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Epidemiologic Notes and Reports

Jimson Weed Poisoning — Texas, New York, and California, 1994

Ingestion of Jimson weed (*Datura stramonium*), which contains the anticholinergics atropine and scopolamine, can cause serious illness or death. Sporadic incidents of intentional misuse have been reported throughout the United States, and clusters of poisonings have occurred among adolescents unaware of its potential adverse effects. This report describes incidents of Jimson weed poisoning that occurred in Texas, New York, and California during June–November 1994.

Texas

On June 19, 1994, the El Paso City-County Health and Environmental District was notified of two male adolescents (aged 16 and 17 years) who had died from *D. stramonium* intoxication. On June 18, the decedents and two other male adolescents had consumed tea brewed from a mixture of roots from a Jimson weed plant and alcoholic beverages, then fell asleep on the ground in the desert. Family and police found the decedents the following afternoon. The other two adolescents reported drinking only small amounts of the tea: one experienced hallucinations; the other had no signs or symptoms. Neither was treated, nor were biologic specimens collected. Screening of a toxicologic postmortem blood sample from one decedent detected atropine (55 ng/mL) and a blood alcohol concentration (BAC) of 0.03 g/dL (in Texas, intoxication is defined as a BAC $\geq$0.1 g/dL). Analysis of the tea identified atropine, ethanol, and scopolamine.

New York

On the morning of October 9, 1994, an 18-year-old man from Long Island was brought to an emergency department (ED) by his mother after she found him in his bedroom unclothed and hallucinating. Reports from friends indicated he had ingested 50 Jimson weed seeds and had used controlled substances (i.e., cocaine, "ecstacy," and marijuana) at a party the previous night. On evaluation, the patient was hallucinating and had fully dilated pupils, dry mouth, and decreased bowel sounds. He became progressively agitated and was sedated with intravenous diazepam and alprazolam.

Jimson Weed Poisoning — Continued

Hallucinations continued for 36 hours. On October 11, he was discharged for psychiatric counseling. He had a history of chronic substance abuse.

During October 8–November 15, a regional poison-control center was contacted about this case and for information about 13 other identified cases of Jimson weed intoxication. The mean age of the 14 patients was 16.8 years (range: 14–21 years), and eight were male. In the five incidents for which quantity of Jimson weed exposure was reported, ingestion ranged from 30 to 50 seeds per person. Manifestations included visual hallucinations (12 persons), mydriasis (10), tachycardia (six), dry mouth (five), agitation (four), nausea and vomiting (four), incoherence (three), disorientation (three), auditory hallucinations (two), combativeness (two), decreased bowel sounds (two), slurred speech (two), urinary retention (one), and hypertension (one). Four patients were treated and released from EDs, six were hospitalized, three were admitted to an intensive-care unit (ICU), and one refused medical care. Five of these patients were treated with activated charcoal, one was administered gastric lavage, and none received physostigmine.

California

On October 22, 1994, two male and four female adolescents (aged 15–17 years) with a history of drinking Jimson weed tea were transported to an ED. Two persons were discharged from the ED; four were admitted to the ICU because of symptoms that included headache, fatigue, disorientation, fixed or sluggish dilated pupils, tachycardia (heart rates >120 beats per minute), and hallucinations. These four patients were monitored with electrocardiograms, treated with physostigmine and activated charcoal, and discharged on October 23. The Los Angeles County Forestry Division reported that fires in the Los Angeles area may have promoted regrowth of Jimson weed in defoliated areas.

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Editorial Note: *D. stramonium* grows throughout the United States and, historically, was used by American Indians for medicinal and religious purposes. All parts of the Jimson weed plant are poisonous, containing the alkaloids atropine, hyoscyamine, and scopolamine. Jimson weed—also known as thorn apple, angel's trumpet, and Jamestown weed (because the first record of physical symptoms following ingestion occurred in Jamestown, Virginia, in 1676 [*1*])—is a member of the nightshade family. The toxicity of Jimson weed varies by year, between plants, and among different leaves on the same plant. Although all parts of the plant are toxic, the highest concentrations of anticholinergic occur in the seeds (equivalent to 0.1 mg of atropine per seed). The estimated lethal doses of atropine and scopolamine in adults are ≥10 mg and >2–4 mg, respectively (*1,2*).

Symptoms of Jimson weed toxicity usually occur within 30–60 minutes after ingestion and may continue for 24–48 hours because the alkaloids delay gastrointestinal motility. Ingestion of Jimson weed manifests as classic atropine poisoning. Initial

Jimson Weed Poisoning — Continued

manifestations include dry mucous membranes, thirst, difficulty swallowing and speaking, blurred vision, and photophobia, and may be followed by hyperthermia, confusion, agitation, combative behavior, hallucinations typically involving insects, urinary retention, seizures, and coma (*3*). Treatment consists of supportive care, gastrointestinal decontamination (i.e., emesis and/or activated charcoal), and physostigmine in severe cases (*4*).

In 1993, a total of 94,725 poisonings associated with toxic plants was reported in the United States (Table 1). Although most cases of Jimson weed poisoning in the United States occur sporadically, increased incidence or clustering of cases may follow press and broadcast reports that heighten interest in—but do not emphasize the adverse effects of— Jimson weed ingestion. In 1993, the American Association of Poison Control Centers Toxic Exposure Surveillance System received 318 reports of Jimson weed exposure. Although the total number of reported exposures to Jimson weed did not rank among the 20 most frequently reported exposures to poisonous plants (Table 1) (*5*), telephone calls to poison-control centers about Jimson weed poisoning are more likely than those about other hallucinogens to prompt a need for medical care (*6*). Poisoning associated with Jimson weed can be prevented through education of health-care providers and by press and broadcast reports to the public that emphasize the health hazards of Jimson weed ingestion, but that reduce access to the plant by omitting detailed descriptions and drawings and photographs.

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TABLE 1. Twenty most frequently reported plants associated with human poisonings, by plant and number of reported exposures — United States, 1993

Plant (Botanical name)	No. reported exposures
Philodendron (*Philodendron* sp.)	4726
Pepper (*Capsicum annuum*)	3912
Dumb cane (*Dieffenbachia* sp.)	2837
Poinsettia (*Euphorbia putcherrima*)	2798
Holly (*Liex* sp.)	2651
Pokeweed/Inkberry (*Phytolacoa Americana*)	2231
Peace lilly (*Spathiphyllum* sp.)	2086
Jade plant (*Crassula* sp.)	1658
Pothos/Devil's ivy (*Epipremnum aureum*)	1401
Poison ivy (*Toxicodendron/Rhus radicans*)	1308
Umbrella tree (*Brassaia actinophylia*)	1141
African violet (*Saintpaulia ionantha*)	1137
Rhododendron/Azalea (*Rhododendron* sp.)	1029
Yew (*Taxus* sp.)	969
Eucalyptus (*Eucalyptus globulua*)	945
Pyracantha (*Pyracantha* sp.)	894
Spider plant (*Chlorophytum comosum*)	787
Christmas cactus (*Schlumbergera bridgesii*)	781
English ivy (*Hedera helix*)	765
Climbing nightshade (*Solanum dulcamara*)	754

Source: American Association of Poison Control Centers Toxic Exposure Surveillance System.

Jimson Weed Poisoning — Continued

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Epidemiologic Notes and Reports

Lead Poisoning Among Sandblasting Workers — Galveston, Texas, March 1994

In the United States, an estimated 95% of elevated blood lead levels (BLLs) in adults are attributable to occupational exposure (*1*). This report summarizes the findings of an investigation by the Galveston County (Texas) Health District (GCHD) of occupational lead poisoning associated with sandblasting during February–March 1994.

On April 26, 1994, GCHD was notified by an emergency department physician of a 32-year-old man with a BLL of 111 μg/dL. On April 8, the patient had presented to the emergency department with onset of symptoms on March 15 including abdominal pain, vomiting, weight loss, constipation, headache, memory loss, tinnitus, metallic taste in mouth, stuttering, arthralgias, and discoloration of the gums. Acute lead poisoning was suspected, and a blood sample was obtained. The patient reported that, during February 15–March 30, he and seven other workers had sandblasted interior surfaces of a 100-year-old, five-story building in Galveston and that large quantities of dust had been created during the sandblasting process.

Follow-up investigation by GCHD revealed that when one of the other workers—a 39-year-old man—had developed similar symptoms and was hospitalized on March 28, his BLL was 245 μg/dL. Although this elevated result was recorded in his chart, lead poisoning was not diagnosed or treated, and his blood lead results were not reported to the Texas Department of Health (TDH) as required by Texas law.* The other six workers were located and evaluated during late April and early May. One of these workers (a 39-year-old man) had worked at the site for only 1 week; his BLL was 15 μg/dL. BLLs for the other five workers (age range: 34–43 years) ranged from 47 to 92 μg/dL.† Only one worker (BLL of 83 μg/dL) reported a previous occupational history with potential for lead exposure; he had worked as a boilermaker for 17 years. All eight workers were referred for further evaluation and treatment.

Lead content in paint and sandblasting residue collected from the worksite on May 4 was 1900 μg/g and 25,000 μg/g, respectively; content in dust obtained from wipe samples of the floor and the interior surface of a window pane was 75,000 and 145,000 μg/ft^2, respectively.§

*Texas Health and Safety Code, chapter 84, section 99.1, 1985, mandates that BLLs ≥40 μg/dL in adults be reported to TDH.

†These workers were not tested until 5–6 weeks after their exposure ended.

§For comparison, U.S. Environmental Protection Agency-recommended acceptable levels after residential lead abatement are 100 μg/ft^2 for uncarpeted floors and 500 μg/ft^2 for window sills (*2*). The extremely high levels measured in these wipe samples represent an occupational hazard and also pose a potential environmental exposure hazard.

Lead Poisoning Among Sandblasting Workers — Continued

GCHD notified TDH and the Occupational Safety and Health Administration (OSHA) about these exposures. OSHA subsequently issued citations for violation of regulations at the worksite and levied fines on both the contractor and the building owner. In particular, employer-initiated monitoring of the worksite for airborne lead had not been conducted as required by law (*3*). Instead, workers had been instructed by the employer to keep the windows closed and had not been provided with adequate training; respirators or other protective equipment; or proper facilities for washing, changing clothes, and eating. The employer denied responsibility for the workplace hazards and refused to provide any medical or disability benefits for the exposed workers. The Texas Workers' Compensation Commission also conducted an investigation that culminated in the disbursement of benefits to the workers.

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Editorial Note: The incident described in this report underscores the continuing risks for adult lead poisoning in the United States, particularly among workers in construction trades (*4*). In addition, the findings of the GCHD investigation indicate the need for increased education of employers, employees, and health-care providers regarding lead exposure and poisoning. In this incident, the employer was unaware of, or disregarded, the hazard associated with sandblasting older buildings that are likely to have surfaces coated with lead-containing paint; the employees also may not have recognized the immediate potential for workplace-related lead exposure. Finally, although this problem was eventually recognized by a health-care provider who then notified local health authorities, the opportunity for earlier intervention was missed because of delays in identification of lead toxicity and reporting of elevated BLLs.

One of the national health objectives for the year 2000 is to eliminate occupational exposures that result in BLLs >25 μg/dL (objective 10.8) (*5*). The prevention of occupational lead poisoning requires increased awareness by both employers and employees of the sources of lead exposure in the workplace and the methods for reducing worker exposure and requires an increased level of suspicion and compliance with reporting requirements by health-care providers.

References

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Current Trends

Ectopic Pregnancy — United States, 1990–1992

Ectopic pregnancy is the leading cause of pregnancy-related death during the first trimester (*1*). Women who have one ectopic pregnancy are at increased risk for another such pregnancy and for future infertility (*2*). In the United States, the reported number of hospitalizations for ectopic pregnancy increased from 17,800 in 1970 to 88,400 in 1989 (*1*). This report summarizes trends in hospitalizations for ectopic pregnancy in the United States during 1990–1992 and presents the incidence of ectopic pregnancy in 1992, based on aggregated inpatient and outpatient data.

Data about hospitalizations for ectopic pregnancy were obtained from CDC's National Hospital Discharge Survey (NHDS), a national probability sample of inpatient admissions to noninstitutional general and short-stay hospitals (excluding federal, military, and Veterans Administration hospitals). Data for outpatient diagnosis and treatment of ectopic pregnancy were obtained from CDC's National Hospital Ambulatory Medical Care Survey (NHAMCS), a national probability sample of visits to the emergency and outpatient departments of hospitals with the same characteristics as those sampled in NHDS. Because the actual numbers of ectopic pregnancy in NHAMCS were insufficient to provide a reliable point estimate, data from NHAMCS and NHDS were combined to create an aggregate estimate of ectopic pregnancies treated in both inpatient and outpatient settings in 1992. Data for women treated as outpatients who were subsequently admitted to the hospital were excluded from the combined estimate to avoid double counting. Data were weighted to represent the U.S. civilian, noninstitutionalized population, and 95% confidence intervals (CIs) were calculated using standard errors generated by SUDAAN.

Based on NHDS, the estimated number of hospitalizations for ectopic pregnancy in 1990 was 64,400 (95% CI=54,100–74,800) (rate: 11.4 per 1000 reported pregnancies [i.e., ectopic, legal abortions, and live births]); in 1991, 55,600 (95% CI=45,800–65,500) (rate: 10.0); and in 1992, 58,200 (95% CI=48,600–67,700) (rate: 10.6) (Figure 1).

Based on aggregated data from NHDS and NHAMCS, the estimated total number of ectopic pregnancies in 1992 was 108,800 (95% CI=83,600–134,000) (rate: 19.7 per 1000 reported pregnancies) (Figure 1).

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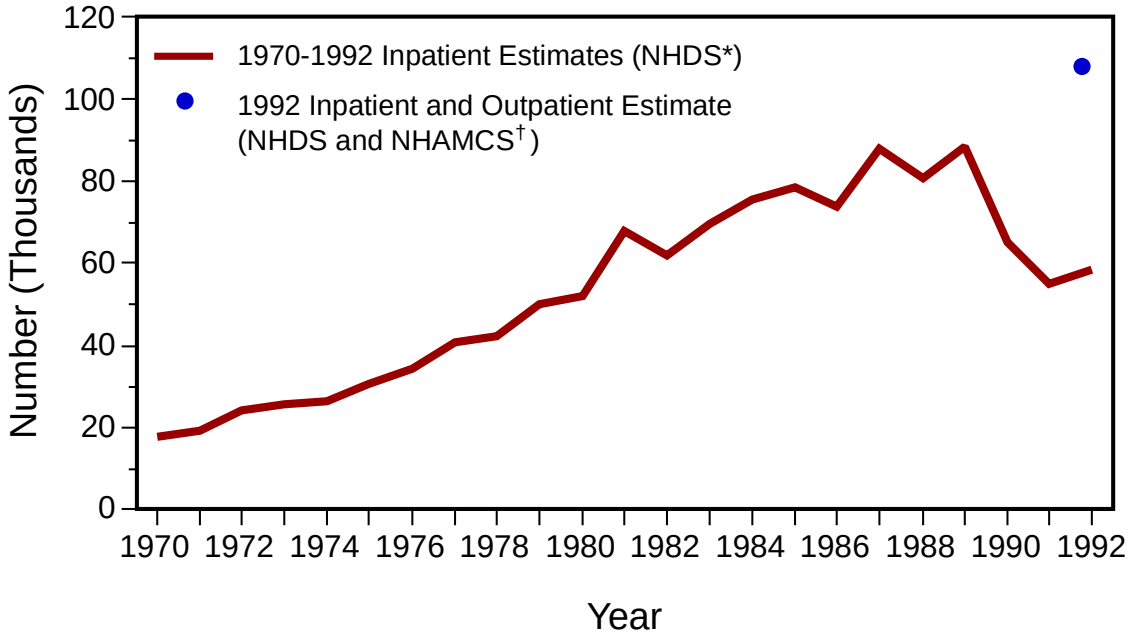
Editorial Note: In 1992, ectopic pregnancies accounted for approximately 2% of reported pregnancies, and ectopic pregnancy-related deaths accounted for 9% of all pregnancy-related deaths (*3*). The findings in this report indicate that, for 1992, the estimated total number of ectopic pregnancies, based on aggregated NHDS and NHAMCS data, was 47% higher than that based on hospitalizations only. Analysis of the estimated number of ectopic pregnancies, based only on hospitalizations, indicates a decline since the late 1980s. This decline may reflect the shift toward treating ectopic pregnancy in an outpatient setting. This hypothesis is supported by the estimated total number of ectopic pregnancies, which suggests that incidence—instead of declining in the late 1980s—may have increased steadily since 1970 (Figure 1). The

Ectopic Pregnancy — Continued

FIGURE 1. Number of ectopic pregnancies — United States, 1970–1992



*National Hospital Discharge Survey.
†National Hospital Ambulatory Medical Care Survey.

increased occurrence of ectopic pregnancy in the United States is consistent with the trend in increased prevalence of important risk factors for ectopic pregnancy, including chlamydia and other sexually transmitted infections (*4*), induction of ovulation, and tubal sterilization (*5*).

This report is the first to document the incidence of ectopic pregnancy by including information about patients managed and treated on an outpatient basis. Although the addition of the outpatient reports has substantially improved the accuracy of this estimate for 1992, the NHAMCS database does not include patients examined and treated exclusively in physician offices. Therefore, the estimates in this report may underestimate the true incidence of ectopic pregnancy in the United States in 1992.

Outpatient management of ectopic pregnancy—which was first reported in 1987 (*6*)—is believed to have increased in association with the early detection of unruptured ectopic pregnancies as the result of sensitive radioimmunoassays for human chorionic gonadotropin and high-resolution transvaginal ultrasound (*7,8*). Outpatient treatment may include laparoscopic salpingectomy or salpingostomy, or methotrexate therapy. In particular, outpatient pharmacologic treatment of ectopic pregnancy with methotrexate has resulted in decreased patient morbidity, a preservation of reproductive capability, and—when compared with inpatient surgical treatment—an estimated cost savings of $10,000 per case (*9,10*).

Approximately half of all ectopic pregnancies reported in 1992 involved hospitalization. However, it is unknown whether these women required hospitalization because of more severe disease or because their providers preferred inpatient management. In the inpatient setting, management of ectopic pregnancy has deemphasized more

Ectopic Pregnancy — Continued

invasive procedures (e.g., laparotomy with salpingectomy) and instead emphasized more conservative procedures, such as laparoscopy with salpingostomy (*8*).

The findings in this report underscore that surveillance and other efforts to monitor national trends in ectopic pregnancy must include women who are treated or managed in both inpatient and outpatient settings. Despite substantial improvements in diagnosis and treatment of ectopic pregnancy, strategies to prevent this condition are needed. Other priorities include increased characterization of risk factors and etiology, and development and implementation of effective interventions.

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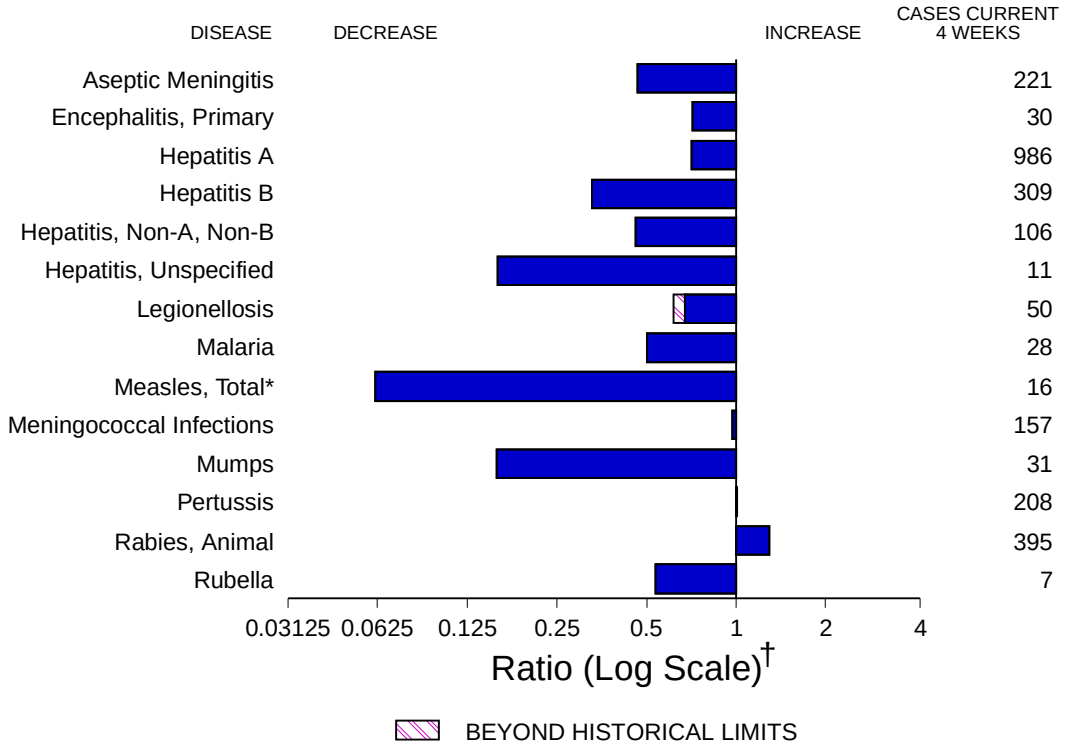
There is a registration fee. Registration materials and other information are available from HIV infection in Women Conference, Conference Secretariat, P.O. Box 7210, McLean, VA 22106-7270; telephone (703) 356-8376; fax (703) 790-7237.

FIGURE I. Notifiable disease reports, comparison of 4-week totals ending January 21, 1995, with historical data — United States



*The large apparent decrease in the number of reported cases of measles (total), reflect dramatic fluctuations in the historical baseline. (Ratio (log scale) for week 3 measles (total) is 0.06116).
†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 January 21, 1995 (3rd Week)

	Cum. 1995		Cum. 1995
Anthrax	-	Plague	-
Aseptic Meningitis	140	Poliomyelitis, Paralytic	-
Brucellosis	6	Psittacosis	1
Cholera	-	Rabies, human	-
Congenital rubella syndrome	-	Rocky Mountain Spotted Fever	4
Diphtheria	-	Syphilis, congenital, age < 1 year†	-
Encephalitis, primary	13	Tetanus	1
Encephalitis, post-infectious	1	Toxic shock syndrome	5
*Haemophilus influenzae**	*68*	*Trichinosis*	-
Hansen Disease	3	Tularemia	1
Hepatitis, unspecified	3	Typhoid fever	14
Leptospirosis	2		

*Of 66 cases of known age, 15 (23%) were reported among children less than 5 years of age.
†Updated quarterly from reports to the Division of STD & 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 January 21, 1995, and January 22, 1994 (3rd 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	-	16,900	21,381	740	974	194	536	70	224	34	84
NEW ENGLAND	-	226	454	9	16	3	18	-	9	-	1
Maine	-	3	3	2	-	1	-	-	-	-	-
N.H.	-	1	-	-	-	-	1	-	1	-	-
Vt.	-	1	1	-	-	-	-	-	-	-	-
Mass.	-	191	169	2	10	1	12	-	3	-	-
R.I.	-	30	23	2	6	1	2	-	5	-	1
Conn.	-	-	258	3	-	-	3	-	-	-	-
MID. ATLANTIC	-	1,001	1,729	15	63	6	66	9	17	1	6
Upstate N.Y.	-	32	-	1	5	3	3	6	3	-	-
N.Y. City	-	-	1,189	5	32	1	20	-	-	-	-
N.J.	-	26	27	-	15	-	26	-	9	-	2
Pa.	-	943	513	9	11	2	17	3	5	1	4
E.N. CENTRAL	-	4,763	4,415	152	123	31	98	11	31	12	39
Ohio	-	2,049	1,597	114	23	4	11	1	-	11	15
Ind.	-	218	510	13	26	7	19	1	1	1	12
Ill.	-	1,083	864	-	50	-	22	-	4	-	4
Mich.	-	1,324	1,025	25	12	20	26	9	26	-	7
Wis.	-	89	419	-	12	-	20	-	-	-	1
W.N. CENTRAL	-	1,060	999	14	53	5	29	1	-	4	6
Minn.	-	185	148	1	1	-	-	-	-	-	-
Iowa	-	85	34	3	1	3	2	1	-	2	4
Mo.	-	583	608	6	37	2	25	-	-	2	-
N. Dak.	-	-	1	-	-	-	-	-	-	-	-
S. Dak.	-	1	3	-	-	-	-	-	-	-	-
Nebr.	-	-	7	-	12	-	-	-	-	-	1
Kans.	-	206	198	4	2	-	2	-	-	-	1
S. ATLANTIC	-	5,758	5,799	29	29	45	95	16	30	8	6
Del.	-	126	74	1	1	1	2	-	-	-	-
Md.	-	1,061	1,094	11	11	5	16	1	3	1	2
D.C.	-	385	408	-	3	5	3	-	-	-	-
Va.	-	337	907	4	1	4	-	-	-	-	2
W. Va.	-	53	27	1	1	2	1	3	1	1	-
N.C.	-	894	1,455	5	3	19	33	4	8	5	1
S.C.	-	380	736	1	3	4	-	5	-	-	1
Ga.	-	1,332	-	-	1	-	33	-	16	1	-
Fla.	-	1,190	1,098	6	5	5	7	3	2	-	-
E.S. CENTRAL	-	2,397	2,818	16	112	20	90	-	79	1	19
Ky.	-	215	204	6	20	3	13	-	3	-	-
Tenn.	-	-	632	4	8	12	69	-	76	-	2
Ala.	-	1,741	1,368	5	5	5	8	-	-	-	-
Miss.	-	441	614	1	79	-	-	-	-	1	17
W.S. CENTRAL	-	735	2,291	15	14	7	19	8	10	-	1
Ark.	-	-	220	-	1	-	-	-	-	-	-
La.	-	735	1,023	-	-	-	-	-	-	-	-
Okla.	-	-	178	9	7	6	18	8	10	-	1
Tex.	-	-	870	6	6	1	1	-	-	-	-
MOUNTAIN	-	398	414	172	176	18	29	4	22	2	4
Mont.	-	-	20	2	-	1	1	2	-	-	1
Idaho	-	4	4	18	17	1	3	1	5	-	-
Wyo.	-	3	2	-	-	-	1	-	2	-	-
Colo.	-	157	202	48	14	6	5	1	8	-	1
N. Mex.	-	35	64	45	55	6	11	-	3	-	1
Ariz.	-	128	25	20	83	-	4	-	-	-	-
Utah	-	1	22	32	5	-	2	-	2	-	-
Nev.	-	70	75	7	2	4	2	-	2	2	1
PACIFIC	-	562	2,462	318	388	59	92	21	26	6	2
Wash.	-	-	178	2	27	1	4	-	1	-	1
Oreg.	-	-	81	74	21	6	2	3	-	-	-
Calif.	-	487	2,110	238	329	52	81	15	23	4	1
Alaska	-	54	41	1	8	-	-	-	-	-	-
Hawaii	-	21	52	3	3	-	5	3	2	2	-
Guam	-	-	7	-	-	-	-	-	-	-	-
P.R.	-	24	27	-	-	-	-	-	-	-	-
V.I.	-	-	3	-	-	-	1	-	-	-	-
Amer. Samoa	-	1	2	-	2	-	-	-	-	-	-
C.N.M.I.	-	-	4	-	-	-	-	-	-	-	-

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

*Updated monthly to the Division of HIV/AIDS, National Center for Infectious Diseases.

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending January 21, 1995, and January 22, 1994 (3rd Week)

Reporting Area	Lyme		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	97	152	13	33	2	6	-	-	6	4	122	209	26	59
NEW ENGLAND	4	10	3	4	-	2	-	-	2	1	9	11	-	1
Maine	-	-	-	1	-	-	-	-	-	-	2	3	-	-
N.H.	-	1	-	-	-	-	-	-	-	-	2	1	-	1
Vt.	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mass.	4	-	1	-	-	-	-	-	-	1	5	3	-	-
R.I.	-	3	2	3	-	2	-	-	2	-	-	-	-	-
Conn.	-	6	-	-	-	-	-	-	-	-	-	4	-	-
MID. ATLANTIC	78	123	-	5	-	-	-	-	-	2	5	13	3	4
Upstate N.Y.	8	93	-	1	-	-	-	-	-	-	4	2	2	-
N.Y. City	-	8	-	1	-	-	-	-	-	-	-	-	-	-
N.J.	-	18	-	2	U	-	U	-	-	2	-	5	-	-
Pa.	70	4	-	1	-	-	-	-	-	-	1	6	1	4
E.N. CENTRAL	3	-	1	6	-	-	-	-	-	-	25	41	8	15
Ohio	3	-	-	1	-	-	-	-	-	-	6	5	4	-
Ind.	-	-	-	-	-	-	-	-	-	-	9	8	-	-
Ill.	-	-	-	4	-	-	-	-	-	-	8	14	-	11
Mich.	-	-	1	1	-	-	-	-	-	-	2	7	4	4
Wis.	-	-	-	-	-	-	-	-	-	-	-	7	-	-
W.N. CENTRAL	2	2	-	1	-	-	-	-	-	-	4	13	2	3
Minn.	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Iowa	-	-	-	1	-	-	-	-	-	-	3	-	1	-
Mo.	-	1	-	-	-	-	-	-	-	-	1	9	1	3
N. Dak.	-	-	-	-	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	-	-	-	-	-	1	-	-
Nebr.	-	-	-	-	-	-	-	-	-	-	-	1	-	-
Kans.	2	1	-	-	-	-	-	-	-	-	-	2	-	-
S. ATLANTIC	6	6	3	6	-	-	-	-	-	-	27	30	1	10
Del.	-	2	-	-	-	-	-	-	-	-	-	-	-	-
Md.	2	-	-	2	-	-	-	-	-	-	-	2	-	-
D.C.	-	-	-	1	-	-	-	-	-	-	1	1	-	-
Va.	-	-	-	2	-	-	-	-	-	-	-	3	1	-
W. Va.	-	-	-	-	-	-	-	-	-	-	-	1	-	-
N.C.	3	4	1	1	-	-	-	-	-	-	6	5	-	8
S.C.	1	-	-	-	-	-	-	-	-	-	2	-	-	1
Ga.	-	-	1	-	-	-	-	-	-	-	5	8	-	-
Fla.	-	-	1	-	-	-	-	-	-	-	13	10	-	1
E.S. CENTRAL	-	4	-	2	-	-	-	-	-	-	3	53	2	9
Ky.	-	4	-	-	-	-	-	-	-	-	1	4	-	-
Tenn.	-	-	-	1	-	-	-	-	-	-	-	2	-	-
Ala.	-	-	-	-	-	-	-	-	-	-	2	10	2	-
Miss.	-	-	-	1	-	-	-	-	-	-	-	37	-	9
W.S. CENTRAL	-	-	-	-	1	1	-	-	1	1	7	2	-	7
Ark.	-	-	-	-	-	-	-	-	-	-	-	1	-	-
La.	-	-	-	-	-	-	-	-	-	-	1	-	-	-
Okla.	-	-	-	-	-	-	-	-	-	-	1	1	-	3
Tex.	-	-	-	-	1	1	-	-	1	1	5	-	-	4
MOUNTAIN	2	3	1	1	1	3	-	-	3	-	17	14	2	-
Mont.	-	-	-	-	-	-	-	-	-	-	-	1	-	-
Idaho	-	-	-	-	-	-	-	-	-	-	1	1	-	-
Wyo.	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Colo.	1	-	1	-	-	-	-	-	-	-	5	2	-	-
N. Mex.	-	3	-	-	1	3	-	-	3	-	5	1	N	N
Ariz.	-	-	-	-	-	-	-	-	-	-	6	5	-	-
Utah	-	-	-	1	-	-	-	-	-	-	-	2	1	-
Nev.	1	-	-	-	-	-	-	-	-	-	-	2	1	-
PACIFIC	2	4	5	8	-	-	-	-	-	-	25	32	8	10
Wash.	-	-	-	-	-	-	-	-	-	-	2	2	1	1
Oreg.	-	-	1	-	-	-	-	-	-	-	4	3	N	N
Calif.	2	4	3	4	-	-	-	-	-	-	18	27	7	7
Alaska	-	-	1	-	-	-	-	-	-	-	-	-	-	2
Hawaii	-	-	-	4	-	-	-	-	-	-	1	-	-	-
Guam	-	-	-	-	U	-	U	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	-	-	-	-	-	-	-	-
V.I.	-	-	-	-	U	-	U	-	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-	-	-	-	-	-
C.N.M.I.	-	-	-	1	U	-	U	-	-	9	-	-	-	-

*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 January 21, 1995, and January 22, 1994 (3rd 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	38	116	202	6	6	2	624	1,076	410	1,074	260	239
NEW ENGLAND	2	8	8	-	-	-	10	12	2	7	83	74
Maine	1	5	-	-	-	-	-	-	-	-	-	-
N.H.	-	-	3	-	-	-	-	-	-	-	9	7
Vt.	-	1	3	-	-	-	-	-	-	-	7	6
Mass.	1	2	-	-	-	-	5	3	-	-	48	34
R.I.	-	-	-	-	-	-	-	-	2	-	-	1
Conn.	-	-	2	-	-	-	5	9	-	7	19	26
MID. ATLANTIC	2	13	43	-	-	1	77	67	31	43	76	69
Upstate N.Y.	1	1	5	-	-	1	-	-	-	7	54	40
N.Y. City	-	-	-	-	-	-	68	56	22	34	-	-
N.J.	U	-	2	U	-	-	-	1	-	-	12	15
Pa.	1	12	36	-	-	-	9	10	9	2	10	14
E.N. CENTRAL	6	15	60	-	-	-	97	94	54	51	1	3
Ohio	6	11	17	-	-	-	28	18	16	8	1	-
Ind.	-	-	-	-	-	-	6	13	1	1	-	-
Ill.	-	-	22	-	-	-	45	32	36	41	-	-
Mich.	-	4	5	-	-	-	15	10	-	-	-	1
Wis.	-	-	16	-	-	-	3	21	1	1	-	2
W.N. CENTRAL	2	6	8	-	-	-	29	69	14	2	8	7
Minn.	-	-	-	-	-	-	3	4	-	-	-	-
Iowa	-	-	-	-	-	-	4	2	5	-	5	4
Mo.	-	1	3	-	-	-	22	63	3	-	2	-
N. Dak.	-	-	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	-	-	-	-	-	-
Nebr.	-	-	-	-	-	-	-	-	-	-	-	-
Kans.	2	5	5	-	-	-	-	-	6	2	1	3
S. ATLANTIC	9	30	24	-	-	-	171	294	49	59	68	53
Del.	-	-	-	-	-	-	1	-	-	1	2	1
Md.	-	-	5	-	-	-	13	6	30	17	17	7
D.C.	-	-	-	-	-	-	8	8	3	7	-	-
Va.	-	-	2	-	-	-	19	40	-	-	14	18
W. Va.	-	-	1	-	-	-	-	-	6	-	2	2
N.C.	8	29	12	-	-	-	60	111	3	-	20	6
S.C.	-	-	4	-	-	-	21	38	6	21	2	3
Ga.	1	1	-	-	-	-	22	52	1	13	8	16
Fla.	-	-	-	-	-	-	27	39	-	-	3	-
E.S. CENTRAL	-	1	11	-	-	-	172	249	24	287	14	5
Ky.	-	-	1	-	-	-	11	9	4	-	-	-
Tenn.	-	-	1	-	-	-	-	63	-	4	8	-
Ala.	-	1	2	-	-	-	43	57	17	24	6	5
Miss.	-	-	7	-	-	-	118	120	3	259	-	-
W.S. CENTRAL	-	-	11	6	6	-	60	218	1	-	1	2
Ark.	-	-	-	-	-	-	-	28	-	-	-	1
La.	-	-	-	-	-	-	60	113	-	-	1	-
Okla.	-	-	11	-	-	-	-	11	1	-	-	1
Tex.	-	-	-	6	6	-	-	66	-	-	-	-
MOUNTAIN	13	31	5	-	-	-	8	16	7	28	5	5
Mont.	1	1	-	-	-	-	-	-	-	-	3	-
Idaho	10	13	-	-	-	-	-	-	1	1	-	-
Wyo.	-	-	-	-	-	-	-	-	-	-	-	-
Colo.	-	-	2	-	-	-	7	8	-	-	-	-
N. Mex.	2	2	1	-	-	-	-	-	-	4	-	-
Ariz.	-	15	2	-	-	-	1	3	6	17	2	5
Utah	-	-	-	-	-	-	-	2	-	-	-	-
Nev.	-	-	-	-	-	-	-	3	-	6	-	-
PACIFIC	4	12	32	-	-	1	-	57	228	597	4	21
Wash.	-	-	5	-	-	-	-	1	12	6	-	-
Oreg.	-	-	3	-	-	-	-	-	-	6	-	-
Calif.	3	11	23	-	-	1	-	56	208	573	4	17
Alaska	-	-	-	-	-	-	-	-	-	4	-	4
Hawaii	1	1	1	-	-	-	-	-	8	8	-	-
Guam	U	-	-	U	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	5	13	-	-	4	-
V.I.	U	-	-	U	-	-	-	1	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	1	-	-	-
C.N.M.I.	U	-	-	U	-	-	-	-	-	6	-	-

U: Unavailable -: no reported cases

TABLE III. Deaths in 121 U.S. cities,* week ending January 21, 1995 (3rd Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	647	474	106	49	8	10	59
Boston, Mass.	144	101	22	15	2	4	11
Bridgeport, Conn.	32	22	4	5	-	1	2
Cambridge, Mass.	27	21	3	3	-	-	2
Fall River, Mass.	22	16	4	2	-	-	-
Hartford, Conn.	64	48	11	4	1	-	-
Lowell, Mass.	33	23	7	3	-	-	7
Lynn, Mass.	19	17	1	-	1	-	3
New Bedford, Mass.	32	25	4	3	-	-	1
New Haven, Conn.	47	32	9	2	2	2	4
Providence, R.I.	47	36	9	2	-	-	6
Somerville, Mass.	6	4	1	1	-	-	-
Springfield, Mass.	63	44	13	3	2	1	9
Waterbury, Conn.	30	22	6	1	-	1	2
Worcester, Mass.	81	63	12	5	-	1	12
MID. ATLANTIC	2,979	2,004	547	323	56	49	185
Albany, N.Y.	60	46	8	1	-	5	3
Allentown, Pa.	30	24	4	1	1	-	1
Buffalo, N.Y.	113	88	19	5	1	-	10
Camden, N.J.	24	14	5	3	-	2	3
Elizabeth, N.J.	24	19	2	3	-	-	3
Erie, Pa.§	35	27	6	-	-	2	1
Jersey City, N.J.	65	40	11	11	1	2	-
New York City, N.Y.	1,611	1,069	298	194	28	22	81
Newark, N.J.	100	45	30	16	6	3	13
Paterson, N.J.	52	33	9	6	3	1	4
Philadelphia, Pa.	399	250	81	52	10	6	26
Pittsburgh, Pa.§	80	58	12	6	4	-	5
Reading, Pa.	24	20	3	1	-	-	9
Rochester, N.Y.	131	98	23	9	-	1	13
Schenectady, N.Y.	25	20	3	1	1	-	-
Scranton, Pa.§	22	16	3	2	1	-	1
Syracuse, N.Y.	100	73	18	5	-	4	6
Trenton, N.J.	39	29	5	4	-	1	4
Utica, N.Y.	16	13	3	-	-	-	-
Yonkers, N.Y.	29	22	4	3	-	-	2
E.N. CENTRAL	2,371	1,583	435	193	95	65	141
Akron, Ohio	64	43	15	3	1	2	4
Canton, Ohio	42	33	6	2	-	1	3
Chicago, Ill.	439	184	98	79	63	15	12
Cincinnati, Ohio	184	145	27	7	1	4	17
Cleveland, Ohio	172	116	33	13	2	8	5
Columbus, Ohio	166	116	30	13	3	4	9
Dayton, Ohio	132	98	25	4	1	4	11
Detroit, Mich.	244	144	57	23	9	11	10
Evansville, Ind.	46	36	7	2	1	-	-
Fort Wayne, Ind.	62	46	8	6	2	-	8
Gary, Ind.	10	8	2	-	-	-	-
Grand Rapids, Mich.	55	43	9	2	-	1	5
Indianapolis, Ind.	230	162	42	16	5	5	16
Madison, Wis.	52	39	10	2	1	-	7
Milwaukee, Wis.	153	117	23	8	1	4	12
Peoria, Ill.	55	38	11	2	1	3	5
Rockford, Ill.	56	40	11	3	2	-	6
South Bend, Ind.	59	47	7	3	2	-	4
Toledo, Ohio	100	84	10	4	-	2	5
Youngstown, Ohio	50	44	4	1	-	1	2
W.N. CENTRAL	751	544	113	53	16	17	44
Des Moines, Iowa	97	77	9	7	2	2	11
Duluth, Minn.	18	16	2	-	-	-	3
Kansas City, Kans.	20	15	3	1	-	1	-
Kansas City, Mo.	117	79	21	5	3	1	6
Lincoln, Nebr.	29	20	7	2	-	-	3
Minneapolis, Minn.	186	129	29	15	4	9	14
Omaha, Nebr.	99	64	23	8	2	2	2
St. Louis, Mo.	116	87	15	10	4	-	-
St. Paul, Minn.	U	U	U	U	U	U	U
Wichita, Kans.	69	57	4	5	1	2	5
S. ATLANTIC	1,629	1,039	294	198	55	41	112
Atlanta, Ga.	196	122	34	20	11	9	12
Baltimore, Md.	356	223	65	51	11	6	39
Charlotte, N.C.	122	79	27	14	1	1	10
Jacksonville, Fla.	126	89	13	14	6	4	11
Miami, Fla.	117	70	27	11	5	3	-
Norfolk, Va.	64	33	17	9	-	5	5
Richmond, Va.	98	68	18	7	4	1	8
Savannah, Ga.	57	42	12	2	1	-	7
St. Petersburg, Fla.	79	63	9	3	1	3	3
Tampa, Fla.	173	127	24	20	2	-	14
Washington, D.C.	235	119	48	46	13	9	3
Wilmington, Del.	6	4	-	1	-	-	-
E.S. CENTRAL	969	629	188	94	34	24	83
Birmingham, Ala.	135	79	26	18	9	3	5
Chattanooga, Tenn.	94	64	20	6	4	-	9
Knoxville, Tenn.	94	62	20	9	3	-	9
Lexington, Ky.	117	81	20	10	3	3	11
Memphis, Tenn.	215	143	41	20	8	3	33
Mobile, Ala.	82	50	12	10	2	8	-
Montgomery, Ala.	87	64	16	5	-	2	1
Nashville, Tenn.	145	86	33	16	5	5	15
W.S. CENTRAL	1,610	1,021	342	145	57	45	124
Austin, Tex.	72	47	16	7	1	1	5
Baton Rouge, La.	56	40	11	5	-	-	1
Corpus Christi, Tex.	55	44	7	2	1	1	2
Dallas, Tex.	206	123	50	21	3	9	6
El Paso, Tex.	56	39	7	7	2	1	2
Ft. Worth, Tex.	97	69	16	10	-	2	6
Houston, Tex.	475	271	111	54	23	16	41
Little Rock, Ark.	83	53	20	5	1	4	8
New Orleans, La.	69	42	16	6	3	2	-
San Antonio, Tex.	234	155	46	17	12	4	30
Shreveport, La.	84	53	18	7	5	1	11
Tulsa, Okla.	123	85	24	4	6	4	12
MOUNTAIN	809	536	141	87	30	15	56
Albuquerque, N.M.	89	55	15	14	3	2	3
Colo. Springs, Colo.	48	39	6	1	2	-	8
Denver, Colo.	99	65	14	12	4	4	8
Las Vegas, Nev.	131	88	31	8	4	-	4
Ogden, Utah	32	28	1	3	-	-	5
Phoenix, Ariz.	165	101	29	25	8	2	12
Pueblo, Colo.	24	17	3	3	-	1	1
Salt Lake City, Utah	99	61	19	9	6	4	10
Tucson, Ariz.	122	82	23	12	3	2	5
PACIFIC	1,485	1,016	248	145	35	21	114
Berkeley, Calif.	13	8	3	1	-	1	1
Fresno, Calif.	91	64	17	4	5	1	8
Glendale, Calif.	25	17	4	-	4	-	1
Honolulu, Hawaii	96	71	18	5	2	-	7
Long Beach, Calif.	71	54	7	7	-	3	7
Los Angeles, Calif.	418	268	72	54	13	4	16
Pasadena, Calif.	26	18	4	3	-	1	5
Portland, Oreg.	122	89	16	12	4	1	9
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	U	U	U	U	U	U	U
San Francisco, Calif.	128	72	26	14	1	2	18
San Jose, Calif.	153	107	30	13	2	1	17
Santa Cruz, Calif.	28	22	4	1	1	-	5
Seattle, Wash.	148	97	24	22	2	3	5
Spokane, Wash.	68	51	11	4	-	2	8
Tacoma, Wash.	98	78	12	5	1	2	7
TOTAL	13,250¶	8,846	2,414	1,287	386	287	918

*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.

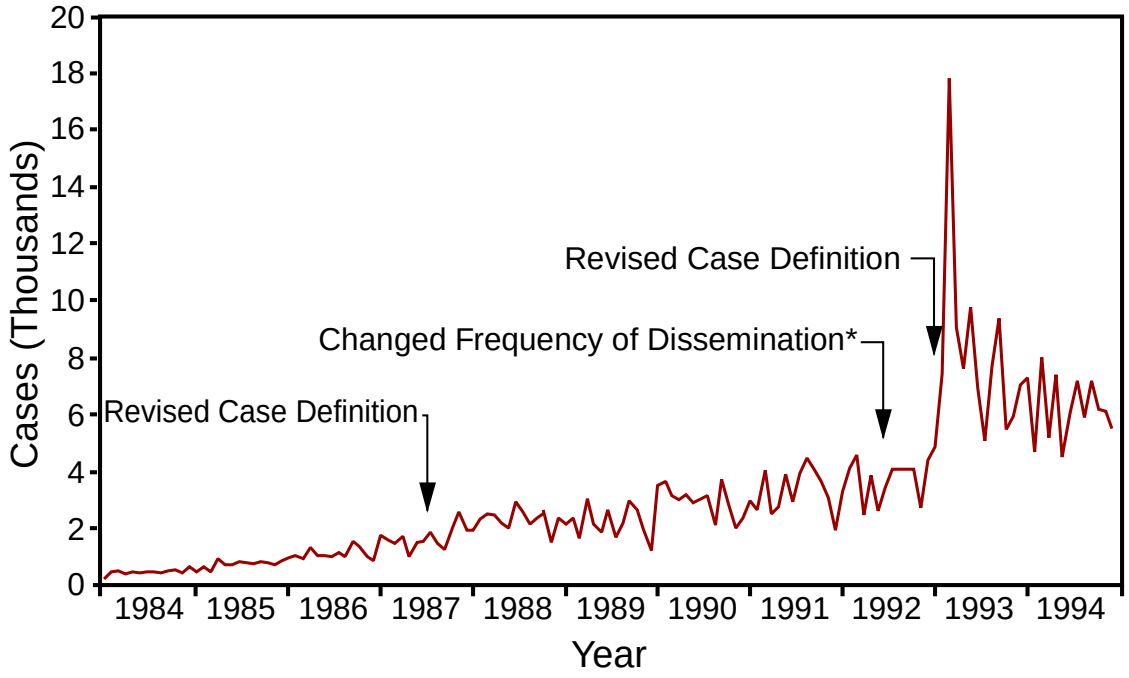
§Because of changes in reporting methods in these 3 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶Total includes unknown ages.

U: Unavailable.

-: no reported cases.

FIGURE II. Acquired immunodeficiency syndrome cases, by 4-week period of report — United States, 1984–1994



*Change to reflect Notice to Readers, Vol. 41., No. 18., p. 325.

FIGURE III. Tuberculosis cases, by 4-week period of report — United States, 1984–1994

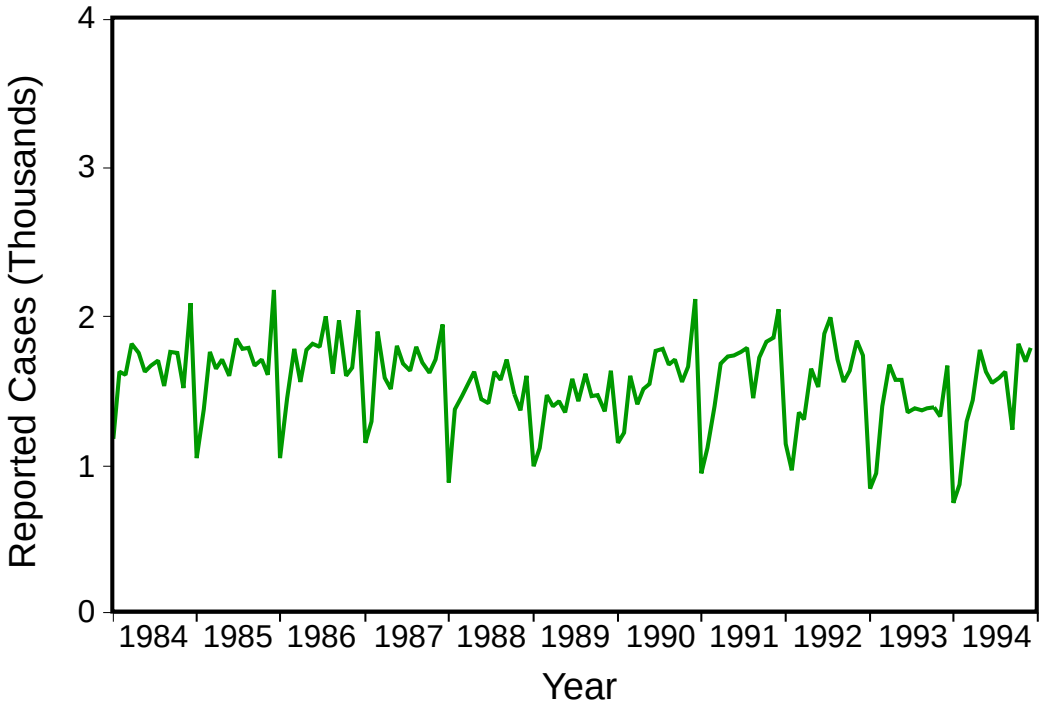


FIGURE IV. Gonorrhea cases, by 4-week period of report — United States, 1984–1994

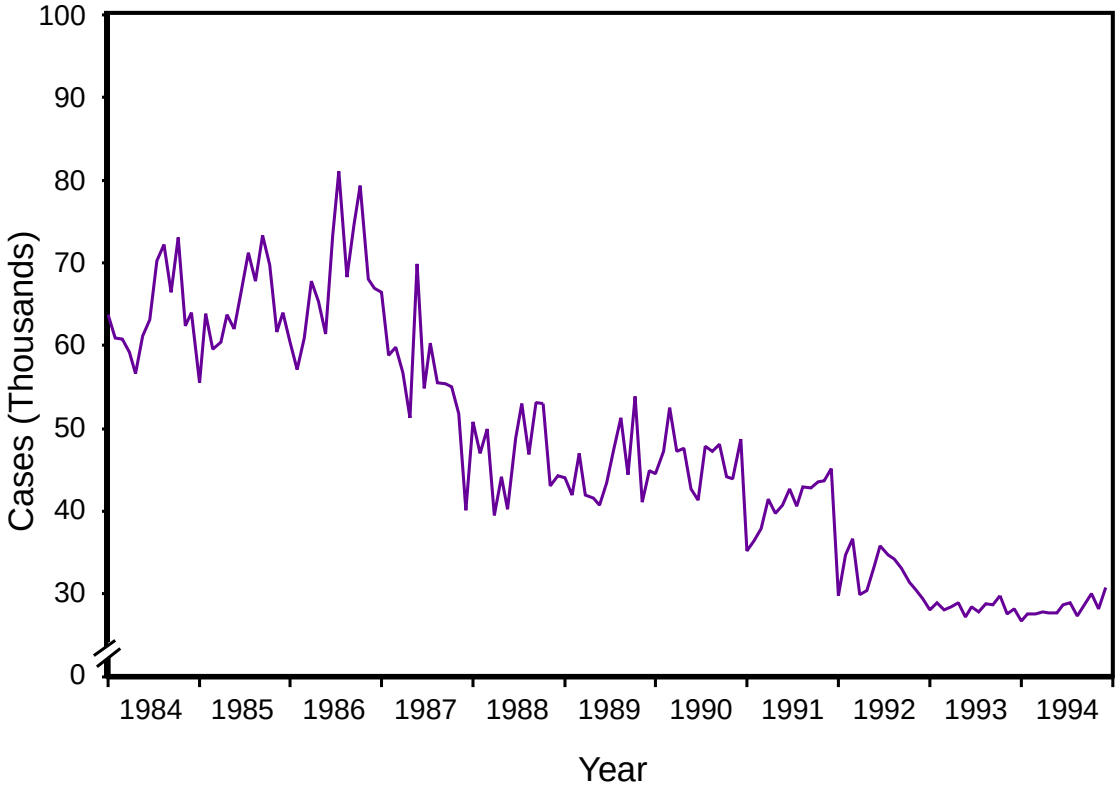
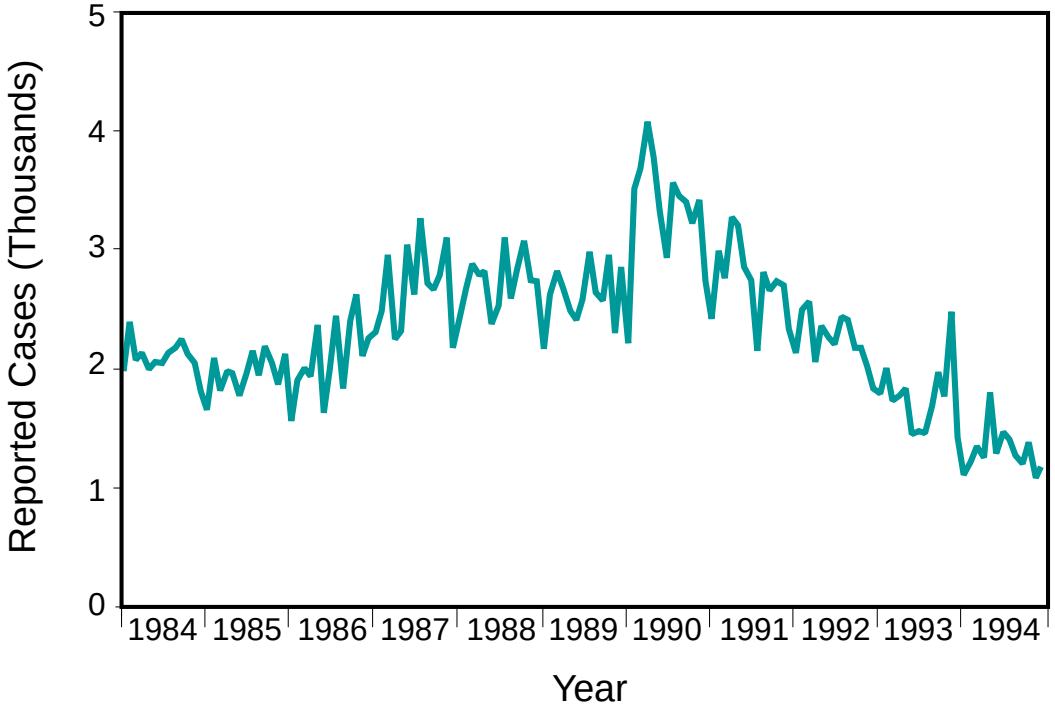


FIGURE V. Syphilis cases, by 4-week period of report — United States, 1984–1994



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