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Assessment of Sexually Transmitted Diseases Services in City and County Jails — United States, 1997

Approximately 15 million arrests were made in the United States in 1995, and the number of persons incarcerated has increased 72% since 1990 (*1*). At any given time, approximately 567,000 persons are incarcerated in local jails (i.e., county or city correctional facilities housing persons serving short-term sentences or awaiting trial) (*1*). The prevalence of sexually transmitted diseases (STDs) among incarcerated women is high: syphilis, 35%; chlamydia, 27%; and gonorrhea, 8% (*2,3*). However, limited information is available about the extent of STD diagnosis and treatment services in correctional facilities. During July–August 1997, CDC conducted a survey of STD testing and treatment policies and practices in jails. This report summarizes the results of the survey, which indicates that most facilities treat for STDs based on symptoms or by arrestee request and do not routinely screen asymptomatic persons.

Counties were selected on the basis of the following criteria: 1) counties reporting >40 cases of primary and secondary syphilis in 1996; or 2) counties containing cities with populations >200,000 persons, regardless of STD morbidity. STD program managers, in collaboration with county health department officials and administrative personnel at the main jail facilities in the sampled counties, completed the survey. STD testing policy was classified as routine (provided to all arrestees), symptomatic (provided to arrestees who indicate signs or symptoms of an STD), by request (provided to arrestees who request STD testing), or not provided. STD testing rates were calculated using reported monthly testing and admission data.

Of the 92 counties surveyed, 88 (96%) completed the assessment, representing 115 city and county jails. Of these 115 facilities, 94 (82%) housed both men and women, 13 (11%) housed men only, and eight (7%) housed women only.

Less than half (range: 12%–47%) of the facilities had a policy of offering routine STD testing to arrestees for chlamydia, gonorrhea, or syphilis (Table 1). However, in jails with routine testing policies, less than half (range: 3%–48%) of arrestees were tested for any of the three diseases (Table 2). More than half (52%–77%) of the facilities offered STD testing to symptomatic arrestees or to arrestees who requested testing for chlamydia, gonorrhea, or syphilis (Table 1). In these facilities, <8% of women and <3% of men were tested for any of the three diseases. Ten (9%) facilities had a policy of offering routine syphilis screening using rapid plasma reagin (Stat RPR) (a 15-minute on-site test using venipuncture blood). In these facilities, syphilis testing rates for

Sexually Transmitted Diseases Services — Continued

TABLE 1. Number and percentage of jail facilities with a policy of offering sexually transmitted disease and pregnancy testing*, by testing policy, sex, and type of test — United States, 1997

	Type of test							
	Chlamydia		Gonorrhea		Syphilis		Pregnancy†	
Policy/Sex	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Provided routine testing								
Women	20	(20%)	23	(22%)	48	(47%)	34	(33%)
Men	13	(12%)	17	(16%)	49	(46%)	N/A	
Provided testing to arrestees who had symptoms or who requested testing								
Women	74	(72%)	73	(72%)	53	(52%)	64	(63%)
Men	76	(71%)	82	(77%)	57	(53%)	N/A	
Did not test								
Women	8	(8%)	6	(6%)	1	(1%)		
Men	18	(17%)	8	(7%)	1	(1%)		

*107 facilities for men and 102 facilities for women.
† Four facilities did not provide information.

TABLE 2. Percentage of arrestees tested for sexually transmitted diseases and pregnancy, by testing policy and sex — United States, 1997

	Type of test			
Policy/Sex	Chlamydia	Gonorrhea	Syphilis	Pregnancy
Provided routine testing				
Women	29%	35%	48%	39%
Men	3%	14%	48%	N/A
Provided testing to arrestees who had symptoms or who requested testing				
Women	3%	4%	7%	4%
Men	0.4%	0.5%	2%	N/A

women (70%) and men (72%) were higher than rates for facilities where no Stat RPR was available. Twenty-nine facilities (28%) had a policy of routinely offering both pregnancy and syphilis testing. In these facilities, 47% of women were tested for syphilis and 40% were tested for pregnancy.

Approximately half of arrestees were released within 48 hours after incarceration. Approximately 45% of facilities received STD test results >48 hours after testing.

Most facilities used protocols to guide STD treatment (92%) and screening (73%). Fifty-six percent of facilities used the 1993 CDC STD treatment guidelines (*4*), and 19% used the 1993 CDC *Chlamydia* screening guidelines (*5*).

Reported by: Div of STD Prevention, National Center for HIV, STD, and TB Prevention, CDC.

Sexually Transmitted Diseases Services — Continued

Editorial Note: The findings in this report indicate that most facilities had a policy of STD screening based on symptoms or arrestee request. Less than half of the facilities had a policy of offering routine testing. In those facilities with a policy of routine testing, less than half of the arrestees were actually tested. Many STDs, including chlamydia, gonorrhea, and syphilis, can be asymptomatic and can only be detected through routine screening activities (*6*). Therefore, routine testing policies and greater implementation of existing routine testing policies in jails can increase STD diagnosis and treatment. Previous studies support the use of rapid syphilis testing and document its effectiveness in increasing diagnosis and treatment of syphilis in jail populations (*2,7*). Routinely offering women pregnancy and Stat RPR testing at incarceration can prevent congenital syphilis (*2*).

Although most facilities reported using STD treatment and screening guidelines from some source, the CDC guidelines were not widely used. To increase the number of arrestees diagnosed and treated for STDs and to improve the quality of the services delivered, CDC STD treatment guidelines or other evidence-based guidelines should be used. This can be achieved by the continued communication between health departments and jail facilities and by increasing the number of jail personnel attending STD training.

Because the data for this survey were based on monthly testing and admission data reported to STD program managers, they may not represent true STD testing rates. However, in the absence of active STD surveillance, these data provide the most reliable estimates.

Treatment of persons after release is labor intensive, often unsuccessful (*2,8*), and represents a missed opportunity for STD control and prevention. Arrestees are a transient population with limited access to health care (*7,9*). A comprehensive STD control and prevention strategy should incorporate correctional facilities as an important setting for public health intervention (*6,10*). Health departments and correctional facilities can benefit from a partnership that facilitates STD testing and treatment in jails in areas with high rates of disease.

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Syphilis Screening Among Women Arrestees at the Cook County Jail — Chicago, 1996

Cook County (Chicago) Department of Corrections (i.e., Cook County Jail [CCJ]) is one of the largest jail systems in the United States, with a daily census of approximately 10,000 arrestees. CCJ contracts with Cermak Health Services (CHS)* to provide medical services, including routine syphilis screening, to arrestees at CCJ. On January 6, 1996, the Chicago Department of Public Health (CDPH) STD/HIV Program, in collaboration with the CCJ, CHS, and CDC, implemented the Rapid Plasma Reagin (Stat RPR) Project at CCJ to improve syphilis identification and treatment rates among women. This report describes the project and provides data from the first year of operation. The findings indicate that Stat RPR yields a higher treatment rate for women arrestees than routine syphilis testing.

The Stat RPR project provides testing on admission to all women arrestees entering CCJ during the second shift (3 p.m.–11 p.m.), Monday through Friday. All women arrestees who are screened consent to testing. A four-step protocol is followed. First, CDPH staff perform the Stat RPR (a 15-minute on-site test using venipuncture blood), then a routine quantitative RPR is performed on site for all samples that were reactive to Stat RPR. Second, CDPH staff review the Chicago syphilis registry, a computerized database of reactive syphilis serologies (screening and confirmatory) and treatment histories, to determine whether women arrestees with reactive serologies are in the registry and require treatment based on standard serologic criteria (CDC's 1993 STD treatment guidelines [*1*]). Third, CDPH staff notify the CCJ physician's assistant (PA) of women with reactive serologies who have an indication for treatment. Finally, the PA provides on-site clinical examination, diagnosis, and treatment to women arrestees within a few hours after the initial test.

Women admitted on the weekend and during the first and third shifts on weekdays received off-site syphilis screening using a quantitative RPR. Arrestees with reactive serologies who met standard criteria for treatment were examined at the CCJ STD clinic, usually within 3–5 days of testing.

Of the 616 women with positive Stat RPR tests during 1996, a total of 158 (26%) had indications for treatment. Of these, 125 (79%) received treatment the same day, eight (5%) received treatment at a later date at CCJ, and 25 (16%) were released before receiving treatment. A total of 133 (84%) women with indications for treatment were treated before release; of these, 128 (96%) were later confirmed as having syphilis by fluorescent treponemal antibody absorbed (FTA-ABS). Of the 25 women released before treatment, six (24%) could not be located on follow-up, and 12 (48%) were not followed up.

Of the 597 women with positive screening tests by routine RPR, 226 (38%) had indications for treatment. Of these, 94 (42%) received treatment at CCJ, and 132 (58%) were released before receiving treatment. Of women who received treatment at CCJ, 91 (97%) were later confirmed as having syphilis by FTA-ABS. Of the 132 women released before treatment, 60 (45%) could not be located on follow-up, and 24 (18%) were not followed up. Women screened with Stat RPR were more likely than women screened with routine RPR to receive treatment before release (relative risk=2.0; 95% confidence interval=1.7–2.4).

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

Syphilis Screening — Continued

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Editorial Note: Rapid STD diagnosis and treatment before release is critical for syphilis control and prevention in incarcerated populations because many arrestees are released within a few days after entering a jail facility (*2*). After release, many arrestees are difficult to reach, may not seek treatment in the absence of symptoms (*3*), and may have limited access to health care (*2,4*). The findings in this report indicate that rapid syphilis screening methods improve syphilis treatment rates. Compared with routine screening methods, the use of on-site Stat and quantitative RPR substantially reduced the percentage of women with reactive serologies released before receiving treatment and the percentage of women requiring follow up after release.

As syphilis rates among women in Chicago have declined and as screening in CCJ has increased, the proportion of disease that occurs in CCJ women arrestees has increased. In 1995, CCJ reported 10% (108 of 1041) of early syphilis cases among women in Chicago. After implementation of the Stat RPR project in 1996, early syphilis morbidity reported from CCJ increased to 22% of the city's total (176 of 803). Compared with 1995, early syphilis morbidity rates per 100,000 women in Chicago in 1996 decreased by 24% (68 to 52). Although the findings from this study do not establish a direct association between syphilis morbidity in Chicago and in CCJ, they indicate that declining syphilis morbidity in Chicago may be related, in part, to improved syphilis diagnosis and treatment of women arrestees who would not otherwise be diagnosed and treated outside the jail.

This project demonstrates that Stat RPR screening in jails can substantially improve the treatment rates of women with reactive serologies for syphilis before release and prevent the release of infected women to the community where disease and transmission of infection could continue unabated. Broad implementation of such interventions could help decrease overall syphilis morbidity in Chicago and the United States.

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Assessing Adolescent Pregnancy — Maine, 1980–1996

Despite prevention efforts at the state and federal levels, adolescent pregnancy rates in the United States are among the highest in developed countries (*1*). The 1996 Personal Responsibility and Work Opportunity Reconciliation Act* mandates a national strategy to prevent pregnancy among teenagers and requires that states establish goals to reduce the incidence of "out-of-wedlock" pregnancies, particularly among teenagers. Adolescent pregnancy and birth rates are declining across the na-

*Public Law 104–193.

Adolescent Pregnancy — Continued

tion (*2*); in particular, the rates have decreased substantially in Maine (*2*). This report summarizes an evaluation of pregnancy rates for persons aged 15–19 years in Maine and an assessment of clinical and behavioral factors that may have contributed to decreasing rates during 1980–1996 by the Maine Department of Human Services, Bureau of Health (MBH); the Family Planning Association of Maine (FPA); and CDC. From 1980 through 1996, pregnancy rates in Maine among females aged 15–19 years decreased from 67.9 to 45.6 pregnancies per 1000. A decrease in oral contraceptive (OC) use and increases in the use of condoms and long-acting methods were significantly correlated with the decrease in adolescent pregnancy rates from 1984 to 1996.

Maine vital statistics data for 1980–1996 were used to assess adolescent pregnancies, births, and abortions by age, marital status, education, partner's age, and previous pregnancies. Annual reports from FPA, the only recipient of Title X[†] funds in Maine and the largest provider of reproductive health-care services in the state, were used to examine clinical factors that may have contributed to decreasing adolescent pregnancy rates (e.g., what contraceptive methods clients reported using). The Maine Pregnancy Risk Assessment Monitoring System (PRAMS), a survey of new mothers about pregnancy behaviors, practices, and outcomes, was used to determine the number and rate of unintended pregnancies among adolescents who gave birth. Chlamydia rates from the MBH Sexually Transmitted Diseases Surveillance System were used as a proxy indicator to help evaluate trends in unprotected intercourse among adolescents. The Maine Youth Risk Factor Behavior Survey, a survey of adolescents in grades 9–12, was used to obtain information about adolescent sexual behavior. Data from the Maine Department of Education were used to assess high school drop-out rates and the percentage of high school seniors who intended to pursue postsecondary education.

Adolescent pregnancy rates were calculated as the total reported live-born infants, abortions, and fetal deaths per 1000 females in Maine for females aged 15–17, 18–19, and 15–19 years (*3*); fetal losses at <20 weeks' gestation were not included. Population data are from the MBH, Office of Data, Research and Vital Statistics. Trends in adolescent pregnancy, birth, and abortion rates were tabulated by demographic variables, and changes in potential explanatory variables were examined over time. Correlation coefficients (r) and p values were used to assess the strength and significance of correlations between these factors and adolescent pregnancy rates.

From 1980 through 1996, pregnancy rates in Maine among females aged 15–19 years decreased from 67.9 to 45.6 pregnancies per 1000; the largest decrease occurred from 1991 to 1992 (Table 1, Figure 1). Both birth and abortion rates decreased among females aged 15–17 and 18–19 years. Among females aged 15–19 years, the percentage of pregnancies among those who were unmarried increased from 58% to 83%, while the percentage of pregnancies among those with a previous pregnancy decreased from 29% to 24%. There were no substantial changes in mean years of education or partner's age among adolescents who became pregnant.

From 1984 through 1996, the percentage of females aged 15–19 years who were seen at FPA clinics was approximately 22% per year (Table 1). OCs have been the predominant family planning method of adolescents at the FPA clinics, but the percentage using OCs declined from 75% to 58%. Condom use increased from 5% to 14%, and

[†]Title X provides federal grants for family planning services to adolescents and low-income women.

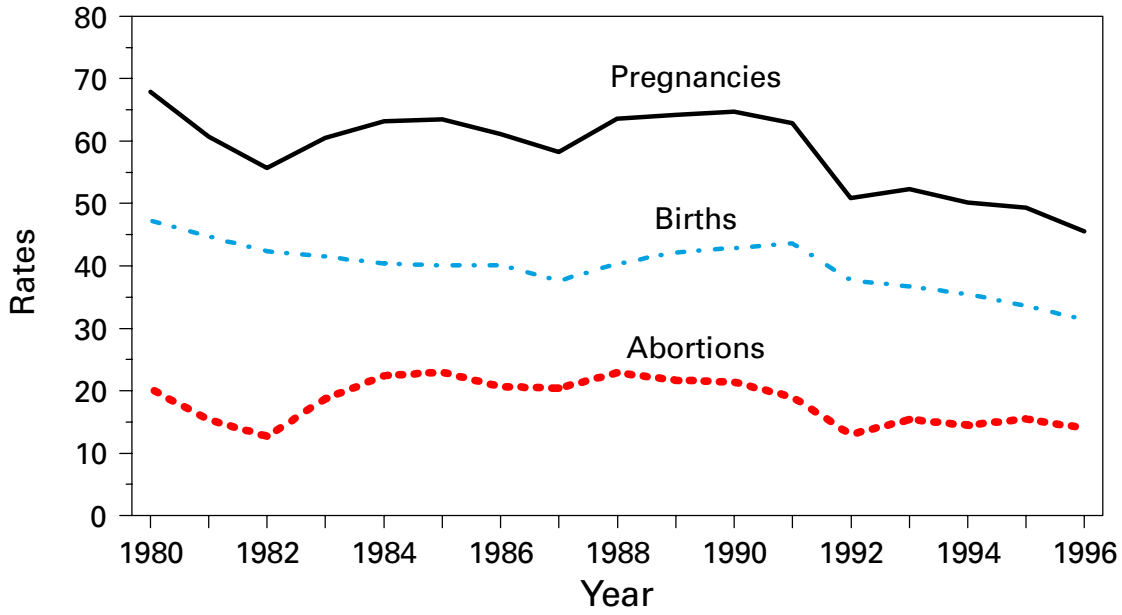
TABLE 1. Pregnancy rates* and potential determinants of pregnancy among adolescents, by percentage or rate, and correlations between the potential determinants and adolescent pregnancy rates — Maine, 1980–1996

	Females aged 15–19 years								Males and females in high school	
			% of FPA† clients reporting primary contraceptive method				Births unintended at conception			
Year	Pregnancy rate	% Who were FPA clients	OCs§	Condoms	Long-acting methods¶	Chlamydia rates	%	(95% CI**)	% High school dropouts	% High school seniors with intent to pursue post-secondary education
1980	67.9								4.2%	44.8%
1981	60.7								3.9%	45.9%
1982	55.7								3.6%	45.7%
1983	60.5								3.6%	47.7%
1984	63.2	21.8%	75.4%	5.2%	0.4%				3.6%	51.1%
1985	63.5	22.5%	78.0%	4.5%	0.3%				3.5%	53.6%
1986	61.1	23.6%	81.0%	3.8%	0.2%				3.5%	56.3%
1987	58.3	24.1%	82.4%	4.1%	0.1%				3.8%	56.6%
1988	63.6	22.2%	81.8%	5.3%	0.1%	27.4			4.0%	56.7%
1989	64.2	23.3%	80.0%	5.9%	0.1%	30.4	65.0%	(54.6%–75.3%)	3.7%	53.6%
1990	64.7	23.8%	78.4%	6.7%	0.0%	29.8	70.7%	(60.2%–81.3%)	3.3%	54.7%
1991	62.9	23.7%	77.9%	6.9%	0.1%	21.4	60.5%	(49.7%–71.3%)	3.0%	56.6%
1992	50.9	21.7%	78.3%	7.5%	0.3%	15.7	80.5%	(69.3%–91.8%)	2.9%	56.4%
1993	52.3	22.2%	74.4%	9.7%	1.2%	13.0	76.4%	(65.5%–87.3%)	2.7%	57.8%
1994	50.2	21.7%	68.7%	10.8%	4.4%	10.3	72.1%	(60.0%–83.9%)	2.9%	58.4%
1995	49.3	26.0%	55.1%	12.0%	10.1%	10.8	85.2%	(75.8%–94.5%)	3.0%	59.4%
1996	45.6	23.9%	58.5%	14.1%	11.2%	7.5	76.5%	(65.8%–87.2%)	2.9%	62.1%
Correlation with adolescent pregnancy rates (r)		–0.12	0.76††	–0.85††	–0.77††	0.96††		–0.77††	0.74††	–0.57††

* Per 1000 female population aged 15–19 years.
† Family Planning Association of Maine.
§ Oral contraceptives.
¶ E.g., Norplant® (Wyeth-Ayerst, Philadelphia, Pennsylvania) and Depo-Provera® (The Upjohn Company, Kalamazoo, Michigan). Use of trade names and commercial sources is for identification only and does not imply endorsement by CDC or the U.S. Department of Health and Human Services.
** Confidence interval
†† $p<0.05$.

Adolescent Pregnancy — Continued

FIGURE 1. Pregnancy, birth, and abortion rates per 1000 females aged 15–19 years—Maine, 1980–1996



the use of long-acting contraceptive methods (primarily Norplant®§ [Wyeth-Ayerst, Philadelphia, Pennsylvania] and Depo-Provera® [The Upjohn Company, Kalamazoo, Michigan]) increased from <1% to 11%. Both the decrease in OC use and the increase in use of condoms and long-acting contraceptive methods among FPA clients were significantly correlated with the decrease in adolescent pregnancy rates from 1984 to 1996 (r=0.76, –0.85, and –0.77, respectively).

Changes in some behavioral factors also were significantly correlated with the decrease in adolescent pregnancy rates. From 1988 to 1996, rates for chlamydia among females aged 15–19 years (a proxy for having unprotected intercourse) decreased from 27 to eight cases per 1000 (correlation with decrease in adolescent pregnancy rates: r=0.96). From 1989 to 1996, unintended pregnancies among adolescent females who gave birth increased from 65% to 77% (correlation with decrease in adolescent pregnancy rates: r=–0.77). Among males and females, from 1980 to 1996, the high school dropout rate decreased from 4% to 3% (correlation with decrease in adolescent pregnancy rates: r=0.74), and the percentage of high school seniors who indicated a goal to pursue postsecondary education increased from 45% to 62% (correlation with decrease in adolescent pregnancy rates: r=–0.57). The percentage of males and females aged 15–19 years who had ever had sexual intercourse was 58% in 1991, 49% in 1995, and 52% in 1997; the changes in these percentages were not statistically significant.

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

Adolescent Pregnancy — Continued

Editorial Note: A thorough assessment of factors influencing adolescent pregnancy rates at the state level can be used to target adolescent pregnancy prevention efforts and evaluate progress toward national health objectives for 2000. This retrospective assessment of pregnancy rates among adolescents in Maine illustrates how states can identify trends in adolescent pregnancy rates and associated factors. In Maine, changes in behavioral factors may have had the greatest impact on adolescent pregnancy rates, including increased condom use, decreased high school drop-out rates, and increased intent to pursue postsecondary education. The use of long-acting contraceptive methods was rare before 1993 and therefore could not have contributed to the large decrease in adolescent pregnancy rates from 1991 to 1992. Decreases in rates for chlamydia may indicate a decrease in the incidence of unprotected intercourse among this group.

This report is subject to at least five limitations. First, a critical factor that could not be assessed adequately was the school health education program in Maine. However, the 1996 Maine School Health Education Profile indicates that 97% of public middle schools and senior high schools require education about human immunodeficiency virus; of those schools, 85% taught condom efficacy and 62% taught correct use of condoms (J. Foster, Maine Department of Education, personal communication, 1998). Second, individual characteristics or behaviors could not be connected to the outcome of adolescent pregnancy and persons could not be followed over time. Third, data were incomplete for some factors that were examined and lacking for other potentially important determinants (e.g., patterns of care and visits at family-planning clinics and qualitative data about attitudes of adolescents over time). Fourth, most of the data had not been computerized, which limited analytic possibilities. Finally, changes in reporting practices over time could account for the change in pregnancy rates among adolescents; however, there were no obvious changes in reporting practices during 1980–1996 (Maine Vital Statistics Office, personal communication, 1998).

As a result of the findings in this report, the collaborating agencies have recommended the development of a prospective system to monitor and assess adolescent pregnancy rates and potential determinants of risk for pregnancy among adolescents. The Maine Adolescent Pregnancy Assessment Team would be a collaboration between agencies that collect data and agencies that use the data in making decisions on policies and programs (i.e., FPA; state departments of human services, education, and labor; and other state, professional, and community-based organizations). Changes in existing data availability and evaluation (providing adequate confidentiality) would need to facilitate 1) access to data about persons to allow follow-up over time, 2) examination of data by relevant geographic areas (e.g., county, school district, or community), 3) the linking of vital statistics and family planning clinic data to adolescents' clinic experience and pregnancy status, and 4) access to additional relevant data sources (e.g., the Maine School Health Education Profile). The information would enable policy makers and program planners to develop plans for adolescent pregnancy-prevention efforts. Other states may want to consider using a similar prospective assessment of adolescent pregnancy rates and potential determinants to better guide research and prevention efforts at the state level.

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Adolescent Pregnancy — Continued

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Notice to Readers

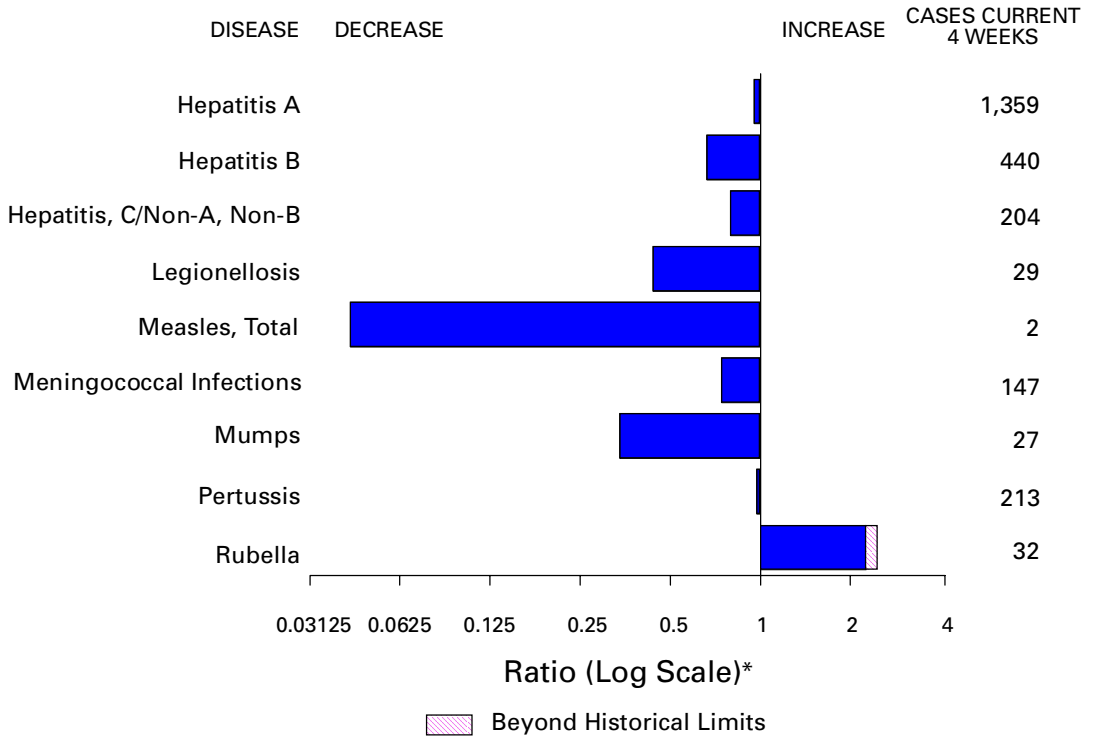
Availability of Applications for Public Health Leadership Institute

The CDC/University of California Public Health Leadership Institute (PHLI) is a 1-year scholars' program that includes an intensive on-site week, scheduled for March 13–19, 1999. The PHLI is conducted under a cooperative agreement between CDC's Public Health Practice Program Office and the University of California at Los Angeles. The purpose of the PHLI is to strengthen the U.S. public health system by enhancing the leadership capacities of senior city, county, state, federal, and international public health officials.

The eighth year of the PHLI will begin November 14, 1998, with an orientation for PHLI scholars at the American Public Health Association annual meeting in Washington, D.C. Approximately 35 senior public health officials from city, county, state, federal, and international health agencies will be selected to participate in the Institute.

Senior state and local health officials, including "deputy" level staff nominated by state health directors, or local health directors with a service population of >200,000 are eligible to apply. Applications must be submitted no later than August 15, 1998. Selected scholars will be notified during the week of September 29, 1998. Additional information and applications are available from the Director, PHLI, telephone (510) 986-0140.

FIGURE I. Selected notifiable disease reports, comparison of provisional 4-week totals ending May 30, 1998, with historical data — United States



*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 — provisional cases of selected notifiable diseases, United States, cumulative, week ending May 30, 1998 (21st Week)

	Cum. 1998		Cum. 1998
Anthrax	-	Plague	-
Brucellosis	9	Poliomyelitis, paralytic¶	-
Cholera	3	Psittacosis	17
Congenital rubella syndrome	2	Rabies, human	-
Cryptosporidiosis*	693	Rocky Mountain spotted fever (RMSF)	38
Diphtheria	1	Streptococcal disease, invasive Group A	939
Encephalitis: California*	-	Streptococcal toxic-shock syndrome*	29
eastern equine*	-	Syphilis, congenital**	70
St. Louis*	-	Tetanus	10
western equine*	-	Toxic-shock syndrome	54
Hansen Disease	45	Trichinosis	5
Hantavirus pulmonary syndrome*†	2	Typhoid fever	111
Hemolytic uremic syndrome, post-diarrheal*	11	Yellow fever	-
HIV infection, pediatric*§	106		

-:no reported cases
*Not notifiable in all states.
† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID).
§ Updated monthly to the Division of HIV/AIDS Prevention–Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP), last update May 24, 1998.
¶ One suspected case of polio with onset in 1998 has also been reported to date.
**Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending May 30, 1998, and May 24, 1997 (21st Week)

Reporting Area	AIDS		Chlamydia		*Escherichia coli* O157:H7		Gonorrhea		Hepatitis C/NA,NB	
					NETSS†	PHLIS§				
	Cum. 1998*	Cum. 1997	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1998	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997
UNITED STATES	20,034	24,160	203,583	183,020	404	224	119,601	110,281	1,592	1,165
NEW ENGLAND	640	745	7,462	6,963	44	30	1,924	2,375	19	27
Maine	13	25	364	368	1	-	14	22	-	-
N.H.	21	14	365	312	8	6	34	54	-	-
Vt.	10	18	151	163	-	-	12	23	-	1
Mass.	275	279	3,395	2,816	21	18	826	883	18	24
R.I.	58	55	1,011	845	3	1	149	198	1	2
Conn.	263	354	2,176	2,459	11	5	889	1,195	-	-
MID. ATLANTIC	5,695	8,107	25,636	22,821	38	10	14,352	13,997	157	127
Upstate N.Y.	710	1,334	N	N	30	-	2,416	2,458	127	98
N.Y. City	3,153	4,136	13,996	12,274	2	5	5,899	5,531	-	-
N.J.	993	1,696	3,803	4,138	6	4	2,476	2,884	-	-
Pa.	839	941	7,837	6,409	N	1	3,561	3,124	30	29
E.N. CENTRAL	1,518	1,638	34,316	29,844	68	38	23,224	17,427	195	280
Ohio	281	348	9,889	9,055	23	6	5,991	5,562	6	7
Ind.	293	301	2,902	3,475	10	19	1,894	2,398	3	6
Ill.	610	504	9,934	5,306	18	-	7,806	2,595	7	45
Mich.	252	394	8,486	7,672	17	5	6,335	5,073	179	207
Wis.	82	91	3,105	4,336	N	8	1,198	1,799	-	15
W.N. CENTRAL	351	497	12,247	12,616	51	28	6,046	5,577	103	27
Minn.	56	83	1,830	2,643	20	14	650	908	-	2
Iowa	20	58	1,692	1,908	6	-	528	485	12	12
Mo.	176	253	4,691	4,686	8	12	3,500	3,061	87	4
N. Dak.	4	4	290	343	1	1	29	23	-	2
S. Dak.	9	2	616	463	1	-	104	46	-	-
Nebr.	36	34	920	800	6	-	331	282	2	1
Kans.	50	63	2,208	1,773	9	1	904	772	2	6
S. ATLANTIC	5,037	5,885	43,057	34,090	32	14	35,002	32,777	73	84
Del.	57	111	1,036	612	-	1	543	443	-	-
Md.	571	727	3,343	2,856	10	4	3,693	4,701	3	1
D.C.	413	400	N	N	1	-	1,416	1,621	-	-
Va.	368	484	3,665	4,399	N	7	2,459	3,279	3	8
W. Va.	47	38	1,151	1,284	N	-	324	399	3	6
N.C.	335	362	9,143	6,743	7	2	7,696	6,518	11	23
S.C.	318	293	7,534	4,988	1	-	4,874	4,494	-	19
Ga.	608	691	9,932	3,482	2	-	8,270	4,551	8	-
Fla.	2,320	2,779	7,253	9,726	10	-	5,727	6,771	45	27
E.S. CENTRAL	788	722	14,023	13,506	29	9	13,118	13,696	57	145
Ky.	101	111	2,518	2,674	7	-	1,385	1,746	9	6
Tenn.	272	303	5,166	5,015	17	9	4,339	4,210	45	87
Ala.	233	196	3,608	3,256	5	-	4,621	4,566	3	5
Miss.	182	112	2,731	2,561	-	-	2,773	3,174	-	47
W.S. CENTRAL	2,473	2,558	28,112	21,001	24	4	16,240	14,096	458	129
Ark.	81	96	1,235	1,066	1	1	1,114	1,771	1	5
La.	415	461	4,720	3,194	-	-	4,021	3,029	2	78
Okla.	134	138	4,052	3,000	3	3	2,179	1,874	4	4
Tex.	1,843	1,863	18,105	13,741	20	-	8,926	7,422	451	42
MOUNTAIN	725	706	7,302	10,611	36	27	2,695	2,902	193	140
Mont.	13	18	475	415	2	-	22	16	4	5
Idaho	14	22	769	590	4	-	69	44	80	20
Wyo.	2	13	275	211	-	-	11	24	29	48
Colo.	127	194	-	1,897	8	8	941	754	11	17
N. Mex.	111	66	1,531	1,578	8	6	284	359	39	27
Ariz.	286	157	3,315	4,112	N	7	1,213	1,295	1	15
Utah	57	46	684	674	10	1	63	88	16	2
Nev.	115	190	253	1,134	4	5	92	322	13	6
PACIFIC	2,807	3,302	31,428	31,568	82	64	7,000	7,434	337	206
Wash.	203	287	4,511	3,728	20	22	755	803	10	10
Oreg.	88	144	2,237	1,891	23	21	304	287	2	2
Calif.	2,463	2,825	23,088	24,722	39	18	5,638	5,978	271	125
Alaska	12	18	769	564	-	-	138	178	1	-
Hawaii	41	28	823	663	N	3	165	188	53	69
Guam	-	2	8	189	N	-	2	25	-	-
P.R.	834	517	U	U	-	U	158	250	-	44
V.I.	17	34	N	N	N	U	-	-	-	-
Amer. Samoa	-	-	-	-	N	U	-	-	-	-
C.N.M.I.	-	1	N	N	N	U	7	15	-	2

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

*Updated monthly to the Division of HIV/AIDS Prevention–Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention, last update May 24, 1998.

†National Electronic Telecommunications System for Surveillance.

§Public Health Laboratory Information System.

TABLE II. (Cont'd.) Provisional cases of selected notifiable diseases, United States, weeks ending May 30, 1998, and May 24, 1997 (21st Week)

Reporting Area	Legionellosis		Lyme Disease		Malaria		Syphilis (Primary & Secondary)		Tuberculosis		Rabies, Animal
	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997	Cum. 1998*	Cum. 1997	Cum. 1998
UNITED STATES	397	336	1,626	1,329	406	531	2,671	3,525	2,817	6,527	2,715
NEW ENGLAND	22	27	396	299	17	23	29	68	114	160	533
Maine	1	1	1	3	1	1	1	-	U	15	84
N.H.	2	4	8	7	3	2	1	-	2	1	33
Vt.	1	3	2	3	-	2	2	-	-	2	30
Mass.	8	11	93	55	11	16	20	37	94	81	165
R.I.	4	4	27	34	2	2	-	-	18	13	33
Conn.	6	4	265	197	-	-	5	31	U	48	188
MID. ATLANTIC	87	58	976	810	111	148	90	172	217	1,184	577
Upstate N.Y.	26	12	513	103	28	22	12	18	U	163	390
N.Y. City	14	2	3	65	52	88	21	33	U	621	U
N.J.	4	8	124	222	17	27	18	80	217	240	80
Pa.	43	36	336	420	14	11	39	41	U	160	107
E.N. CENTRAL	125	130	30	25	28	56	365	317	213	671	31
Ohio	58	61	29	10	2	4	68	101	5	132	25
Ind.	17	19	1	9	1	5	66	70	U	57	-
Ill.	12	5	-	3	6	27	138	34	208	334	2
Mich.	24	31	-	3	18	16	72	45	U	103	4
Wis.	14	14	U	U	1	4	21	67	U	45	-
W.N. CENTRAL	28	25	13	13	21	12	64	70	95	193	284
Minn.	3	1	4	9	8	5	3	13	U	49	51
Iowa	2	6	7	-	2	4	-	3	U	20	59
Mo.	11	2	-	3	8	2	48	35	66	81	15
N. Dak.	-	2	-	-	1	-	-	-	U	4	52
S. Dak.	-	1	-	-	-	-	1	-	9	2	54
Nebr.	9	10	-	1	-	1	4	1	5	4	2
Kans.	3	3	2	-	2	-	8	18	15	33	51
S. ATLANTIC	51	42	142	120	107	94	1,155	1,417	409	1,139	872
Del.	7	5	-	25	1	2	12	11	-	14	17
Md.	10	10	101	74	37	32	265	395	106	115	220
D.C.	3	2	4	5	7	6	31	53	45	35	-
Va.	4	8	10	-	16	22	72	116	89	111	261
W. Va.	N	N	4	-	-	-	2	3	21	21	39
N.C.	6	5	3	7	8	6	330	291	148	132	136
S.C.	4	2	1	1	3	7	138	177	U	98	65
Ga.	-	-	2	1	13	12	213	251	U	213	45
Fla.	16	10	17	7	22	7	92	120	U	400	89
E.S. CENTRAL	13	12	19	27	10	14	433	781	152	498	112
Ky.	8	-	4	3	1	3	47	65	U	69	16
Tenn.	4	5	8	9	6	4	227	320	U	177	67
Ala.	1	2	7	2	3	4	98	205	152	168	29
Miss.	-	5	-	13	-	3	61	191	U	84	-
W.S. CENTRAL	9	5	5	4	10	7	323	476	41	969	71
Ark.	-	-	2	2	-	1	48	65	41	80	1
La.	-	1	-	1	4	4	111	163	-	77	-
Okla.	4	1	-	-	1	2	20	50	U	72	70
Tex.	5	3	3	1	5	-	144	198	U	740	-
MOUNTAIN	24	20	1	3	20	31	80	75	128	209	63
Mont.	1	1	-	-	-	2	-	-	12	2	21
Idaho	-	2	-	-	2	-	-	-	4	4	-
Wyo.	1	1	-	1	-	1	-	-	2	2	36
Colo.	4	4	-	-	7	15	4	2	U	42	1
N. Mex.	2	1	-	-	6	4	10	4	7	7	-
Ariz.	4	5	-	1	4	4	61	60	82	97	5
Utah	11	4	-	-	1	1	3	3	21	10	-
Nev.	1	2	1	1	-	4	2	6	U	45	-
PACIFIC	38	17	44	28	82	146	132	149	1,448	1,504	172
Wash.	4	4	1	-	6	8	7	6	-	116	-
Oreg.	-	-	5	8	9	8	2	3	U	58	-
Calif.	34	12	38	20	66	126	123	138	1,370	1,213	156
Alaska	-	-	-	-	-	2	-	1	16	36	16
Hawaii	-	1	-	-	1	2	-	1	62	81	-
Guam	-	-	-	-	-	-	-	3	-	13	-
P.R.	-	-	-	-	-	3	92	88	46	88	24
V.I.	-	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-	-	-
C.N.M.I.	-	-	-	-	-	-	1	5	8	-	-

N: Not notifiable U: Unavailable -: no reported cases

*Additional information about areas displaying "U" for cumulative 1998 Tuberculosis cases can be found in Notice to Readers, *MMWR* Vol. 47, No. 2, p. 39.

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks May 30, 1998, and May 24, 1997 (21st Week)

Reporting Area	*H. influenzae*, invasive		Hepatitis (Viral), by type				Measles (Rubeola)					
			A		B		Indigenous		Imported†		Total	
	Cum. 1998*	Cum. 1997	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997	1998	Cum. 1998	1998	Cum. 1998	Cum. 1998	Cum. 1997
UNITED STATES	453	492	8,304	11,416	2,915	3,714	2	8	-	10	18	56
NEW ENGLAND	25	28	109	271	35	73	-	-	-	1	1	7
Maine	2	3	12	35	-	4	-	-	-	-	-	-
N.H.	1	4	6	16	7	5	-	-	-	-	-	-
Vt.	2	-	10	6	1	2	-	-	-	-	-	-
Mass.	18	18	25	136	12	35	-	-	-	1	1	7
R.I.	2	2	8	22	15	8	-	-	-	-	-	-
Conn.	-	1	48	56	-	19	-	-	-	-	-	-
MID. ATLANTIC	66	61	543	1,000	435	560	1	2	-	1	3	12
Upstate N.Y.	27	3	140	109	121	98	1	1	-	-	1	4
N.Y. City	10	21	140	450	122	228	-	-	-	-	-	5
N.J.	26	24	113	147	60	107	-	1	-	-	1	2
Pa.	3	13	150	294	132	127	-	-	-	1	1	1
E.N. CENTRAL	63	78	1,042	1,267	292	652	1	3	-	2	5	6
Ohio	32	40	140	173	28	39	-	-	-	-	-	-
Ind.	14	7	71	127	24	44	-	2	-	1	3	-
Ill.	16	22	158	315	51	126	-	-	-	-	-	5
Mich.	-	9	595	562	177	206	1	1	-	1	2	1
Wis.	1	-	78	90	12	237	-	-	-	-	-	-
W.N. CENTRAL	32	22	719	789	132	222	-	-	-	-	-	10
Minn.	17	14	28	68	11	18	-	-	-	-	-	1
Iowa	1	2	339	100	20	15	-	-	-	-	-	-
Mo.	9	3	280	444	79	166	-	-	-	-	-	1
N. Dak.	-	-	2	9	2	1	-	-	-	-	-	-
S. Dak.	-	2	8	12	1	-	-	-	-	-	-	8
Nebr.	-	1	13	22	6	8	-	-	-	-	-	-
Kans.	5	-	49	134	13	14	-	-	-	-	-	-
S. ATLANTIC	97	86	697	586	424	424	-	1	-	5	6	2
Del.	-	-	2	11	-	3	-	-	-	1	1	-
Md.	28	35	147	98	62	64	-	-	-	1	1	1
D.C.	-	-	25	13	6	18	-	-	-	-	-	1
Va.	12	6	115	73	45	46	-	-	-	2	2	-
W. Va.	3	3	1	5	3	6	-	-	-	-	-	-
N.C.	12	14	41	90	82	93	-	-	-	-	-	-
S.C.	3	3	13	55	1	42	-	-	-	-	-	-
Ga.	18	17	116	117	61	47	-	-	-	1	1	-
Fla.	21	8	237	124	164	105	-	1	-	-	1	-
E.S. CENTRAL	27	33	158	287	171	275	-	-	-	-	-	1
Ky.	4	4	8	34	20	16	-	-	-	-	-	-
Tenn.	17	20	112	169	125	175	-	-	-	-	-	-
Ala.	6	7	38	45	26	30	-	-	-	-	-	1
Miss.	-	2	-	39	-	54	-	-	-	-	-	-
W.S. CENTRAL	26	21	1,439	2,319	429	424	-	-	-	-	-	4
Ark.	-	1	24	111	23	26	-	-	-	-	-	-
La.	12	4	14	84	12	45	-	-	-	-	-	-
Okla.	12	14	236	689	28	12	-	-	-	-	-	-
Tex.	2	2	1,165	1,435	366	341	-	-	-	-	-	4
MOUNTAIN	62	51	1,382	1,680	333	358	-	-	-	-	-	3
Mont.	-	-	38	46	3	5	-	-	-	-	-	-
Idaho	-	1	104	73	17	12	-	-	-	-	-	-
Wyo.	-	1	20	18	2	12	-	-	-	-	-	-
Colo.	12	9	105	190	41	71	-	-	-	-	-	-
N. Mex.	4	3	73	115	129	126	-	-	-	-	-	-
Ariz.	36	13	891	786	92	74	-	-	-	-	-	2
Utah	4	3	90	303	28	38	-	-	-	-	-	-
Nev.	6	21	61	149	21	20	U	-	U	-	-	1
PACIFIC	55	112	2,215	3,217	664	726	-	2	-	1	3	11
Wash.	3	1	389	220	49	27	-	-	-	-	-	-
Oreg.	27	21	167	165	51	47	-	-	-	-	-	-
Calif.	22	86	1,628	2,752	553	636	-	2	-	1	3	8
Alaska	1	1	11	17	6	10	-	-	-	-	-	-
Hawaii	2	3	20	63	5	6	-	-	-	-	-	3
Guam	-	-	-	-	-	3	U	-	U	-	-	-
P.R.	2	-	16	159	227	555	-	-	-	-	-	-
V.I.	-	-	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	U	-	U	-	-	-
C.N.M.I.	-	5	-	1	7	21	U	-	U	-	-	1

N: Not notifiable U: Unavailable -: no reported cases

*Of 111 cases among children aged <5 years, serotype was reported for 60 and of those, 27 were type b.

†For imported measles, cases include only those resulting from importation from other countries.

TABLE III. (Cont'd.) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending May 30, 1998, and May 24, 1997 (21st Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 1998	Cum. 1997	1998	Cum. 1998	Cum. 1997	1998	Cum. 1998	Cum. 1997	1998	Cum. 1998	Cum. 1997
UNITED STATES	1,222	1,700	7	194	286	62	1,533	2,170	6	209	38
NEW ENGLAND	66	105	-	-	7	4	265	489	-	32	-
Maine	4	8	-	-	-	-	5	6	-	-	-
N.H.	4	11	-	-	-	-	19	58	-	-	-
Vt.	1	2	-	-	-	-	24	161	-	-	-
Mass.	31	58	-	-	2	1	208	244	-	6	-
R.I.	3	7	-	-	4	3	3	12	-	-	-
Conn.	23	19	-	-	1	-	6	8	-	26	-
MID. ATLANTIC	124	171	-	10	30	11	178	181	5	98	13
Upstate N.Y.	31	40	-	3	4	11	112	62	5	94	2
N.Y. City	13	30	-	4	1	-	4	44	-	2	11
N.J.	35	32	-	-	5	-	5	11	-	2	-
Pa.	45	69	-	3	20	-	57	64	-	-	-
E.N. CENTRAL	169	247	-	33	34	4	155	208	-	-	3
Ohio	71	94	-	16	12	1	62	63	-	-	-
Ind.	25	30	-	2	4	3	45	22	-	-	-
Ill.	33	76	-	1	8	-	10	27	-	-	-
Mich.	22	23	-	14	9	-	21	28	-	-	-
Wis.	18	24	-	-	1	-	17	68	-	-	3
W.N. CENTRAL	101	123	1	19	8	5	130	117	-	3	-
Minn.	16	17	-	10	3	2	78	69	-	-	-
Iowa	15	24	-	5	4	1	27	7	-	-	-
Mo.	41	60	1	3	-	2	11	21	-	2	-
N. Dak.	-	1	-	1	-	-	-	2	-	-	-
S. Dak.	6	4	-	-	-	-	4	1	-	-	-
Nebr.	4	4	-	-	1	-	4	2	-	-	-
Kans.	19	13	-	-	-	-	6	15	-	1	-
S. ATLANTIC	214	283	-	30	34	8	108	173	-	4	2
Del.	1	4	-	-	-	1	1	-	-	-	-
Md.	20	31	-	-	1	-	19	70	-	-	-
D.C.	-	5	-	-	-	-	1	2	-	-	-
Va.	20	27	-	4	4	-	6	19	-	-	1
W. Va.	5	10	-	-	-	-	1	3	-	-	-
N.C.	29	49	-	7	6	-	42	35	-	3	-
S.C.	32	36	-	4	9	1	13	9	-	-	1
Ga.	40	52	-	1	5	1	2	6	-	-	-
Fla.	67	69	-	14	9	5	23	29	-	1	-
E.S. CENTRAL	88	120	-	-	16	-	43	40	-	-	-
Ky.	13	31	-	-	2	-	17	10	-	-	-
Tenn.	36	37	-	-	3	-	14	12	-	-	-
Ala.	39	33	-	-	5	-	12	11	-	-	-
Miss.	-	19	-	-	6	-	-	7	-	-	-
W.S. CENTRAL	131	156	4	29	34	2	91	53	1	56	3
Ark.	17	23	-	-	-	-	12	3	-	-	-
La.	25	30	-	2	7	-	-	7	-	-	-
Okla.	23	21	-	-	-	-	13	8	-	-	-
Tex.	66	82	4	27	27	2	66	35	1	56	3
MOUNTAIN	76	108	1	17	36	19	361	578	-	5	2
Mont.	2	7	-	-	-	-	1	5	-	-	-
Idaho	3	7	-	1	2	4	165	385	-	-	-
Wyo.	3	-	-	1	1	-	7	4	-	-	-
Colo.	17	31	1	3	3	1	54	138	-	-	-
N. Mex.	12	18	N	N	N	-	56	25	-	1	-
Ariz.	28	23	-	4	22	14	57	10	-	1	2
Utah	8	11	-	3	4	-	14	3	-	2	-
Nev.	3	11	U	5	4	U	7	8	U	1	-
PACIFIC	253	387	1	56	87	9	202	331	-	11	15
Wash.	31	48	-	5	10	8	123	154	-	8	2
Oreg.	48	82	N	N	N	1	13	22	-	-	-
Calif.	169	254	1	37	62	-	62	146	-	2	7
Alaska	1	1	-	2	5	-	-	2	-	-	-
Hawaii	4	2	-	12	10	-	4	7	-	1	6
Guam	-	1	U	-	1	U	-	-	U	-	-
P.R.	2	9	-	2	4	-	2	-	-	-	-
V.I.	-	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	-	-	U	-	-	U	-	-	U	-	-
C.N.M.I.	-	-	U	-	1	U	-	-	U	-	-

N: Not notifiable U: Unavailable -: no reported cases

TABLE IV. Deaths in 122 U.S. cities,* week ending May 30, 1998 (21st Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	>65	45-64	25-44	1-24	<1	
NEW ENGLAND	512	372	86	37	8	8	26
Boston, Mass.	145	99	23	14	4	5	7
Bridgeport, Conn.	U	U	U	U	U	U	U
Cambridge, Mass.	14	10	4	-	-	-	1
Fall River, Mass.	26	20	3	3	-	-	-
Hartford, Conn.	44	31	12	1	-	-	1
Lowell, Mass.	27	22	3	2	-	-	3
Lynn, Mass.	10	8	1	1	-	-	-
New Bedford, Mass.	20	15	3	1	1	-	1
New Haven, Conn.	33	25	7	-	1	-	4
Providence, R.I.	67	51	7	6	1	1	-
Somerville, Mass.	3	1	2	-	-	-	-
Springfield, Mass.	36	26	5	4	-	1	3
Waterbury, Conn.	25	18	7	-	-	-	2
Worcester, Mass.	62	46	9	5	1	1	4
MID. ATLANTIC	2,201	1,521	459	154	39	28	95
Albany, N.Y.	41	27	9	2	2	1	2
Allentown, Pa.	24	18	2	4	-	-	1
Buffalo, N.Y.	67	54	10	1	1	1	6
Camden, N.J.	18	12	2	2	1	1	1
Elizabeth, N.J.	22	15	6	1	-	-	-
Erie, Pa.	51	38	12	1	-	-	3
Jersey City, N.J.	38	23	9	6	-	-	-
New York City, N.Y.	1,111	759	235	87	17	13	31
Newark, N.J.	48	26	16	3	2	1	3
Paterson, N.J.	28	16	8	2	2	-	-
Philadelphia, Pa.	400	278	81	27	8	6	26
Pittsburgh, Pa.§	36	21	12	2	1	-	4
Reading, Pa.	37	27	6	4	-	-	1
Rochester, N.Y.	116	80	24	7	3	2	6
Schenectady, N.Y.	U	U	U	U	U	U	U
Scranton, Pa.	26	22	3	1	-	-	2
Syracuse, N.Y.	80	60	16	2	1	1	8
Trenton, N.J.	25	19	3	-	1	2	-
Utica, N.Y.	12	10	1	1	-	-	-
Yonkers, N.Y.	21	16	4	1	-	-	1
E.N. CENTRAL	1,819	1,205	366	141	48	59	90
Akron, Ohio	48	36	6	2	2	2	-
Canton, Ohio	32	25	5	1	-	1	1
Chicago, Ill.	394	217	104	42	13	18	17
Cincinnati, Ohio	91	64	17	4	2	4	11
Cleveland, Ohio	102	70	24	5	1	2	1
Columbus, Ohio	124	84	20	7	4	9	8
Dayton, Ohio	98	75	18	3	1	1	8
Detroit, Mich.	206	123	38	31	8	6	2
Evansville, Ind.	29	18	7	1	-	3	1
Fort Wayne, Ind.	57	44	8	4	-	1	3
Gary, Ind.	7	4	1	1	1	-	-
Grand Rapids, Mich.	55	39	9	3	3	1	6
Indianapolis, Ind.	166	102	39	12	7	6	-
Lansing, Mich.	63	47	10	4	-	2	1
Milwaukee, Wis.	102	74	15	9	1	3	13
Peoria, Ill.	42	34	6	1	1	-	3
Rockford, Ill.	49	34	8	5	2	-	5
South Bend, Ind.	30	21	7	2	-	-	5
Toledo, Ohio	70	53	14	2	1	-	5
Youngstown, Ohio	54	41	10	2	1	-	-
W.N. CENTRAL	591	420	91	46	17	14	31
Des Moines, Iowa	50	41	7	2	-	-	6
Duluth, Minn.	26	21	4	1	-	-	1
Kansas City, Kans.	18	12	4	-	2	-	-
Kansas City, Mo.	85	54	14	9	2	3	4
Lincoln, Nebr.	18	14	4	-	-	-	-
Minneapolis, Minn.	77	68	7	2	-	-	4
Omaha, Nebr.	70	52	8	4	3	3	4
St. Louis, Mo.	112	60	22	19	8	3	9
St. Paul, Minn.	73	55	10	5	1	2	2
Wichita, Kans.	62	43	11	4	1	3	1

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	>65	45-64	25-44	1-24	<1	
S. ATLANTIC	1,074	704	220	101	30	19	65
Atlanta, Ga.	104	64	25	8	5	2	-
Baltimore, Md.	160	95	38	17	6	4	5
Charlotte, N.C.	111	81	21	6	2	1	19
Jacksonville, Fla.	116	72	24	12	6	2	2
Miami, Fla.	U	U	U	U	U	U	U
Norfolk, Va.	42	25	9	7	-	1	2
Richmond, Va.	60	42	8	5	2	3	3
Savannah, Ga.	59	35	20	3	-	1	4
St. Petersburg, Fla.	53	40	6	7	-	-	3
Tampa, Fla.	149	107	25	13	3	1	18
Washington, D.C.	214	140	44	20	6	4	9
Wilmington, Del.	6	3	-	3	-	-	-
E.S. CENTRAL	786	509	167	63	25	20	52
Birmingham, Ala.	137	83	33	12	5	2	4
Chattanooga, Tenn.	52	38	14	-	-	-	3
Knoxville, Tenn.	82	50	20	8	4	-	10
Lexington, Ky.	66	41	12	9	-	4	6
Memphis, Tenn.	161	101	36	11	5	8	11
Mobile, Ala.	118	82	15	13	3	5	1
Montgomery, Ala.	40	31	7	-	2	-	2
Nashville, Tenn.	130	83	30	10	6	1	15
W.S. CENTRAL	1,150	733	259	83	39	36	67
Austin, Tex.	55	34	12	8	1	-	2
Baton Rouge, La.	31	22	5	4	-	-	-
Corpus Christi, Tex.	45	30	11	1	1	2	3
Dallas, Tex.	163	85	43	16	9	10	4
El Paso, Tex.	67	47	11	4	1	4	4
Ft. Worth, Tex.	98	72	20	1	-	5	10
Houston, Tex.	307	185	81	23	12	6	21
Little Rock, Ark.	61	41	14	4	1	1	3
New Orleans, La.	44	20	12	6	4	2	-
San Antonio, Tex.	169	114	34	10	5	6	11
Shreveport, La.	U	U	U	U	U	U	U
Tulsa, Okla.	110	83	16	6	5	-	9
MOUNTAIN	824	558	147	69	24	26	44
Albuquerque, N.M.	84	56	17	7	4	-	3
Boise, Idaho	32	28	-	3	1	-	1
Colo. Springs, Colo.	50	38	8	2	1	1	3
Denver, Colo.	75	40	19	10	1	5	10
Las Vegas, Nev.	168	111	34	15	4	4	4
Ogden, Utah	32	23	7	2	-	-	1
Phoenix, Ariz.	150	94	30	11	4	11	12
Pueblo, Colo.	31	21	9	1	-	-	2
Salt Lake City, Utah	61	41	9	4	4	3	4
Tucson, Ariz.	141	106	14	14	5	2	4
PACIFIC	833	596	140	61	22	14	53
Berkeley, Calif.	12	9	3	-	-	-	3
Fresno, Calif.	116	82	19	8	5	2	6
Glendale, Calif.	U	U	U	U	U	U	U
Honolulu, Hawaii	66	49	14	2	-	1	4
Long Beach, Calif.	71	53	13	3	2	-	7
Los Angeles, Calif.	U	U	U	U	U	U	U
Pasadena, Calif.	U	U	U	U	U	U	U
Portland, Oreg.	U	U	U	U	U	U	U
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	110	72	20	11	6	1	12
San Francisco, Calif.	108	77	17	11	-	3	6
San Jose, Calif.	98	76	11	7	1	3	8
Santa Cruz, Calif.	33	22	6	4	-	1	2
Seattle, Wash.	94	67	17	6	4	-	1
Spokane, Wash.	46	31	6	3	3	3	1
Tacoma, Wash.	79	58	14	6	1	-	3
TOTAL	9,790¶	6,618	1,935	755	252	224	523

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 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

†Pneumonia and influenza.

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

¶Total includes unknown ages.

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