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Competitive Foods and Beverages Available for Purchase in Secondary Schools — Selected Sites, United States, 2004

The percentage of overweight youths aged 12–19 years in the United States more than tripled from 5% during 1976–1980 to 16% during 1999–2002 (*1*). Overweight youths are at increased risk for cardiovascular consequences and other serious physical and psychosocial health problems (*2*). Because most youths are enrolled in school, the school nutrition environment is integral to any strategy to improve dietary behavior and reduce overweight among youths. In most schools, the nutrition environment has two components: the U.S. Department of Agriculture (USDA) school meals program and the sale of competitive foods. USDA defines competitive foods as those foods and beverages, regardless of nutritional value, sold at a school separate from the USDA school meals program (*3*). To identify the types of competitive foods and beverages available for purchase from school vending machines or at school stores, canteens, or snack bars, CDC analyzed data from the 2004 School Health Profiles for public secondary schools in 27 states and 11 large urban school districts. This report summarizes the results of that analysis, which indicated that, in 2004, the majority of secondary schools (median across states: 89.5%; median across large urban school districts: 81.5%) allowed students to purchase snack foods or beverages from vending machines or at the school store, canteen, or snack bar. In addition, the percentage of schools offering certain types of snack foods and beverages varied across states and large urban school districts. Although the majority of schools offered some nutritious foods and beverages in these settings, the majority of schools also offered less nutritious choices. Educators, families, and school and public health officials should work together to provide school nutrition environments that will help improve dietary behavior and reduce overweight among youths.

School Health Profiles* is conducted biennially to assess characteristics of school health programs. State and local departments of education and health select either all public secondary schools within their jurisdictions or a systematic, equal-probability sample of public secondary schools to participate in School Health Profiles. At each school, the principal and lead health education teacher are sent questionnaires to be self-administered and returned to the state or local agency conducting the survey. Only principals (or their designees) were asked questions regarding competitive foods available for purchase by students in their schools. Participation in School Health Profiles is confidential and voluntary. Follow-up telephone calls and written reminders were used to encourage participation. Data from each survey were weighted to reflect the likelihood of principals being selected and to

* Available at http://www.cdc.gov/healthyyouth/profiles.

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adjust for differing patterns of nonresponse. Results represent all public secondary schools in each jurisdiction.

Principals were asked the following questions: 1) "Can students purchase snack foods or beverages from vending machines or at the school store, canteen, or snack bar?" 2) "Can students purchase each snack food or beverage (chocolate candy; other kinds of candy; salty snacks that are not low in fat; soft drinks, sports drinks, or fruit drinks that are not 100% juice; fruits or vegetables; salty snacks that are low in fat; low-fat cookies, crackers, cakes, or other low-fat baked goods; 100% fruit juice; or bottled water) from vending machines or at the school store, canteen, or snack bar?" and 3) "Can students purchase candy; high-fat snacks; or soft drinks, sports drinks, or fruit drinks that are not 100% juice during the following times (before classes begin in the morning, during any school hours when meals are not being served, and during school lunch periods)?"

In 2004, a total of 27 states and 11 large urban school districts† obtained weighted data from their survey of principals. Among states, the number of principals participating ranged from 58 to 607 (median: 281), and response rates ranged from 70% to 93% (median: 80%). Among large urban school districts, the number of principals participating ranged from 16 to 262 (median: 50), and response rates ranged from 73% to 98% (median: 84%).

The percentage of schools that allowed students to purchase snack foods or beverages from vending machines or at the school store, canteen, or snack bar ranged from 59.8% to 95.0% (median: 89.5%) across states and from 33.2% to 96.1% (median: 81.5%) across large urban school districts (Table). Among schools allowing purchases, the types of less nutritious foods and beverages available for purchase from the vending machine or at the school store, canteen, or snack bar varied. Chocolate candy was offered by 34.5% to 93.4% (median: 65.0%) of schools across states and by 27.3% to 82.4% (median: 58.0%) of schools across large urban school districts. Other kinds of candy were offered by 39.7% to 94.4% (median: 67.7%) of schools across states and by 33.7% to 82.5% (median: 62.3%) of schools across large urban school districts. Salty snacks not low in fat were offered by 53.5% to 89.4% (median: 74.5%) of schools across states and by 52.4%

† Secondary schools (i.e., middle, junior high, and senior high schools) serving students in grades 6–12 were surveyed in the following CDC-funded states and large urban school districts. **States:** Alaska, Arizona, Arkansas, Connecticut, Delaware, Idaho, Iowa, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Washington, and Wisconsin. **School districts:** Chicago, Illinois; Dallas, Texas; District of Columbia; Los Angeles, California; Memphis, Tennessee; Miami, Florida; New Orleans, Louisiana; Orange County, Florida; Philadelphia, Pennsylvania; San Bernardino, California; and San Diego, California.

TABLE. Percentage of public secondary schools allowing students to purchase foods and beverages from vending machines or at the school store, canteen, or snack bar and, among those schools allowing purchases, the percentage offering selected types of foods and beverages, by state or school district — School Health Profiles, United States, 2004

State	Schools allowing purchases from vending machines or at the school store, canteen, or snack bar (%)	Less nutritious foods and beverages				More nutritious foods and beverages				
		Chocolate candy (%)	Other kinds of candy (%)	Salty snacks not low in fat (%)	Soft drinks, sports drinks, or fruit drinks not 100% juice (%)	Fruits or vegetables (%)	Salty snacks low in fat (%)	Low-fat baked goods (%)	100% fruit juice (%)	Bottled water (%)
Alaska	59.8	76.5	77.0	81.6	94.3	21.5	79.6	55.6	81.6	83.9
Arizona	73.8	63.0	64.7	74.8	88.0	43.4	77.6	60.5	71.1	90.8
Arkansas	93.8	69.7	73.7	74.3	96.6	28.4	72.5	49.7	71.9	90.3
Connecticut	81.1	38.3	41.2	72.7	88.9	57.8	82.8	63.1	85.6	93.2
Delaware	80.5	35.6	39.9	74.5	89.2	45.0	76.8	68.4	95.5	100.0
Idaho	92.7	72.4	73.4	73.9	97.3	32.9	73.2	52.9	77.0	96.2
Iowa	89.5	66.8	67.7	71.3	97.0	43.0	71.8	60.1	87.4	94.8
Maine	91.7	40.0	45.1	61.4	78.9	50.0	79.6	68.9	94.9	100.0
Massachusetts	85.4	35.3	40.5	73.9	86.4	51.0	79.8	58.0	86.1	94.0
Michigan	92.1	72.3	76.0	86.2	96.8	55.0	85.8	66.2	85.9	98.9
Minnesota	91.1	78.7	80.7	83.9	95.9	46.7	88.5	69.0	87.0	96.4
Missouri	90.2	68.6	71.1	75.9	97.2	32.6	76.1	56.8	76.3	90.5
Montana	88.8	60.1	61.9	53.5	94.5	27.4	57.5	46.0	85.9	90.4
Nebraska	84.1	61.9	63.3	61.2	99.5	24.8	61.7	53.3	82.3	93.5
New Hampshire	91.4	34.5	39.7	68.7	85.0	54.4	80.4	61.6	83.4	98.6
New York	90.1	41.5	43.4	70.3	84.9	44.5	75.1	58.0	83.6	93.3
North Carolina	88.4	54.9	60.0	81.8	92.4	40.4	81.1	68.2	84.2	94.8
North Dakota	77.0	61.7	62.9	56.5	96.7	21.9	55.6	41.0	83.5	98.7
Oklahoma	92.6	88.9	90.4	88.3	98.8	18.5	85.9	60.4	56.6	90.9
Oregon	87.6	70.9	77.6	85.2	95.4	48.0	82.8	62.9	78.3	94.9
Pennsylvania	84.0	60.0	68.0	83.3	90.5	45.7	86.3	64.7	87.4	94.3
South Carolina	92.1	74.1	76.5	87.0	95.8	26.9	83.8	67.1	76.5	92.1
Tennessee	90.1	73.8	78.1	80.1	96.8	27.7	78.7	59.9	75.7	93.3
Texas*	81.1	65.0	56.0	63.9	86.2	56.3	82.8	75.2	89.5	97.8
Utah	95.0	93.4	94.4	89.4	97.6	50.5	92.5	80.2	87.0	94.1
Washington	90.7	71.6	74.7	80.3	96.6	45.6	83.9	64.1	86.1	95.6
Wisconsin	88.4	57.9	62.6	69.0	94.0	48.6	75.2	60.6	85.7	94.8
Median	**89.5**	**65.0**	**67.7**	**74.5**	**95.4**	**44.5**	**79.6**	**60.6**	**84.2**	**94.3**
Range	**59.8–95.0**	**34.5–93.4**	**39.7–94.4**	**53.5–89.4**	**78.9–99.5**	**18.5–57.8**	**55.6–92.5**	**41.0–80.2**	**56.6–95.5**	**83.9–100.0**
School district										
Chicago	33.2	31.7	33.7	53.0	79.5	34.1	50.8	48.0	81.3	83.4
Dallas	95.8	82.4	75.9	89.2	100.0	45.8	82.5	66.4	89.1	97.8
District of Columbia	62.4	33.4	47.9	52.4	84.7	16.0	52.4	28.5	78.3	89.2
Los Angeles	96.1	73.5	82.5	82.6	53.4	54.0	88.1	60.0	86.6	95.6
Memphis	72.5	61.6	65.2	62.8	97.3	20.3	60.0	37.6	90.1	79.6
Miami	83.4	70.2	70.2	78.9	95.0	47.0	77.2	66.9	82.5	84.9
New Orleans	81.5	70.0	77.4	81.1	92.6	14.7	66.5	65.2	61.7	100.0
Orange County	86.3	58.0	62.3	85.8	87.2	61.4	83.5	66.5	84.3	100.0
Philadelphia	71.3	35.2	47.3	81.8	83.1	45.9	76.2	55.7	90.1	88.6
San Bernardino	81.3	27.3	41.7	91.7	100.0	66.7	83.3	75.0	83.3	100.0
San Diego	92.8	47.9	48.1	89.6	92.1	77.1	84.6	65.5	71.9	97.4
Median	**81.5**	**58.0**	**62.3**	**81.8**	**92.1**	**45.9**	**77.2**	**65.2**	**83.3**	**95.6**
Range	**33.2–96.1**	**27.3–82.4**	**33.7–82.5**	**52.4–91.7**	**53.4–100.0**	**14.7–77.1**	**50.8–88.1**	**28.5–75.0**	**61.7–90.1**	**79.6–100.0**

* Survey did not include schools from one of the state's largest school districts.

to 91.7% (median: 81.8%) of schools across large urban school districts. Soft drinks, sports drinks, or fruit drinks not 100% juice were offered by 78.9% to 99.5% (median: 95.4%) of schools across states and by 53.4% to 100.0% (median: 92.1%) of schools across large urban school districts.

Schools also offered foods and beverages that are more nutritious. Fruits or vegetables were offered by 18.5% to 57.8% (median: 44.5%) of schools across states and by 14.7% to 77.1% (median: 45.9%) of schools across large urban school districts (Table). Salty snacks low in fat were offered by 55.6% to 92.5% (median: 79.6%) of schools across states and by 50.8% to 88.1% (median: 77.2%) of schools across large urban school districts. Low-fat baked goods were offered by 41.0% to 80.2% (median: 60.6%) of schools across states and by 28.5% to 75.0% (median: 65.2%) of schools across large urban school districts. One hundred percent fruit juice was offered by 56.6% to 95.5% (median: 84.2%) of schools across states and by 61.7% to 90.1% (median: 83.3%) of schools across large urban school districts. Bottled water was offered by 83.9% to 100% (median: 94.3%) of schools across states

and by 79.6% to 100% (median: 95.6%) of schools across large urban school districts.

Among schools that allowed students to purchase snack foods or beverages from vending machines or at the school store, canteen, or snack bar, the percentage of schools that allowed students to purchase candy; high-fat snacks; or soft drinks, sports drinks, or fruit drinks that are not 100% juice during school lunch periods ranged from 22.2% to 90.1% (median: 66.0%) across states and from 48.7% to 89.5% (median: 70.3%) across large urban school districts. From 34.8% to 82.8% (median: 60.3%) of schools across states and from 18.1% to 83.3% (median: 43.1%) of schools across large urban school districts allowed purchases before classes begin in the morning and from 20.8% to 62.0% (median: 44.7%) of schools across states and from 7.4% to 58.3% (median: 22.1%) of schools across large urban school districts allowed purchases during any school hours when meals were not being served.

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Editorial Note: The findings in this report indicate that the majority of secondary schools in 27 states and 11 large urban school districts allow students to purchase snack foods or beverages from vending machines or at the school store, canteen, or snack bar. The types of competitive foods and beverages available for purchase varies across states and large urban school districts. Overall, fruits or vegetables are less likely to be available for purchase than the other types of foods or beverages. Bottled water and soft drinks, sports drinks, or fruit drinks that are not 100% juice are most likely to be available for purchase.

Multiple federal regulations govern the foods and beverages offered in the USDA school meals program. However, apart from that program, the only federal regulations regarding sale of foods and beverages in schools prohibit access to foods of minimal nutritional value (FMNV)[§] (*4*) in food-service areas during meal times. Under federal regulations, foods such as potato chips, chocolate bars, and doughnuts are not considered FMNV and can be sold in the cafeteria or elsewhere at any time. At least 28 states and many school districts and schools have adopted more stringent regulations (*5*). For example, the Texas Public School Nutrition Policy (*6*) prohibits middle schools or junior high schools from serving or providing access to FMNV and all other forms of candy on school premises until after the end of the last lunch period and prohibits senior high schools from serving or providing access to FMNV during meal periods in areas where reimbursable meals are served or eaten. The policy also restricts portion sizes for foods and beverages sold apart from school meals on school campuses. In the Los Angeles Unified School District (*7*), only foods that meet specified nutrient standards are authorized for sale apart from the school meals program before, during, and until one-half hour after the end of the school day.

The findings in this report are subject to at least three limitations. First, these data apply only to public secondary schools and therefore do not reflect practices at private schools. Second, these data were self-reported by school principals (or their designees) and were not verified by a second source. Finally, these data were collected during spring 2004 and do not reflect any state, district, or school policies enacted since then.

To help improve dietary behavior and reduce overweight among youths, CDC recommends offering appealing and nutritious foods in school snack bars and vending machines and discouraging sale of foods high in fat, sodium, and added sugars on school grounds or as part of fund-raising activities (*8*). Science-based strategies are available to help states, districts, and schools act on these recommendations. For example, the *School Health Index* (*9*) helps schools identify the strengths and weaknesses of their health-promotion policies and programs and develop an action plan to ensure that students have access to appealing and nutritious foods and beverages outside the school meals program. In addition, *Making It Happen! School Nutrition Success Stories* (*10*) describes how 32 schools and school districts across the United States have improved the nutritional quality of foods and beverages offered apart from the school meals program.

Acknowledgments

This report is based on data collected by state and local School Health Profiles coordinators.

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[§] Defined as items that provide less than 5% of the U.S. recommended daily allowance per serving for each of eight essential nutrients. FMNV include carbonated soft drinks, water ices, chewing gum, and certain candies that consist mostly of sweeteners (e.g., hard candies and jelly beans).

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Influenza Vaccination Coverage Among Persons Aged 50–64 Years Enrolled in Commercial Managed Health-Care Plans — United States, 2003–04 and 2004–05 Influenza Seasons

To combat an unexpected shortage of influenza vaccine in the fall of 2004, CDC issued guidance to direct available vaccine supplies to persons in designated priority groups (e.g., persons aged ≥65 years, persons with certain health conditions, health-care workers, and close contacts of persons at high risk for complications from influenza) (*1,2*). Analyses of influenza vaccination coverage for the 2004–05 influenza season indicated that coverage levels for adults in priority groups nearly reached the levels of previous years, whereas coverage levels among adults not in priority groups were approximately half the levels of the 2003–04 season (*3*). These findings suggested that national public health actions to direct available vaccine supply to persons at high risk for complications from influenza during the supply disruption were successful. To assess influenza vaccination coverage among persons aged 50–64 years for the 2004–05 influenza season relative to the 2003-04 season and to estimate the effect of shortages on selected subgroups, the National Committee for Quality Assurance* (NCQA) analyzed data from a survey of persons enrolled in commercial managed care health plans. This report summarizes the findings of that analysis, which indicated that, although vaccination coverage declined substantially from 2003–04 to 2004–05 among all subgroups in this age range, respondents who were older or who reported poorer health status exhibited smaller relative declines in vaccination coverage between the two seasons.

Data for this analysis are from the Consumer Assessment of Health Plans (CAHPS™) survey, a national survey of members of commercial health plans. This annual survey samples the membership of more than 250 managed care organizations (MCOs) with approximately 70 million members, representing more than 90% of the total commercial MCO membership in the United States. Independent samples are selected from each plan every year. The survey is conducted during March–May by independent survey research firms trained and monitored by NCQA to ensure compliance with a common written protocol. The survey uses a mixed mail/telephone protocol that yields an average response rate of 40%, a typical response rate for surveys of the commercially insured population. These data are used as the basis for a performance measure in the Health Plan Employer Data and Information Set (HEDIS™) that assesses the proportion of persons aged 50–64 years who received an influenza vaccination during the preceding year. The 50–64 years age range is consistent with the CDC recommendation for universal influenza vaccination during non-shortage years (*4*).

Members eligible for the influenza vaccination measure must have been aged 50–64 years as of September 1 of the calendar year preceding the survey, enrolled in the MCO at the time of the survey, and continuously enrolled in the same MCO for at least 12 months. Vaccination coverage is determined by the percentage of affirmative responses to the question, "Have you had a flu shot since September 1, YYYY?" where YYYY is the year prior preceding the survey year. Responses to the question about influenza vaccination totaled 55,510 for 2004 and 61,460 for 2005. The questionnaire also included questions about age, sex, education, race, and Hispanic ethnicity and an overall health-status question, "In general, how would you rate your overall health now?"

Influenza vaccination coverage was analyzed for demographic and self-reported–health subgroups and compared by season. To test for possible confounding among these characteristics, NCQA estimated a multiple logistic regression model

*An independent, nonprofit organization committed to measuring and improving the quality of health care provided by managed care organizations.

with receipt of vaccination as the dependent variable and indicator variables for the subgroups and interactions of the subgroups with the season as independent variables. Results were not weighted to account for differences in the sampling proportion across plans because the sampling proportion was uncorrelated with influenza vaccination coverage.

The findings of this analysis indicated that, from 2003–04 to 2004–05, vaccination coverage for the surveyed population decreased from 52.4% (95% confidence interval [CI] = 52.0%–52.8%) to 28.1% (CI = 27.7%–28.4%), a decrease of approximately 46% (Table). All eight regions of the United States experienced similar decreases, with the largest percentage decrease occurring in the Mid-Atlantic region (50.5%) and the smallest in New England (43.9%). Vaccination coverage increased with age, from 45.6% for persons aged 50–54 years to 60.1% for persons aged 60–64 years in 2003–04, with similar relative increases in 2004–05. Persons aged 50–54 years experienced the largest percentage decrease (51.3% compared with 40.9% for persons aged 60–64 years). Compared with women, men had lower vaccination coverage for 2003–04 (50.0% versus 53.9% for women), with a larger percentage decrease in 2004–05 (49.2% for men versus 44.2% for women). For both years, respondents with a high school education or greater had higher vaccination coverage than those with less than a high school education. However, this difference decreased in 2004–05 because of larger declines in vaccination coverage for those with a high school education or greater.

Self-reported health status had a substantial effect on vaccination coverage, with healthier respondents less likely to receive a vaccination. During 2003–04, respondents who described their health as "excellent" had vaccination coverage of 47.9% (CI = 46.8%–49.0%) compared with 58.6% (CI = 55.4%–61.6%) among those who reported having "poor" health. This difference increased in 2004–05, with coverage for respondents who reported being in excellent health decreasing to 23.2% (CI = 22.4%–24.1%), a decline of more than half (51.6%); coverage for respondents of self-reported poor health decreased to 44.8% (CI = 41.6%–47.9%), a decline of less than one fourth (23.5%).

TABLE. Influenza vaccination coverage for persons aged 50–64 years enrolled in commercial managed health-care plans, by region and selected characteristics — United States, 2003–04 and 2004–05 influenza seasons

	2003–04		2004–05		
Characteristic	**%**	**(95% CI*)**	**%**	**(95% CI)**	**% change**
Region					
United States	52.4	(52.0–52.8)	28.1	(27.7–28.4)	-46.4%
East North Central†	52.7	(51.7–53.6)	29.4	(28.5–30.2)	-44.2%
Mid-Atlantic§	49.5	(48.3–50.7)	24.5	(23.6–25.4)	-50.5%
Mountain¶	56.6	(55.1–58.1)	30.6	(29.3–31.8)	-45.9%
New England**	53.7	(52.3–55.0)	30.1	(28.8–31.3)	-43.9%
Pacific††	52.4	(51.2–53.5)	28.3	(27.3–29.3)	-46.0%
South Atlantic§§	48.8	(47.7–49.9)	26.0	(25.1–26.9)	-46.7%
South Central¶¶	52.7	(51.6–53.8)	27.8	(26.8–28.7)	-47.2%
West North Central***	58.2	(56.6–59.7)	31.2	(29.9–32.5)	-46.4%
Age group (yrs)					
50–54	45.6	(44.9–46.3)	22.2	(21.6–22.8)	-51.3%
55–59	52.4	(51.7–53.1)	26.5	(25.9–27.1)	-49.4%
60–64	60.1	(59.3–60.9)	35.5	(34.8–36.2)	-40.9%
Sex					
Men	50.0	(49.3–50.6)	25.4	(24.9–26.0)	-49.2%
Women	53.9	(53.4–54.4)	30.1	(29.6–30.5)	-44.2%
Education					
Less than high school	44.6	(42.8–46.3)	25.9	(24.3–27.4)	-41.9%
High school/Some college	50.9	(50.4–51.5)	27.3	(26.8–27.7)	-46.4%
College graduate	56.5	(55.8–57.2)	29.9	(29.3–30.5)	-47.1%
Race					
White	54.1	(53.6–54.5)	28.6	(28.3–29.0)	-47.1%
Black	38.6	(37.1–40.0)	23.5	(22.3–24.7)	-39.1%
Asian	51.7	(49.3–54.0)	30.2	(28.1–32.2)	-41.6%
Native Hawaiian/ Pacific Islander	54.0	(48.3–59.4)	27.9	(23.4–32.3)	-48.3%
American Indian/ Alaska Native	48.7	(45.3–52.1)	29.7	(26.6–32.7)	-39.0%
Ethnicity					
Hispanic	44.8	(43.0–46.5)	24.9	(23.5–26.3)	-44.4%
Non-Hispanic	53.0	(52.5–53.4)	28.3	(27.9–28.6)	-46.6%
Self-reported health status					
Excellent	47.9	(46.8–49.0)	23.2	(22.4–24.1)	-51.6%
Very good	51.5	(50.8–52.2)	25.4	(24.9–26.0)	-50.7%
Good	53.0	(52.3–53.7)	29.4	(28.8–30.0)	-44.5%
Fair	58.3	(57.0–59.5)	38.0	(36.8–39.2)	-34.8%
Poor	58.6	(55.4–61.6)	44.8	(41.6–47.9)	-23.5%

* Confidence interval.
† Illinois, Indiana, Michigan, Ohio, and Wisconsin.
§ New Jersey, New York, and Pennsylvania.
¶ Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming.
** Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.
†† Alaska, California, Hawaii, Oregon, and Washington.
§§ Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia.
¶¶ Alabama, Arkansas, Kentucky, Louisiana, Mississippi, Oklahoma, Tennessee, and Texas.
*** Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota.

During 2003–04, Hispanics had vaccination coverage of 44.8% (CI = 43.0%–46.5%) versus 53.0% (CI = 52.5%–53.4%) for non-Hispanics. In 2004–05, coverage for Hispanics decreased by less (44.4%) than that for non-Hispanics (46.6%). Similarly, coverage for whites and Native Hawaiians/Pacific Islanders was highest in 2003–04 (approximately 54%) but declined the most (47.1% and 48.3%, respectively) in

2004–05. Among all races, coverage for blacks was lowest in 2003–04 at 38.6% (CI = 37.1%–40.0%) and declined by 39.1% in 2004–05, to 23.5% (CI = 22.3%–24.7%). Multiple logistic regression analysis confirmed the independent effects of these factors on vaccine availability.

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Editorial Note: Data from CAHPS provide insight into the effects of the fall 2004 influenza vaccine shortage on vaccination coverage for a population at low risk for complications from influenza. Overall, the limited availability of vaccine, the media attention to the problem, and calls from public health authorities to direct available supplies to persons at high risk appear to have resulted in decreases in vaccination coverage among MCO enrollees compared with the preceding season. These decreases were consistent across all eight geographic regions, suggesting that available supplies were distributed uniformly across the United States, although variations within smaller geographic areas might have been more extreme.

Respondents who were older or who reported poorer health status exhibited smaller relative reductions in vaccination coverage; this suggests that efforts to target vaccination to higher-risk members of the survey population were somewhat successful. However, CAHPS data indicate that substantial reductions in vaccination coverage occurred among commercially insured persons with fair or poor health status.

The findings of this report are subject to at least four limitations. First, CAHPS data are subject to recall bias regarding receipt of an influenza vaccination. Second, with a response rate of only 40%, the data are subject to nonresponse bias. Third, the commercially insured managed care population might differ from other populations of interest, thereby limiting the generalizability of the results. Finally, self-reported health status might differ from clinical assessments of health, thereby limiting the ability to determine whether survey respondents with fair or poor self-reported health status met the CDC definition of high risk for complications from influenza and were therefore members of a priority group for vaccination (*1,2*).

Further research into medical conditions associated with self-reported fair or poor health status might provide insight into the characteristics and health conditions of these persons, providing an additional tool for managing the public health response to future influenza vaccine shortages.

A simple self-assessment question about health status administered in a waiting room might help clinicians and public health authorities identify persons at high risk and target vaccine to priority groups during vaccine shortages.

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HIV Transmission in the Adult Film Industry — Los Angeles, California, 2004

In April 2004, the Los Angeles County Department of Health Services (LACDHS) received reports of work-related exposure to human immunodeficiency virus (HIV) in the heterosexual segment of the adult film industry in California. This report summarizes an investigation by LACDHS into four work-related HIV-transmission cases among adult film industry workers. The investigation was initiated April 20, 2004, and joined by the California Department of Industrial Relations, Division of Occupational Safety and Health (Cal/OSHA) on April 21, 2004, and by CDC on May 18, 2004. This investigation identified important and remediable gaps in the prevention of HIV and other sexually transmitted diseases (STDs) in the adult film industry.

The first identified case was in a man aged 40 years (index patient) who tested HIV-negative on February 12, 2004, and on March 17, 2004, through regular monthly testing of blood samples, but subsequently tested HIV-positive on April 9, 2004. HIV testing was performed through the Adult Industry Medical Health Care Foundation, a private nonprofit clinic in California, in a Clinical Laboratory Improvement Amendments (CLIA)-approved laboratory by using a polymerase chain reaction (PCR) test for HIV DNA (Amplicor™ HIV-1 Detection Kit, Roche Diagnostics); this clinic has provided voluntary monthly HIV testing to adult film industry workers since 1998. The nucleic acid testing method is approved only for screening blood products and not for individual human testing; however, the method has been used by the private nonprofit clinic for testing adult film industry workers because possible infection can be detected earlier than with standard serologic methods (i.e., enzyme-linked immunoassay [EIA] or Western blot). For blood transfusions, nucleic acid testing methods can detect HIV infection an estimated 10–15 days sooner than antibody-based tests; nucleic acid methods are highly sensitive but less specific than less costly

serologic assays and thus are well-suited for screening of blood products but not for definitive diagnosis (*1*).

On April 20, 2004, LACDHS initiated an investigation regarding the HIV-transmission events to assist with partner elicitation and notification and with medical referral for persons with newly diagnosed HIV infection. Cal/OSHA received an official request for an investigation from LACDHS on April 20, 2004. On April 29, 2004, LACDHS sought technical assistance from CDC to investigate concerns regarding HIV transmission.

During the time between his two negative tests, the index patient performed in film productions in Brazil, engaging in unprotected sexual acts. While in Brazil, he experienced an influenza-like illness that resolved before his return to California on or around March 10, 2004. According to LACDHS investigators, upon the return of the index patient to California, he participated in film productions in which he engaged in unprotected sexual acts with 13 female partners. Three of these 13 female partners subsequently tested HIV-positive by PCR after having tested HIV-negative during the preceding 30 days (attack rate: 23%). HIV PCR testing was conducted by the laboratory used by the nonprofit clinic; the HIV status of all four infected film workers was subsequently confirmed by PCR, enzyme-linked immunosorbent assay (ELISA), and Western blot testing at a separate laboratory.

According to field interviews with LACDHS and Cal/OSHA, two of the three HIV-infected female partners engaged in unprotected sex with the index patient during film production on March 24, 2004. Of these two female partners, one tested HIV-negative on March 20, 2004, and positive on April 13, 2004; the other tested HIV-negative on April 13, 2004, and positive on April 25, 2004. The third female partner engaged in unprotected sex with the index patient on March 30, 2004; she tested HIV-negative on April 12, 2004, and positive on May 5, 2004. During film production, all three of the infected female partners had engaged with the index patient in specific acts associated with increased possibility of mucosal tears. None of the other adult film industry workers or private partners with whom these three women had contact during the 30 days before their diagnoses subsequently tested HIV-positive. As of May 20, 2004, the index patient reported having had no sex partners outside of work since February 12, 2004. The person who was the source of HIV infection for the index patient is unknown.

The index patient and two of his three HIV-infected sex contacts subsequently provided whole blood samples to LACDHS, from which HIV DNA was sequenced at CDC. The third sex contact declined to provide a blood sample for sequencing. Using standard techniques, the HIV p17 region of *gag* and the C2V3C3 and gp41 regions of *env* from each of the three persons was amplified and sequenced by two different CDC laboratory scientists on separate days. All sequences were identical and supported the epidemiologic conclusion that the male index patient was the source of HIV infection and had transmitted HIV to these two women through sexual exposure.

After identification of the HIV outbreak cases, the organization operating the nonprofit clinic providing the HIV PCR testing identified a total of 25 first-generation partners (i.e., workers who had direct sexual contact with the four outbreak patients) and 36 second-generation partners (i.e., workers who had direct sexual contact with a first-generation partner). By June 30, 2004, a total of 24 of the 25 known first-generation partners had received HIV counseling and PCR testing at the nonprofit clinic after their exposure to a known HIV patient; of these 24 partners, 23 were tested at least 1 month after their direct sexual contact with an outbreak patient, and one was tested 3 weeks after the contact. All tested HIV-negative. The one first-generation partner for whom postexposure HIV test results were not available was a female partner of one of the infected female workers. In addition, 35 of 36 known second-generation partners had received HIV counseling and testing at the clinic as of June 30, 2004; among those tested, all were HIV-negative. The one second-generation partner for whom no postexposure testing data were available was a female partner of a male first-generation partner, who did receive postexposure HIV testing and was HIV-negative.

On June 4, 2004, Cal/OSHA opened an inspection of the producer(s) involved in these recent incidents of presumed workplace infection with HIV. On September 15, 2004, Cal/OSHA issued citations to two employers of some of the adult film industry workers with newly diagnosed HIV infection for failing to comply with the state's bloodborne pathogen standard (*2*), failing to report a serious work-related illness, and failing to prepare and follow a written occupational injury and illness prevention program.

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Editorial Note: The occurrence of HIV transmission in the adult film industry underscores the existence of serious risk for HIV infection in this industry and the need for fully informing workers of these risks and for employing all available safeguards to reduce transmission of HIV and other STDs. This industry includes an estimated 200 production companies in Los Angeles County, employing approximately 6,000 workers, of whom 1,200 are workers who engage in direct work-related sexual contact (Los Angeles County Economic Development Corporation, unpublished data, 2005). In the adult film industry, the increased potential for HIV/STD transmission is associated with basic practices, in that workers have multiple sex partners during short periods with whom they engage in frequent and often prolonged sexual acts. The risk for HIV/STD transmission is also greatly increased by lack of condom use. Production companies in the heterosexual segment of this industry have generally not required condom use for any type of sexual act.

Many producers and workers in the heterosexual segment of the adult film industry participate in a voluntary program of periodic HIV and STD testing, with results shared among workers and producers.* However, as demonstrated by the recent incidents of HIV transmission in this industry, screening alone is not adequate to prevent transmission of HIV or other STDs because infected persons can transmit these diseases for a period before their infection can be diagnosed. For HIV infection, the period after infection until virus is detectable by methods such as PCR is called the "eclipse period," and the period until antibodies to the virus are detectable by serologic methods is called the "window period." On the basis of the limited data available, the average eclipse period for HIV infection is estimated to last 10–15 days but can be longer (*1,3*). The index patient described in this report tested negative by HIV PCR twice during the 2 months before engaging in sex acts with the three women who subsequently became infected, including a negative test only 1 week before encounters with two of these women. This negative test likely occurred during the eclipse period when the index patient was able to transmit HIV but before the PCR test could detect the virus.

In addition to the testing program being inadequate as the sole source of protection from HIV transmission, the costs of testing are typically borne by the workers themselves. The cost burden of health services could cause some workers to reduce the range and frequency of HIV and STD screening or to avoid or delay pursuing vaccination for hepatitis B virus (HBV).

Similar episodes of HIV transmission have been identified previously in the heterosexual segment of the adult film industry. In addition to HIV, adult film industry work practices can result in transmission of other STDs. During June 2000–December 2001 (the most recently available prevalence data for this group of workers), before voluntary monthly STD screening was instituted, prevalences of chlamydial infection and gonorrhea among heterosexual adult film industry workers in California were 5.5% for males and 7.7% for females for chlamydial infection and 2.0% for both males and females for gonorrhea (*4*). By comparison, an analysis of a nationally representative sample of young adults aged 18–26 years during April 2001–May 2002 revealed prevalence of chlamydial infection among males and females to be 3.7% and 4.7% respectively, and, similarly, prevalence of gonorrhea to be 0.4% and 0.4%, respectively (*5*).

These instances of HIV transmission in the adult film industry underscore the hazards associated with unprotected sex among workers in this industry and the importance of implementing an effective health and safety program at adult film industry worksites and production agencies, as required by Cal/OSHA (*6*). In issuing citations, Cal/OSHA made the determination that existing occupational health and safety regulations apply to employers in this industry, including development and implementation of a written injury and illness prevention program and compliance with the Cal/OSHA Bloodborne Pathogens Standard (*6*). This standard requires that employees be protected from hazards associated with blood and other potentially infectious substances (including semen and vaginal fluid). Protections include measures such as simulation and use of condoms and other barriers where needed to prevent exposure. Other provisions include employee training and vaccination for HBV. The citations are currently under appeal to the Cal/OSHA Appeals Board. Cal/OSHA, LACDHS, the California State Department of Health Services, and other agencies are also currently collaborating to develop an appropriate model exposure-control plan (ECP) for this industry that is consistent with the existing Cal/OSHA Bloodborne Pathogens Standard (*2*) and the California Injury and Illness Prevention Standard (*7*).

Findings from this investigation emphasize the need to review current health and safety policies in the adult film industry and ensure that they are designed in accordance with Cal/OSHA requirements. This review should involve all of the various industry, employee, policy, and public health organizations. Workers in this industry need to be made aware of the risks associated with participation in various acts (*8*), to be able to participate in decision-making about their health

* Additional information is available at http://democrats.assembly.ca.gov/members/a42/pdf/afi.pdf.

and safety at work, and to benefit from prevention practices (*9*). These recommendations are consistent with existing CDC guidelines for health and safety practices and primary prevention of disease (*10*).

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Perceptions of Neighborhood Characteristics and Leisure-Time Physical Inactivity — Austin/Travis County, Texas, 2004

Regular physical activity improves quality of life and reduces risk for coronary heart disease, colon cancer, hypertension, diabetes, and overall mortality (*1*). Physical activity also has been associated with reduced symptoms of depression and greater independence (*1,2*). A sedentary lifestyle is associated with obesity (*1,3*). However, despite the health benefits of physical activity, 23.1% of adults in the United States report they do not engage in any leisure-time physical activity (*4*). Neighborhood environment (e.g., sidewalks and street lighting) (*5,6*), perceived trustworthiness of neighbors (*5*), and perceptions of neighborhood safety (*6,7*) all have been associated with levels of physical activity. During 2004, to assess the association between these factors and leisure-time physical inactivity in eastern Travis County, Texas, the local health department collected and analyzed data by using the methodology of the Behavioral Risk Factor Surveillance System (BRFSS). This report describes the results of that analysis, which indicated that persons who perceived their neighborhoods as less than extremely safe were more than twice as likely to have no leisure-time physical activity, and those who perceived their neighborhoods as not at all safe were nearly three times as likely to have no leisure-time physical activity. Public health agencies promoting physical activity in neighborhoods should consider how residents perceive their safety and design programs that specifically address those safety concerns.

Austin/Travis County Health and Human Services Department interviewed 1,635 adult residents of eastern Travis County, Texas, by using a random-digit–dialed telephone survey. Applying BRFSS methodologies and core questions, data were collected during a 3-month period in late summer and early fall of 2004. Leisure-time physical inactivity was defined as a response of "no" to the BRFSS core exercise question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?" Self-reported neighborhood environmental characteristics were assessed by using questions from a module added to the 2004 Texas BRFSS. Questions included perceptions of neighborhood safety, presence of sidewalks, adequacy of streetlights, and perceived characteristics of neighbors. For the purposes of the survey, respondents were told that their neighborhoods were defined as the areas within one-half mile or a 10-minute walk from their homes.

The survey was conducted as part of the baseline data collection for the Steps to a HealthierUS program in an area of 20 contiguous postal codes in eastern Travis County with an approximate population of 460,000. Data were weighted to reflect the demographic composition of the area. The overall response rate for the survey was 51.8%, determined by using the Council of American Survey Research Organizations method (*8*). The association between leisure-time physical inactivity and perceived neighborhood characteristics was measured by using adjusted odds ratios (AOR) and 95% confidence intervals (CIs). Odds ratios were obtained by using logistic regression and were adjusted for sex, race/ethnicity (i.e., white non-Hispanic or nonwhite), age, and education level.

Overall, 26.6% of those surveyed were physically inactive during their leisure time. No statistically significant differences in prevalence existed by sex or age (Table 1). A higher prevalence of leisure-time physical inactivity was reported

TABLE 1. Percentage of adults reporting leisure-time physical inactivity, by selected demographic characteristics — Austin/Travis County, Texas, 2004

Characteristic	%	(95% CI*)
Sex		
Male	25.9	(21.8–30.4)
Female	27.3	(24.2–30.7)
Race/Ethnicity		
White	16.5	(13.5–20.1)
Nonwhite	34.3	(30.4–38.4)
Age (yrs)		
18–44	25.7	(22.4–29.3)
≥45	28.4	(24.2–33.0)
Education		
<High school	50.3	(43.2–57.4)
≥High school	19.8	(17.2–22.6)
Total	**26.6**	**(23.9–29.4)**

* Confidence interval.

among nonwhite respondents (34.3%) than whites (16.5%) and among those with less than a high school education (50.3%), compared with high school graduates (19.8%). After adjustment for sex, race/ethnicity, age, and education, associations were identified between respondent perceptions of the safety and pleasantness of their neighborhoods and their leisure-time physical inactivity. Persons who reported their neighborhood as slightly safe or quite safe were more than twice as likely to report being physically inactive during their leisure time as those reporting their neighborhood as extremely safe; persons who described their neighborhood as not at all safe were nearly three times more likely (AOR = 2.87; CI = 1.38–5.97) to be physically inactive during their leisure time than those describing their neighborhood as extremely safe (Table 2). In addition, persons describing their neighborhood as not very or not at all pleasant for walking were more likely to report leisure-time physical inactivity than persons describing their neighborhood as very pleasant for walking (AOR = 1.94; CI = 1.19–3.17). However, the survey identified no association between leisure-time physical inactivity and the presence of sidewalks, adequacy of street lighting, perceived trustworthiness of neighbors, or perceived level of physical activity within the neighborhood.

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Editorial Note: Although previous research has implicated physical neighborhood conditions and other characteristics as determinants of levels of physical activity (*6*), the findings in this report indicate that perceived safety was the factor with the strongest association with leisure-time physical inactivity. Local public health departments have traditionally worked with law enforcement in programs to eliminate intimate partner violence and to promote traffic, pedestrian, and bicycle safety. These findings suggest that one aspect of the physical inactivity of residents might be addressed by health departments' encouraging and aiding law enforcement in its primary role of ensuring public safety and reducing neighborhood crime.

TABLE 2. Association* between perceived neighborhood characteristics and leisure-time physical inactivity — Austin/Travis County, Texas, 2004

	Leisure-time physical inactivity	
Characteristic	**AOR†**	**(95% CI§)**
Does your neighborhood have any sidewalks?		
Yes	1.00	
No	1.33	(0.95–1.87)
How safe from crime do you consider your neighborhood to be?		
Extremely safe	1.00	
Quite safe	2.02	(1.08–3.79)
Slightly safe	2.42	(1.27–4.59)
Not at all safe	2.87	(1.38–5.97)
Overall, how would you rate your neighborhood as a place to walk? Would you say…		
Very pleasant	1.00	
Somewhat pleasant	1.40	(0.99–1.98)
Not very/Not at all pleasant	1.94	(1.19–3.17)
For walking at night, would you describe the street lighting in your neighborhood as…		
Very good/Good	1.00	
Fair	1.21	(0.83–1.76)
Poor/Very poor	1.17	(0.79–1.73)
Generally speaking, would you say most people in your neighborhood can be trusted?		
Yes	1.00	
No/Don't know	1.32	(0.94–1.86)
In general, would you say that the people in your neighborhood are…		
Very physically active	1.00	
Somewhat physically active	1.27	(0.75–2.17)
Not very/Not at all physically active	1.51	(0.85–2.67)

* Adjusted for sex, race/ethnicity, age, and education.
† Adjusted odds ratio.
§ Confidence interval.

The findings in this report are subject to at least five limitations. First, the study was a cross-sectional survey; therefore, no temporal sequence could be established. Second, the response rate was 51.8%, so these findings might not be generalizable to nonrespondents. Third, all information, including physical activity levels and perceptions of neighborhood safety and other characteristics, was self-reported and not validated by any other means. Fourth, the survey was conducted during months with long hours of daylight, and street lighting might not be valued as highly for physical activity as during months when days are shorter. Finally, questions on adequacy of street lighting and overall pleasantness of the

neighborhood both specifically mentioned walking; results might be different if walking was the only physical activity examined or if the two questions were more general.

A comprehensive plan to increase physical activity in neighborhoods, such as the Steps to a Healthier Austin program in the Austin/Travis County area, should consider interventions that improve safety and perceptions of safety, in addition to physical improvements (e.g., sidewalks, street lighting, parks, and beautification). Information about that program is available at http://www.healthierus.gov/steps/grantees/austin.html and http://ithriveaustin.org.

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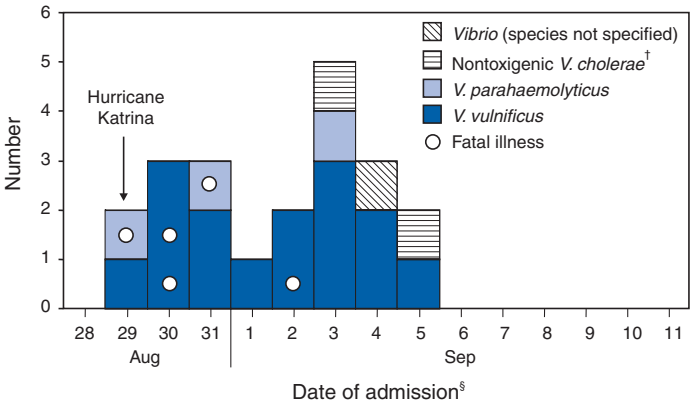
Vibrio Illnesses After Hurricane Katrina — Multiple States, August–September 2005

On September 14, this report was posted as an MMWR Dispatch *on the* MMWR *website* (http://www.cdc.gov/mmwr).

Hurricane Katrina made landfall on August 29, 2005, with major impact on the U.S. Gulf Coast. During August 29–September 11, surveillance identified 22 new cases of *Vibrio* illness with five deaths in persons who had resided in two states (Figure 1). These illnesses were caused by *V. vulnificus, V. parahaemolyticus,* and nontoxigenic *V. cholerae.* These organisms are acquired from the environment and are unlikely to cause outbreaks from person-to-person transmission. No cases of toxigenic *V. cholerae* serogroups O1 or O139, the causative agents of cholera, were identified. This report summarizes the investigation by state and local health departments and CDC, describes three illustrative cases, and provides background information on *Vibrio* illnesses. Results of the investigation underscore the need for heightened clinical awareness, appropriate culturing of specimens from patients, and empiric treatment of illnesses (particularly those associated with wound infections) caused by *Vibrio* species. No confirmed cases of illness have been identified with onset after September 5; additional *Vibrio* cases are under investigation.

FIGURE 1. Cases of post-Hurricane Katrina *Vibrio* illness among residents of Louisiana and Mississippi,* by date of hospital admission — United States, August 29–September 11, 2005



* N = 22; Alabama, a third state under surveillance, reported no cases.
† Nontoxigenic *V. cholerae* illnesses represent infections entirely distinct from the disease cholera, which is caused by toxigenic *V. cholerae* serogroup O1 or O139.
§ Date of admission was not available for one Louisiana resident. In cases that did not require hospitalization, the date represents the first contact with a health-care provider for the illness.

A case of post-hurricane *Vibrio* infection was defined as clinical illness in a person who had resided in a state struck by Hurricane Katrina (i.e., Alabama, Louisiana, or Mississippi) with illness onset and reporting during August 29–September 11, where *Vibrio* species was isolated from a wound, blood, or stool culture. Among cases, a wound-associated *Vibrio* case was defined as an illness that likely resulted from infection of a wound or abrasion acquired before or during immersion in floodwaters.

Wound-Associated Illnesses

Eighteen wound-associated *Vibrio* cases were reported, in residents of Mississippi (seven) and Louisiana (five); in persons displaced from Louisiana to Texas (two), Arkansas (two),

and Arizona (one); and in a person displaced from Mississippi to Florida (one). Speciation was performed in clinical laboratories for 17 of the wound-associated cases; 14 (82%) were *V. vulnificus,* and three (18%) were *V. parahaemolyticus*. Five (28%) patients with wound-associated *Vibrio* infections died; three deaths were associated with *V. vulnificus* infection, and two were associated with *V. parahaemolyticus* infection.

Age of patients with wound-associated illnesses ranged from 31 to 89 years (median: 73 years). Fifteen (83%) were male. The majority of patients were hospitalized; admission dates ranged from August 29 to September 5. Not all patients were initially hospitalized because of their wounds. An underlying condition that might have increased risk for severe *Vibrio* illness was reported in 13 (72%) of the patients with wounds; these conditions included heart disease (seven patients), diabetes mellitus (four), renal disease (three), alcoholism (three), liver disease (two), peptic ulcer disease (one), immunodeficiency (one), and malignancy (one).

Non-Wound–Associated Illnesses

Four persons were reported with non-wound–associated *Vibrio* infections (two in Mississippi, one in Louisiana, and one displaced from Louisiana to Arizona). Information on the *Vibrio* species and clinical illness was available for two of these patients; the species were nontoxigenic *V. cholerae* isolated from patients with gastroenteritis. One of the infections occurred in a boy aged 2 months with diarrhea whose stool culture yielded both *Salmonella* group C2 and *V. cholerae* non-O1, non-O139. He was hospitalized for 2 days in Mississippi. The other *V. cholerae* non-O1, non-O139 isolate was from a stool specimen from an adult who was not hospitalized. No deaths were associated with the non-wound cases.

Case Reports

To illustrate the rapid onset and severity of *Vibrio* wound infections, brief descriptions of three of the cases are provided.

Patient A. A man aged 60 years with a history of stroke, hypertension, and alcohol abuse arrived in Texas on August 31, after spending 3 days wading in the floodwaters of New Orleans, Louisiana. He was not housed at an evacuation center. On September 1, 2005, the man visited an emergency department with bilateral ankle wounds and diarrhea; he was treated and released. No details regarding treatment were available. Blood cultures subsequently yielded *V. vulnificus.* The patient was located and admitted to the hospital on September 2. He died the next day.

Patient B. A man aged 61 years from Mississippi with human immunodeficiency virus infection, coronary artery disease, and hyperlipidemia was examined on August 29 and determined to have hypothermia and multiple second- and third-degree abrasions on his trunk. *V. parahaemolyticus* was isolated from his blood. Despite receiving antimicrobial therapy with levofloxacin, he died the next day.

Patient C. A woman aged 49 years reported by her family to have hepatitis C was evacuated from New Orleans after a boat rescue. She visited an Arkansas hospital on September 4 with bullae, septic shock, and necrotizing fasciitis on her left leg, which was extensively debrided. *V. vulnificus* was isolated from her blood. As of September 12, she was being treated with ceftazidime and doxycycline and remained in critical condition.

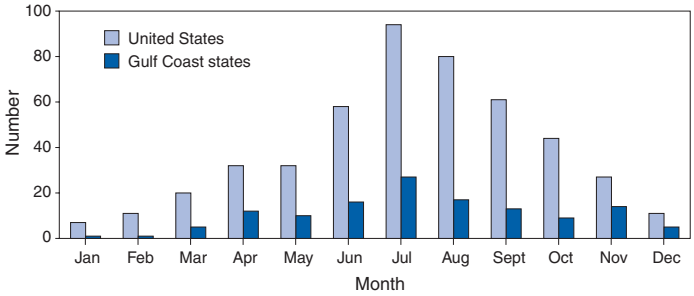
Reported by: *D Engelthaler, MS, K Lewis, MD, S Anderson, MPH, Arizona Dept of Health Svcs. S Snow, MD, L Gladden, Arkansas Dept of Health. RM Hammond, PhD, RJ Hutchinson, Florida Dept of Health. R Ratard, MD, S Straif-Bourgeois, PhD, T Sokol, MPH, A Thomas, MPH, Louisiana Office of Public Health. L Mena, MD, J Parham, MD, School of Medicine, Univ of Mississippi Medical Center, Jackson; S Hand, M McNeill, MD, PhD, P Byers, MD, B Amy, MD, Mississippi Dept of Health. G Charns, Medical City Hospital of Dallas; J Rolling, A Friedman, J Romero, MPH, T Dorse, MD, J Carlo, MD, Dallas County Health and Human Svcs Dept; S Stonecipher, DVM, LK Gaul, PhD, T Betz, MD, Dept of State Health Svcs. RL Moolenar, MD, National Center for Environmental Health; JA Painter, DVM, MJ Kuehnert, MD, J Mott, PhD, DB Jernigan, MD, PA Yu, MPH, TA Clark, MD, National Center for Infectious Diseases; SK Greene, PhD, AM Schmitz, DVM, AC Cohn, MD, JL Liang, DVM, EIS officers, CDC.*

Editorial Note: After natural disasters such as Hurricane Katrina, the risk for illness related to infectious diseases is a public health concern. The findings in this report describe illnesses caused by *Vibrio* species, including wound infections resulting from post-hurricane exposure of wounds to flood waters. These findings underscore the need for prompt recognition and management of *Vibrio* wound infections by health-care providers.

When the number of illnesses from infectious diseases increases after a natural disaster, they usually are caused by infectious agents normally present in the community or local environment (*1*). Nationwide, an average of 412 cases of noncholeragenic *Vibrio** illnesses were reported each year during 2000–2004, including an average of 146 cases reported from the five Gulf Coast states (*2*). The most frequently reported *Vibrio* species are *V. parahaemolyticus*, *V. vulnificus*, and nontoxigenic *V. cholerae*. *Vibrio* illnesses in the United States are seasonal and peak during the summer (Figure 2). During 2000–2004, in the month of September, an average

* All *Vibrio* species other than toxigenic *V. cholerae* O1 or O139.

FIGURE 2. Cases of noncholeragenic *Vibrio* illness by month of onset — United States and Gulf Coast states,* 2004



* Alabama, Florida, Louisiana, Mississippi, and Texas.

of 14 (range: 11–18) noncholeragenic *Vibrio* infections were reported from Gulf Coast states; an average of seven cases (range: 4–8) were wound-associated. Except for toxigenic *V. cholerae* O1 or O139, *Vibrio* illnesses are not nationally notifiable in the United States, and the actual number of noncholeragenic *Vibrio* illnesses is likely greater than the number reported.

Cholera is a severe diarrheal illness caused by *V. cholerae* serogroups O1 or O139, which produce cholera toxin (i.e., toxigenic *V. cholerae* O1 or O139). A small endemic focus of toxigenic *V. cholerae* O1 exists in the Gulf of Mexico (*3*). During 2000–2004, a total of 16 cases of cholera were reported in the United States, and 13 (81%) of these infections were acquired during overseas travel or by consumption of imported seafood. Only three (19%) infections were acquired in the Gulf Coast states, all in the year 2000. Therefore, the risk for acquiring cholera associated with Hurricane Katrina is extremely low.

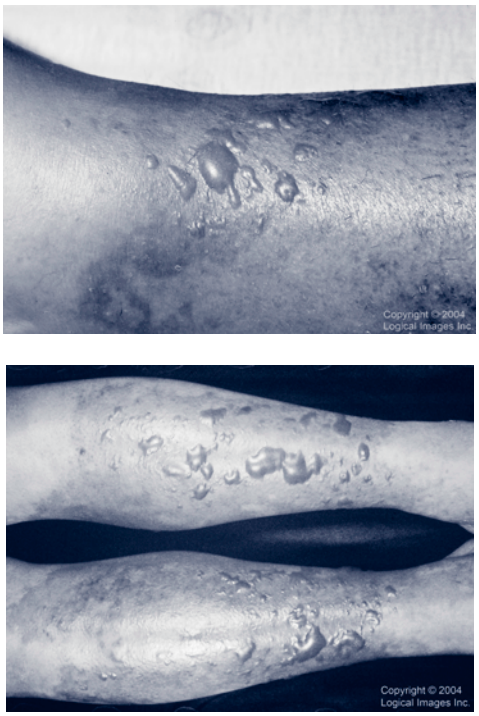
Since 2000, at least seven noncholeragenic *Vibrio* species (*V. vulnificus, V. parahaemolyticus,* nontoxigenic *V. cholerae, V. alginolyticus, V. fluvialis, V. mimicus,* and *V. hollisae*) have been reported as causing illness each year in the United States. Although these organisms and those that cause cholera are grouped together under the genus *Vibrio*, they cause distinctly different illnesses. In the United States, noncholeragenic *Vibrio* usually are either foodborne, (e.g., resulting from eating raw or undercooked shellfish, particularly oysters, or other contaminated foods) or wound-associated (e.g., resulting from exposure to seawater or brackish waters where the organism naturally occurs). The incubation period for noncholeragenic *Vibrio* infection usually is 12–72 hours but can be as long as 1 week (*2*). Noncholeragenic *Vibrio* illnesses are not transmitted easily from person to person. Outbreaks, which are rare, usually are the result of consuming contaminated shellfish.

The most frequently reported post-hurricane *Vibrio* illnesses were *V. vulnificus* and *V. parahaemolyticus* wound infections. These cases represent an increase over the normal reported incidence of *Vibrio* wound infections in Gulf Coast states and are consistent with exposure after hurricane landfall. Although precise exposure histories are not yet available for all patients, the infections caused by *V. vulnificus* likely resulted from wounds exposed to flood waters among persons with medical conditions that predisposed them to *Vibrio* infections. No evidence has been found of increased *Vibrio* gastrointestinal illness.

V. vulnificus wound infections can begin as redness and swelling at the site of the wound and rapidly progress in patients at high risk to cause systemic illness, including sepsis. Whether acquired through wound infection or ingestion, *V. vulnificus* typically causes a severe and life-threatening illness characterized by fever and chills, decreased blood pressure (septic shock), and blood-tinged blistering skin lesions (hemorrhagic bullae) (Figure 3). Persons with chronic liver disease or immunocompromising conditions are particularly at risk for severe *V. vulnificus* infections (*4,5*).

V. parahaemolyticus typically causes gastroenteritis after consumption of contaminated shellfish. Less frequently, *V. parahaemolyticus* causes wound infections that are generally less severe than *V. vulnificus* wound infections. However, in

FIGURE 3. Primary septicemic skin lesions caused by *Vibrio vulnificus*



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persons with liver disease or immunocompromising conditions, *V. parahaemolyticus* wound infections can lead to death.

Nontoxigenic *V. cholerae* causes primarily gastroenteritis, but unlike toxigenic *V. cholerae* O1 or O139, nontoxigenic *V. cholerae* do not cause epidemics. Illness caused by this organism ranges in severity from mild diarrhea to severe watery diarrhea. Fever and bloody diarrhea are not typically observed. Immunocompromised persons and persons with liver disease can experience a more severe illness, including fever, chills, and septic shock. This organism has rarely been reported to cause wound infections.

Vibrio infections are diagnosed by culture of wound, blood, or stool specimens. For stool specimens, a selective media of thiosulfate-citrate-bile salts-sucrose agar (TCBS) is recommended. If clinical suspicion of enteric *Vibrio* infection exists, the microbiology laboratory should be notified so that TCBS media will be used. Clinical laboratories should send all *Vibrio* isolates to state public health laboratories for confirmation. CDC continues to work with local and state public health officials to investigate post-Katrina *Vibrio* illnesses.

Persons working in hurricane-damaged areas, especially in areas with standing brackish water, should wear boots and other protective gear to prevent wounds and to prevent exposure of broken skin to contaminated water. To prevent *Vibrio* infections, persons with open wounds or broken skin should avoid contact with brackish water or seawater, especially if they have preexisting liver disease or other immunocompromising conditions. Injury prevention is especially important for persons in these high-risk populations. Healthy persons are at much lower risk for *Vibrio* infection. In areas where flood waters have receded and surfaces are dry, *Vibrio* should not be a concern because the organism is killed rapidly by drying (*6*).

To reduce the risk for *Vibrio* wound infection, persons should wash all wounds that have been exposed to sea or brackish waters with soap and clean water thoroughly as soon as possible and seek medical care for any wound that appears infected. Clinicians should be vigilant for *Vibrio* infection in hurricane evacuee populations, particularly in patients with infected wounds and especially if the patients are in a high-risk group. If *V. vulnificus* is suspected, antimicrobial therapy should be initiated immediately; prompt treatment can improve survival. Antimicrobials effective against *Vibrio* infections include doxycycline, third-generation cephalosporins (e.g., ceftazidime), fluoroquinolones, and aminoglycosides (*7*). Wound infections also should be treated with aggressive attention to the wound site; amputation of the infected limb is sometimes necessary. Additional information regarding management of *V. vulnificus* wound infections is available at http://www.bt.cdc.gov/disasters/hurricanes/Katrina/vibriofaq.asp. For *Vibrio* gastroenteritis that is mild and self-limited, treatment with oral rehydration usually is sufficient. Antimicrobial therapy might be helpful for patients with severe or prolonged diarrhea.

Acknowledgments

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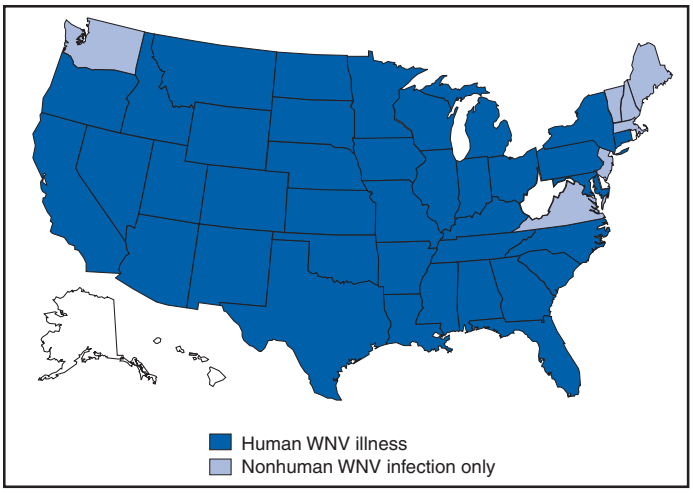
Update: West Nile Virus Activity — United States, 2005

This report summarizes West Nile virus (WNV) surveillance data reported to CDC through ArboNET as of 3 a.m. Mountain Daylight Time, September 20, 2005.

Thirty-eight states have reported 1,512 cases of human WNV illness in 2005 (Figure and Table 1). By comparison, in 2004, a total of 1,604 WNV cases had been reported as of September 21, 2004 (Table 2). A total of 780 (56%) of the 1,396 cases for which such data were available occurred in males; the median age of patients was 50 years (range: 3 months–98 years). Date of illness onset ranged from January 2 to September 16; a total of 41 cases were fatal.

A total of 268 presumptive West Nile viremic blood donors (PVDs) have been reported to ArboNET during 2005. Of these, 84 were reported from California; 45 from Nebraska; 43 from Texas; 15 each from Louisiana and South Dakota; 12 from Arizona; nine from Kansas; eight from Iowa; six from Illinois; five from New Mexico; four each from Alabama and

FIGURE. Areas reporting West Nile virus (WNV) activity — United States, 2005*



* As of September 20, 2005.

Minnesota; two each from Colorado, Michigan, Mississippi, Pennsylvania, and Utah; and one each from Idaho, Montana, Nevada, New York, North Carolina, North Dakota, Ohio, and Oregon. Of the 268 PVDs, two persons aged 53 and 56 years subsequently had neuroinvasive illness; three persons aged 17, 41 and 51 years subsequently had other illnesses; and 61 persons (median age: 47 years [range: 17–78 years]) subsequently had West Nile fever.

In addition, 3,228 dead corvids and 698 other dead birds with WNV infection have been reported from 41 states. WNV infections have been reported in horses from 29 states, four dogs from Idaho, Minnesota, and Nebraska, four squirrels from Arizona, and two unidentified animal species in two states (Arizona and Illinois). WNV seroconversions have been reported in 845 sentinel chicken flocks from 12 states. One seropositive sentinel horse was reported from Minnesota. A total of 9,318 WNV-positive mosquito pools have been reported from 38 states (Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, and Wisconsin) and the District of Columbia.

Additional information about national WNV activity is available from CDC at http://www.cdc.gov/ncidod/dvbid/westnile/index.htm and at http://westnilemaps.usgs.gov.

TABLE 1. Number of human cases of West Nile virus (WNV) illness reported, by state — United States, 2005*

State	Neuroinvasive disease†	West Nile fever§	Other clinical/ unspecified¶	Total**	Deaths
Alabama	3	2	0	**5**	0
Arizona	16	19	8	**43**	2
Arkansas	1	5	0	**6**	0
California	194	354	60	**608**	13
Colorado	7	43	0	**50**	0
Connecticut	2	0	0	**2**	0
Florida	4	8	1	**13**	0
Georgia	1	1	3	**5**	0
Idaho	2	6	4	**12**	0
Illinois	88	56	15	**159**	3
Indiana	1	0	0	**1**	0
Iowa	2	4	1	**7**	1
Kansas	2	2	0	**4**	0
Kentucky	2	0	0	**2**	0
Louisiana	50	16	0	**66**	4
Maryland	1	0	0	**1**	0
Michigan	9	2	4	**15**	2
Minnesota	7	13	0	**20**	1
Mississippi	12	12	0	**24**	3
Missouri	5	6	1	**12**	1
Montana	7	11	0	**18**	0
Nebraska	18	40	0	**58**	1
Nevada	6	12	0	**18**	0
New Mexico	11	6	0	**17**	1
New York	3	2	0	**5**	0
North Carolina	1	1	0	**2**	0
North Dakota	2	14	0	**16**	0
Ohio	19	3	0	**22**	0
Oklahoma	1	1	0	**2**	0
Oregon	0	3	0	**3**	0
Pennsylvania	7	6	0	**13**	0
South Carolina	1	0	0	**1**	1
South Dakota	29	160	1	**190**	1
Tennessee	6	1	0	**7**	1
Texas	35	11	0	**46**	5
Utah	14	19	0	**33**	1
Wisconsin	3	1	0	**4**	0
Wyoming	2	0	0	**2**	0
Total	**574**	**840**	**98**	**1,512**	**41**

* As of September 20, 2005.
† Cases with neurologic manifestations (i.e., West Nile meningitis, West Nile encephalitis, and West Nile myelitis).
§ Cases with no evidence of neuroinvasion.
¶ Illnesses for which sufficient clinical information was not provided.
** Total number of human cases of WNV illness reported to ArboNET by state and local health departments.

TABLE 2. Comparison of human cases and deaths from West Nile virus — United States, 2002–2005

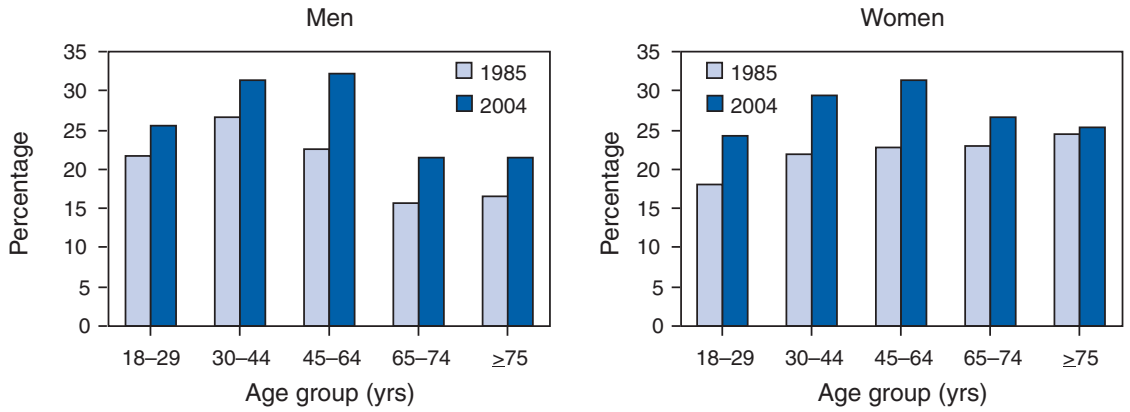
Year	Human cases	Deaths
2002*	1,641	72
2003†	4,137	80
2004§	1,604	48
2005¶	1,512	41

* Data through September 18, 2002.
† Data through September 17, 2003.
§ Data through September 21, 2004.
¶ Data through September 20, 2005.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Adults Who Reported an Average of ≤6 Hours of Sleep per 24-Hour Period, by Sex and Age Group — United States, 1985 and 2004



From 1985 to 2004, the percentage of men and women who reported an average of ≤6 hours of sleep per 24-hour period increased in all age groups.

SOURCES: Unpublished data, National Health Interview Survey, 2004.

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Notice to Readers

Recommendation Regarding Screening of Refugee Children for Treponemal Infection

In October 2004, CDC's Divisions of Sexually Transmitted Disease Prevention and Global Migration and Quarantine received reports of positive syphilis tests for refugee children who arrived in the United States from Liberia and Somalia. Infection with *Treponema pallidum* subsp. *pallidum, T. pallidum* subsp. *pertenue, T. pallidum* subsp. *endemicum,* and *Treponema carateum* cause syphilis, yaws, bejel/endemic syphilis, and pinta, respectively. This group of infections causes various disfiguring skin lesions and rashes; long-term infection can result in deformations of bone and nasopharyngeal tissue, aortitis, and other destructive lesions (*1*). Serologic tests cannot differentiate between infections caused by these treponemes; infection with any of them will cause positive results using both treponemal and nontreponemal tests routinely used for diagnosis of syphilis.

T. pallidum subsp. *pallidum* is the only *T. pallidum* subspecies present in the United States. This bacterium causes syphilis and is the only sexually acquired treponemal infection. The endemic subspecies (i.e., *T. pallidum* subsp. *pertenue, T. pallidum* subsp. *endemicum,* and *T. carateum*) are transmitted by contact with infected skin and usually are diseases of childhood (*2*). Countries in which *T. pallidum* subsp. *pertenue, T. pallidum* subsp. *endemicum,* and *T. carateum* are endemic include Liberia and Somalia (*3*). Refugees and immigrants who originate from these countries can be at risk for these infections.

CDC recommends that all children from areas where treponemes are known to be endemic be considered for screening by Rapid Plasma Reagin or Venereal Disease Research Laboratory tests at the initial health screening. If the screening test is positive (irrespective of titer), a treponemal confir-

matory test (e.g., the fluorescent treponemal antibody absorbed test [FTA-ABS] or the *T. pallidum* particle agglutination assay [TP-PA]) should be performed. In children, treponemal infection as indicated by positive screening and confirmatory tests might be caused by 1) nonsexual exposure to a person infected with non-venereal *T. pallidum* subspecies, 2) congenital transmission from an infected mother (occurs only with syphilis), or 3) consensual or nonconsensual sexual exposure (occurs only with syphilis). An algorithm has been developed to assist in assessment of children from areas with endemic treponematoses with positive screening and treponemal serologic tests.* If the mother's treponemal test is negative, and she reports no history of syphilis, congenital syphilis can be excluded; therefore, testing the mother might be valuable, even if current syphilis infection is not suspected.

To assist in evaluation of refugee and immigrant children, a list of countries in which endemic treponemal infection has been reported is provided. Surveillance for treponemal infections is not performed uniformly in all countries; in areas disrupted by war or civil disturbance, surveillance might not be possible. Therefore, the list of countries where treponemes are endemic is based on data that are not recent and are inconsistently collected (*3*). Countries where disease caused by endemic *T. pallidum* subspecies has been reported include the following: **Africa:** Angola, Benin, Botswana, Burkina Faso, Cameroon, Central African Republic, Chad, Republic of the Congo, Cote d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gabon, Ghana, Guinea, Liberia, Mali, Mauritania, Niger, Rwanda, Senegal, Somalia, South Africa, Sudan, and Togo. **Middle East:** Saudi Arabia. **Asia:** Cambodia, India, Indonesia, Pakistan, and Sri Lanka. **Western Pacific:** Papua New Guinea, Solomon Islands, and Vanuatu. **Americas** (*4*): Colombia, Ecuador, Haiti, Guyana, Martinique, Mexico, Surinam, and Venezuela. **Europe:** none.

In the United States, syphilis is a notifiable disease and should be reported to local and state health departments when diagnosed. Suspected cases of yaws or other non-venereal treponemal infections can be reported to CDC at telephone 404-639-8368.

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* Available at http://www.cdc.gov/std/syphilis/treponemalalgorithm.pdf.

Notice to Readers

Concussion Tool Kit for High School Coaches

CDC has introduced a multimedia tool kit, *Heads Up: Concussion in High School Sports*, to help coaches of high school teams protect their athletes from concussion. Concussions are a type of traumatic brain injury (TBI) caused by a blow or jolt to the head that can range from mild to severe and can disrupt the manner in which the brain normally functions. Approximately 300,000 sports and recreation-related TBIs occur in the United States each year (*1*).

The tool kit contains a *Guide for Coaches* on how to prevent concussions, identify symptoms, and take immediate action when an athlete has signs of a concussion. Contents also include 1) a video and DVD featuring a high school football player who was permanently disabled after sustaining a second, potentially preventable concussion during a game, 2) a wallet card and clipboard sticker for coaches that includes signs and symptoms of concussion and a place to record emergency contacts, 3) posters describing concussion symptoms that can be placed in locker rooms or heavily trafficked areas, 4) concussion fact sheets in English and Spanish for parents and athletes, and 5) a CD-ROM with downloadable kit materials and other concussion-related resources.

The *Heads Up: Concussion in High School Sports* tool kits will be distributed by CDC to coaches, principals, and athletic directors at high schools throughout the United States. The tool kits can be ordered or downloaded free of charge at http://www.cdc.gov/ncipc/tbi/coaches_tool_kit.htm. Additional information is available by contacting CDC Injury Center Media Relations, telephone 770-488-4902.

Reference

1. Sosin DM, Sniezek JE, Thurman DJ. Incidence of mild and moderate brain injury in the United States, 1991. Brain Inj 1996;10:47–54.

Errata: Vol. 53, No. 43

In the report, "Influenza and Pneumococcal Vaccination Coverage Among Persons Aged ≥65 Years and Persons Aged 18–64 Years with Diabetes or Asthma — United States, 2003," errors occurred in Tables 1 and 2.

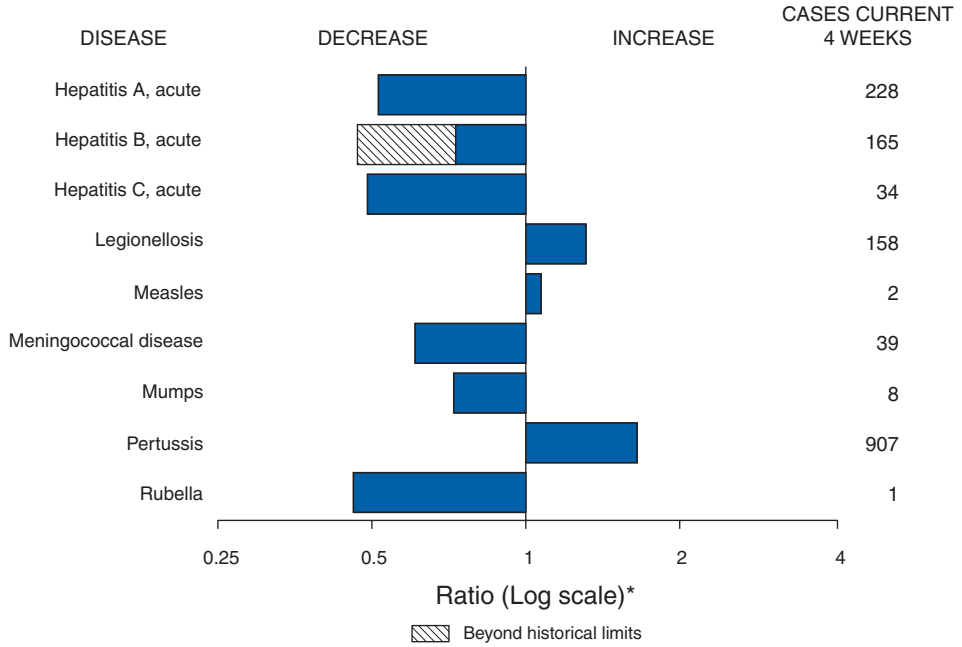
Table 1. The influenza vaccination coverage among adults aged ≥65 years in Hawaii should be 76.4% (95% confidence interval [CI] ±3.5%), % change +2.5%, and in Illinois should be 62.2% (CI ±3.5%), % change +1.1%. Pneumococcal vaccination coverage in Hawaii should be 69.4% (CI ±3.9%), % change +9.8%, and in Illinois should be 57.0% (CI ±3.6%), % change +0.3%. The overall median pneumococcal coverage for adults aged ≥65 years should be 64.5%.

Table 2. The influenza vaccination coverage among adults aged 18–64 years with asthma in Hawaii should be 41.6% (CI = 33.5–50.3), and in Illinois should be 33.9% (CI = 28.5–39.8). The influenza vaccination coverage among adults aged 18–64 years with diabetes in Hawaii should be 61.1% (51.4–70.0), and in Illinois should be 37.2% (30.6–44.2). Pneumococcal vaccination coverage among adults aged 18–64 years with diabetes in Hawaii should be 29.0% (CI = 21.0–38.5), and in Illinois should be 26.7% (CI = 20.9–33.4).

Erratum: Vol. 54, No. 36

In the report, "Update: Influenza Activity — United States and Worldwide, May 22–September 3, 2005, and 2005–06 Season Vaccination Recommendations," on page 901, an error occurred in the second sentence under Vaccination Recommendations for Persons Displaced by Hurricane Katrina. The sentence should read as follows: Any displaced persons aged ≥6 months living in crowded group settings should be administered influenza vaccine; children aged ≤8 years should be administered 2 doses, at least 1 month apart, **unless they have a documented record of a previous dose of influenza vaccine, in which case they should receive 1 dose of influenza vaccine.**

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals September 17, 2005, 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.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending September 17, 2005 (37th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	120	117
Botulism:			HIV infection, pediatric†¶	181	286
foodborne	9	6	Influenza-associated pediatric mortality†**	43	—
infant	56	58	Measles	58††	25§§
other (wound & unspecified)	20	11	Mumps	201	147
Brucellosis	73	65	Plague	3	1
Chancroid	17	19	Poliomyelitis, paralytic	—	—
Cholera	4	4	Psittacosis†	15	8
Cyclosporiasis†	674	190	Q fever†	87	48
Diphtheria	—	—	Rabies, human	1	4
Domestic arboviral diseases			Rubella	8	9
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	1	—
California serogroup†§	15	95	SARS†**	—	—
eastern equine†§	11	3	Smallpox†	—	—
Powassan†§	—	1	*Staphylococcus aureus*:		
St. Louis†§	4	12	Vancomycin-intermediate (VISA)†	—	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	—	1
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome†	92	102
human granulocytic (HGE)†	363	294	Tetanus	16	14
human monocytic (HME)†	260	208	Toxic-shock syndrome	72	65
human, other and unspecified †	56	53	Trichinellosis¶¶	14	1
Hansen disease†	54	71	Tularemia†	96	79
Hantavirus pulmonary syndrome†	17	18	Yellow fever	—	—

—: No reported cases.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
¶ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update June 26, 2005.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of 58 cases reported, 48 were indigenous and 10 were imported from another country.
§§ Of 25 cases reported, eight were indigenous and 17 were imported from another country.
¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending September 17, 2005, and September 18, 2004 (37th Week)*

Reporting area	AIDS		Chlamydia†		Coccidioidomycosis		Cryptosporidiosis	
	Cum. 2005§	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	20,405	28,079	641,828	651,982	3,159	4,060	4,000	2,489
NEW ENGLAND	778	926	22,906	21,506	—	—	179	135
Maine	11	20	1,548	1,445	N	N	14	16
N.H.	20	36	1,304	1,200	—	—	22	24
Vt.¶	4	14	691	802	—	—	27	21
Mass.	368	335	10,213	9,446	—	—	69	51
R.I.	68	98	2,339	2,448	—	—	5	4
Conn.	307	423	6,811	6,165	N	N	42	19
MID. ATLANTIC	4,352	6,423	80,709	79,937	—	—	1,752	351
Upstate N.Y.	800	731	15,904	16,038	N	N	1,513	80
N.Y. City	2,327	3,648	25,598	24,593	—	—	60	94
N.J.	574	1,091	13,179	12,630	N	N	21	38
Pa.	651	953	26,028	26,676	N	N	158	139
E.N. CENTRAL	1,938	2,416	99,485	115,659	6	11	775	784
Ohio	312	465	24,484	28,707	N	N	444	177
Ind.	236	264	14,087	13,071	N	N	47	59
Ill.	983	1,107	30,423	33,821	—	—	52	129
Mich.	322	459	17,411	26,752	6	11	69	112
Wis.	85	121	13,080	13,308	N	N	163	307
W.N. CENTRAL	463	601	39,913	39,845	5	6	414	292
Minn.	123	148	7,507	8,364	3	N	90	98
Iowa	50	47	5,000	4,833	N	N	80	59
Mo.	198	255	15,799	14,657	1	3	194	56
N. Dak.	5	15	837	1,291	N	N	—	9
S. Dak.	10	7	1,971	1,748	—	—	16	23
Nebr.¶	18	35	3,911	3,652	1	3	6	24
Kans.	59	94	4,888	5,300	N	N	28	23
S. ATLANTIC	6,473	8,657	125,691	122,610	1	—	395	367
Del.	100	116	2,351	2,013	N	N	—	—
Md.	812	988	13,210	13,483	1	—	27	14
D.C.	467	523	2,675	2,496	—	—	9	13
Va.¶	307	503	14,777	15,545	—	—	31	42
W. Va.	36	56	1,859	2,009	N	N	10	4
N.C.	531	422	23,518	20,812	N	N	47	55
S.C.¶	386	533	15,352	13,548	—	—	12	17
Ga.	1,103	1,162	21,435	22,907	—	—	74	128
Fla.	2,731	4,354	30,514	29,797	N	N	185	94
E.S. CENTRAL	1,093	1,376	49,120	42,121	—	5	118	105
Ky.	135	157	6,514	4,014	N	N	73	29
Tenn.¶	434	584	17,217	15,955	N	N	28	31
Ala.¶	295	305	10,516	9,631	—	—	15	19
Miss.	229	330	14,873	12,521	—	5	2	26
W.S. CENTRAL	2,206	3,424	76,726	80,699	1	2	60	74
Ark.	72	136	6,112	5,732	—	1	4	13
La.**	436	639	12,572	16,348	1	1	3	3
Okla.	167	130	7,883	7,924	N	N	33	17
Tex.¶	1,531	2,519	50,159	50,695	N	N	20	41
MOUNTAIN	789	997	36,853	39,609	2,193	2,539	96	134
Mont.	4	4	1,416	1,754	N	N	15	34
Idaho¶	9	16	1,655	1,991	N	N	9	19
Wyo.	2	13	783	758	3	2	2	3
Colo.	163	225	9,349	10,077	N	N	33	45
N. Mex.	72	138	3,272	6,368	9	18	3	13
Ariz.	329	357	12,764	11,510	2,145	2,460	10	15
Utah	33	51	3,091	2,631	5	14	15	3
Nev.¶	177	193	4,523	4,520	31	45	9	2
PACIFIC	2,313	3,259	110,425	109,996	953	1,497	211	247
Wash.	229	289	13,063	12,470	N	N	32	23
Oreg.¶	136	216	5,641	5,766	—	—	52	28
Calif.	1,874	2,658	86,219	85,138	953	1,497	125	194
Alaska	14	29	2,793	2,714	—	—	1	—
Hawaii	60	67	2,709	3,908	—	—	1	2
Guam	1	1	—	797	—	—	—	—
P.R.	537	396	2,639	2,546	N	N	N	N
V.I.	10	10	119	263	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	—	U	—	U	—	U

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

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

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

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

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

** Because of Hurricane Katrina, weekly reporting has been disrupted.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 17, 2005, and September 18, 2004 (37th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC) O157:H7 Cum. 2005	O157:H7 Cum. 2004	Shiga toxin positive, serogroup non-O157 Cum. 2005	Shiga toxin positive, serogroup non-O157 Cum. 2004	Shiga toxin positive, not serogrouped Cum. 2005	Shiga toxin positive, not serogrouped Cum. 2004	Giardiasis Cum. 2005	Giardiasis Cum. 2004	Gonorrhea Cum. 2005	Gonorrhea Cum. 2004
UNITED STATES	1,447	1,726	202	186	198	126	11,639	13,254	220,349	229,483
NEW ENGLAND	108	117	39	38	19	12	1,063	1,240	4,249	4,995
Maine	12	11	6	—	—	—	144	103	95	161
N.H.	11	14	2	5	—	—	40	27	118	91
Vt.	12	11	3	—	—	—	123	124	39	66
Mass.	37	51	6	13	19	12	444	544	1,856	2,213
R.I.	3	6	—	1	—	—	70	91	315	616
Conn.	33	24	22	19	—	—	242	351	1,826	1,848
MID. ATLANTIC	185	202	20	28	29	29	2,148	2,813	23,209	25,847
Upstate N.Y.	82	89	12	12	8	14	779	927	4,586	5,226
N.Y. City	9	33	—	—	—	—	537	787	6,933	7,958
N.J.	29	36	2	5	6	6	250	364	3,998	4,889
Pa.	65	44	6	11	15	9	582	735	7,692	7,774
E.N. CENTRAL	281	337	18	40	9	19	1,806	2,080	40,123	48,344
Ohio	90	76	4	8	4	10	535	562	11,662	14,856
Ind.	38	36	—	—	—	—	N	N	5,618	4,719
Ill.	45	73	1	7	1	6	354	594	12,215	14,681
Mich.	60	59	1	7	4	3	518	477	6,938	10,656
Wis.	48	93	12	18	—	—	399	447	3,690	3,432
W.N. CENTRAL	248	365	22	26	32	20	1,363	1,460	12,824	12,014
Minn.	65	85	7	10	18	4	613	535	2,126	2,088
Iowa	53	99	—	—	—	—	185	211	1,120	864
Mo.	58	62	9	13	7	6	306	396	6,587	6,255
N. Dak.	5	11	—	—	—	6	10	18	55	84
S. Dak.	18	27	3	—	—	—	63	42	260	194
Nebr.	21	54	3	3	4	—	66	104	906	749
Kans.	28	27	—	—	3	4	120	154	1,770	1,780
S. ATLANTIC	126	120	52	20	83	28	1,717	2,042	54,522	55,540
Del.	3	2	N	N	N	N	31	34	602	630
Md.	22	20	20	3	10	3	130	86	4,967	5,752
D.C.	—	1	—	—	—	—	37	51	1,512	1,846
Va.	22	24	19	9	17	—	363	346	5,357	6,213
W. Va.	1	2	—	—	1	—	30	28	505	652
N.C.	—	—	—	—	42	19	N	N	11,150	11,035
S.C.	5	10	—	—	1	—	75	86	6,721	6,703
Ga.	17	15	9	6	—	—	379	631	9,851	10,059
Fla.	56	46	4	2	12	6	672	780	13,857	12,650
E.S. CENTRAL	99	78	2	3	17	14	291	272	19,365	18,426
Ky.	31	19	—	1	13	8	N	N	2,193	1,777
Tenn.	40	34	2	—	4	6	156	153	6,257	5,935
Ala.	23	15	—	—	—	—	135	119	6,101	5,849
Miss.	5	10	—	2	—	—	—	—	4,814	4,865
W.S. CENTRAL	36	65	4	3	4	4	196	230	31,174	31,068
Ark.	6	11	—	—	—	—	60	91	3,205	3,011
La.	3	3	3	1	2	—	27	37	6,950	7,551
Okla.	17	15	—	—	—	—	109	102	3,199	3,353
Tex.	10	36	1	2	2	4	N	N	17,820	17,153
MOUNTAIN	129	166	39	27	5	—	941	1,071	7,961	8,271
Mont.	13	12	—	—	—	—	50	47	78	61
Idaho	14	37	8	7	2	—	61	127	68	60
Wyo.	5	7	2	1	—	—	18	17	51	42
Colo.	28	43	1	1	1	—	363	374	2,100	2,136
N. Mex.	6	10	5	5	—	—	44	56	628	847
Ariz.	26	14	N	N	N	N	97	132	2,800	2,657
Utah	27	28	21	12	—	—	262	229	479	409
Nev.	10	15	2	1	2	—	46	89	1,757	2,059
PACIFIC	235	276	6	1	—	—	2,114	2,046	26,922	24,978
Wash.	67	94	—	—	—	—	246	240	2,562	1,829
Oreg.	56	51	6	1	—	—	264	325	993	809
Calif.	91	123	—	—	—	—	1,490	1,363	22,479	20,988
Alaska	12	1	—	—	—	—	70	58	394	433
Hawaii	9	7	—	—	—	—	44	60	494	919
Guam	N	N	—	—	—	—	—	2	—	123
P.R.	1	1	—	—	—	—	103	186	248	186
V.I.	—	—	—	—	—	—	—	—	35	79
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 17, 2005, and September 18, 2004 (37th Week)*

Reporting area	*Haemophilus influenzae*, invasive							
	All ages		Age <5 years					
	All serotypes		Serotype b		Non-serotype b		Unknown serotype	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,524	1,446	3	9	82	83	150	138
NEW ENGLAND	124	132	—	1	10	8	5	1
Maine	6	12	—	—	—	—	1	—
N.H.	6	14	—	—	—	2	—	—
Vt.	7	5	—	—	—	—	2	1
Mass.	59	62	—	1	3	3	1	—
R.I.	7	3	—	—	2	—	—	—
Conn.	39	36	—	—	5	3	1	—
MID. ATLANTIC	307	289	—	1	—	4	37	32
Upstate N.Y.	91	99	—	1	—	4	8	5
N.Y. City	55	65	—	—	—	—	10	12
N.J.	59	54	—	—	—	—	9	2
Pa.	102	71	—	—	—	—	10	13
E.N. CENTRAL	219	274	1	—	4	8	15	41
Ohio	93	79	—	—	—	2	9	14
Ind.	53	38	—	—	4	4	—	1
Ill.	35	96	—	—	—	—	3	20
Mich.	17	18	1	—	—	2	2	4
Wis.	21	43	—	—	—	—	1	2
W.N. CENTRAL	81	80	—	2	3	3	9	8
Minn.	36	36	—	1	3	3	2	—
Iowa	1	1	—	1	—	—	—	—
Mo.	28	30	—	—	—	—	5	6
N. Dak.	1	3	—	—	—	—	1	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	7	4	—	—	—	—	1	1
Kans.	8	6	—	—	—	—	—	1
S. ATLANTIC	365	332	1	—	22	22	21	24
Del.	—	—	—	—	—	—	—	—
Md.	54	51	—	—	5	5	—	—
D.C.	—	2	—	—	—	—	—	1
Va.	37	31	—	—	—	—	2	4
W. Va.	22	15	—	—	1	4	4	—
N.C.	64	44	1	—	7	5	—	1
S.C.	20	10	—	—	—	—	1	1
Ga.	71	91	—	—	—	—	10	16
Fla.	97	88	—	—	9	8	4	1
E.S. CENTRAL	88	58	—	1	1	—	16	7
Ky.	8	5	—	—	1	—	2	—
Tenn.	62	39	—	—	—	—	10	5
Ala.	18	12	—	1	—	—	4	2
Miss.	—	2	—	—	—	—	—	—
W.S. CENTRAL	85	56	1	1	7	6	6	1
Ark.	4	1	—	—	1	—	—	—
La.	28	11	1	—	2	—	6	1
Okla.	51	43	—	—	4	6	—	—
Tex.	2	1	—	1	—	—	—	—
MOUNTAIN	171	153	—	3	13	22	31	18
Mont.	—	—	—	—	—	—	—	—
Idaho	3	5	—	—	—	—	1	2
Wyo.	4	1	—	—	—	1	1	—
Colo.	34	39	—	—	—	—	9	5
N. Mex.	16	32	—	—	4	7	2	6
Ariz.	88	53	—	—	7	9	10	2
Utah	13	12	—	2	—	2	6	2
Nev.	13	11	—	1	2	3	2	1
PACIFIC	84	72	—	—	22	10	10	6
Wash.	3	1	—	—	—	—	2	1
Oreg.	29	33	—	—	—	—	5	2
Calif.	39	25	—	—	22	10	2	1
Alaska	5	5	—	—	—	—	1	1
Hawaii	8	8	—	—	—	—	—	1
Guam	—	—	—	—	—	—	—	—
P.R.	3	2	—	—	—	—	1	2
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 17, 2005, and September 18, 2004 (37th Week)*

Reporting area	Hepatitis (viral, acute), by type					
	A		B		C	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	2,684	4,226	3,799	4,153	566	539
NEW ENGLAND	372	717	197	258	9	12
Maine	1	11	12	1	—	—
N.H.	69	16	16	26	—	—
Vt.	5	8	3	5	9	4
Mass.	249	602	137	137	—	7
R.I.	10	19	1	5	—	—
Conn.	38	61	28	84	U	1
MID. ATLANTIC	459	543	758	548	78	88
Upstate N.Y.	75	66	61	54	13	5
N.Y. City	203	228	77	114	—	—
N.J.	103	127	465	156	—	—
Pa.	78	122	155	224	65	83
E.N. CENTRAL	247	348	334	401	95	78
Ohio	36	38	99	84	3	4
Ind.	37	43	33	34	22	7
Ill.	57	113	82	63	—	13
Mich.	100	114	120	189	70	54
Wis.	17	40	—	31	—	—
W.N. CENTRAL	63	119	199	247	30	18
Minn.	3	28	25	37	5	15
Iowa	16	35	19	14	—	—
Mo.	28	25	113	150	23	3
N. Dak.	—	1	—	4	1	—
S. Dak.	—	3	3	1	—	—
Nebr.	4	10	20	28	1	—
Kans.	12	17	19	13	—	—
S. ATLANTIC	480	773	971	1,296	174	129
Del.	4	5	38	32	82	10
Md.	48	84	109	117	17	3
D.C.	2	5	10	15	—	2
Va.	56	85	103	181	10	13
W. Va.	4	3	27	28	13	18
N.C.	61	70	112	138	12	10
S.C.	26	39	100	101	2	13
Ga.	79	268	118	336	7	12
Fla.	200	214	354	348	31	48
E.S. CENTRAL	190	125	250	359	67	71
Ky.	20	29	44	46	8	23
Tenn.	131	78	100	171	14	24
Ala.	22	6	57	57	10	4
Miss.	17	12	49	85	35	20
W.S. CENTRAL	141	514	286	251	51	72
Ark.	7	59	28	90	—	2
La.	44	38	31	45	9	3
Okla.	4	19	25	52	3	3
Tex.	86	398	202	64	39	64
MOUNTAIN	241	327	383	320	33	34
Mont.	7	5	3	1	1	2
Idaho	15	15	8	10	1	1
Wyo.	—	4	1	7	—	2
Colo.	31	40	36	45	16	8
N. Mex.	18	19	6	16	—	U
Ariz.	142	198	268	158	—	5
Utah	18	32	34	27	7	4
Nev.	10	14	27	56	8	12
PACIFIC	491	760	421	473	29	37
Wash.	32	42	53	39	U	U
Oreg.	33	53	74	81	13	14
Calif.	404	641	283	335	16	22
Alaska	3	4	7	10	—	—
Hawaii	19	20	4	8	—	1
Guam	—	1	—	12	—	9
P.R.	52	32	31	60	—	—
V.I.	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 17, 2005, and September 18, 2004 (37th Week)*

Reporting area	Legionellosis		Listeriosis		Lyme disease		Malaria	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,242	1,393	496	496	14,189	13,278	837	1,035
NEW ENGLAND	72	61	38	30	1,485	2,284	51	75
Maine	3	1	1	5	98	29	5	6
N.H.	6	5	5	2	138	158	5	4
Vt.	4	3	2	1	29	40	1	4
Mass.	25	29	10	9	725	1,277	26	45
R.I.	12	8	5	1	25	152	2	3
Conn.	22	15	15	12	470	628	12	13
MID. ATLANTIC	432	374	129	120	9,894	8,259	224	271
Upstate N.Y.	115	73	39	35	2,674	2,626	35	32
N.Y. City	53	51	23	21	—	296	111	140
N.J.	81	59	29	24	3,314	2,173	52	59
Pa.	183	191	38	40	3,906	3,164	26	40
E.N. CENTRAL	225	349	51	91	701	1,117	66	96
Ohio	119	161	23	33	55	41	17	24
Ind.	13	34	3	16	20	19	1	10
Ill.	12	36	1	19	—	78	24	33
Mich.	68	101	18	21	33	17	18	17
Wis.	13	17	6	2	593	962	6	12
W.N. CENTRAL	56	44	25	10	547	325	36	51
Minn.	16	6	6	2	461	251	11	18
Iowa	3	4	8	1	61	40	6	3
Mo.	22	22	4	4	17	23	15	17
N. Dak.	2	2	3	—	—	—	—	3
S. Dak.	10	3	—	—	—	1	—	1
Nebr.	1	2	1	3	1	7	1	2
Kans.	2	5	3	—	7	3	3	7
S. ATLANTIC	269	279	99	79	1,395	1,133	205	243
Del.	12	9	N	N	406	186	3	6
Md.	77	59	14	10	726	668	77	51
D.C.	8	10	—	3	8	8	8	11
Va.	32	35	8	14	141	103	19	35
W. Va.	12	7	3	3	7	17	1	1
N.C.	23	27	19	16	40	87	22	14
S.C.	10	8	5	5	12	17	6	10
Ga.	18	35	18	13	4	12	32	48
Fla.	77	89	32	15	51	35	37	67
E.S. CENTRAL	52	70	25	20	25	35	21	28
Ky.	16	26	4	4	3	13	6	4
Tenn.	23	29	11	10	22	18	11	8
Ala.	10	12	7	4	—	4	4	11
Miss.	3	3	3	2	—	—	—	5
W.S. CENTRAL	24	104	25	32	49	46	54	109
Ark.	4	—	1	3	4	8	4	7
La.	4	7	7	2	4	2	2	5
Okla.	3	3	3	—	—	—	3	7
Tex.	13	94	14	27	41	36	45	90
MOUNTAIN	66	65	11	17	15	17	39	38
Mont.	5	1	—	—	—	—	—	—
Idaho	3	7	—	1	2	6	—	1
Wyo.	3	5	—	—	3	3	1	—
Colo.	17	16	4	8	4	—	18	14
N. Mex.	2	4	4	—	1	1	2	2
Ariz.	17	11	—	—	2	6	10	10
Utah	11	17	1	1	2	1	6	6
Nev.	8	4	2	7	1	—	2	5
PACIFIC	46	47	93	97	78	62	141	124
Wash.	—	8	7	8	6	9	11	12
Oreg.	N	N	6	5	15	22	7	15
Calif.	45	39	79	80	54	29	106	94
Alaska	—	—	—	—	3	2	4	—
Hawaii	1	—	1	4	N	N	13	3
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	2	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 17, 2005, and September 18, 2004 (37th Week)*

Reporting area	Meningococcal disease									
	All serogroups		Serogroup A, C, Y, and W-135		Serogroup B		Other serogroup		Serogroup unknown	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	880	897	69	71	44	36	—	1	767	789
NEW ENGLAND	60	52	1	5	—	6	—	1	59	40
Maine	2	9	—	—	—	1	—	—	2	8
N.H.	10	4	—	—	—	—	—	—	10	4
Vt.	6	2	—	—	—	—	—	—	6	2
Mass.	28	30	—	5	—	5	—	—	28	20
R.I.	2	1	—	—	—	—	—	—	2	1
Conn.	12	6	1	—	—	—	—	1	11	5
MID. ATLANTIC	115	127	31	35	5	5	—	—	79	87
Upstate N.Y.	29	33	4	5	3	3	—	—	22	25
N.Y. City	17	22	—	—	—	—	—	—	17	22
N.J.	30	28	—	—	—	—	—	—	30	28
Pa.	39	44	27	30	2	2	—	—	10	12
E.N. CENTRAL	91	101	22	23	9	6	—	—	60	72
Ohio	31	50	—	3	5	5	—	—	26	42
Ind.	16	16	—	1	4	1	—	—	12	14
Ill.	12	1	—	—	—	—	—	—	12	1
Mich.	22	19	22	19	—	—	—	—	—	—
Wis.	10	15	—	—	—	—	—	—	10	15
W.N. CENTRAL	59	64	3	—	1	4	—	—	55	60
Minn.	11	21	1	—	—	—	—	—	10	21
Iowa	15	13	—	—	1	2	—	—	14	11
Mo.	18	17	1	—	—	1	—	—	17	16
N. Dak.	—	2	—	—	—	—	—	—	—	2
S. Dak.	3	2	1	—	—	1	—	—	2	1
Nebr.	4	4	—	—	—	—	—	—	4	4
Kans.	8	5	—	—	—	—	—	—	8	5
S. ATLANTIC	172	171	5	2	9	2	—	—	158	167
Del.	3	4	—	—	—	—	—	—	3	4
Md.	19	9	3	—	2	—	—	—	14	9
D.C.	—	5	—	2	—	—	—	—	—	3
Va.	21	13	—	—	—	—	—	—	21	13
W. Va.	6	5	1	—	—	—	—	—	5	5
N.C.	28	26	1	—	7	2	—	—	20	24
S.C.	14	13	—	—	—	—	—	—	14	13
Ga.	15	11	—	—	—	—	—	—	15	11
Fla.	66	85	—	—	—	—	—	—	66	85
E.S. CENTRAL	43	44	1	1	3	1	—	—	39	42
Ky.	14	8	—	1	3	1	—	—	11	6
Tenn.	19	14	—	—	—	—	—	—	19	14
Ala.	6	11	1	—	—	—	—	—	5	11
Miss.	4	11	—	—	—	—	—	—	4	11
W.S. CENTRAL	72	50	1	1	5	1	—	—	66	48
Ark.	11	13	—	—	—	—	—	—	11	13
La.	25	27	—	1	2	—	—	—	23	26
Okla.	12	7	1	—	3	1	—	—	8	6
Tex.	24	3	—	—	—	—	—	—	24	3
MOUNTAIN	70	53	4	1	5	5	—	—	61	47
Mont.	—	3	—	—	—	—	—	—	—	3
Idaho	2	6	—	—	—	—	—	—	2	6
Wyo.	—	4	—	—	—	—	—	—	—	4
Colo.	16	12	3	—	—	—	—	—	13	12
N. Mex.	2	6	—	1	—	3	—	—	2	2
Ariz.	35	11	—	—	2	1	—	—	33	10
Utah	9	4	1	—	2	—	—	—	6	4
Nev.	6	7	—	—	1	1	—	—	5	6
PACIFIC	198	235	1	3	7	6	—	—	190	226
Wash.	39	22	1	3	4	6	—	—	34	13
Oreg.	28	46	—	—	—	—	—	—	28	46
Calif.	119	158	—	—	—	—	—	—	119	158
Alaska	1	4	—	—	—	—	—	—	1	4
Hawaii	11	5	—	—	3	—	—	—	8	5
Guam	—	1	—	—	—	—	—	—	—	1
P.R.	6	13	—	—	—	—	—	—	6	13
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	1	1	—	—	—	—	—	—	1	1
C.N.M.I.	—	—	—	—	—	—	—	—	—	—

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 17, 2005, and September 18, 2004 (37th Week)*

Reporting area	Pertussis		Rabies, animal		Rocky Mountain spotted fever		Salmonellosis		Shigellosis	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	13,724	12,519	3,939	4,766	1,114	1,075	27,144	29,251	8,632	9,297
NEW ENGLAND	783	1,268	523	458	3	14	1,561	1,562	220	216
Maine	17	5	41	42	N	N	106	82	8	5
N.H.	43	46	11	22	1	—	130	108	7	6
Vt.	74	60	42	19	—	—	82	42	15	2
Mass.	596	1,088	274	192	1	12	830	903	137	143
R.I.	21	22	15	32	1	1	74	91	12	13
Conn.	32	47	140	151	—	1	339	336	41	47
MID. ATLANTIC	943	2,032	688	705	74	58	3,335	4,311	854	910
Upstate N.Y.	369	1,437	393	383	3	1	856	879	197	351
N.Y. City	57	140	20	11	4	20	722	987	267	299
N.J.	159	137	N	N	24	10	572	829	219	179
Pa.	358	318	275	311	43	27	1,185	1,616	171	81
E.N. CENTRAL	2,545	4,292	158	148	34	31	3,616	3,825	607	838
Ohio	833	398	56	58	27	8	980	931	78	125
Ind.	224	82	10	9	2	5	444	355	115	152
Ill.	494	855	40	38	1	14	993	1,239	135	317
Mich.	169	152	33	37	4	2	636	610	167	84
Wis.	825	2,805	19	6	—	2	563	690	112	160
W.N. CENTRAL	2,139	1,323	355	485	136	104	1,744	1,749	1,054	317
Minn.	887	194	57	63	2	—	409	432	64	48
Iowa	412	116	110	81	3	1	267	350	60	59
Mo.	313	271	61	44	113	86	567	471	703	123
N. Dak.	81	640	21	50	—	—	26	31	2	3
S. Dak.	23	22	43	82	5	4	108	75	25	9
Nebr.	160	19	—	82	4	13	105	116	51	19
Kans.	263	61	63	83	9	—	262	274	149	56
S. ATLANTIC	915	498	1,169	1,683	548	532	7,579	7,653	1,387	2,167
Del.	5	—	—	9	2	4	56	84	8	6
Md.	120	91	229	237	63	47	587	628	62	113
D.C.	7	7	—	—	2	—	41	45	9	30
Va.	244	135	378	356	47	22	738	823	83	109
W. Va.	36	17	40	50	5	4	107	173	—	5
N.C.	64	62	361	459	329	318	1,071	1,064	133	225
S.C.	261	83	5	123	33	51	853	755	63	459
Ga.	27	17	152	244	53	71	1,103	1,381	324	463
Fla.	151	86	4	205	14	15	3,023	2,700	705	757
E.S. CENTRAL	379	226	103	105	204	151	1,934	1,865	943	599
Ky.	101	51	7	19	2	2	339	250	227	53
Tenn.	175	135	36	34	156	82	550	505	460	311
Ala.	65	26	58	43	42	41	491	480	190	189
Miss.	38	14	2	9	4	26	554	630	66	46
W.S. CENTRAL	1,128	525	648	867	78	162	2,294	2,789	1,791	2,430
Ark.	208	53	26	41	53	83	510	385	48	52
La.	30	13	—	2	5	5	458	641	83	224
Okla.	—	17	63	88	7	70	279	290	491	339
Tex.	890	442	559	736	13	4	1,047	1,473	1,169	1,815
MOUNTAIN	2,911	991	182	163	29	19	1,626	1,685	521	577
Mont.	507	34	13	21	1	3	68	136	5	4
Idaho	109	26	—	3	3	3	77	122	5	9
Wyo.	34	17	14	4	2	4	67	42	3	4
Colo.	950	495	14	41	5	4	446	420	87	120
N. Mex.	110	125	6	4	1	2	163	201	60	98
Ariz.	772	158	110	82	13	2	470	483	299	280
Utah	398	123	13	5	4	1	252	160	34	29
Nev.	31	13	12	3	—	—	83	121	28	33
PACIFIC	1,981	1,364	113	152	8	4	3,455	3,812	1,255	1,243
Wash.	588	484	U	U	—	—	385	371	81	80
Oreg.	524	332	4	6	1	2	279	341	94	56
Calif.	694	520	108	135	7	2	2,531	2,797	1,047	1,058
Alaska	68	11	1	11	—	—	41	42	7	6
Hawaii	107	17	—	—	—	—	219	261	26	43
Guam	—	—	—	—	—	—	—	49	—	41
P.R.	5	3	52	42	N	N	333	298	2	22
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 17, 2005, and September 18, 2004 (37th Week)*

Reporting area	Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive disease				Syphilis			
			Drug resistant, all ages		Age <5 years		Primary & secondary		Congenital	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	3,217	3,388	1,641	1,613	622	556	5,481	5,486	179	282
NEW ENGLAND	122	229	84	103	46	76	147	142	1	4
Maine	9	10	N	N	—	4	1	2	—	—
N.H.	13	16	—	—	4	N	12	3	—	3
Vt.	9	8	10	6	4	1	1	—	—	—
Mass.	83	104	61	28	38	42	95	87	—	—
R.I.	8	17	13	14	—	6	8	19	—	1
Conn.	—	74	U	55	U	23	30	31	1	—
MID. ATLANTIC	709	577	156	115	108	80	715	706	21	27
Upstate N.Y.	208	188	61	48	48	55	61	68	5	1
N.Y. City	127	93	U	U	19	U	443	426	5	12
N.J.	159	122	N	N	19	7	98	116	11	13
Pa.	215	174	95	67	22	18	113	96	—	1
E.N. CENTRAL	633	782	444	361	160	129	562	641	27	38
Ohio	158	183	277	254	62	60	158	168	2	2
Ind.	81	79	156	107	43	26	45	45	1	2
Ill.	116	211	11	—	48	1	274	268	10	11
Mich.	249	238	—	N	—	N	62	134	12	23
Wis.	29	71	N	N	7	42	23	26	2	—
W.N. CENTRAL	207	240	34	17	66	76	174	123	2	4
Minn.	79	119	—	—	40	50	48	18	1	1
Iowa	N	N	N	N	—	N	2	5	—	—
Mo.	52	52	28	12	7	11	103	74	1	2
N. Dak.	9	10	1	—	2	2	—	—	—	—
S. Dak.	19	12	3	5	—	—	1	—	—	—
Nebr.	14	16	2	—	6	6	4	6	—	—
Kans.	34	31	N	N	11	7	16	20	—	1
S. ATLANTIC	669	670	649	836	64	41	1,380	1,358	31	46
Del.	1	3	1	4	—	N	8	6	—	1
Md.	147	103	—	—	42	29	236	260	10	7
D.C.	7	7	15	8	2	4	75	41	—	1
Va.	62	59	N	N	—	N	88	70	3	2
W. Va.	22	20	95	90	20	8	3	3	—	—
N.C.	99	95	N	N	U	U	196	135	8	8
S.C.	24	50	—	80	—	N	45	90	4	10
Ga.	129	163	113	204	—	N	221	245	1	3
Fla.	178	170	425	450	—	N	508	508	5	14
E.S. CENTRAL	130	173	129	113	8	12	314	290	17	19
Ky.	27	51	23	23	N	N	33	30	—	1
Tenn.	103	122	106	88	—	N	150	93	12	7
Ala.	—	—	—	—	—	N	102	127	4	9
Miss.	—	—	—	2	8	12	29	40	1	2
W.S. CENTRAL	200	267	94	46	123	111	885	858	51	56
Ark.	14	16	12	6	13	7	38	39	—	3
La.	6	2	82	40	22	24	176	212	6	3
Okla.	87	52	N	N	19	33	30	19	1	2
Tex.	93	197	N	N	69	47	641	588	44	48
MOUNTAIN	473	369	51	21	38	31	278	289	15	36
Mont.	—	—	—	—	—	—	5	1	—	—
Idaho	1	8	N	N	—	N	20	15	1	2
Wyo.	3	7	21	9	—	—	—	1	—	—
Colo.	175	77	N	N	37	31	31	49	—	—
N. Mex.	37	79	—	N	—	—	34	68	2	2
Ariz.	195	165	N	N	—	N	110	121	12	31
Utah	61	31	28	10	1	—	5	8	—	1
Nev.	1	2	2	2	—	—	73	26	—	—
PACIFIC	74	81	—	1	9	—	1,026	1,079	14	52
Wash.	N	N	N	N	N	N	96	92	—	—
Oreg.	N	N	N	N	6	N	19	23	—	—
Calif.	—	—	N	N	N	N	901	959	14	52
Alaska	—	—	—	—	—	N	6	—	—	—
Hawaii	74	81	—	1	3	—	4	5	—	—
Guam	—	—	—	—	—	—	—	1	—	—
P.R.	N	N	N	N	—	N	144	95	8	5
V.I.	—	—	—	—	—	—	—	4	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 17, 2005, and September 18, 2004 (37th Week)*

Reporting area	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease†		
							Neuroinvasive		Non-neuroinvasive§
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	7,547	9,334	163	237	16,809	19,938	574	1,030	841
NEW ENGLAND	243	307	19	19	997	2,106	2	—	—
Maine	11	13	1	—	213	181	—	—	—
N.H.	5	12	—	—	204	—	—	—	—
Vt.	4	2	—	—	42	413	—	—	—
Mass.	151	176	11	14	538	202	—	—	—
R.I.	21	41	1	1	—	—	—	—	—
Conn.	51	63	6	4	U	1,310	2	—	—
MID. ATLANTIC	1,393	1,451	32	60	3,217	74	10	11	8
Upstate N.Y.	177	197	5	8	—	—	—	2	—
N.Y. City	668	726	10	22	—	—	3	2	2
N.J.	343	312	9	16	—	—	—	1	—
Pa.	205	216	8	14	3,217	74	7	6	6
E.N. CENTRAL	914	840	13	29	4,563	8,520	120	59	62
Ohio	173	148	1	6	1,018	1,049	19	10	3
Ind.	96	89	1	—	482	N	1	7	—
Ill.	438	366	3	13	64	4,339	88	25	56
Mich.	148	175	4	8	2,674	2,629	9	13	2
Wis.	59	62	4	2	325	503	3	4	1
W.N. CENTRAL	305	318	3	7	311	138	65	80	240
Minn.	129	119	3	3	—	—	7	13	13
Iowa	32	26	—	—	N	N	2	10	4
Mo.	69	84	—	2	220	5	5	26	6
N. Dak.	2	3	—	—	13	77	2	2	14
S. Dak.	11	8	—	—	78	56	29	6	160
Nebr.	23	24	—	2	—	—	18	7	40
Kans.	39	54	—	—	—	—	2	16	3
S. ATLANTIC	1,721	1,871	28	33	1,420	1,819	8	59	10
Del.	7	17	—	—	21	4	—	—	—
Md.	188	192	9	11	—	—	1	8	—
D.C.	38	69	—	—	24	20	—	1	—
Va.	221	162	6	5	293	462	—	4	—
W. Va.	17	14	—	—	722	1,008	—	—	N
N.C.	187	219	3	5	—	N	1	3	1
S.C.	147	131	—	—	360	325	1	—	—
Ga.	263	416	2	4	—	—	1	11	1
Fla.	653	651	8	8	—	—	4	32	8
E.S. CENTRAL	363	442	5	7	—	34	23	57	15
Ky.	73	76	2	2	N	N	2	1	—
Tenn.	161	146	—	5	—	—	6	12	1
Ala.	129	136	1	—	—	34	3	15	2
Miss.	—	84	2	—	—	—	12	29	12
W.S. CENTRAL	779	1,390	9	20	4,461	5,572	87	185	33
Ark.	73	84	—	—	—	—	1	13	5
La.	—	—	—	—	107	48	50	61	16
Okla.	92	114	—	1	—	—	1	12	1
Tex.	614	1,192	9	19	4,354	5,524	35	99	11
MOUNTAIN	267	367	8	7	1,840	1,675	65	311	116
Mont.	8	4	—	—	—	—	7	1	11
Idaho	—	3	—	—	—	—	2	1	6
Wyo.	—	2	—	—	46	27	2	2	—
Colo.	46	89	3	2	1,307	1,330	7	41	43
N. Mex.	14	21	—	—	123	U	11	28	6
Ariz.	160	152	3	2	—	—	16	208	19
Utah	21	28	1	1	364	318	14	5	19
Nev.	18	68	1	2	—	—	6	25	12
PACIFIC	1,562	2,348	46	55	—	—	194	268	357
Wash.	175	156	5	4	N	N	—	—	—
Oreg.	54	73	3	1	—	—	—	—	3
Calif.	1,227	2,003	31	44	—	—	194	268	354
Alaska	23	27	—	—	—	—	—	—	—
Hawaii	83	89	7	6	—	—	—	—	—
Guam	—	44	—	—	—	118	—	—	—
P.R.	—	74	—	—	505	302	—	—	—
V.I.	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	—
C.N.M.I.	—	U	—	U	—	U	—	U	—

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

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

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

§ Not previously notifiable.

TABLE III. Deaths in 122 U.S. cities,* week ending September 17, 2005 (37th Week)

Reporting Area	All causes, by age (years)						P&I†
	All Ages	≥65	45–64	25–44	1–24	<1	Total
NEW ENGLAND	415	287	78	32	16	2	21
Boston, Mass.	144	100	21	14	8	1	6
Bridgeport, Conn.	35	27	5	1	2	—	—
Cambridge, Mass.	12	11	1	—	—	—	1
Fall River, Mass.	22	14	5	3	—	—	—
Hartford, Conn.	54	33	16	2	3	—	3
Lowell, Mass.	14	12	—	2	—	—	1
Lynn, Mass.	11	6	3	2	—	—	2
New Bedford, Mass.	25	20	4	1	—	—	2
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	48	33	11	2	2	—	3
Somerville, Mass.	2	2	—	—	—	—	—
Springfield, Mass.	25	15	6	3	1	—	2
Waterbury, Conn.	23	14	6	2	—	1	1
Worcester, Mass.	U	U	U	U	U	U	U
MID. ATLANTIC	1,931	1,303	403	146	40	37	95
Albany, N.Y.	65	47	7	3	2	6	2
Allentown, Pa.	27	21	5	1	—	—	2
Buffalo, N.Y.	69	47	14	3	2	3	6
Camden, N.J.	31	15	11	5	—	—	3
Elizabeth, N.J.	20	9	9	1	1	—	2
Erie, Pa.	37	25	10	2	—	—	7
Jersey City, N.J.	23	19	2	2	—	—	—
New York City, N.Y.	920	625	195	65	22	13	34
Newark, N.J.	54	25	14	13	2	—	2
Paterson, N.J.	U	U	U	U	U	U	U
Philadelphia, Pa.	322	205	73	29	5	8	7
Pittsburgh, Pa.§	30	17	6	3	1	3	3
Reading, Pa.	34	28	5	1	—	—	4
Rochester, N.Y.	107	79	18	5	2	3	12
Schenectady, N.Y.	20	14	3	2	1	—	1
Scranton, Pa.	30	22	5	2	—	1	1
Syracuse, N.Y.	89	67	16	6	—	—	4
Trenton, N.J.	20	10	6	2	2	—	2
Utica, N.Y.	14	11	3	—	—	—	1
Yonkers, N.Y.	19	17	1	1	—	—	2
E.N. CENTRAL	2,104	1,371	490	151	35	56	135
Akron, Ohio	39	21	12	4	—	2	2
Canton, Ohio	33	28	4	1	—	—	2
Chicago, Ill.	324	192	78	32	8	13	18
Cincinnati, Ohio	43	28	11	1	—	3	5
Cleveland, Ohio	249	181	44	18	5	1	10
Columbus, Ohio	185	120	48	10	4	3	10
Dayton, Ohio	126	85	29	7	1	4	7
Detroit, Mich.	183	90	64	17	3	9	15
Evansville, Ind.	53	34	12	6	—	1	2
Fort Wayne, Ind.	86	62	16	3	2	3	5
Gary, Ind.	16	10	4	1	—	1	1
Grand Rapids, Mich.	54	40	9	1	2	2	8
Indianapolis, Ind.	218	131	53	23	6	5	12
Lansing, Mich.	48	33	11	4	—	—	9
Milwaukee, Wis.	130	95	32	2	—	1	9
Peoria, Ill.	39	26	10	1	1	1	—
Rockford, Ill.	56	38	11	5	1	1	10
South Bend, Ind.	34	22	8	1	1	2	2
Toledo, Ohio	116	78	25	9	1	3	5
Youngstown, Ohio	72	57	9	5	—	1	3
W.N. CENTRAL	674	429	157	46	21	20	45
Des Moines, Iowa	59	43	8	4	3	1	6
Duluth, Minn.	27	22	4	—	1	—	1
Kansas City, Kans.	21	10	6	5	—	—	2
Kansas City, Mo.	77	51	21	2	—	3	3
Lincoln, Nebr.	38	30	5	2	1	—	8
Minneapolis, Minn.	65	40	15	1	5	4	4
Omaha, Nebr.	83	54	17	8	3	1	6
St. Louis, Mo.	187	92	61	19	7	7	7
St. Paul, Minn.	56	44	7	3	1	1	4
Wichita, Kans.	61	43	13	2	—	3	4
S. ATLANTIC	957	543	207	125	48	34	37
Atlanta, Ga.	154	77	—	45	20	12	6
Baltimore, Md.	171	84	52	20	6	9	9
Charlotte, N.C.	104	64	25	8	4	3	3
Jacksonville, Fla.	165	101	40	18	5	1	7
Miami, Fla.	98	60	21	12	3	2	4
Norfolk, Va.	50	34	10	2	3	1	1
Richmond, Va.	52	29	14	5	1	3	2
Savannah, Ga.	52	33	12	5	1	1	1
St. Petersburg, Fla.	U	U	U	U	U	U	U
Tampa, Fla.	U	U	U	U	U	U	U
Washington, D.C.	100	53	31	9	5	2	2
Wilmington, Del.	11	8	2	1	—	—	2
E.S. CENTRAL	659	411	173	48	20	7	49
Birmingham, Ala.	—	—	—	—	—	—	—
Chattanooga, Tenn.	73	49	19	3	1	1	3
Knoxville, Tenn.	107	66	29	10	1	1	4
Lexington, Ky.	61	37	18	5	1	—	4
Memphis, Tenn.	142	85	38	11	6	2	14
Mobile, Ala.	72	46	15	4	6	1	3
Montgomery, Ala.	45	33	10	1	1	—	6
Nashville, Tenn.	159	95	44	14	4	2	15
W.S. CENTRAL	1,433	912	321	115	38	47	71
Austin, Tex.	93	65	16	8	1	3	5
Baton Rouge, La.	42	20	12	10	—	—	—
Corpus Christi, Tex.	U	U	U	U	U	U	U
Dallas, Tex.	175	94	49	15	10	7	12
El Paso, Tex.	128	89	22	13	2	2	5
Ft. Worth, Tex.	124	79	24	9	7	5	3
Houston, Tex.	383	226	110	27	5	15	23
Little Rock, Ark.	72	48	14	4	3	3	5
New Orleans, La.¶	U	U	U	U	U	U	U
San Antonio, Tex.	219	156	35	18	5	5	9
Shreveport, La.	55	39	8	3	—	5	4
Tulsa, Okla.	142	96	31	8	5	2	5
MOUNTAIN	805	528	162	72	29	11	40
Albuquerque, N.M.	U	U	U	U	U	U	U
Boise, Idaho	34	22	8	3	1	—	2
Colo. Springs, Colo.	65	43	12	6	2	2	3
Denver, Colo.	98	60	21	12	2	3	1
Las Vegas, Nev.	231	163	42	19	6	—	13
Ogden, Utah	24	17	5	1	—	1	1
Phoenix, Ariz.	210	121	47	22	13	5	5
Pueblo, Colo.	29	23	6	—	—	—	6
Salt Lake City, Utah	114	79	21	9	5	—	9
Tucson, Ariz.	U	U	U	U	U	U	U
PACIFIC	1,623	1,101	337	109	43	33	123
Berkeley, Calif.	21	16	1	2	—	2	1
Fresno, Calif.	203	146	33	10	9	5	7
Glendale, Calif.	20	16	4	—	—	—	1
Honolulu, Hawaii	68	50	12	3	1	2	6
Long Beach, Calif.	U	U	U	U	U	U	U
Los Angeles, Calif.	304	203	64	22	9	6	37
Pasadena, Calif.	26	20	2	3	—	1	2
Portland, Oreg.	121	78	30	11	—	2	5
Sacramento, Calif.	153	98	39	12	4	—	14
San Diego, Calif.	177	119	37	15	1	5	13
San Francisco, Calif.	147	93	31	10	10	3	8
San Jose, Calif.	187	127	39	12	7	2	16
Santa Cruz, Calif.	25	22	1	—	1	1	1
Seattle, Wash.	113	71	32	7	1	2	7
Spokane, Wash.	58	42	12	2	—	2	5
Tacoma, Wash.	U	U	U	U	U	U	U
TOTAL	10,601**	6,885	2,328	844	290	247	616

U: Unavailable. —: No reported cases.

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

†Pneumonia and influenza.

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

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

**Total includes unknown ages.

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