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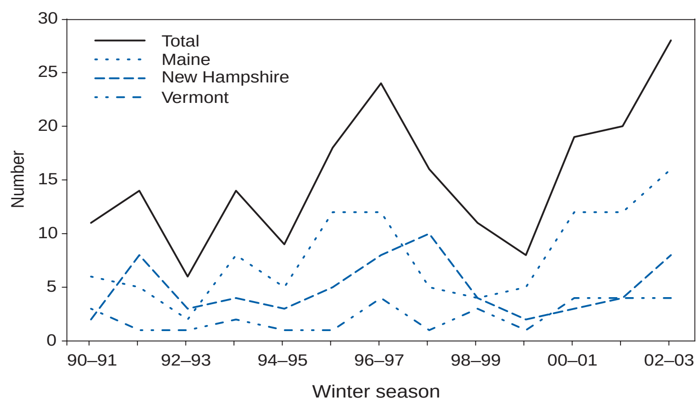
Snowmobile Fatalities — Maine, New Hampshire, and Vermont, 2002–2003

During the 2002–2003 winter season in northern New England, 28 deaths in three states were associated with the use of snowmobiles, more than reported during any of the previous 12 winter seasons (Figure). The New Hampshire Department of Health and Human Services conducted a study to characterize these fatal injuries. This report describes the results of that study, which indicated that the leading contributors to snowmobile fatalities were excessive speed, inattentive or careless operation, and inexperience. Efforts to reduce snowmobile fatalities should focus on improving safety measures, including establishing speed limits, strengthening enforcement of snowmobile operating rules, and promoting safety education.

A case was defined as a fatality involving a person either riding on or struck by a snowmobile in Maine, New Hampshire, or Vermont during December 16, 2002–April 30, 2003. Cases were identified by reviewing reports from the Maine Department of Inland Fisheries and Wildlife, New Hampshire Fish and Game Department, and Vermont Department of Public Safety. The following three case descriptions summarize fatality reports from the three state agencies, based on investigations by enforcement officers.

FIGURE. Number of snowmobile fatalities, by winter season — Maine, New Hampshire, and Vermont*, 1990–2003



* Vermont Department of Public Safety began reporting snowmobile fatality data in 1996. Data before 1996 were based on death certificates using *International Classification of Diseases, Ninth Revision* code E820.

Case Reports

Maine. In early January 2003, driver A, a male aged 17 years, was operating a snowmobile with a 600 cubic centimeter (cc) engine when he collided with another snowmobile at approximately 4:30 p.m., 4 minutes after sunset. According to the investigative report, driver A was speeding when he crested a small rise on a state trail at the same time as driver B, who was traveling in the opposite direction. Driver A, who was wearing a helmet, was struck in the head by the oncoming snowmobile; he died from head injuries. Driver B was not injured.

Vermont. In late January 2003, a man aged 45 years was operating a snowmobile with a 600 cc engine at 4:25 p.m., 20 minutes before sunset, when he attempted to make a right turn while traveling at high speed. The snowmobile overturned, throwing the driver onto the trail. The driver was wearing a helmet; his death was caused by blunt trauma to the chest and abdomen.

INSIDE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

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New Hampshire. In late February 2003, a man aged 30 years was operating a snowmobile with a 700 cc engine on a frozen lake when he fell off his snowmobile at 5:00 p.m., approximately 30 minutes before sunset. Reportedly, the driver was speeding toward an open channel in an attempt to ride the snowmobile over open water, (i.e., "skimming.") The driver's blood alcohol concentration (BAC) was 0.06 mg/dL (New Hampshire's BAC limit for snowmobile operators is <0.08 mg/dL). The driver was not wearing a helmet. He struck his head on ice and fell into the water; death was caused by a basal skull fracture.

Snowmobile Fatalities, Winter 2002–2003

The 28 deaths associated with snowmobile use during the winter of 2002–2003 were the most reported annually by the three states during the previous 12 winter seasons (range: 6–24 deaths; median: 14 deaths). Sixteen (57%) of the 2002–2003 fatalities occurred in Maine, eight (29%) in New Hampshire, and four (14%) in Vermont. The fatality rate was 1.7 deaths per 10,000 registered snowmobiles in Maine, 1.2 per 10,000 registered snowmobiles in New Hampshire, and 1.0 per 10,000 snowmobiles with trail maintenance passes sold in Vermont.

Of the 28 fatalities, 26 (93%) were drivers, one (4%) was a passenger, and one (4%) was a pedestrian. Twenty-six (93%) of the fatalities involved males (Table). The median age was 39 years (range: 15–58 years). Of the 20 fatalities for which BAC was tested, five (25%) involved BACs of ≥0.08 mg/dL. A total of 22 (81%) of the 27 riders fatally injured were wearing a helmet. None of the drivers in New Hampshire or Vermont had taken an operator safety course. Of the 21 snowmobiles with known engine size, 17 (81%) had >500 cc

TABLE. Number* and percentage of snowmobile fatalities, by selected characteristics — Maine, New Hampshire, and Vermont, December 16, 2002–April 30, 2003

Characteristic	No.	(%)
Male	26	(93)
Age group (yrs)		
<20	3	(11)
20–29	7	(25)
30–39	4	(14)
40–49	10	(36)
≥50	4	(14)
Driver (n = 26) or passenger (n = one) wearing proper helmet	22	(81)
Record of driver taking an operator-safety course (n = 12, excludes Maine)	0	(0)
Reportedly involved excessive speed	18	(64)
BAC[†] ≥0.08 mg/dL (n = 20)	5	(25)
Occurred on Saturday or Sunday	17	(61)
Occurred after sunset (n = 26)	14	(54)

* N = 28 (including one pedestrian).
[†] Blood alcohol concentration.

engines. Four (14%) of the 28 fatalities occurred in December, 12 (43%) in January, seven (25%) in February, four (14%) in March, and one (4%) in April; 17 (61%) of the fatalities occurred on Saturday or Sunday. Of the 26 fatal accidents with known time of occurrence, 14 (54%) occurred after sunset. Of the 25 fatalities with known weather condition, 18 (72%) occurred when the weather was clear, five (25%) when it was cloudy, and two (8%) when it was snowing.

According to investigative reports of enforcement officers, 18 (64%) of the fatalities involved excessive speed (i.e., driving too fast for conditions); six (21%), inattentive or careless operation (e.g., driving on the wrong side of trails, attempting to jump embankments, and negotiating curves improperly); six (21%), inexperience; two (7%), mechanical problems; and one (4%), a heart attack; six (21%) fatalities involved more than one risk factor. Thirteen (46%) fatalities were caused by hitting fixed objects (e.g., trees, rocks, and chains across trails), four (14%) by head-on collisions with other snowmobiles, three (11%) by going through ice, three (11%) by going over an embankment, and five (14%) by other causes. Of the 13 fatalities caused by hitting fixed objects, nine (69%) occurred after sunset. Blunt trauma caused 23 (i.e., 14 head and neck, six chest and abdomen, and three other) (82%) of the deaths, two (7%) were caused by drowning, one (4%) by heart attack, and two (7%) were unknown.

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Editorial Note: Snowmobile-related fatalities in Maine, New Hampshire, and Vermont during 2002–2003 were higher than during preceding years. The results of this study indicate that the primary causes of these fatalities were excessive speed, inattentive or careless operation, and inexperience. Excessive speed has been reported as a cause of snowmobile fatalities in Maine and New Hampshire (*1,2*). Engine sizes range from 250 cc to 1,000 cc, with snowmobiles traveling at speeds up to 110 mph. In Maine, no speed limits are posted on state trails; drivers must operate their machines at a "reasonable and prudent speed for the conditions." In New Hampshire, the speed limit on trails is 45 mph unless otherwise posted. In Vermont, the speed limit is 35 mph on public land; drivers must operate at "reasonable and prudent" speeds on private land, which comprises approximately 80% of the state's trail system.

Measures for improving safety on snowmobile trails have been recommended (Box). All three states conduct free safety-training courses for snowmobile operators. Maine does not require drivers to take a safety-training course. New Hampshire requires persons aged <18 years without a valid driver's license to take a safety-training course. Vermont requires snowmobile operators born after July 1, 1983, to take a safety-training course.

BOX. Measures for improving safety on snowmobile trails

- Establish safe speed limits.
- Strengthen enforcement of snowmobile operating rules.
- Require helmet use (*1–3*).
- Require drivers to take a safety course (*4*) that emphasizes
  - — driving at safe speeds,
  - — staying on the proper side of riding trails,
  - — not driving under the influence of alcohol, and
  - — following at a safe distance.
- Impose age restrictions for snowmobile use (*5*).
- Restrict newly licensed operators to driving snowmobiles during daylight hours (*5*).
- Improve trail signage.

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A total of 25% of those drivers tested had BACs of ≥0.08 mg/dL, less than percentages reported previously in Maine (41%; BAC ≥0.08 mg/dL) and New Hampshire (67%; alcohol used) (*1,2*). The reduction might be attributed to increased awareness and enforcement. In 1997, statewide strategic planning to improve snowmobile safety was initiated in Maine, and a Snowmobile Safety Awareness Committee was created in New Hampshire. The focus of these efforts is to increase safe riding, including educating snowmobile operators on the dangers of drinking and driving.

The annual variation in snowmobile fatalities in the three states might be related to at least three factors. First, snowmobile use is dependent on weather conditions; winters with greater snowfalls and lower temperatures allow persons more opportunity to use snowmobiles. The cumulative snowfall for the 2002–2003 season in Concord, New Hampshire, was 89 inches, compared with an average of 45 inches during the previous 12 winter seasons. Second, the number of registered snowmobiles has increased over time, leading to an increase in the number of snowmobile operators, including inexperienced persons. Finally, the number of fatalities in the three states is small and might be unstable.

The findings in this report are subject to at least two limitations. First, data for some variables (e.g., reported speed and BAC) were not available for all fatalities. Second, risk factors could not be assessed from the data available.

Strengthening enforcement of existing laws and increasing safety measures might reduce fatalities associated with snowmobiles. State and local officials should consider enacting additional measures to promote safety, especially those aimed at reducing speed on trails and educating operators on more cautious and attentive use of snowmobiles.

Acknowledgments

This report is based on contributions by K Boynton, Maine Dept of Inland Fisheries and Wildlife. R Shults, PhD, Div of Unintentional Injury Prevention, National Center for Injury Prevention and Control; J Magri, MD, Div of Applied Public Health Training, Epidemiology Program Office, CDC.

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Murine Typhus — Hawaii, 2002

Murine typhus, a zoonotic disease caused by *Rickettsia typhi*, is uncommon in the United States. Hawaii typically reports five or six cases annually; however, 47 cases were reported in 2002. This report summarizes clinical data for three of these cases and describes murine typhus activity in Hawaii during 2002 and control efforts of the Hawaii Department of Health (HDH). The high number of reported cases in 2002 underscores the need for community education to prevent murine typhus and an assessment of environmental factors that might contribute to local disease transmission.

Case Reports

Case 1. In June 2002, a previously healthy man aged 49 years from Maui was hospitalized after 10 days of fever, headache, fatigue, chills, nausea, vomiting, abdominal pain, and bloody stools. On examination, he had a petechial rash on his trunk and extremities, fever of 103.0° F (39.4° C), and mental status changes. The patient had a hematocrit of 25% (normal: 42%–52%), white blood cell count (WBC) of 22,000/mm^3 (normal: 4,500–11,000/mm^3), and platelet count of 38,000/mm^3 (normal: 150,000–400,000/mm^3). Serum creatinine was 12.4 mg/dL (normal: 0.7–1.5 mg/dL). Shortly after admission, he had a seizure and was intubated. Cerebrospinal fluid showed a WBC of 103/mm^3 (normal: 0–5/mm^3), red blood cell count of 29/mm^3 (normal: 0/mm^3), and protein of 140 mg/dL (normal: 15–50 mg/dL). The patient also had elevated serum lactic dehydrogenase, aspartate aminotransferase (AST), and alanine aminotransferase (ALT). Brain magnetic resonance imaging showed bitemporal and thalamic cerebritis. He was treated with intravenous (IV) ceftriaxone and IV doxycycline. The patient also underwent hemodialysis for renal failure. Serum obtained on day 2 of hospitalization was tested by indirect immunofluorescence assay (IFA) for antibodies reactive with typhus group rickettsiae; IgM and IgG were present at titers of 8,192 and 512, respectively. Polymerase chain reaction (PCR) testing of serum revealed DNA of *R. typhi*. After a gradual recovery, the patient had persistent frontal and temporal lobe dysfunction.

The patient had no recent history of travel, camping, or hiking. A site investigation of his beach house in July revealed rat infestations in the yard and attic.

Case 2. In July 2002, a previously healthy man aged 23 years from Molokai sought medical care at a local emergency department (ED) after 9 days of fever (104° F [40° C]), chills, frontal headache, and myalgia. On examination, his temperature was 102.9° F (39.4° C), and he had meningismus, photophobia, conjunctivitis, and hepatosplenomegaly. The patient had a hematocrit of 40%, platelet count of 113,000/mm^3, and elevated serum AST and ALT. He was treated with IV doxycycline and showed immediate marked clinical improvement. Serum collected 23 days after illness onset was tested by IFA and contained IgM and IgG antibodies to typhus group rickettsiae at titers of 256.

The patient reported no recent travel outside Hawaii. He cared for many animals at home, including dogs and domestic farm animals. He reported no direct contact with rodents but reported exposure to fleas.

Case 3. In September 2002, a previously healthy boy aged 15 years from Molokai was taken to a local ED after 5 days of fever, headache, malaise, myalgia, neck pain, and abdominal pain. On examination, he had a fever of 103.0° F (39.4° C), diffuse tenderness of the lower extremities, and hepatomegaly. He had a platelet count of 82,000/mm^3, elevated AST and ALT, a partial thromboplastin time of 44 seconds (normal: 25–38 seconds), and a fibrinogen level of 460 mg/dL (normal: 200–400 mg/dL). He was treated with IV ceftriaxone, but his symptoms persisted. A chest radiograph revealed mild pulmonary edema with small bilateral pleural effusions and hepatosplenomegaly. IV clindamycin and IV penicillin were added to the treatment regimen for a presumptive diagnosis of leptospirosis. Serum samples were tested by IFA for antibodies to typhus group rickettsiae and showed approximately a fourfold change in titer, from nonreactive on day 1 of hospitalization to IgM and IgG titers of 256 and 512, respectively, on day 4. The patient was discharged after 10 days and was later treated with doxycycline.

The patient lived in the same town as patient 2; he reported no recent travel. He reported a noticeable increase in the number of rodents around his home and admitted to handling them, but did not recall any flea exposure.

Murine Typhus Surveillance

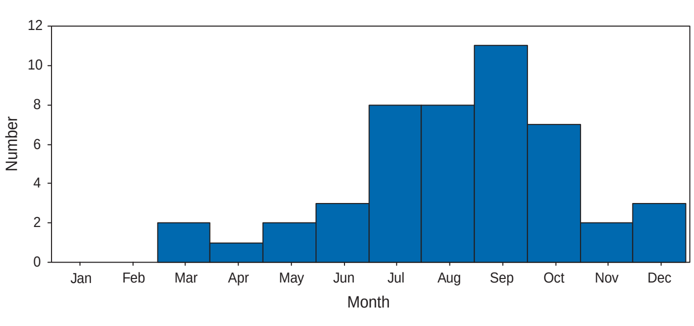
During 2002, a total of 47 cases of murine typhus were identified in Hawaii, the largest number recorded annually since 1947. Of these cases, 25 (53%) were confirmed*, and 22 (47%) were probable†; 34 (72%) cases occurred during July–October (Figure). The median age of the patients was 38 years (range: 1–68 years); 28 (60%) were male. Five islands reported cases of murine typhus: Maui (35 cases), Molokai (six), Oahu (three), Kauai (two), and Hawaii (one).

The most common symptoms reported among the 47 patients were fever (98%), malaise (89%), headache (87%), myalgia (81%), loss of appetite (81%), chills (81%), arthralgia (72%), nausea (66%), vomiting (54%), backache (53%), abdominal pain (51%), stiff neck (47%), and skin rash (45%). Moderate-to-severe disease was observed, including acute renal failure (two cases), gastrointestinal bleeding (two), meningitis (two), encephalitis (one), pneumonitis (one), and congestive heart failure with pleural effusion (one).

* Clinically compatible illness with a fourfold change (or equivalent) in serum antibody titer reactive with typhus group rickettsiae between paired serum specimens, demonstration of typhus group rickettsiae by immunohistochemical methods, demonstration of *R. typhi* by nucleic acid detection, or isolation of *R. typhi* by cell culture.

† Clinically compatible illness with serologic evidence of antibody reactive with typhus group rickettsiae in a single serum sample at a titer considered indicative of current or previous infection (cutoff titers are determined by individual laboratories).

FIGURE. Number* of murine typhus cases, by month of illness onset — Hawaii, 2002



* N = 47.

Control Measures

HDH applied rodenticide (i.e., zinc phosphate oat bait) to grasslands and pasture areas believed to be major sources of peridomestic rodents. Dramatic decreases in the numbers of trapped rodents on Maui and other foci followed. HDH conducted rodent trapping, environmental assessments, and rodent-proofing education at the homes of patients with suspected and confirmed cases. Public awareness campaigns/programs and education about murine typhus were conducted through physician notices, press conferences, and television and newspaper interviews. Clinical manifestations, mode of transmission, and peridomestic rodent- and flea-control measures were emphasized.

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Editorial Note: *R. typhi*, the etiologic agent of murine typhus (Box), is maintained in nature by a rodent-flea cycle, with rats (most commonly *Rattus* spp.) as the primary reservoirs. Humans acquire infection after exposure of abraded or flea-bitten skin to infectious flea feces (*1*). Although murine typhus usually is a self-limiting febrile illness, life-threatening disease and death can occur (*2*). Before World War II, murine typhus was widespread, and approximately 42,000 cases were reported in the United States during 1931–1946 (*1,3*). Improved rodent- and ectoparasite-control practices have decreased transmission substantially in the United States, and <50 cases are reported annually, most often in California, Texas, and Hawaii (*4*).

Murine typhus is considered endemic on the Hawaiian islands of Kauai, Maui, and Oahu (*5*). This report also suggests a possible endemic focus on Molokai. The animal reservoir in Hawaii is unknown, but the disease is suspected to involve a rodent-flea cycle. Rodents on Hawaii that have demonstrated antibodies reactive with typhus group rickettsiae include the Polynesian rat (*Ra. exulans*), the black rat (*Ra. rattus*), the Norway rat (*Ra. norvegicus*), and the house mouse (*Mus musculus*) (*6*; HDH, unpublished data, 2002–2003).

BOX. Epidemiology, diagnosis, treatment, and prevention of murine typhus

Epidemiology
- Zoonotic disease caused by *Rickettsia typhi*.
- Humans become infected through exposure to feces of infected fleas; incubation period typically is 1–2 weeks.
- Cases in the United States are reported most frequently in California, Hawaii, and Texas.

Clinical Findings
- Disease is characterized by fever, headache, and a macular or maculopapular rash.
- Other signs and symptoms can include myalgias, vomiting, diarrhea, abdominal pain, cough, or confusion.
- Laboratory abnormalities can include thrombocytopenia, hyponatremia, and elevations of hepatic aminotransferase levels.
- Severe manifestations can include pneumonitis, myocarditis, acute renal failure, and encephalitis.
- Case-fatality ratio is 1%–4%.

Laboratory Testing
- Laboratory confirmation of infection is essential for diagnosis.
- Serologic testing of paired sera can confirm diagnosis.
- Nucleic acid detection (e.g., polymerase chain reaction), immunohistochemical staining of formalin-fixed tissues, and cell culture also may be used for confirmation.

Treatment
- Doxycycline is the treatment of choice for all patients.
- Dose for adults is 100 mg twice daily.
- Dose for children weighing <45 kg is 2 mg/kg twice daily; children weighing ≥45 kg should receive the adult dose.
- Duration of therapy is 7–10 days or ≥3 days after cessation of fever.

Prevention and Reporting
- Cases should be reported to state health departments.
- Prevention should focus on control of flea vectors and potential flea hosts, especially rodents.
- No vaccine is available.

The Indian mongoose (*Herpestes auropunctatus*) also is a possible reservoir (*7*).

Infection with *R. typhi* is diagnosed typically by using IFA with paired acute- and convalescent-phase serum; however, antibody often is not detected during early stages of the illness. Because delay in appropriate antimicrobial therapy can result in severe disease, physicians should treat suspected cases of murine typhus on the basis of clinical and epidemiologic findings. Doxycycline is the treatment of choice.

The findings in this report are subject to at least two limitations. First, because murine typhus can have a wide range of nonspecific clinical signs and might resemble other diseases (e.g., dengue or leptospirosis), surveillance for this disease can be difficult. Second, although HDH instituted active surveillance for murine typhus during 2002 through physician alerts and mandatory laboratory reporting of *R. typhi* test requests, additional cases probably occurred but were missed.

The most effective method of controlling outbreaks of murine typhus is to reduce the rodent reservoir responsible for maintenance of the pathogen and the ectoparasites responsible for transmission to humans. If rodent depopulation programs are instituted, simultaneous application of appropriate insecticides should be considered to prevent infected arthropods from transmitting disease to humans (*8*). Assessment of rodent numbers and serologic testing of rodents in areas where human murine typhus cases have occurred will help guide prevention efforts.

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Public Health and Aging

Retention of Natural Teeth Among Older Adults — United States, 2002

During the past several decades, the percentage of older adults who have retained their natural teeth has increased steadily (*1*). This trend is expected to continue, resulting in improved oral function and quality of life (*2*). To estimate the prevalences of tooth retention and total tooth loss in 2002 among adults aged ≥65 years, CDC analyzed data from the Behavioral Risk Factor Surveillance System (BRFSS) survey. This report summarizes the results of that analysis, which indicated that in 26 (52%) states, more than half of older adults reported having most (i.e., losing five or fewer) of their natural teeth. However, rates varied substantially among states and by selected characteristics. With tooth retention, older adults remain at risk for dental caries (i.e., tooth decay) and periodontal disease. To help adults maintain healthy teeth for life, community-based strategies should promote healthy behaviors, optimal use of fluoride, timely examinations and clinical services, and increased research into preventing oral diseases and promoting oral health among adults (*3,4*).

BRFSS is a state-based, random-digit–dialed telephone survey of the noninstitutionalized U.S. civilian population aged ≥18 years, administered in all 50 states, the District of Columbia, and three U.S. territories (Guam, Puerto Rico, and the U.S. Virgin Islands). In 2002, the median response rate was 58.6%. In 1999, oral health questions were added to the core interview of the survey to improve surveillance of oral health among older adults at the state level. In 2002, respondents were asked how many of their permanent teeth were removed because of tooth decay or gum disease. Of the 50,635 survey participants aged ≥65 years who were asked this question, 48,866 (96%) responded; nonresponders were excluded from this analysis. State-specific estimates were age-adjusted to the 2000 standard U.S. population. A complete adult dentition is made up of 28–32 permanent teeth; those persons who reported losing five or fewer teeth were considered to have most of their teeth.

In 26 states, >50% of older adults reported having most of their teeth (Table 1). Estimates ranged from 27% in West Virginia to 64% in Utah. In three states (California, Colorado, and Utah), >60% had retained most of their teeth, and in five states and territories (Kentucky, Mississippi, West Virginia, Puerto Rico, and the U.S. Virgin Islands), <40% had done so. The prevalence of edentate persons (i.e., those who have lost all their natural teeth) ranged from 13% in Hawaii and California to 42% in Kentucky. In 12 states, <20% of persons, and in two states (Kentucky and West Virginia), >40% reported total tooth loss (Table 1).

Retention of most of their teeth by older adults was less common among those with less than a high school education (31%) than among those with more education (46%–64%), among those with annual household incomes of <$15,000 (30%) than among those with higher incomes (41%–73%), among non-Hispanic blacks (30%) than among non-Hispanic whites (53%) or Hispanics (53%), among persons who smoked every day (31%) and some days (33%) than among persons who had quit smoking (47%) or who had never smoked (59%), among persons with diabetes (42%) than among those without diabetes (53%), and among persons reporting fair or poor general health status (38%) than among those with good to excellent general health status (56%) (Table 2).

TABLE 1. Age-adjusted* percentage of persons aged ≥65 years who reported loss of all or retention of most† of their natural teeth, by state/area — Behavioral Risk Factor Surveillance System, United States, 2002

	Lost all natural teeth		Have most natural teeth	
State/Area	%	(95% CI§)	%	(95% CI)
Alabama	29.9	(±3.7)	41.2	(±4.1)
Alaska	26.3	(±7.1)	40.1	(±8.3)
Arizona	20.4	(±4.1)	56.6	(±4.5)
Arkansas	30.1	(±3.1)	40.8	(±3.5)
California	13.3	(±2.7)	60.5	(±4.5)
Colorado	19.2	(±4.7)	60.5	(±4.4)
Connecticut	16.0	(±2.5)	58.3	(±3.4)
Delaware	25.8	(±3.7)	46.7	(±4.3)
District of Columbia	16.7	(±4.3)	48.3	(±5.8)
Florida	21.3	(±2.3)	53.6	(±2.8)
Georgia	32.6	(±3.7)	43.2	(±4.0)
Hawaii	13.1	(±2.9)	59.8	(±3.6)
Idaho	22.5	(±2.7)	54.1	(±3.5)
Illinois	24.0	(±4.3)	51.4	(±4.8)
Indiana	24.7	(±2.7)	44.7	(±3.2)
Iowa	21.3	(±2.9)	50.2	(±3.9)
Kansas	22.8	(±2.9)	52.7	(±3.6)
Kentucky	42.3	(±3.3)	35.6	(±3.4)
Louisiana	33.8	(±3.5)	46.0	(±3.5)
Maine	30.4	(±4.7)	43.8	(±5.1)
Maryland	19.3	(±3.7)	52.0	(±4.6)
Massachusetts	22.9	(±2.7)	48.0	(±3.2)
Michigan	18.8	(±2.9)	53.8	(±3.5)
Minnesota	14.8	(±2.5)	59.4	(±3.5)
Mississippi	35.1	(±3.7)	34.4	(±3.6)
Missouri	26.4	(±3.3)	44.6	(±4.1)
Montana	20.9	(±3.5)	52.9	(±4.5)
Nebraska	25.5	(±2.7)	50.9	(±3.2)
Nevada	20.5	(±4.9)	51.9	(±5.8)
New Hampshire	21.8	(±3.2)	53.8	(±3.7)
New Jersey	20.1	(±4.7)	45.1	(±5.2)
New Mexico	25.2	(±3.1)	51.4	(±3.6)
New York	18.7	(±3.1)	50.9	(±3.9)
North Carolina	33.3	(±4.1)	41.2	(±3.8)
North Dakota	23.2	(±3.5)	46.8	(±4.4)
Ohio	23.6	(±3.5)	48.1	(±4.3)
Oklahoma	33.2	(±2.5)	42.4	(±2.6)
Oregon	18.9	(±3.3)	54.8	(±4.3)
Pennsylvania	25.8	(±1.9)	43.1	(±2.3)
Rhode Island	22.5	(±3.3)	48.1	(±3.9)
South Carolina	24.4	(±3.9)	46.3	(±4.3)
South Dakota	24.7	(±2.7)	48.9	(±3.1)
Tennessee	36.0	(±4.1)	41.6	(±4.2)
Texas	20.4	(±2.7)	57.5	(±3.6)
Utah	14.7	(±3.3)	63.8	(±4.6)
Vermont	21.7	(±3.1)	51.4	(±3.8)
Virginia	21.3	(±3.3)	54.7	(±4.5)
Washington	16.8	(±2.9)	55.8	(±3.9)
West Virginia	41.9	(±3.7)	26.6	(±3.3)
Wisconsin	20.6	(±3.2)	54.2	(±3.9)
Wyoming	25.7	(±3.5)	48.3	(±4.1)
Guam¶	14.9	(±18.0)	45.8	(±17.9)
Puerto Rico	31.7	(±3.9)	29.3	(±3.7)
U.S. Virgin Islands	20.8	(±6.5)	33.3	(±7.2)

* Age adjusted to the 2000 standard U.S. population.
† Loss of five teeth or fewer.
§ Confidence interval.
¶ Estimates are highly variable.

TABLE 2. Percentage of persons aged ≥65 years who reported having most* of their natural teeth, by selected characteristics — Behavioral Risk Factor Surveillance System, United States, 2002

Characteristic	No.	Have most natural teeth %	(95% CI†)
Sex			
Male	17,255	50.6	(±1.3)
Female	31,611	50.9	(±1.1)
Education level			
<High school	10,406	30.5	(±2.2)
High school	17,462	45.6	(±1.3)
Some college/College graduate	20,806	63.7	(±1.2)
Annual household income			
<$15,000	8,501	30.4	(±2.1)
$15,000–$24,999	11,130	41.4	(±1.6)
$25,000–$34,999	6,713	52.6	(±2.0)
$35,000–$49,999	5,211	60.3	(±2.3)
≥$50,000	5,612	72.8	(±2.1)
Race/Ethnicity			
White, non-Hispanic	41,240	52.7	(±0.8)
Black, non-hispanic	2,520	30.4	(±3.3)
Multiracial, non-Hispanic	610	38.9	(±6.8)
Hispanic	2,268	53.0	(±5.0)
Other races	1,615	46.4	(±7.5)
Cigarette smoking status			
Current, every day	4,149	30.6	(±3.1)
Current, some day	986	33.0	(±4.9)
Former	18,879	46.5	(±1.2)
Never	24,626	58.5	(±1.1)
General health rating			
Excellent, very good, or good	33,542	56.4	(±1.0)
Fair or poor	15,075	37.7	(±1.5)
Diabetes			
Yes	7,651	41.6	(±2.3)
No	40,895	52.6	(±0.9)

* Loss of five teeth or fewer.
† Confidence interval.

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Editorial Note: Compared with younger persons, the current cohort of older adults likely experienced higher rates of dental caries and tooth extraction as young adults and are more likely to have lost all their teeth (*1,5*). However, data from successive national surveys indicate that the percentage of older adults losing all their natural teeth has declined substantially since the 1950s, when the majority of persons aged ≥65 years were edentate (*1*). The current cohort of older adults has likely benefited from substantial improvements during the preceding 50 years that have resulted in greater tooth retention (*5*). These improvements include community water fluoridation and fluoride dentifrice (i.e., toothpaste), advancements in dental technologies and treatment modalities, changing patient and provider attitudes and treatment preferences, improved oral hygiene, and regular use of dental services (*1,5*).

Throughout the life span, teeth remain at risk for the two most prevalent oral diseases (i.e., dental caries and periodontal disease). Older adults remain at risk for new and recurrent decay that is untreated in approximately 30% of dentate adults (*6*). They are at increased risk for root caries because of both increased gingival (i.e., gum) recession that exposes root surfaces and increased use of medications that produce xerostomia (i.e., dry mouth) (*2*). Approximately 50% of persons aged ≥75 years have root caries affecting at least one tooth (*2*). Approximately 25% of older adults have loss of tooth-supporting structures because of advanced periodontal disease (*2*). Without early prevention and control interventions, these progressive conditions can demand extensive treatment to curb infection and restore function.

The wide variation in rates of tooth loss and retention among states and by selected characteristics suggests that many older adults have not benefited fully from improvements in the prevention and control of oral diseases. Differences in tooth retention by education, income, and race/ethnicity reflect disparities in unmet dental needs (e.g., untreated caries and advanced periodontal diseases) among persons with limited education and income and among non-Hispanic blacks (*2*). The findings in this report indicate that Hispanics and non-Hispanic whites reported similar rates of tooth retention; however, other surveys have indicated that Mexican-Americans had higher rates of untreated caries than non-Hispanic whites (*2*). These associations might reflect differences in health literacy and behaviors, attitudes toward oral health and dental care, and access to and use of dental services and types of treatment received (*1,2,7*). The lower prevalence of tooth retention among smokers might be related directly to the adverse effects of cigarette smoking (*7*), which accounts for approximately half of all cases of periodontal disease in the United States (*8*).

Self-ratings of health have been associated with functional ability (*9*). These associations suggest that older persons who report poorer general health are at increased risk for limited dexterity, mobility, and tolerance of stress; such factors can compromise abilities to maintain oral hygiene, visit a dental office, or tolerate treatment. The results of this study suggest that many aging adults who are in poorer general health have retained most of their natural teeth. These persons likely will need caregiver assistance and innovative strategies to maintain daily self-care, obtain regular oral assessments, and receive primary and secondary prevention services.

The findings in this report are subject to at least four limitations. First, the sample is drawn from the noninstitutionalized population and excludes persons residing elsewhere (e.g., nursing homes or long-term–care facilities). Second, persons without residential telephone service (e.g., persons with lower incomes or households using cellular phones) are excluded. Third, results are self-reported data and have not been validated; however, a strong agreement between self-reported and clinically assessed number of teeth has been documented (*10*). Finally, measures of oral health status are limited to tooth loss.

In the United States, older adults usually pay for dental services themselves without the benefit of insurance (*2*). Medicare does not cover routine services, and Medicaid provides only limited coverage in certain states; the majority of elderly persons lose their dental insurance when they retire (*2*). Community water fluoridation remains the most effective and cost-effective method for caries prevention (*3*); current dental recommendations provide additional guidance on best practices in fluoride use, such as brushing teeth twice daily with fluoride toothpaste (*3*). Expansion of community-based programs could help increasing numbers of dentate older adults manage their oral health needs. Programs that have focused historically on younger populations might promote oral health in older adults by 1) increasing public and professional awareness of common oral conditions, risk factors, and healthy behaviors; 2) expanding partnerships, especially with organizations focused on aging issues; 3) monitoring oral health status of older adults; 4) ensuring access to clinical services; and 5) increasing support for prevention research and involvement of oral health professionals in tobacco-control activities (*3,4,7*).

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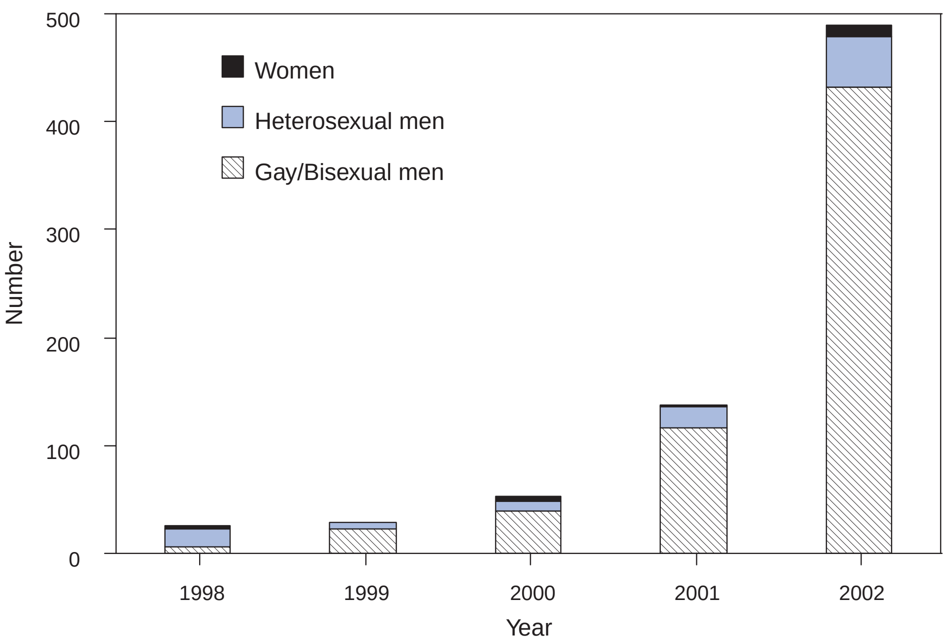
Internet Use and Early Syphilis Infection Among Men Who Have Sex with Men — San Francisco, California, 1999–2003

During the summer of 1999, an outbreak of early syphilis among men who have sex with men (MSM) who met their sex partners on the Internet (*1*) presaged a rapidly expanding syphilis epidemic in San Francisco. By 2002, San Francisco had the highest rates of primary and secondary syphilis of any metropolitan area in the United States (*2*). During 1998–2002, the number of early syphilis cases increased, from 41 cases in 1998 to 495 cases in 2002 (*3*). Concomitant with the increase in early syphilis was an increase in the proportion of cases among MSM, from 22% in 1998 to 88% in 2002 (Figure 1) (*3*). To assess the association between early syphilis infection and use of the Internet by MSM to meet sex partners, the San Francisco Department of Public Health (SFDPH) analyzed surveillance data and case reports. This report summarizes the results of that analysis, which suggest that public health officials might find the Internet to be an important tool for 1) promoting disease awareness, prevention, and control and 2) accessing sex partners of syphilis patients to conduct appropriate partner notification, evaluation, and management. The findings underscore the need for public health officials to understand the role of the Internet in facilitating the spread of sexually transmitted diseases (STDs), including the human immunodeficiency virus (HIV). With the assistance of community partners, other jurisdictions can examine the online social/sexual networks that are used commonly in their gay and bisexual communities and develop an effective means of communicating prevention and control messages online.

In accordance with California law, cases of syphilis are reported to SFDPH by laboratories and public and private health-care providers. A case of early (i.e., <1-year duration) syphilis was defined as a case of primary, secondary, or early latent syphilis diagnosed in a San Francisco resident. Early syphilis cases had darkfield-positive lesions, reactive serologic tests for syphilis and accompanying symptoms, or reactive serologic tests with evidence of syphilis infection occurring during the preceding year.

Persons with early syphilis were interviewed by SFDPH staff. Interviewers obtained demographic data (e.g., sex, age, race/ethnicity, address, and sexual orientation) and risk-behavior information (e.g., sexual behavior, condom use, number and sex of partners, venues for meeting partners, alcohol and recreational drug use, and self-reported HIV status) for the

FIGURE 1. Number of early* syphilis cases, by sex, sexual orientation, and year — San Francisco, California, 1998–2002



* Of <1-year duration.

period when syphilis might have been acquired or transmitted. This period was determined on the basis of stage of disease at the time of treatment (i.e., 3 months before treatment for primary syphilis, 6 months for secondary syphilis, or 12 months for early latent syphilis). Interviews were accompanied by disease-intervention counseling, which assisted in locating and treating sex partners.

Surveillance Data

During 2002, a total of 434 cases of early syphilis among MSM were reported to SFDPH. The median age of MSM with early syphilis was 38 years (range: 14–66 years). Of these 434 patients, 289 (66.6%) were white, 69 (16.0%) were Hispanic, 34 (7.8%) were Asian/Pacific Islander, 31 (7.1%) were black, and 11 (2.5%) were from other racial/ethnic populations; 293 (67.5%) were HIV seropositive. Information about sexual behavior and sex partners was obtained from 415 MSM. These men reported a total of 6,482 sex partners during the period when syphilis might have been acquired or transmitted (median: six partners; range: zero to 500 partners). The most common venues for meeting sex partners reported by the 415 patients with early syphilis were the Internet (32.6%), bars (20.6%), bathhouses (13.3%), sex clubs (12.6%), and adult bookstores (5.5%). During January 2000–December 2002, the proportion of MSM with early syphilis who reported meeting sex partners on the Internet increased significantly (p<0.0001), from 12.2% during the first half of 2000 to 37.4% during the second half of 2002 (Figure 2).

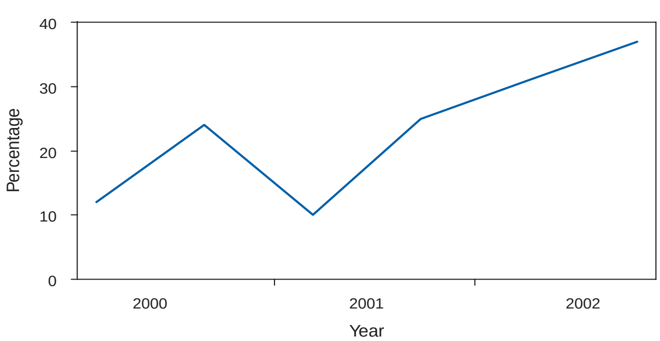
In a review of 151 early syphilis cases among MSM interviewed for partner management during January–April 2003, a total of 67 (44.4%) men reported meeting sex partners over the Internet; 14 (20.9%) provided information about 44 sex partners for whom the only locating information was an Internet e-mail* address. Eleven (25%) of the 44 Internet partners lived outside of the San Francisco Bay Area. SFDPH staff located 15 (34%) of the Internet partners and ensured that they were evaluated and treated appropriately. The following two case reports are illustrative of successful online partner notification, evaluation, and management.

Case Reports

Case 1. In February 2003, a Hispanic man aged 36 years had early latent syphilis diagnosed by his private health-care provider. He reported meeting male sex partners through the Internet but not through sex clubs or at bathhouses. In December 2002, he traveled to Los Angeles, California, where he had sex with three different partners. He did not know his

* E-mail service provided by an Internet service provider or an Internet-based e-mail account.

FIGURE 2. Percentage of persons with early* syphilis who reported meeting sex partners on the Internet, by year — San Francisco, California, 2000–2002



* Of <1-year duration.

total number of partners during the 12-month interview period, but mentioned 16 (i.e., three met in Los Angeles, for whom he had no additional information; five Internet partners; and eight met elsewhere). For the five Internet partners, the patient had only their Internet e-mail addresses, which he provided to SFDPH staff; four lived in San Francisco, and one lived in Minneapolis, Minnesota. All five responded to SFDPH staff e-mail messages and were evaluated and treated preventively for possible incubating syphilis. In addition, the other eight partners were evaluated and treated preventively, including one who lived in Phoenix, Arizona. None of the 13 located partners (Internet and non-Internet) had syphilis at the time of their evaluation.

Case 2. In April 2003, a white man aged 43 years had primary syphilis diagnosed at the San Francisco municipal STD clinic. He did not travel outside of the San Francisco Bay Area during the 3-month interview period. He reported meeting male sex partners through the Internet and at bathhouses. Of the 13 partners that the index patient reported during the interview period, he had information about three (i.e., an Internet e-mail address for two partners and a telephone number for one partner). These three partners lived in the San Francisco Bay Area, and two were evaluated and treated appropriately. As a result of being contacted through Internet e-mail, one of the partners (partner A) had early latent syphilis diagnosed in late April 2003. He had traveled to Chicago, Illinois, in December 2002, during the 12-month interview period when he might have been infectious. He reported 50 partners during the interview period and provided only Internet e-mail addresses for four partners and more complete locating information for two other partners. One of these four Internet partners was the index patient. No other Internet partners were located; however, the other two partners were located and evaluated, including one (partner B) who lived in San Jose, California, and had secondary syphilis diagnosed earlier in April 2003. Partner B named the index patient as his only locatable partner; the index patient did not provide any information about partner B.

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Editorial Note: This report describes the increasing association between early syphilis infection and use of the Internet as a means for MSM to meet sex partners. Often the only link that these men have to their Internet partners is an e-mail address. This report demonstrates how an Internet e-mail address can be used successfully to notify persons that they have been exposed to syphilis. The findings also suggest that the Internet facilitates MSM meeting sex partners when they travel. Meeting new sex partners while traveling might explain, in part, the rapid dissemination of syphilis among MSM throughout the United States and western Europe (*4–7*).

Health departments should learn how the Internet is used to meet sex partners and how health agencies can use the Internet to contact partners for disease intervention. Concerns about the notification of sex partners through the Internet include protecting confidentiality and ensuring that notification messages are not discarded as junk mail or "spam." To respond to these concerns, SFDPH developed interim practices for performing partner notification online (Box). SFDPH is continuing to refine its online partner management program.

The findings in this report are subject to at least three limitations. First, the findings are largely descriptive. Second, not all MSM with early syphilis infection in San Francisco were interviewed; the observations described in this report might not reflect all MSM with early syphilis. Finally, the findings might not be representative of all MSM with early syphilis in the United States.

BOX. Interim practices of the San Francisco Department of Public Health for partner notification online

- If the original patient notifies his partner(s) first, the likelihood of the partner responding to health department staff might be increased.
- Messages sent from within the Internet Service Provider (ISP) or e-mail provider are less likely to be discarded before being read. If the partner's e-mail account is provided through company X, a company X account should be used to send the message. Local health departments can establish their own accounts with these ISPs.
- Credible e-mail accounts (e.g., those with a .gov domain) should be used. Specific, verifiable information about the sender should be provided within the e-mail message.
- Message headers that reference a serious health matter are more likely to be read than general messages. However, messages should not mention that a person has been exposed to a sexually transmitted disease. Message headers should convey urgency but protect confidentiality (e.g., "Urgent Health Matter").
- A message should be sent to each partner individually; no group messages should be sent. To protect confidentiality, notification procedures should apply the same principles used in sending a letter in the mail or leaving a telephone message.
- When a person responds, name and alternative locating information should be obtained to facilitate contact in the future.

Local health departments in other cities that have had large increases in early syphilis cases among MSM should consider using the Internet for partner notification and management. Internet partner management might serve as a useful new tool in addressing this epidemic, even though it might reach only a small number of partners. In contrast to anonymous partners met in sex clubs, bathhouses, and adult bookstores, effective disease intervention is possible for Internet partners. Online prevention activities can include individual outreach, banner ads with links to sexual health promotion sites, and other social marketing activities (*8*). CDC is coordinating local and national efforts to engage the gay and bisexual community, Internet service providers, and public health officials in developing effective Internet-based prevention strategies.

As has been observed in other cities (*4–6*), a high proportion of MSM with early syphilis in San Francisco also were co-infected with HIV. Because STDs increase the risk for HIV transmission (*9*) and MSM are among persons at highest risk for HIV infection (*10*), controlling syphilis among MSM also might be important for preventing further HIV transmission. The findings in this report underscore the importance of coordinated STD- and HIV-prevention efforts among the gay and bisexual community, public health officials, and health-care providers.

Acknowledgments

This report is based on contributions by the Syphilis Team; R Kohn, MPH, San Francisco Dept of Public Health, San Francisco, California. Syphilis Rapid Response Team, Div of STD Prevention, National Center for HIV, STD, and TB Prevention, CDC.

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Update: Influenza Activity — United States, December 7–13, 2003

Influenza activity in the United States continued to increase during December 7–13, 2003*. The proportion of patient visits to sentinel providers for influenza-like illness (ILI)† overall was 7.4%, which is above the national baseline§ of 2.5%. Thirty-six state health departments reported widespread influenza activity, 12 states and New York City reported regional influenza activity, one state and the District of Columbia reported local influenza activity, and one state and Puerto Rico reported sporadic influenza activity¶ (Figure 1).

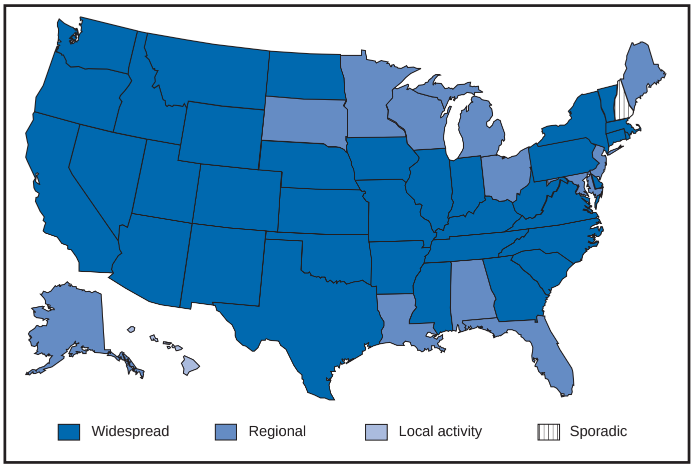
Laboratory Surveillance

During the reporting week of December 7–13, World Health Organization (WHO) and National Respiratory and Enteric Virus Surveillance System (NREVSS) laboratories reported testing 3,814 specimens for influenza viruses; 1,365 (35.8%) were positive. Of these, 262 were influenza A (H3N2) viruses, 1,080 were influenza A viruses that were not subtyped, and 23 were influenza B viruses (Figure 2).

Since September 28, WHO and NREVSS laboratories have tested 32,854 specimens for influenza viruses; 9,464 (28.8%) were positive. Of these, 9,395 (99.3%) were influenza A viruses, and 69 (0.7%) were influenza B viruses. Of the 9,395 influenza A viruses, 2,113 (22.5%) have been subtyped; 2,112 (>99.9%) were influenza A (H3N2) viruses, and one (<0.1%) was an influenza A (H1) virus. All 50 states have reported laboratory-confirmed influenza this season.

* Provisional data reported as of December 17.
† Temperature of >100.0° F (>37.8° C) and cough and/or sore throat in the absence of a known cause other than influenza.
§ Calculated as the mean percentage of visits for ILI during noninfluenza weeks, plus two standard deviations. Wide variability in regional data precludes calculating region-specific baselines and makes it inappropriate to apply the national baseline to regional data.
¶ Levels of activity are 1) *no activity*, 2) *sporadic*—small numbers of laboratory-confirmed influenza cases or a single influenza outbreak reported but no increase in cases of ILI, 3) *local*—outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in a single region of a state, 4) *regional*—outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least two but less than half the regions of a state, and 5) *widespread*—outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of a state.

FIGURE 1. States in which estimated influenza activity levels have been reported by state epidemiologists, by level of activity* — United States, December 7–13, 2003



* Levels of activity are 1) *no activity*, 2) *sporadic*—small numbers of laboratory-confirmed influenza cases or a single influenza outbreak reported but no increase in cases of influenza-like illness (ILI), 3) *local*—outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in a single region of a state, 4) *regional*—outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least two but less than half the regions of a state, and 5) *widespread*—outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of a state.

Antigenic Characterization

Of 269 influenza viruses collected by U.S. laboratories since October 1 and characterized antigenically by CDC, 265 were influenza A (H3N2) viruses, two were influenza A (H1) viruses, and two were influenza B viruses. The hemagglutinin proteins of the influenza A (H1) viruses were similar antigenically to the hemagglutinin of the vaccine strain A/New Caledonia/20/99. Of the 265 influenza A (H3N2) isolates that have been characterized, 62 (23%) were similar antigenically to the vaccine strain A/Panama/2007/99 (H3N2), and 203 (77%) were similar to a drift variant, A/Fujian/411/2002 (H3N2)**. Both influenza B viruses characterized were similar antigenically to B/Sichuan/379/99.

Pneumonia and Influenza (P&I) Mortality Surveillance

As of the week ending December 13, P&I accounted for 7.2% of all deaths reported through the 122 Cities Mortality Reporting System. The epidemic threshold†† for that week was 7.7%.

ILI Surveillance

During the reporting week of December 7–13, the weekly percentage of patient visits§§ to approximately 1,000 U.S. sentinel providers nationwide for ILI increased from 5.3% to 7.4%, which is above the national baseline of 2.5% (Figure 3).

** Although vaccine effectiveness against A/Fujian/411/2002-like viruses might be less than that against A/Panama/2007/99-like viruses, the current U.S. vaccine probably will offer some cross-protective immunity against the A/Fujian/411/2002-like viruses and reduce the severity of disease.

†† The expected baseline proportion of P&I deaths reported by the 122 Cities Mortality Reporting System is projected by using a robust regression procedure that applies a periodic regression model to the observed percentage of deaths from P&I during the previous 5 years; the epidemic threshold is 1.645 standard deviations above the seasonal baseline percentage.

§§ National and regional percentage of patient visits for ILI are weighted on the basis of state population.

FIGURE 2. Number and percentage of specimens testing positive for influenza virus reported by World Health Organization and National Respiratory and Enteric Virus Surveillance System laboratories, by week — United States, October 5–December 13, 2003

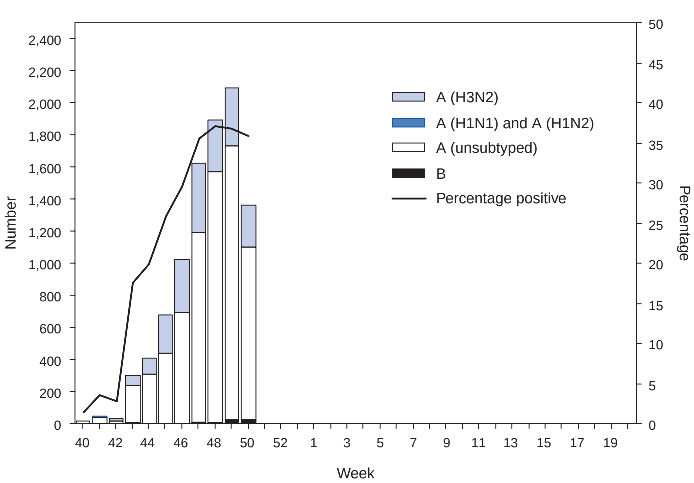
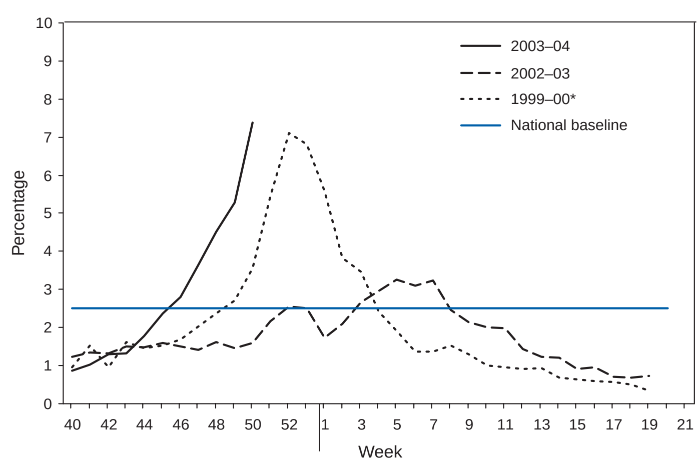


FIGURE 3. Percentage of visits for influenza-like illness reported by Sentinel Provider Surveillance Network, by week — United States, 1999–00, 2002–03, and 2003–04 influenza seasons



* The 1999–00 season was selected for comparison because it was the most recent influenza A (H3N2) season of moderate severity.

The percentage of patient visits for ILI increased in eight of the nine surveillance regions¶¶ but has continued to decline in the West South Central region (8.0% for week 50 compared with 11.3% during week 47). On a regional level, the percentage of visits for ILI was highest in the Pacific region (10.6%), followed by the West South Central region (8.0%), West North Central (7.9%), Mountain (7.7%), East North Central (7.6%), South Atlantic (6.9%), East South Central (6.3%), and the New England and Mid-Atlantic regions (4.7%).

Activity Reported by State and Territorial Epidemiologists

During the week ending December 13, influenza activity was reported as widespread in 36 states (Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Massachusetts, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wyoming), regional in 12 states (Alabama, Alaska, Florida, Louisiana, Maine, Maryland, Michigan, Minnesota, New Jersey, Ohio, South Dakota, and Wisconsin) and New York City. Hawaii and the District of Columbia reported local activity, and New Hampshire and Puerto Rico reported sporadic activity.

Weekly updates on influenza activity will be published in *MMWR* during the influenza season. Additional information about influenza activity is available from CDC at http://www.cdc.gov/flu.

¶¶ *New England*=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont; *Mid-Atlantic*=New Jersey, New York City, Pennsylvania, and upstate New York; *East North Central*=Illinois, Indiana, Michigan, Ohio, and Wisconsin; *West North Central*=Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota; *South Atlantic*=Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia; *East South Central*=Alabama, Kentucky, Mississippi, and Tennessee; *West South Central*=Arkansas, Louisiana, Oklahoma, and Texas; *Mountain*=Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming; and *Pacific*=Alaska, California, Hawaii, Oregon, and Washington.

Notice to Readers

Limited Supply of Pneumococcal Conjugate Vaccine

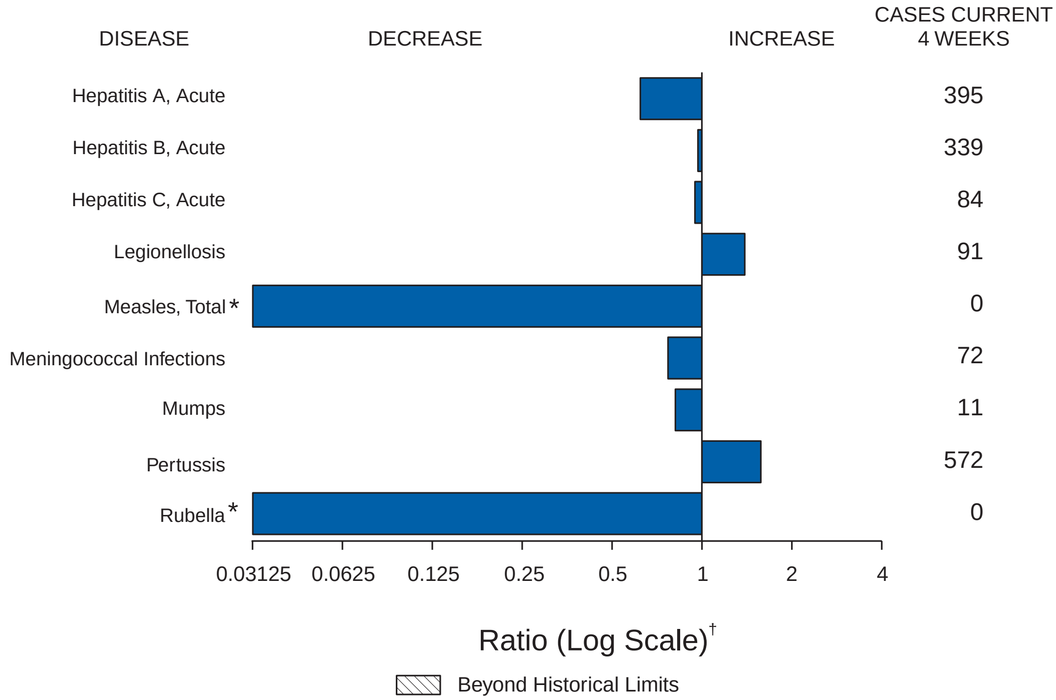
CDC has received notice from Wyeth Vaccines, the only U.S. supplier of 7-valent pneumococcal conjugate vaccine (PCV7, marketed as Prevnar®), that production constraints could cause delays in shipments in the first or second quarters of 2004. Until full production capacity is resumed, local shortages might occur. To minimize shortages, Wyeth Vaccines will implement an allocation plan to ensure the equitable distribution of vaccine supply among private purchasers. CDC will work with Wyeth Vaccines to help achieve equitable vaccine distribution to the states that order through CDC contracts; this distribution will be based in large part on state PCV7 inventories and past usage.

Current supply assessments indicate that the U.S. PCV7 supply is adequate to vaccinate all children beginning at age 2 months using the 4-dose schedule recommended in October 2000 (*1*). Health-care providers who have not received sufficient PCV7 for their private purchase supply should contact their local Wyeth Vaccines representative or call Wyeth Vaccines, telephone 800-666-7248. Providers with insufficient supply from the public sector, including vaccine obtained through the Vaccines for Children (VFC) program, should contact their state health department immunization program. CDC is working closely with Wyeth Vaccines and state health departments to monitor the PCV7 supply on a frequent basis and to ensure equitable vaccine distribution in both the private and public sectors. Schedule recommendations might be modified if future PCV7 supplies prove to be insufficient. Updated information about the national PCV7 supply can be found at http://www.cdc.gov/nip/news/shortages/default.htm.

Reference

1. CDC. Preventing pneumococcal disease among infants and young children: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2000;49(No. RR-9).

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals December 13, 2003, with historical data



* No measles or rubella cases were reported for the current 4-week period yielding a ratio for week 50 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 December 13, 2003 (50th Week)*

	Cum. 2003	Cum. 2002		Cum. 2003	Cum. 2002
Anthrax	-	2	Hansen disease (leprosy)†	54	85
Botulism:	-	-	Hantavirus pulmonary syndrome†	17	17
foodborne	17	26	Hemolytic uremic syndrome, postdiarrheal†	151	197
infant	66	64	HIV infection, pediatric†§	204	152
other (wound & unspecified)	31	19	Measles, total	41¶	40**
Brucellosis†	84	113	Mumps	186	250
Chancroid	44	66	Plague	1	2
Cholera	1	2	Poliomyelitis, paralytic	-	-
Cyclosporiasis†	69	158	Psittacosis†	14	16
Diphtheria	1	1	Q fever†	68	55
Ehrlichiosis:	-	-	Rabies, human	3	3
human granulocytic (HGE)†	342	329	Rubella	7	16
human monocytic (HME)†	199	192	Rubella, congenital	-	1
other and unspecified	41	22	SARS-associated coronavirus disease††	8	NA
Encephalitis/Meningitis:	-	-	Streptococcal toxic-shock syndrome†	134	106
California serogroup viral†	88	146	Tetanus	14	22
eastern equine†	10	9	Toxic-shock syndrome	123	100
Powassan†	-	1	Trichinosis	4	14
St. Louis†	37	20	Tularemia†	77	73
western equine†	5	-	Yellow fever	-	-

-: 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. Last update November 30, 2003.
¶ Of 41 cases reported, 30 were indigenous, and 11 were imported from another country.
** Of 40 cases reported, 24 were indigenous, and 16 were imported from another country.
†† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (notifiable as of July 2003).

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending December 13, 2003, and December 14, 2002 (50th 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	41,832	38,707	789,303	800,478	4,091	3,881	3,164	2,870	1,910	2,700
NEW ENGLAND	1,436	1,486	25,775	26,765	-	-	164	188	6	27
Maine	52	28	1,652	1,718	N	N	20	11	-	-
N.H.	36	35	1,037	1,500	-	-	11	29	-	-
Vt.	16	12	1,001	900	-	-	32	33	-	-
Mass.	599	753	11,017	10,524	-	-	68	76	-	18
R.I.	102	97	2,834	2,689	-	-	16	21	-	-
Conn.	631	561	8,234	9,434	N	N	17	18	6	9
MID. ATLANTIC	9,714	9,061	108,395	91,854	-	-	399	403	188	133
Upstate N.Y.	1,007	1,022	19,264	16,040	N	N	132	137	7	46
N.Y. City	5,201	5,280	33,531	31,480	-	-	97	142	-	28
N.J.	1,448	1,306	14,125	13,682	-	-	11	17	31	23
Pa.	2,058	1,453	41,475	30,652	N	N	159	107	150	36
E.N. CENTRAL	3,863	4,216	134,362	147,218	7	22	958	938	119	1,576
Ohio	757	757	29,764	36,700	-	-	171	118	106	396
Ind.	514	483	16,064	16,664	N	N	105	57	1	18
Ill.	1,718	2,092	42,877	46,656	-	2	86	120	2	554
Mich.	703	706	30,381	30,835	7	20	140	131	10	557
Wis.	171	178	15,276	16,363	-	-	456	512	-	51
W.N. CENTRAL	768	712	44,897	45,282	1	1	561	409	475	192
Minn.	162	149	9,209	9,802	N	N	148	197	49	17
Iowa	82	81	3,344	5,487	N	N	118	47	78	-
Mo.	365	335	17,136	15,506	-	-	49	38	34	107
N. Dak.	2	3	1,294	1,157	N	N	13	24	9	-
S. Dak.	14	10	2,543	2,122	-	-	44	36	65	14
Nebr.¶	52	66	4,659	4,599	1	1	19	51	153	35
Kans.	91	68	6,712	6,609	N	N	170	16	87	19
S. ATLANTIC	11,498	11,380	147,675	152,022	5	4	386	320	191	71
Del.	202	181	2,889	2,555	N	N	4	3	12	-
Md.	1,441	1,670	16,155	16,007	5	4	24	19	51	21
D.C.	863	769	3,016	3,223	-	-	13	5	-	-
Va.	856	811	16,415	17,842	-	-	45	27	22	-
W. Va.	86	79	2,480	2,376	N	N	4	2	1	2
N.C.	1,060	952	24,319	23,892	N	N	49	36	5	-
S.C.¶	756	777	15,590	14,207	-	-	9	6	3	1
Ga.	1,825	1,543	28,561	31,827	-	-	123	121	46	21
Fla.	4,409	4,598	38,250	40,093	N	N	115	101	51	26
E.S. CENTRAL	1,879	1,829	49,310	50,163	N	N	115	122	44	275
Ky.	200	287	7,633	8,454	N	N	24	9	11	42
Tenn.	800	745	19,468	15,436	N	N	39	56	17	8
Ala.	441	389	11,581	15,160	-	-	42	47	16	34
Miss.	438	408	10,628	11,113	N	N	10	10	-	191
W.S. CENTRAL	4,566	3,834	98,555	103,606	4	12	90	63	500	421
Ark.	172	224	7,402	7,086	-	-	18	8	22	13
La.	610	898	17,141	18,071	N	N	2	10	49	204
Okla.	202	180	10,572	10,603	N	N	19	16	25	-
Tex.	3,582	2,532	63,440	67,846	4	12	51	29	404	204
MOUNTAIN	1,461	1,307	42,901	49,758	2,511	2,397	130	153	383	5
Mont.	13	11	2,080	2,200	N	N	18	6	216	1
Idaho	24	28	2,376	2,408	N	N	27	28	-	1
Wyo.	7	8	908	898	1	1	5	9	94	-
Colo.	343	283	10,031	13,632	N	N	34	57	-	-
N. Mex.	102	81	6,690	7,098	9	8	11	19	68	-
Ariz.	646	551	11,965	14,410	2,448	2,333	6	16	2	3
Utah	72	62	3,419	3,392	19	11	21	14	1	-
Nev.	254	283	5,432	5,720	34	44	8	4	2	-
PACIFIC	6,647	4,882	137,433	133,810	1,562	1,444	361	274	4	-
Wash.	491	441	15,946	14,329	N	N	59	36	-	-
Oreg.	242	310	7,047	6,574	-	-	38	39	4	-
Calif.	5,802	3,993	107,473	104,928	1,562	1,444	263	196	-	-
Alaska	15	30	3,516	3,611	-	-	1	1	-	-
Hawaii	97	108	3,451	4,368	-	-	-	2	-	-
Guam	6	2	-	606	-	-	-	-	-	-
P.R.	1,025	1,042	1,761	2,390	N	N	N	N	-	-
V.I.	33	70	208	125	-	-	-	-	-	-
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 November 30, 2003.

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 13, 2003, and December 14, 2002 (50th Week)*

	Escherichia coli, Enterohemorrhagic (EHEC)									
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped		Giardiasis		Gonorrhea	
Reporting area	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	2,494	3,657	262	184	130	52	17,528	19,969	300,981	338,789
NEW ENGLAND	160	258	54	47	17	6	1,391	1,702	6,813	7,466
Maine	10	37	3	8	1	-	179	205	170	138
N.H.	12	33	2	-	-	-	22	43	76	118
Vt.	18	14	-	1	-	1	118	144	83	94
Mass.	67	117	8	20	16	5	738	911	2,922	3,129
R.I.	4	12	-	1	-	-	114	156	908	877
Conn.	49	45	41	17	-	-	220	243	2,654	3,110
MID. ATLANTIC	233	411	19	1	37	8	3,451	4,058	41,703	40,912
Upstate N.Y.	94	171	11	-	19	1	1,026	1,194	7,637	8,297
N.Y. City	5	19	-	-	-	-	1,093	1,387	13,249	12,252
N.J.	22	63	1	-	-	1	367	461	7,762	7,588
Pa.	112	158	7	1	18	6	965	1,016	13,055	12,775
E.N. CENTRAL	553	841	28	31	23	6	2,884	3,507	60,297	72,093
Ohio	131	153	17	11	22	5	876	932	16,384	21,169
Ind.	89	77	-	1	-	-	-	-	6,443	7,213
Ill.	113	191	-	6	-	-	733	1,000	19,404	23,371
Mich.	90	134	1	3	-	1	732	894	13,115	14,250
Wis.	130	286	10	10	1	-	543	681	4,951	6,090
W.N. CENTRAL	431	504	55	31	20	7	1,988	2,052	15,930	17,406
Minn.	132	161	23	26	1	-	772	785	2,634	2,968
Iowa	102	120	-	-	-	-	262	303	775	1,312
Mo.	88	68	18	-	1	-	487	490	8,164	8,595
N. Dak.	13	18	4	-	8	2	38	31	72	71
S. Dak.	28	40	4	2	-	-	84	81	224	261
Nebr.	39	66	5	3	-	-	136	177	1,581	1,499
Kans.	29	31	1	-	10	5	209	185	2,480	2,700
S. ATLANTIC	150	420	70	36	12	1	2,726	2,865	73,446	86,038
Del.	11	10	N	N	N	N	46	54	1,085	1,526
Md.	14	28	-	-	-	-	114	111	7,724	8,844
D.C.	1	3	-	-	-	-	55	45	2,388	2,566
Va.	38	67	11	10	-	-	358	318	7,535	10,132
W. Va.	5	9	-	-	-	1	49	59	817	942
N.C.	4	191	30	-	-	-	N	N	14,014	15,145
S.C.	4	5	-	-	-	-	136	135	8,409	9,065
Ga.	31	45	5	8	-	-	910	887	14,435	17,343
Fla.	42	62	24	18	12	-	1,058	1,256	17,039	20,475
E.S. CENTRAL	83	110	2	-	7	10	340	388	24,523	29,050
Ky.	28	30	2	-	7	10	N	N	3,410	3,644
Tenn.	35	49	-	-	-	-	176	186	8,125	9,050
Ala.	14	20	-	-	-	-	164	202	7,518	9,834
Miss.	6	11	-	-	-	-	-	-	5,470	6,522
W.S. CENTRAL	94	110	4	2	9	9	282	250	40,566	46,461
Ark.	12	12	-	-	-	-	138	169	3,786	4,482
La.	3	4	-	-	-	-	13	6	10,134	11,165
Okla.	29	23	-	-	-	-	131	72	4,371	4,558
Tex.	50	71	4	2	9	9	-	3	22,275	26,256
MOUNTAIN	320	333	26	29	5	5	1,542	1,624	9,391	10,974
Mont.	17	31	-	-	-	-	111	92	104	108
Idaho	81	42	16	18	-	-	195	130	69	92
Wyo.	4	15	1	2	-	-	22	29	42	59
Colo.	71	97	3	6	5	5	418	559	2,408	3,395
N. Mex.	11	12	5	3	-	-	50	147	1,061	1,433
Ariz.	39	33	N	N	N	N	253	189	3,304	3,620
Utah	74	75	-	-	-	-	356	321	356	357
Nev.	23	28	1	-	-	-	137	157	2,047	1,910
PACIFIC	470	670	4	7	-	-	2,924	3,523	28,312	28,389
Wash.	113	145	1	-	-	-	341	421	2,633	2,798
Oreg.	103	205	3	7	-	-	388	436	941	856
Calif.	242	275	-	-	-	-	2,023	2,466	23,382	23,423
Alaska	4	8	-	-	-	-	85	111	528	601
Hawaii	8	37	-	-	-	-	87	89	828	711
Guam	N	N	-	-	-	-	-	7	-	45
P.R.	-	1	-	-	36	-	132	84	188	327
V.I.	-	-	-	-	-	-	-	-	55	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 December 13, 2003, and December 14, 2002 (50th Week)*

	Haemophilus influenzae, invasive†								Hepatitis (viral, acute), by type	
	All ages		Age <5 years							
	All serotypes		Serotype b		Non-serotype b		Unknown serotype		A	
Reporting area	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	1,601	1,589	20	30	89	136	176	145	6,959	8,439
NEW ENGLAND	117	122	1	-	5	12	5	2	316	289
Maine	4	2	-	-	-	-	1	-	19	8
N.H.	11	10	1	-	-	-	-	-	11	11
Vt.	9	7	-	-	-	-	-	-	6	4
Mass.	53	45	-	-	5	5	3	2	194	141
R.I.	9	10	-	-	-	-	1	-	15	32
Conn.	31	48	-	-	-	7	-	-	71	93
MID. ATLANTIC	362	290	-	3	3	16	51	23	1,721	1,082
Upstate N.Y.	131	111	-	2	3	4	13	8	145	177
N.Y. City	60	67	-	-	-	-	10	9	426	436
N.J.	64	54	-	-	-	-	10	6	157	180
Pa.	107	58	-	1	-	12	18	-	993	289
E.N. CENTRAL	230	306	4	4	13	14	32	43	681	1,015
Ohio	69	76	-	-	1	1	11	9	164	295
Ind.	48	42	1	2	8	8	-	-	75	48
Ill.	69	119	-	-	-	-	15	21	195	260
Mich.	22	17	3	2	4	5	1	-	202	218
Wis.	22	52	-	-	-	-	5	13	45	194
W.N. CENTRAL	120	71	2	1	7	3	16	6	188	282
Minn.	53	47	2	1	7	3	2	4	45	42
Iowa	-	1	-	-	-	-	-	-	31	65
Mo.	41	13	-	-	-	-	13	2	70	83
N. Dak.	3	4	-	-	-	-	-	-	1	3
S. Dak.	1	1	-	-	-	-	-	-	-	3
Nebr.	3	-	-	-	-	-	-	-	13	17
Kans.	19	5	-	-	-	-	1	-	28	69
S. ATLANTIC	376	350	3	5	17	17	20	27	1,742	2,341
Del.	-	-	-	-	-	-	-	-	7	15
Md.	89	91	1	2	7	4	1	1	172	296
D.C.	-	-	-	-	-	-	-	-	43	80
Va.	55	32	-	-	-	-	6	5	108	150
W. Va.	15	18	-	-	-	1	-	1	15	22
N.C.	40	31	-	-	3	3	2	-	120	203
S.C.	5	13	-	-	-	-	1	2	39	62
Ga.	61	79	-	-	-	-	5	12	840	486
Fla.	111	86	2	3	7	9	5	6	398	1,027
E.S. CENTRAL	74	67	1	1	2	5	10	13	248	257
Ky.	6	7	-	-	2	1	-	2	32	41
Tenn.	46	34	-	-	-	1	6	7	186	115
Ala.	20	16	1	1	-	3	3	1	15	39
Miss.	2	10	-	-	-	-	1	3	15	62
W.S. CENTRAL	67	58	2	2	8	11	5	3	378	1,017
Ark.	7	1	-	-	1	-	-	-	19	70
La.	12	9	-	-	-	-	5	3	56	85
Okla.	45	46	-	-	7	11	-	-	22	48
Tex.	3	2	2	2	-	-	-	-	281	814
MOUNTAIN	156	184	4	6	19	39	22	16	466	515
Mont.	-	-	-	-	-	-	-	-	8	13
Idaho	5	2	-	-	-	-	2	1	17	30
Wyo.	2	2	-	-	-	-	-	-	1	3
Colo.	37	35	-	-	-	-	7	4	68	73
N. Mex.	17	26	-	-	4	6	1	1	20	29
Ariz.	72	89	4	4	6	27	8	6	257	263
Utah	13	18	-	1	5	4	4	1	46	54
Nev.	10	12	-	1	4	2	-	3	49	50
PACIFIC	99	141	3	8	15	19	15	12	1,219	1,641
Wash.	11	4	-	2	7	2	3	-	64	147
Oreg.	44	55	-	-	-	-	5	3	58	62
Calif.	20	43	3	6	8	17	4	4	1,076	1,396
Alaska	3	2	-	-	-	-	2	2	9	11
Hawaii	21	37	-	-	-	-	1	3	12	25
Guam	-	-	-	-	-	-	-	-	-	1
P.R.	-	1	-	-	-	-	-	-	52	224
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 December 13, 2003, and December 14, 2002 (50th Week)*

	Hepatitis (viral, acute), by type									
	B		C		Legionellosis		Listeriosis		Lyme disease	
Reporting area	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	6,518	7,129	1,795	1,738	1,929	1,237	594	623	17,431	21,483
NEW ENGLAND	241	297	11	20	103	115	45	60	3,343	7,037
Maine	1	12	2	-	2	5	7	5	222	102
N.H.	11	22	-	-	6	7	3	4	95	248
Vt.	4	6	9	13	6	35	1	3	43	36
Mass.	185	159	-	6	44	44	15	33	1,114	1,801
R.I.	18	30	-	1	17	9	1	1	576	335
Conn.	22	68	U	U	28	15	18	14	1,293	4,515
MID. ATLANTIC	857	1,490	159	110	549	349	113	185	11,324	11,012
Upstate N.Y.	127	120	41	47	151	102	34	56	4,387	4,773
N.Y. City	275	719	-	-	56	62	20	39	5	58
N.J.	182	325	-	5	73	33	15	35	2,049	2,322
Pa.	273	326	118	58	269	152	44	55	4,883	3,859
E.N. CENTRAL	395	682	152	115	388	288	69	88	801	1,253
Ohio	139	104	12	2	221	119	24	24	76	75
Ind.	36	56	9	-	29	21	10	12	22	20
Ill.	1	158	17	23	3	27	8	22	33	47
Mich.	188	315	114	86	117	84	19	22	12	26
Wis.	31	49	-	4	18	37	8	8	658	1,085
W.N. CENTRAL	336	225	268	629	65	67	22	19	460	455
Minn.	35	35	9	2	3	17	11	3	333	357
Iowa	11	20	1	1	10	13	-	2	50	42
Mo.	238	112	255	610	33	19	5	10	64	40
N. Dak.	2	5	-	-	1	1	-	1	-	1
S. Dak.	2	2	-	1	2	4	-	1	1	2
Nebr.	29	29	3	15	5	13	4	1	2	6
Kans.	19	22	-	-	11	-	2	1	10	7
S. ATLANTIC	2,032	1,683	157	203	505	221	133	81	1,221	1,380
Del.	9	13	-	-	27	10	N	N	185	192
Md.	132	128	17	14	130	55	28	20	606	716
D.C.	12	21	-	-	19	6	-	-	12	23
Va.	189	196	11	15	93	30	12	7	159	204
W. Va.	38	18	9	3	17	-	6	-	27	17
N.C.	150	216	11	26	37	12	17	6	137	127
S.C.	149	118	24	5	7	10	5	8	15	24
Ga.	747	454	5	64	32	19	33	14	17	2
Fla.	606	519	80	76	143	79	32	26	63	75
E.S. CENTRAL	418	370	85	136	93	48	31	21	61	71
Ky.	72	52	20	4	43	22	9	4	15	22
Tenn.	195	133	19	30	34	18	8	12	17	26
Ala.	61	96	7	10	13	8	12	4	5	11
Miss.	90	89	39	92	3	-	2	1	24	12
W.S. CENTRAL	828	1,018	782	360	63	33	42	36	80	140
Ark.	59	110	3	10	2	-	1	-	-	3
La.	112	132	115	96	1	4	3	4	6	5
Okla.	41	77	2	5	7	3	3	9	-	-
Tex.	616	699	662	249	53	26	35	23	74	132
MOUNTAIN	582	570	53	54	73	52	30	30	19	17
Mont.	16	10	3	1	4	3	2	-	-	-
Idaho	8	7	1	1	4	2	2	2	3	4
Wyo.	31	17	-	5	2	2	-	-	2	2
Colo.	79	76	17	6	15	9	10	7	4	1
N. Mex.	33	146	-	3	3	2	2	3	1	1
Ariz.	274	199	7	4	11	14	10	14	3	3
Utah	61	49	-	4	23	14	-	3	3	5
Nev.	80	66	25	30	11	6	4	1	3	1
PACIFIC	829	794	128	111	90	64	109	103	122	118
Wash.	73	71	16	25	10	5	6	8	3	10
Oreg.	107	123	16	13	N	N	5	9	18	12
Calif.	615	580	85	72	80	56	93	78	98	93
Alaska	11	9	1	-	-	2	-	-	3	3
Hawaii	23	11	10	1	-	1	5	8	N	N
Guam	-	1	-	-	-	-	-	-	-	-
P.R.	85	180	-	-	-	-	-	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 December 13, 2003, and December 14, 2002 (50th Week)*

Reporting area	Malaria Cum. 2003	Malaria Cum. 2002	Meningococcal disease Cum. 2003	Meningococcal disease Cum. 2002	Pertussis Cum. 2003	Pertussis Cum. 2002	Rabies, animal Cum. 2003	Rabies, animal Cum. 2002	Rocky Mountain spotted fever Cum. 2003	Rocky Mountain spotted fever Cum. 2002
UNITED STATES	1,118	1,341	1,498	1,700	7,715	8,330	5,345	7,457	936	999
NEW ENGLAND	42	78	70	90	1,181	852	549	886	1	7
Maine	4	6	6	5	12	17	67	58	-	-
N.H.	4	7	3	14	60	57	13	48	-	-
Vt.	2	4	3	4	65	163	37	89	-	-
Mass.	11	33	44	47	1,001	573	207	296	1	3
R.I.	2	7	2	5	20	13	58	72	-	4
Conn.	19	21	12	15	23	29	167	323	-	-
MID. ATLANTIC	283	364	191	206	1,095	523	917	1,318	38	59
Upstate N.Y.	58	44	51	51	695	353	411	681	2	-
N.Y. City	140	228	38	36	-	22	6	21	13	10
N.J.	42	43	27	27	107	5	62	186	12	16
Pa.	43	49	75	92	293	143	438	430	11	33
E.N. CENTRAL	86	158	208	258	699	970	161	162	15	32
Ohio	23	23	55	74	299	420	53	39	9	13
Ind.	3	14	43	32	69	145	30	31	1	4
Ill.	26	62	43	57	-	168	24	31	-	12
Mich.	24	45	46	45	116	60	47	46	5	3
Wis.	10	14	21	50	215	177	7	15	-	-
W.N. CENTRAL	49	57	127	148	477	717	571	466	72	104
Minn.	22	17	26	35	141	357	40	37	2	-
Iowa	6	4	26	27	135	135	101	77	2	3
Mo.	6	15	55	50	132	142	55	50	55	96
N. Dak.	1	1	1	3	6	8	53	57	-	-
S. Dak.	3	2	1	2	5	7	67	93	5	1
Nebr.	-	5	7	23	15	8	100	-	4	4
Kans.	11	13	11	8	43	60	155	152	4	-
S. ATLANTIC	313	315	254	275	660	407	2,389	2,587	600	475
Del.	3	5	9	7	8	4	60	53	1	1
Md.	73	105	26	9	83	64	256	384	106	40
D.C.	15	21	-	-	3	2	-	-	1	2
Va.	40	32	24	42	90	140	477	570	30	40
W. Va.	4	3	6	4	25	32	81	169	5	2
N.C.	25	22	36	32	126	43	747	689	317	285
S.C.	4	8	21	31	184	45	238	145	43	72
Ga.	64	50	33	31	32	27	346	398	82	19
Fla.	85	69	99	119	109	50	184	179	15	14
E.S. CENTRAL	22	20	85	94	141	253	171	213	107	132
Ky.	9	7	19	17	45	96	37	26	3	5
Tenn.	7	3	29	36	73	114	100	108	66	84
Ala.	3	5	15	22	17	34	33	75	12	16
Miss.	3	5	22	19	6	9	1	4	26	27
W.S. CENTRAL	73	80	175	207	683	1,613	220	1,226	92	171
Ark.	4	3	15	23	37	488	25	99	39	97
La.	4	4	35	45	6	7	-	-	-	-
Okla.	4	10	18	22	90	35	195	119	42	61
Tex.	61	63	107	117	550	1,083	-	1,008	11	13
MOUNTAIN	50	49	76	93	899	1,302	166	308	10	14
Mont.	-	2	6	3	5	9	21	19	1	1
Idaho	1	-	7	5	75	147	15	38	2	-
Wyo.	1	-	2	-	125	11	6	18	2	5
Colo.	22	24	22	26	340	452	38	59	2	2
N. Mex.	3	3	11	4	67	194	5	10	1	1
Ariz.	16	12	15	30	126	339	63	140	-	-
Utah	5	5	5	5	126	102	14	13	2	-
Nev.	2	3	8	20	35	48	4	11	-	5
PACIFIC	200	220	312	329	1,880	1,693	201	291	1	5
Wash.	29	24	37	63	692	451	-	-	-	-
Oreg.	11	11	60	46	435	184	7	14	-	3
Calif.	152	175	202	207	735	1,024	186	251	1	2
Alaska	1	2	3	4	7	5	8	26	-	-
Hawaii	7	8	10	9	11	29	-	-	-	-
Guam	-	-	-	1	-	2	-	-	-	-
P.R.	1	1	5	7	1	3	68	86	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 December 13, 2003, and December 14, 2002 (50th Week)*

Reporting area	Salmonellosis		Shigellosis		Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive: Drug resistant, all ages		*Streptococcus pneumoniae*, invasive: Age <5 years	
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	39,344	41,955	21,058	21,264	4,989	4,374	1,976	2,357	445	369
NEW ENGLAND	2,003	2,144	320	341	360	315	41	113	9	3
Maine	136	140	7	10	28	20	-	-	-	-
N.H.	100	137	5	13	21	35	-	-	N	N
Vt.	72	74	8	1	19	10	7	5	5	2
Mass.	1,194	1,193	215	201	174	106	N	N	N	N
R.I.	125	163	20	17	16	15	10	13	4	1
Conn.	376	437	65	99	102	129	24	95	U	U
MID. ATLANTIC	4,426	5,647	2,224	1,781	875	684	126	121	97	84
Upstate N.Y.	1,127	1,486	573	336	345	275	70	90	74	70
N.Y. City	1,235	1,362	394	487	124	152	U	U	U	U
N.J.	573	1,029	280	607	148	142	N	N	N	N
Pa.	1,491	1,770	977	351	258	115	56	31	23	14
E.N. CENTRAL	5,108	5,385	1,663	2,187	1,001	938	423	243	179	152
Ohio	1,300	1,356	294	643	282	197	276	82	99	28
Ind.	565	544	179	112	105	51	147	159	49	64
Ill.	1,624	1,754	838	1,057	182	275	-	2	-	-
Mich.	763	847	232	186	347	294	N	N	N	N
Wis.	856	884	120	189	85	121	N	N	31	60
W.N. CENTRAL	2,481	2,559	800	1,056	315	247	161	432	62	61
Minn.	557	565	102	212	155	125	-	292	52	57
Iowa	380	497	87	122	N	N	N	N	N	N
Mo.	953	814	369	198	69	43	14	5	3	1
N. Dak.	38	41	6	18	15	3	3	1	7	3
S. Dak.	118	111	17	157	21	14	1	1	-	-
Nebr.	152	182	106	258	25	25	-	26	N	N
Kans.	283	349	113	91	30	37	143	107	N	N
S. ATLANTIC	10,812	11,107	6,995	7,329	870	695	995	1,081	18	35
Del.	98	101	156	385	6	2	1	3	N	N
Md.	835	907	564	1,182	265	118	-	-	-	25
D.C.	49	76	74	63	14	9	3	-	7	3
Va.	1,068	1,200	426	981	97	73	N	N	N	N
W. Va.	123	149	-	12	35	19	71	46	11	7
N.C.	1,351	1,509	971	550	102	113	N	N	U	U
S.C.	810	827	509	128	37	38	141	192	N	N
Ga.	2,150	1,905	1,579	1,728	114	127	233	269	N	N
Fla.	4,328	4,433	2,716	2,300	200	196	546	571	N	N
E.S. CENTRAL	2,622	3,205	910	1,502	199	110	140	131	-	-
Ky.	384	386	125	197	44	19	19	17	N	N
Tenn.	732	819	369	158	155	91	121	114	N	N
Ala.	531	847	249	808	-	-	-	-	N	N
Miss.	975	1,153	167	339	-	-	-	-	-	-
W.S. CENTRAL	4,617	4,564	4,458	3,206	337	288	60	187	75	30
Ark.	773	1,040	97	194	5	8	8	11	-	-
La.	523	783	298	490	1	1	52	176	9	10
Okla.	450	498	833	573	88	46	N	N	43	8
Tex.	2,871	2,243	3,230	1,949	243	233	N	N	23	12
MOUNTAIN	2,203	2,167	1,216	906	438	553	27	49	5	4
Mont.	110	89	2	4	2	-	-	-	-	-
Idaho	170	159	33	15	19	11	N	N	N	N
Wyo.	76	106	8	8	2	7	8	13	-	-
Colo.	443	583	277	206	126	120	-	-	-	-
N. Mex.	269	319	247	233	113	109	19	35	-	-
Ariz.	741	521	533	354	163	275	-	-	N	N
Utah	221	176	50	33	11	31	-	-	5	4
Nev.	173	214	66	53	2	-	-	1	-	-
PACIFIC	5,072	5,177	2,472	2,956	594	544	3	-	-	-
Wash.	556	502	154	174	70	60	-	-	N	N
Oreg.	411	330	210	108	N	N	N	N	N	N
Calif.	3,793	4,004	2,055	2,600	399	380	N	N	N	N
Alaska	96	81	10	5	-	-	-	-	N	N
Hawaii	216	260	43	69	125	104	3	-	-	-
Guam	-	42	-	36	-	-	-	4	-	-
P.R.	350	540	8	31	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 December 13, 2003, and December 14, 2002 (50th 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	6,476	6,508	354	417	10,871	12,376	302	308	12,608
NEW ENGLAND	195	141	1	1	298	418	23	13	1,727
Maine	7	2	1	-	5	20	-	-	780
N.H.	14	7	-	-	7	17	2	-	-
Vt.	1	2	-	-	7	7	-	-	791
Mass.	129	94	-	1	197	230	12	7	151
R.I.	20	9	-	-	32	49	2	-	5
Conn.	24	27	-	-	50	95	7	6	-
MID. ATLANTIC	844	704	62	66	2,091	2,117	58	76	38
Upstate N.Y.	43	32	15	4	274	301	11	9	N
N.Y. City	483	414	32	26	1,084	1,015	25	41	-
N.J.	162	158	15	35	426	483	16	18	-
Pa.	156	100	-	1	307	318	6	8	38
E.N. CENTRAL	838	1,181	69	68	1,112	1,266	23	34	5,803
Ohio	195	155	3	3	194	227	2	7	1,177
Ind.	55	61	12	3	128	120	4	2	-
Ill.	334	461	20	39	530	601	7	17	-
Mich.	242	475	34	23	208	253	10	4	3,777
Wis.	12	29	-	-	52	65	-	4	849
W.N. CENTRAL	141	122	4	2	463	502	4	10	73
Minn.	42	59	-	1	185	216	-	4	N
Iowa	7	4	-	-	25	31	2	-	N
Mo.	53	33	4	1	109	126	1	2	-
N. Dak.	2	-	-	-	4	6	-	-	73
S. Dak.	2	-	-	-	20	12	-	-	-
Nebr.	12	6	-	-	27	25	1	4	-
Kans.	23	20	-	-	93	86	-	-	-
S. ATLANTIC	1,720	1,693	68	89	2,243	2,523	51	41	2,071
Del.	6	11	-	-	23	21	-	-	28
Md.	291	211	10	15	226	269	8	8	-
D.C.	52	54	-	1	-	-	-	-	29
Va.	75	68	1	1	255	274	12	7	503
W. Va.	2	2	-	-	21	28	-	-	1,251
N.C.	146	269	19	19	345	368	9	2	N
S.C.	93	130	7	13	161	147	-	-	260
Ga.	457	366	11	13	361	508	8	5	-
Fla.	598	582	20	27	851	908	14	19	N
E.S. CENTRAL	306	442	10	31	639	726	7	4	2
Ky.	32	87	1	3	124	125	1	4	N
Tenn.	131	163	2	11	198	279	3	-	N
Ala.	111	147	5	10	229	202	3	-	-
Miss.	32	45	2	7	88	120	-	-	2
W.S. CENTRAL	886	816	69	88	1,442	1,773	32	30	2,225
Ark.	50	33	2	11	95	119	-	-	-
La.	160	147	-	-	-	-	-	-	13
Okla.	62	68	1	2	142	164	1	2	N
Tex.	614	568	66	75	1,205	1,490	31	28	2,212
MOUNTAIN	288	318	25	16	344	421	6	10	669
Mont.	-	-	-	-	5	12	-	-	N
Idaho	13	8	-	-	8	14	1	-	N
Wyo.	-	-	-	-	4	3	-	-	97
Colo.	24	64	3	2	64	93	3	5	-
N. Mex.	63	36	4	-	6	34	-	1	4
Ariz.	167	188	18	14	200	220	2	-	4
Utah	10	7	-	-	35	31	-	2	564
Nev.	11	15	-	-	22	14	-	2	-
PACIFIC	1,258	1,091	46	56	2,239	2,630	98	90	-
Wash.	75	59	-	2	229	241	4	6	-
Oreg.	43	26	-	-	100	105	5	2	-
Calif.	1,138	997	46	53	1,789	2,100	88	77	-
Alaska	-	-	-	-	53	48	-	-	-
Hawaii	2	9	-	1	68	136	1	5	-
Guam	-	6	-	-	-	64	-	-	-
P.R.	183	276	1	23	86	104	-	-	423
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 December 13, 2003 (50th Week)

Reporting Area	All causes, by age (years)						P&I†
	All Ages	≥65	45-64	25-44	1-24	<1	Total
NEW ENGLAND	581	428	102	29	15	7	64
Boston, Mass.	159	103	34	8	8	6	20
Bridgeport, Conn.	30	18	9	3	-	-	2
Cambridge, Mass.	24	23	1	-	-	-	3
Fall River, Mass.	28	25	3	-	-	-	4
Hartford, Conn.	49	38	5	5	-	1	6
Lowell, Mass.	18	16	1	1	-	-	3
Lynn, Mass.	11	7	3	1	-	-	1
New Bedford, Mass.	20	18	-	2	-	-	3
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	62	45	12	4	1	-	6
Somerville, Mass.	5	3	2	-	-	-	-
Springfield, Mass.	55	38	13	2	2	-	4
Waterbury, Conn.	63	50	10	1	2	-	7
Worcester, Mass.	57	44	9	2	2	-	5
MID. ATLANTIC	2,213	1,512	507	124	32	34	135
Albany, N.Y.	35	27	5	1	1	1	2
Allentown, Pa.	27	23	3	1	-	-	3
Buffalo, N.Y.	102	69	23	6	1	3	8
Camden, N.J.	17	11	2	3	-	1	1
Elizabeth, N.J.	16	13	2	1	-	-	-
Erie, Pa.	43	32	7	3	-	1	3
Jersey City, N.J.	29	20	8	1	-	-	-
New York City, N.Y.	1,069	730	242	69	12	12	60
Newark, N.J.	47	23	18	2	2	2	2
Paterson, N.J.	23	13	7	1	2	-	1
Philadelphia, Pa.	381	230	107	25	11	8	14
Pittsburgh, Pa.§	40	30	7	-	1	2	2
Reading, Pa.	23	19	3	1	-	-	-
Rochester, N.Y.	125	94	27	3	1	-	15
Schenectady, N.Y.	26	23	3	-	-	-	2
Scranton, Pa.	35	26	6	2	-	1	3
Syracuse, N.Y.	92	73	15	2	-	2	12
Trenton, N.J.	38	22	13	2	-	1	3
Utica, N.Y.	20	16	3	1	-	-	2
Yonkers, N.Y.	25	18	6	-	1	-	2
E.N. CENTRAL	2,287	1,577	482	124	42	60	180
Akron, Ohio	64	46	9	3	1	5	9
Canton, Ohio	33	28	5	-	-	-	5
Chicago, Ill.	389	250	93	22	12	10	30
Cincinnati, Ohio	83	58	16	6	2	1	7
Cleveland, Ohio	241	186	46	8	1	-	14
Columbus, Ohio	238	166	40	14	5	13	18
Dayton, Ohio	161	112	37	9	1	2	18
Detroit, Mich.	161	84	48	14	7	8	9
Evansville, Ind.	68	48	16	3	-	1	5
Fort Wayne, Ind.	85	62	16	5	1	1	6
Gary, Ind.	23	13	8	1	-	1	-
Grand Rapids, Mich.	61	46	9	3	-	3	5
Indianapolis, Ind.	177	117	33	17	6	4	11
Lansing, Mich.	24	22	2	-	-	-	4
Milwaukee, Wis.	148	99	34	7	3	5	8
Peoria, Ill.	62	47	12	2	1	-	4
Rockford, Ill.	59	44	13	2	-	-	11
South Bend, Ind.	65	51	11	1	-	2	8
Toledo, Ohio	93	62	24	4	-	3	7
Youngstown, Ohio	52	36	10	3	2	1	1
W.N. CENTRAL	616	426	127	34	25	4	47
Des Moines, Iowa	107	76	27	2	2	-	4
Duluth, Minn.	39	27	6	5	1	-	2
Kansas City, Kans.	66	46	9	7	3	1	10
Kansas City, Mo.	U	U	U	U	U	U	U
Lincoln, Nebr.	64	50	10	3	1	-	9
Minneapolis, Minn.	58	32	15	6	4	1	4
Omaha, Nebr.	120	83	25	7	3	2	12
St. Louis, Mo.	U	U	U	U	U	U	U
St. Paul, Minn.	62	46	11	4	1	-	2
Wichita, Kans.	100	66	24	-	10	-	4

Reporting Area	All causes, by age (years)						P&I†
	All Ages	≥65	45-64	25-44	1-24	<1	Total
S. ATLANTIC	1,177	717	278	95	37	49	61
Atlanta, Ga.	175	89	44	18	7	17	4
Baltimore, Md.	178	96	49	21	7	5	3
Charlotte, N.C.	98	62	23	10	1	2	18
Jacksonville, Fla.	188	121	48	14	3	2	9
Miami, Fla.	34	21	6	3	4	-	3
Norfolk, Va.	44	30	9	1	2	2	3
Richmond, Va.	66	36	17	7	-	5	3
Savannah, Ga.	55	37	12	4	1	1	4
St. Petersburg, Fla.	52	37	9	2	3	1	2
Tampa, Fla.	168	123	32	5	3	5	9
Washington, D.C.	100	52	25	9	6	8	3
Wilmington, Del.	19	13	4	1	-	1	-
E.S. CENTRAL	937	648	191	62	16	19	65
Birmingham, Ala.	205	137	39	17	10	1	15
Chattanooga, Tenn.	103	73	18	7	-	5	4
Knoxville, Tenn.	97	75	19	2	-	1	2
Lexington, Ky.	79	51	20	5	2	1	2
Memphis, Tenn.	153	102	34	7	2	8	5
Mobile, Ala.	70	50	14	5	-	1	5
Montgomery, Ala.	59	45	12	2	-	-	12
Nashville, Tenn.	171	115	35	17	2	2	20
W.S. CENTRAL	1,681	1,066	399	126	56	34	113
Austin, Tex.	113	73	25	6	6	3	11
Baton Rouge, La.	75	54	16	3	1	1	-
Corpus Christi, Tex.	63	44	12	2	2	3	2
Dallas, Tex.	195	118	39	23	8	7	16
El Paso, Tex.	69	48	8	6	6	1	6
Ft. Worth, Tex.	143	90	40	7	1	5	8
Houston, Tex.	403	237	117	31	11	7	22
Little Rock, Ark.	86	53	22	7	2	2	7
New Orleans, La.	43	16	16	7	4	-	-
San Antonio, Tex.	283	191	62	18	8	4	21
Shreveport, La.	63	46	13	3	-	1	7
Tulsa, Okla.	145	96	29	13	7	-	13
MOUNTAIN	913	624	192	55	21	21	73
Albuquerque, N.M.	157	107	31	14	2	3	5
Boise, Idaho	67	47	13	2	1	4	10
Colo. Springs, Colo.	85	61	15	4	2	3	5
Denver, Colo.	108	78	19	6	3	2	9
Las Vegas, Nev.	261	166	72	13	10	-	11
Ogden, Utah	37	25	5	7	-	-	4
Phoenix, Ariz.	U	U	U	U	U	U	U
Pueblo, Colo.	54	44	7	2	1	-	8
Salt Lake City, Utah	144	96	30	7	2	9	21
Tucson, Ariz.	U	U	U	U	U	U	U
PACIFIC	2,469	1,774	462	156	49	27	193
Berkeley, Calif.	14	10	3	1	-	-	2
Fresno, Calif.	194	148	24	17	3	2	12
Glendale, Calif.	63	54	6	3	-	-	1
Honolulu, Hawaii	86	68	14	3	1	-	9
Long Beach, Calif.	109	70	31	5	2	1	8
Los Angeles, Calif.	1,055	732	212	70	26	15	83
Pasadena, Calif.	34	28	5	1	-	-	5
Portland, Oreg.	153	109	33	8	2	1	8
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	205	146	36	15	4	3	13
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	208	146	44	15	3	-	31
Santa Cruz, Calif.	36	32	2	2	-	-	2
Seattle, Wash.	123	85	28	3	3	4	5
Spokane, Wash.	75	58	12	3	2	-	9
Tacoma, Wash.	114	88	12	10	3	1	5
TOTAL	12,874¶	8,772	2,740	805	293	255	931

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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