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National Colorectal Cancer Awareness Month — March 2008

March is National Colorectal Cancer Awareness Month. In 2004, a total of 145,083 cases of colorectal cancer were diagnosed in U.S. adults, and 53,580 adults died from this disease (*1*). Although regular colorectal cancer screening can reduce the incidence of and mortality from this disease, (*2*) approximately 40% of U.S. residents who should be screened for colorectal cancer have not been screened in accordance with national guidelines (*3*).

CDC is engaged in a number of activities aimed at colorectal cancer prevention and control, including conducting behavioral research, monitoring national surveillance data, and supporting educational and screening initiatives. CDC established a colorectal cancer screening demonstration program in 2005 for low-income and underinsured or uninsured persons in the United States. CDC also educates the public about the benefits of colorectal cancer screening through its Screen for Life: National Colorectal Cancer Action Campaign. Additional information about CDC colorectal cancer control programs is available at http://www.cdc.gov/cancer/colorectal.

References

1. US Cancer Statistics Working Group. United States cancer statistics: 2004 incidence and mortality (preliminary data). Atlanta, GA: US Department of Health and Human Services, CDC, National Cancer Institute; 2007.
2. Agency for Healthcare Research and Quality. Guide to clinical preventive services, 2005: recommendations of the U.S. Preventive Services Task Force. Rockville, MD: Agency for Healthcare Research and Quality; 2005. AHRQ publication no. 05-0570. Available at http://www.ahrq.gov/clinic/pocketgd05.
3. CDC. Use of colorectal cancer tests—United States, 2002, 2004, and 2006. MMWR 2008;57:253–8.

Use of Colorectal Cancer Tests — United States, 2002, 2004, and 2006

Colorectal cancer is the second-leading cause of cancer-related deaths in the United States among cancers that affect both men and women (*1*). The U.S. Preventive Task Force and other national organizations recommend that persons aged ≥50 years at average risk be screened for colorectal cancer using one or more of the following methods: fecal occult blood testing (FOBT) every year, sigmoidoscopy or double-contrast barium enema every 5 years, or colonoscopy every 10 years (*2–4*). To estimate rates of use of colorectal cancer tests and to evaluate changes in test use, CDC compared data from the 2002, 2004, and 2006 Behavioral Risk Factor Surveillance System (BRFSS) surveys (*5*). This report describes the results of that comparison, which indicated that the proportion of respondents aged ≥50 years reporting use of FOBT and/or sigmoidoscopy or colonoscopy increased overall from 2002 to 2006; however, certain populations, such as racial/ethnic minorities and those who reported no health insurance coverage, had lower prevalence of testing. Specific measures to increase colorectal cancer screening and address disparities in screening are needed.

INSIDE

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BRFSS is a state-based, random-digit–dialed telephone survey of the noninstitutionalized, U.S. civilian population aged ≥18 years. Survey data were available for the 50 states (except for Hawaii in 2004) and the District of Columbia. The median state response rate, based on Council of American Survey and Research Organizations (CASRO) guidelines, was 58.3% in 2002, 52.7% in 2004, and 51.4% in 2006. Respondents who refused to answer, had a missing answer, or did not know the answer to a question were excluded from analysis of that specific question. Of persons aged ≥50 years who responded, approximately 3% of 108,028 were excluded from 2002 results, approximately 3% of 146,794 persons were excluded from 2004 results, and approximately 4.5% of 195,318 were excluded from 2006 results.

Survey questions and response options were identical for all three survey years. Respondents aged ≥50 years were asked if they had ever used a "special kit at home to determine whether the stool contains blood (FOBT)," whether they had ever had "a tube inserted into the rectum to view the colon for signs of cancer or other health problems (sigmoidoscopy or colonoscopy)," and when these tests were last performed. For this report, sigmoidoscopy and colonoscopy are described as "lower endoscopy." Percentages were estimated for persons aged ≥50 years who reported receiving an FOBT within 1 year preceding the survey or lower endoscopy within 10 years preceding the survey. Because BRFSS does not differentiate between sigmoidoscopy and colonoscopy, the surveillance period used was 10 years, the recommended interval for colonoscopy for persons at average risk. Aggregate percentages and 95% confidence intervals were calculated. Data were weighted to the sex, racial/ethnic, and age distribution of each state's adult population using intercensal estimates and were age standardized to the 2006 BRFSS population aged ≥50 years. Differences in prevalence were considered statistically significant if confidence intervals did not overlap. The Wald F-test was used to determine significance for differences across the three surveys.

In 2006, 60.8% of respondents aged ≥50 years reported having had an FOBT within 1 year preceding the survey or lower endoscopy within 10 years preceding the survey, compared with 56.8% in 2004 and 53.9% in 2002 (Table 1). Across all survey years, the proportion of persons aged ≥50 years who reported having had either test within recommended intervals was greater among those aged ≥65 years compared with those aged 50–64 years. The proportion also was greater for whites compared with all other races; non-Hispanics compared with Hispanics; and persons with health insurance compared with those with no health

TABLE 1. Percentage of respondents aged ≥50 years who reported receiving a fecal occult blood test (FOBT) within 1 year and/or a lower endoscopy* within 10 years, by selected characteristics — Behavioral Risk Factor Surveillance System (BRFSS), United States, 2002, 2004, and 2006†

Characteristic	2002		2004		2006	
	%	(95% CI§)	%	(95% CI)	%	(95% CI)
Total	**53.9**	**(53.4–54.5)**	**56.8**	**(56.3–57.3)**	**60.8¶**	**(60.4–61.3)**
Age group (yrs)						
50–64	47.9	(47.1–48.6)	50.2	(49.6–50.9)	54.7	(54.1–55.4)
≥65	62.3	(61.5–63.1)	65.9	(65.2–66.6)	69.3	(68.6–69.9)
Sex						
Male	55.3	(54.4–56.1)	58.0	(57.2–58.8)	61.5	(60.8–62.3)
Female	53.1	(52.4–53.8)	55.9	(55.3–56.5)	60.4	(59.8–61.0)
Race						
White, non-Hispanic	55.4	(54.9–55.9)	58.4	(57.9–58.8)	62.6	(62.1–63.0)
Black, non-Hispanic	52.0	(49.8–54.2)	55.2	(53.3–57.1)	59.0	(57.3–60.6)
Asian/Pacific Islander	42.7	(36.4–49.1)	47.6	(41.0–54.4)	55.9	(51.0–60.7)
American Indian/Alaska Native	51.2	(45.6–56.8)	47.0	(41.7–52.4)	48.4	(43.5–53.2)
Other	43.3	(39.4–47.2)	46.2	(42.1–50.3)	46.2	(42.7–49.8)
Ethnicity**						
Non-Hispanic	54.8	(54.3–55.4)	57.8	(57.3–58.2)	62.0	(61.5–62.4)
Hispanic	43.9	(40.6–47.3)	46.2	(43.2–49.2)	47.2	(44.5–49.9)
Education level						
Less than high school diploma	41.0	(39.3–42.7)	43.9	(42.1–45.6)	45.5	(43.8–47.2)
High school diploma or equivalent	50.7	(49.7–51.6)	52.9	(52.1–53.8)	56.7	(55.9–57.4)
Some college/technical school	56.5	(55.5–57.5)	58.5	(57.5–59.4)	62.6	(61.8–63.5)
College degree	62.0	(61.0–63.0)	64.8	(63.9–65.6)	68.7	(67.9–69.5)
Annual household income						
<$15,000	43.4	(41.5–45.2)	45.0	(43.3–46.7)	48.4	(46.8–50.1)
$15,000–$34,999	49.1	(48.1–50.1)	51.2	(50.2–52.2)	53.9	(53.0–54.9)
$35,000–$49,999	56.0	(54.7–57.4)	58.6	(57.4–59.8)	62.0	(60.8–63.1)
$50,000–$74,999	59.4	(57.5–61.3)	62.1	(60.7–63.5)	67.2	(66.1–68.3)
≥$75,000	64.8	(63.2–66.4)	68.1	(66.8–69.3)	70.4	(69.3–71.4)
Health insurance coverage						
Yes	55.9	(55.3–56.5)	58.9	(58.3–59.4)	63.0	(62.5–63.5)
No	33.1	(30.8–35.5)	34.7	(32.2–37.3)	36.7	(34.3–39.1)

* Sigmoidoscopy or colonoscopy.
† Age standardized to the 2006 BRFSS population aged ≥50 years.
§ Confidence interval.
¶ Wald F-test of significance for differences across the three survey years, p<0.001.
** Race and ethnicity are not mutually exclusive.

insurance. The percentage of positive responses also increased with increasing education level and with increasing household income. Although a greater proportion of men compared with women had a colorectal cancer test in all three survey years, this difference was not statistically significant in 2006.

By state, the proportion of respondents who reported having had an FOBT within 1 year preceding the survey or lower endoscopy within 10 years preceding the survey in 2006 ranged from 51.8% in Mississippi to 70.5% in Connecticut (Table 2). The proportion of respondents who reported having had an FOBT within 1 year preceding the survey ranged from 6.8% in Utah to 22.7% in the District of Columbia and Maine. The proportion of respondents who reported a lower endoscopy within 10 years preceding the survey ranged from 46.7% in Mississippi to 66.7% in Minnesota.

The proportion of respondents who reported never being tested decreased from 34.2% in 2002, to 32.2% in 2004, and to 29.5% in 2006 (Figure). The proportion of respondents aged ≥50 years who reported having had an FOBT within 1 year of the survey declined from 21.6% in 2002, to 18.5% in 2004, and to 16.2% in 2006. In contrast, the proportion of respondents who reported having had a lower endoscopy within 10 years preceding the survey increased from 44.8% in 2002, to 50.1% in 2004, and to 55.7% in 2006.

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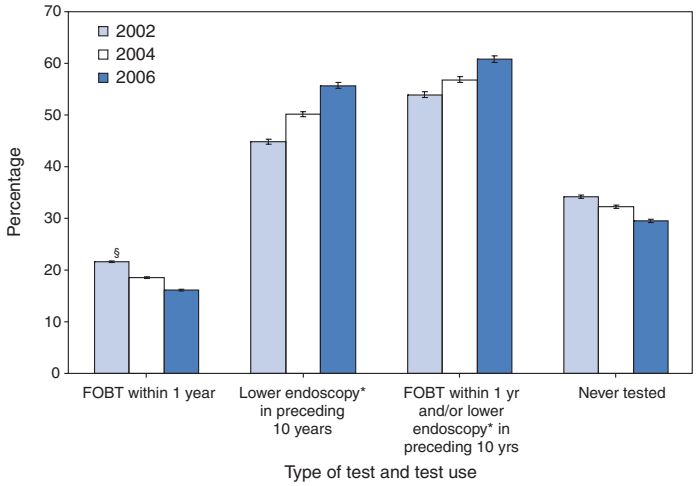
Editorial Note: The findings in this report indicate that overall use of colorectal cancer tests increased from 2002 to 2006. Although this increase is encouraging, disparities persist in colorectal cancer test use. Colorectal cancer test

TABLE 2. Percentage of respondents aged ≥50 years who reported receiving a fecal occult blood test (FOBT) within 1 year and/or lower endoscopy* within 10 years, by state/area — Behavioral Risk Factor Surveillance System (BRFSS), United States, 2006†

State/Area	FOBT within 1 year		Lower endoscopy in preceding 10 yrs		FOBT within 1 yr and/or lower endoscopy in preceding 10 yrs		
	%	(95% CI§)	%	(95% CI)	No.	%	(95% CI)
United States	**16.2**	**(15.9–16.5)**	**55.7**	**(55.2–56.2)**	**186,438**	**60.8**	**(60.4–61.3)**
Alabama	15.2	(13.4–17.3)	49.8	(47.2–52.4)	1,827	55.7	(53.1–58.3)
Alaska	11.4	(8.7–14.8)	49.9	(45.1–54.7)	871	53.5	(48.7–58.2)
Arizona	18.8	(16.4–21.5)	52.7	(49.3–56.0)	2,693	59.5	(56.1–62.8)
Arkansas	15.3	(13.9–16.7)	47.6	(45.6–49.5)	3,166	53.1	(51.2–55.1)
California	15.8	(14.2–17.6)	54.7	(52.3–57.1)	2,786	59.1	(56.7–61.5)
Colorado	19.2	(17.7–20.8)	53.8	(51.9–55.7)	2,940	60.8	(58.9–62.7)
Connecticut	17.9	(16.5–19.3)	66.1	(64.3–67.8)	4,500	70.5	(68.8–72.1)
Delaware	14.4	(12.6–16.4)	65.1	(62.4–67.8)	2,141	69.2	(66.5–71.7)
District of Columbia	22.7	(20.4–25.1)	61.8	(59.1–64.5)	1,833	67.3	(64.7–69.9)
Florida	21.2	(19.9–22.6)	54.7	(53.0–56.5)	6,116	61.6	(59.9–63.3)
Georgia	18.1	(16.6–19.7)	54.7	(52.7–56.6)	3,906	60.6	(58.6–62.5)
Hawaii	19.0	(17.4–20.8)	49.9	(47.8–52.0)	3,445	55.7	(53.5–57.8)
Idaho	13.4	(12.0–15.0)	50.5	(48.3–52.7)	2,672	55.3	(53.1–57.5)
Illinois	12.9	(11.5–14.4)	52.0	(49.8–54.2)	2,748	56.6	(54.4–58.8)
Indiana	13.3	(12.1–14.6)	52.0	(50.1–53.9)	3,339	56.7	(54.8–58.6)
Iowa	15.5	(14.1–17.0)	51.7	(49.7–53.7)	2,931	57.4	(55.4–59.4)
Kansas	16.6	(15.4–17.8)	51.7	(50.1–53.3)	4,550	58.1	(56.6–59.7)
Kentucky	13.4	(11.9–15.1)	56.0	(53.6–58.3)	3,177	60.2	(57.8–62.5)
Louisiana	17.0	(15.6–18.4)	46.9	(45.0–48.8)	3,510	54.5	(52.6–56.4)
Maine	22.4	(20.5–24.4)	60.9	(58.5–63.1)	2,148	67.8	(65.6–70.0)
Maryland	19.0	(17.6–20.5)	63.1	(61.2–65.0)	4,575	68.4	(66.6–70.2)
Massachusetts	18.5	(17.2–19.8)	63.4	(61.7–65.0)	6,261	67.9	(66.2–69.5)
Michigan	17.6	(16.1–19.1)	61.8	(59.8–63.7)	3,145	66.7	(64.8–68.6)
Minnesota	14.8	(13.3–16.4)	66.7	(64.6–68.8)	2,291	69.7	(67.6–71.7)
Mississippi	14.6	(13.3–16.1)	46.7	(44.7–48.6)	3,389	51.8	(49.8–53.8)
Missouri	13.0	(11.3–14.9)	54.1	(51.3–56.9)	2,952	59.2	(56.5–61.9)
Montana	17.7	(16.2–19.3)	49.2	(47.3–51.1)	3,339	56.4	(54.5–58.4)
Nebraska	18.0	(16.6–19.5)	47.8	(46.0–49.7)	4,457	55.6	(53.8–57.5)
Nevada	17.5	(15.2–20.0)	48.5	(45.3–51.6)	1,881	53.9	(50.7–57.0)
New Hampshire	19.9	(18.3–21.5)	61.6	(59.6–63.5)	3,173	67.4	(65.5–69.2)
New Jersey	14.3	(13.3–15.4)	55.3	(53.8–56.7)	7,249	59.8	(58.3–61.2)
New Mexico	13.2	(11.8–14.6)	49.2	(47.2–51.2)	3,498	54.5	(52.4–56.5)
New York	15.1	(13.6–16.6)	60.6	(58.5–62.6)	3,121	65.3	(63.2–67.3)
North Carolina	20.6	(19.6–21.7)	58.7	(57.4–60.0)	8,562	65.1	(63.8–66.4)
North Dakota	15.1	(13.5–16.8)	51.9	(49.7–54.1)	2,655	56.5	(54.2–58.7)
Ohio	15.7	(13.5–18.3)	53.9	(50.7–57.0)	3,199	59.3	(56.1–62.3)
Oklahoma	12.9	(11.8–14.2)	47.1	(45.3–48.9)	3,919	52.1	(50.3–53.9)
Oregon	19.0	(17.5–20.7)	57.5	(55.5–59.5)	2,795	63.1	(61.2–65.0)
Pennsylvania	13.9	(12.6–15.3)	54.7	(52.7–56.8)	7,246	59.6	(57.6–61.6)
Rhode Island	17.4	(15.8–19.2)	66.4	(64.2–68.5)	2,397	70.1	(67.9–72.2)
South Carolina	14.5	(13.3–15.7)	55.6	(53.9–57.3)	5,122	60.9	(59.2–62.5)
South Dakota	14.2	(13.0–15.6)	52.2	(50.3–54.0)	3,688	57.4	(55.5–59.2)
Tennessee	15.7	(13.9–17.7)	53.4	(50.8–55.9)	2,435	58.9	(56.3–61.4)
Texas	13.7	(12.0–15.5)	52.9	(50.3–55.5)	3,503	57.4	(54.8–59.9)
Utah	6.8	(5.6–8.2)	59.7	(57.3–62.0)	2,357	61.4	(59.0–63.7)
Vermont	17.0	(15.8–18.4)	62.3	(60.7–63.9)	3,981	67.7	(66.2–69.3)
Virginia	16.4	(14.3–18.8)	63.0	(60.3–65.5)	2,882	66.7	(64.1–69.1)
Washington	20.9	(20.0–21.8)	60.3	(59.2–61.3)	13,756	65.8	(64.7–66.8)
West Virginia	18.4	(16.7–20.3)	49.2	(46.9–51.5)	2,191	56.1	(53.7–58.3)
Wisconsin	12.7	(11.2–14.3)	60.3	(58.0–62.6)	2,413	64.0	(61.7–66.2)
Wyoming	13.0	(11.6–14.4)	48.6	(46.6–50.7)	2,707	53.8	(51.7–55.8)

* Sigmoidoscopy or colonoscopy.
† Age standardized to the 2006 BRFSS population aged ≥50 years.
§ Confidence interval.

FIGURE. Percentage of respondents aged ≥50 years reporting colorectal cancer test use, by type of test* and test use — Behavioral Risk Factor Surveillance System (BRFSS), United States, 2002, 2004, and 2006†



*Lower endoscopy (sigmoidoscopy or colonoscopy) and/or fecal occult blood test (FOBT).
†Age standardized to the 2006 BRFSS population aged ≥50 years.
§95% confidence interval.

use increased among racial/ethnic minorities, those without health insurance, those with annual household incomes <$35,000, and those with less than a high school education; however, these groups had a substantially lower prevalence of colorectal cancer test use than did other groups surveyed. Factors that might contribute to disparities in colorectal cancer test use include lack of awareness of the need for screening, lack of recommendation for screening from a physician, lack of health insurance, and lack of a usual source of health care (*6,7*).

Previous studies have documented a greater prevalence of colorectal cancer test use among men than women (*6,7*). Data in this report suggest that the gap in prevalence between men and women is closing.

Respondents aged ≥65 years were found to have a greater prevalence of colorectal cancer test use compared with those aged 50–64 years, which might be associated with the availability of Medicare coverage for colorectal cancer screening starting at age 65 years (*6,7*). Previous studies have indicated that colorectal cancer testing has increased since 2000 (*7*). Multiple factors might have contributed to the increase in colorectal cancer test use. For example, Medicare coverage of screening colonoscopy (starting in 2001) contributed to increased use of colonoscopy in the Medicare population (*7*). Increased public awareness of the importance of screening (*5*) and adoption of the Health Plan Employer Data and Information Set (HEDIS) measure (in 2004) that encourages health plans to cover colorectal screening tests also might have contributed to the increase in test use.* In addition, a number of state initiatives support increased test use, including a statewide social marketing campaign implemented by Maine's Comprehensive Cancer Control Program, a statewide endoscopy screening program in Colorado funded by the state tobacco tax, and New York State's Colorectal Cancer Screening and Prostate Initiative Program, which provides colorectal cancer screening to uninsured or underinsured residents. New York also passed the Colon-Prostate Treatment Act in 2006, which provides funds for treatment of colorectal cancer cases detected through the state screening program.†

The reported use of FOBT declined steadily over the study period, whereas the reported use of lower endoscopy increased. These changes might have been driven by patient or physician preference for lower endoscopy over FOBT and increased availability of insurance coverage for screening colonoscopy (*8,9*). Variations in prevalence of test use by state might result from variations in demographic characteristics, health insurance coverage, and availability of providers to perform endoscopy.

The findings in this report are subject to at least five limitations. First, the results might overestimate actual colorectal cancer screening tests because BRFSS does not determine the indication for the test (screening versus diagnostic use). Second, assessment of use of lower endoscopy within 10 years included persons who had a sigmoidoscopy more than 5 years preceding the survey, which is outside the screening recommendation. Third, only persons with landline telephones are represented in the analysis. Fourth, responses are self-reports and not validated by medical record review. Finally, the survey response rate was low for all three survey years.

To address disparities in colorectal cancer screening rates and to improve access to underserved populations, CDC established a colorectal cancer screening demonstration program in August 2005 for persons with inadequate or no insurance coverage for colorectal cancer screening. These programs are located in Baltimore, Maryland; St. Louis, Missouri; Nebraska (statewide); Suffolk County, New York; and Clallam, Jefferson, and King counties, Washington; they vary in design and screening test selection. Each program is designed for all low-income U.S. men and women aged ≥50 years, and two of the programs are targeted to racial/ethnic minorities. CDC is conducting a detailed evaluation of the programs, including a multiple case study,

* Available at http://www.ncqa.org/tabid/59/default.aspx.
† Information about Article 5: Title 11: Sections 364-I and 366 available at http://public.leginfo.state.ny.us/menugetf.cgi.

a cost assessment, and an evaluation of clinical outcomes. CDC also provides funds to 21 state programs to implement specific colorectal cancer control strategies identified in their statewide cancer control plans.[§]

Screening reduces colorectal cancer incidence and mortality (*2*). The coordinated efforts by CDC, state and local health departments, and the medical community to address barriers to and disparities in screening must be sustained so that the burden of this disease can be reduced in all persons.

Acknowledgments

This report is based, in part, on data contributed by state BRFSS coordinators.

References

1. US Cancer Statistics Working Group. United States cancer statistics: 2004 incidence and mortality. Atlanta, GA: US Department of Health and Human Services, CDC, National Cancer Institute; 2007. Available at http://www.cdc.gov/cancer/npcr/npcrpdfs/us_cancer_statistics_2004_incidence_and_mortality.pdf.
2. US Preventive Services Task Force. Screening for colorectal cancer: recommendations and rationale, 2002. Rockville, MD: Agency for Healthcare Research and Quality; 2002. Available at http://www.ahrq.gov/clinic/3rduspstf/colorectal/colorr.htm.
3. Winawer S, Fletcher R, Rex D, et al. Colorectal cancer screening and surveillance: clinical guidelines and rationale: update based on new evidence. Gastroenterology 2003;124:544–60.
4. Smith RA, Cokkinides V, Eyre HJ. American Cancer Society guidelines for the early detection of cancer, 2004. CA Cancer J Clin 2004;54:41–52.
5. CDC. Increased use of colorectal cancer tests—United States, 2002 and 2004. MMWR 2006;55:308–11.
6. Seeff LC, Nadel MR, Klabunde CN, et al. Patterns and predictors of colorectal cancer test use in the adult US population. Cancer 2004;100:2093–103.
7. Meissner HI, Breen N, Klabunde CN, Vernon SW. Patterns of colorectal cancer screening uptake among men and women in the United States. Cancer Epidemiol Biomarkers Prev 2006;15:389–94.
8. Wolf RL, Basch CE, Brouse CH, Shmukler C, Shea S. Patient preferences and adherence to colorectal cancer screening in an urban population. Am J Public Health 2006;96:809–11.
9. Ling BS, Moskowitz MA, Wachs D, Pearson B, Schroy PC. Attitudes toward colorectal cancer screening tests: a survey of patients and physicians. J Gen Intern Med 2001;16:822–30.

[§] Available at http://www.cdc.gov/cancer/colorectal/what_cdc_is_doing/about_cdc_program.htm.

Update: Recommendations from the Advisory Committee on Immunization Practices (ACIP) Regarding Administration of Combination MMRV Vaccine

On February 27, 2008, new information was presented to the Advisory Committee on Immunization Practices (ACIP) regarding the risk for febrile seizures among children aged 12–23 months after administration of the combination measles, mumps, rubella, and varicella (MMRV) vaccine (ProQuad®, Merck & Co., Inc., Whitehouse Station, New Jersey). This report summarizes current knowledge regarding the risk for febrile seizures after MMRV vaccination and presents updated ACIP recommendations that were issued after presentation of the new information. These updated recommendations remove ACIP's previous preference for administering combination MMRV vaccine over separate injections of equivalent component vaccines (i.e., measles, mumps, and rubella [MMR] vaccine and varicella vaccine).

The combination tetravalent MMRV vaccine was licensed by the Food and Drug Administration (FDA) on September 6, 2005, for use in children aged 12 months–12 years (*1*). MMRV vaccine can be used in place of trivalent MMR vaccine and monovalent varicella vaccine to implement the recommended 2-dose vaccine policies for prevention of measles, mumps, rubella, and varicella (*1,2*). The first vaccine dose is recommended at age 12–15 months and the second at age 4–6 years.

In MMRV vaccine prelicensure studies, an increased rate of fever was observed 5–12 and 0–42 days after the first vaccine dose, compared with administration of MMR vaccine and varicella vaccine at the same visit (*3,4*). Because of the known association between fever and febrile seizures (*5*), CDC and Merck initiated postlicensure studies to better understand the risk for febrile seizures that might be associated with MMRV vaccination.

The Vaccine Safety Datalink (VSD),* which routinely monitors vaccine safety by near real-time surveillance using computerized patient data, detected a signal of increased risk for seizures of any etiology among children aged 12–23 months after administration of MMRV vaccine compared with administration of MMR vaccine (many

* Additional information available at http://www.cdc.gov/od/science/iso/vsd.

children also received varicella vaccine). When children who received MMRV vaccine were compared with children who received MMR vaccine and varicella vaccine administered at the same visit, statistically significant clustering of seizures was observed 7–10 days after vaccination in both groups. Once the signal was detected, a VSD study was initiated that evaluated the risk for febrile seizures 7–10 days after vaccination among 43,353 children aged 12–23 months who received MMRV vaccine and 314,599 children aged 12–23 months who received MMR vaccine and varicella vaccine administered at the same visit. Medical records were reviewed to validate the diagnosis, and a multivariate logistic regression was used to adjust for age and influenza season.

The preliminary results indicated a rate of febrile seizure of nine per 10,000 vaccinations among MMRV vaccine recipients compared with four per 10,000 vaccinations among MMR vaccine and varicella vaccine recipients (adjusted odds ratio = 2.3; 95% confidence interval [CI] = 1.6–3.2; p<0.0001). These results suggest that, in the 7–10 day postvaccination period, approximately one additional febrile seizure would occur among every 2,000 children vaccinated with MMRV vaccine, compared with children vaccinated with MMR vaccine and varicella vaccine administered at the same visit. Of the 166 children who experienced febrile seizures after vaccination and had hospitalization information available, 26 (16%) were hospitalized. No child who had a febrile seizure died.

At the ACIP meeting, representatives from Merck presented interim results of an ongoing postlicensure study being conducted among children aged 12–60 months (99% of the children were aged 12–23 months). All potential cases of febrile seizure were reviewed using Brighton Collaboration guidelines (*6*). This interim analysis found a 2.3 times (CI = 0.6–9.0) higher relative risk for confirmed febrile seizures 5–12 days after MMRV vaccination (14,263 children; rate = five per 10,000 vaccinations) when compared with a historic control group of children (matched on age, sex, and date of vaccination) vaccinated with MMR vaccine and varicella vaccine at the same visit (14,263 children; rate = two per 10,000 vaccinations). Although the relative risk was not statistically significant, it was similar to the adjusted odds ratio reported by the VSD study for the 7–10 days after vaccination. The Merck study also evaluated the risk for febrile seizures during the 0–30 days after vaccination. This risk was not significantly different (relative risk = 0.7; CI = 0.4–1.5) for children who received MMRV vaccine (10 per 10,000) compared with those who received MMR vaccine and varicella vaccine at the same visit (13 per 10,000). The Merck results are considered interim; approximately half of the final sample size needed to investigate the risk for febrile seizures was available for this analysis.

Neither the VSD study nor the Merck study assessed the risk for febrile seizures after MMRV vaccine administered as a second dose at age 4–6 years. However, previous studies have determined that the second dose of MMRV vaccine is less likely to cause fever than the first dose (*3*), and rates of febrile seizure are lower in the general population of children aged 4–6 years than in the population aged 12–15 months (*5*).

Febrile seizures are not uncommon in young children and generally have an excellent prognosis (*7*), although they often are distressing to parents and other family members. Approximately one in 25 (4%) young children will have at least one febrile seizure, usually at age 6–59 months; the peak age for febrile seizures is 14–18 months (*5,7*). Febrile seizures occur most commonly with the fevers caused by typical childhood illnesses, such as middle ear infections, viral upper respiratory tract infections, and roseola, but can be associated with any condition that results in fever. Febrile seizures can occur after certain vaccinations, although rarely. MMR vaccination has been associated previously with febrile seizures occurring 8–14 days later; approximately one additional febrile seizure occurs among every 3,000–4,000 children vaccinated with MMR vaccine, compared with children not vaccinated during the preceding 30 days (*8*).

Availability of MMRV vaccine currently is limited in the United States because of manufacturing constraints unrelated to vaccine safety or efficacy (*9*). MMRV vaccine is not expected to be widely available before 2009; however, some clinics might have MMRV vaccine in stock.

Consistent with ACIP General Recommendations on Immunization (*10*), the 2007 ACIP recommendations for prevention of varicella included a preference for use of combination MMRV vaccine over separate injections of equivalent component vaccines (i.e., MMR vaccine and varicella vaccine) (*2*). At its February 27, 2008, meeting, ACIP considered the preliminary results from the VSD and Merck studies, which suggested an increased risk for febrile seizures after the first dose of MMRV vaccine. Given the availability of alternative options for vaccination against measles, mumps, rubella, and varicella and the limited supply of MMRV vaccine, ACIP voted to change the preference language for MMRV vaccine to read as follows: "Combination MMRV vaccine is approved for use among healthy children aged 12 months–12 years. MMRV vaccine is indicated for simultaneous vaccination against measles, mumps, rubella, and varicella. ACIP does not express a preference

for use of MMRV vaccine over separate injections of equivalent component vaccines (i.e., MMR vaccine and varicella vaccine)." ACIP also recommended establishing a work group to conduct in-depth evaluation of the findings regarding the increased risk for febrile seizures after the first dose of MMRV vaccine to present for consideration of future policy options. CDC, FDA, and ACIP will communicate updates and implement further necessary actions based on these evaluations.

Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at http://www.vaers.hhs.gov or by telephone, 800-822-7967. Additional information on MMRV vaccine and febrile seizures is available at http://www.cdc.gov/od/science/iso/vsd/mmrv.htm and http://www.fda.gov/cber/label/proquadlbinfo.htm.

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References

1. CDC. Licensure of a combined live attenuated measles, mumps, rubella, and varicella vaccine. MMWR 2005;54:1212–3.
2. CDC. Prevention of varicella: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2007;56(No. RR-4).
3. Shinefield H, Black S, Digilio L, et al. Evaluation of a quadrivalent measles, mumps, rubella and varicella vaccine in healthy children. Pediatr Infect Dis J 2005;24:665–9.
4. Merck & Co., Inc. ProQuad® (measles, mumps, rubella, and varicella [Oka/Merck] virus vaccine live) [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; 2005.
5. Seizures in childhood. In: Kliegman RM, Behrman RE, Jenson HB, Stanton BF, eds. Nelson textbook of pediatrics. 18th ed. Philadelphia, PA: Saunders; 2007:2457–75.
6. Bonhoeffer J, Menkes J, Gold MS, et al. Generalized convulsive seizure as an adverse event following immunization: case definition and guidelines for data collection, analysis, and presentation. Vaccine 2004;22:557–62.
7. National Institute of Neurological Disorders and Stroke. Febrile seizures fact sheet. Washington, DC: US Department of Health and Human Services, National Institutes of Health, National Institute of Neurological Disorders and Stroke; 2008. Available at http://www.ninds.nih.gov/disorders/febrile_seizures/detail_febrile_seizures.htm.
8. Barlow WE, Davis RL, Glasser JW, et al. The risk of seizures after receipt of whole-cell pertussis or measles, mumps, and rubella vaccine. N Engl J Med 2001;345:656–61.
9. CDC. Update on supply of vaccines containing varicella-zoster virus. MMWR 2007;56:453.
10. CDC. General recommendations on immunization: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2006;55(No. RR-15).

Nonoccupational Logging Fatalities — Vermont, 1997–2007

Professional logging is one of the most hazardous occupations in the United States (*1*), and the factors contributing to injuries and fatalities associated with this occupation are well documented (*2,3*). However, little has been reported about logging fatalities in the nonoccupational setting. To better characterize nonoccupational logging fatalities, the Vermont Department of Health analyzed medical examiner data from Vermont for the period 1997–2007. This report describes four cases and summarizes data on all nonoccupational logging fatalities. The findings indicated that tree felling accounted for 15 (83%) of the 18 nonoccupational logging fatalities during the 11-year period and that 14 (78%) of the fatalities were attributed to injuries resulting from being struck by a falling tree or limb. Contributing factors in these incidents included absence of personal protective equipment (PPE), misjudgment of the path of falling trees, and being alone. Measures to reduce nonoccupational logging fatalities should focus on promoting safe tree-felling practices and increasing helmet use among nonprofessional woodcutters. Ideally, however, nonprofessionals should not participate in tree felling.

Data were obtained through a review of all unintentional deaths reported to the Office of the Chief Medical Examiner in Vermont during 1997–2007. Death certificates, autopsy reports, and law enforcement investigation reports from this period were reviewed. A case was defined as any nonoccupational fatality in a Vermont resident resulting from logging (i.e., cutting or moving trees or portions of trees).

Case Reports

Case 1. In May 2006, a man aged 60 years was alone cutting sugar maple trees for firewood on his property. While he was cutting a partially downed tree with a chain saw, the tree gave way, rolling over the man's lower torso and killing him. Investigation revealed that the man was alive for some time, attempting to extract himself before his death. The cause of death was ruled as blunt impact of the torso and abdomen, resulting in exsanguination and respiratory arrest.

Case 2. In December 2005, a man aged 54 years was handling the rope in a tree-felling operation at his home with the help of a friend, who was cutting branches above him. The decedent was struck on the head and killed by a branch of approximately 2 inches in diameter, which broke free from a tree and fell 40–50 feet. The cause of death was ruled as massive cranial instability attributed to blunt impact to the head. Both men had been wearing helmets, but the decedent had removed his shortly before the fatal incident.

Case 3. In January 1998, a man aged 42 years was clearing debris and partially downed trees immediately after an ice storm. While he was cutting one of these trees with a chain saw, the tree fell, hit him on the head, and then landed across him, trapping him beneath the tree. Onlookers responded immediately; however, because of the weight of the tree, they were unable to extract the man. The cause of death was ruled as an injury to the head. The man was not wearing a helmet.

Case 4. In March 1998, a man aged 70 years was attempting to remove a stump from a tree he had cut down on his property. The man placed a chain, attached to his tractor, around the base of the stump. Upon engaging the tractor, a rear rollover occurred, pinning the man underneath. The cause of death was ruled as suffocation attributed to chest compression from the tractor.

Summary of Cases

A total of 18 nonoccupational logging fatalities occurred in Vermont during 1997–2007, compared with 16 occupational logging fatalities during the same period (Table). Among the nonoccupational fatalities, all occurred in white males with a mean and median age of 58 years (range: 19–83 years). Ten (56%) of the decedents were alone at the time of the incident. Fourteen (78%) fatalities resulted from being struck by a tree, two (11%) resulted from tractor rollovers, one (6%) resulted from a fall from a ladder, and one (6%) resulted from a motor-vehicle rollover. Nine (50%) of the fatalities occurred during November–February, and 11 (61%) occurred during Friday–Sunday. The time of the injury was known for 12 incidents, all of which occurred during daylight hours. Blood alcohol concentrations (BACs)

TABLE. Number and percentage of occupational and nonoccupational logging fatalities, by selected characteristics — Vermont, 1997–2007

	Occupational								Nonoccupational	
	Total (N = 16)		Not self-employed (n = 6)		Self-employed (n = 7)		Unclassified (n = 3)		(N = 18)	
Characteristic	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Sex										
Male	16	(100)	6	(100)	7	(100)	3	(100)	18	(100)
Race/Ethnicity										
White, non-Hispanic	16	(100)	6	(100)	7	(100)	3	(100)	18	(100)
Primary site										
Chest	7	(44)	1	(17)	5	(71)	1	(33)	5	(28)
Head	7	(44)	4	(67)	2	(29)	1	(33)	7	(39)
Multiple	2	(13)	0	—	0	—	1	(33)	5	(28)
Leg	0	—	0	—	0	—	0	—	1	(6)
Primary mechanism										
Fall from height	1	(6)	1	(17)	0	—	0	—	1	(6)
Vehicle rollover	0	—	0	—	0	—	0	—	1	(6)
Pinned by tree	0	—	0	—	0	—	0	—	3	(17)
Struck by fallen tree	10	(63)	2	(33)	5	(71)	3	(100)	11	(61)
Tractor rollover	1	(6)	0	—	1	(14)	0	—	2	(11)
Electrocution	1	(6)	1	(17)	0	—	0	—	0	—
Equipment failure	1	(6)	1	(17)	0	—	0	—	0	—
Pinned by machinery	1	(6)	0	—	1	(14)	0	—	0	—
Struck by branch (wind related)	1	(6)	1	(17)	0	—	0	—	0	—
Alone/Not alone at death										
Alone	7	(44)	0	—	6	(86)	1	(33)	10	(56)
Not Alone	9	(56)	6	(100)	1	(14)	2	(67)	8	(44)

and toxicologic screening results were available for 12 decedents. Of those 12, one had a BAC of 0.02 mg/dL, and one had evidence of marijuana use (blood carboxy tetrahydracannabinol 20.8 ng/mL).

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Editorial Note: Although nonoccupational logging activities (e.g., cutting firewood, property cleanup, trimming limbs, and pruning and cutting trees) are not easily quantifiable, they are common, especially in rural settings. Most of these activities are not regulated and do not require special training or a permit. As such, the level of experience, awareness of safety measures, and prevalence of PPE use among persons involved in nonoccupational logging is likely more varied than among those involved in occupational logging (*4*), for which occupational standards (e.g., training and use of PPE) are a requirement. Therefore, the risk for injury and death likely is greater among those involved in nonoccupational logging.

Factors that likely contributed to these fatalities include improper tree-felling techniques, misjudgment of the path of falling trees, being alone, lack of helmet use, and improper use of equipment (*2,4,5*). Impairment from drugs or alcohol, darkness, and chainsaw injuries were not major contributors.

The findings in this report are subject to at least two limitations. First, not all data (e.g., data on helmet use or toxicologic screening results) were available for all cases. Second, some nonoccupational logging fatalities might have occurred during the study period but were not identified as such. For example, a death in a person who sustained an injury while logging (e.g., a traumatic brain injury) and died days or weeks after the incident might have not been detected.

The majority of logging fatalities result from being struck by falling trees or branches (*1,2*). Multiple factors determine when, where, and how a tree will fall. As a tree falls, it can strike another tree, knocking down branches. In addition, connecting vines can pull other trees or dead branches in the canopy down upon the tree feller. Prediction of fall trajectory for partially downed trees is difficult. In addition, nonoccupational tree harvesting usually is conducted in areas not specifically managed for timber harvesting, further compounding the risk.

The risks associated with nonoccupational logging can be minimized, and many nonoccupational logging fatalities are preventable. Ideally, only professionals should participate in tree felling. The following measures are recommended by the Vermont Department of Health to reduce the risk for injury and death associated with nonoccupational logging: 1) professional loggers should be hired for tree felling; 2) persons engaged in logging activities should receive appropriate training in safe tree-felling practices (which is often offered through county extension offices); 3) helmets and other appropriate PPE should be worn during all logging activities; 4) tree felling should not be undertaken by one person alone; and 5) farm tractors should not be used for logging activities (*6*).

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References

1. US Department of Labor, Bureau of Labor Statistics. National census of fatal occupational injuries in 2006. Washington, DC: US Department of Labor, Bureau of Labor Statistics; 2007. Available at http://www.bls.gov/news.release/pdf/cfoi.pdf.
2. Scott DF. A study of logger fatalities from 1992–2000. Inj Prev 2004;10:239–43.
3. CDC. NIOSH alert: request for assistance in preventing injuries and deaths of loggers. MMWR 1995;44:264–5.
4. Johnson CM, Lagares-Garcia JA, Miller SL. When the bough breaks: a 10-year review of logging injuries treated at a rural trauma center in Pennsylvania. Am Surg 2002;68:573–81.
5. Helmkamp JC, Kennedy RD, Fosbroke DE, Myers ML. Occupational fatalities in the fishing, logging and air transport industries in Alaska, 1991. Scand J Work Environ Health 1992;18(Suppl 2):55–7.
6. CDC. Fatalities associated with improper hitching to farm tractors—New York, 1991–1995. MMWR 1996;45:307–11.

Progress Toward Measles Mortality Reduction and Elimination — Eastern Mediterranean Region, 1997–2007

In 2005, the World Health Assembly set a goal of achieving a 90% reduction in global measles mortality by 2010, compared with levels in 2000 (*1*). Eight years earlier, in 1997, the 22 countries in the World Health Organization (WHO) Eastern Mediterranean Region (EMR)* had resolved to eliminate measles from their region by 2010.† To reach these two goals, the WHO Regional Office for the Eastern Mediterranean developed a four-pronged strat-

* Afghanistan, Bahrain, Djibouti, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, United Arab Emirates, West Bank and Gaza Strip, and Yemen. For this report, the geographic regions West Bank and Gaza Strip are considered to constitute one country.

† Measles elimination is defined as the absence of endemic measles cases for ≥12 months in the presence of adequate surveillance. One indicator of measles elimination is a sustained measles incidence of less than one case per 1 million population.

egy: 1) achieve and maintain ≥90% vaccination coverage of children with the first dose of measles-containing vaccine (MCV1) in every district of each country through routine immunization services, 2) achieve ≥90% vaccination coverage with the second dose of measles-containing vaccine (MCV2) in every district either through a routine 2-dose vaccination schedule or through supplementary immunization activities (SIAs),[§] 3) establish case-based surveillance with investigation and laboratory testing of all suspected cases of measles, and 4) provide optimal clinical-case management, including supplementation of diets with vitamin A (*2*). This report summarizes the progress made in the EMR during 1997–2007 toward reducing mortality from measles and eliminating measles from the region. Countries in the EMR reduced the number of measles-related deaths by approximately 75% from 2000 to 2007. However, large measles outbreaks continue to occur throughout the region, suggesting that much work remains to eliminate measles in the EMR.

[§] Initial nationwide catch-up SIAs in EMR countries target all children aged 9 months–14 years and have the goal of eliminating susceptibility to measles in the general population. Periodic follow-up SIAs target all children born since the last SIA, including children who have already been vaccinated. Follow-up SIAs generally are conducted nationwide every 2–4 years and target children aged 9–59 months, with the goals of eliminating any measles susceptibility that has developed in recent birth cohorts and protecting children who did not respond to their first measles vaccination.

Routine Immunization

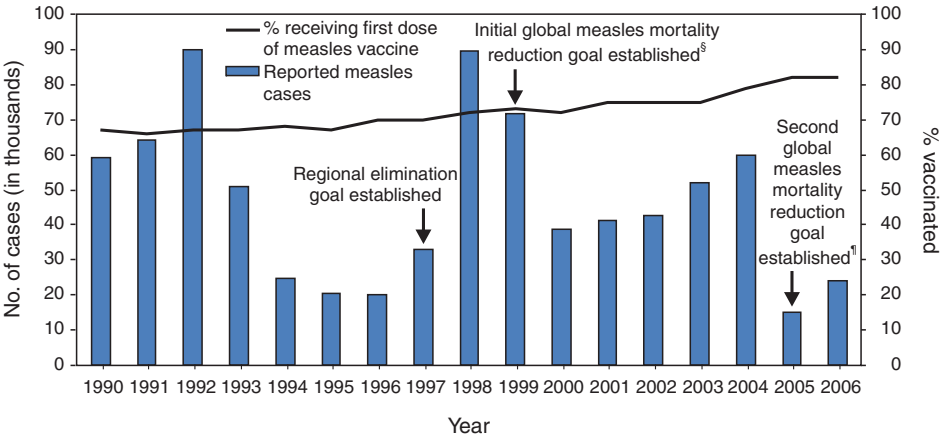
MCV1 is administered at age 9 months in 12 (55%) of the 22 EMR countries and at age 10–15 months in the remaining 10 (45%). A total of 16 (73%) countries (accounting for 53% of the region's population) have a 2-dose MCV schedule (Table 1). Vaccination coverage with MCV1 and MCV2 is calculated annually for each country by dividing the total number of doses administered to children in the targeted age group by the census count of the number of children in that group. In addition, WHO and UNICEF estimate coverage of MCV1 annually for each country using reported coverage of MCV1 and survey results (*3*). For the region overall, estimated MCV1 coverage increased from 67% in 1990 to 83% in 2006 (Figure). In 19 countries, MCV1 coverage increased from 1997 to 2006 (Table 1). In 2006, 15 countries achieved ≥90% coverage of MCV1 nationally but did not achieve this cover-

TABLE 1. Recommended 2006 routine measles vaccination schedules and percentage of children who received their first dose of measles vaccine,* by country/area — World Health Organization (WHO) Eastern Mediterranean Region, 1997–2006

Country/ Area	Age at first dose	Age at second dose	Coverage (%)									
			1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Afghanistan	9 mos	—[†]	48	40	40	35	46	44	50	61	64	68[§]
Bahrain	12 mos	5 yrs	94	99	94	98	98	99	99	99	99	99
Djibouti	9 mos	—	31	21	23	50	49	62	66	60	65	67[§]
Egypt	9 mos	18 mos	92	98	96	98	97	97	98	97	98	98
Iran	12 mos	6 yrs	95	99	99	99	96	99	99	96	94	99
Iraq	9 mos	15 mos	85	88	90	85	80	75	70	65	60	60[§]
Jordan	9 mos	15 mos	95	93	94	94	99	95	96	99	95	99
Kuwait	12 mos	4 yrs	95	99	96	99	99	97	97	97	99	99
Lebanon	12 mos	5 yrs	89	91	79	90	94	96	96	96	96	96
Libya	12 mos	18 mos	91	92	92	92	93	91	95	99	97	98
Morocco	9 mos	6 yrs	92	91	90	93	96	94	90	95	97	95
Oman	12 mos	18 mos	98	98	99	99	99	99	98	98	98	96
West Bank and Gaza Strip	9 mos	15 mos	96	94	91	93	98	94	100	95	99	99
Pakistan	9 mos	—	52	55	56	56	57	63	61	67	78	80[§]
Qatar	12 mos	5 yrs	87	89	87	91	92	99	93	99	99	99
Saudi Arabia	9 mos	5 yrs	92	93	92	94	94	97	96	97	96	95
Somalia	9 mos	—	25	47	38	38	36	45	40	40	35	35[§]
Sudan[¶]	9 mos	—	58	49	51	58	58	58	65	67	69	73[§]
Syria	10 mos	15 mos	93	97	97	96	93	98	98	98	98	98
Tunisia	15 mos	6 yrs	92	94	90	95	92	94	90	95	96	98
United Arab Emirates	15 mos	6 yrs	95	95	96	94	94	94	94	94	92	92
Yemen	9 mos	—	46	66	74	71	79	65	66	76	76	80[§]
Region overall			**70**	**72**	**73**	**73**	**74**	**75**	**75**	**78**	**82**	**83**

* By age 12 months or later if first dose was scheduled after age 12 months. Data are from WHO and United Nations Children Fund (UNICEF) estimates.
† Second dose was not included in the routine vaccination schedule.
§ Vaccination coverage was below the regional goal of 90% in 2006.
¶ Includes partial data for Southern Sudan.

FIGURE. Number of reported measles cases* and estimated percentage of children who received their first dose of measles vaccine† — World Health Organization (WHO) Eastern Mediterranean Region, 1990–2006



* Confirmed cases of measles reported to WHO and the United Nations Childrens Fund (UNICEF) through the Joint Reporting Form Regional Office for the Eastern Mediterranean Region.
† By age 12 months or later if first dose was scheduled after age 12 months. Data are from WHO and UNICEF estimates.
§ This goal, to reduce measles mortality by 50% from 1999 to 2005, has been achieved.
¶ This goal is to reduce measles mortality by 90% from 2000 to 2010.

age in all districts. In the 16 countries with a routine 2-dose schedule, eight reported MCV2 coverage ≥90% in 2006.

Supplementary Immunization Activities

During 1994–2007, approximately 188 million children in the EMR were vaccinated through SIAs. The majority of countries completed a catch-up SIA (*4*), with the exceptions of Morocco and Pakistan. In 2008, Morocco plans to conduct a catch-up SIA, and Pakistan plans to complete the final phase (phase 5) of the catch-up SIA begun in 2007 (Table 2). Kuwait, Saudi Arabia, and Syria each conducted a repeat catch-up SIA because timely follow-up SIAs were delayed and large measles outbreaks occurred. Egypt and Lebanon plan to conduct a repeat catch-up SIA in 2008. In 2007, follow-up SIAs were implemented in Afghanistan and Iraq; Sudan plans to complete a follow-up SIA in 2008.

Surveillance Activities

Since 2006, all countries in the region except Somalia, Morocco, and Pakistan have conducted case-based surveillance. Morocco and Pakistan have sentinel surveillance for measles with laboratory confirmation of cases identified at sentinel sites. In the countries with case-based surveillance systems, at least 80% of all cases of suspected measles are investigated using an individual case-reporting form. Confirmation of measles is made by clinical diagnosis, epidemiologic linking, or laboratory testing.[¶] In EMR countries with case-based surveillance, a blood specimen is sent to the laboratory for testing for measles immunoglobulin M (IgM) antibody in at least 80% of suspected measles cases.

An EMR regional measles laboratory network has been established, with a national laboratory in each country and regional reference laboratories in Oman and Tunisia. National laboratories perform confirmatory testing of suspected cases using an enzyme-linked immunosorbent assay to detect measles IgM antibody. In 2007, workers at nine of the 21 national laboratories were trained to perform measles virus isolation and polymerase chain reaction testing for viral detection. During 2003–2007, measles virus genotype D4 was the predominant strain of measles in eight of the 16 EMR countries where genotypes were identified, followed by B3 in six countries; however, genotype C2 was predominant in Morocco.

In 2006, WHO's Technical Advisory Group on Immunization in the Eastern Mediterranean Region recommended monitoring surveillance performance through standardized indicators and targets. These standards include ensuring that 1) at least two suspected cases of measles per 100,000 persons per year are detected and reported (to monitor the sensitivity of the surveillance system), 2) at least 80% of suspected measles cases are tested for measles IgM antibody (to monitor adequacy of testing), 3) at least 80% of specimens are received by a laboratory within 7 days of collection (to monitor timeliness of specimen transport), 4) at least 80% of specimens sent to the laboratory arrive in adequate condition (to monitor adequacy of specimen collection), and 5) at least 80% of laboratory test results are reported within 7 days (to monitor timely reporting).

[¶] A clinically confirmed case is defined as illness in 1) any person with both fever and maculopapular rash plus cough, coryza, or conjunctivitis; or 2) any person in whom a clinician suspects measles infection. An epidemiologically confirmed case is defined as any illness meeting the clinical case definition for measles in a person who had direct contact with a person with laboratory-confirmed measles in which rash onset occurred 7–18 days before the epidemiologically confirmed case. Additional information available at http://www.emro.who.int/vpi/measles/media/pdf/measlesplan_2006_2010.pdf.

TABLE 2. Measles supplementary immunization activities (SIAs), by country/area, target age group, type of SIA, and number and percentage of targeted children vaccinated — World Health Organization (WHO) Eastern Mediterranean Region, 1994–2007

Country/Area	Year	Target age group	Type of SIA	No. and % of targeted children vaccinated	
				No.	(%)
Afghanistan	1999	<2 yrs	High-risk area	74,200	(53)
	2002	6 mos–12 yrs	Catch-up	8,791,569	(74)
	2003	9–59 mos	Follow-up	5,338,285	(96)
	2006	9–59 mos	Follow-up phase 1	1,064,000	(109)
	2006	9–59 mos	Follow-up phase 2	1,809,823	(105)
	2007	9–59 mos	Follow-up phase 3	2,085,479	(106)
Bahrain	1998	6–18 yrs	Catch-up phase 1	127,092	(97)
	1999	1–7 yrs	Catch-up phase 2	63,000	(90)
Djbouti	2002	9–59 mos	Catch-up	91,068	(80)
	2003	9–59 mos	Catch-up	77,854	(83)
	2006	9 mos–15 yrs	Catch-up	186,317	(85)
Egypt*	1998	1–5 yrs	High-risk area	1,864,549	(99)
	2001	6–11 yrs	Catch-up phase 1	5,616,000	(78)
	2002	3–5 yrs	Catch-up phase 2	3,220,000	(92)
Iran	1997	9 mos–14 yrs	High-risk area	6,518,295	(99)
	2003	5–25 yrs	Catch-up	33,422,642	(102)
	2007	1–5 yrs	Follow-up	310,859	(99)
Iraq	1995	1–5 yrs	High-risk area	2,388,439	(74)
	2002	1–5 yrs	Catch-up phase 1	3,619,402	(99)
	2004	6–12 yrs	Catch-up phase 2	5,161,813	(99)
	2005	1–5 yrs	Follow-up	2,629,299	(98)
	2007	12–59 mos	Follow-up	3,560,538	(92)
Jordan	1997	6–15 yrs	Catch-up	1,090,250	(99)
	1999	4–6 yrs	Catch-up	251,581	(63)
	2003	9 mos–14 yrs	High-risk area	3,244	(100)
	2005	8–16 yrs	Catch-up	175,291	(87)
Kuwait	1994	6–18 yrs	Catch-up	295,239	(94)
	1998	6–11 yrs	Follow-up	154,814	(93)
Lebanon*	2000	1–15 yrs	Catch-up	1,059,873	(74)
Libya	2005	9 mos–20 yrs	Catch-up	2,695,000	(98)
Morocco*		No SIAs conducted during 1994–2007			
Oman	1994	9 mos–18 yrs	Catch-up	705,000	(94)
Pakistan†	2005	1–5 yrs	High-risk area	1,232,000	(77)
	2007	9 mos–15 yrs	Catch-up phase 1	2,511,837	(98)
	2007	9 mos–13 yrs	Catch-up phase 2	1,282,232	(105)
	2007	9 mos–13 yrs	Catch-up phase 3	6,906,376	(100)
	2007	9 mos–13 yrs	Catch-up phase 4	20,566,497	(97)
Qatar	2000	6–16 yrs	Catch-up	80,065	(94)
	2007	12 mos–5 yrs	Catch-up	32,000	(92)
Saudi Arabia	1998	12–18 yrs	Catch-up phase 1	1,623,624	(96)
	2000	6–13 yrs	Catch-up phase 2	2,421,715	(97)
	2004	6–8 yrs	Follow-up	1,079,431	(97)
	2007	9–59 mos	Catch-up phase 1	1,920,976	(93)
	2007	6–16 yrs	Catch-up phase 2	4,753,190	(96)
Somalia	2002	9 mos–5 yrs	High-risk area	NA§	(NA)
	2005	9 mos–15 yrs	Catch-up phase 1	345,792	(82)
	2006	9 mos–15 yrs	Catch-up phase 2	2,226,102	(88)
	2007	9 mos–15 yrs	Catch-up phase 3	450,508	(108)
Sudan	1998	9 mos–5 yrs	High-risk area	115,200	(48)
	1999	9 mos–5 yrs	High-risk area	980,000	(98)
	2004	9 mos–15 yrs	Catch-up phase 1	1,438,765	(99)
	2004	9 mos–15 yrs	Catch-up phase 2	2,686,285	(95)
	2004	9 mos–15 yrs	Catch-up phase 3	4,020,994	(100)
	2005	9 mos–15 yrs	Catch-up phase 4	3,899,914	(93)
	2007	9 mos–5 yrs	Follow-up phase 1¶	1,490,822	(96)
Southern Sudan	2005	6 mos–15 yrs	Catch-up phase 1	1,169,862	(81)
	2006	6 mos–15 yrs	Catch-up phase 2	362,577	(76)
	2007	6 mos–15 yrs	Catch-up phase 3**	1,698,058	(72)

* Countries with a catch-up SIA planned for 2008.
† Final phase (phase 5) of catch-up SIA planned for completion in 2008.
§ Not available.
¶ Phase 1 included six states in northern Sudan, planned for completion in 2008.
** Conducted in Southern Sudan and planned for completion in 2008.

TABLE 2. (*Continued*) Measles supplementary immunization activities (SIAs), by country/area, target age group, type of SIA, and number and percentage of targeted children vaccinated — World Health Organization (WHO) Eastern Mediterranean Region, 1994–2007

Country/Area	Year	Target age group	Type of SIA	No. and % of targeted children vaccinated	
				No.	(%)
Syria	1998	9 mos–15 yrs	Catch-up	6,636,752	(99)
	2007	9 mos–6 yrs	Catch-up phase 1	3,172,840	(103)
	2007	7–10 yrs	Catch-up phase 2	1,610,338	(98)
Tunisia	1998	7–16 yrs	Catch-up	1,754,239	(95)
	2001	9 mos–5 yrs	Follow-up	514,900	(94)
	2002	6 mos–15 yrs	Catch-up	126,412	(99)
United Arab Emirates	1998	9–59 mos	Catch-up phase 1	154,960	(92)
	1999	6–18 yrs	Catch-up phase 2	168,435	(90)
	2001	9 mos–18 yrs	Catch-up	893,000	(94)
West Bank and Gaza Strip	2000	0–48 mos	High-risk area	17,804	(88)
	2004	2–15 yrs	Catch-up	415,000	(98)
Yemen	2001	1–5 yrs	Catch-up	2,205,453	(94)
	2006	9 mos–15 yrs	Catch-up	9,310,000	(98)
	2007	9 mos–15 yrs	Catch-up	1,291,206	(91)

In 2007, among the 18 reporting countries, regional targets for surveillance sensitivity were met by nine (50%) countries, adequacy of testing by 14 (78%) countries, timeliness of specimen transport by 11 (61%) countries, adequacy of specimen collection by 17 (94%) countries, and timeliness of laboratory reporting by 16 (89%) countries. Although countries in the region have made progress in strengthening case-based surveillance, as of December 2007, seven countries had not yet provided complete reports, and only one country had met all quality targets.

Monitoring Measles Mortality Reduction and Elimination

Before introduction of measles vaccination in the early 1980s, approximately 200,000 clinically diagnosed cases of measles were reported each year in EMR countries (*5*). After strengthening measles-control activities throughout the 1980s, reported cases declined 70% to approximately 60,000 in 1990, and the interval between measles epidemics increased from 2–4 years during 1980–1991 to 6 years during 1992–2004 (Figure). Overall, measles incidence was lowest in 2005 (29 cases per 1 million population); in 2006, incidence increased to 44 cases per 1 million population. In 2007, the reported number of cases of measles decreased, but those data are incomplete.** During 2006–2007, despite reported MCV1 coverage rates of ≥95%, a routine 2-dose schedule, and a catch-up SIA held during the preceding 8 years, measles outbreaks occurred in Egypt

** Data on the number of reported measles cases for 2007 are incomplete for Djibouti, Egypt, Lebanon, Pakistan, and Somalia.

(2,315 cases), Lebanon (1,344), Qatar (495), Saudi Arabia (4,215), and Syria (868).

In the absence of a routine surveillance system for measles deaths, WHO uses a model to estimate measles mortality based on measles case counts (corrected for a certain level of underreporting), estimated case-fatality rates, and estimated vaccination coverage (*6*). In 2000, an estimated 96,000 measles deaths occurred in EMR countries compared with 23,000 in 2006, representing a 76% decrease (*7*).

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Editorial Note: EMR countries have made progress toward the global goal of achieving a 90% reduction in measles mortality by 2010. However, the regional goal of achieving a sustained measles incidence of less than one case per 1 million population might not be achieved by 2010 because implementation of the regional measles elimination strategy varies among countries. Attaining high coverage of MCV1 with routine vaccination and high MCV2 coverage with routine vaccination or SIAs will be critical to reaching both goals. Since adoption of the 2010 regional measles elimination goal in 1997, coverage of MCV1 increased from 70% to 82% in 2006, and measles incidence decreased by 70%, from 146 per 1 million population in 1998 to 44 per 1 million population in 2006. Nonetheless, periodic measles outbreaks in several countries with high coverage with MCV1, a routine 2-dose schedule, and recently implemented catch-up SIAs suggest that reported vaccination coverage might overestimate actual coverage. In-depth reviews of immunization services, including independent surveys of vaccination coverage and assessments of data quality, are needed to identify and address programmatic shortfalls in these countries.

Certain countries where the burden of measles remains high (notably Afghanistan, Iraq, Lebanon, Pakistan, Somalia, and Sudan) have encountered major challenges to establishing comprehensive measles-control activities because of competing public health priorities, natural disasters, and civil unrest. Nonetheless, a catch-up SIA was conducted in parts of Pakistan in 2007, and successful implementation of planned activities in Afghanistan, the state of Punjab in Pakistan, and Somalia in 2008 will accelerate progress toward the regional elimination and global mortality reduction goals. Despite these achievements, armed conflict and war present major challenges for measles-control activities in several areas of the EMR. Unpredictable mass population displacements and resettlements complicate the delivery of routine immunization services and planning of SIAs. Conducting SIAs in conflict settings and in areas with no local government requires establishing close linkages with the local community. A strategy of coordinating special "days of tranquility" for vaccination activities during SIAs has been employed in parts of Afghanistan, Pakistan, Somalia, and Sudan. However, vaccination teams and civilian populations remain at risk for violence during these SIAs, and coverage often is suboptimal. In 2007, the SIA in Somalia achieved the lowest coverage in areas with the most insecurity. Protracted armed conflicts over many years in parts of Sudan and Afghanistan create logistic challenges to the transportation and storage of vaccine during SIAs.

Strategies for implementing SIAs vary substantially among EMR countries (Table 2). SIA coverage data and implementation reports indicate that some countries did not achieve high coverage for all susceptible age cohorts; this might be related to the use of different SIA strategies (e.g., conducted over extended periods, targeted at different age groups, or covering fragmented areas). To prevent an accumulation of persons susceptible to measles and subsequent measles outbreaks, follow-up SIAs need to be implemented periodically until routine 2-dose measles coverage ≥90% with both MCV1 and MCV2 is achieved and maintained in every district.

WHO's Regional Office for the Eastern Mediterranean recommends that a routine dose of MCV2 be introduced into national immunization schedules after MCV1 coverage ≥80% has been achieved for at least 3 years. Receipt of 2 doses of MCV provides immunity to nearly all vaccinated children. Serologic studies indicate that 1 dose of MCV provides immunity in approximately 85% of children when administered at age 9 months and in ≥95% of children when administered at age ≥12 months (*8*). To further enhance the effectiveness of MCV1 on population immunity, EMR countries with low transmission and high coverage with MCV1 and MCV2 should consider revising the schedule for MCV1 so that it is administered at age ≥12 months.

Although advances have been made in EMR countries toward the goal of reducing global mortality, successful implementation of all components of the EMR elimination strategy will be needed to achieve the regional goal of measles elimination. Much work remains to be done to increase vaccination coverage with MCV1 and MCV2, to confirm the validity of reported vaccination coverage, and to ensure that routine immunization services and SIAs reach populations at high risk who reside in areas with poor access or civil strife.

References

1. World Health Organization, United Nations Children's Fund. Global immunization vision and strategy 2006–2015. Geneva, Switzerland: World Health Organization, UNICEF; 2005. Available at http://www.who.int/vaccines-documents/docspdf05/givs_final_en.pdf.
2. World Health Organization. Measles: regional strategy for measles elimination. Geneva, Switzerland: World Health Organization. Available at http://www.emro.who.int/vpi/measles/regionalstrategy.htm.
3. World Health Organization, United Nations Children's Fund. WHO/UNICEF estimates of national immunization coverage, 1980–2006. Geneva, Switzerland: World Health Organization, UNICEF; 2007. Available at http://www.who.int/immunization_monitoring/routine/immunization_coverage/en/index4.html.
4. World Health Organization Eastern Mediterranean Region. Measles campaigns. Geneva, Switzerland: World Health Organization; 2008. Available at http://www.emro.who.int/vpi/measles/campaigns.htm.
5. CDC. Progress toward measles elimination—Eastern Mediterranean Region. MMWR 1999;48:1081–6.
6. Wolfson LJ, Strebel PM, Gacic-Dobo M, et al. Has the 2005 measles mortality reduction goal been achieved? A natural history modelling study. Lancet 2007;369:191–200.
7. CDC. Progress in global measles control and mortality reduction, 2000–2006. MMWR 2007;56:1237–41.
8. World Health Organization. Measles vaccines. Wkly Epidemiol Rec 2004;79:130–42.

Notice to Readers

SurvCost: Tool for Estimating Cost of Surveillance Systems

Since 1998, CDC, with support from the United States Agency for International Development (USAID), has been a technical partner with the World Health Organization Regional Headquarters for Africa (WHO/AFRO) in the design, development, implementation, monitoring, and evaluation of Integrated Disease Surveillance and Response systems. The purpose of this strategy is to develop surveillance and response capacities in African countries to improve timely detection, confirmation, and response to infectious diseases of concern to African communities.

To help national surveillance programs estimate the costs of initiating and operating an integrated surveillance system, CDC collaborated with WHO/AFRO to develop a spreadsheet-based tool, SurvCost, to estimate the costs of supporting a surveillance program. SurvCost leads users through a series of guided prompts that require entry of actual program costs in categories such as personnel, laboratory, office, capital equipment, transportation, and treatment. Users can analyze costs by health facility, surveillance activity, or disease. Such data can help disease surveillance system managers plan their budgets and advocate for additional resources to improve such systems. SurvCost is available at http://www.cdc.gov/idsr/survcost.htm.

Notice to Readers

National Poison Prevention Week — March 16–22, 2008

This year's National Poison Prevention Week will be observed March 16–22. This observance is organized each year by the National Poison Prevention Week Council, a coalition of national organizations working to highlight the dangers of poisoning and its prevention.

During 1999–2005, unintentional poisoning death rates increased by 80%, largely because of increases in recreational drug overdoses among adults (*1*). In addition, U.S. poison-control centers reported an estimated 2.3 million exposures to poisonous substances during 2006 (*2*). Approximately 93% of these exposures occurred at a residence, and nearly half occurred in children aged ≤6 years (*2*). Poisonous agents most often implicated in pediatric exposures include cosmetics, personal-care products, cleaning substances, analgesics, cough and cold preparations, and other products usually found in the home.

Resources for consumer education about poisoning and its prevention are available from CDC at http://www.cdc.gov/ncipc/factsheets/poisoning.htm and from the National Poison Prevention Week Council at http://www.poisonprevention.org. In addition, Consumer Product Safety Commission publications are available to educate consumers about identifying and correcting situations in the home that could lead to poisoning. These resources are available at http://www.cpsc.gov/cpscpub/pubs/pois_prv.html. Information about carbon monoxide poisoning is available from CDC at http://www.cdc.gov/co/basics.htm#guideline.

Additional information about National Poison Prevention Week is available from CDC at http://www.cdc.gov/ncipc/duip/poisonweek.htm. The national toll-free telephone number for poison-control centers is 1-800-222-1222.

References

1. CDC. Unintentional poisoning deaths—United States, 1999–2004. MMWR 2007;56:93–6.
2. Bronstein AC, Spyker DA, Cantilena LR, Green G, Rumack BH, Heard SE. 2006 annual report of the American Association of Poison Control Centers' National Poison Data System (NPDS). Clinical Toxicology 2007;45:815–917.

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending March 8, 2008 (10th Week)*

Disease	Current week	Cum 2008	5-year weekly average†	Total cases reported for previous years 2007	2006	2005	2004	2003	States reporting cases during current week (No.)
Anthrax	—	—	0	—	1	—	—	—	
Botulism:									
foodborne	—	1	0	22	20	19	16	20	
infant	—	7	2	84	97	85	87	76	
other (wound & unspecified)	—	—	0	24	48	31	30	33	
Brucellosis	—	7	2	129	121	120	114	104	
Chancroid	—	8	0	31	33	17	30	54	
Cholera	—	—	—	7	9	8	6	2	
Cyclosporiasis§	1	11	3	99	137	543	160	75	FL (1)
Diphtheria	—	—	—	—	—	—	—	1	
Domestic arboviral diseases§,¶:									
California serogroup	—	—	0	44	67	80	112	108	
eastern equine	—	—	—	4	8	21	6	14	
Powassan	—	—	—	1	1	1	1	—	
St. Louis	—	—	—	7	10	13	12	41	
western equine	—	—	—	—	—	—	—	—	
Ehrlichiosis/Anaplasmosis§,**:									
Ehrlichia chaffeensis	1	15	2	743	578	506	338	321	TN (1)
Ehrlichia ewingii	—	1	—	—	—	—	—	—	
Anaplasma phagocytophilum	—	4	1	672	646	786	537	362	
undetermined	—	1	0	160	231	112	59	44	
Haemophilus influenzae,†† invasive disease (age <5 yrs):									
serotype b	—	6	0	22	29	9	19	32	
nonserotype b	2	26	4	168	175	135	135	117	OH (1), FL (1)
unknown serotype	5	49	4	194	179	217	177	227	NY (1), MD (1), FL (1), AZ (1), UT (1)
Hansen disease§	1	11	1	70	66	87	105	95	CA (1)
Hantavirus pulmonary syndrome§	—	—	0	32	40	26	24	26	
Hemolytic uremic syndrome, postdiarrheal§	—	8	2	263	288	221	200	178	
Hepatitis C viral, acute	8	94	16	788	766	652	720	1,102	ME (1), NY (2), OH (2), MO (1), MD (1), OK (1)
HIV infection, pediatric (age <13 yrs)§§	—	—	5	—	—	380	436	504	
Influenza-associated pediatric mortality§,¶¶	8	41	2	76	43	45	—	N	MA (1), ME (1), NJ (1), NM (1), PA (2), VA (1), WI (1)
Listeriosis	5	60	9	780	884	896	753	696	PA (1), OH (2), FL (1), AZ (1)
Measles***	—	1	1	40	55	66	37	56	
Meningococcal disease, invasive†††:									
A, C, Y, & W-135	8	41	8	282	318	297	—	—	MN (2), MO (2), TX (2), WA (2)
serogroup B	4	28	4	146	193	156	—	—	MN (1), SC (1), TX (1), CO (1)
other serogroup	1	7	1	31	32	27	—	—	FL (1)
unknown serogroup	15	100	20	605	651	765	—	—	NY (1), PA (4), NE (1), MD (2), FL (1), TN (1), OR (1), CA (4)
Mumps	7	119	24	774	6,584	314	258	231	NY (1), PA (1), MI (1), MN (1), KS (1), CO (1), AZ (1)
Novel influenza A virus infections	—	—	—	4	N	N	N	N	
Plague	—	—	0	6	17	8	3	1	
Poliomyelitis, paralytic	—	—	—	—	—	1	—	—	
Poliovirus infection, nonparalytic§	—	—	—	—	N	N	N	N	
Psittacosis§	—	—	0	10	21	16	12	12	
Q fever§,§§§ total:	—	5	2	187	169	136	70	71	
acute	—	5	—	—	—	—	—	—	
chronic	—	—	—	—	—	—	—	—	
Rabies, human	—	—	—	—	3	2	7	2	
Rubella¶¶¶	—	—	0	12	11	11	10	7	
Rubella, congenital syndrome	—	—	0	—	1	1	—	1	
SARS-CoV§,****	—	—	0	—	—	—	—	8	

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

* Incidence data for reporting years 2007 and 2008 are provisional, whereas data for 2003, 2004, 2005, and 2006 are finalized.

† Calculated by summing the incidence counts for the current week, the 2 weeks preceding the current week, and the 2 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. Data from states where the condition is not notifiable are excluded from this table, except in 2007 and 2008 for the domestic arboviral diseases and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/epo/dphsi/phs/infdis.htm.

¶ Includes both neuroinvasive and nonneuroinvasive. Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for West Nile virus are available in Table II.

** The names of the reporting categories changed in 2008 as a result of revisions to the case definitions. Cases reported prior to 2008 were reported in the categories: Ehrlichiosis, human monocytic (analogous to *E. chaffeensis*); Ehrlichiosis, human granulocytic (analogous to *Anaplasma phagocytophilum*), and Ehrlichiosis, unspecified, or other agent (which included cases unable to be clearly placed in other categories, as well as possible cases of *E. ewingii*).

†† 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. Implementation of HIV reporting influences the number of cases reported. Updates of pediatric HIV data have been temporarily suspended until upgrading of the national HIV/AIDS surveillance data management system is completed. Data for HIV/AIDS, when available, are displayed in Table IV, which appears quarterly.

¶¶ Updated weekly from reports to the Influenza Division, National Center for Immunization and Respiratory Diseases. Forty-one cases occurring during the 2007–08 influenza season have been reported.

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

††† Data for meningococcal disease (all serogroups) are available in Table II.

§§§ In 2008, Q fever acute and chronic reporting categories were recognized as a result of revisions to the Q fever case definition. Prior to that time, case counts were not differentiated with respect to acute and chronic Q fever cases.

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

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

TABLE I. (*Continued*) Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending March 8, 2008 (10th Week)*

Disease	Current week	Cum 2008	5-year weekly average†	Total cases reported for previous years 2007	2006	2005	2004	2003	States reporting cases during current week (No.)
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	1	16	4	103	125	129	132	161	OH (1)
Syphilis, congenital (age <1 yr)	—	9	7	270	349	329	353	413	
Tetanus	—	—	0	23	41	27	34	20	
Toxic-shock syndrome (staphylococcal)§	—	6	2	82	101	90	95	133	
Trichinellosis	1	2	0	6	15	16	5	6	VA (1)
Tularemia	—	2	0	114	95	154	134	129	
Typhoid fever	1	45	5	365	353	324	322	356	MD (1)
Vancomycin-intermediate *Staphylococcus aureus*§	—	1	0	28	6	2	—	N	
Vancomycin-resistant *Staphylococcus aureus*§	—	—	—	—	1	3	1	N	
Vibriosis (noncholera *Vibrio* species infections)§	—	17	1	379	N	N	N	N	
Yellow fever	—	—	—	—	—	—	—	—	

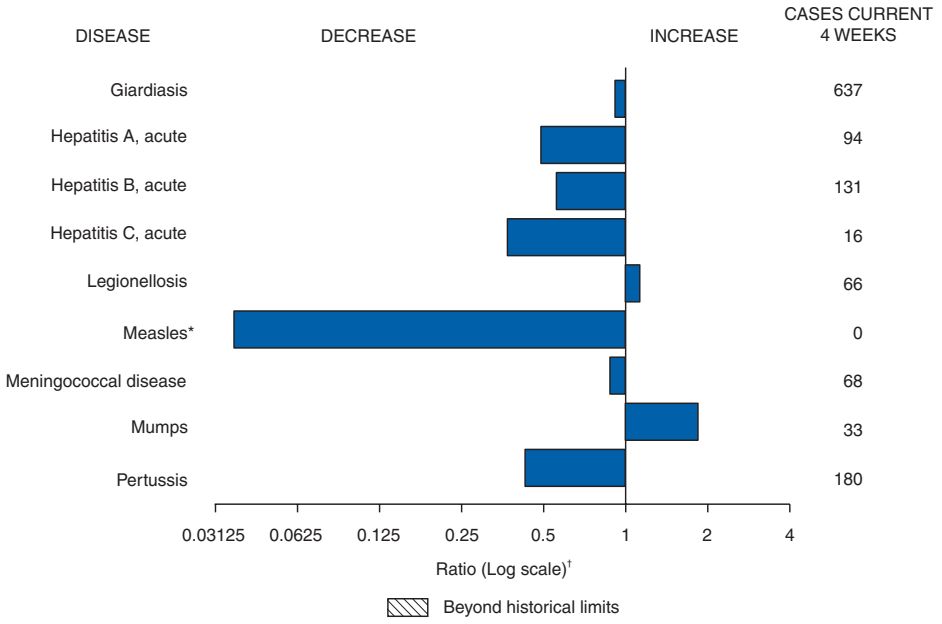
—: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts.

* Incidence data for reporting years 2007 and 2008 are provisional, whereas data for 2003, 2004, 2005, and 2006 are finalized.

† Calculated by summing the incidence counts for the current week, the 2 weeks preceding the current week, and the 2 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. Data from states where the condition is not notifiable are excluded from this table, except in 2007 and 2008 for the domestic arboviral diseases and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/epo/dphsi/phs/infdis.htm.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals March 8, 2008, with historical data



* No measles cases were reported for the current 4-week period yielding a ratio for week 10 of zero (0).

† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

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TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending March 8, 2008, and March 10, 2007 (10th Week)*

Reporting area	Chlamydia†					Coccidioidomycosis					Cryptosporidiosis				
	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007
		Med	Max				Med	Max				Med	Max		
United States	7,516	20,764	24,800	156,915	194,115	71	137	285	1,175	1,518	27	84	974	484	578
New England	389	686	1,516	6,126	6,155	—	0	1	1	—	—	4	16	14	69
Connecticut	—	223	1,091	1,176	1,311	N	0	0	N	N	—	0	2	2	42
Maine§	58	49	74	509	499	—	0	0	—	—	—	1	5	—	6
Massachusetts	305	305	661	3,468	3,090	—	0	0	—	—	—	2	11	—	9
New Hampshire	26	38	73	428	388	—	0	1	1	—	—	1	5	3	8
Rhode Island§	—	61	98	539	676	—	0	0	—	—	—	0	3	—	—
Vermont§	—	14	32	6	191	N	0	0	N	N	—	1	4	9	4
Mid. Atlantic	1,474	2,747	4,168	19,382	25,983	—	0	0	—	—	7	10	118	69	65
New Jersey	231	402	524	2,346	4,292	N	0	0	N	N	—	0	8	3	3
New York (Upstate)	705	557	2,037	4,190	3,803	N	0	0	N	N	4	3	20	15	10
New York City	89	903	2,194	5,385	9,697	N	0	0	N	N	—	1	10	10	20
Pennsylvania	449	789	1,754	7,461	8,191	N	0	0	N	N	3	6	103	41	32
E.N. Central	543	3,369	6,195	24,442	32,632	1	1	3	6	9	8	20	134	122	115
Illinois	3	1,014	2,193	6,155	9,497	—	0	0	—	—	—	2	13	4	19
Indiana	—	394	629	2,975	4,216	—	0	0	—	—	—	2	32	14	7
Michigan	285	704	992	6,892	7,803	—	0	2	3	7	1	4	11	31	19
Ohio	117	816	3,618	4,667	7,294	1	0	1	3	2	7	5	61	39	38
Wisconsin	138	377	604	3,753	3,822	N	0	0	N	N	—	7	59	34	32
W.N. Central	595	1,196	1,462	9,689	12,016	—	0	30	—	2	3	15	125	81	75
Iowa	—	158	251	1,466	1,620	N	0	0	N	N	1	3	61	21	12
Kansas	136	150	394	999	1,540	N	0	0	N	N	—	2	16	9	10
Minnesota	—	256	318	1,567	2,589	—	0	30	—	—	1	4	34	24	20
Missouri	372	459	551	4,371	4,465	—	0	1	—	2	1	2	13	10	12
Nebraska§	37	90	183	724	960	N	0	0	N	N	—	2	24	10	5
North Dakota	—	28	65	37	370	N	0	0	N	N	—	0	6	1	1
South Dakota	50	52	81	525	472	N	0	0	N	N	—	2	16	6	15
S. Atlantic	2,234	3,970	6,237	32,078	34,806	—	0	1	1	2	4	20	69	113	139
Delaware	56	64	140	710	678	—	0	0	—	—	—	0	4	4	2
District of Columbia	—	114	182	748	1,013	—	0	0	—	—	—	0	0	—	3
Florida	1,092	1,260	1,565	12,511	7,241	N	0	0	N	N	4	8	35	56	74
Georgia	—	488	1,502	54	7,637	N	0	0	N	N	—	5	17	35	27
Maryland§	328	454	696	3,887	2,903	—	0	1	1	2	—	0	3	—	4
North Carolina	—	316	2,595	4,946	5,456	—	0	0	—	—	—	1	18	7	6
South Carolina§	38	515	3,030	4,488	4,919	N	0	0	N	N	—	1	15	5	11
Virginia§	710	485	628	4,183	4,368	N	0	0	N	N	—	1	5	3	11
West Virginia	10	59	95	551	591	N	0	0	N	N	—	0	5	3	1
E.S. Central	849	1,496	2,248	12,675	16,011	—	0	0	—	—	—	4	65	18	31
Alabama§	—	484	605	3,134	4,866	N	0	0	N	N	—	1	14	11	13
Kentucky	295	194	357	2,316	1,120	N	0	0	N	N	—	1	40	2	8
Mississippi	—	273	1,049	2,078	4,302	N	0	0	N	N	—	0	11	1	8
Tennessee§	554	505	719	5,147	5,723	N	0	0	N	N	—	1	18	4	2
W.S. Central	546	2,569	3,568	24,032	21,107	—	0	1	—	—	3	6	28	33	39
Arkansas§	270	204	395	2,607	1,629	N	0	0	N	N	1	0	8	2	3
Louisiana	—	353	851	1,876	3,184	—	0	1	—	—	—	1	4	2	11
Oklahoma	276	241	467	2,079	2,408	N	0	0	N	N	1	1	11	9	9
Texas§	—	1,712	3,420	17,470	13,886	N	0	0	N	N	1	3	16	20	16
Mountain	96	1,229	1,668	5,069	11,393	68	94	172	1,021	991	2	8	571	27	31
Arizona	30	444	665	557	3,979	68	91	170	1,006	966	—	1	6	6	5
Colorado	—	185	384	423	1,841	N	0	0	N	N	—	2	26	—	13
Idaho§	—	57	233	674	612	N	0	0	N	N	—	1	72	8	1
Montana§	18	45	345	525	548	N	0	0	N	N	—	1	7	4	1
Nevada§	—	186	291	1,086	1,779	—	1	6	11	6	—	0	6	1	—
New Mexico§	—	161	394	873	1,556	—	0	2	2	7	—	2	9	3	9
Utah	48	118	218	920	841	—	1	7	2	12	—	1	488	2	1
Wyoming§	—	22	35	11	237	—	0	1	—	—	2	0	8	3	1
Pacific	790	3,356	4,014	23,422	34,012	2	40	176	146	514	—	1	20	7	14
Alaska	68	86	123	752	885	N	0	0	N	N	—	0	2	—	—
California	535	2,687	3,429	19,813	26,811	2	40	176	146	514	—	0	0	—	—
Hawaii	—	109	134	762	1,100	N	0	0	N	N	—	0	4	—	—
Oregon§	187	181	403	1,987	1,838	N	0	0	N	N	—	1	16	7	14
Washington	—	143	621	108	3,378	N	0	0	N	N	—	0	0	—	—
American Samoa	—	0	32	37	—	N	0	0	N	N	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	10	34	16	153	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	114	612	779	1,551	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	3	10	—	46	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2007 and 2008 are provisional. Data for HIV/AIDS, AIDS, and TB, when available, are displayed in Table IV, which appears quarterly.
† 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 March 8, 2008, and March 10, 2007 (10th Week)*

Reporting area	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive All ages, all serotypes†				
	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007
		Med	Max				Med	Max				Med	Max		
United States	160	298	1,060	2,068	2,731	2,256	6,723	7,944	46,883	64,304	33	43	116	503	528
New England	5	23	54	103	203	36	104	227	823	990	—	3	8	8	44
Connecticut	—	6	18	35	53	—	42	199	244	292	—	0	7	—	15
Maine§	2	3	10	19	31	2	2	8	17	16	—	0	3	2	2
Massachusetts	—	8	29	—	96	30	50	127	477	543	—	1	6	—	22
New Hampshire	1	0	3	10	2	4	2	6	21	25	—	0	2	1	5
Rhode Island§	—	1	15	14	—	—	7	14	64	101	—	0	2	2	—
Vermont§	2	3	8	25	21	—	1	5	—	13	—	0	1	3	—
Mid. Atlantic	23	59	117	347	488	441	666	1,008	4,525	6,915	4	9	27	100	116
New Jersey	—	7	15	21	67	110	117	159	891	1,241	—	1	6	15	20
New York (Upstate)	16	23	100	142	137	168	129	517	1,048	992	2	3	20	28	23
New York City	3	16	29	70	171	15	159	376	686	2,241	—	1	6	15	31
Pennsylvania	4	14	30	114	113	148	233	551	1,900	2,441	2	3	11	42	42
E.N. Central	19	48	91	325	423	169	1,291	2,579	8,761	13,484	5	6	14	71	70
Illinois	—	14	33	59	121	—	378	762	1,923	3,410	—	2	6	16	22
Indiana	N	0	0	N	N	—	161	308	1,302	1,679	—	1	7	10	5
Michigan	1	11	22	58	124	93	285	531	2,694	3,319	—	0	3	3	8
Ohio	18	15	37	154	122	33	346	1,558	1,689	3,676	5	2	6	41	30
Wisconsin	—	7	21	54	56	43	126	210	1,153	1,400	—	0	1	1	5
W.N. Central	33	22	578	267	178	186	373	446	2,633	3,934	1	3	24	43	25
Iowa	1	4	23	47	39	—	32	56	218	407	—	0	1	1	—
Kansas	—	3	11	20	23	35	41	102	256	481	—	0	1	1	4
Minnesota	19	0	573	100	4	1	63	90	449	698	—	1	21	9	6
Missouri	10	8	23	64	81	125	188	255	1,431	2,053	1	1	5	24	12
Nebraska§	3	3	8	24	20	21	26	57	233	216	—	0	3	7	2
North Dakota	—	0	3	4	1	—	2	6	2	21	—	0	1	1	1
South Dakota	—	1	6	8	10	4	5	11	44	58	—	0	0	—	—
S. Atlantic	25	54	95	426	455	735	1,593	2,339	11,673	14,107	10	11	30	142	128
Delaware	—	1	6	7	5	18	24	44	240	293	—	0	3	1	1
District of Columbia	—	0	6	—	13	—	45	71	256	443	—	0	1	—	2
Florida	19	23	47	191	195	380	490	623	4,554	3,275	6	3	10	45	40
Georgia	—	12	36	135	106	—	202	621	21	3,125	—	2	8	35	28
Maryland§	2	5	18	36	47	95	125	234	1,111	1,005	4	1	6	34	27
North Carolina	—	0	0	—	—	45	231	1,176	2,447	2,909	—	0	9	10	8
South Carolina§	2	2	6	17	9	78	202	1,361	1,785	1,995	—	1	4	8	9
Virginia§	2	10	39	38	79	113	129	224	1,129	901	—	1	23	5	11
West Virginia	—	0	8	2	1	6	17	38	130	161	—	0	3	4	2
E.S. Central	2	10	23	63	96	254	582	868	4,584	5,997	2	2	8	25	33
Alabama§	1	4	11	40	59	—	206	281	1,319	2,096	—	0	3	5	9
Kentucky	N	0	0	N	N	104	79	161	892	398	—	0	1	—	2
Mississippi	N	0	0	N	N	—	112	400	809	1,550	—	0	2	1	2
Tennessee§	1	5	16	23	37	150	176	261	1,564	1,953	2	2	6	19	20
W.S. Central	3	7	21	28	61	240	1,012	1,353	8,396	9,024	4	2	15	24	15
Arkansas§	1	1	9	9	25	123	77	138	883	765	—	0	2	—	1
Louisiana	—	2	14	4	19	—	207	384	1,112	1,947	—	0	2	1	3
Oklahoma	2	3	9	15	17	117	87	235	858	1,037	4	1	8	22	10
Texas§	N	0	0	N	N	—	639	963	5,543	5,275	—	0	3	1	1
Mountain	14	31	67	141	262	18	233	321	818	2,294	7	5	14	74	67
Arizona	—	3	10	19	42	9	97	130	162	820	1	2	10	42	33
Colorado	11	9	26	24	93	—	35	85	24	552	1	1	4	2	15
Idaho§	—	3	19	25	21	—	5	19	34	31	—	0	1	1	2
Montana§	—	2	8	9	12	—	1	48	14	25	—	0	1	1	—
Nevada§	—	3	8	17	18	—	45	85	286	419	—	0	1	4	3
New Mexico§	—	2	5	10	26	—	30	64	212	298	—	1	4	7	6
Utah	3	7	33	32	40	9	13	36	86	133	5	1	6	17	7
Wyoming§	—	1	4	5	10	—	1	5	—	16	—	0	1	—	1
Pacific	36	61	207	368	565	177	661	799	4,670	7,559	—	3	6	16	30
Alaska	—	1	5	9	13	4	9	18	71	97	—	0	4	4	4
California	25	42	84	256	424	158	582	711	4,221	6,440	—	0	5	—	6
Hawaii	—	1	4	2	14	—	12	23	86	117	—	0	2	1	1
Oregon§	6	8	17	73	88	15	23	63	276	209	—	1	4	11	19
Washington	5	8	119	28	26	—	20	142	16	696	—	0	3	—	—
American Samoa	—	0	0	—	—	—	0	2	1	2	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	—	—	—	1	13	5	14	—	0	1	—	—
Puerto Rico	2	3	21	5	55	—	5	23	46	70	—	0	1	—	—
U.S. Virgin Islands	—	0	0	—	—	—	1	3	—	13	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2007 and 2008 are provisional.
† Data for *H. influenzae* (age <5 yrs for serotype b, nonserotype b, and unknown serotype) are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 8, 2008, and March 10, 2007 (10th Week)*

Reporting area	Hepatitis (viral, acute), by type† A: Current week	A: Previous 52 weeks Med	A: Previous 52 weeks Max	A: Cum 2008	A: Cum 2007	B: Current week	B: Previous 52 weeks Med	B: Previous 52 weeks Max	B: Cum 2008	B: Cum 2007	Legionellosis: Current week	Legionellosis: Previous 52 weeks Med	Legionellosis: Previous 52 weeks Max	Legionellosis: Cum 2008	Legionellosis: Cum 2007
United States	25	53	132	412	490	37	80	185	500	756	15	47	91	313	282
New England	2	2	6	14	8	—	1	6	6	12	—	2	14	12	9
Connecticut	—	0	3	3	2	—	0	5	3	3	—	0	4	3	1
Maine§	1	0	1	2	—	—	0	2	2	1	—	0	2	—	—
Massachusetts	—	0	4	—	5	—	0	1	—	1	—	0	2	—	7
New Hampshire	—	0	3	—	1	—	0	1	1	3	—	0	2	1	—
Rhode Island§	1	0	2	9	—	—	0	3	—	3	—	0	6	6	—
Vermont§	—	0	1	—	—	—	0	1	—	1	—	0	2	2	1
Mid. Atlantic	1	9	21	55	78	1	8	17	44	113	2	13	37	70	74
New Jersey	—	2	6	6	24	—	1	4	—	35	—	1	11	6	15
New York (Upstate)	1	1	6	14	13	1	2	7	9	10	—	4	15	14	17
New York City	—	3	9	14	29	—	2	6	2	30	—	3	11	4	12
Pennsylvania	—	2	5	21	12	—	3	13	33	38	2	5	21	46	30
E.N. Central	2	6	13	48	69	1	8	15	55	101	9	10	30	79	72
Illinois	—	2	5	9	31	—	2	6	5	28	—	2	12	7	14
Indiana	—	0	4	4	1	—	0	8	4	2	—	1	7	4	4
Michigan	2	2	5	26	19	—	2	6	15	34	—	3	11	18	25
Ohio	—	1	4	7	12	1	2	7	29	28	9	4	17	50	25
Wisconsin	—	0	3	2	6	—	0	2	2	9	—	0	1	—	4
W.N. Central	5	3	18	51	10	1	2	8	14	33	—	1	9	15	11
Iowa	—	1	5	16	4	—	0	2	2	8	—	0	2	2	1
Kansas	—	0	3	4	—	—	0	2	4	2	—	0	1	—	—
Minnesota	4	0	17	6	—	—	0	4	—	1	—	0	6	1	1
Missouri	—	0	3	12	3	1	1	5	7	17	—	1	3	6	6
Nebraska§	1	0	3	12	1	—	0	1	1	3	—	0	2	5	2
North Dakota	—	0	0	—	—	—	0	1	—	—	—	0	0	—	—
South Dakota	—	0	1	1	2	—	0	1	—	2	—	0	1	1	1
S. Atlantic	3	10	21	66	78	12	18	53	157	182	3	7	27	69	66
Delaware	—	0	1	—	—	—	0	2	—	2	—	0	2	1	1
District of Columbia	—	0	5	—	8	—	0	1	—	—	—	0	1	—	—
Florida	2	3	8	27	31	6	6	12	66	62	3	3	12	34	30
Georgia	—	1	4	10	12	—	2	6	18	31	—	1	3	13	7
Maryland§	1	1	5	11	10	3	2	7	15	24	—	1	5	11	15
North Carolina	—	0	9	9	1	—	0	16	24	21	—	0	4	3	6
South Carolina§	—	0	4	2	3	—	1	6	14	11	—	0	2	1	3
Virginia§	—	1	5	6	13	3	2	15	16	24	—	1	6	4	3
West Virginia	—	0	2	1	—	—	0	23	4	7	—	0	5	2	1
E.S. Central	—	2	5	7	22	3	7	14	54	61	—	2	6	14	15
Alabama§	—	0	4	1	5	—	2	6	20	21	—	0	1	1	2
Kentucky	—	0	2	3	3	—	1	7	18	5	—	1	3	8	5
Mississippi	—	0	1	—	4	—	0	3	2	9	—	0	0	—	—
Tennessee§	—	1	3	3	10	3	2	8	14	26	—	1	4	5	8
W.S. Central	1	5	45	33	38	12	18	73	101	97	—	2	11	7	6
Arkansas§	—	0	2	—	2	—	1	4	2	9	—	0	3	1	1
Louisiana	—	0	3	—	5	—	1	6	7	17	—	0	1	—	—
Oklahoma	1	0	8	2	—	3	1	38	10	6	—	0	2	—	—
Texas§	—	4	44	31	31	9	13	55	82	65	—	2	11	6	5
Mountain	3	4	10	42	59	1	3	9	15	51	1	2	6	19	16
Arizona	—	2	10	25	47	—	1	5	2	25	1	0	5	10	3
Colorado	1	0	2	3	5	1	0	3	2	7	—	0	2	1	4
Idaho§	2	0	2	6	—	—	0	1	1	3	—	0	1	1	1
Montana§	—	0	2	—	—	—	0	1	—	—	—	0	1	1	—
Nevada§	—	0	1	—	3	—	1	3	7	12	—	0	2	2	2
New Mexico§	—	0	1	4	1	—	0	2	1	2	—	0	1	—	2
Utah	—	0	2	2	2	—	0	2	2	2	—	0	3	4	3
Wyoming§	—	0	1	2	1	—	0	1	—	—	—	0	1	—	1
Pacific	8	12	44	96	128	6	9	33	54	106	—	3	15	28	13
Alaska	—	0	1	—	1	—	0	2	2	2	—	0	0	—	—
California	4	10	36	73	118	4	7	23	38	79	—	2	13	24	13
Hawaii	—	0	2	—	2	—	0	2	1	—	—	0	1	—	—
Oregon§	1	1	3	10	4	—	1	3	7	20	—	0	2	3	—
Washington	3	1	7	13	3	2	1	10	6	5	—	0	2	1	—
American Samoa	—	0	0	—	—	—	0	13	—	—	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	1	—	1	—	0	0	—	—
Puerto Rico	—	0	3	1	18	—	1	4	4	17	—	0	1	—	2
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2007 and 2008 are provisional.
† Data for acute hepatitis C, viral are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 8, 2008, and March 10, 2007 (10th Week)*

Reporting area	Lyme disease					Malaria					Meningococcal disease, invasive† All serogroups				
	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007
		Med	Max				Med	Max				Med	Max		
United States	44	320	1,304	857	1,431	1	24	107	119	171	28	19	51	176	235
New England	11	44	302	35	105	—	1	23	1	6	—	0	3	2	10
Connecticut	—	12	214	—	20	—	0	16	—	—	—	0	1	1	1
Maine§	11	6	61	21	1	—	0	2	—	1	—	0	1	1	2
Massachusetts	—	0	31	—	39	—	0	3	—	5	—	0	2	—	5
New Hampshire	—	8	88	11	41	—	0	4	1	—	—	0	1	—	—
Rhode Island§	—	0	79	—	—	—	0	7	—	—	—	0	1	—	—
Vermont§	—	1	13	3	4	—	0	2	—	—	—	0	1	—	2
Mid. Atlantic	24	163	665	509	736	—	7	18	24	38	5	2	8	22	24
New Jersey	—	36	177	46	223	—	0	4	—	3	—	0	2	1	4
New York (Upstate)	19	54	220	62	92	—	1	8	3	4	1	1	3	8	6
New York City	—	5	27	4	27	—	4	9	15	25	—	0	4	1	4
Pennsylvania	5	51	322	397	394	—	1	4	6	6	4	1	5	12	10
E.N. Central	1	11	169	14	51	—	2	7	24	29	—	3	6	28	41
Illinois	—	1	16	—	3	—	1	6	9	14	—	1	3	8	14
Indiana	—	0	7	—	1	—	0	2	1	1	—	0	4	4	6
Michigan	—	0	5	5	2	—	0	2	5	5	—	0	2	6	7
Ohio	1	0	4	2	2	—	0	3	8	4	—	1	2	9	9
Wisconsin	—	10	149	7	43	—	0	1	1	5	—	0	1	1	5
W.N. Central	—	4	665	2	18	1	0	8	2	12	6	1	8	28	18
Iowa	—	1	11	2	2	—	0	1	—	2	—	0	2	7	4
Kansas	—	0	2	—	1	—	0	1	—	—	—	0	1	—	2
Minnesota	—	0	665	—	15	1	0	8	1	7	3	0	7	10	2
Missouri	—	0	4	—	—	—	0	1	—	1	2	0	3	7	7
Nebraska§	—	0	1	—	—	—	0	1	1	2	1	0	2	3	1
North Dakota	—	0	2	—	—	—	0	1	—	—	—	0	1	—	1
South Dakota	—	0	0	—	—	—	0	1	—	—	—	0	1	1	1
S. Atlantic	7	61	215	266	489	—	4	14	36	35	5	3	11	25	29
Delaware	2	11	34	67	71	—	0	1	—	1	—	0	1	—	—
District of Columbia	—	0	7	—	1	—	0	1	—	1	—	0	0	—	—
Florida	3	1	11	15	4	—	1	7	15	8	2	1	7	10	10
Georgia	—	0	3	1	—	—	1	3	10	2	—	0	3	1	5
Maryland§	2	33	132	166	359	—	1	5	8	11	2	0	2	3	8
North Carolina	—	0	8	2	—	—	0	4	2	4	—	0	4	3	—
South Carolina§	—	0	4	1	3	—	0	1	1	—	1	0	3	8	2
Virginia§	—	17	62	14	51	—	1	7	—	8	—	0	2	—	4
West Virginia	—	0	9	—	—	—	0	1	—	—	—	0	1	—	—
E.S. Central	—	0	5	—	4	—	0	3	2	7	1	1	3	15	13
Alabama§	—	0	3	—	1	—	0	1	1	1	—	0	2	—	3
Kentucky	—	0	2	—	—	—	0	1	1	1	—	0	2	4	1
Mississippi	—	0	1	—	—	—	0	1	—	1	—	0	2	3	4
Tennessee§	—	0	4	—	3	—	0	2	—	4	1	0	2	8	5
W.S. Central	1	1	6	2	8	—	2	54	6	12	3	2	11	16	26
Arkansas§	—	0	1	—	—	—	0	1	—	—	—	0	2	1	2
Louisiana	—	0	1	—	1	—	0	2	—	5	—	0	3	3	10
Oklahoma	—	0	0	—	—	—	0	2	1	1	—	0	4	3	4
Texas§	1	1	6	2	7	—	1	53	5	6	3	1	6	9	10
Mountain	—	1	3	1	2	—	1	5	5	13	1	1	4	16	19
Arizona	—	0	1	—	—	—	0	1	1	4	—	0	2	3	3
Colorado	—	0	1	1	—	—	0	2	1	7	1	0	2	2	5
Idaho§	—	0	2	—	—	—	0	2	—	—	—	0	2	2	1
Montana§	—	0	2	—	1	—	0	1	—	—	—	0	1	1	1
Nevada§	—	0	2	—	1	—	0	3	3	—	—	0	2	3	2
New Mexico§	—	0	2	—	—	—	0	1	—	1	—	0	1	3	1
Utah	—	0	2	—	—	—	0	3	—	1	—	0	2	1	6
Wyoming§	—	0	1	—	—	—	0	0	—	—	—	0	1	1	—
Pacific	—	3	10	28	18	—	3	9	19	19	7	4	20	24	55
Alaska	—	0	2	—	2	—	0	0	—	2	—	0	1	—	1
California	—	2	8	28	16	—	2	8	13	13	4	2	11	11	39
Hawaii	N	0	0	N	N	—	0	1	1	—	—	0	2	—	2
Oregon§	—	0	1	—	—	—	0	2	3	3	1	1	3	7	7
Washington	—	0	7	—	—	—	0	3	2	1	2	0	8	6	6
American Samoa	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	1	—	—	—	0	0	—	—
Puerto Rico	N	0	0	N	N	—	0	1	—	1	—	0	1	—	3
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2007 and 2008 are provisional.
† Data for meningococcal disease, invasive caused by serogroups A, C, Y, & W-135; serogroup B; other serogroup; and unknown serogroup are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 8, 2008, and March 10, 2007 (10th Week)*

Reporting area	Pertussis					Rabies, animal					Rocky Mountain spotted fever				
	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007
		Med	Max				Med	Max				Med	Max		
United States	60	167	534	951	1,840	17	103	197	472	797	—	34	147	35	89
New England	1	21	45	24	319	6	10	22	42	85	—	0	1	—	1
Connecticut	—	0	5	—	17	4	4	10	25	35	—	0	0	—	—
Maine†	—	1	5	14	21	—	1	5	2	20	—	0	1	—	—
Massachusetts	—	17	33	—	251	—	0	0	—	N	—	0	1	—	1
New Hampshire	—	1	5	1	13	1	1	4	6	7	—	0	1	—	—
Rhode Island†	1	0	8	5	2	1	1	4	5	4	—	0	0	—	—
Vermont†	—	0	6	4	15	—	2	13	4	19	—	0	0	—	—
Mid. Atlantic	12	22	38	149	336	9	25	56	51	194	—	1	7	2	9
New Jersey	—	2	6	1	52	N	0	0	N	N	—	0	3	—	1
New York (Upstate)	4	8	24	49	177	9	9	20	51	58	—	0	1	—	—
New York City	—	2	7	15	33	—	0	5	—	15	—	0	3	1	3
Pennsylvania	8	7	22	84	74	—	15	44	—	121	—	0	3	1	5
E.N. Central	13	24	181	375	342	1	4	49	1	3	—	1	4	1	3
Illinois	—	2	8	10	53	—	1	15	—	1	—	0	3	—	1
Indiana	—	0	9	3	1	—	0	1	—	—	—	0	2	—	—
Michigan	—	4	16	20	81	—	1	28	—	1	—	0	1	—	1
Ohio	13	12	176	342	159	1	1	11	1	1	—	0	2	1	1
Wisconsin	—	0	24	—	48	N	0	0	N	N	—	0	0	—	—
W.N. Central	2	12	108	89	118	1	4	13	14	24	—	5	37	9	11
Iowa	—	2	8	12	41	—	0	3	1	2	—	0	4	—	1
Kansas	1	2	5	2	44	—	1	7	—	15	—	0	2	—	3
Minnesota	—	0	106	—	—	1	0	6	9	3	—	0	3	—	—
Missouri	—	2	16	61	14	—	0	3	—	1	—	5	29	9	7
Nebraska†	1	1	12	12	4	—	0	0	—	—	—	0	2	—	—
North Dakota	—	0	4	—	1	—	0	5	2	3	—	0	0	—	—
South Dakota	—	0	7	2	14	—	0	2	2	—	—	0	1	—	—
S. Atlantic	5	15	48	93	192	—	41	63	315	420	—	14	111	20	44
Delaware	—	0	2	1	1	—	0	0	—	—	—	0	2	—	4
District of Columbia	—	0	1	—	2	—	0	0	—	—	—	0	1	—	—
Florida	3	3	17	25	65	—	0	6	23	124	—	0	3	1	2
Georgia	—	0	3	1	12	—	5	31	70	36	—	0	6	3	3
Maryland†	—	2	6	12	32	—	9	18	58	60	—	1	5	4	7
North Carolina	—	5	34	35	43	—	9	19	66	72	—	5	96	11	18
South Carolina†	1	1	22	9	15	—	0	11	—	23	—	0	7	—	4
Virginia†	1	2	11	10	22	—	12	31	85	97	—	2	11	1	6
West Virginia	—	0	12	—	—	—	0	11	13	8	—	0	3	—	—
E.S. Central	2	6	35	39	63	—	3	6	13	23	—	5	16	2	18
Alabama†	—	1	6	10	19	—	0	0	—	—	—	1	10	1	9
Kentucky	—	0	4	6	3	—	0	3	2	5	—	0	2	—	—
Mississippi	1	3	32	16	11	—	0	1	—	—	—	0	3	—	1
Tennessee†	1	1	5	7	30	—	2	6	11	18	—	2	10	1	8
W.S. Central	—	20	112	40	71	—	1	23	7	12	—	1	30	1	2
Arkansas†	—	2	17	7	5	—	1	3	7	3	—	0	15	—	—
Louisiana	—	0	2	—	4	—	0	0	—	—	—	0	1	—	1
Oklahoma	—	0	26	1	—	—	0	22	—	9	—	0	20	—	—
Texas†	—	16	102	32	62	—	0	0	—	—	—	1	5	1	1
Mountain	9	19	40	87	273	—	3	18	18	10	—	0	4	—	1
Arizona	—	2	10	9	81	—	2	12	11	9	—	0	1	—	—
Colorado	5	5	14	17	78	—	0	0	—	—	—	0	2	—	—
Idaho†	—	0	4	3	9	—	0	4	—	—	—	0	1	—	1
Montana†	—	0	7	14	8	—	0	3	—	—	—	0	1	—	—
Nevada†	—	0	6	2	7	—	0	2	—	—	—	0	0	—	—
New Mexico†	—	1	7	1	12	—	0	2	6	—	—	0	1	—	—
Utah	4	6	27	41	67	—	0	2	—	1	—	0	0	—	—
Wyoming†	—	0	2	—	11	—	0	4	1	—	—	0	2	—	—
Pacific	16	16	179	55	126	—	4	10	11	26	—	0	2	—	—
Alaska	1	1	6	17	9	—	0	3	4	16	N	0	0	N	N
California	—	8	29	—	70	—	3	8	7	10	—	0	2	—	—
Hawaii	—	0	2	1	7	N	0	0	N	N	N	0	0	N	N
Oregon†	—	1	14	9	14	—	0	3	—	—	—	0	1	—	—
Washington	15	3	156	28	26	—	0	0	—	—	N	0	0	N	N
American Samoa	—	0	0	—	—	N	0	0	N	N	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—	N	0	0	N	N
Puerto Rico	—	0	1	—	—	—	0	5	4	15	N	0	0	N	N
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 years 2007 and 2008 are 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 March 8, 2008, and March 10, 2007 (10th Week)*

Reporting area	Salmonellosis					Shiga toxin-producing *E. coli* (STEC)†					Shigellosis				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2008	Cum 2007	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2008	Cum 2007	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2008	Cum 2007
United States	281	859	1,718	4,071	6,023	24	73	215	282	363	133	359	947	2,235	1,947
New England	2	31	73	109	642	—	4	11	10	71	1	3	11	10	77
Connecticut	—	0	55	55	430	—	0	3	3	45	—	0	3	3	44
Maine§	1	2	14	23	20	—	0	4	2	6	—	0	4	—	2
Massachusetts	—	21	58	—	157	—	2	10	—	15	—	2	8	—	30
New Hampshire	—	3	10	10	18	—	0	4	2	5	—	0	1	1	1
Rhode Island§	1	2	15	13	10	—	0	2	1	—	1	0	9	5	—
Vermont§	—	1	5	8	7	—	0	3	2	—	—	0	1	1	—
Mid. Atlantic	32	108	190	492	829	1	8	27	27	47	20	18	152	150	102
New Jersey	—	19	48	12	169	—	2	7	—	16	—	3	11	26	13
New York (Upstate)	20	27	63	143	177	1	3	12	12	12	19	3	19	45	18
New York City	3	25	52	141	205	—	1	5	4	4	1	5	13	56	60
Pennsylvania	9	34	69	196	278	—	2	11	11	15	—	2	141	23	11
E.N. Central	22	105	255	391	759	4	9	35	27	49	11	56	134	440	189
Illinois	—	30	188	62	292	—	1	13	—	7	—	15	27	124	109
Indiana	—	11	34	37	56	—	2	13	5	1	—	4	81	149	9
Michigan	3	19	43	93	125	1	2	8	6	9	—	1	7	10	9
Ohio	19	25	64	154	158	3	2	9	11	26	11	18	104	130	35
Wisconsin	—	15	50	45	128	—	3	11	5	6	—	4	13	27	27
W.N. Central	30	49	103	311	362	3	12	38	42	33	13	29	80	130	308
Iowa	—	9	18	52	62	—	2	13	8	—	—	1	6	7	8
Kansas	2	7	20	26	54	—	0	4	2	5	—	0	3	3	6
Minnesota	17	13	40	93	66	—	4	17	12	13	3	4	11	24	51
Missouri	6	14	29	91	112	3	2	12	16	8	6	20	72	55	222
Nebraska§	2	5	13	33	26	—	2	6	2	7	—	0	3	—	3
North Dakota	3	0	9	5	7	—	0	1	—	—	4	0	5	13	6
South Dakota	—	3	11	11	35	—	0	5	2	—	—	1	30	28	12
S. Atlantic	77	228	434	1,324	1,579	10	13	38	70	71	27	82	153	531	645
Delaware	—	2	8	13	16	—	0	2	2	3	—	0	2	—	3
District of Columbia	—	0	4	—	8	—	0	1	—	—	—	0	1	—	3
Florida	49	87	181	694	641	5	3	18	28	19	16	36	75	203	402
Georgia	—	33	81	203	236	—	1	6	4	12	—	28	86	216	191
Maryland§	9	14	44	91	127	—	1	5	13	12	1	2	7	11	16
North Carolina	—	25	191	122	278	—	1	24	10	9	—	0	12	12	8
South Carolina§	16	18	51	115	120	1	0	3	4	—	9	5	20	75	8
Virginia§	3	22	50	73	146	4	3	9	8	16	1	3	14	14	14
West Virginia	—	4	25	13	7	—	0	3	1	—	—	0	62	—	—
E.S. Central	11	59	145	288	406	—	4	26	39	16	11	49	177	302	162
Alabama§	2	16	50	96	104	—	1	19	23	3	3	13	43	82	58
Kentucky	2	10	23	49	81	—	1	12	3	4	1	8	35	36	14
Mississippi	—	13	57	50	101	—	0	1	1	1	—	18	111	88	40
Tennessee§	7	17	35	93	120	—	2	12	12	8	7	5	32	96	50
W.S. Central	41	93	684	303	300	—	4	13	13	19	31	45	533	418	126
Arkansas§	7	13	50	41	36	—	0	3	4	5	7	2	11	25	11
Louisiana	—	16	43	32	78	—	0	0	—	3	—	9	22	13	50
Oklahoma	4	9	43	44	39	—	0	3	2	2	1	3	9	22	7
Texas§	30	51	637	186	147	—	3	11	7	9	23	32	512	358	58
Mountain	22	49	83	298	379	5	10	42	40	35	2	17	40	106	135
Arizona	7	17	40	126	133	4	2	8	16	10	2	10	30	60	63
Colorado	8	10	24	32	92	—	1	17	—	8	—	2	6	5	19
Idaho§	5	3	10	25	22	—	2	16	16	2	—	0	2	1	1
Montana§	1	1	9	8	14	—	0	0	—	—	—	0	2	—	2
Nevada§	—	5	12	33	36	—	0	3	2	4	—	1	10	31	9
New Mexico§	—	5	13	38	41	—	0	3	4	9	—	1	6	6	25
Utah	1	4	17	27	26	1	1	9	2	2	—	0	5	1	4
Wyoming§	—	1	5	9	15	—	0	0	—	—	—	0	5	2	12
Pacific	44	115	368	555	767	1	9	38	14	22	17	27	70	148	203
Alaska	1	1	5	7	12	N	0	0	N	N	—	0	1	—	4
California	31	86	227	429	624	—	5	33	6	13	12	21	61	126	172
Hawaii	—	5	14	30	46	—	0	4	1	—	—	0	3	5	7
Oregon§	1	6	16	42	47	—	1	11	3	3	1	1	6	10	9
Washington	11	12	136	47	38	1	1	18	4	6	4	2	20	7	11
American Samoa	—	0	1	1	—	—	0	0	—	—	—	0	1	1	1
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	5	1	2	N	0	0	N	N	—	0	3	2	4
Puerto Rico	5	12	55	35	127	—	0	0	—	—	—	0	2	—	9
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2007 and 2008 are 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 March 8, 2008, and March 10, 2007 (10th Week)*

Reporting area	Streptococcal disease, invasive, group A					*Streptococcus pneumoniae*, invasive disease, nondrug resistant† Age <5 years				
	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007
		Med	Max				Med	Max		
United States	74	91	170	990	1,081	27	35	130	309	363
New England	1	4	28	13	72	—	1	4	5	35
Connecticut	—	0	22	—	2	—	0	1	—	6
Maine§	—	0	3	6	7	—	0	1	1	—
Massachusetts	—	1	12	—	51	—	1	4	—	26
New Hampshire	—	0	4	4	5	—	0	1	4	—
Rhode Island§	—	0	1	—	—	—	0	1	—	2
Vermont§	1	0	1	3	7	—	0	1	—	1
Mid. Atlantic	23	16	40	180	224	2	6	38	45	49
New Jersey	—	2	11	9	44	—	1	5	9	12
New York (Upstate)	18	6	20	84	54	2	2	14	22	26
New York City	—	3	13	19	59	—	2	35	14	11
Pennsylvania	5	4	11	68	67	N	0	0	N	N
E.N. Central	11	16	52	237	224	3	5	19	63	56
Illinois	—	4	10	40	83	—	1	6	14	8
Indiana	—	2	10	29	17	—	0	11	7	3
Michigan	4	3	10	40	51	2	1	5	14	23
Ohio	7	4	14	71	66	—	1	5	14	18
Wisconsin	—	0	38	57	7	1	0	9	14	4
W.N. Central	3	5	33	73	72	3	3	19	28	15
Iowa	—	0	0	—	—	—	0	0	—	—
Kansas	—	0	3	8	10	—	0	1	2	—
Minnesota	—	0	29	20	29	2	1	18	8	4
Missouri	2	2	10	28	25	1	0	2	13	8
Nebraska§	1	0	3	10	2	—	0	3	2	2
North Dakota	—	0	3	3	4	—	0	0	—	1
South Dakota	—	0	2	4	2	—	0	1	3	—
S. Atlantic	15	23	49	225	212	4	5	10	44	78
Delaware	1	0	1	4	1	—	0	0	—	—
District of Columbia	—	0	3	—	3	—	0	0	—	—
Florida	7	6	16	66	45	2	1	4	13	11
Georgia	—	4	12	51	48	—	0	4	—	25
Maryland§	5	4	9	47	42	—	1	5	17	23
North Carolina	—	2	22	19	14	—	0	0	—	—
South Carolina§	1	1	7	13	23	2	1	4	11	7
Virginia§	1	3	12	23	33	—	0	3	3	12
West Virginia	—	0	3	2	3	—	0	1	—	—
E.S. Central	2	4	13	36	46	3	2	11	20	22
Alabama§	N	0	0	N	N	N	0	0	N	N
Kentucky	—	1	3	8	12	N	0	0	N	N
Mississippi	N	0	0	N	N	—	0	3	4	2
Tennessee§	2	3	13	28	34	3	2	9	16	20
W.S. Central	8	7	49	75	63	7	5	50	43	50
Arkansas§	1	0	2	1	7	—	0	2	3	4
Louisiana	—	0	4	1	8	—	0	3	—	13
Oklahoma	2	1	9	31	19	3	1	5	20	12
Texas§	5	5	40	42	29	4	3	45	20	21
Mountain	9	10	21	126	143	3	4	12	51	48
Arizona	1	4	9	49	53	2	2	8	34	26
Colorado	6	2	9	29	31	1	1	4	8	10
Idaho§	—	0	2	6	4	—	0	1	1	—
Montana§	N	0	0	N	N	N	0	0	N	N
Nevada§	—	0	1	2	2	—	0	1	1	—
New Mexico§	1	2	5	28	26	—	0	4	6	9
Utah	1	1	6	12	25	—	0	2	1	3
Wyoming§	—	0	1	—	2	—	0	0	—	—
Pacific	2	3	7	25	25	2	0	4	10	10
Alaska	2	0	3	8	3	2	0	4	10	6
California	N	0	0	N	N	N	0	0	N	N
Hawaii	—	2	5	17	22	—	0	1	—	4
Oregon§	N	0	0	N	N	N	0	0	N	N
Washington	N	0	0	N	N	N	0	0	N	N
American Samoa	—	0	4	—	—	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	N	0	0	N	N
Puerto Rico	—	0	0	—	—	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2007 and 2008 are provisional.
† Includes cases of invasive pneumococcal disease, in children aged <5 years, caused by *S. pneumoniae*, which is susceptible or for which susceptibility testing is not available (NNDSS event code 11717).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 8, 2008, and March 10, 2007 (10th Week)*

Reporting area	*Streptococcus pneumoniae*, invasive disease, drug resistant†										Syphilis, primary and secondary				
	All ages					Age <5 years									
	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007
		Med	Max				Med	Max				Med	Max		
United States	42	42	95	606	730	7	7	23	82	136	108	217	279	1,698	1,798
New England	—	1	7	8	44	—	0	2	2	3	7	6	14	42	39
Connecticut	—	0	4	—	28	—	0	1	—	2	—	0	6	3	5
Maine§	—	0	1	3	3	—	0	1	1	—	1	0	2	1	—
Massachusetts	—	0	0	—	—	—	0	0	—	—	6	3	8	34	24
New Hampshire	—	0	0	—	—	—	0	0	—	—	—	0	3	3	4
Rhode Island§	—	0	3	2	7	—	0	1	—	1	—	0	5	1	5
Vermont§	—	0	2	3	6	—	0	1	1	—	—	0	5	—	1
Mid. Atlantic	1	2	6	30	45	—	0	3	3	10	39	31	46	326	292
New Jersey	—	0	0	—	—	—	0	0	—	—	1	5	10	47	34
New York (Upstate)	—	1	4	8	16	—	0	1	—	6	5	3	10	22	24
New York City	—	0	0	—	—	—	0	0	—	—	30	18	35	201	185
Pennsylvania	1	1	6	22	29	—	0	2	3	4	3	5	11	56	49
E.N. Central	14	12	38	173	201	2	2	12	21	34	22	15	25	130	168
Illinois	—	1	13	35	45	—	0	6	6	15	—	6	14	18	82
Indiana	—	3	22	39	28	—	0	9	3	3	—	1	6	15	10
Michigan	—	0	1	3	—	—	0	1	1	—	9	2	12	24	23
Ohio	14	6	17	96	128	2	1	3	11	16	13	3	10	62	46
Wisconsin	N	0	0	N	N	—	0	0	—	—	—	1	4	11	7
W.N. Central	2	2	49	37	53	—	0	3	1	5	4	7	14	75	47
Iowa	—	0	0	—	—	—	0	0	—	—	—	0	2	—	1
Kansas	—	0	7	2	31	—	0	1	—	2	1	0	5	6	4
Minnesota	—	0	46	—	—	—	0	3	—	1	—	1	4	17	12
Missouri	2	1	8	35	21	—	0	1	1	—	3	5	10	51	30
Nebraska§	—	0	1	—	—	—	0	0	—	—	—	0	1	1	—
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	1	—	—
South Dakota	—	0	1	—	1	—	0	1	—	2	—	0	3	—	—
S. Atlantic	15	19	43	247	287	1	4	11	37	64	21	50	112	358	336
Delaware	—	0	1	—	1	—	0	1	—	1	—	0	3	1	2
District of Columbia	—	0	1	—	3	—	0	0	—	—	—	2	12	14	32
Florida	15	11	27	158	152	1	2	7	26	31	7	17	35	149	100
Georgia	—	5	16	85	122	—	1	5	9	27	—	9	94	7	34
Maryland§	—	0	1	1	—	—	0	1	1	—	4	6	15	60	57
North Carolina	—	0	0	—	—	—	0	0	—	—	3	5	23	68	53
South Carolina§	—	0	0	—	—	—	0	0	—	—	—	1	11	18	15
Virginia§	N	0	0	N	N	—	0	0	—	—	7	4	16	41	42
West Virginia	—	1	12	3	9	—	0	1	1	5	—	0	1	—	1
E.S. Central	9	4	12	81	35	4	1	3	10	6	6	20	31	174	121
Alabama§	N	0	0	N	N	—	0	0	—	—	—	8	17	73	38
Kentucky	1	0	3	13	9	2	0	1	3	—	1	1	4	12	18
Mississippi	—	0	0	—	—	—	0	0	—	—	—	2	15	13	19
Tennessee§	8	3	12	68	26	2	0	3	7	6	5	8	15	76	46
W.S. Central	1	1	12	13	46	—	0	3	4	7	4	38	55	302	300
Arkansas§	1	0	1	3	1	—	0	1	2	—	4	2	10	14	23
Louisiana	—	1	4	10	21	—	0	2	2	1	—	10	20	44	60
Oklahoma	—	0	10	—	24	—	0	1	—	6	—	1	4	11	16
Texas§	—	0	0	—	—	—	0	0	—	—	—	25	39	233	201
Mountain	—	1	5	17	19	—	0	2	3	7	—	7	25	34	72
Arizona	—	0	0	—	—	—	0	0	—	—	—	3	17	2	36
Colorado	—	0	0	—	—	—	0	0	—	—	—	1	5	9	7
Idaho§	N	0	0	N	N	—	0	0	—	—	—	0	1	1	—
Montana§	—	0	0	—	—	—	0	0	—	—	—	0	3	—	1
Nevada§	—	0	3	14	12	—	0	2	1	3	—	2	6	16	16
New Mexico§	—	0	1	—	—	—	0	0	—	—	—	1	3	6	9
Utah	—	0	5	3	5	—	0	2	2	3	—	0	2	—	2
Wyoming§	—	0	2	—	2	—	0	1	—	1	—	0	1	—	1
Pacific	—	0	0	—	—	—	0	1	1	—	5	42	61	257	423
Alaska	—	0	0	—	—	—	0	0	—	—	—	0	1	—	2
California	N	0	0	N	N	—	0	0	—	—	2	38	58	212	400
Hawaii	—	0	0	—	—	—	0	1	1	—	—	0	2	6	1
Oregon§	N	0	0	N	N	—	0	0	—	—	—	0	2	4	3
Washington	N	0	0	N	N	—	0	0	—	—	3	3	13	35	17
American Samoa	N	0	0	N	N	—	0	1	—	—	—	0	4	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	N	0	0	N	N	—	0	0	—	—	—	3	10	20	19
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2007 and 2008 are provisional.
† Includes cases of invasive pneumococcal disease caused by drug-resistant *S. pneumoniae* (DRSP) (NNDSS event code 11720).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 8, 2008, and March 10, 2007 (10th Week)*

Reporting area	Varicella (chickenpox)					West Nile virus disease†									
						Neuroinvasive					Nonneuroinvasive§				
	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007
		Med	Max				Med	Max				Med	Max		
United States	606	581	1,281	5,032	8,857	—	1	141	—	—	—	2	299	—	1
New England	7	12	47	97	138	—	0	2	—	—	—	0	2	—	—
Connecticut	—	0	1	—	1	—	0	2	—	—	—	0	1	—	—
Maine¶	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	0	—	—	—	0	2	—	—	—	0	2	—	—
New Hampshire	2	6	18	43	58	—	0	0	—	—	—	0	0	—	—
Rhode Island¶	—	0	0	—	—	—	0	0	—	—	—	0	1	—	—
Vermont¶	5	5	38	54	79	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	21	66	154	442	1,333	—	0	3	—	—	—	0	3	—	—
New Jersey	N	0	0	N	N	—	0	1	—	—	—	0	0	—	—
New York (Upstate)	N	0	0	N	N	—	0	1	—	—	—	0	1	—	—
New York City	—	0	0	—	—	—	0	3	—	—	—	0	3	—	—
Pennsylvania	21	66	154	442	1,333	—	0	1	—	—	—	0	1	—	—
E.N. Central	111	161	358	1,251	2,867	—	0	18	—	—	—	0	12	—	1
Illinois	5	3	11	42	43	—	0	13	—	—	—	0	8	—	—
Indiana	N	0	0	N	N	—	0	4	—	—	—	0	2	—	—
Michigan	32	70	154	537	1,138	—	0	5	—	—	—	0	0	—	—
Ohio	74	69	208	672	1,341	—	0	4	—	—	—	0	3	—	1
Wisconsin	—	9	80	—	345	—	0	2	—	—	—	0	2	—	—
W.N. Central	25	23	114	283	439	—	0	41	—	—	—	1	117	—	—
Iowa	N	0	0	N	N	—	0	4	—	—	—	0	3	—	—
Kansas	3	6	28	119	228	—	0	3	—	—	—	0	7	—	—
Minnesota	—	0	0	—	—	—	0	9	—	—	—	0	12	—	—
Missouri	22	12	78	151	165	—	0	9	—	—	—	0	3	—	—
Nebraska¶	N	0	0	N	N	—	0	5	—	—	—	0	15	—	—
North Dakota	—	0	60	1	24	—	0	11	—	—	—	0	49	—	—
South Dakota	—	0	14	12	22	—	0	9	—	—	—	0	32	—	—
S. Atlantic	112	92	214	838	1,156	—	0	12	—	—	—	0	6	—	—
Delaware	—	1	4	3	8	—	0	1	—	—	—	0	0	—	—
District of Columbia	—	0	8	—	—	—	0	0	—	—	—	0	0	—	—
Florida	87	26	83	460	269	—	0	1	—	—	—	0	0	—	—
Georgia	N	0	0	N	N	—	0	8	—	—	—	0	5	—	—
Maryland¶	N	0	0	N	N	—	0	2	—	—	—	0	2	—	—
North Carolina	—	0	0	—	—	—	0	1	—	—	—	0	1	—	—
South Carolina¶	14	15	55	137	333	—	0	2	—	—	—	0	1	—	—
Virginia¶	—	20	85	67	245	—	0	1	—	—	—	0	1	—	—
West Virginia	11	21	66	171	301	—	0	0	—	—	—	0	0	—	—
E.S. Central	14	12	82	205	112	—	0	11	—	—	—	0	14	—	—
Alabama¶	14	12	82	204	110	—	0	2	—	—	—	0	1	—	—
Kentucky	N	0	0	N	N	—	0	1	—	—	—	0	0	—	—
Mississippi	—	0	1	1	2	—	0	7	—	—	—	0	12	—	—
Tennessee¶	N	0	0	N	N	—	0	1	—	—	—	0	2	—	—
W.S. Central	260	169	696	1,652	2,087	—	0	34	—	—	—	0	18	—	—
Arkansas¶	5	13	46	121	124	—	0	5	—	—	—	0	2	—	—
Louisiana	—	1	8	9	38	—	0	5	—	—	—	0	3	—	—
Oklahoma	—	0	0	—	—	—	0	11	—	—	—	0	7	—	—
Texas¶	255	155	679	1,522	1,925	—	0	18	—	—	—	0	10	—	—
Mountain	54	35	130	260	706	—	0	36	—	—	—	1	143	—	—
Arizona	—	0	0	—	—	—	0	8	—	—	—	0	10	—	—
Colorado	39	13	62	96	277	—	0	17	—	—	—	0	65	—	—
Idaho¶	N	0	0	N	N	—	0	3	—	—	—	0	22	—	—
Montana¶	2	6	40	50	87	—	0	10	—	—	—	0	30	—	—
Nevada¶	—	0	1	—	1	—	0	1	—	—	—	0	3	—	—
New Mexico¶	3	5	37	36	93	—	0	8	—	—	—	0	6	—	—
Utah	10	8	72	77	247	—	0	8	—	—	—	0	8	—	—
Wyoming¶	—	0	9	1	1	—	0	4	—	—	—	0	33	—	—
Pacific	2	0	4	4	19	—	0	18	—	—	—	0	23	—	—
Alaska	2	0	4	4	19	—	0	0	—	—	—	0	0	—	—
California	—	0	0	—	—	—	0	17	—	—	—	0	21	—	—
Hawaii	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
Oregon¶	N	0	0	N	N	—	0	3	—	—	—	0	4	—	—
Washington	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
American Samoa	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	3	19	11	73	—	0	0	—	—	—	0	0	—	—
Puerto Rico	11	10	37	55	139	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2007 and 2008 are provisional.
† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for California serogroup, eastern equine, Powassan, St. Louis, and western equine diseases are available in Table I.
§ Not notifiable in all states. Data from states where the condition is not notifiable are excluded from this table, except in 2007 for the domestic arboviral diseases and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/epo/dphsi/phs/infdis.htm.
¶ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE III. Deaths in 122 U.S. cities,* week ending March 8, 2008 (10th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
New England	565	429	92	18	12	14	60
Boston, MA	127	93	21	5	4	4	12
Bridgeport, CT	26	21	5	—	—	—	2
Cambridge, MA	16	12	2	1	1	—	4
Fall River, MA	29	25	1	1	—	2	4
Hartford, CT	80	48	20	6	2	4	6
Lowell, MA	18	13	5	—	—	—	2
Lynn, MA	7	7	—	—	—	—	—
New Bedford, MA	17	15	2	—	—	—	1
New Haven, CT	39	32	5	—	2	—	6
Providence, RI	67	52	10	2	1	2	10
Somerville, MA	5	4	1	—	—	—	—
Springfield, MA	48	40	6	1	—	1	5
Waterbury, CT	33	24	6	1	2	—	1
Worcester, MA	53	43	8	1	—	1	7
Mid. Atlantic	2,448	1,741	508	136	39	23	163
Albany, NY	58	43	11	4	—	—	7
Allentown, PA	27	21	5	1	—	—	1
Buffalo, NY	83	60	16	3	3	1	9
Camden, NJ	22	16	5	—	—	1	2
Elizabeth, NJ	20	18	1	1	—	—	3
Erie, PA	63	51	12	—	—	—	3
Jersey City, NJ	22	17	3	2	—	—	3
New York City, NY	1,234	867	270	63	21	12	60
Newark, NJ	48	19	16	9	1	3	1
Paterson, NJ	22	15	6	1	—	—	—
Philadelphia, PA	378	254	82	31	8	3	23
Pittsburgh, PA§	50	35	12	2	1	—	6
Reading, PA	28	21	5	2	—	—	1
Rochester, NY	157	122	27	6	1	1	17
Schenectady, NY	17	11	5	1	—	—	—
Scranton, PA	42	34	5	2	1	—	7
Syracuse, NY	96	73	14	5	2	2	14
Trenton, NJ	31	23	7	1	—	—	—
Utica, NY	21	17	3	—	1	—	2
Yonkers, NY	29	24	3	2	—	—	4
E.N. Central	2,280	1,600	459	118	61	42	216
Akron, OH	46	28	10	3	2	3	2
Canton, OH	39	33	6	—	—	—	7
Chicago, IL	366	245	71	32	11	7	40
Cincinnati, OH	101	59	20	3	11	8	16
Cleveland, OH	250	172	60	9	7	2	13
Columbus, OH	220	156	44	13	6	1	24
Dayton, OH	129	91	29	8	1	—	7
Detroit, MI	175	118	39	10	4	4	9
Evansville, IN	64	49	11	2	2	—	7
Fort Wayne, IN	67	42	17	5	2	1	7
Gary, IN	22	14	5	2	—	1	—
Grand Rapids, MI	66	45	18	1	1	1	18
Indianapolis, IN	225	152	46	16	6	5	22
Lansing, MI	39	27	8	2	2	—	4
Milwaukee, WI	96	69	23	2	—	2	5
Peoria, IL	57	37	14	3	2	1	7
Rockford, IL	56	46	8	1	—	1	4
South Bend, IN	54	46	6	—	2	—	4
Toledo, OH	128	94	22	5	2	5	9
Youngstown, OH	80	77	2	1	—	—	11
W.N. Central	730	487	142	34	18	17	71
Des Moines, IA	70	49	18	2	1	—	10
Duluth, MN	35	27	5	—	1	2	1
Kansas City, KS	36	21	11	1	1	2	6
Kansas City, MO	114	84	17	7	2	4	16
Lincoln, NE	47	33	11	1	2	—	3
Minneapolis, MN	60	41	12	3	2	2	6
Omaha, NE	108	74	23	6	3	2	11
St. Louis, MO	88	47	22	8	6	5	3
St. Paul, MN	61	39	18	4	—	—	8
Wichita, KS	111	72	5	2	—	—	7
S. Atlantic	1,249	797	305	86	33	26	88
Atlanta, GA	135	71	38	14	8	4	6
Baltimore, MD	137	83	35	7	6	6	16
Charlotte, NC	149	101	37	9	2	—	15
Jacksonville, FL	158	110	33	9	3	3	12
Miami, FL	103	64	27	10	1	1	4
Norfolk, VA	42	26	9	3	1	2	1
Richmond, VA	65	32	25	5	1	2	3
Savannah, GA	69	51	11	3	3	1	5
St. Petersburg, FL	52	42	7	1	1	1	3
Tampa, FL	217	146	48	16	4	3	21
Washington, D.C.	98	54	30	8	3	3	1
Wilmington, DE	24	17	5	1	—	—	1
E.S. Central	948	623	223	60	14	28	95
Birmingham, AL	206	138	48	13	2	5	19
Chattanooga, TN	69	45	13	7	1	3	6
Knoxville, TN	130	93	26	7	2	2	14
Lexington, KY	40	29	8	—	—	3	6
Memphis, TN	175	106	48	14	3	4	16
Mobile, AL	79	58	17	4	—	—	5
Montgomery, AL	62	46	6	4	3	3	7
Nashville, TN	187	108	57	11	3	8	22
W.S. Central	1,923	1,231	467	124	44	57	138
Austin, TX	92	56	23	11	2	—	8
Baton Rouge, LA	60	33	9	8	—	10	—
Corpus Christi, TX	79	50	23	4	—	2	2
Dallas, TX	276	158	72	22	11	13	19
El Paso, TX	207	152	40	10	2	3	19
Fort Worth, TX	122	85	27	6	2	2	15
Houston, TX	405	222	127	28	14	14	23
Little Rock, AR	88	54	26	4	—	4	6
New Orleans, LA¶	U	U	U	U	U	U	U
San Antonio, TX	310	210	75	16	7	2	20
Shreveport, LA	99	70	20	4	1	4	9
Tulsa, OK	185	141	25	11	5	3	17
Mountain	1,419	988	299	81	29	20	140
Albuquerque, NM	116	83	24	6	3	—	15
Boise, ID	72	56	12	2	1	1	4
Colorado Springs, CO	90	61	21	6	—	2	4
Denver, CO	97	70	17	3	3	4	8
Las Vegas, NV	424	269	112	35	5	3	40
Ogden, UT	24	18	3	1	1	1	3
Phoenix, AZ	203	124	50	17	7	3	19
Pueblo, CO	52	41	9	1	1	—	7
Salt Lake City, UT	129	93	19	6	7	4	13
Tucson, AZ	212	173	32	4	1	2	27
Pacific	1,962	1,377	403	109	41	32	200
Berkeley, CA	16	13	3	—	—	—	4
Fresno, CA	168	115	38	11	3	1	21
Glendale, CA	34	29	5	—	—	—	7
Honolulu, HI	63	52	5	2	2	2	8
Long Beach, CA	82	50	19	9	2	2	17
Los Angeles, CA	294	189	77	13	8	7	40
Pasadena, CA	24	21	2	1	—	—	2
Portland, OR	149	103	31	9	3	3	13
Sacramento, CA	224	165	46	9	3	1	24
San Diego, CA	153	110	23	7	7	6	13
San Francisco, CA	150	97	37	14	1	1	12
San Jose, CA	236	169	42	12	8	5	11
Santa Cruz, CA	42	33	5	3	1	—	4
Seattle, WA	141	96	32	8	3	2	12
Spokane, WA	75	57	13	4	—	1	6
Tacoma, WA	111	78	25	7	—	1	6
Total	13,524**	9,273	2,898	766	291	259	1,171

U: Unavailable. —:No reported cases.

* Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

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

** Total includes unknown ages.

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