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Update: Mortality Attributable to HIV Infection Among Persons Aged 25–44 Years — United States, 1994

During the 1980s, human immunodeficiency virus (HIV) infection, the cause of acquired immunodeficiency syndrome (AIDS), emerged as a leading cause of death in the United States (*1*). In 1993, HIV infection became the most common cause of death among persons aged 25–44 years. This report updates national trends in deaths caused by HIV infection in 1994, which continue to increase.*

Provisional estimates of deaths in 1993 and 1994 were based on a 10% sample of death certificates of U.S. residents filed in all 50 states and the District of Columbia (*2,3*). Demographic data were reported by funeral directors, and causes of death were reported by physicians, medical examiners, or coroners and encoded according to the *International Classification of Diseases, Ninth Revision*. Underlying causes of death were classified into the categories in CDC's "List of 72 Selected Causes of Death" for ranking (*2*). Rates were calculated using midyear U.S. population estimates based on decennial census data compiled by the U.S. Bureau of the Census. Information on Hispanic ethnicity and races other than white and black was unavailable in the provisional mortality data; each race includes Hispanics.

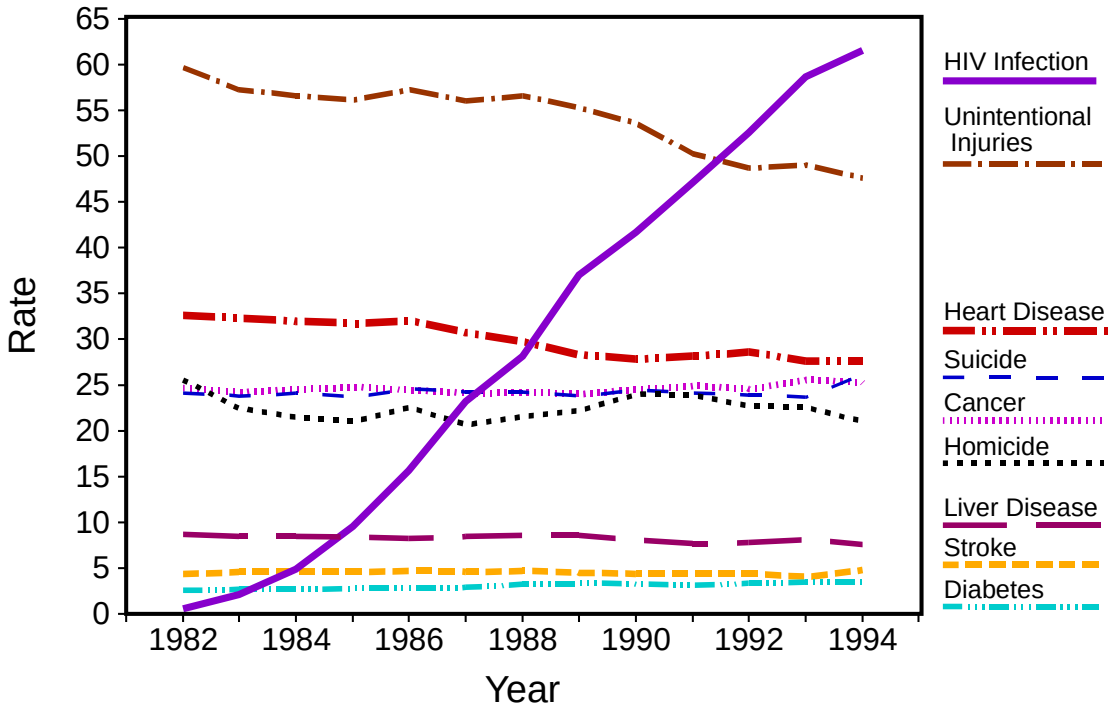
In 1994, an estimated 41,930 U.S. residents died from HIV infection, a 9% increase over the estimated 38,500 in 1993; of these, 3% were aged <25 years; 72%, 25–44 years; and 25%, ≥45 years. HIV infection was the eighth leading cause of death overall, accounting for 2% of all deaths. Among persons aged 25–44 years, HIV infection was the leading cause of death and accounted for 19% of deaths in this age group. In 1994, HIV infection became the fourth leading cause of years of potential life lost before age 65 (YPLL-65) (compared with fifth in 1993), accounting for 9% of YPLL-65 from all causes.

Among men aged 25–44 years, HIV infection was the leading cause of death for all men (23% of deaths) (Figure 1) and for white and black men (20% and 32% of deaths, respectively). HIV infection was the third leading cause of death for all women in this age group (11% of deaths) (Figure 2), the fifth leading cause for white women (6% of deaths), and the leading cause for black women (22% of deaths).

*Single copies of this report will be available until February 16, 1997, from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone (800) 458-5231 or (301) 217-0023.

Mortality Attributable to HIV Infection — Continued

FIGURE 1. Death rates* from leading causes of death among men aged 25–44 years, by year — United States, 1982–1994†



*Per 100,000 population.
†National vital statistics based on underlying cause of death, using final data for 1982–1992 and provisional data for 1993–1994.

In 1994, the death rate from HIV infection per 100,000 population among persons aged 25–44 years was almost four times as high for black men (177.9) as for white men (47.2) and nine times as high for black women (51.2) as for white women (5.7). Compared with 1993, the rate for white men in 1994 was similar (47.5 and 47.2, respectively), and rates for the three other sex-racial groups continued to increase: the percentage increase was 13% for black men, 28% for black women, and 30% for white women (Figure 3).

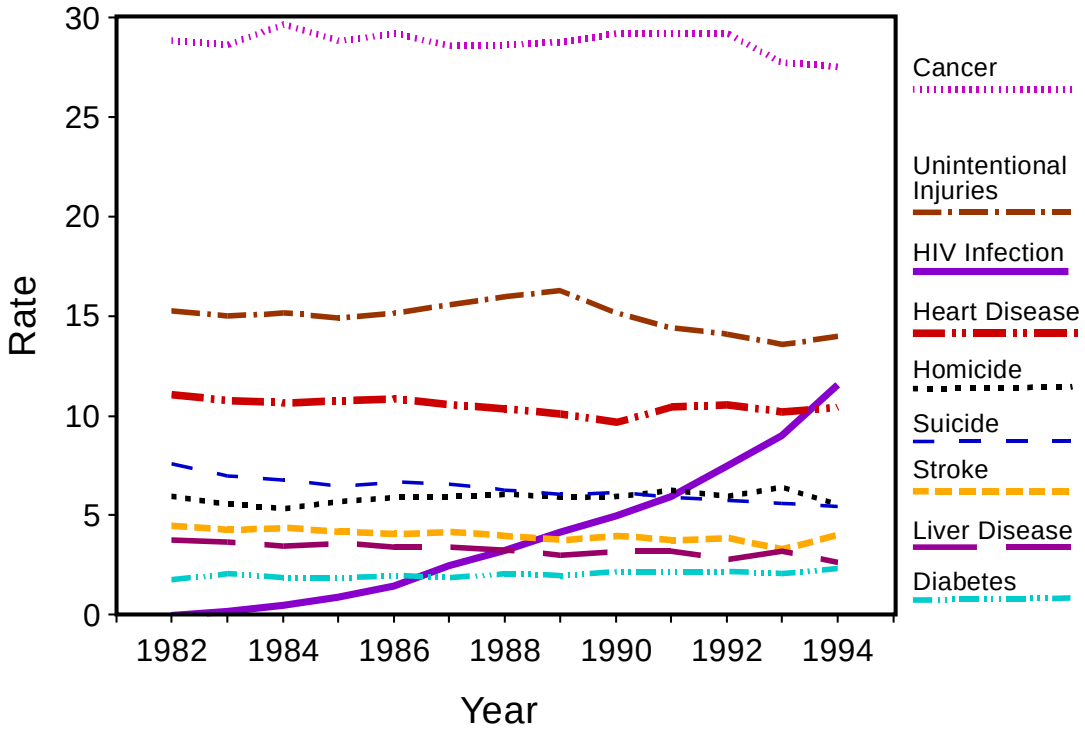
Reported by: Surveillance Br, Div of HIV/AIDS Prevention, National Center for Prevention Svcs; Mortality Statistics Br, Div of Vital Statistics, National Center for Health Statistics, CDC.

Editorial Note: This analysis of provisional mortality data for 1993 and 1994 indicates a continuing increase in HIV infection as a leading cause of death in the United States, particularly among persons aged 25–44 years. Among persons in this age group, HIV infection became the most common cause of death for black men in 1991, for all men (all racial/ethnic groups combined) in 1992, and for white men in 1994. HIV became the third leading cause of death among women in this age group in 1994. In addition, as reflected by YPLL-65, HIV infection has become a leading cause of premature mortality.

Because this analysis was based on the underlying cause of death recorded on death certificates, the findings in this report probably underestimate the impact of HIV infection on mortality in the United States. Previous studies have indicated that,

Mortality Attributable to HIV Infection — Continued

FIGURE 2. Death rates* from leading causes of death among women aged 25–44 years, by year — United States, 1982–1994†



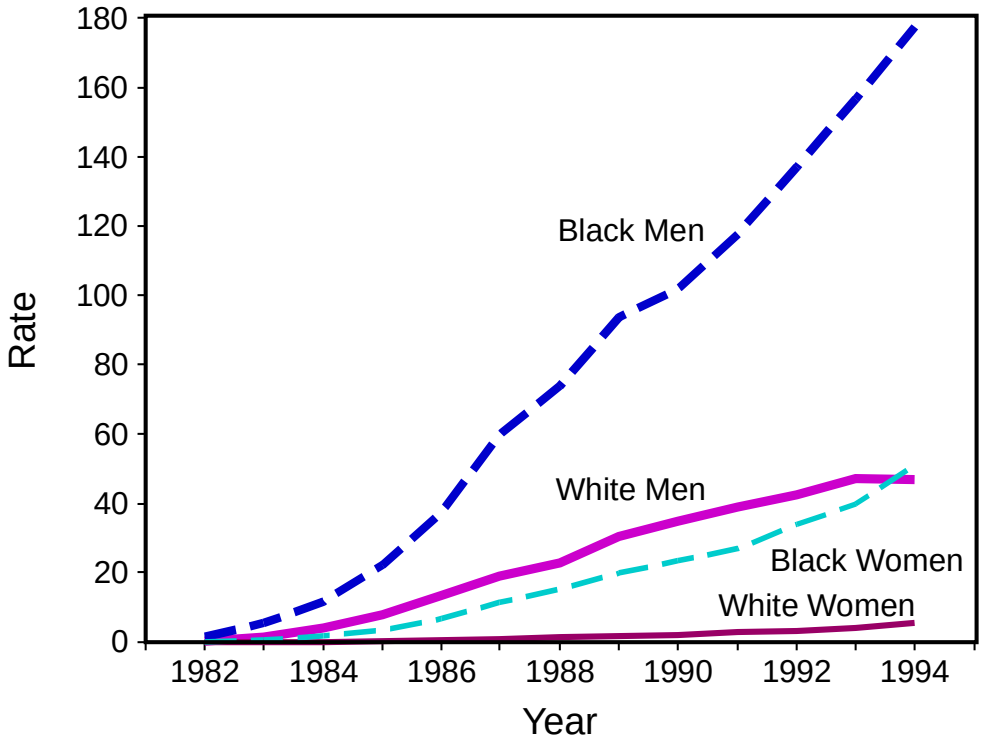
*Per 100,000 population.
†National vital statistics based on underlying cause of death, using final data for 1982–1992 and provisional data for 1993–1994.

among persons aged 25–44 years, deaths for which HIV infection was designated the underlying cause represent approximately two thirds to three fourths of all deaths attributable to HIV infection (*4,5*). The estimated number of death certificates with any mention of HIV infection (i.e., underlying or nonunderlying cause) in 1994 was 48,000 (CDC, unpublished data, 1995), compared with the approximately 42,000 on which HIV was listed as an underlying cause. Based on survival analysis of cases reported to CDC through the AIDS surveillance system—which includes other sources in addition to data from death certificates—and the completeness of reporting of AIDS cases and of deaths, an estimated 55,000 to 60,000 persons with AIDS died in 1994 (CDC, unpublished data, 1995).

Trends in HIV-related mortality reflect changes in the demographic patterns of the HIV epidemic. For example, from 1993 to 1994, the death rate for HIV infection for white men aged 25–44 years did not change, and rates for women and black men increased; in 1994, the rate for black women aged 25–44 years surpassed that for white men in that age group. The increasing death rate for women affects the care of their children: the estimated 80,000 HIV-infected women of childbearing age who were alive in 1992 will leave approximately 125,000 to 150,000 children when they die during the 1990s (*6*). Racial differences in death rates for HIV infection probably reflect social, economic, behavioral, and other factors associated with HIV transmission risks.

Mortality Attributable to HIV Infection — Continued

FIGURE 3. Death rates* from HIV infection among persons aged 25–44 years, by sex, race§, and year — United States, 1982–1994†



*Per 100,000 population.
†National vital statistics based on underlying cause of death, using final data for 1982–1992 and provisional data for 1993–1994.
§Data were unavailable for races other than white and black.

Such factors are being addressed through prevention efforts designed to meet the needs of specific communities (*7*).

Because of the prolonged period from initial HIV infection to onset of severe HIV disease (AIDS) (*8*), recent trends in HIV-related mortality reflect trends in HIV transmission several years earlier. Similarly, trends in HIV-related mortality in several years will indicate, in part, the effectiveness of current efforts to prevent HIV infection. Despite recent increases in HIV-related mortality, decreases in the percentages of HIV-related deaths resulting from particular opportunistic infections (pneumocystosis, cryptococcosis, and candidiasis) (*9*) suggest some success in the treatment and prevention of opportunistic infections resulting from HIV infection and underscore the importance of following recently published guidelines for preventing HIV-related opportunistic infections (*10*).

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Mortality Attributable to HIV Infection — Continued

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Accessibility of Tobacco Products to Youths Aged 12–17 Years — United States, 1989 and 1993

Although the sale of tobacco products to minors is illegal in all states and the District of Columbia (*1*), the prevalence of cigarette smoking among adolescents has continued to increase (*2*), and most minors are able to purchase tobacco products (*3*). Reducing sales to minors is believed to be an effective measure for reducing the prevalence of tobacco use (*4*). To determine recent patterns of minors' access to tobacco products from retail outlets and vending machines, data were analyzed from the 1989 and 1993 Teenage Attitudes and Practices surveys (TAPS I and TAPS II). This report summarizes the results of that analysis, which indicate that most minors who use tobacco purchase their own tobacco and that small stores are the sources of most purchases.

Samples for both TAPS I and II were drawn from households that participated in the National Health Interview Survey (NHIS), a continuing nationwide household survey that collects information from a representative sample of the U.S. civilian, noninstitutionalized population aged ≥18 years. Both TAPS I and II collected information on adolescents' knowledge, attitudes, and practices regarding tobacco use. TAPS I data were collected by telephone interviews; TAPS II data were collected by telephone and personal interviews and included both a new probability sample and a follow-up of respondents from TAPS I. Data for persons aged 12–17 years in each survey were analyzed (n=7773 for TAPS I; n=6165 for TAPS II) and weighted to provide national estimates. SUDAAN was used to calculate standard errors for determining 95% confidence intervals (CIs) and to perform multivariate logistic regression analyses of TAPS II data; simultaneous adjustments were made for age, sex, race/ethnicity, and region of the country. Differences between TAPS I and TAPS II for selected estimates were assessed by using the Generalized Estimating Equations software (*5*). Adjustments were made for subject correlation and age.

Accessibility of Tobacco Products — Continued

Adolescents in both TAPS I and II who were current smokers were asked about purchase practices, and all respondents were asked about perceived ease of purchase (*6*). In TAPS II, adolescents who usually bought, ever bought, or ever tried to buy their own cigarettes were asked, "Have you ever been asked to show proof of age when buying/trying to buy cigarettes?" With the exception of questions regarding purchase from vending machines, similar questions were asked of TAPS II adolescents regarding the purchase of smokeless tobacco (SLT) products. Data were analyzed by race/ethnicity because, after controlling for sociodemographic differences, the prevalence of cigarette smoking is higher among minors in some racial/ethnic groups (*3*).

The overall percentage of smokers aged 12–17 years who usually bought their own cigarettes was higher in 1993 than in 1989 (Table 1). In 1993, minors residing in the

TABLE 1. Percentage of smokers* aged 12–17 years† who usually bought their own cigarettes in 1989 and 1993, by selected characteristics — United States, Teenage Attitudes and Practices Surveys I and II, 1989§ and 1993§

	1989			1993			% Point change
Characteristic	**No.**	**(%)**	**(95% CI¶)**	**No.**	**(%)**	**(95% CI)**	**1989 to 1993**
Age (yrs)							
12–15	439	(45.4)	(± 4.9%)	264	(52.4)	(± 6.3%)	+ 7.0
16–17	559	(66.6)	(± 4.1%)	446	(69.1)	(± 4.3%)	+ 2.5
Sex							
Male	521	(59.6)	(± 4.5%)	367	(63.6)	(± 4.8%)	+ 4.0
Female	477	(55.3)	(± 4.8%)	343	(60.5)	(± 5.7%)	+ 5.2
Race**							
White	914	(58.7)	(± 3.3%)	639	(62.1)	(± 4.0%)	+ 3.4
Black	64	(43.3)	(±11.5%)	52	(64.1)	(±14.3%)	+20.8
Ethnicity††							
Hispanic	68	(41.3)	(±12.8%)	56	(59.1)	(±13.8%)	+17.8
Non-Hispanic	924	(59.0)	(± 3.3%)	654	(62.4)	(± 3.9%)	+ 3.4
Region§§							
Northeast	218	(58.8)	(± 6.8%)	146	(68.4)	(± 8.4%)	+ 9.6
Midwest	275	(55.0)	(± 5.5%)	225	(61.6)	(± 6.2%)	+ 6.6
South	305	(61.5)	(± 5.9%)	201	(66.2)	(± 6.2%)	+ 4.7
West	200	(53.6)	(± 7.6%)	138	(50.9)	(± 9.4%)	– 2.7
Total	**998**	**(57.5)**	(± **3.2%**)	**710**	**(61.9)**	**(æ 3.9%)**	**+ 4.4¶¶**

*Youths who reported smoking at least one cigarette during the 30 days preceding the survey.
†As of November 1, 1989, or March 15, 1993.
§Prevalence estimates were calculated from weighted data.
¶Confidence interval.
**Excludes 39 persons of other, multiple, and unknown races because numbers were too small to calculate precise estimates.
††Excludes six persons with unknown Hispanic origin.
§§Northeast=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; Midwest=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; South=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; West=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.
¶¶The log odds ratio for the change in the overall prevalence of "bought own cigarettes" from 1989 to 1993 estimated using the Generalized Estimating Equations software is 0.21 (odds ratio=1.2). This log odds ratio was significantly different than zero at the 0.05 level. The logistic model used to calculate the above included age as a covariate.

Accessibility of Tobacco Products — Continued

Northeast (adjusted odds ratio [AOR]=2.2; 95% CI=1.2–3.8) and South (AOR=1.8; 95% CI=1.1–3.0) were more likely than minors residing in the West to report they usually bought their own cigarettes.* In addition to the 61.9% of U.S. smokers aged 12–17 years who usually bought their own cigarettes in 1993, 15.5% reported they ever (but not usually) had bought cigarettes, and 2.3% reported they ever had tried unsuccessfully to buy their own cigarettes.

Among minors aged 12–17 years who usually bought their own cigarettes, 14.6% in 1989 and 12.7% in 1993 often or sometimes bought their cigarettes from vending machines; 49.6% in 1989 and 36.8% in 1993 often or sometimes bought from large stores; and 84.6% in 1989 and 88.5% in 1993 often or sometimes bought from small stores (Table 2). In 1993, minors aged 12–15 years were more likely than those aged 16–17 years (AOR=2.1; 95% CI=1.1–4.3) to often or sometimes use vending machines; those aged 12–15 years were less likely than those aged 16–17 years to often or sometimes buy their cigarettes from small stores (AOR=0.5; 95% CI=0.4–0.7).

In 1993, 55.3% (95% CI=51.0%–59.6%) of minors aged 12–17 years reported ever having been asked to show proof of age when buying or trying to buy cigarettes. Blacks (AOR=0.4; 95% CI=0.2–0.9) were less likely than whites to ever have been asked for proof of age, and Hispanics (AOR=0.3; 95% CI=0.1–0.6) were less likely than non-Hispanics to ever have been asked for proof of age.† Minors residing in the Northeast (AOR=0.4; 95% CI=0.2–0.7) or in the Midwest (AOR=0.4; 95% CI=0.2–0.8) were less likely than minors residing in the West to ever have been asked for proof of age.

In 1993, among minors aged 12–17 years who never had smoked a cigarette, 44.6% (95% CI=42.8%–46.3%) believed it would be easy for them to buy cigarettes, including 34.4% (95% CI=32.4%–36.3%) of minors aged 12–15 years and 76.4% (95% CI=73.8%–79.0%) of minors aged 16–17 years. In 1993, 51.7% (95% CI=43.9%–59.5%) of minors aged 12–17 years who had used SLT on one or more of the 30 days preceding the survey usually purchased their own SLT; 18.3% of SLT users in 1993 ever (but not usually) had bought their own SLT, and 3.1% ever had tried unsuccessfully to buy SLT. Among minors aged 12–17 years who usually bought their own SLT, 82.1% (95% CI=74.2%–90.0%) often or sometimes bought from small stores, and 40.5% (95% CI=33.3%–47.9%) often or sometimes bought from large stores. In 1993, 43.2% (95% CI=34.4%–52.0%) of minors aged 12–17 years reported ever having been asked to show proof of age when buying or trying to buy SLT. Among males aged 12–17 years who had never used SLT in 1993, 39.0% (95% CI=36.7%–41.4%) believed it would be easy for them to buy SLT, including 28.1% (95% CI=25.6%–30.7%) of minors aged 12–15 years and 70.7% (95% CI=67.0%–74.5%) of minors aged 16–17 years.

Reported by: Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: The findings in this report are consistent with previous documentation of the ease with which minors can purchase tobacco products over the counter and

* Northeast=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; Midwest=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; South=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; West=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

† Numbers for other racial/ethnic groups were too small to calculate precise estimates.

Accessibility of Tobacco Products — Continued

TABLE 2. Percentage of smokers* aged 12–17 years† who usually bought their own cigarettes and who often/sometimes purchased cigarettes from a vending machine, large store, or small store, by selected characteristics — United States, Teenage Attitudes and Practices Survey, 1989§ and 1993§

	Vending machine			Large store			Small store		
Characteristic	1989	1993	% Point change 1989 to 1993	1989	1993	% Point change 1989 to 1993	1989	1993	% Point change 1989 to 1993
Age (yrs)									
12–15	20	18	– 2.0	41	36	– 4.9	79	83	+3.5
16–17	12	10	– 2.3	54	37	–17.2	87	92	+4.7
Sex									
Male	18	12	– 5.8	51	36	–15.0	82	90	+8.3
Female	11	13	+ 2.3	49	38	–10.9	88	88	–0.5
Region¶									
Northeast	15	18	+ 3.3	50	30	–20.1	84	88	+3.8
Midwest	20	8	–12.2	51	33	–17.5	89	88	–0.8
South	12	15	+ 2.3	50	44	– 6.2	85	90	+5.6
West	11	9	– 1.8	47	37	–10.3	80	88	+8.8
Total	**15**	**13**	**– 1.9**	**50**	**37**	**–12.8**	**85**	**89**	**+3.9****

* Youths who reported smoking at least one cigarette during the 30 days preceding the survey.
† As of November 1, 1989, or March 15, 1993.
§ Prevalence estimates were calculated from weighted data.
¶ Northeast=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; Midwest=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; South=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; West=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.
** The log odds ratio (LOR) for the change in the overall prevalence from 1989 to 1993 using the Generalized Estimating Equations software was calculated for those who usually bought their own cigarettes and who often/sometimes purchased cigarettes from a vending machine (LOR=0.17; odds ratio [OR]=1.18), large store (LOR=0.51; OR=1.67), or small store (LOR=0.34; OR=1.40). The LORs were significantly different than zero at the 0.01 level for large stores and at the 0.05 level for small stores. The logistic model used to calculate the above included age as a covariate.

from vending machines and of the more frequent use of vending machines by younger adolescents (*3*). In surveys of tobacco outlets using unannounced over-the-counter purchase attempts by minors, purchase rates were usually highest in small stores and gas stations (*3*). In addition, previous studies using self-reported surveys of minors' tobacco use indicate that these locations are the most common source of purchased cigarettes by minors (*3,6*).

Differences in access among racial/ethnic groups may be influenced by differences in socioeconomic status and by racial and cultural phenomena. The substantial race/ethnicity-specific differences for some of the variables in this analysis indicate the need to examine factors including attitudes of vendors, enforcement practices, and community norms.

Vendors' requiring proof of age is an important method of preventing tobacco sales to minors (*3,4*; CDC, unpublished data, 1994). Widespread adherence to laws requiring age verification should assist substantially in preventing tobacco sales to minors.

Accessibility of Tobacco Products — Continued

However, in 1993, approximately half of minors who ever had attempted to purchase their own tobacco products reported they never had been asked to show proof of age.

The findings in this report are subject to at least two limitations. First, TAPS II may be associated with nonresponse bias; for example, TAPS I respondents who were followed up in TAPS II were less likely to be smokers in 1989 than were those who could not be reinterviewed, possibly contributing to the lower smoking prevalence estimates in TAPS II when compared with other national surveys (CDC, unpublished data, 1993). Second, because the information was collected during telephone and personal interviews, young persons may have been reluctant to disclose tobacco-related behavior when a parent was in the household during the interview (*3*).

Although all states have enacted youth access laws, enforcement of these laws varies and needs to be strengthened. In 1994, enforcement activities were maintained only in 24 (44%) states and territories (*7*). Federal regulations now require states to develop a strategy and a time frame for achieving an inspection failure rate of ≤20% (*8*).

The establishment and enforcement of laws that prohibit sales to minors are consistent with and reinforce existing social norms (*4*). One of the national health objectives for the year 2000 is to enforce laws to reduce the sales rate observed during compliance checks to 20% (objective 3.13) (*9*). In the United States, approximately 70% of purchase attempts made by minors are successful (*3*).

In August 1995, the Food and Drug Administration proposed regulations that could reduce for minors both access to and the appeal of nicotine-containing cigarettes and SLT products (*10*). The regulations would 1) require retailers to verify the age of persons who want to purchase cigarettes or SLT products; 2) eliminate "impersonal" methods of sale and distribution that do not readily allow age verifications (e.g., mail orders, self-service displays, free samples, and vending machines), 3) limit advertising to which minors may be exposed to a text-only format; 4) ban outdoor advertising of tobacco products within 1000 feet of schools and playgrounds; 5) prohibit the sale or distribution of brand-identifiable nontobacco items and services; and 6) prohibit the sponsorship of events in the brand name. FDA is reviewing public comments on the proposed regulations.

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Accessibility of Tobacco Products — Continued

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Postnatal Causes of Developmental Disabilities in Children Aged 3–10 Years — Atlanta, Georgia, 1991

Primary prevention of developmental disabilities requires knowledge of the specific causes of these conditions. Postnatal causes account for 3%–15% of all developmental disabilities and often are preventable (*1*). To assess the prevalence and determine the specific etiology of postnatally acquired developmental disabilities, CDC analyzed data from its ongoing Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP) for 1991 (the most recent year for which complete data were available). This report summarizes the findings of the analysis, which indicate that bacterial meningitis and child battering were the leading postnatal causes of developmental disabilities and that children with postnatally acquired developmental disabilities had a higher average number of disabilities than all other children with developmental disabilities.

MADDSP identifies all children aged 3–10 years residing in five counties of metropolitan Atlanta (Clayton, Cobb, DeKalb, Fulton, and Gwinnett [total 1990 estimated population of children aged 3–10 years: 252,377]) with any of four developmental disabilities: cerebral palsy, mental retardation, moderate-to-severe hearing impairment, and moderate-to-severe vision impairment. Children with these conditions are identified through a systematic review of records at public schools, hospitals, and other public or private programs for children with disabilities. Detailed information about the underlying cause associated with each developmental disability is abstracted for all children identified with a developmental disability. For this analysis, a developmental pediatrician reviewed all abstracted information to determine whether children had a disability with a postnatal cause. A postnatal cause was defined as any event that occurred from age 30 days through 10 years.

Of the 2685 children identified with a developmental disability in 1991, a total of 122 (4.5%) had at least one with a postnatal cause (Table 1); overall, these children had a total of 186 postnatally acquired developmental disabilities (Table 2). No children had more than one postnatal cause for their disability. The percentages of developmental disabilities accounted for by postnatal causes ranged from 3.5% (mental retardation) to 12.4% (hearing impairment).

The most common postnatal causes of developmental disability were bacterial meningitis and child battering, which accounted for 57 (30.6%) and 27 (14.5%) postnatally acquired developmental disabilities, respectively (Table 2). The highest average number of disabilities per affected child was in those who had a developmental

Developmental Disabilities — Continued

TABLE 1. Prevalence rate* of developmental disabilities (DDs) among children aged 3–10 years, by type of developmental disability — Atlanta, Georgia, Metropolitan Atlanta Developmental Disabilities Surveillance Program, 1991†

Type of DD	Postnatal causes		All causes		% DDs with postnatal causes
	No.	Rate	No.	Rate	
Cerebral palsy	58	0.2	**599**	**2.4**	9.7
Mental retardation	77	0.3	**2193**	**8.7**	3.5
Hearing impairment (moderate to severe)	35	0.1	**283**	**1.1**	12.4
Visual impairment (moderate to severe)	17	<0.1	**209**	**0.8**	7.7
Total	**122**	**0.5**	**2685**	**10.6**	**4.5**

*Per 1000 children aged 3–10 years.
†Disability groups are not mutually exclusive; therefore, a child can be represented in more than one disability group.

disability caused by a near-drowning incident (2.3). Stroke, child battering, bacterial meningitis, and motor-vehicle crashes also accounted for high average numbers of developmental disabilities per affected child (1.9, 1.8, 1.8, and 1.7, respectively). Of the three major etiologic groupings analyzed (infectious diseases, chronic diseases, and injuries), injuries accounted for the greatest proportion of postnatal cases of each developmental disability except hearing impairment.

To assess the severity of different types of developmental disabilities, the number of developmental disabilities in children with such conditions attributable to a postnatal cause was compared with the number in those with such conditions attributable to other causes. The prevalence of two or more developmental disabilities was more than twofold higher among children with postnatally acquired developmental disabilities than those with developmental disabilities attributable to other causes (42.6% versus 17.0%) (Table 3).

Reported by: Developmental Disabilities Br, Div of Birth Defects and Developmental Disabilities, National Center for Environmental Health, CDC.

Editorial Note: This analysis of MADDSP data identified distinct causes for the four postnatally acquired developmental disabilities analyzed, most of which are preventable. Among children in metropolitan Atlanta, the proportions of developmental disabilities attributable to postnatal causes are consistent with previous studies (*1–4*). In addition, the MADDSP data indicate that children with a postnatally acquired developmental disability were more likely to have multiple disabilities than other children identified with developmental disabilities, suggesting that postnatally acquired developmental disabilities have a greater impact on a child's health status than other developmental disabilities.

In metropolitan Atlanta, of the specific causes of postnatally acquired developmental disabilities, bacterial meningitis caused the greatest number of those disabilities, and *Haemophilus influenzae* serotype b (Hib) accounted for 47% of meningitis-related developmental disabilities. Hib vaccine was licensed for use in infants in the United States in 1990 and has been distributed widely (*5*); however, the 1991 MADDSP data include information about children born during 1981–1988 (before the vaccine became available). The continued identification of Hib cases by MADDSP should prompt intensification of prevention programs.

TABLE 2. Number and percentage of children aged 3–10 years with selected postnatally acquired developmental disabilities (PADDs), by specific cause — Atlanta, Georgia, Metropolitan Atlanta Developmental Disabilities Surveillance Program, 1991*

Cause	Cerebral palsy		Mental retardation		Hearing impairment		Vision impairment		Total PADDs		Total children		Average no. PADDs per child
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	
Infectious disease													
Bacterial meningitis†	18	(31.0)	23	(29.9)	11	(31.4)	5	(31.3)	**57**	**(30.6)**	**32**	**(26.2)**	1.8
Otitis media	0	—	0	—	21	(60.0)	0	—	**21**	**(11.3)**	**21**	**(17.2)**	1.0
Encephalitis	0	—	2	(2.6)	0	—	0	—	**2**	**(1.1)**	**2**	**(1.6)**	1.0
Total	**20**	**(34.5)**	**27**	**(35.1)**	**34**	**(97.1)**	**5**	**(31.3)**	**86**	**(46.2)**	**58**	**(47.5)**	**1.5**
Chronic disease													
Stroke§	8	(13.8)	5	(6.5)	0	—	2	(12.5)	**15**	**(8.1)**	**8**	**(6.6)**	1.9
Brain tumor	0	—	1	(1.3)	0	—	2¶	(12.5)	**3**	**(1.6)**	**3**	**(2.5)**	1.0
Total	**8**	**(13.8)**	**7**	**(9.1)**	**0**	**—**	**4**	**(25.0)**	**19**	**(10.2)**	**12**	**(9.8)**	**1.6**
Injury													
Child battering	10	(17.2)	14	(18.2)	0	—	3	(18.8)	**27**	**(14.5)**	**15**	**(12.3)**	1.8
Near drowning	3	(5.2)	3	(3.9)	0	—	1	(6.3)	**7**	**(3.8)**	**3**	**(2.5)**	2.3
Motor-vehicle crash	6	(10.3)	3	(3.9)	0	—	1	(6.3)	**10**	**(5.4)**	**6**	**(4.9)**	1.7
Hit by motor vehicle	3	(5.2)	7	(9.1)	1	(2.9)	0	—	**11**	**(5.9)**	**8**	**(6.6)**	1.4
Fall	2	(3.4)	6	(7.8)	0	—	0	—	**8**	**(4.3)**	**7**	**(5.7)**	1.1
Total	**30**	**(51.7)**	**43**	**(55.8)**	**1**	**(2.9)**	**7**	**(43.8)**	**81**	**(43.5)**	**52**	**(42.6)**	**1.6**
Total	**58**	**(100.0)**	**77**	**(100.0)**	**35**	**(100.0)**	**16**	**(100.0)**	**186**	**(100.0)**	**122**	**(100.0)**	**1.5**

*Etiologic events with only one attributable case and "not otherwise specified" head injuries were excluded from the table by cause but are included in overall totals. Disability groups are not mutually exclusive.

†Of the 57 total disabilities in the 32 children who had had meningitis, *Haemophilus influenzae* serotype b caused 27 of the disabilities in 15 children.

§Of the 15 total disabilities in the eight children who had stroke, sickle cell anemia caused nine disabilities in five children.

¶Includes one case of pseudotumor cerebri and one case of tumor on the optic chiasm.

Developmental Disabilities — Continued

TABLE 3. Number and percentage of children aged 3–10 years with developmental disabilities (DDs), by number of disabilities and etiology — Atlanta, Georgia, Metropolitan Atlanta Developmental Disabilities Surveillance Program, 1991

	Etiology					
	Postnatal		Other		Total	
No. DDs	No.	(%)	No.	(%)	No.	(%)
One	70	(57.4)	2127	(83.0)	**2197**	**(81.8)**
Two	40	(32.8)	340	(13.3)	**380**	**(14.2)**
Three to four	12	(9.8)	96	(3.7)	**108**	**(4.0)**
Total	**122**	**(100.0)**	**2563**	**(100.0)**	**2685**	**(100.0)**
Average no. DDs per child	*1.5*		*1.2*		*1.2*	

Child battering, including shaken baby syndrome, accounted for the second largest number of postnatally acquired developmental disabilities and a high average number of developmental disabilities for each affected child. The reported number of child battering cases is probably an underestimate because of the inability of the medical delivery system to identify all cases of abuse. Developmental disabilities caused by other types of injuries may be reduced through intensified implementation of existing prevention efforts (e.g., mandatory restraint systems for infants and toddlers to reduce the severity of motor-vehicle crash-related injuries). The detection of five children with postnatally acquired developmental disabilities associated with sickle cell anemia underscores the need for increased awareness about the severity of the consequences of sickle cell disease and the role of transfusion therapy for preventing recurrent stroke among children with this disease (*6*).

The reported percentage of postnatally acquired developmental disabilities most likely underrepresents the actual percentage of such cases. Although the MADDSP methodology included a comprehensive review of records from multiple sources in a population-based setting, the cause was defined as "other than postnatal" when etiologic information was confusing, conflicting, or missing. In addition, postnatal events for which the causal link was more difficult to establish in individual cases (e.g., poor nutrition or an impoverished social environment [*7*]) were not included in this analysis.

Surveillance for developmental disabilities should include information about the specific underlying cause(s). Because most postnatally acquired developmental disabilities are potentially preventable, knowledge of specific causes can be used to design cause-specific interventions. Surveillance systems such as MADDSP provide a population-based method for monitoring trends in disability causation and the effectiveness of intervention programs. MADDSP can be adapted for monitoring trends in other cities or states.

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Developmental Disabilities — Continued

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Update: Influenza Activity — United States, 1995–96 Season

Influenza activity in the United States increased from late October through mid- to late December 1995. Although activity began to decline during January 1996, for the week ending February 3, a total of 19 states reported continuing regional or widespread activity*. Influenza type A(H1N1) predominated in all regions except the Mountain, Pacific, and New England regions, where type A(H3N2) predominated. Influenza type B accounted for only 1% of all isolates nationwide.

As of February 3, 1996, of the 19,520 specimens submitted to World Health Organization collaborating laboratories in the United States for respiratory virus testing, 2965 (15%) have been positive for influenza virus: 2925 (99%) were influenza type A, and 40 (1%) were influenza type B. Of the 1803 type A isolates that have been subtyped, 1188 (66%) were type A(H1N1) and 615 (34%) were type A(H3N2). In six of the nine regions in the United States, influenza type A(H1N1) has accounted for from 64% to 89% of subtyped influenza type A strains. In the Mountain, Pacific, and New England regions, influenza type A(H1N1) has circulated at lower levels, accounting for 41%, 46%, and 48% of subtyped influenza A strains, respectively.

Regional influenza activity was first reported the week ending October 28, 1995. The number of states reporting regional or widespread activity increased each week from November 5 through December 23, 1995, peaking at 35 states the first week of January 1996. Most outbreaks reported by states to CDC were among school-aged children. Some outbreaks among elderly persons in nursing homes also were reported.

The proportion of patients with influenza-like illness (ILI) who visited 150 U.S. sentinel physicians began to increase the week ending December 16; this increase continued through December, with a peak of 7% of total office visits during the week ending December 30. During January, the proportion of patients with ILI began to decline, reaching 3% by the week ending January 20.

The proportion of deaths attributed to pneumonia and influenza (P&I) reported from 121 U.S. cities exceeded the epidemic threshold† by a small margin during three

*Levels of activity are 1) *sporadic*—sporadically occurring influenza-like illness (ILI) or culture-confirmed influenza with no outbreaks detected; 2) *regional*—outbreaks of ILI or culture-confirmed influenza in counties with a combined population of <50% of the state's total population; and 3) *widespread*—outbreaks of ILI or culture-confirmed influenza in counties having a combined population of ≥50% of the state's total population.

†The epidemic threshold is 1.645 standard deviations above the seasonal baseline calculated using a periodic regression model applied to observed percentages since 1983. The baseline was calculated using a robust regression procedure.

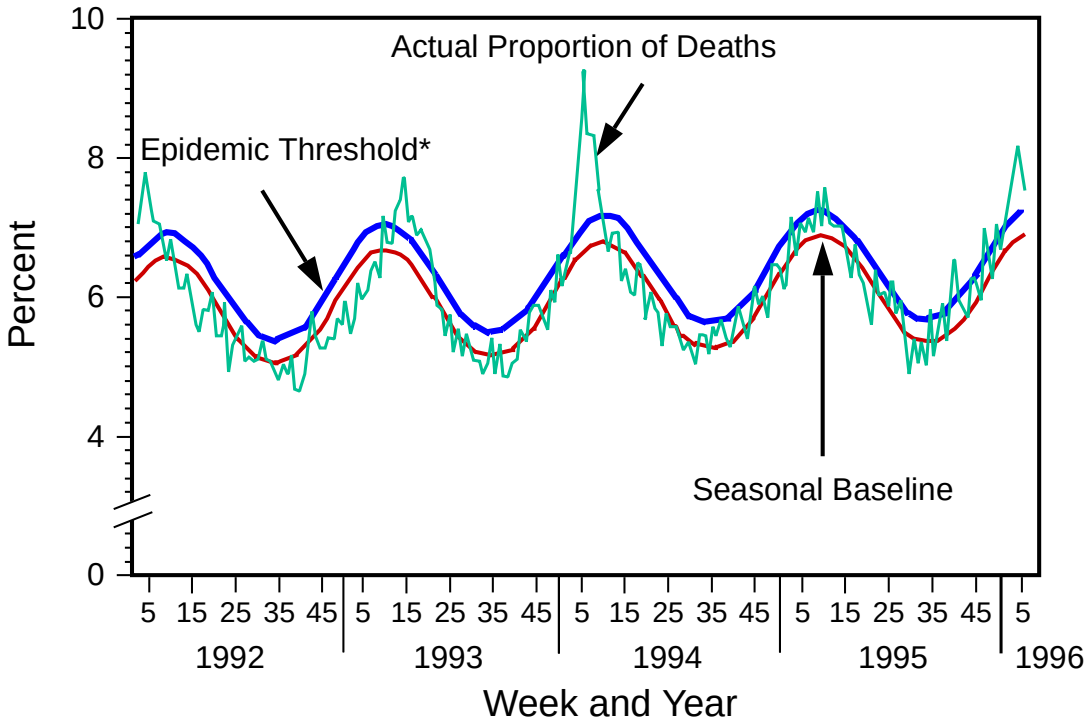
Influenza Activity — Continued

of the eight weeks from October 29 through December 23, 1995. The proportion of P&I deaths increased from the week ending December 30 through the week ending January 20 and began to decline the week ending January 27, but remained above the epidemic threshold (Figure 1).

Reported by: Participating state and territorial epidemiologists and state public health laboratory directors. World Health Organization collaborating laboratories. Sentinel Physicians Influenza Surveillance System of the American Academy of Family Physicians. Influenza Br and WHO Collaborating Center for Surveillance, Epidemiology, and Control of Influenza, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases, CDC.

Editorial Note: Although influenza activity in the United States peaked during late December 1995, influenza viruses have continued to circulate through early February 1996. The occurrence of a high proportion of reported outbreaks among school-aged children is consistent with patterns during previous influenza seasons when type A(H1N1) viruses have predominated. Influenza A(H1N1) outbreaks among children and younger adults can be associated with high absenteeism in schools and workplaces, and severe secondary medical complications in a small proportion of infected persons. Surveillance findings this season suggest that the incidence of influenza among younger children is substantially higher than usual. Influenza type A(H1N1) has not predominated in the United States since the 1986–87 season, and has circulated at low levels since 1989. As a consequence, a high proportion of children born in

FIGURE 1. Weekly pneumonia and influenza mortality as a percentage of all deaths for 121 cities — United States, January 1, 1992–February 3, 1996



*The epidemic threshold is 1.645 standard deviations above the seasonal baseline calculated using a periodic regression model applied to observed percentages since 1983. The baseline was calculated using a robust regression procedure.

Influenza Activity — Continued

the United States since the late 1980s would not be expected to have been exposed to type A(H1N1) viruses before this influenza season.

Despite the ability of type A(H1N1) to cause widespread outbreaks, since 1977—when type A(H1N1) viruses reemerged after an absence of 20 years—this strain has not been associated with substantial morbidity among older adults nor with excess mortality. In comparison, type A(H3N2) viruses, which emerged in 1968, more commonly have been associated with excess mortality, >90% of which has occurred among persons aged ≥65 years. Epidemics of influenza type B also have been associated with excess mortality (*1,2*). Although the contribution of type A(H1N1) and type A(H3N2) viruses to the excess P&I mortality this influenza season cannot be assessed precisely, observations during previous influenza seasons strongly suggest that most of these deaths were caused by type A(H3N2) viruses.

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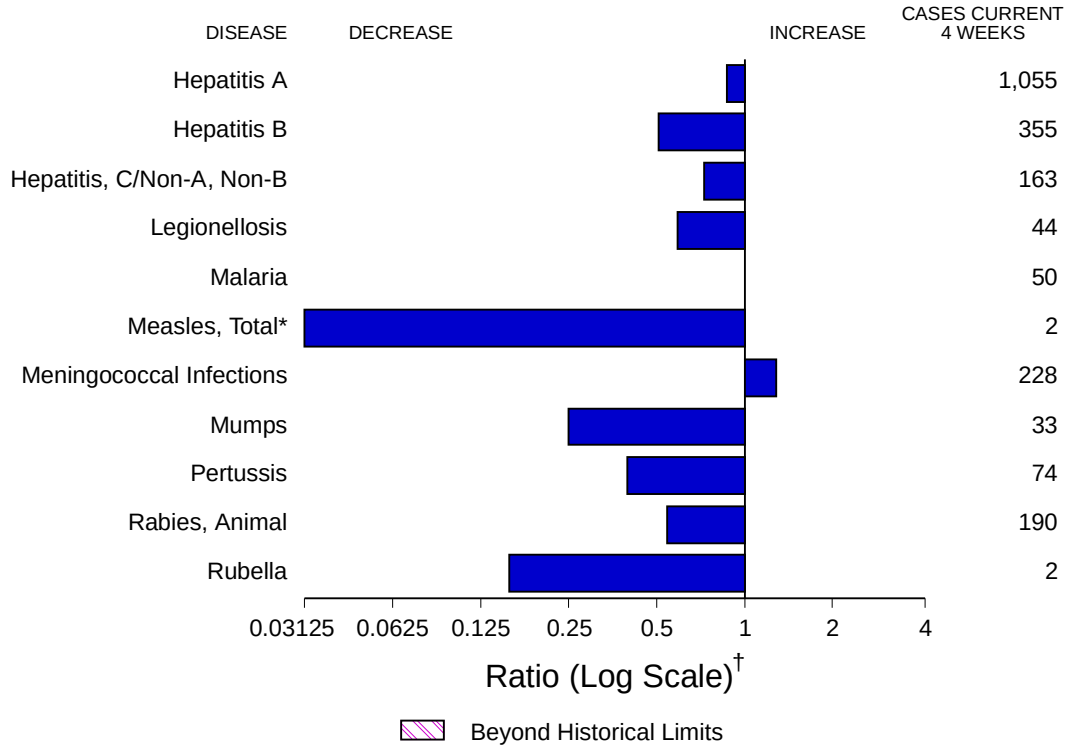
FIGURE I. Selected notifiable disease reports, comparison of 4-week totals ending February 10, 1996, with historical data — United States



*The large apparent decrease in the number of reported cases of measles (total) reflects dramatic fluctuations in the historical baseline. (Ratio [log scale] for week 6 measles [total] is 0.020747.)
†Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary — cases of selected notifiable diseases, United States, cumulative, week ending February 10, 1996 (6th Week)

	Cum. 1996		Cum. 1996
Anthrax	-	HIV infection, pediatric*§	26
Brucellosis	5	Plague	-
Cholera	-	Poliomyelitis, paralytic¶	-
Congenital rubella syndrome	-	Psittacosis	2
Cryptosporidiosis*	92	Rabies, human	-
Diphtheria	1	Rocky Mountain spotted fever (RMSF)	5
Encephalitis: California*	-	Streptococcal toxic-shock syndrome*	-
eastern equine*	-	Syphilis, congenital**	-
St. Louis*	-	Tetanus	-
western equine*	-	Toxic-shock syndrome	14
Hansen Disease	6	Trichinosis	3
Hantavirus pulmonary syndrome*†	-	Typhoid fever	13

*Not notifiable in all states.
†Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID).
§Updated monthly to the Division of HIV/AIDS Prevention, National Center for Prevention Services (NCPS), last update January 30, 1996.
¶No suspected cases of polio reported for 1996.
**Updated quarterly from reports to the Division of STD Prevention, NCPS. First quarter 1996 is not yet available.
-: no reported cases

TABLE II. Cases of selected notifiable diseases, United States, weeks ending February 10, 1996, and February 11, 1995 (6th Week)

Reporting Area	AIDS*		Chlamydia	*Escherichia coli* O157:H7		Gonorrhea		Hepatitis C/NA,NB		Legionellosis	
				NETSS†	PHLIS§						
	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1996	Cum. 1996	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995
UNITED STATES	4,357	7,085	15,215	64	13	27,817	45,776	272	353	71	114
NEW ENGLAND	208	398	1,106	11	2	755	750	5	5	3	-
Maine	7	15	-	1	-	3	7	-	-	-	-
N.H.	3	5	69	1	1	13	15	-	-	-	-
Vt.	-	-	-	2	1	13	2	2	-	-	-
Mass.	135	282	787	4	-	293	401	3	5	2	-
R.I.	9	9	250	2	-	61	52	-	-	1	-
Conn.	54	87	-	1	-	372	273	-	-	N	N
MID. ATLANTIC	1,235	1,817	870	4	3	690	5,368	17	32	8	13
Upstate N.Y.	158	227	N	3	3	-	920	15	14	2	2
N.Y. City	696	922	-	-	-	-	1,923	1	1	-	1
N.J.	244	439	870	-	-	234	380	-	12	-	4
Pa.	137	229	-	N	-	456	2,145	1	5	6	6
E.N. CENTRAL	419	515	4,412	11	1	5,522	9,770	39	37	31	48
Ohio	143	31	648	8	-	432	3,143	2	1	15	19
Ind.	50	77	1,027	2	-	941	934	-	-	6	7
Ill.	156	245	-	1	-	2,226	2,304	-	14	-	10
Mich.	37	133	2,526	-	1	1,767	2,544	37	22	10	5
Wis.	33	29	211	N	-	156	845	-	-	-	7
W.N. CENTRAL	145	165	1,570	8	3	1,442	2,625	29	8	1	11
Minn.	20	25	-	2	2	-	398	-	-	-	-
Iowa	17	14	-	2	1	-	184	28	2	1	2
Mo.	53	97	1,091	-	-	1,081	1,504	1	3	-	9
N. Dak.	-	-	-	-	-	-	-	-	-	-	-
S. Dak.	2	-	91	-	-	12	17	-	1	-	-
Nebr.	15	20	388	-	-	57	124	-	1	-	-
Kans.	38	9	-	4	-	292	398	-	1	-	-
S. ATLANTIC	880	1,358	4,758	8	-	12,057	13,836	16	22	10	25
Del.	32	30	-	-	-	182	260	-	-	-	-
Md.	69	178	445	N	-	1,458	1,775	-	1	1	6
D.C.	64	77	N	-	-	566	786	-	-	1	-
Va.	36	162	1,353	N	-	1,119	1,397	1	-	2	-
W. Va.	7	4	-	N	-	45	73	3	6	1	3
N.C.	1	81	-	3	-	2,253	3,046	4	7	3	7
S.C.	13	73	-	1	-	1,649	1,538	1	1	1	2
Ga.	215	234	699	1	-	2,778	2,551	-	1	-	4
Fla.	443	519	2,261	-	-	2,007	2,410	7	6	1	3
E.S. CENTRAL	152	133	909	3	-	3,174	5,174	-	148	9	4
Ky.	43	7	-	-	-	506	602	-	2	2	1
Tenn.	56	73	903	N	-	1,001	1,209	-	145	3	1
Ala.	35	35	-	1	-	1,607	2,298	-	1	-	1
Miss.	18	18	6	2	-	60	1,065	-	-	4	1
W.S. CENTRAL	495	750	-	3	-	1,257	3,626	53	6	-	1
Ark.	19	20	-	2	-	292	392	-	-	-	-
La.	113	130	-	N	-	965	1,472	6	-	-	-
Okla.	1	36	-	1	-	-	58	42	4	-	1
Tex.	362	564	-	-	-	-	1,704	5	2	-	-
MOUNTAIN	120	205	470	6	-	707	951	65	33	3	8
Mont.	2	7	-	-	-	2	15	3	2	-	1
Idaho	1	5	153	2	-	9	14	26	5	-	1
Wyo.	-	1	69	-	-	6	6	13	15	-	-
Colo.	54	75	-	2	-	234	310	4	6	3	1
N. Mex.	8	7	-	-	-	108	145	11	-	-	-
Ariz.	37	38	-	N	-	271	275	4	2	-	1
Utah	17	5	68	1	-	26	23	4	3	-	2
Nev.	1	67	180	1	-	51	163	-	-	-	2
PACIFIC	703	1,744	1,120	10	4	2,213	3,676	48	62	6	4
Wash.	65	91	1,059	1	4	300	306	3	3	-	-
Oreg.	48	59	-	4	-	9	29	2	4	-	-
Calif.	580	1,536	-	3	-	1,833	3,155	24	48	6	2
Alaska	3	18	N	-	-	53	120	1	-	-	-
Hawaii	7	40	61	N	-	18	66	18	7	-	2
Guam	-	-	-	N	-	-	11	-	-	-	-
P.R.	255	62	N	N	U	18	75	3	7	-	-
V.I.	1	-	N	N	U	-	-	-	-	-	-
Amer. Samoa	-	-	-	N	U	-	4	-	-	-	-
C.N.M.I.	-	-	N	N	U	-	4	-	-	-	-

N: Not notifiable U: Unavailable -: no reported cases C.N.M.I.: Commonwealth of Northern Mariana Islands

*Updated monthly to the Division of HIV/AIDS Prevention, National Center for Prevention Services, last update January 30, 1996.
†National Electronic Telecommunications System for Surveillance.
§Public Health Laboratory Information System.

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending February 10, 1996, and February 11, 1995 (6th Week)

Reporting Area	Lyme Disease		Malaria		Meningococcal Disease		Syphilis (Primary & Secondary)		Tuberculosis		Rabies, Animal	
	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995
UNITED STATES	182	375	72	93	414	340	991	1,784	925	1,237	297	605
NEW ENGLAND	19	11	3	3	18	24	18	24	27	21	52	163
Maine	-	-	-	-	5	2	-	-	4	-	-	-
N.H.	-	-	-	-	1	6	-	1	-	-	5	22
Vt.	-	-	1	-	1	1	-	-	-	-	10	20
Mass.	4	1	2	-	4	7	8	9	3	7	13	83
R.I.	10	-	-	2	-	-	-	-	7	6	8	-
Conn.	5	10	-	1	7	8	10	14	13	8	16	38
MID. ATLANTIC	144	286	16	19	20	35	20	130	65	146	34	158
Upstate N.Y.	10	42	2	2	2	12	-	13	-	19	18	96
N.Y. City	97	27	13	7	5	6	10	89	20	49	-	-
N.J.	-	52	-	7	9	11	6	15	32	29	7	28
Pa.	37	165	1	3	4	6	4	13	13	49	9	34
E.N. CENTRAL	4	5	8	15	50	62	233	299	221	170	2	1
Ohio	3	3	-	-	29	17	95	101	37	31	1	1
Ind.	1	1	1	-	4	12	32	22	16	6	-	-
Ill.	-	1	1	12	14	21	67	107	148	92	-	-
Mich.	-	-	5	1	3	6	26	38	17	38	-	-
Wis.	-	-	1	2	-	6	13	31	3	3	1	-
W.N. CENTRAL	5	7	1	4	31	16	40	101	21	41	23	36
Minn.	-	-	-	2	-	-	-	3	3	10	3	2
Iowa	5	-	1	-	12	5	-	8	5	10	17	10
Mo.	-	4	-	2	8	8	37	88	9	11	1	4
N. Dak.	-	-	-	-	1	-	-	-	-	-	2	4
S. Dak.	-	-	-	-	2	-	-	-	-	-	-	11
Nebr.	-	-	-	-	4	1	3	2	-	-	-	-
Kans.	-	3	-	-	4	2	-	-	4	10	-	5
S. ATLANTIC	9	55	14	21	74	57	335	441	70	193	154	171
Del.	-	8	2	-	1	1	7	3	-	6	9	10
Md.	8	37	4	4	9	1	59	45	15	56	51	43
D.C.	-	-	1	2	2	1	11	20	6	14	-	1
Va.	-	1	3	3	4	4	57	61	1	-	42	32
W. Va.	-	5	-	-	3	-	1	-	9	12	3	6
N.C.	1	3	2	3	10	7	94	118	17	10	15	36
S.C.	-	1	-	-	14	3	45	67	19	25	6	12
Ga.	-	-	2	2	22	23	27	76	-	31	23	22
Fla.	-	-	-	7	9	17	34	51	3	39	5	9
E.S. CENTRAL	-	2	-	1	33	15	254	449	96	88	7	22
Ky.	-	-	-	-	6	4	30	30	18	6	-	3
Tenn.	-	1	-	-	-	2	72	75	-	36	-	10
Ala.	-	-	-	1	15	7	56	83	44	46	7	9
Miss.	-	1	-	-	12	2	96	261	34	-	-	-
W.S. CENTRAL	-	-	1	-	57	21	76	233	12	46	1	19
Ark.	-	-	-	-	7	3	24	51	3	9	-	10
La.	-	-	-	-	10	4	52	112	-	-	-	7
Okla.	-	-	-	-	2	6	-	23	9	12	1	2
Tex.	-	-	1	-	38	8	-	47	-	25	-	-
MOUNTAIN	-	1	7	7	39	30	14	25	42	25	4	6
Mont.	-	-	-	1	1	-	-	-	-	-	-	3
Idaho	-	-	1	-	4	2	-	-	1	2	-	-
Wyo.	-	-	-	-	-	1	-	-	-	-	3	-
Colo.	-	-	4	4	4	9	8	11	2	2	-	-
N. Mex.	-	-	1	2	10	4	-	6	1	4	1	-
Ariz.	-	-	-	-	13	12	4	3	31	13	-	3
Utah	-	-	1	-	3	1	-	1	-	3	-	-
Nev.	-	1	-	-	4	1	2	4	7	1	-	-
PACIFIC	1	8	22	23	92	80	1	82	371	507	20	29
Wash.	-	-	-	2	6	5	-	1	30	29	-	-
Oreg.	1	-	3	2	20	17	1	1	5	2	-	-
Calif.	-	8	19	17	63	57	-	80	316	447	17	28
Alaska	-	-	-	1	1	-	-	-	10	12	3	1
Hawaii	-	-	-	1	2	1	-	-	10	17	-	-
Guam	-	-	-	-	-	1	-	1	-	4	-	-
P.R.	-	-	-	-	-	4	21	35	-	-	2	9
V.I.	-	-	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-	1	-	-
C.N.M.I.	-	-	-	-	-	-	-	-	-	3	-	-

N: Not notifiable U: Unavailable -: no reported cases

TABLE III. Cases of selected notifiable diseases preventable by vaccination, United States, weeks ending February 10, 1996, and February 11, 1995 (6th Week)

Reporting Area	*H. influenzae*, invasive		Hepatitis (viral), by type				Measles (Rubeola)			
			A		B		Indigenous		Imported†	
	Cum. 1996*	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	1996	Cum. 1996	1996	Cum. 1996
UNITED STATES	125	161	1,981	2,558	562	825	1	3	-	1
NEW ENGLAND	5	1	21	13	2	27	-	2	-	-
Maine	-	-	3	3	-	1	-	1	-	-
N.H.	4	-	2	-	-	1	-	-	-	-
Vt.	-	1	-	-	-	1	-	-	-	-
Mass.	1	-	8	2	1	3	-	1	-	-
R.I.	-	-	2	3	1	4	-	-	-	-
Conn.	-	-	6	5	-	17	-	-	-	-
MID. ATLANTIC	20	16	115	116	83	70	-	-	-	-
Upstate N.Y.	6	4	12	13	11	20	-	-	-	-
N.Y. City	2	2	95	60	66	14	-	-	-	-
N.J.	6	4	-	21	-	19	-	-	-	-
Pa.	6	6	8	22	6	17	-	-	-	-
E.N. CENTRAL	16	40	188	432	63	135	-	-	-	-
Ohio	14	21	114	242	14	9	-	-	-	-
Ind.	-	2	31	24	1	26	-	-	-	-
Ill.	2	14	7	93	2	43	-	-	-	-
Mich.	-	3	34	46	43	50	-	-	-	-
Wis.	-	-	2	27	3	7	-	-	-	-
W.N. CENTRAL	8	5	132	100	46	61	-	-	-	-
Minn.	-	-	-	4	-	-	-	-	-	-
Iowa	7	1	57	8	29	7	-	-	-	-
Mo.	1	4	43	80	9	52	-	-	-	-
N. Dak.	-	-	1	-	-	-	-	-	-	-
S. Dak.	-	-	6	-	-	-	U	-	U	-
Nebr.	-	-	10	3	2	2	-	-	-	-
Kans.	-	-	15	5	6	-	-	-	-	-
S. ATLANTIC	24	37	88	91	104	107	-	-	-	-
Del.	-	-	1	2	-	1	-	-	-	-
Md.	7	11	22	24	30	23	-	-	-	-
D.C.	-	-	3	1	1	7	-	-	-	-
Va.	-	4	7	20	14	10	-	-	-	-
W. Va.	-	-	2	4	3	9	-	-	-	-
N.C.	5	10	17	10	37	39	-	-	-	-
S.C.	1	-	9	1	6	2	-	-	-	-
Ga.	11	5	-	-	-	1	-	-	-	-
Fla.	-	7	27	29	13	15	-	-	-	-
E.S. CENTRAL	2	2	61	137	5	101	-	-	-	-
Ky.	-	1	4	12	-	13	-	-	-	-
Tenn.	-	-	-	101	-	75	-	-	-	-
Ala.	2	1	9	16	5	13	-	-	-	-
Miss.	-	-	48	8	-	-	-	-	-	-
W.S. CENTRAL	6	2	226	152	27	35	-	-	-	-
Ark.	-	1	61	3	4	-	-	-	-	-
La.	-	-	6	3	5	4	-	-	-	-
Okla.	6	1	98	63	6	8	-	-	-	-
Tex.	-	-	61	83	12	23	-	-	-	-
MOUNTAIN	10	18	347	519	96	62	-	-	-	-
Mont.	-	-	9	9	-	4	-	-	-	-
Idaho	1	1	59	54	10	10	-	-	-	-
Wyo.	1	1	1	19	-	-	-	-	-	-
Colo.	1	1	24	79	9	16	-	-	-	-
N. Mex.	3	4	64	106	46	19	-	-	-	-
Ariz.	2	6	73	106	9	7	-	-	-	-
Utah	1	2	96	128	15	2	-	-	-	-
Nev.	1	3	21	18	7	4	-	-	-	-
PACIFIC	34	40	803	998	136	227	1	1	-	1
Wash.	-	1	30	20	7	6	1	1	-	-
Oreg.	3	4	142	208	7	17	-	-	-	-
Calif.	29	33	610	754	119	200	-	-	-	-
Alaska	-	-	6	12	2	1	-	-	-	-
Hawaii	2	2	15	4	1	3	-	-	-	1
Guam	-	-	-	-	-	-	U	-	U	-
P.R.	-	1	11	2	19	12	-	-	-	-
V.I.	-	-	-	-	-	-	U	-	U	-
Amer. Samoa	-	-	-	2	-	-	U	-	U	-
C.N.M.I.	-	-	-	1	-	-	U	-	U	-

*Of 23 cases among children aged <5 years, serotype was reported for 6 and of those, 1 was type B.
†For imported measles, cases include only those resulting from importation from other countries.
N: Not notifiable U: Unavailable -: no reported cases

TABLE III. (Cont'd.) Cases of selected notifiable diseases preventable by vaccination, United States, weeks ending February 10, 1996, and February 11, 1995 (6th Week)

Reporting Area	Measles (Rubeola), cont'd. Total		Mumps			Pertussis			Rubella		
	Cum. 1996	Cum. 1995	1996	Cum. 1996	Cum. 1995	1996	Cum. 1996	Cum. 1995	1996	Cum. 1996	Cum. 1995
UNITED STATES	4	32	14	57	78	27	111	301	-	11	7
NEW ENGLAND	2	3	-	-	-	3	11	36	-	2	1
Maine	1	-	-	-	-	1	2	5	-	-	-
N.H.	-	-	-	-	-	2	3	1	-	-	-
Vt.	-	-	-	-	-	-	2	2	-	-	-
Mass.	1	1	-	-	-	-	4	26	-	-	1
R.I.	-	2	-	-	-	-	-	-	-	-	-
Conn.	-	-	-	-	-	-	-	2	-	2	-
MID. ATLANTIC	-	-	4	5	9	15	20	15	-	-	-
Upstate N.Y.	-	-	2	3	2	12	17	7	-	-	-
N.Y. City	-	-	2	2	1	3	3	5	-	-	-
N.J.	-	-	-	-	-	-	-	3	-	-	-
Pa.	-	-	-	-	6	-	-	-	-	-	-
E.N. CENTRAL	-	-	5	17	16	3	30	42	-	-	-
Ohio	-	-	3	8	7	2	21	19	-	-	-
Ind.	-	-	-	-	2	1	2	2	-	-	-
Ill.	-	-	-	-	-	-	-	-	-	-	-
Mich.	-	-	2	9	7	-	5	20	-	-	-
Wis.	-	-	-	-	-	-	2	1	-	-	-
W.N. CENTRAL	-	1	-	2	8	-	-	14	-	-	-
Minn.	-	-	-	-	-	-	-	-	-	-	-
Iowa	-	-	-	-	1	-	-	1	-	-	-
Mo.	-	1	-	-	7	-	-	6	-	-	-
N. Dak.	-	-	-	2	-	-	-	1	-	-	-
S. Dak.	-	-	U	-	-	U	-	1	U	-	-
Nebr.	-	-	-	-	-	-	-	-	-	-	-
Kans.	-	-	-	-	-	-	-	5	-	-	-
S. ATLANTIC	-	-	1	3	10	3	11	34	-	-	-
Del.	-	-	-	-	-	-	-	1	-	-	-
Md.	-	-	-	-	2	1	6	-	-	-	-
D.C.	-	-	-	-	-	-	-	1	-	-	-
Va.	-	-	1	1	3	-	-	-	-	-	-
W. Va.	-	-	-	-	-	-	-	-	-	-	-
N.C.	-	-	-	-	3	-	-	30	-	-	-
S.C.	-	-	-	1	1	-	2	1	-	-	-
Ga.	-	-	-	1	-	-	1	-	-	-	-
Fla.	-	-	-	-	1	2	2	1	-	-	-
E.S. CENTRAL	-	-	-	3	4	-	5	9	-	-	-
Ky.	-	-	-	-	-	-	4	-	-	-	-
Tenn.	-	-	-	-	-	-	-	-	-	-	-
Ala.	-	-	-	3	2	-	1	9	-	-	-
Miss.	-	-	-	-	2	-	-	-	N	N	N
W.S. CENTRAL	-	-	2	3	5	-	2	4	-	-	-
Ark.	-	-	-	-	2	-	1	-	-	-	-
La.	-	-	2	3	-	-	1	-	-	-	-
Okla.	-	-	-	-	-	-	-	-	-	-	-
Tex.	-	-	-	-	3	-	-	4	-	-	-
MOUNTAIN	-	28	-	6	2	-	14	102	-	-	-
Mont.	-	-	-	-	-	-	-	2	-	-	-
Idaho	-	-	-	-	-	-	1	36	-	-	-
Wyo.	-	-	-	-	-	-	-	-	-	-	-
Colo.	-	17	-	-	-	-	-	15	-	-	-
N. Mex.	-	6	N	N	N	-	8	3	-	-	-
Ariz.	-	5	-	-	-	-	2	46	-	-	-
Utah	-	-	-	-	1	-	-	-	-	-	-
Nev.	-	-	-	6	1	-	3	-	-	-	-
PACIFIC	2	-	2	18	24	3	18	45	-	9	6
Wash.	1	-	1	2	1	2	5	1	-	-	-
Oreg.	-	-	N	N	N	-	12	-	-	-	-
Calif.	-	-	-	9	20	-	-	42	-	9	6
Alaska	-	-	-	1	2	-	-	-	-	-	-
Hawaii	1	-	1	6	1	1	1	2	-	-	-
Guam	-	-	U	-	-	U	-	-	U	-	-
P.R.	-	-	-	-	-	-	-	1	-	-	-
V.I.	-	-	U	-	-	U	-	-	U	-	-
Amer. Samoa	-	-	U	-	-	U	-	-	U	-	-
C.N.M.I.	-	-	U	-	-	U	-	-	U	-	-

N: Not notifiable U: Unavailable -: no reported cases

TABLE IV. Deaths in 121 U.S. cities,* week ending February 10, 1996 (6th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	611	441	103	48	8	11	41
Boston, Mass.	149	85	36	20	2	6	1
Bridgeport, Conn.	30	19	10	1	-	-	3
Cambridge, Mass.	21	18	-	3	-	-	1
Fall River, Mass.	38	32	4	2	-	-	1
Hartford, Conn.	63	45	10	7	1	-	4
Lowell, Mass.	21	17	1	3	-	-	4
Lynn, Mass.	13	10	1	1	1	-	-
New Bedford, Mass.	22	19	-	3	-	-	2
New Haven, Conn.	34	24	8	-	-	2	3
Providence, R.I.	65	49	11	3	1	1	6
Somerville, Mass.	10	9	1	-	-	-	-
Springfield, Mass.	41	30	8	-	2	1	6
Waterbury, Conn.	33	25	5	3	-	-	-
Worcester, Mass.	71	59	8	2	1	1	10
MID. ATLANTIC	2,543	1,751	458	264	36	34	131
Albany, N.Y.	56	45	6	5	-	-	3
Allentown, Pa.	25	20	4	-	1	-	-
Buffalo, N.Y.	78	63	9	4	1	1	1
Camden, N.J.	26	14	5	3	2	2	-
Elizabeth, N.J.	19	13	2	4	-	-	1
Erie, Pa.§	48	41	4	2	1	-	3
Jersey City, N.J.	57	41	10	5	-	1	3
New York City, N.Y.	1,451	936	296	177	23	19	58
Newark, N.J.	47	18	18	10	-	1	6
Paterson, N.J.	16	11	2	2	-	1	-
Philadelphia, Pa.	299	212	53	26	4	4	16
Pittsburgh, Pa.§	69	54	12	2	1	-	9
Reading, Pa.	15	14	1	-	-	-	5
Rochester, N.Y.	130	111	10	7	-	2	10
Schenectady, N.Y.	23	18	3	2	-	-	-
Scranton, Pa.§	26	23	3	-	-	-	-
Syracuse, N.Y.	85	66	9	4	3	3	8
Trenton, N.J.	55	34	10	11	-	-	8
Utica, N.Y.	18	17	1	-	-	-	-
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	2,135	1,472	388	164	54	57	152
Akron, Ohio	57	41	8	6	-	2	-
Canton, Ohio	43	33	6	3	-	1	8
Chicago, Ill.	336	188	79	48	11	10	32
Cincinnati, Ohio	216	145	37	19	7	8	20
Cleveland, Ohio	147	92	34	13	3	5	1
Columbus, Ohio	176	123	37	8	4	4	14
Dayton, Ohio	157	118	32	4	3	-	13
Detroit, Mich.	234	141	42	28	16	7	9
Evansville, Ind.	42	35	6	-	-	1	-
Fort Wayne, Ind.	54	42	5	4	2	1	5
Gary, Ind.	U	U	U	U	U	U	U
Grand Rapids, Mich.	77	56	16	2	-	3	5
Indianapolis, Ind.	110	77	19	6	3	5	3
Madison, Wis.	47	29	10	5	2	1	6
Milwaukee, Wis.	134	104	16	11	-	3	14
Peoria, Ill.	57	49	4	1	2	1	7
Rockford, Ill.	51	39	10	1	-	1	3
South Bend, Ind.	46	41	4	1	-	-	4
Toledo, Ohio	87	63	17	3	-	4	6
Youngstown, Ohio	64	56	6	1	1	-	2
W.N. CENTRAL	890	618	165	55	17	21	57
Des Moines, Iowa	U	U	U	U	U	U	U
Duluth, Minn.	29	23	5	1	-	-	2
Kansas City, Kans.	16	10	4	-	1	1	-
Kansas City, Mo.	115	73	20	8	2	3	4
Lincoln, Nebr.	62	41	17	3	1	-	-
Minneapolis, Minn.	280	205	46	15	3	6	27
Omaha, Nebr.	93	49	28	9	3	4	10
St. Louis, Mo.	150	108	23	11	4	4	2
St. Paul, Minn.	75	55	10	6	2	2	8
Wichita, Kans.	70	54	12	2	1	1	4
S. ATLANTIC	1,437	911	297	148	42	36	84
Atlanta, Ga.	191	96	50	32	5	8	10
Baltimore, Md.	215	128	44	29	8	6	18
Charlotte, N.C.	106	71	23	11	-	1	5
Jacksonville, Fla.	132	92	20	9	9	2	4
Miami, Fla.	124	73	32	15	3	1	1
Norfolk, Va.	57	32	12	7	1	5	4
Richmond, Va.	85	58	17	6	1	3	9
Savannah, Ga.	56	35	13	3	4	1	3
St. Petersburg, Fla.	57	42	7	4	1	3	3
Tampa, Fla.	271	192	49	18	3	6	24
Washington, D.C.	122	77	24	14	7	-	3
Wilmington, Del.	21	15	6	-	-	-	-
E.S. CENTRAL	711	446	154	61	29	20	51
Birmingham, Ala.	72	46	11	8	2	4	4
Chattanooga, Tenn.	54	32	13	5	-	4	2
Knoxville, Tenn.	74	48	16	7	3	-	8
Lexington, Ky.	34	20	7	1	5	1	1
Memphis, Tenn.	162	115	26	13	6	2	15
Mobile, Ala.	52	35	9	5	3	-	4
Montgomery, Ala.	81	53	16	5	3	4	3
Nashville, Tenn.	182	97	56	17	7	5	14
W.S. CENTRAL	1,140	757	232	89	31	31	85
Austin, Tex.	84	55	14	9	1	5	10
Baton Rouge, La.	68	34	23	8	3	-	1
Corpus Christi, Tex.	56	32	14	6	1	3	8
Dallas, Tex.	208	128	42	27	8	3	6
El Paso, Tex.	52	36	11	2	2	1	3
Ft. Worth, Tex.	119	82	28	6	1	2	1
Houston, Tex.	U	U	U	U	U	U	U
Little Rock, Ark.	62	42	12	5	-	3	7
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	269	188	47	16	11	7	34
Shreveport, La.	83	62	15	3	-	3	7
Tulsa, Okla.	139	98	26	7	4	4	8
MOUNTAIN	1,003	686	166	94	31	26	81
Albuquerque, N.M.	112	81	13	12	6	-	4
Colo. Springs, Colo.	55	41	7	4	2	1	4
Denver, Colo.	78	51	13	10	1	3	8
Las Vegas, Nev.	249	169	55	17	5	3	20
Ogden, Utah	29	24	-	4	-	1	3
Phoenix, Ariz.	202	126	31	24	8	13	20
Pueblo, Colo.	24	19	4	-	1	-	2
Salt Lake City, Utah	101	66	21	9	3	2	8
Tucson, Ariz.	153	109	22	14	5	3	12
PACIFIC	1,719	1,173	310	166	34	35	129
Berkeley, Calif.	13	8	3	1	-	1	1
Fresno, Calif.	U	U	U	U	U	U	U
Glendale, Calif.	26	19	3	3	-	1	2
Honolulu, Hawaii	102	75	17	8	1	1	5
Long Beach, Calif.	75	50	9	12	1	3	9
Los Angeles, Calif.	562	355	109	71	20	7	22
Pasadena, Calif.	U	U	U	U	U	U	U
Portland, Oreg.	106	72	21	7	3	3	8
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	143	95	26	16	2	3	13
San Francisco, Calif.	160	102	34	19	1	4	22
San Jose, Calif.	195	149	33	9	-	4	26
Santa Cruz, Calif.	43	33	4	3	3	-	5
Seattle, Wash.	138	93	30	10	1	4	2
Spokane, Wash.	61	48	9	1	1	2	7
Tacoma, Wash.	95	74	12	6	1	2	7
TOTAL	12,189¶	8,255	2,273	1,089	282	271	811

*Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

†Pneumonia and influenza.

§Because of changes in reporting methods in these 3 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶Total includes unknown ages.

U: Unavailable -: no reported cases

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