MMWR™
Morbidity and Mortality Weekly Report
Weekly November 12, 2004 / Vol. 53 / No. 44

Great American Smokeout — November 18, 2004

In 2002, a total of 45.8 million U.S. adults (22.5%) were current smokers, a decrease from 24.1% in 1998, and an estimated 46 million adults were former smokers (*1*). For the first time, more adults had quit smoking than were still smoking (*1*). To assist in continuing this trend, the American Cancer Society (ACS) is sponsoring the 28th Great American Smokeout on November 18, 2004. Cigarette smokers are encouraged to quit smoking for at least 24 hours in the hope they might stop smoking.

The likelihood of permanently quitting smoking is increased when effective therapies are used, such as physician assistance, pharmacologic treatment, and behavioral counseling (*2*). In addition to individual methods, an environmental approach to reducing tobacco use involves increasing the excise tax for tobacco products, developing multicomponent mass media campaigns, fostering provider reminder systems, using telephone quitlines, reducing patient out-of-pocket costs for effective cessation therapies, and reducing exposure to secondhand smoke through smoking bans and restrictions (*3*). Additional information about the Great American Smokeout is available at http://www.cancer.org or by telephone, 800-227-2345.

References

1. CDC. Cigarette smoking among adults—United States, 2002. MMWR 2004;53:427–31.
2. Fiore MC, Bailey WC, Cohen SJ, et al. Treating tobacco use and dependence: clinical practice guidelines. Rockville, MD: US Department of Health and Human Services, Public Health Service; 2000. AHQR publication 00-0032.
3. CDC. Strategies for reducing exposure to environmental tobacco smoke, increasing tobacco-use cessation, and reducing initiation in communities and health-care systems: a report on recommendations of the Task Force on Community Preventive Services. MMWR 2000;49(No. RR-12):2–9.

State-Specific Prevalence of Current Cigarette Smoking Among Adults — United States, 2003

Cigarette smoking causes approximately 440,000 deaths annually in the United States (*1*). To assess the prevalence of current cigarette smoking among adults, CDC analyzed data from the 2003 Behavioral Risk Factor Surveillance System (BRFSS) survey. This report summarizes the results of that analysis, which indicated substantial variation in cigarette smoking prevalence in the 50 states, the District of Columbia (DC), Guam, Puerto Rico, and the U.S. Virgin Islands (USVI) (range: 10.0%–34.0%). To further reduce the prevalence of smoking, states/areas should implement comprehensive tobacco-control programs.

BRFSS is a state-based, random-digit–dialed, telephone survey of the U.S. civilian, noninstitutionalized population aged ≥18 years. In 2003, the median state/area response rate was 53.2% (range: 34.4%–80.5%). Estimates were weighted by age and sex distributions for each state's population, and 95% confidence intervals were calculated. BRFSS respondents were asked, "Have you smoked at least 100 cigarettes in your entire life?" and "Do you now smoke cigarettes every day, some

INSIDE

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

The *MMWR* series of publications is published by the Coordinating Center for Health Information and Service (Proposed), Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

SUGGESTED CITATION
Centers for Disease Control and Prevention. [Article Title]. MMWR 2004;53:[inclusive page numbers].

days, or not at all?" Current smokers were defined as those who reported having smoked ≥100 cigarettes during their lifetimes and who currently smoke every day or some days.

In 2003, the median prevalence of current cigarette smoking among adults was 22.1% in the 50 states and DC (range: 12.0% [Utah]–30.8% [Kentucky]) (Table). Smoking prevalence was higher among men (median: 24.8%; range: 14.0%–33.8%) than women (median: 20.3%; range: 9.9%–28.1%) in the 50 states and DC. Smoking prevalence for both men and women was highest in Kentucky (men: 33.8%; women: 28.1%) and lowest in Utah (men: 14.0%; women: 9.9%). In areas other than the 50 states and DC, the median prevalence of current cigarette smoking among adults was 13.6% (range: 10.0% [USVI]–34.0% [Guam]).

Reported by: *J Bombard, MSPH, A Malarcher, PhD, M Schooley, MPH, A MacNeil, MPH, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

Editorial Note: Although the prevalence of current cigarette smoking among U.S. adults has declined, the rate of decline has not been rapid enough for the nation to achieve the 2010 national health objective of ≤12% of adults smoking cigarettes (objective 27-1) (*2,3*). The median prevalence of adult smoking decreased 1 percentage point from 2002 to 2003, and the national objective for 2010 was achieved in Utah and the USVI. The high prevalence of current cigarette smoking in most of the remaining states/areas underscores the need for increased efforts to reduce tobacco use.

The findings in this report are subject to at least three limitations. First, the BRFSS survey does not sample persons in households without telephones, a population that might be more likely to smoke (*4*). Second, data for cigarette smoking are based on self-reports and are not validated with biochemical tests. However, self-reported data on current smoking status have high validity (*4*). Third, the median response rate was 53.2% (range: 34.4%–80.5%); lower response rates indicate a potential for response bias. However, BRFSS estimates for cigarette smoking are comparable with current smoking estimates from other surveys with higher response rates (*5*).

Comprehensive tobacco control is effective in preventing and reducing tobacco use (*6*). CDC recommends the following evidence-based interventions as strategies within comprehensive tobacco-control programs: clean indoor air laws, telephone support quitlines, media campaigns, increased excise taxes on tobacco products, insurance coverage for cessation counseling and pharmaceuticals, and health-care system changes that support cessation (*7*). Substantial variation exists across states in their use of these strategies. For example, in 2002, two states offered Medicaid coverage for all recommended medication and counseling treatments for tobacco dependence, whereas 11 states covered no tobacco-dependence

TABLE. Prevalence of current cigarette smoking among adults*, by state/area and sex — Behavioral Risk Factor Surveillance System, 50 states, District of Columbia, Guam, Puerto Rico, and U.S. Virgin Islands, 2003

State/Area	Men		Women		Total	
	%	(95% CI†)	%	(95% CI)	%	(95% CI)
Alabama	28.5	(±3.1)	22.4	(±2.0)	**25.3**	**(±1.8)**
Alaska	30.3	(±3.6)	21.9	(±3.0)	**26.3**	**(±2.4)**
Arizona	23.8	(±3.9)	18.2	(±2.7)	**21.0**	**(±2.4)**
Arkansas	27.6	(±2.5)	22.3	(±1.8)	**24.8**	**(±1.5)**
California	20.5	(±2.3)	13.2	(±1.5)	**16.8**	**(±1.4)**
Colorado	19.6	(±2.2)	17.5	(±1.7)	**18.5**	**(±1.4)**
Connecticut	19.7	(±1.9)	17.9	(±1.6)	**18.7**	**(±1.2)**
Delaware	26.0	(±3.0)	18.2	(±2.0)	**21.9**	**(±1.8)**
District of Columbia	26.2	(±4.2)	19.0	(±2.9)	**22.3**	**(±2.5)**
Florida	26.0	(±3.1)	22.1	(±2.3)	**23.9**	**(±1.9)**
Georgia	25.8	(±2.3)	20.0	(±1.5)	**22.8**	**(±1.4)**
Hawaii	20.1	(±2.5)	14.4	(±1.7)	**17.3**	**(±1.5)**
Idaho	19.5	(±2.1)	18.5	(±1.7)	**19.0**	**(±1.3)**
Illinois	28.3	(±2.8)	20.5	(±1.9)	**24.3**	**(±1.7)**
Indiana	28.6	(±2.2)	23.8	(±1.6)	**26.1**	**(±1.3)**
Iowa	22.8	(±2.2)	20.7	(±1.9)	**21.7**	**(±1.5)**
Kansas	21.0	(±2.3)	19.7	(±1.7)	**20.4**	**(±1.4)**
Kentucky	33.8	(±2.7)	28.1	(±1.9)	**30.8**	**(±1.7)**
Louisiana	30.3	(±2.5)	23.2	(±1.7)	**26.6**	**(±1.5)**
Maine	23.1	(±3.1)	24.0	(±2.5)	**23.6**	**(±2.0)**
Maryland	23.0	(±2.6)	17.7	(±1.8)	**20.2**	**(±1.6)**
Massachusetts	20.0	(±1.8)	18.4	(±1.4)	**19.2**	**(±1.2)**
Michigan	30.2	(±3.0)	22.3	(±2.1)	**26.2**	**(±1.8)**
Minnesota	22.4	(±2.4)	19.9	(±1.9)	**21.1**	**(±1.5)**
Mississippi	31.1	(±2.7)	20.7	(±1.7)	**25.6**	**(±1.6)**
Missouri	31.2	(±3.1)	23.8	(±2.5)	**27.3**	**(±2.0)**
Montana	19.5	(±2.5)	20.3	(±2.2)	**19.9**	**(±1.7)**
Nebraska	23.6	(±2.2)	19.0	(±1.6)	**21.3**	**(±1.4)**
Nevada	29.0	(±3.5)	21.3	(±2.9)	**25.2**	**(±2.3)**
New Hampshire	22.4	(±2.2)	20.2	(±1.8)	**21.2**	**(±1.4)**
New Jersey	21.2	(±1.5)	17.9	(±1.1)	**19.5**	**(±0.9)**
New Mexico	23.6	(±2.2)	20.5	(±1.7)	**22.0**	**(±1.4)**
New York	24.8	(±2.2)	18.8	(±1.6)	**21.6**	**(±1.3)**
North Carolina	28.0	(±2.4)	21.9	(±1.7)	**24.8**	**(±1.5)**
North Dakota	22.0	(±2.5)	19.0	(±2.2)	**20.5**	**(±1.7)**
Ohio	26.9	(±2.8)	24.0	(±2.2)	**25.4**	**(±1.8)**
Oklahoma	27.8	(±2.0)	22.7	(±1.4)	**25.2**	**(±1.2)**
Oregon	23.1	(±2.4)	18.9	(±1.8)	**21.0**	**(±1.5)**
Pennsylvania	27.1	(±2.7)	24.1	(±2.1)	**25.5**	**(±1.7)**
Rhode Island	23.8	(±2.7)	21.1	(±2.0)	**22.4**	**(±1.6)**
South Carolina	28.5	(±2.3)	22.8	(±1.6)	**25.5**	**(±1.4)**
South Dakota	24.7	(±2.3)	20.7	(±1.8)	**22.7**	**(±1.4)**
Tennessee	27.3	(±3.3)	24.2	(±2.4)	**25.7**	**(±2.0)**
Texas	26.7	(±2.2)	17.6	(±1.4)	**22.1**	**(±1.3)**
Utah	14.0	(±2.2)	9.9	(±1.6)	**12.0**	**(±1.4)**
Vermont	19.8	(±2.3)	19.4	(±1.9)	**19.6**	**(±1.5)**
Virginia	26.4	(±2.5)	18.0	(±1.6)	**22.1**	**(±1.5)**
Washington	20.9	(±1.2)	18.2	(±0.9)	**19.5**	**(±0.7)**
West Virginia	27.6	(±2.8)	27.2	(±2.3)	**27.4**	**(±1.8)**
Wisconsin	24.0	(±2.6)	20.3	(±2.0)	**22.1**	**(±1.6)**
Wyoming	25.2	(±2.4)	24.1	(±2.0)	**24.6**	**(±1.6)**
Median	*24.8*		*20.3*		***22.1***	
Guam	42.0	(±5.9)	25.8	(±4.6)	**34.0**	**(±3.8)**
Puerto Rico	19.3	(±2.6)	8.5	(±1.3)	**13.6**	**(±1.5)**
U.S. Virgin Islands	14.2	(±3.2)	6.6	(±1.6)	**10.0**	**(±1.7)**
Median	*19.3*		*8.5*		***13.6***	

* Persons aged ≥18 years who reported having smoked ≥100 cigarettes during their lifetimes and who currently smoke every day or some days.
† Confidence interval.

treatments (*8*). In addition, the average cost of a single pack of cigarettes (which includes state-based excise taxes) ranged from $3.10 in Kentucky to $5.54 in New York in 2003 (*9*). The majority of states offer telephone support quitlines, and residents of all states soon will have access to a nationwide network of quitlines. Finally, only six states (California, Connecticut, Delaware, Maine, Massachusetts, and New York) have comprehensive statewide bans in effect on smoking in indoor workplaces and public places.

The more funds that states spend on comprehensive tobacco-control programs, the greater the reduction in smoking (*6*). However, the amount of money that states spend for tobacco control decreased 28% during the preceding 2 years to $541.1 million, which is less than 3% of the estimated $19 billion states expected to receive from tobacco excise taxes and tobacco settlement money in 2003 (*10*). For fiscal year 2004 (i.e., July 1, 2003–June 31, 2004), only four states (Arkansas, Delaware, Maine, and Mississippi) were investing at least the minimum per capita amount that CDC recommends for tobacco-control programs (*10*). Efforts and resources must be expanded if more states are to reduce smoking prevalence to ≤12% by 2010.

References

1. CDC. Annual smoking-attributable mortality, years of potential life lost, and economic costs—United States 1995–1999. MMWR 2002;51:300–3.
2. CDC. Cigarette smoking among adults—United States, 2002. MMWR 2004;53:427–31.
3. US Department of Health and Human Services. Healthy people 2010 (conference ed, in 2 vols). Washington, DC: US Department of Health and Human Services; 2000. Available at http://www.health.gov/healthypeople.
4. Nelson DE, Holtzman D, Bolen J, Stanwyck CA, Mack KA. Reliability and validity of measures from the Behavioral Risk Factor Surveillance System (BRFSS). Social Prev Med 2001;46:S3–S42.
5. US Department of Health and Human Services. Women and smoking: a report of the Surgeon General. Rockville, MD: US Department of Health and Human Services, Public Health Service, Office of the Surgeon General; 2001:24–25.
6. Farrelly MC, Pechacek TP, Chaloupka FJ. The impact of tobacco control program expenditures on aggregate cigarette sales: 1981–2000. Health Econ 2003;22:843–59.
7. Task Force on Community Preventive Services. Guide to community preventive services: tobacco use prevention and control. Am J Prev Med 2001;20(2 Suppl 1):1–87.
8. CDC. State Medicaid coverage for tobacco-dependence treatments—United States, 1994–2002. MMWR 2004;53:54–7.
9. Orzechowski W, Walker RC. The tax burden on tobacco, volume 38. Arlington, VA: Orzechowski and Walker; 2003.
10. Campaign for Tobacco-Free Kids, American Heart Association, American Cancer Society, American Lung Association. A broken promise to our children: the 1998 state tobacco settlement five years later. Washington, DC: Campaign for Tobacco-Free Kids; 2003. Available at http://www.tobaccofreekids.org/reports/settlements/2004/fullreport.pdf.

Indoor Air Quality in Hospitality Venues Before and After Implementation of a Clean Indoor Air Law — Western New York, 2003

Secondhand smoke (SHS) contains more than 50 carcinogens (*1*). SHS exposure is responsible for an estimated 3,000 lung cancer deaths and more than 35,000 coronary heart disease deaths among never smokers in the United States each year (*2*), and for lower respiratory infections, asthma, sudden infant death syndrome, and chronic ear infections among children (*3*). Even short-term exposures to SHS, such as those that might be experienced by a patron in a restaurant or bar that allows smoking, can increase the risk of experiencing an acute cardiovascular event (*4*). Although population-based data indicate declining SHS exposure in the United States over time (*5*), SHS exposure remains a common but preventable public health hazard. Policies requiring smoke-free environments are the most effective method of reducing SHS exposure (*6*). Effective July 24, 2003, New York implemented a comprehensive state law requiring almost all indoor workplaces and public places (e.g., restaurants, bars, and other hospitality venues) to be smoke-free. This report describes an assessment of changes in indoor air quality that occurred in 20 hospitality venues in western New York where smoking or indirect SHS exposure from an adjoining room was observed at baseline. The findings indicate that, on average, levels of respirable suspended particles (RSPs), an accepted marker for SHS levels, decreased 84% in these venues after the law took effect. Comprehensive clean indoor air policies can rapidly and effectively reduce SHS exposure in hospitality venues.

The specific class of RSP monitored was $PM_{2.5}$ (i.e., particulate matter that is <2.5 microns in diameter). Particles of this size are released in substantial amounts from burning cigarettes and are easily inhaled deep into the lungs. Baseline measurements were made during July 11–23 in a purposeful sample of 22 hospitality venues in three counties in western New York. Sites were selected to provide a range of venue types, sizes, and locations. The sample consisted of seven bars, six bar/restaurants, five restaurants, two bowling alleys, a pool hall, and a bingo hall. The venues were located in popular downtown entertainment districts and suburban areas and ranged from small neighborhood bars to large bar/restaurant chains.

At baseline, smoking was occurring in 14 bars and restaurants and four large recreation venues. Two bar/restaurant combinations allowed smoking in the bar section but not in the adjoining restaurant section. In these two venues, air quality was monitored separately in the restaurant and bar areas. In two restaurants, no smoking was occurring at baseline because restaurants were already required to be smoke-free by local clean indoor air ordinances. Follow-up measurements of air quality were made in all 22 venues during September 9–November 1. The follow-up measurements were taken on the same day of the week and at approximately the same time of day as the measurements taken before the smoke-free law was implemented.

The median time spent in each venue for all 44 baseline and follow-up observations combined was 38 minutes (range: 22–140 minutes). Measurements were taken at 1-second intervals. The number of persons and the number of burning cigarettes in each venue were recorded every 10 minutes during sampling, and the average number of persons and the average number of burning cigarettes in each venue were calculated. The volume of each venue also was measured*, and the cigarette density was calculated by dividing the average number of burning cigarettes by the room volume.

An air monitor† was used to sample and record RSP levels. The monitor was placed in a central location on a table or bar near the height at which a person breathes air. The monitor recorded continuous measurements, which were averaged over time. The first and last minute of logged data were removed, and the remaining data points were averaged to provide an average concentration of $PM_{2.5}$ within the venue. The percentage change in $PM_{2.5}$ levels was then determined by comparing average $PM_{2.5}$ levels in each venue before the law went into effect with levels after the law was implemented. The Wilcoxon signed-rank test was used to assess changes between pre-law and post-law $PM_{2.5}$ levels, stratified by type of venue.

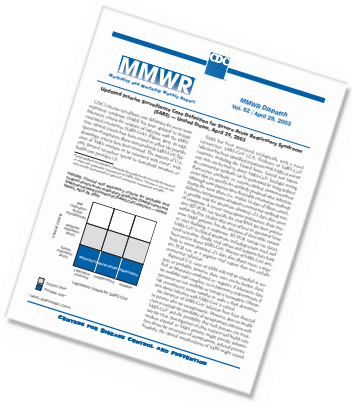
The average $PM_{2.5}$ concentration was substantially lower after the law went into effect in every venue where smoking or indirect SHS exposure had been observed at baseline, with a grand mean reduction in $PM_{2.5}$ concentration of 84% (324 $\mu g/m^3$ to 25 $\mu g/m^3$; $p<0.001$) (Table). When stratified by the type of venue sampled, the average $PM_{2.5}$ concentration decreased 90% (412 $\mu g/m^3$ to 27 $\mu g/m^3$; $p<0.001$) in the 14 bars and restaurants in which smoking was occurring at baseline (including bar/restaurant J, which was the only venue where smoking was observed during the post-law sampling). The restaurant portions of the two bar/restaurants that allowed smoking in the bar section but not in the restaurant section experienced an average 58% decrease in $PM_{2.5}$

*The Zircon DM S50 Sonic Measure® (Zircon Corporation, Campbell, California) was used to perform this measurement.

†The air monitor used was a TSI SidePak AM510 Personal Aerosol Monitor® (TSI, Inc., St. Paul, Minnesota). The SidePak uses a built-in sampling pump to draw air through the device, which then measures the real-time concentration in milligrams per cubic meter of $PM_{2.5}$. The SidePak was calibrated against a SHS-calibrated nephelometer, which had been previously calibrated and used in similar studies. The SidePak was zero-calibrated before each use according to the manufacturer's specifications.

up-to-the-minute: *adj*

1 : extending up to the immediate present, including the very latest information; see also *MMWR*.



know what matters.

MMWR™
Dispatch

TABLE. Change in concentrations of respirable suspended particles after the implementation of a clean indoor air law, by venue — western New York, 2003

Venue	Size (m^3)	Cigarette density*		Average $PM_{2.5}$† level ($\mu g/m^3$)		% reduction in $PM_{2.5}$
		Before July 24, 2003	After July 24, 2003	Before July 24, 2003	After July 24, 2003	
Bars and restaurants in which smoking was occurring						
Bar A	349	0.86	0	353	56	84.1
Bar B	453	1.32	0	375	20	94.7
Bar C	225	1.34	0	1,375	52	96.2
Bar D	319	0.94	0	386	35	90.9
Bar E	245	0.86	0	104	28	73.1
Bar F	339	3.25	0	569	26	95.4
Bar G	335	1.79	0	681	13	98.1
Bar/Restaurant H	299	1.34	0	425	10	97.6
Bar/Restaurant I	321	1.56	0	198	21	89.3
Bar/Restaurant J	551	1.45	0.09	597	83	86.1
Bar/Restaurant K	479	0.42	0	62	10	83.9
Bar/Restaurant L	318	0.52	0	352	6	98.0
Bar/Restaurant M	786	0.25	0	54	11	79.6
Restaurant N	95	3.15	0	233	6	97.4
Mean§	*365*	*1.36*	*0.01*	*412*	*27*	*90.3*
Restaurant portions of bar/restaurant combinations with indirect secondhand smoke (SHS) exposure¶						
Restaurant O	438	0	0	273	34	87.5
Restaurant P	381	0	0	38	27	28.9
Mean§	*410*	*0*	*0*	*156*	*31*	*58.2*
Other venues in which smoking was occurring						
Bowling alley Q	5,930	0.03	0	35	13	62.9
Bowling alley R	2,916	0.17	0	87	26	70.1
Pool hall S	1,570	0.26	0	176	6	96.6
Bingo hall T	3,704	0.40	0	105	26	75.2
Mean§	*3,530*	*0.22*	*0*	*101*	*18*	*76.2*
Grand mean**	**1,003**	**1.01**	**0.01**	**324**	**25**	**84.3**
Restaurants in which no smoking and no indirect SHS exposure was occurring						
Restaurant U	446	0	0	6	6	0.0
Restaurant V	337	0	0	41	40	2.4
Mean§	*392*	*0*	*0*	*24*	*23*	*1.2*

* Average number of burning cigarettes per 100 m^3.
† Particulate matter <2.5 microns in diameter.
§ Results represent the average of the values for the venues listed in each category.
¶ Restaurant O is attached to Bar A with little physical separation between the two spaces; Restaurant P is attached to Bar B but with substantial physical separation between the two spaces.
** For all venues where any smoking or indirect SHS exposure was occurring at baseline (i.e., venues A–T).

concentrations (156 $\mu g/m^3$ to 31 $\mu g/m^3$; $p<0.001$) after the law was implemented, even though they had only indirect SHS exposure at baseline. In the four other large recreation venues, which had larger volumes and lower smoker densities, the average $PM_{2.5}$ concentration decreased 76% (101 $\mu g/m^3$ to 18 $\mu g/m^3$). In contrast, the $PM_{2.5}$ concentration remained low and virtually constant in the two restaurants that were already smoke-free at baseline; these venues were not included in the grand mean calculation.

Reported by: *MJ Travers, KM Cummings, PhD, A Hyland, PhD, Dept of Health Behavior, Roswell Park Cancer Institute, Buffalo, New York. J Repace, MSc, Repace Associates, Bowie, Maryland. S Babb, MPH, T Pechacek, PhD, R Caraballo, PhD, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

Editorial Note: The findings in this report indicate that a statewide law to eliminate smoking in enclosed workplaces and public places substantially reduced RSP levels in western New York hospitality venues. RSP levels were reduced in

every venue that permitted smoking before the law was implemented, including venues in which only SHS from an adjacent room was observed at baseline.

These findings are consistent with those of previous studies. In Delaware, a similar decline in RSP levels was observed in eight hospitality venues after smoking was prohibited there by state law (*7*). Previous studies also have assessed the health effects of smoke-free laws. One study indicated that respiratory health improved rapidly among a sample of bartenders after a state smoke-free workplace law was implemented in California (*8*), and another study reported a 40% reduction in acute myocardial infarction admissions to a regional hospital during the 6 months that a local smoke-free ordinance was in effect in Helena, Montana (*9*). The results of these studies (both those assessing changes in indoor air quality and those assessing changes in health) suggest that improvements can occur within months of policy implementation.

The findings in this report are subject to at least two limitations. First, the venues sampled were not necessarily representative of venues in western New York. However, they did provide a range of venue types, sizes, and locations. Second, SHS is not the only source of indoor particulate matter. However, although ambient particle concentrations and cooking are additional sources of indoor particle levels, secondhand smoke is the largest contributor to indoor RSP pollution (*3*).

Eliminating nonsmoker exposure to SHS is one of the four goals of comprehensive state tobacco-control programs, as set forth in CDC's *Best Practices for Comprehensive Tobacco Control Programs* (*10*). The results of the study described in this report indicate that a comprehensive statewide ban on smoking in indoor workplaces and public places can substantially reduce SHS exposure in these settings. Six states (California, Connecticut, Delaware, Maine, Massachusetts, and New York) currently meet the national health objective for 2010 calling for implementation of such laws. These six states account for approximately 23% of the U.S. population. Rhode Island also has adopted such a law, but the law does not take full effect until 2006. To further reduce the nearly 40,000 deaths among never smokers caused by SHS exposure each year, similar comprehensive laws are needed in the other 43 states and the District of Columbia.

References

1. National Toxicology Program. 9th report on carcinogens. Research Triangle Park, NC: US Department of Health and Human Services, National Institute of Environmental Health Sciences; 2000.
2. CDC. Annual smoking-attributable mortality, years of potential life lost, and economic costs—United States, 1995–1999. MMWR 2002;51:300–3.
3. National Cancer Institute. Health effects of exposure to environmental tobacco smoke: the report of the California Environmental Protection Agency. Bethesda, MD: US Department of Health and Human Services, National Institutes of Health, National Cancer Institute; 1999.
4. Pechacek TF, Babb S. Commentary: how acute and reversible are the cardiovascular risks of secondhand smoke? BMJ 2004;328:980–3.
5. CDC. Second national report on human exposure to environmental chemicals. Atlanta, GA: US Department of Health and Human Services, CDC; 2003.
6. CDC. Reducing tobacco use: a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, CDC; 2000.
7. Repace J. Respirable particles and carcinogens in the air of Delaware hospitality venues before and after a smoking ban. J Occup Environ Med 2004;46:887–905.
8. Eisner MD, Smith AK, Blanc PD. Bartenders' respiratory health after establishment of smoke-free bars and taverns. JAMA 1998;280:1909–14.
9. Sargent RP, Shepard RM, Glantz SA. Reduced incidence of admissions for myocardial infarction associated with public smoking ban: before and after study. BMJ 2004;328:977–80.
10. CDC. Best practices for comprehensive tobacco control programs—August 1999. Atlanta, GA: US Department of Health and Human Services, CDC; 1999. Available at http://www.cdc.gov/tobacco/bestprac.htm.

Vaccination Coverage Among Children Entering School — United States, 2003–04 School Year

One of the national health objectives for 2010 is to sustain ≥95% vaccination coverage among children in kindergarten through first grade (objective 14-23) (*1*). To determine the percentage of vaccination coverage among children entering kindergarten, data on vaccination coverage were analyzed from reports submitted to the National Immunization Program by states, the District of Columbia (DC)*, and eight current or former U.S. territories for the 2003–04 school year. This report summarizes the results of that analysis, which determined that coverage for all vaccines except hepatitis B (HepB) and varicella was reported at >90% in 45 areas. However, the vaccines required in each reporting area and the methods for surveying kindergarten-aged children vary substantially; in seven states, <20% of eligible children were surveyed. The wide variations in survey populations underscore the need for CDC to continue working with immunization programs in states, DC, and current or former territories to improve survey methods and automate reporting of data.

For the 2003–04 school year, all states except one submitted reports of vaccination coverage levels for children entering kindergarten. Fifty reports included coverage for poliovirus vaccine, diphtheria and tetanus toxoids and pertussis vaccine, diphtheria and tetanus toxoids and acellular pertussis vaccine,

* For this report, DC is included in state totals.

or diphtheria and tetanus toxoids (DTP/DTaP/DT), measles vaccine, and rubella vaccines; 49 reports included coverage for mumps vaccine (Table 1). Coverage for HepB vaccine was included in 43 reports, and coverage for varicella vaccine was included in 33 state reports. DC reported on all of the vaccination coverages. When determining coverage, up-to-date (UTD) status was used rather than number of doses because the doses required to be UTD vary depending on timing of vaccinations, area requirements regarding number of doses, and brand of vaccines.

The number of state reports based on 100% of children entering kindergarten increased from 18 in the 2002–03 school year to 22 in 2003–04 (*2*). In an additional 21 states, coverage was assessed in surveys of >80% of eligible children. In the remaining seven states, coverage was assessed in surveys of <20% of eligible children (range: 0.5%–18.5%). National estimates of coverage were calculated by weighting each state's coverage estimate by the size of the state's kindergarten enrollment.

Coverage for all vaccines except HepB and varicella was reported at 90%–95% in 16 (31.3%) states and at >95% in 29 (56.9%) states (Table 1). Nationally, coverage was reported at >95% for all vaccines except varicella, for which coverage was 93.3%.

Five (63%) of the eight current or former U.S. territories reported data for the 2003–04 school year. All five reports included coverage for poliovirus vaccine, DTP/DTaP/DT vaccine, and vaccines for measles, mumps, rubella, and HepB (Table 2). Two territories reported coverage for 1 dose of varicella vaccine. The percentage of children surveyed by the current or former U.S. territories ranged from 10.0% to 100.0%. Coverage for all vaccines except DTP/DTaP/DT vaccine was reported to be >86%.

Reported by: *B Lyons, MPH, C Stanwyck, PhD, Immunization Svcs Div; M McCauley, MTSC, National Immunization Program, CDC.*

Editorial Note: CDC has increased efforts to help states and current or former U.S. territories collect and report data on vaccination coverage among children entering school by providing a new online reporting system, available since the 2002–03 school year. Anecdotal reports from states indicate that the online reporting system, which automates data management and calculation tasks, has made it easier for states to report their coverage. CDC also has encouraged greater standardization of reporting; unlike previous reports, this report is based only on coverage among children entering kindergarten, rather than on a mix of those children and first graders.

TABLE 1. Estimated vaccination coverage among children enrolled in kindergarten, by vaccine and state*— Annual School Surveillance, United States, 2003–04 school year

State	% surveyed[†]	Polio (%)	DTP/DTaP/DT[§] (%)	Measles (%)	Mumps (%)	Rubella (%)	HepB[¶] (%)	Varicella (%)
Alabama	100.0	96.8	96.8	96.8	96.8	96.8	—**	94.7
Alaska	91.1	96.4	95.5	95.1	95.1	95.1	95.1	—
Arizona	97.0	97.9	95.6	95.6	95.6	95.6	96.5	—
Arkansas	100.0	91.4	91.3	91.3	92.7	92.7	93.2	93.4
California	100.0	96.9	96.8	96.8	96.8	96.8	98.1	98.6
Colorado	99.0	84.0	84.0	84.0	84.0	84.0	84.0	84.0
Connecticut	100.0	99.0	99.0	99.2	99.2	99.2	85.5	85.6
Delaware	82.3	98.3	98.4	94.1	94.1	94.1	97.2	86.1
District of Columbia	100.0	95.3	94.2	90.7	90.7	90.8	93.8	95.3
Florida	100.0	94.4	94.4	94.4	94.4	94.4	94.4	94.4
Georgia	97.7	92.0	92.0	92.0	92.0	92.0	92.0	92.0
Hawaii	99.3	99.4	99.1	99.4	99.4	99.4	99.6	99.8
Idaho	100.0	96.9	95.7	97.2	97.2	97.2	96.3	—
Illinois	1.1	90.4	95.1	93.8	93.8	93.8	93.6	66.2
Indiana	100.0	97.5	97.1	97.1	97.1	99.5	98.5	—
Iowa	98.7	88.9	88.9	88.9	88.9	88.9	88.9	—
Kansas	8.8	97.5	96.6	96.3	96.3	96.3	—	—
Kentucky	93.1	96.3	96.3	95.6	95.6	95.6	95.8	84.5
Louisiana	100.0	97.1	95.3	99.6	99.6	99.6	91.6	90.4
Maine	98.1	93.3	95.1	93.8	93.8	93.8	—	93.1
Maryland	91.8	98.7	98.5	97.8	98.4	98.4	98.5	98.8
Massachusetts	98.8	94.6	94.0	94.8	94.8	94.8	98.1	98.2
Michigan	100.0	98.8	98.1	97.4	97.4	97.4	98.2	92.1
Minnesota	100.0	97.0	96.0	98.0	98.0	98.0	97.0	—
Mississippi	100.0	99.8	99.8	99.8	99.8	99.8	99.8	99.8
Missouri	98.1	97.3	96.9	97.0	97.3	97.4	97.7	—
Montana	99.3	98.6	98.6	80.3	80.3	80.3	—	—
Nebraska	100.0	96.4	98.0	95.9	95.9	95.9	97.8	—
Nevada	—	—	—	—	—	—	—	—
New Hampshire	89.8	89.0	89.1	87.5	85.9	85.9	89.0	86.6
New Jersey	100.0	95.7	95.7	95.7	95.7	95.7	95.7	—
New Mexico	100.0	91.3	91.1	91.3	91.3	91.3	92.2	91.9
New York	100.0	98.5	98.3	96.8	98.4	98.4	98.1	96.9
North Carolina	91.2	99.7	99.7	99.7	99.7	99.7	99.7	—
North Dakota	100.0	97.5	97.1	94.8	94.8	94.8	97.0	—
Ohio	100.0	94.6	94.1	97.2	97.2	97.2	96.3	—
Oklahoma	90.1	95.2	94.0	93.0	93.0	93.0	97.9	97.4
Oregon	100.0	96.5	96.0	96.2	97.3	97.3	94.0	96.5
Pennsylvania	94.0	88.0	88.0	88.0	88.0	88.0	88.0	88.0
Rhode Island	100.0	95.9	95.5	95.3	95.3	95.3	98.0	97.8
South Carolina	11.5	99.1	99.2	98.2	98.2	98.2	98.9	98.6
South Dakota	100.0	98.1	98.1	94.7	94.7	94.7	—	94.8
Tennessee	98.3	96.8	96.8	96.8	96.8	96.8	96.8	96.8
Texas	0.5	95.4	95.7	95.5	98.8	98.8	97.2	95.9
Utah	99.4	98.5	97.9	98.4	98.5	98.6	98.6	98.5
Vermont	99.8	96.9	97.3	92.7	—	92.7	—	—
Virginia	6.2	97.4	96.1	97.2	97.2	97.2	95.5	92.8
Washington	100.0	93.3	93.3	91.2	95.7	95.7	95.2	—
West Virginia	84.8	95.6	96.8	96.1	96.1	96.1	—	—
Wisconsin	1.4	92.1	93.0	89.0	89.0	89.0	89.0	91.8
Wyoming	18.5	98.1	98.4	98.5	98.5	98.5	98.4	76.1
Total		**95.6**	**95.5**	**95.4**	**96.0**	**95.9**	**95.7**	**93.3**

* Includes District of Columbia.
† Percentage of eligible children included in the survey.
§ Diphtheria and tetanus toxoids and pertussis vaccine, diphtheria and tetanus toxoids and acellular pertussis vaccine, or diphtheria and tetanus toxoids.
¶ Hepatitis B vaccine.
** Data not available.

TABLE 2. Estimated vaccination coverage among children enrolled in kindergarten, by vaccine and territory — Annual School Surveillance, current or former U.S. territories, 2003–04 school year

Territory	% surveyed*	Polio (%)	DTP/DTaP/DT† (%)	Measles (%)	Mumps (%)	Rubella (%)	HepB§ (%)	Varicella (%)
American Samoa	100.0	97.4	95.8	98.2	98.2	98.2	97.4	—¶
Guam	10.0	97.8	97.4	98.1	98.1	98.1	87.3	—
Marshall Islands	—	—	—	—	—	—	—	—
Micronesia	—	—	—	—	—	—	—	—
N. Mariana Islands	100.0	95.9	95.9	95.9	95.9	95.9	100.0	—
Palau	—	—	—	—	—	—	—	—
Puerto Rico	58.2	91.1	69.4	90.7	90.7	90.7	97.1	92.0
U.S. Virgin Islands	60.6	86.4	83.3	88.8	88.8	88.8	91.5	90.0
Total		**91.4**	**71.4**	**91.2**	**91.2**	**92.2**	**96.6**	**92.0**

* Percentage of eligible children included in the survey.
† Diphtheria and tetanus toxoids and pertussis vaccine, diphtheria and tetanus toxoids and acellular pertussis vaccine, or diphtheria and tetanus toxoids.
§ Hepatitis B vaccine.
¶ Data not available.

State laws requiring proof of vaccination before entering school have been referred to as a "safety net" for the U.S. vaccination program because they ensure that no child is missed (*3*). This safety net relies on the efforts of school nurses, teachers, and others to identify children who are not UTD. Findings of uniformly high nationwide coverage during the 2002–03 and 2003–04 school years underscore the success of school entry requirements in boosting vaccine coverage. Childhood vaccination coverage is also measured nationally among children aged 19–35 months (*4*). Higher percentages of children are UTD at kindergarten entry than at younger ages, suggesting that school entry laws are a key to ensuring high coverage.

The findings in this report are subject to at least two limitations. First, methods for assessing vaccination coverage among children entering school vary because state and local laws determine which vaccines and doses are required, and sampling methods differ. The substantial variation in sampling methods among states limits the comparability of these data. Second, children attending private schools and those who are home-schooled were not surveyed by all states. The difference in vaccination rates between children schooled at home and children in traditional school environments is unknown.

Additional information about assessing and reporting vaccination coverage among children entering school is available from the National Immunization Program Immunization Information Hotline, telephone 800-232-2522 (English) or 800-232-0233 (Spanish), or by e-mail at nipinfo@cdc.gov.

References

1. US Department of Health and Human Services. Healthy people 2010 (conference ed, in 2 vols). Washington, DC: US Department of Health and Human Services; 2000. Available at http://www.health.gov/healthypeople.
2. CDC. Vaccination coverage among children entering school—United States, 2002–03 school year. MMWR 2003;52:791–3.
3. Orenstein WA, Bernier RH. Surveillance. Information for action. Pediatr Clin North Am 1990;37:709–34.
4. CDC. National, state, and urban area vaccination levels among children aged 19–35 months—United States, 2003. MMWR 2004;53:658–61.

Awareness of Family Health History as a Risk Factor for Disease — United States, 2004

Persons who have close relatives with certain diseases (e.g., heart disease, diabetes, and osteoporosis) are more likely to develop those diseases themselves (*1*). Family health history is an important risk factor that reflects inherited genetic susceptibility, shared environment, and common behaviors. Although clinicians are trained to collect family histories, substantial barriers exist to obtaining this information in primary care practice (e.g., lack of time or lack of reimbursement) (*2*). To promote the use of family history as a screening tool for disease prevention and health promotion, several initiatives have called for new self-administered family history collection tools and educational programs to help clinicians interpret and apply family history information to patient care (*3,4*). To assess attitudes, knowledge, and practices of U.S. residents regarding their family health histories, CDC analyzed data from the 2004 HealthStyles Survey. This report summarizes the results of that analysis, which indicated that although 96.3% of survey respondents believe their family history is important for their own health, few have actively collected health information from their relatives to develop a family history. Targeted public health efforts are needed to 1) help persons collect family history information to share with their health-care providers and 2) educate and assist providers to interpret and apply this information effectively.

HealthStyles is an annual mail survey of the U.S. population aged ≥18 years that examines health-related attitudes and behaviors (*5*). The survey is designed and conducted by Porter Novelli (Washington, DC), with technical assistance from health organizations, including CDC. In July and August 2004, a stratified random sample of 6,175 respondents was selected from approximately 600,000 households previously recruited to participate in a consumer marketing survey. In return for their participation, respondents were given small gifts (e.g., a 20-minute calling card) and entered into a sweepstakes drawing. Of the 6,175 households contacted by mail, 4,345 (70.4%) returned the survey. Survey data were weighted to match the 2003 Current Population Survey estimates relative to age, race/ethnicity, sex, income, and household size.

The survey included the following two general questions related to family history: 1) "How important do you think knowledge of your family's health history is to your personal health?" (possible responses were "very important," "somewhat important," "not at all important," or "not sure") and 2) "Have you ever actively collected heath information from your relatives for purposes of developing a family health history?" The likelihood of collecting a family health history was evaluated in relation to personal characteristics by using a multivariable logistic regression model. In addition, the 2004 HealthStyles Survey had a special focus on type 2 diabetes, so five questions were included to assess family history of this condition: 1) "Has your mother ever been diagnosed with type 2 diabetes?" 2) "Has your father ever been diagnosed with type 2 diabetes?" 3) "How many of your brothers and sisters were diagnosed with type 2 diabetes?" 4) "How many of your mother's relatives (her sisters, brothers, and parents) were diagnosed with type 2 diabetes?" and 5) "How many of your father's relatives (his sisters, brothers, and parents) were diagnosed with type 2 diabetes?" Knowledge of family history of type 2 diabetes was assessed by comparing "yes" or "no" responses with "don't know" responses.

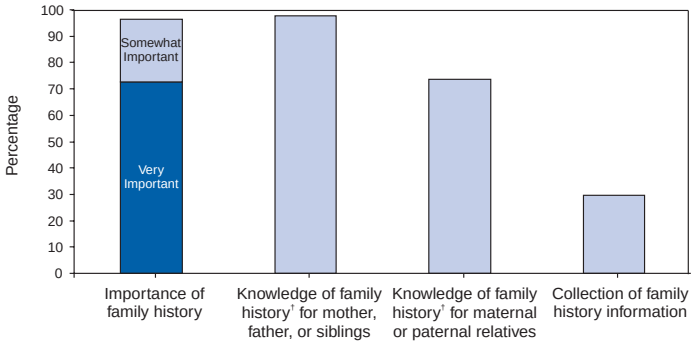
Of the 4,345 respondents, 3,063 (70.5%) were non-Hispanic whites and 3,012 (69.3%) were aged 18–54 years; 2,732 (62.9%) had at least some college education, and 3,395 (78.1%) reported ever being married (Table). Slightly more than half of all respondents were female (2,246; 51.7%) and reported annual incomes ≥$40,000 (2,355; 54.2%). Almost all of the respondents (4,183; 96.3%) considered knowledge of family history either very important (3,151; 72.5%) or somewhat important (1,032; 23.8%) to their personal health. Women were slightly more likely than men to report that family history was very important to their own health; equal proportions of men and women considered family history somewhat important. Respondents who had a high school education or less or who were aged ≥55 years were less likely to report that family history was important for their own

TABLE. Number and percentage of survey respondents* who actively collected health information on relatives to develop a family health history, by selected characteristics — HealthStyles Survey, United States, 2004

Characteristic	No. of respondents	No. of respondents who collected family health information	(%)	Odds ratio†	(95% CI§)
Sex					
Female	2,246	815	(36.3)	1.00	(ref¶)
Male	2,099	481	(22.9)	0.53	(0.46–0.61)
Race/Ethnicity					
White, non-Hispanic	3,063	923	(30.2)	1.00	(ref)
Black, non-Hispanic	500	165	(32.9)	1.10	(0.88–1.37)
Hispanic	530	129	(24.4)	0.77	(0.61–0.97)
Other	252	78	(31.0)	1.11	(0.82–1.51)
Age group (yrs)					
18–54	3,012	905	(30.1)	1.00	(ref)
≥55	1,333	390	(29.1)	1.13	(0.96–1.32)
Marital status					
Ever married	3,395	1,055	(31.1)	1.00	(ref)
Never married	875	226	(25.9)	0.77	(0.63–0.94)
Education					
Some college	2,732	911	(33.3)	1.00	(ref)
High school or less	1,222	312	(25.5)	0.69	(0.59–0.82)
Annual income					
≥$40,000	2,355	746	(31.7)	1.00	(ref)
<$40,000	1,990	550	(27.6)	0.95	(0.81–1.10)
Personal history of type 2 diabetes					
No	3,851	1,124	(29.2)	1.00	(ref)
Yes	419	156	(37.2)	1.53	(1.22–1.93)

* N = 4,345.
† Multivariate logistic regression model included the following variables: sex, race/ethnicity, age, marital status, education, income, and personal history of type 2 diabetes. All variables were weighted to match 2003 Current Population Survey estimates relative to age, race/ethnicity, sex, income, and household size.
§ Confidence interval.
¶ Reference value.

FIGURE. Percentage of respondents* reporting importance of family history to their personal health, knowledge of family history of type 2 diabetes, and collection of family history information — HealthStyles Survey, United States, 2004



* N = 4,345.
† Family history of type 2 diabetes.

health. Although the majority of respondents reported that family history was important, substantially fewer persons (1,296; 29.8%) reported actively collecting information to develop a family health history (Figure). Those who had collected a family health history were more likely to be female, previously or currently married, and to have more than a high school education. Respondents with a personal history of type 2 diabetes were also more likely to have collected health information from their relatives (Table).

Respondents' knowledge of family history of type 2 diabetes varied by type of relative (Figure). Moreover, more respondents reported knowing the type 2 diabetes status of their siblings (94.5%) and mother (91.2%) than of their father (87.8%; p<0.0001). Similarly, a greater percentage of respondents reported knowing the type 2 diabetes status of maternal relatives (77.0%) than paternal relatives (70.4%; p<0.0001). Non-Hispanic white race/ethnicity and higher education and income levels were positively associated with knowledge of family history of type 2 diabetes.

Reported by: *PW Yoon, ScD, MT Scheuner, MD, M Gwinn, MD, MJ Khoury, MD, PhD, Office of Genomics and Disease Prevention; C Jorgensen, DrPH, Div of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion; S Hariri, PhD, S Lyn, MD, EIS officers, CDC.*

Editorial Note: The findings in this report indicate that 96.3% of respondents considered knowledge of family history important to their personal health and that 70.0%–94.5% could report the type 2 diabetes status of their relatives, depending on the type of relative. However, only 29.8% reported actively collecting health information from their relatives to develop a family health history. This suggests that many persons know their family health histories but are not actively collecting the information. The analysis also suggests that certain population characteristics (e.g., sex, race, education, and socioeconomic status) might affect attitudes, knowledge, and practices regarding family health history.

The findings of this analysis are subject to at least two limitations. First, the HealthStyles Survey is subject to selection bias because the survey population is not a randomly drawn sample of the U.S. population. The results from this survey should be compared with data from population-based surveys, such as the Behavioral Risk Factor Surveillance System survey (*6*). Second, the assessment of awareness of disease status among relatives was limited to type 2 diabetes. Family history of other common diseases (e.g., cardiovascular diseases and cancer) should be assessed.

Most diseases are the result of complex interactions between genetic and environmental factors (*7*). Family health history reflects these interactions and helps predict risk for certain disorders, including birth defects, asthma, cardiovascular disease, cancer, diabetes, depression, Alzheimer's disease, and osteoporosis (*1,8*) For example, an evaluation of the risk for coronary heart disease (CHD) using a high school–based family history project determined that family history of CHD and stroke was identified in only 14% and 11% of families, respectively; however, these families accounted for 72% of all early-onset CHD and 86% of early stroke events (*9*).

Although family history can identify persons at increased risk for disease, its potential as a screening tool has not been realized in clinical and public health practice (*2*). An observational study of primary care physicians indicated that family histories were discussed about half the time at new visits and 22% of the time during follow-up visits (*10*). The average duration of the family history discussion was 2.5 minutes and focused more often on psychosocial concerns than on other health matters. To improve the use of family history in the clinical setting, the barriers to providers' collection and interpretation of a family history must be addressed.

The Department of Health and Human Services is highlighting the importance of family history for disease prevention with the U.S. Surgeon General's Family History Initiative. This initiative has proposed that Thanksgiving Day be designated a National Family History Day in which persons collect their family health histories. A new web-based tool, My Family Health Portrait (http://www.hhs.gov/familyhistory),

enables persons to collect family history for six diseases (CHD, stroke, diabetes, and colorectal, breast, and ovarian cancer) and identify additional diseases that occur in their families. After the family history information is completed, a report is generated that includes a pedigree drawing, a listing of the family history data entered, and a statement about the importance of sharing the history with their health-care providers. My Family Health Portrait is based on a self-administered tool being developed by CDC that will enable collection of family health history and provide recommendations tailored to the level of familial risk. In 2005, the CDC tool will be evaluated in clinical settings. Information about the tool can be found at http://www.cdc.gov/genomics/activities/ogdp/2003/chap06.htm.

Although national efforts have begun to promote the collection and use of family history information, the HealthStyles Survey data presented in this report suggest that certain subgroups of the population might benefit from targeted programs to raise awareness about the collection and recording of family health histories.

References

1. Bennett RL. The practical guide to the genetic family history. New York, NY: John Wiley & Sons, Inc.; 1999.
2. Rich EC, Burke W, Heaton CJ, et al. Reconsidering the family history in primary care. J Gen Inter Med 2004;19:273–80.
3. Yoon PW, Scheuner MT, Khoury MJ. Research priorities for evaluating family history in the prevention of common chronic diseases. Am J Prev Med 2003;24:128–35.
4. National Coalition for Health Professional Education in Genetics. Genetic family history resources. Lutherville, MD: National Coalition for Health Professional Education in Genetics; 2004. Available at http://www.nchpeg.org.
5. Pollard WE. Use of consumer panel survey data for public health communication planning: an evaluation of survey results. American Statistical Association Proceedings of the Section on Health Policy Statistics 2002:2720–4.
6. Balluz L, Ahluwalia IB, Murphy W, Mokdad A, Giles W, Harris VB. Surveillance for certain health behaviors among selected local areas—United States, Behavioral Risk Factor Surveillance System, 2002. MMWR 2004;53(No. SS-5).
7. Khoury MJ. Genetic epidemiology. In: Rothman KJ , Greenland S, eds. Modern epidemiology. Philadelphia, PA: Lippincott-Raven; 1998.
8. Scheuner MT, Wang SJ, Raffel LJ, Larabell SK, Rotter JI. Family history: a comprehensive genetic risk assessment method for the chronic conditions of adulthood. Am J Med Genet 1997;71:315–24.
9. Hunt SC, Gwinn M, Adams TD. Family history assessment: strategies for prevention of cardiovascular disease. Am J Prev Med 2003;24:136–42.
10. Acheson LS, Wiesner GL, Zyzanski SJ, Goodwin MA, Stange KC. Family history-taking in community family practice: implications for genetic screening. Genet Med 2000;2:180–5.

Preventive-Care Practices Among Adults with Diabetes — Puerto Rico, 2000–2002

Preventive-care practices among persons with diabetes can prevent or delay complications such as eye disease, kidney disease, or nerve damage that is a precursor to disabling foot disease (*1,2*). However, the level of diabetes-related preventive care is inadequate in the United States (*3–6*), and little has been reported about preventive care in Puerto Rico, where an estimated 10% of adults have diagnosed diabetes (*7*). CDC analyzed data from 2000, 2001, and 2002 Behavioral Risk Factor Surveillance System (BRFSS) surveys to assess the percentage of adults with diabetes in Puerto Rico who engaged in five selected preventive-care practices. This report summarizes the results of that analysis, which indicated that, with the exception of hemoglobin A1c testing, the percentages of adults engaging in preventive-care practices were lower than the target percentages* set by U.S. national health objectives for 2010 (*8*).

BRFSS conducts state-based, random-digit–dialed telephone surveys of the U.S. civilian, noninstitutionalized population aged ≥18 years in all 50 states, the District of Columbia, Puerto Rico, and other U.S. territories. For this analysis, respondents were considered to have diabetes if they answered "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who were told they had diabetes, but only during pregnancy, were classified as not having diabetes. Persons who reported they had diabetes were asked questions from the BRFSS diabetes module on preventive-care practices, including: "About how many times in the past 12 months has a health professional checked you for hemoglobin A1c?" "When was the last time you had an eye exam in which the pupils were dilated?" "About how many times in the last year has a health professional checked your feet for any sores or irritations?" "Have you ever taken a course in how to manage your diabetes yourself?" and "About how often do you check your blood for glucose or sugar?"

The response rate to the BRFSS survey in Puerto Rico was 65.3% in 2000, 81.5% in 2001, and 75.2% in 2002. Data were aggregated for 2000–2002 to obtain reliable estimates

* Hemoglobin A1c testing at least twice a year, 65% (objective 5-12†); annual dilated eye examination, 75% (objective 5-13); annual foot examination, 75% (objective 5-14); ever having education on diabetes self-management, 60% (objective 5-1); and self-monitoring of blood glucose at least once daily, 60% (objective 5-17).

† Objective 5-12 was revised since its original publication.

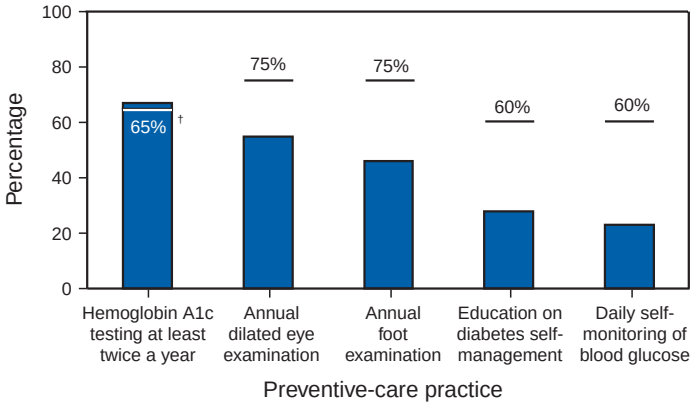
and weighted to reflect the age and sex distribution of the Puerto Rican population. The percentages of persons with diabetes who engaged in each of the five preventive-care practices as frequently as recommended (i.e., hemoglobin A1c testing at least twice a year, eye and foot examinations at least annually, formal diabetes education ever, and self-monitoring of blood glucose [SMBG] at least daily) were age-adjusted to the 2000 U.S. standard population for comparison with U.S. national health objectives for 2010 (*8*). Percentages were calculated for specific age and sex groups, and a t-test was performed to determine whether differences between groups were statistically significant. In addition, the total number of preventive-care practices per person was examined. For all analyses, statistical software was used to obtain standard errors and calculate 95% confidence intervals (CIs).

During 1998–2002, 10.0% of adults in Puerto Rico had diagnosed diabetes; prevalence was highest (25.3%) among those aged ≥65 years (*7*). However, during 2000–2002, the percentages of adults with diabetes in Puerto Rico who engaged in preventive-care practices as frequently as recommended, with the exception of hemoglobin A1c testing, were lower than U.S. national health objectives for 2010 (Figure 1). The age-adjusted percentage for hemoglobin A1c testing at least twice a year was 67.3%, compared with the national target of 65%. Age-adjusted percentages for annual eye and foot examinations were 54.6% and 45.6%, respectively, versus the target of 75% for both practices; percentages for ever having received diabetes self-management education and for daily SMBG were 28.1% and 22.6%, respectively, versus a national target of 60% for both.

The percentage of adults receiving A1c testing at least twice a year was higher than the U.S. national target for 2010 for both men (69.0%) and women (65.7%) and for persons aged 18–64 years and those aged ≥65 years; however, the percentage was significantly lower in the 18–64 age group (65.5% versus 76.2%; p<0.05) (Table). The percentage who received annual foot examinations also was significantly lower among those aged 18–64 years than among those aged ≥65 years (43.8% versus 54.6%; p<0.05). However, for the other three preventive-care practices, no significant differences by age were observed. For all of the practices, the percentages for men and women were similar.

Of the five preventive-care practices analyzed, 63.0% of adults with diabetes in Puerto Rico reported engaging in two or fewer practices, and 13.5% reported engaging in no preventive-care practices (Figure 2). A total of 37.0% of adults reported engaging in three or more practices, and 3.3% reported engaging in all five.

FIGURE 1. Percentage* of adults with diabetes who engaged in each of five preventive-care practices, compared with percentage targeted by national health objectives for 2010 — Behavioral Risk Factor Surveillance System, Puerto Rico, 2000–2002



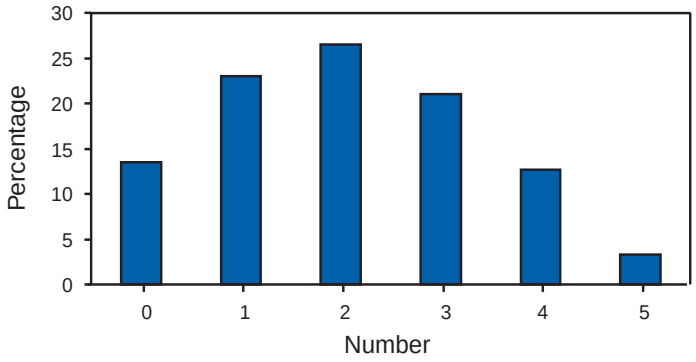
* Age-adjusted to the 2000 U.S. standard population.
† National health objective.

TABLE. Percentage of adults with diabetes who engaged in a preventive-care practice, by age group, sex, and practice — Behavioral Risk Factor Surveillance System, Puerto Rico, 2000–2002

Characteristic	Hemoglobin A1c testing* %	(95% CI†)	Dilated eye examination %	(95% CI)	Foot examination %	(95% CI)	Education on diabetes self-management %	(95% CI)	Self-monitoring of blood glucose (SMBG) %	(95% CI)
Age group (yrs)										
18–64	65.5	(60.7–70.3)	53.6	(49.0–58.2)	43.8	(39.2–48.4)	28.8	(24.6–33.0)	22.6	(18.6–26.6)
≥65	76.2	(71.3–81.0)	59.5	(54.5–64.4)	54.6	(49.7–59.5)	24.7	(20.5–28.9)	22.4	(18.5–26.3)
Total	**69.3**	**(65.8–72.9)**	**56.1**	**(52.7–59.5)**	**47.9**	**(44.5–51.3)**	**27.4**	**(24.3–30.5)**	**22.8**	**(19.9–25.7)**
Total§	**67.3**	**(63.3–71.3)**	**54.6**	**(50.7–58.5)**	**45.6**	**(41.7–49.5)**	**28.1**	**(24.5–31.6)**	**22.6**	**(19.2–26.0)**
Sex§										
Men	69.0	(62.9–75.0)	53.2	(47.2–59.3)	46.8	(40.7–52.8)	28.6	(23.0–34.2)	21.3	(16.0–26.6)
Women	65.7	(60.3–71.0)	56.0	(51.0–60.9)	44.4	(39.5–49.3)	27.6	(23.2–32.0)	23.8	(19.5–28.0)

* At least twice a year for hemoglobin A1c testing, annually for dilated eye and foot examinations, ever for education on diabetes self-management, and at least daily for self-monitoring of blood glucose.
† Confidence interval.
§ Age-adjusted to the 2000 U.S. standard population.

FIGURE 2. Percentage of adults with diabetes who engaged in 0–5 preventive-care practices — Behavioral Risk Factor Surveillance System, Puerto Rico, 2000–2002



Reported by: *Z Kianes-Pérez, MS, M Pérez-Padua, L Pérez-Rivera, MPHE, Diabetes Prevention and Control Program, Puerto Rico Dept of Health. NR Burrows, MPH, RV Díaz-Kenney, MPH, LS Geiss, MA, Div of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

Editorial Note: Effective interventions are available that can prevent or delay diabetes complications (*1,2*). Consistent with previous reports of diabetes-related preventive care in the United States (*3–6*), the findings in this report indicate that the percentages of adults with diabetes in Puerto Rico who engage in preventive-care practices, with the exception of A1c testing, were lower than U.S. national health targets for 2010. Fewer than 5% of adults with diabetes engaged in all five practices. Improvement in diabetes care, particularly in self-management education and in SMBG, is needed to achieve the U.S. national health objectives for 2010 and to reduce diabetes complications. In addition, younger persons with diabetes need interventions to improve their preventive care.

The findings in this report are subject to at least three limitations. First, BRFSS collects data through telephone surveys that do not include institutionalized persons (e.g., nursing home residents) or persons without telephones. As a result, the percentages of persons with diabetes who engaged in preventive-care practices in this report might be higher than the actual percentages because persons without telephones are more likely to have lower levels of education and less likely to receive preventive care (*3–6*). Second, self-reported data are subject to recall bias, and the effect of this bias on the magnitude and direction of the results is unknown. Such bias might cause preventive-care practices to be either under- or overreported. Finally, BRFSS response rates in Puerto Rico ranged from 65.3% to 81.5% during the study period; however, compared with census data, BRFSS data have minimal bias (*9*).

Since 1997, CDC has provided funding to the Diabetes Prevention and Control Program (DPCP) in Puerto Rico. DPCP adapted the Spanish version of CDC's train-the-trainer program, Diabetes Today (La Comunidad en Acción), to the Puerto Rican culture; the program is used to guide health professionals and community leaders in training lay health workers (promotores), improving diabetes self-management, and preventing diabetes complications. DPCP also develops protocols for standards of care and diabetes education materials, sponsors mass media and face-to-face educational campaigns focused on diabetes prevention and control, and collaborates with the Puerto Rico Diabetes Advisory Council and community-based organizations to improve diabetes care.

DPCP implemented the Puerto Rico Diabetes Surveillance System by using data from the BRFSS diabetes module and information from health insurance companies on diabetes, its complications, and use of health-care services. The BRFSS diabetes module is also used to evaluate program objectives and activities. Continued surveillance is essential to monitor the effectiveness of measures to improve levels of preventive-care practices among persons with diabetes in Puerto Rico.

References

1. UK Prospective Diabetes Study Group. Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33). Lancet 1998;352:839–55.
2. Narayan KM, Gregg EW, Fagot-Campagna A, Engelgau MM, Vinicor F. Diabetes—a common, growing, serious, costly, and potentially preventable public health problem. Diabetes Res Clin Pract 2000;50(Suppl 2): S77–84.
3. CDC. Preventive-care practices among persons with diabetes—United States, 1995 and 2001. MMWR 2002;51:965–9.
4. Saaddine JB, Engelgau MM, Beckles GL, Gregg EW, Thompson TJ, Venkat Narayan KM. A diabetes report card for the United States: quality of care in the 1990s. Ann Intern Med 2002;136:565–74.
5. CDC. Levels of diabetes-related preventive-care practices—United States, 1997–1999. MMWR 2000;49:954–8.
6. Beckles GL, Engelgau MM, Narayan KM, Herman WH, Aubert RE, Williamson DF. Population-based assessment of the level of care among adults with diabetes in the U.S. Diabetes Care 1998;21:1432–8.
7. CDC. Prevalence of diabetes among Hispanics—selected areas, 1998–2002. MMWR 2004;53:941–4.
8. US Department of Health and Human Services. Healthy people 2010 (conference ed, in 2 vols). Washington, DC: US Department of Health and Human Services; 2000. Available at http://www.health.gov/healthypeople.
9. Nelson DE, Holtzman D, Bolen J, Stanwyck CA, Mack KA. Reliability and validity of measures from the Behavioral Risk Factor Surveillance System (BRFSS). Social Prev Med 2001;46:S3–S42.

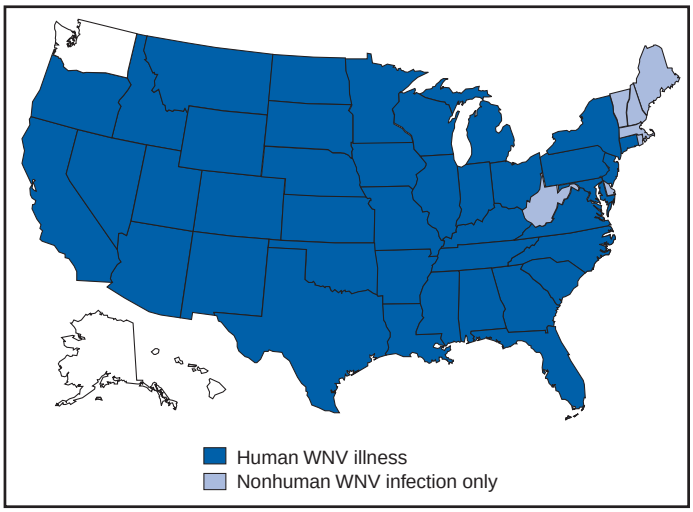
West Nile Virus Activity — United States, November 3–8, 2004

During November 3–8, a total of 41 cases of human West Nile virus (WNV) illness were reported from seven states (California, Maryland, Minnesota, New Mexico, Oregon, Tennessee, and Texas).

During 2004, 40 states and the District of Columbia (DC) have reported 2,282 cases of human WNV illness to CDC through ArboNET (Figure and Table). Of these, 737 (32%) cases were reported in California, 381 (17%) in Arizona, and 276 (12%) in Colorado. A total of 1,318 (59%) of the 2,251 cases for which such data were available occurred in males; the median age of patients was 52 years (range: 1 month–99 years). Date of illness onset ranged from April 23 to October 31; a total of 77 cases were fatal.

A total of 195 presumptive West Nile viremic blood donors (PVDs) have been reported to ArboNET in 2004. Of these, 68 (35%) were reported in California; 38 (19%) in Arizona; 16 in Texas; 15 in New Mexico; seven in Colorado; six each in Louisiana and Oklahoma; five in Nevada; four in Georgia and Iowa; three each in Florida, Michigan, and South Dakota; two each in Minnesota, Mississippi, Missouri, and Wisconsin; and one each in Delaware, Kentucky, Maryland, Nebraska, New Jersey, New York, North Dakota, Oregon, and Pennsylvania. Of the 195 PVDs, three persons aged 35, 69, and 77 years subsequently had neuroinvasive illness, and 48 persons (median age: 52 years; range: 17–73 years) subsequently had West Nile fever.

FIGURE. Areas reporting West Nile virus (WNV) activity — United States, 2004*



* As of 3 a.m., Mountain Standard Time, November 8, 2004.

TABLE. Number of human cases of West Nile virus (WNV) illness, by area — United States, 2004*

Area	Neuro-invasive disease†	West Nile fever§	Other clinical/ unspecified¶	Total reported to CDC**	Deaths
Alabama	13	0	0	**13**	0
Arizona	128	70	183	**381**	10
Arkansas	12	9	1	**22**	0
California	150	256	331	**737**	20
Colorado	39	237	0	**276**	3
Connecticut	0	1	0	**1**	0
District of Columbia	1	0	0	**1**	0
Florida	29	8	0	**37**	2
Georgia	11	6	0	**17**	0
Idaho	0	0	2	**2**	0
Illinois	28	27	1	**56**	3
Indiana	5	0	2	**7**	1
Iowa	11	7	4	**22**	2
Kansas	18	25	0	**43**	2
Kentucky	1	6	0	**7**	0
Louisiana	68	17	0	**85**	7
Maryland	6	6	1	**13**	0
Michigan	10	1	0	**11**	0
Minnesota	13	21	0	**34**	2
Mississippi	23	5	2	**30**	3
Missouri	25	9	2	**36**	1
Montana	2	3	1	**6**	0
Nebraska	4	26	0	**30**	0
Nevada	25	19	0	**44**	0
New Jersey	1	0	0	**1**	0
New Mexico	30	50	4	**84**	4
New York	3	3	0	**6**	0
North Carolina	3	0	0	**3**	0
North Dakota	2	18	0	**20**	1
Ohio	11	1	0	**12**	2
Oklahoma	10	6	0	**16**	1
Oregon	0	3	0	**3**	0
Pennsylvania	8	3	1	**12**	2
South Carolina	0	1	0	**1**	0
South Dakota	6	45	0	**51**	1
Tennessee	13	1	0	**14**	0
Texas	84	29	0	**113**	8
Utah	6	5	0	**11**	0
Virginia	4	0	1	**5**	1
Wisconsin	4	6	0	**10**	1
Wyoming	2	5	2	**9**	0
Total	**809**	**935**	**538**	**2,282**	**77**

* As of November 8, 2004.
† Cases with neurologic manifestations (i.e., West Nile meningitis, West Nile encephalitis, and West Nile myelitis).
§ Cases with no evidence of neuroinvasion.
¶ Illnesses for which sufficient clinical information was not provided.
** Total number of human cases of WNV illness reported to ArboNet by state and local health departments.

In addition, 5,562 dead corvids and 1,401 other dead birds with WNV infection have been reported from 46 states and New York City during 2004. WNV infections have been reported in horses in 37 states; one bat in Wisconsin; nine dogs in Nevada, New Mexico, and Wisconsin; six squirrels in Arizona and Wyoming; and 14 unidentified animal species in nine states (Arizona, Idaho, Illinois, Iowa, Kentucky, Missouri, Nevada, New York, and South Carolina). WNV seroconversions have been reported in 1,409 sentinel chicken flocks in 14 states (Alabama, Arizona, Arkansas, California, Delaware, Florida, Iowa, Louisiana, Nebraska, Nevada, North Carolina, Pennsylvania, South Dakota, and Utah) and in 25 wild hatchling birds in Missouri and Ohio. Four seropositive sentinel horses were reported in Minnesota and Puerto Rico. A total of 8,131 WNV-positive mosquito pools have been reported in 38 states, DC, and New York City.

Additional information about national WNV activity is available from CDC at http://www.cdc.gov/ncidod/dvbid/westnile/index.htm and at http://westnilemaps.usgs.gov.

Notice to Readers

Maps of National, State, and County Data Now Available on CDC WONDER

Two CDC online data-access systems, WONDER (Wide-ranging Online Data for Epidemiologic Research) and GATHER (Geographic Analysis Tool for Health and Environmental Research), have collaborated to produce maps for WONDER data-query applications. WONDER users can now create maps for each data element measured, select quantiles or set custom break-points for data groups, choose whether to display highways and rivers, add labels, and choose a color scheme. Maps are available for the following WONDER data requests:

- census population estimates (http://wonder.cdc.gov/censj.html)
- bridged-race population estimates (http://wonder.cdc.gov/bridged-racej.html)
- natality (births) (http://wonder.cdc.gov/nataj.html)

Mapping capability will eventually be available for other data-query applications with location data elements.

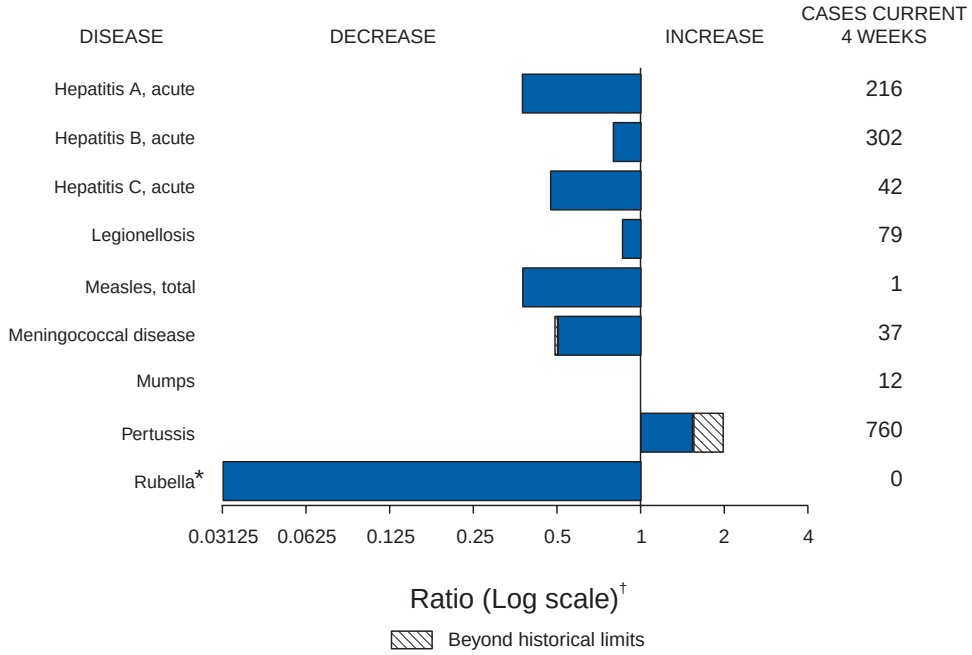
WONDER (available at http://wonder.cdc.gov) is an Internet system that makes CDC information resources and public health information available to public health professionals and the general public. GATHER (available at http://gis.cdc.gov/atsdr/default.asp) uses spatial analysis tools for public health applications, and is a product of CDC's Geographic Research, Analysis, and Services Program of the National Center for Environmental Health/Agency for Toxic Substances and Disease Registry.

Notice to Readers

Guidance on Initial Responses to Suspicious Letters and Packages

Law enforcement agencies and emergency responders are charged with investigation of suspicious letters and packages in the United States. Those responding are at risk from potential exposure to biologic agents, chemical substances, or radiologic materials. Guidelines for responding to five different types of situations (e.g., letter with unknown powder-like substance and threatening communication) have been developed by the Federal Bureau of Investigation, Department of Homeland Security, and Department of Health and Human Services/CDC. This guidance is now available at http://www.bt.cdc.gov/planning/pdf/suspicious-package-biothreat.pdf.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals November 6, 2004, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 44 of zero (0).
† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending November 6, 2004 (44th Week)*

	Cum. 2004	Cum. 2003		Cum. 2004	Cum. 2003
Anthrax	-	-	HIV infection, pediatric†¶	126	179
Botulism:	-	-	Influenza-associated pediatric mortality**	-	NA
foodborne	11	11	Measles, total	23††	51§§
infant	61	57	Mumps	169	186
other (wound & unspecified)	9	26	Plague	1	1
Brucellosis†	85	85	Poliomyelitis, paralytic	-	-
Chancroid	31	51	Psittacosis†	9	11
Cholera	4	1	Q fever†	60	57
Cyclosporiasis†	204	63	Rabies, human	3	2
Diphtheria	-	1	Rubella	10	7
Ehrlichiosis:	-	-	Rubella, congenital syndrome	-	1
human granulocytic (HGE)†	288	284	SARS-associated coronavirus disease† **	-	8
human monocytic (HME)†	254	235	Smallpox† ¶¶	-	NA
human, other and unspecified	28	39	*Staphylococcus aureus*:	-	-
Encephalitis/Meningitis:	-	-	Vancomycin-intermediate (VISA)† ¶¶	-	NA
California serogroup viral† §	75	108	Vancomycin-resistant (VRSA)† ¶¶	1	NA
eastern equine† §	3	13	Streptococcal toxic-shock syndrome†	89	138
Powassan† §	-	-	Tetanus	15	16
St. Louis† §	8	40	Toxic-shock syndrome	108	105
western equine† §	-	-	Trichinosis	4	1
Hansen disease (leprosy)†	69	69	Tularemia†	77	77
Hantavirus pulmonary syndrome†	18	18	Yellow fever	-	-
Hemolytic uremic syndrome, postdiarrheal†	123	147			

-: No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
¶ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update September 26, 2004.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of 23 cases reported, 10 were indigenous, and 13 were imported from another country.
§§ Of 51 cases reported, 31 were indigenous, and 20 were imported from another country.
¶¶ Not previously notifiable.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending November 6, 2004, and November 1, 2003 (44th 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	31,120	38,111	731,379	728,601	4,925	3,276	2,828	2,939	809	2,840
NEW ENGLAND	981	1,276	24,921	23,418	-	-	156	169	-	29
Maine	15	49	1,719	1,676	N	N	18	18	-	-
N.H.	37	34	1,454	1,327	-	-	30	19	-	2
Vt.	14	15	853	905	-	-	23	29	-	-
Mass.	343	518	11,052	9,314	-	-	54	73	-	12
R.I.	109	89	2,848	2,474	-	-	4	15	-	5
Conn.	463	571	6,995	7,722	N	N	27	15	-	10
MID. ATLANTIC	6,925	8,995	89,390	90,583	-	-	466	373	12	222
Upstate N.Y.	724	825	18,736	16,866	N	N	162	111	1	-
N.Y. City	3,949	4,987	28,111	29,375	-	-	94	105	2	56
N.J.	1,140	1,362	12,799	13,375	-	-	30	15	1	21
Pa.	1,112	1,821	29,744	30,967	N	N	180	142	8	145
E.N. CENTRAL	2,742	3,543	127,357	133,264	15	7	807	890	58	150
Ohio	525	717	30,886	36,601	N	N	200	134	11	84
Ind.	300	482	15,162	14,509	N	N	80	87	5	15
Ill.	1,290	1,597	35,364	40,646	-	-	77	91	28	30
Mich.	493	584	31,450	26,545	15	7	141	122	10	14
Wis.	134	163	14,495	14,963	-	-	309	456	4	7
W.N. CENTRAL	641	687	44,900	42,329	5	2	352	522	79	696
Minn.	152	140	8,352	9,065	N	N	117	137	13	48
Iowa	50	75	5,293	4,263	N	N	79	113	11	81
Mo.	277	320	17,427	15,457	3	1	61	42	25	39
N. Dak.	14	3	1,229	1,341	N	N	10	12	2	94
S. Dak.	8	10	2,135	2,199	-	-	37	37	6	151
Nebr.**	41	49	4,260	3,952	2	1	23	23	4	194
Kans.	99	90	6,204	6,052	N	N	25	158	18	89
S. ATLANTIC	9,492	10,557	145,520	137,034	-	5	466	322	54	184
Del.	121	192	2,490	2,556	N	N	-	4	-	12
Md.	1,252	1,281	15,954	13,738	-	5	15	23	6	49
D.C.	621	858	2,817	2,671	-	-	12	12	1	3
Va.	513	813	18,550	16,341	-	-	55	40	4	19
W. Va.	67	78	2,314	2,204	N	N	5	4	-	1
N.C.	482	989	24,286	22,020	N	N	70	44	3	16
S.C.**	535	713	17,317	12,147	-	-	15	8	-	2
Ga.	1,327	1,665	26,394	29,990	-	-	178	99	11	25
Fla.	4,574	3,968	35,398	35,367	N	N	116	88	29	57
E.S. CENTRAL	1,528	1,699	46,722	46,999	4	1	109	116	50	89
Ky.	187	175	4,880	6,896	N	N	39	21	1	11
Tenn.**	617	733	18,751	17,373	N	N	29	37	13	21
Ala.	360	391	9,382	12,167	-	-	20	48	13	25
Miss.	364	400	13,709	10,563	4	1	21	10	23	32
W.S. CENTRAL	3,581	4,058	88,435	89,059	2	-	66	99	174	597
Ark.	174	164	5,964	6,700	1	-	14	17	12	23
La.	719	520	18,539	16,727	1	-	3	4	68	92
Okla.	154	177	9,116	9,635	N	N	20	13	10	56
Tex.**	2,534	3,197	54,816	55,997	N	N	29	65	84	426
MOUNTAIN	1,178	1,327	39,926	40,929	3,175	1,975	144	120	232	871
Mont.	6	13	1,946	1,711	N	N	34	18	2	75
Idaho	15	22	2,277	2,057	N	N	24	26	-	-
Wyo.	16	6	876	821	2	1	3	5	2	92
Colo.	257	327	9,779	11,018	N	N	48	32	39	621
N. Mex.	152	98	4,333	6,277	20	9	11	10	30	74
Ariz.	437	576	13,330	11,136	3,067	1,924	17	5	128	7
Utah	53	60	3,002	3,156	34	8	5	17	6	-
Nev.	242	225	4,383	4,753	52	33	2	7	25	2
PACIFIC	4,052	5,969	124,208	124,986	1,724	1,286	262	328	150	2
Wash.	313	420	14,555	13,979	N	N	36	43	-	-
Oreg.	239	229	6,974	6,314	-	-	30	36	-	-
Calif.	3,357	5,214	95,226	96,905	1,724	1,286	194	248	150	2
Alaska	39	18	3,137	3,195	-	-	-	1	-	-
Hawaii	104	88	4,316	4,593	-	-	2	-	-	-
Guam	2	5	-	527	-	-	-	-	-	-
P.R.	595	940	2,858	2,255	N	N	N	N	-	-
V.I.	10	31	272	351	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	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 weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).

¶ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update September 26, 2004.

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 6, 2004, and November 1, 2003 (44th 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	2,054	2,260	228	210	148	136	14,983	16,143	260,532	279,007
NEW ENGLAND	140	135	46	37	15	12	1,468	1,364	5,806	6,130
Maine	10	10	-	1	-	-	112	163	184	173
N.H.	21	17	5	3	-	-	40	33	107	104
Vt.	12	15	-	-	-	-	148	108	73	75
Mass.	57	59	15	8	15	12	623	682	2,610	2,437
R.I.	9	1	1	-	-	-	107	95	712	816
Conn.	31	33	25	25	-	-	438	283	2,120	2,525
MID. ATLANTIC	244	224	47	21	29	33	3,171	3,208	28,926	34,834
Upstate N.Y.	112	83	34	10	14	17	1,137	883	6,119	6,609
N.Y. City	33	7	-	-	-	-	838	1,030	9,052	11,491
N.J.	37	30	4	2	5	-	344	432	5,031	6,860
Pa.	62	104	9	9	10	16	852	863	8,724	9,874
E.N. CENTRAL	372	521	36	30	27	17	2,080	2,775	54,085	59,497
Ohio	87	119	10	16	20	17	700	768	15,934	19,301
Ind.	51	74	-	-	-	-	-	-	5,548	5,664
Ill.	58	115	2	2	1	-	384	809	15,606	18,298
Mich.	76	82	7	-	6	-	615	655	13,230	11,448
Wis.	100	131	17	12	-	-	381	543	3,767	4,786
W.N. CENTRAL	442	405	29	48	16	20	1,714	1,773	14,235	14,835
Minn.	107	123	15	21	1	1	626	674	2,531	2,572
Iowa	119	94	-	-	-	-	258	239	938	1,051
Mo.	74	76	11	14	7	1	443	438	7,470	7,402
N. Dak.	14	12	-	4	6	8	21	32	87	79
S. Dak.	31	26	2	4	-	-	58	70	239	190
Nebr.	60	43	1	5	-	-	117	125	861	1,317
Kans.	37	31	-	-	2	10	191	195	2,109	2,224
S. ATLANTIC	149	127	38	39	50	38	2,372	2,286	65,968	68,522
Del.	2	9	N	N	N	N	39	40	758	977
Md.	20	12	4	3	4	1	100	100	6,826	6,579
D.C.	1	1	-	-	-	-	57	44	2,126	2,100
Va.	35	33	16	11	-	-	461	302	7,405	7,597
W. Va.	2	4	-	-	-	-	32	35	769	743
N.C.	-	-	-	-	34	30	N	N	12,778	12,786
S.C.	7	2	-	-	-	-	51	123	8,457	7,147
Ga.	22	25	11	5	-	-	691	736	11,614	14,924
Fla.	60	41	7	20	12	7	941	906	15,235	15,669
E.S. CENTRAL	78	75	4	2	9	6	325	338	20,367	23,554
Ky.	24	24	2	2	6	6	N	N	2,240	3,070
Tenn.	31	33	2	-	3	-	157	154	7,105	7,217
Ala.	16	14	-	-	-	-	168	184	5,743	7,813
Miss.	7	4	-	-	-	-	-	-	5,279	5,454
W.S. CENTRAL	66	81	2	4	2	4	269	256	34,267	36,875
Ark.	14	10	1	-	-	-	103	131	2,995	3,573
La.	4	3	-	-	-	-	37	11	8,710	9,649
Okla.	17	25	-	-	-	-	129	114	3,879	3,992
Tex.	31	43	1	4	2	4	N	N	18,683	19,661
MOUNTAIN	211	278	25	25	-	6	1,285	1,374	8,660	8,793
Mont.	16	16	-	-	-	-	68	95	58	92
Idaho	46	70	15	15	-	-	163	175	79	61
Wyo.	8	3	2	1	-	-	22	20	54	38
Colo.	44	62	2	4	-	6	444	394	2,168	2,432
N. Mex.	9	10	2	4	-	-	60	45	603	1,009
Ariz.	21	31	N	N	N	N	143	211	3,233	3,078
Utah	46	63	3	-	-	-	283	308	467	330
Nev.	21	23	1	1	-	-	102	126	1,998	1,753
PACIFIC	352	414	1	4	-	-	2,299	2,769	28,218	25,967
Wash.	127	98	-	1	-	-	317	317	2,240	2,321
Oreg.	66	95	1	3	-	-	404	360	1,042	847
Calif.	148	209	-	-	-	-	1,431	1,943	23,468	21,319
Alaska	1	4	-	-	-	-	79	76	453	463
Hawaii	10	8	-	-	-	-	68	73	1,015	1,017
Guam	N	N	-	-	-	-	-	2	-	55
P.R.	-	1	-	-	-	-	110	282	212	239
V.I.	-	-	-	-	-	-	-	-	80	77
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 November 6, 2004, and November 1, 2003 (44th 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	1,537	1,569	13	25	89	97	147	168	4,606	5,883
NEW ENGLAND	133	117	1	2	5	5	3	3	860	276
Maine	12	4	-	-	-	-	-	1	11	12
N.H.	17	12	-	1	2	-	-	-	25	15
Vt.	7	8	-	-	-	-	1	-	8	6
Mass.	52	55	1	1	-	5	2	1	734	155
R.I.	3	6	-	-	-	-	-	1	21	14
Conn.	42	32	-	-	3	-	-	-	61	74
MID. ATLANTIC	321	333	1	3	4	3	35	41	565	1,115
Upstate N.Y.	103	121	1	3	4	3	5	8	87	116
N.Y. City	69	57	-	-	-	-	14	11	221	388
N.J.	64	61	-	-	-	-	3	9	124	186
Pa.	85	94	-	-	-	-	13	13	133	425
E.N. CENTRAL	227	263	-	3	6	5	35	46	464	548
Ohio	87	63	-	-	2	-	15	11	43	100
Ind.	41	41	-	-	4	-	1	5	88	60
Ill.	50	95	-	-	-	-	11	20	161	162
Mich.	18	22	-	3	-	5	6	1	131	182
Wis.	31	42	-	-	-	-	2	9	41	44
W.N. CENTRAL	92	98	2	2	3	7	10	12	151	147
Minn.	40	41	1	2	3	7	1	2	32	37
Iowa	1	-	1	-	-	-	-	-	45	25
Mo.	32	36	-	-	-	-	6	9	38	47
N. Dak.	4	3	-	-	-	-	-	-	1	1
S. Dak.	-	1	-	-	-	-	-	-	3	-
Nebr.	8	2	-	-	-	-	1	-	10	12
Kans.	7	15	-	-	-	-	2	1	22	25
S. ATLANTIC	383	348	1	2	21	15	29	19	921	1,506
Del.	-	-	-	-	-	-	-	-	5	8
Md.	52	83	-	1	4	7	-	1	97	157
D.C.	-	1	-	-	-	-	-	-	7	37
Va.	36	47	-	-	-	-	1	5	117	89
W. Va.	15	14	-	-	1	-	3	-	6	13
N.C.	52	36	1	-	6	3	1	2	99	92
S.C.	4	6	-	-	-	-	-	2	24	35
Ga.	124	64	-	-	-	-	22	6	316	710
Fla.	100	97	-	1	10	5	2	3	250	365
E.S. CENTRAL	59	71	1	1	-	3	8	8	140	246
Ky.	5	6	-	-	-	2	-	-	29	29
Tenn.	38	42	-	-	-	1	6	5	80	179
Ala.	13	21	1	1	-	-	2	3	8	23
Miss.	3	2	-	-	-	-	-	-	23	15
W.S. CENTRAL	64	70	1	2	7	10	2	4	311	582
Ark.	3	6	-	-	-	1	1	-	56	30
La.	11	20	-	-	-	2	1	4	47	41
Okla.	49	41	-	-	7	7	-	-	19	17
Tex.	1	3	1	2	-	-	-	-	189	494
MOUNTAIN	168	141	4	6	25	22	18	16	391	410
Mont.	-	-	-	-	-	-	-	-	6	8
Idaho	5	4	-	-	-	-	2	1	19	15
Wyo.	1	1	-	-	1	-	-	-	5	1
Colo.	41	34	-	-	-	-	5	6	48	61
N. Mex.	34	16	1	-	7	4	5	1	20	20
Ariz.	61	64	-	6	12	9	2	4	235	225
Utah	14	12	2	-	2	5	3	4	46	34
Nev.	12	10	1	-	3	4	1	-	12	46
PACIFIC	90	128	2	4	18	27	7	19	803	1,053
Wash.	3	11	2	-	-	7	1	3	53	57
Oreg.	42	33	-	-	-	-	3	2	61	51
Calif.	33	55	-	4	18	20	1	9	662	925
Alaska	4	18	-	-	-	-	1	5	5	8
Hawaii	8	11	-	-	-	-	1	-	22	12
Guam	-	-	-	-	-	-	-	-	-	2
P.R.	-	1	-	-	-	-	-	1	23	73
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 November 6, 2004, and November 1, 2003 (44th 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	5,362	5,963	723	900	1,546	1,821	530	580	15,192	17,839
NEW ENGLAND	308	310	10	7	53	103	33	45	2,337	3,422
Maine	2	1	-	-	-	2	7	6	53	141
N.H.	36	16	-	-	10	9	3	4	183	153
Vt.	5	4	5	7	5	5	2	1	46	41
Mass.	174	195	4	-	8	51	5	17	813	1,466
R.I.	5	13	-	-	15	14	1	-	183	515
Conn.	86	81	1	-	15	22	15	17	1,059	1,106
MID. ATLANTIC	1,070	645	127	107	452	531	127	118	10,142	11,871
Upstate N.Y.	81	77	15	13	99	132	42	30	3,455	3,960
N.Y. City	94	166	-	-	46	62	17	22	-	189
N.J.	648	159	-	-	87	78	21	22	2,858	2,697
Pa.	247	243	112	94	220	259	47	44	3,829	5,025
E.N. CENTRAL	467	447	102	128	411	384	87	77	793	875
Ohio	104	122	5	7	197	203	38	22	60	64
Ind.	38	33	7	8	66	26	16	8	16	20
Ill.	71	60	12	18	20	41	5	19	1	70
Mich.	231	191	78	90	121	97	25	19	30	7
Wis.	23	41	-	5	7	17	3	9	686	714
W.N. CENTRAL	274	277	42	206	44	61	15	15	500	343
Minn.	46	31	17	8	7	3	5	4	399	228
Iowa	13	10	-	1	5	9	2	-	42	48
Mo.	164	192	25	195	22	31	5	6	48	60
N. Dak.	4	2	-	-	2	1	-	-	-	-
S. Dak.	-	2	-	-	4	2	1	-	-	1
Nebr.	33	24	-	2	1	5	2	4	7	2
Kans.	14	16	-	-	3	10	-	1	4	4
S. ATLANTIC	1,663	1,725	146	132	328	461	98	114	1,228	1,072
Del.	28	9	-	-	12	24	N	N	137	186
Md.	143	111	15	8	67	116	15	23	712	633
D.C.	19	10	3	-	8	17	-	1	9	8
Va.	232	155	16	7	42	85	17	9	155	82
W. Va.	34	27	23	3	8	16	3	6	23	20
N.C.	139	148	11	11	29	36	21	16	109	91
S.C.	65	144	6	24	3	7	3	4	12	8
Ga.	572	581	17	13	39	33	16	29	13	10
Fla.	431	540	55	66	120	127	23	26	58	34
E.S. CENTRAL	382	395	86	71	82	94	21	28	44	59
Ky.	60	61	23	13	35	38	4	8	15	15
Tenn.	174	173	35	17	33	32	10	8	17	15
Ala.	62	82	4	5	11	19	5	10	3	8
Miss.	86	79	24	36	3	5	2	2	9	21
W.S. CENTRAL	254	951	106	144	56	66	26	47	34	89
Ark.	65	73	2	3	-	2	2	1	8	-
La.	55	109	61	95	4	1	3	4	4	6
Okla.	47	51	3	2	5	7	-	3	-	-
Tex.	87	718	40	44	47	56	21	39	22	83
MOUNTAIN	395	491	41	44	70	57	25	31	32	14
Mont.	2	16	2	2	2	4	-	2	-	-
Idaho	10	7	-	1	7	3	1	2	6	3
Wyo.	7	29	2	-	5	2	-	-	3	2
Colo.	48	68	8	10	17	9	12	9	3	-
N. Mex.	12	32	7	-	4	2	1	2	1	1
Ariz.	208	221	5	7	11	10	-	10	6	3
Utah	43	43	4	-	20	20	3	2	13	2
Nev.	65	75	13	24	4	7	8	4	-	3
PACIFIC	549	722	63	61	50	64	98	105	82	94
Wash.	45	65	19	17	10	8	9	7	13	3
Oreg.	99	97	14	13	N	N	6	4	31	14
Calif.	380	535	25	29	40	56	79	89	36	74
Alaska	15	4	-	-	-	-	-	-	2	3
Hawaii	10	21	5	2	-	-	4	5	N	N
Guam	-	9	-	5	-	-	-	-	-	-
P.R.	49	116	-	-	1	-	-	-	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 November 6, 2004, and November 1, 2003 (44th 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	1,083	1,142	1,072	1,401	12,125	7,628	4,784	6,025	1,266	787
NEW ENGLAND	67	59	60	67	1,357	1,206	577	525	18	8
Maine	6	2	9	6	2	12	39	63	-	-
N.H.	5	6	7	4	72	87	27	23	-	-
Vt.	4	2	3	3	63	60	33	30	-	-
Mass.	34	29	32	41	1,177	975	250	185	15	8
R.I.	4	2	2	2	31	16	34	62	1	-
Conn.	14	18	7	11	12	56	194	162	2	-
MID. ATLANTIC	273	310	131	168	2,398	907	493	804	80	40
Upstate N.Y.	41	47	31	42	1,667	409	453	371	3	-
N.Y. City	139	169	23	38	128	125	11	6	19	13
N.J.	52	58	31	22	198	143	-	62	30	16
Pa.	41	36	46	66	405	230	29	365	28	11
E.N. CENTRAL	94	95	150	222	2,614	847	145	158	25	19
Ohio	29	18	61	53	505	233	70	50	13	8
Ind.	14	3	23	39	175	55	10	26	5	1
Ill.	22	40	12	63	351	79	47	23	2	5
Mich.	19	23	43	40	255	104	16	45	5	5
Wis.	10	11	11	27	1,328	376	2	14	-	-
W.N. CENTRAL	61	43	79	112	1,592	386	445	591	109	60
Minn.	25	20	22	25	313	141	81	34	-	1
Iowa	4	5	16	23	134	120	100	96	1	2
Mo.	18	5	18	44	268	70	55	40	92	48
N. Dak.	3	1	2	1	701	6	53	52	-	-
S. Dak.	1	3	2	1	30	3	10	123	4	5
Nebr.	3	-	4	7	43	9	53	93	12	3
Kans.	7	9	15	11	103	37	93	153	-	1
S. ATLANTIC	293	284	196	236	575	553	1,690	2,344	658	445
Del.	6	2	3	8	8	9	9	56	4	1
Md.	64	65	10	24	107	76	270	312	60	96
D.C.	13	13	4	5	4	2	-	-	-	1
Va.	45	34	18	24	170	91	410	457	30	30
W. Va.	2	4	5	5	18	16	57	78	4	5
N.C.	19	20	27	30	79	118	527	703	460	207
S.C.	9	4	11	21	42	113	125	210	17	32
Ga.	54	63	21	27	32	29	290	340	64	64
Fla.	81	79	97	92	115	99	2	188	19	9
E.S. CENTRAL	27	27	56	77	243	138	126	189	170	118
Ky.	4	8	11	17	64	44	20	35	2	2
Tenn.	7	5	15	22	135	63	36	98	88	62
Ala.	11	7	15	20	30	18	59	55	46	21
Miss.	5	7	15	18	14	13	11	1	34	33
W.S. CENTRAL	91	115	98	155	654	651	954	1,033	176	87
Ark.	7	4	15	14	63	43	45	25	98	31
La.	5	4	34	37	10	10	-	2	5	-
Okla.	7	4	9	14	33	77	96	178	71	42
Tex.	72	103	40	90	548	521	813	828	2	14
MOUNTAIN	40	37	58	72	1,277	821	197	169	25	9
Mont.	-	-	3	5	46	5	25	20	3	1
Idaho	1	1	7	6	35	70	7	15	4	2
Wyo.	-	1	3	2	28	124	6	6	4	2
Colo.	13	21	14	21	651	289	42	38	2	2
N. Mex.	3	2	7	8	129	65	5	5	2	1
Ariz.	11	7	12	21	194	118	101	66	2	-
Utah	7	4	5	1	156	116	8	14	8	1
Nev.	5	1	7	8	38	34	3	5	-	-
PACIFIC	137	172	244	292	1,415	2,119	157	212	5	1
Wash.	16	23	29	29	613	648	-	-	-	-
Oreg.	16	9	53	51	371	404	6	6	3	-
Calif.	100	133	153	193	399	995	143	197	2	1
Alaska	2	1	3	7	11	62	8	9	-	-
Hawaii	3	6	6	12	21	10	-	-	-	-
Guam	-	1	-	-	-	1	-	-	-	-
P.R.	-	2	7	9	6	4	53	65	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 November 6, 2004, and November 1, 2003 (44th 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	33,584	36,842	9,981	19,828	3,841	4,844	1,824	1,694	582	600
NEW ENGLAND	1,757	1,828	253	287	156	414	26	86	59	8
Maine	79	115	4	6	8	26	2	-	3	-
N.H.	124	129	8	7	17	29	-	-	N	N
Vt.	55	65	3	7	8	19	7	6	3	4
Mass.	998	1,064	159	193	105	181	N	N	46	N
R.I.	107	108	18	13	18	14	17	10	7	4
Conn.	394	347	61	61	-	145	-	70	U	U
MID. ATLANTIC	4,676	4,247	993	2,045	618	839	113	113	101	86
Upstate N.Y.	1,067	998	383	431	207	312	49	61	71	65
N.Y. City	1,051	1,180	324	350	89	130	U	U	U	U
N.J.	785	701	200	319	142	159	-	-	6	2
Pa.	1,773	1,368	86	945	180	238	64	52	24	19
E.N. CENTRAL	4,224	4,945	919	1,622	753	1,139	414	369	136	265
Ohio	1,128	1,195	151	266	202	266	292	239	67	84
Ind.	504	486	186	144	86	108	122	130	33	26
Ill.	1,168	1,741	278	877	161	291	-	-	-	106
Mich.	758	683	168	222	261	326	N	N	N	N
Wis.	666	840	136	113	43	148	N	N	36	49
W.N. CENTRAL	2,065	2,158	364	690	267	300	17	16	91	65
Minn.	531	471	62	92	130	145	-	-	59	45
Iowa	390	335	61	68	N	N	N	N	N	N
Mo.	529	804	137	324	55	67	12	12	13	3
N. Dak.	40	33	3	6	11	15	-	3	3	6
S. Dak.	112	103	10	16	17	22	5	1	-	-
Nebr.	130	147	22	86	14	24	-	-	6	5
Kans.	333	265	69	98	40	27	N	N	10	6
S. ATLANTIC	9,522	9,238	2,333	5,890	850	797	953	912	46	18
Del.	81	93	6	161	3	6	4	1	N	N
Md.	682	740	121	531	138	196	-	19	33	-
D.C.	53	39	34	69	9	8	5	-	3	7
Va.	1,076	912	147	387	65	92	N	N	N	N
W. Va.	189	114	6	-	22	31	94	61	10	11
N.C.	1,406	1,157	306	837	115	93	N	N	U	U
S.C.	765	653	275	415	37	38	69	126	N	N
Ga.	1,710	1,772	596	1,067	262	158	276	203	N	N
Fla.	3,560	3,758	842	2,423	199	175	505	502	N	N
E.S. CENTRAL	2,193	2,573	685	846	186	171	120	122	5	-
Ky.	297	349	61	118	54	41	26	16	N	N
Tenn.	522	657	327	281	132	130	93	106	N	N
Ala.	632	659	251	284	-	-	-	-	N	N
Miss.	742	908	46	163	-	-	1	-	5	-
W.S. CENTRAL	2,897	5,423	2,330	5,107	225	245	53	65	106	96
Ark.	480	721	67	97	16	6	8	20	8	7
La.	679	789	244	419	2	1	45	45	24	19
Okla.	360	419	408	738	60	77	N	N	39	47
Tex.	1,378	3,494	1,611	3,853	147	161	N	N	35	23
MOUNTAIN	2,066	1,906	700	1,061	445	400	34	7	38	62
Mont.	176	95	4	2	-	1	-	-	-	-
Idaho	135	155	13	29	8	18	N	N	N	N
Wyo.	48	73	5	7	8	2	10	6	-	-
Colo.	493	430	140	280	134	115	-	-	35	46
N. Mex.	239	234	109	220	70	99	5	-	-	11
Ariz.	614	567	338	419	184	132	N	N	N	N
Utah	218	196	44	43	38	31	17	1	3	5
Nev.	143	156	47	61	3	2	2	-	-	-
PACIFIC	4,184	4,524	1,404	2,280	341	539	94	4	-	-
Wash.	488	494	96	147	53	56	-	-	N	N
Oreg.	376	369	68	201	N	N	N	N	N	N
Calif.	2,945	3,410	1,191	1,883	183	369	N	N	N	N
Alaska	53	62	6	9	-	-	-	-	N	N
Hawaii	322	189	43	40	105	114	94	4	-	-
Guam	-	40	-	33	-	-	-	-	-	-
P.R.	238	564	8	27	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 November 6, 2004, and November 1, 2003 (44th 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	6,183	5,957	282	377	8,770	10,526	245	312	15,045	13,879
NEW ENGLAND	157	181	5	1	310	357	19	26	607	2,763
Maine	2	7	-	-	-	19	-	-	180	760
N.H.	4	16	3	-	13	11	-	2	-	-
Vt.	-	1	-	-	-	9	-	-	427	631
Mass.	100	115	-	-	206	187	13	15	-	147
R.I.	21	20	1	-	29	43	1	2	-	5
Conn.	30	22	1	1	62	88	5	7	-	1,220
MID. ATLANTIC	804	733	41	58	1,708	1,848	58	72	76	34
Upstate N.Y.	84	34	5	9	226	241	9	12	-	-
N.Y. City	486	421	13	31	852	941	20	34	-	-
N.J.	129	147	22	18	352	368	15	21	-	-
Pa.	105	131	1	-	278	298	14	5	76	34
E.N. CENTRAL	712	777	52	68	999	969	17	32	4,796	4,722
Ohio	183	175	1	3	167	171	5	2	1,139	1,042
Ind.	46	39	8	12	111	112	-	4	-	-
Ill.	296	326	14	20	457	458	-	16	-	-
Mich.	158	222	29	32	193	175	10	10	3,265	2,921
Wis.	29	15	-	1	71	53	2	-	392	759
W.N. CENTRAL	128	132	5	4	370	388	9	6	130	48
Minn.	15	40	1	-	148	161	5	2	-	-
Iowa	5	8	-	-	33	28	-	2	N	N
Mo.	81	52	2	4	94	97	2	1	5	-
N. Dak.	-	2	-	-	4	-	-	-	82	48
S. Dak.	-	2	-	-	8	16	-	-	43	-
Nebr.	5	5	-	-	27	16	2	1	-	-
Kans.	22	23	2	-	56	70	-	-	-	-
S. ATLANTIC	1,616	1,573	44	74	1,568	2,112	42	44	1,922	1,841
Del.	8	6	1	-	-	23	-	-	4	29
Md.	290	265	7	12	196	210	11	9	-	1
D.C.	71	43	1	-	66	-	-	-	21	27
Va.	89	72	3	1	223	222	8	14	487	478
W. Va.	2	2	-	-	17	19	-	-	1,156	1,084
N.C.	161	133	10	16	233	268	7	7	N	N
S.C.	101	87	7	12	151	145	-	-	254	222
Ga.	270	414	1	13	11	437	6	5	-	-
Fla.	624	551	14	20	671	788	10	9	-	-
E.S. CENTRAL	338	280	18	12	446	586	7	6	-	-
Ky.	41	31	1	1	96	102	3	1	-	-
Tenn.	110	116	8	2	164	196	4	2	-	-
Ala.	142	102	7	7	153	191	-	3	-	-
Miss.	45	31	2	2	33	97	-	-	-	-
W.S. CENTRAL	1,010	790	43	68	921	1,544	19	30	5,366	3,962
Ark.	35	42	-	2	94	77	-	-	-	-
La.	237	140	-	1	-	-	-	-	46	16
Okla.	24	56	2	1	135	124	1	1	-	-
Tex.	714	552	41	64	692	1,343	18	29	5,320	3,946
MOUNTAIN	299	272	45	30	392	373	6	6	2,148	509
Mont.	-	-	-	-	4	5	-	-	-	-
Idaho	18	10	2	2	4	8	-	1	-	-
Wyo.	3	-	-	-	4	4	-	-	40	45
Colo.	36	30	-	3	85	88	1	3	1,644	-
N. Mex.	46	55	1	7	18	40	-	-	84	3
Ariz.	157	160	42	18	175	176	2	2	-	-
Utah	7	7	-	-	34	30	1	-	380	461
Nev.	32	10	-	-	68	22	2	-	-	-
PACIFIC	1,119	1,219	29	62	2,056	2,349	68	90	-	-
Wash.	110	66	-	-	191	205	6	3	-	-
Oreg.	24	40	-	-	74	90	2	4	-	-
Calif.	978	1,106	28	60	1,665	1,910	54	82	-	-
Alaska	1	1	-	-	32	48	-	-	-	-
Hawaii	6	6	1	2	94	96	6	1	-	-
Guam	-	1	-	-	-	48	-	-	-	121
P.R.	138	182	5	14	84	95	-	-	251	513
V.I.	4	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 November 6, 2004 (44th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
NEW ENGLAND	445	316	92	17	9	11	33
Boston, Mass.	132	89	32	5	2	4	15
Bridgeport, Conn.	29	20	5	4	-	-	3
Cambridge, Mass.	13	9	3	1	-	-	1
Fall River, Mass.	35	22	8	2	3	-	1
Hartford, Conn.	72	48	17	5	2	-	4
Lowell, Mass.	22	15	7	-	-	-	1
Lynn, Mass.	15	11	3	1	-	-	-
New Bedford, Mass.	24	20	3	-	1	-	1
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	2	2	-	-	-	-	-
Springfield, Mass.	44	27	9	2	-	6	4
Waterbury, Conn.	27	23	3	1	-	-	2
Worcester, Mass.	74	61	10	1	1	1	5
MID. ATLANTIC	2,137	1,440	472	141	45	35	126
Albany, N.Y.	54	31	19	1	1	2	3
Allentown, Pa.	27	23	4	-	-	-	2
Buffalo, N.Y.	92	65	18	5	3	1	8
Camden, N.J.	19	12	4	1	U	2	1
Elizabeth, N.J.	21	13	5	2	1	-	3
Erie, Pa.	47	37	8	1	1	-	4
Jersey City, N.J.	33	23	5	1	1	3	-
New York City, N.Y.	1,203	838	253	77	18	14	70
Newark, N.J.	56	27	16	8	4	1	1
Paterson, N.J.	28	15	10	2	-	1	-
Philadelphia, Pa.	333	189	84	35	15	9	15
Pittsburgh, Pa.§	46	30	9	-	-	7	1
Reading, Pa.	22	17	4	-	-	1	1
Rochester, N.Y.	140	91	38	9	1	1	15
Schenectady, N.Y.	23	18	3	-	2	-	3
Scranton, Pa.	23	18	5	-	-	-	-
Syracuse, N.Y.	83	59	15	5	1	3	8
Trenton, N.J.	9	8	1	-	-	-	-
Utica, N.Y.	15	14	1	-	-	-	-
Yonkers, N.Y.	20	19	1	-	-	-	1
E.N. CENTRAL	1,230	860	258	64	21	27	91
Akron, Ohio	60	43	11	5	-	1	13
Canton, Ohio	39	29	7	3	-	-	1
Chicago, Ill.	315	194	78	27	6	10	24
Cincinnati, Ohio	67	51	10	3	1	2	4
Cleveland, Ohio	230	181	35	8	3	3	8
Columbus, Ohio	188	117	50	11	6	4	12
Dayton, Ohio	U	U	U	U	U	U	U
Detroit, Mich.	138	78	43	13	1	3	11
Evansville, Ind.	35	24	9	-	2	-	2
Fort Wayne, Ind.	62	52	9	-	1	-	6
Gary, Ind.	U	U	U	U	U	U	U
Grand Rapids, Mich.	97	61	24	6	4	2	12
Indianapolis, Ind.	U	U	U	U	U	U	U
Lansing, Mich.	U	U	U	U	U	U	U
Milwaukee, Wis.	84	55	21	5	-	3	10
Peoria, Ill.	49	34	11	4	-	-	4
Rockford, Ill.	68	42	19	4	1	2	4
South Bend, Ind.	54	42	5	4	-	3	3
Toledo, Ohio	108	85	15	2	2	4	5
Youngstown, Ohio	U	U	U	U	U	U	U
W.N. CENTRAL	440	293	98	25	18	6	20
Des Moines, Iowa	53	40	7	4	2	-	3
Duluth, Minn.	U	U	U	U	U	U	U
Kansas City, Kans.	U	U	U	U	U	U	U
Kansas City, Mo.	93	65	19	7	2	-	3
Lincoln, Nebr.	29	21	5	2	-	1	1
Minneapolis, Minn.	U	U	U	U	U	U	U
Omaha, Nebr.	84	63	19	1	1	-	8
St. Louis, Mo.	84	46	26	5	6	1	1
St. Paul, Minn.	U	U	U	U	U	U	U
Wichita, Kans.	97	58	22	6	7	4	4
S. ATLANTIC	969	605	239	77	31	17	62
Atlanta, Ga.	152	86	44	17	3	2	4
Baltimore, Md.	142	80	42	11	5	4	16
Charlotte, N.C.	87	57	19	6	2	3	9
Jacksonville, Fla.	167	102	43	14	5	3	10
Miami, Fla.	52	33	9	8	2	-	3
Norfolk, Va.	44	26	9	6	1	2	1
Richmond, Va.	45	27	13	1	2	2	2
Savannah, Ga.	62	44	12	3	1	2	7
St. Petersburg, Fla.	66	44	9	8	5	-	5
Tampa, Fla.	184	124	47	6	6	1	9
Washington, D.C.	U	U	U	U	U	U	U
Wilmington, Del.	30	26	4	-	-	-	3
E.S. CENTRAL	742	464	180	49	25	24	49
Birmingham, Ala.	148	88	36	10	8	6	8
Chattanooga, Tenn.	58	41	11	3	2	1	8
Knoxville, Tenn.	95	69	20	3	3	-	3
Lexington, Ky.	66	48	14	3	1	-	6
Memphis, Tenn.	183	112	47	13	3	8	7
Mobile, Ala.	53	37	11	2	1	2	4
Montgomery, Ala.	48	35	8	4	1	-	4
Nashville, Tenn.	186	103	53	14	9	7	12
W.S. CENTRAL	783	495	186	62	21	19	33
Austin, Tex.	77	52	14	4	2	5	2
Baton Rouge, La.	U	U	U	U	U	U	U
Corpus Christi, Tex.	43	29	7	3	1	3	2
Dallas, Tex.	218	126	56	26	7	3	12
El Paso, Tex.	65	42	12	8	1	2	6
Ft. Worth, Tex.	109	65	30	9	3	2	5
Houston, Tex.	347	216	85	30	12	4	23
Little Rock, Ark.	U	U	U	U	U	U	U
New Orleans, La.	54	40	14	-	-	-	-
San Antonio, Tex.	252	162	57	21	9	3	22
Shreveport, La.	86	51	24	3	5	3	6
Tulsa, Okla.	131	90	29	9	2	1	-
MOUNTAIN	840	552	186	64	18	19	66
Albuquerque, N.M.	114	80	27	4	2	1	10
Boise, Idaho	52	29	14	4	3	2	4
Colo. Springs, Colo.	65	47	11	5	2	-	4
Denver, Colo.	105	59	24	14	4	4	12
Las Vegas, Nev.	245	158	57	23	3	4	15
Ogden, Utah	31	23	5	-	-	3	1
Phoenix, Ariz.	93	53	27	7	1	4	6
Pueblo, Colo.	25	20	4	1	-	-	4
Salt Lake City, Utah	110	83	17	6	3	1	10
Tucson, Ariz.	U	U	U	U	U	U	U
PACIFIC	543	364	117	30	18	14	38
Berkeley, Calif.	8	5	2	1	-	-	-
Fresno, Calif.	66	49	12	4	-	1	7
Glendale, Calif.	20	17	2	1	-	-	1
Honolulu, Hawaii	72	56	8	5	2	1	8
Long Beach, Calif.	59	36	16	2	1	4	4
Los Angeles, Calif.	U	U	U	U	U	U	U
Pasadena, Calif.	U	U	U	U	U	U	U
Portland, Oreg.	129	88	25	11	2	3	13
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	162	107	34	12	5	4	14
San Francisco, Calif.	115	63	36	15	1	-	12
San Jose, Calif.	U	U	U	U	U	U	U
Santa Cruz, Calif.	34	19	7	5	1	2	3
Seattle, Wash.	89	61	21	2	3	2	4
Spokane, Wash.	52	40	12	-	-	-	6
Tacoma, Wash.	105	70	23	3	8	1	5
TOTAL	8,129¶	5,389	1,828	529	206	172	518

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.

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

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Address inquiries about the *MMWR* Series, including material to be considered for publication, to Editor, *MMWR* Series, Mailstop E-96, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone 888-232-3228.

All *MMWR* references are available on the Internet at http://www.cdc.gov/mmwr. Use the search function to find specific articles.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

References to non-CDC sites on the Internet are provided as a service to *MMWR* readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of these sites. URL addresses listed in *MMWR* were current as of the date of publication.

☆U.S. Government Printing Office: 2005-733-116/00056 Region IV ISSN: 0149-2195