



# **Morbidity and Mortality Weekly Report**

Weekly

December 2, 2005 / Vol. 54 / No. 47

# Severe Clostridium difficile—Associated Disease in Populations Previously at Low Risk — Four States, 2005

Clostridium difficile is a spore-forming, gram-positive bacillus that produces exotoxins that are pathogenic to humans. C. difficile-associated disease (CDAD) ranges in severity from mild diarrhea to fulminant colitis and death. Antimicrobial use is the primary risk factor for development of CDAD because it disrupts normal bowel flora and promotes C. difficile overgrowth. C. difficile typically has affected older or severely ill patients who are hospital inpatients or residents of longterm-care facilities. Recently, however, both the frequency and severity of health-care-associated CDAD has increased; from 2000 to 2001, the rate of U.S. hospital discharge diagnoses of CDAD increased by 26% (1). One possible explanation for these increases is the emergence of a previously uncommon strain of C. difficile responsible for severe hospital outbreaks (2). Although individual cases of CDAD are not nationally reportable, in 2005, the Pennsylvania Department of Health (PADOH) and CDC received several case reports of serious CDAD in otherwise healthy patients with minimal or no exposure to a health-care setting. An investigation was initiated by the Philadelphia Department of Public Health (PDPH), PADOH, and CDC to determine the scope of the problem and explore a possible change in CDAD epidemiology. This report summarizes the results of the investigation in Pennsylvania and three other states, which indicated the presence of severe CDAD in healthy persons living in the community and peripartum women, two populations previously thought to be at low risk. The findings underscore the importance of judicious antimicrobial use, the need for community clinicians to maintain a higher index of suspicion for CDAD, and the need for surveillance to better understand the changing epidemiology of CDAD.

### **Case Reports**

Case 1. A woman aged 31 years who was 14 weeks pregnant with twins went to a local emergency department (ED) after 3 weeks of intermittent diarrhea, followed by 3 days of cramping and watery, black stools 4-5 times daily. Stools specimens tested positive for C. difficile toxin, and the patient was admitted. Her only antimicrobial exposure during the preceding year was trimethoprim-sulfamethoxazole (for a urinary tract infection) approximately 3 months before admission. She was treated with metronidazole and discharged but was readmitted the next day for 18 days with severe colitis, receiving metronidazole, cholestyramine, and oral vancomycin. She improved on vancomycin and was allowed to return home. However, 4 days later she was readmitted with diarrhea and hypotension. She spontaneously aborted her fetuses. Despite aggressive treatment including a subtotal colectomy, intubation, and inotropic medication, the patient died on the third hospital day. Histopathologic examination of the colon demonstrated megacolon with evidence of pseudomembranous colitis.

**Case 2.** A girl aged 10 years (unrelated and without contact with case 1) went to a children's hospital ED because of intractable diarrhea, projectile vomiting, and abdominal pain. She had not taken antimicrobials during the preceding year.

#### INSIDE

- 1205 Early-Onset and Late-Onset Neonatal Group B Streptococcal Disease — United States, 1996–2004
- 1208 Adult Participation in Recommended Levels of Physical Activity — United States, 2001 and 2003
- 1212 Notices to Readers
- 1215 QuickStats

The *MMWR* series of publications is published by the Coordinating Center for Health Information and Service, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

#### SUGGESTED CITATION

Centers for Disease Control and Prevention. [Article title]. MMWR 2005;54:[inclusive page numbers].

#### **Centers for Disease Control and Prevention**

Julie L. Gerberding, MD, MPH Director

Dixie E. Snider, MD, MPH Chief Science Officer

Tanja Popovic, MD, PhD Associate Director for Science

# Coordinating Center for Health Information and Service

Steven L. Solomon, MD Director

#### **National Center for Health Marketing**

Jay M. Bernhardt, PhD, MPH Director

#### **Division of Scientific Communications**

Maria S. Parker (Acting) Director

Mary Lou Lindegren, MD *Editor*, MMWR *Series* 

Suzanne M. Hewitt, MPA Managing Editor, MMWR Series

Douglas W. Weatherwax (Acting) Lead Technical Writer-Editor

Stephanie M. Neitzel Jude C. Rutledge *Writers-Editors* 

Lynda G. Cupell Malbea A. LaPete Visual Information Specialists

Quang M. Doan, MBA Erica R. Shaver Information Technology Specialists

#### Notifiable Disease Morbidity and 122 Cities Mortality Data

Patsy A. Hall Deborah A. Adams Lenee Blanton Felicia J. Connor Rosaline Dhara Pearl C. Sharp Stool specimens were positive for *C. difficile* toxin. The child had been healthy until 2 weeks before the ED visit, when she became symptomatic within days of her younger brother having a febrile diarrheal illness. The boy was not on antimicrobials when he became ill. His symptoms resolved within 2–3 days without medical treatment, but his sister had fever as high as 102°F (39°C), abdominal pain, and diarrhea. One week into her illness, she was examined by a clinician, who performed a rapid streptococcal antigen test on a swab from her oropharynx; the result was positive. The patient was prescribed amoxicillin but was unable to take it because of her stomach cramps and diarrhea; her symptoms worsened until she was having liquid stools up to 14 times daily. Symptoms resolved with hospital admission and the administration of intravenous fluids, electrolytes, and metronidazole.

## **Epidemiologic and Laboratory Investigations**

In May and June 2005, a request for voluntary reports of peripartum CDAD (i.e., 4 weeks before and after delivery) was initiated by PDPH; case definitions for peripartum CDAD were developed and distributed nationally through the *Epidemic Information Exchange (Epi-X)* and locally through the PDPH Health Alert Network (HAN). The New Jersey Department of Health and Senior Services also distributed the alert statewide through its HAN system. A separate request for reporting of community-associated CDAD (CA-CDAD) along with a case definition was developed and distributed in June in Philadelphia and four surrounding Pennsylvania counties (Bucks, Chester, Delaware, and Montgomery) through local and statewide HANs (Box).

Detailed, open-ended interviews were conducted with patients who were reported by hospital personnel to state and local health departments after distribution of the notices. Medical details, such as type of antimicrobial agent and duration, were confirmed with treating clinicians whenever possible. To determine the minimum population rate and rate per antimicrobial prescription of CA-CDAD, the number of cases reported from Philadelphia and four surrounding counties were divided by 2004 U.S. census population estimates for these five areas. The number of antimicrobial prescriptions were calculated on the basis of census estimates of the population surveyed, multiplied by national prescribing rate estimates (3). Available toxin-positive stool samples were cultured for C. difficile using standard methods. Isolates underwent pulsedfield gel electrophoresis (PFGE), toxinotyping, and detection of binary toxin and deletions in tcdC, a putative negative regulator of toxin production (2,4).

# BOX. Case definition for *Clostridium difficile*—associated disease (CDAD)

#### Confirmed case of community-associated CDAD

Any adult or child with each of the following:

- Diarrhea
- No serious, chronic underlying illness (e.g., severe chronic liver or kidney disease)
- No overnight stay in a health-care facility for ≥3 months before diarrhea onset
- Evidence of CDAD by any of the following:
  - positive assay for C. difficile toxin
  - colonic histopathology characteristic of *C. difficile* infection
  - pseudomembranous colitis observed on lower gastrointestinal endoscopy
  - positive stool culture for *C. difficile*

#### Confirmed case of peripartum CDAD

Any peripartum female (defined for this purpose as 4 weeks before and 4 weeks after delivery) with each of the following:

- Diarrhea
- No serious, chronic underlying illness
- Evidence of CDAD by any of the following:
  - positive assay for *C. difficile* toxin
  - colonic histopathology characteristic of *C. difficile* infection
  - pseudomembranous colitis observed on lower gastrointestinal endoscopy
  - positive stool culture for *C. difficile*

Ten peripartum and 23 CA-CDAD cases were reported from four states during May–June 2005 (Table 1), with onset dates ranging from February 26, 2003, to June 28, 2005. All but one of the cases occurred during 2004–2005. Age of nonperipartum cases ranged from 6 months to 72 years (mean:

26 years; median: 23 years). Peripartum cases occurred in patients from New Hampshire, New Jersey, Ohio, and Pennsylvania; because CA-CDAD surveillance was conducted only in the greater Philadelphia area, these cases were only from this area. Transmission to close contacts was evident for four cases: two were in children of CDAD patients with peripartum exposures, one was in an adult caring for a hospitalized parent with confirmed CDAD, and one was in an adult who visited a parent with confirmed CDAD in a nursing home. One peripartum mother who transmitted *C. difficile* to her child also transmitted CDAD to a family friend.

Eight (24%) of 33 patients reported no exposure to antimicrobial agents within 3 months before CDAD onset. Five of these were children, three of whom required hospitalization. Three of the eight cases without exposure to antimicrobial agents occurred in patients who had close contact with a person with diarrheal illness; two of these persons had confirmed CDAD. An additional three (9%) of 33 patients contracted CDAD after receiving ≤3 doses of antimicrobials; two received only 1 dose of clindamycin for group B streptococcus prophylaxis before CDAD onset. Clindamycin was the most common antimicrobial exposure noted; overall, 10 (30%) of 33 cases were in patients who reported exposure to the drug before disease onset; these 10 patients included the two who had ≤3 doses of antimicrobials. Fifteen (46%) patients required hospitalization or an ED visit. Thirteen (39%) patients had a relapse of disease and required antimicrobials.

The estimated minimum annual incidence of CA-CDAD in Philadelphia and its surrounding four counties during July 2004–June 2005 was 7.6 cases per 100,000 population, with one case of CDAD for every 5,549 outpatient antimicrobial prescriptions; this figure is based on national estimates of antimicrobial prescribing in ambulatory settings applied to the Philadelphia area. Two patient isolates were available for characterization and were compared with the recently described "epidemic strain" that has been detected as the cause of either

TABLE 1. Clinical features of *Clostridium difficile*—associated disease (CDAD) in patients\* with community and peripartum exposures, by case type and selected characteristics — New Hampshire, New Jersey, Ohio, and Pennsylvania, 2005

		Characteristic														
	Aged ≤18 yrs Female sex		Previous antimicrobial use <sup>†</sup>		Contact with gastrointestinal illness§		Bloody diarrhea		Hospitalization necessary for CDAD treatment		Emergency department visit necessary		Rela	pse		
Туре	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Community	11/23	(48)	15/23	(65)	15/23	(65)	7/23	(30)	6/23	(26)	6/23	(26)	3/23	(13)	8/23	(35)
Peripartum	0/10	(0)	10/10	(100)	9/10	(90)	0/10	(0)	2/10	(20)	4/10	(40)	2/10	(20)	5/10	(50)
Total	11/33	(33)	25/33	(76)	24/33	(73)	7/23	(30)	8/33	(24)	10/33	(30)	5/33	(15)	13/33	(39)

 $<sup>^{*}</sup>_{+}N = 33.$ 

Defined as receipt of an antimicrobial within 3 months before diarrhea onset.

<sup>§</sup> Defined as direct or household contact with another person with diarrheal illness.

severe hospital outbreaks or hospital-endemic cases of CDAD in 16 states (2; CDC, unpublished data, 2005). Neither shared the same toxinotype as the epidemic strain, but both were binary toxin positive; one isolate, from an Ohio peripartum CDAD case, was >80% related by PFGE to the epidemic strain, and the other, from a Philadelphia-area CA-CDAD case, had an 18-bp deletion in *tcdC* (Table 2).

Reported by: E Chernak, MD, CC Johnson, MD, Philadelphia Dept of Public Health; A Weltman, MD, Pennsylvania Dept of Health. LC McDonald, MD, L Wiggs, G Killgore, DrPH, A Thompson, MSSc, Div of Healthcare Quality Promotion, National Center for Infectious Diseases; M LeMaile-Williams, MD, E Tan, MBBS, FM Lewis, MD, EIS officers, CDC.

**Editorial Note:** Considered in the context of recent highmorbidity, hospital-associated outbreaks in North America, Great Britain, and the Netherlands (5), these cases of severe CDAD disease in populations previously thought to be at low risk might further reflect the changing epidemiology of CDAD. Certain features of CDAD that have been uncommon in the past, such as close-contact transmission, high recurrence rate, young patient age, bloody diarrhea, and lack of antimicrobial exposure, might be changing.

C. difficile exotoxins A and B cause colonic dysfunction and cell death. The epidemic strain produces 16 times more toxin A and 23 times more toxin B compared with other common strains (5). The increased severity of epidemic CDAD might result from this level of toxin production; however, the actual role of tcdC deletions in increased toxin production has not been determined. C. difficile toxinotype 0 is the historical standard type; variant toxinotypes have previously accounted for <20% of U.S. hospital isolates (6). Although the role of this binary toxin in human disease is unknown, it was previously detected in only 6% of clinical isolates but now is found

TABLE 2. Comparison of molecular characteristics of two Clostridium difficile isolates with historical standard-type strains and a recently recognized epidemic strain, by selected characteristics — Ohio and Pennsylvania, 2005

	Strain								
Characteristic	Standard	<b>Epidemic</b>	Ohio	Pennsylvania					
Toxinotype	0	Ш	IX	XIV/XV					
PFGE* pattern	<80% relate to NAP1 <sup>†</sup>	d NAP1	85% related to NAP1	64% related to NAP1					
Binary toxin	-	+	+	+					
18-bp deletion in <i>tcdC</i>	-	+	-	+					

<sup>\*</sup>Pulsed-field gel electrophoresis.

uniformly in the epidemic strain (6). The isolates recovered during this investigation were both variant toxinotypes and carried the gene for binary toxin; one also carried the same 18-bp deletion in *tcdC* as the epidemic strain.

Virulent strains, which cause more severe disease in populations at high risk, might also cause more frequent, severe disease in populations previously at low risk (e.g., otherwise healthy persons with little or no exposure to health-care settings or antimicrobial use). Although the minimum annual incidence cited in this report is similar to previous estimates in ambulatory populations (eight to 12 cases per 100,000 population), the CA-CDAD case definition more stringently excluded hospital-acquired CDAD (7,8). The estimated case rate per antimicrobial prescription is twice as high as the <1 case per 10,000 incidence cited in these earlier studies (7,8). Because reporting in this investigation was voluntary, the true incidence of community CDAD is probably higher. Because historic surveillance data are not available, determining whether CDAD rates in peripartum women are changing is not possible; however, the only available report suggests a low baseline incidence, with only three obstetric cases identified among 74,120 obstetrics and gynecology admissions to one North Carolina hospital during 1985–1995 (9).

The findings in this report are subject to at least two limitations. First, because the report describes a convenience sample, the results are subject to reporting and selection biases. Second, because this sample was collected in a limited geographic region, results might not be generalizable to other regions. Moreover, although a single national estimate for ambulatory prescribing rates was applied to this region, substantial variation in these rates might exist.

Further investigation into the scope of CA-CDAD acquisition and related risk factors is warranted. Nonetheless, the cases described in this report demonstrate the need for clinicians to consider the diagnosis of CDAD in patients with severe diarrhea even if the patients do not necessarily have traditional risk factors such as recent hospitalization or antimicrobial use. Patients should seek medical attention for diarrhea lasting longer than 3 days or accompanied by blood or high fever. The findings underscore the fact that antimicrobial exposure is not benign and that judicious antimicrobial use in all health-care settings should continue to be emphasized.

#### **Acknowledgments**

This report is based, in part, on contributions by the New Hampshire Dept of Health. C Tan, MD, C Booker, MD, E Bresnitz, MD, New Jersey Dept of Health and Senior Svcs. R Nieman, MD, K Klemick, Abington Memorial Hospital, Abington, Pennsylvania. R Plotinsky, MD, EIS Officer, CDC.

North American pulsed-field type 1.

**SOURCE:** McDonald LC, Killgore GE, Thompson A, et al. Emergence of an epidemic, toxin gene variant strain of *Clostridium difficile* responsible for outbreaks in the United States between 2000 and 2004. N Engl J Med 2005 (in press).

#### References

- 1. McDonald CL, Banerjee S, Jernigan DB. Increasing incidence of *Clostridium difficile*-associated disease in U.S. acute care hospitals, 1992–2001 [Abstract]. In: Proceedings of the 14th Annual Scientific Meeting of the Society for Healthcare Epidemiology of America, Philadelphia, PA; April 17–20, 2004.
- McDonald LC, Killgore GE, Thompson A, et al. Emergence of an epidemic, toxin gene variant strain of *Clostridium difficile* responsible for outbreaks in the United States between 2000 and 2004. N Engl J Med 2005 (in press).
- 3. McCaig LF, Besser RE, Hughes JM. Antimicrobial drug prescriptions in ambulatory care settings, United States, 1992–2000. Emerg Infect Dis 2003;9:432–7.
- Rupnik M, Avesani V, Janc M, Eichel-Streiber C, Delmee M. A novel toxinotyping scheme and correlation of toxinotypes with serogroups of *Clostridium difficile*. J Clin Microbiol 1998;36:2240–7.
- Warny M, Pepin J, Fang A, et al. Increased toxins A and B production by an emerging strain of *Clostridium difficile* associated with outbreaks of severe disease in North America and Europe. Lancet 2005;366:1079–84.
- Geric B, Rupnik M, Gerding DN, Grabnar M, Johnson S. Distribution of *Clostridium difficile* variant toxinotypes and strains with binary toxin genes among clinical isolates in an American hospital. J Med Microbiol 2004;53:887–94.
- Levy DG, Stergachis A, McFarland LV, et al. Antibiotics and Clostridium difficile diarrhea in the ambulatory care setting. Clin Ther 2000;22:91–102.
- Hirschhorn L, Trnka Y, Onderdonk A, Lee M, Platt R. Epidemiology of community-acquired *Clostridium difficile*-associated diarrhea. J Infect Dis 1994;169:127–33.
- 9. James A, Katz V, Dotters D, Rogers R. *Clostridium difficile* infection in obstetric and gynecologic patients. South Med J 1997;90:889–92.

# Early-Onset and Late-Onset Neonatal Group B Streptococcal Disease — United States, 1996–2004

In 2002, CDC, the American College of Obstetricians and Gynecologists (ACOG), and the American Academy of Pediatrics (AAP) issued revised guidelines for prevention of perinatal invasive group B streptococcal (GBS) disease (1,2). These guidelines recommend universal screening of pregnant women for rectovaginal GBS colonization at 35-37 weeks' gestation and administering intrapartum antimicrobial prophylaxis to carriers. To assess the impact of the guidelines on multistate trends in neonatal GBS disease incidence, CDC analyzed data from the Active Bacterial Core surveillance (ABCs) system from 1996–2004. This report summarizes the results of that analysis, which determined that incidence of GBS disease in infants aged 0-6 days (i.e., early-onset disease) in 2004 had decreased by 31% from 2000-2001, the period immediately before universal screening was implemented. Incidence of GBS disease in infants aged 7-89 days (i.e., late-onset disease) remained unchanged during the 9-year period reviewed. Continued monitoring is needed to assess the impact of the 2002 guidelines on early-onset disease and the long-term effect of widespread intrapartum use of antimicrobial agents on neonatal GBS disease.

ABCs, part of CDC's Emerging Infections Program (EIP) Network, conducts active, population-based surveillance for invasive GBS disease, defined as isolation of GBS from a normally sterile site. The surveillance areas represented approximately 337,000 live births in 1996 and approximately 427,000 live births in 2004.\* ABCs collects data from standardized case-report forms that capture demographic, obstetric, and neonatal data from medical records. For this analysis, infants were classified by race and by Hispanic ethnicity independently.† Where race or ethnicity was missing from the casereport form, race or ethnicity as recorded on the birth certificate was used. Otherwise, race was imputed (for 15% of cases) using a multiple imputation method (3). To calculate annual incidence, natality data reported by state vital records or national vital statistics reports (4) were used as denominators. Incidence for 2004 was calculated using 2003 natality data in the denominator. The Cochran-Armitage chi-square test was conducted to determine trend significance.

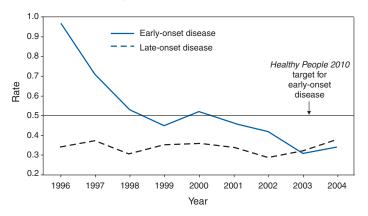
In 2004, a total of 308 cases of neonatal GBS disease were reported in EIP surveillance areas participating since 2001, including 146 (47%) early-onset cases and 162 (53%) lateonset cases. By race, 55% of infants with neonatal disease (early-onset and late-onset) were white, 42% were black, and 3% were of other races; by ethnicity, 19% were Hispanic, 48% were non-Hispanic, and 33% were of unknown ethnicity. Overall, 51% of the infants were female. Among early-onset cases with complete data, the proportion born at <37 weeks' gestation increased significantly from 20% (40 of 204) in 2000 to 29% (41 of 141) in 2004 (p<0.01). Among late-onset cases with complete data in 2004, 55% (81 of 147) were born preterm. Among both early-onset and late-onset cases, casefatality ratios remained highest for preterm infants, at 23% (nine of 40) and 9% (seven of 80) for early-onset and lateonset cases, respectively. Among term infants, the casefatality ratio was 4% (four of 100) for early-onset cases, and no deaths were reported for 66 late-onset cases.

<sup>\*</sup>In 1996, the ABCs system included surveillance areas in California (three-county San Francisco Bay area), Connecticut, Georgia (eight-county Atlanta area), Maryland, Minnesota (seven-county Minneapolis-St. Paul area), Oregon (three-county Portland area), and Tennessee (five urban counties). By 2000, surveillance had expanded to include 12 additional counties in the Atlanta area of Georgia, all of Minnesota, seven counties in the Rochester area and eight counties in the Albany area of New York, and six additional urban counties in Tennessee. The five-county Denver area of Colorado was added in 2001, and the state of New Mexico joined in 2004.

<sup>†</sup> In this report, infants classified as white, black, or of other races include both those classified as Hispanic and non-Hispanic. Conversely, infants classified as Hispanic or non-Hispanic include infants from all racial classifications.

Incidence of early-onset disease remained stable during 1999–2001, averaging 0.47 cases per 1,000 live births (5); incidence declined to 0.32 in 2003 and was stable at 0.34 in 2004 (Figure 1). During 1996-2004, late-onset disease incidence varied little, averaging 0.35 per 1,000 live births, with annual rates ranging from 0.29-0.39 per 1,000 live births (Figure 1). The rate of late-onset disease surpassed that of earlyonset disease for the first time in 2003, a trend that continued in 2004. Incidence of both early-onset and late-onset disease varied by site (Table).

FIGURE 1. Rate\* of early-onset and late-onset† invasive group B streptococcal disease in infants, by year — Active Bacterial Core surveillance system,§ United States, 1996–2004



\* Per 1,000 live births.

Ages 0-6 days for early-onset; ages 7-89 days for late-onset. § Rates for 1996-1999 correspond to surveillance areas participating in 1996. Rates for 2000-2004 correspond to surveillance areas participating in 2000, with the addition of Colorado in 2001.

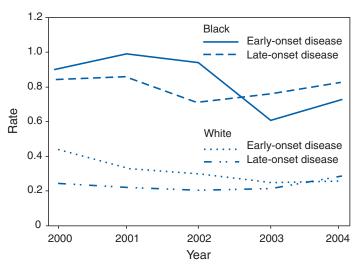
TABLE. Number and rate\* of early-onset and late-onset invasive group B streptococcal (GBS) disease in infants, by year and state of surveillance area — Active Bacterial Core surveillance system, United States, 2004

	•	set disease )–6 days)		et disease -89 days)
State	No.	Rate	No.	Rate
California	6	0.14	17	0.39
Colorado	8	0.22	17	0.47
Connecticut	8	0.19	11	0.26
Georgia	32	0.43	31	0.42
Maryland	30	0.40	21	0.28
Minnesota	26	0.38	17	0.25
New Mexico	9	0.32	8	0.29
New York	8	0.33	13	0.53
Oregon	4	0.19	8	0.38
Tennessee	24	0.57	27	0.64
Total <sup>†</sup>	146	0.34	162	0.38

Compared with the pre-prevention era baseline rate in 1993, the absolute difference in early-onset disease incidence between blacks and whites had declined by 68% in 2003 (5). However, racial disparities in the incidence of both early-onset and lateonset GBS disease persist (Figure 2). In 2004, the rates per 1,000 live births for early-onset disease were 0.73 for black infants, 0.26 for white infants, and 0.15 for infants of other races. The rates per 1,000 live births for late-onset disease were 0.83 for blacks, 0.28 for whites, and 0.19 for infants of other races.

Reported by: S Brooks, MPH, M Apostol, MPH, J Nadle, MPH, K Wymore, MPH, California Emerging Infections Program, Oakland, California. N Haubert, S Burnite, A Daniels, MSPH, Emerging Infections Program, Colorado Dept of Public Health. JL Hadler, MD, Emerging Infections Program, Connecticut Dept of Public Health. MM Farley, MD, P Martell-Cleary, MSW, Georgia Emerging Infections Program, Veterans Affairs Medical Center and Emory Univ School of Medicine, Atlanta, Georgia. LH Harrison, MD, LT Sanza, Maryland Emerging Infections Program, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland. C Morin, MPH, R Lynfield, MD, Minnesota Dept of Health. B Albanese, MD, J Bareta, MS, Emerging Infections Program, New Mexico Dept of Health. B Anderson, PhD, Emerging Infections Program, New York State Dept of Health. P Cieslak, MD, K Stefonek, MPH, Oregon Dept of Human Svcs. B Barnes, Vanderbilt Univ School of Medicine, Nashville, Tennessee; AS Craig, MD, Tennessee Dept of Health. SJ Schrag, DPhil, E Zell, MStat, Div of Bacterial and Mycotic Diseases, National Center for Infectious Diseases; CR Phares, PhD, EIS Officer, CDC.

FIGURE 2. Rate\* of early-onset and late-onset† invasive group B streptococcal disease in infants, by race§ and year — Active Bacterial Core surveillance system, United States, 2000–2004



Per 1,000 live births.

Ages 0-6 days for early-onset; ages 7-89 days for late-onset.

<sup>\*</sup> Per 1,000 live births.

† To allow for historical comparison, total excludes New Mexico, which began surveillance for neonatal GBS in 2004.

Infants classified as black or white include both Hispanic and non-Hispanic infants.

Rates correspond to surveillance areas participating in 2000, with the addition of Colorado in 2001.

Editorial Note: Invasive GBS disease emerged in the 1970s as a leading cause of neonatal morbidity and mortality in the United States. In the mid-1980s, clinical trials demonstrated that administering antimicrobials intrapartum to GBS carriers protected their newborns from early-onset disease. In 1996, CDC, in collaboration with ACOG and AAP, formally recommended intrapartum antimicrobial prophylaxis for women with late antenatal GBS colonization or, as an alternative to screening for colonization, for those women with obstetrical risk factors for transmitting infection (6). A large, populationbased cohort study of deliveries during 1998-1999 demonstrated that routine screening and prophylaxis for carriers prevented more cases of early-onset disease than the risk-based method (7). In response to this finding, in 2002, CDC, ACOG, and AAP endorsed revised guidelines that discarded the risk-based approach in favor of universal screening of pregnant women for GBS carriage and administering prophylaxis to carriers (1,2).

Multistate ABCs data indicated a 65% decline in the incidence of early-onset disease from 1993 to 1998, coinciding with increased use of intrapartum prophylaxis, followed by a plateau during 1999–2001 (5,8). Adoption of the 2002 guidelines was expected to result in further reductions in earlyonset disease, and a subsequent decline was observed during 2003–2004. Whether the maximum benefit provided by the current prevention strategy has been achieved is unknown. A multistate retrospective cohort study had predicted that universal screening would achieve an incidence of 0.32 per 1,000 live births for early-onset disease, nearly equal to the incidence of 0.34 recorded by ABCs in 2004 (7). However, improved implementation of the screening strategy by clinicians and laboratorians and potential use of a polymerase chain reaction test (approved in 2002) for women whose GBS status is unknown at the time of labor might produce additional gains.

No strategies exist to prevent late-onset disease, although more than half of reported cases of neonatal GBS disease now occur during the late-onset period. In addition, concern continues among health officials that widespread intrapartum antimicrobial use might delay, rather than prevent, GBS disease onset, resulting in increased rates of late-onset disease. No evidence exists to suggest an increase; however, careful monitoring of disease trends remains a priority.

Black infants remain at highest risk for both early-onset and late-onset GBS disease. Although white infants achieved the *Healthy People 2010* target of fewer than 0.5 early-onset cases per 1,000 live births in 1998, the incidence of early-onset disease among black infants remains above the target. This disparity might be associated with less access to prenatal care among black mothers, higher rates of preterm birth (a risk factor for both early-onset and late-onset disease) among black

infants, and higher GBS colonization rates among black mothers (9).

The findings in this report are subject to at least two limitations. First, although incidence trends enable tracking of the effects of prevention measures, these data cannot be directly linked to changes in provider practices. Second, although racial disparities in disease incidence are monitored, the data do not permit evaluation of why these disparities exist.

To characterize provider practices, CDC is collaborating with the EIP Network to abstract a large, population-based sample of maternal labor and delivery records for live births during 2003–2004 in 10 states that participate in ABCs. This effort will 1) provide data on provider adherence to the revised prevention guidelines, 2) identify barriers to adherence, 3) detect missed opportunities for prevention, and 4) increase understanding of racial disparities.

Information for patients, providers, and public health practitioners regarding GBS is available from CDC at http://www.cdc.gov/groupbstrep. Brochures explaining GBS testing and prevention are available in both English and Spanish by telephone at 404-639-2215; bulk orders can be placed through the CDC Foundation by telephone at 877-252-1200.

#### Acknowledgments

This report is based in part on contributions by P Daily, MPH, G Rothrock, MPH, California Emerging Infections Program, Oakland, California; J Mohle-Boetani, MD, California Dept of Health Svcs. K Gershman, MD, Colorado Dept of Public Health. NL Barrett, MS, S Petit, MPH, MZ Fraser, Emerging Infections Program, Connecticut Dept of Public Health. W Baughman, MSPH, Emerging Infections Program, Veterans Affairs Medical Center, Atlanta, Georgia. Maryland Active Bacterial Core surveillance, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland. L Triden, B Jewell, J Rainbow, MPH, R Danila, PhD, Minnesota Dept of Health. K Angeles, MPH, L Butler, K Johnson, MPH, J Keefe, MPH, Emerging Infections Program, Univ of New Mexico, Albuquerque; New Mexico Dept of Health. N Spina, MPH, G Smith, Emerging Infections Program, New York State Dept of Health. M Dragoon, A Zeigler, Multnomah County Health Dept, Portland, Oregon. W Schaffner, MD, Vanderbilt Univ School of Medicine, Nashville, Tennessee. TH Skoff, MS, A Roberson, MS, C Wright, Div of Bacterial and Mycotic Diseases, National Center for Infectious Diseases, CDC.

#### References

- CDC. Prevention of perinatal group B streptococcal disease: revised guidelines from CDC. MMWR 2002;51(No. RR-11).
- ACOG Committee Opinion: number 279, December 2002. Prevention of early-onset group B streptococcal disease in newborns. Obstet Gynecol 2002;100:1405–12.
- Little RJ, Rubin DB. Statistical analysis with missing data. 2nd ed. Wiley series in probability and statistics. Hoboken, NJ: John Wiley & Sons; 2002

- 4. CDC. National Vital Statistics System: birth data. Hyattsville, MD: US Department of Health and Human Services, CDC; 2004. Available at http://www.cdc.gov/nchs/births.htm.
- CDC. Diminishing racial disparities in early-onset neonatal group B streptococcal disease—United States, 2000–2003. MMWR 2004; 53:502–5.
- 6. CDC. Prevention of perinatal group B streptococcal disease: a public health perspective. MMWR 1996;45(No. RR-7).
- 7. Schrag SJ, Zell ER, Lynfield R, et al. A population-based comparison of strategies to prevent early-onset group B streptococcal disease in neonates. N Engl J Med 2002;347:233–9.
- 8. Schrag SJ, Zywicki S, Farley MM, et al. Group B streptococcal disease in the era of intrapartum antibiotic prophylaxis. N Engl J Med 2000:342:15–20.
- 9. Regan JA, Klebanoff MA, Nugent RP. The epidemiology of group B streptococcal colonization in pregnancy. Vaginal Infections and Prematurity Study Group. Obstet Gynecol 1991;77:604–10.

# Adult Participation in Recommended Levels of Physical Activity — United States, 2001 and 2003

Physical activity is associated with a range of health benefits, and its absence can have harmful effects on health and well being, increasing the risk for coronary heart disease, diabetes, certain cancers, obesity, and hypertension (1). CDC and the American College of Sports Medicine recommend that adults engage in at least 30 minutes of moderateintensity physical activity on most days, preferably all days, to have a beneficial effect on their health (2). Two Healthy People 2010 objectives (objectives 22-1 and 22-2) are to increase the proportion of adults who engage in regular moderate or vigorous activity to at least 50% and to decrease the proportion of adults who engage in no leisure-time physical activity to 20% (3). To examine differences from 2001 to 2003 in overall U.S. and state- and territory-specific prevalence estimates of 1) adult participation in the minimum recommended level of physical activity and 2) physical inactivity among adults during lifestyle activities, CDC analyzed data from the Behavioral Risk Factor Surveillance System (BRFSS) surveys for 2001 and 2003. The findings indicated that more than half of U.S. adults continue not to participate in physical activity at a level recommended as beneficial to health. Concerted public health efforts at federal, state, and local levels are needed to improve participation in physical activity.

BRFSS is a population-based, random-digit—dialed telephone survey of the U.S. civilian, noninstitutionalized population aged ≥18 years in 50 states, the District of Columbia, and certain U.S. territories (Guam, Puerto Rico, and the U.S. Virgin Islands). For this study, CDC analyzed data from

BRFSS surveys for 2001 (214,500 respondents; median response rate: 51.1%; range: 33.3%–81.5%) and 2003 (264,684 respondents; median response rate: 53.2%; range: 34.4%–80.5%).

Since 2001, BRFSS has used six survey questions about physical activity in three domains (household work, transportation, and discretionary/leisure time) to quantify its frequency, duration, and intensity. These questions are asked in all states once every 2 years. Respondents are asked to provide information on overall frequency and duration of time spent in bouts of 10 minutes or more of physical activity of moderate intensity (e.g., brisk walking or gardening) and vigorous intensity (e.g., heavy yard work, running, or aerobics) during a usual week. Moderate-intensity activity is described to respondents as any activity "that causes small increases in breathing and heart rate," and vigorous-intensity activity is described as any activity "that causes large increases in breathing or heart rate." Respondents are classified as active at the minimum recommended level if they report moderateintensity activity at least 30 minutes per day, 5 or more days per week, or vigorous-intensity activity at least 20 minutes per day, 3 or more days per week. Respondents are classified as inactive if they report no activity of 10 minutes or more per week of moderate or vigorous intensity. For this analysis, prevalence estimates were age-adjusted to the 2000 U.S. standard population. Pairwise comparisons for changes in prevalence from 2001 to 2003 were performed for each state and territory to calculate t-statistics. Differences were considered statistically significant at p<0.05. Statistical analysis software was used to account for the complex sampling design.

From 2001 to 2003, the age-adjusted prevalence of adults participating in physical activity at the minimum recommended level remained similar (45.3% in 2001 and 45.9% in 2003) (Table 1). Although an increase in prevalence of physical activity was observed in 41 states and territories from 2001 to 2003, the increase was significant only in nine states (Table 1). The prevalence of such activity decreased in 12 states and territories; the decrease was significant in Florida (45.5% in 2001 versus 41.7% in 2003), North Carolina (42.3% versus 37.6%), West Virginia (48.4% versus 43.6%), and Puerto Rico (43.5% versus 34.5%) (Table 1). Nebraska had the largest percentage-point increase in the prevalence of recommended level of physical activity (+10.3%); Puerto Rico had the largest percentage-point decrease (-9.1%) (Table 1). In 2003, the prevalence of physical activity in 22 states and the District of Columbia was equal to or greater than the target (50%) for the national health objective to increase the prevalence of regular moderate- or vigorous-intensity physical activity (Table 1 and Figure) (3).

TABLE 1. Age-adjusted percentage of respondents aged ≥18 years who engaged in a level of activity consistent with physical activity recommendations,\* by state/territory — Behavioral Risk Factor Surveillance System, United States, 2001 and 2003

		2001		2003	Percentage-poi	int		
State/Territory	%	(95% CI†)	%	(95% CI)	change	(95% CI)	% change	
labama	42.4	(40.3–44.6)	40.4	(38.4–42.4)	-2.0	(-5.0–0.9)	-4.8	
laska <sup>§</sup>	54.6	(51.6–57.5)	56.7	(53.9–59.5)	2.1	(-1.9–6.2)	3.9	
rizona§	51.2	(48.7–53.7)	50.0	(47.3–52.7)	-1.2	(-5.0–2.5)	-2.4	
rkansas	45.4	(43.3–47.5)	45.4	(43.6–47.3)	0	(-2.8–2.8)	0	
California	45.8	(44.0–47.7)	46.4	(44.7–48.2)	0.6	(-1.9–3.2)	1.4	
colorado <sup>§</sup>	53.0	(50.4–55.5)	54.5	(52.8–56.3)	1.6	(-1.5–4.6)	2.9	
Connecticut§	48.6	(47.2–50.0)	52.2	(50.6–53.9)	3.7 <sup>¶</sup>	(1.5–5.8)	7.5	
)elaware	41.4	(39.3–43.6)	43.8	(41.7–46.0)	2.4	(-0.6–5.4)	5.8	
istrict of Columbia§	49.7	(46.9–52.5)	51.4	(48.6–54.1)	1.6	(-2.3–5.6)	3.3	
lorida	45.5	(43.7–47.3)	41.7	(39.4–43.9)	-3.9¶	(-6.8– -1.0)	-8.5	
ieorgia	39.2	(37.3–41.1)	41.6	(40.0–43.3)	2.4	(-0.1–4.9)	6.2	
lawaii§	50.4	(48.3–52.4)	50.1	(48.2–52.0)	-0.3	(-3.1–2.5)	-0.6	
daho <sup>§</sup>	54.3	(52.5–56.1)	55.5	(53.8–57.2)	1.2	(-1.3–3.6)	2.1	
inois	45.6	(43.0–48.1)	43.4	(41.9–45.0)	-2.1	(-5.1–0.9)	-4.6	
idiana	45.9	(44.1–47.6)	46.7	(45.2–48.2)	0.8	(-1.5–3.2)	1.8	
owa	43.8	(41.8–45.7)	43.9	(42.2–45.7)	0.0	(-2.4–2.8)	0.4	
wa ansas	43.6 44.1	(42.4–45.8)	43.8	(42.2–45.7) (42.1–45.5)	-0.3	(-2.4–2.6) (-2.6–2.1)	-0.6	
entucky	28.9	(27.3–30.6)	33.7	(32.0–35.5)	4.8¶	(2.4–7.2)	16.6	
ouisiana	35.1	(33.5–36.7)	39.9	(38.3–41.6)	4.9¶	(2.4–7.2)	13.9	
laine <sup>§</sup>	50.3	(48.0–52.7)	53.6	(51.2–55.9)	3.2	(-0.1–6.5)	6.4	
aryland	45.0	(43.1–46.9)	48.8	(46.8–50.8)	3.8¶	(1.0–6.5)	8.4	
lassachusetts§		'		` ,			2.6	
	51.4	(50.1–52.8)	52.8	(51.3–54.3)	1.3	(-0.7–3.3)		
ichigan	45.5	(43.7–47.3)	47.5	(45.5–49.5) (47.2–50.9)	2.0	(-0.7–4.7)	4.4	
linnesota	48.5	(46.6–50.3)	49.0	` ,	0.6	(-2.0–3.2)	1.2	
lississippi	37.6	(35.6–39.7)	40.0	(38.3–41.8)	2.4 5.4¶	(-0.3–5.1)	6.5	
lissouri	39.9	(37.9–42.0)	45.3	(43.2–47.5)	5.4¶	(2.4–8.4)	13.5	
Iontana <sup>§</sup>	51.5	(49.1–53.9)	58.6	(56.4–60.7)	7.1 <sup>¶</sup>	(3.8–10.3)	13.7	
ebraska	34.2	(32.3–36.1)	44.5	(42.9–46.1)	10.3 <sup>¶</sup>	(7.8–12.8)	30.2	
levada <sup>§</sup>	49.8	(46.9–52.7)	51.1	(48.5–53.8)	1.3	(-2.6–5.2)	2.7	
ew Hampshire <sup>§</sup>	50.7	(48.8–52.5)	54.6	(53.0–56.3)	4.0¶	(1.5–6.4)	7.9	
ew Jersey	44.0	(42.3–45.8)	45.0	(43.8–46.2)	1.0	(-1.1–3.1)	2.3	
ew Mexico§	50.0	(48.1–52.0)	51.2	(49.5–52.8)	1.1	(-1.4–3.7)	2.3	
ew York	44.8	(42.9–46.8)	44.5	(42.9–46.2)	-0.3	(-2.8–2.2)	-0.7	
orth Carolina	42.3	(40.4–44.3)	37.6	(36.1–39.3)	-4.7 <sup>¶</sup>	(-7.22.1)	-11.0	
orth Dakota <sup>§</sup>	46.8	(44.6–49.0)	49.7	(47.6–51.7)	2.9	(-0.1–5.9)	6.2	
hio	46.1	(44.1–48.2)	47.3	(45.3-49.3)	1.1	(-1.7–4.0)	2.5	
klahoma	38.9	(37.0–40.8)	40.0	(38.7–41.3)	1.1	(-1.2–3.4)	2.9	
regon§	52.9	(50.7–55.2)	54.0	(52.1–55.8)	1.0	(-1.9–3.9)	1.9	
ennsylvania <sup>§</sup>	46.8	(44.8–48.7)	50.1	(48.2–52.0)	3.3 <sup>¶</sup>	(0.6-6.0)	7.1	
hode Island <sup>§</sup>	48.7	(46.8–50.6)	50.5	(48.6–52.4)	1.8	(-0.8–4.5)	3.8	
outh Carolina	45.3	(43.2–47.4)	46.1	(44.6–47.7)	0.9	(-1.7–3.5)	1.9	
outh Dakota	44.5	(42.9–46.0)	46.8	(45.1–48.4)	2.3	(0-4.6)	5.2	
ennessee	36.9	(34.7 - 39.2)	37.5	(35.3-39.9)	0.6	(-2.6-3.8)	1.7	
exas	42.9	(41.5–44.4)	44.1	(42.6–45.6)	1.2	(-0.9-3.3)	2.7	
tah <sup>§</sup>	53.1	(50.9-55.2)	55.5	(53.4–57.5)	2.4	(-0.6-5.3)	4.5	
ermont <sup>§</sup>	55.0	(53.2-56.7)	55.8	(54.1-57.6)	0.9	(-1.6-3.4)	1.6	
rginia	47.6	(45.4 - 49.7)	49.3	(47.4–51.2)	1.8	(-1.1-4.6)	3.7	
ashington <sup>§</sup>	55.5	(53.8-57.3)	54.2	(53.3-55.2)	-1.3	(-3.3-0.7)	-2.3	
est Virginia	48.4	(46.4-50.5)	43.6	(41.6-45.6)	-4.8 <sup>¶</sup>	(-7.71.9)	-9.9	
'isconsin <sup>§</sup>	52.3	(50.3–54.3)	54.7	(52.8–56.6)	2.3	(-0.4–5.1)	4.5	
/yoming <sup>§</sup>	55.8	(53.8–57.8)	55.3	(53.5–57.0)	-0.5	(-3.2–2.2)	-0.9	
uam	46.3	(42.1–50.6)	47.3	(43.1–51.5)	0.9	(-5.0–6.9)	2.0	
uerto Rico	43.5	(41.5–45.6)	34.5	(32.5–36.4)	-9.1 <sup>¶</sup>	(-11.96.2)	-20.8	
.S. Virgin Islands	38.2	(35.7–40.9)	39.8	(36.9–42.8)	1.6	(-2.3–5.5)	4.2	
J		(/		,,	• • •	,/		

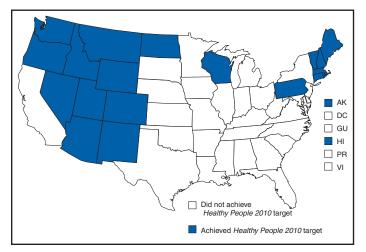
<sup>\*</sup> Reported moderate-intensity activities (i.e., brisk walking, bicycling, vacuuming, gardening, or any activity that causes small increases in breathing or heart rate) for ≥30 minutes per day, ≥5 days per week, or vigorous-intensity activities (i.e., running, aerobics, heavy yard work, or any activity that causes large increases in breathing or heart rate) for ≥20 minutes per day, ≥3 days per week.

Confidence interval.

Sequal to or greater than national *Healthy People 2010* target (objective 22–2) in 2003.

Significant difference.

FIGURE. States and territories that achieved or exceeded the national *Healthy People 2010* target\* for adult participation in recommended levels of physical activity — Behavioral Risk Factor Surveillance System, United States, 2003



\*To increase the proportion of adults who engage in regular moderate- or vigorous-intensity activity to at least 50% (objective 22-2).

In 2001 and 2003, the overall prevalence of lifestyle inactivity (i.e., no activity of at least 10 minutes per week of moderate or vigorous intensity) was similar (16.0% in 2001 versus 15.6% in 2003) (Table 2). A decrease in prevalence of lifestyle inactivity was observed in 32 states and territories (percentage-point change ranging from 0.1% in Arkansas, North Dakota, and Oregon to 12.9% in Nebraska); the decrease was significant in 14 states (Table 2). An increase in prevalence of inactivity was observed in 19 states and territories; these increases were significant in North Carolina (16.9% in 2001 versus 22.5% in 2003), Washington (6.3% versus 9.9%), West Virginia (14.9% versus 17.4%), Wyoming (8.6% versus 10.6%), and Puerto Rico (24.1% versus 33.9%) (Table 2). Inactivity in 2003 ranged from 7.7% (Minnesota) to 33.9% (Puerto Rico).

**Reported by:** S Sapkota, MBBS, MPH, HR Bowles, MS, SA Ham, MS, HW Kohl III, PhD, Div of Nutrition and Physical Activity, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: The findings in this report indicate that, in 2003, the majority (54.1%) of U.S. adults did not engage in physical activity at the minimum recommended level and that the prevalence of meeting recommend levels of physical activity was similar in 2001 and 2003 (45.3% and 45.9%, respectively). From 2001 to 2003, the prevalence of adults participating in recommended levels of physical activity increased significantly in nine states and decreased significantly in three states and Puerto Rico. The remainder of the states had no statistically significant differences. In addition, the

prevalence of lifestyle physical inactivity was similar for the two years (16.0% in 2001 versus 15.6% in 2003).

Although 2 years is a relatively short period for which to examine state- and territory-specific trends in prevalence of physical activity, this study is valuable as the first national report using 2 years of data to determine whether U.S. adults engaged in the recommended levels of physical activity in any of three domains: household work, transportation, and discretionary/leisure time. Earlier reports examined trends in one domain only (discretionary/leisure time) (4–6).

The findings in this report are subject to at least three limitations. First, BRFSS data are based on self-reports and thus are subject to social desirability and recall biases. Second, the survey misclassifies a small proportion of the sample because the instrument is designed to measure only those who meet the recommendation in one of two intensities, moderate or vigorous, and misses those who would be deemed adequately active when the intensities were combined (e.g., being moderately active 3 days a week and vigorously active 2 days a week). Finally, the response rates were low in 2001 (51.1%) and 2003 (53.2%), indicating possible nonresponse bias.

Promotion of physical activity is integral to national health promotion policies. Physical activity levels can be increased by incorporating physical activity into daily routines, such as being active in housework, walking and biking for transportation, participating in worksite physical activity programs, and pursuing physically active hobbies and recreational activities. The Guide to Community Preventive Services: Physical Activity highlights recommended evidence-based strategies for successful physical activity promotion in these settings (7). CDC coordinates multiple programs at state and local levels, including Steps to a Healthier US, that aim to prevent or control obesity, diabetes, and cardiovascular disease; physical activity is an important component of such programs. Public health agencies should continue to increase and promote opportunities for physical activity among adults in communities and workplaces.

#### References

- 1. US Department of Health and Human Services. Physical activity and health: report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion; 1996.
- Pate RR, Pratt M, Blair SN, et al. Physical activity and public health: a recommendation from the Centers for Disease Control and Prevention and the American College of Sports Medicine. JAMA 1995;273:402–7.
- US Department of Health and Human Services, CDC. DATA2010: the Healthy People 2010 database, 2004. Available at http://wonder. cdc.gov/data2010.
- Kruger J, Ham SA, Kohl HW III. Trends in leisure-time physical inactivity by age, sex, and race/ethnicity—United States, 1994–2004. MMWR 2005;54:991–4.

TABLE 2. Age-adjusted percentage of respondents aged ≥18 years categorized as physically inactive,\* by state/territory — Behavioral Risk Factor Surveillance System, United States, 2001 and 2003

Behavioral Risk Factor	Sui veillarice	2001	u States,	2001 and 2003	Doveoutone ne	int	
State/Torritory	%	(95% CI†)	%	(95% CI)	Percentage-po change	(95% CI)	% change
State/Territory Alabama	16.5	(15.0–18.0)	17.0	(15.6–18.5)	0.6	(-1.5–2.6)	3.3
Alaska	10.0	(8.4–11.9)	17.0	(10.4–14.0)	2.1	(-0.4–4.6)	20.7
Arizona	12.2	(10.6–13.9)	14.5	(12.6–14.0)	2.3	(-0.3–4.9)	19.1
Arkansas	15.6	(14.2–17.2)	15.5	(14.3–16.8)	-0.1	(-2.0–1.9)	-0.6
California	13.2	(11.9–14.6)	12.5	(11.3–13.8)	-0.7	(-2.5–1.2)	-5.1
Colorado	10.0	(8.5–11.7)	10.0	(9.0–11.1)	0	(-2.5–1.2) (-1.9–1.9)	-0.1
Connecticut	14.6	(13.6–15.7)	13.3	(12.2–14.5)	-1.3	(-2.8–0.2)	-8.8
Delaware	16.4	` ,	16.4	,	-1.3	(-2.2–2.2)	-o.o 0
District of Columbia		(14.9–18.1)		(14.9–18.1) (14.4–18.5)			0
	16.3	(14.3–18.6)	16.3	` ,	0	(-3.0–3.0)	
Florida	18.4	(17.1–19.9)	17.9	(16.3–19.7)	-0.5	(-2.7–1.8)	-2.6
Georgia	22.1	(20.6–23.7)	18.3	(17.1–19.6)	-3.8§	(-5.81.9)	-17.3
Hawaii	13.3	(12.0–14.7)	13.5	(12.3–14.9)	0.2	(-1.6–2.1)	1.9
Idaho	10.2	(9.1–11.4)	9.9	(9.0–10.9)	-0.3	(-1.8–1.2)	-2.9
Illinois	17.8	(15.9–19.9)	16.9	(15.8–18.2)	-0.9	(-3.2–1.4)	-5.0
Indiana	13.6	(12.5–14.8)	13.9	(12.9–14.9)	0.3	(-1.2–1.9)	2.3
lowa	13.7	(12.5–15.1)	13.8	(12.7–15.0)	0.1	(-1.6–1.8)	0.5
Kansas	19.0	(17.7–20.4)	16.7	(15.5–18.0)	-2.3§	(-4.1– -0.5)	-12.2
Kentucky	33.2	(31.6–34.8)	26.2	(24.8–27.8)	-6.9 <sup>§</sup>	(-9.14.7)	-20.8
Louisiana	29.9	(28.4–31.3)	22.6	(21.3–23.9)	-7.3§	(-9.3– -5.3)	-24.4
Maine	13.4	(11.9–14.9)	12.9	(11.5–14.5)	-0.5	(-2.6–1.6)	-3.6
Maryland	15.5	(14.1–16.9)	13.7	(12.4–15.2)	-1.7	(-3.7–0.3)	-11.3
Massachusetts	14.1	(13.2-15.0)	13.4	(12.5–14.4)	-0.7	(-2.0-0.7)	-4.7
Michigan	14.4	(13.1-15.7)	12.4	(11.2-13.7)	-2.0§	(-3.80.2)	-13.8
Minnesota	9.2	(8.1-10.3)	7.7	(6.8-8.6)	-1.5 <sup>§</sup>	(-2.90.1)	-16.2
Mississippi	23.0	(21.4–24.8)	20.7	(19.3–22.1)	-2.4§	(-4.60.2)	-10.4
Missouri	16.8	(15.2–18.4)	13.8	(12.5–15.3)	-2.9§	(-5.00.8)	-17.4
Montana	13.8	(12.4–15.4)	8.9	(7.9–10.1)	-4.9§	(-6.8— -3.0)	-35.4
Nebraska	26.7	(25.0–28.6)	13.9	(12.8–15.0)	-12.9 <sup>§</sup>	(-15.0— -10.8)	-48.2
Nevada	12.9	(11.1–14.9)	15.2	(13.3–17.3)	2.3	(-0.4–5.1)	18.1
New Hampshire	11.7	(10.7–12.9)	10.6	(9.7–11.6)	-1.1	(-2.6–0.4)	-9.6
New Jersey	16.8	(15.5–18.1)	17.3	(16.4–18.2)	0.5	(-1.1–2.0)	2.8
New Mexico	13.6	(12.4–15.0)	13.1	(12.0–14.2)	-0.5	(-2.3–1.2)	-4.0
New York	19.0	(17.5–20.6)	19.1	(17.8–20.6)	0.1	(-2.0–2.2)	0.7
North Carolina	16.9	(15.4–18.4)	22.5	(21.2–23.9)	5.6§	(3.6–7.6)	33.2
North Dakota	11.3	(10.0–12.8)	11.2	(10.1–12.4)	-0.1	(-1.9–1.7)	-0.8
Ohio	15.8	(14.2–17.5)	14.3	(13.0–15.7)	-1.5	(-3.6–0.7)	-9.3
Oklahoma	21.3	(19.7–23.0)	18.7	(17.7–19.7)	-2.6§	(-4.7– -0.6)	-12.2
Oregon	11.7	(10.3–13.2)	11.5	(10.4–12.7)	-0.1	(-2.0–1.7)	-1.3
Pennsylvania	13.3	(12.1–14.6)	12.0	(10.9–13.3)	-1.3	(-3.0–0.5)	-9.6
Rhode Island	15.2	(13.9–16.6)	14.4	(13.2–15.8)	-0.8	(-2.7–1.0)	-5.4
South Carolina	16.0	(14.5–17.5)	15.0	(13.9–16.1)	-1.0	(-2.9–0.9)	-6.3
South Dakota	17.9	· · · · · · · · · · · · · · · · · · ·		` ,	-1.0 -3.5§	(-2.9-0.9) (-5.01.9)	-0.3 -19.3
Tennessee		(16.8–19.2)	14.5	(13.5–15.6)	-4.9§	'	
	26.0	(24.3–27.9)	21.2	(19.4–23.0)		(-7.42.3)	-18.7
Texas	16.7	(15.6–17.9)	18.3	(17.1–19.5)	1.6	(-0.1–3.2)	9.5
Utah	8.8	(7.7–10.1)	9.6	(8.4–10.9)	0.8	(-0.9–2.5)	8.8
Vermont	11.5	(10.5–12.6)	9.6	(8.7–10.5)	-1.9 <sup>§</sup>	(-3.3– -0.5)	-16.7
Virginia	13.3	(11.9–14.8)	14.0	(12.8–15.2)	0.7	(-1.2–2.5)	5.1
Washington	6.3	(5.5–7.2)	9.9	(9.3–10.5)	3.6 <sup>§</sup>	(2.6–4.6)	57.0
West Virginia	14.9	(13.6–16.3)	17.4	(16.0–18.8)	2.5§	(0.5–4.4)	16.6
Wisconsin	8.4	(7.3-9.5)	8.6	(7.7–9.7)	0.3	(-1.2–1.7)	3.0
Wyoming	8.6	(7.6-9.7)	10.6	(9.6–11.7)	2.1 <sup>§</sup>	(0.6-3.5)	23.9
Guam	19.1	(15.8–22.8)	18.6	(15.3–22.4)	-0.5	(-5.5–4.5)	-2.6
Puerto Rico	24.1	(22.5-25.9)	33.9	(32.1-35.7)	9.7 <sup>§</sup>	(7.3-12.2)	40.3
U.S. Virgin Islands	24.5	(22.2-26.9)	25.4	(22.9-28.2)	0.9	(-2.6-4.5)	3.8
Mean	16.0	(15.8–16.3)	15.6	(15.4–15.9)	-0.4§	(-0.8–0)	-2.6
				•		• • • • • • • • • • • • • • • • • • • •	

<sup>\*</sup>No bouts of ≥10 minutes of moderate- or vigorous-intensity activity (including household work, transportation, or discretionary/leisure-time activity). 
§ Confidence interval.
§ Significant difference.

- Ham SA, Yore MM, Fulton JE, Kohl HW III. Prevalence of no leisuretime physical activity—35 states and the District of Columbia, 1988– 2002. MMWR 2004;53:82–6.
- CDC. Physical activity trends—United States, 1990–1998. MMWR 2001;50:166–9.
- 7. Task Force on Community Preventive Services. The guide to community preventive services: physical activity. Atlanta, GA: US Department of Health and Human Services, CDC; 2001. Available at http://www.thecommunityguide.org/pa.

#### Notice to Readers

## Licensure of a Combined Live Attenuated Measles, Mumps, Rubella, and Varicella Vaccine

On September 6, 2005, the Food and Drug Administration licensed a combined live attenuated measles, mumps, rubella, and varicella (MMRV) vaccine (ProQuad®, Merck & Co., Inc., Whitehouse Station, New Jersey) for use in children aged 12 months–12 years. The attenuated measles, mumps, and rubella vaccine viruses in ProQuad are identical and of equal titer to those in the measles, mumps, and rubella (MMR) vaccine, MMRII® (Merck). The titer of Oka/Merck varicella-zoster virus is higher in MMRV vaccine than in single antigen varicella vaccine, VARIVAX® (Merck), a minimum of 3.13 log<sub>10</sub> plaque-forming units (pfu) versus 1,350 pfu (approximately 1.13 log<sub>10</sub>), respectively.

Advisory Committee on Immunization Practices (ACIP) current recommendations are that children aged 12 months—12 years receive 2 doses of MMR vaccine at least 1 month apart and 1 dose of varicella vaccine (1).\* MMRV vaccine can decrease the number of injections received by children when all of the component antigens are indicated for administration. One dose of MMRV vaccine should be administered on or after the first birthday, preferably as soon as the child becomes eligible for vaccination (2).

MMRV vaccine was licensed on the basis of equivalence of immunogenicity of the antigenic components rather than clinical efficacy; the efficacy of the individual components of MMRV has been established previously (3,4). Clinical studies of 7,484 healthy children aged 12–23 months (of whom 5,446 received MMRV vaccine) indicated that those who received 1 dose of MMRV vaccine developed levels of antibody to measles, mumps, rubella, and varicella similar to those of children who received 1 dose of MMR and 1 dose of varicella vaccines concomitantly at separate injection sites. The respective prevalences of detectable antibody (i.e., positive serologic

response) using defined cutoff levels among MMRV vaccine recipients were 97.4% (95% confidence interval [CI] = 96.9%–97.9%) for measles (≥255 mIU/mL when compared with the WHO II [66/202] reference immunoglobulin for measles), 95.8% (CI = 95.1%–96.4%) for mumps<sup>†</sup> (≥10 enzyme-linked immunosorbent assay [ELISA] units/mL), 98.5% (CI = 98.1%–98.8%) for rubella (≥10 IU rubella antibody/mL when compared with the WHO international reference serum for rubella), and 91.2% (CI = 90.3%–92.0%) for varicella (≥5 gpELISA units/mL [a response rate highly correlated with long-term protection]) (5).

A subgroup of the children (n = 1,035) who received 1 dose of MMRV vaccine received a second dose of MMRV vaccine approximately 3 months after the first dose. Positive serologic response after 2 doses was 99.4% (CI = 98.6%–99.8%) for measles, 99.9% (CI = 99.4%–100%) for mumps, 98.3% (CI = 97.2%–99.0%) for rubella, and 99.4% (CI = 98.7%–99.8%) for varicella among the children who were seronegative before receipt of the first dose of MMRV vaccine (5). The geometric mean titers (GMTs) after the second dose of MMRV vaccine increased approximately two-fold each for measles, mumps, and rubella and 41-fold for varicella.

To assess the immunogenicity of a second dose of MMRV vaccine at ages 4–6 years, a trial was conducted among 799 healthy children in this age group who had received 1 dose of MMR and 1 dose of varicella vaccine at age ≥12 months and at least 1 month before enrollment in the study (5). In that study, subjects were administered either 1) MMRV vaccine and placebo (n = 399), 2) MMR and varicella vaccines (n = 195), or 3) MMR vaccine and placebo (n = 205) concomitantly at separate sites. Recipients of MMRV vaccine had seropositivity rates of 99.2% (CI = 97.6%–99.8%) for measles, 99.5% (CI = 98.0%–99.9%) for mumps, 100% (CI = 99.0%–100.0%) for rubella, and 98.9% (CI = 97.2%–99.7%) for varicella and had postvaccination GMT increases, compared with prevaccination GMTs, of 1.2 for measles, 2.4 for mumps, 3.0 for rubella, and 12.0 for varicella.

The postvaccination GMTs for measles, mumps, rubella, and varicella among MMRV vaccine recipients were comparable to that of the group vaccinated with MMR and varicella vaccines. Likewise, the GMTs were similar for measles, mumps, and rubella among the MMRV vaccine recipients and the group vaccinated with MMR vaccine and placebo (5).

Concomitant administration of MMRV with other vaccines was assessed among 1,913 healthy children aged 12–15 months. A group concomitantly administered at separate sites

<sup>\*</sup> During a varicella outbreak, a second dose of varicella vaccine may be administered to persons who previously received 1 dose of varicella vaccine to provide additional protection from varicella disease, if the appropriate vaccination interval (3 months for persons aged 12 months—12 years) has elapsed since the first dose.

<sup>&</sup>lt;sup>†</sup> Two separate assays, one based on wild type and one on vaccine type strains, were used to assess mumps immune response rates; the data presented here are the lower values obtained; more detailed information is contained in the package insert.

MMRV vaccine, diphtheria and tetanus toxoids and acellular pertussis adsorbed (DTaP) vaccine, *Haemophilus influenzae* type b conjugate (meningococcal protein conjugate) (Hib) vaccine, and hepatitis B (recombinant) (HepB) vaccine (n = 949) was compared with 1) a group receiving MMRV at the initial visit, followed by DTaP, Hib, and HepB vaccines administered concomitantly 6 weeks later (n = 485), and 2) a group receiving MMR and varicella vaccines concomitantly (n = 479) (5). Seroconversion rates and antibody titers were comparable for the measles, mumps, rubella, and varicella components for all three groups; the Hib and HepB seroconversion rates for the two groups that received those vaccines also were comparable.

The safety profile of MMRV vaccine without concomitant administration of other vaccines was studied in healthy children aged 12-23 months who were monitored for 42 days postvaccination. Rates of most local and systemic adverse events for children vaccinated with MMRV (n = 4,497 recipients) were comparable to rates for MMR and varicella vaccines administered concomitantly (n = 2,038 recipients). Two systemic vaccine-related adverse events were reported at significantly greater rates among MMRV vaccine recipients; fever of ≥102°F (≥38.9°C) was observed in 21.5% of MMRV recipients versus 14.9% of MMR and varicella vaccine recipients, and measleslike rash was observed in 3.0% of recipients of MMRV vaccine recipients versus 2.1% of those administered MMR and varicella vaccines (5). Both of these adverse events were reported to occur more frequently during day 5 through day 12 postvaccination and typically resolved spontaneously without sequelae. Rash at the injection site was the only local vaccine-related adverse event reported more commonly among MMRV recipients (2.3%) than among MMR and varicella vaccine recipients (1.5%). Among 2,108 healthy children aged 12–23 months who received MMRV vaccine and were followed for up to 1 year, two cases of herpes zoster were reported; both cases were unremarkable and resolved without sequelae. In two studies of 1,035 vaccinees aged 12-23 months who received 2 doses of MMRV vaccine, the rates of adverse events after the second dose were generally similar or lower than those observed with the first dose (5).

## **Indications and Usage**

1. MMRV vaccine is indicated for simultaneous vaccination against measles, mumps, rubella, and varicella among children aged 12 months–12 years; MMRV is not indicated for persons outside of this age group. Use of licensed combination vaccines, such as MMRV vaccine, is preferred over separate injection of equivalent component vaccines (6). MMRV

- vaccine can reduce the number of injections when administered to children aged 12 months—12 years for whom 1) the first dose of MMR and varicella vaccines is indicated and 2) the second dose of MMR and either the first or second dose (e.g., during a varicella outbreak) of varicella vaccine is indicated. MMRV vaccine is administered subcutaneously as a single 0.5-mL dose.
- 2. MMRV vaccine may be used whenever any components of the combination vaccine are indicated and the other components are not contraindicated. Using combination vaccines containing some antigens not indicated at the time of administration might be justified when 1) products that contain only the needed antigens are not readily available or would result in extra injections and 2) potential benefits to the child outweigh the risk of adverse events associated with the extra antigen(s).
- 3. At least 1 month should elapse between a dose of measlescontaining vaccine, such as MMR vaccine, and a dose of MMRV vaccine. Should a second dose of varicella vaccine be indicated for children aged 12 months–12 years (e.g., during a varicella outbreak), at least 3 months should elapse between administration of any 2 doses of varicella-containing vaccine, including single antigen varicella vaccine or MMRV vaccine.
- 4. Simultaneous administration of the most widely used live and inactivated vaccines have produced seroconversion rates and rates of adverse reactions similar to those observed when the vaccines are administered separately (7). Therefore, MMRV may be administered simultaneously with other vaccines recommended at ages 12 month–12 years, although data are absent or limited for the concomitant use of MMRV vaccine with DTaP, inactivated polio, pneumococcal conjugate, influenza, and hepatitis A vaccines.
- 5. MMRV vaccine must be stored frozen at an average temperature  $\leq$ 5°F ( $\leq$ -15°C) for up to 18 months. Adequacy of the freezer should be checked before obtaining or storing MMRV vaccine. Unlike single antigen varicella vaccine, MMRV vaccine cannot be stored at refrigerator temperature. Once reconstituted, the vaccine should be used immediately to minimize loss of potency and should be discarded if not used within 30 minutes. The diluent should be stored separately at room temperature or in the refrigerator.
- 6. MMRV vaccine should not be administered as a substitute for the component vaccines when vaccinating children with human immunodeficiency virus (HIV) infection until revised recommendations can be considered for the use of MMRV vaccine in this population; current recommendations for vaccination of HIV-infected children with MMR and varicella vaccines are available (3,8).

ACIP recommendations for MMR and varicella vaccines have been previously published (3,4,8,9) and are applicable for the respective components of MMRV vaccine. Additional information regarding ProQuad is available from the package insert (5) provided by the manufacturer (http://www.merck.com).

#### References

- 1. CDC. Recommended childhood and adolescent immunization schedule—United States, 2005. MMWR 2005;53:Q1–3.
- CDC. Preventable measles among U.S. residents, 2001–2004. MMWR 2005;54:817–20.
- CDC. Measles, mumps, and rubella—vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1998;47(No. RR-8).
- CDC. Prevention of varicella: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1996;45 (No. RR-11).
- Merck & Co., Inc. ProQuad<sup>®</sup> [measles, mumps, rubella and varicella (Oka/Merck) virus vaccine live] prescribing information. Whitehouse Station, NJ: Merck & Co., Inc.; 2005.
- CDC. Combination vaccines for childhood immunization: recommendations of the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). MMWR 1999;48(No. RR-5).
- CDC. General recommendations on immunizations: recommendations of the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Family Physicians (AAFP). MMWR 2002;51 (No. RR-2):5.
- 8. Advisory Committee on Immunization Practices (ACIP). Prevention of varicella—provisional updated ACIP recommendations for varicella vaccine use. Atlanta, GA: US Department of Health and Human Services, Advisory Committee on Immunization Practices; 2005. Available at <a href="http://wwwdev.cdc.gov/nip/vaccine/varicella/varicella\_acip\_recs.pdf">http://wwwdev.cdc.gov/nip/vaccine/varicella/varicella\_acip\_recs.pdf</a>.
- CDC. Prevention of varicella: updated recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1999;48(No. RR-6).

#### Notice to Readers

# National Drunk and Drugged Driving Prevention Month — December 2005

December is National Drunk and Drugged Driving Prevention Month (3D Month). During 2004, alcohol-related motor-vehicle crashes resulted in 16,694 deaths in the United States, accounting for 39% of all traffic fatalities. This amounts to one alcohol-related death every 31 minutes (1). Moreover, approximately 21% of all crashes that killed children aged ≤14 years in 2004 were alcohol-related (1), and nearly two thirds of children killed in alcohol-related crashes were in the same car as the drinking driver (2).

To decrease alcohol-related traffic fatalities, communities must implement and enforce strategies that are known to be effective, such as sobriety checkpoints, 0.08% blood alcohol concentration laws, minimum legal drinking age laws, and "zero tolerance" laws for young drivers. Information about such interventions is available at http://www.thecommunity guide.org/mvoi. Information about National 3D Month is available at http://www.nhtsa.dot.gov and http://www.stop impaireddriving.org/holidayplanner2005/planner/index.cfm.

#### References

- National Highway Traffic Safety Administration. Traffic safety facts 2004, alcohol. Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration; 2004. Publication no. DOT-HS-809-905.
- Quinlan KP, Brewer RD, Sleet DA, Dellinger AM. Characteristics of child passenger deaths and injuries involving drinking drivers. JAMA 2000;283:2249–52.

#### Notice to Readers

## **MMWR** Subscriber Survey

MMWR readers are invited to participate in the MMWR Subscriber Survey. Reader input will enable MMWR to improve its content, identify potential new topic areas, and deliver new features.

Readers who wish to participate in the survey can do so online at http://websurveyor.net/wsb.dll/23779/mmwr.htm. The survey is estimated to take approximately 20 minutes to complete. Participation is completely voluntary.

## Errata: Vol. 54, No. 31

In the Final 2004 Reports of Notifiable Diseases, multiple errors occurred in Table 2, titled "Reported cases of notifiable diseases, by geographic division and area — United States, 2004." The corrected Table 2, with corrections highlighted, is available at http://www.cdc.gov/mmwr/preview/mmwr html/mm5447a7.htm.

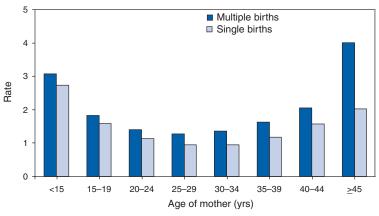
#### Errata: Vol 54, No. SS-6

In the *MMWR Surveillance Summary*, "Contraceptive Use—United States and Territories, Behavioral Risk Factor Surveillance System, 2002," two errors occurred in Table 1. On page 11, in the column labeled "Oral contraceptives (pill)," the prevalence for Connecticut should be **35.8**. On page 13, in the column labeled "Rhythm," the prevalence for Alabama should be **2.1**.

# **QuickStats**

#### FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Rate\* of Very Low Birthweight,† by Age of Mother and Multiple-Birth Status — United States, 2003



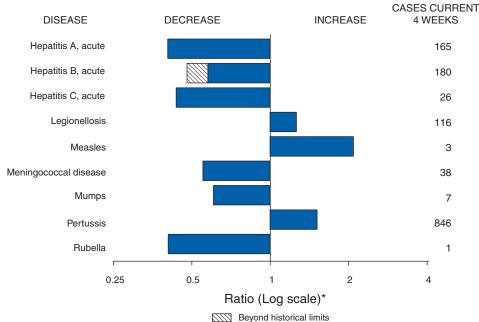
\* Per 100 live births.

The risk of giving birth to a very low birthweight infant is higher for both younger and older mothers. Much of the added risk among older women is attributable to higher multiple birth rates. On average, infants born in multiple births are smaller than infants born in single births.

**SOURCES:** National Vital Statistics System, 2003 natality file; Martin JA, Hamilton BE, Sutton PD, et al. Births: final data for 2003. Natl Vital Stat Rep 2005;54(2). Available at http://www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54\_02.pdf.

 $<sup>^{\</sup>dagger}$  Defined as <1,500 g (<3 lbs, 4 oz).

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals November 26, 2005, with historical data



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

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending November 26, 2005 (47th Week)\*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	_	_	Hemolytic uremic syndrome, postdiarrheal†	157	161
Botulism:			HIV infection, pediatric <sup>†¶</sup>	181	339
foodborne	13	9	Influenza-associated pediatric mortality†**	45	_
infant	75	78	Measles	64 <sup>††</sup>	26§§
other (wound & unspecified)	25	14	Mumps	237	213
Brucellosis	97	94	Plague	3	2
Chancroid	25	25	Poliomyelitis, paralytic	1	_
Cholera	6	4	Psittacosis†	20	11
Cyclosporiasis†	720	201	Q fever <sup>†</sup>	129	57
Diphtheria	_	–	Rabies, human	2	6
Domestic arboviral diseases			Rubella	17	9
(neuroinvasive & non-neuroinvasive):	_	–	Rubella, congenital syndrome	1	_
California serogroup <sup>†§</sup>	64	116	SARS†**	_	_
eastern equine <sup>†§</sup>	21	5	Smallpox <sup>†</sup>	_	_
Powassan <sup>†§</sup>	l –	1	Staphylococcus aureus:		
St. Louis†§	8	13	Vancomycin-intermediate (VISA)†	1	_
western equine <sup>† §</sup>	_	–	Vancomycin-resistant (VRSA)†	_	1
Ehrlichiosis:	l –	l —	Streptococcal toxic-shock syndrome <sup>†</sup>	97	119
human granulocytic (HGE)†	558	390	Tetanus	18	22
human monocytic (HME)†	425	288	Toxic-shock syndrome	86	82
human, other and unspecified †	80	66	Trichinellosis <sup>15</sup>	16	2
Hansen disease <sup>†</sup>	69	94	Tularemia <sup>†</sup>	134	105
Hantavirus pulmonary syndrome†	22	21	Yellow fever	_	_

No reported cases.

reported since October 2, 2005 (40th Week).

Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

Not notifiable in all states.

Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).

Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update June 26, 2005. \*\* Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases. Of the 45 cases reported, one was

Of 64 cases reported, 53 were indigenous and 11 were imported from another country.

<sup>§§</sup> Of 26 cases reported, nine were indigenous and 17 were imported from another country.

<sup>19</sup> Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending November 26, 2005, and November 27, 2004 (47th Week)\*

(47th Week)*	1	100	,	, P.A.	0	, , , , , , , , , , , , , , , , , , ,	0 1	
		IDS L Cum		mydia <sup>†</sup>		domycosis		oridiosis
Reporting area	Cum. 2005§	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	20,405	35,513	822,513	826,334	4,281	5,398	6,838	3,294
NEW ENGLAND	778	1,129	28,633	26,951	<del>_</del>	<del>_</del>	312	161
Maine N.H.	11 20	23 39	2,003 1,632	1,880 1,557	<u>N</u>	<u>N</u>	25 33	18 30
Vt. <sup>¶</sup>	4	14	846	1.016	_	_	35	23
Mass.	368	425	12,984	12,023	_	_	130	59
R.I. Conn.	68 307	114 514	2,838 8,330	3,064 7,411	 N	N	13 76	4 27
MID. ATLANTIC	4,352	7,866	103,783	101,690	_	_	3,121	537
Upstate N.Y.	800	855	20,906	20,535	N	N	2,691	170
N.Y. City N.J.	2,327 574	4,452 1,302	33,440 15,984	31,157	N	N	121 63	129 43
Pa.	651	1,257	33,453	15,776 34,222	N	N	246	195
E.N. CENTRAL	1,938	2,818	135,862	145,700	11	13	1,404	982
Ohio	312	541	36,579	35,948	N	N	751	211
Ind. III.	236 983	327 1,274	18,137 40,565	16,709 43,027	<u>N</u>	<u>N</u>	77 134	70 150
Mich.	322	535	24,184	32,583	11	13	101	144
Wis.	85	141	16,397	17,433	N	N	341	407
W.N. CENTRAL	463	720	50,663	51,460	5	6	547	376
Minn. Iowa	123 50	190 57	9,702 6,461	10,626 6,271	3 N	N N	131 105	123 81
Mo.	198	297	20,016	19,140	1	3	244	66
N. Dak.	5	16	1,066	1,616	N	N	1	12
S. Dak. Nebr. <sup>1</sup>	10 18	8 44	2,496 4,559	2,294 4,768	1	 3	24 9	37 27
Kans.	59	108	6,363	6,745	Ň	Ň	33	30
S. ATLANTIC	6,473	11,141	156,225	154,760	2	_	663	490
Del. Md.	100 812	136 1,293	3,068 16,599	2,658 17,350	N 2	<u>N</u>	5 34	 22
D.C.	467	785	3,415	3,208	_	_	15	15
Va. <sup>1</sup>	307	565	18,495	19,545			60	57
W. Va. N.C.	36 531	71 1,015	2,455 28,137	2,517 25,924	N N	N N	14 84	6 75
S.C. <sup>1</sup>	386	643	18,983	17,005	_	_	17	22
Ga.	1,103	1,410	26,997	28,553	_	_	111	171
Fla.	2,731	5,223	38,076	38,000	N	N	323	122
E.S. CENTRAL Ky.	1,093 135	1,647 212	62,070 7,724	54,513 5,643	 N	5 N	202 138	134 43
Tenn. <sup>1</sup>	434	684	21,377	20,109	N	N	40	41
Ala. <sup>¶</sup> Miss.	295 229	382 369	14,324 18,645	12,127 16,634	_	<u> </u>	20 4	22 28
W.S. CENTRAL	2,206	4,223	94,438	99,841	1	3	180	127
Ark.	72	183	7,798	7,210		1	6	15
La.	436	799	14,484	20,066	1	2	81	5
Okla. Tex. <sup>¶</sup>	167 1,531	169 3,072	9,570 62,586	9,494 63,071	N N	N N	41 52	22 85
MOUNTAIN	789	1,242	46,338	50,858	2,944	3,396	124	160
Mont.	4	5	2,019	2,230	N	N	18	34
Idaho¶ Wyo.	9 2	17 14	2,253 1,028	2,555 973	N 3	N 2	15 3	27 4
Colo.	163	278	11,712	13,047	Ň	N	48	55
N. Mex.	72	164	5,135	8,088	14	21	8	18
Ariz. Utah	329 33	454 62	15,034 3,831	14,791 3,399	2,889 6	3,292 23	9 14	15 5
Nev. <sup>¶</sup>	177	248	5,326	5,775	32	58	9	2
PACIFIC	2,313	4,727	144,501	140,561	1,318	1,975	285	327
Wash.	229 136	348 249	16,762 8,088	15,872	N	N —	43 65	42 29
Oreg. <sup>1</sup> Calif.	1,874	3,981	113,024	7,598 108,753	1,318	1,975	65 173	29 254
Alaska	14	43	3,547	3,481		_	3	_
Hawaii	60	106	3,080	4,857	_	_	1	2
Guam P.R.	1 537	1 635	 3,413	803 3,141	 N	N	 N	N
V.I.	10	18	196	308	_	_	_	_
Amer. Samoa C.N.M.I.	U 2	U U	<u>U</u>	U U	U —	U U	<u>U</u>	U U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

\* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

\* Chlamydia refers to genital infections caused by *C. trachomatis*.

\* Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update June 26, 2005.

\* Contains data reported through National Electronic Disease Surveillance System (NEDSS). Due to a technical problem with hardware, data from these states are not included this week.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 26, 2005, and November 27, 2004 (47th Week)\*

(47th Week)*		Escher	ichia coli, Ente	rohemorrhagio	(EHEC)					
				n positive,	Shiga toxi	n positive,				
		7:H7	<del></del>	non-O157	not sero	-	Giardi	$\overline{}$		orrhea
Reporting area	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	2,250	2,333	326	278	296	179	16,194	17,861	284,975	293,325
NEW ENGLAND	153	154	53	42	23	14	1,494	1,617	5,170	6,155
Maine	14	14	11	_	_	_	190	137	122	198
N.H. Vt.	12 13	21 13	2 4	5 —	_	_	48 166	44 156	160 54	116 82
Mass.	62	69	12	13	23	14	636	727	2,287	2,801
R.I. Conn.	7 45	9 28	<u> </u>	1 23	_	_	107 347	107 446	384 2,163	762 2,196
MID. ATLANTIC	287	279	37	61	30	34	2,995	3,687	30,174	32,905
Upstate N.Y.	129	119	19	42	9	17	1,100	1,281	6,272	6,683
N.Y. City N.J.	14 49	35 56	_ 3	<u> </u>	 11	6	760 362	993 461	9,067 4,855	9,982 6,115
Pa.	95	69	15	13	10	11	773	952	9,980	10,125
E.N. CENTRAL	432	446	33	46	25	32	2,572	3,002	55,517	61,993
Ohio Ind.	141 62	92 48	6	9	16 —	18 —	734 N	725 N	17,201 7,265	18,831 6,111
III.	46	101	1	7	1	8	578	756	16,475	18,790
Mich. Wis.	74 109	81 124	2 24	11 19	6 2	6	698 562	663 858	9,857 4,719	13,717 4,544
W.N. CENTRAL	395	463	38	38	59	21	1,968	1,967	16,266	15,698
Minn.	125	105	21	15	32	4	898	744	2,759	2,642
Iowa Mo.	92 73	117 93	 11	— 17	— 13	<u> </u>	248 457	278 521	1,429 8,416	1,130 8,281
N. Dak.	7	14	_	_	1	7	15	22	74	99
S. Dak. Nebr.	26 30	31 62	3 3	2 4	4	_	85 85	58 139	313 1,032	265 996
Kans.	42	41	_	_	9	4	180	205	2,243	2,285
S. ATLANTIC	185	165	78	33	110	54	2,310	2,695	68,777	70,529
Del. Md.	7 30	3 21	N 30	N 6	N 11	N 3	52 184	44 135	806 6,358	803 7,349
D.C.	1	1	_	_		_	51	66	1,920	2,369
Va. W. Va.	39	33 2	27	17	21 1	_	478 42	471	6,867	7,789
N.C.	3	_	_	_	60	<u> </u>	42 N	41 N	664 13,526	818 13,838
S.C.	6	12	1	_	1	_	94	109	8,470	8,457
Ga. Fla.	28 71	22 71	16 4	7 3	— 16	7	528 881	828 1,001	12,589 17,577	12,704 16,402
E.S. CENTRAL	130	100	10	5	31	15	385	381	25,023	23,901
Ky.	47	25	7	1	20	9	N	N	2,715	2,475
Tenn. Ala.	47 29	38 26	2	<u>2</u>	11 —	6	195 190	205 176	7,957 8,105	7,633 7,431
Miss.	7	11	1	2	_	_	_	_	6,246	6,362
W.S. CENTRAL	48	82	14	3	8	9	293	309	38,483	39,160
Ark. La.	8 4	17 4	 11	_ 1	3	3	77 54	119 49	4,085 8,147	3,810 9,578
Okla.	22	18	2	_	1	_	162	141	3,854	4,047
Tex.	14	43	1	2	4	6	N	N	22,397	21,725
MOUNTAIN Mont.	218 16	232 16	55 —	49 —	10	_	1,360 67	1,395 76	9,864 122	10,826 76
Idaho	27	53	13	13	7	_	142	181	95	88
Wyo. Colo.	6 65	9 51	2 3	5 1	_ 1	_	26 495	23 480	72 2,569	58 2,747
N. Mex.	12	10	9	9	_	_	76	68	985	1,145
Ariz. Utah	44 38	23 43	N 26	N 20	N —	N —	138 367	158 294	3,342 627	3,552 520
Nev.	10	27	2	1	2	_	49	115	2,052	2,640
PACIFIC	402	412	8	1	_	_	2,817	2,808	35,701	32,158
Wash.	104	137	_	_ 1	_	_	319	348	3,326	2,486
Oreg. Calif.	144 129	68 196	<u>8</u>		_	_	355 1,986	411 1,885	1,415 29,891	1,148 26,890
Alaska	12	1	_	_	_	_	98	91	487	517
Hawaii	13 N	10 N	_	_	_	_	59	73	582	1,117
Guam P.R.	N 2	N 2	_	_	_	_	 186	4 263	316	125 225
V.I.	_	_	<del></del>	_		_	_	_	45	82
Amer. Samoa C.N.M.I.	<u>U</u>	U U	U —	U U	<u>U</u>	U U	<u>U</u>	U U	<u>U</u>	U U
N: Not potifiable	H: Unavailable		concreted cases				aorn Mariana Isla			

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

\* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 26, 2005, and November 27, 2004 (47th Week)\*

(47th Week)*								
				Haemophilus infl	<i>uenzae</i> , invasiv	re		
	All a	ges			Age <	5 years		
	All sero	otypes	Sero	type b	Non-se	erotype b	Unknown	serotype
Departing over	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum.	Cum. 2004	Cum. 2005	Cum.
Reporting area UNITED STATES	1,855	1,796	4	14	<b>2005</b> 98	109	179	<b>2004</b> 159
NEW ENGLAND	147	169	_	1	10	10	5	2
Maine	6	12	_	_	_	_	1	_
N.H. Vt.	8 9	19 8	_	_	_	<u>2</u> —	2	1 1
Mass.	72	76	_	1	3	4	1	_
R.I. Conn.	7 45	6 48	_	_	2 5	1 3	_ 1	_
MID. ATLANTIC	380	378	_	2	1	5	38	36
Upstate N.Y. N.Y. City	108 69	118 81	_	2	_	5	8 11	5 15
N.J.	79	71	_	_	_	_	10	3
Pa.	124	108	_	_	1	_	9	13
E.N. CENTRAL Ohio	266 103	340 93	<u>1</u>	2 1	4	8 2	19 9	47 15
Ind.	59	49	_	_	4	4	_	1
III. Mich.	62 19	120 21	1	<u> </u>	_		7 2	21 4
Wis.	23	57	_	_	_	_	1	6
W.N. CENTRAL Minn.	102 40	99 43	_	2 1	3 3	3 3	9 2	11 1
Iowa	1	1	_	1	_	_	_	_
Mo. N. Dak.	34 4	38 4	_	_			5 1	<u>7</u>
S. Dak.	_	_	_	_	_	_	_	_
Nebr. Kans.	9 14	5 8	_	_	_	_	<u>1</u>	2 1
S. ATLANTIC	443	396	1	1	26	26	32	26
Del. Md.	<u> </u>	<u> </u>	_	_	<u> </u>	<u> </u>	_	_
D.C. Va.	40	3 39	_	_	_	_		1 5
W. Va.	26	16	_	_	1	4	6	_
N.C. S.C.	72 30	54 13	1	1	<u>8</u>	6	3	1 1
Ga.	89	103	_	_	_	_	14	17
Fla.	120	106	_	_	12	10	7	1
E.S. CENTRAL Ky.	101 8	69 11	_	<u>1</u>	1 1	2 2	19 2	11 1
Tenn. Ala.	75 18	43 13	_	_ 1	_	_	13 4	8 2
Miss.	<del>-</del>	2	_		=	_	_	_
W.S. CENTRAL	94	74	1	1	8	9	7	1
Ark. La.	5 31	2 15	<u> </u>	_	1 2	1	7	
Okla.	56	56	_	_	5	8	_	_
Tex. MOUNTAIN	2 199	1 175	_	1	15			10
Mont.	_	_	_	<u>4</u>	15 —	25 —	34	18 —
Idaho Wyo.	5 6	5 1	_	_	_	<u> </u>	_ 1	2
Colo.	39	44	_	<del>-</del>	1	_	9	5
N. Mex. Ariz.	20 98	37 59	_	1	4 7	8 11	2 12	6 2
Utah	17	16	_	2	1	2	7	2 2
Nev. PACIFIC	14	13 96	_	1	2	3	3	1 7
Wash.	123 4	1	<u>1</u>	=	30 —	21 —	16 3	1
Oreg. Calif.	29 54	43 38	_ 1	_	30	 21	5 2	3 1
Alaska	26	5	_	_	_	_	6	1
Hawaii	10	9	_	_	_	_	_	1
Guam P.R.	3		_	_	_	_	_ 1	2
V.I. Amer. Samoa			 U	 U	 U	 U	 U	
C.N.M.I.		Ü		ŭ		Ŭ		ŭ

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands. \* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 26, 2005, and November 27, 2004 (47th Week)\*

(47th Week)*			Hepatitis (vi	ral, acute), by type		
	Cum.	A Cum.	Cum.	B Cum.	Cum.	Cum.
Reporting area	2005	2004	2005	2004	2005	2004
UNITED STATES	3,682	5,364	4,915	5,616	643	727
NEW ENGLAND	486 4	945	263	349	17	16
Maine N.H.	76	13 25	16 26	5 33	_	_
Vt. Mass.	6 337	8 808	5 185	6 198	13 1	8 7
R.I.	15	21	3	5	_	_
Conn.	48	70	28	102	3	1
MID. ATLANTIC Upstate N.Y.	622 100	747 103	948 87	688 73	97 18	133 11
N.Y. City	271	325	109	143	_	_
N.J. Pa.	158 93	169 150	558 194	194 278	— 79	 122
E.N. CENTRAL	356	481	473	506	124	106
Ohio Ind.	49 51	47 55	123 55	103 40	8 23	6 9
III.	87	140	103	86	_	15
Mich. Wis.	138 31	133 106	161 31	238 39	93 —	76 —
W.N. CENTRAL	84	143	243	296	27	20
Minn.	3	32	29	44	5	17
Iowa Mo.	20 39	46 29	18 147	14 175	 20	3
N. Dak.	_	1	_	4	1	_
S. Dak. Nebr.	<del>_</del> 6	3 12	3 21	1 41		_
Kans.	16	20	25	17	_	_
S. ATLANTIC Del.	647 5	939 6	1,222 47	1,678 48	137 7	180 33
Md.	68	100	141	147	23	10
D.C. Va.	4 72	7 113	11 125	19 237	 12	4 13
W. Va.	5	5	37	40	21	23
N.C. S.C.	82 37	98 40	150 126	171 130	21 3	11 15
Ga. Fla.	104 270	302 268	143 442	425 461	8 42	15 56
E.S. CENTRAL	226	143	322	448	75	84
Ky.	24	29	55	66	9	23
Tenn. Ala.	147 35	91 8	129 85	212 71	17 14	29 5
Miss.	20	15	53	99	35	27
W.S. CENTRAL	242	625 60	460	630	81	101
Ark. La.	13 63	45	45 66	104 64	1 14	3 3
Okla. Tex.	5 161	20 500	34 315	64 398	6 60	3 92
MOUNTAIN	326	388	505	441	43	42
Mont.	9	6	3	1	1	2
Idaho Wyo.	22 —	19 5	13 2	10 7	1 1	1 2
Cólo. N. Mex.	40 23	47 23	53 9	54	23 —	14 U
Ariz.	203	237	356	17 240	_	5
Utah Nev.	19 10	35 16	41 28	42 70	8 9	5 13
PACIFIC	693	953	479	580	42	45
Wash.	44	57	58	48	U	U
Oreg. Calif.	40 583	62 803	92 317	102 409	17 24	15 28
Alaska	4 22	4 27	7 5	11 10	<del>_</del>	
Hawaii Guam		1	5 —	12	ı	9
P.R.	— 58	45	41	72	_	_
V.I. Amer. Samoa	 U	 U		 U	 U	
C.N.M.I.	_	Ŭ	_	Ŭ	_	Ŭ

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

\* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 26, 2005, and November 27, 2004 (47th Week)\*

(47th Week)*								
	Legion			riosis		disease	Mala	
Reporting area	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,800	1,855	717	665	19,088	17,046	1,132	1,293
NEW ENGLAND	121	86	54	48	2,376	3,086	61	84
Maine N.H.	6 8	1 10	3 7	8 3	207 195	29 203	4 5	7 5
Vt.	9	6	2	2	46	48	1	4
Mass.	46	39	16	18	1,004	1,488	31	49
R.I. Conn.	19 33	15 15	6 20	1 16	32 892	201 1,117	2 18	4 15
MID. ATLANTIC	628	517	182	161	12,105	10,368	308	351
Upstate N.Y.	176	112	56	44	3,727	3,653	48	48
N.Y. City	85 94	67	35	25	3,300	345	158	192
N.J. Pa.	273	83 255	33 58	35 57	5,078	2,582 3,788	70 32	68 43
E.N. CENTRAL	340	450	76	114	1,373	1,297	89	116
Ohio Ind.	183	207 45	31	39 17	61 33	48	24 4	28
III.	22 15	45 48	5 2	24	33 —	27 87	29	16 39
Mich.	102	130	27	26	58	26	21	19
Wis.	18	20	11	8	1,221	1,109	11	14
W.N. CENTRAL Minn.	93 26	59 7	41 13	19 5	885 774	539 454	44 11	65 24
Iowa	6	6	8	3	82	49	8	4
Mo. N. Dak.	33 2	30 2	6 4	<del>7</del>	23	24 —	17 —	20 3
S. Dak.	21	4	_	1	1	1	_	1
Nebr.	3 2	4 6	5	3	2	8	3	4 9
Kans.			5			3	5	
S. ATLANTIC Del.	360 16	378 13	151 N	112 N	2,098 594	1,547 317	275 3	319 6
Md.	103	76	19	17	1,103	830	97	74
D.C. Va.	12 37	11 48	 14	5 17	8 219	13 166	8 27	13 50
W. Va.	18	10	4	4	17	28	3	2
N.C. S.C.	31 13	37 15	32 12	24 10	44 19	111 26	30 8	19 11
Ga.	24	41	21	14	5	12	41	59
Fla.	106	127	49	21	89	44	58	85
E.S. CENTRAL Ky.	79 28	95 39	28 4	23 4	35 5	44 15	28 9	32 4
Tenn.	35	40	12	12	28	24	13	11
Ala. Miss.	13 3	12 4	8 4	5 2	2	5 —	6	12 5
W.S. CENTRAL	25	129	31	39	— 59	67	80	122
Ark.	4	1	2	3	4	8	6	8
La.	1 7	8 6	10 5	3 1	7	2	3	6 7
Okla. Tex.	13	114	14	32	— 48	— 57	10 61	101
MOUNTAIN	82	77	16	23	21	17	52	50
Mont. Idaho	5 3	2 9	_		_ 2	<u> </u>	_	1 1
	4	6	_		3	3	2	
Wyo. Colo.	21	20	7	12	3	_	23 2	18
N. Mex. Ariz.	2 24	4 11	4	<u>1</u>	1 8	1 6	2 14	4 13
Utah	15	21	3	1	2	1	9	8
Nev.	8	4	2	8	2	_	2	5
PACIFIC Wash.	72 —	64 9	138 9	126 9	136 9	81 12	195 15	154 16
Oreg.	N	N	11	7	19	26	11	17
Calif. Alaska	69 —	54 1	117 —	106	105 3	41 2	148 5	115 2
Hawaii	3	<u>.</u>	1	4	Ň	N	16	4
Guam	_	_	_	_			_	_
P.R. V.I.	_	_	_	_	<u>N</u>	<u>N</u>	2	_
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.		U		U		U		U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands. 
\* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 26, 2005, and November 27, 2004 (47th Week)\*

· · · · · · · · · · · · · · · · · · ·		Meningococcal disease												
	All sero	aroune		group ind W-135	Serogi	roup B	Other se	rograup	Serogroup	unknown				
Deposition area	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004				
Reporting area UNITED STATES	1,033	1,078	84	85	51	41		1	898	951				
NEW ENGLAND	65	67	1	6	_	6	_	1	64	54				
Maine	2	10	_	_	_	1	_	_	2	9				
N.H. Vt.	12 5	7 3	_	_	_	_	_	_	12 5	7 3				
Mass.	31	35	_	5	_	5	_	_	31	25				
R.I. Conn.	3 12	2 10	_ 1	<u>1</u>	_	_	_	_ 1	3 11	1 9				
MID. ATLANTIC	137	148	37	40	9	5	_	_	91	103				
Upstate N.Y.	36	39	4	6	6	3	_	_	26	30				
N.Y. City N.J.	20 34	26 31	_	_	_	_	_	_	20 34	26 31				
Pa.	47	52	33	34	3	2	_	_	11	16				
E.N. CENTRAL	117	122	32	29	1 <u>1</u>	6	_	_	74	87				
Ohio Ind.	42 18	62 18	_	4 1	7 4	5 1	_	_	35 14	53 16				
III.	15	1	_	_		<u> </u>	_	_	15	1				
Mich. Wis.	32 10	24 17	32	24	_	_	_	_	 10	 17				
W.N. CENTRAL	74	74	3	_	1	5	_	_	70	69				
Minn.	15	23	1	_	_	_	_	_	14	23				
Iowa Mo.	16 26	17 19	_ 1	_	1	3 1	_	_	15 25	14 18				
N. Dak.	∠6 1	2		_	_	_	_	_	25 1	2				
S. Dak.	4	2	1	_	_	1	_	_	3	1				
Nebr. Kans.	5 7	4 7	_	_	_	_	_	_	5 7	4 7				
S. ATLANTIC	198	203	6	2	9	4	_	_	183	197				
Del.	4	6	_	_	_	_	_	_	4	6				
Md. D.C.	21 —	10 5	3		2	_	_	_	16 —	10 3				
Va.	30	20	_	_	_	_	_	_	30	20				
W. Va. N.C.	6 32	5 28	1 2	_	<del>-</del> 7	4	_	_	5 23	5 24				
S.C.	15	15	_	_	<u>.</u>		_	_	15	15				
Ga. Fla.	15 75	14 100	_	_	_	_	_	_	15 75	14 100				
E.S. CENTRAL	52	64	1	1	3	1	_	_	48	62				
Ky.	16	11	_	i	3	i	_	_	13	9				
Tenn. Ala.	24 6	22 16		_	_	_	_	_	24 5	22 16				
Miss.	6	15	<u>.</u>	_	_	_	_	_	6	15				
W.S. CENTRAL	89	66	1	3	5	2	_	_	83	61				
Ark. La.	14 27	15 31	_	_ 1		1	_	_	14 25	14 30				
Okla.	13	10	1	2	3	1	_	_	9	7				
Tex.	35	10	_	_	_	_	_	_	35	10				
MOUNTAIN Mont.	80	60 3	2	1	6	5	_	_	72	54 3				
Idaho	6	7	_	_	=	_	_	_	6	7				
Wyo.		4	_	_	_	_	_	_		4				
Colo. N. Mex.	17 3	15 8	<u>1</u>	1	<u>1</u>	3	_	_	15 3	15 4				
Ariz.	36	11	_	_	2	1	_	_	34 7	10				
Utah Nev.	10 8	5 7	1	_	2 1	1	_	_	7	5 6				
PACIFIC	221	274	1	3	7	7	_	_	213	264				
Wash.	42	28	1	3	4	7	_	_	37	18				
Oreg. Calif.	28 136	52 181	_	_	_		_	_	28 136	52 181				
Alaska	3	4	_	_	_	_	_	_	3	4				
Hawaii	12	9	_	_	3	_	_	_	9	9				
Guam P.R.	<u> </u>	1 17	_	_	_	_	_	_	<u> </u>	1 17				
V.I.	_	_	_	_	_	_	_	_	_	_				
Amer. Samoa C.N.M.I.	1	1	_	_	_	_	_	_	1	1				

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

\* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 26, 2005, and November 27, 2004 (47th Week)\*

(47th Week)*											
	Pertussis		Rabies	, animal		lountain d fever	Salmoi	nellosis	Shigellosis		
Reporting area	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	
UNITED STATES	18,388	19,447	4,932	5,954	1,611	1,436	38,016	38,000	12,365	12,371	
NEW ENGLAND	1,104	1,845	638	649	3	20	1,934	1,887	271	276	
Maine N.H.	30 65	40 93	49 12	52 30	N 1	N —	139 152	96 129	9 8	8 9	
Vt. Mass.	76 857	95 1,518	53 312	35 275	_ 1	1 15	89 1,028	57 1,083	16 172	3 173	
R.I.	34	38	22	43	i	1	87	108	14	18	
Conn.	42	61	190	214	_	3	439	414	52	65	
MID. ATLANTIC Upstate N.Y.	1,200 484	2,573 1,771	877 511	906 499	100 5	74 1	4,514 1,153	5,221 1,145	1,120 249	1,085 389	
N.Y. City N.J.	85 192	180 190	27 N	12 N	8 31	23 14	1,077 770	1,185 983	367 279	375 221	
Pa.	439	432	339	395	56	36	1,514	1,908	225	100	
E.N. CENTRAL Ohio	3,211 1,063	7,434 552	196 69	184 74	34 21	34 10	4,757 1,220	4,681 1,115	887 112	1,123 153	
Ind.	302	223	11	10	3	6	557	441	164	189	
III. Mich.	580 274	1,322 273	50 37	50 41	1 7	14 2	1,410 808	1,500 771	269 208	382 197	
Wis.	992	5,064	29	9	2	2	762	854	134	202	
W.N. CENTRAL Minn.	3,044 1,025	2,307 438	393 67	583 84	162 3	122 4	2,310 523	2,193 569	1,477 86	391 63	
Iowa	614	495	104	97	4	2 97	396	405	96	60	
Mo. N. Dak.	474 139	349 710	75 25	58 58	141 —	_	763 39	562 40	935 4	155 3	
S. Dak. Nebr.	153 177	124 59	48	93 96	5 4	4 15	139 120	112 158	45 79	10 28	
Kans.	462	132	74	97	5	_	330	347	232	72	
S. ATLANTIC Del.	1,236 15	736 5	1,509	2,045 9	810 4	750 6	11,450 114	10,305 103	2,150 11	2,668 10	
Md.	167	137	303	295	84	69	760	770	99	140	
D.C. Va.	8 315	9 196	481	446	2 99	30	53 1,001	59 1,060	13 114	38 145	
W. Va. N.C.	43 118	22 79	52 445	63 550	7 468	5 484	169 1,556	221 1,526	1 184	9 341	
S.C.	341 40	143 24	5	156	62 66	60 78	1,215	909	91	501 602	
Ga. Fla.	189	121	216 7	321 205	18	18	1,749 4,833	1,808 3,849	567 1,070	882	
E.S. CENTRAL	443 127	272	131	145	260	193	2,711	2,508	1,104	853	
Ky. Tenn.	191	67 150	16 43	22 50	3 190	2 109	449 721	319 645	294 504	72 443	
Ala. Miss.	80 45	39 16	70 2	62 11	63 4	54 28	700 841	690 854	216 90	288 50	
W.S. CENTRAL	1,571	864	803	1,033	197	218	3,306	3,979	2,397	3,373	
Ark. La.	268 35	78 19	33	50 4	121 5	134 5	692 777	528 898	59 128	74 283	
Okla. Tex.	1,268	38 729	72 698	106 873	52 19	71 8	371 1,466	367 2,186	596 1,614	430 2,586	
MOUNTAIN	3,709	1,552	217	214	36	21	2,116	2,162	852	2,380 771	
Mont.	547	54	15	26	1	3	124	179	5	4	
Idaho Wyo.	223 47	37 31	17	8 6	3 2	4 5	138 79	144 49	17 5	13 5	
Colo. N. Mex.	1,260 127	860 149	16 10	47 5	5 3	4 2	543 215	504 265	154 117	147 132	
Ariz.	910	207	131	111	18	2	626	633	483	372	
Utah Nev.	563 32	172 42	15 13	8 3	<u>4</u>	1 —	305 86	222 166	43 28	43 55	
PACIFIC	2,870	1,864	168	195	9	4	4,918	5,064	2,107	1,831	
Wash. Oreg.	782 568	675 482	U 7	U 6			494 350	505 395	126 117	99 81	
Calif. Alaska	1,261 115	667 14	160 1	178 11	7	2	3,743 56	3,766 57	1,824 7	1,600 6	
Hawaii	144	26	<u>.</u>		_	_	275	341	33	45	
Guam P.R.	<del>-</del>	 5	— 59	— 57	N	N	<u> </u>	50 456	<u> </u>	42 32	
V.I. Amer. Samoa	<del>-</del> U	<del>-</del> U	<del>-</del> U	<del>-</del> U	<u></u>	<u></u> U	U	<u>-</u> U	<del>-</del> U	<u>-</u> U	
C.N.M.I.		Ü		Ü		Ü		Ü		Ü	

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

\* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 26, 2005, and November 27, 2004 (47th Week)\*

(47th Week)*			Streptod	coccus pneum	oniae, invasiv	re disease					
		cal disease, , group A	Drug res				Syp Primary & secondary		hilis  Congenital		
	Cum.	Cum.	all aç Cum.	ges Cum.	Age <5 Cum.	years Cum.	Cum.	Cum.	Cum.	Cum.	
Reporting area	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	
UNITED STATES	3,818	3,961	1,938	2,006	814	737	7,239	7,009	240	344	
NEW ENGLAND Maine	156 10	254 11	108 N	154 N	61 —	103 7	194 1	174 2	1	4	
N.H.	14	18	_	_	4	N	14	4	_	3	
Vt. Mass.	10 113	9 111	12 80	7 49	6 50	3 58	1 115	107	_	_	
R.I.	9	21	16	20	1	6	20	25	_	1	
Conn.	U	84	U	78	U	29	43	36	1	_	
MID. ATLANTIC Upstate N.Y.	780 233	653 211	179 70	139 57	128 56	113 77	899 78	909 83	30 7	34 4	
N.Y. City	146	111	Ű	Ű	20	Ú	551	578	5	15	
N.J.	155	133	N 100	N	24	10	117	133	18	14	
Pa.	246	198	109	82	28	26	153	115	_	1	
E.N. CENTRAL Ohio	754 177	891 207	552 328	448 308	247 74	175 71	765 199	801 215	32 1	54 2	
Ind.	92	93	174	140	47	42	56	55	1	3	
III. Mich.	168 281	232 272	14 36	N	58 51	12 N	403 75	339 163	12 15	18 30	
Wis.	36	87	N	N	17	50	32	29	3	1	
W.N. CENTRAL	243	285	45	19	84	98	214	143	5	5	
Minn. Iowa	96 N	137 N	_ N	N	49 —	65 N	54 4	24 5	1	1	
Mo.	62	59	37	14	9	13	132	85	4		
N. Dak.	9	12	3	_	4	4	1	_	_	_	
S. Dak. Nebr.	20 21	17 20	3 2	5 —	7	 8	1 4	<u> </u>	_	_	
Kans.	35	40	N	N	15	8	18	23	_	2	
S. ATLANTIC	845	793	744	995	76	53	1,829	1,779	38	56	
Del. Md.	5 186	3 134	1	4	<u> </u>	N 38	10 278	8 328	13	1 9	
D.C.	10	10	15	9	3	4	90	61	_	1	
Va. W. Va.	77 22	67 24	N 104	N 99	 22	N 11	123 4	94 3	4	3	
N.C.	118	118	N	N	Ü	U	242	177	9	10	
S.C. Ga.	30 166	51 184	— 116	83 269	_	N N	72 352	109 345	4 1	12 4	
Fla.	231	202	508	531		N	658	654	7	16	
E.S. CENTRAL	159	200	152	147	13	16	423	365	24	21	
Ky.	32	58	25	30	N	N	47	44		1	
Tenn. Ala.	127 —	142	127	115	_	N N	196 140	117 152	17 6	8 10	
Miss.	_	_	_	2	13	16	40	52	1	2	
W.S. CENTRAL	239	314	102	75	147	142	1,152	1,108	67	69	
Ark. La.	21 7	16 2	13 89	10 65	15 24	8 31	44 230	46 291	1 11	3 6	
Okla.	104	63	N	N	29	44	37	25	1	2	
Tex.	107	233	N	N	79	59	841	746	54	58	
MOUNTAIN Mont.	543	448	56 —	28	49 —	34	346 5	355 1	17 —	45 —	
Idaho	3	9	N	N	_	N	20	22	1	2	
Wyo. Colo.	4 187	9 101	23 N	11 N	— 48	 34	38	3 57	_ 1	_ 1	
N. Mex.	42	88		N	<del>40</del>	- -	44	76	2	2	
Ariz.	231	201	N	N	_	N	155	149	12	39	
Utah Nev.	75 1	36 4	31 2	15 2	1	_	6 78	11 36	_ 1	1	
PACIFIC	99	123	_	1	9	3	1,417	1,375	26	56	
Wash.	N	N	N	N	N	N	137	127	_	_	
Oreg. Calif.	N —	N —	N N	N N	6 N	N N	32 1,233	25 1,215	<u> </u>	<u> </u>	
Alaska	_	_	<del></del>	_	_	N	6	1	_	_	
Hawaii	99	123	_	1	3	3	9	7	_	_	
Guam P.R.	N	N	 N	N	_	 N	— 196	2 156	9	<u> </u>	
V.I.	_	_	_	_	_	_	_	4	_	_	
Amer. Samoa	U	U U	U	U U	U	U U	U	U U	<u>U</u>	U U	
C.N.M.I.		U		0		U		U		U	

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands. \* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 26, 2005, and November 27, 2004 (47th Week)\*

(47th Week)*					Var	icella	West Nile virus disease <sup>†</sup>					
	Tuberculosis		s Typhoid fever			(chickenpox)		nvasive	Non-neuroinvasive§			
Reporting area	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005			
UNITED STATES	10,195	11,967	240	292	22,918	25,757	1,146	1,139	1,427			
NEW ENGLAND	310	395	23	21	2,227	3,089	9	_	4			
Maine N.H.	14 6	18 16	1	_	213 1,382	226	_	_	_			
/t.	5	3	_	_	90	413	_	_	_			
Mass. R.I.	204 29	225 48	13 1	15 1	542	743	4 1	_	<u>2</u>			
Conn.	52	85	8	5	U	1,707	4		2			
MID. ATLANTIC	1,808	1,867	46	71	4,228	86	26	17	17			
Jpstate N.Y. N.Y. City	227 885	262 923	5 20	10 29	_	_	 10	5 2	4			
۱.J.	425	416	13	17	_	_	2	1	2			
Pa.	271	266	8	15	4,228	86	14	9	11			
E.N. CENTRAL Ohio	1,095 219	1,047 178	22 2	34 6	5,777 1,359	11,348 1,291	233 46	66 11	115 15			
nd.	118	113	1	_	482	N	10	8	1			
II. Mich.	509 181	470 205	8 6	16 9	72 3,502	5,750 3,689	130 36	29 13	88 5			
Vis.	68	81	5	3	362	618	11	5	6			
W.N. CENTRAL	390	418	6	8	536	169	141	86	417			
Minn. Iowa	163 38	159 42	<u>5</u> —	<u>4</u>	N	N	16 12	13 13	27 18			
Mo. N. Dak.	93 2	111 4	_	2	394	5	17 12	27 2	13 74			
N. Dak. S. Dak.	13	8	_	_	55 87	82 82	35	6	197			
Nebr. Kans.	29 52	34 60	_ 1	2	_	_	36 13	7 18	80 8			
S. ATLANTIC	2,214	2,535	48	43	2,092	2,098	30	65	22			
Del.	19	17	1	_	28	5	1	_	_			
Md. D.C.	236 47	250 75	11	12	 37	23	4	10 1	<u>1</u>			
/a.	264	248	17	9	558	481	_	4	_			
W. Va. N.C.	24 248	21 299		<u> </u>	1,016	1,194 N		3	N 2			
S.C.	199	163	_	_	453	395	5	_	_			
Ga. Fla.	343 834	516 946	3 11	4 10	_	_	9 9	14 33	7 12			
E.S. CENTRAL	503	583	6	8	_	48	63	60	38			
<у.	97	103	2	3	N	N	5	1	_			
Геnn. Ala.	233 173	197 179	1 1	5 —	_	— 48	13 6	13 15	3 4			
Miss.	_	104	2	_	_	_	39	31	31			
N.S. CENTRAL Ark.	1,310 94	1,734 106	16 —	26	5,753 19	6,656	231 11	234 17	115 15			
La.	_	_	1	_	111	 54	100	82	38			
Okla. Tex.	126 1,090	149 1,479	1 14	1 25	 5,623	6,602	13 107	16 119	11 51			
MOUNTAIN	335	461	9	7	2,305	2,263	134	322	205			
∕lont.	8	4	_	_	_		8	2	17			
daho Vyo.	_	3 4	_	_	<u> </u>	 55	2 6	1 2	7 6			
Colo.	51	112	5	2	1,655	1,797	19	41	72			
N. Mex. Ariz.	19 200	32 187			153	<u>U</u>	20 44	31 214	13 44			
Jtah Nev.	26 31	35 84	1	1 2	445	411	21 14	6 25	31 15			
Nev. PACIFIC	2,230	2,927	64	74	_	_	279	25 289	494			
Vash.	222	203	5	6	N	N	_	— —	_			
Oreg. Calif.	54 1,812	92 2,498	3 44	1 61	_	_	1 278	 289	6 488			
Alaska	38	33	_	_	_	_	_	209	<del></del>			
Hawaii	104	101	12	6	_	_	_	_	_			
Guam P.R.	_	49 98	_	_	— 565	209 368	_	_	_			
V.I.	_	_	_	_	_	_	_	_	_			
Amer. Samoa C.N.M.I.	<u>U</u>	U U	<u>U</u>	U U	<u>U</u>	U U	<u>U</u>	U U	_			
N: Not notifiable	II: Unavailable					— U — U — U — — WM I : Commonwealth of Northern Mariana Islands						

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

\* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).

§ Not previously notifiable.

TABLE III. Deaths in 122 U.S. cities.\* week ending November 26, 2005 (47th Week)

TABLE III. Deaths	III. Deaths in 122 U.S. cities,* week ending November 26, 2005 (47th Week)  All causes, by age (years)  All causes, by age (years)								_						
-	AII	A	Jauses, D	y age (ye	ais)		P&I <sup>†</sup>		All All			P&I <sup>†</sup>			
Reporting Area	Ages	<u>≥</u> 65	45–64	25–44	1–24	<1	Total	Reporting Area	Ages	<u>≥</u> 65	45–64	25–44	1–24	<1	Total
NEW ENGLAND	423	286	104	14	9	10 3	38	S. ATLANTIC	771	449	204	77	22	19	35
Boston, Mass. Bridgeport, Conn.	118 34	79 27	30 5	4 1	2	1	11 5	Atlanta, Ga. Baltimore, Md.	135 156	70 78	37 49	22 21	4 3	2 5	8 10
Cambridge, Mass.	12	9	2		1		1	Charlotte, N.C.	63	46	13	3	_	1	2
Fall River, Mass.	15	11	4	_	_	_	1	Jacksonville, Fla.	117	79	25	8	3	2	6
Hartford, Conn.	41	22	12	4	1	2	3	Miami, Fla.	U	U	U	U	U	U	U
Lowell, Mass.	21 10	15 7	6 3	_	_	_	3	Norfolk, Va.	37 36	22 18	8 12	2 1	3 3	2	2 2
Lynn, Mass. New Bedford, Mass.	13	8	3	2	_	_	1	Richmond, Va. Savannah, Ga.	32	19	8	2	2	1	_
New Haven, Conn.	18	12	4	_	1	1	2	St. Petersburg, Fla.	22	15	6	1	_		2
Providence, R.I.	58	33	19	1	3	2	5	Tampa, Fla.	87	55	22	6	2	2	2
Somerville, Mass.	4	3	1	_		_	_	Washington, D.C.	76	38	23	11	2	2	1
Springfield, Mass. Waterbury, Conn.	32 10	23 7	8 3	_	1	_	3 1	Wilmington, Del.	10	9	1	_	_	_	_
Worcester, Mass.	37	30	4	2	_	1	2	E.S. CENTRAL	594	386	136	46	13	13	37
				97	20		117	Birmingham, Ala.	104	69	21	8	3	3	8
MID. ATLANTIC Albany, N.Y.	1,786 42	1,244 31	388 8	97 1	30	24 2	3	Chattanooga, Tenn. Knoxville, Tenn.	40 73	29 49	10 16	1 5	_	1	3
Allentown, Pa.	29	22	5		2	_	3	Lexington, Ky.	35	24	7	2	_	2	3
Buffalo, N.Y.	80	50	26	3	1	_	10	Memphis, Tenn.	192	126	41	13	7	5	13
Camden, N.J.	23	14	7	_	2	_	4	Mobile, Ala.	27	19	5	2	_	1	_
Elizabeth, N.J.	14	9	2	3	_	_	3	Montgomery, Ala.	29	19	6	4	_	_	2
Erie, Pa. Jersey City, N.J.	32 16	27 11	4 3	1 1	1	_	3	Nashville, Tenn.	94	51	30	11	1	1	8
New York City, N.Y.	916	645	190	52	15	11	46	W.S. CENTRAL	958	589	254	72	19	24	53
Newark, N.J.	33	15	9	4	_	5	2	Austin, Tex. Baton Rouge, La.	67 30	40 20	19 8	6 2	1	1	5 2
Paterson, N.J.	8	5	_2		1	_		Corpus Christi, Tex.	34	22	7	4	1	_	2
Philadelphia, Pa.	261	168 9	70 3	15 1	6 1	2	16	Dallas, Tex.	108	61	30	12	1	4	6
Pittsburgh, Pa.§ Reading, Pa.	14 28	20	7	1		_	2 2	El Paso, Tex.	69	47	13	5	2	2	4
Rochester, N.Y.	92	69	18	3	_	2	11	Ft. Worth, Tex.	96	57	25	9	3	2	2
Schenectady, N.Y.	19	16	3	_	_	_	1	Houston, Tex. Little Rock, Ark.	264 35	149 25	78 7	18 3	6	13	19 1
Scranton, Pa.	32	26	4	2		_	1	New Orleans, La. <sup>¶</sup>	U	Ü	ύ	Ü	U	U	ΰ
Syracuse, N.Y. Trenton, N.J.	86 19	62 14	15 4	6 1	1	2	8	San Antonio, Tex.	160	105	41	10	2	2	10
Utica, N.Y.	20	18	2				1	Shreveport, La.	24	22	_	2	_	_	1
Yonkers, N.Y.	22	13	6	3	_	_	1	Tulsa, Okla.	71	41	26	1	3	_	1
E.N. CENTRAL	1,746	1,149	396	128	38	35	140	MOUNTAIN Albuquerque, N.M.	765 106	487 69	172 24	64 8	26 5	16	49 9
Akron, Ohio	37	26	6	3	2	_	2	Boise, Idaho	24	19	3	1	_	1	_
Canton, Ohio Chicago, III.	35 378	23 203	9 105	1 48	 10	2 12	6 22	Colo. Springs, Colo.	55	40	9	2	2	2	2
Cincinnati, Ohio	116	82	17	5	5	7	16	Denver, Colo.	80	48	19	8	1	4	6
Cleveland, Ohio	233	168	44	13	3	5	15	Las Vegas, Nev.	214	133	51	22	4	4	18
Columbus, Ohio	150	104	29	11	5	1	15	Ogden, Utah Phoenix, Ariz.	17 131	14 79	1 34	2 11	4	_ 3	6
Dayton, Ohio	88	57	22	7	2	_	9	Pueblo, Colo.	33	22	11			_	2
Detroit, Mich. Evansville, Ind.	103 42	52 26	38 8	12 5	_	1 1	11 3	Salt Lake City, Utah	105	63	20	10	10	2	6
Fort Wayne, Ind.	39	30	7	1	_	i	2	Tucson, Ariz.	U	U	U	U	U	U	U
Gary, Ind.	10	6	3	1	_	_	_	PACIFIC	901	613	187	56	23	22	75
Grand Rapids, Mich.	34	25	5	1	2	1	3	Berkeley, Calif.	9	6	2	1		_	<del>-</del>
Indianapolis, Ind. Lansing, Mich.	155 32	114 22	29 10	7	3	2	6 3	Fresno, Calif. Glendale, Calif.	U 8	U 7	U 1	U	U	U	U 1
Milwaukee, Wis.	62	40	16	3	1	2	7	Honolulu, Hawaii	49	31	11	1	_	4	4
Peoria, III.	38	25	10	2	1	_	3	Long Beach, Calif.	57	40	10	5	2	_	7
Rockford, III.	37	28	7	2	_	_	1	Los Angeles, Calif.	101	65	28	6	_	2	5
South Bend, Ind.	15	10	5	_	_	_	_	Pasadena, Calif.	20	12	5	1	_	2	1
Toledo, Ohio Youngstown, Ohio	100 42	73 35	19 7	6	2	_	10 6	Portland, Oreg. Sacramento, Calif.	115 U	76 U	25 U	7 U	1 U	6 U	6 U
, , , , , , , , , , , , , , , , , , ,								San Diego, Calif.	96	60	22	6	4	4	9
W.N. CENTRAL	480	320	107	28	12	13	29	San Francisco, Calif.	86	62	14	6	1	3	14
Des Moines, Iowa Duluth, Minn.	98 15	72 13	16 1	7 1	1	2	7	San Jose, Calif.	149	106	29	8	6	_	20
Kansas City, Kans.	16	9	6		1	_	2	Santa Cruz, Calif.	18	11	6	1	_	_	_
Kansas City, Mo.	91	49	25	10	3	4	1	Seattle, Wash. Spokane, Wash.	84 41	58 34	17 4	5 2	3 1	1	4 1
Lincoln, Nebr.	27	20	5	_	2	_	2	Tacoma, Wash.	68	34 45	13	7	3	_	3
Minneapolis, Minn.	36	23	11		2	_	3	1						170	
Omaha, Nebr. St. Louis, Mo.	59 51	37 25	14 18	4 5	_	4 3	6 3	TOTAL	8,424**	5,523	1,948	582	192	176	573
St. Paul, Minn.	34	30	4	_	_	_	2								
Wichita, Kans.	53	42	7	1	3	_	3								
								L							

U: Unavailable. —: No reported cases.

<sup>\*</sup>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.

 $<sup>^{\</sup>dagger}\,\mbox{Pneumonia}$  and influenza.

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

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

<sup>\*\*</sup> Total includes unknown ages.

The Morbidity and Mortality Weekly Report (MMWR) Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format and on a paid subscription basis for paper copy. To receive an electronic copy each week, send an e-mail message to listserv@listserv.cdc.gov. The body content should read SUBscribe mmwr-toc. Electronic copy also is available from CDC's World-Wide Web server at http://www.cdc.gov/mmwr or from CDC's file transfer protocol server at ftp://ftp.cdc.gov/pub/publications/mmwr. To subscribe for paper copy, contact Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone 202-512-1800.

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Address inquiries about the *MMWR* Series, including material to be considered for publication, to Editor, *MMWR* Series, Mailstop K-95, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone 888-232-3228.

All material in the MMWR Series is in the public domain and may be used and reprinted without permission; citation as to source, however, is appreciated.

All MMWR references are available on the Internet at http://www.cdc.gov/mmwr. Use the search function to find specific articles.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

References to non-CDC sites on the Internet are provided as a service to MMWR readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of these sites. URL addresses listed in MMWR were current as of the date of publication.

☆U.S. Government Printing Office: 2006-523-056/40008 Region IV ISSN: 0149-2195