The selection of injection equipment

WHO and UNICEF recommended re-usable syringes and needles for use in developing countries.1 They should be steam-sterilized between uses. Disposable needles and syringes should only be used if it can be ensured that they will actually be destroyed after a single use. Jet injectors may also provide an alternative. However, until further studies clarify the risks of disease transmission, their use should be restricted to special circumstances where the use of needles and syringes is not feasible because of the large numbers of persons to be immunized within a short period of time.

Immunizing HIV-infected individuals

In October, the EPI Global Advisory Group considered the problem of immunizing children with AIDS.2 They concluded:

"In countries where human immunodeficiency virus (HIV) infection is considered a problem, individuals should be immunized with the EPI antigens according to standard schedules. This also applies to individuals with asymptomatic HIV infection. Unimmunized individuals with clinical (symptomatic) AIDS in countries where the EPI target diseases remain serious risks should not receive BCG, but should receive the other vaccines (Table 1).

In general, live vaccines are not given to immunocompromised individuals, but in developing countries, the risk of measles and poliomyelitis in unimmunized infants is high and the risk from these vaccines, even in the presence of symptomatic HIV infection, appears to be low."


Premature mortality in the United States of America, as measured by years of potential life lost before age 65 (YPLL), increased from 1983 to 1984 for the first time since 1980. Total YPLL from all causes of death increased from 11,712,000 in 1983 to 11,761,000 in 1984, a 0.4% increase. The rate of YPLL per 1,000 persons under 65 years old, however, decreased by 0.4% from 1983's level to 56.5/1,000 persons. An increase of 1.5 million persons under 65 years of age accounts for this discrepancy.

The relative rankings of the leading causes of YPLL did not change substantially from 1983 to 1984. The only change was cerebrovascular diseases replacing chronic liver diseases as the eighth leading cause of YPLL. Unintentional injuries (accidents) continue to head the list, accounting for 20% of the total YPLL, followed by malignant neoplasms (15%), diseases of the heart (13%), and suicides/homicides (11%).

The rate of YPLL per 1,000 persons increased for eight of the 12 leading causes (Figure 1). The largest proportionate increase in the rate of YPLL was recorded for cerebrovascular diseases, up 13.1%. Increases in YPLL rates were also noted for prematurity, up 3.3%, sudden infant death syndrome, 2.7%;
pneumonia and influenza, 2.6%; and diabetes mellitus, 1.8%. In contrast, the rate of YPLL for chronic liver diseases and cirrhosis decreased by 7.4%; diseases of the heart declined 3.6%; chronic obstructive pulmonary diseases and allied conditions, 3.3%, and malignant neoplasms, 1.3%.

Starting on January 17, 1986 the Centers for Disease Control changed the method of calculation of YPLL to include causes of mortality in the first year of life. The relatively high age-specific death rate of these infants, combined with the years of life remaining before age 65, adds two new causes to the list of leading causes of YPLL—sudden infant death syndrome (ICD code 798) and deaths attributable to prematurity, including neonatal respiratory distress syndrome (ICD code 769) and disorders relating to short gestation and unspecified low birthweight (ICD code 765).

The inclusion of deaths during the first year of life does not account for the increase in total YPLL from 1983 to 1984. Although total YPLL decreased each year from 1980 to 1984, the slight increase in 1984 is present when YPLL is calculated by either the birth-to-age-65-years or the age 1-to-65-years method. The rate of YPLL per 1,000 persons, however, has decreased each year since at least 1979 with both methods of calculation and now stands 12.3% below the 1979 level when measured from age 1 year to 65 years, and 14.1% when measured from birth to age 65 years.

Considerable variability continues to be demonstrated in the year-to-year comparison of YPLL rate due to specific causes of mortality. The rate of YPLL attributable to cerebrovascular diseases, for example, increased by 13.1% in 1984, reversing the 12.4% decline of the previous year. In contrast, the YPLL rate for unintentional injuries, which has consistently decreased from 1979 until 1984, increased by 0.4% in 1984, but remains 22.5% below the 1979 level.

(Source: Adapted from MMWR Vol. 35, No. 2, 1986.)

Brazilian Purpuric Fever

Brazilian purpuric fever (BPF) was first recognized in late 1984 in the town of Promissão, São Paulo State, Brazil (1). The disease was characterized by the acute onset of high fever, vomiting, and abdominal pain, followed by purpura, vascular collapse, and death in children 3 months to 8 years of age. There was no evidence of meningitis, and blood cultures were negative when obtained, although some patients may have received antibiotics. *Haemophilus aegyptius* (Haemo-

philus influenzae, biotype III) was isolated from a nonaseptically obtained skin scraping of a petechia from an affected child.

Although the etiology could not be determined at the time of the outbreak, an epidemiologic investigation indicated disease was associated with preceding purulent conjunctivitis. *H. aegyptius* was the most commonly isolated organism from children with purulent conjunctivitis in Promissão; however, conjunctival