MMWR™
Morbidity and Mortality Weekly Report
Weekly August 9, 2002 / Vol. 51 / No. 31

West Nile Virus Activity — United States, July 31–August 7, 2002, and Louisiana, January 1–August 7, 2002

This report summarizes West Nile virus (WNV) surveillance data reported to CDC through ArboNET and by states and other jurisdictions as of August 7, 2002.

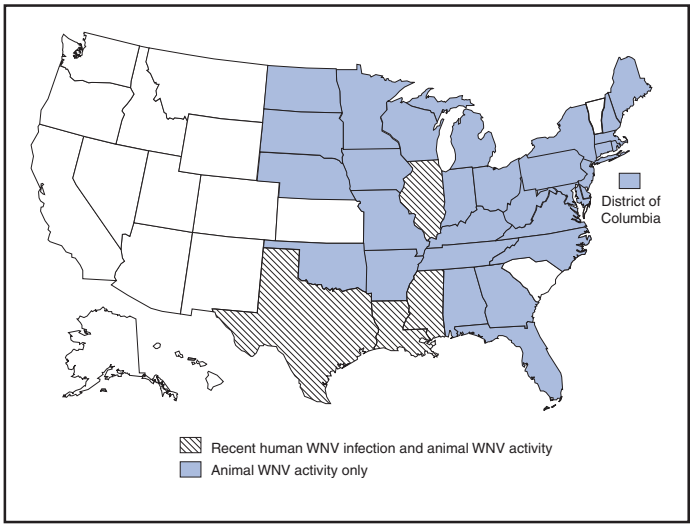
United States

During the reporting period of July 31–August 7, a total of 68 laboratory-positive human cases of WNV-associated illness were reported from Louisiana (n=40), Mississippi (n=23), Texas (n=four), and Illinois (n=one). During the same period, WNV infections were reported in 447 dead crows, 263 other dead birds, 42 horses, and 183 mosquito pools.

During 2002, a total of 112 human cases with laboratory evidence of recent WNV infection have been reported from Louisiana (n=71), Mississippi (n=28), Texas (n=12), and Illinois (n=one). Five deaths have been reported, all from Louisiana. Among the 98 cases with available data, 59 (60%) occurred among men; the median age was 55 years (range: 3–88 years), and the dates of illness onset ranged from June 10 to July 29.

In addition, 1,076 dead crows and 827 other dead birds with WNV infection were reported from 34 states, New York City, and the District of Columbia (Figure 1); 87 WNV infections in horses have been reported from 12 states (Alabama, Florida, Georgia, Illinois, Kentucky, Louisiana, Minnesota, Mississippi, North Dakota, South Dakota, Tennessee, and Texas). During 2002, WNV seroconversions have been reported in 52 sentinel chicken flocks from Florida, Nebraska, and Pennsylvania; and 425 WNV-positive mosquito pools have been reported from 12 states (Alabama, Georgia, Illinois, Indiana, Massachusetts, Mississippi, New Jersey, Ohio, Pennsylvania, South Dakota, Texas, and Virginia), New York City, and the District of Columbia.

FIGURE 1. Areas reporting West Nile virus (WNV) activity — United States, 2002*



* As of August 7, 2002.

INSIDE

The *MMWR* series of publications is published by the Epidemiology Program Office, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

SUGGESTED CITATION
Centers for Disease Control and Prevention. [Article Title]. MMWR 2002;51:[inclusive page numbers].

Louisiana

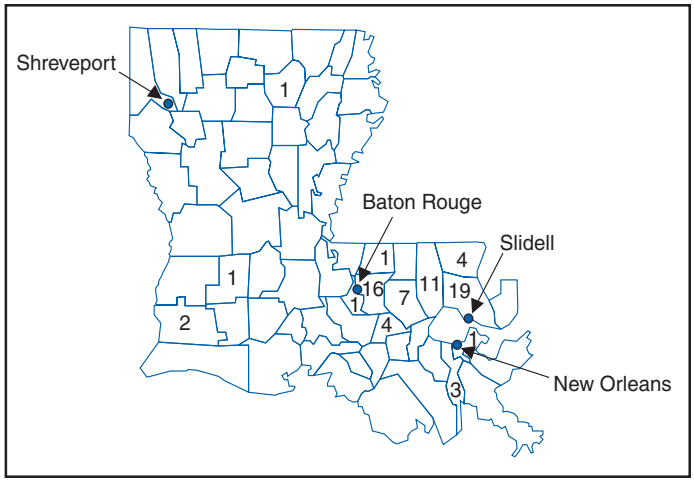
During January 1–August 7, Louisiana Office of Public Health (LOPH) has identified 71 laboratory-positive human cases of WNV. Clinically, 55 patients presented with WNV-associated meningoencephalitis (including five fatalities) and nine with WNV-associated fever. The clinical presentations of seven patients have not been ascertained.

Of the 71 cases, 38 (54%) occurred in males. Patients ranged in age from 13 to 88 years (median: 55 years). Decedents ranged in age from 53 to 83 years (median: 75 years). Patients resided in 13 different Louisiana parishes including the southeast (Ascension, East Baton Rouge, East Feliciana, Jefferson, Livingston, Orleans, St. Tammany, Tangipahoa, Washington, West Baton Rouge), southwest (Allen and Calcasieu), and north (Ouachita) regions of the state (Figure 2).

LOPH, with the assistance of CDC, has initiated a hospital-based, active surveillance system for viral encephalitis and meningitis. In addition, the incidence of WNV-associated fever in the community is being investigated through intensive evaluation of febrile patients with symptoms compatible with WNV-associated fever who consult physicians and hospitals. A clinical case-series has been established, and entomological and avian studies are under way.

Surveillance for WNV has been ongoing in Louisiana since spring 2000 and involves testing of dead birds, sick horses, mosquito pools, and sentinel chicken flocks. The increase in dead bird collections during the last week of May 2002 triggered the intensification of mosquito-control activities, including warnings to mosquito-control district staff and communities. The Louisiana Department of Health and Hospitals also created a website (http://www.FightTheBiteLouisiana.com) to provide the public with information about personal protective measures. A related media campaign was launched dur-

FIGURE 2. Number of West Nile virus cases in humans, by parish — Louisiana, January 1–August 7, 2002



ing the third week of June. Mosquito surveillance has guided vector-control activities, including larviciding of potential breeding sites and ultra-low volume applications of insecticide against adult mosquitoes.

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.

Outbreak of *Salmonella* Serotype Javiana Infections — Orlando, Florida, June 2002

On July 16, 2002, the Minnesota Department of Health identified two cases of *Salmonella* serotype Javiana infections among persons who had attended the 2002 U.S. Transplant Games held at theme park A in Orlando, Florida, during June 25–29. Isolates from both patients were indistinguishable by pulsed field gel electrophoresis (PFGE). The U.S. Transplant Games is a 4-day athletic competition among recipients of solid organ transplants (i.e., heart, liver, kidney, lung, and pancreas) and bone marrow transplants. Approximately 6,000 persons from the United States and five other countries, including 1,500 transplant-recipient athletes, participated in the games. This report summarizes the results of an ongoing epidemiologic and laboratory investigation that has identified 141 ill persons in 32 states who attended the games.

For case ascertainment and investigation purposes, a web-based survey was distributed electronically on July 20 to 1,100 attendees with known e-mail addresses, including athletes, donors, family members, and transplant professionals. Anonymous e-mail addresses for these persons were obtained from the organizers of the games. A case was defined as fever or diarrhea with onset during June 25–July 7 in a person who visited Orlando. A total of 369 (34%) persons responded by August 1; of these, 296 (80%) responded by July 22. Ninety-four (25%) persons reported that at least one household member had an illness that met the case definition, representing 141 ill persons.

For each of the 369 households, detailed information was collected for one person who was selected on the basis of birth date. Among these persons, 82 (22%) reported illness. The median age of ill respondents was 47 years (range: 4–71 years); 48 (59%) were transplant recipients, and 43 (52%) were receiving immunosuppressive therapy. Dates of illness onset ranged from June 26 to July 7. Predominant symptoms included diarrhea (93%), abdominal pain (79%), and fever (51%). Three (4%) respondents were hospitalized.

All survey respondents were asked about places they stayed, events they attended, and foods they ate while in Orlando. Fifty-one (66%) ill persons stayed at resorts located in theme park A during their time in Orlando, and 75 (91%) reported eating food items at establishments located in theme park A. On July 31, a second web-based survey containing questions about potentially suspect food items available in theme park A was distributed electronically to the 369 persons who responded to the first survey. Ill persons were asked about specific foods eaten during the 3 days before illness onset, and well persons were asked about the middle 3 days of the games (June 26–28). By August 2, a total of 222 (60%) persons had responded to the second survey; 41 had been ill. Univariate analysis demonstrated that ill persons were significantly more likely to report eating foods containing diced Roma tomatoes than were well persons (44% of ill versus 14% of well persons; adjusted odds ratio=4.3; 95% confidence interval=2.1–9.1). Preliminary microbiologic evaluation indicates fecal coliform contamination of the diced tomatoes.

To identify other potential cases of *S.* Javiana, the PFGE pattern for the outbreak strain was posted on PulseNet, the National Molecular Subtyping Network for Foodborne Disease Surveillance. A total of 18 additional infections caused by *S.* Javiana with an indistinguishable PFGE pattern were identified in nine states (Illinois, Massachusetts, Michigan, Minnesota, New Hampshire, North Carolina, Pennsylvania, Tennessee, and Virginia). Of 16 patients who were interviewed, one was a games participant, and 12 others had visited theme park A during the last week of June but did not attend the games. Dates of illness onset ranged from June 24 to July 8. State and local health departments are investigating additional cases to establish epidemiologic links to the outbreak.

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Editorial Note: Salmonellosis causes an estimated 1.4 million illnesses each year in the United States (*1*). *S.* Javiana is the fifth most common *Salmonella* serotype in the United States and accounted for 3.4% of *Salmonella* isolates reported to CDC during 2001 (CDC, unpublished data, 2002). The majority of persons infected with *Salmonella* have diarrhea, fever, and abdominal cramps 12–72 hours after exposure. The illness usually lasts 4–7 days, and the majority of persons recover without treatment.

Persons with impaired immune systems are at increased risk for having a more severe illness, atypical symptoms, and complications of infection. Among organ transplant recipients,

salmonellosis is associated strongly with antirejection therapy (*2*), and febrile illness with bacteremia is a more common presentation (*3*). Organ transplant patients are at increased risk for focal manifestations of illness including meningitis, urinary tract infections, abscesses of soft tissues, septic arthritis, osteomyelitis, and vascular infections, including infections of vascular grafts (*4–6*). Recurrence of nontyphoidal salmonellosis is common among this population and might occur in up to 35% of renal transplant recipients (*2,3*).

Physicians caring for recipients of solid organ and bone marrow transplants should be aware of possible exposure to *S.* Javiana at the 2002 U.S. Transplant Games and should consider obtaining cultures (i.e., stool, blood, and urine) from ill patients with this exposure. The optimal therapy for *Salmonella* infection in transplant recipients is not known (*4*). However, because of the increased susceptibility to infection and the potential for complications, physicians might consider empiric antimicrobial therapy in transplant recipients with suspected salmonellosis from whom appropriate cultures have been obtained. The strain of *S.* Javiana responsible for this outbreak is susceptible to several commonly used antimicrobials, including trimethoprim-sulfamethoxazole, ciprofloxacin, and ceftriaxone. Physicians should report culture-confirmed cases of salmonellosis to their local health department.

The use of a web-based survey in this investigation allowed a substantial number of persons who were dispersed geographically to be asked about potential exposures in a relatively short period of time. Twelve culture-confirmed cases of *S.* Javiana among visitors to theme park A who did not attend the games were identified through PulseNet, indicating that the number of ill persons in this outbreak is probably much larger than what has been identified in the surveyed Transplant Games population. The combination of molecular subtyping, web-based technology, and routine public health surveillance facilitated the outbreak investigation.

The findings in this report are subject to at least two limitations. First, a web-based investigation limited responses to only those attendees with known e-mail addresses and Internet access. Second, although responses were received from both well and ill persons, households with ill persons might have been more likely to respond to a web-based survey. Therefore, it is difficult to calculate an accurate attack rate among attendees of the games.

Preliminary findings of the epidemiologic investigation have implicated fresh, pre-packaged diced Roma tomatoes supplied to theme park A as the probable vehicle for this outbreak. Efforts are under way to identify the source of these tomatoes and possible routes of contamination. Tomatoes are not a commonly recognized vehicle for *Salmonella,* and no evidence exists for widespread contamination of tomatoes available for purchase. However, tomatoes have been implicated in at least one previous outbreak of *S.* Javiana infections (*7*), and cut surfaces of tomatoes and other fresh fruits and vegetables can support the growth of *Salmonella* and other enteric pathogens (*8,9*). Produce is recognized increasingly as a source of *Salmonella* infections in the United States, and consumers should wash tomatoes and other produce items thoroughly before eating. The Food and Drug Administration guidelines for safe produce-handling practices are available at http://www.cfsan.fda.gov/~lrd/tpproduc.html.

Acknowledgments

This report is based on data contributed by R Baker, MS, Florida Dept of Health. C Langkop, MSPH, Illinois Dept of Public Health. T LaPorte, MS, Massachusetts Dept of Public Health. S Bidol, MPH, Michigan Dept of Community Health. L Anderson, MD, New Hampshire Dept of Health and Human Svcs. P Jenkins, North Carolina Dept of Health and Human Svcs. J Murphy, DVM, Virginia Dept of Health.

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Childhood Lead Poisoning Associated with Tamarind Candy and Folk Remedies — California, 1999–2000

Lead poisoning affects children adversely worldwide. In the United States, elevated blood lead levels (BLLs) (≥10 μg/dL)

result primarily from exposure to lead-based paint or from associated lead-contaminated dust and soil; however, other sources of lead exposure, including folk remedies, Mexican terra cotta pottery, and certain imported candies, also have been associated with elevated BLLs in children (*1*). This report describes five cases in California of lead poisoning from atypical sources. Health-care providers should be aware of the potential hazards of certain food products, and community members should be educated about potential sources of lead poisoning for children.

Case Reports

Cases 1 and 2. In March 1999, two Hispanic children residing in Stanislaus County in the Central Valley, a boy aged 4 years and his sister aged 6 years, were identified during routine screening by California's Child Health and Disability Prevention (CHDP) Program. The boy had a BLL of 88.0 g/dL and the girl a BLL of 69.0 μg/dL. Both children underwent chelation therapy. Their parents had not traveled recently outside the United States but had used greta, a Mexican folk remedy (taken commonly for stomachache or intestinal illness) that usually contains high levels of lead. No pottery in the home tested positive for lead, and tests on paint and dust from their home did not indicate high lead levels. Greta powder collected from the family's home had 770,000 parts per million (ppm) of lead, and miniblinds on the windows of the home tested positive for lead by swab. Imported candies, including Dulmex-brand Bolirindo lollipops, which were identified later to be contaminated with lead, were found in the home.

Case 3. In May 2000, a Hispanic boy aged 4 years residing in Fresno County was identified during routine CHDP screening with a BLL of 26 μg/dL. His family had moved to California recently from Oaxaca, Mexico, where they had used a ceramic bean pot and water jug regularly. An environmental investigation did not reveal high lead levels in dust, paint, or soil, but tests on imported candies collected from the home revealed a candy wrapper with a lead level of 16,000 ppm. The child's BLL had decreased to 13.2 μg/dL by February 2002.

Case 4. In June 2000, a Hispanic boy aged 2 years residing in Orange County was identified through routine screening as having a BLL of 26 μg/dL. The family's house was built in 1963 and had been renovated during early 2000. Tests on soil, paint, and dust in and around the child's home did not reveal high lead levels. The child had been given greta and azarcon (a folk remedy that usually contains substantial amounts of lead) and had eaten various imported tamarind fruit candies purchased routinely by his family in Mexico. High lead levels were found in one of the three brands of imported candies the child had eaten. A Dulmex-brand Bolirindo lollipop had levels of 404 ppm and 21,000 ppm of lead in the stick and wrapper, respectively, and 0.2 ppm and 0.3 ppm in the candy and seed, respectively. Subsequent tests by the Food and Drug Administration (FDA) confirmed high lead levels in the wrapper of this product, and a public health warning was issued by FDA and the California Department of Health Services (CDHS).

Case 5. In August 2000, a Hispanic boy aged 4 years residing in Los Angeles County was identified through routine screening by California's Medicaid program with a BLL of 22 μg/dL. When the child was tested at age 1 year, he had an acceptable BLL of 5 μg/dL. Family members reported that he had been eating Mexican candies regularly for 3 years but denied use of folk remedies and imported pottery. An environmental investigation of their apartment, which was built in 1986, did not reveal high lead levels. The child was born in the United States and had not traveled to Mexico, and investigators identified no other potential sources of lead other than the Mexican candies. The family was advised not to allow the child to eat Mexican candies. As of December 2001, the boy's BLL had decreased to 11 μg/dL.

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Editorial Note: The findings in this report underscore the importance of routine screening for lead and of conducting a thorough risk assessment of children with elevated BLLs including taking a complete history and environmental sampling. Although household paint and resulting contaminated dust and soil are the most common sources of exposure, all sources of lead poisoning should be identified and removed.

Of approximately 1,000 cases of elevated BLLs among California children that were reported to CDHS during May 2001–January 2002, candy produced in Mexico was identified as a possible exposure source in approximately 150 cases. When children eat lead-contaminated candies, exposure can exceed FDA's provisional tolerable daily intake level (PTIL) for lead of 6 μg in a typical 30-g food serving. FDA's PTIL corresponds to a lead intake capable of elevating the BLLs of a small child by 1 μg/dL. In the cases described in this report, the wrappers often contained amounts of lead that could greatly exceed FDA's PTIL if the lead were to leach into the candy. In addition, a substantial quantity of the lead could be released into saliva by a child licking the wrapper. When conducting investigations of lead exposures, clinicians and health educators are encouraged to consider inquiring about these

products, together with folk remedies and the use of imported pottery, as potential sources of lead poisoning.

Lead poisoning associated with tamarind candy has been reported previously (*2*–*5*). Although the lead content of the particular candies that the five children described in this report ate could not be measured because the candy had been eaten, substantial concentrations of lead were found in the wrappers in four cases. Because the candies are sticky and can adhere to the wrapper, the children might have ingested lead from the wrapper; in addition, other sources of lead exposure (e.g., greta consumption) were found. In the cases described in this report, the frequency of eating Mexican candies and the brands eaten were not always ascertained. An investigation is ongoing to determine which specific candy products are contaminated with lead. CDHS has identified lead in several other tamarind candies. In addition, FDA has embargoed food products containing tamarind fruit from entry into the United States because of filth from insects, rodents, and other pests.

These cases illustrate successful cooperation between FDA and state and local health departments to identify lead-contaminated products. Health-care providers should be aware of the potential hazards of food products, including candy, when evaluating a child with an elevated BLL. In addition, increasing education efforts are needed to inform persons in Hispanic communities that certain Mexican candies, pottery, and folk remedies can be potential sources of lead poisoning for children (*6*). Additional information about childhood lead poisoning is available from CDHS at http://www.dhs.ca.gov/ps/deodc/childlead and from CDC at http://www.cdc.gov/nceh/lead/lead.htm.

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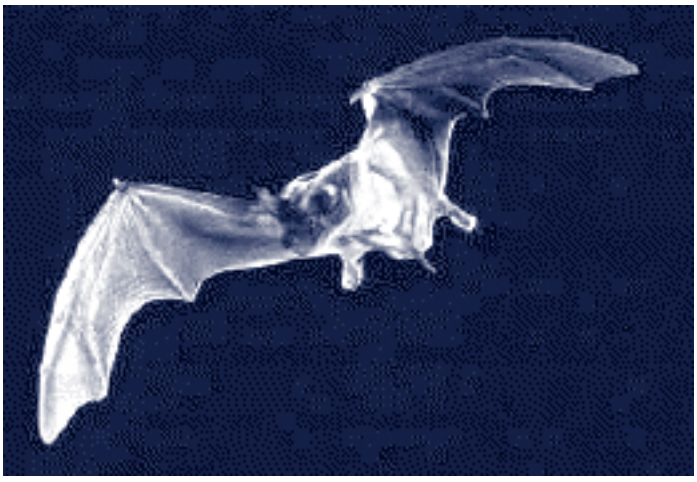
Human Rabies — California, 2002

On March 31, 2002, a man aged 28 years residing in Glenn County, California, died from rabies encephalitis caused by a rabies virus variant associated with the Mexican free-tailed bat (*Tadarida brasiliensis*) (Figure). This report summarizes the investigation by the Glenn County Health Department (GCHD) and the California Department of Health Services (CDHS). Persons who observe abnormal behavior in any wildlife species should contact animal control or animal rescue agencies immediately and should avoid approaching or handling these animals.

On March 18, the patient sought medical care at the emergency department (ED) of a medical center with symptoms including headache, jaw pain, photophobia, agitation, dizziness, numbness, nausea, and vomiting. He was treated for dehydration, administered analgesics, and discharged. On the following day, the patient returned to the ED with increasing headache, pain, agitation, tingling of the head and legs, nausea, and vomiting. The patient was hospitalized later that evening, and treatment was initiated with ceftriaxone. A computerized tomography scan performed on March 19 was unremarkable, except for right-sided ethmoid sinusitis. Lumbar punctures were performed on March 19 and March 22 and yielded normal results. Laboratory results from serum specimens obtained on March 28 indicated hyponatremia of 131 meq/L (normal: 136–145 meq/L), decreased uric acid of 1.5 mg/dL (normal: 2.5–8.0 mg/dL), creatine phosphokinase of 236 units/ml (normal: 25–90 units/ml), and a white blood cell count of 11,500/uL (normal: 3,700–9,400/uL). Blood and cerebrospinal fluid bacterial cultures were negative. The

FIGURE. Mexican free-tailed bat (*Tadarida brasiliensis*)



Photo/CDC

patient's condition continued to deteriorate with symptoms of a rapidly progressive encephalopathy. He had fever, incoherent speech, increased agitation, and copious salivation. The patient became comatose on March 27 and was placed on ventilatory support; support was withdrawn on March 31, and the patient died.

On March 27, rabies was suspected, and samples, including serum, corneal impressions, a nuchal biopsy, and saliva, were collected and sent to the CDHS Viral and Rickettsial Disease Laboratory (VRDL). No rabies virus–specific antibody was detected in the serum, and the direct fluorescent antibody (DFA) test on corneal impressions was inconclusive. On March 29, additional samples of serum and corneal impressions were collected and showed that the corneal impressions were positive for rabies virus–specific antigen by DFA and that the saliva sample was positive for rabies virus RNA by reverse transcription polymerase chain reaction (RT-PCR). The nuchal biopsy was negative by DFA. Rabies was diagnosed presumptively pending confirmation by CDC. Serum samples also were collected on March 30 and 31. The diagnosis was confirmed by CDC on April 1, with a saliva sample positive by RT-PCR. The virus was identified by genetic sequence analysis as a variant associated with the Mexican free-tailed bat. Rabies virus–specific antibody was detected at VRDL by indirect immunofluorescent antibody test in the serum samples from March 30 and 31. Histopathology results of brain tissue obtained from the autopsy showed lymphocytic infiltration of the meninges and perivascular areas within the brain parenchyma. Eosinophilic inclusions consistent with Negri bodies were found primarily in the brainstem. These features were consistent with a diagnosis of rabies viral encephalitis.

The patient's family reported that he had killed a bat in his house on March 10, although he had denied having any direct contact. The family also reported numerous bats in the home environment. An investigation of the patient's home by GCHD revealed a bat colony in the attic of the house. A bat that appeared ill was found inside the living spaces of the house on March 31 and was submitted for rabies testing and species identification. The bat was identified as a Mexican free-tailed bat; it was negative for rabies by DFA.

Four household members, two other family members, and 12 social contacts received postexposure prophylaxis (PEP) because of possible exposure to the patient through saliva. In addition, 28 health-care workers who had contact with the patient also received PEP.

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Editorial Note: This report describes a case of human rabies caused by a Mexican free-tailed bat virus variant occurring in Glenn County, California, in 2002. The last case of human rabies acquired endemically in California occurred in September 2000 in Amador County and was associated with the same variant. A definitive exposure through an animal bite was not established for the patient in this report. The proximity of a bat colony suggests an unrecognized bite as the most probable source of exposure. Because the typical incubation period of rabies extends from weeks to months, it is unlikely that the patient's experience with a bat 1 week before illness was the source of exposure. Because the patient's home housed a bat colony, other unrecognized exposures appear likely.

In the contiguous United States, bats are a reservoir for the rabies virus, and distinct viral variants can be distinguished and associated with particular bat species. During 1990–2000, a total of 24 (75%) of 32 human rabies cases were attributed to variants of rabies virus associated with bats (*1*). Five cases were associated with the Mexican free-tailed bat rabies virus variant; only one person reported an exposure through a bite. Although they prefer undisturbed habitats, Mexican free-tailed bats roost in buildings, increasing the chance of contact between bats and humans (*2*). Only two of 24 patients with rabies caused by a bat-associated virus had been bitten by a bat (*1,3*). Rabies virus can be transmitted into bite wounds, open cuts, abrasions, or mucous membranes through saliva (*4*).

Because bats have small teeth, a bite might go undetected or be minor. Situations in which an exposure might have occurred in the absence of an obvious bite wound include awakening and observing a bat in the room, finding a bat in the room of an unattended child, or seeing a bat near a mentally impaired or intoxicated person. Persons cannot become infected with rabies from having contact with bat guano (feces), blood, or urine or from touching a bat on its fur. In all cases in which bat-human contact has occurred, the bat should be collected and submitted for rabies testing. If the bat is not available, local or state public health officials should be contacted to evaluate the need for rabies prophylaxis. Human and domestic animal contact with bats may be minimized by physical exclusion of bats from dwellings. Bats and other wildlife should not be handled, fed, or kept as pets. If abnormal behavior is observed in any wildlife species, animal control or animal rescue agencies should be contacted. Additional information about rabies is available from CDC at http://www.cdc.gov/ncidod/dvrd/rabies.

Acknowledgments

This report is based on data contributed by D Schnurr, PhD, R Devlin, MT, S Honarmand, E Tu, A Hewitt, E Yeh, C Kohlmeier, A Wong, D Constantine, DVM, Viral and Rickettsial Disease Laboratory; M Jay, DVM, B Sun, DVM, Div of Communicable Disease Control, California Dept of Health Svcs; D Galvon, MD, G Norton, D Holm, Glenn County Health Dept, Willows; M Lundberg, MD, T Baptista, Butte County Health Dept, Oroville; S Forner, MD, E O'Regan, MD, Enloe Medical Center; L Wong, MD, Path Sciences Medical Group, Chico, California. C Hanlon, VMD, L Orciari, MS, M Niezgoda, MS, J Smith, MS, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases, CDC.

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Public Health Dispatch

Outbreak of Tularemia Among Commercially Distributed Prairie Dogs, 2002

Tularemia has been identified recently as the cause of a die-off in captured wild prairie dogs (*Cynomys ludovicianus*) (Figure) at a commercial exotic animal distributor in Texas. The Texas Department of Health and CDC immediately notified all state health departments and are investigating the outbreak.

FIGURE. Black-tailed prairie dogs (*Cynomys ludovicianus*)

Photo/CDC

Until shipments were halted on August 1, 2002, approximately 250 of an estimated 3,600 prairie dogs that passed through the Texas facility had died. The sick animals were believed to be part of a single shipment of prairie dogs that were caught in South Dakota starting on May 18 and shipped to the Texas distributor on June 16. All prairie dogs that were shipped by the Texas facility after June 16 or by the South Dakota trader after May 18 are being recalled.

Potentially infected prairie dogs were distributed to wholesalers, retailers, and persons in Arkansas, Florida, Illinois, Michigan, Mississippi, Nevada, Ohio, Texas, Washington, and West Virginia and exported to Belgium, the Czech Republic, Japan, The Netherlands, and Thailand. States and countries that received shipments of potentially infected animals have been notified. Unusually high numbers of sick or dead prairie dogs were reported from Texas and the Czech Republic.

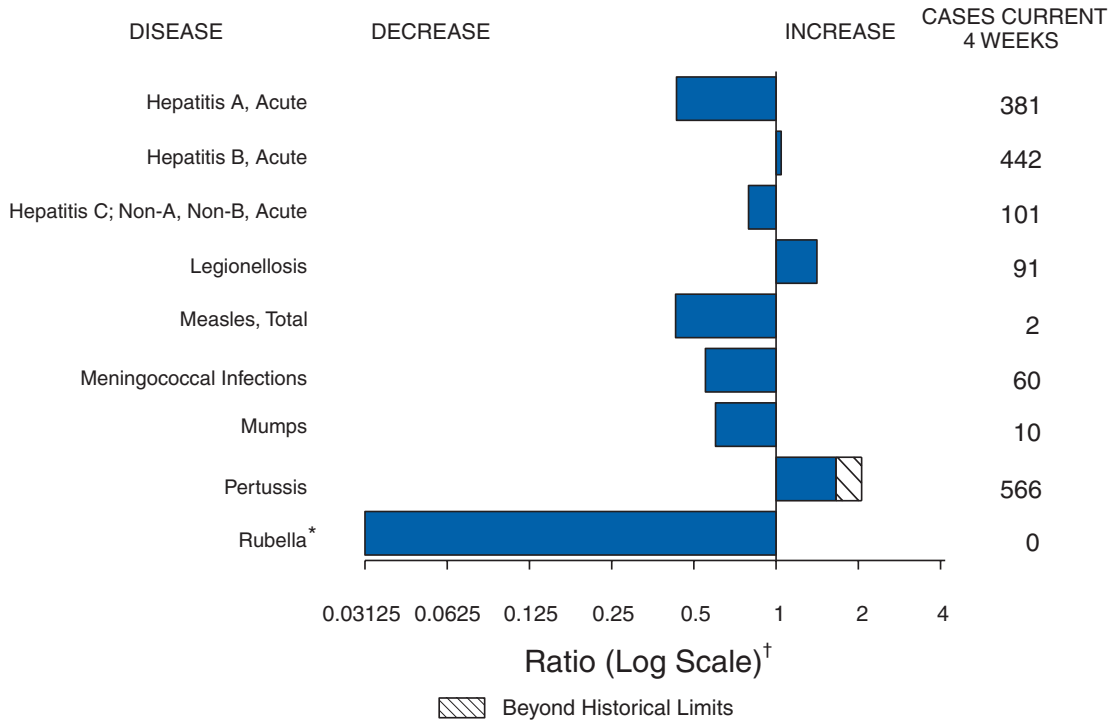
Tularemia is caused by infection with *Francisella tularensis*. The incubation time in humans is normally 2–6 days but can be 1–14 days. The disease usually begins suddenly with high fever, chills, head and muscle aches, and a feeling of weakness. Chest discomfort and a dry cough are common. Other symptoms might appear depending on how the infection is acquired. For example, if the bacteria enter through a break in the skin, an ulcer will usually develop at the site of entry, accompanied by regional lymphadenopathy. In the United States, humans usually acquire tularemia by handling wild rabbits (e.g., while skinning the animal) or by being bitten by infective ticks and certain flies (e.g., deer flies and horse flies). Two known *F. tularensis* biotypes exist in the United States. Type A is more virulent than type B, but both can result in severe and sometimes fatal illness. *F. tularensis* recovered from the sick prairie dogs was type B.

Adults who have handled sick or dead prairie dogs from the suspected shipments in the last 2 weeks are being advised to take doxycycline (100 mg twice daily for 14 days) or ciprofloxacin (500 mg twice daily for 14 days). Because these drugs have a higher risk for side effects in children, children who are considered at risk should not take antibiotics but have their temperature monitored for 14 days. Persons who have been in contact with prairie dogs during the preceding 2 weeks and who have fever and other symptoms suggesting tularemia should see their physician. Preferred drugs for treatment of tularemia are gentamicin and streptomycin.

To report human tularemia cases that might be associated with prairie dog exposure or to inquire about shipment of potentially infected prairie dogs, state health departments should contact CDC's Division of Vector-borne Infectious Diseases, telephone 970-221-6400, fax 970-221-6476, e-mail ncidprairiedoginquiries@cdc.gov.

(Continued on page 699)

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending August 3, 2002, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 31 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 August 3, 2002 (31st Week)*

		Cum. 2002	Cum. 2001		Cum. 2002	Cum. 2001
Anthrax		2	1	Encephalitis: West Nile†	33	3
Botulism:	foodborne	9	12	Hansen disease (leprosy)†	49	44
	infant	37	57	Hantavirus pulmonary syndrome†	8	5
	other (wound & unspecified)	9	9	Hemolytic uremic syndrome, postdiarrheal†	99	77
Brucellosis†		45	72	HIV infection, pediatric†§	116	107
Chancroid		41	23	Plague	-	2
Cholera		4	3	Poliomyelitis, paralytic	-	-
Cyclosporiasis†		104	71	Psittacosis†	14	9
Diphtheria		1	1	Q fever†	22	16
Ehrlichiosis:	human granulocytic (HGE)†	165	111	Rabies, human	1	1
	human monocytic (HME)†	62	64	Streptococcal toxic-shock syndrome†	58	55
	other and unspecified	4	4	Tetanus	18	24
Encephalitis:	California serogroup viral†	23	14	Toxic-shock syndrome	71	79
	eastern equine†	1	2	Trichinosis	10	11
	Powassan†	-	-	Tularemia†	36	72
	St. Louis†	-	4	Yellow fever	1	-
	western equine†	-	-			

-:No reported cases.
* Incidence data for reporting year 2001 and 2002 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 July 28, 2002.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending August 3, 2002, and August 4, 2001 (31st Week)*

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7		*Escherichia coli* Shiga Toxin Positive, Serogroup non-O157	
	Cum. 2002§	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	24,713	23,760	435,265	449,014	1,217	1,369	1,309	1,365	55	57
NEW ENGLAND	1,011	845	15,265	12,917	73	64	122	140	15	23
Maine	23	22	859	708	3	6	17	17	-	-
N.H.	20	16	943	791	14	2	9	18	-	3
Vt.	8	10	460	347	15	18	4	9	-	-
Mass.	519	479	6,277	5,038	22	28	58	70	6	7
R.I.	71	61	1,631	1,660	13	3	5	6	-	-
Conn.	370	257	5,095	4,373	6	7	29	20	9	13
MID. ATLANTIC	5,619	6,282	43,874	48,329	148	170	103	107	-	-
Upstate N.Y.	404	976	9,738	7,861	50	51	84	64	-	-
N.Y. City	3,210	3,338	16,956	17,929	64	69	4	9	-	-
N.J.	925	1,070	4,157	7,607	8	9	15	34	-	-
Pa.	1,080	898	13,023	14,932	26	41	N	N	-	-
E.N. CENTRAL	2,494	1,689	76,351	82,761	319	498	320	320	4	3
Ohio	453	300	19,572	21,432	78	79	67	75	3	2
Ind.	347	197	9,560	9,125	26	38	32	43	-	-
Ill.	1,170	776	18,911	25,076	43	77	92	89	-	-
Mich.	398	322	18,855	17,528	60	87	52	36	1	1
Wis.	126	94	9,453	9,600	112	217	77	77	-	-
W.N. CENTRAL	421	504	24,321	22,733	137	153	210	192	5	4
Minn.	90	92	5,523	4,620	60	69	70	72	3	2
Iowa	54	54	2,765	2,742	13	34	51	30	-	-
Mo.	189	233	8,553	8,163	18	25	33	30	N	N
N. Dak.	1	1	522	603	6	7	3	9	-	-
S. Dak.	3	18	1,196	969	5	5	20	12	1	1
Nebr.	43	51	1,857	2,054	26	13	16	24	1	1
Kans.	41	55	3,905	3,582	9	-	17	15	-	-
S. ATLANTIC	7,537	7,131	83,225	87,248	181	194	125	106	18	14
Del.	131	142	1,557	1,697	2	2	4	1	-	-
Md.	1,066	899	8,657	8,983	13	28	7	7	-	-
D.C.	371	507	1,908	1,958	4	9	-	-	-	-
Va.	538	593	9,422	11,423	5	13	28	29	2	2
W. Va.	58	50	1,345	1,392	2	1	2	4	-	-
N.C.	555	494	14,614	12,897	23	18	19	27	-	-
S.C.	547	434	7,355	9,220	2	3	1	3	-	-
Ga.	1,160	852	15,586	18,281	84	81	43	19	9	7
Fla.	3,111	3,160	22,781	21,397	46	39	21	16	7	5
E.S. CENTRAL	1,128	1,075	29,358	29,492	83	26	55	67	-	-
Ky.	173	219	5,060	5,213	3	3	13	31	-	-
Tenn.	483	333	9,470	8,898	43	5	23	22	-	-
Ala.	197	260	8,506	8,175	33	9	13	9	-	-
Miss.	275	263	6,322	7,206	4	9	6	5	-	-
W.S. CENTRAL	2,696	2,406	62,840	63,591	18	45	19	126	-	-
Ark.	163	123	3,893	4,589	6	5	5	5	-	-
La.	693	548	11,112	10,635	4	7	1	4	-	-
Okla.	133	128	6,240	6,429	8	6	13	14	-	-
Tex.	1,707	1,607	41,595	41,938	-	27	-	103	-	-
MOUNTAIN	790	843	27,054	26,422	89	72	141	133	8	8
Mont.	8	13	1,309	1,231	4	6	9	7	-	-
Idaho	18	16	1,470	1,011	18	8	11	18	2	2
Wyo.	6	2	503	482	6	1	3	5	1	-
Colo.	157	184	8,232	7,641	26	20	48	54	2	4
N. Mex.	53	75	3,234	3,442	14	12	4	9	2	2
Ariz.	327	336	8,789	8,764	12	4	16	16	1	-
Utah	43	71	1,280	985	6	17	36	17	-	-
Nev.	178	146	2,237	2,866	3	4	14	7	-	-
PACIFIC	3,017	2,985	72,977	75,521	169	147	214	174	5	5
Wash.	302	325	8,327	8,084	24	U	30	48	-	-
Oreg.	216	119	4,052	4,307	26	18	55	25	5	5
Calif.	2,416	2,489	55,999	59,207	118	126	99	89	-	-
Alaska	17	14	2,089	1,623	-	-	5	3	-	-
Hawaii	66	38	2,510	2,300	1	3	25	9	-	-
Guam	2	8	-	248	-	-	N	N	-	-
P.R.	668	732	1,635	1,582	-	-	-	1	-	-
V.I.	66	2	98	111	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	122	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 and 2002 are provisional and cumulative (year-to-date).

† 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 July 28, 2002.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 3, 2002, and August 4, 2001 (31st Week)*

Reporting Area	*Escherichia coli* Shiga Toxin Positive, Not Serogrouped		Giardiasis	Gonorrhea		*Haemophilus influenzae*, Invasive			
						All Ages, All Serotypes		Age <5 Years Serotype B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	24	7	8,133	183,766	206,398	973	939	15	17
NEW ENGLAND	-	1	855	4,293	3,509	69	64	-	1
Maine	-	-	96	70	84	1	1	-	-
N.H.	-	-	27	68	96	6	-	-	-
Vt.	-	1	71	56	43	5	3	-	-
Mass.	-	-	426	1,917	1,503	34	35	-	1
R.I.	-	-	77	509	422	10	2	-	-
Conn.	-	-	158	1,673	1,361	13	23	-	-
MID. ATLANTIC	-	-	1,773	19,883	23,840	168	132	3	3
Upstate N.Y.	-	-	626	4,942	4,753	75	41	2	-
N.Y. City	-	-	690	6,926	7,453	38	34	-	-
N.J.	-	-	148	2,982	4,281	36	31	-	-
Pa.	-	-	309	5,033	7,353	19	26	1	3
E.N. CENTRAL	10	2	1,504	36,623	42,663	156	176	2	2
Ohio	9	2	471	10,504	11,672	62	49	-	1
Ind.	-	-	-	4,158	3,859	32	34	1	-
Ill.	-	-	355	10,225	13,601	45	59	-	-
Mich.	1	-	434	8,361	10,117	10	10	1	-
Wis.	-	-	244	3,375	3,414	7	24	-	1
W.N. CENTRAL	-	2	980	9,532	9,567	41	43	1	1
Minn.	-	-	359	1,610	1,477	27	24	1	-
Iowa	-	-	144	619	708	1	-	-	-
Mo.	N	N	267	4,873	4,928	9	13	-	-
N. Dak.	-	2	11	28	22	-	4	-	-
S. Dak.	-	-	38	147	146	-	-	-	-
Nebr.	-	-	74	652	722	-	1	-	1
Kans.	-	-	87	1,603	1,564	4	1	-	-
S. ATLANTIC	-	-	1,405	48,122	54,089	242	228	2	1
Del.	-	-	28	939	959	-	-	-	-
Md.	-	-	59	4,835	5,163	58	59	1	-
D.C.	-	-	23	1,590	1,727	-	-	-	-
Va.	-	-	121	5,497	6,617	20	18	-	-
W. Va.	-	-	27	558	364	8	9	-	1
N.C.	-	-	-	9,799	10,314	23	32	-	-
S.C.	-	-	45	4,424	6,841	12	4	-	-
Ga.	-	-	511	8,603	9,942	71	61	-	-
Fla.	-	-	591	11,877	12,162	50	45	1	-
E.S. CENTRAL	4	1	192	16,806	18,957	42	56	1	-
Ky.	4	1	-	2,052	2,028	4	2	-	-
Tenn.	-	-	88	5,439	5,871	21	27	-	-
Ala.	-	-	104	5,539	6,356	12	25	1	-
Miss.	-	-	-	3,776	4,702	5	2	-	-
W.S. CENTRAL	-	-	101	27,734	31,231	36	37	2	1
Ark.	-	-	74	2,205	2,870	1	-	-	-
La.	-	-	2	6,896	7,421	2	6	-	-
Okla.	-	-	25	2,665	2,974	31	30	-	-
Tex.	-	-	-	15,968	17,966	2	1	2	1
MOUNTAIN	10	1	784	5,683	6,082	126	100	2	4
Mont.	-	-	40	56	76	-	-	-	-
Idaho	-	-	60	48	42	2	1	-	-
Wyo.	-	-	15	35	36	1	1	-	-
Colo.	10	1	254	1,976	1,866	26	28	-	-
N. Mex.	-	-	91	623	556	19	15	-	1
Ariz.	-	-	109	2,133	2,394	59	40	1	1
Utah	-	-	140	122	88	14	5	-	-
Nev.	-	-	75	690	1,024	5	10	1	2
PACIFIC	-	-	539	15,090	16,460	93	103	2	4
Wash.	-	-	193	1,623	1,785	2	2	1	-
Oreg.	-	-	237	483	682	44	31	-	-
Calif.	-	-	-	12,253	13,392	19	45	1	4
Alaska	-	-	53	360	229	1	4	-	-
Hawaii	-	-	56	371	372	27	21	-	-
Guam	-	-	-	-	29	-	-	-	-
P.R.	-	-	11	243	362	1	1	-	-
V.I.	-	-	-	25	17	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	12	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 3, 2002, and August 4, 2001 (31st Week)*

Reporting Area	*Haemophilus influenzae*, Invasive, Age <5 Years, Non-Serotype B, Cum. 2002	*Haemophilus influenzae*, Invasive, Age <5 Years, Non-Serotype B, Cum. 2001	*Haemophilus influenzae*, Invasive, Age <5 Years, Unknown Serotype, Cum. 2002	*Haemophilus influenzae*, Invasive, Age <5 Years, Unknown Serotype, Cum. 2001	Hepatitis (Viral, Acute), By Type, A, Cum. 2002	Hepatitis (Viral, Acute), By Type, A, Cum. 2001	Hepatitis (Viral, Acute), By Type, B, Cum. 2002	Hepatitis (Viral, Acute), By Type, B, Cum. 2001	Hepatitis (Viral, Acute), By Type, C; Non-A, Non-B, Cum. 2002	Hepatitis (Viral, Acute), By Type, C; Non-A, Non-B, Cum. 2001
UNITED STATES	150	153	15	19	4,801	5,417	3,780	4,111	1,989	2,456
NEW ENGLAND	7	10	-	-	198	317	126	75	20	29
Maine	-	-	-	-	6	5	5	5	-	-
N.H.	-	-	-	-	11	10	12	10	-	-
Vt.	-	-	-	-	1	8	3	5	12	6
Mass.	4	7	-	-	86	132	71	14	8	23
R.I.	-	-	-	-	28	16	17	14	-	-
Conn.	3	3	-	-	66	146	18	27	-	-
MID. ATLANTIC	22	20	-	3	582	715	803	812	991	734
Upstate N.Y.	9	6	-	1	122	163	82	72	37	18
N.Y. City	6	5	-	-	244	252	439	382	-	-
N.J.	4	3	-	-	64	172	154	175	937	674
Pa.	3	6	-	2	152	128	128	183	17	42
E.N. CENTRAL	23	31	1	1	680	668	507	509	62	113
Ohio	7	9	1	-	223	147	68	70	6	7
Ind.	7	5	-	1	33	53	28	27	-	1
Ill.	7	11	-	-	181	227	64	74	9	9
Mich.	1	-	-	-	138	197	347	313	47	96
Wis.	1	6	-	-	105	44	-	25	-	-
W.N. CENTRAL	2	2	3	4	210	226	133	122	545	750
Minn.	2	1	1	2	27	16	12	11	2	3
Iowa	-	-	-	-	54	24	11	13	1	-
Mo.	-	-	2	2	59	47	75	70	531	739
N. Dak.	-	1	-	-	1	2	4	-	-	-
S. Dak.	-	-	-	-	3	1	-	1	-	-
Nebr.	-	-	-	-	11	29	18	17	8	3
Kans.	-	-	-	-	55	107	13	10	3	5
S. ATLANTIC	36	30	2	5	1,441	1,021	965	744	103	40
Del.	-	-	-	-	9	5	7	15	5	2
Md.	3	4	-	1	178	149	78	83	8	4
D.C.	-	-	-	-	53	29	12	11	-	-
Va.	3	4	-	-	56	76	124	88	2	-
W. Va.	-	1	1	-	12	7	13	20	1	8
N.C.	3	1	-	4	141	92	145	113	16	10
S.C.	4	1	-	-	45	45	59	19	4	5
Ga.	16	14	-	-	331	537	290	224	24	-
Fla.	7	5	1	-	616	81	237	171	43	11
E.S. CENTRAL	9	11	1	2	159	220	200	281	112	153
Ky.	1	-	-	1	36	58	34	32	2	5
Tenn.	5	5	-	-	61	81	77	139	21	46
Ala.	3	5	1	1	24	63	45	57	4	2
Miss.	-	1	-	-	38	18	44	53	85	100
W.S. CENTRAL	7	4	-	-	84	590	224	507	24	506
Ark.	-	-	-	-	30	45	64	59	4	6
La.	1	-	-	-	21	66	30	76	16	106
Okla.	6	4	-	-	32	89	17	69	4	4
Tex.	-	-	-	-	1	390	113	303	-	390
MOUNTAIN	24	12	7	1	373	474	347	293	62	39
Mont.	-	-	-	-	9	8	3	2	-	1
Idaho	1	-	-	-	22	47	6	9	-	1
Wyo.	-	-	-	-	2	3	11	1	7	4
Colo.	2	-	-	-	63	46	54	67	26	5
N. Mex.	4	6	1	1	9	23	70	75	1	11
Ariz.	12	4	5	-	203	245	141	96	4	9
Utah	4	2	-	-	36	51	26	15	4	2
Nev.	1	-	1	-	29	51	36	28	20	6
PACIFIC	20	33	1	3	1,074	1,186	475	768	70	92
Wash.	1	1	-	1	109	76	35	76	15	16
Oreg.	4	5	-	-	50	75	80	98	14	12
Calif.	11	25	1	1	907	1,009	352	574	41	64
Alaska	1	1	-	-	7	14	4	5	-	-
Hawaii	3	1	-	1	1	12	4	15	-	-
Guam	-	-	-	-	-	1	-	-	-	-
P.R.	-	1	-	-	70	109	61	161	-	1
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	32	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 3, 2002, and August 4, 2001 (31st Week)*

Reporting Area	Legionellosis		Listeriosis		Lyme Disease		Malaria		Measles Total	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	499	558	252	325	5,287	7,744	680	839	13†	90§
NEW ENGLAND	32	29	31	29	714	2,271	37	50	-	5
Maine	2	3	2	-	53	-	2	3	-	-
N.H.	4	5	2	1	84	38	5	2	-	-
Vt.	4	4	1	1	12	5	1	-	-	1
Mass.	14	9	17	15	371	790	15	24	-	3
R.I.	1	2	1	1	113	197	3	3	-	-
Conn.	7	6	8	11	81	1,241	11	18	-	1
MID. ATLANTIC	119	122	45	57	3,705	4,056	147	233	5	17
Upstate N.Y.	41	31	22	17	2,335	1,259	26	36	-	4
N.Y. City	20	19	11	14	77	52	88	136	5	6
N.J.	12	9	3	11	181	1,536	19	36	-	1
Pa.	46	63	9	15	1,112	1,209	14	25	-	6
E.N. CENTRAL	129	149	33	50	43	524	81	107	1	10
Ohio	64	68	12	9	37	14	13	16	1	3
Ind.	11	11	6	4	6	9	6	13	-	4
Ill.	-	19	1	19	-	26	21	47	-	3
Mich.	36	28	11	15	-	4	33	19	-	-
Wis.	18	23	3	3	U	471	8	12	-	-
W.N. CENTRAL	27	36	8	8	133	155	45	26	-	4
Minn.	2	9	-	-	88	111	16	6	-	2
Iowa	6	6	1	-	17	17	2	3	-	-
Mo.	10	12	5	5	23	21	12	10	-	2
N. Dak.	-	1	1	-	-	-	1	-	-	-
S. Dak.	2	3	-	-	-	-	-	-	-	-
Nebr.	7	4	-	1	1	4	5	2	-	-
Kans.	-	1	1	2	4	2	9	5	-	-
S. ATLANTIC	103	95	43	36	578	580	196	176	1	5
Del.	6	3	-	2	61	84	1	1	-	-
Md.	17	24	9	5	346	366	58	72	-	3
D.C.	5	7	-	-	13	7	11	11	-	-
Va.	10	14	3	7	48	89	16	35	-	1
W. Va.	N	N	-	4	5	8	3	1	-	-
N.C.	7	5	3	2	59	19	11	9	-	-
S.C.	5	4	6	3	8	2	5	5	-	-
Ga.	10	9	10	7	1	-	57	28	-	1
Fla.	43	29	12	6	37	5	34	14	1	-
E.S. CENTRAL	16	40	8	11	27	30	9	21	-	2
Ky.	7	9	2	4	13	11	2	7	-	2
Tenn.	4	18	3	3	8	9	2	8	-	-
Ala.	5	9	3	4	6	6	3	3	-	-
Miss.	-	4	-	-	-	4	2	3	-	-
W.S. CENTRAL	4	17	5	27	4	62	8	59	1	1
Ark.	-	-	-	1	2	-	1	3	-	-
La.	1	6	-	-	1	4	3	4	-	-
Okla.	3	3	5	2	-	-	4	2	-	-
Tex.	-	8	-	24	1	58	-	50	1	1
MOUNTAIN	24	32	20	25	13	6	33	33	1	1
Mont.	3	-	-	-	-	-	1	2	-	-
Idaho	-	2	2	1	2	3	-	3	-	1
Wyo.	1	2	-	1	-	1	-	-	-	-
Colo.	4	11	3	5	3	-	18	18	-	-
N. Mex.	1	2	2	6	1	-	2	2	-	-
Ariz.	7	8	9	6	2	-	5	3	-	-
Utah	7	4	3	1	4	-	4	2	-	-
Nev.	1	3	1	5	1	2	3	3	1	-
PACIFIC	45	38	59	82	70	60	124	134	4	45
Wash.	3	6	5	4	3	3	11	4	-	15
Oreg.	N	N	5	4	10	7	7	10	-	2
Calif.	42	27	44	71	56	48	98	111	3	22
Alaska	-	1	-	-	1	2	2	1	-	-
Hawaii	-	4	5	3	N	N	6	8	1	6
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	2	1	-	N	N	-	3	-	-
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Of 13 cases reported, four were indigenous and nine were imported from another country.
§ Of 90 cases reported, 42 were indigenous and 48 were imported from another country.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 3, 2002, and August 4, 2001 (31st Week)*

Reporting Area	Meningococcal Disease		Mumps		Pertussis		Rabies, Animal	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	1,017	1,588	168	139	3,909	2,980	3,314	4,111
NEW ENGLAND	68	75	7	-	357	268	471	385
Maine	6	1	-	-	5	-	28	42
N.H.	8	9	4	-	8	14	11	6
Vt.	4	5	-	-	70	24	70	37
Mass.	32	44	2	-	264	213	160	141
R.I.	5	2	-	-	4	2	36	34
Conn.	13	14	1	-	6	15	166	125
MID. ATLANTIC	107	166	14	17	168	215	605	706
Upstate N.Y.	33	45	2	2	121	105	369	437
N.Y. City	13	26	1	11	8	33	10	18
N.J.	22	30	1	-	3	8	91	111
Pa.	39	65	10	4	36	69	135	140
E.N. CENTRAL	151	234	18	17	493	397	53	57
Ohio	57	62	3	1	254	187	16	17
Ind.	23	28	2	1	36	32	13	1
Ill.	30	59	6	12	83	43	8	9
Mich.	29	51	6	2	34	33	16	22
Wis.	12	34	1	1	86	102	-	8
W.N. CENTRAL	92	100	12	6	348	134	239	216
Minn.	22	15	3	2	118	31	20	23
Iowa	12	21	1	-	115	16	42	47
Mo.	35	36	3	-	72	65	21	20
N. Dak.	-	5	1	-	-	-	11	24
S. Dak.	2	4	-	-	5	3	41	32
Nebr.	16	10	-	1	3	4	-	4
Kans.	5	9	4	3	35	15	104	66
S. ATLANTIC	178	243	19	20	233	137	1,455	1,430
Del.	6	3	-	-	2	-	24	25
Md.	4	34	4	4	31	20	168	286
D.C.	-	-	-	-	1	1	-	-
Va.	28	30	3	4	93	15	289	259
W. Va.	-	10	-	-	17	1	109	80
N.C.	19	57	1	1	20	46	409	344
S.C.	17	26	2	1	28	22	65	75
Ga.	28	34	4	7	17	17	237	244
Fla.	76	49	5	3	24	15	154	117
E.S. CENTRAL	65	105	12	3	132	70	104	153
Ky.	11	19	4	1	51	16	17	16
Tenn.	26	44	2	-	50	29	55	106
Ala.	17	29	3	-	24	22	32	31
Miss.	11	13	3	2	7	3	-	-
W.S. CENTRAL	60	246	11	9	1,023	283	75	774
Ark.	20	14	-	-	388	12	-	-
La.	23	61	1	2	4	5	-	5
Okla.	16	23	-	-	62	12	75	46
Tex.	1	148	10	7	569	254	-	723
MOUNTAIN	67	72	13	9	522	956	150	161
Mont.	2	3	-	-	3	14	8	21
Idaho	3	7	1	-	46	165	12	10
Wyo.	-	4	-	1	8	-	14	20
Colo.	21	27	2	2	198	195	26	-
N. Mex.	3	9	1	2	113	62	4	7
Ariz.	20	11	1	1	95	461	82	100
Utah	4	7	5	1	34	48	2	2
Nev.	14	4	3	2	25	11	2	1
PACIFIC	229	347	62	58	633	520	162	229
Wash.	44	50	-	1	279	88	-	-
Oreg.	34	42	N	N	126	34	3	-
Calif.	144	244	50	29	213	367	135	191
Alaska	1	2	-	1	4	3	24	38
Hawaii	6	9	12	27	11	28	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	3	4	-	-	1	-	49	64
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	1	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 3, 2002, and August 4, 2001 (31st Week)*

Reporting Area	Rocky Mountain Spotted Fever		Rubella				Salmonellosis	
			Rubella		Congenital Rubella			
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	454	282	7	15	2	-	18,542	20,258
NEW ENGLAND	-	2	-	-	-	-	1,096	1,395
Maine	-	-	-	-	-	-	80	120
N.H.	-	-	-	-	-	-	68	111
Vt.	-	-	-	-	-	-	40	42
Mass.	-	2	-	-	-	-	613	806
R.I.	-	-	-	-	-	-	72	64
Conn.	-	-	-	-	-	-	223	252
MID. ATLANTIC	25	14	3	6	-	-	2,361	2,730
Upstate N.Y.	7	-	2	1	-	-	797	635
N.Y. City	3	1	-	4	-	-	698	721
N.J.	5	3	1	1	-	-	329	655
Pa.	10	10	-	-	-	-	537	719
E.N. CENTRAL	11	14	-	2	-	-	2,975	2,820
Ohio	8	1	-	-	-	-	796	768
Ind.	1	1	-	-	-	-	265	282
Ill.	-	12	-	2	-	-	910	801
Mich.	2	-	-	-	-	-	535	501
Wis.	-	-	-	-	-	-	469	468
W.N. CENTRAL	65	42	-	3	-	-	1,347	1,160
Minn.	-	-	-	-	-	-	319	358
Iowa	1	1	-	1	-	-	230	176
Mo.	58	39	-	1	-	-	487	295
N. Dak.	-	-	-	-	-	-	25	17
S. Dak.	-	2	-	-	-	-	46	74
Nebr.	4	-	-	-	-	-	70	88
Kans.	2	-	-	1	-	-	170	152
S. ATLANTIC	232	125	-	3	-	-	4,648	4,515
Del.	2	-	-	-	-	-	35	47
Md.	30	23	-	-	-	-	481	444
D.C.	-	-	-	-	-	-	44	46
Va.	16	13	-	-	-	-	519	797
W. Va.	1	-	-	-	-	-	67	63
N.C.	126	63	-	-	-	-	634	627
S.C.	35	16	-	2	-	-	285	425
Ga.	18	7	-	-	-	-	965	835
Fla.	4	3	-	1	-	-	1,618	1,231
E.S. CENTRAL	42	56	-	-	1	-	1,311	1,163
Ky.	3	1	-	-	-	-	180	194
Tenn.	28	37	-	-	1	-	363	293
Ala.	11	10	-	-	-	-	383	341
Miss.	-	8	-	-	-	-	385	335
W.S. CENTRAL	67	21	1	-	-	-	819	2,410
Ark.	21	4	-	-	-	-	437	335
La.	-	2	-	-	-	-	155	436
Okla.	46	15	-	-	-	-	225	190
Tex.	-	-	1	-	-	-	2	1,449
MOUNTAIN	9	8	-	-	-	-	1,164	1,205
Mont.	1	1	-	-	-	-	59	44
Idaho	-	1	-	-	-	-	72	80
Wyo.	2	2	-	-	-	-	34	40
Colo.	1	-	-	-	-	-	291	332
N. Mex.	-	1	-	-	-	-	154	136
Ariz.	-	-	-	-	-	-	327	332
Utah	-	3	-	-	-	-	108	129
Nev.	5	-	-	-	-	-	119	112
PACIFIC	3	-	3	1	1	-	2,821	2,860
Wash.	-	-	-	-	-	-	260	284
Oreg.	1	-	-	-	-	-	218	172
Calif.	2	-	3	-	-	-	2,138	2,173
Alaska	-	-	-	-	-	-	39	27
Hawaii	-	-	-	1	1	-	166	204
Guam	-	-	-	-	-	-	-	18
P.R.	-	-	-	3	-	-	120	549
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	23	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 3, 2002, and August 4, 2001 (31st Week)*

Reporting Area	Shigellosis		Streptococcal Disease, Invasive, Group A		*Streptococcus pneumoniae*, Drug Resistant, Invasive		*Streptococcus pneumoniae*, Invasive (<5 Years)	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	8,224	9,753	2,740	2,501	1,416	1,877	156	291
NEW ENGLAND	156	155	135	165	9	90	1	30
Maine	3	6	18	10	-	-	-	-
N.H.	5	2	26	N	-	-	N	N
Vt.	-	4	9	9	4	7	1	-
Mass.	100	111	69	53	N	N	N	N
R.I.	7	8	13	8	5	-	-	2
Conn.	41	24	-	85	-	83	-	28
MID. ATLANTIC	485	921	465	453	80	120	48	75
Upstate N.Y.	139	337	218	195	72	118	48	75
N.Y. City	215	249	115	131	U	U	U	U
N.J.	48	179	91	82	N	N	N	N
Pa.	83	156	41	45	8	2	-	-
E.N. CENTRAL	863	2,024	499	593	154	129	65	76
Ohio	384	1,196	157	149	27	-	-	-
Ind.	56	138	32	47	122	129	40	39
Ill.	250	330	105	193	2	-	-	37
Mich.	93	173	205	153	3	-	N	N
Wis.	80	187	-	51	N	N	25	-
W.N. CENTRAL	675	912	180	257	150	99	36	45
Minn.	143	269	95	108	48	49	36	38
Iowa	71	276	-	-	N	N	N	N
Mo.	97	164	37	56	6	9	-	-
N. Dak.	15	16	-	11	1	4	-	7
S. Dak.	149	89	10	7	1	3	-	-
Nebr.	141	50	14	30	25	9	N	N
Kans.	59	48	24	45	69	25	N	N
S. ATLANTIC	3,212	1,289	528	429	860	1,004	1	4
Del.	20	5	1	2	3	2	N	N
Md.	608	72	90	N	N	N	N	N
D.C.	36	32	6	15	48	5	1	3
Va.	569	137	51	61	N	N	N	N
W. Va.	4	7	13	17	34	37	-	1
N.C.	180	225	96	111	N	N	U	U
S.C.	58	165	28	7	135	204	N	N
Ga.	987	163	130	141	253	286	N	N
Fla.	750	483	113	75	387	470	N	N
E.S. CENTRAL	766	898	70	65	99	186	-	-
Ky.	81	333	12	28	11	22	N	N
Tenn.	34	60	58	37	88	163	N	N
Ala.	417	154	-	-	-	1	N	N
Miss.	234	351	-	-	-	-	-	-
W.S. CENTRAL	496	1,702	41	231	35	216	3	61
Ark.	124	408	5	-	5	14	-	-
La.	85	159	-	-	30	202	1	61
Okla.	286	28	35	33	N	N	2	-
Tex.	1	1,107	1	198	N	N	-	-
MOUNTAIN	367	526	469	266	29	31	2	-
Mont.	3	1	-	-	-	-	-	-
Idaho	4	23	5	6	N	N	N	N
Wyo.	3	2	7	7	9	5	-	-
Colo.	72	130	153	110	-	-	-	-
N. Mex.	65	67	71	56	19	24	-	-
Ariz.	179	231	207	84	-	-	N	N
Utah	23	35	26	3	1	-	2	-
Nev.	18	37	-	-	-	2	-	-
PACIFIC	1,204	1,326	353	42	-	2	-	-
Wash.	75	113	36	-	-	-	N	N
Oreg.	60	71	N	N	N	N	N	N
Calif.	1,033	1,106	273	-	N	N	N	N
Alaska	2	4	-	-	-	-	N	N
Hawaii	34	32	44	42	-	2	-	-
Guam	-	32	-	1	-	-	-	-
P.R.	5	13	N	N	-	-	N	N
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	-	-	U	U
C.N.M.I.	15	U	-	U	-	-	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 3, 2002, and August 4, 2001 (31st Week)*

Reporting Area	Syphilis				Tuberculosis		Typhoid Fever	
	Primary & Secondary		Congenital					
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	3,620	3,399	188	315	6,596	7,876	143	189
NEW ENGLAND	77	28	-	3	221	274	10	8
Maine	-	-	-	-	5	12	-	1
N.H.	2	1	-	-	8	11	-	1
Vt.	1	2	-	-	-	4	-	-
Mass.	57	16	-	2	123	139	8	5
R.I.	2	3	-	-	21	38	-	-
Conn.	15	6	-	1	64	70	2	1
MID. ATLANTIC	412	293	33	48	1,213	1,307	39	63
Upstate N.Y.	20	12	4	2	169	185	5	14
N.Y. City	248	166	14	25	641	664	19	23
N.J.	73	58	14	21	283	304	12	23
Pa.	71	57	1	-	120	154	3	3
E.N. CENTRAL	605	576	26	46	692	780	14	25
Ohio	82	54	-	2	102	159	5	3
Ind.	44	99	-	7	60	55	2	2
Ill.	163	185	20	29	353	379	1	12
Mich.	304	221	6	5	136	147	3	5
Wis.	12	17	-	3	41	40	3	3
W.N. CENTRAL	54	56	-	7	309	308	6	7
Minn.	21	24	-	2	134	138	3	3
Iowa	2	3	-	-	17	18	-	-
Mo.	14	11	-	4	84	74	1	4
N. Dak.	-	-	-	-	1	3	-	-
S. Dak.	-	-	-	-	9	8	-	-
Nebr.	4	2	-	-	9	21	2	-
Kans.	13	16	-	1	55	46	-	-
S. ATLANTIC	960	1,207	44	78	1,299	1,502	21	24
Del.	9	10	-	-	13	9	-	-
Md.	112	155	8	3	150	128	5	8
D.C.	54	17	1	2	-	43	-	-
Va.	44	67	1	4	98	149	1	6
W. Va.	-	-	-	-	14	19	-	-
N.C.	175	283	15	8	180	192	1	2
S.C.	75	159	5	18	109	119	-	-
Ga.	184	208	1	17	201	275	7	6
Fla.	307	308	13	26	534	568	7	2
E.S. CENTRAL	316	362	12	24	399	485	4	-
Ky.	61	26	2	-	71	73	4	-
Tenn.	118	203	3	14	150	176	-	-
Ala.	105	64	6	4	126	155	-	-
Miss.	32	69	1	6	52	81	-	-
W.S. CENTRAL	491	416	41	50	853	1,244	-	12
Ark.	16	25	1	5	73	89	-	-
La.	81	85	-	-	-	78	-	-
Okla.	38	41	2	4	80	88	-	-
Tex.	356	265	38	41	700	989	-	12
MOUNTAIN	158	123	10	20	203	307	10	6
Mont.	-	-	-	-	6	-	-	1
Idaho	1	-	1	-	8	6	-	-
Wyo.	-	-	-	-	2	2	-	-
Colo.	12	15	1	1	27	74	5	-
N. Mex.	25	10	-	2	21	38	-	-
Ariz.	112	88	8	17	109	118	-	1
Utah	3	7	-	-	17	18	3	-
Nev.	5	3	-	-	13	51	2	4
PACIFIC	547	338	22	39	1,407	1,669	39	44
Wash.	29	34	1	-	140	149	4	3
Oreg.	10	7	1	-	56	60	2	3
Calif.	501	290	19	39	1,094	1,345	32	35
Alaska	-	-	-	-	33	26	-	1
Hawaii	7	7	1	-	84	89	1	2
Guam	-	2	-	1	-	41	-	2
P.R.	139	162	10	2	33	53	-	-
V.I.	1	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	13	U	-	U	27	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,* week ending August 3, 2002 (31st Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	484	333	106	29	7	9	51
Boston, Mass.	146	92	37	11	2	4	15
Bridgeport, Conn.	36	23	9	-	1	3	4
Cambridge, Mass.	17	13	4	-	-	-	2
Fall River, Mass.	29	21	6	1	1	-	1
Hartford, Conn.	38	25	7	4	2	-	5
Lowell, Mass.	27	22	4	-	1	-	3
Lynn, Mass.	16	9	4	3	-	-	2
New Bedford, Mass.	26	23	2	1	-	-	4
New Haven, Conn.	34	25	7	2	-	-	1
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	2	1	1	-	-	-	-
Springfield, Mass.	41	25	14	2	-	-	4
Waterbury, Conn.	20	15	4	1	-	-	1
Worcester, Mass.	52	39	7	4	-	2	9
MID. ATLANTIC	1,979	1,367	390	141	43	36	95
Albany, N.Y.	47	34	10	1	2	-	6
Allentown, Pa.	15	12	2	1	-	-	1
Buffalo, N.Y.	79	55	15	5	-	4	8
Camden, N.J.	25	15	7	1	-	2	-
Elizabeth, N.J.	9	6	1	2	-	-	-
Erie, Pa.	67	44	12	5	2	4	1
Jersey City, N.J.	43	24	17	2	-	-	-
New York City, N.Y.	1,095	766	216	68	26	17	35
Newark, N.J.	41	11	18	10	1	1	1
Paterson, N.J.	23	13	6	2	2	-	3
Philadelphia, Pa.	191	128	45	8	7	3	13
Pittsburgh, Pa.§	35	24	6	2	1	2	1
Reading, Pa.	18	12	1	4	-	1	2
Rochester, N.Y.	112	83	17	11	-	1	3
Schenectady, N.Y.	21	20	-	-	1	-	6
Scranton, Pa.	30	25	4	1	-	-	6
Syracuse, N.Y.	92	67	9	15	-	1	8
Trenton, N.J.	18	15	1	2	-	-	-
Utica, N.Y.	18	13	3	1	1	-	1
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,477	959	286	137	41	47	85
Akron, Ohio	57	34	11	3	2	-	6
Canton, Ohio	33	21	10	1	1	-	4
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	U	U	U	U	U	U	U
Cleveland, Ohio	120	81	22	7	3	7	7
Columbus, Ohio	196	129	37	24	3	3	10
Dayton, Ohio	95	67	18	6	3	1	2
Detroit, Mich.	208	100	41	57	5	5	6
Evansville, Ind.	41	30	9	-	1	1	4
Fort Wayne, Ind.	62	45	12	3	1	1	5
Gary, Ind.	19	13	4	2	-	-	-
Grand Rapids, Mich.	57	35	10	6	3	3	5
Indianapolis, Ind.	156	106	32	5	4	9	7
Lansing, Mich.	37	21	7	1	4	4	4
Milwaukee, Wis.	112	79	20	6	3	4	8
Peoria, Ill.	63	41	14	5	1	2	5
Rockford, Ill.	57	41	13	1	1	1	3
South Bend, Ind.	31	18	9	-	2	2	2
Toledo, Ohio	81	56	10	8	4	3	6
Youngstown, Ohio	52	42	7	2	-	1	1
W.N. CENTRAL	496	317	112	36	17	14	21
Des Moines, Iowa	20	15	4	-	1	-	-
Duluth, Minn.	42	33	5	3	-	1	1
Kansas City, Kans.	26	14	8	2	1	1	1
Kansas City, Mo.	93	55	17	11	7	3	4
Lincoln, Nebr.	31	26	3	-	1	1	2
Minneapolis, Minn.	64	44	11	5	3	1	8
Omaha, Nebr.	94	58	26	7	2	1	2
St. Louis, Mo.	U	U	U	U	U	U	U
St. Paul, Minn.	57	39	15	1	2	-	-
Wichita, Kans.	69	33	23	7	-	6	3
S. ATLANTIC	1,115	724	229	99	28	35	72
Atlanta, Ga.	135	84	32	15	3	1	4
Baltimore, Md.	135	91	18	13	7	6	12
Charlotte, N.C.	97	68	18	5	4	2	13
Jacksonville, Fla.	125	73	29	15	3	5	8
Miami, Fla.	89	58	18	9	1	3	4
Norfolk, Va.	61	46	8	5	1	1	4
Richmond, Va.	60	33	18	5	1	3	2
Savannah, Ga.	67	48	12	3	1	3	9
St. Petersburg, Fla.	56	42	5	5	2	2	5
Tampa, Fla.	174	112	42	13	1	6	9
Washington, D.C.	104	57	29	11	4	3	2
Wilmington, Del.	12	12	-	-	-	-	-
E.S. CENTRAL	533	343	116	44	15	15	33
Birmingham, Ala.	125	78	29	9	6	3	9
Chattanooga, Tenn.	60	39	13	5	2	1	1
Knoxville, Tenn.	78	54	16	8	-	-	4
Lexington, Ky.	32	22	8	-	1	1	2
Memphis, Tenn.	U	U	U	U	U	U	U
Mobile, Ala.	78	51	19	4	1	3	1
Montgomery, Ala.	34	21	4	6	2	1	5
Nashville, Tenn.	126	78	27	12	3	6	11
W.S. CENTRAL	1,360	851	275	127	63	44	78
Austin, Tex.	73	44	18	7	2	2	3
Baton Rouge, La.	37	25	8	3	-	1	1
Corpus Christi, Tex.	39	28	7	3	-	1	1
Dallas, Tex.	219	131	51	20	6	11	14
El Paso, Tex.	75	49	15	9	2	-	1
Ft. Worth, Tex.	122	78	25	14	1	4	6
Houston, Tex.	371	216	61	43	40	11	25
Little Rock, Ark.	78	50	15	6	3	4	1
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	189	126	41	12	5	5	15
Shreveport, La.	21	15	5	1	-	-	2
Tulsa, Okla.	136	89	29	9	4	5	9
MOUNTAIN	794	516	180	55	25	18	43
Albuquerque, N.M.	74	51	14	5	3	1	1
Boise, Idaho	39	25	9	3	-	2	4
Colo. Springs, Colo.	63	39	13	6	3	2	3
Denver, Colo.	87	55	22	7	3	-	8
Las Vegas, Nev.	205	125	57	16	4	3	14
Ogden, Utah	36	21	8	4	2	1	3
Phoenix, Ariz.	U	U	U	U	U	U	U
Pueblo, Colo.	25	16	9	-	-	-	1
Salt Lake City, Utah	141	90	25	9	8	9	2
Tucson, Ariz.	124	94	23	5	2	-	7
PACIFIC	1,595	1,102	311	117	42	23	97
Berkeley, Calif.	13	9	3	-	-	1	-
Fresno, Calif.	97	69	18	6	2	2	5
Glendale, Calif.	21	16	4	1	-	-	-
Honolulu, Hawaii	83	57	21	3	-	2	6
Long Beach, Calif.	80	60	13	5	2	-	6
Los Angeles, Calif.	356	244	72	28	9	3	1
Pasadena, Calif.	31	21	7	1	2	-	5
Portland, Oreg.	85	61	13	7	4	-	6
Sacramento, Calif.	212	150	41	15	4	2	18
San Diego, Calif.	160	106	30	14	7	3	17
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	181	131	29	12	5	4	20
Santa Cruz, Calif.	29	22	5	2	-	-	4
Seattle, Wash.	116	68	28	14	4	2	6
Spokane, Wash.	42	28	9	1	1	3	-
Tacoma, Wash.	89	60	18	8	2	1	3
TOTAL	9,833¶	6,512	2,005	785	281	241	575

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. 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.

(Continued from page 688)

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Notice to Readers

National Syndromic Surveillance Conference

The National Syndromic Surveillance Conference will be held September 23–24, 2002, at the New York Academy of Medicine in New York City. The conference is sponsored by the New York Academy of Medicine, the New York City Department of Health and Mental Hygiene, and CDC, with the support of the Alfred P. Sloan Foundation.

Recent bioterrorism events have highlighted the need for improved public health surveillance systems to detect outbreaks. Systems using real-time electronic surveillance of nonspecific disease indicators (i.e., syndromic surveillance) might provide early warning of large outbreaks, whether intentional or occurring naturally. The conference will provide public, private, and academic entities with a forum to evaluate syndromic surveillance critically and assist public health entities in defining their needs and priorities. Poster and presentations will address syndromic surveillance in the context of national and local public health, CDC guidelines for evaluating syndromic surveillance systems, model syndromic surveillance systems, temporal and temporal-spatial outbreak detection, nontraditional data sources, systems with dedicated data collection, data transfer and transformation, legal mandate and confidentiality, and investigation of syndromic alarms.

Registration information is available at http://ww.nyam.org/events/syndromicconference. Deadlines are August 16 for abstracts and September 20 for registration. Additional information is available from Jessica Hartman at jhartman@health.nyc.gov, telephone 212-788-4340, fax 212-788-5470.

Notice to Readers

Satellite Broadcast on HIV Prevention

CDC and the Public Health Training Network will co-sponsor a satellite broadcast, "Public-Private Partnerships: A New Model for Community Mobilization Against AIDS," on Thursday, November 21, 2002, at 1 p.m., EST. The 2-hour forum will address CDC's public-private partnerships to engage the private sector as a mobilizing agent for community-based human immunodeficiency virus (HIV) prevention. Presentations, interviews, and panel response to audience questions will include legal issues, employee education, management training, and resources related to HIV prevention for businesses.

This broadcast is designed for executives, human resources directors, medical staffs, and other persons in community and national organizations, business and labor organizations, public health agencies, trade associations, and foundations. Viewers can fax questions and comments before, during, and after the broadcast. Additional information is available at http://www.cdcnpin.org/broadcast and through CDC's fax information system, 888-232-3299, by entering document number 130043 and a return fax number.

Organizations are responsible for setting up their own viewing sites and are encouraged to register their sites as early as possible so that viewers can access information about viewing locations when visiting the website or calling the information line. Health departments and other organizations are encouraged to invite leaders in the business community and other areas of the private sector to view this broadcast.

The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format and on a paid subscription basis for paper copy. To receive an electronic copy each week, send an e-mail message to *listserv@listserv.cdc.gov*. The body content should read *SUBscribe mmwr-toc*. Electronic copy also is available from CDC's World-Wide Web server at *http://www.cdc.gov/mmwr* or from CDC's file transfer protocol server at *ftp://ftp.cdc.gov/pub/publications/mmwr*. To subscribe for paper copy, contact Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone 202-512-1800.

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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