ically as a result of the use of medical instruments that may retain patient material even after vigorous cleaning.

The FDA is asking doctors, dentists, and hospitals to stop using the products immediately and switch to alternatives. Institutions needing more information on alternatives can call the EPA's National Pesticide Telecommunications hotline at (800) 858-7378.

From the Centers for Disease Control

ASEPTIC MENINGITIS-NEW YORK STATE AND THE UNITED STATES, WEEKS i-36,1991

During April-October 1991, several state health departments noted increased reports of aseptic meningitis (The Centers for Disease Control [CDC] case definition for aseptic meningitis is a syndrome characterized by acute onset of meningeal symptoms, fever, and cerebrospinal fluid pleocytosis, with bacteriologically sterile cultures[1]). This report summarizes finding from epidemiologic investigation of and surveillance efforts for aseptic meningitis in New York state and elsewhere in the United States.

New York

In New York, information on cases is collected by local health units and forwarded to the New York State Department of Health (NYSDOH), using the Council of State and Territorial Epidemiologists' (CSTE) case definition for surveillance.[1] From January through August 1991, 636 cases of aseptic meningitis were reported to the NYSDOH (excluding New York City), a 153% increase over the average number of cases reported during the same eight-month period for 1987-1990.

From January through August 1991, the statewide incidence rate was 8.9 cases per 100,000 population, compared with 3.9 cases per 100,000 for the same period in 1990. The increase in reporting occurred statewide.

Preliminary data from 11 state laboratories that perform viral isolation showed increased isolations of coxsackieviruses, echovirus 30, and enteroviruses not yet typed. During June-July 1991, the Nassau County Medical Center detected echovirus 30 in 12 (67%) of 18 patient specimens from which nonpolio enteroviruses were isolated; during 1990, echovirus 30 was isolated from one (2%) of 57 patient specimens.

United States

From the reporting period ending August 24, 1991, through the period ending October 12, 1991, reports of aseptic meningitis nationally have exceeded historical limits for each four-week reporting period. Cases of aseptic meningitis are not reportable in five states (Connecticut, Idaho, New Jersey, Oregon, and Washington); however, among states with reporting requirements, 8,415 cases were reported during the first 36 weeks of 1991, compared with an average of 2,992 cases reported during weeks 1-36 of 1986-1990. The highest rates were reported from Vermont and Rhode Island (34.3 and 29.1 cases per 100,000 persons, respectively). In Vermont, reported cases increased ten-fold over baseline from April through July. States reporting elevated rates of aseptic meningitis were concentrated in the eastern United States, particularly in New England and among the mid-Atlantic states.

Outbreaks were reported in Massachusetts, Ohio, and other states. For example, in Massachusetts, echovirus 30 was isolated from specimens from seven patients involved in a community-wide outbreak. In Ohio, a middle school football coach, a student manager, and three members of the team developed aseptic meningitis during an eight-day period in September; in this outbreak, an enterovirus (not yet identified) was isolated from two patients. The local health department initiated an education campaign that promoted handwashing and discouraged the shared use of drinking vessels and open ice buckets.

REFERENCE

1. Centers for Disease Control. Case definitions for public health surveillance. MMWR. 1990;39:6.

From the *MMWR*. 1991;40:773-775.

SCREENING FOR HEPATITIS B VIRUS INFECTION AMONG REFUGEES ARRIVING IN THE UNITED STATES, 1979-1991

Because hepatitis B virus (HBV) infection is highly endemic in several areas of the world, both the prevalence of and risk for HBV infection are substantially greater among persons emigrating from these areas to the United States than for the overall US population. In 1985, federal funds were made available to supplement ongoing state and local health department refugee-screening programs and to promote serologic screening for HBV infection in pregnant Indochinese women and household contacts of these female HBV carriers among persons identified by the Department of State as refugees entering the United States. This report summarizes data collected during 1979-1991 by selected screening programs that implements universal hepatitis B (HB) screening at different times.

Health-screening programs established by state and local health agencies for newly arrived refugees generally include tuberculosis screening, stool screening for ova and parasites, and serologic screening for HBV infection; screening is done as soon as possible after arrival. Services may be provided in special refugee health clinics, local health department clinics, or the offices of private-practice physicians. For this report, programs were selected that screened all incoming refugees and had data on the results of testing for hepatitis B surface antigen (HBsAg) that could be used to calculate nationality-specific estimates of the prevalence of current HBV infection. Because these data did not include more detailed demographic information, neither age- nor gender-specific prevalence estimates could be calculated.

Crude prevalence rates of HBsAg were highest among refugees from countries in Southeast Asia (range = 11.7%-15.5%), intermediate among refugees from Africa, and lower among refugees from other countries in Asia, including Afghanistan (4.1%) and Iran (2.4%). Crude prevalence rates were substantially higher among refugees form Bulgaria (5.3%) and Romania (4.1%) than among refugees from other eastern European countries, who had the lowest rates for all groups tested.

From the *MMWR*. 1991;40:773-786.