women were reevaluated during and following therapy. A group of 296 women with uncomplicated lower genital tract infection was included for comparison.

PID was diagnosed using standard criteria\(^1\) and defined as sexually transmitted disease PID (STD PID) if endocervical cultures or direct antigen detection tests were positive for *Neisseria gonorrhoeae* or *Chlamydia trachomatis*. Demographic and clinical data were obtained that included age, race, marital status, sexual activity, contraception, history of sexually transmitted disease, clinical symptoms, signs, and severity of PID.

Compared with women with uncomplicated infections, PID patients were significantly more likely to have multiple partners (OR 2.39, 95% CI = 1.35, 4.20, \(P = .002\)), prior PID (OR 3.80, 95% CI = 2.20, 6.54, \(P < .001\)), and prior trichomoniasis (2.30, 95% CI = 1.40, 3.77, \(P < .001\)). Among the 102 women with PID, 50 (49.0%) were diagnosed with STD PID and were more likely to have a symptomatic sex partner (OR 4.20, 95% CI = 1.60, 11.25; \(P = .002\)) and present with more acute and severe clinical findings, e.g., fever, vaginal discharge, dysuria, and mucopurulent endocervical discharge, i.e., “mucopus” (Table 1). In contrast, those with non-STD PID were more likely to have multiple and prior episodes of PID and asymptomatic partners but persistent clinical tenderness despite recommended therapy (Table 1). For most of the other categories, STD PID was similar to non-STD PID (Table 1).

Despite changing or undefined trends in gonorrhea and chlamydial infections, recommended PID outpatient management in public health practice has remained essentially unchanged.\(^5\) The results of this study reinforce the issues associated with the management of both STD and non-STD PID, offer insight on the clinical course of PID, particularly non-STD PID, and pose important implications for future development and implementation of the most appropriate and cost-effective PID prevention and treatment strategies.

![Figure 1](https://example.com/figure1.png)

**FIGURE 1**—The year-to-year differences in life expectancy, by race and sex, 1971 through 1989.

### Acknowledgments

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### References


### Smaller Increases in Life Expectancy for Blacks and Whites between the 1970s and 1980s

The excellent article by Kochanek et al.\(^1\) on the decline of Black life expectancy from 1984 to 1989 includes a table of annual life expectancies for the total population, White males, White females, Black males, and Black females from 1970 to 1989. However, when the interannual differences are plotted against year, the similarity in the fluctuations of the four race/sex subpopulations stands out strikingly (see Figure 1). Indeed, when regressions are performed on these interannual differences, the following high correlation coefficients are obtained: for White males vs Black males, \(R^2 = 59.2\%\); for White females vs Black females, \(R^2 = 79.8\%\); for White females vs White males, \(R^2 = 80.2\%\); and for Black females vs Black males, \(R^2 = 74.1\%\). Clearly, everyone was part of the same system, although the Blacks, especially Black males, were more affected than the Whites by both favorable and unfavorable factors.

Additionally, the 1970s were kinder to everyone than the 1980s. Improvements in life expectancy were much greater in that earlier decade, as is seen in Table 1. Although a hierarchy of vulner-
TABLE 1—Differences in Life Expectancy (in Years)

<table>
<thead>
<tr>
<th>Decade</th>
<th>Total</th>
<th>White Males</th>
<th>White Females</th>
<th>Black Males</th>
<th>Black Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>1971–1979</td>
<td>2.8</td>
<td>2.5</td>
<td>2.6</td>
<td>3.5</td>
<td>4.0</td>
</tr>
<tr>
<td>1981–1989</td>
<td>1.1</td>
<td>1.6</td>
<td>0.8</td>
<td>0.3</td>
<td>0.3</td>
</tr>
</tbody>
</table>

ability is clear (Black males, Black females, White females, White males), all four subpopulations show smaller increases in life expectancy from 1981 to 1989 than from 1971 to 1979. Everyone suffered in the 1980s, although unequally; White women did not fare well, but they did not fare as badly as Blacks.

What these data show is that we are all in the same boat. The socioeconomic factors that heavily affect the morbidity and mortality of Blacks do not leave the Whites unscathed. The widening gap between Blacks and Whites in life expectancy, although rightly demonstrated by the authors, is not the whole story. Whites must not be led to see their own situation as just fine and unrelated to that of Blacks. The data show that they cannot “make a covenant with death.”

Deborah Wallace, PhD

Reference

Request for Information: An Evaluation of Occupational Safety Interventions

We are extending our work, reviewing the effectiveness of workplace safety measures. We would like to identify relevant studies, including those that formally published in the scientific literature.

If you have conducted or know of studies evaluating workplace safety measures, please send us details. We are interested in all types of safety measures. We want to find reports regardless of whether they were published in peer-reviewed journals, released in official reports, or never disseminated at all.

It is our understanding that many readers of the *American Journal of Public Health* are employed by or contractors for public and private organizations worldwide and may have access to the information we need. We believe that the results of this cooperative effort will be of substantial value to the organizations, communities, and individuals we all serve professionally. If you can help us, please send Professor Stephen J. Guastello your information by September 30, 1995. We will send a copy of our report to all responders.

Stephen J. Guastello, PhD
Harry S. Shannon, PhD

Stephen J. Guastello is with the Department of Industrial Psychology and Human Factors Engineering, Marquette University, Milwaukee, Wis. Harry S. Shannon is with the Department of Clinical Epidemiology and Biostatistics, McMaster University, Hamilton, Ontario, Canada.

Information should be sent to Stephen J. Guastello, PhD, Department of Industrial Psychology and Human Factors Engineering, PO Box 1881, Marquette University, Milwaukee, WI 53201-1881.

Reference