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World AIDS Day — December 1, 2006

December 1 marks the 19th observance of World AIDS Day. The theme for this year is "Stop AIDS. Keep the Promise."

At the end of 2003, an estimated 1.0–1.2 million persons in the United States were living with human immunodeficiency virus (HIV) infection (*1*). Of these, an estimated 25% were unaware of their infection, underscoring a critical need to expand HIV testing (*1*).

To address this need, CDC has released revised recommendations for HIV testing (*2*). These recommendations aim to make HIV testing a routine part of medical care and to further improve rates of HIV diagnosis among pregnant women. Earlier diagnosis of HIV infection will enable more persons to receive life-saving treatment, resulting in improved health and extended life. In addition, the majority of persons who learn they have HIV infection adopt safer behaviors, thereby reducing HIV transmission to others (*3*). Finally, making HIV testing a routine part of medical care might help reduce the stigma that some associate with an HIV test.

Additional information is available at http://www.worldaidscampaign.info and at http://worldaidsday2006.org. Surveillance data on HIV/AIDS for 2005 will be available at http://www.cdc.gov/hiv/topics/surveillance/resources/reports/index.htm#surveillance (*4*).

References

1. Glynn M, Rhodes P. Estimated HIV prevalence in the United States at the end of 2003 [Abstract T1-B1101]. Presented at the 2005 National HIV Prevention Conference, Atlanta, GA; June 12–15, 2005.
2. CDC. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. MMWR 2006;55(No. RR-14):1–17.
3. Marks G, Crepaz N, Senterfitt JW, Janssen RS. Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States: implications for HIV prevention programs. J Acquir Immune Defic Syndr 2005;39:446–53.
4. CDC. HIV/AIDS surveillance report, 2005. Vol. 17. Atlanta, GA: US Department of Health and Human Services, CDC; 2006. In press.

Missed Opportunities for Earlier Diagnosis of HIV Infection — South Carolina, 1997–2005

In September 2006, CDC published revised recommendations for human immunodeficiency virus (HIV) testing in health-care settings to 1) increase early detection of HIV infection by expanding HIV screening of patients and 2) improve access to HIV care and prevention services (e.g., by conducting screening in locations such as emergency departments and urgent-care facilities, where persons who do not otherwise access HIV testing seek health-care services) (*1*). HIV screening is now recommended for patients aged 13–64 years in all health-care settings after patients are notified that testing will be performed unless they decline (opt-out screening). This represents a substantial change from earlier recommendations to 1) offer HIV testing routinely to all patients only in health-care settings with high HIV prevalence and 2) conduct targeted screening on the basis of risk behaviors for patients in low-prevalence settings (*2*). This report examines HIV and acquired immunodeficiency syndrome (AIDS) case reporting in South Carolina before the 2006 recommendations were published. During 2001–2005, a total of 4,315 cases of HIV infection were reported in South Carolina. Of these, 41% were in persons (referred to as late testers) in whom AIDS was diagnosed within 1 year of their initial HIV diagnosis* (*4*).

* The average latent period from HIV infection to onset of AIDS is approximately 10 years (*3*).

INSIDE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Of these late testers, 73% made a total of 7,988 visits to a South Carolina health-care facility during 1997–2005 before their first reported positive HIV test. The diagnoses reported for 79% of these visits were not likely to prompt HIV testing under a risk-based testing strategy. These findings suggest that routine, opt-out HIV screening of all patients in health-care settings, rather than risk-based HIV testing, might result in substantially earlier HIV diagnoses in South Carolina.

HIV/AIDS cases have been reportable by patient name in South Carolina since 1986. This analysis used data from the South Carolina HIV/AIDS Reporting System (HARS) for 2001–2005 and included date of first HIV-positive test, date of AIDS diagnosis, and state of residence. Data quality from HARS exceeds CDC minimum standards on reporting timeliness (95% of cases reported within 6 months of a diagnosis) and completeness of reporting (98%, based on a comparison with other data sources) (South Carolina Department of Health and Environment Control [DHEC], unpublished data, 2005).

Since 1996, state law has required that the Office of Research and Statistics (ORS), South Carolina Budget and Control Board receive reports on all diagnoses (classified by *International Classification of Diseases* [ICD] codes) from all emergency departments, hospital inpatient facilities, ambulatory-care facilities, and outpatient surgery facilities within the state. The health-care data for this report were supplied by 60 emergency departments, 62 inpatient facilities, 63 ambulatory-care facilities or outpatient surgery facilities, and 19 free medical clinics in the state, and represent visits that occurred during 1997–2005. ICD diagnoses were grouped into two categories: 1) diagnoses not suggestive of HIV infection and unlikely to have prompted an HIV test (e.g., hypertension, diabetes, and constipation) and 2) diagnoses suggestive of HIV infection that should have prompted an HIV test (e.g., sexually transmitted diseases, symptoms suggestive of acute retroviral syndrome [*5*], intravenous drug use, and diseases possibly or probably related to HIV infection [*6*]).

Data from HARS and ORS were linked using several identifiers, including patient name, date of birth, sex, race/ethnicity, and county of residence. This use of the data was approved by DHEC and the ORS Data Oversight Committee. The data were matched in a secured location by authorized persons who were trained in HARS security and confidentiality guidelines. All identifiers were removed from the analysis dataset provided to investigators, who also signed confidentiality agreements.

During 2001–2005, a total of 4,315 persons with HIV infection in South Carolina were reported to HARS, of whom 1,784 (41.3%) were late testers, including 710 (16.5%) who had AIDS diagnosed within 30 days of their initial HIV diagnoses. Women were less likely than men to be late testers; other demographic and risk characteristics of late testers were similar to those of persons reported to HARS who did not have onset of AIDS within 1 year of their HIV diagnoses. Of the 1,784 late testers, 1,302 (73.0%) had at least one documented visit to a South Carolina health-care facility during 1997–2005 and before the reported date of HIV diagnosis (Table 1).

A total of 7,988 health-care visits were recorded for the 1,302 late testers who had previously visited a health-care facility. Information on transmission category indicated that 441 (33.9%) of these 1,302 persons were identified as injection-drug users or men who have sex with men, persons with high-risk practices that should have prompted HIV screening if risk histories had been elicited during the health-care visits. However, diagnoses reported for 6,277 (78.6%) of these visits were not likely to prompt an HIV test (Table 2). Of the 7,988 visits, 6,303 (78.9%) were to emergency departments, 982 (12.3%) to inpatient settings, 594 (7.4%) to outpatient facilities, and 109 (1.4%) to free clinics. The median time between the visit to a health-care facility and the date of HIV diagnosis was 2.5 years (range: 0–9 years). The 1,302 late testers made a median of four health-care visits before HIV diagnosis (range: 1–132 visits); 280 (21.5%) late testers made only one health-care visit before HIV diagnosis, 567 (43.5%) made two to five previous visits, 259 (19.9%) made six to 10 visits, and 196 (15.1%) made more than 10 visits. Visits occurring ≤6 months before HIV diagnosis accounted for 1,202 (15.1%) of the 7,988 visits; 818 (10.2%) of visits were made >6 months to 1 year before, 1,340 (16.8%) were >1 to 2 years before, 1,337 (16.7%) were >2 to 3 years before, and 3,291 (41.2%) were >3 years before HIV diagnosis.

TABLE 1. Number and percentage of HIV-infected persons* with AIDS subsequently diagnosed within 1 year of HIV diagnosis who had visited a health-care facility before date of HIV diagnosis, by selected characteristics — South Carolina, 2001–2005

Characteristic	No.	(%)
Sex		
Male	888	(68.2)
Female	414	(31.8)
Race/Ethnicity†		
Black, non-Hispanic	1,057	(81.2)
White, non-Hispanic	214	(16.4)
Hispanic	21	(1.6)
Age at HIV diagnosis (yrs)		
13–19	23	(1.8)
20–29	202	(15.5)
30–39	430	(33.0)
40–49	411	(31.6)
≥50	236	(18.1)
Transmission category§		
Heterosexual	466	(35.8)
Men who have sex with men (MSM)	340	(26.1)
Injection-drug user (IDU)	83	(6.4)
MSM/IDU	18	(1.4)
Risk not specified	387	(29.7)

* N = 1,302. Reported in South Carolina during 2001–2005.
† Asians/Pacific Islanders, American Indians/Alaska Natives, and persons of multiple races were excluded because numbers were too small for meaningful analysis.
§ Transfusion recipients and persons with hemophilia were excluded because numbers were too small for meaningful analysis.

TABLE 2. Number and percentage of health-care visits by HIV-infected persons* with AIDS subsequently diagnosed within 1 year of HIV diagnosis who had visited a health-care facility before date of HIV diagnosis, by reported diagnosis — South Carolina, 1997–2005

Reported diagnosis	No.	(%)
Visits with diagnoses likely to prompt an HIV test	1,711	(21.4)
Sexually transmitted disease and related diagnoses	165	(2.1)
Symptoms suggestive of acute retroviral syndrome†	1,191	(14.9)
Diseases possibly related to HIV§	478	(6.0)
Diseases probably related to HIV¶	94	(1.2)
Intravenous drug use and related behaviors	85	(1.1)
Visits with diagnoses not likely to prompt an HIV test	6,277	(78.6)
Total visits	**7,988**	**(100.0)**

* N = 1,302. Reported in South Carolina during 2001–2005.
† Including fever, lymphadenopathy, and rash.
§ Including peripheral neuropathy, pneumonia, and thrombocytopenia.
¶ Including cerebral toxoplasmosis, pulmonary tuberculosis, and thrush.

Reported by: *W Duffus, MD, L Kettinger, MPH, T Stephens, MSPH, J Gibson, MD, South Carolina Dept of Health and Environmental Control; K Weis, MPH, School of Public Health, Univ of South Carolina; M Tyrell, PhD, D Patterson, PhD, C Finney, MPH, WP Bailey, MPH, Office of Research and Statistics, South Carolina Budget and Control Board. B Branson, MD, L Gardner, PhD, PH Kilmarx, MD, Div of HIV/AIDS Prevention, National Center for HIV, Viral Hepatitis, STDs, and Tuberculosis Prevention (proposed), CDC.*

Editorial Note: The findings in this report indicate that HIV-testing practices in South Carolina failed to identify a substantial proportion of HIV-infected persons early in the course of their infection. Early diagnosis of HIV infection is beneficial to the health of the patient (*7*) and might have a role in limiting further HIV transmission (*8*). Among the persons identified in this report as late testers (i.e., persons who received an AIDS diagnosis within 1 year of HIV diagnosis), approximately three fourths had visited a South Carolina health-care facility before having HIV diagnosed. Most of the late testers made multiple visits, and most of their visits occurred 1 year or more before diagnosis of HIV infection. These health-care encounters represent missed opportunities for earlier HIV diagnosis. The majority of diagnoses for these previous visits probably would not have prompted HIV testing under a risk-based testing strategy. In addition, the information on transmission category indicated that 441 (33.9%) of 1,302 persons were identified as injection-drug users or men who have sex with men, persons with high-risk practices that should have prompted HIV screening. Combined, these findings support the new recommendations for routine, opt-out HIV screening of patients in all health-care settings.

In 2004, South Carolina ranked tenth in rate of annual reported AIDS cases in the United States, with 18.1 AIDS cases per 100,000 population (*9*). The state's data on persons with newly diagnosed HIV in 2004–2005 indicate that a substantial proportion had low CD4+ T cell counts, which would have qualified them for antiretroviral treatment; nearly one third had $\leq$200 cells per mm^3, and approximately half had $\leq$350 cells per mm^3 (DHEC, unpublished data, 2006). These data also suggest a high prevalence and long duration of undiagnosed HIV infections in South Carolina.

The findings in this report are subject to at least five limitations. First, although HARS and ORS data are comprehensive, certain HIV/AIDS diagnoses and health-care visits probably were not reported. Second, although several variables were available for linking records between the two datasets, matching might not have been successful in all cases. Third, certain late testers might not have been HIV infected at the time of the previous health-care encounters, some of which occurred up to 8 years before AIDS was diagnosed; therefore, those instances might not have been missed opportunities for HIV diagnosis. However, given the long average latent period of approximately 10 years after HIV infection before the onset of AIDS (*3*), most persons who had AIDS during 2001–2005 would already have been HIV infected during most of their health-care visits beginning in 1997. Fourth, HIV testing might have been recommended but rejected by certain patients during earlier visits; refusal to test might have been related to the stigma that can be associated with risk-based HIV testing. Finally, referral for HIV testing might have occurred during some of the health-care encounters before HIV was diagnosed, so these visits might not represent missed opportunities.

Given the substantial number of health-care encounters in South Carolina during which an earlier diagnosis of HIV might have been made and the high proportion of these visits that would not have suggested the benefit of an HIV test under the risk-based HIV-testing strategy, these findings underscore the need for routine HIV screening of adults and adolescents visiting health-care facilities. The capacity of treatment and preventive services will need to be increased if HIV testing is made routine. Efforts are ongoing in South Carolina to expand these services. The benefit of routine HIV screening, early diagnosis of HIV infection, and linkage of infected persons to these services might be considerable because previous practices of testing based on risk factors or symptoms did not identify a substantial proportion of HIV-infected persons until late in the course of their disease.

References

1. CDC. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. MMWR 2006; 55(No. RR-14):1–17.
2. CDC. Revised guidelines for HIV counseling, testing, and referral. MMWR 2001;50(No. RR-19).
3. Fauci AS, Pantaleo G, Stanley S, Weissman D. Immunopathogenic mechanisms of HIV infection. Ann Intern Med 1996;124:654–63.
4. CDC. Late versus early testing of HIV—16 sites, United States, 2000–2003. MMWR 2003;52:581–6.
5. Kahn JO, Walker BD. Acute human immunodeficiency virus type 1 infection. N Engl J Med 1998;339:33–9.
6. Greenwald JL, Rich CA, Bessega S, et al. Evaluation of the Centers for Disease Control and Prevention's recommendations regarding routine testing for human immunodeficiency virus by an inpatient service: who are we missing? Mayo Clin Proc 2006;81:452–8.
7. Palella FJ, Deloria-Knoll M, Chmiel JS, et al. Survival benefit of initiating antiretroviral therapy in HIV-infected persons in different CD4+ cell strata. Ann Intern Med 2003;138:620–6.
8. Marks G, Crepaz N, Senterfitt JW, Janssen RS. Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States: implications for HIV prevention programs. J Acquir Immune Defic Syndr 2005;39:446–53.
9. CDC. HIV/AIDS surveillance report. Vol. 16. Atlanta, GA: US Department of Health and Human Services, CDC; 2004:29–30. Available at http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2004report/pdf/2004surveillancereport.pdf.

Injuries from Motor-Vehicle Collisions with Moose — Maine, 2000–2004

Moose are among the largest mammals in North America. Standing up to 7.5 feet at the shoulder and weighing up to 1,600 lbs, they are the largest members of the deer family (*1–3*). Maine's moose population (approximately 29,000) is the biggest in the United States outside of Alaska (*4*). During a collision with a motor vehicle, a moose usually is struck in the legs, causing its body to roll onto the hood of the vehicle, often collapsing the windshield and roof. As a result, motor-vehicle collisions involving moose are capable of causing substantial injury to vehicle occupants (*3*). To assess motor-vehicle collisions with moose in Maine and evaluate risk factors for injuries from these types of collisions, the Maine Department of Health and Human Services studied collision reports from 2000–2004. The results of that study indicated that collision rates varied by county but had clear patterns by season and time of day. Variables associated with risk for injury were posted speed limit, type of vehicle, and sex and age of the driver. Measures to reduce collisions with moose should focus on improving driver education programs and developing better engineering controls (e.g., removing roadside vegetation to improve visibility for drivers). In addition, herd management (i.e., decreasing moose population size through hunting) is

FIGURE 1. Number of motor-vehicle collisons with moose, by month — Maine, 2000–2004

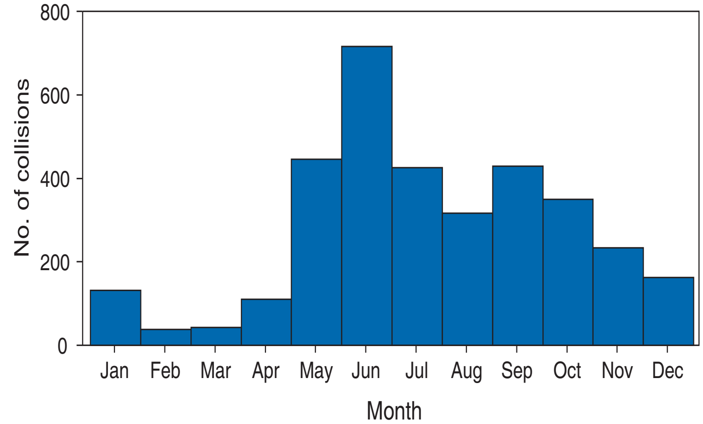
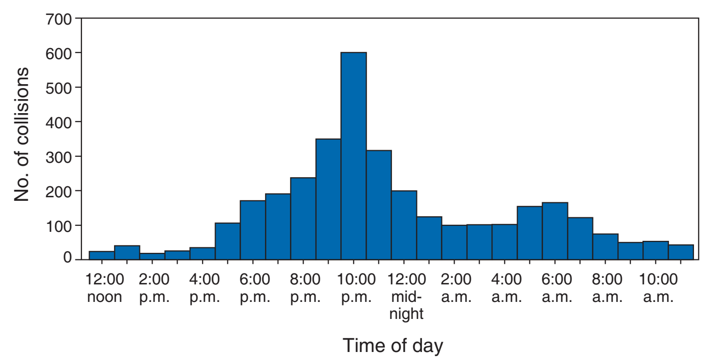


FIGURE 2. Number of motor-vehicle collisions with moose, by time of day — Maine, 2000–2004



currently being used in areas of Maine with high numbers of collisions, although studies are needed to assess its effectiveness.

Information was obtained from motor-vehicle collision reports submitted to the Maine Department of Transportation (DOT) by state, county, and local police during 2000–2004 using a standard form. DOT then entered the report information into two separate data sets: one containing collision information and the other containing driver information. DOT classified collisions into three categories: 1) collisions causing fatal injuries, 2) collisions causing nonfatal injuries, and 3) collisions causing no injuries (*5*). A nonfatal injury was subcategorized as an incapacitating injury, a nonincapacitating injury, or a possible injury. A noninjury collision was one that resulted in property damage only. Collision rates were calculated using population figures from the 2000 U.S. census. Relative risks (RRs) were calculated for selected exposure variables. Significant ($p<0.05$) variables were then assessed by logistic regression analysis.

During the 5-year period, 22,516 motor-vehicle collisions with animals were reported in Maine. Of these collisions, 18,289 (81%) were with deer, 3,400 (15%) with moose, and 827 (4%) with other animals. A total of 1,600 injuries (1,583 nonfatal and 17 fatal) were caused by these collisions. Although collisions with moose accounted for only 15% of collisions with animals, they accounted for 803 (50%) of the 1,600 total injuries: 14 (82%) of the 17 fatal injuries and 789 (50%) of the 1,583 nonfatal injuries.

The yearly collision rate with moose was 53 per 100,000 persons overall and ranged from seven to 310 in Maine's 16 counties. Rates were highest in the less populous northern part of the state and lowest in the more populous southeastern part of the state. The majority (2,683 [79%]) of collisions with moose occurred during May–October, with the greatest number of crashes (716 [21%]) occurring in June (Figure 1). The peak time of day for collisions was 10–11 p.m., with 600 collisions (18%); a total of 2,645 (78%) collisions occurred during 6 p.m.–6 a.m. (Figure 2). Occupants of vehicles involved in motor-vehicle collisions with moose were more likely to be injured from the collision when the posted speed limit was ≥40 m.p.h. (RR = 1.9, 95% confidence interval [CI] = 1.1–3.3). Neither daylight nor wet road conditions caused by precipitation were significantly associated with a higher risk of being injured in a moose collision. Data regarding locations of collisions were limited to the county level, so particularly high-risk roads or locations could not be identified.

Of the 3,400 collisions with moose, 33 were multivehicle collisions; a total of 3,442 drivers were involved. Because the data assessment did not include identity of the drivers, whether a particular driver had been involved in more than one collision could not be determined. The median age of drivers was 43 years (range: 15–90 years). Seventy-three percent of drivers were male, and 99% were considered in normal physical condition at the time the collision occurred; 1% were classified as fatigued, ill, handicapped, or under the influence of alcohol or drugs. Among drivers involved in collisions with moose, drivers of cars had a higher (38%) chance of being injured than drivers of certain other vehicles (10%) (e.g., sport-utility vehicles [SUVs], trucks, vans, buses, farm vehicles, and commercial vehicles) (RR = 3.4, CI = 2.9–3.9).* Drivers aged <25 years were more likely to be injured than drivers aged ≥25 years (RR = 1.5, CI = 1.3–1.8), and women were more likely to be injured than men (RR = 1.6, CI = 1.4–1.8).

In logistic regression analysis, only driver age and vehicle type were associated with risk for driver injury. Drivers aged <25 years had higher odds of injury than older drivers (odds ratio [OR] = 1.3, CI = 1.0–1.6). Male drivers of cars had higher odds of injuries (OR = 4.7, CI = 3.7–5.9) than female drivers of cars (OR = 2.8, CI = 1.9–3.9).

* Because few collisions occurred with motorcycles, they were excluded from the analyses but are included in the total numbers of collisions presented in this report.

Reported by: *A Pelletier, MD, Div of State and Local Readiness, Coordinating Office for Terrorism Preparedness and Emergency Response, CDC. A Rey, MPH, EIS Officer, CDC.*

Editorial Note: Collisions between moose and motor vehicles in Maine cause a disproportionately high number of injuries compared with collisions with other animals. Differences in rates among counties likely are a result of variations in the moose and human population sizes in different areas of the state. The moose population is greater in the northern region of Maine, which has fewer persons than the southern region. The distinct seasonal pattern of collisions with moose (i.e., higher numbers in May–October) correlates with the increased activity of moose during the warmer months and the September–October mating season; in contrast, the deer mating season occurs during October–December, which correlates with higher numbers of deer collisions during these months. The daily time pattern, with higher numbers of collisions occurring during 6 p.m.–6 a.m., seems to correspond with daily patterns of moose activity; moose are more active in the evening and at dawn. In addition, few roads in Maine are lighted, so seeing moose on roads at night is difficult.

The finding that vehicle type was associated with injury in the logistic regression model supports other studies that have found that vehicle type influences likelihood of injury (*2*). The additional height and mass of larger vehicles such as trucks and SUVs might help protect drivers of these types of vehicles from injury. The association between younger driver age and higher risk for injury might be a result of younger drivers' inexperience and driving habits such as speeding or not using safety belts (*6,7*). Differences in injury by sex might have been the result of factors that were not included in the logistic regression model (e.g., speed limit, safety-belt use, or driver behavior).

The findings in this report are subject to at least three limitations. First, information on safety-belt use was not included in either data set provided by DOT, although it is recorded in the vehicle collision reports that are submitted to DOT by police. Although the association of safety-belt use with risk for injury could not be assessed in this study, the use of safety belts is the most effective means of reducing fatal and nonfatal injuries in motor-vehicle crashes (*8*). Second, information regarding the distribution of moose throughout the state was limited. As a result, collision rates based on moose population density could not be calculated. Finally, although the posted speed limit was associated with injury in the bivariate analysis, it was not included in the logistic regression model because of difficulties associated with merging the collision and driver data sets.

Several public awareness initiatives to prevent motor-vehicle collisions with moose in Maine are ongoing. For example, a statewide campaign involves alerting the public about moose collisions and providing tips for drivers on ways to avoid or decrease the severity of collisions with moose. Brochures are available at libraries, schools, state parks, tourism centers, and other distribution points throughout Maine. In addition, a module on large-animal collisions is a component of Maine Department of Motor Vehicles driver education programs. Other strategies include engineering controls such as clearing roadside vegetation to improve sight lines and placing signs on roads known to have frequent vehicle-moose collisions. Herd management might be an effective strategy in areas with large moose populations. Maine currently manages the size of the moose population through hunting by increasing the number of available moose-hunting permits in areas with high numbers of collisions. Studies are needed to assess the effectiveness of this and other strategies currently being used to reduce the numbers of motor-vehicle collisions with moose.

Acknowledgments

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References

1. Bartalucci A, Weinstein B, Dewey T. *Alces alces*. Ann Arbor, MI: University of Michigan, Museum of Zoology; 2000. Available at http://animaldiversity.ummz.umich.edu/site/accounts/information/Alces_alces.html.
2. Farrell TM, Sutton JE, Clark DE, et al. Moose-motor vehicle collisions: an increasing hazard in northern New England. Arch Surg 1996;131:377–81.
3. Pynn TP, Pynn BR. Moose and other large animal wildlife vehicle collisions: implications for prevention and emergency care. J Emerg Nurs 2004;30:542–7.
4. Seymour T. Southern moose hunt. Maine Fish Wildl 2006;47:8–10.
5. Maine Department of Transportation. Collisions between wildlife species and motor vehicles in Maine 1999–2003. Augusta, ME: Maine Department of Transportation; 2004.
6. Boyce TE, Geller ES. An instrumented vehicle assessment of problem behavior and driving style: do younger males really take more risks? Accid Anal Prev 2002;34:51–64.
7. McKnight AJ, McKnight AS. Young novice drivers: careless or clueless? Accid Anal Prevention 2003;35:921–5.
8. Dinh-Zarr TB, Sleet DA, Shults RA, et al. Reviews of evidence regarding interventions to increase the use of safety belts. Am J Prev Med 2001;21(Suppl 4):S48–65.

Racial/Ethnic Differences Among Youths in Cigarette Smoking and Susceptibility to Start Smoking — United States, 2002–2004

Limited information on cigarette smoking in racial/ethnic subpopulations hinders development and implementation of targeted interventions for smoking prevention and cessation. Because of small sample sizes or inadequate study formats, cigarette smoking among youths has been studied mostly in major racial/ethnic populations (e.g., Asian or Hispanic) instead of subsets of these populations (e.g., Vietnamese or Cuban). Data on major population categories might mask differences in tobacco-use prevalence among subpopulations. To assess the prevalence of cigarette smoking among youths aged 12–17 years in six major racial/ethnic populations* and nine Asian or Hispanic subpopulations† in the United States, the Substance Abuse and Mental Health Services Administration and CDC analyzed self-reported data collected during 2002–2004 from the National Survey on Drug Use and Health (NSDUH). This report summarizes the results of that analysis, which indicated that the estimated prevalence of cigarette smoking in this age group ranged from 23.1% for American Indians/Alaska Natives (AI/ANs) to 2.2% for Vietnamese. Implementing tobacco-control programs that include culturally appropriate interventions might help reduce cigarette smoking in racial/ethnic subpopulations.

NSDUH is an annual, in-person household survey that collects information on drug use and abuse from a nationally representative sample of the U.S. civilian, noninstitutionalized population aged ≥12 years. The average, weighted, overall response rate for the 2002–2004 surveys was 81% for youths aged 12–17 years, based on a household screening response rate of 91% and an interview response rate of 89%; the final sample size was 68,611. Racial/ethnic classifications by NSDUH were based on standards for classification of federal data (*1*). Prevalences and 95% confidence intervals (CIs) were calculated; data were weighted to account for different probabilities of selection within strata. Differences in prevalences were considered statistically significant if CIs did not overlap; no other test for statistical significance was performed.

Current cigarette smoking was assessed by asking respondents aged 12–17 years, "During the past 30 days, have you smoked part or all of a cigarette?" Youths who answered "yes" were classified as current smokers. Susceptibility to start smoking among self-reported nonsmokers was determined by the following two questions: 1) "If one of your best friends offered you a cigarette, would you smoke it?" and 2) "At any time during the next 12 months, do you think that you will smoke a cigarette?" Possible answers were "definitely not," "probably not," "probably yes," and "definitely yes." Those who answered "definitely not" to both questions were classified as nonsusceptible; those who answered with any other combination of responses were considered susceptible to start smoking.

Among youths, AI/ANs had the greatest cigarette smoking prevalence (23.1%), followed by non-Hispanic whites (14.9%), Hispanics (9.3%), non-Hispanic blacks (6.5%), and Asians (4.3%) (Table 1). Among Asian subpopulations, smoking prevalence ranged from 2.2% for Vietnamese to 6.8% for Koreans; among Hispanic populations, prevalence ranged from 7.3% for Central and South Americans to 11.2% for Cubans. However, none of the differences among Asian subpopulations and Hispanic subpopulations were statistically significant. No significant differences were observed between male and female youths in any of the major populations or subpopulations, except for non-Hispanic white youths, among whom females had a greater prevalence of cigarette smoking (16.0%) than males (13.4%).

A wide range in susceptibility to start smoking was observed among youths who had never smoked (Table 2). Overall, 22.2% were susceptible to start smoking. Youths in the Mexican subpopulation were significantly more susceptible (28.8%) to start smoking than non-Hispanic white (20.8%), non-Hispanic black (23.0%), Cuban (16.4%), Asian Indian (15.4%), Chinese (15.3%), and Vietnamese (13.8%) youths. No significant differences in susceptibility to start smoking were observed between male and female youths in any of the major populations or subpopulations.

Reported by: *J Gfroerer, Office of Applied Studies, Substance Abuse and Mental Health Services Admin. R Caraballo, PhD, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

Editorial Note: The findings in this report indicate that cigarette smoking varied among racial/ethnic subpopulations in addition to major populations of youths aged 12–17 years and that AI/AN youths had the highest prevalence of cigarette smoking in the United States. Differences in smoking prevalence might be attributable to multiple factors, including cigarette prices and discount offers, exposure to antismoking campaigns, and ability to buy cigarettes, all of which can vary by racial/ethnic population (*2*).

This study also suggests that, overall, approximately one in five nonsmokers aged 12–17 years is susceptible to start smoking. Among the six major populations and nine Asian or

* Major racial/ethnic populations include: Hispanics and the following non-Hispanic populations: white, black or African American, American Indian/Alaska Native, Hawaiian or other Pacific Islander, and Asian.

† Asian subpopulations: Chinese, Filipino, Asian Indian, Korean, and Vietnamese. Hispanic subpopulations: Mexican, Puerto Rican, Central or South American, and Cuban.

TABLE 1. Percentage of youths aged 12–17 years who had smoked one or more cigarettes during the preceding month,* by race/ethnicity and sex — National Survey on Drug Use and Health, United States, 2002–2004

	Total		Male		Female	
Race/Ethnicity	%	(95% CI†)	%	(95% CI)	%	(95% CI)
Overall§	**12.3**	**(12.0–12.7)**	**11.8**	**(11.4–12.3)**	**12.9**	**(12.4–13.4)**
All non-Hispanic§	**12.9**	**(12.6–13.3)**	12.3	(11.8–12.8)	13.6	(13.1–14.1)
White	**14.9**	**(14.5–15.4)**	13.9	(13.4–14.5)	16.0	(15.3–16.6)
Black or African American	**6.5**	**(5.9–7.1)**	7.1	(6.2–8.1)	5.9	(5.1–6.8)
American Indian/Alaska Native	**23.1**	**(18.9–28.1)**	18.7	(14.7–23.4)	28.3	(21.5–36.3)
Hawaiian or other Pacific Islander	**7.1**	**(4.0–12.5)**	NA¶		7.8	(4.0–14.6)
Asian§	**4.3**	**(3.3–5.7)**	5.2	(3.6–7.4)	3.4	(2.2–5.1)
Chinese	***2.9***	***(1.4–6.0)***	*3.7*	*(1.4–9.2)*	*2.1*	*(0.7–6.6)*
Filipino	***4.6***	***(2.3–8.9)***	*3.9*	*(1.5–9.9)*	*5.3*	*(2.0–12.9)*
Asian Indian	***4.5***	***(2.4–8.3)***	*5.0*	*(1.8–12.9)*	*4.1*	*(2.1–7.7)*
Korean	***6.8***	***(3.3–13.4)***	*7.4*	*(3.2–16.4)*	*NA*	
Vietnamese	***2.2***	***(0.7–6.9)***	*NA*		*NA*	
Hispanic§	**9.3**	**(8.5–10.1)**	9.2	(8.1–10.5)	9.4	(8.4–10.5)
Mexican	***9.0***	***(8.0–10.1)***	*9.7*	*(8.3–11.3)*	*8.2*	*(7.1–9.6)*
Puerto Rican	***11.1***	***(9.0–13.7)***	*9.2*	*(6.2–13.4)*	*13.4*	*(10.3–17.1)*
Central or South American	***7.3***	***(5.4–9.7)***	*6.1*	*(3.7–9.9)*	*8.6*	*(6.1–12.1)*
Cuban	***11.2***	***(6.9–17.6)***	*NA*		*12.2*	*(6.9–20.8)*

* As determined by a "yes" response to the question: "During the past 30 days, have you smoked part or all of a cigarette?"
† Confidence interval.
§ Totals include data from respondents reporting other racial/ethnic subpopulations or more than one of those listed.
¶ Not applicable; values too small for meaningful analysis.

TABLE 2. Percentage of youths aged 12–17 years who had never smoked but were susceptible to start smoking cigarettes,* by race/ethnicity and sex — National Survey on Drug Use and Health, United States, 2002–2004

	Total		Male		Female	
Race/Ethnicity	%	(95% CI†)	%	(95% CI)	%	(95% CI)
Overall§	**22.2**	**(21.8–22.7)**	**22.7**	**(22.0–23.4)**	**21.8**	**(21.0–22.5)**
All non-Hispanic§	**21.3**	**(20.8–21.8)**	21.8	(21.1–22.6)	20.7	(20.0–21.5)
White	**20.8**	**(20.3–21.4)**	21.0	(20.2–21.8)	20.7	(19.8–21.5)
Black or African American	**23.0**	**(21.9–24.2)**	24.1	(22.5–25.9)	21.9	(20.3–23.5)
American Indian/Alaska Native	**26.3**	**(21.0–32.3)**	32.1	(24.3–41.0)	19.4	(12.7–28.3)
Hawaiian or other Pacific Islander	**NA¶**		NA		NA	
Asian§	**18.3**	**(15.7–21.2)**	22.1	(18.1–26.7)	14.6	(11.7–18.2)
Chinese	***15.3***	***(10.4–21.9)***	*14.3*	*(7.9–24.4)*	*16.2*	*(10.2–24.7)*
Filipino	***22.4***	***(16.6–29.5)***	*26.6*	*(17.9–37.5)*	*17.9*	*(10.8–28.4)*
Asian Indian	***15.4***	***(10.7–21.8)***	*NA*		*9.9*	*(6.0–15.9)*
Korean	***24.9***	***(16.8–35.2)***	*NA*		*NA*	
Vietnamese	***13.8***	***(7.9–23.0)***	*NA*		*NA*	
Hispanic§	**27.0**	**(25.6–28.4)**	27.1	(25.0–29.2)	26.9	(24.8–29.2)
Mexican	***28.8***	***(27.1–30.6)***	*29.5*	*(27.1–32.0)*	*28.1*	*(25.5–30.9)*
Puerto Rican	***23.3***	***(19.4–27.7)***	*20.2*	*(14.7–27.2)*	*27.2*	*(21.4–33.8)*
Central or South American	***24.7***	***(20.6–29.4)***	*25.4*	*(19.4–32.5)*	*23.9*	*(18.7–29.8)*
Cuban	***16.4***	***(11.2–23.4)***	*16.6*	*(10.4–25.4)*	*16.2*	*(9.2–26.9)*

* Susceptibility to start smoking among self-reported nonsmokers was determined by the following two questions: 1) "If one of your best friends offered you a cigarette, would you smoke it?" and 2) "At any time during the next 12 months, do you think that you will smoke a cigarette?" Possible answers were "definitely not," "probably not," "probably yes," and "definitely yes." Those who answered "definitely not" to both questions were classified as nonsusceptible; those who answered with any other combination of responses were considered susceptible to start smoking.
† Confidence interval.
§ Totals include data from respondents reporting other racial/ethnic subpopulations or more than one of those listed.
¶ Not applicable; values too small for meaningful analysis.

Hispanic subpopulations studied, Mexican youths who had never smoked appeared most susceptible to start smoking. Youths in this subpopulation might need specialized prevention interventions to lower their susceptibility.

Two major public health objectives are 1) to prevent the initiation of cigarette smoking among children, adolescents, and young adults and 2) to help those who already smoke, including children and adolescents, to quit. The overall prevalence of cigarette smoking among high school students declined from 36.4% in 1997 to 23.0% in 2005 (*3*); however, recent evidence suggests that the reduction in smoking rates over time might have stalled (*4*).

Children and teens constitute the majority of all new smokers (*5*). In 2003, cigarette companies spent approximately $15.2 billion to promote their products, nearly triple their spending in 1996 (*6*). Conversely, spending by state tobacco-control programs declined from $749.7 million in 2002 to $551.0 million in 2006, an amount still less than 3% of the $21.3 billion that the states received in 2005 from tobacco excise taxes and the 1998 Tobacco Master Settlement Agreement (*7*). The decline in spending on tobacco-control programs might have been a factor in slowing the progress made in reducing smoking among adolescents (*3,8*).

The findings in this report are subject to at least four limitations. First, NSDUH surveys are conducted only in English or Spanish, which might have limited participation by some persons (e.g., Asians). Second, the precision of smoking prevalence estimates for certain racial/ethnic subpopulations is low, especially when reported by sex; therefore, differences in prevalence among these subpopulations might not have been detected, and estimates should be interpreted with caution. Third, the data in this report were self-reported in participant households and subject to social-desirability bias (*2*). However, to reduce this bias, the tobacco-use section in the NSDUH survey was administered using computer-assisted self-interviewing, in which participants read the questions on a computer screen or listened to them through headphones and then entered their responses into the computer. Finally, because of changes in the NSDUH survey methodology in 2002, comparison of the estimates in this report with pre-2002 NSDUH data is not recommended (*9*).

Sustained, culturally appropriate interventions to prevent youths from starting to smoke or help them to quit might be effective in racial/ethnic populations and subpopulations with high prevalences of cigarette smoking. Effective tobacco-control initiatives might result from comprehensive behavior-based approaches enhanced by 1) using culturally targeted media and education campaigns (*10*) and 2) increasing the capacities (e.g., for program development) of specific populations to address tobacco use within their communities. To aid these populations in developing programs, systematic reviews of the effectiveness of interventions to reduce or prevent tobacco use are offered by the *Guide to Community Preventive Services* at http://www.thecommunityguide.org/tobacco.

References

1. Office of Management and Budget. Standards for the classification of federal data on race and ethnicity. Federal Register 1995;60:4674–93.
2. CDC. Preventing tobacco use among young people: a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, CDC; 1994.
3. CDC. Youth risk behavior surveillance—United States, 2005. MMWR 2006;55(No. SS-5).
4. Johnston LD, O'Malley PM, Bachman JG, Schulenberg JE. Monitoring the future national results on adolescent drug use: overview of key findings, 2005. Bethesda, MD: National Institute on Drug Abuse. In press.
5. Substance Abuse and Mental Health Services Administration. Results from the 2005 National Survey on Drug Use and Health: national findings. Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies; 2006.
6. Federal Trade Commission. Cigarette report for 2003. Washington, DC: Federal Trade Commission; 2005.
7. Campaign for Tobacco-Free Kids. A broken promise to our children: the 1998 state tobacco settlement seven years later. Washington, DC: Campaign for Tobacco Free Kids; 2005. Available at http://www.tobaccofreekids.org/reports/settlements/2006/fullreport.pdf.
8. Tauras JA, Chaloupka FJ, Farrelly MC, et al. State tobacco control spending and youth smoking. Am J Public Health 2005;95:338–4.
9. Bowman KR, Chromy JR, Hunter SR, Martin PC, Odom DM, eds. 2003 NSDUH methodological resource book. Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies; 2005.
10. Office of Minority Health. Closing the health gap. Washington, DC: US Department of Health and Human Services, Office of Minority Health; 2003. Available at http://www.omhrc.gov/healthgap.

Brief Report

Respiratory Syncytial Virus Activity — United States, 2005–2006

Respiratory syncytial virus (RSV) is a major cause of lower respiratory tract infections (LRTIs) (e.g., bronchiolitis and pneumonia) among young children in the United States (*1*). RSV also causes severe respiratory disease and a substantial number of deaths among older adults (*2*) and persons with compromised respiratory, cardiac, or immune systems (*3*). RSV is transmitted person to person through close contact or inhalation of large droplets from a sneeze or cough; infection also can occur through contact with fomites (i.e., contaminated surfaces or objects). In temperate climates, peak RSV activity typically occurs during the winter. This report presents preliminary data on RSV activity reported to the National Respiratory and Enteric Virus Surveillance System (NREVSS) for the weeks ending July 8–November 18, 2006, indicating the onset of the 2006–2007 RSV season, and summarizes RSV trends during July 2005–June 2006. Health-care providers should consider RSV in the differential diagnosis for persons of all ages with LRTIs and implement appropriate isolation precautions to prevent nosocomial transmission from RSV-infected patients (*4*). Immune prophylaxis should be considered for certain infants and young children at high risk for complications from RSV infection (e.g., certain premature infants or infants and children with chronic lung and heart disease) (*5*).

NREVSS is a laboratory-based passive surveillance system that monitors temporal and geographic trends for several respiratory and enteric viruses. The laboratories report weekly to CDC the number of specimens tested for viral pathogens, including RSV, and number of positive test results. During July 2005–June 2006, a total of 71 clinical and public health laboratories in 39 states* and the District of Columbia reported RSV data and are included in this analysis. Eighteen laboratories were excluded because of inconsistent reporting or reporting fewer than 35 weeks of data. A total of 120,503 tests were performed, and 19,533 (16.2%) were positive by antigen-detection testing. National RSV activity† began the week ending November 19, 2005, and continued for 21 weeks until April 1, 2006.

Data were summarized by region (West, East, South, and Central) except those from Florida. Data from Florida came from three laboratories (two in Miami and one in Orlando) and were presented separately because they differed substantially from RSV-detection data from the remainder of the South region (Figure). Regional RSV activity§ was highest during October for Florida, during late December and early January for the South (27 laboratories reporting), during January for the Northeast and Midwest (19 laboratories reporting), and during February for the West (15 laboratories reporting). The Florida RSV season seems similar to those reported from some tropical settings in the Northern Hemisphere (*6*).

Although 17,736 (91%) RSV detections were reported during November 12, 2005–April 15, 2006, sporadic detections were reported throughout the year. During mid-April through September 2006, laboratories in 36 states and the District of Columbia reported 1,072 RSV detections; of these, 511 (48%) were from Florida. Additional data from Florida laboratories not participating in NREVSS are available at http://www.doh.state.fl.us/disease_ctrl/epi/RSV/rsv.htm.

For the current reporting period (July 8–November 18, 2006), 62 laboratories in 37 states reported testing for RSV. Preliminary 2006 data suggest that the annual seasonal peak began in Florida during the week ending July 1, in the rest of the South during the week ending October 14, and in the Northeast during the week ending November 11 (Figure).

Health-care providers should consider RSV as a cause of acute respiratory disease in all age groups during the annual seasonal peak. Because the onset of RSV activity can vary among regions and communities, physicians and health-care facilities can consult their local clinical laboratories for the latest data on RSV activity. Although several tests can be used to detect RSV infection in young children, only sensitive reverse transcription–polymerase chain reaction (RT-PCR) assays are sufficient to reliably detect RSV in older children and adults (*7*). NREVSS expanded reporting to include RT–PCR testing for RSV in 2004. However, these data are not included in the annual summary because of the limited number of laboratories reporting RT–PCR results.

Currently, no vaccine or effective therapy is available for RSV. Infants and children at risk for serious RSV infection can receive immune prophylaxis with monthly doses of a humanized murine anti-RSV monoclonal antibody during the RSV season. Infants and children at risk include those aged <24 months with chronic lung disease who have required medical therapy within 6 months of RSV season onset and those with hemodynamically significant heart disease, and preterm infants born at <32 weeks' gestation or preterm infants born at 32–35 weeks' gestation with at least two additional risk factors (e.g., day care attendance, exposure to environmental pollutants, school-aged siblings, congenital abnormalities of the airways, or neuromuscular disease) during their first RSV season (*5*). Additional information and updates on RSV national and regional trends are available at http://www.cdc.gov/ncidod/dvrd/revb/nrevss/index.htm.

Reported by: *National Respiratory and Enteric Virus Surveillance System collaborating laboratories. AL Fowlkes, AM Fry, MD, LJ Anderson, MD, Div of Viral Diseases, National Center for Immunization and Respiratory Diseases (proposed), CDC.*

* *Northeast:* Connecticut, Massachusetts, New Hampshire, New Jersey, New York, and Rhode Island; *Midwest:* Illinois, Indiana, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; *South:* Alabama, Arkansas, Delaware, District of Columbia, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, and Virginia; *West:* Alaska, Arizona, California, Colorado, Hawaii, Montana, Washington, and Wyoming; Florida.

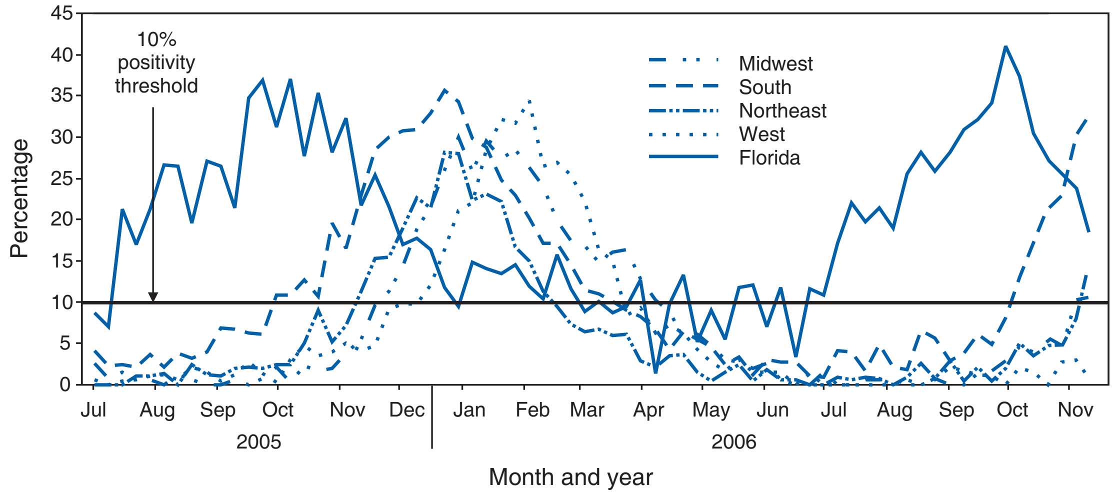
† National RSV activity is defined as the first of 2 consecutive weeks during which 50% of participating laboratories report RSV detections and the mean percentage of specimens positive by antigen detection is >10%.

§ Regional RSV onset and conclusion are defined by NREVSS as the median date that indicates the first of 2 consecutive weeks a participating laboratory reports >10% of specimens testing positive by antigen detection and the last week of >10% positive tests preceding 2 consecutive weeks of <10% positive tests.

References

1. Shay DK, Holman RC, Newman RD, Liu LL, Stout JW, Anderson LJ. Bronchiolitis-associated hospitalizations among U.S. children, 1980–1996. JAMA 1999;282:1440–6.
2. Thompson WW, Shay DK, Weintraub E, et al. Mortality associated with influenza and respiratory syncytial virus in the United States. JAMA 2003;289:179–86.

FIGURE. Percentage of specimens testing positive for respiratory syncytial virus, by region* and week of report — United States, July 9, 2005–November 18, 2006



* *Northeast:* Connecticut, Massachusetts, New Hampshire, New Jersey, New York, and Rhode Island; *Midwest:* Illinois, Indiana, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; *South:* Alabama, Arkansas, Delaware, District of Columbia, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, and Virginia; *West:* Alaska, Arizona, California, Colorado, Hawaii, Montana, Washington, and Wyoming; Florida. Data from Florida were presented separately because they differed substantially from RSV-detection data from the remainder of the South region.

3. Falsey, AR, Hennessey PA, Formica MA, Cox C, Walsh EE. Respiratory syncytial virus infection in elderly and high-risk adults. N Engl J Med 2005;352:1749–59.
4. CDC. Guidelines for preventing health-care–associated pneumonia, 2003: recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee. MMWR 2004;53(No. RR-3).
5. Meissner HC, Long SS, American Academy of Pediatrics Committee on Infectious Diseases and Committee on Fetus and Newborn. Revised indications for the use of palivizumab and respiratory syncytial virus immune globulin intravenous for the prevention of respiratory syncytial virus infections. Pediatrics 2003;112(6 Pt 1):1447–52.
6. Weber MW, Mullholland EK, Greenwood BM. Respiratory syncytial virus infection in tropical and developing countries. Top Med Int Health 1998;3:268–80.
7. Weinberg GA, Erdman DD, Edwards KM, et al. Superiority of reverse-transcription polymerase chain reaction to conventional viral culture in the diagnosis of acute respiratory tract infections in children. J Infect Dis 2004;189:706–10.

Notice to Readers

Epidemiology in Action: Intermediate Analytic Methods Course

CDC and Emory University's Rollins School of Public Health will cosponsor the course Epidemiology in Action: Intermediate Analytic Methods, February 26–March 2, 2007, at Emory University, Rollins School of Public Health. The course is designed for practicing public health professionals who have had training and experience in basic applied epidemiology and would like training in additional quantitative skills related to analysis and interpretation of epidemiologic data.

The course includes a review of the fundamentals of descriptive epidemiology and biostatistics, measures of association, normal and binomial distributions, confounding, statistical tests, stratification, logistic regression models, and computer programs as used in epidemiology.

The prerequisite is an introductory course in epidemiology, such as Epidemiology in Action or the International Course in Applied Epidemiology. Tuition will be charged. The application deadline is January 26, 2007, or until all slots have been filled.

Additional information and applications are available from Emory University, Hubert Global Health Dept (Attn: Pia), 1518 Clifton Rd. NE, Rm. 746, Atlanta, GA 30322; telephone, (404) 727-3485; fax (404) 727-4590; http://www.sph.emory.edu/epicourses or email pvaleri@sph.emory.edu.

Erratum: Vol. 55, No. 46

In the QuickStats on page 1255, the third line of the title is missing. The title should read: "Percentage of Persons Aged 22–44 Years at Increased Risk for Human Immunodeficiency Virus (HIV) Infection, by Race/Ethnicity and **Education — National Survey of Family Growth,* United States, 2002."**

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending November 25, 2006 (47th 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	—	1	0	—	—	—	2	23	
Botulism:									
foodborne	—	13	1	19	16	20	28	39	
infant	1	73	2	90	87	76	69	97	WA (1)
other (wound & unspecified)	—	43	1	33	30	33	21	19	
Brucellosis	—	100	2	122	114	104	125	136	
Chancroid	1	27	1	17	30	54	67	38	MI (1)
Cholera	—	6	0	8	5	2	2	3	
Cyclosporiasis[§]	1	108	1	716	171	75	156	147	OK (1)
Diphtheria	—	—	—	—	—	1	1	2	
Domestic arboviral diseases[§,¶]:									
California serogroup	—	50	1	80	112	108	164	128	
eastern equine	—	7	0	21	6	14	10	9	
Powassan	—	1	—	1	1	—	1	N	
St. Louis	—	7	0	13	12	41	28	79	
western equine	—	—	—	—	—	—	—	—	
Ehrlichiosis[§]:									
human granulocytic	3	354	8	790	537	362	511	261	NY (3)
human monocytic	4	354	5	521	338	321	216	142	NY (2), NC (2)
human (other & unspecified)	1	160	1	122	59	44	23	6	NY (1)
Haemophilus influenzae,**									
invasive disease (age <5 yrs):									
serotype b	—	9	0	9	19	32	34	—	
nonserotype b	—	76	3	135	135	117	144	—	
unknown serotype	1	172	3	217	177	227	153	—	OH (1)
Hansen disease[§]	—	66	2	88	105	95	96	79	
Hantavirus pulmonary syndrome[§]	—	30	0	29	24	26	19	8	
Hemolytic uremic syndrome, postdiarrheal[§]	—	219	3	221	200	178	216	202	
Hepatitis C viral, acute	7	673	28	751	713	1,102	1,835	3,976	PA (2), MI (3), OK (1), WA (1)
HIV infection, pediatric (age <13 yrs)[§,††]	—	52	5	380	436	504	420	543	
Influenza-associated pediatric mortality[§,§§]	—	40	0	45	—	N	N	N	
Listeriosis	8	647	13	892	753	696	665	613	PA (2), OH (1), MD (2), FL (1), CA (2)
Measles[¶¶]	—	44	1	66	37	56	44	116	
Meningococcal disease, invasive***:									
A, C, Y, & W-135	1	177	4	297	—	—	—	—	WV (1)
serogroup B	—	110	3	157	—	—	—	—	
other serogroup	1	19	0	27	—	—	—	—	IN (1)
Mumps	35	6,086	5	314	258	231	270	266	MN (33), MD (1), CO (1)
Plague	—	16	0	8	3	1	2	2	
Poliomyelitis, paralytic	—	—	—	1	—	—	—	—	
Psittacosis[§]	—	19	0	19	12	12	18	25	
Q fever[§]	—	136	1	139	70	71	61	26	
Rabies, human	—	1	0	2	7	2	3	1	
Rubella	—	9	—	11	10	7	18	23	
Rubella, congenital syndrome	—	1	0	1	—	1	1	3	
SARS-CoV[§,†††]	—	—	—	—	—	8	N	N	
Smallpox[§]	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome[§]	1	85	1	129	132	161	118	77	OH (1)
Streptococcus pneumoniae,[§]									
invasive disease (age <5 yrs)	12	994	18	1,257	1,162	845	513	498	RI (2), NY (4), OH (3), MD (2), AZ (1)
Syphilis, congenital (age <1 yr)	—	239	8	361	353	413	412	441	
Tetanus	—	19	1	27	34	20	25	37	
Toxic-shock syndrome (other than streptococcal)[§]	1	89	2	96	95	133	109	127	CA (1)
Trichinellosis	—	11	0	19	5	6	14	22	
Tularemia[§]	—	80	2	154	134	129	90	129	
Typhoid fever	—	244	5	324	322	356	321	368	
Vancomycin-intermediate *Staphylococcus aureus*[§]	—	3	0	2	—	N	N	N	
Vancomycin-resistant *Staphylococcus aureus*[§]	—	—	—	3	1	N	N	N	
Yellow fever	—	—	—	—	—	—	1	—	

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

* Incidence data for reporting year 2006 are provisional, whereas data for 2001, 2002, 2003, 2004, and 2005 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 Zoonotic, Vector-Borne, and Enteric Diseases (proposed) (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/AIDS, Viral Hepatitis, STD, and TB Prevention (proposed). Implementation of HIV reporting influences the number of cases reported. Pediatric HIV data will not be updated monthly for the remainder of this year due to upgrading of the national HIV/AIDS surveillance data management system. Data for HIV/AIDS are available in Table IV quarterly.

§§ Updated weekly from reports to the Influenza Division, National Center for Immunization and Respiratory Diseases (proposed).

¶¶ No measles cases were reported for the current week.

*** Data for meningococcal disease (all serogroups and unknown serogroups) are available in Table II.

††† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (proposed).

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending November 25, 2006, and November 26, 2005 (47th Week)*

	Chlamydia†					Coccidioidomycosis					Cryptosporidiosis				
		Previous 52 weeks					Previous 52 weeks					Previous 52 weeks			
Reporting area	Current week	Med	Max	Cum 2006	Cum 2005	Current week	Med	Max	Cum 2006	Cum 2005	Current week	Med	Max	Cum 2006	Cum 2005
United States	6,193	19,352	35,170	860,931	863,357	78	150	1,643	7,315	4,179	39	73	594	4,726	7,196
New England	261	650	1,550	29,963	28,920	—	0	0	—	—	6	3	36	270	337
Connecticut	54	174	1,214	8,511	8,510	N	0	0	N	N	—	0	33	33	77
Maine§	41	42	67	2,043	2,036	N	0	0	N	N	4	0	4	39	30
Massachusetts	125	296	607	13,930	12,923	—	0	0	—	—	—	1	14	88	145
New Hampshire	4	38	71	1,804	1,665	—	0	0	—	—	—	1	5	47	36
Rhode Island	19	63	107	2,682	2,939	—	0	0	—	—	—	0	6	14	13
Vermont§	18	20	43	993	847	N	0	0	N	N	2	0	5	49	36
Mid. Atlantic	1,107	2,410	3,696	108,583	107,077	—	0	0	—	—	10	10	444	523	3,129
New Jersey	63	363	496	16,110	17,334	N	0	0	N	N	—	0	3	11	56
New York (Upstate)	519	497	1,727	21,800	21,378	N	0	0	N	N	8	3	441	165	2,670
New York City	314	727	1,567	34,729	35,112	N	0	0	N	N	—	2	7	95	141
Pennsylvania	211	768	1,104	35,944	33,253	N	0	0	N	N	2	4	17	252	262
E.N. Central	702	3,140	12,578	141,256	146,823	—	1	3	42	11	2	15	105	1,149	1,569
Illinois	322	977	1,697	47,285	45,665	—	0	0	—	—	—	2	18	140	154
Indiana	—	387	478	17,243	18,119	N	0	0	N	N	1	1	18	90	79
Michigan	256	658	9,888	31,236	25,377	—	0	3	36	11	—	2	8	129	103
Ohio	46	636	1,424	28,189	39,189	—	0	2	6	—	1	5	33	335	751
Wisconsin	78	385	531	17,303	18,473	N	0	0	N	N	—	5	53	455	482
W.N. Central	511	1,160	1,455	53,326	53,247	—	0	12	1	4	2	12	77	801	584
Iowa	99	159	225	7,495	6,661	N	0	0	N	N	—	1	28	167	120
Kansas	106	150	269	6,479	6,665	N	0	0	N	N	—	1	8	77	36
Minnesota	—	236	347	10,091	11,120	—	0	12	—	3	—	3	22	214	127
Missouri	139	440	612	20,535	20,224	—	0	1	1	1	2	2	21	174	244
Nebraska§	107	96	176	4,858	4,580	N	0	0	N	N	—	1	16	88	26
North Dakota	12	33	61	1,500	1,511	N	0	0	N	N	—	0	4	9	1
South Dakota	48	51	116	2,368	2,486	N	0	0	N	N	—	1	7	72	30
S. Atlantic	1,653	3,695	4,936	167,079	158,817	—	0	1	3	2	16	15	70	1,053	698
Delaware	59	67	92	3,212	3,068	N	0	0	N	N	—	0	3	15	6
District of Columbia	38	53	138	2,629	3,418	—	0	0	—	—	—	0	2	14	15
Florida	423	964	1,157	44,022	38,646	N	0	0	N	N	6	6	32	504	323
Georgia	21	685	2,142	29,247	28,427	—	0	0	—	—	5	4	12	224	139
Maryland§	205	328	487	15,895	16,677	—	0	1	3	2	1	0	3	19	30
North Carolina	572	593	1,772	30,218	28,575	N	0	0	N	N	3	1	11	93	84
South Carolina§	108	347	1,452	17,622	17,075	N	0	0	N	N	—	1	13	122	23
Virginia§	207	430	840	21,445	20,459	N	0	0	N	N	—	1	6	52	64
West Virginia	20	58	227	2,789	2,472	N	0	0	N	N	1	0	3	10	14
E.S. Central	433	1,420	1,947	66,452	62,731	—	0	0	—	—	3	3	12	174	210
Alabama§	48	407	756	18,717	14,922	N	0	0	N	N	3	1	10	80	25
Kentucky	61	163	613	7,876	7,772	N	0	0	N	N	—	1	5	35	139
Mississippi	—	365	807	16,845	19,121	—	0	0	—	—	—	0	3	16	2
Tennessee§	324	512	608	23,014	20,916	N	0	0	N	N	—	1	5	43	44
W.S. Central	125	2,177	3,605	97,353	99,521	—	0	1	2	—	—	4	44	322	220
Arkansas	77	153	335	7,386	7,780	—	0	1	1	—	—	0	2	20	6
Louisiana	48	245	607	11,854	15,771	—	0	1	1	N	—	0	9	67	81
Oklahoma	—	227	2,159	11,232	10,463	N	0	0	N	N	—	1	4	38	41
Texas§	—	1,458	1,903	66,881	65,507	N	0	0	N	N	—	2	35	197	92
Mountain	262	1,025	1,839	46,119	56,307	62	109	452	5,018	2,707	—	3	39	359	133
Arizona	232	368	881	17,294	18,824	62	106	448	4,899	2,605	—	0	3	24	10
Colorado	—	145	395	5,480	13,932	N	0	0	N	N	—	1	7	67	49
Idaho§	—	48	191	2,333	2,454	N	0	0	N	N	—	0	5	35	14
Montana§	23	45	195	2,309	2,088	N	0	0	N	N	—	1	26	131	18
Nevada§	7	85	432	4,569	6,418	—	1	4	52	62	—	0	1	9	11
New Mexico§	—	189	339	8,477	7,442	—	0	3	13	19	—	0	5	27	17
Utah	—	94	176	4,470	4,105	—	1	3	52	18	—	0	3	18	11
Wyoming	—	27	54	1,187	1,044	—	0	2	2	3	—	0	11	48	3
Pacific	1,139	3,320	5,079	150,800	149,914	16	46	1,179	2,249	1,455	—	2	52	75	316
Alaska	32	82	152	3,657	3,822	—	0	0	—	—	—	0	1	4	3
California	653	2,570	4,231	118,552	116,258	16	46	1,179	2,249	1,455	—	0	14	—	189
Hawaii	2	101	135	4,627	4,985	N	0	0	N	N	—	0	1	4	1
Oregon§	209	165	315	7,937	8,075	N	0	0	N	N	—	1	7	67	67
Washington	243	348	604	16,027	16,774	N	0	0	N	N	—	0	38	—	56
American Samoa	U	0	46	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	—	17	27	—	768	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	82	187	3,855	3,678	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	5	16	178	196	—	0	0	—	—	—	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 year 2006 is provisional.
† Chlamydia refers to genital infections caused by *Chlamydia trachomatis*.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 25, 2006, and November 26, 2005 (47th Week)*

Reporting area	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive All ages, all serotypes				
	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	138	319	1,029	15,341	17,388	1,893	6,584	14,136	299,360	297,772	19	39	142	1,770	1,996
New England	13	23	75	1,094	1,562	40	110	288	5,053	5,173	2	2	19	138	150
Connecticut	—	1	37	268	347	14	42	241	2,017	2,190	—	0	9	43	44
Maine†	6	2	13	168	192	2	2	8	117	126	—	0	4	19	10
Massachusetts	—	9	18	357	685	14	47	98	2,233	2,254	—	1	7	52	72
New Hampshire	—	0	9	27	59	1	3	9	175	160	—	0	2	9	8
Rhode Island	2	0	25	102	107	7	9	19	450	389	2	0	7	6	7
Vermont†	5	3	12	172	172	2	1	4	61	54	—	0	2	9	9
Mid. Atlantic	43	62	254	2,987	3,134	233	646	1,014	29,113	30,835	4	7	30	339	385
New Jersey	—	9	13	339	418	47	102	160	4,580	5,136	—	0	4	—	80
New York (Upstate)	37	24	227	1,141	1,093	77	122	455	5,619	6,290	3	3	27	129	106
New York City	1	15	29	782	823	50	175	378	8,712	9,419	—	2	6	78	73
Pennsylvania	5	15	32	725	800	59	224	399	10,202	9,990	1	3	8	132	126
E.N. Central	8	47	82	2,205	3,059	242	1,279	7,047	57,621	59,695	4	5	14	246	337
Illinois	—	9	21	359	718	116	378	711	18,051	18,081	—	1	6	47	113
Indiana	N	0	0	N	N	—	161	244	7,670	7,313	1	1	11	73	58
Michigan	—	14	37	625	729	64	261	5,880	13,160	10,310	—	0	3	20	23
Ohio	8	16	32	744	733	16	303	648	12,828	18,731	3	2	6	79	103
Wisconsin	—	10	40	477	879	46	133	172	5,912	5,260	—	0	4	27	40
W.N. Central	4	28	260	1,610	2,056	143	370	444	16,893	16,919	1	2	15	137	102
Iowa	—	5	15	263	257	19	37	62	1,665	1,472	—	0	1	2	—
Kansas	—	3	11	180	192	28	41	124	1,815	2,333	—	0	3	14	14
Minnesota	—	1	238	481	894	1	63	105	2,613	3,161	—	0	9	72	40
Missouri	3	9	28	492	472	55	190	252	9,059	8,499	—	0	6	32	31
Nebraska†	1	2	9	105	111	33	26	56	1,284	1,038	—	0	2	8	14
North Dakota	—	0	7	17	17	—	3	7	115	103	1	0	3	9	3
South Dakota	—	1	5	72	113	7	6	15	342	313	—	0	0	—	—
S. Atlantic	22	50	95	2,391	2,500	668	1,607	2,334	74,948	70,214	4	10	24	475	475
Delaware	—	1	4	36	53	27	27	44	1,336	806	—	0	1	1	—
District of Columbia	—	1	4	57	51	43	35	61	1,680	1,926	—	0	2	7	9
Florida	13	19	44	1,022	880	205	458	549	20,780	17,916	4	3	9	155	120
Georgia	3	11	28	524	675	13	337	1,014	14,807	13,363	—	2	6	89	101
Maryland†	3	3	11	194	194	77	125	188	5,847	6,305	—	1	5	63	69
North Carolina	N	0	0	N	N	180	310	766	15,680	13,804	—	0	9	51	72
South Carolina†	—	1	7	91	101	52	150	704	7,977	7,937	—	1	3	32	32
Virginia†	3	8	50	435	501	63	130	288	5,939	7,519	—	1	8	58	46
West Virginia	—	0	6	32	45	8	18	43	902	638	—	0	4	19	26
E.S. Central	2	8	41	480	390	182	568	870	26,890	25,264	2	2	7	94	107
Alabama†	—	5	29	268	183	18	188	311	8,587	8,359	—	0	5	21	17
Kentucky	N	0	0	N	N	38	56	180	2,866	2,735	—	0	1	5	12
Mississippi	—	0	0	—	—	—	143	436	6,643	6,394	—	0	1	3	—
Tennessee†	2	4	12	212	207	126	191	238	8,794	7,776	2	1	4	65	78
W.S. Central	3	5	31	279	303	103	898	1,430	42,161	40,677	1	1	15	61	105
Arkansas	—	2	8	126	78	54	81	142	3,850	4,068	—	0	2	7	7
Louisiana	—	0	5	34	59	49	148	354	7,361	8,769	—	0	3	11	35
Oklahoma	3	2	24	119	166	—	82	764	4,189	4,157	1	1	14	43	56
Texas†	N	0	0	N	N	—	567	915	26,761	23,683	—	0	1	—	7
Mountain	11	30	66	1,519	1,413	66	222	552	10,562	12,057	1	4	8	174	199
Arizona	1	3	36	141	134	59	92	201	4,286	4,345	—	1	7	79	98
Colorado	5	9	33	504	496	—	45	85	2,067	2,900	1	1	4	45	39
Idaho†	5	3	12	172	142	—	2	15	139	106	—	0	1	6	5
Montana†	—	2	11	99	67	5	3	20	178	136	—	0	0	—	—
Nevada†	—	1	8	85	108	2	25	194	1,475	2,494	—	0	1	1	14
New Mexico†	—	1	6	63	81	—	32	65	1,540	1,366	—	0	4	24	25
Utah	—	7	24	419	359	—	18	25	767	637	—	0	4	16	9
Wyoming	—	1	4	36	26	—	2	6	110	73	—	0	1	3	9
Pacific	32	59	202	2,776	2,971	216	795	967	36,119	36,938	—	2	15	106	136
Alaska	1	1	17	96	105	7	11	24	501	523	—	0	2	9	27
California	16	42	105	1,972	2,110	127	654	834	29,775	30,742	—	0	9	27	56
Hawaii	—	1	3	40	60	4	18	29	794	927	—	0	1	16	9
Oregon†	2	8	14	350	384	28	27	49	1,208	1,415	—	1	6	52	44
Washington	13	6	90	318	312	50	76	142	3,841	3,331	—	0	4	2	—
American Samoa	U	0	0	U	U	U	0	2	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	—	11	—	3	15	—	82	—	0	1	—	14
Puerto Rico	—	1	12	77	243	—	5	16	239	332	—	0	0	—	4
U.S. Virgin Islands	—	0	0	—	—	—	0	5	30	45	—	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 year 2006 is provisional.
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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 25, 2006, and November 26, 2005 (47th Week)*

	Hepatitis (viral, acute), by type										Legionellosis				
	A					B									
		Previous 52 weeks					Previous 52 weeks					Previous 52 weeks			
Reporting area	Current week	Med	Max	Cum 2006	Cum 2005	Current week	Med	Max	Cum 2006	Cum 2005	Current week	Med	Max	Cum 2006	Cum 2005
United States	23	68	245	3,065	3,801	17	84	574	3,658	4,379	23	41	127	2,173	2,013
New England	2	3	20	154	432	—	2	8	87	142	2	2	12	115	143
Connecticut	—	1	2	37	48	—	0	3	29	44	1	0	9	49	33
Maine†	—	0	2	6	4	—	0	2	19	12	—	0	2	8	7
Massachusetts	—	0	6	51	279	—	0	5	14	48	—	0	4	27	64
New Hampshire	—	0	16	37	80	—	0	2	13	29	—	0	1	1	9
Rhode Island	2	0	4	14	15	—	0	4	9	3	1	0	10	22	21
Vermont†	—	0	2	9	6	—	0	1	3	6	—	0	2	8	9
Mid. Atlantic	1	6	17	321	606	2	8	55	382	598	5	15	47	823	697
New Jersey	—	1	6	71	144	—	2	8	96	219	—	1	11	96	116
New York (Upstate)	1	1	14	84	92	1	1	43	57	53	2	6	30	305	176
New York City	—	2	10	107	276	—	2	5	80	124	—	2	14	124	112
Pennsylvania	—	1	5	59	94	1	3	9	149	202	3	4	18	298	293
E.N. Central	—	6	13	283	338	1	8	24	367	529	4	8	26	427	412
Illinois	—	1	4	61	118	—	1	7	60	149	—	0	4	21	57
Indiana	—	0	5	30	19	—	0	17	53	40	—	0	4	34	30
Michigan	—	2	8	106	106	—	3	6	129	173	1	2	9	123	109
Ohio	—	1	4	49	49	1	2	10	117	123	3	4	19	213	183
Wisconsin	—	1	4	37	46	—	0	2	8	44	—	0	5	36	33
W.N. Central	—	2	30	122	84	1	4	22	151	249	—	1	15	74	93
Iowa	—	0	2	11	19	—	0	3	16	27	—	0	3	10	8
Kansas	—	0	5	27	16	1	0	2	11	27	—	0	2	6	3
Minnesota	—	0	29	16	3	—	0	13	23	29	—	0	11	24	26
Missouri	—	1	3	43	30	—	2	6	78	135	—	0	3	20	29
Nebraska†	—	0	2	17	15	—	0	3	20	24	—	0	2	9	4
North Dakota	—	0	2	—	—	—	0	0	—	—	—	0	1	—	2
South Dakota	—	0	3	8	1	—	0	1	3	7	—	0	1	5	21
S. Atlantic	6	10	29	515	671	5	23	66	1,043	1,261	4	8	19	398	384
Delaware	—	0	2	12	6	—	1	4	44	30	—	0	2	11	16
District of Columbia	1	0	2	8	4	—	0	2	7	11	1	0	5	30	12
Florida	4	4	13	198	269	3	8	19	378	437	2	3	9	146	104
Georgia	1	1	5	57	117	2	3	8	151	189	—	0	4	20	37
Maryland†	—	1	6	61	69	—	3	10	138	142	—	1	7	83	105
North Carolina	—	0	20	95	82	—	0	23	147	150	1	0	5	34	31
South Carolina†	—	0	3	23	40	—	2	7	73	142	—	0	1	4	15
Virginia†	—	1	11	55	80	—	1	18	56	123	—	1	7	57	44
West Virginia	—	0	3	6	4	—	0	18	49	37	—	0	3	13	20
E.S. Central	2	2	8	118	229	2	6	16	315	341	1	1	9	93	81
Alabama†	—	0	3	18	42	2	2	12	110	87	—	0	2	10	13
Kentucky	—	0	5	31	24	—	1	5	66	66	—	0	5	38	29
Mississippi	1	0	1	9	19	—	0	2	17	47	—	0	2	3	3
Tennessee†	1	1	5	60	144	—	2	7	122	141	1	1	7	42	36
W.S. Central	4	7	77	323	432	—	13	315	644	575	6	0	32	49	43
Arkansas	—	0	9	38	18	—	1	3	50	65	—	0	3	3	6
Louisiana	—	0	4	20	62	—	0	5	33	66	—	0	2	4	2
Oklahoma	3	0	2	9	5	—	0	17	70	39	6	0	3	7	7
Texas†	1	5	73	256	347	—	10	295	491	405	—	0	26	35	28
Mountain	1	5	17	247	302	2	3	16	155	173	—	2	8	115	91
Arizona	—	2	16	151	169	—	0	3	32	—	—	1	5	38	23
Colorado	1	1	4	36	39	2	1	5	34	53	—	0	2	21	19
Idaho†	—	0	2	9	21	—	0	2	13	16	—	0	3	11	4
Montana†	—	0	3	11	9	—	0	7	—	3	—	0	1	6	5
Nevada†	—	0	2	11	20	—	1	5	30	46	—	0	2	8	19
New Mexico†	—	0	3	13	24	—	0	2	19	18	—	0	1	5	4
Utah	—	0	2	13	19	—	0	5	27	35	—	0	6	26	13
Wyoming	—	0	1	3	1	—	0	1	—	2	—	0	0	—	4
Pacific	7	18	163	982	707	4	11	61	514	511	1	1	9	79	69
Alaska	—	0	0	—	4	—	0	3	9	7	—	0	0	—	1
California	3	15	162	885	590	1	8	41	381	344	1	1	9	79	65
Hawaii	—	0	2	10	24	—	0	1	6	8	—	0	0	—	3
Oregon†	1	0	5	40	44	2	1	5	73	93	N	0	0	N	N
Washington	3	0	13	47	45	1	0	18	45	59	—	0	0	—	—
American Samoa	U	0	0	U	1	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	—	2	—	0	0	—	18	—	0	0	—	—
Puerto Rico	—	0	6	30	60	—	0	8	27	49	—	0	1	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 November 25, 2006, and November 26, 2005 (47th Week)*

Reporting area	Lyme disease Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005	Malaria Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005
United States	152	236	2,153	15,780	20,175	7	26	125	1,145	1,269
New England	83	30	780	2,798	3,671	—	1	11	45	68
Connecticut	16	11	753	1,646	823	—	0	3	11	18
Maine†	18	1	34	271	241	—	0	1	4	5
Massachusetts	—	0	14	33	2,287	—	0	3	19	36
New Hampshire	—	5	90	522	233	—	0	3	9	6
Rhode Island	49	0	93	235	37	—	0	8	1	2
Vermont†	—	1	14	91	50	—	0	1	1	1
Mid. Atlantic	57	129	1,176	8,925	11,526	4	5	13	249	333
New Jersey	2	22	173	1,918	3,290	—	0	3	28	74
New York (Upstate)	52	59	1,150	3,734	3,728	4	1	11	46	48
New York City	—	1	18	153	385	—	3	9	133	177
Pennsylvania	3	40	235	3,120	4,123	—	1	4	42	34
E.N. Central	—	9	145	1,368	1,700	—	2	7	113	137
Illinois	—	0	1	—	126	—	1	4	45	71
Indiana	—	0	3	19	30	—	0	3	10	7
Michigan	—	1	6	49	56	—	0	2	17	21
Ohio	—	1	5	42	53	—	0	3	27	24
Wisconsin	—	8	141	1,258	1,435	—	0	3	14	14
W.N. Central	—	6	169	720	878	1	0	32	59	46
Iowa	—	1	8	87	91	—	0	1	2	8
Kansas	—	0	2	5	3	—	0	2	7	7
Minnesota	—	3	167	606	765	—	0	30	37	11
Missouri	—	0	2	10	14	—	0	1	6	17
Nebraska†	—	0	2	11	3	1	0	1	5	3
North Dakota	—	0	3	—	—	—	0	1	1	—
South Dakota	—	0	1	1	2	—	0	1	1	—
S. Atlantic	10	26	113	1,687	2,154	—	7	15	294	280
Delaware	—	7	28	447	623	—	0	1	5	3
District of Columbia	—	0	7	56	8	—	0	2	5	8
Florida	4	1	5	49	43	—	1	4	56	57
Georgia	—	0	1	6	6	—	1	6	76	47
Maryland†	6	13	70	821	1,159	—	1	5	65	95
North Carolina	—	0	4	29	44	—	0	8	28	30
South Carolina†	—	0	2	18	19	—	0	2	9	8
Virginia†	—	3	25	248	235	—	1	9	48	29
West Virginia	—	0	44	13	17	—	0	1	2	3
E.S. Central	—	0	3	28	34	1	0	3	22	29
Alabama†	—	0	3	10	3	—	0	2	9	6
Kentucky	—	0	2	7	5	1	0	1	4	10
Mississippi	—	0	1	1	—	—	0	1	4	—
Tennessee†	—	0	2	10	26	—	0	2	5	13
W.S. Central	1	0	3	18	76	1	2	31	83	116
Arkansas	—	0	1	—	4	—	0	1	2	6
Louisiana	—	0	0	—	3	—	0	1	5	5
Oklahoma	—	0	0	—	—	—	0	2	7	10
Texas†	1	0	3	18	69	1	1	29	69	95
Mountain	—	0	4	27	21	—	1	9	65	52
Arizona	—	0	2	9	8	—	0	9	22	13
Colorado	—	0	1	1	—	—	0	2	15	24
Idaho†	—	0	2	6	2	—	0	1	1	—
Montana†	—	0	0	—	—	—	0	1	2	—
Nevada†	—	0	1	2	3	—	0	1	4	3
New Mexico†	—	0	1	2	3	—	0	1	4	3
Utah	—	0	1	6	2	—	0	2	17	7
Wyoming	—	0	1	1	3	—	0	0	—	2
Pacific	1	4	16	209	115	—	4	13	215	208
Alaska	—	0	1	3	4	—	0	4	23	6
California	1	4	15	190	81	—	4	10	144	153
Hawaii	N	0	0	N	N	—	0	2	4	18
Oregon†	—	0	2	13	20	—	0	2	12	13
Washington	—	0	3	3	10	—	0	5	32	18
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	1	4
U.S. Virgin Islands	—	0	0	—	—	—	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 year 2006 is provisional.
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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 25, 2006, and November 26, 2005 (47th 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	19	85	907	1,091	7	12	58	601	677	67	257	2,877	11,583	20,864
New England	1	1	3	42	64	1	0	2	29	22	1	25	83	1,040	1,349
Connecticut	—	0	2	10	12	—	0	2	3	1	—	1	5	45	67
Maine†	—	0	1	6	2	—	0	1	4	2	—	1	11	84	50
Massachusetts	—	0	2	15	30	—	0	2	15	5	—	16	43	594	1,016
New Hampshire	—	0	2	6	12	—	0	2	6	12	—	2	36	163	97
Rhode Island	—	0	1	2	3	—	0	0	—	—	1	0	17	50	36
Vermont†	1	0	1	3	5	1	0	0	1	2	—	2	14	104	83
Mid. Atlantic	—	2	13	100	140	—	2	11	96	108	14	36	137	1,663	1,206
New Jersey	N	0	1	N	31	N	0	1	N	31	—	4	13	185	174
New York (Upstate)	N	0	7	N	37	N	0	5	N	13	12	15	123	785	470
New York City	—	1	4	58	24	—	1	4	58	24	—	1	8	64	98
Pennsylvania	—	1	5	42	48	—	1	5	38	40	2	13	26	629	464
E.N. Central	3	2	11	108	150	1	1	6	75	118	22	39	133	1,725	3,547
Illinois	—	0	4	18	33	—	0	4	18	33	—	6	23	231	853
Indiana	1	0	5	22	18	—	0	1	8	8	8	4	75	221	298
Michigan	—	0	3	20	34	—	0	1	9	18	7	9	39	557	291
Ohio	2	1	4	43	42	1	1	3	35	36	7	12	29	548	1,062
Wisconsin	—	0	2	5	23	—	0	2	5	23	—	4	19	168	1,043
W.N. Central	—	1	4	56	77	—	0	3	18	33	3	24	552	1,101	3,585
Iowa	—	0	2	18	15	—	0	1	5	1	—	6	38	250	1,016
Kansas	—	0	1	2	9	—	0	1	2	9	1	6	25	282	455
Minnesota	—	0	2	13	15	—	0	1	4	6	—	0	485	161	1,025
Missouri	—	0	2	14	28	—	0	1	2	13	1	6	42	274	500
Nebraska†	—	0	2	6	5	—	0	1	4	3	1	2	9	88	274
North Dakota	—	0	1	1	1	—	0	1	1	1	—	0	25	26	139
South Dakota	—	0	1	2	4	—	0	0	—	—	—	0	4	20	176
S. Atlantic	2	4	14	172	205	1	1	7	72	92	3	18	46	909	1,306
Delaware	—	0	1	4	4	—	0	1	4	4	—	0	1	3	15
District of Columbia	1	0	1	2	5	1	0	1	2	4	—	0	3	6	8
Florida	—	1	6	65	75	—	0	5	24	31	2	4	9	194	187
Georgia	—	0	3	14	15	—	0	3	14	15	—	0	3	22	46
Maryland†	—	0	2	12	22	—	0	1	2	5	1	3	9	119	188
North Carolina	—	0	11	30	32	—	0	3	10	9	—	0	22	177	118
South Carolina†	—	0	2	20	13	—	0	2	9	8	—	3	11	162	383
Virginia†	—	0	4	16	33	—	0	1	7	14	—	1	27	183	316
West Virginia	1	0	2	9	6	—	0	0	—	2	—	0	9	43	45
E.S. Central	—	1	4	40	53	—	1	4	32	42	3	7	27	347	477
Alabama†	—	0	1	6	5	—	0	1	4	3	2	1	18	106	78
Kentucky	—	0	2	11	17	—	0	2	11	17	—	1	5	54	143
Mississippi	—	0	1	4	7	—	0	1	4	7	1	1	4	41	58
Tennessee†	—	0	2	19	24	—	0	2	13	15	—	3	10	146	198
W.S. Central	—	1	23	55	100	—	0	6	23	25	7	15	360	673	2,179
Arkansas	—	0	3	9	14	—	0	2	6	3	2	1	21	75	286
Louisiana	—	0	2	6	29	—	0	1	3	6	—	0	2	13	49
Oklahoma	—	0	4	11	14	—	0	0	—	2	—	0	124	19	3
Texas†	—	0	16	29	43	—	0	4	14	14	5	13	215	566	1,841
Mountain	1	1	5	64	82	1	0	4	24	23	8	53	230	2,369	3,717
Arizona	—	0	3	17	31	—	0	2	10	10	—	8	177	447	896
Colorado	—	0	2	20	17	—	0	1	2	—	6	14	40	703	1,234
Idaho†	1	0	1	4	6	1	0	1	3	5	2	1	8	84	199
Montana†	—	0	1	4	—	—	0	1	2	—	—	2	9	105	572
Nevada†	—	0	1	4	12	—	0	0	—	2	—	0	9	55	49
New Mexico†	—	0	1	6	5	—	0	1	3	4	—	2	6	108	176
Utah	—	0	1	5	11	—	0	0	—	2	—	15	39	795	542
Wyoming	—	0	2	4	—	—	0	2	4	—	—	1	8	72	49
Pacific	3	5	29	270	220	3	5	25	232	214	6	31	1,334	1,756	3,498
Alaska	1	0	1	3	3	1	0	1	3	3	—	1	15	63	133
California	1	3	14	167	138	1	3	14	167	138	—	22	1,136	1,249	1,769
Hawaii	—	0	1	7	11	—	0	1	7	6	—	1	4	70	159
Oregon†	—	1	7	62	49	—	1	4	43	49	1	1	8	95	616
Washington	1	0	25	31	19	1	0	11	12	18	5	4	195	279	821
American Samoa	U	0	0	—	—	U	0	0	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	—	1	—	0	0	—	1	—	0	0	—	2
Puerto Rico	N	0	0	N	7	N	0	0	N	7	—	0	1	2	6
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	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 year 2006 is provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 25, 2006, and November 26, 2005 (47th 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	39	119	231	5,683	5,412	28	38	246	1,950	1,652	291	779	2,291	37,606	39,972
New England	5	12	26	615	649	—	0	2	2	8	3	23	456	1,686	2,001
Connecticut	3	3	14	195	190	—	0	0	—	—	—	0	448	448	437
Maine†	—	2	8	105	54	N	0	0	N	N	—	2	10	109	157
Massachusetts	—	4	17	178	313	—	0	1	1	6	—	16	53	782	1,059
New Hampshire	2	1	5	50	12	—	0	1	1	1	1	3	25	195	163
Rhode Island	—	0	3	24	27	—	0	2	—	1	—	0	17	83	95
Vermont†	—	1	5	63	53	—	0	0	—	—	2	1	6	69	90
Mid. Atlantic	7	27	61	1,415	916	1	1	5	75	94	27	83	272	4,602	4,711
New Jersey	N	0	0	N	N	—	0	1	7	29	—	14	48	803	912
New York (Upstate)	5	10	24	504	512	—	0	2	5	1	20	24	233	1,175	1,116
New York City	2	0	5	35	28	—	0	3	19	7	1	22	50	1,116	1,123
Pennsylvania	—	16	45	876	376	1	1	3	44	57	6	29	67	1,508	1,560
E.N. Central	4	2	18	161	168	—	0	6	41	41	36	102	187	4,572	5,223
Illinois	—	0	7	46	50	—	0	2	5	11	—	23	51	1,005	1,716
Indiana	—	0	2	11	11	—	0	1	7	1	6	15	67	785	572
Michigan	—	1	5	46	37	—	0	1	3	6	—	18	35	873	851
Ohio	4	0	9	58	70	—	0	4	25	21	30	23	56	1,160	1,214
Wisconsin	N	0	0	N	N	—	0	1	1	2	—	16	27	749	870
W.N. Central	3	6	20	296	305	1	3	15	207	151	15	44	107	2,400	2,367
Iowa	—	1	7	57	—	—	0	1	5	7	—	8	22	403	385
Kansas	2	1	5	76	74	1	0	1	3	5	1	7	16	338	333
Minnesota	—	1	6	39	67	—	0	2	4	2	—	11	60	650	515
Missouri	1	1	6	65	70	—	3	11	171	125	6	14	35	693	740
Nebraska†	—	0	0	—	—	—	0	5	24	7	7	3	8	175	208
North Dakota	—	0	7	24	30	—	0	1	—	—	1	0	46	28	38
South Dakota	—	1	4	35	64	—	0	0	—	5	—	2	7	113	148
S. Atlantic	17	38	176	2,003	1,963	25	16	94	1,097	831	99	219	392	10,208	11,660
Delaware	—	0	0	—	—	—	0	3	18	7	—	2	10	137	116
District of Columbia	—	0	0	—	—	—	0	1	1	2	2	1	4	59	53
Florida	—	0	160	160	201	1	0	3	20	13	54	95	176	4,318	4,832
Georgia	—	5	24	213	241	1	0	5	42	85	14	30	72	1,586	1,819
Maryland†	—	7	13	315	354	1	1	6	71	67	9	12	29	650	759
North Carolina	11	9	22	481	446	22	14	87	817	468	13	33	130	1,521	1,556
South Carolina†	—	3	11	160	206	—	0	5	33	71	—	18	51	921	1,313
Virginia†	6	11	27	573	450	—	1	13	92	111	4	20	57	889	1,039
West Virginia	—	2	13	101	65	—	0	2	3	7	3	2	19	127	173
E.S. Central	2	4	16	226	142	1	5	30	354	284	33	52	149	2,827	2,751
Alabama†	1	1	8	79	75	1	1	10	115	72	17	15	71	1,005	668
Kentucky	1	0	4	28	17	—	0	1	3	3	3	8	23	406	456
Mississippi	—	0	2	4	5	—	0	1	4	18	—	11	42	709	863
Tennessee†	—	2	9	115	45	—	3	21	232	191	13	14	31	707	764
W.S. Central	—	11	34	562	812	—	1	161	115	209	15	74	922	3,724	3,984
Arkansas	—	0	5	31	33	—	0	10	51	121	7	15	47	865	686
Louisiana	—	0	0	—	—	—	0	1	4	6	—	12	42	740	859
Oklahoma	—	1	9	60	74	—	0	154	36	52	8	8	48	462	377
Texas†	—	10	29	471	705	—	0	4	24	30	—	31	839	1,657	2,062
Mountain	—	3	27	199	254	—	0	6	52	32	15	52	88	2,322	2,201
Arizona	—	2	10	129	165	—	0	6	13	17	5	17	67	786	616
Colorado	—	0	0	—	18	—	0	1	2	4	8	12	30	565	536
Idaho†	—	0	25	25	—	—	0	3	14	3	2	3	9	161	141
Montana†	—	0	2	14	15	—	0	2	2	1	—	3	16	118	125
Nevada†	—	0	1	2	14	—	0	0	—	—	—	3	20	174	183
New Mexico†	—	0	2	10	10	—	0	2	8	4	—	4	15	221	232
Utah	—	0	1	11	15	—	0	2	6	—	—	5	15	254	287
Wyoming	—	0	2	8	17	—	0	1	7	3	—	1	4	43	81
Pacific	1	4	12	206	203	—	0	1	7	2	48	111	426	5,265	5,074
Alaska	—	0	4	15	1	—	0	0	—	—	1	1	7	67	57
California	1	3	11	166	195	—	0	1	5	—	41	90	292	4,161	3,867
Hawaii	—	0	0	—	—	—	0	0	—	—	—	5	10	220	273
Oregon†	—	0	4	25	7	—	0	1	2	2	1	8	16	373	385
Washington	U	0	0	U	U	N	0	0	N	N	5	8	124	444	492
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	7
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	2	3	—	37
Puerto Rico	—	1	6	68	61	N	0	0	N	N	—	4	35	230	586
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 November 25, 2006, and November 26, 2005 (47th 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	37	53	297	2,548	2,987	116	256	1,013	12,036	13,825	26	92	282	4,281	4,060
New England	5	3	73	247	208	—	3	65	217	297	1	4	15	184	262
Connecticut	—	0	72	72	55	—	0	59	59	52	U	0	2	U	93
Maine[§]	5	0	8	43	29	—	0	2	3	14	—	0	2	17	14
Massachusetts	—	1	9	82	83	—	2	11	128	181	—	2	6	101	119
New Hampshire	—	0	3	25	16	—	0	4	8	13	—	0	9	44	17
Rhode Island	—	0	2	8	7	—	0	3	13	20	1	0	3	8	9
Vermont[§]	—	0	2	2	18	—	0	2	6	17	—	0	2	14	10
Mid. Atlantic	1	4	107	188	334	4	16	72	756	1,147	5	18	43	821	799
New Jersey	—	0	3	3	71	—	3	34	242	293	—	2	8	122	169
New York (Upstate)	—	0	103	10	126	3	4	60	209	242	3	5	32	278	221
New York City	—	0	4	32	17	—	5	13	222	382	—	3	8	136	158
Pennsylvania	—	0	4	8	120	1	1	6	83	230	2	6	13	285	251
E.N. Central	7	10	56	593	604	4	20	37	915	1,081	4	14	44	715	820
Illinois	—	1	7	75	135	—	7	18	316	371	—	3	11	144	273
Indiana	1	1	8	78	68	2	2	18	150	167	—	2	11	104	93
Michigan	—	1	7	86	86	—	3	8	139	218	—	3	12	196	192
Ohio	6	3	18	179	163	2	3	14	176	111	4	4	19	219	177
Wisconsin	—	2	39	175	152	—	3	9	134	214	—	1	4	52	85
W.N. Central	4	9	32	495	497	1	35	77	1,534	1,564	—	5	57	313	255
Iowa	—	2	8	116	94	1	2	10	103	93	N	0	0	N	N
Kansas	—	0	4	25	53	—	3	20	133	228	—	1	5	52	38
Minnesota	—	3	27	219	163	—	3	23	203	83	—	0	52	143	96
Missouri	—	1	10	82	90	—	10	69	613	928	—	1	5	71	64
Nebraska[§]	—	1	8	55	58	—	2	14	119	137	—	0	4	28	22
North Dakota	—	0	15	—	8	—	0	18	103	4	—	0	5	11	10
South Dakota	—	0	5	47	31	—	5	22	260	91	—	0	1	8	25
S. Atlantic	6	9	39	434	380	65	57	137	2,978	2,196	6	21	44	1,043	849
Delaware	—	0	2	9	9	—	0	2	10	11	—	0	2	10	6
District of Columbia	1	0	1	3	1	1	0	2	16	13	—	0	2	15	10
Florida	3	2	29	87	85	25	27	76	1,423	1,070	1	5	16	273	229
Georgia	1	2	6	83	49	25	19	73	1,092	609	4	5	12	220	186
Maryland[§]	1	1	8	91	72	4	2	10	120	95	—	4	12	182	162
North Carolina	—	2	7	104	60	8	1	21	151	184	—	0	26	148	118
South Carolina[§]	—	0	2	9	11	—	1	9	72	96	—	1	6	54	33
Virginia[§]	—	0	8	—	89	2	1	9	90	117	1	2	11	115	83
West Virginia	—	0	5	12	4	—	0	2	4	1	—	0	6	26	22
E.S. Central	—	1	12	92	172	1	13	79	812	1,126	1	3	11	179	164
Alabama[§]	—	0	5	39	29	—	4	71	354	211	N	0	0	N	N
Kentucky	—	1	12	92	74	1	4	15	226	300	—	0	5	35	31
Mississippi	—	0	0	—	8	—	1	9	86	91	—	0	0	—	—
Tennessee[§]	—	0	4	24	61	—	3	12	146	524	1	3	9	144	133
W.S. Central	8	1	52	76	103	12	36	596	1,640	3,302	1	7	58	335	285
Arkansas	—	0	7	33	13	3	2	9	113	57	—	0	5	25	21
Louisiana	—	0	1	—	21	—	1	25	132	133	—	0	2	8	—
Oklahoma	8	0	17	43	26	3	2	286	125	602	—	2	14	93	105
Texas[§]	1	2	44	105	43	6	30	308	1,270	2,510	1	4	43	209	159
Mountain	3	5	16	297	295	16	23	88	1,314	872	6	11	77	578	524
Arizona	3	2	13	119	30	8	13	36	665	459	4	6	57	314	224
Colorado	—	1	8	101	79	7	3	15	225	156	2	3	8	123	160
Idaho[§]	3	1	7	79	49	1	0	3	15	17	—	0	2	8	3
Montana[§]	—	0	1	—	16	—	0	10	41	5	—	0	0	—	—
Nevada[§]	—	0	5	22	23	—	1	20	103	59	—	0	0	—	—
New Mexico[§]	—	0	1	4	24	—	2	15	158	129	—	1	7	66	76
Utah	—	1	14	114	64	—	1	6	75	42	—	1	7	63	56
Wyoming	—	0	3	18	10	—	0	8	32	5	—	0	1	4	5
Pacific	3	2	50	126	394	13	39	148	1,870	2,240	2	2	9	113	102
Alaska	—	0	0	—	—	—	0	2	9	11	—	0	0	—	—
California	—	2	18	—	135	11	32	104	1,573	1,942	—	0	0	—	—
Hawaii	—	0	2	17	13	—	1	4	42	32	2	2	9	113	102
Oregon[§]	—	2	14	106	152	—	1	31	112	121	N	0	0	N	N
Washington	3	2	32	109	94	2	2	43	134	134	N	0	0	N	N
American Samoa	U	0	0	U	U	U	0	0	U	7	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	3	—	17	—	0	0	—	—
Puerto Rico	—	0	0	—	2	—	0	2	13	9	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 year 2006 is provisional.
† Includes *E. coli* O157:H7; Shiga toxin positive, serogroup non-O157; and Shiga toxin positive, not serogrouped.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 25, 2006, and November 26, 2005 (47th Week)*

Reporting area	*Streptococcus pneumoniae*, invasive disease Drug resistant, all ages					Syphilis, primary and secondary					Varicella (chickenpox)				
	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	29	51	333	2,222	2,293	44	175	334	8,118	7,685	570	835	2,857	37,226	26,018
New England	3	1	24	36	206	12	4	17	187	193	27	34	144	1,330	4,789
Connecticut	U	0	7	U	82	10	0	11	48	44	U	0	55	U	1,490
Maine†	—	0	2	9	N	—	0	2	8	1	—	2	20	151	277
Massachusetts	—	0	6	—	95	—	2	6	107	111	—	0	54	94	2,094
New Hampshire	—	0	0	—	—	—	0	2	11	15	4	6	47	447	303
Rhode Island	3	0	11	13	18	2	0	2	11	21	—	0	0	—	—
Vermont†	—	0	2	14	11	—	0	1	2	1	23	12	50	638	625
Mid. Atlantic	4	3	15	158	189	8	21	35	1,004	927	86	102	183	4,414	4,346
New Jersey	N	0	0	N	N	4	3	8	150	120	—	0	0	—	—
New York (Upstate)	4	1	10	60	72	2	3	14	136	69	—	0	0	—	—
New York City	U	0	0	U	U	1	10	23	488	557	—	0	0	—	—
Pennsylvania	—	2	9	98	117	1	5	12	230	181	86	102	183	4,414	4,346
E.N. Central	4	11	41	512	573	4	17	39	805	834	284	245	587	13,279	5,323
Illinois	—	0	3	17	32	1	8	23	381	470	—	1	7	68	91
Indiana	—	2	21	146	173	—	1	4	80	57	—	0	475	475	—
Michigan	—	0	4	18	40	—	2	19	109	75	46	102	168	4,137	3,410
Ohio	4	6	32	331	328	3	4	8	174	197	238	129	420	7,955	1,414
Wisconsin	N	0	0	N	N	—	1	4	61	35	—	13	52	644	408
W.N. Central	—	1	191	101	42	1	5	11	236	235	28	28	98	1,610	570
Iowa	N	0	0	N	N	—	0	3	18	8	N	0	0	N	N
Kansas	N	0	0	N	N	—	0	3	23	17	2	3	24	295	—
Minnesota	—	0	191	60	—	—	0	2	26	67	—	0	0	—	—
Missouri	—	1	3	39	34	1	3	8	153	137	26	22	82	1,196	380
Nebraska†	—	0	1	1	2	—	0	1	3	4	—	0	0	—	—
North Dakota	—	0	1	—	3	—	0	1	1	1	—	0	25	45	61
South Dakota	—	0	1	1	3	—	0	3	12	1	—	1	10	74	129
S. Atlantic	17	25	53	1,173	963	11	42	186	1,924	1,922	44	88	860	3,943	2,278
Delaware	—	0	0	—	3	—	0	2	17	10	—	1	6	62	28
District of Columbia	—	0	3	26	13	—	2	9	116	102	—	0	5	45	37
Florida	13	13	36	649	514	5	15	23	670	644	—	0	0	—	—
Georgia	2	7	29	395	325	—	7	147	347	442	—	0	0	—	—
Maryland†	—	0	0	—	—	—	5	19	262	273	—	0	4	11	—
North Carolina	N	0	0	N	N	1	5	17	272	248	—	0	0	—	—
South Carolina†	—	0	0	—	—	—	1	6	61	75	6	16	53	962	557
Virginia†	N	0	0	N	N	5	3	17	174	125	20	28	812	1,505	632
West Virginia	2	1	14	103	108	—	0	1	5	3	18	25	70	1,358	1,024
E.S. Central	1	3	13	133	163	1	13	26	663	429	—	1	70	119	221
Alabama†	N	0	0	N	N	1	5	19	288	142	—	1	70	117	221
Kentucky	—	0	2	—	29	—	1	8	63	47	N	0	0	N	N
Mississippi	—	0	0	—	1	—	1	7	69	43	—	0	1	2	—
Tennessee†	1	3	13	133	133	—	5	13	243	197	N	0	0	N	N
W.S. Central	—	0	5	20	107	1	28	52	1,412	1,140	81	187	1,757	10,021	6,115
Arkansas	—	0	3	12	13	—	1	6	74	46	60	9	110	805	25
Louisiana	—	0	4	8	94	1	4	27	264	256	—	0	8	48	120
Oklahoma	N	0	0	N	N	—	1	6	66	36	—	0	0	—	—
Texas†	N	0	0	N	N	—	22	36	1,008	802	21	170	1,647	9,168	5,970
Mountain	—	2	9	89	50	3	8	25	374	384	20	58	137	2,510	2,376
Arizona	N	0	0	N	N	3	3	16	164	157	—	0	0	—	—
Colorado	N	0	0	N	N	—	1	3	44	43	19	31	76	1,358	1,655
Idaho†	N	0	0	N	N	—	0	1	2	20	—	0	0	—	—
Montana†	—	0	1	—	—	—	0	1	1	6	—	0	2	2	—
Nevada†	—	0	0	—	—	—	1	12	95	98	—	0	0	—	—
New Mexico†	—	0	1	1	—	—	1	5	59	51	1	4	34	339	203
Utah	—	1	9	46	25	—	0	2	9	9	—	13	55	758	465
Wyoming	—	1	4	42	25	—	0	0	—	—	—	0	11	53	53
Pacific	—	0	0	—	—	3	34	51	1,513	1,621	—	0	0	—	—
Alaska	—	0	0	—	—	—	0	4	9	6	—	0	0	—	—
California	N	0	0	N	N	1	29	42	1,310	1,435	—	0	0	—	—
Hawaii	—	0	0	—	—	—	0	2	17	10	N	0	0	N	N
Oregon†	N	0	0	N	N	1	0	3	18	33	N	0	0	N	N
Washington	N	0	0	N	N	1	2	10	159	137	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	—	3	—	2	5	—	430
Puerto Rico	N	0	0	N	N	—	3	10	120	199	—	7	47	316	644
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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* Incidence data for reporting year 2006 is provisional.
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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 25, 2006, and November 26, 2005 (47th Week)*

	West Nile virus disease†									
	Neuroinvasive					Non-neuroinvasive				
		Previous 52 weeks					Previous 52 weeks			
Reporting area	Current week	Med	Max	Cum 2006	Cum 2005	Current week	Med	Max	Cum 2006	Cum 2005
United States	—	1	176	1,381	1,191	—	1	383	2,443	1,683
New England	—	0	3	9	9	—	0	2	3	4
Connecticut	—	0	3	7	4	—	0	1	2	2
Maine§	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	1	2	4	—	0	1	1	2
New Hampshire	—	0	0	—	—	—	0	0	—	—
Rhode Island	—	0	0	—	1	—	0	0	—	—
Vermont§	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	—	0	11	26	47	—	0	4	10	22
New Jersey	—	0	2	2	3	—	0	1	2	3
New York (Upstate)	—	0	5	8	19	—	0	1	3	5
New York City	—	0	4	8	11	—	0	2	4	3
Pennsylvania	—	0	2	8	14	—	0	1	1	11
E.N. Central	—	0	43	235	259	—	0	22	99	156
Illinois	—	0	21	116	137	—	0	19	70	115
Indiana	—	0	7	26	11	—	0	2	7	12
Michigan	—	0	10	46	54	—	0	1	2	8
Ohio	—	0	11	36	46	—	0	3	11	15
Wisconsin	—	0	2	11	11	—	0	2	9	6
W.N. Central	—	0	35	216	169	—	0	79	473	463
Iowa	—	0	3	21	14	—	0	4	13	23
Kansas	—	0	3	17	17	—	0	3	13	N
Minnesota	—	0	6	30	18	—	0	7	35	27
Missouri	—	0	13	47	17	—	0	2	12	13
Nebraska§	—	0	9	43	55	—	0	37	208	133
North Dakota	—	0	5	20	12	—	0	28	117	74
South Dakota	—	0	7	38	36	—	0	22	75	193
S. Atlantic	—	0	2	14	34	—	0	4	7	29
Delaware	—	0	0	—	1	—	0	0	—	1
District of Columbia	—	0	0	—	3	—	0	1	1	2
Florida	—	0	1	3	10	—	0	0	—	11
Georgia	—	0	1	2	9	—	0	3	5	11
Maryland§	—	0	2	7	4	—	0	1	1	1
North Carolina	—	0	0	—	2	—	0	0	—	2
South Carolina§	—	0	1	1	5	—	0	0	—	—
Virginia§	—	0	0	—	—	—	0	0	—	1
West Virginia	—	0	1	1	—	N	0	0	N	N
E.S. Central	—	0	14	106	65	—	0	15	92	38
Alabama§	—	0	2	7	6	—	0	0	—	4
Kentucky	—	0	0	—	5	—	0	1	1	—
Mississippi	—	0	10	84	39	—	0	15	89	31
Tennessee§	—	0	4	15	15	—	0	2	2	3
W.S. Central	—	0	59	347	157	—	0	26	207	150
Arkansas	—	0	4	23	13	—	0	2	5	15
Louisiana	—	0	14	88	—	—	0	9	81	54
Oklahoma	—	0	6	26	17	—	0	4	18	14
Texas§	—	0	38	210	127	—	0	15	103	67
Mountain	—	0	61	342	145	—	0	222	1,320	240
Arizona	—	0	9	48	52	—	0	12	57	61
Colorado	—	0	10	63	21	—	0	51	269	85
Idaho§	—	0	30	111	3	—	0	151	752	10
Montana§	—	0	3	12	8	—	0	7	21	17
Nevada§	—	0	9	34	14	—	0	13	75	17
New Mexico§	—	0	1	3	20	—	0	1	5	13
Utah	—	0	8	56	21	—	0	17	101	31
Wyoming	—	0	7	15	6	—	0	8	40	6
Pacific	—	0	15	86	306	—	0	45	232	581
Alaska	—	0	0	—	—	—	0	0	—	—
California	—	0	15	79	305	—	0	33	179	575
Hawaii	—	0	0	—	—	—	0	0	—	—
Oregon§	—	0	2	7	1	—	0	12	50	6
Washington	—	0	0	—	—	—	0	2	3	—
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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U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting year 2006 is provisional.
† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (proposed) (ArboNET Surveillance).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE III. Deaths in 122 U.S. cities,* week ending November 25, 2006 (47th Week)

Reporting Area	All causes, by age (years) All Ages	≥65	45-64	25-44	1-24	<1	P&I† Total
New England	458	314	104	23	10	7	38
Boston, MA	124	76	30	7	5	6	9
Bridgeport, CT	24	18	6	—	—	—	5
Cambridge, MA	15	13	2	—	—	—	—
Fall River, MA	14	7	5	1	1	—	1
Hartford, CT	45	31	9	2	3	—	8
Lowell, MA	17	12	3	2	—	—	1
Lynn, MA	12	8	2	1	1	—	1
New Bedford, MA	24	19	4	1	—	—	1
New Haven, CT	43	30	11	1	—	1	3
Providence, RI	48	36	8	4	—	—	3
Somerville, MA	3	2	1	—	—	—	—
Springfield, MA	17	9	7	1	—	—	1
Waterbury, CT	18	11	6	1	—	—	2
Worcester, MA	54	42	10	2	—	—	3
Mid. Atlantic	1,806	1,248	390	106	35	23	92
Albany, NY	37	18	12	5	—	2	—
Allentown, PA	29	24	5	—	—	—	2
Buffalo, NY	82	58	21	3	—	—	6
Camden, NJ	28	14	11	2	1	—	—
Elizabeth, NJ	12	5	6	—	—	1	1
Erie, PA	40	31	8	—	1	—	1
Jersey City, NJ	22	16	1	2	3	—	2
New York City, NY	824	569	171	59	13	8	35
Newark, NJ	33	16	8	3	4	2	1
Paterson, NJ	18	9	8	—	1	—	—
Philadelphia, PA	350	228	84	22	8	8	17
Pittsburgh, PA§	19	13	4	2	—	—	—
Reading, PA	24	19	4	—	1	—	—
Rochester, NY	110	88	18	2	1	1	8
Schenectady, NY	17	13	4	—	—	—	2
Scranton, PA	23	19	3	1	—	—	2
Syracuse, NY	86	72	11	2	1	—	13
Trenton, NJ	21	12	6	1	1	1	1
Utica, NY	16	12	3	1	—	—	1
Yonkers, NY	15	12	2	1	—	—	—
E.N. Central	1,579	1,060	346	111	33	29	95
Akron, OH	U	U	U	U	U	U	U
Canton, OH	36	26	7	3	—	—	2
Chicago, IL	257	127	74	40	12	4	24
Cincinnati, OH	41	28	9	1	1	2	3
Cleveland, OH	203	143	47	9	3	1	13
Columbus, OH	153	104	29	11	3	6	10
Dayton, OH	94	71	18	2	3	—	4
Detroit, MI	79	38	32	7	1	1	1
Evansville, IN	27	25	1	1	—	—	2
Fort Wayne, IN	44	26	12	2	3	1	2
Gary, IN	11	6	3	2	—	—	—
Grand Rapids, MI	64	45	11	3	1	4	10
Indianapolis, IN	187	122	40	15	5	5	10
Lansing, MI	33	26	5	2	—	—	3
Milwaukee, WI	57	43	8	2	—	4	2
Peoria, IL	45	32	9	3	1	—	3
Rockford, IL	79	54	21	3	—	1	3
South Bend, IN	33	28	3	2	—	—	1
Toledo, OH	93	76	16	1	—	—	1
Youngstown, OH	43	40	1	2	—	—	1
W.N. Central	365	231	89	22	6	17	22
Des Moines, IA	50	38	9	3	—	—	8
Duluth, MN	20	14	5	1	—	—	1
Kansas City, KS	14	5	4	4	—	1	—
Kansas City, MO	67	45	11	3	2	6	1
Lincoln, NE	14	11	2	1	—	—	1
Minneapolis, MN	32	20	9	2	—	1	1
Omaha, NE	53	32	18	1	—	2	2
St. Louis, MO	58	29	18	5	4	2	6
St. Paul, MN	26	17	7	—	—	2	—
Wichita, KS	31	20	6	2	—	3	2
S. Atlantic	669	405	163	57	25	19	39
Atlanta, GA	U	U	U	U	U	U	U
Baltimore, MD	121	64	35	14	4	4	7
Charlotte, NC	71	43	12	8	6	2	5
Jacksonville, FL	115	70	25	7	9	4	9
Miami, FL	53	31	13	6	3	—	1
Norfolk, VA	25	14	8	—	1	2	2
Richmond, VA	27	17	9	1	—	—	3
Savannah, GA	31	19	7	3	—	2	2
St. Petersburg, FL	34	25	4	3	—	2	6
Tampa, FL	106	73	20	10	2	1	3
Washington, D.C.	74	39	28	5	—	2	—
Wilmington, DE	12	10	2	—	—	—	1
E.S. Central	742	487	170	57	13	15	54
Birmingham, AL	129	89	25	9	3	3	9
Chattanooga, TN	66	44	17	3	—	2	1
Knoxville, TN	82	56	18	6	2	—	2
Lexington, KY	40	29	4	5	1	1	5
Memphis, TN	212	122	63	19	4	4	24
Mobile, AL	82	60	16	4	1	1	3
Montgomery, AL	31	17	10	2	—	2	5
Nashville, TN	100	70	17	9	2	2	5
W.S. Central	924	559	235	74	27	29	41
Austin, TX	58	32	14	9	2	1	5
Baton Rouge, LA	48	29	14	2	3	—	—
Corpus Christi, TX	34	28	3	1	2	—	3
Dallas, TX	115	63	29	7	5	11	7
El Paso, TX	62	41	12	6	2	1	5
Fort Worth, TX	74	52	12	7	—	3	3
Houston, TX	206	113	64	16	6	7	5
Little Rock, AR	50	27	14	7	1	1	2
New Orleans, LA¶	U	U	U	U	U	U	U
San Antonio, TX	177	110	48	15	2	2	5
Shreveport, LA	30	18	9	2	1	—	2
Tulsa, OK	70	46	16	2	3	3	4
Mountain	841	571	176	57	16	21	56
Albuquerque, NM	88	55	22	8	2	1	8
Boise, ID	30	21	7	2	—	—	5
Colorado Springs, CO	41	29	5	3	1	3	4
Denver, CO	62	40	15	2	4	1	4
Las Vegas, NV	228	145	58	19	3	3	17
Ogden, UT	19	13	1	2	—	3	—
Phoenix, AZ	140	94	24	13	2	7	7
Pueblo, CO	29	19	9	1	—	—	1
Salt Like City, UT	103	75	20	5	2	1	3
Tucson, AZ	101	80	15	2	2	2	7
Pacific	1,270	846	281	85	32	26	107
Berkeley, CA	8	5	2	—	1	—	2
Fresno, CA	87	52	23	8	3	1	8
Glendale, CA	6	1	4	1	—	—	—
Honolulu, HI	68	46	13	3	—	6	5
Long Beach, CA	60	39	14	1	5	1	2
Los Angeles, CA	110	46	36	21	5	2	3
Pasadena, CA	20	14	4	—	1	1	3
Portland, OR	100	69	23	4	4	—	12
Sacramento, CA	139	97	28	8	2	4	12
San Diego, CA	84	54	21	6	3	—	9
San Francisco, CA	146	95	41	8	—	2	20
San Jose, CA	200	157	27	9	2	5	14
Santa Cruz, CA	25	21	4	—	—	—	2
Seattle, WA	72	44	18	6	2	2	4
Spokane, WA	47	35	7	3	—	2	7
Tacoma, WA	98	71	16	7	4	—	4
Total	8,654**	5,721	1,954	592	197	186	544

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.

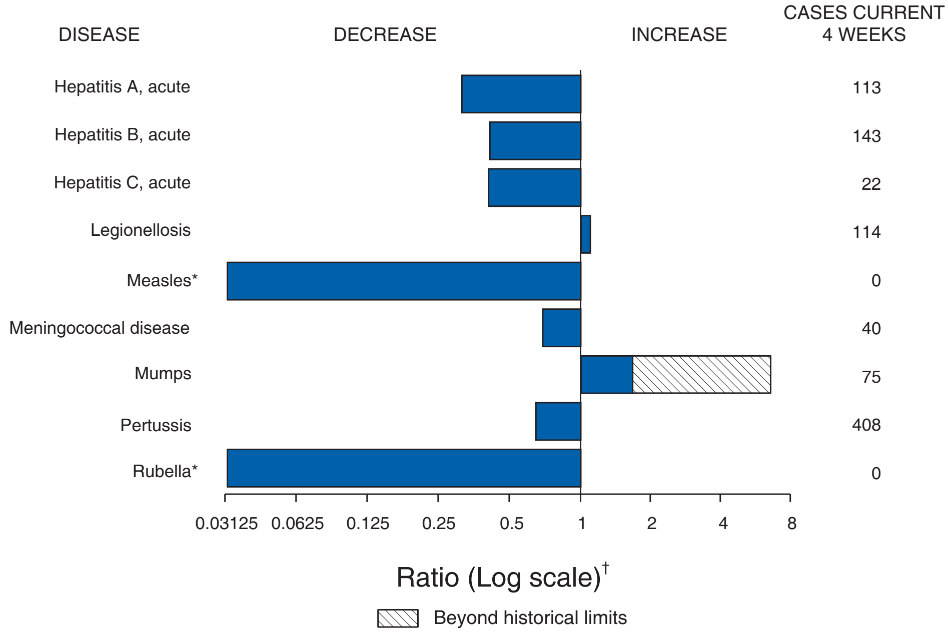
† Pneumonia and influenza.

§ 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 November 25, 2006, with historical data



* No measles or rubella cases were reported for the current 4-week period yielding a ratio for week 47 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.

Notifiable Disease Data Team and 122 Cities Mortality Data Team

Patsy A. Hall

Deborah A. Adams	Rosaline Dhara
Willie J. Anderson	Vernitta Love
Lenee Blanton	Pearl C. Sharp

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