Update: Outbreak of Poliomyelitis—Dominican Republic and Haiti, 2000-2001


This outbreak was the first in the Americas since 1991 and was associated with the circulation of a type 1 OPV-derived virus, having substitutions affecting 1.8% to 4.1% of nucleotides encoding the major capsid protein (VP1). The circulating vaccine-derived poliovirus associated with the outbreak recovered the capacity to cause paralytic disease and widespread person-to-person transmission and was biologically indistinguishable from type 1 wild poliovirus. Contemporary vaccine-derived poliovirus isolates from persons with AFP cases in other countries of the Americas are more closely related (>99.5% VP1 sequence similarity) to the respective OPV strains, are unrelated to the Hispaniola outbreak viruses, and show no evidence of extensive person-to-person transmission. The outbreak in Hispaniola occurred in areas of very low OPV coverage.

In response to the outbreak, health authorities in both countries conducted house-to-house vaccination with OPV. Three rounds of mass vaccination campaigns were conducted in the Dominican Republic in December 2000, and February and April 2001. In each round, approximately 1.2 million OPV doses were administered to an estimated population of 1.1 million children aged <5 years. Haiti conducted two rounds of mass vaccination in February and March 2001. However, these campaigns were hampered by logistic difficulties and heavy rains and reached an estimated 40% of the 1.2 million children aged <5 years. During May-July 2001, a door-to-door and school-based campaign among all 2.3 million children aged <10 years was conducted sequentially in all of the country's departments. Preliminary results suggest that 2.4 million OPV doses were administered, and a second door-to-door campaign is underway.

Travelers to the Dominican Republic and Haiti who are not vaccinated adequately are at risk for polio. Travelers should have received poliovirus vaccination according to national vaccination policies.3

Reported by: Ministry of Health, Pan American Health Organization, Santo Domingo, Dominican Republic. Ministry of Health, Pan American Health Organization, Port-au-Prince, Haiti. Caribbean Epidemiology Center Laboratory, Pan American Health Organization, Trinidad and Tobago. Div of Vaccines and Immunization, Pan American Health Organization, Washington, DC. Respiratory and Enteric Viruses Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; Vaccine Preventable Disease Eradication Div, National Immunization Program, CDC.

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Cigarette Smoking Among Adults—United States, 1999

ONE OF THE NATIONAL HEALTH OBJECTIVES FOR 2010 IS TO REDUCE THE PREVALENCE OF CIGARETTE SMOKING AMONG ADULTS FROM 24% IN 1998 TO ≤12% (OBJECTIVE 27.1a).1 TO ASSESS PROGRESS TOWARD THIS OBJECTIVE, CDC ANALYZED SELF-REPORTED DATA FROM THE 1999 NATIONAL HEALTH INTERVIEW SURVEY (NHIS) ABOUT CIGARETTE SMOKING AMONG U.S. ADULTS. THIS REPORT SUMMARIZES THE FINDINGS OF THIS ANALYSIS, WHICH INDICATE THAT, IN 1999, APPROXIMATELY 23.5% OF ADULTS WERE CURRENT SMOKERS, REPRESENTING A MODEST DECLINE IN PREVALENCE SINCE 1993. IF STATES WERE TO INVEST RESOURCES CONSISTENT WITH CDC RECOMMENDATIONS AND IMPLEMENT PROVEN INTERVENTIONS, THE DECLINE IN CIGARETTE SMOKING COULD BE ACCELERATED.

The 1999 NHIS adult core questionnaire was administered by personal interview to a nationally representative sample (n=30,801) of the U.S. non-institutionalized civilian population aged ≥18 years; the overall response rate was 69.6%. Respondents were asked, “Have you smoked ≥100 cigarettes in your entire life?” and “Do you now smoke cigarettes every day, some days, or not at all?” Current smokers were persons who reported both having smoked ≥100 cigarettes during their...
lifetime and who smoked every day or some days. Former smokers were those who had smoked ≥100 cigarettes during their lifetime but currently did not smoke. Attempts to quit were determined by asking current smokers, “During the past 12 months, have you stopped smoking for 1 day or longer because you were trying to stop smoking?” Data were adjusted for nonresponses and weighted to provide national estimates. Confidence intervals (CIs) were calculated using SUDAAN.

In 1999, an estimated 46.5 million adults (23.5% [95% CI=±0.6]) were current smokers. Overall, 19.2% (95% CI=±0.6) of adults were everyday smokers and 4.3% (95% CI=±0.3) were some day smokers. The prevalence of smoking was higher among men (25.7% [95% CI=±0.9]) than women (21.5% [95% CI=±0.7]). Among racial/ethnic groups, Hispanics (18.1% [95% CI=±1.3]) and Asians/Pacific Islanders (15.1% [95% CI=±3.1]) had the lowest prevalence of cigarette use; American Indians/Alaska Natives had the highest prevalence (40.8% [95% CI=±8.6]). Adults who had earned a General Educational Development diploma had the highest smoking prevalence (44.4% [95% CI=±4.5]); persons with masters, professional, and doctoral degrees had the lowest prevalence and met the 2010 objective (8.9% [95% CI=±3.1]). Prevalence was highest among persons aged 18-24 years (27.9% [95% CI=±1.9]) and 25-44 years (27.3% [95% CI=±1.0]) and lowest among those aged ≥65 years (10.6% [95% CI=±0.9]). The prevalence of smoking was highest among adults living below the poverty level (33.1% [95% CI=±2.0]) compared with those living at or above the poverty level (23.4% [95% CI=±0.7]), and lowest among those with unknown poverty status (20.2% [95% CI=±1.2]).

In 1999, an estimated 45.7 million adults (23.1% [95% CI=±0.6]) were former smokers; 25.8 million were men and 19.9 million were women. Former smokers constituted 49.5% (95% CI=±1.0) of persons who had ever smoked ≥100 cigarettes. Among current smokers, an estimated 15.7 million (41.3% [95% CI=±1.5]) had stopped smoking at least 1 day during the preceding 12 months because they were trying to quit.

During 1998-1999, significant changes in smoking prevalence did not occur; however, since 1993, the prevalence of current smoking has slowly declined. To assess changes over time, 1993 data were compared with 1999 data.[ref]3 Overall prevalence of current smoking declined significantly from 1993 (25.0% [95% CI=±0.7]) to 1999 (23.5% [95% CI=±0.6]). Data for 2000 (23.3% [95% CI=±0.6]) and preliminary data for January-March 2001 (22.3% [95% CI=±1.1]) suggest a continuing decline.4

During 1993-1999, no significant changes were observed in current smoking prevalence for any racial/ethnic group or for the population living below the poverty level; however, reductions were reported in adults with 12 years of education (from 29.2% [95% CI=±1.2] to 26.3% [95% CI=±1.1]), and in persons aged 45-64 years (from 26.0% [95% CI=±1.3] to 23.3% [95% CI=±1.0]). Prevalence of smoking among persons aged 18-24 years has not increased significantly; this age group continues to have the highest smoking prevalence.2

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

CDC Editorial Note: After 4 years during which the prevalence of current smoking among U.S. adults remained unchanged,2 data from 1999 indicated a slow but significant decline; however, the 2010 objective of ≤12% for adult smoking prevalence will not be met unless the rate of decline increases significantly. The 2000 report of the Surgeon General5 concluded that the 2010 objective could be met if comprehensive approaches to tobacco control were implemented fully.

Increasing the unit price of tobacco products, smoking bans and restrictions, and mass media education campaigns for tobacco-use cessation are among the recommended measures5,6 to increase quitting among a wide range of smokers. The decline in smoking prevalence that began in 1997 may be explained, in part, by the December 1997—December 1999 increase in taxes and wholesale prices that resulted in a 49% price increase.7

The findings in this report are subject to at least two limitations. First, questionnaires and data collection procedures for NHIS have changed since 1993. In 1993, the sample was redesigned; in 1997, questions on tobacco use were moved from supplementary questionnaires to the adult core questionnaire. It is impossible to assess how these changes affected prevalence estimates and trend analysis or comparisons; therefore, statistical trend analysis from the years preceding 1997 should be approached with caution. Second, because the NHIS sample size of some racial/ethnic populations was small (e.g., American Indians/Alaska Natives), data for a single year might be unstable. Combining data from several years would produce more reliable estimates.

Expanded access to treatment for nicotine dependence (e.g., FDA-approved pharmacotherapy and individual, group, and telephone counseling) will help more persons stop smoking. One method to increase access to treatment is to reduce out-of-pocket costs by covering therapies as a standard insurance benefit.1,2,3,7 Best Practices for Comprehensive Tobacco Control8 recommends that cessation interventions be incorporated into comprehensive, statewide programs. Following the implementation of a comprehensive program, the Arizona Department of Health Services Tobacco Education and Prevention Program reported that prevalence among adult smokers decreased from 23.1% to 18.3% during 1996-1999, and the proportion of Arizona smokers who reported that a health-care provider had both asked them about their tobacco use and advised them to quit increased significantly during this pe-
Pesticide-Related Illnesses Associated With the Use of a Plant Growth Regulator—Italy, 2001

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During January-February 2001, eight cases of acute illness in the county of Ragusa, Italy, were reported to the Italian National Institute for Health (INIH) by the Milan Poison Control Center (MPCC) and were attributed to exposure to Dormex®; a plant growth regulator with hydrogen cyanamide as the active ingredient. These cases were identified during a pilot project for acute pesticide-related illness surveillance. Subsequent active case finding at health-care clinics by the Ragusa Occupational Health Unit identified six additional cases. MPCC identified nine cases in other areas of Italy. Of the 23 cases of acute illness, 22 resulted from occupational exposure during mixing and/or applying of Dormex®, and one was from unintentional ingestion. This report summarizes the investigation of these cases, which implicates a pesticide as the causative agent and demonstrates the usefulness of surveillance for detecting pesticide-related illnesses.

All 22 workers were male with a median age of 41 years (range: 16-76 years). It is not known whether personal protection equipment was used. Eighteen of the workers reported dermatologic manifestations, including macular or papular rash (11), erythema/hyperemia (nine), pruritus (two), and caustic burns to the hand (two). Two workers reported eye irritation. Fourteen workers had systemic signs and/or symptoms characteristic of adverse effects of the active ingredient, including tachycardia (four), weakness (four), dizziness (four), palpitations (three), headache (three), vomiting and/or nausea (three), dyspnea (three), and hypotension (one). Of 21 persons initially treated in an emergency department, 12 (52%) were hospitalized; one person was treated by a local physician. Thirteen patients had low severity effects (i.e., minimal effects that rapidly resolved), and nine had moderate severity effects (i.e., nonlife threatening effects that are more pronounced, prolonged, or of a systemic nature) (CDC, unpublished data, 2001).

The nonoccupational case occurred in a man aged 44 years who unintentionally ingested the product that had been placed in a plastic water bottle in the refrigerator. He became seriously ill with third degree shock, coma, miosis, and hepatic necrosis and required care in an intensive care unit.

In May 2001, INIH notified the Italian Ministry of Health (IMH) about the outbreak. IMH, which acts as the regulatory agency for pesticides and agricultural products, suspended use of the product in Italy.

CDC Editorial Note: This report describes the adverse health effects of hydrogen cyanamide, the active ingredient in Dormex®, which is a plant growth regulator designed to stimulate more uniform flowering and maturity at harvest. Dormex® is applied by nebulization with an atomizer. Adverse health effects from contact with hydrogen cyanamide include severe irritation and ulceration of the eyes, skin, and respiratory tract. It also inhibits alcohol dehydrogenase and can produce the acetaldehyde syndrome (e.g., vomiting, parasympathetic hyperactivity, dyspnea, hypotension, tachycardia, and confusion) when exposure coincides with alcohol use.

Hydrogen cyanamide is classified in the European Union as “toxic” if swallowed, “harmful” in contact with skin, “irritating” to eyes and skin, and—
pable of producing sensitization after skin contact. The U.S. Environmental Protection Agency (EPA) places both the active ingredient (hydrogen cyanamide) and the product (Dormex®), which contains 50% hydrogen cyanamide, into the acute toxicity category I (danger). The Dormex® product label provided by the manufacturer to EPA indicates that the following personal protective equipment must be used by applicators and other handlers of this product: chemical-resistant suit, chemical-resistant gloves, chemical-resistant footwear, eye and face protection, and a respirator with chemical-resistant suit, chemical-resistant gloves, and face protection.

On the basis of experimental trials of the product, Dormex® was classified in Italy as “harmful” if swallowed, “harmful” in contact with the skin, “irritating” to the eyes and skin, capable of causing serious damage to the eyes, and of causing sensitization after skin contact. This corresponds to EPA acute toxicity category II. The product sold in Italy was for use only by licensed applicators and required wearing suitable protective clothing, gloves, and eye and face protection.

Since 1981, only five cases of acute pesticide-related illness associated with hydrogen cyanamide have been identified in the United States (CDC, unpublished data, 2001). All five patients were exposed in California. No cases were identified in the other seven states with acute pesticide-related illness surveillance programs or by the Toxic Exposure Surveillance System, which collects poisoning reports submitted by approximately 85% of U.S. poison control centers. The low number of U.S. cases compared with Italy may be related to greater precautions required by the label of the U.S.-distributed product.

The findings in this report are subject to at least two limitations. First, because active surveillance for acute pesticide-related illness cases was conducted in Ragusa only, patients who sought health care in other parts of Italy may have been missed. Second, lack of detailed information on the events surrounding exposure may have precluded identification of additional risk factors for hydrogen cyanamide-related illness.

Although use of Dormex® in Italy began in 2000, only three cases of acute illness associated with this product were identified by MPCC in 2000 (i.e., before establishment of the pilot surveillance program). One occurred in Ragusa and the other two were from other regions in southern Italy. These data suggest that fewer cases occurred in 2000 compared with 2001. Because emergency department medical records in Ragusa for 2000 were not available to the Occupational Health Unit, the total number of Ragusa cases that occurred in 2000 is unknown. The establishment of the pilot surveillance system in January 2001 probably enabled the detection of this outbreak through active case-finding and the use of a standardized form. Ragusa was selected for this pilot program, in part, because it is an area characterized by greenhouse cultivation of fruits and vegetables with extensive use of pesticides and because of heightened awareness of pesticide-related illnesses by the Ragusa Occupational Health Unit.

These findings demonstrate the usefulness of surveillance for detecting emerging pesticide problems. In addition, this outbreak suggests the need for international uniformity in both the acute toxicity category assigned to a pesticide and in the detailed recommendations and requirements provided on the pesticide label.

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death in 1998 for the total population and for both racial populations. Other causes of death were categorized as “all other causes.”

In the United States during 1998, whites lived 6.2 years longer than blacks. Among the leading causes of death that contributed to the difference were heart disease (1.7 years; 27.4%), cancer (1.2 years; 19.0%), homicide (0.6 years; 0.9%), stroke (0.5 years; 8.1%), and “all other causes” (1.9 years; 30.6%). The LE differential was 6.4 years for males and 4.4 years for females. Among males, some of the leading causes of death that contributed to the LE differential were heart disease (1.2 years; 19.0%), cancer (1.0 years; 15.6%), and homicide (0.9 years; 14.1%), and among females were heart disease (1.2 years; 27.3%), cancer (0.5 years; 11.4%), and perinatal disease (e.g., birth trauma, birth asphyxia, ectopic pregnancy, and maternal death) (0.4 years; 9.1%). Stroke and human immunodeficiency virus (HIV) accounted for 0.3 years (6.8%) and 0.3 years (6.8%), respectively, of the LE differential among females and 0.4 years (6.3%) and 0.6 years (9.4%), respectively, among males. Homicide among black females contributed 0.2 years (4.5%) to the LE differential.

During 1985, the U.S. Department of Health and Human Services conducted the first analyses using health indicators that documented the health status of minority populations and found that approximately 60,000 excess deaths (i.e., the difference between the number of deaths observed in a racial/ethnic group and the number of deaths that would have occurred in that group if it had the same death rate as the non-Hispanic white population) occurred among blacks each year in the United States. Health disparities between blacks and the general population have been attributed to less access to health care and to health-care coverage. Risk factors for violence include living at or below the poverty level, living in single parent households, and having poor academic performance and/or exposure to neighborhood violence (e.g., gangs).7

The 1998 publication of The Initiative to Eliminate Racial and Ethnic Disparities in Health indicated a commitment to eliminating longstanding racial/ethnic disparities in health status by 2010. The initiative focuses on six key areas of health that disproportionately affect multiple racial/ethnic minority groups at all ages: infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV, and vaccination coverage. The findings in this report are consistent with previous findings that show homicide to be a leading contributor to the difference in LE between blacks and whites and underscore the need to include homicide among the key areas.

The findings in this report are subject to at least three limitations. First, incorrect diagnoses or errors can result in inaccuracies in death records. Second, although approximately 99% of deaths in the United States are reported systematically, denominator data (population estimates) that refer to race or color may be inaccurate. Third, several assumptions (e.g., that life expectancy is aged 85 years) that could be technically flawed were made in constructing the life table model in this analysis.7 Preventing homicide requires integrated approaches from multiple disciplines, including criminal justice, education, social services, community advocacy, and public health. Strategies for preventing violence among youth (e.g., social-cognitive, mentoring, and family-based approaches) have been described in Best Practices to Prevent Violence by Children and Adolescents: A Sourcebook for Community Action and in the Surgeon General’s Report on Youth Violence.7 These prevention programs and strategies could be implemented by educators, public health practitioners, and law enforcement agencies to target black males. Reducing the racial LE differential in homicide will improve the health of blacks in the United States and thus reduce racial disparities in health.

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