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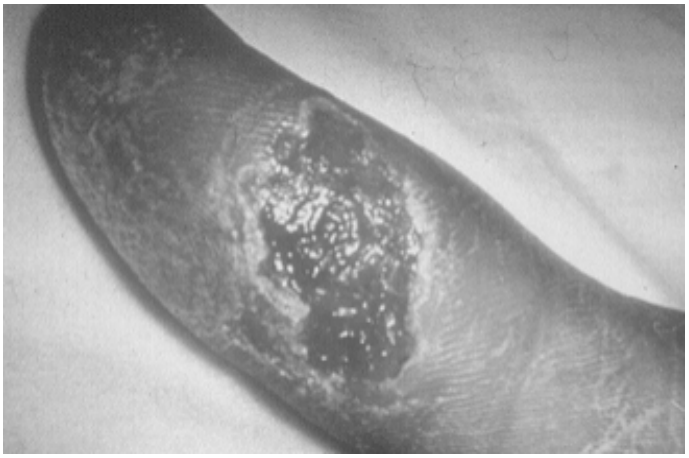
Tularemia — United States, 1990–2000

Tularemia is a zoonotic disease caused by the gram-negative coccobacillus *Francisella tularensis*. Known also as "rabbit fever" and "deer fly fever," tularemia was first described in the United States in 1911 and has been reported from all states except Hawaii. Tularemia was removed from the list of nationally notifiable diseases in 1994, but increased concern about potential use of *F. tularensis* as a biological weapon led to its reinstatement in 2000. This report summarizes tularemia cases reported to CDC during 1990–2000, which indicate a low level of natural transmission. Understanding the epidemiology of tularemia in the United States enables clinicians and public health practitioners to recognize unusual patterns of disease occurrence that might signal an outbreak or a bioterrorism event.

Tularemia characteristically presents as an acute febrile illness. Various clinical manifestations can occur depending on the route of infection and host response, including an ulcer at the site of cutaneous or mucous membrane inoculation (Figure 1), pharyngitis, ocular lesions, regional lymphadenopathy, and pneumonia. A diagnosis of tularemia can be laboratory-confirmed by culture of *F. tularensis* from clinical specimens or by a fourfold titer change of serum antibodies against *F. tularensis*. Presumptive diagnosis can be made by detecting *F. tularensis* antigens with fluorescent assays or by a single elevated antibody level (*1*). For purposes of national surveillance, confirmed and probable tularemia cases are defined as clinically compatible illness with confirmatory or presumptive laboratory evidence of *F. tularensis* infection, respectively. Before September 1996, because of ambiguity in the case definition, some cases of tularemia might have been considered confirmed by fluorescent assay alone. Case status is determined at the state level. For the purposes of this report, any case reported to CDC was assumed to have laboratory evidence of infection. Similar results were obtained when the analysis was limited to cases with documented confirmed or probable status.

During 1990–2000, a total of 1,368 cases of tularemia were reported to CDC from 44 states, averaging 124 cases (range: 86–193) per year; 807 cases (59%) were reported as confirmed and 85 cases (6%) were reported as probable; the status of 476 cases is unknown. Most (91%) unclassified cases were reported

FIGURE 1. Finger of patient infected with tularemia



Photo/CDC file

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during 1990–1992; all cases during 1990–1991 and 54% of cases from 1992 were not classified. The number of cases reported annually did not decrease substantially during the lapse in status as a notifiable disease during 1995–1999, but an increase in reporting occurred during 2000, when notifiable status was restored. Four states accounted for 56% of all reported tularemia cases: Arkansas (315 cases [23%]), Missouri (265 cases [19%]), South Dakota (96 cases [7%]), and Oklahoma (90 cases [7%]).

County of residence was available for 1,357 reported cases. Among the 3,143 U.S. counties, 543 (17.3%) reported at least one case during 1990–2000. The counties with the highest number of reported cases were located throughout Arkansas and Missouri, in the eastern parts of Oklahoma and Kansas, in southern South Dakota and Montana, and in Dukes County, Massachusetts (the island of Martha's Vineyard) (Figure 2).

During 1990–2000, the average annual incidence of tularemia reported using 1995 population estimates was highest in persons aged 5–9 years and in persons aged ≥75 years (Figure 3). Males had a higher incidence in all age categories. Incidence was highest among American Indians/Alaska Natives (0.5 per 100,000), compared with 0.04 per 100,000 among whites and ≤0.01 per 100,000 among blacks and Asians/Pacific Islanders. Of the 936 cases reported with date of onset, 654 cases (70%) reported onset during May–August, but cases were reported in all months of the year.

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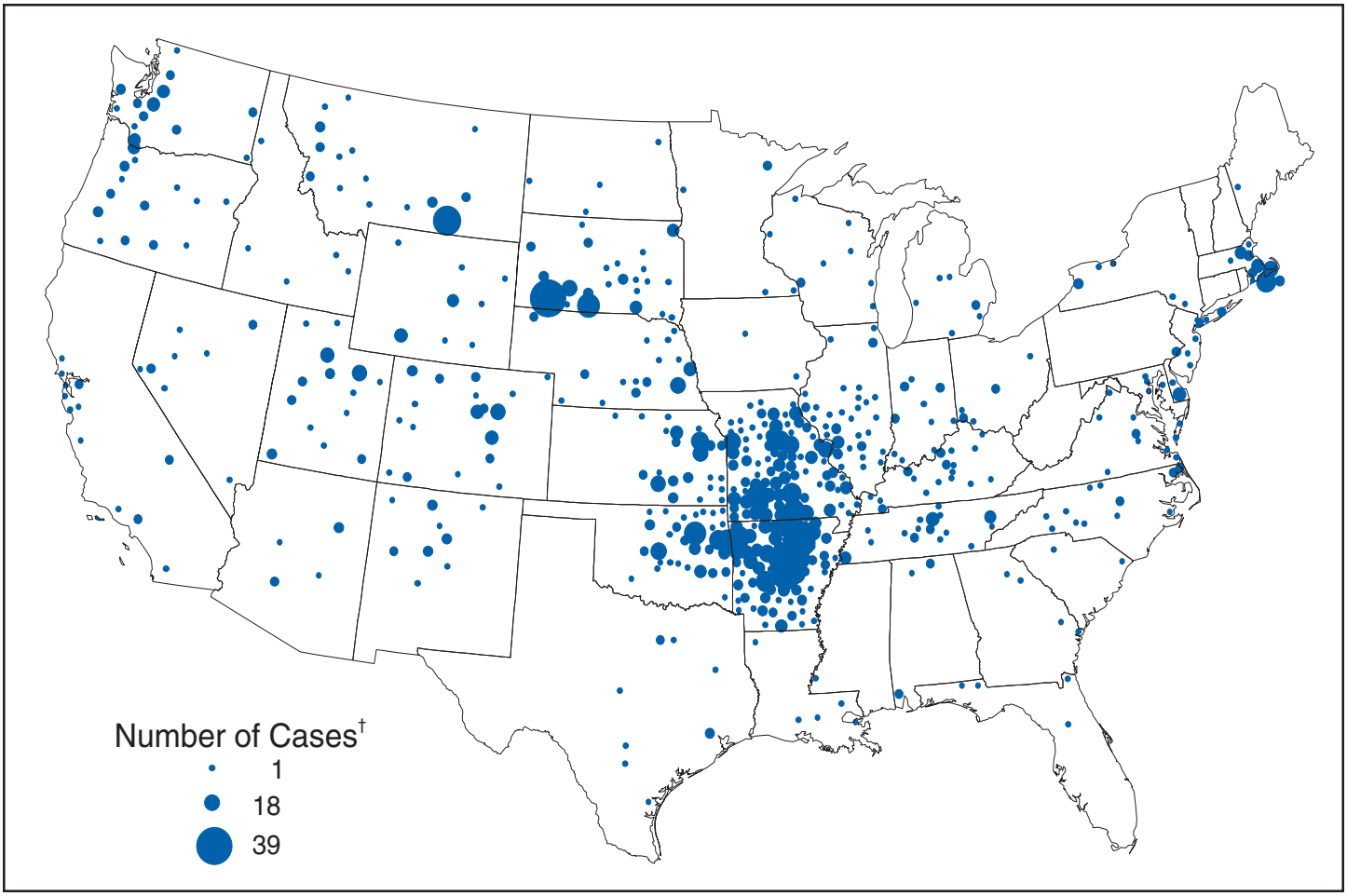
Editorial Note: The number of tularemia cases reported annually has decreased substantially since the first half of the 1900s. The incidence was highest in 1939, when 2,291 cases were reported (2) and remained high throughout the 1940s. The number of cases declined substantially in the 1950s and 1960s to the relatively constant number of cases reported since that time.

In the United States, most persons with tularemia acquire the infection from arthropod bites, particularly tick bites, or from contact with infected mammals, particularly rabbits. Historically, most cases of tularemia occurred in summer, related to arthropod bites, and in winter, related to hunters coming into contact with infected rabbit carcasses. In recent years, a seasonal increase in incidence has occurred only in the late spring and summer months, when arthropod bites are most common. Outbreaks of tularemia in the United States have been associated with muskrat handling (*3*), tick bites (*4,5*), deerfly bites (*6*), and lawn mowing or cutting brush (*7*). Sporadic cases in the United States have been associated with contaminated

FIGURE 2. Reported cases* of tularemia — United States, 1990–2000



* Based on 1,347 patients reporting county of residence in the lower continental United States. Alaska reported 10 cases in four counties during 1990–2000.
† Circle size is proportional to the number of cases, ranging from 1–39.

drinking water (*8*) and various laboratory exposures (*9*). Outbreaks of pneumonic tularemia, particularly in low-incidence areas, should prompt consideration of bioterrorism (*10*).

The high incidence of tularemia among males and among children aged <10 years might be associated with increased opportunity for exposure to infected ticks or animals, less use of personal protective measures against tick bites, or diagnostic or reporting bias. The high incidence among American Indians/Alaska Natives might be associated with their increased risk for exposure; outbreaks of tularemia have been reported on reservations in Montana and South Dakota, where a high prevalence of tularemia infection was found in ticks and dogs (*4,5*).

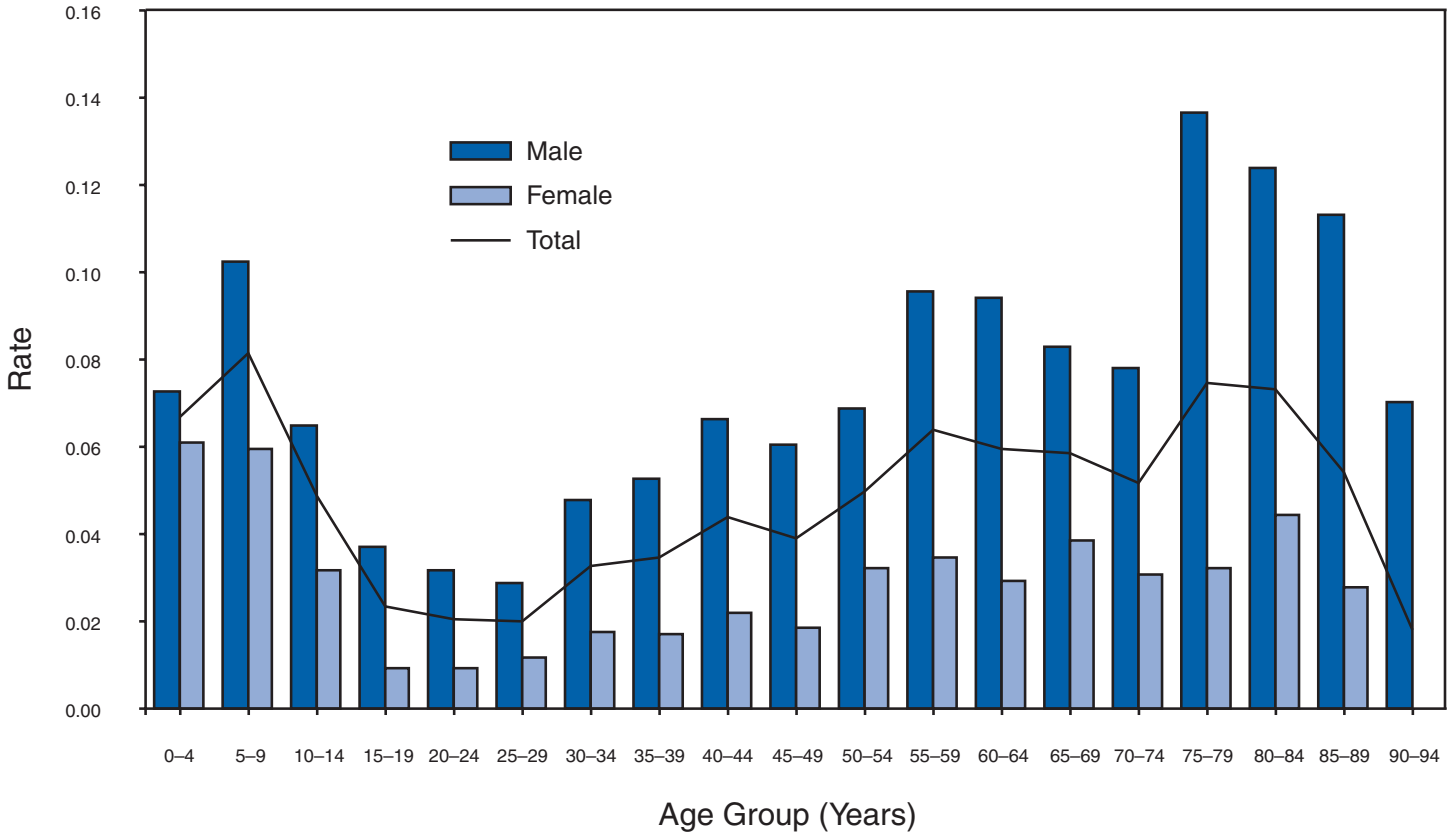
The findings in this report are subject to several limitations, including underreporting and the lack of documented laboratory confirmation for all cases. Surveillance for tularemia could be improved by documenting laboratory confirmation of diagnosis and by including additional data (e.g., clinical presentation, exposure history, and outcome).

Following a dramatic decline in the second half of the 20th century, the incidence of tularemia in the United States remains low. The epidemiologic characteristics described in this report provide a background against which unusual patterns of disease occurrence, including bioterrorism events, may be recognized more quickly.

Acknowledgement

This report was based on data contributed by state and local health departments.

FIGURE 3. Average annual incidence rate* of tularemia, by sex and age group — United States, 1990–2000



* Per 100,000 population, calculated using 1995 population estimates.

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Point-of-Purchase Tobacco Environments and Variation by Store Type — United States, 1999

To promote its products, the tobacco industry spent $8.2 billion on marketing in 1999, an increase of $1.5 billion over the previous year (*1*). Tobacco advertising in various media increases tobacco consumption (*2*) and adolescents are more susceptible than adults to being influenced by some forms of tobacco advertising (*3*). To describe the retail tobacco advertising and marketing environment, researchers from the Robert Wood Johnson Foundation-sponsored ImpacTeen Project* collected and analyzed store observation data in 163 communities throughout the United States. This report summarizes the extent of point-of-purchase (POP) tobacco advertising and marketing found in various types of stores.

* A policy research partnership for reducing youth substance use. Member institutions include the University of Illinois at Chicago, the University of Michigan, Andrews University, Roswell Park Cancer Institute, and the University of Minnesota.

The findings in this report indicate that certain retail environments frequented by teenagers heavily promote tobacco use. To reduce demand for tobacco products among adolescents, public health efforts should address POP environment exposure to tobacco advertising and marketing.

During a 4-month period in 1999, ImpacTeen researchers observed POP environments in 3,031 retail outlets in 163 communities with public schools participating in the nationally representative Monitoring the Future (MTF) study of eighth-, 10th-, and 12th-grade students (*4*). Private and magnet schools (comprising approximately 20% of the original sample) were not included in this study. Community boundaries were defined by the area from which each school drew at least 80% of its student population. Random samples of up to 30 retailers per community were drawn from lists of stores selling tobacco and/or liquor products as identified by their Standard Industrial Classifications (SIC) Index codes[†]. Two additional samples of 10 stores each were drawn as replacements for any stores on the original list that did not meet study criteria (i.e., those that had ceased business, had relocated, were not open during the days observers were on site, or did not sell tobacco products). If field observers could not reach the desired sample size of 30 using the original and replacement lists of retailers, they added tobacco retailers identified on site. Of the 3,031 observed stores, 2,309 (76.2%) were from the original sample, 355 (11.7%) were from randomly generated replacement lists, and 367 (12.1%) were added in the field based on study protocol. Overall, 2,999 (98.9%) of all observed stores were tobacco retailers and were eligible for inclusion in the study.

Field observers collected information on the presence of various POP tobacco environment features including 1) tobacco product placement (self-service versus clerk-assisted); 2) promotions (multipack/cents-off discounts and gift-with-purchase offers); 3) tobacco-branded functional objects (free items provided by the industry such as counter change mats or shopping baskets displaying the sponsoring company's logo); 4) presence and extent of exterior and interior advertisements (such as those indicating special prices); 5) presence of low-height interior advertising or advertisements directly in the line of sight of very young children (at a height of <3½ feet above the floor); and 6) tobacco-control signage (including Food and Drug Administration [FDA][§]- or industry-sponsored signage, health warnings, or messages indicating that identification is required to purchase tobacco products). Data were weighted to account for both the community-level multistage sampling procedures and the store selection probabilities. The GENMOD procedure in SAS v.8 was used to run generalized estimating equations that accounted for community clustering while specifying a binomial distribution and a logit link function. Results were expressed as unadjusted odds ratios and 95% Wald confidence intervals. For all analyses, supermarkets were used as the referent category.

Some form of tobacco POP presence (i.e., interior or exterior advertising, self-service pack placement, multipack discounts, tobacco-branded functional objects, or vending machines) was observed in 92.1% of the stores: self-service cigarette pack placement in 36.4%, multipack discounts in 25.2%, and at least one tobacco-branded functional object in 68.5%. Most (80%) retailers displayed interior tobacco advertising; 22.8% had high levels of interior advertising (i.e., advertisements outside areas where tobacco products were sold or displayed), and 42.9% had low-height advertisements. Exterior tobacco advertisements were observed in 58.9% of the stores, with 40.4% having high levels of exterior advertising (i.e., five or more advertisements or at least one advertisement >1 foot in any dimension). Some form of tobacco advertising (interior or exterior) was present in 84.1% of the stores. Convenience/gas retailers were significantly more likely to have five of the six POP measures, convenience and liquor stores were significantly more likely to have four of the measures, and drug stores were significantly less likely to have two of the measures (Table 1).

Tobacco-control signage was observed in 65.8% of the stores (Table 2). Forty-eight percent of stores had industry-sponsored signage warning minors that proof of age is required to purchase tobacco products (e.g., "We Card" signs), 32.7% had FDA-sponsored signage, 4.1% had health warning signs, and 6.3% had other minors' access signs. Convenience stores and convenience/gas stores were significantly more likely to have industry-sponsored signs. Both gas stations and liquor stores were significantly less likely to have health warning signage.

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[†] A numeric system used to classify U.S. industries and businesses for the collection, analysis, and dissemination of industry statistics developed by the Office of Management and Budget.

[§] FDA-sponsored signage was created prior to March 2000. As a result of a ruling in 2000 by the U.S. Supreme Court (FDA v. Brown & Williamson Tobacco Corp., 120 S. Ct. 1291), the FDA has withdrawn programs regulating conventionally marketed tobacco products.

TABLE 1. Percent of tobacco point-of-purchase retail marketing and advertising, by store type* — United States, 1999

Store type	Packs: self-service (n=2,930) %	OR†	(95% CI§)	Multipack discounts (n=2,951) %	OR	(95% CI)	Functional objects (n=2,960) %	OR	(95% CI)	Interior advertisements: high levels (n=2,947) %	OR	(95% CI)	Interior advertisements: low height (n=2,246) %	OR	(95% CI)	Exterior advertisements: high levels (n=2,942) %	OR	(95% CI)
All stores	36.4			25.2			68.5			22.8			42.9			40.4		
Supermarkets	40.6	1.0	(Referent)	22.1	1.0	(Referent)	56.6	1.0	(Referent)	6.6	1.0	(Referent)	32.1	1.0	(Referent)	5.2	1.0	(Referent)
Convenience	35.1	0.8	(0.4–1.6)	22.6	1.0	(0.6–1.7)	79.6	3.0	(1.7– 5.4)	24.4	4.6	(1.7– 12.6)	47.4	1.9	(1.1–3.3)	56.9	23.9	(11.2–51.1)
Convenience/gas	44.4	1.2	(0.8–1.8)	34.8	1.9	(1.2–2.9)	80.4	3.1	(1.7– 5.7)	28.5	5.7	(2.6– 12.3)	44.3	1.7	(1.1–2.6)	57.9	24.9	(11.7–53.2)
Gas stations	28.9	0.6	(0.3–1.3)	13.0	0.5	(0.3–1.0)	58.0	1.1	(0.5– 2.0)	19.6	3.4	(1.6– 7.4)	17.1	0.4	(0.3–0.7)	29.8	7.7	(3.9–15.3)
Corner/grocery	23.4	0.4	(0.2–1.0)	12.4	0.5	(0.3–0.9)	59.5	1.1	(0.4 – 2.8)	26.6	5.1	(2.2– 12.3)	57.1	2.8	(1.4–5.6)	34.4	9.5	(4.7–19.2)
Drug stores/ pharmacy	28.5	0.5	(0.3–0.9)	25.4	1.2	(0.7–2.0)	36.1	0.4	(0.3– 0.7)	4.1	0.6	(0.1– 2.5)	30.9	0.9	(0.6–1.5)	7.1	1.4	(0.5– 3.9)
Liquor stores	34.6	0.8	(0.4–1.6)	23.3	1.1	(0.5–2.3)	79.9	3.0	(1.5– 6.1)	23.9	4.5	(1.7– 11.4)	48.6	2.0	(1.1–3.6)	44.7	14.6	(6.0–35.4)
Tobacco stores	58.3	2.0	(0.8–5.0)	33.4	1.8	(0.9–3.6)	86.5	4.9	(2.0–12.2)	64.8	26.2	(6.8–100.1)	41.3	1.5	(0.5–4.4)	56.0	23.0	(9.7–54.6)
General merchandise	51.6	1.0	(1.0–1.1)	29.6	1.0	(1.0–1.1)	67.1	1.0	(0.9– 1.2)	8.4	1.0	(0.9– 1.2)	34.1	1.0	(0.9–1.2)	1.6	0.9	(0.8– 1.0)

* Supermarkets serve as the referent category in all odds ratios. The total for each analysis varies as indicated above; the range of sample sizes by store type is as follows: supermarkets 149–237; convenience 260–306; convenience/gas 918–1,063; gas stations 156–257; corner/grocery 323–439; drug stores/pharmacies 170–291; liquor stores 171–232; tobacco stores 51–59; general merchandise 36–61, and "other" 11–22. "Other" store category included in analyses, but not shown in table.
† Odds ratio.
§ Confidence interval.

TABLE 2. Percent of tobacco-control signage, by store type* — United States, 1999

Store type	Any control signage† (n=2,990) %	OR§§	(95% CI¶¶)	FDA-sponsored§ (n=2,990) %	OR	(95% CI)	Industry-sponsored¶ (n=2,990) %	OR	(95% CI)	Health warnings** (n=2,990) %	OR	(95% CI)	Store-specific†† (n=2,990) %	OR	(95% CI)
All stores	65.8			32.7			48.3			4.1			6.3		
Supermarkets	58.2	1.0	(Referent)	27.1	1.0	(Referent)	39.0	1.0	(Referent)	8.0	1.0	(Referent)	6.2	1.0	(Referent)
Convenience	68.1	1.5	(1.0–2.4)	25.7	0.9	(0.6–1.5)	51.6	1.7	(1.0–2.7)	3.8	0.5	(0.2–1.2)	4.9	0.9	(0.4–1.9)
Convenience/gas	72.0	1.8	(1.3–2.6)	33.7	1.4	(0.8–2.2)	57.7	2.1	(1.5–3.1)	3.8	0.4	(0.2–1.2)	7.7	1.4	(0.7–2.9)
Gas stations	60.6	1.1	(0.7–1.8)	34.6	1.4	(0.8–2.5)	45.4	1.3	(0.7–2.4)	2.1	0.2	(0.1–0.9)	1.4	0.2	(0.1–0.7)
Corner/grocery	62.5	1.2	(0.7–2.0)	36.3	1.5	(1.0–2.3)	38.4	1.0	(0.5–1.9)	4.1	0.5	(0.2–1.0)	6.7	1.2	(0.6–2.5)
Drug stores/ pharmacy	58.8	1.0	(0.6–1.6)	29.1	1.1	(0.7–1.7)	36.2	0.9	(0.5–1.5)	4.3	0.5	(0.2–1.6)	5.0	0.9	(0.4–2.0)
Liquor stores	65.2	1.3	(0.8–2.2)	36.7	1.6	(1.0–2.4)	52.6	1.7	(1.0–3.1)	1.5	0.2	(0.1–0.6)	6.2	1.1	(0.4–3.0)
Tobacco stores	80.7	3.0	(1.3–6.9)	55.1	3.3	(1.4–7.6)	51.1	1.6	(0.8–3.2)	3.8	0.5	(0.1–2.7)	7.1	1.3	(0.4–4.2)
General merchandise	51.9	1.0	(0.9–1.0)	23.8	1.0	(0.9–1.1)	27.8	1.0	(0.9–1.0)	12.7	1.1	(0.9–1.2)	13.1	1.1	(1.0–1.3)

* Supermarkets serve as the referent category in all odds ratios. Sample sizes by store type are as follows: supermarkets 241; convenience 306; convenience/gas 1,065; gas stations 257; corner/grocery 441; drug stores/pharmacies 290; liquor stores 248; tobacco stores 59; general merchandise 61, and "other" 22. "Other" store category included in analyses, but not shown in table.
† Presence of any of the following: Food and Drug Administration- or industry-sponsored, health warning, or store-specific control signage.
§ Tobacco control signage sponsored by the Food and Drug Administration.
¶ Tobacco control signage sponsored by the tobacco industry.
** Control signage dealing specifically with health warnings regarding tobacco use.
†† Tobacco control signage provided directly by the retailer in which the signage is located. Because no store-specific signage was observed for "other" stores, this category was not included for this analysis model.
§§ Odds ratio.
¶¶ Confidence interval.

Editorial Note: The findings in this report indicate that convenience, convenience/gas, and liquor stores were most likely to have pro-tobacco environments (i.e., environments in which patrons are exposed to high levels of tobacco-related advertisements, promotions, and functional objects). Convenience and convenience/gas stores account for the largest share of retail tobacco sales (*5*). Because 75% of teenagers shop at convenience or convenience/gas stores at least once a week (*6*), adolescents will continue to be exposed to high levels of tobacco POP influence unless pro-tobacco marketing in these retail environments is restricted.

Although virtually all tobacco retailers in this study had some form of tobacco POP presence, fewer of these stores had a visible tobacco-control environment, and even fewer displayed health warnings. Although this study did not measure the extent of tobacco-specific control signage, observers generally reported that pro-tobacco signage predominated.

The findings in this report are subject to at least three limitations. First, only retailers in communities with public schools participating in the MTF study were included in this report and might not be representative of all stores in the United States. Second, although original and replacement retailer

selection was random, no effort was made to ensure that the various store types were represented proportionally. Third, some minor differences were observed between both replacement stores and stores added in the field when compared with other stores. Replacement stores were less likely to have multipack promotions, counter signage, and FDA-sponsored signage. Added stores were less likely to have functional objects or FDA-sponsored signage, were more likely to have packs available via self-service, and showed some differences in store type (fewer other and corner/grocery stores, and more liquor stores). No significant differences were observed for either replacement or added stores with regard to either presence or extent of exterior or interior tobacco advertising.

Exposure to POP advertising and marketing influences youth access to, experimentation with, and purchase of cigarettes (*7*–*9*). Public health efforts should include strategies to decrease pro-tobacco POP environment exposure and reduce demand for tobacco products among adolescents. Recommendations include eliminating or severely restricting self-service product displays, free samples, functional objects, and advertisements (*10*). Public practitioners or policy makers may facilitate the implementation of these recommendations by working with retailer associations and within communities to decrease overall POP tobacco-promotion activities. Initial efforts should target those store types most frequented by adolescents in which a pro-tobacco environment predominates.

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Variation in Homicide Risk During Infancy — United States, 1989–1998

Homicide is the 15th leading cause of death during the first year of life (i.e., infancy) in the United States. In addition, the risk for homicide is greater in infancy than in any other year of childhood before age 17 years (*1*) and is greatest during the first 4 months of life (*2*). To determine how the risk for homicide varied by week during infancy and by day during the first week of life, CDC analyzed death certificate data for 1989–1998. This report summarizes the results of this analysis, which indicated that risk for infant homicide is greatest on the day of birth. Efforts to prevent infant homicides should focus on early infancy.

Most infant deaths are certified by medical examiners or coroners. Statistical information from death certificates is consolidated into a national database through the National Vital Statistics System (*1*). Information on U.S. resident infant homicide deaths for 1989–1998 was obtained from CDC's National Center for Health Statistics. An infant was defined as a person aged <1 year at death. Homicide was defined as an underlying cause coded through the *International Classification of Disease, Ninth Revision*, codes E960–E969 (*3*). Age at death in days was defined as one plus the difference between the dates of death and birth recorded on the death certificate. An infant killed on its date of birth had an age at death of 1 day. In comparison, homicide rates during different time periods within infancy were presented as rates per person-years of exposure. The U.S. infant population during 1989–1998 accounted for 39,941,628 person years of exposure, of which days of birth accounted for 109,354 person years, and the remainder of infancy accounted for 39,832,274 person years.

During 1989–1998, a total of 3,312 infant homicides were reported for a rate of 8.3 per 100,000 person years. Of these, 81 (2.4%) were excluded because of a missing date of birth. The proportion of homicides occurring each week of infancy varied, with 9.1% of homicides occurring during the first week of life (Figure 1); a secondary peak in the distribution of homicides occurred at week 8.

Among homicides during the first week of life, 82.6% occurred on the day of birth, 9.2% on the second day, and 8.2% during the remainder of the week. After the first 2 days of life, the number of deaths in the remainder of the first week was comparable to the number of deaths in the second week of life. Overall, 243 (7.3%) of all infant homicides occurred on the day of birth. When homicide rates on the first day of life and during the remainder of infancy were compared with homicide rates during later age groups (Figure 2),

FIGURE 1. Percentage of infant homicides, by week of age at death — United States, 1989–1998

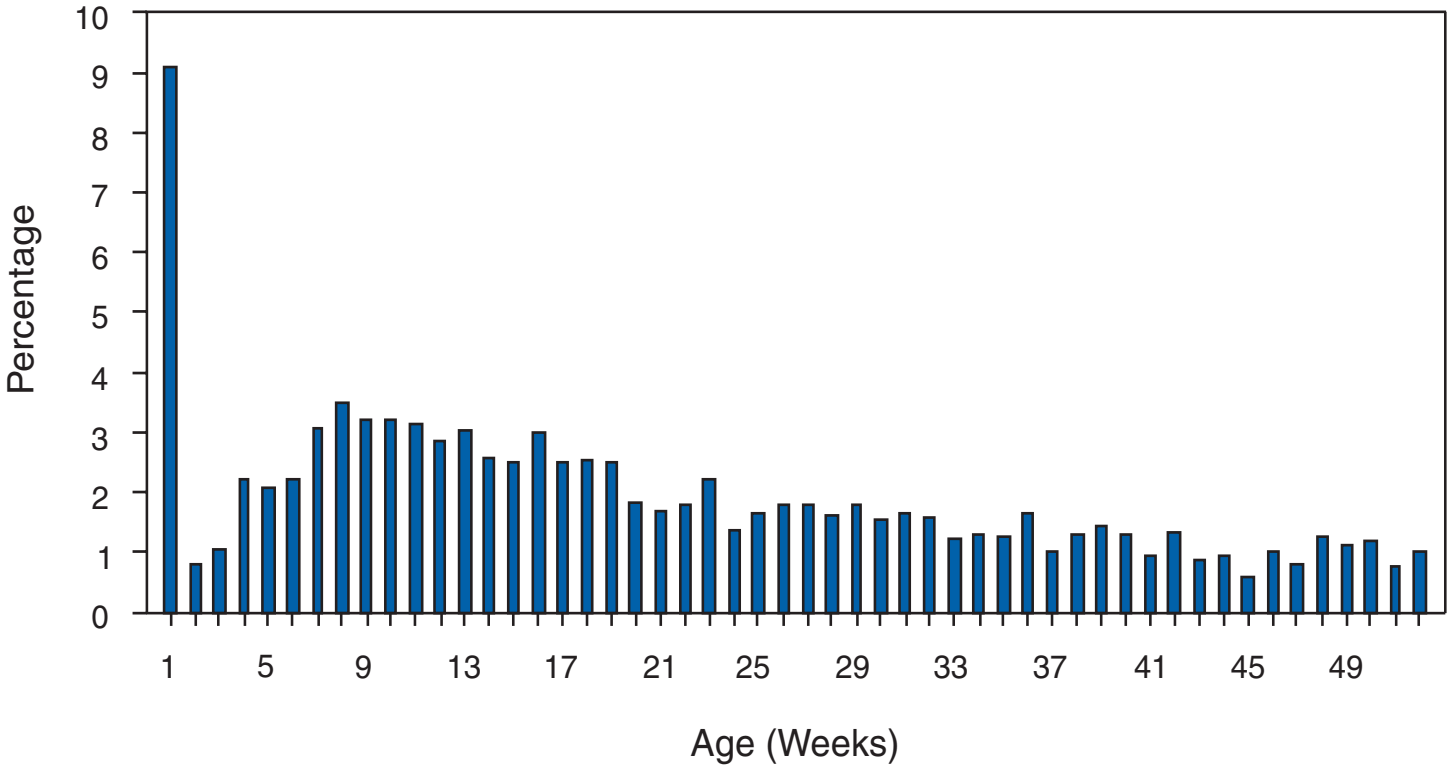
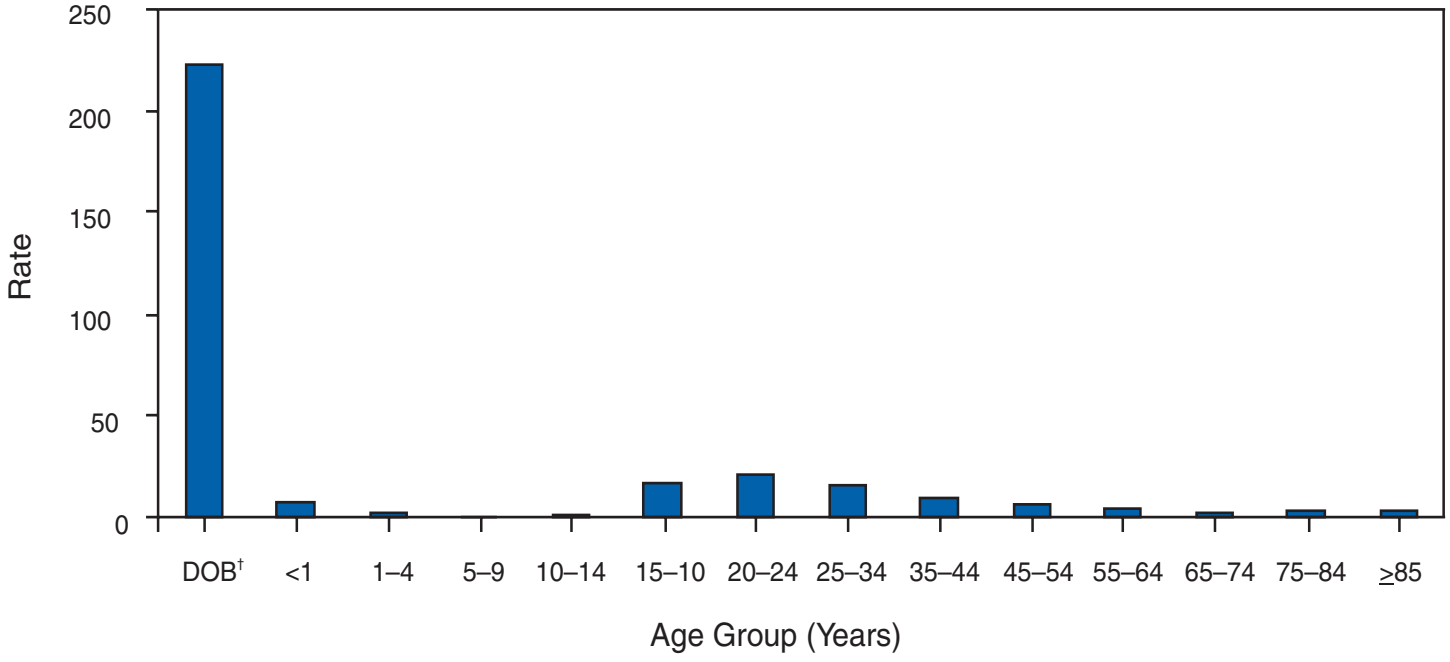


FIGURE 2. Homicide rate,* by age group — United States, 1989–1998



* Per 100,000 person years.
† Day of birth.

the homicide rate on the first day of life was at least ten times greater than the rate during any other time of life.

Reported by: *L Paulozzi, MD, Div of Violence Prevention, National Center for Injury Prevention and Control; M Sells, MS, Public Health Prevention Specialist Program, Div of Applied Public Health Training, Epidemiology Program Office, CDC.*

Editorial Note: The findings in this report highlight the high risk for homicide on the day of birth. Risk is comparatively small after the day of birth, even during the highest risk periods of adulthood. Among homicides on the first day of life, 95% of the victims are not born in a hospital. Among homicides later in infancy, 8% of infants are not born in a hospital (*2*). Among homicides during the first week of life, 89% of known perpetrators are female, usually the mother (*4*). Mothers who kill their infants are more likely to be adolescents and have a history of mental illness (*2,5*). The secondary peak in risk in week 8 might reflect the peak in the daily duration of crying among normal infants between weeks 6 and 8 (*6*).

The limitations of these findings include the potential under and overascertainment of homicides through vital records. Infant homicides probably are underascertained by being either labeled as unintentional injuries or attributed to sudden infant death syndrome (SIDS) (*7*). Underascertainment probably does not vary by week of life and is unlikely to account for the observed pattern. Overascertainment might have occurred if some of the cases classified as homicides on the first day of life were actually stillbirths. It is not known what percent of cases of homicide on the day of birth might have been stillbirths. However, the percentage is probably small because medical examiners usually will attribute a death to infanticide only if autopsy evidence indicates that respiration had occurred, no evidence indicates death from natural causes, and circumstantial evidence is consistent with homicide (*8*).

Preventing out-of-hospital births among high-risk women might help reduce the number of homicides on the day of birth. Home visitation and parenting programs, especially those that begin during pregnancy, might help reduce child abuse during infancy by focusing on the weeks of greatest risk early in infancy (*9*).

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Public Health Dispatch

Manufacturer's Recall of Rapid Assay Kits Based on False Positive *Cryptosporidium* Antigen Tests — Wisconsin, 2001–2002

The Wisconsin Division of Public Health and the Wisconsin State Laboratory of Hygiene (WSLH) reported that a recent cluster of cryptosporidiosis cases in a three-county area in southeastern Wisconsin was the result of false-positive tests. During December 1, 2001–February 1, 2002, approximately 30 cases of cryptosporidiosis were diagnosed at a laboratory in southeastern Wisconsin using the Becton, Dickinson, and Company (Franklin Lakes, New Jersey) ColorPAC™ *Cryptosporidium/Giardia* rapid assay (lot number 219370, expiration date 2002-06-05). Seventeen stool specimens, which were collected from 11 patients and tested positive by the rapid assay, were re-evaluated at WSLH. Six of these stool specimens were in EcoFix (Meridian Bioscience Inc., Cincinnati, Ohio), eight were in Cary-Blair transport media, and three were formalin fixed. All 17 specimens tested negative for *Cryptosporidium* at WSLH using the hot safranin stain and MeriFluor (Meridian Bioscience Inc., Cincinnati, Ohio) *Cryptosporidium*/*Giardia* direct fluorescent antibody kit with concentrated specimens.

For comparison, WSLH repeated the rapid assay tests of the specimens using Becton, Dickinson, and Company ColorPAC™ *Cryptosporidium/Giardia* rapid assay from the same lot used at the southeastern Wisconsin laboratory. Eleven (65%) of the 17 stool specimens were positive on repeat testing, including five (83%) specimens in EcoFix, four (50%) of specimens in Cary-Blair transport media, and two (67%) of the formalin-fixed specimens. The ColorPAC™ kits also were used to test four known *Cryptosporidium* negative stool specimens, and two of these tests were positive. Becton, Dickinson, and Company has voluntarily recalled this lot from laboratories.

Reported by *T Haupt, MS, JP Davis, MD, Wisconsin Div of Public Health; D Warshauer, PhD, Wisconsin State Laboratory of Hygiene. M Beach, PhD, S Johnson, MS, Div of Parasitic Diseases, National Center for Infectious Diseases; D Croft, MD, EIS Officer, CDC.*

Notice to Readers

Pseudomonas aeruginosa Infections Associated with Defective Bronchoscopes

Investigators at Johns Hopkins University have notified CDC of *Pseudomonas aeruginosa* infections and colonizations that may be associated with defective bronchoscopes. The source of bacteria is believed to be a loose port, which might act as a reservoir for *Pseudomonas aeruginosa* infections.

On November 30, 2001, Olympus issued a voluntary recall of defective Olympus bronchoscopes with a loose port. The recall involved the following models: BF-40, BF-P40, BF-1T40, BF-3C40, BF-XP40, BF-XT40, BF-240, BF-P240, BF-1T240, BF-6C240, BF-160, BF-P160, BF-1T160, BF-3C160, and BF-XT160.

Additional information is available from Olympus, telephone (800) 848-9024, and from the Food and Drug Administration, telephone (800) 638-2041.

Notice to Readers

Shortage of Varicella and Measles, Mumps and Rubella Vaccines and Interim Recommendations from the Advisory Committee on Immunization Practices

A temporary shortage of varicella (VARIVAX®) and combined measles, mumps and rubella (MMR) (M-M-R II®) vaccines in the United States has resulted from two voluntary interruptions to manufacturing operations by Merck & Co., Inc., the only U.S. manufacturer of these products. One interruption was attributed to modifications Merck made voluntarily in response to issues raised by the U.S. Food and Drug Administration (FDA) during a routine Good Manufacturing Practices inspection. The other was the result of scheduled modifications made to the manufacturer's facility, which took longer than expected to be completed and had a substantial impact on production during September–October 2001. Following the interruptions of production, vaccine supply rapidly declined at the end of 2001.

Varicella Vaccine

Although the duration of the varicella vaccine shortage is uncertain, Merck predicts that the shortage will be resolved by late spring or early summer 2002. The annual need for varicella vaccine in the United States is about 6 to 7 million doses or 500,000–583,000 doses per month. Because of supply decreases, by March 4, approximately 1.1 million doses were on back order for both public and private sectors. Merck estimates an average of 60 days to fill these orders. Meanwhile, shortages are expected nationwide.

Interim ACIP Recommendations for Use of Varicella Vaccine

Varicella is a more severe disease among adolescents and adults; however, the highest incidence of disease is among elementary school aged-children (*1,2*). Until adequate supplies of varicella vaccine are available, ACIP recommends that all vaccine providers in the United States delay administration of the routine childhood varicella vaccine dose from age 12–18 months until age 18–24 months (*3,4*). If the shortage persists after delaying the dose at age 12–18 months and is of sufficient severity that further prioritization of vaccine use is needed, recommendations for use (highest to lowest priority) of Varivax® for susceptible persons are:

1. Vaccination of health-care workers, family contacts of immuocompromised persons, adolescents aged ≥13 years, and adults and high-risk children (e.g., children infected with human immunodeficiency virus and children with asthma or eczema).
2. Vaccination of susceptible children aged 5–12 years, particularly children entering school and adolescents aged 11–12 years. States may elect to provide guidance on priority cohorts for vaccination.
3. Vaccination of children aged 2–4 years. Within this age group, states may elect to provide guidance on priorities (e.g., children attending child care centers) for vaccination.

Measles, Mumps and Rubella Vaccine

Although the duration of the shortage is uncertain, the manufacturer predicts that problems with the MMR vaccine supply should be resolved in 1–3 months. The annual need for MMR vaccine in the United States is about 13 million doses. The average number of MMR doses shipped during January–September 2001 was 943,000 doses; during October–November 2001, an average of 586,000 doses was shipped; during December 2001–February 2002, an average of 819,000 doses was shipped each month. As of March 4, a total of 1,077,670 doses was on back order for both the public and private sectors. As of February 28, 2002, the manufacturer projects that 5.6 million doses will be supplied during March–May 2002.

Interim ACIP Recommendation for Use of MMR Vaccine

Two doses of MMR vaccine, separated by at least a month and administered on or after the first birthday, are recommended for children, adolescents, and adults who lack adequate documentation of vaccination or other acceptable evidence of immunity (*5*). The first dose is recommended at age 12–15 months and the second dose at age 4–6 years. If providers are unable to obtain sufficient amounts of MMR vaccine to implement fully ACIP recommendations for MMR vaccination, ACIP recommends that they defer the second MMR dose. Because of the severity of measles in young children, providers should not delay administration of the first dose of the MMR series.

Tracking and Recall

Records should be maintained for children who experience a delay in administration of either varicella or MMR vaccines so they can be recalled when vaccine becomes available. The latest information about vaccine supply issues is available at http://www.cdc.gov/nip/news/shortages.

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Notice to Readers

Availability of Continuing Education CD-ROM Program on Strategies to Increase Adult Vaccination Rates

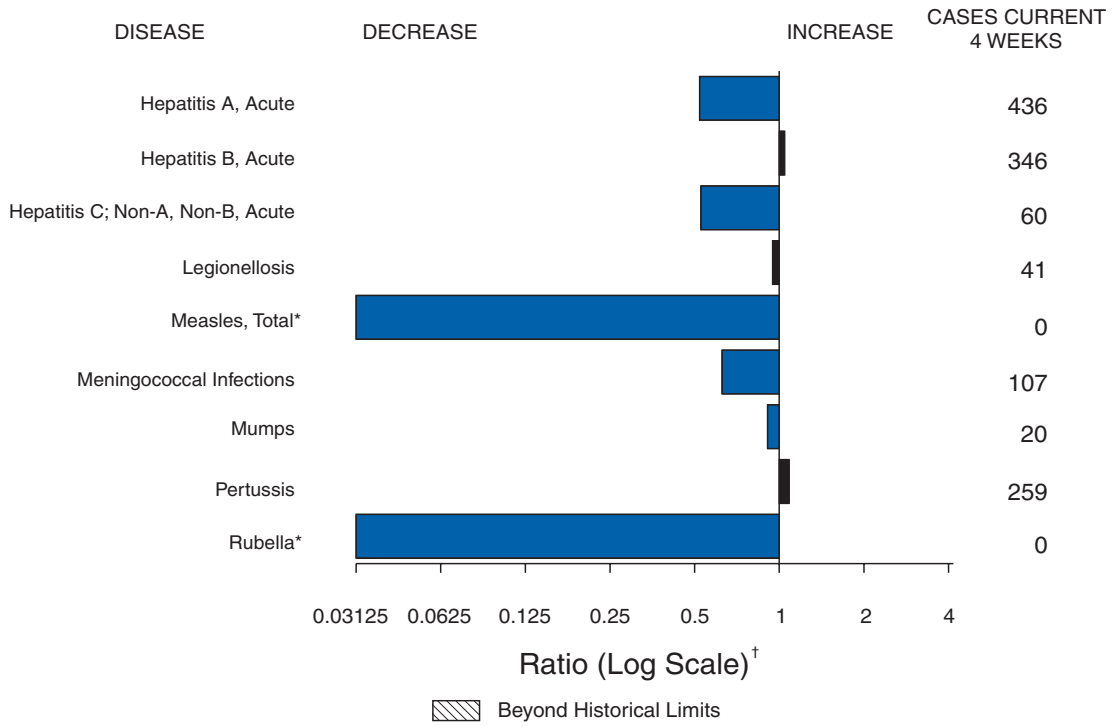
The Association of Teachers of Preventive Medicine (ATPM) and the National Immunization Program (NIP)/CDC have released "Increasing Adult Vaccination Rates: WhatWorks," an interactive instructional program on CD-ROM that offers primary-care providers strategies to increase vaccination rates among their adult patients.

The program gives users the opportunity to test their knowledge of vaccine usage and explore facts about vaccine-preventable diseases; access reference materials and answers to frequently asked questions; review information about effective strategies (e.g., standing orders, chart reminders, and mailed/telephoned reminders) and test their knowledge of how to best implement these strategies; and develop a customized adult vaccination action plan for their practice.

The CD-ROM features web links to appropriate resources, predominantly those on the NIP/CDC Web site. The program is approved for 2 hours of Continuing Medical Education credit, 2.3 hours Continuing Nursing Education credit, and 0.2 hours Continuing Education units through CDC.

WhatWorks can be ordered free of charge through ATPM at http://www.atpm.org. Additional information is available through ATPM, telephone (800) 789-6737, or by e-mail at whatworks@atpm.org.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending March 2, 2002, with historical data



* No measles or rubella cases were reported for the current 4-week period yielding a ratio for week 9 of zero (0).
† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending March 2, 2002 (9th Week)*

		Cum. 2002	Cum. 2001		Cum. 2002	Cum. 2001
Anthrax		-	-	Encephalitis: West Nile†	5	-
Botulism:	foodborne	5	5	Hansen disease (leprosy)†	3	15
	infant	11	14	Hantavirus pulmonary syndrome†	-	1
	other (wound & unspecified)	2	-	Hemolytic uremic syndrome, postdiarrheal†	14	17
Brucellosis†		11	9	HIV infection, pediatric †§	4	31
Chancroid		6	8	Plague	-	-
Cholera		-	-	Poliomyelitis, paralytic	-	-
Cyclosporiasis†		14	32	Psittacosis†	8	1
Diphtheria		-	-	Q fever†	5	-
Ehrlichiosis:	human granulocytic (HGE)†	7	5	Rabies, human	-	-
	human monocytic (HME)†	1	4	Streptococcal toxic-shock syndrome†	8	17
	other and unspecified	-	-	Tetanus	2	5
Encephalitis:	California serogroup viral†	8	1	Toxic-shock syndrome	17	22
	eastern equine†	-	-	Trichinosis	2	4
	Powassan†	-	-	Tularemia†	5	2
	St. Louis†	-	-	Yellow fever	-	-
	western equine†	-	-			

-:No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update January 27, 2002.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending March 2, 2002, and March 3, 2001 (9th Week)*

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7		*Escherichia coli* Shiga Toxin Positive, Serogroup non-O157	
	Cum. 2002§	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	6,083	7,142	103,447	124,931	281	258	175	167	7	6
NEW ENGLAND	213	194	3,735	3,901	8	7	10	13	-	1
Maine	1	3	199	221	-	-	-	1	-	-
N.H.	4	12	253	208	2	-	-	2	-	-
Vt.	4	9	128	112	-	2	-	-	-	-
Mass.	137	116	1,792	1,511	2	2	5	10	-	1
R.I.	23	22	452	524	3	1	2	-	-	-
Conn.	44	32	911	1,325	1	2	3	-	-	-
MID. ATLANTIC	1,403	2,616	7,689	11,683	19	39	13	18	-	-
Upstate N.Y.	75	516	1,549	1,625	6	6	12	9	-	-
N.Y. City	874	1,720	3,965	4,622	8	23	-	1	-	-
N.J.	269	214	466	1,769	-	2	1	8	-	-
Pa.	185	166	1,709	3,667	5	8	N	N	-	-
E.N. CENTRAL	671	457	16,406	24,761	88	98	56	31	-	-
Ohio	156	69	2,952	6,814	30	19	12	12	-	-
Ind.	85	44	2,365	2,618	9	8	4	4	-	-
Ill.	333	230	4,420	7,254	10	8	14	8	-	-
Mich.	66	97	5,193	5,164	20	19	10	2	-	-
Wis.	31	17	1,476	2,911	19	44	16	5	-	-
W.N. CENTRAL	101	116	4,428	6,565	18	7	24	17	3	-
Minn.	20	27	1,222	1,482	7	-	8	8	3	-
Iowa	23	15	461	560	2	3	8	2	-	-
Mo.	36	37	1,623	2,329	5	1	4	3	-	-
N. Dak.	-	1	37	167	-	-	-	-	-	-
S. Dak.	1	-	349	320	2	-	1	1	-	-
Nebr.	12	18	-	615	-	3	-	-	-	-
Kans.	9	18	736	1,092	2	-	3	3	-	-
S. ATLANTIC	2,041	1,634	21,600	24,160	75	38	28	24	2	3
Del.	46	37	470	508	-	-	1	-	-	-
Md.	255	129	2,435	2,525	3	3	-	-	-	-
D.C.	87	165	460	530	1	2	-	-	-	-
Va.	160	175	2,722	2,790	1	3	2	3	-	1
W. Va.	13	10	399	369	-	-	-	1	-	-
N.C.	155	77	3,644	3,534	9	6	4	13	-	-
S.C.	148	159	2,272	3,601	1	-	-	1	-	-
Ga.	476	187	3,875	5,161	40	12	17	3	1	2
Fla.	701	695	5,323	5,142	20	12	4	3	1	-
E.S. CENTRAL	278	336	8,685	8,301	14	4	3	6	-	-
Ky.	31	51	1,378	1,449	1	-	-	-	-	-
Tenn.	133	110	2,825	2,572	2	-	3	3	-	-
Ala.	57	94	2,707	2,119	10	2	-	3	-	-
Miss.	57	81	1,775	2,161	1	2	-	-	-	-
W.S. CENTRAL	752	590	17,301	18,517	4	6	-	19	-	-
Ark.	35	45	1,191	1,551	2	2	-	-	-	-
La.	192	175	3,063	3,044	1	2	-	-	-	-
Okla.	35	35	1,366	1,787	1	1	-	2	-	-
Tex.	490	335	11,681	12,135	-	1	-	17	-	-
MOUNTAIN	208	239	6,610	7,256	16	16	15	10	1	1
Mont.	4	3	442	246	-	-	2	-	-	-
Idaho	4	5	411	343	4	2	1	2	-	-
Wyo.	1	-	141	134	-	-	-	-	1	-
Colo.	35	53	834	2,309	5	8	2	4	-	1
N. Mex.	7	18	755	1,090	-	3	2	-	-	-
Ariz.	92	81	2,024	2,093	4	1	3	4	-	-
Utah	13	21	1,070	131	2	2	3	-	-	-
Nev.	52	58	933	910	1	-	2	-	-	-
PACIFIC	416	960	16,993	19,787	39	43	26	29	1	1
Wash.	86	113	2,368	2,216	10	U	4	3	-	-
Oreg.	92	38	1,073	1,100	7	6	7	1	1	1
Calif.	227	798	12,466	15,352	22	37	15	21	-	-
Alaska	2	2	560	400	-	-	-	-	-	-
Hawaii	9	9	526	719	-	-	-	4	-	-
Guam	1	4	-	-	-	-	N	N	-	-
P.R.	166	156	-	503	-	-	-	-	-	-
V.I.	46	1	-	32	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	25	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 year 2001 and 2002 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 — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update March 2, 2002.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 2, 2002, and March 3, 2001 (9th Week)*

Reporting Area	*Escherichia coli* Shiga Toxin Positive, Not Serogrouped		Giardiasis	Gonorrhea		*Haemophilus influenzae*, Invasive			
						All Ages, All Serotypes		Age <5 Years Serotype B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	1	1	1,803	46,851	58,701	254	276	1	4
NEW ENGLAND	-	-	187	1,161	1,063	16	9	-	1
Maine	-	-	27	13	28	1	-	-	-
N.H.	-	-	10	17	21	3	-	-	-
Vt.	-	-	18	19	15	2	-	-	-
Mass.	-	-	65	643	443	9	9	-	1
R.I.	-	-	18	160	133	-	-	-	-
Conn.	-	-	49	309	423	1	-	-	-
MID. ATLANTIC	-	-	328	3,794	5,822	40	44	-	-
Upstate N.Y.	-	-	126	854	994	22	8	-	-
N.Y. City	-	-	121	1,784	2,022	11	14	-	-
N.J.	-	-	-	338	880	4	16	-	-
Pa.	-	-	81	818	1,926	3	6	-	-
E.N. CENTRAL	1	-	371	8,438	12,642	32	45	-	-
Ohio	1	-	142	1,680	3,652	23	16	-	-
Ind.	-	-	-	1,099	1,146	6	5	-	-
Ill.	-	-	51	2,613	3,774	-	15	-	-
Mich.	-	-	127	2,586	3,001	1	3	-	-
Wis.	-	-	51	460	1,069	2	6	-	-
W.N. CENTRAL	-	-	183	2,123	2,842	3	4	-	-
Minn.	-	-	68	402	487	-	-	-	-
Iowa	-	-	42	134	158	1	-	-	-
Mo.	-	-	47	1,192	1,418	2	4	-	-
N. Dak.	-	-	-	-	6	-	-	-	-
S. Dak.	-	-	9	42	36	-	-	-	-
Nebr.	-	-	-	-	238	-	-	-	-
Kans.	-	-	17	353	499	-	-	-	-
S. ATLANTIC	-	-	327	12,856	15,159	74	90	-	1
Del.	-	-	10	298	280	-	-	-	-
Md.	-	-	19	1,320	1,491	16	20	-	-
D.C.	-	-	8	403	525	-	-	-	-
Va.	-	-	15	1,657	1,646	3	6	-	-
W. Va.	-	-	3	165	75	-	3	-	1
N.C.	-	-	-	2,597	2,413	9	16	-	-
S.C.	-	-	3	1,329	3,016	1	1	-	-
Ga.	-	-	110	2,206	2,809	28	24	-	-
Fla.	-	-	159	2,881	2,904	17	20	-	-
E.S. CENTRAL	-	1	42	5,023	5,568	10	11	1	-
Ky.	-	1	-	554	619	1	-	-	-
Tenn.	-	-	14	1,629	1,812	4	4	-	-
Ala.	-	-	28	1,763	1,814	5	6	1	-
Miss.	-	-	-	1,077	1,323	-	1	-	-
W.S. CENTRAL	-	-	12	8,045	9,290	13	4	-	-
Ark.	-	-	12	771	1,000	1	-	-	-
La.	-	-	-	2,025	2,097	-	1	-	-
Okla.	-	-	-	570	884	12	3	-	-
Tex.	-	-	-	4,679	5,309	-	-	-	-
MOUNTAIN	-	-	191	1,732	1,734	38	48	-	1
Mont.	-	-	8	26	12	-	-	-	-
Idaho	-	-	4	18	18	-	1	-	-
Wyo.	-	-	1	10	13	1	-	-	-
Colo.	-	-	66	604	638	8	9	-	-
N. Mex.	-	-	14	146	179	8	9	-	-
Ariz.	-	-	42	558	553	17	28	-	1
Utah	-	-	31	78	11	3	-	-	-
Nev.	-	-	25	292	310	1	1	-	-
PACIFIC	-	-	162	3,679	4,581	28	21	-	1
Wash.	-	-	32	533	502	-	-	-	-
Oreg.	-	-	90	159	196	21	-	-	-
Calif.	-	-	-	2,800	3,717	-	15	-	1
Alaska	-	-	15	117	44	1	1	-	-
Hawaii	-	-	25	70	122	6	5	-	-
Guam	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	169	-	-	-	-
V.I.	-	-	-	-	5	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	3	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 2, 2002, and March 3, 2001 (9th Week)*

Reporting Area	*Haemophilus influenzae*, Invasive, Age <5 Years, Non-Serotype B		*Haemophilus influenzae*, Invasive, Age <5 Years, Unknown Serotype		Hepatitis (Viral, Acute), By Type, A		B		C; Non-A, Non-B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	42	54	1	5	1,218	2,302	734	1,011	222	909
NEW ENGLAND	2	4	-	-	66	82	21	24	4	12
Maine	-	-	-	-	3	1	-	1	-	-
N.H.	-	-	-	-	3	2	3	3	-	-
Vt.	-	-	-	-	-	2	2	1	4	2
Mass.	2	4	-	-	29	33	15	4	-	10
R.I.	-	-	-	-	4	3	1	4	-	-
Conn.	-	-	-	-	27	41	-	11	-	-
MID. ATLANTIC	4	7	-	-	102	222	90	245	52	435
Upstate N.Y.	3	-	-	-	26	24	8	10	10	10
N.Y. City	1	3	-	-	24	70	43	111	-	-
N.J.	-	-	-	-	13	99	19	88	40	414
Pa.	-	4	-	-	39	29	20	36	2	11
E.N. CENTRAL	4	9	-	-	136	636	114	93	18	60
Ohio	3	2	-	-	50	45	20	18	1	3
Ind.	1	-	-	-	7	6	4	2	-	-
Ill.	-	5	-	-	36	490	2	2	1	20
Mich.	-	-	-	-	38	81	88	71	16	37
Wis.	-	2	-	-	5	14	-	-	-	-
W.N. CENTRAL	-	-	1	1	52	93	29	36	76	204
Minn.	-	-	-	-	4	3	2	1	-	-
Iowa	-	-	-	-	15	7	5	5	1	-
Mo.	-	-	1	1	9	30	19	22	75	202
N. Dak.	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	2	1	-	1	-	-
Nebr.	-	-	-	-	-	17	-	4	-	1
Kans.	-	-	-	-	22	35	3	3	-	1
S. ATLANTIC	12	14	-	2	380	281	243	223	16	13
Del.	-	-	-	-	1	1	1	4	3	1
Md.	-	1	-	-	74	46	21	20	3	3
D.C.	-	-	-	-	13	5	2	2	-	-
Va.	1	2	-	-	5	25	17	13	-	-
W. Va.	-	-	-	-	3	-	5	1	-	-
N.C.	1	1	-	2	64	16	36	41	3	4
S.C.	-	-	-	-	11	9	3	-	1	-
Ga.	6	6	-	-	53	102	100	104	1	1
Fla.	4	4	-	-	156	77	58	38	5	4
E.S. CENTRAL	3	1	-	1	32	55	28	79	22	14
Ky.	-	-	-	-	11	6	6	12	1	-
Tenn.	1	-	-	-	-	28	-	25	5	11
Ala.	2	-	-	1	6	19	11	23	2	-
Miss.	-	1	-	-	15	2	11	19	14	3
W.S. CENTRAL	4	1	-	-	19	413	47	51	1	142
Ark.	-	-	-	-	6	16	22	17	-	1
La.	-	-	-	-	3	16	-	21	1	61
Okla.	4	1	-	-	9	31	1	12	-	-
Tex.	-	-	-	-	1	350	24	1	-	80
MOUNTAIN	9	7	-	1	125	164	52	79	13	10
Mont.	-	-	-	-	4	3	-	1	-	-
Idaho	-	-	-	-	-	18	-	3	-	1
Wyo.	-	-	-	-	2	1	4	-	4	2
Colo.	1	-	-	-	23	23	15	17	7	2
N. Mex.	3	3	-	1	4	4	2	18	-	5
Ariz.	4	4	-	-	69	83	22	30	-	-
Utah	-	-	-	-	10	9	4	1	-	-
Nev.	1	-	-	-	13	23	5	9	2	-
PACIFIC	4	11	-	-	306	356	110	181	20	19
Wash.	-	-	-	-	10	9	5	11	2	2
Oreg.	3	-	-	-	25	3	25	3	6	1
Calif.	-	10	-	-	269	333	79	162	12	16
Alaska	1	-	-	-	2	10	1	1	-	-
Hawaii	-	1	-	-	-	1	-	4	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	1	7	-	21	-	1
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	4	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 2, 2002, and March 3, 2001 (9th Week)*

Reporting Area	Legionellosis		Listeriosis		Lyme Disease		Malaria		Measles Total	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	101	125	45	72	544	738	135	196	-	33†
NEW ENGLAND	5	2	6	7	28	119	8	18	-	4
Maine	-	-	1	-	-	-	1	-	-	-
N.H.	1	-	2	-	9	2	4	-	-	-
Vt.	-	1	-	-	1	1	-	-	-	1
Mass.	2	1	1	5	15	40	-	9	-	3
R.I.	-	-	-	-	3	-	-	-	-	-
Conn.	2	-	2	2	-	76	3	9	-	-
MID. ATLANTIC	14	29	5	8	405	502	20	48	-	1
Upstate N.Y.	4	4	3	2	300	116	6	5	-	-
N.Y. City	-	3	1	2	-	5	6	26	-	-
N.J.	1	4	-	2	23	101	6	10	-	-
Pa.	9	18	1	2	82	280	2	7	-	1
E.N. CENTRAL	42	40	8	11	10	28	12	32	-	2
Ohio	26	15	6	1	10	10	7	4	-	-
Ind.	2	2	-	-	-	-	-	7	-	-
Ill.	-	7	-	3	-	3	-	10	-	2
Mich.	14	10	1	5	-	-	5	11	-	-
Wis.	-	6	1	2	U	15	-	-	-	-
W.N. CENTRAL	3	9	1	2	8	5	13	5	-	2
Minn.	1	1	-	-	2	3	5	1	-	-
Iowa	-	2	-	-	3	-	2	1	-	-
Mo.	2	3	1	1	3	2	3	3	-	2
N. Dak.	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	-	-	-	-
Nebr.	-	2	-	-	-	-	-	-	-	-
Kans.	-	1	-	1	-	-	3	-	-	-
S. ATLANTIC	20	15	7	7	68	55	46	42	-	3
Del.	3	-	-	-	5	4	-	1	-	-
Md.	5	6	1	1	42	46	17	15	-	3
D.C.	-	-	-	-	3	1	2	2	-	-
Va.	1	2	-	1	-	2	-	8	-	-
W. Va.	N	N	-	1	-	-	-	-	-	-
N.C.	3	2	1	-	4	2	5	1	-	-
S.C.	-	-	2	-	1	-	2	-	-	-
Ga.	3	1	2	2	-	-	11	9	-	-
Fla.	5	4	1	2	13	-	9	6	-	-
E.S. CENTRAL	2	8	3	4	1	2	3	7	-	-
Ky.	1	2	-	1	-	2	-	1	-	-
Tenn.	-	2	2	2	1	-	1	3	-	-
Ala.	1	2	1	1	-	-	1	3	-	-
Miss.	-	2	-	-	-	-	1	-	-	-
W.S. CENTRAL	-	2	1	9	2	16	2	3	-	-
Ark.	-	-	-	1	-	-	-	-	-	-
La.	-	1	-	-	1	1	2	1	-	-
Okla.	-	-	1	-	-	-	-	1	-	-
Tex.	-	1	-	8	1	15	-	1	-	-
MOUNTAIN	7	4	3	5	4	-	6	9	-	1
Mont.	-	-	-	-	-	-	-	1	-	-
Idaho	2	-	-	-	-	-	-	1	-	1
Wyo.	-	-	-	-	-	-	-	-	-	-
Colo.	2	3	1	1	1	-	2	3	-	-
N. Mex.	1	-	-	1	1	-	-	1	-	-
Ariz.	-	1	2	1	2	-	1	1	-	-
Utah	2	-	-	-	-	-	2	1	-	-
Nev.	-	-	-	2	-	-	1	1	-	-
PACIFIC	8	16	11	19	18	11	25	32	-	20
Wash.	-	3	-	-	-	-	1	1	-	14
Oreg.	N	N	1	2	1	1	-	2	-	2
Calif.	8	13	10	17	17	10	21	26	-	3
Alaska	-	-	-	-	-	-	1	1	-	-
Hawaii	-	-	-	-	N	N	2	2	-	1
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	2	-	-	N	N	-	-	-	-
V.I.	-	-	-	-	-	-	-	-	-	-
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.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Of 33 cases reported, 25 were indigenous and eight were imported from another country.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 2, 2002, and March 3, 2001 (9th Week)*

Reporting Area	Meningococcal Disease		Mumps		Pertussis		Rabies, Animal	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	274	643	36	26	661	944	512	937
NEW ENGLAND	23	38	2	-	160	132	86	74
Maine	2	-	-	-	3	-	5	12
N.H.	2	3	2	-	1	14	1	1
Vt.	3	3	-	-	21	17	20	17
Mass.	13	22	-	-	135	96	27	17
R.I.	2	-	-	-	-	-	4	8
Conn.	1	10	-	-	-	5	29	19
MID. ATLANTIC	30	77	6	2	47	68	86	138
Upstate N.Y.	11	15	2	1	40	41	69	79
N.Y. City	4	15	1	1	3	7	4	1
N.J.	5	30	1	-	-	-	-	19
Pa.	10	17	2	-	4	20	13	39
E.N. CENTRAL	42	71	3	2	99	117	2	7
Ohio	23	20	2	1	71	77	1	-
Ind.	7	1	-	-	8	3	1	1
Ill.	-	18	1	1	10	7	-	-
Mich.	8	20	-	-	9	13	-	2
Wis.	4	12	-	-	1	17	-	4
W.N. CENTRAL	11	35	2	1	85	31	25	53
Minn.	-	-	-	-	10	-	5	12
Iowa	3	10	-	-	35	5	4	11
Mo.	5	16	-	-	25	16	1	3
N. Dak.	-	-	-	-	-	-	-	8
S. Dak.	2	1	-	-	4	2	-	9
Nebr.	-	2	-	-	-	-	-	-
Kans.	1	6	2	1	11	8	15	10
S. ATLANTIC	53	102	4	2	57	35	226	273
Del.	1	-	-	-	1	-	3	-
Md.	1	15	1	1	11	10	38	55
D.C.	-	-	-	-	-	-	-	-
Va.	4	12	1	1	15	1	70	57
W. Va.	-	2	-	-	-	1	10	19
N.C.	7	22	1	-	9	10	76	69
S.C.	7	5	1	-	15	4	8	7
Ga.	8	19	-	-	-	6	19	41
Fla.	25	27	-	-	6	3	2	25
E.S. CENTRAL	15	40	4	-	22	24	19	111
Ky.	2	7	1	-	6	7	3	2
Tenn.	4	12	1	-	15	11	11	106
Ala.	8	15	1	-	1	3	5	3
Miss.	1	6	1	-	-	3	-	-
W.S. CENTRAL	13	140	3	-	50	3	17	180
Ark.	5	7	-	-	5	2	-	-
La.	2	27	-	-	-	-	-	2
Okla.	5	10	-	-	4	1	17	11
Tex.	1	96	3	-	41	-	-	167
MOUNTAIN	28	27	2	4	97	440	22	46
Mont.	-	-	-	-	2	2	-	5
Idaho	-	3	1	-	7	78	-	-
Wyo.	-	-	-	1	1	-	1	14
Colo.	9	11	-	1	57	105	-	-
N. Mex.	-	5	-	2	15	9	-	1
Ariz.	10	4	-	-	9	241	21	26
Utah	4	2	1	-	5	5	-	-
Nev.	5	2	-	-	1	-	-	-
PACIFIC	59	113	10	15	44	94	29	55
Wash.	10	18	-	-	25	8	-	-
Oreg.	13	2	N	N	11	2	-	-
Calif.	33	88	10	8	6	76	13	31
Alaska	1	1	-	-	2	-	16	24
Hawaii	2	4	-	7	-	8	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	-	1	-	-	-	1	13	20
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.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 2, 2002, and March 3, 2001 (9th Week)*

Reporting Area	Rocky Mountain Spotted Fever		Rubella				Salmonellosis	
			Rubella		Congenital Rubella			
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	44	12	1	1	-	-	3,600	4,087
NEW ENGLAND	-	-	1	-	-	-	209	250
Maine	-	-	-	-	-	-	33	9
N.H.	-	-	-	-	-	-	7	14
Vt.	-	-	-	-	-	-	9	13
Mass.	-	-	1	-	-	-	112	169
R.I.	-	-	-	-	-	-	5	11
Conn.	-	-	-	-	-	-	43	34
MID. ATLANTIC	4	1	-	1	-	-	299	643
Upstate N.Y.	-	-	-	1	-	-	96	90
N.Y. City	-	-	-	-	-	-	84	156
N.J.	-	-	-	-	-	-	37	233
Pa.	4	1	-	-	-	-	82	164
E.N. CENTRAL	3	2	-	-	-	-	625	555
Ohio	3	-	-	-	-	-	238	164
Ind.	-	1	-	-	-	-	39	29
Ill.	-	1	-	-	-	-	197	173
Mich.	-	-	-	-	-	-	100	103
Wis.	-	-	-	-	-	-	51	86
W.N. CENTRAL	1	2	-	-	-	-	268	223
Minn.	-	-	-	-	-	-	48	75
Iowa	-	-	-	-	-	-	45	27
Mo.	1	2	-	-	-	-	131	56
N. Dak.	-	-	-	-	-	-	-	1
S. Dak.	-	-	-	-	-	-	15	14
Nebr.	-	-	-	-	-	-	-	16
Kans.	-	-	-	-	-	-	29	34
S. ATLANTIC	34	5	-	-	-	-	1,075	958
Del.	-	-	-	-	-	-	9	12
Md.	6	1	-	-	-	-	86	105
D.C.	-	-	-	-	-	-	9	13
Va.	1	-	-	-	-	-	81	89
W. Va.	-	-	-	-	-	-	5	3
N.C.	23	4	-	-	-	-	162	170
S.C.	3	-	-	-	-	-	63	75
Ga.	-	-	-	-	-	-	321	301
Fla.	1	-	-	-	-	-	339	190
E.S. CENTRAL	2	2	-	-	-	-	211	221
Ky.	-	-	-	-	-	-	27	37
Tenn.	2	1	-	-	-	-	68	47
Ala.	-	1	-	-	-	-	76	91
Miss.	-	-	-	-	-	-	40	46
W.S. CENTRAL	-	-	-	-	-	-	84	431
Ark.	-	-	-	-	-	-	40	32
La.	-	-	-	-	-	-	1	76
Okla.	-	-	-	-	-	-	41	17
Tex.	-	-	-	-	-	-	2	306
MOUNTAIN	-	-	-	-	-	-	264	247
Mont.	-	-	-	-	-	-	3	8
Idaho	-	-	-	-	-	-	14	7
Wyo.	-	-	-	-	-	-	7	11
Colo.	-	-	-	-	-	-	80	62
N. Mex.	-	-	-	-	-	-	36	28
Ariz.	-	-	-	-	-	-	64	89
Utah	-	-	-	-	-	-	25	27
Nev.	-	-	-	-	-	-	35	15
PACIFIC	-	-	-	-	-	-	565	559
Wash.	-	-	-	-	-	-	22	29
Oreg.	-	-	-	-	-	-	50	9
Calif.	-	-	-	-	-	-	446	455
Alaska	-	-	-	-	-	-	12	7
Hawaii	-	-	-	-	-	-	35	59
Guam	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	9	126
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	1	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 2, 2002, and March 3, 2001 (9th Week)*

Reporting Area	Shigellosis		Streptococcal Disease, Invasive, Group A		*Streptococcus pneumoniae*, Drug Resistant, Invasive		*Streptococcus pneumoniae*, Invasive (<5 Years)	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	1,846	2,116	618	703	391	541	27	22
NEW ENGLAND	36	31	26	24	1	2	7	1
Maine	2	-	6	5	-	-	-	-
N.H.	2	-	10	4	-	-	-	-
Vt.	-	-	1	4	1	2	7	1
Mass.	28	25	9	11	-	-	-	-
R.I.	-	-	-	-	-	-	-	-
Conn.	4	6	-	-	-	-	-	-
MID. ATLANTIC	59	283	103	134	19	30	8	13
Upstate N.Y.	15	72	55	41	19	29	8	13
N.Y. City	28	84	25	53	-	-	-	-
N.J.	-	72	16	36	-	-	-	-
Pa.	16	55	7	4	-	1	-	-
E.N. CENTRAL	261	313	94	172	19	37	6	8
Ohio	164	74	36	41	-	-	1	-
Ind.	10	35	4	-	19	37	5	8
Ill.	44	108	1	58	-	-	-	-
Mich.	31	61	53	61	-	-	-	-
Wis.	12	35	-	12	-	-	-	-
W.N. CENTRAL	168	236	21	48	52	8	4	-
Minn.	22	105	-	-	24	-	4	-
Iowa	10	32	-	-	-	-	-	-
Mo.	24	52	13	23	1	1	-	-
N. Dak.	-	8	-	2	-	1	-	-
S. Dak.	94	3	1	2	1	-	-	-
Nebr.	-	13	-	4	-	3	-	-
Kans.	18	23	7	17	26	3	-	-
S. ATLANTIC	816	283	145	119	255	365	2	-
Del.	2	2	-	1	3	-	-	-
Md.	83	18	16	9	-	-	-	-
D.C.	4	8	2	-	2	1	2	-
Va.	188	14	10	29	-	-	-	-
W. Va.	2	2	-	2	4	8	-	-
N.C.	47	65	34	22	-	-	-	-
S.C.	10	13	7	1	35	55	-	-
Ga.	341	83	49	30	85	127	-	-
Fla.	139	78	27	25	126	174	-	-
E.S. CENTRAL	114	139	21	15	31	61	-	-
Ky.	23	51	1	5	1	7	-	-
Tenn.	13	13	20	10	30	53	-	-
Ala.	40	29	-	-	-	1	-	-
Miss.	38	46	-	-	-	-	-	-
W.S. CENTRAL	60	366	12	91	2	27	-	-
Ark.	21	40	-	-	2	8	-	-
La.	4	37	-	-	-	19	-	-
Okla.	34	1	11	9	-	-	-	-
Tex.	1	288	1	82	-	-	-	-
MOUNTAIN	73	119	91	75	12	10	-	-
Mont.	-	-	-	-	-	-	-	-
Idaho	2	4	1	1	-	-	-	-
Wyo.	1	-	1	1	6	-	-	-
Colo.	18	23	61	45	-	-	-	-
N. Mex.	10	25	28	22	6	10	-	-
Ariz.	28	59	-	5	-	-	-	-
Utah	7	2	-	1	-	-	-	-
Nev.	7	6	-	-	-	-	-	-
PACIFIC	259	346	105	25	-	1	-	-
Wash.	5	34	16	-	-	-	-	-
Oreg.	26	3	-	-	-	-	-	-
Calif.	217	300	77	15	-	-	-	-
Alaska	1	1	-	-	-	-	-	-
Hawaii	10	8	12	10	-	1	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	-	4	-	-	-	-	-	-
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.
*Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 2, 2002, and March 3, 2001 (9th Week)*

Reporting Area	Syphilis				Tuberculosis		Typhoid Fever	
	Primary & Secondary		Congenital†					
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	819	862	2	80	896	1,464	30	50
NEW ENGLAND	11	4	-	-	39	51	3	4
Maine	-	-	-	-	-	-	-	-
N.H.	-	-	-	-	1	2	-	-
Vt.	-	-	-	-	-	1	-	-
Mass.	6	1	-	-	10	27	2	4
R.I.	2	-	-	-	7	4	-	-
Conn.	3	3	-	-	21	17	1	-
MID. ATLANTIC	67	73	-	11	203	237	2	20
Upstate N.Y.	5	3	-	8	18	31	-	4
N.Y. City	43	45	-	-	150	108	2	1
N.J.	17	9	-	3	-	64	-	15
Pa.	2	16	-	-	35	34	-	-
E.N. CENTRAL	167	114	-	16	150	129	6	3
Ohio	24	8	-	1	28	28	2	1
Ind.	9	24	-	2	17	14	1	-
Ill.	45	52	-	11	69	60	-	1
Mich.	86	25	-	2	30	15	2	1
Wis.	3	5	-	-	6	12	1	-
W.N. CENTRAL	5	20	-	1	60	44	-	4
Minn.	2	11	-	-	27	30	-	-
Iowa	-	-	-	-	-	-	-	-
Mo.	3	5	-	-	28	8	-	4
N. Dak.	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	5	1	-	-
Nebr.	-	-	-	-	-	5	-	-
Kans.	-	4	-	1	-	-	-	-
S. ATLANTIC	207	317	-	23	130	270	8	9
Del.	3	3	-	-	-	-	-	-
Md.	11	49	-	1	17	15	-	3
D.C.	8	7	-	1	-	16	-	-
Va.	7	25	-	-	7	25	-	-
W. Va.	-	-	-	-	5	7	-	-
N.C.	64	81	-	2	34	13	-	1
S.C.	21	49	-	7	9	21	-	-
Ga.	27	32	-	5	16	58	5	3
Fla.	66	71	-	7	42	115	3	2
E.S. CENTRAL	104	97	-	4	75	91	-	-
Ky.	9	8	-	-	15	11	-	-
Tenn.	44	50	-	2	32	22	-	-
Ala.	35	19	-	2	24	39	-	-
Miss.	16	20	-	-	4	19	-	-
W.S. CENTRAL	125	124	2	14	7	260	-	4
Ark.	6	10	-	2	4	19	-	-
La.	25	18	-	-	-	-	-	-
Okla.	11	15	-	1	3	5	-	-
Tex.	83	81	2	11	-	236	-	4
MOUNTAIN	42	34	-	2	29	60	2	2
Mont.	-	-	-	-	-	-	-	1
Idaho	1	-	-	-	-	3	-	-
Wyo.	-	-	-	-	1	-	-	-
Colo.	-	3	-	-	5	15	1	-
N. Mex.	6	4	-	-	7	6	-	-
Ariz.	33	22	-	2	12	19	-	-
Utah	2	4	-	-	2	2	1	-
Nev.	-	1	-	-	2	15	-	1
PACIFIC	91	79	-	9	203	322	9	4
Wash.	8	13	-	-	26	26	-	-
Oreg.	4	2	-	-	11	10	2	-
Calif.	78	61	-	9	131	252	7	3
Alaska	-	-	-	-	16	9	-	-
Hawaii	1	3	-	-	19	25	-	1
Guam	-	-	-	-	-	-	-	-
P.R.	-	53	-	1	-	11	-	-
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	-	U	11	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE III. Deaths in 122 U.S. cities,* week ending March 2, 2002 (9th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	452	328	82	27	7	8	44
Boston, Mass.	U	U	U	U	U	U	U
Bridgeport, Conn.	31	25	3	2	-	1	4
Cambridge, Mass.	18	15	3	-	-	-	3
Fall River, Mass.	23	18	4	1	-	-	3
Hartford, Conn.	80	53	17	4	3	3	2
Lowell, Mass.	26	21	4	1	-	-	3
Lynn, Mass.	11	7	4	-	-	-	1
New Bedford, Mass.	45	36	9	-	-	-	-
New Haven, Conn.	51	35	9	6	1	-	11
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	8	7	-	-	1	-	1
Springfield, Mass.	48	31	10	5	-	2	4
Waterbury, Conn.	27	19	4	3	1	-	2
Worcester, Mass.	84	61	15	5	1	2	10
MID. ATLANTIC	2,290	1,628	432	145	43	42	183
Albany, N.Y.	63	50	8	1	3	1	11
Allentown, Pa.	17	16	1	-	-	-	2
Buffalo, N.Y.	120	93	19	3	1	4	16
Camden, N.J.	34	21	6	3	3	1	3
Elizabeth, N.J.	28	20	5	3	-	-	3
Erie, Pa.	56	48	6	1	-	1	5
Jersey City, N.J.	35	22	9	3	1	-	-
New York City, N.Y.	1,235	838	268	88	22	19	76
Newark, N.J.	U	U	U	U	U	U	U
Paterson, N.J.	27	14	6	3	3	1	3
Philadelphia, Pa.	274	174	57	24	9	10	15
Pittsburgh, Pa.§	34	29	2	2	-	1	2
Reading, Pa.	20	16	3	1	-	-	2
Rochester, N.Y.	184	149	25	8	1	1	24
Schenectady, N.Y.	18	14	3	1	-	-	2
Scranton, Pa.	32	29	2	1	-	-	1
Syracuse, N.Y.	63	55	6	1	-	1	15
Trenton, N.J.	29	23	2	2	-	2	1
Utica, N.Y.	21	17	4	-	-	-	2
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,752	1,278	301	107	21	45	137
Akron, Ohio	58	41	10	6	-	1	3
Canton, Ohio	52	41	7	4	-	-	3
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	U	U	U	U	U	U	U
Cleveland, Ohio	150	104	30	6	1	9	9
Columbus, Ohio	222	176	28	12	4	2	18
Dayton, Ohio	121	82	32	2	2	3	14
Detroit, Mich.	213	126	53	21	6	7	14
Evansville, Ind.	71	58	7	4	-	2	6
Fort Wayne, Ind.	71	55	12	3	-	1	8
Gary, Ind.	31	16	7	6	1	1	1
Grand Rapids, Mich.	85	65	9	3	-	8	11
Indianapolis, Ind.	208	146	35	15	2	10	20
Lansing, Mich.	U	U	U	U	U	U	U
Milwaukee, Wis.	120	94	14	11	1	-	10
Peoria, Ill.	55	40	10	3	2	-	3
Rockford, Ill.	60	48	10	1	-	1	4
South Bend, Ind.	59	43	13	2	1	-	3
Toledo, Ohio	111	85	19	6	1	-	6
Youngstown, Ohio	65	58	5	2	-	-	4
W.N. CENTRAL	600	429	96	39	17	19	56
Des Moines, Iowa	46	40	2	4	-	-	12
Duluth, Minn.	U	U	U	U	U	U	U
Kansas City, Kans.	53	36	10	5	2	-	7
Kansas City, Mo.	124	84	24	7	3	6	4
Lincoln, Nebr.	34	24	9	1	-	-	3
Minneapolis, Minn.	4	2	1	1	-	-	-
Omaha, Nebr.	76	56	11	6	2	1	10
St. Louis, Mo.	96	59	18	7	6	6	-
St. Paul, Minn.	75	57	11	3	1	3	9
Wichita, Kans.	92	71	10	5	3	3	11
S. ATLANTIC	1,405	963	279	111	33	19	118
Atlanta, Ga.	180	111	40	18	4	7	6
Baltimore, Md.	228	145	52	25	4	2	15
Charlotte, N.C.	108	74	22	9	1	2	22
Jacksonville, Fla.	146	94	31	14	5	2	24
Miami, Fla.	147	100	32	11	4	-	12
Norfolk, Va.	66	53	6	3	2	2	2
Richmond, Va.	83	51	22	7	2	1	14
Savannah, Ga.	47	36	9	1	1	-	8
St. Petersburg, Fla.	63	52	6	5	-	-	1
Tampa, Fla.	225	164	38	12	8	3	12
Washington, D.C.	99	70	21	6	2	-	2
Wilmington, Del.	13	13	-	-	-	-	-
E.S. CENTRAL	1,006	703	202	54	23	24	89
Birmingham, Ala.	194	141	36	6	5	6	34
Chattanooga, Tenn.	87	69	14	1	-	3	6
Knoxville, Tenn.	121	91	20	6	4	-	3
Lexington, Ky.	67	42	19	2	3	1	11
Memphis, Tenn.	231	162	44	12	6	7	12
Mobile, Ala.	92	57	23	11	1	-	6
Montgomery, Ala.	50	35	11	2	1	1	6
Nashville, Tenn.	164	106	35	14	3	6	11
W.S. CENTRAL	1,758	1,081	391	152	78	56	134
Austin, Tex.	89	61	19	5	2	2	9
Baton Rouge, La.	146	87	34	16	6	3	1
Corpus Christi, Tex.	65	44	13	6	-	2	4
Dallas, Tex.	249	135	72	27	8	7	20
El Paso, Tex.	71	52	13	5	1	-	7
Ft. Worth, Tex.	122	83	22	6	5	6	15
Houston, Tex.	429	224	91	56	41	17	28
Little Rock, Ark.	79	55	16	4	1	3	3
New Orleans, La.	39	27	6	4	2	-	-
San Antonio, Tex.	245	170	49	12	6	8	25
Shreveport, La.	59	36	18	3	1	1	5
Tulsa, Okla.	165	107	38	8	5	7	17
MOUNTAIN	1,090	766	205	78	17	22	125
Albuquerque, N.M.	140	100	27	9	2	2	14
Boise, Idaho	31	23	7	-	-	1	3
Colo. Springs, Colo.	55	37	9	7	1	1	3
Denver, Colo.	107	69	23	8	1	6	11
Las Vegas, Nev.	221	144	54	15	3	5	22
Ogden, Utah	35	28	4	2	-	1	4
Phoenix, Ariz.	197	133	35	18	7	2	20
Pueblo, Colo.	24	19	3	2	-	-	2
Salt Lake City, Utah	134	101	19	11	2	1	30
Tucson, Ariz.	146	112	24	6	1	3	16
PACIFIC	2,062	1,483	357	116	72	31	217
Berkeley, Calif.	17	12	4	1	-	-	2
Fresno, Calif.	117	90	16	6	2	3	8
Glendale, Calif.	16	14	-	1	1	-	3
Honolulu, Hawaii	75	60	11	2	1	1	8
Long Beach, Calif.	77	57	9	4	6	1	12
Los Angeles, Calif.	449	307	92	33	10	7	30
Pasadena, Calif.	30	24	3	1	-	2	5
Portland, Oreg.	94	60	21	9	1	3	9
Sacramento, Calif.	264	190	52	12	6	4	32
San Diego, Calif.	180	139	27	8	2	4	21
San Francisco, Calif.	92	69	18	2	1	-	17
San Jose, Calif.	262	180	33	9	38	2	37
Santa Cruz, Calif.	34	29	5	-	-	-	3
Seattle, Wash.	157	102	28	22	2	3	11
Spokane, Wash.	65	49	13	1	2	-	13
Tacoma, Wash.	133	101	25	5	-	1	6
TOTAL	12,415¶	8,659	2,345	829	311	266	1,103

U: Unavailable. -:No reported cases.

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

† Pneumonia and influenza.

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

¶ Total includes unknown ages.

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