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A.N.S.W.E.R

CDS 87/29
(A16)

(AIDS News Supplement, CDS Weekly Report)

Prepared and presented as a professional service by the Communicable Diseases (Scotland) Unit, Ruchill Hospital, Glasgow G20 9NB, Scotland

POSITIVE HIV ANTIBODY RESULTS FOR SEXUALLY ACTIVE FEMALE MEMBERS OF SOCIAL/SEXUAL CLUBS - MINNESOTA

(Based on, and reproduced with acknowledgement from, *Morbidity and Mortality Weekly Report* (1986) Centers for Disease Control, US Public Health Service, 35, no. 45, 697-9)

In June 1986, two sexually active women in Minnesota were found to have antibody to human immunodeficiency virus (HIV). Both belonged to social/sexual clubs whose stated purpose was to provide their members (primarily couples) with opportunities for social and sexual contacts. These clubs are popularly known as "swing clubs". A national organisation in the US lists more than 100 such clubs internationally. Each of the two seropositive women reported having sexual contact with a number of other persons from these clubs, including two men who were bisexual.

Infection was detected in these two women during a serological screening programme conducted by the St Paul Division of Public Health, in consultation with the Minnesota Department of Health. This screening was undertaken because members of these clubs were known to have been involved in outbreaks of other sexually transmitted diseases (including syphilis and gonorrhoea). From a total of 285 members (143 women and 142 men) of two of these social/sexual clubs in the Minneapolis-St Paul area, 134 volunteers were tested with an enzyme-linked immunosorbent assay (ELISA) test for antibody to HIV in June and July 1986. Any ELISA-positive specimens were also tested with the Western blot assay. All 75 men tested had 'negative' ELISA results for antibody to HI Virus. Two of 59 women tested had 'postive' antibody test results for HIV with both ELISA and Western blot. Antibody results for these women were again 'positive' with ELISA and Western blot when repeated six weeks later. The seroprevalence rate of 3% among female club members tested is significantly higher than the seroprevalence rate of zero (none of 56,000) among female blood donors in Minnesota.

The two seropositive women had belonged to two different social/sexual clubs for approximately two years. Both denied intravenous drug use, a history of blood transfusion, or receipt of clotting factor concentrates. One woman was 31 years old, married and had sexual relations only with other club members; her husband (also a member) had 'negative' test results for HIV antibody. The other woman was 25 years old, unmarried and occasionally had sexual relations with men outside the club.

Each of these two women reported having had sexual contact with more than 25 other club members, including five men with whom they both had had sexual intercourse. Two of these five men could be located for testing and had 'negative' results for HIV antibody. Two of the other three men whose serological status could not be determined were reported to be bisexual men with whom both women had had repeated vaginal and anal intercourse.

An additional bisexual man, who was a former member of one of these clubs, is known to have developed acquired immunodeficiency syndrome (AIDS). He had no history of sexual contact with either of the seropositive women or with either of the two bisexual men who had sexual contact with these women.

To date, 55 of the 134 club members tested for antibody to HIV (including the two seropositive women) have participated in follow-up interviews and have received counselling about their sexual practices and attitudes. Four (15%) of 27 men reported homosexual contact with other club members as well as with men who were not members of either of the two clubs. When asked whether they perceived themselves as being at increased risk of having AIDS, 40 members (73%) replied that they did not. One man reported that he "usually" used condoms while having sexual intercourse. When asked whether they would continue to participate in the activities promoted by social/sexual clubs if they knew such activities were associated with a high risk of having AIDS, 54/55 (98%) answered that they would not.

When it was known that one member of each of the two clubs was 'positive' for HIV antibody, both clubs disbanded. In an effort to minimise the transmission of HI Virus educational programmes for sexually active adults (including former club members) are currently being implemented in the Minneapolis-St Paul area. Follow-up studies of former club members are planned to assess whether the other changes in sexual behaviour are occurring.

MMWR Editorial Note

The risk of having HIV infection and other sexually transmitted diseases is increased for persons who have multiple sexual partners as well as for persons who have sexual encounters with high-risk individuals. However, most members of two social/sexual clubs in Minnesota who were interviewed did not consider themselves at increased risk of having AIDS and did not take precautions to protect themselves against AIDS or other sexually transmitted diseases.

Both seropositive women discussed above had a history of multiple sexual encounters - including vaginal and anal intercourse - with high-risk individuals. Although receptive anal intercourse is associated with increased risk of HIV infection for homosexual men, most women infected with HI Virus through sexual contact have denied having had anal intercourse.

To reduce the risk of HIV infection, the US Public Health Service recommends avoiding sexual contact with multiple partners or with persons who have been sexually active with multiple partners. Persons who do not follow this recommendation and who a) initiate a sexual relationship with another person who is at increased risk of having HIV infection or b) maintain multiple sexual partnerships should at least avoid sexual practices that permit the exchange of blood, semen, urine, faeces, saliva, or vaginal/cervical secretions. Consistent use of condoms may reduce transmission of HIV. Other efforts to reduce HIV transmission include making available voluntary serological testing and health education and counselling for all persons believed to be at increased risk of having HIV infection.

29th August, 1987

ANSWER

CDS 87/35
(A22)

(AIDS News Supplement, CDS Weekly Report)

Prepared and presented as a professional service by the Communicable Diseases (Scotland) Unit, Ruchill Hospital, Glasgow, G20 9NB, Scotland

US Public Health Service Guidelines for Counselling and Antibody Testing to Prevent HIV Infection and AIDS

(Based on and reproduced, with acknowledgement, from *Morbidity and Mortality Weekly Report* of the Centres for Disease Control, US Public Health Service (1987), 36, no. 31, 509-515)

Introduction

These guidelines are the outgrowth of the 1986 recommendations published by the Centers for Disease Control (CDC), US Public Health Service (CDC 1986 a); the report on the February 24-25, 1987, US Conference on Counselling and Testing; and a series of meetings with representatives from the Association of State and Territorial Health Officials, the Association of State and Territorial Public Health Laboratory Directors, the Council of State and Territorial Epidemiologists, the National Association of County Health Officials, the United States Conference of Local Health Officers, and the National Association of State Alcohol and Drug Abuse Directors.

Human immunodeficiency virus (HIV), the causative agent of acquired immunodeficiency syndrome (AIDS) and related clinical manifestations, has been shown to be spread by sexual contact; by parenteral exposure to blood (most often through intravenous (IV) drug abuse) and, rarely, by other exposures to blood; and from an infected woman to her foetus or infant.

Persons exposed to HIV usually develop detectable levels of antibody against the virus within six to twelve weeks of infection. The presence of antibody indicates current infection, though many infected persons may have minimal or no clinical evidence of disease for years. Counselling and testing persons who are infected or at risk for acquiring HIV infection is an important component of prevention strategy. Most of the estimated 1.0 to 1.5 million infected persons in the United States are unaware that they are infected with HIV. The primary public health purposes of counselling and testing are to help uninfected individuals initiate and sustain behavioural changes that reduce their risk of becoming infected and to assist infected individuals avoid infecting others.

Along with the potential personal, medical, and public health benefits of testing for HIV antibody, public health agencies must be concerned about actions that will discourage the use of counselling and testing facilities, most notably the unauthorised disclosure of personal information and the possibility of inappropriate discrimination.

Priorities for public health counselling and testing should be based upon providing ready access to persons who are most likely to be infected or who practice high-risk behaviours, thereby helping to reduce further spread of infection. There are other considerations for determining testing priorities, including the likely effectiveness or preventing the spread of infection among persons who would not otherwise realise that they are at risk. Knowledge of the prevalence of HIV infection in different populations is useful in determining the most

Articles on aspects of AIDS and HIV infection are welcomed for publication in "ANSWER". This would not preclude the future publication elsewhere of the paper by the contributor(s). However, anyone wishing to make use of such contributed material should first obtain the permission of the contributor(s).

efficient and effective locations providing such services. For example, programmes that offer counselling and testing to homosexual men, IV drug abusers, persons with haemophilia, sexual and/or needle-sharing partners of these persons, and patients of sexually transmitted disease clinics may be most effective since persons in these groups are at high risk for infection. After counselling and testing are effectively implemented in settings of high and moderate prevalence, consideration should be given to establishing programmes in settings of lower prevalence.

Interpretation of HIV-Antibody Test Results

In the United States, a test for HIV antibody is considered 'positive' when a sequence of tests, starting with a repeatedly reactive enzyme immunoassay (EIA) and including an additional, more specific assay, such as a Western blot, are consistently reactive.

The *sensitivity* of the currently licensed EIA tests is 99% or greater when performed under optimal laboratory conditions. Given this performance, the probability of a 'false-negative' test result is remote, except during the first weeks after infection, before antibody is detectable.

The *specificity* of the currently licensed EIA tests is approximately 99% when repeatedly reactive tests are considered. Repeat testing of specimens initally reactive by EIA is required to reduce the likelihood of 'false-positive' test results due to laboratory error. To further increase the specificity of the testing process, laboratories must use a supplemental test - most often the Western blot test - to validate repeatedly reactive EIA results. The sensitivity of the licensed Western blot test is comparable to that of the EIA, and it is highly specific when strict criteria are used for interpretation. Under ideal circumstances, the probability that a testing sequence will be falsely 'positive' in a population with a low rate of infection ranges from less than 1 in 100,00 (Minnesota Department of Health, unpublished data) to an estimated 5 in 100,000 (Burke *et al* 1987, Meyer and Pauker 1987). Laboratories using different Western blot reagents or other tests or using less stringent interpretive criteria may experience higher rates of 'false-positive' results.

Laboratories should guard carefully against human errors, which are likely to be the most common source of 'false-positive' test results. All laboratories should anticipate the need for assuring quality performance of tests for HIV antibody by training personnel, establishing quality controls, and participating in performance evaluation systems. Health department laboratories should facilitate the quality assurance of the performance of laboratories in their jurisdiction.

Guidelines for Counselling and Testing for HIV Antibody

These guidelines are based on public health considerations for HIV testing, including the principles of counselling before and after testing, confidentiality of personal information, and the understanding that a person may decline to be tested without being denied health care or other services, except where testing is required by law (Bayer, Levine and Wolf 1986). Counselling before testing may not be practical when screening for HIV antibody is required. This is true for donors of blood, organs, and tissue; prisoners; and immigrants for whom testing is a Federal requirement as well as for persons admitted to state correctional institutions in states that require testing. When there is no counselling before testing, persons should be informed that testing for HIV antibody will be performed, that individual results will be kept confidential to the extent permitted by law, and that appropriate counselling will be offered. Individual counselling of those who are either HIV-antibody 'positive' or at continuing risk for HIV infection is critical for reducing further transmission and for ensuring timely medical care.

Specific recommendations are as follows -

1. *Persons who may have sexually transmitted disease.* All persons seeking treatment for a sexually transmitted disease, in all health-care settings including the offices of private physicians, should be routinely counselled and tested for HIV antibody (see Footnote).

2. *IV drug abusers.* All persons seeking treatment for IV drug abuse or having a history of IV drug abuse should be routinely counselled and tested for HIV antibody. Medical professsionals in all health-care settings, including prison clinics, should seek a history of IV drug abuse from patients and should be aware of its implications for HIV infection. In addition, state and local health policy makers should address the following issues:

   a) Treatment programmes for IV drug abusers should be sufficiently available to allow persons seeking assistance to enter promptly and be encouraged to alter the behaviour that places them and others at risk for HIV infection.

   b) Outreach programmes for IV drug abusers should be undertaken to increase their knowledge of AIDS and of ways to prevent HIV infection, to encourage them to obtain counselling and testing for HIV antibody, and to persuade them to be treated for substance abuse.

3. *Persons who consider themselves at risk.* All persons who consider themselves at risk for HIV infection should be counselled and offered testing for HIV antibody.

4. *Women of childbearing age.* All women of childbearing age with identifiable risks for HIV infection should be routinely counselled and tested for HIV antibody, regardless of the health-care setting. Each encounter between a health-care provider and a woman at risk and/or her sexual partners is an opportunity to reach them with information and education about AIDS and prevention of HIV infection. Women are at risk for HIV infection if they:

   a) Have used IV drugs.

   b) Have engaged in prostitution.

   c) Have had sexual partners who are infected or are at risk for infection because they are bisexual or are IV drug abusers or haemophiliacs.

   d) Are living in communities or were born in countries where there is a known or suspected high prevalence of infection among women.

   e) Received a transfusion before blood was being screened for HIV antibody but after HIV infection occurred in the United States (e.g. between 1978 and 1985)

   Educating and testing these women before they become pregnant allows them to avoid pregnancy and subsequent intrauterine perinatal infection of their infants (30% - 50% of the infants born to HIV-infected women will also be infected).

Footnote

"Routine Counselling and testing" is defined as a policy to provide these services to all clients after informing them that testing will be done. Except where testing is required by law, individuals have the right to decline to be tested without being denied health care or other services.

All pregnant women at risk for HIV infection should be routinely counselled and tested for HIV antibody. Identifying pregnant women with HIV infection as early in pregnancy as possible is important for ensuring appropriate medical care for these women; for planning medical care for their infants; and for providing counselling on family planning, future pregnancies, and the risk of sexual transmission of HIV to others.

All women who seek family planning services and who are at risk for HIV infection should be routinely counselled about AIDS and HIV infection and tested for HIV antibody. Decisions about the need for counselling and testing programmes in a community should be based on the best available estimates of the prevalence of HIV infection and the demographic variables of infection.

5. *Persons planning marriage*. All persons considering marriage should be given information about AIDS, HIV infection, and the availability of counselling and testing for HIV antibody. Decisions about instituting routine or mandatory premarital testing for HIV antibody should take into account the prevalence of HIV infection in the area and/or population group as well as other factors and should be based upon the likely cost-effectiveness of such testing in preventing further spread of infection. Premarital testing in an area with a prevalence of HIV infection as low as 0.1% may be justified if reaching an infected person through testing can prevent subsequent transmission to the spouse or prevent pregnancy in a woman who is infected.

6. *Persons undergoing medical evaluation or treatment*. Testing for HIV antibody is a useful diagnostic tool for evaluating patients with selected clinical signs and symptoms such as generalised lymphadenopathy; unexplained dementia; chronic, unexplained fever or diarrhoea; unexplained weight loss; or diseases such as tuberculosis as well as sexually transmitted diseases, generalised herpes, and chronic candidiasis.

Since persons infected with both HIV and the tubercle bacillus are at high risk for severe clinical tuberculosis, all patients with tuberculosis should be routinely counselled and tested for HIV antibody (CDC 1987 a). Guidelines for managing patients with both HIV and tuberculous infection have been published (CDC 1986).

The risk of HIV infection from transfusions of blood or blood components from 1978-1985 was greatest for persons receiving large numbers of units of blood collected from areas with high incidences of AIDS. Persons who have this increased risk should be counselled about the potential risk of HIV infection and should be offered antibody testing (CDC 1987b).

7. *Persons admitted to hospitals*. Hospitals, in conjunction with state and local health departments, should periodically determine the prevalence of HIV infections in the age groups at highest risk for infection. Consideration should be given to routine testing in those age groups deemed to have a high prevalence of HIV infection.

8. *Persons in correctional systems*. Correctional systems should study the best means of implementing programmes for counselling inmates about HIV infection and for testing them for such infection at admission to, and discharge from, the system. In particular, they should examine the usefulness of these programmes in preventing further transmission of HIV infection and the impact of the testing programmes on both the inmates and the correctional system. Federal prisons have been instructed to test all prisoners when they enter and leave the prison system.

9. *Prostitutes*. Male and female prostitutes should be counselled and tested and made aware of the risks of HIV infection to themselves and others. Particularly, prostitutes who are HIV-antibody 'positive' should be instructed to discontinue the practice of prostitution. Local or state jurisdictions should adopt procedures to assure that these instructions are followed.

Partner Notification/Contact Tracing

Sexual partners and those who share needles with HIV-infected persons are at risk for HIV infection and should be routinely counselled and tested for HIV antibody. Persons who are HIV-antibody 'positive' should be instructed in how to notify their partners and to refer them for counselling and testing. If they are unwilling to notify their partners or if it cannot be assured that their partners will seek counselling, physicians or health department personnel should use confidential procedures to assure that the partners are notified.

Confidentiality and Antidiscrimination Considerations

The ability of health departments, hospitals, and other health-care providers and institutions to assure confidentiality of patient information and the public's confidence in that ability are crucial to efforts to increase te number of persons being counselled and tested for HIV infection. Moreover, to assure broad participation in the counselling and testing programmes, it is of equal or greater importance that the public perceive that persons found to be 'positive' will not be subject to inappropriate discrimination.

Every reasonable effort should be made to improve confidentiality of test results. The confidentiality of related records can be improved by a careful review of actual record-keeping practices and by assessing the degree to which these records can be protected under applicable state laws. State laws should be examined and strengthened when found necessary. Because of the wide scope of "need-to-know" situations, because of the possibility of inappropriate disclosures, and because of established authorisation procedures for releasing records, it is recognised that there is not perfect solution to confidentiality problems in all situations. Whether disclosures of HIV-testing information are deliberate, inadvertent, or simply unavoidable, public health policy needs to consider carefully ways to reduce the harmful impact of such disclosures.

Public health prevention policy to reduce the transmission of HIV infection can be furthered by an expanded programme of counselling and testing for HIV antibody, but the extent to which these programmes are successful depends on the level of participation. Persons are more likely to participate in counselling and testing programmes if they believe that they will not experience negative consequences in areas such as employment, school admission, housing, and medical services should they test 'positive'. There is no known medical reason to avoid an infected person in these and ordinary social situations since the cumulative evidence is strong that HIV infection is not spread through casual contact. It is essential to the success of counselling and testing programmes that persons who are tested for HIV are not subjected to inappropriate discrimination.

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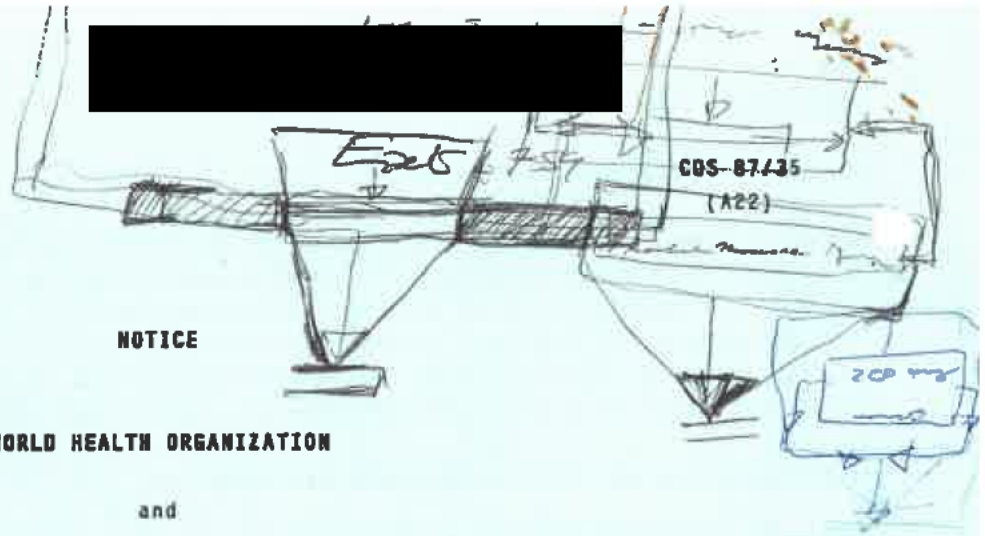
29th August, 1987

CDS-87/35
(A22)



NOTICE

WORLD HEALTH ORGANIZATION

and

PAN-AMERICAN HEALTH ORGANIZATION

and (in London) LIVE-NET Project of London University

The first Pan-American Teleconference on AIDS is to be held on September 14 and 15, 1987. Project LIVE-NET at London University plans to make participation in the conference possible via a satellite link with Ecuador.

If you are interested in attending this teleconference, please notify the LIVE-NET Project *as soon as possible*. The main site in London will be Senate House, WC1. It is not anticipated that a charge will be made for attendance. A full agenda will be circulated in due course.

Objectives

To increase the awareness of health workers, decision makers, the media, and the general public regarding AIDS. Topics will cover the prevalence of AIDS, its history, current research, the prognosis for the Americas, and the epidemiology of AIDS in the Americas and throughout the world.

Contact address: LIVE-NET Project, University of London, Senate House, Malet Street, London, WC1E 7HU.

Telex: [redacted]
Facsimile: [redacted]

[redacted] [redacted]

5th September, 1987

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(A23)

ANSWER

(AIDS News Supplement, CDS Weekly Report)

Prepared and presented as a professional service by the Communicable Diseases (Scotland) Unit, Ruchill Hospital, Glasgow G20 9NB, Scotland

UPDATE: ACQUIRED IMMUNODEFICIENCY SYNDROME - UNITED STATES

Based on and reproduced, with acknowledgement, from *Morbidity and Mortality Weekly Report* of the Centers for Disease Control, US Public Health Service (1987) **36**, no. 31, 522-526

As of August 10, 1987, physicians and health departments in the United States had reported 40,051 patients (39,493 adults and 558 children) meeting the current case definition for national reporting of the acquired immunodeficiency syndrome (AIDS). Of these patients, 23,165 (58% of the adults and 65% of the children) are known to have died. The number of AIDS cases reported per year continues to increase in all patient groups (Table). AIDS cases have been reported from all 50 states, the District of Columbia, and four U.S. territories.

AIDS surveillance is conducted by health departments in each state, territory, and the District of Columbia. Most areas employ multifaceted active surveillance programmes that include four major sources of AIDS information: hospitals and hospital-based physicians, physicians in non-hospital practices, public and private clinics, and medical record systems (death certificates, tumour registries, hospital discharge abstracts, and communicable disease reports). Epidemiological and clinical AIDS patient information is reported through state and local health departments to CDC on a standard, confidential case report form. The median interval between diagnosis of an AIDS case and notification of CDC is two months. At present, an estimated 6,000 to 8,000 AIDS cases (15% to 20% of the total number of cases) have been diagnosed and will be reported soon to the Centers for Disease Control (CDC) in Atlanta, Georgia

In late 1985, a three-month review of death certificates was conducted in four major U.S. cities to assess the completeness of AIDS case reporting. Data from this review suggests that 11% of AIDS cases are not reported to state and local public health departments, primarily because of breakdowns in established reporting procedures (e.g., absence of the individual responsible for reporting when the case was diagnosed).

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CDC Editorial Note:

In comparison to many reportable diseases, the reporting level for AIDS has been high. Previous AIDS validation studies conducted in New York City and San Francisco showed that the level of reporting exceeded 95%. The major reporting sources employed in active surveillance (hospitals and hospital-based physicians, physicians in non-hospital practice, public and private clinics, and medical records systems) frequently complement each other. Thus, an AIDS patient not identified by one source may be identified by another.

As described in the Supplement to *Morbidity and Mortality Weekly Report* being released this week, CDC, in consultation with state and local public health officials and clinical specialists, has revised the case definition for national reporting of AIDS. With this revision, AIDS cases involving patients with presumptively diagnosed indicator diseases, which were previously not reportable because they lacked biopsy or other specific confirmation required by the former surveillance case definition, will now be reportable. Inclusion of this category will allow for national reporting of an estimated 10% to 15% of patients not previously eligible for reporting. Because, historically, most health departments have not required reporting of the additional manifestations of human immunodeficiency virus (HIV) infection included in the expanded case definition (HIV dementia complex, chronic wasting syndrome, etc.), the number of cases that will be added to existing case counts as a result of this revision is unknown. Since most patients with the wasting syndrome and HIV dementia develop the opportunistic diseases included in the previous AIDS case definition, addition of these conditions to the case definition may result in earlier reporting without adding substantially to the ultimate case count.

To evaluate the impact of the revised case definition on long-term trends of overall reporting, future data analyses will include separate tallies for cases meeting the previous and the revised case definitions.

Targeted epidemiological surveys and serological studies as well as prompt and complete reporting are essential for effectively monitoring the HIV epidemic. They are also necessary for projecting trends and health-care costs; for identifying patterns of infection; for formulating and targeting prevention strategies; and for providing timely guidelines for risk-reduction and other information to the public, the scientific and public health communities, and members of high-risk groups.

TABLE Adult and paediatric acquired immunodeficiency syndrome (AIDS) cases reported by year and yearly percent increases, by transmission category - United States, June 1981 through August 10, 1987

AIDS Cases Reported From Before August 11, 1983 to August 10, 1985

Transmission Category*	Before 11 Aug. '83 No.	11 Aug. '83 - 10 Aug. '84 No.	(% Inc.)+	11 Aug. '84 - 10 Aug. '85 No.	(% Inc.)+
Adult Male					
Homosexual/bisexual only	1,249	2,196	(76)	4,482	(104)
IV drug abuser only	264	483	(83)	931	(93)
Both homosexual/ IV drug abuser	181	316	(75)	580	(84)
Haemophilia/coagulation disorder	15	26	(73)	33	(27)
Other heterosexual					
Sexual contact@	2	5	(150)	21	(320)
Non-U.S. born$	89	92	(3)	97	(5)
Transfusion	12	22	(83)	72	(227)
Undetermined	38	77	(103)	108	(40)
Male subtotal	**1,850**	**3,217**	**(74)**	**6,324**	**(97)**
Adult Female					
IV drug abuser only	66	145	(120)	224	(54)
Haemophilia/coagulation disorder	-	-	-	4	-
Other heterosexual					
Sexual contact@	20	35	(75)	87	(149)
Non-U.S. born	16	14	(-13)	25	(79)
Transfusion	8	19	(138)	45	(137)
Undetermined	18	23	(28)	43	(87)
Female subtotal	**128**	**236**	**(84)**	**428**	**(81)**
Adult subtotal	**1,978**	**3,453**	**(75)**	**6,752**	**(96)**
Paediatric	**35**	**32**	**(-9)**	**75**	**(134)**
Total	**2,013**	**3,485**	**(73)**	**6,827**	**(96)**

* Transmission categories are hierarchically ordered; patients with multiple risk factors are tabulated only in the category listed first.

\+ Percent increase

@ Heterosexual sexual partners of persons with AIDS or at risk for AIDS.

$ Includes persons who do not have other identified risks and who were born in countries in which heterosexual transmission is believed to play a major role.

Table Adult and paediatric acquired immunodeficiency syndrome (AIDS) cases reported by year and yearly percent increases, by transmission category - United States, June 1981 through August 10, 1987 (Continued)

AIDS Cases Reported From August 11, 1985, to August 10, 1987 and Total for All Years

Transmission Category*	11 Aug. '85 - 10 Aug. '86 No.	(% Inc.)+	11 Aug. '86 - 10 Aug. '87 No.	(% Inc.)+	Total
Adult Male					
Homosexual/bisxual only	7,382	(65)	10,777	(46)	26,086
IV drug abuser only	1,528	(64)	1,946	(27)	5,152
Both homosexual/ IV drug abuser	758	(31)	1,147	(51)	2,982
Haemophilia/coagulation disorder	113	(242)	169	(50)	356
Other heterosexual					
Sexual contact@	36	(71)	110	(206)	174
Non-U.S.born$	119	(23)	164	(38)	561
Transfusion	161	(124)	276	(71)	543
Undetermined	220	(104)	476	(116)	919
Male subtotal	**10,317**	**(63)**	**15,065**	**(46)**	**36,773**
Adult Female					
IV drug abuser only	392	(75)	527	(34)	1,354
Haemophilia/coagulation disorder	2	(-50)	2	(-)	8
Other heterosexual					
Sexual contact@	194	(123)	316	(63)	652
Non-U.S. born$	34	(36)	56	(65)	145
Transfusion	70	(56)	154	(120)	296
Undetermined	58	(35)	123	(112)	265
Female subtotal	**750**	**(75)**	**1,178**	**(57)**	**2,720**
Adult subtotal	**11,067**	**(64)**	**16,243**	**(47)**	**39,493**
Paediatric	**189**	**(152)**	**227**	**(20)**	**558**
Total	**11,256**	**(65)**	**16,470**	**(46)**	**40,051**

* Transmission categories are hierarchically ordered; patients with multiple risk factors are tabulated only in the category listed first

\+ Percent increase

@ Heterosexual sexual partners of persons with AIDS or at risk for AIDS

$ Includes persons who do not have other identified risks and who were born in countries in which heterosexual transmission is believed to play a major role

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Centers for Disease Control (1987), *Morbidity and Mortality Weekly Report* 36, Supplement No.15