

laws using retailer compliance checks has proven effective in reducing retail sales of alcohol to minors.<sup>16</sup> Families could consider using a parent–teen driver agreement<sup>17</sup> to establish and enforce the “rules of the road” for their newly licensed teen, including complying with all state GDL provisions, never drinking and driving, and always wearing a seat belt. Additionally, teen alcohol consumption<sup>9,18</sup> and drinking and driving patterns<sup>18</sup> are correlated with those of adults living in the same state. Effective strategies to reduce alcohol consumption and drinking and driving aimed at the general population, such as those recommended by the Community Preventive Services Task Force, also can reduce both behaviors among teens.<sup>10,11,16,19</sup> Multifaceted community-based programs that address the local social, economic, and legal context in which teens access alcohol and drink and drive<sup>20</sup> are more likely to succeed than any single approach. Lastly, effective strategies to increase seat belt use, such as primary seat belt laws and enhanced enforcement of seat belt laws, reduce injury severity when crashes occur.<sup>21</sup>

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### REFERENCES

1. CDC. Web-based injury statistics query and reporting system (WISQARS). US Department of Health and Human Services, CDC; 2011. Available at [www.cdc.gov/ncipc/wisqars](http://www.cdc.gov/ncipc/wisqars). Accessed July 9, 2012.
2. Insurance Institute for Highway Safety. Fatality facts 2010: teenagers. Arlington, VA: Insurance Institute for Highway Safety, Highway Loss Data Institute; 2012. Available at <http://www.iihs.org/research/fatality.aspx?topicname=teenagers&year=2010>. Accessed June 12, 2012.
3. CDC. Youth risk behavior surveillance—United States, 2011. *MMWR Surveill Summ*. 2012;61(4):1-162.
4. Insurance Institute for Highway Safety. Summary table: young driver licensing systems in the U.S. Arlington, VA: Insurance Institute for Highway Safety, Highway Loss Data Institute; 2012. Available at <http://www.iihs.org/laws/graduatedlicensecompare.aspx>. Accessed August 10, 2012.

5. CDC. Trends in the prevalence of alcohol use national YRBS: 1991–2011. US Department of Health and Human Services, CDC; 2012. Available at [http://www.cdc.gov/healthyyouth/yrbs/pdf/us\\_alcohol\\_trend\\_yrbs.pdf](http://www.cdc.gov/healthyyouth/yrbs/pdf/us_alcohol_trend_yrbs.pdf). Accessed June 15, 2012.
6. Fell JC, Todd M, Voas RB. A national evaluation of the nighttime and passenger restriction components of graduated driver licensing. *J Safety Res*. 2011;42(4):283-290.
7. Sivak M. Is the U.S. on the path to the lowest motor vehicle fatalities in a decade? Ann Arbor, MI: University of Michigan Transportation Research Institute; 2008. Available at <http://deepblue.lib.umich.edu/bitstream/2027.42/60424/1/100969.pdf>. Accessed July 5, 2012.
8. Voas RB, Torres P, Romano E, Lacey JH. Alcohol-related risk of driver fatalities: an update using 2007 data. *J Stud Alcohol Drugs*. 2012;73(3):341-350.
9. Centers for Disease Control and Prevention (CDC). Vital signs: binge drinking among high school students and adults—United States, 2009. *MMWR Morb Mortal Wkly Rep*. 2010;59(39):1274-1279.
10. Hingson RW, Assailly J-P, Williams AF. Underage drinking: frequency, consequences, and interventions. *Traffic Inj Prev*. 2004;5(3):228-236.
11. Shults RA, Elder RW, Sleet DA, et al; Task Force on Community Preventive Services. Reviews of evidence regarding interventions to reduce alcohol-impaired driving. *Am J Prev Med*. 2001;21(4)(Suppl):66-88.
12. Children's Safety Network. Injury prevention: what works? A summary of cost-outcome analysis for impaired driving (2010 update). Calverton, MD: Children's Safety Network; 2010. Available at <http://www.childrensafetynetwork.org/sites/childrensafetynetwork.org/files/InjuryPreventionWhatWorks.pdf>. Accessed July 2, 2012.
13. Cavazos-Reh PA, Krauss MJ, Spitznagel EL, et al. Associations between selected state laws and teenagers' drinking and driving behaviors. *Alcohol Clin Exp Res*. 2012;36(9):1647-1652.
14. Brenner ND, Kann L, McManus T, Kinchen SA, Sundberg EC, Ross JG. Reliability of the 1999 youth risk behavior survey questionnaire. *J Adolesc Health*. 2002;31(4):336-342.
15. Chapman C, Laird J, Ifill N, KewalRamani A. Trends in high school dropout and completion rates in the United States: 1972–2009 (NCES 2012-006). Washington, DC: US Department of Education, National Center for Education Statistics; 2011. Available at <http://nces.ed.gov/pubsw2012/2012006.pdf>. Accessed May 30, 2012.
16. The Community Preventive Services Task Force. Preventing excessive alcohol consumption. Atlanta, GA: Task Force on Community Preventive Services; 2012. Available at <http://www.thecommunityguide.org/alcohol/index.html>. Accessed June 15, 2012.
17. CDC. Parents are the key campaign. US Department of Health and Human Services, CDC; 2012. Available at <http://www.cdc.gov/parentsarethekey/about/index.html>. Accessed July 2, 2012.
18. Nelson DE, Naimi TS, Brewer RD, Nelson HA. State alcohol-use estimates among youth and adults, 1993–2005. *Am J Prev Med*. 2009;36(3):218-224.
19. Nelson TF, Naimi TS, Brewer RD, Wechsler H. The state sets the rate: the relationship among state-specific college binge drinking, state binge drinking rates, and selected state alcohol control policies. *Am J Public Health*. 2005;95(3):441-446.
20. Poulin C, Boudreau B, Asbridge M. Adolescent passengers of drunk drivers: a multi-level exploration into the inequities of risk and safety. *Addiction*. 2007;102(1):51-61.
21. The Community Preventive Services Task Force. Motor vehicle-related injury prevention. Atlanta, GA: Task Force on Community Preventive Services; 2011. Available at <http://www.thecommunityguide.org/mvoi/safetybelts/index.html>. Accessed June 15, 2012.

\*Overall response rate=(number of participating schools/number of eligible sampled schools) × (number of usable questionnaires/number of eligible students sampled).

†A quadratic trend indicates a significant but nonlinear trend in the data over time; whereas a linear trend is depicted with a straight line, a quadratic trend is depicted with a curve with one bend. Trends that include significant quadratic and linear components demonstrate nonlinear variation in addition to an overall increase or decrease over time.

‡Data available at <http://monitoringthefuture.org/data/11data.html#2011data-drugs>.

§Data available at <http://monitoringthefuture.org/pubs.html#refvols>.

\*\*Definition available at <http://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/moderate-binge-drinking>.

## Severe Respiratory Illness Associated With a Novel Coronavirus — Saudi Arabia and Qatar, 2012

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CDC IS WORKING CLOSELY WITH THE World Health Organization (WHO) and other partners to better understand the public health risk presented by a recently detected, novel coronavirus. This virus has been identified in two patients, both previously healthy adults who suffered severe respiratory illness.<sup>1,2</sup> The first patient, a man aged 60 years from Saudi Arabia, was hospitalized in June 2012 and died; the second patient, a man aged 49 years from Qatar with onset of symptoms in September 2012 was transported to the United Kingdom for intensive care. He remains hospitalized on life support with both pulmonary and renal failure.<sup>3,4</sup> Person-to-person or health-care-associated transmission has not been identified to date.<sup>5</sup> Interim case definitions based on acute respiratory illness and travel history were issued by WHO on September 29 and include criteria for “patient under investigation,” “probable case,” and “confirmed case.”<sup>6</sup> This information is current as of October 4. Updates on the investigation and the WHO case definition are available at <http://www.who.int/csr/don/en/index.html>.

Coronaviruses are a large, diverse group of viruses that affect many animal species. A few of these viruses cause a wide range of respiratory illness in humans, typically with “common cold” symptoms. Genetic sequence data indicate that this new virus is a beta-coronavirus similar to bat coronaviruses, but not similar to any other coronavirus previously described in humans, including the coronavirus that caused severe acute respiratory syndrome (SARS).<sup>1</sup> Comparison of viral genetic sequences from the two patients indicated that the two viruses are closely related. Treatment is supportive because no specific therapy has been shown to be effective.

WHO and CDC have not issued any travel alerts at this time. The risk to U.S. residents traveling in the region currently is estimated to be low. For persons traveling to Saudi Arabia to participate in the Hajj, scheduled for October 24-29, 2012, requirements and recommendations remain unchanged and can be found at <http://www.cdc.gov/features/Hajj>.

Persons who develop acute respiratory illness within 10 days after returning from Saudi Arabia or Qatar (excluding persons who only passed through airports) should consult a physician and mention their recent travel. Persons with acute severe lower respiratory illness requiring hospitalization should be evaluated using the guidance at the CDC coronavirus website (<http://www.cdc.gov/coronavirus/ncv>), which is based on the WHO case definition. Persons whose respiratory illness remains unexplained and who meet the WHO criteria for “patient under investigation” should be reported immediately to CDC through state and local health departments. At present, testing of specimens for the novel coronavirus will be conducted by CDC; widely available diagnostic tests for coronaviruses are not suitable for detecting this new virus.

Recommendations and guidance on the case definitions, infection control including personal protective equipment, case investigation, and specimen collection and shipment, are avail-

able at the CDC coronavirus website. Because of the possibility of frequent updates as new information becomes available, readers are encouraged to consult the CDC coronavirus website for current information. State and local health departments with questions should contact the CDC Emergency Operations Center (770-488-7100).

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**REFERENCES**

1. Corman VM, Eckerle I, Bleicker T, et al. Detection of a novel human coronavirus by real-time reverse-transcription polymerase chain reaction. *Euro Surveill.* 2012;17(39).

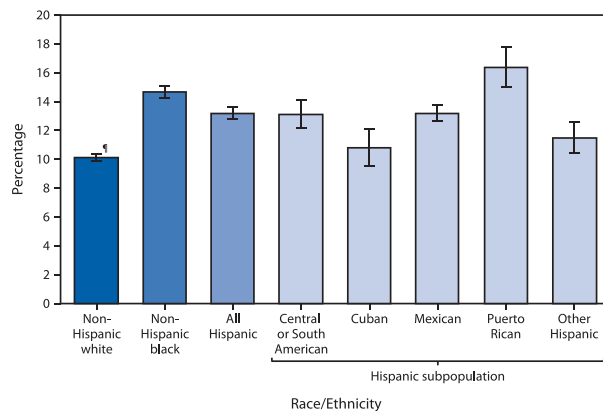
2. Danielsson N, Catchpole M; ECDC Internal Response Team. Novel coronavirus associated with severe respiratory disease: Case definition and public health measures. *Euro Surveill.* 2012;17(39).  
 3. Bermingham A, Chand MA, Brown CS, et al. Severe respiratory illness caused by a novel coronavirus, in a patient transferred to the United Kingdom from the Middle East, September 2012. *Euro Surveill.* 2012;17(40).  
 4. European Centre for Disease Prevention and Control (ECDC). Rapid risk assessment: severe respiratory disease associated with a novel coronavirus. Stockholm, Sweden: ECDC; 2012. Available at <http://ecdc.europa.eu/en/publications/Publications/RRR-Novel-coronavirus-final20120924.pdf>. Accessed October 4, 2012.  
 5. Pebody RG, Chand MA, Thomas HL, et al. The United Kingdom public health response to an imported laboratory confirmed case of a novel coronavirus in September 2012. *Euro Surveill.* 2012;17(40).  
 6. World Health Organization. Global alert and response (GAR): revised interim case definition—novel coronavirus. Geneva, Switzerland: World Health Organization; 2012. Available at [http://www.who.int/csr/disease/coronavirus\\_infections/case\\_definition/en/index.html](http://www.who.int/csr/disease/coronavirus_infections/case_definition/en/index.html). Accessed October 4, 2012.

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**QuickStats**

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

**Percentage of Adults Aged 18–64 years Who Needed Prescription Medicine But Did Not Get it Because of Cost During the Preceding 12 months,\* by Black or White Race and Hispanic Subpopulation† — National Health Interview Survey, United States, 2009–2011‡**



\* Based on a survey question that asked respondents, “During the past 12 months, was there any time when you needed (prescription medicine) but didn’t get it because you couldn’t afford it?” Unknowns were not included in the denominators when calculating percentages.  
 † Persons of Hispanic ethnicity might be of any race or combination of races. Non-Hispanic persons are those who are not of Hispanic ethnicity, regardless of race.  
 ‡ Estimates were based on household interviews of a sample of the U.S. civilian, noninstitutionalized population.  
 § 95% confidence interval.

During 2009–2011, Hispanic adults aged 18–64 years were less likely (13.2%) than non-Hispanic blacks (14.7%) but more likely than non-Hispanic whites (10.1%) to have needed prescription medicine but not gotten it because of cost during the preceding 12 months. Among Hispanic subpopulations, the percentage of Puerto Rican adults needing prescription medicine but not getting it because of cost was higher (16.4%) than for Mexican adults (13.2%), other Hispanic adults (11.5%), and Cuban adults (10.8%), but not significantly different from Central or South American adults (13.1%).

Source: National Health Interview Survey, 2009–2011 Sample Adult Core component. Available at <http://www.cdc.gov/nchs/nhis.htm>.  
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