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Physical Activity Levels Among Children Aged 9–13 Years — United States, 2002

Three national health objectives for 2010 (objectives no. 22-6, 22-7, and 22-11) aim to increase levels of physical activity and reduce sedentary behavior among children and adolescents (*1*). To promote a healthy, more active lifestyle among U.S. youth, CDC developed the Youth Media Campaign (YMC), a national initiative to encourage children aged 9–13 years to engage in and maintain high levels of regular physical activity. To provide a baseline assessment of physical activity levels among children aged 9–13 years, CDC conducted the YMC Longitudinal Survey (YMCLS), a nationally representative survey of children aged 9–13 years and their parents. This report presents data from the survey, which indicate that 61.5% of children aged 9–13 years do not participate in any organized physical activity during their nonschool hours and that 22.6% do not engage in any free-time physical activity. Improving levels of physical activity among this population will require innovative solutions that motivate children and that address parents' perceived barriers to their children engaging in physical activity.

YMCLS is a national, random-digit–dialed telephone survey of children aged 9–13 years and their parents. CDC surveyed approximately 4,500 child/parent dyads living in approximately 3,600 households; 3,120 child/parent dyads (representing 87.0% of eligible adult respondents and 81.3% of eligible child respondents) completed a survey*. Data were adjusted for parent and child nonresponses and standardized to decennial census estimates of children's race/ethnicity, age, and sex. WesVarPC software was used to calculate point estimates and 95% confidence intervals (*2*). Data on race/ethnicity were analyzed only for non-Hispanic black, non-Hispanic white, and Hispanic children aged 9–13 years because numbers for other racial/ethnic populations were too small for meaningful analysis. T-tests were conducted when appropriate by using a Bonferoni adjustment to identify statistically significant differences among subpopulations.

Participation in an organized physical activity was defined as self-reported participation during the 7 days preceding the survey in a physical activity "with an organized group that has a coach, instructor, or leader." Participation in free-time physical activity was defined as self-reported engagement during the 7 days preceding the survey in a free-time physical activity. Participation in both after-school and weekend physical activities was included; participation in activities engaged in during the school day was excluded. Parents were asked about their perceptions of five potential barriers to their children's participation in physical activities: transportation problems, lack of opportunities to participate in physical activities in their area, expense, parents' lack of time, and concerns about neighborhood safety.

Fewer children aged 9–13 years reported involvement in organized sports (38.5%) than in free-time physical activity

* Of the 48,675 households sampled, persons in 29,444 (60.5%) households completed the screening interview. Of 3,543 eligible adult respondents, 3,084 (87.0%) completed the parent interview, and of 3,840 eligible child respondents, 3,120 (81.3%) completed the child interview. The overall response rate, 42.8%, is the product of the completion rate for the screening, parent, and child interviews.

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(77.4%) during the 7 days preceding the survey (Table 1). Non-Hispanic black and Hispanic children were significantly less likely (p<0.05) than non-Hispanic white children to report involvement in organized activities, as were children with parents who had lower incomes and education levels.

Although parents generally perceived the same barriers to participation in physical activities regardless of the child's sex and age, concerns about transportation, opportunities in their area, and expense were reported significantly more often (p<0.05) by non-Hispanic black and Hispanic parents than by non-Hispanic white parents (Table 2). Concerns about neighborhood safety were reported more frequently for girls (17.6%) than for boys (14.6%) and were reported more frequently by Hispanic parents (41.2%) than by non-Hispanic white (8.5%) and non-Hispanic black (13.3%) parents. Overall, parents with lower incomes and education levels reported more barriers.

Regardless of race/ethnicity, age, and sex, the three organized physical activities engaged in most often by children aged 9–13 years were baseball/softball, soccer, and basketball. Among children aged 12–13 years, basketball was mentioned

TABLE 1. Percentage of children aged 9–13 years who reported participation in organized and free-time physical activity during the preceding 7 days, by selected characteristics — Youth Media Campaign Longitudinal Survey, United States, 2002

	Participated in organized physical activity during preceding 7 days		Participated in free-time physical activity during preceding 7 days	
Characteristic	**%**	**(95% CI*)**	**%**	**(95% CI)**
Sex				
Female	38.6	(±2.5)	74.1†	(±2.0)
Male	38.3	(±2.9)	80.5†	(±1.7)
Age (yrs)				
9	36.1	(±4.0)	75.8	(±3.1)
10	37.5	(±4.0)	77.0	(±2.7)
11	43.1	(±3.6)	78.9	(±3.0)
12	37.7	(±4.1)	77.5	(±3.5)
13	38.1	(±4.2)	78.0	(±4.0
Race/Ethnicity§				
Black, non-Hispanic	24.1†	(±3.8)	74.7	(±4.6)
Hispanic	25.9†	(±4.0)	74.6	(±3.9)
White, non-Hispanic	46.6†	(±3.0)	79.3	(±1.7)
Parental education				
<High school	19.4†	(±4.8)	75.3	(±5.7)
High school	28.3†	(±3.4)	75.4	(±2.9)
>High school	46.8†	(±2.5)	78.7	(±2.0)
Parental income				
≤$25,000	23.5†	(±3.7)	74.1	(±3.1)
$25,001–$50,000	32.8†	(±3.4)	78.6	(±2.5)
>$50,000	49.1†	(±2.6)	78.3	(±2.0)
Total	**38.5**	**(±2.0)**	**77.4**	**(±1.2)**

* Confidence interval.
† Statistically significant difference (p<0.05).
§ Numbers for other racial/ethnic populations were too small for meaningful analysis.

TABLE 2. Percentage of parents of children aged 9–13 years who reported barriers to their children's participation in physical activities, by barrier and selected characteristics — Youth Media Campaign Longitudinal Survey, United States, 2002

	Transportation problems		Lack of opportunities in area		Expense		Lack of parents' time		Lack of neighborhood safety	
Characteristic	%	(95% CI*)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Sex										
Female	26.9	(±2.7)	20.8	(±2.3)	47.5	(±3.2)	22.8†	(±2.2)	17.6†	(±2.3)
Male	24.4	(±2.6)	19.5	(±2.0)	45.8	(±2.7)	19.2†	(±2.4)	14.6†	(±1.9)
Age (yrs)										
9	25.6	(±3.7)	20.5	(±3.1)	46.3	(±3.3)	20.3	(±3.6)	16.9	(±2.9)
10	26.2	(±3.5)	19.2	(±3.5)	46.4	(±3.9)	21.6	(±3.4)	18.0	(±3.4)
11	26.1	(±4.3)	21.1	(±3.1)	46.0	(±4.6)	20.7	(±3.2)	16.9	(±3.6)
12	24.9	(±3.0)	20.0	(±3.7)	49.0	(±3.6)	20.8	(±3.2)	15.9	(±3.0)
13	25.2	(±3.1)	19.8	(±3.5)	45.4	(±4.2)	21.5	(±3.1)	12.4	(±2.7)
Race/Ethnicity§										
Black, non-Hispanic	32.6†	(±4.8)	30.6†	(±5.7)	54.9†	(±6.2)	23.3	(±5.6)	13.3†	(±3.3)
Hispanic	36.9†	(±5.8)	30.8†	(±3.6)	62.3†	(±5.5)	23.3	(±4.7)	41.2†	(±5.8)
White, non-Hispanic	18.9†	(±2.3)	13.4†	(±2.1)	39.5†	(±2.5)	19.1	(±2.1)	8.5†	(±1.5)
Parental education										
<High school	42.7†	(±7.2)	36.7†	(±6.2)	65.9†	(±7.7)	27.3	(±6.6)	42.9†	(±7.3)
High school	32.3†	(±3.6)	23.8†	(±3.7)	54.8†	(±4.3)	20.5	(±3.1)	18.2†	(±3.4)
>High school	19.3†	(±2.0)	15.4†	(±2.2)	39.2†	(±2.5)	20.0	(±2.4)	10.2†	(±1.5)
Parental income										
≤$25,000	44.5†	(±4.7)	35.6†	(±4.4)	70.6†	(±4.6)	25.6†	(±3.5)	29.4†	(±4.0)
$25,001–$50,000	28.9†	(±3.9)	21.9†	(±3.2)	53.6†	(±3.4)	20.4	(±3.1)	17.8†	(±3.1)
>$50,000	14.4†	(±2.1)	11.5†	(±2.3)	30.8†	(±2.6)	19.0†	(±2.6)	8.6†	(±1.6)
Total	**25.6**	**(±1.9)**	**20.1**	**(±1.7)**	**46.6**	**(±2.0)**	**21.0**	**(±1.6)**	**16.1**	**(±1.4)**

* Confidence interval.
† Statistically significant difference ($p<0.05$).
§ Numbers for other racial/ethnic populations were too small for meaningful analysis.

most often by non-Hispanic black girls and boys, soccer was mentioned most often by Hispanic girls and boys, and baseball/softball was mentioned most often by non-Hispanic white girls and boys. Among children aged 9–11 years, dance was among the three activities mentioned most often by non-Hispanic black and white girls, and baseball/softball and soccer were mentioned most often by Hispanic boys. Overall, regardless of age or sex, children reported that their most frequent free-time activities were riding bicycles and playing basketball. Basketball was the only activity that was reported frequently for both organized and free time. Bicycle riding was reported more frequently by children aged 9–11 years, and basketball was the most common free-time activity among children aged 12–13 years. Other activities engaged in frequently during free time were walking and playing active games (reported by girls), playing football (reported by boys), and running and playing active games (reported by girls and boys).

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Editorial Note: The findings in this report constitute the first nationally representative information about levels and types of physical activity among children aged 9–13 years. The findings indicate that although the majority of children aged 9–13 years engage in some level of free-time physical activity, increased rates of participation in both free-time and organized physical activities are needed, especially for non-Hispanic black and Hispanic children.

Insufficient physical activity is a risk factor for persons being overweight or obese and for having many related chronic diseases (*3*), and regular physical activity is associated with immediate and long-term health benefits (e.g., weight control, lower blood pressure, improved cardiorespiratory function, and enhanced psychological well-being) (*4–5*). Active children are more likely to become active adults (*6*), but as many children age into adolescence, their physical activity levels decline (*7–8*).

The findings in this report are subject to at least five limitations. First, YMCLS is a telephone survey and does not include U.S. households without telephone service. Second, data were self-reported and subject to error, including respondent over-reporting of socially desirable responses. Third, because data were weighted to the national population of children aged 9–13 years as the main unit of analysis, parent estimates might not represent precisely the national population of parents. Fourth, because the survey was conducted during April–June, the activities reported might reflect seasonal participation in certain sports. Finally, duration of physical activity could not be measured because children aged <10 years are unable to aggregate minutes of physical activity accurately over several days.

Although the primary purpose of the data collection described in this report was to establish a baseline level of physical activity among children aged 9–13 years, these data can help public health agencies and community organizations assess current and future needs of middle school children and plan physical activity programs and interventions. The survey findings demonstrate a need to address common barriers to participation in organized physical activities among children, especially members of certain racial/ethnic populations.

Participation in an organized sport probably will result in a meaningful increase in time spent in physical activity. However, socioeconomic barriers that might impede participation in organized sports do not exist for free-time play. For this reason, current promotional efforts focus on increasing free-time physical activity. In October 2002, CDC initiated a media campaign, *VERB*™ *It's what you do*, a 5-year effort to promote physical activity through research, media, partnership, and community efforts. VERB advertisements aimed at children portray physical activity as being "cool," fun, and socially appealing; advertisements aimed at parents encourage them to engage in physical activity with their children and suggest ways to overcome perceived barriers to physical activity. VERB partnership efforts address other issues, including the need to ensure access to safe and affordable physical activity opportunities, both free-time and organized. Information about the VERB campaign is available at http://www.cdc.gov/verb. Additional information about VERB is available at http://www.verbnow.com (for children) and at http://www.verbparents.com (for parents). Information about receiving regular e-mail updates about VERB is available at http://www.cdc.gov/youthcampaign/working_together/index.htm.

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Suspected Moonflower Intoxication — Ohio, 2002

During October 11–November 20, 2002, the Cincinnati Drug and Poison Information Center (DPIC) received notification of and offered treatment advice for 14 adolescents in the Akron/Cleveland, Ohio, area who became ill after intentional exposure to toxic seeds that DPIC identified as *Datura inoxia* (Figure). All became ill shortly after eating the seeds or drinking tea brewed using the seeds. All patients recovered fully after treatment. This report summarizes these cases,

FIGURE. *Datura inoxia*, one of several plants known commonly as "moonflowers"

Photo/R Goetz, Cincinnati Drug and Poison Information Center

discusses the characteristics of the various plants known commonly as "moonflowers," and underscores the need for awareness of the potential toxicity from recreational use of a plant.

Of the 14 patients, 12 (86%) were male; median age was 17 years (range: 12–19 years). All 14 patients reported to the emergency department (ED) with anticholinergic signs and symptoms, including dilated pupils, tachycardia, hallucinations, and urinary retention. Signs and symptoms typically lasted 24–48 hours, and the illness resolved with supportive care and benzodiazepine administration. No long-term effects were documented.

On November 5, a local newspaper described some of the cases of "toxic seed" exposure. Use of the common name moonflower had led to some confusion about which of the several moonflower plants were involved in these exposures. Parents of several adolescents who ingested these seeds as a group reported that the seeds were from a moonflower plant, specifically *D. inoxia*, and noted that this plant was cultivated widely and available in local garden stores. On the basis of clinical presentations and a photograph taken of a plant submitted to the ED by one of the parents, a toxicologist at DPIC agreed that *D. inoxia* was the source of these illnesses.

No reports of moonflower exposure or moonflower information calls in the Akron/Cleveland area during 2000–2001 were found in the DPIC database (DPIC, unpublished data, 2002). Calls about poisonings with *D. stramonium*, a commonly abused plant related to *D. inoxia*, did not increase substantially during the same period.

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Editorial Note: Moonflower is not on the U.S. Drug Enforcement Agency's list of controlled substances, but local law enforcement measures in the Akron/Cleveland area prohibit selling seedpods for illicit use. The cluster of moonflower exposures reported to DPIC might represent a new form of substance abuse in the Akron/Cleveland area. The illicit use of this plant might be related to the increasing knowledge of moonflower's hallucinogenic properties combined with the local availability of this plant.

Plants with large fragrant flowers that bloom at dusk are referred to as moonflowers. Poisindex® lists two species as moonflower: *Ipomoea muricata* (purple moonflower) and *I. alba* (white moonflower) (*1*). Ingestion of *I. muricata* might cause hallucinations and cholinergic effects such as diaphoresis, salivation, lacrimation, and diarrhea. Neither hallucinations nor other anticholinergic effects occur with *I. alba* poisoning (*1*).

The clinical features of cases reported to DPIC are most consistent with the anticholinergic properties of *Datura* species. Scopolamine and hyoscyamine, both of which are major constituents of *Datura* species, are most concentrated in the seeds and can cause anticholinergic poisoning in exposed persons.

Symptoms of *Datura* toxicity occur typically within 60 minutes after ingestion and continue for 24–48 hours. Ingestion of *Datura* manifests as a classic anticholinergic syndrome comprising central and peripheral signs and symptoms. Central toxic effects include confusion, agitation, anxiety, hallucinations, seizures, and coma. Peripheral toxic effects include dry mucous membranes, thirst, flushed face, blurred vision, hyperthermia, urinary retention, and decreased gut motility (*2*). Treatment consists of supportive care, gastrointestinal decontamination (e.g., activated charcoal), benzodiazepines as needed for agitation, and, in severe cases, physostigmine, the antidote for anticholinergic poisoning (*3*).

D. inoxia is a plant with large white flowers that blooms at dusk; it has a bushy growth habit with up to 200 seeds borne in pods with closely spaced thorns (*4*). *D. inoxia* is related to another commonly abused plant, *D. stramonium* (jimson weed) (*5–7*). *D. stramonium* has clinical features of toxicity similar to *D. inoxia* (*8–10*). The plant features described by the parents of the exposed adolescents are consistent with *D. inoxia* but not *D. stramonium* or the other moonflower plants.

This report highlights four important points. First, the clinical effects of recreational use of a plant might vary drastically from the desired effects. Adolescents and parents should be aware of the potential toxicity from recreational use of a plant and the need for medical attention if an exposure occurs. Second, gardening practices in a community might provide novel opportunities for experimenting with intoxicating substances. Because *D. inoxia* is used as an ornamental plant in the Akron/Cleveland area, local garden suppliers should discuss the potential toxicity of the plant at the time of purchase. Third, because toxicity differs for various plants of this type, use of the common name moonflower can be misleading clinically and might complicate identification of some species. Finally, poison-control centers can detect new trends in drug abuse or poisonings and provide information that local and state health departments can use to inform the public. In Ohio, an early-warning network is designed to release timely alerts to inform schools, health-care providers, and the public statewide about emerging drug-abuse trends and poisonings (*10*).

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Vaccination Coverage Among Children Entering School — United States, 2002–03 School Year

All states require proof of vaccination for children before school entry, and a summary of that coverage is reported to CDC. Rather than reporting vaccination status on school entry, state reports to CDC reflect coverage attained after evaluating students' vaccination status and ensuring that all children receive required vaccines. School vaccination requirements have been credited with ensuring high coverage (*1,2*), and one of the national health objectives for 2010 is to sustain ≥95% vaccination coverage among children in kindergarten through the first grade (objective 14-23) (*3*). This report presents data regarding vaccination coverage from the 50 states and the District of Columbia (DC)* for the 2002–03 school year, which highlight high reporting rates and overall high coverage. Findings indicate that vaccines required by each state and the methods for surveying schools vary. CDC is working with states to standardize data collection procedures.

For the 2002–03 school year, 49 (96.1%) states submitted vaccination coverage levels for children enrolled in kindergarten and/or first grade. All 49 states reported coverage for ≥3 doses of poliovirus vaccine, ≥1 dose of measles-containing vaccine, ≥1 dose of mumps-containing vaccine, and ≥1 dose of rubella-containing vaccine (Table 1). For diphtheria and tetanus toxoids and acellular pertussis vaccine, 39 (76.5%) states reported coverage for ≥4 doses, and 10 (19.6%) reported coverage for ≥3 doses; 39 states also reported coverage for 3 doses of hepatitis B (HepB) vaccine.

Coverage for all vaccines except HepB was reported to be ≥95% in 29 (56.9%) states and ≥90% in 45 (88.2%) states. A total of 18 states based reports on a census of children entering kindergarten and first grade, 15 states on surveys of >95% of children, and five states on surveys of <50% of children (range: 5.1%–42.2%). National estimates of coverage were calculated by weighting each state's coverage estimate by the size of the state's birth cohort; all national estimates were >95% (Table).

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Editorial Note: Since the previous report on vaccination coverage for the 2000–01 school year (*4*), reporting increased from 36 (70.6%) states to 49 (96.1%) states. CDC has increased efforts to support states in collecting and reporting coverage among children entering school. One component of this increased effort is a new online reporting system that automates data management and calculation tasks.

State laws requiring proof of vaccination before entering school have been referred to as a "safety net" for the U.S. vaccination program because they ensure that no child is missed (*1*). The safety net relies on the efforts of school nurses, teachers, and others to identify children who need ≥1 dose of vaccine. A recent survey of school nurses in DC indicated that approximately 50% of children needed one or more vaccinations to meet DC's school entry requirements (CDC, unpublished data, 2002). Findings of uniformly high nationwide coverage during the 2002–03 school year underscore the success of school entry requirements in boosting vaccine coverage.

The findings in this report are subject to at least two limitations. First, methods for assessing vaccination coverage among children entering school vary because state and local laws determine which vaccines and doses are required, and sampling methods differ. The resulting variation in sampling methods among states limits the generalizability and comparability of these data. Second, children attending private schools and those who are home-schooled were not surveyed by all states. Population-based vaccination registries might someday provide uniform, reliable data on the vaccination status of children entering school, saving resources now devoted to gathering and processing children's vaccination histories.

The findings in this report supplement those of the National Immunization Survey (*5*), which describe vaccination coverage among preschool-aged children. Together, these reports provide a comprehensive view of vaccination coverage among U.S. children.

Additional information about assessing and reporting coverage among children entering school is available from the National Immunization Program Immunization Information

* For this report, the District of Columbia is included as a state.

TABLE. Estimated vaccination coverage among children enrolled in kindergarten (K) and first grade, by state* and vaccine — United States, 2002–03 school year†

State	Grade§	Population surveyed (%)¶	≥3 Polio (%)**	3 DTP/DTaP/DT (%)††	≥4 DTP/DTaP/DT (%)	Measles (%)§§	Mumps (%)¶¶	Rubella (%)***	3 HepB (%)†††
Alabama	K-1	100.0	97.4	—	97.4	97.4	97.4	97.4	—
Alaska	K	84.8	96.3	—	97.1	96.0	96.0	96.0	97.0
Arizona	K	98.5	98.2	—	97.3	96.6	96.6	96.6	96.9
Arkansas	K	100.0	90.9	90.2	—	90.8	91.8	91.7	91.7
California	K	100.0	97.2	—	96.6	97.0	97.0	97.0	98.1
Colorado	K-1	83.9	85.7	85.7	—	85.7	85.7	85.7	85.7
Connecticut	K	98.6	98.8	—	98.4	98.6	99.4	99.4	98.9
Delaware	K	87.1	98.9	—	96.6	92.4	92.4	92.4	96.0
District of Columbia	K-1	100.0	96.7	96.0	—	94.6	94.6	94.6	95.4
Florida	K	100.0	92.5	—	92.5	92.5	92.5	92.5	92.5
Georgia	K	97.2	87.9	—	87.9	87.9	87.9	87.9	87.9
Hawaii	K	99.8	99.2	—	98.9	99.3	99.3	99.3	99.4
Idaho	K-1	95.5	96.2	—	95.3	96.5	96.5	96.5	95.6
Illinois	—	—	—	—	—	—	—	—	—
Indiana	K-1	99.7	97.1	—	95.5	96.3	99.3	99.3	98.3
Iowa	K-1	99.7	93.0	93.0	—	93.0	93.0	93.0	93.0
Kansas	K	15.6	98.0	—	96.9	97.5	97.5	97.5	—
Kentucky	K	93.4	96.7	—	96.2	96.9	96.9	96.9	96.6
Louisiana	K-1	100.0	96.7	—	95.8	97.8	97.8	97.8	94.9
Maine	K	95.0	88.5	—	90.0	89.2	89.2	89.2	—
Maryland	K	84.6	99.6	—	99.4	98.7	99.6	99.6	99.4
Massachusetts	K	96.8	95.1	—	94.3	95.1	97.8	97.8	99.2
Michigan	K	90.4	98.9	—	98.1	97.5	97.5	97.5	98.2
Minnesota	K	98.7	96.8	96.8	—	98.8	98.8	98.8	97.8
Mississippi	K-1	100.0	99.6	—	99.6	99.6	99.6	99.6	99.6
Missouri	K	98.0	98.1	—	98.2	97.4	99.3	99.3	98.4
Montana	K-1	97.9	99.9	—	99.8	99.8	99.8	99.8	—
Nebraska	K	95.9	98.3	97.0	—	96.2	96.2	96.2	97.1
Nevada	1	100.0	93.6	—	93.7	94.9	94.9	94.9	66.5
New Hampshire	K-1	98.0	96.4	—	94.0	95.6	96.3	96.3	93.6
New Jersey	K-1	42.2	99.9	—	99.9	99.9	99.9	99.9	—
New Mexico	K-1	100.0	96.0	—	94.5	95.7	95.7	95.7	97.2
New York§§§	K	100.0	98.7	98.8	—	97.0	98.7	98.7	98.0
New York City	*K*	*100.0*	*98.2*	*98.3*	—	*95.5*	*98.3*	*98.3*	*97.1*
North Carolina	K	100.0	100.0	—	100.0	100.0	100.0	100.0	100.0
North Dakota	K-1	100.0	96.0	—	95.7	95.9	95.9	95.9	97.3
Ohio	K	100.0	94.8	—	94.1	96.6	96.6	96.6	94.4
Oklahoma	K	100.0	96.4	—	94.4	94.0	94.0	94.0	98.7
Oregon	K	99.2	96.6	—	96.2	96.5	97.4	97.4	96.6
Pennsylvania¶¶¶	K-1	100.0	96.3	—	96.3	96.3	96.3	96.3	96.3
Philadelphia	*K-1*	*100.0*	*92.5*	—	*92.5*	*92.5*	*92.5*	*92.5*	*92.5*
Rhode Island	K	99.3	95.0	—	94.3	93.8	93.8	93.8	97.6
South Carolina	K	10.0	99.2	99.3	—	97.6	97.6	97.6	99.1
South Dakota	K	100.0	98.2	—	98.2	94.9	94.9	94.9	—
Tennessee	K	92.9	96.3	—	96.3	96.3	96.3	96.3	96.3
Texas	—	—	—	—	—	—	—	—	—
Utah	K	99.7	98.3	—	97.9	98.1	98.8	98.8	98.2
Vermont	K-1	99.7	97.5	98.1	—	95.2	—	95.2	—
Virginia	K	6.5	90.1	—	80.3	87.7	87.7	87.7	90.2
Washington	K-1	100.0	92.5	—	90.5	92.3	95.0	95.0	95.1
West Virginia	K-1	45.4	95.7	97.3	—	97.3	—	97.3	—
Wisconsin	K	5.1	96.0	—	96.2	89.7	89.7	89.7	94.7
Wyoming	K	28.1	94.2	—	89.0	96.2	96.2	96.2	98.7
Total****	**—**	**—**	**96.2**	**95.5**	**—**	**95.7**	**96.1**	**96.1**	**96.0**

* For this report, the District of Columbia is included as a state.
† Required vaccination dosage among children varied by state. In addition to the states included in this report, several territories reported coverage; detailed reports are available at http://www2.cdc.gov/nip/schoolsurv/schoolrptg.asp.
§ Coverage estimates are from state and local immunization programs that reported data for children entering kindergarten and/or first grade only.
¶ The proportion of eligible children included in the assessment survey.
** At least 3 doses of poliovirus vaccine.
†† Three doses of diphtheria and tetanus toxoids and pertussis vaccine, diphtheria and tetanus toxoids and acellular pertussis vaccine, or tetanus toxoids.
§§ Measles-containing vaccine.
¶¶ Mumps-containing vaccine.
*** Rubella-containing vaccine.
††† Three doses of hepatitis B vaccine.
§§§ Includes New York City.
¶¶¶ Includes Philadelphia.
**** Weighted average. Calculated by using estimates with ≥1 dose of measles, mumps, and rubella–containing vaccines; ≥3 doses of DTP, DTaP, or DT; and ≥4 doses of DTP, DTaP, or DT.

Hotline, telephone 800-232-2522 (English) or 800-232-0233 (Spanish), or by e-mail, nipinfo@cdc.gov.

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Methicillin-Resistant *Staphylococcus aureus* Infections Among Competitive Sports Participants — Colorado, Indiana, Pennsylvania, and Los Angeles County, 2000–2003

Although outbreaks of methicillin-resistant *Staphylococcus aureus* (MRSA) usually have been associated with health-care institutions, MRSA is emerging as a cause of skin infections in the community. This report summarizes several reported clusters of skin and soft tissue infections associated with MRSA among participants in competitive sports and identifies possible risk factors for infection (e.g., physical contact, skin damage, and sharing of equipment or clothing). The findings underscore 1) the potential for MRSA infections among sports participants; 2) the need for health-care providers to be aware that skin and soft tissue infections occurring in these settings might be caused by MRSA; and 3) the importance of implementing prevention measures by players, coaches, parents, and school and team administrators.

Fencers

In February 2003, the Colorado Department of Public Health and Environment was notified by a local health department about a cluster of MRSA infections among members of a Colorado fencing club and their household contacts. After club leaders reported five cases of infection to the local health department, all members (n = 70) of the fencing club were asked to complete a questionnaire that included questions about infections and possible risk behaviors such as sharing of clothing or equipment. A total of 62 (89%) fencers responded to the survey. No additional cases were identified from the survey. A confirmed case of MRSA infection was defined as signs and symptoms of an infection (e.g., fever, pus, swelling, or pain) during July 2002–February 2003 in a fencer or household contact of a fencer from whom MRSA was cultured from a clinical isolate. A probable case was defined as skin or soft tissue infection during the outbreak period in a fencer or household contact of a fencer from whom no clinical culture was obtained.

Three confirmed and two probable cases were identified; one patient was a household contact. Median age of patients was 31 years (range: 11–51 years); three (60%) were female. One patient had paraspinal myositis with bacteremia and was hospitalized for 11 days. The other four patients reported one to six abscesses each, located on the legs or thighs (n = four), abdomen (n = three), axilla (n = one), buttocks (n = one), hand (n = one), and behind the knee (n = one). Three (60%) patients were hospitalized and received intravenous antimicrobial therapy. Two of the patients with confirmed cases reported recurrent infections for which they received antimicrobial therapy and made multiple health-care visits before their wounds were cultured. All patients have recovered.

Pulsed-field gel electrophoresis (PFGE) testing was performed on isolates from two patients; an isolate from one of the patients with a confirmed case was not available. The PFGE patterns from both were indistinguishable.

Facilities at the fencing club included changing rooms and practice areas. No showers were available. Although none of the fencers with infections reported sharing clothing, masks, and weapons, such sharing was common among team members. In addition, fencers wear a sensor wire under their clothes to record when they have been touched by an opponent's weapon. Interviews with club members indicated that these wires were shared routinely and had no routine schedule for cleaning. No other common sources of exposure outside of the fencing club were identified.

Club members, coaches, and administrators were instructed in MRSA transmission control measures. These included 1) increased hand hygiene, 2) showering with soap after every practice or tournament, 3) covering cuts and abrasions with a bandage until healed, 4) laundering personal items such as towels and supporters after each use, 5) cleaning or laundering shared athletic equipment such as pads or helmets at least once a week but ideally after each use, 6) establishing a routine cleaning schedule for the sensor wires, and 7) consulting a health-care provider for wounds that do not heal or appear infected. No further infections have been reported.

Football Players and Wrestlers

Clusters of MRSA infection among sports team participants were identified during September 2000 in Pennsylvania and during the fall and winter of 2002–2003 in Indiana and Los Angeles County, California. Affected persons included college and high school–aged football players and wrestlers; the numbers of infected members per team ranged from two to 10 players. During September–October 2000, CDC assisted the Pennsylvania Department of Health in an investigation of an outbreak of MRSA culture-positive skin and soft tissue infections among 10 members of a Pennsylvania college football team, seven (70%) of whom were hospitalized. All isolates from the Pennsylvania athletes had indistinguishable PFGE patterns. Several possible risk factors for infection were identified, including skin trauma from turf burns and shaving and sharing of unwashed bath towels.

In September 2002, the Los Angeles County Department of Health Services investigated two cases of MRSA skin infection among members of a college football team. Both patients were hospitalized; one received surgical debridement and skin grafts. Isolates from the two players had indistinguishable PFGE patterns. Team players reported frequent skin trauma and reported covering wounds approximately half of the time. In addition, health department staff identified the potential for spread through shared items such as balms and lubricants.

In January 2003, the Indiana Department of Health was notified of two wrestlers on a high school team who had MRSA skin infections diagnosed. Neither patient was hospitalized, and isolates were not available for PFGE testing. The two players were in different weight groups and had never wrestled each other, suggesting that transmission could have occurred through sharing items rather than direct contact. No other common exposures were identified.

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Editorial Note: Outbreaks of community-associated MRSA (CA-MRSA) occur in various populations, including children attending child care, prison inmates, and men who have sex with men (*1–3*). This report demonstrates that CA-MRSA has the potential to spread and cause outbreaks among players of competitive sports, including those sports that involve little skin-to-skin contact among players, such as fencing. Physicians should be aware of the potential for MRSA infections in sports participants when evaluating patients and making treatment decisions. As demonstrated by this cluster of MRSA infections among fencers, patients with recurrent MRSA infections might make multiple health-care visits before a wound culture is obtained. Recurrence of infections might be avoided if physicians obtain cultures more routinely when athletes have infected wounds.

Transmission of *S. aureus*, for both susceptible and antimicrobial resistant strains, usually occurs through close contact with a person who has either a draining lesion or asymptomatic carriage of *S. aureus*. Although the investigations described in this report did not determine the roots of MRSA transmission definitively, three factors might have contributed to transmission in these outbreaks. First, competitive sports participants might develop abrasions and other skin trauma, which could facilitate entry of pathogens. Even in sports with less direct contact, protective clothing can be hot and might chafe skin, resulting in abrasions and lacerations. Fencers reported developing skin rashes frequently under protective clothing. Second, some sports for which MRSA infections have been reported involve frequent physical contact among players (e.g., football and wrestling). *S. aureus* and other skin flora can be transmitted easily from person to person with direct contact. Third, sports such as fencing have limited skin-to-skin contact but require multiple pieces of protective clothing and equipment, which often might be shared. The use of shared equipment or other personal items that are not cleaned or laundered between users could be a vehicle for *S. aureus* transmission.

Previous outbreaks of staphylococcal skin infection have been reported among wrestlers and rugby and football players (*4–7*). In these outbreaks, risk factors have included skin trauma (*4,7*) and contact with lesions of other players (*7*). The findings in this report, particularly the cluster of MRSA infections among participants in a sport with little skin-to-skin contact, suggest that sharing equipment or personal items also might facilitate MRSA transmission. Although none of the fencers reported sharing equipment or clothing items, their use of shared sensor wires was not assessed specifically.

Maintaining good hygiene and avoiding contact with drainage from skin lesions of other players are the best methods for preventing spread of staphylococcal skin infections. Guidelines for preventing skin infections among sports team participants should be followed (*6–10*). All persons associated with competitive sports teams, including players, coaches, teachers, parents, and administrators, can help prevent sports-related skin infections and should be aware of prevention measures (Box). Sports team administrators should be encouraged to provide facilities and equipment necessary to promote good hygiene, such as clean facilities and adequate supplies of soap and towels. Coaches and parents should encourage good hygiene among players, and they should be taught to administer proper first aid, practice appropriate hand hygiene, and implement a system to ensure adequate wound care and to cover skin lesions appropriately before play. Players should be encouraged to practice good hygiene, avoid sharing towels or other personal items, and inform coaches about active skin infections. Additional information about MRSA is available at http://www.cdc.gov/ncidod/hip/aresist/mrsa.htm, or by telephone, 800-893-0485.

BOX. Measures for preventing staphylococcal skin infections among sports participants

- Cover all wounds. If a wound cannot be covered adequately, consider excluding players with potentially infectious skin lesions from practice or competitions until the lesions are healed or can be covered adequately.
- Encourage good hygiene, including showering and washing with soap after all practices and competitions.
- Ensure availability of adequate soap and hot water.
- Discourage sharing of towels and personal items (e.g., clothing or equipment).
- Establish routine cleaning schedules for shared equipment.
- Train athletes and coaches in first aid for wounds and recognition of wounds that are potentially infected.
- Encourage athletes to report skin lesions to coaches and encourage coaches to assess athletes regularly for skin lesions.

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West Nile Virus Activity — United States, August 14–20, 2003

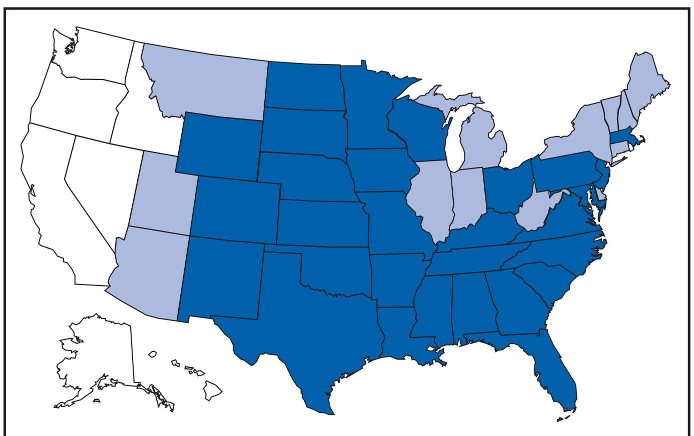
This report summarizes West Nile virus (WNV) surveillance data reported to CDC through ArboNET as of 3 a.m., Mountain Daylight Time, August 20, 2003.

During the reporting week of August 14–20, a total of 322 human cases of WNV infection were reported from 21 states (Alabama, Colorado, Georgia, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Minnesota, Nebraska, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, Virginia, and Wyoming), including five fatal cases from three states (Colorado, Nebraska, and Ohio). During the same period, WNV infections were reported in 1,143 dead birds, 291 horses, one dog, and 491 mosquito pools.

During 2003, a total of 715 human cases of WNV infection have been reported from Colorado (n = 263), South Dakota (n = 117), Nebraska (n = 99), Texas (n = 70), Louisiana (n = 30), Wyoming (n = 21), Pennsylvania (n = 17), Mississippi (n = 14), Minnesota (n = 12), Alabama (n = 11), Iowa (n = nine), Ohio (n = nine), New Mexico (n = eight), North Dakota (n = six), Florida (n = four), Kansas (n = four), Kentucky (n = three), Oklahoma (n = three), Georgia (n = two), North Carolina (n = two), Tennessee (n = two), Virginia (n = two), Arkansas (n = one), Maryland (n = one), Massachusetts (n = one), Missouri (n = one), New Jersey (n = one), South Carolina (n = one), and Wisconsin (n = one) (Figure). Among 692 (97%) cases for which demographic data were available, 394 (57%) occurred among men; the median age was 46 years (range: 17 months–97 years), and the dates of illness onset ranged from May 29–August 11. Of the 692 cases, 14 fatal cases were reported from Colorado (n = six), Nebraska (n = three), Alabama (n = two), Texas (n = two), and Ohio (n = one). A total of 103 presumptive WNV viremic donors have been reported from nine states (Colorado, Florida, Louisiana, Minnesota, Mississippi, Nebraska, New Mexico, South Dakota, and Texas). Of these donors, 10 had WNV fever and none had WNV meningoenciphalitis. In addition, 3,405 dead birds with WNV infection were reported from 38 states and New York City; 703 WNV infections in horses have been reported from 31 states (Alabama, Arizona, Arkansas, Colorado, Delaware, Florida, Georgia, Illinois, Iowa, Kansas, Kentucky, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming), four WNV infections were reported in dogs, one infection in a squirrel, and five infections in unidentified animal species. During 2003, WNV seroconversions have been reported in 338 sentinel chicken flocks from 11 states (Colorado, Delaware, Florida, Georgia, Iowa, Louisiana, Nebraska, North Carolina, Pennsylvania, Utah, and Virginia). Louisiana and South Dakota each reported three seropositive sentinel horses. A total of 1,959 WNV-positive mosquito pools have been reported from 31 states (Arizona, Arkansas, Colorado, Connecticut, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming) and New York City.

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

FIGURE. Areas reporting West Nile virus (WNV) activity — United States, 2003*



* As of 3:00 a.m., Mountain Daylight Time, August 20, 2003.

Notice to Readers

Supplemental Recommendations About the Timing of Influenza Vaccination, 2003–04 Season

In response to delays in production and distribution of influenza vaccine during 2000, the Advisory Committee on Immunization Practices (ACIP) recommended that first-available supplies of vaccine be administered to persons at increased risk for complications from influenza and to health-care workers. The committee also recommended that mass vaccination campaigns for the 2000–01 season be delayed until the availability of supply was assured (*1,2*). ACIP issued similar recommendations for the 2001–02 influenza season (*3*) and has incorporated this prioritization into its annual influenza recommendations (*4*).

To assist vaccinators in determining if administration of influenza vaccine should be prioritized because of anticipated delays or shortages, ACIP requested that CDC develop a process to assess the projected vaccine supply in advance of the influenza vaccination season. Each year, this process will be conducted collaboratively by CDC, the Food and Drug Administration, and the manufacturers who produce influenza vaccine.

On August 11, 2003, CDC determined that vaccine production for the 2003–04 influenza season is proceeding satisfactorily and that projected production and distribution schedules will allow for sufficient supply of influenza vaccine during October and November. Therefore, influenza vaccination can proceed for all high-risk and healthy persons, individually and through mass campaigns, as soon as vaccine is available.

Additional information about influenza and influenza vaccination is available from CDC at http://www.cdc.gov/nip/flu/default.htm.

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3. CDC. Delayed influenza vaccine availability for 2001–02 season and supplemental recommendations of the Advisory Committee on Immunization Practices. MMWR 2001;50:582–5.
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Notice to Readers

Recommendations for Public Health Surveillance of Syphilis in the United States

In March 2003, CDC's Division of Sexually Transmitted Disease Prevention (DSTDP) published *Recommendations for Public Health Surveillance of Syphilis in the United States*. The recommendations were developed for state and local public health programs. The recommendations are intended to make the collection and reporting of syphilis surveillance data more uniform and comparable.

Copies can be obtained from the Training and Health Communication Branch, Division of STD Prevention, National Center for HIV, STD, and TB Prevention, CDC, 1600 Clifton Road, Mail Stop E-06, Atlanta, Georgia 30333. Printed copies also can be obtained at http://www.cdc.gov/std. The document is available at http://www.cdc.gov/std/syphsurvreco.pdf.

Notice to Readers

Revision of Guidelines for Surveillance, Prevention, and Control of West Nile Virus Infection

The revised "Epidemic/Epizootic West Nile Virus in the United States: Guidelines for Surveillance, Prevention, and Control," is available from CDC at http://www.cdc.gov/ncidod/dvbid/westnile/resources/wnv-guidelines-aug-2003.pdf.

Revisions of the 2001 Guidelines (*1*) were derived from discussions during the national meeting on West Nile virus in New Orleans, Louisiana, during February 9–11, 2003.

Reference

1. CDC. Revision of guidelines for surveillance, prevention, and control of West Nile virus infection. MMWR 2001;50:273.

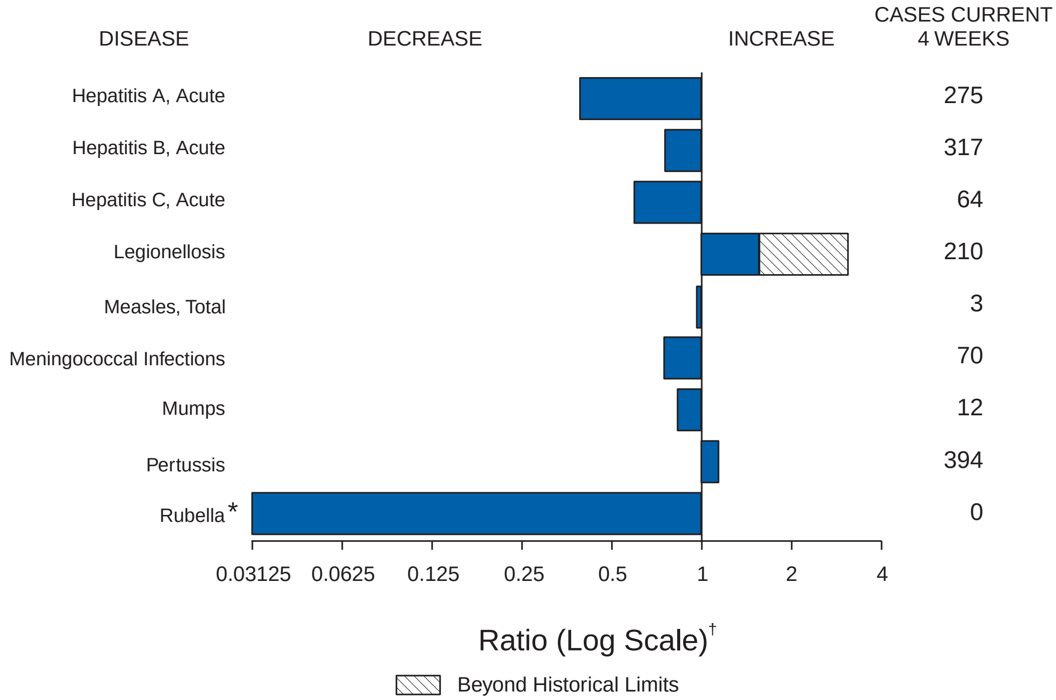
Notice to Readers

Release of CDC's Yellow Book

CDC has released the 2003–2004 edition of *Health Information for International Travel* (The Yellow Book). The edition contains a new chapter focusing on recommendations for children; new recommendations for malaria chemoprophylaxis; expanded text on injury during travel, motion sickness, altitude sickness, and travelers with disabilities; changes in vaccine recommendations; changes in recommendations for insect repellent use; new text on scuba diving safety and high-risk travelers; and improved and colorized maps and expanded indexing

The Yellow Book will be available on CD-ROM later this year. The book can be obtained by telephone, 877-252-1200, or at http://bookstore.phf.org.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals August 16, 2003, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 33 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 16, 2003 (33rd Week)*

	Cum. 2003	Cum. 2002		Cum. 2003	Cum. 2002
Anthrax	-	2	Hansen disease (leprosy)†	35	64
Botulism:	-	-	Hantavirus pulmonary syndrome†	12	14
foodborne	7	18	Hemolytic uremic syndrome, postdiarrheal†	67	116
infant	34	45	HIV infection, pediatric†§	144	104
other (wound & unspecified)	17	10	Measles, total	34¶	23**
Brucellosis†	44	71	Mumps	130	182
Chancroid	28	46	Plague	1	-
Cholera	2	1	Poliomyelitis, paralytic	-	-
Cyclosporiasis†	45	133	Psittacosis†	12	12
Diphtheria	-	1	Q fever†	46	33
Ehrlichiosis:	-	-	Rabies, human	-	1
human granulocytic (HGE)†	163	178	Rubella	6	10
human monocytic (HME)†	72	110	Rubella, congenital	-	1
other and unspecified	15	14	Streptococcal toxic-shock syndrome†	116	79
Encephalitis/Meningitis:	-	-	Tetanus	8	16
California serogroup viral†	5	31	Toxic-shock syndrome	83	72
eastern equine†	4	1	Trichinosis	1	13
Powassan†	-	1	Tularemia†	44	49
St. Louis†	-	9	Yellow fever	-	-
western equine†	16	-			

-: No reported cases.
* Incidence data for reporting years 2002 and 2003 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 27, 2003.
¶ Of 34 cases reported, 27 were indigenous and seven were imported from another country.
** Of 23 cases reported, 12 were indigenous and 11 were imported from another country.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending August 16, 2003, and August 17, 2002 (33rd Week)*

Reporting area	AIDS		Chlamydia†		Coccidiodomycosis		Cryptosporidiosis		Encephalitis/Meningitis West Nile	
	Cum. 2003§	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	26,605	24,521	495,982	513,393	2,193	2,820	1,300	1,553	74	454
NEW ENGLAND	905	1,003	17,191	16,969	-	-	89	100	-	-
Maine	49	23	1,200	994	N	N	8	5	-	-
N.H.	22	20	930	1,004	-	-	10	16	-	-
Vt.	11	8	620	528	-	-	20	18	-	-
Mass.	371	514	6,979	6,755	-	-	34	40	-	-
R.I.	69	70	1,681	1,731	-	-	12	13	-	-
Conn.	383	368	5,781	5,957	N	N	5	8	-	-
MID. ATLANTIC	6,223	5,658	55,580	57,043	-	-	175	206	9	5
Upstate N.Y.	665	466	11,930	10,329	N	N	55	53	1	-
N.Y. City	3,189	3,202	20,641	19,248	-	-	47	87	-	4
N.J.	1,044	922	7,774	8,155	-	-	4	12	-	1
Pa.	1,325	1,068	15,235	19,311	N	N	69	54	8	-
E.N. CENTRAL	2,625	2,488	80,455	94,000	6	18	300	493	8	108
Ohio	466	447	17,830	23,910	-	-	56	80	8	6
Ind.	345	345	9,607	10,354	N	N	40	26	-	-
Ill.	1,238	1,170	24,525	29,973	-	2	33	71	-	91
Mich.	451	401	19,063	19,190	6	16	64	70	-	3
Wis.	125	125	9,430	10,573	-	-	107	246	-	8
W.N. CENTRAL	486	419	29,216	28,512	1	1	169	183	19	4
Minn.	95	91	6,215	6,615	N	N	62	81	3	-
Iowa	55	50	2,676	3,018	N	N	39	16	-	-
Mo.	230	187	10,870	9,626	-	-	15	21	-	1
N. Dak.	2	1	700	770	N	N	11	10	-	-
S. Dak.	8	3	1,612	1,332	-	-	22	7	9	3
Nebr.¶	35	43	2,769	2,734	1	1	6	37	6	-
Kans.	61	44	4,374	4,417	N	N	14	11	1	-
S. ATLANTIC	7,717	7,404	98,021	96,691	3	3	193	182	9	7
Del.	149	130	1,904	1,628	N	N	3	2	-	-
Md.	882	1,062	10,367	9,730	3	3	12	10	-	1
D.C.	725	371	1,850	2,056	-	-	8	4	-	-
Va.	627	535	10,632	10,832	-	-	21	7	-	-
W. Va.	54	57	1,595	1,523	N	N	3	2	-	-
N.C.	799	536	16,429	15,448	N	N	19	23	-	-
S.C.¶	504	533	9,099	9,022	-	-	3	3	1	-
Ga.	1,202	1,161	20,789	19,953	-	-	69	74	1	6
Fla.	2,775	3,019	25,356	26,499	N	N	55	57	7	-
E.S. CENTRAL	1,144	1,105	32,987	33,136	N	N	63	87	1	119
Ky.	98	172	5,188	5,385	N	N	15	3	1	-
Tenn.	517	467	12,090	10,225	N	N	23	44	-	-
Ala.	271	194	8,245	10,425	-	-	22	36	-	3
Miss.	258	272	7,464	7,101	N	N	3	4	-	116
W.S. CENTRAL	2,737	2,677	64,528	68,869	-	6	18	39	20	211
Ark.	107	164	4,736	4,831	-	-	5	7	1	-
La.	402	685	11,061	12,039	N	N	2	8	1	135
Okla.	139	130	6,828	7,184	N	N	7	8	-	-
Tex.	2,089	1,698	41,903	44,815	-	6	4	16	18	76
MOUNTAIN	967	777	29,287	31,729	1,489	1,893	75	95	8	-
Mont.	10	8	1,283	1,331	N	N	13	4	6	-
Idaho	15	18	1,576	1,532	N	N	15	18	-	-
Wyo.	6	6	618	554	1	-	2	6	1	-
Colo.	215	156	6,730	8,755	N	N	18	33	-	-
N. Mex.	75	53	4,143	4,742	4	6	6	15	1	-
Ariz.	432	315	8,765	9,383	1,453	1,854	4	11	-	-
Utah	40	43	2,863	1,664	7	10	11	5	-	-
Nev.	174	178	3,309	3,768	24	23	6	3	-	-
PACIFIC	3,801	2,990	88,717	86,444	693	898	218	168	-	-
Wash.	290	299	10,121	9,308	N	N	25	9	-	-
Oreg.	165	213	4,378	4,330	-	-	28	25	-	-
Calif.	3,271	2,394	70,127	67,726	693	898	165	133	-	-
Alaska	13	17	2,287	2,293	-	-	-	-	-	-
Hawaii	62	67	1,804	2,787	-	-	-	1	-	-
Guam	6	1	-	383	-	-	-	-	-	-
P.R.	724	667	1,241	1,602	N	N	N	N	-	-
V.I.	22	62	142	121	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	-	U	-	U	-	U	-	U

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

* Incidence data for reporting years 2002 and 2003 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 27, 2003.

¶ Contains data reported through National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 16, 2003, and August 17, 2002 (33rd Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC) O157:H7 Cum. 2003	O157:H7 Cum. 2002	Shiga toxin positive, serogroup non-O157 Cum. 2003	Shiga toxin positive, serogroup non-O157 Cum. 2002	Shiga toxin positive, not serogrouped Cum. 2003	Shiga toxin positive, not serogrouped Cum. 2002	Giardiasis Cum. 2003	Giardiasis Cum. 2002	Gonorrhea Cum. 2003	Gonorrhea Cum. 2002
UNITED STATES	1,079	1,768	122	107	73	25	9,595	11,491	187,218	218,350
NEW ENGLAND	69	147	23	27	8	3	659	1,056	4,377	4,768
Maine	6	22	1	4	-	-	94	109	127	77
N.H.	10	17	1	-	-	-	19	31	71	75
Vt.	6	5	-	-	-	-	59	78	48	66
Mass.	25	68	3	15	8	3	275	566	1,750	2,041
R.I.	1	5	-	-	-	-	74	83	549	538
Conn.	21	30	18	8	-	-	138	189	1,832	1,971
MID. ATLANTIC	123	198	7	1	20	2	1,882	2,382	22,373	26,202
Upstate N.Y.	49	89	3	-	10	-	557	661	4,607	5,259
N.Y. City	3	11	-	-	-	-	628	915	7,973	7,864
N.J.	5	36	-	-	-	-	157	279	4,923	4,877
Pa.	66	62	4	1	10	2	540	527	4,870	8,202
E.N. CENTRAL	249	420	15	23	11	3	1,550	1,936	35,575	45,476
Ohio	50	72	12	8	10	2	512	506	9,599	13,329
Ind.	51	38	-	-	-	-	-	-	3,698	4,489
Ill.	40	111	-	6	-	-	366	574	10,901	15,197
Mich.	43	75	-	3	-	1	415	501	8,147	8,678
Wis.	65	124	3	6	1	-	257	355	3,230	3,783
W.N. CENTRAL	196	264	19	18	16	3	1,023	1,086	10,106	11,086
Minn.	62	87	10	15	1	-	394	368	1,649	1,944
Iowa	44	56	-	-	-	-	145	161	607	703
Mo.	49	39	6	-	1	-	277	287	5,176	5,480
N. Dak.	6	4	-	-	7	-	22	13	30	43
S. Dak.	13	27	3	1	-	-	25	47	129	158
Nebr.	8	33	-	2	-	-	67	103	905	940
Kans.	14	18	-	-	7	3	93	107	1,610	1,818
S. ATLANTIC	86	143	42	17	3	-	1,599	1,706	48,339	55,905
Del.	1	5	N	N	N	N	22	31	751	991
Md.	4	16	-	-	-	-	66	68	4,956	5,560
D.C.	1	-	-	-	-	-	25	28	1,457	1,667
Va.	22	32	5	2	-	-	208	140	4,926	6,332
W. Va.	3	2	-	-	-	-	24	30	539	627
N.C.	5	23	12	-	-	-	N	N	9,397	10,336
S.C.	-	2	-	-	-	-	68	53	4,905	5,690
Ga.	18	37	2	7	-	-	546	553	10,281	10,884
Fla.	32	26	23	8	3	-	640	803	11,127	13,818
E.S. CENTRAL	48	65	2	-	6	8	188	209	16,006	19,030
Ky.	14	18	2	-	6	8	N	N	2,260	2,217
Tenn.	21	26	-	-	-	-	88	96	4,904	5,834
Ala.	10	13	-	-	-	-	100	113	5,086	6,705
Miss.	3	8	-	-	-	-	-	-	3,756	4,274
W.S. CENTRAL	31	69	1	-	3	2	171	126	26,531	30,780
Ark.	5	5	-	-	-	-	94	85	2,510	2,965
La.	2	2	-	-	-	-	5	2	6,613	7,480
Okla.	14	15	-	-	-	-	72	38	2,691	3,054
Tex.	10	47	1	-	3	2	-	1	14,717	17,281
MOUNTAIN	133	185	11	16	6	4	836	902	6,149	6,865
Mont.	5	13	-	-	-	-	52	57	68	55
Idaho	26	24	6	8	-	-	90	67	47	52
Wyo.	2	6	-	1	-	-	13	18	28	38
Colo.	35	63	2	4	6	4	235	304	1,566	2,139
N. Mex.	4	4	3	3	-	-	25	95	692	947
Ariz.	21	20	N	N	N	N	152	122	2,373	2,279
Utah	30	37	-	-	-	-	195	159	273	158
Nev.	10	18	-	-	-	-	74	80	1,102	1,197
PACIFIC	144	277	2	5	-	-	1,687	2,088	17,762	18,238
Wash.	42	70	1	-	-	-	153	239	1,722	1,793
Oreg.	24	55	1	5	-	-	221	251	581	530
Calif.	71	119	-	-	-	-	1,216	1,474	14,748	15,122
Alaska	1	5	-	-	-	-	47	57	321	383
Hawaii	6	28	-	-	-	-	50	67	390	410
Guam	N	N	-	-	-	-	-	6	-	33
P.R.	-	1	-	-	-	-	35	38	137	234
V.I.	-	-	-	-	-	-	-	-	36	31
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 years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 16, 2003, and August 17, 2002 (33rd Week)*

Reporting area	*Haemophilus influenzae*, invasive†								Hepatitis (viral, acute), by type	
	All ages		Age <5 years							
	All serotypes		Serotype b		Non-serotype b		Unknown serotype		A	
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	1,099	1,120	9	22	61	90	119	102	3,625	5,853
NEW ENGLAND	86	72	1	-	6	7	5	1	178	209
Maine	2	1	-	-	-	-	1	-	9	7
N.H.	11	6	1	-	-	-	-	-	8	11
Vt.	6	5	-	-	-	-	-	-	5	1
Mass.	42	32	-	-	6	3	3	1	102	92
R.I.	4	10	-	-	-	-	1	-	11	28
Conn.	21	18	-	-	-	4	-	-	43	70
MID. ATLANTIC	246	202	-	2	1	11	32	20	697	739
Upstate N.Y.	95	78	-	2	1	4	9	6	81	122
N.Y. City	41	48	-	-	-	-	8	9	221	267
N.J.	40	42	-	-	-	-	6	5	85	123
Pa.	70	34	-	-	-	7	9	-	310	227
E.N. CENTRAL	143	225	1	2	5	9	23	30	396	733
Ohio	49	62	-	-	-	1	8	7	76	207
Ind.	32	33	-	1	3	7	-	-	45	33
Ill.	41	83	-	-	-	-	11	15	115	196
Mich.	15	9	1	1	2	1	2	-	125	156
Wis.	6	38	-	-	-	-	2	8	35	141
W.N. CENTRAL	83	48	-	1	6	2	9	3	122	214
Minn.	32	29	-	1	6	2	1	1	33	32
Iowa	-	1	-	-	-	-	-	-	20	49
Mo.	34	10	-	-	-	-	8	2	43	60
N. Dak.	1	4	-	-	-	-	-	-	-	1
S. Dak.	1	1	-	-	-	-	-	-	-	3
Nebr.	2	-	-	-	-	-	-	-	6	14
Kans.	13	3	-	-	-	-	-	-	20	55
S. ATLANTIC	260	252	1	5	9	13	14	19	880	1,619
Del.	-	-	-	-	-	-	-	-	4	10
Md.	60	64	-	2	5	2	-	1	91	196
D.C.	-	-	-	-	-	-	-	-	26	55
Va.	38	22	-	-	-	-	5	3	48	61
W. Va.	11	9	-	-	-	-	-	1	13	13
N.C.	22	24	-	-	1	3	1	-	46	151
S.C.	3	10	-	-	-	-	-	2	25	45
Ga.	50	55	-	-	-	-	5	9	347	331
Fla.	76	68	1	3	3	8	3	3	280	757
E.S. CENTRAL	49	47	1	1	-	4	6	7	101	184
Ky.	2	4	-	-	-	1	-	-	22	39
Tenn.	29	22	-	-	-	-	4	5	55	74
Ala.	16	14	1	1	-	3	1	1	11	26
Miss.	2	7	-	-	-	-	1	1	13	45
W.S. CENTRAL	43	41	-	2	5	7	3	2	176	626
Ark.	6	1	-	-	1	-	-	-	16	36
La.	7	5	-	-	-	-	2	2	38	58
Okla.	28	33	-	-	4	7	1	-	10	31
Tex.	2	2	-	2	-	-	-	-	112	501
MOUNTAIN	124	131	4	4	17	21	19	11	304	363
Mont.	-	-	-	-	-	-	-	-	5	10
Idaho	3	2	-	-	-	-	1	1	-	23
Wyo.	1	2	-	-	-	-	-	-	1	2
Colo.	23	25	-	-	-	-	5	2	44	56
N. Mex.	15	20	-	-	4	4	2	1	11	12
Ariz.	64	60	4	2	6	13	8	5	182	198
Utah	11	14	-	1	4	3	3	-	24	27
Nev.	7	8	-	1	3	1	-	2	37	35
PACIFIC	65	102	1	5	12	16	8	9	771	1,166
Wash.	6	2	-	1	4	1	1	-	38	113
Oreg.	33	39	-	-	-	-	3	3	41	44
Calif.	16	33	1	4	8	15	4	2	679	984
Alaska	-	1	-	-	-	-	-	1	7	7
Hawaii	10	27	-	-	-	-	-	3	6	18
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	1	-	-	-	-	-	-	24	140
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 years 2002 and 2003 are provisional and cumulative (year-to-date).

† Non-serotype b: nontypeable and type other than b; Unknown serotype: type unknown or not reported. Previously, cases reported without type information were counted as non-serotype b.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 16, 2003, and August 17, 2002 (33rd Week)*

Reporting area	Hepatitis (viral, acute), by type: B Cum. 2003	B Cum. 2002	C Cum. 2003	C Cum. 2002	Legionellosis Cum. 2003	Legionellosis Cum. 2002	Listeriosis Cum. 2003	Listeriosis Cum. 2002	Lyme disease Cum. 2003	Lyme disease Cum. 2002
UNITED STATES	3,838	4,630	882	1,184	993	634	328	339	8,064	11,041
NEW ENGLAND	146	170	2	18	37	59	27	35	1,357	2,374
Maine	1	5	-	-	1	2	5	2	112	49
N.H.	11	12	-	-	4	4	2	3	51	136
Vt.	2	3	2	12	2	25	-	2	18	19
Mass.	116	97	-	6	15	20	12	19	192	1,480
R.I.	8	17	-	-	3	1	-	1	181	138
Conn.	8	36	U	U	12	7	8	8	803	552
MID. ATLANTIC	594	990	111	61	222	157	61	82	5,441	6,504
Upstate N.Y.	67	75	34	27	68	42	16	27	2,377	2,830
N.Y. City	246	498	-	-	15	27	10	22	2	51
N.J.	109	199	-	4	4	21	7	13	544	1,768
Pa.	172	218	77	30	135	67	28	20	2,518	1,855
E.N. CENTRAL	253	406	135	68	221	168	39	49	302	955
Ohio	89	61	7	-	142	65	14	13	32	40
Ind.	22	31	4	-	14	11	3	6	11	11
Ill.	1	81	9	13	3	19	5	12	-	40
Mich.	118	197	115	52	51	46	14	12	1	17
Wis.	23	36	-	3	11	27	3	6	258	847
W.N. CENTRAL	194	133	138	525	42	30	9	10	173	158
Minn.	26	12	7	2	3	2	3	-	126	91
Iowa	4	12	1	1	9	7	-	1	16	28
Mo.	132	70	129	513	19	10	3	6	24	30
N. Dak.	1	4	-	-	1	-	-	1	-	-
S. Dak.	2	-	-	-	1	2	-	-	-	-
Nebr.	16	19	1	9	2	9	3	1	2	5
Kans.	13	16	-	-	7	-	-	1	5	4
S. ATLANTIC	1,245	1,127	113	130	304	117	72	49	654	834
Del.	5	12	-	-	13	6	N	N	98	124
Md.	80	88	10	7	72	20	13	10	396	510
D.C.	7	13	-	-	8	5	-	-	6	15
Va.	104	131	4	2	57	12	7	3	44	57
W. Va.	16	18	1	1	11	-	4	-	8	8
N.C.	111	162	8	18	23	7	11	4	56	69
S.C.	95	72	23	4	5	6	2	7	1	10
Ga.	400	305	3	58	19	9	20	9	12	1
Fla.	427	326	64	40	96	52	15	16	33	40
E.S. CENTRAL	255	239	82	82	60	23	15	9	30	37
Ky.	44	40	8	4	24	9	3	2	7	13
Tenn.	118	92	41	19	24	8	4	4	10	10
Ala.	41	48	6	4	11	6	6	3	1	7
Miss.	52	59	27	55	1	-	2	-	12	7
W.S. CENTRAL	197	635	193	181	13	17	15	19	33	100
Ark.	33	83	3	10	2	-	1	-	-	2
La.	46	81	45	61	-	4	1	1	3	3
Okla.	31	31	2	4	5	3	1	6	-	-
Tex.	87	440	143	106	6	10	12	12	30	95
MOUNTAIN	386	391	43	42	43	22	20	20	12	10
Mont.	8	3	1	-	2	3	1	-	-	-
Idaho	-	6	-	-	3	-	1	2	2	2
Wyo.	23	12	-	5	2	1	-	-	-	1
Colo.	49	49	23	5	8	3	9	3	4	-
N. Mex.	19	113	-	2	2	1	2	2	-	1
Ariz.	196	142	6	4	9	6	5	9	-	2
Utah	41	26	-	4	13	7	-	3	3	3
Nev.	50	40	13	22	4	1	2	1	3	1
PACIFIC	568	539	65	77	51	41	70	66	62	69
Wash.	38	42	10	15	5	3	2	5	1	6
Oreg.	75	92	10	10	N	N	3	8	14	11
Calif.	437	393	43	52	46	38	62	47	45	51
Alaska	8	6	1	-	-	-	-	-	2	1
Hawaii	10	6	1	-	-	-	3	6	N	N
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	39	117	-	-	-	-	-	2	N	N
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 years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 16, 2003, and August 17, 2002 (33rd Week)*

Reporting area	Malaria		Meningococcal disease		Pertussis		Rabies, animal		Rocky Mountain spotted fever	
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	544	855	1,056	1,258	3,841	4,839	3,248	4,705	356	606
NEW ENGLAND	24	55	51	74	364	433	322	542	-	2
Maine	2	3	5	4	11	5	34	30	-	-
N.H.	2	6	3	9	30	9	13	27	-	-
Vt.	-	2	-	4	46	83	21	72	-	-
Mass.	9	23	33	39	269	301	117	175	-	2
R.I.	-	3	2	5	7	10	36	42	-	-
Conn.	11	18	8	13	1	25	101	196	-	-
MID. ATLANTIC	117	214	133	160	369	216	283	753	16	41
Upstate N.Y.	34	27	33	37	202	141	220	420	1	-
N.Y. City	51	135	25	28	-	11	1	10	6	9
N.J.	10	27	19	23	22	-	62	105	5	15
Pa.	22	25	56	72	145	64	-	218	4	17
E.N. CENTRAL	55	119	160	184	281	561	75	87	6	25
Ohio	13	14	45	57	142	268	33	16	4	10
Ind.	1	9	33	23	32	40	9	21	-	3
Ill.	18	51	35	42	-	100	8	16	-	10
Mich.	19	36	33	30	52	37	23	23	2	2
Wis.	4	9	14	32	55	116	2	11	-	-
W.N. CENTRAL	28	47	99	102	198	377	393	313	31	78
Minn.	15	16	20	24	59	141	24	21	1	-
Iowa	3	2	16	14	45	106	60	43	2	2
Mo.	2	13	47	39	56	77	13	29	23	72
N. Dak.	1	1	1	-	3	5	40	29	-	-
S. Dak.	2	1	1	2	3	5	67	65	2	-
Nebr.	-	5	7	18	4	5	58	-	1	4
Kans.	5	9	7	5	28	38	131	126	2	-
S. ATLANTIC	166	190	207	193	354	260	1,665	1,672	223	275
Del.	2	2	7	6	1	2	26	24	-	-
Md.	43	67	24	5	49	42	244	267	62	31
D.C.	8	15	-	-	-	1	-	-	-	-
Va.	20	17	20	28	64	96	342	369	14	19
W. Va.	4	3	4	3	6	23	60	118	4	1
N.C.	13	12	27	24	83	24	514	431	97	164
S.C.	3	5	19	18	67	28	136	78	12	37
Ga.	28	29	22	22	28	20	244	265	26	18
Fla.	45	40	84	87	56	24	99	120	8	5
E.S. CENTRAL	8	13	52	72	91	154	125	163	45	80
Ky.	2	5	11	12	31	60	27	18	-	3
Tenn.	4	3	14	28	42	59	83	108	35	44
Ala.	2	3	13	17	14	27	15	35	3	11
Miss.	-	2	14	15	4	8	-	2	7	22
W.S. CENTRAL	17	40	72	153	297	1,227	162	798	28	92
Ark.	4	1	11	20	10	448	25	-	-	21
La.	3	3	24	31	6	6	-	-	-	-
Okla.	3	5	12	17	12	34	137	76	27	61
Tex.	7	31	25	85	269	739	-	722	1	10
MOUNTAIN	24	35	53	74	630	598	95	187	7	11
Mont.	-	1	3	2	1	4	14	10	1	1
Idaho	1	-	6	3	46	50	3	20	1	-
Wyo.	1	-	2	-	119	10	3	14	2	4
Colo.	12	20	13	22	209	227	19	29	2	1
N. Mex.	-	2	6	3	37	116	5	7	-	-
Ariz.	7	5	15	22	122	103	42	99	1	-
Utah	2	4	1	4	73	55	6	5	-	-
Nev.	1	3	7	18	23	33	3	3	-	5
PACIFIC	105	142	229	246	1,257	1,013	128	190	-	2
Wash.	16	13	21	46	343	301	-	-	-	-
Oreg.	7	7	38	35	317	125	5	11	-	2
Calif.	77	114	161	157	588	560	120	153	-	-
Alaska	-	2	1	2	-	4	3	26	-	-
Hawaii	5	6	8	6	9	23	-	-	-	-
Guam	-	-	-	1	-	2	-	-	-	-
P.R.	-	1	2	5	-	2	48	55	N	N
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 years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 16, 2003, and August 17, 2002 (33rd Week)*

Reporting area	Salmonellosis Cum. 2003	Salmonellosis Cum. 2002	Shigellosis Cum. 2003	Shigellosis Cum. 2002	Streptococcal disease, invasive, group A Cum. 2003	Streptococcal disease, invasive, group A Cum. 2002	*Streptococcus pneumoniae*, invasive: Drug resistant, all ages Cum. 2003	*Streptococcus pneumoniae*, invasive: Drug resistant, all ages Cum. 2002	*Streptococcus pneumoniae*, invasive: Age <5 years Cum. 2003	*Streptococcus pneumoniae*, invasive: Age <5 years Cum. 2002
UNITED STATES	21,244	23,610	12,314	10,812	3,768	3,273	1,500	1,720	295	222
NEW ENGLAND	1,236	1,271	181	187	319	253	40	75	6	1
Maine	84	87	6	3	22	20	-	-	-	-
N.H.	83	78	5	7	19	28	-	-	N	N
Vt.	41	43	6	-	16	9	6	4	3	1
Mass.	731	727	121	124	151	85	N	N	N	N
R.I.	62	92	7	6	9	13	10	6	3	-
Conn.	235	244	36	47	102	98	24	65	U	U
MID. ATLANTIC	2,367	3,247	1,346	968	618	547	93	81	70	57
Upstate N.Y.	602	853	217	144	282	220	51	72	53	47
N.Y. City	640	844	217	286	90	127	U	U	U	U
N.J.	211	678	161	376	42	115	N	N	N	N
Pa.	914	872	751	162	204	85	42	9	17	10
E.N. CENTRAL	3,139	3,500	1,105	1,208	849	704	321	153	130	81
Ohio	888	813	242	402	246	159	209	28	76	-
Ind.	358	288	100	60	89	39	112	123	34	40
Ill.	978	1,228	517	535	179	205	-	2	-	-
Mich.	484	586	172	102	289	219	N	N	N	N
Wis.	431	585	74	109	46	82	N	N	20	41
W.N. CENTRAL	1,473	1,460	508	705	243	186	125	326	42	40
Minn.	344	347	60	141	121	95	-	220	36	36
Iowa	213	239	35	74	N	N	N	N	N	N
Mo.	565	482	267	107	51	38	9	5	2	1
N. Dak.	25	24	3	16	10	-	3	1	4	3
S. Dak.	60	65	9	151	18	10	1	1	-	-
Nebr.	87	103	87	154	21	16	-	25	N	N
Kans.	179	200	47	62	22	27	112	74	N	N
S. ATLANTIC	5,588	5,540	4,899	3,430	689	543	771	796	9	22
Del.	49	47	144	32	6	2	1	3	N	N
Md.	481	553	415	676	209	86	-	-	-	17
D.C.	21	48	42	39	11	6	2	-	5	3
Va.	572	550	262	580	85	57	N	N	N	N
W. Va.	78	80	-	5	30	14	51	34	4	2
N.C.	674	709	596	215	80	102	N	N	U	U
S.C.	318	346	269	71	30	29	110	139	N	N
Ga.	1,066	1,045	1,284	788	84	104	188	198	N	N
Fla.	2,329	2,162	1,887	1,024	154	143	419	422	N	N
E.S. CENTRAL	1,360	1,685	564	842	142	77	95	109	-	-
Ky.	248	203	67	86	35	14	12	13	N	N
Tenn.	447	425	197	44	107	63	83	96	N	N
Ala.	296	437	177	436	-	-	-	-	N	N
Miss.	369	620	123	276	-	-	-	-	-	-
W.S. CENTRAL	1,820	2,448	1,692	1,664	140	213	33	147	34	18
Ark.	383	502	64	134	5	6	8	6	-	-
La.	236	456	142	303	1	1	25	141	10	5
Okla.	259	269	534	300	64	35	N	N	24	2
Tex.	942	1,221	952	927	70	171	N	N	-	11
MOUNTAIN	1,249	1,322	592	404	345	405	19	33	4	3
Mont.	61	63	2	3	2	-	-	-	-	-
Idaho	103	85	14	3	14	6	N	N	N	N
Wyo.	61	39	1	5	2	7	4	10	-	-
Colo.	284	381	101	86	97	83	-	-	-	-
N. Mex.	116	171	109	75	85	76	15	23	-	-
Ariz.	400	341	303	188	135	206	-	-	N	N
Utah	125	101	32	20	9	27	-	-	4	3
Nev.	99	141	30	24	1	-	-	-	-	-
PACIFIC	3,012	3,137	1,427	1,404	423	345	3	-	-	-
Wash.	328	289	103	96	38	18	-	-	N	N
Oreg.	246	228	148	61	N	N	N	N	N	N
Calif.	2,260	2,407	1,144	1,210	315	282	N	N	N	N
Alaska	50	42	5	2	-	-	-	-	N	N
Hawaii	128	171	27	35	70	45	3	-	-	-
Guam	-	29	-	19	-	-	-	4	-	-
P.R.	159	285	2	20	N	N	N	N	N	N
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 years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 16, 2003, and August 17, 2002 (33rd Week)*

	Syphilis				Tuberculosis		Typhoid fever		Varicella (Chickenpox)
	Primary & secondary		Congenital						
Reporting area	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003
UNITED STATES	4,203	4,083	227	253	6,601	7,899	161	186	8,131
NEW ENGLAND	134	84	1	-	184	255	16	10	1,241
Maine	6	2	1	-	5	10	-	-	633
N.H.	13	2	-	-	7	8	2	-	-
Vt.	-	1	-	-	3	4	-	-	492
Mass.	89	59	-	-	112	130	7	7	113
R.I.	13	2	-	-	24	35	2	-	3
Conn.	13	18	-	-	33	68	5	3	-
MID. ATLANTIC	485	435	43	36	1,275	1,365	20	48	18
Upstate N.Y.	26	22	12	1	154	209	5	3	N
N.Y. City	292	257	24	16	723	655	9	25	-
N.J.	82	84	7	18	215	306	5	13	-
Pa.	85	72	-	1	183	195	1	7	18
E.N. CENTRAL	570	773	42	38	699	791	10	20	3,762
Ohio	133	91	2	2	126	126	-	5	925
Ind.	31	39	7	2	86	70	3	2	-
Ill.	215	299	14	28	327	390	1	7	-
Mich.	181	328	19	6	126	159	6	3	2,261
Wis.	10	16	-	-	34	46	-	3	576
W.N. CENTRAL	93	78	3	-	285	340	2	7	38
Minn.	32	38	-	-	109	143	-	3	N
Iowa	4	2	-	-	17	17	1	-	N
Mo.	33	17	3	-	77	93	1	1	-
N. Dak.	-	-	-	-	-	4	-	-	38
S. Dak.	1	-	-	-	16	10	-	-	-
Nebr.	3	5	-	-	8	17	-	3	-
Kans.	20	16	-	-	58	56	-	-	-
S. ATLANTIC	1,121	1,003	40	58	1,342	1,605	35	24	1,543
Del.	4	9	-	-	-	13	-	-	19
Md.	193	119	8	10	140	178	7	5	-
D.C.	34	32	-	1	-	-	-	-	22
Va.	55	48	1	1	159	177	10	2	427
W. Va.	2	2	-	-	12	18	-	-	907
N.C.	100	182	11	16	194	198	6	1	N
S.C.	66	80	4	7	97	115	-	-	168
Ga.	268	210	3	9	196	328	6	4	-
Fla.	399	321	13	14	544	578	6	12	N
E.S. CENTRAL	197	332	12	19	417	465	5	4	-
Ky.	26	63	1	3	77	80	-	4	N
Tenn.	84	122	6	6	141	176	2	-	N
Ala.	71	113	4	7	139	131	3	-	-
Miss.	16	34	1	3	60	78	-	-	-
W.S. CENTRAL	553	532	39	55	923	1,224	6	22	1,159
Ark.	37	20	-	3	62	80	-	-	-
La.	79	94	-	-	-	-	-	-	4
Okla.	34	41	1	1	90	102	-	-	N
Tex.	403	377	38	51	771	1,042	6	22	1,155
MOUNTAIN	193	195	21	9	203	239	3	7	370
Mont.	-	-	-	-	5	6	-	-	N
Idaho	6	1	-	-	5	10	-	-	N
Wyo.	-	-	-	-	2	2	-	-	42
Colo.	12	38	3	1	43	51	3	3	-
N. Mex.	35	21	-	-	6	22	-	-	-
Ariz.	127	123	18	8	97	117	-	-	4
Utah	5	4	-	-	23	18	-	2	324
Nev.	8	8	-	-	22	13	-	2	-
PACIFIC	857	651	26	38	1,273	1,615	64	44	-
Wash.	50	32	-	1	146	155	2	4	-
Oreg.	27	11	-	-	59	71	3	2	-
Calif.	779	601	26	36	999	1,263	59	37	-
Alaska	-	-	-	-	34	32	-	-	-
Hawaii	1	7	-	1	35	94	-	1	-
Guam	-	6	-	-	-	42	-	-	-
P.R.	118	158	1	20	33	67	-	-	275
V.I.	1	1	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,[*] week ending August 16, 2003 (33rd Week)

Reporting Area	All causes, by age (years)						
	All Ages	≥65	45-64	25-44	1-24	<1	P&I[†] Total
NEW ENGLAND	498	314	125	41	9	8	34
Boston, Mass.	146	85	41	13	4	3	14
Bridgeport, Conn.	29	16	10	3	-	-	1
Cambridge, Mass.	32	23	7	1	-	1	3
Fall River, Mass.	28	20	5	2	1	-	1
Hartford, Conn.	32	20	6	4	1	1	3
Lowell, Mass.	20	11	8	1	-	-	1
Lynn, Mass.	12	7	3	2	-	-	-
New Bedford, Mass.	33	19	9	4	1	-	2
New Haven, Conn.	26	16	6	2	1	1	3
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	4	1	1	1	1	-	1
Springfield, Mass.	59	41	11	6	-	-	2
Waterbury, Conn.	31	25	4	1	-	1	2
Worcester, Mass.	46	30	14	1	-	1	1
MID. ATLANTIC	2,159	1,479	447	154	45	34	109
Albany, N.Y.	50	37	6	3	2	2	3
Allentown, Pa.	18	14	2	2	-	-	1
Buffalo, N.Y.	75	52	15	3	2	3	4
Camden, N.J.	20	10	6	3	1	-	2
Elizabeth, N.J.	19	14	3	2	-	-	-
Erie, Pa.	39	35	2	-	1	1	1
Jersey City, N.J.	U	U	U	U	U	U	U
New York City, N.Y.	1,163	787	251	93	20	12	47
Newark, N.J.	64	33	18	7	4	2	6
Paterson, N.J.	21	12	3	2	1	3	-
Philadelphia, Pa.	277	189	55	18	9	6	17
Pittsburgh, Pa.[§]	31	20	5	3	1	2	1
Reading, Pa.	18	12	6	-	-	-	-
Rochester, N.Y.	133	97	28	5	2	1	10
Schenectady, N.Y.	26	22	2	2	-	-	-
Scranton, Pa.	32	27	5	-	-	-	-
Syracuse, N.Y.	111	74	29	5	2	1	12
Trenton, N.J.	18	12	3	2	-	1	-
Utica, N.Y.	19	14	4	1	-	-	2
Yonkers, N.Y.	25	18	4	3	-	-	3
E.N. CENTRAL	1,807	1,186	390	131	52	46	125
Akron, Ohio	50	35	11	-	1	3	7
Canton, Ohio	32	22	5	5	-	-	6
Chicago, Ill.	317	172	93	29	15	7	17
Cincinnati, Ohio	74	57	13	3	-	1	8
Cleveland, Ohio	105	66	30	6	1	1	4
Columbus, Ohio	200	120	46	20	5	9	22
Dayton, Ohio	92	64	15	7	6	-	6
Detroit, Mich.	119	65	36	14	3	1	9
Evansville, Ind.	36	31	4	-	1	-	1
Fort Wayne, Ind.	52	34	13	4	1	-	5
Gary, Ind.	U	U	U	U	U	U	U
Grand Rapids, Mich.	56	38	10	2	-	6	4
Indianapolis, Ind.	200	126	42	15	9	8	12
Lansing, Mich.	53	41	8	4	-	-	3
Milwaukee, Wis.	120	89	18	8	4	1	7
Peoria, Ill.	51	37	9	1	-	4	4
Rockford, Ill.	55	39	7	4	3	2	3
South Bend, Ind.	52	40	9	2	1	-	3
Toledo, Ohio	86	65	13	4	2	2	1
Youngstown, Ohio	57	45	8	3	-	1	3
W.N. CENTRAL	504	322	124	32	12	13	35
Des Moines, Iowa	87	55	21	7	1	3	8
Duluth, Minn.	24	16	5	1	2	-	5
Kansas City, Kans.	28	16	10	-	1	1	4
Kansas City, Mo.	90	53	20	10	4	2	3
Lincoln, Nebr.	32	21	8	2	-	1	-
Minneapolis, Minn.	54	28	17	3	2	4	3
Omaha, Nebr.	78	57	16	3	1	1	5
St. Louis, Mo.	U	U	U	U	U	U	U
St. Paul, Minn.	34	26	6	1	1	-	3
Wichita, Kans.	77	50	21	5	-	1	4

Reporting Area	All causes, by age (years)						
	All Ages	≥65	45-64	25-44	1-24	<1	P&I[†] Total
S. ATLANTIC	796	492	164	91	26	22	41
Atlanta, Ga.	U	U	U	U	U	U	U
Baltimore, Md.	139	77	34	18	6	4	8
Charlotte, N.C.	86	56	17	8	1	4	8
Jacksonville, Fla.	126	77	22	15	7	5	4
Miami, Fla.	73	42	18	8	3	2	5
Norfolk, Va.	49	34	9	4	1	1	2
Richmond, Va.	57	38	8	6	3	2	1
Savannah, Ga.	58	40	9	7	1	1	4
St. Petersburg, Fla.	73	48	14	8	1	2	3
Tampa, Fla.	U	U	U	U	U	U	U
Washington, D.C.	119	68	30	16	3	1	4
Wilmington, Del.	16	12	3	1	-	-	2
E.S. CENTRAL	815	517	201	48	24	21	53
Birmingham, Ala.	166	110	34	7	5	6	15
Chattanooga, Tenn.	76	54	20	-	1	1	5
Knoxville, Tenn.	92	52	25	10	3	2	-
Lexington, Ky.	65	38	16	5	1	5	3
Memphis, Tenn.	166	94	51	9	8	4	8
Mobile, Ala.	67	47	13	4	1	2	1
Montgomery, Ala.	40	31	7	2	-	-	4
Nashville, Tenn.	143	91	35	11	5	1	17
W.S. CENTRAL	1,016	611	240	94	45	26	59
Austin, Tex.	76	51	12	9	3	1	6
Baton Rouge, La.	6	2	2	2	-	-	-
Corpus Christi, Tex.	48	30	10	4	1	3	2
Dallas, Tex.	171	96	51	16	4	4	15
El Paso, Tex.	79	52	17	5	3	2	2
Ft. Worth, Tex.	92	60	25	4	1	2	5
Houston, Tex.	375	217	77	38	30	13	23
Little Rock, Ark.	62	36	18	6	1	1	2
New Orleans, La.	38	20	11	5	2	-	-
San Antonio, Tex.	U	U	U	U	U	U	U
Shreveport, La.	69	47	17	5	-	-	4
Tulsa, Okla.	U	U	U	U	U	U	U
MOUNTAIN	857	555	170	84	32	16	48
Albuquerque, N.M.	106	58	25	19	4	-	4
Boise, Idaho	44	33	5	2	2	2	2
Colo. Springs, Colo.	54	35	15	2	1	1	-
Denver, Colo.	102	66	20	8	3	5	4
Las Vegas, Nev.	235	145	51	23	11	5	15
Ogden, Utah	29	22	2	4	-	1	1
Phoenix, Ariz.	U	U	U	U	U	U	U
Pueblo, Colo.	20	15	3	2	-	-	5
Salt Lake City, Utah	118	75	26	12	4	1	8
Tucson, Ariz.	149	106	23	12	7	1	9
PACIFIC	1,525	1,046	314	99	33	33	107
Berkeley, Calif.	13	10	3	-	-	-	-
Fresno, Calif.	99	72	13	7	6	1	2
Glendale, Calif.	28	24	4	-	-	-	4
Honolulu, Hawaii	76	56	14	3	2	1	5
Long Beach, Calif.	66	41	13	3	4	5	6
Los Angeles, Calif.	522	355	115	39	5	8	35
Pasadena, Calif.	U	U	U	U	U	U	U
Portland, Oreg.	127	73	40	5	4	5	10
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	165	115	28	15	5	2	16
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	170	124	29	9	2	6	14
Santa Cruz, Calif.	22	18	3	1	-	-	1
Seattle, Wash.	103	63	28	9	1	2	9
Spokane, Wash.	55	39	9	3	3	1	2
Tacoma, Wash.	79	56	15	5	1	2	3
TOTAL	9,977[¶]	6,522	2,175	774	278	219	611

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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