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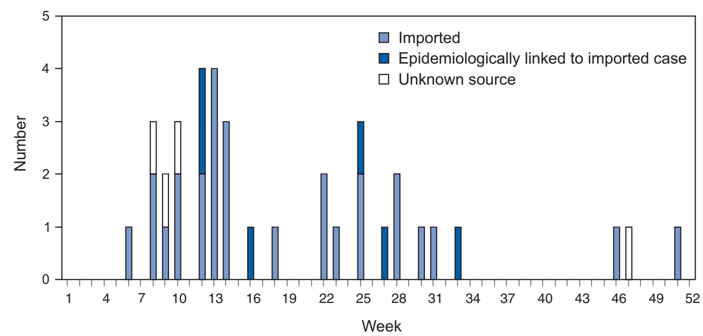
Measles — United States, 2004

Measles is a highly infectious, acute viral illness that can cause severe pneumonia, diarrhea, encephalitis, and death. During 2004, a total of 37 cases (incidence: <1 case per million population) was reported to CDC by local and state health departments, the lowest number of measles cases ever reported in 1 year in the United States and a decrease of 16% from the previous low of 44 cases in 2002 (*1*). This report describes the epidemiology of measles in the United States in 2004, documenting the absence of endemic measles and the continued risk for internationally imported measles cases that can result in indigenous transmission.

FIGURE. Number of measles cases, by import status and week of rash onset — United States, 2004



Case Characteristics

Of the 37 cases, 34 (92%) were confirmed by laboratory testing (i.e., detection of measles-specific IgM antibodies or measles virus) and the remaining three (8%) were confirmed by meeting the clinical case definition (*2*) and by being epidemiologically linked to a laboratory-confirmed case. Confirmed measles cases occurred predominantly among preschool-aged children (aged 1–4 years), with 18 cases (49%), followed by children aged 5–19 years, with seven cases (19%), and persons aged 20–34 years and infants aged <12 months, with five cases each (14%); two cases occurred in persons aged ≥35 years. Three states accounted for 49% of cases: Washington (seven cases), California (six cases), and New York (five cases, including four from New York City); 11 other states reported one to three cases. No cases were reported during 32 of the 52 reporting weeks; 12 consecutive weeks was the longest period during which no cases were reported (Figure). The maximum number of reported cases occurring during a single week was four, and the median number of cases per week was one (range: zero to four cases).

Twenty-seven (73%) of the 37 cases were imported*; 14 (52%) cases occurred in U.S. residents who acquired measles while traveling abroad, and 13 (48%) occurred in foreign nationals who acquired disease abroad and traveled to the United States. The countries from which measles was imported were China (13 cases), India (four), Bangladesh (two), and Thailand (two), with six other countries contributing one case each (Malaysia, Nigeria, Philippines, Russia, Saudi Arabia, and the United Kingdom). Of the 27 persons with imported measles cases, 13 (48%) were infectious during aircraft flights

* Imported cases are those in persons infected outside the United States.

INSIDE

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(i.e., rash onset occurred within 4 days before through 4 days after the date of arrival). One case of transmission after exposure on an aircraft flight was documented in a passenger who had been vaccinated with 2 doses of measles-containing vaccine and who was seated next to a person with infectious disease. All 14 U.S. residents with imported cases were eligible for measles vaccination, according to recommendations from the Advisory Committee on Immunization Practices (*3*). Of these, nine (64%) were unvaccinated, three (21%) had unknown vaccination status, and two (14%) had been vaccinated with $\geq$1 dose of measles-containing vaccine. Of the 13 imported cases among non-U.S. residents, 10 (77%) were in unvaccinated persons and three (23%) were in persons with unknown vaccination status.

Ten (27%) of the cases were indigenous,[†] of which six (60%) were import-linked and four (40%) had unknown sources of exposure (two occurring in a two-case chain of transmission and two sporadic cases with no epidemiologic link to any other measles case). Eight (80%) cases occurred in vaccine-eligible persons (i.e., aged $\geq$12 months and born after 1957); of these, five (63%) persons were unvaccinated, one (13%) had unknown vaccination status, and two (25%) had been vaccinated.

Outbreaks

During 2004, two measles outbreaks, defined as three or more epidemiologically linked cases, were reported to CDC. These outbreaks occurred in five states and accounted for 13 (35%) of the 37 cases. In one outbreak, nine children aged 12–18 months who acquired disease while in orphanages in China traveled as adoptees to three states (Maryland, New York, and Washington). One case of secondary spread was identified in a California resident aged 19 years with a nonmedical exemption for measles vaccination who had had close contact with one of the adoptees (*4*). In the second outbreak, a U.S. student aged 19 years with a nonmedical exemption for measles vaccination was infected in India and returned to Iowa, where two secondary cases occurred: one in an unvaccinated close contact of the index patient and one in a person who had been seated next to the index patient on an aircraft (*5*).

[†] Indigenous cases are those in persons infected in the United States. Indigenous cases are classified into three groups: import-linked (i.e., epidemiologically linked to an imported case); imported virus (i.e., cases that cannot be linked epidemiologically to an imported case but for which imported virus has been isolated from the patient or from an epidemiologically linked patient); and unknown source (i.e., all other cases acquired in the United States for which no epidemiologic link or virologic evidence indicates importation).

Viral Genotypes

Three genotypes of measles virus were identified among viral samples collected from nine patients. D8, a genotype found in South Asia, was identified from cases in the outbreak arising from the U.S. traveler returning from India, a two-case chain of transmission resulting from travel of the index patient from India, and a single case imported from Bangladesh. Genotype H1, endemic in East Asia, was detected from cases in the outbreak traced to adoptees from China and from an unrelated two-case chain of transmission involving an adoptee from China. Virus isolated from a single case imported from the Philippines was determined to belong to genotype D3.

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Editorial Note: The 37 confirmed cases in 2004 represent a record low number of reported measles cases since measles became a nationally reportable disease in 1912. The epidemiology of measles in 2004 confirms the previous finding that endemic transmission of measles virus has been eliminated in the United States (*6*). Thirty-three (89%) cases were import-associated (i.e., imported or import-linked), and 14 imported cases occurred among U.S. residents who contracted measles while traveling abroad. Sixty-four percent of the imported cases among U.S. residents could have been prevented if long-standing ACIP recommendations concerning measles vaccination of foreign travelers (*3*) had been followed.

Of the 27 persons with imported cases in 2004, 13 (48%) traveled on aircraft while infectious. Measles virus is a highly infectious pathogen, and intercontinental flights create the potential for prolonged exposure. However, on the basis of available data, the risk for in-flight measles transmission among passengers appears to be low (*7*). Of the hundreds of persons on the same flights as the 13 persons who traveled while infectious in 2004, only one case of secondary transmission was identified, in a person seated immediately next to an infectious passenger. For the 8-year period (1996–2004) for which such transmission data have been recorded, 117 passengers with imported measles cases were considered infectious while traveling by aircraft (carrying an estimated 10,000 passengers), but only four secondary-spread cases were identified from three index patients (CDC, unpublished data, 1996–2004). Seating location was recorded for two of the three index patients, both of whom were seated immediately adjacent to the secondary-spread patients. The low in-flight attack rate might be related to high vaccination/immunity levels among persons traveling by air (most of whom are adults) and to vertical airflow patterns within airplanes, which might decrease in-flight exposure to measles.

As long as measles is endemic in most countries worldwide, sustaining measles elimination in the United States will require maintenance of high levels of vaccination coverage (i.e., >90%) (*8*), vigilance in detecting and containing imported cases, and enhanced surveillance to detect and characterize cases and identify sources and viral genotypes.

Acknowledgments

This report is based, in part, on data contributed by state and local health departments.

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Late Relapse of *Plasmodium ovale* Malaria — Philadelphia, Pennsylvania, November 2004

Approximately 1,300 cases of malaria are reported each year in the United States; nearly all of these cases occur in travelers, many of whom fail to receive or adhere to prescribed chemoprophylaxis or do not follow recommendations for prevention of mosquito bites. Malaria can persist if not treated or if treated incorrectly (e.g., with an ineffective drug or an incorrect dosage of an effective drug) (*1*). Early treatment is required to avoid severe illness or death. Although malaria typically becomes clinically apparent within 1 month of infection, cases can occur years after the last presumed exposure. In November 2004, CDC received a report of a late relapse of malaria in a Nigerian man aged 23 years in Philadelphia, Pennsylvania. His malaria was determined to have been caused by *Plasmodium ovale*, one of the four species of *Plasmodium* parasite that are transmitted by mosquitoes and cause malaria. The patient had been treated for malaria in Nigeria on multiple occasions, most recently 6 years before onset of his illness in the United States. This report describes the Philadelphia case, which underscores the importance of taking a detailed travel and immigration history when evaluating unexplained fever and considering malaria in the differential diagnosis.

Case Report

The man sought care at a hospital emergency department after 10 days of nocturnal fevers, chills, and night sweats, occurring every 48–72 hours. He had a history of identical symptoms that had been treated empirically as presumed malaria, a common practice with patients with unexplained fever in malaria-endemic areas with limited diagnostic capabilities; no laboratory tests had been performed in Nigeria to confirm this diagnosis, the most recent of which was made 6 years earlier. The patient did not recall which medications he had received. The patient said he had no unexplained episodes of fever during the 4 years since immigrating to the United States and no recent travel to Nigeria or any other area where malaria is endemic; moreover, the patient said he had not traveled outside of the Philadelphia area since immigrating.

The patient was afebrile in the emergency department. Physical examination was normal; the liver and spleen were not palpable. Laboratory work was notable only for hemoglobin of 12.8 g/dL (normal range: 14–18 g/dL) and total bilirubin of 5.0 mg/dL (normal: <1.5 mg/dL), with direct bilirubin of 0.4 mg/dL (normal range: 0–0.3 mg/dL). A peripheral blood film revealed *P. ovale* (0.2% of red blood cells infected). These blood-film results subsequently were confirmed at CDC.

The patient was admitted to the hospital for less than 2 hours and then discharged with a treatment regimen of 7 days of quinine and doxycycline; he was not administered chloroquine, the treatment of choice for *P. ovale* infection, because none was available at the hospital pharmacy and the regimen prescribed was an appropriate immediate alternative. His symptoms resolved within 48 hours. Subsequently, a screen for glucose-6-phosphate dehydrogenase (G6PD) deficiency was negative (a requirement for primaquine), and a 14-day course of primaquine (30 mg daily) was administered. After 4 months, the patient reported no further symptoms.

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Editorial Note: Malaria is caused by any of the four species of *Plasmodium* (*P. falciparum*, *P. vivax*, *P. ovale*, or *P. malariae*) parasite transmitted by the bite of an infective female *Anopheles* mosquito. Nearly all malaria cases in the United States occur among persons who have traveled to areas with ongoing transmission. Infections also can be acquired locally through exposure to infected blood products, by congenital transmission, or by local mosquito-borne transmission. Treatment decisions take into account the infecting *Plasmodium* species, percentage of red blood cells infected, likely geographic origin of the infection, and clinical status of the patient (*2*). With *P. ovale* and *P. vivax* infections, certain parasites can remain dormant in the liver (i.e., hypnozoites) before infecting red blood cells and causing a relapse, even after appropriate treatment of a blood-stage infection. Fewer relapses occur with *P. ovale* malaria than with *P. vivax* (*3*).

Malaria caused by *P. ovale* is the least common malaria reported in the United States, accounting for only 2.6% of cases in 2003 (*1*). However, in Nigeria, malaria caused by *P. ovale* is second only to *P. falciparum* in frequency. In one clinical study of U.S. cases of *P. ovale*, relapses occurred 17–255 days after the primary attack (*4*). Other reports describe a relapse occurring 45 months after treatment of the primary attack of *P. ovale*, (*5*) and transmission of *P. ovale* from a blood donor exposed 7 years before donation (*6*).

The case described in this report highlights the importance of taking a complete travel and immigration history from persons with unexplained febrile illnesses. The history should include all foreign travel, immigration details, and any history of malaria, including whether or not the malaria was laboratory confirmed. Primaquine, the only available drug that kills hypnozoites, is used to clear the liver of *P. ovale* and *P. vivax* hypnozoites and thereby prevent malaria relapses. When primaquine is administered presumptively in conjunction with a blood-stage prophylactic agent to prevent a possible *P. vivax* or *P. ovale* relapse, this therapy is called terminal prophylaxis or presumptive antirelapse therapy (PART) (*7*). Primaquine used in conjunction with an effective drug for killing blood-stage parasites (i.e., schizonts) in a patient with *P. vivax* or *P. ovale* malaria is called radical cure. PART and radical cure are the current strategies for preventing *P. vivax* and *P. ovale* relapses (*7*).

CDC recommends a primaquine phosphate dose of 30 mg (base) by mouth daily for 14 days. Primaquine must not be used during pregnancy because it can cross the placenta and cause hemolysis in a G6PD-deficient fetus. Because of the risk for hemolysis from primaquine, patients must be screened for G6PD deficiency before starting treatment. For persons with G6PD deficiency, radical cure options should be reviewed with a specialist in infectious disease or tropical medicine. Primaquine is not recommended for PART in persons with G6PD deficiency (*7*).

Health-care practitioners should consider malaria in their differential diagnoses of patients who have unexplained fever and 1) have a history of malaria, 2) have lived in a malaria-endemic country, or 3) have traveled to a malaria-endemic country. A malaria blood film should be performed and appropriate treatment administered. Current guidelines for the diagnosis and treatment of malaria are available at http://www.cdc.gov/malaria.

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Outbreak of Cutaneous *Bacillus cereus* Infections Among Cadets in a University Military Program — Georgia, August 2004

Although *Bacillus cereus* is known mainly as an agent of food poisoning, other infections caused by this organism have been documented in immunocompromised patients, including sepsis, meningitis, pneumonia, and wound infections (*1,2*). Certain populations are at increased risk for *B. cereus* infection, including cancer patients, neonates, intravenous drug users, and patients with a history of trauma, surgery, or catheterization (*3–6*). Primary cutaneous disease attributed to *B. cereus* in immunocompetent persons or in non–health-care settings rarely has been reported (*7*). This report is the first to document such an outbreak. On August 24, 2004, a local health department in Georgia received a call from a university health center describing 90 cadets with nonpruritic, impetigo-like lesions on their scalps; *B. cereus* was the common organism among the three patients whose lesions were cultured. The cases occurred during the freshman military orientation week that preceded the start of the fall term. The Georgia Division of Public Health (GDPH) conducted an investigation to determine the source of the infections, identify associated risk factors, and implement control measures. This report summarizes the results of the outbreak investigation, which identified receiving a short haircut at the start of orientation week, sharing sunscreen during the week, and membership in Company B as strongly associated with having scalp lesions. Recommendations to the university included changing the type of haircut required, increasing time allowed for showering, and issuing individual sunscreen. The results of this investigation underscore the need for military programs to incorporate good hygiene and infection-control measures into school orientation events.

GDPH reviewed the events of orientation week, investigated cases of scalp dermatitis, collected environmental samples, and conducted a cohort study of participants in the military program during four site visits to the university. University personnel provided a schedule of orientation activities and a tour of each event location. Medical records from patients were reviewed and clinical findings discussed with university health-care staff. Patients were interviewed, and available clinical isolates were sent to the Georgia Public Health Laboratory for confirmation. Samples, including talc, Barbicide® disinfectant, and swabs of electric clippers, were collected from two barbershops providing haircuts to cadets. Soil and water samples were collected from event sites, and swabs were taken of shared helmets and sunscreen. Five patients donated their hats for the environmental and laboratory investigation. CDC analyzed the environmental samples and characterized bacterial isolates by biochemical analysis, 16S rRNA gene sequencing (*8*), and multilocus sequence typing (MLST) (*9*).

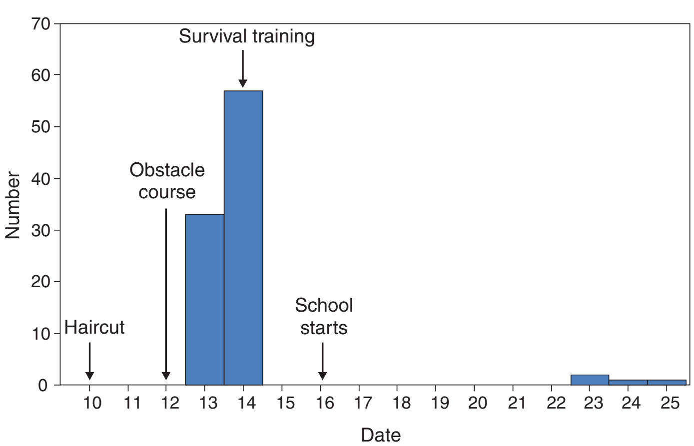
After the initial investigation, GDPH conducted a cohort study of all cadets in the military program at the university. GDPH distributed questionnaires to all 660 cadets, including upperclassmen, 3 weeks after orientation week. The cadets were asked about demographic information, company and dormitory assignment, clinical symptoms, orientation event participation, exposure to soil and water, and hygiene practices, including laundry, bathing, and shared products. A case was defined as an occurrence of scalp lesions in a cadet treated with oral cephalexin from the school health center during August 10–30, 2004. Measures of association were estimated using multivariate logistic regression to control for confounding.

The 4-year military program at the university had 660 students (292 freshman and 368 upperclassmen) organized into seven discrete companies. Cadets lived in five separate dormitories, two per room, organized by company, sex, and class year. Each floor shared a bathroom and a common living room. Orientation directly involved 292 freshmen; 115 upperclassmen supervised the events. Orientation started with a short haircut for all 255 freshman males at one of two civilian barbershops. Haircuts were performed by one of eight barbers in random order using electric clippers without a scalp guard. The third day of orientation week, the cadets completed an obstacle course involving immersion in mud and river water. On the final day, participants were required to rappel from rock walls and participate in survival training exercises. Helmets were worn and sunscreen was shared among cadets during these activities.

Ninety-four (14%) of 660 cadets had scalp lesions, and one cadet was infected twice during the period from the start of orientation to when the questionnaire was administered. Thirty-three patients sought care at the student health center on the fourth day of orientation week, and 57 sought care on the fifth day. Five more cases, including the recurrent case, occurred 1 week after the start of school (Figure). All patients participated in orientation week; all were male and ranged in age from 16 to 24 years. The majority of patients were freshmen (84/94; 89%) and received a haircut on the first day of orientation (89/94; 95%). Approximately one third of the patients (33/94; 35%) were in Company B.

The index patient noted onset of symptoms on the third day of orientation. Yellow sticky discharge followed by honey-colored crusts on the crown of his head were noted. Lesions were nonpruritic. Other patients had similar lesions with the same distribution. Infections resolved within 48 hours with the use of antibacterial soap and oral cephalexin (5-day prescription). Health-care providers obtained samples for culture from lesions of three cadets (Table). *B. cereus* was the only common organism isolated from all three patients and was identified by using biochemical tests and 16S rRNA gene sequencing. When analyzed by MLST, all three clinical *B. cereus* isolates were indistinguishable. *B. cereus* also was cultured from two separate barbershop clippers (two isolates), soil from the school grounds and orientation events (five isolates), and helmets (two isolates) worn during rappelling exercises. Five environmental isolates (three soil samples and two clippers) matched the clinical isolates by 16S rRNA. MLST was performed on these isolates, resulting in four unique sequence types (three from the soil samples and one from the two clippers), with no matches to the clinical *B. cereus* sequence type.

FIGURE. Number* of university military program cadets with scalp lesions, by date of diagnosis — Georgia, August 13–25, 2004



* N = 94. One recurrent case occurred on August 23, and two on September 20, 2004.

The response rate for the cohort study was 73% (483/660); the response rate for freshmen was 84% (248/292). Of the respondents, 423 (88%) were male, and 248 (51%) were freshmen, which was representative of the entire cohort. The median age was 19 years, and 405 (84%) cadets were white. After adjusting for sex, freshman class status, and participation in orientation week, the multivariate logistic regression model indicated a statistically significant association between having scalp lesions and receiving a haircut (adjusted odds ratio [AOR] = 10.6; 95% confidence internal [CI] = 2.3–49.3, p<0.01), membership in Company B (AOR = 9.7; CI = 3.4–27.8, p<0.01), and sharing sunscreen (AOR = 2.7; CI = 1.3–5.4, p<0.01). Other risk factors examined included demographic information, exposure to soil and water, and hygiene practices (e.g., laundry, bathing, and use of shared products).

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Editorial Note: *Bacillus cereus* is a recognized bacterial pathogen in humans. Nongastrointestinal infections are usually the result of a breakdown in natural protective barriers such as the skin or immune system (*1,2,5*). The findings in this

TABLE. Positive scalp bacterial culture results for three university military program cadets, by date and organism — Georgia, August 2004

Organism	Cadet A (August 13)	Cadet B (August 13)	Cadet C (August 23)
Bacillus cereus	X	X	X
Staphylococcus aureus	X		
Coagulase (-) *Staphylococcus spp.*			X
Acinetobacter baumanni			X

report indicate that immunocompetent persons can be vulnerable to cutaneous *B. cereus* infections when skin is compromised. Isolation of three indistinguishable *B. cereus* isolates from three patients on two separate days suggested that this was a common-source outbreak and not a laboratory contaminant, even though the environmental source of *B. cereus* was not identified during the investigation. All but five cases were diagnosed on two concurrent days, making person-to-person transmission unlikely. Transmission most likely occurred from an exposure at the beginning of the orientation week. The short haircut likely caused microabrasions, compromising the protective effect of scalp epidermis. Exposure to mud, sun, and sunscreen further provided an environment suitable for bacterial growth.

The findings in this report are subject to at least three limitations. First, only three clinical samples were available for culture. Because of the number of cases and the positive response to therapy, the health-center staff treated cases empirically before GDPH involvement. Second, other risk factors and potential confounders might not have been identified during the site visits. Finally, cadets were asked about their orientation exposures nearly 3 weeks after the events occurred; recall bias might have influenced the findings.

As a result of this investigation, GDPH made recommendations to the university military program for future orientations to minimize the risk for another outbreak. These included 1) changing the type of haircut required for male cadets that would allow for more hair and less injury to the scalp, 2) allowing adequate time for personal hygiene, and 3) distributing individual packets of sunscreen and discouraging sharing of sunscreen. These recommendations were implemented during the 2005 orientation activities; no skin infections were reported. University military programs should establish infection-control practices including good hygiene as part of their organized orientation events.

Acknowledgments

The findings in this report are based, in part, on contributions from P Blake, MD, M Tobin-D'Angelo, MD, Georgia Div of Public Health.

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Notice to Readers

FDA Approval of Havrix® (Hepatitis A Vaccine, Inactivated) for Persons Aged 1–18 Years

On October 17, 2005, the Food and Drug Administration approved an application to allow use of the pediatric/adolescent formulation of Havrix® (hepatitis A vaccine, inactivated) (GlaxoSmithKline Biologicals, Rixensart, Belgium) for persons aged 1–18 years. Previously, pediatric use of Havrix was approved for use in persons aged 2–18 years.

Vaccine Description

The formulation, dosage, and schedule for Havrix were not changed. Each 0.5-mL dose of pediatric/adolescent Havrix contains 720 enzyme-linked immunosorbent assay units of formalin-inactivated hepatitis A viral antigen adsorbed onto aluminum hydroxide. The formulation contains 0.5% 2-phenoxyethanol as a preservative.

The pediatric/adolescent formulation of Havrix is indicated for vaccination of persons aged 1–18 years against disease caused by hepatitis A virus. Recommendations for hepatitis A vaccination have been published previously (*1*) and are periodically updated. The primary vaccination schedule is unchanged and consists of 2 doses, administered on a 0, 6–12-month schedule.

In a study presented as part of the labeling change application, 99% of 218 children aged 11–13 months and 100% of 200 children aged 15–18 months who received 2 doses of Havrix developed a vaccine response. The approval included concomitant use of Havrix with *Haemophilus influenzae* type b conjugate vaccine (PRP-T Hib). Data regarding concomitant use with other routinely recommended childhood vaccines are limited. According to general recommendations of the Advisory Committee on Immunization Practices, inactivated vaccines usually do not interfere with the immune response to other inactivated or live vaccines (*2*).

Among the 723 healthy children who received 1 or more dose of Havrix, the most common adverse events were similar among children aged 11–18 months and children aged 23–25 months. Havrix is contraindicated in persons with known hypersensitivity to any component of the vaccine. Additional information is available from the manufacturer's package insert and GlaxoSmithKline Biologicals at telephone 888-825-5249.

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Notice to Readers

Epidemiology in Action Course

The Rollins School of Public Health at Emory University and CDC will cosponsor a course, Epidemiology in Action, March 27–April 7, 2006 at Emory University. The course is designed for state and local public health workers.

The course emphasizes the practical application of epidemiology to public health problems and will consist of lectures, workshops, classroom exercises (including actual epidemiologic problems), and roundtable discussions. Topics include descriptive epidemiology and biostatistics, analytic epidemiology, epidemic investigations, public health surveillance, surveys and sampling, Epi Info (Windows version) training, and discussions of selected prevalent diseases. Tuition is charged.

Additional information and applications are available from Emory University, Rollins School of Public Health, Global Health Dept (Pia), 1518 Clifton Rd. NE, Rm. 746, Atlanta, GA 30322; by telephone, 404-727-3845; by fax, 404-727-4590; online at http://www.sph.emory.edu/epicourses; or by e-mail, pvaleri@sph.emory.edu.

Notice to Readers

Epidemiology in Action: Intermediate Methods

CDC and Emory University's Rollins School of Public Health will co-sponsor a course, Epidemiology in Action: Intermediate Methods, February 27–March 3, 2006, at Emory University. The course is designed for practicing public health professionals who have had training and experience in basic applied epidemiology and desire training in additional quantitative skills related to analysis and interpretation of epidemiologic data.

The course includes a review of the fundamentals of descriptive epidemiology and biostatistics, measures of association, normal and binomial distributions, confounding, statistical tests, stratification, logistic regression, models, and computers as used in epidemiology.

Prerequisite is an introductory course in epidemiology, such as Epidemiology in Action, the International Course in Applied Epidemiology, or any other introductory class. Tuition is charged. Application deadline is January 27, 2006.

Additional information and applications are available from Emory University, Rollins School of Public Health, Global Health Dept (Pia), 1518 Clifton Rd. NE, Rm. 746, Atlanta, GA 30322; by telephone, 404-727-3845; by fax, 404-727-4590; online at http://www.sph.emory.edu/epicourses; or by e-mail, pvaleri@sph.emory.edu.

Notice to Readers

Epi Info: A Course to Develop Public Health Software Applications

CDC and Emory University's Rollins School of Public Health will cosponsor "Epi Info: A Course to Develop Public Health Software Applications" on March 13–15, 2006, at Emory University. The course is designed for practitioners of epidemiology and computing with intermediate-to-advanced computer skills who wish to develop public health software applications using Epi Info for Windows 98, NT, 2000, and XP.

The 3-day course covers hands-on experience with the new Windows version of Epi Info, programming Epi Info software at beginning-to-intermediate level, and computerized interactive exercises for developing public health information systems. All Epi Info modules, such as Makeview, Checkcode, Enter, Analysis, Epi Map, and Epi Report, will be covered. Tuition is charged.

Additional information and applications are available from Emory University, Rollins School of Public Health, Global Health Dept (Pia), 1518 Clifton Rd. NE, Rm. 746, Atlanta, GA 30322; by telephone, 404-727-3845; by fax, 404-727-4590; online at http://www.sph.emory.edu/epicourses; or by e-mail, pvaleri@sph.emory.edu.

Errata: Vol. 54, No. 47

In the Notice to Readers, "Licensure of a Combined Live Attenuated Measles, Mumps, Rubella, and Varicella Vaccine," multiple errors occurred.

On page 1212, in the last sentence of the first paragraph, the sentence should read: The titer of Oka/Merck varicella-zoster virus is higher in MMRV vaccine than in single antigen varicella vaccine, VARIVAX® (Merck), a minimum of **3.99** $\log_{10}$ plaque-forming units (pfu) versus 1,350 pfu (approximately **3.13** $\log_{10}$), respectively.

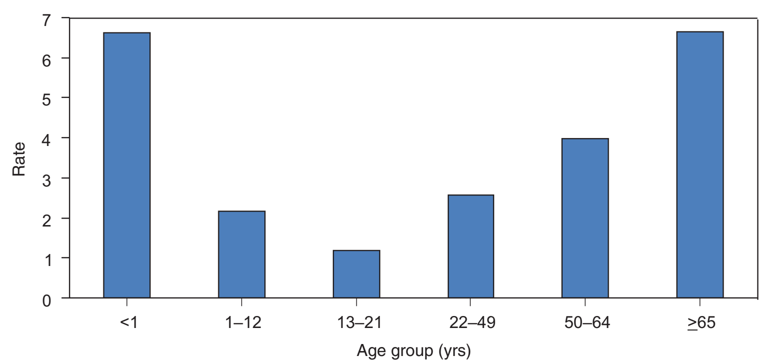
On page 1213, under "Indications and Usage," No. 1, the last sentence should read: MMRV vaccine can reduce the number of injections when administered to children aged 12 months–12 years for whom 1) the first doses of MMR and varicella vaccines **are** indicated and 2) the second dose of MMR and either the first or second dose (e.g., during a varicella outbreak) of varicella vaccine **are** indicated. MMRV vaccine is administered subcutaneously as a single 0.5-mL dose.

On page 1214, in Reference 8, the Internet address should read: **http://www.cdc.gov/nip/vaccine/varicella/varicella_acip_recs.pdf**.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

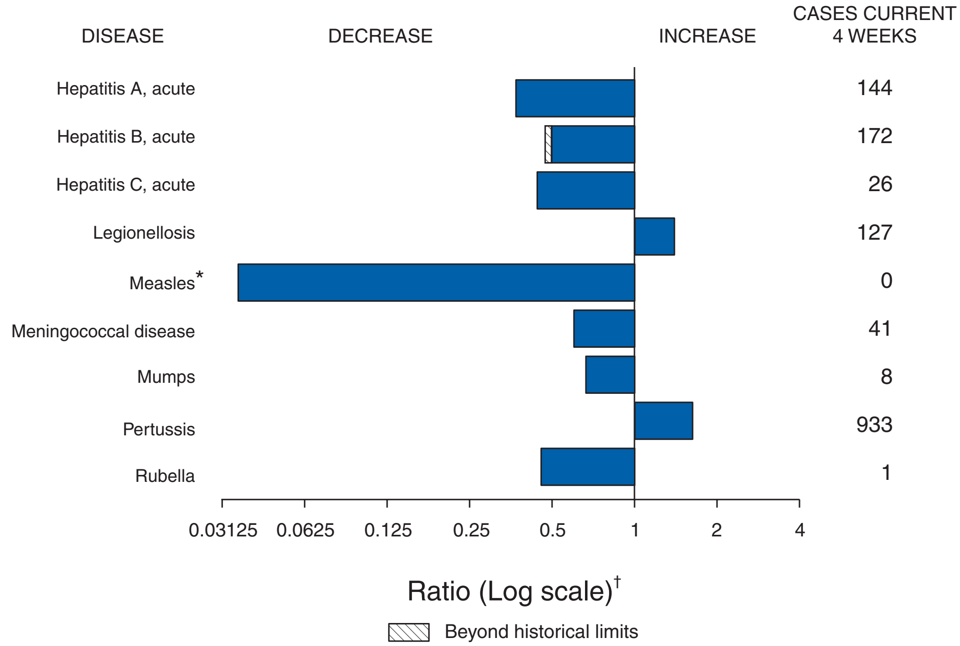
Annual Rate of Visits per Person to Physician Offices, by Patient Age Group — United States, 2003



During 2003, an estimated 906 million visits were made to physician offices in the United States, approximately 3.2 visits per person overall. Infants aged <1 year and adults aged ≥65 years were the most frequent visitors, with approximately 6.6 visits per person in each of those age groups.

SOURCE: Hing E, Cherry DK, Woodwell DA. National Ambulatory Medical Care Survey: 2003 summary. Advance data from vital and health statistics; no. 365. Hyattsville, MD: US Department of Health and Human Services, CDC, National Center for Health Statistics; 2005.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals December 3, 2005, with historical data



* No measles cases were reported for the current 4-week period yielding a ratio for week 48 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 December 3, 2005 (48th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	159	165
Botulism:			HIV infection, pediatric†¶	255	350
foodborne	13	13	Influenza-associated pediatric mortality†**	46	—
infant	78	82	Measles	64††	27§§
other (wound & unspecified)	26	16	Mumps	250	222
Brucellosis	99	95	Plague	3	2
Chancroid	26	26	Poliomyelitis, paralytic	1	—
Cholera	6	4	Psittacosis†	22	11
Cyclosporiasis†	722	202	Q fever†	133	60
Diphtheria	—	—	Rabies, human	2	7
Domestic arboviral diseases			Rubella	17	9
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	1	—
California serogroup†§	65	116	SARS†**	—	—
eastern equine†§	21	5	Smallpox†	—	—
Powassan†§	—	1	*Staphylococcus aureus*:		
St. Louis†§	9	13	Vancomycin-intermediate (VISA)†	1	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	—	1
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome†	99	120
human granulocytic (HGE)†	593	398	Tetanus	18	24
human monocytic (HME)†	437	292	Toxic-shock syndrome	89	86
human, other and unspecified †	82	66	Trichinellosis¶¶	17	2
Hansen disease†	79	96	Tularemia†	134	113
Hantavirus pulmonary syndrome†	22	21	Yellow fever	—	—

—: No reported cases.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
¶ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update September 25, 2005.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases. Of the 46 cases reported, two were reported since October 2, 2005 (40th Week).
†† Of 64 cases reported, 53 were indigenous and 11 were imported from another country.
§§ Of 27 cases reported, nine were indigenous and 18 were imported from another country.
¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending December 3, 2005, and December 4, 2004 (48th Week)*

	AIDS		Chlamydia†		Coccidioidomycosis		Cryptosporidiosis	
Reporting area	Cum. 2005§	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	30,568	38,663	843,503	847,009	4,331	5,531	6,941	3,368
NEW ENGLAND	1,141	1,294	29,126	27,680	—	—	318	162
Maine	19	48	2,082	1,930	N	N	25	18
N.H.	26	41	1,695	1,606	—	—	33	30
Vt.¶	7	16	889	1,048	—	—	37	24
Mass.	561	483	12,984	12,399	—	—	133	59
R.I.	105	131	2,922	3,135	—	—	13	4
Conn.	423	575	8,554	7,562	N	N	77	27
MID. ATLANTIC	6,597	9,001	106,647	104,402	—	—	3,153	548
Upstate N.Y.	891	1,462	21,569	20,998	N	N	2,713	174
N.Y. City	3,522	4,759	34,468	32,252	—	—	125	131
N.J.	956	1,361	16,298	16,118	N	N	64	43
Pa.	1,228	1,419	34,312	35,034	N	N	251	200
E.N. CENTRAL	2,929	3,254	140,659	148,819	11	13	1,426	989
Ohio	518	598	37,808	36,526	N	N	754	214
Ind.	348	350	18,523	17,162	N	N	79	72
Ill.	1,504	1,537	42,290	43,836	—	—	138	150
Mich.	439	613	25,505	33,460	11	13	102	146
Wis.	120	156	16,533	17,835	N	N	353	407
W.N. CENTRAL	690	788	51,574	52,639	5	6	563	393
Minn.	176	203	9,702	10,847	3	N	136	129
Iowa	72	64	6,576	6,423	N	N	106	83
Mo.	299	327	20,497	19,602	1	3	246	71
N. Dak.	9	17	1,077	1,653	N	N	1	12
S. Dak.	13	11	2,548	2,330	—	—	29	40
Nebr.¶	27	56	4,637	4,843	1	3	9	28
Kans.	94	110	6,537	6,941	N	N	36	30
S. ATLANTIC	9,183	11,727	158,476	159,635	2	—	678	500
Del.	134	137	3,128	2,724	N	N	5	—
Md.	1,370	1,361	17,061	17,894	2	—	35	22
D.C.	474	913	3,471	3,269	—	—	15	15
Va.¶	441	612	18,495	20,081	—	—	60	58
W. Va.	51	83	2,511	2,570	N	N	14	6
N.C.	636	1,067	28,137	27,445	N	N	84	75
S.C.¶	413	703	18,983	17,380	—	—	18	22
Ga.	1,701	1,520	27,700	29,294	—	—	116	172
Fla.	3,963	5,331	38,990	38,978	N	N	331	130
E.S. CENTRAL	1,546	1,820	63,017	56,229	—	5	203	139
Ky.	198	229	7,843	5,900	N	N	139	43
Tenn.¶	675	722	21,843	20,634	N	N	40	46
Ala.¶	385	433	14,686	12,431	—	—	20	22
Miss.	288	436	18,645	17,264	—	5	4	28
W.S. CENTRAL	3,543	4,307	96,364	101,777	1	3	180	129
Ark.	173	184	7,922	7,339	—	1	6	15
La.	650	853	14,502	20,450	1	2	81	5
Okla.	229	195	9,570	9,564	N	N	41	22
Tex.¶	2,491	3,075	64,370	64,424	N	N	52	87
MOUNTAIN	1,172	1,349	47,188	51,868	2,947	3,489	128	163
Mont.	15	5	2,027	2,244	N	N	20	34
Idaho¶	15	20	2,253	2,571	N	N	15	27
Wyo.	3	16	1,085	997	3	2	3	4
Colo.	260	301	11,913	13,285	N	N	48	55
N. Mex.	115	173	5,135	8,218	14	21	10	19
Ariz.	473	506	15,387	15,094	2,889	3,384	9	16
Utah	55	69	4,062	3,479	9	23	14	6
Nev.¶	236	259	5,326	5,980	32	59	9	2
PACIFIC	3,767	5,123	150,452	143,960	1,365	2,015	292	345
Wash.	352	368	17,037	16,192	N	N	43	42
Oreg.¶	193	281	8,244	7,838	—	—	66	29
Calif.	3,105	4,302	116,666	111,414	1,365	2,015	179	272
Alaska	25	48	3,594	3,558	—	—	3	—
Hawaii	92	124	4,911	4,958	—	—	1	2
Guam	2	2	—	803	—	—	—	—
P.R.	814	637	3,455	3,302	N	N	N	N
V.I.	10	19	196	322	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).
† Chlamydia refers to genital infections caused by *C. trachomatis*.
§ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update September 25, 2005.
¶ Contains data reported through National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 3, 2005, and December 4, 2004 (48th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC) O157:H7 Cum. 2005	O157:H7 Cum. 2004	Shiga toxin positive, serogroup non-O157 Cum. 2005	Shiga toxin positive, serogroup non-O157 Cum. 2004	Shiga toxin positive, not serogrouped Cum. 2005	Shiga toxin positive, not serogrouped Cum. 2004	Giardiasis Cum. 2005	Giardiasis Cum. 2004	Gonorrhea Cum. 2005	Gonorrhea Cum. 2004
UNITED STATES	2,304	2,380	329	282	303	191	16,591	18,277	291,937	300,889
NEW ENGLAND	157	158	54	42	24	15	1,527	1,650	5,257	6,335
Maine	14	14	11	—	—	—	192	137	130	203
N.H.	12	21	2	5	—	—	52	45	166	120
Vt.	14	13	4	—	—	—	176	157	55	82
Mass.	63	71	12	13	24	15	653	739	2,287	2,893
R.I.	7	11	—	1	—	—	107	117	401	779
Conn.	47	28	25	23	—	—	347	455	2,218	2,258
MID. ATLANTIC	288	281	41	62	34	36	3,090	3,753	30,988	33,800
Upstate N.Y.	130	119	21	42	12	19	1,128	1,304	6,466	6,828
N.Y. City	14	35	—	—	—	—	792	1,013	9,344	10,343
N.J.	49	56	5	6	12	6	374	470	4,943	6,268
Pa.	95	71	15	14	10	11	796	966	10,235	10,361
E.N. CENTRAL	445	454	30	47	23	32	2,604	3,073	57,340	63,363
Ohio	144	93	6	9	15	18	742	747	17,821	19,128
Ind.	62	50	—	—	—	—	N	N	7,428	6,341
Ill.	46	103	1	7	1	8	584	767	17,128	19,168
Mich.	75	82	2	11	6	6	708	677	10,225	14,058
Wis.	118	126	21	20	1	—	570	882	4,738	4,668
W.N. CENTRAL	401	471	38	38	62	23	2,032	2,032	16,614	16,085
Minn.	125	106	21	15	32	5	898	782	2,759	2,714
Iowa	93	118	—	—	—	—	254	280	1,454	1,146
Mo.	77	95	11	17	15	7	483	527	8,664	8,490
N. Dak.	7	14	—	—	1	7	16	22	78	101
S. Dak.	26	33	3	2	—	—	107	73	319	271
Nebr.	30	62	3	4	4	—	85	141	1,054	1,013
Kans.	43	43	—	—	10	4	189	207	2,286	2,350
S. ATLANTIC	192	169	79	33	111	57	2,363	2,762	69,877	72,599
Del.	7	3	N	N	N	N	53	44	822	822
Md.	32	22	30	6	11	3	189	138	6,536	7,542
D.C.	1	1	—	—	—	—	52	68	1,961	2,408
Va.	40	34	28	17	21	—	484	484	6,867	7,945
W. Va.	3	3	—	—	1	—	45	46	681	834
N.C.	—	—	—	—	60	47	N	N	13,526	14,469
S.C.	7	12	1	—	1	—	94	110	8,470	8,634
Ga.	30	22	16	7	—	—	552	840	12,943	13,071
Fla.	72	72	4	3	17	7	894	1,032	18,071	16,874
E.S. CENTRAL	130	106	10	5	31	15	395	394	25,400	24,582
Ky.	47	28	7	1	20	9	N	N	2,763	2,568
Tenn.	47	39	2	2	11	6	205	215	8,119	7,825
Ala.	29	27	—	—	—	—	190	179	8,272	7,619
Miss.	7	12	1	2	—	—	—	—	6,246	6,570
W.S. CENTRAL	50	85	14	3	8	13	295	313	39,283	40,020
Ark.	10	17	—	—	—	—	79	120	4,157	3,893
La.	4	4	11	1	3	3	54	49	8,154	9,800
Okla.	22	20	2	—	1	4	162	144	3,854	4,088
Tex.	14	44	1	2	4	6	N	N	23,118	22,239
MOUNTAIN	225	236	55	50	10	—	1,402	1,428	10,070	11,123
Mont.	16	16	—	—	—	—	71	78	123	76
Idaho	29	54	13	13	7	—	149	186	95	88
Wyo.	8	9	2	6	—	—	27	24	75	58
Colo.	66	51	3	1	1	—	506	483	2,706	2,817
N. Mex.	13	10	9	9	—	—	79	69	985	1,181
Ariz.	45	25	N	N	N	N	142	159	3,387	3,631
Utah	38	44	26	20	—	—	379	311	647	534
Nev.	10	27	2	1	2	—	49	118	2,052	2,738
PACIFIC	416	420	8	2	—	—	2,883	2,872	37,108	32,982
Wash.	104	139	—	—	—	—	319	359	3,396	2,529
Oreg.	148	68	8	2	—	—	364	416	1,440	1,183
Calif.	139	202	—	—	—	—	2,042	1,927	30,850	27,611
Alaska	12	1	—	—	—	—	99	95	495	524
Hawaii	13	10	—	—	—	—	59	75	927	1,135
Guam	N	N	—	—	—	—	—	4	—	125
P.R.	2	2	—	—	—	—	186	272	320	237
V.I.	—	—	—	—	—	—	—	—	45	86
Amer. Samoa	U	U	U	U	U	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.

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 3, 2005, and December 4, 2004 (48th Week)*

	Haemophilus influenzae, invasive							
	All ages		Age <5 years					
	All serotypes		Serotype b		Non-serotype b		Unknown serotype	
Reporting area	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,891	1,842	4	14	103	112	181	162
NEW ENGLAND	146	174	—	1	10	10	5	2
Maine	6	12	—	—	—	—	1	—
N.H.	8	19	—	—	—	2	—	1
Vt.	9	8	—	—	—	—	2	1
Mass.	71	79	—	1	3	4	1	—
R.I.	7	6	—	—	2	1	—	—
Conn.	45	50	—	—	5	3	1	—
MID. ATLANTIC	391	383	—	2	1	5	39	36
Upstate N.Y.	115	119	—	2	—	5	8	5
N.Y. City	69	81	—	—	—	—	11	15
N.J.	79	73	—	—	—	—	10	3
Pa.	128	110	—	—	1	—	10	13
E.N. CENTRAL	273	352	1	2	5	8	19	48
Ohio	103	98	—	1	—	2	9	16
Ind.	63	52	—	—	5	4	—	1
Ill.	62	124	—	—	—	—	7	21
Mich.	22	21	1	1	—	2	2	4
Wis.	23	57	—	—	—	—	1	6
W.N. CENTRAL	106	101	—	2	3	3	10	11
Minn.	41	43	—	1	3	3	2	1
Iowa	1	1	—	1	—	—	—	—
Mo.	35	40	—	—	—	—	6	7
N. Dak.	4	4	—	—	—	—	1	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	10	5	—	—	—	—	1	2
Kans.	15	8	—	—	—	—	—	1
S. ATLANTIC	452	410	1	1	30	27	31	26
Del.	—	—	—	—	—	—	—	—
Md.	68	65	—	—	5	7	—	—
D.C.	—	3	—	—	—	—	—	1
Va.	40	41	—	—	—	—	2	5
W. Va.	26	17	—	—	4	4	3	—
N.C.	72	55	1	1	8	6	—	1
S.C.	30	13	—	—	—	—	3	1
Ga.	92	109	—	—	—	—	16	17
Fla.	124	107	—	—	13	10	7	1
E.S. CENTRAL	103	70	—	1	1	2	19	12
Ky.	8	11	—	—	1	2	2	1
Tenn.	77	44	—	—	—	—	13	9
Ala.	18	13	—	1	—	—	4	2
Miss.	—	2	—	—	—	—	—	—
W.S. CENTRAL	97	76	1	1	8	9	8	1
Ark.	5	2	—	—	1	1	—	—
La.	32	15	1	—	2	—	8	1
Okla.	56	58	—	—	5	8	—	—
Tex.	4	1	—	1	—	—	—	—
MOUNTAIN	200	178	—	4	15	27	34	19
Mont.	—	—	—	—	—	—	—	—
Idaho	5	5	—	—	—	—	—	2
Wyo.	6	1	—	—	—	1	1	—
Colo.	40	44	—	—	1	—	9	5
N. Mex.	20	37	—	1	4	8	2	6
Ariz.	98	60	—	—	7	12	12	2
Utah	17	18	—	2	1	3	7	3
Nev.	14	13	—	1	2	3	3	1
PACIFIC	123	98	1	—	30	21	16	7
Wash.	4	1	—	—	—	—	3	1
Oreg.	29	43	—	—	—	—	5	3
Calif.	54	39	1	—	30	21	2	1
Alaska	26	6	—	—	—	—	6	1
Hawaii	10	9	—	—	—	—	—	1
Guam	—	—	—	—	—	—	—	—
P.R.	3	2	—	—	—	—	1	2
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 3, 2005, and December 4, 2004 (48th Week)*

	Hepatitis (viral, acute), by type					
	A		B		C	
Reporting area	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	3,728	5,469	5,029	5,777	654	756
NEW ENGLAND	490	967	270	359	18	17
Maine	4	13	11	5	—	—
N.H.	76	25	26	34	—	—
Vt.	6	8	5	6	14	8
Mass.	341	829	197	206	1	7
R.I.	15	22	3	6	—	—
Conn.	48	70	28	102	3	2
MID. ATLANTIC	635	763	986	710	98	136
Upstate N.Y.	102	105	91	76	18	12
N.Y. City	274	333	116	147	—	—
N.J.	165	173	578	200	—	—
Pa.	94	152	201	287	80	124
E.N. CENTRAL	337	489	481	520	125	109
Ohio	49	49	123	111	8	6
Ind.	51	55	56	43	23	9
Ill.	87	140	103	86	—	16
Mich.	116	136	165	241	94	78
Wis.	34	109	34	39	—	—
W.N. CENTRAL	90	149	252	308	27	21
Minn.	3	32	29	47	5	18
Iowa	20	48	20	14	—	—
Mo.	42	32	152	183	20	3
N. Dak.	—	1	—	4	1	—
S. Dak.	1	3	4	1	—	—
Nebr.	8	12	21	42	1	—
Kans.	16	21	26	17	—	—
S. ATLANTIC	652	949	1,241	1,726	138	191
Del.	5	6	45	49	7	41
Md.	68	101	145	151	23	12
D.C.	4	7	11	19	—	4
Va.	73	115	125	246	12	13
W. Va.	5	5	39	40	21	23
N.C.	82	98	150	172	21	11
S.C.	37	40	129	134	3	15
Ga.	104	307	144	443	8	15
Fla.	274	270	453	472	43	57
E.S. CENTRAL	227	145	327	461	75	89
Ky.	24	30	60	68	9	24
Tenn.	147	91	129	221	17	31
Ala.	36	8	85	72	14	5
Miss.	20	16	53	100	35	29
W.S. CENTRAL	245	635	462	638	88	104
Ark.	15	60	46	105	1	3
La.	64	48	67	64	15	3
Okla.	5	20	34	67	6	3
Tex.	161	507	315	402	66	95
MOUNTAIN	336	404	522	460	44	43
Mont.	10	7	3	1	1	2
Idaho	22	19	14	11	1	1
Wyo.	—	5	2	7	1	2
Colo.	42	50	53	56	24	15
N. Mex.	23	23	9	17	—	U
Ariz.	209	248	371	253	—	5
Utah	20	35	42	44	8	5
Nev.	10	17	28	71	9	13
PACIFIC	716	968	488	595	41	46
Wash.	44	58	58	50	U	U
Oreg.	40	62	92	105	16	15
Calif.	606	817	326	419	24	29
Alaska	4	4	7	11	—	—
Hawaii	22	27	5	10	1	2
Guam	—	1	—	12	—	9
P.R.	58	45	41	73	—	—
V.I.	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 3, 2005, and December 4, 2004 (48th Week)*

Reporting area	Legionellosis Cum. 2005	Legionellosis Cum. 2004	Listeriosis Cum. 2005	Listeriosis Cum. 2004	Lyme disease Cum. 2005	Lyme disease Cum. 2004	Malaria Cum. 2005	Malaria Cum. 2004
UNITED STATES	1,871	1,891	740	687	19,674	17,444	1,150	1,313
NEW ENGLAND	121	91	55	51	2,555	3,134	63	84
Maine	6	1	3	8	215	29	4	7
N.H.	8	10	8	4	202	204	5	5
Vt.	9	6	2	2	48	48	1	4
Mass.	46	41	16	18	1,061	1,506	31	49
R.I.	19	18	6	2	32	224	2	4
Conn.	33	15	20	17	997	1,123	20	15
MID. ATLANTIC	672	524	187	163	12,398	10,625	313	358
Upstate N.Y.	200	112	58	46	3,832	3,809	49	50
N.Y. City	90	69	36	25	—	349	161	197
N.J.	98	84	33	35	3,383	2,628	71	68
Pa.	284	259	60	57	5,183	3,839	32	43
E.N. CENTRAL	347	456	80	116	1,407	1,304	90	119
Ohio	187	208	33	39	60	48	24	29
Ind.	22	45	5	18	33	28	4	16
Ill.	15	48	2	24	—	87	30	39
Mich.	105	133	29	26	58	26	21	21
Wis.	18	22	11	9	1,256	1,115	11	14
W.N. CENTRAL	95	61	41	21	910	589	44	65
Minn.	26	7	13	5	796	502	11	24
Iowa	6	6	8	3	83	49	8	4
Mo.	35	31	6	7	24	26	17	20
N. Dak.	2	2	4	2	—	—	—	3
S. Dak.	21	4	—	1	2	1	—	1
Nebr.	3	5	5	3	2	8	3	4
Kans.	2	6	5	—	3	3	5	9
S. ATLANTIC	370	384	155	116	2,137	1,580	278	324
Del.	16	13	N	N	601	322	3	6
Md.	103	78	19	18	1,133	852	97	75
D.C.	12	12	—	5	8	14	9	13
Va.	41	49	14	17	220	170	27	50
W. Va.	20	10	4	4	17	29	3	2
N.C.	31	38	32	26	44	111	30	19
S.C.	14	15	12	10	19	26	9	11
Ga.	24	42	23	14	5	12	41	59
Fla.	109	127	51	22	90	44	59	89
E.S. CENTRAL	79	96	29	24	36	46	28	32
Ky.	29	39	5	4	5	15	9	4
Tenn.	34	41	12	13	29	25	13	11
Ala.	13	12	8	5	2	6	6	12
Miss.	3	4	4	2	—	—	—	5
W.S. CENTRAL	25	134	33	39	59	67	80	123
Ark.	4	1	2	3	4	8	6	8
La.	1	9	12	3	7	2	3	6
Okla.	7	9	5	1	—	—	10	7
Tex.	13	115	14	32	48	57	61	102
MOUNTAIN	83	79	16	26	21	18	52	52
Mont.	6	2	—	—	—	—	—	1
Idaho	3	9	—	1	2	6	—	1
Wyo.	4	7	—	—	3	3	2	1
Colo.	21	20	7	13	3	—	23	18
N. Mex.	2	4	4	2	1	1	2	4
Ariz.	24	11	—	—	8	6	14	13
Utah	15	22	3	2	2	1	9	8
Nev.	8	4	2	8	2	1	2	6
PACIFIC	79	66	144	131	151	81	202	156
Wash.	—	9	9	11	9	12	15	17
Oreg.	N	N	11	7	19	26	11	18
Calif.	75	56	123	108	120	41	155	115
Alaska	1	1	—	—	3	2	5	2
Hawaii	3	—	1	5	N	N	16	4
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	2	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 3, 2005, and December 4, 2004 (48th Week)*

	Meningococcal disease									
	All serogroups		Serogroup A, C, Y, and W-135		Serogroup B		Other serogroup		Serogroup unknown	
Reporting area	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,049	1,103	86	85	52	43	—	1	911	974
NEW ENGLAND	68	68	1	6	—	6	—	1	67	55
Maine	2	10	—	—	—	1	—	—	2	9
N.H.	12	7	—	—	—	—	—	—	12	7
Vt.	5	3	—	—	—	—	—	—	5	3
Mass.	31	36	—	5	—	5	—	—	31	26
R.I.	4	2	—	1	—	—	—	—	4	1
Conn.	14	10	1	—	—	—	—	1	13	9
MID. ATLANTIC	140	153	38	40	9	6	—	—	93	107
Upstate N.Y.	37	42	4	6	6	4	—	—	27	32
N.Y. City	22	26	—	—	—	—	—	—	22	26
N.J.	34	33	—	—	—	—	—	—	34	33
Pa.	47	52	34	34	3	2	—	—	10	16
E.N. CENTRAL	119	127	33	29	12	7	—	—	74	91
Ohio	43	66	—	4	8	5	—	—	35	57
Ind.	18	19	—	1	4	2	—	—	14	16
Ill.	15	1	—	—	—	—	—	—	15	1
Mich.	33	24	33	24	—	—	—	—	—	—
Wis.	10	17	—	—	—	—	—	—	10	17
W.N. CENTRAL	75	74	3	—	1	5	—	—	71	69
Minn.	16	23	1	—	—	—	—	—	15	23
Iowa	16	17	—	—	1	3	—	—	15	14
Mo.	26	19	1	—	—	1	—	—	25	18
N. Dak.	1	2	—	—	—	—	—	—	1	2
S. Dak.	4	2	1	—	—	1	—	—	3	1
Nebr.	5	4	—	—	—	—	—	—	5	4
Kans.	7	7	—	—	—	—	—	—	7	7
S. ATLANTIC	200	205	6	2	9	4	—	—	185	199
Del.	4	6	—	—	—	—	—	—	4	6
Md.	21	10	3	—	2	—	—	—	16	10
D.C.	—	5	—	2	—	—	—	—	—	3
Va.	31	20	—	—	—	—	—	—	31	20
W. Va.	6	6	1	—	—	—	—	—	5	6
N.C.	32	28	2	—	7	4	—	—	23	24
S.C.	15	15	—	—	—	—	—	—	15	15
Ga.	15	14	—	—	—	—	—	—	15	14
Fla.	76	101	—	—	—	—	—	—	76	101
E.S. CENTRAL	52	65	1	1	3	1	—	—	48	63
Ky.	16	11	—	1	3	1	—	—	13	9
Tenn.	24	22	—	—	—	—	—	—	24	22
Ala.	6	17	1	—	—	—	—	—	5	17
Miss.	6	15	—	—	—	—	—	—	6	15
W.S. CENTRAL	89	70	1	3	5	2	—	—	83	65
Ark.	14	16	—	—	—	1	—	—	14	15
La.	27	32	—	1	2	—	—	—	25	31
Okla.	13	10	1	2	3	1	—	—	9	7
Tex.	35	12	—	—	—	—	—	—	35	12
MOUNTAIN	80	62	2	1	6	5	—	—	72	56
Mont.	—	3	—	—	—	—	—	—	—	3
Idaho	6	7	—	—	—	—	—	—	6	7
Wyo.	—	4	—	—	—	—	—	—	—	4
Colo.	17	15	1	—	1	—	—	—	15	15
N. Mex.	3	9	—	1	—	3	—	—	3	5
Ariz.	36	11	—	—	2	1	—	—	34	10
Utah	10	6	1	—	2	—	—	—	7	6
Nev.	8	7	—	—	1	1	—	—	7	6
PACIFIC	226	279	1	3	7	7	—	—	218	269
Wash.	42	28	1	3	4	7	—	—	37	18
Oreg.	28	53	—	—	—	—	—	—	28	53
Calif.	140	185	—	—	—	—	—	—	140	185
Alaska	4	4	—	—	—	—	—	—	4	4
Hawaii	12	9	—	—	3	—	—	—	9	9
Guam	—	1	—	—	—	—	—	—	—	1
P.R.	6	17	—	—	—	—	—	—	6	17
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	1	1	—	—	—	—	—	—	1	1
C.N.M.I.	—	—	—	—	—	—	—	—	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 3, 2005, and December 4, 2004 (48th Week)*

Reporting area	Pertussis		Rabies, animal		Rocky Mountain spotted fever		Salmonellosis		Shigellosis	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	19,045	20,286	5,096	6,045	1,638	1,469	38,770	38,872	12,725	12,698
NEW ENGLAND	1,142	1,930	653	667	3	21	1,969	1,950	281	278
Maine	32	47	53	58	N	N	140	101	9	8
N.H.	73	94	12	30	1	—	155	130	12	9
Vt.	82	122	55	35	—	1	92	58	17	3
Mass.	879	1,565	316	283	1	15	1,049	1,111	175	174
R.I.	34	40	22	45	1	2	87	128	14	19
Conn.	42	62	195	216	—	3	446	422	54	65
MID. ATLANTIC	1,232	2,643	934	917	101	74	4,621	5,310	1,151	1,105
Upstate N.Y.	502	1,799	527	506	5	1	1,171	1,175	264	393
N.Y. City	85	186	27	12	8	23	1,128	1,202	375	384
N.J.	199	197	N	N	32	14	784	995	283	227
Pa.	446	461	380	399	56	36	1,538	1,938	229	101
E.N. CENTRAL	3,295	7,666	196	186	34	34	4,828	4,784	916	1,164
Ohio	1,091	579	69	76	21	10	1,240	1,136	119	159
Ind.	316	242	11	10	3	6	560	469	169	205
Ill.	597	1,368	50	50	1	14	1,425	1,529	276	387
Mich.	279	281	37	41	7	2	828	789	216	207
Wis.	1,012	5,196	29	9	2	2	775	861	136	206
W.N. CENTRAL	3,206	2,474	408	592	172	127	2,353	2,250	1,564	415
Minn.	1,062	438	68	86	3	4	526	581	86	64
Iowa	686	527	105	100	8	2	399	407	95	61
Mo.	507	421	76	58	147	102	786	573	987	165
N. Dak.	139	721	25	58	—	—	39	40	4	3
S. Dak.	153	143	60	94	5	4	143	122	66	13
Nebr.	177	66	—	97	4	15	121	165	82	34
Kans.	482	158	74	99	5	—	339	362	244	75
S. ATLANTIC	1,263	761	1,528	2,083	814	756	11,716	10,536	2,230	2,708
Del.	15	6	—	9	4	6	114	105	11	10
Md.	173	145	303	306	87	70	771	779	101	142
D.C.	8	9	—	—	2	—	53	61	15	38
Va.	328	196	485	449	100	33	1,021	1,083	115	150
W. Va.	44	26	65	66	7	5	173	225	1	9
N.C.	118	80	445	557	468	484	1,556	1,564	184	341
S.C.	344	150	5	164	62	62	1,248	927	92	506
Ga.	40	24	216	327	66	78	1,792	1,862	589	618
Fla.	193	125	9	205	18	18	4,988	3,930	1,122	894
E.S. CENTRAL	448	281	177	149	267	199	2,731	2,558	1,114	873
Ky.	127	70	17	22	3	2	454	327	300	73
Tenn.	196	153	88	51	197	115	736	663	508	455
Ala.	80	42	70	65	63	54	700	701	216	293
Miss.	45	16	2	11	4	28	841	867	90	52
W.S. CENTRAL	1,696	888	803	1,041	201	231	3,319	4,066	2,400	3,484
Ark.	273	79	33	50	124	147	692	541	60	75
La.	36	19	—	4	5	5	790	923	129	290
Okla.	—	38	72	107	52	71	371	374	596	445
Tex.	1,387	752	698	880	20	8	1,466	2,228	1,615	2,674
MOUNTAIN	3,808	1,675	229	214	37	23	2,170	2,203	884	785
Mont.	564	58	15	26	1	3	131	181	5	4
Idaho	228	42	12	8	3	4	146	145	17	13
Wyo.	47	34	17	6	2	5	80	49	5	5
Colo.	1,296	938	16	47	5	4	556	513	157	148
N. Mex.	131	151	10	5	3	2	219	271	126	134
Ariz.	925	210	131	111	19	4	643	647	500	378
Utah	585	200	15	8	4	1	309	226	46	45
Nev.	32	42	13	3	—	—	86	171	28	58
PACIFIC	2,955	1,968	168	196	9	4	5,063	5,215	2,185	1,886
Wash.	782	713	U	U	—	—	494	526	126	103
Oreg.	570	514	7	6	2	2	358	399	119	82
Calif.	1,342	700	160	179	7	2	3,880	3,879	1,900	1,650
Alaska	117	14	1	11	—	—	56	58	7	6
Hawaii	144	27	—	—	—	—	275	353	33	45
Guam	—	—	—	—	—	—	—	50	—	42
P.R.	6	5	68	57	N	N	422	464	5	32
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 3, 2005, and December 4, 2004 (48th Week)*

Reporting area	Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive disease				Syphilis			
			Drug resistant, all ages		Age <5 years		Primary & secondary		Congenital	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	3,917	4,037	2,009	2,067	844	753	7,403	7,165	247	354
NEW ENGLAND	160	260	109	163	63	105	196	174	1	4
Maine	12	11	N	N	—	7	1	2	—	—
N.H.	14	19	—	—	5	N	14	4	—	3
Vt.	10	9	12	8	6	3	1	—	—	—
Mass.	115	115	81	53	51	58	115	107	—	—
R.I.	9	21	16	20	1	8	20	25	—	1
Conn.	U	85	U	82	U	29	45	36	1	—
MID. ATLANTIC	795	668	180	145	132	115	920	921	31	34
Upstate N.Y.	240	218	70	61	58	77	80	86	8	4
N.Y. City	148	114	U	U	20	U	565	583	5	15
N.J.	156	134	N	N	26	11	120	137	18	14
Pa.	251	202	110	84	28	27	155	115	—	1
E.N. CENTRAL	791	905	566	456	259	178	779	818	32	55
Ohio	179	210	335	314	76	73	201	221	1	2
Ind.	94	94	179	142	50	42	56	56	1	3
Ill.	168	236	15	—	60	13	412	344	12	19
Mich.	291	276	37	N	52	N	78	168	15	30
Wis.	59	89	N	N	21	50	32	29	3	1
W.N. CENTRAL	253	289	45	19	91	100	217	145	5	5
Minn.	101	137	—	—	56	65	54	25	1	1
Iowa	N	N	N	N	—	N	4	5	—	—
Mo.	64	60	37	14	9	14	134	86	4	2
N. Dak.	12	12	3	—	4	4	1	—	—	—
S. Dak.	20	20	3	5	—	—	1	—	—	—
Nebr.	21	20	2	—	7	9	5	6	—	—
Kans.	35	40	N	N	15	8	18	23	—	2
S. ATLANTIC	861	805	785	1,027	80	57	1,882	1,812	38	57
Del.	6	3	2	4	—	N	10	8	—	1
Md.	190	141	—	—	54	40	299	339	13	9
D.C.	11	10	17	9	3	4	89	61	—	1
Va.	78	67	N	N	—	N	123	94	4	3
W. Va.	22	26	110	107	23	13	4	3	—	—
N.C.	118	118	N	N	U	U	242	181	9	11
S.C.	30	51	—	83	—	N	72	112	4	12
Ga.	169	184	128	280	—	N	372	348	1	4
Fla.	237	205	528	544	—	N	671	666	7	16
E.S. CENTRAL	164	203	162	149	13	16	436	371	27	22
Ky.	32	59	27	30	N	N	50	46	—	1
Tenn.	132	144	135	117	—	N	200	120	20	8
Ala.	—	—	—	—	—	N	146	153	6	11
Miss.	—	—	—	2	13	16	40	52	1	2
W.S. CENTRAL	239	316	104	78	148	145	1,179	1,151	70	72
Ark.	21	16	15	10	16	8	45	46	1	4
La.	7	2	89	68	24	31	234	308	11	7
Okla.	104	63	N	N	29	44	37	25	1	2
Tex.	107	235	N	N	79	62	863	772	57	59
MOUNTAIN	554	466	58	29	49	34	349	359	17	46
Mont.	—	—	—	—	—	—	5	1	—	—
Idaho	3	9	N	N	—	N	20	22	1	2
Wyo.	4	10	23	11	—	—	—	3	—	—
Colo.	191	106	N	N	48	34	40	59	1	2
N. Mex.	42	89	—	N	—	—	44	76	2	2
Ariz.	234	209	N	N	—	N	156	151	12	39
Utah	79	38	33	16	1	—	6	11	—	1
Nev.	1	5	2	2	—	—	78	36	1	—
PACIFIC	100	125	—	1	9	3	1,445	1,414	26	59
Wash.	N	N	N	N	N	N	139	131	—	—
Oreg.	N	N	N	N	6	N	35	25	—	—
Calif.	—	—	N	N	N	N	1,254	1,250	26	59
Alaska	—	—	—	—	—	N	6	1	—	—
Hawaii	100	125	—	1	3	3	11	7	—	—
Guam	—	—	—	—	—	—	—	2	—	—
P.R.	N	N	N	N	—	N	203	159	9	5
V.I.	—	—	—	—	—	—	—	4	—	—
Amer. Samoa	U	U	U	U	U	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.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 3, 2005, and December 4, 2004 (48th Week)*

	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease†		
							Neuroinvasive		Non-neuroinvasive§
Reporting area	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	10,564	12,199	250	295	23,738	26,437	1,149	1,142	1,436
NEW ENGLAND	327	404	24	22	2,255	3,206	9	—	4
Maine	14	20	1	—	213	262	—	—	—
N.H.	6	16	—	—	1,386	—	—	—	—
Vt.	5	5	—	—	114	413	—	—	—
Mass.	221	230	14	15	542	806	4	—	2
R.I.	29	48	1	1	—	—	1	—	—
Conn.	52	85	8	6	U	1,725	4	—	2
MID. ATLANTIC	1,864	1,912	47	72	4,408	88	26	17	17
Upstate N.Y.	230	266	5	10	—	—	—	5	—
N.Y. City	909	941	21	29	—	—	10	2	4
N.J.	433	427	13	18	—	—	2	1	2
Pa.	292	278	8	15	4,408	88	14	9	11
E.N. CENTRAL	1,127	1,076	22	35	5,998	11,635	233	66	115
Ohio	221	182	2	7	1,417	1,338	46	11	15
Ind.	121	121	1	—	482	N	10	8	1
Ill.	530	478	8	16	75	5,868	130	29	88
Mich.	187	213	6	9	3,653	3,798	36	13	5
Wis.	68	82	5	3	371	631	11	5	6
W.N. CENTRAL	397	426	6	8	568	177	142	86	413
Minn.	167	164	5	4	—	—	16	13	27
Iowa	38	42	—	—	N	N	13	13	19
Mo.	94	112	—	2	421	5	17	27	13
N. Dak.	2	4	—	—	55	82	12	2	74
S. Dak.	14	8	—	—	92	90	35	6	192
Nebr.	29	36	—	2	—	—	36	7	80
Kans.	53	60	1	—	—	—	13	18	8
S. ATLANTIC	2,228	2,574	51	43	2,282	2,141	30	65	22
Del.	19	17	1	—	28	5	1	—	—
Md.	239	259	12	12	—	—	4	10	1
D.C.	48	77	—	—	37	23	—	1	—
Va.	268	249	18	9	684	481	—	4	—
W. Va.	24	22	—	—	1,062	1,223	—	—	N
N.C.	248	317	5	8	—	N	2	3	2
S.C.	199	164	—	—	471	409	5	—	—
Ga.	345	521	4	4	—	—	9	14	7
Fla.	838	948	11	10	—	—	9	33	12
E.S. CENTRAL	507	592	7	8	—	48	64	60	38
Ky.	99	108	2	3	N	N	5	1	—
Tenn.	233	197	2	5	—	—	14	13	3
Ala.	175	182	1	—	—	48	6	15	4
Miss.	—	105	2	—	—	—	39	31	31
W.S. CENTRAL	1,321	1,772	16	26	5,876	6,789	231	237	115
Ark.	105	108	—	—	24	—	11	17	15
La.	—	—	1	—	111	56	100	85	38
Okla.	126	151	1	1	—	—	13	16	11
Tex.	1,090	1,513	14	25	5,741	6,733	107	119	51
MOUNTAIN	335	500	11	7	2,351	2,353	134	322	205
Mont.	8	14	—	—	—	—	8	2	17
Idaho	—	3	—	—	—	—	2	1	7
Wyo.	—	4	—	—	52	55	6	2	6
Colo.	51	120	7	2	1,690	1,874	19	41	72
N. Mex.	19	35	—	—	156	U	20	31	13
Ariz.	200	198	2	2	—	—	44	214	44
Utah	26	35	1	1	453	424	21	6	31
Nev.	31	91	1	2	—	—	14	25	15
PACIFIC	2,458	2,943	66	74	—	—	280	289	507
Wash.	228	216	5	6	N	N	—	—	—
Oreg.	54	95	3	1	—	—	1	—	6
Calif.	2,034	2,498	46	61	—	—	279	289	501
Alaska	38	33	—	—	—	—	—	—	—
Hawaii	104	101	12	6	—	—	—	—	—
Guam	—	49	—	—	—	209	—	—	—
P.R.	—	104	—	—	565	377	—	—	—
V.I.	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	—
C.N.M.I.	—	U	—	U	—	U	—	U	—

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).
† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
§ Not previously notifiable.

TABLE III. Deaths in 122 U.S. cities,* week ending December 3, 2005 (48th Week)

Reporting Area	All causes, by age (years)						P&I†
	All Ages	≥65	45–64	25–44	1–24	<1	Total
NEW ENGLAND	654	462	129	34	14	15	56
Boston, Mass.	141	98	26	9	6	2	14
Bridgeport, Conn.	44	31	8	2	1	2	3
Cambridge, Mass.	17	15	2	—	—	—	3
Fall River, Mass.	28	25	2	1	—	—	3
Hartford, Conn.	64	42	14	3	1	4	6
Lowell, Mass.	29	26	—	3	—	—	4
Lynn, Mass.	4	1	2	1	—	—	—
New Bedford, Mass.	27	19	5	1	2	—	1
New Haven, Conn.	55	32	11	4	3	5	8
Providence, R.I.	73	57	12	3	—	1	3
Somerville, Mass.	3	2	—	—	1	—	—
Springfield, Mass.	56	34	17	4	—	1	6
Waterbury, Conn.	35	25	10	—	—	—	3
Worcester, Mass.	78	55	20	3	—	—	2
MID. ATLANTIC	2,401	1,697	479	146	44	33	144
Albany, N.Y.	48	32	12	3	1	—	3
Allentown, Pa.	31	27	4	—	—	—	2
Buffalo, N.Y.	87	55	22	4	4	2	10
Camden, N.J.	35	21	8	3	3	—	2
Elizabeth, N.J.	20	16	4	—	—	—	6
Erie, Pa.	52	37	13	2	—	—	4
Jersey City, N.J.	47	27	11	7	1	1	—
New York City, N.Y.	1,259	897	257	71	15	17	58
Newark, N.J.	67	34	19	8	5	1	2
Paterson, N.J.	21	7	1	10	3	—	1
Philadelphia, Pa.	238	159	50	16	8	5	12
Pittsburgh, Pa.§	38	32	4	—	1	1	3
Reading, Pa.	27	23	3	1	—	—	—
Rochester, N.Y.	172	130	30	6	1	5	18
Schenectady, N.Y.	31	22	9	—	—	—	3
Scranton, Pa.	37	31	2	3	1	—	3
Syracuse, N.Y.	104	84	13	6	—	1	13
Trenton, N.J.	43	28	14	—	1	—	—
Utica, N.Y.	15	11	1	3	—	—	2
Yonkers, N.Y.	29	24	2	3	—	—	2
E.N. CENTRAL	2,325	1,554	515	161	44	51	176
Akron, Ohio	66	48	16	1	1	—	8
Canton, Ohio	26	18	4	4	—	—	3
Chicago, Ill.	337	205	88	27	11	6	24
Cincinnati, Ohio	52	27	14	3	3	5	6
Cleveland, Ohio	228	168	40	13	1	6	27
Columbus, Ohio	213	130	51	21	4	7	15
Dayton, Ohio	147	104	34	7	2	—	7
Detroit, Mich.	228	123	66	23	9	7	10
Evansville, Ind.	81	50	22	8	—	1	7
Fort Wayne, Ind.	75	57	11	5	1	1	10
Gary, Ind.	22	13	5	3	—	1	—
Grand Rapids, Mich.	68	56	6	2	1	3	14
Indianapolis, Ind.	194	137	38	10	5	4	11
Lansing, Mich.	93	68	17	5	2	1	5
Milwaukee, Wis.	153	101	41	4	1	6	13
Peoria, Ill.	61	43	10	5	1	2	4
Rockford, Ill.	64	48	13	3	—	—	2
South Bend, Ind.	51	37	9	5	—	—	1
Toledo, Ohio	83	60	15	5	2	1	3
Youngstown, Ohio	83	61	15	7	—	—	6
W.N. CENTRAL	569	369	142	37	11	10	35
Des Moines, Iowa	32	26	5	—	1	—	4
Duluth, Minn.	44	35	8	1	—	—	—
Kansas City, Kans.	24	13	8	2	—	1	4
Kansas City, Mo.	82	56	17	7	—	2	2
Lincoln, Nebr.	28	20	6	2	—	—	—
Minneapolis, Minn.	70	42	20	3	3	2	2
Omaha, Nebr.	105	67	24	9	3	2	12
St. Louis, Mo.	35	21	12	1	1	—	2
St. Paul, Minn.	66	41	16	6	2	1	4
Wichita, Kans.	83	48	26	6	1	2	5

Reporting Area	All causes, by age (years)						P&I†
	All Ages	≥65	45–64	25–44	1–24	<1	Total
S. ATLANTIC	1,376	865	323	105	43	38	83
Atlanta, Ga.	113	64	30	13	2	4	3
Baltimore, Md.	115	76	23	9	5	2	12
Charlotte, N.C.	137	86	31	8	7	5	10
Jacksonville, Fla.	192	117	49	14	5	7	7
Miami, Fla.	155	98	29	19	3	6	13
Norfolk, Va.	60	38	15	2	2	3	—
Richmond, Va.	77	42	21	3	5	6	4
Savannah, Ga.	51	33	15	2	1	—	4
St. Petersburg, Fla.	67	43	17	5	2	—	11
Tampa, Fla.	263	184	51	18	8	2	14
Washington, D.C.	124	67	38	11	3	3	2
Wilmington, Del.	22	17	4	1	—	—	3
E.S. CENTRAL	892	572	219	62	25	14	58
Birmingham, Ala.	181	128	32	11	8	2	22
Chattanooga, Tenn.	96	57	25	7	4	3	3
Knoxville, Tenn.	88	57	22	8	1	—	2
Lexington, Ky.	71	43	20	4	3	1	8
Memphis, Tenn.	158	94	45	11	6	2	3
Mobile, Ala.	77	43	26	6	1	1	2
Montgomery, Ala.	51	35	10	6	—	—	4
Nashville, Tenn.	170	115	39	9	2	5	14
W.S. CENTRAL	1,639	1,039	402	128	39	31	83
Austin, Tex.	88	45	30	10	2	1	4
Baton Rouge, La.	44	31	9	4	—	—	—
Corpus Christi, Tex.	51	34	11	5	1	—	—
Dallas, Tex.	224	136	67	17	1	3	16
El Paso, Tex.	101	67	19	11	1	3	5
Ft. Worth, Tex.	121	90	17	7	3	4	5
Houston, Tex.	437	253	115	43	21	5	28
Little Rock, Ark.	88	69	14	1	2	2	4
New Orleans, La.¶	U	U	U	U	U	U	U
San Antonio, Tex.	256	164	65	14	5	8	12
Shreveport, La.	55	42	9	3	—	1	3
Tulsa, Okla.	174	108	46	13	3	4	6
MOUNTAIN	1,176	778	270	77	30	21	71
Albuquerque, N.M.	161	110	33	11	5	2	12
Boise, Idaho	43	33	10	—	—	—	1
Colo. Springs, Colo.	82	59	18	3	2	—	6
Denver, Colo.	91	56	26	3	3	3	6
Las Vegas, Nev.	247	154	66	19	5	3	13
Ogden, Utah	45	34	4	5	2	—	4
Phoenix, Ariz.	180	107	47	14	3	9	7
Pueblo, Colo.	30	25	4	1	—	—	4
Salt Lake City, Utah	139	89	33	10	6	1	13
Tucson, Ariz.	158	111	29	11	4	3	5
PACIFIC	1,656	1,151	336	93	46	30	148
Berkeley, Calif.	23	16	5	1	—	1	2
Fresno, Calif.	110	84	14	5	4	3	5
Glendale, Calif.	7	6	1	—	—	—	—
Honolulu, Hawaii	92	63	23	2	—	4	9
Long Beach, Calif.	57	44	10	3	—	—	10
Los Angeles, Calif.	221	153	38	19	9	2	20
Pasadena, Calif.	23	20	1	1	1	—	1
Portland, Oreg.	118	72	31	7	6	2	10
Sacramento, Calif.	135	106	20	6	2	1	11
San Diego, Calif.	218	146	44	13	9	6	25
San Francisco, Calif.	133	82	28	15	8	—	5
San Jose, Calif.	156	110	33	4	4	5	30
Santa Cruz, Calif.	22	15	7	—	—	—	2
Seattle, Wash.	160	102	39	12	1	6	8
Spokane, Wash.	77	59	14	3	1	—	5
Tacoma, Wash.	104	73	28	2	1	—	5
TOTAL	12,688**	8,487	2,815	843	296	243	854

U: Unavailable. —: No reported cases.

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

† Pneumonia and influenza.

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

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

** Total includes unknown ages.

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