CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

September 28, 2001 / Vol. 50 / No. 38

MMWR™
MORBIDITY AND MORTALITY
WEEKLY REPORT

821 New York City Department of Health Response to Terrorist Attack
822 Update: Influenza Activity — United States and Worldwide
826 Progress Toward Poliomyelitis Eradication — Angola, Democratic Republic of Congo, Ethiopia, and Nigeria
830 Weekly Update: West Nile Virus Activity — United States
831 Notices to Readers

Notice to Readers

New York City Department of Health Response to Terrorist Attack, September 11, 2001

In response to two jet aircraft crashing into and causing the collapse of the 110-storied World Trade Center (WTC) towers and the subsequent destruction of nearby portions of lower Manhattan, the New York City Department of Health (NYCDOH) immediately activated its emergency response protocol, including the mobilization of an Emergency Operations Center. Surveillance, clinical, environmental, sheltering, laboratory, management information systems, and operations were among the preestablished emergency committees. Because of its proximity to the WTC site, an emergency clinic was established at NYCDOH for triage and treatment of injured persons. NYCDOH focused its initial efforts on assessing the public health and medical impact of the attack and the resources needed to respond to it such as the care and management of large numbers of persons injured or killed by the crash; subsequent fire and building collapse; the health and safety of rescue workers; the environmental health risks (e.g., asbestos, smoke, dust, or chemical inhalation); other illnesses related to the disruption of the physical infrastructure (e.g., waterborne and foodborne diseases); and mental health concerns. Despite the evacuation and relocation of NYCDOH's headquarters, the department continued essential public health services, including death registration.

A rapid assessment conducted by NYCDOH during the first 24 hours after the incident indicated that most emergency department (ED) visits were for minor injuries; approximately 10%–15% of ED patients were admitted and few deaths occurred. Hospital bed and staff capacity was adequate.

Following the incident, NYCDOH prioritized four surveillance activities: 1) in collaboration with the Greater New York Hospital Association, an ongoing assessment of hospital staffing and equipment needs, and cumulative numbers of incident-related ED visits and hospital admissions; 2) an epidemiologic assessment of the types of injuries seen during the first 48 hours after the attack at one tertiary referral hospital and the four EDs closest to the crash site where the largest number of incident-related cases presented; 3) prospective surveillance of illnesses and injuries among rescue workers evaluated at the four hospitals and Disaster Medical Assistance Team triage units located at the crash site; and 4) active surveillance in EDs for specified clinical syndromes to identify unusual disease manifestations or clusters associated with these incidents, including those syndromes that could result from the release of a biologic agent. To assist NYCDOH with

Terrorist Attack — Continued

syndromic surveillance, CDC Epidemic Intelligence Service officers have been stationed at EDs in 15 sentinel hospitals distributed throughout the five New York City boroughs. Other NYCDOH activities included an already existing syndromic surveillance system to monitor 911 emergency calls. No unusual patterns of illness have been identified. NYCDOH also conducted laboratory testing of environmental samples and did not find evidence of a biologic agent release.

Air quality, safety of the municipal water supply, restaurant safety and rodent control, and other environmental conditions in the area continue to be monitored by NYCDOH, in collaboration with local, state, and federal agencies, to ensure the health and safety of workers at the site and residents in the immediate vicinity. Frequent alerts are sent by broadcast facsimile and electronic mail to advise metropolitan New York health-care providers of ongoing public health concerns related to the aftermath of the attack. Advisories have been developed to address the public's concerns about such issues as asbestos exposure in collapsed buildings, decomposing bodies, and managing emotional trauma. Working with the American Red Cross, NYCDOH school health program has provided nursing services and physician consultations to Red Cross shelters. The shelters serve families and persons displaced by the incident and provide respite to rescue workers. NYCDOH nurses provide nursing assessments, first-aid services, and medical referrals when needed.

In response to events in lower Manhattan and the related attack on the Pentagon in Washington, DC, the Federal Response Plan was activated. The U.S. Department of Health and Human Services (DHHS) deployed federal resources under Emergency Support Function #8 (Health and Medical) to augment the state and local medical response. A shipment of intravenous supplies, airway supplies, emergency medication, bandages and dressings, and other materials arrived in New York City the night of September 11; this was the first emergency mobilization of the National Pharmaceutical Stockpile. NYCDOH and the health department in Washington, DC, also obtained adequate supplies of tetanus vaccine from vaccine manufacturers. CDC has sent epidemiologists, occupational health specialists, industrial hygienists, and other public health professionals to supplement local efforts. Information about federal support of the local public health response is available from DHHS at <http://www.hhs.gov>.

Update: Influenza Activity — United States and Worldwide, May–September 2001

During October 2000–May 2001, influenza A (H1N1), A (H3N2), and B viruses were identified in the Northern Hemisphere. Influenza A (H1N1) and B viruses circulated widely; influenza A (H3N2) viruses were reported infrequently and were not associated with widespread outbreaks in any country during October 2000–May 2001. Since May 2001, influenza A (H1N1) and B viruses have predominated in Asia and Oceania; influenza A (H3N2) and B viruses have predominated in Africa and South America. This report summarizes influenza activity in the United States* (*1*) and worldwide during May–September 25; influenza A (H1N1), A (H3N2), and B viruses continued to circulate worldwide and were associated with mild to moderate levels of activity. This activity underscores the need to follow the recommendations of the Advisory Committee on Immunization Practices (ACIP) (*2,3*) for the timely vaccination of persons at high risk for influenza-related complications.

*The four components of the influenza surveillance system have been described (*1*).

Influenza Activity — Continued

United States

Influenza B viruses were reported more frequently than influenza A viruses during May 2001. Unsubtyped influenza A viruses were reported from Alaska and Missouri during June; influenza A (H1N1) viruses were reported from one case in Michigan and one case in Texas in June and July, respectively. In Hawaii, an influenza A (H3N2) virus was isolated from one case during June and two A (H1N1) viruses were isolated in July and August. Influenza B viruses were isolated in Hawaii each month during May–July.

Worldwide

During May–September 25, influenza A (H1N1) and B viruses circulated in Asia and Oceania; influenza A (H3N2) viruses were identified less frequently than influenza A (H1N1) and B viruses and were not associated with widespread activity. In Africa, influenza A (H3N2) viruses were reported from Senegal and South Africa, and influenza B viruses were reported from Mauritius and South Africa. In South America, influenza A (H3N2) and B viruses circulated widely, and influenza A (H1N1) viruses have been identified less frequently. Influenza A (H3N2) viruses predominated in Argentina and Chile; in Brazil and Paraguay, influenza type B viruses were reported more frequently than influenza type A viruses. Both influenza A (H3N2) and B viruses also were reported from Uruguay. In Canada, influenza A and B viruses were identified during May–August.

Isolate Analysis

The WHO Collaborating Center for Surveillance, Epidemiology, and Control of Influenza at CDC analyzes isolates from laboratories worldwide. This report describes the antigenic characteristics of influenza isolates collected during May–September 25, including isolates from the Northern Hemisphere and Southern Hemisphere. Of the 25 influenza A (H1N1) isolates antigenically characterized, 24 (96%) were similar to A/New Caledonia/20/99, the H1N1 component of the 2001–02 influenza vaccine, and one (4%) showed reduced titers with A/New Caledonia/20/99 antisera. Of the 25 influenza A (H1N1) isolates, six were from Asia, 10 were from Oceania, eight were from South America, and one was from the United States. Of the 67 influenza A (H3N2) viruses antigenically characterized, 61 (91%) were similar to A/Panama/2007/99, the H3N2 component of the 2001–02 influenza vaccine, and six (9%) showed reduced titers with A/Panama/2007/99 antisera. Of the 67 influenza A (H3N2) viruses, 17 were from Asia, two were from Oceania, 47 were from South America, and one was from the United States.

Circulating influenza B viruses can be divided into two antigenic and genetic groups represented by B/Yamagata/16/88 and B/Victoria/2/87 reference strains (Table 1). B/Victoria/2/87 group viruses circulated widely before 1991; however, during 1991–2000, these viruses were identified only in Asia (China, Hong Kong/China, Japan, Singapore, Taiwan, and Thailand). Since 1990, B/Yamagata/16/88 group viruses have circulated worldwide. The recommended influenza B vaccine strain, B/Sichuan/379/99, belongs to the B/Yamagata/16/88 group. Most of the viruses in the B/Victoria/2/87 group are represented by the reference strain B/Hong Kong/22/2001. Of the 54 antigenically characterized influenza B viruses collected worldwide during May–September 25, 37 (69%) belong to the B/Yamagata/16/88 group, and 17 (31%) belong to the B/Victoria/2/87 group. Of 37 B/Yamagata/16/88 group viruses, 35 (95%) were similar to recommended vaccine strain B/Sichuan/379/99, and two (5%) showed reduced titers with B/Sichuan/379/99 antisera. These B/Sichuan/379/99-like viruses were from the United States (Hawaii and Massachusetts), Asia (China, Hong Kong/China, Japan, and Thailand), South America

Influenza Activity — Continued

TABLE 1. Hemagglutination-inhibition titers of influenza B viruses* — United States and worldwide, May–September 25, 2001

Viral antigen	Antisera			
	B/Sichuan/ 379/99	B/Victoria/ 504/2000	B/Hong Kong/ 6/2001	B/Hong Kong/ 22/2001
B/Yamagata/16/88 group viruses				
B/Sichuan/379/99	320	2560	20	10
B/Victoria/504/2000	320	2560	10	<10
B/Victoria/2/87 group viruses				
B/Hong Kong/6/2001	<10	20	1280	640
B/Hong Kong/22/2001	<10	10	640	640

* A fourfold difference in hemagglutination-inhibition titer between two viruses usually indicates antigenic variation between viruses.

(Argentina, Brazil, Chile, and Costa Rica) and Oceania (Australia and New Zealand). The influenza B/Victoria/2/87 group viruses collected during May–September 25 were isolated in Hawaii and Hong Kong/China. During March, one B/Victoria/2/87 group virus was reported in Canada from a patient who recently had traveled in Asia. No B/Victoria/2/87 group viruses have been identified in Europe, Oceania, or South America.

Reported by: World Health Organization National Influenza Centers, Communicable Diseases, Surveillance and Response, World Health Organization, Geneva, Switzerland. A Hay, PhD, WHO Collaborating Center for Reference and Research on Influenza, National Institute for Medical Research, London, England. I Gust, MD, A Hampson, WHO Collaborating Center for Reference and Research on Influenza, Parkville, Australia. M Tashiro, MD, WHO Collaborating Center for Reference and Research on Influenza, National Institute of Infectious Diseases, Tokyo, Japan. R Ueki, S Nagaue, L Muus, G Kunimoto, Virology Section, State Laboratories Div; T Tom, MS, M leong, MPH, Epidemiology Br, Hawaii Dept of Health, Honolulu. WHO collaborating laboratories. National Respiratory and Enteric Virus Surveillance System laboratories. WHO Collaborating Center for Surveillance, Epidemiology and Control of Influenza, Influenza Br and Respiratory and Enteric Viruses Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases, CDC.

Editorial Note: Influenza A (H1N1), A (H3N2), and B viruses circulated during the winter in the Southern Hemisphere (May–mid-September) and summer (May–mid-September) in the Northern Hemisphere. The identification of influenza cases and sporadic influenza outbreaks during summer and fall are not unusual. From June through mid-September, few influenza isolates were identified in Alaska, Canada, and the continental United States. Most of the viruses identified were influenza type A; two influenza A viruses were subtyped (H1N1). The most frequently isolated influenza viruses in Hawaii were influenza B viruses and both of the antigenic groups have been identified. Most of the viruses isolated worldwide since May are well matched to the current vaccine strains.

For the 2001–02 season in the Northern Hemisphere, the type(s) and subtype(s) of influenza virus that will circulate and the onset, peak, and severity of disease activity cannot be predicted. The optimal time for persons at increased risk for influenza-related complications to receive annual influenza vaccination is October and November; vaccination of other persons should continue through December and later as long as vaccine is available (*2,3*). The three influenza vaccine manufacturers distributing in the United States are expected to produce and distribute approximately 79 million doses combined.

Influenza Activity — Continued

Distribution of 44.6 million doses (56% of projected season totals) may be delayed until the end of October; the remaining 35 million doses are expected to be distributed in November and December.

During July 2001, ACIP issued recommendations to address an anticipated delay in influenza vaccine availability (*3*). The primary recommendations for health-care providers were 1) to target vaccine available in September and October to persons at increased risk for influenza complications and to health-care workers, 2) beginning in November, also to offer vaccine to contacts of high-risk persons, healthy persons aged 50–64 years, and others who want to reduce their risk for influenza, and 3) to continue vaccinating patients, especially those at high risk and in other target groups, in December and throughout the influenza season as long as vaccine is available. Recommendations for influenza vaccine manufacturers and distributors were 1) to delay until November distribution of vaccine to worksites, where campaigns primarily vaccinate healthy persons, and 2) to process orders so that all providers who have ordered vaccine receive some early season vaccine. Previously, ACIP extended the recommended optimal time for vaccination from October through the end of November (*2*).

Each February, the World Health Organization (WHO) recommends influenza virus strains for inclusion in the following season's Northern Hemisphere influenza vaccine (*4*). The regulatory authorities in each country then determine the actual viruses to be used for vaccine production. In the United States, the Food and Drug Administration's Vaccines and Related Biological Products Advisory Committee is responsible for the selection of vaccine strains to be used by U.S. vaccine manufacturers. The regulatory authorities in a country frequently will substitute an antigenically equivalent virus for one or more of the WHO recommended viruses because of better growth or processing properties. For the 2001–02 influenza season, WHO recommended A/New Caledonia/20/99-like (H1N1), A/Moscow/10/99-like (H3N2), and B/Sichuan/379/99-like viruses for inclusion in the Northern Hemisphere influenza vaccine (*4*). Influenza vaccines sold in North America will use A/New Caledonia/20/99 for the H1N1 component and the antigenically equivalent stains of A/Panama/2007/99 (H3N2) for the A/Moscow/10/99-like strain and B/Johannesburg/5/99, B/Victoria/504/2000, or B/Guangdong/120/2000 for the B/Sichuan/379/99-like strain.

Updated information about vaccine availability is available at <http://www.cdc.gov/nip/flu/>. This site also has patient education materials, suggestions on establishing a patient reminder/recall system, and other information that may assist providers in distributing influenza vaccine. Formal surveillance for influenza in the United States and reporting by CDC is conducted during October–May. This information is updated weekly and is available through CDC's voice information system, telephone (888) 232-3228, the fax information system, telephone (888) 232-3299, by requesting document number 361100, or at <http://www.cdc.gov/ncidod/diseases/flu/weekly.htm>.

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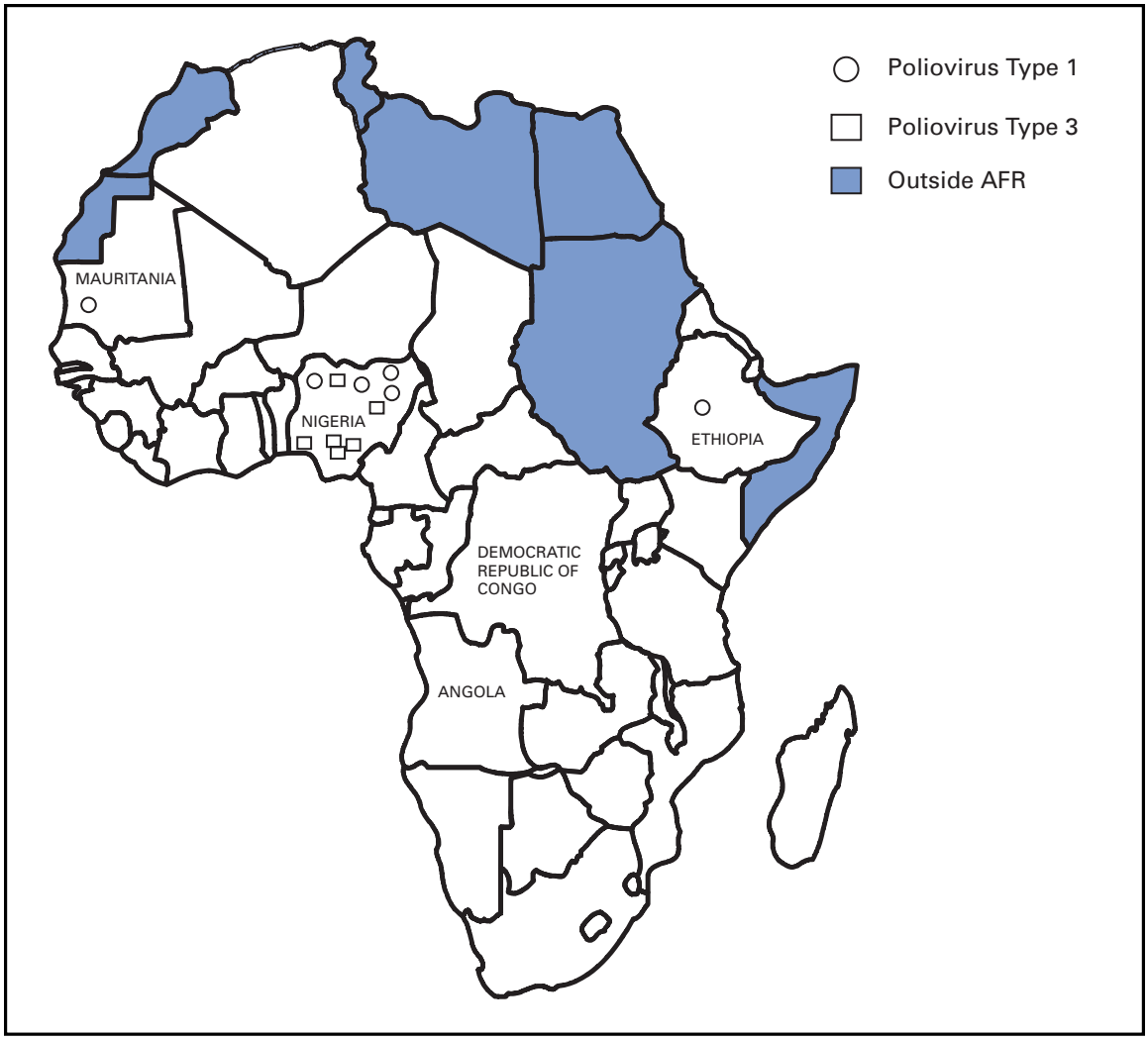
2. CDC. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2001;50(no. RR-4).
3. CDC. Delayed influenza vaccine availability for 2001–02 season and supplemental recommendations of the Advisory Committee on Immunization Practices. MMWR 2001;50:582–5.
4. World Health Organization. Recommended composition of influenza virus vaccines for use in the 2001–02 season. Wkly Epidemiol Rec 2001;76:58–61.

Progress Toward Poliomyelitis Eradication — Angola, Democratic Republic of Congo, Ethiopia, and Nigeria, January 2000–July 2001

In 1988, the World Health Assembly, governing body of the World Health Organization (WHO), resolved to eradicate poliomyelitis globally by 2000 (*1*). In the African Region (AFR), WHO member countries began to implement polio eradication strategies in 1995. Although rapid progress has occurred in much of eastern and southern Africa, wild poliovirus transmission continues to occur in four priority countries: Angola, Democratic Republic of Congo (DR Congo), Ethiopia, and Nigeria (*2*). This report summarizes progress toward polio eradication in Angola, DR Congo, Ethiopia, and Nigeria during January 2000–July 2001, and indicates that 11 of 12 cases of wild poliovirus in AFR were identified in these priority countries during January–July 2001 (Figure 1).

FIGURE 1. Location of wild poliovirus cases, by type — African Region (AFR), World Health Organization, January–July 2001



Poliomyelitis Eradication — Continued

Routine Vaccination

The four priority countries have reported low rates of routine coverage with three doses of oral polio vaccine (OPV3). In 2000, reported OPV3 coverage among infants was 42% in DR Congo, 42% in Ethiopia, 38% in Nigeria, and 33% in Angola.

Supplemental OPV Vaccination Activities

Supplemental OPV vaccination activities were conducted in all four priority countries in 2000 and 2001. In Angola, three rounds of national immunization days (NIDs)* were conducted in June, July, and August 2000 with an additional subnational immunization day (SNID)† conducted just before and after NIDs in accessible areas. Access to rebel-controlled areas could not be secured, and approximately 100,000 children aged <5 years did not receive OPV. In DR Congo, three rounds of NIDs were conducted in July, August, and September 2000. A house-to-house strategy was implemented for the first time in one third of the country, excluding some rebel-controlled areas. Similar to Angola, monitoring of NIDs in DR Congo indicated that 3%–10% of houses were not visited, suggesting that children were not reached even in accessible areas. Ethiopia conducted two rounds of SNIDs in March and April 2000 and two rounds of NIDs in November and December 2000. Nigeria conducted four rounds of NIDs in May and June and October and November 2000. During October–November 2000, NIDs in Nigeria were synchronized with those of 15 other countries in west and central Africa with substantial cross-border vaccination activities, high political commitment, and community mobilization (*3*). NIDs and SNIDs in the four priority countries reported >90% vaccination coverage by round in accessible areas, reaching approximately 73 million children aged <5 years with OPV.

In 2001, SNIDs were conducted in Angola and Ethiopia during February–April 2001, using the house-to-house strategy. Three rounds of NIDs were conducted in Nigeria in January, May, and June 2001. The first two rounds of the central African synchronized NIDs were completed in Angola, Gabon, Congo (Brazzaville), and DR Congo during July–August 2001. Preliminary results indicate that approximately 16 million children were vaccinated during synchronized NIDs, including 11,898,767 in DR Congo.

Acute Flaccid Paralysis (AFP) Surveillance

The goal of AFP surveillance is to detect circulating polioviruses and provide data for developing appropriate supplementary vaccination strategies. AFP surveillance is evaluated by two key indicators: sensitivity of reporting (target: nonpolio AFP rate of $\geq$1 case per 100,000 children aged <15 years) and completeness of specimen collection (target: two adequate stool specimens§ from $\geq$80% of all persons with AFP).

From January 2000 through July 2001, the annualized nonpolio AFP rate increased from 0.7 to 3.8 in Nigeria (Table 1). In DR Congo, the annualized nonpolio AFP rate increased from 2.3 in 2000 to 9.0 in 2001 but remained relatively stable in Angola (1.2 in 2001) and Ethiopia (0.6 in 2001). The percentage of adequate stool specimens collected from persons with AFP increased substantially for DR Congo and Nigeria, increased for

*Mass campaigns over a period of days to weeks, in which two doses of OPV are administered to all children (usually aged <5 years), regardless of previous vaccination history, with an interval of 4–6 weeks between doses.

† Same procedure as NIDS but in a smaller area.

§ Two stool specimens collected at least 24 hours apart within 14 days from onset of paralysis and shipped adequately to the laboratory.

Poliomyelitis Eradication — Continued

TABLE 1. Number of reported cases of acute flaccid paralysis (AFP), nonpoliomyelitis AFP rates, and confirmed polio cases in priority countries — African Region, World Health Organization, January 2000–July 2001

	2000				January–July 2001			
Country	No. AFP cases	Non-polio AFP rate*	Persons with AFP with adequate specimens† (%)	Polio cases (wild virus confirmed)	No. AFP cases	Non-polio AFP rate	Persons with AFP with adequate specimens (%)	Polio cases (wild virus confirmed)
Angola	217	1.6	54	119 (55)	63	1.2	52	20 (0)
DR Congo§	1078	2.3	35	513 (28)	1312	9.0	72	0 —
Ethiopia	345	0.7	45	144 (3)	170	0.6	53	69 (1)
Nigeria	978	0.7	37	637 (28)	1090	3.8	64	10 (10)
Total	**2618**			**1413 (114)**	**2635**			**99 (11)**

* Per 100,000 children aged <15 years.
† Two stool specimens collected at an interval of at least 24 hours within 14 days of onset of paralysis and adequately shipped to the laboratory.
§ Democratic Republic of Congo.

Ethiopia, and decreased for Angola. In all four priority countries, the percentage of adequate stool specimens remained <80%. The geographic distribution of reported AFP cases is proportionate to population density in Ethiopia and Nigeria but is skewed to accessible areas in Angola and DR Congo.

Polio Incidence

Despite surveillance improvements in these countries, no wild poliovirus has been detected in Angola and DR Congo in 2001. Both countries contain inaccessible areas because of civil conflict. Only 10 cases of wild poliovirus have been isolated in Nigeria in 2001. In Ethiopia, wild poliovirus was isolated from a child residing in an area where poliovirus was detected in 1999 and 2000, suggesting that wild poliovirus transmission has continued in 2001.

The polio laboratory network for AFR includes 15 national polio laboratories, three of which serve as regional reference laboratories (Central African Republic, Ghana, and South Africa). All stool specimens collected in the four countries are processed in WHO accredited laboratories. Angola is served by the regional laboratory in South Africa. DR Congo, Ethiopia, and Nigeria are served by their national laboratories. As of July 8, 2001, DR Congo, Ethiopia, and Nigeria submitted 4040 stool specimens. Of 3402 specimens with completed test results to date, 2865 (84%) were negative and 382 (11%) contained nonpolio enteroviruses (NPEV). An NPEV rate of 10%–20% indicates good quality of stool condition on arrival in the laboratory.

Reported by: Expanded Program on Immunization, World Health Organization Regional Office for Africa, Harare, Zimbabwe. Vaccines and Biologicals Dept, World Health Organization, Geneva, Switzerland. Respiratory and Enteric Viruses Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; Vaccine Preventable Disease Eradication Div, National Immunization Program, CDC.

Poliomyelitis Eradication — Continued

Editorial Note: During January–July 2001, only three of 46 countries in AFR (Nigeria, Ethiopia, and Mauritania) reported wild poliovirus isolates; however, Angola and DR Congo contain inaccessible areas because of civil conflict. The incidence of wild poliovirus decreased throughout the region from 61 cases reported in AFR as of August 28, 2000, to 12 cases as of August 28, 2001 (WHO, unpublished data, 2001). These achievements resulted from improvements in surveillance and supplemental immunization activities (SIAs) during the preceding 18 months.

Interrupting the remaining chains of wild poliovirus transmission through high-quality SIAs is critical for AFR priority countries during 2001–2002. In Angola, improving SIAs in accessible areas and strengthening the AFP surveillance system will enable identification of areas with poliovirus circulation. The quality and geographic extent of SIAs in Angola need to be improved, especially mapping, marking of houses, record keeping, supervising, using of independent monitors, and social mobilizing. Access to children residing in rebel-controlled areas remains a challenge. In DR Congo, the high AFP rate in 2001 raises a concern of reporting of AFP cases that may not meet the case definition. The NPEV isolation rate of 14.5% for the first half of 2001 suggests that the reverse cold chain that transports these samples to the national laboratory is adequate. In Ethiopia, coordinating surveillance and supplemental OPV vaccination activities with other countries of the Horn of Africa (i.e., Djibouti, Somalia, and Sudan) is important because of nomadic border populations. In July 2001, an internal surveillance review recommended targeting Nigerian states with continuing wild poliovirus transmission for conducting mop-up campaigns¶, conducting regular active AFP searches (especially in the riverine areas of the Niger-Delta area), and strengthening project management at national and zonal levels.

The substantial progress toward polio eradication in the four AFR priority countries underscores the feasibility of interrupting poliovirus. Future priorities for the region include 1) improving AFP surveillance to allow for better targeting of supplemental vaccination and mop-up activities, 2) reaching previously unvaccinated children and gaining access to all children in the four priority countries, 3) assuring an adequate supply of OPV vaccines for routine and supplemental vaccination activities, and 4) improving basic infrastructure for the Expanded Program on Immunization. Meeting these priorities will require continued external support.

References

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2. CDC. Progress toward poliomyelitis eradication—African Region, 1999–March 2000. MMWR 2000;49:445–9.
3. CDC. Progress toward poliomyelitis eradication—west and central Africa, 1999–2000. MMWR 2001;50:481–5.

¶ Intensive house-to-house vaccination with OPV in high-risk districts, conducted in two rounds, 4–6 weeks apart.

Weekly Update: West Nile Virus Activity — United States, September 19–25, 2001

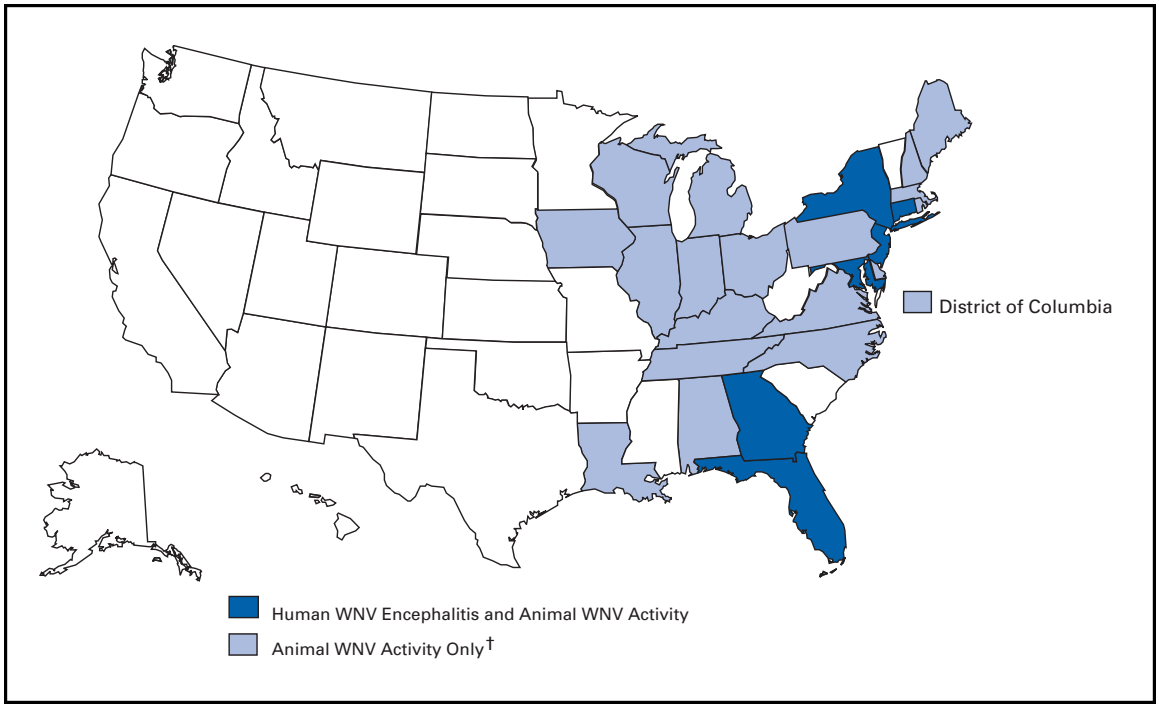
The following report summarizes West Nile virus (WNV) surveillance data reported to CDC through ArboNET and verified by states and other jurisdictions as of September 25, 2001.

During the week of September 19–25, eight human cases of WNV encephalitis were reported in Maryland (five) and New York (three); no deaths were reported. During the same period, WNV infections were reported in 430 crows, 76 other birds, and nine horses. A total of 57 WNV-positive mosquito pools were reported in five states (Connecticut, Illinois, Massachusetts, New Jersey, and Pennsylvania).

During 2001, 20 human cases of WNV encephalitis have been reported in New York (six), Maryland (five), Florida (four), Connecticut (three), Georgia (one), and New Jersey (one); one death occurred in Georgia. A total of 2521 crows and 952 other birds with WNV infection were reported from 23 states and the District of Columbia (Figure 1); 89 WNV infections in other animals (all horses) were reported from 10 states (Alabama, Connecticut, Florida, Georgia, Kentucky, Louisiana, Massachusetts, New York, Pennsylvania, and Virginia); and 568 WNV-positive mosquito pools were reported from 12 states (Connecticut, Florida, Georgia, Illinois, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, and Rhode Island).

Additional information about WNV activity is available at <http://www.cdc.gov/ncidod/dvbid/westnile/index.htm> and <http://cindi.usgs.gov/hazard/event/west_nile/west_nile.html>.

FIGURE 1. Areas reporting West Nile virus (WNV) activity — United States, 2001*



* As of September 25, 2001.
† Kentucky reported WNV infection in a horse but no birds.

Notice to Readers

Walk to School Day — October 2, 2001

October 2 has been designated International Walk to School Day. The goal of this event is to increase public awareness of the importance of regular physical activity for children, improve pedestrian safety, and create more walkable communities. This year, an estimated 20 countries and 49 states will participate by encouraging children to walk or bike to school in a safe, supportive environment.

CDC supports Walk to School Day and walking and biking to school year-long through the KidsWalk-to-School program, which is a part of CDC's Active Community Environments (ACEs) initiative. ACEs is exploring how policies and the design of new and existing communities can promote physical activity for recreation and utilitarian purposes. KidsWalk-to-School is a community-based program that encourages and promotes walking and biking to school. As part of the program, communities build partnerships with schools, local police, public works, politicians, businesses, and civic associations to create an environment that supports safe and active travel to school. The program was developed in response to low rates of walking, inadequate levels of physical activity, and a 50% increase in the proportion of children who are overweight since the late 1970s.

Many states are implementing walk-to-school efforts. For example, California is piloting Safe Routes to School Legislation, which allocates a percentage of TEA-21 federal highway funds to improve pedestrian safety near schools. Similar legislation is pending in Georgia, Maryland, and Montana.

CDC's KidsWalk-to-School information and materials are available at <http://www.cdc.gov/nccdphp/dnpa/kidswalk.htm>. Information on Walk to School Day is available at <http://www.walktoschool-usa.org> and <http://www.iwalktoschool.org>.

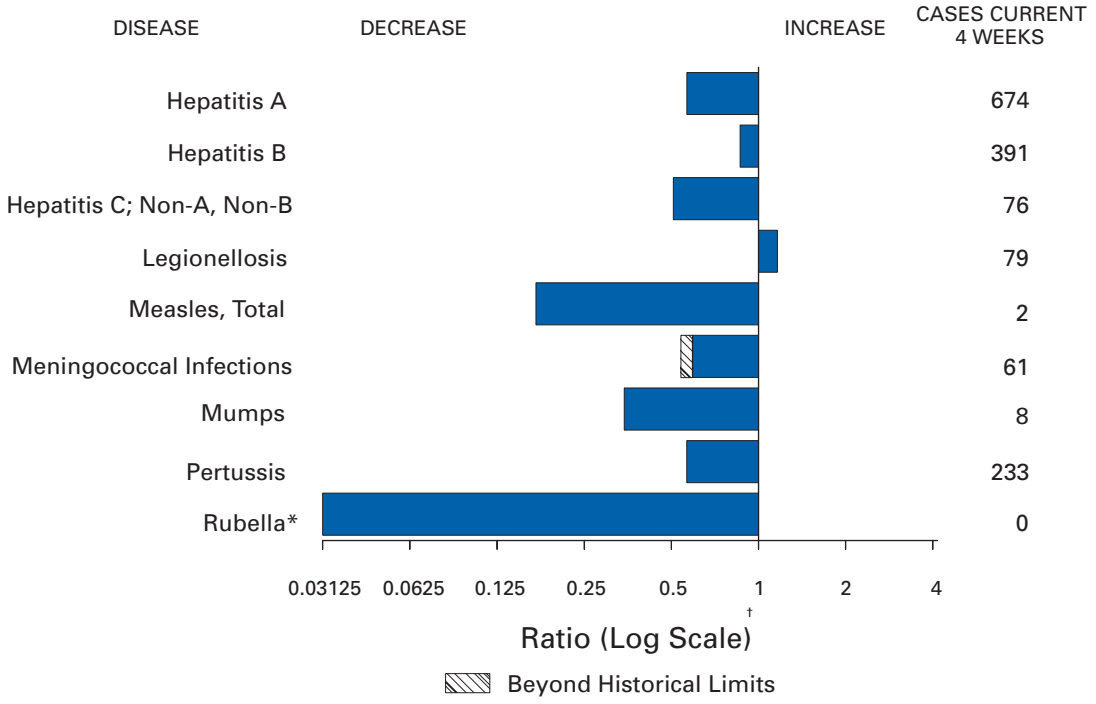
Notice to Readers

Satellite Broadcast on HIV Prevention

"Update on CDC's Revised Guidelines for HIV Counseling, Testing, and Referral," a satellite broadcast, is scheduled for Thursday, November 15, 2001, from 1 p.m. to 3 p.m. eastern daylight time. CDC and the Public Health Training Network are co-sponsoring this forum, which will focus on why quality HIV counseling, testing, and referral are critical to prevention and care services, and on key recommendations of CDC's *Revised Guidelines for HIV Counseling, Testing, and Referral*. Presentations and interviews will provide an update on implementation issues for the updated guidelines. This broadcast is designed for policy developers and service providers of HIV counseling, testing, and referral. Viewers are invited to submit questions before and during the broadcast.

Additional information is available at <http://www.cdcnpin.org/broadcast> and through CDC's fax information system, telephone (888) 232-3299 ([888] CDC-FAXX]), by entering document number 130040 and a return fax number. Organizations setting up viewing sites are encouraged to register online or by fax as early as possible so that viewers can access information about viewing locations when visiting the Internet site or calling the information line.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending September 22, 2001, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 38 of zero (0).

† 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 of provisional cases of selected notifiable diseases, United States, cumulative, week ending September 22, 2001 (38th Week)*

	Cum. 2001		Cum. 2001
Anthrax	-	Poliomyelitis, paralytic	-
Brucellosis†	57	Psittacosis†	10
Cholera	3	Q fever†	16
Cyclosporiasis†	113	Rabies, human	1
Diphtheria	2	Rocky Mountain spotted fever (RMSF)	380
Ehrlichiosis: human granulocytic (HGE)†	143	Rubella, congenital syndrome	-
human monocytic (HME)†	60	Streptococcal disease, invasive, group A	2,697
Encephalitis: California serogroup viral†	46	Streptococcal toxic-shock syndrome†	45
eastern equine†	5	Syphilis, congenital¶	166
St. Louis†	1	Tetanus	22
western equine†	-	Toxic-shock syndrome	89
Hansen disease (leprosy)†	56	Trichinosis	15
Hantavirus pulmonary syndrome†	5	Tularemia†	79
Hemolytic uremic syndrome, postdiarrheal†	96	Typhoid fever	190
HIV infection, pediatric§	131	Yellow fever	-
Plague	2		

-: No reported cases.
*Incidence data for reporting year 2001 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ 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 August 28, 2001.
¶ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending September 22, 2001, and September 23, 2000 (38th Week)*

Reporting Area	AIDS		Chlamydia§		Cryptosporidiosis		*Escherichia coli* O157:H7†			
							NETSS		PHLIS	
	Cum. 2001¶	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	25,869	28,145	490,605	503,993	1,910	2,038	1,941	3,388	1,503	2,852
NEW ENGLAND	996	1,531	15,978	16,875	84	101	181	303	168	315
Maine	26	25	754	1,046	13	17	24	24	26	25
N.H.	27	27	932	791	8	15	28	29	21	31
Vt.	11	29	433	386	27	20	11	28	8	30
Mass.	541	998	6,868	7,134	29	29	89	140	77	143
R.I.	72	61	2,131	1,903	3	2	10	11	8	14
Conn.	319	391	4,860	5,615	4	18	19	71	28	72
MID. ATLANTIC	5,634	6,389	55,475	46,609	192	268	148	342	122	239
Upstate N.Y.	697	610	9,852	1,194	80	71	109	215	85	42
N.Y. City	2,742	3,478	20,641	19,148	68	138	8	21	8	14
N.J.	1,194	1,249	8,393	8,106	7	14	31	106	29	106
Pa.	1,001	1,052	16,589	18,161	37	45	N	N	-	77
E.N. CENTRAL	1,922	2,581	74,314	86,989	683	694	512	834	318	610
Ohio	367	389	14,908	22,927	135	171	138	194	97	182
Ind.	225	250	10,174	9,556	60	41	57	96	32	72
Ill.	882	1,365	19,427	24,254	1	87	114	161	80	129
Mich.	328	437	21,461	18,425	124	74	67	108	62	92
Wis.	120	140	8,344	11,827	363	321	136	275	47	135
W.N. CENTRAL	571	634	24,531	28,399	279	195	300	480	275	480
Minn.	104	129	4,878	5,825	121	22	95	109	98	149
Iowa	63	65	1,858	3,971	66	58	63	145	48	126
Mo.	271	288	9,400	9,480	31	23	40	91	58	82
N. Dak.	2	2	685	661	9	9	12	15	24	17
S. Dak.	19	6	1,314	1,323	6	13	29	45	39	48
Nebr.	49	43	2,132	2,743	45	61	47	53	-	44
Kans.	63	101	4,264	4,396	1	9	14	22	8	14
S. ATLANTIC	8,247	7,777	92,629	95,073	236	315	172	277	118	237
Del.	185	131	2,041	2,101	4	5	4	2	6	1
Md.	1,089	958	8,138	10,148	31	9	20	25	1	1
D.C.	591	500	2,087	2,253	10	7	-	1	U	U
Va.	673	517	13,359	11,424	16	14	46	53	36	50
W. Va.	58	44	1,700	1,554	2	3	9	13	8	7
N.C.	574	502	14,743	16,512	21	19	36	61	28	61
S.C.	500	610	8,362	6,902	-	-	7	18	11	15
Ga.	935	876	18,610	20,077	84	114	19	35	13	36
Fla.	3,642	3,639	23,589	24,102	68	144	31	69	15	66
E.S. CENTRAL	1,279	1,438	35,036	36,899	38	39	95	103	84	87
Ky.	245	147	6,525	5,769	4	5	43	30	39	27
Tenn.	408	635	10,859	10,569	12	10	31	46	33	43
Ala.	308	338	9,459	11,682	12	12	14	7	6	7
Miss.	318	318	8,193	8,879	10	12	7	20	6	10
W.S. CENTRAL	2,836	2,956	71,134	75,795	25	121	46	202	60	250
Ark.	144	149	5,291	4,862	6	9	7	54	-	37
La.	602	445	12,410	13,354	7	10	3	13	25	41
Okla.	172	259	7,662	6,421	10	10	19	13	20	13
Tex.	1,918	2,103	45,771	51,158	2	92	17	122	15	159
MOUNTAIN	955	1,059	28,153	28,645	145	112	210	312	118	240
Mont.	14	10	1,455	1,022	25	10	16	27	-	-
Idaho	17	16	1,332	1,335	13	8	46	48	-	31
Wyo.	2	7	601	570	4	5	5	14	1	9
Colo.	197	257	5,284	8,277	30	53	71	118	63	85
N. Mex.	84	116	4,193	3,557	19	12	11	17	8	16
Ariz.	395	318	10,284	9,476	6	10	22	37	21	31
Utah	84	98	1,454	1,569	44	11	28	41	24	58
Nev.	162	237	3,550	2,839	4	3	11	10	1	10
PACIFIC	3,429	3,780	93,355	88,709	228	193	277	535	240	394
Wash.	371	332	9,573	9,417	37	U	65	172	62	176
Oreg.	134	113	5,362	4,926	35	14	44	111	37	100
Calif.	2,871	3,227	73,737	69,955	152	179	147	213	137	105
Alaska	15	15	1,940	1,818	1	-	4	26	-	3
Hawaii	38	93	2,743	2,593	3	-	17	13	4	10
Guam	10	13	-	354	-	-	N	N	U	U
P.R.	816	869	1,847	U	-	-	1	6	U	U
V.I.	2	26	53	-	-	-	-	-	U	U
Amer. Samoa	-	-	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	96	U	-	U	-	U	U	U

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

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

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

§ Chlamydia refers to genital infections caused by *C. trachomatis*.

¶ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update August 28, 2001.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending September 22, 2001, and September 23, 2000 (38th Week)*

Reporting Area	Gonorrhea		Hepatitis C; Non-A, Non-B		Legionellosis		Listeriosis	Lyme Disease	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	225,809	256,450	2,418	2,342	692	752	328	8,093	12,454
NEW ENGLAND	4,529	4,793	14	23	38	41	35	2,280	3,956
Maine	86	62	-	2	5	2	-	-	-
N.H.	128	77	-	-	8	2	3	104	51
Vt.	50	48	6	4	5	4	2	12	27
Mass.	2,090	1,965	8	12	9	15	17	484	1,032
R.I.	591	461	-	5	4	4	1	341	307
Conn.	1,584	2,180	-	-	7	14	12	1,339	2,539
MID. ATLANTIC	27,794	27,274	1,194	527	137	204	52	4,274	6,455
Upstate N.Y.	5,990	5,163	44	27	43	55	22	2,258	2,621
N.Y. City	8,627	8,228	-	-	13	30	8	2	155
N.J.	5,127	5,326	1,107	465	7	17	10	783	2,231
Pa.	8,050	8,557	43	35	74	102	12	1,231	1,448
E.N. CENTRAL	40,245	52,051	129	182	182	201	41	447	693
Ohio	8,275	13,952	8	9	94	82	13	98	47
Ind.	4,300	4,487	1	-	15	29	4	17	20
Ill.	12,161	15,292	12	18	-	25	1	-	33
Mich.	12,592	13,236	108	155	48	33	18	1	21
Wis.	2,917	5,084	-	-	25	32	5	331	572
W.N. CENTRAL	10,462	12,564	514	420	43	46	11	289	236
Minn.	1,570	2,309	8	5	9	3	-	237	150
Iowa	428	888	-	1	6	12	1	26	24
Mo.	5,683	6,053	496	403	18	22	6	21	44
N. Dak.	25	55	-	-	1	-	-	-	1
S. Dak.	212	218	-	-	3	2	-	-	-
Nebr.	701	1,091	3	4	5	3	1	3	3
Kans.	1,843	1,950	7	7	1	4	3	2	14
S. ATLANTIC	57,619	67,043	82	72	149	138	53	643	913
Del.	1,212	1,226	-	2	5	8	-	33	167
Md.	4,486	6,981	13	10	30	45	9	415	533
D.C.	1,900	1,825	-	3	7	3	-	8	4
Va.	8,046	7,217	-	3	18	25	9	102	120
W. Va.	477	485	9	14	N	N	5	10	26
N.C.	12,337	13,522	16	13	7	12	2	32	39
S.C.	5,714	6,199	5	2	9	4	4	4	5
Ga.	10,117	12,889	-	3	9	6	10	-	-
Fla.	13,330	16,699	39	22	64	35	14	39	19
E.S. CENTRAL	22,642	26,589	163	349	44	25	16	41	42
Ky.	2,553	2,536	8	30	9	14	4	18	8
Tenn.	7,322	8,443	52	73	21	8	7	14	26
Ala.	7,367	9,015	3	7	12	2	5	8	5
Miss.	5,400	6,595	100	239	2	1	-	1	3
W.S. CENTRAL	34,990	39,976	165	570	5	21	6	7	64
Ark.	3,229	2,842	3	7	-	-	1	-	5
La.	8,543	9,840	78	321	2	7	-	1	7
Okla.	3,495	2,797	3	7	3	2	2	-	-
Tex.	19,723	24,497	81	235	-	12	3	6	52
MOUNTAIN	7,191	7,692	54	59	38	28	28	12	7
Mont.	83	31	1	4	-	1	-	-	-
Idaho	59	64	2	3	2	4	1	6	1
Wyo.	57	39	6	2	1	-	1	1	3
Colo.	2,054	2,329	17	12	12	10	6	1	-
N. Mex.	679	796	11	12	2	1	6	-	-
Ariz.	2,829	3,178	9	14	11	7	6	-	-
Utah	116	162	2	-	7	5	2	2	1
Nev.	1,314	1,093	6	12	3	-	6	2	2
PACIFIC	20,337	18,468	103	140	56	48	86	100	88
Wash.	2,137	1,651	17	24	7	14	7	7	7
Oreg.	834	683	12	23	N	N	5	6	7
Calif.	16,630	15,538	74	91	45	33	68	85	72
Alaska	300	251	-	-	-	-	-	2	2
Hawaii	436	345	-	2	4	1	6	N	N
Guam	-	39	-	2	-	-	-	-	-
P.R.	430	382	1	1	2	1	-	N	N
V.I.	6	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	-	U	U
C.N.M.I.	9	U	-	U	-	U	-	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending September 22, 2001, and September 23, 2000 (38th Week)*

Reporting Area	Malaria		Rabies, Animal		Salmonellosis†			
					NETSS		PHLIS	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	838	1,060	4,661	5,243	24,638	28,040	20,150	24,164
NEW ENGLAND	49	57	523	605	1,697	1,707	1,621	1,742
Maine	4	5	52	100	145	98	134	77
N.H.	2	1	19	9	141	103	120	102
Vt.	1	2	51	47	61	96	63	93
Mass.	19	27	194	208	1,011	996	801	1,003
R.I.	6	6	48	44	88	106	133	123
Conn.	17	16	159	197	251	308	370	344
MID. ATLANTIC	211	277	932	968	3,069	3,715	2,594	3,994
Upstate N.Y.	50	48	594	608	882	881	816	997
N.Y. City	105	159	22	8	750	939	830	1,004
N.J.	25	40	155	142	651	917	527	786
Pa.	31	30	161	210	786	978	421	1,207
E.N. CENTRAL	79	111	110	136	3,564	3,933	3,020	2,646
Ohio	21	15	42	45	1,065	1,008	991	1,117
Ind.	14	5	3	-	398	466	354	481
Ill.	1	54	22	20	886	1,211	704	1
Mich.	29	25	37	60	605	672	610	734
Wis.	14	12	6	11	610	576	361	313
W.N. CENTRAL	29	43	266	441	1,539	1,795	1,646	1,971
Minn.	6	13	32	69	399	415	474	544
Iowa	5	2	65	64	238	269	222	267
Mo.	11	12	36	43	444	533	620	641
N. Dak.	-	2	33	100	43	48	66	63
S. Dak.	-	-	25	79	116	74	108	87
Nebr.	2	8	4	1	117	173	-	124
Kans.	5	6	71	85	182	283	156	245
S. ATLANTIC	229	233	1,673	1,775	6,264	5,607	4,310	4,420
Del.	1	4	30	39	61	84	84	103
Md.	99	78	243	321	627	591	652	534
D.C.	13	14	-	-	60	42	U	U
Va.	41	44	324	431	1,060	743	747	706
W. Va.	1	2	111	90	96	124	100	116
N.C.	12	23	445	436	932	766	905	829
S.C.	6	2	91	118	605	537	532	421
Ga.	12	16	271	218	949	1,019	918	1,312
Fla.	44	50	158	122	1,874	1,701	372	399
E.S. CENTRAL	29	37	167	154	1,784	1,677	1,281	1,334
Ky.	12	14	21	18	271	293	143	202
Tenn.	10	9	90	80	450	427	566	609
Ala.	5	13	54	55	520	471	409	432
Miss.	2	1	2	1	543	486	163	91
W.S. CENTRAL	10	64	515	700	1,721	3,538	1,434	2,141
Ark.	3	3	20	20	589	497	92	415
La.	4	10	-	3	274	594	566	481
Okla.	2	7	53	48	312	291	265	226
Tex.	1	44	442	629	546	2,156	511	1,019
MOUNTAIN	40	38	201	217	1,563	2,042	1,216	1,950
Mont.	2	1	31	55	59	70	-	-
Idaho	3	3	21	9	108	92	4	90
Wyo.	-	-	20	46	48	51	43	44
Colo.	18	20	-	-	420	556	399	540
N. Mex.	3	-	13	18	204	180	158	171
Ariz.	5	6	103	74	436	515	453	554
Utah	4	4	12	9	179	369	136	373
Nev.	5	4	1	6	109	209	23	178
PACIFIC	162	200	274	247	3,437	4,026	3,028	3,966
Wash.	5	23	-	-	371	400	491	509
Oreg.	10	32	2	7	180	229	244	289
Calif.	137	135	235	215	2,569	3,183	2,052	2,959
Alaska	1	-	37	25	32	42	2	30
Hawaii	9	10	-	-	285	172	239	179
Guam	-	2	-	-	-	21	U	U
P.R.	3	4	71	59	426	474	U	U
V.I.	-	-	-	-	-	-	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	10	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

† Individual cases can 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 September 22, 2001, and September 23, 2000 (38th Week)*

Reporting Area	Shigellosis† NETSS Cum. 2001	Shigellosis† NETSS Cum. 2000	Shigellosis† PHLIS Cum. 2001	Shigellosis† PHLIS Cum. 2000	Syphilis (Primary & Secondary) Cum. 2001	Syphilis (Primary & Secondary) Cum. 2000	Tuberculosis Cum. 2001	Tuberculosis Cum. 2000
UNITED STATES	11,895	16,161	5,613	9,209	4,037	4,391	8,476	10,181
NEW ENGLAND	205	308	183	301	39	61	301	300
Maine	6	9	2	11	-	1	7	12
N.H.	4	4	2	7	1	1	11	15
Vt.	7	4	5	-	2	-	2	4
Mass.	145	223	116	205	20	43	170	176
R.I.	16	22	20	25	8	4	27	27
Conn.	27	46	38	53	8	12	84	66
MID. ATLANTIC	1,012	2,043	583	1,313	340	203	1,690	1,651
Upstate N.Y.	402	585	93	179	21	7	238	221
N.Y. City	265	814	268	559	176	90	865	889
N.J.	185	429	157	368	86	48	371	388
Pa.	160	215	65	207	57	58	216	153
E.N. CENTRAL	3,173	3,320	1,386	920	681	904	907	979
Ohio	2,259	274	969	228	58	58	163	210
Ind.	166	1,262	29	135	124	273	73	96
Ill.	296	954	204	2	200	315	432	454
Mich.	235	563	163	511	281	217	185	153
Wis.	217	267	21	44	18	41	54	66
W.N. CENTRAL	1,228	1,769	994	1,508	55	53	321	366
Minn.	296	578	341	658	22	11	166	116
Iowa	325	386	265	269	1	10	18	27
Mo.	245	536	146	378	13	25	97	136
N. Dak.	20	14	23	37	-	-	3	2
S. Dak.	229	5	188	3	-	-	10	14
Nebr.	56	91	-	72	2	2	27	17
Kans.	57	159	31	91	17	5	-	54
S. ATLANTIC	1,765	2,053	584	871	1,426	1,464	1,704	2,041
Del.	12	16	10	17	9	8	15	14
Md.	115	147	67	86	170	221	157	188
D.C.	43	57	U	U	35	30	51	21
Va.	230	335	124	261	83	100	184	196
W. Va.	8	4	8	3	-	3	22	22
N.C.	279	152	143	203	335	382	249	271
S.C.	206	99	107	74	185	156	134	205
Ga.	182	188	91	143	252	280	317	458
Fla.	690	1,055	34	84	357	284	575	666
E.S. CENTRAL	1,033	761	403	406	453	635	551	687
Ky.	376	294	175	57	34	62	78	83
Tenn.	76	266	77	305	245	385	207	262
Ala.	180	48	124	39	90	92	188	230
Miss.	401	153	27	5	84	96	78	112
W.S. CENTRAL	1,094	2,543	720	790	497	601	714	1,500
Ark.	431	157	155	43	27	77	102	148
La.	117	211	137	133	116	169	-	135
Okla.	43	85	16	32	50	88	100	113
Tex.	503	2,090	412	582	304	267	512	1,104
MOUNTAIN	693	841	468	600	175	167	344	377
Mont.	4	7	-	-	-	-	6	10
Idaho	27	42	-	25	1	1	8	6
Wyo.	3	5	1	3	1	1	3	2
Colo.	163	182	163	143	31	7	78	61
N. Mex.	95	105	58	71	16	14	21	33
Ariz.	294	331	197	223	114	139	151	157
Utah	48	63	41	69	7	1	26	32
Nev.	59	106	8	66	5	4	51	76
PACIFIC	1,692	2,523	292	2,500	371	303	1,944	2,280
Wash.	146	355	167	337	37	50	175	179
Oreg.	62	132	78	93	11	10	79	72
Calif.	1,426	2,001	-	2,041	313	242	1,553	1,850
Alaska	5	7	1	3	-	-	36	81
Hawaii	53	28	46	26	10	1	101	98
Guam	-	34	U	U	-	3	-	39
P.R.	8	28	U	U	172	123	76	109
V.I.	-	-	U	U	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	4	U	U	U	3	U	22	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

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

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending September 22, 2001, and September 23, 2000 (38th Week)*

Reporting Area	*H. influenzae*, Invasive		Hepatitis (Viral), By Type				Measles (Rubeola)					
			A		B		Indigenous		Imported†		Total	
	Cum. 2001§	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	2001	Cum. 2001	2001	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	979	933	6,872	9,502	4,725	5,076	1	49	-	42	91	71
NEW ENGLAND	59	74	404	288	67	82	-	4	-	1	5	6
Maine	1	1	9	14	5	5	-	-	-	-	-	-
N.H.	4	12	12	18	12	14	-	-	-	-	-	3
Vt.	3	7	8	8	4	6	-	1	-	-	1	3
Mass.	35	35	160	110	2	12	-	2	-	1	3	-
R.I.	3	4	29	19	20	14	-	-	-	-	-	-
Conn.	13	15	186	119	24	31	-	1	-	-	1	-
MID. ATLANTIC	146	174	700	1,078	791	871	-	4	-	11	15	21
Upstate N.Y.	56	72	181	163	103	90	-	1	-	4	5	10
N.Y. City	36	47	209	370	322	428	-	2	-	1	3	10
N.J.	38	32	159	211	168	138	-	-	-	1	1	-
Pa.	16	23	151	334	198	215	-	1	-	5	6	1
E.N. CENTRAL	131	146	760	1,250	661	528	-	-	-	10	10	7
Ohio	53	44	181	210	86	86	-	-	-	3	3	2
Ind.	39	26	74	73	36	39	-	-	-	4	4	-
Ill.	10	48	212	546	113	90	-	-	-	3	3	3
Mich.	7	9	247	353	426	290	-	-	-	-	-	2
Wis.	22	19	46	68	-	23	-	-	-	-	-	-
W.N. CENTRAL	51	56	309	568	141	219	-	4	-	-	4	1
Minn.	30	29	30	161	16	30	-	2	-	-	2	1
Iowa	-	-	28	59	19	26	-	-	-	-	-	-
Mo.	13	17	86	230	73	107	-	2	-	-	2	-
N. Dak.	6	2	2	3	-	2	-	-	-	-	-	-
S. Dak.	-	1	2	1	1	1	-	-	-	-	-	-
Nebr.	1	3	29	26	17	32	U	-	U	-	-	-
Kans.	1	4	132	88	15	21	-	-	-	-	-	-
S. ATLANTIC	289	207	1,709	1,031	1,006	888	-	4	-	1	5	3
Del.	-	-	-	11	-	10	-	-	-	-	-	-
Md.	68	60	199	157	108	97	-	2	-	1	3	-
D.C.	-	-	33	20	11	27	U	-	U	-	-	-
Va.	21	33	101	116	124	120	-	1	-	-	1	2
W. Va.	14	6	10	52	20	10	-	-	-	-	-	-
N.C.	41	19	152	114	149	182	-	-	-	-	-	-
S.C.	5	7	62	48	24	13	-	-	-	-	-	-
Ga.	69	52	661	189	244	155	-	1	-	-	1	-
Fla.	71	30	491	324	326	274	-	-	-	-	-	1
E.S. CENTRAL	62	39	293	323	321	354	-	2	-	-	2	-
Ky.	2	12	98	41	32	62	-	2	-	-	2	-
Tenn.	32	16	112	112	172	165	-	-	-	-	-	-
Ala.	26	9	67	43	63	44	-	-	-	-	-	-
Miss.	2	2	16	127	54	83	-	-	-	-	-	-
W.S. CENTRAL	36	58	645	1,828	475	809	-	1	-	-	1	-
Ark.	-	2	59	115	71	75	-	-	-	-	-	-
La.	3	16	54	66	30	111	-	-	-	-	-	-
Okla.	33	38	99	199	69	113	-	-	-	-	-	-
Tex.	-	2	433	1,448	305	510	U	1	U	-	1	-
MOUNTAIN	116	90	589	673	395	383	1	2	-	1	3	12
Mont.	-	1	10	5	3	6	-	-	-	-	-	-
Idaho	1	3	50	19	10	6	1	1	-	1	2	-
Wyo.	-	1	6	4	2	2	-	-	-	-	-	-
Colo.	29	22	67	156	83	64	-	-	-	-	-	2
N. Mex.	18	18	30	60	119	110	-	-	-	-	-	-
Ariz.	52	35	317	339	121	143	-	1	-	-	1	-
Utah	6	7	63	41	25	17	-	-	-	-	-	3
Nev.	10	3	46	49	32	35	U	-	U	-	-	7
PACIFIC	89	89	1,463	2,463	868	942	-	28	-	18	46	21
Wash.	2	5	98	216	100	76	U	13	U	2	15	3
Oreg.	17	26	64	146	72	82	-	3	-	-	3	-
Calif.	42	30	1,286	2,077	672	765	-	10	-	11	21	14
Alaska	6	6	14	11	9	9	-	-	-	-	-	1
Hawaii	22	22	1	13	15	10	-	2	-	5	7	3
Guam	-	1	-	1	-	9	U	-	U	-	-	-
P.R.	1	3	80	203	131	208	-	-	-	-	-	2
V.I.	-	-	-	-	-	-	U	-	U	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	28	U	U	-	U	-	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

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

§ Of 252 cases among children aged <5 years, serotype was reported for 100, and of those, 17 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending September 22, 2001, and September 23, 2000 (38th Week)*

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000
UNITED STATES	1,635	1,660	1	159	264	51	3,273	4,779	-	17	123
NEW ENGLAND	89	100	-	-	4	1	279	1,200	-	-	12
Maine	2	8	-	-	-	-	-	33	-	-	-
N.H.	12	11	-	-	-	1	26	83	-	-	2
Vt.	5	2	-	-	-	-	26	181	-	-	-
Mass.	49	56	-	-	1	-	208	850	-	-	8
R.I.	3	8	-	-	1	-	5	14	-	-	1
Conn.	18	15	-	-	2	-	14	39	-	-	1
MID. ATLANTIC	168	186	-	18	20	-	230	465	-	5	9
Upstate N.Y.	46	52	-	3	7	-	118	201	-	1	1
N.Y. City	31	36	-	9	6	-	34	68	-	3	8
N.J.	40	35	-	2	3	-	13	30	-	1	-
Pa.	51	63	-	4	4	-	65	166	-	-	-
E.N. CENTRAL	219	291	-	15	19	20	469	565	-	3	1
Ohio	75	70	-	1	7	11	246	263	-	-	-
Ind.	33	32	-	1	1	5	61	75	-	1	-
Ill.	22	70	-	11	6	2	57	68	-	2	1
Mich.	49	84	-	2	4	2	51	60	-	-	-
Wis.	40	35	-	-	1	-	54	99	-	-	-
W.N. CENTRAL	113	117	-	7	16	-	187	368	-	3	1
Minn.	16	17	-	3	-	-	70	215	-	-	-
Iowa	21	25	-	-	7	-	19	44	-	1	-
Mo.	41	55	-	-	4	-	75	50	-	1	-
N. Dak.	5	2	-	-	1	-	-	3	-	-	-
S. Dak.	5	5	-	-	-	-	3	3	-	-	-
Nebr.	12	6	U	1	1	U	4	21	U	-	1
Kans.	13	7	-	3	3	-	16	32	-	1	-
S. ATLANTIC	308	231	-	28	38	6	182	352	-	4	72
Del.	4	-	-	-	-	-	-	8	-	-	-
Md.	36	26	-	5	9	2	29	87	-	-	-
D.C.	-	-	U	-	-	U	1	3	U	-	-
Va.	33	35	-	6	8	3	35	66	-	-	-
W. Va.	11	11	-	-	-	-	2	1	-	-	-
N.C.	59	32	-	3	5	-	51	77	-	-	64
S.C.	31	19	-	2	10	-	32	23	-	2	6
Ga.	36	38	-	7	2	-	7	34	-	-	-
Fla.	98	70	-	5	4	1	25	53	-	2	2
E.S. CENTRAL	112	114	1	6	5	4	93	92	-	-	6
Ky.	19	25	-	1	1	-	19	45	-	-	1
Tenn.	50	45	1	1	2	2	41	27	-	-	1
Ala.	30	31	-	-	2	2	29	17	-	-	4
Miss.	13	13	-	4	-	-	4	3	-	-	-
W.S. CENTRAL	178	173	-	9	28	5	270	284	-	-	8
Ark.	17	11	-	1	1	-	12	33	-	-	1
La.	56	40	-	2	5	-	2	18	-	-	1
Okla.	25	23	-	-	-	5	6	16	-	-	-
Tex.	80	99	U	6	22	U	250	217	U	-	6
MOUNTAIN	79	73	-	9	17	10	1,081	565	-	1	2
Mont.	4	4	-	1	1	-	31	33	-	-	-
Idaho	7	6	-	1	-	-	167	51	-	-	-
Wyo.	5	-	-	1	1	-	1	4	-	-	-
Colo.	27	25	-	1	-	5	210	310	-	1	1
N. Mex.	12	6	-	2	1	5	111	79	-	-	-
Ariz.	12	22	-	1	4	-	491	62	-	-	1
Utah	7	7	-	1	4	-	59	16	-	-	-
Nev.	5	3	U	1	6	U	11	10	U	-	-
PACIFIC	369	375	-	67	117	5	482	888	-	1	12
Wash.	53	40	U	1	9	U	110	282	U	-	7
Oreg.	32	51	N	N	N	5	42	95	-	-	-
Calif.	271	268	-	30	80	-	298	461	-	-	5
Alaska	2	8	-	1	8	-	3	18	-	-	-
Hawaii	11	8	-	35	20	-	29	32	-	1	-
Guam	-	-	U	-	12	U	-	3	U	-	1
P.R.	4	8	-	-	-	-	2	6	-	-	-
V.I.	-	-	U	-	-	U	-	-	U	-	-
Amer. Samoa	U	U	U	U	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.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

TABLE IV. Deaths in 122 U.S. cities,* week ending September 22, 2001 (38th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	549	418	85	32	6	8	50
Boston, Mass.	138	92	30	10	4	2	16
Bridgeport, Conn.	33	23	8	2	-	-	2
Cambridge, Mass.	21	15	2	4	-	-	2
Fall River, Mass.	35	30	3	2	-	-	4
Hartford, Conn.	48	36	9	3	-	-	-
Lowell, Mass.	23	19	3	1	-	-	-
Lynn, Mass.	11	9	2	-	-	-	-
New Bedford, Mass.	22	17	3	2	-	-	2
New Haven, Conn.	30	27	2	-	1	-	1
Providence, R.I.	63	46	13	1	1	2	2
Somerville, Mass.	4	4	-	-	-	-	-
Springfield, Mass.	33	25	3	2	-	3	3
Waterbury, Conn.	29	25	3	1	-	-	4
Worcester, Mass.	59	50	4	4	-	1	14
MID. ATLANTIC	991	699	196	62	17	16	69
Albany, N.Y.	48	41	5	1	1	-	5
Allentown, Pa.	12	9	3	-	-	-	-
Buffalo, N.Y.	80	59	16	5	-	-	11
Camden, N.J.	32	21	6	2	2	1	2
Elizabeth, N.J.	24	18	4	2	-	-	-
Erie, Pa.§	36	29	4	2	-	1	-
Jersey City, N.J.	44	32	9	2	1	-	-
New York City, N.Y.	U	U	U	U	U	U	U
Newark, N.J.	U	U	U	U	U	U	U
Paterson, N.J.	16	10	4	2	-	-	-
Philadelphia, Pa.	319	194	83	25	9	7	15
Pittsburgh, Pa.§	38	24	8	1	3	2	1
Reading, Pa.	24	17	5	2	-	-	1
Rochester, N.Y.	128	104	18	5	1	-	12
Schenectady, N.Y.	19	13	4	2	-	-	3
Scranton, Pa.§	30	25	3	2	-	-	1
Syracuse, N.Y.	90	68	15	2	-	5	14
Trenton, N.J.	33	20	8	5	-	-	3
Utica, N.Y.	18	15	1	2	-	-	1
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,633	1,088	346	115	37	47	112
Akron, Ohio	44	31	7	4	1	1	3
Canton, Ohio	35	29	5	-	1	-	5
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	100	65	17	11	3	4	5
Cleveland, Ohio	135	78	24	21	9	3	7
Columbus, Ohio	170	119	31	12	3	5	10
Dayton, Ohio	133	87	38	6	-	2	11
Detroit, Mich.	181	94	63	18	2	4	10
Evansville, Ind.	38	29	8	1	-	-	4
Fort Wayne, Ind.	74	59	7	4	3	1	1
Gary, Ind.	9	7	2	-	-	-	-
Grand Rapids, Mich.	56	39	8	2	5	2	4
Indianapolis, Ind.	203	132	44	13	4	10	23
Lansing, Mich.	61	43	11	4	-	3	1
Milwaukee, Wis.	102	67	22	8	2	3	7
Peoria, Ill.	37	31	6	-	-	-	5
Rockford, Ill.	60	36	17	2	1	4	4
South Bend, Ind.	39	28	8	3	-	-	1
Toledo, Ohio	97	67	19	4	2	5	9
Youngstown, Ohio	59	47	9	2	1	-	2
W.N. CENTRAL	604	422	118	34	14	18	37
Des Moines, Iowa	33	28	2	1	-	2	6
Duluth, Minn.	29	23	2	1	1	2	3
Kansas City, Kans.	U	U	U	U	U	U	U
Kansas City, Mo.	87	68	14	3	1	1	5
Lincoln, Nebr.	40	33	5	2	-	-	2
Minneapolis, Minn.	167	111	39	9	5	3	10
Omaha, Nebr.	94	60	26	4	1	3	4
St. Louis, Mo.	80	49	15	7	4	5	-
St. Paul, Minn.	74	50	15	7	2	-	7
Wichita, Kans.	U	U	U	U	U	U	U
S. ATLANTIC	1,267	798	293	107	45	24	94
Atlanta, Ga.	172	106	43	17	5	1	1
Baltimore, Md.	189	107	58	14	7	3	21
Charlotte, N.C.	116	74	25	11	-	6	13
Jacksonville, Fla.	157	107	34	7	6	3	12
Miami, Fla.	120	68	32	13	4	3	11
Norfolk, Va.	34	24	5	2	2	1	-
Richmond, Va.	71	41	21	4	2	3	2
Savannah, Ga.	59	41	12	4	1	1	6
St. Petersburg, Fla.	59	46	3	7	3	-	8
Tampa, Fla.	175	117	34	15	6	3	17
Washington, D.C.	100	55	23	13	9	-	3
Wilmington, Del.	15	12	3	-	-	-	-
E.S. CENTRAL	794	534	169	56	18	17	57
Birmingham, Ala.	146	95	35	8	4	4	12
Chattanooga, Tenn.	77	50	22	5	-	-	5
Knoxville, Tenn.	108	75	21	7	4	1	9
Lexington, Ky.	46	29	11	-	4	2	5
Memphis, Tenn.	159	106	34	12	1	6	10
Mobile, Ala.	105	71	22	8	1	3	4
Montgomery, Ala.	35	23	7	2	3	-	2
Nashville, Tenn.	118	85	17	14	1	1	10
W.S. CENTRAL	1,487	959	340	113	48	27	88
Austin, Tex.	94	52	27	11	3	1	8
Baton Rouge, La.	50	29	12	6	2	1	3
Corpus Christi, Tex.	55	41	5	7	-	2	2
Dallas, Tex.	188	102	49	19	12	6	8
El Paso, Tex.	116	83	22	5	4	2	4
Ft. Worth, Tex.	119	70	33	10	3	3	5
Houston, Tex.	376	231	101	33	7	4	17
Little Rock, Ark.	42	28	9	2	3	-	-
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	221	155	44	14	5	3	14
Shreveport, La.	106	76	19	4	5	2	13
Tulsa, Okla.	120	92	19	2	4	3	14
MOUNTAIN	1,005	720	165	73	24	23	66
Albuquerque, N.M.	161	119	25	11	6	-	12
Boise, Idaho	41	32	7	2	-	-	4
Colo. Springs, Colo.	72	51	12	6	1	2	4
Denver, Colo.	101	62	22	12	1	4	4
Las Vegas, Nev.	189	139	31	14	2	3	14
Ogden, Utah	30	22	5	2	1	-	1
Phoenix, Ariz.	144	87	29	12	8	8	7
Pueblo, Colo.	29	23	4	1	-	1	2
Salt Lake City, Utah	98	74	13	5	1	5	7
Tucson, Ariz.	140	111	17	8	4	-	11
PACIFIC	1,896	1,310	359	154	37	36	138
Berkeley, Calif.	17	14	3	-	-	-	2
Fresno, Calif.	126	74	30	14	4	4	4
Glendale, Calif.	35	31	3	1	-	-	6
Honolulu, Hawaii	72	57	9	5	1	-	3
Long Beach, Calif.	72	56	10	4	-	2	7
Los Angeles, Calif.	575	384	116	53	14	8	33
Pasadena, Calif.	16	13	2	-	-	1	2
Portland, Oreg.	162	106	39	14	1	2	7
Sacramento, Calif.	188	130	35	13	6	4	25
San Diego, Calif.	177	130	30	11	2	4	14
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	170	119	31	12	3	5	10
Santa Cruz, Calif.	25	23	2	-	-	-	4
Seattle, Wash.	109	65	24	14	2	4	12
Spokane, Wash.	59	41	11	4	1	2	4
Tacoma, Wash.	93	67	14	9	3	-	5
TOTAL	10,226¶	6,948	2,071	746	246	216	711

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 ³100,000. 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.

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