resources to address this problem are limited in certain affected countries. Because of increasing evidence that avian influenza viruses infect humans, persons involved in the slaughter of poultry potentially infected with avian influenza viruses or their contaminated environments should follow WHO recommendations for worker protection.

Because the influenza A (H5N1) virus could develop the ability to maintain sustained person-to-person transmission, WHO collaborating centers are working to coordinate vaccine development. Efforts are under way in the United Kingdom and the United States to develop influenza A (H5N1) reference viruses for use in vaccine preparation. The minimum estimated time necessary to complete reference virus development and safety testing is 3 months. Production by vaccine manufacturers of pilot lots of vaccine for clinical testing can begin only after reference virus development and safety testing have been completed. Decisions on whether to proceed with vaccine manufacture will depend, in part, on the evolution of the current outbreaks.

On February 4, CDC issued an order for an immediate ban on the import of all birds from Cambodia, China (including Hong Kong), Indonesia, Japan, Laos, South Korea, Thailand, and Vietnam. Birds from these affected countries potentially can infect humans with influenza A (H5N1). This order complements a similar action taken by the U.S. Department of Agriculture (USDA).

CDC advises that travelers to countries in Asia with documented H5N1 outbreaks should avoid poultry farms, contact with animals in live food markets, and any surfaces that appear to be contaminated with feces from poultry or other animals. More information on travel is available from CDC at http://www.cdc.gov/travel. Additional information on influenza viruses and avian influenza is available from CDC at http://www.cdc.gov/flu. Updated information on human infections is available from WHO at http://www.who.int/en.

REFERENCES


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weights and design variables to produce national estimates. The recommended age categories used are based on the survey sample domains. Because of differences in the relative age distribution, estimates for persons aged 20-74 years were adjusted by direct standardization to the 2000 U.S. Census population by using the age groups 20-39, 40-59, and 60-74 years. Six persons who reported fasting (i.e., consuming 0 kcal) during the preceding 24 hours were excluded from these analyses.

During 1971-2000, a statistically significant increase in average energy intake occurred (Table). For men, average energy intake increased from 2,450 kcal to 2,618 kcal (p<0.01), and for women, from 1,542 kcal to 1,877 kcal (p<0.01). For men, the percentage of kcals from carbohydrate increased between 1971-1974 and 1999-2000, from 42.4% to 49.0% (p<0.01), and for women, from 45.4% to 51.6% (p<0.01) (Table). The percentage of kcals from total fat decreased from 36.9% to 32.8% (p<0.01) for men and from 36.1% to 32.8% (p<0.01) for women. In addition, the percentage of kcals from saturated fat decreased from 13.5% to 10.9% (p<0.01) for men and from 13.0% to 11.0% (p<0.01) for women. A slight decrease was observed in the percentage of kcals from protein, from 16.5% to 15.5% (p<0.01) for men and from 16.9% to 15.1% (p<0.01) for women.

The decrease in the percentage of kcals from fat during 1971-1991 is attributed to an increase in total kcals consumed; absolute fat intake in grams increased. USDA food consumption survey data from 1989-1991 and 1994-1996 indicated that the increased energy intake was caused primarily by higher carbohydrate intake. Data from NHANES for 1971-2000 indicate similar trends. The increase in energy intake is attributable primarily to an increase in carbohydrate intake, with a 62.4-gram increase among women (p<0.01) and a 67.7-gram increase among men (p<0.01). Total fat intake in grams increased among women by 6.5 g (p<0.01) and decreased among men by 5.3 g (p<0.01).

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CDC Editorial Note: The increase in caloric intake described in this report is consistent with previously reported trends in dietary intake in the United States. USDA food consumption survey data for 1977-1996 suggest that factors contributing to the increase in energy intake in the United States include consumption of food away from home; increased energy consumption from salty snacks, soft drinks, and pizza; and increased portion sizes.

The findings in this report are subject to at least two limitations. First, information on dietary intake is self-reported and subject to recall bias. Second, although the majority of the increase in average energy intake occurred between 1976-1980 and 1988-1994, changes in the 24-hour dietary recall interview method between these two periods might account for some of this difference. Beginning in 1988, dietary recalls were collected for weekend days as well as weekdays because food consumption differs on weekend days. The interview format was revised, and questions were added that might have allowed for collection of more complete dietary intake data.

The latest national dietary data available indicate that the previously reported increase in energy intake has continued, reflecting primarily increased carbohydrate intake. A focus on total energy intake and energy balance (i.e., the balance of energy intake with energy expenditure) is fundamental to preventing and reducing obesity in the United States. Continuing efforts to decrease saturated fat intake are important to reduce the risk for cardiovascular disease and should include assessment of fat intake in grams in addition to fat intake as a percentage of kcals. The energy- and macronutrient-intake trends described in this report should help guide the forthcoming revision of Dietary Guidelines for Americans and reviews of USDA’s Food Guide Pyramid and the Healthy People 2010 nutrition objectives.

REFERENCES

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IN THE REPORT, “CHILD PASSENGER DEATHS INVOLVING DRINKING DRIVERS—UNITED STATES, 1997–2002,” on page 77 in the third sentence of the first paragraph, the number of children who died in alcohol-related crashes was incorrect. The correct number is 2,335.