

MORBIDITY AND MORTALITY

WEEKLY REPORT

- **357** Outbreak of Legionnaires' Disease Among Automotive Plant Workers — Ohio, 2001
- 359 Update: Outbreak of Acute Febrile Respiratory Illness Among College Students — Acapulco, Mexico, March 2001
- 361 Pregnancy-Related Deaths Among Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native Women — United States, 1991–1997
 365 Notices to Readers

Outbreak of Legionnaires' Disease Among Automotive Plant Workers — Ohio, 2001

тм

During March 12–15, 2001, four cases of Legionnaires' disease (LD) among workers at an automotive engine manufacturing plant (plant X) were reported to the Cuyahoga County Board of Health, Cleveland, Ohio; all four diagnoses were confirmed by *Legionella* urine antigen. Illness onset among the four workers occurred during March 2–4; two workers died. Beginning March 14, CDC assisted state and local health departments with an investigation to identify new cases and potential sources of *Legionella* transmission in the plant. This report summarizes the investigation; findings indicate an epidemiologic association with exposure to one of the plant finishing lines but did not identify a specific source.

Plant X manufactures cast iron engine components, is operated by approximately 2500 employees, and covers approximately 1.6 million square feet of floor space. The plant is divided into four areas: core making, mold production, iron melting, and finishing. A confirmed case of LD was defined as radiograph-confirmed pneumonia and laboratory evidence of *Legionella* infection, defined as a positive *Legionella* urine antigen or isolation of *Legionella* from respiratory secretions or lung tissue. Specimens from the four initial case-patients were sent to CDC for isolation of *Legionella*; available specimens included one sputum specimen, one broncho-alveolar lavage specimen, and lung tissue from the two decedents. Active LD surveillance was established in all hospitals in the greater Cleveland area. Hospital records and plant X employee absentee records were reviewed to identify additional cases. An environmental investigation was conducted to identify aerosol-producing water sources for *Legionella* transmission, including cooling towers, water hoses, and water heaters.

No additional confirmed LD cases were identified among the workers. Nine workers from plant X were hospitalized during February 14–March 28; four had pneumonia, and all nine had negative *Legionella* urine antigen tests. *Legionella pneumophila*, serogroup 1, was isolated from a worker's sputum sample, which was stored at 40 F (4 C) for >1 week before culture. Results are pending from lung tissue samples. *Legionella* was isolated from 18 (9%) of 197 environmental samples, and at least five species were identified. Three samples grew *L. pneumophila*, serogroup 1; none matched the clinical isolate by monoclonal antibody staining.

A case-control study was conducted to determine risk factors for exposure to *Legionella* among plant workers. A case-patient was defined as a worker at plant X during February 14–March 28 who had either a confirmed case of LD or a possible case of legionellosis. A possible case-patient of legionellosis was defined as a worker with a

Legionnaires' Disease — Continued

titer of anti-legionella IgG antibody \geq 1:1024 and any two of the following symptoms: cough, shortness of breath, fever, headache, myalgia, or fatigue. Controls were randomly selected workers with fewer than two symptoms and IgG antibody \leq 1:64. Serologic specimens were collected 4–5 weeks after the presumed exposure. Each study participant was asked detailed questions about time spent inside and outside of the plant and information about underlying medical conditions associated with LD.

Among 855 workers who were contacted, 484 (57%) agreed to participate in the case-control study; 11 met case criteria (four confirmed and seven possible cases), and 105 met criteria for controls. Visiting one of the finishing lines in the plant (odds ratio [OR]=15.1; 95% confidence interval [CI]=3.0–76.2) and working in the finishing region of the plant (OR=3.8; CI=1.0–13.8) were associated with disease.

Plant X was closed during March 14–19 to facilitate environmental sampling and decontamination. All water systems were decontaminated, and ongoing environmental surveillance for *Legionella* was implemented throughout the plant, including the finishing area. Sources of aerosolized water from the finishing area that had been sampled before decontamination did not yield cultures positive for *Legionella*. On the basis of the case-control study results, additional environmental samples were collected in the finishing area on April 14; all samples were negative for *Legionella*. County health officials are obtaining maintenance records from the implicated area of plant X to determine how transmission might have occurred.

Reported by: T Allan, T Horgan, H Scaife, Cuyahoga County Board of Health, Cleveland; E Koch, S Nowicki, MK Parrish, E Salehi, Ohio Dept of Health. Respiratory Diseases Br, Div of Bacterial and Mycotic Diseases, National Center for Infectious Diseases; Hazard Evaluations and Technical Assistance Br, Div of Surveillance, Hazard Evaluations and Field Studies, National Institute for Occupational Safety and Health; and EIS officers, CDC.

Editorial Note: Industrial plants can be a source for the propagation and transmission of *Legionella*. The identification of *L. pneumophila* in the environmental samples demonstrated that legionellae can survive in this work environment. The tightly clustered onset of illness, lack of other epidemiologic associations among the four confirmed patients besides working in plant X, and the results of the case-control study implicated a particular finishing line within the plant as the likely source of *Legionella*. The narrow period of illness onset and the failure to identify new cases among plant workers suggest that exposure to the infecting *Legionella* strain was short-lived and transient, which may explain the failure to find an environmental sample that matched the clinical isolate.

LD outbreaks have been reported in industrial settings, including an automotive plant where workers were exposed to contaminated metal-working fluids (1), factories that used water to cool molded plastics (2), and waste-water treatment facilities (3). In each setting, an aerosol-producing device was implicated. Guidelines to minimize the risk for *Legionella* transmission in these sites are available (4). In addition to LD, clinicians should consider hypersensitivity pneumonitis, metal fume fever, and humidifier fever as possible diagnoses of an acute febrile respiratory illness with systemic symptoms in persons who work in an industrial setting (5).

Legionella species are estimated to account for 2%–15% of all community-acquired pneumonia; however, only 1200–1500 cases are reported annually (6,7). Appropriate diagnostic testing for LD includes Legionella urine antigen and culture of respiratory secretions. Legionella urine antigen tests provide rapid and accurate diagnosis of disease caused by L. pneumophila, serogroup 1; however, these tests do not identify less common species or serogroups and do not provide an isolate necessary to compare

Legionnaires' Disease — Continued

clinical with environmental isolates during outbreak investigations. LD also can be diagnosed by a four-fold rise in anti-legionella antibody titer or by direct fluorescent antibody on sputum samples, although the latter method lacks specificity and sensitivity. In addition to testing for Legionella urine antigen, the diagnosis and investigation of LD cases would be improved if clinicians obtained respiratory specimens for culture by a laboratory proficient in *Legionella* isolation. To facilitate appropriate investigation and improve understanding of disease associated with *Legionella* species, health-care providers should report legionellosis cases to county or state health departments, and state health departments should report legionellosis cases to CDC.

References

- 1. Herwaldt LA, Gorman GW, McGrath T, et al. A new *Legionella* species, *Legionella* feeleii species nova, causes Pontiac fever in an automobile plant. Ann Intern Med 1984;100:333–8.
- Muraca PW, Stout JE, Yu VL, Yee YC. Legionnaires' disease in the work environment: implications for environmental health. Am Ind Hyg Assoc J 1988;49:584–90.
- 3. Gregersen P, Grunnet K, Uldum SA, Andersen BH, Madsen H. Pontiac fever at a sewage treatment plant in the food industry. Scand J Work Environ Health 1999;25:291–5.
- 4. American Society of Heating, Refrigerating and Air-Conditioning Engineers. ASHRAE standard: minimizing the risk of legionellosis associated with building water systems. ASHRAE guideline 12-2000. Atlanta, Georgia: American Society of Heating, Refrigerating and Air-Conditioning Engineers, Inc., 2000.
- 5. Rose CS, Blanc PD. Inhalation fever. In: Rom WN, ed. Environmental & occupational medicine. 3rd ed. Philadelphia, Pennsylvania: Lippincott-Raven Publishers, 1998:467–80.
- 6. Marston BJ, Plouffe JF, File TM, et al. Incidence of community-acquired pneumonia requiring hospitalization: results of a population-based active surveillance study in Ohio. Arch Intern Med 1997;157:1709–18.
- 7. CDC. Summary of notifiable diseases, United States, 1999. MMWR 2001;48(no. 53):7.

Public Health Dispatch

Update: Outbreak of Acute Febrile Respiratory Illness Among College Students — Acapulco, Mexico, March 2001

On March 30, CDC was notified by the Pennsylvania Department of Health of an acute febrile respiratory illness characterized by fever, chills, dry cough, chest pain, and headache among college students who traveled to Acapulco during March 2001. Initial laboratory testing indicated that most students had histoplasmosis, an infection caused by the soil-inhabiting fungus, *Histoplasma capsulatum*. While in Acapulco, most ill students had stayed at the Calinda Beach Hotel. This report updates the investigation of the outbreak and presents possible evidence of ongoing transmission (1).

As of May 1, 44 colleges in 22 states* and the District of Columbia have reported 229 students with acute febrile respiratory illness defined by fever for at least 3 days and one or more of the following symptoms: cough, shortness of breath, chest pain, or

^{*}Arizona, Connecticut, Delaware, Florida, Illinois, Iowa, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Texas, and Wisconsin.

Outbreak of Acute Febrile Respiratory Illness — Continued

headache. Laboratory testing of serum specimens from many of these students is ongoing to confirm the cause of illness. Confirmation of histoplasmosis ideally requires testing of acute- and convalescent-phase serum specimens using complement fixation and immunodiffusion methods (2).

To determine where the infection may have been acquired, a cohort study was conducted among students who stayed at three different hotels in Acapulco during the first 2 weeks of March. A total of 109 randomly selected students were interviewed using a standardized questionnaire about symptoms, daily activities, and environmental exposures while in Acapulco. Thirty-one students stayed at the Calinda Beach Hotel, and 78 stayed at other hotels; 58 (53%) were women, and the median age was 21 years (range: 17–25 years). Univariate analysis indicated that having stayed at the Calinda Beach Hotel was significantly associated with illness (22 [71%] of 31 versus four [5%] of 78; risk ratio [RR]=13.8; p<0.001). Other activities (e.g., visiting clubs and restaurants) were not associated with illness.

During April, CDC and the Mexico Ministry of Health conducted a joint investigation of the Calinda Beach Hotel and surrounding areas to determine potential sources of *H. capsulatum* (e.g., construction sites and bird and bat roosts). No sources at the hotel or in its vicinity were identified. Reports of illness in travelers who visited the hotel during April are continuing to be obtained and investigated. To identify specific sources of infection, a cohort study is being conducted among college students who stayed at the hotel during March. This study involves administration of a detailed questionnaire about activities in and near the Calinda Beach Hotel and collection of serum specimens from ill and non-ill visitors. Environmental samples were collected from areas in and around the hotel that were frequented by the students; testing of these environmental specimens for *H. capsulatum* is difficult and requires intraperitoneal mouse inoculation. CDC is awaiting results of the cohort study to determine which samples to test.

On May 3, CDC was notified about two cases of histoplasmosis in a couple from California who had traveled to Acapulco during April 9–16 and had stayed at the Calinda Beach Hotel. The couple, both aged 26 years, had onset of symptoms consistent with acute histoplasmosis 8 days after returning from Acapulco. Urine antigen test for histoplasmosis (3) at the Histoplasmosis Reference Laboratory (Indianapolis, Indiana) was positive for both persons. Although this test is not sensitive for diagnosis of acute pulmonary histoplasmosis, the test is very specific. These cases suggest ongoing transmission of histoplasmosis associated with the hotel.

Visitors to the Calinda Beach Hotel should be aware of the risk for histoplasmosis and should contact their physicians if they develop symptoms. Physicians should contact CDC's Mycotic Diseases Branch, telephone (404) 639-1299 or e-mail: zqg9@cdc.gov. Until further information is available, U.S. visitors to Acapulco are advised to avoid the area of the Calinda Beach Hotel.

Reported by: Pennsylvania Dept of Health. Council of State and Territorial Epidemiologists. American College Health Association. Naval Medical Center, San Diego, California. Mycotic Diseases Br, Respiratory Diseases Br, Div of Bacterial and Mycotic Diseases, National Center for Infectious Diseases; and EIS officers, CDC.

References

- 1. CDC. Outbreak of acute respiratory febrile illness among college students—Acapulco, Mexico, March 2001. MMWR 2001;50:261–2.
- 2. Kaufman L, Reiss E. Serodiagnosis of fungal disease. In: Rose NR, ed. Manual of clinical laboratory immunology. 4th ed. Washington, DC: ASM Press, 1992:506–28.
- Wheat LJ, Kohler RB, Tewari RP. Diagnosis of disseminated histoplasmosis by detection of Histoplasma capsulatum antigen in serum and urine specimens. N Engl J Med 1986;314:83–8.

Pregnancy-Related Deaths Among Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native Women — United States, 1991–1997

In the United States in 1997, the Hispanic, Asian/Pacific Islander, and American Indian/ Alaska Native population represented 16% of all reproductive-age women (aged 15–49 years) but accounted for 23.5% of all live births (1,2). Although statistics by race/ethnicity are available for maternal deaths (3), pregnancy-related mortality ratios (PRMRs) have been reported regularly only for black and white women. Pregnancy-related deaths in Hispanic women have been studied (4); however, combining pregnancy-related mortality risk among Asians/Pacific Islanders and American Indians/Alaska Natives into an "other" category masks differences in their health status. This report presents PRMRs among Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native women in the United States during 1991–1997. The findings indicate that these groups have higher PRMRs than non-Hispanic white (white) women and lower ratios than non-Hispanic black (black) women and underscore the need for targeted interventions that address the maternal health needs of racial/ethnic minority women.

For this report, pregnancy-related death was defined as a death that occurred during pregnancy or within 1 year after the end of pregnancy and resulted from 1) complications of pregnancy itself, 2) a chain of events initiated by pregnancy, or 3) aggravation of an unrelated condition by the physiologic effects of pregnancy. PRMRs were defined as the number of pregnancy-related deaths per 100,000 live births. PRMRs were calculated using data from the National Pregnancy Mortality Surveillance System (NPMSS) for the numerator and the public use natality files from CDC's National Center for Health Statistics for the denominator (2). NPMSS data are derived from death certificates sent to CDC by the 50 states, the District of Columbia (DC), and New York City. The death certificates are those on which pregnancy was indicated and for women who had given birth during the year preceding their death; matching live birth and fetal death certificates also are forwarded when available. In this analysis, racial/ethnic categories used were Hispanic, defined as a woman of any race who was of Hispanic origin, Asian/Pacific Islander, and American Indian/Alaska Native. Findings for white and black women were included for comparison. Place of birth (i.e., the 50 states, DC, and outside the United States) was analyzed for 1993 through 1997.

During 1991–1997, 3193 pregnancy-related deaths occurred. The overall PRMR was 11.5. PRMR among American Indians/Alaska Natives was 12.2, among Asians/Pacific Islanders was 11.3, and among Hispanics was 10.3. PRMR was 29.6 and 7.3 among blacks and whites, respectively (Table 1). The risk among Hispanics, Asians/Pacific Islanders, and American Indians/Alaska Natives was lower than for blacks but higher than for whites; relative ratios ranged from 1.4 to 1.7. Among racial/ethnic groups for which rates have been estimated, the risk for death was lowest among women aged <30 years and increased after age 35 years. In all age groups, the risk for death was highest among black women, with a risk three to four times greater than white women. During 1993– 1997, approximately 19% of all live births were to women born outside the 50 states and DC: among white, black, and American Indian/Alaska Native women, the percentage of live births to foreign-born women was <10%; among Hispanic women, approximately 62%; and among Asian/Pacific Islander women, approximately 86%. Hispanic women born outside the United States had a PRMR approximately 50% higher than U.S.-born Hispanic women (Table 2). Asian/Pacific Islander women born outside the United States also had a higher PRMR than their U.S.-born counterparts. However, the estimate should

spanic,	white)	
ong His	white (
s)* amo	panic v	
PRMRs	ion-His	
atios (, and r	
tality .	(black)	
ed mor	: black	
y-relat	lispanic	
egnanc	H-non,	
and pro	Native,	97
deaths	Alaska	991-19
elated o	ndian//	tates, 1
ancy-re	erican l	nited St
pregn	er, Am€	n – d
nber of	Island	ge grou
1. Nur	Pacific	n, by aç
TABLE	Asian/	wome

			A	sian/	Americ	an Indian/						
Age	Ϊ	spanic	Pacific	c Islander	Alask	ta Native	-	3lack	>	Vhite		Total
group (yrs)	No.	PRMR	No.	PRMR	No.	PRMR	No.	PRMR	No.	PRMR	No.	PRMR
<20	45	5.5	Ť		Ť		160	16.0	96	5.8	306	8.5
20–29	200	7.4	43	8.4	16	11.0 [§]	590	25.0	35	6.0	1384	9.3
30–34	125	16.0	28	8.7	ţ		260	38.8	330	7.4	749	11.9
35–39	82	26.0	34	22.7	Ţ		202	70.8	226	12.3	549	21.1
>39	31	48.2	14	42.4⁵	Ţ		80	151.2	79	25.5	205	44.3
Total	483	10.3	121	11.3	31	12.2	1292	29.6	1266	7.3	3193	11.5
RR [¶]		1.4		1.6		1.7		4.0		(ref)		
95% CI**		(1.3–1.6)		(1.3–1.9)		(1.2–2.4)		(3.8–4.4)				

* Per 100,000 live births. * Fewer than seven pregnancy-related deaths; considered unreliable (relative standard error [RSE]=>38%). * fewer than seven pregnancy-related deaths are highly variable (RSE=23%--38%). * Relative ratio of PRMR for each racial/ethnic group divided by PRMR for whites. **Confidence interval.

Pregnancy-Related Deaths — Continued

PRMR	Hispanic	Asian/ Pacific Islander	American Indian/Alaska Native	Black	White	Total
U.Sborn women [†]	8.0	6.1 [§]	13.2	30.0	7.6	11.6
Foreign-born womer	n 11.8	12.7	1	29.5	6.2	12.4

TABLE 2. Pregnancy-related mortality ratios (PRMRs) among Hispanic, Asian/ Pacific Islander, American Indian/Alaska Native, non-Hispanic black (black), and non-Hispanic white (white) women — United States, 1993–1997*

* n=2334.

⁺ The 50 states or District of Columbia.

[§] Fewer than seven pregnancy-related deaths; considered unreliable (relative standard error [RSE]=>38%).

[¶] Point estimates based on seven-19 deaths are highly variable (RSE=23%-38%).

be interpreted with caution because of the small number of events. Black and white women had no significant differences in PRMRs by place of birth. PRMR for American Indians/Alaska Natives could not be analyzed by place of birth because of small numbers. *Reported by: Div of Reproductive Health, National Center for Chronic Disease Prevention and*

Health Promotion; and an EIS Officer, CDC.

Editorial Note: By 2025, Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native women are expected to represent approximately 25% of the females of reproductive age in the United States (1). The findings in this report indicate that these women have a significantly higher risk for pregnancy-related death than white women. The report also found that being born outside the 50 states and DC may be a more important risk factor than racial/ethnic heritage for some groups; increased risk for pregnancy-related death was found among foreign-born Hispanic women and possibly among Asians/Pacific Islanders.

Examination of health outcomes only by racial and ethnic classification is insufficient to understand and reduce health disparities. Race and ethnicity may be indicators of differences in socioeconomic status, access to and guality of care, and psychosocial and environmental stress. Nativity also may be associated with factors (e.g., low income, low levels of education, lack of health insurance, and legal, language, and cultural barriers) that can adversely affect health outcomes, including inadequate health care (5). In addition, heterogeneity within racial/ethnic minority groups should be considered. Among Hispanics, reproductive health outcomes may differ among Mexican, Puerto Rican, and Cuban women (3,6). Asians/Pacific Islanders have many differences in language, culture, history, demographic characteristics, and circumstances of migration, and have a pattern of socioeconomic extremes, with a large proportion at high income levels and a large proportion in poverty (7). American Indians/Alaska Natives are from more than 500 different tribes, with differences in health status among tribes and between urban and reservation communities. This heterogeneity means that the PRMRs in this report could mask higher levels of risk among groups that have been combined with other groups at lower risk.

The findings in this report are subject to at least four limitations. First, race/ethnicity information on death certificates, which is reported by a funeral director, may be less accurate than on birth certificates, which is usually reported by the mother. Death rates are estimated to be understated for Native Americans by 21%, for Asians/Pacific Islanders by 11%, and for Hispanics by 2% (8). Second, pregnancy-related deaths in general

Pregnancy-Related Deaths — Continued

are underestimated because the death certificate frequently does not reflect the relation between a woman's pregnancy and her death (*9*). Third, in some groups the number of cases is small, which can lead to unstable PRMR estimates. Fourth, this report is limited to women who lived in the 50 states, DC, and New York City. Inclusion of data from Puerto Rico would be useful for investigating reproductive health outcomes among Hispanic women from that commonwealth.

An important national health objective for 2010 is to eliminate racial disparities, including those in pregnancy-related death. Additional information on maternal health of minority women is needed to plan effective interventions. Studies could address the unique concerns of immigrant women in pregnancy and the prevalence and case-fatality rates for specific conditions in each group.

Although rare, pregnancy-related deaths can be viewed as sentinel events in women's health; pregnancy-related illness is more common, with 18 pregnancy-associated hospitalizations per 100 live births (10). Developing systems to monitor pregnancy-related illness would contribute to a comprehensive understanding of factors that affect maternal health. Existing systems to monitor maternal health, such as the Pregnancy Risk Assessment Monitoring System, may be adapted to assist in this process. Reducing the maternal health disparities will require ongoing surveillance of morbidity and mortality, prevention research to identify the impact of key cultural and health issues, and prevention programs to address them.

References

- 1. US Bureau of the Census. Statistical abstract of the United States: 1998. 118th ed. Washington, DC: US Government Printing Office, 1998.
- Ventura SJ, Martin JA, Curtin SC, Mathews TJ. Births: final data for 1997. Hyattsville, Maryland: US Department of Health and Human Services, CDC, National Center for Health Statistics, 1999. National Vital Statistics Report 1999;47(18).
- 3. National Center for Health Statistics. Health, United States, with adolescent chartbook. Hyattsville, Maryland: US Department of Health and Human Services, CDC, National Center for Health Statistics, 2000.
- 4. Hopkins FW, Mackay AP, Koonin LM, Berg CJ, Irwin MI, Atrash HK. Pregnancy-related mortality in Hispanic women in the United States. Obstet Gynecol 1999;94:747–52.
- 5. Chavez LR, Cornelius WA, Jones OW. Mexican immigrants and the utilization of U.S. health services: the case of San Diego. Soc Sci Med 1985;21:93–102.
- 6. Becerra JE, Hogue CJR, Atrash HK, Perez N. Infant mortality among Hispanics: a portrait of heterogeneity. JAMA 1991;265:217–21.
- 7. Lin-Fu JS. Population characteristics and health care needs of Asian Pacific Americans. Public Health Rep 1988;103:18–27.
- Rosenberg HM, Maurer JD, Sorle PD, et al. Quality of death rates by race and Hispanic origin: a summary of current research, 1999. Vital Health Stat 1999;2:1–13.
- 9. Berg CJ, Atrash HK, Koonin LM, Tucker M. Pregnancy-related mortality in the United States, 1987–1990. Obstet Gynecol 1996;88:161–7.
- Bennett TA, Kotelchuck M, Cox CE, Tucker MJ, Nadeau DA. Pregnancy-associated hospitalizations in the United States in 1991 and 1992: a comprehensive view of maternal morbidity. Am J Obstet Gynecol 1998;178:346–54.

Notice to Readers

National Melanoma/Skin Cancer Detection and Prevention Month — May 2001

May is National Melanoma/Skin Cancer Detection and Prevention Month. This month is dedicated to increasing public awareness of the importance of prevention, early detection, and treatment of skin cancer, including basal cell, squamous cell, and melanoma. The American Cancer Society estimates that in 2001, approximately 1.3 million new cases of curable basal cell and squamous cell carcinomas will be detected, approximately 51,400 new cases of malignant melanoma will be diagnosed, and an estimated 7800 persons will die from melanoma and 2000 from other skin cancers (1). Although death rates from basal cell and squamous cell carcinomas are low, these cancers can cause damage and disfigurement if left untreated. However, when detected early, approximately 95% of these carcinomas can be cured.

Malignant melanoma, the most rapidly increasing form of cancer in the United States, causes approximately 75% of all skin cancer deaths. This disease can spread to other organs, most commonly to the lungs and liver. Malignant melanoma diagnosed at an early stage usually can be cured; melanoma diagnosed at a late stage is more likely to spread and cause death.

CDC's skin cancer prevention and education efforts, including the Choose Your Cover campaign aimed at young persons, encourage all persons to protect themselves from the sun's ultraviolet (UV) rays year-round. The goals include influencing social norms related to sun protection and tanned skin, and improving awareness, knowledge, and behaviors related to skin cancer. CDC's efforts focus on 1) informing the public that even a few serious sunburns can increase a person's risk for skin cancer, and 2) promoting the Choose Your Cover sun protection options: seeking shade, covering up, wearing a hat and sunglasses, and using sunscreen that has a sun protection factor of 15 or higher and has both UVA and UVB protection. Additional information about Choose Your Cover skin cancer prevention campaign is available at http://www.cdc.gov/chooseyourcover or telephone, (770) 488-3070.

Reference

 American Cancer Society. Cancer facts and figures, January 2001. Atlanta, Georgia: American Cancer Society, 2001. Notice to Readers — Continued

Notice to Readers

Buckle Up America! Week — May 21–28, 2001

May 21–28, 2001, is Buckle Up America! Week. During this week, the National Highway Traffic Safety Administration (NHTSA) and the Air Bag and Seat Belt Safety Campaign, through Operation ABC (<u>A</u>merica <u>B</u>uckles Up <u>C</u>hildren) Mobilization, will call the public's attention to the need for drivers and passengers always to wear safety belts on short, low-speed trips in addition to longer trips driven on high-speed highways. During the week, law enforcement agencies will increase enforcement of child restraint and safety-belt laws on rural roads, city streets, and in local neighborhoods as well as on highways and interstates. Adult safety belt use is being emphasized because research shows that when adults buckle up, they buckle up their children a higher percentage of the time.

During 2000, approximately 42,000 persons died in traffic-related crashes in the United States; of these, 18,000 failed to wear their safety belts (1). In 1999, of the 550 vehicle-occupant deaths among children aged <5 years, 53% were unrestrained (2). Motor-vehicle collisions are the leading cause of death among children aged 1–14 years (CDC, unpublished data, 2000). Safety-belt laws and law enforcement are the most effective means of reducing crash-related deaths and serious injuries (3)—saving an estimated 11,000 lives in 1999 (4). However, approximately 30% of drivers do not use safety belts regularly.

Partner organizations and community-based advocates are urged to take the following actions during Buckle Up America! Week: 1) express support for local law enforcement's strict enforcement of local safety-belt laws; 2) conduct educational and media activities about the importance of using safety belts on every trip; 3) assess the rates of local safety belt and child safety seat use and promote increased use; and 4) conduct press events in support of law enforcement mobilization activities. Additional information on child passenger safety and Operation ABC Mobilization is available from NHTSA at http://www.nhtsa.dot.gov or telephone, (888) 327-4236.

Reference

- National Highway Traffic Safety Administration. 1999 annual report and 2000 early assessment files. Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration, National Center for Statistics and Analysis, 2000.
- National Highway Traffic Safety Administration. Traffic safety facts 1999—children. Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration, 2000.
- CDC. Motor-vehicle occupant injury: strategies for increasing use of child safety seats, increasing use of safety belts, and reducing alcohol-impaired driving. A report on recommendations of the Task Force on Community Preventive Services. MMWR 2001;50(no. RR-7)(in press).
- National Highway Traffic Safety Administration. Traffic safety facts 1999—occupant protection. Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration, 2000.



FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending May 5, 2001, with historical data

- * No rubella cases were reported for the current 4-week period yielding a ratio for week 16 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.

		Cum. 2001		Cum. 2001
Anthrax		-	Poliomvelitis, paralytic	-
Brucellosis*		18	Psittacosis*	4
Cholera		-	Ofever*	4
Cyclosporiasis	*	35	Rabies, human	-
Diphtheria		-	Rocky Mountain spotted fever (RMSF)	42
Ehrlichiosis:	human granulocytic (HGE)*	27	Rubella, congenital syndrome	-
	human monocytic (HME)*	4	Streptococcal disease, invasive, group A	1.348
Encephalitis:	California serogroup viral*	-	Streptococcal toxic-shock syndrome*	19
	eastern equine*	-	Syphilis, congenital ¹	35
	St. Louis*	-	Tetanus	6
	western equine*	-	Toxic-shock syndrome	51
Hansen diseas	e (leprosy)*	27	Trichinosis	5
Hantavirus pu	Imonary syndrome**	3	Tularemia*	9
Hemolytic ure	mic syndrome, postdiarrheal*	21	Typhoid fever	66
HIV infection,	pediatric* [§]	72	Yellow fever	-
Plague		-		

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending May 5, 2001 (18th Week)

-: No reported cases.

*Not notifiable in all states.

¹ 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 April 24, 2001.

[§] Updated from reports to the Division of STD Prevention, NCHSTP.

Escherichia coli 0157:H7* AIDS Chlamydia[†] Cryptosporidiosis NETSS PHUS Cum. Cum. Cum Cum Cum Cum Cum Cum Cum. Cum. **Reporting Area** 2001^s UNITED STATES 11,921 12,725 208,487 233,615 NEW ENGLAND 7.830 7.982 Maine N.H. Vt 3,565 Mass. 3,479 R.I. Conn. 2,309 2,715 2,254 3,159 17,359 22,308 MID. ATLANTIC Upstate N.Y. N N 9.518 9.571 1 028 N.Y. City 1.930 N.J. 1 374 4 5 2 9 6 467 8 208 N N Pa 29,788 E.N. CENTRAL 1,259 41,385 Ohio 3,394 10,787 5,121 4,523 Ind. 7,859 11,968 III. Mich. 10,115 8,283 Wis. 3,299 5,824 W.N. CENTRAL 10,420 13,313 2,804 Minn. 2,102 1,325 1,711 lowa Mo 3,195 4,492 N. Dak. S. Dak Nebr. 1,245 Kans 2.005 2.125 S. ATLANTIC 3.720 3,357 44.443 42.244 Del 1,034 1 049 4,370 4,253 Md 1,206 D.C. 1.097 U U 6,230 5,137 Va. W. Va. 3 2 N.C. 7,168 6,863 S.C. 4,339 3,604 8,758 8,407 Ga. 1,785 1,606 10,539 11,112 Fla. E.S. CENTRAL 16,364 17,477 Ky. 3,052 2,795 Ténn. 5,051 4,987 5,599 Ala. 4,183 Miss 4.078 4.096 W.S. CENTRAL 1,296 1,097 31,279 35,077 2 728 Ark. 2.016 5.624 La. ž ž Okla 3 374 3 054 19 553 23 591 Tex -MOUNTAIN 11,135 13,674 Mont. Idaho ž ż Wyo. Colo. 3,915 N. Mex. 1,968 1,725 4,599 Ariz. 4,357 Utah Nev. 1.629 1.290 1,753 PACIFIC 1,821 40,155 39,869 Wash. 4,759 4,504 Ν U Oreg 2.374 32,451 31,492 Calif. 1,526 1,456 Alaska q Hawaii 1,176 υ Guam Ν Ν U 1.859 Ŭ P.R. U Ú Ŭ V.I. Ú Amer. Samoa ũ U U U U U Û Ŭ C.N.M.I. Ŭ Û Ŭ Ŭ Ŭ Ŭ Û Ŭ

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending May 5, 2001, and May 6, 2000 (18th Week)

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.

⁵ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update April 24, 2001.

	Gono	rhea	Hepatit Non-A, I	is C; Ion-B	Legione	llosis	Listeriosis	Ly Dise	me ease
Reporting Area	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	98,219	115,575	736	7,023	2201	233	121	723	1,475
NEW ENGLAND Maine N.H. Vt. Mass. R.I. Conn.	2,126 43 42 30 1,094 255 662	2,218 26 32 18 895 208 1,039	12 - 5 7 -	7 - 3 3 1 -	10 - 3 3 - 1	16 2 - 9 - 3	11 - - 7 - 4	208 - 42 1 45 - 120	227 18 2 91 116
MID. ATLANTIC Upstate N.Y. N.Y. City N.J. Pa.	10,467 2,472 4,014 829 3,152	12,445 2,119 3,907 2,541 3,878	24 15 - 9	244 19 212 13	22 14 4 3 1	55 20 6 2 27	20 9 3 5 3	303 241 - 62	966 374 38 111 443
E.N. CENTRAL Ohio Ind. III. Mich. Wis.	16,372 2,486 2,137 4,752 5,892 1,105	23,348 6,004 2,051 7,146 5,692 2,455	77 5 3 69	92 2 - 10 80 -	60 33 5 - 15 7	66 28 9 7 11 11	14 3 - 8 1	20 19 1 - U	50 7 - 4 1 38
W.N. CENTRAL Minn. Iowa Mo. N. Dak. S. Dak. Nebr. Kans.	4,216 626 349 2,008 11 79 255 888	5,577 1,080 378 2,709 16 88 436 870	201 - 197 - 1 3	172 1 - 165 - 2 4	19 1 5 9 - 3 1	11 1 3 5 - 1 - 1	2 - 1 - - 1	25 16 2 4 - 2 1	27 11 - 10 - 1 5
S. ATLANTIC Del. D.C. Va. W. Va. N.C. S.C. Ga. Fla.	27,158 548 2,566 1,046 2,986 179 5,943 3,155 4,870 5,865	30,077 581 2,943 763 3,581 210 5,918 3,148 5,289 7,644	35 - - 4 7 3 - 10	26 2 4 - 3 9 - 7	34 - 7 1 6 N 4 1 2 13	43 4 11 3 N 6 2 2 15	24 2 4 2 7 7 7	135 99 7 21 1 4 1 - 2	160 29 107 - 12 4 4 - - 4
E.S. CENTRAL Ky. Tenn. Ala. Miss.	10,458 1,183 3,289 3,396 2,590	12,216 1,135 3,804 4,153 3,124	82 3 26 1 52	169 15 34 5 115	22 6 9 5 2	6 4 1 1	7 1 3 3	3 2 1 -	1 - 1 -
W.S. CENTRAL Ark. La. Okla. Tex.	15,259 1,711 3,805 1,594 8,149	18,056 1,023 4,476 1,348 11,209	144 3 58 2 81	6,223 3 207 1 6,012	3 - 2 1 -	9 - 5 1 3	2 1 - 1	1 - 1 -	16 - 1 - 15
MOUNTAIN Mont. Idaho Wyo. Colo. N. Mex. Ariz. Utah Nev.	3,422 41 29 17 1,098 334 1,256 33 614	3,533 14 30 24 1,113 352 1,438 102 460	126 - 1 101 8 9 4 - 3	32 1 13 4 10 - 3	19 - 1 6 1 6 3 2	13 - 1 - 6 1 2 3 -	11 - - 1 3 2 1 4	3 - 1 - - - 1	1 - - - - - -
PACIFIC Wash. Oreg. Calif. Alaska Hawaii	8,741 1,056 97 7,263 116 209	8,105 799 302 6,771 103 130	35 9 2 24 -	58 8 12 38 -	32 6 N 24 2	14 6 N 8 -	30 2 1 27 -	25 2 1 22 - N	27 3 24 N
Guam P.R. V.I. Amer. Samoa	616 6 U	- 177 - U	- - - U	- 1 - U	2 - U	- - - U	- - -	N U	N U
C.N.M.I.	U	U	U	U	U	U	-	U	U

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending May 5, 2001, and May 6, 2000 (18th Week)

N: Not notifiable.

-: No reported cases.

			-			Salmo	nellosis*	
	Mal	aria	Rabies	s, Animal	NE	TSS	Pł	ILIS
Reporting Area	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	277	340	1,629	2,058	7,271	8,791	5,764	8,741
NEW ENGLAND Maine N.H. Vt. Mass. R.I. Conn.	23 2 - 6 1 12	11 1 - 2 6 - 2	197 28 7 30 56 23 53	223 53 15 73 18 61	611 82 46 27 359 28 69	543 39 36 38 316 22 92	519 36 37 25 252 46 123	578 31 40 47 314 41 105
MID. ATLANTIC Upstate N.Y. N.Y. City N.J. Pa.	53 14 28 8 3	63 18 28 7 10	248 195 3 49 1	327 229 3 49 46	656 259 241 107 49	1,278 281 385 325 287	861 122 338 159 242	1,504 383 408 285 428
E.N. CENTRAL Ohio Ind. III. Mich. Wis.	30 7 8 1 14	42 3 25 9 3	9 1 1 6	16 3 - 7 6	1,080 406 104 239 208 123	1,300 288 130 454 212 216	889 346 91 179 184 89	1,211 273 152 464 232 90
W.N. CENTRAL Minn. Iowa Mo. N. Dak. S. Dak. Nebr. Kans.	8 1 3 - 1 2	18 4 1 2 2 - 3 6	110 15 19 8 17 15 - 36	186 24 25 8 48 41 - 40	404 71 77 127 1 28 34 66	459 42 59 163 14 24 65 92	480 178 64 157 14 23 - 44	611 176 65 205 22 31 43 69
S. ATLANTIC Del. Md. D.C. Va. W. Va. N.C. S.C. Ga. Fla.	72 1 30 4 15 - 1 3 3 15	78 2 33 - 17 - 8 1 2 15	702 12 92 - 138 49 205 43 78 85	701 13 141 - 177 40 174 47 67 42	1,923 24 208 23 326 19 335 229 265 494	1,462 29 197 182 42 226 128 245 413	1,171 23 183 U 262 18 175 215 249 46	1,253 33 221 U 188 32 177 110 368 124
E.S. CENTRAL Ky. Tenn. Ala. Miss.	8 2 3 3	12 2 3 6 1	65 7 49 9	72 10 43 19	417 73 121 161 62	440 93 105 140 102	206 45 115 31 15	344 64 154 108 18
W.S. CENTRAL Ark. La. Okla. Tex.	4 1 1 1 1	9 1 3 - 5	90 - - 31 59	371 - 27 344	516 87 89 48 292	955 87 159 83 626	421 29 155 39 198	571 57 115 71 328
MOUNTAIN Mont. Idaho Wyo. Colo. N. Mex. Ariz. Utah Nev.	19 2 9 1 1 2 2	16 1 - 8 - 2 3 2	83 13 - 16 - 2 52 - -	70 23 - - - - - - - - - - - - - - - - - -	560 23 24 25 168 68 161 60 31	773 31 43 18 251 64 181 118 67	439 4 13 145 56 140 58 23	738 40 16 233 60 196 121 72
PACIFIC Wash. Oreg. Calif. Alaska Hawaii	60 2 3 51 1 3	91 4 19 66 - 2	125 - 91 34	92 - 80 12	1,104 107 28 852 14 103	1,581 98 106 1,296 20 61	778 205 75 401 - 97	1,931 206 142 1,508 18 57
Guam P.R. V.I. Amer. Samoa C.N.M.I.	- - U U	- 2 - U U	53 - U U	- 18 - U U	- 101 - U U	100 - - - - -	U U U U	U U U U U

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending May 5, 2001, and May 6, 2000 (18th Week)

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).

-	NET	Shige	losis*		Sy (Primary 8	philis Secondary)	Tuba	roulocie
ŀ	Cum.	Cum.	Cum.	Cum.	Cum.	Cum.	Cum.	Cum.
Reporting Area	2001	2000	2001	2000	2001	2000	2001	2000
UNITED STATES	3,415	5,638	1,766	3,650	1,705	2,241	3,221	4,179
NEW ENGLAND Maine	57 1	103 4	61 1	90	13	24	111 5	98 3
N.H. Vt	1	1	1	4	-	-	7	3
Mass.	39	71	35	56	9	20	ຜິ	81
R.I. Conn.	6 8	7 19	9 14	10 20	1 3	1 3	10 24	10
MID. ATLANTIC	314	842	287	573	117	103	668	705
N.Y. City	107	427	164	286	81	49	365	400
N.J. Pa.	40 30	69 59	52 65	74 77	14 18	20 30	149 68	173 54
E.N. CENTRAL	518	988	293	587	253	502	339	444
Ind.	84	187	17	30	62	165	28	48
III. Mich	133 110	354 275	84 71	268 229	63 92	168 119	173	225 57
Wis.	29	110	8	14	9	24	27	30
W.N. CENTRAL Minn.	355 105	354 44	341 184	306 88	20 9	31 3	141 77	174 58
lowa Mo	75 91	67 195	67	84 110	-	8	9 27	13
N. Dak.	9	2	1	1	-	-	-	-
S. Dak. Nebr.	26 26	1 22	16	11	-	- 2	4 14	8
Kans.	33	23	14	12	5	3	-	23
S. AILANTIC Del.	580 4	641 5	169 3	196 4	681 2	723	628	741 2
Md.	42	36	14	10	84 13	117	63 15	78
Va.	38	33	19	32	50	45	60	81
vv. va. N.C.	4 135	2 38	6 54	22	162	196	10 79	14
S.C.	41 74	13 81	25 44	18 68	100	74 130	24 121	26 169
Fla.	223	433	4	40	178	143	256	270
E.S. CENTRAL	313 106	259 52	85 33	197 31	199 15	336	206 32	279 29
Tenn.	35	131	28	152	116	211	43	114
Ala. Miss.	90 82	13 63	1/ 7	11 3	30 38	44 48	98 33	90 46
W.S. CENTRAL	489	958 71	262	295	231	311	363	662 59
La.	27	97	63	48	50	72	4/	46
Okla. Tex.	10 259	11 779	2 132	215 215	31 133	57 148	41 275	35 523
MOUNTAIN Mont	224	307 2	149	203	66	68	93	156
Idaho	8	27	-	18	-	-	4	3
vvyo. Colo.	52	2 55	- 38	29	9	3	27	19
N. Mex. Ariz	40 94	32 106	28 61	20 62	6 42	6 56	11 27	20 61
Utah	14	25	14	30	6	-	5	10
PACIFIC	10 565	58 1.186	8 119	42	3 125	2 143	672	39 920
Wash.	56	208	76	255	22	20	61	66
Calif.	485	868	-	883	∠ 98	3 119	543	761
Alaska Hawaii	2 14	6 14	12	3 10	3	- 1	14 54	26 39
Guam	- 7	- 14	U	U	-	-	- 20	-
V.I.	-	-	Ŭ	Ŭ	-	-	-	
Amer. Samoa C.N.M.I.	U U	U U	U U	U U	U U	U U	U U	U U

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending May 5, 2001, and May 6, 2000 (18th Week)

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).

	H. influ	ienzae,	н	epatitis (V	iral), By Ty	ре			Meas	les (Rubeo	ola)	
	Inva	sive	Α		В	_	Indige	nous	Impo	rted*	Tota	
Reporting Area	Cum. 2001 [†]	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	2001	Cum. 2001	2001	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	518	475	2,962	4,360	2,004	2,072	2	22	2	19	41	29
NEW ENGLAND Maine N.H. Vt.	17 1 -	41 1 6 3	139 3 5 2	109 6 11 3	34 3 7 1	37 2 8 3	-	3 - - 1	- - -	1 - -	4 - - 1	- - -
Mass. R.I. Conn.	16 - -	23 1 7	45 6 78	44 6 39	3 8 12	1 7 16	-	2 - -	-	1 - -	3 - -	-
MID. ATLANTIC Upstate N.Y. N.Y. City N.J. Pa.	59 23 21 14 1	70 28 24 14 4	258 81 116 46 15	319 81 164 - 74	266 43 160 44 19	349 40 193 15 101	1 - U -	2 1 - 1	- - U	5 4 - 1 -	7 5 1 1	10 - 10 -
E.N. CENTRAL Ohio Ind. III. Mich. Wis.	62 28 17 10 3 4	77 24 8 28 6 11	345 93 30 91 125 6	603 117 17 243 188 38	250 46 7 21 176	237 36 16 33 142 10	- - - -		2 - 2 - -	9 2 4 3 -	9 2 4 3 -	3 2 - 1 -
W.N. CENTRAL Minn. Iowa Mo. N. Dak. S. Dak. Nobe	21 9 1 8 - -	17 7 7 1 -	154 12 15 42 - 1 20	312 44 33 168 -	68 10 7 37 - 1	89 7 14 47 - 16	- - - -	4 2 - 2 -		- - - -	4 2 - 2 -	-
Kans.	1 1 174	- 11/	64 64	48	7 /38	5 344	-	- 3	-	-	-	-
Del. Md. D.C.	44	28	98 16	435 6 50	-52 3	5 50 -	-	2	-	1	3	-
Va. W. Va. N.C. S.C. Ga. Fla.	10 4 22 4 43 47	24 3 9 33 14	48 2 43 22 227 185	52 35 80 14 56 140	45 10 84 5 110 129	51 2 96 2 48 90		- - - 1	-	- - - -	- - - 1 -	
E.S. CENTRAL Ky. Tenn. Ala. Miss.	34 1 14 18 1	20 9 8 3	103 12 47 40 4	193 20 68 25 80	123 14 44 34 31	156 29 64 18 45	- - -			- - -	- - -	- - - -
W.S. CENTRAL Ark. La. Okla. Tex.	18 - 2 16 -	28 - 10 17 1	377 18 32 63 264	850 69 33 121 627	236 36 16 34 150	225 36 59 30 100	- - -	1 - - 1		- - - -	1 - - 1	
MOUNTAIN Mont. Idaho Wyo. Colo. N. Mex. Ariz.	86 - 4 19 12 40	52 2 11 11 22	289 4 27 15 28 8 148	308 1 12 3 61 35 153	212 1 16 42 54 68	168 3 4 33 52 56	- - - - - -		- - - - - -	1 - - - -	1 - - - - -	10 - - 3 - -
Utah Nev.	3 7	4 2	26 33	18 25	10 15	4 16	U	-	Ū	-	-	34
Wash. Oreg. Calif. Alaska Hawaii	4/ 1 3 23 2 18	50 3 16 22 1 14	24 20 600 11 1	1,233 93 91 1,037 4 8	377 31 10 324 4 8	407 17 37 405 2 6	- - - 1	9 - 1 7 - 1	-	2 - - 1 - 1	- 1 8 - 2	8 - 3 - -
Guam P.R. VI	-	2	39	119	25	82	U	-	U	-	-	-
Amer. Samoa C.N.M.I.	U U	U U	U U	U U	U U	U U	Ŭ	U U	Ŭ U	U U	U U	U U

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending May 5, 2001, and May 6, 2000 (18th Week)

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

*For imported measles, cases include only those resulting from importation from other countries. † Of 109 cases among children aged <5 years, serotype was reported for 54, and of those, eight were type b.

	Mening Dis	jococcal ease		Mumps			Pertussis			Rubella	
Benorting Area	Cum.	Cum.	2001	Cum.	Cum.	2001	Cum.	Cum.	2001	Cum.	Cum.
UNITED STATES	984	975	3	62	151	40	1,590	1,801	2001	6	43
NEW ENGLAND Maine N.H. Vt. Mass	64 1 6 4 37	54 3 3 2 36	-	-	2 - - -	-	229 - 16 22 183	470 10 52 87 297	-	-	9 - 1 - 7
R.I.	1	3	-	-	1	-	1	6	-	-	-
Conn. MID. ATLANTIC Upstate N.Y. N.Y. City N.J. Pa.	15 75 31 20 22 2	91 22 25 20 24	- - U	- 1 - 1 -	1 11 5 3 - 3	5 5 U	7 95 79 6 2 8	18 163 75 33 - 55	- - - U	- 1 - -	1 6 2 4 -
E.N. CENTRAL Ohio Ind. III. Mich. Wis.	125 44 19 20 23 19	166 28 18 45 54 21	- - - -	7 1 5 -	19 6 - 4 8 1	6 1 1 4 -	182 117 12 18 17 18	243 142 17 23 16 45	1 - 1 - -	2 - 1 - -	
W.N. CENTRAL Minn. Iowa Mo. N. Dak. S. Dak. S. Dak. Nebr. Kans	64 8 17 23 3 2 2 9	57 3 13 31 4 3 2		4 - - - - 3	8 - 2 - - 1 1		75 17 10 33 - 3 2 10	58 31 8 1 1 2 7		1 - - - - -	1 - - - 1
S. ATLANTIC	190	135	2	8	20	11	81	135	1	2	11
Del. Md.	24	- 13	- 1	4	- 5	2	- 13	1 36	-	-	-
D.C. Va. W. Va. N.C. S.C. Ga. Fla.	21 4 40 19 27 55	- 24 25 11 23 35	- - - - 1	- 2 - 1 - 1	- - 3 6 1 1	- 2 - 5 1 - 1	1 10 30 15 2 9	- 13 - 38 16 16 15	- - - - 1	- - - 1 1	- - 8 2 - 1
E.S. CENTRAL Ky. Tenn. Ala. Miss.	69 13 23 27 6	63 12 27 18 6	- - -	1 1 - -	4 - 2 1 1	1 - - 1 -	38 11 16 8 3	39 25 5 8 1			4 1 - 3 -
W.S. CENTRAL Ark. La. Okla. Tex.	141 10 46 16 69	138 6 32 18 82	- - -	6 1 2 - 3	15 1 3 - 11	8 - - 8	43 3 1 38	63 9 4 - 50			4 - 1 - 3
MOUNTAIN Mont. Idaho Wyo. Colo. N. Mex. Ariz. Utah Nev.	51 - 4 1 20 8 9 5 4	52 1 - 14 7 16 6 2	1 - - - - - U	6 - 1 1 2 - - 1	9 1 - 1 1 - 4 2	9 - - 2 3 4 - U	719 5 160 1 133 45 359 11 5	305 6 37 - 184 44 25 6 3	- - - - - U		
PACIFIC Wash. Oreg. Calif. Alaska Hawaii	205 34 15 147 1 8	219 15 25 170 3 6	- N - -	29 - N 18 1 10	63 1 N 55 2 5	- - - -	128 30 6 83 - 9	325 89 28 186 4 18			8 - 2 -
Guam P.R. V.I. Amer. Samoa C.N.M.I.	- 1 - U U	- 4 - U U	U U U U	- - U U	- - U U	U U U U	- - U U	- 1 - U U	U - U U U	- - U U	- - U U

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending May 5, 2001, and May 6, 2000 (18th Week)

N: Not notifiable.

U: Unavailable.

-: No reported cases.

		All Cau	ises, By	Age (Ye	ears)		D9.11	• • • • • •		All Cau	ises, By	/Age (Y	ears)		D9.IT
Reporting Area	All Ages	≥65	45-64	25-44	1-24	<1	Total	Reporting Area	All Ages	≥65	45-64	25-44	1-24	<1	Total
NEW ENGLAND Boston, Mass. Bridgeport, Conr Cambridge, Mass Fall River, Mass. Hartford, Conn. Lowell, Mass. Lynn, Mass. New Bedford, M& New Haven, Conr Providence, R.I. Somerville, Mass Springfield, Mass	563 163 163 26 20 35 23 24 21 1 155. 24 1. 45 . 40 . 3 5. 40 . 3 21	403 110 15 14 27 13 15 16 22 35 31 31 31 21	91 31 6 4 7 5 7 2 2 4 6 - 3	44 12 3 1 5 2 2 - 5 2 - 3 2	15 4 1 - - 1 - 1 - 2	10 6 1 - - - 1 1 1	57 16 2 3 - 2 3 1 2 4 8 1 3 1	S. ATLANTIC Atlanta, Ga. Baltimore, Md. Charlotte, N.C. Jacksonville, Fla Miami, Fla. Norfolk, Va. Richmond, Va. Savannah, Ga. St. Petersburg, F Tampa, Fla. Washington, D.C Wilmington, De	1,152 165 182 114 . 142 71 51 69 58 Fla. 68 58 Fla. 0 C. 200 I. 32	732 96 108 71 101 42 32 38 37 49 U 126 32	244 41 42 18 28 11 9 19 13 11 U 52 -	118 19 23 16 9 6 6 7 5 U 18	33 75 6 2 6 1 4 - 1 U 1 -	25 2 4 3 2 3 3 2 1 2 U 3 -	75 4 21 10 10 1 3 4 7 U 3 -
Worcester, Mass. MID. ATLANTIC Albany, N.Y. Allentown, Pa. Buffalo, N.Y. Camden, N.J. Elizabeth, N.J. Erie, Pa.S	- 68 2,255 46 21 96 23 22 50	1,634 32 19 68 18 17 44	6 413 8 1 20 4 4 5	6 145 3 1 7 1 1	5 36 1 - 1 -	1 27 2 - - - - -	11 115 6 7 2 -	E.S. CENTRAL Birmingham, Al. Chattanooga, Te Knoxville, Tenn. Lexington, Ky. Memphis, Tenn. Mobile, Ala. Montgomery, A Nashville, Tenn.	920 a. 208 ann. 69 96 54 . 244 77 Ia. 34 138	623 140 54 64 34 158 51 24 98	185 41 25 13 46 15 10 23	60 14 2 6 4 22 3 - 9	27 4 1 3 12 4 - 2	23 7 - 6 4 - 6	63 18 5 4 2 17 4 6 7
Jersey City, N.J. New York City, N. Paterson, N.J. Philadelphia, Pa. Reading, Pa. Rochester, N.Y. Schenectady, N.Y. Scranton, Pa.§ Syracuse, N.Y. Trenton, N.J. Utica, N.Y. Yonkers, N.Y.	382 Y. 1,142 22 379 45 23 147 7. 25 33 69 45 29 U	30 793 U 283 30 176 116 255 53 29 21 U	4 231 2 66 11 5 15 2 5 11 13 6 U	4 82 U 3 20 2 1 8 - 3 3 3 2 U	- 18 U 1 9 2 - 3 - 1 - U	18 U 1 5 - 1 - U	38 U 2 25 4 2 11 2 1 9 1 5 U	W.S. CENTRAL Austin, Tex. Baton Rouge, La Corpus Christi, 7 Dallas, Tex. El Paso, Tex. Ft. Worth, Tex. Houston, Tex. Little Rock, Ark. New Orleans, La San Antonio, Te Shreveport, La	1,431 100 . 38 Fex. 72 225 65 131 347 59 . 53 x. 217 U 124	923 66 27 51 124 47 102 191 37 34 154 U 90	289 16 7 13 50 13 16 94 14 8 40 U 18	127 15 - 28 3 10 36 3 5 14 U 9	54 2 2 1 10 1 21 3 6 5 U 1	37 12 3 13 1 5 2 4 U 5	89 8 2 5 9 5 3 16 2 8 17 U 14
E.N. CENTRAL Akron, Ohio Canton, Ohio Chicago, Ill. Cincinnati, Ohio Cleveland, Ohio Dayton, Ohio Detroit, Mich. Evansville, Ind. Fort Wayne, Ind.	1,742 56 32 U 93 147 199 136 213 49 69	1,156 45 24 U 55 93 118 92 123 41 51	368 8 5 U 22 31 50 29 56 5 14	118 1 - - - - - - - - - - - - - - - - -	46 1 1 U 6 5 5 1 6 - 2	54 1 2 U 6 4 7 4 4 2	121 6 4 7 4 7 12 17 1 3	MOUNTAIN Albuquerque, N Boise, Idaho Colo. Springs, C Denver, Colo. Las Vegas, Nev. Ogden, Utah Phoenix, Ariz. Pueblo, Colo. Salt Lake City, U Tucson, Ariz.	1,097 .M. 111 39 olo. 65 102 254 37 180 35 tah 110 164	739 82 29 48 159 30 110 23 71 119	206 16 5 9 21 57 3 41 8 21 25	100 11 3 9 28 3 20 2 11 10	31 - 3 2 7 1 5 2 8	20 1 2 2 3 - 3 5 2	92 13 7 4 12 23 6 13 2 8 4
Gary, Ind. Grand Rapids, Mi Indianapolis, Ind Lansing, Mich. Milwaukee, Wis. Peoria, III. Rockford, III. South Bend, Ind. Toledo, Ohio Youngstown, Oh	24 24 230 39 114 61 45 44 94 io 57	13 32 142 28 83 41 34 34 88 39	8 3 51 8 22 12 7 8 17 12	2 1 23 1 4 2 2 4 3	1 1 7 2 4 1 - 3	3 7 4 3 2 2 3	1 3 18 4 8 5 7 1 9 4	PACIFIC Berkeley, Calif. Fresno, Calif. Glendale, Calif. Honolulu, Hawa Long Beach, Cal Los Angeles, Cal Pasadena, Calif. Portland, Oreg. Sacramento, Cal	1,628 20 124 9 ii 48 if. 69 lif. 232 25 183 lif. 203	1,176 14 100 9 32 47 172 18 138 148	310 3 18 - 13 16 37 4 29 46	87 1 3 - 3 5 19 2 9 6	26 - - - - 2 - 3 3	25 2 1 - 1 2 1 4 -	131 1 9 2 4 6 17 1 11 21
W.N. CENTRAL Des Moines, Iowi Duluth, Minn. Kansas City, Kans Kansas City, Mo. Lincoln, Nebr. Minneapolis, Mir Omaha, Nebr. St. Louis, Mo. St. Paul, Minn.	659 a 58 30 s. 19 U 24 110. 171 90 116 80	475 47 21 8 U 22 126 68 64 67	115 6 5 8 U 1 30 15 31 9	29 1 2 1 U 1 3 4 9 2	16 1 1 U 2 2 6 2	24 4 1 U - 10 6	40 8 1 U 3 15 4 - 4	San Diego, Calif San Francisco, C San Jose, Calif. Santa Cruz, Cali Seattle, Wash. Spokane, Wash. Tacoma, Wash. TOTAL	. 160 alif. U 200 f. 44 131 68 112 11,447 ¹	112 U 136 36 90 47 77 7,861	28 U 48 6 23 15 24 2,221	10 U 10 2 8 4 5 828	4 U 2 - 8 - 2 284	6 U 2 2 2 245	19 U 12 4 13 3 8 783

TABLE IV. Deaths in 122 U.S. cities,* week ending May 5, 2001 (18th Week)

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 \geq 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.

⁴Because 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.

¹Total includes unknown ages.

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 Carol A. Worsham

CDC Operations Team Carol M. Knowles Deborah A. Adams Willie J. Anderson Patsy A. Hall Mechele Hester Felicia J. Perry Pearl Sharp

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/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 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.	Director, Epidemiology Program Office Stephen B. Thacker, M.D., M.Sc.	Writers-Editors, <i>MMWR</i> (Weekly) Jill Crane David C. Johnson
Deputy Director for Science and Public Health, Centers for Disease	Editor, <i>MMWR</i> Series John W. Ward, M.D.	Desktop Publishing
David W. Fleming, M.D.	Acting Managing Editor, <i>MMWR</i> (Weekly) Teresa F. Rutledge	Lynda G. Cupell Morie M. Higgins
	t Duinting Officer 2001 622	172/49220 Deview IV/

☆U.S. Government Printing Office: 2001-633-173/48230 Region IV

Official Business Penalty for Private Use \$300 Return Service Requested

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

HEALTH AND HUMAN SERVICES Centers for Disease Control

and Prevention (CDC)

DEPARTMENT OF

Atlanta, Georgia 30333

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/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 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	Director,	Writers-Editors, <i>MMWR</i> (Weekly)
Control and Prevention	Epidemiology Program Office	Jill Crane
Jeffrey P. Koplan, M.D., M.P.H.	Stephen B. Thacker, M.D., M.Sc.	David C. Johnson
Deputy Director for Science and Public Health, Centers for Disease Control and Prevention David W. Fleming, M.D.	Editor, <i>MMWR</i> Series John W. Ward, M.D. Acting Managing Editor, <i>MMWR</i> (Weekly) Teresa F. Rutledge	Desktop Publishing Lynda G. Cupell Morie M. Higgins

☆U.S. Government Printing Office: 2001-633-173/48230 Region IV

Official Business Penalty for Private Use \$300 Return Service Requested Washington, D.C. 20402

SUPERINTENDENT OF DOCUMENTS

UNITED STATES GOVERNMENT PRINTING

OFFICE

PRESORTED STANDARD POSTAGE & FEES PAID GPO Permit No. G-26