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National Breast Cancer Awareness Month — October 1998

October is National Breast Cancer Awareness Month. This nationwide educational campaign directly supports efforts such as CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) to increase public awareness of the importance of screening. A key date in the month-long campaign is October 16, National Mammography Day, a yearly observance formally established by the President in 1992.

Now in its ninth year, the NBCCEDP supports critical breast and cervical cancer screening services for underserved women, including older women, women with low income, and women of racial/ethnic minority populations. CDC supports early detection programs in 50 states, the District of Columbia, five territories, and 15 programs serving American Indians/Alaskan Natives. Through March 1998, these programs have provided more than 1.7 million screenings.

Additional information about National Breast Cancer Awareness Month and the NBCCEDP is available from CDC's Division of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion, World-Wide Web site http://www.cdc.gov/nccdphp/dcpc/nbccedp, and telephone (770) 488-4751.

Self-Reported Use of Mammography and Insurance Status Among Women Aged ≥40 Years — United States, 1991–1992 and 1996–1997

In the United States, breast cancer is the most commonly diagnosed malignancy among women and the second leading cause of cancer death (*1*). Lack of health insurance coverage often is an important financial barrier to seeking preventive health care such as mammography screenings (*2,3*). To assess mammography use and the impact of insurance status on mammography use, state-specific proportions of women aged ≥40 years who reported receiving a mammogram during the preceding 2 years by insurance status were derived using data from the Behavioral Risk Factor Surveillance System (BRFSS) for 1991–1992 and 1996–1997. This report describes the results of this analysis, which indicate that the percentage of women reporting having had a

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screening mammogram during the previous 2 years increased, but women with insurance were substantially more likely than women without insurance to have had a mammogram.

Forty-six states and the District of Columbia (DC) participated in BRFSS surveys during 1991–1992 and 1996–1997.* Using a multistage sampling design and random-digit dialing, each state conducted monthly telephone interviews sampling noninstitutionalized adults (aged ≥18 years) (*3,4*). Annual data were weighted to the age, sex, and race distribution of each state's adult population using 1994 census or intercensal estimates. Female respondents aged ≥40 years were asked, "Have you ever had a mammogram?" If the respondent answered "yes," she was asked, "How long has it been since your last mammogram?" and "Was it part of a routine checkup, or was it because of a breast problem other than cancer, or was it because you had already had breast cancer?" Respondents also were asked, "Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?" In the 1996 and 1997 surveys, respondents who answered "no" were asked to reconsider the question. For consistency between the surveys, this analysis categorized respondents in 1996 and 1997 who first answered "no" to the insurance question as uninsured, even if they answered "yes" when asked again; the increase in the percentage of persons insured based on "yes" responses on reconsideration of the question was <2%.

Almost all women aged ≥65 years have Medicare coverage (*3*). However, the aggregated results for all women aged ≥40 years are presented because this format is consistent with prior analyses of trends in mammography coverage using data from the BRFSS and national objectives for breast cancer screening (*5,6*). To compensate for the potential affects of the resulting differences in age distributions between insured and uninsured women, estimates were age-adjusted to the age distribution of women in the 1994 BRFSS sample for participating states.

The overall pooled age-adjusted proportion of women with insurance who reported having had a mammogram was 65.2% in 1991–1992 and 70.9% in 1996–1997; the proportion of women without insurance who reported having had a mammogram was 39.6% in 1991–1992 and 46.2% in 1996–1997. In each of the 46 states and DC in both 1991–1992 and 1996–1997, the prevalence of self-reported screening mammography use within the previous 2 years was higher among insured women than among uninsured women; uninsured women represented approximately 9% of the sample in 1996–1997 (Table 1).

Among insured women, from 1991–1992 to 1996–1997, the age-adjusted proportion aged ≥40 years who reported having had a mammogram during the preceding 2 years increased in 43 states. Increases in 26 states were statistically significant; the largest absolute increases in mammography use were in Mississippi (from 51.4% to 65.3%) and Alaska (from 63.9% to 76.4%). Mammography use decreased in three states (Minnesota, Vermont, and Washington), and DC, but the changes were not statistically significant.

Among uninsured women, mammography use increased in 33 states; the increase was significant in six. The largest absolute increases were 31.0% in Alaska (from 33.8% to 64.8%) and 23.9% in New Jersey (from 23.7% to 47.6%). Although there were

*Arkansas, Kansas, Nevada, and Wyoming did not participate.

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decreases in 14 states, the only statistically significant decrease was in New Hampshire (from 51.1% to 32.4%; p=0.047).

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Editorial Note: The findings in this report indicate that the percentage of women reporting having had a screening mammogram in the previous 2 years has increased over time, and this increase has been observed among both insured and uninsured women. However, women without insurance continue to be substantially less likely than women with insurance to have this procedure. These results underscore the importance of public health activities to increase access to breast and cervical cancer screening services for women who are medically underserved (*7*). If breast cancer mortality is to continue to decrease, then access to mammography for all women, particularly the uninsured, must be enhanced (*8*).

The findings in this report are subject to at least three limitations. First, because the BRFSS is a telephone survey, women living in a household without a telephone (5% of U.S. households) are excluded (*9*). Second, the survey's self-reported data may not be consistent with reports of mammography use from medical records. However, studies comparing self-reports with medical records found that the error in self-reporting mammography use is not substantial enough to explain the differences seen in the analyses described in this report (*10*). Finally, the response rates within the BRFSS have dropped from 84.1% and 82.9% in 1991 and 1992, respectively, to 77.9% and 76.8% in 1996 and 1997, respectively. Because respondents may differ from nonrespondents, this increase in nonresponse could portend greater bias in later samples.

This study indicates that lack of health insurance decreases the likelihood that a woman will receive a mammogram. This is an important finding given the efforts being made to reduce breast cancer mortality in this country, where a substantial proportion of women lack health insurance. The demonstrated efficacy of regular breast cancer screening with mammography suggests that efforts such as CDC's National Breast and Cervical Cancer Early Detection Program, a comprehensive nationwide program administered through state health departments and American Indian/ Alaskan Native tribal organizations, could facilitate the early detection of breast cancer in underserved women.

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TABLE 1. Percentage of women aged ≥40 years who reported having had a mammogram during the previous 2 years, by insurance status — United States, Behavioral Risk Factor Surveillance System (BRFSS), 1991–1992 and 1996–1997*

State	Insured						Uninsured					
	Sample size		Percentage 1991–1992		Percentage 1996–1997		Sample size		Percentage 1991–1992		Percentage 1996–1997	
	1991–1992	1996–1997	%	(SE[†])	%	(SE)	1991–1992	1996–1997	%	(SE)	%	(SE)
Alabama	1,225	1,424	68.3	(1.5)	70.7	(1.4)	190	200	41.5	(4.3)	43.0	(5.1)
Alaska	641	754	63.9	(2.8)	76.4[§]	(2.4)	83	162	33.8	(8.1)	64.8[§]	(5.2)
Arizona	977	1,231	63.6	(2.2)	73.2[§]	(2.2)	133	119	47.2	(4.5)	41.8	(7.0)
California	1,764	2,370	72.0	(1.3)	74.1	(1.1)	185	263	43.1	(6.7)	45.9	(6.0)
Colorado	997	1,128	68.7	(1.6)	71.7	(1.6)	85	80	42.9	(6.6)	30.5	(5.9)
Connecticut	1,144	1,375	69.5	(1.6)	74.1[§]	(1.4)	64	83	50.3	(7.3)	36.4	(7.4)
Delaware	973	1,636	69.2	(1.7)	77.2[§]	(1.3)	83	106	36.3	(6.8)	41.8	(5.4)
District of Columbia	853	822	80.7	(1.7)	76.9	(1.7)	114	83	54.9	(5.2)	63.4	(6.7)
Florida	1,581	2,356	65.4	(1.6)	77.3[§]	(1.1)	207	294	39.0	(4.4)	43.6	(4.2)
Georgia	1,017	1,383	64.0	(1.7)	70.9[§]	(1.4)	139	105	44.7	(5.8)	60.2[§]	(4.6)
Hawaii	1,076	1,418	66.8	(1.8)	74.2[§]	(1.4)	67	74	32.0	(5.8)	48.6	(10.7)
Idaho	1,055	2,430	56.0	(1.8)	59.5	(1.3)	112	245	26.0	(4.0)	24.6	(4.3)
Illinois	1,244	1,828	66.1	(1.7)	68.7	(1.3)	112	143	40.6	(5.7)	54.3	(5.1)
Indiana	1,422	1,458	61.5	(1.5)	65.9[§]	(1.5)	103	127	25.7	(4.6)	33.8	(6.7)
Iowa	1,046	2,627	60.0	(1.9)	64.1	(1.2)	57	125	45.2	(10.2)	40.3	(8.0)
Kentucky	1,264	2,695	55.8	(1.7)	68.0[§]	(1.2)	183	223	31.8	(4.0)	33.3	(6.3)
Louisiana	926	974	56.8	(1.9)	65.1[§]	(1.8)	175	186	29.0	(5.3)	49.9[§]	(5.6)
Maine	744	1,132	68.1	(2.0)	72.5	(1.7)	52	106	42.8	(8.2)	39.4	(7.0)
Maryland	1,172	2,899	75.0	(1.5)	78.5	(1.0)	88	195	42.9	(6.1)	56.8	(5.5)
Massachusetts	781	1,081	71.8	(1.8)	76.1	(1.6)	43	66	39.8	(9.7)	62.6	(8.4)
Michigan	1,440	1,605	68.5	(1.4)	75.1[§]	(1.3)	89	98	45.2	(7.3)	50.1	(6.2)
Minnesota	2,007	2,908	69.4	(1.2)	68.7	(1.0)	89	137	42.7	(6.8)	35.3	(4.8)
Mississippi	1,013	1,114	51.4	(1.9)	65.3[§]	(1.8)	148	128	35.6	(4.9)	39.8	(7.0)
Missouri	938	1,172	63.7	(1.9)	66.4	(1.6)	115	110	35.1	(5.2)	43.2	(8.3)
Montana	725	1,195	62.5	(2.1)	69.2[§]	(1.5)	75	135	23.7	(5.1)	37.8[§]	(4.6)
Nebraska	993	1,755	55.7	(2.0)	64.5[§]	(1.6)	48	94	36.6	(8.0)	45.2	(11.6)
New Hampshire	845	982	70.6	(1.8)	73.5	(1.5)	54	64	51.1	(8.1)	32.4[§]	(4.8)
New Jersey	1,036	1,881	60.6	(1.8)	68.9[§]	(1.3)	48	136	23.7	(7.9)	47.6[§]	(5.9)
New Mexico	587	902	64.0	(2.4)	69.1	(1.9)	128	164	34.1	(5.1)	41.1	(6.4)

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New York	1,221	2,448	64.4	(1.7)	73.9§	(1.1)	98	184	35.2	(6.8)	45.0	(5.4)
North Carolina	1,256	2,133	64.2	(1.7)	71.0§	(1.2)	127	192	35.2	(5.0)	42.6	(4.6)
North Dakota	1,105	1,222	65.6	(1.7)	71.1§	(1.6)	60	88	29.2	(7.6)	27.5	(6.0)
Ohio	790	1,715	60.4	(2.1)	69.8	(1.6)	56	120	46.9	(7.1)	56.4	(5.9)
Oklahoma	931	1,235	57.9	(1.9)	64.8§	(1.7)	157	147	29.2	(4.2)	26.7	(5.3)
Oregon	2,094	2,084	70.3	(1.1)	73.3	(1.1)	183	160	42.0	(5.1)	37.6	(5.0)
Pennsylvania	1,521	2,472	62.1	(1.5)	68.5§	(1.1)	73	159	46.4	(7.7)	53.8	(5.5)
Rhode Island	1,093	1,220	69.5	(1.6)	77.0§	(1.5)	48	63	37.1	(7.7)	48.3	(8.8)
South Carolina	1,258	1,352	64.2	(1.7)	71.5§	(1.6)	177	155	43.2	(4.6)	54.4	(6.6)
South Dakota	1,113	1,439	59.7	(1.7)	67.3§	(1.5)	68	107	24.4	(5.4)	37.4	(7.6)
Tennessee	1,588	2,167	60.4	(1.4)	66.5§	(1.3)	174	179	36.9	(4.7)	45.8	(5.0)
Texas	1,033	1,167	62.7	(1.8)	66.3	(1.7)	196	222	40.6	(5.0)	47.3	(4.9)
Utah	944	1,606	62.9	(1.8)	64.6	(1.6)	71	150	35.8	(9.6)	21.8	(5.6)
Vermont	1,038	1,813	69.6	(1.6)	69.2	(1.3)	96	168	35.1	(6.0)	50.0	(5.1)
Virginia	931	1,752	65.6	(1.8)	70.5§	(1.5)	101	206	48.7	(6.0)	47.0	(5.4)
Washington	1,319	2,289	69.9	(1.5)	68.7	(1.1)	99	133	39.1	(6.7)	49.9	(7.4)
West Virginia	1,664	1,783	60.1	(1.4)	69.1§	(1.3)	232	196	31.2	(3.8)	43.4	(6.0)
Wisconsin	803	1,402	64.7	(1.9)	67.4	(1.8)	31	84	60.8	(8.7)	50.3	(8.1)
Pooled	53,188	77,834	65.2	(0.3)	70.9§	(0.3)	5,116	6,764	39.6	(1.3)	46.2§	(1.3)

*Percentages are age-adjusted to the distribution of the 1994 BRFSS sample.
†Standard error.
§Difference within insurance group between 1991–1992 and 1996–1997 is significant ($p<0.05$).

Mammography — Continued

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Update: Influenza Activity — Worldwide, April–September 1998

In collaboration with the World Health Organization (WHO), the WHO international network of approximately 110 collaborating laboratories in 83 countries, and U.S. state and local health departments, CDC conducts surveillance to monitor influenza activity and to detect antigenic changes in the circulating strains of influenza viruses. During October 1997–April 1998. influenza activity was moderate to severe in the Northern Hemisphere (*1*). Influenza A(H3N2) viruses were predominant, but influenza A(H1N1) viruses were associated with outbreaks, and influenza B viruses were identified sporadically in all regions. Since April 1998, increased influenza outbreak and epidemic level activity, primarily associated with influenza A(H3N2), has been reported in the Southern Hemisphere. This report summarizes worldwide influenza activity during April–September 1998 and the antigenic characteristics of influenza isolates collected during April–September.

Africa. Influenza activity in South Africa primarily was associated with influenza A(H3N2) viruses. Activity began earlier, in March, and was more extensive than usual. Influenza A(H3N2) activity peaked from mid-May through the first week of June, but viruses continued to be isolated through July. Influenza A(H1N1) and influenza B viruses were detected sporadically during June–July. In Mauritius, outbreaks of influenza A(H3N2) were detected from the end of April through May; viruses were isolated sporadically through June. Influenza A(H3N2) viruses were isolated in Senegal during May–July, and in Réunion during July.

Asia. Influenza A(H3N2) viruses predominated in Asia, but influenza A(H1N1) and influenza B viruses also were isolated. In China, outbreaks of influenza A(H3N2) viruses were reported each month from April through June. Influenza B viruses were isolated less frequently, but were detected each month from April through June with outbreaks reported in April; influenza A(H1N1) viruses were isolated during April. In

Influenza Activity — Continued

Hong Kong, influenza A(H3N2) viruses were predominant. The number of virus isolations peaked during March with a second smaller peak during July. Influenza B viruses were isolated every month from April through August with the numbers increasing during June–July. Influenza A(H1N1) virus isolations declined after the beginning of 1998, but H1N1 viruses were detected sporadically during April and June. In Japan, influenza A(H3N2) viruses predominated during the winter and continued to be isolated through April; influenza B viruses were detected each month from April to July. In Sri Lanka, outbreaks of influenza A(H3N2) began during the last week of April and continued through May. In Myanmar, an influenza A outbreak was detected in late June; four of five isolates were influenza A(H3N2) and one was influenza A(H1N1). In Thailand, influenza A viruses were detected during June–July; most subtyped viruses were A(H3N2), but a few influenza A(H1N1) viruses were isolated. In Guam, influenza A(H3N2) viruses were isolated during April–June, and in Nepal during April–May. In Malaysia, influenza A(H3N2) and A(H1N1) viruses were isolated during June. Influenza B viruses were isolated in Turkey during May.

Europe. During the 1997–98 season, influenza activity was lower in Europe than last season and began later than in North America. Activity levels peaked in many European countries during March, but isolation of influenza viruses was common through April. Influenza A(H3N2) viruses were most frequently isolated, but influenza A(H1N1) viruses predominated in Belarus, Latvia, and Portugal. In Finland, Sweden, Switzerland, and the United Kingdom, influenza A(H3N2) viruses continued to be isolated during May and during June in France. Influenza B viruses were isolated in Finland and France during May, in Spain during June, and in Finland during September.

North America. In the United States, influenza A(H3N2) viruses predominated during the winter and continued to be isolated every month through September. Influenza B viruses were isolated through June and during August. No influenza A(H1N1) viruses have been isolated in the United States since March. Summer outbreaks associated with influenza A(H3N2) viruses were reported in Montana, Florida, Tennessee (*2*), and Alaska and the Yukon Territory, Canada (*3,4*). During September, an outbreak of influenza A(H3N2) in a nursing home was reported in California. In addition to the influenza activity in the Yukon Territory, Canada reported influenza A and influenza B isolates through May and April, respectively, and influenza A again in September.

Oceania. Influenza activity peaked in southern Australia during July and in Sydney and Brisbane during August and September, respectively. Influenza A(H3N2) viruses predominated, but influenza B viruses were detected sporadically; no influenza A(H1N1) viruses were isolated. In New Zealand, rates of influenza-like illness were lower than in recent years. Influenza A viruses were isolated during June–August; influenza A(H1N1) viruses were isolated more frequently, but influenza A(H3N2) viruses also were detected. A small number of influenza B viruses were detected in New Zealand during May. In New Caledonia, outbreaks of influenza A(H3N2) viruses were reported from the beginning of April through the first week of July.

South America. Influenza A(H3N2) viruses predominated in South America during 1998. In Argentina, influenza A(H3N2) viruses were associated with outbreaks during March and each month from May through August. In Brazil, influenza A(H3N2) viruses predominated and were isolated from March through August. Influenza type B viruses were isolated less frequently but were associated with outbreaks in São Paulo during April–June; a single influenza A(H1N1) virus was identified in June. In Chile, influenza

Influenza Activity — Continued

A(H3N2) viruses first were detected during March. Influenza activity peaked during the first half of May, and lower activity levels were reported through August. All influenza viruses identified from Chile were influenza A(H3N2) with the exception of one influenza A(H1N1) virus. In Uruguay, influenza activity peaked during June–July and was associated with influenza A(H3N2) viruses. Influenza A(H3N2) viruses were identified in Peru during April, in French Guyana during May, and in Venezuela during June. Influenza A(H1N1) viruses were detected in French Guyana during May. Outbreaks of influenza A were reported from Colombia in September.

Characterization of influenza virus isolates. The WHO Collaborating Center for Surveillance, Epidemiology, and Control of Influenza at CDC analyzes isolates received worldwide. This report describes isolates collected during April–September, including those from the end of the influenza season in the Northern Hemisphere and from the epidemic season in the Southern Hemisphere. Of the 40 influenza B isolates that were characterized antigenically or genetically, 35 were similar to B/Harbin/07/94, the B/Beijing/184/93-like virus contained in the 1998–99 influenza vaccine. Of the 35 B/Harbin/07/94-like viruses, 19 were collected in the United States and Europe, four were from South America, two were from New Zealand, and 10 were from Asia. The remaining five influenza B isolates were B/Victoria/02/87-like viruses collected in Asia. These viruses have not been identified outside of Asia since 1991.

Among 10 influenza A(H1N1) viruses collected during April–September, seven H1N1 viruses from Asia were similar to A/Beijing/262/95, the H1N1 component of the 1998–99 influenza vaccine. Three influenza A(H1N1) viruses from Brazil and New Zealand were antigenically related to A/Bayern/07/95.

Of 312 influenza A(H3N2) viruses tested, 305 (98%) were similar to A/Sydney/05/97, the H3N2 component of the 1998–99 influenza vaccine, and seven were similar to older H3N2 strains. Of the H3N2 isolates, 45 (14%) were from North America, four (1%) were from Europe, 88 (28%) were from Asia, 146 (47%) were from Central and South America, and 29 (9%) were from South Africa, Australia, or New Zealand.

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Editorial Note: Worldwide surveillance for influenza viruses provides the basis for selecting influenza vaccine strains. Vaccine strains are chosen approximately 7 months before the start of the following influenza vaccination season. In the United States, all of the influenza isolates identified during the past summer have been similar to the strains contained in the 1998–99 influenza vaccine. The influenza vaccine for the 1998–99 influenza season contains A/Beijing/262/95-like (H1N1), A/Sydney/05/97-like (H3N2), and B/Beijing/184/93-like antigens. U.S. vaccine manufacturers will use the antigenically equivalent strain B/Harbin/07/94 for the B/Beijing/184/93-like antigen, because of its growth properties (*1*).

Annual vaccination against influenza is recommended by the Advisory Committee on Immunization Practices for persons aged ≥65 years; persons who reside in nursing homes or chronic-care facilities; persons with chronic cardiovascular or pulmonary disorders, including children with asthma; persons who required medical follow-up or hospitalization during the previous year because of diabetes or other chronic metabolic diseases, renal dysfunction, hemoglobinopathies, or immunosuppression; children

Influenza Activity — Continued

and teenagers (aged 6 months–18 years) receiving long-term aspirin therapy (who may therefore be at risk for developing Reye syndrome after influenza); and women who will be in the second or third trimester of pregnancy during the influenza season. Vaccination also is recommended for health-care workers and other persons, including household members, in frequent contact with persons at high risk for influenza-related complications. Influenza vaccine also can be administered to other persons who want to reduce their likelihood of acquiring influenza and for whom vaccination is not contraindicated (*5*).

In the United States, the optimal time for organized influenza vaccination campaigns is October through mid-November. After mid-November, health-care providers should continue to offer influenza vaccine to unvaccinated high-risk persons even after influenza activity has begun in the community. Influenza surveillance reports from local health departments can be useful for determining the period during which continuing influenza vaccination is beneficial.

Influenza vaccine production during the 1997–98 influenza season was approximately 80 million doses (Food and Drug Administration, unpublished data, 1998), and vaccine production for the 1998–99 influenza season is expected to match or exceed that amount. Although vaccination against influenza is the most effective means of reducing the impact of influenza, antiviral agents provide a useful adjunct (*5*). Amantadine and rimantadine are available for the prophylaxis or treatment of influenza type A infection, but neither is effective against influenza type B viruses.

Information about influenza surveillance is available through the toll-free CDC Voice Information System, telephone (888) 232-3238, fax (888) 232-3299 (document no. 361100), or CDC's World-Wide Web site http://www.cdc.gov/ncidod/diseases/flu/weekly.htm. From October through May, the information is updated weekly.

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Outbreaks of Group B Meningococcal Disease — Florida, 1995 and 1997

Since 1992, *Neisseria meningitidis* serogroup B strains have caused several community- and school-based outbreaks in the United States (*1*). Response to such outbreaks is difficult because no serogroup B vaccine is licensed currently for use in the United States, and mass chemoprophylaxis has been evaluated only in restricted settings (*2,3*). This report describes the use of mass prophylaxis to control outbreaks of serogroup B meningococcal disease in Florida in two unusual settings: a hotel resort and a nursing home.

Miami-Dade County

During July–August 1995, the Miami-Dade County Health Department was notified of one probable and four laboratory-confirmed cases of serogroup B meningococcal disease among children vacationing at a local resort area. All of the cases occurred among county residents who either stayed at or visited Hotel A. One child died.

The first reported case was in a guest at Hotel A who developed a fever on July 8. On July 9, symptoms developed in a sister and brother staying at Hotel B who had visited Hotel A to play with other children. The sister died shortly after admission to a local hospital; *N. meningitidis* serogroup B was isolated from blood cultures. Her brother was admitted with fever, vomiting, leg pain, and a petechial rash, and gram negative diplococci were observed in the cerebrospinal fluid (CSF). However, cultures were negative for *N. meningitidis.*

For the investigation, a hotel-related confirmed case was defined as isolation of *N. meningitidis* serogroup B from the blood or CSF of a person with classic symptoms of meningitis who was staying at or visiting hotel A. A presumptive case was defined as detection of gram-negative diplococci in specimens from a normally sterile site (blood and CSF) in a person with classic symptoms who had close contact with a confirmed case-patient.

Investigators noted overcrowding at hotel A, where some rooms had as many as 12 residents. An estimated 730 persons stayed or worked at hotels A and B during the week before onset of symptoms in the first two cases (attack rate: 274 per 100,000 population). The Advisory Committee on Immunization Practices defines an outbreak of serogroup C meningococcal disease as three or more confirmed or probable cases occurring during a period of approximately 3 months in persons with a common affiliation but no close contact, resulting in a primary disease attack rate of at least 10 cases per 100,000 persons (*4*).

After consultation with epidemiologists at the Florida Department of Health and CDC, county health officials offered prophylaxis on site to all guests and employees at both hotels. Over a 2-day period, 480 persons (66% of the targeted group) received the recommended rifampin dosage. The hotel swimming pool, the site of organized activities for children, was closed.

Approximately 5 weeks after the first cluster of cases was identified, a case was diagnosed in a 17-year-old who provided child care at hotel A during the days before onset of symptoms. A secondary case (occurring at least 24 hours after onset in the primary case) was diagnosed in a child who had been in this 17-year-old's care and who had resided at the hotel since June. The child and her family had received prophylaxis at the time of the first meningitis cluster. The county again offered prophylaxis to all guests and employees at hotel A. No further cases were identified among visitors to the resort area.

Skilled Nursing Facility

On December 5, 1997, the Florida Department of Health was notified of a laboratory-confirmed case of *N. meningitidis* in a resident of a 104-bed skilled nursing facility. Within 5 days, two additional laboratory-confirmed cases were diagnosed from the facility; all three cases were serogroup B.

For the investigation, a suspected case of meningococcal disease was defined as clinical diagnosis of meningococcal disease in a nursing home resident or staff member; a case was confirmed by isolation of *N. meningitidis* from blood or CSF.

A nurse had been hospitalized on December 1 with confusion and fever following 2 weeks of influenza-like symptoms. His CSF contained elevated protein, decreased glucose, and a mononuclear cell count of 7500 per cc. Specimens for culture were not obtained until 3 hours after antibiotics were started and were negative for bacterial pathogens.

On December 2, a 90-year-old patient in the wing where the staff nurse was assigned was hospitalized with a fever of 104 F (40 C) and vomiting. She died the following day. Blood cultures were positive for *N. meningitidis*. On December 5, a 56-year-old nursing assistant who had cared for the first confirmed case-patient was hospitalized after abrupt onset of fever and stiff neck; her CSF was positive for *N. meningitidis*.

On December 5, the Florida Department of Health recommended chemoprophylaxis for all patients and staff. However, the facility had consulted a community physician who recommended administration of prophylaxis to all persons who had visited the facility during the previous 14 days, nasopharyngeal swabs for culturing of all patients and staff, and closure of the facility to all visitors.

Ciprofloxacin (750 mg) was administered to all 114 staff members, 103 of 104 patients, and to approximately 250 visitors. Nasopharyngeal swabs, obtained post prophylaxis from all available patients, were negative for *N. meningitidis*. The facility placed itself on quarantine from December 6 through December 10, permitting no visitors, discharges, or admissions.

On December 10, a 73-year-old man who resided on the same floor as the first confirmed case-patient was hospitalized with fever and lethargy. Blood cultures were positive for *N. meningitidis*. This patient had refused prophylaxis on December 6. No further cases were reported.

The state laboratory performed pulsed-field gel electrophoresis on the first two outbreak-related case-patients and on two serogroup B case-patients that were linked to each other in another county. The two isolates from the facility showed similar banding patterns, but were different from the controls from the other county. Multilocus enzyme electrophoresis (MEE) subtyping was not performed.

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Editorial Note: Organization-based outbreaks of meningococcal disease previously have been identified in military barracks, schools, universities, among jail inmates, and in a Job Corps center (*3,5–8*). The Florida serogroup B outbreaks occurred in institutions that have not been reported previously as settings for meningococcal outbreaks.

Crowding may have contributed to the outbreak at the resort hotel, where the hotel pool was the center of activities for a large number of children, and investigators noted room overcrowding. Crowding previously has been identified as a factor in the transmission of *N. meningitidis* at a university campus bar (*7*) and among jail in-

Group B Meningococcal Disease — Continued

mates (*5*), and outbreaks have been reported among children participating in school-based group activities (*6*). In the nursing home outbreak, the first illness occurred in a nurse who had had symptoms of a respiratory infection during the preceding 2 weeks. Coincident upper respiratory infections have been suggested as predisposing risk factors for the subsequent development of meningococcal disease and spread of infection (*9*). Guidelines for evaluation and management of suspected outbreaks are available only for serogroup C (*4*); these guidelines were adapted for use in the Florida clusters of serogroup B cases.

The primary tool in the control and prevention of meningococcal disease is identification and chemoprophylaxis of close contacts. Serogrouping of isolates also is necessary to determine whether an outbreak exists and whether vaccination should be considered. Pulsed-field gel electrophoresis and MEE may be useful for identifying the particular strain involved and for linking cases. In the nursing home outbreak, electrophoresis was able to establish that at least three of the four cases were related. Because MEE was not performed on isolates from either outbreak, it is not known whether the Florida outbreaks were caused by the ET-5 strains that have emerged recently as important causes of disease in Europe and the Americas (*1*).

When an outbreak is confirmed, a decision must be made on the appropriateness of more extensive control measures. Chemoprophylaxis of small, well-defined populations is the only available mass intervention for serogroup B outbreaks.

In many situations, the disadvantages of mass chemoprophylaxis (i.e., expense, side effects, and the emergence of resistant organisms) outweigh the benefits. However, in outbreaks involving small populations (e.g., an outbreak in a nursing home or a single school), administration of chemoprophylaxis to all persons within this population may be effective in preventing larger outbreaks (*3*).

To be effective, mass prophylaxis must be given simultaneously to all persons at risk. Otherwise, persons may reinfect each other. That may have been the explanation for the occurrence of the second cluster of cases in the hotel outbreak.

Although mass prophylaxis was justified for staff and patients in the nursing home outbreak, more than 250 casual contacts received prophylaxis unnecessarily, which has implications for the development of resistant strains (*3*). The extensive inappropriate treatment and testing suggests the need for education of medical students and public health professionals about appropriate public health responses to outbreaks of meningococcal disease.

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Incidence of Initiation of Cigarette Smoking — United States, 1965–1996

Tobacco use is the single leading preventable cause of death in the United States, and the risk for smoking-attributable disease increases the earlier in life smoking begins (*1*). Trends in the initiation of cigarette smoking are important indicators for directing and evaluating prevention activities (*2*). CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA) analyzed self-reported data from the National Household Survey on Drug Abuse (NHSDA) for 1994–1997 to study the incidence of initiation of first cigarette smoking and of first daily smoking in the United States during 1965–1996 among persons aged ≤66 years and to estimate the number of new smokers aged <18 years. The findings from the analysis indicated that, during 1988–1996 among persons aged 12–17 years, the incidence of initiation of first use increased by 30% and of first daily use increased by 50%, and 1,226,000 persons aged <18 years became daily smokers in 1996.

The NHSDA samples households, noninstitutional group quarters (e.g., shelters, rooming houses, and dormitories), and civilians living on military bases (*3*). The surveys for 1994–1997 were administered to a multistage area probability sample (n=78,330) of the U.S. population aged ≥12 years. The overall response rates for specific years ranged from 73% to 76%. Data were weighted to provide national estimates, and confidence intervals (CIs) were calculated using SUDAAN®* (*4*).

Respondents completed the questionnaire that included questions about cigarette use. To estimate age of first use, respondents were asked, "How old were you the first time you smoked a cigarette, even one or two puffs?" To estimate age of first daily use, respondents were asked, "How old were you when you first started smoking cigarettes every day?" The year of initiation of first use and of first daily use were calculated by subtracting each respondent's date of birth from the interview date and then adding the age of first use or first daily use. Estimates of the number of new smokers for a given year during 1965–1995 (for first use) and 1965–1996 (for first daily use) were calculated by combining data on all respondents and applying sample weights; age-specific estimates for any given year used only data for persons in the respective age ranges during the year (*2*). Because the calculation of initiation of first use for 1996 would have excluded data on persons aged ≤11 years, estimates of the incidence of first use were not made for 1996. Age-specific (i.e., 5–11 years, 12–17 years, 18–25 years, and 26–34 years) incidence of initiation estimates for a given year were calculated using weighted estimates of the number of persons who were in the relevant age group and who first smoked or first smoked daily during that year divided by the number of persons who were in the relevant age group and who were

*Differences between estimates were considered statistically significant if the 95% CIs did not overlap. 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.

Initiation of Cigarette Smoking — Continued

exposed to risk for first use during the year (weighted by their estimated exposure time measured in years) (*2*). Incidences are expressed as per 1000 person-years (PY) of exposure.[†]

Among persons aged 12–17 years, the incidence of first cigarette use decreased from 1974 (132.2) to 1987 (98.6) and increased from 1988 (107.0) to 1995 (139.1) (Table 1). For persons aged 18–25 years, first use decreased from the late 1960s through the late 1980s and increased during the 1990s. For persons aged 5–11 years and 26–34 years, first use was <23 throughout the study period.

Among persons aged 12–17 years, the incidence of first daily cigarette use fluctuated from 1966 (42.6) to 1983 (43.8) and gradually increased from 1988 (51.2) to 1996 (77.0) (Table 1). For persons aged 18–25 years, first daily use generally decreased from the 1960s through the early 1990s and then stabilized. First daily use among persons aged 12–17 years was equivalent to that of persons aged 18–25 years during the late 1980s. Among persons aged 26–34 years, first daily use decreased from 1974 (23.7) to 1996 (7.5). During 1965–1988, first daily use was <4.3 for persons aged 5–11 years.

The number of new smokers in the United States increased from the 1980s to 1995 and 1996. The number of persons aged <18 years who first smoked a cigarette was 1,929,000 (95% CI=±153,000) in 1988, 2,175,000 (95% CI=±180,000) in 1993, 2,392,000 (95% CI=±231,000) in 1994, and 2,441,000 (95% CI=±298,000) in 1995. The number of persons aged <18 years who first smoked daily was 708,000 (95% CI=±84,000) in 1988, 897,000 (95% CI=±100,000) in 1993, 1,056,000 (95% CI=±112,000) in 1994, 1,174,000 (95% CI=±163,000) in 1995, and 1,226,000 (95% CI=±196,000) in 1996. In 1995, 3,263,000 persons of all ages first smoked a cigarette; of these, 2,441,000 (74.8%) were aged <18 years. In 1996, 1,851,000 persons of all ages became daily smokers; of these, 1,226,000 (66.2%) were aged <18 years. If the incidence of initiation had not increased during 1988–1996, approximately 1,492,000 fewer persons aged <18 years would have been daily smokers by 1996.

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Editorial Note: The findings in this report indicate that, during 1988–1996 among persons aged 12–17 years, the incidence of initiation of first use increased by 30% and of first daily use increased by 50%, more than 6000 persons aged <18 years try a cigarette each day, and more than 3000 persons aged <18 years become daily smokers each day. These findings are consistent with previous studies that suggest significant increases in smoking prevalence among U.S. adolescents since 1991 (*5,6*). Overall, these data show that public health gains observed during the 1970s and 1980s are being reversed.

The magnitude and patterns of the incidence calculated from the mid-1960s through the mid-1980s are generally consistent with those observed from a previous study (*2*). An estimated 1.1 million persons aged 20 years were regular smokers in 1985 (*7*), consistent with data from this study that showed 1.0 million persons aged <20 years became daily smokers in 1985

[†]For example, a 34-year-old person who was surveyed in 1994 and first smoked a cigarette at age 15 years in 1975 would have been 5 years old in 1965 and would have contributed person-years from 1965 to 1975. From 1965 through 1974, exposure time was 1 for each year. For 1975, exposure time was 0.5 (this assumes that persons initiate, on average, midway through the year). For subsequent years, exposure time was 0.

Initiation of Cigarette Smoking — Continued

TABLE 1. Estimated annual age-specific incidence* of first use and of first daily use of cigarettes among persons aged 12–17 years and 18–25 years, by year and age group — United States, 1965–1996

	First use				First daily use			
	12–17 years		18–25 years		12–17 years		18–25 years	
Year	Incidence	(95% CI†)	Incidence	(95% CI)	Incidence	(95% CI)	Incidence	(95% CI)
1965	101.3	(±14.9)	112.9	(±27.2)	44.0	(±14.1)	106.2	(±22.7)
1966	88.3	(±14.3)	125.4	(±28.4)	42.6	(± 9.6)	117.0	(±27.2)
1967	112.9	(±14.5)	114.6	(±21.8)	48.1	(±11.6)	100.8	(±25.3)
1968	101.6	(±16.5)	114.6	(±22.0)	49.7	(±11.6)	155.2	(±28.4)
1969	111.0	(±15.5)	122.3	(±24.3)	57.1	(±12.2)	116.4	(±24.3)
1970	113.7	(±17.8)	112.9	(±22.1)	52.5	(±10.0)	101.9	(±20.6)
1971	119.3	(±15.3)	102.1	(±21.6)	58.0	(±11.0)	117.9	(±23.7)
1972	129.6	(±14.7)	107.9	(±19.8)	57.7	(±10.0)	95.4	(±17.6)
1973	114.8	(±13.5)	87.2	(±15.1)	65.3	(±13.1)	106.5	(±19.4)
1974	132.2	(±15.9)	84.3	(±19.4)	66.2	(±11.8)	109.2	(±21.0)
1975	125.0	(±15.1)	95.7	(±18.8)	49.4	(± 7.8)	87.1	(±18.0)
1976	124.8	(±14.5)	87.6	(±19.4)	54.8	(± 8.2)	93.1	(±16.5)
1977	126.9	(±11.8)	87.8	(±18.4)	66.8	(±10.0)	108.0	(±22.5)
1978	112.0	(± 9.4)	72.7	(±12.9)	59.6	(± 7.6)	88.1	(±15.1)
1979	111.0	(±11.2)	83.8	(±17.4)	54.7	(±17.8)	92.5	(±13.7)
1980	105.1	(± 9.6)	70.0	(±12.9)	51.6	(± 6.7)	81.7	(±13.5)
1981	107.0	(±10.2)	66.7	(±12.5)	56.4	(± 7.6)	73.3	(±14.5)
1982	102.4	(± 9.2)	67.2	(±12.9)	49.2	(± 6.7)	73.3	(±15.3)
1983	106.0	(±10.4)	64.5	(± 9.4)	43.8	(± 6.3)	73.9	(±12.0)
1984	99.4	(± 9.0)	71.1	(±11.2)	52.3	(± 7.1)	65.4	(± 7.8)
1985	111.3	(±10.2)	69.4	(± 7.8)	50.2	(± 7.4)	66.2	(±10.0)
1986	107.0	(±11.2)	77.2	(±11.2)	56.7	(± 7.6)	69.5	(± 9.0)
1987	98.6	(± 9.6)	66.1	(± 9.2)	51.8	(± 9.2)	68.0	(± 9.8)
1988	107.0	(±10.0)	58.6	(± 9.0)	51.2	(± 7.4)	60.8	(± 8.8)
1989	99.5	(± 9.4)	60.9	(± 8.6)	53.8	(± 6.9)	61.4	(± 8.8)
1990	101.6	(± 8.0)	71.3	(±10.2)	57.8	(± 7.1)	63.6	(± 8.6)
1991	100.5	(± 8.8)	66.4	(±11.0)	57.6	(± 7.4)	58.0	(± 8.4)
1992	115.0	(± 8.2)	64.7	(± 8.8)	61.9	(± 7.8)	69.1	(± 8.2)
1993	121.4	(± 9.8)	70.1	(± 9.6)	58.7	(± 6.3)	60.0	(± 8.4)
1994§	131.0	(±12.9)	82.0	(±14.3)	67.7	(± 7.3)	68.9	(±11.6)
1995¶	139.1	(±17.8)	85.8	(±19.8)	71.8	(± 8.8)	62.3	(±12.7)
1996**	NA††		NA		77.0	(±13.7)	68.4	(±15.3)

*Per 1000 person-years of exposure.
†Confidence interval.
§Estimated using 1995, 1996, and 1997 data only.
¶Estimated using 1996 and 1997 data only.
**Estimated using 1997 data only.
††Not available.

Source: Substance Abuse and Mental Health Services Administration, National Household Survey on Drug Abuse for 1994–1997 (*3*).

Initiation of Cigarette Smoking — Continued

The findings of this report are subject to at least three potential limitations. First, differential mortality could have influenced the results for the earlier years of the study period because persons who become smokers, especially at a young age, experience higher death rates than persons who do not (*2*). Second, some persons either may have forgotten that they had ever smoked or reported that initiation occurred more recently than it actually did (*2*). Third, some persons (especially younger respondents [*8*]) may not have disclosed smoking behavior because of concerns about social acceptability or fear of disclosure.

If trends continue, approximately 5 million persons aged <18 years will die eventually from a smoking-attributable disease (*9*). Data on the comprehensive tobacco prevention and control programs in California and Massachusetts indicate that the recent pattern of increases in youth smoking rates can be attenuated (*10*). Efforts to reduce smoking initiation can be enhanced by further research on the interactions of factors such as tobacco product marketing, distress, and the drug effects of nicotine. Although primary prevention is the major goal of programmatic efforts, immediate cessation is critically important for adolescents (*8*). Tobacco-use prevention activities should include increasing tobacco prices; reducing the access to, and appeal of, tobacco products; conducting mass media campaigns and school-based tobacco use prevention programs; increasing provision of smoke-free indoor air; decreasing tobacco use by parents, teachers, and influential role models; developing and disseminating effective youth smoking cessation programs; and increasing support and involvement from parents and schools (*8*).

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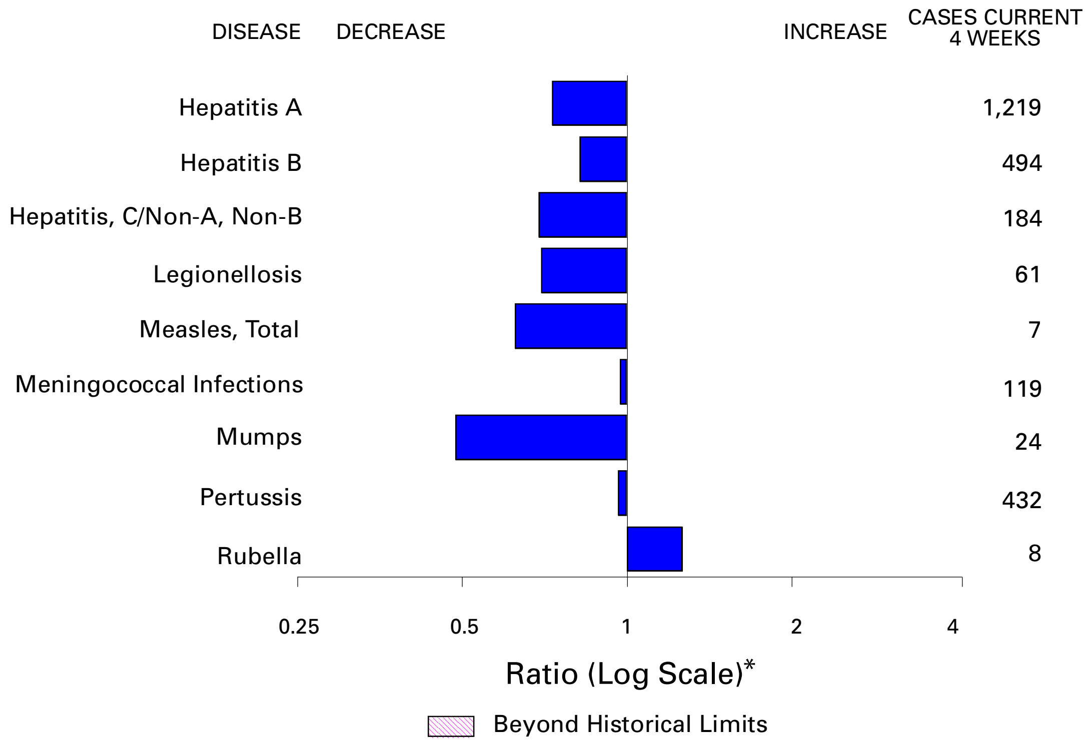
FIGURE I. Selected notifiable disease reports, comparison of provisional 4-week totals ending October 3, 1998, with historical data — United States



*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 October 3, 1998 (39th Week)

	Cum. 1998		Cum. 1998
Anthrax	-	Plague	6
Brucellosis	42	Poliomyelitis, paralytic	1
Cholera	7	Psittacosis	30
Congenital rubella syndrome	3	Rabies, human	-
Cryptosporidiosis*	2,541	Rocky Mountain spotted fever (RMSF)	247
Diphtheria	1	Streptococcal disease, invasive Group A	1,677
Encephalitis: California*	63	Streptococcal toxic-shock syndrome*	41
eastern equine*	4	Syphilis, congenital¶	307
St. Louis*	3	Tetanus	32
western equine*	-	Toxic-shock syndrome	100
Hansen Disease	86	Trichinosis	9
Hantavirus pulmonary syndrome*†	15	Typhoid fever	254
Hemolytic uremic syndrome, post-diarrheal*	54	Yellow fever	-
HIV infection, pediatric*§	178		

-: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 September 27, 1998.
¶ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending October 3, 1998, and September 27, 1997 (39th Week)

Reporting Area	AIDS Cum. 1998*	AIDS Cum. 1997	Chlamydia Cum. 1998	Chlamydia Cum. 1997	*Escherichia coli* O157:H7 NETSS† Cum. 1998	*Escherichia coli* O157:H7 PHLIS§ Cum. 1998	Gonorrhea Cum. 1998	Gonorrhea Cum. 1997	Hepatitis C/NA,NB Cum. 1998	Hepatitis C/NA,NB Cum. 1997
UNITED STATES	35,486	43,681	396,438	343,217	2,245	1,325	241,098	217,368	2,917	2,670
NEW ENGLAND	1,381	1,895	14,256	13,294	273	220	4,104	4,447	51	46
Maine	24	46	743	773	32	-	53	52	-	-
N.H.	28	29	673	599	37	40	71	74	-	-
Vt.	17	31	315	305	17	10	28	42	-	2
Mass.	712	640	6,275	5,434	130	131	1,636	1,593	48	37
R.I.	94	119	1,710	1,506	11	1	282	344	3	7
Conn.	506	1,030	4,540	4,677	46	38	2,034	2,342	-	-
MID. ATLANTIC	9,642	13,711	47,100	42,877	231	63	27,037	28,306	288	248
Upstate N.Y.	1,102	2,133	N	N	173	-	4,168	4,838	224	178
N.Y. City	5,457	7,287	26,156	20,249	6	12	11,673	10,369	-	-
N.J.	1,765	2,685	7,858	7,421	52	41	4,952	5,740	-	-
Pa.	1,318	1,606	13,086	15,207	N	10	6,244	7,359	64	70
E.N. CENTRAL	2,567	3,310	65,965	45,338	336	255	46,660	29,681	391	446
Ohio	540	676	18,995	16,285	94	53	12,187	10,668	7	14
Ind.	414	444	4,656	6,873	76	40	3,353	4,603	4	12
Ill.	993	1,345	18,908	U	84	39	15,697	U	25	74
Mich.	468	648	15,932	13,989	82	54	12,212	10,876	355	321
Wis.	152	197	7,474	8,191	N	69	3,211	3,534	-	25
W.N. CENTRAL	664	823	22,676	24,053	407	234	11,469	10,557	247	49
Minn.	136	156	4,571	4,930	200	98	1,723	1,724	9	3
Iowa	58	85	2,063	3,264	79	46	660	845	8	24
Mo.	312	380	8,950	8,973	32	47	6,561	5,542	222	9
N. Dak.	4	10	616	627	10	13	51	48	-	2
S. Dak.	13	8	1,156	982	22	21	181	103	-	-
Nebr.	59	71	1,471	1,916	42	-	508	768	3	2
Kans.	82	113	3,849	3,361	22	9	1,785	1,527	5	9
S. ATLANTIC	9,235	10,556	81,681	70,006	186	119	68,014	68,667	138	180
Del.	112	183	1,920	-	-	2	1,109	904	-	-
Md.	1,304	1,384	5,599	5,338	27	12	6,658	8,627	8	4
D.C.	691	751	N	N	1	-	2,729	3,293	-	-
Va.	688	878	10,309	8,793	N	38	6,913	6,134	11	23
W. Va.	70	80	1,904	2,205	8	6	609	700	6	15
N.C.	638	679	16,473	12,859	44	37	14,440	12,767	18	41
S.C.	604	576	13,334	9,286	11	8	8,526	8,525	5	33
Ga.	972	1,265	17,684	11,998	61	-	15,487	13,982	9	-
Fla.	4,156	4,760	14,458	19,527	34	16	11,543	13,735	81	64
E.S. CENTRAL	1,444	1,553	29,027	25,913	93	33	28,514	26,099	168	279
Ky.	222	292	4,776	4,812	24	-	2,762	3,085	18	11
Tenn.	522	631	9,916	9,517	45	29	8,678	8,202	143	187
Ala.	395	384	7,611	6,378	21	2	9,811	8,934	5	7
Miss.	305	246	6,724	5,206	3	2	7,263	5,878	2	74
W.S. CENTRAL	4,202	4,634	59,586	47,947	103	14	35,192	31,445	515	361
Ark.	159	180	2,808	2,242	9	6	1,827	3,703	13	11
La.	708	763	11,165	6,980	5	2	9,644	6,744	41	163
Okla.	238	240	7,535	5,641	12	6	4,140	3,704	12	7
Tex.	3,097	3,451	38,078	33,084	77	-	19,581	17,294	449	180
MOUNTAIN	1,230	1,228	16,687	22,094	275	194	6,384	5,992	282	240
Mont.	23	34	999	772	15	-	32	34	7	19
Idaho	19	41	1,497	1,191	34	19	135	102	87	49
Wyo.	1	13	399	436	51	54	18	43	51	61
Colo.	230	313	10	5,291	62	48	1,716	1,600	23	26
N. Mex.	179	141	2,453	2,822	17	13	623	662	76	45
Ariz.	499	269	7,537	8,116	21	25	2,724	2,698	3	24
Utah	101	98	1,527	1,262	65	21	163	202	21	3
Nev.	178	319	2,265	2,204	10	14	973	651	14	13
PACIFIC	5,121	5,971	59,460	51,695	341	193	13,724	12,174	837	821
Wash.	335	455	8,155	6,800	71	56	1,425	1,450	17	22
Oreg.	138	249	4,334	3,619	91	89	635	555	5	3
Calif.	4,500	5,173	43,797	38,821	175	35	11,063	9,490	760	665
Alaska	17	43	1,405	1,136	4	-	242	300	1	-
Hawaii	131	51	1,769	1,319	N	13	359	379	54	131
Guam	-	2	201	193	N	-	24	27	-	-
P.R.	1,246	1,509	U	U	6	U	284	449	-	-
V.I.	24	79	N	N	N	U	U	U	U	U
Amer. Samoa	-	-	U	U	N	U	U	U	U	U
C.N.M.I.	-	1	N	N	N	U	28	17	-	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 September 27, 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 October 3, 1998, and September 27, 1997 (39th 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	891	721	9,161	9,201	996	1,384	5,383	6,402	10,670	13,314	5,299
NEW ENGLAND	58	64	2,271	2,470	47	70	56	113	346	323	1,111
Maine	1	2	11	8	4	1	1	-	9	17	179
N.H.	3	6	34	26	5	8	1	-	9	10	47
Vt.	5	11	8	8	1	2	4	-	2	5	51
Mass.	25	23	626	267	15	25	35	56	196	175	397
R.I.	15	6	427	338	4	5	1	2	41	29	73
Conn.	9	16	1,165	1,823	18	29	14	55	89	87	364
MID. ATLANTIC	210	145	5,774	5,278	249	412	204	308	2,120	2,328	1,199
Upstate N.Y.	71	42	3,237	2,190	75	58	28	31	273	318	851
N.Y. City	25	17	19	145	109	259	51	66	1,102	1,170	U
N.J.	11	20	1,139	1,555	41	73	67	124	451	484	148
Pa.	103	66	1,379	1,388	24	22	58	87	294	356	200
E.N. CENTRAL	272	233	89	466	97	129	736	489	893	1,318	114
Ohio	103	86	63	34	13	17	110	161	75	220	50
Ind.	50	38	20	25	10	13	150	135	85	108	10
Ill.	25	21	5	12	27	52	286	U	485	678	14
Mich.	64	55	1	24	40	35	141	102	245	222	30
Wis.	30	33	U	371	7	12	49	91	3	90	10
W.N. CENTRAL	60	39	173	82	75	45	101	141	293	413	564
Minn.	6	1	143	56	42	19	7	16	111	109	97
Iowa	8	9	21	5	8	8	-	6	28	46	127
Mo.	20	7	1	15	14	9	76	91	88	168	19
N. Dak.	-	2	-	-	2	3	-	-	8	9	119
S. Dak.	3	2	-	1	-	1	1	-	16	10	121
Nebr.	16	14	3	2	1	1	4	3	11	15	6
Kans.	7	4	5	3	8	4	13	25	31	56	75
S. ATLANTIC	110	92	628	625	234	249	2,200	2,612	1,512	2,520	1,559
Del.	11	9	12	107	3	5	18	17	18	25	17
Md.	23	15	463	407	64	73	493	731	218	238	367
D.C.	6	4	4	7	15	14	59	87	81	75	-
Va.	16	20	50	46	48	60	119	180	187	254	456
W. Va.	N	N	9	5	2	-	2	3	30	45	62
N.C.	9	12	43	27	19	14	571	669	321	321	136
S.C.	10	6	4	2	5	15	240	285	199	252	117
Ga.	8	-	5	1	32	28	536	411	388	473	245
Fla.	25	26	38	23	46	40	162	229	70	837	159
E.S. CENTRAL	53	43	71	73	24	32	910	1,362	826	990	227
Ky.	24	9	14	12	4	11	81	107	129	132	28
Tenn.	17	25	40	35	13	7	426	582	243	351	118
Ala.	5	2	16	7	5	10	219	347	295	324	79
Miss.	7	7	1	19	2	4	184	326	159	183	2
W.S. CENTRAL	24	24	23	62	24	18	782	980	1,535	1,933	125
Ark.	-	1	6	18	1	4	81	121	104	147	29
La.	2	2	4	2	11	9	318	276	106	183	-
Okla.	12	1	2	12	4	5	80	97	134	157	96
Tex.	10	20	11	30	8	-	303	486	1,191	1,446	-
MOUNTAIN	51	44	12	9	45	61	165	135	291	422	174
Mont.	2	1	-	-	1	2	-	-	16	6	46
Idaho	2	2	3	3	7	-	2	1	8	7	-
Wyo.	1	1	1	1	-	2	1	-	4	2	54
Colo.	15	16	3	-	16	27	9	11	U	66	29
N. Mex.	2	2	3	1	12	8	22	8	45	45	5
Ariz.	10	9	-	1	8	10	119	101	138	188	12
Utah	18	8	-	1	1	3	3	5	46	26	26
Nev.	1	5	2	2	-	9	9	9	34	82	2
PACIFIC	53	37	120	136	201	368	229	262	2,854	3,067	226
Wash.	9	6	6	8	17	18	27	9	164	236	-
Oreg.	-	-	18	17	15	19	5	7	102	119	4
Calif.	42	30	95	109	164	319	195	244	2,428	2,510	199
Alaska	1	-	1	2	2	3	1	1	35	60	23
Hawaii	1	1	-	-	3	9	1	1	125	142	-
Guam	2	-	-	-	1	-	1	3	36	13	-
P.R.	-	-	-	-	-	5	150	181	68	164	40
V.I.	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	-	-	-	-	164	9	77	2	-

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 ending October 3, 1998, and September 27, 1997 (39th Week)

	H. influenzae, invasive		Hepatitis (Viral), by type				Measles (Rubeola)					
			A		B		Indigenous		Imported†		Total	
Reporting Area	Cum. 1998*	Cum. 1997	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997	1998	Cum. 1998	1998	Cum. 1998	Cum. 1998	Cum. 1997
UNITED STATES	805	837	16,193	21,094	6,111	7,103	-	42	-	20	62	116
NEW ENGLAND	55	48	204	509	136	132	-	1	-	2	3	19
Maine	2	5	16	47	2	6	-	-	-	-	-	1
N.H.	8	7	9	23	14	11	-	-	-	-	-	1
Vt.	6	3	14	11	4	7	-	-	-	1	1	-
Mass.	33	29	79	208	39	54	-	1	-	1	2	16
R.I.	5	2	14	115	59	13	-	-	-	-	-	-
Conn.	1	2	72	105	18	41	-	-	-	-	-	1
MID. ATLANTIC	116	129	1,071	1,608	826	1,028	-	8	-	5	13	23
Upstate N.Y.	46	42	273	258	223	220	-	1	-	1	2	5
N.Y. City	26	32	248	717	204	372	-	-	-	-	-	7
N.J.	39	38	255	231	161	190	-	7	-	1	8	3
Pa.	5	17	295	402	238	246	-	-	-	3	3	8
E.N. CENTRAL	133	137	2,471	2,198	657	1,111	-	11	-	3	14	10
Ohio	43	74	253	250	59	60	-	-	-	1	1	-
Ind.	36	13	120	230	88	79	-	2	-	1	3	-
Ill.	45	34	420	589	127	207	-	-	-	-	-	7
Mich.	5	15	1,542	973	357	330	-	9	-	1	10	2
Wis.	4	1	136	156	26	435	-	-	-	-	-	1
W.N. CENTRAL	76	39	1,086	1,675	311	357	-	-	-	-	-	17
Minn.	59	27	101	133	36	27	-	-	-	-	-	8
Iowa	2	5	377	354	51	28	-	-	-	-	-	-
Mo.	8	4	464	863	186	260	-	-	-	-	-	1
N. Dak.	-	-	3	10	4	5	-	-	-	-	-	-
S. Dak.	-	2	21	18	2	1	-	-	-	-	-	8
Nebr.	1	1	36	75	11	12	-	-	-	-	-	-
Kans.	6	-	84	222	21	24	-	-	-	-	-	-
S. ATLANTIC	167	128	1,454	1,286	886	937	-	3	-	5	8	11
Del.	-	-	3	24	2	6	-	-	-	1	1	-
Md.	48	47	246	150	122	131	-	-	-	1	1	2
D.C.	-	-	46	17	10	25	-	-	-	-	-	1
Va.	15	12	170	171	81	95	-	-	-	2	2	1
W. Va.	4	3	4	10	5	14	-	-	-	-	-	-
N.C.	23	19	90	150	174	197	-	-	-	-	-	2
S.C.	3	4	33	88	30	84	-	-	-	-	-	1
Ga.	35	24	446	274	129	104	-	1	-	1	2	1
Fla.	39	19	416	402	333	281	-	2	-	-	2	3
E.S. CENTRAL	42	43	301	476	305	532	-	-	-	2	2	1
Ky.	7	6	19	61	33	31	-	-	-	-	-	-
Tenn.	23	25	181	293	209	338	-	-	-	1	1	-
Ala.	10	10	58	68	62	55	-	-	-	1	1	1
Miss.	2	2	43	54	1	108	U	-	U	-	-	-
W.S. CENTRAL	46	40	3,168	4,326	1,040	957	-	1	-	-	1	7
Ark.	-	2	79	181	70	65	-	-	-	-	-	-
La.	21	10	68	174	98	115	-	1	-	-	1	-
Okla.	23	26	459	1,173	71	38	-	-	-	-	-	-
Tex.	2	2	2,562	2,798	801	739	-	-	-	-	-	7
MOUNTAIN	78	71	2,311	3,296	626	672	-	-	-	-	-	8
Mont.	-	-	84	60	5	7	-	-	-	-	-	-
Idaho	-	1	208	109	27	28	-	-	-	-	-	-
Wyo.	1	4	33	27	4	22	U	-	U	-	-	-
Colo.	17	13	241	323	92	122	-	-	-	-	-	-
N. Mex.	6	7	112	271	266	198	-	-	-	-	-	-
Ariz.	43	28	1,382	1,683	138	157	-	-	-	-	-	5
Utah	4	3	165	475	60	74	-	-	-	-	-	1
Nev.	7	15	86	348	34	64	-	-	-	-	-	2
PACIFIC	92	202	4,127	5,720	1,324	1,377	-	18	-	3	21	20
Wash.	7	4	810	441	93	57	-	-	-	1	1	2
Oreg.	36	29	289	284	93	85	-	-	-	-	-	-
Calif.	41	158	2,977	4,849	1,123	1,216	-	5	-	2	7	14
Alaska	1	4	16	25	9	11	-	13	-	-	13	-
Hawaii	7	7	35	121	6	8	-	-	-	-	-	4
Guam	-	-	-	-	2	3	U	-	U	-	-	-
P.R.	2	-	49	227	319	571	-	-	-	-	-	-
V.I.	U	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	6	3	1	53	34	U	-	U	-	-	1

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

*Of 188 cases among children aged <5 years, serotype was reported for 103 and of those, 39 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 October 3, 1998, and September 27, 1997 (39th Week)

	Meningococcal Disease		Mumps			Pertussis			Rubella		
Reporting Area	Cum. 1998	Cum. 1997	1998	Cum. 1998	Cum. 1997	1998	Cum. 1998	Cum. 1997	1998	Cum. 1998	Cum. 1997
UNITED STATES	2,045	2,530	4	368	479	101	4,200	4,052	4	324	140
NEW ENGLAND	80	158	-	6	8	9	683	722	-	39	1
Maine	5	17	-	-	-	-	5	9	-	-	-
N.H.	4	12	-	-	-	1	75	101	-	-	-
Vt.	3	4	-	-	-	-	65	193	-	-	-
Mass.	40	77	-	4	2	8	495	388	-	9	1
R.I.	3	15	-	-	5	-	9	12	-	1	-
Conn.	25	33	-	2	1	-	34	19	-	29	-
MID. ATLANTIC	182	264	1	20	48	6	423	306	-	130	31
Upstate N.Y.	47	71	1	5	10	6	230	121	-	111	4
N.Y. City	20	45	-	4	3	-	23	59	-	14	27
N.J.	49	52	-	2	7	-	5	12	-	4	-
Pa.	66	96	-	9	28	-	165	114	-	1	-
E.N. CENTRAL	303	377	-	60	54	3	420	437	-	-	6
Ohio	114	134	-	23	20	-	191	124	-	-	-
Ind.	51	42	-	6	7	-	96	45	-	-	-
Ill.	77	113	-	10	8	3	65	62	-	-	2
Mich.	35	55	-	21	16	-	51	48	-	-	-
Wis.	26	33	-	-	3	-	17	158	-	-	4
W.N. CENTRAL	172	181	1	26	14	12	384	314	-	27	-
Minn.	29	29	-	12	5	12	212	201	-	-	-
Iowa	32	39	-	9	7	-	61	29	-	-	-
Mo.	63	79	-	3	-	-	22	55	-	2	-
N. Dak.	5	2	1	2	-	-	2	1	-	-	-
S. Dak.	7	5	-	-	-	-	8	4	-	-	-
Nebr.	9	9	-	-	1	-	14	5	-	-	-
Kans.	27	18	-	-	1	-	65	19	-	25	-
S. ATLANTIC	353	426	1	44	57	19	262	356	3	18	63
Del.	2	5	-	-	-	2	5	1	-	-	-
Md.	25	40	-	-	1	1	47	102	-	1	-
D.C.	1	8	-	-	-	-	1	3	-	-	1
Va.	29	43	1	7	10	7	26	42	1	1	1
W. Va.	12	15	-	-	-	-	1	6	-	-	-
N.C.	49	78	-	10	9	7	88	99	2	13	53
S.C.	49	46	-	6	10	1	25	23	-	-	6
Ga.	77	83	-	1	8	-	21	11	-	-	-
Fla.	109	108	-	20	19	1	48	69	-	3	2
E.S. CENTRAL	189	190	-	13	24	1	85	112	1	3	1
Ky.	26	40	-	-	3	-	25	49	-	-	-
Tenn.	60	62	-	1	4	1	32	32	1	2	-
Ala.	79	64	-	7	7	-	25	21	-	1	1
Miss.	24	24	U	5	10	U	3	10	U	-	-
W.S. CENTRAL	256	248	-	52	68	3	276	189	-	88	4
Ark.	26	29	-	7	1	2	60	21	-	-	-
La.	53	47	-	9	12	-	5	17	-	1	-
Okla.	34	33	-	-	-	-	19	28	-	-	-
Tex.	143	139	-	36	55	1	192	123	-	87	4
MOUNTAIN	114	147	-	31	51	26	787	916	-	5	7
Mont.	4	7	-	-	-	-	9	15	-	-	-
Idaho	9	10	-	4	2	2	228	484	-	-	2
Wyo.	5	2	U	1	1	U	8	7	U	-	-
Colo.	23	38	-	7	3	1	151	270	-	-	-
N. Mex.	22	24	N	N	N	-	80	79	-	1	-
Ariz.	35	39	-	5	31	14	162	31	-	1	5
Utah	11	12	-	5	7	9	120	14	-	2	-
Nev.	5	15	-	9	7	-	29	16	-	1	-
PACIFIC	396	539	1	116	155	22	880	700	-	14	27
Wash.	54	68	-	7	14	17	255	288	-	9	5
Oreg.	68	101	N	N	N	1	88	36	-	-	-
Calif.	266	361	1	85	110	3	515	343	-	3	14
Alaska	3	2	-	2	8	-	14	16	-	-	-
Hawaii	5	7	-	22	23	1	8	17	-	2	8
Guam	1	1	U	2	1	U	-	-	U	-	-
P.R.	6	8	-	1	7	-	3	-	-	-	-
V.I.	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	U	2	4	U	1	-	U	-	-

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

TABLE IV. Deaths in 122 U.S. cities,* week ending October 3, 1998 (39th Week)

Reporting Area	All Causes, By Age (Years)						P&I[†] Total
	All Ages	>65	45-64	25-44	1-24	<1	
NEW ENGLAND	530	375	103	38	5	9	48
Boston, Mass.	136	88	28	12	2	6	21
Bridgeport, Conn.	27	25	1	-	1	-	2
Cambridge, Mass.	14	11	3	-	-	-	1
Fall River, Mass.	20	16	2	2	-	-	1
Hartford, Conn.	46	29	7	8	1	1	2
Lowell, Mass.	28	23	3	2	-	-	3
Lynn, Mass.	17	11	6	-	-	-	-
New Bedford, Mass.	16	13	2	1	-	-	-
New Haven, Conn.	43	28	11	4	-	-	3
Providence, R.I.	58	40	12	4	-	2	2
Somerville, Mass.	6	4	2	-	-	-	1
Springfield, Mass.	34	25	6	3	-	-	3
Waterbury, Conn.	30	20	9	1	-	-	4
Worcester, Mass.	55	42	11	1	1	-	5
MID. ATLANTIC	2,225	1,527	435	180	37	46	108
Albany, N.Y.	53	40	8	3	2	-	4
Allentown, Pa.	22	17	4	1	-	-	-
Buffalo, N.Y.	99	75	16	6	1	1	7
Camden, N.J.	29	20	6	1	-	2	2
Elizabeth, N.J.	5	1	2	2	-	-	-
Erie, Pa.	55	43	7	4	1	-	1
Jersey City, N.J.	33	21	8	2	1	1	-
New York City, N.Y.	1,084	717	229	102	16	20	45
Newark, N.J.	57	32	19	4	1	1	6
Paterson, N.J.	12	7	3	2	-	-	-
Philadelphia, Pa.	399	270	74	32	10	13	17
Pittsburgh, Pa.§	51	34	9	3	-	5	3
Reading, Pa.	23	21	2	-	-	-	2
Rochester, N.Y.	129	101	19	7	-	2	9
Schenectady, N.Y.	23	17	5	-	1	-	-
Scranton, Pa.	20	16	3	1	-	-	-
Syracuse, N.Y.	88	67	15	4	1	1	10
Trenton, N.J.	24	16	3	4	1	-	1
Utica, N.Y.	19	12	3	2	2	-	1
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,855	1,226	409	133	43	44	103
Akron, Ohio	48	30	12	3	1	2	-
Canton, Ohio	38	27	8	3	-	-	3
Chicago, Ill.	366	231	87	32	14	2	21
Cincinnati, Ohio	179	122	43	6	2	6	23
Cleveland, Ohio	124	84	28	10	1	1	1
Columbus, Ohio	167	115	34	9	4	5	15
Dayton, Ohio	100	71	27	-	1	1	7
Detroit, Mich.	169	96	38	21	7	7	6
Evansville, Ind.	50	45	4	1	-	-	2
Fort Wayne, Ind.	42	31	8	2	-	1	4
Gary, Ind.	6	-	4	1	-	1	-
Grand Rapids, Mich.	51	36	10	3	-	2	4
Indianapolis, Ind.	188	112	43	18	9	6	8
Lansing, Mich.	52	37	12	3	-	-	1
Milwaukee, Wis.	105	70	26	6	-	3	4
Peoria, Ill.	45	35	3	2	-	5	2
Rockford, Ill.	27	17	5	3	1	1	1
South Bend, Ind.	43	30	7	4	1	1	1
Toledo, Ohio	U	U	U	U	U	U	U
Youngstown, Ohio	55	37	10	6	2	-	-
W.N. CENTRAL	856	602	149	59	26	15	41
Des Moines, Iowa	62	47	8	3	1	3	8
Duluth, Minn.	26	17	4	4	1	-	-
Kansas City, Kans.	40	28	9	1	2	-	-
Kansas City, Mo.	103	68	23	5	2	-	5
Lincoln, Nebr.	34	25	5	2	1	1	1
Minneapolis, Minn.	196	147	30	10	3	6	15
Omaha, Nebr.	80	67	9	3	1	-	4
St. Louis, Mo.	112	68	25	13	4	2	-
St. Paul, Minn.	83	63	16	3	-	1	6
Wichita, Kans.	120	72	20	15	11	2	2

Reporting Area	All Causes, By Age (Years)						P&I[†] Total
	All Ages	>65	45-64	25-44	1-24	<1	
S. ATLANTIC	1,145	716	237	121	36	34	54
Atlanta, Ga.	172	85	49	25	4	9	2
Baltimore, Md.	216	121	54	31	6	4	15
Charlotte, N.C.	79	51	16	9	3	-	6
Jacksonville, Fla.	128	85	20	10	4	9	4
Miami, Fla.	107	68	20	16	1	2	-
Norfolk, Va.	48	32	7	4	3	2	2
Richmond, Va.	68	44	14	5	1	3	3
Savannah, Ga.	34	26	5	3	-	-	2
St. Petersburg, Fla.	39	33	5	1	-	-	2
Tampa, Fla.	141	105	20	8	7	1	13
Washington, D.C.	101	56	25	9	7	4	5
Wilmington, Del.	12	10	2	-	-	-	-
E.S. CENTRAL	808	554	162	55	13	21	45
Birmingham, Ala.	167	114	34	7	3	6	11
Chattanooga, Tenn.	71	45	16	6	2	2	4
Knoxville, Tenn.	82	49	21	7	1	4	5
Lexington, Ky.	90	58	17	9	3	3	5
Memphis, Tenn.	128	100	19	5	2	2	11
Mobile, Ala.	110	81	19	8	1	1	2
Montgomery, Ala.	33	21	9	2	-	1	3
Nashville, Tenn.	127	86	27	11	1	2	4
W.S. CENTRAL	1,384	896	272	129	49	38	92
Austin, Tex.	77	51	14	6	4	2	5
Baton Rouge, La.	17	6	5	3	2	1	1
Corpus Christi, Tex.	66	49	8	6	2	1	7
Dallas, Tex.	181	120	31	16	7	7	7
El Paso, Tex.	81	58	13	6	3	1	4
Ft. Worth, Tex.	101	68	20	6	2	5	8
Houston, Tex.	333	200	72	38	16	7	36
Little Rock, Ark.	71	40	17	10	1	3	2
New Orleans, La.	65	42	6	13	3	1	-
San Antonio, Tex.	212	137	54	14	3	4	13
Shreveport, La.	75	49	17	3	5	1	4
Tulsa, Okla.	105	76	15	8	1	5	5
MOUNTAIN	794	547	130	74	23	20	49
Albuquerque, N.M.	92	60	19	8	3	2	3
Boise, Idaho	36	29	6	1	-	-	-
Colo. Springs, Colo.	53	38	7	6	-	2	4
Denver, Colo.	U	U	U	U	U	U	U
Las Vegas, Nev.	183	126	32	18	2	5	11
Ogden, Utah	23	17	2	3	1	-	1
Phoenix, Ariz.	145	94	24	12	9	6	8
Pueblo, Colo.	22	16	3	1	1	1	2
Salt Lake City, Utah	96	60	12	18	2	4	5
Tucson, Ariz.	144	107	25	7	5	-	15
PACIFIC	1,584	1,112	290	105	43	34	125
Berkeley, Calif.	16	9	2	4	1	-	3
Fresno, Calif.	111	80	18	9	4	-	13
Glendale, Calif.	16	14	2	-	-	-	1
Honolulu, Hawaii	68	49	11	6	1	1	3
Long Beach, Calif.	75	49	15	5	2	4	10
Los Angeles, Calif.	270	197	47	14	7	5	14
Pasadena, Calif.	23	20	2	1	-	-	3
Portland, Oreg.	115	84	18	7	4	2	5
Sacramento, Calif.	157	114	29	8	4	2	18
San Diego, Calif.	140	88	36	12	3	1	14
San Francisco, Calif.	116	70	29	8	3	6	11
San Jose, Calif.	179	135	28	12	3	1	16
Santa Cruz, Calif.	23	18	1	3	1	-	3
Seattle, Wash.	137	92	25	8	5	7	2
Spokane, Wash.	61	46	9	3	1	2	4
Tacoma, Wash.	77	47	18	5	4	3	5
TOTAL	11,181[¶]	7,555	2,187	894	275	261	665

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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