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Mumps Epidemic — United Kingdom, 2004–2005

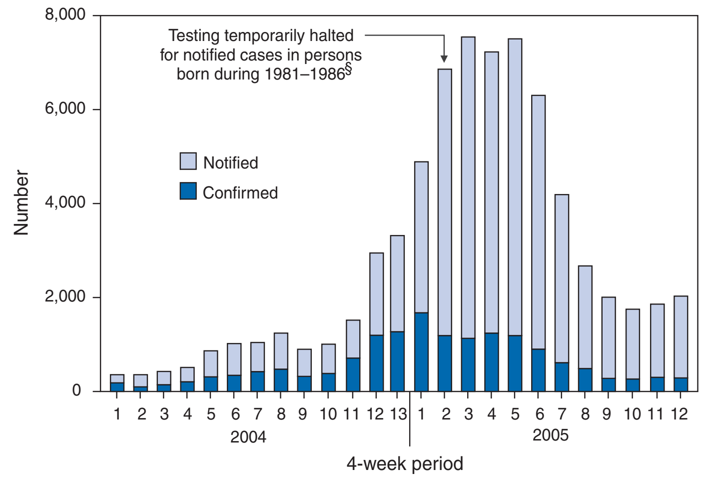
During 2004–2005, the United Kingdom (UK) experienced a nationwide epidemic of mumps, which peaked during 2005 when 56,390* notified cases were reported in England and Wales. The majority of confirmed cases during 2004–2005 were in persons aged 15–24 years, most of whom had not been eligible for routine mumps vaccination. Mumps usually is a self-limited viral disease that appears as parotitis. However, mumps also can lead to serious complications such as encephalitis or pancreatitis. This report summarizes the epidemiology of the 2004–2005 mumps epidemic in England and Wales.

Reporting was based on notified cases (i.e., clinically diagnosed cases of mumps reported by general practitioners). Since late 1994, laboratory confirmation of all notified cases of mumps has been recommended using a test to detect mumps-specific IgM antibodies in either serum or an oral fluid (*1*). The proportion of such cases began to increase in 1999 and increased further in each subsequent year, indicating an increase in the incidence of true infection.

The number of notified cases began increasing in 2003 and continued to increase during 2004–2005, accompanied by further increases in the proportion of confirmed cases (Figure 1). During 2004, a total of 16,367 cases were notified; 10,641 (65.0%) of these were tested for oral fluid IgM, and 6,047 of those cases (56.8%) were determined to be IgM positive. When combined with those cases confirmed by serum IgM testing, a total of 8,128 (49.7%) cases were laboratory confirmed during 2004, compared with 3,907 (29.9%) of 13,087 notified cases during 1999–2003. In February 2005, because of high rates of laboratory confirmation of cases among persons born during 1981–1986, the UK Health Protection Agency recommended a temporary halt to testing persons with

* Provisional total.

FIGURE 1. Number of notified* cases of mumps and proportion of cases that were laboratory confirmed† — England and Wales, 2004–2005



* Clinically diagnosed cases of mumps reported by general practitioners.
† Cases confirmed by measure of mumps-specific IgM in oral fluid samples only.
§ The number of confirmed cases is artificially low from the second 4-week period in 2005 through the end of the year because of this temporary change in the oral fluid testing program.

INSIDE

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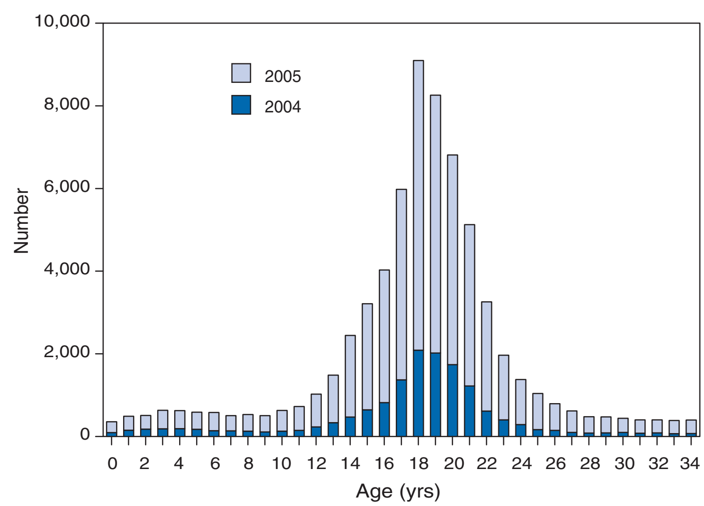
notified cases of mumps born during those years (*2*), although persons in other age groups with lower rates of confirmation continued to be tested. Testing for all age groups resumed in January 2006 after a sustained decline in the number of notified cases in the last quarter of 2005.

During 2004, approximately 79.1% of confirmed cases were in persons aged 15–24 years. Among all mumps patients during 2004, approximately 3.3% were reported as having received 2 doses of measles, mumps, and rubella (MMR) vaccine, and another 30.1% had received 1 dose of MMR. The number of notified cases of mumps continued to increase through the first 6 months of 2005, with 20,653 cases occurring during the first quarter and 21,981 cases during the second quarter. During the third quarter of 2005, the number of notified cases decreased by 64.0% to 7,907; during the fourth quarter, a further decrease to 5,882 notified cases was observed (Figure 1). During the first month of 2006, notified cases of mumps averaged approximately 500 per week.

During 2005, the majority of notified mumps cases were in persons aged 19–23 years and attending colleges or universities (Figure 2); the third-quarter decrease in the number of notified cases coincided with summer vacations. Local health services have been encouraged by the UK Health Protection Agency to ensure that all students have received 2 doses of MMR before leaving school. In addition, many universities have advised enrolling first-year students to receive MMR vaccination before arriving at college.

FIGURE 2. Number of notified* cases of mumps, by patient age — England and Wales, 2004–2005†



* Clinically diagnosed cases of mumps reported by general practitioners.
† Excludes 200 cases in 2004 and 784 in 2005 with patient date of birth unknown and 1,162 cases in 2004 and 4,404 in 2005 in persons aged >35 years.

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Editorial Note: In October 1988, mumps vaccination was added to the UK vaccination schedule as part of the new combined MMR vaccine. MMR replaced single measles vaccine offered at age 12–15 months; since 1996, a second dose of MMR has been offered at age 3.5–5 years. Vaccination coverage in the UK peaked during 1995, when 92% of children aged 2 years were reported as having received at least 1 dose of MMR. As of the second quarter of 2005, vaccination coverage with at least 1 dose by age 2 years had declined to 82%, with 75% of children having received 2 doses by age 5 years.

During November 1994, approximately 8 million school children aged 5–16 years (i.e., born during September 1978–August 1989) were offered combined measles-rubella vaccine to prevent a predicted epidemic of measles. At that time, a global shortage prevented offering MMR to this group. Therefore, a proportion of the 8 million children remained susceptible to mumps. Modelling based on serologic surveillance data for 1993 estimated that 19% of children aged 11–15 years in 1997 (i.e., aged 19–23 years in 2005) would be susceptible to mumps (*4*).

The 2004–2005 mumps epidemic in the UK did not result from the decrease in MMR vaccination coverage in recent years, but rather from gaps in eligibility of certain cohorts, which has been evident during the epidemic by the age breakdown among patients with confirmed cases; mumps occurred predominantly in older teens and young adults, with the highest attack rate occurring in those born during 1983–1986 (*3*). Persons born before September 1987 generally were not eligible for any routine mumps vaccination, although some might have received 1 dose of MMR upon school entry as part of a catch-up campaign after October 1988 that targeted children who missed their measles vaccination. Persons born before 1982 are more likely to have been exposed to mumps infection when it was still a common childhood disease. Only 2.4% of confirmed cases in 2004 occurred in persons who would have been eligible for 2 doses of MMR routinely.

The UK epidemic illustrates the susceptibility of certain cohorts who have not been vaccinated and have not developed immunity through exposure to mumps because of a decrease in mumps circulation after implementation of a childhood immunization program. The epidemic also underscores the importance of ensuring high levels of mumps immunity among adolescents and young adults when vaccination with mumps-containing vaccine is introduced into the routine immunization schedule for children.

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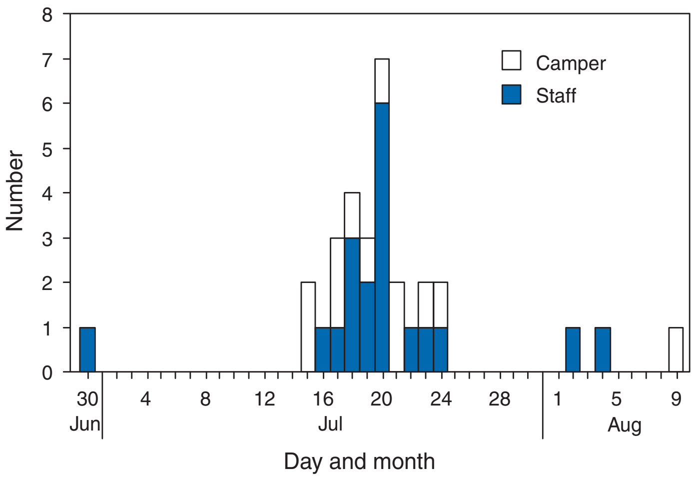
Mumps Outbreak at a Summer Camp — New York, 2005

On July 26, 2005, the Sullivan County Health Department (SCHD) and the New York State Department of Health (NYSDOH) were notified of a cluster of cases of parotitis among campers and staff members at a summer camp. An investigation conducted by NYSDOH identified 31 cases of mumps, likely introduced by a camp counselor who had traveled from the United Kingdom (UK) and had not been vaccinated for mumps. This report summarizes the results of the subsequent investigation by NYSDOH, which determined that, even in a population with 96% vaccination coverage, as was the case with participants in the summer camp, a mumps outbreak can result from exposure to virus imported from a country with an ongoing mumps epidemic.

Camp was in session during June 28–August 18. A case of mumps was defined as unilateral or bilateral parotitis of >2 days' duration with no other apparent cause in a camper or staff member who was examined during June 30–September 1, 2005 (*1*). Among 541 campers and staff members, 31 cases of mumps were identified (attack rate: 5.7%), with illness onsets during June 30–August 9 (Figure). The index patient was a man aged 20 years who resided in the UK and who had not been vaccinated for mumps. The man came to the United States on June 19 to work as a counselor at the camp; on June 30, he had left-sided parotitis, sore throat, and a low-grade fever. However, mumps was not considered as a diagnosis by health-care staff members at the infirmary.

The patient was not isolated and continued to work among the camp population. During July 15–23, a total of 25 additional cases of parotitis were identified, consistent with exposure beginning June 28. However, the diagnosis of mumps was not made by members of the health-care staff at the infirmary or by community health-care providers for any patient with parotitis until July 24. SCHD and NYSDOH were alerted to a possible outbreak on July 26, and diagnosis of mumps for the first 23 (74%) cases was made via retrospective chart

FIGURE. Number* of cases of mumps at a summer camp, by date of onset and participant status — New York, June 30–August 9, 2005



* N = 31.

review by NYSDOH on July 27. At that time, five (16%) patients were either symptomatic or in isolation. Subsequently, an additional three (10%) cases were identified, beginning on August 2.

Of the 31 mumps cases identified, 17 (55%) were in females. All patients had parotitis, 24 (77%) had jaw pain, and eight (26%) had bilateral disease. Four male patients had unilateral orchitis; all recovered spontaneously. Specimens for serology and viral culture/nucleic acid detection (i.e., nasopharyngeal swabs and urine) were obtained from six patients. All six serologic specimens tested positive for mumps-specific IgM; however, no virus was successfully amplified or cultured from any clinical specimen.

Twelve (39%) of the 31 mumps cases were among campers (Figure). All were U.S. residents aged 10–15 years who had been vaccinated with 2 doses of measles, mumps, and rubella (MMR) vaccine after the first birthday. Nineteen (61%) of the mumps cases were among staff members; of these, nine (47%) were UK residents, five (26%) were U.S. residents, three (16%) were residents of Australia, and two (11%) were residents of Germany. Staff members with mumps ranged in age from 19 to 41 years (median: 21 years). Of the 17 staff members with mumps for whom vaccination history could be obtained by vaccination or medical record, nine (53%) had not been vaccinated for mumps, four (24%) had been vaccinated with 1 dose, and four (24%) had been vaccinated with 2 doses of a mumps-containing vaccine. Symptoms, illness duration, and complications (e.g., orchitis) did not differ substantially between vaccinated and unvaccinated patients.

Outbreak-control measures were instituted at the camp immediately after SCHD and NYSDOH were notified on July 26. Persons exhibiting signs or symptoms of mumps were isolated from other campers and staff members for 9 days after onset of symptoms. A total of 513 persons who were neither known to have mumps nor symptomatic for mumps were quarantined to the grounds of the camp; these persons were not permitted to enter or leave the camp until their mumps immunity status had been verified. Mumps immunity was assessed in accordance with Advisory Committee on Immunization Practices (ACIP) criteria as follows: 1) birth before 1957, 2) history of physician-diagnosed mumps before arriving at camp, 3) laboratory evidence of mumps immunity (i.e., positive for mumps-specific IgG), or 4) receipt of 1 dose of a mumps-containing vaccine on or after the first birthday, as documented by a health-care provider (*1*). Twenty persons who could not verify their vaccination status and did not meet any other immunity criteria had their sera tested for mumps-specific IgG.

A total of 73 persons without immunity or with a record of 1 dose of mumps-containing vaccine were administered MMR vaccine. Mumps information was provided to camp personnel, and alerts were distributed to health-care providers statewide. Letters from NYSDOH, written in collaboration with the camp operators, were sent to the parents of campers and directors of other New York camps. After August 9, 2005, no further reports of mumps disease were received at the camp, in the county where the camp was located, or in any U.S. counties of origin for campers and staff members.

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Editorial Note: Mumps generally is a mild and self-limited viral infection; an estimated 15%–20% of infections are asymptomatic. However, infections occasionally can lead to serious complications, with or without parotitis. Meningitis occurs in an estimated 15% of cases, of which a small percentage can progress to encephalitis and permanent central nervous system sequelae; pancreatitis is observed in approximately 4% of cases and sensorineural deafness in an estimated one in 20,000 cases (*2*). First-trimester mumps infection in pregnant women is associated with a 25% incidence of spontaneous abortion (*2*). In addition, mumps causes orchitis in approximately 40% of postpubertal males, with infertility as a rare consequence (*2*). The number of mumps cases reported annually in the United States ranged from 231 to 277 cases during 2001–2005. However, mumps remains endemic in many countries throughout the world, and mumps vaccine is used in only 57% of World Health Organization member-countries, predominantly in countries with more developed economies (*2,3*).

Mumps vaccine was first licensed in the United States in 1967; vaccination with at least 1 dose of mumps-containing vaccine has been required for school entry in New York since 1986. MMR vaccination coverage in the United States has been estimated at >90% among children aged 19–35 months since 1994.* During 2004–2005, estimates of immunity to mumps in New York, according to ACIP criteria, were 96% in schools and 98% in post-secondary institutions (D. Gonzalez, NYSDOH Immunization Program, personal communication, 2006).

Previous investigations of mumps outbreaks reported similar clinical symptoms among vaccinated and unvaccinated patients (*4*). With the decrease in mumps incidence in the United States, health-care providers have become less likely to suspect mumps in patients with parotitis. In the camp outbreak, although patients were evaluated by multiple health-care providers, including camp and hospital physicians, parotitis was not recognized as mumps until well into the outbreak. Providers, parents, and child-care and school staff members need to be aware of mumps signs and symptoms, potential complications, and communicability and the need to suspect mumps regardless of patient vaccination status. In addition, given the low prevalence of mumps in the U.S. population, laboratory confirmation should be encouraged to diagnose mumps accurately (*5,6*).

In the camp outbreak, mumps likely was introduced by an unvaccinated counselor who traveled from the UK, where an epidemic of mumps was ongoing, with 56,390 notified cases reported during 2005 in England and Wales (*7*). The likelihood of disease in U.S. residents as a result of imported virus from areas with mumps epidemics remains high (*5*). Vaccination of counselors who will be working in summer camps is recommended, particularly because mumps vaccine effectiveness can be <85% in outbreak settings (*4,8,9*). As a result of this outbreak, agencies involved in assigning foreign staff to U.S. camps and organizations of camp administrators have begun revising their admission requirements to include immunity to vaccine-preventable diseases such as mumps.

The outbreak described in this report likely resulted from a combination of delay in diagnosis of mumps and failure to report the cluster of illnesses in a timely manner, in addition to close contact and social mixing among camp participants. Controlling the outbreak resulted in a substantial burden on the camp and its staff, including cancellation of activities and likely loss of revenue. Previous mumps outbreaks also have carried substantial burden, particularly with respect to costs associated with school absenteeism (*9*). To prevent large outbreaks of mumps in their communities, U.S. health-care providers should suspect mumps independent of vaccination history, diagnose mumps by using laboratory testing, and report mumps immediately to local health authorities.

Acknowledgments

The findings in this report are based, in part, on contributions from staff of the New York State Dept of Health Immunization Program; and from C LeBaron, MD, National Immunization Program, and L Lowe and N Williams, National Center for Infectious Diseases, CDC.

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Hypertension-Related Mortality Among Hispanic Subpopulations — United States, 1995–2002

Hypertension remains a major public health problem in the United States even though effective therapy has been available for more than 50 years (*1*). Hypertension is a strong independent risk factor for heart disease and stroke and a predictor of premature death and disability from cardiovascular complications (*2*). Although age-adjusted prevalence of hypertension is lower among Hispanics than among blacks or non-Hispanic whites (*3–5*), recent data indicate that certain Hispanic subpopulations (Mexican Americans, Puerto Rican Americans, Cuban Americans, and other Hispanic Americans) are characterized by low levels of hypertension awareness, treatment, and control. Because Hispanics are the fastest growing and youngest racial/ethnic population in the United States (*6*), targeted strategies to reduce morbidity and mortality rates among this population are essential. Since 1995, information

* National Immunization Surveys, 1994–2004. Available at http://www.cdc.gov/nip/coverage/default.htm#nis.

on Hispanic ethnicity has been provided on nearly all death certificates issued in the United States.* Although data on Hispanic subpopulations are also available on death certificates, no national mortality statistics on hypertension-related deaths among specific Hispanic subpopulations have been published. To compare age-standardized, hypertension-related death rates among Hispanic subpopulations, CDC analyzed death certificate data from 1995 and 2002. This report describes the results of that analysis, which indicated that Puerto Rican Americans had consistently higher hypertension-related mortality (HRM) rates than all other Hispanic subpopulations and non-Hispanic whites. Comprehensive hypertension prevention and control programs are needed to target these Hispanic subpopulations.

National death certificate data were obtained from the multiple cause-of-death files compiled by CDC. Most analyses of mortality data are based on the underlying cause of death (i.e., the disease or injury that initiated the sequence of events leading directly to death). However, hypertension is not only an important underlying cause of death but also is a common complicating factor for other disease. Therefore, in this report, hypertension-related mortality (HRM) includes those deaths for which hypertension (*International Classification of Diseases, Ninth Revision* (ICD-9) codes 401-404 for 1995 and ICD-10 codes I10-I13 for 2002) was reported either as the underlying cause or as a contributory cause of death (i.e., a condition reported on the death certificate other than the underlying cause). Included are deaths attributed to essential hypertension (i.e., high blood pressure with no identifiable cause), hypertensive heart disease, hypertensive renal disease, hypertensive heart and renal disease, and secondary hypertension. This report was limited to deaths occurring in the 50 states and the District of Columbia among U.S. residents aged ≥25 years. Age-standardized death rates based on the 2000 U.S. standard population were estimated for non-Hispanic whites, Hispanics, and four Hispanic subpopulations (Mexican Americans, Puerto Rican Americans, Cuban Americans, and other Hispanic Americans). Population denominators from the U.S. Census Bureau used to calculate death rates included postcensal estimates of the U.S. resident population for 2002 and intercensal population estimates for 1995. The change in HRM from 1995 to 2002 among Hispanic subpopulations was defined as the percentage change in age-standardized death rates. Non-Hispanic whites were the referent group for all estimates of HRM disparity.

In 2002, a total of 13,526 hypertension-related deaths were reported among all Hispanics, compared with 209,833 among all non-Hispanic whites. The age-standardized HRM rate was 127.2 per 100,000 population for all Hispanics, similar to that of non-Hispanic whites (135.9). The age-standardized HRM rate for Hispanic women (118.3) was substantially lower than that observed for Hispanic men (135.9) (Table). Male HRM rates were higher than female rates for all Hispanic subpopulations. Puerto Rican Americans had the highest death rate among all Hispanic subpopulations (154.0), and Cuban Americans had the lowest (82.5). Compared with non-Hispanic whites, Puerto Rican Americans had 13% (p<0.01) higher age-standardized HRM rates; other Hispanic Americans were 12% (p<0.01) higher. Age-standardized HRM rates for Cuban Americans were 39% lower (p<0.01) than those for non-Hispanic whites. Rates for Mexican Americans did not differ significantly from non-Hispanic whites (95% CI = 0.97–1.01) (Figure 1).

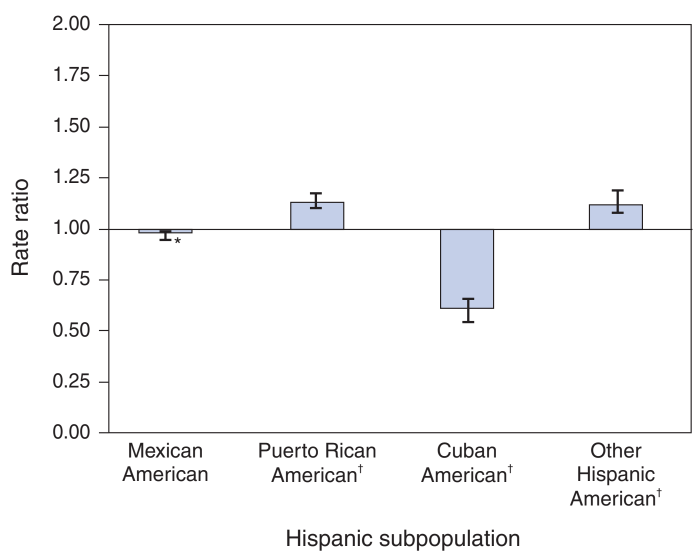
* Oklahoma did not provide this information until 1997.

TABLE. Number and age-standardized rate* of hypertension-related deaths among Hispanics aged ≥25 years, compared with non-Hispanic whites, by sex and subpopulation — United States, 2002

Characteristic	No. of deaths	Rate
All Hispanics	**13,526**	**127.2**
Sex		
Male	6,477	135.9
Female	7,049	118.3
Hispanic subpopulation		
Mexican American	7,662	134.5
Puerto Rican American	1,901	154.0
Cuban American	1,264	82.5
Other Hispanic American	2,699	152.4
Non-Hispanic whites	**209,833**	**135.9**

* Per 100,000 population.

FIGURE 1. Rate ratios of age-standardized, hypertension-related mortality rates among adults aged ≥25 years, comparing selected Hispanic subpopulations to non-Hispanic whites — United States, 2002



* 95% confidence interval.
† p<0.01.

In 1995, age-standardized HRM rates (per 100,000 population) were highest among Puerto Rican Americans (159.9), followed by non-Hispanic whites (107.4), other Hispanic Americans (104.3), Mexican Americans (102.9), and Cuban Americans (87.0) (Figure 2). HRM rates increased for Mexican and other Hispanic Americans but decreased for Puerto Rican and Cuban Americans. The greatest percentage increase from 1995 to 2002 was 46.1% ($p<0.01$) for other Hispanic Americans, followed by increases of 30.7% ($p<0.01$) for Mexican Americans and 26.5% ($p<0.01$) for non-Hispanic whites. A 5.2% ($p<0.01$) decrease occurred from 1995 to 2002 among Cuban Americans, and a 3.7% decrease was observed among Puerto Rican Americans.

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Editorial Note: HRM rates increased substantially in the United States during 1995–2002, especially among the Hispanic population. This trend is most evident among Mexican Americans and other Hispanic Americans, who experienced the greatest percentage increases in HRM from 1995 to 2002. Although their HRM rate decreased slightly from 1995 to 2002, Puerto Rican Americans had the highest death rates during all years surveyed, compared with other Hispanic subpopulations and non-Hispanic whites. The higher HRM rates among Puerto Ricans might be the result of greater prevalence of the classic risk factors for hypertensive conditions, including diabetes mellitus, obesity, and physical inactivity in this population. Compared with non-Hispanic whites, Mexican Americans have a three- to five-fold higher incidence of diabetes mellitus and a three-fold higher prevalence of obesity (*4*); however, their HRM rates are only 4% higher than that of whites. In addition, Mexican American (39%) and Cuban American (34%) women are nearly as likely to be overweight as Puerto Rican American women (37%); however, they have lower HRM rates (*7*). Because diabetes and overweight are risk factors for hypertension, these higher prevalences could place these populations at higher risk for HRM in the future.

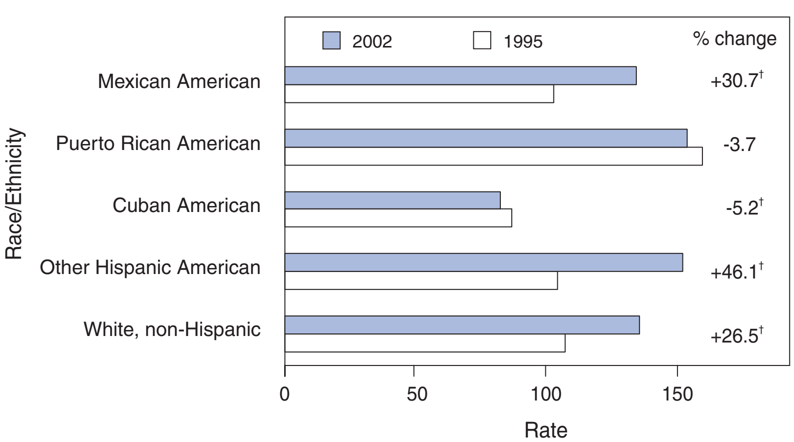
The Hispanic population is estimated to account for approximately 13% (35.3 million) of the total 2000 U.S. population. On the basis of current trends, the Hispanic population is projected to increase 2% per year until 2030 and will account for 25% (81 million) of the total U.S. population by 2050. Similar demographic trends have also been projected for Hispanic subpopulations (*3*).

A recent study revealed that, among hypertensive persons, Mexican Americans were less likely than non-Hispanic whites to be treated for hypertension (35% versus 49%, respectively) (*5*). Hispanics, although generally thought to have lower blood pressure as a population, received therapy for their hypertension in clinics only 50% of the time, and thus were at increased risk for HRM (*8*). Moreover, untreated hypertension elevates risk for mortality and morbidity from diseases of the heart and stroke, the first and third leading causes of death in the United States, respectively (*9*).

The findings of this study are subject to at least two limitations. First, the multiple-cause mortality data are subject to errors in the certification of cause of death and in the reporting of Hispanic origin and Hispanic subpopulations. Problems associated with the underreporting of Hispanic origin on death certificates and undercoverage in population estimates are well documented (*10*). Second, misreporting and undercoverage might also vary by Hispanic subpopulation. However, the overall quality and completeness of the mortality data from the vital statistics system are a strength of this study.

Two major Hispanic subpopulations (Mexican Americans and other Hispanic Americans) have HRM rates that have substantially increased from 1995 to 2002. Although HRM rates have also increased 26% in the general non-Hispanic population, the rate of increase for these subpopulations has been higher. Three factors might contribute to this growing burden: the increasing Hispanic population (*3*), the increased risk for HRM among Hispanics, and the low percentage of hypertensive Hispanics receiving therapy for hypertension (*5*). Only 45% of U.S. persons with hypertension receive therapy for their condition; this figure is considerably lower

FIGURE 2. Age-standardized, hypertension-related mortality rates* and relative percentage changes among adults aged ≥25 years for non-Hispanic whites and selected Hispanic subpopulations — United States, 1995 and 2002



* Per 100,000 population.
† $p<0.01$.

(34%) among Mexican Americans (*5*). Even fewer Mexican Americans have their hypertension under control (17%), compared with non-Hispanic whites (30%) (*5*). Awareness, treatment, and control of hypertension among members of these subpopulations is critical if the burden of hypertension and its serious heart disease and stroke sequelae are to be reduced.

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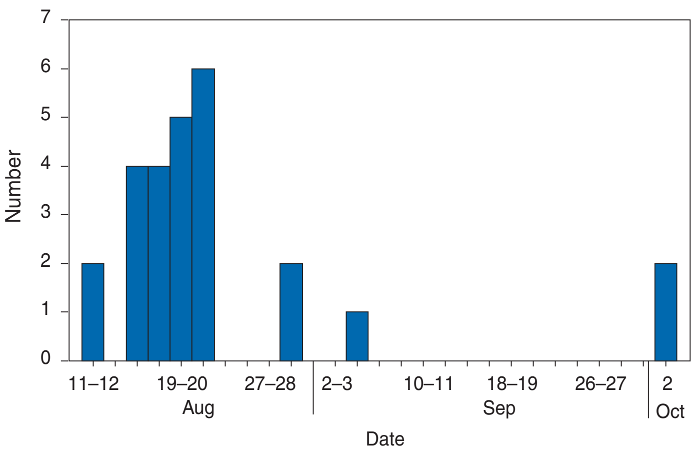
Multistate Outbreak of *Salmonella* Typhimurium Infections Associated with Eating Ground Beef — United States, 2004

Salmonella infections cause an estimated 1.4 million human illnesses and 400 deaths annually in the United States (*1*). Although the incidence of several other foodborne bacterial infections decreased substantially during 1996–2004, the incidence of *Salmonella* infections declined modestly (*2*). In September 2004, the New Mexico Department of Health received reports from the New Mexico Scientific Laboratory Division of eight *Salmonella enterica* serotype Typhimurium isolates that had indistinguishable pulsed-field gel electrophoresis (PFGE) patterns using *Xba*I and *Bln*I restriction enzymes. The patients were from three New Mexico counties and had onsets of illness during August 18–29. A review of PFGE patterns submitted to the National Molecular Subtyping Network for Foodborne Disease Surveillance (PulseNet) database for *Salmonella* revealed 31 indistinguishable patient isolates of *S.* Typhimurium from nine states (Colorado, Kansas, Minnesota, New Jersey, New Mexico, New York, Ohio, Tennessee, and Wisconsin) and the District of Columbia, with illness onset occurring during August 11–October 2, 2004. The *S.* Typhimurium isolates were susceptible to all antimicrobial agents tested. An investigation conducted by state health departments, CDC, and the U.S. Department of Agriculture Food Safety and Inspection Service (FSIS) identified ground beef purchased at a national chain of supermarkets as the source of *S.* Typhimurium infections. Traceback results indicated product originating from a common supplier; however, evaluators determined that plant practices conformed to FSIS production guidelines, and no product recalls were made. This report describes the investigation and underscores the risk for salmonellosis from contact with contaminated ground beef, despite regulatory directives to reduce *Salmonella* contamination in beef production. Reduced contamination and consumption of raw or undercooked meat and further education of the food service industry and consumers are critical to reducing foodborne salmonellosis.

A case was defined as infection with *S.* Typhimurium with a PFGE pattern indistinguishable from the outbreak pattern. Participating health departments (Colorado, Kansas, Minnesota, New Mexico, Ohio, Wisconsin, and District of Columbia) used questionnaires to collect detailed information about patient history of food consumption before illness onset. After careful review of food histories and information on other possible exposures among patients, contaminated ground beef was suspected as the vehicle for this outbreak. Several patients reported having eaten ground beef purchased at the same national chain of supermarkets (chain A). To identify exposures associated with illness and to investigate the source of potentially contaminated ground beef, the participating health departments conducted a case-control study during September 30–October 19, 2004. The case-control study included case-patients from the six states and the District of Columbia and controls identified by sequential telephone digit dialing. The controls were matched by age group (ages 2–10, 11–17, 18–60, and >60 years) to case-patients and had no reported gastrointestinal illness within 7 days before onset of illness of the matched case-patients. Case-patients and controls were asked detailed questions regarding ground beef consumption and brand, location, and date of purchase of ground beef.

Twenty-six of 31 case-patients (Figure) and 46 controls were enrolled in the case-control study. Five patients were not enrolled in the study; three were from states that declined to participate, and two could not be contacted. Fourteen (53.9%) case-patients were female, and the median age was 30.5 years

FIGURE. Number of culture-positive patients* with *Salmonella enterica* serotype Typhimurium, by date of illness onset — Colorado, Kansas, Minnesota, New Mexico, Ohio, Wisconsin, and District of Columbia, August 11–October 2, 2004



* N = 26.

(range: 2–80 years). Twenty-one (47.7%) controls were female, and the median age was 35 years (range: 2–87 years). Symptoms reported by the case-patients included diarrhea (100%), abdominal cramps (92%), fever (92%), vomiting (65%), and bloody diarrhea (46%). Median duration of illness was 7.5 days (range: 2–30 days); 35% of patients were hospitalized. No patients died.

Of the 26 case-patients, 23 with matched controls were included in the analyses (three with no matched controls were excluded). Among 23 matched case-patients, 21 (91%) reported eating ground beef during the 7 days before illness, compared with 37 (80%) of 46 controls (matched odds ratio [mOR] = 2.4; 95% confidence interval [CI] = 0.5–11.8). Ten (44%) matched case-patients reported eating raw or undercooked ground beef or tasting the beef while cooking, compared with eight (17%) controls (mOR = 7.4; CI = 1.2–44.6). Among 21 case-patients who ate ground beef, 15 (71%) purchased the beef within 3 weeks before illness onset from chain A, compared with nine (24%) controls (mOR = 12.7; CI = 1.6–99.2).

The Minnesota Department of Agriculture tested a sample of leftover frozen ground beef provided by a Minnesota case-patient. The sample yielded *S.* Typhimurium with a PFGE pattern indistinguishable from the outbreak pattern.

For seven case-patients who reported consumption of ground beef purchased at chain A, shopper cards or purchase receipts were used to determine the source of ground beef and its production date. Traceback results indicated that the ground beef was packaged at three processing plants. One supplier common to all three plants was identified, although beef was mixed at the three processing plants with ingredients from other suppliers. Two other case-patients provided approximate dates for when they purchased ground beef at chain A; records indicated that their purchases could have been from one of the three implicated plants with product originating from the common supplier.

FSIS evaluators assessed the three processing plants and their common supplier by reviewing existing FSIS records and internal plant Hazard Analysis and Critical Control Point plans, processes, and records, including microbial analyses conducted by FSIS officers for the relevant production periods. After extensive investigation, evaluators determined that plant practices conformed to current FSIS production guidelines. No products were recalled.

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Editorial Note: *Salmonella* species colonize the gastrointestinal tracts of cattle and other animals. Many infected cattle are asymptomatic carriers. Carcasses can become contaminated with *Salmonella* spp. during slaughter operations. Although FSIS has documented a decrease in *Salmonella* spp. in ground beef, from a baseline prevalence of 7.5% in 1996 to 1.6% of 30,984 regulatory samples collected in 2004 (*3,4*), outbreaks of human *Salmonella* infections associated with ground beef continue to occur.

Investigation of this outbreak of *S.* Typhimurium infection implicated ground beef, particularly consumption of raw or undercooked ground beef, as the source of infection. Ground beef has been implicated as the vehicle for transmission of *Salmonella* spp. in previous foodborne outbreaks (*5–7*). Outbreaks of nontyphoidal *Salmonella* infections and sporadic illness have been associated with various causes, particularly foods of animal origin (*1*). Recently, the first multistate outbreak of multidrug-resistant *S.* Typhimurium phage type DT104 associated with consumption of store-bought ground beef occurred in the northeastern United States (*8*). Epidemiologic and traceback investigations performed during the outbreak described in this report suggested one common supplier as the source. However, processing plant practices appeared to adhere to current FSIS production guidelines. In light of these findings and the findings from previous salmonellosis outbreak investigations (*5–8*), regulatory requirements and guidelines along the beef production chain, from farming through consumption, should be reviewed to determine whether current critical control points (i.e., preventive measures to control food safety hazards) and pathogen reduction strategies are adequate for *Salmonella* control.

Although the overall incidence of salmonellosis declined by only 8% from 1996 to 2004, infection with *S*. Typhimurium declined by 41% (*2*). A proportion of the decline in the incidence of *S*. Typhimurium infection might be a consequence of increased pathogen reduction strategies for *E. coli* O157:H7 in ground beef. In 2003 and 2004, incidence of human infections caused by *E. coli* O157:H7 declined, according to cases reported to the CDC Foodborne Diseases Active Surveillance Network (FoodNet) (*2*). This decline in human illness was consistent with declines in *E. coli* O157:H7 contamination of ground beef reported by FSIS during the same period (*9*). These declines might have been attributable to multiple interventions by regulators (e.g., USDA's declaration of *E. coli* O157:H7 as an adulterant in ground beef and a compulsory reassessment of the Pathogen Reduction/Hazard Analysis Critical Control Point plans) and beef industry (e.g., increased product testing, more efficient cleaning and sanitizing of carcasses, and diversion of contaminated product from raw ground-beef manufacturing [*9*]). Such interventions might have concurrently reduced *Salmonella* contamination of ground beef and salmonellosis in humans. However, regulatory and industry prevention measures and public health education need to be strengthened to meet the national health objective for reducing *Salmonella* infection.*

The findings in this report also highlight the importance of using PFGE (*10*) to identify clusters of illness, particularly for *S.* Typhimurium. Use of PulseNet to disseminate PFGE subtype data, combined with specific case interview information, allowed for an efficient and timely traceback investigation. State and local health departments should continue to conduct timely epidemiologic investigations of *Salmonella* cases. Routine subtyping of isolates of common *Salmonella* spp. serotypes such as *S.* Typhimurium and comparison of isolate PFGE patterns through PulseNet might help focus limited epidemiologic resources by identifying cases that likely are linked (*10*). Investigation of *Salmonella* spp. clusters associated with raw or undercooked ground beef consumption can 1) elucidate the mechanisms and possible sources of contamination of ground beef, 2) help determine whether regulatory requirements for the beef industry are adequate, and 3) help identify control points for reducing *Salmonella* spp. in the meat supply.

Salmonellosis outbreaks associated with ground beef continue, despite Hazard Analysis and Critical Control Point systems, enhanced adherence to good manufacturing practices, and education of food processors, preparers, and servers at all levels in the food industry and in the home. Targeting interventions at various steps, from beef production through consumption, might help prevent salmonellosis. Consumers should continue to be made aware of the risks associated with eating raw or undercooked ground beef, tasting ground beef during food preparation, and cross-contamination from raw meat to ready-to-eat foods, as well as the importance of hand washing after handling raw ground beef.

Acknowledgments

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* *Healthy People 2010* objective 10-1d is to reduce the incidence of *Salmonella* species infections to 6.8 per 100,000 population.

Update: Influenza Activity — United States, February 5–11, 2006

During February 5–11, 2006,* the number of states reporting widespread influenza activity† increased to 13. Twenty-one states reported regional activity, 11 reported local activity, and five reported sporadic activity (Figure 1).§

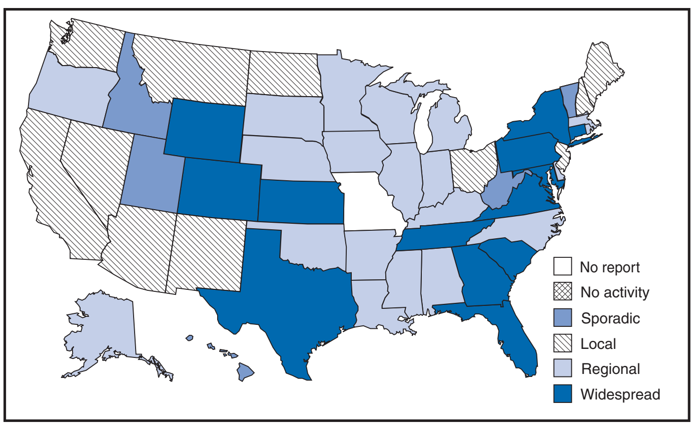
The percentage of specimens testing positive for influenza increased in the United States overall. During the preceding 3 weeks (weeks 4–6), the largest number of isolates were reported from the South Atlantic and Mountain regions. During this time, the percentage of specimens testing positive for influenza ranged from 26.3% and 23.4% in the East North Central and South Atlantic regions, respectively, to 7.4% in the Pacific region. The percentage of outpatient visits for influenza-like illness (ILI)¶ increased during the week ending February 11 and remains above the national baseline.** The percentage of deaths attributed to pneumonia and influenza (P&I) was below the epidemic threshold for the week ending February 11.

* Provisional data reported as of February 17. Additional information about influenza activity is updated each Friday and is available from CDC at http://www.cdc.gov/flu.

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

§ *Widespread:* Colorado, Connecticut, Florida, Georgia, Kansas, Maryland, New York, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, and Wyoming; *regional:* Alabama, Alaska, Arkansas, Delaware, Illinois, Indiana, Iowa, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, Oregon, Rhode Island, South Dakota, and Wisconsin; *local:* Arizona, California, Maine, Montana, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, Ohio, and Washington; *sporadic:* Hawaii, Idaho, Utah, Vermont, and West Virginia; *no activity:* none; *no report:* Missouri.

FIGURE 1. Estimated influenza activity levels reported by state epidemiologists, by state and level of activity* — United States, February 5–11, 2006



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

Laboratory Surveillance

During February 5–11, World Health Organization (WHO) collaborating laboratories and National Respiratory and Enteric Virus Surveillance System (NREVSS) laboratories in the United States reported testing 2,438 specimens for influenza viruses, of which 455 (18.7%) were positive. Of these, 136 were influenza A (H3N2) viruses, six were influenza A (H1N1) viruses, 280 were influenza A viruses that were not subtyped, and 33 were influenza B viruses.

Since October 2, 2005, WHO and NREVSS laboratories have tested 66,129 specimens for influenza viruses, of which 5,216 (7.9%) were positive. Of these, 5,025 (96.3%) were influenza A viruses, and 191 (3.7%) were influenza B viruses. Of the 5,025 influenza A viruses, 2,378 (47.3%) have been subtyped; 2,351 (98.9%) were influenza A (H3N2) viruses, and 27 (1.1%) were influenza A (H1N1) viruses.

P&I Mortality and ILI Surveillance

During the week ending February 11, P&I accounted for 7.0% of all deaths reported through the 122 Cities Mortality Reporting System. This percentage is below the epidemic threshold†† of 8.3% (Figure 2).

The percentage of patient visits for ILI was 2.5%, which is above the national baseline of 2.2% (Figure 3). The percentage of patient visits for ILI ranged from 1.5% in the Pacific region to 4.7% in the West South Central region.

Pediatric Deaths and Hospitalizations

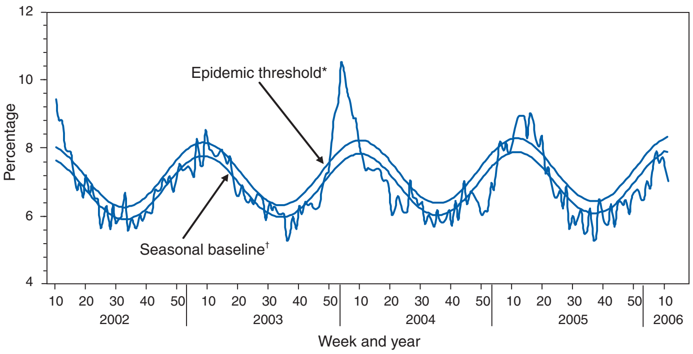
During October 2, 2005–February 11, 2006, CDC received reports of 14 influenza-associated deaths in U.S. residents aged <18 years. Twelve of the deaths occurred during the current

¶ Temperature of ≥100.0°F (≥37.8°C) and cough and/or sore throat in the absence of a known cause other than influenza.

** The national baseline was calculated as the mean percentage of visits for ILI during noninfluenza weeks for the preceding three seasons, plus two standard deviations. Noninfluenza weeks are those in which <10% of laboratory specimens are positive for influenza. Wide variability in regional data precludes calculating region-specific baselines; therefore, applying the national baseline to regional data is inappropriate.

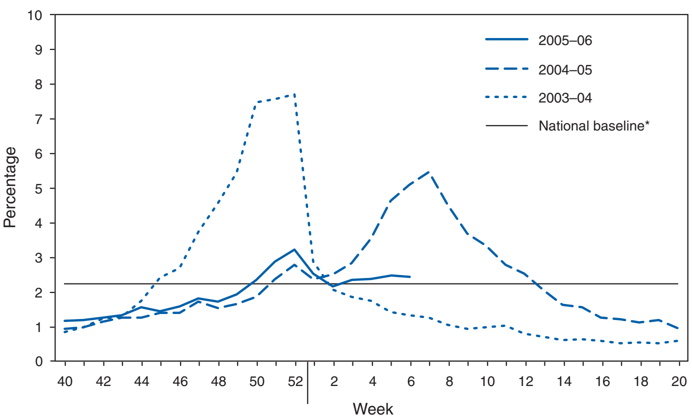
†† The expected seasonal baseline proportion of P&I deaths reported by the 122 Cities Mortality Reporting System is projected using a robust regression procedure in which a periodic regression model is applied to the observed percentage of deaths from P&I that occurred during the preceding 5 years. The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

FIGURE 2. Percentage of deaths attributed to pneumonia and influenza (P&I) reported by the 122 Cities Mortality Reporting System, by week and year — United States, 2002–2006



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

FIGURE 3. Percentage of visits for influenza-like illness (ILI) reported by the Sentinel Provider Surveillance Network, by week — United States, 2003–04, 2004–05, and 2005–06 influenza seasons



* The national baseline was calculated as the mean percentage of visits for ILI during noninfluenza weeks for the preceding three seasons, plus two standard deviations. Noninfluenza weeks are those in which <10% of laboratory specimens are positive for influenza. Wide variability in regional data precludes calculating region-specific baselines; therefore, applying the national baseline to regional data is inappropriate.

influenza season, and two occurred during the 2004–05 influenza season.

During October 1, 2005–February 4, 2006, the preliminary laboratory-confirmed influenza-associated hospitalization rate reported by the Emerging Infections Program[§§] for children aged 0–17 years was 0.30 per 10,000. For children aged 0–4 years and 5–17 years, the rate was 0.78 per 10,000 and 0.04 per 10,000, respectively. During October 30, 2005–February 4, 2006, the preliminary laboratory-confirmed influenza-associated hospitalization rate for children aged 0–4 years in the New Vaccine Surveillance Network[¶¶] was 0.33 per 10,000.

Human Avian Influenza A (H5N1)

No human avian influenza A (H5N1) virus infection has ever been identified in the United States. From December 2003 through February 20, 2006, a total of 170 laboratory-confirmed human avian influenza A (H5N1) infections were reported to WHO from Cambodia, China, Indonesia, Iraq, Thailand, Turkey, and Vietnam.*** Of these, 92 (54%) were fatal (Table). This represents an increase of one case and one death in Indonesia since February 13, 2006. The majority of infections appear to have been acquired from direct contact with infected poultry. No evidence of sustained human-to-human transmission of H5N1 has been detected, although rare instances of human-to-human transmission likely have occurred (*1*).

§§ The Emerging Infections Program (EIP) Influenza Project conducts surveillance in 60 counties associated with 12 metropolitan areas: San Francisco, California; Denver, Colorado; New Haven, Connecticut; Atlanta, Georgia; Baltimore, Maryland; Minneapolis/St. Paul, Minnesota; Albuquerque, New Mexico; Las Cruces, New Mexico; Albany, New York; Rochester, New York; Portland, Oregon; and Nashville, Tennessee.
¶¶ The New Vaccine Surveillance Network (NVSN) conducts surveillance in Monroe County, New York; Hamilton County, Ohio; and Davidson County, Tennessee.
*** Available at http://www.who.int/csr/disease/avian_influenza/en.

Reference

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TABLE. Number of laboratory-confirmed human cases and deaths from avian influenza A (H5N1) infection reported to the World Health Organization, by country — worldwide, 2003–2006*

	Year of onset									
	2003		2004		2005		2006		Total	
Country	No. of cases	Deaths	No. of cases	Deaths	No. of cases	Deaths	No. of cases	Deaths	No. of cases	Deaths
Cambodia	0	0	0	0	4	4	0	0	**4**	**4**
China	0	0	0	0	8	5	4	3	**12**	**8**
Indonesia	0	0	0	0	17	11	9	8	**26**	**19**
Iraq	0	0	0	0	0	0	1	1	**1**	**1**
Thailand	0	0	17	12	5	2	0	0	**22**	**14**
Turkey	0	0	0	0	0	0	12	4	**12**	**4**
Vietnam	3	3	29	20	61	19	0	0	**93**	**42**
Total	**3**	**3**	**46**	**32**	**95**	**41**	**26**	**16**	**170**	**92**

* As of February 20, 2006.

Notice to Readers

Release of Computer-Based Case Study: Gastroenteritis at a University in Texas

A new computer-based case study, "Gastroenteritis at a University in Texas," is now available from CDC. Based on an actual outbreak investigation, this self-instructional, interactive exercise teaches public health practitioners epidemiologic skills in outbreak investigation and allows them to apply and practice those skills.

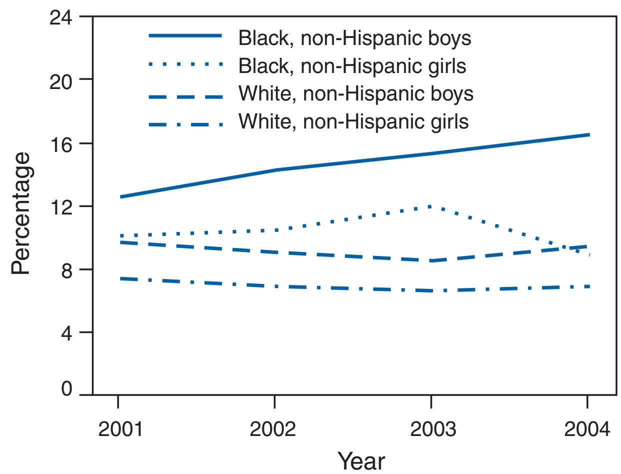
"Gastroenteritis at a University in Texas" is the third in the Foodborne Disease Outbreak Investigation Case Study Series. Other case studies include "Botulism in Argentina" (released in 2002) and "*E. coli* O157:H7 Infection in Michigan" (released in 2004). The three case studies cover a range of outbreak investigation topics. Because these case studies are self-instructional, students can complete them at their own convenience and pace. Students can select which learning activities to undertake and focus on areas in which they are deficient or that are most relevant to their job activities.

The Foodborne Disease Outbreak Investigation series was created for students with knowledge of basic epidemiologic and public health concepts. Each case study was developed in collaboration with the original investigators and experts from CDC and the Council of State and Territorial Epidemiologists. Students can receive continuing education credits (e.g., CEUs, CMEs, CNEs, and CECHs) for completing each case study. All three case studies can be downloaded for free or purchased on CD-ROM through the Epidemiologic Case Studies website at http://www.cdc.gov/epicasestudies.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage* of Children Aged <18 Years with Current Asthma, by Race/Ethnicity and Sex — United States, 2001–2004



* Based on household interviews of a sample of the noninstitutionalized U.S. civilian population.

The percentage of children who currently have asthma was stable from 2001 to 2004 for black non-Hispanic girls and white non-Hispanic boys and girls. Percentages for black non-Hispanic boys were higher than for the other populations and continued to increase during this period.

SOURCE: National Health Interview Survey annual data files, 2001–2004. Available at http://www.cdc.gov/nchs/nhis.htm.

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending February 18, 2006 (7th Week)*

Disease	Current week	Cum 2006	5-year weekly average†	Total cases reported for previous years 2005	2004	2003	2002	2001	States reporting cases during current week (No.)
Anthrax	—	—	0	—	—	—	2	23	
Botulism:									
foodborne	—	—	0	20	16	20	28	39	
infant	—	2	1	87	87	76	69	97	
other (wound & unspecified)	1	8	0	24	30	33	21	19	CA (1)
Brucellosis	2	9	2	104	114	104	125	136	MI (1), CA (1)
Chancroid	—	3	1	27	30	54	67	38	
Cholera	—	—	0	6	5	2	2	3	
Cyclosporiasis§	—	5	2	735	171	75	156	147	
Diphtheria	—	—	—	—	—	1	1	2	
Domestic arboviral diseases§¶:									
California serogroup	—	—	—	71	112	108	164	128	
eastern equine	—	—	—	21	6	14	10	9	
Powassan	—	—	—	1	1	—	1	N	
St. Louis	—	—	—	10	12	41	28	79	
western equine	—	—	—	—	—	—	—	—	
Ehrlichiosis§:									
human granulocytic	—	3	1	722	537	362	511	261	
human monocytic	2	26	1	476	338	321	216	142	MD (2)
human (other & unspecified)	—	—	0	119	59	44	23	6	
*Haemophilus influenzae,***									
invasive disease (age <5 yrs):									
serotype b	—	1	0	8	19	32	34	—	
nonserotype b	1	6	4	115	135	117	144	—	NY (1)
unknown serotype	5	22	4	201	177	227	153	—	NY (1), PA (1), MI (2), WA (1)
Hansen disease§	—	7	1	88	105	95	96	79	
Hantavirus pulmonary syndrome§	—	1	0	22	24	26	19	8	
Hemolytic uremic syndrome, postdiarrheal§	1	6	2	204	200	178	216	202	CA (1)
Hepatitis C viral, acute	5	85	33	751	713	1,102	1,835	3,976	NY (2), FL (1), CO (2)
HIV infection, pediatric (age <13 yrs)§††	—	—	5	255	436	504	420	543	
Influenza-associated pediatric mortality§,§§,¶¶	—	9	1	49	—	N	N	N	
Listeriosis	10	47	8	823	753	696	665	613	NY (1), OH (2), MN (1), MD (1), FL (1), UT (1), CA (3)
Measles	—	1***	1	63	37	56	44	116	
Meningococcal disease,††† invasive:									
A, C, Y, & W-135	3	29	7	276	—	—	—	—	FL (2), WA (1)
serogroup B	1	14	4	153	—	—	—	—	WA (1)
other serogroup	—	2	1	19	—	—	—	—	
Mumps	1	29	5	291	258	231	270	266	OH (1)
Plague	—	—	—	7	3	1	2	2	
Poliomyelitis, paralytic	—	—	—	1	—	—	—	—	
Psittacosis§	—	—	0	21	12	12	18	25	
Q fever§	—	10	1	132	70	71	61	26	
Rabies, human	—	—	—	2	7	2	3	1	
Rubella	—	—	0	11	10	7	18	23	
Rubella, congenital syndrome	—	—	0	1	—	1	1	3	
SARS-CoV§,§§	—	—	0	—	—	8	N	N	
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	6	14	3	103	132	161	118	77	OH (2), NC (4)
Streptococcus pneumoniae,§									
invasive disease (age <5 yrs)	16	98	15	1,012	1,162	845	513	498	MA (1), NY (2), OH (2), IN (4), MI (1), AR (1), OK (2), CO (3)
Syphilis, congenital (age <1 yr)	—	24	8	307	353	413	412	441	
Tetanus	—	1	0	20	34	20	25	37	
Toxic-shock syndrome (other than streptococcal)§	1	8	2	90	95	133	109	127	NC (1)
Trichinellosis	—	2	0	18	5	6	14	22	
Tularemia§	—	3	0	135	134	129	90	129	
Typhoid fever	5	26	6	298	322	356	321	368	MO (1), GA (1), FL (2), CA (1)
Vancomycin-intermediate *Staphylococcus aureus*§	—	—	—	2	—	N	N	N	
Vancomycin-resistant *Staphylococcus aureus*§	—	—	—	—	1	N	N	N	
Yellow fever	—	—	—	—	—	—	1	—	

—: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts.

* Incidence data for reporting years 2004, 2005, and 2006 are provisional, whereas data for 2001, 2002, and 2003 are finalized.
† Calculated by summing the incidence counts for the current week, the two weeks preceding the current week, and the two weeks following the current week, for a total of 5 preceding years. Additional information is available at http://www.cdc.gov/epo/dphsi/phs/files/5yearweeklyaverage.pdf.
§ Not notifiable in all states.
¶ Includes both neuroinvasive and non-neuroinvasive. Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNET Surveillance).
** Data for *H. influenzae* (all ages, all serotypes) are available in Table II.
†† Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Implementation of HIV reporting influences the number of cases reported. Data for HIV/AIDS are available in Table IV quarterly.
§§ Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
¶¶ Of the 14 cases reported since October 2, 2005 (week 40), only 12 occurred during the current 2005–06 season.
*** No measles cases were reported for the current week.
††† Data for meningococcal disease (all serogroups and unknown serogroups) are available in Table II.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending February 18, 2006, and February 19, 2005 (7th Week)*

	Chlamydia†					Coccidioidomycosis					Cryptosporidiosis				
	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum
Reporting area	week	Med	Max	2006	2005	week	Med	Max	2006	2005	week	Med	Max	2006	2005
United States	8,696	18,483	21,772	90,955	124,645	39	76	799	313	663	22	70	851	264	234
New England	360	599	1,513	3,190	3,866	—	0	0	—	—	1	4	34	11	12
Connecticut	—	150	1,176	229	789	N	0	0	N	N	—	0	14	2	3
Maine	—	41	74	221	301	N	0	0	N	N	—	0	2	2	1
Massachusetts	273	276	417	1,925	1,925	—	0	0	—	—	—	2	16	4	3
New Hampshire	1	34	64	194	245	—	0	0	—	—	1	0	3	2	3
Rhode Island	59	64	99	446	458	—	0	0	—	—	—	0	5	—	—
Vermont§	27	19	43	175	148	—	0	0	—	—	—	0	5	1	2
Mid. Atlantic	1,223	2,264	3,537	11,058	14,374	—	0	0	—	—	3	10	601	48	39
New Jersey	53	361	529	863	2,528	N	0	0	N	N	—	0	11	—	2
New York (Upstate)	535	498	1,601	1,958	2,003	N	0	0	N	N	2	3	562	8	8
New York City	323	674	1,189	4,174	4,785	—	0	0	—	—	—	2	15	12	12
Pennsylvania	312	706	1,085	4,063	5,058	N	0	0	N	N	1	4	21	28	17
E.N. Central	1,043	3,077	4,060	14,906	19,277	1	0	3	4	1	5	12	162	50	44
Illinois	—	882	1,700	3,759	4,645	—	0	0	—	—	—	1	16	4	8
Indiana	342	387	558	2,673	2,806	N	0	0	N	N	—	1	13	2	2
Michigan	458	542	1,015	4,628	2,528	—	0	3	2	1	1	2	7	11	5
Ohio	146	804	1,446	2,658	6,471	1	0	1	2	—	4	4	109	26	14
Wisconsin	97	380	495	1,188	2,827	N	0	0	N	N	—	4	38	7	15
W.N. Central	375	1,109	1,302	6,148	7,967	—	0	3	—	—	2	8	51	28	32
Iowa	—	142	221	932	888	N	0	0	N	N	—	1	11	3	6
Kansas	—	145	263	971	1,124	N	0	0	N	N	—	0	5	5	4
Minnesota	—	227	294	453	1,704	—	0	3	—	—	2	2	10	14	6
Missouri	245	437	525	2,645	3,025	—	0	1	—	—	—	2	37	5	14
Nebraska§	74	98	200	605	689	—	0	1	—	—	—	0	2	1	—
North Dakota	1	24	48	179	158	N	0	0	N	N	—	0	1	—	—
South Dakota	55	52	119	363	379	—	0	0	—	—	—	0	4	—	2
S. Atlantic	2,729	3,382	4,677	18,520	23,682	—	0	1	2	—	9	12	53	88	45
Delaware	61	68	92	482	427	N	0	0	N	N	—	0	2	—	—
District of Columbia	—	67	103	105	500	—	0	0	—	—	2	0	3	4	—
Florida	808	862	1,008	5,631	5,672	N	0	0	N	N	3	5	28	30	16
Georgia	4	600	1,135	294	3,393	—	0	0	—	—	—	2	12	28	11
Maryland	387	358	525	2,414	2,277	—	0	1	2	—	—	0	4	4	5
North Carolina	694	533	1,743	4,784	4,660	N	0	0	N	N	4	1	10	20	7
South Carolina§	204	328	1,418	1,303	3,204	—	0	0	—	—	—	0	4	—	—
Virginia§	491	425	841	2,798	3,251	—	0	0	—	—	—	1	8	2	2
West Virginia	80	46	355	709	298	N	0	0	N	N	—	0	3	—	4
E.S. Central	947	1,343	2,188	7,582	9,200	—	0	0	—	—	—	3	21	3	6
Alabama§	—	314	1,048	1,402	1,785	—	0	0	—	—	—	0	3	2	3
Kentucky	177	158	408	1,375	1,777	N	0	0	N	N	—	1	20	1	1
Mississippi	260	385	801	1,495	2,713	—	0	0	—	—	—	0	1	—	1
Tennessee§	510	456	624	3,310	2,925	N	0	0	N	N	—	0	4	—	1
W.S. Central	217	1,936	3,188	8,071	16,428	—	0	1	—	—	1	2	30	18	9
Arkansas	210	168	340	1,011	1,218	—	0	0	—	—	—	0	1	1	—
Louisiana	7	268	760	280	1,898	—	0	1	—	—	—	0	21	2	1
Oklahoma	—	218	2,023	1,167	1,516	N	0	0	N	N	1	0	10	7	3
Texas§	—	1,316	1,820	5,613	11,796	N	0	0	N	N	—	1	8	8	5
Mountain	76	1,065	1,561	4,402	7,999	—	58	204	16	382	1	2	8	6	13
Arizona	71	327	516	2,162	2,997	—	55	204	—	363	—	0	1	—	3
Colorado	—	254	376	991	1,964	N	0	0	N	N	—	1	3	2	4
Idaho§	—	25	236	—	224	N	0	0	N	N	—	0	2	—	—
Montana	—	41	171	—	350	N	0	0	N	N	—	0	3	1	—
Nevada§	—	140	465	808	1,015	—	1	4	9	15	—	0	2	—	3
New Mexico§	—	108	281	—	733	—	0	2	—	3	—	0	2	—	2
Utah	5	87	132	270	559	—	0	3	5	1	1	0	3	3	1
Wyoming	—	23	43	171	157	—	0	2	2	—	—	0	2	—	—
Pacific	1,726	3,167	4,239	17,078	21,852	38	28	710	291	280	—	6	49	12	34
Alaska	67	77	121	361	446	—	0	0	—	—	—	0	2	—	—
California	1,298	2,447	3,477	13,013	16,993	38	28	710	291	280	—	3	14	—	31
Hawaii	—	105	132	638	759	—	0	0	—	—	—	0	1	—	—
Oregon§	—	168	315	786	1,143	—	0	0	—	—	—	1	20	12	3
Washington	361	366	485	2,280	2,511	N	0	0	N	N	—	0	35	—	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	76	141	490	466	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	4	12	—	63	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
† Chlamydia refers to genital infections caused by *Chlamydia trachomatis*.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS). Because of a technical problem with hardware, NEDSS data from these states are not included this week.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 18, 2006, and February 19, 2005 (7th Week)*

	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive All ages, all serotypes				
	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum
Reporting area	week	Med	Max	2006	2005	week	Med	Max	2006	2005	week	Med	Max	2006	2005
United States	177	321	686	1,348	1,899	3,266	6,225	7,443	32,310	43,114	20	38	77	231	322
New England	2	27	90	70	118	56	103	280	555	736	—	3	12	13	18
Connecticut	—	0	65	—	1	—	36	233	64	270	—	0	6	—	3
Maine	—	4	11	3	16	—	2	7	15	16	—	0	1	1	1
Massachusetts	2	12	34	46	84	46	50	86	359	364	—	2	5	10	11
New Hampshire	—	1	7	5	4	3	4	9	38	19	—	0	3	1	—
Rhode Island	—	0	25	2	—	6	8	25	72	64	—	0	4	—	—
Vermont†	—	3	11	14	13	1	1	4	7	3	—	0	1	1	3
Mid. Atlantic	33	66	205	256	390	316	647	982	3,328	4,287	6	8	23	61	66
New Jersey	—	7	15	—	73	34	110	166	368	778	—	2	5	—	9
New York (Upstate)	28	22	176	100	99	133	123	417	626	708	5	2	19	16	18
New York City	—	16	33	67	110	75	181	405	1,033	1,311	—	1	5	19	14
Pennsylvania	5	16	29	89	108	74	211	339	1,301	1,490	1	3	8	26	25
E.N. Central	27	53	102	201	346	789	1,261	1,801	7,045	7,680	5	5	10	29	56
Illinois	—	13	32	8	82	—	364	729	1,501	1,802	—	1	5	1	17
Indiana	N	0	0	N	N	162	154	234	1,227	1,156	2	1	6	7	6
Michigan	5	14	29	71	98	514	228	581	2,788	865	3	0	3	8	7
Ohio	22	15	34	105	71	55	371	682	1,084	3,071	—	2	6	11	22
Wisconsin	—	12	33	17	95	58	108	158	445	786	—	0	3	2	4
W.N. Central	34	37	142	143	141	132	356	461	1,992	2,543	—	2	7	11	15
Iowa	—	5	14	24	34	—	30	54	172	189	—	0	1	—	—
Kansas	—	4	9	15	18	—	47	99	288	388	—	0	2	1	1
Minnesota	29	16	113	48	17	—	63	89	130	491	—	0	5	—	5
Missouri	5	9	32	43	50	110	182	241	1,206	1,238	—	0	7	9	7
Nebraska†	—	1	5	4	19	15	21	40	130	185	—	0	1	1	2
North Dakota	—	0	3	1	—	1	2	5	15	9	—	0	2	—	—
South Dakota	—	2	7	8	3	6	6	15	51	43	—	0	0	—	—
S. Atlantic	32	48	84	214	297	1,132	1,480	2,199	7,524	10,643	7	8	22	64	82
Delaware	—	1	3	2	9	16	18	40	181	109	—	0	0	—	—
District of Columbia	2	1	6	5	4	—	40	67	87	314	—	0	0	—	—
Florida	29	19	40	116	101	370	394	503	2,643	2,539	3	2	12	17	17
Georgia	1	10	24	41	89	2	271	586	157	1,544	—	2	6	14	27
Maryland	—	4	11	27	21	116	141	242	1,055	959	3	1	5	12	13
North Carolina	N	0	0	N	N	348	276	766	2,289	2,417	1	1	11	12	18
South Carolina†	—	2	9	8	11	87	134	783	497	1,428	—	1	3	6	1
Virginia†	—	9	38	14	58	165	146	289	487	1,239	—	1	7	3	3
West Virginia	—	0	6	1	4	28	13	34	128	94	—	0	3	—	3
E.S. Central	3	7	19	34	57	308	519	868	3,002	3,682	—	2	8	10	12
Alabama†	3	3	13	26	32	—	164	491	722	1,112	—	0	2	3	1
Kentucky	N	0	0	N	N	57	55	107	485	551	—	0	3	—	—
Mississippi	—	0	0	—	—	85	133	225	629	866	—	0	0	—	—
Tennessee†	—	4	11	8	25	166	170	284	1,166	1,153	—	2	5	7	11
W.S. Central	6	5	23	23	28	125	789	1,230	3,217	6,550	—	2	7	15	16
Arkansas	2	1	5	7	12	114	85	187	637	628	—	0	2	2	—
Louisiana	—	1	5	3	6	11	147	461	210	1,107	—	0	3	1	11
Oklahoma	4	3	16	13	10	—	80	713	379	686	—	1	5	12	5
Texas†	N	0	0	N	N	—	476	632	1,991	4,129	—	0	1	—	—
Mountain	10	27	58	116	139	18	223	479	1,250	1,718	1	3	19	19	40
Arizona	—	2	12	—	35	18	72	166	539	637	—	1	9	—	16
Colorado	6	9	26	45	47	—	57	90	319	411	—	1	4	12	10
Idaho†	—	2	12	10	18	—	1	10	—	12	—	0	1	1	1
Montana	1	1	7	8	6	—	2	9	—	19	—	0	0	—	—
Nevada†	—	2	6	3	7	—	54	195	309	412	—	0	3	—	5
New Mexico†	—	1	6	2	6	—	21	48	—	139	—	0	4	3	6
Utah	3	7	28	46	19	—	14	22	55	82	1	0	2	3	1
Wyoming	—	0	2	2	1	—	2	6	28	6	—	0	2	—	1
Pacific	30	60	169	291	383	390	787	1,049	4,397	5,275	1	2	20	9	17
Alaska	—	2	6	1	5	5	10	23	41	68	—	0	19	2	2
California	24	41	84	233	309	313	650	805	3,587	4,423	—	1	7	—	4
Hawaii	—	1	6	4	15	—	19	36	109	135	—	0	2	1	1
Oregon†	2	6	21	46	40	—	30	58	134	194	—	1	4	5	10
Washington	4	5	80	7	14	72	72	210	526	455	1	0	4	1	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	3	14	1	9	—	6	16	41	43	—	0	1	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	20	—	26	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS). Because of a technical problem with hardware, NEDSS data from these states are not included this week.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 18, 2006, and February 19, 2005 (7th Week)*

Reporting area	Hepatitis A: Current week	Hepatitis A: Previous 52 weeks Med	Hepatitis A: Previous 52 weeks Max	Hepatitis A: Cum 2006	Hepatitis A: Cum 2005	Hepatitis B: Current week	Hepatitis B: Previous 52 weeks Med	Hepatitis B: Previous 52 weeks Max	Hepatitis B: Cum 2006	Hepatitis B: Cum 2005	Legionellosis: Current week	Legionellosis: Previous 52 weeks Med	Legionellosis: Previous 52 weeks Max	Legionellosis: Cum 2006	Legionellosis: Cum 2005
United States	46	78	182	392	524	25	100	155	384	766	16	37	111	126	156
New England	—	8	23	33	62	2	5	12	30	35	—	2	11	5	4
Connecticut	—	1	3	2	9	—	0	5	—	9	—	0	8	1	—
Maine	—	0	2	1	—	—	0	2	—	—	—	0	1	1	—
Massachusetts	—	5	14	21	49	2	4	10	27	23	—	1	5	2	4
New Hampshire	—	1	12	5	4	—	0	3	3	2	—	0	1	—	—
Rhode Island	—	0	4	1	—	—	0	2	—	—	—	0	7	—	—
Vermont†	—	0	2	3	—	—	0	1	—	1	—	0	3	1	—
Mid. Atlantic	3	12	23	22	97	2	13	37	25	142	2	11	53	34	50
New Jersey	—	3	11	—	18	—	5	26	—	76	—	1	12	1	8
New York (Upstate)	1	2	17	5	8	1	2	10	3	8	1	3	25	10	12
New York City	—	5	12	9	48	—	2	7	5	21	—	2	20	4	1
Pennsylvania	2	1	6	8	23	1	4	8	17	37	1	5	17	19	29
E.N. Central	3	7	18	31	58	2	10	25	32	77	1	6	23	16	39
Illinois	—	1	9	—	25	—	2	7	—	23	—	0	2	—	7
Indiana	—	1	10	2	2	—	0	11	—	1	—	0	5	1	3
Michigan	—	2	11	17	13	1	3	7	16	28	—	2	6	7	10
Ohio	3	1	7	11	13	1	2	8	14	22	1	3	19	8	17
Wisconsin	—	1	5	1	5	—	0	6	2	3	—	0	2	—	2
W.N. Central	—	2	31	13	12	1	5	13	9	31	—	1	12	2	5
Iowa	—	0	2	—	2	—	0	2	—	1	—	0	1	—	—
Kansas	—	0	3	8	2	—	0	3	2	4	—	0	1	—	—
Minnesota	—	0	31	—	—	—	0	6	—	—	—	0	10	—	—
Missouri	—	0	5	3	6	1	3	7	7	19	—	0	3	2	5
Nebraska†	—	0	3	—	2	—	0	2	—	7	—	0	1	—	—
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	1	—	—
South Dakota	—	0	1	2	—	—	0	1	—	—	—	0	6	—	—
S. Atlantic	26	13	33	76	65	12	24	52	113	220	10	8	19	40	34
Delaware	—	0	1	1	1	—	1	6	1	7	—	0	4	1	—
District of Columbia	—	0	2	1	—	1	0	4	1	—	—	0	2	—	—
Florida	4	5	18	26	29	11	9	21	57	71	6	2	6	19	11
Georgia	1	1	6	5	18	—	2	6	5	47	1	0	3	2	3
Maryland	1	2	6	13	5	—	2	8	22	25	3	2	9	13	11
North Carolina	20	0	18	28	3	—	0	19	19	26	—	0	3	3	5
South Carolina†	—	1	3	2	3	—	3	9	6	16	—	0	2	—	—
Virginia†	—	1	7	—	6	—	2	12	2	26	—	1	8	2	3
West Virginia	—	0	2	—	—	—	0	11	—	2	—	0	3	—	1
E.S. Central	—	3	16	10	27	—	7	20	23	43	—	1	6	2	2
Alabama†	—	0	6	—	3	—	1	7	8	14	—	0	2	—	2
Kentucky	—	0	3	1	1	—	1	6	6	10	—	0	4	—	—
Mississippi	—	0	2	—	6	—	1	4	3	5	—	0	1	—	—
Tennessee†	—	2	13	9	17	—	2	12	6	14	—	1	4	2	—
W.S. Central	1	6	19	8	36	—	12	35	91	65	—	0	4	2	—
Arkansas	—	0	3	—	—	—	1	3	2	11	—	0	1	—	—
Louisiana	—	1	5	1	11	—	1	5	2	10	—	0	2	2	—
Oklahoma	1	0	1	2	1	—	0	5	—	4	—	0	3	—	—
Texas†	—	4	16	5	24	—	9	33	87	40	—	0	3	—	—
Mountain	1	6	21	13	53	—	9	39	13	73	1	2	8	5	10
Arizona	—	3	20	—	30	—	5	34	—	48	—	0	3	—	3
Colorado	1	1	5	7	7	—	1	4	7	8	—	0	3	1	1
Idaho†	—	0	3	1	5	—	0	2	1	3	—	0	2	—	—
Montana	—	0	1	—	4	—	0	2	—	—	—	0	1	—	—
Nevada†	—	0	2	2	2	—	1	4	3	4	—	0	2	3	2
New Mexico†	—	0	3	2	3	—	0	3	1	3	—	0	1	—	1
Utah	—	0	3	1	2	—	0	5	1	7	1	0	2	1	1
Wyoming	—	0	0	—	—	—	0	1	—	—	—	0	1	—	2
Pacific	12	15	148	186	114	6	10	49	48	80	2	1	10	20	12
Alaska	—	0	2	—	1	—	0	1	—	—	—	0	1	—	—
California	11	13	147	175	92	5	6	34	38	59	2	1	10	20	12
Hawaii	1	0	2	4	3	—	0	1	—	1	—	0	1	—	—
Oregon†	—	1	4	3	9	—	2	5	9	19	N	0	0	N	N
Washington	—	1	11	4	9	1	0	11	1	1	—	0	0	—	—
American Samoa	U	0	1	U	—	U	0	0	U	—	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	1	6	—	7	—	1	6	—	2	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 18, 2006, and February 19, 2005 (7th Week)*

	Lyme disease					Malaria				
	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum
Reporting area	week	Med	Max	2006	2005	week	Med	Max	2006	2005
United States	31	291	1,316	290	915	9	23	46	113	154
New England	—	43	209	13	75	—	1	12	5	4
Connecticut	—	9	154	9	—	—	0	10	—	—
Maine	—	2	25	1	4	—	0	1	—	—
Massachusetts	—	12	141	—	61	—	0	4	4	4
New Hampshire	—	3	17	3	9	—	0	1	—	—
Rhode Island	—	0	12	—	—	—	0	1	—	—
Vermont†	—	0	5	—	1	—	0	2	1	—
Mid. Atlantic	17	183	918	149	623	2	6	15	20	44
New Jersey	—	35	305	6	219	—	1	7	—	13
New York (Upstate)	15	48	781	52	85	1	1	6	4	4
New York City	—	0	0	—	—	—	3	8	10	22
Pennsylvania	2	59	458	91	319	1	1	2	6	5
E.N. Central	1	13	156	9	37	—	2	6	11	15
Illinois	—	0	6	—	—	—	0	2	3	5
Indiana	—	0	4	—	1	—	0	1	—	—
Michigan	—	1	7	2	1	—	0	2	1	6
Ohio	1	1	5	2	11	—	0	3	4	2
Wisconsin	—	10	148	5	24	—	0	2	3	2
W.N. Central	2	13	99	10	5	—	0	5	4	7
Iowa	—	1	8	—	3	—	0	1	—	2
Kansas	—	0	3	1	2	—	0	1	—	1
Minnesota	2	9	96	8	—	—	0	3	2	1
Missouri	—	0	2	1	—	—	0	3	1	3
Nebraska†	—	0	1	—	—	—	0	2	—	—
North Dakota	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	1	—	—	—	0	1	1	—
S. Atlantic	5	32	125	83	160	2	6	15	35	25
Delaware	—	9	37	28	66	—	0	1	—	1
District of Columbia	1	0	2	2	1	—	0	2	—	—
Florida	2	1	8	6	7	1	1	6	4	4
Georgia	—	0	1	—	—	1	0	6	11	6
Maryland	2	16	86	42	74	—	1	9	13	8
North Carolina	—	0	5	5	7	—	0	8	3	2
South Carolina†	—	0	3	—	3	—	0	2	1	—
Virginia†	—	3	20	—	2	—	0	5	3	3
West Virginia	—	0	6	—	—	—	0	2	—	1
E.S. Central	—	1	4	—	2	—	0	2	1	3
Alabama†	—	0	1	—	—	—	0	1	—	1
Kentucky	—	0	1	—	—	—	0	2	1	1
Mississippi	—	0	0	—	—	—	0	0	—	—
Tennessee†	—	0	4	—	2	—	0	2	—	1
W.S. Central	—	1	8	—	3	—	1	9	4	15
Arkansas	—	0	2	—	—	—	0	2	—	1
Louisiana	—	0	2	—	1	—	0	1	—	1
Oklahoma	—	0	0	—	—	—	0	6	1	—
Texas†	—	0	7	—	2	—	1	9	3	13
Mountain	—	0	4	—	—	1	0	6	6	11
Arizona	—	0	4	—	—	—	0	4	—	2
Colorado	—	0	1	—	—	—	0	3	2	5
Idaho†	—	0	1	—	—	—	0	0	—	—
Montana	—	0	0	—	—	—	0	0	—	—
Nevada†	—	0	2	—	—	—	0	2	—	—
New Mexico†	—	0	1	—	—	—	0	1	—	1
Utah	—	0	1	—	—	1	0	2	4	2
Wyoming	—	0	1	—	—	—	0	1	—	1
Pacific	6	3	10	26	10	4	4	12	27	30
Alaska	—	0	1	—	1	—	0	1	1	1
California	6	2	10	26	8	4	3	9	22	28
Hawaii	N	0	0	N	N	—	0	4	—	—
Oregon†	—	0	2	—	1	—	0	2	2	1
Washington	—	0	3	—	—	—	0	4	2	—
American Samoa	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	N	0	0	N	N	—	0	1	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 18, 2006, and February 19, 2005 (7th Week)*

	Meningococcal disease, invasive										Pertussis				
	All serogroups					Serogroup unknown									
	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum
Reporting area	week	Med	Max	2006	2005	week	Med	Max	2006	2005	week	Med	Max	2006	2005
United States	10	20	56	133	192	6	13	46	88	101	111	424	618	1,231	3,311
New England	—	1	5	6	15	—	1	2	6	5	—	26	49	172	198
Connecticut	—	0	3	2	1	—	0	2	2	—	—	0	4	—	14
Maine	—	0	1	2	1	—	0	1	2	1	—	0	5	—	6
Massachusetts	—	0	3	2	10	—	0	2	2	2	—	19	39	160	139
New Hampshire	—	0	2	—	1	—	0	2	—	1	—	1	15	3	—
Rhode Island	—	0	2	—	—	—	0	0	—	—	—	0	8	—	—
Vermont†	—	0	1	—	2	—	0	1	—	1	—	1	6	9	39
Mid. Atlantic	1	3	14	25	27	1	2	13	23	20	24	23	102	139	264
New Jersey	—	0	4	—	7	—	0	4	—	7	—	3	9	6	34
New York (Upstate)	—	0	6	2	6	—	0	5	1	2	12	9	92	41	73
New York City	—	0	5	11	4	—	0	5	11	4	—	2	6	—	12
Pennsylvania	1	1	3	12	10	1	1	3	11	7	12	7	28	92	145
E.N. Central	1	2	9	7	19	1	1	6	6	18	15	63	121	176	858
Illinois	—	0	2	2	5	—	0	2	2	5	—	14	31	7	151
Indiana	—	0	3	—	2	—	0	2	—	2	5	5	23	8	9
Michigan	—	0	3	2	3	—	0	3	1	2	1	4	26	29	35
Ohio	1	0	5	3	4	1	0	4	3	4	9	20	43	124	362
Wisconsin	—	0	2	—	5	—	0	2	—	5	—	21	40	8	301
W.N. Central	—	1	5	6	12	—	0	3	2	4	—	58	205	171	538
Iowa	—	0	2	—	3	—	0	2	—	—	—	9	55	25	203
Kansas	—	0	1	—	1	—	0	1	—	1	—	11	29	74	58
Minnesota	—	0	2	—	2	—	0	1	—	—	—	0	148	—	93
Missouri	—	0	3	3	5	—	0	2	—	2	—	9	39	62	84
Nebraska†	—	0	1	3	1	—	0	1	2	1	—	2	12	8	47
North Dakota	—	0	1	—	—	—	0	1	—	—	—	0	28	2	16
South Dakota	—	0	1	—	—	—	0	0	—	—	—	2	9	—	37
S. Atlantic	3	4	13	28	29	1	2	7	11	12	8	24	90	107	178
Delaware	—	0	1	1	—	—	0	1	1	—	—	0	1	1	10
District of Columbia	—	0	0	—	—	—	0	0	—	—	—	0	3	2	—
Florida	3	1	7	10	9	1	1	6	4	2	5	4	14	39	15
Georgia	—	0	2	1	6	—	0	2	1	6	—	1	3	—	6
Maryland	—	0	2	3	2	—	0	1	1	—	1	4	8	33	44
North Carolina	—	0	11	11	4	—	0	3	3	—	2	0	21	19	14
South Carolina†	—	0	2	—	6	—	0	1	—	4	—	6	17	13	72
Virginia†	—	0	3	2	2	—	0	3	1	—	—	1	72	—	14
West Virginia	—	0	1	—	—	—	0	1	—	—	—	0	12	—	3
E.S. Central	—	1	4	4	7	—	1	4	2	4	—	8	25	15	76
Alabama†	—	0	1	1	—	—	0	1	1	—	—	1	9	8	20
Kentucky	—	0	3	1	2	—	0	3	1	2	—	3	10	2	19
Mississippi	—	0	1	—	2	—	0	1	—	2	—	1	4	1	12
Tennessee†	—	0	2	2	3	—	0	1	—	—	—	3	17	4	25
W.S. Central	1	2	7	10	18	1	0	5	6	4	4	40	111	42	48
Arkansas	1	0	3	2	4	1	0	2	2	1	4	5	19	10	6
Louisiana	—	0	3	6	8	—	0	2	4	2	—	0	3	1	3
Oklahoma	—	0	3	2	3	—	0	3	—	—	—	0	1	2	—
Texas†	—	0	4	—	3	—	0	3	—	1	—	36	98	29	39
Mountain	1	2	7	10	16	1	1	5	4	9	48	74	145	350	609
Arizona	—	0	5	—	5	—	0	5	—	2	—	15	86	—	41
Colorado	—	0	2	8	7	—	0	2	2	7	28	24	43	229	298
Idaho†	—	0	2	—	—	—	0	2	—	—	—	3	19	9	43
Montana	—	0	0	—	—	—	0	0	—	—	—	8	29	16	150
Nevada†	—	0	2	—	2	—	0	1	—	—	—	0	8	8	4
New Mexico†	—	0	2	—	1	—	0	2	—	—	—	3	9	1	42
Utah	1	0	2	2	1	1	0	1	2	—	20	12	35	80	26
Wyoming	—	0	0	—	—	—	0	0	—	—	—	1	4	7	5
Pacific	3	4	28	37	49	1	3	13	28	25	12	69	272	59	542
Alaska	—	0	1	—	—	—	0	1	—	—	1	2	12	15	5
California	1	2	11	25	21	1	2	11	25	21	—	40	146	—	319
Hawaii	—	0	2	—	3	—	0	1	—	1	—	3	10	6	19
Oregon†	—	0	4	5	18	—	0	2	1	2	—	6	26	21	164
Washington	2	0	25	7	7	—	0	11	2	1	11	11	178	17	35
American Samoa	U	0	1	—	—	U	0	1	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	—	—	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	2	—	1	—	0	2	—	1	—	0	2	—	1
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 18, 2006, and February 19, 2005 (7th Week)*

Reporting area	Rabies, animal					Rocky Mountain spotted fever					Salmonellosis				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005
United States	35	105	160	297	717	3	34	98	162	63	302	856	1,449	2,801	3,047
New England	2	13	33	42	79	—	0	1	—	—	1	40	76	122	132
Connecticut	—	3	13	8	11	—	0	0	—	—	—	9	25	25	26
Maine	2	1	4	6	5	N	0	0	N	N	—	3	8	2	8
Massachusetts	—	5	22	22	54	—	0	1	—	—	—	20	38	81	80
New Hampshire	—	0	3	1	2	—	0	1	—	—	1	2	12	8	9
Rhode Island	—	0	4	1	—	—	0	1	—	—	—	0	15	4	—
Vermont†	—	1	7	4	7	—	0	0	—	—	—	1	10	2	9
Mid. Atlantic	5	18	40	66	66	—	2	8	1	3	26	95	183	267	350
New Jersey	N	0	0	N	N	—	0	6	—	1	—	16	45	2	72
New York (Upstate)	5	12	24	45	25	—	0	2	—	—	21	22	146	58	58
New York City	—	0	3	—	4	—	0	2	1	1	1	24	43	79	108
Pennsylvania	—	7	22	21	37	—	1	6	—	1	4	30	61	128	112
E.N. Central	—	3	19	2	6	1	0	3	1	1	36	93	243	282	364
Illinois	—	1	4	—	1	—	0	1	—	—	—	29	160	13	102
Indiana	—	0	3	—	1	—	0	1	—	—	—	10	71	30	11
Michigan	—	0	4	1	2	—	0	1	—	—	6	17	35	64	81
Ohio	—	0	13	1	2	1	0	3	1	1	30	23	52	131	89
Wisconsin	—	0	3	—	—	—	0	1	—	—	—	15	45	44	81
W.N. Central	—	7	23	15	30	—	2	16	2	3	9	43	91	185	192
Iowa	—	1	10	3	6	—	0	2	—	—	—	7	18	31	44
Kansas	—	1	5	3	4	—	0	2	—	—	—	7	17	21	19
Minnesota	—	1	5	1	11	—	0	1	—	—	—	10	31	36	41
Missouri	—	1	7	1	4	—	1	14	2	3	9	14	40	73	59
Nebraska†	—	0	0	—	—	—	0	2	—	—	—	2	8	11	16
North Dakota	—	0	4	2	—	—	0	0	—	—	—	0	5	—	2
South Dakota	—	1	6	5	5	—	0	2	—	—	—	2	11	13	11
S. Atlantic	21	30	49	121	407	—	16	94	155	42	125	253	511	925	846
Delaware	—	0	0	—	—	—	0	2	—	—	—	2	9	5	6
District of Columbia	—	0	0	—	—	—	0	1	—	—	—	1	7	7	—
Florida	3	0	14	21	201	—	0	1	2	2	69	99	230	422	338
Georgia	15	5	9	16	31	—	1	9	14	1	6	32	75	158	110
Maryland	1	6	16	6	35	—	2	7	4	1	11	14	39	67	64
North Carolina	2	8	19	23	56	—	5	87	133	35	39	30	114	222	187
South Carolina†	—	0	1	—	4	—	1	6	2	3	—	21	146	28	70
Virginia†	—	9	26	47	78	—	1	10	—	—	—	19	66	15	63
West Virginia	—	0	13	8	2	—	0	2	—	—	—	2	13	1	8
E.S. Central	4	3	9	25	11	—	5	25	1	1	12	55	134	167	182
Alabama†	3	1	5	8	10	—	0	9	—	—	12	13	39	84	64
Kentucky	—	0	3	—	—	—	0	1	—	—	—	7	26	26	21
Mississippi	—	0	1	—	—	—	0	3	—	—	—	13	66	12	24
Tennessee†	1	1	5	17	1	—	3	19	1	1	—	15	40	45	73
W.S. Central	—	14	42	8	86	2	2	32	2	1	30	79	157	261	236
Arkansas	—	0	3	1	6	2	0	32	2	—	24	12	67	50	32
Louisiana	—	0	0	—	—	—	0	2	—	1	—	15	42	18	60
Oklahoma	—	1	7	7	9	—	0	23	—	—	6	7	26	31	27
Texas†	—	12	39	—	71	—	0	7	—	—	—	43	121	162	117
Mountain	2	4	19	12	27	—	0	8	—	10	18	50	112	155	190
Arizona	2	2	11	12	24	—	0	8	—	8	—	13	28	—	65
Colorado	—	0	2	—	—	—	0	1	—	—	6	10	45	67	52
Idaho†	—	0	12	—	—	—	0	2	—	—	—	2	17	11	14
Montana	—	0	3	—	—	—	0	1	—	—	—	2	16	13	7
Nevada†	—	0	2	—	—	—	0	0	—	—	—	3	8	15	22
New Mexico†	—	0	1	—	1	—	0	1	—	—	—	5	14	11	15
Utah	—	0	5	—	—	—	0	1	—	2	8	6	31	29	9
Wyoming	—	0	2	—	2	—	0	1	—	—	4	1	12	9	6
Pacific	1	4	15	6	5	—	0	2	—	2	45	101	357	437	555
Alaska	1	0	3	2	1	—	0	0	—	—	—	1	5	12	9
California	—	3	15	4	4	—	0	1	—	2	37	77	242	355	430
Hawaii	—	0	0	—	—	—	0	0	—	—	—	5	15	28	59
Oregon†	—	0	1	—	—	—	0	1	—	—	—	7	23	28	26
Washington	U	0	0	U	U	—	0	0	—	—	8	9	107	14	31
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	2	U	—
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	1	6	9	11	N	0	0	N	N	1	8	23	5	36
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 18, 2006, and February 19, 2005 (7th Week)*

	Shiga toxin-producing *E. coli* (STEC)†					Shigellosis					Streptococcal disease, invasive, group A				
	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum
Reporting area	week	Med	Max	2006	2005	week	Med	Max	2006	2005	week	Med	Max	2006	2005
United States	5	50	156	72	161	69	275	452	913	1,193	55	80	151	555	621
New England	—	4	14	6	16	1	5	15	27	22	—	3	8	18	25
Connecticut	—	1	4	—	8	—	1	4	3	2	U	0	0	U	U
Maine	—	0	5	—	—	—	0	1	—	—	—	0	2	3	2
Massachusetts	—	2	8	6	7	1	3	9	23	18	—	2	6	10	18
New Hampshire	—	0	2	—	—	—	0	4	1	1	—	0	2	4	1
Rhode Island	—	0	2	—	—	—	0	6	—	—	—	0	3	—	—
Vermont§	—	0	2	—	1	—	0	4	—	1	—	0	2	1	4
Mid. Atlantic	—	7	24	—	14	7	22	67	51	123	7	16	38	98	135
New Jersey	—	1	6	—	3	—	5	14	—	40	—	3	9	5	29
New York (Upstate)	—	2	16	1	6	7	4	42	31	17	5	4	19	30	43
New York City	—	0	2	—	1	—	7	22	17	60	—	3	9	15	22
Pennsylvania	—	2	8	—	4	—	2	48	3	6	2	5	12	48	41
E.N. Central	—	8	31	13	40	9	16	78	57	88	7	15	41	106	131
Illinois	—	1	7	—	10	—	5	24	4	25	—	3	10	9	32
Indiana	—	1	7	5	1	—	1	56	5	1	2	1	11	16	13
Michigan	—	1	8	2	8	—	4	14	21	41	1	6	15	32	52
Ohio	—	2	14	6	13	9	2	11	21	10	3	4	14	38	22
Wisconsin	—	2	15	—	8	—	3	9	6	11	1	1	8	11	12
W.N. Central	—	7	39	17	26	6	38	64	133	98	—	5	19	27	21
Iowa	—	1	10	4	5	—	1	9	2	12	N	0	0	N	N
Kansas	—	1	4	—	2	—	4	20	12	4	—	1	5	15	2
Minnesota	—	2	23	13	3	2	2	6	11	4	—	1	15	—	—
Missouri	—	1	7	5	9	4	22	45	90	57	—	1	6	7	9
Nebraska§	—	0	4	—	5	—	1	9	7	14	—	0	4	4	4
North Dakota	—	0	2	—	—	—	0	2	1	1	—	0	3	1	2
South Dakota	—	0	5	—	2	—	1	17	10	6	—	0	2	—	4
S. Atlantic	3	7	39	10	30	27	44	117	259	157	26	19	33	166	126
Delaware	—	0	2	—	—	—	0	2	—	1	—	0	2	1	—
District of Columbia	—	0	1	—	—	—	0	2	1	—	1	0	2	3	1
Florida	3	1	31	10	11	20	22	66	131	77	11	5	12	49	44
Georgia	—	0	6	—	5	5	11	32	81	46	3	3	9	40	23
Maryland	—	1	5	—	5	2	2	8	18	11	3	4	12	32	29
North Carolina	—	1	11	9	7	—	2	22	18	6	8	1	13	21	15
South Carolina§	—	0	2	—	—	—	2	6	10	8	—	1	3	9	7
Virginia§	—	2	9	—	2	—	2	9	—	8	—	2	11	9	5
West Virginia	—	0	1	—	—	—	0	1	—	—	—	0	5	2	2
E.S. Central	—	3	12	3	6	1	20	54	55	130	1	3	11	19	19
Alabama§	—	0	3	—	3	1	3	20	13	30	—	0	0	—	—
Kentucky	—	1	9	3	—	—	6	31	28	6	1	0	3	4	3
Mississippi	—	0	2	—	—	—	2	7	9	10	—	0	0	—	—
Tennessee§	—	1	3	1	3	—	5	46	5	84	—	3	8	15	16
W.S. Central	—	2	9	—	6	2	61	121	90	227	8	6	16	49	33
Arkansas	—	0	2	—	1	1	1	3	6	10	—	0	4	1	6
Louisiana	—	0	2	—	2	—	2	11	7	24	—	0	1	2	3
Oklahoma	—	0	3	—	1	1	10	41	17	56	8	2	13	32	13
Texas§	—	1	4	—	2	—	45	105	60	137	—	3	14	14	11
Mountain	—	5	15	6	15	2	17	47	38	78	6	12	28	59	114
Arizona	—	0	4	—	2	—	9	29	—	36	—	4	16	—	53
Colorado	—	1	6	6	4	—	3	17	12	13	3	4	11	38	38
Idaho§	—	1	8	—	5	—	0	4	2	—	—	0	2	—	1
Montana	—	0	2	—	1	—	0	1	—	—	—	0	0	—	—
Nevada§	—	0	4	—	—	—	1	6	8	15	—	0	6	—	—
New Mexico§	—	0	3	—	—	—	2	9	6	10	—	1	6	6	17
Utah	—	1	7	1	2	2	1	4	9	4	3	2	6	14	4
Wyoming	—	0	3	—	1	—	0	1	1	—	—	0	1	1	1
Pacific	2	6	52	17	8	14	40	124	203	270	—	2	8	13	17
Alaska	—	0	3	—	1	—	0	1	—	1	—	0	0	—	—
California	1	1	6	14	1	8	35	90	147	244	—	0	0	—	—
Hawaii	—	0	4	—	1	—	1	4	9	4	—	2	8	13	17
Oregon§	—	1	47	3	—	—	1	27	34	14	N	0	0	N	N
Washington	1	1	39	3	5	6	2	35	13	7	N	0	0	N	N
American Samoa	U	0	0	U	U	U	0	2	U	—	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	1	—	—	—	0	1	—	—	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
† Includes *E. coli* O157:H7; Shiga toxin positive, serogroup non-0157; and Shiga toxin positive, not serogrouped.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS). Because of a technical problem with hardware, NEDSS data from these states are not included this week.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 18, 2006, and February 19, 2005 (7th Week)*

	Streptococcus pneumoniae, invasive disease Drug resistant, all ages					Syphilis, primary & secondary					Varicella (chickenpox)				
	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum
Reporting area	week	Med	Max	2006	2005	week	Med	Max	2006	2005	week	Med	Max	2006	2005
United States	45	49	90	383	370	80	167	213	786	946	692	557	1,778	5,371	3,341
New England	—	2	12	3	21	3	4	15	24	25	12	36	1,128	167	402
Connecticut	U	0	0	U	U	—	0	11	1	—	U	0	0	U	U
Maine	N	0	0	N	N	—	0	1	1	—	—	5	20	19	55
Massachusetts	—	1	6	—	20	3	2	5	19	24	—	26	86	—	337
New Hampshire	—	0	0	—	—	—	0	2	3	1	12	4	1,110	58	—
Rhode Island	—	0	7	—	—	—	0	6	—	—	—	0	0	—	—
Vermont†	—	0	2	3	1	—	0	1	—	—	—	2	25	90	10
Mid. Atlantic	4	3	10	22	48	8	20	33	97	130	86	116	211	845	402
New Jersey	N	0	0	N	N	3	2	7	18	14	—	0	0	—	—
New York (Upstate)	2	1	9	6	13	4	2	12	13	6	—	0	0	—	—
New York City	U	0	0	U	U	1	12	21	55	90	—	0	0	—	—
Pennsylvania	2	2	9	16	35	—	4	7	11	20	86	116	211	845	402
E.N. Central	10	11	31	86	65	11	17	40	99	62	422	125	486	2,648	1,343
Illinois	—	0	2	1	—	—	8	31	28	13	—	1	5	2	11
Indiana	6	3	16	14	12	1	1	5	12	8	—	0	245	—	—
Michigan	—	1	3	6	9	4	2	8	21	5	83	82	231	708	967
Ohio	4	7	20	65	44	5	4	11	32	32	339	29	348	1,849	264
Wisconsin	N	0	0	N	N	1	1	3	6	4	—	9	27	89	101
W.N. Central	1	1	15	9	9	—	5	9	20	34	25	11	70	274	10
Iowa	N	0	0	N	N	—	0	1	—	2	N	0	0	N	N
Kansas	N	0	0	N	N	—	0	2	4	2	—	0	0	—	—
Minnesota	—	0	15	—	—	—	1	5	2	5	—	0	0	—	—
Missouri	1	0	3	9	8	—	2	8	14	24	25	9	69	254	1
Nebraska†	—	0	1	—	—	—	0	1	—	1	—	0	1	—	—
North Dakota	—	0	1	—	—	—	0	1	—	—	—	0	25	8	—
South Dakota	—	0	1	—	1	—	0	1	—	—	—	1	23	12	9
S. Atlantic	30	21	41	211	162	24	39	90	190	209	23	46	445	310	294
Delaware	—	0	2	—	—	—	0	2	5	2	—	0	4	3	5
District of Columbia	1	0	4	7	—	—	1	9	4	11	2	0	6	3	—
Florida	26	11	34	112	88	9	15	29	96	103	—	0	0	—	—
Georgia	3	5	18	81	65	—	7	47	—	8	—	0	0	—	—
Maryland	—	0	0	—	—	3	6	19	30	28	—	0	0	—	—
North Carolina	N	0	0	N	N	3	4	17	35	37	—	0	0	—	—
South Carolina†	—	0	0	—	—	4	1	8	5	9	—	10	41	83	61
Virginia†	N	0	0	N	N	5	3	11	15	11	—	7	436	8	15
West Virginia	—	2	8	11	9	—	0	1	—	—	21	18	61	213	213
E.S. Central	—	3	14	20	24	6	9	18	49	60	—	0	0	—	—
Alabama†	—	0	0	—	—	—	3	11	14	32	—	0	0	—	—
Kentucky	—	0	5	3	4	—	1	4	6	2	N	0	0	N	N
Mississippi	—	0	0	—	—	—	0	5	5	6	—	0	0	—	—
Tennessee†	—	3	13	17	20	6	4	11	24	20	—	0	0	—	—
W.S. Central	—	1	13	12	32	7	24	38	142	164	31	135	765	655	341
Arkansas	—	0	3	5	3	4	1	6	11	4	31	0	32	75	—
Louisiana	—	1	11	7	29	3	3	17	8	23	—	1	32	18	5
Oklahoma	N	0	0	N	N	—	0	6	7	9	—	0	0	—	—
Texas†	N	0	0	N	N	—	18	30	116	128	—	130	733	562	336
Mountain	—	1	28	20	9	12	8	17	50	47	93	47	118	472	549
Arizona	N	0	0	N	N	11	3	13	32	18	—	0	0	—	—
Colorado	N	0	0	N	N	—	1	6	4	5	74	35	87	354	395
Idaho†	N	0	0	N	N	—	0	6	—	6	—	0	0	—	—
Montana	—	0	1	—	—	—	0	3	—	—	—	0	0	—	—
Nevada†	—	0	27	12	1	—	2	7	13	8	—	0	4	1	—
New Mexico†	—	0	0	—	—	—	1	3	—	8	—	3	15	11	36
Utah	—	0	6	5	5	1	0	1	1	2	19	8	38	104	99
Wyoming	—	0	3	3	3	—	0	0	—	—	—	0	8	2	19
Pacific	—	0	0	—	—	9	33	56	115	215	—	0	0	—	—
Alaska	—	0	0	—	—	—	0	2	—	2	—	0	0	—	—
California	N	0	0	N	N	3	28	54	79	197	—	0	0	—	—
Hawaii	—	0	0	—	—	—	0	2	2	2	—	0	0	—	—
Oregon†	N	0	0	N	N	—	0	6	2	—	—	0	0	—	—
Washington	N	0	0	N	N	6	2	11	32	14	N	0	0	N	N
American Samoa	—	0	0	—	—	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	—	0	0	—	—	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	N	0	0	N	N	—	4	16	15	13	1	9	47	17	51
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 18, 2006, and February 19, 2005 (7th Week)*

	West Nile virus disease†									
	Neuroinvasive					Non-neuroinvasive				
	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum
Reporting area	week	Med	Max	2006	2005	week	Med	Max	2006	2005
United States	—	1	152	—	—	—	1	203	—	2
New England	—	0	3	—	—	—	0	2	—	—
Connecticut	—	0	2	—	—	—	0	1	—	—
Maine	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	3	—	—	—	0	1	—	—
New Hampshire	—	0	0	—	—	—	0	0	—	—
Rhode Island	—	0	1	—	—	—	0	0	—	—
Vermont§	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	—	0	9	—	—	—	0	3	—	—
New Jersey	—	0	1	—	—	—	0	2	—	—
New York (Upstate)	—	0	6	—	—	—	0	1	—	—
New York City	—	0	2	—	—	—	0	2	—	—
Pennsylvania	—	0	3	—	—	—	0	2	—	—
E.N. Central	—	0	39	—	—	—	0	18	—	—
Illinois	—	0	25	—	—	—	0	16	—	—
Indiana	—	0	2	—	—	—	0	1	—	—
Michigan	—	0	14	—	—	—	0	3	—	—
Ohio	—	0	9	—	—	—	0	4	—	—
Wisconsin	—	0	3	—	—	—	0	2	—	—
W.N. Central	—	0	26	—	—	—	0	78	—	—
Iowa	—	0	3	—	—	—	0	5	—	—
Kansas	—	0	2	—	—	N	0	2	N	N
Minnesota	—	0	5	—	—	—	0	5	—	—
Missouri	—	0	4	—	—	—	0	3	—	—
Nebraska§	—	0	9	—	—	—	0	22	—	—
North Dakota	—	0	4	—	—	—	0	15	—	—
South Dakota	—	0	7	—	—	—	0	33	—	—
S. Atlantic	—	0	5	—	—	—	0	4	—	—
Delaware	—	0	1	—	—	—	0	0	—	—
District of Columbia	—	0	0	—	—	—	0	0	—	—
Florida	—	0	2	—	—	—	0	4	—	—
Georgia	—	0	3	—	—	—	0	3	—	—
Maryland	—	0	2	—	—	—	0	1	—	—
North Carolina	—	0	1	—	—	—	0	1	—	—
South Carolina§	—	0	1	—	—	—	0	0	—	—
Virginia§	—	0	0	—	—	—	0	0	—	—
West Virginia	—	0	0	—	—	N	0	0	N	N
E.S. Central	—	0	10	—	—	—	0	5	—	—
Alabama§	—	0	1	—	—	—	0	2	—	—
Kentucky	—	0	1	—	—	—	0	0	—	—
Mississippi	—	0	9	—	—	—	0	5	—	—
Tennessee§	—	0	3	—	—	—	0	1	—	—
W.S. Central	—	0	32	—	—	—	0	21	—	2
Arkansas	—	0	3	—	—	—	0	2	—	—
Louisiana	—	0	20	—	—	—	0	8	—	2
Oklahoma	—	0	6	—	—	—	0	3	—	—
Texas§	—	0	16	—	—	—	0	13	—	—
Mountain	—	0	16	—	—	—	0	39	—	—
Arizona	—	0	8	—	—	—	0	8	—	—
Colorado	—	0	5	—	—	—	0	13	—	—
Idaho§	—	0	2	—	—	—	0	3	—	—
Montana	—	0	3	—	—	—	0	9	—	—
Nevada§	—	0	3	—	—	—	0	8	—	—
New Mexico§	—	0	3	—	—	—	0	4	—	—
Utah	—	0	6	—	—	—	0	8	—	—
Wyoming	—	0	2	—	—	—	0	1	—	—
Pacific	—	0	50	—	—	—	0	89	—	—
Alaska	—	0	0	—	—	—	0	0	—	—
California	—	0	50	—	—	—	0	88	—	—
Hawaii	—	0	0	—	—	—	0	0	—	—
Oregon§	—	0	1	—	—	—	0	2	—	—
Washington	—	0	0	—	—	—	0	0	—	—
American Samoa	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

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* Incidence data for reporting years 2005 and 2006 are provisional.
† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS). Because of a technical problem with hardware, NEDSS data from these states are not included this week.

TABLE III. Deaths in 122 U.S. cities,* week ending February 18, 2006 (7th Week)

Reporting Area	All causes, by age (years)						
	All Ages	≥65	45-64	25-44	1-24	<1	P&I† Total
New England	590	430	114	22	12	12	57
Boston, MA	153	103	31	8	7	4	13
Bridgeport, CT	28	22	6	—	—	—	3
Cambridge, MA	25	21	4	—	—	—	3
Fall River, MA	23	21	1	—	1	—	2
Hartford, CT	48	34	11	—	—	3	7
Lowell, MA	33	26	6	1	—	—	2
Lynn, MA	11	7	2	2	—	—	2
New Bedford, MA	28	22	6	—	—	—	—
New Haven, CT	41	30	5	2	1	3	4
Providence, RI	67	46	14	3	2	2	6
Somerville, MA	2	—	2	—	—	—	—
Springfield, MA	35	27	6	2	—	—	3
Waterbury, CT	33	27	4	2	—	—	3
Worcester, MA	63	44	16	2	1	—	9
Mid. Atlantic	1,950	1,362	419	110	26	33	126
Albany, NY	35	23	10	1	—	1	4
Allentown, PA	34	30	4	—	—	—	2
Buffalo, NY	56	34	16	3	1	2	3
Camden, NJ	34	16	14	1	—	3	1
Elizabeth, NJ	16	9	5	2	—	—	—
Erie, PA	38	31	6	1	—	—	6
Jersey City, NJ	U	U	U	U	U	U	U
New York City, NY	1,123	817	223	61	11	11	68
Newark, NJ	61	29	14	12	3	3	4
Paterson, NJ	12	7	4	—	—	1	—
Philadelphia, PA	206	107	67	19	7	6	15
Pittsburgh, PA§	23	18	3	1	—	1	2
Reading, PA	30	27	2	1	—	—	2
Rochester, NY	135	105	21	3	4	2	12
Schenectady, NY	19	13	4	1	—	1	1
Scranton, PA	37	31	5	—	—	1	—
Syracuse, NY	27	17	8	1	—	1	1
Trenton, NJ	26	18	7	1	—	—	1
Utica, NY	16	11	3	2	—	—	—
Yonkers, NY	22	19	3	—	—	—	4
E.N. Central	2,106	1,418	469	131	36	52	142
Akron, OH	43	31	9	2	1	—	3
Canton, OH	34	20	13	—	—	1	4
Chicago, IL	326	192	90	24	12	8	28
Cincinnati, OH	88	59	19	4	2	4	12
Cleveland, OH	253	190	49	9	2	3	12
Columbus, OH	203	136	42	16	3	6	17
Dayton, OH	132	95	28	5	3	1	7
Detroit, MI	169	91	49	18	4	7	12
Evansville, IN	43	35	7	1	—	—	2
Fort Wayne, IN	79	62	7	3	2	5	3
Gary, IN	16	10	3	3	—	—	—
Grand Rapids, MI	64	42	16	3	1	2	4
Indianapolis, IN	190	126	37	15	2	10	9
Lansing, MI	52	39	8	4	1	—	4
Milwaukee, WI	101	58	34	7	—	2	9
Peoria, IL	54	31	18	4	—	1	2
Rockford, IL	53	42	6	3	1	1	2
South Bend, IN	43	30	7	5	—	1	4
Toledo, OH	92	71	15	5	1	—	2
Youngstown, OH	71	58	12	—	1	—	6
W.N. Central	732	510	147	39	18	18	49
Des Moines, IA	73	60	8	1	2	2	3
Duluth, MN	32	24	8	—	—	—	1
Kansas City, KS	34	19	11	2	2	—	3
Kansas City, MO	102	62	28	8	—	4	5
Lincoln, NE	61	51	8	1	1	—	3
Minneapolis, MN	79	55	14	4	4	2	3
Omaha, NE	109	74	24	9	2	—	12
St. Louis, MO	80	51	16	7	3	3	10
St. Paul, MN	59	40	12	1	1	5	5
Wichita, KS	103	74	18	6	3	2	4
S. Atlantic	1,366	824	344	103	37	58	70
Atlanta, GA	172	77	47	19	6	23	2
Baltimore, MD	148	86	45	12	3	2	13
Charlotte, NC	134	81	27	12	7	7	13
Jacksonville, FL	159	107	34	11	4	3	4
Miami, FL	193	120	51	13	4	5	13
Norfolk, VA	56	32	13	7	2	2	—
Richmond, VA	56	35	15	3	3	—	2
Savannah, GA	56	37	10	3	2	4	2
St. Petersburg, FL	65	44	14	3	1	3	9
Tampa, FL	210	145	49	12	3	1	11
Washington, D.C.	104	53	33	8	2	8	1
Wilmington, DE	13	7	6	—	—	—	—
E.S. Central	858	541	218	62	19	18	63
Birmingham, AL	195	130	43	12	4	6	20
Chattanooga, TN	83	52	22	6	1	2	3
Knoxville, TN	104	64	29	5	3	3	6
Lexington, KY	55	37	14	3	1	—	2
Memphis, TN	148	89	44	12	2	1	12
Mobile, AL	66	49	8	7	2	—	5
Montgomery, AL	44	28	11	3	1	1	4
Nashville, TN	163	92	47	14	5	5	11
W.S. Central	1,595	1,055	349	115	44	32	121
Austin, TX	120	88	23	7	1	1	9
Baton Rouge, LA	64	46	14	2	2	—	—
Corpus Christi, TX	64	44	12	5	1	2	7
Dallas, TX	203	136	39	11	6	11	17
El Paso, TX	99	69	23	3	2	2	6
Fort Worth, TX	135	92	23	9	4	7	10
Houston, TX	440	266	109	43	17	5	41
Little Rock, AR	64	43	17	3	—	1	1
New Orleans, LA¶	U	U	U	U	U	U	U
San Antonio, TX	253	162	59	25	5	2	21
Shreveport, LA	36	28	5	—	3	—	6
Tulsa, OK	117	81	25	7	3	1	3
Mountain	1,060	696	239	74	28	18	92
Albuquerque, NM	135	92	26	11	5	1	18
Boise, ID	56	45	8	1	1	1	4
Colorado Springs, CO	76	43	23	7	2	1	2
Denver, CO	102	66	21	9	4	2	8
Las Vegas, NV	278	184	70	19	4	1	27
Ogden, UT	37	22	13	1	1	—	3
Phoenix, AZ	224	143	48	17	8	4	17
Pueblo, CO	26	22	2	2	—	—	2
Salt Like City, UT	126	79	28	7	3	8	11
Tucson, AZ	U	U	U	U	U	U	U
Pacific	1,588	1,118	336	84	33	17	150
Berkeley, CA	17	8	8	1	—	—	—
Fresno, CA	64	48	13	2	1	—	5
Glendale, CA	12	6	5	—	1	—	1
Honolulu, HI	42	32	8	—	1	1	—
Long Beach, CA	68	48	16	4	—	—	13
Los Angeles, CA	209	131	43	17	13	5	21
Pasadena, CA	17	13	4	—	—	—	1
Portland, OR	145	97	32	9	5	2	6
Sacramento, CA	178	139	25	11	2	1	19
San Diego, CA	140	100	28	9	3	—	11
San Francisco, CA	150	104	37	6	3	—	16
San Jose, CA	214	160	42	7	1	4	34
Santa Cruz, CA	20	16	4	—	—	—	1
Seattle, WA	136	91	34	10	—	1	9
Spokane, WA	55	41	12	1	—	1	4
Tacoma, WA	121	84	25	7	3	2	9
Total	11,845**	7,954	2,635	740	253	258	870

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.

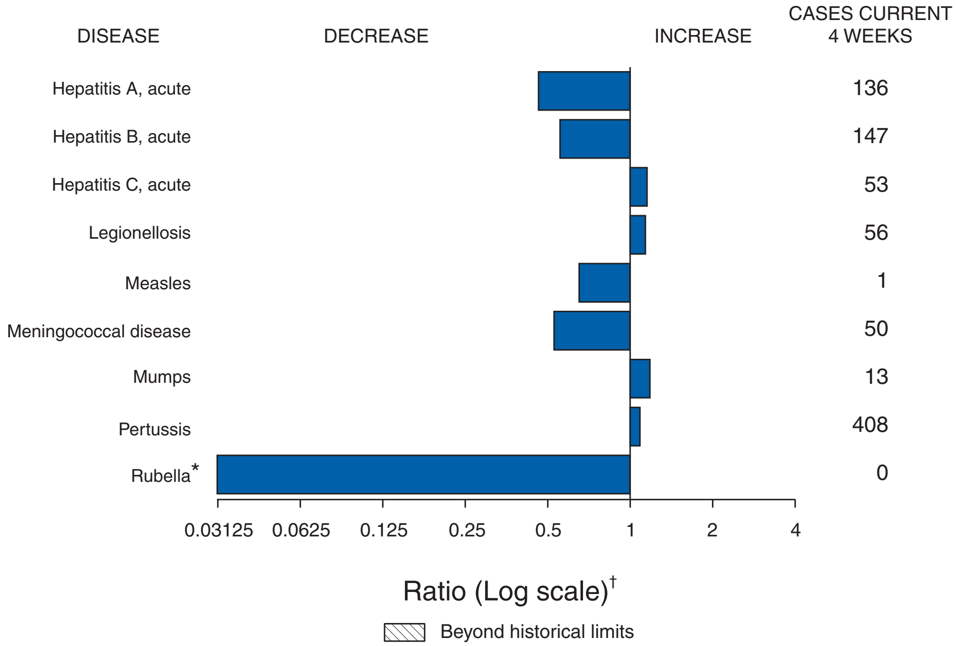
† Pneumonia and influenza.

§ 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.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals February 18, 2006, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 7 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.

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