CDC

MMWR

Morbidity and Mortality Weekly Report

Weekly February 18, 2005 / Vol. 54 / No. 6

Hepatitis A Vaccination Coverage Among Children Aged 24–35 Months — United States, 2003

Hepatitis A vaccine was first licensed in the United States in 1995. In 1996, the Advisory Committee on Immunization Practices (ACIP) recommended vaccination of children aged ≥24 months in populations with the highest incidence of hepatitis A (e.g., American Indian/Alaska Native [AI/AN], Asian/Pacific Islander, and selected Hispanic and religious communities) (*1*). In 1999, these guidelines were expanded to recommend routine vaccination for children residing in 11 states* where average annual hepatitis A incidence during 1987–1997 was at least 20 per 100,000 population (twice the national average) and to consider routine vaccination for children in six states† where average annual incidence was 10–20 per 100,000 population (*2*). This report is the first national analysis of hepatitis A vaccination coverage among children. The results indicate that, in 2003, vaccination coverage levels with at least 1 dose of hepatitis A vaccine for children aged 24–35 months varied from 6.4% to 72.7% in areas where routine vaccination is recommended (Table). In addition, hepatitis A vaccination coverage rates for children aged 24–35 months are lower than overall rates for other vaccines recommended for children (*3*). Sustaining and improving vaccination coverage among young children is needed to ensure continued declines in hepatitis A incidence in the United States.

The National Immunization Survey (NIS) provides annual estimates of vaccination coverage as of the time of household interview among children aged 19–35 months for the 50 states and 28 selected urban areas. In 2003, NIS began to collect data regarding hepatitis A vaccination coverage. Hepatitis A vaccine is a 2-dose regimen (administered at least 6 months apart) licensed for use in children aged ≥24 months. Hepatitis A vaccination coverage data were limited to children aged 24–35 months and calculated by considering children who had received at least 1 vaccine dose. To collect vaccination data for all age-eligible children, NIS uses a quarterly, random-digit–dialing sample of telephone numbers for each of the 78 survey areas and determines vaccination status from health-care provider records (*4,5*). During 2003, information on vaccination history was collected from telephone interviews for 19,979 children; provider verified vaccination records were available for 13,731 (68.7%).

Among children aged 24–35 months residing in the 11 states where routine hepatitis A vaccination is recommended, 50.9% (95% confidence interval [CI] = 47.6%–54.2%; range among states: 6.4%–72.7%) received at least 1 dose of hepatitis A vaccine. Among children aged 24–35 months residing in the six states where routine hepatitis A vaccination should be considered, 25.0% (CI = 21.8%–28.2%; range: 0.6%–32.3%) had received at least 1 dose of hepatitis A vaccine. Among children aged 24–35 months residing in the 33 states without a specific recommendation, 1.4% (CI = 1.0%–1.8%; range: 0.0%–4.3%) had received at least 1 dose of hepatitis A vaccine (Table). Two states (Alaska and Arizona) and four urban areas had coverage estimates >60%. Hispanic and AI/AN children had higher coverage rates than non-Hispanic white or black children in areas where routine vaccination is recommended or should be considered (Figure).

* Alaska, Arizona, California, Idaho, Nevada, New Mexico, Oklahoma, Oregon, South Dakota, Utah, and Washington.
† Arkansas, Colorado, Missouri, Montana, Texas, and Wyoming.

INSIDE

144 Nonfatal Motor-Vehicle–Related Backover Injuries Among Children — United States, 2001–2003
146 Measuring Exposure to an Elemental Mercury Spill — Dakota County, Minnesota, 2004
149 Tuberculosis Transmission in a Homeless Shelter Population — New York, 2000–2003
152 QuickStats

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*, 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 2005;54:[inclusive page numbers].

Reported by: *A Fiore, MD, B Bell, MD, Div of Viral Hepatitis, National Center for Infectious Diseases; L Barker, PhD, N Darling, MPH, National Immunization Program; J Amon, PhD, EIS Officer, CDC.*

Editorial Note: The national hepatitis A vaccination coverage estimates described in this report indicate that, in 2003, current hepatitis A childhood vaccination recommendations were being implemented in many states. However, coverage varied among areas and populations, likely because of targeted programs within these states. For example, higher coverage in El Paso County, Texas (71%), compared with the overall Texas coverage rate (32%), likely is attributable to vaccination requirements in Texas border counties for all children attending child care programs.

Vaccination coverage also varied by race/ethnicity. Higher coverage among Hispanic and AI/AN children than among children of other racial/ethnic populations might be related to greater disease recognition in these populations and local and national vaccination recommendations that have identified these populations as having higher hepatitis A rates (*6,7*).

The findings in this report are subject to at least three limitations. First, NIS is a telephone survey; although statistical weights adjust for nonresponse and households without telephones, some bias might remain. Second, although NIS relies on provider-verified vaccination histories, incomplete records or reporting could result in underestimates of coverage. Finally, although national estimates are reliable, estimates for states and urban areas and for racial/ethnic populations should be interpreted with caution (*8*).

The 1999 ACIP hepatitis A prevention recommendations encouraged state and local immunization programs to analyze their surveillance data and implement vaccination strategies that address the epidemiology of hepatitis A in their areas. The variation by state in coverage among children aged 24–35 months likely reflects the varying vaccination strategies adopted by state and local public health officials in response to the ACIP recommendations. Higher coverage among Hispanic and AI/AN children is one indication that vaccination efforts targeting children at higher risk for illness have been successful.

These data do not provide information on why hepatitis A vaccination coverage for children aged 24–35 months remains below that for other childhood vaccinations in most areas where it is recommended. Low coverage rates for young children might be the result of 1) a focus by health-care providers and immunization programs on vaccinating older children, 2) the few areas with hepatitis A vaccine mandates (*9*), or 3) the lack of a licensed hepatitis A vaccine that can be administered to children aged <24 months. Sustaining and improving vaccination coverage among young children is

TABLE. Hepatitis A vaccination coverage levels (≥1 dose) among children aged 24–35 months, by state and selected urban area and vaccination recommendation status — National Immunization Survey, United States, 2003

Recommendation status/ State/Urban area	Sample size*	(%)	(95% CI†)
Recommend			
Alaska	191	72.7	(±7.4)
Arizona	385	63.8	(±5.5)
Maricopa County	207	70.5	(±6.9)
Rest of state	178	51.4	(±9.0)
California	693	54.5	(±5.5)
Los Angeles County	159	62.0	(±8.5)
San Diego County	167	59.4	(±8.8)
Santa Clara County	181	42.6	(±8.0)
Rest of state	186	50.9	(±8.5)
Idaho	162	42.5	(±8.7)
Nevada	177	49.3	(±8.2)
New Mexico	164	42.6	(±9.8)
Oklahoma	178	55.1	(±9.3)
Oregon	169	33.1	(±7.9)
South Dakota	157	6.4	(±5.7)
Utah	171	47.3	(±8.9)
Washington	369	27.0	(±5.3)
King County	187	45.3	(±8.5)
Rest of state	182	20.0	(±6.7)
Overall	**2,647**	**50.9**	**(±3.3)**
Consider			
Arkansas	158	0.6	(±1.0)
Colorado	195	13.8	(±5.9)
Missouri	163	14.4	(±6.7)
Montana	173	8.1	(±5.2)
Texas	920	32.3	(±4.6)
Bexar County	174	62.9	(±8.4)
Houston	175	45.1	(±8.7)
Dallas County	199	38.7	(±7.6)
El Paso County	148	70.9	(±8.0)
Rest of state	224	23.3	(±6.5)
Wyoming	184	14.8	(±6.1)
Overall	**1,793**	**25.0**	**(±3.2)**
No recommendation			
Alabama	355	0.0	(±0.0)
Jefferson County	162	0.0	(±0.0)
Rest of state	193	0.0	(±0.0)
Connecticut	172	0.0	(±0.0)
Delaware	186	1.0	(±1.5)
District of Columbia	169	2.3	(±2.1)
Florida	537	0.4	(±0.5)
Miami-Dade County	184	2.4	(±2.9)
Duval County	182	0.0	(±0.0)
Rest of state	171	0.0	(±0.0)
Georgia	366	4.1	(±3.2)
Fulton/DeKalb counties	198	6.8	(±3.9)
Rest of state	168	3.5	(±3.8)

TABLE. (*Continued*) Hepatitis A vaccination coverage levels (≥1 dose) among children aged 24–35 months, by state and selected urban area and vaccination recommendation status — National Immunization Survey, United States, 2003

Recommendation status/ State/Urban area	Sample size	(%)	(95% CI)
Hawaii	183	1.3	(±1.8)
Illinois	339	3.9	(±2.1)
Chicago	177	10.0	(±4.4)
Rest of state	162	1.7	(±2.4)
Indiana	354	0.2	(±0.3)
Marion County	189	1.0	(±2.0)
Rest of state	165	0.0	(±0.0)
Iowa	164	0.0	(±0.0)
Kansas	161	1.5	(±1.7)
Kentucky	172	0.0	(±0.0)
Louisiana	388	0.3	(±0.6)
Orleans Parish	178	0.0	(±0.0)
Rest of state	210	0.4	(±0.7)
Maine	191	0.0	(±0.0)
Maryland	372	1.0	(±1.1)
Baltimore	184	2.4	(±2.2)
Rest of state	188	0.8	(±1.3)
Massachusetts	359	0.6	(±0.6)
Boston	175	3.9	(±4.1)
Rest of state	184	0.2	(±0.4)
Michigan	353	0.1	(±0.1)
Detroit	167	0.4	(±0.8)
Rest of state	186	0.0	(±0.1)
Minnesota	170	0.0	(±0.0)
Mississippi	161	0.4	(±0.8)
Nebraska	186	0.2	(±0.5)
New Hampshire	175	0.3	(±0.5)
New Jersey	327	3.1	(±3.8)
Newark	159	0.0	(±0.0)
Rest of state	168	3.2	(±4.0)
New York	333	3.4	(±2.6)
NYC five counties	164	3.3	(±3.0)
Rest of state	169	3.5	(±4.0)
North Carolina	180	0.0	(±0.0)
North Dakota	164	4.3	(±3.7)
Ohio	496	0.1	(±0.2)
Cuyahoga County	175	0.9	(±1.7)
Franklin County	160	0.0	(±0.0)
Rest of state	161	0.0	(±0.0)
Pennsylvania	372	0.1	(±0.2)
Philadelphia	185	0.8	(±1.5)
Rest of state	187	0.0	(±0.0)
Rhode Island	152	0.7	(±1.4)
South Carolina	172	0.0	(±0.0)
Tennessee	569	3.2	(±1.6)
Davidson County	173	0.4	(±0.7)
Shelby County	214	17.2	(±8.0)
Rest of state	182	0.0	(±0.0)
Overall	**9,291**	**1.4**	**(±0.4)**

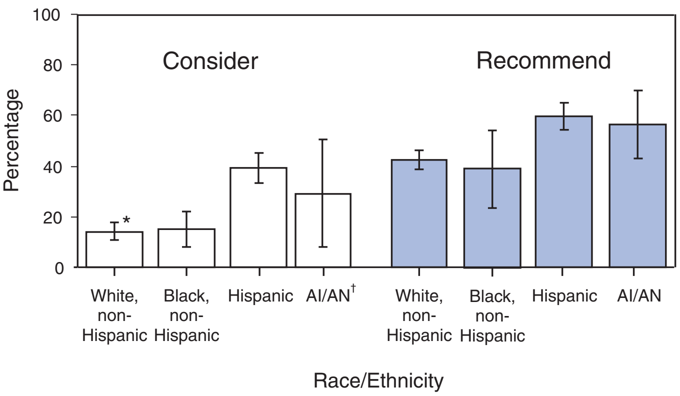
* Unweighted.
† Confidence interval.

needed to ensure continued declines in hepatitis A incidence in the United States.

References

1. CDC. Prevention of hepatitis A through active or passive immunization: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1996;45(No. RR-15).
2. CDC. Prevention of hepatitis A through active or passive immunization: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1999;48(No. RR-12).
3. CDC. National, state, and urban area vaccination coverage among children aged 19–35 months—United States, 2003. MMWR 2004;53:658–61.

FIGURE. Hepatitis A vaccination coverage levels among children aged 24–35 months in areas where routine vaccination is recommended versus areas where routine vaccination should be considered, by race/ethnicity — National Immunization Survey, United States, 2003



* 95% confidence interval.
† American Indian/Alaska Native.

4. Zell ER, Ezzati-Rice TM, Battaglia MP, Wright RA. National Immunization Survey: the methodology of a vaccination surveillance system. Public Health Rep 2000;115:65–77.
5. Smith PJ, Battaglia MP, Huggins VJ, et al. Overview of the sampling design and statistical methods used in the National Immunization Survey. Am J Prev Med 2001;20:17–24.
6. CDC. Hepatitis surveillance report 59. Atlanta, GA: US Department of Health and Human Services, CDC; September 2004. Available at http://www.cdc.gov/ncidod/diseases/hepatitis/resource/PDFs/hep_surveillance_59.pdf.
7. Bialek SR, Thoroughman DA, Hu D, et al. Hepatitis A incidence and hepatitis A vaccination among American Indians and Alaska Natives, 1990–2001. Am J Public Health 2004;94:996–1001.
8. Simpson DM, Rodewald LE, Barker LE. What's in a number? The use and abuse of survey data. Am J Prev Med 2001;20(Suppl 4):86–7.
9. Immunization Action Coalition. Hepatitis A vaccination recommendations and policies. St. Paul, MN: Immunization Action Coalition; March 2003. Available at http://www.immunize.org/laws/hepa.htm.

Nonfatal Motor-Vehicle–Related Backover Injuries Among Children — United States, 2001–2003

Motor-vehicle (MV)–related backovers (i.e., incidents involving children being struck by or rolled over by a vehicle moving in reverse) represent a risk for severe injury and death (*1,2*). To characterize nonfatal MV backover injuries among children, CDC analyzed data from the National Electronic Injury Surveillance System All Injury Program (NEISS-AIP). This report summarizes the results of that analysis, which determined that, during 2001–2003, an estimated 7,475 children (2,492 per year) aged 1–14 years were treated for nonfatal MV backover injuries in U.S. hospital emergency departments (EDs). The report also highlights differences in type and severity of MV backover injuries by age and underscores the need for effective interventions. NEISS-AIP data can increase the understanding of nonfatal MV backover injuries and help guide the development of prevention strategies, such as education, environmental improvements, and changes in vehicle design, that might help reduce these injuries among children.

NEISS-AIP provides data on approximately 500,000 consumer product– and injury-related ED cases each year. Operated by the U.S. Consumer Product Safety Commission, the program collects data on initial visits for all types and causes of injuries treated in EDs (*3*). NEISS-AIP data are drawn from a nationally representative subsample of 66 of 100 hospitals selected as a stratified probability sample of U.S. hospitals with a minimum of six beds and a 24-hour ED.

For this study, MV backover injury cases were identified from narratives abstracted from medical records. NEISS-AIP obtains data for each nonfatal injury regarding the principal diagnosis, body part primarily affected, external cause of injury, ED discharge disposition, and location of the incident (e.g., home or public place). Cases were defined as nonfatal injuries to children aged 1–14 years as a result of being struck by or rolled over by an MV (e.g., car, truck, van, or sport utility vehicle) moving in reverse in a driveway, parking lot, or on a street. Cases involving child pedestrians (i.e., children standing, sitting, lying, playing, or walking) or children riding bicycles or tricycles near or behind an MV were included. Cases involving children injured while getting into or out of stationary MVs were excluded.

Each case was assigned a sample weight based on the inverse probability of selection; these weights were summed to provide national estimates of MV backover injuries. Estimates were based on weighted data for 168 children treated for MV backover injuries at NEISS-AIP hospital EDs during 2001–2003. Population estimates for 2001–2003 were obtained from the U.S. Census Bureau to compute injury rates. A direct variance estimation procedure was used to calculate 95% confidence intervals (CIs) and to account for the complex sample design.

Of the 168 cases identified, 81 (48.2%) involved children aged 1–4 years; 92 (54.8%) of the children were male. Injuries occurred predominantly to the head, face, and neck region (47 cases [28.0%]) and to the extremities (90 cases [53.6%]). Injuries to the head, face, and neck region decreased with age, from a high of 31 (38.3%) among children aged 1–4 years to a low of three (7.5%) among those aged 10–14 years. Injuries to the extremities, specifically the lower part of the body, increased with age, from 24 (29.6%) among children aged 1–4 years to 29 (72.5%) among those aged 10–14 years. Ninety-four (56.0%) children sustained minor contusions and abrasions, and these varied by age group, from 40 (49.4%) among those aged 1–4 years to 25 (62.5%) among those aged 10–14 years. More serious injuries, such as fractures and internal injuries, occurred among 47 (28.0%) children; this proportion decreased with age, from 32 (39.5%) among children aged 1–4 years to seven (17.5%) among those aged 10–14 years.

The 168 study cases were weighted to provide estimates for the United States overall. During 2001–2003, an estimated 7,475 (CI = 4,453–10,497) children were treated in EDs for nonfatal MV backover injuries, at an annual rate of 4.40 per 100,000 age-specific population (CI = 2.62–6.18) (Table). Among all ages, the rate for females (4.60) was slightly higher than that for males (4.21). Approximately 86% of the injured children were classified as pedestrians; these children sustained MV backover injuries at a rate six times greater (3.78) than that of children who were riding a bicycle or tricycle (0.62). Nontraffic events (i.e., those not occurring on public roadways) accounted for approximately 61% of MV backover incidents, a rate of 2.67. Location of the incident was known in approximately 80% of cases; the majority of injuries occurred either at home (47.4%) or on public property (31.9%). For at least 40% of all cases, injuries occurred in driveways or parking lots. A majority of injured children (78.1%) were treated and released from the ED.

Reported by: *R Patel, MPH, AM Dellinger, PhD, Div of Unintentional Injury Prevention; JL Annest, PhD, Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC.*

Editorial Note: The findings in this report indicate that, during 2001–2003, an estimated 2,492 children aged 1–14 years were injured annually after being struck by or rolled over by an MV moving in reverse. Many were pedestrians near or behind an MV and were at home when the incident occurred. The majority were treated and released from hospitals. A study by the National Highway Traffic Safety Administration examined death certificate data and identified approximately 47 deaths in 1998 among children aged <19 years that were attributable to MV backover injuries (*4*). Of these deaths, 21 occurred in driveways. The results of this study are consistent with those of other studies that illustrate the risk children face when left unattended near or behind an MV (*1,2,5–7*).

The findings in this report are subject to at least four limitations. First, NEISS-AIP captures only injuries treated in hospital EDs and does not include children seen in physician offices and clinics or who might not have received medical care. Second, NEISS-AIP provides national estimates only and does not allow for estimates by region, state, or local jurisdiction. Third, cases were identified from narratives obtained from medical records, but not all medical charts contained complete descriptions of events, such as whether a vehicle was in reverse. Finally, in cases with multiple injuries, only data regarding the most severe injury are recorded.

Various prevention strategies, including education, environmental modifications, and changes in vehicle design, might reduce the risk for MV backover injuries among children. Public education to increase awareness among parents and caregivers should emphasize the following: 1) adults should adequately supervise children who are playing in areas near

TABLE. Estimated annual number, percentage, and rate of nonfatal motor-vehicle–related backover injuries treated in emergency departments (EDs) among children aged 1–14 years, by selected characteristics — United States, 2001–2003

Characteristic	Estimated no.*	(%)	Rate†	(95% CI§)
Age group (yrs)				
1–4	1,246¶	(50.0)	—	—
5–9	603	(24.2)	3.02	(1.69–4.35)
10–14	642	(25.8)	3.05	(1.41–4.68)
Sex				
Male	1,220	(49.0)	4.21	(2.62–5.80)
Female	1,271	(51.0)	4.60	(2.23–6.98)
Activity at time of injury				
Riding bicycle or tricycle	350	(14.0)	0.62	(0.32–0.92)
Pedestrian**	2,142	(86.0)	3.78	(2.16–5.41)
Type††				
Traffic	519¶	(20.8)	—	—
Nontraffic	1,514	(60.7)	2.67	(1.49–3.86)
Unspecified	459	(18.4)	0.81	(0.13–1.50)
Location of incident				
Home	1,180	(47.4)	2.08	(1.13–3.04)
Public§§	794	(31.9)	1.40	(0.70–2.11)
Other/Unspecified	518¶	(20.8)	—	—
Disposition at ED discharge				
Treated and released	1,945	(78.1)	3.44	(2.15–4.72)
Hospitalized or transferred¶¶	547¶	(21.9)	—	—
Total	**2,492**		**4.40**	**(2.62–6.18)**

* Estimates are based on 168 cases that occurred during a 3-year period that were weighted to provide a nationally representative sample; numbers might not add to total because of rounding.
† Per 100,000 population.
§ Confidence interval.
¶ Estimate might be unstable because the coefficient of variation is >30% or was based on fewer than 20 cases.
** Includes injuries incurred by children who were standing, sitting, lying, playing, walking, in or near driveway, parking lot, or other location.
†† "Traffic" refers to events occurring on public roadways; "nontraffic" includes those events that occurred at all other locations (e.g., driveways or parking lots).
§§ Includes street, school, sports arena, or other public place.
¶¶ Includes patients transferred to another facility for specialized care.

parked MVs, 2) drivers should look carefully for children before and while backing up, and 3) MVs should be locked in garages or driveways with keys kept out of reach of children (*6,8*). Potential environmental modifications include fenced driveways, fenced play areas away from driveways and streets, and circular driveway designs that eliminate the need to back out. Potential automobile modifications include back-up warning alarms when vehicles are placed in reverse or mirrors, sensing devices, or cameras to alert drivers to out-of-sight objects, such as small children (*1*). Research is needed to determine the effectiveness of such approaches.

Data from injury surveillance systems such as NEISS-AIP highlight the preventable morbidity and mortality resulting from MV-related backover injuries in children. Effective engineering and environmental approaches to prevent MV-related backover injuries need to be identified, evaluated, and disseminated to public health and transportation officials and policy makers for implementation nationwide. Meanwhile, drivers and caregivers can take simple precautions to prevent these injuries. To this end, child MV safety programs and health professionals should ensure that parents, caregivers, and the public are aware of the risks for injury associated with MV backovers and appropriate prevention measures.

Acknowledgments

This report is based on information contributed by T Schroeder, MS, C Irish, and other staff, Div of Hazard and Injury Data Systems, US Consumer Product Safety Commission. K Gotsch, MPH, P Holmgreen, MS, Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC.

References

1. Winn DG, Agran PF, Castillo DN. Pedestrian injuries to children and youth younger than 5 years of age. Pediatrics 1991;88:776–82.
2. Agran PF, Winn D, Castillo D. Unsupervised children and youth in vehicles: a risk for pediatric trauma. Pediatrics 1991;87:70–3.
3. CDC. National estimates of nonfatal injuries treated in hospital emergency departments—United States, 2000. MMWR 2001;50:340–6.
4. National Highway Traffic Safety Administration. Data collection study: deaths and injuries resulting from certain non-traffic and non-crash events. Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration; May 2004. Available at http://www.nhtsa.dot.gov/cars/problems/studies/nontraffic-noncrash/images/noncrash.pdf.
5. Brison RJ, Wicklund K, Mueller BA. Fatal pedestrian injuries to young children and youth: a different pattern of injury. Am J Public Health 1988;78:793–5.
6. Nadler EP, Courcoulas AP, Gardner MJ, Ford HR. Driveway injuries in children and youth: risk factors, morbidity, and mortality. Pediatrics 2001;108:326–8.
7. CDC. Injuries and deaths among children and youth left unattended in or around motor vehicles—United States, July 2000–June 2001. MMWR 2002;51:570–2.
8. Wright MS. Nonambulatory "pedestrians": infants injured by motor vehicles in driveways. Clin Pediat 1998;37:515–8.

Measuring Exposure to an Elemental Mercury Spill — Dakota County, Minnesota, 2004

Elemental mercury spills can cause contamination of neighborhoods and homes and result in neurologic and kidney disorders in exposed persons who inhale mercury vapors. Often, however, difficulties exist in determining the magnitude of exposure and effectiveness of decontamination or in recognizing that reexposure has occurred. This report summarizes the response to an elemental mercury exposure that resulted in the decontamination of 48 persons and the subsequent analysis of blood and urine samples from 14 exposed youths aged 6–16 years. Data from these analyses suggest that 1) blood samples are more sufficiently acquired and can be used to evaluate recent acute exposure and 2) use of a real-time mercury vapor analyzer can help public health officials determine the magnitude of exposures and help prevent reexposures. In addition, demolition and waste-disposal firms and government agencies must take actions to ensure that elemental mercury is adequately secured before disposal.

Case Report

In preparation for demolition of a factory in Dakota County, Minnesota, hazardous waste from the factory was temporarily stored in a shed, which was not effectively secured. During a late afternoon in September 2004, two teenagers entered the shed and found two canning jars containing approximately 21 pounds of elemental mercury. The teenagers brought the mercury back to their neighborhood, where they and approximately 12 other youths played with it, throwing handfuls of mercury at each other and splashing in a large puddle of mercury on an outdoor basketball court. This initial exposure was limited to <2 hours because of rapid response by a parent who saw what the youths were doing, told them to go home and shower, and contacted the police. Subsequently, 48 persons, including 18 youths, were decontaminated with water and detergent by the Dakota County Special Operations Team between 10 p.m. and 2 a.m. Beginning at 9 p.m., homes were scanned for contamination by using a real-time mercury vapor analyzer (RA-915+; Ohio Lumex Company; Twinsburg, Ohio). On the recommendation of Minnesota Department of Health (MDH) staff, residents of 12 contaminated homes* were sheltered in a motel by the American Red Cross.

* In this incident, MDH recommended evacuation of homes with a maximum mercury vapor concentration >1,000 ng/m^3 and recommended cleanup of all homes with a maximum concentration (unventilated) >500 ng/m^3, as measured by a mercury vapor analyzer. Cleanup or disposal of vehicles was recommended at concentrations >1,000 ng/m^3. These cleanup/clearance criteria were intended to limit exposures to no more than the Environmental Protection Agency chronic reference concentration of 300 ng/m^3 or the acute California reference effects level of 1,800 ng/m^3.

As part of its epidemiologic investigation, MDH staff interviewed some of the youths the morning after the event and learned that the teenagers had attempted to ignite the mercury and might have been exposed to fumes. Subsequent sampling with the mercury vapor analyzer in motel rooms of displaced families revealed mercury contamination, and high concentrations of mercury vapor found near the hair of three youths 24 hours after exposure (Table 1) suggested that exposures might have been more severe than initially indicated, that decontamination was incomplete, and that exposures were continuing. Consequently, 14 youths aged 6–16 years with known exposures were examined by physicians; 11 were evaluated at Regions Hospital in St. Paul, Minnesota.

Blood and/or urine samples were obtained from all 14 youths. However, although the youths were provided bottles for urine samples when their blood was drawn, the first samples were not provided until 3 days later, during the weekend. In addition, at Regions Hospital and at one extended-stay motel, mercury vapor concentrations were measured with a mercury vapor analyzer near the skin of the youths, and exhaled air mercury vapor concentrations were measured by analyzing air in plastic bags inflated by some of the youths. Contaminated hair and scalps of the youths were washed at the hospital with shampoo containing selenium sulfide and dried with terry-cloth towels, which were then discarded. Decontamination was verified with a mercury vapor analyzer. Follow-up samples were obtained for youths with elevated mercury levels.

Epidemiologic and Sampling Findings

All 14 patients had routine physical examinations. Two had new onset cough, and one complained of a poor appetite; these symptoms had resolved by a follow-up visit. Samples from four youths were taken at different times because not every patient agreed to provide a blood sample on day 2. In addition, blood samples drawn from two youths on day 2 coagulated; one of these persons was retested on day 10. Elevated mercury ($\geq$8 μg/L) was found in five of eight analyzed blood samples taken on day 2 (Table 2). Additionally, measurable amounts (5 μg/L and 6 μg/L, respectively) of mercury were found in samples collected from one child on day 4 and another child on day 10. Second blood samples collected during days 9–15 from the five youths with the initial elevated readings determined their blood mercury levels had declined below the laboratory reporting limit (5 μg/L). Second blood samples could not be obtained from two youths. Measurable mercury was found in the urine samples of five youths (Table 2). However, these urine sample results might be unreliable because of small sample volumes.

From hour 44 to hour 98, exhaled mercury decreased for three youths (patients 5, 6, and 7), whereas readings for two youths (patients 3 and 9) indicated increases (Table 1). The increases, along with high concentrations in a motel room, suggested reexposure; investigation identified the source as a contaminated motor vehicle. Patient 7, who had a longer half-life of exposure than patients 5 or 6, was determined to have been reexposed by the same contaminated motor vehicle (Table 1). Comparison of mercury vapor concentrations near the skin and hair at hours 42–44 and 98 confirmed the reexposures observed in exhaled mercury (Table 1) and the motel room. Mercury vapor concentrations in motel rooms decreased after isolation of the contaminated motor vehicle and disposal of contaminated personal items. The last blood mercury analyses for all youths, except patients 12 and 13, indicated concentrations below laboratory reporting limits (4–5 μg/L), suggesting cessation of the exposure. No further treatment was indicated for any patient. The correlation

TABLE 1. Mercury vapor concentrations (ng/m^3)* associated with nine patients after mercury exposure — Dakota County, Minnesota, 2004

	Near hair				Near skin (chest)		Exhaled air		
Patient no.	Hour 24	Hour 42	Hour 43†	Hour 98	Hour 44	Hour 98	Hour 44	Hour 98	$t_{1/2}$§(hrs)
1	635¶	1,742		664¶			571		
2		376		142**	597	454**	990		
3		430		327**	546	1,662**	575	1,890**	††
4		381		38	128	48		66	
5		1,247		169		273	380	90	26
6	17,000¶	4,812	2,690	94	1,634	62	442	101	25
7		9,681	873	3,926**	1,384	1,163**	1,446	616**	44
9		283		106**	424	254**	239	379**	††
12	35,000¶		850¶						

* Sampling volume ~20 L/min; sampling rate: mean of 3 x 10 second averages, by using a real-time mercury vapor analyzer.
† After shampooing at hospital.
§ Exhalation half-life: calculated from two exhaled mercury vapor data points.
¶ Data likely a maximum, by using a real-time mercury vapor analyzer at a 1-second sampling rate.
** Patient determined to be reexposed.
†† Sampling data indicated increase.

TABLE 2. Total mercury in whole blood and urine* of 14 patients after exposure to mercury — Dakota County, Minnesota, 2004

Patient	μg mercury/L blood							μg mercury/g creatinine (mL urine)		
no.	Day 2	Day 4	Day 7	Day 9	Day 10	Day 11	Day 15	Day 5	Day 7	Day 10
1	9						<5	3 (850)		
2	9				<5			7 (300)		
3	13				<5					6 (750)
4	<5		<5							
5	<5		<5							
6	†								6§	
7	12				<5			5 (350)		
8				<5						
9	8			<5					<10§	
10						<5				
11	<4									
12	†				6				<10 (450) no date	
13		5								
14							<4			

* 24-hour urine sample requested.
† Sample coagulated, not analyzed.
§ Small sample volume; presumed random.

between blood mercury and exhaled mercury for individual youths was low (R^2 = 0.27).

Testing in eight of the youths' residences indicated maximum mercury vapor concentrations ranging from <60 ng/m^3 to >50,000 ng/m^3 (Table 3). Three additional homes were found to be contaminated by adults tracking mercury. Cleanup in accordance with MDH criteria and reoccupancy of all contaminated homes was completed 22 days after the initial incident. The Minnesota Pollution Control Agency used a mercury-sniffing dog (*1*) to find the source of contamination in the last house cleared. Tracked mercury was located by using a mercury vapor analyzer. Three of four contaminated cars could not be cleaned to the MDH criterion for clearance and were scrapped. All visible traces of mercury were cleaned from the basketball court and other affected outdoor areas. Dakota County Public Health nurses tracked all of the youths, facilitating medical examinations and testing and providing support for families.

Reported by: *BA Baker, MD, Regions Hospital Occupational Medicine Clinic, St. Paul; C Herbrandson, PhD, T Eshenaur, MPH, RB Messing, PhD, Minnesota Dept of Health.*

Editorial Note: Exposure to elemental mercury occurs largely from inhaling mercury vapors; very little mercury is absorbed through the skin or by ingestion. Mercury spills pose a serious health hazard and are difficult to clean because most common methods (e.g., sweeping or vacuuming) disperse mercury, increasing the surface area of the mercury, increasing evaporation, and exacerbating the contamination. This report illustrates that use of real-time portable instruments such as mercury vapor analyzers can enable investigators to rapidly measure mercury vapor concentrations and determine the extent of an exposure incident.

Geometric mean and 95% total blood mercury concentrations in the 1999–2002 National Health and Nutrition Examination Surveys (NHANES) for women of childbearing age were 0.92 μg/L and 6.04 μg/L, respectively, and for young children were 0.33 μg/L and 2.21 μg/L, respectively (*2*). Almost all inorganic mercury blood concentrations in the

TABLE 3. Maximum mercury vapor concentrations (ng/m^3)* in eight households of 13 patients exposed to mercury — Dakota County, Minnesota, 2004

Patient no.	Mercury vapor	Location	Time (hrs)	Mercury vapor	Location	Time (hrs)
1	1,500	At front door	24	2,270	Shower	48
2, 3, 7	17,000	Dresser drawer	98	1,900	Ambient air	98
4, 5	17,000	Outdoor steps	114	>50,000	Floor by couch	114
6	<200	Throughout home	98			
8	<60	Throughout home	9	1,300	Bag of clothes	9
9	735	Bedroom, ambient	114	3,412	Closet in bedroom	114
10, 12	3,600	Backpack	20	765	Bedroom	20
13	1,900	Ambient in house	9	7,500	Living room chair	Unknown
14	<200	Ambient in house	9			

* Using a real-time mercury vapor analyzer.

NHANES study were below the detection level of 0.4 µg/L (*2*). Geometric mean and 95% concentrations of urine mercury for women aged 16–49 years in the 1999–2000 NHANES data were 0.72 µg/L and 5.00 µg/L, respectively (*3*). Normal exhaled air mercury concentrations are typically <50 ng/m^3 for persons without dental amalgams (Minnesota Department of Health and Minnesota Pollution Control Agency, unpublished data, 2004).

The half-life of total mercury in blood for persons exposed to mercury vapor is 2–5 days, reflecting distribution to tissues and elimination through exhalation (*4,5*), which corresponds to the results in this report; blood mercury levels were below the detection limit 7–13 days after initial positive measurement. Exhaled mercury concentrations have been found to decrease, with half-lives of 13–25 hours (*6*) and 1.6–2.3 days (*7*). These half-lives also are consistent with the results in this report. However, exhalation half-lives longer than 30 hours might indicate continuing exposure or reexposure to mercury. The patient with the calculated half-life of 44 hours had been reexposed on day 4. Exhaled vapor concentrations can also depend on proper exhalation by patients. To compare data between patients, investigators should instruct all patients to exhale in the same manner; however, mercury vapor half-lives are repeated measures and will not be as sensitive to individual differences. The lack of correlation between exhaled mercury and blood mercury is likely caused by measurement of different forms of mercury (i.e., total mercury for blood and mercury vapor for exhaled) and the small range of exposures.

Approximately 70%–80% of inhaled mercury enters the blood before distribution to tissues; the rest is immediately exhaled. An estimated 7% of retained mercury is exhaled in the first 3 days after exposure (*8,9*). Approximately 9.2% and 2.4% is excreted in feces and urine, respectively, within 7 days (*4*). Conversely, mercury concentrations in blood can increase rapidly after an acute exposure to mercury, providing timely indication of exposure. In addition, the short half-life of mercury in blood can enable confirmation of the cessation of exposure. However, investigators should be aware of potential confounders to measurements of mercury concentrations (e.g., fish consumption, dental amalgams, medicinal use, and ritualistic use of mercury such as sprinkling on a floor for good luck) (*10*).

In this report, the experiences of responders and investigators also underscore several recommendations for demolition and waste-disposal companies and government agencies. These include 1) securing elemental mercury at demolition sites, 2) confirming mercury decontamination by sampling, 3) providing sensitive field instruments and appropriate training for tracking mercury contamination and exposure, and 4) incorporating quality-assurance controls into all data collection activities.

Acknowledgments

This report is based on information contributed by Regions Hospital/Health Partners, St. Paul; G Kalstabakken, D Kuhns, Rosemount Police Dept; P Adams, K Dickinson, B Schroeder, J Springsted, K Wick, Dakota County Public Health Dept; D Fier-Tucker, C Hubbard, S Lee, H Neve, Minnesota Pollution Control Agency; DBW Jones, Minnesota Dept of Health. Agency for Toxic Substances and Disease Registry.

References

1. Minnesota Pollution Control Agency. Mercury free zone. St. Paul, MN: Minnesota Pollution Control Agency, 2004. Available at http://www.pca.state.mn.us/programs/mercury-free/index.html.
2. CDC. Blood mercury levels in young children and childbearing-aged women—United States, 1999–2002. MMWR 2004;53:1018–20.
3. CDC. Second national report on human exposure to environmental chemicals. Atlanta, GA: US Department of Health and Human Services, CDC; 2003.
4. Cherian MG, Hursh JB, Clarkson TW, Allen J. Radioactive mercury distribution in biological fluids and excretion in human subjects after inhalation of mercury vapor. Arch Environ Health 1978;33:109–14.
5. Barregard L, Sallsten G, Schutz A, Attewell R, Skerfving S, Jarvholm B. Kinetics of mercury in blood and urine after brief occupational exposure. Arch Environ Health 1992;47:176–84.
6. Hursh JB, Cherian MG, Clarkson TW, Vostal JJ, Mallie RV. Clearance of mercury (HG-197, HG-203) vapor inhaled by human subjects. Arch Environ Health 1976;31:302–9.
7. Sandborgh-Englund G, Elinder CG, Johanson G, Lind B, Skare I, Ekstrand J. The absorption, blood levels, and excretion of mercury after a single dose of mercury vapor in humans. Toxicol Appl Pharmacol 1998;150:146–53.
8. US Environmental Protection Agency. Integrated risk information system. Cincinnati, OH: US Environmental Protection Agency; 2004. Available at http://www.epa.gov/iris.
9. California Office of Environmental Health Hazard Assessment. Reference exposure levels. Sacramento, CA: California Office of Environmental Health Hazard Assessment; 2000. Available at http://www.oehha.org/air/acute_rels/allacrels.html.
10. Agency for Toxic Substances and Disease Registry. Toxicological profile for mercury. Atlanta, GA: US Department of Health and Human Services, Agency for Toxic Substances and Disease Registry; 1999. Available at http://www.atsdr.cdc.gov/toxprofiles/tp46.html.

Tuberculosis Transmission in a Homeless Shelter Population — New York, 2000–2003

In 2003, the incidence of tuberculosis (TB) cases in the United States declined for the eleventh consecutive year to a record low of 5.1 cases per 100,000 population (*1*). In 2003, 6.3% of reported TB cases in the United States were among homeless persons (*2*). Compared with the general population, this group has a greater risk for latent TB infection (LTBI) and progression to active disease (*3*). This report summarizes a recent outbreak of TB and highlights the challenges of preventing TB among homeless persons, particularly when multiple chains of transmission are occurring and multiple jurisdictions are involved. The findings underscore the complementary role of rapid DNA genotyping in the detection of possible TB transmission in homeless populations. To ensure early detection of unsuspected TB transmission in homeless populations, health department TB-control programs are encouraged to use CDC's universal *Mycobacterium tuberculosis* rapid genotyping system.

During January–July 2003, four TB cases were reported by the Orange County Health Department (OCHD), New York, among residents of a homeless shelter for men. The New York City (NYC) Department of Homeless Services (DHS) operates the shelter, located 65 miles north of NYC. The New York State Department of Health (NYSDOH) communicated with the NYC Department of Health and Mental Hygiene (NYCDOHMH), which had identified four additional TB cases among residents of the same shelter during the same period. A joint investigation of this cluster was undertaken by OCHD, NYSDOH, and NYCDOHMH.

Before recognition of this cluster in July 2003, two patients associated with this shelter had been reported to NYSDOH and NYCDOHMH in 2001, and another two patients in 2002. TB contact investigations in the shelter focused on residents who shared a dormitory with persons who had TB. Few of these contacts successfully completed tuberculin skin tests (TSTs) and chest clinic referrals because of difficulties with transportation, transience of the population, and follow-ups not being mandatory. The shelter is a 1,001-bed, 28-dormitory, 3–housing-unit facility. Six dormitories have air-handling systems that provide outdoor air (i.e., nonrecirculating systems) on a continuous basis; the remainder of the facility has mechanical heating that does not provide continuous outdoor air ventilation. Although clients requesting NYC shelter services are immediately offered screening for medical conditions including TB, they may decline both the physical examination and the TST.

To determine the extent of the outbreak and to implement control measures, *M. tuberculosis*–genotyping databases at NYSDOH were searched for strains matching the genotype of the isolates of the initial cases reported in 2003. These databases include approximately 20,000 isolates identified during a 12-year period, mainly from the northeastern United States, and include all isolates from New York state since 2001. In addition, a list of shelter residents since January 2001 was matched to the statewide TB registry from 2000–2003. Five additional TB cases among former residents of this shelter were identified from genotyping databases from patients with disease onset during 2002–2003, and six other cases were identified from the registry match from patients with disease onset during 2000–2003.

The decision to conduct intensive, active case finding was based on 1) identification of two long-term residents with acid-fast-bacillus (AFB) sputum-smear–positive pulmonary TB in August 2003, one of whom had bilateral cavitary lesions on chest radiograph (CXR); 2) newly identified human immunodeficiency virus (HIV) coinfections in four of the TB patients; and 3) suspicion of recent TB transmission in the shelter.

During September 13–15, 2003, the health departments, with logistical support from DHS and shelter staff, screened residents by using results from TB symptom surveys, CXRs, and TSTs. Of 1,038 residents, 958 (92%) were registered for the screening and interviewed for TB symptoms and HIV risk factors. Among residents screened, 927 (97%) had a portable CXR, and 593 (62%) had TSTs administered, with 583 (98%) having TSTs read. Of the 583 TSTs that were read, 223 (38%) were positive (defined as induration $\geq$5 mm). An additional 213 residents had positive TST results before screening, for an overall minimum TST-reactivity prevalence of 46%. Residents with no TST performed during the screening might have been tested during the contact investigation or had a previous TST-positive result. Few residents refused TST. A total of 537 residents underwent further medical evaluation on the basis of these initial screening results; of these, 51 (10%) had a sputum smear taken and culture performed. Four additional culture-positive pulmonary TB cases were identified as a result of the screening.

Treatment with isoniazid through twice-weekly, directly observed therapy (DOT) provided at the shelter was started by 161 (72%) of the 225 residents for whom LTBI treatment (*3*) was recommended. Fast-food coupons were provided to promote adherence.

Of 297 shelter workers, 228 (77%) were assessed for TB; of these, 25 had a documented previous positive TST, and 16 (7%) were newly TST positive. TB disease was not identified among shelter workers.

During 2000–2003, a total of 29 TB cases were identified among residents in this facility. Three local health jurisdictions received the initial reports: NYC (17), Orange County (11), and Dutchess County (one). The median age of patients was 49 years (range: 39–81 years); 16 (55%) were born in the United States, all of whom were black, and 13 (45%) were foreign-born. Twelve (41%) patients had positive AFB sputum smears and thus were potentially more contagious; seven (24%) had cavitary lesions on CXRs, and 12 (57%) of 21 tested had HIV coinfection. All *M. tuberculosis* isolates were susceptible to first-line medications. TB patients and those with known HIV were offered and referred to appropriate treatment.

Of 26 TB cases with genotype data available, 11 (42%) shared the *M. tuberculosis* genotype associated with this facility* (Figure 1). One additional TB case was identified in an outside contact to a source patient with the same genotype. The earliest case identified with this strain occurred in a patient who had culture-confirmed pulmonary TB diagnosed on three occasions: in 1996 and 2000, when the patient had incomplete treatment for TB before being lost to follow-up, and in April 2001, approximately 6 months after the patient had entered the shelter with his TB status unknown to shelter staff. At that time, the patient completed a full course of DOT. His *M. tuberculosis* isolates from 1996 and 2001 had the same genotype and were susceptible to anti-TB drugs. The only patient outside the shelter with this strain had TB diagnosed in October 2000. This patient and the probable source patient had worked together in 2000. All subsequent shelter residents who had *M. tuberculosis* isolates with this strain were documented to have stayed in the shelter with at least one AFB sputum-smear–positive TB patient with the same genotype (Figure 2). Patients resided at the shelter for a median of 2.5 years (range: 4 months–6 years), and all patients shared the same dining and recreational areas. Analysis of dormitory contacts revealed that three patients had shared a dormitory during the infectious period of a person with TB who had a positive sputum-smear result.

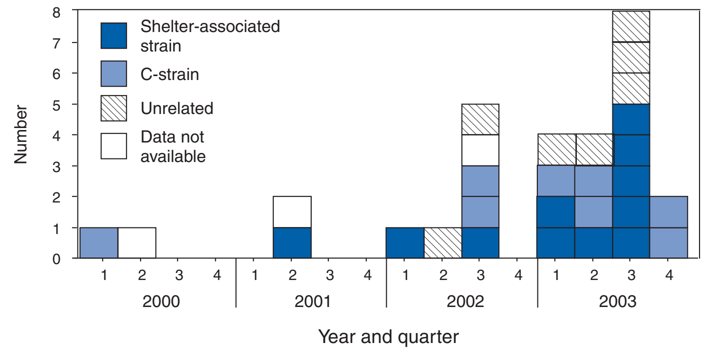
The isolates from eight other shelter residents shared a different genotype†, known as C-strain (Figure 1). Of 79 patients with this pattern identified in NYC during 2001–2003, a total of 33 (42%) were homeless persons from shelters throughout NYC. Seven (24%) TB patients had genotypes not matching those of other shelter patients, and specimens were not available for three patients.

Reported by: *J Hudson, MD, S Van Zetta, MPH, B Brissette, Orange County Health Dept, Goshen; C Driver, M Macaraig, MPH, A Winters, MD, S Poonja, MPH, S Munsiff, MD, M Beatty, MD, New York City Dept of Health and Mental Hygiene; D Marder, MD, A Gutkovich, New York City Dept of Homeless Svcs; M Oxtoby, MD, J Grabau, PhD, J Driscoll, PhD, P Smith, MD, New York State Dept of Health. Div of Tuberculosis Elimination, National Center for Infectious Diseases; F Coronado, MD, EIS Officer, CDC.*

Editorial Note: This investigation and recent reports from Maine and Washington (*4,5*) indicate ongoing transmission of *M. tuberculosis* among homeless persons. In addition, rapid disease progression in persons coinfected with HIV was noted in this and other shelter-associated outbreaks (*6,7*). Notification of cases to three different local health departments and incomplete sharing of information across jurisdictions initially masked the extent of TB disease and transmission in this population. Some cases were not linked initially to the shelter because of homelessness and varying methods of recording addresses but were later linked through matches in the homeless shelter registry. Genotyping helped elucidate transmission among TB patients and suggested that multiple chains of *M. tuberculosis* transmission were occurring simultaneously. Other TB clusters at homeless shelters have been documented through genotyping (*4–6,8*). To improve nationwide access to this useful technology, in 2004, CDC began offering universal *M. tuberculosis* rapid genotyping to all health department TB-control programs in the United States. This system is expected to help with early detection of unsuspected transmission (*9*).

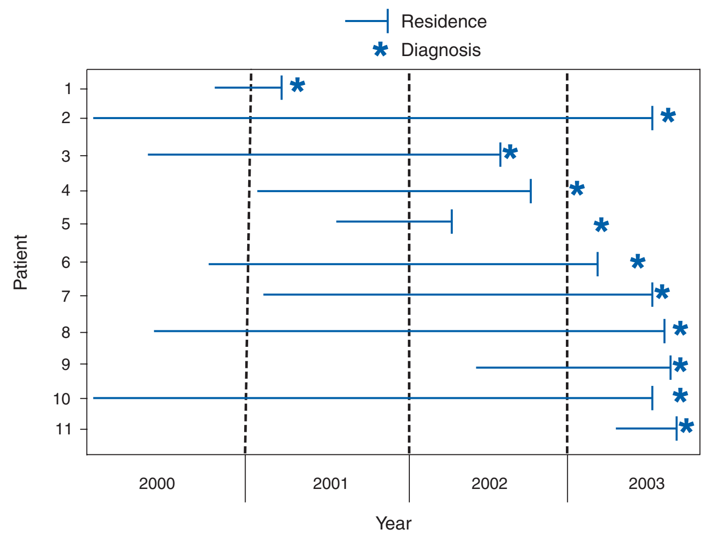
* 13-band IS6110-RFLP and spoligotype octal code designation 777777600060771.
† 3-band IS6110-RFLP and spoligotype octal code designation 700036777760731.

FIGURE 1. Number* of tuberculosis cases among residents of a homeless shelter, by year and quarter of diagnosis and DNA genotype — New York, 2000–2003



* N = 29.

FIGURE 2. Patients infected with shelter-associated tuberculosis strain, by dates of residence and date of diagnosis — New York, 2000–2003



In this outbreak, 11 TB cases could have been prevented if the index patient with the shelter-associated strain had completed treatment when his TB was diagnosed in 1996 or when his disease reactivated in 2000. The extensive occurrence of TB in this homeless population underscores the need for strengthening and maintaining interjurisdictional reporting procedures. As a result of this investigation, the shared responsibilities of NYSDOH and NYCDOHMH were evaluated with regard to case management, infection control, and TB contact investigation, and the intake procedures at shelters for TB screening and for LTBI treatment were strengthened. The impact of the control measures will be monitored through analysis of future cases and through surveys of screening results.

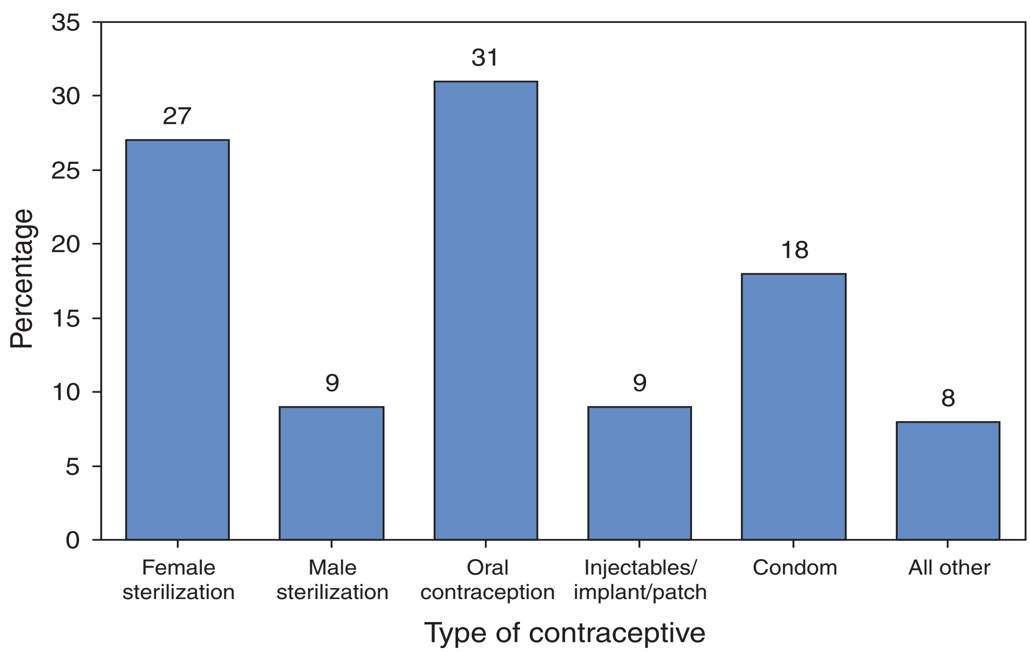
References

1. CDC. Trends in tuberculosis—United States, 1998–2003. MMWR 2004;53:209–14.
2. CDC. Reported tuberculosis in the United States, 2003. Atlanta, GA: US Department of Health and Human Services, CDC; September 2004.
3. CDC. Targeted tuberculin testing and treatment of latent tuberculosis infection. MMWR 2000;49(No. RR-6).
4. CDC. Tuberculosis outbreak in a homeless population—Portland, Maine, 2002–2003. MMWR 2003;52:1184–5.
5. CDC. Tuberculosis outbreak among homeless persons—King County, Washington, 2002–2003. MMWR 2003;52:1209–10.
6. McElroy P, Southwick K, Fortenberry E, et al. Outbreak of tuberculosis among homeless persons coinfected with human immunodeficiency virus. Clin Infect Dis 2003;36:1305–12.
7. CDC. Prevention and control of tuberculosis among homeless persons: recommendations of the Advisory Council for the Elimination of Tuberculosis. MMWR 1992;41(No. RR-5).
8. Curtis AB, Ridzon R, Novick LF, et al. Analysis of *Mycobacterium tuberculosis* transmission in a homeless shelter outbreak. Int J Tuberc Lung Dis 2000;4:308–13.
9. McNabb S, Braden C, Navin T. DNA fingerprinting of *Mycobacterium tuberculosis*: lessons learned and implications for the future. Emerg Infect Dis 2002;8:1314–9.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

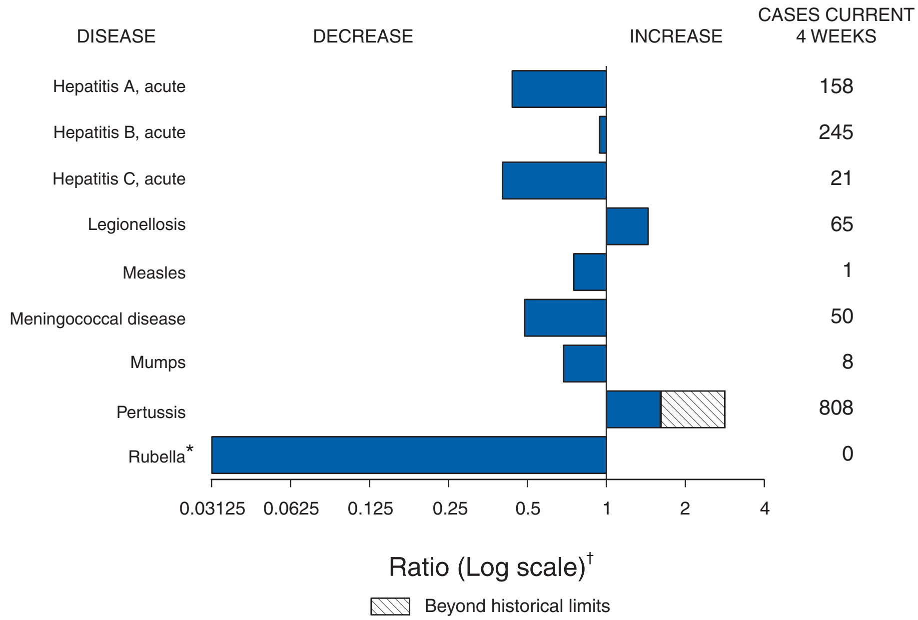
Primary Contraceptive Methods Among Women Aged 15–44 Years — United States, 2002



In 2002, the most frequent contraceptive method among women aged 15–44 years was oral contraception. Other leading methods were female sterilization and the male condom. A smaller, but significant, number of women were using the newer, long-acting hormonal methods, including injectables, implants, and the patch. Additional information is available at http://www.cdc.gov/nchs/nsfg.htm.

Source: CDC. Use of contraception and use of family planning services in the United States, 1982–2002. Available at http://www.cdc.gov/nchs/data/ad/ad350.pdf.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals February 12, 2005, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 6 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 February 12, 2005 (6th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal[†]	7	5
Botulism:			HIV infection, pediatric[†¶]	31	22
foodborne	3	1	Influenza-associated pediatric mortality[†**]	6	—
infant	3	9	Measles	1[††]	1[§§]
other (wound & unspecified)	3	—	Mumps	20	22
Brucellosis	9	9	Plague	—	—
Chancroid	4	4	Poliomyelitis, paralytic	—	—
Cholera	—	2	Psittacosis[†]	—	—
Cyclosporiasis[†]	1	10	Q fever[†]	4	6
Diphtheria	—	—	Rabies, human	—	—
Domestic arboviral diseases			Rubella	1	4
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	—	—
California serogroup[†§]	—	—	SARS[†**]	—	—
eastern equine[†§]	—	—	Smallpox[†]	—	—
Powassan[†§]	—	—	*Staphylococcus aureus*:		
St. Louis[†§]	—	—	Vancomycin-intermediate (VISA)[†]	—	—
western equine[†§]	—	—	Vancomycin-resistant (VRSA)[†]	—	—
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome[†]	6	26
human granulocytic (HGE)[†]	5	6	Tetanus	—	1
human monocytic (HME)[†]	4	6	Toxic-shock syndrome	10	17
human, other and unspecified [†]	3	1	Trichinellosis[¶¶]	—	—
Hansen disease[†]	5	9	Tularemia[†]	1	4
Hantavirus pulmonary syndrome[†]	—	2	Yellow fever	—	—

—: No reported cases.
* Incidence data for reporting years 2004 and 2005 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, National Center for HIV, STD, and TB Prevention. Last update January 30, 2005.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of one case reported, one was indigenous and none were imported from another country.
§§ Of one case reported, none were indigenous and one was imported from another country.
¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending February 12, 2005, and February 14, 2004 (6th Week)*

Reporting area	AIDS Cum. 2005§	AIDS Cum. 2004	Chlamydia† Cum. 2005	Chlamydia† Cum. 2004	Coccidioidomycosis Cum. 2005	Coccidioidomycosis Cum. 2004	Cryptosporidiosis Cum. 2005	Cryptosporidiosis Cum. 2004
UNITED STATES	2,989	2,511	79,820	98,576	507	233	149	298
NEW ENGLAND	133	50	3,116	3,477	—	—	3	16
Maine	3	1	275	226	N	N	—	4
N.H.	2	4	177	207	—	—	—	3
Vt.¶	—	7	119	127	—	—	1	2
Mass.	47	1	1,664	1,582	—	—	2	7
R.I.	14	16	371	494	—	—	—	—
Conn.	67	21	510	841	N	N	—	—
MID. ATLANTIC	447	459	9,951	11,682	—	—	28	50
Upstate N.Y.	39	24	1,455	1,695	N	N	6	8
N.Y. City	221	281	3,227	3,985	—	—	6	17
N.J.	87	98	1,201	2,043	N	N	1	4
Pa.	100	56	4,068	3,959	N	N	15	21
E.N. CENTRAL	275	307	8,472	18,322	—	—	18	71
Ohio	59	96	417	4,741	N	N	14	17
Ind.	37	53	2,333	2,029	N	N	—	5
Ill.	147	125	3,677	5,206	—	—	—	17
Mich.	26	15	854	4,353	—	—	2	13
Wis.	6	18	1,191	1,993	N	N	2	19
W.N. CENTRAL	85	60	3,968	6,384	—	1	23	19
Minn.	35	12	584	1,367	N	N	5	2
Iowa	16	5	—	789	N	N	4	1
Mo.	17	12	1,921	2,401	—	—	9	8
N. Dak.	—	5	105	169	N	N	—	—
S. Dak.	3	—	328	280	—	—	2	4
Nebr.¶	—	5	404	559	—	1	—	—
Kans.	14	21	626	819	N	N	3	4
S. ATLANTIC	1,108	715	17,696	17,271	—	—	39	57
Del.	—	12	364	337	N	N	—	—
Md.	82	10	1,769	2,013	—	—	5	5
D.C.	28	21	371	393	—	—	—	1
Va.	58	3	2,913	2,355	—	—	3	2
W. Va.	12	8	286	321	N	N	2	—
N.C.	127	1	4,058	1,951	N	N	5	13
S.C.¶	42	27	2,266	1,929	—	—	—	2
Ga.	231	192	1,132	3,803	—	—	10	21
Fla.	528	441	4,537	4,169	N	N	14	13
E.S. CENTRAL	141	98	6,021	6,098	—	1	6	18
Ky.	25	20	1,369	680	N	N	1	5
Tenn.¶	59	33	1,930	2,550	N	N	1	7
Ala.¶	54	26	288	1,560	—	—	3	4
Miss.	3	19	2,434	1,308	—	1	1	2
W.S. CENTRAL	331	383	11,826	13,030	—	—	3	17
Ark.	35	15	966	846	—	—	—	6
La.	39	28	1,034	3,494	—	—	—	—
Okla.	43	5	1,315	1,096	N	N	3	4
Tex.¶	214	335	8,511	7,594	N	N	—	7
MOUNTAIN	112	70	5,311	6,216	355	58	11	13
Mont.	—	—	181	27	N	N	—	—
Idaho¶	1	1	208	413	N	N	—	—
Wyo.	—	—	141	110	—	—	—	1
Colo.	12	1	917	1,305	N	N	3	8
N. Mex.	17	—	422	878	—	4	1	—
Ariz.	57	64	2,512	2,388	345	39	3	3
Utah	8	3	346	384	1	4	1	—
Nev.¶	17	1	584	711	9	11	3	1
PACIFIC	357	369	13,459	16,096	152	173	18	37
Wash.	28	22	2,121	1,817	N	N	—	—
Oreg.¶	32	16	943	810	—	—	1	3
Calif.	291	318	9,749	12,410	152	173	17	34
Alaska	5	—	320	330	—	—	—	—
Hawaii	1	13	326	729	—	—	—	—
Guam	1	—	—	135	—	—	—	—
P.R.	1	47	350	232	N	N	N	N
V.I.	3	—	—	58	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	2	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 2004 and 2005 are provisional and cumulative (year-to-date).
† Chlamydia refers to genital infections caused by *C. trachomatis*.
§ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update January 30, 2005.
¶ Contains data reported through National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 12, 2005, and February 14, 2004 (6th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	91	105	12	18	16	12	1,184	1,651	28,090	36,530
NEW ENGLAND	9	6	—	3	3	1	76	108	603	836
Maine	—	—	—	—	—	—	8	15	12	38
N.H.	—	1	—	—	—	—	2	3	14	14
Vt.	—	—	—	—	—	—	4	7	3	6
Mass.	3	1	—	2	3	1	61	80	335	357
R.I.	—	—	—	—	—	—	—	3	55	116
Conn.	6	4	—	1	—	—	1	—	184	305
MID. ATLANTIC	13	13	—	—	1	1	245	356	3,151	4,011
Upstate N.Y.	7	2	—	—	—	—	64	68	589	647
N.Y. City	1	5	—	—	—	—	65	138	920	1,318
N.J.	1	—	—	—	—	1	39	41	439	776
Pa.	4	6	—	—	1	—	77	109	1,203	1,270
E.N. CENTRAL	16	25	2	6	3	1	108	287	3,467	7,925
Ohio	9	10	—	—	2	1	59	94	201	2,669
Ind.	—	4	—	—	—	—	N	N	961	778
Ill.	2	3	1	—	—	—	4	101	1,576	2,313
Mich.	3	5	—	—	1	—	30	58	354	1,656
Wis.	2	3	1	6	—	—	15	34	375	509
W.N. CENTRAL	17	12	2	4	1	6	95	127	1,335	2,180
Minn.	2	6	—	—	—	—	1	28	178	547
Iowa	5	—	—	—	—	—	27	22	—	140
Mo.	8	3	2	4	1	1	33	50	790	1,000
N. Dak.	—	—	—	—	—	3	—	2	5	11
S. Dak.	2	—	—	—	—	—	3	4	39	26
Nebr.	—	1	—	—	—	—	14	9	106	148
Kans.	—	2	—	—	—	2	17	12	217	308
S. ATLANTIC	15	7	2	2	8	3	217	251	8,079	8,173
Del.	—	—	N	N	N	N	—	6	90	122
Md.	4	2	1	—	—	—	17	12	770	923
D.C.	—	—	—	—	—	—	1	10	243	269
Va.	—	—	—	1	1	—	48	22	1,133	1,096
W. Va.	—	—	—	—	—	—	1	1	91	97
N.C.	—	—	—	—	6	3	N	N	2,130	1,144
S.C.	—	—	—	—	—	—	5	1	999	1,054
Ga.	3	2	—	—	—	—	62	88	579	1,694
Fla.	8	3	1	1	1	—	83	111	2,044	1,774
E.S. CENTRAL	4	3	—	—	—	—	22	29	2,173	2,969
Ky.	—	1	—	—	—	—	N	N	453	320
Tenn.	1	—	—	—	—	—	4	11	739	1,008
Ala.	3	1	—	—	—	—	18	18	210	934
Miss.	—	1	—	—	—	—	—	—	771	707
W.S. CENTRAL	2	8	—	—	—	—	21	31	4,890	5,083
Ark.	1	—	—	—	—	—	11	14	498	390
La.	—	—	—	—	—	—	—	6	643	1,661
Okla.	1	2	—	—	—	—	10	11	574	497
Tex.	—	6	—	—	—	—	N	N	3,175	2,535
MOUNTAIN	4	11	6	2	—	—	109	167	1,261	1,530
Mont.	—	1	—	—	—	—	5	5	3	8
Idaho	1	2	4	—	—	—	13	23	12	9
Wyo.	—	—	1	—	—	—	1	1	7	5
Colo.	1	2	1	1	—	—	36	63	312	373
N. Mex.	—	1	—	—	—	—	5	6	64	105
Ariz.	1	1	N	N	N	N	26	32	545	679
Utah	1	2	—	—	—	—	19	24	56	36
Nev.	—	2	—	1	—	—	4	13	262	315
PACIFIC	11	20	—	1	—	—	291	295	3,131	3,823
Wash.	2	3	—	—	—	—	12	20	243	334
Oreg.	—	2	—	1	—	—	28	56	153	107
Calif.	6	12	—	—	—	—	235	209	2,624	3,152
Alaska	1	—	—	—	—	—	3	5	48	57
Hawaii	2	3	—	—	—	—	13	5	63	173
Guam	N	N	—	—	—	—	—	—	—	27
P.R.	—	—	—	—	—	—	—	1	37	15
V.I.	—	—	—	—	—	—	—	—	—	19
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. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 12, 2005, and February 14, 2004 (6th Week)*

Reporting area	*Haemophilus influenzae*, invasive							
	All ages		Age <5 years					
	All serotypes		Serotype b		Non-serotype b		Unknown serotype	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	207	273	—	3	8	13	17	29
NEW ENGLAND	13	29	—	—	1	3	2	—
Maine	—	1	—	—	—	—	—	—
N.H.	—	6	—	—	—	1	—	—
Vt.	4	3	—	—	—	—	2	—
Mass.	5	12	—	—	—	1	—	—
R.I.	—	1	—	—	—	—	—	—
Conn.	4	6	—	—	1	1	—	—
MID. ATLANTIC	48	53	—	—	—	—	3	7
Upstate N.Y.	12	16	—	—	—	—	—	1
N.Y. City	7	11	—	—	—	—	—	3
N.J.	9	9	—	—	—	—	—	1
Pa.	20	17	—	—	—	—	3	2
E.N. CENTRAL	27	60	—	—	—	4	2	13
Ohio	19	20	—	—	—	2	2	3
Ind.	3	3	—	—	—	1	—	1
Ill.	2	17	—	—	—	—	—	5
Mich.	3	7	—	—	—	1	—	3
Wis.	—	13	—	—	—	—	—	1
W.N. CENTRAL	12	10	—	—	—	1	2	1
Minn.	—	3	—	—	—	1	—	—
Iowa	—	—	—	—	—	—	—	—
Mo.	10	3	—	—	—	—	2	1
N. Dak.	—	—	—	—	—	—	—	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	1	4	—	—	—	—	—	—
Kans.	1	—	—	—	—	—	—	—
S. ATLANTIC	65	54	—	—	1	1	4	2
Del.	—	—	—	—	—	—	—	—
Md.	11	17	—	—	1	1	1	—
D.C.	—	—	—	—	—	—	—	—
Va.	1	6	—	—	—	—	—	—
W. Va.	—	2	—	—	—	—	—	—
N.C.	14	1	—	—	—	—	—	—
S.C.	1	—	—	—	—	—	—	—
Ga.	21	15	—	—	—	—	3	2
Fla.	17	13	—	—	—	—	—	—
E.S. CENTRAL	4	11	—	—	—	—	—	1
Ky.	—	—	—	—	—	—	—	—
Tenn.	3	5	—	—	—	—	—	—
Ala.	1	6	—	—	—	—	—	1
Miss.	—	—	—	—	—	—	—	—
W.S. CENTRAL	6	7	—	—	—	1	1	—
Ark.	—	—	—	—	—	—	—	—
La.	2	3	—	—	—	—	1	—
Okla.	4	4	—	—	—	1	—	—
Tex.	—	—	—	—	—	—	—	—
MOUNTAIN	27	37	—	1	6	3	2	3
Mont.	—	—	—	—	—	—	—	—
Idaho	1	1	—	—	—	—	—	—
Wyo.	1	—	—	—	—	—	—	—
Colo.	3	10	—	—	—	—	—	1
N. Mex.	4	9	—	—	2	1	—	1
Ariz.	14	13	—	—	2	1	2	1
Utah	1	1	—	1	—	—	—	—
Nev.	3	3	—	—	2	1	—	—
PACIFIC	5	12	—	2	—	—	1	2
Wash.	—	3	—	2	—	—	—	1
Oreg.	3	6	—	—	—	—	1	—
Calif.	—	3	—	—	—	—	—	1
Alaska	1	—	—	—	—	—	—	—
Hawaii	1	—	—	—	—	—	—	—
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	—	—	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	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 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 12, 2005, and February 14, 2004 (6th Week)*

	Hepatitis (viral, acute), by type					
	A		B		C	
Reporting area	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	313	723	488	602	45	111
NEW ENGLAND	60	101	24	43	—	2
Maine	—	4	—	—	—	—
N.H.	3	2	1	5	—	—
Vt.	—	3	—	1	—	1
Mass.	48	81	23	22	—	1
R.I.	—	—	—	—	—	—
Conn.	9	11	—	15	—	—
MID. ATLANTIC	42	100	105	100	5	19
Upstate N.Y.	5	6	7	4	—	2
N.Y. City	18	37	4	18	—	—
N.J.	6	22	70	44	—	—
Pa.	13	35	24	34	5	17
E.N. CENTRAL	21	70	30	43	12	8
Ohio	6	7	18	18	2	—
Ind.	4	7	1	1	—	—
Ill.	4	30	—	—	—	1
Mich.	5	22	11	15	10	7
Wis.	2	4	—	9	—	—
W.N. CENTRAL	11	13	16	31	2	12
Minn.	—	—	—	2	—	—
Iowa	2	3	1	1	—	—
Mo.	5	2	10	25	2	12
N. Dak.	—	—	—	—	—	—
S. Dak.	—	—	—	—	—	—
Nebr.	2	5	3	1	—	—
Kans.	2	3	2	2	—	—
S. ATLANTIC	47	134	173	184	13	22
Del.	—	1	—	1	—	—
Md.	3	24	16	14	5	2
D.C.	—	1	—	1	—	—
Va.	2	7	10	5	—	1
W. Va.	—	1	2	—	—	1
N.C.	3	5	26	23	1	1
S.C.	—	1	2	3	—	—
Ga.	17	60	53	69	—	4
Fla.	22	34	64	68	7	13
E.S. CENTRAL	6	19	17	39	3	9
Ky.	1	—	2	3	—	2
Tenn.	3	11	4	13	1	4
Ala.	2	2	10	6	2	—
Miss.	—	6	1	17	—	3
W.S. CENTRAL	6	106	5	28	—	29
Ark.	—	11	—	11	—	—
La.	3	3	2	15	—	20
Okla.	1	4	—	2	—	—
Tex.	2	88	3	—	—	9
MOUNTAIN	47	46	61	38	5	4
Mont.	4	—	—	—	—	—
Idaho	3	2	2	1	—	—
Wyo.	—	—	—	1	—	—
Colo.	6	2	3	7	—	—
N. Mex.	2	2	—	2	—	—
Ariz.	29	33	47	15	—	1
Utah	2	6	7	5	4	—
Nev.	1	1	2	7	1	3
PACIFIC	73	134	57	96	5	6
Wash.	4	5	1	6	—	1
Oreg.	6	13	11	20	1	1
Calif.	62	112	44	69	4	3
Alaska	—	1	—	—	—	—
Hawaii	1	3	1	1	—	1
Guam	—	—	—	—	—	—
P.R.	—	3	1	1	—	—
V.I.	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U
C.N.M.I.	—	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 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 12, 2005, and February 14, 2004 (6th Week)*

Reporting area	Legionellosis		Listeriosis		Lyme disease		Malaria	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	119	162	40	50	385	846	100	134
NEW ENGLAND	2	2	—	1	10	55	2	10
Maine	—	—	—	—	—	—	—	—
N.H.	—	—	—	—	6	—	—	—
Vt.	—	—	—	—	—	—	—	—
Mass.	2	1	—	—	4	51	2	8
R.I.	—	—	—	—	—	—	—	—
Conn.	—	1	—	1	—	4	—	2
MID. ATLANTIC	43	35	7	13	304	678	24	28
Upstate N.Y.	10	3	—	1	24	142	4	3
N.Y. City	—	—	1	2	—	—	7	15
N.J.	7	15	3	6	136	186	10	5
Pa.	26	17	3	4	144	350	3	5
E.N. CENTRAL	20	50	8	5	13	20	6	11
Ohio	12	26	3	3	12	4	2	1
Ind.	5	6	—	1	—	—	—	1
Ill.	—	10	—	—	—	—	1	2
Mich.	2	6	1	—	1	—	3	4
Wis.	1	2	4	1	U	16	—	3
W.N. CENTRAL	4	4	6	—	1	10	7	9
Minn.	—	—	1	—	—	3	1	4
Iowa	—	—	2	—	1	2	2	1
Mo.	4	3	2	—	—	5	3	3
N. Dak.	—	—	1	—	—	—	—	—
S. Dak.	—	1	—	—	—	—	—	—
Nebr.	—	—	—	—	—	—	—	—
Kans.	—	—	—	—	—	—	1	1
S. ATLANTIC	26	30	10	10	50	65	22	39
Del.	—	—	N	N	—	7	—	—
Md.	7	5	3	2	32	48	7	13
D.C.	—	2	—	—	1	—	—	—
Va.	—	2	—	—	—	—	2	—
W. Va.	—	—	—	1	—	—	—	—
N.C.	4	5	2	3	5	5	2	1
S.C.	—	1	—	—	—	—	—	2
Ga.	3	2	1	1	—	2	7	7
Fla.	12	13	4	3	12	3	4	16
E.S. CENTRAL	—	6	—	2	2	—	4	3
Ky.	—	1	—	1	—	—	1	—
Tenn.	—	2	—	1	2	—	2	—
Ala.	—	3	—	—	—	—	1	2
Miss.	—	—	—	—	—	—	—	1
W.S. CENTRAL	—	14	1	3	—	7	2	15
Ark.	—	—	—	—	—	—	—	1
La.	—	1	1	—	—	—	—	2
Okla.	—	1	—	—	—	—	—	1
Tex.	—	12	—	3	—	7	2	11
MOUNTAIN	9	9	—	4	—	2	9	2
Mont.	—	—	—	—	—	—	—	—
Idaho	—	1	—	—	—	—	—	—
Wyo.	2	2	—	—	—	1	1	—
Colo.	—	1	—	1	—	—	4	—
N. Mex.	1	—	—	—	—	—	—	1
Ariz.	3	2	—	—	—	—	2	—
Utah	1	2	—	—	—	1	2	—
Nev.	2	1	—	3	—	—	—	1
PACIFIC	15	12	8	12	5	9	24	17
Wash.	—	2	2	2	—	1	—	2
Oreg.	N	N	—	4	—	4	1	1
Calif.	15	10	6	6	5	4	22	14
Alaska	—	—	—	—	—	—	1	—
Hawaii	—	—	—	—	N	N	—	—
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	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 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 12, 2005, and February 14, 2004 (6th Week)*

	Meningococcal disease									
	All serogroups		Serogroup A, C, Y, and W-135		Serogroup B		Other serogroup		Serogroup unknown	
Reporting area	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	101	228	11	17	6	7	—	—	84	204
NEW ENGLAND	11	7	—	—	—	—	—	—	11	7
Maine	1	2	—	—	—	—	—	—	1	2
N.H.	1	—	—	—	—	—	—	—	1	—
Vt.	3	1	—	—	—	—	—	—	3	1
Mass.	5	4	—	—	—	—	—	—	5	4
R.I.	—	—	—	—	—	—	—	—	—	—
Conn.	1	—	—	—	—	—	—	—	1	—
MID. ATLANTIC	19	32	7	10	2	3	—	—	10	19
Upstate N.Y.	6	8	1	2	1	1	—	—	4	5
N.Y. City	1	7	—	—	—	—	—	—	1	7
N.J.	3	4	—	—	—	—	—	—	3	4
Pa.	9	13	6	8	1	2	—	—	2	3
E.N. CENTRAL	7	28	2	5	1	1	—	—	4	22
Ohio	3	16	—	3	1	1	—	—	2	12
Ind.	2	5	—	—	—	—	—	—	2	5
Ill.	—	1	—	—	—	—	—	—	—	1
Mich.	2	2	2	2	—	—	—	—	—	—
Wis.	—	4	—	—	—	—	—	—	—	4
W.N. CENTRAL	6	9	—	—	—	1	—	—	6	8
Minn.	—	1	—	—	—	—	—	—	—	1
Iowa	1	1	—	—	—	1	—	—	1	—
Mo.	4	4	—	—	—	—	—	—	4	4
N. Dak.	—	—	—	—	—	—	—	—	—	—
S. Dak.	—	1	—	—	—	—	—	—	—	1
Nebr.	—	1	—	—	—	—	—	—	—	1
Kans.	1	1	—	—	—	—	—	—	1	1
S. ATLANTIC	20	39	1	—	2	1	—	—	17	38
Del.	—	—	—	—	—	—	—	—	—	—
Md.	2	4	—	—	1	—	—	—	1	4
D.C.	—	1	—	—	—	—	—	—	—	1
Va.	—	2	—	—	—	—	—	—	—	2
W. Va.	—	3	—	—	—	—	—	—	—	3
N.C.	4	3	1	—	1	1	—	—	2	2
S.C.	2	4	—	—	—	—	—	—	2	4
Ga.	5	5	—	—	—	—	—	—	5	5
Fla.	7	17	—	—	—	—	—	—	7	17
E.S. CENTRAL	3	11	—	—	—	—	—	—	3	11
Ky.	1	2	—	—	—	—	—	—	1	2
Tenn.	2	4	—	—	—	—	—	—	2	4
Ala.	—	2	—	—	—	—	—	—	—	2
Miss.	—	3	—	—	—	—	—	—	—	3
W.S. CENTRAL	6	27	1	1	—	—	—	—	5	26
Ark.	1	3	—	—	—	—	—	—	1	3
La.	3	8	—	1	—	—	—	—	3	7
Okla.	2	1	1	—	—	—	—	—	1	1
Tex.	—	15	—	—	—	—	—	—	—	15
MOUNTAIN	7	12	—	—	—	1	—	—	7	11
Mont.	—	1	—	—	—	—	—	—	—	1
Idaho	—	1	—	—	—	—	—	—	—	1
Wyo.	—	1	—	—	—	—	—	—	—	1
Colo.	4	3	—	—	—	—	—	—	4	3
N. Mex.	—	—	—	—	—	—	—	—	—	—
Ariz.	3	3	—	—	—	—	—	—	3	3
Utah	—	1	—	—	—	—	—	—	—	1
Nev.	—	2	—	—	—	1	—	—	—	1
PACIFIC	22	63	—	1	1	—	—	—	21	62
Wash.	5	3	—	1	1	—	—	—	4	2
Oreg.	7	11	—	—	—	—	—	—	7	11
Calif.	10	47	—	—	—	—	—	—	10	47
Alaska	—	—	—	—	—	—	—	—	—	—
Hawaii	—	2	—	—	—	—	—	—	—	2
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	—	—	—	—	—	—
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	—	—	—	—	—	—	—	—	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 12, 2005, and February 14, 2004 (6th Week)*

Reporting area	Pertussis		Rabies, animal		Rocky Mountain spotted fever		Salmonellosis		Shigellosis	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,543	936	315	666	51	57	2,076	2,885	717	1,257
NEW ENGLAND	64	241	62	27	—	5	96	122	17	31
Maine	3	—	4	1	N	N	4	5	—	—
N.H.	—	4	2	1	—	—	5	5	1	2
Vt.	10	9	—	4	—	—	8	3	1	—
Mass.	51	221	46	13	—	5	57	86	14	22
R.I.	—	—	—	—	—	—	—	4	—	—
Conn.	—	7	10	8	—	—	22	19	1	7
MID. ATLANTIC	204	263	22	57	—	5	200	385	79	138
Upstate N.Y.	61	143	18	25	—	—	39	45	14	40
N.Y. City	—	15	4	1	—	2	59	133	43	44
N.J.	17	43	N	N	—	—	32	99	17	34
Pa.	126	62	—	31	—	3	70	108	5	20
E.N. CENTRAL	464	149	3	1	2	—	192	459	38	126
Ohio	324	55	1	1	2	—	82	108	9	27
Ind.	3	—	1	—	—	—	13	25	1	5
Ill.	2	2	1	—	—	—	11	173	3	64
Mich.	15	13	—	—	—	—	34	72	19	15
Wis.	120	79	—	—	—	—	52	81	6	15
W.N. CENTRAL	179	54	23	43	2	1	162	152	68	44
Minn.	30	2	9	7	—	—	31	37	1	10
Iowa	1	15	6	8	—	—	40	26	10	2
Mo.	69	32	4	2	2	1	49	44	41	12
N. Dak.	9	—	—	5	—	—	2	4	1	1
S. Dak.	1	—	—	9	—	—	9	8	6	1
Nebr.	27	—	—	—	—	—	14	11	6	2
Kans.	42	5	4	12	—	—	17	22	3	16
S. ATLANTIC	52	39	107	381	43	38	715	648	146	314
Del.	—	—	—	1	—	—	—	2	—	1
Md.	24	18	17	29	1	—	64	50	10	17
D.C.	—	4	—	—	—	—	—	—	—	5
Va.	1	6	36	38	—	—	48	48	8	10
W. Va.	—	—	3	8	—	—	1	1	—	—
N.C.	—	—	47	55	35	35	133	102	6	24
S.C.	12	2	—	7	1	2	25	36	—	24
Ga.	3	1	—	36	4	1	151	107	57	75
Fla.	12	8	4	207	2	—	293	302	65	158
E.S. CENTRAL	24	13	7	47	1	7	88	164	42	62
Ky.	6	2	—	2	—	—	18	13	4	2
Tenn.	9	7	—	36	1	2	23	45	25	29
Ala.	9	1	7	5	—	1	47	67	13	17
Miss.	—	3	—	4	—	4	—	39	—	14
W.S. CENTRAL	10	6	66	92	—	—	105	277	88	278
Ark.	1	3	6	4	—	—	27	22	7	6
La.	1	2	—	—	—	—	31	33	7	26
Okla.	—	1	8	7	—	—	21	23	44	37
Tex.	8	—	52	81	—	—	26	199	30	209
MOUNTAIN	416	82	21	11	2	—	168	226	64	107
Mont.	142	4	—	—	—	—	7	7	—	1
Idaho	19	13	—	—	—	—	8	25	—	—
Wyo.	5	2	1	—	—	—	6	2	—	1
Colo.	189	47	—	—	—	—	44	57	8	25
N. Mex.	5	8	—	—	—	—	10	21	4	21
Ariz.	29	3	20	11	—	—	69	83	37	42
Utah	24	4	—	—	2	—	8	17	4	7
Nev.	3	1	—	—	—	—	16	14	11	10
PACIFIC	130	89	4	7	1	1	350	452	175	157
Wash.	25	25	—	—	—	—	15	23	6	5
Oreg.	84	21	—	—	—	—	12	43	8	10
Calif.	13	42	4	7	1	1	288	339	156	133
Alaska	1	1	—	—	—	—	8	16	1	—
Hawaii	7	—	—	—	—	—	27	31	4	9
Guam	—	—	—	—	—	—	—	—	—	3
P.R.	—	—	7	9	N	N	3	22	—	1
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 12, 2005, and February 14, 2004 (6th Week)*

Reporting area	Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive disease: Drug resistant, all ages		*Streptococcus pneumoniae*, invasive disease: Age <5 years		Syphilis: Primary & secondary		Syphilis: Congenital	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	416	615	233	359	55	88	581	810	10	62
NEW ENGLAND	16	36	—	1	6	9	25	12	—	—
Maine	1	1	N	N	—	—	—	—	—	—
N.H.	1	4	—	—	—	N	2	1	—	—
Vt.	2	—	—	—	—	—	—	—	—	—
Mass.	12	29	—	—	6	9	23	5	—	—
R.I.	—	2	—	1	—	—	—	1	—	—
Conn.	—	—	—	—	U	U	—	5	—	—
MID. ATLANTIC	80	97	26	22	13	7	69	109	1	13
Upstate N.Y.	30	23	6	6	6	3	6	3	1	1
N.Y. City	6	26	U	U	U	U	48	69	—	3
N.J.	13	22	N	N	1	—	12	19	—	8
Pa.	31	26	20	16	6	4	3	18	—	1
E.N. CENTRAL	39	150	41	98	15	26	39	81	—	14
Ohio	17	38	35	81	11	16	15	23	—	—
Ind.	5	8	6	17	3	3	5	7	—	2
Ill.	2	42	—	—	1	—	15	38	—	2
Mich.	15	48	—	N	—	N	3	10	—	10
Wis.	—	14	N	N	—	7	1	3	—	—
W.N. CENTRAL	20	29	8	1	3	9	16	24	—	—
Minn.	—	—	—	—	—	3	1	4	—	—
Iowa	N	N	N	N	—	N	—	1	—	—
Mo.	11	10	8	1	—	3	13	15	—	—
N. Dak.	1	3	—	—	1	—	—	—	—	—
S. Dak.	3	3	—	—	—	—	—	—	—	—
Nebr.	3	3	—	—	1	2	1	4	—	—
Kans.	2	10	N	N	1	1	1	—	—	—
S. ATLANTIC	102	103	117	173	8	8	181	188	2	9
Del.	—	—	—	—	—	N	2	1	—	—
Md.	31	23	—	—	8	6	41	32	—	2
D.C.	—	—	—	3	—	2	11	6	—	—
Va.	3	7	N	N	—	N	5	3	1	1
W. Va.	—	4	—	7	—	—	—	2	—	—
N.C.	14	11	N	N	U	U	33	13	—	—
S.C.	—	1	—	11	—	N	9	16	—	2
Ga.	21	28	42	58	—	N	—	26	—	—
Fla.	33	29	75	94	—	N	80	89	1	4
E.S. CENTRAL	6	33	11	19	—	—	38	48	2	2
Ky.	2	15	2	4	N	N	1	8	—	—
Tenn.	4	18	9	15	—	N	14	22	1	1
Ala.	—	—	—	—	—	N	20	13	1	1
Miss.	—	—	—	—	—	—	3	5	—	—
W.S. CENTRAL	15	56	14	13	2	19	106	119	4	16
Ark.	2	2	3	1	—	—	3	9	—	—
La.	2	1	11	12	1	6	12	20	—	—
Okla.	11	8	N	N	1	2	8	3	1	2
Tex.	—	45	N	N	—	11	83	87	3	14
MOUNTAIN	103	37	9	8	8	10	28	42	1	1
Mont.	1	—	—	—	—	—	—	—	—	—
Idaho	—	1	N	N	—	N	—	4	—	—
Wyo.	1	3	2	3	—	—	—	1	—	—
Colo.	40	13	N	N	7	10	—	8	—	—
N. Mex.	8	15	—	3	—	—	6	11	—	1
Ariz.	49	3	N	N	—	N	17	14	1	—
Utah	4	2	6	1	1	—	—	2	—	—
Nev.	—	—	1	1	—	—	5	2	—	—
PACIFIC	35	74	7	24	—	—	79	187	—	7
Wash.	N	N	N	N	N	N	14	11	—	—
Oreg.	N	N	N	N	—	N	—	9	—	—
Calif.	20	54	N	N	—	N	64	166	—	7
Alaska	—	—	—	—	—	N	—	—	—	—
Hawaii	15	20	7	24	—	—	1	1	—	—
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	N	N	N	N	—	N	10	10	—	—
V.I.	—	—	—	—	—	—	—	2	—	—
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. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 12, 2005, and February 14, 2004 (6th Week)*

Reporting area	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease† Neuroinvasive		West Nile virus disease† Non-neuroinvasive§
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	464	917	15	31	1,925	1,929	—	1	—
NEW ENGLAND	14	26	—	3	39	130	—	—	—
Maine	—	—	—	—	37	6	—	—	—
N.H.	1	—	—	—	—	—	—	—	—
Vt.	—	—	—	—	1	124	—	—	—
Mass.	8	13	—	3	1	—	—	—	—
R.I.	—	5	—	—	—	—	—	—	—
Conn.	5	8	—	—	—	—	—	—	—
MID. ATLANTIC	174	157	4	9	251	7	—	—	—
Upstate N.Y.	2	12	—	—	—	—	—	—	—
N.Y. City	117	116	—	4	—	—	—	—	—
N.J.	30	21	1	3	—	—	—	—	—
Pa.	25	8	3	2	251	7	—	—	—
E.N. CENTRAL	110	83	—	2	915	867	—	—	—
Ohio	18	16	—	1	145	224	—	—	—
Ind.	11	22	—	—	N	N	—	—	—
Ill.	71	31	—	—	—	—	—	—	—
Mich.	—	7	—	1	734	547	—	—	—
Wis.	10	7	—	—	36	96	—	—	—
W.N. CENTRAL	22	24	—	—	10	24	—	—	—
Minn.	7	10	—	—	—	—	—	—	—
Iowa	—	—	—	—	N	N	—	—	—
Mo.	10	10	—	—	1	—	—	—	—
N. Dak.	—	—	—	—	—	12	—	—	—
S. Dak.	—	—	—	—	9	12	—	—	—
Nebr.	1	—	—	—	—	—	—	—	—
Kans.	4	4	—	—	—	—	—	—	N
S. ATLANTIC	39	186	3	3	168	179	—	—	—
Del.	—	2	—	—	—	—	—	—	—
Md.	15	10	1	—	—	—	—	—	—
D.C.	—	4	—	—	—	4	—	—	—
Va.	—	2	—	1	3	1	—	—	—
W. Va.	6	2	—	—	160	163	—	—	N
N.C.	2	2	1	1	—	N	—	—	—
S.C.	16	11	—	—	5	11	—	—	—
Ga.	—	81	—	—	—	—	—	—	—
Fla.	—	72	1	1	—	—	—	—	—
E.S. CENTRAL	15	48	1	—	—	—	—	—	—
Ky.	15	4	1	—	N	N	—	—	—
Tenn.	—	18	—	—	—	—	—	—	—
Ala.	—	17	—	—	—	—	—	—	—
Miss.	—	9	—	—	—	—	—	—	—
W.S. CENTRAL	20	213	—	4	123	480	—	1	—
Ark.	8	6	—	—	—	—	—	1	—
La.	—	—	—	—	2	11	—	—	—
Okla.	12	12	—	—	—	—	—	—	—
Tex.	—	195	—	4	121	469	—	—	—
MOUNTAIN	5	25	—	2	419	242	—	—	—
Mont.	—	—	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—	—
Wyo.	—	—	—	—	15	10	—	—	—
Colo.	—	6	—	—	295	137	—	—	—
N. Mex.	—	4	—	—	18	10	—	—	—
Ariz.	4	9	—	—	—	—	—	—	—
Utah	1	6	—	1	91	85	—	—	—
Nev.	—	—	—	1	—	—	—	—	—
PACIFIC	65	155	7	8	—	—	—	—	—
Wash.	28	29	—	1	N	N	—	—	—
Oreg.	9	10	1	—	—	—	—	—	—
Calif.	9	101	3	5	—	—	—	—	—
Alaska	2	3	—	—	—	—	—	—	—
Hawaii	17	12	3	2	—	—	—	—	—
Guam	—	9	—	—	—	15	—	—	—
P.R.	—	—	—	—	5	38	—	—	—
V.I.	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	—
C.N.M.I.	—	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 2004 and 2005 are provisional and cumulative (year-to-date).
† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
§ Not previously notifiable.

TABLE III. Deaths in 122 U.S. cities,* week ending February 12, 2005 (6th Week)

	All causes, by age (years)						
Reporting Area	All Ages	≥65	45–64	25–44	1–24	<1	P&I† Total
NEW ENGLAND	687	522	115	30	8	11	83
Boston, Mass.	168	120	29	10	4	5	20
Bridgeport, Conn.	42	31	7	2	—	1	7
Cambridge, Mass.	9	6	2	1	—	—	—
Fall River, Mass.	44	35	8	1	—	—	9
Hartford, Conn.	56	42	10	2	1	1	13
Lowell, Mass.	26	21	4	1	—	—	1
Lynn, Mass.	15	11	3	—	1	—	1
New Bedford, Mass.	40	35	4	—	1	—	5
New Haven, Conn.	48	42	4	2	—	—	4
Providence, R.I.	84	68	13	—	1	2	9
Somerville, Mass.	2	2	—	—	—	—	—
Springfield, Mass.	46	29	14	2	—	1	4
Waterbury, Conn.	30	20	5	5	—	—	5
Worcester, Mass.	77	60	12	4	—	1	5
MID. ATLANTIC	2,634	1,874	526	168	27	38	220
Albany, N.Y.	63	38	14	5	2	4	6
Allentown, Pa.	25	23	2	—	—	—	3
Buffalo, N.Y.	112	72	27	9	1	3	21
Camden, N.J.	33	22	5	3	1	2	4
Elizabeth, N.J.	16	14	2	—	—	—	—
Erie, Pa.	53	35	13	4	—	1	3
Jersey City, N.J.	36	27	5	3	—	1	—
New York City, N.Y.	1,485	1,063	299	88	15	19	102
Newark, N.J.	98	50	29	18	1	—	6
Paterson, N.J.	6	1	4	1	—	—	—
Philadelphia, Pa.	227	139	60	21	2	5	16
Pittsburgh, Pa.§	26	17	6	1	—	2	1
Reading, Pa.	37	32	3	1	1	—	4
Rochester, N.Y.	172	145	20	6	1	—	23
Schenectady, N.Y.	38	29	8	1	—	—	5
Scranton, Pa.	30	29	—	1	—	—	3
Syracuse, N.Y.	119	94	18	3	3	1	20
Trenton, N.J.	23	17	5	1	—	—	1
Utica, N.Y.	16	14	2	—	—	—	2
Yonkers, N.Y.	19	13	4	2	—	—	—
E.N. CENTRAL	2,066	1,471	405	95	42	52	166
Akron, Ohio	55	40	9	2	2	2	11
Canton, Ohio	48	37	8	3	—	—	6
Chicago, Ill.	269	174	68	17	3	6	22
Cincinnati, Ohio	62	46	8	1	2	5	8
Cleveland, Ohio	237	180	43	7	5	2	16
Columbus, Ohio	209	147	45	5	3	9	20
Dayton, Ohio	114	81	25	5	2	1	10
Detroit, Mich.	159	94	44	11	4	6	7
Evansville, Ind.	39	30	9	—	—	—	—
Fort Wayne, Ind.	48	36	6	5	1	—	4
Gary, Ind.	14	7	4	1	—	2	2
Grand Rapids, Mich.	80	67	7	1	2	3	12
Indianapolis, Ind.	198	145	31	7	6	9	13
Lansing, Mich.	29	23	6	—	—	—	—
Milwaukee, Wis.	130	89	25	7	6	3	10
Peoria, Ill.	56	37	11	8	—	—	5
Rockford, Ill.	73	48	12	5	5	3	8
South Bend, Ind.	71	57	9	4	1	—	2
Toledo, Ohio	120	86	27	6	—	1	8
Youngstown, Ohio	55	47	8	—	—	—	2
W.N. CENTRAL	492	327	104	30	17	14	48
Des Moines, Iowa	45	34	7	3	1	—	6
Duluth, Minn.	30	26	3	1	—	—	6
Kansas City, Kans.	10	5	1	2	1	1	1
Kansas City, Mo.	79	52	20	3	—	4	5
Lincoln, Nebr.	44	31	10	2	1	—	5
Minneapolis, Minn.	67	46	7	6	6	2	6
Omaha, Nebr.	76	54	18	3	1	—	7
St. Louis, Mo.	33	20	11	2	—	—	2
St. Paul, Minn.	69	47	17	2	1	2	8
Wichita, Kans.	39	12	10	6	6	5	2

	All causes, by age (years)						
Reporting Area	All Ages	≥65	45–64	25–44	1–24	<1	P&I† Total
S. ATLANTIC	1,192	771	263	87	40	30	73
Atlanta, Ga.	139	85	33	10	7	4	3
Baltimore, Md.	207	125	48	28	6	—	25
Charlotte, N.C.	121	85	21	11	2	2	12
Jacksonville, Fla.	155	98	41	6	4	6	1
Miami, Fla.	88	62	12	7	6	1	3
Norfolk, Va.	52	32	8	3	3	6	2
Richmond, Va.	51	21	19	5	2	3	4
Savannah, Ga.	56	43	13	—	—	—	4
St. Petersburg, Fla.	64	48	10	3	2	1	1
Tampa, Fla.	205	145	42	8	7	3	16
Washington, D.C.	34	16	9	5	—	4	—
Wilmington, Del.	20	11	7	1	1	—	2
E.S. CENTRAL	886	594	202	47	24	19	62
Birmingham, Ala.	191	126	40	13	6	6	19
Chattanooga, Tenn.	96	69	22	4	1	—	8
Knoxville, Tenn.	104	69	24	4	3	4	2
Lexington, Ky.	65	46	12	5	2	—	4
Memphis, Tenn.	174	111	50	6	5	2	10
Mobile, Ala.	43	31	9	3	—	—	4
Montgomery, Ala.	61	42	14	2	3	—	3
Nashville, Tenn.	152	100	31	10	4	7	12
W.S. CENTRAL	1,545	1,007	337	121	48	32	101
Austin, Tex.	77	58	11	3	4	1	3
Baton Rouge, La.	33	24	5	1	2	1	1
Corpus Christi, Tex.	58	33	15	4	3	3	2
Dallas, Tex.	188	115	47	19	3	4	15
El Paso, Tex.	96	70	17	3	5	1	6
Ft. Worth, Tex.	122	88	24	9	1	—	8
Houston, Tex.	385	237	91	34	14	9	29
Little Rock, Ark.	79	51	16	8	2	2	—
New Orleans, La.	55	35	13	7	—	—	—
San Antonio, Tex.	265	182	48	20	10	5	26
Shreveport, La.	46	28	9	5	2	2	5
Tulsa, Okla.	141	86	41	8	2	4	6
MOUNTAIN	1,135	739	246	74	35	34	71
Albuquerque, N.M.	130	81	31	13	1	4	12
Boise, Idaho	45	39	4	—	1	1	6
Colo. Springs, Colo.	71	51	9	6	2	3	3
Denver, Colo.	109	60	28	6	5	10	3
Las Vegas, Nev.	259	178	62	12	4	2	21
Ogden, Utah	30	21	4	4	1	—	2
Phoenix, Ariz.	204	109	53	18	11	7	11
Pueblo, Colo.	30	29	1	—	—	—	2
Salt Lake City, Utah	107	66	25	6	5	5	5
Tucson, Ariz.	150	105	29	9	5	2	6
PACIFIC	1,595	1,122	310	100	30	33	155
Berkeley, Calif.	9	7	—	—	—	2	2
Fresno, Calif.	118	90	17	6	4	1	9
Glendale, Calif.	26	18	6	2	—	—	2
Honolulu, Hawaii	94	67	14	6	4	3	7
Long Beach, Calif.	99	60	26	6	3	4	12
Los Angeles, Calif.	375	247	81	28	8	11	36
Pasadena, Calif.	U	U	U	U	U	U	U
Portland, Oreg.	136	99	28	7	1	1	10
Sacramento, Calif.	150	109	29	11	1	—	16
San Diego, Calif.	179	133	31	9	3	3	11
San Francisco, Calif.	100	58	24	13	1	4	15
San Jose, Calif.	U	U	U	U	U	U	U
Santa Cruz, Calif.	25	22	3	—	—	—	1
Seattle, Wash.	128	94	26	7	1	—	12
Spokane, Wash.	60	52	3	2	1	2	12
Tacoma, Wash.	96	66	22	3	3	2	10
TOTAL	12,232¶	8,427	2,508	752	271	263	979

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.

☆U.S. Government Printing Office: 2005-733-116/00071 Region IV ISSN: 0149-2195