

This "military" action prevented any foreign commerce, thus aggravating the misery of the civilian population in a country devastated by years of war and Weyler's relocation of farmers.

With regard to the more recent epidemic, Perez-Stable and Boza refute that there is a blockade now. They refer to the current US economic "embargo" instead. We also used this official euphemism in our article. However, if the discussion is to focus on semantics, we ask Perez-Stable and Boza to consider whether the recently approved Helms-Burton law does not amount to an economic and commercial "blockade," according to a standard definition of the English term (i.e., "a restrictive measure designed to obstruct the commerce and communications of an unfriendly nation").<sup>4</sup>

Finally, it is not our intention to engage Perez-Stable and Boza in a political debate on what percentage of the recent crisis was due to the "embargo" and what percentage was due to the "inefficiencies of socialistic planning." That is not the point. We would like to remind our colleagues, however, that the Cuban government that they so emphatically criticize as the primary cause of the recent epidemic is the same government that implemented an exemplary health system<sup>5</sup> and that, in the midst of deep economic crisis, was able to protect the most vulnerable population groups from the devastating effects of the recent epidemic, which affected very few children, pregnant women, and elderly people.<sup>6</sup>

The issue is what Perez-Stable and Boza also explicitly recognize: that the "embargo . . . aggravate[s] the suffering of the Cuban people." The issue is how politics, colonialism, and war (whether economic or military) can have devastating consequences on the health of an entire nation. For epidemiologists and health practitioners, the lesson is how important it is to go beyond the usual scope of our research if we want to understand the ultimate causes of these episodes and how to prevent them in the future. □

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## References

1. Ordúñez-García PO, Nieto FJ, Caballero B, Espinosa-Brito AD. Cuban epidemic neuropathy, 1991-1994: history repeats itself a century after the "amblyopia of the blockade." *Am J Public Health.* 1996;86:738-743.
2. Santos Fernández J. Ambliopia por neuritis periférica debida a autointoxicación de origen intestinal por alimentación defectuosa. *Crónica Med Quirúrgica de La Habana.* 1900;26:330-334.
3. Millis W. *The Martial Spirit: A Study of Our War with Spain.* Boston, Mass: Houghton Mifflin; 1931:151.
4. *Webster's Ninth New Collegiate Dictionary.* Springfield, Mass: Merriam-Webster; 1985:160.
5. Susser M. Health as a human right: an epidemiologist's perspective on the public health. *Am J Public Health.* 1993;83:418-426.
6. Román GC. An epidemic in Cuba of optic neuropathy, sensorineural deafness, peripheral sensory neuropathy and dorsolateral myeloneuropathy. *J Neurol Sci.* 1994;127:11-28.

## Cause-of-Death Categories

We were pleased to see the excellent article on infant mortality from infectious diseases in which the authors (Read et al.) used the National Center for Health Statistics linked birth/infant death data sets.<sup>1</sup> However, we have serious concerns about the authors' recommendations to alter the Public Health Service procedures for ranking leading causes of death in the United States. The tabulation lists used to present mortality data in the United States—which are the basis for ranking causes of death<sup>2-4</sup>—were developed to be consistent with those recommended by the World Health Organization (WHO) in the *International Classification of Diseases* (ICD).<sup>5</sup> Under an international agreement, the United States uses the ICD to ensure comparability of cause-of-death statistics within and between nations. In the ICD, not all infectious diseases are grouped together. Influenza and pneumonia, for example, are classified under respiratory diseases, not under infectious diseases.

We also have concerns about the authors' suggestion to combine into a single category for ranking purposes such disparate conditions as influenza, human immunodeficiency virus (HIV) infection, and septicemia. These diseases have different etiologies and require different

prevention protocols. Separate rankings for these causes provide a more detailed picture of the impact of diseases and thus a clearer picture of what needs to be done from a prevention standpoint. One can always add categories together, as Read et al. did, to get a combined category for infectious diseases.

One of the advantages of the ICD system is its flexibility, as causes of death can be grouped differently depending on the nature and goals of a particular research study. Thus, researchers studying the impact of infectious diseases on overall mortality may want to include pneumonia in their list of infectious diseases. Similarly, researchers studying the impact of respiratory diseases on overall mortality would want to include pneumonia in a list of respiratory diseases. Separate categories allow researchers to classify data in a manner relevant to the goals of their particular study. Adherence to WHO recommendations does not inhibit researchers' ability to analyze mortality data in ways most appropriate for their study goals, but it does allow the United States to maintain comparability with other nations.

In conclusion, we strongly disagree with the recommendation to combine infectious diseases for ranking purposes. Such a recommendation runs counter to widely accepted internationally recognized practices and does not appear to best serve prevention programs. □

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## References

1. Read JS, Troendle JF, Klebanoff MA. Infectious disease mortality among infants in the United States, 1983 through 1987. *Am J Public Health.* 1997;87:192-198.
2. *Vital Statistics of the United States, 1992. Vol. II. Mortality, Part A.* Hyattsville, Md: National Center for Health Statistics; 1996. Technical Appendix.
3. Singh GK, Kochanek KD, MacDorman MF. Advance report of final mortality statistics, 1994. *Month Vital Stat Rep.* 1996;45(3)(suppl).
4. *Health, United States, 1995.* Hyattsville, Md: National Center for Health Statistics; 1996.
5. *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, Based on the Recommendations of the Ninth Revision Conference, 1975.* Geneva, Switzerland: World Health Organization; 1977.