other drugs and the specific substances included in testing. In addition, states were more likely to test victims of suspected poisoning suicide than nonpoisoning suicide. However, the similarities in positive test results involving four of the five substance types in poisoning and nonpoisoning suicides suggest that use of alcohol or other drugs might contribute substantially to suicides overall, regardless of cause of death. The finding that opiates (the fifth substance type) were nearly five times more prevalent among poisoning suicide victims is consistent with evidence that prescription opioid analgesics cause more intentional overdose deaths than illegal non-opioid drugs (CDC, unpublished data, 2006).

The relationship between substance use and other suicide risk factors is complex; the chronology and causal pathway of events leading to suicide are difficult to determine. To better understand the results of this study, CDC is funding a survey of coroner and medical examiner toxicology laboratories to examine practices and protocols regarding testing of suicide victims.

The findings in this report are subject to at least three limitations. First, high percentages of positive results in a state might reflect targeted testing rather than greater drug use in that state. Second, manner of death for certain suspected suicides might have been listed as undetermined, excluding those cases from the study; the scope of this limitation has been documented previously.9 Finally, the alcohol or other drugs in the bodies of victims were only recorded as present or absent; no evaluations were conducted to determine whether the concentrations present were lethal or intoxicating.

Despite evidence of substance use among substantial numbers of suicide victims, none of the 13 states reporting to NVDRS in 2004 conducted comprehensive alcohol and drug screenings on all suicide victims. Previous studies of subpopulations by specific substance, geographic area, race/ethnicity, and age have documented the limited toxicology screening performed in certain states. Descriptions of cases selected for toxicology screening suggest subjective determinations for testing on the basis of local policy and individual coroner or medical examiner preference.10

More comprehensive toxicology testing for suicide victims might provide greater insight into trends and geographic variations in the role of substance use in suicides. Comprehensive toxicology data also could be linked with demographic data already collected by coroners and medical examiners at the state and local levels. These combined data could enable studies of the relationship of substance use to suicides in specific populations at greatest risk. Such studies remain critical to better understanding of suicidal behavior and development of effective interventions.

REFERENCES
certain infants and young children at high risk for complications from RSV infection (e.g., certain premature infants or children with chronic lung and heart disease).5

NREVSS is a laboratory-based passive surveillance system that monitors temporal and geographic trends for several respiratory and enteric viruses. The laboratories report weekly to CDC the number of specimens tested for viral pathogens, including RSV, and number of positive test results. During July 2005–June 2006, a total of 71 clinical and public health laboratories in 39 states and the District of Columbia reported 1,072 RSV detections; of these, 511 (48%) were from Florida. Additional data from Florida laboratories not participating in NREVSS are available at http://www.doh.state.fl.us/disease_ctl/epi/RSV/rsv.htm.

For the current reporting period (July 8–November 18, 2006), laboratories in 37 states reported testing for RSV. Preliminary 2006 data suggest that the annual seasonal peak began in Florida during the week ending July 1, in the rest of the South during the week ending October 14, and in the Northeast during the week ending November 11.

Health-care providers should consider RSV as a cause of acute respiratory disease in all age groups during the annual seasonal peak. Because the onset of RSV activity can vary among regions and communities, physicians and health-care facilities can consult their local clinical laboratories for the latest data on RSV activity. Although several tests can be used to detect RSV infection in young children, only sensitive reverse transcription–polymerase chain reaction (RT–PCR) assays are sufficient to reliably detect RSV in older children and adults.7 NREVSS expanded reporting to include RT–PCR testing for RSV in 2004. However, these data are not included in the annual summary because of the limited number of laboratories reporting RT–PCR results.

Currently, no vaccine or effective therapy is available for RSV. Infants and children at risk for serious RSV infection can receive immune prophylaxis with monthly doses of a humanized murine anti-RSV monoclonal antibody during the RSV season. Infants and children at risk include those aged <24 months with chronic lung disease who have required medical therapy within 6 months of RSV season onset and those with hemodynamically significant heart disease, and preterm infants born at <32 weeks’ gestation or preterm infants born at 32–35 weeks’ gestation with at least two additional risk factors (e.g., day care attendance, exposure to environmental pollutants, school-aged siblings, congenital abnormalities of the airways, or neuromuscular disease) during their first RSV season.5 Additional information and updates on RSV national and regional trends are available at http://www.cdc.gov/ncidod/dvrd/revb/nrevss/index.htm.

Reported by: National Respiratory and Enteric Virus Surveillance System collaborating laboratories. AL Fowlkes, AM Fry, MD, LJ Anderson, MD, Div of Viral Diseases, National Center for Immunization and Respiratory Diseases (proposed), CDC.

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