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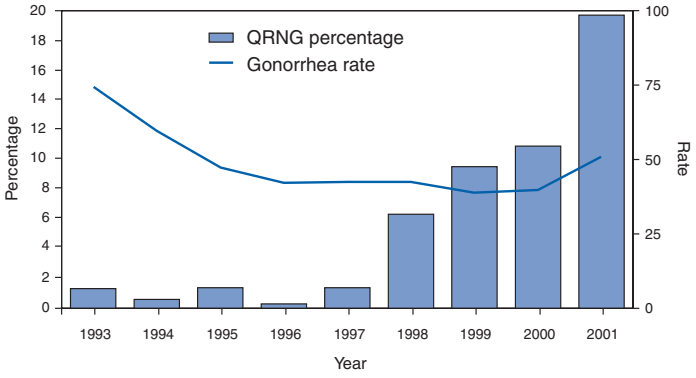
Increases in Fluoroquinolone-Resistant *Neisseria gonorrhoeae* — Hawaii and California, 2001

Neisseria gonorrhoeae is a major cause of pelvic inflammatory disease, ectopic pregnancy, and infertility, and it can facilitate human immunodeficiency virus (HIV) transmission (*1*). Gonorrhea is the second most frequently reported communicable disease in the United States, with 361,705 reported cases in 2001 (*2*). During the 1980s, gonococcal resistance to penicillin and tetracycline became widespread; as a result, CDC recommended using cephalosporins as first-line treatment for gonorrhea. Since 1993, CDC also has recommended using fluoroquinolones (i.e., ciprofloxacin, ofloxacin, or levofloxacin) for gonorrhea treatment. Fluoroquinolone therapy is used widely because it is a relatively inexpensive, oral, and single-dose therapy. However, fluoroquinolone-resistant *N. gonorrhoeae* (QRNG)* is being identified more frequently (*3*). This report summarizes investigations of increases in QRNG in Hawaii and California in 2001 and provides data to support the recommendation that cephalosporins (i.e., ceftriaxone or cefixime) be used instead of fluoroquinolones as first-line treatment for gonorrhea acquired in these two states. The increases in QRNG highlight the importance of monitoring gonococcal resistance throughout the United States to guide local treatment decisions.

Hawaii

In 2001, the Hawaii State Laboratory performed gonorrhea culture and antimicrobial susceptibility tests on specimens from 265 (44%) of 605 reported gonorrhea cases. Patients seeking care at the public sexually transmitted disease (STD) clinic accounted for 44% (117 of 265) of these isolates. Overall, QRNG accounted for 20% (53 of 265) of gonococcal isolates tested, compared with 11% in 2000 and 10% in 1999 (Figure 1). In 2001, 36% (19 of 53) of QRNG infections were among STD clinic patients.

FIGURE 1. Percentage of fluoroquinolone-resistant *Neisseria gonorrhoeae* (QRNG)* among tested gonococcal isolates and gonorrhea rate†, by year§ — Hawaii, 1993–2001



* Defined as *N. gonorrhoeae* resistant to ciprofloxacin (minimal inhibitory concentration [MIC] ≥1.0 μg/mL by agar dilution or disk diffusion zone size ≤27 mm) or ofloxacin (MIC ≥2.0 μg/mL or disk diffusion zone size ≤24 mm) by the National Committee on Clinical Laboratory Standards.
† Per 100,000 population.
§ Data for 1993–2001 include Gonococcal Isolate Surveillance Project (GISP) and non-GISP isolates.

* Defined as *N. gonorrhoeae* resistant to ciprofloxacin (minimal inhibitory concentration [MIC] ≥1.0 μg/mL by agar dilution or disk diffusion zone size ≤27 mm) or ofloxacin (MIC ≥2.0 μg/mL or disk diffusion zone size ≤24 mm) by the National Committee on Clinical Laboratory Standards.

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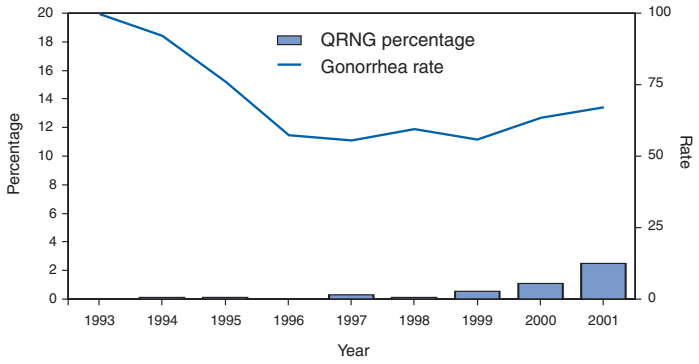
Medical and interview records of the 117 STD clinic patients with positive gonococcal cultures diagnosed during January–December 2001 were reviewed to identify risk factors for QRNG; 19 (16%) had QRNG isolates. QRNG prevalence was higher for men who had sex exclusively with women than for men who had sex with men (MSM) (11 [20%] of 55 versus one [3%] of 29; p=0.05). Persons with a history of recent travel to Asia or a sex partner with such a history were not significantly more likely to have QRNG (four [36%] of 11) than persons without such a history (14 [14%] of 102; p=0.07). Unlike in Hawaii in 1999 (*4*), QRNG prevalence was not significantly higher among Asians/Pacific Islanders than among non-Asians/Pacific Islanders (10 [19%] of 54 versus nine [14%] of 63; p=0.54).

Since 2000, the Hawaii Department of Health (HDH) has recommended that clinicians avoid using fluoroquinolones to treat gonorrhea. Because of the 25% increase in reported gonorrhea morbidity (from 39.9 cases per 100,000 population in 2000 to 49.9 in 2001), adherence to this recommendation is particularly important. In February 2002, HDH informed all clinicians of the increases in gonorrhea and QRNG and organized STD training for an expanded network of clinicians and workers in community-based organizations. Preliminary analysis of gonococcal susceptibility results for 147 patients during January–June 2002 suggests that QRNG prevalence remains >14%.

California

San Francisco, Long Beach, Orange County, and San Diego are participants in the Gonococcal Isolate Surveillance Project (GISP), a CDC-sponsored sentinel surveillance system that monitors antimicrobial resistance in *N. gonorrhoeae* through antimicrobial susceptibility testing of male urethral gonococcal isolates obtained from patients at public STD clinics in 26 U.S. cities. During 1990–2000, <1% of isolates tested annually from each GISP site in California were QRNG, except for Orange County, where 5.6% (six of 107) of GISP isolates were QRNG in 2000. In 2001, susceptibility testing was expanded beyond the GISP sample to include all gonococcal isolates from Orange County and San Diego STD clinic patients, including those from women and nonurethral sites. Susceptibility testing also was performed on all gonococcal isolates obtained from patients at a large southern California health maintenance organization (HMO) during February–April 2001. In 2001, QRNG was identified in 2.5% (33 of 1,311) of patients with tested isolates (Figure 2). Among STD clinic patients with gonorrhea, 3.4% (10 of 297) in San Francisco, 3.0% (three of 99) in Long Beach, 3.3% (seven of 212) in Orange County, and 2.4% (eight of 330) in San Diego had QRNG. Among HMO patients with gonorrhea, 1.3% (five

FIGURE 2. Percentage of fluoroquinolone-resistant *Neisseria gonorrhoeae* (QRNG)* among tested gonococcal isolates and gonorrhea rate†, by year§ — California, 1993–2001



* Defined as *N. gonorrhoeae* resistant to ciprofloxacin (minimal inhibitory concentration [MIC] ≥1.0 μg/mL by agar dilution or disk diffusion zone size ≤27 mm) or ofloxacin (MIC ≥2.0 μg/mL or disk diffusion zone size ≤24 mm) by the National Committee on Clinical Laboratory Standards.
† Per 100,000 population.
§ Data for 1993–2000 are exclusively from the Gonococcal Isolate Surveillance Project (GISP), and data for 2001 include GISP and non-GISP isolates.

of 373) had QRNG. The 1,311 patients with tested isolates accounted for 5.6% of all reported gonorrhea cases in California in 2001. Among 29 men infected with QRNG in 2001 whose sexual orientation was known, 20 (69%) were MSM. Among MSM with QRNG, 19 had a median of three recent (within 2–6 months) sex partners (range: one–40); 10 heterosexual men and women with QRNG had a median of 1.5 recent sex partners (range: one–eight), indicating the potential for more rapid spread among MSM. Although 12 (43%) of 28 QRNG patients interviewed in 2001 reported recent travel to Asia, the Pacific Islands, or Hawaii by themselves or a sex partner, 57% denied such travel, suggesting endemic spread of QRNG within California.

Medical records were reviewed for all 469 gonorrhea patients whose isolates were tested for susceptibility and who were seen in San Francisco, Long Beach, Orange County, or San Diego STD clinics during July 1–December 31, 2001. QRNG was identified in 23 (4.9%) of the 469 patients tested. QRNG was more common among Asians/Pacific Islanders than among non-Asians/Pacific Islanders (four [16.7%] of 24 versus 19 [4.4%] of 427; p=0.03). QRNG prevalence was similar among MSM (5.2% [15 of 289]), heterosexual men (4.7% [seven of 149]), and women (3.6% [one of 28]). However, geographic variation was noted in California: in San Diego, QRNG was more common among MSM than among heterosexual men and women (6.6% [seven of 106] versus zero of 65; p=0.03), and in San Francisco, QRNG was more common among heterosexuals than among MSM (11.4% [five of 44] versus 1.1% [one of 93]; p=0.01).

In response to the increasing prevalence of QRNG, in May 2002 the California Department of Health Services advised clinicians to avoid using fluoroquinolones for treatment of gonorrhea. Preliminary data collected during January–June 2002 indicate that the prevalence of QRNG infection among STD clinic patients with tested gonococcal isolates in GISP sites in California has increased, exceeding 9% during this period.

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Editorial Note: These data demonstrate that in 2001, QRNG prevalence increased in Hawaii and in California, where the epidemiology of QRNG varies within the state. In California, antimicrobial susceptibility data are available for a smaller proportion of reported gonorrhea cases than in Hawaii (6% versus 44%). Demographic data suggest that this low proportion might limit the generalizability of California's findings: patients with susceptibility-tested isolates in California were more likely to be male, older, and white, and to have their condition diagnosed in STD clinics than were other gonorrhea patients. However, the data from California indicate that QRNG has reached the continental United States, increasing the risk for its spread. Sporadic cases of QRNG have been identified in other states through GISP and non-GISP reporting, but no sustained increase in QRNG >1% has been identified in any other state (*3*). Increases in QRNG in California and Hawaii highlight the ongoing need for monitoring antimicrobial susceptibilities of gonococcal isolates throughout the United States.

CDC recommends that fluoroquinolones not be used to treat gonococcal infections acquired in Asia, where QRNG prevalence exceeds 40% (*5*); in the Pacific Islands, including Hawaii; in California; and in other areas with increased prevalence of fluoroquinolone resistance (*6*). The recommended treatment options for persons who might have acquired infection in those areas are cefixime (*7*), ceftriaxone, or spectinomycin. To select appropriate gonorrhea treatment in areas outside Hawaii and California, clinicians should ask suspected gonorrhea patients about their recent travel history and that of their sex partners (*8*).

Treatment of gonorrhea with fluoroquinolones can continue in areas where the prevalence of resistance is <1% (*9*). In areas where resistance is ≥1%, health departments making local treatment recommendations for gonorrhea also should consider other local factors such as the overall prevalence of

gonorrhea, the availability of antimicrobial susceptibility data, and the cost of various diagnostic and treatment options (*10*). Fluoroquinolones remain an important gonorrhea treatment option in the United States because they are inexpensive and easy to administer. In addition, their use might decrease use of cephalosporins and delay the development of cephalosporin resistance.

As part of effective gonorrhea control, state health departments should monitor local gonococcal antimicrobial susceptibility prevalence routinely to assist in developing local treatment recommendations. Symptomatic treatment failures are not a reliable indicator of emerging antimicrobial resistance because gonococcal infections, especially in women, are frequently asymptomatic. In 2001, a survey of STD project areas found that nonculture gonococcal tests were used widely and that approximately half of project areas had antimicrobial susceptibility data (*3*). Because nonculture tests cannot provide antimicrobial susceptibility results, local gonococcal culture capacity should be maintained. The antimicrobial susceptibility testing panel should, at a minimum, include a fluoroquinolone, cefixime, ceftriaxone, spectinomycin, azithromycin, and any other drugs in local use for gonorrhea treatment.

In cases of persistent gonococcal infection after treatment, clinicians should consider performing culture and antimicrobial susceptibility testing. In areas where fluoroquinolones are used for treating gonorrhea and small numbers of patients with QRNG are identified, health departments should notify and treat partners of patients with known QRNG to minimize the spread of resistance. Through their state and local health departments, clinicians and laboratorians should report treatment failures or resistant gonococcal isolates to CDC, telephone 404-639-8373; isolates may be submitted to CDC's Neisseria Reference Laboratory for confirmation testing, telephone 404-639-3470.

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Multistate Outbreaks of *Salmonella* Serotype Poona Infections Associated with Eating Cantaloupe from Mexico — United States and Canada, 2000–2002

Three multistate outbreaks of *Salmonella* serotype Poona infections associated with eating cantaloupe imported from Mexico occurred in the spring of consecutive years during 2000–2002. In each outbreak, the isolates had indistinguishable pulsed-field gel electrophoresis (PFGE) patterns; the PFGE patterns observed in the 2000 and 2002 outbreaks were

indistinguishable, but the pattern from 2001 was unique among them. Outbreaks were identified first by the California Department of Health Services (2000 and 2001) and the Washington State Department of Health (2002) and involved residents of 12 states and Canada. This report describes the investigations, which led ultimately to an import alert on cantaloupes from Mexico. To limit the potential for cantaloupe contamination, the Food and Drug Administration (FDA) continues to work with the Mexican government on a food-safety program for the production, packing, and shipping of fresh cantaloupes.

April–June 2000 Outbreak

A total of 47 confirmed cases of *S.* Poona infections with indistinguishable PFGE patterns were identified from California (26), Washington (10), Nevada (five), New Mexico (three), Oregon (two), and Colorado (one), with illness onset occurring during April 14–June 2. The median age of ill persons was 7 years (range: 1–95 years); 28 (60%) patients were aged <10 years, and nine (19%) were aged >60 years. Twenty-four (51%) patients were male and nine (19%) were hospitalized.

A matched case-control study was conducted; 20 case-patients were matched by age category to 37 community controls. A case was defined as laboratory-confirmed infection with *S.* Poona of the outbreak PFGE pattern in a person with illness onset during April–June. By multivariable modeling, illness was associated only with eating cantaloupe (matched odds ratio [MOR]=6.7; 95% confidence interval [CI]=1.3–34.0), with 16 (80%) case-patients versus seven (19%) controls reporting eating cantaloupe. Cantaloupe was purchased either pre-cut or whole.

April–May 2001 Outbreak

In April, an initial cluster of *S.* Poona was identified in California. Isolates had a rare biochemical trait, the inability to produce hydrogen sulfide (H_2S), and PFGE patterns that were indistinguishable. A total of 50 cases of H_2S-negative *S.* Poona infections were identified in residents of California (28), Washington (eight), Nevada (seven), Arizona (six), and Oregon (one). Demographic and illness-history data from the 28 California patients indicated that illness onset occurred during April 6–May 28. The age distribution was bimodal; the 19 children had a median age of 3 years (range: 1–5 years) and the nine adults had a median age of 80 years (range: 39–91 years). Fifteen (54%) patients were female. Ten (36%) patients were bacteremic; one infant girl had *S.* Poona isolated from a urine specimen. Nine (33%) patients were hospitalized, and two patients (a man aged 78 years and a woman aged 91 years) died with *Salmonella* septicemia.

A matched case-control study was conducted; 11 case-patients from California (seven), Nevada (two), Arizona (one), and Washington (one) were matched by age category to 19 community controls. Case-patients had laboratory-confirmed infections of the outbreak strain of H_2S-negative *S.* Poona and illness onset during the first 2 weeks of April. Illness was associated only with eating cantaloupe (MOR=7.4; 95% CI=1.0–178.0). Eight (80%) case-patients and six (33%) controls recalled eating cantaloupe. Cantaloupe was purchased either pre-cut or whole.

March–May 2002 Outbreak

A total of 58 cases with *S.* Poona isolates with indistinguishable PFGE patterns were identified in California (21), Washington (nine), Oregon (five), British Columbia (four), Colorado (three), Nevada (three), Manitoba (two), Missouri (two), Ontario (two), Saskatchewan (two), Texas (two), Arkansas (one), Minnesota (one), and Vermont (one). Illness onset occurred during March 30–May 31; the median age of patients was 6 years (range: 4 months–91 years); 32 (55%) were aged <10 years, and 11 (19%) were aged >60 years. A total of 31 (55%) were female. Ten patients were hospitalized.

A matched case-control study was conducted; 27 case-patients were matched by age category to 54 community controls. A case was defined as *S.* Poona infection with the outbreak PFGE pattern in a person aged ≥2 years with illness onset during March 15–May 3. The only exposure significantly associated with illness was eating cantaloupe; 20 (74%) case-patients recalled eating cantaloupe compared with 11 (20%) controls (MOR=15.5; 95% CI=3.3–125.0). Case-patients (50%) were more likely than controls (13%) to eat cantaloupe purchased whole (MOR=5.8; 95% CI=1.6–23.3) or to eat cantaloupe in a fruit salad or as a garnish (28% versus 5%) (MOR=6.5; 95% CI=1.2–63.0). No other factors were significantly associated with illness.

Traceback and Regulatory Action

FDA, in conjunction with state and provincial food regulatory agencies, conducted traceback investigations of cantaloupe purchased by patients in all three outbreaks. In each instance, point-of-sale sources of cantaloupe were traced back to shippers and then to farms in Mexico. In response to the 2000 and 2001 outbreaks, FDA conducted on-farm investigations in Mexico and concluded that measures were not in place to minimize microbial contamination in the growing, harvesting, packaging, and cooling of cantaloupe. Possible

sources of contamination include irrigation of fields with water contaminated with sewage, processing (cleaning and cooling) produce with *Salmonella*-contaminated water, poor hygienic practices of workers who harvest and process the cantaloupe, pests in packing facilities, and inadequate cleaning and sanitizing of equipment that comes in contact with cantaloupe. In association with the 2001 outbreak, FDA detained product imported by the shipper on May 31, and the shipper voluntarily recalled its imported Mexican cantaloupe. The shipper and the implicated farm in Mexico remain on detention. In association with the 2002 outbreak, the importer voluntarily recalled the implicated Mexican cantaloupe, and FDA placed the implicated farms on detention. On October 28, 2002, FDA issued an import alert on cantaloupe from Mexico that detains all products offered for entry at all U.S. ports.

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Editorial Note: *Salmonella* infections have been linked to melons at least since 1990 when *Salmonella* serotype Chester traced to cantaloupe caused 245 illnesses in 30 states (*1*). The cantaloupe were imported from either Mexico or Guatemala. In 1991, an outbreak of cantaloupe-associated *S.* Poona infections caused 400 illnesses in 23 states (*2*). Illness was associated with eating pre-cut cantaloupe in fruit salads or from salad bars. Although industry sources identified the lower Rio Grande Valley in Texas as the probable source of the implicated cantaloupe, some might have come from Mexico. In response to this outbreak, FDA conducted a microbiologic survey that isolated a variety of *Salmonella* serotypes from approximately 1% of sampled imported cantaloupe and watermelon (*2*). In 1997, an outbreak of *Salmonella* serotype Saphra infections affected 25 persons in California. Illness was associated with cantaloupe imported from Mexico (*3*). After the 2000 and 2001 *S.* Poona outbreaks, FDA conducted farm investigations in Mexico, issued press releases to warn consumers, placed implicated farms on detention, and conducted sampling surveys of imported cantaloupe. The 1999 and 2000 FDA surveys of imported produce indicated that 5% of cantaloupe sampled (eight of 151) was contaminated with *Salmonella* (*4*). A 2001 survey of imported produce indicates that of 29 cantaloupes from Mexico tested, none yielded *Salmonella*, *Shigella*, or *Escherichia coli* O157:H7 (FDA, unpublished data, 2001). The interpretation of the 2001 survey is limited by of the small sample size.

S. Poona is a relatively rare serotype that is responsible for 1% of human *Salmonella* isolates reported in the United States in 2001; however, of the six cantaloupe-associated *Salmonella* outbreaks, four were attributed to infections with *S.* Poona. Typically, human infection with *S.* Poona is associated with reptile exposure (*5,6*). The three outbreaks attributed to *S.* Poona-contaminated cantaloupe traced to Mexican farms suggest the possibility of a unique natural reservoir in the Mexican farm environment, possibly from reptiles such as iguanas drawn to feed on melon crops that enter the packing sheds and contaminate the equipment. Subsequently, water used in the washing and cooling process might spread the contamination.

FDA provides information about the decontamination of melons to the retail industry, food-service establishments, and commercial processors of pre-cut melon (*7,8*). The use of sodium hypochlorite or other permitted antimicrobials in combination with brushing is recommended. The potential for microbial contamination also might be reduced by using only good-quality fruit that is free from open wounds or defects that might allow bacteria to contaminate the interior of the fruit (*9*). Additional research is needed to determine the effectiveness of consumer produce-washing practices. Consumers should be sure that fresh-cut melons are refrigerated or surrounded by ice; leftover cut melons should be discarded if left at room temperature for >2 hours. Additional information for consumers is available at http://www.fda.gov/bbs/topics/answers/2002/ans01167.html.

On October 28, 2002, in response to the three outbreaks during 2000–2002 and analytical results from the sampling of imported Mexican cantaloupe, FDA issued an import alert that detains all cantaloupe from Mexico offered for entry at all U.S. ports. FDA will continue to work with the Mexican government on a food-safety program for the production, packing, and shipping of fresh cantaloupe. The Mexican government is developing a certification program based on sound agricultural and manufacturing practices that would allow FDA to identify farms that have adopted and implemented such a food-safety program.

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Enterovirus Surveillance — United States, 2000–2001

Enteroviruses are common viruses associated with diverse clinical manifestations ranging from mild febrile illness to severe and potentially fatal syndromes including aseptic meningitis, encephalitis, neonatal systemic enteroviral disease, and paralytic poliomyelitis (*1*). A total of 64 enterovirus serotypes are recognized, including 61 nonpolio enteroviruses (*2*)*. Individual serotypes have different temporal patterns of circulation and often are associated with different clinical manifestations (*1,4*). This report describes temporal trends in reported enterovirus infections in the United States during 2000–2001, including widespread activity of two serotypes (echoviruses 13 and 18) that previously were detected rarely. Monitoring of circulating enterovirus serotypes helped identify these two agents as the primary causes of aseptic meningitis outbreaks in the United States in 2001. Further improvements in timeliness of reporting and geographic representation of the system are needed to allow more complete surveillance for enteroviruses.

Other than paralytic polio, diseases associated with enterovirus infections, including aseptic meningitis, are not nationally notifiable in the United States. The National Enterovirus Surveillance System (NESS) collects information on enterovirus serotypes and monitors temporal and geographic trends to help public health officials recognize and control outbreaks of enteroviral disease. Enterovirus detections from human specimens that are submitted for testing to participating laboratories are reported voluntarily to NESS along with basic demographic information, specimen type, and date of collection.

The number of laboratories participating in NESS increased from eight in 1999 to 21 in 2000 and 25 in 2001. During 2000–2001, a total of 27 laboratories participated in NESS, including 24 state public health laboratories, two private laboratories, and CDC's Enterovirus Laboratory, which receive specimens from multiple states. Enterovirus detections were reported in 36 states in 2000 and in 30 states in 2001. During 2000–2001, a total of 40 states reported enterovirus detections; of 2,319 reports, 1,925 (83.0%) were submitted by public health laboratories, 318 (13.7%) by private laboratories, and 76 (3.3%) by CDC. Of the 27 laboratories, three used genomic sequencing for enterovirus typing, and 24 used traditional antigenic typing methods. Serotypes were identified for 1,863 (80.3%) reports (Table 1). Consistent with the trend observed throughout the 1990s, the proportion of reported enteroviruses with unknown serotype increased from 13.1% during 1997–1999 to 19.7% during 2000–2001. Because the high proportion of unknown serotypes could lead

TABLE 1. Number and percentage of enterovirus detection reports, by serotype identification status — National Enterovirus Surveillance System, United States, 2000–2001

	Years					
	2000		2001		Total	
Serotype status	No.	(%)	No.	(%)	No.	(%)
With known serotypes	578	(78.6%)	1,285	(81.1%)	**1,863**	**(80.3%)**
With unknown serotypes	157	(21.4%)	299	(18.9%)	**456**	**(19.7%)**
Total	**735**		**1,584**		**2,319**	

*Echoviruses 22 and 23 have been reclassified recently as human parechoviruses 1 and 2, respectively, members of genus *Parechovirus,* which is related to (but distinct from) the genus *Enterovirus.* Epidemiologic and clinical features of these viruses are similar to those of the enteroviruses (*3*), and detection of these viruses continues to be reported to the National Enterovirus Surveillance System.

to underestimating the number of individual enteroviruses, reports with unknown serotypes were excluded from the analysis of serotype distribution.

During 2000–2001, echovirus 18 and echovirus 13 were the predominant serotypes, accounting for 22.0% and 20.8% respectively of the reports with an identified serotype, followed by coxsackievirus B5 (11.9%), coxsackievirus B2 (6.3%), and echovirus 6 (6.1%) (Table 2). The serotype detected most commonly for 2000 was coxsackievirus B5 (34.4%). The predominant enteroviruses in 2001 were echoviruses 18 and 13, which accounted for 30.8% and 29.3%, respectively; echovirus 13 was reported in 24 states and echovirus 18 in 19 states. Illinois, Michigan, Tennessee, and Wisconsin reported the most echovirus 13 detections, and Illinois, Minnesota, New York, and Texas reported the most echovirus 18 detections. One vaccine-related type 3 poliovirus was reported in 2000.

The most common source for enterovirus detection was cerebrospinal fluid (980 [51.2%] of 1,915 reports indicating the source specimen), followed by stool or rectal swab (338 [17.7%]). Children aged <1 year accounted for 859 (44.0%) of 1,951 reports for which age data were available.

Reported by: *State virology laboratory directors. Diagnostic Virology Laboratory, Associated Regional and Univ Pathologists Laboratories, Salt Lake City, Utah. Diagnostic Virology Laboratory, Texas Children's Hospital, Houston, Texas. S Oberste, PhD, A LaMonte, MPH, N Khetsuriani, MD, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; V Hsu, MD, J Mullins, DVM, EIS officers, CDC.*

TABLE 2. Distribution of the 15 most commonly reported nonpolio enterovirus serotypes, by rank — National Enterovirus Surveillance System, United States, 2000–2001

	2000 (n=577)		2001 (n=1,285)		2000–2001 (n=1,862)	
Rank	Serotype	%	Serotype	%	Serotype	%
1	coxsackie B5	34.4	echo 18	30.8	echo 18	22.0
2	echo 6	8.8	echo 13	29.3	echo 13	20.8
3	coxsackie A9	8.7	coxsackie B2	7.6	coxsackie B5	11.9
4	coxsackie B4	8.3	echo 6	4.8	coxsackie B2	6.3
5	echo 11	6.9	echo 4	4.1	echo 6	6.1
6	echo 9	6.2	echo 11	3.4	echo 11	4.5
7	coxsackie B2	3.5	coxsackie B3	3.0	coxsackie A9	4.0
8	echo 25	2.6	coxsackie B1	2.7	echo 9	3.3
9	echo 18	2.3	echo 9	2.0	coxsackie B4	3.2
10	enterovirus 71	2.1	coxsackie A9	2.0	echo 4	3.1
11	echo 16	1.9	coxsackie B5	1.7	coxsackie B3	2.4
12	echo 30	1.9	echo 30	1.7	coxsackie B1	2.0
13	echo 13	1.7	coxsackie B4	0.9	echo 30	1.8
14	echo 21	1.6	echo 25	0.6	echo 25	1.2
15	parecho 1*	1.4	enterovirus 71	0.6	enterovirus 71	1.1
Total†		**92.2**		**95.3**		**93.5**

* Formerly echo 22.
† Totals might be slightly different from sums of percentages because of rounding. For all other serotypes, percentages were 7.8% in 2000, 4.7% in 2001, and 6.5% during 2000–2001.

Editorial Note: Serotype-based enterovirus surveillance in the United States has five objectives. First, NESS data help to determine long-term patterns of circulation for individual serotypes (*4*). Second, the data are used to associate trends in enteroviral diseases with circulating serotypes such as viral meningitis–associated hospitalizations during periods of high activity of echoviruses 9 and 30 and lower numbers of these cases for years when group B coxsackieviruses predominate (CDC, unpublished data, 1988–1999). Third, the data are used to guide outbreak investigations. Fourth, because different serotypes have differential sensitivity to at least one candidate antienterovirus drug (*5*), information on circulating serotypes helps guide the development of new diagnostic tests and therapies. Finally, NESS monitors circulation of poliovirus strains to supplement poliovirus surveillance; this aspect of enterovirus surveillance will remain important until successful global poliovirus eradication ends the need for polio surveillance.

The findings in this report are consistent with previous observations on temporal variability of predominant serotypes. Of the 15 serotypes reported most commonly during 2000–2001, seven (coxsackieviruses A9, B2, and B4 and echoviruses 6, 9, 11, and 30) have appeared consistently among the 15 most common serotypes each year during 1993–1999 (*6,7*). Two enteroviruses (echovirus 18 and echovirus 13) that previously were rarely reported emerged as the predominant serotypes in 2001. Timely identification of increased activity by these serotypes helped guide investigation of outbreaks of aseptic meningitis reported to CDC in 2001 from six states (Alaska, Louisiana, Maryland, Mississippi, Montana, and Tennessee); all of these outbreaks were linked subsequently to one or both of these serotypes (*8*). For echovirus 13, this was the first report of widespread circulation in the United States and probably reflected the worldwide activity of this serotype that has been observed since 2000 (*8*).

Multiple factors might explain the increase in unknown serotypes, including limited availability of the appropriate typing antisera, high cost of reagents, and labor intensity of testing. The use of enterovirus typing based on genomic sequencing (*9*) could increase the proportion of identified serotypes, including those for which reagents are not readily available. The virtual absence of vaccine-related poliovirus isolates after 2000 is associated with the discontinuation of the use of oral polio vaccine in the United States beginning in 2000 (*10*).

The findings in this report are subject to at least two limitations. First, because of the voluntary and passive nature of NESS, the small number of reports for some states, and the lack of reporting or testing by others, these results might not be fully representative of the entire United States. Second, because many serotypes were not identified, the number of individual enteroviruses might be underestimated.

As laboratory participation in NESS increases, the data will become more representative geographically. More timely reporting from laboratories would allow NESS to provide frequent feedback in the form of an online enterovirus surveillance summary, which would increase the public health utility of this surveillance system.

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West Nile Virus Activity — United States, November 14–20, 2002, and Missouri, January 1–November 9, 2002

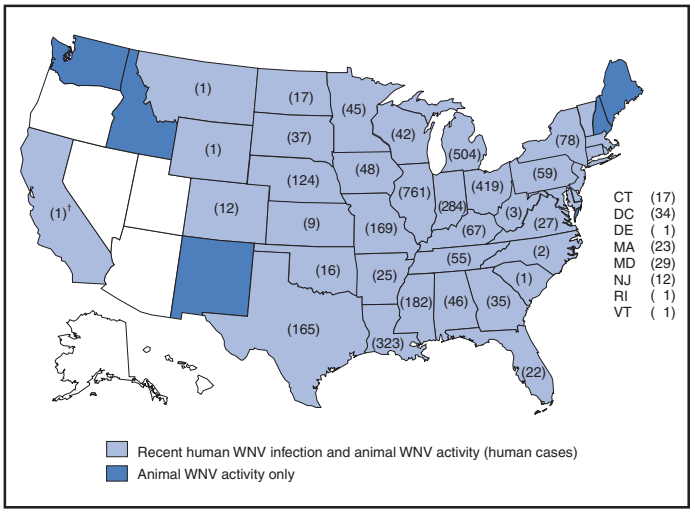
This report summarizes West Nile virus (WNV) surveillance data reported to CDC through ArboNET and by states and other jurisdictions as of 9 a.m. Mountain Standard Time, November 20, 2002.

United States

During November 14–20, a total of 111 laboratory-positive human cases of WNV-associated illness were reported from Indiana (n=37), Illinois (n=23), Texas (n=17), Nebraska (n=nine), Ohio (n=six), Georgia (n=five), Arkansas (n=four), Florida (n=four), Minnesota (n=three), Maryland (n=one), Massachusetts (n=one), and Tennessee (n=one). During the same period, WNV infections were reported in 90 dead crows and 330 other dead birds. A total of 411 veterinary cases and 25 WNV-positive mosquito pools were reported.

During 2002, a total of 3,698 human cases with laboratory evidence of recent WNV infection have been reported from Illinois (n=761), Michigan (n=504), Ohio (n=419), Louisiana (n=323), Indiana (n=284), Mississippi (n=182), Missouri (n=169), Texas (n=165), Nebraska (n=124), New York (n=78), Kentucky (n=67), Pennsylvania (n=59), Tennessee (n=55), Iowa (n=48), Alabama (n=46), Minnesota (n=45), Wisconsin (n=42), South Dakota (n=37), Georgia (n=35), the District of Columbia (n=34), Maryland (n=29), Virginia (n=27), Arkansas (n=25), Massachusetts (n=23), Florida (n=22), Connecticut (n=17), North Dakota (n=17), Oklahoma (n=16), Colorado (n=12), New Jersey (n=12), Kansas (n=nine), West Virginia (n=three), North Carolina (n=two), California (n=one), Delaware (n=one), Montana (n=one), Rhode Island (n=one), South Carolina (n=one), Vermont (n=one), and Wyoming (n=one) (Figure 1). Among the 3,287 patients for whom data were available, the median age was 55 years (range: 1.5 months–99 years); 1,755 (54%) were male, and the dates of illness onset ranged from June 10 to

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



* As of 9 a.m. Mountain Standard Time, November 20, 2002.
† California has reported human WNV activity only.

November 4. A total of 198 human deaths have been reported. The median age of decedents was 78 years (range: 24–99 years); 120 (61%) deaths were among men. In addition, 7,612 dead crows and 6,060 other dead birds with WNV infection were reported from 42 states and the District of Columbia; 8,723 WNV infections in mammals (8,710 equines, three canines, and 10 other species) have been reported from 38 states (Alabama, Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, Wisconsin, and Wyoming). During 2002, WNV seroconversions have been reported in 366 sentinel chicken flocks from Florida, Iowa, Nebraska, North Carolina, Pennsylvania, Texas, and New York City; 4,931 WNV-positive mosquito pools have been reported from 27 states (Alabama, Arkansas, Connecticut, Delaware, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Vermont, and Virginia), New York City, and the District of Columbia.

Missouri

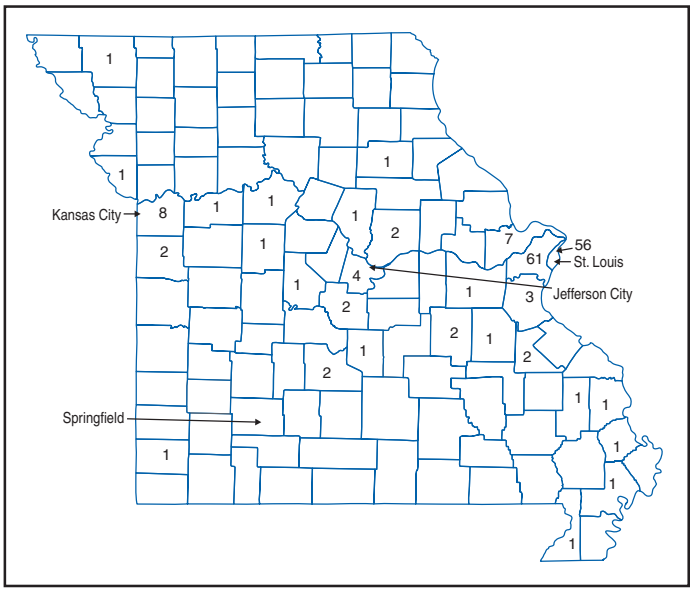
During January 1–November 9, 2002, the Missouri Department of Health and Senior Services (MDHSS) identified 168 persons with laboratory evidence of West Nile virus (WNV) infection; 34 cases were confirmed by CDC on the basis of the plaque-reduction neutralization test, and 134 cases were classified as probable pending CDC confirmation. Five cases were fatal; all five patients had encephalitis.

The 168 patients had a median age of 53.2 years (range: 4–92 years); 91 patients (53%) were male. Median age of decedents was 75.6 years (range: 61–88 years). Dates of illness onset ranged from July 31 to October 12.

Of Missouri's 114 reporting local public health agencies (LPHAs), 109 (96%) have reported WNV-positive animal tests, representing nearly all geographic regions and human population centers in Missouri (Figure 2). Human WNV cases have occurred among persons from 32 (28%) of LPHA districts; 126 (75%) patients resided in metropolitan St. Louis districts. The metropolitan Kansas City area has recorded eight cases; no human WNV cases have been reported from the Springfield area (Greene County).

The elevated WNV incidence rate in the metropolitan St. Louis area, especially within St. Louis city limits (16.1

FIGURE 2. Number of West Nile virus cases in humans*, by county — Missouri, January 1–November 9, 2002



* n=168.

cases per 100,000 population), is under investigation. Of 134 Missouri WNV cases for which case investigations are completed, 86 (64%) patients recalled being bitten by a mosquito 3 weeks before onset of illness. In addition, 86 (64%) patients reported not using repellent during that time. Patients spent an average of 4.4 hours outdoors per day for leisure and work. Morning (47%) was the time that patients most frequently reported being active outdoors for leisure and work. A total of 58 (43%) patients reported having standing water around their home during the 3 weeks preceding onset of illness. The top four reported sources of standing water were birdbaths, flowerpots, pet watering containers, and tires.

MDHSS provides frequent updates on human cases of WNV and activity by county for dead birds and infected horses on its website (http://www.dhss.state.mo.us/westnilevirus/positives.pdf). Results on specimens submitted for laboratory testing are provided to patient providers, submitting laboratories, and local health departments. MDHSS issues press releases updating case numbers, reminding the public of personal protection measures, and advising elimination of sources of standing water around residences. MDHSS produced a statewide prevention campaign based on the slogan "Don't Let It Bug You," which included posters and brochures distributed to all 114 LPHAs, direct-mail appeals to St. Louis area clergy for increased community awareness of mosquito habitats, television and radio public service announcements, and a toll-free hotline for citizens' questions. Mosquito-control program recommendations, developed by MDHSS

are available at http://www.dhss.state.mo.us. The decision to initiate a control program has been left to local municipalities.

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

Notice to Readers

Approval of a New Rapid Test for HIV Antibody

On November 7, 2002, the Food and Drug Administration announced approval of the OraQuick Rapid HIV-1 Antibody Test (OraSure Technologies, Inc., Bethlehem, Pennsylvania) for use by trained personnel as a point-of-care test to aid in the diagnosis of infection with human immunodeficiency virus type 1 (HIV-1). OraQuick is a simple, rapid test that can detect antibodies to HIV in fingerstick whole blood specimens and provide results in ≤20 minutes. The test has been categorized as moderate complexity under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). A second FDA-approved moderate-complexity rapid HIV test, Single Use Diagnostic System for HIV-1 (Abbott-Murex Inc., Norcross, Georgia), remains available in the United States for use with serum or plasma specimens.

Use of a rapid test that allows same-day results can substantially increase the number of persons who receive their test results, which improves the delivery of counseling and treatment services (*1*). On the basis of data submitted by the manufacturer for test approval, the sensitivity* of OraQuick in the clinical studies performed was 99.6% (95% confidence interval [CI]=98.5%–99.9%), and specificity was 100% (95% CI=99.7%–100%), comparable to those of FDA-approved enzyme immunoassays in widespread use. Because HIV prevalence is low in most U.S. testing settings, the negative predictive value† of screening with a single rapid test is high. Therefore, a negative rapid HIV test does not require further testing, and negative results with counseling can be provided at the initial visit. Retesting is recommended for those persons with a recent (within 3 months) history of known or possible exposure to HIV because there might have been insufficient time for detectable antibodies to develop (*2*). As with any HIV screening test, all reactive (preliminary positive) rapid test results should be confirmed by supplemental testing by either a Western blot or immunofluorescence assay (*3*). The confirmatory tests can be performed on serum specimens obtained by phlebotomy, dried blot spots obtained on filter paper, or oral fluid specimens collected with the OraSure collection device.

Persons whose rapid-test results are reactive should be counseled about their likelihood of being infected with HIV and precautions to prevent HIV transmission, but they should return for definitive test results before medical referrals or partner counseling is initiated (*3*). A simple message to convey this information could be a statement that "Your preliminary test result was positive, but we won't know for sure if you are HIV-infected until we get the results from your confirmatory test. In the meantime, you should take precautions to avoid possibly transmitting the virus."

The Public Health Service recommends that rapid HIV tests should be used and preliminary positive test results provided when tested persons might benefit (*1*). Decisions about whether to use rapid tests should be based on considerations of return rates for standard test results and urgency of the need for test results (i.e., when necessary to make decisions about postexposure or perinatal prophylaxis) (*1,4,5*). The use of rapid tests will facilitate the acceptance of HIV testing and improve receipt of results in other health-care settings in which HIV testing is recommended, such as hospitals and acute-care clinics, where persons who are unaware of their HIV status might seek health-care services (*6*). Additional information and guidance on the use of rapid HIV tests are available from CDC at http://www.cdc.gov/hiv/testing.htm.

Sites wanting to perform this new HIV-1 rapid test that are not already certified to perform moderate-complexity laboratory tests under CLIA must enroll in the CLIA program, administered by the Centers for Medicare and Medicaid Services. The application and state agency contact information are available at http://www.cms.hhs.gov/clia. Information about enrollment and the requirements for moderate-complexity testing are available at http://www.phppo.cdc.gov/clia/default.asp.

CLIA moderate-complexity requirements provide minimum standards for personnel, quality control, proficiency testing, and quality assurance. In addition, some states have specific requirements that might apply to laboratory testing in general or to HIV testing specifically.

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* Sensitivity is the probability that the test result will be reactive if the specimen is a true positive; specificity is the probability that the test result will be nonreactive if the specimen is a true negative.

† The predictive value of a screening test is the probability that the test accurately predicts the true infection status of the person tested.

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Notice to Readers

Discontinuation of Cefixime Tablets — United States

In July 2002, Wyeth Pharmaceuticals (Collegeville, Pennsylvania) discontinued manufacturing cefixime (Suprax®) in the United States. In October 2002, the company ceased marketing cefixime tablets (200 mg and 400 mg) because of depletion of company inventory. Wyeth's patent for cefixime expired on November 10, 2002. No other pharmaceutical company manufactures or sells cefixime tablets in the United States. Wyeth will continue to sell cefixime suspension (100 mg/5 ml) until March 31, 2003, or until company inventory is depleted, whichever is sooner.

Cefixime is the only CDC-recommended oral antimicrobial agent to which *Neisseria gonorrhoeae* has not developed significant resistance (*1*). Uncomplicated *N. gonorrhoeae* infections may be treated with single-dose regimens of cefixime 400 mg orally, ceftriaxone 125 mg intramuscularly, or an oral fluoroquinolone (ciprofloxacin 500 mg, levofloxacin 250 mg, or ofloxacin 400 mg). However, fluoroquinolones should not be used for treatment of gonorrhea if the infection was acquired in Asia, the Pacific Islands (including Hawaii), or California because the prevalence of fluoroquinolone-resistant *N. gonorrhoeae* is high in those areas (*1,2*).

In the absence of cefixime, the primary recommended treatment option for gonorrhea in Hawaii and California is ceftriaxone. Also, in the absence of cefixime, ceftriaxone is the only CDC-recommended gonorrhea treatment option for young children and pregnant women throughout the United States. Fluoroquinolones can continue to be used for treating gonorrhea in areas of the United States with low prevalence of fluoroquinolone-resistant *N. gonorrhoeae*, but antimicrobial susceptibility monitoring should routinely be performed (*2*). Other oral antimicrobial agents, such as cefpodoxime, cefuroxime axetil, and azithromycin, are not recommended by CDC for the treatment of gonorrhea. Additional information on the use of oral antimicrobials in treating *N. gonorrhoeae* infections will be available from CDC at http://www.cdc.gov/std.

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Erratum: Vol. 51, No. 45

In the report "Influenza Outbreak—Madagascar, July–August, 2002," in Figure 2 on page 1017, the number of districts with laboratory-confirmed influenza was incorrectly indicated. Because a limited number of patients in a few districts were tested for influenza, the map has been changed to depict only districts with reported influenza-like illness cases.

FIGURE 2. Districts reporting cases of influenza-like illness (ILI) — Madagascar, July–August 2002

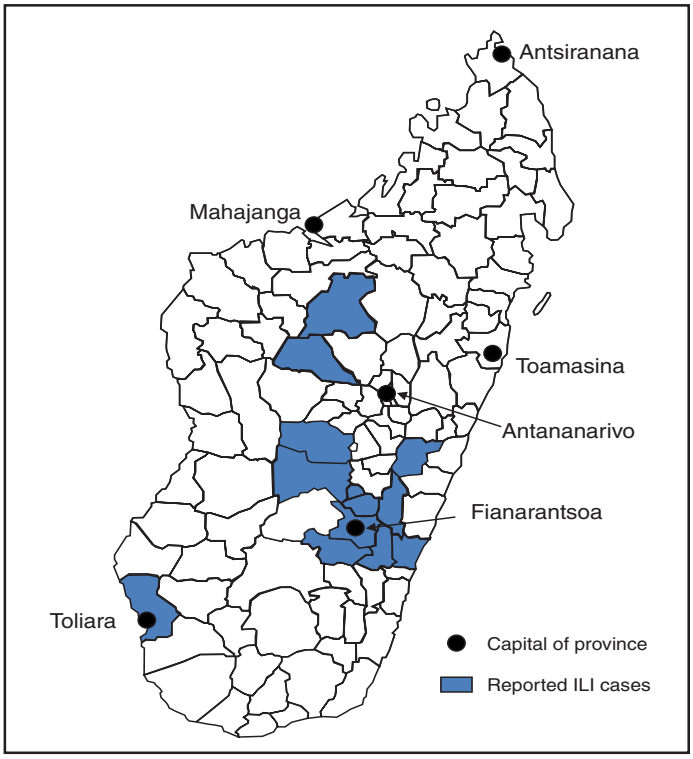
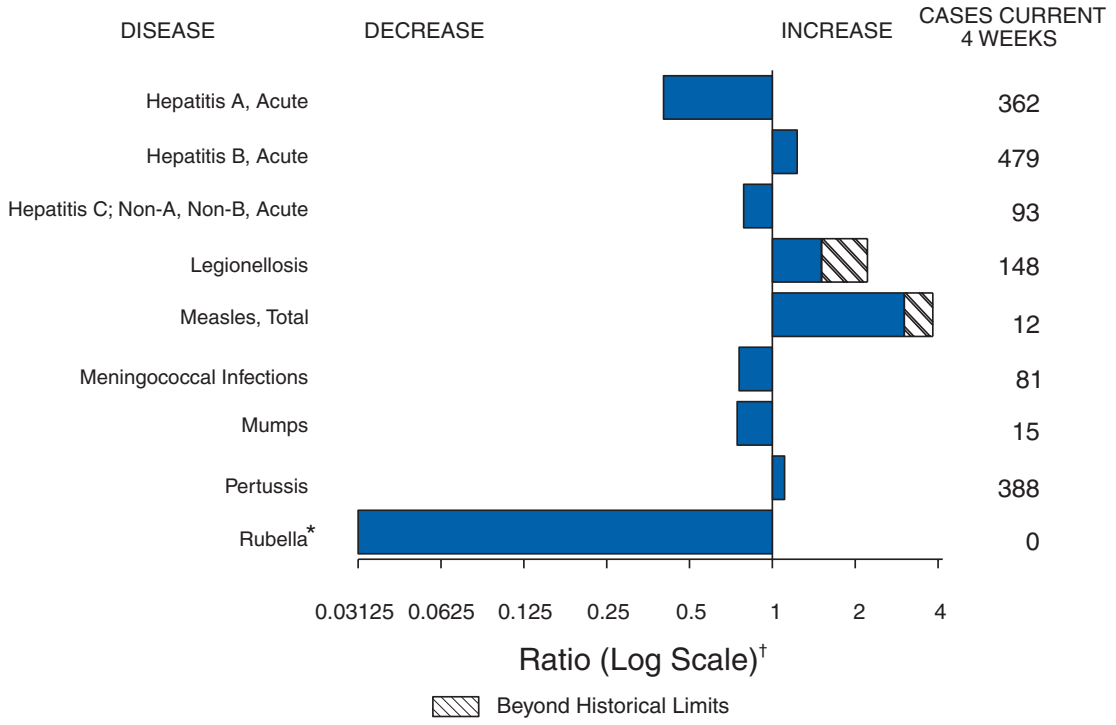


FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending November 16, 2002, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 46 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 November 16, 2002 (46th Week)*

		Cum. 2002	Cum. 2001		Cum. 2002	Cum. 2001
Anthrax		2	21	Encephalitis: West Nile†	1,339	52
Botulism:	foodborne	12	33	Hansen disease (leprosy)†	59	60
	infant	48	86	Hantavirus pulmonary syndrome†	13	7
	other (wound & unspecified)	26	16	Hemolytic uremic syndrome, postdiarrheal†	172	163
Brucellosis†		68	115	HIV infection, pediatric†§	116	172
Chancroid		61	31	Plague	-	2
Cholera		5	4	Poliomyelitis, paralytic	-	-
Cyclosporiasis†		158	141	Psittacosis†	17	20
Diphtheria		1	2	Q fever†	43	23
Ehrlichiosis:	human granulocytic (HGE)†	314	203	Rabies, human	2	1
	human monocytic (HME)†	158	103	Streptococcal toxic-shock syndrome†	72	68
	other and unspecified	9	5	Tetanus	20	27
Encephalitis:	California serogroup viral†	117	112	Toxic-shock syndrome	100	105
	eastern equine†	3	8	Trichinosis	12	21
	Powassan†	-	-	Tularemia†	56	124
	St. Louis†	8	76	Yellow fever	1	-
	western equine†	2	-			

-: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 October 31, 2002.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending November 16, 2002, and November 17, 2001 (46th Week)*

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli, Enterohemorrhagic*			
							O157:H7		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	34,080	681,846	684,617	2,555	3,458	3,220	2,884	150	142
NEW ENGLAND	1,011	1,268	23,786	21,449	167	137	252	230	32	38
Maine	23	40	1,466	1,187	11	18	37	26	5	1
N.H.	20	31	1,398	1,228	29	15	32	31	-	3
Vt.	8	13	835	544	31	32	12	13	1	1
Mass.	519	654	9,650	9,100	60	52	113	112	9	10
R.I.	71	84	2,443	2,602	20	4	14	13	-	1
Conn.	370	446	7,994	6,788	16	16	44	35	17	22
MID. ATLANTIC	5,619	8,977	76,678	74,744	312	316	220	218	-	-
Upstate N.Y.	404	1,168	14,968	12,534	126	94	160	139	-	-
N.Y. City	3,210	4,773	24,569	26,379	120	114	12	16	-	-
N.J.	925	1,509	10,764	12,416	10	19	48	63	-	-
Pa.	1,080	1,527	26,377	23,415	56	89	N	N	-	-
E.N. CENTRAL	2,494	2,499	119,570	127,395	817	1,509	778	749	19	11
Ohio	453	476	28,881	33,798	119	164	146	204	15	9
Ind.	347	306	15,168	13,712	51	78	68	79	1	-
Ill.	1,170	1,110	32,255	38,393	85	478	164	162	-	-
Mich.	398	457	28,812	26,784	112	173	131	90	3	2
Wis.	126	150	14,454	14,708	450	616	269	214	-	-
W.N. CENTRAL	421	718	37,450	34,775	386	497	483	464	37	38
Minn.	90	118	8,408	7,270	201	168	155	188	32	29
Iowa	54	80	4,761	4,451	42	80	115	76	-	-
Mo.	189	337	13,525	12,440	32	48	69	59	N	N
N. Dak.	1	2	801	901	20	13	17	19	-	2
S. Dak.	3	23	1,884	1,581	28	7	39	41	2	6
Nebr.	43	72	2,456	2,859	47	178	54	59	3	1
Kans.	41	86	5,615	5,273	16	3	34	22	-	-
S. ATLANTIC	7,537	10,268	131,239	131,527	316	344	347	224	36	33
Del.	131	217	2,363	2,488	3	6	8	4	-	1
Md.	1,066	1,517	14,542	13,547	21	36	25	28	-	-
D.C.	371	733	3,036	2,865	4	11	-	-	-	-
Va.	538	843	14,698	16,177	21	24	57	48	9	5
W. Va.	58	71	2,081	2,102	2	2	9	10	-	-
N.C.	555	778	22,110	19,279	32	27	130	46	-	-
S.C.	547	612	10,607	13,470	6	7	5	16	-	-
Ga.	1,160	1,232	26,326	28,506	133	150	54	43	10	9
Fla.	3,111	4,265	35,476	33,093	94	81	59	29	17	18
E.S. CENTRAL	1,128	1,532	41,595	44,064	109	48	99	127	-	-
Ky.	173	299	7,818	8,040	8	5	30	63	-	-
Tenn.	483	488	14,092	12,804	52	13	44	37	-	-
Ala.	197	378	11,034	12,536	42	16	18	16	-	-
Miss.	275	367	8,651	10,684	7	14	7	11	-	-
W.S. CENTRAL	2,696	3,435	94,418	94,900	35	123	64	183	-	-
Ark.	163	176	6,381	6,575	8	8	10	15	-	-
La.	693	699	16,946	16,254	5	7	2	7	-	-
Okla.	133	204	9,496	9,458	16	14	22	31	-	-
Tex.	1,707	2,356	61,595	62,613	6	94	30	130	-	-
MOUNTAIN	790	1,175	41,253	40,729	149	225	335	267	18	16
Mont.	8	15	1,976	1,677	5	37	29	20	-	-
Idaho	18	19	2,228	1,761	29	21	48	64	8	3
Wyo.	6	3	823	735	9	7	14	9	2	2
Colo.	157	262	12,003	11,737	53	39	87	87	4	6
N. Mex.	53	133	5,739	5,398	18	28	12	14	3	5
Ariz.	327	446	12,947	12,848	17	7	34	27	1	-
Utah	43	98	2,354	2,245	14	80	83	31	-	-
Nev.	178	199	3,183	4,328	4	6	28	15	-	-
PACIFIC	3,017	4,208	115,857	115,034	264	259	642	422	8	6
Wash.	302	427	13,010	12,010	43	U	138	115	-	-
Oreg.	216	177	6,000	6,461	38	52	219	66	8	6
Calif.	2,416	3,525	89,908	90,654	180	203	239	220	-	-
Alaska	17	19	3,121	2,331	1	1	7	4	-	-
Hawaii	66	60	3,818	3,578	2	3	39	17	-	-
Guam	2	11	-	359	-	-	N	N	-	-
P.R.	668	1,017	1,997	2,432	-	-	-	2	-	-
V.I.	66	2	125	132	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	138	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 October 31, 2002.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 16, 2002, and November 17, 2001 (46th Week)*

Reporting Area	*Escherichia coli Enterohemorrhagic* Shiga Toxin Positive, Not Serogrouped		Giardiasis	Gonorrhea		*Haemophilus influenzae*, Invasive All Ages, All Serotypes		*Haemophilus influenzae*, Invasive 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	39	17	15,103	288,197	316,755	1,335	1,291	22	22
NEW ENGLAND	1	1	1,497	6,704	6,108	115	98	-	1
Maine	-	-	192	120	119	1	2	-	-
N.H.	-	-	41	116	161	8	6	-	-
Vt.	1	1	129	84	61	7	3	-	-
Mass.	-	-	752	2,914	2,810	50	41	-	1
R.I.	-	-	140	841	753	10	5	-	-
Conn.	-	-	243	2,629	2,204	39	41	-	-
MID. ATLANTIC	-	3	3,264	35,186	37,697	235	197	4	3
Upstate N.Y.	-	-	1,111	7,664	7,554	106	67	2	-
N.Y. City	-	-	1,151	10,284	11,186	55	51	-	-
N.J.	-	-	342	6,130	7,230	49	44	-	-
Pa.	-	3	660	11,108	11,727	25	35	2	3
E.N. CENTRAL	12	6	2,908	58,330	66,971	188	242	3	2
Ohio	11	6	850	16,157	18,829	71	65	-	1
Ind.	-	-	-	6,538	6,164	38	46	1	-
Ill.	-	-	672	17,254	21,186	57	87	-	-
Mich.	1	-	839	13,087	15,391	14	13	2	-
Wis.	-	-	547	5,294	5,401	8	31	-	1
W.N. CENTRAL	1	3	1,809	14,652	14,871	60	66	1	1
Minn.	-	-	714	2,564	2,322	42	36	1	-
Iowa	-	-	279	1,117	1,184	1	-	-	-
Mo.	N	N	431	7,696	7,696	11	18	-	-
N. Dak.	1	3	27	47	42	-	7	-	-
S. Dak.	-	-	66	232	247	-	-	-	-
Nebr.	-	-	133	713	1,048	1	3	-	1
Kans.	-	-	159	2,283	2,332	5	2	-	-
S. ATLANTIC	1	-	2,560	74,107	81,547	329	319	4	1
Del.	-	-	49	1,404	1,522	-	-	-	-
Md.	-	-	104	7,760	8,127	78	79	2	-
D.C.	-	-	42	2,442	2,544	-	-	-	-
Va.	-	-	276	8,297	9,506	29	27	-	-
W. Va.	1	-	53	812	623	15	14	-	1
N.C.	-	-	-	14,208	15,008	30	44	-	-
S.C.	-	-	118	6,387	9,584	12	6	-	-
Ga.	-	-	775	14,575	15,773	84	86	-	-
Fla.	-	-	1,143	18,222	18,860	81	63	2	-
E.S. CENTRAL	8	3	337	23,838	28,452	60	68	1	-
Ky.	8	3	-	3,336	3,202	5	2	-	-
Tenn.	-	-	161	8,291	8,602	30	38	-	-
Ala.	-	-	176	7,118	9,692	16	26	1	-
Miss.	-	-	-	5,093	6,956	9	2	-	-
W.S. CENTRAL	4	-	219	42,278	46,620	58	51	2	2
Ark.	-	-	150	4,027	4,171	2	1	-	-
La.	-	-	4	10,446	11,103	9	9	-	-
Okla.	-	-	65	4,088	4,294	42	39	-	-
Tex.	4	-	-	23,717	27,052	5	2	2	2
MOUNTAIN	12	1	1,483	8,869	9,160	172	131	4	8
Mont.	-	-	78	99	94	-	-	-	-
Idaho	-	-	119	83	69	2	2	-	-
Wyo.	-	-	29	55	76	1	1	-	-
Colo.	12	1	494	3,009	2,829	31	37	-	-
N. Mex.	-	-	132	1,204	893	25	21	-	1
Ariz.	-	-	190	3,220	3,460	84	52	2	4
Utah	-	-	298	239	169	17	7	1	1
Nev.	-	-	143	960	1,570	12	11	1	2
PACIFIC	-	-	1,026	24,233	25,329	118	119	3	4
Wash.	-	-	376	2,558	2,672	3	5	2	-
Oreg.	-	-	401	764	995	59	34	-	-
Calif.	-	-	73	19,765	20,732	22	52	1	4
Alaska	-	-	96	516	381	1	6	-	-
Hawaii	-	-	80	630	549	33	22	-	-
Guam	-	-	-	-	45	-	-	-	-
P.R.	-	-	38	292	530	1	1	-	-
V.I.	-	-	-	31	25	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	1	13	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 November 16, 2002, and November 17, 2001 (46th Week)*

Reporting Area	*Haemophilus influenzae*, Invasive, Age <5 Years, Non-Serotype B		*Haemophilus influenzae*, Invasive, Age <5 Years, Unknown Serotype		Hepatitis (Viral, Acute), By Type, A		B		C; Non-A, Non-B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	222	216	15	26	7,446	9,095	6,011	6,411	3,098	3,506
NEW ENGLAND	13	15	-	-	266	643	212	125	22	33
Maine	-	-	-	-	8	11	11	5	-	-
N.H.	-	1	-	-	11	15	20	13	-	-
Vt.	-	-	-	-	1	16	4	5	13	7
Mass.	8	7	-	-	129	322	115	30	9	26
R.I.	-	-	-	-	30	59	26	25	-	-
Conn.	5	7	-	-	87	220	36	47	-	-
MID. ATLANTIC	28	32	-	3	941	1,149	1,366	1,219	1,592	1,198
Upstate N.Y.	12	9	-	1	168	239	122	111	62	26
N.Y. City	8	11	-	-	456	399	695	569	-	-
N.J.	5	5	-	-	122	262	345	266	1,499	1,109
Pa.	3	7	-	2	195	249	204	273	31	63
E.N. CENTRAL	31	38	1	2	983	1,094	561	852	92	150
Ohio	8	12	1	-	297	225	94	88	8	8
Ind.	7	6	-	1	45	91	43	46	-	1
Ill.	11	14	-	-	252	402	126	132	13	11
Mich.	3	-	-	1	216	302	298	546	71	130
Wis.	2	6	-	-	173	74	-	40	-	-
W.N. CENTRAL	6	5	3	6	281	352	202	190	721	1,027
Minn.	5	3	1	2	39	40	28	21	-	9
Iowa	-	-	-	-	74	33	17	21	1	-
Mo.	-	-	2	4	78	77	108	108	702	1,005
N. Dak.	-	1	-	-	3	3	5	1	-	-
S. Dak.	-	-	-	-	3	3	2	1	1	-
Nebr.	1	1	-	-	17	32	22	26	13	6
Kans.	-	-	-	-	67	164	20	12	4	7
S. ATLANTIC	45	44	2	6	2,151	2,207	1,461	1,349	168	95
Del.	-	-	-	-	12	16	7	25	5	10
Md.	4	8	-	1	277	235	109	130	6	8
D.C.	-	-	-	-	71	51	22	11	-	-
Va.	4	5	-	-	132	120	178	158	16	-
W. Va.	1	1	1	1	18	18	18	20	3	9
N.C.	3	2	-	4	197	206	207	191	25	19
S.C.	2	1	-	-	56	70	112	29	4	6
Ga.	18	18	-	-	410	855	338	388	29	-
Fla.	13	9	1	-	978	636	470	397	80	43
E.S. CENTRAL	13	12	1	3	241	368	339	424	181	182
Ky.	1	-	-	1	41	122	48	49	3	9
Tenn.	7	6	-	1	109	142	120	214	25	63
Ala.	3	5	1	1	36	71	95	79	10	4
Miss.	2	1	-	-	55	33	76	82	143	106
W.S. CENTRAL	14	9	-	-	554	773	605	759	160	649
Ark.	1	1	-	-	45	64	79	89	7	10
La.	2	2	-	-	65	85	94	112	66	143
Okla.	9	6	-	-	46	107	44	85	5	4
Tex.	2	-	-	-	398	517	388	473	82	492
MOUNTAIN	49	21	7	1	518	640	557	412	60	50
Mont.	-	-	-	-	13	11	9	3	1	1
Idaho	1	-	-	-	28	52	6	11	1	2
Wyo.	-	-	-	-	3	7	17	3	5	7
Colo.	3	2	-	-	72	80	70	89	18	8
N. Mex.	6	9	1	1	28	40	140	119	1	11
Ariz.	30	8	5	-	265	323	204	122	4	9
Utah	5	2	-	-	62	64	56	22	4	3
Nev.	4	-	1	-	47	63	55	43	26	9
PACIFIC	23	40	1	5	1,511	1,869	708	1,081	102	122
Wash.	1	3	-	2	141	138	64	129	24	21
Oreg.	5	7	-	-	61	92	113	151	16	14
Calif.	13	28	1	1	1,297	1,609	519	774	62	87
Alaska	1	1	-	-	10	14	4	9	-	-
Hawaii	3	1	-	2	2	16	8	18	-	-
Guam	-	-	-	-	-	1	-	-	-	-
P.R.	-	1	-	-	96	204	84	238	-	1
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	37	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 November 16, 2002, and November 17, 2001 (46th 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	1,030	981	527	538	15,161	13,725	1,136	1,314	36†	114§
NEW ENGLAND	94	66	55	52	4,426	3,973	58	87	-	5
Maine	3	8	5	2	111	-	5	4	-	-
N.H.	6	10	4	4	232	97	7	2	-	-
Vt.	36	5	3	3	32	17	4	1	-	1
Mass.	30	19	29	27	1,150	1,110	21	47	-	3
R.I.	5	10	1	1	327	449	7	9	-	-
Conn.	14	14	13	15	2,574	2,300	14	24	-	1
MID. ATLANTIC	282	232	148	95	8,869	7,538	292	396	7	20
Upstate N.Y.	94	61	54	25	4,680	3,165	43	59	1	4
N.Y. City	49	43	30	23	150	61	181	234	6	7
N.J.	27	21	31	17	1,641	1,980	36	60	-	1
Pa.	112	107	33	30	2,398	2,332	32	43	-	8
E.N. CENTRAL	239	281	69	82	86	703	124	159	3	10
Ohio	110	122	24	14	67	40	22	23	1	3
Ind.	20	20	9	8	19	22	12	16	2	4
Ill.	-	24	11	23	-	31	30	65	-	3
Mich.	75	73	18	24	-	17	46	36	-	-
Wis.	34	42	7	13	U	593	14	19	-	-
W.N. CENTRAL	54	46	17	17	360	364	56	34	3	5
Minn.	14	9	3	-	269	292	17	6	1	3
Iowa	11	8	2	2	36	34	4	7	-	-
Mo.	15	20	8	10	40	32	15	13	2	2
N. Dak.	-	1	1	-	1	-	1	-	-	-
S. Dak.	4	3	1	-	2	-	1	-	-	-
Nebr.	10	4	1	1	6	4	5	2	-	-
Kans.	-	1	1	4	6	2	13	6	-	-
S. ATLANTIC	189	168	76	72	1,192	893	323	266	2	5
Del.	9	12	-	2	161	152	4	2	-	-
Md.	42	32	18	14	632	543	104	108	-	3
D.C.	6	8	-	-	21	15	19	13	-	-
Va.	24	20	7	12	145	115	31	45	-	1
W. Va.	N	N	-	5	17	11	3	1	-	-
N.C.	11	10	6	5	124	38	21	17	-	-
S.C.	8	13	8	5	20	5	7	6	-	-
Ga.	17	11	12	14	2	-	73	42	-	1
Fla.	72	62	25	15	70	14	61	32	2	-
E.S. CENTRAL	41	56	19	22	47	63	19	35	12	2
Ky.	19	12	4	7	22	23	7	14	-	2
Tenn.	14	27	11	8	22	25	3	11	-	-
Ala.	8	13	4	7	3	8	4	6	12	-
Miss.	-	4	-	-	-	7	5	4	-	-
W.S. CENTRAL	16	24	18	31	17	82	16	83	2	1
Ark.	-	-	-	1	3	-	2	3	-	-
La.	4	6	-	-	4	8	4	6	-	-
Okla.	3	3	9	2	-	-	9	3	-	-
Tex.	9	15	9	28	10	74	1	71	2	1
MOUNTAIN	47	49	27	36	20	11	45	54	2	2
Mont.	3	-	-	-	-	-	2	3	-	-
Idaho	1	3	2	1	4	5	-	3	-	1
Wyo.	1	2	-	2	1	1	-	-	-	-
Colo.	7	14	6	9	3	-	22	22	-	-
N. Mex.	2	3	3	7	1	-	3	3	-	-
Ariz.	13	16	12	8	3	1	10	10	-	1
Utah	15	7	3	2	7	1	5	4	1	-
Nev.	5	4	1	7	1	3	3	9	1	-
PACIFIC	68	59	98	131	144	98	203	200	5	64
Wash.	7	9	8	10	10	7	22	10	-	15
Oreg.	N	N	9	12	15	11	9	16	-	3
Calif.	60	44	73	103	116	78	163	162	3	39
Alaska	-	1	-	-	3	2	2	1	-	-
Hawaii	1	5	8	6	N	N	7	11	2	7
Guam	-	-	-	-	-	-	-	1	-	-
P.R.	-	2	1	-	N	N	-	5	-	1
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 36 cases reported, 23 were indigenous and 13 were imported from another country.
§ Of 114 cases reported, 60 were indigenous and 54 were imported from another country.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 16, 2002, and November 17, 2001 (46th 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	1,467	2,031	236	217	6,632	4,939	5,507	6,418
NEW ENGLAND	80	95	8	2	552	496	841	663
Maine	7	4	1	-	17	22	54	63
N.H.	11	12	4	-	17	27	45	19
Vt.	4	5	-	-	124	35	87	58
Mass.	39	52	2	2	355	389	276	246
R.I.	5	4	-	-	13	5	70	65
Conn.	14	18	1	-	26	18	309	212
MID. ATLANTIC	136	231	24	25	411	320	1,037	1,187
Upstate N.Y.	40	64	6	3	298	130	637	724
N.Y. City	22	41	2	12	13	53	10	36
N.J.	26	40	-	3	4	18	171	175
Pa.	48	86	16	7	96	119	219	252
E.N. CENTRAL	194	315	38	27	801	767	147	148
Ohio	72	80	13	1	380	280	39	42
Ind.	31	35	2	3	123	79	31	15
Ill.	36	79	14	16	144	90	31	24
Mich.	40	73	8	5	49	133	46	47
Wis.	15	48	1	2	105	185	-	20
W.N. CENTRAL	137	141	16	8	673	344	407	342
Minn.	32	20	4	3	340	146	36	43
Iowa	21	29	1	-	130	65	72	77
Mo.	45	50	5	1	129	93	49	40
N. Dak.	3	6	1	-	1	4	29	35
S. Dak.	2	5	-	-	6	4	65	55
Nebr.	26	17	-	1	8	5	-	4
Kans.	8	14	5	3	59	27	156	88
S. ATLANTIC	263	316	25	38	376	230	2,266	2,247
Del.	7	5	-	-	3	-	24	30
Md.	8	38	5	6	57	42	321	466
D.C.	-	-	-	-	2	1	-	-
Va.	40	37	4	8	133	40	460	441
W. Va.	4	12	-	-	31	3	161	131
N.C.	30	62	2	5	40	69	654	522
S.C.	28	31	3	5	41	31	133	102
Ga.	34	48	4	9	21	21	347	372
Fla.	112	83	7	5	48	23	166	183
E.S. CENTRAL	86	125	13	9	236	177	156	197
Ky.	14	22	3	3	91	80	26	26
Tenn.	36	56	2	1	104	58	98	106
Ala.	22	31	3	-	32	35	28	61
Miss.	14	16	5	5	9	4	4	4
W.S. CENTRAL	180	298	17	13	1,485	594	112	1,030
Ark.	23	21	-	-	468	151	3	-
La.	33	74	1	2	7	8	-	8
Okla.	20	28	-	-	66	28	108	57
Tex.	104	175	16	11	944	407	1	965
MOUNTAIN	86	87	17	14	938	1,225	279	253
Mont.	2	4	-	1	5	36	18	38
Idaho	4	7	1	1	65	170	38	28
Wyo.	-	5	-	1	11	1	18	28
Colo.	21	34	2	3	374	294	59	-
N. Mex.	4	10	1	2	170	129	7	15
Ariz.	30	13	1	1	169	496	115	128
Utah	5	8	7	1	97	75	13	15
Nev.	20	6	5	4	47	24	11	1
PACIFIC	305	423	78	81	1,160	786	262	351
Wash.	60	59	-	2	399	140	-	-
Oreg.	42	56	N	N	173	51	13	4
Calif.	191	293	64	39	567	549	225	309
Alaska	4	2	-	1	4	11	24	38
Hawaii	8	13	14	39	17	35	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	5	5	-	1	3	-	49	85
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 November 16, 2002, and November 17, 2001 (46th 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	934	538	13	21	2	-	36,774	35,540
NEW ENGLAND	8	3	-	-	-	-	1,994	2,158
Maine	-	-	-	-	-	-	134	161
N.H.	-	1	-	-	-	-	126	155
Vt.	-	-	-	-	-	-	70	74
Mass.	4	2	-	-	-	-	1,103	1,245
R.I.	4	-	-	-	-	-	153	120
Conn.	-	-	-	-	-	-	408	403
MID. ATLANTIC	42	31	1	8	-	-	4,596	4,655
Upstate N.Y.	7	2	1	1	-	-	1,402	1,077
N.Y. City	9	2	-	6	-	-	1,278	1,174
N.J.	10	9	-	1	-	-	671	1,084
Pa.	16	18	-	-	-	-	1,245	1,320
E.N. CENTRAL	18	16	1	2	-	-	4,749	4,531
Ohio	12	2	-	-	-	-	1,285	1,227
Ind.	3	1	-	-	-	-	441	478
Ill.	-	12	-	2	-	-	1,445	1,266
Mich.	3	1	1	-	-	-	804	794
Wis.	-	-	-	-	-	-	774	766
W.N. CENTRAL	97	67	-	3	-	-	2,375	2,068
Minn.	-	-	-	-	-	-	523	558
Iowa	3	2	-	1	-	-	461	320
Mo.	89	61	-	1	-	-	791	567
N. Dak.	-	1	-	-	-	-	42	58
S. Dak.	1	2	-	-	-	-	102	143
Nebr.	4	1	-	-	-	-	150	143
Kans.	-	-	-	1	-	-	306	279
S. ATLANTIC	487	264	5	5	-	-	10,167	8,346
Del.	4	10	-	-	-	-	87	90
Md.	56	38	-	1	-	-	854	711
D.C.	2	-	-	-	-	-	71	75
Va.	39	25	-	-	-	-	1,112	1,205
W. Va.	2	-	-	-	-	-	137	126
N.C.	274	149	-	-	-	-	1,367	1,209
S.C.	68	29	-	2	-	-	720	792
Ga.	27	9	-	-	-	-	1,855	1,539
Fla.	15	4	5	2	-	-	3,964	2,599
E.S. CENTRAL	102	106	-	-	1	-	2,873	2,467
Ky.	5	2	-	-	-	-	353	337
Tenn.	76	74	-	-	1	-	738	583
Ala.	18	15	-	-	-	-	806	692
Miss.	3	15	-	-	-	-	976	855
W.S. CENTRAL	159	39	2	1	-	-	3,262	4,633
Ark.	97	8	-	-	-	-	986	842
La.	-	2	-	-	-	-	725	792
Okla.	61	29	-	-	-	-	457	438
Tex.	1	-	2	1	-	-	1,094	2,561
MOUNTAIN	14	11	1	-	-	-	1,978	1,955
Mont.	1	1	-	-	-	-	81	71
Idaho	-	1	-	-	-	-	135	127
Wyo.	5	2	-	-	-	-	92	58
Colo.	2	2	-	-	-	-	496	542
N. Mex.	1	1	-	-	-	-	281	263
Ariz.	-	-	-	-	-	-	528	534
Utah	-	3	1	-	-	-	187	199
Nev.	5	1	-	-	-	-	178	161
PACIFIC	7	1	3	2	1	-	4,780	4,727
Wash.	-	-	-	-	-	-	471	464
Oreg.	2	1	-	-	-	-	325	250
Calif.	5	-	3	1	-	-	3,660	3,650
Alaska	-	-	-	-	-	-	72	41
Hawaii	-	-	-	1	1	-	252	322
Guam	-	-	-	-	-	-	-	24
P.R.	-	-	-	3	-	-	201	834
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	25	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 November 16, 2002, and November 17, 2001 (46th 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	16,530	17,183	3,624	3,249	2,058	2,288	235	374
NEW ENGLAND	296	280	168	204	18	114	3	40
Maine	10	6	20	12	-	-	-	-
N.H.	11	6	35	N	-	-	N	N
Vt.	1	7	9	15	5	7	2	1
Mass.	176	197	89	60	N	N	N	N
R.I.	17	17	15	12	13	4	1	3
Conn.	81	47	-	105	-	103	-	36
MID. ATLANTIC	1,251	1,372	590	601	102	147	61	97
Upstate N.Y.	291	440	265	239	84	140	59	97
N.Y. City	386	379	135	157	U	U	U	U
N.J.	349	255	128	128	N	N	N	N
Pa.	225	298	62	77	18	7	2	-
E.N. CENTRAL	1,592	3,960	658	721	209	166	104	116
Ohio	575	2,633	198	184	60	3	21	-
Ind.	91	205	45	56	144	163	57	54
Ill.	611	554	145	232	2	-	-	62
Mich.	167	283	269	198	3	-	N	N
Wis.	148	285	1	51	N	N	26	-
W.N. CENTRAL	922	1,760	224	343	417	139	49	54
Minn.	205	394	113	156	292	63	49	45
Iowa	115	347	-	-	N	N	N	N
Mo.	171	289	42	70	5	9	-	-
N. Dak.	16	21	3	17	1	6	-	9
S. Dak.	150	554	13	11	1	4	-	-
Nebr.	179	87	18	39	29	19	N	N
Kans.	86	68	35	50	89	38	N	N
S. ATLANTIC	6,109	2,489	723	531	1,078	1,203	8	6
Del.	296	14	2	4	3	6	N	N
Md.	1,068	137	126	N	N	N	N	N
D.C.	56	54	7	21	49	5	1	4
Va.	892	365	68	70	N	N	N	N
W. Va.	12	8	19	19	42	37	7	2
N.C.	399	313	112	134	N	N	U	U
S.C.	106	237	34	11	169	247	N	N
Ga.	1,393	479	154	167	270	378	N	N
Fla.	1,887	882	201	105	545	530	N	N
E.S. CENTRAL	1,313	1,548	104	108	120	218	-	-
Ky.	165	733	18	36	17	24	N	N
Tenn.	99	92	86	72	103	193	N	N
Ala.	737	196	-	-	-	1	N	N
Miss.	312	527	-	-	-	-	-	-
W.S. CENTRAL	1,608	2,651	105	296	74	259	6	61
Ark.	184	540	7	-	7	16	-	-
La.	390	223	-	1	67	243	3	61
Okla.	525	81	41	39	N	N	3	-
Tex.	509	1,807	57	256	N	N	-	-
MOUNTAIN	810	872	529	369	40	38	4	-
Mont.	3	8	-	-	-	-	-	-
Idaho	15	39	9	7	N	N	N	N
Wyo.	9	7	7	11	9	7	-	-
Colo.	163	226	133	143	-	-	-	-
N. Mex.	194	112	96	77	30	29	-	-
Ariz.	347	356	254	128	-	-	N	N
Utah	34	55	30	3	-	-	4	-
Nev.	45	69	-	-	1	2	-	-
PACIFIC	2,629	2,251	523	76	-	4	-	-
Wash.	158	187	65	-	-	-	N	N
Oreg.	103	101	N	N	N	N	N	N
Calif.	2,301	1,901	366	-	N	N	N	N
Alaska	6	7	-	-	-	-	N	N
Hawaii	61	55	92	76	-	4	-	-
Guam	-	47	-	1	-	-	-	-
P.R.	8	16	N	N	-	-	N	N
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	-	-	U	U
C.N.M.I.	17	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 November 16, 2002, and November 17, 2001 (46th 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	5,583	5,339	304	437	10,359	12,205	238	321
NEW ENGLAND	121	56	-	8	341	409	14	16
Maine	2	1	-	3	10	16	-	1
N.H.	7	1	-	-	13	16	-	2
Vt.	1	3	-	-	-	4	-	-
Mass.	81	32	-	3	197	211	8	10
R.I.	6	9	-	-	34	57	-	-
Conn.	24	10	-	2	87	105	6	3
MID. ATLANTIC	628	465	58	70	1,859	2,011	54	106
Upstate N.Y.	29	18	9	5	261	326	9	15
N.Y. City	387	253	22	32	933	1,000	26	44
N.J.	138	112	26	33	439	438	15	38
Pa.	74	82	1	-	226	247	4	9
E.N. CENTRAL	954	949	52	62	1,000	1,243	18	32
Ohio	147	69	4	2	126	245	6	4
Ind.	61	141	1	10	108	90	2	2
Ill.	287	342	30	40	508	575	1	17
Mich.	435	374	17	6	217	262	4	5
Wis.	24	23	-	4	41	71	5	4
W.N. CENTRAL	94	89	-	9	471	478	8	15
Minn.	48	31	-	2	203	201	3	6
Iowa	2	4	-	-	24	34	-	-
Mo.	24	23	-	5	117	123	1	9
N. Dak.	-	-	-	-	4	3	-	-
S. Dak.	-	-	-	-	10	12	-	-
Nebr.	3	8	-	-	23	32	4	-
Kans.	17	23	-	2	90	73	-	-
S. ATLANTIC	1,489	1,798	67	102	2,113	2,256	44	41
Del.	11	14	-	-	15	15	-	1
Md.	172	240	14	4	254	204	7	10
D.C.	58	35	1	2	-	51	-	-
Va.	59	93	1	5	166	232	7	11
W. Va.	2	4	-	-	28	26	-	-
N.C.	261	409	18	12	309	307	2	2
S.C.	114	216	8	21	146	150	-	-
Ga.	315	348	10	22	353	425	9	9
Fla.	497	439	15	36	842	846	19	8
E.S. CENTRAL	417	591	19	30	639	743	4	1
Ky.	83	44	3	1	118	115	4	-
Tenn.	153	294	9	17	253	269	-	1
Ala.	140	119	4	5	179	239	-	-
Miss.	41	134	3	7	89	120	-	-
W.S. CENTRAL	754	660	64	73	1,455	1,856	5	18
Ark.	32	33	2	7	112	136	-	-
La.	135	159	-	-	-	114	-	-
Okla.	61	56	3	6	122	136	2	-
Tex.	526	412	59	60	1,221	1,470	3	18
MOUNTAIN	257	197	15	29	299	493	10	8
Mont.	-	-	-	-	6	14	-	1
Idaho	5	1	-	-	9	7	-	-
Wyo.	-	1	-	-	3	3	-	-
Colo.	44	20	1	1	48	116	5	1
N. Mex.	30	16	-	2	22	49	1	-
Ariz.	162	142	14	26	171	198	-	1
Utah	8	10	-	-	26	33	2	1
Nev.	8	7	-	-	14	73	2	4
PACIFIC	869	534	29	54	2,182	2,716	81	84
Wash.	54	42	1	-	198	210	6	5
Oreg.	20	13	1	-	97	98	2	7
Calif.	787	467	26	54	1,717	2,234	68	68
Alaska	-	-	-	-	43	46	-	1
Hawaii	8	12	1	-	127	128	5	3
Guam	-	9	-	1	-	54	-	3
P.R.	227	246	15	13	75	95	-	-
V.I.	1	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	15	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 III. Deaths in 122 U.S. cities,* week ending November 16, 2002 (46th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	652	464	115	45	12	16	67
Boston, Mass.	151	98	29	11	6	7	17
Bridgeport, Conn.	40	28	5	3	-	4	5
Cambridge, Mass.	26	22	3	1	-	-	2
Fall River, Mass.	38	30	6	2	-	-	8
Hartford, Conn.	98	66	22	7	3	-	10
Lowell, Mass.	23	19	1	3	-	-	-
Lynn, Mass.	5	4	1	-	-	-	2
New Bedford, Mass.	21	16	2	2	1	-	2
New Haven, Conn.	38	21	9	5	-	3	6
Providence, R.I.	68	44	19	3	1	1	-
Somerville, Mass.	4	4	-	-	-	-	-
Springfield, Mass.	39	31	6	2	-	-	6
Waterbury, Conn.	39	32	3	4	-	-	2
Worcester, Mass.	62	49	9	2	1	1	7
MID. ATLANTIC	2,249	1,604	426	147	41	31	103
Albany, N.Y.	56	43	6	3	3	1	1
Allentown, Pa.	25	23	2	-	-	-	1
Buffalo, N.Y.	105	71	24	3	6	1	11
Camden, N.J.	33	18	7	7	-	1	1
Elizabeth, N.J.	15	12	2	1	-	-	-
Erie, Pa.	38	29	5	1	1	2	2
Jersey City, N.J.	48	27	12	7	-	2	-
New York City, N.Y.	1,227	880	236	74	23	14	43
Newark, N.J.	46	20	16	7	2	1	5
Paterson, N.J.	25	13	5	5	-	2	-
Philadelphia, Pa.	230	148	61	16	2	3	3
Pittsburgh, Pa.§	39	30	7	2	-	-	3
Reading, Pa.	28	24	2	2	-	-	2
Rochester, N.Y.	125	105	12	5	1	2	16
Schenectady, N.Y.	23	15	3	3	1	1	2
Scranton, Pa.	23	21	1	1	-	-	2
Syracuse, N.Y.	94	74	15	4	1	-	7
Trenton, N.J.	22	14	4	2	1	1	-
Utica, N.Y.	20	17	1	2	-	-	2
Yonkers, N.Y.	27	20	5	2	-	-	2
E.N. CENTRAL	1,752	1,240	333	89	48	42	119
Akron, Ohio	53	42	10	1	-	-	5
Canton, Ohio	36	24	9	-	-	3	2
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	63	42	14	3	2	2	8
Cleveland, Ohio	124	86	27	8	2	1	5
Columbus, Ohio	233	158	50	8	9	8	21
Dayton, Ohio	121	89	23	6	3	-	12
Detroit, Mich.	178	106	40	18	7	7	11
Evansville, Ind.	45	36	3	4	1	1	3
Fort Wayne, Ind.	53	37	10	4	2	-	4
Gary, Ind.	15	6	6	1	2	-	-
Grand Rapids, Mich.	79	59	10	2	5	3	5
Indianapolis, Ind.	206	144	36	13	7	6	12
Lansing, Mich.	46	36	6	2	1	1	4
Milwaukee, Wis.	148	102	34	7	1	4	11
Peoria, Ill.	73	54	14	3	2	-	3
Rockford, Ill.	67	55	7	1	1	3	4
South Bend, Ind.	45	34	7	2	2	-	1
Toledo, Ohio	108	81	21	3	1	2	6
Youngstown, Ohio	59	49	6	3	-	1	2
W.N. CENTRAL	541	393	97	33	10	8	49
Des Moines, Iowa	77	62	12	2	1	-	11
Duluth, Minn.	38	26	9	2	1	-	1
Kansas City, Kans.	49	28	12	7	2	-	3
Kansas City, Mo.	74	57	12	5	-	-	4
Lincoln, Nebr.	40	31	4	3	1	1	5
Minneapolis, Minn.	51	35	12	2	-	2	8
Omaha, Nebr.	78	56	15	4	-	3	11
St. Louis, Mo.	U	U	U	U	U	U	U
St. Paul, Minn.	49	39	8	1	-	1	4
Wichita, Kans.	85	59	13	7	5	1	2
S. ATLANTIC	1,097	693	252	100	25	27	75
Atlanta, Ga.	U	U	U	U	U	U	U
Baltimore, Md.	190	114	50	22	3	1	17
Charlotte, N.C.	98	55	29	8	2	4	13
Jacksonville, Fla.	137	95	29	5	5	3	7
Miami, Fla.	105	64	24	12	3	2	9
Norfolk, Va.	41	26	8	2	2	3	2
Richmond, Va.	63	41	12	7	2	1	3
Savannah, Ga.	59	44	7	4	1	3	8
St. Petersburg, Fla.	80	52	17	9	-	2	3
Tampa, Fla.	161	109	34	13	3	2	8
Washington, D.C.	148	80	41	17	4	6	2
Wilmington, Del.	15	13	1	1	-	-	3
E.S. CENTRAL	792	502	186	59	26	19	65
Birmingham, Ala.	119	76	30	8	2	3	6
Chattanooga, Tenn.	57	39	16	1	-	1	7
Knoxville, Tenn.	80	56	18	3	3	-	2
Lexington, Ky.	59	39	10	6	3	1	2
Memphis, Tenn.	206	125	48	18	7	8	27
Mobile, Ala.	54	35	15	2	2	-	1
Montgomery, Ala.	60	39	10	5	5	1	7
Nashville, Tenn.	157	93	39	16	4	5	13
W.S. CENTRAL	1,085	710	243	83	23	18	63
Austin, Tex.	73	51	16	6	-	-	4
Baton Rouge, La.	49	42	6	-	-	1	6
Corpus Christi, Tex.	50	36	11	1	1	1	6
Dallas, Tex.	182	103	47	21	6	5	8
El Paso, Tex.	121	89	19	11	1	1	7
Ft. Worth, Tex.	116	76	25	7	5	3	7
Houston, Tex.	U	U	U	U	U	U	U
Little Rock, Ark.	53	32	7	4	-	2	-
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	275	177	66	25	5	2	16
Shreveport, La.	50	30	15	2	2	1	1
Tulsa, Okla.	116	74	31	6	3	2	8
MOUNTAIN	863	562	195	60	25	21	55
Albuquerque, N.M.	120	79	29	5	5	2	7
Boise, Idaho	57	35	12	8	1	1	1
Colo. Springs, Colo.	72	50	12	6	2	2	3
Denver, Colo.	102	60	25	6	4	7	5
Las Vegas, Nev.	225	134	64	18	6	3	10
Ogden, Utah	31	27	3	1	-	-	3
Phoenix, Ariz.	U	U	U	U	U	U	U
Pueblo, Colo.	26	16	9	1	-	-	5
Salt Lake City, Utah	107	68	19	10	5	5	12
Tucson, Ariz.	123	93	22	5	2	1	9
PACIFIC	1,034	726	209	63	16	20	88
Berkeley, Calif.	13	6	5	-	-	2	-
Fresno, Calif.	76	45	20	8	2	1	6
Glendale, Calif.	U	U	U	U	U	U	U
Honolulu, Hawaii	84	59	16	5	-	4	2
Long Beach, Calif.	67	56	7	3	1	-	9
Los Angeles, Calif.	U	U	U	U	U	U	U
Pasadena, Calif.	27	21	3	3	-	-	5
Portland, Oreg.	108	76	23	4	4	1	2
Sacramento, Calif.	158	108	41	6	-	3	14
San Diego, Calif.	149	106	25	10	4	4	15
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	161	109	39	9	1	3	18
Santa Cruz, Calif.	30	23	4	2	1	-	5
Seattle, Wash.	113	78	21	11	2	1	7
Spokane, Wash.	48	39	5	2	1	1	5
Tacoma, Wash.	U	U	U	U	U	U	U
TOTAL	10,065¶	6,894	2,056	679	226	202	684

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.

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