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Alyene Denney
Epidemiology Division

ANNUAL MORBIDITY REPORT

TEXAS 1942

COMPILED BY DIVISION OF EPIDEMIOLOGY
TEXAS STATE DEPARTMENT OF HEALTH
GEO. W. COX, M.D., STATE HEALTH OFFICER
AUSTIN, TEXAS

IN COOPERATION WITH
THE UNITED STATES PUBLIC HEALTH SERVICE

TEXAS STATE DEPARTMENT OF HEALTH

WEEK ENDING ANNUAL REPORT 1942

DISEASE	DIPHTHERIA	DYSENTERY	INFLUENZA	MALARIA	MEASLES	MENINGITIS	PNEUMONIA	POLIOMYELITIS	SCARLET FEVER	SMALLPOX	TUBERCULOSIS	TULAREMIA	TYPHOID FEVER	TYPHUS FEVER	UNDULANT FEVER	WHOOPING COUGH	DENGUE	GONORRHEA **	SYPHILIS
REPORTS BY COUNTIES																			
Anderson	35	48	109	59	152	1	36	1			6		1	5	3	67		14	3
Andrews			13		20	1	2												
Angelina			3	2	7		3			2	3		9	1		6		1	4
Aransas		3	54		14		4		2		3					22	1	2	7
Archer	1	4	98	3	22	2	21	1	3	1	3		1	1		10			
Armstrong		1	82		11		15		3						1				
Atascosa																			
Austin			42		2												2		
Bailey			2						3				4						
Bandera	5	2	60		15		8		2							56		2	
Bastrop	2	1	29	3	37		10		3		16		1			5		3	10
Baylor			12	6	67		2		7							1			
Bee	30	198	506	19	177	3	21			6	53		15	49		13	6	23	18
Bell	5	8	470	6	389	1	112	8	8	4	5		9	4		152		57	295
Bexar	56	273	129	5	361	1	456	55	74		840		10	26	3	106		671	960
Blanco	1		58		14	1	10									2		1	3
Borden																			
Bosque		7	106	19	2		3						3	11		3			1
Bowie	14	8	199	183	245	1	34		27		24		14	2		47		127	342
Brazoria	10	68	117	143	222		23	1			8				1	36	1	40	22
Brazos	31	355	1457	294	707	4	259	3	1		36	1	4			19	1	177	161
Brewster	1	37	292		76		29				7				8	30		13	3
Briscoe	1		42		209		2								3	2			
Brooks	1	7	241	46	70		6				7			2		55		2	3
Brown	24	21	64	4	278	2	168	1	43		34		8	13		8		609	171
Burleson		8	44	83	10		11		1		3			5		10	1	7	
Burnet		122	436		63		45		1		4					2		2	
Caldwell	3	3	67	16	143	1	35	1		35	11			2		23		2	3
Calhoun	3	7	288	1	2		26	1			16				1	4	1	12	10
Callahan	2		12		10			4			1								
Cameron	20	105	93	22	246		16	3	3		70		7	17		28	4	8	2
Camp	5		116	37	133		26		1		1		8		1	8		5	15
Carson		1	268	2	128	3	25				11			3	12	16		17	3
Cass	6	65	214	22	177	1	16		5		4		2			11		4	7
Castro	2	5	38	2	47		18		4	4	1				6	68			3
Chambers	5																		
Cherokee	6	65	144	288	55	1	20		9	1	5		6	2		29		3	1
Childress	3	3	10		20		5		3		1								
Clay	5		122	5	125		18		2							1		4	10
Cochran																			
Coke	3	8	189		61		44	2	2		2			1	1			5	
Coleman	20	12	304	7	58	1	49	1	5		4			1		6		14	6
Collin	4	168	38	275	250		5		7		13		2		2	30		20	2
Collingsworth	4		6		21		2				1				1				
Colorado	1		35		15		6							6		25			
Comal	10	111	486	3	27	1	63		9		34			17		194		21	8
Comanche	16	18	272	1	73		14		2		14			1		20		16	54
Concho			10		8		1												
Cooke	5	123	354		86		10		8			2	2	1		5			
Coryell	3	22	102	4	11	6	11	1	3		2		1	8	1	20		26	11

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TEXAS STATE DEPARTMENT OF HEALTH WEEK ENDING ANNUAL REPORT 1942

DISEASE	DIPHTHERIA	DYSENTERY	INFLUENZA	MALARIA	MEASLES	MENINGITIS	PNEUMONIA	POLIOMYELITIS	SCARLET FEVER	SMALLPOX	TUBERCULOSIS	TULAREMIA	TYPHOID FEVER	TYPHUS FEVER	UNDULANT FEVER	WHOOPING COUGH	DENGUE	GONORRHEA	SYPHILIS
REPORTS BY COUNTIES																			
Cottle		7	102	25	60		8	1	1		2		3		1	9		2	3
Crane	2	40	184		82		10									3		1	10
Crockett			35		185		51		1		2								
Crosby	3		141		88		10		17	4						8		2	
Culberson		12	64	2	27		5				4					1		15	14
Dallam			93	3	78	1	35		1		2		1		3	18		40	27
Dallas	128	31	271	29	3971		738	7	236		318		28	14	1	392		700	2619
Dawson	14		89	2	265		49	2	8		11		1	19		19		2	3
Deaf Smith			25	12	72		3			1					3	9		1	
Delta	10	129	549	33	342		18	1	2		22			1		117		46	21
Denton	13	3	186	3	61		24		6		3		4	5		52		7	2
De Witt	9	3	39	3	5		17		1		2			24				12	10
Dickens	8		167		205	4	19		6	2						2		15	26
Dimmit	1	135	206	1	99		29	1	7		29	5	4	1	2	84		21	4
Donley	8	28	92	5	82		48		13		4				4	30			
Duval		10	42		38		3		1		1			4		20			
Eastland	10	37	372	1	600		66	1	18		3		2	6		54		13	3
Ector	9	2	179	1	259	2	47		2		10	1	1	2		66		13	7
Edwards	2				33		2						1					8	2
Ellis	3	5	43	5	5		11		1	2					1	7		1	4
El Paso	11	2			242	2		1	32		80		8	1		140		137	482
Erath	1	1	392	4	166	1	62		54		9		4	6		180		47	5
Falls	3	5	292	4	389		57				6		2	7	1	44		6	5
Fannin	5	92	159	45	47		63		15	1	5		1			7		2	14
Fayette	4	48	82	13	124		34		1	1	4			60		8	1	12	12
Fisher	2	7	87	1	135	5	79	3	15		16	1		2		15			
Floyd	4	2	225		161		19	1	21						1	26		1	1
Foard	1	7	18		117		13			1	1		1			16		7	3
Fort Bend	8	2	51	3	26		10		2		6		2	3	1	7			
Franklin	32		124	194	102	1	10		1							10		1	
Freestone			19	1	2			1			20		1	1		8			
Frio	6		91	8	31		8				1			12		9			
Gaines		2	23		66		6		1		1					6		1	
Galveston	7		21		125	3	9	4	22	1	38		7	9		102	13	2	
Garza		2	6	2	16		7		14				1			5			
Gillespie		4	200	2	148		3		6		1		2			15		2	
Glasscock																			
Goliad		5	31	4	1		1				4		1	1		8			
Gonzales	10		97	1	90		8	1			4	1	1	18	1	11		4	8
Gray	3		359	9	121		90		10		3		1		14	94		70	28
Grayson	35	16	204	9	62	3	84		20	2	14		5		1	1		57	27
Gregg	7	3	21	40	234	2	7		12		5	3	4	3		30		15	
Grimes	2		61		11		22		5				2	2					
Guadalupe	9	10	86	8	37	3	2	3	1		11			16		21		6	2
Hale	2	12	401	1	422		66	4	1		2		5		2	4		10	2
Hall	1		21		45		10		2	1	2				3				
Hamilton		85	8		15		10		2		3		2			4		3	2
Hansford	2		172		4		28								1			8	
Hardeman																		16	
Hardin		12	156	10	220	1	35			3	8			1		5		14	10

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DISEASE	DIPHTHERIA	DYSENTERY	INFLUENZA	MALARIA	MEASLES	MENINGITIS	PNEUMONIA	POLIOMYELITIS	SCARLET FEVER	SMALLPOX	TUBERCULOSIS	TULAREMIA	TYPHOID FEVER	TYPHUS FEVER	UNDULANT FEVER	WHOOPING COUGH	DENGUE	GONORRHEA	SYPHILIS
REPORTS BY COUNTIES																			
Harris	139	5	116	13	1159	3	155	6	137	1	405		62	47	1	184	1	12	26
Harrison	5	12	247	39	286	1	41	2	41		7					37		34	35
Hartley																			
Haskell	17	20	435		410	7	28		5		1		2	5		9		5	2
Hays		3	22	6	18		6		1	1	1					2			
Hemphill	1		1				4		1							3			
Henderson	28	221	796	325	98		128	1	5	1	24		20	11	1	11	1		
Hidalgo	26	108	128	61	112		28		1		124		8	4		63	2	10	8
Hill	10	85	382	11	93		29	2	12		27		10	13		19			
Hockley	3	16	116	2	156	1	219		11		10					7		7	12
Hood			13				9		4							3			
Hopkins	1				1				1		1								
Houston	4	15	108	57	63		25		4	6	36	1	8	18		7		16	22
Howard	27	66	1		22	1	11		4		3			74	3	4		4	5
Hudspeth			16	6	63		6						1			9			7
Hunt	12	20	220	118	253		71		20		44		8		2	102		6	8
Hutchinson	2	1	182	1	222		4		4	1	1		1	1	3	7		18	
Irion			15		49	2	1								1				
Jack	1		25															1	
Jackson	3	3	36	7	186	1	16	1			26			7		9		4	7
Jasper	5	78	93	159	442	4	51				18	1	11	9	2	30		23	18
Jeff Davis		9	17				2												
Jefferson	95	26	565	59	1637	6	146	5	87	6	46		9	29	13	123	1	1	
Jim Hogg																			
Jim Wells		1	34		12	1	2	1			5		3	22		3		2	
Johnson	1	55	91	18	81	1	12		1	5	4		8	4	2	17		14	
Jones	11		29	1	119		39	4	19		4		3	44	2	24		1	3
Karnes	6	27	44	3	70	1	24	2	6				1	14		52		5	
Kaufman	2	26	48	17	5	1	10						1	1	1	1		6	4
Kendall	4		6				1							1		1			
Kenedy																			
Kent																			
Kerr	2		22		15		20	1	6	3	10								
Kimble	1		188		63		8	3							2	4			3
King					23														
Kinney		52	63		11		3		1		19					8		20	18
Kleberg	2		20		3		3		1			1		1					
Knox	8	3	8		21		5		8		1			3		4			
Lamar	31	364	442	789	555		234		29	1	60		6		6	77		605	501
Lamb		4	114	24	156	25	15		3							26	6	1	2
Lampasas	20	14	300	17	33		47		1		5		3	3		40	4	42	20
La Salle	8		49	5	3		2												1
Lavaca	20	137	465	3	322		36		2		24	2	2	65		66	17	23	29
Lee	3	8	138	39	125		4		1		1			1		13		6	4
Leon		1	207	356	11		71		1		30		6		2	70		58	123
Liberty	11	3	15	23	52	4	14				1		1	15		35		8	2
Limestone	7	31	71	39	42		15	1	2		4		1		2	15		1	9
Lipscomb		1	1	5			10		1							2			
Live Oak						1								1					
Llano		5	197		89		10				1							2	

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REPORTS BY COUNTIES																			
Loving																			
Lubbock	13	7	763	23	796		259		17		15		3		2	570		16	10
Lynn		19	22	12	193		24	1	4		8				2	8		18	14
McCulloch	5	23	44		12		6		2		1			2		55		1	1
McLennan	38	208	454	34	75	3	99	3	10		30		10	21	3	88		176	400
McMullen																			
Madison	14	13	105	95	31		4		2				11	7		19		10	6
Marion	6	132	391	198	480		37				4	1				168		30	7
Martin																			
Mason	9	23	20		21		3		7				6			29			
Matagorda	9	2	138	19	151	1	123	2	10	4	17	1	4	3		3		131	74
Maverick	13	22			49			1	2		15			1	2	48		6	27
Medina	4	281	224	1	187		9	3			4			3	3	45	8	33	7
Menard		1	16		16		1		5		1								
Midland		7	197		700		34	1	7		16				1	13	4	17	32
Milam	23	14	183	64	196	3	23		13		29	1	1	9	1	11		19	5
Mills	13	10	79		27		28		1						1	10		8	2
Mitchell	3	2	79		106		31		2		1		2	10		43		1	
Montague	5	2	50		6		3		1		2			6		9		2	11
Montgomery	2													1					
Moore			98		46		40												
Morris		16	78	33	16		11									5		1	
Motley	7	17	517	60	154		35				2				2	19			4
Nacogdoches	15	30	289	175	564	1	28		4	2				3		15		5	1
Navarro	41	1	187		7		6	3	13		12		4	2		16		6	
Newton	2	8	62	127	220		14		1		3		4			2			
Nolan	1	4	283	1	541	2	75		18		17			3		8			
Nueces	47	5	5	1	99		6	33	29		78		2	53	1	33		6	
Ochiltree			8				3												
Oldham	1	3	24	1	22	2	16		6							4			1
Orange	53	16	434	130	374		66		3	3			2	1	1	77		75	246
Palo Pinto	18	8	323	11	187		127		29		12	1	2	2	1	14		755	123
Panola	4	2	3	36	17		8		4				3			23		27	11
Parker			97		11		6	1	5					1					
Parmer			268		43	4	25		1		2				2				
Pecos		28	73		83		14			1						2			
Polk	5				2				1		3								
Potter	8	1	307	5	167	4	49	1	49	1	84		4		2	2		48	397
Presidio	2	37	261	5	35	4	9	1	24		3				12	48	1	17	18
Rains																			
Randall					11		1									3		1	
Reagan	1	4	76	4	110		4		1						4	4		4	45
Real																			
Red River					3		2	2											
Reeves	2	121	216		87	6	53						4			64		29	2
Refugio	1	79	76	2	165		15	2	6		15			1		20		14	14
Roberts			23		6		2				1								
Robertson	6		78	16	145	1	10				39			8				7	7
Rockwall			34	43	39		17		3							13		1	2
Runnels	1	39	151	2	247		2	1	8		17			27		11		52	26

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REPORTS BY COUNTIES																			
Rusk	3		46	45	25	3	3	1			1			1		51		27	7
Sabine	2	2	5						1							1			
San Augustine	2	15	97	118	184	1	52	1			1			1		24		7	13
San Jacinto	2	1	116	167	10		30									32		52	158
San Patricio	2	87	81	2	58		13	2	1		27			47	4	45		19	18
San Saba	2	25	231	15	138	1	13				7		1		6	33		2	
Schleicher		34	119		115		24						18		8	38			
Scurry	4								10										
Shackelford	1	11	5		16		1		1		1								7
Shelby	1	62	181	122	116		12				3					26		37	9
Sherman			49		68	4	7				1					6		2	
Smith	9	6	473	315	200	1	135		19		14	1	7	4		51		102	121
Somervell		9	25	3	9		6		1	1	1					5			4
Starr											1								
Stephens	3		135	10	279		40				4			1		8		3	
Sterling		12	59	1	79		3									17			2
Stonewall																			
Sutton		20	162		125	1	37									28			
Swisher			31	19	114		9						1		11	5			
Tarrant	32	13	1	3	375	2	2	10	126		76		37	50	9	193		1	
Taylor	23	53	383	14	1229	7	153	9	37		134	1	4	16	1	108		192	237
Terrell	1	7	19		3		3				1		1			2			1
Terry	3	6	302		152	1	100		1					1		42		8	8
Throckmorton	6	54	140	3	515		20		10	1	1	2		4	1	116	2	23	12
Titus		25	122	63	133		4		9		2					43		1	
Tom Green	1				118			1	1		7		10					1	
Travis	45	15	239	4	812	2	126	12	9		116		7	18	2	23		4	
Trinity	7		273	9	146	7	61				2			1		7			
Tyler			21	16	92		1												6
Upshur	16	133	175	168	673	1	76	2	2		9	2	3	1		14		14	263
Upton		2	52		98		3	1	1		1				2	16		2	3
Uvalde	9	45	109	1	80		30		5		61		3			105		1	9
Val Verde	5	2	66	2	104		13				3								
Van Zandt	7	3	819	862	60		44		17	3	21					190		17	
Victoria	26	10	266	2	116		25	1	16	1	46		5	9		27		52	10
Walker																			
Waller	5	8	156	18	41	1	35		9		9		1	20		10	2	3	
Ward		2	18		4		9	1		11	3					4		1	1
Washington			326		3				1					16				18	4
Webb	37	66	289	7	85		14		29		102		15	13		111	11	54	80
Wharton	4	171	509	55	401	4	70	2	6		41		1	12		267		107	85
Wheeler	4		445		274		7		3		2				17	121		2	5
Wichita	14		430	3	1645	2	26		20	2	48		5	1		38		1	
Wilbarger	8	2	146		224	1	35	1	8	2	16	2	1	2		4		2	1
Willacy		3		2	1						8			11				3	3
Williamson	9	30	20		78		6		2	1			2	2					
Wilson	6	12	38	7	63	3	14				20			19		3		4	10
Winkler		2	219		201		38		45							27		5	3
Wise	5	9	48	2	12	1	11		2		1			1	3	24		4	6
Wood	14	115	538	275	235		37		3	6	6	1	1			74		19	6

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REPORTS BY COUNTIES																			
Yoakum							1												
Young	6							1	3				1						
Zapata											1								
Zavala		10	40		3	1	3		2		38		1			9			
Total																		6469	8948

** V. D. morbidity data from health officers' reports.

931

Other reportable diseases or conditions by counties:

Anthrax: Uvalde 1; Walker 2; Wharton 2.

Encephalitis: Archer 1; Bee 1; Bexar 1; Cooke 1; Dallas 1; El Paso 2; Fisher 1; Grayson 1; Hale 1; Hansford 1; Harrison 1; Houston 1; Jeff Davis 2; Lampasas 3; Milam 1; Nueces 2; Presidio 1; Shelby 2; Tarrant 1; Travis 1.

Leprosy: Bell 1; Bexar 1; El Paso 1; Jackson 1; Kleberg 1; Lamar 1; Matagorda 2; Nueces 1; San Patricio 1; Tarrant 1.

Ophthalmia: Aransas 1; Archer 6; Bee 2; Bexar 10; Bosque 2; Bowie 1; Brazos 1; Collin 1; Comal 8; Dallas 5; Fort Bend 1; Grayson 1; Hall 4; Harris 1; Hill 1; Kinney 1; Lamar 3; Lamb 20; Lipscomb 1; McLennan 1; Matagorda 2; Midland 2; Nacogdoches 28; Orange 2; Polk 1; Swisher 1; Upshur 2; Uvalde 1; Van Zandt 2; Webb 4; Wharton 2; Wilson 1.

Paratyphoid: Bee 1; Bell 1; Bexar 1; Brazos 1; Cameron 1; Collin 1; Dallam 2; De Witt 1; Dimmit 1; Ector 4; El Paso 2; Guadalupe 1; Harris 1; Hockley 1; Hudspeth 1; Hutchinson 1; Jackson 1; Jefferson 3; Johnson 1; Taylor 2; Victoria 1; Winkler 1.

Pneumonitis: Anderson 1; Grayson 1; Guadalupe 1; Midland 2.

Relapsing Fever: Baylor 1; Cameron 2; Camp 3; Cass 3; Coleman 2; Cottle 1; Dimmit 1; El Paso 1; Grayson 2; Guadalupe 1; Howard 3; Jasper 1; Jones 1; Knox 1; Lampasas 7; McCulloch 1; Navarro 1; Potter 3; Presidio 1; Refugio 1; Schleicher 1; Sherman 1; Travis 2; Upshur 1.

Trachoma: Bell 2; Comanche 2; Cooke 1; Dawson 1; Delta 3; Gillespie 1; Guadalupe 1; Hardin 2; Henderson 3; Hudspeth 1; Jefferson 1; Jim Wells 1; Karnes 2; Lamar 1; Lee 4; Liberty 2; Limestone 1; McLennan 6; Mitchell 1; Nacogdoches 1; Palo Pinto 1; Refugio 3; San Saba 2; Taylor 1; Uvalde 4; Van Zandt 65; Wheeler 1; Willacy 1; Wood 1.

Although occasional reports were received from Borden county, no communicable disease or notifiable conditions were reported.

No reports were received from the following counties at any time during 1942: Atascosa, Cochran, Glasscock, Hartley, Jim Hogg, Kenedy, Kent, Loving, McMullen, Martin, Rains, Real, and Stonewall.

NUMBER OF CASES REPORTED BY DISEASE AND BY YEAR

DISEASES	1942	1941	1940	1939	1938	1937	1936	1935	1934	1933	1932	1931	1930
ANTHRAX	5	6	1	2	8	8	8	8	11	10	1	3	7
CHICKENPOX	10,284	7,506	5,939	7,221	6,628	6,035	2,694	4,060	5,554	3,650	2,247	2,252	2,340
DENGUE	91	526	7	56	143	257	30	107	133	100	35	16	17
DIPHTHERIA	1,930	1,902	1,450	1,643	2,348	2,205	2,155	3,512	3,943	5,756	4,304	2,276	1,936
DYSENTERY, AMEBIC	368	341	331	85	64	23	6	10	-	-	-	-	-
" , BACILLARY	5,965	3,198	2,989	1,600	873	1,980	377	426	1,344	780	90	52	277
ENCEPHALITIS, INF.	26	92	23	26	35	47	19	16	34	73	4	3	5
INFLUENZA	34,995	128,372	57,289	24,384	16,219	40,962	15,273	14,421	12,573	15,208	11,275	1,952	2,617
LEPROSY	11	15	12	21	16	15	10	19	27	5	-	2	-
MALARIA	7,678	8,068	6,606	4,540	4,400	19,026	25,373	26,304	21,790	17,124	7,132	7,756	8,958
MEASLES	37,622	23,221	19,939	8,365	5,710	14,768	8,119	4,073	28,632	22,146	4,694	2,424	4,274
MENINGITIS, EPI.	194	87	73	87	90	241	273	148	93	86	20	44	50
MUMPS	28,976	7,421	2,199	1,616	2,204	8,177	9,659	3,610	1,140	1,357	574	1,483	935
OPHTHALMIA, NEO.	119	94	43	30	53	72	27	28	55	22	5	4	10
PARATYPHOID	39	40	38	40	71	103	71	68	108	101	55	24	14
PELLAGRA	1,321	1,612	1,367	1,308	1,926	1,676	589	546	782	523	19	54	33
PNEUMONIA	7,871	10,037	6,752	4,900	5,156	6,104	3,892	3,489	4,190	1,885	953	682	711
POLIOMYELITIS	243	123	187	232	63	635	68	79	152	53	72	33	134
RABIES IN MAN	1	-	-	1	5	7	6	12	13	6	-	-	-
RELAPSING FEVER	42	13	15	36	37	43	3	12	8	5	-	-	-
ROCKY MT. SPOTTED FEVER	6	1	-	1	-	3	2	-	-	1	-	1	-
SCARLET FEVER	1,907	2,061	1,824	2,426	4,445	4,378	2,982	2,792	3,484	3,004	2,601	1,893	1,716
SMALLPOX	136	47	121	502	636	166	76	547	886	859	1,035	1,819	2,718
TRACHOMA	116	148	74	82	101	152	73	60	400	171	42	69	65
TUBERCULOSIS	4,110	2,840	2,906	3,033	3,600	3,362	2,643	3,029	3,018-	3,017	1,268	1,066	1,186
TULAREMIA	32	46	35	71	83	44	18	15	24	42	16	4	1
TYPHOID FEVER	564	775	965	1,153	1,612	1,729	918	1,389	1,796	1,831	941	836	669
TYPHUS FEVER	1,204	733	410	538	497	453	327	265	465	398	227	43	13
UNDULANT FEVER	231	330	354	327	238	198	43	46	21	43	33	11	5
WHOOPING COUGH	7,344	11,012	10,152	4,735	9,846	10,091	1,764	3,009	9,145	6,019	1,967	1,251	788

REPORTED MONTHLY INCIDENCE OF COMMUNICABLE DISEASES 1942

DISEASES	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	TOTAL
ANTHRAX	0	0	0	0	0	0	3	2	0	0	0	0	5
CHICKENPOX	1514	1706	1992	1912	1331	409	143	94	76	297	369	441	10284
DENGUE	22	22	3	2	6	20	6	2	1	1	3	3	91
DIPHTHERIA	278	182	179	134	121	72	78	103	118	298	221	146	1930
DYSENTERY, AMEBIC	16	11	17	13	29	62	30	69	27	70	14	10	368
" , BACILLARY	190	147	190	138	480	1024	1130	865	465	609	476	251	5965
ENCEPHALITIS, INF.	4	0	1	0	2	6	0	3	2	2	6	0	26
INFLUENZA	7638	6968	5723	3083	1736	628	442	469	633	2261	2217	3197	34995
LEPROSY	1	2	0	2	3	1	0	1	0	1	0	0	11
MALARIA	253	216	270	367	667	747	1066	1598	977	798	461	258	7678
MEASLES	3701	7658	10314	8764	5378	1119	313	164	43	67	51	50	37622
MENINGITIS (EPI.)	24	40	29	21	24	8	16	7	4	3	7	11	194
MUMPS	3206	4458	6096	5609	4919	1889	875	533	270	337	357	427	28976
OPHTHALMIA, NEO.	10	7	27	12	18	13	8	10	1	9	3	1	119
PARATYPHOID	2	1	0	1	1	3	6	7	10	2	3	3	39
PELLAGRA	159	108	188	152	133	119	80	90	74	112	66	40	1321
PNEUMONIA	1433	1513	1267	900	579	226	145	167	187	395	408	651	7871
POLIOMYELITIS	5	7	3	7	6	7	6	16	11	48	53	74	243
RABIES (INCLUDES DOG BITES)	1	2	2	0	0	0	0	0	1	6	2	0	14
RELAPSING FEVER	5	1	5	0	1	3	1	5	4	6	2	9	42
SCARLET FEVER	294	215	218	193	153	90	55	92	49	199	173	176	1907
SMALLPOX	12	46	25	24	12	2	3	1	1	4	3	3	136
TRACHOMA	8	12	7	7	11	7	11	10	10	11	8	14	116
TUBERCULOSIS	282	213	268	288	304	212	230	341	305	1052	415	200	4110
TULAREMIA	0	2	2	2	7	3	2	6	5	2	0	1	32
TYPHOID FEVER	25	12	18	23	38	62	99	115	69	67	14	22	564
TYPHUS FEVER	57	42	37	26	41	69	134	267	163	162	105	101	1204
UNDULANT FEVER	20	19	15	26	25	27	17	20	25	17	5	15	231
WHOOPING COUGH	464	631	687	696	974	668	691	581	387	506	452	607	7344

MORBIDITY AND MORTALITY DATA BY DISEASE, 1933 - 42

Disease	1942 Cases Reported	1942 Case Rates*	1933 - 1942 Cases Reported	1933 - 1942 Deaths Registered	1933 - 1942 Ratio: Cases to Deaths	CASE RATES 1933 - 42 Mean	Median	Maximum
Diphtheria	1,930	29.4	26,844	3,047	8.8	43.3	34.9	95.9
Dysentery Infectious	6,333	95.4	20,770	21,171	.9	32.4	26.5	95.4
Influenza	34,995	535.7	359,696	20,911	17.2	561.3	257.6	1982.9
Malaria	7,678	117.5	140,909	3,249	43.4	227.7	124.6	429.8
Measles	37,622	575.9	172,595	2,379	72.6	274.4	310.8	575.9
Meningitis	194	2.9	1,372	578	2.4	2.2	1.4	4.4
Pneumonia, All Types	7,871	120.5	54,276	42,975	1.3	85.8	77.1	155.0
Poliomyelitis	243	3.8	1,835	577	3.2	3.2	1.9	10.2
Tuberculosis	4,110	62.9	31,558	40,312	.8	50.3	49.8	62.9
Typhoid Fever	564	8.8	12,732	4,078	2.9	20.5	22.7	30.5
Typhus Fever	1,204	18.4	5,290	284	18.6	8.4	7.7	18.4
Whooping Cough	7,344	112.4	73,117	2,842	25.8	101.7	100.3	170.1

*Case rate is number of cases reported per 100,000 estimated population.

MORTALITY RATES PER 100,000 POPULATION FROM CERTAIN COMMUNICABLE DISEASES IN TEXAS, 1933-1942

POPULATION (Est.)	6,001,748	6,060,759	6,119,770	6,178,751	6,237,792	6,296,803	6,355,814	6,414,824	6,473,835	6,532,846
	1933	1934	1935	1936	1937	1938	1939	1940	1941	1942
DIARRHEA & ENTERITIS (Under 2 yrs.)	31.1	27.2	29.0	26.6	31.2	24.6	28.1	30.8	16.4	18.2
DIARRHEA & ENTERITIS (Over 2 yrs.)	10.1	8.4	8.0	7.3	7.0	6.1	8.9	8.6	5.8	5.9
DYSENTERY (All types)	7.8	7.9	7.2	6.6	8.0	5.7	6.2	9.9	1.7	1.8
DIPHTHERIA	10.7	7.3	7.6	5.6	3.9	3.8	2.8	2.4	2.4	2.4
ENCEPHALITIS	.7	.5	.5	.4	.6	.5	.3	.4	.2	.2
INFLUENZA	43.1	28.7	39.0	52.6	52.5	24.0	24.4	27.4	30.6	13.5
MALARIA	7.2	8.2	10.5	8.0	5.8	4.1	2.6	2.6	2.4	1.4
MEASLES	9.8	10.7	2.6	2.7	3.5	1.8	1.2	3.3	1.3	1.6
MENINGITIS	.9	.9	1.2	2.1	1.5	.6	.4	.5	.4	.6
PERTUSSIS	6.1	8.2	3.4	2.2	5.9	5.9	4.6	4.9	3.5	2.9
PNEUMONIA (All types)	65.7	77.7	83.1	99.9	85.5	69.0	61.2	53.6	50.8	42.5
POLIOMYELITIS	.8	1.2	.8	.6	2.2	.7	1.0	.7	.8	.8
SCARLET FEVER	1.2	1.1	.9	1.0	.7	.5	.4	.2	.1	.2
SMALLPOX	.2	.1	.1	.0	.0	.1	.1	.1	.0	.0
SYPHILIS	9.8	10.2	10.3	10.6	10.5	9.5	9.5	14.4	12.3	12.2
TUBERCULOSIS	71.8	65.4	68.8	70.8	68.8	65.6	61.7	59.7	56.9	54.6
TYPHOID & PARATYPHOID	9.9	8.1	8.8	6.5	6.3	6.2	4.5	3.4	2.1	1.4
TYPHUS	.1	.3	.2	.4	.4	.4	.6	.5	.7	.9

DEATHS FROM CERTAIN COMMUNICABLE DISEASES IN TEXAS
1932 - 1942

DISEASES	1932	1933	1934	1935	1936	1937	1938	1939	1940	1941	1942
DIARRHEA & ENTERITIS (Under 2 yrs.)	1,549	1,863	1,655	1,776	1,642	1,939	1,550	1,775	1,973	1,061	1,193
DIARRHEA & ENTERITIS (Over 2 yrs.)	477	605	509	488	451	435	381	563	553	372	387
DYSENTERY (All types)	347	470	482	441	386	501	360	392	634	110	119
DIPHTHERIA	850	650	442	466	345	242	241	187	153	162	159
ENCEPHALITIS (End.)	16	45	30	28	26	37	29	21	28	17	15
INFLUENZA	3,408	2,588	1,718	2,384	3,257	3,266	1,530	1,544	1,760	1,979	885
MALARIA	284	429	497	644	495	361	256	163	165	148	91
MEASLES	134	589	649	159	167	217	114	87	210	84	103
MENINGITIS (Meningococcus)	33	53	58	84	130	94	38	28	31	25	37
PERTUSSIS	310	368	494	207	137	367	370	231	251	224	193
PNEUMONIA (All types)	3,940	3,941	4,716	5,094	6,163	5,338	4,346	3,874	3,436	3,288	2,779
POLIOMYELITIS	57	47	73	49	35	127	41	63	42	50	50
SCARLET FEVER	99	73	63	59	64	47	31	23	15	8	13
SMALLPOX	13	14	8	5	0	0	7	4	1	0	0
SYPHILIS	517	588	617	634	652	651	600	602	927	796	795
TUBERCULOSIS	4,317	4,308	4,020	4,202	4,374	4,289	4,129	3,911	3,824	3,688	3,567
TYPHOID & PARATYPHOID	541	594	489	539	400	392	391	285	218	138	91
TYPHUS	0	7	16	14	23	28	23	36	35	46	56

FROM BUREAU OF VITAL STATISTICS

BACILLARY DYSENTERY (PRIMARY ACUTE INFECTIOUS DIARRHEAL DISORDERS), 1942

The primary acute infectious diarrheal disorders are usually reported as bacillary dysentery. This group of diseases is one of the most important in this State and is the leading cause of the unfavorable infant mortality record. These infections occasionally are food borne infections and multiplication of these organisms may actually occur in food. In reporting these infections specific type of organism should be indicated when this is known. In numerous localities these infections are poorly reported.

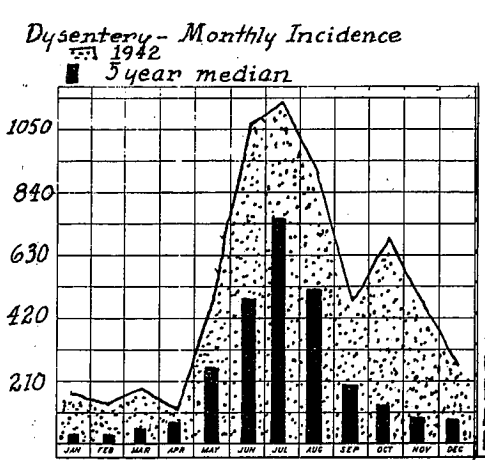
The reported incidence of bacillary dysentery in 1942 revealed a full 50 per cent increase over 1941 and reached a height of approximately 6,000 cases. While the mortality increase was evidently of lesser degree, nevertheless, the recorded mortality increased from 1543 deaths in 1941 to 1699 including 1193 infant deaths in 1942. Bacillary dysentery and diarrhea is endemic in this State at all seasons of the year, but the largest number of cases and more extensive outbreaks are most often reported in the summer months of the year.

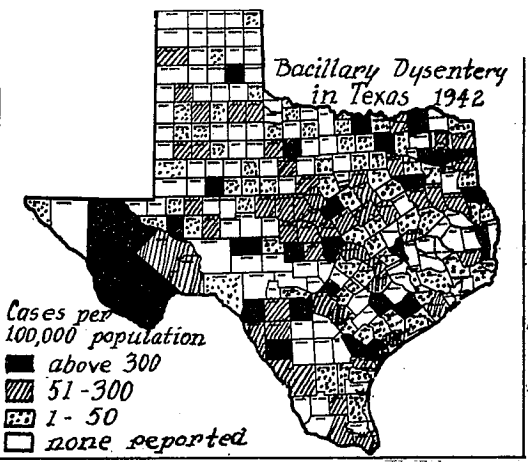
Epidemiological investigations of bacillary dysentery and the acute infectious diarrheal disorders can be very productive of results useful in the control of these infections. It is regrettable that more health officers do not take the time to submit appropriate specimens to the laboratory for careful bacteriological examination.

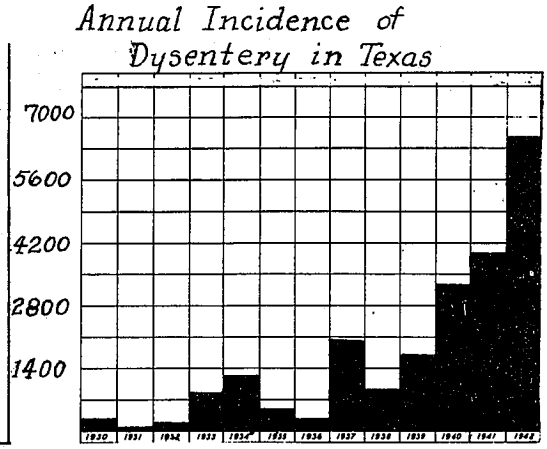
Among the etiological agents involved, the Flexner organisms and their close relatives, are of particular importance. The Flexner bacilli, types V, W, and Z, and the closely allied Newcastle type are widely distributed over the State. The Duval-Sonne types are only less widely distributed. The latter are possibly more resistant than the former to sulfonamide therapy. While true Shiga infections are rarely recognized in this State, it should be noted that this organism is more difficult to culture from preserved specimens of stool. The Salmonella infections, of which there are several types, frequently require consideration in the differential diagnosis or in epidemiological investigations of the acute diarrheal disorders.

The epidemiology of these infections is none too well understood. While extra-human sources of the so-called Shigella or dysentery bacilli seldom are given consideration, animal sources, particularly the droppings from rodents, have long been recognized with Salmonella incitants, but the danger from bird droppings oftentimes is overlooked. Flies are of importance and it is possible that roaches or other arthropods may require consideration at times in transmission of these infections to man. The transient human carriers and unrecognized infections appear to be of great importance in dissemination of these infections. Little is known about chronic carriers.

Immunization against these infections is not feasible at present and control measures must necessarily involve general protective procedures. Modern sanitary practices have been devised particularly for protection against bacillary dysentery and the acute infectious diarrheal disorders. In general, whatever type of causative agent is involved, the control of these infections is founded on provision of clean water, milk and food, good personal hygiene, control of flies and rodents, and proper disposal of excreta.







DENGUE FEVER IN TEXAS, 1942

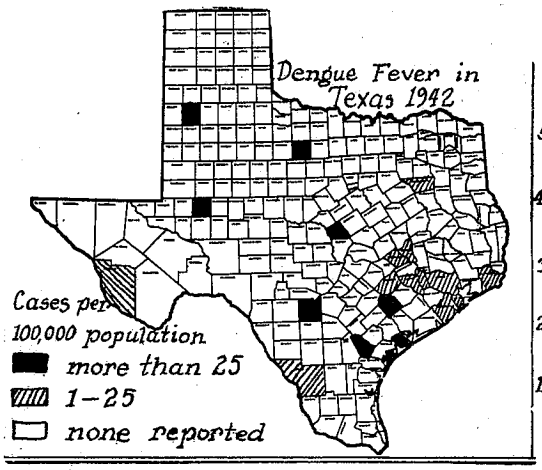
Possibility of the occurrence of dengue fever in epidemic proportions over extensive areas was entertained because numerous cases undoubtedly occurred in 1941, for the first time since 1922. Likewise it has not been forgotten that dengue in times past has oftentimes been a forerunner of yellow fever. However, the reported incidence of dengue was very low in 1942. Presumably this was not due to lack of susceptible persons but possibly was due in part to a more unfavorable mosquito season.

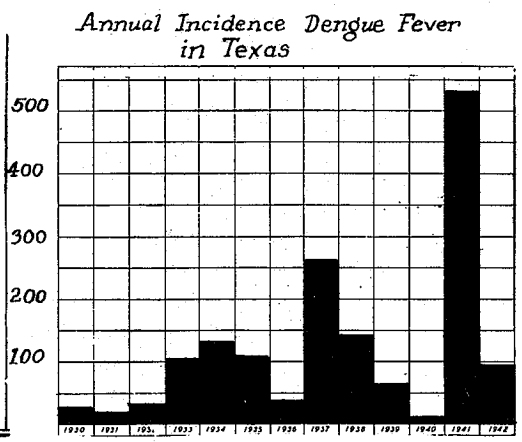
Dengue is an acute febrile infection of sharp onset which is quite readily confused with any one of several other ailments. This is particularly true when physicians who have not seen cases in recent years encounter sporadic cases. "Breakbone fever" is descriptive of the intense joint and muscle pains which usually accompany this disease. Intense headache and an eruption are also usual. The illness is of shorter duration than typhus and, furthermore, the febrile course is commonly of saddle-back type. Lack of respiratory symptoms and appearance of rash helps exclude concern with influenza in the differential diagnosis. The slow pulse and leucopenia help exclude consideration of scarlatina while absence of Koplik's spots helps rule out measles. The leucopenia is a very constant feature and one of the best diagnostic aids supplied by the laboratory.

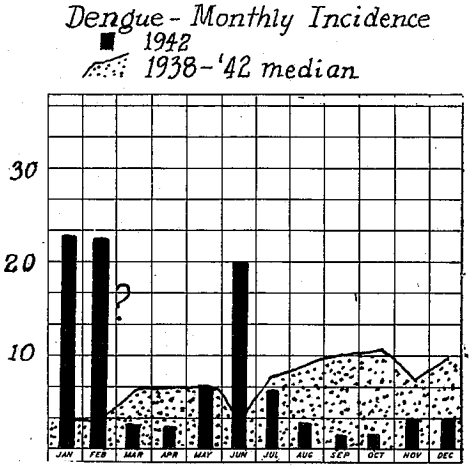
Dengue is a virus disease which is believed to be transmitted in Texas principally by Aedes aegypti, a common little black mosquito. This mosquito also is sometimes known as the "yellow fever" mosquito. The origin of the 1941 outbreak of dengue is obscure, but since sporadic cases are reported every year, it is possible that dengue is endemic in Texas. Importation of infectious cases or infected mosquitoes could have started this outbreak.

This infection is not known to be enzootic in Texas, since no animal reservoir of the dengue virus is recognized in this state. It must be said, however, that search for this virus in animals and confirmation of diagnosis by laboratory methods are both particularly hampered by the lack of suitable susceptible animals for testing purposes. Information concerning the dengue virus has been acquired through inoculation of human volunteers supplemented with monkey inoculations. Infection in the monkey is of the inapparent symptomless type.

Control of dengue is basically dependent upon application of mosquito control measures for which cooperative community efforts are required. Patients should be housed in screened rooms. The Texas State Health Department in conjunction with the U. S. Public Health Service is conducting a campaign to prevent an outbreak of dengue fever. Since facilities do not permit 100% control, we are extremely anxious to be informed as quickly as possible of suspected cases, so that we may eliminate adult Aedes aegypti from the home and business places of afflicted individuals and make especially careful searches for breeding places in areas near where cases occur.







The satisfying steady decrease in morbidity and mortality from diphtheria, which was evident during the past few years, in the past two or three years has not been maintained. The State still has more deaths from this preventable disease than any other state in the Union. Nearly 2,000 cases of diphtheria were recognized in 1942 with 159 deaths. Intensified efforts are required to bring once again a consistent decrease both in incidence and mortality.

The presence of a case or a death from diphtheria in a community is an indictment of that community; it means that somehow there has been a breakdown in prevention. Penurious community attitudes with regard to public health result in the increase of morbidity and mortality.

Quarantine of cases is considered essential and the length of quarantine or date of release should be based entirely on cultures of the nose and throat. Two consecutive negative cultures are suitable for release. The State Health Department Laboratories are equipped to furnish culture media and to do both diagnostic and release cultures for indigent cases and virulence tests on suspected carriers.

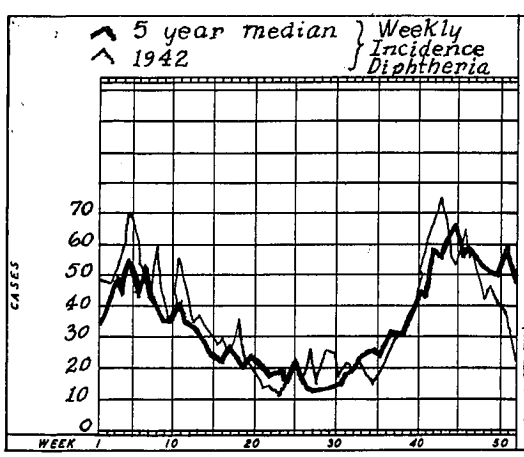
The importance of the carrier in the spread of the disease makes release culturing and cultures in epidemiological investigation essential. Carriers may exist without any history of the disease. It is important, however, that individuals not be indicted as carriers until it is determined whether or not the diphtheria bacillus harbored is virulent or not.

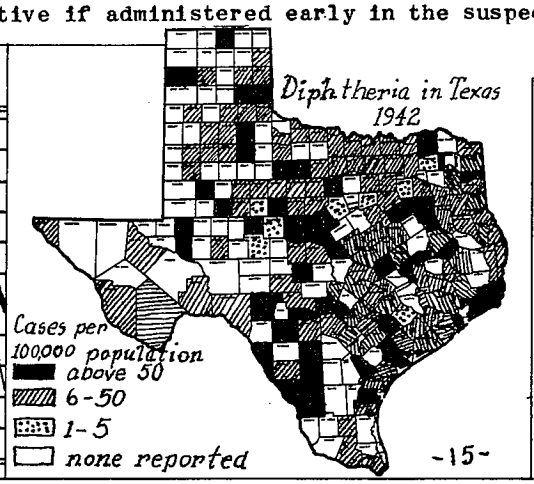
Since about 1900 an effective therapeutic agent has been available for treatment of the disease and the immunizing agents have proved efficacious producing immunity in over 90% of cases. In the Schick test there is a suitable method for determining susceptibility. Thus one may determine those who need immunization, the immunizing agent is available, and if this fails, the treatment is effective if administered early.

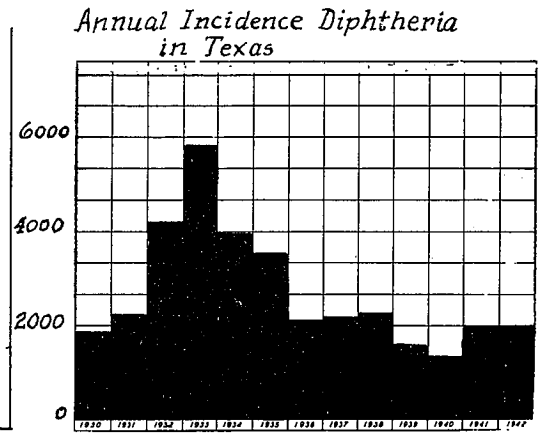
If the mother is immune to the disease, the newborn infant has an immunization at birth that lasts about 6 months; for this reason the Department advocates the immunization of every child between 6 months and one year of age. This is doubly important because immunization for school entry is too late since 90% of all deaths occur in the first five years of life. The Schick test should be performed after immunization so that, if it is necessary, extra dosage may be given. Either two doses of alum precipitated or three doses of plain diphtheria toxoid given at one month intervals is recommended by this Department. Immunization for school entry is advisable particularly if this was previously neglected.

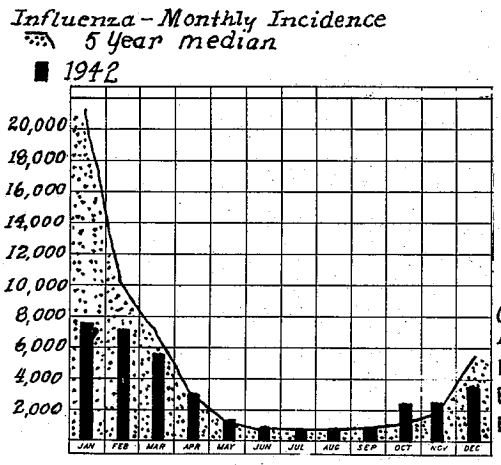
In the presence of an epidemic, this Department does not advocate closing schools. Children should be given the regular toxoid if they have never had it and should be observed closely for signs of sore throat in which case therapy may be given. Passive immunization may be practiced in isolated areas where the child cannot be observed closely for several days, but otherwise the regular immunization procedure is preferred.

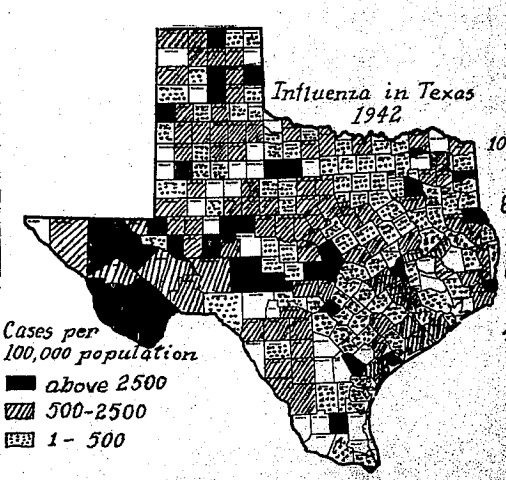
Fumigation is of little or no value in this or other communicable disease. Disinfection of the class room or sick room is achieved by thorough airing of the room, exposing movable equipment to direct sunlight for a few hours and washing or thorough cleaning of woodwork and fixed furniture. Antitoxin treatment is effective if administered early in the suspected or recognized infections.

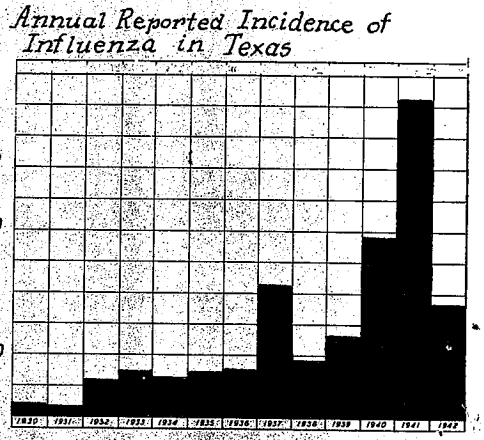












EPIDEMIOLOGY OF INFLUENZA

Since the greatest number of reported cases of influenza in Texas since 1918-1919 occurred in 1941, this Department was somewhat apprehensive as the year 1942 approached. However, the incidence was much lower in 1942, although the total number of cases reported remained in excess of 35,000. The disease was mild and of short duration and was infrequently followed or accompanied by pneumonia or other complications. The 885 deaths from influenza reported in 1942 were less than half the number reported for this infection in 1941. In the ten-year period 1933-1942 influenza was reported as the cause of approximately 20,000 Texans' deaths.

It is almost ten years since "Influenza A" virus was first obtained from humans by the inoculation of the ferret. In some outbreaks the "Influenza B" virus has also been found. That these are not the only causes of epidemic influenza has been indicated by the frequent failure to find either the "A" or the "B" virus. Epidemic influenza of unknown etiology has sometimes been called "Influenza Y." In one outbreak "Influenza Y" appeared to constitute 80% of the cases. Thus, it is clear there are at least three, and possibly more, immunological types of epidemic influenza virus. Although "Influenza A" or "B" may result in massive pneumonia in animals, there is no evidence that this occurs in man; in fact, epidemic influenza in man in recent years has been characterized by a notable lack of complications. It should be noted that the cause of "pandemic influenza" is still unknown despite much astute speculation. Likewise, the cause of "endemic influenza" is also in the unknown category. Clinically, there is no way to differentiate between the sporadic case of endemic influenza and cases of epidemic influenza.

Reporting of influenza is rather unsatisfactory both because of incomplete reporting and frequent disagreement regarding the criteria of diagnosis, particularly in dealing with the occasional or sporadic case. While laboratory tests are unlikely to be of value in dealing with the sporadic case, these tests can be of great help in investigations of epidemic influenza. Collection outfits are obtainable for selected, limited investigations by the State Health Laboratories.

There is good evidence, at least with epidemic influenza, that the incubation period is 24 to 48 hours. The infection is apparently spread by droplets or droplet nuclei from active cases of unrecognized infections. Little or nothing is known about carriers since neither the "A" nor "B" viruses have been found in the respiratory tract of carriers. Quarantine has been impractical in dealing with contacts, but cases should be isolated during the active stage of infection. Active immunization appears to be impractical at present either because of the diverse etiology or poor antigenicity and because of relatively low incidence and mild infections. Avoidance of crowds, adequate rest, and maintenance of good physical condition are advised for protection against these infections. Since the onset of "pandemic influenza" may be characterized by a simultaneous appearance of virulent epidemic influenza in widely scattered localities, early and careful epidemiological investigations should be instituted whenever virulent influenza appears. The causative agent would need to be determined before the preparation of a vaccine could be attempted.

MALARIA IN TEXAS, 1942

The incidence of malaria in Texas in 1942 was reported slightly under the total for 1941, halting temporarily, at least, the slow but constant upward surge of the past four years. Lesser rainfall in 1942 in many parts of the State possibly was a contributory factor. It is quite probable that the cycle of increased incidence has not yet been completed.

Reporting of malaria in this State is far from satisfactory in many respects. Diagnosticians should be thoroughly familiar with the thick film technic and other diagnostic aids. In this State malaria is reported throughout the year, but the greatest number of cases invariably occurs from June until October with considerable variations, however, over different parts of the State. The greatest incidence appears to center in north and central east Texas.

The more arid portions of the State have been relatively free of malaria until recent years when flood control measures, localized erosion control projects, irrigation projects and increased stock tanks were developed and afforded breeding places for the mosquito, Anopheles quadrimaculatus, which is the principal vector.

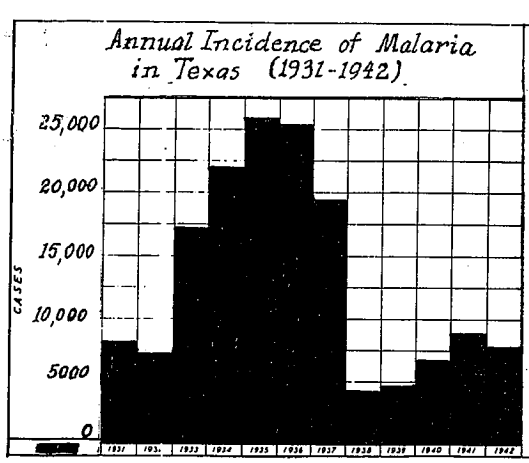
The offending parasite for the most part is Plasmodium vivax or the benigntertian form: however, the Plasmodium falciparum or estivo-autumnal type is also found in several localities. The latter type of infection is of particular importance because of its greater severity and higher mortality.

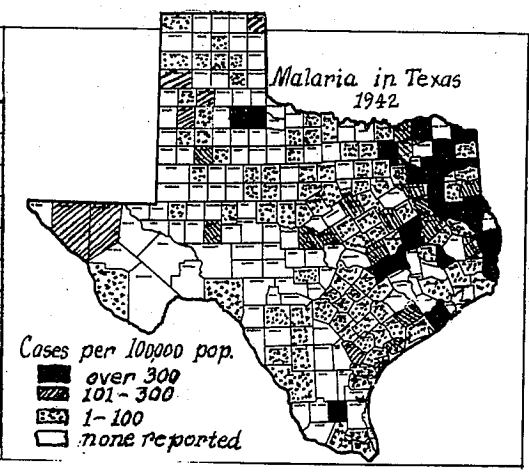
Since malaria depends on two factors, the human carrier and the Anopheline mosquito, control measures may be directed from either of two directions but either way is an expensive and laborious process. Control measures directed at lowering the density of the Anopheles quadrimaculatus population are frequently favored because of the significance of mosquitoes as pests and the difficulties of detecting human carriers. However, the carrier approach may be a less expensive procedure in certain localities.

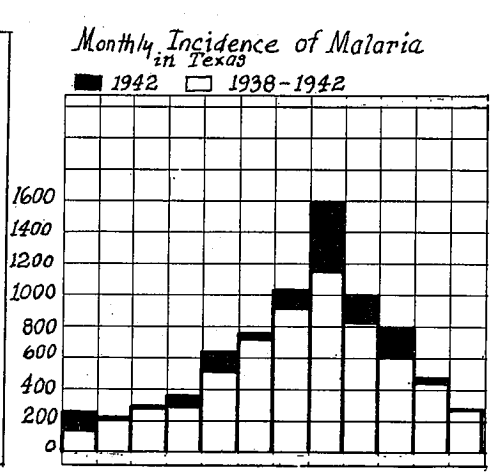
Epidemiological investigations of malaria frequently are very productive and the cost of control procedures oftentimes can be tremendously reduced if the malarial centers are accurately charted. Control procedures require consistent and intelligent practices and effective control measures in one locality are oftentimes impractical in another situation. The importance of consistent and planned procedures cannot be over-emphasized.

Chronic cases or carriers may persist for long periods of time, unless they are detected and properly treated. At times the question arises whether an increased incidence is due to recrudescence of old or introduction of new cases. A survey of infants may resolve and answer this question.

The introduction of new and more vigorous malarial mosquitoes, such as Anopheles gambiae, is always a possibility. Malaria remains Enemy Number One and is another of the war diseases, which will create havoc again unless constant vigilance is maintained.







PNEUMONIA IN TEXAS, 1942

Since the greatest number of pneumonia cases on record were reported in 1941, it is gratifying to note that the reported incidence showed a substantial decrease in 1942; however, the number of reported cases still approached 8,000. The heaviest attack rates were principally, but by no means altogether, reported from Central West Texas and Panhandle areas.

Although 2,779 deaths from pneumonia from all causes were reported in 1942, this was much the smallest number of deaths ever recorded for pneumonia in this state. It is interesting that the crude pneumonia death rate dropped from 50.8* to 42.5 while the influenza death rate dropped from 30.6 to 13.5 in 1942.

It has long been recognized that while many causative agents may be involved in pneumonia, pneumococcus pneumonia remains by far the most important. With reports on pneumonia, the etiological type should be designated for both morbidity and mortality tabulations, whenever the information is available. While Type I pneumococci are involved more often than any other type, other types at times are of great significance.

Both "virus pneumonia" and "atypical pneumonia of unknown type" have been increasingly reported. One should be cautious in placing cases in these categories on the basis of negative bacteriological findings or failure of response to usual therapeutic measures. For laboratory diagnostic tests based on virus recovery in test animals or changes in titer with serological analyses, collection outfits are obtainable for limited investigations by the State Health Laboratories.

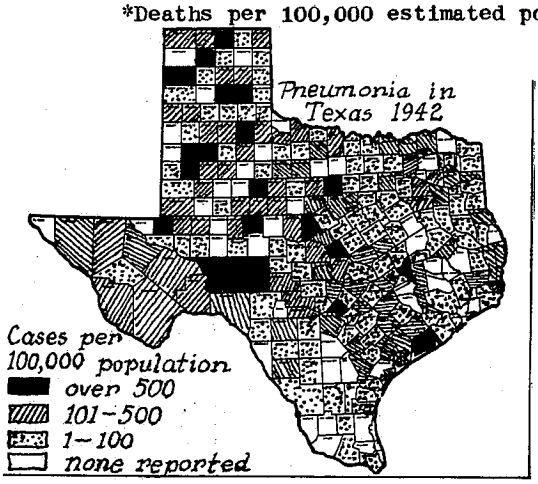
Transmission of pneumonia probably is accomplished by transfer of discharges from the respiratory tract largely by carriers or persons suffering from colds. Persons suffering from severe colds should avoid contacts with others and remain away from public meeting places. Quarantine is generally impracticable but cases should be isolated during active state of infection. Active immunization against pneumonia remains a problem for the future.

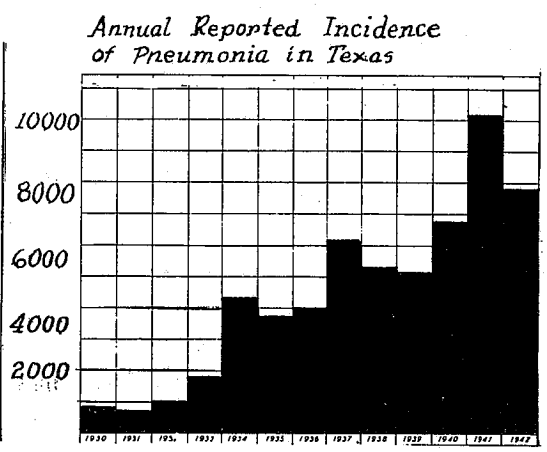
In pneumonia, early diagnosis, hospitalization, good nursing care, and proper medical treatment are particularly important. These factors have great influence in reduction of mortality. Although chemotherapy has largely replaced serotherapy, serotherapy should not be entirely overlooked and sometimes is valuable in conjunction with chemotherapy, or necessarily must be substituted for chemotherapy.

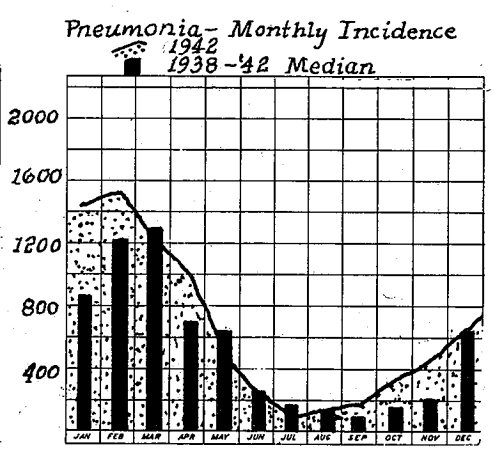
In guarding against pneumonia, personal prophylactic measures are very important. It is well known that pneumonia is often secondary to some other illness and frequently is a complication of a bad cold or influenza. Minor respiratory ailments are too often neglected. Maintenance of good physical condition, plenty of sleep, and good nutrition are powerful weapons in the prevention of pneumonia. The therapeutic or treatment aspects of pneumonia are very encouraging. With proper and adequate use of new drugs the pneumonia death rate should be reduced much more.

Pneumonia still holds a high place among the Disease Saboteurs!

*Deaths per 100,000 estimated population.







POLIOMYELITIS IN TEXAS, 1942

During 1942 the incidence of poliomyelitis (infantile paralysis) reached the highest level since 1937 in Texas. Sporadic cases occur at all seasons of the year in this state but the incidence characteristically rises rapidly during June and July with peak incidence in August, followed by a sluggish return to low levels in the fall and winter months.

During the past eight years the highest incidence had occurred in west Texas. In these areas there are high plains and plateaus. In general this is a high, dry area with the population sparcely distributed and where the principal occupations are ranching, cotton and grain production.

Several new features were added in 1942 with the highest incidence being recorded during the last three months of the year and particularly in south or southeast Texas. Despite the unusually late appearance of cases the total number of cases for the year was scarcely more than we normally expect. December was the peak month and the peak week was not reached until the last week of the year, suggesting that the virus might overwinter better than usual. Poliomyelitis was more prevalent than usual in 1936 late in the year.

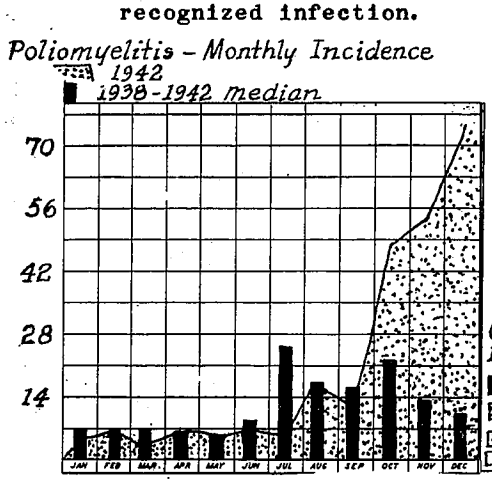
The reporting of poliomyelitis is far from satisfactory, principally because of disagreement regarding diagnostic criteria in the very severe and very mild cases. It is frequently suggested that large numbers of persons have experience with the poliomyelitis virus but that the occurrence of the paralytic syndrome is a relatively rare feature of the infection. The early reporting of poliomyelitis affords the opportunity for investigation at the stage when such effort is productive and affords the opportunity for early treatment by Kinney or other methods and use of orthopedic appliances made available through the Crippled Children's Service.

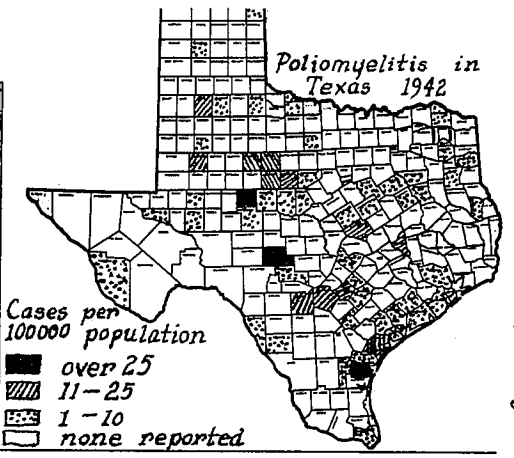
A diagnosis of virus meningitis, lymphocytic choriomeningitis or encephalitis should be made cautiously unless abortive poliomyelitis is evidently ruled out. Abortive poliomyelitis is not easily ruled out particularly when undoubted poliomyelitis is present in the community. In epidemiological investigations, differential diagnostic laboratory aids can be helpful and are, in fact, oftentimes indispensible. Blood taken aseptically but without coagulant or preservative and spinal fluid taken with aseptic precautions should be sent to the laboratory. Convalescent blood should later be obtained; frequently another blood sample in late convalescence or after recovery is also needed. Laboratory tests for viruses are frequently slow and time-consuming.

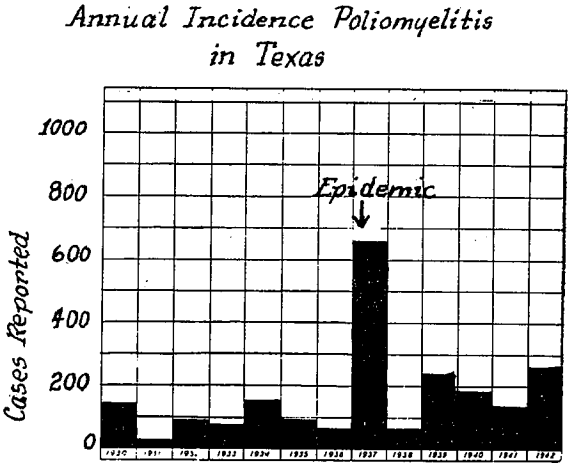
The control of poliomyelitis is particularly difficult because of lack of definite information regarding mode of transmission and route of infection. With the reports of isolation of the virus from the stools of patients, contacts, from sewage, and from flies, it seems apparent that the excreta should be handled in the same manner as with typhoid and other enteric diseases.

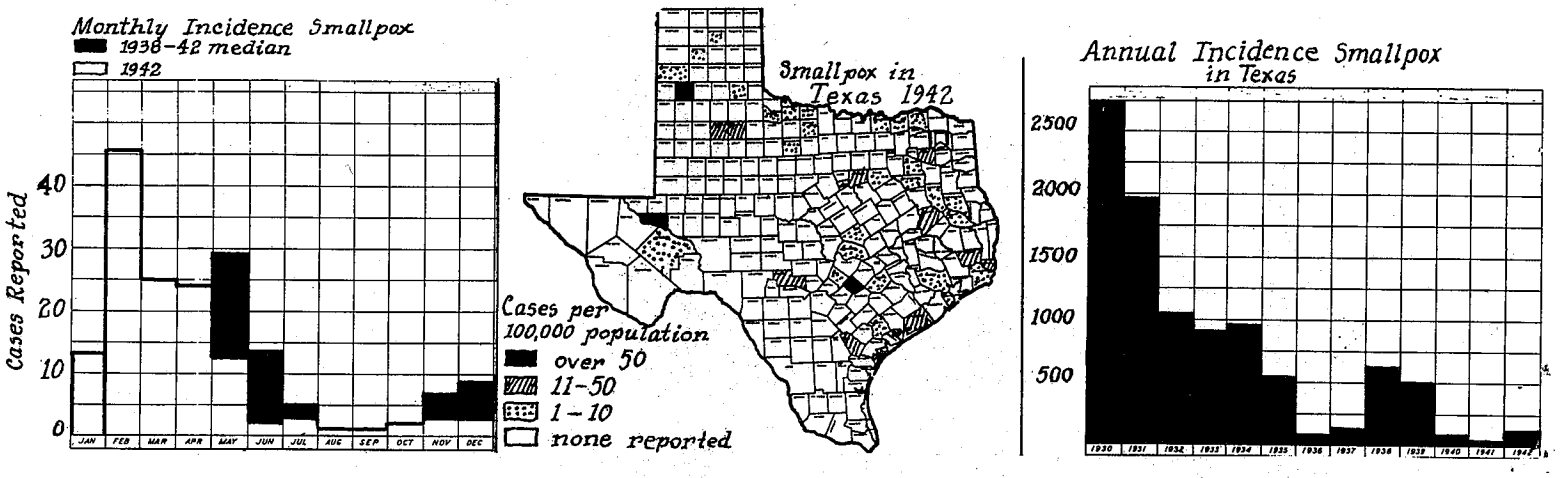
These facts point to local improvements in sanitation for prevention and control of poliomyelitis. Clean-up campaigns should be instituted at once when poliomyelitis is found in community.

Efforts to develop specific immunizing agents are still in experimental stages. Both the mother and physician should develop a high index of suspicion when the child develops illness ushered in by vomiting, accompanied or followed by unusual pain or stiffness of neck and back. When suspicious symptoms of poliomyelitis appear the child should be particularly protected from overexertion or strain. Careful therapy is the foundation stone of recovery of function in the recognized infection.









SMALLPOX IN TEXAS, 1942, EPIDEMIOLOGY, AND CONTROL MEASURES

The recorded incidence of smallpox in 1942 was slightly above that of 1941 but the incidence remained at low levels. The seasonal incidence is very sharply limited to winter months.

Reference to some of the outbreaks of the past keeps us from feeling complacent about the future. In the Minneapolis outbreak of 1924 there were 221 deaths among 993 cases. In the Vancouver outbreak of 1933 there were 16 deaths in previously unvaccinated persons among numerous cases, but not even one case in a person vaccinated as recently as 15 years.

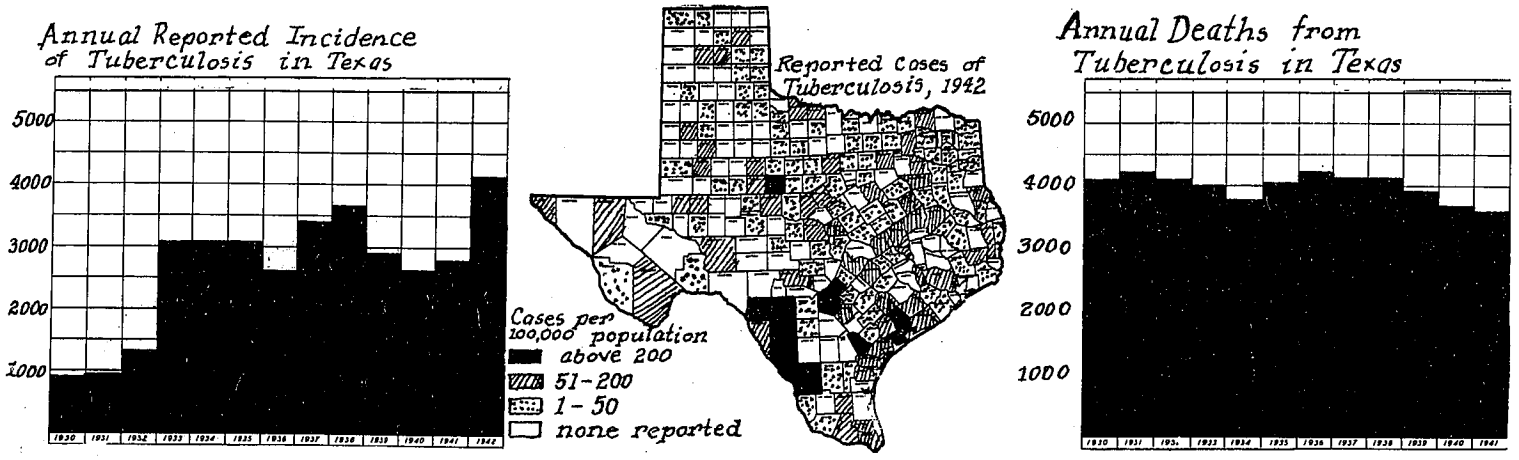
In Texas, as well as in many other parts of the world, in recent years smallpox has not been very virulent. Malignant smallpox in Texas for several years has been replaced largely by the mild or alastrim type. Large numbers of our population have never been vaccinated and the reactivation of more virulent infections is a definite possibility. In 1939 we investigated a rumor that smallpox was prevalent in the Latin-American population in a city of southwest Texas. Under the guise of chickenpox, the smallpox virus had gained in virulence in a highly susceptible group. When the situation was made clear, everyone in town was vaccinated and further trouble was averted. In this outbreak it was estimated there were 100 cases, but there were no deaths.

Epidemiological investigations are frequently fruitful and should be instituted promptly where any suspicion of the presence of smallpox exists. The results of prompt investigation can be turned to fruitful advantage in vaccination of contacts where smallpox actually exists. Cases require isolation until exfoliation of crusts is complete.

The possible introduction of malignant smallpox from other parts of the world is a menace to our large unvaccinated population. Vigilance must be maintained at all times in Texas.

Because of occasional disagreement regarding application of diagnostic criteria, particularly in the differentiation of chickenpox and smallpox, the State Health Laboratory is prepared to perform laboratory tests to aid in diagnosis. Upon request a collection outfit is obtainable with suggestions for sending pustular specimens in suspected smallpox.

Of all the mass immunization procedures, smallpox vaccination is most acclaimed and accepted. Unsightly scars resulting from unsuitable technic have sometimes been the cause of community prejudice against smallpox vaccination. Every physician should be thoroughly familiar with and skilled in this technic. The multiple pressure method is generally favored and recommended. It should be recalled that smallpox vaccine is a "live" vaccine which must be constantly stored at low temperature to avoid loss of potency. Potent vaccine, if administered with suitable technic, will produce some sort of "take" or immune reaction in every instance. Either the immune or the accelerated "take" is effective in rebuilding or maintaining immunity. Susceptible individuals should be included as a check on potency of virus. A "no take" on a susceptible individual indicates unsuitable technic or unsuitable virus.



TUBERCULOSIS IN TEXAS, 1942, EPIDEMIOLOGY, AND CONTROL MEASURES

Even with a slight decline in tuberculosis deaths over the past ten-year period, tuberculosis continues to remain in first place in mortality from communicable diseases in Texas. The decrease in rate and mortality of the past ten years probably represents the natural decline of the disease rather than the effect of control measures.

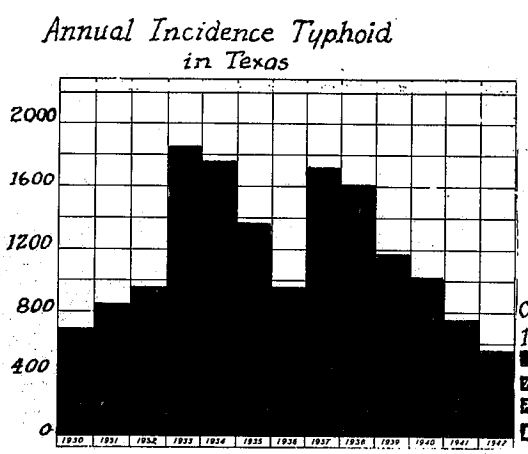
The reporting of this disease has always been unsatisfactory, and for the first time in 1942 the total number of reported cases exceeded the number of deaths. This increase is largely due to the finding of cases in Selective Service examinations, the reporting from other branches of the military service, and an extensive case finding.

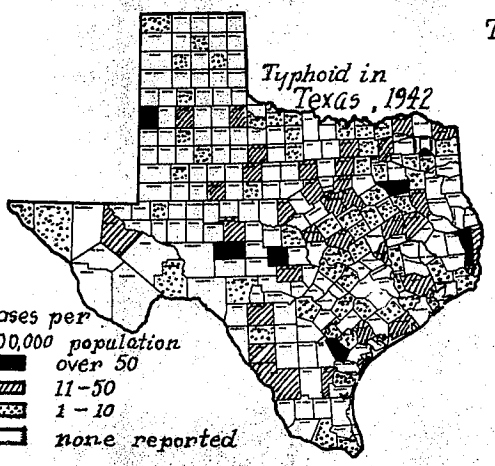
Although this disease occurs throughout the State, it is more prevalent in those locations having a Latin-American and Negro population. The problem of tuberculosis among Negroes is limited to the eastern half of the State while the Latin-American population occurs in the southwestern part of the State. The incidence of tuberculosis in the Latin-American population is more than seven times that of the remainder of the white population and more than thrice that of the colored population.

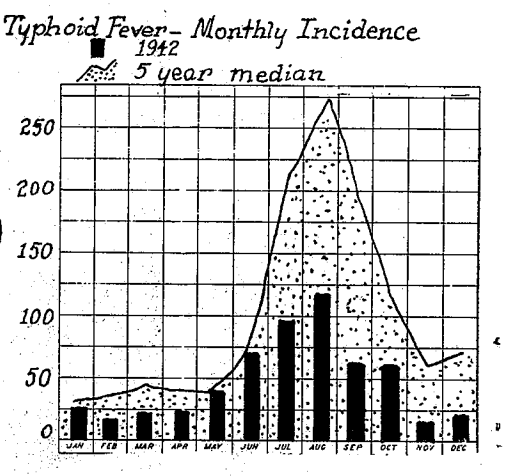
The progress made in elimination of tuberculosis in cattle and the extensive pasteurization processes available to milk producers and processors has reduced bovine tuberculosis to a negligible level.

In order to control tuberculosis, infectious cases must be recognized and early treatment instituted. Those persons with open lesions who are spitting out tubercle bacilli in large numbers constitute the infectious cases. Infection usually results from careless handling of contaminated sputum. When tuberculosis is found, the foremost idea should be 'Where did it originate?' To this end, with each case, epidemiological investigations should be instituted and the parent case recognized. Every case of tuberculosis resulted from another case and oftentimes several cases result from the same case. Unless the chain can be broken, other cases will result from the parent case. The importance of how the disease is spread and proper control of this spread are of paramount interest in prevention of other cases. The infectious cases of tuberculosis occur primarily in adults and the unrecognized cases are most often found in the older age groups. Elderly individuals with chronic pulmonary complaints reveal a high incidence of the disease; and, in order to eliminate potential infectious sources, complete examination including an X-ray film of the chest is advisable.

The contacts of known infectious cases should be followed and urged to have frequent and periodical examinations to catch new cases and institute proper treatment before negligence leads to new victims. Overcrowded living quarters subjecting the younger age groups to close contact with an infectious case constitute an important and difficult problem. Oftentimes in these poor and ignorant families nutritional deficiences aggravate the situation. Educational and preventive measures and treatment of the active cases must receive attention. Proper integration of tuberculosis control activities by various organizations under wise guidance is important.







TYPHOID FEVER IN TEXAS, 1942, EPIDEMIOLOGY, AND CONTROL

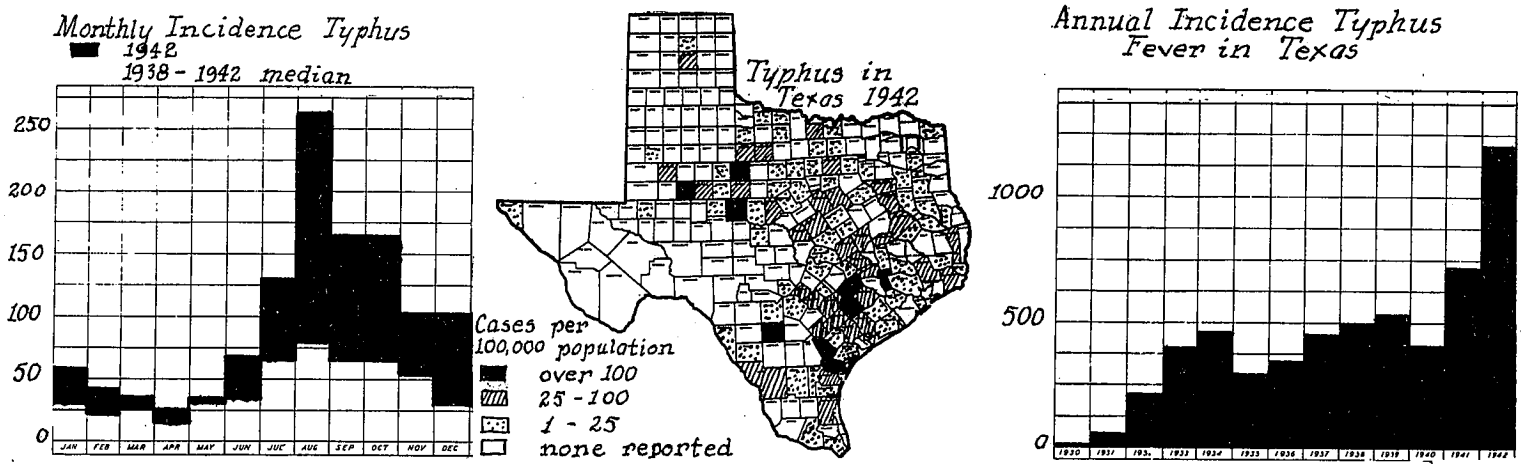
Typhoid fever formerly was one of the great epidemic diseases. Since 1937 the typhoid rate has steadily declined in Texas. Since 1942 there has been an increase in reports of dysentery, outbreaks of food poisoning and minor intestinal infections, but the rate for typhoid has not increased.

It will be surprising if the decreased incidence of typhoid fever is maintained unless more definite and intensified control measures are pursued. While typhoid fever is predominantly a problem of small urban communities where sewage disposal is inadequate, and water and food handling are less than satisfactory, this disease remains all too prevalent in some of our larger cities. Typhoid fever occurs at every season of the year, although the incidence is higher in the summer.

Early diagnosis of typhoid fever should be confirmed by laboratory tests on blood and stool. The typhoid patient is a menace to others as soon as the typhoid bacilli begin to appear in the stool. The body excreta should be carefully disinfected with strong lysol. Susceptible contacts should be vaccinated at once. A large portion of cases continue to discharge typhoid bacilli well into convalescence. Only a few of the convalescent carriers become chronic carriers. One who continues to excrete typhoid bacilli six months after onset of infection is defined as a chronic carrier. Females are more likely to become carriers than males. Apparently not all chronic carriers are potentially equally dangerous. However, in the case of women who continually carelessly handle food, even the most intermittent carrier is a menace. The carrier state can be determined only by laboratory examinations of which stool cultures are primarily recommended. The typhoid convalescent should be followed with frequent stool cultures. It should not be assumed that the convalescent carrier state has ceased until three or more consecutive satisfactory stool cultures have failed to reveal typhoid bacilli.

Careful epidemiological investigations supplemented by laboratory aid will result in the detection of the carrier. Bacteriophage typing can help in tracing cases and in excluding or relating carriers to cases. Routine examinations of food handlers seldom accomplish what is intended, and routine stool examinations rarely result in discovery of a carrier. With food handlers who give histories suggestive of typhoid fever, repeated careful stool examinations are justified. A previous history of typhoid fever is nearly always obtainable with the carrier. If the carrier state becomes evident, the individual must be taught scrupulous personal hygiene; she should avoid handling food and must be provided with adequate excreta disposal. Handling the typhoid carrier requires understanding, tact and a helpful attitude.

Mass immunization and improved sanitation help protect indivuduals from typhoid carriers. Immunization carries the disadvantage of incomplete or transient immunity. Many individuals object to the unpleasant reactions which occasionally result in loss of time from work. The intradermal method with revaccinations helps meet some of the objections. The ultimate conquest of typhoid will only come when knowledge and supervision of chronic carriers is complete.



TYPHUS IN TEXAS, 1942, EPIDEMIOLOGY, AND CONTROL MEASURES

The reported incidence of typhus fever in Texas, barring an occasional reverse, steadily has shown an upward trend for a number of years. Although the reporting of this disease has apparently improved, it is possible that the incidence is actually on the increase. 1204 cases of typhus with 56 deaths were reported in 1942. While the disease was first recognized in the lower and middle Rio Grande area, the disease has been spreading rapidly over the entire State.

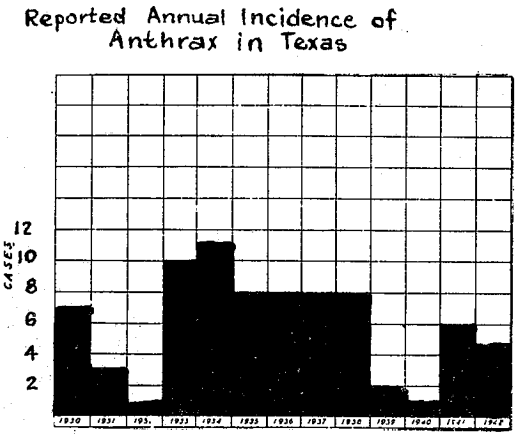
Typhus in Texas is primarily an urban problem, although cases are occasionally reported from rural communities. Typhus in Texas occurs at all seasons of the year, but the highest incidence occurs in July, August, September and October with a peak in August or September. All ages are susceptible. Males are somewhat more often attacked but this is probably because of greater exposure.

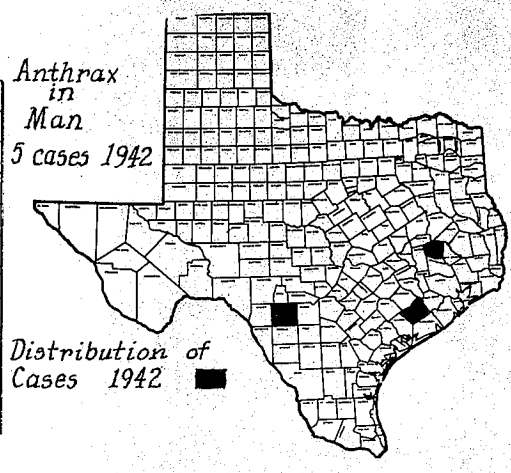
Typhus in Texas is known as endemic or murine as distinguished from epidemic or classical European typhus. Epidemic typhus is transmitted by the body louse while murine typhus is transmitted primarily by rats through the agency of the tropical rat flea, Xenopsylla cheopis. It is possible that other fleas occasionally constitute the source of human infections. For instance, recently we proved the presence of typhus in fleas combed from kittens found in a feed store. There was strong suspicion that three companion kittens, carried home by customers, were responsible for four cases of typhus in two families. It is also worth noting that typhus has been recovered not only from the brains of rats but also from mice.

In contrast with murine typhus, louse-borne typhus is primarily a disease of the colder climates or at least is likely to be more prevalent in the winter season. Louse-borne typhus oftentimes has been associated with overcrowding of sleeping quarters and low living standards, promoted by poverty, war or disaster. It seems quite possible that endemic murine typhus is potentially changeable into the epidemic louse-borne variety.

Typhus is an acute illness of man characterized by intense headache and fever of about two weeks' duration. A rash appears over chest and abdomen about the sixth day. Diagnosis is frequently aided by performance of the Weil-Felix test, an agglutination test with the patient's serum, but the test is rarely positive before the beginning of the second week of illness. A second specimen showing a subsequent increase in titer bears special significance for diagnosis.

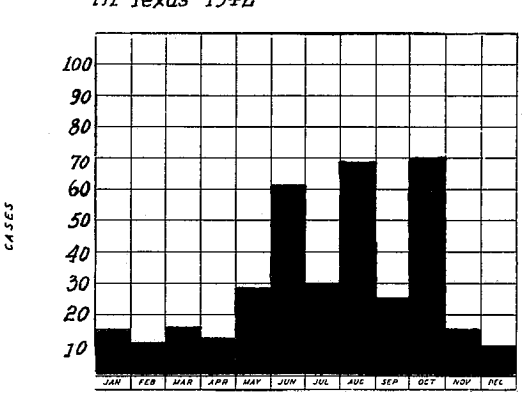
In the institution of preventive and control procedures the known foci or sources of infection should be located and should receive first attention. The source of infection is likely to be a rat-ridden feed store, meat market, eating establishment or similar places. The known foci should be rid of rats by poisoning, trapping or other means and buildings should be rat-proofed. Nothing can be accomplished of permanent value in any community in the absence of an informed public. After the known foci are eliminated, control measures should be extended and maintained.





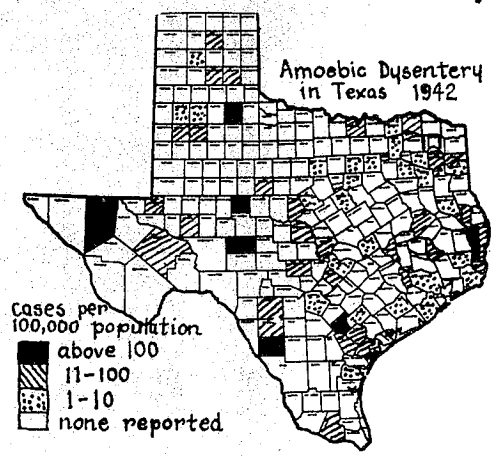
ANTHRAX

Five cases of anthrax with one death were reported in Texas in 1942. At least four cases were acquired from "doctoring" or skinning cattle. Two of these infections involved a farmer and his wife who had skinned a cow in which anthrax bacilli subsequently were found The skin of this animal was recovered and destroyed. Four of these infections were acquired in southeast Texas while the fifth was evidently acquired in southwest Texas. The source of each human infection should be thoroughly investigated.



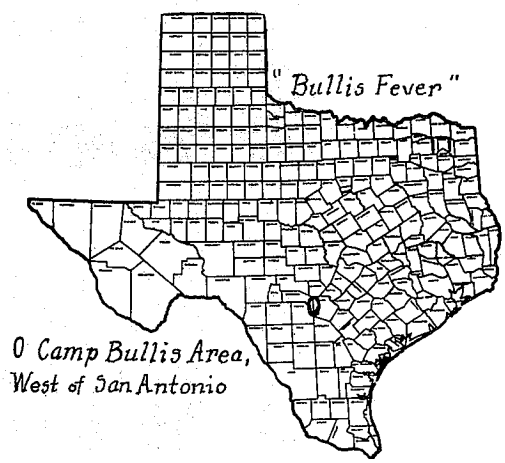
AMEBIASIS AND AMEBIC DYSENTERY IN TEXAS, 1942

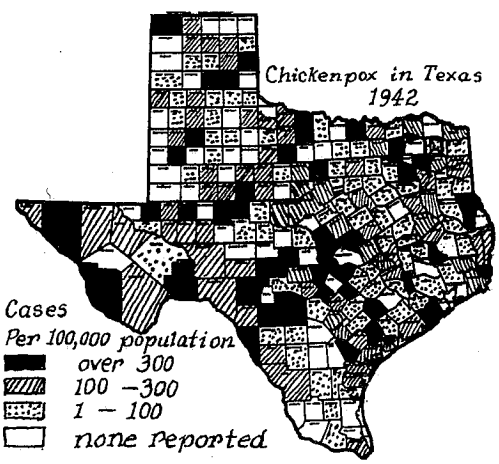
The reported incidence of amebic dysentery has risen slowly during the past few years. 1940 was the median for the past five years with 331 cases reported. The 368 cases recorded in 1942 were reported from 65 of the state's 254 counties. Undoubtedly, amebic dysentery is poorly reported. The carrier condition, amebiasis, is even much more common. Infection is acquired by ingesting the cysts of Endameba histolytica originating in the intestinal contents of a carrier or unrecognized case.



"BULLIS FEVER" IN TEXAS, 1942

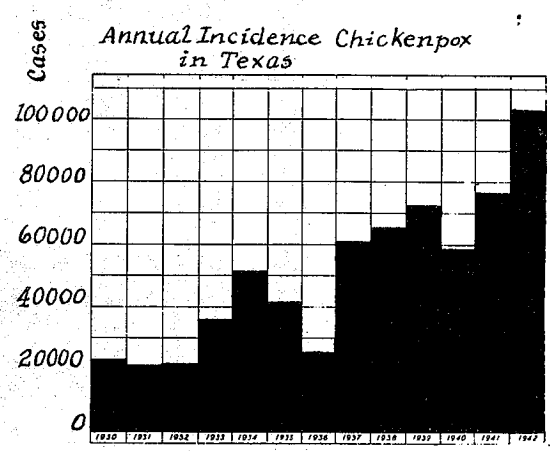
During the spring and summer of 1942 many patients were admitted to the Brooke General Hospital, Fort Sam Houston, Texas and it became apparent that a number were suffering from a clinical disease which defied definite identification. This infection was characterized by fever of 4-14 days duration, leucopenia, severe headache and constant lymphadenitis. All men comprising this group had been on manuevers at Camp Bullis a week or more prior to onset of illness. In all instances there was evidence of multiple tick bites. The "Lone Star" tick, Amblyomma americanum, seemed to be the tick involved. While (chigger) bites were a frequent occurrence massive exposure to ticks was peculiar to these patients. Extensive studies on this disease have been conducted in the Eighth Service Command laboratory with suggestions that the causative agent may be a member of the Rickettsiae. Attempts have been made to recover the agent from pools of ticks in the laboratories of this Department. Apparently this disease is not a variety of spotted or Q fever, both of which have been recovered from Amblyomma americanum, in Texas or Oklahoma.





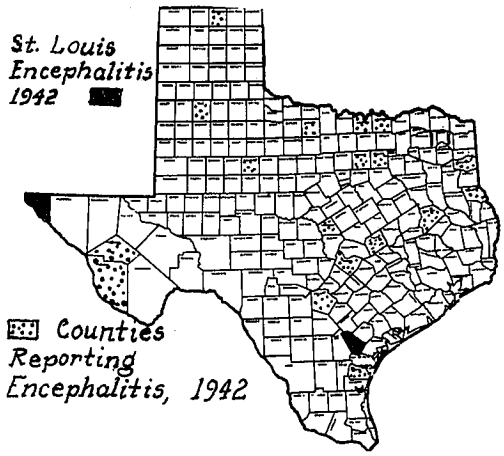
CHICKENPOX IN TEXAS, 1942

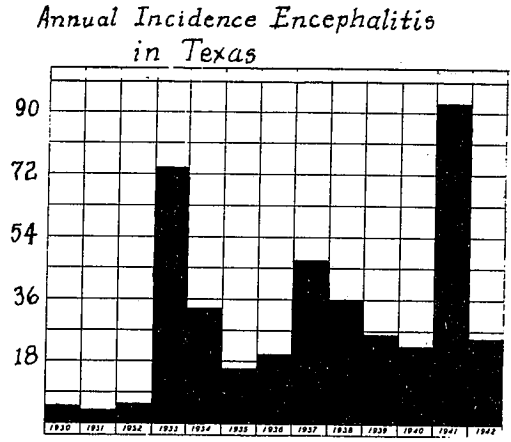
The reported incidence of chickenpox has risen steadily in the past few years. More than 100,000 cases were reported in 1942. Areas of high incidence were found in numerous Texas counties. Secondary infections are to be avoided to prevent formation of unsightly scars. Chickenpox frequently requires investigation in view of the possibility of confusion with smallpox. In the event of possible smallpox, susceptible exposed individuals should be vaccinated at once. Chickenpox is included among the diseases quarantinable for school purposes.

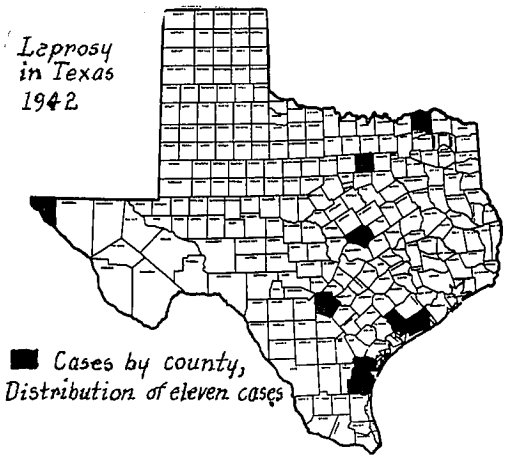


ENCEPHALITIS IN TEXAS, 1942

Following the increased incidence of encephalitis in 1941, the reported incidence in 1942 again reached a very low level. Of the three primary summer virus encephalitides of the St. Louis and both equine types which had occurred in this state in the previous year, only two infections, both of the St. Louis type, were recognized in man in 1942. Careful laboratory studies are required to differentiate among these virus infections. Other types of encephalitis sometimes occur as complications of or sequels to acute infectious diseases.

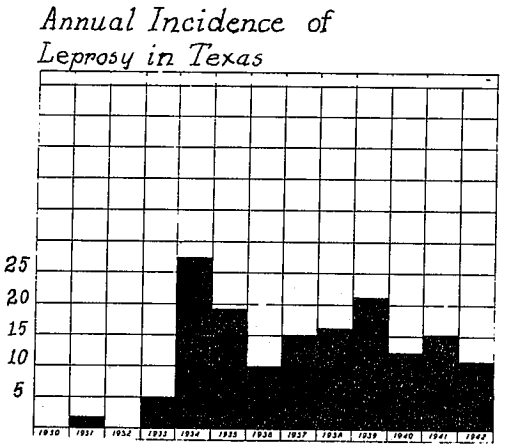


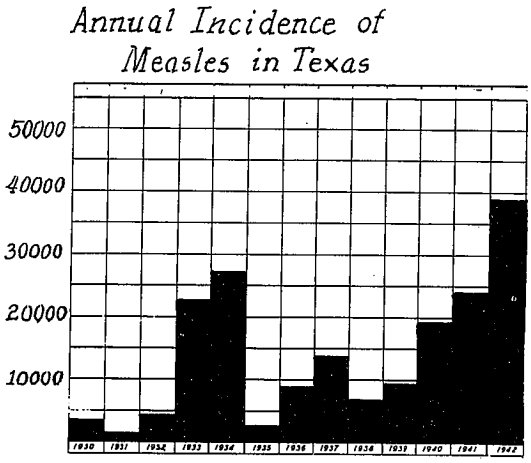




LEPROSY IN TEXAS, 1942

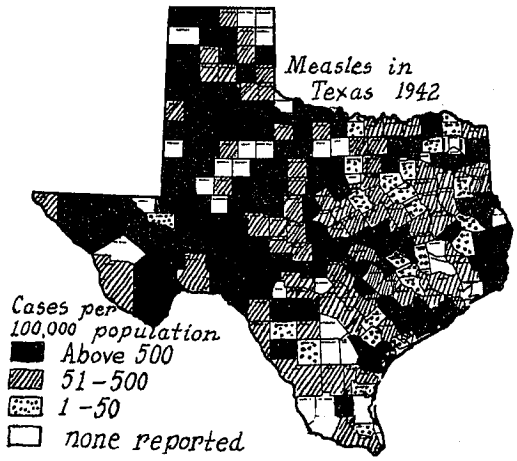
Eleven cases of leprosy were reported in Texas in 1942. This was the smallest number of cases reported in any one year since 1936 when ten cases were reported. Although only a small number of cases are reported in Texas each year, this disease shows a decided tendency to maintain itself in this state. Most cases evidently acquire infection in the Gulf Coast areas but there are exceptions. Infections are most often seen in adolescent or young adult males. Patients with active infections should be treated and cared for at the National Leprosarium, Carville, Louisiana.

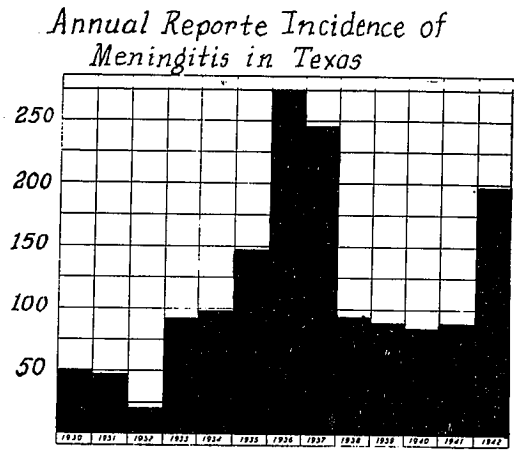




MEASLES IN TEXAS, 1942

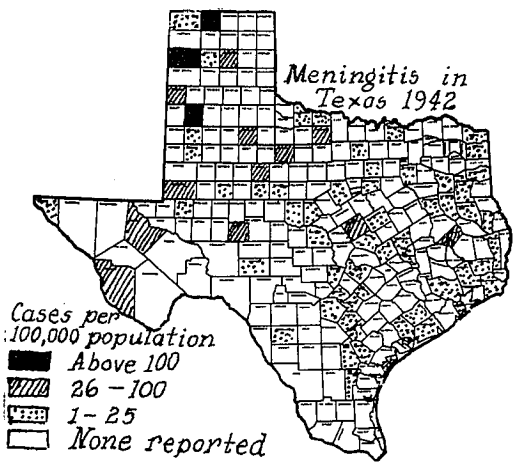
The incidence of measles was the highest on record in 1942. The incidence had also been high the two previous years. Areas of high incidence were found all over the state, particularly in the West Texas and Panhandle counties. Young children particularly should not be exposed to measles. The patient should be isolated during the active stage of infection, not only to avoid infecting others, but also to protect himself from mixed or secondary infections. Susceptible contacts should be quarantined for two weeks.

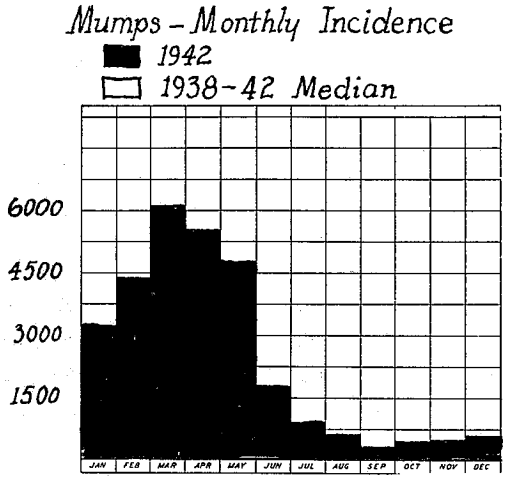




MENINGOCOCCUS MENINGITIS IN TEXAS 1942

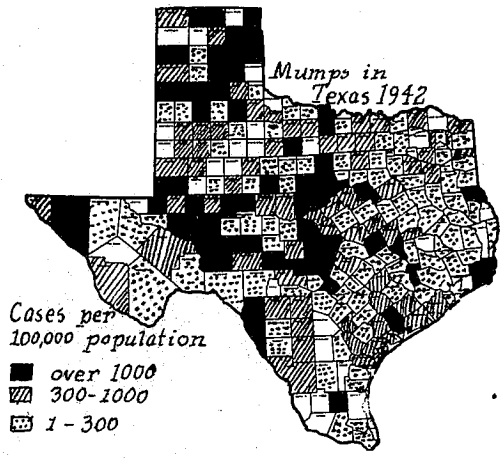
The reported incidence of meningitis in 1942 reached the highest level since 1937. Cases were scattered, but the highest incidence was principally in the Panhandle and West Texas localities. As usual, most of the cases occurred in the first four months of the year. This infection is likely to occur where there is overcrowding, overwork, or undue fatigue. Crowding of sleeping quarters particularly is to be avoided. Carriers usually become very numerous before cases appear.

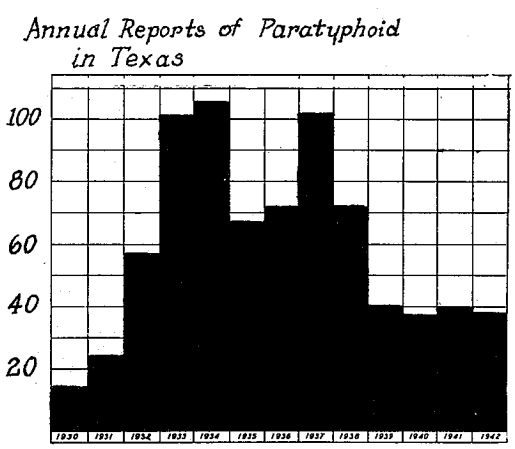




MUMPS (INFECTIOUS PAROTITIS) IN TEXAS, 1942

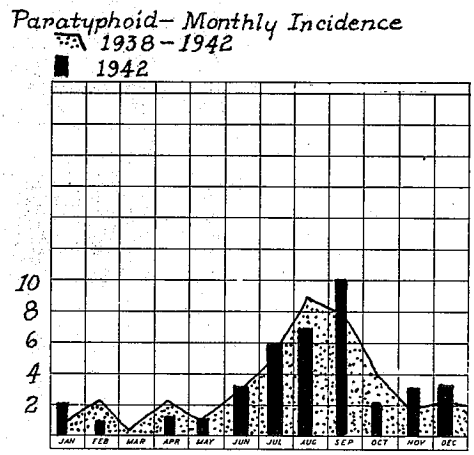
In 1942 the reported incidence of mumps practically trebled the incidence of 1936 which was the highest for any previous year. Areas of high incidence were found in nearly all sections of the state. Increased prevalence of mumps was undoubtedly real, although better reporting was obviously a factor in increasing the totals. Mumps is a disease of the late winter and spring months. This infection is usually much less prevalent than other diseases, such as measles, chickenpox, and whooping cough. Complications of this infection should be avoided.





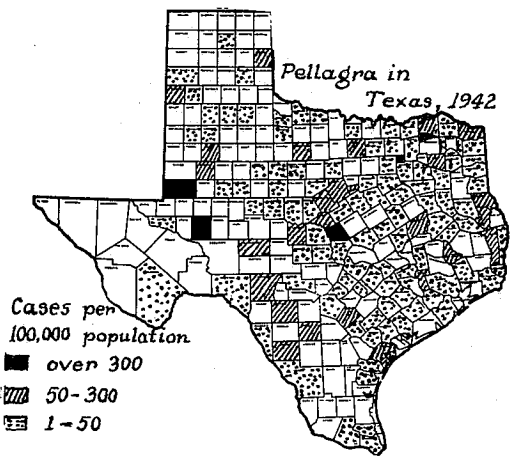
PARATYPHOID FEVER AND THE SALMONELLOSES

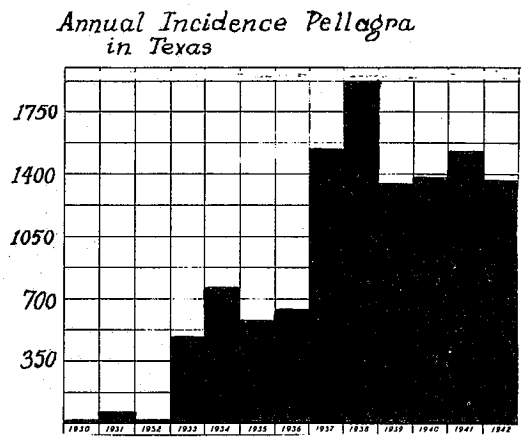
While approximately 40 cases of paratyphoid fever have been reported for each of the past four years, very few of these have been confirmed by laboratory tests. While prolonged paratyphoid fever appears to be rare in this state, Salmonella gastrointestinal upsets are not uncommon. In the differentiation of these infections, early stool cultures are necessary. Sources of infection may involve human carriers or excreta of animals or birds.



PELLAGRA IN TEXAS, 1942

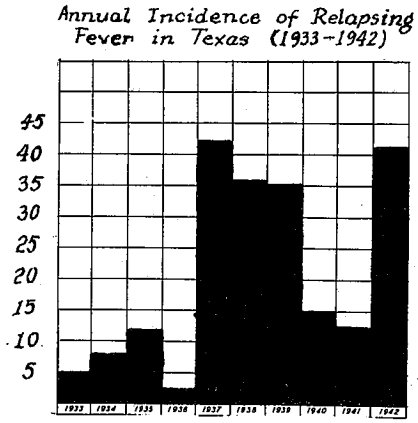
While pellagra is a nutritional deficiency disease rather than a communicable disease, health officers do not object to its inclusion in the list of reportable diseases since this is about the only information available on the nutritional deficiency diseases. Fewer cases of pellagra were reported in 1942 than for any year of the past five years. More than one-fourth of the cases in 1942 were reported from Delta and Rockwall counties in northeast Texas. Where pellagra exists, other nutritional deficiency diseases are likely to be present.

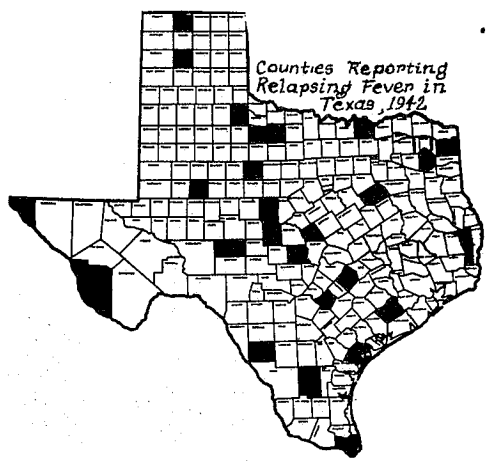


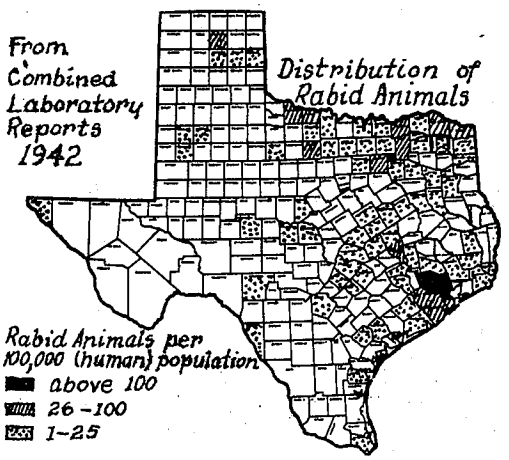


RELAPSING FEVER IN TEXAS, 1942

The 42 cases of relapsing fever reported in Texas in 1942 exceeded the number of cases reported in any year excepting 1937. Cases were reported from 26 counties, but the actual location of the source of infection, in some instances, was unknown. Prevention is limited largely to avoidance of the blue bugs, ticks which invariably constitute the source of infection. These ticks are found characteristically in the dust of certain limestone caves, and curious persons do well to heed local advice against entering certain definite caves or caverns.

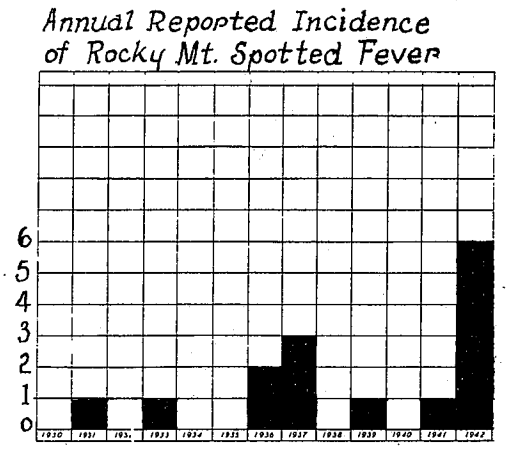






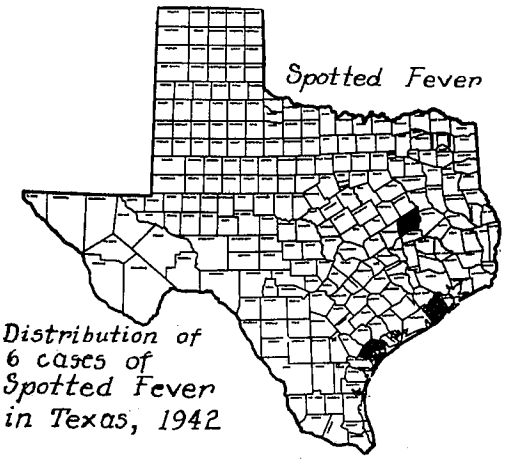
RABIES IN TEXAS, 1942

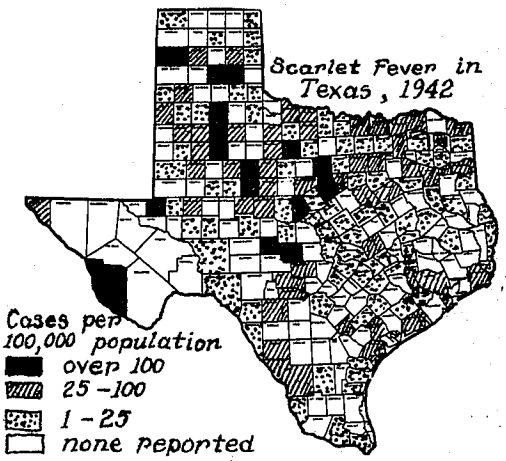
In 1942 statewide laboratory reports showed finding of 1105 rabid animals of which 1040 were "mad" dogs. Although laboratory reports indicate increased prevalence of rabies in animals in 1942, there was no evidence of increased prevalence of this disease in man. In fact, only one death was registered for rabies in man. The Texas State Health Department distributed antirabies vaccine for treatment of 1530 persons in 1941, and 1564 in 1942. The control of rabies necessarily must involve restrictions on dogs and particularly stray or ownerless dogs.



ROCKY MOUNTAIN SPOTTED FEVER IN TEXAS, 1942

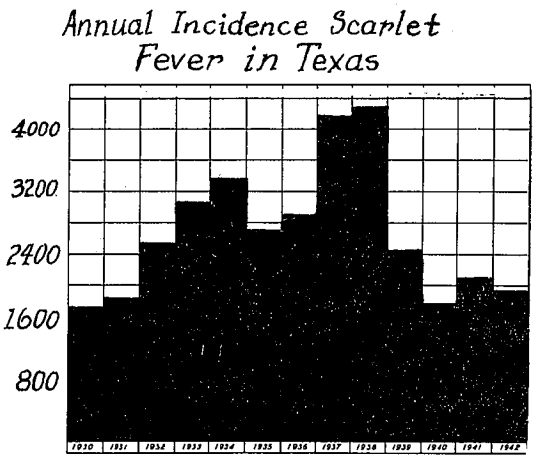
Six cases of Rocky Mountain spotted fever with two deaths were reported in Texas during the summer of 1942. From 1931 to 1942 only nine cases with three deaths had been reported. Four of the 1942 cases including the two fatal cases apparently acquired infection at a trailer camp in Brazoria County. Presumably the tick, Amblyomma americanum, was responsible for these four infections, but attempts to prove the presence of the Rickettsiae in a collection of 6,000 ticks taken near the camp resulted unsuccessfully.

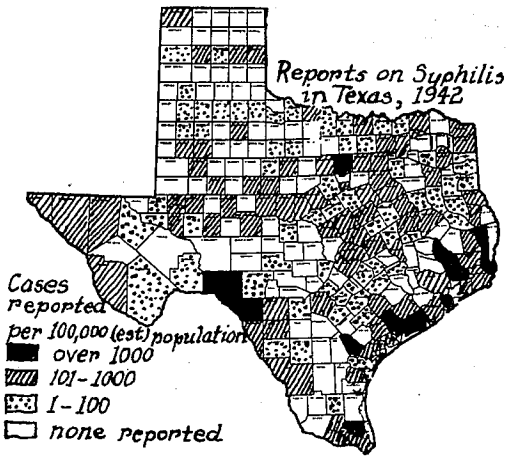




SCARLET FEVER IN TEXAS, 1942

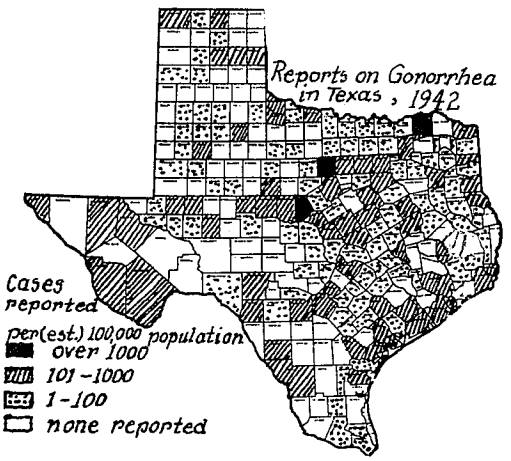
With the exception of 1940 the reported incidence of scarlet fever was at the lowest level in 1942 recorded for any year during the past ten years. Associated with decreased incidence has been the continued reduction of mortality. Scarlet fever is relatively rare in the southern half of the state. The scarlet fever case should be isolated during the acute stage of illness and secondary infections or complications are to be avoided. The source of infection should be investigated, with particular reference to the milk supply.

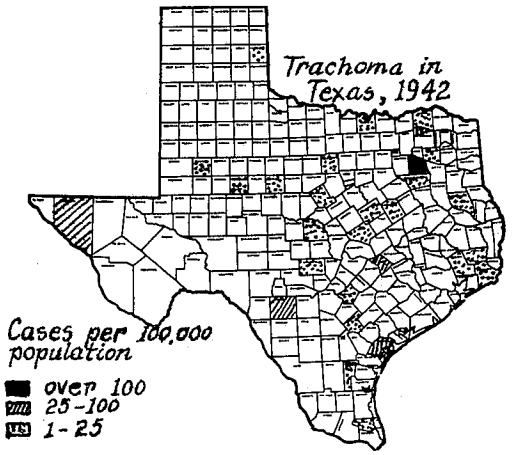




SYPHILIS AND GONORRHEA IN TEXAS, 1942

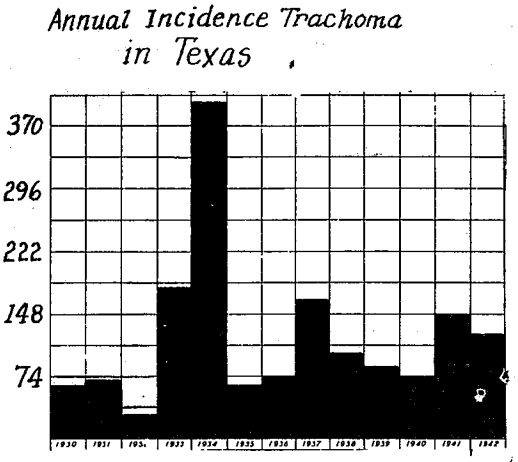
Because reporting of syphilis and gonorrhea until quite recently has been badly neglected by Texas health officers, there is no comparable information regarding the incidence of these infections for the State as a whole for any appreciable length of time. The 10,827 cases of gonorrhea and 25,858 cases of syphilis reported by Texas health officers in 1942 was unquestionably far from complete. Information regarding reports from V. D. clinics is on file with the V. D. Division, State Health Department. Many of the clinic reports are included in health officers' reports.

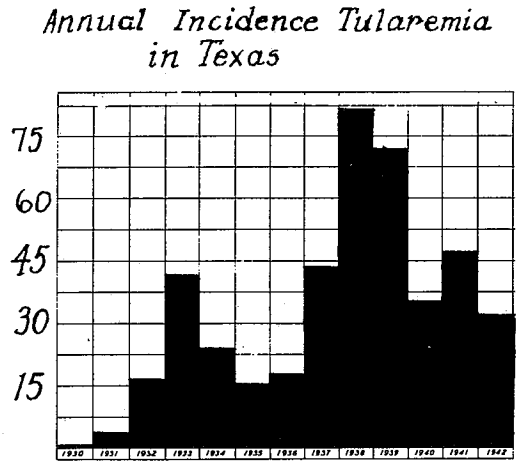




TRACHOMA IN TEXAS, 1942

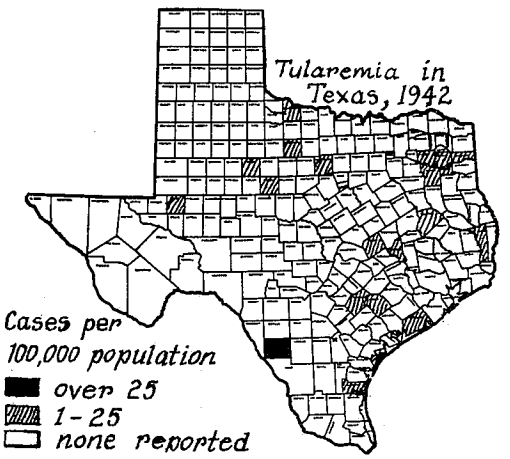
116 cases of trachoma were reported from 29 scattered counties in Texas in 1942. The majority of these cases were reported from northeast Texas with 65 from Van Zandt county. Cases are not reported during any particular season of the year. In the last 5-year period, 1938 was the median year with 101 cases reported. Trachoma is a specific infectious disease resulting in chronic inflammation of the eyelids which frequently affects eyesight, even to the point of blindness. Early recognition of the disease and treatment are important in combatting this disease.

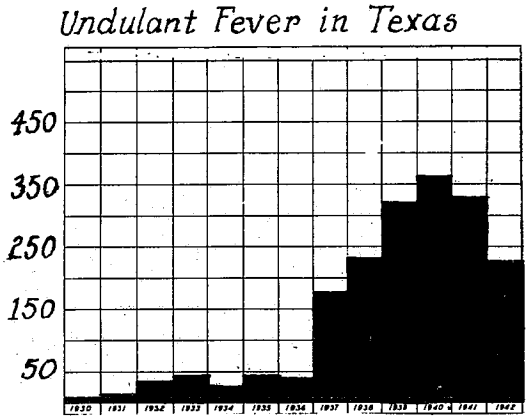




TULAREMIA IN TEXAS, 1942

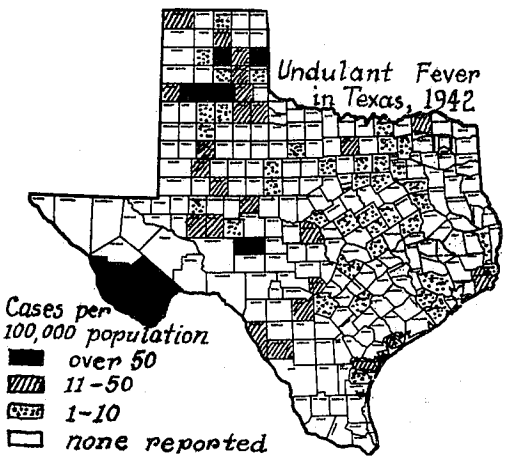
Tularemia was reported in Texas less frequently in 1942 than for any year since 1936. This disease is frequently called "rabbit fever," and it has been estimated that one per cent or more of wild rabbits harbor the infectious agent. Most infections in Texas are acquired during the summer months through the bites of ticks or other arthropods. During the hunting season infections are occasionally acquired through contamination of skin abrasions in handling carcasses of infected rabbits.

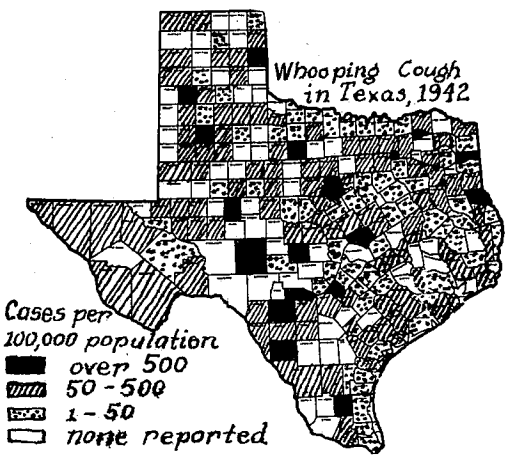




UNDULANT FEVER IN TEXAS, 1942

The incidence of undulant fever was lower in 1942 than in any other year since 1937. Since reporting of communicable diseases has generally shown improvements in recent years, the implication of the 1942 tabulations is not entirely clear. It seems evident enough that the number of reported cases compares unfavorably with the actual extent of this disease in this state. The disease results from ingestion of unpasteurized or contaminated milk or meat products. The ultimate goal is elimination of the infection in animals, particularly dairy herds, but this is a long way from realization.





WHOOPING COUGH IN TEXAS, 1942

The reported incidence of whooping cough in Texas during 1942 revealed a considerable decline in contrast with the incidence for the previous two years. An incidence of 500 cases per 100,000 was reported in several areas of the state, however, in 1942. This disease differs from most of the diseases of the respiratory group in that the greatest incidence occurs in the late spring or summer. This infection is particularly to be avoided with infants. Early immunization is believed to be of considerable value.