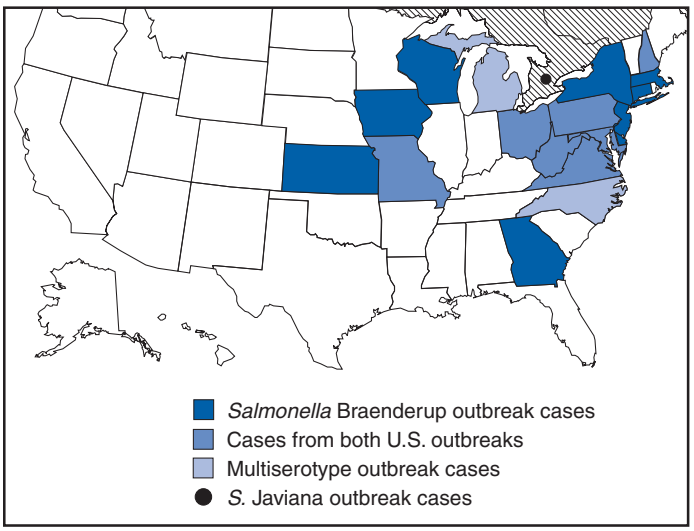
MMWR
Morbidity and Mortality Weekly Report
Weekly April 8, 2005 / Vol. 54 / No. 13

Outbreaks of *Salmonella* Infections Associated with Eating Roma Tomatoes — United States and Canada, 2004

Three outbreaks of *Salmonella* infections associated with eating Roma tomatoes were detected in the United States and Canada in the summer of 2004. In one multistate U.S. outbreak during June 25–July 18, multiple *Salmonella* serotypes were isolated, and cases were associated with exposure to Roma tomatoes from multiple locations of a chain delicatessen. Each of the other two outbreaks was characterized by a single *Salmonella* serotype: Braenderup in one multistate outbreak and Javiana in an outbreak in Canada. In the three outbreaks, 561 outbreak-related illnesses from 18 states (Figure 1) and one province in Canada were identified. This report describes the subsequent investigations by public health and food safety agencies. Although a single tomato-packing house in Florida was common to all three outbreaks, other growers or packers also might have supplied contaminated Roma tomatoes that resulted in some of the illnesses. Environmental investigations are continuing. Because current knowledge of mechanisms of tomato contamination and methods of eradication of *Salmonella* in fruit is inadequate to ensure produce safety, further research should be a priority for the agricultural industry, food safety agencies, and the public health community.

FIGURE 1. Areas with Roma tomato–associated salmonellosis cases — United States and Canada, June–July 2004



Multiserotype *Salmonella* Outbreak — Multistate

In July 2004, a total of 429 culture-confirmed, outbreak-associated salmonellosis cases were identified in nine states (Maryland, Michigan, Missouri, North Carolina, New Hampshire, Ohio, Pennsylvania, Virginia, and West Virginia); these cases occurred among persons eating at delicatessen chain A sites, with symptom onset during July 2–27(Figure 2). The median age of patients was 35 years (range: 1–81 years); 52% were male. No deaths occurred, but 30% of patients were hospitalized. These cases yielded *Salmonella* serotypes Javiana (383), Typhimurium (27), Anatum (five), Thompson (four), Muenchen (four), and Group D untypable (six).

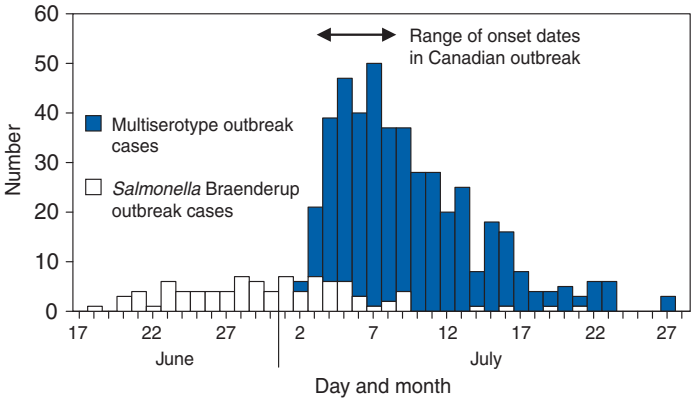
State and local health departments, in collaboration with CDC, conducted a case-control study, which included 53 case-patients and 53 well meal-companion controls. Of the 53 case-patients, 47 (90%) ate Roma tomatoes, compared with 24 (48%) of the controls. Multivariate analysis data demonstrated a strong association with consumption of Roma tomatoes

INSIDE

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].

FIGURE 2. Number of outbreak-related salmonellosis cases, by date of illness onset — United States, June–July 2004



(adjusted odds ratio = 7.1; 95% confidence interval [CI] = 1.5–34). Delicatessen chain A had purchased presliced Roma tomatoes from a single processor for all of its 302 stores in five states. *S.* Anatum, with a pulsed-field gel electrophoresis (PFGE) pattern indistinguishable from that of five cases in four states, was isolated from presliced Roma tomatoes sampled at a delicatessen chain A site on July 13.

Roma tomatoes were removed from all delicatessen chain A sites on July 14. A total of 22 (5%) patients reported illness onset after July 19, outside the incubation period for *Salmonella*. These illnesses might be explained by factors such as continued Roma tomato use, poor recall, low infectious dose, food saved and eaten later, or secondary transmission.

S. Braenderup Outbreak — Multistate

In the summer of 2004, a total of 125 confirmed cases of *S.* Braenderup infection with an indistinguishable PFGE pattern were identified from 16 states (Delaware, Connecticut, Georgia, Iowa, Kansas, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Virginia, West Virginia, and Wisconsin); patients had illness onset during June 18–July 21. The median age of patients was 30 years (range: 0–84 years); 66% were female. No deaths occurred, but 20% of patients were hospitalized.

State and local health departments, in collaboration with CDC, conducted a case-control study among persons aged 15–60 years. A case was defined as infection with *S.* Braenderup yielding the outbreak PFGE pattern, with illness onset after June 15. Controls were enrolled through sequential-digit telephone dialing by using patients' area codes. A total of 38 case-patients and 79 controls were included. Patients were more likely than controls to have eaten out multiple times during the 5 days preceding illness onset (53% versus 34%) (odds ratio [OR] = 2.1; CI = 1.0–4.7). A higher proportion of patients

than controls ate cheese, lettuce, and tomatoes outside the home, but these differences were not statistically significant. Using meal information from 27 case-patients and 29 controls, restaurant managers were asked about specific types of cheese, lettuce, and tomatoes used in dishes eaten by customers. Roma tomatoes, which were eaten by 41% of case-patients but only 14% of controls (OR = 4.1; CI = 1.1–15.3), were the only exposure significantly associated with illness. These restaurants purchased whole Roma tomatoes from tomato distributors.

S. Javiana Outbreak — Canada

Seven confirmed cases of *S.* Javiana infections with indistinguishable PFGE patterns, but with patterns distinct from the multiserotype *Salmonella* outbreak, were identified from one Canadian province, Ontario; illness onset occurred during July 4–8, 2004. The median age of ill persons was 28 years (range: 23–36 years). No deaths were reported, but 14% of persons were hospitalized. All patients ate at the same restaurant. Although a case-control study was not conducted, Roma tomatoes were the suspected outbreak vehicle because Roma tomatoes were the only common food exposure among all patients.

Traceback and Environmental Investigation

The Food and Drug Administration (FDA), in conjunction with state and provincial food regulatory agencies and state health departments, conducted traceback investigations of the Roma tomatoes eaten by patients in all three outbreaks. For each outbreak, Roma tomatoes were traced from restaurants back to distributors, packers, or growers in the United States. Traceback investigation of tomatoes from the multiserotype outbreak identified one field-packing operation and three packing houses from three states as possible sources. Of these four sources, Florida packing house A was also identified as a possible source for the two other concurrent Roma tomato–associated salmonellosis outbreaks (i.e., the *S.* Braenderup and *S.* Javiana outbreaks).

Quality-control procedures at the tomato-slicing facility associated with the multiserotype *Salmonella* outbreak were inspected while the facility was in active operation; no source of contamination was identified. In addition, *S.* Javiana is typically associated with the coastal Southeast, whereas the slicing facility is located in the Northeast.

Environmental investigation of four packers and five associated farms in Florida and South Carolina during August–November 2004 did not reveal a clear source of contamination, and the packing houses appeared to be following food-safety guidance. However, of these nine facilities, only Florida packing house A and one associated farm were in active operation at the time of inspection. Investigations will continue during the corresponding 2005 growing season.

Reported by: *R Corby, V Lanni, Brant County Health Unit, Ontario, Canada. V Kistler, MEd, Allentown Health Bur; V Dato, MD, A Weltman, MD, C Yozviak, K Waller, MD, K Nalluswami, MD, M Moll, MD, Pennsylvania Dept of Health. Center for Food Safety and Applied Nutrition; Office of Crisis Management, Food and Drug Admin. J Lockett, S Montgomery, DVM, M Lynch, MD, C Braden, MD, Div of Bacterial and Mycotic Diseases, National Center for Infectious Diseases; SK Gupta, MD, A DuBois, MD, EIS officers, CDC.*

Editorial Note: Tomatoes originated in South America, were introduced into Europe in the 16th century, and are now a popular food worldwide. The Roma tomato was developed in the mid-1950s as a firmer and more disease-resistant variety (*1*). Uncooked tomatoes have become an integral and nutritious component of the daily diet. Approximately 5 billion pounds of fresh market tomatoes are eaten annually in the United States, and thus the potential for large outbreaks of *Salmonella* infections is a concern. This report describes three outbreaks in the United States and Canada in which Roma tomatoes were implicated; as a result of these outbreaks, 2004 had the highest number of recorded annual tomato-associated *Salmonella* infections.

In the eastern United States, tomatoes are grown in natural habitats for many known *Salmonella* reservoirs, including birds, amphibians, and reptiles. *Salmonella* infections have been linked to tomatoes since 1990, when *S.* Javiana caused 176 illnesses in four midwestern states (*2*). Those tomatoes, and those implicated in a subsequent outbreak in 1993, were traced to a South Carolina packing house. Cross-contamination might have occurred at the packing house, where substantial numbers of tomatoes passed through a common wash tank (*2*). In 1994 and 1995, a Hazard Analysis Critical Control Points program was implemented at this packing house and disseminated to the tomato industry (*3*). The key critical-control point implemented was maintenance of water quality, specifically monitoring chlorine levels, pH, and water temperature in the wash tank. Of seven subsequent tomato-associated *Salmonella* outbreaks, six have been traced to other packing houses in the southeastern United States (*4,5*). Although produce packing houses are specifically exempt from the requirements of Good Manufacturing Practices (GMPs), FDA guidance (*6*) to the produce industry encourages GMP controls for water used in packing houses. However, the extent to which FDA guidance has been adopted by the industry is unknown. Tomato-associated *Salmonella* outbreaks reported to CDC have increased in frequency and magnitude in recent years and caused 1,616 reported illnesses in nine outbreaks during 1990–2004, representing approximately

60,000 illnesses when accounting for the estimated proportion (97.5%) of unreported illness (*7*).

Salmonella can enter tomato plants through roots or flowers (*8*) and can enter the tomato fruit through small cracks in the skin, the stem scar, or the plant itself (*9*). However, whether *Salmonella* can travel from roots to the fruit, or if seeds can contaminate subsequent generations of tomato plants, is unknown. Understanding the mechanism of contamination and amplification of contamination of large volumes of tomatoes is critical to prevent large-scale, tomato-associated outbreaks. Contamination might occur during multiple steps from the tomato seed nursery to the final kitchen. Eradication of *Salmonella* from the interior of the tomato is difficult without cooking, even if treated with highly concentrated chlorine solution (*10*).

Public health professionals should be aware of tomatoes as a possible vehicle when investigating *Salmonella* outbreaks. Current knowledge of mechanisms of tomato contamination and methods of eradication of *Salmonella* in fruit are inadequate to fully define interventions that will ensure produce safety. Studies into these concerns should be a priority for the agricultural industry, food safety agencies, and the public health community.

Acknowledgments

The findings in this report are based, in part, on contributions by state public health departments in Connecticut, Delaware, Georgia, Iowa, Kansas, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Virginia, West Virginia, and Wisconsin. M Hoekstra, M Balasegaram, M Perch, C Snider, Div of Bacterial and Mycotic Diseases, National Center for Infectious Diseases; D Burmeister, EIS Officer, CDC.

References

1. Committee on Varietal Pedigrees. Interim report of the Committee on Varietal Pedigrees. Report of the Tomato Genetics Cooperative [Appendix 36]. Gainesville, FL: University of Florida; 1961. Available at http://gcrec.ifas.ufl.edu/tgc/newsletters/vol11/v11p36.html.
2. Hedberg CW, Angulo FJ, White KE, et al. Outbreaks of salmonellosis associated with eating uncooked tomatoes: implications for public health. Epidemiol Infect 1999;122:385–93.
3. Rushing JW, Angulo FJ, Beuchat LR. Implementation of a HACCP program in a commercial fresh-market tomato packinghouse: a model for the industry. Dairy, Food, and Environmental Sanitation 1996; 16:549–53.
4. Cummings K, Barrett E, Mohle-Boetani JC, et al. A multistate outbreak of *Salmonella enterica* serotype Baildon associated with domestic raw tomatoes. Emerg Infect Dis 2001;7:1046–8.
5. CDC. Outbreak of *Salmonella* serotype Javiana infections—Orlando, Florida, June 2002. MMWR 2002;51:683–4.
6. Food and Drug Administration, Center for Food Safety and Applied Nutrition. Guidance for industry: guide to minimize microbial food safety hazards for fresh fruits and vegetables. Washington, DC: Food and Drug Administration; 1998. Available at http://www.foodsafety.gov/~dms/prodguid.html.
7. Voetsch AC, Van Gilder TJ, Angulo FJ, et al. FoodNet estimate of the burden of illness caused by nontyphoidal *Salmonella* infections in the United States. Clin Infect Dis 2004;38(Suppl 3):S127–34.
8. Guo X, van Iersel MW, Chen J, et al. Evidence of association of *Salmonellae* with tomato plants grown hydroponically in inoculated nutrient solution. Appl Environ Microbiol 2002;68:3639–43.
9. Guo X, Chen J, Brackett RE, et al. Survival of *Salmonellae* on and in tomato plants from the time of inoculation at flowering and early stages of fruit development through fruit ripening. Appl Environ Microbiol 2001;67:4760–4.
10. Zhuang RY, Beuchat LR, Angulo FJ. Fate of *Salmonella* Montevideo on and in raw tomatoes as affected by temperature and treatment with chlorine. Appl Environ Microbiol 1995;61:2127–31.

Update: Influenza Activity — United States, 2004–05 Season

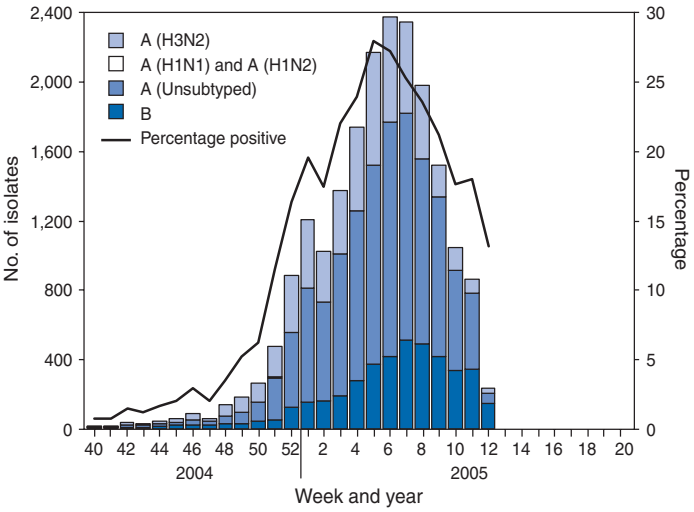
This report summarizes influenza activity in the United States during October 3, 2004–March 26, 2005,* updates the previous summary (*1*), and describes the composition of the 2005–06 influenza vaccine. Influenza activity was moderate in the United States overall, but varied by region. Preliminary data collected through the seven components of the CDC Influenza Surveillance System† indicate that national influenza activity peaked in early-February.

Influenza Viral Surveillance and Characterization

As of the week ending March 26, the World Health Organization (WHO) and National Respiratory and Enteric Virus Surveillance System collaborating laboratories in the United States had tested 121,373 respiratory specimens for influenza viruses; 20,135 (16.6%) were positive. The percentage of specimens that tested positive for influenza first exceeded 10.0% during the week ending December 25, 2004, and peaked at 27.8% (Figure 1) during the week ending February 5, 2005. During the 2001–02, 2002–03, and 2003–04 influenza seasons, peak percentages of specimens that tested positive for influenza ranged from 24.9% to 34.7% (CDC, unpublished data, 2004). The timing of the peaks varied from late November during the 2003–04 season to mid-to-late February during the 2001–02 season. During the weeks ending March 12–26, 2005, the percentage of specimens that tested positive

* As of March 26, 2005, reporting is incomplete.
† The CDC Influenza Surveillance System comprises the following seven components: 1) World Health Organization and National Respiratory and Enteric Virus Surveillance System collaborating laboratories, 2) U.S. Influenza Sentinel Providers Surveillance Network, 3) 122 Cities Mortality Reporting System, 4) State and Territorial Epidemiologists' Reports, 5) Influenza-associated pediatric mortality, 6) Emerging Infections Program, and 7) New Vaccine Surveillance Network.

FIGURE 1. Number* and percentage of respiratory specimens testing positive for influenza reported by World Health Organization and National Respiratory and Enteric Virus Surveillance System collaborating laboratories, by week and year — United States, 2004–05 influenza season†



*N = 20,135.
†As of March 26, 2005, reporting is incomplete.

for influenza ranged from 7.5% in the Pacific region to 28.5% in the South Atlantic region[§].

Of the 20,135 influenza viruses reported since October 3, 2004, a total of 15,932 (79.1%) were influenza A viruses, and 4,203 (20.9%) were influenza B viruses. Of the 5,083 influenza A viruses that were subtyped, 5,070 (99.7%) were influenza A (H3N2), and 13 (0.3%) were influenza A (H1)[¶]. Since October 3, 2004, a total of 68.5% and 55.6% of viruses reported from the Mountain and Pacific regions, respectively, were influenza type A. In the remaining seven surveillance regions, the proportion of influenza A viruses ranged from 78.5% in the South Atlantic region to 89.3% in the East South Central region. During the weeks ending March 12–26, 2005, influenza B viruses accounted for increasing proportions of influenza viruses in all nine surveillance regions, with the highest proportion (72.3%) reported from the New England region. In the Mid-Atlantic, East North Central, and Pacific regions, more than 60.0% of recent influenza isolates also were influenza B.

Using hemagglutination-inhibition tests with postinfection ferret serum, CDC has antigenically characterized 638 influenza viruses collected by U.S. laboratories since October 1, 2004. Of these, 419 (65.7%) were influenza A (H3N2) viruses, six (0.9%) were influenza A (H1) viruses, and 213 (33.4%) were influenza B viruses. Of the 419 influenza A (H3N2) isolates, 151 (36.0%) were similar antigenically to A/Wyoming/3/2003, the A/Fujian/411/2002-like (H3N2) strain recommended for the 2004–05 influenza vaccine, and 268 (64.0%) were antigenically similar to A/California/7/2004 (H3N2), a recently characterized drift variant of A/Fujian/411/2002-like (H3N2) viruses. The hemagglutinin proteins of the influenza A (H1) viruses were similar antigenically to hemagglutinin of the vaccine strain A/New Caledonia/20/99. Current influenza B viruses fall into one of two antigenically and genetically distinct lineages represented by B/Yamagata/16/88 and B/Victoria/2/87 viruses (*2*). A total of 139 (65.3%) of the influenza B viruses belonged to the B/Yamagata lineage and were similar antigenically to B/Shanghai/361/2002-like viruses, the influenza B strain recommended for the 2004–05 influenza vaccine. Twenty-four (11.3%) viruses had reduced titers to B/Shanghai/361/2002 using ferret antisera, and 50 (23.5%) influenza B viruses belonged to the B/Victoria lineage.

Influenza Activity Levels Reported by State and Territorial Epidemiologists

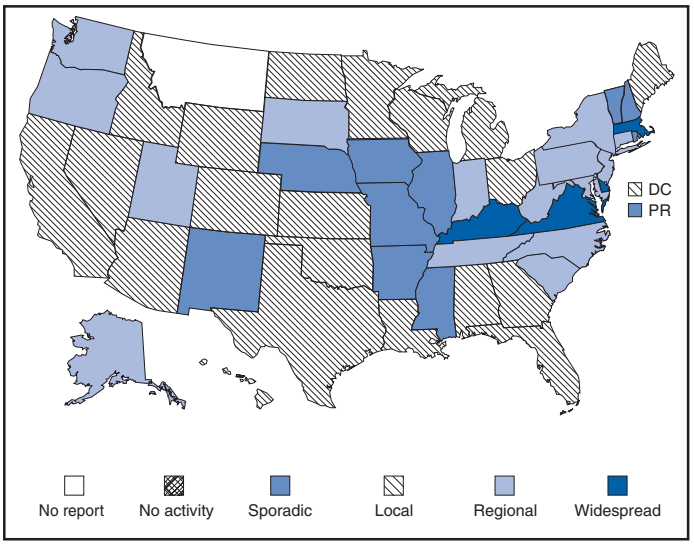
For the week ending March 26, 2005, a total of four states reported widespread influenza activity**; 15 states reported regional activity; 20 states, New York City, and the District of Columbia reported local activity; and 10 states and Puerto Rico reported sporadic activity (Figure 2). One state did not report. Widespread influenza activity was first reported during the week ending November 13, 2004, by one state (Delaware), and since then, a total of 42 states and New York City have reported widespread activity for at least 1 week.

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

[¶] Includes both the A (H1N1) and A (H1N2) influenza virus sybtypes.

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

FIGURE 2. States in which estimated influenza activity levels have been reported by state and territorial epidemiologists, by level of activity* — United States, 2005†



* Levels of activity are 1) *no activity*, 2) *sporadic*: small numbers of laboratory-confirmed influenza cases or a single influenza outbreak reported but no increase in cases of influenza-like illness (ILI), 3) *local*: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in a single region of a state, 4) *regional*: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least two but less than half the regions of a state, and 5) *widespread*: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of a state.
† As of March 26, 2005.

Patient Visits for Influenza-Like Illness

For the week ending March 26, 2005, the weekly percentage of patient visits for influenza-like illness (ILI)[††] reported by approximately 1,400 U.S. sentinel providers was 2.6%. During the weeks ending October 9, 2004–March 26, 2005, the percentage of patient visits for ILI ranged from 1.0% to 5.4% and has exceeded the national baseline of 2.5%[§§] for 11 consecutive weeks from the week ending January 15, 2005, through the week ending March 26, 2005. These patient visits peaked at 5.4% during the week ending February 19. During the 2001–02, 2002–03, and 2003–04 influenza seasons, national weekly peak percentages of patient visits for ILI ranged from 3.2% in mid-February during the 2001–02 and 2002–03 seasons to 7.6% in mid-to-late December during the 2003–04 season (CDC, unpublished data, 2004).

†† Temperature of ≥100.0°F (≥37.8°C) and either cough or sore throat in the absence of a known cause.

§§ The national baseline was calculated as the mean weighted percentage of visits for ILI during noninfluenza weeks, plus two standard deviations. Wide variability in regional data precludes calculating region-specific baselines; applying the national baseline to regional data is inappropriate.

Pediatric Hospitalizations Associated with Laboratory-Confirmed Influenza Infection

CDC monitors laboratory-confirmed influenza-associated pediatric hospitalizations by using two population-based surveillance networks: the Emerging Infections Program (EIP) and the New Vaccine Surveillance Network (NVSN)[¶¶]. Surveillance methods and case definitions differ slightly between the two systems[***]. During October 1, 2004–March 19, 2005, the preliminary influenza-associated hospitalization rates for children aged 0–4 years were 5.2 and 1.9 per 10,000 in the NVSN and EIP sites, respectively. EIP also monitors hospitalizations in children aged 5–17 years; the preliminary influenza-associated hospitalization rate for this age group was 0.3 per 10,000. The overall hospitalization rate reported by EIP for children aged 0–17 years was 0.9 per 10,000. During 2000–2004, the end-of-season hospitalization rate for NVSN ranged from 3.7 (2002–03) to 12 (2003–04) per 10,000 children. The 2003–04 end-of-season hospitalization rate for EIP was 7.8 per 10,000 for children aged 0–4 years and 0.8 per 10,000 for children aged 5–17 years.

Influenza-Associated Mortality Surveillance

During the week ending March 26, 2005, an estimated 8.6% of deaths in the United States reported through the 122 Cities Mortality Reporting System were attributed to pneumonia and influenza (P&I), which was above the epidemic threshold[†††] of 8.1% for that week. The percentage of P&I deaths exceeded the epidemic threshold (Figure 3) for 6 consecutive weeks (weeks ending February 19–March 26, 2005).

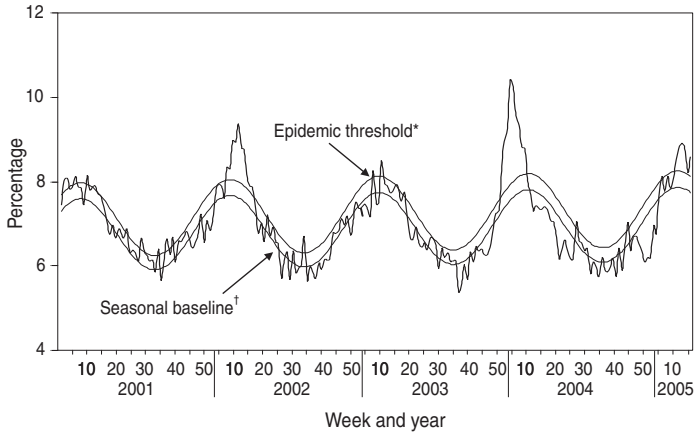
In October 2004, pediatric deaths associated with laboratory-confirmed influenza infection were made a nationally notifiable condition. As of March 26, a total of 24 pediatric

¶¶ EIP Influenza Project conducts surveillance in 57 counties associated with 11 metropolitan areas: San Francisco (CA), Denver (CO), New Haven (CT), Atlanta (GA), Baltimore (MD), Minneapolis/St. Paul (MN), Albuquerque (NM), Albany (NY), Rochester (NY), Portland (OR), and Nashville (TN). NVSN conducts surveillance in Monroe County (NY), Hamilton County (OH), and Davidson County (TN).

*** NVSN provides population-based estimates of laboratory-confirmed influenza hospitalization rates in children aged <5 years admitted to NVSN hospitals with fever or respiratory symptoms. Children are prospectively enrolled, and respiratory samples are collected and tested by viral culture and reverse transcriptase-polymerase chain reaction (PCR). The EIP conducts surveillance for laboratory-confirmed influenza-related hospitalizations in person aged <18 years. Hospital laboratory and admission databases and infection-control logs are reviewed to identify children with a positive influenza test result (i.e., culture, direct or indirect fluorescent antibody assays, PCR, or a rapid test) from testing conducted as a part of their routine care.

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

FIGURE 3. Percentage of deaths attributable to pneumonia and influenza (P&I) reported by 122 Cities Mortality Reporting System, by week and year — United States, 2001–2005



* The epidemic threshold is 1.645 standard deviations above the seasonal baseline percentage.
† The seasonal baseline is projected by using a robust regression procedure that applies a periodic regression model to the observed percentage of deaths from P&I during the preceding 5 years.

deaths from 12 states (California, Colorado, Georgia, Iowa, Maine, Massachusetts, Mississippi, New Jersey, New York, Ohio, Pennsylvania, and Vermont) had been reported to CDC; all deaths were reported during January–March.

Composition of the 2005–06 Influenza Vaccine

The Food and Drug Administration's Vaccines and Related Biological Products Advisory Committee has recommended that the 2005–06 trivalent influenza vaccine for the United States contain A/New Caledonia/20/99-like (H1N1), A/California/7/2004-like (H3N2), and B/Shanghai/361/2002-like viruses (*3*). This recommendation was based on antigenic analyses of recently isolated influenza viruses, epidemiologic data, and postvaccination serologic studies in humans. Because of the growth properties of A/New Caledonia/20/99 (H1N1) and B/Jangsu/10/2003 viruses, U.S. vaccine manufacturers will retain these antigenically equivalent strains for the inactivated vaccine. B/Jilin/20/2003 will be used for the live attenuated vaccine. At this time, the most likely candidate for the A/California/7/2004-like (H3N2) component will be A/New York/55/2004 (H3N2).

Reported by: *S Wang, MPH, L Brammer, MPH, A Postema, MPH, K Teates, MPH, E Murray, MSPH, K Fukuda, MD, A Klimov, PhD, T Wallis, MS, N Cox, PhD, WHO Collaborating Center for Surveillance, Epidemiology, and Control of Influenza, Div of Viral and Rickettsial Diseases; R Seither, MPH, M Iwane, PhD, Epidemiology and Surveillance Div; J Copeland, MS, National Immunization Program, CDC.*

Editorial Note: Influenza activity during the 2004–05 season has been moderate in the United States. Activity steadily increased during January, peaked in mid-February, and has declined nationwide. Numerous influenza outbreaks associated with both influenza A and influenza B viruses have been reported in long-term–care facilities and among school children. Influenza B viruses have made up an increasing proportion of influenza isolates as the season has progressed, which is not unusual.

Although influenza activity for the 2004–05 season in the United States is declining, influenza should continue to be considered as a cause of outbreaks of respiratory disease because viruses are still circulating and use of antiviral drugs and other infection-control measures can substantially reduce morbidity and mortality in such situations. Recommendations on the use of these drugs and measures are available at http://www.cdc.gov/flu/protect/antiviral/index.htm and http://www.cdc.gov/flu/professionals/infectioncontrol.

Based on pediatric hospitalization and mortality data collected since October 1, 2004, hospitalization rates and the number of influenza-associated pediatric deaths this season appear to be lower than the 2003–04 influenza season. However, as new data become available, cumulative rates reported for pediatric hospitalizations and the number of pediatric deaths might continue to increase. Because data collection is currently ongoing, any comparison of the data from this season with the previous is premature.

Influenza surveillance reports for the United States are published weekly during October–May and are available at http://www.cdc.gov/flu/weekly/fluactivity.htm or through the CDC voice (888-232-3228) and fax (888-232-3299, document number 361100) information systems.

Acknowledgments

The findings in this report are based, in part, on data contributed by participating state and territorial health departments and state public health laboratories, WHO collaborating laboratories, National Respiratory and Enteric Virus Surveillance System collaborating laboratories, the U.S. Influenza Sentinel Provider Surveillance System, the New Vaccine Surveillance Network, the Emerging Infections Program, and the 122 Cities Mortality Reporting System.

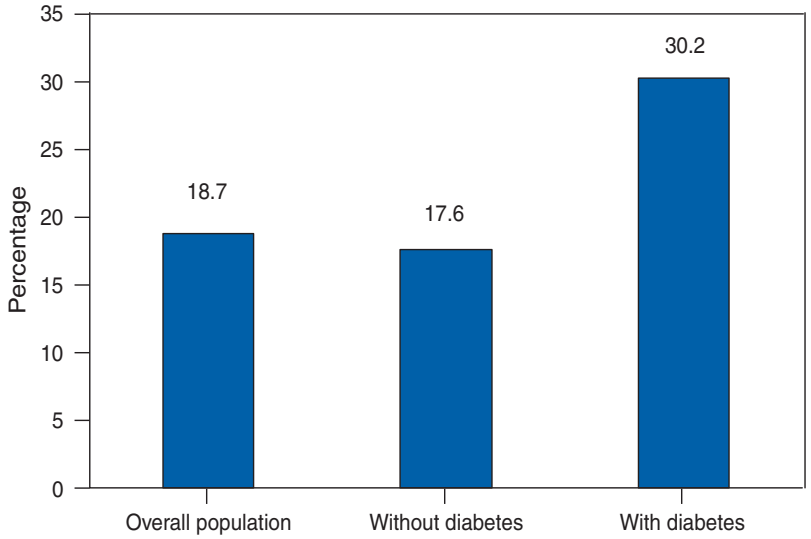
References

1. CDC. Update: influenza activity—United States, 2004–05 season. MMWR 2005;54:193–6.
2. Lin YP, Gregory V, Bennett M, Hay A. Recent changes among human influenza viruses. Virus Research 2004;103:47–52.
3. World Health Organization. Recommended composition of influenza virus vaccines for use in the 2005–2006 influenza season. Wkly Epidemiol Rec 2005;80:71–5.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Prevalence of Lower Extremity Disease (LED)* Among Adults Aged ≥40 Years With and Without Diabetes — United States, 1999–2000



*LED includes presence of either peripheral arterial disease (ankle-brachial blood pressure index <0.9), peripheral neuropathy (≥1 insensate area), foot ulcers, or lower-extremity amputation.

During 1999–2000, approximately 20% of U.S. adults aged ≥40 years had LED, with LED nearly twice as prevalent among those with diabetes compared with those without diabetes. Additional information is available at http://www.cdc.gov/nchs/nhanes.htm.

SOURCE: Gregg EW, Sorlie P, Paulose-Ram R, et al. Prevalence of lower extremity disease in the U.S. adult population ≥40 years of age with and without diabetes: 1999–2000 National Health and Nutrition Examination Survey. Diabetes Care 2004;27:1591–7.

Diabetes-Related Preventive-Care Practices — Guam, 2001–2003

Persons with diabetes are at risk for serious complications, such as blindness, kidney failure, nontraumatic lower-extremity amputations, and cardiovascular disease (*1*). Preventive-care practices have been determined effective in reducing both the incidence and progression of diabetes-specific complications (*2,3*). Despite the benefits of these practices, their level of use has been lower than recommended in the United States (*4*). To emphasize the importance of preventive-care practices, national health objectives for 2010 for persons with diabetes, include the following targets: have an annual dilated eye examination (75%; objective 5-13), have an annual foot examination (75%; objective 5-14), perform self-monitoring of blood glucose (SMBG) at least once daily (60%; objective 5-17), and have a glycated hemoglobin (HbA1c) measurement at least twice per year (65%; objective 5-12 [revised]) (*5*). In the U.S. territory of Guam (2004 population: 166,090), no previous population-based assessment of the use of diabetes-related preventive-care practices has been conducted. For this report, data from the 2001–2003 Guam Behavioral Risk Factor Surveillance System (BRFSS) were analyzed to determine the prevalence of preventive-care practices among persons with diabetes in Guam, which is the southernmost and largest of the Marianas Islands, located approximately 3,300 miles west of Hawaii and 1,550 miles south of Japan. Results of the analysis indicated that Guam residents with diabetes remain below the national targets for 2010 for four preventive-care practices, most notably SMBG. The preventive care programs and surveillance activities of the Guam Diabetes Prevention and Control Program (DPCP) should be continued, with emphasis on SMBG recommendations, to prevent poor health outcomes in persons with diabetes and achieve the national health objectives.

The Guam BRFSS is an ongoing, random-digit–dialed telephone survey of noninstitutionalized civilian adults aged ≥18 years. CASRO response rates were 54.4% in 2001, 52.7% in 2002, and 36.2% in 2003. The total number of respondents for the 3 years combined was 2,484 (861 in 2001, 825 in 2002, and 798 in 2003). Participants were those who answered "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who were told they had diabetes only during pregnancy were classified as not having diabetes. A total of 209 persons (67 from 2001, 63 from 2002, and 79 from 2003) were included in the analysis; they were asked the following four questions: "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?" (Persons who indicated having bilateral amputations were not asked this question.) "About how often do you check your blood for glucose or sugar?" "About how many times in the last year has a doctor, nurse, or other health professional checked you for glycated hemoglobin or hemoglobin 'A one C'?" Data were weighted to reflect the age, sex, and racial distribution of the adult, noninstitutionalized population of Guam; all estimates were age-adjusted to the 2000 U.S. adult population. Statistical analysis software was used to calculate estimates and 95% confidence intervals (CIs); t-tests were used to determine significant differences between groups.

The estimated prevalence of diabetes during 2001–2003 among adults in Guam was 11%. A total of 65.6% (95% CI = 57.8%–73.4%) reported having annual eye examinations, 70.4% (CI = 62.6%–78.2%) reported having annual foot examinations, 32.2% (CI = 24.6%–39.8%) reported performing daily SMBG, and 56.7% (CI = 47.3%–66.1%) reported having their HbA1c measured at least twice annually (Table). Men were significantly ($p<0.05$) less likely than women to report daily SMBG (21.4% [CI = 11.2%–31.6%] versus 50.3% [CI = 38.5%–62.1%]); persons aged 18–44 years were significantly less likely than persons aged ≥65 years to report having their HbA1c measured at least twice annually (42.5% [CI = 24.3%–60.7%] versus 71.1% [CI = 53.7%– 68.5%]) (Table). The percentages of Guam residents with diabetes were below all four U.S. national targets for 2010 for diabetes-related preventive care (Figure). For comparison, the Guam percentages for eye and foot examinations were higher than U.S. national estimates for 2003 (65.6% versus 61.3% and 70.4% versus 67.4%, respectively). However, the Guam percentages trailed U.S. estimates substantially in HbA1c measurements and SMBG (56.7% versus 65.9% and 32.2% versus 58.3%, respectively) (*6*).

Reported by: *G Suguitan, MPA, Guam Dept of Health. KY McDuffie, PhD, Div of Public Health Partnerships, National Center for Health Marketing; R Valdez, PhD, G Beckles, MD, D Glover, MSW, S Benjamin, PhD, Div of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

Editorial Note: The findings in this report represent the first population-based assessment of preventive-care practices among persons with diabetes in Guam; the results might be compared with those of future analyses to track progress toward the targets established in the U.S. national health objectives for 2010. During 2001–2003, for all four diabetes-related preventive-care practices analyzed, the percentages of Guam residents reporting adherence to the recommended practices were below the national targets for 2010.

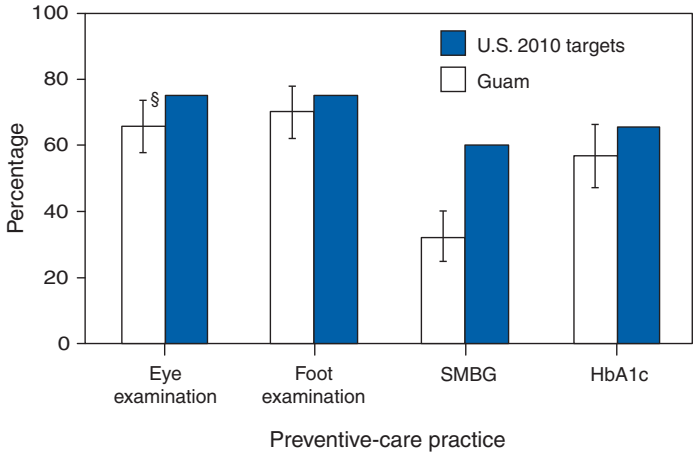
For HbA1c measurements and eye and foot examinations, the percentages of Guam residents with diabetes were substantially closer to the national targets than the percentage of persons who reported performing SMBG at least once a day.

TABLE. Estimated percentage of residents with diabetes who used four preventive-care practices, by selected characteristics* — Behavioral Risk Factor Surveillance System (BRFSS), Guam, 2001–2003†

Characteristic	Dilated eye examination at least once a year		Foot examination by a health professional at least once a year		Self-monitoring of blood glucose at least once a day		Glycated hemoglobin (HbA1C) test at least twice a year	
	%	(95% CI§)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Age group (yrs)								
18–44	52.1	(33.5–70.7)	74.0	(58.6–89.4)	34.2	(18.6–49.8)	42.5	(24.3–60.7)¶
45–54	66.1	(52.9–79.3)	70.8	(57.4–84.2)	34.1	(19.9–48.3)	63.0	(47.0–79.0)
55–64	72.8	(58.2–87.4)	59.4	(42.4–76.4)	23.9	(9.9–37.9)	50.0	(30.2–69.8)
≥65	69.8	(54.0–85.6)	78.1	(63.3–92.9)	36.6	(19.4–53.8)	71.1	(53.7–88.5)¶
Sex**								
Men	67.6	(53.0–82.2)	70.3	(56.5–84.1)	21.4	(11.2–31.6)¶	46.8	(32.8–60.8)
Women	49.5	(37.3–61.7)	74.2	(62.8–85.6)	50.3	(38.5–62.1)¶	57.5	(43.3–71.7)
Race/Ethnicity††								
Pacific Islander/Hawaiian	61.4	(50.0–72.8)	69.9	(58.9–80.9)	40.4	(28.4–52.4)	55.3	(41.5–69.1)
Other	59.2	(42.4–76.0)	73.5	(58.1–88.9)	32.4	(22.2–42.6)	44.9	(31.1–58.7)
Education level††								
Less than high school	65.2	(45.8–84.6)	74.9	(55.9–93.9)	29.1	(13.1–45.1)	42.9	(23.7–62.1)
High school	49.4	(35.8–63.0)	72.4	(61.2–83.6)	39.2	(28.2–50.2)	46.0	(32.4–59.6)
More than high school	61.6	(44.4–78.8)	75.2	(62.2–88.2)	21.8	(11.4–32.2)	46.6	(31.4–61.8)
Health insurance††								
Yes	57.8	(47.7–68.5)	73.1	(64.1–82.1)	34.4	(25.6–43.2)	50.4	(38.8–62.0)
No	62.4	(49.8–75.0)	69.0	(54.2–83.8)	38.2	(24.2–52.2)	58.2	(49.4–67.0)
Total	**65.6**	**(57.8–73.4)**	**70.4**	**(62.6–78.2)**	**32.2**	**(24.6–39.8)**	**56.7**	**(47.3–66.1)**

* Estimates are age-adjusted to the 2000 U.S. adult population based on 3-year BRFSS averages.
† Unweighted sample size = 209; weighted sample size = 9,271.
§ Confidence interval.
¶ Significant difference between groups ($p<0.05$).
** Standardized by age.
†† Standardized by age and sex.

FIGURE. Estimated percentage of residents* with diabetes who participated in four preventive-care practices†, compared with target levels from the U.S. national health objectives for 2010 — Behavioral Risk Factor Surveillance System (BRFSS), Guam, 2001–2003



* Estimates are age-adjusted to the 2000 U.S. adult population based on 3-year BRFSS averages.
† Foot examination: professional foot examination at least once a year; eye examination: dilated pupil eye examination at least once a year; SMBG: self-monitoring of blood glucose at least once a day; HbA1c: glycated hemoglobin test at least twice a year.
§ 95% confidence interval.

Success with SMBG requires incorporation of the practice into a person's daily routine, which might be more challenging than scheduling and following through with annual and semiannual appointments with health-care providers. Therefore, the Guam DPCP might need to focus its efforts more closely on self-management of diabetes, including daily SMBG.

The findings in this report are subject to at least four limitations. First, because persons residing in long-term–care facilities and in households with no telephone or only a cellular telephone are not included in BRFSS surveys, results cannot be generalized to these segments of the population. Second, because data are self-reported, they are subject to recall bias and might be under- or overreported. However, previous studies indicated that self-reports of diabetes and dilated eye examinations were accurate (*7,8*), self-reports of SMBG were determined to be reliable in a study of persons with type 1 diabetes (*9*), and self-reports of HbA1c measurements had high sensitivity and low specificity in another study (*10*). Further investigation is needed into the reliability and validity of self-reports of foot examinations among persons with diabetes and SMBG among persons with type 2 diabetes. Third, the small sample size resulted in the ability to detect only two

statistically significant differences in preventive-care practices among persons grouped by selected characteristics. When more data become available, a similar analysis should be conducted to compare findings with the results in this report. Finally, the response rate (36.2%) to the Guam BRFSS survey was substantially lower in 2003 than in 2001 and 2002. This resulted from miscoding of thousands of telephone numbers as busy instead of as nonworking, increasing the denominator of the response rate. The problem, which did not affect the quality of the data, has since been corrected.

CDC has taken an active role in improving the quality of care among persons with diabetes through its state- and territorial-based DPCPs. These programs provide leadership for a coordinated, multifaceted approach to increasing awareness about diabetes, educating persons about diabetes, improving the quality of diabetes care, promoting early detection of diabetic complications, and monitoring trends in the quality of care received by persons with diabetes. Guam DPCP works with local public health programs such as the Maternal/Child Health Program and the Special Supplemental Nutrition Program for Women, Infants, and Children, home health-care organizations, the Diabetes Network, civic groups, and local health-care providers to improve preventive health care by 1) developing low-literacy educational brochures and posters in English, Tagalog, and Chamorro; 2) hosting island-wide diabetes conferences; and 3) sponsoring training for health-care providers.

In addition, CDC and the National Institutes of Health jointly sponsor the National Diabetes Education Program (NDEP), which develops educational tools and community-based interventions and establishes public- and private-sector partnerships to address the needs of persons with diabetes and raise general awareness about the disease. NDEP (http://www.ndep.nih.gov) also seeks to improve diabetes prevention, treatment, and outcomes and to promote early detection. Guam DPCP has teamed with NDEP to conduct several nutrition and cooking education classes for persons with diabetes and their families. Finally, Guam DPCP, in coordination with the Bureau of Primary Care Services, actively participates in the Diabetes Health Disparities Collaborative (http://www.healthdisparities.net/hdc/html/collaboratives.topics.diabetes.aspx), which aims to achieve optimal results with diabetes-related preventive-care practices, including HbA1c testing, diabetes education, foot examination, dilated eye examination, cholesterol screening, influenza and pneumoccoccal vaccines, and urine protein tests.

References

1. Harris MI. Diabetes in America: epidemiology and scope of the problem. Diabetes Care 1998;21(Suppl 3):11C–14C.
2. Allen BT, DeLong ER, Feussner JR. Impact of glucose self-monitoring on non-insulin treated patients with type II diabetes mellitus. Diabetes Care 1990;13:1044–50.
3. The Diabetes Control and Complications Trial Research Group. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. N Engl J Med 1993;329:977–86.
4. 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.
5. US Department of Health and Human Services. Healthy People 2010 (conference ed., 2 vols.). Washington, DC: US Department of Health and Human Services; 2000.
6. CDC. National Diabetes Surveillance System: preventive-care practices. Atlanta, GA: US Department of Health and Human Services, CDC; 2004. Available at http://www.cdc.gov/diabetes/statistics/preventive/tx.htm and http://www.cdc.gov/diabetes/statistics/preventive/ty.htm.
7. Bowlin SJ, Morrill BD, Nafziger AN, Lewis C, Pearson TA. Reliability and changes in validity of self-reported cardiovascular disease risk factors using dual response: the Behavioral Risk Factor survey. J Clin Epidemiol 1996;49:511–7.
8. Will JC, German RR, Schuman E, Michael S, Kurth DM, Deeb L. Patient adherence to guidelines for diabetic eye care: results from the Diabetic Eye Disease Follow-up Study. Am J Public Health 1994;4:1669–71.
9. Gonder-Fredrick LA, Julian DN, Cox DJ, Clarke WL, Carter WL. Self-measurement of blood glucose: accuracy of self-reported data and adherence to recommended regimen. Diabetes Care 1988;11:579–85.
10. Fowles JB, Rosheim K, Fowler EJ, Craft C, Arrichiello L. The validity of self-reported diabetes quality of care measures. Int J Qual Health Care 1999;11:407–12.

Notice to Readers

50th Anniversary of the First Effective Polio Vaccine — April 12, 2005

April 12, 2005, marks the 50th anniversary of the announcement that the polio vaccine, developed by Jonas Salk and his team of scientists at the University of Pittsburgh, worked. "Safe, effective, and potent" were the words used to announce to the world that an effective vaccine had been found against a disease that once paralyzed 13,000–20,000 persons each year in the United States.

In 1979, fewer than 25 years after introduction of the vaccine, the last indigenously acquired case of polio caused by wild poliovirus was detected in the United States; 15 years later, in 1994, the Western Hemisphere was certified polio-free.

Through support by the National Foundation for Infantile Paralysis (known today as the March of Dimes), Thomas Francis Jr. of the University of Michigan led the pioneering field studies of inactivated polio vaccine that led to the April 12, 1955, announcement. Approximately 1.8 million children from 217 areas of the United States, Canada, and Finland participated in the vaccine field studies. Thousands of health-care workers and lay persons volunteered to assist with the field studies, the largest ever in U.S. history. The National

Foundation for Infantile Paralysis also supported the development work of Albert Sabin, whose oral polio vaccine (OPV) was licensed in 1961.

The Global Polio Eradication Initiative, spearheaded by the World Health Organization, Rotary International, UNICEF, and CDC, was begun in 1988. That year, an estimated 350,000 children were stricken with polio worldwide; in 2004, polio cases had decreased to approximately 1,200 cases globally. Although the Americas are polio-free, the disease still exists in some countries in Asia and Africa. Using the Sabin OPV, the Initiative continues to conduct immunization campaigns in those countries that have not been declared polio-free.

In recognition of the anniversary of the first effective polio vaccine, the Smithsonian's National Museum of American History will open a year-long exhibition, "Whatever Happened to Polio?" The exhibition will tell the story of the polio epidemic in the United States, the vaccine development, and current world efforts to stop transmission. Also highlighted will be stories of polio survivors and the influences they have had on society in the United States. Information about the exhibit is available at http://www.americanhistory.si.edu. Information about polio disease, vaccine, and eradication efforts is available at http://www.cdc.gov/nip.

Notice to Readers

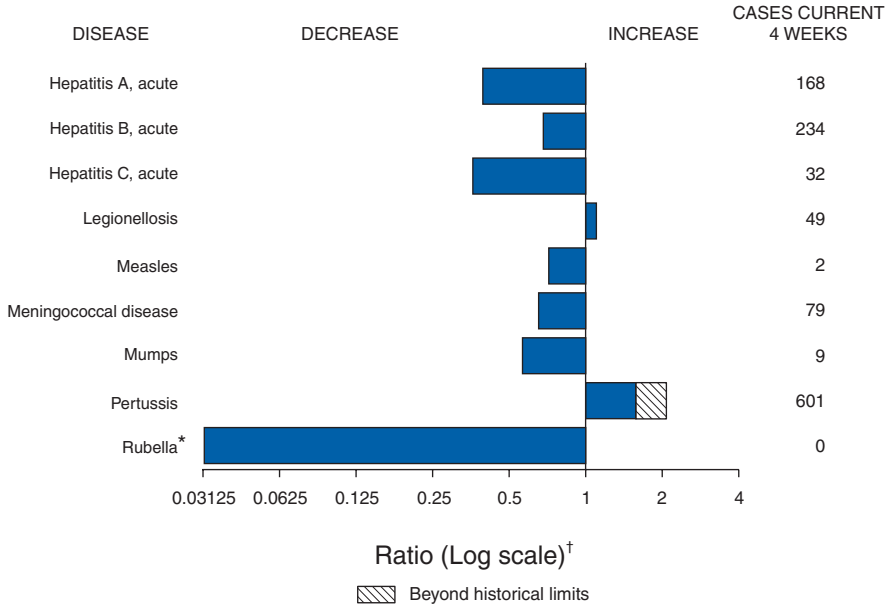
International Course in Applied Epidemiology

CDC and Emory University's Rollins School of Public Health will cosponsor a course, "International Course in Applied Epidemiology" during September 26–October 21, 2005, in Atlanta, Georgia. This course is directed at public health professionals from countries other than the United States and will include presentations and discussions of epidemiologic principles, basic statistical analysis, public health surveillance, field investigations, surveys and sampling, and discussions of the epidemiologic aspects of current major public health problems in global health. Included are small group discussions of epidemiologic case exercises based on field investigations. Participants are encouraged to give a short presentation reviewing epidemiologic data from their own country.

Computer training using Epi Info (Windows® version), a software program developed at CDC and the World Health Organization for epidemiologists, is included. Prerequisites include familiarity with the vocabulary and principles of basic epidemiology or completion of CDC's "Principles of Epidemiology" home-study course or equivalent. Preference will be given to applicants whose work involves priority public health problems in international health. Early registration deadline is June 1; late registration deadline is September 1. There is a tuition charge.

Additional information and applications are available from Emory University's Rollins School of Public Health, International Health Dept. (Attn: Pia), 1518 Clifton Road, N.E., Room 746, Atlanta, GA 30322; fax, 404-727-4590; at http://www.sph.emory.edu/epicourses; or by email, pvaleri@sph.emory.edu.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals April 2, 2005, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 13 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 April 2, 2005 (13th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	23	13
Botulism:			HIV infection, pediatric†¶	74	72
foodborne	4	2	Influenza-associated pediatric mortality†**	26	—
infant	10	22	Measles	7††	12§§
other (wound & unspecified)	4	1	Mumps	61	49
Brucellosis	20	25	Plague	—	—
Chancroid	7	8	Poliomyelitis, paralytic	—	—
Cholera	—	2	Psittacosis†	2	2
Cyclosporiasis†	6	79	Q fever†	12	11
Diphtheria	—	—	Rabies, human	1	—
Domestic arboviral diseases			Rubella	4	7
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	1	—
California serogroup†§	—	1	SARS†**	—	—
eastern equine†§	—	—	Smallpox†	—	—
Powassan†§	—	—	*Staphylococcus aureus*:		
St. Louis†§	—	—	Vancomycin-intermediate (VISA)†	—	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	—	—
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome†	28	45
human granulocytic (HGE)†	16	15	Tetanus	2	2
human monocytic (HME)†	19	15	Toxic-shock syndrome	26	33
human, other and unspecified †	5	1	Trichinellosis¶¶	6	—
Hansen disease†	9	21	Tularemia†	3	4
Hantavirus pulmonary syndrome†	3	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 February 27, 2005.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of seven cases reported, five were indigenous and two were imported from another country.
§§ Of 12 cases reported, six were indigenous and six were imported from another country.
¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending April 2, 2005, and April 3, 2004 (13th Week)*

Reporting area	AIDS		Chlamydia†		Coccidioidomycosis		Cryptosporidiosis	
	Cum. 2005§	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	5,673	8,770	199,277	225,389	987	1,371	377	647
NEW ENGLAND	171	311	6,355	7,550	—	—	24	35
Maine	3	5	564	476	N	N	1	5
N.H.	2	10	470	432	—	—	4	9
Vt.¶	—	8	251	293	—	—	8	5
Mass.	61	84	3,635	3,398	—	—	7	10
R.I.	14	33	830	889	—	—	1	1
Conn.	91	171	605	2,062	N	N	3	5
MID. ATLANTIC	1,105	1,292	23,884	28,289	—	—	58	114
Upstate N.Y.	103	132	4,900	5,197	N	N	17	21
N.Y. City	637	381	7,201	9,208	—	—	13	35
N.J.	196	386	2,564	4,649	N	N	3	8
Pa.	169	393	9,219	9,235	N	N	25	50
E.N. CENTRAL	534	805	26,232	40,886	1	4	53	159
Ohio	83	227	3,450	10,155	N	N	26	40
Ind.	84	116	4,661	4,646	N	N	6	21
Ill.	273	282	8,721	11,952	—	—	—	23
Mich.	72	131	5,355	9,575	1	4	9	32
Wis.	22	49	4,045	4,558	N	N	12	43
W.N. CENTRAL	117	222	12,318	13,973	—	3	52	64
Minn.	52	45	2,155	2,880	N	N	14	27
Iowa	18	9	2,165	1,734	N	N	11	9
Mo.	20	104	5,258	5,220	—	2	19	14
N. Dak.	—	11	254	439	N	N	—	—
S. Dak.	3	—	702	606	—	—	2	5
Nebr.¶	—	8	404	1,266	—	1	—	—
Kans.	24	45	1,380	1,828	N	N	6	9
S. ATLANTIC	2,033	3,419	40,332	43,045	—	—	89	129
Del.	16	41	777	754	N	N	—	—
Md.	205	340	4,395	5,019	—	—	5	7
D.C.	80	148	942	912	—	—	1	2
Va.¶	104	135	5,775	5,673	—	—	11	13
W. Va.	16	29	614	714	N	N	4	2
N.C.	219	236	8,718	7,233	N	N	12	25
S.C.¶	60	203	5,545	4,362	—	—	2	4
Ga.	364	508	2,899	8,174	—	—	26	43
Fla.	969	1,779	10,667	10,204	N	N	28	33
E.S. CENTRAL	397	442	14,682	13,239	—	3	8	31
Ky.	48	41	2,963	1,494	N	N	1	6
Tenn.¶	157	187	5,168	5,602	N	N	2	12
Ala.¶	121	124	881	3,335	—	—	4	9
Miss.	71	90	5,670	2,808	—	3	1	4
W.S. CENTRAL	672	1,292	27,470	28,767	—	2	12	24
Ark.	41	44	2,146	1,983	—	1	—	7
La.	60	279	4,407	6,353	—	1	2	—
Okla.	71	36	2,361	2,498	N	N	6	7
Tex.¶	500	933	18,556	17,933	N	N	4	10
MOUNTAIN	246	254	12,916	12,181	635	890	23	27
Mont.	3	—	521	250	N	N	—	2
Idaho¶	3	2	391	793	N	N	1	1
Wyo.	—	3	279	263	—	—	2	2
Colo.	14	47	2,959	3,081	N	N	7	15
N. Mex.	35	20	748	1,507	2	7	1	1
Ariz.	113	104	5,480	4,345	609	863	3	5
Utah	12	19	977	665	2	4	4	—
Nev.¶	66	59	1,561	1,277	22	16	5	1
PACIFIC	398	733	35,088	37,459	351	469	58	64
Wash.	58	127	4,986	4,215	N	N	5	—
Oreg.¶	32	50	2,262	1,961	—	—	6	7
Calif.	297	518	25,816	28,839	351	469	47	56
Alaska	6	7	939	938	—	—	—	—
Hawaii	5	31	1,085	1,506	—	—	—	1
Guam	1	—	—	231	—	—	—	—
P.R.	1	142	1,025	511	N	N	N	N
V.I.	4	2	32	112	—	—	—	—
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 February 27, 2005.

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 2, 2005, and April 3, 2004 (13th 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	230	221	30	43	39	30	3,312	3,920	66,332	79,607
NEW ENGLAND	16	10	7	12	6	2	253	343	1,188	1,740
Maine	—	—	1	—	—	—	32	28	40	73
N.H.	—	2	1	—	—	—	11	11	33	28
Vt.	1	—	—	—	—	—	33	19	8	18
Mass.	5	2	1	4	6	2	139	181	739	744
R.I.	1	1	—	—	—	—	17	23	137	234
Conn.	9	5	4	8	—	—	21	81	231	643
MID. ATLANTIC	28	20	2	3	2	9	609	863	6,882	9,117
Upstate N.Y.	13	6	2	1	—	3	204	219	1,557	1,762
N.Y. City	1	5	—	—	—	—	152	302	1,763	2,883
N.J.	7	1	—	1	1	4	74	109	896	1,701
Pa.	7	8	—	1	1	2	179	233	2,666	2,771
E.N. CENTRAL	54	52	3	9	3	4	432	605	9,895	16,786
Ohio	23	12	1	—	2	4	133	187	1,717	5,259
Ind.	8	13	—	—	—	—	N	N	1,807	1,646
Ill.	6	10	1	—	—	—	76	202	3,550	4,950
Mich.	8	8	—	1	1	—	139	136	1,739	3,802
Wis.	9	9	1	8	—	—	84	80	1,082	1,129
W.N. CENTRAL	29	38	4	7	5	6	422	408	3,901	4,540
Minn.	3	19	1	3	2	—	194	131	626	1,090
Iowa	6	4	—	—	—	—	56	51	446	307
Mo.	11	3	2	4	1	1	89	129	2,184	2,134
N. Dak.	—	2	—	—	—	3	1	6	15	44
S. Dak.	2	—	—	—	—	—	19	14	82	63
Nebr.	4	4	1	—	1	—	28	39	106	274
Kans.	3	6	—	—	1	2	35	38	442	628
S. ATLANTIC	41	18	6	5	17	6	605	612	17,482	19,322
Del.	—	—	N	N	N	N	8	13	191	262
Md.	4	3	2	—	—	2	40	25	1,732	2,141
D.C.	—	—	—	—	—	—	12	21	523	595
Va.	1	—	2	4	2	—	119	81	2,187	2,345
W. Va.	—	1	—	—	—	—	7	9	189	203
N.C.	—	—	—	—	9	3	N	N	4,444	3,951
S.C.	—	1	—	—	—	—	25	17	2,387	2,115
Ga.	6	5	1	—	—	—	193	175	1,249	3,510
Fla.	30	8	1	1	6	1	201	271	4,580	4,200
E.S. CENTRAL	9	10	—	—	4	2	86	75	5,083	6,003
Ky.	—	4	—	—	3	2	N	N	906	639
Tenn.	6	2	—	—	1	—	37	31	1,852	2,075
Ala.	3	1	—	—	—	—	49	44	631	1,854
Miss.	—	3	—	—	—	—	—	—	1,694	1,435
W.S. CENTRAL	5	17	1	2	1	1	58	69	10,805	10,809
Ark.	1	1	—	1	—	—	19	33	1,100	920
La.	—	1	1	—	1	—	8	11	2,376	2,998
Okla.	1	3	—	—	—	—	31	25	1,091	1,086
Tex.	3	12	—	1	—	1	N	N	6,238	5,805
MOUNTAIN	22	24	7	4	1	—	274	303	2,835	2,816
Mont.	1	2	—	—	—	—	9	6	30	10
Idaho	3	5	4	1	—	—	25	46	19	16
Wyo.	—	—	1	—	—	—	3	1	15	13
Colo.	3	4	1	1	—	—	93	92	687	737
N. Mex.	—	5	1	1	—	—	9	18	141	181
Ariz.	5	2	N	N	N	N	50	62	1,156	1,257
Utah	3	3	—	—	—	—	68	57	172	72
Nev.	7	3	—	1	1	—	17	21	615	530
PACIFIC	26	32	—	1	—	—	573	642	8,261	8,474
Wash.	5	4	—	—	—	—	37	47	869	691
Oreg.	1	6	—	1	—	—	50	115	404	245
Calif.	14	18	—	—	—	—	453	451	6,658	6,990
Alaska	2	1	—	—	—	—	13	11	119	170
Hawaii	4	3	—	—	—	—	20	18	211	378
Guam	N	N	—	—	—	—	—	—	—	50
P.R.	—	—	—	—	—	—	8	6	108	49
V.I.	—	—	—	—	—	—	—	—	2	37
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 April 2, 2005, and April 3, 2004 (13th 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	567	569	1	4	32	26	54	58
NEW ENGLAND	42	55	—	1	3	4	2	—
Maine	2	5	—	—	—	—	—	—
N.H.	—	9	—	—	—	1	—	—
Vt.	6	4	—	—	—	—	2	—
Mass.	16	26	—	1	—	2	—	—
R.I.	4	1	—	—	2	—	—	—
Conn.	14	10	—	—	1	1	—	—
MID. ATLANTIC	107	115	—	—	—	1	13	14
Upstate N.Y.	31	36	—	—	—	1	2	2
N.Y. City	18	21	—	—	—	—	3	4
N.J.	21	24	—	—	—	—	4	2
Pa.	37	34	—	—	—	—	4	6
E.N. CENTRAL	75	104	—	—	1	6	2	15
Ohio	41	35	—	—	—	2	2	4
Ind.	18	13	—	—	1	3	—	1
Ill.	3	26	—	—	—	—	—	6
Mich.	8	9	—	—	—	1	—	3
Wis.	5	21	—	—	—	—	—	1
W.N. CENTRAL	31	24	—	1	2	1	5	3
Minn.	13	9	—	—	2	1	—	—
Iowa	—	1	—	1	—	—	—	—
Mo.	13	10	—	—	—	—	2	3
N. Dak.	1	—	—	—	—	—	1	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	2	4	—	—	—	—	1	—
Kans.	2	—	—	—	—	—	1	—
S. ATLANTIC	156	130	—	—	6	2	11	10
Del.	—	—	—	—	—	—	—	—
Md.	23	29	—	—	2	1	1	—
D.C.	—	—	—	—	—	—	—	—
Va.	13	10	—	—	—	—	—	—
W. Va.	11	6	—	—	1	1	3	2
N.C.	24	12	—	—	2	—	—	—
S.C.	5	2	—	—	—	—	1	—
Ga.	46	38	—	—	—	—	4	8
Fla.	34	33	—	—	1	—	2	—
E.S. CENTRAL	27	20	—	—	—	—	6	5
Ky.	—	—	—	—	—	—	—	—
Tenn.	22	12	—	—	—	—	4	4
Ala.	5	8	—	—	—	—	2	1
Miss.	—	—	—	—	—	—	—	—
W.S. CENTRAL	30	23	1	—	2	3	5	—
Ark.	—	—	—	—	—	—	—	—
La.	11	8	1	—	—	—	5	—
Okla.	19	15	—	—	2	3	—	—
Tex.	—	—	—	—	—	—	—	—
MOUNTAIN	75	72	—	2	12	8	8	9
Mont.	—	—	—	—	—	—	—	—
Idaho	2	2	—	—	—	—	1	1
Wyo.	1	—	—	—	—	—	—	—
Colo.	15	15	—	—	—	—	2	2
N. Mex.	7	19	—	—	3	3	—	4
Ariz.	35	31	—	—	7	5	1	1
Utah	5	3	—	2	—	—	2	—
Nev.	10	2	—	—	2	—	2	1
PACIFIC	24	26	—	—	6	1	2	2
Wash.	—	1	—	—	—	—	—	1
Oreg.	12	14	—	—	—	—	2	—
Calif.	9	7	—	—	6	1	—	1
Alaska	1	1	—	—	—	—	—	—
Hawaii	2	3	—	—	—	—	—	—
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 April 2, 2005, and April 3, 2004 (13th Week)*

Reporting area	Hepatitis (viral, acute), by type					
	A		B		C	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	892	1,538	1,353	1,468	140	195
NEW ENGLAND	137	234	76	99	3	3
Maine	—	7	2	1	—	—
N.H.	13	6	3	12	—	—
Vt.	—	5	1	1	3	1
Mass.	103	187	61	48	—	2
R.I.	5	5	—	—	—	—
Conn.	16	24	9	37	—	—
MID. ATLANTIC	140	191	341	212	26	33
Upstate N.Y.	26	20	29	13	5	1
N.Y. City	61	70	15	50	—	—
N.J.	22	40	238	61	—	—
Pa.	31	61	59	88	21	32
E.N. CENTRAL	83	145	82	115	30	14
Ohio	22	15	39	44	—	2
Ind.	13	21	5	3	4	—
Ill.	14	54	2	—	—	3
Mich.	28	38	36	55	26	9
Wis.	6	17	—	13	—	—
W.N. CENTRAL	32	25	58	89	11	1
Minn.	3	1	—	8	—	1
Iowa	6	5	5	3	—	—
Mo.	17	7	39	66	11	—
N. Dak.	—	—	—	1	—	—
S. Dak.	—	2	—	—	—	—
Nebr.	2	7	8	7	—	—
Kans.	4	3	6	4	—	—
S. ATLANTIC	157	269	415	449	39	50
Del.	2	3	4	9	—	2
Md.	13	48	47	42	10	3
D.C.	1	3	—	5	—	1
Va.	24	18	48	42	6	9
W. Va.	—	1	7	1	2	2
N.C.	24	16	42	44	7	3
S.C.	4	7	30	21	—	4
Ga.	36	109	95	143	—	6
Fla.	53	64	142	142	14	20
E.S. CENTRAL	30	48	73	121	13	23
Ky.	3	4	21	12	—	8
Tenn.	20	27	32	49	5	5
Ala.	4	5	16	18	4	1
Miss.	3	12	4	42	4	9
W.S. CENTRAL	26	209	54	64	2	52
Ark.	1	32	11	31	—	—
La.	13	6	8	21	2	31
Okla.	1	11	4	11	—	—
Tex.	11	160	31	1	—	21
MOUNTAIN	100	121	117	99	6	5
Mont.	6	1	—	—	—	1
Idaho	8	4	3	3	—	—
Wyo.	—	—	—	1	—	—
Colo.	9	11	7	13	—	—
N. Mex.	5	5	4	4	—	1
Ariz.	59	80	81	53	—	2
Utah	9	19	15	13	4	—
Nev.	4	1	7	12	2	1
PACIFIC	187	296	137	220	10	14
Wash.	15	12	12	21	2	1
Oreg.	10	24	25	39	3	5
Calif.	154	253	98	156	5	6
Alaska	3	1	1	2	—	—
Hawaii	5	6	1	2	—	2
Guam	—	1	—	1	—	—
P.R.	1	8	2	9	—	—
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 April 2, 2005, and April 3, 2004 (13th 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	253	286	108	102	1,167	1,829	237	271
NEW ENGLAND	8	6	2	5	29	160	4	23
Maine	—	—	—	1	2	17	—	—
N.H.	2	—	1	1	13	8	2	—
Vt.	—	—	—	—	1	7	—	1
Mass.	4	3	—	1	7	97	2	15
R.I.	—	1	—	—	1	13	—	2
Conn.	2	2	1	2	5	18	—	5
MID. ATLANTIC	76	55	22	26	869	1,399	59	59
Upstate N.Y.	19	11	6	6	132	441	13	9
N.Y. City	4	3	4	3	—	—	25	27
N.J.	16	7	5	9	363	283	14	11
Pa.	37	34	7	8	374	675	7	12
E.N. CENTRAL	50	79	16	13	31	42	16	19
Ohio	27	32	6	5	19	8	3	3
Ind.	8	13	—	2	2	—	3	3
Ill.	—	14	—	—	—	—	3	4
Mich.	12	18	5	4	2	—	6	4
Wis.	3	2	5	2	8	34	1	5
W.N. CENTRAL	10	5	8	3	33	17	9	17
Minn.	1	—	2	2	30	6	1	6
Iowa	—	—	3	—	2	4	2	1
Mo.	7	4	2	1	1	7	5	4
N. Dak.	1	—	1	—	—	—	—	1
S. Dak.	—	1	—	—	—	—	—	1
Nebr.	—	—	—	—	—	—	—	1
Kans.	1	—	—	—	—	—	1	3
S. ATLANTIC	59	64	26	16	181	168	60	79
Del.	—	1	N	N	25	21	—	1
Md.	15	10	3	3	104	89	17	22
D.C.	1	2	—	—	1	4	1	4
Va.	4	4	2	—	14	5	7	4
W. Va.	3	2	—	1	1	1	1	—
N.C.	7	7	6	4	14	30	8	4
S.C.	—	1	—	—	5	1	1	4
Ga.	6	4	4	3	—	5	12	12
Fla.	23	33	11	5	17	12	13	28
E.S. CENTRAL	3	13	4	5	4	6	8	8
Ky.	1	3	—	1	—	1	2	1
Tenn.	—	5	2	4	4	1	5	1
Ala.	2	5	2	—	—	—	1	5
Miss.	—	—	—	—	—	4	—	1
W.S. CENTRAL	4	28	2	12	6	15	19	24
Ark.	1	—	—	1	—	—	1	1
La.	3	2	1	1	—	—	—	2
Okla.	—	2	—	—	—	—	2	1
Tex.	—	24	1	10	6	15	16	20
MOUNTAIN	23	20	—	2	—	4	13	11
Mont.	1	—	—	—	—	—	—	—
Idaho	1	1	—	1	—	1	—	—
Wyo.	2	4	—	—	—	1	1	—
Colo.	5	3	—	1	—	—	7	5
N. Mex.	1	—	—	—	—	—	—	1
Ariz.	5	5	—	—	—	1	2	1
Utah	3	6	—	—	—	1	3	2
Nev.	5	1	—	—	—	—	—	2
PACIFIC	20	16	28	20	14	18	49	31
Wash.	1	2	2	5	—	1	2	1
Oreg.	N	N	2	4	1	8	1	3
Calif.	19	14	24	11	12	9	42	27
Alaska	—	—	—	—	1	—	2	—
Hawaii	—	—	—	—	N	N	2	—
Guam	—	—	—	—	—	—	—	—
P.R.	—	1	—	—	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 April 2, 2005, and April 3, 2004 (13th Week)*

Reporting area	Meningococcal disease									
	All serogroups		Serogroup A, C, Y, and W-135		Serogroup B		Other serogroup		Serogroup unknown	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	344	455	25	30	21	14	—	—	298	411
NEW ENGLAND	26	24	1	3	—	—	—	—	25	21
Maine	1	7	—	—	—	—	—	—	1	7
N.H.	2	2	—	—	—	—	—	—	2	2
Vt.	3	1	—	—	—	—	—	—	3	1
Mass.	11	14	—	3	—	—	—	—	11	11
R.I.	2	—	—	—	—	—	—	—	2	—
Conn.	7	—	1	—	—	—	—	—	6	—
MID. ATLANTIC	44	64	11	17	2	5	—	—	31	42
Upstate N.Y.	11	21	1	3	1	3	—	—	9	15
N.Y. City	5	14	—	—	—	—	—	—	5	14
N.J.	14	7	—	—	—	—	—	—	14	7
Pa.	14	22	10	14	1	2	—	—	3	6
E.N. CENTRAL	29	45	8	8	4	3	—	—	17	34
Ohio	11	23	—	3	3	3	—	—	8	17
Ind.	5	9	—	—	1	—	—	—	4	9
Ill.	—	1	—	—	—	—	—	—	—	1
Mich.	8	5	8	5	—	—	—	—	—	—
Wis.	5	7	—	—	—	—	—	—	5	7
W.N. CENTRAL	25	21	1	—	1	1	—	—	23	20
Minn.	5	7	1	—	—	—	—	—	4	7
Iowa	9	4	—	—	1	1	—	—	8	3
Mo.	6	6	—	—	—	—	—	—	6	6
N. Dak.	—	—	—	—	—	—	—	—	—	—
S. Dak.	1	1	—	—	—	—	—	—	1	1
Nebr.	1	1	—	—	—	—	—	—	1	1
Kans.	3	2	—	—	—	—	—	—	3	2
S. ATLANTIC	61	83	2	1	4	1	—	—	55	81
Del.	—	1	—	—	—	—	—	—	—	1
Md.	7	5	1	—	2	—	—	—	4	5
D.C.	—	4	—	1	—	—	—	—	—	3
Va.	5	2	—	—	—	—	—	—	5	2
W. Va.	1	3	—	—	—	—	—	—	1	3
N.C.	6	10	1	—	2	1	—	—	3	9
S.C.	9	6	—	—	—	—	—	—	9	6
Ga.	7	5	—	—	—	—	—	—	7	5
Fla.	26	47	—	—	—	—	—	—	26	47
E.S. CENTRAL	19	23	—	—	1	—	—	—	18	23
Ky.	7	3	—	—	1	—	—	—	6	3
Tenn.	8	8	—	—	—	—	—	—	8	8
Ala.	—	6	—	—	—	—	—	—	—	6
Miss.	4	6	—	—	—	—	—	—	4	6
W.S. CENTRAL	28	49	1	1	3	—	—	—	24	48
Ark.	6	8	—	—	—	—	—	—	6	8
La.	10	15	—	1	2	—	—	—	8	14
Okla.	4	1	1	—	1	—	—	—	2	1
Tex.	8	25	—	—	—	—	—	—	8	25
MOUNTAIN	23	25	—	—	3	3	—	—	20	22
Mont.	—	1	—	—	—	—	—	—	—	1
Idaho	1	2	—	—	—	—	—	—	1	2
Wyo.	—	2	—	—	—	—	—	—	—	2
Colo.	7	9	—	—	—	—	—	—	7	9
N. Mex.	—	4	—	—	—	2	—	—	—	2
Ariz.	11	4	—	—	2	—	—	—	9	4
Utah	2	1	—	—	1	—	—	—	1	1
Nev.	2	2	—	—	—	1	—	—	2	1
PACIFIC	89	121	1	—	3	1	—	—	85	120
Wash.	16	6	1	—	3	1	—	—	12	5
Oreg.	19	29	—	—	—	—	—	—	19	29
Calif.	47	80	—	—	—	—	—	—	47	80
Alaska	2	2	—	—	—	—	—	—	2	2
Hawaii	5	4	—	—	—	—	—	—	5	4
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	—	2	—	—	—	—	—	—	—	2
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 April 2, 2005, and April 3, 2004 (13th 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	3,709	2,176	1,023	1,395	147	121	5,283	6,174	2,122	2,798
NEW ENGLAND	172	383	164	102	1	4	317	284	48	58
Maine	7	—	11	11	N	N	15	12	—	1
N.H.	—	10	2	6	—	—	18	17	4	3
Vt.	41	19	12	5	—	—	23	12	3	1
Mass.	119	335	116	38	—	4	178	174	28	39
R.I.	5	7	2	4	1	—	11	12	1	1
Conn.	—	12	21	38	—	—	72	57	12	13
MID. ATLANTIC	426	566	124	149	9	11	616	814	233	310
Upstate N.Y.	151	394	74	64	—	—	164	164	72	123
N.Y. City	5	46	7	1	1	3	172	266	85	93
N.J.	61	33	N	N	2	—	85	148	63	59
Pa.	209	93	43	84	6	8	195	236	13	35
E.N. CENTRAL	1,036	333	9	3	2	—	493	1,008	120	256
Ohio	515	111	4	2	1	—	167	226	14	45
Ind.	83	11	1	1	—	—	66	81	18	43
Ill.	61	11	2	—	—	—	18	344	4	111
Mich.	42	28	2	—	1	—	126	166	69	31
Wis.	335	172	—	—	—	—	116	191	15	26
W.N. CENTRAL	430	105	56	107	7	3	385	368	158	83
Minn.	92	14	12	11	—	—	93	87	10	12
Iowa	66	25	15	11	—	—	73	71	32	24
Mo.	114	52	7	3	7	3	112	105	84	23
N. Dak.	14	3	1	11	—	—	6	8	2	1
S. Dak.	1	1	5	19	—	—	28	17	6	1
Nebr.	60	—	—	29	—	—	34	33	19	3
Kans.	83	10	16	23	—	—	39	47	5	19
S. ATLANTIC	268	123	350	652	107	83	1,617	1,347	386	774
Del.	1	—	—	9	—	2	1	9	—	2
Md.	44	31	72	77	6	2	124	102	19	27
D.C.	—	4	—	—	—	—	10	9	3	14
Va.	56	29	116	101	—	—	168	142	22	28
W. Va.	15	2	5	16	1	—	18	29	—	—
N.C.	21	26	107	148	80	66	309	192	44	111
S.C.	81	13	5	20	5	4	108	78	26	105
Ga.	10	5	44	74	9	7	271	211	116	149
Fla.	40	13	1	207	6	2	608	575	156	338
E.S. CENTRAL	102	26	18	60	2	14	273	342	227	149
Ky.	24	3	—	5	—	—	35	57	19	23
Tenn.	45	15	—	36	1	3	102	104	121	55
Ala.	24	4	18	15	1	2	104	116	71	51
Miss.	9	4	—	4	—	9	32	65	16	20
W.S. CENTRAL	66	57	233	275	1	3	341	556	432	629
Ark.	15	8	10	13	—	—	57	54	14	13
La.	1	2	—	—	1	3	75	67	27	62
Okla.	—	6	26	24	—	—	52	51	119	91
Tex.	50	41	197	238	—	—	157	384	272	463
MOUNTAIN	868	249	47	20	16	—	367	458	137	197
Mont.	215	4	—	3	—	—	18	23	1	3
Idaho	36	13	—	—	—	—	15	38	—	1
Wyo.	7	2	6	—	1	—	8	10	—	1
Colo.	386	125	—	—	—	—	95	106	22	31
N. Mex.	33	40	—	—	—	—	21	47	15	39
Ariz.	78	46	41	17	13	—	139	159	65	96
Utah	101	19	—	—	2	—	36	51	11	11
Nev.	12	—	—	—	—	—	35	24	23	15
PACIFIC	341	334	22	27	2	3	874	997	381	342
Wash.	87	75	—	—	—	—	73	52	11	14
Oreg.	169	78	—	—	—	2	45	77	16	18
Calif.	50	171	21	25	2	1	691	772	344	294
Alaska	12	6	1	2	—	—	12	23	3	3
Hawaii	23	4	—	—	—	—	53	73	7	13
Guam	—	—	—	—	—	—	—	8	—	14
P.R.	—	1	19	15	N	N	26	42	—	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 April 2, 2005, and April 3, 2004 (13th Week)*

Reporting area	Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive disease				Syphilis			
			Drug resistant, all ages		Age <5 years		Primary & secondary		Congenital	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,268	1,504	789	781	203	226	1,524	1,826	59	105
NEW ENGLAND	44	74	3	8	17	30	48	40	—	—
Maine	2	2	N	N	—	—	1	—	—	—
N.H.	3	8	—	—	1	N	3	1	—	—
Vt.	6	2	3	3	1	1	—	—	—	—
Mass.	30	60	—	3	15	27	42	25	—	—
R.I.	3	2	—	2	—	2	1	1	—	—
Conn.	—	—	—	—	U	U	1	13	—	—
MID. ATLANTIC	262	240	78	50	39	30	186	240	13	19
Upstate N.Y.	104	73	32	18	23	18	14	13	9	1
N.Y. City	28	48	U	U	U	U	124	148	3	7
N.J.	53	49	N	N	5	4	28	45	1	10
Pa.	77	70	46	32	11	8	20	34	—	1
E.N. CENTRAL	184	316	177	181	47	59	124	197	3	20
Ohio	61	80	123	143	26	29	53	55	1	1
Ind.	34	27	54	38	8	11	10	10	—	1
Ill.	2	90	—	—	9	—	41	81	1	4
Mich.	80	95	—	N	—	N	16	43	—	14
Wis.	7	24	N	N	4	19	4	8	1	—
W.N. CENTRAL	76	116	13	5	23	19	39	41	—	—
Minn.	26	57	—	—	12	9	2	6	—	—
Iowa	N	N	N	N	—	N	1	2	—	—
Mo.	26	21	12	4	1	5	33	23	—	—
N. Dak.	1	3	—	—	1	—	—	—	—	—
S. Dak.	5	7	1	1	—	—	—	—	—	—
Nebr.	8	7	—	—	2	3	1	5	—	—
Kans.	10	21	N	N	7	2	2	5	—	—
S. ATLANTIC	257	271	363	398	32	15	415	463	11	16
Del.	—	1	—	2	—	N	2	2	—	—
Md.	86	52	—	—	25	11	86	70	5	3
D.C.	2	2	9	4	2	4	32	21	—	1
Va.	12	15	N	N	—	N	20	11	3	1
W. Va.	2	9	21	41	5	—	2	3	—	—
N.C.	25	34	N	N	U	U	58	38	1	1
S.C.	7	19	—	34	—	N	16	34	—	3
Ga.	52	74	148	112	—	N	24	82	—	1
Fla.	71	65	185	205	—	N	175	202	2	6
E.S. CENTRAL	51	71	48	54	1	—	92	95	10	4
Ky.	12	26	7	12	N	N	6	14	—	—
Tenn.	39	45	41	42	—	N	35	39	8	1
Ala.	—	—	—	—	—	N	43	30	2	2
Miss.	—	—	—	—	1	—	8	12	—	1
W.S. CENTRAL	65	114	49	25	26	53	282	280	14	25
Ark.	6	3	6	3	2	4	12	14	—	3
La.	4	1	43	22	7	15	37	59	1	—
Okla.	46	19	N	N	11	15	11	7	1	2
Tex.	9	91	N	N	6	19	222	200	12	20
MOUNTAIN	228	165	33	12	18	20	81	89	8	3
Mont.	—	—	—	—	—	—	5	—	—	—
Idaho	1	3	N	N	—	N	6	8	—	—
Wyo.	1	4	11	4	—	—	—	1	—	—
Colo.	103	27	N	N	17	18	8	14	—	—
N. Mex.	14	36	—	5	—	—	7	24	1	1
Ariz.	85	84	N	N	—	N	35	38	7	2
Utah	24	11	21	1	1	2	1	2	—	—
Nev.	—	—	1	2	—	—	19	2	—	—
PACIFIC	101	137	25	48	—	—	257	381	—	18
Wash.	N	N	N	N	N	N	41	21	—	—
Oreg.	N	N	N	N	—	N	7	11	—	—
Calif.	75	108	N	N	—	N	206	345	—	18
Alaska	—	—	—	—	—	N	1	—	—	—
Hawaii	26	29	25	48	—	—	2	4	—	—
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	N	N	N	N	—	N	35	32	3	2
V.I.	—	—	—	—	—	—	—	4	—	—
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 April 2, 2005, and April 3, 2004 (13th Week)*

Reporting area	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease†		
							Neuroinvasive		Non-neuroinvasive§
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	1,770	2,606	40	61	5,940	5,522	—	—	—
NEW ENGLAND	61	72	1	7	97	230	—	—	—
Maine	—	—	—	—	80	43	—	—	—
N.H.	3	1	—	—	—	—	—	—	—
Vt.	—	—	—	—	16	187	—	—	—
Mass.	44	39	—	6	1	—	—	—	—
R.I.	2	13	—	1	—	—	—	—	—
Conn.	12	19	1	—	—	—	—	—	—
MID. ATLANTIC	439	416	13	16	1,207	15	—	—	—
Upstate N.Y.	43	48	2	—	—	—	—	—	—
N.Y. City	238	214	1	7	—	—	—	—	—
N.J.	96	94	3	6	—	—	—	—	—
Pa.	62	60	7	3	1,207	15	—	—	—
E.N. CENTRAL	282	228	1	3	2,068	2,188	—	—	—
Ohio	56	43	—	1	432	596	—	—	—
Ind.	28	36	1	—	N	N	—	—	—
Ill.	140	101	—	—	4	—	—	—	—
Mich.	41	29	—	2	1,472	1,391	—	—	—
Wis.	17	19	—	—	160	201	—	—	—
W.N. CENTRAL	97	73	1	2	40	91	—	—	—
Minn.	40	28	1	1	—	—	—	—	—
Iowa	7	9	—	—	N	N	—	—	—
Mo.	31	23	—	1	2	2	—	—	—
N. Dak.	1	2	—	—	9	65	—	—	—
S. Dak.	4	2	—	—	29	24	—	—	—
Nebr.	3	2	—	—	—	—	—	—	—
Kans.	11	7	—	—	—	—	—	—	N
S. ATLANTIC	335	539	7	8	536	599	—	—	—
Del.	—	5	—	—	1	2	—	—	—
Md.	52	46	1	2	—	—	—	—	—
D.C.	21	6	—	—	5	8	—	—	—
Va.	46	31	—	2	37	143	—	—	—
W. Va.	7	6	—	—	407	367	—	—	N
N.C.	37	43	1	2	—	N	—	—	—
S.C.	38	30	—	—	86	79	—	—	—
Ga.	9	173	2	—	—	—	—	—	—
Fla.	125	199	3	2	—	—	—	—	—
E.S. CENTRAL	103	120	1	—	—	—	—	—	—
Ky.	25	13	1	—	N	N	—	—	—
Tenn.	58	41	—	—	—	—	—	—	—
Ala.	20	35	—	—	—	—	—	—	—
Miss.	—	31	—	—	—	—	—	—	—
W.S. CENTRAL	49	467	3	7	1,020	1,622	—	—	—
Ark.	19	30	—	—	—	—	—	—	—
La.	—	—	—	—	53	33	—	—	—
Okla.	30	36	—	—	—	—	—	—	—
Tex.	—	401	3	7	967	1,589	—	—	—
MOUNTAIN	40	103	2	2	972	777	—	—	—
Mont.	—	—	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—	—
Wyo.	—	—	—	—	38	14	—	—	—
Colo.	8	21	—	—	668	564	—	—	—
N. Mex.	1	7	—	—	48	25	—	—	—
Ariz.	28	45	1	1	—	—	—	—	—
Utah	3	14	1	1	218	174	—	—	—
Nev.	—	16	—	—	—	—	—	—	—
PACIFIC	364	588	11	16	—	—	—	—	—
Wash.	51	46	—	1	N	N	—	—	—
Oreg.	21	17	1	1	—	—	—	—	—
Calif.	254	489	6	9	—	—	—	—	—
Alaska	9	8	—	—	—	—	—	—	—
Hawaii	29	28	4	5	—	—	—	—	—
Guam	—	13	—	—	—	18	—	—	—
P.R.	—	12	—	—	52	91	—	—	—
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 April 2, 2005 (13th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
NEW ENGLAND	594	432	117	31	7	7	73
Boston, Mass.	135	82	33	10	5	5	20
Bridgeport, Conn.	45	37	7	1	—	—	6
Cambridge, Mass.	18	12	6	—	—	—	1
Fall River, Mass.	37	28	9	—	—	—	7
Hartford, Conn.	72	52	14	4	2	—	12
Lowell, Mass.	24	19	4	1	—	—	2
Lynn, Mass.	16	9	5	2	—	—	1
New Bedford, Mass.	25	21	2	2	—	—	1
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	70	54	14	1	—	1	7
Somerville, Mass.	6	4	1	1	—	—	—
Springfield, Mass.	48	39	8	1	—	—	5
Waterbury, Conn.	32	27	2	3	—	—	2
Worcester, Mass.	66	48	12	5	—	1	9
MID. ATLANTIC	2,141	1,487	460	113	44	37	142
Albany, N.Y.	42	29	7	2	2	2	2
Allentown, Pa.	19	14	4	1	—	—	1
Buffalo, N.Y.	86	64	11	7	3	1	5
Camden, N.J.	31	18	9	3	—	1	2
Elizabeth, N.J.	20	11	8	1	—	—	2
Erie, Pa.	58	52	5	1	—	—	4
Jersey City, N.J.	55	35	11	4	2	3	—
New York City, N.Y.	1,059	744	229	48	18	20	58
Newark, N.J.	52	27	16	9	—	—	9
Paterson, N.J.	17	8	6	2	1	—	—
Philadelphia, Pa.	326	212	72	26	12	4	25
Pittsburgh, Pa.§	26	17	7	2	—	—	3
Reading, Pa.	31	24	5	1	—	1	2
Rochester, N.Y.	133	91	35	1	4	2	13
Schenectady, N.Y.	25	19	5	—	—	1	4
Scranton, Pa.	26	23	3	—	—	—	3
Syracuse, N.Y.	77	56	16	4	1	—	4
Trenton, N.J.	31	19	8	1	1	2	2
Utica, N.Y.	12	10	2	—	—	—	—
Yonkers, N.Y.	15	14	1	—	—	—	3
E.N. CENTRAL	2,459	1,701	514	152	32	59	220
Akron, Ohio	50	39	8	1	1	1	8
Canton, Ohio	65	52	11	1	—	1	4
Chicago, Ill.	346	213	86	30	6	10	25
Cincinnati, Ohio	86	64	12	5	1	4	10
Cleveland, Ohio	345	260	63	16	2	4	19
Columbus, Ohio	222	162	42	13	—	5	38
Dayton, Ohio	139	101	28	7	3	—	9
Detroit, Mich.	217	115	75	16	4	7	17
Evansville, Ind.	63	42	19	2	—	—	4
Fort Wayne, Ind.	75	53	15	4	1	2	9
Gary, Ind.	14	10	2	1	—	1	1
Grand Rapids, Mich.	61	42	9	5	2	3	3
Indianapolis, Ind.	231	151	48	13	7	12	11
Lansing, Mich.	59	35	18	5	1	—	8
Milwaukee, Wis.	136	91	28	12	2	3	16
Peoria, Ill.	63	42	15	5	—	1	4
Rockford, Ill.	61	44	9	8	—	—	8
South Bend, Ind.	61	55	3	1	—	2	11
Toledo, Ohio	92	63	19	6	1	3	8
Youngstown, Ohio	73	67	4	1	1	—	7
W.N. CENTRAL	651	469	125	31	10	16	77
Des Moines, Iowa	105	80	20	4	1	—	16
Duluth, Minn.	35	28	6	1	—	—	3
Kansas City, Kans.	31	17	8	2	3	1	3
Kansas City, Mo.	103	72	23	5	—	3	15
Lincoln, Nebr.	49	41	5	1	—	2	8
Minneapolis, Minn.	59	38	10	5	1	5	11
Omaha, Nebr.	69	50	11	4	1	3	5
St. Louis, Mo.	47	28	12	5	2	—	2
St. Paul, Minn.	37	32	4	—	—	1	5
Wichita, Kans.	116	83	26	4	2	1	9
S. ATLANTIC	1,169	784	251	80	23	31	101
Atlanta, Ga.	164	94	42	16	5	7	10
Baltimore, Md.	128	80	34	9	1	4	15
Charlotte, N.C.	116	88	17	7	2	2	18
Jacksonville, Fla.	189	116	45	18	4	6	8
Miami, Fla.	93	61	21	8	—	3	7
Norfolk, Va.	45	35	4	4	1	1	3
Richmond, Va.	66	34	23	2	4	3	7
Savannah, Ga.	60	46	9	5	—	—	9
St. Petersburg, Fla.	47	37	8	—	1	1	6
Tampa, Fla.	142	110	21	5	3	3	12
Washington, D.C.	99	69	21	6	2	1	3
Wilmington, Del.	20	14	6	—	—	—	3
E.S. CENTRAL	1,016	670	244	68	21	12	92
Birmingham, Ala.	170	120	34	10	2	3	17
Chattanooga, Tenn.	108	77	24	6	1	—	8
Knoxville, Tenn.	115	91	18	4	—	2	11
Lexington, Ky.	116	82	27	4	—	3	14
Memphis, Tenn.	180	108	52	14	3	3	13
Mobile, Ala.	106	61	34	8	2	1	8
Montgomery, Ala.	57	31	19	5	2	—	5
Nashville, Tenn.	164	100	36	17	11	—	16
W.S. CENTRAL	2,544	1,800	469	159	62	54	200
Austin, Tex.	104	64	24	5	5	6	13
Baton Rouge, La.	25	17	7	—	—	1	1
Corpus Christi, Tex.	66	50	13	3	—	—	1
Dallas, Tex.	217	136	43	19	9	10	16
El Paso, Tex.	73	53	15	3	1	1	7
Ft. Worth, Tex.	113	84	21	4	1	3	9
Houston, Tex.	389	251	82	34	14	8	31
Little Rock, Ark.	57	41	9	3	2	2	—
New Orleans, La.	954	734	134	53	21	12	71
San Antonio, Tex.	274	179	59	22	7	7	26
Shreveport, La.	79	47	25	4	1	2	6
Tulsa, Okla.	193	144	37	9	1	2	19
MOUNTAIN	1,155	759	251	80	33	28	91
Albuquerque, N.M.	128	87	30	7	1	3	12
Boise, Idaho	49	39	8	1	1	—	5
Colo. Springs, Colo.	68	43	17	5	3	—	4
Denver, Colo.	109	69	21	9	3	7	13
Las Vegas, Nev.	275	176	71	13	11	4	21
Ogden, Utah	31	19	5	6	—	1	1
Phoenix, Ariz.	207	116	50	25	7	5	16
Pueblo, Colo.	30	21	7	2	—	—	6
Salt Lake City, Utah	97	72	11	6	4	4	4
Tucson, Ariz.	161	117	31	6	3	4	9
PACIFIC	1,769	1,248	349	100	36	36	176
Berkeley, Calif.	21	16	3	1	—	1	3
Fresno, Calif.	50	36	9	1	3	1	7
Glendale, Calif.	9	6	3	—	—	—	—
Honolulu, Hawaii	101	75	15	7	1	3	8
Long Beach, Calif.	102	68	25	7	—	2	10
Los Angeles, Calif.	241	165	49	11	7	9	27
Pasadena, Calif.	18	14	4	—	—	—	3
Portland, Oreg.	120	81	25	11	1	2	8
Sacramento, Calif.	221	155	43	10	10	3	13
San Diego, Calif.	126	80	31	10	1	4	8
San Francisco, Calif.	183	136	31	7	3	6	27
San Jose, Calif.	236	169	47	12	7	1	35
Santa Cruz, Calif.	20	12	5	3	—	—	1
Seattle, Wash.	125	98	21	5	—	1	11
Spokane, Wash.	76	57	13	4	1	1	9
Tacoma, Wash.	120	80	25	11	2	2	6
TOTAL	13,498¶	9,350	2,780	814	268	280	1,172

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: 2005-733-116/00083 Region IV ISSN: 0149-2195