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National Poison Prevention Week, March 21–27, 2004

March 21–27 is National Poison Prevention Week. This week is organized each year by the National Poison Prevention Week Council, a coalition of national organizations working to prevent poisonings. This year's activities will focus on reducing unintentional poisonings among children by emphasizing the responsibility of parents, grandparents, and other caregivers for preventing poisonings in the home.

In 2002, U.S. poison-control centers reported approximately 2.3 million poisonings (*1*). Approximately 90% of these occurred in the home and involved common household items (e.g., cleaning products, detergents, medicines, vitamins, cosmetics, and plants) (*2*).

As part of promotion efforts for National Poison Prevention Week, the U.S. Consumer Product Safety Commission has issued a poison lookout checklist, which highlights areas of the home that are common sites of unintentional poisonings and how to correct situations that might lead to poisonings. The checklist is available at http://www.cpsc.gov/cpscpub/pubs/383.html.

Additional information about National Poison Prevention Week is available at http://www.poisonprevention.org/main.html and http://www.cdc.gov/injury. The national toll-free telephone number for poison-control centers is 1-800-222-1222.

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Unintentional and Undetermined Poisoning Deaths — 11 States, 1990–2001

During 1990–2001, the death rate from poisoning* in the United States increased 56%, from 5.0 per 100,000 population in 1990 to 7.8 in 2001 (*1*). In 2001, of 22,242 poisoning deaths, 14,078 (63%) were unintentional (*1*). To describe trends in poisoning deaths, state health professionals in 11 states† analyzed vital statistics data for 1990–2001. This report summarizes the results of that analysis, which indicated that increases in state death rates from unintentional and undetermined poisonings varied, but increased by an average of 145%; a total of 89% of poisonings involved drugs and other biologic substances. State public health professionals can use local, state, and national surveillance data to monitor trends in drug misuse and to develop effective interventions that can reduce deaths from drug overdoses.

* Poisoning refers to the damaging physiologic effects of ingestion, inhalation, or other exposure to a range of pharmaceuticals, illicit drugs, and chemicals, including pesticides, heavy metals, gases/vapors, and common household substances, such as bleach and ammonia.

† Colorado, Delaware, Florida, Kentucky, Massachusetts, New Mexico, North Carolina, Oregon, Utah, Washington, and Wisconsin. These 11 states participated in the 1999 State Injury Indicators Report (*2*), a collaborative effort of 26 state health departments, CDC, the Council of State and Territorial Epidemiologists, and the State and Territorial Injury Prevention Directors Association, which noted an increase in poisoning deaths.

INSIDE

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Overall poisoning death rates per 100,000 population and sex-, age-, and intent-specific death rates were calculated. Trends were examined for the following categories[§]: 1) all poisonings, 2) unintentional poisonings, 3) suicides, 4) homicides, and 5) poisonings of undetermined intent. Poisoning deaths might be classified as of undetermined intent if the medical examiner or coroner lacked sufficient evidence to determine whether the death was unintentional, suicide, or homicide. Unintentional and undetermined subcategories were combined for most of the analyses. States with low poisoning death rates because of undetermined intent had high unintentional poisoning death rates and vice versa because intent coding practices varied by state.

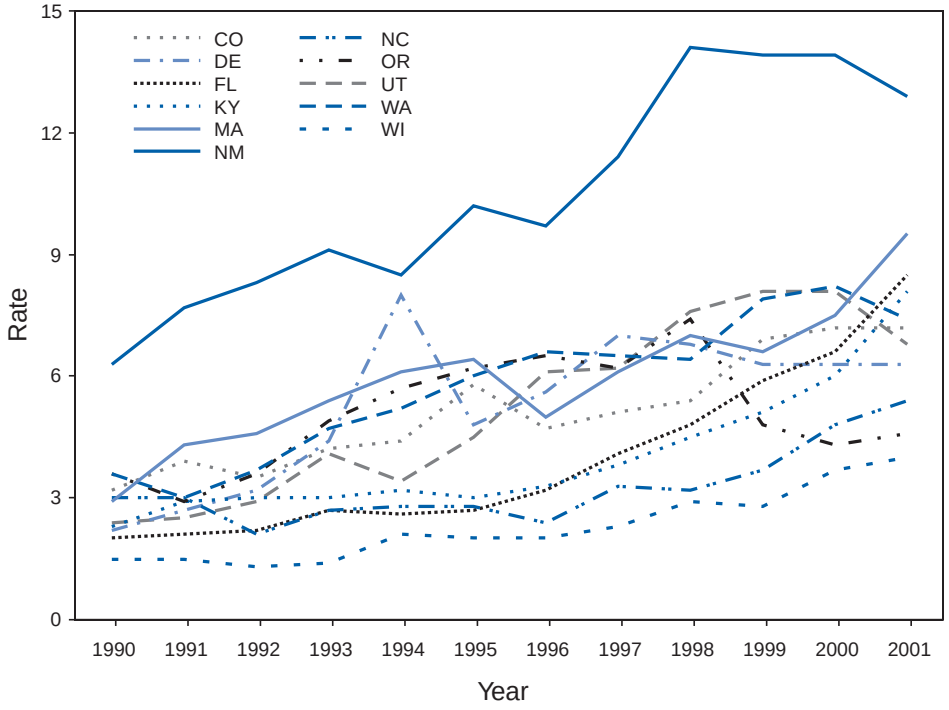
Of the 11 states, eight[¶] had multiple cause-of-death data for 1999 and 2000 to identify the specific substances or classes of substances involved in poisoning deaths in their states. To analyze these data, codes were used from *International Classification of Diseases and Related Health Problems, Tenth Revision* (ICD-10), which was implemented in 1999. ICD-10 contains specific information about substances and classes of substances in codes T36–T50 (i.e., poisoning by drugs, medications, and biologic substances). Because more than one T-code was reported for deaths for which multiple substances were implicated, the percentages reported for specific substances represent each substance as a percentage of all identified T-codes.

During 1990–2001, death rates attributed to unintentional and undetermined poisoning increased in all 11 states (Figure), with an average increase of 145% (range: 28%–325%); poisoning homicide rates were stable, and poisoning suicide rates declined. Nine states (Colorado, Delaware, Florida, Kentucky, New Mexico, North Carolina, Oregon, Washington, and Wisconsin) reported increases in unintentional poisoning deaths; Massachusetts and Utah reported increases in undetermined poisoning deaths. The largest percentage increases in poisoning deaths were in Florida (325%), Kentucky (252%), and Massachusetts (228%). In Colorado (125%), Massachusetts, and Washington (108%), death rates began to increase during 1991–1992. The death rates in Florida, Kentucky, North Carolina (80%), and Wisconsin (123%) were stable during 1990–1996 but increased thereafter. In contrast,

[§] Categorized on the basis of the following codes: **all poisonings:** *International Classification of Diseases, Ninth Revision* (ICD-9), E850–E869, E950–E952, E962, E980–E982, E972; *International Classification of Diseases and Related Health Problems, Tenth Revision* (ICD-10), X40–X49, X60–X69, X85–X90, Y10–Y19, Y35.2; **unintentional poisonings:** (ICD-9), E850–E869; (ICD-10), X40–X49; **suicides:** (ICD-9), E950–E952; (ICD-10), X60–X69; **homicides:** (ICD-9), E962; (ICD-10), X85–X90; and **poisonings of undetermined intent:** (ICD-9), E980–E982; (ICD-10), Y10–Y19.

[¶] Colorado, Florida, Kentucky, Massachusetts, North Carolina, Utah, Washington, and Wisconsin.

FIGURE. Death rates* for unintentional and undetermined poisonings, by year and state — 11 states†, 1990–2001



* Per 100,000 population.
† Colorado (CO), Delaware (DE), Florida (FL), Kentucky (KY), Massachusetts (MA), New Mexico (NM), North Carolina (NC), Oregon (OR), Utah (UT), Washington (WA), and Wisconsin (WI).

the rates in Delaware (186%), New Mexico (105%), Oregon (28%), and Utah (183%) increased substantially during 1990–1998, but declined thereafter.

During 1990–2001, in all 11 states, the increases in unintentional and undetermined poisoning death rates were greatest for persons aged 45–54 years (average increase: 359%; range: 139%–710%) and persons aged 35–44 years (average increase: 195%; range: 14%–910%). Among persons aged ≥65 years, the rate declined an average of 28%. Sex-specific unintentional and undetermined poisoning death rates also increased for males (average increase: 126%; range: 11%–339%) and females (average increase: 203%; range: 95%–486%).

Narcotics and psychodysleptics accounted for 51% of all poisoning deaths. In the eight states that examined T-code frequencies, the substances associated most frequently with unintentional and undetermined poisoning deaths were cocaine (15% of all identified T-codes), alcohol (8%), heroin (7%), antidepressants (5%), benzodiazepines (5%), and methadone (5%). However, the proportion of deaths for which these substances were listed varied substantially by state (Table). Nonspecific categories, such as "other opioids" (e.g., codeine, morphine, oxycodone, and hydrocodone), "other synthetic narcotics," "other and unspecified narcotics," and "other and unspecified drugs, medicaments, and biological substances" accounted for approximately half of all the documented substances associated with unintentional and undetermined poisoning deaths.

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Editorial Note: The findings in this report indicate that in these 11 states the unintentional and undetermined poisoning death rate increased during 1990–2001 and that the types of substances associated with these deaths varied by state. Among U.S. adults, drug overdoses are the largest cause of poisoning deaths. In 1992, the total cost of medical spending for all poisoning treatment was approximately $3 billion, an average of $925 per case (*3*). Unintentional drug overdose deaths often are caused by the misuse of multiple drugs, leaving substantial uncertainty about the contribution of each drug to the death. Illicit drugs (e.g., cocaine and heroin) have been known to cause unintentional poisoning deaths. In certain states, the misuse of prescription drugs (e.g., pain-management opioids such as oxycodone HCI with acetaminophen, hydrocodone with acetaminophen, and methadone) has contributed to the increase in deaths from unintentional poisoning (*4*).

The findings in this report are subject to at least four limitations. First, because external cause-of-injury codes used to

TABLE. Number and percentage* of selected substances identified from *International Classification of Diseases and Related Health Problems, Tenth Revision* (ICD-10) T-codes involved in unintentional or undetermined poisoning deaths, by state — eight states†, 1999–2000

Category	ICD-10 codes	Colorado		Florida		Kentucky		Massachusetts	
		No.	(%)	No.	(%)	No.	(%)	No.	(%)
Total no. poisoning deaths		**628**		**1,939**		**443**		**918**	
Total no. T-codes identified (T36–T65)	**T36–T65**	**1,145**		**3,819**		**867**		**1,192**	
Poisoning by drugs, medicaments, and biological substances	T36–T50	972	(84.9)	3,542	(92.7)	747	(86.2)	1,143	(95.9)
Systemic antibiotics	T36	0	—	0	—	0	—	0	—
Other systemic antiinfectives and antiparasitics	T37	1	(0.1)	0	—	0	—	0	—
Hormones and their synthetic substitutes and antagonists, not elsewhere classified (NEC)	T38	7	(0.6)	5	(0.1)	0	(0.0)	1	(0.1)
Nonopioid analgesics, antipyretics, and antirheumatics	T39	12	(1.0)	75	(2.0)	26	(3.0)	9	(0.8)
Narcotics and psychodysleptics (hallucinogens)	T40	510	(44.5)	1,585	(41.5)	232	(26.8)	966	(81.0)
Heroin	T40.1	78	(6.8)	321	(8.4)	2	(0.2)	24	(2.0)
Other opioids	T40.2	79	(6.9)	449	(11.8)	92	(10.6)	45	(3.8)
Methadone	T40.3	29	(2.5)	123	(3.2)	41	(4.7)	18	(1.5)
Other synthetic narcotics	T40.4	32	(2.8)	135	(3.5)	12	(1.4)	17	(1.4)
Cocaine	T40.5	169	(14.8)	426	(11.2)	38	(4.4)	309	(25.9)
Other and unspecified narcotics	T40.6	118	(10.3)	122	(3.2)	45	(5.2)	553	(46.4)
Anaesthetics and therapeutic gases	T41	2	(0.2)	15	(0.4)	1	(0.1)	0	—
Antiepileptic, sedative-hypnotic, and antiparkinson drugs	T42	52	(4.5)	249	(6.5)	56	(6.5)	27	(2.3)
Barbiturates	T42.3	7	(0.6)	23	(0.6)	2	(0.2)	5	(0.4)
Benzodiazepines	T42.4	38	(3.3)	185	(4.8)	51	(5.9)	19	(1.6)
Other antiepileptic and sedative-hypnotic drugs	T42.6	2	(0.2)	4	(0.1)	0	—	1	(0.1)
Antiparkinsonism drugs and other central muscle tone depressants	T42.8	2	(0.2)	33	(0.9)	1	(0.1)	2	(0.2)
Psychotropic drugs, NEC	T43	92	(8.0)	236	(6.2)	63	(7.3)	48	(4.0)
Tricyclic and tetracyclic antidepressants	T43.0	34	(3.0)	85	(2.2)	29	(3.3)	38	(3.2)
Drugs primarily affecting the autonomic nervous system	T44	2	(0.2)	6	(0.2)	0	—	0	—
Primarily systemic and haematological agents, NEC	T45	9	(0.8)	50	(1.3)	9	(1.0)	3	(0.3)
Agents primarily affecting the cardiovascular system	T46	9	(0.8)	27	(0.7)	8	(0.9)	6	(0.5)
Agents primarily affecting the gastrointestinal system	T47	0	—	0	—	0	—	0	—
Agents primarily acting on smooth, skeletal muscle and respiratory system	T48	3	(0.3)	3	(0.1)	3	(0.3)	2	(0.2)
Topical agents primarily affecting skin, mucous membrane	T49	0	—	6	(0.2)	0	—	0	—
Diuretics and other and unspecified drugs, medicaments, and biological substances	T50	273	(23.8)	1,285	(33.6)	349	(40.3)	81	(6.8)
Other and unspecified drugs, medicaments, and biological substances	T50.9	271	(23.7)	1,275	(33.4)	345	(39.8)	81	(6.8)
Toxic effects of substances: chiefly nonmedicinal source	T51–T65	173	(15.1)	277	(7.3)	120	(13.8)	49	(4.1)
Alcohol	T51	134	(11.7)	201	(5.3)	62	(7.2)	27	(2.3)
Carbon monoxide	T58	25	(2.2)	35	(0.9)	32	(3.7)	13	(1.1)
Other gases, fumes, and vapors	T59	3	(0.3)	20	(0.5)	17	(2.0)	4	(0.3)

* Percentages represent each substance as a percentage of all T-codes identified.
† Colorado, Florida, Kentucky, Massachusetts, North Carolina, Utah, Washington, and Wisconsin.

classify underlying causes of death often do not provide sufficient information to identify the particular substances to which a victim was exposed, T-codes were used to identify specific substances that contributed to death (*5*). However, approximately half of the substances identified by T-codes on the death certificates were nonspecific, including 27% classified only as "other and unspecified drugs, medicaments and biological substances." This lack of specificity could reflect limited information provided on the death certificate rather than deficiency in the T-codes. Second, analyses based on T-codes also are limited because the underlying causal agent in deaths involving multiple drugs cannot be identified. Third, these data are state specific and might not be representative of the entire United States; death certificate reporting practices might differ both within and among states. Finally, the poisoning death trends presented in this report should be interpreted with caution because the analysis spans two revisions of the ICD (ICD-9 and ICD-10), and the two classification systems do not always produce comparable figures (*6*).

Key risk factors for drug overdose deaths include multidrug misuse and recent abstinence from substance abuse (*7,8*). Interventions directed at providing assistance to overdose

TABLE. (*Continued*) Number and percentage* of selected substances identified from *International Classification of Diseases and Related Health Problems, Tenth Revision* (ICD-10) T-codes involved in unintentional or undetermined poisoning deaths, by state — eight states†, 1999–2000

Category	North Carolina		Utah		Washington		Wisconsin		Total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Total no. poisoning deaths	**687**		**359**		**965**		**384**		**6,323**	
Total no. T-codes identified (T36–T65)	**913**		**793**		**1,157**		**670**		**10,556**	
Poisoning by drugs, medicaments, and biological substances	767	(84.0)	732	(92.3)	928	(80.2)	584	(87.2)	**9,415**	**(89.2)**
Systemic antibiotics	1	(0.1)	0	—	0	—	0	—	**1**	**(0.0)**
Other systemic antiinfectives and antiparasitics	0	—	1	(0.1)	2	(0.2)	1	(0.1)	**4**	**(0.0)**
Hormones and their synthetic substitutes and antagonists, NEC	4	(0.4)	0	—	4	(0.3)	1	(0.1)	**22**	**(0.2)**
Nonopioid analgesics, antipyretics, and antirheumatics	19	(2.1)	8	(1.0)	44	(3.8)	15	(2.2)	**208**	**(2.0)**
Narcotics and psychodysleptics (hallucinogens)	528	(57.8)	480	(60.5)	751	(64.9)	286	(42.7)	**5,338**	**(50.6)**
Heroin	80	(8.8)	85	(10.7)	114	(9.9)	49	(7.3)	**753**	**(7.1)**
Other opioids	121	(13.3)	177	(22.3)	162	(14.0)	69	(10.3)	**1,194**	**(11.3)**
Methadone	112	(12.3)	45	(5.7)	115	(9.9)	27	(4.0)	**510**	**(4.8)**
Other synthetic narcotics	49	(5.4)	12	(1.5)	41	(3.5)	32	(4.8)	**330**	**(3.1)**
Cocaine	151	(16.5)	136	(17.2)	280	(24.2)	98	(14.6)	**1,607**	**(15.2)**
Other and unspecified narcotics	15	(1.6)	25	(3.2)	351	(30.3)	9	(1.3)	**1,238**	**(11.7)**
Anaesthetics and therapeutic gases	3	(0.3)	0	—	1	(0.1)	2	(0.3)	**22**	**(0.2)**
Antiepileptic, sedative-hypnotic, and antiparkinson drugs	49	(5.4)	32	(4.0)	123	(10.6)	53	(7.9)	**641**	**(6.1)**
Barbiturates	7	(0.8)	3	(0.4)	12	(1.0)	2	(0.3)	**61**	**(0.6)**
Benzodiazepines	31	(3.4)	17	(2.1)	92	(8.0)	39	(5.8)	**472**	**(4.5)**
Other antiepileptic and sedative-hypnotic drugs	6	(0.7)	3	(0.4)	8	(0.7)	3	(0.4)	**25**	**(0.2)**
Antiparkinsonism drugs and other central muscle-tone depressants	3	(0.3)	7	(0.9)	18	(1.6)	6	(0.9)	**70**	**(0.7)**
Psychotropic drugs, NEC	35	(3.8)	46	(5.8)	288	(24.9)	55	(8.2)	**863**	**(8.2)**
Tricyclic and tetracyclic antidepressants	18	(2.0)	7	(0.9)	106	(9.2)	23	(3.4)	**340**	**(3.2)**
Drugs primarily affecting the autonomic nervous system	3	(0.3)	3	(0.4)	9	(0.8)	5	(0.7)	**26**	**(0.2)**
Primarily systemic and haematological agents, NEC	19	(2.1)	7	(0.9)	41	(3.5)	14	(2.1)	**152**	**(1.4)**
Agents primarily affecting the cardiovascular system	13	(1.4)	1	(0.1)	16	(1.4)	11	(1.6)	**91**	**(0.9)**
Agents primarily affecting the gastrointestinal system	0	—	0	—	1	(0.1)	0	—	**1**	**(0.0)**
Agents primarily acting on smooth, skeletal muscle and respiratory system	4	(0.4)	2	(0.3)	4	(0.3)	11	(1.6)	**32**	**(0.3)**
Topical agents primarily affecting skin, mucous membrane	3	(0.3)	2	(0.3)	2	(0.2)	1	(0.1)	**14**	**(0.1)**
Diuretics and other and unspecified drugs, medicaments, and biological substances	86	(9.4)	150	(18.9)	478	(41.3)	129	(19.3)	**2,831**	**(26.8)**
Other and unspecified drugs, medicaments, and biological substances	85	(9.3)	149	(18.8)	478	(41.3)	129	(19.3)	**2,813**	**(26.6)**
Toxic effects of substances: chiefly nonmedicinal source	146	(16.0)	61	(7.7)	229	(19.8)	86	(12.8)	**1,141**	**(10.8)**
Alcohol	97	(10.6)	40	(5.0)	202	(17.5)	36	(5.4)	**799**	**(7.6)**
Carbon monoxide	28	(3.1)	10	(1.3)	18	(1.6)	37	(5.5)	**198**	**(1.9)**
Other gases, fumes, and vapors	9	(1.0)	7	(0.9)	6	(0.5)	5	(0.7)	**71**	**(0.7)**

patients could include using naloxone, teaching rescue breathing, and encouraging use of 911 to obtain emergency medical services. However, preventing these deaths is a complex challenge that might require a combination of psychological, behavioral, educational, and medical interventions.

States in this study reported different mortality profiles for different substances, suggesting that local surveillance data are needed to help guide prevention efforts. Understanding distribution patterns of medications and illicit drugs in each state, the circumstances of their use (e.g., while alone or with others who could intervene), and the factors that contribute to increased use (e.g., chronic pain, substance abuse, or mental illness) also could help in developing effective public health strategies. Public health professionals should engage the help of others (e.g., substance abuse and mental health workers, law enforcement officials, medical examiners, and physicians) to reduce use of illicit drugs and misuse of prescription drugs, particularly opioids prescribed for pain management (*9,10*).

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Progress Toward Poliomyelitis Eradication — India, 2003

Since the World Health Assembly resolved in May 1988 to eradicate poliomyelitis, the estimated global incidence of polio has decreased >99%, and three World Health Organization (WHO) regions (Americas, Western Pacific, and European) have been certified as polio-free (*1*). Since 1994, when the countries of the WHO South-East Asia Region (SEAR)* began accelerating polio-eradication activities, substantial progress toward that goal has been made (*2–4*). By 2001, poliovirus circulation in India had been limited primarily to the two northern states of Uttar Pradesh and Bihar, with 268 cases reported nationwide. However, a major resurgence of polio occurred during 2002, with 1,600 cases detected nationwide, of which 1,363 (85%) were in Uttar Pradesh and Bihar (*5*). This report summarizes the status of polio eradica-

* Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Mongolia, Myanmar, Nepal, Sri Lanka, and Thailand.

tion activities in India during 2003 and describes the actions being taken to reduce poliovirus transmission.

Acute Flaccid Paralysis Surveillance

In 2003, a network of 248 trained surveillance medical officers (SMOs) assisted local health authorities at the district or subdistrict level with acute flaccid paralysis (AFP) surveillance. Since 2000, India has exceeded the WHO-established AFP surveillance quality targets (i.e., nonpolio AFP rate of ≥1 per 100,000 population aged <15 years and adequate stool specimens[†] collected from ≥80% of persons with AFP) (Table). However, during 2003, the nonpolio AFP rate was <1 per 100,000 in seven small states (Chandigarh, Dadra and Nagar Haveli, Lakshadweep, Manipur, Mizoram, Nagaland, and Tripura) with approximately 1% of India's total population, and inadequate (70%–80%) stool specimen collection was reported in 11 states (Bihar, Chhattisgarh, Dadra and Nagar Haveli, Daman and Diu, Delhi, Lakshadweep, Madhya Pradesh, Mizoram, Sikkim, Uttaranchal, and Uttar Pradesh) with approximately 35% of India's total population.

Wild Poliovirus Incidence

During 2003, a total of 225 wild poliovirus (WPV) cases were reported[§] from India, a substantial decrease from the 1,600 cases reported in 2002 (Table). Of these 225 cases, 203 (90%) were WPV type 1 (P1), and 22 (10%) were WPV type 3 (P3). During 2003, incidence decreased substantially in the three states that had the highest number of cases in 2002: from 1,242 to 88 in Uttar Pradesh, from 121 to 18 in Bihar, and from 49 to 28 in West Bengal. However, new foci of disease were reported in the southern Indian states of Karnataka (36), Andhra Pradesh (21), and Tamil Nadu (two), each of which had reported no polio cases for ≥2 years. Cases were reported from 88 (15%) of 587 districts nationwide, compared with 159 districts (27%) in 2002 (Figure 1). P3 circulation occurred primarily in Uttar Pradesh (16 [73%] cases). Of the 88 cases in Uttar Pradesh that were confirmed virologically, 60 (68%) occurred in minority populations, which constitute approximately 17% of the state's total population.

During 2002–2003, the number of circulating genetic lineages of WPV remained constant for P1 (n = three) and P3 (n = four). All lineages circulating in India in 2003 were derived from strains that circulated in Uttar Pradesh during 2000–2001.

Vaccination Coverage

During 2002, approximately 68% of infants aged <1 year received ≥3 doses of oral poliovirus vaccine (OPV) through routine vaccination. Substantial variations by state were found in routine coverage with 3 doses of OPV (OPV3), ranging from 21% in Bihar to 99% in Madhya Pradesh; OPV3 coverage through routine vaccination in Uttar Pradesh was estimated to be 41% (*6*).

Since 1995, biannual national immunization days (NIDs)[¶] that use fixed-site vaccination posts to administer OPV have been conducted to supplement routine vaccination and interrupt transmission of WPV. During 1999, supplementary immunization activities (SIAs) were intensified with the addition of house-to-house vaccination after an initial day of fixed-site activities. During 1999–2002, the number of large-scale NIDs and subnational immunization days (SNIDs)** conducted in India decreased, from six during October 1999–March 2000 to four during 2000–2001 and three during 2001–2002 (Figure 2). During 2002–2003, two NIDs and four large SNIDs (the latter targeting 60–70 million children during each round) were conducted. In addition, monitoring of SIA quality was enhanced by the introduction of new vac-

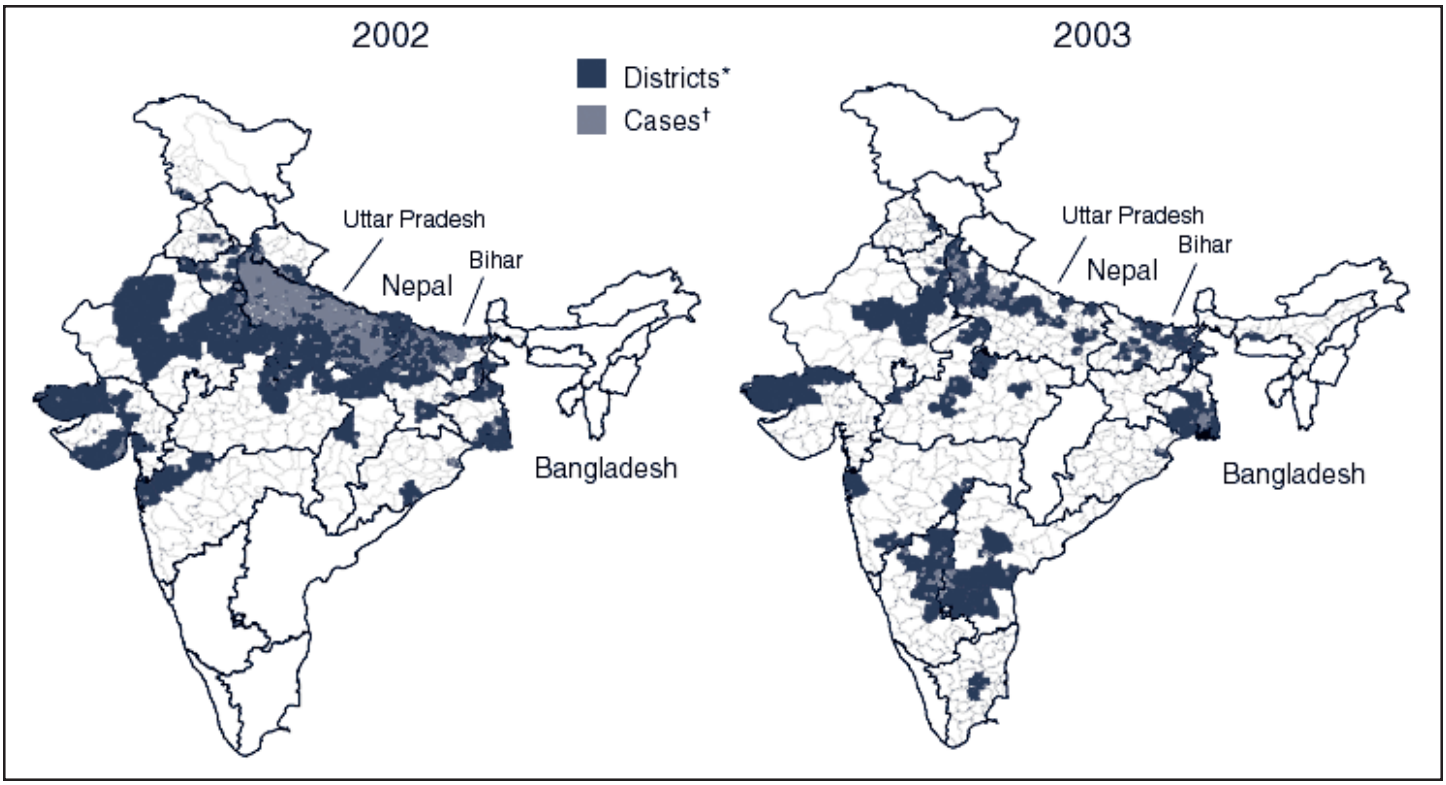
[†] Two specimens collected ≥24 hours apart, both within 14 days of paralysis onset and shipped properly to the laboratory.
[§] Data as of February 28, 2004.
[¶] Nationwide mass campaigns during a short period (days to weeks) in which 2 doses of OPV are administered to all children (usually aged <5 years), regardless of previous vaccination history, with an interval of 4–6 weeks between doses.
** Mass campaigns same as NIDs but limited to parts of a country.

TABLE. Number of reported cases of acute flaccid paralysis (AFP) and number of confirmed poliomyelitis cases, by key surveillance indicators, location, and year — India, 2002–2003*

Location	No. AFP cases		Nonpolio AFP rate[†]		% persons with AFP with adequate specimens		No. laboratory-confirmed wild poliovirus cases	
	2002	2003	2002	2003	2002	2003	2002	2003
India	9,705	8,539	1.87	1.90	82	81	1,600	225
Uttar Pradesh (UP)	3,515	2,027	2.72	2.47	79	78	1,242	88
Western UP	*1,557*	*770*	*3.01*	*2.54*	*75*	*75*	*626*	*74*
Eastern/Central UP	*1,958*	*1,257*	*2.57*	*2.44*	*82*	*79*	*616*	*14*
Bihar	874	828	1.94	2.05	76	70	121	18

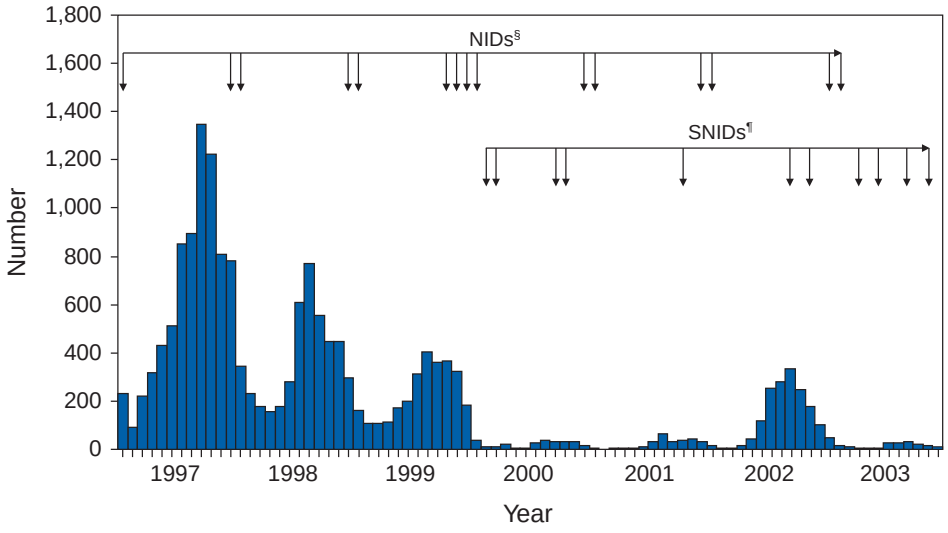
* As of February 28, 2004.
† Per 100,000 population aged <15 years.

FIGURE 1. Districts with wild poliovirus — India, 2002–2003



* Number of districts was 159 in 2002 and 88 in 2003.
† Number of cases was 1,600 in 2002 and 225 in 2003.

FIGURE 2. Number of cases* of poliomyelitis, by month and year — India, January 1997–December 2003†



* Adjusted for surveillance sensitivity of 10% before June 1997; per nonpolio acute flaccid paralysis rate after June 1997.
† As of February 28, 2004.
§ National Immunization Days.
¶ Subnational Immunization Days.

cinator data-collection forms and standardized independent observer checklists. Data were analyzed to identify areas of programmatic weakness and to focus attention on specific districts and blocks with deficiencies in SIA quality.

In Uttar Pradesh and Bihar, vaccination coverage data for AFP cases that were not caused by polioviruses indicate that OPV coverage improved substantially during 2002–2003. The proportion of children aged 6–59 months with nonpolio AFP who had ≤3 OPV doses (routine or supplemental) decreased from 20% to 6% in western Uttar Pradesh and from 17% to 7% in Bihar. However, during the same period, the proportion of such children increased to >23% in eastern Karnataka and to 10% in Andhra Pradesh.

Reported by: *Ministry of Health and Family Welfare, Government of India; National Polio Surveillance Project, World Health Organi-*

zation, India; Dept of Immunization and Vaccine Development, World Health Organization, Regional Office for South-East Asia, New Delhi, India. Dept of Immunization, Vaccines and Biologicals, World Health Organization, Geneva, Switzerland. Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; Global Immunization Div, National Immunization Program, CDC.

Editorial Note: India, the only remaining country in SEAR with ongoing indigenous WPV transmission, made major progress toward elimination of WPV in 2003. The 225 cases reported in 2003 represent the lowest annual number of polio cases in India's history, and the two states (Uttar Pradesh and Bihar) that have accounted for the majority of polio cases in India reported the lowest number of cases ever. The increased number and quality of SIAs and expanded social mobilization activities improved the immunity status of the population in every state in which these actions were taken, leading to a decline in disease rates.

Although several cases were reported early in 2003 in Delhi, Gujarat, Haryana, and Rajasthan, no cases were reported from these states during July–December, suggesting cessation of WPV transmission in these areas. The outbreak of disease in the south in 2003 was attributable to an increasing proportion of children with ≤3 doses of OPV, which allowed spread of WPV once introduced. With intensified SIAs, these states should become polio-free again.

All cases of paralytic polio reported in India during 2003 were caused by lineages traceable to WPVs circulating in western Uttar Pradesh, which remains the source of polio that has been introduced to areas of the country that had been polio-free for several months or years. Although cases were reported during 2003 from 16 (46%) of India's 35 states, Uttar Pradesh alone had sustained transmission throughout the year. The elimination of these reservoirs of poliovirus is critical to the success of polio eradication in India.

In areas where SIA numbers and quality were enhanced in 2003, OPV coverage increased. OPV coverage also increased among minority populations, reflecting efforts made to address operational and social mobilization gaps. However, in several states in the south where additional SIAs were not conducted, vulnerability to infection with WPV increased. During July–December 2003, large mop-up vaccination campaigns were conducted; the impact of these SIAs will be evaluated by using data on nonpolio AFP cases collected during the next 3 months.

During January–May 2004, three NIDs and one SNID are planned. These SIAs will be followed by intensive mop-up activities for any cases identified after April, with two additional NIDs planned for the fall. Each NID will target approximately 165 million children, and each SNID will target approximately 100 million children. Statewide AFP surveillance reviews initiated systematically in 2003 will continue, and the results will be used to fill any remaining gaps in surveillance, ensuring detection of any WPV transmission so that mop-up vaccination can be initiated rapidly. The government of India, WHO, United Nations Children's Fund (UNICEF), Rotary International, CDC, and other partners are providing increased support for this effort through additional personnel and funding.

Because of its population size, its geographic location, and the ongoing threat of importation of WPV into polio-free countries, eliminating polio from India is the greatest challenge facing the global polio-eradication effort. With fewer cases reported in 2003 than ever before during the traditional high season (June–December), India is close to eliminating WPV transmission nationally. For this effort to succeed in 2004, sustained and effective commitment of national and state governments is required, along with continued support by India's major international partners.

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Osteomyelitis/Septic Arthritis Caused by *Kingella kingae* Among Day Care Attendees — Minnesota, 2003

Kingella kingae is a fastidious gram-negative coccobacillus that colonizes the respiratory and oropharyngeal tract in children. *K. kingae* occasionally causes invasive disease, primarily osteomyelitis/septic arthritis in young children, bacteremia in infants, and endocarditis in school-aged children and adults (*1–8*). Although diagnosis of this organism frequently is missed, invasive disease is uncommon. Only sporadic, non-epidemiologically linked cases have been reported previously. In October 2003, the Minnesota Department of Health (MDH) investigated a cluster of two confirmed cases and one probable case of osteomyelitis/septic arthritis caused by *K. kingae* among children aged 17–21 months attending the

same toddler classroom in a day care center. All reported within the same week with onset of fever, preceding or concurrent upper respiratory illness (URI), and refusal to bear weight on the affected limb. This report summarizes these cases and describes the epidemiologic investigation of the day care center. The findings underscore the need for clinicians and laboratorians to consider *K. kingae* infection in young children with Gram stain–negative or culture-negative skeletal infections.

Case Reports

Case 1. In mid-October 2003, a boy aged 21 months was taken to his pediatrician after 6 days of worsening limp. He had a history of prematurity (32 weeks' gestation), reflux disease, reactive-airway disease, and eczema, but was otherwise healthy with no history of recent antibiotic use. Nine days before, he had an isolated temperature reaching 103° F (39.4° C), which resolved with acetaminophen. His white blood cell (WBC) count and erythrocyte sedimentation rate (ESR) were normal. A right hip radiograph showed an abnormality in the proximal femur, which was diagnosed as a possible fracture. The patient's limp deteriorated to a crawl, and he underwent surgery 7 days after the initial examination. Femoral neck osteomyelitis and hip septic arthritis were diagnosed. At the time of surgery, his WBC count and ESR were elevated (17,200 cells/mm^3 and 51 mm/hr, respectively [normal ranges: 6,000–17,000 cells/mm^3 and 0–10 mm/hr, respectively]) and C-reactive protein (CRP) was normal (<0.5 mg/dL). Gram stain of synovial fluid showed several WBCs but no organisms; synovial fluid and bone cultures were positive for *K. kingae* 5 days later.

Case 2. In mid-October, a previously healthy girl aged 20 months who had completed a 14-day course of amoxicillin/clavulanic acid for otitis media in early October was reported with irritability, refusal to bear weight on her right foot, and a warm right ankle. During the next few days, she had a temperature reaching 101.6° F (38.7° C), and her right ankle became swollen and red. An MRI revealed fluid in her ankle joint. She had a normal WBC count and slightly elevated ESR (38 mm/hr). Three days later, she underwent surgery for ankle and subtalar septic arthritis. Gram stain of synovial fluid was negative, but *K. kingae* was identified from culture 4–5 days later.

Case 3. In mid-October, a previously healthy boy aged 17 months with recent but transient neutropenia related to viral illness, was taken to the emergency department with irritability, a limp of 2 days' duration, and a temperature of 102° F (38.9° C). His right ankle was moderately warm and swollen, and radiographs were normal. His WBC was high-normal (12,500 cells/mm^3), and his CRP was slightly elevated (1.27 mg/dL). He had synovitis and otitis media diagnosed and was administered a 7-day course of oral amoxicillin. Although his clinical status improved, he continued to limp after foot manipulation; MRI of his right ankle 16 days later revealed evidence of distal tibial osteomyelitis. No specimens were obtained.

Investigation

The day care staff members were interviewed, and a site visit was performed; absentee, illness, and biting records were examined. No obvious outbreak source was identified, and no unusual practices or behaviors were noted that could explain this cluster of illnesses. Oropharyngeal cultures were obtained from center staff and from children aged 0–5 years to assess *K. kingae* colonization. Of 122 children, 115 (94%) were cultured; 16 (14%) children were colonized with *K. kingae*. The highest prevalence occurred in the toddler class (nine [45%] of 20 tested positive; patients 1–3 tested negative, but all had received antibiotics). The remaining seven colonized children were distributed among four classes of older children; two were siblings of colonized children in the toddler class. No staff or children aged <16 months were colonized.

Pulsed-field gel electrophoresis (PFGE) of the *K. kingae* isolates from the two confirmed patients and from 15 of the 16 colonized children (nine toddlers and six from older classes) demonstrated indistinguishable PFGE patterns. Antimicrobial susceptibility testing revealed a minimum inhibitory concentration (MIC) of 0.047–0.125 μg/mL to rifampin and a MIC of 0.004–0.047 μg/mL to penicillin.

All children (n = 20) and staff (n = six) in the toddler classroom received a prophylactic 2-day course of rifampin, and oropharyngeal cultures were collected again 10–14 days later. Of the nine toddlers colonized originally, three (33%) remained positive on reculture. An additional toddler, who was initially culture-negative, was positive for *K. kingae* on reculture.

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Editorial Note: This report describes the first reported cluster of epidemiologically linked cases of invasive *K. kingae* disease. The high incidence in the toddler class and the matching PFGE pattern are consistent with child-to-child transmission. This report also describes the first reported attempt to use rifampin to eliminate *K. kingae* carriage; this attempt proved to be moderately effective.

K. kingae constitutes part of the normal respiratory flora in children but can cause isolated cases of invasive disease, primarily osteomyelitis/septic arthritis (65%–75% of cases) in young children and bacteremia (20%–30% of cases) in infants (*1,2,7,8*). The majority of children who have invasive disease are previously healthy without immunosuppressive conditions; >90% are aged <2 years (*1,2,5–8*).

Invasive disease is associated frequently with concomitant or precedent URI or stomatitis (*3,4*); disrupted respiratory or buccal mucosa might facilitate bacterial invasion and hematogenous dissemination. Biting might be an alternative means of introducing oropharyngeal pathogens into the bloodstream.

The presence of *K. kingae* is difficult to detect without immediate clinical suspicion. Gram stain of synovial fluid shows WBCs but frequently is negative for organisms. Recovery of the organism in culture is difficult because of its fastidious nature, and might require laboratories to hold culture plates for up to 7 days. For cases described in this report, cultures were held longer than routine laboratory protocol recommends (usually 3 days) because an atypical organism was suspected. Studies of cases in Israel indicate that 40%–50% of culture-negative septic arthritis cases in children aged <2 years might be attributable to *K. kingae* (*5,8*). Inoculating synovial fluid or bony exudates directly into blood-culture bottles with a continuous monitoring system increases the rate of *K. kingae* recovery substantially, compared with direct plating of specimens on solid media (*5,8*). The increased awareness and enhanced capability of laboratories to isolate this organism might lead to an observed increase in incidence of *K. kingae* invasive disease.

Although limited data are available about the epidemiology and transmission of *K. kingae*, the organism most likely is transmitted through respiratory secretions and saliva. In one study of an Israeli day care center, the monthly prevalence of *K. kingae* colonization ranged from 6% to 35%, and approximately 70% of children were colonized at some point during the 11-month study period. No invasive disease was observed (*9*). Subtyping by PFGE, immunoblotting, and ribotyping of the isolates demonstrated that children were colonized continuously, or intermittently with different subtypes over weeks to months. Two distinct subtypes with temporal clustering represented approximately 75% of the isolates (*10*). In comparison, a cohort of epidemiologically unrelated cases showed substantially more subtype variability (*10*). These findings suggest person-to-person transmission within the facility.

The pattern of colonization and invasive disease described in this report is consistent with previous studies. The indistinguishable PFGE pattern of the isolates further indicates the person-to-person mode of *K. kingae* transmission among children who attend day care centers. The incidence of invasive disease was exceptionally high among these children. Further examination into potential risk factors and DNA sequencing of the day care *K. kingae* isolates are being conducted by MDH.

The findings in this report underscore the need for clinicians to suspect infection with *K. kingae* and other atypical organisms in young children with Gram stain–negative or culture-negative skeletal infections and for laboratorians to perform appropriate laboratory diagnostic testing. The use of blood-culture bottles for inoculation and cultivation of synovial fluid/bone tissue and the incubation of culture plates for ≥1 week might increase the diagnosis of pediatric skeletal infections attributed to *K. kingae*.

Acknowledgments

This report is based on contributions by P Yagupsky, Clinical Microbiology Laboratory and Pediatric Infectious Disease Unit, Soroka Univ Medical Center, Beer-Sheva, Israel. K Marbin, Gillette Children's Hospital, St. Paul, Minnesota. J Jorgenson, Health Science Center, Univ of Texas-San Antonio, Texas. F Tenover, D Jernigan, Div of Healthcare Quality Promotion; M Fischer, Div of Bacterial and Mycotic Diseases, National Center for Infectious Diseases, CDC.

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Brief Report

Kingella kingae Infections in Children — United States, June 2001–November 2002

Kingella kingae is recognized increasingly as a cause of skeletal infections in children (*1*). Recent studies indicate that direct inoculation of clinical specimens into aerobic blood culture bottles (ABCBs), instead of direct plating of specimens on solid media, might improve recovery of the fastidious bacteria (*2,3*). Prompted by a report of a possible cluster of osteoarticular infections caused by *K. kingae* among children, the Infectious Diseases Society of America Emerging Infections Network (IDSA-EIN) surveyed pediatric infectious disease consultants (PIDCs) about their experiences in diagnosing *K. kingae* and other skeletal infections in children. This report summarizes the findings of that survey, which identified 23 *K. kingae* pediatric cases and indicated that 35% of responding PIDCs did not use ABCBs in diagnosing skeletal infections. Efforts to increase use of ABCBs among clinicians and laboratorians might lead to increased detection of *K. kingae* cases.

In November 2002, a questionnaire was distributed to PIDCs in IDSA-EIN. This query aimed to 1) identify the diagnostic approaches of PIDCs in evaluating skeletal infections in children and 2) determine the number of cases and types of infections attributed to *K. kingae* diagnosed by these physicians during June 2001–November 2002. Of 254 PIDCs surveyed, 156 (61%) responded.

During June 2001–November 2002, PIDCs diagnosed skeletal infections, including septic arthritis, osteomyelitis, diskitis, tenosynovitis, and dactylitis, in 1,908 patients aged <5 years. For these cases, 56 (43%) PIDCs reported no organism found in ≤25% of their cases, 43 (33%) in ≤50% of their cases, and 24 (18%) in >50% of their cases. Eighteen (12%) PIDCs diagnosed 23 cases of *K. kingae* infection: septic arthritis (12), osteomyelitis (nine), endocarditis (one), and bacteremia (one). Median age of patients was 2.3 years (range: 0.5–10.0 years); no *K. kingae* case clusters were reported. At diagnosis, four persons had upper respiratory tract infections, and one had stomatitis.

When diagnosing skeletal infections, the majority (97 [62%]) of PIDCs requested that specimens be inoculated into ABCBs for some (55 [35%]) or all (42 [27%]) of their cases; 55 (35%) PIDCs never made that request. The most common specimens inoculated into ABCBs were synovial fluid (78 [80%]) and bone aspirate (49 [51%]). Of those using ABCBs, 53 (54%) had been making this request for <5 years. Of all respondents, 89 (57%) were aware that use of ABCBs might improve isolation of this organism and subsequent identification. PIDCs reported several barriers to use of ABCBs in diagnosing skeletal infections, including 1) specimens obtained for diagnosis commonly being taken before consulting PIDCs and 2) laboratories being unwilling to perform requested tests.

This survey identified 23 *K. kingae* pediatric cases; the majority (91%) of infections were either septic arthritis or osteomyelitis. When diagnosing skeletal infections, 43% of PIDCs reported that no organism was found in <25% of cases; 38% of PIDCs did not use ABCBs for recovery of *K. kingae*. Several studies have indicated that commercial blood-culture systems improve the recovery of *K. kingae* from synovial fluid (*2,3*). Increased use of ABCBs might reveal *K. kingae* to be a more common cause of skeletal infections. Educational efforts to improve the selection of diagnostic methods for infectious diseases should be targeted not only to infectious disease consultants but also to clinical microbiology laboratorians and those physicians most likely to obtain specimens (e.g., orthopedic surgeons for skeletal infections).

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Brief Report

Imported Measles Case Associated with Nonmedical Vaccine Exemption — Iowa, March 2004

On March 19, this report was posted as an MMWR Dispatch *on the* MMWR *website* (http://www.cdc.gov/mmwr).

On March 13, 2004, the Iowa Department of Public Health (IDPH) reported to CDC that a male student aged 19 years with measles in the infectious stage had flown from New Delhi, India, to Cedar Rapids, Iowa, on March 12. Because of a nonmedical exemption, the student had not received measles-containing vaccine (MCV). This report describes the measles case, the public health response to prevent secondary cases, and the impact on the public health system. Health-care providers and state and local public health departments should be alert to possible cases of measles in persons who traveled with this stu-

dent or their contacts. Parents considering nonmedical exemptions for their children should be aware of the potential risk for disease both for their children and the public.

Measles is a highly infectious acute viral illness that can cause severe pneumonia, diarrhea, encephalitis, and death. Measles is not endemic in the United States because of high levels of vaccine coverage (>90% by age 3 years) (*1*) and the requirement that school-aged children receive 2 doses of MCV (*2*). However, an estimated 745,000 measles deaths occur annually worldwide (*3*), making measles a major vaccine-preventable disease.

The index patient was a member of a group of approximately 28 students and two supervisors from college A in Iowa who had traveled to India, where approximately 52,000 cases of measles were reported in 2002 (*4*). A high percentage of students from college A are reported to be unvaccinated because of nonmedical exemptions. Six measles cases occurred among the students while they were in India. The group had been scheduled to return to the United States on March 7. To avoid potential spread during the prolonged airline flights, IDPH recommended that these six students stay in India for at least 4 days after rash onset (i.e., the period of infectivity). Contacts of these infectious students who lacked immunity for measles were asked to stay in India for 18 days after the last possible exposure. Despite these recommendations, the index patient, who was an unvaccinated contact, returned to the United States early, flying on March 12 from New Delhi through Amsterdam and the Detroit Metro Airport to Cedar Rapids, Iowa. During his travel, he had a cough and conjunctivitis, and within 24 hours of his arrival in Iowa on March 13, he had a rash. A local physician reported the case to IDPH. Subsequently, measles was confirmed serologically, and throat swab and urine specimens were collected for viral isolation.

On March 13, IDPH and the Michigan Department of Community Health (MDCH) issued press releases to alert air passengers, visitors, and employees who had been in the involved airports about their risk for measles exposure and state health advisories to alert physicians and enhance surveillance. On March 18, CDC issued a health advisory recommending that every person who had been on the plane with the student or who had been in one of the involved airports at the same time be evaluated and, if determined to be susceptible, receive MCV or immune globulin according to the recommendations of the Advisory Committee on Immunization Practices (ACIP) (*5*). Measles vaccination clinics were held on March 14 at the office of Linn County Public Health (LCPH) in Iowa and on March 15 in Michigan. Passenger lists were subpoenaed from the airline, and LCPH, IDPH, and MDCH attempted to contact all passengers on flights with the index patient. Other states in which exposed passengers reside also are taking public health measures to control the potential spread of measles.

State and local public health departments should be alert to possible cases of measles in persons who traveled with this student or their contacts. Diagnosis can be confirmed by serologic testing. In addition to serologic (IgM) specimens, throat swabs or urine specimens should be collected for viral isolation.

The occurrence of six cases in this group of students who traveled abroad demonstrates the high transmissibility of measles when susceptible persons are exposed. The majority of states require 2 doses of MCV for children attending school and post-high school educational institutions; however, nonmedical exemptions are permitted in some states. Persons who have chosen a nonmedical exemption from vaccination are >22 times more likely to acquire measles than persons who are vaccinated (*6*). In addition, increases in the number of persons who have chosen to be exempt increase the risk of disease in nonexempt persons (*7*). To reduce the risk of infection among travelers, ACIP recommends that all international travelers be immune to measles because the disease is endemic or epidemic in many parts of the world (*5,8*).

This case demonstrates the importance of following the ACIP recommendations and underscores the impact of nonmedical exemptions on the public health system. Physicians, public health authorities, and school personnel who counsel parents considering nonmedical exemptions for their children should ensure that parents understand the risk that opting out of vaccination places upon their children and the public.

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Notice to Readers

Update: Manufacturer's Recall of Rapid Cartridge Assay Kits on the Basis of False-Positive *Cryptosporidium* Antigen Tests

On March 23, this notice was posted as an MMWR Dispatch *on the* MMWR *website* (http://www.cdc.gov/mmwr).

On March 4, 2004, CDC announced that a manufacturer had voluntarily recalled rapid cartridge assay kits because of false-positive *Cryptosporidium* antigen tests (*1*). An additional lot of a *Cryptosporidium*/*Giardia* rapid assay has been recalled voluntarily from laboratories by the distributor (Meridian Bioscience, Inc., Cincinnati, Ohio) on the basis of their findings that *Cryptosporidium*-negative samples were weakly reactive with this lot (ImmunoCard STAT!®, lot no. 081138 [expires October 5, 2004]). CDC recommends reconfirmation of positive test results (by using direct fluorescent antibody testing or modified acid-fast stained smears) obtained with ImmunoCard STAT!® rapid assays from all recalled lots.

Reference

1. CDC. Manufacturer's recall of rapid cartridge assay kits on the basis of false-positive *Cryptosporidium* antigen tests—Colorado, 2004. MMWR 2004;53:198.

Notice to Readers

Manufacturer's Recall of Nasal Spray Contaminated with *Burkholderia cepacia* Complex

On March 24, this notice was posted as an MMWR Dispatch *on the* MMWR *website* (http://www.cdc.gov/mmwr).

CDC has been notified of a voluntary recall of over-the-counter oxymetazoline HCl 0.05% nasal spray because of intrinsic contamination with *Burkholderia cepacia* complex. The nasal spray is distributed as "Major Twice-A-Day 12 Hour Nasal Spray." The manufacturer (Propharma Inc., Miami, Florida) has recalled lot no. K4496, released in November 2003, with an expiration date of October 2006.

Preliminary molecular epidemiology indicates that isolates related to the strain found in the nasal spray have been recovered from patients in multiple states. Clinicians should be aware that patients using product from this lot number might have been exposed to *B. cepacia* complex. Patients with underlying lung disease (especially cystic fibrosis) might be at increased risk for severe infections with *B. cepacia* complex. Cases of *B. cepacia* complex infection or colonization associated with use of this product should be reported to the local or state health department and CDC, telephone 800-893-0485.

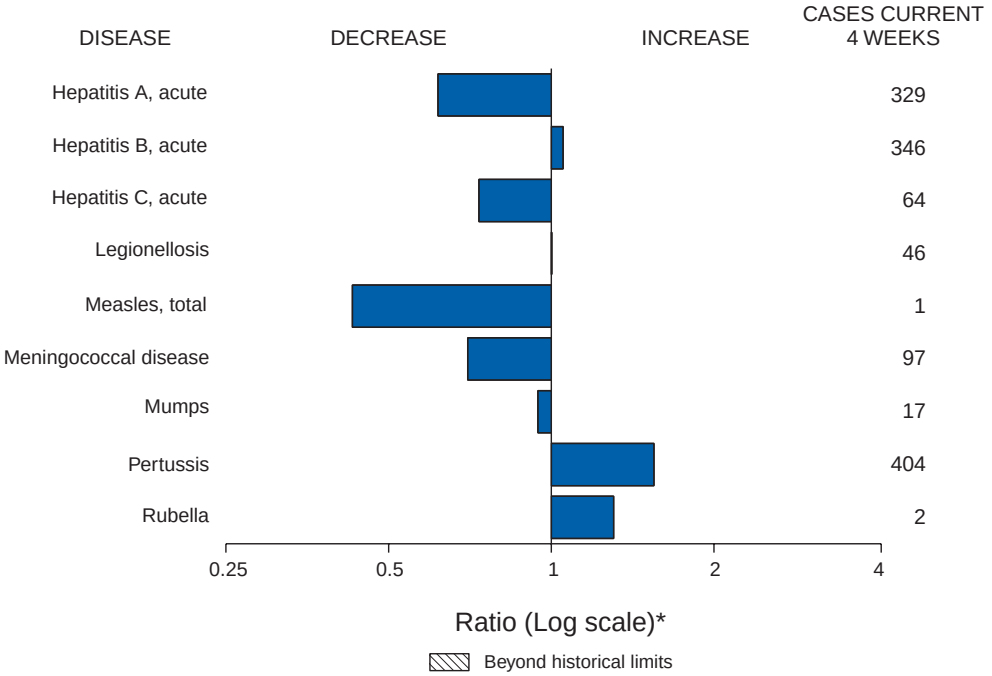
Erratum: Vol. 53, No. 9

In the report, "*Mycobacterium chelonae* Infections Associated with Face Lifts—New Jersey, 2002–2003," an error occurred in the third sentence of the third paragraph of the Editorial Note on page 194. The sentence should read, "Because *M. abscessus* was classified previously as a subspecies of *M. chelonae*, determining which pathogen was responsible for rapidly growing mycobacterial infections described in older reports is difficult (*1*)."

Erratum: Vol. 53, No. 10

In the report, "Trends in Tuberculosis—United States, 1998–2003," on page 212, the last sentence of the sixth paragraph of the report should read, "Among U.S.-born persons in 2003, the non-Hispanic black population had the largest number of TB cases (3,041 cases, 45.0%)."

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals March 20, 2004, with historical data



* 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 March 20, 2004 (11th Week)*

	Cum. 2004	Cum. 2003		Cum. 2004	Cum. 2003
Anthrax	-	-	Hemolytic uremic syndrome, postdiarrheal†	9	30
Botulism:	-	-	HIV infection, pediatric†§	-	48
foodborne	2	3	Measles, total	3¶	4**
infant	14	16	Mumps	36	43
other (wound & unspecified	4	4	Plague	-	-
Brucellosis†	12	25	Poliomyelitis, paralytic	-	-
Chancroid	7	10	Psittacosis†	2	5
Cholera	1	-	Q fever†	4	14
Cyclosporiasis†	6	21	Rabies, human	-	-
Diphtheria	-	-	Rubella	7	1
Ehrlichiosis:	-	-	Rubella, congenital syndrome	1	-
human granulocytic (HGE)†	5	18	SARS-associated coronavirus disease† ††	-	4
human monocytic (HME)†	6	19	Smallpox† §§	-	NA
human, other and unspecified	-	1	*Staphylococcus aureus*:	-	-
Encephalitis/Meningitis:	-	-	Vancomycin-intermediate (VISA)† §§	4	NA
California serogroup viral†	-	-	Vancomycin-resistant (VRSA)† §§	-	NA
eastern equine†	-	2	Streptococcal toxic-shock syndrome†	22	49
Powassan†	-	-	Tetanus	2	4
St. Louis†	1	2	Toxic-shock syndrome	27	25
western equine†	-	-	Trichinosis	1	-
Hansen disease (leprosy)†	11	22	Tularemia†	3	4
Hantavirus pulmonary syndrome†	2	5	Yellow fever	-	-

-: No reported cases.
* Incidence data for reporting years 2003 and 2004 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 December 28, 2003.
¶ Of three cases reported, two were indigenous, and one was imported from another country.
** Of four cases reported, two were indigenous, and two 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).
§§ Not previously notifiable.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending March 20, 2004, and March 15, 2003 (11th Week)*

Reporting area	AIDS		Chlamydia†		Coccidiodomycosis		Cryptosporidiosis		Encephalitis/Meningitis West Nile	
	Cum. 2004§	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	-	8,321	154,928	174,526	1,145	772	550	486	6	57
NEW ENGLAND	-	279	5,944	5,819	-	-	29	28	-	-
Maine	-	8	295	384	N	N	4	1	-	-
N.H.	-	3	356	311	-	-	7	3	-	-
Vt.	-	5	247	230	-	-	3	4	-	-
Mass.	-	111	3,011	2,247	-	-	10	15	-	-
R.I.	-	21	759	617	-	-	1	3	-	-
Conn.	-	131	1,276	2,030	N	N	4	2	-	-
MID. ATLANTIC	-	2,163	22,832	19,789	-	-	102	55	2	-
Upstate N.Y.	-	92	4,217	3,246	N	N	21	11	-	-
N.Y. City	-	1,272	6,884	7,158	-	-	18	23	-	-
N.J.	-	296	2,630	3,127	-	-	7	2	-	-
Pa.	-	503	9,101	6,258	N	N	56	19	2	-
E.N. CENTRAL	-	856	23,046	33,416	4	2	108	83	-	-
Ohio	-	128	2,735	9,217	-	-	37	12	-	-
Ind.	-	119	3,754	3,739	N	N	18	4	-	-
Ill.	-	365	6,192	10,646	-	-	8	15	-	-
Mich.	-	202	8,505	6,219	4	2	23	18	-	-
Wis.	-	42	1,860	3,595	-	-	22	34	-	-
W.N. CENTRAL	-	136	8,958	10,189	-	1	65	34	1	-
Minn.	-	23	1,529	2,308	N	N	27	19	-	-
Iowa	-	23	-	984	N	N	8	5	-	-
Mo.	-	73	3,990	3,733	-	1	14	2	1	-
N. Dak.	-	-	207	250	N	N	-	-	-	-
S. Dak.	-	4	514	489	-	-	4	6	-	-
Nebr.¶	-	6	1,143	914	-	-	-	2	-	-
Kans.	-	7	1,575	1,511	N	N	12	-	-	-
S. ATLANTIC	-	1,814	24,989	30,925	-	1	114	169	2	57
Del.	-	49	653	643	N	N	-	1	-	-
Md.	-	187	4,197	3,305	-	1	7	6	-	-
D.C.	-	233	759	729	-	-	1	-	-	-
Va.	-	264	1,245	3,145	-	-	9	5	-	-
W. Va.	-	13	619	536	N	N	-	-	-	-
N.C.	-	192	5,277	4,956	N	N	24	7	-	-
S.C.¶	-	169	3,934	2,746	-	-	2	1	1	-
Ga.	-	415	802	6,379	-	-	42	20	-	-
Fla.	-	292	7,503	8,486	N	N	29	129	1	57
E.S. CENTRAL	-	324	10,629	11,637	N	N	24	19	-	-
Ky.	-	38	1,258	1,814	N	N	6	2	-	-
Tenn.	-	145	4,134	3,927	N	N	10	9	-	-
Ala.	-	64	2,763	3,035	-	-	6	6	-	-
Miss.	-	77	2,474	2,861	N	N	2	2	-	-
W.S. CENTRAL	-	940	21,952	21,644	-	1	20	9	1	-
Ark.	-	23	1,624	1,311	-	-	8	2	-	-
La.	-	49	5,433	4,136	N	N	-	-	1	-
Okla.	-	40	1,481	1,715	N	N	8	1	-	-
Tex.	-	828	13,414	14,482	-	1	4	6	-	-
MOUNTAIN	-	312	9,140	10,872	767	561	30	15	-	-
Mont.	-	7	27	453	N	N	3	1	-	-
Idaho	-	4	692	503	N	N	1	4	-	-
Wyo.	-	2	226	220	-	-	2	-	-	-
Colo.	-	72	1,466	2,824	N	N	17	3	-	-
N. Mex.	-	27	1,245	1,671	6	-	1	-	-	-
Ariz.	-	145	3,863	3,374	748	553	5	1	-	-
Utah	-	14	567	538	4	1	-	4	-	-
Nev.	-	41	1,054	1,289	9	7	1	2	-	-
PACIFIC	-	1,497	27,438	30,235	374	206	58	74	-	-
Wash.	-	117	3,643	3,127	N	N	3	-	-	-
Oreg.	-	66	1,449	1,512	-	-	6	5	-	-
Calif.	-	1,294	21,644	23,714	374	206	48	69	-	-
Alaska	-	7	691	746	-	-	-	-	-	-
Hawaii	-	13	11	1,136	-	-	1	-	-	-
Guam	-	1	-	-	-	-	-	-	-	-
P.R.	-	235	298	243	N	N	N	N	-	-
V.I.	-	6	20	66	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	32	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 2003 and 2004 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 December 28, 2003.
¶ Contains data reported through National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 20, 2004, and March 15, 2003 (11th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	181	246	29	56	21	20	2,874	4,088	54,486	67,541
NEW ENGLAND	11	9	2	3	2	2	248	230	1,449	1,517
Maine	-	-	-	-	-	-	25	20	55	26
N.H.	1	2	-	1	-	-	8	14	24	23
Vt.	-	-	-	-	-	-	16	17	14	22
Mass.	1	3	1	-	2	2	121	117	695	568
R.I.	1	-	-	-	-	-	23	18	200	198
Conn.	8	4	1	2	-	-	55	44	461	680
MID. ATLANTIC	16	24	1	1	3	2	626	655	7,517	8,331
Upstate N.Y.	4	4	1	-	1	-	193	140	1,390	1,310
N.Y. City	4	3	-	-	-	-	197	269	2,257	2,874
N.J.	-	4	-	-	1	-	49	88	1,100	1,892
Pa.	8	13	-	1	1	2	187	158	2,770	2,255
E.N. CENTRAL	37	52	7	7	3	2	365	557	9,078	15,225
Ohio	11	13	-	4	3	2	158	176	1,244	4,828
Ind.	9	7	-	-	-	-	-	-	1,373	1,421
Ill.	4	8	-	-	-	-	56	159	2,450	4,703
Mich.	8	9	1	-	-	-	107	139	3,490	2,992
Wis.	5	15	6	3	-	-	44	83	521	1,281
W.N. CENTRAL	27	31	7	4	6	2	277	312	3,185	3,515
Minn.	11	12	3	3	-	-	96	83	673	573
Iowa	3	3	-	-	-	-	39	40	-	188
Mo.	5	8	4	1	1	-	82	112	1,629	1,862
N. Dak.	1	1	-	-	3	1	4	10	24	8
S. Dak.	-	2	-	-	-	-	12	10	52	25
Nebr.	4	4	-	-	-	-	20	33	255	293
Kans.	3	1	-	-	2	1	24	24	552	566
S. ATLANTIC	11	52	8	33	3	10	485	1,399	11,909	15,666
Del.	-	-	N	N	N	N	11	11	216	287
Md.	2	-	-	-	-	-	19	22	1,780	1,628
D.C.	-	-	-	-	-	-	10	3	493	543
Va.	-	2	2	-	-	-	64	39	472	1,566
W. Va.	-	-	-	-	-	-	7	5	189	170
N.C.	-	-	3	6	-	-	N	N	3,254	2,871
S.C.	-	-	-	-	-	-	10	18	1,830	1,567
Ga.	5	3	2	2	-	-	127	165	544	3,128
Fla.	4	47	1	25	3	10	237	1,136	3,131	3,906
E.S. CENTRAL	8	11	1	-	3	-	63	59	4,990	5,863
Ky.	4	1	1	-	3	-	N	N	546	753
Tenn.	2	6	-	-	-	-	25	26	1,550	1,797
Ala.	1	3	-	-	-	-	38	33	1,631	1,880
Miss.	1	1	-	-	-	-	-	-	1,263	1,433
W.S. CENTRAL	8	10	-	2	-	2	58	44	8,206	8,957
Ark.	-	1	-	-	-	-	28	28	747	769
La.	-	-	-	-	-	-	7	3	2,592	2,343
Okla.	3	-	-	-	-	-	23	13	690	694
Tex.	5	9	-	2	-	2	-	-	4,177	5,151
MOUNTAIN	37	21	2	5	1	-	288	261	2,182	2,365
Mont.	1	-	-	-	-	-	5	5	8	31
Idaho	3	6	1	3	-	-	42	30	13	16
Wyo.	-	-	-	-	-	-	1	3	11	10
Colo.	19	5	1	1	1	-	88	71	415	668
N. Mex.	1	-	-	1	-	-	11	13	152	278
Ariz.	8	8	N	N	N	N	80	55	1,067	937
Utah	2	2	-	-	-	-	44	55	61	51
Nev.	3	-	-	-	-	-	17	29	455	374
PACIFIC	26	36	1	1	-	-	464	571	5,970	6,102
Wash.	5	11	-	-	-	-	46	33	599	572
Oreg.	2	4	1	1	-	-	82	68	179	194
Calif.	15	21	-	-	-	-	315	436	5,069	5,014
Alaska	-	-	-	-	-	-	8	14	122	113
Hawaii	4	-	-	-	-	-	13	20	1	209
Guam	N	N	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	2	13	24	28
V.I.	-	-	-	-	-	-	-	-	4	21
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	3	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 20, 2004, and March 15, 2003 (11th 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. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	435	457	4	6	27	30	45	50	1,134	1,598
NEW ENGLAND	36	29	-	1	2	2	1	-	218	38
Maine	3	1	-	-	-	-	-	-	7	1
N.H.	9	3	-	-	1	-	-	-	5	3
Vt.	3	5	-	-	-	-	-	-	4	2
Mass.	13	14	-	1	-	2	1	-	177	21
R.I.	1	-	-	-	-	-	-	-	4	2
Conn.	7	6	-	-	1	-	-	-	21	9
MID. ATLANTIC	80	66	-	-	1	1	13	8	132	241
Upstate N.Y.	27	23	-	-	1	1	3	4	14	20
N.Y. City	11	11	-	-	-	-	3	2	43	96
N.J.	15	9	-	-	-	-	2	-	26	40
Pa.	27	23	-	-	-	-	5	2	49	85
E.N. CENTRAL	57	53	-	1	9	2	6	13	89	144
Ohio	32	13	-	-	2	-	4	4	14	26
Ind.	10	5	-	-	3	1	1	-	5	10
Ill.	-	24	-	-	-	-	-	8	30	51
Mich.	8	5	-	1	4	1	1	-	34	41
Wis.	7	6	-	-	-	-	-	1	6	16
W.N. CENTRAL	17	26	1	-	1	3	-	3	29	33
Minn.	8	8	-	-	1	3	-	-	1	4
Iowa	1	-	1	-	-	-	-	-	6	9
Mo.	4	11	-	-	-	-	-	3	10	8
N. Dak.	-	1	-	-	-	-	-	-	-	-
S. Dak.	-	1	-	-	-	-	-	-	2	-
Nebr.	4	-	-	-	-	-	-	-	7	3
Kans.	-	5	-	-	-	-	-	-	3	9
S. ATLANTIC	126	165	-	1	2	8	11	11	237	625
Del.	3	-	-	-	-	-	2	-	2	2
Md.	22	16	-	-	1	1	-	-	38	37
D.C.	-	-	-	-	-	-	-	-	3	3
Va.	9	5	-	-	-	-	-	1	19	10
W. Va.	6	2	-	-	-	-	3	-	1	4
N.C.	10	3	-	-	-	-	-	-	15	15
S.C.	-	1	-	-	-	-	-	-	5	15
Ga.	44	15	-	-	-	-	5	1	95	127
Fla.	32	123	-	1	1	7	1	9	59	412
E.S. CENTRAL	18	25	-	-	-	1	5	3	36	37
Ky.	-	3	-	-	-	1	-	-	2	6
Tenn.	10	10	-	-	-	-	4	2	24	17
Ala.	8	11	-	-	-	-	1	1	4	9
Miss.	-	1	-	-	-	-	-	-	6	5
W.S. CENTRAL	15	17	-	-	2	1	-	-	42	110
Ark.	-	3	-	-	-	-	-	-	6	5
La.	1	4	-	-	-	-	-	-	1	20
Okla.	14	10	-	-	2	1	-	-	11	3
Tex.	-	-	-	-	-	-	-	-	24	82
MOUNTAIN	69	48	1	1	9	8	7	6	121	81
Mont.	-	-	-	-	-	-	-	-	-	-
Idaho	2	-	-	-	-	-	1	-	4	4
Wyo.	-	-	-	-	-	-	-	-	1	1
Colo.	19	8	-	-	-	-	4	2	16	5
N. Mex.	10	4	-	-	2	2	1	-	3	5
Ariz.	34	28	-	1	6	3	1	3	80	50
Utah	1	5	1	-	-	1	-	1	15	5
Nev.	3	3	-	-	1	2	-	-	2	11
PACIFIC	17	28	2	2	1	4	2	6	230	289
Wash.	3	3	2	-	-	2	1	1	11	12
Oreg.	10	12	-	-	-	-	-	3	16	20
Calif.	2	11	-	2	1	2	1	2	198	251
Alaska	-	-	-	-	-	-	-	-	2	3
Hawaii	2	2	-	-	-	-	-	-	3	3
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	-	-	3	5
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 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 20, 2004, and March 15, 2003 (11th Week)*

Reporting area	Hepatitis (viral, acute), by type				Legionellosis		Listeriosis		Lyme disease	
	B		C							
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	1,068	2,083	272	523	202	342	73	126	1,145	1,551
NEW ENGLAND	48	70	-	-	3	10	3	5	51	80
Maine	1	-	-	-	-	-	1	-	11	-
N.H.	10	2	-	-	-	-	1	1	2	2
Vt.	1	1	-	-	-	1	-	-	1	3
Mass.	36	52	-	-	1	4	-	2	14	71
R.I.	-	-	-	-	1	1	-	-	9	4
Conn.	-	15	U	U	1	4	1	2	14	-
MID. ATLANTIC	134	240	33	29	42	43	17	17	922	1,183
Upstate N.Y.	11	14	3	4	10	10	4	2	293	343
N.Y. City	9	117	-	-	-	6	1	5	-	-
N.J.	65	54	-	-	11	4	5	3	173	245
Pa.	49	55	30	25	21	23	7	7	456	595
E.N. CENTRAL	74	100	12	35	55	55	9	9	20	38
Ohio	41	33	2	3	32	22	4	1	14	6
Ind.	1	-	-	-	3	2	1	1	-	3
Ill.	-	1	-	10	-	9	-	3	-	-
Mich.	32	48	10	22	18	17	3	4	-	-
Wis.	-	18	-	-	2	5	1	-	6	29
W.N. CENTRAL	91	59	129	55	4	6	2	2	16	19
Minn.	8	4	1	1	-	1	1	1	3	13
Iowa	1	4	-	-	-	2	-	-	2	2
Mo.	75	42	128	54	3	1	1	-	10	3
N. Dak.	1	-	-	-	-	1	-	-	-	-
S. Dak.	-	1	-	-	1	-	-	-	-	-
Nebr.	5	5	-	-	-	-	-	1	-	-
Kans.	1	3	-	-	-	1	-	-	1	1
S. ATLANTIC	368	1,002	36	102	52	181	14	52	109	178
Del.	1	2	-	-	2	-	N	N	7	26
Md.	33	25	1	5	8	12	2	3	60	57
D.C.	5	-	1	-	-	1	-	-	1	1
Va.	28	15	5	-	4	4	-	1	2	2
W. Va.	-	1	1	-	2	-	1	-	-	-
N.C.	32	30	3	3	7	5	4	5	27	9
S.C.	11	14	-	8	-	2	-	2	1	-
Ga.	119	279	5	6	5	6	3	3	-	3
Fla.	139	636	20	80	24	151	4	38	11	80
E.S. CENTRAL	71	73	34	17	8	4	2	4	1	9
Ky.	9	13	8	2	2	-	1	-	-	-
Tenn.	30	17	25	3	5	2	1	-	1	2
Ala.	14	20	-	2	1	1	-	3	-	-
Miss.	18	23	1	10	-	1	-	1	-	7
W.S. CENTRAL	16	224	16	266	8	18	4	8	2	23
Ark.	4	23	-	2	-	-	-	-	-	-
La.	6	34	9	39	-	-	-	-	-	2
Okla.	6	10	-	-	2	2	-	1	-	-
Tex.	-	157	7	225	6	16	4	7	2	21
MOUNTAIN	106	123	5	8	14	11	5	10	3	3
Mont.	-	4	-	1	-	-	-	1	-	-
Idaho	2	2	-	-	1	1	1	-	-	1
Wyo.	1	3	-	-	2	1	-	-	1	-
Colo.	13	16	1	3	3	2	1	5	-	-
N. Mex.	4	8	-	-	-	-	-	-	-	-
Ariz.	67	66	2	3	2	3	2	4	1	-
Utah	8	7	-	-	5	2	-	-	1	1
Nev.	11	17	2	1	1	2	1	-	-	1
PACIFIC	160	192	7	11	16	14	17	19	21	18
Wash.	17	10	2	1	3	1	3	1	2	-
Oreg.	22	32	2	3	N	N	3	1	8	5
Calif.	116	144	2	6	13	13	11	17	11	13
Alaska	4	2	-	-	-	-	-	-	-	-
Hawaii	1	4	1	1	-	-	-	-	N	N
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	5	22	-	-	-	-	-	-	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 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 20, 2004, and March 15, 2003 (11th Week)*

Reporting area	Malaria		Meningococcal disease		Pertussis		Rabies, animal		Rocky Mountain spotted fever	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	190	274	394	510	1,496	1,393	617	1,009	102	69
NEW ENGLAND	13	7	13	21	443	137	73	83	4	-
Maine	-	1	-	1	-	-	10	6	-	-
N.H.	-	2	2	1	7	9	5	5	-	-
Vt.	1	-	1	-	10	17	4	7	-	-
Mass.	8	4	10	17	416	110	27	30	4	-
R.I.	1	-	-	-	7	-	1	2	-	-
Conn.	3	-	-	2	3	1	26	33	-	-
MID. ATLANTIC	35	46	47	48	432	139	93	153	8	9
Upstate N.Y.	9	7	13	7	316	56	64	47	1	-
N.Y. City	16	26	9	11	-	-	-	1	1	4
N.J.	3	4	6	7	35	22	-	38	1	4
Pa.	7	9	19	23	81	61	29	67	5	1
E.N. CENTRAL	14	22	45	70	164	97	3	4	2	1
Ohio	3	5	18	19	96	56	2	-	2	1
Ind.	-	-	6	12	7	6	1	2	-	-
Ill.	1	10	1	16	-	-	-	-	-	-
Mich.	5	5	17	14	24	10	-	2	-	-
Wis.	5	2	3	9	37	25	-	-	-	-
W.N. CENTRAL	13	4	19	27	72	77	75	94	2	2
Minn.	6	2	5	4	14	27	9	5	-	-
Iowa	1	2	3	5	10	30	9	9	-	1
Mo.	3	-	5	15	36	12	2	-	2	1
N. Dak.	1	-	-	-	3	-	11	14	-	-
S. Dak.	1	-	1	-	1	1	10	11	-	-
Nebr.	-	-	1	1	-	1	15	11	-	-
Kans.	1	-	4	2	8	6	19	44	-	-
S. ATLANTIC	73	124	74	151	76	206	290	563	74	53
Del.	1	-	1	6	3	1	9	-	-	-
Md.	22	17	4	7	23	14	50	66	4	6
D.C.	4	-	-	-	1	-	-	-	-	-
Va.	4	3	2	6	16	28	15	87	-	1
W. Va.	-	2	3	1	-	1	13	12	-	-
N.C.	3	4	9	5	17	41	120	130	66	27
S.C.	3	1	6	8	3	3	16	35	-	-
Ga.	9	5	10	11	-	4	64	61	2	1
Fla.	27	92	39	107	13	114	3	172	2	18
E.S. CENTRAL	6	5	19	23	26	23	24	35	8	2
Ky.	1	1	3	2	3	3	3	4	-	-
Tenn.	1	2	7	4	15	10	8	26	2	1
Ala.	3	2	5	6	4	8	13	5	1	-
Miss.	1	-	4	11	4	2	-	-	5	1
W.S. CENTRAL	5	18	40	60	19	30	27	39	-	2
Ark.	1	1	5	3	2	2	8	13	-	-
La.	2	1	10	21	2	4	-	-	-	-
Okla.	1	-	1	4	1	4	19	26	-	-
Tex.	1	16	24	32	14	20	-	-	-	2
MOUNTAIN	8	8	24	19	166	229	17	14	-	-
Mont.	-	-	1	1	4	-	2	1	-	-
Idaho	-	1	2	-	13	7	-	-	-	-
Wyo.	-	-	2	2	2	58	-	-	-	-
Colo.	3	6	11	5	87	82	-	-	-	-
N. Mex.	1	-	3	2	9	17	-	-	-	-
Ariz.	2	1	4	6	34	44	15	13	-	-
Utah	1	-	1	-	17	16	-	-	-	-
Nev.	1	-	-	3	-	5	-	-	-	-
PACIFIC	23	40	113	91	98	455	15	24	4	-
Wash.	2	4	7	8	71	53	-	-	-	-
Oreg.	2	5	28	21	26	50	-	-	2	-
Calif.	19	31	74	59	-	351	13	23	2	-
Alaska	-	-	1	-	1	-	2	1	-	-
Hawaii	-	-	3	3	-	1	-	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	2	1	-	14	10	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 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 20, 2004, and March 15, 2003 (11th Week)*

Reporting area	Salmonellosis		Shigellosis		Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive			
							Drug resistant, all ages		Age <5 years	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	4,731	9,258	2,026	6,160	1,109	1,674	641	1,140	84	98
NEW ENGLAND	208	227	46	71	50	131	1	27	1	1
Maine	7	13	-	3	2	7	-	-	-	-
N.H.	14	16	3	-	6	7	-	-	N	N
Vt.	9	4	-	1	1	6	-	3	-	1
Mass.	120	142	31	45	39	68	N	N	N	N
R.I.	13	10	1	2	2	-	1	-	1	-
Conn.	45	42	11	20	-	43	-	24	U	U
MID. ATLANTIC	594	646	211	353	161	270	36	32	20	19
Upstate N.Y.	132	94	88	45	61	86	16	17	13	14
N.Y. City	173	205	56	95	19	39	U	U	U	U
N.J.	107	127	38	89	28	68	N	N	N	N
Pa.	182	220	29	124	53	77	20	15	7	5
E.N. CENTRAL	647	742	165	315	186	366	147	107	35	55
Ohio	190	209	44	59	71	83	116	80	24	32
Ind.	62	45	16	23	16	21	31	27	8	4
Ill.	164	276	59	155	16	98	-	-	-	-
Mich.	125	108	28	48	75	102	N	N	N	N
Wis.	106	104	18	30	8	62	N	N	3	19
W.N. CENTRAL	282	278	67	150	87	85	62	68	7	11
Minn.	61	76	11	18	39	31	-	-	7	9
Iowa	59	67	11	6	N	N	N	N	N	N
Mo.	81	69	23	57	16	22	3	3	-	-
N. Dak.	6	5	1	3	3	5	-	3	-	2
S. Dak.	12	15	1	8	6	8	1	-	-	-
Nebr.	23	14	2	44	6	8	-	-	N	N
Kans.	40	32	18	14	17	11	58	62	N	N
S. ATLANTIC	1,187	5,363	667	3,613	315	394	327	836	2	3
Del.	5	14	2	75	-	2	2	-	N	N
Md.	87	120	24	134	61	64	-	1	-	-
D.C.	6	3	9	9	2	-	-	-	2	-
Va.	117	77	19	46	11	8	N	N	N	N
W. Va.	17	5	-	-	7	5	19	15	-	3
N.C.	162	236	110	158	32	22	N	N	U	U
S.C.	60	75	79	40	18	5	17	48	N	N
Ga.	234	164	129	302	127	57	134	161	N	N
Fla.	499	4,669	295	2,849	57	231	155	611	N	N
E.S. CENTRAL	258	300	126	175	52	36	37	27	-	-
Ky.	38	55	21	32	22	7	8	2	N	N
Tenn.	71	98	46	49	30	29	29	25	N	N
Ala.	106	96	43	61	-	-	-	-	N	N
Miss.	43	51	16	33	-	-	-	-	-	-
W.S. CENTRAL	269	446	265	724	34	131	21	33	18	7
Ark.	42	54	11	8	3	2	3	7	4	2
La.	25	72	24	77	-	1	18	26	2	3
Okla.	44	36	78	140	15	22	N	N	9	2
Tex.	158	284	152	499	16	106	N	N	3	-
MOUNTAIN	476	338	220	218	94	137	10	9	1	2
Mont.	19	16	3	-	-	-	-	-	-	-
Idaho	31	23	1	3	2	8	N	N	N	N
Wyo.	7	4	1	1	3	-	4	-	-	-
Colo.	111	98	38	31	42	38	-	-	-	-
N. Mex.	29	30	29	38	20	35	5	9	-	-
Ariz.	222	119	129	130	19	54	-	-	N	N
Utah	36	26	9	6	8	2	-	-	1	2
Nev.	21	22	10	9	-	-	1	-	-	-
PACIFIC	810	918	259	541	130	124	-	1	-	-
Wash.	58	69	13	26	10	-	-	-	N	N
Oreg.	55	61	17	14	N	N	N	N	N	N
Calif.	618	742	216	489	93	104	N	N	N	N
Alaska	24	18	2	3	1	-	-	-	N	N
Hawaii	55	28	11	9	26	20	-	1	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	24	93	1	2	N	N	N	N	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	3	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 20, 2004, and March 15, 2003 (11th Week)*

Reporting area	Syphilis: Primary & secondary		Syphilis: Congenital		Tuberculosis		Typhoid fever		Varicella (Chickenpox)	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	1,238	1,450	41	108	1,115	2,085	41	70	2,944	3,376
NEW ENGLAND	17	35	1	-	38	58	5	3	188	581
Maine	-	-	-	-	-	-	-	-	21	300
N.H.	1	6	-	-	-	4	-	-	-	-
Vt.	-	-	-	-	-	1	-	-	167	226
Mass.	10	24	-	-	34	28	5	2	-	53
R.I.	2	2	-	-	3	8	-	-	-	2
Conn.	4	3	1	-	1	17	-	1	-	-
MID. ATLANTIC	178	158	6	16	303	377	6	13	8	4
Upstate N.Y.	11	4	3	1	18	32	-	2	-	-
N.Y. City	97	77	3	7	188	189	2	7	-	-
N.J.	30	44	-	8	56	64	3	3	-	-
Pa.	40	33	-	-	41	92	1	1	8	4
E.N. CENTRAL	113	209	13	19	181	188	2	4	1,313	1,628
Ohio	41	41	-	2	36	34	1	-	315	358
Ind.	10	6	-	5	13	26	-	2	-	-
Ill.	28	85	-	9	113	88	-	1	-	-
Mich.	31	74	13	3	8	31	1	1	966	1,038
Wis.	3	3	-	-	11	9	-	-	32	232
W.N. CENTRAL	25	46	-	-	41	89	-	-	83	8
Minn.	3	16	-	-	18	26	-	-	-	-
Iowa	-	2	-	-	4	5	-	-	N	N
Mo.	15	18	-	-	11	26	-	-	2	-
N. Dak.	-	-	-	-	2	-	-	-	61	8
S. Dak.	-	-	-	-	2	8	-	-	20	-
Nebr.	4	1	-	-	-	2	-	-	-	-
Kans.	3	9	-	-	4	22	-	-	-	-
S. ATLANTIC	335	336	4	22	222	320	8	24	389	545
Del.	2	1	-	-	-	-	-	-	-	1
Md.	57	52	1	4	33	28	2	3	1	-
D.C.	16	4	-	-	-	-	-	-	5	1
Va.	1	15	-	1	6	26	2	4	50	113
W. Va.	1	-	-	-	5	2	-	-	277	393
N.C.	32	33	-	3	21	24	2	1	-	-
S.C.	26	27	-	3	16	20	-	-	56	37
Ga.	46	73	-	5	11	93	-	1	-	-
Fla.	154	131	3	6	130	127	2	15	-	-
E.S. CENTRAL	66	84	2	7	69	121	-	1	1	-
Ky.	14	14	-	1	9	16	-	-	-	-
Tenn.	29	32	1	1	30	33	-	-	-	-
Ala.	17	30	1	4	30	55	-	1	-	-
Miss.	6	8	-	1	-	17	-	-	1	-
W.S. CENTRAL	218	171	13	16	46	309	2	1	333	596
Ark.	11	10	-	-	23	15	-	-	-	-
La.	42	17	-	-	-	-	-	-	-	5
Okla.	6	8	2	-	23	14	-	-	-	-
Tex.	159	136	11	16	-	280	2	1	333	591
MOUNTAIN	85	62	2	14	37	43	3	2	629	14
Mont.	-	-	-	-	-	-	-	-	-	-
Idaho	6	-	-	-	-	1	-	-	-	-
Wyo.	1	-	-	-	-	1	-	-	13	2
Colo.	-	8	-	2	2	20	-	2	460	-
N. Mex.	20	15	-	4	-	2	-	-	21	-
Ariz.	54	36	2	8	24	18	1	-	-	-
Utah	2	1	-	-	11	1	1	-	135	12
Nev.	2	2	-	-	-	-	1	-	-	-
PACIFIC	201	349	-	14	178	580	15	22	-	-
Wash.	13	13	-	-	43	46	1	-	-	-
Oreg.	9	12	-	-	15	15	2	2	-	-
Calif.	179	319	-	14	87	482	8	20	-	-
Alaska	-	-	-	-	7	14	-	-	-	-
Hawaii	-	5	-	-	26	23	4	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	20	34	-	1	-	11	-	-	75	103
V.I.	-	1	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	-	U	10	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,* week ending March 20, 2004 (11th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	525	372	111	30	8	4	50
Boston, Mass.	152	100	37	11	1	3	17
Bridgeport, Conn.	27	26	1	-	-	-	3
Cambridge, Mass.	20	16	4	-	-	-	2
Fall River, Mass.	32	26	5	1	-	-	3
Hartford, Conn.	58	36	15	4	2	1	8
Lowell, Mass.	20	14	2	3	1	-	1
Lynn, Mass.	12	10	1	1	-	-	1
New Bedford, Mass.	26	17	8	1	-	-	2
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	60	41	14	2	3	-	4
Somerville, Mass.	4	1	1	1	1	-	-
Springfield, Mass.	40	29	10	1	-	-	2
Waterbury, Conn.	24	17	5	2	-	-	3
Worcester, Mass.	50	39	8	3	-	-	4
MID. ATLANTIC	2,940	2,056	603	185	52	43	182
Albany, N.Y.	47	32	13	1	1	-	1
Allentown, Pa.	24	21	2	-	1	-	2
Buffalo, N.Y.	84	56	24	2	1	1	8
Camden, N.J.	32	21	6	1	1	3	1
Elizabeth, N.J.	29	16	9	3	1	-	2
Erie, Pa.	40	31	5	1	2	1	1
Jersey City, N.J.	45	37	6	2	-	-	-
New York City, N.Y.	1,823	1,292	370	117	26	17	106
Newark, N.J.	66	30	24	9	3	-	2
Paterson, N.J.	20	12	3	3	1	1	1
Philadelphia, Pa.	328	216	68	28	8	8	23
Pittsburgh, Pa.§	25	14	7	3	-	1	1
Reading, Pa.	23	18	5	-	-	-	4
Rochester, N.Y.	136	103	20	7	4	2	11
Schenectady, N.Y.	34	24	8	1	-	1	5
Scranton, Pa.	32	20	8	2	1	1	4
Syracuse, N.Y.	91	72	12	3	1	3	7
Trenton, N.J.	32	19	7	1	1	4	2
Utica, N.Y.	29	22	6	1	-	-	1
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	2,213	1,545	441	140	39	47	151
Akron, Ohio	44	31	9	3	-	1	2
Canton, Ohio	41	28	7	4	-	2	5
Chicago, Ill.	351	218	85	30	9	8	26
Cincinnati, Ohio	78	50	14	7	5	2	3
Cleveland, Ohio	266	195	47	19	2	3	12
Columbus, Ohio	221	150	52	8	5	6	21
Dayton, Ohio	127	88	28	9	1	1	14
Detroit, Mich.	169	93	49	12	7	8	8
Evansville, Ind.	49	40	5	1	2	1	4
Fort Wayne, Ind.	62	49	11	2	-	-	6
Gary, Ind.	17	10	3	1	1	2	1
Grand Rapids, Mich.	37	26	6	1	1	3	3
Indianapolis, Ind.	217	147	47	14	1	8	12
Lansing, Mich.	52	41	9	2	-	-	3
Milwaukee, Wis.	120	81	30	7	2	-	5
Peoria, Ill.	49	44	2	2	-	1	7
Rockford, Ill.	60	53	5	1	1	-	3
South Bend, Ind.	52	40	7	3	1	1	5
Toledo, Ohio	85	66	16	3	-	-	7
Youngstown, Ohio	116	95	9	11	1	-	4
W.N. CENTRAL	933	588	225	68	22	28	51
Des Moines, Iowa	87	57	22	3	2	3	2
Duluth, Minn.	27	21	5	1	-	-	3
Kansas City, Kans.	63	36	17	6	2	2	9
Kansas City, Mo.	211	129	53	13	6	8	10
Lincoln, Nebr.	42	36	4	1	1	-	3
Minneapolis, Minn.	73	38	23	5	4	3	8
Omaha, Nebr.	90	56	25	7	1	1	4
St. Louis, Mo.	140	84	35	11	3	7	6
St. Paul, Minn.	65	49	11	3	-	2	1
Wichita, Kans.	135	82	30	18	3	2	5
S. ATLANTIC	1,441	907	332	116	50	35	87
Atlanta, Ga.	145	84	38	17	5	1	5
Baltimore, Md.	183	111	39	22	10	1	15
Charlotte, N.C.	128	72	31	13	2	10	13
Jacksonville, Fla.	153	93	40	11	5	3	4
Miami, Fla.	153	115	28	5	4	1	11
Norfolk, Va.	63	42	12	2	5	2	4
Richmond, Va.	67	35	19	6	2	5	5
Savannah, Ga.	54	36	12	3	1	2	4
St. Petersburg, Fla.	57	46	8	2	-	1	4
Tampa, Fla.	215	140	55	13	1	6	15
Washington, D.C.	199	112	47	22	15	3	5
Wilmington, Del.	24	21	3	-	-	-	2
E.S. CENTRAL	893	579	227	51	18	16	72
Birmingham, Ala.	169	109	46	8	3	1	11
Chattanooga, Tenn.	94	55	30	6	1	2	4
Knoxville, Tenn.	111	70	29	6	2	4	3
Lexington, Ky.	68	43	19	3	1	2	7
Memphis, Tenn.	204	133	50	14	4	3	18
Mobile, Ala.	67	50	13	2	1	1	7
Montgomery, Ala.	43	33	10	-	-	-	9
Nashville, Tenn.	137	86	30	12	6	3	13
W.S. CENTRAL	1,543	1,035	317	114	43	34	93
Austin, Tex.	94	67	16	6	4	1	8
Baton Rouge, La.	32	28	4	-	-	-	1
Corpus Christi, Tex.	48	42	6	-	-	-	5
Dallas, Tex.	202	114	54	20	6	8	12
El Paso, Tex.	122	85	22	10	2	3	7
Ft. Worth, Tex.	149	95	34	9	8	3	11
Houston, Tex.	311	192	74	25	12	8	23
Little Rock, Ark.	65	41	16	4	2	2	4
New Orleans, La.	39	25	11	3	-	-	-
San Antonio, Tex.	314	224	49	24	8	9	21
Shreveport, La.	53	39	10	4	-	-	1
Tulsa, Okla.	114	83	21	9	1	-	-
MOUNTAIN	1,091	729	227	88	24	22	89
Albuquerque, N.M.	141	91	34	12	2	2	9
Boise, Idaho	30	17	8	2	1	2	2
Colo. Springs, Colo.	78	59	13	4	-	2	1
Denver, Colo.	104	52	20	17	6	9	11
Las Vegas, Nev.	265	189	52	21	1	2	16
Ogden, Utah	26	23	1	2	-	-	5
Phoenix, Ariz.	106	68	23	11	2	1	12
Pueblo, Colo.	31	22	6	-	2	1	2
Salt Lake City, Utah	140	87	30	12	8	3	18
Tucson, Ariz.	170	121	40	7	2	-	13
PACIFIC	1,960	1,396	385	100	39	40	207
Berkeley, Calif.	17	12	3	-	-	2	-
Fresno, Calif.	172	124	37	6	3	2	18
Glendale, Calif.	28	21	5	1	1	-	5
Honolulu, Hawaii	72	56	11	4	-	1	3
Long Beach, Calif.	72	49	14	4	1	4	11
Los Angeles, Calif.	591	411	115	38	12	15	72
Pasadena, Calif.	U	U	U	U	U	U	U
Portland, Oreg.	143	97	27	11	3	5	5
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	204	151	39	7	4	3	30
San Francisco, Calif.	127	85	30	5	6	1	15
San Jose, Calif.	167	118	37	8	1	3	20
Santa Cruz, Calif.	35	32	2	1	-	-	5
Seattle, Wash.	143	102	31	6	3	1	10
Spokane, Wash.	75	58	9	4	1	3	8
Tacoma, Wash.	114	80	25	5	4	-	5
TOTAL	13,539¶	9,207	2,868	892	295	269	982

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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