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Influenza-Associated Pediatric Deaths — United States, September 2010–August 2011

Influenza-associated pediatric mortality has been a nationally notifiable condition since October 2004. This report summarizes the 115 cases of influenza-associated pediatric mortality reported to CDC that occurred from September 1, 2010, through August 31, 2011. Deaths occurred in 33 states. Nearly half of the deaths (46%) occurred in children aged <5 years. Of the children who died, 49% had no known Advisory Committee on Immunization Practices (ACIP)–defined* high-risk medical conditions, and 35% died at home or in the emergency department. Of the 74 children aged ≥6 months for whom vaccination data were available, 17 (23%) had been fully vaccinated. ACIP recommends that all children aged ≥6 months receive vaccination against influenza annually (*1,2*). These findings underscore the importance of vaccinating children to prevent influenza virus infection and its potentially severe complications. Health-care providers should develop a comprehensive strategy to increase vaccination coverage among children.

A case is defined as a death from a clinically compatible illness confirmed to be influenza by a diagnostic test in a U.S. resident aged <18 years, with no period of complete recovery between illness and death. Cases are identified by state and local health departments, which collect demographic, clinical, and laboratory information using a standard form and transmit the information to CDC via a secure, web-based interface for data entry. Confirmatory influenza testing methods include commercial rapid diagnostic tests, viral culture, fluorescent antibody, enzyme immunoassay, reverse transcription–polymerase chain reaction, and immunohistochemistry. Although influenza vaccination of women during pregnancy has been shown to be effective in reducing hospitalizations (*1*) and deaths among infants aged <6 months (*3*), data on maternal vaccination during pregnancy were not available for infants aged <6 months.

Of the 115 influenza-associated pediatric deaths reported, 72 (63%) occurred in males (Table). The majority of cases were in non-Hispanic white children (52%), followed by non-Hispanic black (18%) and Hispanic (15%) children. The highest numbers of deaths occurred in late January and early February 2011 (Figure 1). The median age of patients was 6 years, and 53 cases (46%) were in children aged <5 years (Table). Seventy-one (62%) of these cases were associated with influenza A virus infection: 30 (26%) 2009 influenza A (H1N1), 21 (18%) influenza A (H3N2), and 20 (18%) influenza A viruses for which the subtype was not determined. The remaining 44 (38%) cases were associated with influenza B virus infections. In comparison, U.S. national viral surveillance data from World Health Organization (WHO) and National Respiratory and Enteric Virus Surveillance System (NREVSS) collaborating laboratories indicated that 74% of circulating viruses were influenza A and 26% were influenza B viruses.†

Nearly half of the children who died (49%) had no known ACIP-defined high-risk medical conditions, 57 (50%) children were reported with medical conditions recognized by ACIP that

* Children receiving long-term aspirin therapy who might be at risk for experiencing Reye syndrome after influenza virus infection or those with chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematologic, or metabolic disorders (including diabetes mellitus), and children with immunosuppression (including immunosuppression caused by medications or by human immunodeficiency virus) or any neurologic condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration. Morbid obesity is a risk factor for adults.

† Data available at http://www.cdc.gov/flu/weekly.

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placed them at increased risk for influenza-related complications, and the medical history of two children was unknown (2%) (Table). Of the 57 children with at least one ACIP-defined high-risk condition, 31 (54%) had a neurologic disorder, 17 (30%) had pulmonary disease, 14 (25%) had a chromosomal abnormality or genetic disorder, 11 (19%) had congenital heart disease or other cardiac disease, and 11 (19%) had asthma or reactive airway disease. Obesity was reported in two (4%) of the 57 children.

Information on the location of death was available for 114 children; 20 (18%) died outside the hospital, 20 (18%) died in the emergency department, and 74 (65%) died in the hospital after admission (Table). Duration of illness ranged from 0 to 57 days (Figure 2); 33 (31%) children died within 3 days of illness onset, and 69 (65%) died within 7 days. When compared with pediatric deaths among children with at least one ACIP-defined high-risk condition, children without high-risk conditions were significantly more likely to die at home or in the emergency department (p<0.01 by chi-square test). The median illness duration before death was 7 days among children with at least one ACIP-defined high-risk condition and 4 days among children without a high-risk condition (p<0.01 by Wilcoxon rank-sum test).

Of 64 children who had specimens collected for bacterial culture from normally sterile sites (including 58 blood cultures), 25 (39%) had positive cultures; *Staphylococcus aureus* was detected in nine (36%) patients (six with methicillin-resistant *S. aureus*, two with methicillin-sensitive *S. aureus*, and one with unknown sensitivity), *Streptococcus pneumoniae* was detected in six patients, and Group A streptococcus was detected in three. Of the 25 cases with positive cultures, 17 (68%) were in children without high-risk conditions. When compared with children with at least one ACIP-defined high-risk condition, children without a high-risk condition were significantly more likely to have a positive bacterial culture from a sterile site (p<0.01 by chi-square test).

The most frequent complications reported were radiographically confirmed pneumonia (62%), shock or sepsis (40%), and acute respiratory distress syndrome (34%). Encephalopathy or encephalitis was reported in 12 children (14%). The antiviral medications approved by the Food and Drug Administration (FDA) for treatment of influenza are oseltamivir for children aged ≥1 year and zanamivir for children aged ≥7 years (*4*). Of the 47 children who received antiviral therapy, three (6%) died in the emergency department, and 44 (94%) died after being admitted to the hospital. All three children who died in the emergency department received oseltamivir. Of the children who died after being admitted to the hospital, 41 received oseltamivir only, two received oseltamivir and zanamivir, and one received zanamivir only.

Information about influenza vaccination was available for 74 children aged ≥6 months; 17 (23%) received influenza vaccine in the appropriate number of doses at least 14 days before illness onset. Of 39 vaccine-eligible children with ACIP-defined high-risk medical conditions who had vaccination data available, 12 (31%) had been vaccinated according to 2010 ACIP recommendations (*1*).

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TABLE. Number and percentage of children who died from influenza-associated illness (N = 115), by selected characteristics — United States, September 1, 2010–August 31, 2011

Characteristic	No.	(%)
Sex		
Male	72	(63)
Female	43	(38)
Median age (range) (yrs)	6 (0–17)	
Age group		
<6 mos	16	(14)
6–23 mos	17	(15)
24–59 mos	20	(19)
5–8 yrs	21	(18)
9–12 yrs	18	(16)
13–17 yrs	23	(20)
Race/Ethnicity		
White, non-Hispanic	60	(52)
Black, non-Hispanic	21	(18)
Hispanic	17	(15)
Asian	4	(3)
Native Hawaiian or Pacific Islander	2	(2)
American Indian or Alaska Native	3	(3)
Unknown	8	(7)
Influenza isolates		
Influenza A	71	(62)
Influenza A, 2009 (H1N1)	30	(26)
Influenza A, (H3N2)	21	(18)
Influenza A, subtype not determined	20	(17)
Influenza B	44	(38)
ACIP-defined high-risk condition*		
Yes	57	(50)
No	56	(49)
Unknown	2	(2)
Type of ACIP-defined high-risk conditions†		
Neurologic disorder	31	(27)
Moderate or severe developmental delay	22	(19)
Seizure disorder	13	(12)
Cerebral palsy	9	(8)
Neuromuscular disorder	4	(4)
Other neurologic disorder	8	(7)
Pulmonary disease	17	(15)
Asthma or reactive airway disease	11	(10)
Chronic pulmonary disease	8	(7)
Chromosome/Genetic disorder	14	(12)
Congenital heart disease or other cardiac disease	11	(10)
Immunosuppressive condition	9	(8)
Received steroids before illness	6	(5)
Cancer (received chemotherapy or radiation)	3	(3)
Endocrine disorder	5	(4)
Diabetes mellitus	1	(1)
Mitochondrial disorder	3	(3)
Renal disease	2	(2)
Pregnant	1	(1)
Obesity	2	(2)

See table footnotes on page 1236.

TABLE. (*Continued*) Number and percentage of children who died from influenza-associated illness (N = 115), by selected characteristics — United States, September 1, 2010–August 31, 2011

Characteristic	No.	(%)
Location of death§		
Outside hospital (i.e., at home or in transit)	20	(18)
Emergency department	20	(18)
Hospital, admitted¶	74	(65)
Duration of disease (days)**	6 (0–57)	
Duration of disease ≤3	33	(31)
Duration of disease ≤7	69	(66)
≥1 high-risk condition, median (range)	7 (0–57)	
No high-risk condition, median (range)	4 (0–21)	
Bacterial testing from sterile site performed		
Yes	64	(56)
No	43	(37)
Unknown	8	(7)
≥1 bacterial coinfection††	25	(39)
Bacteria isolated from sterile site§§		
Staphylococcus aureus	9	(36)
Methicillin-resistant *S. aureus*	6	(24)
Methicillin-sensitive *S. aureus*	2	(8)
Sensitivity testing not performed	1	(4)
Streptococcus species¶¶		
Streptococcus pneumoniae	6	(24)
Group A streptococcus	3	(12)
Group B streptococcus	2	(8)
Group C streptococcus, beta hemolytic	1	(4)
Group D streptococcus, non-hemolytic	1	(4)
Viridans group streptococcus***	2	(8)
Other or not specified streptococcus†††	2	(8)
Pseudomonas aeruginosa	2	(8)
Complications during acute illness		
Yes	85	(74)
No	19	(17)
Unknown	11	(10)
Complications§§§		
Pneumonia	53	(62)
Shock or sepsis	34	(40)
Acute respiratory distress syndrome	29	(34)
Other complication	19	(22)
Encephalopathy/Encephalitis	12	(14)
Seizures	11	(13)
Hemorrhagic pneumonia/pneumonitis	5	(6)
Croup	4	(5)
Cardiomyopathy/Myocarditis	3	(4)
Bronchiolitis	2	(2)
Received antibiotic therapy¶¶¶	49	(52)
Received antiviral therapy¶¶¶	47	(50)
Received oseltamivir	46	(49)
Received zanamivir	3	(3)

See table footnotes on page 1236.

Reported by

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Editorial Note

Nearly half of the children who died from influenza virus infections during the 2010–11 influenza season and whose deaths were reported to CDC had no known ACIP-defined high-risk medical conditions. Of children with ACIP-defined high-risk

TABLE. (*Continued*) Number and percentage of children who died from influenza-associated illness (N = 115), by selected characteristics — United States, September 1, 2010–August 31, 2011

Characteristic	No.	(%)
Vaccination status		
Ineligible for vaccine	16	(14)
Eligible for vaccine	99	(86)
Fully vaccinated****	17	(23)
Not vaccinated****	57	(77)
Eligible for vaccine, ≥1 ACIP-defined high-risk condition††††		
Fully vaccinated	12	(31)
Not fully vaccinated	27	(69)
Eligible for vaccine, no ACIP-defined high-risk condition††††		
Fully vaccinated	4	(12)
Not fully vaccinated	30	(88)
Unknown vaccination status	25	(22)

Abbreviation: ACIP = Advisory Committee on Immunization Practices.

* Children receiving long-term aspirin therapy who might be at risk for experiencing Reye syndrome after influenza virus infection or those with chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematologic, or metabolic disorders (including diabetes mellitus), and children with immunosuppression (including immunosuppression caused by medications or by human immunodeficiency virus) or any neurologic condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration. Morbid obesity is a risk factor for adults.

† Percentage reported out of 113 children with a known medical history; conditions are not mutually exclusive.

§ Location of death was known for 114 children.

¶ Includes inpatient ward (10), intensive-care unit (62), operating room (one), and hospice (one).

** Illness onset date was not available for nine deaths.

†† Percentage reported out of 64 children with specimen collected for bacterial culture from a normally sterile site.

§§ Percentage reported out of 25 children with positive bacteria culture from a normally sterile site.

¶¶ More than one *Streptococcus* species could be isolated from each patient.

*** Includes one *Streptococcus parasanguinis* and one not specified.

††† Includes one non-hemolytic and one alpha-hemolytic.

§§§ Percentage reported out of 85 children with known complications; complications were not mutually exclusive.

¶¶¶ Percentage reported out of 94 children who died in a health-care facility.

**** Percentage reported out of 74 children who had a known vaccination history and were eligible for vaccine.

†††† Percentage reported out of children with known vaccination status.

medical conditions, neurologic disorders and pulmonary disease were identified most frequently. The underlying reason for the vulnerability of patients with neurologic disorders remains unclear but likely is attributable, in part, to compromised respiratory function and decreased ability to handle secretions (*5*). These data are consistent with findings from the 2004–05 through 2008–09 influenza seasons (*5–7*). Children with no high-risk conditions had a shorter interval between illness onset and death (4 days versus 7 days), and were more likely to die at home or in the emergency department, and were more likely to have a positive bacterial culture from a sterile site. In children with no high-risk conditions, the development of a secondary bacterial coinfection might have been the immediate cause for seeking medical care. Physicians of children with ACIP-defined high-risk conditions might have been more likely to hospitalize their patients early in their illness, given their perceived greater risk of influenza-related complications. Health-care providers should be aware that severe complications of influenza can occur in children without high-risk medical conditions. Information for parents, including guidance on influenza vaccination and danger signs in children with influenza-like illness symptoms, is available at http://www.cdc.gov/flu/pdf/freeresources/family/a_flu_guide_for_parents.pdf.

This report highlights several important points about influenza epidemiology, vaccination, and treatment in children. Although influenza-associated pediatric mortality is rare, influenza B was identified in a disproportionate number of pediatric influenza-associated deaths (38%). During the 2010–11 influenza season, only 26% of circulating influenza viruses were influenza B. In previous seasons, the percentage of influenza B viruses among children with influenza-associated mortality has been comparable to or higher than the percentage of influenza B viruses circulating for that season (*6,7*).

What is already known on this topic?

Since influenza-associated pediatric deaths became a nationally notifiable condition in 2004, the number of deaths reported to CDC has ranged from 46 during the 2005–06 influenza season to 282 during the 2009–10 season.

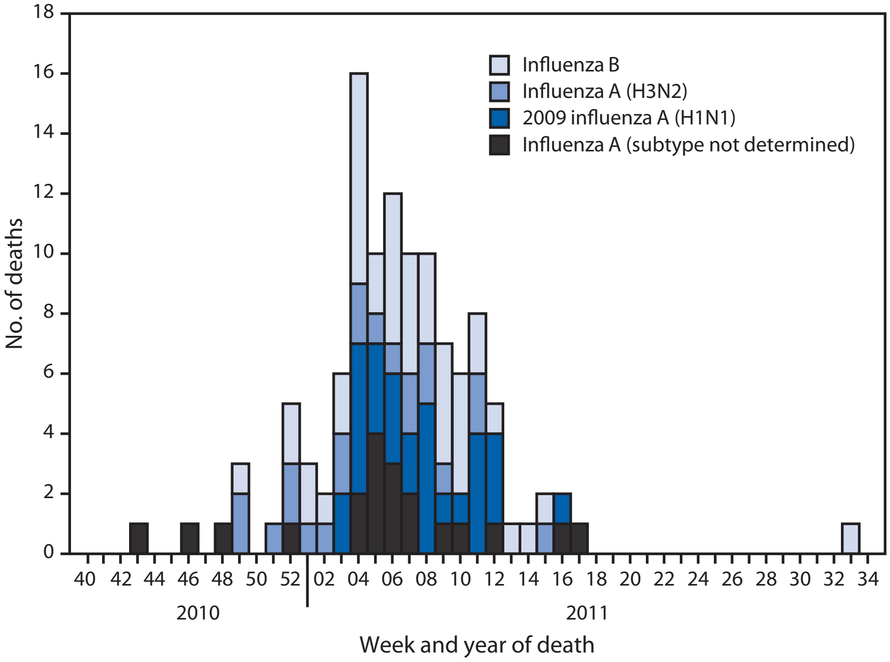
What is added by this report?

A total of 115 influenza-associated pediatric deaths were reported to CDC that occurred from September 1, 2010 to August 31, 2011. Fifty-six (49%) children who died from influenza virus infections during the 2010–11 influenza season had no reported Advisory Committee on Immunization Practices (ACIP)–defined high-risk medical conditions. Children without high-risk conditions had a shorter interval between illness onset and death (4 days versus 7 days), were more likely to die at home or in the emergency department, and were more likely to have a positive bacterial culture from a sterile site. Among children who died from influenza, few (23%) were vaccinated, and 50% received antiviral therapy.

What are the implications for public health practice?

Continued efforts are needed to ensure annual influenza vaccination in all persons aged ≥6 months, and children with high-risk medical conditions should be specially targeted for vaccination. Health-care providers should be aware that severe complications of influenza can occur in children without high-risk medical conditions. Early and aggressive treatment with oseltamivir or zanamivir is recommended as soon as possible after symptom onset in patients with confirmed or suspected influenza who are hospitalized; who have severe, complicated, or progressive illness; or who are at a higher risk for influenza complications.

FIGURE 1. Number of influenza-associated pediatric deaths (N = 115), by week of death and type of influenza virus — United States, September 1, 2010–August 31, 2011



Annual influenza vaccination for all children aged ≥6 months is recommended and is the most effective way to prevent influenza and its complications. Influenza vaccination campaigns should proceed for all persons (children and adults) as soon as vaccine is available. Since 2010, ACIP has recommended annual influenza vaccination for all persons aged ≥6 months, and children with ACIP-defined high-risk medical conditions should be specially targeted for vaccination (*1,2*). Healthy children aged 2–18 years may receive either live, attenuated influenza vaccine (LAIV) or trivalent inactivated influenza vaccine (TIV) (*1*). Children aged 6–23 months and those aged 2–4 years who have asthma or wheezing, or who have medical conditions that put them at higher risk for influenza complications should receive TIV (*1*). Children aged 6 months–8 years who did not receive at least 1 dose of the 2010–11 seasonal influenza vaccine should receive 2 doses of the 2011–12 seasonal influenza vaccine administered at least 4 weeks apart. Children in this age group who did receive at least 1 dose of the 2010–11 vaccine, as well as persons aged ≥9 years, should receive 1 dose of the 2011–12 vaccine (*2*).

In the United States, influenza vaccination coverage for the 2010–11 season was estimated at 49% in children aged 6 months–17 years.[§] Among children who died from influenza described in this report, 23% were vaccinated. Vaccination coverage was higher among children with ACIP-defined high-risk medical conditions than among children without high-risk medical conditions (31% versus 12%). These findings emphasize the need to improve vaccination coverage among all children, especially those at increased risk for influenza-related complications. To protect infants aged <6 months who are too young to be vaccinated, ACIP recommends that pregnant women (*3*) and household contacts and out-of-home caregivers of such infants receive vaccination against influenza (*1*). Because influenza vaccination of women during pregnancy has been shown to be effective in reducing hospitalizations (*1*) and deaths among infants aged <6 months (*3*), improving vaccination rates among pregnant women is a priority.

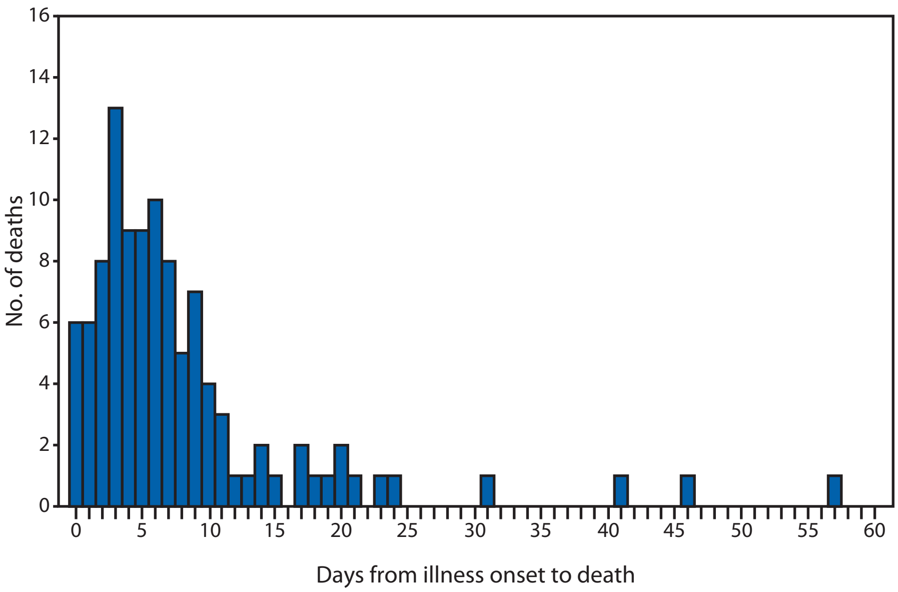
Half of the children described in this report received influenza antiviral therapy. Early and aggressive treatment with oseltamivir or zanamivir[¶] is recommended as soon as possible after symptom onset in a patient with confirmed or suspected influenza who is hospitalized; who has severe, complicated, or progressive illness; or who is at higher risk for influenza complications,[**] even if influenza testing is negative (*4*). In outpatients without risk factors for complications, influenza antiviral treatment should be considered if treatment can be initiated within 48 hours of symptom onset. Results of one randomized, controlled trial of oseltamivir treatment among children aged 1–3 years indicated that when oseltamivir was started within 24 hours of illness onset, the median time to illness resolution was shortened by 3.5 days compared with placebo (*8*). Treatment with influenza antiviral therapy of any person with confirmed or suspected influenza who requires hospitalization is recommended, even if the patient enters care >48 hours after illness onset (*4,9*).

[§] Data available at http://www.cdc.gov/flu/professionals/vaccination/vaccinecoverage.htm.

[¶] Oseltamivir is FDA-approved for treatment and chemoprophylaxis of influenza among children aged ≥1 year. Zanamivir is FDA-approved for treatment of influenza among children aged ≥7 years. Zanamivir is approved for chemoprophylaxis of influenza among children aged ≥5 years.

[**] Persons at higher risk include children aged <5 years (especially those aged <2 years); adults aged ≥65 years; persons with chronic pulmonary (including asthma), cardiovascular (except hypertension alone), renal, hepatic, hematologic (including sickle cell disease), metabolic disorders (including diabetes mellitus), or neurologic and neurodevelopment conditions (including disorders of the brain, spinal cord, peripheral nerve, and muscle, such as cerebral palsy, epilepsy [seizure disorders], stroke, intellectual disability [mental retardation], moderate to severe developmental delay, muscular dystrophy, or spinal cord injury); persons with immunosuppression, including that caused by medications or by human immunodeficiency virus infection; women who are pregnant or postpartum (within 2 weeks after delivery); persons aged ≤18 years who are receiving long-term aspirin therapy; American Indians/Alaska Natives; persons who are morbidly obese (i.e., body mass index ≥40); and residents of nursing homes and other chronic-care facilities.

FIGURE 2. Number of influenza-associated pediatric deaths (N = 106),* by number of days from influenza illness onset until death — United States, September 1, 2010–August 31, 2011



* Illness onset date not available for nine deaths.

S. aureus, *S. pneumoniae*, and Group A streptococcus were the pathogens most commonly identified in children with invasive bacterial coinfection. Empiric antibiotic therapy and early influenza antiviral therapy are recommended in patients with community-acquired pneumonia and suspected influenza coinfection (*4*). In 2010, ACIP recommended the use of the 13-valent pneumococcal polysaccharide-protein conjugate vaccine for all children aged 2–59 months and children aged 60–71 months with underlying medical conditions that increase their risk for pneumococcal disease or complications (*10*).

The findings in this report are subject to at least four limitations. First, the actual burden of influenza-associated pediatric mortality likely is underestimated because the current surveillance method will only detect those patients who are tested for influenza, who have a positive test, and who are reported to the surveillance system. Second, some data about medical conditions, vaccination status, clinical course, and treatment were missing; these data depend on the thoroughness and consistency of case reporting. Third, invasive bacterial testing is not performed systematically for all children and therefore depends on testing being part of clinical care or autopsy. Finally, determination of obesity as a high-risk medical condition did not use height and weight data, which might lead to underestimation of obesity among children.

This report emphasizes the importance of continued surveillance for influenza-associated pediatric mortality. State health departments should notify the Influenza Division at CDC of laboratory-confirmed influenza-associated pediatric deaths that occur in their jurisdiction as soon as possible by submitting the web-based case report form. Surveillance provides information about risk factors associated with severe disease and death that can be used to monitor the impact of influenza on children, plan interventions, inform policy and resource allocation decisions, develop vaccination recommendations, and provide information to public health professionals, the media, and the general public regarding the severity of the influenza season. Health-care providers should be mindful of the potential for severe outcomes of influenza in children. Although antiviral medications are a valuable adjunct to preventing and reducing the impact of influenza, vaccination remains the primary prevention tool against influenza-associated complications.

References

1. CDC. Prevention and control of influenza with vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP), 2010. MMWR 2010;59(No. RR-8).
2. CDC. Prevention and control of influenza with vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP), 2011. MMWR 2011;60:1128–32.
3. Zaman K, Roy E, Arifeen SE, et al. Effectiveness of maternal influenza immunization in mothers and infants. N Engl J Med 2008;359:1555–64.
4. CDC. Antiviral agents for the treatment and chemoprophylaxis of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2011;60(No. RR-1).
5. Cox CM, Blanton L, Dhara R, Brammer L, Finelli L. 2009 pandemic influenza A (H1N1) deaths among children—United States, 2009–2010. Clin Infect Dis 2011;52(Suppl 1):S69–74.
6. Peebles PJ, Dhara R, Brammer L, Fry AM, Finelli L. Influenza-associated mortality among children—United States: 2007–2008. Influenza Other Respi Viruses 2011;5:25–31.
7. Finelli L, Fiore A, Dhara R, et al. Influenza-associated pediatric mortality in the United States: increase of *Staphylococcus aureus* coinfections. Pediatrics 2008;122:805–11.
8. Heinonen S, Silvennoinen H, Lehtinen P, et al. Early oseltamivir treatment of influenza in children 1–3 years of age: a randomized controlled trial. Clin Infect Dis 2010;51:887–94.
9. Harper SA, Bradley JS, Englund JA, et al. Seasonal influenza in adults and children—diagnosis, treatment, chemoprophylaxis, and institutional outbreak management: clinical practice guidelines of the Infectious Diseases Society of America. Clin Infect Dis 2009;48:1003–32.
10. CDC. Prevention of pneumococcal disease among infants and children — use of 13-valent pneumococcal conjugate vaccine and 23-valent pneumococcal polysaccharide vaccine: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2010; 59(No. RR-11).

Update: Influenza Activity — United States and Worldwide, May 22–September 3, 2011

During May 22–September 3, 2011, the United States experienced low levels of influenza activity; 2009 influenza A (H1N1), influenza A (H3N2), and influenza B viruses were detected worldwide and identified sporadically in the United States. Typical seasonal patterns of influenza activity occurred in the Southern Hemisphere. This report summarizes influenza activity in the United States and worldwide since the last update (*1*).

United States

The U.S. influenza surveillance system is a collaborative effort between CDC and its federal, state, and local partners. CDC uses eight systems* to collect influenza information (*2*), six of which provide data year-round: 1) U.S. World Health Organization (WHO) collaborating laboratories; 2) the National Respiratory and Enteric Virus Surveillance System (NREVSS); 3) reports of novel influenza A virus cases from the National Notifiable Disease Surveillance System (NNDSS); 4) the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet); 5) the 122 Cities Mortality Reporting System; and 6) the Influenza-Associated Pediatric Mortality Reporting System.

During May 22– September 3,† U.S. WHO and NREVSS collaborating laboratories tested 20,868 respiratory specimens for influenza viruses; 122 (0.6%) tested positive for influenza (Figure). Of these, 87 (71%) were influenza A viruses, and 35 (29%) were influenza B viruses. Of the influenza A viruses, 39 (45%) were subtyped: 24 (62%) were influenza A (H3N2) viruses and 15 (38%) were 2009 influenza A (H1N1) viruses. Four human infections with a novel influenza A virus (swine-origin influenza A [H3N2]) were reported in August (*3*) and September. These viruses are genetically and antigenically different from currently circulating influenza A (H3N2) viruses. Influenza viruses were reported from 26 states in all 10 U.S. Department of Health and Human Services (HHS) Regions. The largest proportion of positive samples came from the southeastern United States (HHS Region 4: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee) (52%), followed by western states (HHS Region 9: Arizona, California, Hawaii, and Nevada) (17%).

During May 22–September 3, data from ILINet indicated that the weekly percentage of outpatient visits to ILINet providers for influenza-like illness (ILI)§ remained below the national baseline¶ of 2.5% and ranged from 0.5% to 1.2%. The percentage of deaths attributed to pneumonia and influenza (P&I), as reported by the 122 Cities Mortality Reporting System, remained below the epidemic threshold** except for 3 weeks in June. One influenza-associated pediatric death was reported in August and was associated with an influenza B virus.

Worldwide

During May 22–September 3, typical seasonal patterns of influenza activity occurred in the Southern Hemisphere. In Australia, influenza activity began increasing in mid-May; 2009 influenza A (H1N1) virus predominated and cocirculated with influenza B viruses, with small numbers of influenza A (H3N2) virus reported. However, in New Zealand, influenza B viruses predominated, with lower levels of influenza A (H3N2) and 2009 influenza A (H1N1) viruses cocirculating. In South America, influenza activity was low and influenza A viruses were reported more frequently, but the predominant subtype varied by country. In countries in southern Africa, 2009 influenza A (H1N1) viruses were the most common, followed by influenza B viruses, but in general influenza virus activity was low. The predominant subtype identified in Asia was influenza A (H3N2) virus, with a smaller number of influenza B viruses identified, although outbreaks of 2009 influenza A (H1N1) virus have been reported. In Europe and North America, influenza activity was low, and small numbers of 2009 influenza A (H1N1), influenza A (H3N2), and influenza B viruses were identified.

* The CDC influenza surveillance system collects five categories of information from eight data systems: 1) viral surveillance (World Health Organization collaborating laboratories, the National Respiratory and Enteric Virus Surveillance System, and novel influenza A virus case reporting); 2) outpatient illness surveillance (U.S. Outpatient Influenza-like Illness Surveillance Network); 3) mortality (122 Cities Mortality Reporting System and influenza-associated pediatric mortality reports); 4) hospitalizations (FluSurv-NET, which includes the Emerging Infections Program and surveillance in four additional states); and 5) summary of the geographic spread of influenza (state and territorial epidemiologist reports).

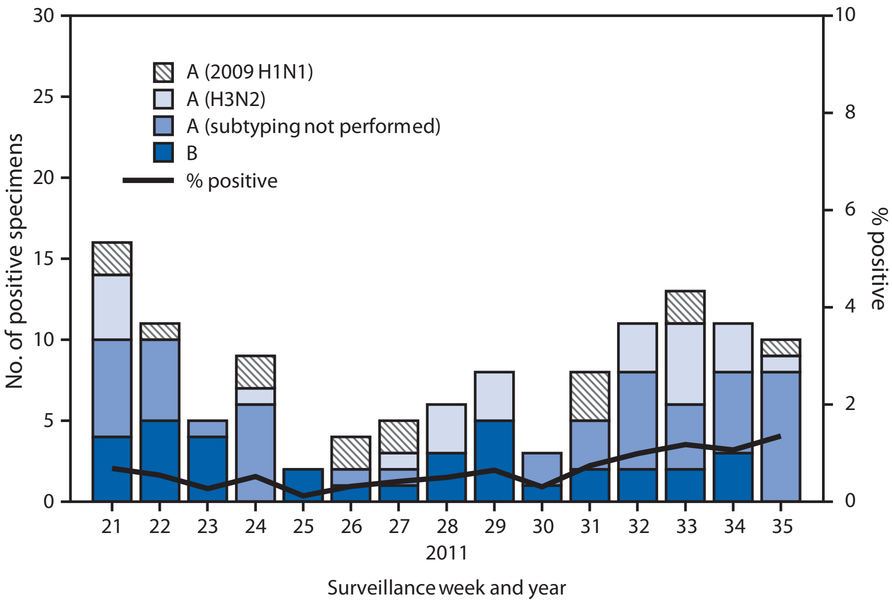
† Data as of September 9, 2011.

§ Defined as a temperature of ≥100°F (≥37.8°C), oral or equivalent, and cough and/or sore throat, in the absence of a known cause other than influenza.

¶ The national and regional baselines are the mean percentage of visits for ILI during noninfluenza weeks for the previous three seasons plus two standard deviations. A noninfluenza week is a week during which <10% of specimens tested positive for influenza. National and regional percentages of patient visits for ILI are weighted on the basis of state population. Use of the national baseline for regional data is not appropriate.

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

FIGURE. Number* and percentage of respiratory specimens testing positive for influenza, by type, surveillance week, and year — U.S. World Health Organization and National Respiratory and Enteric Virus Surveillance System collaborating laboratories, United States, May 22–September 3, 2011†



* N = 20,868.
† As of September 9, 2011.

Antigenic Characterization of Influenza Virus Isolates

The WHO Collaborating Center for Surveillance, Epidemiology, and Control of Influenza, located at CDC, receives and analyzes influenza virus isolates from laboratories worldwide. Sixty-eight 2009 influenza A (H1N1) viruses collected from May 22 to September 3 were analyzed (two from the United States, 44 from South America, 14 from Asia, and eight from Africa); all 68 (100%) were antigenically similar to A/California/7/2009, the influenza A (H1N1) component of the 2011–12 season influenza vaccine for the Northern Hemisphere. Of the 54 influenza A (H3N2) viruses characterized (two from the United States, 43 from South America, and nine from Asia), all 54 (100%) were antigenically similar to A/Perth/16/2009, the influenza A (H3N2) component of the 2011–12 influenza vaccine for the Northern Hemisphere. Finally, of 34 influenza B isolates collected during this period and analyzed by CDC, 31 (91%) belong to the B/Victoria lineage (two from the United States, 17 from South America, seven from Asia, and five from Africa), and all of those were antigenically similar to B/Brisbane/60/2008, the recommended influenza B component for the 2011–12 Northern Hemisphere influenza vaccine. The remaining three influenza B viruses (from Asia) belong to the B/Yamagata lineage and therefore are not related to the vaccine strain.

Antiviral Resistance Profiles of Influenza Virus Isolates

The WHO Collaborating Center for Surveillance, Epidemiology, and Control of Influenza at CDC tested isolates collected during May 22–September 3 for resistance to influenza antiviral medications. Of 154 isolates tested for resistance to the neuraminidase inhibitor oseltamivir, 144 were received from foreign countries; 61 were 2009 influenza A (H1N1), 53 were influenza A (H3N2), and 30 were influenza B viruses. Ten were collected in the United States; five were 2009 influenza A (H1N1), three were influenza A (H3N2), and two were influenza B viruses. Of 151 isolates tested for resistance to the neuraminidase inhibitor zanamivir, 144 were received from foreign countries; 61 were 2009 influenza A (H1N1), 53 were influenza A (H3N2), and 30 were influenza B viruses. Seven were collected from the United States; two were 2009 influenza A (H1N1), three were influenza A (H3N2), and two were influenza B viruses. None of the tested viruses were found to be resistant to either oseltamivir or zanamivir. High levels of resistance to the adamantanes (i.e., amantadine and rimantadine) persisted among 2009 influenza A (H1N1) viruses and influenza A (H3N2) viruses circulating globally (*4*). Worldwide, oseltamivir-resistant 2009 influenza A (H1N1) viruses have been detected occasionally. For example, in the Newcastle region of Australia, in a limited geographic area, 25 cases of oseltamivir-resistant 2009 influenza A (H1N1) viruses were identified from May to August (*5*). CDC will continue to conduct surveillance for antiviral resistance among influenza viruses throughout the upcoming season.

Reported by

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What is already known on this topic?

CDC collects, compiles, and analyzes data on influenza activity year-round in the United States. The influenza season generally begins in the fall and continues through the winter and spring months; however, the timing and severity of circulating influenza viruses can vary by geographic location and season.

What is added by this report?

The United States experienced low levels of influenza activity from May 22 to September 3, 2011, and influenza A (H3N2), 2009 influenza A (H1N1), and influenza B viruses were identified sporadically. The vast majority of viral isolates submitted during the summer demonstrated that they are antigenically similar to the influenza vaccine strains in the Northern Hemisphere 2011–12 vaccine.

What are the implications for public health practice?

To prevent influenza and its associated complications, influenza vaccination is recommended in all persons aged ≥6 months. Year-round influenza surveillance provides critical information for planning interventions to prevent and control influenza, developing vaccine recommendations and antiviral treatment guidance, and presenting information to the public regarding the progress and severity of the influenza season.

Editorial Note

During May 22–September 3, surveillance data indicated that 2009 influenza A (H1N1), influenza A (H3N2), and influenza B viruses cocirculated worldwide. Although neither the influenza virus strain that will predominate nor the severity of influenza-related disease activity for the 2011–12 influenza season in the United States can be predicted, antigenic characterization of viral isolates submitted during the summer demonstrated that the vast majority of isolates were antigenically similar to the influenza vaccine strains in the Northern Hemisphere 2011–12 vaccine.

Influenza vaccination is the best method for preventing influenza and its associated complications. For optimal protection against influenza viruses, annual influenza vaccination is recommended regardless of whether the vaccine virus strains have changed since the previous season. In 2010, the Advisory Committee on Immunization Practices extended influenza vaccination recommendations to include all persons aged ≥6 months (*6,7*). Vaccine manufacturers project ample supplies of influenza vaccine in the United States for the 2011–12 influenza season; approximately 68 million doses had been distributed as of September 2, and influenza vaccination should proceed for all persons without contraindications to vaccination as soon as vaccine is available in their community. Multiple influenza vaccines are approved for use and are being distributed during the 2011–12 season, including trivalent inactivated vaccine (TIV) for persons aged ≥6 months, live, attenuated influenza vaccine (LAIV) for nonpregnant otherwise healthy persons aged 2–49 years; a high-dose inactivated vaccine for persons aged ≥65 years; and a new intradermally administered vaccine, Fluzone Intradermal, which was licensed by the Food and Drug Administration on May 10, 2011, for adults aged 18–64 years (*7*). Children aged 6 months–8 years who did not receive at least 1 dose of the 2010–11 seasonal influenza vaccine should receive 2 doses (administered at least 4 weeks apart) of the 2011–12 seasonal influenza vaccine. Children in this age group, who did receive at least 1 dose of the 2010–11 vaccine, and persons aged ≥9 years, should receive 1 dose of the 2011–12 seasonal vaccine (*7*).

For the 2011–12 influenza season, ACIP recommends that persons who have experienced only hives following exposure to eggs should still receive the influenza vaccine, with the following additional safety measures: vaccine should be administered by a health-care provider who is familiar with the subject of egg allergy, TIV should be used rather than LAIV, and the recipient should be observed for at least 30 minutes by the health-care provider after vaccination to monitor for possible reactions (*7*). Severe allergic reactions (e.g., anaphylaxis) to egg protein or other vaccine components continue to be contraindications to receipt of influenza vaccination. Also, severe allergic reaction to a previous dose of influenza vaccine, regardless of the component thought to be responsible for the reaction, continues to be a contraindication to the future receipt of vaccine.

Although annual vaccination is the best method for preventing and reducing the impact of influenza, influenza antiviral medications are an important adjunct. The benefits of influenza antiviral treatment are likely to be greatest if treatment is started as soon as possible after illness onset, and evidence for benefit is strongest in studies in which treatment was started within 48 hours of illness onset (*8*). Antiviral treatment is recommended as early as possible for patients with confirmed or suspected influenza who have severe, complicated, or progressive illness; who require hospitalization; or who are at greater risk for influenza-related complications (*8*).[††] However, substantial observational data and one study in pregnant women

[††] Persons at greater risk include children aged <5 years (especially those aged <2 years); adults aged ≥65 years; persons with chronic pulmonary (including asthma), cardiovascular (except hypertension alone), renal, hepatic, hematologic (including sickle cell disease), metabolic (including diabetes mellitus), or neurologic and neurodevelopmental conditions (including disorders of the brain, spinal cord, peripheral nerve, and muscle, such as cerebral palsy, epilepsy [seizure disorders], stroke, intellectual disability [mental retardation], moderate to severe developmental delay, muscular dystrophy, or spinal cord injury); persons with immunosuppression, including that caused by medications or by human immunodeficiency virus infection; women who are pregnant or postpartum (within 2 weeks after delivery); persons aged ≤18 years who are receiving long-term aspirin therapy; American Indians/Alaska Natives; persons who are morbidly obese (i.e., body mass index ≥40); and residents of nursing homes and other chronic-care facilities.

(*9*) have indicated that antiviral treatment still can be beneficial in patients with severe, complicated, or progressive illness and in hospitalized patients even when administered >48 hours after illness onset (*8,10*). In such cases, decisions on starting antiviral treatment should not wait for laboratory confirmation of influenza. Antiviral treatment also may be considered for outpatients with confirmed or suspected influenza who do not have known risk factors for severe illness if treatment can be initiated within 48 hours of illness onset. Recommended antiviral medications include oseltamivir and zanamivir.

As a result of the ongoing investigation into the source of infection in the two cases of human infection with swine-origin influenza A (H3N2) virus in Indiana and Pennsylvania that were reported to CDC in August (*3*), two additional cases of swine-origin influenza A (H3N2) virus infection were identified in children in Pennsylvania and reported to CDC in September. Three of the four children had direct exposure to swine at an agricultural fair, but no exposure to swine was identified for the other child. One child is recovering at home, and the other three children have recovered fully.

Transmission of swine-origin influenza A viruses to humans is rare and usually occurs among persons in direct contact with swine or among persons who have visited places where swine are present (e.g., agricultural fairs, farms, and petting zoos). Clinicians should consider swine-origin influenza A virus infection as well as seasonal influenza virus infections in the differential diagnosis of patients with febrile respiratory illness who have been near swine (*3*). Clinicians who suspect influenza virus infection in humans with recent exposure to swine should obtain a nasopharyngeal swab from the patient, place the swab in a viral transport medium, contact their state or local health department to facilitate transport and timely diagnosis at a state public health laboratory, and consider empiric neuraminidase inhibitor antiviral treatment (*3,6*). Public health laboratories are requested to submit 1) summer specimens, 2) any specimens that cannot be subtyped by standard methods, or 3) specimens that are otherwise unusual, to CDC for further antigenic characterization, antiviral resistance monitoring, and identification of novel influenza A viruses. Early identification and prompt investigation of novel influenza A cases is critical to evaluating the extent of outbreaks and possible human-to-human transmission.

Influenza surveillance reports for the United States are posted online weekly and are available at http://www.cdc.gov/flu/weekly. Additional information regarding influenza viruses, influenza surveillance, influenza vaccine, influenza antiviral medications, and novel influenza A infections in humans is available at http://www.cdc.gov/flu.

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References

1. CDC. Update: influenza activity–United States, 2010–11 season, and composition of the 2011–12 influenza vaccine. MMWR 2011; 60:705–12.
2. Brammer L, Blanton L, Epperson S, et al. Surveillance for influenza during the 2009 influenza A (H1N1) pandemic—United States, April 2009–March 2010. Clin Infect Dis 2011;52(Suppl 1):S27–35.
3. CDC. Swine-origin influenza A (H3N2) virus infection in two children—Indiana and Pennsylvania, July–August 2011. MMWR 2011;60:1213–5.
4. World Health Organization. Summary of influenza antiviral susceptibility surveillance findings, September 2010–March 2011. 2011. Geneva, Switzerland: World Health Organization; 2011. Available at http://www.who.int/csr/disease/influenza/influenzanetwork/flunet/antiviral_susceptibility/en. Accessed September 9, 2011.
5. World Health Organization. Influenza virus activity in the world: 9 September 2011. Geneva, Switzerland: World Health Organization; 2011. Available at http://www.who.int/influenza/gisrs_laboratory/updates/summaryreport/en/index.html. Accessed September 13, 2011.
6. CDC. Prevention and control of influenza with vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP), 2010. MMWR 2010;59(No. RR-8).
7. CDC. Prevention and control of influenza with vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP), 2011. MMWR 2011;60:1128–32.
8. CDC. Antiviral agents for the treatment and chemoprophylaxis of influenza—recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2011;60(No. RR-1).
9. Siston AM, Rasmussen SA, Honein MA, et al. Pandemic 2009 influenza A (H1N1) virus illness among pregnant women in the United States. JAMA 2010;303:1517–25.
10. Yu H, Feng Z, Uyeki T, et al. Risk factors for severe illness with 2009 pandemic influenza A (H1N1) virus infection in China. Clin Infect Dis 2011;52:457–65.

State-Specific Trends in Lung Cancer Incidence and Smoking — United States, 1999–2008

Lung cancer is the most commonly diagnosed cancer and the leading cause of cancer death in the United States (*1*). Most deaths from lung cancer are caused by cigarette smoking and exposure to secondhand smoke (*2*). Large variations in lung cancer (*1,3*), smoking behavior (*4*), and tobacco control programs and policies (*5,6*) have been observed among states. Effective tobacco control policies can decrease smoking prevalence, ultimately leading to decreases in lung cancer (*7*). To assess lung cancer incidence by state, CDC analyzed data from the National Program of Cancer Registries (NPCR) and the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) program for the period 1999–2008. To assess smoking behavior by state, data from the Behavioral Risk Factor Surveillance System (BRFSS) for the period 1994–2009 were analyzed. This report summarizes the results of these analyses. From 1999 to 2008, decreases in lung cancer incidence were observed among men in 35 states and among women in six states. Regionally, the lowest rates and most rapid rate of decline in lung cancer were concentrated among states in the West, correlating with low smoking prevalence and high ratios of former smokers to ever smokers. Further reductions in smoking prevalence are critical to continue the decline in lung cancer incidence.

Data on new cases of invasive lung cancer (*International Classification of Diseases for Oncology, Third Edition*: C34.0–C34.9) diagnosed during 1999–2008 were obtained from population-based cancer registries affiliated with the NPCR and SEER programs, which, combined, cover all of the U.S. population. Data were evaluated according to United States Cancer Statistics (USCS) data-quality criteria.* Annual incidence rates per 100,000 persons were age-adjusted by the direct method to the 2000 U.S. standard population (19 age groups).[†] Adjustments to population data were made by the U.S. Census Bureau to account for the Gulf Coast population in Alabama, Mississippi, Louisiana, and Texas displaced by major population shifts resulting from hurricanes Katrina and Rita in 2005.[§] Annual percentage change (APC) was used to quantify the change in incidence rates over time and was calculated using joinpoint regression, which involves fitting a series of joined straight lines on a logarithmic scale to the trends in the annual age-adjusted rates. Up to two joined straight lines were allowed for nationwide and region-specific rates; one straight line was used for state-specific rates. Data from all states and the District of Columbia (DC) met USCS data quality criteria for 2008, but data from only 44 states and three U.S. Census regions (covering 90% of the U.S. population) met these criteria for all years 1999–2008; for this report, APC was calculated only for these states and regions.

Smoking behavior was estimated using results from BRFSS, a state-based surveillance system that collects information on health-risk behaviors, including tobacco use. BRFSS is a random-digit–dialed landline telephone survey of noninstitutionalized civilian adults aged ≥18 years conducted annually in all 50 states, DC, Puerto Rico, Guam, and the U.S. Virgin Islands. Smoking status was determined by asking respondents "Have you smoked at least 100 cigarettes in your entire life?" and "Do you now smoke cigarettes every day, some days or not at all?" Ever smokers were defined as those who reported having smoked at least 100 cigarettes during their lifetime; of these, current smokers were those who reported currently smoking every day or some days and former smokers were those who reported not currently smoking. Quit ratios were calculated as the ratio of former smokers to ever smokers.

The Pearson correlation was used to evaluate the association between lung cancer incidence (1999–2008) and smoking prevalence and quit ratios 5 years prior (1994–2003). Lung cancer rates begin to decline as soon as 5 years after smoking rates decline (*6,7*). Analyses were weighted by the inverse variances of the age-adjusted rates. All tests of statistical significance were two sided ($p<0.05$).

Among men, lung cancer incidence continued to decrease nationwide (APC 1999–2005 = -1.4 and APC 2005–2008 = -2.9) (Figure 1). Since 1999, lung cancer incidence among men declined at a faster rate in the West (APC 1999–2006 = -2.3 and 2006–2008 = -3.9) than in other U.S. Census regions. From 1999 to 2008 lung cancer incidence among men decreased in 35 of the 44 states analyzed and remained stable in the other nine states (Figure 2). Many of the states with lowest lung cancer incidence, as well as smoking prevalence, were clustered in the West (Figure 2). The correlation between

* CDC and the National Cancer Institute, in collaboration with the North American Association of Central Cancer Registries, maintain the USCS dataset, which contains the official federal statistics on cancer incidence. Cancer registries demonstrated that cancer incidence data were of high quality by meeting six USCS publication criteria: 1) case ascertainment is ≥90% complete, 2) ≤5% of cases are ascertained solely on the basis of a death certificate, 3) ≤3% of cases are missing information on sex, 4) ≤3% of cases are missing information on age, 5) ≤5% of cases are missing information on race, and 6) ≥97% of the registry's records passed a set of single-field and inter-field computerized edits that test the validity and logic of data components. Additional information is available at http://www.cdc.gov/uscs and http://www.cdc.gov/cancer/npcr/uscs/2007/technical_notes/stat_methods/suppression.htm.

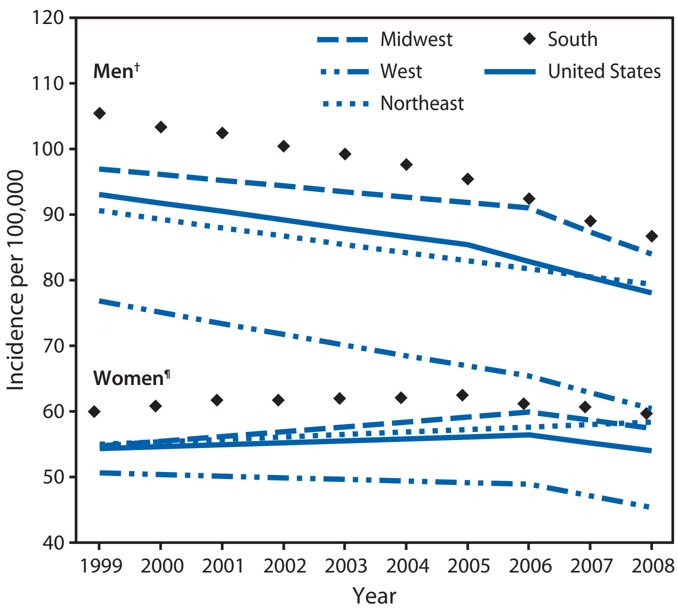
† Additional information is available at http://seer.cancer.gov/popdata/index.html.

§ Additional information is available at http://www.census.gov/popest/topics/methodology.

lung cancer incidence and smoking prevalence 5 years prior was 0.72 (p<0.001). Many of the states with high quit ratios were clustered in the West and Northeast (Figure 2). The correlation between lung cancer incidence and quit ratios 5 years prior was -0.55 (p<0.001).

Among women, lung cancer incidence decreased nationwide (APC 2006–2008 = -2.2) after increasing for years (APC 1999–2006 = 0.5). Lung cancer incidence among women decreased in the West (APC 1999–2006 = -0.5; APC 2006–2008 = -3.7) and stabilized in the Midwest, but was still increasing in the Northeast (APC 1999–2008 = 0.7) (not calculated for the South) (Figure 1). From 1999 to 2008,

FIGURE 1. Lung cancer incidence per 100,000 persons, by sex and U.S. Census region — United States, 1999–2008*



* Based on data from the National Program of Cancer Registries and the National Cancer Institute's Surveillance, Epidemiology, and End Results program that met United States Cancer Statistics data quality criteria for each year 1999–2008 (covering 90% of the U.S. population). Rates for 1999–2008 per 100,000 persons were calculated for U.S. census regions that met criteria for inclusion (http://www.cdc.gov/cancer/npcr/uscs/2007/technical_notes/stat_methods/suppression.htm) and age-adjusted to the 2000 U.S. standard population. Rates for the South census region did not meet inclusion criteria; instead rates were calculated for southern states that met data quality criteria for all years of 1999–2008 (Alabama, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Oklahoma, South Carolina, Texas, and West Virginia); these might not be representative of the entire South census region. Trends were measured with annual percentage change (APC) in age-adjusted rates estimated by joinpoint regression which allowed different slopes for two periods; the year at which slopes changed could vary by region. All trends were significant with p<0.05. Trends were not calculated for southern states.

† Among men, the APC nationwide was -1.4 for 1999–2005 and -2.9 for 2005–2008; in the Northeast, the APC was -1.5 for 1999–2008; in the Midwest, the APC was -0.9 for 1999–2006 and -3.9 for 2006–2008; and in the West, the APC was -2.3 for 1999–2006 and -3.9 for 2006–2008.

§ Among women, the nationwide APC nationwide was 0.5 for 1999–2006 and -2.2 for 2006–2008; in the Northeast, the APC was 0.7 for 1999–2008; in the Midwest, the APC was 1.3 for 1999–2006 and was stable for 2006–2008; and in the West, the APC was -0.5 for 1999–2006 and -3.7 for 2006–2008.

What is already known on this topic?

Cigarette smoking causes lung cancer in men and women. Wide variations in state tobacco control efforts, smoking prevalence, and lung cancer incidence have been observed in the United States. Lung cancer incidence has been decreasing for the past several decades among men but not among women.

What is added by this report?

Lung cancer incidence is beginning to decrease among women and is continuing to decrease among men in most states. Lung cancer rates are declining more rapidly in the West, which corresponds with smoking behavior; states with low smoking prevalence and high quit ratios are concentrated in this region.

What are the implications for public health practice?

Decreases in lung cancer incidence provide compelling evidence for state tobacco control policies, such as increasing tobacco excise taxes, enacting smoke-free laws, and funding policies to assist smokers in quitting. To continue these decreases in lung cancer incidence, current tobacco control funding for states needs to be increased to implement and sustain successful programs to reduce cigarette smoking and secondhand smoke exposure.

lung cancer incidence among women decreased in six states (California and Nevada [-1.5%], Washington [-1.0%], Florida and Oregon [-0.9%], and Texas [-0.7%]), remained stable in 24 states, and increased slightly in 14 states (not calculated for six states and DC) (Figure 3). Nearly half of states with higher smoking prevalence for women and more than a third of states with higher lung cancer incidence are in the South (Figure 3). The correlation between lung cancer incidence and smoking prevalence 5 years prior was 0.69 (p<0.0001). High quit ratios among women were clustered among states in the West and Northeast (Figure 3). The correlation between lung cancer incidence and quit ratios 5 years prior was -0.33 (p<0.001).

Reported by

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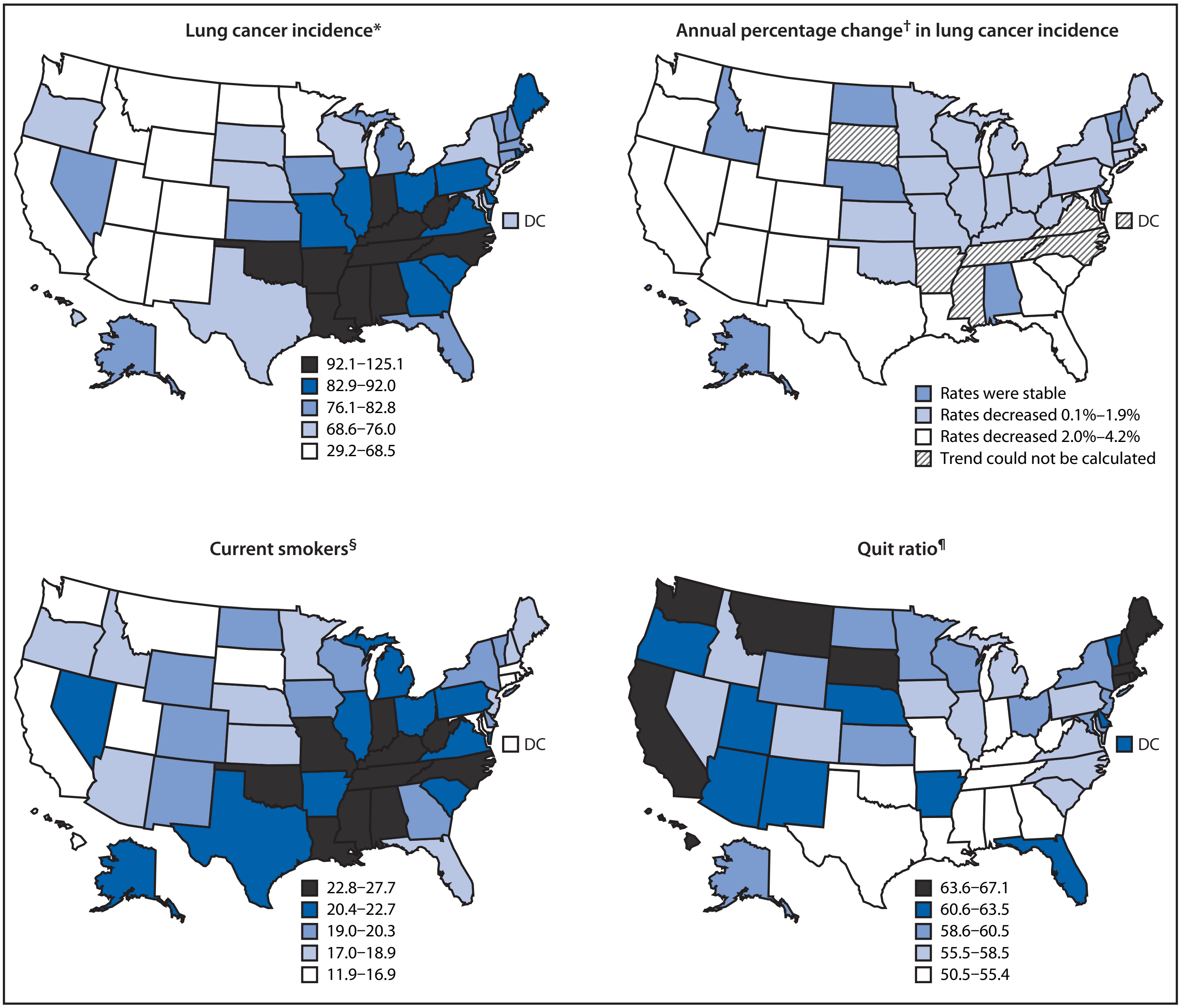
Editorial Comment

This report documents recent decreases in lung cancer incidence that closely parallel smoking behavior patterns across the United States. States vary substantially in their success at reducing smoking prevalence and lung cancer incidence (*1,4*).

FIGURE 2. Lung cancer incidence and trends, and smoking behavior among men — United States



* Rates for 2008, per 100,000 persons, based on data from the National Program of Cancer Registries and National Cancer Institute's Surveillance, Epidemiology, and End Results program, and age-adjusted to the 2000 U.S. standard population. Categories are based on quintiles.

† Linear increase or decrease in age-adjusted rates was measured with annual percentage change (APC) for the period 1999–2008. Rates were considered to increase or decrease if the APC was signficant ($p<0.05$); rates were considered stable if the APC was not significant. APC was not calculated for states that did not meet data quality criteria for all years 1999–2008.

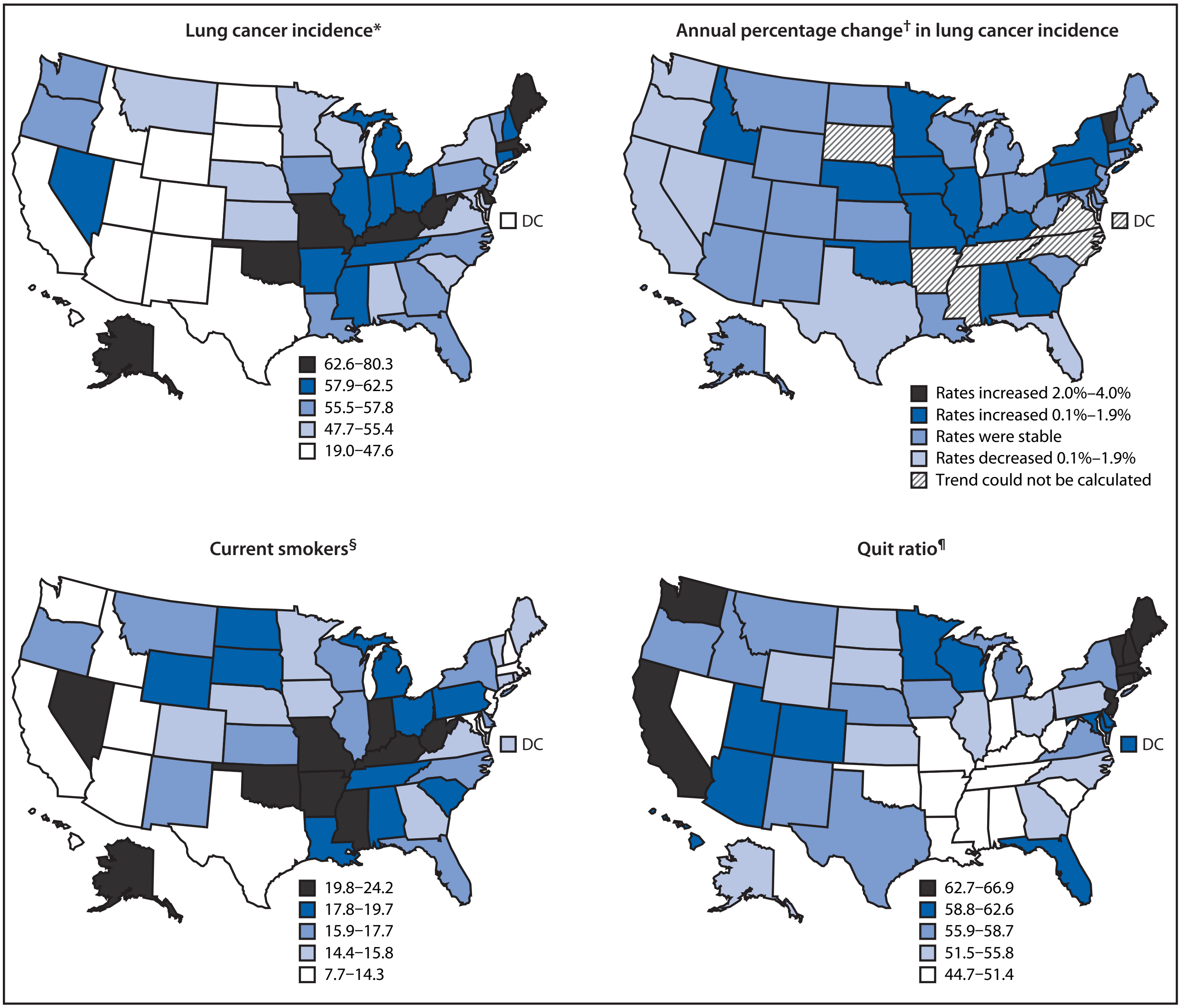
§ Percentage of men aged ≥18 years who were current smokers (reported smoking at least 100 cigarettes during their lifetimes and who, at the time of interview, reported smoking every day or some days), based on Behavioral Risk Factor Surveillance System 2009 data. Categories are based on quintiles.

¶ Quit ratios were calculated as the ratio of former smokers (persons who reported smoking at least 100 cigarettes during their lifetime but currently did not smoke) to ever smokers and is a measure of cessation over time, based on Behavioral Risk Factor Surveillance System 2009 data. Categories are based on quintiles.

A previous analysis of lung cancer incidence reported that the lowest incidence was in the West and the highest in the South (*3*). The results of this subsequent analysis demonstrate that lung cancer incidence is decreasing at a faster rate in the West than in other regions of the United States, which corresponds with changes in smoking behavior (*1,4*).

Since 1999, CDC has recommended and supported state efforts to implement and sustain comprehensive tobacco

Figure 3. Lung cancer incidence and trends, and smoking behavior among women — United States



* Rates for 2008, per 100,000 persons, based on data from the National Program of Cancer Registries and National Cancer Institute's Surveillance, Epidemiology, and End Results program, and age-adjusted to the 2000 U.S. standard population. Categories are based on quintiles.

† Linear increase or decrease in age-adjusted rates was measured with annual percentage change (APC) for the period 1999–2008. Rates were considered to increase or decrease if the APC was signficant ($p<0.05$); rates were considered stable if the APC was not significant. APC was not calculated for states that did not meet data quality criteria for all years 1999–2008.

§ Percentage of women aged ≥18 years who were current smokers (reported smoking at least 100 cigarettes during their lifetimes and who, at the time of interview, reported smoking every day or some days), based on Behavioral Risk Factor Surveillance System 2009 data. Categories are based on quintiles.

¶ Quit ratios were calculated as the ratio of former smokers (persons who reported smoking at least 100 cigarettes during their lifetime but currently did not smoke) to ever smokers and is a measure of cessation over time, based on Behavioral Risk Factor Surveillance System 2009 data. Categories are based on quintiles.

control programs to discourage smoking initiation, encourage smoking cessation, and protect nonsmokers from secondhand smoke exposure.¶ Decreases in lung cancer incidence and the correlation between lung cancer incidence and quit ratios provide compelling evidence of the value of these tobacco control efforts (*1,6*). State smoke-free laws continue to be implemented nation-wide, and tobacco excise taxes continue to increase in most, but not all, states (*5,8*).** In fiscal year 2011,

¶ Pertinent CDC recommendations are available at http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm.

** Additional information is available at http://apps.nccd.cdc.gov/statesystem/default/default.aspx.

states will collect $25.3 billion from tobacco excise taxes and the tobacco settlement, a 46% increase over the past decade (*8*). Yet, in the past 3 years, states have cut funding for tobacco control programs by 28% ($199.3 million), and this year states will invest less than 2% of tobacco revenues ($518 million) in tobacco control programs (*8*). States that invest more fully in these programs, such as California, have experienced decreases in youth and adult smoking prevalence (*7–9*), decreases in lung cancer (*7*), and significant health-care savings (*8,9*).

The findings in this report are subject to at least five limitations. First, not all states met USCS data quality criteria for this period; many of these states were in the South, one of the regions with the highest smoking prevalence. Second, cigarette smoking status is self-reported by BRFSS participants; however, these data have high validity (*4*). Third, smoking prevalence might be underestimated because BRFSS is a land-line survey and adults with wireless-only service are more likely to smoke cigarettes than the rest of the U.S. population.[††] Fourth, BRFSS data are not generalizable to certain populations who are not included in the survey, such as institutionalized persons or persons in the military. Fifth, the majority of lung cancers are caused by cigarette smoking and secondhand smoke exposure; however, lung cancer from other causes, such as other forms of tobacco use or exposure to radon or occupational hazards, might influence geographic variations in lung cancer incidence.

Lung cancer incidence is beginning to decrease among women and is continuing to decrease among men in most states. Variations among states in lung cancer incidence are influenced by variations in smoking behavior. Tobacco control strategies to prevent initiation, accelerate declines in use, and promote cessation have decreased lung cancer incidence among men (*1,7*) and progress is now being observed among women (*10*), especially in the West. Lung cancer incidence among women is declining in states with long-running, comprehensive tobacco control programs (*8*). Tobacco use is an endemic problem and warrants a long-term solution (*1,7*). Research has shown that the longer and more heavily states invest in comprehensive tobacco control programs, the greater the reduction in smoking and the greater the subsequent savings from reduced smoking-related health costs (*8*). Research also has shown that any slackening of effort can jeopardize progress.[§§] Although great strides in tobacco control and lung cancer incidence reduction have been made, further progress requires intensified efforts to reduce cigarette smoking and secondhand smoke exposure. These efforts depend on adequate funding of tobacco control programs.

[††] Additional information is available at http://www.cdc.gov/nchs/data/nhsr/nhsr039.pdf.

[§§] Additional information is available at http://www.iom.edu/reports/2007/ending-the-tobacco-problem-a-blueprint-for-the-nation.aspx.

Acknowledgment

State and regional cancer registry staffs and Behavioral Risk Factor Surveillance System state coordinators.

References

1. Jemal A, Thun MJ, Ries LAG, et al. Annual report to the nation on the status of cancer, 1975–2005, featuring trends in lung cancer, tobacco use, and tobacco control. J Natl Cancer Inst 2008;100:1672–94.
2. CDC. Smoking-attributable mortality, years of potential life lost, and productivity losses—United States, 2000–2004. MMWR 2008;57:1226–8.
3. CDC. Racial/ethnic disparities and geographic differences in lung cancer incidence—38 states and the District of Columbia, 1998–2006. MMWR 2010;59:1433–8.
4. CDC. Vital Signs: current cigarette smoking among adults aged ≥18 years—United States, 2005–2010. MMWR 2011;60:1207–12.
5. Cokkinides VE, Prandi P, McMahon C, et al. Tobacco control in the United States: recent progress and opportunities. CA Cancer J Clin 2009;59:353–65.
6. Jemal A, Cokkinides VE, Shafey O, Thun MJ. Lung cancer trends in young adults: an early indicator of progress in tobacco control (United States). Cancer Causes Control 2003;14:579–85.
7. Pierce JP, Messer K, White MM, Kealey S, Cowling DW. Forty years of faster decline in cigarette smoking in California explains current lower lung cancer rates. Cancer Epidemiol Biomarkers Prev 2010;19:2801–10.
8. Campaign for Tobacco-Free Kids. A broken promise to our children: the 1998 state tobacco settlement 12 years later. Washington, DC: Campaign for Tobacco-Free Kids; 2010. Available at http://www.tobaccofreekids.org/what_we_do/state_local/tobacco_settlement. Accessed September 9, 2011.
9. Lightwood J, Glantz S. Effect of the Arizona tobacco control program on cigarette consumption and healthcare expenditures. Soc Sci Med 2011;72:166–72.
10. Kohler BA, Ward E, McCarthy BJ, et al. Annual report to the nation on the status of cancer, 1975–2007, featuring tumors of the brain and other nervous system. J Natl Cancer Inst 2011;103:714–36.

Million Hearts: Strategies to Reduce the Prevalence of Leading Cardiovascular Disease Risk Factors — United States, 2011

On September 13, 2011, this report was posted as an MMWR *Early Release on the* MMWR *website (http://www.cdc.gov/mmwr).*

Cardiovascular disease (CVD) causes one in three (approximately 800,000) deaths reported each year in the United States (*1*). Annual direct and overall costs resulting from CVD are estimated at $273 billion and $444 billion, respectively (*2*). Strategies that address leading CVD risk factors, such as hypertension, high cholesterol levels, and smoking, can greatly reduce the burden of CVD (*3*). To estimate the U.S. prevalence of these three risk factors, CDC analyzed data from the National Health and Nutrition Examination Survey (NHANES) on uncontrolled hypertension, uncontrolled high levels of low-density lipoprotein cholesterol (LDL-C), and current smoking. This report summarizes the results of that analysis, which found that 49.7% of U.S. adults aged ≥20 years (an estimated 107.3 million persons) have at least one of the three risk factors. To reduce the prevalence of CVD risk factors among persons in the United States, the U.S. Department of Health and Human Services, in collaboration with nonprofit and private organizations, is launching Million Hearts, a multifaceted combination of evidence-based interventions and strategies aimed at preventing 1 million heart attacks and strokes over the next 5 years.

NHANES is a complex, multistage probability sample of the civilian, noninstitutionalized U.S. population that combines interviews and physical examinations.* Data from 2007–2008, the most recent NHANES survey data available, were used to estimate the current U.S. prevalence of uncontrolled hypertension, uncontrolled high levels of LDL-C, and current smoking among adults aged ≥20 years; five NHANES survey cycles (1999–2000, 2001–2002, 2003–2004, 2005–2006, and 2007–2008) were analyzed to examine changes in prevalence over time. Examination participation rates for the five cycles ranged from 75% to 80%. During 1999–2008, a total of 24,693 persons aged ≥20 years were interviewed and examined for NHANES. From that total, 1,154 pregnant women were excluded. Of the 23,539 remaining adults, 9,891 had been randomly assigned to a morning examination and had fasted for 8–24 hours. Of the 9,891 examined, 790 with missing blood pressure or LDL-C measurements were excluded (none were missing smoking status), yielding a final sample of 9,101.

Uncontrolled hypertension was defined as a systolic blood pressure ≥140 mm Hg or a diastolic blood pressure ≥90 mm Hg, based on the average of up to three measurements.† Uncontrolled high levels of LDL-C were defined as levels above the treatment goals established by the National Cholesterol Education Program (NCEP) Adult Treatment Panel-III (ATP-III) guidelines: <160 mg/dL, <130 mg/dL, and <100 mg/dL for low-, intermediate-, and high-risk groups, respectively.§ LDL-C was used because it is identified by NCEP as the primary target for lipid-lowering therapy. Current cigarette smoking was defined in persons who 1) reported having smoked ≥100 cigarettes in their lifetime and who currently smoke every day or some days, or 2) had a measured serum cotinine (the primary nicotine metabolite) level >10 ng/mL.

All analyses were conducted using statistical software to account for the complex sampling design and to calculate prevalence estimates and 95% confidence intervals (CIs). The estimated number of persons with at least one of the three CVD risk factors was derived from Current Population Surveys, based on weighted, unstandardized prevalence estimates.

In 2007–2008, among U.S. adults aged ≥20 years, an estimated 49.7% (CI = 46.4%–53.0%) had at least one of the following CVD risk factors: uncontrolled hypertension, uncontrolled high levels of LDL-C, or current smoking. That prevalence represented an estimated 107.3 million (CI = 99.9–114.8) persons aged ≥20 years. Of the 107.3 million persons, an estimated 21.3% had two of the three risk factors, and 2.4% had all three. After adjusting for sex, age group, race/ethnicity, and poverty-income ratio, a significant decline in prevalence, from 57.8% (CI = 52.9%–62.5%) to 49.7%, was observed from 1999–2000 to 2007–2008 ($p<0.01$ for linear trend). However, because of U.S. population growth, the number of persons represented by thosee prevalences did not change significantly (109 million versus 107 million) (Figure).

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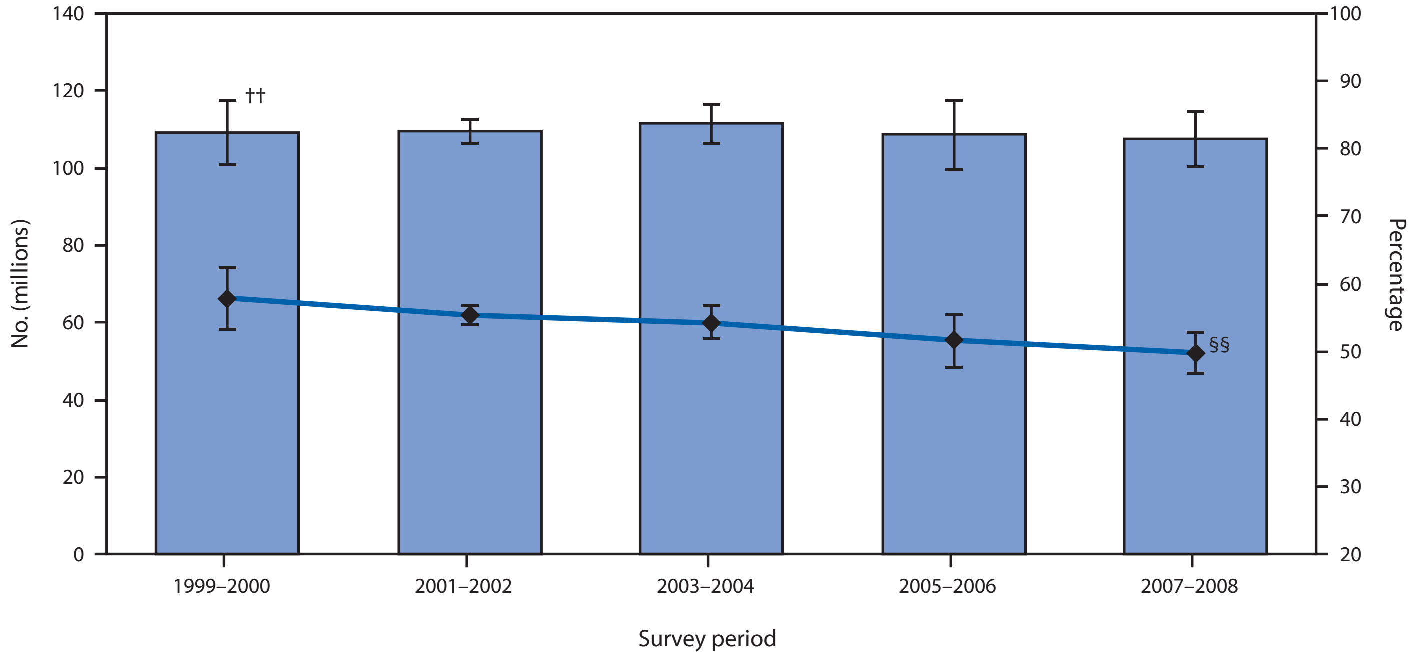
* Additional information available at http://www.cdc.gov/nchs/nhanes.htm.

† Among the participants, 92% had two or three blood pressure measurements during a single physical examination at the mobile examination center; for those with only one blood pressure measurement, that single measurement was used in place of an average.

§ Available at http://www.nhlbi.nih.gov/guidelines/cholesterol.

FIGURE. Age-standardized prevalence* and estimated number of adults aged ≥20 years† who currently smoke,§ or have uncontrolled hypertension,¶ or have uncontrolled high levels of cholesterol— National Health and Nutrition Examination Survey, United States, 1999–2008**



* Weighted prevalence estimates, directly standardized to the 2000 U.S. standard population, based on the following age groups: 20–39, 40–59, and ≥60 years.

† Numbers were calculated using Current Population Survey data and weighted, unstandardized prevalence estimates. Additional information available at http://www.cdc.gov/nchs/tutorials/nhanes/faqs.htm.

§ Defined as 1) a "Yes" response to the question, "Have you smoked at least 100 cigarettes in your entire life?" plus a response of "Every day" or "Some days" to the question, "Do you now smoke cigarettes . . . ?" or 2) a measured serum cotinine level of >10 ng/mL.

¶ Average systolic blood pressure ≥140 mm Hg or average diastolic pressure ≥90 mm Hg.

** Low-density lipoprotein cholesterol (LDL-C) level above the treatment goals established by the National Cholesterol Education Program Adult Treatment Panel-III guidelines: <160 mg/dL, <130 mg/dL, and <100 mg/dL for low-, intermediate-, and high-risk groups, respectively.

†† 95% confidence interval.

§§ Linear trend in prevalence shows significant decline (p<0.01) from 1999–2000 to 2007–2008 after adjustment for sex, age group, race/ethnicity, and poverty-income ratio.

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Editorial Note

The decrease in the prevalence of U.S. adults aged ≥20 years with uncontrolled hypertension, uncontrolled high levels of LDL-C, or current smoking might, in part, reflect improved treatment and control of hypertension and high levels of LDL-C (*4,5*) and implementation of effective smoking interventions, such as smokefree policies for public places, increased cigarette excise taxes, and cessation treatments and services (*6*). Nevertheless, approximately half of the U.S. adult population still has one or more of these preventable risk factors for CVD.

Optimal prevention of CVD will require complementary clinical and community efforts and monitoring of interventions, risk factors, and disease at individual and population levels. Although safe, feasible, and effective clinical preventive services are available that can substantially reduce cardiovascular morbidity and mortality (e.g., the ABCS: aspirin therapy, blood pressure control, cholesterol management, and smoking cessation), these basic preventive and control measures are underprovided and underused (Table). Community interventions also could be enhanced. The prevention, treatment, and control of CVD are influenced by a wide range of diverse community and clinical factors (*2,3*). Approximately 90% of persons in the United States consume sodium at levels above those recommended in dietary guidelines (*7*), trans fat remains an avoidable hazard in restaurant and processed food, and approximately one in five adults currently smoke (*8*). In addition, funding of state tobacco control programs is significantly below levels recommended by CDC (*6*). Communitywide changes and policies addressing these issues have the potential to reduce CVD and have a substantial positive impact on the health of the public.

The findings in the report are subject to at least one limitation. NHANES only surveys the noninstitutionalized

TABLE. Estimated performance level for ABCS (aspirin therapy, blood pressure control, cholesterol management, and smoking cessation) measures to prevent cardiovascular disease — United States, 2011

Preventive measure	Data source	Definition of measure	Estimated performance level	Discussion
Aspirin therapy	NAMCS and NHAMCS, 2007–2008	% of outpatient visits by patients aged ≥18 yrs with ischemic vascular disease who are prescribed aspirin or other antiplatelet medication	47%*	Antiplatelet medication use among patients with ischemic vascular disease is strongly recommended by many guidelines and incorporated in many National Quality Forum–approved measures to prevent atherosclerotic heart disease, ischemic stroke and transient ischemic attacks, and symptomatic peripheral vascular disease.
Blood pressure control	NHANES, 2005–2008	% of adults aged ≥18 yrs with hypertension who have adequately controlled blood pressure†	46%§	Approximately 68 million U.S. adults have high blood pressure.§ Predictive modeling in a recent study suggests that a 10% increase in treatment of hypertension could prevent 14,000 premature deaths each year in adults aged <80 years.¶
Cholesterol management	NHANES, 2005–2008	% of adults aged ≥20 yrs with high cholesterol who have adequately controlled LDL-C**	33%††	Approximately 71 million U.S. adults have high LDL-C.†† Predictive modeling in a recent study suggests that a 10% increase in treatment of elevated cholesterol could prevent 8,000 premature deaths each year in adults aged <80 years.¶
Smoking cessation	NAMCS, 2005–2008	% of outpatient visits by persons aged ≥18 yrs who screened positive for current tobacco use where tobacco cessation counseling or cessation medications were provided	23%§§	Among visits by patients who screened positive for tobacco use, 20.9% (CI = 19.1%–22.7%) were provided tobacco cessation counseling, and 7.6% (CI = 6.5%–8.7%) were provided cessation medications.§§ Tobacco cessation rates can be increased by offering and providing cessation counseling and the seven FDA-approved medications.¶¶ *** Frequent interaction with a health-care professional, as well as provider-reminder systems (e.g., chart stickers, vital sign stamps, medical record flow sheets, and checklists), are effective in treating tobacco use and improving the probability of successful quitting and abstinence. ***

Abbreviations: NAMCS = National Ambulatory Medical Care Survey; NHAMCS = National Hospital Ambulatory Medical Care Survey; NHANES = National Health and Nutrition Examination Survey; LDL-C = low-density lipoprotein cholesterol; CI = 95% confidence interval; FDA = Food and Drug Administration.

* Source: CDC, unpublished data, 2011.

† Systolic blood pressure <140 mm Hg and diastolic blood pressure <90 mm Hg.

§ Source: CDC. Vital signs: prevalence, treatment, and control of hypertension—United States, 1999–2002 and 2005–2008. MMWR 2011;60:103–8.

¶ Source: Farley TA, Dalal MA, Mostashari F, Frieden TR. Deaths preventable in the U.S. by improvements in use of clinical preventive services. Am J Prev Med 2010;38:600–9.

** According to LDL-C treatment goals established by the National Cholesterol Education Program Adult Treatment Panel-III guidelines: <160 mg/dL, <130 mg/dL, and <100 mg/dL for low-, intermediate-, and high-risk groups, respectively.

†† Source: CDC. Vital Signs: prevalence, treatment, and control of high levels of low-density lipoprotein cholesterol—United States, 1999–2002 and 2005–2008. MMWR 2011;60:109–14.

§§ Source: CDC, unpublished data, 2011.

¶¶ Except when medically contraindicated or among persons in populations (e.g., pregnant women, smokeless tobacco users, light smokers, and adolescents) for whom evidence of effectiveness is insufficient.

*** Source: Fiore MC, Jaen CR, Baker TB, et al. Treating tobacco use and dependence: 2008 update. Clinical practice guideline. Rockville, MD: US Department of Health and Human Services, Public Health Service; 2008. Available at http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf.

U.S. population and does not include military personnel and persons who reside in nursing homes and other institutions. The prevalence of the three CVD risk factors might be underestimated because older persons living in nursing homes and other institutions might be more likely to have age-related hypertension and high levels of LDL-C (*1*).

To reduce the burden of CVD risk factors, the U.S. Department of Health and Human Services, in collaboration with nonprofit and private organizations, is launching Million Hearts, with the goal of preventing 1 million heart attacks and strokes over the next 5 years. Million Hearts is expected to align policies, programs, and resources to improve access to care; focus attention on improved care through use of the ABCS and health information technology; increase public awareness about risk factors; improve medication adherence; promote healthier behaviors and environments; and enhance surveillance and monitoring.

Million Hearts incorporates technological advances occurring in the clinical setting (e.g., health information technology development and linkages with electronic medical records), modifications in health-care coverage and reimbursement (e.g., Physician Quality Reporting System and increased coverage of clinical preventive services), and comprehensive environmental and policy initiatives (e.g., Community Transformation Grants) that are under way at worksites and in communities. Million Hearts draws upon the extensive evidence base of

What is already known on this topic?

Cardiovascular disease (CVD) causes one in three (approximately 800,000) deaths each year in the United States. Total annual costs resulting from CVD are estimated at $444 billion.

What is added by this report?

Based on data from the 2007–2008 National Health and Nutrition Examination Survey, 49.7%, or an estimated 107.3 million U.S. adults aged ≥20 years, have at least one of the following three preventable CVD risk factors: uncontrolled hypertension, uncontrolled high cholesterol, or smoking.

What are the implications for public health practice?

To reduce the prevalence of these CVD risk factors, the U.S. Department of Health and Human Services, in conjunction with nonprofit and private organizations, is launching Million Hearts, a multifaceted combination of evidence-based interventions designed to prevent 1 million heart attacks and strokes over the next 5 years. Among the effective clinical services that can substantially reduce cardiovascular morbidity and mortality are the ABCS: aspirin therapy, blood pressure control, cholesterol management, and smoking cessation.

established standards in clinical (e.g., U.S. Preventive Services Task Force) and community (e.g., *Guide to Community Preventive Services*) settings, complements *Healthy People 2020* objectives,¶ and serves as the tactical implementation of the National Strategy for Quality Improvement in Health Care's focus on CVD prevention. Although Million Hearts has a 5-year goal, improvements in clinical and community prevention are intended to continue to produce benefits over a much longer period.

¶ Additional information available at http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx.

Acknowledgment

NHANES staff members, National Center for Health Statistics, CDC.

References

1. Roger VL, Go AS, Lloyd-Jones DM, et al. Heart disease and stroke statistics—2011 update: a report from the American Heart Association. Circulation 2011;123:e18–209.
2. Heidenreich PA, Trogdon JG, Khavjou OA, et al. Forecasting the future of cardiovascular disease in the United States: a policy statement from the American Heart Association. Circulation 2011;123:933–44.
3. Farley TA, Dalal MA, Mostashari F, Frieden TR. Deaths preventable in the U.S. by improvements in use of clinical preventive services. Am J Prev Med 2010;38:600–9.
4. CDC. Vital signs: prevalence, treatment, and control of hypertension—United States, 1999–2002 and 2005–2008. MMWR 2011;60:103–8.
5. CDC. Vital signs: prevalence, treatment, and control of high levels of low-density lipoprotein cholesterol—United States, 1999–2002 and 2005–2008. MMWR 2011;60:109–14.
6. CDC. Best practices for comprehensive tobacco control programs—2007. Atlanta, GA: US Department of Health and Human Services, CDC; 2007. Available at http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm. Accessed September 9, 2011.
7. CDC. Sodium intake among adults—United States, 2005–2006. MMWR 2010;59:746–9.
8. CDC. Vital signs: current cigarette smoking among adults aged ≥18 years—United States, 2005–2010. MMWR 2011;60:1207–12.

Announcement

National Child Passenger Safety Week — September 18–24, 2011

In the United States, motor vehicle–related injuries are the leading cause of death among children of all ages (*1*). In 2009, a total of 1,051 passenger vehicle occupants aged <16 years died as a result of crashes; 45% of these occupants were unrestrained (*2*). The lack of restraint use increased with age among the fatally injured. Specifically, 31% of children aged <4 years, 42% of children aged 4–7 years, 53% of children aged 8–12 years, and 67% of children aged 13–15 years were unrestrained at the time of the crash (*2*).

During 1975–2009, child restraints saved an estimated 9,310 lives (*2*). Child safety seats reduce fatal injury by 71% among infants and by 54% among toddlers (*2*). Belt-positioning booster seats reduce the risk for injury by 59% compared with seat belts alone (*3*), and seat belts reduce the risk for fatal or serious injury by nearly 50% (*2*). Seating position also contributes to child passenger safety. To keep child passengers as safe as possible, drivers should properly restrain children aged <13 years in a back seat and follow the American Academy of Pediatrics' child passenger safety recommendations, including the updated recommendation that all infants and toddlers ride rear-facing until they are aged 2 years or until they reach the highest rear-facing weight or height limit allowed by the manufacturer of their seat (*4*).

This year, National Child Passenger Safety Week is September 18–24. As part of the campaign, Saturday, September 24, is designated as National Seat Check Saturday, when drivers with child passengers are encouraged to visit a child safety seat inspection station to have a certified technician inspect their car seat and give hands-on advice free of charge. Additional information and an inspection station locator are available from the National Highway Traffic Safety Administration at http://www.nhtsa.gov/Safety/CPS. Promotional materials (in English and Spanish) are available at http://www.trafficsafetymarketing.gov/CAMPAIGNS/Child+Safety/Child+Passenger+Safety+Week.

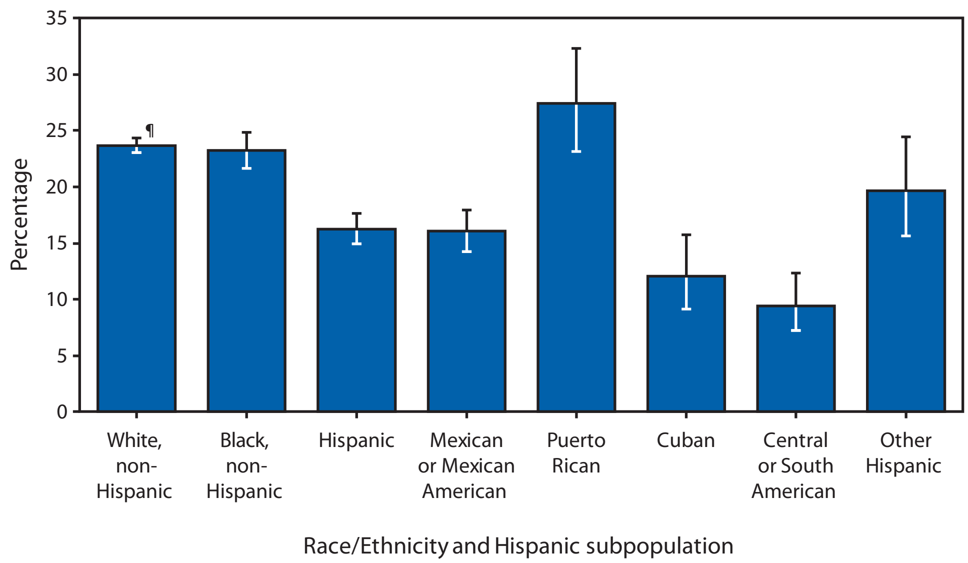
References

1. CDC. Web-based Injury Statistics Query and Reporting System (WISQARS). Available at www.cdc.gov/ncipc/wisqars. Accessed September 6, 2011.
2. National Highway Traffic Safety Administration. Traffic safety facts 2009 data. Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration; 2010. Available at http://www-nrd.nhtsa.dot.gov/pubs/811390.pdf. Accessed September 6, 2011.
3. Durbin DR, Elliott MR, Winston FK. Belt-positioning booster seats and reduction in risk of injury among children in vehicle crashes. JAMA 2003;289:2835–40.
4. American Academy of Pediatrics. National Child Passenger Safety Week, September 18–24, 2011. Elk Grove Village, IL: American Academy of Pediatrics; 2011. Available at http://www.aap.org/advocacy/ncpsw.htm. Accessed September 6, 2011.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Adults Aged ≥18 Years Who Had Some Form of Arthritis or a Related Condition,* by Race/Ethnicity and Hispanic† Subpopulation — National Health Interview Survey, United States, 2009§



* Respondents were asked if they had ever been told by a doctor or other health professional that they had some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia.

† Persons of Hispanic origin might be of any race or combination of races.

§ Estimates are based on household interviews of a sample of the U.S. civilian, noninstitutionalized population. Estimates are age-adjusted using the projected 2000 U.S. standard population and using four age groups: 18–44 years, 45–64 years, 65–74 years, and ≥75 years.

¶ 95% confidence interval.

In 2009, Hispanic adults (16.2%) were less likely to have been told by a doctor or other health-care professional that they had some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia compared with non-Hispanic white adults (23.6%) and non-Hispanic black adults (23.2%). Puerto Rican adults (27.4%) were more likely to have arthritis or a related condition than were other Hispanic subgroups.

Source: National Health Interview Survey, 2009 data. Available at http://www.cdc.gov/nchs/nhis.htm.

Notifiable Diseases and Mortality Tables

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending September 10, 2011 (36th week)*

Disease	Current week	Cum 2011	5-year weekly average†	Total cases reported for previous years 2010	2009	2008	2007	2006	States reporting cases during current week (No.)
Anthrax	—	—	0	—	1	—	1	1	
Arboviral diseases§, ¶:									
California serogroup virus disease	—	49	4	75	55	62	55	67	
Eastern equine encephalitis virus disease	—	2	0	10	4	4	4	8	
Powassan virus disease	—	12	0	8	6	2	7	1	
St. Louis encephalitis virus disease	—	1	1	10	12	13	9	10	
Western equine encephalitis virus disease	—	—	—	—	—	—	—	—	
Babesiosis	8	395	0	NN	NN	NN	NN	NN	NY (8)
Botulism, total	—	64	3	112	118	145	144	165	
foodborne	—	7	0	7	10	17	32	20	
infant	—	49	2	80	83	109	85	97	
other (wound and unspecified)	—	8	1	25	25	19	27	48	
Brucellosis	—	57	2	115	115	80	131	121	
Chancroid	—	12	0	24	28	25	23	33	
Cholera	—	27	0	13	10	5	7	9	
Cyclosporiasis§	2	128	2	179	141	139	93	137	NY (1), GA (1)
Diphtheria	—	—	—	—	—	—	—	—	
Haemophilus influenzae,** invasive disease (age <5 yrs):									
serotype b	—	5	0	23	35	30	22	29	
nonserotype b	1	79	2	200	236	244	199	175	NY (1)
unknown serotype	—	165	2	223	178	163	180	179	
Hansen disease§	—	33	2	98	103	80	101	66	
Hantavirus pulmonary syndrome§	—	17	0	20	20	18	32	40	
Hemolytic uremic syndrome, postdiarrheal§	2	101	9	266	242	330	292	288	NY (1), OH (1)
Influenza-associated pediatric mortality§,††	1	112	1	61	358	90	77	43	CT (1)
Listeriosis	14	380	21	821	851	759	808	884	NY (1), MD (1), FL (3), MT (2), CO (2), WA (1), CA (4)
Measles§§	—	185	1	63	71	140	43	55	
Meningococcal disease, invasive¶¶:									
A, C, Y, and W-135	—	130	3	280	301	330	325	318	
serogroup B	—	67	2	135	174	188	167	193	
other serogroup	—	8	0	12	23	38	35	32	
unknown serogroup	—	287	7	406	482	616	550	651	
Novel influenza A virus infections***	2	6	0	4	43,774	2	4	NN	PA (2)
Plague	—	1	0	2	8	3	7	17	
Poliomyelitis, paralytic	—	—	—	—	1	—	—	—	
Polio virus Infection, nonparalytic§	—	—	—	—	—	—	—	NN	
Psittacosis§	—	2	0	4	9	8	12	21	
Q fever, total§	2	71	3	131	113	120	171	169	
acute	2	54	2	106	93	106	—	—	MI (1), CA (1)
chronic	—	17	0	25	20	14	—	—	
Rabies, human	—	1	—	2	4	2	1	3	
Rubella†††	—	3	0	5	3	16	12	11	
Rubella, congenital syndrome	—	—	—	—	2	—	—	1	
SARS-CoV§	—	—	—	—	—	—	—	—	
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	—	84	1	142	161	157	132	125	
Syphilis, congenital (age <1 yr)§§§	—	133	9	377	423	431	430	349	
Tetanus	—	5	1	26	18	19	28	41	
Toxic-shock syndrome (staphylococcal)§	—	58	2	82	74	71	92	101	
Trichinellosis	—	8	0	7	13	39	5	15	
Tularemia	—	79	3	124	93	123	137	95	
Typhoid fever	—	242	14	467	397	449	434	353	
Vancomycin-intermediate *Staphylococcus aureus*§	1	45	1	91	78	63	37	6	OH (1)
Vancomycin-resistant *Staphylococcus aureus*§	—	1	0	2	1	—	2	1	
Vibriosis (noncholera *Vibrio* species infections)§	16	449	22	846	789	588	549	NN	PA (1), OH (1), FL (5), WA (5), CA (3), HI (1)
Viral hemorrhagic fever¶¶¶	—	—	—	1	NN	NN	NN	NN	
Yellow fever	—	—	—	—	—	—	—	—	

See Table 1 footnotes on next page.

TABLE I. (*Continued*) Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending September 10, 2011 (36th week)*

—: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts.

* Case counts for reporting years 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/osels/ph_surveillance/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf.

† 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/osels/ph_surveillance/nndss/phs/files/5yearweeklyaverage.pdf.

§ Not reportable in all states. Data from states where the condition is not reportable are excluded from this table except starting in 2007 for the arboviral diseases, STD data, TB data, and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/osels/ph_surveillance/nndss/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.

** Data for H. influenzae (all ages, all serotypes) are available in Table II.

†† Updated weekly from reports to the Influenza Division, National Center for Immunization and Respiratory Diseases. Since October 3, 2010, 116 influenza-associated pediatric deaths occurring during the 2010-11 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.

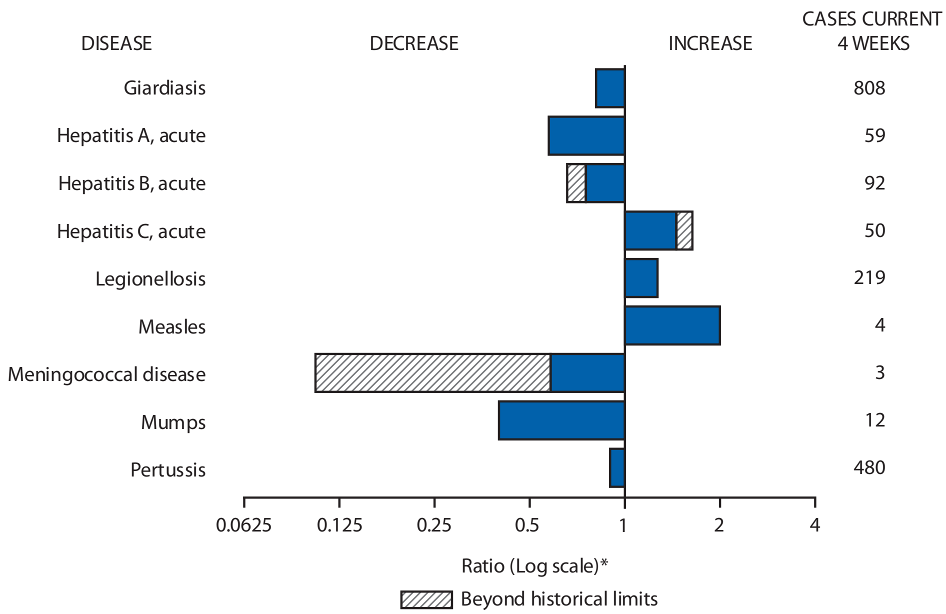
*** CDC discontinued reporting of individual confirmed and probable cases of 2009 pandemic influenza A (H1N1) virus infections on July 24, 2009. During 2009, four cases of human infection with novel influenza A viruses, different from the 2009 pandemic influenza A (H1N1) strain, were reported to CDC. The four cases of novel influenza A virus infection reported to CDC during 2010, and the six cases reported during 2011, were identified as swine influenza A (H3N2) virus and are unrelated to the 2009 pandemic influenza A (H1N1) virus. Total case counts for 2009 were provided by the Influenza Division, National Center for Immunization and Respiratory Diseases (NCIRD).

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

§§§ Updated weekly from reports to the Division of STD Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.

¶¶¶ There was one case of viral hemorrhagic fever reported during week 12 of 2010. The one case report was confirmed as lassa fever. See Table II for dengue hemorrhagic fever.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals September 10, 2011, with historical data



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

Notifiable Disease Data Team and 122 Cities Mortality Data Team

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TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending September 10, 2011, and September 11, 2010 (36th week)*

	Chlamydia trachomatis infection					Coccidioidomycosis					Cryptosporidiosis				
	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum
Reporting area	week	Med	Max	2011	2010	week	Med	Max	2011	2010	week	Med	Max	2011	2010
United States	10,093	25,821	31,142	887,446	888,678	71	335	567	12,060	NN	188	134	309	5,527	6,420
New England	764	846	2,043	30,186	28,093	—	0	1	1	NN	—	5	55	252	396
Connecticut	208	218	1,557	6,933	7,335	—	0	0	—	NN	—	0	49	49	77
Maine†	—	59	100	2,086	1,771	—	0	0	—	NN	—	1	4	35	79
Massachusetts	453	414	860	15,472	14,124	—	0	0	—	NN	—	3	7	89	125
New Hampshire	1	53	81	1,851	1,636	—	0	1	1	NN	—	1	5	46	48
Rhode Island†	76	76	154	2,849	2,378	—	0	0	—	NN	—	0	1	1	15
Vermont†	26	26	84	995	849	—	0	0	—	NN	—	1	4	32	52
Mid. Atlantic	1,287	3,312	5,069	108,150	116,316	—	0	1	3	NN	11	17	33	635	616
New Jersey	99	519	931	18,805	18,049	—	0	0	—	NN	—	0	4	20	34
New York (Upstate)	534	712	2,099	24,566	23,059	—	0	0	—	NN	6	4	15	150	150
New York City	—	1,102	2,612	29,549	42,711	—	0	0	—	NN	—	2	6	48	63
Pennsylvania	654	957	1,240	35,230	32,497	—	0	1	3	NN	5	9	26	417	369
E.N. Central	768	3,971	7,039	134,513	141,090	—	0	5	37	NN	100	32	120	1,607	1,826
Illinois	18	1,076	1,320	33,803	41,575	—	0	0	—	NN	—	3	23	121	257
Indiana	136	474	3,376	18,331	13,621	—	0	0	—	NN	—	4	14	166	210
Michigan	443	921	1,408	32,515	34,399	—	0	3	22	NN	2	5	13	213	246
Ohio	100	1,005	1,134	34,464	35,455	—	0	3	15	NN	96	9	89	717	327
Wisconsin	71	458	559	15,400	16,040	—	0	0	—	NN	2	8	50	390	786
W.N. Central	350	1,441	1,668	48,931	49,796	—	0	2	6	NN	43	19	88	945	1,391
Iowa	5	210	255	7,198	7,269	—	0	0	—	NN	—	7	18	273	299
Kansas	—	195	288	6,709	6,722	—	0	0	—	NN	—	0	3	15	85
Minnesota	—	282	368	7,876	10,744	—	0	0	—	NN	—	0	13	—	321
Missouri	311	530	759	19,302	17,847	—	0	0	—	NN	35	4	62	376	412
Nebraska†	26	108	218	4,270	3,463	—	0	2	6	NN	8	4	26	151	173
North Dakota	—	43	90	1,336	1,576	—	0	0	—	NN	—	0	9	16	16
South Dakota	8	63	93	2,240	2,175	—	0	0	—	NN	—	1	13	114	85
S. Atlantic	2,828	5,225	6,650	187,303	179,092	—	0	2	3	NN	13	21	37	818	762
Delaware	95	84	220	2,949	2,906	—	0	0	—	NN	—	0	1	7	6
District of Columbia	51	107	180	3,600	3,689	—	0	0	—	NN	—	0	1	5	3
Florida	663	1,494	1,706	52,544	52,463	—	0	0	—	NN	6	8	17	315	282
Georgia	500	981	2,384	35,339	30,665	—	0	0	—	NN	3	5	11	202	197
Maryland†	252	447	1,125	15,709	16,504	—	0	2	3	NN	2	1	6	48	31
North Carolina	—	811	1,477	31,924	30,775	—	0	0	—	NN	—	0	13	36	66
South Carolina†	497	516	946	19,416	17,997	—	0	0	—	NN	2	3	8	103	85
Virginia†	705	648	965	22,972	21,512	—	0	0	—	NN	—	2	8	86	79
West Virginia	65	79	121	2,850	2,581	—	0	0	—	NN	—	0	5	16	13
E.S. Central	594	1,804	3,314	65,051	63,527	—	0	0	—	NN	12	7	19	220	228
Alabama†	—	524	1,566	19,067	18,140	—	0	0	—	NN	—	3	14	84	112
Kentucky	253	267	2,352	10,818	10,793	—	0	0	—	NN	10	1	4	40	57
Mississippi	191	398	696	14,383	15,122	—	0	0	—	NN	—	0	4	27	14
Tennessee†	150	593	795	20,783	19,472	—	0	0	—	NN	2	1	6	69	45
W.S. Central	2,112	3,366	4,338	121,720	122,287	—	0	1	1	NN	1	7	62	262	300
Arkansas†	319	315	440	11,365	10,680	—	0	0	—	NN	—	0	3	12	25
Louisiana	113	520	1,052	15,743	17,801	—	0	1	1	NN	—	0	9	35	50
Oklahoma	24	226	850	7,408	10,034	—	0	0	—	NN	1	2	34	62	61
Texas†	1,656	2,400	3,107	87,204	83,772	—	0	0	—	NN	—	4	28	153	164
Mountain	658	1,650	2,155	58,881	57,577	59	267	432	9,582	NN	4	12	30	427	441
Arizona	81	512	698	17,531	18,831	58	265	427	9,465	NN	—	1	4	27	28
Colorado	296	414	845	16,200	13,378	—	0	0	—	NN	3	3	12	121	99
Idaho†	—	75	235	2,619	2,745	—	0	0	—	NN	—	2	9	84	73
Montana†	—	60	88	2,193	2,097	—	0	2	3	NN	1	1	6	54	38
Nevada†	150	201	380	7,496	7,021	1	1	5	67	NN	—	0	7	3	28
New Mexico†	131	195	1,183	7,170	7,540	—	0	4	34	NN	—	3	7	91	100
Utah	—	132	175	4,403	4,538	—	0	2	10	NN	—	1	5	27	55
Wyoming†	—	38	90	1,269	1,427	—	0	2	3	NN	—	0	5	20	20
Pacific	732	3,849	6,559	132,711	130,900	12	55	142	2,427	NN	4	11	29	361	460
Alaska	—	109	157	3,805	4,288	—	0	0	—	NN	—	0	3	7	3
California	239	2,936	5,763	102,217	100,050	12	55	142	2,422	NN	1	7	19	217	243
Hawaii	—	108	138	3,386	4,250	—	0	0	—	NN	—	0	0	—	1
Oregon	221	267	524	9,444	7,753	—	0	1	5	NN	—	2	11	83	149
Washington	272	423	522	13,859	14,559	—	0	0	—	NN	3	1	9	54	64
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	NN	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	NN	—	—	—	—	—
Guam	—	6	81	189	691	—	0	0	—	NN	—	0	0	—	—
Puerto Rico	66	102	349	3,704	4,263	—	0	0	—	NN	N	0	0	N	N
U.S. Virgin Islands	—	16	27	539	395	—	0	0	—	NN	—	0	0	—	—

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 10, 2011, and September 11, 2010 (36th week)*

	Dengue Virus Infection†									
	Dengue Fever§					Dengue Hemorrhagic Fever¶				
	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum
Reporting area	week	Med	Max	2011	2010	week	Med	Max	2011	2010
United States	—	3	22	82	548	—	0	2	—	9
New England	—	0	3	1	5	—	0	0	—	—
Connecticut	—	0	0	—	—	—	0	0	—	—
Maine**	—	0	2	—	3	—	0	0	—	—
Massachusetts	—	0	0	—	—	—	0	0	—	—
New Hampshire	—	0	0	—	—	—	0	0	—	—
Rhode Island**	—	0	1	—	—	—	0	0	—	—
Vermont**	—	0	1	1	2	—	0	0	—	—
Mid. Atlantic	—	1	9	22	189	—	0	1	—	5
New Jersey	—	0	3	—	25	—	0	0	—	—
New York (Upstate)	—	0	1	—	28	—	0	0	—	2
New York City	—	0	6	10	118	—	0	1	—	3
Pennsylvania	—	0	2	12	18	—	0	0	—	—
E.N. Central	—	0	4	6	51	—	0	0	—	1
Illinois	—	0	2	1	14	—	0	0	—	—
Indiana	—	0	1	1	11	—	0	0	—	—
Michigan	—	0	1	2	8	—	0	0	—	—
Ohio	—	0	1	—	13	—	0	0	—	—
Wisconsin	—	0	2	2	5	—	0	0	—	1
W.N. Central	—	0	6	4	22	—	0	1	—	—
Iowa	—	0	1	3	1	—	0	0	—	—
Kansas	—	0	1	1	3	—	0	0	—	—
Minnesota	—	0	1	—	13	—	0	0	—	—
Missouri	—	0	1	—	4	—	0	0	—	—
Nebraska**	—	0	6	—	—	—	0	0	—	—
North Dakota	—	0	0	—	1	—	0	0	—	—
South Dakota	—	0	0	—	—	—	0	1	—	—
S. Atlantic	—	1	10	29	194	—	0	1	—	2
Delaware	—	0	0	—	—	—	0	0	—	—
District of Columbia	—	0	0	—	—	—	0	0	—	—
Florida	—	1	8	25	150	—	0	1	—	2
Georgia	—	0	2	3	9	—	0	0	—	—
Maryland**	—	0	0	—	—	—	0	0	—	—
North Carolina	—	0	1	1	6	—	0	0	—	—
South Carolina**	—	0	0	—	13	—	0	0	—	—
Virginia**	—	0	2	—	14	—	0	0	—	—
West Virginia	—	0	0	—	2	—	0	0	—	—
E.S. Central	—	0	1	—	5	—	0	0	—	—
Alabama**	—	0	1	—	2	—	0	0	—	—
Kentucky	—	0	0	—	2	—	0	0	—	—
Mississippi	—	0	0	—	—	—	0	0	—	—
Tennessee**	—	0	0	—	1	—	0	0	—	—
W.S. Central	—	0	2	5	24	—	0	0	—	1
Arkansas**	—	0	0	—	—	—	0	0	—	1
Louisiana	—	0	1	2	4	—	0	0	—	—
Oklahoma	—	0	1	—	4	—	0	0	—	—
Texas**	—	0	1	3	16	—	0	0	—	—
Mountain	—	0	2	3	16	—	0	0	—	—
Arizona	—	0	2	2	6	—	0	0	—	—
Colorado	—	0	0	—	—	—	0	0	—	—
Idaho**	—	0	1	—	2	—	0	0	—	—
Montana**	—	0	1	—	3	—	0	0	—	—
Nevada**	—	0	0	—	4	—	0	0	—	—
New Mexico**	—	0	0	—	1	—	0	0	—	—
Utah	—	0	1	1	—	—	0	0	—	—
Wyoming**	—	0	0	—	—	—	0	0	—	—
Pacific	—	0	4	12	42	—	0	0	—	—
Alaska	—	0	0	—	1	—	0	0	—	—
California	—	0	2	2	29	—	0	0	—	—
Hawaii	—	0	4	5	—	—	0	0	—	—
Oregon	—	0	0	—	—	—	0	0	—	—
Washington	—	0	1	5	12	—	0	0	—	—
Territories										
American Samoa	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	29	453	608	8,172	—	0	10	9	190
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

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† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance).
§ Dengue Fever includes cases that meet criteria for Dengue Fever with hemorrhage, other clinical and unknown case classifications.
¶ DHF includes cases that meet criteria for dengue shock syndrome (DSS), a more severe form of DHF.
** Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 10, 2011, and September 11, 2010 (36th week)*

Reporting area	Ehrlichiosis/Anaplasmosis†														
	Ehrlichia chaffeensis					*Anaplasma phagocytophilum*					Undetermined				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	1	7	109	526	528	9	16	42	392	1,393	6	1	13	76	75
New England	—	0	2	4	3	—	2	15	106	74	—	0	1	1	2
Connecticut	—	0	0	—	—	—	0	6	—	31	—	0	0	—	—
Maine§	—	0	1	1	2	—	0	2	12	13	—	0	0	—	—
Massachusetts	—	0	0	—	—	—	0	10	49	—	—	0	0	—	—
New Hampshire	—	0	1	2	1	—	0	4	12	12	—	0	1	1	2
Rhode Island§	—	0	1	1	—	—	0	10	30	17	—	0	0	—	—
Vermont§	—	0	0	—	—	—	0	1	3	1	—	0	0	—	—
Mid. Atlantic	1	1	7	45	75	9	4	27	197	194	2	0	2	9	9
New Jersey	—	0	1	—	47	—	0	3	—	57	—	0	0	—	1
New York (Upstate)	1	0	7	40	22	9	3	25	170	127	2	0	2	9	6
New York City	—	0	1	5	5	—	0	5	25	10	—	0	0	—	—
Pennsylvania	—	0	1	—	1	—	0	1	2	—	—	0	1	—	2
E.N. Central	—	0	3	21	37	—	1	9	10	431	1	0	4	35	40
Illinois	—	0	2	11	12	—	0	1	3	5	—	0	1	2	3
Indiana	—	0	0	—	—	—	0	0	—	—	1	0	3	28	14
Michigan	—	0	2	4	2	—	0	1	—	3	—	0	2	3	—
Ohio	—	0	1	6	6	—	0	1	4	2	—	0	1	1	—
Wisconsin	—	0	1	—	17	—	0	9	3	421	—	0	1	1	23
W.N. Central	—	1	17	133	113	—	1	20	27	624	—	0	11	14	9
Iowa	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Kansas	—	0	1	2	6	—	0	1	1	1	—	0	0	—	—
Minnesota	—	0	12	—	—	—	0	20	1	613	—	0	11	—	—
Missouri	—	0	17	130	106	—	0	7	23	10	—	0	7	13	9
Nebraska§	—	0	1	—	1	—	0	0	—	—	—	0	1	1	—
North Dakota	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
South Dakota	—	0	1	1	—	—	0	1	2	—	—	0	0	—	—
S. Atlantic	—	3	33	186	201	—	1	8	40	50	—	0	1	5	4
Delaware	—	0	2	14	16	—	0	1	1	4	—	0	0	—	—
District of Columbia	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Florida	—	0	3	13	8	—	0	3	7	3	—	0	0	—	—
Georgia	—	0	3	16	19	—	0	2	7	1	—	0	1	1	1
Maryland§	—	0	3	19	18	—	0	2	3	12	—	0	0	—	2
North Carolina	—	0	17	55	70	—	0	6	17	20	—	0	0	—	—
South Carolina§	—	0	1	1	4	—	0	1	—	—	—	0	0	—	—
Virginia§	—	1	13	68	64	—	0	2	5	10	—	0	1	3	1
West Virginia	—	0	1	—	2	—	0	0	—	—	—	0	1	1	—
E.S. Central	—	0	7	56	79	—	0	2	10	18	3	0	1	9	8
Alabama§	—	0	1	—	10	—	0	1	3	7	N	0	0	N	N
Kentucky	—	0	2	9	13	—	0	0	—	—	—	0	0	—	1
Mississippi	—	0	1	3	3	—	0	0	—	2	—	0	0	—	1
Tennessee§	—	0	5	44	53	—	0	1	7	9	3	0	1	9	6
W.S. Central	—	0	87	81	19	—	0	9	1	2	—	0	0	—	1
Arkansas§	—	0	12	35	4	—	0	2	1	—	—	0	0	—	—
Louisiana	—	0	0	—	1	—	0	0	—	—	—	0	0	—	—
Oklahoma	—	0	82	45	11	—	0	7	—	2	—	0	0	—	—
Texas§	—	0	1	1	3	—	0	1	—	—	—	0	0	—	1
Mountain	—	0	0	—	—	—	0	0	—	—	—	0	1	3	—
Arizona	—	0	0	—	—	—	0	0	—	—	—	0	1	3	—
Colorado	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Idaho§	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Montana§	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Nevada§	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
New Mexico§	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Utah	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Wyoming§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Pacific	—	0	1	—	1	—	0	1	1	—	—	0	0	—	2
Alaska	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
California	—	0	1	—	1	—	0	0	—	—	—	0	0	—	2
Hawaii	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Oregon	—	0	0	—	—	—	0	1	1	—	—	0	0	—	—
Washington	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Territories															
American Samoa	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Puerto Rico	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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† Cumulative total E. ewingii cases reported for year 2010 = 10, and 11 cases reported for 2011.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 10, 2011, and September 11, 2010 (36th week)*

Reporting area	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive† All ages, all serotypes				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010
United States	199	288	545	9,609	13,458	2,490	5,812	7,484	200,193	209,090	18	64	141	2,225	2,124
New England	12	25	50	798	1,171	91	102	206	3,631	3,738	—	4	12	138	126
Connecticut	—	4	12	131	213	34	43	150	1,541	1,692	—	1	6	37	25
Maine§	7	3	11	113	142	—	3	17	146	124	—	0	2	15	10
Massachusetts	—	12	21	343	504	50	48	80	1,589	1,587	—	2	6	62	67
New Hampshire	—	2	6	69	128	2	2	7	91	103	—	0	2	10	8
Rhode Island§	—	0	10	39	49	4	7	16	228	186	—	0	2	9	10
Vermont§	5	2	8	103	135	1	0	8	36	46	—	0	3	5	6
Mid. Atlantic	34	57	103	1,886	2,249	290	718	1,121	24,196	24,036	8	13	32	500	400
New Jersey	—	6	20	132	326	21	128	215	4,883	3,862	—	2	7	77	73
New York (Upstate)	24	21	72	691	762	112	114	271	3,902	3,726	5	3	18	135	105
New York City	4	17	28	560	637	—	228	497	6,336	8,181	1	3	6	110	67
Pennsylvania	6	16	27	503	524	157	260	364	9,075	8,267	2	4	11	178	155
E.N. Central	29	47	93	1,553	2,322	282	1,011	2,091	35,161	38,695	4	11	22	391	345
Illinois	—	9	14	260	532	2	264	369	8,409	10,634	—	3	10	115	120
Indiana	—	6	14	181	285	38	114	1,018	4,427	3,842	—	2	7	71	68
Michigan	4	10	25	312	480	181	232	490	8,334	9,523	—	1	4	45	25
Ohio	25	16	29	551	574	43	319	392	10,900	11,329	4	2	7	110	85
Wisconsin	—	8	28	249	451	18	94	127	3,091	3,367	—	1	5	50	47
W.N. Central	16	25	73	745	1,465	112	298	363	10,229	10,047	—	4	10	112	155
Iowa	6	5	15	190	208	1	37	53	1,286	1,216	—	0	0	—	1
Kansas	—	2	7	62	164	—	40	57	1,348	1,430	—	0	2	16	16
Minnesota	—	0	30	—	575	—	37	52	1,088	1,502	—	0	5	—	55
Missouri	6	8	26	284	271	99	147	182	5,185	4,694	—	1	5	59	60
Nebraska§	4	4	11	138	162	12	24	49	844	794	—	1	3	25	14
North Dakota	—	0	12	22	15	—	4	8	125	138	—	0	6	11	9
South Dakota	—	1	6	49	70	—	10	20	353	273	—	0	1	1	—
S. Atlantic	40	54	127	1,835	2,668	794	1,464	1,862	50,060	53,211	5	15	31	537	548
Delaware	—	0	2	20	24	16	17	48	567	665	—	0	2	3	5
District of Columbia	—	1	3	26	42	12	38	69	1,299	1,442	—	0	1	—	3
Florida	20	24	75	820	1,432	177	379	486	13,440	14,141	5	5	12	176	130
Georgia	4	13	51	519	523	206	313	874	10,721	10,595	—	3	7	101	124
Maryland§	13	4	11	180	199	64	118	246	3,763	4,833	—	2	5	59	46
North Carolina	N	0	0	N	N	—	272	468	10,333	10,310	—	1	8	54	95
South Carolina§	3	2	7	79	105	172	144	257	5,479	5,526	—	1	5	56	67
Virginia§	—	7	32	169	318	129	109	185	3,888	5,350	—	2	8	74	62
West Virginia	—	0	8	22	25	18	15	29	570	349	—	0	9	14	16
E.S. Central	—	4	11	105	137	158	495	1,007	17,649	17,231	—	3	11	136	127
Alabama§	—	4	11	105	137	—	159	410	5,768	5,272	—	1	4	40	21
Kentucky	N	0	0	N	N	76	68	712	2,958	2,822	—	0	4	20	24
Mississippi	N	0	0	N	N	52	118	197	3,925	4,249	—	0	3	12	10
Tennessee§	N	0	0	N	N	30	142	204	4,998	4,888	—	2	5	64	72
W.S. Central	5	5	17	169	271	532	911	1,319	31,324	33,534	—	3	26	99	97
Arkansas§	5	3	9	84	79	83	95	138	3,387	3,226	—	0	3	24	14
Louisiana	—	3	12	85	130	23	143	372	4,444	5,465	—	1	4	36	20
Oklahoma	—	0	0	—	62	4	61	254	2,132	2,965	—	1	19	38	56
Texas§	N	0	0	N	N	422	595	867	21,361	21,878	—	0	4	1	7
Mountain	25	26	51	868	1,235	100	191	253	6,987	6,600	1	5	12	188	229
Arizona	1	3	8	89	109	15	69	110	2,585	2,213	—	2	6	73	84
Colorado	19	12	24	423	497	43	45	89	1,542	1,878	1	1	5	46	66
Idaho§	2	3	9	102	143	—	2	14	82	77	—	0	2	14	12
Montana§	3	2	5	51	78	—	1	4	48	79	—	0	1	2	2
Nevada§	—	1	7	35	74	35	34	103	1,432	1,277	—	0	2	12	6
New Mexico§	—	1	6	54	74	7	28	98	1,115	811	—	1	4	27	28
Utah	—	3	10	97	226	—	4	9	158	240	—	0	3	13	26
Wyoming§	—	0	5	17	34	—	0	3	25	25	—	0	1	1	5
Pacific	38	49	128	1,650	1,940	131	611	791	20,956	21,998	—	4	10	124	97
Alaska	—	2	7	58	69	—	20	34	676	928	—	0	3	19	17
California	15	32	67	1,114	1,178	85	493	695	17,219	17,964	—	0	6	29	16
Hawaii	—	0	4	23	44	—	13	26	441	512	—	0	3	17	17
Oregon	6	7	20	219	351	17	24	40	918	701	—	2	6	56	42
Washington	17	8	57	236	298	29	52	86	1,702	1,893	—	0	2	3	5
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	—	3	—	0	17	6	72	—	0	0	—	—
Puerto Rico	—	1	7	28	63	8	6	14	231	201	—	0	0	—	1
U.S. Virgin Islands	—	0	0	—	—	—	2	7	83	101	—	0	0	—	—

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† 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 September 10, 2011, and September 11, 2010 (36th week)*

	Hepatitis (viral, acute), by type														
	A					B					C				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
Reporting area		Med	Max				Med	Max				Med	Max		
United States	11	23	74	748	1,104	24	49	167	1,571	2,259	18	17	39	656	569
New England	—	1	4	37	79	—	1	8	46	42	—	1	4	40	39
Connecticut	—	0	3	9	21	—	0	4	10	16	—	0	3	25	25
Maine†	—	0	2	4	7	—	0	2	6	11	—	0	2	6	2
Massachusetts	—	0	2	16	42	—	0	6	29	8	—	0	2	5	12
New Hampshire	—	0	1	—	—	—	0	1	1	5	N	0	0	N	N
Rhode Island†	—	0	1	3	9	U	0	0	U	U	U	0	0	U	U
Vermont†	—	0	2	5	—	—	0	0	—	2	—	0	1	4	—
Mid. Atlantic	1	4	12	138	178	3	5	12	184	215	—	1	6	55	75
New Jersey	—	1	4	18	52	—	1	4	32	58	—	0	4	1	17
New York (Upstate)	—	1	4	33	37	1	1	9	34	35	—	0	4	31	36
New York City	—	1	6	47	53	—	1	5	56	67	—	0	0	—	3
Pennsylvania	1	1	3	40	36	2	2	4	62	55	—	0	3	23	19
E.N. Central	1	4	9	130	136	3	5	37	234	363	2	3	12	126	66
Illinois	—	1	3	32	37	—	1	6	50	93	—	0	1	5	—
Indiana	—	0	3	11	11	—	1	3	31	53	—	0	5	44	24
Michigan	—	1	6	53	46	—	1	6	61	96	2	2	7	72	28
Ohio	1	1	5	29	28	3	1	30	72	82	—	0	1	4	8
Wisconsin	—	0	2	5	14	—	0	3	20	39	—	0	1	1	6
W.N. Central	—	1	25	32	59	—	2	16	93	81	—	0	6	6	11
Iowa	—	0	3	4	9	—	0	1	7	12	—	0	0	—	—
Kansas	—	0	2	3	10	—	0	2	9	6	—	0	1	2	—
Minnesota	—	0	22	9	13	—	0	15	9	6	—	0	6	2	6
Missouri	—	0	1	10	16	—	2	5	56	47	—	0	1	—	3
Nebraska†	—	0	3	4	10	—	0	3	11	9	—	0	1	2	2
North Dakota	—	0	3	—	—	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	2	2	1	—	0	1	1	1	—	0	0	—	—
S. Atlantic	5	5	13	155	243	11	12	33	405	624	4	4	11	158	127
Delaware	—	0	1	2	6	—	0	1	—	20	U	0	0	U	U
District of Columbia	—	0	0	—	1	—	0	0	—	3	—	0	0	—	2
Florida	3	1	6	49	96	4	4	11	139	212	4	1	5	39	36
Georgia	—	1	4	31	27	1	2	8	61	124	—	1	3	26	17
Maryland†	1	0	4	21	16	—	1	4	39	44	—	0	2	28	18
North Carolina	1	0	3	18	39	5	2	12	82	69	—	1	7	39	30
South Carolina†	—	0	2	9	22	—	1	4	22	40	—	0	1	1	1
Virginia†	—	1	4	17	34	1	1	7	43	65	—	0	2	9	9
West Virginia	—	0	5	8	2	—	0	18	19	47	—	0	6	16	14
E.S. Central	—	0	6	32	30	2	9	14	283	247	3	3	7	113	107
Alabama†	—	0	2	1	5	—	2	4	63	47	—	0	1	7	5
Kentucky	—	0	6	7	13	—	2	6	77	86	2	1	6	47	73
Mississippi	—	0	1	6	2	—	1	3	31	22	U	0	0	U	U
Tennessee†	—	0	5	18	10	2	3	7	112	92	1	1	5	59	29
W.S. Central	1	3	15	73	90	5	7	67	192	377	4	2	11	65	50
Arkansas†	—	0	1	—	1	—	1	4	29	45	—	0	0	—	1
Louisiana	—	0	1	2	6	—	1	4	22	42	—	0	2	5	2
Oklahoma	—	0	4	3	1	1	1	16	47	69	1	1	10	34	18
Texas†	1	2	11	68	82	4	3	45	94	221	3	0	3	26	29
Mountain	—	1	5	50	116	—	2	5	53	101	1	1	4	39	46
Arizona	—	0	2	13	50	—	0	3	11	16	U	0	0	U	U
Colorado	—	0	2	17	31	—	0	3	15	34	1	0	3	14	10
Idaho†	—	0	1	6	6	—	0	1	2	6	—	0	2	7	8
Montana†	—	0	1	2	4	—	0	0	—	—	—	0	1	3	2
Nevada†	—	0	3	5	12	—	0	3	16	33	—	0	1	5	4
New Mexico†	—	0	1	4	3	—	0	2	5	4	—	0	1	7	12
Utah	—	0	2	1	7	—	0	1	4	7	—	0	1	1	10
Wyoming†	—	0	1	2	3	—	0	1	—	1	—	0	1	2	—
Pacific	3	3	15	101	173	—	3	25	81	209	4	1	12	54	48
Alaska	—	0	1	2	1	—	0	1	4	2	U	0	0	U	U
California	2	2	15	73	136	—	1	22	32	142	—	1	4	22	20
Hawaii	—	0	2	7	6	—	0	1	5	4	U	0	0	U	U
Oregon	—	0	2	4	15	—	0	4	24	32	—	0	3	11	11
Washington	1	0	4	15	15	—	0	4	16	29	4	0	5	21	17
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	5	8	4	—	0	8	28	64	—	0	8	10	52
Puerto Rico	—	0	2	4	11	—	0	3	6	16	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 10, 2011, and September 11, 2010 (36th week)*

Reporting area	Legionellosis					Lyme disease					Malaria				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	60	53	128	1,912	2,228	280	361	1,575	19,475	23,746	15	27	114	872	1,164
New England	1	4	15	118	181	—	73	290	3,268	7,182	—	1	20	50	78
Connecticut	—	1	6	25	29	—	33	173	1,438	2,439	—	0	20	6	2
Maine†	—	0	3	7	10	—	10	58	316	481	—	0	1	2	5
Massachusetts	—	2	9	58	93	—	16	62	494	2,822	—	1	5	33	61
New Hampshire	—	0	3	11	15	—	12	60	513	1,058	—	0	2	2	2
Rhode Island†	—	0	4	9	26	—	1	35	109	117	—	0	4	2	6
Vermont†	1	0	1	8	8	—	5	62	398	265	—	0	1	5	2
Mid. Atlantic	39	15	53	572	573	255	150	1,140	12,705	8,410	2	7	18	183	354
New Jersey	—	2	18	73	92	52	51	541	5,078	2,964	—	0	6	8	79
New York (Upstate)	22	5	19	199	172	115	35	214	2,436	1,871	2	1	6	29	53
New York City	—	3	17	91	105	—	1	18	39	545	—	3	12	107	181
Pennsylvania	17	5	19	209	204	88	62	476	5,152	3,030	—	1	4	39	41
E.N. Central	7	10	49	449	493	2	21	87	924	3,304	—	3	7	99	123
Illinois	—	1	6	52	121	—	1	18	95	119	—	1	4	38	48
Indiana	—	1	5	65	43	—	0	15	76	75	—	0	2	6	10
Michigan	—	2	13	94	125	1	0	10	65	82	—	0	4	19	25
Ohio	7	4	34	237	155	1	1	9	40	22	—	1	4	30	31
Wisconsin	—	0	4	1	49	—	16	63	648	3,006	—	0	2	6	9
W.N. Central	1	2	9	55	82	—	3	32	84	1,857	—	1	45	22	51
Iowa	—	0	2	7	13	—	0	11	63	78	—	0	3	14	10
Kansas	—	0	2	5	7	—	0	2	8	10	—	0	2	6	8
Minnesota	—	0	8	—	23	—	0	31	—	1,748	—	0	45	—	3
Missouri	1	1	5	37	23	—	0	0	—	4	—	0	2	—	15
Nebraska†	—	0	1	3	8	—	0	2	7	8	—	0	1	2	13
North Dakota	—	0	1	1	3	—	0	10	4	8	—	0	1	—	—
South Dakota	—	0	2	2	5	—	0	1	2	1	—	0	1	—	2
S. Atlantic	4	9	22	300	377	17	52	162	2,268	2,718	9	8	20	304	305
Delaware	—	0	2	8	13	1	10	43	592	524	1	0	1	4	2
District of Columbia	—	0	3	9	14	—	0	2	11	32	—	0	1	5	10
Florida	2	3	9	107	115	1	2	8	83	56	2	2	7	76	90
Georgia	1	1	4	27	41	—	0	3	15	9	1	1	5	57	54
Maryland†	1	1	6	49	86	5	18	103	762	1,143	4	1	10	76	62
North Carolina	—	1	7	47	43	2	0	8	51	60	—	0	6	33	32
South Carolina†	—	0	3	12	10	1	0	6	22	27	—	0	1	3	3
Virginia†	—	1	9	35	45	7	18	76	684	782	1	1	8	50	50
West Virginia	—	0	2	6	10	—	0	14	48	85	—	0	1	—	2
E.S. Central	1	2	10	103	100	1	1	3	35	37	1	0	3	22	23
Alabama†	—	0	2	10	13	—	0	2	7	2	—	0	1	3	5
Kentucky	—	0	3	21	20	—	0	1	—	5	—	0	1	6	6
Mississippi	—	0	3	10	12	—	0	1	1	—	—	0	1	1	2
Tennessee†	1	1	8	62	55	1	0	3	27	30	1	0	3	12	10
W.S. Central	—	2	13	78	116	1	1	29	29	82	1	1	18	25	66
Arkansas†	—	0	2	7	14	—	0	0	—	—	—	0	1	3	4
Louisiana	—	0	3	13	6	—	0	1	1	3	—	0	1	1	2
Oklahoma	—	0	3	7	11	—	0	0	—	—	1	0	1	4	5
Texas†	—	2	11	51	85	1	1	29	28	79	—	0	17	17	55
Mountain	—	2	5	59	127	3	0	4	28	22	1	1	4	50	45
Arizona	—	1	3	21	43	1	0	2	8	2	1	0	4	20	20
Colorado	—	0	2	4	23	—	0	1	1	2	—	0	3	18	15
Idaho†	—	0	1	4	4	—	0	2	2	8	—	0	1	2	1
Montana†	—	0	1	—	4	2	0	2	7	2	—	0	1	1	2
Nevada†	—	0	2	11	18	—	0	1	3	—	—	0	2	6	3
New Mexico†	—	0	1	5	7	—	0	2	5	5	—	0	1	2	1
Utah	—	0	2	12	21	—	0	1	1	3	—	0	1	1	3
Wyoming†	—	0	1	2	7	—	0	1	1	—	—	0	0	—	—
Pacific	7	5	21	178	179	1	3	11	134	134	1	4	10	117	119
Alaska	—	0	0	—	2	—	0	2	6	6	—	0	2	4	3
California	7	4	15	155	151	1	3	9	110	83	—	2	8	81	79
Hawaii	—	0	1	1	1	N	0	0	N	N	—	0	1	5	2
Oregon	—	0	3	10	10	—	0	2	12	38	—	0	4	11	9
Washington	—	0	6	12	15	—	0	4	6	7	1	0	5	16	26
Territories															
American Samoa	N	0	0	N	N	N	0	0	N	N	—	0	1	1	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	1	—	1	N	0	0	N	N	—	0	1	—	5
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 10, 2011, and September 11, 2010 (36th week)*

Reporting area	Meningococcal disease, invasive[†] All serogroups					Mumps					Pertussis				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	—	14	53	492	560	1	7	47	195	2,360	162	301	2,925	9,025	14,394
New England	—	0	3	23	14	—	0	1	5	24	1	8	22	290	352
Connecticut	—	0	1	3	2	—	0	0	—	11	—	1	8	30	75
Maine[§]	—	0	1	3	3	—	0	1	—	1	1	2	8	89	35
Massachusetts	—	0	2	11	4	—	0	1	3	9	—	4	10	99	191
New Hampshire	—	0	1	1	—	—	0	0	—	3	—	1	7	45	12
Rhode Island[§]	—	0	1	—	—	—	0	1	1	—	—	0	4	17	28
Vermont[§]	—	0	3	5	5	—	0	1	1	—	—	0	3	10	11
Mid. Atlantic	—	1	6	58	57	—	1	23	23	2,043	37	34	125	1,022	925
New Jersey	—	0	1	5	18	—	0	2	8	337	—	2	7	77	119
New York (Upstate)	—	0	4	18	9	—	0	3	5	655	34	13	81	445	316
New York City	—	0	3	22	14	—	0	22	9	1,031	—	0	19	38	57
Pennsylvania	—	0	2	13	16	—	0	16	1	20	3	15	70	462	433
E.N. Central	—	2	7	67	95	—	1	7	51	46	21	63	198	1,878	3,269
Illinois	—	0	3	20	19	—	1	3	30	16	—	15	50	471	572
Indiana	—	0	2	11	22	—	0	1	—	3	—	4	26	131	470
Michigan	—	0	4	7	15	—	0	1	7	17	—	22	57	484	927
Ohio	—	1	2	20	23	—	0	5	11	9	20	17	80	536	1,019
Wisconsin	—	0	2	9	16	—	0	1	3	1	1	10	26	256	281
W.N. Central	—	1	4	33	39	1	0	4	28	79	5	23	501	791	1,389
Iowa	—	0	1	8	8	—	0	1	5	37	—	6	36	132	367
Kansas	—	0	1	2	6	—	0	1	4	4	—	2	10	68	129
Minnesota	—	0	2	—	3	—	0	4	1	4	—	0	469	295	430
Missouri	—	0	2	12	16	1	0	3	10	9	3	6	43	202	274
Nebraska[§]	—	0	2	8	5	—	0	1	4	23	1	1	13	41	130
North Dakota	—	0	1	1	1	—	0	3	4	—	1	0	10	37	32
South Dakota	—	0	1	2	—	—	0	0	—	2	—	0	5	16	27
S. Atlantic	—	2	8	98	104	—	0	3	19	45	12	31	106	935	1,191
Delaware	—	0	1	1	—	—	0	0	—	—	—	0	5	21	9
District of Columbia	—	0	1	1	1	—	0	0	—	3	—	0	2	3	6
Florida	—	1	5	38	48	—	0	2	5	8	11	6	17	239	228
Georgia	—	0	1	11	8	—	0	2	4	2	—	3	13	120	177
Maryland[§]	—	0	1	10	6	—	0	1	1	9	1	2	6	53	91
North Carolina	—	0	3	13	12	—	0	2	7	7	—	3	35	127	225
South Carolina[§]	—	0	1	9	10	—	0	0	—	4	—	3	25	99	271
Virginia[§]	—	0	2	10	17	—	0	2	2	10	—	7	41	221	147
West Virginia	—	0	3	5	2	—	0	0	—	2	—	0	41	52	37
E.S. Central	—	0	3	20	28	—	0	1	3	9	2	9	28	242	550
Alabama[§]	—	0	2	9	5	—	0	1	1	6	—	3	11	89	152
Kentucky	—	0	2	2	12	—	0	0	—	1	—	1	16	55	181
Mississippi	—	0	1	2	3	—	0	1	2	—	—	1	10	22	56
Tennessee[§]	—	0	2	7	8	—	0	1	—	2	2	2	10	76	161
W.S. Central	—	1	12	39	60	—	1	15	48	66	4	23	297	630	2,069
Arkansas[§]	—	0	1	8	5	—	0	1	1	5	—	1	16	38	166
Louisiana	—	0	2	8	12	—	0	2	—	5	—	0	3	15	30
Oklahoma	—	0	2	7	14	—	0	1	1	—	—	0	92	25	39
Texas[§]	—	0	10	16	29	—	1	14	46	56	4	20	187	552	1,834
Mountain	—	1	4	34	44	—	0	4	6	14	4	43	100	1,246	980
Arizona	—	0	1	10	11	—	0	0	—	5	—	14	29	525	306
Colorado	—	0	1	8	15	—	0	1	3	7	4	9	63	285	148
Idaho[§]	—	0	1	4	5	—	0	1	1	—	—	2	15	95	127
Montana[§]	—	0	2	3	1	—	0	0	—	—	—	2	16	70	40
Nevada[§]	—	0	1	1	8	—	0	1	—	—	—	0	5	18	22
New Mexico[§]	—	0	1	1	3	—	0	2	2	—	—	2	10	84	88
Utah	—	0	2	7	1	—	0	1	—	2	—	5	16	164	240
Wyoming[§]	—	0	1	—	—	—	0	1	—	—	—	0	2	5	9
Pacific	—	3	26	120	119	—	0	3	12	34	76	68	1,710	1,991	3,669
Alaska	—	0	1	2	1	—	0	1	1	1	—	0	6	19	28
California	—	2	17	87	76	—	0	3	5	22	1	53	1,569	1,389	3,134
Hawaii	—	0	1	4	1	—	0	1	2	3	—	1	9	68	58
Oregon	—	0	3	15	24	—	0	1	4	2	2	5	11	185	218
Washington	—	0	8	12	17	—	0	1	—	6	73	9	131	330	231
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	2	9	12	435	—	0	14	31	2
Puerto Rico	—	0	1	—	1	—	0	1	1	1	—	0	1	2	1
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
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† Data for meningococcal disease, invasive caused by serogroups A, C, Y, and 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 September 10, 2011, and September 11, 2010 (36th week)*

Reporting area	Rabies, animal					Salmonellosis					Shiga toxin-producing *E. coli* (STEC)†				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010
United States	32	54	119	1,769	3,205	617	928	1,639	29,157	35,070	43	96	264	3,175	3,543
New England	—	3	13	123	227	2	27	351	1,266	1,869	1	2	36	135	171
Connecticut	—	0	9	28	103	—	0	330	330	491	—	0	36	36	60
Maine§	—	1	6	48	45	2	2	8	93	89	—	0	3	22	15
Massachusetts	—	0	0	—	—	—	17	38	554	964	—	1	10	44	64
New Hampshire	—	0	3	15	15	—	3	8	119	137	1	0	3	18	18
Rhode Island§	—	0	4	15	24	—	1	62	128	138	—	0	2	4	2
Vermont§	—	1	2	17	40	—	1	5	42	50	—	0	3	11	12
Mid. Atlantic	8	13	29	433	790	59	93	182	3,334	4,181	5	10	25	394	399
New Jersey	—	0	0	—	—	—	12	35	322	860	—	2	6	58	92
New York (Upstate)	8	7	20	255	379	39	25	66	930	979	4	4	12	147	129
New York City	—	0	4	9	134	3	21	45	766	946	—	1	6	58	51
Pennsylvania	—	6	17	169	277	17	32	110	1,316	1,396	1	3	15	131	127
E.N. Central	8	2	16	136	207	39	87	145	3,006	4,370	6	12	36	524	630
Illinois	2	1	6	44	105	—	28	57	1,016	1,468	—	2	8	90	119
Indiana	—	0	5	16	—	—	10	23	308	566	—	2	7	80	101
Michigan	—	1	6	41	59	6	13	33	520	701	1	2	15	109	123
Ohio	6	0	3	35	43	33	21	47	852	968	5	2	10	125	110
Wisconsin	N	0	0	N	N	—	9	44	310	667	—	3	12	120	177
W.N. Central	7	2	40	64	205	37	47	87	1,591	2,135	10	13	39	500	657
Iowa	—	0	1	—	22	—	9	21	315	393	—	2	15	133	133
Kansas	1	0	4	24	48	5	7	20	283	318	1	1	8	66	51
Minnesota	—	0	34	—	25	—	0	17	—	556	—	0	9	—	221
Missouri	—	0	2	—	57	31	16	43	681	560	7	4	14	180	174
Nebraska§	3	0	3	29	43	1	4	13	165	172	2	1	7	77	51
North Dakota	3	0	6	11	10	—	0	15	30	26	—	0	10	10	5
South Dakota	—	0	0	—	—	—	3	17	117	110	—	1	4	34	22
S. Atlantic	8	18	85	762	831	313	279	710	8,852	9,265	6	14	29	442	467
Delaware	—	0	0	—	—	—	3	9	112	121	—	0	2	11	4
District of Columbia	—	0	0	—	—	—	1	4	38	76	—	0	1	3	8
Florida	—	0	76	76	121	167	107	226	3,497	3,773	4	3	15	96	143
Georgia	—	0	0	—	—	36	42	121	1,584	1,862	—	2	8	82	73
Maryland§	—	6	14	204	264	18	18	37	632	756	2	1	8	30	67
North Carolina	—	0	0	—	—	60	34	251	1,310	848	—	2	11	84	44
South Carolina§	N	0	0	N	N	22	30	99	946	958	—	0	4	14	17
Virginia§	8	11	27	419	393	10	21	68	691	738	—	3	9	119	97
West Virginia	—	0	30	63	53	—	0	14	42	133	—	0	4	3	14
E.S. Central	—	2	7	75	140	15	60	168	2,279	2,503	1	5	22	197	178
Alabama§	—	1	7	51	58	—	16	57	555	662	—	1	15	65	37
Kentucky	—	0	2	10	16	1	9	32	278	375	—	1	5	29	44
Mississippi	—	0	1	1	—	3	21	59	808	785	—	0	12	17	12
Tennessee§	—	0	4	13	66	11	17	50	638	681	1	2	11	86	85
W.S. Central	—	1	31	53	611	58	133	515	3,722	4,280	—	7	151	214	203
Arkansas§	—	0	10	41	22	30	14	46	520	463	—	0	3	28	41
Louisiana	—	0	0	—	—	—	14	52	505	892	—	0	2	6	14
Oklahoma	—	0	20	12	40	23	11	95	431	404	—	1	55	38	16
Texas§	—	0	30	—	549	5	87	381	2,266	2,521	—	5	95	142	132
Mountain	—	0	5	22	51	26	47	91	1,648	2,052	4	11	30	372	440
Arizona	N	0	0	N	N	6	14	39	501	686	1	2	14	63	42
Colorado	—	0	0	—	—	14	10	24	403	421	1	3	11	85	165
Idaho§	—	0	2	2	8	3	3	8	108	121	1	3	6	71	57
Montana§	N	0	0	N	N	1	2	10	92	73	1	1	5	34	29
Nevada§	—	0	2	4	5	2	3	11	98	231	—	0	7	26	27
New Mexico§	—	0	2	10	9	—	6	19	199	222	—	1	6	27	33
Utah	—	0	2	6	7	—	6	15	201	252	—	1	7	53	69
Wyoming§	—	0	4	—	22	—	1	9	46	46	—	0	3	13	18
Pacific	1	3	15	101	143	68	109	288	3,459	4,415	10	13	46	397	398
Alaska	—	0	2	9	11	—	1	6	44	62	—	0	1	1	2
California	—	3	8	84	119	38	80	232	2,642	3,213	5	8	36	260	170
Hawaii	—	0	0	—	—	7	6	14	237	241	1	0	1	6	27
Oregon	1	0	2	8	13	—	6	14	166	400	2	1	11	51	69
Washington	—	0	14	—	—	23	12	42	370	499	2	2	16	79	130
Territories															
American Samoa	N	0	0	N	N	—	0	0	—	2	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	3	6	8	—	0	0	—	—
Puerto Rico	—	0	6	24	33	—	5	25	127	400	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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† 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 September 10, 2011, and September 11, 2010 (36th week)*

Reporting area	Shigellosis					Spotted Fever Rickettsiosis (including RMSF)[†] Confirmed					Spotted Fever Rickettsiosis (including RMSF)[†] Probable				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010
United States	119	224	742	7,102	9,659	1	2	16	124	106	13	25	245	1,195	1,137
New England	—	3	29	133	281	—	0	0	—	—	—	0	1	3	2
Connecticut	—	0	28	28	69	—	0	0	—	—	—	0	0	—	—
Maine[§]	—	0	4	19	5	—	0	0	—	—	—	0	1	—	1
Massachusetts	—	2	6	76	186	—	0	0	—	—	—	0	1	1	—
New Hampshire	—	0	2	1	9	—	0	0	—	—	—	0	1	1	1
Rhode Island[§]	—	0	4	6	11	—	0	0	—	—	—	0	1	1	—
Vermont[§]	—	0	1	3	1	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	12	14	74	460	1,293	—	0	2	11	2	—	1	5	27	78
New Jersey	—	2	10	51	298	—	0	0	—	1	—	0	3	—	45
New York (Upstate)	10	3	18	165	162	—	0	1	3	1	—	0	2	5	10
New York City	2	4	10	164	230	—	0	0	—	—	—	0	2	12	11
Pennsylvania	—	3	56	80	603	—	0	2	8	—	—	0	3	10	12
E.N. Central	8	16	40	505	1,250	—	0	2	4	3	1	1	6	69	69
Illinois	—	5	10	115	722	—	0	1	—	2	—	0	2	23	31
Indiana[§]	—	1	4	40	46	—	0	0	—	1	1	0	4	35	19
Michigan	2	3	10	116	188	—	0	1	1	—	—	0	1	—	1
Ohio	6	5	27	234	236	—	0	2	3	—	—	0	2	11	12
Wisconsin	—	0	4	—	58	—	0	0	—	—	—	0	1	—	6
W.N. Central	2	9	38	218	1,722	—	0	7	24	11	2	4	30	264	221
Iowa	—	0	4	12	40	—	0	0	—	—	—	0	2	4	5
Kansas[§]	—	2	12	39	200	—	0	0	—	—	—	0	0	—	—
Minnesota	—	0	4	—	41	—	0	0	—	—	—	0	2	—	—
Missouri	2	5	18	155	1,407	—	0	4	17	8	2	4	30	257	213
Nebraska[§]	—	0	10	8	27	—	0	3	5	3	—	0	1	3	2
North Dakota	—	0	0	—	—	—	0	1	2	—	—	0	0	—	1
South Dakota	—	0	2	4	7	—	0	0	—	—	—	0	0	—	—
S. Atlantic	56	68	133	2,565	1,619	1	1	8	67	67	7	6	53	345	343
Delaware[§]	—	0	1	3	36	—	0	1	1	1	—	0	4	15	17
District of Columbia	—	0	2	10	25	—	0	1	1	—	—	0	1	1	—
Florida[§]	44	42	98	1,849	694	—	0	1	3	2	1	0	2	8	7
Georgia	8	12	26	380	521	—	0	5	36	48	—	0	0	—	—
Maryland[§]	2	2	5	67	92	—	0	1	2	—	1	0	3	19	33
North Carolina	2	4	36	151	106	—	0	4	12	12	5	1	49	199	176
South Carolina[§]	—	1	4	36	51	1	0	2	9	1	—	0	2	15	12
Virginia[§]	—	2	8	65	93	—	0	1	3	3	—	2	8	85	98
West Virginia	—	0	66	4	1	—	0	0	—	—	—	0	1	3	—
E.S. Central	5	13	29	384	510	—	0	3	4	16	2	5	18	251	317
Alabama[§]	—	4	15	116	114	—	0	1	—	4	—	0	5	28	61
Kentucky	5	1	6	44	189	—	0	1	1	6	—	0	0	—	—
Mississippi	—	2	9	105	37	—	0	0	—	1	—	0	4	9	17
Tennessee[§]	—	4	14	119	170	—	0	2	3	5	2	4	18	214	239
W.S. Central	16	59	503	1,687	1,733	—	0	8	3	1	1	1	235	208	96
Arkansas[§]	—	2	7	48	39	—	0	2	2	—	1	0	37	181	61
Louisiana	—	5	19	154	186	—	0	0	—	—	—	0	1	3	2
Oklahoma	1	2	161	67	200	—	0	5	1	—	—	0	202	21	17
Texas[§]	15	49	338	1,418	1,308	—	0	1	—	1	—	0	5	3	16
Mountain	13	15	32	504	529	—	0	5	11	2	—	0	6	28	10
Arizona	5	6	19	174	287	—	0	4	11	—	—	0	6	15	1
Colorado[§]	5	2	8	71	66	—	0	1	—	—	—	0	1	2	—
Idaho[§]	1	0	3	15	18	—	0	0	—	—	—	0	1	1	4
Montana[§]	—	1	15	115	7	—	0	0	—	2	—	0	1	1	1
Nevada[§]	2	0	6	19	23	—	0	0	—	—	—	0	0	—	—
New Mexico[§]	—	3	9	76	95	—	0	0	—	—	—	0	1	1	1
Utah	—	1	4	32	33	—	0	0	—	—	—	0	1	1	3
Wyoming[§]	—	0	1	2	—	—	0	0	—	—	—	0	2	7	—
Pacific	7	21	63	646	722	—	0	2	—	4	—	0	0	—	1
Alaska	—	0	2	5	1	N	0	0	N	N	N	0	0	N	N
California	6	17	59	521	569	—	0	2	—	4	—	0	0	—	—
Hawaii	—	1	3	39	36	N	0	0	N	N	N	0	0	N	N
Oregon	1	1	4	28	41	—	0	0	—	—	—	0	0	—	1
Washington	—	1	8	53	75	—	0	1	—	—	—	0	0	—	—
Territories															
American Samoa	—	1	1	1	1	N	0	0	N	N	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	1	5	N	0	0	N	N	N	0	0	N	N
Puerto Rico	—	0	1	—	4	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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† Illnesses with similar clinical presentation that result from Spotted fever group rickettsia infections are reported as Spotted fever rickettsioses. Rocky Mountain spotted fever (RMSF) caused by Rickettsia rickettsii, is the most common and well-known spotted fever.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 10, 2011, and September 11, 2010 (36th week)*

Reporting area	*Streptococcus pneumoniae*,† invasive disease — All ages: Current week	Previous 52 weeks: Med	Previous 52 weeks: Max	Cum 2011	Cum 2010	*Streptococcus pneumoniae*,† invasive disease — Age <5: Current week	Previous 52 weeks: Med	Previous 52 weeks: Max	Cum 2011	Cum 2010	Syphilis, primary and secondary: Current week	Previous 52 weeks: Med	Previous 52 weeks: Max	Cum 2011	Cum 2010
United States	66	298	937	9,806	10,750	5	23	101	707	1,323	62	253	363	8,382	9,329
New England	2	17	79	546	600	—	1	5	29	77	2	8	18	247	326
Connecticut	—	6	49	235	246	—	0	3	6	22	—	1	8	39	66
Maine§	2	2	13	96	86	—	0	1	3	6	—	0	3	11	16
Massachusetts	—	0	3	21	53	—	0	3	8	37	2	5	11	147	203
New Hampshire	—	2	8	73	82	—	0	1	5	4	—	0	3	13	14
Rhode Island§	—	2	8	70	73	—	0	1	2	4	—	0	7	32	25
Vermont§	—	1	6	51	60	—	0	2	5	4	—	0	2	5	2
Mid. Atlantic	2	33	81	981	1,105	—	3	27	83	166	5	29	46	941	1,171
New Jersey	—	13	35	463	497	—	1	4	28	41	—	5	13	138	163
New York (Upstate)	—	2	10	59	108	—	1	9	33	82	2	3	20	126	95
New York City	2	14	42	459	500	—	0	14	22	43	—	14	31	440	662
Pennsylvania	N	0	0	N	N	N	0	0	N	N	3	7	13	237	251
E.N. Central	16	66	112	2,126	2,168	—	4	10	116	196	2	30	48	1,034	1,362
Illinois	N	0	0	N	N	N	0	0	N	N	2	13	22	416	650
Indiana	—	15	32	469	490	—	0	4	20	41	—	3	8	109	131
Michigan	2	15	29	474	496	—	1	4	25	59	—	5	11	173	178
Ohio	11	26	45	873	836	—	2	7	59	68	—	9	21	298	369
Wisconsin	3	9	24	310	346	—	0	3	12	28	—	1	5	38	34
W.N. Central	—	4	35	124	564	—	0	5	9	78	—	7	17	199	228
Iowa	N	0	0	N	N	N	0	0	N	N	—	0	2	12	15
Kansas	N	0	0	N	N	N	0	0	N	N	—	0	3	17	14
Minnesota	—	0	24	—	426	—	0	5	—	63	—	3	10	80	84
Missouri	N	0	0	N	N	N	0	0	N	N	—	2	6	84	106
Nebraska§	—	2	9	81	93	—	0	2	8	13	—	0	2	5	6
North Dakota	—	0	25	43	45	—	0	1	1	2	—	0	1	1	—
South Dakota	N	0	0	N	N	N	0	0	N	N	—	0	1	—	3
S. Atlantic	19	72	170	2,724	2,934	1	7	22	202	369	24	64	178	2,176	2,123
Delaware	—	1	6	36	27	—	0	1	—	—	—	0	4	15	4
District of Columbia	—	1	3	28	53	—	0	1	4	7	1	3	8	117	101
Florida	13	23	68	980	1,080	1	3	13	89	146	1	23	37	766	762
Georgia	3	23	54	726	945	—	2	7	50	116	7	12	130	421	460
Maryland§	2	10	32	393	373	—	1	4	26	42	2	8	18	307	200
North Carolina	N	0	0	N	N	N	0	0	N	N	10	7	19	258	294
South Carolina§	1	8	25	332	366	—	0	3	20	42	3	4	10	147	100
Virginia§	N	0	0	N	N	N	0	0	N	N	—	4	16	143	198
West Virginia	—	0	48	229	90	—	0	6	13	16	—	0	2	2	4
E.S. Central	10	19	36	645	735	2	1	4	41	71	7	15	34	502	607
Alabama§	N	0	0	N	N	N	0	0	N	N	—	4	11	133	172
Kentucky	N	0	0	N	N	N	0	0	N	N	3	2	16	79	92
Mississippi	N	0	0	N	N	N	0	0	N	N	3	3	16	124	151
Tennessee§	10	19	36	645	735	2	1	4	41	71	1	5	11	166	192
W.S. Central	8	31	368	1,301	1,323	—	4	30	123	178	13	35	59	1,179	1,446
Arkansas§	3	3	26	162	124	—	0	3	12	12	7	4	10	141	156
Louisiana	—	3	11	116	73	—	0	2	10	18	—	7	27	249	364
Oklahoma	N	0	0	N	N	N	0	0	N	N	3	1	6	39	65
Texas§	5	25	333	1,023	1,126	—	3	27	101	148	3	23	33	750	861
Mountain	9	32	72	1,244	1,242	2	3	8	95	172	—	12	23	380	401
Arizona	4	12	45	595	600	1	1	5	45	78	—	4	8	150	157
Colorado	5	11	23	387	371	1	0	4	27	52	—	2	8	77	86
Idaho§	N	0	0	N	N	N	0	0	N	N	—	0	2	6	2
Montana§	N	0	0	N	N	N	0	0	N	N	—	0	1	4	3
Nevada§	N	0	0	N	N	N	0	0	N	N	—	3	9	91	72
New Mexico§	—	3	13	169	115	—	0	2	11	14	—	1	4	45	31
Utah	—	2	8	74	145	—	0	3	12	25	—	0	4	7	50
Wyoming§	—	0	15	19	11	—	0	1	—	3	—	0	0	—	—
Pacific	—	3	11	115	79	—	0	1	9	16	9	51	66	1,724	1,665
Alaska	—	2	11	112	79	—	0	1	8	16	—	0	1	1	3
California	N	0	0	N	N	N	0	0	N	N	4	41	57	1,410	1,416
Hawaii	—	0	3	3	—	—	0	1	1	—	—	0	5	8	27
Oregon	N	0	0	N	N	N	0	0	N	N	—	2	10	111	48
Washington	N	0	0	N	N	N	0	0	N	N	5	5	13	194	171
Territories															
American Samoa	N	0	0	N	N	N	0	0	N	N	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—	2	4	13	148	161
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 reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/osels/ph_surveillance/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Includes drug resistant and susceptible cases of invasive Streptococcus pneumoniae disease among children <5 years and among all ages. Case definition: Isolation of S. pneumoniae from a normally sterile body site (e.g., blood or cerebrospinal fluid).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 10, 2011, and September 11, 2010 (36th week)*

	Varicella (chickenpox)					West Nile virus disease†									
						Neuroinvasive					Nonneuroinvasive§				
	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum
Reporting area	week	Med	Max	2011	2010	week	Med	Max	2011	2010	week	Med	Max	2011	2010
United States	113	273	367	8,306	10,647	2	1	71	134	449	—	0	37	68	332
New England	—	22	46	679	759	—	0	2	5	10	—	0	1	—	4
Connecticut	—	5	16	169	235	—	0	1	3	6	—	0	1	—	3
Maine¶	—	5	16	147	135	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	6	18	260	198	—	0	1	1	3	—	0	0	—	1
New Hampshire	—	0	9	9	94	—	0	0	—	1	—	0	0	—	—
Rhode Island¶	—	0	6	29	26	—	0	0	—	—	—	0	0	—	—
Vermont¶	—	2	10	65	71	—	0	1	1	—	—	0	0	—	—
Mid. Atlantic	16	36	71	1,501	1,179	—	0	14	10	102	—	0	10	5	55
New Jersey	11	12	60	875	418	—	0	2	1	12	—	0	6	2	10
New York (Upstate)	N	0	0	N	N	—	0	5	1	48	—	0	1	2	29
New York City	—	0	0	—	—	—	0	5	6	28	—	0	1	—	9
Pennsylvania	5	19	41	626	761	—	0	3	2	14	—	0	2	1	7
E.N. Central	33	68	118	1,916	3,445	1	0	15	19	49	—	0	7	6	23
Illinois	6	17	31	490	898	—	0	10	5	25	—	0	4	1	11
Indiana¶	6	4	18	168	256	—	0	2	4	2	—	0	1	—	6
Michigan	4	20	38	620	1,016	—	0	4	6	20	—	0	1	—	3
Ohio	17	20	58	637	906	1	0	2	4	2	—	0	3	5	1
Wisconsin	—	0	22	1	369	—	0	0	—	—	—	0	1	—	2
W.N. Central	—	9	42	242	611	1	0	3	7	27	—	0	7	10	66
Iowa	N	0	0	N	N	—	0	1	—	3	—	0	1	—	3
Kansas¶	—	3	15	77	256	—	0	1	—	3	—	0	2	—	11
Minnesota	—	0	0	—	—	—	0	1	—	3	—	0	0	—	4
Missouri	—	4	24	108	291	—	0	1	1	3	—	0	1	2	—
Nebraska¶	—	0	5	3	9	1	0	2	5	9	—	0	7	5	25
North Dakota	—	0	10	31	32	—	0	0	—	2	—	0	1	3	7
South Dakota	—	1	7	23	23	—	0	1	1	4	—	0	0	—	16
S. Atlantic	16	36	64	1,240	1,545	—	0	4	20	26	—	0	2	5	18
Delaware¶	—	0	3	6	25	—	0	0	—	—	—	0	0	—	—
District of Columbia	—	0	2	12	17	—	0	1	—	2	—	0	1	—	2
Florida¶	10	16	38	626	741	—	0	4	11	6	—	0	1	1	2
Georgia	N	0	0	N	N	—	0	1	1	4	—	0	1	2	8
Maryland¶	N	0	0	N	N	—	0	3	3	11	—	0	1	2	5
North Carolina	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
South Carolina¶	—	0	9	12	75	—	0	1	—	—	—	0	0	—	—
Virginia¶	6	8	25	305	373	—	0	1	4	3	—	0	0	—	1
West Virginia	—	7	32	279	314	—	0	1	1	—	—	0	0	—	—
E.S. Central	5	5	15	183	215	—	0	4	18	5	—	0	2	12	8
Alabama¶	5	4	14	172	208	—	0	0	—	1	—	0	0	—	2
Kentucky	N	0	0	N	N	—	0	1	—	1	—	0	0	—	1
Mississippi	—	0	3	11	7	—	0	3	16	2	—	0	2	12	3
Tennessee¶	N	0	0	N	N	—	0	1	2	1	—	0	0	—	2
W.S. Central	30	43	258	1,651	2,041	—	0	12	9	73	—	0	1	6	16
Arkansas¶	3	3	17	140	147	—	0	2	—	6	—	0	1	—	—
Louisiana	—	2	6	52	55	—	0	2	3	14	—	0	1	3	6
Oklahoma	N	0	0	N	N	—	0	1	—	—	—	0	0	—	—
Texas¶	27	38	247	1,459	1,839	—	0	11	6	53	—	0	1	3	10
Mountain	13	19	65	813	769	—	0	18	26	108	—	0	10	11	107
Arizona	4	3	50	381	—	—	0	13	17	68	—	0	5	6	49
Colorado¶	5	4	31	160	284	—	0	4	—	23	—	0	5	2	47
Idaho¶	N	0	0	N	N	—	0	1	1	—	—	0	0	—	1
Montana¶	2	2	28	108	158	—	0	0	—	—	—	0	0	—	—
Nevada¶	N	0	0	N	N	—	0	2	6	—	—	0	1	2	2
New Mexico¶	2	1	2	28	84	—	0	6	2	16	—	0	1	—	4
Utah	—	4	26	128	230	—	0	1	—	—	—	0	1	—	—
Wyoming¶	—	0	3	8	13	—	0	1	—	1	—	0	1	1	4
Pacific	—	2	6	81	83	—	0	7	20	49	—	0	6	13	35
Alaska	—	1	4	40	32	—	0	0	—	—	—	0	0	—	—
California	—	0	3	8	26	—	0	7	20	49	—	0	6	13	34
Hawaii	—	1	4	33	25	—	0	0	—	—	—	0	0	—	—
Oregon	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
Washington	N	0	0	N	N	—	0	1	—	—	—	0	0	—	1
Territories															
American Samoa	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	4	16	23	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	5	21	109	447	—	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 reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/osels/ph_surveillance/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† 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 reportable in all states. Data from states where the condition is not reportable are excluded from this table, except starting 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/osels/ph_surveillance/nndss/phs/infdis.htm.
¶ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE III. Deaths in 122 U.S. cities,* week ending September 10, 2011 (36th week)

Reporting area	All causes, by age (years)						P&I†
	All Ages	≥65	45–64	25–44	1–24	<1	Total
New England	500	356	102	21	11	10	38
Boston, MA	137	82	38	7	5	5	8
Bridgeport, CT	26	20	4	1	1	—	2
Cambridge, MA	14	11	3	—	—	—	—
Fall River, MA	24	19	4	1	—	—	—
Hartford, CT	47	36	9	1	—	1	6
Lowell, MA	18	11	3	3	1	—	1
Lynn, MA	10	7	3	—	—	—	1
New Bedford, MA	31	22	6	3	—	—	1
New Haven, CT	33	23	4	3	2	1	4
Providence, RI	63	53	7	—	1	2	1
Somerville, MA	3	2	1	—	—	—	—
Springfield, MA	24	13	9	1	—	1	3
Waterbury, CT	17	14	3	—	—	—	—
Worcester, MA	53	43	8	1	1	—	11
Mid. Atlantic	2,340	1,533	584	138	54	31	108
Albany, NY	39	30	8	—	1	—	—
Allentown, PA	17	13	4	—	—	—	—
Buffalo, NY	69	45	17	3	3	1	4
Camden, NJ	16	8	6	—	1	1	2
Elizabeth, NJ	16	8	6	2	—	—	2
Erie, PA	56	43	12	1	—	—	5
Jersey City, NJ	14	9	3	1	1	—	3
New York City, NY	855	607	174	51	16	7	36
Newark, NJ	29	15	9	4	1	—	4
Paterson, NJ	25	14	5	2	2	2	—
Philadelphia, PA	896	524	259	67	27	19	33
Pittsburgh, PA§	23	16	6	1	—	—	2
Reading, PA	21	14	6	1	—	—	2
Rochester, NY	68	46	20	1	1	—	3
Schenectady, NY	20	14	6	—	—	—	1
Scranton, PA	20	15	5	—	—	—	—
Syracuse, NY	105	79	21	3	1	1	9
Trenton, NJ	22	12	10	—	—	—	—
Utica, NY	12	10	2	—	—	—	—
Yonkers, NY	17	11	5	1	—	—	2
E.N. Central	1,785	1,166	433	111	41	34	113
Akron, OH	48	26	14	6	1	1	2
Canton, OH	25	14	9	1	—	1	2
Chicago, IL	244	153	60	20	9	2	14
Cincinnati, OH	71	37	23	1	3	7	6
Cleveland, OH	216	146	54	9	4	3	12
Columbus, OH	162	98	45	8	7	4	4
Dayton, OH	107	73	24	9	1	—	8
Detroit, MI	137	67	46	16	6	2	7
Evansville, IN	35	27	6	2	—	—	1
Fort Wayne, IN	60	47	12	1	—	—	2
Gary, IN	18	11	3	3	1	—	2
Grand Rapids, MI	55	40	7	5	1	2	7
Indianapolis, IN	196	128	51	10	1	6	20
Lansing, MI	35	25	7	3	—	—	1
Milwaukee, WI	87	55	21	6	2	3	5
Peoria, IL	49	39	8	1	—	1	4
Rockford, IL	48	32	11	3	1	1	5
South Bend, IN	64	45	15	1	3	—	8
Toledo, OH	63	45	13	3	1	1	1
Youngstown, OH	65	58	4	3	—	—	2
W.N. Central	576	343	164	40	20	8	34
Des Moines, IA	56	38	13	3	1	1	3
Duluth, MN	31	24	6	1	—	—	4
Kansas City, KS	19	14	3	2	—	—	1
Kansas City, MO	81	43	31	4	1	2	1
Lincoln, NE	34	20	9	1	4	—	2
Minneapolis, MN	64	43	15	2	4	—	5
Omaha, NE	50	36	11	2	—	1	3
St. Louis, MO	113	49	39	17	5	2	3
St. Paul, MN	48	35	11	1	—	1	6
Wichita, KS	80	41	26	7	5	1	6

Reporting area (*Continued*)	All causes, by age (years)						P&I†
	All Ages	≥65	45–64	25–44	1–24	<1	Total
S. Atlantic	939	592	232	66	27	22	61
Atlanta, GA	119	70	35	10	3	1	7
Baltimore, MD	111	55	36	12	6	2	7
Charlotte, NC	120	76	32	4	4	4	7
Jacksonville, FL	96	67	19	8	1	1	1
Miami, FL	79	57	14	5	3	—	5
Norfolk, VA	40	24	10	2	3	1	2
Richmond, VA	53	32	17	1	—	3	4
Savannah, GA	33	26	3	2	1	1	5
St. Petersburg, FL	33	22	5	3	2	1	3
Tampa, FL	140	94	29	13	1	3	9
Washington, D.C.	98	55	30	5	3	5	9
Wilmington, DE	17	14	2	1	—	—	2
E.S. Central	758	453	213	59	17	16	41
Birmingham, AL	153	91	40	15	6	1	11
Chattanooga, TN	51	28	15	5	3	—	4
Knoxville, TN	98	67	24	6	1	—	—
Lexington, KY	62	31	17	10	—	4	5
Memphis, TN	142	89	35	12	3	3	8
Mobile, AL	94	56	27	6	3	2	5
Montgomery, AL	28	17	9	—	1	1	3
Nashville, TN	130	74	46	5	—	5	5
W.S. Central	1,026	633	284	66	22	19	45
Austin, TX	81	48	24	5	2	2	9
Baton Rouge, LA	68	46	10	10	2	—	—
Corpus Christi, TX	43	29	11	1	2	—	6
Dallas, TX	186	104	59	16	4	2	7
El Paso, TX	68	50	13	4	—	1	1
Fort Worth, TX	U	U	U	U	U	U	U
Houston, TX	157	112	36	3	1	5	1
Little Rock, AR	65	34	26	1	4	—	—
New Orleans, LA	U	U	U	U	U	U	U
San Antonio, TX	190	113	54	13	4	5	13
Shreveport, LA	49	28	14	3	1	3	4
Tulsa, OK	119	69	37	10	2	1	4
Mountain	1,027	681	222	74	20	29	65
Albuquerque, NM	97	63	20	10	3	1	7
Boise, ID	62	44	10	5	—	3	4
Colorado Springs, CO	77	61	9	3	1	3	—
Denver, CO	51	30	16	5	—	—	1
Las Vegas, NV	251	172	59	11	6	3	21
Ogden, UT	27	18	6	1	—	2	—
Phoenix, AZ	178	98	51	17	2	9	10
Pueblo, CO	33	25	5	2	1	—	—
Salt Lake City, UT	129	78	30	10	3	8	14
Tucson, AZ	122	92	16	10	4	—	8
Pacific	1,421	974	308	83	37	18	125
Berkeley, CA	9	5	2	—	—	2	—
Fresno, CA	128	80	32	10	4	2	15
Glendale, CA	21	16	4	—	—	1	2
Honolulu, HI	69	52	12	5	—	—	5
Long Beach, CA	57	33	16	4	4	—	4
Los Angeles, CA	227	143	56	13	8	7	28
Pasadena, CA	18	14	2	1	—	1	4
Portland, OR	110	82	21	6	—	—	7
Sacramento, CA	173	129	31	9	4	—	14
San Diego, CA	122	90	26	3	3	—	13
San Francisco, CA	84	62	14	6	1	1	5
San Jose, CA	145	98	36	6	2	3	10
Santa Cruz, CA	34	23	6	4	1	—	3
Seattle, WA	96	59	26	7	3	1	8
Spokane, WA	63	44	13	3	3	—	4
Tacoma, WA	65	44	11	6	4	—	3
Total¶	**10,372**	**6,731**	**2,542**	**658**	**249**	**187**	**630**

U: Unavailable. —: No reported cases.

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

† Pneumonia and influenza.

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

¶ Total includes unknown ages.

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