MMWR™
Morbidity and Mortality Weekly Report
Weekly November 18, 2005 / Vol. 54 / No. 45

Trends in HIV/AIDS Diagnoses — 33 States, 2001–2004

In 2003, more than 1 million persons in the United States were estimated to be living with human immunodeficiency virus (HIV) infection (*1*). As a result of advances in treatment with highly active antiretroviral therapy (HAART) since 1996, persons infected with HIV are living longer than before and progression to acquired immunodeficiency syndrome (AIDS) has decreased. Consequently, AIDS surveillance no longer provides accurate population-based monitoring of the current HIV epidemic. Therefore, CDC recommends that all states and territories adopt confidential, name-based surveillance systems to report HIV infection (*2*). This report describes the characteristics of persons for whom HIV infection was diagnosed during 2001–2004 and reported to 33 state and local health departments with name-based HIV reporting. The findings indicate that the rate of HIV diagnosis in these states decreased among non-Hispanic blacks* from 2001 to 2004; however, the rate of HIV diagnosis among blacks remained disproportionately high. In 2004, the rate among blacks was 8.4 times higher than among whites. Improved knowledge of HIV status and access to care and prevention services is important to decrease the number of new HIV infections among those populations most affected.

Included in this analysis are HIV cases reported to CDC from 33 states† that have conducted name-based HIV/AIDS reporting for at least 4 years. The addition of New York, a state with high AIDS morbidity, has resulted in data for a greater percentage of U.S. cases of HIV infection. Cases of HIV/AIDS diagnosed during 2001–2004 and reported to CDC through June 2005 were analyzed. Cases included 1) diagnosis of HIV infection that had not progressed to AIDS, 2) diagnosis of HIV infection followed by a diagnosis of AIDS, and 3) concurrent diagnoses of AIDS and HIV infection (i.e., AIDS and HIV diagnoses in the same calendar month). Data from U.S. territories were not included.

Cases were classified in the following hierarchy of transmission categories: 1) male-to-male sexual contact, 2) injection-drug use, 3) both male-to-male sexual contact and injection-drug use, 4) high-risk heterosexual contact (i.e., with someone of the opposite sex known to have HIV/AIDS or a risk factor [e.g., male-to-male sexual contact or injection-drug use] for HIV/AIDS), and 5) all other HIV risk factors combined. The number of HIV/AIDS diagnoses, rates per 100,000 population, and associated 95% confidence intervals (CIs) were calculated. Data were adjusted for reporting delays and redistribution of risk among persons initially reported without sufficient information to classify into a transmission category (*3*). Estimated annual percentage changes and 95% CIs were calculated for the annual numbers of diagnoses and rates.

During 2001–2004, an estimated 157,252 persons had HIV/AIDS diagnosed in the 33 states reporting to CDC. Of these, 112,106 (71%) were male and 45,146 (29%) were female (Table 1). Blacks accounted for 80,187 (51%) of per-

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*For this report, persons identified as white, black, Asian, American Indian/Alaska Native, or of other/unknown race are all non-Hispanic. Persons identified as Hispanic might be of any race.

†Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

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].

sons with HIV/AIDS diagnosed (68% among females and 44% among males); 45,479 (29%) were white; 28,673 (18%) were Hispanic; 1,340 (1%) were Asian/Pacific Islander; and 766 (<1%) were American Indian/Alaska Native. The route of HIV infection for the majority (61%) of males was through male-to-male sexual contact; 17% occurred through high-risk heterosexual contact, and 16% occurred through injection-drug use. The majority (76%) of females with HIV/AIDS diagnosed were exposed through high-risk heterosexual contact; 21% were exposed through injection-drug use. The proportional distribution of HIV/AIDS diagnosed among males and females by transmission category varied by race/ethnicity (Table 2). Although the main transmission category for males was male-to-male sexual contact, among blacks, one fourth of HIV infections occurred through high-risk heterosexual contact.

The total number of HIV/AIDS diagnoses decreased from 41,207 (CI = 40,961–41,453) in 2001 to 38,685 (CI = 37,924–39,445) in 2004; the average annual decrease was not statistically significant. A nonsignificant average annual increase occurred in the number of HIV/AIDS diagnoses among men who have sex with men (MSM), from 16,609 (CI = 16,260–16,957) cases in 2001 to 18,196 (CI = 17,609–18,782) cases in 2004 (Figure 1). From 2003 to 2004, the number of HIV/AIDS diagnoses among MSM increased 8%; this increase was statistically significant ($p<0.05$). A significant average annual decrease of 9.1% occurred among injection-drug users (IDUs).

The overall annual rate of HIV/AIDS diagnoses per 100,000 population did not change significantly, from 22.8 per 100,000 in 2001 to 20.7 per 100,000 in 2004. However, a significant 5.0% average annual decrease in rates among blacks was observed, from 88.7 per 100,000 in 2001 to 76.3 per 100,000 in 2004. Among Asian/Pacific Islanders, a significant 9.0% average annual increase occurred, from 5.6 per 100,000 in 2001 to 7.2 per 100,000 in 2004 (Figure 2). The highest annual rates were among blacks, followed by Hispanics, American Indian/Alaska Natives, whites, and Asian/Pacific Islanders.

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Editorial Note: An important event in HIV/AIDS reporting is the inclusion of data from New York in the analysis of national HIV data in 2005. Although New York implemented name-based HIV/AIDS reporting in June 2000, this is the first time these data have been included in analyses of national surveillance data. As a result, an additional 36,111 HIV/AIDS diagnoses were added to the surveillance system during 2001–2004; this substantial addition should be considered when making comparisons with previous reports (*4*).

TABLE 1. Estimated* number and percentage of persons with HIV/AIDS diagnosed,† by sex and selected characteristics — 33 states,§ 2001–2004

Characteristic	Male		Female		Total	
	No.	(%)	No.	(%)	No.	(%)
Age group (yrs)						
<13	492	(<1)	531	(1)	**1,023**	**(1)**
13–24	11,104	(10)	6,720	(15)	**17,824**	**(11)**
25–34	29,520	(26)	12,713	(28)	**42,233**	**(27)**
35–44	41,280	(37)	14,430	(32)	**55,710**	**(35)**
45–54	21,291	(19)	7,789	(17)	**29,080**	**(18)**
55–64	6,488	(6)	2,240	(5)	**8,727**	**(6)**
≥65	1,931	(2)	724	(2)	**2,655**	**(2)**
Race/Ethnicity						
White, non-Hispanic	38,218	(34)	7,262	(16)	**45,479**	**(29)**
Black, non-Hispanic	49,704	(44)	30,483	(68)	**80,187**	**(51)**
Hispanic¶	22,062	(20)	6,610	(15)	**28,673**	**(18)**
Asian/Pacific Islander	1,036	(1)	304	(1)	**1,340**	**(1)**
American Indian/Alaska Native	543	(<1)	223	(<1)	**766**	**(<1)**
Unknown	543	(<1)	264	(1)	**807**	**(1)**
HIV transmission category						
Male-to-male sexual contact	68,434	(61)	—	—	**68,434**	**(44)**
Injection-drug use (IDU)	17,540	(16)	9,665	(21)	**27,206**	**(17)**
Male-to-male sexual contact/IDU	5,723	(5)	—	—	**5,723**	**(4)**
Heterosexual contact	19,209	(17)	34,204	(76)	**53,412**	**(34)**
Other**	1,199	(1)	1,278	(3)	**2,477**	**(2)**
Region of residence††						
Northeast (two states)	30,087	(27)	14,763	(33)	**44,851**	**(29)**
Midwest (11 states)	12,932	(12)	4,017	(9)	**16,949**	**(11)**
South (12 states)	62,128	(55)	25,080	(56)	**87,208**	**(55)**
West (eight states)	6,959	(6)	1,286	(3)	**8,245**	**(5)**
Year of diagnosis						
2001	28,759	(26)	12,447	(28)	**41,207**	**(26)**
2002	27,785	(25)	11,436	(25)	**39,222**	**(25)**
2003	27,352	(24)	10,787	(24)	**38,139**	**(24)**
2004	28,209	(25)	10,476	(23)	**38,685**	**(25)**
Total§§	**112,106**	**(71)**	**45,146**	**(29)**	**157,252**	**(100)**

* All estimates are adjusted for reporting delays and reclassification of cases reported without a known risk factor for human immunodeficiency virus (HIV).
† Data include persons with a diagnosis of HIV infection. This includes persons with 1) diagnosis of HIV infection only, 2) diagnosis of HIV infection and a later acquired immunodeficiency syndrome (AIDS) diagnosis, and 3) concurrent diagnoses of HIV infection and AIDS.
§ Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.
¶ Persons of Hispanic origin might be of any race.
** Includes mother-to-child exposure; receipt of transfusion of blood, blood components, or blood products; and risk factor not reported or not identified.
†† *Northeast*: New Jersey and New York. *Midwest*: Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin. *South*: Alabama, Arkansas, Florida, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia. *West*: Alaska, Arizona, Colorado, Idaho, Nevada, New Mexico, Utah, and Wyoming.
§§ Because column totals were calculated independently of the values for the subpopulations, the values in each column do not sum to the column total.

An evaluation of the impact of adding a state with high morbidity to national surveillance data is under way.

In April 2003, CDC launched the Advancing HIV Prevention (AHP) initiative to increase emphasis on HIV testing and providing prevention services for persons living with HIV (*5*). An estimated 25% of persons living with HIV do not know they are infected (*1*). AHP is aimed at getting persons with undiagnosed HIV tested and into care and prevention services. Because AHP emphasizes increased testing, an increase in HIV/AIDS diagnoses might be expected; however, a decrease in diagnoses among IDUs and blacks was observed. Subsequent analyses will examine whether these changes were a result of a differential change in testing patterns among various populations, decreased incidence of HIV infections, or the effect of additional data added to the national surveillance system. In addition, CDC is working with states to develop a new system for monitoring HIV incidence (i.e., new HIV infections) more directly through the use of a testing method that distinguishes recent from longstanding infections.

The decrease in rates of diagnoses among blacks during 2001–2004 was driven, in part, by decreases in New York, which might be attributed to the New York epidemic being older than the epidemic in some other areas of the United States, the volume of cases reported into the system, and recent changes in reporting requirements.§ Decreases in HIV diagnoses among IDUs were consistent with other reports of success in reducing HIV incidence among IDUs (*6*) and might account, in part, for decreases observed among blacks. However, rates among blacks have remained high and warrant increased prevention efforts, especially among black MSM and black women.

Although a statistically significant increase occurred from 2003 to 2004 in the number of diagnosed infections among MSM, the overall annual average percentage change from 2001 to 2004 was not significant. Flat trends in diagnoses were observed among white, black, and Hispanic MSM. The small upturn in diagnoses in 2003–2004 occurred for all racial/ethnic MSM populations. Increases in HIV diagnoses during this period are more difficult to interpret because of increasing emphasis on the benefits of increased

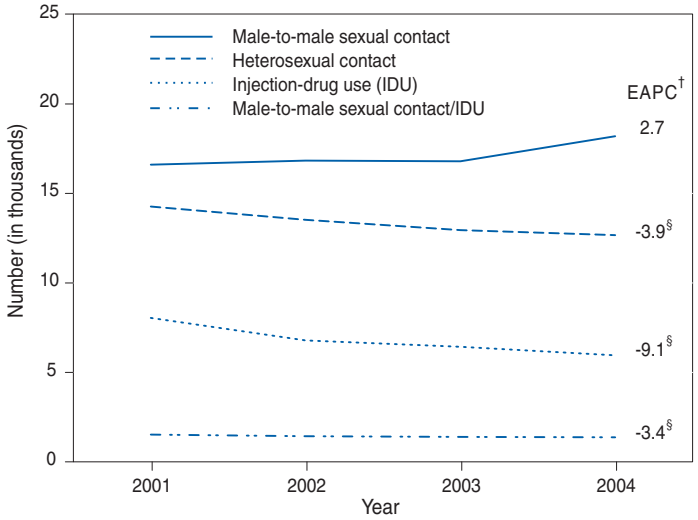
§ In addition to AIDS cases, in June 2000, New York began requiring that all confirmed HIV diagnostic tests, detectable HIV viral load tests, and CD4 counts of <500 μL be reported to the health department. Health-care providers are required to report all cases of HIV diagnosis, HIV illness, and AIDS. In June 2005, reporting requirements were changed to include all HIV viral load tests and all CD4 counts, regardless of value.

TABLE 2. Estimated* number and percentage of persons with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) diagnosed,† by race/ethnicity, sex, and HIV transmission category —33 states,§ 2001–2004

HIV transmission category	White, non-Hispanic		Black, non-Hispanic		Hispanic¶		Asian/Pacific Islander		American Indian/ Alaska Native	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Male										
Male-to-male sexual contact	29,506	(77)	24,597	(49)	13,028	(59)	669	(65)	336	(61)
Injection-drug use (IDU)	3,612	(10)	9,558	(19)	4,083	(19)	130	(13)	74	(14)
Male-to-male sexual contact/IDU	2,364	(6)	2,239	(5)	986	(4)	36	(3)	60	(11)
Heterosexual contact	2,443	(6)	12,650	(25)	3,745	(17)	188	(18)	67	(12)
Other**	292	(1)	660	(1)	220	(1)	12	(1)	6	(1)
Total††	**38,218**	**(100)**	**49,704**	**(100)**	**22,062**	**(100)**	**1,036**	**(100)**	**543**	**(100)**
Female										
IDU	2,166	(30)	5,790	(19)	1,551	(23)	50	(16)	64	(29)
Heterosexual contact	4,935	(68)	23,820	(78)	4,841	(73)	242	(79)	154	(69)
Other**	161	(2)	873	(3)	219	(3)	13	(4)	5	(2)
Total††	**7,262**	**(100)**	**30,483**	**(100)**	**6,610**	**(100)**	**304**	**(100)**	**223**	**(100)**

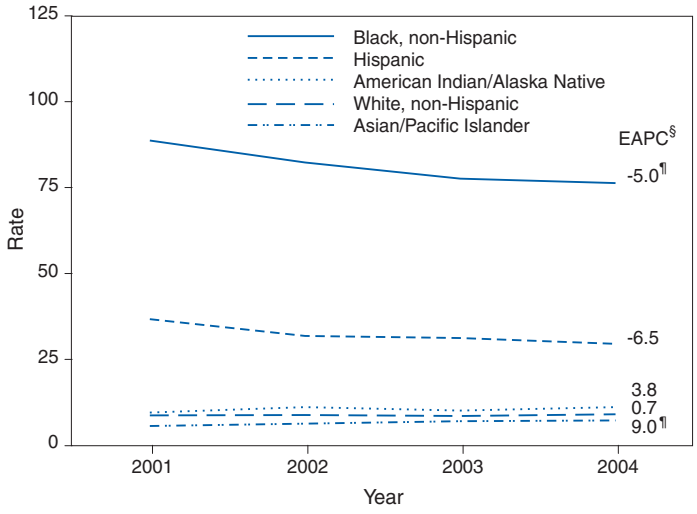
* All estimates are adjusted for reporting delays and reclassification of cases reported without a known risk factor for HIV.
† Data include persons with a diagnosis of HIV infection, including persons with 1) diagnosis of HIV infection only, 2) diagnosis of HIV infection and a later AIDS diagnosis, and 3) concurrent diagnoses of HIV infection and AIDS.
§ Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.
¶ Persons of Hispanic origin might be of any race.
** Includes mother-to-child exposure; receipt of transfusion of blood, blood components, or blood products; and risk factor not reported or not identified.
†† Because column totals were calculated independently of the values for the subpopulations, the values in each column do not sum to the column total.

FIGURE 1. Estimated number of human immunodeficiency virus/ acquired immunodeficiency syndrome (HIV/AIDS) diagnoses, by HIV transmission category and year of diagnosis — 33 states,* 2001–2004



* Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.
† Estimated annual percentage change.
§ Statistically significant (i.e., 95% confidence interval excludes zero).

FIGURE 2. Estimated rate* of human immunodeficiency virus/ acquired immunodeficiency syndrome (HIV/AIDS) diagnosis, by race/ethnicity and year of diagnosis — 33 states,† 2001–2004



* Per 100,000 population.
† Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.
§ Estimated annual percentage change.
¶ Statistically significant (i.e., 95% confidence interval excludes zero).

testing among persons at high risk. Whereas increases among MSM might reflect increases in HIV incidence, consistent with increases in syphilis and other risk behaviors, they might also reflect increases in HIV testing among MSM. Increasing HIV testing among MSM is critical in light of a study of MSM aged 15–29 years in six U.S. cities, which reported that the proportion of unrecognized HIV infection was as high as 77% (*7*). Although a significant increase occurred in HIV/AIDS diagnoses among Asian/Pacific Islanders from 2001 to 2004, this population continues to have the lowest HIV/AIDS rates of any racial/ethnic population in the United States.

The findings in this report are subject to at least two limitations. First, although AIDS is a reportable condition in all 50 states, name-based HIV data are not reportable in all states. The 33 states analyzed in this report are estimated to represent 63% of all AIDS cases in the United States during 2001–2004. Although the representativeness of the national data has improved, data from California are not included, which results in an under-representation of cases in the West. To describe the epidemic more completely, CDC is recommending that all states conduct name-based HIV reporting. As of October 2005, a total of 38 states[¶] conducted name-based HIV/AIDS reporting that met CDC standards (*2,8*), and additional states have initiated procedures to adopt name-based HIV-infection reporting beginning in 2006. Personal identifiers are removed before data are submitted to CDC. Second, classification of cases with no identified risk factor was based on follow-up investigations; those cases were assumed to constitute a representative sample of all cases initially reported without a risk factor.

In this analysis, the average annual diagnosis rate among blacks decreased; however, the rate in 2004 was 8.4 times higher among blacks than whites. Several factors contribute to higher risk for HIV infection among blacks, including higher prevalence of infection in the black community and, for females, greater likelihood of encountering high-risk heterosexual or bisexual male partners (*9*). The epidemic has continued to concentrate in groups that traditionally have had limited access to prevention services, medical care, and effective therapies. Prevention will require reassessment of ongoing activities to ensure resources target those at highest risk. Strengthening the partnership between government public health programs and affected communities and developing novel interventions that are culturally appropriate are essential to meet the needs of all groups affected by the epidemic.

[¶] Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

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Cruise-Ship–Associated Legionnaires Disease, November 2003–May 2004

More than 9.4 million passengers traveled on pleasure cruises departing from North American ports in 2004, an increase of 13% since 2003 and 41% since 2001 (*1*). Cruise ships typically transport closed populations of thousands of persons, often from diverse parts of the world. Travelers are at risk for becoming ill while on board, most commonly from person-to-person spread of viral gastrointestinal illnesses. Certain environmental organisms, such as *Legionella* spp., pose a risk to vulnerable passengers. During November 2003–May 2004, eight cases of Legionnaires disease (LD) among persons who had recently traveled on cruise ships were reported to CDC. This report describes these cases to raise clinician awareness of the potential for cruise-ship–associated LD and to emphasize the need for identification and reporting of cases to facilitate investigation.

LD is a severe community– or health-care–associated pneumonia caused by *Legionella* spp., most commonly *L. pneumophila*. LD can result from inhalation or aspiration of warm (25°C–42°C), aerosolized water containing *Legionella*. Symptoms typically begin 2–10 days after exposure. Person-to-person transmission does not occur. Because symptoms of LD (e.g., fever, cough, or chest pain) are nonspecific, LD cannot be reliably dis-

tinguished from other forms of pneumonia on the basis of clinical presentation alone.

In the United States, LD can be reported to CDC through two surveillance systems. The National Electronic Telecommunications System for Surveillance collects information on all reportable diseases from state and territorial health departments but does not collect information on travel history. In contrast, the paper-based Legionnaires Disease Reporting System collects details of any recent travel from LD patients but receives data on only a fraction of the total cases estimated to occur. The cases described in this report were initially relayed to CDC by direct communication from state health departments, cruise lines, and the European Working Group for Legionella Infections (EWGLI), which operates a surveillance scheme (EWGLINET) for LD among European travelers (http://www.ewgli.org). Cases were defined as laboratory-confirmed LD in a person with cruise-ship travel during the 10 days before symptom onset. Exposure history was collected by the state and local health departments, and environmental samples, when obtained, were tested by contractors hired by the cruise lines.

The eight cases were among passengers who had been aboard five different cruise ships and associated with seven different voyages (Table). Two of the eight cases occurred on the same voyage. The mean age of the patients was 55.8 years (range: 23–76 years). Five (63%) were male; seven (88%) were U.S. residents. The sole case in a foreign traveler occurred in a Dutch woman aged 23 years who had onset of fever and cough 4 days after returning from a cruise in the Caribbean. Two (25%) cases were fatal. Of the seven patients with known medical histories, six (86%) had comorbidities or risk behaviors known to be risk factors for LD (e.g., diabetes, history of heart disease, or smoking) (Table). The mean time from cruise-ship boarding to onset of symptoms was 10.4 days (range: 4–16 days). Although two passengers had symptoms before the end of their respective cruises, only one had LD diagnosed while still aboard the ship. Seven (88%) were diagnosed by urinary antigen testing for *Legionella pneumophila* serogroup 1 (Lp1). The only person with LD diagnosed by a fourfold increase in anti-*Legionella* spp. serology had a negative *Legionella* urinary antigen test. Only the Dutch traveler had a culture for *Legionella* obtained at the onset of illness. The culture was positive for Lp1; a urinary antigen test also was positive.

Two cases occurred on each of three cruise ships. Two patients were aboard the same ship during the same period but had been friends preceding the cruise and therefore had other exposures in common. A definite source of exposure could not be identified for any of the cases because of the limited number of cases. In addition, all but one patient lacked a clinical isolate, limiting the ability to link clinical and environmental isolates. For the Dutch passenger, the sole patient with a clinical isolate, environmental sampling was performed, but no matching environmental isolate was identified. Additional case-finding measures included review of infirmary records by cruise lines and CDC, passive surveillance by cruise lines, public health alerts via the Epidemic Information Exchange (*Epi-X*), and notifications to EWGLI in the event vacationing European travelers had become ill. Despite these activities, no other cases were identified.

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TABLE. Cases of travel-associated Legionnaires disease among cruise-ship travelers, November 2003–May 2004

Case no.	Age group (yrs)	Sex	Ship	Month of departure	Region traveled	Cruise duration (days)	Illness onset	Comorbid conditions	Method of diagnosis	Outcome
1	53	Female	A	November	Caribbean, Mexico	7	2 days after returning	Smoker	Urine antigen, serology	Recovered
2	45	Female	A	November	Caribbean, Mexico	7	4 days after returning	Diabetes	Serology	Died
3	23	Female	B	November	Caribbean, Mexico	7	4 days after returning	None	Urine antigen, culture	Recovered
4	76	Male	C	February	Caribbean, Central America	10	1 day after returning	COPD*	Urine antigen	Died
5	68	Male	D	March	Trans-Atlantic	9	Last day of cruise	Diabetes, recent pleural effusion	Urine antigen	Recovered
6	65	Male	E	April	Caribbean	11	5 days after returning	History of heart disese	Urine antigen	Recovered
7	51	Male	B	May	Caribbean, Mexico	7	Day 4 of cruise	History of lymphoma	Urine antigen	Recovered
8	65	Male	E	May	Trans-Atlantic, Mediterranean	14	Day 12 of cruise	Unknown	Urine antigen	Recovered

*Chronic obstructive pulmonary disease.

Editorial Note: During 1980–1998, CDC received an average of 360 paper-based reports of LD annually, primarily during summer months (*2*). However, previous research using population-based active surveillance estimated that 8,000–18,000 cases of *Legionella* spp. infection requiring hospitalization occur in the United States annually, suggesting that legionellosis is underdiagnosed and/or underreported (*3*). Since the first recognized outbreak of LD occurred in 1976 among persons attending the American Legion convention in Philadelphia, travel has been identified as a risk factor for both outbreak-associated (*4*) and sporadic infection (*5*). However, for multiple reasons, outbreaks of travel-associated legionellosis are difficult to detect and investigate (*6,7*). First, trends toward empirical use of antimicrobial agents have led to declines in diagnostic testing for etiologic agents of community-acquired pneumonia (*8*). Second, the incubation period of 2–10 days allows travelers to return home before they have symptoms, making it unlikely for a medical provider to see more than a single case. Third, because LD can be diagnosed within hours of specimen collection by urine antigen testing, diagnosis by culture, which requires several days, has declined substantially in recent years (*2*).

The lack of clinical isolates hinders epidemiologic investigations and prevention strategies. *Legionella* spp. can be identified by culture in up to 40% of freshwater environmental samples and in up to 80% of environmental samples by polymerase chain reaction (*9*). Although Lp1 causes approximately 70% of cases, at least 22 species of *Legionella* have been associated with disease in humans (*9*). To determine which of many potential environmental *Legionella* spp. is the causative organism, a clinical isolate from a respiratory culture must be matched to the environmental isolate by monoclonal antibody subtyping or by molecular methods. For these reasons, when evaluating a patient with suspected LD, clinicians should obtain a travel history and collect respiratory secretions for culture, in addition to collecting urine for antigen testing.

Reporting of LD is mandatory in every state. However, dispersion of travelers to multiple states after an exposure might result in a health department receiving only one report in association with a particular ship or hotel. Cruise-ship–associated travel poses additional difficulties for notification and investigation of LD cases. For cruise ships that sail in international waters, patients might be hospitalized in other countries, delaying or precluding reporting to authorities in the patients' home countries. Because travelers often stay in hotels before or after cruise-ship travel and often disembark at various international ports of call during a cruise, numerous potential sources exist for authorities to investigate. In certain instances, cruise-ship travel might be of insufficient duration (e.g., a single day or overnight trip) to be inclusive of the 2–10-day incubation period of LD. In addition, the limited number of reported cases associated with cruises limits the ability of traditional epidemiologic methods to identify a source. Thus, the task of identifying a source often relies on matching a clinical isolate to an environmental isolate. However, few cases have been reported for which an environmental isolate identified from a cruise ship (most often from a whirlpool spa) was identical to a clinical isolate from an ill passenger (*6,7*). Obtaining a clinical isolate from a patient with travel-associated LD is essential to identifying the source of infection.

Public health programs have focused on reducing the risk for LD among cruise-ship passengers. In 1994, CDC investigated an LD outbreak on board a cruise ship and subsequently issued recommendations to reduce transmission of *Legionella* spp. from shipboard whirlpool spas. (*10*). In addition, CDC's Vessel Sanitation Program regularly conducts inspections of these spas and other environmental sources. Given the difficulties in confirming cases of LD, cooperation of clinicians and local, national, and international public health agencies is essential to foster diagnosis and prevention. Because a single case of LD in a traveler might indicate an outbreak, prompt recognition and direct reporting to local, state, and federal officials can prevent additional cases of travel-associated illness.

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Immunization Information System Progress — United States, 2004

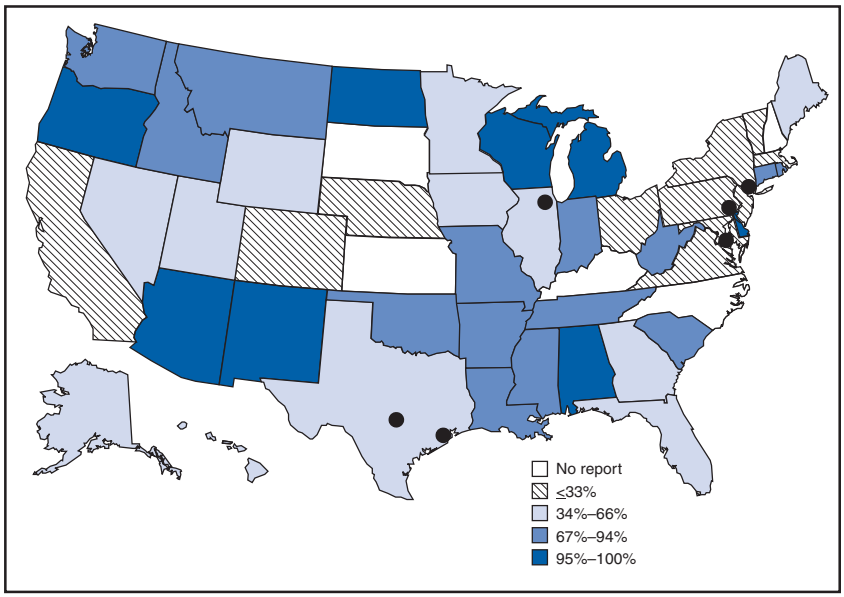
One of the national health objectives for 2010 is to increase to at least 95% the proportion of children aged <6 years who participate* in fully operational, population-based immunization registries (objective no. 14-26) (*1*). Immunization registries are confidential, computerized information systems that collect and consolidate vaccination data from multiple health-care providers, generate reminder and recall notifications, and assess vaccination coverage within a defined geographic area (*2,3*). A registry with added capabilities, such as vaccine management, adverse event reporting, lifespan vaccination histories, and linkages with electronic data sources, is called an immunization information system (IIS). This report summarizes data from CDC's 2004 IIS Annual Report, a survey of 56 grantees in 50 states, five cities, and the District of Columbia (DC) that receive funding under section 317b of the Public Health Service Act. The findings indicate that approximately 48% of U.S. children aged <6 years participated in an IIS. Moreover, 76% of public vaccination provider sites and 39% of private vaccination provider sites submitted immunization data to an IIS during the last 6 months of 2004. Overcoming challenges and barriers to increasing the number of provider sites and the percentage of children aged <6 years participating in an IIS is critical to achieving the national health objective. CDC has developed a plan of action to address those challenges. Major components of the plan include, but are not limited to, a multiyear IIS business plan for each grantee and enhanced technical assistance to grantees with unresolved challenges.

The 2004 IIS Annual Report, a self-administered, Internet-based questionnaire, was made available to immunization program managers as part of an annual reporting requirement. As in previous years, respondents were asked about the number of children aged <6 years participating in the IIS, the number of health-care provider sites participating in the IIS, and the ability to perform other programmatic and technical functions (e.g., data linkages with other public health programs, data use, vaccine management, software/hardware capability, and reporting functions). All 56 grantees were asked to complete the questionnaire; 51 reported on the number of children aged <6 years participating in an IIS. Estimates of the total number of children aged <6 years were based on 2004 U.S. Census data.

The findings suggested that, of approximately 23 million U.S. children aged <6 years, an estimated 48% (11 million) participated in an IIS. Ten (18%) grantees (Alabama, Arizona, Delaware, Michigan, New Mexico, New York City, North Dakota, Oregon, Philadelphia, and Wisconsin) have achieved the national health objective of ≥95% of children aged <6 years participating in an IIS (Figure). An additional seven (13%) IIS grantees (Arkansas, Mississippi, Montana, Oklahoma, Missouri, Rhode Island, and Tennessee) were approaching the national health objective, with participation rates of 81%–94%.

Approximately 76% of public vaccination provider sites and 39% of private vaccination provider sites submitted vaccination data to an IIS during the last 6 months of 2004.† Twenty-eight (50%) grantees reported that ≥95% of public provider vaccination sites submitted vaccination data to an IIS; five (9%) reported submission of vaccination data by 81%–94% of public provider vaccination sites. Seven (13%) grantees (Arkansas, Connecticut, Mississippi, New Mexico, Philadel-

FIGURE. Percentage of children aged <6 years participating* in a grantee† immunization information system — United States, five cities, and the District of Columbia,§ 2004



* Participation is defined as a child having two or more vaccinations recorded in an immunization information system.
† Grantees include 50 states, five cities, and the District of Columbia, funded under section 317b of the Public Health Service Act.
§ Chicago, Illinois (no report); District of Columbia (67%–94%); Houston, Texas (34%–66%); New York, New York (95%–100%); Philadelphia, Pennsylvania (95%–100%); and San Antonio, Texas (67%–94%).

* Participation is defined as a child having two or more vaccinations recorded in an immunization information system.

† Number of provider vaccination sites (public and private) is based on grantee self-reports.

phia, San Antonio, and South Dakota) reported that ≥95% of private provider vaccination sites submitted vaccination data to an IIS; eight (14%) (Arizona, Delaware, DC, Michigan, North Dakota, Oregon, South Carolina, and Wisconsin) reported data submission by 81%–94% of private provider vaccination sites.

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Editorial Note: In 2004, approximately 48% of U.S. children aged <6 years participated in an IIS; the national health objective for 2010 is to increase this proportion to at least 95%. The 2004 rate represents a 4% increase from 2003, with approximately 1 million more children participating in an IIS (*4*). In addition, private health-care–provider site participation in an IIS increased by 3%. These small percentage increases from 2003 indicate that several grantees must overcome substantial obstacles to meet the national health objective, some of which have been reported previously by the National Vaccine Advisory Committee (*2*) and CDC (*5*). These include inadequate technical and managerial resources to oversee IIS development and implementation or provider perceptions about the administrative burden on staff. To address some of these problems, CDC developed a plan of action that includes grantee development of IIS business plans and enhanced technical assistance to select grantees.

A detailed IIS business plan is a requirement in the 2006 annual grantee application for those grantees requesting IIS funds exceeding $100,000. An IIS business plan summarizes the operational and financial objectives of an immunization program and details activities and budgets, indicating how objectives should be achieved. Enhancing business best practices and project management methodologies should assist grantees in planning, developing, and implementing IIS activities throughout the project lifecycle. Use of this plan creates a transparent structure for operational and financial accountability for both grantees and CDC. This methodology will provide a common understanding of the programmatic and technical challenges faced by grantees in IIS planning, development, implementation, maintenance, and evaluation.

In addition, a grantee business plan will assist CDC in monitoring IIS project activities more closely for those grantees that require additional technical assistance. To identify technical assistance needs, immunization program grantees were stratified into three groups on the basis of 2004 IIS Annual Report data and input from CDC IIS staff. The first group of grantees reported no or very low child participation rates and was identified for "active IIS project intervention." This group represents approximately 38% of all U.S. children aged <6 years and is considered to be a primary target group for enhanced technical assistance. The second group includes grantees that have a plan to address their challenges and are making satisfactory progress. These grantees are identified as "under active IIS project implementation" and represent approximately 25% of U.S. children aged <6 years. The third group consists of grantees identified as "mature IIS projects or making excellent progress" and represents approximately 37% of U.S. children aged <6 years. Interventions must be targeted to the first group if IIS grantees are to meet the 2010 national health objective.

To target interventions to the first group for the coming year, CDC has identified grantees amenable to technical or administrative support. CDC will provide enhanced technical support for these grantees. Enhanced technical support services might include but are not limited to the following: assessment of grantee accomplishments and barriers, assistance in the development or refinement of a business plan or reporting requirements, and proposed plans to remediate barriers and challenges. Key performance indicators will be designated to evaluate the success of grantee interventions.

The findings in this report are subject to at least two limitations. First, data from the 2004 IIS Annual Report are self-reported and might result in reporting bias. Second, because some grantees did not report data, the participation of children aged <6 years and provider participation rates might be underestimated.

Implementing CDC's plan of action will enhance IIS function and use. As a result, IIS likely will be 1) more comprehensive in geographic area participation and coverage levels; 2) interoperable with other public health and clinical information systems; and 3) able to generate data to support all aspects of immunization program operations at national, state, and local levels.

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Lower Extremity Disease Among Persons Aged ≥40 Years With and Without Diabetes — United States, 1999–2002

Lower extremity disease (LED), including peripheral arterial disease (PAD) and peripheral insensate neuropathy (PN), is a chronic condition that disproportionately affects older persons and persons with diabetes. LED can result in disabling foot complications (e.g., ulcers, infection, gangrene, or amputation) (*1,2*). PAD has been associated with increased risk for cardiovascular morbidity (*3*) and mortality (*4,5*). For this report, CDC analyzed data collected during 1999–2002 from the National Health and Nutrition Examination Survey (NHANES) to update previously published estimates of the prevalence of LED among persons aged ≥40 years with and without diabetes (*6*). The results of this analysis indicated that approximately 18% of persons aged ≥40 years had LED and that LED was twice as prevalent among persons with diabetes as among those without diabetes. Approximately two thirds of persons with LED and half of those with both diabetes and LED were asymptomatic. Multiple complications of LED can be prevented if LED is detected early (*1,2*). Increasing knowledge among clinicians and the public of the prevalence of LED and associated risk factors might lead to early detection, intervention, and treatment to prevent disabling consequences.

NHANES is an ongoing, cross-sectional survey of representative samples of the civilian, noninstitutionalized U.S. population (aged ≥2 months for the 1988–1994 surveys and all ages for the 1999–2002 surveys). For the 1999–2000 and 2001–2002 NHANES surveys, participants were administered detailed in-person home interviews followed by standardized health examinations in a mobile exam center (MEC). In the MEC, persons aged ≥40 years received noninvasive tests for PAD (i.e., ankle-brachial blood pressure measurements) and PN (i.e., monofilament testing of foot sensation) and examinations for foot abnormalities and lesions by trained health technicians. LED was defined as 1) PAD (ankle-brachial blood pressure index [ABI] of <0.9 in either leg), 2) PN (one or more insensate areas in either foot), 3) self-reported history of a foot ulcer or sore on a leg or foot that took >4 weeks to heal, or 4) observed foot lesions or foot/toe amputation. PAD cases were classified as symptomatic if participants answered "yes" when asked whether they ever had calf pain in either leg while walking. PN cases were classified as symptomatic if participants reported having numbness/loss of feeling or painful sensations/tingling in their feet during the preceding 3 months. Diabetes was defined as self-report of a physician's previous diagnosis. Women with diabetes diagnosed only during pregnancy were classified as without diabetes. Details of these measurements and exclusion criteria have been described previously (*6*). Complete PAD, PN, and LED data were collected for 5,071, 5,313, and 4,929 persons with diabetes data, respectively. All analyses used examination weights to account for the unequal probability of selection, oversampling, and survey nonresponse. Age-adjusted estimates were made (using the direct method) to the 2000 U.S. census population using three age groups: 40–59, 60–74, and ≥75 years. Race/ethnicity was categorized as non-Hispanic white, non-Hispanic black, and Mexican-American. Estimates were not shown separately for persons of other racial/ethnic populations, although these persons were included in totals and strata by other characteristics.

Among U.S. adults aged ≥40 years, approximately 5.0% had PAD (Figure); approximately two thirds of these persons were asymptomatic, and approximately one fourth (1.4%; 95% confidence interval [CI] = 1.0–1.8) had severe PAD (i.e., ABI of <0.7 in either leg). Approximately 12.9% had PN; approximately three fourths of these persons were asymptomatic, and one fourth (3.3%; CI = 2.6-4.0) had severe PN (i.e., three or more insensate areas). Approximately 4% of persons reported a foot ulcer or were observed to have a current foot lesion or toe/foot amputation. Overall, approximately 18.6% of the U.S. adult population aged ≥40 years had at least one LED condition (i.e., PAD, PN, history of ulcer, current foot lesion, or amputation), among whom two thirds were asymptomatic. The percentage of adults with PN or with any LED who were symptomatic was greater among persons with diagnosed diabetes than among persons without diagnosed diabetes. Among persons with PN, 42% of those with diabetes were symptomatic, compared with 21% of those without diabetes. Among persons with any LED, 53% of those with diabetes were symptomatic, compared with 31% of those without diabetes. However, among persons with PAD, approximately one third were symptomatic regardless of diabetes status.

Among adults aged ≥40 years, prevalence of LED was higher among persons aged ≥75 years (40.8%) and 60–74 years (26.2%) than among persons aged 40–59 years (12.3%). Prevalence of LED also was higher among men than among women (23.1% versus 16.6%) (Table) and higher among non-Hispanic blacks than among non-Hispanic whites or Mexican-Americans (27.0% versus 19.1% and 21.1%, respectively). Among all age, sex, and racial/ethnic subpopulations, the age-adjusted prevalence of any LED was 1.5–1.8 times greater among adults with diagnosed diabetes than among those without diabetes (Table).

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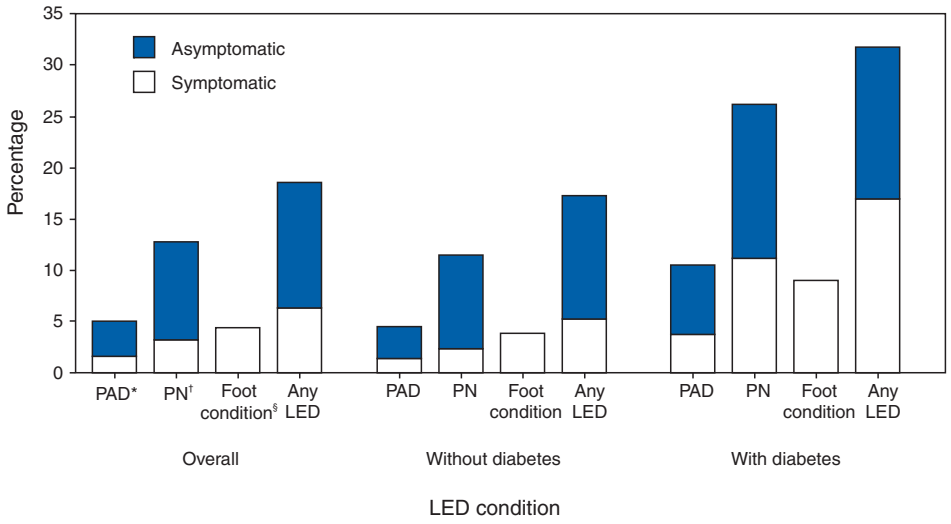
FIGURE. Prevalence of lower extremity disease (LED) among adults aged ≥40 years overall and with and without diabetes, by LED condition and symptom status — National Health and Nutrition Examination Survey, United States, 1999–2002



* Peripheral arterial disease. Symptomatic persons reported calf pain in either leg while walking.
† Peripheral insensate neuropathy. Symptomatic persons reported numbness/loss of feeling or painful sensations/tingling in feet during the preceding 3 months.
§ Foot ulcers, lesions, or foot/toe amputations.

TABLE. Age-adjusted* prevalence of lower extremity disease† among adults aged ≥40 years overall and with and without diabetes, by selected characteristics — National Health and Nutrition Examination Survey, United States, 1999–2002

Characteristic	Overall		Without diabetes		With diabetes	
	%	(95% CI§)	%	(95% CI)	%	(95% CI)
Age group (yrs)¶						
40–59 (referent)	12.3	(10.7–13.8)	11.6	(10.1–13.2)	21.4**	(14.1–28.7)
60–74	26.2††	(23.0–29.3)	24.1††	(20.8–27.3)	39.3††**	(30.3–48.4)
≥75	40.8††	(36.7–45.0)	40.3††	(36.4–44.3)	44.4††	(31.2–57.7)
Sex¶						
Men (referent)	23.1	(21.0–25.2)	21.9	(19.8–24.0)	33.2**	(24.9–41.5)
Women	16.6††	(14.8–18.4)	15.9††	(14.2–17.7)	24.7**	(18.5–30.9)
Race/Ethnicity						
Black, non-Hispanic (referent)	27.0	(23.0–31.0)	23.8	(19.6–28.0)	44.0**	(33.7–54.3)
White, non-Hispanic	19.1††	(17.3–21.0)	18.5††	(16.7–20.4)	25.3††	(16.8–33.8)
Mexican-American	21.1††	(17.7–24.5)	19.2	(15.4–23.0)	33.6**	(23.8–43.3)

* Age adjusted to the 2000 standard U.S. population.
† Including peripheral arterial disease, peripheral insensate neuropathy, or history of foot ulcer, lesions, or foot/toe amputation.
§ Confidence interval.
¶ Includes data for racial/ethnic populations not shown separately.
** Significant difference (p<0.05) between persons with diabetes and persons without diabetes.
†† Significantly different (p<0.05) from referent.

Editorial Note: The findings in this report indicate that approximately one fifth of the U.S. adult population aged ≥40 years has LED, and the majority of cases are asymptomatic; prevalence of LED is approximately twice as high among persons with diagnosed diabetes as among those without diabetes. These results highlight the importance of improved detection and prevention of asymptomatic and symptomatic LED among both persons with and without diabetes.

In 2003, the Prevention of Atherothrombotic Disease Network identified five steps to improve PAD treatment and outcomes: 1) increase awareness of PAD and its consequences, 2) identify persons with symptomatic PAD, 3) screen for patients at high risk, 4) improve treatment for symptomatic PAD cases, and 5) increase early detection of asymptomatic cases (*2*). In 2003, the American Diabetes Association (ADA) recommended PAD screening for all persons with diabetes aged >50 years, including those without symptoms (*7*).

Early detection and control of diabetes and coexisting risk factors for peripheral neuropathy (e.g., smoking or hypertension) can prevent, delay, or slow progression of diabetic neuropathy (*8*). In 1993, the Diabetes Control Complications Trial (DCCT) demonstrated that tight glycemic control can reduce the risk for developing clinical neuropathy (*9*). ADA has adopted the DCCT standards for tight glycemic control in persons with type 1 diabetes (*8*). Several foot-related conditions, including PN and PAD, are associated with increased risk for amputation (*1*). Because early detection and aggressive care of foot ulcers and lesions can reduce risk for amputation, ADA also recommends an extensive annual foot examination for all persons with diabetes (*8*).

The findings in this report are subject to at least four limitations. First, NHANES samples the noninstitutionalized population and does not include persons in nursing homes and other institutions. Second, within the NHANES sample, 17% were missing ABI measurements and 12% were missing PN measurements (e.g., because of participant refusal or equipment failure); these persons might have had LED. However, nonresponse analyses were performed and adjustment procedures were conducted. Estimates computed with the adjusted weights (based on age, sex,

race/ethnicity, and diabetes status) produced only minor differences in point and variance estimates (0.1%–0.6%); therefore, all estimates in this report were based on the original 4-year examination weights. Third, 9% of the PAD sample had ABI measurements performed on only one foot and might have been misclassified as without PAD even if the other foot had disease. Finally, although foot lesions and lower extremity amputations were identified by trained health technicians, the causes of these conditions were not determined.

Advanced age and diabetes are strong risk factors for PAD and PN. As the U.S. population ages and the prevalence of diabetes increases, the public health burden associated with PAD and PN will increase. NHANES provides the first nationally representative data on the prevalence of these diseases and should inform policy makers, clinicians, and researchers regarding the magnitude of LED to guide programs addressing prevention and treatment. CDC also provides resources and technical assistance to state and territorial diabetes control and prevention programs to increase awareness and understanding of diabetes, improve and monitor the quality of diabetes care, and promote early detection of diabetes complications. In addition, CDC collaborates with the National Institutes of Health in administering the National Diabetes Education Program, which seeks to increase public and professional awareness regarding diabetes and proper foot care. Information for persons with diabetes regarding how to prevent problems and take better care of their feet is available at http://www.cdc.gov/diabetes/consumer/problems.htm.

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Brief Report

Imported Case of Congenital Rubella Syndrome — New Hampshire, 2005

In 2004, an independent panel convened by CDC declared rubella no longer endemic in the United States (*1*). Nine cases of rubella were reported in 2004, and four cases of congenital rubella syndrome (CRS) were reported during 2001–2004 (*1*). However, worldwide, an estimated 100,000 infants are born with CRS annually (*2*). This report describes a case of imported CRS diagnosed in an infant girl aged 10 weeks born in New Hampshire to Liberian refugee parents. To prevent transmission of rubella, clinicians should consider a diagnosis of CRS in infants with compatible clinical signs, particularly those born to mothers who recently immigrated from countries without rubella control programs, and rubella vaccine should be administered to susceptible persons.

The infant's family resettled in the United States on February 17, 2004. On March 1, 2004, the family reported to a local health department for refugee health screening, which included review of vaccination history and receipt of additional vaccinations recommended by the Advisory Committee on Immunization Practices (*3*). A medical record from the International Organization of Migration indicated that the mother had received measles vaccination during refugee encampment in Côte d'Ivoire in October 2003; no additional vaccination history was documented. Contraindications to live virus vaccination, including current or planned pregnancy, were assessed with assistance of a trained medical interpreter. No contraindications were reported, and the mother received vaccinations, including measles-mumps-rubella (MMR) vaccination.

On March 26, 2004, the infant's mother reported to an emergency department (ED) with nausea and vomiting and was determined by urine test to be pregnant, with confirmation by blood test. During a routine prenatal visit 1 month later, the mother was determined to be immune to rubella on the basis of presence of rubella-specific IgG antibodies. On November 4, 2004, she gave birth to a female infant weighing 5 lbs, 10 oz. Estimated gestational age was approximately 38 weeks on the basis of prenatal ultrasound performed during the first trimester of pregnancy. At birth, the infant was noted to have a left eye cataract, prompting referral to an ophthalmologist, who repaired the cataract 5 weeks later. A newborn hearing screen was conducted; the infant's right ear passed the screening test but the left ear required further evaluation by an audiologist. No other physical abnormalities were noted. During two subsequent well-baby visits, a head circumference of <5th percentile was noted. No other abnormalities were noted.

At age 10 weeks, the infant was taken to an ED with fever, vomiting, irritability, and poor feeding and was hospitalized. During her hospital course, the infant received diagnoses of microcephaly, patent ductus arteriosus, bilateral hearing impairment, hepatosplenomegaly, and failure to thrive. On the basis of these clinical findings, CRS was suspected. Diagnosis was confirmed by positive rubella IgM and positive viral cultures from urine and nasopharyngeal specimens. The genetic sequence was determined to be that of the wild-type rubella virus (a similar sequence to one found in Uganda in 2001) by laboratories at CDC.

Contact investigation by the state and local health departments targeted community and medical settings in which exposure might have occurred. Contacts were defined as those who had touched the infant or come into contact with the infant's secretions. Of 20 contacts identified, 18 were immune to rubella by history or antibody titer. One contact could not be reached, and one was unvaccinated because of human immunodeficiency virus infection. The unvaccinated person exhibited no symptoms of rubella infection for at least 4 weeks after contact with the infant.

On January 31, 2005, the U.S. Department of State notified investigators that a rubella outbreak had occurred during February–April 2004 in Côte d'Ivoire. This outbreak, linked to four refugee transit centers, resulted in 34 confirmed rubella cases; no cases of CRS were documented. The first rubella case had been identified on February 14 and resulted in administration of approximately 3,000 doses of MMR vaccine to refugees. The transit center in which the infant's family had lived was unaffected by this outbreak, but the family had come into contact with refugees from affected transit centers during a brief hotel stay in Abidjan, Côte d'Ivoire, on February 16 before departing for the United States. On the basis of the infant's estimated gestational age, the mother's last menstrual period and conception were projected to have occurred on February 8 and February 22, 2004, respectively. Viremia begins 5–7 days after exposure to rubella and lasts approximately 1 week; in utero infection of the fetus likely occurred during this viremic stage (*4,5*).

The mother reported no history of symptoms of acute rubella infection, including rash, fever, lymphadenopathy, or arthralgia, either before leaving Côte d'Ivoire or after resettlement. However, subclinical infections are estimated to occur in up to 50% of rubella cases (*4*).

Clinicians should maintain a high index of suspicion for CRS in infants exhibiting relevant clinical signs, particularly infants of recently immigrated women who were born or resided in countries that have no national rubella control program or only recently implemented a program. Congenital rubella infection can affect all organ systems. Manifestations of CRS include deafness, cataracts, heart defects, microcephaly, mental retardation, bone abnormalities, and liver and spleen damage. Timely diagnosis of CRS can prevent exposure of vulnerable persons to rubella virus shed by an infant with CRS. Vaccination of susceptible populations, such as recently resettled refugees, and of those who serve these populations will also help prevent disease transmission (*6*).

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Acknowledgments

The findings in this report are based, in part, on contributions from B Jensen, Manchester Health Dept, Manchester, New Hampshire.

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Erratum: Vol. 54, No. RR-8

In the *MMWR Recommendations and Reports*, "Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices," on page 14 in Table 4, the first line of the * footnote should read "A 0.5-mL dose contains 15 μg each of…"

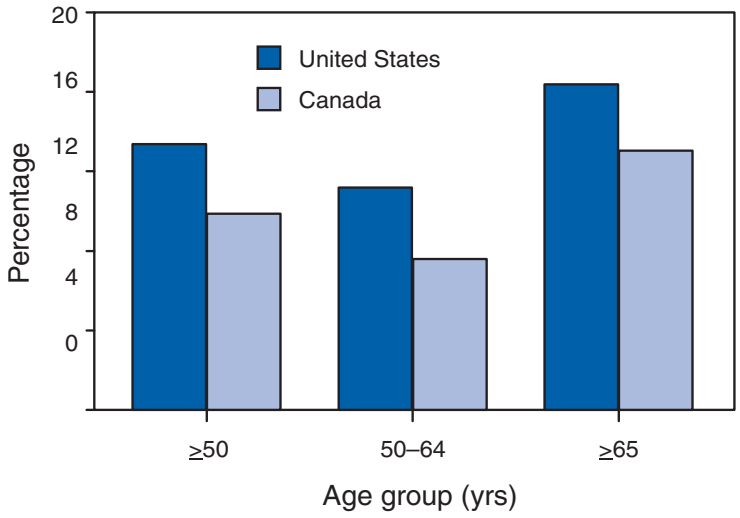
Erratum: Vol 54 No. RR-12

In the report, "Controlling Tuberculosis in the United States: Recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America," an error occurred in Figure 4 on page 47. The last box on the lower right side of the figure should read: "AFB negative (Class B1 [Noninfectious])."

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

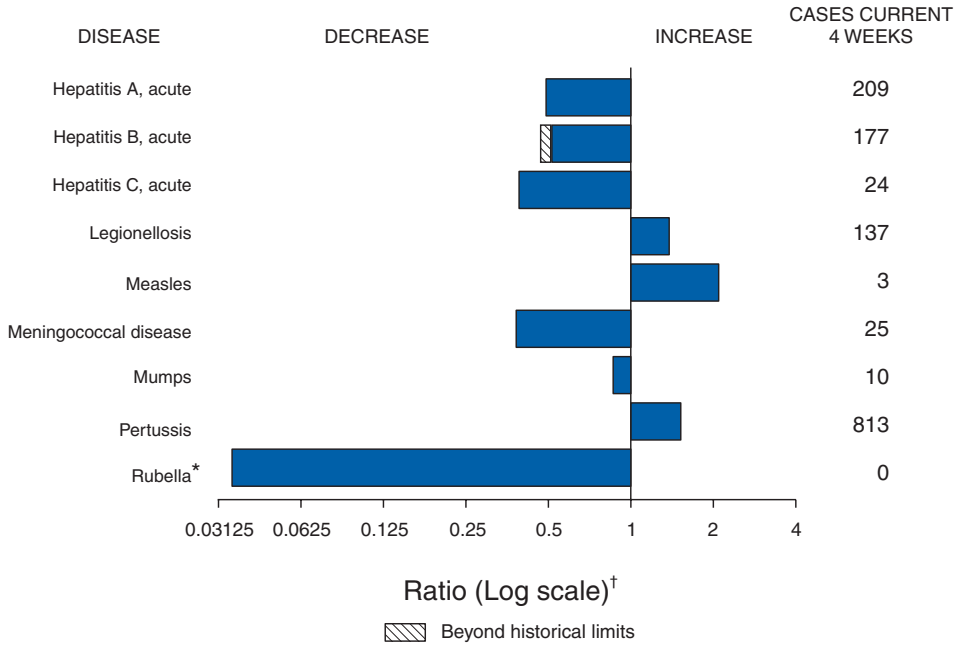
Percentage of Adults Aged ≥50 Years Told by a Health-Care Professional That They Had Diabetes, by Age Group — United States and Canada, 2002–2003



During 2002–2003, diabetes was significantly more prevalent among adults aged ≥50 years in the United States than in Canada. Approximately 13% of U.S. adults in that age group had been told by a health-care professional that they had diabetes, compared with approximately 10% of that age group in Canada. Among those aged 50–64 years, 11% of U.S. adults had been told they had diabetes, compared with 8% in Canada.

SOURCE: Powell-Griner E, Blackwell DL, Martinez M. Health profiles of noninstitutionalized senior citizens in the U.S. and Canada: findings from the Joint Canada/United States Survey of Health. Presented at the 70th Annual Meeting of the Population Association of America, Philadelphia, PA; March 31–April 2, 2005.

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



* No rubella cases were reported for the current 4-week period yielding a ratio for week 45 of zero (0).
† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending November 12, 2005 (45th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	152	150
Botulism:			HIV infection, pediatric†¶	181	322
foodborne	12	8	Influenza-associated pediatric mortality†**	44	—
infant	69	74	Measles	64††	25§§
other (wound & unspecified)	25	14	Mumps	233	202
Brucellosis	93	85	Plague	3	2
Chancroid	25	23	Poliomyelitis, paralytic	1	—
Cholera	4	4	Psittacosis†	20	11
Cyclosporiasis†	708	199	Q fever†	129	57
Diphtheria	—	—	Rabies, human	2	6
Domestic arboviral diseases			Rubella	15	9
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	1	—
California serogroup†§	52	116	SARS†**	—	—
eastern equine†§	20	4	Smallpox†	—	—
Powassan†§	—	1	*Staphylococcus aureus*:		
St. Louis†§	7	13	Vancomycin-intermediate (VISA)†	1	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	—	1
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome†	96	118
human granulocytic (HGE)†	544	372	Tetanus	17	21
human monocytic (HME)†	394	272	Toxic-shock syndrome	85	77
human, other and unspecified †	76	65	Trichinellosis¶¶	16	2
Hansen disease†	68	87	Tularemia†	131	96
Hantavirus pulmonary syndrome†	22	19	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 June 26, 2005.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of 64 cases reported, 53 were indigenous and 11 were imported from another country.
§§ Of 25 cases reported, eight were indigenous and 17 were imported from another country.
¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending November 12, 2005, and November 13, 2004 (45th 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	20,405	34,502	789,736	795,913	4,029	5,024	6,399	3,198
NEW ENGLAND	778	1,129	27,307	26,018	—	—	308	161
Maine	11	23	1,952	1,806	N	N	25	18
N.H.	20	39	1,601	1,509	—	—	30	30
Vt.¶	4	14	830	976	—	—	36	23
Mass.	368	425	12,443	11,562	—	—	128	59
R.I.	68	114	2,733	2,936	—	—	13	4
Conn.	307	514	7,748	7,229	N	N	76	27
MID. ATLANTIC	4,352	7,360	99,634	97,469	—	—	2,817	518
Upstate N.Y.	800	837	19,892	19,593	N	N	2,411	163
N.Y. City	2,327	4,039	31,993	29,948	—	—	117	123
N.J.	574	1,229	15,603	15,231	N	N	52	43
Pa.	651	1,255	32,146	32,697	N	N	237	189
E.N. CENTRAL	1,938	2,816	129,383	141,068	10	13	1,364	964
Ohio	312	540	34,848	34,799	N	N	737	206
Ind.	236	326	17,431	16,132	N	N	74	70
Ill.	983	1,274	38,652	41,379	—	—	128	147
Mich.	322	535	22,370	31,958	10	13	96	139
Wis.	85	141	16,082	16,800	N	N	329	402
W.N. CENTRAL	463	710	48,981	49,183	5	6	537	366
Minn.	123	190	9,516	10,245	3	N	130	120
Iowa	50	57	6,176	6,015	N	N	103	79
Mo.	198	296	19,364	18,131	1	3	239	64
N. Dak.	5	15	1,011	1,558	N	N	1	10
S. Dak.	10	8	2,405	2,201	—	—	24	37
Nebr.¶	18	44	4,423	4,554	1	3	8	27
Kans.	59	100	6,086	6,479	N	N	32	29
S. ATLANTIC	6,473	10,881	150,697	149,659	2	—	623	473
Del.	100	131	2,946	2,526	N	N	4	—
Md.	812	1,292	15,976	16,340	2	—	33	20
D.C.	467	785	3,322	3,077	—	—	10	14
Va.¶	307	565	18,039	19,227	—	—	60	55
W. Va.	36	71	2,300	2,437	N	N	13	6
N.C.	531	1,014	26,862	25,533	N	N	77	72
S.C.¶	386	640	18,170	16,166	—	—	17	22
Ga.	1,103	1,375	26,412	27,787	—	—	106	166
Fla.	2,731	5,008	36,670	36,566	N	N	303	118
E.S. CENTRAL	1,093	1,646	58,604	52,085	—	5	189	133
Ky.	135	212	7,635	5,059	N	N	129	42
Tenn.¶	434	684	20,723	19,357	N	N	38	41
Ala.¶	295	381	12,954	11,731	—	—	18	22
Miss.	229	369	17,292	15,938	—	5	4	28
W.S. CENTRAL	2,206	4,000	91,659	96,581	1	3	174	123
Ark.	72	183	7,535	6,936	—	1	5	15
La.	436	799	14,205	19,275	1	2	77	5
Okla.	167	169	9,236	9,343	N	N	40	21
Tex.¶	1,531	2,849	60,683	61,027	N	N	52	82
MOUNTAIN	789	1,233	44,776	48,734	2,763	3,108	111	155
Mont.	4	5	1,844	2,150	N	N	16	34
Idaho¶	9	17	2,253	2,380	N	N	11	26
Wyo.	2	14	997	911	3	2	3	3
Colo.	163	278	11,521	12,556	N	N	44	53
N. Mex.	72	164	4,394	7,814	14	21	5	17
Ariz.	329	454	14,712	14,159	2,709	3,007	8	15
Utah	33	53	3,729	3,247	5	22	15	5
Nev.¶	177	248	5,326	5,517	32	56	9	2
PACIFIC	2,313	4,727	138,695	135,116	1,248	1,889	276	305
Wash.	229	348	16,097	15,272	N	N	43	33
Oreg.¶	136	249	6,462	7,238	—	—	64	29
Calif.	1,874	3,981	109,994	104,606	1,248	1,889	165	241
Alaska	14	43	3,433	3,333	—	—	3	—
Hawaii	60	106	2,709	4,667	—	—	1	2
Guam	1	1	—	803	—	—	—	—
P.R.	537	614	3,193	2,908	N	N	N	N
V.I.	10	18	196	299	—	—	—	—
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 June 26, 2005.

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 12, 2005, and November 13, 2004 (45th 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	2,082	2,243	314	261	288	163	15,606	17,020	273,305	282,438
NEW ENGLAND	147	149	47	41	29	14	1,438	1,569	4,877	5,949
Maine	14	14	11	—	—	—	185	132	117	189
N.H.	12	21	2	5	—	—	46	41	150	111
Vt.	13	13	3	—	—	—	168	152	51	77
Mass.	59	64	7	13	29	14	622	699	2,173	2,697
R.I.	7	9	—	1	—	—	107	107	371	737
Conn.	42	28	24	22	—	—	310	438	2,015	2,138
MID. ATLANTIC	277	262	34	56	27	34	2,882	3,529	28,942	31,616
Upstate N.Y.	124	115	16	37	9	17	1,057	1,197	5,909	6,414
N.Y. City	14	35	—	—	—	—	734	960	8,699	9,657
N.J.	48	49	3	6	9	6	352	452	4,749	5,862
Pa.	91	63	15	13	9	11	739	920	9,585	9,683
E.N. CENTRAL	415	430	35	44	20	30	2,490	2,847	52,820	60,032
Ohio	132	90	9	9	12	18	708	695	16,348	18,233
Ind.	62	48	—	—	—	—	N	N	6,957	5,924
Ill.	45	96	1	7	1	7	550	727	15,653	18,048
Mich.	72	76	2	10	6	5	686	632	9,229	13,479
Wis.	104	120	23	18	1	—	546	793	4,633	4,348
W.N. CENTRAL	370	454	37	36	58	20	1,887	1,841	15,757	14,949
Minn.	125	103	20	14	33	4	863	668	2,704	2,545
Iowa	75	117	—	—	—	—	241	267	1,379	1,091
Mo.	73	89	11	16	12	6	439	494	8,136	7,813
N. Dak.	6	13	—	—	1	6	12	21	70	98
S. Dak.	26	31	3	2	—	—	85	58	306	248
Nebr.	26	62	3	4	4	—	84	137	1,004	962
Kans.	39	39	—	—	8	4	163	196	2,158	2,192
S. ATLANTIC	181	159	79	30	105	45	2,256	2,584	66,213	67,985
Del.	7	3	N	N	N	N	49	43	771	766
Md.	30	21	29	6	10	3	178	131	6,102	7,040
D.C.	—	1	—	—	—	—	42	66	1,850	2,282
Va.	39	33	27	15	21	—	478	458	6,591	7,608
W. Va.	2	2	—	—	1	—	41	40	635	792
N.C.	—	—	—	—	58	35	N	N	13,079	13,468
S.C.	6	12	1	—	1	—	91	102	8,031	7,988
Ga.	28	21	18	6	—	—	521	793	12,244	12,322
Fla.	69	66	4	3	14	7	856	951	16,910	15,719
E.S. CENTRAL	122	95	8	5	30	15	367	369	23,500	22,969
Ky.	46	25	5	1	19	9	N	N	2,674	2,302
Tenn.	41	37	2	2	11	6	188	199	7,653	7,373
Ala.	28	22	—	—	—	—	179	170	7,438	7,138
Miss.	7	11	1	2	—	—	—	—	5,735	6,156
W.S. CENTRAL	46	80	13	3	9	5	281	295	37,298	37,756
Ark.	7	17	—	—	—	—	75	115	3,936	3,662
La.	3	4	11	1	3	1	50	47	7,965	9,100
Okla.	22	18	1	—	2	—	156	133	3,666	3,982
Tex.	14	41	1	2	4	4	N	N	21,731	21,012
MOUNTAIN	201	226	53	45	10	—	1,246	1,327	9,585	10,380
Mont.	15	16	—	—	—	—	65	73	118	70
Idaho	22	52	11	13	7	—	85	166	95	81
Wyo.	6	9	2	5	—	—	24	22	71	55
Colo.	62	51	3	1	1	—	469	460	2,545	2,634
N. Mex.	10	10	9	6	—	—	71	64	864	1,100
Ariz.	39	21	N	N	N	N	134	152	3,238	3,413
Utah	37	43	26	19	—	—	349	282	602	498
Nev.	10	24	2	1	2	—	49	108	2,052	2,529
PACIFIC	323	388	8	1	—	—	2,759	2,659	34,313	30,802
Wash.	97	132	—	—	—	—	313	328	3,206	2,364
Oreg.	77	68	8	1	—	—	344	403	1,115	1,093
Calif.	127	177	—	—	—	—	1,955	1,769	29,020	25,760
Alaska	12	1	—	—	—	—	92	88	478	496
Hawaii	10	10	—	—	—	—	55	71	494	1,089
Guam	N	N	—	—	—	—	—	2	—	125
P.R.	2	2	—	—	—	—	176	258	290	211
V.I.	—	—	—	—	—	—	—	—	45	82
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 November 12, 2005, and November 13, 2004 (45th 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	1,788	1,715	4	12	95	106	178	155
NEW ENGLAND	141	162	—	1	10	10	6	1
Maine	6	12	—	—	—	—	1	—
N.H.	8	17	—	—	—	2	—	—
Vt.	10	8	—	—	—	—	3	1
Mass.	66	74	—	1	3	4	1	—
R.I.	7	6	—	—	2	1	—	—
Conn.	44	45	—	—	5	3	1	—
MID. ATLANTIC	368	360	—	2	1	5	38	36
Upstate N.Y.	106	115	—	2	—	5	9	5
N.Y. City	67	78	—	—	—	—	10	15
N.J.	77	67	—	—	—	—	10	3
Pa.	118	100	—	—	1	—	9	13
E.N. CENTRAL	256	321	1	—	4	8	17	47
Ohio	99	88	—	—	—	2	7	15
Ind.	57	42	—	—	4	4	—	1
Ill.	59	116	—	—	—	—	7	21
Mich.	18	19	1	—	—	2	2	4
Wis.	23	56	—	—	—	—	1	6
W.N. CENTRAL	97	93	—	2	3	3	9	11
Minn.	40	40	—	1	3	3	2	1
Iowa	1	1	—	1	—	—	—	—
Mo.	32	37	—	—	—	—	5	7
N. Dak.	2	4	—	—	—	—	1	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	9	5	—	—	—	—	1	2
Kans.	13	6	—	—	—	—	—	1
S. ATLANTIC	424	386	1	1	26	25	30	26
Del.	—	—	—	—	—	—	—	—
Md.	62	58	—	—	5	5	—	—
D.C.	—	3	—	—	—	—	—	1
Va.	40	39	—	—	—	—	2	5
W. Va.	25	16	—	—	1	4	6	—
N.C.	71	54	1	1	8	6	—	1
S.C.	30	13	—	—	—	—	3	1
Ga.	83	100	—	—	—	—	13	17
Fla.	113	103	—	—	12	10	6	1
E.S. CENTRAL	101	63	—	1	1	1	19	8
Ky.	8	7	—	—	1	1	2	—
Tenn.	75	41	—	—	—	—	13	6
Ala.	18	13	—	1	—	—	4	2
Miss.	—	2	—	—	—	—	—	—
W.S. CENTRAL	91	66	1	1	8	8	7	1
Ark.	5	2	—	—	1	1	—	—
La.	30	13	1	—	2	—	7	1
Okla.	54	50	—	—	5	7	—	—
Tex.	2	1	—	1	—	—	—	—
MOUNTAIN	193	170	—	4	14	25	36	18
Mont.	—	—	—	—	—	—	—	—
Idaho	4	5	—	—	—	—	1	2
Wyo.	6	1	—	—	—	1	1	—
Colo.	39	41	—	—	1	—	9	5
N. Mex.	18	37	—	1	4	8	2	6
Ariz.	95	58	—	—	7	11	12	2
Utah	17	15	—	2	—	2	8	2
Nev.	14	13	—	1	2	3	3	1
PACIFIC	117	94	1	—	28	21	16	7
Wash.	4	1	—	—	—	—	3	1
Oreg.	29	41	—	—	—	—	5	3
Calif.	50	38	1	—	28	21	2	1
Alaska	26	5	—	—	—	—	6	1
Hawaii	8	9	—	—	—	—	—	1
Guam	—	—	—	—	—	—	—	—
P.R.	3	2	—	—	—	—	1	2
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 November 12, 2005, and November 13, 2004 (45th 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	3,579	5,151	4,738	5,118	613	699
NEW ENGLAND	476	898	250	335	16	16
Maine	4	13	16	5	—	—
N.H.	74	24	23	32	—	—
Vt.	6	8	5	6	13	8
Mass.	330	763	175	186	—	7
R.I.	15	21	3	5	—	—
Conn.	47	69	28	101	3	1
MID. ATLANTIC	604	714	906	669	94	130
Upstate N.Y.	94	99	83	72	17	11
N.Y. City	268	302	104	137	—	—
N.J.	152	167	533	191	—	—
Pa.	90	146	186	269	77	119
E.N. CENTRAL	336	455	445	479	116	98
Ohio	47	44	116	98	7	6
Ind.	49	55	44	39	23	7
Ill.	79	137	101	76	—	13
Mich.	130	130	153	230	86	72
Wis.	31	89	31	36	—	—
W.N. CENTRAL	83	140	238	287	25	20
Minn.	3	32	29	44	5	17
Iowa	20	44	18	14	—	—
Mo.	37	28	142	171	18	3
N. Dak.	—	1	—	4	1	—
S. Dak.	—	3	3	1	—	—
Nebr.	6	12	21	37	1	—
Kans.	17	20	25	16	—	—
S. ATLANTIC	626	916	1,180	1,607	130	171
Del.	4	6	46	46	7	31
Md.	67	97	134	140	22	5
D.C.	4	7	10	19	—	4
Va.	72	111	125	232	12	13
W. Va.	5	5	35	39	21	22
N.C.	81	98	150	153	19	11
S.C.	34	40	122	125	3	15
Ga.	102	298	135	410	7	14
Fla.	257	254	423	443	39	56
E.S. CENTRAL	224	141	310	428	75	82
Ky.	24	29	55	61	9	23
Tenn.	145	90	124	204	17	29
Ala.	35	8	78	66	14	4
Miss.	20	14	53	97	35	26
W.S. CENTRAL	241	600	454	341	78	98
Ark.	13	60	43	103	1	2
La.	63	44	62	62	11	3
Okla.	4	20	34	60	6	3
Tex.	161	476	315	116	60	90
MOUNTAIN	308	372	482	411	39	41
Mont.	8	6	3	1	1	2
Idaho	17	17	12	10	1	1
Wyo.	—	5	1	7	1	2
Colo.	38	46	51	53	19	13
N. Mex.	22	23	9	17	—	U
Ariz.	194	224	338	216	—	5
Utah	19	35	40	38	8	5
Nev.	10	16	28	69	9	13
PACIFIC	681	915	473	561	40	43
Wash.	42	55	57	45	U	U
Oreg.	39	61	88	100	15	15
Calif.	575	770	316	395	24	27
Alaska	4	4	7	11	—	—
Hawaii	21	25	5	10	1	1
Guam	—	1	—	12	—	9
P.R.	58	42	40	71	—	—
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 November 12, 2005, and November 13, 2004 (45th 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	1,706	1,783	683	635	18,263	16,584	1,091	1,242
NEW ENGLAND	115	82	49	47	2,227	3,002	60	83
Maine	6	1	3	8	200	29	4	7
N.H.	8	10	6	3	179	197	5	5
Vt.	9	5	2	2	44	47	1	4
Mass.	40	36	14	17	956	1,464	31	49
R.I.	19	15	6	1	32	193	2	4
Conn.	33	15	18	16	816	1,072	17	14
MID. ATLANTIC	594	505	177	150	11,592	10,098	295	331
Upstate N.Y.	163	107	54	44	3,516	3,557	47	41
N.Y. City	83	65	34	25	—	334	155	181
N.J.	89	83	33	32	3,158	2,513	62	66
Pa.	259	250	56	49	4,918	3,694	31	43
E.N. CENTRAL	320	432	69	110	1,344	1,278	87	110
Ohio	174	200	29	38	62	47	24	28
Ind.	18	42	4	17	31	25	3	13
Ill.	15	45	2	24	—	87	29	38
Mich.	95	125	23	26	50	26	20	19
Wis.	18	20	11	5	1,201	1,093	11	12
W.N. CENTRAL	91	53	40	16	835	509	42	63
Minn.	26	7	13	4	727	424	11	24
Iowa	6	5	8	2	79	49	8	4
Mo.	32	25	6	6	23	24	16	19
N. Dak.	2	2	4	—	—	—	—	3
S. Dak.	21	4	—	1	1	1	—	1
Nebr.	2	4	5	3	2	8	3	4
Kans.	2	6	4	—	3	3	4	8
S. ATLANTIC	338	362	141	107	2,023	1,494	262	306
Del.	16	13	N	N	586	301	3	6
Md.	96	74	19	15	1,043	803	96	70
D.C.	9	10	—	5	8	12	8	13
Va.	37	45	14	17	219	161	27	47
W. Va.	17	10	4	4	16	28	3	2
N.C.	27	35	28	22	44	111	30	19
S.C.	12	13	11	10	19	22	8	10
Ga.	23	40	21	14	5	12	39	58
Fla.	101	122	44	20	83	44	48	81
E.S. CENTRAL	74	89	28	23	32	43	26	31
Ky.	25	35	4	4	5	15	9	4
Tenn.	34	39	12	12	26	23	13	10
Ala.	12	12	8	5	1	5	4	12
Miss.	3	3	4	2	—	—	—	5
W.S. CENTRAL	25	127	28	37	56	67	79	121
Ark.	4	1	2	3	4	8	6	8
La.	1	7	9	3	4	2	3	6
Okla.	7	6	3	—	—	—	9	7
Tex.	13	113	14	31	48	57	61	100
MOUNTAIN	80	74	16	23	21	17	52	49
Mont.	5	2	—	—	—	—	—	—
Idaho	3	9	—	1	2	6	—	1
Wyo.	4	6	—	—	3	3	2	—
Colo.	21	18	7	12	3	—	23	18
N. Mex.	2	4	4	1	1	1	2	4
Ariz.	23	11	—	—	8	6	14	13
Utah	14	20	3	1	2	1	9	8
Nev.	8	4	2	8	2	—	2	5
PACIFIC	69	59	135	122	133	76	188	148
Wash.	—	9	9	9	8	12	13	15
Oreg.	N	N	11	7	18	25	10	16
Calif.	66	49	114	102	104	37	146	111
Alaska	—	1	—	—	3	2	5	2
Hawaii	3	—	1	4	N	N	14	4
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	2	—
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.
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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 12, 2005, and November 13, 2004 (45th 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	995	1,044	79	80	48	40	—	1	868	923
NEW ENGLAND	66	63	1	6	—	6	—	1	65	50
Maine	2	10	—	—	—	1	—	—	2	9
N.H.	12	7	—	—	—	—	—	—	12	7
Vt.	6	3	—	—	—	—	—	—	6	3
Mass.	31	34	—	5	—	5	—	—	31	24
R.I.	3	2	—	1	—	—	—	—	3	1
Conn.	12	7	1	—	—	—	—	1	11	6
MID. ATLANTIC	128	141	35	38	7	5	—	—	86	98
Upstate N.Y.	33	36	4	5	4	3	—	—	25	28
N.Y. City	19	25	—	—	—	—	—	—	19	25
N.J.	33	30	—	—	—	—	—	—	33	30
Pa.	43	50	31	33	3	2	—	—	9	15
E.N. CENTRAL	108	116	29	27	10	6	—	—	69	83
Ohio	36	58	—	4	6	5	—	—	30	49
Ind.	18	18	—	1	4	1	—	—	14	16
Ill.	15	1	—	—	—	—	—	—	15	1
Mich.	29	22	29	22	—	—	—	—	—	—
Wis.	10	17	—	—	—	—	—	—	10	17
W.N. CENTRAL	67	71	3	—	1	4	—	—	63	67
Minn.	13	22	1	—	—	—	—	—	12	22
Iowa	16	16	—	—	1	2	—	—	15	14
Mo.	23	18	1	—	—	1	—	—	22	17
N. Dak.	—	2	—	—	—	—	—	—	—	2
S. Dak.	3	2	1	—	—	1	—	—	2	1
Nebr.	5	4	—	—	—	—	—	—	5	4
Kans.	7	7	—	—	—	—	—	—	7	7
S. ATLANTIC	192	198	6	2	9	4	—	—	177	192
Del.	4	6	—	—	—	—	—	—	4	6
Md.	21	10	3	—	2	—	—	—	16	10
D.C.	—	5	—	2	—	—	—	—	—	3
Va.	30	19	—	—	—	—	—	—	30	19
W. Va.	6	5	1	—	—	—	—	—	5	5
N.C.	29	28	2	—	7	4	—	—	20	24
S.C.	15	15	—	—	—	—	—	—	15	15
Ga.	15	13	—	—	—	—	—	—	15	13
Fla.	72	97	—	—	—	—	—	—	72	97
E.S. CENTRAL	51	61	1	1	3	1	—	—	47	59
Ky.	16	11	—	1	3	1	—	—	13	9
Tenn.	24	20	—	—	—	—	—	—	24	20
Ala.	6	15	1	—	—	—	—	—	5	15
Miss.	5	15	—	—	—	—	—	—	5	15
W.S. CENTRAL	87	63	1	2	5	2	—	—	81	59
Ark.	14	15	—	—	—	1	—	—	14	14
La.	26	31	—	1	2	—	—	—	24	30
Okla.	13	9	1	1	3	1	—	—	9	7
Tex.	34	8	—	—	—	—	—	—	34	8
MOUNTAIN	78	58	2	1	6	5	—	—	70	52
Mont.	—	3	—	—	—	—	—	—	—	3
Idaho	4	7	—	—	—	—	—	—	4	7
Wyo.	—	4	—	—	—	—	—	—	—	4
Colo.	17	14	1	—	1	—	—	—	15	14
N. Mex.	3	7	—	1	—	3	—	—	3	3
Ariz.	36	11	—	—	2	1	—	—	34	10
Utah	10	5	1	—	2	—	—	—	7	5
Nev.	8	7	—	—	1	1	—	—	7	6
PACIFIC	218	273	1	3	7	7	—	—	210	263
Wash.	41	28	1	3	4	7	—	—	36	18
Oreg.	28	52	—	—	—	—	—	—	28	52
Calif.	134	181	—	—	—	—	—	—	134	181
Alaska	3	4	—	—	—	—	—	—	3	4
Hawaii	12	8	—	—	3	—	—	—	9	8
Guam	—	1	—	—	—	—	—	—	—	1
P.R.	6	15	—	—	—	—	—	—	6	15
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	1	1	—	—	—	—	—	—	1	1
C.N.M.I.	—	—	—	—	—	—	—	—	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 12, 2005, and November 13, 2004 (45th 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	17,445	18,023	4,805	5,765	1,520	1,386	36,435	36,614	11,885	11,801
NEW ENGLAND	1,047	1,704	622	609	3	18	1,884	1,827	264	267
Maine	30	36	48	50	N	N	136	95	9	7
N.H.	59	83	12	28	1	—	145	124	8	8
Vt.	79	67	52	33	—	1	93	55	16	3
Mass.	804	1,429	305	260	1	13	993	1,048	166	168
R.I.	34	31	22	40	1	1	87	107	14	18
Conn.	41	58	183	198	—	3	430	398	51	63
MID. ATLANTIC	1,142	2,477	860	874	98	71	4,317	5,066	1,097	1,057
Upstate N.Y.	454	1,728	494	480	5	1	1,111	1,098	246	382
N.Y. City	85	179	27	11	7	22	1,008	1,149	354	363
N.J.	177	174	N	N	31	14	736	963	274	218
Pa.	426	396	339	383	55	34	1,462	1,856	223	94
E.N. CENTRAL	3,078	6,962	193	179	37	34	4,600	4,564	835	1,085
Ohio	1,012	508	68	72	24	10	1,192	1,093	101	150
Ind.	293	207	11	10	3	6	543	440	154	189
Ill.	577	1,240	50	49	1	14	1,323	1,462	242	369
Mich.	257	264	35	40	7	2	790	747	205	179
Wis.	939	4,743	29	8	2	2	752	822	133	198
W.N. CENTRAL	2,814	1,955	384	574	157	118	2,204	2,108	1,383	368
Minn.	966	315	66	81	2	3	510	529	84	62
Iowa	556	384	100	96	4	2	346	391	76	59
Mo.	432	320	74	57	136	95	740	548	900	141
N. Dak.	130	699	24	56	—	—	37	40	4	3
S. Dak.	122	76	48	93	5	4	130	112	41	10
Nebr.	173	47	—	96	4	14	118	156	72	23
Kans.	435	114	72	95	6	—	323	332	206	70
S. ATLANTIC	1,176	696	1,447	1,985	782	735	10,907	9,908	2,030	2,576
Del.	15	3	—	9	4	5	112	102	11	8
Md.	158	124	289	291	84	65	734	750	95	137
D.C.	7	8	—	—	2	—	45	58	11	36
Va.	301	196	460	430	99	29	1,000	1,044	114	142
W. Va.	43	22	52	59	7	5	156	221	1	9
N.C.	98	79	420	536	443	477	1,470	1,431	179	310
S.C.	336	130	5	146	60	59	1,183	880	90	496
Ga.	32	19	216	309	66	78	1,660	1,747	511	583
Fla.	186	115	5	205	17	17	4,547	3,675	1,018	855
E.S. CENTRAL	434	262	130	138	256	188	2,614	2,422	1,079	783
Ky.	127	65	16	21	3	2	436	306	281	66
Tenn.	189	144	43	46	189	104	676	624	499	411
Ala.	77	37	69	60	60	54	675	655	212	258
Miss.	41	16	2	11	4	28	827	837	87	48
W.S. CENTRAL	1,554	819	794	1,006	147	197	3,176	3,805	2,372	3,208
Ark.	260	71	33	49	116	114	669	505	58	69
La.	34	16	—	4	5	5	740	860	124	277
Okla.	—	38	69	101	7	71	356	361	576	411
Tex.	1,260	694	692	852	19	7	1,411	2,079	1,614	2,451
MOUNTAIN	3,498	1,407	211	208	32	21	1,975	2,070	798	730
Mont.	544	50	15	25	1	3	100	177	5	4
Idaho	131	35	—	7	3	4	90	138	11	13
Wyo.	46	29	17	6	2	5	78	48	5	5
Colo.	1,202	745	16	47	5	4	517	488	147	142
N. Mex.	123	146	7	5	3	2	211	256	109	127
Ariz.	885	203	128	109	14	2	593	600	452	348
Utah	535	161	15	6	4	1	300	210	41	40
Nev.	32	38	13	3	—	—	86	153	28	51
PACIFIC	2,702	1,741	164	192	8	4	4,758	4,844	2,027	1,727
Wash.	756	644	U	U	—	—	470	491	125	97
Oreg.	565	427	6	6	1	2	335	389	113	77
Calif.	1,135	633	157	175	7	2	3,647	3,574	1,753	1,502
Alaska	113	13	1	11	—	—	48	55	7	6
Hawaii	133	24	—	—	—	—	258	335	29	45
Guam	—	—	—	—	—	—	—	50	—	42
P.R.	6	5	58	56	N	N	409	431	4	31
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 12, 2005, and November 13, 2004 (45th 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	3,697	3,839	1,828	1,894	716	696	6,836	6,755	223	335
NEW ENGLAND	156	246	107	140	56	98	184	168	1	4
Maine	10	11	N	N	—	7	1	2	—	—
N.H.	14	17	—	—	4	N	14	4	—	3
Vt.	9	8	11	6	5	3	1	—	—	—
Mass.	114	109	80	44	46	55	109	104	—	—
R.I.	9	21	16	18	1	6	20	23	—	1
Conn.	U	80	U	72	U	27	39	35	1	—
MID. ATLANTIC	763	638	174	131	122	106	851	864	25	32
Upstate N.Y.	227	207	68	57	53	74	77	81	6	4
N.Y. City	143	108	U	U	20	U	520	542	5	14
N.J.	153	132	N	N	22	8	113	129	14	13
Pa.	240	191	106	74	27	24	141	112	—	1
E.N. CENTRAL	731	863	488	423	177	162	708	774	29	53
Ohio	171	199	311	293	67	66	189	200	1	2
Ind.	91	89	165	130	45	37	55	53	1	3
Ill.	157	226	12	—	53	10	361	332	10	18
Mich.	277	265	—	N	—	N	72	160	14	30
Wis.	35	84	N	N	12	49	31	29	3	—
W.N. CENTRAL	233	276	40	18	80	92	211	141	5	5
Minn.	90	130	—	—	48	59	54	23	1	1
Iowa	N	N	N	N	—	N	4	5	—	—
Mo.	61	59	33	13	9	13	128	85	4	2
N. Dak.	9	11	2	—	4	4	1	—	—	—
S. Dak.	20	17	3	5	—	—	2	—	—	—
Nebr.	20	19	2	—	7	8	4	6	—	—
Kans.	33	40	N	N	12	8	18	22	—	2
S. ATLANTIC	809	779	718	946	71	53	1,729	1,716	37	55
Del.	5	3	1	4	—	N	10	8	—	1
Md.	180	131	—	—	46	38	262	312	13	9
D.C.	9	10	15	8	3	4	86	58	—	1
Va.	77	66	N	N	—	N	120	90	4	3
W. Va.	22	24	104	99	22	11	4	3	—	—
N.C.	115	118	N	N	U	U	227	171	8	10
S.C.	29	51	—	83	—	N	68	101	4	11
Ga.	155	179	111	242	—	N	319	336	1	4
Fla.	217	197	487	510	—	N	633	637	7	16
E.S. CENTRAL	154	196	147	138	13	15	384	357	18	21
Ky.	31	58	25	26	N	N	46	42	—	1
Tenn.	123	138	122	110	—	N	188	114	12	8
Ala.	—	—	—	—	—	N	115	149	5	10
Miss.	—	—	—	2	13	15	35	52	1	2
W.S. CENTRAL	231	303	99	70	141	135	1,106	1,076	65	66
Ark.	19	16	12	8	14	8	43	46	—	3
La.	6	2	87	62	24	31	223	280	11	5
Okla.	100	62	N	N	24	40	32	25	1	2
Tex.	106	223	N	N	79	56	808	725	53	56
MOUNTAIN	529	426	55	27	47	33	328	339	17	44
Mont.	—	—	—	—	—	—	5	1	—	—
Idaho	2	8	N	N	—	N	20	21	1	2
Wyo.	4	9	22	10	—	—	—	3	—	—
Colo.	183	96	N	N	46	33	33	55	1	1
N. Mex.	41	86	—	N	—	—	38	74	2	2
Ariz.	225	188	N	N	—	N	148	139	12	38
Utah	73	35	31	15	1	—	6	11	—	1
Nev.	1	4	2	2	—	—	78	35	1	—
PACIFIC	91	112	—	1	9	2	1,335	1,320	26	55
Wash.	N	N	N	N	N	N	126	119	—	—
Oreg.	N	N	N	N	6	N	22	25	—	—
Calif.	—	—	N	N	N	N	1,177	1,168	26	55
Alaska	—	—	—	—	—	N	6	1	—	—
Hawaii	91	112	—	1	3	2	4	7	—	—
Guam	—	—	—	—	—	—	—	1	—	—
P.R.	N	N	N	N	—	N	179	139	8	5
V.I.	—	—	—	—	—	—	—	4	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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* 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 November 12, 2005, and November 13, 2004 (45th 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	9,887	11,290	229	283	20,745	24,417	1,102	1,134	1,410
NEW ENGLAND	302	376	22	20	1,090	2,843	9	—	4
Maine	14	18	1	—	213	226	—	—	—
N.H.	6	14	—	—	260	—	—	—	—
Vt.	5	3	—	—	75	413	—	—	—
Mass.	200	215	13	14	542	603	4	—	2
R.I.	25	44	1	1	—	—	1	—	—
Conn.	52	82	7	5	U	1,601	4	—	2
MID. ATLANTIC	1,757	1,792	39	69	4,027	85	26	17	17
Upstate N.Y.	220	250	5	10	—	—	—	5	—
N.Y. City	857	886	15	28	—	—	10	2	4
N.J.	412	397	11	16	—	—	2	1	2
Pa.	268	259	8	15	4,027	85	14	9	11
E.N. CENTRAL	1,072	1,024	19	33	5,436	10,504	230	66	111
Ohio	214	175	2	6	1,258	1,230	45	11	14
Ind.	108	112	1	—	482	N	10	8	1
Ill.	506	457	6	16	68	5,217	130	29	86
Mich.	177	203	5	9	3,274	3,462	35	13	4
Wis.	67	77	5	2	354	595	10	5	6
W.N. CENTRAL	372	391	6	8	430	165	139	86	416
Minn.	159	148	5	4	—	—	16	13	26
Iowa	38	42	—	—	N	N	12	13	18
Mo.	82	97	—	2	318	5	16	27	13
N. Dak.	2	4	—	—	25	82	12	2	74
S. Dak.	11	8	—	—	87	78	35	6	197
Nebr.	28	32	—	2	—	—	36	7	80
Kans.	52	60	1	—	—	—	12	18	8
S. ATLANTIC	2,161	2,360	48	40	1,918	2,048	28	65	22
Del.	14	17	1	—	28	5	1	—	—
Md.	231	238	11	11	—	—	4	10	1
D.C.	42	74	—	—	34	21	—	1	—
Va.	259	246	17	8	471	481	—	4	—
W. Va.	21	20	—	—	946	1,168	—	—	N
N.C.	239	265	5	7	—	N	2	3	2
S.C.	190	158	—	—	439	373	4	—	—
Ga.	332	502	3	4	—	—	9	14	6
Fla.	833	840	11	10	—	—	8	33	13
E.S. CENTRAL	480	571	5	8	—	45	62	60	38
Ky.	87	101	2	3	N	N	4	1	—
Tenn.	227	197	—	5	—	—	13	13	3
Ala.	166	171	1	—	—	45	6	15	4
Miss.	—	102	2	—	—	—	39	31	31
W.S. CENTRAL	1,203	1,674	16	26	5,636	6,579	201	229	106
Ark.	91	102	—	—	11	—	11	16	15
La.	—	—	1	—	111	52	78	81	33
Okla.	123	145	1	1	—	—	12	16	9
Tex.	989	1,427	14	25	5,514	6,527	100	116	49
MOUNTAIN	325	439	9	7	2,208	2,148	134	322	204
Mont.	8	4	—	—	—	—	8	2	17
Idaho	—	3	—	—	—	—	2	1	7
Wyo.	—	4	—	—	52	45	6	2	6
Colo.	46	107	5	2	1,580	1,713	19	41	72
N. Mex.	18	24	—	—	149	U	20	31	13
Ariz.	196	179	2	2	—	—	44	214	44
Utah	26	34	1	1	427	390	21	6	30
Nev.	31	84	1	2	—	—	14	25	15
PACIFIC	2,215	2,663	65	72	—	—	273	289	492
Wash.	212	195	5	6	N	N	—	—	—
Oreg.	54	85	3	1	—	—	—	—	5
Calif.	1,812	2,249	45	59	—	—	273	289	487
Alaska	38	33	—	—	—	—	—	—	—
Hawaii	99	101	12	6	—	—	—	—	—
Guam	—	46	—	—	—	189	—	—	—
P.R.	—	98	—	—	557	358	—	—	—
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 November 12, 2005 (45th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
NEW ENGLAND	494	342	95	34	11	12	50
Boston, Mass.	142	90	29	14	4	5	15
Bridgeport, Conn.	32	29	2	1	—	—	3
Cambridge, Mass.	11	9	2	—	—	—	—
Fall River, Mass.	21	17	2	2	—	—	2
Hartford, Conn.	52	32	12	5	1	2	7
Lowell, Mass.	15	9	5	1	—	—	—
Lynn, Mass.	8	5	3	—	—	—	2
New Bedford, Mass.	15	12	2	1	—	—	1
New Haven, Conn.	31	21	3	3	1	3	7
Providence, R.I.	47	32	10	1	2	2	3
Somerville, Mass.	1	—	1	—	—	—	—
Springfield, Mass.	36	23	6	4	3	—	2
Waterbury, Conn.	29	23	5	1	—	—	3
Worcester, Mass.	54	40	13	1	—	—	5
MID. ATLANTIC	1,854	1,301	343	128	39	42	91
Albany, N.Y.	48	32	10	2	—	4	2
Allentown, Pa.	15	13	—	2	—	—	3
Buffalo, N.Y.	78	58	15	5	—	—	7
Camden, N.J.	28	12	7	6	—	3	1
Elizabeth, N.J.	15	8	2	2	3	—	2
Erie, Pa.	31	29	1	1	—	—	2
Jersey City, N.J.	19	13	3	3	—	—	—
New York City, N.Y.	939	688	164	59	13	15	43
Newark, N.J.	41	23	9	7	—	2	3
Paterson, N.J.	12	8	2	1	1	—	1
Philadelphia, Pa.	257	117	77	27	19	16	7
Pittsburgh, Pa.§	33	26	6	1	—	—	—
Reading, Pa.	18	16	1	1	—	—	3
Rochester, N.Y.	115	87	19	6	2	1	6
Schenectady, N.Y.	23	20	3	—	—	—	2
Scranton, Pa.	41	35	5	—	—	1	1
Syracuse, N.Y.	89	78	9	2	—	—	4
Trenton, N.J.	18	13	4	1	—	—	1
Utica, N.Y.	21	17	2	1	1	—	1
Yonkers, N.Y.	13	8	4	1	—	—	2
E.N. CENTRAL	1,952	1,285	441	147	47	31	114
Akron, Ohio	58	36	17	2	1	2	1
Canton, Ohio	39	26	10	2	1	—	4
Chicago, Ill.	255	154	64	29	6	1	21
Cincinnati, Ohio	85	52	14	11	3	5	10
Cleveland, Ohio	232	168	42	12	4	6	12
Columbus, Ohio	213	136	44	20	10	3	13
Dayton, Ohio	89	62	21	5	—	1	4
Detroit, Mich.	136	75	43	12	5	1	8
Evansville, Ind.	47	32	13	1	—	1	2
Fort Wayne, Ind.	73	56	15	2	—	—	4
Gary, Ind.	12	3	5	3	—	1	—
Grand Rapids, Mich.	62	46	13	1	—	2	9
Indianapolis, Ind.	257	164	57	20	12	4	9
Lansing, Mich.	36	26	7	1	1	1	2
Milwaukee, Wis.	89	58	25	5	1	—	4
Peoria, Ill.	35	25	7	3	—	—	2
Rockford, Ill.	62	46	8	6	—	2	4
South Bend, Ind.	44	37	3	2	1	1	1
Toledo, Ohio	88	54	25	7	2	—	3
Youngstown, Ohio	40	29	8	3	—	—	1
W.N. CENTRAL	520	310	132	46	12	20	41
Des Moines, Iowa	60	39	16	2	1	2	4
Duluth, Minn.	14	10	3	—	—	1	2
Kansas City, Kans.	21	10	6	2	—	3	1
Kansas City, Mo.	84	45	22	10	2	5	6
Lincoln, Nebr.	41	32	8	1	—	—	3
Minneapolis, Minn.	47	27	11	5	2	2	4
Omaha, Nebr.	72	46	16	4	3	3	3
St. Louis, Mo.	87	39	33	9	3	3	7
St. Paul, Minn.	41	27	9	4	1	—	5
Wichita, Kans.	53	35	8	9	—	1	6
S. ATLANTIC	1,040	658	241	89	35	17	43
Atlanta, Ga.	120	68	32	12	7	1	4
Baltimore, Md.	145	84	40	14	4	3	13
Charlotte, N.C.	94	64	18	9	1	2	5
Jacksonville, Fla.	130	80	29	12	5	4	4
Miami, Fla.	123	83	26	8	4	2	3
Norfolk, Va.	44	32	7	3	1	1	1
Richmond, Va.	58	34	13	8	3	—	4
Savannah, Ga.	30	26	3	—	1	—	3
St. Petersburg, Fla.	47	31	11	2	2	1	2
Tampa, Fla.	135	92	28	10	3	2	2
Washington, D.C.	102	54	32	11	4	1	1
Wilmington, Del.	12	10	2	—	—	—	1
E.S. CENTRAL	737	488	168	55	15	11	49
Birmingham, Ala.	173	126	35	6	5	1	11
Chattanooga, Tenn.	61	41	11	6	3	—	4
Knoxville, Tenn.	94	68	19	5	1	1	1
Lexington, Ky.	34	22	10	1	—	1	4
Memphis, Tenn.	120	67	36	14	1	2	9
Mobile, Ala.	65	38	14	9	1	3	3
Montgomery, Ala.	36	27	4	5	—	—	1
Nashville, Tenn.	154	99	39	9	4	3	16
W.S. CENTRAL	1,374	876	327	106	38	27	75
Austin, Tex.	81	53	15	7	3	3	3
Baton Rouge, La.	140	110	23	7	—	—	4
Corpus Christi, Tex.	39	29	6	2	—	2	2
Dallas, Tex.	188	102	46	27	6	7	13
El Paso, Tex.	131	94	25	10	2	—	10
Ft. Worth, Tex.	105	59	30	8	2	6	3
Houston, Tex.	288	169	90	15	11	3	14
Little Rock, Ark.	80	46	25	5	3	1	—
New Orleans, La.¶	U	U	U	U	U	U	U
San Antonio, Tex.	186	120	40	16	7	3	12
Shreveport, La.	44	29	10	4	—	1	6
Tulsa, Okla.	92	65	17	5	4	1	8
MOUNTAIN	914	595	192	77	33	15	43
Albuquerque, N.M.	101	67	19	12	2	1	8
Boise, Idaho	21	17	3	1	—	—	1
Colo. Springs, Colo.	53	36	13	2	2	—	—
Denver, Colo.	84	48	24	6	3	3	5
Las Vegas, Nev.	220	142	50	18	6	4	9
Ogden, Utah	25	18	2	2	2	1	1
Phoenix, Ariz.	151	86	31	21	7	4	11
Pueblo, Colo.	26	21	3	1	—	1	3
Salt Lake City, Utah	115	77	24	6	7	1	5
Tucson, Ariz.	118	83	23	8	4	—	—
PACIFIC	1,299	903	270	68	29	29	113
Berkeley, Calif.	8	7	1	—	—	—	—
Fresno, Calif.	52	33	14	2	2	1	7
Glendale, Calif.	3	2	1	—	—	—	1
Honolulu, Hawaii	58	53	3	2	—	—	4
Long Beach, Calif.	70	49	13	4	2	2	10
Los Angeles, Calif.	119	66	30	15	5	3	10
Pasadena, Calif.	19	15	3	1	—	—	2
Portland, Oreg.	102	64	30	4	—	4	3
Sacramento, Calif.	213	146	43	9	7	8	13
San Diego, Calif.	133	96	28	5	2	2	18
San Francisco, Calif.	100	62	23	11	—	4	12
San Jose, Calif.	150	112	27	6	5	—	20
Santa Cruz, Calif.	23	17	3	1	2	—	4
Seattle, Wash.	96	62	28	4	1	1	3
Spokane, Wash.	48	38	8	1	1	—	2
Tacoma, Wash.	105	81	15	3	2	4	4
TOTAL	10,184**	6,758	2,209	750	259	204	619

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.

¶ Because of Hurricane Katrina, weekly reporting of deaths has been temporarily disrupted.

** Total includes unknown ages.

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☆U.S. Government Printing Office: 2006-523-142/40003 Region IV ISSN: 0149-2195