal hyperbilirubinemia in the United States since 1972 have suggested an association between excessive use of a phenolic disinfectant detergent and hyperbilirubinemia in newborns. The epidemic investigations were conducted in New Jersey and Wyoming.

NEW JERSEY

Eight (62%) of 13 babies born between March 29 and April 7, 1972, at a hospital in New Jersey required exchange transfusions for idiopathic hyperbilirubinemia. The average total bilirubin level was 29.6 mg/100 ml, with 1 baby having a level of 42 mg/100 ml (direct reacting = 2.1 mg/100 ml).

CONTENTS

TABLE I. CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES
(Cumulative totals include revised and delayed reports through previous weeks)

DISEASE	35th WEEK ENDING		MEDIAN 1970-1974	CUMULATIVE, FIRST 35 WEEKS		MEDIAN 1970-1974
	August 30, 1975	August 31, 1974		August 30, 1975	August 31, 1974	
Aseptic meningitis	125	113	189	1,960	1,859	2,689
Brucellosis	2	7	3	153	111	121
Chickenpox	228	240	– – –	116,515	99,165	– – –
Diphtheria	5	8	4	210	173	123
Encephalitis, Primary	62	22	38	637	615	900
Encephalitis, Post-Infectious	5	5	5	231	189	210
Hepatitis, Viral, Type B	259	198	186	7,770	6,388	5,751
Hepatitis, Viral, Type A	749	722	988	23,605	28,417	36,994
Hepatitis, Viral, Type unspecified	150	145		5,417	5,624	
Malaria	9	7	9	277	140	674
Measles (rubeola)	69	109	109	21,145	19,689	26,750
Meningococcal infections, total	28	17	17	1,060	948	1,035
Civilian	26	17	17	1,035	923	1,010
Military	2	–	–	25	25	38
Mumps	320	210	287	46,457	44,091	56,278
Pertussis	46	51	– – –	1,014	1,097	– – –
Rubella (German measles)	51	104	174	14,704	9,669	25,836
Tetanus	1	2	2	59	62	69
Tuberculosis	629	604	– – –	22,545	20,668	– – –
Tularemia	3	12	7	83	104	
Typhoid fever	11	18	10	211	263	234
Typhus, tick-borne (Rky. Mt. spotted fever)	26	41	22	643	647	400
Venereal Diseases:						
Gonorrhea, Civilian	20,391	18,068	– – –	655,987	589,172	– – –
Gonorrhea, Military	326	625	– – –	20,045	19,841	– – –
Syphilis, primary and secondary, Civilian	462	507	– – –	17,172	16,953	– – –
Syphilis, primary and secondary, Military	6	10	– – –	240	313	– – –
Rabies in animals	42	58	60	1,667	1,987	2,517

TABLE II. NOTIFIABLE DISEASES OF LOW FREQUENCY

	Cum.		Cum.
Anthrax:	1	Poliomyelitis, total:	3
Botulism:	14	Paralytic:	3
Congenital rubella syndrome:	17	Psittacosis: Mich. 1, Fla. 1	32
Leprosy: Ill. 1, Calif. 1	114	Rabies in man:	1
Leptospirosis: Fla. 1, Ala. 1, Calif. 1	32	Trichinosis* Conn. 3, Wisc. 1	65
Plague:	9	Typhus, murine: Texas 1	25

*Delayed reports: Trichinosis: N.J. 15

HYPERBILIRUBINEMIA – Continued

The affected babies had no illnesses or other conditions. Furthermore, they did not differ from a random sample of other infants born in the hospital regarding factors that might explain a sudden increase in the number of cases of hyperbilirubinemia.

Investigation revealed that a phenolic disinfectant detergent (active ingredients: glycolic acid 12.6%, o-benzyl-p-chlorophenol 6.4%, p-tertiary amylphenol 3%, and o-phenylphenol 0.5%) was routinely used in the nursery to clean walls and floors, and in concentrations 2 to 4 times the recommended strength (½ ounce per gallon of water), to clean bassinets and incubators after each baby was discharged. Most nurses reported wiping the disinfectant off the surfaces of this equipment after application. A mechanical engineer found no major abnormalities in the air-handling system of the hospital.

The nursery had been given a particularly thorough cleaning with the disinfectant on April 5, and beginning that day and continuing for the next 2 days, peak bilirubin levels occurred in 6 of the 8 infants.

After the disinfectant was removed and nursing procedures revised, the epidemic ceased. In the period April 10-November 30, 1972, only 1 of 557 babies born in the hospital required an exchange transfusion for idiopathic hyperbilirubinemia.

(Reported by Ronald Altman, MD, State Epidemiologist, and Martin Goldfield, MD, Assistant Commissioner, New Jersey State Department of Health: and an EIS Officer.)

WYOMING

Between May 1 and May 31, 1975, 10 (18.5%) of 54 newborns in a hospital nursery in Wyoming developed idiopathic hyperbilirubinemia, compared to 11 (7.5%) of 147 newborns in all of 1974. Two of the 10 infants had peak levels between 17 and 20 mg/100 ml, and 4 had bilirubin concentrations greater than 20 mg/100 ml (average direct reacting = 1.75 mg/100 ml). The highest level was 24 mg/100 ml. Affected babies had no other illnesses, nor did they differ significantly from unaffected infants regarding factors that might account for the hyperbilirubinemia.

The same phenolic disinfectant detergent used in the New Jersey hospital was also used in this nursery. The detergent was diluted according to directions to clean the walls and floors, but in January 1975 a change of personnel brought about more frequent cleanings. Some of the nursing staff also used this compound in concentrations 4 or more times the recommended strength to clean bassinets, mattresses, and incubators. Equipment was not wiped or rinsed after application of the disinfectant detergent. A professional engineer inspected the ventilation system within the nursery and found it to be inadequate as operated. The air-handling unit was manually turned off at times, and a blocked exhaust air register had resulted in little or no air movement within the nursery.

Use of the disinfectant in the nursery was stopped on June 9, and on July 2 the ventilation defects were corrected. In June and July, 3 (12%) of newborn infants had idiopathic hyperbilirubinemia; the highest total bilirubin concentrations recorded were 14.3 mg/100 ml in a term infant and 15.6 mg/100 ml in a preterm infant. Measurements of levels of the phenolic disinfectant components in blood and urine specimens from housekeeping staff and from both affected and unaffected infants are pending.

(Reported by James R Little, MD, Private Pediatrician; Herman S Parish, MD, State Epidemiologist, Wyoming Department of Health; the Microbiologic Control Branch, Bacterial Diseases Division, and the Birth Defects Branch, Cancer and Birth Defects Division, Bureau of Epidemiology, CDC; and an EIS Officer.)

Editorial Note

In both of these episodes serum bilirubin concentrations in affected infants exceeded values normally attributable to physiologic jaundice of the newborn (12 mg/100 ml in term infants and 15 mg/100 ml in preterm infants) (*1*). Some babies had levels high enough to require exchange transfusions to prevent possible brain damage associated with excessive concentrations of serum bilirubin.

The results of these investigations suggest a causal relationship between the use of this disinfectant detergent and the occurrence of marked idiopathic hyperbilirubinemia. Despite the widespread hospital use of this and other phenolic disinfectant detergents, reports of such outbreaks have been infrequent, suggesting that they either go unnoticed or that the compounds are toxic only in rare, unusual circumstances. Circumstances suggested here include: using the disinfectant in concentrations greater than those recommended; too frequently cleaning the nursery surfaces and equipment; and/or inadequately ventilating the nursery.

Further information concerning this possible association is needed, as are delineation of the offending agent(s), the route(s) of absorption, and their mode of action in the newborn infant. Until more is known about this phenomenon, the importance of diluting and using phenolic disinfectant detergents according to label directions should be stressed. Where such detergents are used in newborn nurseries, it would be appropriate to review records for previously unrecognized episodes of hyperbilirubinemia.

Reference

1. Brown AK: Jaundice. In Neonatology Diseases of the Fetus and Infant, edited by Behrman RE, St. Louis, The CV Mosby Co, 1973, p 222

PLAGUE IN ANIMALS – Texas

On August 1, 1975, personnel from the Texas State Health Department and the U.S. Fish and Wildlife Service discovered a widespread prairie dog die-off in the Muleshoe National Wildlife Refuge, Bailey County, Texas. Rodent fleas collected from prairie dog burrows were forwarded to CDC's Plague Branch, and 1 of 6 flea pools was positive for *Yersinia pestis*. On the basis of field evidence of a plague epizootic among prairie dogs on the Refuge, it was recommended on August 7 that the area be closed to public access and treated with carbaryl for flea control. Approximately 25 acres near Refuge Headquarters and management residences have now been treated, and the Fish and Wildlife Service stated that the area will be closed to public access for at least the next 6 weeks.

Aerial surveys of Bailey County by the U.S. Fish and Wildlife Service, Lubbock, Texas, indicated that prairie dog colonies in a number of rangeland areas may have experienced die-offs in the past several months. None of these colonies are believed to present a hazard requiring treatment.

(Reported by M S Dickerson, MD, State Epidemiologist, Texas State Department of Health; Terrence Anderson, Regional Director, Albuquerque, New Mexico, Milton Caroline, Texas State Supervisor, and H D Ellard, Lubbock District Director, US Fish and Wildlife Service; and the Plague Branch, Vector-Borne Diseases Division, Bureau of Laboratories, CDC.)

TRANSDUCER-ASSOCIATED BACTEREMIA – North Carolina

Between April 29 and June 9, 1975, a total of 5 of 44 thoracic surgery patients (11.4%) in an acute care unit (ACU) developed *Pseudomonas acidivorans* bacteremia without an underlying site of infection. Two of the 5 bacteremic patients also had *Enterobacter cloacae* isolated from their blood. The 5 *P. acidivorans* isolates had identical antimicrobial susceptibility patterns (resistance to kanamycin, gentamicin, ampicillin, sulfisoxazole, and cephalosporin), and both *E. cloacae* isolates were resistant only to ampicillin and cephalosporin. No deaths attributable to these gram-negative infections occurred.

Two to 10 days before infection, each of the 5 patients had undergone thoracic surgery. Although a different type of surgical procedure had been performed in each of the 5 patients (coronary artery bypass surgery, repair of an atrioventricular canal defect, repair of a tetrology of Fallot, resection of a subclavian artery and vein, and plication of a left ventricular false aneurysm), each patient had arterial and venous catheters inserted before surgery for cardiovascular monitoring with pressure transducers.

Since a similar outbreak recently reported in the MMWR (Vol. 23, No. 49) had called attention to transducer contamination as a source of bacteremia, the possible role of transducers in this outbreak was investigated. It was learned that after surgery the pressure transducers used to monitor the patients in the operating room had been disconnected, and the patients had been admitted to the ACU, where another set of pressure transducers had been connected to the patients' monitoring lines. Subsequently, all 5 patients had onset of fever and bacteremia; despite appropriate antibiotic therapy, at least 2 of the patients remained symptomatic until monitoring was discontinued. Furthermore, although the pressure transducers used in the operating room were routinely disinfected with alkalinized glutaraldehyde for 30 minutes between use in different patients, the 11 pressure transducers used in the ACU were not.

On June 6, 1975, cultures were obtained from the arterial pressure transducers and from fluid in the arterial monitoring lines of 6 apparently noninfected patients in the ACU. Five of the 6 pressure transducers cultured were contaminated with the epidemic organisms (3 with *P. acidivorans* and 2 with *E. cloacae*). *P. acidivorans* was also isolated from the heparinized normal saline solution in the lines of 3 patients. One of these 3 patients also had *P. acidivorans* in his arterial transducer, but the other 2 patients had *E. cloacae* isolated from their pressure transducers. Blood cultures from all 6 patients were sterile.

After this investigation a protocol for disinfecting all ACU pressure transducers with alkalinized glutaraldehyde between use in different patients was established. In addition, patients requiring lengthy monitoring had their transducers and monitoring lines replaced with sterilized units every 24 hours. Since these measures were begun, no bacteremias with *P. acidivorans* or *E. cloacae* have been noted.

(Reported by Mary V Higgins, MSPH, Medical Center Environmentalist, and Mrs. Donna Dzubay, MS, Medical Laboratory Supervisor, Diagnostic Bacteriology, Clinical Microbiology Laboratories, Duke University Medical Center, Durham, North Carolina; Nancy King, Special Bacteriology Unit, Public Health Laboratory, North Carolina Department of Human Resources, Raleigh, North Carolina; and the Special Bacteriology Unit, Clinical Bacteriology Section, Bureau of Laboratories, and the Hospital Infections Branch, Bacterial Disease Division, Bureau of Epidemiology, Center for Disease Control.)

Editorial Note

This epidemic again suggests that transducers may serve as a source of nosocomial bacteremia in patients undergoing cardiovascular monitoring. Although the reservoir for transducer contamination was not identified in this outbreak, previous epidemics (MMWR, Vol. 23, No. 49) have resulted from contaminated products used to clean transducers or from retrograde contamination of transducers by bacteremic patients. Intravenous fluids or medications, particularly those in multi-dose containers, should also be considered as potential reservoirs for microbial contamination of transducers.

Thorough washing of transducers followed by sterilization with ethylene oxide or glutaraldehyde *(1)* between use in different patients, as well as strict aseptic technique when using monitoring systems, will help prevent cross-infections. Hospitals should distribute protocols for sterilizing and handling pressure transducers to all individuals and units using such equipment. Periodically, cultures of transducers and of the fluid in monitoring lines should be obtained to assess the adequacy of sterilization procedures and monitoring practices.

While the effect of replacing transducers every 24 hours has not been subjected to controlled study, this practice may also help to reduce the risk of transducer-associated bacteremia. However, since transducers are expensive and often in short supply in many hospitals, such frequent changes may not always be possible. As a minimum, it is recommended that infusion lines and fluid be changed every 24 hours, that monitoring be discontinued as soon as medically feasible, and that transducers be sterilized between use in different patients.

Reference

1. American Hospital Association: Infection Control in the Hospital. 3rd ed. Chicago, American Hospital Association, 1974, p 108

FOLLOW-UP ON WESTERN EQUINE ENCEPHALITIS – North Dakota, Minnesota

Through September 2, 1975, a total of 61 cases of acute, febrile central nervous system (CNS) disease in humans had been reported from North Dakota and 21 cases from the adjacent portion of Northwestern Minnesota. Nine of these cases have been confirmed by 4-fold or greater rises in hemagglutination inhibition (HI) antibody to western equine encephalitis virus, and 5 other cases are considered probable, based on single HI titers of 1:80 or greater. Six deaths have occurred, 3 of which are confirmed or probable cases on the basis of serology.

(Reported by D H Lawrence, MD, Fargo City Health Officer, Fargo Health Department, North Dakota; Kenneth Mosser, Director, Eleanor Conway, Linda Johnson, and Janet Alm, Disease Control Division, Hal D Neugebauer, State Communicable Disease Representative, and Willis Van Heuvelen, Executive Officer, North Dakota State Department of Health; Fred Heisel, Director, Charles Schneider, Division of Environmental Health, and Barry Levy, MD, Acting State Epidemiologist, Minnesota State Health Department; the Vector-borne Diseases Division, Bureau of Laboratories, the Vector Biology and Control Division, Bureau of Tropical Diseases, and the Viral Diseases and Field Services Divisions, Bureau of Epidemiology, CDC; and 5 EIS Officers.)

HEPATITIS A - Oregon

On July 26, 1975, a food handler who worked in a kitchen serving 2 large restaurants in downtown Portland, Oregon, was diagnosed as having acute hepatitis A infection. He became symptomatic on July 19 and continued working in the restaurant until July 24. Subsequently, 4 other food handlers in these restaurants developed clinical hepatitis A infection; and both restaurants voluntarily closed on August 22. Investigation has revealed 29 other confirmed and 39 suspected cases of hepatitis A infection within the community that have been traced to food consumption at these restaurants. Mass immune serum globulin administration to patrons of these restaurants and family contacts of confirmed cases was begun on August 8, and over 5,000 doses have been administered.

Food served at these restaurants could possibly have been contaminated from approximately July 1 to August 22. During this time, a number of out-of-town convention guests and visitors to Portland may have eaten at these restaurants. Individuals, therefore, who ate at either the Hungry Horse or Olivers' Pub between July 1 and August 22 should contact a physician for evaluation and appropriate immune serum globulin prophylaxis. The investigation is still in progress.

(Reported by Hugh Telson, MD, Multnomah County Health Director, and John A Googins, MD, State Epidemiologist, Oregon State Health Division; and the Phoenix Laboratories Division, Bureau of Epidemiology, CDC.)

CURRENT TRENDS
PRIMARY AND SECONDARY SYPHILIS
United States – July 1975 (Provisional Data)

The 2,149 primary and secondary syphilis cases reported in July 1975 were slightly less (1.2%) than the number reported in July 1974. This was the third successive month in which a decrease of cases has been reported. In the first 7 months (January-July) of 1975, such cases totaled 14,911, representing an increase of 2.6% over the number reported in the same time period of the previous year.

(Reported by the Venereal Disease Control Division, Bureau of State Services, CDC.)

SUMMARY OF REPORTED PRIMARY AND SECONDARY SYPHILIS CASES BY REPORTING AREA: JULY 1975 AND JULY 1974 – PROVISIONAL DATA

Reporting Area	JULY		Calendar Year Cumulative JAN. JULY	
	1974	1973	1974	1973
Connecticut	28	17	142	108
Maine	2	6	17	19
Massachusetts	49	61	338	384
New Hampshire	1	2	11	7
Rhode Island	3	0	8	8
Vermont	1	0	6	1
DHEW REGION I TOTAL	84	86	522	527
New Jersey	58	63	466	515
New York (Excl. NYC)	45	39	259	311
New York City	232	231	1666	1796
DHEW REGION II TOTAL	335	333	2391	2622
Delaware	8	4	61	45
Dist. of Columbia	64	58	391	376
Md. (Excl. Baltimore)	15	19	125	144
Baltimore	32	28	226	279
Penn. (Excl. Philadelphia)	33	19	230	119
Philadelphia	25	56	256	395
Virginia	59	62	343	467
West Virginia	2	0	17	9
DHEW REGION III TOTAL	238	246	1649	1834
Alabama	21	11	150	131
Florida	248	265	1936	1578
Georgia (Excl. Atlanta)	56	41	381	412
Atlanta*	31	48	241	265
Kentucky	19	31	105	172
Mississippi	25	24	158	139
North Carolina	74	76	602	542
South Carolina	56	69	318	413
Tennessee	36	38	240	280
DHEW REGION IV TOTAL	566	603	4131	3932
Illinois (Excl. Chicago)	34	26	175	154
Chicago	50	92	449	488
Ind. (Excl. Indianapolis)	12	9	65	73
Indianapolis*	11	3	24	33
Michigan	28	44	201	251
Minnesota	11	7	67	49
Ohio	19	19	276	159
Wisconsin	4	17	52	64
DHEW REGION V TOTAL	169	217	1309	1271

Reporting Area	JULY		Calendar Year Cumulative JAN. JULY	
	1974	1973	1974	1973
Arkansas	6	3	37	65
Louisiana	46	60	300	390
New Mexico	9	9	97	50
Oklahoma	5	12	44	80
Texas	149	132	869	781
DHEW REGION VI TOTAL	215	216	1347	1366
Iowa	4	6	22	25
Kansas	24	8	80	37
Missouri	19	32	176	236
Nebraska	7	3	13	8
DHEW REGION VII TOTAL	54	49	291	306
Colorado	10	10	67	78
Montana	0	0	4	2
North Dakota	0	0	4	4
South Dakota	0	0	3	2
Utah	1	2	10	8
Wyoming	2	0	6	2
DHEW REGION VIII TOTAL	13	12	94	96
Arizona	21	16	144	137
California (Excl. LA & SF)	145	90	1054	663
Los Angeles*	176	191	1122	1106
San Francisco*	93	95	574	482
Hawaii	1	2	34	22
Nevada	3	3	33	36
DHEW REGION IX TOTAL	439	397	2961	2446
Alaska	1	1	3	2
Idaho	0	1	10	7
Oregon	11	7	72	51
Washington	24	8	131	69
DHEW REGION X TOTAL	36	17	216	129
UNITED STATES TOTAL	2149	2176	14911	14529
Puerto Rico	62	77	466	520
Virgin Islands	0	1	17	20
U.S. INCL. TERR.	2211	2254	15394	15069

Note: Cumulative totals include revised and delayed reports through previous months.
Source: HSM 9.98 CDC, VD Control Division, Atlanta, Ga. 30333.

*COUNTY DATA

TABLE III. CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES FOR WEEKS ENDING AUGUST 30, 1975 AND AUGUST 31, 1974 (35th WEEK)

AREA	ASEPTIC MENINGITIS	BRUCELLOSIS	CHICKENPOX	DIPHTHERIA		ENCEPHALITIS			HEPATITIS, VIRAL			MALARIA	
						Primary: Arthropod-borne and Unspecified		Post Infectious	Type B	Type A	Type Unspecified		
	1975	1975	1975	1975	Cum. 1975	1975	1974	1975	1975	1975	1975	1975	Cum. 1975
UNITED STATES	125	2	228	5	210	62	22	5	259	749	150	9	277
NEW ENGLAND	7	–	15	–	–	–	–	–	1	17	9	–	11
Maine *	–	–	–	–	–	–	–	–	–	3	–	–	1
New Hampshire	–	–	–	–	–	–	–	–	–	3	–	–	–
Vermont *	4	–	–	–	–	–	–	–	–	–	–	–	3
Massachusetts	2	–	9	–	–	–	–	–	–	2	9	–	3
Rhode Island	1	–	6	–	–	–	–	–	1	4	–	–	1
Connecticut	–	–	–	–	–	–	–	–	–	5	–	–	3
MIDDLE ATLANTIC	28	–	32	–	–	8	–	2	65	128	18	4	68
Upstate New York	9	–	9	–	–	1	–	1	11	15	2	–	6
New York City	18	–	10	–	–	2	–	–	17	24	–	4	19
New Jersey	–	–	NN	–	–	–	–	–	26	37	13	–	8
Pennsylvania *	1	–	13	–	–	5	–	1	11	52	3	–	35
EAST NORTH CENTRAL	23	–	77	1	5	4	1	–	34	99	5	–	6
Ohio *	1	–	2	–	1	4	–	–	6	27	–	–	1
Indiana	6	–	–	–	–	–	–	–	–	14	–	–	–
Illinois	–	–	9	1	3	–	–	–	12	13	1	–	4
Michigan	15	–	25	–	1	–	1	–	9	34	3	–	1
Wisconsin	1	–	41	–	–	–	–	–	7	11	1	–	–
WEST NORTH CENTRAL	23	–	6	–	6	21	8	–	13	48	5	1	12
Minnesota	–	–	–	–	–	2	–	–	1	5	–	1	5
Iowa	–	–	5	–	–	–	3	–	7	7	1	–	–
Missouri *	22	–	–	–	–	19	5	–	2	31	3	–	5
North Dakota *	–	–	–	–	6	–	–	–	1	–	–	–	1
South Dakota	–	–	–	–	–	–	–	–	–	2	–	–	–
Nebraska	1	–	1	–	–	–	–	–	–	–	1	–	1
Kansas	–	–	–	–	–	–	–	–	2	3	–	–	–
SOUTH ATLANTIC	13	–	41	–	–	9	8	–	44	105	38	2	43
Delaware	–	–	–	–	–	–	–	–	–	–	1	–	–
Maryland	1	–	1	–	–	–	–	–	14	12	9	–	9
District of Columbia	–	–	1	–	–	–	–	–	4	1	–	–	9
Virginia	2	–	6	–	–	4	–	–	9	9	13	–	5
West Virginia *	4	–	33	–	–	–	–	–	1	4	1	–	1
North Carolina	2	–	NN	–	–	3	1	–	3	6	2	1	4
South Carolina	1	–	–	–	–	–	–	–	1	7	2	–	1
Georgia	–	–	–	–	–	1	–	–	–	10	–	1	9
Florida	3	–	–	–	–	1	7	–	12	56	10	–	5
EAST SOUTH CENTRAL	1	1	4	–	–	6	3	–	12	65	8	–	10
Kentucky	–	–	2	–	–	5	–	–	3	13	–	–	3
Tennessee	–	–	NN	–	–	1	1	–	3	36	1	–	–
Alabama *	–	1	2	–	–	–	2	–	5	5	7	–	5
Mississippi	1	–	–	–	–	–	–	–	1	11	–	–	2
WEST SOUTH CENTRAL	18	1	9	–	6	14	–	–	14	96	10	1	20
Arkansas *	–	1	–	–	–	3	–	–	–	8	1	–	1
Louisiana	6	–	NN	–	–	4	–	–	7	15	3	–	–
Oklahoma	2	–	–	–	–	5	–	–	2	2	–	–	1
Texas *	10	–	9	–	6	2	–	–	5	71	6	1	18
MOUNTAIN	–	–	29	1	17	–	1	–	5	79	34	–	13
Montana	–	–	3	–	1	–	–	–	1	1	1	–	–
Idaho	–	–	–	–	–	–	–	–	–	17	1	–	–
Wyoming	–	–	–	–	–	–	–	–	–	–	1	–	–
Colorado	–	–	2	–	–	–	–	–	2	4	10	–	8
New Mexico	–	–	–	–	2	–	1	–	1	39	16	–	–
Arizona	–	–	–	1	14	–	–	–	1	4	1	–	3
Utah	–	–	24	–	–	–	–	–	–	14	4	–	2
Nevada	–	–	–	–	–	–	–	–	–	–	–	–	–
PACIFIC	12	–	15	3	176	–	1	3	71	112	23	1	94
Washington	–	–	10	3	167	–	–	–	9	10	7	–	4
Oregon	–	–	1	–	–	–	–	–	2	19	7	–	8
California *	12	–	–	–	4	–	1	3	60	79	9	1	77
Alaska	–	–	–	–	5	–	–	–	–	4	–	–	2
Hawaii	–	–	4	–	–	–	–	–	–	–	–	–	3
Guam *	–	–	–	–	–	–	–	–	–	–	–	–	–
Puerto Rico	–	–	5	–	–	–	–	–	4	18	–	–	1
Virgin Islands	–	–	–	–	–	–	–	–	–	–	–	–	–

NN: Not Notifiable

*Delayed reports: Aseptic Meningitis: Mo. delete 1, Ark. 17
Brucellosis: Vt. delete 1
Chickenpox: Calif. 1, Guam 3
Diphtheria: Ohio delete 1
Encephalitis, Primary: Pa. 1, Mo. delete 1, N.D. 5, W. Va. 1
Hepatitis B: Mo. delete 4, Ala. 1, Texas 1
Hepatitis A: Mo. delete 6, Guam 3
Hepatitis unspecified: Me. 1, Mo. delete 2,

TABLE III. CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES FOR WEEKS ENDING AUGUST 30, 1975 AND AUGUST 31, 1974 (35th WEEK) – Continued

AREA	MEASLES (Rubeola)			MENINGOCOCCAL INFECTIONS, TOTAL			MUMPS		PERTUSSIS	RUBELLA		TETANUS
	1975	Cumulative		1975	Cumulative		1975	Cum. 1975	1975	1975	Cum. 1975	Cum. 1975
		1975	1974		1975	1974						
UNITED STATES	69	21,145	19,689	28	1,060	948	320	46,457	46	51	14,704	59
NEW ENGLAND	3	314	924	2	60	47	13	1,596	–	2	2,043	3
Maine *	–	14	43	–	6	3	–	76	–	–	38	–
New Hampshire	–	21	208	–	2	7	–	74	–	–	305	–
Vermont	–	49	56	–	–	2	–	16	–	–	70	–
Massachusetts *	–	116	380	–	20	15	5	206	–	1	1,195	1
Rhode Island	–	3	61	–	3	7	4	590	–	–	26	–
Connecticut	3	111	176	2	29	13	4	634	–	1	409	2
MIDDLE ATLANTIC	10	1,751	7,976	2	105	146	19	2,508	3	9	1,680	9
Upstate New York	3	574	928	2	31	55	–	917	2	1	270	1
New York City	1	139	580	–	29	33	14	734	–	3	159	2
New Jersey	3	460	5,521	–	17	42	1	338	–	2	980	3
Pennsylvania	3	578	947	–	28	16	4	519	1	3	271	3
EAST NORTH CENTRAL	23	6,294	7,585	7	145	113	99	19,264	3	17	4,098	4
Ohio	–	109	3,025	6	42	41	6	2,179	–	1	611	2
Indiana	4	378	223	–	6	11	2	1,971	–	11	944	–
Illinois	11	1,792	1,972	–	19	10	9	2,230	1	–	293	2
Michigan *	3	3,008	1,904	1	59	35	23	7,992	1	2	1,399	–
Wisconsin	5	1,007	461	–	19	16	59	4,892	1	3	851	–
WEST NORTH CENTRAL	4	4,970	681	1	63	69	1	3,247	2	3	1,460	3
Minnesota	–	182	83	–	15	22	–	38	–	–	37	1
Iowa	3	574	134	1	6	13	1	1,002	–	–	30	–
Missouri *	1	267	257	–	30	16	–	903	2	1	730	1
North Dakota	–	1,051	28	–	–	3	–	461	–	–	65	–
South Dakota	–	356	27	–	1	3	–	6	–	–	18	–
Nebraska	–	395	2	–	2	3	–	34	–	2	21	–
Kansas	–	2,145	150	–	9	9	–	803	–	–	559	1
SOUTH ATLANTIC	3	330	514	6	214	189	69	3,086	5	8	1,525	13
Delaware	–	35	7	–	–	5	–	8	–	–	19	–
Maryland	–	48	22	–	24	18	15	226	–	–	37	–
District of Columbia	–	1	3	–	5	1	1	113	–	–	–	–
Virginia	–	38	31	1	18	30	29	750	1	1	313	1
West Virginia	3	151	176	–	5	7	5	1,028	–	7	196	–
North Carolina	–	2	5	1	37	40	–	102	1	–	43	6
South Carolina	–	–	48	1	34	16	1	49	1	–	739	2
Georgia	–	30	4	–	14	8	–	17	2	–	2	–
Florida	–	25	218	3	71	64	18	793	–	–	176	4
EAST SOUTH CENTRAL	–	271	209	1	151	98	22	4,381	6	1	938	3
Kentucky	–	83	145	1	62	38	3	1,678	1	–	230	1
Tennessee	–	177	34	–	48	44	14	2,039	5	1	680	–
Alabama *	–	3	17	–	28	9	4	371	–	–	21	1
Mississippi	–	8	13	–	13	7	1	293	–	–	7	1
WEST SOUTH CENTRAL	5	297	189	4	181	156	37	4,212	15	2	705	12
Arkansas	–	–	6	1	9	11	1	169	1	–	19	–
Louisiana	–	1	13	1	31	32	8	335	5	–	280	4
Oklahoma	–	125	25	–	9	17	1	184	–	2	85	–
Texas *	5	171	145	2	132	96	27	3,524	9	–	321	8
MOUNTAIN	2	1,401	734	–	34	30	12	870	8	1	504	–
Montana	–	50	372	–	7	1	–	25	3	–	252	–
Idaho	1	12	51	–	5	2	–	12	5	–	74	–
Wyoming	–	1	1	–	–	3	–	2	–	–	–	–
Colorado	–	1,158	30	–	9	8	3	594	–	1	128	–
New Mexico	–	13	61	–	4	2	–	19	–	–	15	–
Arizona	1	74	15	–	1	5	–	–	–	–	2	–
Utah	–	66	5	–	7	6	9	132	–	–	26	–
Nevada	–	27	199	–	1	3	–	86	–	–	7	–
PACIFIC	19	5,517	877	5	107	100	48	7,293	4	8	1,751	12
Washington	–	288	63	1	17	11	7	3,687	–	–	267	1
Oregon	–	196	–	–	4	12	4	612	–	–	161	–
California	19	4,969	753	3	81	71	37	2,917	4	8	1,306	10
Alaska	–	–	–	1	4	3	–	42	–	–	–	–
Hawaii	–	64	61	–	1	3	–	35	–	–	17	1
Guam	–	22	15	–	2	1	–	22	–	–	7	–
Puerto Rico	9	600	567	–	1	6	5	686	1	1	20	12
Virgin Islands	–	8	24	–	–	–	–	221	–	–	3	2

NN: Not Notifiable

*Delayed reports: Measles: Mass. delete 2
Meningococcal Infection: Ala. 1
Mumps: Texas 8
Pertussis: Mo. 2
Rubella: Me. 1, Mich. delete 4

TABLE III. CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES FOR WEEKS ENDING AUGUST 30, 1975 AND AUGUST 31, 1974 (35th WEEK) – Continued

AREA	TUBERCULOSIS		TULAREMIA	TYPHOID FEVER		TYPHUS-FEVER TICK-BORNE (Rky. Mt. spotted fever)		VENEREAL DISEASES (Civilian Cases Only)						RABIES IN ANIMALS
								GONORRHEA			SYPHILIS (Pri. & Sec.)			
	1975	Cum. 1975	Cum. 1975	1975	Cum. 1975	1975	Cum. 1975	1975	Cumulative 1975	Cumulative 1974	1975	Cumulative 1975	Cumulative 1974	Cum. 1975
UNITED STATES	629	22,545	83	11	211	26	643	20,391	655,987	589,172	462	17,172	16,953	1,667
NEW ENGLAND	32	909	–	–	9	–	6	551	17,840	15,696	13	593	599	47
Maine	–	56	–	–	–	–	–	58	1,402	1,271	–	21	27	28
New Hampshire *	–	24	–	–	–	–	–	12	494	493	–	11	8	2
Vermont	2	18	–	–	–	–	–	14	442	428	–	5	1	–
Massachusetts	15	526	–	–	5	–	2	350	8,364	7,243	13	385	426	9
Rhode Island	5	97	–	–	–	–	3	64	1,482	1,524	–	13	12	1
Connecticut	10	188	–	–	4	–	1	53	5,656	4,937	–	158	125	7
MIDDLE ATLANTIC	107	4,130	4	1	40	3	68	2,423	76,680	72,882	70	3,141	3,688	75
Upstate New York	15	594	3	1	6	–	29	494	13,577	13,534	10	305	363	60
New York City	52	1,660	–	–	19	–	–	954	33,054	31,486	47	1,799	2,126	–
New Jersey	25	797	1	–	6	1	9	342	10,619	10,504	12	491	593	–
Pennsylvania	15	1,079	–	–	9	2	30	633	19,430	17,358	1	546	606	15
EAST NORTH CENTRAL	76	3,097	5	2	26	–	15	3,385	107,642	93,447	53	1,419	1,434	79
Ohio *	17	889	–	–	8	–	14	711	29,807	24,249	3	328	201	5
Indiana	11	395	–	–	–	–	–	499	9,364	9,031	9	110	128	7
Illinois	27	840	–	1	12	–	1	1,197	37,173	30,538	38	692	742	18
Michigan *	21	879	1	–	5	–	–	670	20,874	21,164	3	229	291	6
Wisconsin	–	94	4	1	1	–	–	308	10,424	8,465	–	60	72	43
WEST NORTH CENTRAL	17	828	14	2	9	2	25	1,028	32,419	30,708	8	426	435	384
Minnesota	2	110	–	–	2	–	–	232	6,773	6,451	3	77	56	95
Iowa	–	82	1	–	1	–	–	44	4,454	4,113	1	24	28	77
Missouri	6	409	10	1	5	2	13	513	11,784	10,280	4	205	289	43
North Dakota	–	9	–	–	–	–	–	11	503	473	–	5	5	75
South Dakota	–	53	–	–	–	–	–	58	1,287	1,412	–	5	2	47
Nebraska *	2	29	1	–	–	–	2	99	2,885	2,577	–	14	9	4
Kansas	7	136	2	1	1	–	10	71	4,733	5,402	–	96	46	43
SOUTH ATLANTIC	130	5,003	15	–	29	14	333	4,861	162,375	151,890	127	5,341	5,318	233
Delaware	–	97	–	–	–	–	3	112	2,359	2,081	–	65	55	–
Maryland	30	825	1	–	5	–	25	766	19,470	15,411	5	391	527	7
District of Columbia *	7	270	–	–	–	–	–	238	9,496	13,375	13	464	433	–
Virginia	10	578	6	–	5	6	90	470	16,122	13,799	16	418	532	85
West Virginia	2	181	–	–	4	–	3	66	2,007	1,771	1	39	11	3
North Carolina *	32	814	–	–	2	2	103	642	22,590	20,397	9	661	627	6
South Carolina	3	297	3	–	3	5	72	259	15,048	14,635	5	356	476	8
Georgia	15	726	4	–	1	1	32	1,072	30,410	29,598	25	696	795	107
Florida	31	1,215	1	–	9	–	5	1,236	44,873	40,823	53	2,251	1,862	17
EAST SOUTH CENTRAL	57	1,924	10	–	20	2	80	1,555	55,392	50,457	17	743	845	121
Kentucky *	16	356	1	–	6	–	3	232	7,219	6,235	7	119	196	83
Tennessee	19	729	9	–	10	2	59	574	21,915	19,908	5	282	322	18
Alabama	12	569	–	–	2	–	6	462	15,305	13,974	–	167	163	20
Mississippi	10	270	–	–	2	–	12	287	10,953	10,340	5	175	164	–
WEST SOUTH CENTRAL	55	2,536	31	–	10	2	109	2,193	80,305	76,908	42	1,472	1,513	359
Arkansas	7	345	13	–	–	2	17	177	8,448	7,962	3	46	72	57
Louisiana *	16	332	1	–	4	–	–	485	14,787	16,147	–	340	424	4
Oklahoma	4	222	9	–	–	–	74	259	7,763	6,557	5	58	89	77
Texas	28	1,637	8	–	6	–	18	1,272	49,307	46,242	34	1,028	928	221
MOUNTAIN	22	679	2	1	7	3	6	720	25,713	22,612	11	401	381	186
Montana	–	39	1	–	–	3	4	30	1,373	1,250	–	4	2	142
Idaho	6	23	–	–	–	–	1	54	1,297	1,186	–	10	7	–
Wyoming	1	20	1	–	1	–	–	23	599	502	–	9	2	5
Colorado	4	140	–	–	1	–	1	217	6,364	6,289	1	69	90	–
New Mexico	2	93	–	–	2	–	–	148	4,718	3,193	4	108	57	28
Arizona	9	295	–	1	3	–	–	196	7,008	6,543	5	150	169	9
Utah	–	30	–	–	–	–	–	52	1,649	1,264	1	12	8	2
Nevada	–	39	–	–	–	–	–	–	2,705	2,385	–	39	46	–
PACIFIC	133	3,439	2	5	61	–	1	3,675	97,621	74,572	121	3,636	2,740	183
Washington	29	265	1	1	5	–	1	228	8,814	7,962	–	118	84	–
Oregon	6	127	–	–	–	–	–	400	7,439	7,340	4	93	63	6
California	84	2,612	1	3	54	–	–	2,918	77,344	55,919	117	3,386	2,568	174
Alaska	–	43	–	1	1	–	–	66	2,359	1,806	–	5	3	3
Hawaii	14	392	–	–	1	–	–	63	1,665	1,545	–	34	22	–
Guam *	–	40	–	–	–	–	–	–	263	–	–	8	–	–
Puerto Rico	11	354	–	–	3	–	–	81	1,973	2,245	19	491	600	37
Virgin Islands	–	3	–	–	2	–	–	3	121	521	5	27	44	–

NN: Not Notifiable

*Delayed reports: Tuberculosis: N.H. 1, Ohio delete 1, Mich. delete 1 Neb. delete 1, N.C. delete 5, La. delete 4

Tularemia: D.C. 1

Gonorrhea: Ky. 142 Mil., Guam 11

Week No. 35

TABLE IV. DEATHS IN 121 UNITED STATES CITIES FOR WEEK ENDING AUGUST 30, 1975

(By place of occurrence and week of filing certificate. Excludes fetal deaths)

Area	All Causes					Pneumonia and Influenza All Ages
	All Ages	65 years and over	45-64 years	25-44 years	Under 1 year	
NEW ENGLAND	599	362	160	39	21	16
Boston, Mass.	185	106	48	16	10	9
Bridgeport, Conn.	36	27	5	3	–	2
Cambridge, Mass.	20	15	4	1	–	–
Fall River, Mass.	23	12	8	2	–	–
Hartford, Conn.	52	29	17	2	2	1
Lowell, Mass.	14	10	3	1	–	1
Lynn, Mass.	16	13	2	–	1	–
New Bedford, Mass.	28	16	9	1	1	–
New Haven, Conn.	40	22	13	2	2	–
Providence, R. I.	46	23	16	4	1	1
Somerville, Mass.	8	5	3	–	–	–
Springfield, Mass.	52	33	13	3	1	1
Waterbury, Conn.	32	20	8	1	2	1
Worcester, Mass.	47	31	11	3	1	–
MIDDLE ATLANTIC	2,950	1,734	807	203	100	106
Albany, N. Y.	59	27	20	4	7	1
Allentown, Pa.	20	10	8	–	1	–
Buffalo, N. Y.	124	65	41	8	6	5
Camden, N. J.	32	18	12	2	–	3
Elizabeth, N. J.	30	22	6	2	–	–
Erie, Pa.	27	16	9	1	1	–
Jersey City, N. J.	45	29	7	4	4	4
Newark, N. J.	57	20	23	8	2	6
New York City, N. Y. †	1,342	806	342	102	36	56
Paterson, N. J.	34	22	8	4	–	–
Philadelphia, Pa.	598	348	164	42	22	4
Pittsburgh, Pa.	185	98	56	11	11	9
Reading, Pa.	24	17	3	2	1	1
Rochester, N. Y.	119	73	32	4	6	9
Schenectady, N. Y.	21	13	6	1	–	1
Scranton, Pa.	60	41	15	2	1	2
Syracuse, N. Y.	87	58	24	3	1	2
Trenton, N. J.	36	23	10	2	1	–
Utica, N. Y.	20	13	7	–	–	3
Yonkers, N. Y.	30	15	14	1	–	–
EAST NORTH CENTRAL	2,299	1,305	636	149	99	59
Akron, Ohio	45	25	11	4	3	1
Canton, Ohio	46	32	9	2	–	3
Chicago, Ill.	569	305	169	46	26	11
Cincinnati, Ohio	143	74	45	6	7	3
Cleveland, Ohio	171	95	51	6	10	2
Columbus, Ohio	135	69	42	6	8	3
Dayton, Ohio	104	60	28	4	8	1
Detroit, Mich.	295	156	86	32	6	2
Evansville, Ind.	59	43	10	2	–	–
Fort Wayne, Ind.	59	32	20	1	–	7
Gary, Ind.	26	14	8	3	1	1
Grand Rapids, Mich.	43	26	14	2	1	4
Indianapolis, Ind.	143	79	31	12	12	4
Madison, Wis.	32	19	6	2	–	4
Milwaukee, Wis.	125	84	29	6	5	3
Peoria, Ill.	34	15	10	3	4	–
Rockford, Ill.	34	16	11	1	4	2
South Bend, Ind.	60	47	11	2	–	1
Toledo, Ohio	115	74	29	8	3	5
Youngstown, Ohio	61	40	16	1	1	2
WEST NORTH CENTRAL	685	414	165	43	32	37
Des Moines, Iowa	56	34	15	1	3	2
Duluth, Minn.	21	15	3	3	–	1
Kansas City, Kans.	36	19	8	3	–	2
Kansas City, Mo.	112	75	23	8	3	5
Lincoln, Nebr.	20	17	2	1	–	5
Minneapolis, Minn.	89	48	24	6	8	1
Omaha, Nebr.	78	41	22	5	4	2
St. Louis, Mo.	162	91	44	13	9	11
St. Paul, Minn.	55	39	12	1	3	–
Wichita, Kans.	56	35	12	2	2	8
SOUTH ATLANTIC	1,202	650	337	103	64	48
Atlanta, Ga.	117	59	38	5	6	5
Baltimore, Md.	168	88	42	17	13	2
Charlotte, N. C.	52	26	14	4	5	–
Jacksonville, Fla.	58	29	16	10	1	–
Miami, Fla.	118	60	32	16	6	1
Norfolk, Va.	49	25	16	2	5	5
Richmond, Va.	81	45	24	7	1	5
Savannah, Ga.	27	18	8	1	–	5
St. Petersburg, Fla.	69	58	10	1	–	1
Tampa, Fla.	78	54	12	5	4	7
Washington, D. C.	335	162	108	33	20	14
Wilmington, Del.	50	26	17	2	3	3
EAST SOUTH CENTRAL	682	382	205	45	16	34
Birmingham, Ala.	103	51	30	10	8	5
Chattanooga, Tenn.	52	33	14	2	1	3
Knoxville, Tenn.	39	23	13	2	–	2
Louisville, Ky.	130	75	42	8	2	11
Memphis, Tenn.	165	95	44	12	1	4
Mobile, Ala.	59	30	19	5	2	–
Montgomery, Ala.	37	22	13	1	–	5
Nashville, Tenn.	97	53	30	5	2	4
WEST SOUTH CENTRAL	1,121	585	330	78	64	39
Austin, Tex.	41	29	11	1	–	2
Baton Rouge, La.	54	22	21	3	2	–
Corpus Christi, Tex.	33	18	8	1	3	1
Dallas, Tex.	162	90	44	12	7	8
El Paso, Tex.	53	32	10	5	3	4
Fort Worth, Tex.	91	49	26	6	6	2
Houston, Tex.	237	110	70	27	12	7
Little Rock, Ark.	38	27	8	1	–	3
New Orleans, La.	154	70	52	7	18	1
San Antonio, Tex.	133	66	45	9	9	4
Shreveport, La.	59	35	18	4	1	3
Tulsa, Okla.	66	37	17	2	3	4
MOUNTAIN	475	265	114	49	21	14
Albuquerque, N. Mex.	56	26	15	7	6	2
Colorado Springs, Colo.	37	24	6	4	1	5
Denver, Colo.	93	52	26	5	5	4
Las Vegas, Nev.	25	13	7	4	–	–
Ogden, Utah	23	13	6	1	–	1
Phoenix, Ariz.	107	60	32	7	5	–
Pueblo, Colo.	22	15	3	2	1	1
Salt Lake City, Utah	48	25	7	11	1	1
Tucson, Ariz.	64	37	12	8	2	–
PACIFIC	1,553	1,005	373	88	41	43
Berkeley, Calif.	17	14	3	–	–	–
Fresno, Calif.	55	32	12	4	4	2
Glendale, Calif.	26	19	5	1	–	–
Honolulu, Hawaii	49	29	9	3	5	–
Long Beach, Calif.	89	58	26	4	–	–
Los Angeles, Calif.	484	317	115	31	8	11
Oakland, Calif.	87	57	20	6	3	5
Pasadena, Calif.	41	30	7	–	2	–
Portland, Oreg.	127	81	34	6	3	5
Sacramento, Calif.	77	45	23	3	1	–
San Diego, Calif.	105	59	29	5	6	1
San Francisco, Calif.	142	89	37	13	2	3
San Jose, Calif.	57	41	12	3	–	2
Seattle, Wash.	110	71	25	5	5	1
Spokane, Wash.	50	35	9	2	2	11
Tacoma, Wash.	37	28	7	2	–	2
Total	11,566	6,702	3,127	797	458	396
Expected Number	11,833	6,984	3,139	820	374	372

†Delayed report for week ending August 23, 1975

SURVEILLANCE OF CHILDHOOD LEAD POISONING – United States

Table 1 summarizes provisional results of screening by the Childhood Lead Poisoning Control Projects in the third quarter of FY 1975. In the first 3 quarters of FY 75, a total of 324,355 children were screened, a 60% increase over the total screened by this same period last year. However, this total represents only 58.3% of the yearly screening objective established by the individual project objectives. Although the number of children identified with increased lead absorption has surpassed the total identified in FY 74 by more than 32%, there has been a decreasing confirmed positive ratio (number confirmed positive per number screened), from 8.4/100 in the first quarter of FY 75 to 5.9/100 in the third quarter of FY 75.

The number of children receiving chelation treatment decreased slightly, from 2,601 through the third quarter of FY 74 to 2,583 for the same period in FY 75. The number of houses identified with lead hazard increased slightly.

(Reported by Environmental Health Services Division, Bureau of State Services, CDC.)

Table 1

Results of Screening in Childhood Lead Poisoning Control Projects

United States* – Third Quarter of FY 1975 (January 1, 1975-March 31, 1975)

Projects	Number of Children Screened	Number of Screened Children Confirmed Positive	Number of Children Receiving Chelation Treatment	Number of Dwelling Units Inspected and Found with Lead Hazard
Androscoggin Co. , Me.	1,399	14	0	87
Augusta, Me.	2,727	26	1	35
Bangor (Penquis), Me.	551	7	0	3
Boston, Mass.	3,275	281	21	398
Cambridge, Mass.	479	8	2	15
Chelsea, Mass.	185	6	1	27
Fall River, Mass.	365	28	0	22
Hartford, Conn.	1,335	143	29	47
Lowell, Mass.	1,162	60	3	24
Lynn, Mass.	1,311	43	8	45
New Britain, Conn.	298	13	0	11
New Haven, Conn.	1,146	70	3	43
Portland, Me.	311	7	0	15
Somerville, Mass.	600	26	0	19
Stamford, Conn.	799	59	6	39
Waltham, Mass.	323	4	1	15
Waterbury, Conn.	1,082	31	1	152
Worcester, Mass.	1,222	51	8	48
DHEW REGION I	**18,570**	**877**	**84**	**1,045**
CUMULATIVE FY 75	**53,922**	**4,088**	**391**	**2,747**
Albany, N.Y.	417	33	1	20
Camden, N.J.	1,020	50	5	26
Erie Co., N.Y.	1,549	251	61	99
Hoboken, N.J.	743	5	3	48
Monroe Co., N.Y.	770	8	4	31
Nassau Co., N.Y.	NR	NR	NR	NR
New York City	18,575+	1,952	23	257
Newark, N.J.	NR	NR	8	76
Onondaga Co., N.Y.	1,878	74	6	24
Paterson, N.J.	385	20	2	19
Plainfield, N.J.	363	7	1	6
Rensselaer, N.Y.	492	25	0	9
Westchester, N.Y.	1,351	45	2	20
DHEW REGION II	**27,543**	**2,470**	**116**	**635**
CUMULATIVE FY 75	**89,893**	**7,516**	**485**	**1,910**
Allegheny Co., Pa.	1,221	14	0	NR
Baltimore, Md.	1,676	98	14	90
Chester, Penn.	443	18	0	5
Norfolk, Va.	595	23	3	17
Philadelphia, Pa.	865	21	1	42
Richmond, Va.	2,713	171	35	420
Washington, D.C.	273	33	1	67
Wilkes-Barre, Pa.	2,711	175	3	104
Delaware State	1,144	20	1	11
DHEW REGION III	**11,641**	**573**	**58**	**756**
CUMULATIVE FY 75	**38,354**	**2,671**	**363**	**2,181**

+ – Estimated or Contains Estimate; NR – Not Reported; * – Provisional 7/11/75

(Continued on next page)

Table 1 – Continued

Projects	Number of Children Screened	Number of Screened Children Confirmed Positive	Number of Children Receiving Chelation Treatment	Number of Dwelling Units Inspected and Found with Lead Hazard
Charleston, S.C.	286	52	13	60
Chattanooga, Tenn.	1	3	0	2
Greenville, S.C.	238	11	0	2
Louisville, Ky.	1,881	157	16	185
Memphis, Tenn.	965	41	3	38
Mobile, Ala.	2,311	102	2	1
Nashville, Tenn.	544	17	0	1
Savannah, Ga.	330	15	4	46
DHEW REGION IV	**6,556**	**398**	**38**	**335**
CUMULATIVE FY 75	**20,985**	**1,009**	**68**	**700**
Chicago, Ill.	13,898+	939	135	322
Cincinnati, Ohio	1,029	85	0	59
Cleveland, Ohio	2,980	25	1	31
Columbus, Ohio	858	37	3	9
Detroit, Mich.	4,301	136	NR	236
East Cleveland, Ohio	434	12	0	8
East St. Louis, Ill.	382	22	3	14
Gary, Ind.	386	17	8	32
Milwaukee, Wis.	803	34	13	32
Peoria, Ill.	323	7	1	16
Rockford, Ill.	877	29	1	24
St. Paul, Minn.	215	7	0	6
Springfield, Ill.	534	28	17	20
Toledo, Ohio	433	12	2	35
Wayne Co., Mich.	1,723	15	1	24
Wisconsin State	29,176	1,405	185	868
DHEW REGION V	**85,733**	**4,949**	**976**	**3,061**
CUMULATIVE FY 75				
	273	6	0	1
Arkansas State	2,160	4	0	0
Houston, Tex.	1,661	0	0	2
New Mexico State	3,250	326+	4	34
New Orleans, La.	909	1	0	1
Tulsa, Okla.	8,253	337	4	38
DHEW REGION VI	**19,417**	**668**	**11**	**107**
CUMULATIVE FY 75				
Burlington, Iowa	237	1	0	10
Des Moines, Iowa	2,138	17	5	164
Kansas City-Wyandotte Co., Kan.	1,284	8	9	8
St. Louis, Mo.	2,266	365	42	371
Springfield, Mo.	188	1	0	23
DHEW REGION VII	**6,113**	**392**	**56**	**576**
CUMULATIVE FY 75	**14,390**	**1,201**	**278**	**1,307**
Alameda Co., Calif.	83	0	0	0
Contra Costa Co., Calif.	342	0	0	5
Los Angeles, Calif.	448	24	2	3
DHEW REGION IX	**873**	**24**	**2**	**8**
CUMULATIVE FY 75	**1,661**	**54**	**11**	**42**
UNITED STATES (Projects)				
TOTAL	**108,725**	**6,476**	**543**	**4,261**
CUMULATIVE FY 75	**324,355**	**22,156**	**2,583**	**12,055**

+ – Estimated or Contains Estimate

NR – Not Reported

* – Provisional 7/11/75

EPIDEMIOLOGIC NOTES AND REPORTS
ST. LOUIS ENCEPHALITIS – Illinois, Texas

ILLINOIS

Through September 2, 1975, a total of 84 suspected, probable, and confirmed cases of St. Louis encephalitis (SLE) virus infection had been reported from Illinois. Although onset dates ranged from June 25 to August 30, most cases have occurred since August 15. Sixty-one of the 84 cases have been reported from Cook County in the northeastern corner of the state (Table 2).

(Reported by John B Hall, MD, Director, and Collette Rasmussen, MD, Chief, Division of Preventive Medicine, Cook County Department of Public Health; Byron J Francis, MD, State Epidemiologist, Russell James Martin, DVM, Assistant State Epidemiologist, and Richard Morrisey, Director, Infectious Disease Public Health Laboratory, Illinois Department of Public Health.)

Table 2
Cases of St. Louis Encephalitis
Illinois – Through September 2, 1975

	Suspected[a]	Probable[b]	Confirmed[c]	Total
Cook County	26	29	8	63
Illinois, excl. Cook County	9	7	11	27
Total	35	36	19	90

[a]Hemagglutination inhibition (HI) antibody titer ≥ 1:20 and < 1:80
[b]HI titer ≥ 1:80 and < 1:640
[c]HI titer ≥ 1:640 or 4-fold rise

TEXAS

From August 3 through 29, a total of 5 confirmed and 8 suspected cases of SLE virus infection occurred among residents of Houston. All cases have had presumed central nervous system involvement, but no deaths have been reported.

Reservoir and vector studies conducted in Houston have revealed that the first birds seropositive for SLE virus were collected on July 25. Twelve of 96 birds collected between July 25 and August 25 had HI titers ≥1:50; however, no birds tested since August 27 have been seropositive. In addition, no isolations of SLE virus from mosquito pools have been made.

(Reported by M S Dickerson, MD, State Epidemiologist, Texas State Department of Health; Albert G Randall, MD, Director, Robert A McClean, MD, Director of Communicable Diseases, Justus Baird, Epidemiology Supervisor, Houston Health Department; Francine Jensen, MD, Director, Harris County Health Department; and 2 EIS Officers.)

POLIOMYELITIS – Texas, Connecticut

TEXAS

On July 8, 1975, a 13-month-old Mexican-American girl was admitted to R. E. Thomason General Hospital, El Paso, Texas, with a chief complaint of being "unable to walk." The child had been seen on July 4, 1975, in the Emergency Room for watery diarrhea, anorexia, and low grade fever. On July 6 she was seen at another hospital, where a diagnosis of intestinal flu was made and a single dose of ampicillin administered. On admission the child was afebrile with areflexia and a lack of muscle tone in lower extremities and no Babinski. The admission diagnosis was acute infantile paraplegia of unknown etiology.

India Ink, gram stain, and bacterial culture of cerebrospinal fluid were negative. A stool culture sent on July 17 grew out type 1 poliovirus at the Texas Department of Health Resources Laboratory in Austin. The child currently has a flaccid paralysis of both lower extremities and weakness of the left upper extremity.

Epidemiologic investigation revealed that the child had received no polio vaccinations. In April the mother and child visited Zacatecas, Mexico, and returned to Texas through Chihuahua, arriving in El Paso in early May. On May 9 a physician who saw the child for an upper respiratory infection noted no neurologic abnormalities. The mother had had visitors from Chihuahua June 15-17 and stated that 1 of the children became ill with a lower gastrointestinal illness and returned to Mexico.

Immediate surveillance of the apartment complex revealed 350 families living there, with a population of 737 children under 19. All families in the complex were contacted and advised of the presence of polio, and the immunization status of all 737 children was obtained. Five unimmunized children were discovered, all less than age 5.

Currently an educational and informational program is being conducted through local news media, and all people of questionable immune status are being advised to report to special clinics for vaccination.

(Reported by M S Dickerson, MD, Chief, Bureau of Communicable Disease Services, John L Bradley, MD, State Representative Regional Medical Director, Region 3, Kenneth S Wheatley, Health Program Specialist, Immunizations Division, Region 3, and Paul Turner, Public Health Advisor, Texas Department of Health Resources; Bernard F Rosenblum, Director, MD, El Paso City County Health Department; Jose Alva, MD, Chief of Pediatrics, R E Thomason General Hospital, El Paso; and an EIS Officer.)

CONNECTICUT

On June 30, 1975, a 35-year-old mechanic was admitted to the Yale-New Haven Hospital with a 2-day history of lower back pain, fever, and inability to move his left leg. In addition, he complained of numbness and paresthesias in both legs. Admission physical examination was unremarkable except for the presence of fever, paralysis of both lower extremities, and the absence of deep tendon reflexes in both lower extremities. Sensory examination and upper extremity reflexes were intact. Initial lumbar puncture revealed an opening pressure of 200 mm H_2O with 229 white blood cells (88% lymphs, 12% monos), protein 112 mg%, and a normal glucose. The patient was presumptively diagnosed as having the Landry-Guillain-Barré syndrome. In the next few days paralysis progressed, and he required respiratory assistance. On July 17, 1975, type 3 poliovirus was isolated from the stool. Acute and convalescent sera revealed a 16-fold antibody titer rise to type 3 poliovirus, consistent with type 3

POLIOMYELITIS – Continued

poliomyelitis infection. In addition, the patient had a 4-fold titer rise to type 2 poliovirus.

Epidemiologic investigation revealed that the man has a 4-month-old son, who had received 1 dose of trivalent oral polio vaccine (TOPV) on May 9, 1975. The patient has 3 other family members (wife, and 2 daughters), who had not been ill and had been completely immunized. No increase in enterovirus activity was noted in the surrounding area, and the patient had had no foreign travel. The patient received monovalent oral polio vaccine in the following manner: 1 dose each of type 1, July 1963, type 3, August 1963, and type 2, January 1964. The patient is currently regaining motor activity in his upper extremities and has been successfully weaned from the respirator. Rectal swabs for virus isolation from all other family members is pending. This is the first case of polio in the State of Connecticut since 1972.

(Reported by Richard V Lee, MD, Dorothy M Horstmann, MD, Yale-New Haven Hospital; Frances M Steele, PhD, Martin Ross, PhD, Division of Laboratories, and James C Hart, MD, Preventable Diseases Division, Connecticut State Health Department; and an EIS Officer.)

Editorial Note

This represents a contact vaccine-associated case of poliomyelitis, since the patient's illness occurred within 60 days of his son's receipt of vaccine (*1,2*).

References

1. Evidence on the safety and efficacy of live poliomyelitis vaccines currently in use, with special references to type 3 poliovirus. Bull WHO 42:925-945, 1970
2. Center for Disease Control: Neurotropic Diseases Surveillance – Annual Poliomyelitis Summary, 1973, February 1975

ERRATUM – Vol. 24, No. 27, p. 229

In "Microbiologic Standards for Raw Ground Beef, Coldcuts, and Frankfurters," the outbreak caused by *Trichinella spiralis* attributed to frankfurters referred to on the second page of the article has been reanalyzed in light of new information. The affected persons are now considered to have acquired trichinosis from an undetermined source while traveling abroad. Frankfurters were not the cause of this outbreak.

The Morbidity and Mortality Weekly Report, circulation 45,000, is published by the Center for Disease Control, Atlanta, Ga.

Director, Center for Disease Control	David J. Sencer, M.D.
Director, Bureau of Epidemiology, CDC	Philip S. Brachman, M.D.
Editor, MMWR	Michael B. Gregg, M.D.
Managing Editor, MMWR	Katherine A. Sheram, M.A.

The data in this report are provisional, based on weekly telegraphs 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.

In addition to the established procedures for reporting morbidity and mortality, the editor welcomes accounts of interesting cases, outbreaks, environmental hazards, or other public health problems of current interest to health officials.

Send reports to:
Center for Disease Control
Attn: Editor, Morbidity and Mortality Weekly Report
Atlanta, Georgia 30333

Send mailing list additions, deletions, and address changes to:
Center for Disease Control
Attn: Distribution Services, GSO, 1-SB40
Atlanta, Georgia 30333

When requesting changes, be sure to give your former address, including zip code and mailing list code number, or send an old address label.

DHEW Publication No. (CDC) 76-8017