CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

March 10, 1995 / Vol. 44 / No. 9

MMWR
MORBIDITY AND MORTALITY WEEKLY REPORT

Escherichia coli O157:H7 Outbreak Linked to Commercially Distributed Dry-Cured Salami — Washington and California, 1994

From November 16 through December 21, 1994, a total of 20 laboratory-confirmed cases of diarrhea caused by *Escherichia coli* O157:H7 were reported to the Seattle-King County Department of Public Health (SKCDPH). In comparison, three cases were reported during October 1994. Epidemiologic investigation linked *E. coli* O157:H7 infection with consumption of a commercial dry-cured salami product distributed in several western states. Three additional cases subsequently were identified in northern California. This report summarizes preliminary findings from the outbreak investigation.

Washington

Infection with *E. coli* O157:H7 has been a reportable disease in Washington since 1987; cases are identified through routine follow-up of infections reported from local laboratories to the SKCDPH. Among the 20 case-patients, the median age was 6 years (range: 23 months to 77 years), 11 (55%) were male, and all resided in King County. Three patients required hospitalization, including a 2-year-old who developed hemolytic uremic syndrome (HUS).

Interviews with initial patients suggested that brand A dry-cured salami purchased at a local grocery chain was associated with illness. Based on these preliminary findings, during November 23–25, the grocery chain voluntarily withdrew brand A salami from its King County stores. To assess potential risk factors for infection, the SKCDPH conducted a case-control study of 16 cases and age-matched controls. A case was defined as culture-confirmed *E. coli* O157:H7 in a King County resident with onset of illness during November 15–29. Eleven (68%) case-patients and one (6%) control reported eating brand A dry-cured salami within 7 days before onset of illness (Mantel-Haenszel matched odds ratio=undefined; $p<0.01$). No other food item was significantly associated with infection.

All salami was purchased from the delicatessen counters of the local grocery chain. On November 28 and 29, environmental investigations were conducted at three of these delicatessens, and food samples were collected. No errors in food-handling practices were identified. *E. coli* O157:H7 was isolated from samples of brand A presliced dry-cured salami from two of the delicatessens on December 2 and

Escherichia coli — *Continued*

subsequently from a sample from a third delicatessen in the grocery chain. On December 2, the SKCDPH issued a press release informing the public of this problem and notified the U.S. Department of Agriculture (USDA). On December 6, the manufacturing company voluntarily recalled 10,000 pounds of implicated product labeled "Sell by May 7, 1995," which had been distributed in California, Oregon, and Washington. In addition, the company requested that their distributors suspend the sale of all of its products until the source of contamination was determined. The last case-patient had onset of illness on December 6.

Restriction fragment length polymorphism (Shiga-like toxin RFLP and lambda-RFLP) analysis by the University of Washington School of Public Health and Community Medicine determined that patterns were identical in 15 of 19 clinical isolates and in the three salami isolates. Sources for the matching isolates included 12 patients who ate salami, two secondary cases, and one person who ate sliced turkey purchased from a delicatessen where brand A dry-cured salami was sold, suggesting possible cross-contamination. The four nonmatching isolates were from specimens from patients who did not eat salami. These findings were confirmed at CDC by pulsed-field gel electrophoresis on a sample of outbreak-related isolates.

California

Three patients with laboratory-confirmed *E. coli* O157:H7 infection who reported consumption of brand A salami during the week before illness onset were hospitalized in northern California during November. Two patients resided in Sonoma County and one in Sacramento County. Patients were aged 4, 25, and 71 years; the 4-year-old developed HUS. Dates of onset ranged from November 17 through November 27. In addition, a 20-month-old resident of Sacramento who had consumed brand A dry-cured salami before onset of illness was hospitalized with postdiarrheal HUS on November 24. Although cultures of stool from this patient were negative for routine bacterial pathogens, screening for *E. coli* O157:H7 had not been performed before institution of antibiotic therapy. However, serum antibody to O157 antigen subsequently was detected at the Microbial Diseases Laboratory of the California State Department of Health Services (CSDHS).

CSDHS subsequently cultured *E. coli* O157:H7 from two samples of presliced brand A dry-cured salami obtained from stores in California.

Reported by: ER Alexander, MD, J Boase, MSN, M Davis, DVM, L Kirchner, C Osaki, MSPH, T Tanino, Seattle-King County Dept of Public Health, M Samadpour, PhD, Univ of Washington, P Tarr, MD, Children's Hospital and Medical Center, Seattle; M Goldoft, MD, S Lankford, J Kobyashi, MD, P Stehr-Green, DrPH, State Epidemiologist, Washington Dept of Health. P Bradley, B Hinton, MD, Sacramento County Health Dept, Sacramento; P Tighe, B Pearson, GR Flores, MD, Sonoma County Health Dept, Santa Rosa; S Abbott, R Bryant, SB Werner, MD, DJ Vugia, MD, State Epidemiologist, California State Dept of Health Svcs. Food Safety Inspection Svc, US Dept of Agriculture. Div of Training, Epidemiology Program Office; Foodborne and Diarrheal Diseases Br, Div of Bacterial and Mycotic Diseases, National Center for Infectious Diseases, CDC.

Editorial Note: *E. coli* O157:H7 was first recognized as a human pathogen in 1982 (*1*) and is now an important cause of bloody diarrhea and a leading cause of acute renal failure in children (*2*). Each year in the United States, *E. coli* O157:H7 infection accounts for a minimum 20,000 cases of illness and 250 deaths (CDC, unpublished data, 1995). In 1993, the Council of State and Territorial Epidemiologists recommended that *E. coli* O157:H7 be a nationally reportable disease and that clinical laboratories screen

Escherichia coli — *Continued*

at least all bloody stools for this pathogen (*3*). In response to increased culturing, during 1993–1994, a total of 46 clusters of *E. coli* O157:H7 infections involving an estimated 1300 persons were recognized in the United States. The outbreak described in this report highlights the critical role of both microbiologic surveillance for *E. coli* O157:H7 on diarrheal stool specimens submitted for bacterial culture and a reporting system to detect evolving communitywide outbreaks (*4,5*). As of January 1995, 32 states required that *E. coli* O157:H7 isolates be reported to the state health department, and an additional 16 states were considering establishing this requirement (CDC, unpublished data, 1995).

The identification of dry-cured salami as a source of *E. coli* O157:H7 infection in this outbreak extends the spectrum of food vehicles associated with this organism. Previous outbreaks have been associated with other foods of animal origin—including ground beef, roast beef, and raw milk (*2*)—and raw vegetables and apple cider possibly contaminated with cow feces (*6,7*). Dry-cured salami is not cooked but is usually produced through fermentation followed by drying. Specific manufacturing processes may vary among companies and for different types of salami. Experimental inoculation of a salami batter with *E. coli* O157:H7 has demonstrated that the organism survives but does not grow during fermentation, drying, and storage for 2 months at 39.2 F (4 C) (*8*).

On December 9, representatives of the USDA's Food Safety Inspection Service (FSIS) and 250 dry-sausage makers met to address the isolation of *E. coli* O157:H7 from this product. Industry representatives agreed to evaluate their production methods to assess the survival of *E. coli* O157:H7. FSIS will review industry findings and initiate any necessary changes in manufacturing processes (e.g., fermentation or time and temperature procedures).

The investigation in this report illustrates the usefulness of molecular subtyping techniques to distinguish outbreak strains of *E. coli* O157:H7 from others circulating in the community. Subtyping methods have included RFLP, pulsed-field gel electrophoresis, and phage typing (*9,10*). The combined use of methods may assist efforts to determine the relatedness of strains and assess epidemiologic associations (*10*). Prospective subtyping of *E. coli* O157:H7 strains may be used as an adjunct to microbiologic surveillance to detect clusters of related cases, guide interviewing, ascertain the source of infection, and prevent additional cases.

References

1. Riley LW, Remis RS, Helgerson SD, et al. Hemorrhagic colitis associated with a rare *Escherichia coli* serotype. N Engl J Med 1983;308:681–5.
2. Griffin PM, Tauxe RV. The epidemiology of infections caused by *Escherichia coli* O157:H7, other enterohemorrhagic *E. coli*, and the associated hemolytic uremic syndrome. Epidemiol Rev 1991;13:60–98.
3. Council of State and Territorial Epidemiologists. CSTE position statement #4: national surveillance of *Escherichia coli* O157:H7. Atlanta: Council of State and Territorial Epidemiologists, June 1993.
4. Alexander ER. Editorial response: surveillance of *Escherichia coli* O157:H7—a necessity for the prevention of an emerging infectious disease [Editorial]. Clin Infect Dis 1994;19:844–5.
5. Tarr PI. "4^{+} Normal flora" (or is it?) [Editorial]. J Pediatr Gastroenterol Nutr 1994;19:145–7.
6. Cieslak P, Barrett T, Griffin P. *Escherichia coli* O157:H7 infection from a manured garden. Lancet 1993;342:367.
7. Besser RE, Lett SM, Weber TJ, et al. An outbreak of diarrhea and hemolytic uremic syndrome from *Escherichia coli* O157:H7 in fresh-pressed apple cider. JAMA 1993;269:2217–20.

Escherichia coli — *Continued*

8. Glass KA, Loeffelholz JM, Ford JP, Doyle MP. Fate of *Escherichia coli* O157:H7 as affected by pH or sodium chloride in fermented, dry sausage. Appl Environ Microbiol 1992;58:2513–6.
9. Samadpour M, Grimm LM, Desai B, Alfi D, Ongerth JE, Tarr PI. Molecular epidemiology of *Escherichia coli* O157:H7 strains by bacteriophage restriction fragment length polymorphism analysis: application to a multistate foodborne outbreak and day-care center cluster. J Clin Microbiol 1993;31:3179–83.
10. Barrett TJ, Lior H, Green JH, et al. Laboratory investigation of a multistate food-borne outbreak of *Escherichia coli* O157:H7 by using pulsed-field gel electrophoresis and phage typing. J Clin Microbiol 1994;32:3013–7.

Emergency Department Surveillance for Weapon-Related Injuries — Massachusetts, November 1993–April 1994

During 1992, a total of 37,776 firearm-related deaths occurred in the United States (*1*), and in 1991, firearm-related deaths were the leading or second leading cause of injury death in 15 states (*2*). Because of limitations in data, however, the epidemiology of nonfatal firearm- and other weapon-related injuries has not been well characterized. To improve characterization of these problems, in 1989, the Massachusetts Department of Public Health (MDPH) began a pilot project to develop the first emergency-department–based statewide Weapon-Related Injury Surveillance System (WRISS) in the United States (*3*). All 85 hospital emergency departments in Massachusetts (1990 population: 6,016,425) now participate in this system. This report summarizes results from the first 6 months of statewide reporting (November 1993–April 1994), including previously unavailable statewide morbidity data on gunshot and stabbing injuries.

Since 1927, physicians in Massachusetts have been required to report to law enforcement authorities all gunshot wounds (GSWs) and all violence-related sharp instrument wounds (SIWs).* GSWs are defined as "all injuries resulting from, or caused by, the discharge of a gun, pistol, BB gun, or other air rifle or firearm." Violence-related SIWs are defined as nonself-inflicted "wounds or injuries caused by a knife or sharp or pointed instrument if, in the physician's judgment, a criminal act was involved." Although the statute requires reporting by all physicians, WRISS is a voluntary reporting system that has been implemented only in hospital-based emergency departments. The goal of WRISS is to ascertain all reportable weapon-related injuries treated in an emergency department regardless of outcome. WRISS does not ascertain nonfatal injuries treated outside the emergency department or injuries declared fatal at the scene whose victims are taken directly to the state medical examiner's office.

To facilitate reporting to WRISS and minimize reporting burden for providers, the existing police reporting form was modified and variables were added to a new voluntary reporting portion of the form. Completed forms are sent periodically from hospitals to the MDPH and state law enforcement authorities. Variables in WRISS include demographics (age, race/ethnicity, sex, and community of residence), location of incident, injury characteristics (type of weapon and location of wound), suspected drug or alcohol use, and injury severity (treated and released, admitted to hospital, or died). Reports for GSWs include type of injury (nonself-inflicted violence related; unintentional; or self-inflicted), and reports for violence-related GSWs and SIWs include victim-offender relationship and precipitating circumstance. Based on

*Mass. Gen. L. ch. 112, § 12A (1986).

Weapon-Related Injuries — Continued

periodic audits of records, reporting compliance is 70%–80% systemwide. Responses are unknown or missing for ≤25% of demographic variables, injury characteristics, and injury severity; 32%–68% of victim-offender relationships; and 26%–57% of precipitating circumstances.

During November 1993–April 1994, WRISS received reports of 1345 weapon-related injuries, including 451 GSWs and 894 SIWs. Based on these findings, estimated annual statewide rates were 15 GSWs per 100,000 residents and 30 violence-related SIWs per 100,000 residents. Of the 1345 injured persons, 1139 (85%) were male. The mean age was 27 years; 613 (46%) were aged 15–24 years, 396 (29%) were aged 25–34 years, and 267 (20%) were aged ≥35 years. Persons with GSWs were more likely to be hospitalized (240 [53%]) than persons with SIWs (258 [29%]).

Although 37% of persons in Massachusetts reside in large communities (population ≥50,000), 71% (300) of the GSW-related injuries occurred among persons who resided in large communities. Persons incurring GSWs in large communities were more likely than those in small communities to be aged <35 years (264 [88%] compared with 94 [76%]). In comparison, persons incurring SIWs in large communities were more likely than those in small communities to be aged ≥35 years (158 [25%] compared with 39 [17%]). In large communities, most (68%) GSW injuries were violence related, while in small communities 30% were violence related and 40% were unintentional (Table 1). Community size was not associated with victim-offender relationship or precipitating circumstances for either GSWs or SIWs. Among violence-related GSW incidents, when the victim-offender relationship was known, a higher proportion was associated with a stranger (28% in large communities and 22% in small communities) than with someone known by the victim (14% and 11%, respectively) while among SIW injuries, the offender was more likely to be known by the victim (34% and 39%) than to be a stranger (24% and 30%). For GSWs for which information on circumstance was known, argument or abuse was involved in 18% of incidents in large communities and 11% in small communities. Approximately half (46% in large communities and 52% in small communities) of incidents associated with SIWs involved argument or abuse.

The annualized crude rate for GSW injuries was 27 per 100,000 persons in large communities, compared with seven per 100,000 persons in small communities; however, the difference was greatest for violence-related GSWs (Table 2). Of the 451 GSWs, 60 (13%) were associated with BB guns and other nonpowder guns; of these, 45 (75%) occurred in small communities. In addition, BB guns and other nonpowder guns accounted for 19 (42%) of all reported weapon-related injuries to children aged <15 years. Most (36 [60%]) BB gun injuries were unintentional, and 13 (22%) were violence related; the remaining injuries were self-inflicted or of unknown intent.

Of the 894 SIWs, 636 (71%) occurred among persons in large communities (annualized crude rate: 57 per 100,000 residents), and 225 (25%) occurred in small communities (12 per 100,000 residents); information on community of residence was missing or unknown for 33 (4%). Most (734 [82%] of 894) injured persons were male, and the mean age was 28 years.

Weapon-Related Injuries — Continued

TABLE 1. Number and percentage of gunshot wounds and sharp instrument wounds reported by emergency departments, by type of injury and size of victim's community of residence* — Weapon-Related Injury Surveillance System, Massachusetts, November 1, 1993–April 30, 1994

	Large communities		Small communities	
Injury	**No.**	**(%)**	**No.**	**(%)**
Gunshot wounds†				
Violence-related	204	(68)	37	(30)
Victim-offender relationship				
Offender known to victim	*26*	*(14)*	*4*	*(11)*
Stranger-to-stranger	*57*	*(28)*	*8*	*(22)*
Missing/Unknown	*121*	*(59)*	*25*	*(68)*
Circumstance				
Argument/Abuse	*37*	*(18)*	*4*	*(11)*
Other crime-related	*40*	*(20)*	*5*	*(14)*
Other	*25*	*(12)*	*7*	*(19)*
Missing/Unknown	*102*	*(50)*	*21*	*(57)*
Suspected violence-related	28	(9)	9	(7)
Unintentional	25	(8)	50	(40)
Self-inflicted	7	(2)	14	(11)
Missing/Unknown	36	(12)	14	(11)
Total	**300**	**(100)**	**124**	**(100)**
Sharp instrument wounds§				
Violence-related	549	(86)	186	(83)
Victim-offender relationship				
Offender known to victim	*190*	*(34)*	*71*	*(39)*
Stranger-to-stranger	*130*	*(24)*	*56*	*(30)*
Missing/Unknown	*229*	*(42)*	*59*	*(32)*
Circumstance				
Argument/Abuse	*253*	*(46)*	*97*	*(52)*
Other crime-related	*83*	*(15)*	*29*	*(16)*
Other	*35*	*(6)*	*11*	*(6)*
Missing/Unknown	*178*	*(32)*	*49*	*(26)*
Suspected violence-related	87	(14)	39	(17)
Total	**636**	**(100)**	**225**	**(100)**

*Large communities=populations ≥50,000; small communities=populations <50,000.
†Excludes 27 reports in which victim's community was missing/unknown.
§Excludes 33 reports in which victim's community was missing/unknown.

Reported by: V Ozonoff, C Barber, B Hume, L Jannelli, M Schuster, H McLaughlin, Massachusetts Dept of Public Health. Div of Violence Prevention, National Center for Injury Prevention and Control, CDC.

Editorial Note: National injury-control priorities include reductions in intentional, unintentional, and self-inflicted firearm injuries (*4*). Surveillance for weapon-related injuries—which involves the systematic collection of data about both fatal and nonfatal injuries—is an essential component in the development of a science-based approach to preventing these injuries and can assist in efforts to provide public education, develop legislation to reduce risks for weapon-related injuries, identify groups and communities at highest risk for such injuries, and evaluate prevention initiatives (*5*).

In Massachusetts, findings from WRISS routinely have been disseminated throughout the state to violence-prevention groups, hospitals, and policymakers through newsletters, presentations, and staff training. These data have been used by hospitals to obtain funding for victim services programs, design violence-prevention

Weapon-Related Injuries — Continued

TABLE 2. Number of reported weapon-related injuries and estimated annual incidence rates*, by size of victim's community of residence† — Weapon-Related Injury Surveillance System, Massachusetts, November 1, 1993–April 30, 1994

	Large communities		Small communities		Large/Small communities
Injury	**No.**	**Rate**	**No.**	**Rate**	**Rate ratio**
Gunshot wounds§					
Violence-related and suspected violence-related	232	21.0	46	2.0	10.5
Unintentional	25	2.0	50	3.0	0.7
Self-inflicted	7	1.0	14	1.0	1.0
Total¶	**300**	**27.0**	**124**	**7.0**	**3.9**
Sharp instrument wounds**					
Violence-related and suspected violence-related	636	57.0	225	12.0	4.7

*Per 100,000 persons.
†Large communities=populations ≥50,000; small communities=populations <50,000.
§Excludes 27 reports in which victim's community was missing/unknown.
¶Includes injuries of unknown intent.
**Excludes 33 reports in which victim's community was missing/unknown.

educational materials, and train postgraduate medical staff. WRISS data also were used by an adolescent violence-prevention coalition to select neighborhoods for a teen mentoring program and by a community coalition in Boston in planning a gun buy-back initiative and related public education efforts. In addition, data have been requested by mayors and city councils and cited by the governor in a newspaper editorial addressing gun access.

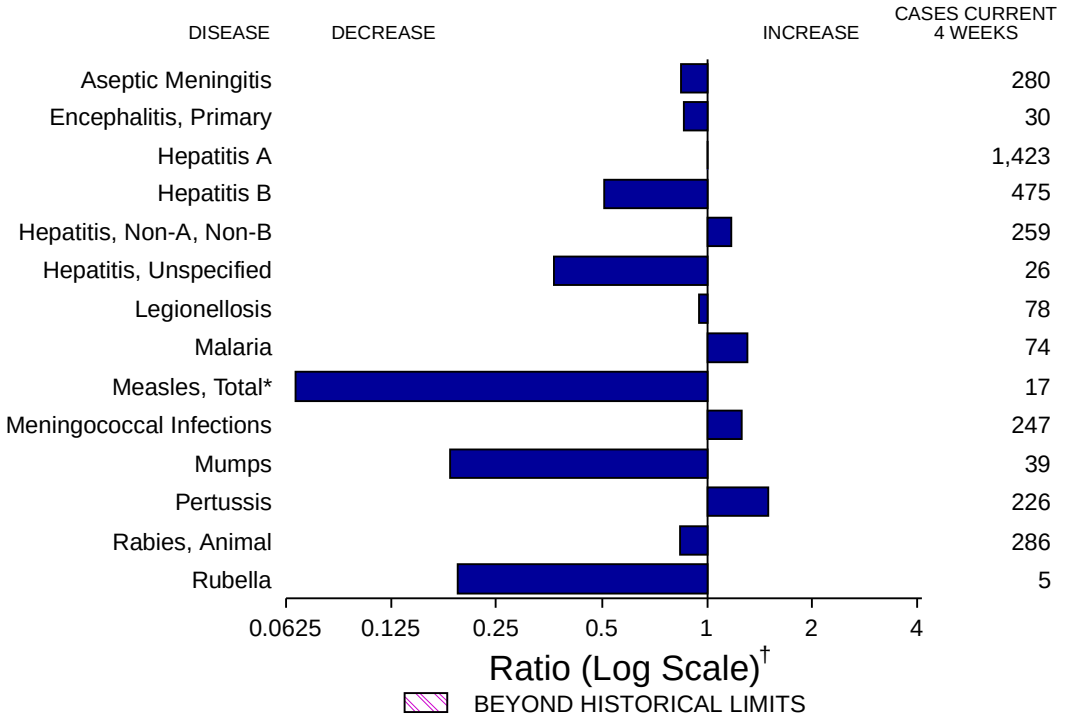
Analysis of the statewide findings in Massachusetts indicates important variations in injury patterns that cannot be discerned based only on findings from localities. For example, the types of weapons and related injuries differed substantially between small and large communities. In addition, this emergency-department–based system enabled recognition of the magnitude of childhood injuries associated with BB guns. Although BB guns and other nonpowder guns are an important cause of injury among children (*6*), data about these injuries are not otherwise available because the injuries rarely cause death or result in hospital admission.

The MDPH is using WRISS data to establish an enhanced firearm surveillance system by linking it with mortality and hospital discharge data to estimate weapon-related injury costs, identifying potential risk factors through interviews with victims of unintentional GSWs, and interviewing violence-related GSW victims to assess data validity and provide additional information on victim-offender relationships and precipitating circumstances. In addition, WRISS data will be used for a new MDPH initiative to develop statewide surveillance for violence against women; data on victim-offender relationship and precipitating circumstance will be particularly important for that project.

The development of WRISS in Massachusetts has established the feasibility and utility of a statewide, emergency-department–based surveillance system for weapon-related injury. In addition, this system may provide guidance in developing surveillance systems in other states. In Massachusetts, implementation of a voluntary, emergency-department–based system for reporting to MDPH was facilitated by the

(Continued on page 169)

FIGURE I. Notifiable disease reports, comparison of 4-week totals ending March 4, 1995, 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 of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary — cases of specified notifiable diseases, United States, cumulative, week ending March 4, 1995 (9th Week)

	Cum. 1995		Cum. 1995
Anthrax	-	Plague	-
Aseptic Meningitis	666	Poliomyelitis, Paralytic	-
Brucellosis	11	Psittacosis	4
Cholera	-	Rabies, human	-
Congenital rubella syndrome	2	Rocky Mountain Spotted Fever	17
Diphtheria	-	Syphilis, congenital, age < 1 year†	-
Encephalitis, primary	73	Tetanus	4
Encephalitis, post-infectious	13	Toxic shock syndrome	33
*Haemophilus influenzae**	254	Trichinosis	2
Hansen Disease	15	Tularemia	3
Hepatitis, unspecified	48	Typhoid fever	42
Leptospirosis	11		

*Of 248 cases of known age, 54 (22%) were reported among children less than 5 years of age.
†Updated quarterly from reports to the Division of Sexually Transmitted Diseases and HIV Prevention, National Center for Prevention Services. First quarter data not yet available.
-: no reported cases

TABLE II. Cases of selected notifiable diseases, United States, weeks ending March 4, 1995, and March 5, 1994 (9th Week)

Reporting Area	AIDS*	Gonorrhea		Hepatitis (Viral), by type						Legionellosis	
				A		B		NA,NB			
	Cum. 1995	Cum. 1995	Cum. 1994	Cum. 1995	Cum. 1994	Cum. 1995	Cum. 1994	Cum. 1995	Cum. 1994	Cum. 1995	Cum. 1994
UNITED STATES	11,161	59,525	63,640	3,545	3,272	1,070	1,951	474	697	176	260
NEW ENGLAND	521	1,015	1,452	28	48	37	50	11	19	3	2
Maine	15	10	8	6	3	1	-	-	-	-	-
N.H.	12	22	8	1	2	3	4	1	4	-	-
Vt.	2	5	6	-	-	-	-	-	-	-	-
Mass.	294	570	512	7	24	8	33	10	8	2	-
R.I.	31	104	74	7	10	6	2	-	7	1	2
Conn.	167	304	844	7	9	19	11	-	-	-	-
MID. ATLANTIC	2,980	6,407	7,293	153	240	104	230	45	92	15	32
Upstate N.Y.	249	832	1,497	34	56	42	49	25	33	4	7
N.Y. City	1,592	1,923	2,977	76	103	21	46	1	1	-	-
N.J.	690	759	695	20	46	23	68	13	46	4	6
Pa.	449	2,893	2,124	23	35	18	67	6	12	7	19
E.N. CENTRAL	1,138	12,990	12,317	509	381	123	246	39	71	51	102
Ohio	238	4,627	4,568	367	97	14	36	2	1	26	37
Ind.	80	1,188	1,301	22	71	26	42	1	3	11	34
Ill.	535	3,422	2,233	39	121	8	64	4	22	3	7
Mich.	222	3,391	3,040	70	53	75	62	32	45	7	16
Wis.	63	362	1,175	11	39	-	42	-	-	4	8
W.N. CENTRAL	242	3,308	3,692	132	150	54	94	13	7	12	18
Minn.	66	546	639	11	13	4	6	-	1	-	-
Iowa	14	283	174	9	6	11	5	2	-	2	13
Mo.	99	1,854	1,917	91	86	34	76	8	2	10	2
N. Dak.	-	3	4	2	1	1	-	-	-	-	-
S. Dak.	-	37	28	-	7	-	-	1	-	-	-
Nebr.	20	-	276	7	27	4	3	-	-	-	2
Kans.	43	585	654	12	10	-	4	2	4	-	1
S. ATLANTIC	2,676	19,379	17,751	176	199	175	472	57	151	38	52
Del.	69	355	276	3	3	1	3	1	-	-	-
Md.	357	2,579	3,384	35	37	34	52	3	11	10	9
D.C.	142	983	1,151	1	6	7	10	-	-	2	-
Va.	238	1,965	2,388	35	22	13	17	-	8	1	2
W. Va.	13	110	118	6	3	12	4	14	4	3	1
N.C.	161	4,563	4,754	17	18	45	63	13	11	7	5
S.C.	168	2,114	1,970	3	6	6	7	-	-	6	1
Ga.	361	2,969	U	8	13	12	245	7	99	3	25
Fla.	1,167	3,741	3,710	68	91	45	71	19	18	6	9
E.S. CENTRAL	393	6,970	5,697	65	81	85	245	71	172	4	14
Ky.	38	817	761	10	47	9	26	2	5	1	2
Tenn.	172	597	1,965	24	25	54	206	68	166	1	9
Ala.	104	3,964	2,971	23	9	22	13	1	1	1	3
Miss.	79	1,592	U	8	U	-	U	-	U	1	U
W.S. CENTRAL	919	5,172	7,081	279	329	103	154	64	37	3	7
Ark.	45	354	1,196	12	8	1	5	-	1	-	1
La.	170	2,214	2,619	10	12	6	17	7	4	1	-
Okla.	59	14	727	94	44	56	63	55	31	2	6
Tex.	645	2,590	2,539	163	265	40	69	2	1	-	-
MOUNTAIN	430	1,448	1,550	787	666	104	101	76	69	30	22
Mont.	7	23	25	10	7	4	2	3	-	2	7
Idaho	16	26	11	78	58	15	14	8	20	3	-
Wyo.	3	9	20	28	3	2	5	32	16	-	1
Colo.	187	531	604	105	72	20	18	15	17	12	4
N. Mex.	34	210	174	165	179	33	35	9	4	1	1
Ariz.	86	545	351	166	262	15	16	7	4	8	1
Utah	30	1	59	211	53	10	4	2	4	2	-
Nev.	67	103	306	24	32	5	7	-	4	2	8
PACIFIC	1,862	2,836	6,807	1,416	1,178	285	359	98	79	20	11
Wash.	148	474	546	69	67	15	14	26	13	-	2
Oreg.	74	18	224	241	61	14	13	4	2	-	-
Calif.	1,549	2,147	5,794	1,079	1,000	251	317	60	61	17	8
Alaska	29	117	144	14	42	1	1	-	-	-	-
Hawaii	62	80	99	13	8	4	14	8	3	3	1
Guam	-	3	29	-	-	-	-	-	-	-	-
P.R.	596	77	92	11	6	125	39	133	10	-	-
V.I.	-	3	6	-	-	1	1	-	-	-	-
Amer. Samoa	-	6	4	4	2	-	-	-	-	-	-
C.N.M.I.	-	-	13	-	1	-	-	-	-	-	-

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, National Center for Infectious Diseases; last update February 23, 1995.

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending March 4, 1995, and March 5, 1994 (9th Week)

Reporting Area	Lyme Disease		Malaria		Measles (Rubeola)						Meningococcal Infections		Mumps	
					Indigenous		Imported*		Total					
	Cum. 1995	Cum. 1994	Cum. 1995	Cum. 1994	1995	Cum. 1995	1995	Cum. 1995	Cum. 1995	Cum. 1994	Cum. 1995	Cum. 1994	Cum. 1995	Cum. 1994
UNITED STATES	503	549	136	169	3	34	-	1	35	54	541	593	112	225
NEW ENGLAND	21	44	7	16	-	2	-	1	3	1	40	29	2	7
Maine	1	-	-	1	-	-	-	-	-	-	3	6	2	3
N.H.	1	2	-	2	-	-	-	-	-	-	6	1	-	2
Vt.	-	1	-	-	-	-	-	-	-	-	3	1	-	-
Mass.	19	11	1	5	-	-	-	1	1	1	16	9	-	-
R.I.	-	8	2	4	-	2	-	-	2	-	-	-	-	-
Conn.	-	22	4	4	-	-	-	-	-	-	12	12	-	2
MID. ATLANTIC	382	409	23	29	-	1	-	-	1	8	38	48	14	26
Upstate N.Y.	184	321	3	9	-	-	-	-	-	1	18	18	4	3
N.Y. City	-	9	11	4	-	1	-	-	1	1	6	-	-	-
N.J.	26	61	7	12	U	-	U	-	-	5	11	15	-	4
Pa.	172	18	2	4	-	-	-	-	-	1	3	15	10	19
E.N. CENTRAL	10	5	13	23	-	-	-	-	-	12	73	99	16	44
Ohio	10	4	1	2	-	-	-	-	-	9	22	24	7	8
Ind.	-	-	1	6	-	-	-	-	-	-	11	18	2	2
Ill.	-	1	9	9	-	-	-	-	-	-	29	32	-	21
Mich.	-	-	2	5	-	-	-	-	-	-	11	9	7	11
Wis.	-	-	-	1	-	-	-	-	-	3	-	16	-	2
W.N. CENTRAL	9	9	4	6	-	2	-	-	2	-	24	43	5	8
Minn.	-	1	3	-	-	-	-	-	-	-	1	1	-	-
Iowa	-	1	-	1	-	-	-	-	-	-	7	4	1	2
Mo.	2	6	1	4	-	2	-	-	2	-	10	28	3	5
N. Dak.	-	-	-	-	-	-	-	-	-	-	-	-	-	1
S. Dak.	-	-	-	-	-	-	-	-	-	-	-	3	-	-
Nebr.	-	-	-	1	-	-	-	-	-	-	2	1	1	-
Kans.	7	1	-	-	-	-	-	-	-	-	4	6	-	-
S. ATLANTIC	57	57	37	39	-	-	-	-	-	4	104	105	20	42
Del.	1	5	1	2	-	-	-	-	-	-	1	-	-	-
Md.	44	7	9	7	-	-	-	-	-	-	2	7	-	8
D.C.	-	-	3	6	-	-	-	-	-	-	1	1	-	-
Va.	1	8	6	8	-	-	-	-	-	1	11	12	4	9
W. Va.	5	3	-	-	-	-	-	-	-	-	-	6	-	2
N.C.	4	14	4	1	-	-	-	-	-	-	13	18	10	15
S.C.	2	-	-	1	-	-	-	-	-	-	14	4	1	4
Ga.	-	19	4	6	-	-	-	-	-	-	30	17	-	2
Fla.	-	1	10	8	-	-	-	-	-	3	32	40	5	2
E.S. CENTRAL	2	6	1	5	-	-	-	-	-	20	25	42	3	-
Ky.	1	5	-	1	-	-	-	-	-	-	10	13	-	-
Tenn.	-	-	-	3	-	-	-	-	-	20	2	12	-	-
Ala.	-	1	1	1	-	-	-	-	-	-	8	17	2	-
Miss.	1	U	-	U	-	-	-	-	-	U	5	U	1	U
W.S. CENTRAL	6	2	3	4	-	-	-	-	-	1	67	68	5	46
Ark.	-	-	2	-	-	-	-	-	-	-	5	6	-	-
La.	-	-	-	-	-	-	-	-	-	-	8	4	1	1
Okla.	6	2	-	-	-	-	-	-	-	-	7	7	-	13
Tex.	-	-	1	4	-	-	-	-	-	1	47	51	4	32
MOUNTAIN	2	4	11	3	3	29	-	-	29	-	46	41	7	6
Mont.	-	-	1	-	-	-	-	-	-	-	1	2	-	-
Idaho	-	1	-	-	-	-	-	-	-	-	1	4	-	2
Wyo.	-	-	-	-	-	-	-	-	-	-	1	1	-	-
Colo.	1	-	6	1	-	-	-	-	-	-	11	3	1	-
N. Mex.	-	3	2	1	1	22	-	-	22	-	12	3	N	N
Ariz.	-	-	1	-	2	7	-	-	7	-	18	18	1	-
Utah	-	-	1	1	-	-	-	-	-	-	1	7	1	1
Nev.	1	-	-	-	-	-	-	-	-	-	1	3	3	3
PACIFIC	14	13	37	44	-	-	-	-	-	8	124	118	40	46
Wash.	1	-	5	1	-	-	-	-	-	-	13	8	1	2
Oreg.	-	-	4	1	-	-	-	-	-	-	31	24	N	N
Calif.	13	13	26	36	-	-	-	-	-	8	79	82	35	40
Alaska	-	-	1	-	-	-	-	-	-	-	-	1	3	2
Hawaii	-	-	1	6	-	-	-	-	-	-	1	3	1	2
Guam	-	-	-	-	-	-	-	-	-	1	-	-	-	2
P.R.	-	-	-	-	-	-	-	-	-	5	9	2	-	1
V.I.	-	-	-	-	U	-	U	-	-	-	-	-	1	-
Amer. Samoa	-	-	-	-	U	-	U	-	-	-	-	-	-	1
C.N.M.I.	-	-	-	1	U	-	U	-	-	22	-	-	-	-

*For imported measles, cases include only those resulting from importation from other countries.
N: Not notifiable U: Unavailable -: no reported cases

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending March 4, 1995, and March 5, 1994 (9th Week)

Reporting Area	Pertussis			Rubella			Syphilis (Primary & Secondary)		Tuberculosis		Rabies, Animal	
	1995	Cum. 1995	Cum. 1994	1995	Cum. 1995	Cum. 1994	Cum. 1995	Cum. 1994	Cum. 1995	Cum. 1994	Cum. 1995	Cum. 1994
UNITED STATES	82	488	643	1	14	57	2,672	3,206	1,963	2,453	850	903
NEW ENGLAND	15	51	67	-	1	42	37	30	39	51	247	229
Maine	1	6	2	-	-	-	-	-	-	-	-	-
N.H.	-	4	14	-	-	-	1	-	1	1	38	20
Vt.	-	2	7	-	-	-	-	-	-	-	30	17
Mass.	14	36	40	-	1	42	13	8	16	20	119	100
R.I.	-	-	2	-	-	-	-	5	7	6	-	5
Conn.	-	3	2	-	-	-	23	17	15	24	60	87
MID. ATLANTIC	4	31	125	1	1	4	179	246	362	343	199	223
Upstate N.Y.	2	21	42	1	1	4	12	28	26	64	132	131
N.Y. City	-	6	8	-	-	-	105	147	209	175	-	-
N.J.	U	-	7	U	-	-	31	23	60	68	37	49
Pa.	2	4	68	-	-	-	31	48	67	36	30	43
E.N. CENTRAL	6	58	146	-	-	2	460	451	259	244	1	3
Ohio	1	24	50	-	-	-	166	179	41	40	1	-
Ind.	3	4	12	-	-	-	40	56	4	20	-	-
Ill.	-	-	33	-	-	2	163	105	149	137	-	-
Mich.	2	30	13	-	-	-	63	59	61	40	-	1
Wis.	-	-	38	-	-	-	28	52	4	7	-	2
W.N. CENTRAL	-	11	13	-	2	-	138	232	59	44	40	21
Minn.	-	-	-	-	-	-	6	10	10	7	2	-
Iowa	-	1	-	-	-	-	11	11	15	6	12	12
Mo.	-	2	6	-	2	-	121	209	22	22	7	2
N. Dak.	-	1	-	-	-	-	-	-	-	1	5	-
S. Dak.	-	2	-	-	-	-	-	-	-	4	7	1
Nebr.	-	-	1	-	-	-	-	2	-	-	-	-
Kans.	-	5	6	-	-	-	-	-	12	4	7	6
S. ATLANTIC	1	44	93	-	1	3	651	986	329	481	272	277
Del.	1	2	-	-	-	-	4	3	-	2	10	2
Md.	-	-	30	-	-	-	22	43	74	44	68	97
D.C.	-	1	1	-	-	-	30	39	18	20	1	1
Va.	-	-	12	-	-	-	118	122	10	58	50	60
W. Va.	-	-	1	-	-	-	-	5	13	11	15	8
N.C.	-	30	27	-	-	-	201	343	19	14	56	24
S.C.	-	7	7	-	-	-	110	114	52	74	14	22
Ga.	-	1	6	-	-	-	85	152	40	104	46	58
Fla.	-	3	9	-	1	3	81	165	103	154	12	5
E.S. CENTRAL	-	9	22	-	-	-	749	327	114	155	29	35
Ky.	-	-	3	-	-	-	47	44	22	40	3	-
Tenn.	-	-	13	-	-	-	60	167	-	52	11	16
Ala.	-	9	6	-	-	-	119	116	65	63	15	19
Miss.	-	-	U	-	-	U	523	U	27	U	-	U
W.S. CENTRAL	2	12	23	-	-	-	412	663	137	132	14	49
Ark.	-	-	-	-	-	-	120	92	30	15	2	3
La.	-	-	1	-	-	-	186	362	-	-	9	-
Okla.	-	-	19	-	-	-	20	24	1	14	3	9
Tex.	2	12	3	-	-	-	86	185	106	103	-	37
MOUNTAIN	47	197	36	-	2	-	42	46	94	88	7	13
Mont.	-	2	-	-	-	-	2	-	-	-	3	1
Idaho	-	26	14	-	-	-	-	-	2	3	-	-
Wyo.	-	-	-	-	-	-	2	-	-	-	-	4
Colo.	-	-	13	-	-	-	27	28	-	2	-	-
N. Mex.	-	4	2	-	-	-	1	1	17	15	-	-
Ariz.	46	162	5	-	2	-	10	10	40	48	4	8
Utah	1	1	2	-	-	-	-	4	3	-	-	-
Nev.	-	2	-	-	-	-	-	3	32	20	-	-
PACIFIC	7	75	118	-	7	6	4	225	570	915	41	53
Wash.	4	15	10	-	-	-	1	2	38	34	-	-
Oreg.	-	1	12	-	-	-	-	-	3	17	-	-
Calif.	3	56	93	-	7	6	3	223	493	816	40	40
Alaska	-	-	-	-	-	-	-	-	6	13	1	13
Hawaii	-	3	3	-	-	-	-	-	30	35	-	-
Guam	-	-	-	-	-	-	-	1	4	7	-	-
P.R.	1	2	-	-	-	-	43	67	-	-	8	12
V.I.	U	-	-	U	-	-	-	3	-	-	-	-
Amer. Samoa	U	-	1	U	-	-	-	-	2	-	-	-
C.N.M.I.	U	-	-	U	-	-	-	-	-	12	-	-

U: Unavailable -: no reported cases

TABLE III. Deaths in 121 U.S. cities,* week ending March 4, 1995 (9th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	714	483	111	72	27	19	69
Boston, Mass.	171	108	31	19	4	7	14
Bridgeport, Conn.	38	28	6	3	1	-	2
Cambridge, Mass.	15	11	2	2	-	-	2
Fall River, Mass.	46	33	8	5	-	-	1
Hartford, Conn.	71	32	11	13	14	1	6
Lowell, Mass.	34	25	6	2	1	-	6
Lynn, Mass.	15	12	2	1	-	-	2
New Bedford, Mass.	27	22	4	-	-	1	3
New Haven, Conn.	46	33	7	4	1	1	3
Providence, R.I.	62	42	13	3	-	4	9
Somerville, Mass.	5	2	1	2	-	-	-
Springfield, Mass.	75	55	7	5	5	3	8
Waterbury, Conn.	35	28	3	4	-	-	1
Worcester, Mass.	74	52	10	9	1	2	12
MID. ATLANTIC	2,676	1,750	510	303	55	58	165
Albany, N.Y.	59	38	16	1	1	3	2
Allentown, Pa.	16	10	4	2	-	-	1
Buffalo, N.Y.	112	83	15	10	4	-	9
Camden, N.J.	29	17	6	2	-	4	1
Elizabeth, N.J.	25	15	4	4	-	2	1
Erie, Pa.§	40	30	5	4	-	1	8
Jersey City, N.J.	38	22	8	3	1	4	-
New York City, N.Y.	1,439	924	290	173	25	27	77
Newark, N.J.	51	20	18	9	2	2	8
Paterson, N.J.	23	10	6	4	3	-	1
Philadelphia, Pa.	404	247	82	54	13	8	25
Pittsburgh, Pa.§	78	55	8	10	2	3	6
Reading, Pa.	20	14	3	3	-	-	-
Rochester, N.Y.	118	90	19	8	1	-	10
Schenectady, N.Y.	31	29	2	-	-	-	2
Scranton, Pa.§	26	22	1	3	-	-	2
Syracuse, N.Y.	115	90	13	10	2	-	9
Trenton, N.J.	33	19	10	1	-	3	3
Utica, N.Y.	19	15	-	2	1	1	-
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	2,417	1,571	464	218	92	72	152
Akron, Ohio	65	48	13	-	2	2	-
Canton, Ohio	40	29	7	-	-	4	4
Chicago, Ill.	347	137	90	74	41	5	9
Cincinnati, Ohio	223	156	42	16	1	8	15
Cleveland, Ohio	203	140	38	12	7	6	4
Columbus, Ohio	269	185	52	19	7	6	20
Dayton, Ohio	128	103	17	3	2	3	13
Detroit, Mich.	306	182	69	32	10	13	11
Evansville, Ind.	56	46	7	2	-	1	1
Fort Wayne, Ind.	49	33	10	2	4	-	5
Gary, Ind.	27	11	6	7	3	-	2
Grand Rapids, Mich.	62	44	9	5	2	2	10
Indianapolis, Ind.	187	133	27	10	6	11	15
Madison, Wis.	65	45	12	6	2	-	5
Milwaukee, Wis.	131	94	20	11	-	6	19
Peoria, Ill.	45	37	4	2	-	2	8
Rockford, Ill.	52	38	10	1	1	2	6
South Bend, Ind.	35	22	6	4	3	-	1
Toledo, Ohio	127	88	25	12	1	1	4
Youngstown, Ohio	U	U	U	U	U	U	U
W.N. CENTRAL	900	658	132	62	20	16	77
Des Moines, Iowa	52	43	5	-	3	1	4
Duluth, Minn.	55	44	7	3	1	-	5
Kansas City, Kans.	22	17	4	1	-	-	-
Kansas City, Mo.	139	87	23	11	3	3	12
Lincoln, Nebr.	36	29	4	2	-	1	3
Minneapolis, Minn.	218	166	28	17	3	4	19
Omaha, Nebr.	108	80	15	8	2	3	10
St. Louis, Mo.	128	86	25	10	6	1	15
St. Paul, Minn.	69	53	11	3	-	2	4
Wichita, Kans.	73	53	10	7	2	1	5
S. ATLANTIC	1,523	979	318	154	41	29	92
Atlanta, Ga.	158	88	42	17	5	6	1
Baltimore, Md.	222	135	47	30	4	5	17
Charlotte, N.C.	139	97	27	10	5	-	14
Jacksonville, Fla.	157	108	33	11	4	1	10
Miami, Fla.	104	65	20	17	2	-	3
Norfolk, Va.	50	33	13	1	3	-	5
Richmond, Va.	94	54	24	10	3	3	-
Savannah, Ga.	54	39	3	9	1	2	7
St. Petersburg, Fla.	82	63	16	1	2	-	3
Tampa, Fla.	211	156	41	7	3	4	22
Washington, D.C.	247	137	52	41	9	8	10
Wilmington, Del.	5	4	-	-	-	-	-
E.S. CENTRAL	836	573	145	64	28	26	79
Birmingham, Ala.	157	111	28	6	5	7	10
Chattanooga, Tenn.	56	36	12	3	1	4	4
Knoxville, Tenn.	95	75	12	7	-	1	14
Lexington, Ky.	89	64	17	5	2	1	12
Memphis, Tenn.	187	122	26	27	8	4	20
Mobile, Ala.	64	46	10	1	4	3	3
Montgomery, Ala.	50	32	8	3	5	2	4
Nashville, Tenn.	138	87	32	12	3	4	12
W.S. CENTRAL	1,388	923	245	134	55	30	130
Austin, Tex.	80	58	11	6	4	1	6
Baton Rouge, La.	68	45	12	5	5	1	2
Corpus Christi, Tex.	52	40	7	3	2	-	2
Dallas, Tex.	216	133	41	26	13	3	5
El Paso, Tex.	69	36	16	10	4	3	8
Ft. Worth, Tex.	119	81	14	13	3	8	16
Houston, Tex.	221	131	48	31	7	3	35
Little Rock, Ark.	91	57	19	8	4	3	10
New Orleans, La.	48	33	7	6	2	-	-
San Antonio, Tex.	256	185	46	14	7	4	25
Shreveport, La.	81	58	14	6	3	-	12
Tulsa, Okla.	87	66	10	6	1	4	9
MOUNTAIN	709	506	123	54	19	7	58
Albuquerque, N.M.	97	69	16	10	1	1	2
Colo. Springs, Colo.	53	37	8	7	1	-	8
Denver, Colo.	94	65	15	10	3	1	11
Las Vegas, Nev.	185	135	35	10	4	1	9
Ogden, Utah	32	23	5	2	2	-	3
Phoenix, Ariz.	U	U	U	U	U	U	U
Pueblo, Colo.	26	18	4	3	1	-	7
Salt Lake City, Utah	94	66	15	7	4	2	7
Tucson, Ariz.	128	93	25	5	3	2	11
PACIFIC	1,798	1,198	303	194	40	35	142
Berkeley, Calif.	28	14	8	2	1	3	4
Fresno, Calif.	98	65	12	8	4	9	3
Glendale, Calif.	18	13	5	-	-	-	2
Honolulu, Hawaii	89	60	20	6	2	-	6
Long Beach, Calif.	77	54	12	7	2	2	11
Los Angeles, Calif.	437	259	76	77	14	5	24
Pasadena, Calif.	20	13	5	1	-	1	3
Portland, Oreg.	118	87	19	9	2	1	5
Sacramento, Calif.	202	135	36	22	1	8	21
San Diego, Calif.	U	U	U	U	U	U	U
San Francisco, Calif.	149	88	19	19	2	-	20
San Jose, Calif.	202	147	34	13	6	2	22
Santa Cruz, Calif.	42	36	3	3	-	-	8
Seattle, Wash.	182	124	31	18	5	4	8
Spokane, Wash.	50	36	13	1	-	-	3
Tacoma, Wash.	86	67	10	8	1	-	2
TOTAL	12,961¶	8,641	2,351	1,255	377	292	964

*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

Weapon-Related Injuries — Continued

pre-existing police reporting requirement. At least 40 other states (*7*) have mandatory reporting requirements for GSWs that could be used in developing and implementing surveillance systems similar to WRISS.

References

1. NCHS. Vital statistics mortality data, underlying cause-of-death detail, 1992 [Machine-readable public-use data tape]. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, CDC, 1994.
2. Fingerhut LA, Jones C, Makuc DM. Firearm and motor vehicle injury mortality—variations by state, race, and ethnicity: United States, 1990–91. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, CDC, 1994. (Advance data no. 242).
3. Ozonoff VV, Barber CW, Spivak H, Hume B, Jannelli L, Scott NJ. Weapon-related injury surveillance in the emergency department. Am J Public Health 1994;84:2024–5.
4. CDC/National Highway Traffic Safety Administration. Position papers from the Third National Injury Control Conference: setting the national agenda for injury control in the 1990s. Atlanta: US Department of Health and Human Services, Public Health Service, CDC, 1992.
5. CDC. Deaths resulting from firearm- and motor-vehicle–related injuries—United States, 1968–91. MMWR 1994;43:37–42.
6. Christoffel T, Christoffel K. Nonpowder firearm injuries: whose job is it to protect children? Am J Public Health 1987;77:735–8.
7. Lee RK, Waxweiler RJ, Dobbins JG, Paschetag T. Incidence rates of firearm injuries in Galveston, Texas, 1979–1981. Am J Epidemiol 1991;134:511–21.

HIV Counseling and Testing — United States, 1993

Counseling and testing (CT) are important components of state and local human immunodeficiency virus (HIV)-prevention programs (*1*). Analysis of national data sources indicates that HIV-antibody tests are obtained from a variety of testing sites, including private physicians, hospitals, and outpatient clinics (66.7%), and publicly funded sites (33.1%) (*2*). This report uses data from CDC's 1993 Behavioral Risk Factor Surveillance System (BRFSS) to examine variations in rates of use of private and public HIV CT sites by state.

In 1993, a total of 49 states and the District of Columbia participated in the BRFSS, a state-specific population-based, random-digit–dialed telephone survey that collects information monthly from U.S. adults aged ≥18 years. Thirteen questions about HIV/AIDS-related knowledge and attitudes and HIV-antibody testing history during the preceding year were asked only to respondents aged ≤65 years. In 1993, a total of 84,039 persons responded to these questions (state-specific range: 993 to 3667). The state-specific median percentage of 82% of eligible respondents completed interviews (*3*). Data for each state were weighted by demographic characteristics and by selection probability; results are representative of persons aged 18–65 years in each state. Confidence intervals for percentages and estimated numbers of persons tested were based on standard errors that accounted for complex survey design (*4*).

A median of 25.5% of persons (range: 14.4% [Iowa] to 37.5% [Alaska]) answered yes to the question: "Except for donating or giving blood, have you ever had your blood tested for the AIDS virus infection?" (Table 1). The number (weighted estimate) of adults who had ever been tested for HIV was highest in California (6.3 million).

A median of 9.6% of persons (range: 4.1% [Maine and South Dakota] to 16.9% [District of Columbia]) reported obtaining HIV-antibody tests primarily for diagnostic

HIV Counseling and Testing — Continued

TABLE 1. Percentage of persons surveyed and estimated number of persons who reported ever having an HIV-antibody test and who reported their last HIV test was primarily for diagnostic reasons* — Behavioral Risk Factor Surveillance System, United States, 1993

Reporting area	Sample size	Persons who reported ever having an HIV-antibody test				Persons who reported their last HIV-antibody test was primarily for diagnostic reasons†			
		%	(95% CI§)	Estimated no. (thousands)	(95% CI)	%	(95% CI)	Estimated no. (thousands)	(95% CI)
Alabama	1758	18.5	(±2.0%)	473	(± 52)	9.0	(±1.5%)	231	(± 38)
Alaska	1414	37.5	(±3.8%)	135	(± 16)	13.5	(±2.5%)	48	(± 9)
Arizona	1318	23.7	(±3.2%)	561	(± 92)	8.9	(±2.5%)	211	(± 64)
Arkansas	1374	23.8	(±2.6%)	339	(± 39)	9.7	(±1.7%)	138	(± 24)
California	3122	32.2	(±2.0%)	6327	(±423)	14.5	(±1.5%)	2860	(±300)
Colorado	1553	30.5	(±2.4%)	677	(± 58)	13.6	(±1.8%)	302	(± 40)
Connecticut	1494	20.3	(±2.3%)	433	(± 50)	6.3	(±1.4%)	134	(± 29)
Delaware	1751	29.5	(±2.4%)	131	(± 12)	14.1	(±2.0%)	62	(± 9)
District of Columbia	1288	24.6	(±2.8%)	102	(± 12)	16.9	(±2.4%)	70	(± 11)
Florida	2364	33.2	(±2.2%)	2748	(±199)	15.8	(±1.8%)	1306	(±152)
Georgia	1847	24.4	(±2.4%)	1043	(±105)	8.5	(±1.5%)	364	(± 65)
Hawaii	1893	30.3	(±2.7%)	208	(± 20)	11.9	(±1.7%)	82	(± 12)
Idaho	1474	24.4	(±2.8%)	149	(± 18)	10.2	(±2.0%)	62	(± 13)
Illinois	1753	23.3	(±2.2%)	1673	(±165)	8.8	(±1.5%)	634	(±106)
Indiana	1675	20.4	(±2.2%)	717	(± 79)	7.8	(±1.4%)	273	(± 50)
Iowa	1405	14.4	(±2.0%)	241	(± 34)	5.5	(±1.3%)	92	(± 22)
Kansas	1196	16.8	(±2.2%)	254	(± 34)	7.2	(±1.5%)	108	(± 23)
Kentucky	1888	21.0	(±2.1%)	491	(± 52)	7.4	(±1.3%)	173	(± 30)
Louisiana	1354	26.5	(±2.7%)	685	(± 74)	10.9	(±1.8%)	282	(± 47)
Maine	993	15.4	(±2.5%)	119	(± 20)	4.1	(±1.2%)	32	(± 9)
Maryland	3667	29.1	(±1.7%)	942	(± 60)	14.6	(±1.4%)	474	(± 47)
Massachusetts	1321	23.9	(±2.5%)	927	(±101)	9.6	(±1.8%)	375	(± 71)
Michigan	2041	27.4	(±2.1%)	1620	(±129)	11.3	(±1.4%)	669	(± 85)
Minnesota	2804	22.1	(±1.7%)	612	(± 50)	8.6	(±1.1%)	237	(± 32)
Mississippi	1311	27.7	(±2.7%)	430	(± 44)	13.3	(±2.0%)	205	(± 32)
Missouri	1195	22.5	(±2.6%)	714	(± 85)	11.0	(±2.0%)	349	(± 65)
Montana	974	23.2	(±2.9%)	113	(± 16)	9.4	(±2.2%)	46	(± 11)
Nebraska	1410	17.8	(±2.1%)	170	(± 21)	4.2	(±1.1%)	40	(± 11)
Nevada	1543	36.8	(±2.7%)	290	(± 24)	15.7	(±2.0%)	124	(± 16)
New Hampshire	1262	24.5	(±2.7%)	176	(± 20)	9.3	(±1.8%)	66	(± 13)
New Jersey	1271	24.5	(±2.7%)	1232	(±140)	10.8	(±2.0%)	543	(±105)
New Mexico	1082	30.2	(±3.2%)	286	(± 33)	13.7	(±2.5%)	130	(± 24)
New York	1984	26.0	(±2.3%)	3025	(±278)	12.4	(±1.6%)	1440	(±196)
North Carolina	1928	23.8	(±2.2%)	1047	(±101)	8.8	(±1.4%)	388	(± 61)
North Dakota	1418	17.9	(±2.3%)	68	(± 9)	6.4	(±1.3%)	24	(± 5)
Ohio	1105	21.1	(±2.8%)	1445	(±197)	6.5	(±1.8%)	443	(±129)
Oklahoma	1192	19.3	(±2.7%)	378	(± 57)	8.7	(±1.9%)	171	(± 39)
Oregon	2411	27.1	(±2.0%)	493	(± 38)	12.2	(±1.4%)	221	(± 27)
Pennsylvania	1932	21.2	(±2.0%)	1589	(±152)	7.7	(±1.3%)	574	(± 97)
Rhode Island	1459	30.9	(±2.7%)	197	(± 21)	13.6	(±2.0%)	86	(± 14)
South Carolina	1738	27.6	(±2.6%)	625	(± 66)	13.1	(±2.0%)	296	(± 48)
South Dakota	1422	16.3	(±2.2%)	66	(± 9)	4.1	(±1.2%)	17	(± 5)
Tennessee	2515	20.3	(±1.7%)	644	(± 56)	7.1	(±1.1%)	225	(± 35)
Texas	2132	32.0	(±2.4%)	3488	(±282)	10.4	(±1.5%)	1131	(±172)
Utah	1527	19.1	(±2.2%)	189	(± 22)	8.2	(±1.5%)	81	(± 15)
Vermont	1583	19.3	(±2.1%)	69	(± 8)	6.7	(±1.3%)	24	(± 5)
Virginia	1520	32.8	(±2.7%)	1371	(±122)	13.5	(±1.9%)	563	(± 83)
Washington	2219	28.3	(±2.0%)	908	(± 66)	14.3	(±1.6%)	460	(± 50)
West Virginia	1873	18.2	(±1.9%)	202	(± 22)	6.4	(±1.2%)	70	(± 14)
Wisconsin	1286	21.6	(±2.5%)	658	(± 80)	7.5	(±1.6%)	2227	(± 50)
Median		*24.0%*				*9.6%*			

*For this study, diagnostic HIV tests were defined as those administered primarily to learn infection status rather than voluntary tests to qualify for insurance, military induction, immigration, marriage license application, or employment.

† Persons in this category were identified by one of three responses to the question "What was the main reason you had your last AIDS blood test?": "to find out if infected," "because of referral by doctor or health department or sex partner," or "for routine checkup." The response "for routine checkup" was included in "diagnostic" reasons to avoid excluding respondents who initiated a routine examination to determine whether they were infected with HIV.

§ Confidence interval.

HIV Counseling and Testing — Continued

reasons* (Table 1). Persons categorized as having obtained diagnostic HIV-antibody tests were identified by one of three responses to the question "What was the main reason you had your last AIDS blood test?": "to find out if infected," "because of referral by a doctor or health department or sex partner," or "for routine checkup†."

In 43 states and the District of Columbia, at least 50.0% (median: 60.9%) of respondents had obtained their last diagnostic test from a private physician, health maintenance organization, or private outpatient clinic (Table 2). A median of 16.2% of persons (range: 5.0% [North Dakota] to 37.6% [Mississippi]) had obtained their last diagnostic test at a publicly funded prevention site (including health departments; AIDS, sexually transmitted disease [STD], or tuberculosis clinics; and drug-treatment programs).

The estimated number of persons who obtained a diagnostic test at a publicly funded site during the preceding year correlated with the number of tests reported to CDC's HIV Counseling and Testing System by publicly funded sites in each state (*5*) (correlation coefficient=0.96; $p<0.01$).

A median of 60.7% of persons who had obtained their most recent diagnostic HIV-antibody test at a publicly funded site (range: 30.8% [New Jersey] to 95.7% [Oklahoma]) received counseling with their test results (Table 2). In comparison, a median of 28.2% of persons who had obtained their tests from a private site (range: 7.7% [Kentucky] to 77.3% [Oklahoma]) also received counseling. In most (90%) of the reporting areas, the number of persons who received counseling with their HIV test results was ≥1.5 times greater for persons tested at publicly funded sites than those tested at private sites.

Reported by the following BRFSS coordinators: S Jackson, MPA, Alabama; P Owen, Alaska; B Bender, Arizona; J Senner, PhD, Arkansas; B Davis, PhD, California; M Leff, MSPH, Colorado; M Adams, MS, Connecticut; F Breukelman, Delaware; C Mitchell, District of Columbia; D McTague, MS, Florida; E Pledger, MPA, Georgia; F Newfield, MPH, Hawaii; C Johnson, MPH, Idaho; B Steiner, MS, Illinois; R Guest, MPH, Indiana; P Busick, Iowa; M Perry, Kansas; K Bramblett, Kentucky; D Hargrove-Roberson, MSW, Louisiana; D Maines, Maine; A Weinstein, MA, Maryland; R Lederman, MPH, Massachusetts; H McGee, MPH, Michigan; N Salem, PhD, Minnesota; E Jones, MS, Mississippi; J Jackson-Thompson, PhD, Missouri; P Smith, Montana; S Huffman, Nebraska; E DeJan, Nevada; K Zaso, MPH, New Hampshire; G Boeselager, MS, New Jersey; P Jaramillo, MPA, New Mexico; C Maylahn, MPH, New York; G Lengerich, MD, North Carolina; D Young, MS, North Dakota; E Capwell, PhD, Ohio; N Hann, MPH, Oklahoma; J Grant-Worley, MS, Oregon; J Romano, MPH, Pennsylvania; J Hesser, PhD, Rhode Island; M Lane, MPH, South Carolina; B Miller, South Dakota; D Ridings, Tennessee; R Diamond, MPH, Texas; R Giles, Utah; R McIntyre, PhD, Vermont; S Carswell, MA, Virginia; K Holm, MPH, Washington; F King, West Virginia; E Cautley, MS, Wisconsin. Behavioral and Prevention Research Br, Div of Sexually Transmitted Diseases and HIV Prevention, National Center for Prevention Svcs; Behavioral Risk Factor Surveillance Br, Office of Surveillance and Analysis, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: The findings from the 1993 BRFSS document a high degree of state-specific variability in self-reported HIV-antibody tests in the United States. This variability may reflect state-specific differences in such factors as the prevalence of HIV infection and HIV testing in high-risk groups, the presence and impact of HIV-prevention programs, and age distribution. The BRFSS estimates of the number of persons last tested for voluntary or diagnostic reasons at a publicly funded clinic

*For this study, diagnostic HIV-antibody tests were defined as those administered primarily to learn infection status rather than voluntary tests to qualify for insurance, military induction, immigration, marriage license application, or employment.

†This response was included in "diagnostic" reasons to avoid excluding respondents who initiated a routine examination to determine whether they were infected with HIV.

TABLE 2. Percentage of persons surveyed and estimated number of persons who reported that their last HIV-antibody test was for diagnostic reasons* and estimated percentage of persons who received HIV counseling with their test results, by site where the test was obtained — Behavioral Risk Factor Surveillance System, United States, 1993

		Persons whose last diagnostic HIV-antibody test was obtained at a private site†						Persons whose last diagnostic HIV-antibody test was obtained at a publicly funded prevention site§					
Reporting area	Sample size	% Tested	(95% CI¶)	Estimated no. (thousands)	(95% CI)	% Received counseling	(95% CI)	% Tested	(95% CI)	Estimated no. (thousands)	(95% CI)	% Received counseling	(95% CI)
Alabama	172	53.8	(± 8.3%)	124	(± 28)	24.0	(± 9.6%)	36.9	(± 8.1%)	85	(± 24)	57.5	(±14.1%)
Alaska	212	55.6	(± 9.9%)	27	(± 7)	28.2	(±11.8%)	18.6	(± 8.2%)	9	(± 4)	53.5	(±25.2%)
Arizona	107	55.6	(±14.2%)	117	(± 43)	35.3	(±19.0%)	13.1	(± 7.4%)	28	(± 15)	56.8	(±27.9%)
Arkansas	140	53.6	(± 9.2%)	74	(± 18)	28.5	(±10.4%)	30.6	(± 8.8%)	42	(± 15)	43.9	(±17.6%)
California	480	58.7	(± 5.4%)	1679	(±241)	27.3	(± 6.8%)	13.9	(± 3.9%)	397	(±119)	75.7	(±15.7%)
Colorado	238	64.2	(± 6.9%)	194	(± 33)	23.2	(± 7.1%)	11.3	(± 4.6%)	34	(± 15)	81.8	(±15.9%)
Connecticut	100	68.1	(±10.1%)	92	(± 25)	29.8	(±12.9%)	7.9	(± 5.7%)	11	(± 8)	68.0	(±32.7%)
Delaware	241	53.0	(± 7.1%)	33	(± 6)	24.5	(± 8.5%)	37.5	(± 6.8%)	23	(± 6)	51.3	(±12.4%)
District of Columbia	218	60.5	(± 7.2%)	42	(± 8)	50.7	(± 9.5%)	19.5	(± 5.8%)	14	(± 4)	66.0	(±16.3%)
Florida	383	56.8	(± 5.5%)	742	(±112)	24.6	(± 6.6%)	24.8	(± 5.2%)	324	(± 79)	58.8	(±11.5%)
Georgia	160	60.9	(± 9.2%)	222	(± 51)	22.1	(± 9.2%)	25.8	(± 7.7%)	94	(± 31)	54.9	(±17.1%)
Hawaii	273	44.9	(± 7.3%)	37	(± 8)	15.6	(± 7.8%)	18.2	(± 6.4%)	15	(± 6)	45.4	(±18.9%)
Idaho	157	59.6	(±10.1%)	37	(± 11)	18.5	(±10.9%)	24.3	(± 8.3%)	15	(± 6)	61.4	(±19.1%)
Illinois	177	69.8	(± 7.4%)	442	(± 88)	24.8	(± 8.4%)	13.8	(± 5.6%)	88	(± 38)	53.9	(±21.8%)
Indiana	139	60.5	(± 9.3%)	165	(± 38)	25.5	(±10.3%)	17.6	(± 7.0%)	48	(± 21)	77.8	(±18.9%)
Iowa	86	52.8	(±11.8%)	48	(± 15)	27.9	(±15.0%)	24.0	(±11.1%)	22	(± 12)	82.3	(±23.0%)
Kansas	95	54.8	(±10.9%)	59	(± 18)	29.3	(±14.7%)	16.8	(± 7.8%)	18	(± 9)	40.5	(±24.0%)
Kentucky	140	62.9	(± 9.1%)	109	(± 25)	7.7	(± 5.0%)	18.9	(± 7.4%)	33	(± 14)	55.2	(±21.3%)
Louisiana	155	70.4	(± 8.5%)	199	(± 40)	30.3	(± 9.4%)	13.0	(± 5.7%)	37	(± 17)	46.2	(±23.6%)
Maine	50	65.1	(±15.2%)	21	(± 7)	44.1	(±18.3%)	19.3	(±13.6%)	6	(± 5)	93.3	(±13.4%)
Maryland	527	76.5	(± 4.2%)	362	(± 42)	25.6	(± 4.8%)	8.9	(± 2.9%)	42	(± 15)	63.9	(±15.7%)
Massachusetts	129	66.7	(± 9.4%)	250	(± 58)	31.9	(±11.0%)	7.7	(± 5.1%)	29	(± 20)	65.9	(±35.6%)
Michigan	254	62.1	(± 6.7%)	415	(± 68)	30.6	(± 7.9%)	9.5	(± 3.8%)	63	(± 26)	59.4	(±20.8%)
Minnesota	247	55.6	(± 6.9%)	132	(± 23)	28.2	(± 8.4%)	7.1	(± 3.9%)	17	(± 10)	85.1	(±14.0%)
Mississippi	187	46.0	(± 7.9%)	94	(± 22)	25.3	(±10.0%)	37.6	(± 8.2%)	77	(± 21)	44.8	(±13.7%)
Missouri	133	61.6	(± 9.6%)	215	(± 47)	25.2	(± 9.6%)	11.6	(± 5.9%)	40	(± 22)	52.7	(±27.2%)
Montana	83	62.1	(±12.7%)	28	(± 9)	37.5	(±15.8%)	19.4	(±10.3%)	9	(± 5)	75.2	(±21.4%)
Nebraska	66	73.3	(±11.3%)	29	(± 9)	35.7	(±16.3%)	13.6	(± 8.5%)	5	(± 4)	72.5	(±28.4%)
Nevada	250	55.1	(± 7.1%)	68	(± 13)	21.2	(± 7.7%)	17.2	(± 5.4%)	21	(± 7)	32.0	(±15.2%)
New Hampshire	112	49.2	(±10.2%)	33	(± 9)	32.9	(±13.7%)	10.5	(± 5.7%)	7	(± 4)	52.9	(±28.4%)
New Jersey	129	79.7	(± 8.0%)	433	(± 95)	29.8	(±10.1%)	7.8	(± 5.2%)	42	(± 29)	30.8	(±28.3%)
New Mexico	145	57.1	(± 9.5%)	74	(± 19)	32.3	(±12.3%)	16.3	(± 6.8%)	21	(± 9)	51.9	(±22.8%)
New York	266	61.5	(± 6.8%)	885	(±152)	33.9	(± 8.1%)	22.2	(± 5.8%)	320	(± 97)	66.0	(±14.6%)
North Carolina	174	61.5	(± 8.0%)	239	(± 51)	37.5	(±11.2%)	30.4	(± 7.5%)	118	(± 34)	53.8	(±14.4%)

North Dakota	91	46.7	(±11.0%)	11	(± 3)	9.5	(± 9.4%)	5.0	(± 4.5%)	1	(± 1)	64.7	(±42.9%)
Ohio	65	62.7	(±15.1%)	278	(± 94)	26.1	(±13.5%)	12.3	(± 9.0%)	54	(± 42)	60.7	(±36.0%)
Oklahoma	95	65.0	(±10.0%)	111	(± 32)	77.3	(±11.2%)	16.0	(± 8.1%)	27	(± 15)	95.7	(± 8.4%)
Oregon	306	48.4	(± 6.2%)	107	(± 18)	26.9	(± 7.7%)	23.6	(± 5.4%)	52	(± 14)	75.1	(±12.4%)
Pennsylvania	161	63.1	(± 8.4%)	363	(± 77)	26.0	(± 9.5%)	5.4	(± 3.5%)	31	(± 21)	74.0	(±30.5%)
Rhode Island	206	63.3	(± 8.0%)	55	(± 12)	29.3	(± 9.5%)	7.1	(± 3.4%)	6	(± 3)	56.6	(±24.6%)
South Carolina	205	57.7	(± 8.4%)	171	(± 36)	30.3	(± 9.6%)	28.0	(± 7.7%)	83	(± 27)	49.3	(±16.5%)
South Dakota	65	59.6	(±14.7%)	10	(± 4)	32.2	(±18.7%)	6.3	(± 5.9%)	1	(± 1)	86.7	(±25.7%)
Tennessee	199	73.2	(± 6.8%)	164	(± 30)	38.5	(± 9.0%)	18.9	(± 6.1%)	42	(± 15)	58.7	(±18.5%)
Texas	250	53.3	(± 7.8%)	603	(±131)	27.3	(± 9.8%)	15.0	(± 5.8%)	69	(± 71)	71.5	(±19.9%)
Utah	141	60.5	(± 9.3%)	49	(± 12)	31.9	(±10.6%)	20.0	(± 7.7%)	16	(± 7)	72.3	(±18.1%)
Vermont	120	62.8	(±10.1%)	15	(± 4)	25.5	(±10.6%)	11.1	(± 6.8%)	3	(± 2)	59.3	(±31.1%)
Virginia	209	59.5	(± 7.3%)	335	(± 63)	18.6	(± 7.4%)	16.2	(± 5.5%)	92	(± 35)	64.8	(±18.2%)
Washington	343	67.2	(± 5.5%)	309	(± 42)	28.2	(± 6.5%)	9.6	(± 3.3%)	44	(± 16)	78.3	(±14.2%)
West Virginia	120	66.9	(± 9.6%)	47	(± 11)	21.8	(± 9.6%)	14.8	(± 7.6%)	10	(± 6)	32.9	(±26.4%)
Wisconsin	103	48.5	(±11.4%)	110	(± 35)	15.2	(±14.7%)	14.0	(± 8.2%)	32	(± 20)	68.6	(±27.2%)
Median		*60.9%*				*28.2%*		*16.2%*				*60.7%*	

* For this study, diagnostic HIV tests were defined as those administered primarily to learn infection status rather than voluntary tests to qualify for insurance, military induction, immigration, marriage license application, or employment.
† Private physician, health maintenance organization, hospital, or private outpatient clinic.
§ Including health departments; AIDS, sexually transmitted disease, or tuberculosis clinics; and drug-treatment programs.
¶ Confidence interval.

HIV Counseling and Testing — Continued

correlated highly with estimates from CDC's HIV Counseling and Testing System, and the median percentage of respondents ever tested for HIV (25%) is consistent with estimates based on CDC's National Health Interview Survey (22%).

Health-care visits to seek and obtain HIV tests are important opportunities to counsel persons about the risk for HIV infection and methods to reduce such risk (*1*). The data in this report indicate that, in most states, approximately threefold more persons reported having obtained their HIV test from a private provider than from a public site; however, persons who had obtained their test from a private provider were substantially less likely to have reported receiving counseling than those who obtained tests at a public site. This finding underscores the need for physicians and other health-care providers in private settings to offer HIV counseling at the time patients receive their HIV test results.

The findings in this report are subject to at least two limitations. First, the sample size of persons who reported having had an HIV-antibody test in individual states did not enable stratification by other respondent characteristics. For example, state-specific sample sizes precluded analysis to determine whether specific high-risk populations that obtained HIV-antibody testing also received counseling. Second, because the BRFSS is a telephone-based system, some persons at high risk for HIV infection most likely were excluded from the survey.

The BRFSS is a unique source for information about HIV-antibody testing behaviors of U.S. adults—particularly patterns of HIV testing outside of public clinics—and can be used both at the federal and state levels to improve HIV-prevention and intervention programs. Questions about CT in the 1993 BRFSS were developed based on input from state health departments; subsequent BRFSS surveys may incorporate additional HIV-related behavioral questions.

References

1. Hinman AR. Strategies to prevent HIV infection in the United States. Am J Public Health 1991;81:1557–9.
2. CDC. HIV counseling and testing services from public and private providers—United States, 1990. MMWR 1992;41:743,749–52.
3. CDC. 1993 BRFSS quality control report. Atlanta: US Department of Health and Human Services, Public Health Service, CDC, 1994.
4. Shah BV. Software for Survey Data Analysis (SUDAAN) version 5.30 [Software documentation]. Research Triangle Park, North Carolina: Research Triangle Institute, 1989.
5. CDC. HIV counseling and testing data system: national profile, 1993. Atlanta: US Department of Health and Human Services, Public Health Service, CDC, 1994.

Clarification: Vol. 43, Nos. 51 & 52

The notice to readers "Recommended Childhood Immunization Schedule—United States, January 1995" (pages 959–960) stated that infants born to hepatitis B surface antigen (HBsAg)-positive mothers should receive immunoprophylaxis with 0.5 mL of hepatitis B immune globulin (HBIG) and 0.5 mL of hepatitis B vaccine administered at separate sites. Hepatitis B vaccines licensed in the United States are produced by Merck and Co., Inc. (Rahway, New Jersey), and SmithKline Beecham (Philadelphia) and are available in various concentrations. The recommended dose of hepatitis B vaccine for infants varies by manufacturer and HBsAg status of the mother (Table 1).

Merck and Co., Inc., recommends 2.5 μg of Recombivax HB® for infants of HBsAg-negative mothers and 5.0 μg for infants of HBsAg-positive mothers; SmithKline Beecham recommends 10 μg of Engerix-B® regardless of the mother's HBsAg status. Providers should know the HBsAg status of an infant's mother and consult the product package insert for the recommended vaccine dose.

Providers also should be aware that the Food and Drug Administration recently lowered the age-appropriate dose of Engerix-B® from 20 μg to 10 μg for adolescents 11–19 years of age (Table 1) (*1*).

Reference

1. Smithkline Beecham Pharmaceuticals. Brief summary of prescribing information: Engerix-B® [Package insert]. Philadelphia: Smithkline Beecham Pharmaceuticals, 1995.

TABLE 1. Recommended doses of currently licensed hepatitis B vaccines, by age or risk group

Group	Recombivax HB®*	Engerix-B®†
Infants of HBsAg-negative mothers	2.5 μg	10.0 μg
Infants of HBsAg-positive mothers	5.0 μg	10.0 μg
Children (Aged 1–10 years)	2.5 μg	10.0 μg
Adolescents (Aged 11–19 years)	5.0 μg	10.0 μg
Adults (Aged ≥20 years)	10.0 μg	20.0 μg
Dialysis patients and other immunocompromised persons	40.0 μg	40.0 μg

*Produced by Merck and Co. Inc. (Rahway, New Jersey).
†Produced by SmithKline Beecham (Philadelphia).

Addendum: Vol. 44, No. 8

In the article, "Exposure of Passengers and Flight Crew to *Mycobacterium tuberculosis* on Commercial Aircraft, 1992–1995," the following names should be added to the credits ("reported by") on the sixth line on page 139: A Ignacio, MD, D Morishige, RL Vogt, MD, State Epidemiologist, Communicable Disease Div, Hawaii Dept of Health.

Errata: Vol. 44, No. 8

In the article, "Exposure of Passengers and Flight Crew to *Mycobacterium tuberculosis* on Commercial Aircraft, 1992–1995," on page 138 in the first sentence under investigation 3, the length of flight is incorrect. The sentence should read, "In March 1993, a foreign-born passenger with pulmonary TB traveled on a *4½*-hour flight from Mexico to San Francisco."

In the article, "Use of Safety Belts—Madrid, Spain, 1994," the first sentence on page 151 should read, "Of 1063 phone numbers called to identify eligible households, 294 (27.7%) could not be contacted (no one answered or the line was busy), and 185 were excluded (because the phone number was commercial, no one aged ≥18 years was in the home at the time of the call, or respondents never traveled by vehicle)."

The *Morbidity and Mortality Weekly Report* (*MMWR*) Series is prepared by the Centers for Disease Control and Prevention (CDC). The data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business each Friday; compiled data on a national basis are officially released to the public the following Friday. Inquiries about the *MMWR* Series and material to be considered for publication should be addressed to Editor, *MMWR* Series, Mailstop C-08, CDC, 1600 Clifton Road, N.E., Atlanta, GA 30333; telephone (404) 332-4555.

The *MMWR* is available on a paid subscription basis for paper copy and free of charge in electronic format. For information about paid subscriptions, contact the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone (202) 783-3238. For electronic copy, send an e-mail message to *lists@list.cdc.gov* — the body content should read *subscribe mmwr-toc.* Electronic copy also is available from CDC's World-Wide Web server at *http://www.cdc.gov/* or CDC's file transfer protocol server at *ftp.cdc.gov.*

☆**U.S. Government Printing Office: 1995-633-175/05058 Region IV**