CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

January 26, 1995 / Vol. 45 / No. 3

MMWR™
MORBIDITY AND MORTALITY WEEKLY REPORT

57 Trends in Cancer Screening — United States, 1987 and 1992
61 State-Specific Rates of Mental Retardation — United States, 1993
65 Nutritional Status of Children Participating in the Special Supplemental Nutrition Program for Women, Infants, and Children — United States, 1988–1991
69 Injury Surveillance in Correctional Facilities — Michigan, April 1994–March 1995

Trends in Cancer Screening — United States, 1987 and 1992

Screening methods and programs are critical strategies for the early detection and timely treatment of some cancers. Established methods for early detection of cancer include mammography, clinical breast examination (CBE), the Papanicolaou (Pap) test, proctosigmoidoscopy, fecal occult blood test (FOBT), and digital rectal examination (DRE) (*1–4*). To examine changes in the reported use of selected cancer screening tests, the National Cancer Institute analyzed data from CDC's National Health Interview Survey (NHIS) for 1987 and 1992 to calculate rates of use and compared these rates with the national health objectives for the year 2000 (*5*). This analysis suggests that, although the use of these tests increased, substantial progress is needed to meet the objectives.

The NHIS is a continuing nationwide household survey that collects information from a representative sample of the U.S. civilian, noninstitutionalized population aged ≥18 years. The overall response rate for the 1987 and 1992 surveys was 95.3% (n=122,859) and 95.7% (n=128,412), respectively. In 1987 and 1992, questions were included to determine respondents' knowledge and practices regarding cancer screening. Respondents were asked whether they had ever had a Pap test, CBE, mammography, DRE, FOBT, or proctosigmoidoscopy. Respondents who answered "yes" to any of the questions were asked when their most recent test had been performed. Screening tests were defined as tests performed for any reason other than as the result of a health problem. For CBE, mammography, DRE, and FOBT, screening was considered recent if it had been performed during the year preceding the interview; for the Pap test and proctosigmoidoscopy, within the preceding 3 years. Data about CBE and mammography are presented for women aged ≥40 years; for DRE, FOBT, and proctosigmoidoscopy, persons aged ≥40 years, and for the Pap test, women aged ≥18 years with an intact uterus. Race/ethnicity-specific data are presented because screening rates and death rates historically have varied by these categories; data are presented only for whites, blacks, and Hispanics because numbers for other racial groups were too small to calculate precise estimates. Race/ethnicity-specific data were weighted using SUDAAN (*6*), and population and standard errors were estimated.

From 1987 to 1992, the overall percentage of women aged ≥18 years who reported having had a recent Pap test remained stable (Table 1). The percentage increased slightly for Hispanic women, and remained low for women aged ≥70 years

Cancer Screening — Continued

TABLE 1. Percentage of persons who reported ever or recently* having had screening tests for cancer, by test, age group of respondent, and year — United States, National Health Interview Survey, 1987 and 1992†

Test/ Age group (yrs)	Persons ever tested				Persons tested recently			
	1987		1992		1987		1992	
	%	(SE§)	%	(SE)	%	(SE)	%	(SE)
Papanicolaou test¶								
18–29	84	(0.4)	85	(0.5)	70	(0.3)	73	(0.8)
30–39	95	(0.5)	95	(0.2)	77	(0.7)	76	(0.8)
40–49	94	(0.9)	97	(1.0)	71	(1.4)	71	(1.6)
50–59	91	(1.0)	94	(0.6)	67	(1.5)	64	(1.1)
60–69	88	(2.0)	92	(1.7)	57	(1.7)	59	(1.7)
≥70	76	(0.2)	82	(1.9)	41	(0.5)	43	(1.7)
Clinical breast examination								
40–49	87	(0.7)	95	(0.7)	49	(0.9)	55	(1.5)
50–59	86	(0.8)	94	(0.7)	47	(0.6)	55	(1.9)
60–69	80	(1.4)	89	(1.5)	42	(1.3)	49	(2.4)
≥70	70	(1.3)	80	(2.5)	35	(1.0)	37	(1.4)
Mammography								
40–49	41	(1.4)	70	(1.7)	17	(1.9)	35	(1.0)
50–59	44	(0.6)	75	(2.2)	20	(0.6)	42	(2.7)
60–69	38	(0.8)	68	(2.4)	17	(0.5)	39	(2.4)
≥70	28	(1.2)	58	(1.9)	12	(0.8)	28	(0.8)
Digital rectal examination								
Men								
40–49	46	(3.0)	53	(1.2)	12	(0.8)	14	(1.7)
50–59	48	(1.4)	55	(2.7)	17	(0.9)	22	(1.1)
60–69	54	(1.6)	55	(1.3)	21	(1.4)	29	(2.1)
≥70	51	(1.3)	53	(1.1)	23	(2.1)	31	(1.6)
Women								
40–49	51	(0.7)	57	(0.6)	26	(0.7)	29	(1.9)
50–59	53	(1.7)	60	(3.6)	25	(1.5)	34	(3.4)
60–69	55	(2.5)	57	(1.0)	26	(1.7)	27	(1.0)
≥70	46	(0.6)	43	(2.0)	18	(1.3)	18	(0.4)
Fecal occult blood test								
Men								
40–49	32	(1.8)	35	(0.3)	8	(1.3)	8	(0.9)
50–59	37	(2.5)	42	(2.5)	12	(1.0)	15	(1.5)
60–69	46	(2.2)	51	(3.6)	14	(2.2)	18	(2.2)
≥70	38	(2.0)	56	(2.9)	15	(1.3)	20	(2.2)
Women								
40–49	28	(1.4)	33	(0.6)	10	(1.1)	9	(0.8)
50–59	42	(1.1)	45	(0.3)	16	(0.5)	17	(1.1)
60–69	45	(0.8)	51	(1.3)	19	(1.0)	21	(1.8)
≥70	39	(1.8)	48	(1.9)	15	(1.0)	16	(1.4)
Proctosigmoidoscopy								
Men								
40–49	15	(1.2)	20	(1.0)	4	(1.0)	6	(0.6)
50–59	23	(1.1)	28	(1.3)	7	(1.2)	12	(2.0)
60–69	33	(1.8)	37	(1.3)	9	(1.2)	13	(1.5)
≥70	28	(1.7)	45	(2.0)	9	(0.6)	15	(2.0)
Women								
40–49	21	(0.8)	15	(1.4)	2	(0.5)	4	(0.4)
50–59	13	(0.7)	29	(1.5)	5	(0.8)	7	(1.2)
60–69	24	(2.0)	31	(1.7)	7	(0.8)	9	(1.7)
≥70	26	(0.8)	33	(0.8)	6	(0.8)	8	(0.6)

* For Papanicolaou and proctosigmoidoscopy, "recently" is defined as during the 3 years preceding the interview; for clinical breast examination, mammography, digital rectal examination, and fecal occult blood test, during the year preceding the interview.

† For 1987, the sample size was 122,859 (response rate: 95.3%), and for 1992 was 128,412 (response rate: 95.7%).

§ Standard error.

¶ Excludes women who had had a hysterectomy.

Cancer Screening — Continued

(Tables 1 and 2). The increase in the percentage of women ever tested was greater for women aged ≥50 years (85% to 89%) than women aged <50 years (90% to 92%), and for black (88% to 92%) and Hispanic women (75% to 83%) than white women (91% to 92%).

During this period, the percentage of respondents who reported recent mammography increased at least twofold for women in every age and racial/ethnic group. The greatest increases were for black and Hispanic women; as a consequence, in 1992, screening rates were similar for white, black, and Hispanic women. However, women aged ≥70 years in 1992 remained less likely to have had a recent screening and to have ever been tested than women aged <70 years. From 1987 to 1992, the percentage of respondents who reported having had a recent CBE also increased; in 1992, at least 75% of women in each age group reported ever having the test.

From 1987 to 1992, the percentage of respondents who reported ever having had a DRE increased from 49% to 54% for men and from 51% to 54% for women (Table 2). Although increases were greater for men than women, rates for recent DRE were lower for men than women (22% versus 21% in 1992). Rates of recent FOBT remained stable; however, the rate for black men increased more than twofold, from 7% to 15%. The overall percentages of respondents who reported ever having had proctosigmoidoscopy increased for men (24% to 30%) and for women (21% to 26%), and the percentage screened recently was higher for men than women in both 1987 and 1992 (7% and 11%, respectively, versus 5% and 7%, respectively).

Reported by: N Breen, PhD, L Kessler, PhD, Applied Research Br, National Cancer Institute, National Institutes of Health. Div of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion; National Center for Health Statistics, CDC.

Editorial Note: The analysis described in this report estimates use of cancer screening tests based on a representative sample of the U.S. population, and four of these tests have been targeted as national health objectives for the year 2000 (objectives 16.11–16.14). Although the findings indicate an increase in the recent use of all cancer screening tests (except the Pap test) from 1987 to 1992, percentages are substantially lower than the national health objectives. For example, one national health objective is to increase the rate of mammography among women aged ≥50 years to 60% every 2 years and among women aged ≥40 years to 80% ever (objective 16.11). Based on this survey, the rate of recent mammography among women aged ≥50 years was 44% in 1992 and ever having had mammography was 70% for women aged ≥40 years.

The differences in the screening rates and the national health objectives may, in part, reflect for respondents a lack of 1) health insurance coverage, 2) a primary-care physician, or 3) clear communication between physicians and patients about the importance of routine screening. For example, the lower rate of mammography use by women aged ≥50 years (who are at greatest risk for breast cancer) may reflect the finding that these women are less likely to visit gynecologists, and of all physician specialists, gynecologists are most likely to recommend mammograms (*7*). In addition, for women with low incomes, the mammography objectives are unlikely to be met because facilities that perform mammography may not accept women without a referral from a primary-care physician, and a disproportionate number of women with low incomes do not have a regular health-care provider. To promote mammography screening among older women, since 1990, Medicare has reimbursed the cost of biennial mammograms. Although the reimbursement fee is substantially less than the

Cancer Screening — Continued

TABLE 2. Percentage of persons who reported ever or recently* having had screening tests for cancer, by test, race/ethnicity,† and year — United States, National Health Interview Survey, 1987 and 1992§

Test/ Race/Ethnicity	Persons ever tested				Persons tested recently			
	1987		1992		1987		1992	
	%	(SE¶)	%	(SE)	%	(SE)	%	(SE)
Papanicolaou test**								
White	91	(0.2)	92	(0.6)	69	(0.2)	66	(0.3)
Black	88	(0.3)	92	(0.8)	70	(0.7)	73	(1.3)
Hispanic	75	(0.2)	83	(1.5)	59	(1.2)	66	(1.4)
Total	**88**	**(0.2)**	**90**	**(0.6)**	**67**	**(0.2)**	**67**	**(0.3)**
Clinical breast examination								
White	84	(0.9)	91	(0.3)	44	(0.5)	50	(1.7)
Black	74	(1.1)	85	(2.2)	46	(2.1)	51	(1.9)
Hispanic	73	(2.1)	86	(3.0)	45	(1.7)	53	(4.0)
Total	**81**	**(0.8)**	**90**	**(0.7)**	**44**	**(0.2)**	**50**	**(1.3)**
Mammography								
White	40	(0.5)	69	(1.3)	18	(0.8)	36	(1.7)
Black	31	(2.0)	64	(1.6)	14	(1.3)	32	(1.4)
Hispanic	28	(1.0)	70	(3.9)	13	(2.3)	38	(3.2)
Total	**38**	**(0.4)**	**68**	**(1.0)**	**17**	**(0.7)**	**36**	**(1.1)**
Digital rectal examination								
Men								
White	52	(1.4)	57	(0.5)	18	(1.1)	23	(0.7)
Black	38	(1.6)	43	(3.1)	16	(1.5)	19	(3.8)
Hispanic	32	(1.7)	37	(6.1)	9	(1.9)	13	(2.5)
Total	**49**	**(1.2)**	**54**	**(1.0)**	**17**	**(1.0)**	**22**	**(1.0)**
Women								
White	54	(0.7)	56	(1.3)	25	(0.4)	28	(1.0)
Black	44	(2.0)	51	(3.7)	22	(1.3)	25	(3.3)
Hispanic	38	(2.0)	39	(0.7)	15	(2.4)	18	(1.5)
Total	**51**	**(0.7)**	**54**	**(0.9)**	**24**	**(0.6)**	**27**	**(1.0)**
Fecal occult blood test								
Men								
White	39	(1.7)	46	(1.2)	13	(0.9)	15	(0.9)
Black	29	(2.3)	41	(4.9)	7	(0.9)	15	(2.1)
Hispanic	30	(5.1)	32	(4.5)	7	(2.4)	6	(0.6)
Total	**38**	**(1.5)**	**44**	**(1.4)**	**12**	**(7.7)**	**14**	**(1.0)**
Women								
White	39	(0.9)	44	(0.8)	16	(0.6)	16	(1.1)
Black	33	(1.4)	39	(2.1)	13	(1.8)	12	(1.8)
Hispanic	28	(2.0)	39	(4.1)	9	(1.4)	11	(2.3)
Total	**38**	**(0.7)**	**43**	**(0.6)**	**15**	**(0.5)**	**15**	**(0.8)**
Proctosigmoidoscopy								
Men								
White	25	(1.0)	32	(1.0)	7	(0.2)	11	(1.1)
Black	15	(1.7)	27	(4.1)	5	(0.9)	11	(2.2)
Hispanic	16	(2.9)	23	(0.9)	2	(1.3)	8	(1.7)
Total	**24**	**(0.9)**	**30**	**(1.1)**	**7**	**(0.2)**	**11**	**(1.1)**
Women								
White	23	(1.0)	27	(0.6)	5	(0.1)	6	(0.3)
Black	12	(0.6)	21	(2.4)	3	(0.4)	8	(1.8)
Hispanic	12	(1.8)	18	(2.7)	2	(0.9)	5	(1.5)
Total	**21**	**(0.8)**	**26**	**(0.5)**	**5**	**(0.2)**	**7**	**(0.4)**

* For Papanicolaou and proctosigmoidoscopy, "recently" is defined as during the 3 years preceding the interview; for clinical breast examination, mammography, digital rectal examination, and fecal occult blood test, during the year preceding the interview.

† Data are presented only for blacks, whites, and Hispanics because numbers for other racial groups were too small to calculate precise estimates.

§ For 1987, the sample size was 122,859 (response rate: 95.3%), and for 1992 was 128,412 (response rate: 95.7%).

¶ Standard error.

** Excludes women who had had a hysterectomy.

Cancer Screening — Continued

median price of mammograms in the United States, the fee is feasible if mammograms are delivered using more effecient methods and established mass-production techniques (*8*).

In the United States, managed care and the increased use of health maintenance organizations (HMOs) are likely to increase the use of all preventive-care services (including screening examinations), particularly if primary-care physicians are encouraged to screen patients routinely and recommend screening tests they currently do not perform. In addition, however, the importance of some screening examinations, such as the Pap test, may need to be emphasized regularly in public health messages.

References

1. Miller AB, Lindsay J, Hill GB. Mortality from cancer of the uterus in Canada and its relationship to screening for cancer of the cervix. Int J Cancer 1976;17:602–12.
2. Mandel JS, Bond JH, Church TR, et al. Reducing mortality from colorectal cancer by screening for fecal occult blood: Minnesota Colon Cancer Control Study. N Engl J Med 1993;328:1365–71.
3. Selby JV, Friedman GD, Quesenberry CP Jr, Weiss NS. A case-control study of screening sigmoidoscopy and mortality from colorectal cancer. N Engl J Med 1992;326:653–7.
4. Newcomb PA, Norfleet RG, Storer BE, Surawicz TS, Marcus PM. Screening sigmoidoscopy and colorectal cancer mortality. J Natl Cancer Inst 1992;84:1572–5.
5. Public Health Service. Healthy people 2000: national health promotion and disease prevention objectives—full report, with commentary. Washington, DC: US Department of Health and Human Services, Public Health Service, 1991; DHHS publication no. (PHS)91-50212.
6. Shah BV, Folsom RE, Harrell FE, Dillard CN. Survey data analysis software for logistic regression. Research Triangle Park, North Carolina: Research Triangle Institute, 1984.
7. Schappert SM. National Ambulatory Medical Care Survey: 1989 summary. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, CDC, NCHS, 1992. (Vital and health statistics; series 13, no. 110).
8. Physician Payment Review Commission. The cost of providing screening mammography: report to Congress. Washington, DC: Physician Payment Review Commission, 1989.

State-Specific Rates of Mental Retardation — United States, 1993

Mental retardation (MR) is the most common developmental disability and ranks first among chronic conditions causing major activity limitations among persons in the United States (*1*). National and state-specific surveillance to measure the prevalence of MR can assist in targeting areas of need and allocating resources. State-specific prevalences for MR can be determined by using data about persons who receive specialized services for MR through entitlement programs. To estimate state-specific prevalences of MR in 1993, data were analyzed from the U.S. Department of Education (DOE) for children with MR who were enrolled in special education programs and from the Social Security Administration (SSA) for adults with MR.* This report summarizes the findings, which suggest substantial state-specific variation in the prevalence of MR in the United States.

For children, the analysis was based on data in reports from the DOE, which included the number of children aged 6–17 years who because of MR were enrolled in

*SSA data for children also were available but were not included in this analysis because a child's eligibility is, in part, based on total household income. For persons aged ≥18 years, eligibility is based on that person's own income without regard to family assets. Therefore, persons with MR are more likely to be included in the SSA database after they reach age 18 years.

Mental Retardation — Continued

special education programs (either Chapter 1 or Part B) during school year 1993–94. For this data set, MR was defined as "... a significantly subaverage general intellectual functioning, with deficits in adaptive behavior" (*2,3*).

For adults aged 18–64 years, the analysis was based on SSA data from 1993. The SSA defines MR as "... significantly subaverage general intellectual functioning, with deficits in adaptive behavior initially manifested during the developmental period (before age 22)" (*4*). The SSA database includes adults with MR who received Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI). To be eligible to receive SSA benefits for MR (and, therefore, be included in the SSA database), adults must have had an intelligence quotient (IQ) of ≤59 or an IQ of 60–70 with other physical or mental impairment(s) resulting in additional and substantial work-related limitations of function. All persons receiving SSA benefits also must meet income-resource eligibility requirements (*4*).

The numbers of children and adults identified through DOE reports and the SSA database in each state and the District of Columbia were combined to estimate the total population with MR. Prevalences of MR were calculated for children by using the total number of children aged 6–17 years in each state and for adults, by using the total number of persons aged 18–64 years. The 1990 census was used as a source for state population estimates and demographic data (i.e., median household income, percentage of total births to teenaged mothers, and percentage of adults aged ≥18 years with less than a ninth-grade education). Multiple linear regression was used to determine the amount of variability in the state MR rates that could be attributed to those three socioeconomic factors.

In 1993, an estimated 1.5 million persons aged 6–64 years in the United States had MR, and the overall rate of MR was 7.6 cases per 1000 population. State-specific rates varied approximately fivefold (range: 3.0 in Alaska to 16.9 in West Virginia) (Table 1). The 10 states with the highest overall rates of MR were contiguous and located in the East South Central (Alabama, Kentucky, Mississippi, and Tennessee), South Atlantic (West Virginia, North Carolina, and South Carolina), West South Central (Arkansas and Louisiana), and East North Central (Ohio) regions. The states with the lowest rates were in the Pacific and Mountain regions.

For children, the MR rate was 11.4 per 1000 and varied approximately ninefold (range: 3.2 in New Jersey to 31.4 in Alabama) (Table 1). For adults, the rate was 6.6 and varied approximately sixfold (range: 2.5 in Alaska to 15.7 in West Virginia). In most (42 [84%]) states, the rate for children was higher than that for adults; in seven (14%) states, the rate for adults was higher, and in two states, both rates were similar. The correlation between state-specific rates for children and for adults was 0.66. Overall, 69% of the state-specific variation in prevalence rates for adults was accounted for by median household income, the percentage of total births to teenaged mothers, and the percentage of the population with less than a ninth-grade education. Low educational attainment was the most important correlate of MR rates among adults.

Reported by: PS Massey, PhD, South Carolina Dept of Disabilities and Special Needs; S McDermott, PhD, Interagency Disability Prevention Program, and Dept of Family and Preventive Medicine, Univ of South Carolina School of Medicine, Columbia. Disabilities Prevention Program, Office of the Director, and Developmental Disabilities Br, Div of Birth Defects and Developmental Disabilities, National Center for Environmental Health, CDC.

Editorial Note: This analysis of data from entitlement service programs suggests wide variation in state-specific rates of MR for children and adults in the United States. Use

Mental Retardation — Continued

TABLE 1. Prevalence rate* of mental retardation, by state — United States, 1993†

Region/State	Children aged 6–17 yrs	Adults aged 18–64 yrs	Total
New England			
Connecticut	7.1	5.1	**5.5**
Maine	6.2	7.1	**6.9**
Massachusetts	13.8	5.1	**6.7**
New Hampshire	4.0	3.7	**3.8**
Rhode Island	5.9	5.9	**5.9**
Vermont	11.8	6.6	**7.7**
Total	**9.8**	**5.3**	**6.1**
Mid Atlantic			
New Jersey	3.2	4.6	**4.3**
New York	5.7	6.2	**6.1**
Pennsylvania	14.0	6.4	**7.9**
Total	**7.9**	**5.9**	**6.3**
East North Central			
Illinois	10.4	6.6	**7.5**
Indiana	17.8	7.6	**9.9**
Michigan	10.3	7.7	**8.2**
Ohio	22.5	8.7	**11.7**
Wisconsin	4.6	6.9	**6.4**
Total	**13.8**	**7.6**	**8.9**
West North Central			
Iowa	21.2	7.3	**10.5**
Kansas	10.9	6.8	**7.7**
Minnesota	11.1	5.1	**6.5**
Missouri	12.5	8.8	**9.6**
Nebraska	15.3	4.7	**7.2**
North Dakota	8.9	6.9	**7.4**
South Dakota	9.3	5.9	**6.7**
Total	**13.3**	**6.8**	**8.3**
South Atlantic			
District of Columbia	13.5	6.0	**7.1**
Delaware	14.4	7.4	**8.8**
Florida	14.8	4.8	**6.8**
Georgia	20.0	8.4	**10.9**
Maryland	6.5	4.8	**5.2**
North Carolina	19.5	8.9	**11.0**
South Carolina	21.9	8.3	**11.3**
Virginia	11.8	6.1	**7.2**
West Virginia	21.1	15.7	**16.9**
Total	**10.4**	**6.9**	**7.6**
East South Central			
Alabama	31.4	11.2	**15.7**
Kentucky	25.5	13.5	**16.2**
Mississippi	12.9	13.9	**13.7**
Tennessee	14.3	11.9	**12.4**
Total	**21.3**	**12.4**	**14.4**
West South Central			
Arkansas	23.1	10.4	**13.4**
Louisiana	12.9	12.5	**12.6**
Oklahoma	19.7	6.4	**9.5**
Texas	6.4	5.0	**5.3**
Total	**10.4**	**6.8**	**7.6**
Mountain			
Arizona	7.7	4.3	**5.1**
Colorado	4.2	4.7	**4.6**
Idaho	12.1	5.0	**6.9**
Montana	7.1	6.2	**6.4**
Nevada	6.6	3.4	**4.0**
New Mexico	5.6	5.8	**5.7**
Utah	6.9	4.3	**5.1**
Wyoming	5.7	5.0	**5.2**
Total	**6.8**	**4.7**	**5.2**
Pacific			
Alaska	5.0	2.5	**3.0**
California	4.5	4.5	**4.5**
Hawaii	8.0	3.2	**4.2**
Oregon	7.6	5.5	**6.0**
Washington	8.3	5.1	**5.8**
Total	**5.3**	**4.6**	**4.7**
Total	**11.4**	**6.6**	**7.6**

*Per 1000 population.
†For children, the analysis was based on data in reports from the U.S. Department of Education and for adults, on data from the Social Security Administration.

Mental Retardation — Continued

of this method of monitoring the prevalence of MR can assist in evaluating temporal trends and in identifying high-risk areas within states. The high rates of MR documented in the South Atlantic and East South Central regions are consistent with rates for disabilities from all causes, which also indicate wide variations among the states (*5*). In addition, the finding that a substantial proportion of state-specific variation was associated with differences in median income, percentage of births to teenaged mothers, and percentage of adults with less than a ninth-grade education is consistent with previous reports documenting the relation between the prevalance of MR and socioeconomic factors (*6*), particularly low maternal education levels (*7*).

The findings in this report are subject to at least four limitations. First, although national guidelines determine the eligibility requirements for entitlement programs, these programs are administered locally, and guidelines are subject to local interpretations and modifications that can influence the numbers of persons served. Second, the DOE data do not include those who drop out of school and those who never enroll in a public education program. Dropout rates and enrollment in private schools can vary substantially among states and can affect the numbers of children identified through this method. Third, the eligibility data for SSA services is based on both personal income and the presence of a disability. Financial eligibility is based on the adult's own income, and an adult with MR can qualify for SSI benefits regardless of family income or assets. However, some adults with MR who meet the disability eligibility requirements may not be eligible because their earned income or other assets exceed eligibility requirements. Reduced participation in these programs in states with higher median household incomes could lower the MR rate for adults in those states; however, the incentive to apply for SSI or SSDI to ensure health benefits and financial support probably ensures consistent participation in this program among all states. Finally, small rate differences among states can result from other data limitations that reflect the problems intrinsic to complicated state and federal cooperative arrangements.

The large state-to-state differences in MR rates in this analysis probably reflect at least some real differences in MR rates (e.g., related to income and educational attainment). State-specific variations in the prevalence of MR should be assessed using multiple data sources, and further efforts should seek to explain the largest differences in rates among states and the difference between the rates for children and adults within states. Some states (e.g., South Carolina and Alabama) are examining variations in rates among counties or local school districts to determine factors possibly influencing their local and state rates. CDC's Metropolitan Atlanta Developmental Disabilities Surveillance Program tracks MR rates for children aged 3–10 years using multiple data sources and can be used as a model for other areas (*8*). Improved understanding of the risk factors for MR and the factors influencing rate variations can assist in developing and targeting prevention strategies and efforts.

References

1. Pope AM, Tarlov AR. Disability in America: toward a national agenda for prevention. Washington, DC: National Academy Press, 1991.
2. US Department of Education. To assure the free appropriate public education of all children with disabilities: sixteenth annual report to Congress on the implementation of the Individuals with Disabilities Education Act. Washington, DC: US Department of Education, 1994.

Mental Retardation — Continued

3. Frankenberger W, Harper J. State definitions and procedures for identifying children with mental retardation: comparisons of 1981–1986 guidelines. Ment Retard 1988;26:133–6.
4. Social Security Administration. Disability evaluation under Social Security. Washington, DC: US Department of Health and Human Services, Public Health Service, 1994; publication no. (SSA) 64-039.
5. McCoy JL, Davis M, Hudson RE. Geographic patterns of disability in the United States. Soc Secur Bull 1994;57(no. 1):25–36.
6. McDermott S. Explanatory model to describe school district prevalence rates for mental retardation and learning disabilities. Am J Ment Retard 1994;99:175–85.
7. Drews CD, Yeargin-Alsopp M, Decouflé P, Murphy CC. Variation in the influence of selected socio-demographic risk factors for mental retardation. Am J Public Health 1995;85:329–34.
8. Decouflé P, Yeargin-Alsopp M, Boyle CA, Doernberg NS. Developmental disabilities. In: Wilcox LS, Marks JS, eds. From data to action—CDC's public health surveillance for women, infants, and children. Atlanta, Georgia: US Department of Health and Human Services, Public Health Service. (CDC monograph).

Nutritional Status of Children Participating in the Special Supplemental Nutrition Program for Women, Infants, and Children — United States, 1988–1991

Recent increases in the prevalence of overweight among school-aged children (*1*) and adults (*2*) in the United States have prompted concern about an increase in overweight among preschool-aged children and a possible association with the foods provided by the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). To assess and compare weight status and nutrient intake among WIC participants and other low-income children, CDC analyzed data from phase 1 of the Third National Health and Nutrition Examination Survey (NHANES III), 1988–1991. This report summarizes the results of this analysis, which indicate that foods provided by WIC are not associated with increased overweight among preschool-aged children.

CDC's NHANES III is a stratified multistage probability sample of the civilian, noninstitutionalized U.S. population aged ≥2 months. The survey consists of two 3-year nationally representative samples (phase 1, 1988–1991 and phase 2, 1991–1994) with oversampling of children aged 2 months–5 years. A standardized physical examination in a mobile examination center included a 24-hour dietary recall and measurements of recumbent length (children aged <2 years for this analysis), stature (children aged ≥2 years), and weight (*3*). Weight status is defined as weight-for-height in relation to the National Center for Health Statistics (NCHS)/CDC reference growth curves (*4*). Mean Z-scores (i.e., the average number of standard deviations a child is from the NCHS/CDC reference mean) are presented for non-Hispanic whites, non-Hispanic blacks, and Mexican Americans aged 2–23 months and 24–59 months.* Mean intakes of energy, percentage of energy from fat, calcium, and calcium per 1000 kilocalories (kcal) also are presented for these subgroups. Data were analyzed by race/ethnicity because, among low-income preschool-aged children, some racial/ethnic groups have a higher prevalence of high weight-for-height than other groups (*5*).

*Numbers for other racial/ethnic groups were too small for meaningful analysis.

Nutritional Status — Continued

Among low-income (≤185% of the poverty level[†]) white and black children, differences in weight status among those who participated in WIC and those who did not participate were neither significant nor consistent (Table 1). However, mean weight-for-height Z-scores were lower among Mexican American WIC participants than nonparticipants. Multivariate analyses indicate that when income is accounted for, the relation between WIC and weight-for-height remains the same.

Nutrient intakes varied by WIC participation (Table 2): although average energy intake was lower among WIC participants than non-WIC participants, both groups received approximately the recommended dietary allowance (RDA) for energy—a pattern consistent among racial/ethnic groups. In general, the percentage of energy obtained from consuming fat was higher for WIC participants than nonparticipants, and all groups aged 24–59 months consumed above the dietary guideline of 30% of energy from fat (*7*). Calcium intake per 1000 kcal of energy also was higher in general for WIC participants than nonparticipants. Total calcium intake generally was higher for WIC participants aged 24–59 months, but lower for those aged <2 years. Black participants consumed more calcium from milk than did nonparticipants. Mean calcium intake for all WIC participants was approximately the RDA.

[†]Poverty statistics are based on a definition originated by the Social Security Administration in 1964, subsequently modified by federal interagency committees in 1969 and 1980, and prescribed by the Office of Management and Budget as the standard to be used by federal agencies for statistical purposes.

TABLE 1. Mean Z-score* weight-for-height for children aged 2–59 months, by race/ethnicity[†], age, and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) participation status — United States, National Health and Nutrition Examination Survey III, Phase I, 1988–1991

Race/Ethnicity/ Age (mos)	WIC		Non-WIC[§]		(95% CL** of difference)
	No.	Mean[¶]	No.	Mean	
White, non-Hispanic					
2–23	134	0.36	160	0.41	(–0.3, 0.1)
24–59	22	[††]	166	0.15	
Total	**156**	**0.33**	**326**	**0.23**	**(–0.2, 0.4)**
Black, non-Hispanic					
2–23	151	0.62	95	0.44	(–0.1, 0.5)
24–59	104	0.01	263	0.14	(–0.4, 0.2)
Total	**255**	**0.37**	**358**	**0.22**	**(–0.1, 0.3)**
Mexican American					
2–23	130	0.25	118	0.39	(–0.5, 0.3)
24–59	56	0.06	345	0.57	[§§]
Total	**186**	**0.20**	**463**	**0.53**	**(–0.6, 0.0)**

*Number of standard deviations from the National Center for Health Statistics/CDC reference mean.
[†]Numbers for other racial/ethnic groups were too small for meaningful analysis.
[§]Children not participating in WIC but living in families with incomes ≤185% of the poverty level.
[¶]Z-scores between age groups within each racial/ethnic group are influenced by a disjunction in the growth charts at age 2 years (*6*).
**Confidence limit.
[††]Sample size was too small to calculate an estimate.
[§§]Potentially unreliable estimate because of small sample size.

TABLE 2. Mean nutrient intake for children aged 2–59 months, by race/ethnicity*, age, and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) participation status — United States, National Health and Nutrition Examination Survey III, Phase I, 1988–1991

Race/Ethnicity/ Age (mos)	Energy (kcal)†			% Fat			Calcium per 1000 kcal			Calcium (mg)†		
	WIC	Non-WIC§	(95% CL¶)	WIC	Non-WIC	(95% CL)	WIC	Non-WIC	(95% CL)	WIC	Non-WIC	(95% CL)
White, non-Hispanic												
2–23	1034	1095	(–197, 76)	37.0	35.4	(–1.3, 4.5)	793	847	(–124, 17)	784	882	(–174, –22)
24–59	**	1479		**	34.3		**	554		**	802	
Total	**1194**	**1368**	**(–320, –30)**	**35.4**	**34.6**	**(–0.5, 2.1)**	**724**	**638**	**(32, 141)**	**812**	**825**	**(–90, 66)**
Black, non-Hispanic												
2–23	1019	1209	(–294, –87)	36.8	36.9	(–1.8, 1.6)	721	642	(0, 157)	702	753	(–166, 64)
24–59	1573	1609	(–173, 102)	37.9	35.3	(0.6, 4.6)	498	412	(50, 122)	774	661	(27, 200)
Total	**1247**	**1510**	**(–358, –167)**	**37.3**	**35.7**	**(0.3, 2.9)**	**629**	**469**	**(107, 213)**	**732**	**684**	**(–25, 121)**
Mexican American												
2–23	977	1117	(–236, –44)	37.4	35.9	(–0.4, 4.2)	815	869	(–173, 67)	767	923	(–230, –82)
24–59	1503	1434	††	33.2	33.6	††	564	565	††	843	804	††
Total	**1133**	**1364**	**(–375, –89)**	**36.1**	**34.1**	**(0.5, 4.1)**	**741**	**631**	**(18, 201)**	**790**	**830**	**(–104, 23)**

*Numbers for other racial/ethnic groups were too small for meaningful analysis.
†Recommended daily allowance of 850 kilocalories (kcal) and 600 mg calcium for ages 6–11 months, 1300 kcal for ages 12–47 months; 1800 kcal for ages 48–59 months; and 800 mg calcium for ages 12–59 months.
§Children not participating in WIC but living in families with incomes ≤185% of the poverty level.
¶95% confidence limit around the difference in means.
**Sample size was too small to calculate an estimate.
††Potentially unreliable estimate because of small sample size.

Nutritional Status — Continued

Reported by: Div of Health Examination Statistics, National Center for Health Statistics; Maternal and Child Health Br, Div of Nutrition, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: In 1972, the federal government established the WIC program following a determination of poor nutritional status among many low-income children in the United States (*8*). To participate in WIC, pregnant and postpartum women, infants, and children aged <5 years must meet income and nutritional risk criteria. The income criterion is determined by state agencies, but usually is not >185% of the poverty level. Nutritional risk is defined as detrimental conditions detectable by biochemical or anthropometric measurements, other documented nutritionally related medical conditions, dietary deficiencies that impair health, or conditions (e.g., drug addiction) that increase the likelihood of inadequate nutritional patterns or nutritionally related medical problems. WIC provides nutrition education, referrals to health services, and supplemental foods high in protein, iron, calcium, vitamin A, and vitamin C. In 1994, approximately 3.2 million children aged 1–4 years and approximately 40% of all babies born in the United States participated in WIC (*9*).

In 1973, CDC, in collaboration with five states, initiated the Pediatric Nutrition Surveillance System (PedNSS) to continuously monitor the nutritional status of children who participate in publicly funded health and nutrition programs such as WIC. By 1990, this system had expanded to include 40 states, Puerto Rico, the District of Columbia, the Navajo Nation, and the Intertribal Council of Arizona. Each visit a child makes to a participating clinic generates a surveillance record that includes height and weight measurements. From 1980 through 1991, the prevalences of both low weight-for-height and high weight-for-height among white and black children participating in PedNSS remained stable at below the expected value of 5% (Mexican American children in PedNSS were not separated from other Hispanic children [*10*]). The 1990 PedNSS data are consistent with the finding that children who participate in WIC were not more overweight than other low-income children. In general, mean weight-for-height Z-scores from PedNSS were lower than the NHANES III mean values for WIC participants.

The findings in this report are subject to at least two limitations. First, the small sample sizes for some subgroups of WIC participants in the NHANES III data are associated with unstable estimates when based only on phase 1 data. Second, children who were not participating in WIC may not have been at nutritional risk and therefore may not have been eligible for participation in WIC. Thus, nutrient intake data differences between WIC and non-WIC participants who are WIC eligible may actually be greater than that observed in this analysis.

WIC foods provide necessary nutrients without contributing to overweight. However, overweight remains a public health problem in the United States. Health departments and other agencies that administer WIC should continue to reinforce the *Dietary Guidelines for Americans* (*7*), emphasizing the importance of diets lower in fat (for those aged ≥2 years) and higher in calcium through consumption of foods such as low-fat dairy products.

References

1. Troiano RP, Flegal KM, Kuczmarski RJ, Campbell SM, Johnson CL. Overweight prevalence and trends for children and adolescents: the National Health and Nutrition Examination Surveys, 1963 to 1991. Arch Pediatr Adolesc Med 1995;149:1085–91.

Nutritional Status — Continued

2. Kuczmarski RJ, Flegal KM, Campbell SM, Johnson CL. Increasing prevalence of overweight among US adults. JAMA 1994;272:205–11.
3. NCHS. Plan and operation of the Third National Health and Nutrition Examination Survey, 1988–94. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, CDC, NCHS, 1994; DHHS publication no. (PHS)94-1308. (Vital and health statistics; series 1, no. 32).
4. Dibley MJ, Goldsby JB, Staehling NW, Trowbridge FL. Development of normalized curves for the international growth reference: historical and technical considerations. Am J Clin Nutr 1987;46:736–48.
5. CDC. Nutritional status of minority children—United States, 1986. MMWR 1987;36:366–9.
6. Dibley MJ, Staehling N, Nieburg P, Trowbridge FL. Interpretation of Z-score anthropometric indicators derived from the international growth reference. Am J Clin Nutr 1987;46:749–62.
7. US Department of Agriculture/US Department of Health and Human Services. Dietary guidelines for Americans. 4th ed. Washington, DC: US Department of Agriculture/US Department of Health and Human Services, 1995. (Home and garden bulletin, no. 232).
8. CDC. Ten-state nutrition survey, 1968–1970. Part III: clinical, anthropometry, dental. Atlanta: US Department of Health and Human Services, Public Health Service, CDC, 1972; DHEW publication no. 72-8131 (HSM).
9. US Department of Agriculture, Randall B, Boast L. Study of WIC participant and program characteristics, 1992. Washington, DC: US Department of Agriculture, Food and Nutrition Service, Office of Analysis and Evaluation, 1994.
10. CDC. Pediatric Nutrition Surveillance System—United States, 1980–1991, and Pregnancy Nutrition Surveillance System—United States, 1979–1990. MMWR 1992;41(no. SS-7).

Injury Surveillance in Correctional Facilities — Michigan, April 1994–March 1995

Following an outbreak of Legionnaires disease in a Michigan prison in 1993 (*1*), which was first recognized at a civilian hospital, the Michigan Department of Public Health (MDPH) recommended that surveillance for acute infectious diseases be established in the Michigan Department of Corrections (MDOC). In April 1994, MDOC and MDPH implemented a pilot system to monitor trends and detect clusters of selected acute infectious diseases and injury in six Michigan state correctional facilities. This report summarizes the findings of injury surveillance during April 1994–March 1995.

In each facility, the nurse in charge of the clinic submitted daily reports by electronic mail of the number of inmates with acute unintentional injury (occurring during recreational, occupational, and other activities) and acute intentional injury (assault and self-inflicted). Of the 34 MDOC facilities, reporting sources were clinics in five facilities (one for females [F]; one regional prison for housing near families [R]; one for young men [aged 15–25 years] [Y]; one with a 25% prevalence of chronic disease [C]; and one in the upper peninsula of Michigan [U]) and the emergency department (ED) of the MDOC hospital serving one large facility and facility C. These sites accounted for approximately 10,000 of the 38,000 prisoners statewide. However, prisoners at facility C and the facility served by the ED were able to use services at other clinics, which were not reporting sources in the pilot system. Incidence rates per 1000 prisoners were calculated based on annual average prisoner populations.

During April 1994–March 1995, a total of 3176 new injury-related visits was reported. The number of reported unintentional injuries (2502) was nearly fourfold greater than that for intentional injuries (674). Nearly half (1446 [46%]) of all unintentional injuries were associated with recreational activities (Table 1). Temporal peaks in

TABLE 1. Number and annual rate* of new injury-related visits by inmates in correctional facilities†, by facility and type of injury — Michigan, April 1994–March 1995

		Unintentional Injury								Intentional Injury							
		Recreational		Occupational		Other		Total		Assault		Self-inflicted		Total		Total	
Facility	Population§	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
F	562	49	87	51	91	83	132	**183**	**326**	11	26	2	5	**13**	**23**	**196**	**349**
R	1303	213	163	32	25	61	47	**306**	**235**	41	31	6	5	**47**	**36**	**353**	**271**
Y	1311	297	227	79	60	135	103	**511**	**390**	153	117	32	24	**185**	**141**	**696**	**531**
C	1000	8	8	13	13	20	20	**41**	**41**	2	2	0	—	**2**	**2**	**43**	**43**
U	1053	344	327	20	19	151	126	**515**	**489**	91	86	37	35	**128**	**122**	**643**	**611**
ED	6000	535	89	185	31	226	38	**946**	**158**	120	20	179	30	**299**	**50**	**1245**	**208**

* Per 1000 prisoners.
† Includes clinics of one for females (F), one regional prison for housing near families (R), one for young men (aged 15–25 years) (Y), one with a 25% prevalence of chronic disease (C), one in the upper peninsula of Michigan (U), and the emergency department (ED) of a hospital serving one large facility and facility C.
§ Average annual population.

Injury Surveillance — Continued

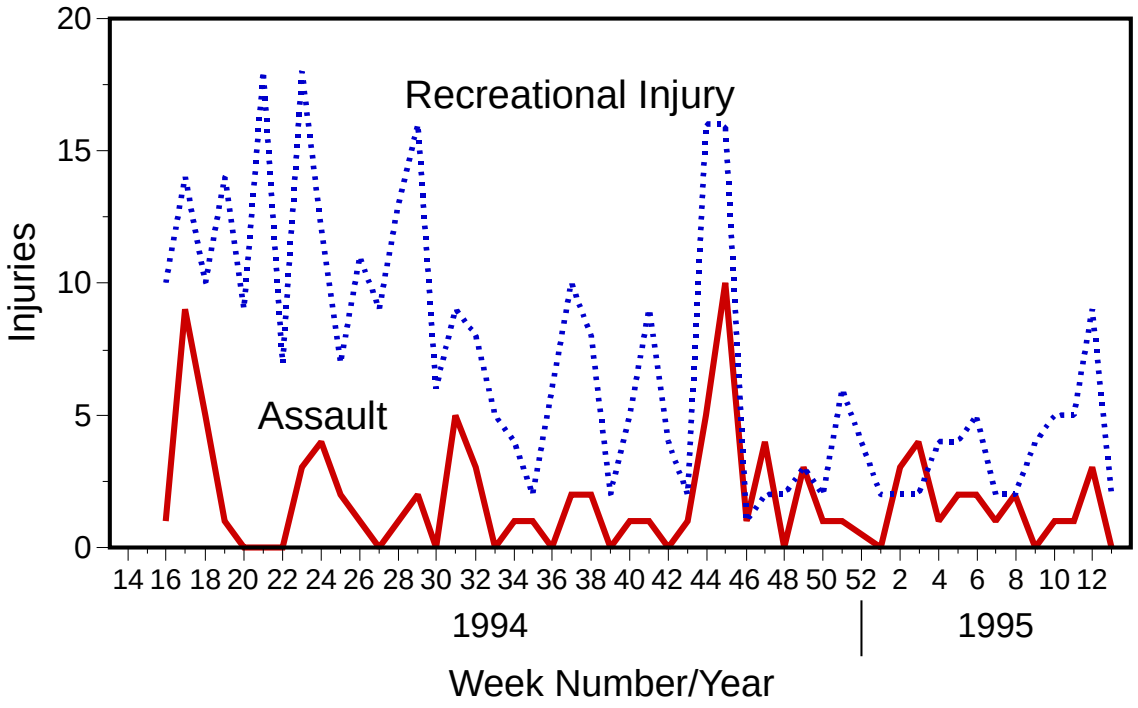
assault injuries coincided with, or were preceded by, peaks in recreational injuries (Figure 1). The high incidence of recreational and occupational injuries at two facilities (Y and F) prompted investigations by facility staff. Based on a review of 30 consecutive recreational injuries at facility Y in July 1994, participation in basketball accounted for more than one third (11) of all recreational injuries that month; other activities resulting in injuries were softball (five), weight lifting (three), volleyball (one), and soccer (one); the activities for nine were unspecified. The most serious injury, which had been sustained in the weight-training area, was a fractured humerus requiring surgery. These findings enabled the development of recommendations for improved training and supervision of prisoners during recreational activities.

Based on a review of the 25 occupational injuries reported at facility F during April–June 1994, most injuries were burns incurred by prisoners while they removed dishes from the oven in a kitchen. Following this investigation, the food-service supervisor instituted a safety training program to prevent occupational injuries in this setting, and numbers of occupational injuries decreased to 13, 10, and three during the three subsequent quarters, respectively.

Reported by: L Green, MD, C Hutchinson, MD, D Lamb, Michigan Dept of Corrections. D Johnson, MD, K Wilcox, MD, State Epidemiologist, Michigan Dept of Public Health. Div of Field Epidemiology, Epidemiology Program Office, CDC.

Editorial Note: During the first year of operation, the pilot disease and injury surveillance system in Michigan prisons suggested the occurrence of high annual rates (>500 per 1000) of new injury-related visits in some facilities. The co-incidence of peaks in assault and recreational injury suggests a possible association between recreational events and subsequent assaults, or that some prisoners reported assault as

FIGURE 1. Number of assault and recreational injury-related visits by inmates in a correctional facility, by week and year — Upper Peninsula, Michigan, April 17, 1994–March 31, 1995



Injury Surveillance — Continued

recreational injury to avoid official investigation or retribution by the perpetrator(s). Based on data from the National Hospital Ambulatory Medical Care Survey and the National Ambulatory Medical Care Survey (*2*), the total rate of injury-related visits at facilities Y and U was 1.7 and 2.4 times higher, respectively, than the estimated comparable age- and sex-specific rates of new injury-related visits to emergency departments and physicians' offices, after excluding traffic injuries. However, these higher rates may reflect differences in thresholds for seeking health care.

The findings from the pilot surveillance system in Michigan are subject to at least three limitations. First, because only injuries resulting in a health-care visit were counted, actual injury incidence was probably higher than that documented in the system. Second, because prisoners at facility C and facilities served by the ED could use other clinics, injury rates for these facilities were underestimated. Third, to ensure simplicity of this system, only counts of different types of injuries were collected without information on cause.

The injury component of the pilot surveillance system recognizes that injury control is a national priority (*3*) and responds to recommendations of the National Research Council to establish injury surveillance systems in prisons (*4*). The information obtained through surveillance in Michigan prisons was used by facility staff to undertake investigations of the high level of specific types of injury in their facilities. Although this surveillance system was not continued when the pilot was completed in March 1994, MDOC plans to reinstate surveillance when its health-care–visit logs for the system statewide are computerized in late 1996 or early 1997. To increase the effectiveness of injury-prevention efforts, more detailed information on injury severity, circumstance, and cause should be collected, particularly from high-incidence facilities; such efforts will require a team approach involving health-care and custody staff.

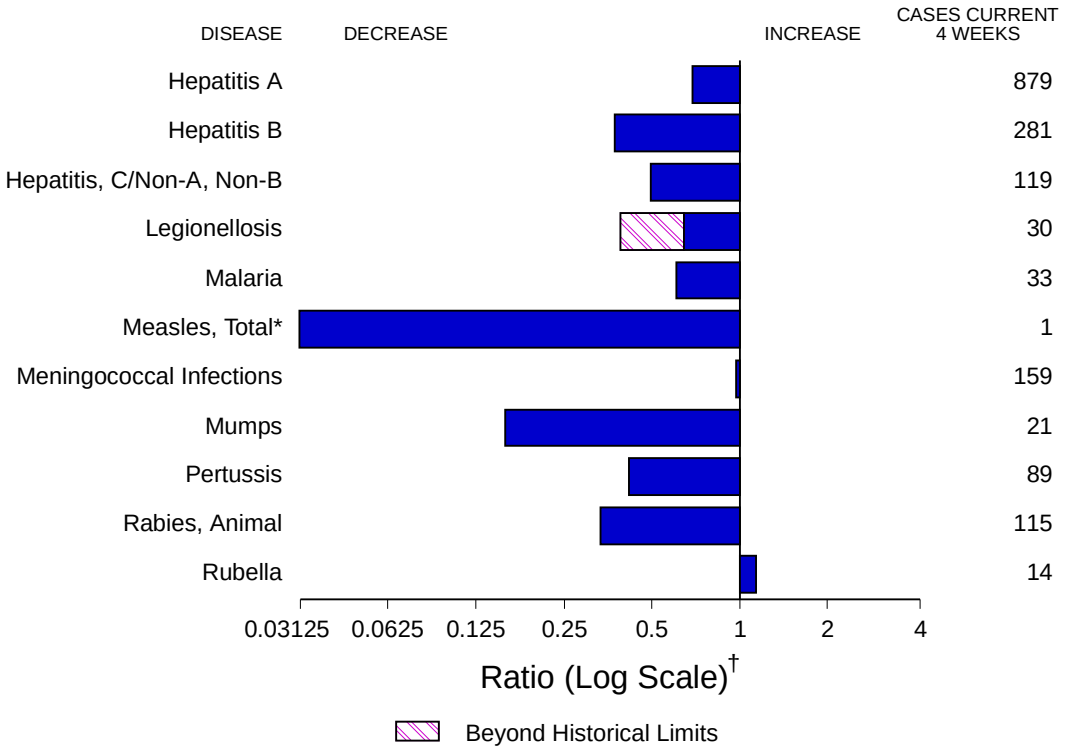
References

1. CDC. Legionnaires' disease associated with cooling towers—Massachusetts, Michigan, and Rhode Island, 1993. MMWR 1994;43:491–3,499.
2. Burt C. Injury related visits to hospital emergency departments, United States, 1992. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, CDC, NCHS, 1995. (Advance data no. 261).
3. National Committee for Injury Prevention and Control. Injury prevention: meeting the challenge. Am J Prev Med 1989;5(no. 3, suppl).
4. National Research Council. Understanding and preventing violence. Reiss A, Roth J, eds. Washington, DC: National Academy Press 1993:152–5,336.

Erratum: Volume 44, No. 23

In the article "Unexplained Illness Among Persian Gulf War Veterans in an Air National Guard Unit: Preliminary Report—August 1990–March 1995," on page 447, the telephone number for the Department of Veterans Affairs' Persian Gulf War Veterans Registry was cited incorrectly. The correct telephone number is (800) 749-8387.

FIGURE I. Selected notifiable disease reports, comparison of 4-week totals ending January 20, 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 3 measles [total] is .0076609.)
†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 January 20, 1996 (3rd Week)

	Cum. 1996		Cum. 1996
Anthrax	-	HIV infection, pediatric*§	-
Brucellosis	-	Plague	-
Cholera	-	Poliomyelitis, paralytic¶	-
Congenital rubella syndrome	-	Psittacosis	1
Cryptosporidiosis*	18	Rabies, human	-
Diphtheria	-	Rocky Mountain spotted fever (RMSF)	1
Encephalitis: California*	-	Streptococcal toxic-shock syndrome*	-
eastern equine*	-	Syphilis, congenital**	-
St. Louis*	-	Tetanus	-
western equine*	-	Toxic-shock syndrome	2
Hansen Disease	-	Trichinosis	-
Hantavirus pulmonary syndrome*†	-	Typhoid fever	1

*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).
¶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 January 20, 1996, and January 21, 1995 (3rd 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	-	3,710	3,593	18	-	11,801	20,634	84	81	29	56
NEW ENGLAND	-	284	487	5	-	296	231	-	-	2	-
Maine	-	-	-	1	-	2	3	-	-	-	-
N.H.	-	-	37	-	-	8	4	-	-	-	-
Vt.	-	-	-	-	-	9	1	-	-	-	-
Mass.	-	190	350	4	-	130	191	-	-	2	-
R.I.	-	9	100	-	-	32	30	-	-	-	-
Conn.	-	85	-	-	-	115	2	-	-	N	N
MID. ATLANTIC	-	1,358	10	1	-	645	1,850	1	14	3	5
Upstate N.Y.	-	38	N	-	-	-	33	-	4	-	-
N.Y. City	-	907	-	-	-	-	680	1	-	-	1
N.J.	-	280	10	-	-	189	194	-	7	-	2
Pa.	-	133	-	N	-	456	943	-	3	3	2
E.N. CENTRAL	-	207	1,211	1	-	2,891	5,332	12	19	11	24
Ohio	-	31	-	-	-	312	2,049	-	1	4	11
Ind.	-	33	-	1	-	499	431	-	-	3	2
Ill.	-	3	-	-	-	1,095	1,083	-	7	-	5
Mich.	-	134	1,202	-	-	964	1,324	12	11	4	1
Wis.	-	6	9	N	-	21	445	-	-	-	5
W.N. CENTRAL	-	92	482	3	-	567	1,329	-	3	-	8
Minn.	-	25	-	-	-	-	185	-	-	-	-
Iowa	-	4	-	1	-	-	85	-	1	-	2
Mo.	-	49	452	-	-	408	827	-	2	-	6
N. Dak.	-	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	30	-	-	4	1	-	-	-	-
Nebr.	-	12	-	-	-	-	25	-	-	-	-
Kans.	-	2	-	2	-	155	206	-	-	-	-
S. ATLANTIC	-	476	887	2	-	5,263	6,249	4	9	4	11
Del.	-	29	-	-	-	86	126	-	-	-	-
Md.	-	171	-	N	-	-	1,066	-	-	2	3
D.C.	-	36	N	-	-	278	428	-	-	-	-
Va.	-	108	636	N	-	590	337	-	-	-	-
W. Va.	-	4	-	N	-	33	47	3	3	1	1
N.C.	-	1	-	-	-	722	894	-	4	1	5
S.C.	-	-	-	-	-	1,406	739	1	1	-	-
Ga.	-	122	-	-	-	1,984	1,422	-	-	-	2
Fla.	-	5	251	-	-	164	1,190	-	1	-	-
E.S. CENTRAL	-	86	353	2	-	1,444	2,619	-	-	6	2
Ky.	-	2	-	-	-	221	315	-	-	2	1
Tenn.	-	34	349	N	-	440	278	-	-	2	-
Ala.	-	33	-	1	-	735	1,585	-	-	-	-
Miss.	-	17	4	1	-	48	441	-	-	2	1
W.S. CENTRAL	-	298	-	1	-	134	941	27	1	-	-
Ark.	-	20	-	1	-	14	174	-	-	-	-
La.	-	20	-	N	-	120	735	1	-	-	-
Okla.	-	35	-	-	-	-	32	26	1	-	-
Tex.	-	223	-	-	-	-	-	-	-	-	-
MOUNTAIN	-	118	163	2	-	256	438	32	8	-	2
Mont.	-	-	-	-	-	1	6	2	2	-	-
Idaho	-	5	64	1	-	5	4	6	1	-	-
Wyo.	-	1	31	-	-	4	3	8	4	-	-
Colo.	-	73	-	-	-	117	160	3	1	-	-
N. Mex.	-	7	-	-	-	51	48	9	-	-	-
Ariz.	-	2	-	N	-	52	128	1	-	-	-
Utah	-	-	68	-	-	26	4	3	-	-	-
Nev.	-	30	-	1	-	-	85	-	-	-	2
PACIFIC	-	791	-	1	-	305	1,645	8	27	3	4
Wash.	-	1	-	-	-	-	143	-	-	-	-
Oreg.	-	31	-	1	-	9	29	2	3	-	-
Calif.	-	701	-	-	-	264	1,391	5	21	3	2
Alaska	-	18	N	-	-	32	58	1	-	-	-
Hawaii	-	40	-	N	-	-	24	-	3	-	2
Guam	-	-	-	N	-	-	3	-	-	-	-
P.R.	-	62	N	N	U	5	24	2	1	-	-
V.I.	-	-	N	N	U	-	-	-	-	-	-
Amer. Samoa	-	-	-	N	U	-	1	-	-	-	-
C.N.M.I.	-	-	N	N	U	-	-	-	-	-	-

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 December 15, 1995.
†National Electronic Telecommunications System for Surveillance.
§Public Health Laboratory Information System.

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending January 20, 1996, and January 21, 1995 (3rd 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	28	167	14	40	140	145	437	804	252	528	93	260
NEW ENGLAND	5	1	2	2	12	6	8	10	8	2	20	82
Maine	-	-	-	-	3	2	-	-	-	-	-	-
N.H.	-	-	-	-	-	3	-	-	-	-	1	9
Vt.	-	-	-	-	1	-	-	-	-	-	1	7
Mass.	5	1	2	-	2	1	4	5	-	-	8	48
R.I.	-	-	-	2	-	-	-	-	4	2	2	-
Conn.	-	-	-	-	6	-	4	5	4	-	8	18
MID. ATLANTIC	16	143	-	10	1	14	9	77	16	21	15	59
Upstate N.Y.	-	8	-	-	-	4	-	-	-	1	8	35
N.Y. City	-	26	-	5	-	3	5	68	3	11	-	-
N.J.	-	32	-	5	-	4	-	-	-	-	5	15
Pa.	16	77	-	-	1	3	4	9	13	9	2	9
E.N. CENTRAL	1	3	3	12	29	30	112	117	113	52	2	1
Ohio	1	1	-	-	19	6	55	28	9	15	1	1
Ind.	-	1	-	-	2	9	22	11	2	-	-	-
Ill.	-	1	-	10	6	10	32	45	102	36	-	-
Mich.	-	-	3	1	2	3	3	15	-	-	-	-
Wis.	-	-	-	1	-	2	-	18	-	1	1	-
W.N. CENTRAL	-	4	-	-	6	6	14	37	5	14	11	14
Minn.	-	-	-	-	-	-	-	3	1	-	1	-
Iowa	-	-	-	-	2	3	-	4	3	5	10	5
Mo.	-	2	-	-	-	3	14	30	1	3	-	3
N. Dak.	-	-	-	-	-	-	-	-	-	-	-	2
S. Dak.	-	-	-	-	1	-	-	-	-	-	-	3
Nebr.	-	-	-	-	-	-	-	-	-	-	-	-
Kans.	-	2	-	-	3	-	-	-	-	6	-	1
S. ATLANTIC	5	14	5	6	27	22	102	206	20	54	40	73
Del.	-	4	2	-	-	-	2	1	-	1	1	5
Md.	5	6	2	2	3	-	-	23	-	32	5	17
D.C.	-	-	1	-	2	1	7	8	-	3	-	-
Va.	-	-	-	1	-	-	31	19	-	-	12	14
W. Va.	-	-	-	-	-	-	-	-	4	6	1	2
N.C.	-	3	-	1	2	6	34	60	11	3	8	20
S.C.	-	1	-	-	8	2	9	43	5	8	4	4
Ga.	-	-	-	1	8	5	14	27	-	1	9	8
Fla.	-	-	-	1	4	8	5	25	-	-	-	3
E.S. CENTRAL	-	-	-	-	14	3	161	204	39	33	-	11
Ky.	-	-	-	-	4	-	16	13	2	5	-	1
Tenn.	-	-	-	-	-	-	38	34	-	11	-	4
Ala.	-	-	-	-	8	2	37	39	14	17	-	6
Miss.	-	-	-	-	2	1	70	118	23	-	-	-
W.S. CENTRAL	-	-	-	-	12	6	27	91	9	-	-	4
Ark.	-	-	-	-	2	-	19	25	-	-	-	3
La.	-	-	-	-	3	1	8	60	-	-	-	1
Okla.	-	-	-	-	1	1	-	6	9	-	-	-
Tex.	-	-	-	-	6	4	-	-	-	-	-	-
MOUNTAIN	1	1	2	3	14	17	3	14	8	7	2	5
Mont.	-	-	-	-	-	-	-	-	-	-	-	3
Idaho	-	-	-	-	1	2	-	-	1	1	-	-
Wyo.	1	-	-	-	-	-	-	-	-	-	2	-
Colo.	-	-	1	1	2	5	3	7	-	-	-	-
N. Mex.	-	-	-	2	5	4	-	3	1	-	-	-
Ariz.	-	-	-	-	5	6	-	1	6	6	-	2
Utah	-	-	1	-	1	-	-	1	-	-	-	-
Nev.	-	1	-	-	-	-	-	2	-	-	-	-
PACIFIC	-	1	2	7	25	41	1	48	34	345	3	11
Wash.	-	-	-	-	-	2	-	1	10	12	-	-
Oreg.	-	-	2	1	14	4	1	1	5	2	-	-
Calif.	-	1	-	5	11	34	-	46	13	318	1	11
Alaska	-	-	-	1	-	-	-	-	6	5	2	-
Hawaii	-	-	-	-	-	1	-	-	-	8	-	-
Guam	-	-	-	-	-	-	-	-	-	4	-	-
P.R.	-	-	-	-	-	-	5	5	-	-	1	4
V.I.	-	-	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-	1	-	-
C.N.M.I.	-	-	-	-	-	-	-	-	-	-	-	-

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

TABLE III. Cases of selected notifiable diseases preventable by vaccination, United States, weeks ending January 20, 1996, and January 21, 1995 (3rd 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	32	74	619	966	166	332	-	-	-	-
NEW ENGLAND	4	1	13	8	2	10	-	-	-	-
Maine	-	-	1	2	-	1	-	-	-	-
N.H.	3	-	1	-	-	-	-	-	-	-
Vt.	-	1	-	-	-	-	-	-	-	-
Mass.	1	-	6	1	1	2	-	-	-	-
R.I.	-	-	2	2	1	1	-	-	-	-
Conn.	-	-	3	3	-	6	-	-	-	-
MID. ATLANTIC	2	8	8	46	4	29	-	-	-	-
Upstate N.Y.	1	2	-	2	-	4	-	-	-	-
N.Y. City	-	1	2	15	1	6	-	-	-	-
N.J.	-	3	-	16	-	12	-	-	-	-
Pa.	1	2	6	13	3	7	-	-	-	-
E.N. CENTRAL	8	20	75	225	26	60	-	-	-	-
Ohio	8	11	56	113	6	4	-	-	-	-
Ind.	-	1	2	17	1	11	-	-	-	-
Ill.	-	7	-	56	-	22	-	-	-	-
Mich.	-	1	17	26	19	21	-	-	-	-
Wis.	-	-	-	13	-	2	-	-	-	-
W.N. CENTRAL	1	3	28	39	8	35	-	-	-	-
Minn.	-	-	-	1	-	-	-	-	-	-
Iowa	1	1	20	3	5	4	-	-	-	-
Mo.	-	2	-	30	-	30	-	-	-	-
N. Dak.	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	4	-	-	-	-	-	-	-
Nebr.	-	-	-	1	-	1	-	-	-	-
Kans.	-	-	4	4	3	-	-	-	-	-
S. ATLANTIC	3	15	24	27	43	47	-	-	-	-
Del.	-	-	1	1	-	1	-	-	-	-
Md.	-	4	9	11	13	9	-	-	-	-
D.C.	-	-	-	-	1	5	-	-	-	-
Va.	-	-	-	4	-	5	-	-	-	-
W. Va.	-	-	1	1	3	2	-	-	-	-
N.C.	1	7	2	5	22	19	-	-	-	-
S.C.	-	-	4	1	3	1	-	-	-	-
Ga.	2	4	-	-	-	-	-	-	-	-
Fla.	-	-	7	4	1	5	-	-	-	-
E.S. CENTRAL	1	-	30	12	2	22	-	-	-	-
Ky.	-	-	2	6	-	6	-	-	-	-
Tenn.	-	-	-	-	-	11	-	-	-	-
Ala.	1	-	4	5	2	5	-	-	-	-
Miss.	-	-	24	1	-	-	-	-	-	-
W.S. CENTRAL	2	-	100	19	23	3	-	-	-	-
Ark.	-	-	17	-	1	-	-	-	-	-
La.	-	-	-	-	1	-	-	-	-	-
Okla.	2	-	74	13	21	2	-	-	-	-
Tex.	-	-	9	6	-	1	-	-	-	-
MOUNTAIN	6	5	149	158	42	22	-	-	-	-
Mont.	-	-	8	3	-	1	-	-	-	-
Idaho	1	-	25	13	3	1	-	-	-	-
Wyo.	-	-	-	3	-	-	-	-	-	-
Colo.	1	-	14	45	9	8	-	-	-	-
N. Mex.	2	2	38	46	18	8	-	-	-	-
Ariz.	1	3	1	20	1	-	-	-	-	-
Utah	-	-	46	21	5	-	-	-	-	-
Nev.	1	-	17	7	6	4	U	-	U	-
PACIFIC	5	22	192	432	16	104	-	-	-	-
Wash.	-	-	2	2	-	1	-	-	-	-
Oreg.	2	4	95	94	1	6	-	-	-	-
Calif.	3	18	95	325	15	97	U	-	U	-
Alaska	-	-	-	8	-	-	-	-	-	-
Hawaii	-	-	-	3	-	-	-	-	-	-
Guam	-	-	-	-	-	-	U	-	U	-
P.R.	-	-	2	-	8	-	-	-	-	-
V.I.	-	-	-	-	-	-	U	-	U	-
Amer. Samoa	-	-	-	-	-	-	U	-	U	-
C.N.M.I.	-	-	-	-	-	-	U	-	U	-

*Of 7 cases among children aged <5 years, serotype was reported for 4 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 January 20, 1996, and January 21, 1995 (3rd 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	-	20	2	18	36	11	29	120	-	-	4
NEW ENGLAND	-	2	-	-	-	2	3	7	-	-	-
Maine	-	-	-	-	-	-	-	5	-	-	-
N.H.	-	-	-	-	-	-	-	-	-	-	-
Vt.	-	-	-	-	-	-	1	1	-	-	-
Mass.	-	-	-	-	-	2	2	1	-	-	-
R.I.	-	2	-	-	-	-	-	-	-	-	-
Conn.	-	-	-	-	-	-	-	-	-	-	-
MID. ATLANTIC	-	-	-	-	2	-	-	3	-	-	-
Upstate N.Y.	-	-	-	-	2	-	-	1	-	-	-
N.Y. City	-	-	-	-	-	-	-	-	-	-	-
N.J.	-	-	-	-	-	-	-	2	-	-	-
Pa.	-	-	-	-	-	-	-	-	-	-	-
E.N. CENTRAL	-	-	1	9	8	3	4	12	-	-	-
Ohio	-	-	1	5	4	-	-	11	-	-	-
Ind.	-	-	-	-	-	-	-	-	-	-	-
Ill.	-	-	-	-	-	-	-	-	-	-	-
Mich.	-	-	-	4	4	3	4	-	-	-	-
Wis.	-	-	-	-	-	-	-	1	-	-	-
W.N. CENTRAL	-	-	-	-	7	-	-	7	-	-	-
Minn.	-	-	-	-	-	-	-	-	-	-	-
Iowa	-	-	-	-	1	-	-	-	-	-	-
Mo.	-	-	-	-	6	-	-	2	-	-	-
N. Dak.	-	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	-	-	-	-	-
Nebr.	-	-	-	-	-	-	-	-	-	-	-
Kans.	-	-	-	-	-	-	-	5	-	-	-
S. ATLANTIC	-	-	-	1	1	1	2	29	-	-	-
Del.	-	-	-	-	-	-	-	-	-	-	-
Md.	-	-	-	-	-	-	-	-	-	-	-
D.C.	-	-	-	-	-	-	-	-	-	-	-
Va.	-	-	-	-	1	-	-	-	-	-	-
W. Va.	-	-	-	-	-	-	-	-	-	-	-
N.C.	-	-	-	-	-	-	-	29	-	-	-
S.C.	-	-	-	1	-	-	1	-	-	-	-
Ga.	-	-	-	-	-	1	1	-	-	-	-
Fla.	-	-	-	-	-	-	-	-	-	-	-
E.S. CENTRAL	-	-	-	1	3	1	1	1	-	-	-
Ky.	-	-	-	-	-	-	-	-	-	-	-
Tenn.	-	-	-	-	-	-	-	-	-	-	-
Ala.	-	-	-	1	2	1	1	1	-	-	-
Miss.	-	-	-	-	1	-	-	-	N	N	N
W.S. CENTRAL	-	-	1	1	1	1	1	-	-	-	-
Ark.	-	-	-	-	1	1	1	-	-	-	-
La.	-	-	1	1	-	-	-	-	-	-	-
Okla.	-	-	-	-	-	-	-	-	-	-	-
Tex.	-	-	-	-	-	-	-	-	-	-	-
MOUNTAIN	-	18	-	6	2	2	8	43	-	-	-
Mont.	-	-	-	-	-	-	-	1	-	-	-
Idaho	-	-	-	-	-	-	1	17	-	-	-
Wyo.	-	-	-	-	-	-	-	-	-	-	-
Colo.	-	15	-	-	-	-	-	12	-	-	-
N. Mex.	-	3	N	N	N	2	4	2	-	-	-
Ariz.	-	-	-	-	-	-	-	11	-	-	-
Utah	-	-	-	-	1	-	-	-	-	-	-
Nev.	-	-	U	6	1	U	3	-	U	-	-
PACIFIC	-	-	-	-	12	1	10	18	-	-	4
Wash.	-	-	-	-	1	-	-	-	-	-	-
Oreg.	-	-	N	N	N	1	10	-	-	-	-
Calif.	-	-	U	-	11	U	-	17	U	-	4
Alaska	-	-	-	-	-	-	-	-	-	-	-
Hawaii	-	-	-	-	-	-	-	1	-	-	-
Guam	-	-	U	-	-	U	-	-	U	-	-
P.R.	-	-	-	-	-	-	-	-	-	-	-
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 January 20, 1996 (3rd Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	757	547	140	50	10	10	51
Boston, Mass.	219	150	43	16	3	7	11
Bridgeport, Conn.	47	36	6	4	-	1	2
Cambridge, Mass.	30	23	7	-	-	-	1
Fall River, Mass.	31	25	4	2	-	-	1
Hartford, Conn.	73	45	16	10	2	-	2
Lowell, Mass.	19	15	4	-	-	-	3
Lynn, Mass.	11	8	3	-	-	-	2
New Bedford, Mass.	31	28	2	1	-	-	2
New Haven, Conn.	59	38	12	6	3	-	2
Providence, R.I.	55	45	8	-	1	1	1
Somerville, Mass.	7	4	3	-	-	-	1
Springfield, Mass.	59	45	10	4	-	-	9
Waterbury, Conn.	36	27	8	1	-	-	5
Worcester, Mass.	80	58	14	6	1	1	9
MID. ATLANTIC	2,966	2,012	553	318	45	37	194
Albany, N.Y.	60	45	8	7	-	-	6
Allentown, Pa.	22	15	7	-	-	-	-
Buffalo, N.Y.	73	48	15	3	3	4	1
Camden, N.J.	31	19	5	4	1	2	4
Elizabeth, N.J.	21	13	4	2	-	2	2
Erie, Pa.§	41	29	7	5	-	-	1
Jersey City, N.J.	63	40	11	7	2	3	2
New York City, N.Y.	1,629	1,065	334	190	23	17	85
Newark, N.J.	84	38	19	23	4	-	4
Paterson, N.J.	32	20	4	6	1	1	3
Philadelphia, Pa.	394	267	75	46	4	2	36
Pittsburgh, Pa.§	108	80	17	6	2	2	11
Reading, Pa.	20	17	2	1	-	-	5
Rochester, N.Y.	135	104	17	7	4	3	10
Schenectady, N.Y.	29	23	5	1	-	-	1
Scranton, Pa.§	36	32	2	2	-	-	2
Syracuse, N.Y.	95	75	14	4	1	1	12
Trenton, N.J.	39	34	3	2	-	-	3
Utica, N.Y.	20	19	-	1	-	-	2
Yonkers, N.Y.	34	29	4	1	-	-	4
E.N. CENTRAL	2,359	1,621	426	192	59	61	173
Akron, Ohio	68	51	9	5	1	2	-
Canton, Ohio	48	38	6	2	-	2	8
Chicago, Ill.	444	274	93	49	16	12	42
Cincinnati, Ohio	114	79	20	9	3	3	9
Cleveland, Ohio	126	80	27	15	-	4	1
Columbus, Ohio	256	174	47	27	2	6	26
Dayton, Ohio	158	118	24	9	4	3	10
Detroit, Mich.	218	123	48	34	10	3	8
Evansville, Ind.	57	42	8	3	4	-	3
Fort Wayne, Ind.	65	54	8	1	2	-	9
Gary, Ind.	17	12	4	-	1	-	2
Grand Rapids, Mich.	70	56	9	1	-	4	9
Indianapolis, Ind.	212	147	33	17	6	9	15
Madison, Wis.	68	43	14	9	1	1	6
Milwaukee, Wis.	117	86	19	5	3	4	5
Peoria, Ill.	53	41	10	-	1	1	5
Rockford, Ill.	41	33	6	-	-	2	3
South Bend, Ind.	40	33	3	-	3	1	4
Toledo, Ohio	110	77	22	6	1	4	3
Youngstown, Ohio	77	60	16	-	1	-	5
W.N. CENTRAL	792	528	140	72	20	12	54
Des Moines, Iowa	42	27	9	4	1	1	6
Duluth, Minn.	24	17	4	2	1	-	2
Kansas City, Kans.	37	22	10	4	1	-	1
Kansas City, Mo.	150	84	25	11	6	4	10
Lincoln, Nebr.	52	32	17	3	-	-	7
Minneapolis, Minn.	140	105	19	10	5	1	16
Omaha, Nebr.	106	63	23	12	3	5	6
St. Louis, Mo.	137	97	22	17	1	-	-
St. Paul, Minn.	52	41	4	6	-	1	2
Wichita, Kans.	52	40	7	3	2	-	4
S. ATLANTIC	1,401	933	267	130	34	35	118
Atlanta, Ga.	214	134	45	23	5	7	6
Baltimore, Md.	152	98	35	14	3	2	19
Charlotte, N.C.	123	82	29	8	3	1	6
Jacksonville, Fla.	170	117	29	19	1	4	19
Miami, Fla.	90	53	18	12	3	4	2
Norfolk, Va.	65	41	9	8	2	5	7
Richmond, Va.	128	88	21	14	4	1	14
Savannah, Ga.	77	56	14	5	2	-	11
St. Petersburg, Fla.	72	57	9	2	3	1	6
Tampa, Fla.	209	153	26	17	4	7	24
Washington, D.C.	85	49	22	8	3	3	4
Wilmington, Del.	16	5	10	-	1	-	-
E.S. CENTRAL	738	509	142	51	21	14	53
Birmingham, Ala.	166	109	31	14	8	3	8
Chattanooga, Tenn.	41	30	8	2	-	1	1
Knoxville, Tenn.	76	57	13	3	1	2	7
Lexington, Ky.	110	76	22	7	4	1	7
Memphis, Tenn.	U	U	U	U	U	U	U
Mobile, Ala.	94	61	19	8	5	1	5
Montgomery, Ala.	85	65	13	4	1	2	10
Nashville, Tenn.	166	111	36	13	2	4	15
W.S. CENTRAL	1,484	984	264	145	55	35	109
Austin, Tex.	92	72	14	1	2	3	11
Baton Rouge, La.	80	52	13	14	1	-	2
Corpus Christi, Tex.	49	31	6	7	4	1	3
Dallas, Tex.	214	135	46	20	10	3	7
El Paso, Tex.	63	42	9	8	1	3	8
Ft. Worth, Tex.	121	77	24	15	3	2	8
Houston, Tex.	348	212	73	41	12	9	23
Little Rock, Ark.	85	62	11	4	6	2	9
New Orleans, La.	54	26	9	9	9	1	-
San Antonio, Tex.	170	123	27	12	4	4	20
Shreveport, La.	94	64	18	6	2	4	11
Tulsa, Okla.	114	88	14	8	1	3	7
MOUNTAIN	765	531	126	70	19	19	79
Albuquerque, N.M.	113	78	16	12	5	2	11
Colo. Springs, Colo.	55	38	10	5	-	2	7
Denver, Colo.	154	92	31	23	2	6	18
Las Vegas, Nev.	155	116	23	13	2	1	13
Ogden, Utah	21	13	3	3	1	1	3
Phoenix, Ariz.	U	U	U	U	U	U	U
Pueblo, Colo.	20	15	4	-	1	-	2
Salt Lake City, Utah	99	67	15	6	6	5	9
Tucson, Ariz.	148	112	24	8	2	2	16
PACIFIC	1,423	1,003	236	130	31	22	183
Berkeley, Calif.	19	10	6	3	-	-	4
Fresno, Calif.	146	104	24	7	5	6	19
Glendale, Calif.	U	U	U	U	U	U	U
Honolulu, Hawaii	80	53	16	5	3	3	8
Long Beach, Calif.	101	63	21	8	6	3	18
Los Angeles, Calif.	U	U	U	U	U	U	U
Pasadena, Calif.	37	28	4	4	1	-	2
Portland, Oreg.	181	139	27	11	2	2	16
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	196	143	31	19	1	1	40
San Francisco, Calif.	179	100	39	39	1	-	20
San Jose, Calif.	186	146	22	10	6	2	30
Santa Cruz, Calif.	33	25	4	4	-	-	5
Seattle, Wash.	140	104	20	12	3	1	6
Spokane, Wash.	50	33	10	2	1	4	6
Tacoma, Wash.	75	55	12	6	2	-	9
TOTAL	12,685¶	8,668	2,294	1,158	294	245	1,014

*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

The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format and on a paid subscription basis for paper copy. To receive an electronic copy on Friday of each week, 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 from CDC's file transfer protocol server at *ftp.cdc.gov*. To subscribe for paper copy, contact Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone (202) 512-1800.

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 on Friday; compiled data on a national basis are officially released to the public on the following Friday. Address inquiries about the *MMWR* Series, including material to be considered for publication, to: Editor, *MMWR* Series, Mailstop C-08, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone (404) 332-4555.

☆**U.S. Government Printing Office: 1996-733-175/27036 Region IV**