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Contraceptive Methods Available to Patients of Office-Based Physicians and Title X Clinics — United States, 2009–2010

Unintended pregnancies, which accounted for an estimated 49% of all pregnancies in the United States in 2001, more often are associated with adverse outcomes for both mother and child than are intended pregnancies (*1*). In 2008, an estimated 36 million U.S. women of reproductive age were in need of family planning services because they were sexually active, able to get pregnant, and not trying to get pregnant; this represented a 6% increase from year 2000 estimates (*2*). To assess the provision of various reversible contraceptive methods by U.S family planning providers, CDC mailed a survey on contraceptive provision to random samples of 2,000 office-based physicians and 2,000 federally funded Title X clinics. This report summarizes those results, which indicated that a greater proportion of Title X clinic providers than office-based physicians offered on-site availability of a number of methods, including injectable depot medroxyprogesterone acetate (DMPA) (96.6% versus 60.9%) and combined oral contraceptive pills (92.1% versus 48.8%). However, a greater proportion of office-based physicians than Title X clinic providers reported on-site availability of the levonorgestrel-releasing intrauterine device (LNG-IUD) (56.4% versus 46.6%). Less than maximal use of long-acting, reversible contraceptive methods (LARCs), including IUDs and contraceptive implants, might be a contributing factor to high unintended pregnancy rates in the United States (*3*). Improving contraceptive delivery by increasing on-site availability in physicians' offices and clinics of a range of contraceptive methods, including LARCs, might increase contraceptive use and reduce rates of unintended pregnancy.

From December 2009 to March 2010, CDC conducted a mailed survey on contraceptive provision to random samples of 2,000 office-based physicians and 2,000 federally funded Title X clinics. Office-based physicians were sampled from the American Medical Association (AMA) Physician Masterfile, which includes information on AMA member and nonmember physicians residing in the United States and select territories. Three primary specialties were included: obstetrics/gynecology, family medicine, and adolescent medicine. Title X clinics, which can represent a range of provider agencies (e.g., public health departments, Planned Parenthood affiliates, hospitals, and community health centers), were sampled randomly from a current directory of Title X clinics maintained by the U.S. Department of Health and Human Services' Office of Population Affairs. Office-based physicians and one provider from each Title X clinic were eligible to participate if they provided family planning services* to women of reproductive age at least twice per week.

The survey included questions on contraceptive method availability and determined whether specific reversible contraceptive methods were 1) directly available to clients on-site, 2) available by prescription (or recommendation, for condoms), 3) available by referral, or 4) not available. For providers reporting multiple categories of availability for a single method (e.g., on-site and by prescription), availability

* A family planning service was defined as any service related to postponing or preventing conception and could include a medical examination related to provision of a method, contraceptive counseling, or method prescription or supply visits. A patient could receive a family planning service even if the primary purpose of her visit was not contraception.

INSIDE

5 Local Health Department Costs Associated with Response to a School-Based Pertussis Outbreak — Omaha, Nebraska, September–November 2008
10 Progress in Immunization Information Systems — United States, 2009
13 Updated Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis (Tdap) Vaccine from the Advisory Committee on Immunization Practices, 2010
16 Notes from the Field: Congenital Lymphocytic Choriomeningitis — New York
17 Notices to Readers
19 QuickStats

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was classified according to the most accessible availability category (i.e., on-site, by prescription, or by referral to other providers, respectively). Surveys were pilot tested with physicians representing each targeted specialty, nurse practitioners, certified nurse midwives, and epidemiologists. Survey packets included a cover letter with signatures of support from key partner agencies and organizations. The initial survey mailing was followed by a reminder post card and a second survey mailing to nonresponders. Additional, systematic efforts to contact nonresponders were made by telephone.

Of the 2,000 office-based physicians sampled, 628 were excluded because they did not meet the eligibility criteria or could not be located. Of the 2,000 Title X clinics sampled, 334 were excluded because their providers did not meet the eligibility criteria, the clinic was closed, or it could not be located. After accounting for ineligibility, the response rate was 47.0% for office-based physicians and 78.5% for Title X clinic providers. The final sample included 635 office-based physicians and 1,368 Title X clinic providers.

A significantly higher proportion of Title X clinic providers than office-based physicians reported on-site availability of all methods ($p<0.05$), except the LNG-IUD, for which on-site availability was reported by 56.4% of office-based physicians and 46.6% of Title X clinic providers (Table). In contrast, a higher proportion of office-based physicians than Title X clinic providers reported prescribing or recommending each contraceptive method rather than having it available on-site, especially combined oral contraceptives (50.4% versus 6.9%), progestin-only oral contraceptives (70.9% versus 17.4%), DMPA (36.4% versus 2.6%), the contraceptive patch (60.5% versus 29.0%), and male condoms (60.8% versus 2.9%). The proportion of Title X clinic providers and office-based physicians who reported referring patients to other providers for contraceptive methods was low (≤8.0%), except for LARCs (including the copper IUD, 29.6% and 25.2%, respectively; LNG-IUD, 37.9% and 24.6%, respectively; and contraceptive implants, 44.5% and 40.0%, respectively. Few family planning providers indicated that specific contraceptive methods were unavailable to their patients; female condoms and implants most frequently were reported as unavailable by office-based physicians (17.8% and 8.0%, respectively) and Title X clinic providers (9.9% and 9.2%, respectively).

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Editorial Note

Despite advances in contraceptive technology, the proportion of U.S. pregnancies that are unintended has remained relatively stable at approximately 50% (*1*). High unintended pregnancy rates in the United States are thought to result, in part, from lesser use of LARCs, which are highly effective (<1% typical use failure rates), compared with more commonly used methods, such as male condoms (15% typical use failure rate) and oral contraceptives (8% typical use failure rate) (*3*). LARCs are more effective at preventing unintended pregnancies during

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TABLE. Availability of reversible contraceptive methods to patients of office-based physicians and Title X clinic providers* — United States, 2009–2010†

Contraceptive method§	Directly available on-site %	Available by prescription¶ %	Available by referral to other providers %	Not available %
Levonorgestrel-releasing intrauterine device (LNG-IUD; Mirena)				
Office-based physicians	56.4	16.2	24.6	1.9
Title X clinics	46.6	9.6	37.9	3.8
Copper intrauterine device (ParaGard)				
Office-based physicians	53.5	15.8	25.2	2.8
Title X clinics	59.7	7.4	29.6	2.0
Implant (Implanon)				
Office-based physicians	32.0	13.2	40.0	8.0
Title X clinics	35.7	6.7	44.5	9.2
Depot medroxyprogesterone acetate (DMPA; Depo-Provera)				
Office-based physicians	60.9	36.4	1.6	0.2
Title X clinics	96.6	2.6	0.2	0.2
Combined oral contraceptives				
Office-based physicians	48.8	50.4	0.0	0.2
Title X clinics	92.1	6.9	0.2	0.2
Progestin-only oral contraceptives				
Office-based physicians	24.9	70.9	1.4	1.1
Title X clinics	78.3	17.4	1.1	1.4
Patch (Ortho Evra)				
Office-based physicians	29.1	60.5	1.7	4.9
Title X clinics	56.9	29.0	7.5	4.8
Vaginal ring (NuvaRing)				
Office-based physicians	43.0	52.3	3.3	0.5
Title X clinics	58.1	28.9	8.0	3.5
Male condom				
Office-based physicians	26.3	60.8	2.4	5.5
Title X clinics	95.6	2.9	0.3	0.4
Female condom				
Office-based physicians	7.1	47.9	6.5	17.8
Title X clinics	49.4	24.9	6.7	9.9

* Total = 2,003; office-based physicians = 635; Title X clinic providers = 1,368.
† Percentages might not sum to 100% because of missing or "not applicable" responses.
§ Classifications of contraceptive method availability were mutually exclusive.
¶ Male and female condoms were available by recommendation.

typical use than user-dependent methods (e.g., condoms and oral contraceptives) because they require only a single act of insertion for long-term use and eliminate the influence of adherence on effectiveness. Access to a range of contraceptive methods, including LARCs, might increase contraceptive use but might be impeded by cost, provider knowledge and training, or other factors (*4*).

Results of this national survey indicate variation in the availability of specific contraceptive methods by method type and by clinical setting, with a higher proportion of Title X clinic providers than office-based physicians offering a range of contraceptive methods on-site. Oral contraceptives, the most commonly used reversible contraceptive method among U.S. women (*5*), were available on-site from nearly all Title X clinic providers, whereas approximately half of office-based physicians had them available on-site and half had them available by prescription. Male condoms, which provide protection against both unintended pregnancy and sexually transmitted infections, were available on-site in nearly all Title X clinics but only in one quarter of physicians' offices. Availability of LARCs, which require insertion by a trained health-care provider, often depended on referral to other providers. Approximately one quarter of office-based physicians and nearly one third of Title X clinic providers referred clients to other providers for IUDs, and both often referred clients seeking implants to other providers, which could impede use of these contraceptive methods.

What is already known on this topic?

In the United States, nearly half of all pregnancies are unintended, and 36 million women of reproductive age are in need of family planning services, but national data on contraceptive method availability are limited, with few studies examining provider-specific availability of a range of contraceptive methods.

What is added by this report?

Approximately half of providers indicated that intrauterine devices (IUDs) and one third of providers indicated that contraceptive implants were available to their patients on-site. A higher proportion of Title X clinic providers than office-based physicians offered a range of contraceptive methods on-site, but availability of long-acting, reversible contraceptives (LARCs), including IUDs and contraceptive implants, often depended on referral to other office-based or Title X clinic providers.

What are the implications for public health practice?

Increasing access to LARCs in addition to other methods, might increase contraceptive use and reduce the rate of unintended pregnancies.

This is believed to be the only national survey to report on-site availability of specific contraceptive methods apart from availability though prescription or provider recommendation. Other studies on contraceptive method availability examined on-site availability in combination with prescription or provider recommendation (*6,7*), or examined on-site availability but combined all hormonal methods into one category (*8*). The findings are comparable to those of previous studies that found that contraceptive method availability either from on-site provision or through prescription or provider recommendation was highest for oral contraceptives and lower for the patch, IUD, and vaginal ring (*6–8*).

Differences in the availability of specific contraceptive methods might reflect variation in factors such as the reimbursable cost for each method (e.g., LARCs) (*7*), clinic or practice type and associated mandates (e.g., health department versus Planned Parenthood clinic) (*7,9*), federal and state policies (*9*), provider training in contraceptive implant or IUD insertion (*8*), health insurance coverage, and patient characteristics (*8*). For example, on-site availability for a range of contraceptive methods might be greater through Title X clinic providers than through office-based physicians because of 1) the federal Title X mandate to provide a broad range of contraceptive methods to all women, and 2) the larger proportion of patients seen at Title X clinics who are in need of contraceptive services (*10*). Additionally, social and demographic differences in patient population or a broad practice scope for office-based physicians could translate to fewer women seeking family planning services in these settings and might have led to lower on-site availability.

The findings in this report are subject to at least three limitations. First, although the 47.0% response rate for office-based physicians was similar to that of another physician provider survey (*6*), the rate was considerably lower than the response rate for Title X clinic providers (78.5%). Potential differences between respondents and nonrespondents in contraceptive method availability could not be determined. Second, the survey did not ascertain reasons for certain contraceptive methods being unavailable. Finally, although Title X providers might indicate that specific methods are available on-site, certain methods (e.g., LNG-IUD) are not available consistently to all clients because of high costs. Clinics or practices might opt to offer less expensive methods to some persons to have funds to serve a greater number of clients (*7*).

Descriptions of reversible contraceptive method availability among office-based physicians and Title X clinic providers can help guide practice, financing, and policy efforts aimed at improving contraceptive delivery. Reducing barriers to accessing a range of contraceptive methods, including LARCs, might reduce rates of unintended pregnancy in the United States.

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Local Health Department Costs Associated with Response to a School-Based Pertussis Outbreak — Omaha, Nebraska, September–November 2008

Pertussis is a highly infectious, vaccine-preventable respiratory illness. With the advent of a vaccine, case numbers fell in the United States from a high of 265,269 in 1934 (*1*) to a low of 1,010 cases in 1976, but then resurged to 25,827 in 2004. During 2004–2008, the average was 18,161 cases per year (*2,3*). Close contacts of persons with pertussis are at increased risk for developing infection and are recommended to receive preventive antibiotics (*4*) for two reasons: 1) the illness can be debilitating, with cough lasting several weeks and sometimes being severe enough to cause urinary incontinence, rib fracture, or other complications; and 2) the illness can be fatal in infants; it caused an average of 17 deaths each year during 2002–2006 (*3*). During pertussis outbreaks, the resources needed to identify and treat contacts can strain local public health resources (*5*). The Douglas County Health Department (DCHD) in Omaha, Nebraska, responded to a school-based pertussis outbreak with 26 cases occurring in late 2008. To assess the costs incurred by a local health department responding to such an outbreak, DCHD and CDC evaluated the total resources used by DCHD. This report describes the results of that analysis, which indicated that 1) staff members reported 1,032 person-hours spent responding to the outbreak, and 2) the total cost of outbreak response, including overhead, labor, travel, and other costs, was $52,131 (measured in 2008 U.S. dollars). The majority of costs (59%) occurred during an intensive 10-day period, when most of the contact tracing and prophylaxis recommendations were made. The elevated incidence of pertussis and the burden of response placed on health departments warrants exploring the impact of alternative response and chemoprophylaxis strategies.

On September 26, 2008, DCHD was notified of a student, aged 5 years, with a diagnosis of pertussis. The student attended a private school with approximately 600 other students in kindergarten through 12th grade. DCHD followed pertussis response protocols in which close contacts were identified and contacted. In keeping with CDC pertussis response guidelines, DCHD recommended chemoprophylaxis for close contacts, defined as persons who had direct face-to-face contact with an ill person, or shared a confined space with an ill person for more than 1 hour, or had direct contact with respiratory, oral, or nasal secretions from a symptomatic person (*4*). DCHD also recommended that the school exclude persons with a cough from school until they were evaluated by a doctor. After four additional cases were reported in the school on October 28, DCHD further recommended that students with cough be excluded from school until evaluated by a physician and either treated or determined not to have pertussis.

On November 17, CDC investigators were deployed at the request of DCHD to assist with the response and data analysis and assess the cost to the health department for its response. Cost data were obtained in a three-step process. First, DCHD management personnel were interviewed to determine the temporal course of the outbreak and response, the number of staff members involved in the response, and the health department's operating costs, including labor and overhead. Second, a survey instrument was created and distributed to DCHD personnel to assess time spent performing various activities during the outbreak response. The survey was voluntary and de-identified. Each survey was confidentially matched with the corresponding salary and fringe benefit rate obtained from accounting staff. Third, cost figures were calculated by multiplying hours worked by salary plus the fringe benefit rate, then adding travel and overhead expenses.* Cost was summed by operating division and compared with the division budget to determine the proportion of the total operating budget required for this outbreak response.

To assess the cost to DCHD during different phases of the response, data were split into three periods: 1) the initial period, from the first case notification to the declaration of the outbreak (September 26–October 26); 2) the outbreak period, when most of the cases were reported and DCHD worked to update control measures (October 27–November 5); and 3) the follow-up and reporting period, when DCHD implemented new control measures and observed reduced incidence of disease (November 6–21). Also, cost was separated by four DCHD divisions involved in the outbreak: Administration, Epidemiology, Data, and Media Relations.† Finally, labor cost was calculated by period and division as a percentage of the total DCHD labor budget. Labor cost as a proportion of labor budget was used to determine how many personnel in each division worked on the outbreak during that period. For example, a percentage of 100% would mean that the division spent all available personnel resources on the outbreak.

* Amortized from an annual rate per full-time employee by the number of hours worked on the outbreak in the following categories: information technology, telephone, and facilities rental expenses.

† DCHD had 113 employees, with seven administrators, eight members of the Epidemiology Division, three employees in the Data Division, and two media relations officers. Other divisions not involved in the outbreak (that incurred no cost) were the Community Health and Nutrition (40 employees), Environmental Health (33 employees), and Administration and Business Finance divisions (four employees).

To classify staff time, the survey captured several time categories, including investigation, communication, decisions and implementation, and "other." The categories were derived from interviews with health department staff members before conducting the survey. Investigation included all activities related to identifying contacts (contact tracing), following up with potential close contacts, analysis of epidemiologic data, other investigation, and record keeping. Communication time was divided among physicians, parents, school, and the media. Decisions and implementation were activities related to coordination of control measures during the outbreak. Specifically, these involved meetings to discuss how to identify close contacts, whether or not to exclude anyone with a cough from school, and "other." The "other" category included meetings with parents of school children and travel time.

In total, 26 laboratory-confirmed pertussis cases occurred (in 24 students and two staff members) (Figure). Two of the 26 cases were identified after the survey was conducted, and the costs associated with them were not included in the analysis. DCHD recommended chemoprophylaxis for 148 close contacts. DCHD staff members contributed 1,031 person-hours to control the outbreak during the period observed (Table 1). Outbreak cost totaled $52,131, or approximately $2,172 per case, which was nearly 1% of DCHD's annual program budget, excluding grants and external funding sources. Each case of pertussis required nearly 42 regular person-hours and approximately 1 hour of overtime. The time spent investigating a pertussis case included tracing of all close contacts, and each pertussis case led to an average of 21 telephone calls and chemoprophylaxis recommendations for six close contacts (range: zero to 70). DCHD did not pay for antibiotics or laboratory testing.

Of the total cost, the largest components were investigations (37.2%) and decisions and implementation (22.9%). Resource use was most intensive during the outbreak period for all divisions (Table 2). The most heavily affected divisions were Epidemiology (156% of budgeted hours), Administration (46%), and Media Relations (41%).[§] The Epidemiology Division's 156% resource use reflected overtime and compensation hours worked during the outbreak period. In total, staff members reported 28 hours of overtime with the largest component of overtime allocated to investigation-related activities.

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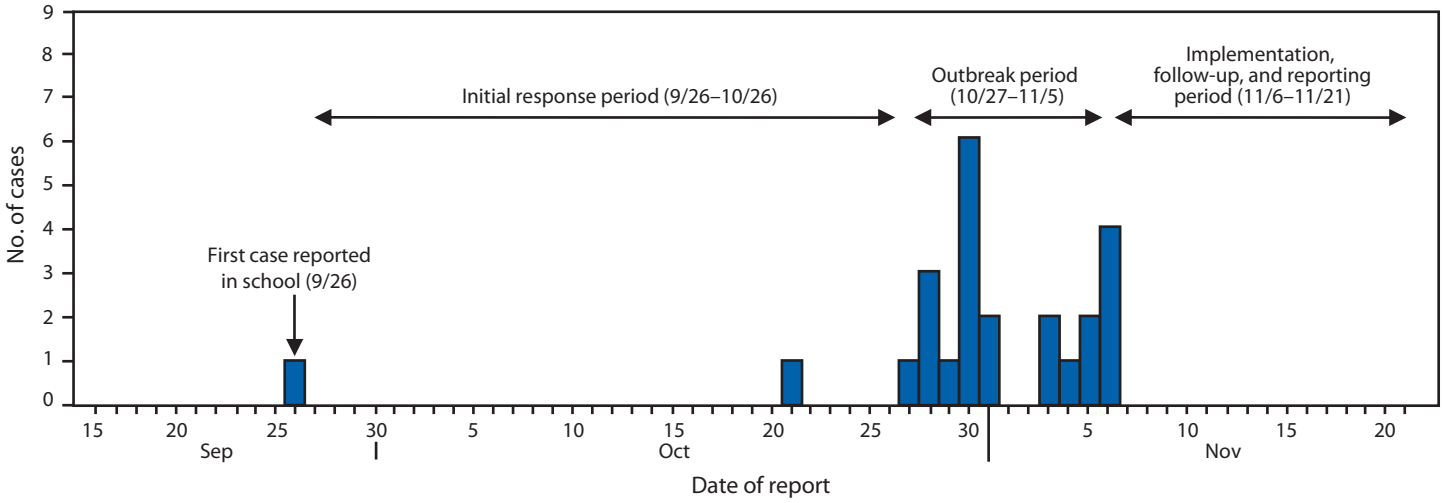
Editorial Note

This pertussis outbreak in Omaha in 2008 was resource-intensive and expensive for the local health department, with total costs estimated at $52,000 and 1,000 hours of staff time committed to the outbreak. Beyond the direct costs measured by the survey, the outbreak affected other projects and public health priorities of DCHD. Many staff members stopped working on their previous projects to work on the outbreak; although most staff members were able to return and complete

[§] Whereas some health departments split epidemiology and disease control functions, the DCHD Epidemiology Division is responsible for both, which might increase their resource use relative to other health departments that separate these functions.

FIGURE. Number of pertussis cases (N = 26*), by date reported — Omaha, Nebraska, September–November 2008



* Two cases identified after November 21 were excluded from the cost analysis because they were reported after the survey completion date.

TABLE 1. Costs* associated with a pertussis outbreak, by type of cost — Douglas County Health Department, Omaha, Nebraska, September–December 2008

	Hours worked		Cost ($) by activity†		Mean cost ($) per hour		Total	
Type of cost	Regular	Overtime	Regular	Overtime	Regular	Overtime	Cost ($)	% of total cost
Investigation								
Identifying contacts	128.6	3.0	4,324	133	34	44	**4,458**	**8.6**
Follow-up with contacts	57.9	1.0	1,950	44	34	44	**1,994**	**3.8**
Analysis of data	155.0	3.0	8,024	165	52	55	**8,189**	**15.7**
Other investigation	18.0	4.0	557	203	31	51	**761**	**1.5**
Record keeping	111.8	1.7	3,882	87	35	52	**3,968**	**7.6**
Subtotal	471.3	12.7	18,737	633			**19,370**	**37.2**
Communication								
Communications with school	80.1	0.5	2,635	39	33	78	**2,674**	**5.1**
Communications with physicians	41.8		1,459		35		**1,459**	**2.8**
Communications with laboratory	15.5	3.0	512	222	33	74	**734**	**1.4**
Media relations and public inquires	85.5	4.8	3,150	221	37	46	**3,372**	**6.5**
Subtotal	222.8	8.3	7,756	482			**8,238**	**15.8**
Decisions and implementation								
Making decisions	103.7		4,375		42		**4,375**	**8.4**
Developing recommendations	88.5	1.5	3,584	111	41	74	**3,695**	**7.1**
Writing letters, press releases, and reports	96.2		3,860		40		**3,860**	**7.4**
Subtotal	288.4	1.5	11,819	111			**11,930**	**22.9**
Other								
Meeting with parents at school	15.5	5.0	611	377	39	75	**988**	**1.9**
Travel	5.5	0.5	229	39	42	78	**268**	**0.5**
Subtotal	21.0	5.5	840	416			**1,256**	**2.4**
Total labor costs	**1,003.5**	**28.0**	**39,152**	**1,642**			**40,794**	**78.3**
Non-labor costs								
Travel (97 miles)							**54**	**0.1**
Telephone, information technology, and rent§							**1,905**	**3.7**
Department and county overhead							**9,379**	**18.0**
Total non-labor costs							**11,337**	**21.7**
Total cost							**52,131**	**100.0**

* All costs measured in 2008 U.S. dollars.
† Labor cost is measured by each individual employee's hours worked multiplied by their salary plus fringe benefit rate and then summed over all individuals for each activity. Overtime hours include nonpaid extra hours worked and are valued at 1.5 times the regular salary.
§ Amortized from an annual rate per full-time employee by the number of hours worked on the outbreak in the following categories: information technology, telephone, and facilities rental expenses.

their projects, DCHD staff members reported a total delay of 83 days on those projects. Staff members reported greater than usual stress resulting from balancing or delaying competing priorities. For example, staff members worked extra hours to respond to a tuberculosis case identified during the outbreak. Had the pertussis outbreak not occurred, staff members would have handled the tuberculosis case during regular working hours.

Such evaluations of public response costs to disease are rare in the literature. One other report evaluated the cost to a state health department responding to a measles outbreak in 2004 (*6*). Using a similar cost evaluation method, the authors found a very high cost of response (approximately $60,000 for one case).

When responding to the outbreak, the major costs to this health department were investigation of cases and decisions and implementation of updated chemoprophylaxis guidelines.

What is already known on this topic?

Although the private costs of pertussis outbreaks have been well studied, little is known about the costs local public health departments incur when responding to pertussis outbreaks.

What is added by this report?

This report measures the cost, from a local health department perspective, to contain a pertussis outbreak in a private school with approximately 600 students. The cost for 24 cases of pertussis was estimated at $52,131 (or approximately $2,172 per case).

What are the implications for public health practice?

The elevated incidence of pertussis and the burden of response placed on health departments warrants exploring the impact of alternative chemoprophylaxis strategies. Knowledge of local public health response costs of pertussis outbreaks can help guide exploration of alternative response and control measures.

TABLE 2. Labor costs* associated with a pertussis outbreak, by division and response period — Douglas County Health Department, Omaha, Nebraska, September–December 2008

Division	Initial response period (9/26–10/26)	Outbreak response period (10/27–11/5)	Implementation, follow-up, and reporting period (11/6–11/21)	Total response period (9/26–11/21)
Administration (three employees)				
Labor hours	1.9	50.9	17.3	**70.0**
Labor cost ($)	126	3,916	954	**4,997**
Available labor budget ($)	22,159	8,441	12,662	**43,263**
% available labor budget	1	46	8	**12**
Epidemiology (four employees)†				
Labor hours	95.4	513.3	279.1	**887.8**
Labor cost ($)	2,960	24,931	15,441	**43,332**
Available labor budget ($)	63,533	16,011	36,304	**115,848**
% available labor budget	5	156	43	**37**
Data (three employees)				
Labor hours	6.2	6.3	6.2	**18.7**
Labor cost ($)	334	334	344	**1,012**
Available labor budget ($)	17,152	6,534	9,801	**33,488**
% available labor budget	2	5	4	**3**
Media relations and health advisor (two employees)				
Labor hours	12.4	30.3	12.4	**55.0**
Labor cost ($)	345	879	345	**1,568**
Available labor budget ($)	5,678	2,163	3,245	**11,086**
% available labor budget	6	41	11	**14**
Total health department				
Labor hours	115.8	600.8	314.9	**1031.5**
Labor cost ($)	3,764	30,060	17,084	**50,909**
Available labor budget ($)	108,523	33,150	62,013	**203,686**
% available labor budget	3.5	90.7	27.5	**25.0**

* All costs measured in 2008 U.S. dollars.
† Eight staff members worked in the Epidemiology Division. However, four members were absent during the outbreak phase for a training program. Therefore, only the hours for four staff members were used in this analysis.

Within these two components, data analysis, tracing contacts, and determining the appropriate close contact definition required the most time of health department personnel. Other health departments have employed guidelines that target tracing and chemoprophylaxis of contacts (*7*). Adoption of such targeted chemoprophylaxis strategies might streamline notification procedures and result in more efficient and complete notification of contacts at risk for severe or fatal disease, including infants (*7*). However, the effectiveness of targeted versus wider chemoprophylaxis remains to be determined.

The findings in this report are subject to at least three limitations. First, this report focused on the direct public cost incurred by a local health department in response to a pertussis outbreak. The private costs of pertussis, including those costs borne by patients, persons recommended chemoprophylaxis, health-care providers, or institutions, were not analyzed in this study. However, private costs of pertussis are well studied elsewhere and can be substantial (*8,9*). Second, although this report measured the total delay in projects resulting from the outbreak, it did not measure the type or number of projects delayed. Future cost analyses also should measure the "opportunity cost" of outbreaks in more detail. Finally, although these data offer a picture of public health cost when responding to an outbreak, they only reflect the resource use of one health department and might differ for other health departments. For example, health departments that pay for laboratory testing and antibiotic courses for patients would incur additional costs.

Costs of response to pertussis outbreaks can be substantial. Investigations and developing recommendations were the most resource-intensive aspects of this outbreak for the local health department. The elevated incidence of pertussis and the burden of response placed on health departments warrants exploring the impact of alternative response and chemoprophylaxis strategies.

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Progress in Immunization Information Systems — United States, 2009

An immunization information system (IIS) is a confidential, computerized, population-based system that collects and consolidates vaccination data from vaccine providers and provides tools for designing and sustaining effective immunization strategies at the provider and program levels. Among the capabilities of an IIS are the capacity to inform vaccine providers of upcoming patient vaccination needs; generate vaccination coverage reports, patient reminders, or recalls for past due vaccinations; and interoperate with electronic health record (EHR) systems. In 2010, the Task Force on Community Preventive Services recommended that immunization information systems be used to increase vaccination coverage after showing strong evidence of their effectiveness (*1*). A *Healthy People 2020* objective is to increase to 95% the percentage of children aged <6 years whose immunization records are housed in a fully operational IIS (*2*). To assess IIS progress toward meeting the *Healthy People* objective, CDC analyzed data from the 2009 Immunization Information Systems Annual Report (IISAR) survey (completed by 53 of 56 federal grantees with IIS sites), which indicated that 77% of all U.S. children aged <6 years participated in an IIS, an increase from 75% in 2008 (*3*). In addition, 59% of grantees reported being able to send and receive vaccination data using Health Level Seven (HL7) messaging standards, and 73% reported that some vaccine providers with EHR systems in their geographic area were providing vaccination data directly to an IIS from EHRs. Enhancing IIS and EHR with standards such as HL7 will provide greater consistency in data exchange and likely help to improve the quality and timeliness of IIS data.

To monitor progress toward IIS program objectives, CDC annually surveys 56 IIS grantees (50 states, five cities,* and the District of Columbia) via IISAR. In 2009, 53 (95%) of the 56 grantees completed the IISAR survey (Kentucky and Massachusetts were implementing a new IIS and did not have data to report; New Hampshire elected not to implement an IIS). The self-administered survey asks about vaccination coverage for all age groups, provider participation in IIS, and IIS functionality (e.g., managing vaccine inventory in the vaccine provider office, EHR communication with IIS, and conducting vaccine provider assessments using IIS).

Participation in an IIS

The percentage of children aged <6 years whose immunization records were housed in a fully operational IIS was calculated for each of the 56 grantees. The calculations were made by dividing the number of children participating in an IIS by the 2009 midyear U.S. Census projection of the population of children aged <6 years for that grantee geographic area.

In 2009, of the 53 responding grantees, 23 (43%) reported that >95% of children aged <6 years in their geographic area were participating in an IIS. Ten (19%) of the 53 reported participation ranging from 80% to 94% (Figure) (*3*). Overall in the United States, approximately 77% of children aged <6 years (18.4 million) participated in an IIS in 2009 (a small but statistically significant increase from 75% in 2008 [*3*]).

IIS Adherence to Standards

In 2001, the Technical Working Group of the National Immunization Program established 12 standards regarding the minimum technical functions an IIS should implement (*4,5*). Three of these standards were considered for this report: 1) electronically store data on all 17 core data elements recommended by the National Vaccine Advisory Committee (NVAC), 2) receive and process immunization information within 1 month of vaccine administration, and 3) exchange immunization records using HL7 standards, which allow for efficient transfer of records and data de-duplication within systems (*6*). To assess adherence to these three standards, data were analyzed from 51 of the 56 grantees (Chicago, Houston, Kentucky, Massachusetts, and New Hampshire were excluded) in 2009 and compared with data from 52 grantees in 2008.

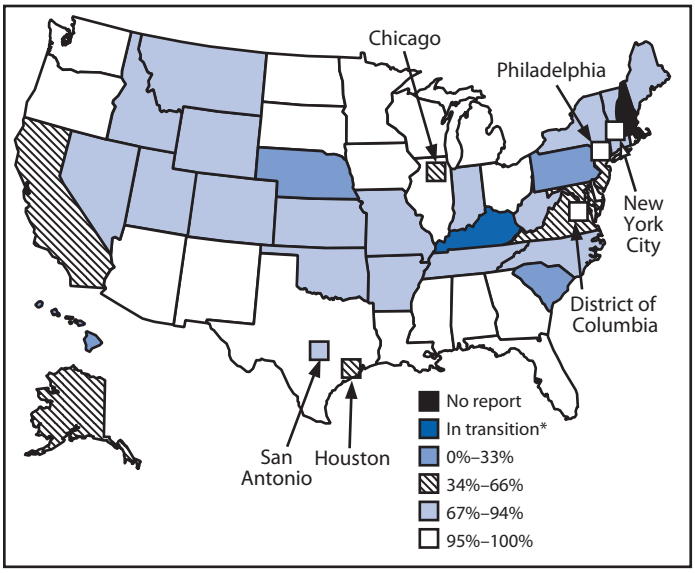
In 2009, six of the 17 NVAC-recommended core data elements (i.e., first name, last name, birth date, sex, vaccine type, and vaccination date) had completion rates of ≥97% for children aged <6 years, a result similar to findings in 2008 (Table). In addition, nine of the remaining 11 core data elements showed increases in completion rates from 2008 to 2009.

Regarding the other standards, 70% of IIS data were received and processed within 1 month of vaccine administration, an increase from 67% in 2008 (*3*). Also, 30 (59%) of the 51 grantees reported the ability to send and receive HL7 messages, four (8%) grantees reported partial ability to meet HL7 capability by either sending or receiving messages, and 17 (33%) grantees reported having no HL7 functionality.

In 2009, 37 (73%) of 51 grantees reported that at least some vaccine provider–site EHR systems were providing immunization data directly to an IIS. A total of 3,618 provider-site EHR systems provided immunization data directly to a grantee IIS, compared with 1,848 in 2008. Of these 3,618 systems, 2,797 (77%) were among the 33 grantees with >80% child participation.

* Chicago, Illinois; Houston and San Antonio, Texas; New York, New York; and Philadelphia, Pennsylvania.

FIGURE. Percentage of children aged <6 years participating in a grantee immunization information system — 50 states, five cities, and District of Columbia, 2009



* Grantee is implementing a new IIS project.

TABLE. Percentage of core data elements* that were complete† in immunization information system (IIS) records for children aged <6 years — United States, 2008 and 2009

Core data element	2008 (52 grantees) (%)	2009 (51 grantees) (%)	Change (%)
First name	100	100	0
Middle name	68	69	+1
Last name	100	100	0
Birth date	100	100	0
Sex	97	97	0
Birth state	44	46	+2
Birth country	28	28	0
Mother's first name	67	71	+4
Mother's maiden name	50	55	+5
Mother's last name	59	63	+4
Vaccine type	98	100	+2
Vaccine manufacture	40	50	+10
Vaccination date	98	100	+2
Vaccine lot number	38	45	+7
Race§	59	63	+4
Ethnicity§	39	43	+4
Patient birth order	63	61	-2

* Recommended by the National Vaccine Advisory Committee. Additional information available at http://www.cdc.gov/vaccines/programs/iis/stds/coredata.htm.

† Calculated using the number of data field completions in IIS records and the overall number of IIS records.

§ Additional core data element recommended by the National Vaccine Advisory Committee in 2007.

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Editorial Note

Despite some progress in increasing the proportion of children aged <6 years whose immunization records are housed in an IIS, challenges remain to successful IIS implementation, such as resource costs to vaccine providers, and quality of data. Some challenges are being addressed through efforts to enhance interoperability of EHR and IIS, increase use of HL7 messaging, and offer vaccine provider incentives. These interventions can help 1) reduce the time from vaccine administration to inclusion of data in an IIS record, 2) reduce dual data entry by vaccine providers because vaccination data will only be entered into the EHR and then exchanged with the IIS using HL7 messaging, and 3) increase completeness of immunization information (core data elements and vaccination data) by adding data not collected previously by an IIS.

Provisions of the Health Information Technology for Clinical and Economic Health (HITECH) Act (*7*) are intended to accelerate adoption of nationally certified EHR systems, standardize EHR products, support growth in the health information technology workforce, and facilitate secure exchange of health data between disparate partners. A centerpiece of the HITECH Act is the EHR Incentive Program (*8*), administered by the Centers for Medicare and Medicaid Services (CMS). CMS provides financial incentives to eligible health-care providers, and hospitals must acquire certified products that support standards-based electronic reporting to IIS, including use of the HL7 table of vaccines administered. To receive their incentive payments, eligible professionals (outpatient vaccine providers) have to satisfy at least one of the following public health reporting requirements. They must conduct an HL7 messaging test, IIS reporting (and fulfill reporting requirements as per locality), laboratory reporting, or syndromic surveillance reporting. States can specify as mandatory any of the public health requirements for the Medicaid "meaningful use" program.

In 2010, CDC received HITECH funding for 20 IIS grantees to measurably enhance EHR-IIS interoperability. Over a 24-month project period, the 20 IIS grantees will be developing or enhancing HL7 messaging capacity and increasing the number of interfaces with EHRs. The grantees also will need to ensure adequate programmatic and technical capacity for increased electronic data submission testing, ensuring that electronic files submitted to EHR are complete and accurate. Finally, the grantees will coordinate with state health information technology coordinators and health information exchange organizations to ensure coordination with overall statewide plans, policies, and protocols for secure exchange of data using standards such as HL7 (*9*).

What is already known on this topic?

An estimated 75% of all U.S. children aged <6 years (17.7 million children) participated in an immunization information system (IIS) in 2008.

What is added by this report?

In 2009, 77% of all U.S. children aged <6 years (18.4 million children) participated in an IIS. Also, 59% of IIS grantees reported being able to send and receive Health Level Seven (HL7) messages, and another 8% of grantees with IIS were partially able to meet HL7 capability by either sending or receiving messages.

What are the implications for public health practice?

Enhancing the interoperability of IIS and electronic health record systems will help provide greater consistency in data exchange and likely reduce interface costs over time. Increased IIS data accuracy, timeliness, and completeness can improve the quality of IIS-based coverage assessments, better support clinical decisions at the health-care provider level, and increase availability of the data for other public health functions.

The findings in this report are subject to at least two limitations. First, although guidance on algorithms to validate their data are provided to IIS grantees by CDC, the data from the 2009 IISAR were self-reported and self-validated. Second, because some of the 56 grantees did not report data during the period studied, the nationwide IIS participation rates for children aged <6 years might be underestimated or overestimated.

Findings from the Taskforce on Community Preventive Services systematic review of the literature have highlighted how the IIS can be effective in increasing vaccination coverage (*1*). IIS offers capabilities such as patient reminder and recall systems, vaccine provider assessment and feedback, use of data for public health responses to outbreaks of vaccine-preventable disease, facilitation of vaccine management and accountability, and assessment of client vaccination status for decisions made by health-care providers (*1*). Enhancing IIS and EHR to adopt national standards and interoperability specifications will help provide greater consistency in data exchange and likely reduce interface costs over time. Increased IIS data accuracy, timeliness, and completeness can improve the quality of IIS-based vaccination coverage assessments, better support clinical decisions at the health-care provider level, and improve the data available for other public health functions.

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Updated Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis (Tdap) Vaccine from the Advisory Committee on Immunization Practices, 2010

Despite sustained high coverage for childhood pertussis vaccination, pertussis remains poorly controlled in the United States. A total of 16,858 pertussis cases and 12 infant deaths were reported in 2009 (*1*; CDC, unpublished data, 2009). Although 2005 recommendations by the Advisory Committee on Immunization Practices (ACIP) called for vaccination with tetanus toxoid, reduced diphtheria toxoid and acellular pertussis (Tdap) for adolescents and adults to improve immunity against pertussis, Tdap coverage is 56% among adolescents and <6% among adults (*2,3*). In October 2010, ACIP recommended expanded use of Tdap. This report provides the updated recommendations, summarizes the safety and effectiveness data considered by ACIP, and provides guidance for implementing the recommendations.

ACIP recommends a single Tdap dose for persons aged 11 through18 years who have completed the recommended childhood diphtheria and tetanus toxoids and pertussis/diphtheria and tetanus toxoids and acellular pertussis (DTP/DTaP) vaccination series and for adults aged 19 through 64 years (*4,5*). Two Tdap vaccines are available in the United States. Boostrix (GlaxoSmithKline Biologicals, Rixensart, Belgium) is licensed for use in persons aged 10 through 64 years, and Adacel (Sanofi Pasteur, Toronto, Canada) is licensed for use in persons aged 11 through 64 years. Both Tdap products are licensed for use at an interval of at least 5 years between the tetanus and diphtheria toxoids (Td) and Tdap dose. On October 27, 2010, ACIP approved the following additional recommendations: 1) use of Tdap regardless of interval since the last tetanus- or diphtheria-toxoid containing vaccine, 2) use of Tdap in certain adults aged 65 years and older, and 3) use of Tdap in undervaccinated children aged 7 through 10 years.

The Pertussis Vaccines Working Group of ACIP reviewed published and unpublished Tdap immunogenicity and safety data from clinical trials and observational studies on use of Tdap. The Working Group also considered the epidemiology of pertussis, provider and program feedback, and data on the barriers to receipt of Tdap. The Working Group then presented policy options for consideration to the full ACIP. These additional recommendations are intended to remove identified barriers and programmatic gaps that contribute to suboptimal vaccination coverage. An important barrier that limited vaccination of persons with Tdap was unknown history of Td booster. Programmatic gaps included lack of a licensed Tdap vaccine for children aged 7 through 10 years and adults aged 65 years and older. In light of the recent increase of pertussis in the United States, the additional recommendations are made to facilitate use of Tdap to reduce the burden of disease and risk for transmission to infants (Box).

Timing of Tdap Following Td

Safety. When Tdap was licensed in 2005, the safety of administering a booster dose of Tdap at intervals <5 years after Td or pediatric DTP/DTaP had not been studied in adults. However, evaluations in children and adolescents suggested that the safety of intervals as short as 18 months was acceptable (*6*). Rates of local and systemic reactions after Tdap vaccination in adults were lower than or comparable to rates in adolescents during U.S. prelicensure trials; therefore, the safety of using intervals as short as 2 years between Td and Tdap in adults was inferred (*4*).

Additional data on the safety of administering Tdap <5 years after Td are now available. Two studies were conducted with 387 persons aged 18 through 76 years who received a Tdap or combined Tdap-inactivated polio vaccine (Tdap-IPV) vaccination either within 21 days, or <2 years following a previous Td-containing vaccine (*7,8*). Tdap-IPV vaccine is not licensed in the United States. In both studies, immediate or short-term adverse events (e.g., 30 minutes to 2 weeks) after receipt of Tdap or Tdap-IPV were examined. The majority of these events were limited to local reactions, including pain (68%–83%), erythema (20%–25%), and swelling (19%–38%) (*7,8*). Serious adverse events related to the receipt of Tdap or Tdap-IPV shortly after Td or Td-IPV vaccinations did not occur. However, the number of subjects in these studies was small and does not exclude the potential for rare, but serious, adverse events.

Guidance for use. ACIP recommends that pertussis vaccination, when indicated, should not be delayed and that Tdap should be administered regardless of interval since the last tetanus or diphtheria toxoid-containing vaccine. ACIP concluded that while longer intervals between Td and Tdap vaccination could decrease the occurrence of local reactions, the benefits of protection against pertussis outweigh the potential risk for adverse events.

Adults Aged 65 Years and Older

Unpublished data from trials for Adacel (N = 1,170) and Boostrix (N = 1,104) on the safety and immunogenicity of Tdap in adults aged 65 years and older who received vaccine were provided to ACIP by Sanofi Pasteur and GlaxoSmithKline.

BOX. Summary of updated recommendations for use of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis (Tdap) vaccine — Advisory Committee on Immunization Practices, 2010

General Recommendations

For routine use, adolescents aged 11 through 18 years who have completed the recommended childhood diphtheria and tetanus toxoids and pertussis/diphtheria and tetanus toxoids and acellular pertussis (DTP/DTaP) vaccination series and adults aged 19 through 64 years should receive a single dose of Tdap. Adolescents should preferably receive Tdap at the 11 to 12 year-old preventive health-care visit.

Timing of Tdap

- Can be administered regardless of interval since the last tetanus- or diphtheria-toxoid containing vaccine.

Adults Aged 65 years and Older

- Those who have or anticipate having close contact with an infant aged less than 12 months should receive a single dose of Tdap.
- Other adults ages 65 years and older may be given a single dose of Tdap.

Children Aged 7 Through 10 Years

- Those not fully vaccinated against pertussis* and for whom no contraindication to pertussis vaccine exists should receive a single dose of Tdap.
- Those never vaccinated against tetanus, diphtheria, or pertussis or who have unknown vaccination status should receive a series of three vaccinations containing tetanus and diphtheria toxoids. The first of these three doses should be Tdap.

* Fully vaccinated is defined as 5 doses of DTaP or 4 doses of DTaP if the fourth dose was administered on or after the fourth birthday.

Safety. For both Tdap vaccines, the frequency and severity of adverse events in persons aged 65 years and older were comparable to those in persons aged less than 65 years. No increase in local or generalized reactions in Tdap recipients was observed, compared with persons who received Td. No serious adverse events were considered related to vaccination.

ACIP reviewed data on vaccine-related adverse events from the Vaccine Adverse Event Reporting System (VAERS). VAERS is a passive surveillance system jointly administered by CDC and the Food and Drug Administration that accepts reports from vaccine manufacturers, health-care providers, and vaccine recipients for vaccine safety. VAERS can be prone to overreporting or underreporting and inconsistency in the quality and completeness of reports. During September 2005–September 2010, a total of 243 VAERS reports were received regarding adults aged 65 years and older administered Tdap, out of 10,981 total VAERS reports on Tdap among recipients of all ages (CDC, unpublished data, 2010). Of the 243 reports regarding adults aged 65 years and older, 232 (96%) were nonserious. The most frequent adverse events after Tdap were local reactions, comprising 37% of all events. Eleven serious events were reported, including two deaths among persons with multiple underlying conditions. Although VAERS cannot assess causality, after review of data, it is unlikely the deaths were related to vaccine receipt. Postmarketing VAERS data also suggest that Tdap vaccine safety in adults aged 65 years and older is comparable to that of Td vaccine. Because Tdap is not licensed for use in this age group, comparisons between these reports and other reports need to be interpreted with caution.

Immunogenicity. Both Tdap vaccines showed that immune responses to diphtheria and tetanus toxoids were noninferior to responses produced by Td. In both Tdap vaccines, immune responses were observed to the pertussis antigens. For Boostrix, immune responses to pertussis antigens (pertussis toxin [PT], filamentous hemagglutinin [FHA], and pertactin [PRN]) were noninferior to those observed following a 3-dose primary pertussis vaccination series, as defined by the Vaccines and Related Biological Products Advisory Committee (VRBPAC) (*9*). For Adacel, immune responses to all pertussis antigens (PT, FHA, PRN, and fimbriae [FIM]) occurred (4.1 to 15.1-fold geometric mean concentration increases). ACIP concluded that both Tdap vaccines would provide pertussis protection in persons aged 65 years and older.

Guidance for use. ACIP recommends that adults aged 65 years and older (e.g., grandparents, child-care providers, and health-care practitioners) who have or who anticipate having close contact with an infant less than 12 months of age and who previously have not received Tdap should receive a single dose of Tdap to protect against pertussis and reduce the likelihood of transmission. For other adults aged 65 years and older, a single dose of Tdap vaccine may be given instead of Td vaccine, in persons who have not previously received Tdap. Tdap can be administered regardless of interval since the last tetanus- or diphtheria-toxoid containing vaccine. After receipt of Tdap, persons should continue to receive Td for routine booster immunization against tetanus and diphtheria, according to previously published guidelines (*4*). Either Tdap vaccine product may be used. Further recommendations on the use of both Tdap vaccines in adults aged 65 years and older will be forthcoming should one or more Tdap products be licensed for use in this age group.

Undervaccinated Children Aged 7 through 10 Years

No data have been published regarding the safety or immunogenicity of Tdap in children aged 7 through 10 years who

have never received pertussis-containing vaccines. One published study assessed the use of Tdap-IPV vaccine as the fifth dose of acellular pertussis vaccine in children aged 4 through 8 years (*10*). A subanalysis of the study data comparing safety and immunogenicity results among children aged 4 through 6 years (n = 703) and 7 through 8 years (n = 118) was provided to ACIP by GlaxoSmithKline. Three additional published studies have assessed use of Tdap in lieu of the fifth DTaP dose in children aged 4 through 6 years who had received 4 previous doses of DTaP (*11–13*). These three studies enrolled 609 subjects who received either Tdap or Tdap-IPV in lieu of the fifth DTaP dose.

Safety. In each study, no increase in risk of severe local reactions or systemic adverse events was observed. The most commonly reported adverse events within 15 days after receipt of Tdap were pain (40%–56%), erythema (34%–53%), and swelling (24%–45%). Fewer local reactions were observed or reported among Tdap or Tdap-IPV recipients compared with those who received DTaP or DTaP-IPV, but the differences were not statistically significant. No differences were noted when children aged 4 through 6 and 7 through 8 years were compared with respect to solicited or unsolicited adverse reactions following vaccination with Tdap-IPV. ACIP concluded that the overall safety of Tdap and frequency of local reactions in undervaccinated children likely would be similar to those observed in children who received 4 doses of DTaP.

Immunogenicity. Immune response to Tdap-IPV was comparable between children aged 4 through 6 and those aged 7 through 8 years, according to the GlaxoSmithKline subanalysis. In both age groups, at least 99.9% of Tdap-IPV recipients had seroprotective levels of antibodies for diphtheria and tetanus, and responses to pertussis antigens were comparable to those observed following a 3-dose primary pertussis vaccination series as defined by VRBPAC.

In children aged 4 through 6 years, the immune response following receipt of Tdap (Boostrix or Adacel) was comparable to DTaP or DTaP-IPV (*11,12*). All subjects had seroprotective antibody levels for diphtheria and tetanus 4 to 6 weeks after vaccination. For pertussis antigens, one study observed no significant difference between Boostrix and DTaP recipients in response rates to any of three pertussis antigens in the vaccines, with similar effects on cell-mediated immune responses 3.5 years after vaccination (*12*). Another study demonstrated a fourfold increase in four pertussis antibodies in the majority of children receiving Adacel or DTaP-IPV (*11*).

Guidance for use. ACIP recommends that children aged 7 through 10 years who are not fully vaccinated* against pertussis and for whom no contraindication to pertussis vaccine exists should receive a single dose of Tdap to provide protection against pertussis. If additional doses of tetanus and diphtheria toxoid–containing vaccines are needed, then children aged 7 through10 years should be vaccinated according to catch-up guidance, with Tdap preferred as the first dose (*5*). Tdap is recommended in this age group because of its reduced antigen content compared with DTaP, resulting in reduced reactogenicity. Currently, Tdap is recommended only for a single dose across all age groups. Further guidance will be forthcoming on timing of revaccination in persons who have received Tdap previously.

* Fully vaccinated is defined as 5 doses of DTaP or 4 doses of DTaP if the fourth dose was administered on or after the fourth birthday.

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Notes from the Field

Congenital Lymphocytic Choriomeningitis — New York

Lymphocytic choriomeningitis virus (LCMV) is an arenavirus carried by rodents, most notably domestic house mice (*Mus musculus*), but also laboratory and pet rodents (*1*). Manifestations of infections in humans are protean, from inapparent or mild febrile illness to choriomeningitis, encephalitis, or severe multi-organ disease. Mother-to-child transmission of LCMV during pregnancy can cause abortion, chorioretinitis, hydrocephalus, or microencephaly, and can result in life-long vision deficits or neurologic impairment (*2,3*). Clinically, congenital LCMV infection closely resembles perinatal infections caused by the pathogens grouped under the TORCH acronym: toxoplasmosis, rubella, cytomegalovirus, and herpes simplex virus.

Reports of congenital LCMV cases are extremely rare in the United States. In January 2010, an infant in upstate New York with hydrocephalus and chorioretinitis was confirmed to have congenital LCMV infection by the Viral Special Pathogens Branch at CDC. A review of records by the Onondaga County Health Department (Syracuse, New York) and the New York State Department of Health found that 7 years earlier, two cases of congenital LCMV infection were diagnosed in infants residing within a 1.5-mile radius of the infant in the 2010 case.

LCMV infection is not a nationally notifiable disease in the United States, the extent of LCMV-associated morbidity is currently unknown, and most LCMV infections are believed to go undiagnosed. Health-care practitioners are encouraged to contact their local or state health department if they have observed cases of suspected LCMV infection. When LCMV-associated disease is suspected, the Viral Special Pathogens Branch at CDC asks that state health departments contact the branch via e-mail (dvd-1spath@cdc.gov) or telephone (404-639-1510) for consultation and diagnostic assistance and to better identify and characterize LCMV-associated morbidity in the United States.

Reported by

Onondaga County Health Dept, Syracuse; New York State Dept of Health. Viral Special Pathogens Br, National Center for Emerging and Zoonotic Infectious Diseases, CDC.

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Notices to Readers

Celebrating the 50th Anniversary of *MMWR* at CDC

January 13, 2011, marks the 50th anniversary of the first publication of *MMWR* by CDC. *MMWR* was not new 50 years ago, but it was new to CDC, which itself had only been organized in 1946. The first ancestor of *MMWR* was the *Bulletin of the Public Health*, which began publication on July 13, 1878, under the National Quarantine Act. In the years between 1878 and 1961, *MMWR* and its antecedents went through several changes in name and format, and were housed in several different federal agencies. By 1960, the publication had assumed its current name, the *Morbidity and Mortality Weekly Report*, and was being published by the National Office of Vital Statistics (NOVS) in Washington, an agency of the U.S. Public Health Service (*1*). NOVS later became the National Center for Health Statistics.

In the late 1950s, Alexander D. Langmuir, CDC's chief epidemiologist, became determined to move the disease surveillance functions of NOVS to CDC, along with *MMWR*. Langmuir worked hard to accomplish this, securing the transfer in 1960 (*2*). CDC published its first issue of *MMWR* on January 13, 1961. On the cover of that issue, Langmuir wrote, "The Center welcomes the addition of this important function. We believe the closer current contact with those reporting morbidity and mortality data will better permit us more rapidly and successfully to carry out our primary role of providing consultation and assistance to the States when communicable disease problems occur" (*3*).

Since 1961, *MMWR* has broadened into a series of six different products: the *MMWR* Weekly, the Surveillance Summary series, Recommendations and Reports, the annual Summary of Notifiable Diseases, the weekly *MMWR* podcasts, and Supplements. Since 1961, *MMWR* has published reports about all of the major infectious diseases affecting the United States and the world. Through the decades, these have included smallpox (1960s), Legionnaire's disease (1970s), the first cases of acquired immunodeficiency disease (AIDS) (1980s), the first iatrogenic transmission of human immunodeficiency virus (HIV) and hantavirus pulmonary syndrome (1990s), and the first reports of severe acute respiratory syndrome (SARS) and 2009 influenza A (H1N1) (2000s) (*4*). By the 1970s, *MMWR* was publishing many reports on noninfectious diseases and injuries, and today, approximately 55% of all reports in the *MMWR* Weekly are on noninfectious disease topics.

In 1961, and for decades afterward, *MMWR* was the primary route by which CDC rapidly disseminated scientific information about public health events. Today, many channels exist for this purpose, and the Internet has revolutionized medical publishing. While recognizing that it must continue to serve as "the voice of CDC" and provide timely, authoritative, and useful public health information and recommendations, *MMWR* also recognizes it must adapt to rapid changes in the public health world. This will be one of the great challenges for *MMWR* in its next 50 years.

To celebrate the 50th anniversary, *MMWR* will publish a special supplement containing a history of *MMWR*, and an anthology of reports depicting the main events, developments, and innovations in public health from 1961 to the present. The supplement will be available later this year to all subscribers and on the *MMWR* website.

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Changes to the National Notifiable Infectious Disease List and Data Presentation — January 2011

This issue of *MMWR* incorporates changes to Table I (Provisional cases of infrequently reported notifiable diseases, United States) and Table II (Provisional cases of selected notifiable diseases, United States). In addition, changes are being made regarding the presentation of data on human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). This year, the Table I and Table II modifications add conditions designated as nationally notifiable by the Council of State and Territorial Epidemiologists (CSTE) in conjunction with CDC (*1–3*).

Modifications to Table I and Table II

Two new conditions have been added to the list of nationally notifiable infectious diseases: babesiosis and coccidioidomycosis. Incidence data for babesiosis will appear in Table I, and incidence data for coccidioidomycosis will appear in Table II. The surveillance case definitions adopted for these conditions

are listed in their respective CSTE position statements (*1,2*) and are posted in the case definitions section of the National Notifiable Diseases Surveillance System (NNDSS) website (*3*).

Elimination of HIV/AIDS Data Display

The Division of HIV/AIDS Prevention has decided to eliminate display of diagnoses of HIV infection in children aged <13 years, formerly displayed in Table I, and display of cases of AIDS and HIV/AIDS, formerly displayed in the quarterly Table IV. The rationales for these decisions are as follows: data on diagnoses of HIV infection in children aged <13 years are not transmitted to CDC on a weekly basis, and displaying data on HIV and AIDS diagnoses resulted in extended time requirements for producing the quarterly data sets. Data on HIV and AIDS diagnoses, including in children aged <13 years, are included in the annual HIV Surveillance Report published online by the Division of HIV/AIDS Prevention and available at http://www.cdc.gov/hiv/topics/surveillance/resources/reports.

2010 State Reportable Conditions Assessment

CSTE is collecting data for the 2010 State Reportable Conditions Assessment (2010 SRCA) from 56 reporting jurisdictions (50 U.S. states, the District of Columbia, New York City, and four U.S. territories) to determine which of the nationally notifiable conditions were reportable in each reporting jurisdiction during 2010. Data collection and validation for 2010 SRCA will conclude in 2011; results will be used to populate the "N" indicators for 2010 and 2011 NNDSS data displayed in the 2011 *MMWR* data tables. The 2010 and 2011 NNDSS data displayed in the 2011 *MMWR* weekly provisional tables will reflect reporting requirements gathered from the 2009 SRCA until 2010 SRCA official results are available.

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3. Council of State and Territorial Epidemiologists. Public health reporting and national surveillance for coccidioidomycosis. Position statement 10-ID-04. Available at http://www.cste.org/ps2010/10-id-04.pdf. Accessed January 7, 2011.

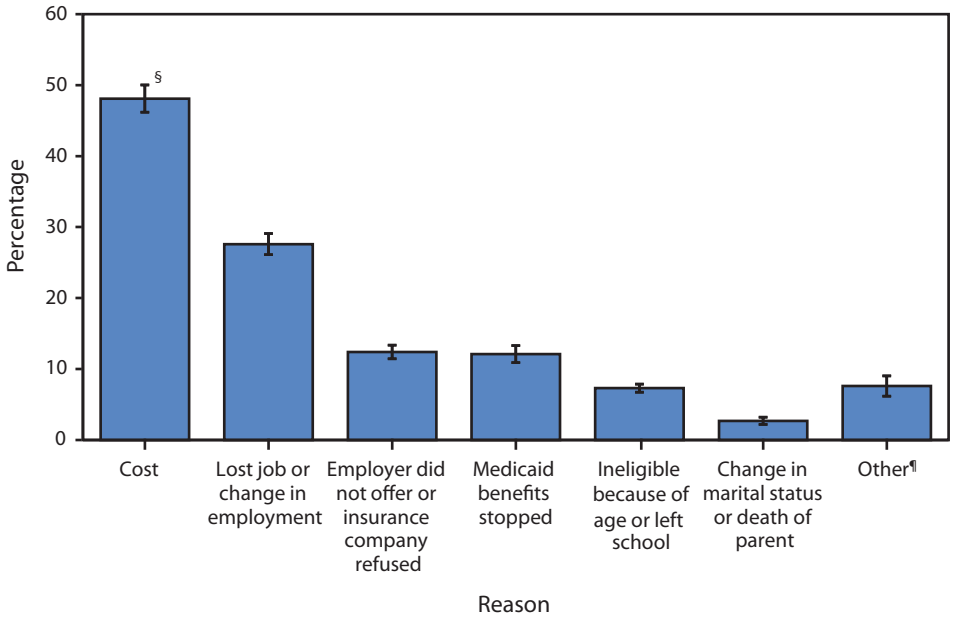
Errata: Vol. 60, No. RR-12

In the Recommendations and Reports, "Sexually Transmitted Diseases Treatment Guidelines, 2010," three errors occurred. In the "Recommended Regimens" boxes on pages 50 and 51, the recommendation for doxycycline should read "**100 mg orally twice a day for 7 days.**" In the "Alternative Regimens" box on page 57, the first recommendation for tinidazole should read "**2 g orally once daily for 2 days.**"

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Reasons for No Health Insurance Coverage* Among Uninsured Persons Aged <65 Years — National Health Interview Survey (NHIS), United States, 2009†



* Based on response to a survey question regarding the reasons a household member stopped being covered by health insurance or did not have health insurance. Persons could provide more than one reason.

† Estimates are age adjusted using the projected 2000 U.S. population as the standard population and using four age groups: 0–11 years, 12–17 years, 18–44 years, and 45–64 years. Estimates are based on household interviews of a sample of the civilian noninstitutionalized U.S. population and are derived from the NHIS Family Core component.

§ 95% confidence interval.

¶ Including moved, self-employed, never had coverage, did not want or need coverage, and other unspecified reasons.

Overall, in 2009, approximately 18% (46 million) of persons aged <65 years in the United States had no health insurance coverage at the time of interview. Of these uninsured persons, 48.1% cited cost as the reason they did not have coverage, and 27.6% cited loss of a job or a change in employment; 12.4% said they did not have coverage because an employer did not offer it or the insurance company refused coverage, and 12.1% said they did not have coverage because of cessation of Medicaid benefits.

Source: Adams PF, Martinez ME, Vickerie, JL. Summary health statistics for the U.S. population: National Health Inteview Survey, 2009. Vital Health Stat 2010;10(248).Available at http://www.cdc.gov/nchs/data/series/sr_10/sr10_248.pdf.

Notifiable Diseases and Mortality Tables

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending January 8, 2011 (1st week)*

Disease	Current week	Cum 2011	5-year weekly average†	Total cases reported for previous years 2010	2009	2008	2007	2006	States reporting cases during current week (No.)
Anthrax	—	—	—	—	1	—	1	1	
Arboviral diseases§,¶:									
California serogroup virus disease	—	—	—	72	55	62	55	67	
Eastern equine encephalitis virus disease	—	—	—	10	4	4	4	8	
Powassan virus disease	—	—	0	5	6	2	7	1	
St. Louis encephalitis virus disease	—	—	0	8	12	13	9	10	
Western equine encephalitis virus disease	—	—	—	—	—	—	—	—	
Babesiosis	—	—	—	NN	NN	NN	NN	NN	
Botulism, total	1	1	3	103	118	145	144	165	
foodborne	—	—	0	7	10	17	32	20	
infant	1	1	2	70	83	109	85	97	PA (1)
other (wound and unspecified)	—	—	1	26	25	19	27	48	
Brucellosis	1	1	2	126	115	80	131	121	FL (1)
Chancroid	1	1	0	37	28	25	23	33	VA (1)
Cholera	—	—	0	8	10	5	7	9	
Cyclosporiasis§	1	1	4	169	141	139	93	137	FL (1)
Diphtheria	—	—	—	—	—	—	—	—	
Haemophilus influenzae,** invasive disease (age <5 yrs):									
serotype b	—	—	1	16	35	30	22	29	
nonserotype b	—	—	5	149	236	244	199	175	
unknown serotype	5	5	6	260	178	163	180	179	PA (2), OH (1), TN (1), NM (1)
Hansen disease§	—	—	1	57	103	80	101	66	
Hantavirus pulmonary syndrome§	—	—	0	17	20	18	32	40	
Hemolytic uremic syndrome, postdiarrheal§	2	2	5	218	242	330	292	288	AL (1), OR (1)
Influenza-associated pediatric mortality§,††	4	4	2	61	358	90	77	43	FL (1), NC (1), NYC (1), PA (1)
Listeriosis	4	4	18	753	851	759	808	884	VA (1), FL (2), CO (1)
Measles§§	—	—	1	57	71	140	43	55	
Meningococcal disease, invasive¶¶:									
A, C, Y, and W-135	1	1	6	232	301	330	325	318	ID (1)
serogroup B	—	—	4	108	174	188	167	193	
other serogroup	—	—	1	9	23	38	35	32	
unknown serogroup	9	9	13	412	482	616	550	651	CT (1), NYC (1), PA (2), OH (2), MO (1), FL (1), OR (1)
Novel influenza A virus infections***	—	—	0	4	43,774	2	4	NN	
Plague	—	—	0	2	8	3	7	17	
Poliomyelitis, paralytic	—	—	0	—	1	—	—	—	
Polio virus Infection, nonparalytic§	—	—	—	—	—	—	—	NN	
Psittacosis§	—	—	0	4	9	8	12	21	
Q fever, total§	1	1	3	117	113	120	171	169	
acute	1	1	1	89	93	106	—	—	GA (1)
chronic	—	—	0	28	20	14	—	—	
Rabies, human	—	—	0	1	4	2	1	3	
Rubella†††	—	—	0	6	3	16	12	11	
Rubella, congenital syndrome	—	—	—	—	2	—	—	1	
SARS-CoV§	—	—	—	—	—	—	—	—	
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	—	—	4	156	161	157	132	125	
Syphilis, congenital (age <1 yr)§§§	—	—	7	221	423	431	430	349	
Tetanus	—	—	0	8	18	19	28	41	
Toxic-shock syndrome (staphylococcal)§	—	—	2	73	74	71	92	101	
Trichinellosis	1	1	0	4	13	39	5	15	CA (1)
Tularemia	—	—	1	110	93	123	137	95	
Typhoid fever	1	1	9	409	397	449	434	353	CA (1)
Vancomycin-intermediate *Staphylococcus aureus*§	1	1	1	89	78	63	37	6	FL (1)
Vancomycin-resistant *Staphylococcus aureus*§	—	—	0	1	1	—	2	1	
Vibriosis (noncholera *Vibrio* species infections)§	—	—	9	766	789	588	549	NN	
Viral hemorrhagic fever¶¶¶	—	—	0	1	NN	NN	NN	NN	
Yellow fever	—	—	—	—	—	—	—	—	

See Table 1 footnotes on next page.

TABLE I. (*Continued*) Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending January 8, 2011 (1st week)*

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

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

† Calculated by summing the incidence counts for the current week, the 2 weeks preceding the current week, and the 2 weeks following the current week, for a total of 5 preceding years. Additional information is available at http://www.cdc.gov/ncphi/disss/nndss/phs/files/5yearweeklyaverage.pdf.

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

¶ Includes both neuroinvasive and nonneuroinvasive. Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for West Nile virus are available in Table II.

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

†† Updated weekly from reports to the Influenza Division, National Center for Immunization and Respiratory Diseases. Since October 3, 2010, eight influenza-associated pediatric death occurred during the 2010-11 influenza season. Since August 30, 2009, a total of 282 influenza-associated pediatric deaths occurring during the 2009-10 influenza season have been reported.

§§ No measles cases were reported for the current week.

¶¶ Data for meningococcal disease (all serogroups) are available in Table II.

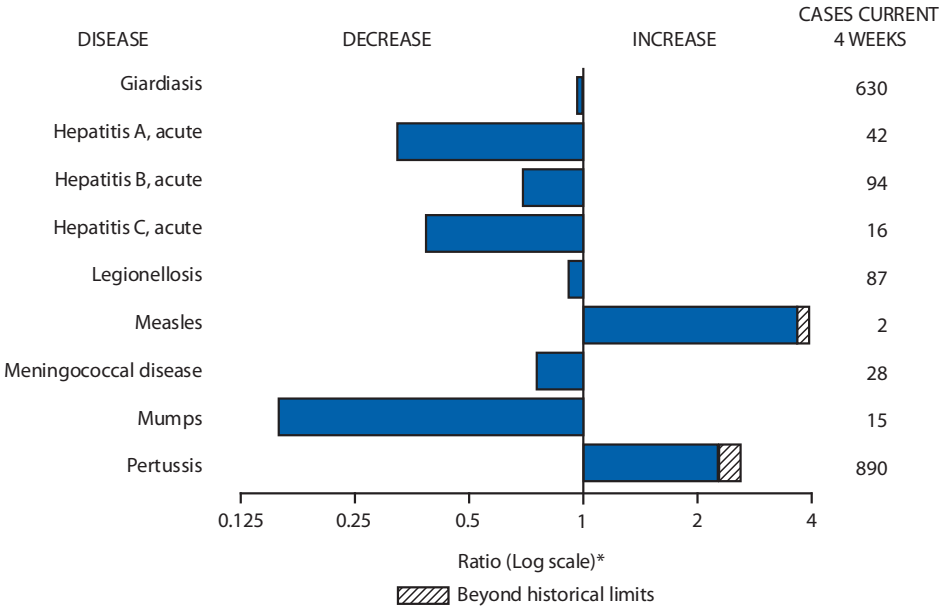
*** CDC discontinued reporting of individual confirmed and probable cases of 2009 pandemic influenza A (H1N1) virus infections on July 24, 2009. During 2009, four cases of human infection with novel influenza A viruses, different from the 2009 pandemic influenza A (H1N1) strain, were reported to CDC.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

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

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

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

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals January 8, 2011, with historical data



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

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TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	*Chlamydia trachomatis* infection					Coccidioidomycosis					Cryptosporidiosis				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010
United States	9,393	23,907	26,312	9,393	21,625	165	—	165	165	NN	43	120	343	43	155
New England	510	781	1,211	510	499	—	0	0	—	NN	—	7	77	—	77
Connecticut	—	177	402	—	20	—	0	0	—	NN	—	0	71	—	71
Maine§	—	50	100	—	45	—	0	0	—	NN	—	1	7	—	2
Massachusetts	432	401	693	432	327	—	0	0	—	NN	—	3	8	—	2
New Hampshire	1	49	114	1	41	—	0	0	—	NN	—	1	5	—	1
Rhode Island§	47	66	120	47	53	—	0	0	—	NN	—	0	2	—	—
Vermont§	30	23	51	30	13	—	0	0	—	NN	—	1	5	—	1
Mid. Atlantic	1,069	3,364	5,073	1,069	2,772	—	0	0	—	NN	4	15	38	4	9
New Jersey	331	512	680	331	427	—	0	0	—	NN	—	0	4	—	1
New York (Upstate)	290	697	1,036	290	187	—	0	0	—	NN	—	4	14	—	1
New York City	—	1,217	2,766	—	1,440	—	0	0	—	NN	—	2	6	—	1
Pennsylvania	448	945	1,092	448	718	—	0	0	—	NN	4	8	26	4	6
E.N. Central	981	3,498	3,975	981	3,379	—	0	0	—	NN	17	30	122	17	31
Illinois	20	762	1,025	20	1,000	—	0	0	—	NN	—	4	21	—	7
Indiana	—	364	797	—	160	—	0	0	—	NN	—	3	10	—	3
Michigan	575	946	1,419	575	888	—	0	0	—	NN	3	5	18	3	8
Ohio	247	992	1,109	247	1,028	—	0	0	—	NN	14	7	24	14	7
Wisconsin	139	426	513	139	303	—	0	0	—	NN	—	9	57	—	6
W.N. Central	263	1,377	1,556	263	1,337	—	0	0	—	NN	6	21	83	6	7
Iowa	15	205	270	15	270	—	0	0	—	NN	—	4	24	—	4
Kansas	53	189	235	53	185	—	0	0	—	NN	—	2	9	—	—
Minnesota	—	283	348	—	321	—	0	0	—	NN	—	0	16	—	—
Missouri	112	505	621	112	409	—	0	0	—	NN	2	4	30	2	3
Nebraska§	56	97	173	56	78	—	0	0	—	NN	4	3	26	4	—
North Dakota	—	28	79	—	11	—	0	0	—	NN	—	0	9	—	—
South Dakota	27	62	78	27	63	—	0	0	—	NN	—	1	6	—	—
S. Atlantic	3,300	4,737	5,653	3,300	3,839	—	0	0	—	NN	9	18	51	9	6
Delaware	83	85	220	83	65	—	0	0	—	NN	—	0	1	—	—
District of Columbia	76	91	177	76	49	—	0	0	—	NN	—	0	1	—	—
Florida	633	1,460	1,712	633	1,316	—	0	0	—	NN	6	7	19	6	4
Georgia	—	610	1,217	—	156	—	0	0	—	NN	1	5	31	1	2
Maryland§	319	469	718	319	164	—	0	0	—	NN	—	1	3	—	—
North Carolina	1,210	756	1,563	1,210	686	—	0	0	—	NN	—	0	12	—	—
South Carolina§	—	535	845	—	458	—	0	0	—	NN	—	1	8	—	—
Virginia§	857	599	902	857	902	—	0	0	—	NN	2	2	8	2	—
West Virginia	122	72	117	122	43	—	0	0	—	NN	—	0	3	—	—
E.S. Central	230	1,741	2,415	230	1,412	—	0	0	—	NN	—	4	19	—	6
Alabama§	—	524	758	—	449	—	0	0	—	NN	—	2	13	—	—
Kentucky	—	269	614	—	49	—	0	0	—	NN	—	1	6	—	1
Mississippi	230	384	780	230	422	—	0	0	—	NN	—	0	3	—	3
Tennessee§	—	555	790	—	492	—	0	0	—	NN	—	1	5	—	2
W.S. Central	715	3,013	4,310	715	4,222	—	0	0	—	NN	—	7	28	—	1
Arkansas§	336	273	391	336	225	—	0	0	—	NN	—	0	3	—	—
Louisiana	378	310	1,073	378	1,073	—	0	0	—	NN	—	1	6	—	—
Oklahoma	1	254	1,374	1	1,339	—	0	0	—	NN	—	1	8	—	—
Texas§	—	2,240	3,183	—	1,585	—	0	0	—	NN	—	4	21	—	1
Mountain	466	1,438	1,913	466	950	111	0	111	111	NN	3	10	30	3	7
Arizona	87	509	706	87	3	110	0	110	110	NN	—	1	3	—	1
Colorado	185	338	560	185	427	—	0	0	—	NN	1	2	8	1	—
Idaho§	—	69	200	—	39	—	0	0	—	NN	2	2	7	2	2
Montana§	—	60	82	—	51	—	0	0	—	NN	—	1	4	—	2
Nevada§	—	172	329	—	158	—	0	0	—	NN	—	0	7	—	1
New Mexico§	122	150	274	122	35	—	0	0	—	NN	—	2	12	—	—
Utah	72	121	175	72	169	1	0	1	1	NN	—	1	5	—	1
Wyoming§	—	41	90	—	68	—	0	0	—	NN	—	0	2	—	—
Pacific	1,859	3,658	4,552	1,859	3,215	54	0	54	54	NN	4	12	28	4	11
Alaska	—	113	148	—	129	—	0	0	—	NN	—	0	1	—	—
California	1,426	2,771	3,563	1,426	2,469	54	0	54	54	NN	2	7	18	2	10
Hawaii	—	112	158	—	128	—	0	0	—	NN	—	0	1	—	—
Oregon	136	212	496	136	127	—	0	0	—	NN	2	3	13	2	1
Washington	297	406	661	297	362	—	0	0	—	NN	—	1	6	—	—
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	NN	N	0	0	N	NN
C.N.M.I.	—	—	—	—	—	—	—	—	—	NN	—	—	—	—	—
Guam	—	8	31	—	—	—	0	0	—	NN	—	0	0	—	—
Puerto Rico	116	92	265	116	76	—	0	0	—	NN	N	0	0	N	NN
U.S. Virgin Islands	—	11	29	—	6	—	0	0	—	NN	—	0	0	—	—

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	Dengue Virus Infection									
	Dengue Fever†					Dengue Hemorrhagic Fever§				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max		
United States	—	0	0	—	—	—	0	0	—	—
New England	—	0	0	—	—	—	0	0	—	—
Connecticut	—	0	0	—	—	—	0	0	—	—
Maine¶	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	0	—	—	—	0	0	—	—
New Hampshire	—	0	0	—	—	—	0	0	—	—
Rhode Island¶	—	0	0	—	—	—	0	0	—	—
Vermont¶	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	—	0	0	—	—	—	0	0	—	—
New Jersey	—	0	0	—	—	—	0	0	—	—
New York (Upstate)	—	0	0	—	—	—	0	0	—	—
New York City	—	0	0	—	—	—	0	0	—	—
Pennsylvania	—	0	0	—	—	—	0	0	—	—
E.N. Central	—	0	0	—	—	—	0	0	—	—
Illinois	—	0	0	—	—	—	0	0	—	—
Indiana	—	0	0	—	—	—	0	0	—	—
Michigan	—	0	0	—	—	—	0	0	—	—
Ohio	—	0	0	—	—	—	0	0	—	—
Wisconsin	—	0	0	—	—	—	0	0	—	—
W.N. Central	—	0	0	—	—	—	0	0	—	—
Iowa	—	0	0	—	—	—	0	0	—	—
Kansas	—	0	0	—	—	—	0	0	—	—
Minnesota	—	0	0	—	—	—	0	0	—	—
Missouri	—	0	0	—	—	—	0	0	—	—
Nebraska¶	—	0	0	—	—	—	0	0	—	—
North Dakota	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	0	—	—	—	0	0	—	—
S. Atlantic	—	0	0	—	—	—	0	0	—	—
Delaware	—	0	0	—	—	—	0	0	—	—
District of Columbia	—	0	0	—	—	—	0	0	—	—
Florida	—	0	0	—	—	—	0	0	—	—
Georgia	—	0	0	—	—	—	0	0	—	—
Maryland¶	—	0	0	—	—	—	0	0	—	—
North Carolina	—	0	0	—	—	—	0	0	—	—
South Carolina¶	—	0	0	—	—	—	0	0	—	—
Virginia¶	—	0	0	—	—	—	0	0	—	—
West Virginia	—	0	0	—	—	—	0	0	—	—
E.S. Central	—	0	0	—	—	—	0	0	—	—
Alabama¶	—	0	0	—	—	—	0	0	—	—
Kentucky	—	0	0	—	—	—	0	0	—	—
Mississippi	—	0	0	—	—	—	0	0	—	—
Tennessee¶	—	0	0	—	—	—	0	0	—	—
W.S. Central	—	0	0	—	—	—	0	0	—	—
Arkansas¶	—	0	0	—	—	—	0	0	—	—
Louisiana	—	0	0	—	—	—	0	0	—	—
Oklahoma	—	0	0	—	—	—	0	0	—	—
Texas¶	—	0	0	—	—	—	0	0	—	—
Mountain	—	0	0	—	—	—	0	0	—	—
Arizona	—	0	0	—	—	—	0	0	—	—
Colorado	—	0	0	—	—	—	0	0	—	—
Idaho¶	—	0	0	—	—	—	0	0	—	—
Montana¶	—	0	0	—	—	—	0	0	—	—
Nevada¶	—	0	0	—	—	—	0	0	—	—
New Mexico¶	—	0	0	—	—	—	0	0	—	—
Utah	—	0	0	—	—	—	0	0	—	—
Wyoming¶	—	0	0	—	—	—	0	0	—	—
Pacific	—	0	0	—	—	—	0	0	—	—
Alaska	—	0	0	—	—	—	0	0	—	—
California	—	0	0	—	—	—	0	0	—	—
Hawaii	—	0	0	—	—	—	0	0	—	—
Oregon	—	0	0	—	—	—	0	0	—	—
Washington	—	0	0	—	—	—	0	0	—	—
Territories										
American Samoa	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

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† Dengue Fever includes cases that meet criteria for Dengue Fever with hemorrhage, other clinical and unknown case classifications.
§ DHF includes cases that meet criteria for dengue shock syndrome (DSS), a more severe form of DHF.
¶ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	Ehrlichiosis/Anaplasmosis†														
	Ehrlichia chaffeensis					*Anaplasma phagocytophilum*					Undetermined				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010
United States	1	8	47	1	2	—	11	56	—	—	—	1	10	—	—
New England	—	0	1	—	—	—	1	8	—	—	—	0	2	—	—
Connecticut	—	0	0	—	—	—	0	5	—	—	—	0	2	—	—
Maine§	—	0	1	—	—	—	0	2	—	—	—	0	0	—	—
Massachusetts	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
New Hampshire	—	0	1	—	—	—	0	3	—	—	—	0	1	—	—
Rhode Island§	—	0	0	—	—	—	0	5	—	—	—	0	0	—	—
Vermont§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	—	1	5	—	—	—	4	12	—	—	—	0	1	—	—
New Jersey	—	0	0	—	—	—	0	1	—	—	—	0	0	—	—
New York (Upstate)	—	0	4	—	—	—	4	12	—	—	—	0	1	—	—
New York City	—	0	3	—	—	—	0	1	—	—	—	0	0	—	—
Pennsylvania	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
E.N. Central	—	0	4	—	—	—	4	39	—	—	—	0	7	—	—
Illinois	—	0	2	—	—	—	0	2	—	—	—	0	2	—	—
Indiana	—	0	0	—	—	—	0	0	—	—	—	0	3	—	—
Michigan	—	0	1	—	—	—	0	0	—	—	—	0	1	—	—
Ohio	—	0	3	—	—	—	0	1	—	—	—	0	0	—	—
Wisconsin	—	0	1	—	—	—	4	39	—	—	—	0	4	—	—
W.N. Central	—	1	13	—	—	—	0	3	—	—	—	0	3	—	—
Iowa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Kansas	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
Minnesota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Missouri	—	1	13	—	—	—	0	3	—	—	—	0	3	—	—
Nebraska§	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
S. Atlantic	1	3	19	1	2	—	1	7	—	—	—	0	2	—	—
Delaware	—	0	3	—	—	—	0	1	—	—	—	0	0	—	—
District of Columbia	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Florida	—	0	2	—	1	—	0	1	—	—	—	0	0	—	—
Georgia	1	0	4	1	1	—	0	1	—	—	—	0	1	—	—
Maryland§	—	0	3	—	—	—	0	2	—	—	—	0	2	—	—
North Carolina	—	1	13	—	—	—	0	4	—	—	—	0	0	—	—
South Carolina§	—	0	2	—	—	—	0	1	—	—	—	0	0	—	—
Virginia§	—	1	8	—	—	—	0	2	—	—	—	0	1	—	—
West Virginia	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
E.S. Central	—	0	10	—	—	—	0	2	—	—	—	0	1	—	—
Alabama§	—	0	3	—	—	—	0	2	—	—	—	0	0	—	—
Kentucky	—	0	2	—	—	—	0	0	—	—	—	0	0	—	—
Mississippi	—	0	1	—	—	—	0	1	—	—	—	0	0	—	—
Tennessee§	—	0	6	—	—	—	0	2	—	—	—	0	1	—	—
W.S. Central	—	0	5	—	—	—	0	2	—	—	—	0	1	—	—
Arkansas§	—	0	5	—	—	—	0	2	—	—	—	0	0	—	—
Louisiana	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
Oklahoma	—	0	5	—	—	—	0	1	—	—	—	0	0	—	—
Texas§	—	0	1	—	—	—	0	1	—	—	—	0	1	—	—
Mountain	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Arizona	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Colorado	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Idaho§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Montana§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Nevada§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
New Mexico§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Utah	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Wyoming§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Pacific	—	0	1	—	—	—	0	0	—	—	—	0	1	—	—
Alaska	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
California	—	0	1	—	—	—	0	0	—	—	—	0	1	—	—
Hawaii	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Oregon	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Washington	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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† Cumulative total *E. ewingii* cases reported for year 2010 = 10 and 0 case reports for 2011.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive† All ages, all serotypes				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	132	329	479	132	252	2,253	5,581	6,382	2,253	5,584	30	58	81	30	81
New England	1	32	54	1	32	46	100	196	46	61	—	3	8	—	5
Connecticut	—	5	13	—	8	—	39	169	—	2	—	0	6	—	—
Maine§	—	4	12	—	3	—	3	11	—	6	—	0	1	—	—
Massachusetts	—	13	24	—	16	42	47	80	42	42	—	2	5	—	3
New Hampshire	1	3	8	1	—	2	3	7	2	5	—	0	2	—	2
Rhode Island§	—	1	7	—	—	—	5	15	—	6	—	0	2	—	—
Vermont§	—	4	10	—	5	2	0	17	2	—	—	0	3	—	—
Mid. Atlantic	14	61	106	14	29	245	690	1,167	245	600	8	11	19	8	18
New Jersey	—	6	18	—	4	96	111	175	96	96	—	2	5	—	3
New York (Upstate)	2	22	54	2	5	36	108	203	36	35	—	3	7	—	1
New York City	2	17	33	2	10	—	238	531	—	274	—	2	6	—	5
Pennsylvania	10	15	27	10	10	113	255	366	113	195	8	4	9	8	9
E.N. Central	25	55	84	25	48	256	947	1,232	256	943	6	10	20	6	13
Illinois	—	11	26	—	12	7	189	278	7	248	—	3	7	—	4
Indiana	—	5	14	—	3	—	99	222	—	59	—	1	6	—	3
Michigan	1	13	25	1	13	159	254	471	159	249	—	0	3	—	—
Ohio	22	17	29	22	16	66	315	381	66	333	6	2	6	6	2
Wisconsin	2	8	32	2	4	24	94	155	24	54	—	2	5	—	4
W.N. Central	13	24	101	13	25	92	286	348	92	271	—	3	14	—	7
Iowa	—	5	11	—	7	6	33	57	6	51	—	0	1	—	—
Kansas	1	4	10	1	7	7	40	62	7	36	—	0	2	—	1
Minnesota	—	0	75	—	—	—	37	62	—	42	—	0	9	—	—
Missouri	8	8	26	8	4	55	141	180	55	118	—	2	6	—	6
Nebraska§	4	4	9	4	4	23	22	48	23	16	—	0	3	—	—
North Dakota	—	0	5	—	—	—	1	8	—	—	—	0	2	—	—
South Dakota	—	1	7	—	3	1	7	20	1	8	—	0	0	—	—
S. Atlantic	38	69	101	38	35	939	1,345	1,790	939	1,348	7	14	26	7	22
Delaware	—	0	5	—	1	23	18	48	23	11	—	0	1	—	—
District of Columbia	—	1	5	—	—	30	34	66	30	26	—	0	1	—	—
Florida	28	41	75	28	21	216	391	490	216	454	5	3	9	5	3
Georgia	—	6	51	—	2	—	205	392	—	56	2	3	9	2	4
Maryland§	4	5	11	4	2	108	132	216	108	66	—	1	5	—	1
North Carolina	N	0	0	N	N	379	245	596	379	392	—	2	9	—	4
South Carolina§	—	2	9	—	2	—	153	262	—	144	—	1	7	—	7
Virginia§	6	9	19	6	7	163	150	223	163	192	—	2	4	—	3
West Virginia	—	0	6	—	—	20	10	26	20	7	—	0	3	—	—
E.S. Central	—	5	12	—	5	80	468	697	80	460	5	3	9	5	3
Alabama§	—	4	11	—	3	—	152	217	—	150	3	0	3	3	—
Kentucky	N	0	0	N	N	—	73	142	—	17	—	1	3	—	2
Mississippi	N	0	0	N	N	80	115	216	80	150	—	0	2	—	—
Tennessee§	—	0	6	—	2	—	137	195	—	143	2	2	9	2	1
W.S. Central	—	7	14	—	8	181	835	1,298	181	1,206	—	2	10	—	2
Arkansas§	—	2	7	—	1	105	80	133	105	73	—	0	3	—	—
Louisiana	—	3	8	—	4	75	90	351	75	351	—	0	4	—	2
Oklahoma	—	1	5	—	3	1	75	359	1	359	—	1	7	—	—
Texas§	N	0	0	N	N	—	599	959	—	423	—	0	1	—	—
Mountain	10	31	51	10	24	104	177	235	104	88	2	5	15	2	10
Arizona	—	3	8	—	5	18	60	100	18	—	—	2	10	—	4
Colorado	8	13	27	8	8	47	54	95	47	52	1	1	5	1	1
Idaho§	2	4	9	2	2	—	2	14	—	2	—	0	2	—	—
Montana§	—	2	7	—	1	—	2	6	—	2	—	0	1	—	—
Nevada§	—	1	11	—	—	—	29	94	—	27	—	0	2	—	—
New Mexico§	—	2	5	—	—	38	20	35	38	3	1	1	5	1	5
Utah	—	4	11	—	8	1	5	15	1	2	—	0	4	—	—
Wyoming§	—	1	7	—	—	—	0	4	—	—	—	0	2	—	—
Pacific	31	53	80	31	46	310	608	815	310	607	2	2	21	2	1
Alaska	—	2	6	—	2	—	24	37	—	22	—	0	2	—	1
California	24	33	57	24	37	263	496	691	263	511	1	0	18	1	—
Hawaii	—	0	4	—	—	—	14	26	—	18	—	0	2	—	—
Oregon	7	9	20	7	7	14	19	34	14	12	1	1	5	1	—
Washington	—	9	21	—	—	33	53	83	33	44	—	0	2	—	—
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	—	—	—	0	5	—	—	—	0	0	—	—
Puerto Rico	—	1	8	—	—	4	5	14	4	2	—	0	1	—	—
U.S. Virgin Islands	—	0	0	—	—	—	2	7	—	1	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Data for H. influenzae (age <5 yrs for serotype b, nonserotype b, and unknown serotype) are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	Hepatitis (viral, acute), by type														
	A					B					C				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	6	30	43	6	29	17	60	90	17	39	6	14	25	6	14
New England	—	2	5	—	2	—	1	5	—	3	—	1	4	—	2
Connecticut	—	0	3	—	—	—	0	2	—	2	—	0	4	—	1
Maine†	—	0	1	—	—	—	0	2	—	—	—	0	0	—	—
Massachusetts	—	1	5	—	2	—	0	2	—	1	—	0	2	—	1
New Hampshire	—	0	1	—	—	—	0	2	—	—	N	0	0	N	N
Rhode Island†	—	0	4	—	—	U	0	0	U	U	U	0	0	U	U
Vermont†	—	0	0	—	—	—	0	1	—	—	—	0	1	—	—
Mid. Atlantic	—	4	10	—	5	1	5	10	1	3	—	2	6	—	1
New Jersey	—	0	2	—	1	—	1	5	—	—	—	0	2	—	—
New York (Upstate)	—	1	4	—	—	—	1	6	—	—	—	1	4	—	1
New York City	—	1	7	—	2	—	1	4	—	2	—	0	1	—	—
Pennsylvania	—	1	4	—	2	1	1	5	1	1	—	0	3	—	—
E.N. Central	1	4	9	1	4	—	9	17	—	6	—	2	7	—	2
Illinois	—	1	3	—	1	—	2	5	—	1	—	0	1	—	—
Indiana	—	0	2	—	—	—	1	5	—	1	—	0	2	—	—
Michigan	—	1	5	—	—	—	3	6	—	2	—	1	6	—	2
Ohio	1	1	5	1	1	—	2	6	—	—	—	0	1	—	—
Wisconsin	—	0	3	—	2	—	2	8	—	2	—	0	2	—	—
W.N. Central	1	1	13	1	3	1	2	7	1	—	—	0	8	—	—
Iowa	1	0	3	1	1	—	0	2	—	—	—	0	0	—	—
Kansas	—	0	2	—	—	—	0	2	—	—	—	0	1	—	—
Minnesota	—	0	12	—	—	—	0	4	—	—	—	0	6	—	—
Missouri	—	0	2	—	1	—	1	3	—	—	—	0	2	—	—
Nebraska†	—	0	4	—	1	1	0	2	1	—	—	0	1	—	—
North Dakota	—	0	3	—	—	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	1	—	—	—	0	1	—	—	—	0	0	—	—
S. Atlantic	2	6	14	2	6	6	16	32	6	11	2	2	6	2	4
Delaware	—	0	1	—	—	—	0	2	—	1	U	0	0	U	U
District of Columbia	—	0	1	—	—	—	0	1	—	—	—	0	1	—	—
Florida	1	3	7	1	1	5	5	11	5	5	—	0	0	—	—
Georgia	1	1	3	1	2	—	3	7	—	3	—	0	2	—	—
Maryland†	—	0	3	—	—	—	1	6	—	—	2	0	3	2	2
North Carolina	—	0	5	—	—	—	1	16	—	1	—	1	3	—	2
South Carolina†	—	0	3	—	3	—	1	4	—	—	—	0	1	—	—
Virginia†	—	1	6	—	—	1	1	6	1	1	—	0	2	—	—
West Virginia	—	0	5	—	—	—	0	12	—	—	—	0	5	—	—
E.S. Central	—	1	5	—	—	7	8	13	7	8	3	3	8	3	1
Alabama†	—	0	2	—	—	—	1	4	—	2	—	0	1	—	—
Kentucky	—	0	5	—	—	4	2	8	4	2	2	2	6	2	1
Mississippi	—	0	1	—	—	—	0	3	—	—	U	0	0	U	U
Tennessee†	—	0	2	—	—	3	2	8	3	4	1	1	4	1	—
W.S. Central	—	2	7	—	—	—	9	29	—	2	—	1	5	—	—
Arkansas†	—	0	1	—	—	—	0	4	—	—	—	0	0	—	—
Louisiana	—	0	2	—	—	—	1	3	—	2	—	0	1	—	—
Oklahoma	—	0	1	—	—	—	2	6	—	—	—	0	3	—	—
Texas†	—	2	7	—	—	—	5	25	—	—	—	0	3	—	—
Mountain	—	3	8	—	4	—	2	8	—	5	1	1	5	1	—
Arizona	—	1	4	—	3	—	0	2	—	1	U	0	0	U	U
Colorado	—	1	3	—	—	—	0	5	—	1	1	0	1	1	—
Idaho†	—	0	2	—	—	—	0	1	—	—	—	0	2	—	—
Montana†	—	0	1	—	—	—	0	1	—	—	—	0	1	—	—
Nevada†	—	0	2	—	—	—	0	3	—	3	—	0	1	—	—
New Mexico†	—	0	1	—	—	—	0	1	—	—	—	0	2	—	—
Utah	—	0	1	—	1	—	0	1	—	—	—	0	2	—	—
Wyoming†	—	0	3	—	—	—	0	1	—	—	—	0	0	—	—
Pacific	2	5	17	2	5	2	6	17	2	1	—	1	4	—	4
Alaska	—	0	1	—	—	—	0	1	—	—	U	0	0	U	U
California	2	4	16	2	5	—	4	16	—	1	—	0	4	—	4
Hawaii	—	0	1	—	—	—	0	1	—	—	U	0	0	U	U
Oregon	—	0	2	—	—	2	1	3	2	—	—	0	3	—	—
Washington	—	0	2	—	—	—	1	4	—	—	—	0	3	—	—
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	6	—	—	—	1	6	—	—	—	0	7	—	—
Puerto Rico	—	0	2	—	—	—	0	2	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for HIV/AIDS, AIDS and TB, when available, are displayed in Table IV, which appears quarterly.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	Legionellosis					Lyme disease					Malaria				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	20	56	114	20	36	35	383	1,655	35	267	7	26	80	7	17
New England	—	3	15	—	3	—	119	495	—	79	—	1	4	—	—
Connecticut	—	1	6	—	—	—	42	211	—	43	—	0	1	—	—
Maine†	—	0	4	—	—	—	11	65	—	—	—	0	1	—	—
Massachusetts	—	2	10	—	2	—	39	216	—	27	—	1	3	—	—
New Hampshire	—	0	5	—	—	—	24	68	—	7	—	0	2	—	—
Rhode Island†	—	0	4	—	1	—	1	40	—	—	—	0	1	—	—
Vermont†	—	0	2	—	—	—	4	27	—	2	—	0	1	—	—
Mid. Atlantic	2	14	47	2	8	16	171	737	16	120	—	7	17	—	6
New Jersey	—	1	11	—	3	—	49	220	—	35	—	0	1	—	—
New York (Upstate)	—	5	19	—	1	1	38	200	1	1	—	1	6	—	2
New York City	—	2	17	—	2	—	2	7	—	4	—	4	14	—	2
Pennsylvania	2	6	18	2	2	15	86	383	15	80	—	1	3	—	2
E.N. Central	3	12	44	3	8	—	24	323	—	12	1	2	9	1	2
Illinois	—	1	15	—	1	—	1	17	—	—	—	1	7	—	1
Indiana	—	2	6	—	—	—	1	7	—	—	—	0	2	—	—
Michigan	—	2	20	—	1	—	1	13	—	—	—	0	4	—	—
Ohio	3	4	15	3	5	—	0	9	—	—	1	1	5	1	1
Wisconsin	—	1	11	—	1	—	21	296	—	12	—	0	1	—	—
W.N. Central	1	2	9	1	1	—	1	11	—	—	—	1	4	—	1
Iowa	—	0	2	—	—	—	0	10	—	—	—	0	2	—	1
Kansas	—	0	2	—	—	—	0	1	—	—	—	0	2	—	—
Minnesota	—	0	8	—	—	—	0	0	—	—	—	0	3	—	—
Missouri	1	0	4	1	1	—	0	1	—	—	—	0	3	—	—
Nebraska†	—	0	2	—	—	—	0	2	—	—	—	0	2	—	—
North Dakota	—	0	1	—	—	—	0	5	—	—	—	0	1	—	—
South Dakota	—	0	2	—	—	—	0	1	—	—	—	0	2	—	—
S. Atlantic	4	10	27	4	7	16	56	174	16	53	6	7	44	6	6
Delaware	—	0	3	—	1	3	11	32	3	11	—	0	1	—	—
District of Columbia	—	0	4	—	—	—	0	4	—	—	—	0	2	—	—
Florida	2	3	9	2	1	1	2	10	1	2	2	3	7	2	—
Georgia	—	1	4	—	—	—	0	2	—	1	2	0	6	2	1
Maryland†	2	2	6	2	4	6	24	101	6	17	—	1	24	—	3
North Carolina	—	0	7	—	—	—	1	9	—	—	—	0	13	—	—
South Carolina†	—	0	2	—	—	—	0	3	—	—	—	0	1	—	—
Virginia†	—	1	10	—	1	6	17	76	6	21	2	1	5	2	2
West Virginia	—	0	3	—	—	—	0	29	—	1	—	0	1	—	—
E.S. Central	2	2	10	2	1	—	0	4	—	1	—	0	3	—	1
Alabama†	—	0	2	—	—	—	0	1	—	—	—	0	1	—	1
Kentucky	1	0	4	1	—	—	0	1	—	—	—	0	1	—	—
Mississippi	—	0	3	—	—	—	0	0	—	—	—	0	2	—	—
Tennessee†	1	1	6	1	1	—	0	4	—	1	—	0	2	—	—
W.S. Central	1	3	8	1	1	—	2	8	—	1	—	1	7	—	—
Arkansas†	—	0	2	—	—	—	0	0	—	—	—	0	1	—	—
Louisiana	—	0	2	—	1	—	0	1	—	—	—	0	1	—	—
Oklahoma	—	0	3	—	—	—	0	0	—	—	—	0	1	—	—
Texas†	1	2	7	1	—	—	2	7	—	1	—	1	7	—	—
Mountain	—	3	10	—	3	—	0	3	—	—	—	1	4	—	1
Arizona	—	1	6	—	1	—	0	1	—	—	—	0	2	—	—
Colorado	—	0	5	—	1	—	0	1	—	—	—	0	3	—	—
Idaho†	—	0	1	—	—	—	0	2	—	—	—	0	1	—	—
Montana†	—	0	1	—	—	—	0	1	—	—	—	0	1	—	—
Nevada†	—	0	2	—	1	—	0	1	—	—	—	0	1	—	—
New Mexico†	—	0	2	—	—	—	0	2	—	—	—	0	1	—	—
Utah	—	0	2	—	—	—	0	1	—	—	—	0	1	—	1
Wyoming†	—	0	2	—	—	—	0	0	—	—	—	0	0	—	—
Pacific	7	4	19	7	4	3	4	10	3	1	—	3	10	—	—
Alaska	—	0	2	—	—	—	0	1	—	—	—	0	1	—	—
California	7	4	19	7	4	3	3	7	3	—	—	2	9	—	—
Hawaii	—	0	1	—	—	N	0	0	N	N	—	0	1	—	—
Oregon	—	0	3	—	—	—	1	4	—	1	—	0	3	—	—
Washington	—	0	4	—	—	—	0	3	—	—	—	0	5	—	—
Territories															
American Samoa	—	0	0	—	—	N	0	0	N	N	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	N	0	0	N	N	—	0	2	—	1
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	Meningococcal disease, invasive† All serogroups					Mumps					Pertussis				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	10	15	26	10	18	3	30	221	3	29	136	449	780	136	129
New England	1	0	3	1	—	—	0	4	—	—	—	8	22	—	2
Connecticut	1	0	1	1	—	—	0	2	—	—	—	1	8	—	—
Maine§	—	0	1	—	—	—	0	1	—	—	—	1	5	—	—
Massachusetts	—	0	2	—	—	—	0	2	—	—	—	5	13	—	1
New Hampshire	—	0	0	—	—	—	0	1	—	—	—	0	2	—	—
Rhode Island§	—	0	0	—	—	—	0	0	—	—	—	0	9	—	—
Vermont§	—	0	1	—	—	—	0	0	—	—	—	0	4	—	1
Mid. Atlantic	3	1	4	3	2	—	22	209	—	26	10	37	142	10	8
New Jersey	—	0	2	—	—	—	4	24	—	19	—	3	9	—	2
New York (Upstate)	—	0	2	—	—	—	3	99	—	7	2	11	77	2	—
New York City	1	0	2	1	1	—	1	201	—	—	—	0	9	—	—
Pennsylvania	2	0	2	2	1	—	0	16	—	—	8	14	69	8	6
E.N. Central	2	2	9	2	8	2	1	6	2	3	51	108	180	51	60
Illinois	—	0	3	—	2	—	0	2	—	1	1	20	49	1	9
Indiana	—	0	3	—	3	—	0	1	—	—	—	12	26	—	8
Michigan	—	0	4	—	2	—	0	2	—	2	11	28	57	11	13
Ohio	2	0	2	2	1	2	0	5	2	—	37	33	80	37	19
Wisconsin	—	0	3	—	—	—	0	2	—	—	2	9	21	2	11
W.N. Central	1	1	5	1	—	1	1	14	1	—	16	33	193	16	13
Iowa	—	0	3	—	—	—	0	7	—	—	—	12	34	—	2
Kansas	—	0	2	—	—	—	0	1	—	—	—	3	9	—	2
Minnesota	—	0	1	—	—	—	0	1	—	—	—	0	143	—	—
Missouri	1	0	4	1	—	—	0	2	—	—	10	8	44	10	4
Nebraska§	—	0	2	—	—	1	0	10	1	—	6	4	13	6	3
North Dakota	—	0	1	—	—	—	0	1	—	—	—	0	30	—	—
South Dakota	—	0	0	—	—	—	0	1	—	—	—	0	5	—	2
S. Atlantic	1	2	7	1	4	—	1	4	—	—	15	30	79	15	15
Delaware	—	0	1	—	—	—	0	0	—	—	—	0	4	—	—
District of Columbia	—	0	0	—	—	—	0	1	—	—	—	0	2	—	—
Florida	1	1	5	1	3	—	0	3	—	—	3	6	28	3	6
Georgia	—	0	2	—	1	—	0	1	—	—	—	4	18	—	1
Maryland§	—	0	1	—	—	—	0	1	—	—	1	3	8	1	2
North Carolina	—	0	2	—	—	—	0	0	—	—	—	0	32	—	3
South Carolina§	—	0	1	—	—	—	0	2	—	—	8	6	22	8	1
Virginia§	—	0	2	—	—	—	0	2	—	—	3	5	34	3	1
West Virginia	—	0	1	—	—	—	0	1	—	—	—	1	21	—	1
E.S. Central	—	1	3	—	2	—	0	2	—	—	10	16	34	10	9
Alabama§	—	0	1	—	1	—	0	2	—	—	—	4	8	—	—
Kentucky	—	0	2	—	1	—	0	1	—	—	9	6	16	9	5
Mississippi	—	0	1	—	—	—	0	0	—	—	—	1	8	—	1
Tennessee§	—	0	2	—	—	—	0	1	—	—	1	4	11	1	3
W.S. Central	—	1	9	—	1	—	1	11	—	—	—	54	113	—	3
Arkansas§	—	0	1	—	1	—	0	1	—	—	—	3	14	—	—
Louisiana	—	0	4	—	—	—	0	2	—	—	—	1	3	—	2
Oklahoma	—	0	7	—	—	—	0	0	—	—	—	0	23	—	—
Texas§	—	1	4	—	—	—	1	11	—	—	—	49	108	—	1
Mountain	1	1	6	1	1	—	0	4	—	—	25	29	123	25	15
Arizona	—	0	2	—	1	—	0	1	—	—	—	7	16	—	8
Colorado	—	0	4	—	—	—	0	1	—	—	25	5	108	25	1
Idaho§	1	0	1	1	—	—	0	1	—	—	—	2	15	—	3
Montana§	—	0	1	—	—	—	0	0	—	—	—	1	16	—	—
Nevada§	—	0	1	—	—	—	0	1	—	—	—	0	7	—	—
New Mexico§	—	0	1	—	—	—	0	2	—	—	—	2	11	—	2
Utah	—	0	1	—	—	—	0	1	—	—	—	4	13	—	1
Wyoming§	—	0	1	—	—	—	0	1	—	—	—	0	2	—	—
Pacific	1	3	9	1	—	—	0	18	—	—	9	66	222	9	4
Alaska	—	0	1	—	—	—	0	1	—	—	—	0	6	—	1
California	—	2	9	—	—	—	0	18	—	—	9	41	194	9	—
Hawaii	—	0	1	—	—	—	0	1	—	—	—	0	6	—	—
Oregon	1	1	2	1	—	—	0	1	—	—	—	6	15	—	3
Washington	—	0	4	—	—	—	0	2	—	—	—	6	38	—	—
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	1	15	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	1	—	—	—	0	1	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Data for meningococcal disease, invasive caused by serogroups A, C, Y, and W-135; serogroup B; other serogroup; and unknown serogroup are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	Rabies, animal					Salmonellosis					Shiga toxin-producing *E. coli* (STEC)†				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	10	62	143	10	36	238	876	1,736	238	990	38	87	212	38	90
New England	1	4	13	1	5	3	31	496	3	496	—	2	57	—	57
Connecticut	—	0	9	—	—	—	0	480	—	480	—	0	57	—	57
Maine§	1	1	4	1	1	2	2	7	2	—	—	0	3	—	—
Massachusetts	—	0	0	—	—	—	22	52	—	11	—	1	9	—	—
New Hampshire	—	0	5	—	1	—	3	12	—	3	—	0	2	—	—
Rhode Island§	—	0	4	—	—	—	2	17	—	2	—	0	1	—	—
Vermont§	—	1	3	—	3	1	1	5	1	—	—	0	2	—	—
Mid. Atlantic	8	19	41	8	11	17	95	218	17	68	—	9	32	—	4
New Jersey	—	0	0	—	—	—	17	57	—	19	—	1	9	—	1
New York (Upstate)	8	9	19	8	5	3	25	63	3	—	—	3	13	—	—
New York City	—	1	12	—	—	1	25	56	1	26	—	1	7	—	1
Pennsylvania	—	8	24	—	6	13	31	81	13	23	—	2	13	—	2
E.N. Central	1	2	27	1	1	22	86	244	22	74	1	10	43	1	13
Illinois	1	1	11	1	—	—	28	114	—	23	—	1	9	—	4
Indiana	—	0	0	—	—	—	11	62	—	12	—	1	10	—	1
Michigan	—	1	5	—	—	4	15	49	4	11	—	2	16	—	1
Ohio	—	0	12	—	1	18	24	47	18	22	1	2	11	1	2
Wisconsin	—	0	0	—	—	—	9	45	—	6	—	3	17	—	5
W.N. Central	—	4	14	—	—	17	46	97	17	15	3	11	39	3	3
Iowa	—	0	3	—	—	3	9	34	3	2	—	2	16	—	—
Kansas	—	1	4	—	—	2	7	18	2	3	—	1	5	—	2
Minnesota	—	0	4	—	—	—	0	32	—	—	—	0	7	—	—
Missouri	—	1	6	—	—	9	13	44	9	9	—	4	27	—	1
Nebraska§	—	1	4	—	—	3	4	13	3	1	3	1	6	3	—
North Dakota	—	0	3	—	—	—	0	13	—	—	—	0	10	—	—
South Dakota	—	0	0	—	—	—	3	17	—	—	—	0	4	—	—
S. Atlantic	—	20	104	—	13	91	258	611	91	169	15	13	30	15	4
Delaware	—	0	0	—	—	1	3	11	1	2	—	0	2	—	—
District of Columbia	—	0	0	—	—	—	1	6	—	—	—	0	1	—	—
Florida	—	0	96	—	—	48	108	226	48	87	8	4	23	8	1
Georgia	—	0	0	—	—	22	43	132	22	44	1	1	15	1	2
Maryland§	—	6	14	—	4	6	17	55	6	15	4	2	9	4	1
North Carolina	—	0	0	—	—	—	32	240	—	1	—	1	10	—	—
South Carolina§	—	0	0	—	—	—	24	99	—	9	—	0	2	—	—
Virginia§	—	10	25	—	8	14	19	57	14	11	2	2	9	2	—
West Virginia	—	1	7	—	1	—	2	13	—	—	—	0	3	—	—
E.S. Central	—	3	7	—	1	18	55	177	18	42	5	5	22	5	2
Alabama§	—	1	4	—	—	2	19	52	2	18	1	1	4	1	2
Kentucky	—	0	4	—	—	10	11	32	10	5	1	1	6	1	—
Mississippi	—	0	1	—	—	1	18	67	1	9	—	0	12	—	—
Tennessee§	—	1	4	—	1	5	15	53	5	10	3	2	7	3	—
W.S. Central	—	0	30	—	—	4	105	261	4	24	—	5	15	—	1
Arkansas§	—	0	7	—	—	2	12	43	2	—	—	1	5	—	—
Louisiana	—	0	0	—	—	2	20	49	2	15	—	0	2	—	1
Oklahoma	—	0	30	—	—	—	12	39	—	1	—	0	8	—	—
Texas§	—	0	0	—	—	—	63	170	—	8	—	3	14	—	—
Mountain	—	1	7	—	2	16	49	108	16	49	1	11	34	1	3
Arizona	—	0	0	—	—	—	16	42	—	21	—	1	13	—	1
Colorado	—	0	0	—	—	14	10	24	14	8	—	3	21	—	2
Idaho§	—	0	2	—	—	2	3	9	2	5	1	2	7	1	—
Montana§	—	0	3	—	—	—	1	7	—	7	—	1	5	—	—
Nevada§	—	0	2	—	—	—	4	22	—	3	—	0	5	—	—
New Mexico§	—	0	2	—	—	—	6	19	—	4	—	1	6	—	—
Utah	—	0	2	—	—	—	6	17	—	1	—	1	7	—	—
Wyoming§	—	0	4	—	2	—	1	8	—	—	—	0	3	—	—
Pacific	—	2	12	—	3	50	114	253	50	53	13	11	36	13	3
Alaska	—	0	2	—	2	—	1	5	—	1	—	0	1	—	—
California	—	1	12	—	1	50	79	217	50	50	13	6	20	13	3
Hawaii	—	0	0	—	—	—	3	14	—	—	—	0	4	—	—
Oregon	—	0	2	—	—	—	8	48	—	2	—	2	14	—	—
Washington	—	0	0	—	—	—	15	33	—	—	—	3	19	—	—
Territories															
American Samoa	N	0	0	N	N	—	0	1	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	2	—	—	—	0	0	—	—
Puerto Rico	—	1	3	—	—	—	10	21	—	8	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Includes E. coli O157:H7; Shiga toxin-positive, serogroup non-O157; and Shiga toxin-positive, not serogrouped.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	Shigellosis					Spotted Fever Rickettsiosis (including RMSF)†									
						Confirmed					Probable				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010
United States	87	267	452	87	252	—	2	11	—	2	—	23	91	—	1
New England	—	4	68	—	68	—	0	0	—	—	—	0	1	—	—
Connecticut	—	0	63	—	63	—	0	0	—	—	—	0	0	—	—
Maine§	—	0	1	—	—	—	0	0	—	—	—	0	1	—	—
Massachusetts	—	4	16	—	5	—	0	0	—	—	—	0	0	—	—
New Hampshire	—	0	2	—	—	—	0	0	—	—	—	0	1	—	—
Rhode Island§	—	0	2	—	—	—	0	0	—	—	—	0	0	—	—
Vermont§	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	1	33	62	1	39	—	0	1	—	—	—	1	4	—	—
New Jersey	—	6	16	—	6	—	0	0	—	—	—	0	0	—	—
New York (Upstate)	—	3	15	—	1	—	0	1	—	—	—	0	3	—	—
New York City	1	5	14	1	9	—	0	1	—	—	—	0	4	—	—
Pennsylvania	—	12	55	—	23	—	0	1	—	—	—	0	3	—	—
E.N. Central	4	26	238	4	24	—	0	1	—	—	—	1	10	—	—
Illinois	—	9	228	—	12	—	0	1	—	—	—	0	5	—	—
Indiana§	—	1	4	—	—	—	0	1	—	—	—	0	5	—	—
Michigan	—	5	10	—	1	—	0	0	—	—	—	0	1	—	—
Ohio	4	5	18	4	6	—	0	0	—	—	—	0	2	—	—
Wisconsin	—	4	21	—	5	—	0	0	—	—	—	0	1	—	—
W.N. Central	12	39	81	12	59	—	0	4	—	—	—	4	21	—	—
Iowa	—	1	5	—	5	—	0	0	—	—	—	0	1	—	—
Kansas§	2	5	13	2	1	—	0	1	—	—	—	0	0	—	—
Minnesota	—	0	3	—	—	—	0	0	—	—	—	0	0	—	—
Missouri	10	31	66	10	53	—	0	4	—	—	—	4	20	—	—
Nebraska§	—	1	10	—	—	—	0	1	—	—	—	0	1	—	—
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	1	—	—
South Dakota	—	0	2	—	—	—	0	0	—	—	—	0	0	—	—
S. Atlantic	39	51	134	39	25	—	1	9	—	1	—	8	60	—	1
Delaware§	—	0	4	—	2	—	0	1	—	—	—	0	3	—	—
District of Columbia	—	0	4	—	—	—	0	1	—	—	—	0	0	—	—
Florida§	31	22	53	31	3	—	0	1	—	—	—	0	2	—	—
Georgia	6	14	39	6	15	—	1	6	—	1	—	0	0	—	—
Maryland§	1	2	8	1	—	—	0	1	—	—	—	0	5	—	—
North Carolina	—	3	36	—	2	—	0	3	—	—	—	2	48	—	—
South Carolina§	—	1	5	—	3	—	0	1	—	—	—	0	2	—	1
Virginia§	1	3	8	1	—	—	0	2	—	—	—	2	12	—	—
West Virginia	—	0	66	—	—	—	0	0	—	—	—	0	0	—	—
E.S. Central	4	13	40	4	6	—	0	3	—	—	—	5	29	—	—
Alabama§	1	4	14	1	1	—	0	1	—	—	—	1	8	—	—
Kentucky	2	3	28	2	—	—	0	2	—	—	—	0	0	—	—
Mississippi	—	1	4	—	1	—	0	0	—	—	—	0	3	—	—
Tennessee§	1	5	14	1	4	—	0	2	—	—	—	4	20	—	—
W.S. Central	1	51	108	1	5	—	0	3	—	—	—	1	18	—	—
Arkansas§	—	1	6	—	1	—	0	2	—	—	—	0	17	—	—
Louisiana	—	5	13	—	3	—	0	0	—	—	—	0	1	—	—
Oklahoma	—	5	13	—	—	—	0	3	—	—	—	0	6	—	—
Texas§	1	38	87	1	1	—	0	1	—	—	—	0	3	—	—
Mountain	13	15	32	13	10	—	0	5	—	—	—	0	4	—	—
Arizona	4	8	18	4	3	—	0	4	—	—	—	0	4	—	—
Colorado§	8	2	6	8	3	—	0	1	—	—	—	0	1	—	—
Idaho§	1	0	3	1	—	—	0	0	—	—	—	0	1	—	—
Montana§	—	0	1	—	—	—	0	1	—	—	—	0	1	—	—
Nevada§	—	0	6	—	—	—	0	0	—	—	—	0	0	—	—
New Mexico§	—	2	10	—	2	—	0	0	—	—	—	0	1	—	—
Utah	—	1	4	—	2	—	0	0	—	—	—	0	1	—	—
Wyoming§	—	0	0	—	—	—	0	0	—	—	—	0	1	—	—
Pacific	13	21	58	13	16	—	0	2	—	1	—	0	0	—	—
Alaska	—	0	1	—	—	N	0	0	N	N	N	0	0	N	N
California	13	17	50	13	16	—	0	2	—	1	—	0	0	—	—
Hawaii	—	0	3	—	—	N	0	0	N	N	N	0	0	N	N
Oregon	—	1	4	—	—	—	0	1	—	—	—	0	0	—	—
Washington	—	1	17	—	—	—	0	0	—	—	—	0	0	—	—
Territories															
American Samoa	—	1	1	—	—	N	0	0	N	N	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	—	—	N	0	0	N	N	N	0	0	N	N
Puerto Rico	—	0	1	—	—	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	*Streptococcus pneumoniae*,† invasive disease										Syphilis, primary and secondary				
	All ages					Age <5									
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	253	267	495	253	430	12	42	84	12	60	40	243	317	40	194
New England	3	9	99	3	11	—	1	14	—	1	4	9	20	4	2
Connecticut	—	0	91	—	—	—	0	12	—	—	—	1	8	—	—
Maine§	3	2	6	3	4	—	0	1	—	1	—	0	3	—	—
Massachusetts	—	1	5	—	—	—	0	4	—	—	3	5	15	3	2
New Hampshire	—	0	7	—	4	—	0	1	—	—	—	0	2	—	—
Rhode Island§	—	0	36	—	—	—	0	3	—	—	1	1	4	1	—
Vermont§	—	1	6	—	3	—	0	1	—	—	—	0	2	—	—
Mid. Atlantic	24	28	56	24	31	—	7	19	—	8	7	32	45	7	26
New Jersey	—	2	8	—	2	—	1	5	—	1	3	4	12	3	4
New York (Upstate)	1	3	7	1	4	—	2	7	—	1	3	2	8	3	—
New York City	6	11	32	6	6	—	2	14	—	1	—	19	31	—	20
Pennsylvania	17	10	22	17	19	—	1	5	—	5	1	7	16	1	2
E.N. Central	55	59	98	55	95	1	6	18	1	10	1	27	48	1	21
Illinois	—	2	7	—	2	—	2	5	—	2	—	8	26	—	12
Indiana	—	9	24	—	18	—	1	6	—	1	—	3	14	—	—
Michigan	7	13	27	7	26	—	1	6	—	4	—	4	12	—	4
Ohio	44	25	49	44	43	1	2	6	1	3	1	9	19	1	5
Wisconsin	4	7	22	4	6	—	0	4	—	—	—	1	3	—	—
W.N. Central	6	10	61	6	9	1	1	12	1	1	1	6	18	1	3
Iowa	—	0	0	—	—	—	0	0	—	—	—	0	3	—	—
Kansas	2	2	7	2	—	—	0	2	—	—	—	0	3	—	—
Minnesota	—	0	46	—	—	—	0	8	—	—	—	2	9	—	1
Missouri	2	2	10	2	3	—	1	4	—	—	1	3	9	1	2
Nebraska§	2	2	9	2	5	1	0	2	1	1	—	0	2	—	—
North Dakota	—	0	11	—	—	—	0	1	—	—	—	0	0	—	—
South Dakota	—	0	3	—	1	—	0	2	—	—	—	0	1	—	—
S. Atlantic	105	62	144	105	126	8	9	27	8	18	23	56	103	23	39
Delaware	2	1	3	2	1	—	0	0	—	—	—	0	4	—	—
District of Columbia	—	0	3	—	1	—	0	2	—	1	2	2	20	2	1
Florida	65	25	89	65	45	4	3	18	4	3	4	21	44	4	11
Georgia	16	9	28	16	28	2	2	9	2	7	—	9	29	—	2
Maryland§	22	9	31	22	25	2	1	6	2	2	5	6	14	5	2
North Carolina	—	0	0	—	—	—	0	0	—	—	8	6	22	8	8
South Carolina§	—	8	25	—	25	—	1	4	—	4	—	3	7	—	4
Virginia§	—	1	4	—	1	—	1	4	—	1	4	5	22	4	11
West Virginia	—	2	9	—	—	—	0	4	—	—	—	0	2	—	—
E.S. Central	18	24	50	18	50	2	2	7	2	6	—	16	39	—	10
Alabama§	—	0	0	—	—	—	0	0	—	—	—	5	11	—	6
Kentucky	5	3	16	5	2	1	0	2	1	—	—	2	12	—	—
Mississippi	—	1	8	—	4	—	0	2	—	1	—	4	16	—	—
Tennessee§	13	20	44	13	44	1	2	6	1	5	—	5	17	—	4
W.S. Central	6	35	109	6	17	—	5	21	—	4	1	37	63	1	33
Arkansas§	—	3	19	—	2	—	0	3	—	—	1	3	12	1	—
Louisiana	1	2	8	1	5	—	0	3	—	3	—	8	28	—	14
Oklahoma	—	1	5	—	1	—	1	5	—	1	—	1	7	—	—
Texas§	5	27	88	5	9	—	3	17	—	—	—	24	33	—	19
Mountain	30	34	82	30	82	—	4	12	—	9	2	10	25	2	1
Arizona	9	13	51	9	51	—	2	7	—	6	1	3	8	1	—
Colorado	20	11	22	20	20	—	1	4	—	1	—	2	8	—	—
Idaho§	—	0	2	—	—	—	0	2	—	—	—	0	2	—	—
Montana§	—	0	2	—	—	—	0	1	—	—	—	0	2	—	—
Nevada§	—	2	4	—	3	—	0	1	—	1	—	2	9	—	1
New Mexico§	—	3	10	—	3	—	0	4	—	—	1	1	4	1	—
Utah	—	4	9	—	5	—	0	3	—	1	—	1	4	—	—
Wyoming§	1	0	15	1	—	—	0	1	—	—	—	0	0	—	—
Pacific	6	5	15	6	9	—	0	7	—	3	1	44	63	1	59
Alaska	—	2	9	—	6	—	0	5	—	2	—	0	1	—	—
California	6	3	14	6	3	—	0	5	—	1	—	38	54	—	54
Hawaii	—	0	2	—	—	—	0	0	—	—	—	0	5	—	—
Oregon	—	0	0	—	—	—	0	0	—	—	—	1	7	—	—
Washington	—	0	0	—	—	—	0	0	—	—	1	4	11	1	5
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—	2	3	15	2	2
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Includes drug resistant and susceptible cases of invasive Streptococcus pneumoniae disease among children <5 years and among all ages. Case definition: Isolation of S. pneumoniae from a normally sterile body site (e.g., blood or cerebrospinal fluid).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	Varicella (chickenpox)§					West Nile virus disease†									
						Neuroinvasive					Nonneuroinvasive¶				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010
United States	62	282	550	62	225	—	0	71	—	—	—	1	53	—	—
New England	—	14	34	—	14	—	0	3	—	—	—	0	1	—	—
Connecticut	—	5	20	—	2	—	0	2	—	—	—	0	1	—	—
Maine§	—	4	15	—	5	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	1	—	—	—	0	2	—	—	—	0	1	—	—
New Hampshire	—	2	8	—	5	—	0	1	—	—	—	0	0	—	—
Rhode Island§	—	0	3	—	1	—	0	0	—	—	—	0	0	—	—
Vermont§	—	0	10	—	1	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	11	32	62	11	30	—	0	19	—	—	—	0	13	—	—
New Jersey	—	8	30	—	16	—	0	3	—	—	—	0	6	—	—
New York (Upstate)	N	0	0	N	N	—	0	9	—	—	—	0	7	—	—
New York City	—	0	1	—	—	—	0	7	—	—	—	0	4	—	—
Pennsylvania	11	23	40	11	14	—	0	3	—	—	—	0	3	—	—
E.N. Central	41	98	176	41	101	—	0	14	—	—	—	0	8	—	—
Illinois	3	22	45	3	28	—	0	10	—	—	—	0	5	—	—
Indiana§	—	5	35	—	6	—	0	2	—	—	—	0	2	—	—
Michigan	12	31	62	12	31	—	0	6	—	—	—	0	1	—	—
Ohio	26	28	56	26	34	—	0	1	—	—	—	0	1	—	—
Wisconsin	—	7	22	—	2	—	0	0	—	—	—	0	1	—	—
W.N. Central	10	15	32	10	13	—	0	7	—	—	—	0	11	—	—
Iowa	N	0	0	N	N	—	0	1	—	—	—	0	2	—	—
Kansas§	—	4	22	—	8	—	0	1	—	—	—	0	3	—	—
Minnesota	—	0	0	—	—	—	0	1	—	—	—	0	3	—	—
Missouri	10	8	23	10	5	—	0	1	—	—	—	0	0	—	—
Nebraska§	N	0	0	N	N	—	0	3	—	—	—	0	7	—	—
North Dakota	—	0	10	—	—	—	0	2	—	—	—	0	2	—	—
South Dakota	—	1	7	—	—	—	0	2	—	—	—	0	3	—	—
S. Atlantic	—	35	100	—	21	—	0	4	—	—	—	0	4	—	—
Delaware§	—	0	3	—	—	—	0	0	—	—	—	0	0	—	—
District of Columbia	—	0	4	—	—	—	0	1	—	—	—	0	1	—	—
Florida§	—	16	57	—	9	—	0	3	—	—	—	0	1	—	—
Georgia	N	0	0	N	N	—	0	1	—	—	—	0	3	—	—
Maryland§	N	0	0	N	N	—	0	3	—	—	—	0	2	—	—
North Carolina	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
South Carolina§	—	0	35	—	2	—	0	1	—	—	—	0	0	—	—
Virginia§	—	10	29	—	2	—	0	1	—	—	—	0	1	—	—
West Virginia	—	8	26	—	8	—	0	0	—	—	—	0	0	—	—
E.S. Central	—	5	22	—	5	—	0	1	—	—	—	0	3	—	—
Alabama§	—	5	22	—	5	—	0	1	—	—	—	0	1	—	—
Kentucky	N	0	0	N	N	—	0	1	—	—	—	0	1	—	—
Mississippi	—	0	2	—	—	—	0	1	—	—	—	0	2	—	—
Tennessee§	N	0	0	N	N	—	0	1	—	—	—	0	2	—	—
W.S. Central	—	43	177	—	8	—	0	15	—	—	—	0	3	—	—
Arkansas§	—	2	32	—	2	—	0	3	—	—	—	0	1	—	—
Louisiana	—	2	5	—	—	—	0	3	—	—	—	0	1	—	—
Oklahoma	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
Texas§	—	40	171	—	6	—	0	15	—	—	—	0	2	—	—
Mountain	—	20	36	—	33	—	0	18	—	—	—	0	15	—	—
Arizona	—	0	0	—	—	—	0	13	—	—	—	0	9	—	—
Colorado§	—	8	18	—	16	—	0	5	—	—	—	0	11	—	—
Idaho§	N	0	0	N	N	—	0	0	—	—	—	0	1	—	—
Montana§	—	3	17	—	5	—	0	0	—	—	—	0	0	—	—
Nevada§	N	0	0	N	N	—	0	0	—	—	—	0	1	—	—
New Mexico§	—	1	8	—	3	—	0	5	—	—	—	0	2	—	—
Utah	—	4	17	—	9	—	0	1	—	—	—	0	1	—	—
Wyoming§	—	0	3	—	—	—	0	1	—	—	—	0	1	—	—
Pacific	—	1	6	—	—	—	0	7	—	—	—	0	6	—	—
Alaska	—	0	5	—	—	—	0	0	—	—	—	0	0	—	—
California	—	0	0	—	—	—	0	7	—	—	—	0	6	—	—
Hawaii	—	0	6	—	—	—	0	0	—	—	—	0	0	—	—
Oregon	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
Washington	N	0	0	N	N	—	0	1	—	—	—	0	1	—	—
Territories															
American Samoa	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	2	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	9	30	—	1	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.

* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.

† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for California serogroup, eastern equine, Powassan, St. Louis, and western equine diseases are available in Table I.

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

¶ Not reportable in all states. Data from states where the condition is not reportable are excluded from this table, except starting in 2007 for the domestic arboviral diseases and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/ncphi/disss/nndss/phs/infdis.htm.

TABLE III. Deaths in 122 U.S. cities,* week ending January 8, 2011 (1st week)

Reporting area	All causes, by age (years)						P&I†
	All Ages	≥65	45–64	25–44	1–24	<1	Total
New England	682	479	149	38	10	6	64
Boston, MA	177	124	39	9	3	2	19
Bridgeport, CT	U	U	U	U	U	U	U
Cambridge, MA	23	17	6	—	—	—	4
Fall River, MA	44	39	3	2	—	—	5
Hartford, CT	57	37	14	4	2	—	6
Lowell, MA	32	24	7	—	1	—	4
Lynn, MA	9	5	2	2	—	—	—
New Bedford, MA	41	28	11	1	—	1	4
New Haven, CT	51	33	12	4	1	1	5
Providence, RI	108	71	26	6	3	2	5
Somerville, MA	3	3	—	—	—	—	—
Springfield, MA	38	27	10	1	—	—	2
Waterbury, CT	31	18	11	2	—	—	—
Worcester, MA	68	53	8	7	—	—	10
Mid. Atlantic	2,450	1,741	541	104	40	21	158
Albany, NY	51	33	13	3	1	1	6
Allentown, PA	40	32	6	2	—	—	3
Buffalo, NY	120	86	24	6	3	1	10
Camden, NJ	45	30	11	4	—	—	3
Elizabeth, NJ	21	13	6	2	—	—	2
Erie, PA	60	40	19	1	—	—	1
Jersey City, NJ	44	30	11	3	—	—	5
New York City, NY	1,444	1,042	317	49	23	10	82
Newark, NJ	39	24	5	5	3	2	—
Paterson, NJ	24	16	4	4	—	—	1
Philadelphia, PA	155	93	46	11	3	2	13
Pittsburgh, PA§	31	25	5	—	1	—	1
Reading, PA	46	36	9	—	—	1	5
Rochester, NY	91	58	23	5	3	2	6
Schenectady, NY	28	21	5	1	1	—	5
Scranton, PA	28	21	4	2	—	1	—
Syracuse, NY	90	75	13	2	—	—	7
Trenton, NJ	43	27	10	3	2	1	2
Utica, NY	16	14	2	—	—	—	2
Yonkers, NY	34	25	8	1	—	—	4
E.N. Central	2,269	1,557	503	136	44	29	159
Akron, OH	50	41	4	2	1	2	7
Canton, OH	38	30	7	1	—	—	5
Chicago, IL	250	174	43	26	7	—	16
Cincinnati, OH	87	64	15	6	1	1	3
Cleveland, OH	341	247	71	15	6	2	22
Columbus, OH	167	106	40	16	2	3	13
Dayton, OH	156	118	29	6	2	1	10
Detroit, MI	211	116	67	17	7	4	17
Evansville, IN	48	35	12	1	—	—	4
Fort Wayne, IN	73	49	17	6	1	—	1
Gary, IN	9	1	3	3	2	—	—
Grand Rapids, MI	47	32	11	2	—	2	4
Indianapolis, IN	215	132	57	15	5	6	12
Lansing, MI	110	82	17	4	4	3	13
Milwaukee, WI	118	68	39	9	2	—	9
Peoria, IL	52	40	8	3	—	1	6
Rockford, IL	84	57	23	2	1	1	3
South Bend, IN	39	31	5	1	1	1	3
Toledo, OH	103	76	22	1	2	2	4
Youngstown, OH	71	58	13	—	—	—	7
W.N. Central	837	577	188	47	15	10	56
Des Moines, IA	97	72	18	4	3	—	5
Duluth, MN	38	28	10	—	—	—	3
Kansas City, KS	31	17	12	—	1	1	—
Kansas City, MO	143	102	27	8	5	1	10
Lincoln, NE	61	51	7	2	—	1	7
Minneapolis, MN	79	49	21	8	—	1	3
Omaha, NE	103	74	19	7	1	2	11
St. Louis, MO	135	75	42	14	3	1	9
St. Paul, MN	70	48	18	1	1	2	4
Wichita, KS	80	61	14	3	1	1	4
S. Atlantic	1,386	928	319	85	31	23	95
Atlanta, GA	152	103	36	8	3	2	10
Baltimore, MD	113	69	26	12	4	2	10
Charlotte, NC	143	101	28	10	1	3	15
Jacksonville, FL	240	167	52	12	5	4	21
Miami, FL	117	72	29	10	4	2	6
Norfolk, VA	80	58	15	3	1	3	—
Richmond, VA	79	49	24	2	3	1	3
Savannah, GA	62	38	17	4	2	1	5
St. Petersburg, FL	71	46	17	4	3	1	5
Tampa, FL	204	144	42	11	5	2	14
Washington, D.C.	111	69	31	9	—	2	6
Wilmington, DE	14	12	2	—	—	—	—
E.S. Central	995	659	253	46	22	15	100
Birmingham, AL	165	117	34	6	3	5	23
Chattanooga, TN	84	61	20	3	—	—	8
Knoxville, TN	143	102	36	4	1	—	16
Lexington, KY	94	59	29	6	—	—	6
Memphis, TN	220	144	54	9	9	4	23
Mobile, AL	75	48	15	5	4	3	3
Montgomery, AL	38	20	13	4	—	1	6
Nashville, TN	176	108	52	9	5	2	15
W.S. Central	1,411	936	348	70	31	25	82
Austin, TX	107	64	30	10	1	2	10
Baton Rouge, LA	67	51	11	4	1	—	1
Corpus Christi, TX	71	50	14	4	2	1	6
Dallas, TX	335	198	95	23	11	7	22
El Paso, TX	133	99	29	4	1	—	8
Fort Worth, TX	U	U	U	U	U	U	U
Houston, TX	84	53	25	2	2	2	2
Little Rock, AR	68	49	14	3	—	2	—
New Orleans, LA	U	U	U	U	U	U	U
San Antonio, TX	321	226	71	11	6	7	19
Shreveport, LA	45	27	13	1	3	1	3
Tulsa, OK	180	119	46	8	4	3	11
Mountain	1,234	846	255	86	24	21	102
Albuquerque, NM	111	81	21	7	1	1	8
Boise, ID	84	61	17	4	1	1	6
Colorado Springs, CO	66	46	14	2	2	2	2
Denver, CO	79	54	14	5	4	2	6
Las Vegas, NV	267	172	65	24	3	3	27
Ogden, UT	38	31	6	—	1	—	8
Phoenix, AZ	184	113	39	17	5	8	13
Pueblo, CO	52	36	10	5	1	—	4
Salt Lake City, UT	167	109	34	15	5	4	15
Tucson, AZ	186	143	35	7	1	—	13
Pacific	2,077	1,434	446	121	43	33	209
Berkeley, CA	12	12	—	—	—	—	1
Fresno, CA	159	103	33	14	3	6	12
Glendale, CA	44	36	6	2	—	—	12
Honolulu, HI	74	49	10	9	5	1	11
Long Beach, CA	79	54	14	7	3	1	4
Los Angeles, CA	322	213	75	21	7	6	38
Pasadena, CA	25	18	5	2	—	—	2
Portland, OR	136	93	32	5	2	4	11
Sacramento, CA	254	164	69	12	6	3	36
San Diego, CA	216	169	35	10	1	1	28
San Francisco, CA	139	89	39	4	2	5	16
San Jose, CA	244	181	48	7	6	2	26
Santa Cruz, CA	41	28	10	1	1	1	1
Seattle, WA	140	82	39	15	4	—	1
Spokane, WA	71	51	8	9	1	2	3
Tacoma, WA	121	92	23	3	2	1	7
Total¶	**13,341**	**9,157**	**3,002**	**733**	**260**	**183**	**1,025**

U: Unavailable. —: No reported cases.

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

† Pneumonia and influenza.

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

¶ Total includes unknown ages.

TABLE IV. Provisional cases of selected notifiable disease,* United States, fourth quarter ending January 1, 2011 (52nd week)

Reporting area	Tuberculosis†				
	Current quarter	Previous 4 quarters			
		Min	Max	Cum 2010	Cum 2009
United States	1,504	1,504	2,467	8,079	11,371
New England	65	65	95	322	390
Connecticut	17	16	23	76	95
Maine	3	0	4	8	9
Massachusetts	39	39	60	200	240
New Hampshire	1	1	4	9	16
Rhode Island	3	3	11	25	24
Vermont	2	0	2	4	6
Mid. Atlantic	312	312	406	1,361	1,616
New Jersey	106	47	124	370	405
New York (Upstate)	39	34	61	180	217
New York City	110	90	195	590	759
Pennsylvania	57	52	57	221	235
E.N. Central	92	92	237	696	912
Illinois	—	0	107	252	413
Indiana	32	13	32	92	119
Michigan	—	0	44	114	137
Ohio	49	32	51	183	178
Wisconsin	11	11	17	55	65
W.N. Central	44	44	61	219	354
Iowa	—	0	8	19	42
Kansas	—	0	1	1	64
Minnesota	32	25	40	128	161
Missouri	7	3	12	33	32
Nebraska	5	3	8	23	32
North Dakota	—	0	0	—	5
South Dakota	—	0	7	15	18
S. Atlantic	286	286	519	1,738	2,221
Delaware	—	0	7	15	19
District of Columbia	7	6	14	38	41
Florida	98	98	233	741	828
Georgia	33	33	122	356	414
Maryland	65	42	65	218	218
North Carolina	—	0	0	—	246
South Carolina	28	10	53	131	164
Virginia	53	44	77	224	272
West Virginia	2	2	7	15	19
E.S. Central	112	97	152	498	568
Alabama	27	27	42	145	168
Kentucky	9	0	28	53	75
Mississippi	26	18	34	106	122
Tennessee	50	37	55	194	203
W.S. Central	56	56	405	1,056	1,859
Arkansas	4	4	16	50	82
Louisiana	28	7	63	150	193
Oklahoma	13	13	21	63	101
Texas	11	11	312	793	1,483
Mountain	138	70	148	474	568
Arizona	59	37	72	225	233
Colorado	25	8	25	61	79
Idaho	3	0	8	13	18
Montana	—	0	4	5	8
Nevada	36	1	45	104	106
New Mexico	11	10	14	46	48
Utah	4	1	9	18	74
Wyoming	—	0	2	2	2
Pacific	399	399	446	1,715	2,883
Alaska	—	0	0	—	37
California	297	297	335	1,294	2,385
Hawaii	34	21	34	110	117
Oregon	22	19	24	85	88
Washington	46	46	65	226	256
Territories					
American Samoa	1	0	1	3	3
C.N.M.I.	—	0	8	20	32
Guam	—	0	0	—	100
Puerto Rico	16	16	22	74	63
U.S. Virgin Islands	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.

U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.

* CDC is in the process of upgrading the national surveillance data management system for human immunodeficiency virus/acquired immunodeficiency syndrome. As a result, the quarterly data scheduled for this issue of MMWR is not being published in Table IV.

† CDC is in the process of implementing Public Health Information Network tuberculosis (TB) case notification message standards, which will simplify reporting of TB cases. As a result, TB provisional incidence counts are now reported from the National Electronic Disease Surveillance System (NEDSS) and the Tuberculosis Information Management System (TIMS) data sources. Previously, provisional TB incidence counts were reported through the National Electronic Telecommunications System for Surveillance (NETSS). The TB provisional incidence counts are low in some reporting jurisdictions as these areas continue to catch up with data entry and transmission to CDC during this transition.

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