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HIV-Related Tuberculosis in a Transgender Network — Baltimore, Maryland, and New York City Area, 1998–2000

During June–August 1998, the Tuberculosis (TB) Control Program of the Baltimore City Health Department (BCHD) identified four cases of TB among young black men. Three of these men also had human immunodeficiency virus (HIV) infection. The four reported belonging to a social network of transgender persons (i.e., persons who identify with or express a gender and/or sex different from their biologic sex) (*1*). By October 1998, test results on *Mycobacterium tuberculosis* isolates from the four men demonstrated a matching 11-band DNA fingerprint pattern (*2*), suggesting that these case-patients were epidemiologically linked. This report describes the public health investigation of these TB case-patients to identify contacts in Baltimore and the New York City area (NYC); the findings suggest that an interstate outbreak of TB has occurred within a social network that includes transgender persons.

Network Investigation

The four patients were identified as men who have sex with men (MSM) and belonged to a transgender social network. Some network members dressed as women and participated in dance and fashion competitions known as "balls." These social networks include "houses" (i.e., a guild providing a social framework for young MSM and transgender persons) that exist in many large U.S. cities (house leader, personal communication, 2000). All four also were commercial sex workers.

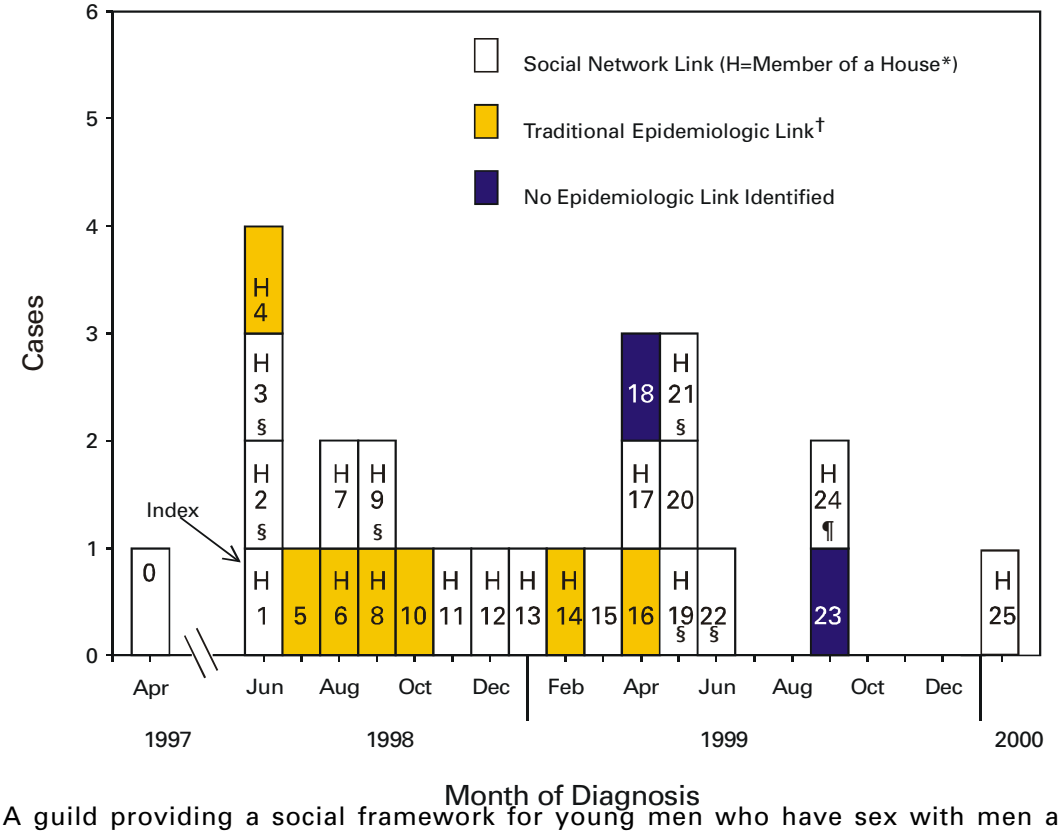
An additional 22 TB patients were identified and linked to this cluster through interviews, provider and hospital referrals, and contact investigations (Figure 1). Twenty-four of the 26 cases were culture-confirmed, and DNA fingerprinting of 23 isolates demonstrated a matching fingerprint pattern. All isolates were susceptible to first-line anti-TB drugs (e.g., isoniazid and rifampicin). Of the 26 case-patients, 24 were U.S.-born, and 25 were black. The median age was 24 years (range: 20–47 years) and 22 (85%) were men. Sixteen case-patients (62%) were known to have HIV infection or acquired immunodeficiency syndrome (AIDS) when TB was diagnosed.

Baltimore, Maryland

Among the 15 male case-patients in Baltimore, 13 (87%) were epidemiologically linked; 11 (73%) were members of a house; eight (73%) belonged to House A (Figure 1). The index case-patient (patient 1) was a 24-year-old transgender man and a member of House A. Patients 4 and 14 were roommates of patient 1. Patients 6 and 8 shared living

HIV-Related Tuberculosis — Continued

FIGURE 1. Outbreak of tuberculosis among transgender persons, by month of diagnosis — Baltimore, Maryland; New York City; and Jersey City, New Jersey, 1998–2000



*A guild providing a social framework for young men who have sex with men and for transgender persons.
† Household, family, or health-care worker contacts.
§ New York City-reported case.
¶ New Jersey-reported case.

accommodations. Despite having isolates with matching fingerprints, patients 18 and 23 had no epidemiologic link to other patients in the outbreak and reported not being MSM (both were HIV-negative). Patient 20 was an HIV-positive man who has sex with men, was not a member of a house, and reported contact with commercial sex workers. DNA fingerprint results are pending for patient 25, a contact of patient 1. The four female patients included an outreach worker (patient 5) who had contact with two case-patients, a physician (patient 10) who spent approximately 1 hour with patient 1 administering medical care, a friend (patient 15) of several House A members, and the biologic mother (patient 16) of patient 11.

Patient 0 had TB diagnosed in the Maryland corrections system in April 1997. He had been incarcerated since May 1996. Patient 0 was not associated with this outbreak until early 1999 when the fingerprint of his isolate was found to match the outbreak strain. During the 2-year period before incarceration, patient 0 lived with patient 11 and frequented balls in Baltimore and NYC.

During BCHD investigations of 105 contacts of these TB patients, 14 persons were named as contacts by 12 infectious TB case-patients. To reach additional persons who may have had contact with infectious persons, a profile of the social network was developed by BCHD and included any history of membership in a house, attendance at

HIV-Related Tuberculosis — Continued

particular nightclubs or balls, or cross-dressing. An additional 91 contacts were identified through visits for home-based anti-TB therapy, two location-based screenings at a nightclub, and referrals from HIV clinics. Among all 105 social network contacts, 96 (91%) had a tuberculin skin test (TST), 65 (68%) tests were read, and 24 (37%) were TST-positive. Six of 19 (32%) Baltimore case-patients were detected through the social network. Because one infectious patient traveled with a community marching band, TST screening was offered to all band members. Screening of 83 band members resulted in a TST-positive rate of 7%, significantly lower ($p<0.01$) than in the social network screening. These investigations identified 37 contacts (including 14 TST-negative, HIV-positive contacts) as candidates for treatment for latent TB infection, which was initiated in 24 (65%).

New York City Area

Because of the travel by some of the Baltimore case-patients, transmission of the outbreak strain was suspected in NYC. Patients 9 and 22 had resided for a short time in Baltimore before TB was diagnosed. Identified by a Baltimore case-patient, patient 22 regularly associated with House A members from Baltimore and NYC and participated in balls. Because of the two NYC-diagnosed and reported cases, in late 1999, CDC conducted DNA fingerprint analysis on *M. tuberculosis* isolates from 1998 and 1999 NYC cases among HIV-positive black males aged 15–35 years. Four of 37 (11%) typed isolates matched the Baltimore strain (patients 2, 3, 19, and 21). Interviews of the patients revealed that all four were house members and participated in balls, and all except patient 21 traveled to Baltimore to attend balls.

Patient 24 was from Jersey City, New Jersey, and was linked to this outbreak because *M. tuberculosis* isolates from all TB cases in New Jersey were fingerprint typed through the National TB Genotyping and Surveillance Network. The patient died before the investigation. Medical record review and interviews with relatives indicated the man was transgender and made frequent trips to Baltimore. Five of the seven TB patients identified in NYC were HIV-positive, and three have died.

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Editorial Note: This outbreak of TB among transgender persons occurred within a social network that is both at high risk for TB and difficult to reach using a traditional public health investigative approach. Early in the outbreak, BCHD recognized the initial cluster of four cases with matching DNA fingerprint patterns. This prompted further investigation to explore chains of transmission not detected through routine epidemiologic links. Traditional contact investigations, where health officials rely on persons with infectious TB to identify persons with whom they have contact regularly at home and in the work place (*3*), were inadequate to control this outbreak. As a result, contacts might have been overlooked if patients had not been asked about the transgender social network, particularly the houses. Most contacts were identified at location-based TST screenings or by TB outreach workers and nurses who encountered contacts while administering TB therapy.

HIV-Related Tuberculosis — Continued

Transgender persons are heterosexual, homosexual, or bisexual and may be cross-dressers (transvestites) or pre-operative and postoperative transsexuals (*4*). Transgender persons often fear discrimination and ridicule and may conceal their identity, move frequently, engage in illicit activities such as commercial sex work, and mistrust public health authorities (*5,6*). In this investigation, many infected persons were reluctant or unable to identify contacts.

The transgender social network includes biologic male house members who appear as women and members who neither cross-dress nor are transgender. Most houses are affiliated with houses in other U.S. cities. An important activity of the social network is attendance and participation in balls, and some house members travel to numerous east coast cities to participate in balls.

The findings in this report are subject to at least two limitations. First, the total number of persons within this transgender social network is unknown; therefore, the extent of transmission cannot be determined. Second, although matching DNA fingerprints of *M. tuberculosis* isolates obtained from different patients strongly suggest common chains of transmission, conclusions should not be drawn in the absence of sufficient epidemiologic data. Despite routine DNA fingerprinting of all *M. tuberculosis* isolates within Maryland and New Jersey, with the exception of patients 18 and 23, this particular 11-band fingerprint pattern has been observed only in persons associated with this social network. Epidemiologic links for patients 18 and 23 were not established.

This outbreak strain was detected in 13 (14%) of the 96 culture-confirmed TB cases reported in Baltimore during June 1998–December 1999, and 10 (67%) of 15 culture-confirmed cases reported among U.S.-born black males aged 15–35 years during this period. Frequent travel and social network links identified among the Baltimore and NYC cases have raised concern that this strain of *M. tuberculosis* may be circulating in other cities among young, mobile, transgender persons with HIV infection. One house leader estimated that there are at least 35 houses in major east coast cities. However, three of the more recent Baltimore patients associated with this outbreak did not acknowledge being transgender or affiliating with a house, raising the possibility that transmission may be occurring beyond the transgender community. CDC is working with TB control staff in Baltimore, Boston, NYC, Philadelphia, Washington, D.C., and Atlanta to determine whether additional TB cases are linked to this outbreak. Health-care providers should report cases to local TB control programs. Health departments may contact CDC for technical assistance at (404) 639-8117.

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Escherichia coli O111:H8 Outbreak Among Teenage Campers — Texas, 1999

In June 1999, the Tarrant County Health Department reported to the Texas Department of Health (TDH) that a group of teenagers attending a cheerleading camp during June 9–11 became ill with nausea, vomiting, severe abdominal cramps, and diarrhea, some of which was bloody. Two teenagers were hospitalized with hemolytic uremic syndrome (HUS), and two others underwent appendectomies. Routine stool cultures from eight ill persons failed to yield a pathogen. Stools subsequently were sent to laboratories at the Texas Department of Health and CDC, where *Escherichia coli* O111:H8 was isolated from two specimens. This report summarizes the investigation of this outbreak.

To identify additional cases, surveillance for non-O157 Shiga toxin-producing *E. coli* (STEC) illnesses in Texas was enhanced by alerting all local health departments, hospitals, clinical laboratories, and physicians about the outbreak. A cohort study of all campers attending the 3-day camp was conducted to identify the source of the outbreak and to collect data describing the clinical illness. Illness was defined as either diarrhea (three or more loose stools during any 24-hour period) accompanied by abdominal cramps or bloody diarrhea alone, occurring within 14 days after the start of the camp. Campers were interviewed for demographic information, medical histories, and symptoms and about their food and beverage consumption during the camp. Sanitarians inspected the cafeteria where meals were prepared and served to campers and the plumbing system in the dormitory where campers resided. Foodhandlers and other kitchen staff were interviewed about food preparation practices, menus, and the delivery schedules and suppliers for food items served to campers. Foodhandlers submitted stool specimens and rectal swabs for testing. Several food items from the cafeteria were cultured.

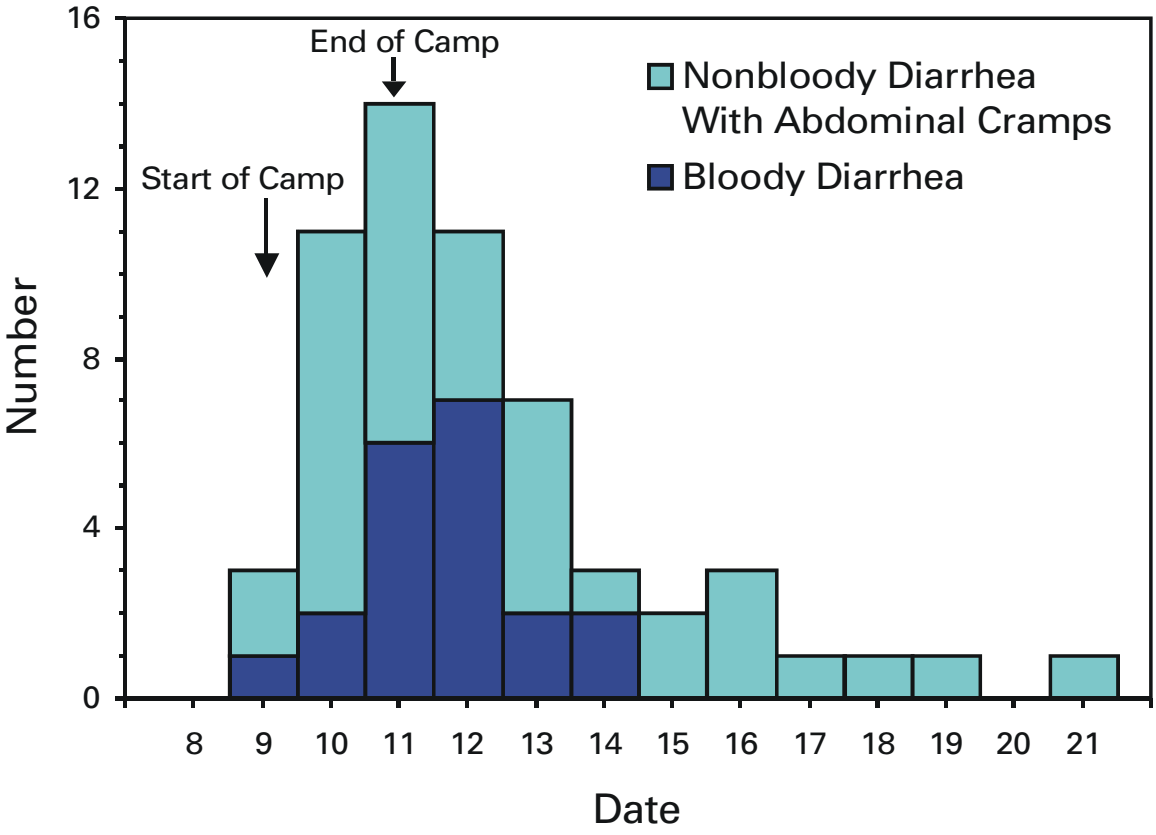
Of the 650 campers composing the cohort, 521 (80%) were interviewed. Of these, 58 (11%) had illnesses that met the case definition. The median age of the 58 ill persons was 16 years (range: 12–53 years), and 95% were female. The median length of illness was 5 days; four (7%) persons were hospitalized. Two persons developed HUS. In addition to diarrhea, reported symptoms included abdominal cramping (100%), nausea (62%), headache (56%), vomiting (38%), bloody diarrhea (37%), and fever with a median temperature of 100 F (38 C) (29%).

Illnesses peaked on the third and final day of camp (Figure 1). Illnesses with bloody diarrhea peaked on the day after the camp ended. No campers reported having a diarrheal illness or contact with a person with diarrhea during the 2 weeks before the start of camp.

One meal (supper on the first day of camp) and 21 other exposures were significantly associated with risk for developing illness. Of these 21 exposures, 19 were specific food items from among 202 foods and beverages served in the cafeteria during the camp and two were more general exposures. Only the two general exposures were significantly and independently associated with illness: consuming any ice from large trash can-style lined barrels that the camp provided in the dormitory lobby for filling water bottles (73% of ill persons versus 43% of nonill persons) (adjusted odds ratio [AOR]=3.4; 95% confidence interval [CI]=1.8–6.3; p=0.0001) and eating any salad from the cafeteria salad bar on at least one occasion (93% of ill persons versus 79% of nonill persons; AOR=3.5; 95% CI=1.4–11.8; p=0.02).

Escherichia coli — *Continued*

FIGURE 1. Number of *Escherichia coli* O111:H8-associated illnesses at a camp, by date of onset — Texas, June 1999



Inspection of the camp's water systems showed no evidence of plumbing cross-connections or failures that might have led to exposures to contaminated water or waste. Coliform testing of ice from the ice machines used to fill the barrels was negative. Campers reported dipping their drink containers and arms, hands, and heads into the ice. They also reported observing floating debris in the ice barrels. Inspection of the cafeteria and kitchen indicated that kitchen staff may have improperly followed cooking times and temperatures recommendations when preparing meals.

The laboratory investigation of stools specimens submitted by 11 ill persons yielded *E. coli* O111:H8 from two specimens. Three enrichment broths prepared from these 11 specimens had detectable Shiga toxin when screened with a commercial enzyme immunoassay (EIA). Two of these three EIA-positive stool specimens yielded colonies of Shiga toxin-producing *E. coli*, which were serotyped as *E. coli* O111:H8. Both isolates contained gene sequences for Shiga toxins 1 and 2 by polymerase chain reaction. *E. coli* O157:H7 was not isolated from any camper, foodhandler, or food or water sample. Samples of the implicated ice and salad items served during the camp were not available for testing.

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Escherichia coli — *Continued*

Editorial Note: This was the first community outbreak of infections attributable to Shiga toxin-producing *E. coli* O111 reported in the United States. The findings of the investigation suggest a point-source outbreak. Although primary infection from eating a contaminated salad item and then secondary spread through the barrel ice is a plausible hypothesis, the original source of contamination and its means of spread are unknown.

Identification of non-O157 STEC requires techniques not used routinely by clinical laboratories. In this outbreak, a commercially available EIA kit was used to detect and isolate STEC in stool specimens; isolates were then serotyped at CDC.

STEC cause illness in otherwise healthy persons, including severe abdominal cramping (sometimes confused for appendicitis), bloody diarrhea, and HUS. *E. coli* O111 was the second most common non-O157 STEC (after *E. coli* O26) isolated from specimens submitted to CDC for serotyping during 1983–1998 and among isolates from persons with diarrhea collected for an ongoing survey in Minnesota initiated in 1995 (Minnesota Department of Public Health, unpublished data, 2000). STEC cause an estimated 110,000 illnesses each year in the United States, of which ≥30% may be attributable to non-O157 serotypes such as O111 (*1*); the burden of disease attributable to non-O157 STEC is unknown.

Most STEC outbreaks in North America have resulted from infection with *E. coli* O157. A household cluster of *E. coli* 0111 infection was reported in 1990 from Ohio (*2*), and outbreaks have occurred in Australia, Europe, and Japan (*3–7*). Despite investigations involving large numbers of persons in well-defined settings, the vehicle of transmission has been epidemiologically implicated and microbiologically confirmed in only one 1995 outbreak in South Australia, which was attributable to mettwurst, a dried fermented sausage (*3*).

As demonstrated by this outbreak, a commercially available kit could be used to screen stool specimens for Shiga toxin and potential STEC. However, culturing and serotyping the causative organism is critical to identify and better understand these emerging pathogens. To facilitate diagnosis of STEC infections, clinicians should inform health departments about clusters of suspected illnesses that could be attributable to STEC (e.g., bloody diarrhea and HUS). Clinical laboratories should screen stool specimens from persons with either bloody diarrhea or HUS for STEC, routinely or when *E. coli* O157 is not isolated, and attempt to isolate STEC from stools that are positive by the screening test and refer isolates to public health laboratories for serotyping. States should consider adding STEC infections to their notifiable disease lists.

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Escherichia coli — *Continued*

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Public Health Aspects of the Rainbow Family of Living Light Annual Gathering — Allegheny National Forest, Pennsylvania, 1999

The Rainbow Family of Living Light (RFLL) is a loosely organized group that developed out of the late 1960s counterculture movement. RFLL has had a 2-week "Gathering for World Peace and the Healing of the Earth" in a different national forest each summer since 1972. For the June 21–July 10, 1999, gathering, RFLL selected the Allegheny National Forest in Pennsylvania. The site was not accessible by vehicle and was an hour's walk to the nearest road. No sanitary facilities were available, and water from streams was consumed without treatment. Approximately 20,000 persons attended from the United States and several foreign countries. The state health department requested federal assistance to establish and maintain public health surveillance and to advise on outbreak prevention and control. This report describes the public health aspects of the gathering and presents recommendations for the management of health risks at large outdoor events.

RFLL was asked by the state health department's epidemiologists to conduct or permit surveillance for persons with injuries, vomiting, and diarrhea at the RFLL clinic, the Center for Alternative Lifestyles Medicine (CALM). CALM was predominately staffed by herbalists, faith healers, and acupuncturists. CALM did not maintain records of patient visits but stocked supplies for obtaining stool samples if the staff encountered large numbers of patients with diarrhea. Public health workers visited the CALM clinic daily to inquire about the number of patients and spectrum of diseases encountered; CALM staff requested that these interactions be informal and not involve written records.

Surveillance for injuries and diseases was conducted at the 15 hospitals and clinics within a 75-mile radius of the Pennsylvania gathering. Emergency department (ED) directors of the 15 facilities were informed in person or by telephone about the gathering and were asked to inform their staff about the gathering. From June 27 to July 7, the peak period of attendance, ED staff asked all persons seeking care at their facility whether they were affiliated with the gathering, and if they were, to record on a provided form the participant's age, sex, reason for visit, and medical disposition. Facilities were requested to return the form by fax each day. Telephone calls to all ED directors were made at the end of the surveillance period to verify data completeness.

Five facilities in the surrounding area reported caring for 115 persons affiliated with the gathering; 112 were attending the gathering, and three were local law enforcement officers detailed to the event. The median age of patients was 23 years (range: 1–70 years) and 69 (60%) were male. Fourteen (12%) of the 115 persons required hospital admission. Twenty-eight (24%) of the 115 sought care for apparent infections, including nine cases of diarrheal illness for which no pathogen was identified. Twenty persons (17%) had musculoskeletal injuries related to falls or altercations; 17 (15%) sought care

Rainbow Family of Living Light — Continued

for soft tissue injuries, 12 of which were bites (e.g., four brown recluse spider bites, two dog bites, and one rattlesnake bite). One death occurred as the result of complications from a myocardial infarction. Other reasons for seeking care included 13 (11%) psychiatric conditions, seven (6%) motor-vehicle–related injuries, five (4%) environmental exposures (e.g., severe sunburn and lightning strike), and obstetric/gynecologic, noninfectious gastrointestinal, neurologic, allergic, and neoplastic conditions (<5% each). Although not a presenting complaint, lice infestation and illicit substance abuse among RFLL members were reported by medical staff.

Outbreak prevention measures included hygiene and health information provided by public health staff, and training sessions for clinic staff about risks for infectious diarrhea, Lyme disease, and rabies. Signs were posted on the grounds describing appropriate latrine use, handwashing, and water treatment. In addition, the state agency that certifies commercial kitchens in Pennsylvania provided a courtesy "walk-through" to reinforce safe foodhandling practices in the kitchens.

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Editorial Note: Mass outdoor gatherings can occur in settings with inadequate sanitary facilities and potable water. Crowded conditions increase the potential for food and water contamination, and foodborne and waterborne outbreaks (*1–3*). Although guidelines are available for public health management of displaced persons (*4,5*), guidelines have not been published for managing the health of persons attending special outdoor events in the United States.

This report is subject to at least two limitations. First, no formal surveillance existed within CALM; therefore, the number of persons seeking health care and the spectrum of illnesses and injuries cannot be determined. Second, persons seeking care in the surrounding medical centers identified through surveillance may have had more serious illnesses than those reporting to CALM. The number of these persons may have been underestimated because they may not have been asked or they did not identify themselves as affiliated with RFLL.

Effective public health planning for special event gatherings can be achieved through collaboration among the event's planners; community representatives; and local, state, and/or federal agencies responsible for health and safety. Plans should include 1) assessing the size of the event and the likely health needs of participants; 2) learning about local environmental hazards and diseases (e.g., rabies, Lyme disease, giardiasis, and vectors); 3) estimating local response capacity for laboratory diagnosis and emergency medical treatment; and 4) preparing triage and evacuation systems. Epidemic diarrheal diseases are a concern at outdoor gatherings where there are no sanitary facilities or safe sources of water; therefore, plans for preventing enterically transmitted diseases should include providing clean water, sanitary facilities, personal hygiene information, and surveillance for the prompt detection of epidemics (*4*).

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Prevalence of Leisure-Time Physical Activity Among Overweight Adults — United States, 1998

In the United States, overweight and obesity have reached epidemic proportions among all segments of the population and regions of the country (*1*). Obesity is a risk factor for numerous chronic health conditions and weight loss can reduce risk factors for these conditions (*2*). National guidelines recommend that weight reduction should involve reducing calorie intake and increasing physical activity (*3*). The National Heart, Lung, and Blood Institute's clinical guidelines (*3*) and the federal dietary guidelines for Americans (*4*) recommend at least 30 minutes of physical activity on most days of the week for all healthy adults. To assess patterns of physical activity among overweight U.S. adults trying to lose weight, and to estimate the proportion who engage in leisure-time physical activity (LTPA) from selected demographic groups, CDC analyzed data from the 1998 Behavioral Risk Factor Surveillance System (BRFSS). This report summarizes the results of that analysis, which indicate that two thirds of overweight persons trying to lose weight reported using physical activity as a strategy for weight loss; however, only one fifth reported being active at recommended levels.

BRFSS is a random-digit–dialed telephone survey of the noninstitutionalized U.S. population aged ≥18 years. During 1998, 146,992 persons were surveyed in 50 states and the District of Columbia. Data on 11,953 (8.1%) persons were not eligible for this analysis because of pregnancy or missing information. Of those remaining, 72,624 (53.8%) were classified as overweight (body mass index [BMI]: 25.0–29.9) or obese (BMI: ≥30.0). For this analysis, the term overweight was used to describe persons who were overweight or obese. Of those overweight, 36,598 (50.4%) were trying to lose weight and were included in this analysis. The state median response rate for 1998 was 73.4%. Respondents who reported they were trying to lose weight were asked, "Are you using physical activity or exercise to lose weight?" Respondents also were asked to list their two most frequent LTPAs during the previous month and the frequency and duration of these activities. LTPA frequency was reported in times per week or per month. To calculate the national guidelines, for this analysis, it was assumed that LTPA occurred on a separate day. Prevalence estimates and 95% confidence intervals were calculated using SUDAAN (*5*).

In 1998, 66.6% of overweight men and 62.2% of overweight women reported they were trying to lose weight by using physical activity (Table 1). For both sexes, using physical activity to lose weight was related inversely to age and BMI and directly related to education level. The prevalence of using physical activity to lose weight was highest among non-Hispanic black men and lowest among Hispanics of both sexes. The prevalence of using physical activity to lose weight was lowest among residents of southern states.

In 1998, 62.7% of overweight adults using LTPA as a weight loss strategy participated in at least 30 minutes per session of LTPA, and 28.0% participated in LTPA five or more times per week. Among both sexes, walking was the most frequently reported activity

TABLE 1. Leisure-time physical activity patterns among overweight adults trying to lose weight, by selected characteristics — United States, Behavioral Risk Factor Surveillance System, 1998

	Men					Women				
Characteristic	Sample size	% using physical activity to lose weight	(95% CI*)	% meeting physical activity guidelines†	(95% CI)	Sample size	% using physical activity to lose weight	(95% CI)	% meeting physical activity guidelines	(95% CI)
Age (yrs)										
18–24	903	83.8	(80.3–87.3)	25.7	(21.6–29.8)	1,294	77.5	(73.4–81.6)	20.3	(16.8–23.8)
25–34	2,570	76.7	(74.4–79.1)	22.5	(20.0–25.1)	3,790	72.0	(69.8–74.2)	20.4	(18.4–22.4)
35–44	3,685	68.2	(65.7–70.8)	18.8	(16.8–20.8)	5,173	65.5	(63.3–67.7)	18.6	(16.8–20.4)
45–54	3,499	63.0	(60.5–65.6)	21.0	(18.8–23.2)	4,391	62.1	(59.8–64.5)	18.4	(16.6–20.2)
55–64	2,256	57.2	(54.1–60.3)	23.8	(21.1–26.5)	3,183	55.4	(52.7–58.1)	18.3	(16.1–20.5)
≥65	2,120	55.1	(51.8–58.4)	25.5	(22.6–28.4)	3,734	46.7	(44.2–49.3)	18.7	(16.5–20.9)
Race/Ethnicity§										
White	12,426	66.5	(65.3–67.7)	22.8	(21.6–24.0)	16,622	63.5	(62.3–64.7)	20.1	(19.1–21.1)
Black	1,049	70.1	(66.2–74.0)	22.6	(18.9–26.3)	2,687	62.8	(60.1–65.5)	16.9	(14.6–19.3)
Hispanic	1,017	63.8	(59.1–68.5)	17.1	(13.6–20.6)	1,614	52.7	(48.8–56.6)	14.3	(11.8–16.9)
Other	541	68.4	(60.6–76.2)	23.0	(15.6–30.5)	642	63.5	(55.7–71.3)	20.6	(14.7–26.5)
Education level										
Less than high school	1,575	47.4	(43.3–51.5)	17.7	(14.4–21.0)	2,921	44.6	(41.7–47.5)	12.7	(10.7–14.7)
High school graduate	4,327	65.7	(63.5–67.9)	19.9	(18.1–21.7)	7,811	60.6	(58.8–62.4)	17.4	(16.0–18.8)
Some college	4,018	68.5	(66.3–70.7)	22.5	(20.5–24.5)	6,234	66.2	(64.2–68.2)	21.0	(19.4–22.6)
College graduate	5,113	72.7	(70.7–74.7)	25.5	(23.5–27.5)	4,599	71.9	(69.9–73.9)	23.5	(21.5–25.5)
Region¶										
Northeast	2,939	68.9	(66.2–71.6)	23.0	(20.5–25.6)	3,777	62.0	(59.5–64.6)	18.4	(16.2–20.6)
Midwest	2,365	69.7	(67.2–72.3)	24.6	(22.3–27.0)	3,593	64.1	(61.9–66.3)	18.3	(16.7–19.9)
South	4,060	62.0	(60.0–64.0)	20.1	(18.5–21.7)	6,518	59.2	(57.6–60.8)	17.8	(16.4–19.2)
West	5,669	67.1	(64.8–69.5)	21.9	(19.9–23.9)	7,677	63.6	(61.4–65.8)	20.8	(19.2–22.4)
BMI status**										
Overweight	8,729	69.7	(68.1–71.3)	24.5	(23.1–25.9)	12,042	66.2	(64.8–67.6)	21.3	(20.1–22.5)
Obese	6,304	62.3	(60.5–64.1)	18.8	(17.2–20.4)	9,523	57.1	(55.5–58.7)	16.1	(14.9–17.3)
Total	**15,033**	**66.6**	**(65.4–67.8)**	**22.2**	**(21.2–23.2)**	**21,565**	**62.2**	**(61.2–63.2)**	**19.0**	**(18.2–19.8)**

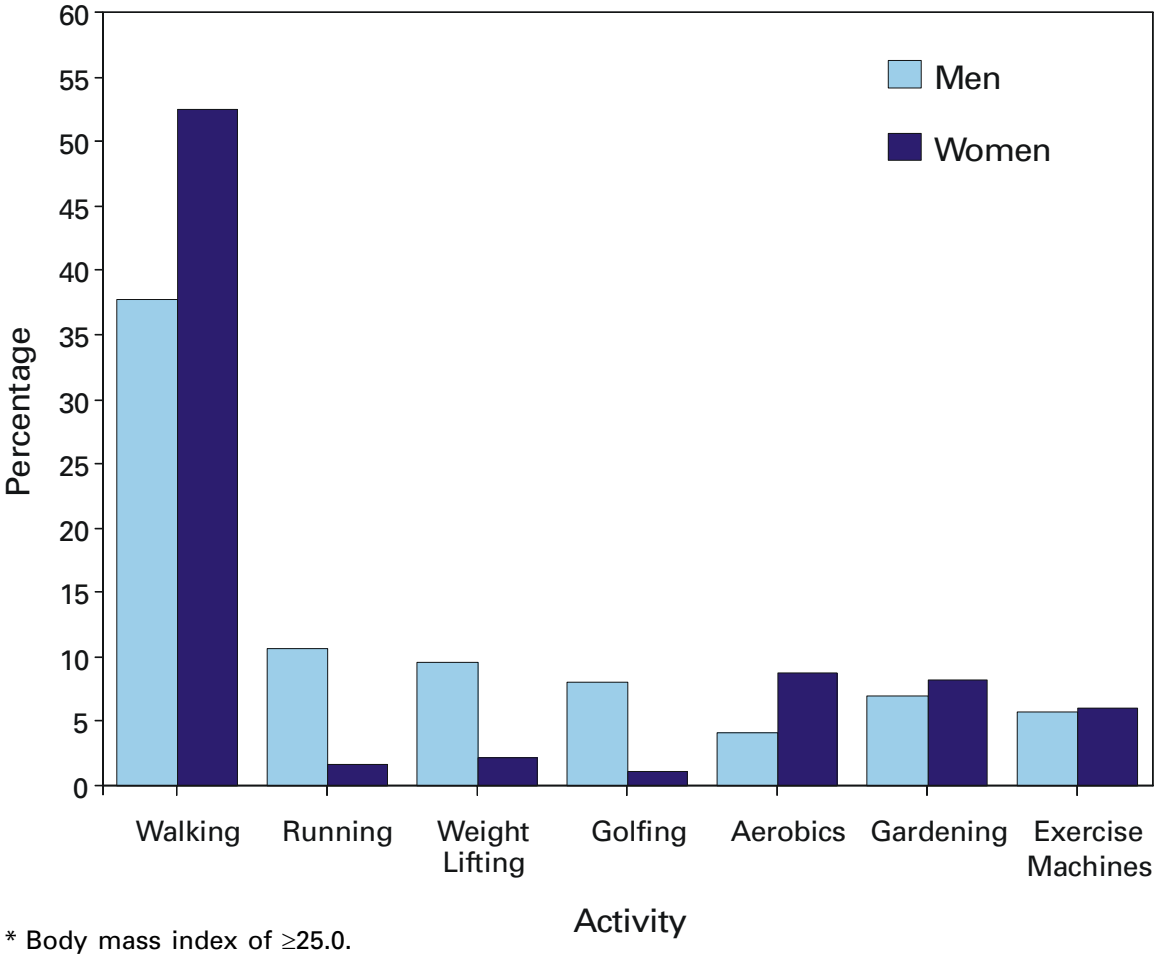
* Confidence interval.
† Five or more times per week and ≥30 minutes per session.
§ Racial groups other than white, black, and Hispanic were combined because, when analyzed separately, data were too small for meaningful analysis.
¶ *Northeast*=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; *Midwest*=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; *South*=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; and *West*=Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.
** Body mass index (BMI) of 25.0–29.9 for overweight persons and ≥30.0 for obese persons.

Leisure-Time Physical Activity — Continued

(37.7% for men and 52.5% for women). Among men, running/jogging (10.7%), weight lifting (9.6%), and golfing (8.1%) were the most commonly reported activities; among women, aerobics (8.7%), gardening (8.2%), and using exercise machines (6.0%) were the most commonly reported activities (Figure 1).

Reported by the following BRFSS coordinators: J Cook, MBA, Alabama; P Owen, Alaska; B Bender, MBA, Arizona; T Clark, Arkansas; B Davis, PhD, California; M Leff, MSPH, Colorado; M Adams, MPH, Connecticut; F Breukelman, Delaware; I Bullo, District of Columbia; S Hoecherl, Florida; L Martin, MS, Georgia; A Onaka, PhD, Hawaii; J Aydelotte, MA, Idaho; B Steiner, MS, Illinois; K Horvath, Indiana; K MacIntyre, Iowa; J Tasheff, Kansas; T Sparks, Kentucky; B Bates, MSPH, Louisiana; D Maines, Maine; A Weinstein, MA, Maryland; D Brooks, MPH, Massachusetts; H McGee, MPH, Michigan; N Salem, PhD, Minnesota; D Johnson, MS, Mississippi; T Murayi, PhD, Missouri; P Feigley, PhD, Montana; L Andelt, PhD, Nebraska; E DeJan, MPH, Nevada; L Powers, MA, New Hampshire; G Boeselager, MS, New Jersey; W Honey, MPH, New Mexico; C Baker, New York; P Buescher, PhD, North Carolina; L Shireley, MPH, North Dakota; P Pullen, Ohio; N Hann, MPH, Oklahoma; J Grant-Worley, MS, Oregon; L Mann, Pennsylvania; J Hesser, PhD, Rhode Island; M Wu, MD, South Carolina; M Gildemaster, South Dakota; D Ridings, Tennessee; K Condon, Texas; K Marti, Utah; C Roe, MS, Vermont; K Carswell, MPH, Virginia; K Wynkoop-Simmons, PhD, Washington; F King, West Virginia; P Imm, MS, Wisconsin; M Futa, MA, Wyoming. Behavioral Surveillance Br, Div of Adult and Community Health, Div

FIGURE 1. Percentage of overweight* adults reporting leisure-time physical activity, by activity — United States, Behavioral Risk Factor Surveillance System, 1998



* Body mass index of ≥25.0.

Leisure-Time Physical Activity — Continued

of Nutrition and Physical Activity, National Center for Chronic Disease Prevention and Health Promotion; and an EIS Officer, CDC.

Editorial Note: The findings in this report indicate that approximately two thirds of overweight adults trying to lose weight reported using physical activity to achieve weight reduction. However, only one fifth met the national recommendations for physical activity. Although most persons exercised ≥30 minutes per session, only a minority exercised at least five times a week. Therefore, low frequency of physical activity was the main reason the national guidelines for physical activity were not achieved. Walking was the preferred LTPA for both sexes; participation in other types of LTPAs varied by sex.

The findings in this report are subject to at least two limitations. First, because weight was self-reported and overweight persons tend to underreport their weight (*6*), those classified as overweight probably represent a heavier subset of all overweight persons. Second, prevalences of LTPA levels are likely to be underestimated because a) respondents were allowed to report only two structured physical activities and b) estimates were based only on LTPAs; physical activity related to occupation could not be assessed. In comparison, prevalences of LTPA could be overestimated because BRFSS is a telephone survey and persons without telephones are likely to be less physically active than persons with telephones (*7*).

Regular physical activity is a recognized factor for long-term weight maintenance (*3*). Increased physical activity boosts energy expenditure and reduces the risk for coronary heart disease beyond that produced by weight reduction alone (*3*). Increased physical activity can create a caloric deficit and contribute to weight loss. Although physical activity alone to achieve weight loss generally produces a 2%–3% decrease in body weight or BMI, increased physical activity is a useful adjunct to long-term weight loss (*3*).

The finding that using physical activity as a method of weight loss was least common among obese, least educated, and older persons is concerning, but is consistent with previous findings (*8*). These patterns suggest that public health interventions to help these groups become physically active remain a challenge. Whether this disparity reflects a lack of knowledge about the value of physical activity in weight reduction, an inability to meet the recommended level of exercise, or poor motivation cannot be addressed with these data. Public health interventions that promote walking may be the most successful, because it is the most popular LTPA among overweight adults. In addition, walking is unique because of its safety, accessibility, and popularity among all groups (*9,10*). Strategies to promote walking may need to identify and address environmental barriers. Understanding sex-based differences in physical activity is important for tailoring interventions and counseling about weight-control practices.

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Leisure-Time Physical Activity — Continued

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Notice to Readers

National Minority Cancer Awareness Week — April 17–23, 2000

National Minority Cancer Awareness Week, April 17–23, 2000, is dedicated to increasing awareness among racial/ethnic minority groups regarding the importance of early cancer detection. In 2000, an estimated 1,220,000 new cancer cases will be diagnosed in the United States (*1*). Some minority populations have higher rates of cancer than others (*2*); for example, blacks are more likely to develop and die from cancer than persons of any other racial/ethnic group. Along with differences in incidence and mortality, recent findings indicate that disparities exist among the five racial and ethnic minority groups in health risk behaviors, such as cigarette smoking and use of clinical preventive services including screening for breast, cervical, and colorectal cancers (*3*).

To improve cancer prevention and control within minority and underserved populations, CDC and other federal, state, and nonprofit organizations encourage and support various activities to reduce racial/ethnic disparities that include the following:

- Eliminating barriers to cancer screening and early detection.
- Implementing community-based education programs and outreach initiatives that target and address specific needs of different racial/ethnic groups.
- Tracking cancer rates among minority populations.
- Increasing and improving research efforts that target minority and underserved populations.
- Recruiting members of minority groups into clinical trials.

Additional information about National Minority Cancer Awareness Week and CDC's national cancer prevention and control efforts is available at http://www.cdc.gov/cancer.

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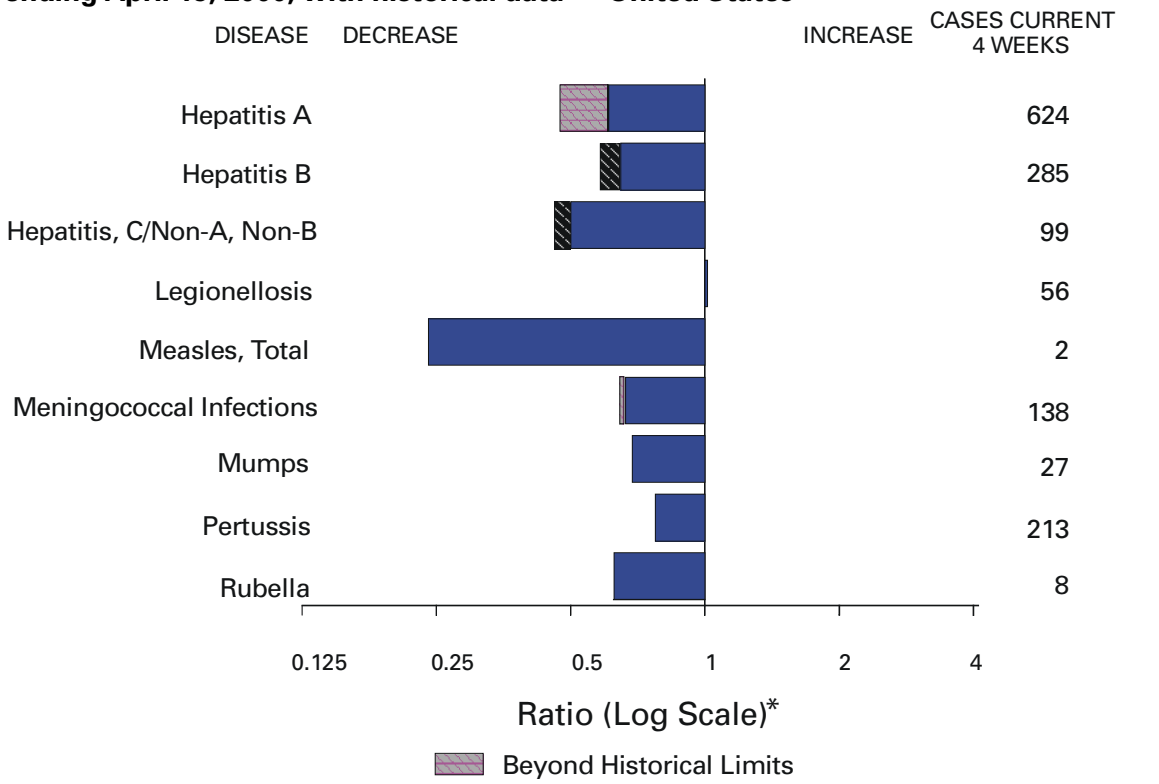
(Continued on page 339)

FIGURE I. Selected notifiable disease reports, comparison of provisional 4-week totals ending April 15, 2000, with historical data — United States



*Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary — provisional cases of selected notifiable diseases, United States, cumulative, week ending April 15, 2000 (15th Week)

	Cum. 2000		Cum. 2000
Anthrax	-	HIV infection, pediatric*§	32
Brucellosis*	7	Plague	2
Cholera	-	Poliomyelitis, paralytic	-
Congenital rubella syndrome	1	Psittacosis*	4
Cyclosporiasis*	4	Rabies, human	-
Diphtheria	-	Rocky Mountain spotted fever (RMSF)	29
Encephalitis: California* serogroup viral	2	Streptococcal disease, invasive Group A	931
eastern equine*	-	Streptococcal toxic-shock syndrome*	33
St. Louis*	-	Syphilis, congenital¶	10
western equine*	-	Tetanus	5
Ehrlichiosis human granulocytic (HGE)*	13	Toxic-shock syndrome	39
human monocytic (HME)*	1	Trichinosis	2
Hansen Disease*	11	Typhoid fever	84
Hantavirus pulmonary syndrome*†	2	Yellow fever	-
Hemolytic uremic syndrome, post-diarrheal*	23		

-: no reported cases
*Not notifiable in all states.
†Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID).
§Updated monthly from reports to the Division of HIV/AIDS Prevention–Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP), last update March 26, 2000.
¶Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending April 15, 2000, and April 17, 1999 (15th Week)

Reporting Area	AIDS		Chlamydia[§]		Cryptosporidiosis		*Escherichia coli* O157:H7*			
							NETSS		PHLIS	
	Cum. 2000[†]	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	10,143	11,376	151,930	188,735	308	426	393	329	242	273
NEW ENGLAND	666	529	6,181	6,013	16	21	33	49	32	41
Maine	11	5	346	202	3	1	3	4	3	-
N.H.	8	19	312	300	1	3	4	3	4	3
Vt.	1	4	152	143	8	2	1	5	2	1
Mass.	446	354	2,894	2,598	2	12	11	24	9	21
R.I.	21	30	677	639	2	-	-	1	-	1
Conn.	179	117	1,800	2,131	-	3	14	12	14	15
MID. ATLANTIC	2,471	2,834	7,444	22,631	29	87	47	19	43	11
Upstate N.Y.	131	359	N	N	21	28	46	14	36	1
N.Y. City	1,441	1,443	778	10,822	5	46	1	2	-	-
N.J.	563	593	1,141	3,645	-	6	-	3	2	10
Pa.	336	439	5,525	8,164	3	7	N	N	5	-
E.N. CENTRAL	921	842	25,319	29,943	54	69	70	62	17	43
Ohio	139	148	6,443	9,230	14	9	15	26	7	13
Ind.	88	124	3,692	3,423	4	6	16	11	4	8
Ill.	542	402	7,118	7,756	3	7	20	14	-	9
Mich.	114	125	6,215	6,317	10	10	12	11	3	7
Wis.	38	43	1,851	3,217	23	37	7	N	3	6
W.N. CENTRAL	203	246	7,149	10,597	25	26	78	76	55	63
Minn.	44	39	1,658	2,228	4	11	18	15	27	16
Iowa	15	30	991	917	5	3	16	8	4	2
Mo.	90	99	1,472	3,873	8	5	34	7	14	5
N. Dak.	-	3	61	275	1	-	2	2	2	2
S. Dak.	2	5	515	483	3	2	1	1	1	2
Nebr.	13	17	763	1,054	2	3	2	29	4	36
Kans.	39	53	1,689	1,767	2	2	5	14	3	-
S. ATLANTIC	2,848	3,163	30,919	37,958	55	70	34	28	17	21
Del.	45	40	860	846	1	-	-	1	-	-
Md.	271	344	3,156	3,898	5	5	5	2	1	-
D.C.	186	118	921	N	-	3	-	-	U	U
Va.	221	177	4,192	4,033	2	1	6	6	5	7
W. Va.	15	19	450	622	-	-	2	-	1	1
N.C.	128	197	5,788	6,476	6	1	8	7	2	6
S.C.	232	313	669	5,815	-	-	2	1	-	1
Ga.	300	349	5,600	7,648	32	46	3	1	3	U
Fla.	1,450	1,606	9,283	8,620	9	14	8	10	5	6
E.S. CENTRAL	415	490	12,958	13,312	12	4	22	24	14	12
Ky.	56	70	2,295	2,212	-	1	8	6	4	5
Tenn.	172	211	3,483	4,085	2	2	7	9	8	3
Ala.	120	109	4,927	3,559	7	1	1	4	-	3
Miss.	67	100	2,253	3,456	3	-	6	5	2	1
W.S. CENTRAL	824	1,174	25,191	25,036	10	28	15	10	24	21
Ark.	42	45	1,399	1,637	1	-	4	3	3	3
La.	143	119	4,759	3,774	-	15	-	3	11	3
Okla.	42	36	2,137	2,242	1	1	4	3	3	4
Tex.	597	974	16,896	17,383	8	12	7	1	7	11
MOUNTAIN	342	397	8,477	9,965	24	26	33	21	14	21
Mont.	5	4	328	380	1	2	8	-	-	-
Idaho	6	5	556	533	3	2	4	1	-	3
Wyo.	2	2	221	228	1	-	3	2	2	3
Colo.	70	74	994	2,201	6	3	10	6	6	4
N. Mex.	40	13	1,138	1,413	1	11	-	1	-	1
Ariz.	115	186	3,714	3,709	3	7	6	5	5	3
Utah	41	37	699	536	8	N	1	6	1	6
Nev.	63	76	827	965	1	1	1	-	-	1
PACIFIC	1,453	1,701	28,292	33,280	83	95	61	40	26	40
Wash.	148	88	3,848	3,537	N	N	7	6	13	16
Oreg.	35	45	1,273	1,795	2	8	9	13	9	10
Calif.	1,230	1,541	21,802	26,437	81	87	41	20	-	13
Alaska	5	6	700	592	-	-	1	-	-	-
Hawaii	35	21	669	919	-	-	3	1	4	1
Guam	13	1	-	132	-	-	N	N	U	U
P.R.	187	413	142	U	-	-	-	4	U	U
V.I.	16	10	-	U	-	U	-	U	U	U
Amer. Samoa	-	-	-	U	-	U	-	U	U	U
C.N.M.I.	-	-	-	U	-	U	-	U	U	U

N: Not notifiable U: Unavailable -: no reported cases C.N.M.I.: Commonwealth of Northern Mariana Islands

* Individual cases may be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

† Updated monthly from reports to the Division of HIV/AIDS Prevention–Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention, last update March 26, 2000.

§ Chlamydia refers to genital infections caused by *C. trachomatis*. Totals reported to the Division of STD Prevention, NCHSTP.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending April 15, 2000, and April 17, 1999 (15th Week)

Reporting Area	Gonorrhea		Hepatitis C/NA,NB		Legionellosis		Lyme Disease	
	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	78,599	100,227	668	1,053	193	257	866	1,290
NEW ENGLAND	1,684	2,008	19	4	11	16	83	283
Maine	22	15	-	-	2	2	-	1
N.H.	26	22	-	-	2	2	18	-
Vt.	14	16	1	2	-	3	-	-
Mass.	742	791	18	1	4	5	25	126
R.I.	167	162	-	1	-	1	-	8
Conn.	713	1,002	-	-	3	3	40	148
MID. ATLANTIC	5,149	12,145	13	38	37	75	616	709
Upstate N.Y.	1,629	1,649	13	19	16	19	300	204
N.Y. City	233	4,720	-	-	-	10	3	20
N.J.	629	2,151	-	-	-	5	-	128
Pa.	2,658	3,625	-	19	21	41	313	357
E.N. CENTRAL	15,903	17,819	69	593	54	75	6	55
Ohio	3,724	4,895	-	-	26	22	6	14
Ind.	1,625	1,923	-	-	11	6	-	1
Ill.	4,797	5,478	5	10	3	10	-	2
Mich.	4,606	4,221	64	191	9	23	-	1
Wis.	1,151	1,302	-	392	5	14	U	37
W.N. CENTRAL	2,413	4,498	155	52	14	8	32	24
Minn.	670	799	-	-	1	-	6	8
Iowa	199	274	-	-	3	3	1	2
Mo.	529	2,166	143	45	7	3	6	6
N. Dak.	4	28	-	-	-	-	-	1
S. Dak.	72	43	-	-	1	1	-	-
Nebr.	241	502	1	1	-	1	-	-
Kans.	698	686	11	6	2	-	19	7
S. ATLANTIC	22,130	29,033	32	71	39	28	103	148
Del.	464	512	-	-	3	2	9	7
Md.	2,187	3,888	4	20	12	4	74	116
D.C.	685	1,946	-	-	-	-	-	1
Va.	2,904	2,725	1	6	3	6	8	3
W. Va.	118	172	2	11	N	N	4	4
N.C.	5,136	5,677	8	17	5	5	4	15
S.C.	574	2,839	-	11	2	5	-	1
Ga.	3,621	5,232	-	1	2	-	-	-
Fla.	6,441	6,042	17	5	12	6	4	1
E.S. CENTRAL	9,160	10,496	121	72	5	14	-	18
Ky.	945	1,033	15	5	3	7	-	1
Tenn.	2,725	3,176	26	30	1	5	-	6
Ala.	3,676	3,233	4	1	1	2	-	6
Miss.	1,814	3,054	76	36	-	-	-	5
W.S. CENTRAL	13,411	14,278	133	111	2	1	-	-
Ark.	741	779	3	5	-	-	-	-
La.	3,526	3,416	44	85	-	1	-	-
Okla.	939	1,179	-	3	1	-	-	-
Tex.	8,205	8,904	86	18	1	-	-	-
MOUNTAIN	2,970	2,729	73	72	13	17	-	3
Mont.	4	12	1	4	-	-	-	-
Idaho	26	27	-	4	1	-	-	-
Wyo.	21	9	44	28	1	-	-	1
Colo.	993	644	11	9	6	1	-	-
N. Mex.	250	244	4	11	-	1	-	1
Ariz.	1,252	1,366	10	13	2	1	-	-
Utah	87	60	-	1	3	8	-	1
Nev.	337	367	3	2	-	6	-	-
PACIFIC	5,779	7,221	53	40	18	23	26	50
Wash.	702	636	5	3	5	5	-	-
Oreg.	152	264	12	4	N	N	2	2
Calif.	4,760	6,070	36	33	13	17	24	48
Alaska	82	114	-	-	-	1	-	-
Hawaii	83	137	-	-	-	-	N	N
Guam	-	18	-	-	-	-	-	-
P.R.	86	117	1	-	-	-	N	N
V.I.	-	U	-	U	-	U	-	U
Amer. Samoa	-	U	-	U	-	U	-	U
C.N.M.I.	-	U	-	U	-	U	-	U

N: Not notifiable U: Unavailable - : no reported cases

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending April 15, 2000, and April 17, 1999 (15th Week)

Reporting Area	Malaria		Rabies, Animal		Salmonellosis*			
					NETSS		PHLIS	
	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	231	323	1,240	1,554	5,925	6,962	3,884	6,317
NEW ENGLAND	6	5	168	242	399	404	385	421
Maine	1	-	47	41	34	28	15	19
N.H.	-	-	3	16	25	16	25	13
Vt.	1	-	11	44	34	15	35	16
Mass.	2	5	53	50	219	236	204	235
R.I.	-	-	-	24	9	19	26	35
Conn.	2	-	54	67	78	90	80	103
MID. ATLANTIC	28	102	236	295	594	1,048	708	750
Upstate N.Y.	14	21	175	188	214	211	199	239
N.Y. City	9	47	U	U	203	317	223	291
N.J.	-	24	39	66	-	259	115	211
Pa.	5	10	22	41	177	261	171	9
E.N. CENTRAL	27	35	8	10	891	1,090	474	938
Ohio	3	4	2	3	236	226	163	181
Ind.	2	5	-	-	103	67	84	74
Ill.	13	15	-	-	278	355	1	334
Mich.	9	8	6	7	153	249	158	239
Wis.	-	3	-	-	121	193	68	110
W.N. CENTRAL	11	14	126	211	314	446	340	485
Minn.	4	2	23	25	42	124	108	170
Iowa	-	3	18	31	46	48	25	43
Mo.	-	7	3	7	115	101	115	144
N. Dak.	-	-	24	30	4	2	15	18
S. Dak.	-	-	32	54	18	16	21	23
Nebr.	1	-	-	1	29	40	22	36
Kans.	6	2	26	63	60	115	34	51
S. ATLANTIC	62	70	525	552	1,181	1,260	711	1,120
Del.	-	-	10	17	15	22	12	30
Md.	22	23	120	124	178	159	147	168
D.C.	2	6	-	-	1	25	U	U
Va.	16	12	131	126	137	140	114	135
W. Va.	-	1	34	30	32	22	24	24
N.C.	7	6	109	122	200	255	122	228
S.C.	-	-	39	44	100	79	74	79
Ga.	1	6	47	46	197	238	212	318
Fla.	14	16	35	43	321	320	6	138
E.S. CENTRAL	10	8	52	77	332	378	134	248
Ky.	2	2	9	17	67	76	36	55
Tenn.	1	3	29	26	87	105	67	97
Ala.	6	3	14	34	114	112	23	82
Miss.	1	-	-	-	64	85	8	14
W.S. CENTRAL	1	11	20	33	390	508	431	490
Ark.	-	2	-	-	60	66	22	54
La.	1	7	-	-	27	82	95	86
Okla.	-	1	20	33	61	68	46	49
Tex.	-	1	-	-	242	292	268	301
MOUNTAIN	15	15	45	48	600	585	427	550
Mont.	1	2	10	16	21	8	-	1
Idaho	-	1	-	-	37	20	-	27
Wyo.	-	-	21	18	7	6	3	9
Colo.	8	5	-	1	167	184	149	184
N. Mex.	-	2	3	-	53	65	44	67
Ariz.	2	4	11	13	173	173	144	137
Utah	2	1	-	-	97	84	87	87
Nev.	2	-	-	-	45	45	-	38
PACIFIC	71	63	60	86	1,224	1,243	274	1,315
Wash.	5	3	-	-	79	93	127	183
Oreg.	17	7	-	1	87	101	97	130
Calif.	48	48	50	81	985	954	-	915
Alaska	-	-	10	4	17	10	8	5
Hawaii	1	5	-	-	56	85	42	82
Guam	-	-	-	-	-	18	U	U
P.R.	-	-	9	29	7	108	U	U
V.I.	-	U	-	U	-	U	U	U
Amer. Samoa	-	U	-	U	-	U	U	U
C.N.M.I.	-	U	-	U	-	U	U	U

N: Not notifiable U: Unavailable -: no reported cases

*Individual cases may be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending April 15, 2000, and April 17, 1999 (15th Week)

Reporting Area	Shigellosis* NETSS Cum. 2000	Shigellosis* NETSS Cum. 1999	Shigellosis* PHLIS Cum. 2000	Shigellosis* PHLIS Cum. 1999	Syphilis (Primary & Secondary) Cum. 2000	Syphilis (Primary & Secondary) Cum. 1999	Tuberculosis Cum. 2000	Tuberculosis Cum. 1999†
UNITED STATES	3,652	3,417	1,605	1,987	1,652	1,929	2,525	3,740
NEW ENGLAND	78	82	59	78	24	23	83	103
Maine	2	1	-	-	-	-	-	6
N.H.	1	5	1	5	-	-	2	-
Vt.	1	4	-	3	-	1	-	-
Mass.	54	52	39	50	20	13	58	50
R.I.	7	12	7	8	1	1	7	15
Conn.	13	8	12	12	3	8	16	32
MID. ATLANTIC	340	286	308	160	47	87	541	614
Upstate N.Y.	201	61	94	20	4	7	47	67
N.Y. City	110	95	155	81	8	34	322	282
N.J.	-	84	27	59	11	20	140	137
Pa.	29	46	32	-	24	26	32	128
E.N. CENTRAL	596	578	209	298	382	309	305	316
Ohio	46	182	30	27	22	26	44	68
Ind.	99	22	10	9	138	89	19	19
Ill.	192	220	2	200	114	136	190	142
Mich.	213	75	161	48	88	49	30	66
Wis.	46	79	6	14	20	9	22	21
W.N. CENTRAL	262	209	159	156	19	48	125	127
Minn.	47	29	58	30	2	5	49	54
Iowa	48	2	21	3	8	3	11	6
Mo.	131	131	67	105	5	33	48	49
N. Dak.	1	1	-	2	-	-	-	1
S. Dak.	1	4	-	3	-	-	3	3
Nebr.	18	14	8	6	2	4	3	4
Kans.	16	28	5	7	2	3	11	10
S. ATLANTIC	517	559	105	126	528	693	524	699
Del.	3	7	2	2	2	1	-	5
Md.	29	35	9	6	93	141	62	64
D.C.	-	20	U	U	17	39	2	14
Va.	16	19	15	5	39	51	46	44
W. Va.	2	3	2	1	1	2	10	12
N.C.	33	69	16	35	159	154	83	93
S.C.	5	31	4	11	11	74	18	96
Ga.	62	58	25	21	95	123	128	152
Fla.	367	317	32	45	111	108	175	219
E.S. CENTRAL	188	349	87	192	237	334	174	225
Ky.	36	34	21	24	27	35	30	30
Tenn.	99	247	63	150	148	161	67	76
Ala.	9	41	1	17	39	86	77	86
Miss.	44	27	2	1	23	52	-	33
W.S. CENTRAL	366	545	334	247	239	286	60	559
Ark.	60	38	3	21	24	26	39	28
La.	19	47	50	36	61	62	-	U
Okla.	8	137	6	38	55	66	21	26
Tex.	279	323	275	152	99	132	-	505
MOUNTAIN	274	201	98	115	52	56	108	127
Mont.	1	3	-	-	-	-	4	-
Idaho	24	3	-	3	-	-	2	-
Wyo.	1	2	1	1	-	-	-	-
Colo.	38	38	21	27	1	-	14	U
N. Mex.	31	27	15	17	7	1	17	19
Ariz.	113	105	43	50	42	54	44	64
Utah	15	14	18	14	-	1	8	12
Nev.	51	9	-	3	2	-	19	32
PACIFIC	1,031	608	246	615	124	93	605	970
Wash.	192	24	188	37	16	16	49	48
Oreg.	80	18	49	19	2	1	-	26
Calif.	739	550	-	544	106	74	513	837
Alaska	7	-	1	-	-	1	16	15
Hawaii	13	16	8	15	-	1	27	44
Guam	-	3	U	U	-	-	-	-
P.R.	1	21	U	U	29	62	-	41
V.I.	-	U	U	U	-	U	-	U
Amer. Samoa	-	U	U	U	-	U	-	U
C.N.M.I.	-	U	U	U	-	U	-	U

N: Not notifiable U: Unavailable -: no reported cases

*Individual cases may be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

†Cumulative reports of provisional tuberculosis cases for 1999 are unavailable ("U") for some areas using the Tuberculosis Information System (TIMS).

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending April 15, 2000, and April 17, 1999 (15th Week)

Reporting Area	*H. influenzae*, invasive		Hepatitis (Viral), by type				Measles (Rubeola)					
			A		B		Indigenous		Imported*		Total	
	Cum. 2000†	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	2000	Cum. 2000	2000	Cum. 2000	Cum. 2000	Cum. 1999
UNITED STATES	354	367	3,269	5,313	1,312	1,756	2	6	-	3	9	31
NEW ENGLAND	19	23	81	62	12	51	-	-	-	-	-	4
Maine	1	2	5	2	1	-	-	-	-	-	-	-
N.H.	6	4	8	6	6	4	-	-	-	-	-	1
Vt.	2	3	3	1	2	1	-	-	-	-	-	-
Mass.	6	10	35	22	3	22	-	-	-	-	-	3
R.I.	-	-	-	6	-	8	-	-	-	-	-	-
Conn.	4	4	30	25	-	16	-	-	-	-	-	-
MID. ATLANTIC	51	57	140	344	143	258	-	-	-	-	-	-
Upstate N.Y.	25	23	69	73	28	51	-	-	-	-	-	-
N.Y. City	10	19	71	95	115	85	-	-	-	-	-	-
N.J.	12	14	-	44	-	34	-	-	-	-	-	-
Pa.	4	1	-	132	-	88	-	-	-	-	-	-
E.N. CENTRAL	46	54	421	1,117	148	160	-	3	-	-	3	-
Ohio	20	22	111	243	32	30	-	2	-	-	2	-
Ind.	4	5	17	43	11	8	-	-	-	-	-	-
Ill.	19	22	137	206	2	-	-	-	-	-	-	-
Mich.	3	5	143	593	102	113	-	1	-	-	1	-
Wis.	-	-	13	32	1	9	-	-	-	-	-	-
W.N. CENTRAL	14	27	380	266	76	92	-	1	-	-	1	-
Minn.	7	11	36	18	6	12	-	-	-	-	-	-
Iowa	-	1	36	48	16	14	-	-	-	-	-	-
Mo.	3	5	217	139	34	46	-	-	-	-	-	-
N. Dak.	1	-	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	1	-	8	-	-	-	-	-	-	-	-
Nebr.	1	3	7	25	8	9	U	-	U	-	-	-
Kans.	2	6	84	28	12	11	-	1	-	-	1	-
S. ATLANTIC	106	78	401	490	299	290	-	-	-	-	-	-
Del.	-	-	-	1	-	-	-	-	-	-	-	-
Md.	25	22	51	106	37	62	-	-	-	-	-	-
D.C.	-	2	2	22	6	7	-	-	-	-	-	-
Va.	20	9	46	37	39	26	-	-	-	-	-	-
W. Va.	3	1	32	5	2	7	-	-	-	-	-	-
N.C.	8	13	65	41	81	67	-	-	-	-	-	-
S.C.	5	2	12	6	2	31	-	-	-	-	-	-
Ga.	27	21	49	149	45	36	-	-	-	-	-	-
Fla.	18	8	144	123	87	54	-	-	-	-	-	-
E.S. CENTRAL	18	28	101	134	85	135	-	-	-	-	-	2
Ky.	9	5	13	25	19	11	-	-	-	-	-	2
Tenn.	6	11	21	57	28	57	-	-	-	-	-	-
Ala.	3	10	22	27	7	36	-	-	-	-	-	-
Miss.	-	2	45	25	31	31	-	-	-	-	-	-
W.S. CENTRAL	18	28	541	1,187	63	231	-	-	-	-	-	2
Ark.	-	1	53	13	22	18	-	-	-	-	-	-
La.	3	7	11	47	18	57	-	-	-	-	-	-
Okla.	15	18	109	174	23	42	-	-	-	-	-	-
Tex.	-	2	368	953	-	114	-	-	-	-	-	2
MOUNTAIN	46	39	253	495	115	146	2	2	-	-	2	-
Mont.	-	1	1	5	3	7	-	-	-	-	-	-
Idaho	2	1	11	17	4	7	-	-	-	-	-	-
Wyo.	-	1	6	2	-	2	-	-	-	-	-	-
Colo.	11	2	53	89	24	28	-	-	-	-	-	-
N. Mex.	10	10	29	14	32	39	-	-	-	-	-	-
Ariz.	20	20	121	304	40	35	-	-	-	-	-	-
Utah	3	3	17	21	3	8	-	-	-	-	-	-
Nev.	-	1	15	43	9	20	2	2	-	-	2	-
PACIFIC	36	33	951	1,218	371	393	-	-	-	3	3	23
Wash.	2	-	55	82	11	13	-	-	-	-	-	5
Oreg.	12	13	71	82	29	34	-	-	-	-	-	8
Calif.	9	17	821	1,049	323	335	-	-	-	3	3	10
Alaska	1	2	4	3	3	7	-	-	-	-	-	-
Hawaii	12	1	-	2	5	4	-	-	-	-	-	-
Guam	-	-	-	2	-	2	U	-	U	-	-	-
P.R.	-	1	22	55	16	64	-	-	-	-	-	-
V.I.	-	U	-	U	-	U	U	-	U	-	-	U
Amer. Samoa	-	U	-	U	-	U	U	-	U	-	-	U
C.N.M.I.	-	U	-	U	-	U	U	-	U	-	-	U

N: Not notifiable U: Unavailable - : no reported cases

*For imported measles, cases include only those resulting from importation from other countries.

†Of 79 cases among children aged <5 years, serotype was reported for 34 and of those, 6 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending April 15, 2000, and April 17, 1999 (15th Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999
UNITED STATES	733	837	9	111	116	60	1,105	1,697	4	16	20
NEW ENGLAND	43	45	-	2	3	5	296	153	-	5	4
Maine	3	3	-	-	-	-	9	-	-	-	-
N.H.	3	5	-	-	1	1	49	19	-	1	-
Vt.	2	3	-	-	-	2	63	9	-	-	-
Mass.	27	27	-	-	2	1	156	118	-	3	4
R.I.	1	2	-	1	-	-	7	2	-	-	-
Conn.	7	5	-	1	-	1	12	5	-	1	-
MID. ATLANTIC	66	84	-	7	15	2	103	367	-	2	1
Upstate N.Y.	14	20	-	5	2	2	66	316	-	2	1
N.Y. City	16	28	-	-	3	-	-	10	-	-	-
N.J.	16	14	-	-	-	-	-	8	-	-	-
Pa.	20	22	-	2	10	-	37	33	-	-	-
E.N. CENTRAL	124	141	2	14	16	23	172	157	-	-	-
Ohio	25	51	2	6	6	23	131	89	-	-	-
Ind.	19	13	-	-	-	-	9	8	-	-	-
Ill.	34	46	-	3	4	-	13	25	-	-	-
Mich.	34	16	-	5	6	-	9	17	-	-	-
Wis.	12	15	-	-	-	-	10	18	-	-	-
W.N. CENTRAL	56	113	1	9	3	2	40	49	-	2	5
Minn.	3	25	-	-	-	-	16	-	-	-	-
Iowa	12	20	-	3	2	-	9	11	-	-	-
Mo.	34	39	-	1	1	2	6	10	-	-	-
N. Dak.	1	-	-	-	-	-	1	-	-	-	-
S. Dak.	4	5	-	-	-	-	1	2	-	-	-
Nebr.	1	7	U	2	-	U	2	1	U	-	5
Kans.	1	17	1	3	-	-	5	25	-	2	-
S. ATLANTIC	117	116	1	14	17	9	87	79	3	6	2
Del.	-	2	-	-	-	-	1	-	-	-	-
Md.	11	22	-	4	4	4	25	31	-	-	1
D.C.	-	1	-	-	1	-	-	-	-	-	-
Va.	19	16	1	3	2	5	10	7	-	-	-
W. Va.	3	1	-	-	-	-	-	1	-	-	-
N.C.	23	16	-	2	4	-	28	22	-	-	1
S.C.	6	18	-	5	2	-	14	6	3	6	-
Ga.	22	21	-	-	-	-	9	6	-	-	-
Fla.	33	19	-	-	4	-	-	6	-	-	-
E.S. CENTRAL	53	68	-	1	3	1	26	41	1	1	-
Ky.	12	12	-	-	-	-	15	12	1	1	-
Tenn.	23	23	-	-	-	1	2	21	-	-	-
Ala.	15	21	-	1	1	-	8	6	-	-	-
Miss.	3	12	-	-	2	-	1	2	-	-	-
W.S. CENTRAL	49	64	-	1	15	-	5	42	-	-	5
Ark.	5	14	-	1	-	-	5	4	-	-	-
La.	13	33	-	-	2	-	-	2	-	-	-
Okla.	16	14	-	-	1	-	-	3	-	-	-
Tex.	15	3	-	-	12	-	-	33	-	-	5
MOUNTAIN	48	64	-	7	7	15	235	225	-	-	2
Mont.	1	-	-	1	-	-	1	1	-	-	-
Idaho	6	8	-	-	-	3	35	84	-	-	-
Wyo.	-	2	-	-	-	-	-	2	-	-	-
Colo.	10	18	-	1	2	10	128	56	-	-	-
N. Mex.	7	7	-	1	N	2	47	13	-	-	-
Ariz.	16	20	-	-	-	-	17	42	-	-	1
Utah	6	4	-	2	4	-	4	25	-	-	1
Nev.	2	5	-	2	1	-	3	2	-	-	-
PACIFIC	177	142	5	56	37	3	141	584	-	-	1
Wash.	14	19	-	2	-	2	46	269	-	-	-
Oreg.	22	30	N	N	N	1	24	8	-	-	-
Calif.	138	85	3	51	31	-	62	289	-	-	1
Alaska	1	4	2	2	1	-	5	2	-	-	-
Hawaii	2	4	-	1	5	-	4	16	-	-	-
Guam	-	-	U	-	1	U	-	1	U	-	-
P.R.	1	7	-	-	-	-	-	-	-	-	-
V.I.	-	U	U	-	U	U	-	U	U	-	U
Amer. Samoa	-	U	U	-	U	U	-	U	U	-	U
C.N.M.I.	-	U	U	-	U	U	-	U	U	-	U

N: Not notifiable U: Unavailable - : no reported cases

TABLE IV. Deaths in 122 U.S. cities,* week ending April 15, 2000 (15th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	520	372	91	41	6	10	59
Boston, Mass.	135	89	29	10	2	5	18
Bridgeport, Conn.	40	28	7	4	1	-	4
Cambridge, Mass.	24	19	3	-	2	-	4
Fall River, Mass.	31	26	2	3	-	-	2
Hartford, Conn.	50	32	8	9	1	-	7
Lowell, Mass.	23	18	4	1	-	-	-
Lynn, Mass.	7	6	1	-	-	-	-
New Bedford, Mass.	21	17	4	-	-	-	4
New Haven, Conn.	40	28	6	4	-	2	6
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	8	5	2	1	-	-	-
Springfield, Mass.	56	45	8	2	-	1	7
Waterbury, Conn.	25	18	5	1	-	1	2
Worcester, Mass.	60	41	12	6	-	1	5
MID. ATLANTIC	2,235	1,518	467	165	35	44	100
Albany, N.Y.	46	31	9	5	-	1	2
Allentown, Pa.	U	U	U	U	U	U	U
Buffalo, N.Y.	105	75	15	7	2	4	8
Camden, N.J.	33	19	7	6	-	1	2
Elizabeth, N.J.	U	U	U	U	U	U	U
Erie, Pa.§	44	36	7	-	1	-	3
Jersey City, N.J.	38	28	3	4	-	3	-
New York City, N.Y.	1,248	856	265	86	19	19	27
Newark, N.J.	40	18	9	7	1	5	4
Paterson, N.J.	22	14	4	2	2	-	3
Philadelphia, Pa.	238	130	69	27	7	4	15
Pittsburgh, Pa.§	45	23	15	7	-	-	2
Reading, Pa.	40	35	5	-	-	-	3
Rochester, N.Y.	120	94	19	3	1	3	8
Schenectady, N.Y.	33	27	4	2	-	-	2
Scranton, Pa.§	26	23	2	1	-	-	5
Syracuse, N.Y.	95	67	21	4	1	2	15
Trenton, N.J.	43	27	9	4	1	2	-
Utica, N.Y.	19	15	4	-	-	-	1
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,984	1,400	370	125	44	43	170
Akron, Ohio	51	37	8	1	4	1	7
Canton, Ohio	39	34	4	1	-	-	8
Chicago, Ill.	382	255	82	30	10	4	40
Cincinnati, Ohio	104	75	15	4	3	7	11
Cleveland, Ohio	146	103	27	9	4	3	5
Columbus, Ohio	222	157	37	19	4	5	17
Dayton, Ohio	109	78	21	7	-	3	7
Detroit, Mich.	155	95	35	16	4	4	13
Evansville, Ind.	37	29	6	1	-	1	1
Fort Wayne, Ind.	80	63	13	1	2	1	5
Gary, Ind.	25	10	3	5	2	5	2
Grand Rapids, Mich.	44	34	5	1	2	2	-
Indianapolis, Ind.	169	129	27	7	2	4	20
Lansing, Mich.	57	40	12	1	3	1	4
Milwaukee, Wis.	120	81	28	9	2	-	16
Peoria, Ill.	39	25	9	3	2	-	3
Rockford, Ill.	46	35	8	2	-	1	3
South Bend, Ind.	54	45	6	3	-	-	3
Toledo, Ohio	105	75	24	5	-	1	5
Youngstown, Ohio	U	U	U	U	U	U	U
W.N. CENTRAL	747	533	136	50	15	13	51
Des Moines, Iowa	U	U	U	U	U	U	U
Duluth, Minn.	24	20	2	1	-	1	6
Kansas City, Kans.	19	14	4	1	-	-	1
Kansas City, Mo.	87	66	13	5	2	1	5
Lincoln, Nebr.	28	21	4	3	-	-	3
Minneapolis, Minn.	207	152	35	12	3	5	17
Omaha, Nebr.	74	50	17	3	2	2	4
St. Louis, Mo.	120	75	26	14	3	2	-
St. Paul, Minn.	107	78	20	6	2	1	7
Wichita, Kans.	81	57	15	5	3	1	8
S. ATLANTIC	1,065	700	223	85	30	26	70
Atlanta, Ga.	U	U	U	U	U	U	U
Baltimore, Md.	225	147	52	13	7	6	17
Charlotte, N.C.	87	47	24	9	2	5	6
Jacksonville, Fla.	139	95	30	8	3	3	12
Miami, Fla.	U	U	U	U	U	U	U
Norfolk, Va.	46	33	6	4	2	1	1
Richmond, Va.	58	40	13	5	-	-	2
Savannah, Ga.	55	43	7	4	1	-	5
St. Petersburg, Fla.	65	51	8	3	2	1	8
Tampa, Fla.	178	119	35	11	4	8	13
Washington, D.C.	199	123	48	19	7	2	6
Wilmington, Del.	13	2	-	9	2	-	-
E.S. CENTRAL	780	507	175	53	19	26	68
Birmingham, Ala.	200	130	40	12	7	11	19
Chattanooga, Tenn.	82	53	19	7	3	-	4
Knoxville, Tenn.	74	53	15	3	2	1	1
Lexington, Ky.	U	U	U	U	U	U	U
Memphis, Tenn.	182	121	38	16	3	4	17
Mobile, Ala.	65	45	13	2	-	5	4
Montgomery, Ala.	35	27	6	2	-	-	7
Nashville, Tenn.	142	78	44	11	4	5	16
W.S. CENTRAL	1,391	905	297	104	50	35	90
Austin, Tex.	92	66	11	7	4	4	10
Baton Rouge, La.	40	28	9	2	1	-	2
Corpus Christi, Tex.	71	54	12	3	-	2	3
Dallas, Tex.	210	120	54	17	10	9	12
El Paso, Tex.	44	29	9	4	1	1	1
Ft. Worth, Tex.	86	61	14	7	-	4	4
Houston, Tex.	315	189	78	30	11	7	25
Little Rock, Ark.	59	32	16	5	6	-	3
New Orleans, La.	70	47	12	2	8	1	5
San Antonio, Tex.	232	161	43	15	7	6	14
Shreveport, La.	62	42	16	3	1	-	3
Tulsa, Okla.	110	76	23	9	1	1	8
MOUNTAIN	1,010	667	209	77	35	20	81
Albuquerque, N.M.	98	65	22	7	3	1	11
Boise, Idaho	34	28	3	2	1	-	1
Colo. Springs, Colo.	77	52	16	6	2	1	4
Denver, Colo.	115	81	24	3	2	5	12
Las Vegas, Nev.	213	135	49	15	11	3	17
Ogden, Utah	23	17	3	2	-	1	2
Phoenix, Ariz.	161	86	39	20	8	6	8
Pueblo, Colo.	28	23	4	1	-	-	4
Salt Lake City, Utah	107	75	17	11	2	2	12
Tucson, Ariz.	154	105	32	10	6	1	10
PACIFIC	1,193	872	213	52	26	29	100
Berkeley, Calif.	14	10	3	1	-	-	1
Fresno, Calif.	49	42	4	2	1	-	6
Glendale, Calif.	20	17	3	-	-	-	1
Honolulu, Hawaii	80	58	17	1	1	2	9
Long Beach, Calif.	83	57	16	4	2	4	13
Los Angeles, Calif.	338	248	60	13	12	5	25
Pasadena, Calif.	27	19	6	2	-	-	3
Portland, Oreg.	139	102	23	9	2	3	8
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	125	89	21	5	3	7	17
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	U	U	U	U	U	U	U
Santa Cruz, Calif.	31	27	4	-	-	-	5
Seattle, Wash.	134	91	26	8	4	5	4
Spokane, Wash.	53	40	10	1	-	2	2
Tacoma, Wash.	100	72	20	6	1	1	6
TOTAL	10,925¶	7,474	2,181	752	260	246	789

U: Unavailable -:no reported cases

*Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

†Pneumonia and influenza.

§Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶Total includes unknown ages.

Erratum: Vol. 49, No. RR-2

An error appeared in the first of four reports published in the *Recommendations and Reports* titled "CDC Recommendations Regarding Selected Conditions Affecting Women's Health." On page 3 of the report "Reducing Falls and Resulting Hip Fractures Among Older Women," the last sentence of the first paragraph gave an incorrect rate. The sentence should read: "... rates for women aged ≥65 years increased *40%*."

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Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Address inquiries about the *MMWR* Series, including material to be considered for publication, to: Editor, *MMWR* Series, Mailstop C-08, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone (888) 232-3228.

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