CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

August 11, 2000 / Vol. 49 / No. 31

MMWR™
MORBIDITY AND MORTALITY
WEEKLY REPORT

Fatal Illnesses Associated With a New World Arenavirus — California, 1999–2000

The California Department of Health Services (CDHS) and the University of Texas Medical Branch (UTMB) recently identified evidence of infection with an arenavirus in three patients hospitalized with similar fatal illnesses. This report summarizes the investigation of these cases.

Patients had onset of illness during June 1999–May 2000. They were aged 14, 30, and 52 years; all were female. Two resided in southern California and the third in the San Francisco Bay area. The patients did not have any activities in common, and none had a history of travel outside California during the 4 weeks preceding their illness.

Illnesses were associated with nonspecific febrile symptoms including fever, headache, and myalgias. Within the first week of hospitalization, lymphopenia (25–700 per mm^3) was observed in all three patients, and thrombocytopenia (30,000–40,000 per mm^3) was seen in two. All three patients had acute respiratory distress syndrome and two developed liver failure and hemorrhagic manifestations. All patients died 1–8 weeks after illness onset.

Arenavirus-specific RNA was detected in one or more materials from each patient using a nested RT-PCR assay. In addition, infectious arenavirus was recovered from materials from the 14-year-old patient by cultivation of the virus in monolayer cultures of Vero E6 cells; virus isolation attempts on materials from the 30-year-old patient are under way. The nucleotide sequence of the PCR products amplified from the patients essentially were identical and shared 87% identity with the Whitewater Arroyo (WWA) virus prototype strain (an arenavirus recovered from a *Neotoma albigula* [white-throated woodrat]) from New Mexico in the early 1990s). Serologic assays (indirect fluorescent antibody assay and IgG enzyme immunoassay) for arenavirus antibody were negative for all three patients.

Family members of the three patients were interviewed about activities and potential exposure sites during the month before illness onset. One patient reportedly cleaned rodent droppings in her home during the 2 weeks before illness onset; no history of rodent contact was solicited for the other two patients.

Reported by: RG Byrd, MD, LA Cone, MD, BC Commess, MD, Riverside County; D Williams-Herman, MD, JM Rowland, MD, B Lee, MD, Alameda County; MW Fitzgibbons, MD, Orange County; CA Glaser, MD, MT Jay, DVM, CI Fritz, DVM, MS Ascher, MD, M Cheung, MD, VL Kramer, PhD, K Reilly, DVM, DJ Vugia, MD, Acting State Epidemiologist, California Dept of Health Svcs. CF Fulhorst, DVM, ML Milazzo, RN Charrel, MD, Center for Tropical Diseases, Univ of Texas

New World Arenavirus — Continued

Medical Br, Galveston, Texas. Special Pathogens Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases.

Editorial Note: Arenaviruses are rodentborne enveloped RNA viruses. Several arenaviruses cause viral hemorrhagic fever syndromes in Africa and South America. The Old World arenaviruses include the agents of Lassa fever and lymphocytic choriomeningitis (LCM). LCM virus, associated with the house mouse (*Mus musculus*), is the only Old World arenavirus that occurs in the Americas. The South American hemorrhagic fever viruses belong to the Tacaribe complex or New World arenaviruses (e.g., Guanarito, Junin, Machupo, and Sabia).

WWA is found in North America among woodrats (*Neotoma* spp.) (*1,2*) and has not previously been known to cause disease in humans. Of 20 *Neotoma* spp. with species status, nine occur in the United States (*3*). The geographic range of these species incorporates most of the United States. At least five of the nine U.S. species may harbor the virus; however, complete description of its distribution requires further study (*1,2*). The abundance and habits of woodrats suggest that potential contact between *Neotoma* spp. and humans is limited.

Preventive measures for arenavirus infections include control and exclusion of rodents in and around human dwellings. Direct contact with rodents, their excreta, and nesting materials should be avoided. Areas and surfaces potentially contaminated by rodent excreta should be wet with a disinfectant before removal. Rodent carcasses and materials should be double-bagged before disposal. Although rare, person-to-person transmission has been documented for some New World viruses; nosocomial transmission can occur through direct contact with an infected patient's blood, urine, or pharyngeal secretions (*4,5*). Standard precautions should be used during treatment of patients with suspected arenavirus infection and standard precautions plus contact/droplet/aerosol-specific precautions should be used for patients with severe clinical manifestations (*6,7*).

CDHS and UTMB, in cooperation with CDC and other agencies, are continuing to investigate these three cases. A determination of the spectrum of illness with WWA will require increased clinical surveillance and community studies to define a precise disease-to-infection ratio and case fatality.

Appropriate laboratory diagnostic tests are being developed to support these efforts. In clinical specimens, the virus is either present in low concentrations or is difficult to isolate with methods commonly used for other arenaviruses. Efforts are under way to evaluate whether specific detection of virus antigens in blood or tissues, presence of specific IgM in the serum of patients, or postmortem diagnostic tests (e.g., immunohistochemistry) can be added to virus isolation and RT-PCR for laboratory diagnosis of infection with this virus. Suspected cases should be reported to local and state health departments or to CDC's Special Pathogens Branch, Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases, telephone (404)639-1510.

References

1. Kosoy MY, Elliot LH, Ksiazek TG, et al. Prevalence of antibodies to arenaviruses in rodents from the southern and western United States: evidence for an arenavirus associated with the genus *Neotoma*. Am J Trop Med Hyg 1996;54:570–6.
2. Fulhorst CF, Bowen MD, Ksiazek TG, et al. Isolation and characterization of Whitewater Arroyo virus, a novel North American arenavirus. Virol 1996;224:114–20.
3. Musser GG, Carleton MD, Family M, Wilson DE, Reeder DM, eds. Mammal species of the world: a taxonomic and geographic reference. 2nd ed. Washington, DC, and London: Smithsonian Institution Press, 1993.

New World Arenavirus — Continued

4. Peters CJ, Kuehne RW, Mercado RR, Le Bow RH, Spertzel RO, Webb PA. Hemorrhagic fever in Cochabamba, Bolivia, 1971. Am J Epidemiol 1974;99:425–33.
5. CDC. Bolivian hemorrhagic fever—El Beni Department, Bolivia, 1994. MMWR 1994;43:942–5.
6. CDC. Management of patients with suspected viral hemorrhagic fever. MMWR 1988;37: 1–16.
7. CDC. Update: management of patients with suspected viral hemorrhagic fever—United States. MMWR 1995;44:475–9.

State-Specific Prevalence of Disability Among Adults — 11 States and the District of Columbia, 1998

Disability is a large public health problem in the United States (*1*), affecting an estimated 54 million persons who report disabling conditions (*2*). One of the national health goals for 2010 is to eliminate health disparities among different segments of the population, including among persons with disabilities (*3*). Although the development and implementation of public health policy and services relating to disability would be aided by public health surveillance (*4*), the lack of a brief case definition of disability limits efforts to obtain state-level prevalence to define the magnitude of disability. To assess state-level prevalence based on uniform criteria, CDC analyzed data from the Disability Module of the 1998 Behavioral Risk Factor Surveillance System (BRFSS). This report summarizes the results of the analyses, which indicated an overall prevalence consistent with national surveys and demonstrated wide variation in disability prevalence in states.

BRFSS is a random-digit–dialed telephone survey of the noninstitutionalized U.S. population aged ≥18 years. The 1998 BRFSS Disability Module collected information on disability from 36,842 survey respondents (by sex and age group) in 11 states (Alabama, Arkansas, Iowa, Kansas, Massachusetts, Missouri, New Mexico, New York, North Carolina, Rhode Island, and South Carolina) and the District of Columbia (DC). Data from four states (Colorado, Oregon, Texas, and Washington) that also collected these data were not comparable and were excluded from analysis. Persons who had a disability were defined based on a qualifying response to either one of two questions: "Are you limited in any way in any activities because of an impairment or health problem?" or "If you use special equipment or help from others to get around, what type do you use?" Responses to type of assistance included wheelchair, walker, cane, or another person. Responses of "don't know" and "not sure" were coded as missing values; persons for whom responses to both questions were missing were excluded from the analyses. Sample estimates were weighted for age, sex, and race to represent the civilian population of each state, and SUDAAN was used to account for the multistage, stratified sampling of this survey. Response rates calculated using the CASRO method (*5*) ranged from 49.8% in Massachusetts to 65.1% in New Mexico (overall national median response rate: 59.2%). The total sample size of 36,842 respondents resulted in a weighted population of 39,247,649 persons.

During 1998, the age-adjusted prevalence of disability ranged from 13.6% (DC) to 21.8% (Alabama) (median: 17.1%) (Table 1). Prevalence of disability was higher among women than among men (18.4% versus 15.7%). Among women, the prevalence ranged from 14.5% (Massachusetts) to 24.4% (Alabama); among men, the prevalence ranged from 10.4% (DC) to 20.3% (Arkansas). Among respondents aged 18–44 years, the prevalence of disability ranged from 6.3% (DC) to 12.8% (New Mexico), and the overall prevalence was 9.7%. The prevalence among respondents aged 45–64 years was 22.1%,

TABLE 1. Prevalence of disability, by state, sex, and age group — 11 states and District of Columbia, Behavorial Risk Factor Surveillance System, 1998

	Sex				Age group (yrs)							
	Men		Women		18–44		45–64		≥65		Overall	
State	Rate	95% CI*	Rate	95% CI	Rate	95% CI	Rate	95% CI	Rate	95% CI	Rate	95% CI
Alabama	18.8%	±3.0	24.4%	±2.4	10.1%	±2.2	31.2%	±3.9	40.4%	±4.8	**21.8%**	**±1.9**
Arkansas	20.3%	±2.6	20.8%	±2.2	8.6%	±1.9	28.0%	±3.2	39.4%	±4.4	**20.6%**	**±1.7**
District of Columbia	10.4%	±3.9	16.2%	±2.7	6.3%	±2.0	18.9%	±5.8	29.9%	±6.2	**13.6%**	**±2.3**
Iowa	18.1%	±2.4	22.7%	±2.1	11.2%	±1.8	23.8%	±3.0	38.5%	±4.0	**20.5%**	**±1.5**
Kansas	12.5%	±1.8	16.3%	±1.7	7.1%	±1.3	17.7%	±2.6	29.8%	±3.3	**14.4%**	**±1.2**
Massachusetts	13.9%	±2.0	14.5%	±1.8	7.8%	±1.4	18.7%	±2.9	26.2%	±3.6	**14.2%**	**±1.3**
Missouri	17.3%	±2.5	20.0%	±2.0	10.8%	±1.9	22.5%	±3.1	34.3%	±4.1	**18.7%**	**±1.6**
New Mexico	19.4%	±2.2	22.2%	±2.0	12.8%	±1.8	26.2%	±2.8	38.9%	±4.1	**20.8%**	**±1.5**
New York	15.3%	±2.5	17.7%	±2.3	10.9%	±2.0	20.5%	±3.5	26.7%	±4.5	**16.6%**	**±1.7**
North Carolina	14.6%	±3.2	17.5%	±2.3	7.4%	±2.0	23.3%	±4.4	31.2%	±4.8	**16.1%**	**±1.9**
Rhode Island	14.7%	±2.1	15.6%	±1.7	9.5%	±1.5	16.6%	±2.6	27.8%	±3.7	**15.2%**	**±1.3**
South Carolina	13.9%	±2.1	16.1%	±1.9	9.2%	±1.7	19.4%	±2.7	26.6%	±4.0	**15.1%**	**±1.4**
Total	**15.7%**	**±1.0**	**18.4%**	**±0.9**	**9.7%**	**±0.8**	**22.1%**	**±1.4**	**30.8%**	**±1.8**	**17.1%**	**±0.7**

*Confidence interval.

Disability — Continued

ranging from 16.6% (Rhode Island) to 31.2% (Alabama). Prevalence of disability was highest among respondents aged ≥65 years (30.8%), ranging from 26.2% (Massachusetts) to 40.4% (Alabama).

Reported by the following BRFSS coordinators: J Cook, Alabama; T Clark, J Senner, Arkansas; C Mitchell, District of Columbia; J Igbokwe, Iowa; J Tasheff, Kansas; D Brooks, N Wilber, Massachusetts; T Murayi, Missouri; W Honey, New Mexico; C Baker, New York; K Passaro, North Carolina; J Hesser, Rhode Island; T Aldrich, South Carolina. M Roth, North Carolina Office on Disability and Health; D Scandlin, Univ of North Carolina, Raleigh, North Carolina. Disability and Health Br, Div of Birth Defects, Child Development, and Disability and Health, National Center for Environmental Health, CDC.

Editorial Note: This is the first report of state-level data generated from the BRFSS Disability Module in 11 participating states and DC. Surveys of national estimates of disability range from 15% in the National Health Interview Survey (*6*) to 20% in the Survey of Income and Program Participation (*2*). Activity limitation and use of assistive devices are generally accepted indicators of disability in surveys (*2,6,7*); however, it is not known whether these questions are valid measures of disability. Further analyses are needed to determine the validity of the specific questions in this report. In addition, analyses are needed to explain the variability of disability prevalence among states and to explain the health disparities between persons with and without disabilities and the risk factors for disability within states. Information about risk factors leading to disability may be available from the core module of BRFSS and from particular modules addressing other health concerns.

The findings of this analysis are subject to at least seven limitations. First, because BRFSS does not sample persons aged <18 years or institutionalized persons, the findings might underestimate the true prevalence of disability in the United States. Second, the sample size for specific racial/ethnic groups is too small to make reliable generalizations about those populations. Third, BRFSS excludes persons without telephones. Fourth, the survey represents undocumented self-reported data; self-reported indicators of activity limitation and compensatory strategies have not been validated as measures of disability. Fifth, the case definition questions used in this analysis do not account for severity or duration of disability. Sixth, persons not included were those who are hearing impaired; have cognitive, speech, and other communication impairments; have limited physical stamina; or could not get to the telephone. Finally, the low response rate could affect the validity of the findings.

The proportion of children and working-aged adults with disabilities is increasing (*7*); in comparison, the disability rate among older persons is declining each year. However, because the older population is increasing rapidly, the number of older persons with disabilities is increasing (*8,9*). Disability rates vary by age, sex, and race/ethnicity in national surveys, and surveillance data are needed to guide state-specific activities to meet the 2010 national health objectives. Various definitions of disability are mandated by approximately 50 federal acts and programs (*10*), and use of these multiple definitions result in varying prevalence estimates. Questions in surveys such as BRFSS should permit uniform surveillance and public health research at the state and national levels.

References

1. Pope AM, Tarlov AR. Disability in America: toward a national agenda for prevention. Washington, DC: National Academy Press, 1991.
2. McNeil JM. Americans with disabilities: 1994–95. Washington, DC: US Department of Commerce, Economics and Statistics Administration, Bureau of the Census, 1997. (Current population reports; series P70-61). Available at http://www.census.gov/prod/3/97pubs/p70-61.pdf. Accessed April 6, 2000.

Disability — Continued

3. US Department of Health and Human Services. Healthy people 2010 (conference ed., 2 vols). Washington, DC: US Department of Health and Human Services, 2000.
4. Lollar D. Public health and disability trends: past, present, and future. In: Albright G, Seelman KD, eds. Handbook of disability studies. New York, New York: Sage, 2000(in press).
5. White AA. Response rate calculation in RDD telephone health surveys: current practices. In: Proceedings of Am Stat Assn 1983:277–82.
6. Adams PF, Marano MA. Current estimates from the National Health Interview Survey, 1994. Hyattsville, Maryland: US Department of Health and Human Services, CDC, National Center for Health Statistics. Vital Health Stat 1995:10(193).
7. Kaye HS, LaPlante MP, Carlson D, Wenger BL. Trends in disability rates in the United States, 1970–1994. San Francisco, California: University of California, San Francisco, Disability Statistics Center, 1996. Available at http://dsc.ucsf.edu/UCSF/pub.taf?_...&&_function=search&recid=63&grow=1. Accessed April 6, 2000.
8. Manton KG, Corder LS, Stallard E. Chronic disability trends in elderly United States populations: 1982–1994. Proc Natl Acad Sci U S A 1997;94:2593–8.
9. Campbell VA, Crews JE, Moriarity DG, Zack MM, Blackman DK. Surveillance for sensory impairment, activity limitation, and health-related quality of life among older adults—United States, 1993–1997. In: CDC surveillance summaries (December). Surveillance for Selected Public Health Indicators Affecting Older Adults—United States. MMWR 1999;48(no. SS-8):131–56.
10. Domzal C. Federal statutory definitions of disability prepared for the National Institute on Disability and Rehabilitation Research, Office of Special Education and Rehabilitative Services, United States Department of Education. Falls Church, Virginia: US Department of Education, National Institute on Disability and Rehabilitation Research, Office of Special Education and Rehabilitative Services, 1995.

Update: West Nile Virus Activity — Northeastern United States, January–August 7, 2000

Surveillance programs initiated in response to the 1999 West Nile virus (WNV) outbreak have detected increased transmission in the northeastern United States (*1*). Seventeen states along the Atlantic and gulf coasts, New York City (NYC), and Washington, D.C., have conducted WNV surveillance and are reporting to CDC (*1*). Surveillance for WNV infection includes monitoring of mosquitoes, sentinel chicken flocks, wild birds, and potentially susceptible mammals (e.g., horses and humans) (*2*). This report summarizes findings of this surveillance system through August 7, 2000.

Avian morbidity and mortality surveillance has identified 188 WNV-infected birds from 34 counties in four northeastern states; 111 (59%) have been reported since August 1. These include 128 birds from New York (Albany, Broome, Columbia, Dutchess, Erie, Franklin, Nassau, New York, Niagara, Onondaga, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Schenectady, Suffolk, Ulster, Warren, Washington, and Westchester counties), 54 from New Jersey (Bergen, Essex, Hudson, Middlesex, Monmouth, Passaic, and Union counties), four from Massachusetts (Middlesex, Norfolk, and Suffolk counties), and two from Connecticut (Fairfield and Tolland counties). Infected species reported include 147 American crows (78%) and 23 blue jays (12%). Infections also have been reported in the red-tailed hawk, fish crow, house sparrow, American robin, merlin, song sparrow, Canada goose, great blue heron, northern mockingbird, eastern bluebird, cockatiel, mute swan, and yellow-rumped warbler. WNV has not been reported in sentinel chickens.

West Nile Virus Activity — Continued

WNV also has been detected by reverse-transcriptase polymerase chain reaction and/or virus isolation in 38 mosquito pools collected in New York (New York, Orange, Richmond, Rockland, Suffolk, and Westchester counties) and one from Connecticut (Fairfield County). Thirty-five of the WNV-positive mosquito pools from New York were *Culex pipiens/restuans*, two were *Aedes japonicus*, and one was *C. pipiens*. The positive pool from Connecticut was *C. restuans*.

On August 4, 2000, the New York City Department of Health (NYCDOH) reported that a person aged 78 years from south Richmond County, hospitalized with viral encephalitis, tested positive for WNV. Cerebrospinal fluid and serum samples were positive for IgM antibody by enzyme-linked immunosorbent assay. Confirmatory testing by plaque reduction neutralization for IgG antibody from convalescent serum is pending. The patient's symptoms began on July 20, indicating that infection had started 3 to 15 days earlier (*3*); therefore, the infection occurred before the initial mosquito adulticide spraying in Richmond County on July 19 and 20. The patient resides in an area where WNV-infected mosquitoes and birds have been found during 2000; no WNV activity was detected in this part of the city in 1999. The patient had not traveled for more than 50 years to areas where other flaviviruses had been endemic and had not left New York during the incubation period.

Reported by: A Novello, MD, D White, PhD, L Kramer, PhD, C Trimarchi, MS, M Eidson, DVM, D Morse, MD, B Wallace, PhD, P Smith, MD, State Epidemiologist, New York State Dept of Health; W Stone, Dept of Environmental Conservation, Albany; Rockland County Health Dept, Pomona; Suffolk County Health Dept, Hauppague; Westchester County Health Dept, New Rochelle; V Kulasekera, PhD, L Mill, MD, A Fine, MD, J Miller, MD, M Layton, MD, New York City Dept of Health. Bergen County Health Dept, Paramus; W Crans, PhD, Rutgers Univ, New Brunswick; F Sorhage, DVM, E Bresnitz, MD, State Epidemiologist, New Jersey Dept of Health and Senior Svcs. R French, DVM, A Garmendia, DVM, Univ of Connecticut, Storrs; T Andreadis, J Anderson, Connecticut Agricultural Experiment Station, New Haven; R Nelson, D Mayo, PhD, M Cartter, MD, J Hadler, MD, State Epidemiologist, Connecticut Dept of Public Health. B Werner, PhD, R Timperi, MPH, A DeMaria, Jr, MD, State Epidemiologist, Massachusetts Dept of Public Health. National Wildlife Health Center, US Geologic Survey, Madison, Wisconsin. P Kelley, MD, Walter Reed Army Institute of Research, M Bunning, DVM, US Air Force. Arbovirus Diseases Br, Div of Vectorborne Infectious Diseases, National Center for Infectious Diseases; and EIS officers, CDC.

Editorial Note: These data suggest an expanding zone of epizootic transmission in four northeastern states with viral activity most intense in the NYC area. The finding of WNV-positive birds in upstate New York and in Massachusetts indicates transmission foci that had not been identified during the 1999 outbreak. American crows typically do not travel long distances during the early summer, and some are permanent, nonmigratory residents of an area (*4*). WNV-infected mosquitoes also have been identified in areas where WNV-positive crows have been found. These facts suggest that WNV-infected crows signify local epizootic transmission; therefore, the presence of WNV-infected crows over a wide geographic area indicates that epizootic transmission is widespread in the northeast and that a potential risk for human infection exists in a wider area in 2000 compared with 1999.

In temperate regions, human WNV infections usually occur in late summer and early fall, a finding consistent with the peak incidence in mid-August during the 1999 outbreak (*5*). A serosurvey conducted after the 1999 outbreak in Queens indicated that most human infections were asymptomatic; <1% of persons developed severe neurologic disease, most frequently the elderly. Health-care providers, especially in the northeastern United States, should consider WNV as the etiology of disease for persons with signs

West Nile Virus Activity — Continued

or symptoms suggesting viral encephalitis (all ages, especially if associated with muscle weakness) or meningitis (especially in persons aged >17 years). Laboratory diagnosis that is based on serum IgM test results should be interpreted in the context of the clinical and epidemiologic findings. In areas where WNV activity occurred in 1999, health-care providers should ensure that IgM reactivity in human serum samples represents recent infection as opposed to persistent antibody from last year. NYCDOH, in collaboration with CDC, has been following the WNV cases diagnosed in 1999 for both long-term clinical sequelae and persistence of antibody. Among the 22 persons participating, approximately 55% had detectable serum IgM antibody 6 months after illness onset. These results indicate that laboratory confirmation by serologic testing of suspected WNV cases occurring in 2000 in regions where epidemic WNV transmission occurred in 1999 should include acute and convalescent serum samples to demonstrate a four-fold increase or decrease in WNV-specific neutralizing antibody. Convalescent serum specimens should be collected 14–21 days after acute serum specimens.

Evidence of intensifying epizootic transmission in NYC and surrounding counties and of epizootic transmission in distant locations suggests a need for broadening previous recommendations for prevention and control (*6*). The following actions may be necessary in affected or potentially affected regions:

1. Continue surveillance to define the geographic spread and intensity of WNV transmission and to assist in targeting and evaluating control efforts. The apparent high sensitivity of wild bird surveillance indicates that WNV surveillance should include an avian morbidity and mortality component. The significance of finding a WNV-positive bird in an area will depend on that species' flight range and other behavioral characteristics and the bird's age.
2. Implement or enhance public education programs that emphasize individual awareness of risk factors for WNV infection and describe risk-reduction actions, such as mosquito avoidance, personal protection (i.e., behavior modification, appropriate clothing, and use of repellents), use or repair of window screens, and residential mosquito source reduction. These measures are particularly important for the elderly, who are at increased risk for severe complications if they contract the illness. The involvement of *Aedes japonicus*, a daytime feeder, as a potential vector indicates a need for persons to be attentive to personal protective measures during outdoor activities regardless of the time of day.
3. Intensify *Culex* mosquito larval mapping and control measures to prevent the emergence of adult mosquitoes that would feed on birds and potentially contribute to viral amplification in or near populated areas.
4. Implement or continue adult mosquito control to reduce vector density in response to surveillance data that reveal one or more of the following: 1) human cases, 2) cases in equine or other mammal species, 3) continued, multiple positive surveillance events (birds or mosquito isolates), and/or 4) in densely populated urban/suburban centers in proximity to areas identified in 1, 2 and 3. In some instances, large-scale aerial applications may be needed to provide adequate coverage in affected areas. Areas with evidence of WNV activity but without the preceding criteria should implement, if necessary, the recommended focal adult mosquito control (*6*). Retreatment 3–4 days after initial application will be needed to appreciably reduce *Culex* populations (*7–9*). Surveillance should be maintained to determine whether further adulticide is required.

A cooperative effort between the U.S. Geological Survey, CDC, and federal, state, and local government agencies in the 19 surveillance jurisdictions has resulted in the

West Nile Virus Activity — Continued

production of interactive, World-Wide Web-based maps to track the spread of WNV. These maps with data from the WNV surveillance system, updated weekly, can be viewed at the U.S. Geological Survey's National Atlas Web site at http://www.nationalatlas.gov/virusmap.html.*

References

1. CDC. Epidemic/epizootic West Nile virus in the United States: guidelines for surveillance, prevention, and control: a workshop cosponsored by US Department of Health and Human Services, CDC, and US Department of Agriculture, Fort Collins, Colorado, November 8–9, 1999. Available at http://www.cdc.gov/ncidod/dvbid/westnile. Accessed August 2000.
2. CDC. National West Nile Virus Surveillance System, 2000: final plan, May 26, 2000. Available at http://www.cdc.gov/ncidod/dvbid/westnile. Accessed August 2000.
3. Hannoun C, Panthier R, Mouchet J, Eouzan JP. Isolement en France du virus West-Nile a partir de malades et du vecteur *Culex modestus* Ficalbi. CR Acad Sc Paris 1964;259: 4170–2.
4. Caceamise DF, Reed LM, Romanowski J, Stauffer PC. Roosting behavior and group territoriality in American crows. Auk 1997;114:628–37.
5. CDC. Update: West Nile virus encephalitis—New York, 1999. MMWR 1999;48:944–6,955.
6. CDC. Update: West Nile virus activity—New York and New Jersey, 2000. MMWR 2000; 49:640–2.
7. Andis MD, Sackett SR, Carroll MK, Bordes ES. Strategies for the emergency control of arboviral epidemics in New Orleans. J Am Mosq Control Assoc 1987;2:125–50.
8. Reiter P, Eliason DA, Francy DB, Moore CG, Campos EG. Apparent influence of the stage of blood meal digestion on the efficacy of ground applied ULV aerosols for the control of urban *Culex* mosquitoes. I. Field evidence. J Am Mosq Control Assoc 1990;6:366–70.
9. Moore CG, Reiter P, Eliason DA, Bailey RE, Campos EG. Apparent influence of the stage of blood meal digestion on the efficacy of ground applied ULV aerosols for the control of urban *Culex* mosquitoes. III. Results of a computer simulation. J Am Mosq Control Assoc 1990;6:376–83.

*References to sites of non-CDC organizations on the World-Wide Web 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 pages found at these sites.

Notice to Readers

CDC Statement on Study Results of Product Containing Nonoxynol-9

During the XIII International AIDS Conference held in Durban, South Africa, July 9–14, 2000, researchers from the Joint United Nations Program on AIDS (UNAIDS) presented results of a study of a product, COL-1492,* which contains nonoxynol-9 (N-9) (*1*). N-9 products are licensed for use in the United States as spermicides and are effective in preventing pregnancy, particularly when used with a diaphragm. The study examined the use of COL-1492 as a potential candidate microbicide, or topical compound to prevent the transmission of human immunodeficiency virus (HIV) and sexually transmitted

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

Notices to Readers — Continued

diseases (STDs). The study found that N-9 did not protect against HIV infection and may have caused more transmission. The women who used N-9 gel became infected with HIV at approximately a 50% higher rate than women who used the placebo gel.

CDC has released a "Dear Colleague" letter that summarizes the findings and implications of the UNAIDS study. The letter is available on the World-Wide Web, http://www.cdc.gov/hiv; a hard copy is available from the National Prevention Information Network, telephone (800) 458-5231. Future consultations will be held to re-evaluate guidelines for HIV, STDs, and pregnancy prevention in populations at high risk for HIV infection. A detailed scientific report will be released on the Web when additional findings are available.

Reference

1. van Damme L. Advances in topical microbicides. Presented at the XIII International AIDS Conference, July 9–14, 2000, Durban, South Africa.

Notice to Readers

Publication of Surgeon General's Report on Smoking and Health

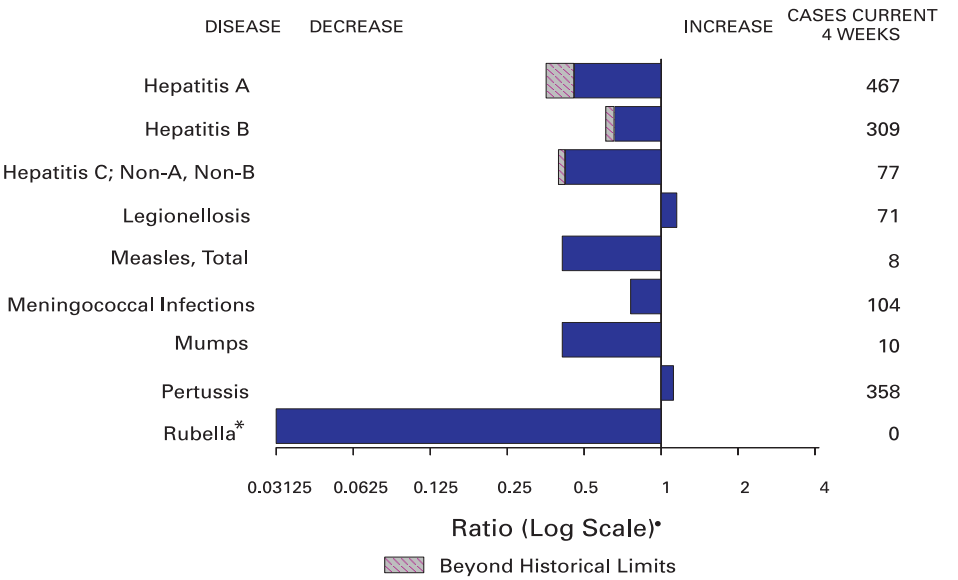
The Surgeon General's report *Reducing Tobacco Use* (*1*) was released on August 9, 2000. This report is the first in the series to offer a composite review of the various methods used to reduce and prevent tobacco use.

The six major conclusions of the report are:

1. Efforts to prevent the onset or continuance of tobacco use face the pervasive, countervailing influence of tobacco promotion by the tobacco industry, a promotion that takes place despite overwhelming evidence of adverse health effects from tobacco use.
2. The available approaches to reducing tobacco use—educational, clinical, regulatory, economic, and comprehensive—differ substantially in their techniques and in the metric by which success can be measured. A hierarchy of effectiveness is difficult to construct.
3. Approaches with the largest span of impact (economic, regulatory, and comprehensive) are likely to have the greatest long-term population impact. Those with a smaller span of impact (educational and clinical) are of greater importance in helping persons resist or abandon the use of tobacco.
4. Each of the modalities reviewed provides evidence of effectiveness.
    - Educational strategies, conducted in conjunction with community- and media-based activities, can postpone or prevent smoking onset in 20% to 40% of adolescents.
    - Pharmacologic treatment of nicotine addiction, combined with behavioral support, will enable 20% to 25% of users to remain abstinent at 1 year posttreatment. Even less intense measures, such as physicians advising their patients to quit smoking, can produce cessation proportions of 5% to 10%.
    - Regulation of advertising and promotion, particularly that directed at young persons, is very likely to reduce both prevalence and uptake of smoking.
    - Clean air regulations and restriction of minors' access to tobacco products contribute to a changing social norm with regard to smoking and may influence prevalence directly.

(Continued on page 727)

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending August 5, 2000, with historical data



*No Rubella cases were reported for the current 4-week period, yielding a ratio for week 31 of zero (0).

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

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending August 5, 2000 (31st Week)

	Cum. 2000		Cum. 2000
Anthrax	-	HIV infection, pediatric*§	127
Brucellosis*	35	Plague	5
Cholera	0	Poliomyelitis, paralytic	-
Congenital rubella syndrome	4	Psittacosis*	8
Cyclosporiasis*	24	Rabies, human	-
Diphtheria	-	Rocky Mountain spotted fever (RMSF)	193
Encephalitis: California serogroup viral*	14	Streptococcal disease, invasive, group A	1,846
eastern equine*	-	Streptococcal toxic-shock syndrome*	60
St. Louis*	-	Syphilis, congenital¶	85
western equine*	-	Tetanus	16
Ehrlichiosis human granulocytic (HGE)*	98	Toxic-shock syndrome	97
human monocytic (HME)*	29	Trichinosis	4
Hansen disease (leprosy)*	34	Typhoid fever	187
Hantavirus pulmonary syndrome*†	17	Yellow fever	-
Hemolytic uremic syndrome, postdiarrheal*	68		

-: No reported cases.
*Not notifiable in all states.
† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID).
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update July 30, 2000.
¶ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending August 5, 2000, and August 7, 1999 (31st Week)

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7*			
							NETSS		PHLIS	
	Cum. 2000§	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	23,669	26,225	369,191	385,463	803	1,138	1,936	1,368	1,152	1,359
NEW ENGLAND	1,335	1,282	12,906	12,472	42	66	209	212	166	206
Maine	20	44	809	661	9	13	14	17	14	-
N.H.	22	33	607	581	7	7	18	19	18	22
Vt.	11	6	318	283	14	13	22	19	17	10
Mass.	852	826	5,728	5,249	10	27	88	94	61	100
R.I.	55	70	1,419	1,383	2	-	11	16	10	18
Conn.	375	303	4,025	4,315	-	6	56	47	46	56
MID. ATLANTIC	5,487	6,723	31,524	40,100	82	227	188	112	84	100
Upstate N.Y.	572	846	N	N	52	74	141	77	38	-
N.Y. City	2,971	3,589	12,359	16,894	7	126	7	8	7	9
N.J.	1,116	1,261	4,633	7,257	3	16	40	27	31	86
Pa.	828	1,027	14,532	15,949	20	11	N	N	8	5
E.N. CENTRAL	2,282	1,715	59,231	65,130	173	243	355	256	148	251
Ohio	360	267	14,913	18,019	29	26	76	94	44	90
Ind.	217	221	7,202	6,987	13	14	64	32	39	27
Ill.	1,295	781	14,966	19,201	7	40	79	84	-	64
Mich.	297	356	14,917	12,459	41	30	63	46	34	39
Wis.	113	90	7,233	8,464	83	133	73	N	31	31
W.N. CENTRAL	575	603	20,922	22,294	100	76	345	261	199	306
Minn.	102	105	3,944	4,475	21	13	100	80	73	102
Iowa	59	56	2,622	2,595	32	22	94	53	13	43
Mo.	284	293	7,479	8,127	15	13	79	20	62	34
N. Dak.	2	4	352	515	7	11	8	3	13	11
S. Dak.	4	13	1,062	912	9	4	17	27	19	33
Nebr.	38	43	1,944	1,995	13	11	31	60	9	79
Kans.	86	89	3,519	3,675	3	2	16	18	10	4
S. ATLANTIC	6,331	7,202	76,123	82,937	152	190	161	151	106	114
Del.	111	95	1,718	1,610	4	-	-	4	-	2
Md.	710	793	7,637	7,746	9	11	12	10	1	-
D.C.	448	271	1,930	N	7	6	-	-	U	U
Va.	418	366	9,631	8,697	4	10	33	37	31	37
W. Va.	39	40	1,177	1,056	3	-	10	7	5	2
N.C.	394	483	13,004	13,620	15	5	30	30	24	39
S.C.	509	674	7,458	10,859	-	-	11	16	2	13
Ga.	704	1,088	14,556	20,620	73	94	26	13	18	1
Fla.	2,998	3,392	19,012	18,729	37	64	39	34	25	20
E.S. CENTRAL	1,128	1,136	27,307	26,919	32	14	69	77	47	58
Ky.	128	173	4,701	4,426	4	4	23	19	18	13
Tenn.	461	439	8,441	8,313	8	4	32	34	25	26
Ala.	304	285	8,247	7,015	10	4	5	16	-	16
Miss.	235	239	5,918	7,165	10	2	9	8	4	3
W.S. CENTRAL	2,418	2,842	57,352	50,690	39	45	101	58	129	68
Ark.	112	107	2,876	3,464	5	-	36	7	30	6
La.	381	542	11,213	5,985	8	20	4	9	27	9
Okla.	182	74	4,461	4,964	4	3	9	14	7	11
Tex.	1,743	2,119	38,802	36,277	22	22	52	28	65	42
MOUNTAIN	862	1,014	22,494	20,576	47	51	213	108	118	99
Mont.	9	5	826	817	8	8	20	7	-	-
Idaho	16	15	1,106	1,020	3	3	25	9	-	9
Wyo.	7	4	423	456	3	-	9	3	2	6
Colo.	199	196	6,909	4,673	14	5	89	40	56	33
N. Mex.	88	65	2,734	3,010	4	21	9	5	6	2
Ariz.	265	515	6,891	7,505	4	9	32	18	24	12
Utah	90	84	1,392	1,261	8	N	25	19	30	26
Nev.	188	130	2,213	1,834	3	5	4	7	-	11
PACIFIC	3,251	3,708	61,332	64,345	136	226	295	133	155	157
Wash.	301	213	7,577	6,971	N	N	106	35	95	64
Oreg.	106	118	3,053	3,733	9	79	51	30	52	32
Calif.	2,749	3,314	47,831	50,636	127	147	127	59	-	54
Alaska	12	13	1,388	1,111	-	-	3	-	1	-
Hawaii	83	50	1,483	1,894	-	-	8	9	7	7
Guam	14	11	-	268	-	-	N	N	U	U
P.R.	710	823	743	U	-	-	4	5	U	U
V.I.	24	18	-	U	-	U	-	U	U	U
Amer. Samoa	-	-	-	U	-	U	-	U	U	U
C.N.M.I.	-	-	-	U	-	U	-	U	U	U

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

* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

† Chlamydia refers to genital infections caused by *C. trachomatis*. Totals reported to the Division of STD Prevention, NCHSTP.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update July 30, 2000.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending August 5, 2000, and August 7, 1999 (31st Week)

Reporting Area	Gonorrhea		Hepatitis C; Non-A, Non-B		Legionellosis		Lyme Disease	
	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	192,707	204,159	1,732	1,602	465	525	5,088	7,688
NEW ENGLAND	3,632	3,791	28	13	24	35	1,267	2,571
Maine	47	33	1	2	2	3	-	15
N.H.	66	64	-	-	2	3	35	2
Vt.	35	34	3	5	3	8	6	5
Mass.	1,545	1,469	20	3	9	12	419	548
R.I.	356	358	4	3	3	3	213	223
Conn.	1,583	1,833	-	-	5	6	594	1,778
MID. ATLANTIC	19,030	23,372	308	78	93	125	2,908	3,703
Upstate N.Y.	3,971	3,693	44	38	37	32	1,530	1,825
N.Y. City	4,917	7,909	-	-	-	16	6	102
N.J.	3,447	4,407	244	-	7	11	578	942
Pa.	6,695	7,363	20	40	49	66	794	834
E.N. CENTRAL	35,726	40,019	144	571	124	161	167	446
Ohio	9,042	10,611	5	1	50	50	54	28
Ind.	3,298	3,737	1	1	31	22	15	10
Ill.	10,097	13,170	10	35	8	22	7	15
Mich.	10,321	8,726	128	518	22	39	-	10
Wis.	2,968	3,775	-	16	13	28	91	383
W.N. CENTRAL	9,380	9,635	395	119	37	28	103	145
Minn.	1,604	1,654	5	4	3	1	48	75
Iowa	592	599	1	-	6	8	9	16
Mo.	4,739	4,781	378	113	22	13	32	36
N. Dak.	15	49	-	-	-	-	-	1
S. Dak.	165	95	-	-	2	2	-	-
Nebr.	712	919	3	2	1	4	-	9
Kans.	1,553	1,538	8	-	3	-	14	8
S. ATLANTIC	56,719	60,709	78	103	92	68	535	658
Del.	972	999	-	-	5	7	89	45
Md.	5,220	5,757	11	15	31	11	303	485
D.C.	1,474	2,221	2	-	-	1	2	3
Va.	5,977	5,840	3	10	14	16	78	53
W. Va.	366	361	12	13	N	N	18	14
N.C.	10,503	11,850	13	28	8	13	25	44
S.C.	9,738	6,997	1	14	2	7	2	4
Ga.	9,212	13,386	2	1	5	-	-	-
Fla.	13,257	13,298	34	22	27	13	18	10
E.S. CENTRAL	20,004	21,297	273	183	17	31	20	50
Ky.	2,031	1,947	22	11	9	12	4	7
Tenn.	6,658	6,677	61	65	6	14	14	25
Ala.	6,663	6,230	7	1	2	3	2	15
Miss.	4,652	6,443	183	106	-	2	-	3
W.S. CENTRAL	29,852	26,887	284	301	12	5	13	25
Ark.	1,552	1,752	6	18	-	1	4	3
La.	7,991	3,773	175	203	8	2	1	4
Okla.	1,924	2,441	5	13	2	2	-	4
Tex.	18,385	18,921	98	67	2	-	8	14
MOUNTAIN	5,797	5,599	115	113	25	29	9	10
Mont.	26	22	2	4	1	-	-	-
Idaho	53	49	3	6	4	-	2	1
Wyo.	33	15	69	34	1	-	1	3
Colo.	1,852	1,413	14	18	8	8	3	1
N. Mex.	587	588	11	20	1	1	-	1
Ariz.	2,262	2,658	11	21	6	4	-	-
Utah	144	116	-	5	4	10	1	2
Nev.	840	738	5	5	-	6	2	2
PACIFIC	12,567	12,850	107	121	41	43	66	80
Wash.	1,332	1,209	18	10	14	9	3	3
Oreg.	407	531	21	12	N	N	4	7
Calif.	10,439	10,664	66	99	27	33	59	70
Alaska	180	182	-	-	-	1	-	-
Hawaii	209	264	2	-	-	-	N	N
Guam	-	34	-	1	-	-	-	-
P.R.	335	195	1	-	-	-	N	N
V.I.	-	U	-	U	-	U	-	U
Amer. Samoa	-	U	-	U	-	U	-	U
C.N.M.I.	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending August 5, 2000, and August 7, 1999 (31st Week)

Reporting Area	Malaria		Rabies, Animal		Salmonellosis*			
					NETSS		PHLIS	
	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	615	781	3,271	3,773	17,868	20,006	12,809	18,562
NEW ENGLAND	35	29	435	489	1,200	1,229	1,096	1,281
Maine	4	2	86	90	86	81	61	65
N.H.	1	2	8	29	79	77	77	84
Vt.	2	2	40	63	69	48	66	43
Mass.	10	12	141	106	670	692	572	693
R.I.	5	3	31	61	65	57	84	94
Conn.	13	8	129	140	231	274	236	302
MID. ATLANTIC	110	209	616	697	2,229	2,717	1,990	2,704
Upstate N.Y.	38	41	436	499	644	673	616	697
N.Y. City	37	104	U	U	534	817	602	820
N.J.	16	40	95	113	509	578	393	600
Pa.	19	24	85	85	542	649	379	587
E.N. CENTRAL	62	95	59	78	2,496	2,966	1,388	2,636
Ohio	13	14	15	23	644	647	453	560
Ind.	4	10	-	-	307	256	264	270
Ill.	21	43	9	4	700	982	1	924
Mich.	18	22	30	38	518	566	470	576
Wis.	6	6	5	13	327	515	200	306
W.N. CENTRAL	33	39	350	457	1,333	1,289	1,327	1,436
Minn.	13	13	56	65	313	335	348	457
Iowa	1	11	50	78	223	142	174	127
Mo.	6	11	22	14	414	426	496	495
N. Dak.	2	-	89	88	34	20	49	41
S. Dak.	-	-	59	131	56	63	60	82
Nebr.	5	-	1	3	90	115	44	102
Kans.	6	4	73	78	203	188	156	132
S. ATLANTIC	171	200	1,325	1,240	3,817	4,010	2,479	3,443
Del.	3	1	20	30	61	66	62	91
Md.	60	62	249	240	469	470	391	480
D.C.	12	13	-	-	33	53	U	U
Va.	33	45	321	313	519	698	458	644
W. Va.	2	1	74	71	94	90	79	88
N.C.	12	12	335	255	513	566	401	703
S.C.	1	5	86	102	360	255	283	238
Ga.	4	19	157	124	657	600	709	875
Fla.	44	42	83	105	1,111	1,212	96	324
E.S. CENTRAL	23	16	112	174	1,070	1,074	725	778
Ky.	7	5	15	24	207	227	150	163
Tenn.	5	6	63	64	279	277	348	315
Ala.	10	4	34	86	307	300	186	250
Miss.	1	1	-	-	277	270	41	50
W.S. CENTRAL	8	13	59	289	1,386	1,775	1,944	1,478
Ark.	2	2	20	14	333	242	250	77
La.	2	9	-	-	108	391	301	338
Okla.	4	2	39	68	206	221	140	174
Tex.	-	-	-	207	739	921	1,253	889
MOUNTAIN	30	24	139	120	1,547	1,742	1,107	1,564
Mont.	1	4	39	41	61	37	-	1
Idaho	2	1	5	-	82	53	-	56
Wyo.	-	1	28	32	38	29	14	30
Colo.	15	11	-	1	455	480	423	467
N. Mex.	-	2	14	5	132	254	121	199
Ariz.	5	2	48	36	403	492	356	453
Utah	3	2	4	3	219	287	193	309
Nev.	4	1	1	2	157	110	-	49
PACIFIC	143	156	176	229	2,790	3,204	753	3,242
Wash.	13	13	-	-	273	364	371	531
Oreg.	26	15	4	1	186	293	241	324
Calif.	101	117	151	221	2,178	2,278	-	2,180
Alaska	-	1	21	7	35	27	21	17
Hawaii	3	10	-	-	118	242	120	190
Guam	-	-	-	-	-	24	U	U
P.R.	-	-	45	51	169	316	U	U
V.I.	-	U	-	U	-	U	U	U
Amer. Samoa	-	U	-	U	-	U	U	U
C.N.M.I.	-	U	-	U	-	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending August 5, 2000, and August 7, 1999 (31st Week)

Reporting Area	Shigellosis* NETSS Cum. 2000	Shigellosis* NETSS Cum. 1999	Shigellosis* PHLIS Cum. 2000	Shigellosis* PHLIS Cum. 1999	Syphilis (Primary & Secondary) Cum. 2000	Syphilis (Primary & Secondary) Cum. 1999	Tuberculosis Cum. 2000	Tuberculosis Cum. 1999†
UNITED STATES	10,388	8,422	5,310	4,927	3,463	3,812	6,749	9,085
NEW ENGLAND	222	313	177	285	47	34	221	248
Maine	6	4	-	-	1	-	2	12
N.H.	4	7	7	6	1	1	7	6
Vt.	2	4	-	3	-	3	2	1
Mass.	154	248	113	226	34	20	137	139
R.I.	19	14	20	10	4	1	24	26
Conn.	37	36	37	40	7	9	49	64
MID. ATLANTIC	1,259	573	751	380	160	177	1,326	1,473
Upstate N.Y.	487	146	162	38	8	12	151	169
N.Y. City	507	197	378	138	66	78	720	776
N.J.	160	140	135	118	29	40	321	325
Pa.	105	90	76	86	57	47	134	203
E.N. CENTRAL	2,238	1,524	624	810	674	715	733	915
Ohio	181	290	96	78	44	59	175	142
Ind.	906	113	96	40	241	239	47	77
Ill.	541	614	2	466	177	264	357	444
Mich.	463	219	390	173	182	129	101	191
Wis.	147	288	40	53	30	24	53	61
W.N. CENTRAL	1,238	721	906	507	40	91	260	292
Minn.	359	144	328	177	4	9	88	115
Iowa	314	15	201	15	10	8	25	29
Mo.	398	472	303	247	21	59	100	105
N. Dak.	4	2	4	2	-	-	2	2
S. Dak.	4	10	3	6	-	-	11	9
Nebr.	40	46	9	34	2	5	11	12
Kans.	119	32	58	26	3	10	23	20
S. ATLANTIC	1,555	1,362	442	340	1,155	1,302	1,438	1,899
Del.	10	9	9	4	5	6	-	20
Md.	99	89	35	26	163	245	151	160
D.C.	30	34	U	U	30	33	13	33
Va.	258	60	193	39	79	98	136	149
W. Va.	3	7	3	3	2	2	20	29
N.C.	92	128	34	60	327	294	172	239
S.C.	68	78	57	39	119	168	64	194
Ga.	144	129	49	52	215	261	303	372
Fla.	851	828	62	117	215	195	579	703
E.S. CENTRAL	517	803	305	501	524	685	439	577
Ky.	153	164	51	113	57	58	58	103
Tenn.	232	500	240	344	317	385	202	189
Ala.	23	71	11	40	71	138	179	177
Miss.	109	68	3	4	79	104	-	108
W.S. CENTRAL	1,123	1,460	1,441	597	491	457	667	1,239
Ark.	128	56	41	20	56	39	109	92
La.	80	127	109	59	123	22	73	U
Okla.	69	369	23	117	79	124	75	100
Tex.	846	908	1,268	401	233	272	410	1,047
MOUNTAIN	590	454	279	303	128	145	273	287
Mont.	5	6	-	-	-	-	6	10
Idaho	38	9	-	6	1	1	5	12
Wyo.	1	2	2	1	1	-	1	1
Colo.	94	81	52	63	3	1	37	U
N. Mex.	66	52	34	42	17	6	29	41
Ariz.	262	236	149	153	101	131	127	137
Utah	37	31	42	32	1	2	26	26
Nev.	87	37	-	6	4	4	42	60
PACIFIC	1,646	1,212	385	1,204	244	206	1,392	2,155
Wash.	327	58	298	59	47	46	163	146
Oreg.	108	42	64	38	4	4	8	64
Calif.	1,177	1,088	-	1,084	192	154	1,078	1,810
Alaska	8	-	3	-	-	1	60	35
Hawaii	26	24	20	23	1	1	83	100
Guam	-	9	U	U	-	-	-	39
P.R.	3	69	U	U	79	102	-	126
V.I.	-	U	U	U	-	U	-	U
Amer. Samoa	-	U	U	U	-	U	-	U
C.N.M.I.	-	U	U	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

*Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

†Cumulative reports of provisional tuberculosis cases for 1999 are unavailable ("U") for some areas using the Tuberculosis Information System (TIMS).

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending August 5, 2000, and August 7, 1999 (31st Week)

Reporting Area	*H. influenzae*, Invasive		Hepatitis (Viral), By Type				Measles (Rubeola)					
			A		B		Indigenous		Imported*		Total	
	Cum. 2000†	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	2000	Cum. 2000	2000	Cum. 2000	Cum. 2000	Cum. 1999
UNITED STATES	724	753	6,545	9,762	3,985	4,101	1	34	-	12	46	64
NEW ENGLAND	51	54	190	153	41	94	-	2	-	4	6	10
Maine	1	5	11	5	5	1	-	-	-	-	-	-
N.H.	10	10	17	9	11	9	-	2	-	1	3	1
Vt.	4	4	7	3	6	2	-	-	-	3	3	-
Mass.	23	22	71	59	6	32	-	-	-	-	-	7
R.I.	1	1	15	11	13	22	-	-	-	-	-	-
Conn.	12	12	69	66	-	28	-	-	-	-	-	2
MID. ATLANTIC	120	134	636	712	567	536	-	8	-	1	9	5
Upstate N.Y.	61	56	127	154	84	121	-	8	-	-	8	2
N.Y. City	26	41	200	201	251	159	-	-	-	-	-	3
N.J.	25	34	104	86	83	77	-	-	-	-	-	-
Pa.	8	3	205	271	149	179	-	-	-	1	1	-
E.N. CENTRAL	100	128	809	1,850	418	439	-	7	-	-	7	2
Ohio	39	41	163	421	72	59	-	2	-	-	2	-
Ind.	17	20	46	66	30	31	-	-	-	-	-	1
Ill.	38	55	301	407	66	39	-	4	-	-	4	-
Mich.	6	10	286	906	249	285	-	1	-	-	1	1
Wis.	-	2	13	50	1	25	-	-	-	-	-	-
W.N. CENTRAL	35	37	590	457	533	167	-	1	-	1	2	-
Minn.	20	19	137	45	21	30	-	-	-	1	1	-
Iowa	-	1	56	86	26	26	-	1	-	-	1	-
Mo.	8	5	308	270	446	92	-	-	-	-	-	-
N. Dak.	1	-	2	1	2	-	-	-	-	-	-	-
S. Dak.	-	2	-	8	-	1	-	-	-	-	-	-
Nebr.	4	4	20	36	22	14	-	-	-	-	-	-
Kans.	2	6	67	11	16	4	-	-	-	-	-	-
S. ATLANTIC	197	167	804	1,100	737	643	1	3	-	-	3	4
Del.	-	-	-	2	-	1	-	-	-	-	-	-
Md.	52	46	109	201	74	94	-	-	-	-	-	-
D.C.	-	4	15	37	19	14	-	-	-	-	-	-
Va.	29	13	91	99	93	58	-	2	-	-	2	3
W. Va.	5	6	48	26	6	16	-	-	-	-	-	-
N.C.	18	25	99	89	154	142	-	-	-	-	-	-
S.C.	11	3	33	24	6	39	-	-	-	-	-	-
Ga.	52	45	126	301	121	86	-	-	-	-	-	-
Fla.	30	25	283	321	264	193	1	1	-	-	1	1
E.S. CENTRAL	35	46	260	260	284	291	-	-	-	-	-	2
Ky.	12	6	30	53	53	25	-	-	-	-	-	2
Tenn.	16	24	96	106	129	146	-	-	-	-	-	-
Ala.	6	14	40	38	34	55	-	-	-	-	-	-
Miss.	1	2	94	63	68	65	-	-	-	-	-	-
W.S. CENTRAL	38	46	1,070	1,899	397	678	-	-	-	-	-	6
Ark.	1	2	97	28	65	47	-	-	-	-	-	-
La.	7	11	28	136	51	119	-	-	-	-	-	-
Okla.	28	29	174	347	92	90	-	-	-	-	-	-
Tex.	2	4	771	1,388	189	422	-	-	-	-	-	6
MOUNTAIN	73	64	548	820	302	382	-	11	-	1	12	1
Mont.	-	1	3	14	3	16	U	-	U	-	-	-
Idaho	3	1	19	29	6	21	-	-	-	-	-	-
Wyo.	1	1	10	4	2	9	-	-	-	-	-	-
Colo.	11	11	128	155	55	57	-	1	-	1	2	-
N. Mex.	16	17	50	31	78	125	-	-	-	-	-	-
Ariz.	34	28	267	473	117	96	-	-	-	-	-	1
Utah	7	3	33	31	14	22	-	3	-	-	3	-
Nev.	1	2	38	83	27	36	-	7	-	-	7	-
PACIFIC	75	77	1,638	2,511	706	871	-	2	-	5	7	34
Wash.	3	3	170	195	50	39	-	-	-	-	-	5
Oreg.	19	26	130	163	61	66	-	-	-	-	-	12
Calif.	27	39	1,326	2,133	582	743	-	1	-	3	4	16
Alaska	6	5	9	5	7	13	-	1	-	-	1	-
Hawaii	20	4	3	15	6	10	-	-	-	2	2	1
Guam	-	-	-	1	-	2	-	-	-	-	-	1
P.R.	1	2	71	198	79	141	-	-	-	-	-	-
V.I.	-	U	-	U	-	U	U	-	U	-	-	U
Amer. Samoa	-	U	-	U	-	U	U	-	U	-	-	U
C.N.M.I.	-	U	-	U	-	U	U	-	U	-	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
*For imported measles, cases include only those resulting from importation from other countries.
†Of 147 cases among children aged <5 years, serotype was reported for 63 and of those, 16 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending August 5, 2000, and August 7, 1999 (31st Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999
UNITED STATES	1,380	1,600	5	214	235	112	3,106	3,500	-	78	182
NEW ENGLAND	83	77	-	2	6	5	777	414	-	6	7
Maine	7	5	-	-	-	-	14	-	-	-	-
N.H.	9	11	-	-	1	-	74	65	-	2	-
Vt.	2	4	-	-	1	1	159	32	-	-	-
Mass.	50	41	-	-	4	3	485	287	-	3	7
R.I.	6	4	-	1	-	1	12	18	-	-	-
Conn.	9	12	-	1	-	-	33	12	-	1	-
MID. ATLANTIC	133	153	1	10	32	20	234	634	-	2	25
Upstate N.Y.	45	41	-	6	6	10	136	523	-	2	17
N.Y. City	29	43	-	-	8	-	-	26	-	-	2
N.J.	25	36	-	-	1	-	-	15	-	-	3
Pa.	34	33	1	4	17	10	98	70	-	-	3
E.N. CENTRAL	239	281	-	24	32	6	358	314	-	1	2
Ohio	58	103	-	7	10	1	195	136	-	-	-
Ind.	35	37	-	-	3	2	40	32	-	-	1
Ill.	60	72	-	5	9	3	33	66	-	1	1
Mich.	66	43	-	12	8	-	41	26	-	-	-
Wis.	20	26	-	-	2	-	49	54	-	-	-
W.N. CENTRAL	119	154	-	14	9	4	187	143	-	-	99
Minn.	14	33	-	-	1	-	89	40	-	-	-
Iowa	21	29	-	5	4	-	30	28	-	-	29
Mo.	67	55	-	5	1	2	36	42	-	-	2
N. Dak.	2	3	-	-	-	1	2	-	-	-	-
S. Dak.	5	10	-	-	-	-	3	5	-	-	-
Nebr.	5	8	-	2	-	1	5	2	-	-	68
Kans.	5	16	-	2	3	-	22	26	-	-	-
S. ATLANTIC	229	259	1	34	35	6	252	225	-	51	22
Del.	-	5	-	-	-	1	7	1	-	-	-
Md.	21	40	-	7	3	2	67	76	-	-	1
D.C.	-	3	-	-	2	-	2	-	-	-	-
Va.	34	32	-	5	8	3	36	15	-	-	-
W. Va.	10	4	-	-	-	-	1	1	-	-	-
N.C.	31	30	-	5	8	-	51	61	-	42	21
S.C.	16	31	1	11	3	-	20	8	-	7	-
Ga.	37	47	-	2	1	-	21	20	-	-	-
Fla.	80	67	-	4	10	-	47	43	-	2	-
E.S. CENTRAL	99	115	-	6	10	-	58	61	-	4	2
Ky.	21	21	-	-	-	-	25	17	-	1	-
Tenn.	40	45	-	2	-	-	19	27	-	-	-
Ala.	28	30	-	2	7	-	13	14	-	3	2
Miss.	10	19	-	2	3	-	1	3	-	-	-
W.S. CENTRAL	96	176	1	22	31	23	155	109	-	4	6
Ark.	11	29	-	2	-	15	26	12	-	-	-
La.	27	53	-	3	7	-	3	6	-	-	-
Okla.	21	26	-	-	1	-	6	13	-	-	-
Tex.	37	68	1	17	23	8	120	78	-	4	6
MOUNTAIN	85	97	-	15	10	7	462	416	-	2	15
Mont.	4	2	U	1	-	U	12	2	U	-	-
Idaho	6	8	-	-	1	1	44	107	-	-	-
Wyo.	-	3	-	1	-	-	2	2	-	-	-
Colo.	25	24	-	1	3	5	252	152	-	1	-
N. Mex.	7	13	-	1	N	1	84	49	-	-	-
Ariz.	34	29	-	3	-	-	47	60	-	1	13
Utah	6	12	-	4	3	-	12	41	-	-	1
Nev.	3	6	-	4	3	-	9	3	-	-	1
PACIFIC	297	288	2	87	70	41	623	1,184	-	8	4
Wash.	36	47	1	5	2	15	207	526	-	-	-
Oreg.	43	53	N	N	N	8	74	23	-	-	-
Calif.	205	176	-	68	60	13	301	606	-	8	4
Alaska	5	6	1	7	1	5	19	4	-	-	-
Hawaii	8	6	-	7	7	-	22	25	-	-	-
Guam	-	1	-	-	1	-	-	1	-	-	-
P.R.	5	9	-	-	-	-	1	15	-	-	-
V.I.	-	U	U	-	U	U	-	U	U	-	U
Amer. Samoa	-	U	U	-	U	U	-	U	U	-	U
C.N.M.I.	-	U	U	-	U	U	-	U	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

TABLE IV. Deaths in 122 U.S. cities,* week ending August 5, 2000 (31st Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	451	331	81	18	13	8	33
Boston, Mass.	142	91	31	10	4	6	7
Bridgeport, Conn.	22	16	4	1	1	-	-
Cambridge, Mass.	9	6	2	1	-	-	1
Fall River, Mass.	29	25	3	1	-	-	4
Hartford, Conn.	45	33	9	1	1	1	5
Lowell, Mass.	18	16	1	-	1	-	1
Lynn, Mass.	10	9	1	-	-	-	1
New Bedford, Mass.	21	18	2	-	1	-	1
New Haven, Conn.	38	28	6	2	1	1	1
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	4	2	2	-	-	-	-
Springfield, Mass.	27	19	5	1	2	-	5
Waterbury, Conn.	37	30	7	-	-	-	3
Worcester, Mass.	49	38	8	1	2	-	4
MID. ATLANTIC	2,049	1,429	387	168	35	30	113
Albany, N.Y.	42	28	9	4	1	-	3
Allentown, Pa.	U	U	U	U	U	U	U
Buffalo, N.Y.	89	61	20	5	2	1	13
Camden, N.J.	32	20	5	4	2	1	1
Elizabeth, N.J.	18	14	2	2	-	-	1
Erie, Pa.§	34	25	6	2	1	-	4
Jersey City, N.J.	36	27	4	3	-	2	-
New York City, N.Y.	987	682	188	85	17	15	40
Newark, N.J.	56	28	11	11	4	2	3
Paterson, N.J.	11	6	1	4	-	-	-
Philadelphia, Pa.	397	265	88	34	4	6	24
Pittsburgh, Pa.§	43	31	9	3	-	-	2
Reading, Pa.	20	16	3	1	-	-	1
Rochester, N.Y.	118	101	13	2	1	1	8
Schenectady, N.Y.	18	14	4	-	-	-	-
Scranton, Pa.§	22	19	3	-	-	-	1
Syracuse, N.Y.	82	63	14	3	1	1	10
Trenton, N.J.	26	15	5	3	2	1	2
Utica, N.Y.	18	14	2	2	-	-	-
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,819	1,225	363	138	45	47	126
Akron, Ohio	53	37	8	4	1	3	1
Canton, Ohio	38	30	5	2	1	-	4
Chicago, Ill.	387	223	98	41	13	11	36
Cincinnati, Ohio	74	50	20	3	1	-	7
Cleveland, Ohio	137	87	32	7	7	4	3
Columbus, Ohio	187	127	38	15	2	5	11
Dayton, Ohio	119	87	19	11	2	-	6
Detroit, Mich.	166	100	36	23	5	2	11
Evansville, Ind.	34	30	2	2	-	-	2
Fort Wayne, Ind.	56	43	10	1	1	1	1
Gary, Ind.	16	8	6	2	-	-	-
Grand Rapids, Mich.	35	30	2	2	-	1	5
Indianapolis, Ind.	169	114	38	5	4	8	18
Lansing, Mich.	34	28	3	2	-	1	4
Milwaukee, Wis.	123	86	21	8	2	6	13
Peoria, Ill.	24	20	2	1	1	-	-
Rockford, Ill.	60	45	10	2	1	2	2
South Bend, Ind.	57	40	4	7	4	2	1
Toledo, Ohio	U	U	U	U	U	U	U
Youngstown, Ohio	50	40	9	-	-	1	1
W.N. CENTRAL	760	529	150	45	17	18	43
Des Moines, Iowa	95	69	14	6	4	2	11
Duluth, Minn.	26	21	3	2	-	-	1
Kansas City, Kans.	20	13	3	3	1	-	3
Kansas City, Mo.	83	50	16	8	4	4	3
Lincoln, Nebr.	29	21	8	-	-	-	-
Minneapolis, Minn.	186	131	39	10	4	2	14
Omaha, Nebr.	72	50	14	4	1	3	2
St. Louis, Mo.	99	65	21	6	1	6	3
St. Paul, Minn.	88	65	18	4	1	-	3
Wichita, Kans.	62	44	14	2	1	1	3
S. ATLANTIC	1,010	661	208	92	27	22	50
Atlanta, Ga.	U	U	U	U	U	U	U
Baltimore, Md.	160	102	33	17	5	3	9
Charlotte, N.C.	76	49	13	7	4	3	4
Jacksonville, Fla.	117	80	23	8	1	5	6
Miami, Fla.	100	64	23	10	2	1	5
Norfolk, Va.	47	37	7	2	1	-	4
Richmond, Va.	78	45	21	10	2	-	3
Savannah, Ga.	49	37	10	-	1	1	6
St. Petersburg, Fla.	50	39	5	4	1	1	2
Tampa, Fla.	207	139	40	17	6	5	7
Washington, D.C.	101	52	29	13	4	3	4
Wilmington, Del.	25	17	4	4	-	-	-
E.S. CENTRAL	812	525	177	60	25	25	71
Birmingham, Ala.	170	121	25	17	2	5	20
Chattanooga, Tenn.	68	38	18	3	2	7	3
Knoxville, Tenn.	84	56	22	3	3	-	7
Lexington, Ky.	50	33	11	3	2	1	7
Memphis, Tenn.	174	120	35	11	3	5	13
Mobile, Ala.	87	54	20	7	4	2	9
Montgomery, Ala.	44	25	14	1	4	-	3
Nashville, Tenn.	135	78	32	15	5	5	9
W.S. CENTRAL	1,469	915	304	152	58	37	89
Austin, Tex.	91	59	19	8	1	4	4
Baton Rouge, La.	46	33	11	-	2	-	-
Corpus Christi, Tex.	49	33	8	4	-	4	5
Dallas, Tex.	213	127	51	19	7	9	9
El Paso, Tex.	93	62	19	9	1	2	4
Ft. Worth, Tex.	78	54	15	4	4	1	7
Houston, Tex.	382	212	94	58	13	5	23
Little Rock, Ark.	64	46	9	2	2	5	3
New Orleans, La.	97	49	9	17	18	1	8
San Antonio, Tex.	183	116	40	17	8	2	8
Shreveport, La.	56	39	11	4	-	2	7
Tulsa, Okla.	117	85	18	10	2	2	11
MOUNTAIN	930	625	170	78	16	24	49
Albuquerque, N.M.	111	77	21	8	2	3	1
Boise, Idaho	48	38	4	3	-	3	1
Colo. Springs, Colo.	38	17	1	1	-	2	3
Denver, Colo.	90	63	18	6	1	2	6
Las Vegas, Nev.	196	124	47	21	1	3	16
Ogden, Utah	27	15	6	5	1	-	4
Phoenix, Ariz.	169	104	34	19	5	7	6
Pueblo, Colo.	30	25	5	-	-	-	2
Salt Lake City, Utah	132	90	24	10	4	4	8
Tucson, Ariz.	89	72	10	5	2	-	2
PACIFIC	1,391	941	275	110	35	25	104
Berkeley, Calif.	20	15	4	1	-	-	3
Fresno, Calif.	123	87	22	9	4	1	8
Glendale, Calif.	24	19	4	-	-	1	3
Honolulu, Hawaii	72	52	12	4	1	3	6
Long Beach, Calif.	76	56	13	5	1	-	5
Los Angeles, Calif.	270	182	51	22	8	7	20
Pasadena, Calif.	26	19	5	1	-	1	3
Portland, Oreg.	120	77	25	8	4	5	7
Sacramento, Calif.	157	113	26	11	5	2	13
San Diego, Calif.	181	120	34	17	6	3	14
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	U	U	U	U	U	U	U
Santa Cruz, Calif.	22	12	8	2	-	-	-
Seattle, Wash.	154	78	50	22	3	1	14
Spokane, Wash.	68	52	10	4	1	1	4
Tacoma, Wash.	78	59	11	4	2	-	4
TOTAL	10,691¶	7,181	2,115	861	271	236	678

U: Unavailable. -:No reported cases.

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

†Pneumonia and influenza.

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

¶Total includes unknown ages.

Notices to Readers — Continued

- An optimal level of excise taxation on tobacco products will reduce the prevalence of smoking, the consumption of tobacco, and the long-term health consequences of tobacco use.

5. The impact of these various efforts, as measured with a variety of techniques, is likely to be underestimated because of the synergistic effect of these modalities. The potential for combined effects underscores the need for comprehensive approaches.
6. State tobacco control programs, funded by excise taxes on tobacco products and settlements with the tobacco industry, have produced early, encouraging evidence of the efficacy of the comprehensive approach to reducing tobacco use.

Additional information about the report or a free copy of the executive summary is available from CDC's Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC, Mailstop K-50, 4770 Buford Highway, NE, Atlanta, Georgia 30341-3724; telephone (770) 488-5705. Copies of the full report (stock no. 017-001-00544-4) can be purchased for $43 from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9328; fax (202) 512-1650. The executive summary of the report will be published as an *MMWR Recommendations and Reports*. Copies of the full report, the executive summary, and At A Glance also may be downloaded from CDC's World-Wide Web site, http://www.cdc.gov/tobacco.

Reference

1. US Department of Health and Human Services. Reducing tobacco use: a report of the Surgeon General. Atlanta, Georgia: US Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000.

Contributors to the Production of the *MMWR* (Weekly)

Weekly Notifiable Disease Morbidity Data and 122 Cities Mortality Data

Samuel L. Groseclose, D.V.M., M.P.H.

State Support Team
Robert Fagan
Jose Aponte
Gerald Jones
David Nitschke
Scott Noldy

CDC Operations Team
Carol M. Knowles
Deborah A. Adams
Willie J. Anderson
Patsy A. Hall
Suzette Parks
Felicia Perry
Pearl Sharp
Carol A. Worsham

Informatics

T. Demetri Vacalis, Ph.D.
Michele D. Renshaw Erica R. Shaver

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 on Friday of 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/* or from CDC's file transfer protocol server at *ftp.cdc.gov*. 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 C-08, 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.

Director, Centers for Disease Control and Prevention
Jeffrey P. Koplan, M.D., M.P.H.

Deputy Director for Science and Public Health, Centers for Disease Control and Prevention
David W. Fleming, M.D.

Acting Director, Epidemiology Program Office
Barbara R. Holloway, M.P.H.

Editor, *MMWR* Series
John W. Ward, M.D.

Acting Managing Editor, *MMWR* (Weekly)
Caran R. Wilbanks

Writers-Editors, *MMWR* (Weekly)
Jill Crane
David C. Johnson
Teresa F. Rutledge

Desktop Publishing
Michael T. Brown
Lynda G. Cupell
Morie M. Higgins

☆U.S. Government Printing Office: 2000-533-206/28031 Region IV

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention (CDC)
Atlanta, Georgia 30333

Official Business
Penalty for Private Use $300
Return Service Requested

FIRST-CLASS MAIL
POSTAGE & FEES PAID
PHS/CDC
Permit No. G-284

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 on Friday of 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/* or from CDC's file transfer protocol server at *ftp.cdc.gov*. 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 C-08, 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.

Director, Centers for Disease Control and Prevention
Jeffrey P. Koplan, M.D., M.P.H.

Deputy Director for Science and Public Health, Centers for Disease Control and Prevention
David W. Fleming, M.D.

Acting Director, Epidemiology Program Office
Barbara R. Holloway, M.P.H.

Editor, *MMWR* Series
John W. Ward, M.D.

Acting Managing Editor, *MMWR* (Weekly)
Caran R. Wilbanks

Writers-Editors, *MMWR* (Weekly)
Jill Crane
David C. Johnson
Teresa F. Rutledge

Desktop Publishing
Michael T. Brown
Lynda G. Cupell
Morie M. Higgins

☆U.S. Government Printing Office: 2000-533-206/28031 Region IV

UNITED STATES GOVERNMENT PRINTING OFFICE
SUPERINTENDENT OF DOCUMENTS
Washington, D.C. 20402

Official Business
Penalty for Private Use $300
Return Service Requested

BULK RATE
POSTAGE & FEES PAID
GPO
Permit No. G-26