CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

December 7, 2001 / Vol. 50 / No. 48

MMWR™
MORBIDITY AND MORTALITY WEEKLY REPORT



# Update: Investigation of Bioterrorism-Related Anthrax — Connecticut, 2001

CDC and state and local health departments continue investigating cases of bioterrorism-related anthrax. This report revises the number of suspected cases and updates the investigation of a 94-year-old Connecticut (CT) resident who died from inhalational anthrax.

As of December 5, a total of 22 cases of anthrax have been identified; 11 were confirmed as inhalational anthrax, and 11 (seven confirmed and four suspected) were cutaneous. A 54-year-old man who lived in Delaware and who worked at a postal facility in New Jersey (NJ) previously had been classified as having a suspected case of cutaneous anthrax. Additional laboratory findings indicate that the patient's illness no longer meets the CDC surveillance case definition for anthrax (*1*). Initially, he was classified as having a suspected case because of a lesion on his left hand and elevated levels of antibody (IgG) to the protective antigen component of anthrax toxin. Subsequent biopsies of the skin lesion did not reveal *Bacillus anthracis* in the tissue, and additional confirmatory antibody tests on serum specimens were negative.

The investigation in CT has not identified any additional cases of anthrax through prospective and retrospective surveillance. For prospective surveillance, hospitals, clinicians, postal facilities, and the state medical examiner have been asked to report daily any persons with clinical findings that might be related to anthrax, including sepsis and pneumonia. To date, 50 such patients have been reported. No evidence of anthrax was found in 43 patients and the remaining seven are being evaluated; preliminary investigations of the seven patients have not identified evidence of anthrax. Retrospective surveillance has included a review of all deaths since September 1 involving residents of Oxford and eight surrounding towns (Beacon Falls, Naugatuck, Ansonia, Derby, Woodbury, Shelton, Seymour, and Southbury [total population: 152,481]); 487 death certificates for persons who died during September–November 2001 have been reviewed. Of the 131 deaths attributed to sepsis, pneumonia, sudden death, respiratory arrest, cardiac arrest, or undetermined cause, 66 occurred in hospitals. Of these, 52 had no apparent anthrax disease. For 14 persons who died soon after arrival to the hospital, review of hospital records revealed no evidence of anthrax, but information in the hospital record was insufficient to determine the specific cause of death, and postmortem examinations were not conducted.

The source of exposure for the case of inhalational anthrax in a 94-year-old woman who lived in Oxford, CT, remains unknown. Multiple environmental samples collected from all places (e.g., the patient's home, church, voting place, restaurants, and cars in which she traveled) the patient was known to have visited during the 60 days preceding illness onset were negative for *B. anthracis* by culture. Nasal swab specimens were negative from 16 persons epidemiologically linked to the case (e.g., persons who worked in the home and assisted with shopping).

Environmental sampling was performed at the postal processing and distribution center in Wallingford, CT, that serves the towns of Oxford and Seymour and identified *B. anthracis* spores in three high-speed mail sorters. This facility receives mail from several postal distribution facilities known to have been contaminated by *B. anthracis* spores, including the postal center in Hamilton, NJ, which was the origination site for envelopes containing *B. anthracis* powder that were addressed to two U.S. senators. To evaluate potential cross-contamination of envelopes (i.e., an envelope contaminated from another *B. anthracis*-contaminated envelope or environmental surface), postal sorting records from the Wallingford facility are being examined to determine the timing and pathways of mail delivered to the CT patient and her local relatives and contacts. Sorting records in Hamilton indicated that an envelope addressed to a postal code adjacent to Oxford had been processed using the same automatic canceling machine at Hamilton <1 minute after one of the two *B. anthracis* powder-containing letters sent to a U.S. senator. This envelope was subsequently sorted at Wallingford and delivered to Seymour. The envelope was received at a residence 4 miles from the home of the CT patient; this envelope was recovered from the recipient and *B. anthracis* spores were detected on the outside of the envelope; none of the members of this household had clinical evidence of anthrax. No record of mail to the CT case-patient processed at Hamilton was found, and no *B. anthracis* spores have been recovered from envelopes found at her home.

*Reported by: N Lustig, MPH, Pomperaug Health District, Oxford; K Spargo, MPH, Naugatuck Valley Health District, Shelton; W Carver, MD, Office of the Chief Medical Examiner, M Cartter, MD, J Garcia, MD, DM Barden, MT (HHS), DR Mayo, ScD, KA Kelley, DrPH, J Hadler, MD, State Epidemiologist, Connecticut Dept of Public Health. G DiFerdinando, MD, E Bresnitz, MD, State Epidemiologist, New Jersey Dept of Health and Senior Svcs. L Hathcock, PhD, State Epidemiologist, Delaware Div of Public Health. EIS officers, CDC.*

**Editorial Note:** As of December 5, a total of 11 inhalational anthrax cases have been identified; direct exposure to a *B. anthracis*-containing envelope was likely in the first nine cases (*2*). The source of exposure to *B. anthracis* for the inhalational anthrax cases in CT and New York City (NYC) remain under investigation by public health and law enforcement officials. No direct exposure to *B. anthracis*-containing envelopes has been identified for these cases. Similar to the first nine cases of inhalational anthrax, exposure to *B. anthracis* might have occurred through the mail from exposure to an envelope containing *B. anthracis* powder. No direct exposure to envelopes containing *B. anthracis* powder has been identified for the inhalational cases in CT and NYC. In the absence of definitive evidence indicating how transmission occurred, infection from a cross-contaminated envelope is one hypothesis being considered by investigators.

Cross-contamination could explain how *B. anthracis* spores were spread to some postal facilities that did not process the envelopes addressed to the U.S. senators.

*Investigation of Bioterrorism-Related Anthrax — Continued*

Approximately 85 million pieces of mail were processed on the days after the implicated envelopes passed through the NJ and the District of Columbia (DC) sorting facilities until they were closed. Both of these facilities had evidence of widespread environmental contamination with *B. anthracis*. Some of the pieces of mail that passed through these facilities could have been cross-contaminated and, in turn, could have contaminated mail processing equipment or other envelopes processed elsewhere. Despite the high volume of mail distributed to metropolitan areas around these facilities, active surveillance has not identified cases of inhalational anthrax among approximately 10.5 million residents in NJ, DC, Pennsylvania, Maryland, and Virginia or in postal workers since the initial cluster of cases associated with the processing of the implicated letters sent to the U.S. senators. The large population, the duration of active surveillance, and the absence of additional cases of inhalational anthrax indicate that if there is a risk for inhalational anthrax associated with exposure to mail cross-contaminated by the letters addressed to the U.S. senators, it is very low.

Despite this very low risk, persons remaining concerned about their risk may want to take additional steps such as not opening suspicious mail; keeping mail away from your face when you open it and not blowing or sniffing mail or mail contents; washing your hands after you handle the mail; avoiding vigorous handling of mail, such as tearing or shredding mail before disposal; and discarding envelopes after opening mail. However, the effectiveness of these steps in reducing any residual risk is not known.

Suspicious persons or situations should be reported to law enforcement authorities. Health-care providers should remain alert for persons with clinical presentations consistent with early anthrax (*3*), obtain appropriate diagnostic tests (e.g., blood cultures and chest radiograph) (*4*), and report suspicious illnesses to local or state public health authorities. Fatalities can be minimized by promptly initiating combination antimicrobial therapy (*5*). Recommendations for risk reduction for persons with potential occupational exposure are available (*6*). Public health surveillance for anthrax and research efforts to further define the risk associated with exposure to *B. anthracis* in the environment as a result of the bioterrorist attack is ongoing. CDC will continue to provide updates as new information becomes available.

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*Public Health Dispatch*

## Update: Unexplained Deaths Following Knee Surgery — Minnesota, 2001

Since November 13, 2001, the Minnesota Department of Health (MDH), in collaboration with CDC, has been conducting an investigation of three patients who died unexpectedly within 1 week following knee surgery (*1*). Patient 1 had received a knee osteochondral allograft, and patients 2 and 3 had undergone total knee replacement surgery. Epidemiologic and microbiologic investigations have not linked the deaths of the three patients.

Blood cultures obtained from patient 1 before his death grew a clostridial species that was identified subsequently at MDH and CDC as *Clostridium sordellii* by biochemical and molecular typing. Blood cultures from patients 2 and 3 did not yield growth of any bacteria. Molecular and special studies have not identified any *Clostridium* species in autopsy tissues from patients 2 and 3, and the cause of death in these patients remains unexplained. On the basis of investigative findings, MDH lifted a moratorium on elective knee surgery on November 25.

As of December 4, neither surveillance in Minnesota by MDH nor enhanced case finding by CDC outside of Minnesota and follow-up of reports to CDC have identified any additional cases of *C. sordellii* infection associated with severe hemodynamic collapse or death in patients recently undergoing knee or large joint surgery. Because infection associated with contaminated graft tissue is a known but uncommon complication of allograft surgery (*2*), MDH, CDC, and the Food and Drug Administration have initiated an investigation to determine whether the osteochondral allograft might have been the source for the *C. sordellii* found in patient 1. Nonimplanted knee tissue from the same donor source as the allograft used in patient 1 was obtained by CDC from the same tissue bank. Preliminary cultures of this tissue have yielded growth of *Clostridium* species; biochemical and molecular testing to identify the species is under way. Reports of other allograft recipients infected with clostridial species have been received at CDC and are being investigated.

Clinicians should consider possible clostridial infection in patients with evidence of infection following allograft implantation. Clinical evaluation should include looking for symptoms and signs of sepsis, including fever, hemodynamic compromise, and/or abdominal pain. In some patients, only local symptoms (e.g., knee pain) may be present during the early course of infection. Diagnostic evaluation should include two sets of blood cultures for both aerobes and anaerobes; these cultures should be incubated for 7 days. If appropriate, other specimens (e.g., knee aspirate or tissue) should be obtained and cultured aerobically and anaerobically. If appropriate, health-care providers should consider expanding empiric therapy to include anaerobic coverage. Consultation with an infectious disease physician might be helpful.

Health-care providers should report cases of clostridial infection following allograft implantation to their state health department or CDC's Division of Healthcare Quality Promotion, telephone 800-893-0485.

*Reported by: KH LeDell, MPH, R Lynfield, MD, RN Danila, PhD, HF Hull, MD, State Epidemiologist, Minnesota Dept of Health. Div of Healthcare Quality Promotion, National Center for Infectious Diseases; and EIS officers, CDC.*

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# Septic Arthritis Following Anterior Cruciate Ligament Reconstruction Using Tendon Allografts — Florida and Louisiana, 2000

In the United States, approximately 50,000 knee surgeries are performed each year for repairing anterior cruciate ligament (ACL) injuries (*1*). Tissue allografts frequently are used for ACL reconstruction, and septic arthritis is a rare complication of such procedures. This report describes four patients who acquired postsurgical septic arthritis probably associated with contaminated bone-tendon-bone allografts used for ACL reconstruction. Effective sterilization methods that do not functionally alter musculoskeletal tissue are needed to prevent allograft-related infections.

**Florida**

On April 5, 2000, at a surgical center, a girl aged 16 years had ACL reconstruction using a bone-tendon-bone allograft. On April 21 at a local orthopedic clinic, she sought medical care for swelling and redness of the left knee. On examination, septic arthritis was diagnosed, and she was treated with joint irrigation, a 6-week course of intravenous antimicrobial therapy, and removal of the allograft and screw. Cultures from the left knee aspirate yielded *Pseudomonas aeruginosa*, *Staphylococcus aureus*, and *Enterococcus faecalis*.

On April 7 at a surgical center, a man aged 40 years underwent ACL reconstruction using a bone-tendon-bone allograft. On April 24, he sought medical care for drainage from the knee. On examination, septic arthritis was diagnosed; his treatment was an 8-week course of antimicrobials and screw removal. *P. aeruginosa* was cultured from the surgical site.

The allografts used for the two patients were supplied by a Texas tissue bank (tissue bank A) and were harvested from a common donor. Both patients' initial ACL reconstruction procedures were performed on different days by different surgeons using different arthroscopic instruments but at the same surgical center. The local health department conducted an onsite investigation of the center and identified no breaches in infection-control procedures. At tissue bank A, the implicated allografts had been irradiated and processed using standard quality-control procedures. All other allografts used during the preceding 4 years at this surgical center had been supplied by a tissue bank other than tissue bank A; no postoperative infections were detected by orthopedic surgeons at follow-up visits among approximately 1,000 ACL reconstructions performed at this center during the 4-year period. *P. aeruginosa* isolates cultured from the surgical site infections of the two patients had genotypic patterns that were indistinguishable from each another by pulsed-field gel electrophoresis.

**Florida and Louisiana**

On October 9 at a surgical center in Florida, a woman aged 55 years had ACL reconstruction using a bone-tendon-bone allograft. On October 17, she was taken to an orthopedic clinic for purulent drainage from the left knee. On examination, septic arthritis was diagnosed, and she was treated with joint irrigation and 12 weeks of antimicrobial therapy. On July 11, 2001, the patient required a total knee arthroplasty. *Citrobacter werkmanii/youngae* and group B beta hemolytic streptococci grew from the knee aspirate.

On October 19 in Louisiana, a woman aged 29 years had ACL reconstruction using a bone-tendon-bone allograft at a local surgical center. On November 7 at an orthopedic clinic, she presented with a temperature of 103° F (39.4° C) and septic arthritis. She was treated with joint irrigation and 13 weeks of antimicrobial therapy. *Klebsiella oxytoca* and *Hafnia alvei* were cultured from the knee aspirate.

*Septic Arthritis — Continued*

Both patients received allografts from the same Florida tissue bank (tissue bank B), and the allografts were from a common donor. When tissue bank B conducted a traceback investigation and reviewed quality-control procedures, the implicated allografts had not received terminal sterilization with gamma irradiation. The same species of organisms isolated from the two recipients and *Serratia liquefaciens* were cultured from the donor allografts during tissue processing; other donor tissues were culture negative. No isolates from the donor or recipients were available for additional testing.

*Reported by: B Lutz, MD, Memorial Medical Center-Baptist Campus, New Orleans; R Ratard, MD, Louisiana Dept of Health and Hospitals. D Dodson, MD, West Palm Beach; JM Malecki, MD, Palm Beach County Health Dept; AC Morse, DO, Div of Sports Medicine, Florida Orthopedic Institute, Tampa; S Wiersma, MD, Florida Dept of Health. D Perrotta, PhD, Texas Dept of Health. Div of Healthcare Quality Promotion, National Center for Infectious Diseases; and an EIS Officer, CDC.*

**Editorial Note:** In the cases described in this report, clinicians suspected contaminated allografts because of the rarity of septic arthritis following arthroscopic interventions and the polymicrobial nature of these infections and worked with local public health authorities and tissue bank staff to link the infections to allografts of common donors. The epidemiologic and laboratory investigation related to tissue bank A indicated that the allografts were the source of the infection despite no apparent lapses in tissue processing. Cases related to tissue bank B were linked to allografts from a common donor that were released inadvertently before standard terminal sterilization procedures were conducted.

In 1999, U.S. tissue banks distributed approximately 750,000 allografts for transplantation (*2*). Transmission of infectious agents (e.g., fungi, bacteria, and human immunodeficiency virus [HIV]) caused by contaminated allografts has been described (*3–5*). The number of persons who develop septic arthritis caused by bacterially contaminated allografts is unknown. In addition, tissue banks, donors, and recipients often are located in different states, complicating detection of bacterial infections associated with contaminated allografts. The Food and Drug Administration (FDA) requires screening of tissue donors for HIV, hepatitis B and C, and other bloodborne pathogens. Reporting of infections resulting from contaminated allografts is not required. FDA has proposed regulations that would require reporting adverse reactions that involve the transmission of communicable diseases if fatal, life threatening, or results in permanent impairment.

The American Association of Tissue Banks (AATB) publishes quality standards for procuring and processing tissue, and provides guidelines on donor screening, time limits for retrieval of soft tissues, and procedures for preservation (e.g., freezing or freeze-drying), sterilization, preparation, and evaluation, and labeling of tissue components (*6*). Gamma irradiation or ethylene oxide are used to sterilize allografts. Tissue banks use gamma irradiation for sterilization, but high doses of gamma irradiation may adversely affect the biomechanical properties of allografts (*7*). Ethylene oxide has limited ability to penetrate tissue and has been associated with adverse patient outcomes (*8,9*). Concern about possible sterilization-related complications has resulted in musculoskeletal tissues (e.g., bone-tendon-bone allografts) being processed aseptically but is not necessarily sterile. Although aseptic processing avoids contamination of tissue at the tissue bank, it does not eliminate contamination originating from the donor that might be inherent to the graft. AATB standards require that tissue banks establish a list of organisms which, when

*Septic Arthritis — Continued*

cultured from tissue, necessitate discarding, sterilization, or disinfection of harvested tissues (*6*). However, not all tissue is cultured, and AATB does not specify the organisms for which corrective actions should be taken (*6*).

According to the Office of the Inspector General, approximately 44% of tissue banks identified were not accredited by AATB or inspected by Florida or New York (the two states that require licensing and inspection of tissue banks) (*2*), and this probably represents an underestimate of the tissue banks that are unaccredited or unlicensed (*10*). Tissue banks that lack accreditation and licensure are not required to comply with external quality requirements beyond donor screening for HIV and hepatitis (*2*).

This report underscores the need for 1) standard practices for screening, disinfecting, sterilizing, or discarding potentially contaminated allografts; 2) mechanisms for certification and oversight of tissue banks and adherence to quality standards; 3) a system for reporting and investigating infections (bacterial, viral, or fungal) potentially transmitted through human tissues; and 4) the development of safe and effective sterilization methods for musculoskeletal tissue. When septic arthritis occurs after use of an allograft, allograft contamination should be suspected, especially when the infection is polymicrobial or associated with Gram-negative organisms. Clinicians should report infections involving allograft tissue to FDA's MedWatch system and through local and state health departments to CDC's Division of Healthcare Quality Promotion, National Center for Infectious Diseases, telephone 800-893-0485.

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# Influenza Activity — United States, 2001–02 Season

In collaboration with the World Health Organization (WHO) and its collaborating laboratories, National Respiratory and Enteric Virus Surveillance System (NREVSS) collaborating laboratories, state and local health departments, and a network of sentinel physicians, CDC conducts surveillance to monitor influenza activity and to detect antigenic changes in circulating strains of influenza viruses. This report summarizes influenza activity in the United States* (*1*) during September 30–November 24, 2001, when the viruses isolated most frequently were influenza A (H3N2). These viruses were well matched antigenically by the 2001–02 influenza A (H3N2) vaccine. Vaccine supplies are plentiful and influenza vaccine should continue to be offered during December and later.

As of November 24, WHO and NREVSS collaborating laboratories in the United States tested 8,140 specimens for influenza viruses; 73 (0.9%) were positive. The percentage of positive influenza isolates identified each week is an indicator of the level of influenza activity, and for the weeks ending October 6 through November 24, the percentage of respiratory specimens testing positive for influenza viruses ranged from 0.4% to 1.7%. These percentages are low compared with the 24%–33% testing positive at the peak of the 1998–99, 1999–2000, and 2000–01 seasons. Of the 73 influenza isolates reported since September 30, 70 (96%) were influenza A viruses and three (4%) were influenza B viruses. Of the 70 influenza A viruses identified, 45 (64%) have been subtyped; 44 were influenza A (H3N2) viruses and one was an influenza A (H1N1) virus. Influenza A (H3N2) isolates were identified in Alaska, Arizona, Colorado, Florida, New York, North Carolina, North Dakota, Texas, Utah, and Wisconsin. The influenza A (H1N1) isolate was identified in Washington, and unsubtyped influenza A isolates were identified in Alabama, Alaska, Hawaii, Louisiana, Minnesota, New York, Washington, and Wisconsin. Influenza B isolates were identified in Louisiana, Michigan, and Texas. Thirty-nine (52%) of the 73 influenza viruses isolated were identified in Alaska.

CDC antigenically characterized 10 influenza isolates collected in September and 13 collected in October. They consisted of 20 influenza A (H3N2) viruses, two influenza A (H1N1) viruses, and one influenza B virus. The antigenically characterized influenza A (H3N2), influenza A (H1N1), and influenza B isolates were similar to the vaccine strains A/Panama/2007/99 (H3N2), A/New Caledonia/20/99 (H1N1), and B/Sichuan/379/99, respectively.

During September 30–November 24, the weekly percentage of patient visits for influenza-like illness (ILI)† to approximately 650 U.S. sentinel physicians ranged from 1.0% to 1.4%. For the week ending November 24, the percentage of patient visits for ILI was 1.4%, which is less than the national baseline of 1.9%§. During the same week, influenza activity¶, as reported by state epidemiologists, was regional in Alaska and

*As of November 29, 2001.

† Temperature of >100.0° F (>37.8° C) and either cough or sore throat in the absence of a known cause.

§ The national baseline was calculated as the mean percentage of visits for ILI during noninfluenza weeks plus two standard deviations. Because of wide variability in regional level data, to calculate region-specific baselines is not possible and to apply the national baseline to regional level data is not appropriate.

¶ Levels of activity: 1) *no activity*, 2) *sporadic*—sporadically occurring ILI or laboratory-confirmed influenza with no outbreaks detected, 3) *regional*—outbreaks of ILI or laboratory-confirmed influenza in counties with a combined population of <50% of the state's population, and 4) *widespread*—outbreaks of ILI or laboratory-confirmed influenza in counties with a combined population of ≥50% of the state's population.

*Influenza Activity — Continued*

sporadic in 25 states (Alabama, Arizona, California, Colorado, Connecticut, Georgia, Indiana, Iowa, Kansas, Kentucky, Maine, Michigan, Missouri, Nevada, New Mexico, New York, North Carolina, Ohio, Tennessee, Texas, Utah, Vermont, West Virginia, Wisconsin, and Wyoming), New York City, and District of Columbia; 23 states reported no influenza activity, and one state did not report.

During the week ending November 24, the 122 Cities Mortality Reporting System attributed 6.1% of recorded deaths to pneumonia and influenza (P&I). This percentage was below the epidemic threshold** of 7.4% for that week. The percentage of P&I deaths has been below the epidemic threshold for each week since September 30.

In November, two virologically confirmed institutional outbreaks caused by influenza A viruses were reported to CDC. On November 14, an elementary school in Fort Collins, Colorado, reported elevated and increasing absenteeism among its students. Of 675 students, 53 (8%) were absent on November 14, 96 (14%) were absent on November 15, and 110 (16%) were absent on November 16. Baseline absenteeism on November 12–13 was 18–20 students. Two of the three specimens submitted to the state laboratory for viral culture were positive for influenza A (H3N2). The school remained open and a letter was sent to parents describing influenza symptoms and requesting that sick children be kept at home. Use of influenza antiviral agents was left to the discretion of the child's health-care provider and family. Nursing homes in the Fort Collins area were advised of influenza activity in the community and a broadcast facsimile outlining antiviral treatments available for influenza was sent to all primary-care providers.

On November 17, an influenza A outbreak was reported in a long-term–care facility with 160 residents located in the Hudson Valley region of New York; 14 residents and eight staff members had an influenza-like illness and four of six ill residents tested positive for influenza A by rapid antigen testing. On November 18, all residents began to receive antiviral medication and since then, no new cases of influenza-like illness in this facility have been reported. The facility received its order of influenza vaccine a week and a half before the outbreak and vaccinated residents on November 12–16.

*Reported by: S Berns, Poudre School District; N Underwood, S Murray, A LeBailly, MD, Larimer County Dept of Health and Environment, Fort Collins; A Scott, K Gershman, MD, L Swanson, P Young, Colorado Dept of Public Health and Environment. C Waters, P Smith, MD, New York Dept of Health. Participating state and territorial epidemiologists and state public health laboratory directors. WHO collaborating laboratories. National Respiratory and Enteric Virus Surveillance System laboratories. Sentinel Physicians Influenza Surveillance System. Surveillance Systems Br, Div of Public Health Surveillance and Informatics, Epidemiology Program Office; Mortality Statistics Br, Div of Vital Statistics, National Center for Health Statistics; WHO Collaborating Center for Surveillance, Epidemiology, and Control of Influenza, Influenza Br and Respiratory and Enteric Virus Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases, CDC.*

** The expected baseline proportion of P&I deaths reported by the 122 Cities Mortality Reporting System is projected using a robust regression procedure in which a periodic regression model is applied to the observed percentage of deaths from P&I since 1983. The epidemic threshold is 1.654 standard deviations above the seasonal baseline. Before the 1999–2000 season, a new case definition for a P&I death was introduced. During the summer of 2000, the baseline and epidemic thresholds were adjusted manually to account for these changes in case definition. For the 2001–02 season, sufficient data have been collected using the new case definition to allow projection of the baseline using the regression procedure employed before the 2000–01 season.

*Influenza Activity — Continued*

**Editorial Note:** The four influenza surveillance system components indicated low levels of influenza activity in the United States during September 30–November 24. The number of influenza viruses isolated this season is relatively low and it is too early to determine which strain(s) will predominate. However, two influenza A outbreaks were detected in November and influenza activity is expected to increase during the next few weeks to months. The viruses isolated most frequently have been influenza A (H3N2) viruses. The 2001–02 influenza vaccine strains are well matched to the influenza isolates that have been characterized antigenically this season.

The best prevention against influenza is vaccination. Vaccine supplies are plentiful and are available for immediate shipment from the three U.S. licensed manufacturers. Manufacturers estimate that approximately 87 million doses of influenza vaccine will be produced this year compared with 76.8 million doses available during the 1999–2000 season and 70.4 million doses available during the 2000–01 season. By the end of November, approximately 74.2 million (85%) of the projected 87 million doses of vaccine will have been distributed. An additional 12.8 million doses are expected to be available in December.

Health-care providers should continue to offer influenza vaccine during December and later because persons can benefit from vaccination after influenza activity has been detected in their community (*2*). The most important persons to be vaccinated are those in groups at increased risk for complications from influenza (i.e., persons aged ≥65 years and persons aged 6 months–64 years with certain underlying medical conditions [*3*]), and health-care providers. In addition, household contacts of high-risk persons, healthy persons aged 50–64 years, and anyone who wants to reduce the likelihood of becoming ill with influenza should be vaccinated.

CDC collects and reports U.S. influenza surveillance data during October–May. This information is updated weekly and is available through CDC voice information, 888-232-3228, fax information, 888-232-3299 (request document number 361100) or at http://www.cdc.gov/ncidod/diseases/flu/weekly.htm.

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*Notice to Readers*

## Use of Onsite Technologies for Rapidly Assessing Environmental *Bacillus anthracis* Contamination on Surfaces in Buildings

Environmental sampling to ascertain the presence of *Bacillus anthracis* spores in buildings is an important tool for assessing risk for exposure. Similar to diagnostic testing, culture with positive identification of *B. anthracis* (CDC culture method) is the confirmatory test. Laboratory-based polymerase chain reaction (PCR) methods for detecting genetic material of *B. anthracis* can be used in preliminary assessments and as adjuncts to microbiologic methods. Although these tests are consistent with culture results, PCR methods are not approved by the Food and Drug Administration, and results should not be the basis for clinical decisions.

Rapid-assay devices that can provide results within minutes are used for onsite detection of environmental contamination. Some of these devices are PCR-based assays, and others are immune-based assays for *B. anthracis*. CDC has not obtained validation data for rapid-assay devices. A recent CDC evaluation of *B. anthracis* contamination at the Brentwood postal facility in the District of Columbia included use of one onsite PCR-based device and CDC culture method. Of 107 samples analyzed using CDC culture method and the PCR-based device, 95 (89%) were negative by both methods. Of six samples identified as positive by CDC culture method, two were positive using the PCR-based device. Of eight samples identified as positive by the PCR-based device, two were positive by CDC culture method. Although these results indicate a poor agreement between results from the onsite PCR-based device and CDC culture method, this assessment was not intended as a formal validation test because of limited capacity to implement adequate quality-control measures and the small number of *B. anthracis* positive samples.

The apparently poor agreement of the onsite PCR-based device could be attributed to several factors such as the concentration of spores on contaminated surfaces, sample collection and preparation procedures, sample splitting, and the methods used for removing the sample from collection material. Furthermore, PCR- or immune-based tests do not distinguish viable from nonviable spores and can produce positive scores for samples that culture methods would define as negative. As a result, these methods are not useful for evaluating the success of disinfection techniques that do not remove nonviable spores.

Public health officials are urged to understand the limitations of onsite, rapid technologies for *B. anthracis* before using them for public health decision making. Until validation testing is complete and guidelines for effective use are developed, PCR- or immune-based assay results for *B. anthracis* should not be used alone, but should be confirmed with samples analyzed by culture methods to make public health decisions.

*Notice to Readers*

## CDC Recognition of Members of *MMWR* Distribution Partnership

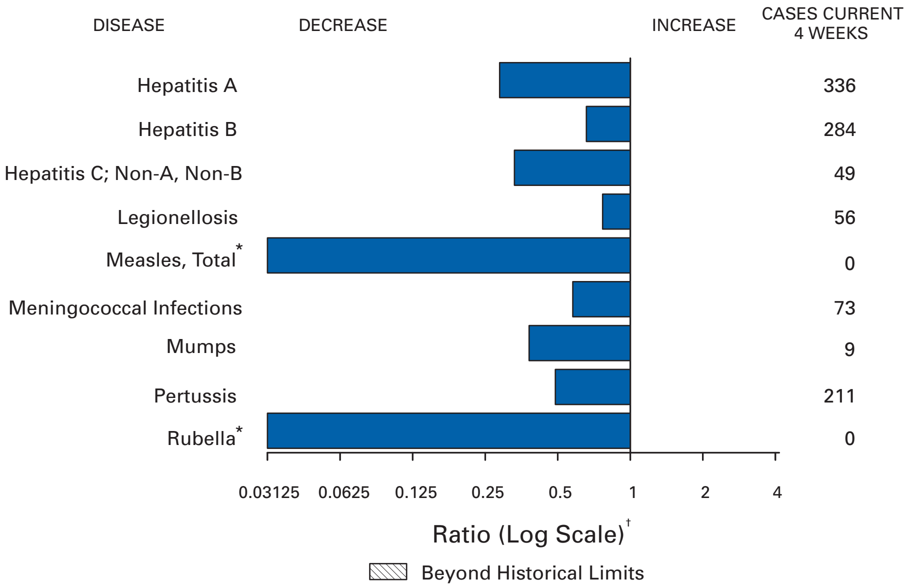
The recent bioterrorist attacks represent a national emergency that requires action by all of those responsible for public health and safety. In October and November in response to these attacks, CDC developed guidelines for anthrax treatment, prophylaxis, and exposure management that required immediate dissemination to all health-care professionals. To expand its distribution, *MMWR* enlisted the assistance of various organizations, agencies, publications, and health-care plans in a distribution partnership. Participants in this partnership electronically distributed to their members and subscribers bioterrorism-related reports published in *MMWR*. As a result, millions of health-care professionals and the public were notified immediately about critical public health information within hours of its release by CDC. CDC appreciates this collective effort to protect public health and safety.

Following are members of the *MMWR* distribution partnership:

Alliance of Community Health Plans
American Academy of Family Physicians
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Association of Health Plans
American Association of Poison Control Centers
American Association of Public Health Laboratories
American College of Emergency Physicians
American College of Physicians, American Society of Internal Medicine
American Hospital Association
American Medical Association, Office of Specialty Society Relations
Association of American Medical Colleges
Association of State and Territorial Health Officials
Blue Cross Blue Shield Association
Council of State and Territorial Epidemiologists
Employers' Managed Health Care Association
Environmental Protection Agency
ePocrates, Inc.
Federal Emergency Management Agency
Federation of State Medical Boards
International Association of Fire Chiefs
*Journal of the American Medical Association*
Kaiser Permanente
MyDrugRep.com, Inc.
National Association of County and City Health Officials
*New England Journal of Medicine*
National Institutes of Health, National Library of Medicine
National Institute for Health Care Management Research and Education Foundation
U.S. Department of State
Washington Business Group on Health
WebMD

CDC invites other organizations and agencies to join this distribution partnership by contacting *MMWR* at mmwrq@cdc.gov.

**FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending December 1, 2001, with historical data**




* No measles or rubella cases were reported for the current 4-week period yielding a ratio for week 48 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 December 1, 2001 (48th Week)***

| | | Cum. 2001 | | Cum. 2001 |
|---|---|---|---|---|
| Anthrax | | 15 | Poliomyelitis, paralytic | - |
| Brucellosis† | | 82 | Psittacosis† | 23 |
| Cholera | | 3 | Q fever† | 22 |
| Cyclosporiasis† | | 131 | Rabies, human | 1 |
| Diphtheria | | 2 | Rocky Mountain spotted fever (RMSF) | 565 |
| Ehrlichiosis: | human granulocytic (HGE)† | 206 | Rubella, congenital syndrome | 1 |
| | human monocytic (HME)† | 86 | Streptococcal disease, invasive, group A | 3,274 |
| Encephalitis: | California serogroup viral† | 99 | Streptococcal toxic-shock syndrome† | 44 |
| | eastern equine† | 8 | Syphilis, congenital¶ | 190 |
| | St. Louis† | 2 | Tetanus | 23 |
| | western equine† | - | Toxic-shock syndrome | 115 |
| Hansen disease (leprosy)† | | 78 | Trichinosis | 26 |
| Hantavirus pulmonary syndrome† | | 6 | Tularemia† | 98 |
| Hemolytic uremic syndrome, postdiarrheal† | | 139 | Typhoid fever | 263 |
| HIV infection, pediatric†§ | | 200 | Yellow fever | - |
| Plague | | 2 | | |

-: No reported cases.
*Incidence data for reporting year 2001 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 updated November 27, 2001.
¶ Updated from reports to the Division of STD Prevention, NCHSTP.

# TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending December 1, 2001, and December 2, 2000 (48th Week)*

| Reporting Area | AIDS Cum. 2001¶ | AIDS Cum. 2000 | Chlamydia§ Cum. 2001 | Chlamydia§ Cum. 2000 | Cryptosporidiosis Cum. 2001 | Cryptosporidiosis Cum. 2000 | *Escherichia coli* O157:H7† NETSS Cum. 2001 | *Escherichia coli* O157:H7† NETSS Cum. 2000 | *Escherichia coli* O157:H7† PHLIS Cum. 2001 | *Escherichia coli* O157:H7† PHLIS Cum. 2000 |
|---|---|---|---|---|---|---|---|---|---|---|
| UNITED STATES | 37,411 | 35,685 | 656,773 | 639,742 | 3,247 | 2,829 | 2,893 | 4,276 | 2,156 | 3,518 |
| NEW ENGLAND | 1,403 | 1,863 | 21,429 | 21,706 | 123 | 130 | 224 | 366 | 225 | 371 |
| Maine | 44 | 38 | 1,239 | 1,344 | 18 | 20 | 27 | 31 | 27 | 28 |
| N.H. | 37 | 30 | 1,246 | 1,032 | 16 | 22 | 35 | 35 | 30 | 38 |
| Vt. | 15 | 37 | 579 | 493 | 31 | 26 | 14 | 35 | 8 | 36 |
| Mass. | 704 | 1,128 | 9,149 | 9,291 | 50 | 34 | 115 | 161 | 112 | 167 |
| R.I. | 95 | 91 | 2,719 | 2,486 | 8 | 3 | 17 | 20 | 11 | 18 |
| Conn. | 508 | 539 | 6,497 | 7,060 | - | 25 | 16 | 84 | 37 | 84 |
| MID. ATLANTIC | 9,346 | 7,605 | 75,103 | 60,869 | 270 | 359 | 207 | 420 | 181 | 338 |
| Upstate N.Y. | 945 | 676 | 13,575 | 3,037 | 106 | 120 | 154 | 281 | 136 | 76 |
| N.Y. City | 5,253 | 3,919 | 27,353 | 24,310 | 99 | 159 | 12 | 23 | 11 | 18 |
| N.J. | 1,607 | 1,554 | 10,980 | 9,855 | 13 | 19 | 41 | 116 | 34 | 116 |
| Pa. | 1,541 | 1,456 | 23,195 | 23,667 | 52 | 61 | N | N | - | 128 |
| E.N. CENTRAL | 2,812 | 3,411 | 107,979 | 110,537 | 1,407 | 930 | 752 | 1,041 | 495 | 734 |
| Ohio | 538 | 533 | 22,404 | 28,959 | 161 | 253 | 214 | 255 | 153 | 223 |
| Ind. | 343 | 347 | 13,985 | 12,499 | 79 | 57 | 81 | 119 | 42 | 83 |
| Ill. | 1,255 | 1,692 | 30,330 | 30,660 | 408 | 119 | 153 | 188 | 128 | 156 |
| Mich. | 500 | 648 | 27,833 | 23,306 | 175 | 91 | 93 | 139 | 82 | 104 |
| Wis. | 176 | 191 | 13,427 | 15,113 | 584 | 410 | 211 | 340 | 90 | 168 |
| W.N. CENTRAL | 808 | 809 | 33,234 | 36,363 | 498 | 345 | 540 | 635 | 449 | 605 |
| Minn. | 133 | 160 | 6,709 | 7,523 | 176 | 123 | 256 | 185 | 212 | 216 |
| Iowa | 85 | 83 | 4,558 | 4,881 | 78 | 74 | 82 | 179 | 62 | 148 |
| Mo. | 405 | 367 | 11,674 | 12,392 | 44 | 29 | 61 | 108 | 89 | 96 |
| N. Dak. | 2 | 3 | 827 | 810 | 13 | 15 | 18 | 19 | 32 | 21 |
| S. Dak. | 23 | 7 | 1,682 | 1,696 | 7 | 15 | 42 | 55 | 41 | 58 |
| Nebr. | 68 | 68 | 2,206 | 3,445 | 177 | 80 | 59 | 61 | - | 48 |
| Kans. | 92 | 121 | 5,578 | 5,616 | 3 | 9 | 22 | 28 | 13 | 18 |
| S. ATLANTIC | 11,517 | 10,027 | 123,700 | 120,423 | 312 | 449 | 227 | 354 | 139 | 280 |
| Del. | 231 | 198 | 2,511 | 2,651 | 6 | 6 | 4 | 3 | 7 | 1 |
| Md. | 1,698 | 1,192 | 11,078 | 12,700 | 38 | 9 | 28 | 34 | 1 | 2 |
| D.C. | 782 | 784 | 2,704 | 2,945 | 11 | 17 | - | 1 | U | U |
| Va. | 911 | 745 | 16,519 | 14,625 | 24 | 18 | 49 | 70 | 39 | 66 |
| W. Va. | 95 | 57 | 2,158 | 1,979 | 2 | 3 | 10 | 15 | 8 | 13 |
| N.C. | 845 | 644 | 18,949 | 20,148 | 27 | 26 | 54 | 87 | 43 | 68 |
| S.C. | 645 | 737 | 10,248 | 8,991 | 7 | - | 17 | 21 | 11 | 16 |
| Ga. | 1,528 | 1,118 | 27,394 | 25,791 | 128 | 170 | 33 | 40 | 15 | 38 |
| Fla. | 4,782 | 4,552 | 32,139 | 30,593 | 69 | 200 | 32 | 83 | 15 | 76 |
| E.S. CENTRAL | 1,671 | 1,781 | 44,785 | 47,046 | 46 | 49 | 125 | 141 | 110 | 113 |
| Ky. | 315 | 185 | 7,882 | 7,431 | 4 | 7 | 58 | 40 | 49 | 32 |
| Tenn. | 540 | 748 | 13,180 | 13,609 | 13 | 11 | 42 | 54 | 46 | 52 |
| Ala. | 415 | 455 | 13,316 | 14,251 | 16 | 15 | 17 | 10 | 6 | 9 |
| Miss. | 401 | 393 | 10,407 | 11,755 | 13 | 16 | 8 | 37 | 9 | 20 |
| W.S. CENTRAL | 3,856 | 3,666 | 96,125 | 96,307 | 112 | 159 | 105 | 222 | 91 | 277 |
| Ark. | 189 | 170 | 6,389 | 6,031 | 8 | 15 | 13 | 56 | - | 38 |
| La. | 806 | 632 | 15,893 | 16,686 | 7 | 12 | 4 | 15 | 26 | 49 |
| Okla. | 214 | 322 | 9,573 | 8,617 | 15 | 17 | 32 | 19 | 28 | 17 |
| Tex. | 2,647 | 2,542 | 64,270 | 64,973 | 82 | 115 | 56 | 132 | 37 | 173 |
| MOUNTAIN | 1,288 | 1,324 | 37,747 | 34,952 | 227 | 168 | 273 | 411 | 131 | 303 |
| Mont. | 15 | 14 | 1,775 | 1,265 | 37 | 10 | 20 | 30 | - | - |
| Idaho | 19 | 20 | 1,788 | 1,727 | 22 | 23 | 71 | 72 | - | 40 |
| Wyo. | 4 | 9 | 767 | 731 | 7 | 5 | 7 | 19 | 1 | 11 |
| Colo. | 267 | 326 | 8,876 | 9,015 | 40 | 69 | 86 | 154 | 53 | 110 |
| N. Mex. | 137 | 140 | 5,313 | 4,775 | 27 | 21 | 14 | 22 | 11 | 18 |
| Ariz. | 502 | 410 | 13,216 | 11,721 | 7 | 10 | 29 | 51 | 23 | 43 |
| Utah | 110 | 133 | 1,619 | 2,077 | 82 | 26 | 30 | 49 | 42 | 71 |
| Nev. | 234 | 272 | 4,393 | 3,641 | 5 | 4 | 16 | 14 | 1 | 10 |
| PACIFIC | 4,710 | 5,199 | 116,671 | 111,539 | 252 | 240 | 440 | 686 | 335 | 497 |
| Wash. | 483 | 463 | 12,473 | 11,929 | - | U | 123 | 221 | 62 | 203 |
| Oreg. | 213 | 170 | 6,757 | 6,397 | 49 | 20 | 65 | 133 | 61 | 114 |
| Calif. | 3,898 | 4,444 | 91,499 | 87,601 | 199 | 220 | 230 | 287 | 203 | 163 |
| Alaska | 18 | 23 | 2,389 | 2,318 | 1 | - | 4 | 31 | 1 | 6 |
| Hawaii | 98 | 99 | 3,553 | 3,294 | 3 | - | 18 | 14 | 8 | 11 |
| Guam | 12 | 13 | - | 465 | - | - | N | N | U | U |
| P.R. | 1,113 | 1,242 | 2,240 | U | - | - | 1 | 7 | U | U |
| V.I. | 11 | 32 | 53 | - | - | - | - | - | U | U |
| Amer. Samoa | 1 | - | U | U | U | U | U | U | U | U |
| C.N.M.I. | - | - | 124 | U | - | U | - | U | U | U |

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

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

† Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

§ 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 updated November 27, 2001.

**TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending December 1, 2001, and December 2, 2000 (48th Week)***

| Reporting Area | Gonorrhea | | Hepatitis C; Non-A, Non-B | | Legionellosis | | Listeriosis | Lyme Disease | |
|---|---|---|---|---|---|---|---|---|---|
| | Cum. 2001 | Cum. 2000 | Cum. 2001 | Cum. 2000 | Cum. 2001 | Cum. 2000 | Cum. 2001 | Cum. 2001 | Cum. 2000 |
| UNITED STATES | 302,379 | 327,661 | 2,957 | 2,913 | 962 | 1,013 | 464 | 11,653 | 15,862 |
| NEW ENGLAND | 6,136 | 6,116 | 20 | 29 | 71 | 53 | 40 | 3,783 | 5,216 |
| Maine | 132 | 85 | - | 2 | 8 | 2 | 2 | - | - |
| N.H. | 171 | 97 | - | - | 11 | 3 | 4 | 148 | 63 |
| Vt. | 63 | 60 | 7 | 4 | 5 | 5 | 3 | 16 | 40 |
| Mass. | 2,868 | 2,539 | 13 | 18 | 21 | 17 | 25 | 826 | 1,145 |
| R.I. | 776 | 604 | - | 5 | 12 | 9 | 1 | 453 | 571 |
| Conn. | 2,126 | 2,731 | - | - | 14 | 17 | 5 | 2,340 | 3,397 |
| MID. ATLANTIC | 38,825 | 36,211 | 1,449 | 641 | 192 | 286 | 66 | 5,762 | 8,150 |
| Upstate N.Y. | 8,111 | 6,792 | 53 | 37 | 64 | 89 | 27 | 3,404 | 3,540 |
| N.Y. City | 11,676 | 10,738 | - | - | 31 | 46 | 12 | 9 | 177 |
| N.J. | 7,426 | 6,667 | 1,342 | 561 | 13 | 22 | 12 | 927 | 2,427 |
| Pa. | 11,612 | 12,014 | 54 | 43 | 84 | 129 | 15 | 1,422 | 2,006 |
| E.N. CENTRAL | 56,276 | 65,648 | 150 | 218 | 280 | 261 | 65 | 656 | 764 |
| Ohio | 12,547 | 17,796 | 5 | 12 | 126 | 106 | 15 | 111 | 58 |
| Ind. | 6,277 | 5,869 | 1 | - | 22 | 36 | 8 | 23 | 22 |
| Ill. | 16,776 | 19,269 | 13 | 19 | 19 | 31 | 11 | 21 | 35 |
| Mich. | 15,797 | 16,234 | 131 | 187 | 77 | 48 | 23 | 13 | 23 |
| Wis. | 4,879 | 6,480 | - | - | 36 | 40 | 8 | 488 | 626 |
| W.N. CENTRAL | 14,141 | 16,483 | 714 | 563 | 47 | 55 | 19 | 380 | 422 |
| Minn. | 2,171 | 2,944 | 9 | 5 | 9 | 7 | 2 | 314 | 322 |
| Iowa | 1,199 | 1,142 | - | 2 | 8 | 13 | 2 | 36 | 33 |
| Mo. | 7,273 | 8,123 | 688 | 544 | 21 | 25 | 10 | 24 | 45 |
| N. Dak. | 37 | 68 | - | - | 1 | - | - | - | 1 |
| S. Dak. | 262 | 261 | - | - | 3 | 2 | - | - | - |
| Nebr. | 713 | 1,385 | 6 | 4 | 4 | 4 | 1 | 4 | 4 |
| Kans. | 2,486 | 2,560 | 11 | 8 | 1 | 4 | 4 | 2 | 17 |
| S. ATLANTIC | 76,101 | 85,108 | 97 | 101 | 185 | 182 | 70 | 803 | 1,051 |
| Del. | 1,545 | 1,598 | - | 2 | 12 | 10 | - | 49 | 167 |
| Md. | 6,205 | 8,833 | 16 | 12 | 35 | 65 | 14 | 522 | 607 |
| D.C. | 2,465 | 2,478 | - | 3 | 8 | 6 | - | 16 | 10 |
| Va. | 9,693 | 9,579 | - | 3 | 23 | 33 | 13 | 116 | 143 |
| W. Va. | 668 | 609 | 9 | 15 | N | N | 5 | 13 | 32 |
| N.C. | 15,240 | 16,439 | 19 | 17 | 11 | 15 | 5 | 39 | 44 |
| S.C. | 6,808 | 7,788 | 6 | 3 | 13 | 6 | 5 | 5 | 14 |
| Ga. | 15,055 | 16,873 | 1 | 3 | 10 | 7 | 14 | - | - |
| Fla. | 18,422 | 20,911 | 46 | 43 | 73 | 40 | 14 | 43 | 34 |
| E.S. CENTRAL | 29,240 | 33,839 | 172 | 427 | 53 | 37 | 20 | 60 | 49 |
| Ky. | 3,168 | 3,248 | 9 | 35 | 11 | 20 | 5 | 22 | 12 |
| Tenn. | 8,883 | 10,842 | 59 | 94 | 27 | 10 | 8 | 29 | 28 |
| Ala. | 10,352 | 11,188 | 4 | 10 | 13 | 4 | 7 | 8 | 6 |
| Miss. | 6,837 | 8,561 | 100 | 288 | 2 | 3 | - | 1 | 3 |
| W.S. CENTRAL | 46,914 | 50,865 | 177 | 695 | 11 | 26 | 18 | 82 | 88 |
| Ark. | 3,961 | 3,529 | 4 | 9 | - | - | 1 | 1 | 5 |
| La. | 10,876 | 12,406 | 88 | 426 | 2 | 7 | - | 2 | 7 |
| Okla. | 4,371 | 3,828 | 4 | 10 | 3 | 5 | 2 | - | 1 |
| Tex. | 27,706 | 31,102 | 81 | 250 | 6 | 14 | 15 | 79 | 75 |
| MOUNTAIN | 9,257 | 9,733 | 52 | 71 | 56 | 43 | 37 | 13 | 13 |
| Mont. | 98 | 48 | 1 | 5 | - | 2 | - | - | - |
| Idaho | 70 | 84 | 2 | 3 | 3 | 5 | 1 | 5 | 3 |
| Wyo. | 77 | 45 | 8 | 2 | 1 | - | 2 | 1 | 3 |
| Colo. | 2,768 | 2,964 | 10 | 13 | 17 | 15 | 10 | 1 | - |
| N. Mex. | 882 | 1,062 | 11 | 14 | 3 | 1 | 7 | 1 | - |
| Ariz. | 3,610 | 3,893 | 9 | 19 | 22 | 7 | 8 | 2 | - |
| Utah | 125 | 209 | 3 | 1 | 6 | 12 | 2 | 1 | 3 |
| Nev. | 1,627 | 1,428 | 8 | 14 | 4 | 1 | 7 | 2 | 4 |
| PACIFIC | 25,489 | 23,658 | 126 | 168 | 67 | 70 | 129 | 114 | 109 |
| Wash. | 2,763 | 2,148 | 23 | 31 | 10 | 17 | 10 | 8 | 9 |
| Oreg. | 1,046 | 937 | 13 | 25 | N | N | 9 | 10 | 12 |
| Calif. | 20,750 | 19,797 | 90 | 110 | 53 | 52 | 104 | 94 | 86 |
| Alaska | 383 | 328 | - | - | - | - | - | 2 | 2 |
| Hawaii | 547 | 448 | - | 2 | 4 | 1 | 6 | N | N |
| Guam | - | 51 | - | 3 | - | - | - | - | - |
| P.R. | 541 | 479 | 1 | 1 | 2 | 1 | - | N | N |
| V.I. | 6 | - | - | - | - | - | - | - | - |
| Amer. Samoa | U | U | U | U | U | U | - | U | U |
| C.N.M.I. | 14 | U | - | U | - | U | - | - | U |

N: Not notifiable. U: Unavailable. - : No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

**TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending December 1, 2001, and December 2, 2000 (48th Week)***

| Reporting Area | Malaria | | Rabies, Animal | | Salmonellosis† NETSS | | Salmonellosis† PHLIS | |
|---|---|---|---|---|---|---|---|---|
| | Cum. 2001 | Cum. 2000 | Cum. 2001 | Cum. 2000 | Cum. 2001 | Cum. 2000 | Cum. 2001 | Cum. 2000 |
| UNITED STATES | 1,156 | 1,373 | 7,218 | 6,526 | 33,911 | 36,341 | 27,020 | 30,299 |
| NEW ENGLAND | 85 | 69 | 686 | 783 | 2,220 | 2,055 | 2,101 | 2,110 |
| Maine | 4 | 6 | 63 | 127 | 162 | 119 | 151 | 97 |
| N.H. | 2 | 1 | 22 | 21 | 162 | 136 | 149 | 140 |
| Vt. | 1 | 3 | 60 | 57 | 76 | 104 | 63 | 101 |
| Mass. | 38 | 32 | 249 | 262 | 1,258 | 1,179 | 1,115 | 1,200 |
| R.I. | 13 | 8 | 67 | 56 | 131 | 124 | 168 | 148 |
| Conn. | 27 | 19 | 225 | 260 | 431 | 393 | 455 | 424 |
| MID. ATLANTIC | 330 | 372 | 1,122 | 1,233 | 4,062 | 4,710 | 3,588 | 4,989 |
| Upstate N.Y. | 65 | 73 | 739 | 789 | 1,179 | 1,158 | 1,213 | 1,217 |
| N.Y. City | 196 | 217 | 29 | 18 | 996 | 1,132 | 1,297 | 1,217 |
| N.J. | 35 | 47 | 180 | 184 | 905 | 1,097 | 657 | 975 |
| Pa. | 34 | 35 | 174 | 242 | 982 | 1,323 | 421 | 1,580 |
| E.N. CENTRAL | 132 | 137 | 142 | 151 | 4,450 | 5,045 | 3,844 | 3,435 |
| Ohio | 22 | 20 | 51 | 50 | 1,184 | 1,459 | 1,076 | 1,372 |
| Ind. | 16 | 6 | 15 | - | 494 | 601 | 459 | 576 |
| Ill. | 34 | 64 | 24 | 22 | 1,227 | 1,428 | 1,049 | 231 |
| Mich. | 39 | 31 | 46 | 68 | 768 | 834 | 778 | 886 |
| Wis. | 21 | 16 | 6 | 11 | 777 | 723 | 482 | 370 |
| W.N. CENTRAL | 35 | 66 | 332 | 511 | 2,203 | 2,255 | 2,281 | 2,412 |
| Minn. | 6 | 27 | 44 | 87 | 624 | 515 | 665 | 645 |
| Iowa | 9 | 2 | 74 | 74 | 330 | 344 | 301 | 337 |
| Mo. | 13 | 19 | 41 | 50 | 630 | 677 | 906 | 826 |
| N. Dak. | - | 2 | 37 | 113 | 56 | 55 | 80 | 75 |
| S. Dak. | - | 1 | 42 | 90 | 144 | 93 | 118 | 101 |
| Nebr. | 2 | 8 | 4 | 2 | 144 | 209 | - | 139 |
| Kans. | 5 | 7 | 90 | 95 | 275 | 362 | 211 | 289 |
| S. ATLANTIC | 269 | 309 | 2,093 | 2,235 | 8,130 | 7,583 | 5,595 | 5,617 |
| Del. | 2 | 5 | 30 | 49 | 87 | 114 | 104 | 125 |
| Md. | 108 | 106 | 332 | 393 | 768 | 711 | 836 | 684 |
| D.C. | 13 | 16 | - | - | 79 | 61 | U | U |
| Va. | 46 | 49 | 461 | 539 | 1,247 | 942 | 958 | 885 |
| W. Va. | 1 | 4 | 131 | 110 | 131 | 156 | 133 | 144 |
| N.C. | 18 | 34 | 550 | 541 | 1,274 | 1,076 | 1,219 | 1,082 |
| S.C. | 7 | 2 | 112 | 149 | 847 | 716 | 677 | 543 |
| Ga. | 30 | 30 | 311 | 302 | 1,630 | 1,434 | 1,210 | 1,649 |
| Fla. | 44 | 63 | 166 | 152 | 2,067 | 2,373 | 458 | 505 |
| E.S. CENTRAL | 33 | 45 | 196 | 196 | 2,473 | 2,298 | 1,735 | 1,726 |
| Ky. | 12 | 18 | 27 | 20 | 355 | 360 | 217 | 249 |
| Tenn. | 11 | 12 | 103 | 100 | 598 | 637 | 758 | 773 |
| Ala. | 6 | 14 | 64 | 75 | 714 | 628 | 474 | 576 |
| Miss. | 4 | 1 | 2 | 1 | 806 | 673 | 286 | 128 |
| W.S. CENTRAL | 12 | 70 | 2,082 | 852 | 3,607 | 4,721 | 2,537 | 2,892 |
| Ark. | 3 | 3 | 20 | 20 | 866 | 691 | 92 | 563 |
| La. | 5 | 12 | 3 | 4 | 413 | 851 | 952 | 720 |
| Okla. | 3 | 9 | 59 | 54 | 454 | 369 | 375 | 286 |
| Tex. | 1 | 46 | 2,000 | 774 | 1,874 | 2,810 | 1,118 | 1,323 |
| MOUNTAIN | 57 | 50 | 231 | 262 | 2,031 | 2,579 | 1,666 | 2,377 |
| Mont. | 3 | 1 | 38 | 64 | 72 | 90 | - | - |
| Idaho | 3 | 4 | 28 | 9 | 134 | 121 | 4 | 109 |
| Wyo. | - | - | 20 | 56 | 55 | 67 | 52 | 58 |
| Colo. | 22 | 24 | - | - | 552 | 664 | 566 | 646 |
| N. Mex. | 3 | - | 14 | 20 | 270 | 222 | 235 | 201 |
| Ariz. | 13 | 9 | 115 | 94 | 588 | 701 | 594 | 723 |
| Utah | 4 | 6 | 15 | 10 | 209 | 462 | 192 | 459 |
| Nev. | 9 | 6 | 1 | 9 | 151 | 252 | 23 | 181 |
| PACIFIC | 203 | 255 | 334 | 303 | 4,735 | 5,095 | 3,673 | 4,741 |
| Wash. | 13 | 32 | - | - | 505 | 554 | 491 | 630 |
| Oreg. | 14 | 39 | 3 | 7 | 227 | 276 | 298 | 339 |
| Calif. | 166 | 174 | 294 | 268 | 3,617 | 3,988 | 2,526 | 3,511 |
| Alaska | 1 | - | 37 | 28 | 45 | 56 | 28 | 33 |
| Hawaii | 9 | 10 | - | - | 341 | 221 | 330 | 228 |
| Guam | - | 2 | - | - | - | 26 | U | U |
| P.R. | 4 | 5 | 85 | 74 | 515 | 652 | U | U |
| V.I. | - | - | - | - | - | - | U | U |
| Amer. Samoa | U | U | U | U | U | U | U | U |
| C.N.M.I. | - | U | - | U | 14 | U | U | U |

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

† Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

## TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending December 1, 2001, and December 2, 2000 (48th Week)*

| Reporting Area | Shigellosis† NETSS Cum. 2001 | Shigellosis† NETSS Cum. 2000 | Shigellosis† PHLIS Cum. 2001 | Shigellosis† PHLIS Cum. 2000 | Syphilis (Primary & Secondary) Cum. 2001 | Syphilis (Primary & Secondary) Cum. 2000 | Tuberculosis Cum. 2001 | Tuberculosis Cum. 2000 |
|---|---|---|---|---|---|---|---|---|
| UNITED STATES | 16,403 | 20,887 | 7,413 | 11,921 | 5,380 | 5,573 | 11,200 | 13,217 |
| NEW ENGLAND | 257 | 383 | 274 | 362 | 59 | 80 | 373 | 390 |
| Maine | 6 | 10 | 3 | 11 | 1 | 1 | 3 | 16 |
| N.H. | 6 | 6 | 4 | 8 | 1 | 2 | 16 | 18 |
| Vt. | 7 | 4 | 5 | - | 3 | - | 4 | 4 |
| Mass. | 194 | 268 | 184 | 245 | 35 | 57 | 219 | 222 |
| R.I. | 22 | 30 | 26 | 32 | 9 | 4 | 36 | 30 |
| Conn. | 22 | 65 | 52 | 66 | 10 | 16 | 95 | 100 |
| MID. ATLANTIC | 1,157 | 2,579 | 713 | 1,634 | 444 | 259 | 2,137 | 2,107 |
| Upstate N.Y. | 458 | 726 | 113 | 211 | 24 | 10 | 337 | 300 |
| N.Y. City | 329 | 907 | 351 | 612 | 255 | 111 | 1,078 | 1,111 |
| N.J. | 185 | 489 | 184 | 421 | 129 | 65 | 458 | 501 |
| Pa. | 185 | 457 | 65 | 390 | 36 | 73 | 264 | 195 |
| E.N. CENTRAL | 3,996 | 3,938 | 1,707 | 1,220 | 934 | 1,129 | 1,233 | 1,344 |
| Ohio | 2,727 | 382 | 1,135 | 305 | 71 | 66 | 243 | 254 |
| Ind. | 216 | 1,481 | 42 | 151 | 147 | 331 | 100 | 133 |
| Ill. | 497 | 1,125 | 288 | 130 | 318 | 394 | 571 | 652 |
| Mich. | 286 | 633 | 215 | 579 | 376 | 294 | 243 | 228 |
| Wis. | 270 | 317 | 27 | 55 | 22 | 44 | 76 | 77 |
| W.N. CENTRAL | 1,857 | 2,318 | 1,255 | 1,931 | 80 | 62 | 423 | 484 |
| Minn. | 435 | 752 | 440 | 842 | 28 | 15 | 214 | 153 |
| Iowa | 356 | 508 | 290 | 336 | 4 | 11 | 34 | 33 |
| Mo. | 307 | 631 | 210 | 451 | 20 | 28 | 128 | 182 |
| N. Dak. | 21 | 42 | 34 | 49 | - | - | 3 | 2 |
| S. Dak. | 583 | 7 | 246 | 4 | - | - | 12 | 16 |
| Nebr. | 86 | 143 | - | 116 | 5 | 2 | 32 | 23 |
| Kans. | 69 | 235 | 35 | 133 | 23 | 6 | - | 75 |
| S. ATLANTIC | 2,327 | 2,784 | 740 | 1,109 | 1,826 | 1,862 | 2,315 | 2,658 |
| Del. | 15 | 24 | 12 | 21 | 12 | 8 | 15 | 14 |
| Md. | 144 | 182 | 91 | 109 | 236 | 291 | 211 | 232 |
| D.C. | 53 | 77 | U | U | 34 | 36 | 51 | 35 |
| Va. | 440 | 434 | 175 | 339 | 102 | 123 | 241 | 240 |
| W. Va. | 8 | 18 | 8 | 11 | 4 | 3 | 26 | 28 |
| N.C. | 318 | 363 | 170 | 254 | 414 | 449 | 324 | 362 |
| S.C. | 244 | 134 | 120 | 89 | 212 | 210 | 164 | 238 |
| Ga. | 368 | 247 | 130 | 181 | 348 | 360 | 437 | 561 |
| Fla. | 737 | 1,305 | 34 | 105 | 464 | 382 | 846 | 948 |
| E.S. CENTRAL | 1,505 | 1,126 | 570 | 550 | 607 | 812 | 749 | 834 |
| Ky. | 699 | 488 | 300 | 111 | 43 | 80 | 109 | 113 |
| Tenn. | 97 | 337 | 110 | 362 | 309 | 485 | 273 | 307 |
| Ala. | 201 | 90 | 130 | 70 | 125 | 115 | 246 | 279 |
| Miss. | 508 | 211 | 30 | 7 | 130 | 132 | 121 | 135 |
| W.S. CENTRAL | 2,167 | 3,313 | 1,146 | 1,085 | 694 | 776 | 783 | 1,925 |
| Ark. | 531 | 198 | 155 | 58 | 39 | 100 | 146 | 167 |
| La. | 145 | 277 | 166 | 182 | 160 | 199 | - | 213 |
| Okla. | 89 | 117 | 36 | 44 | 60 | 112 | 125 | 137 |
| Tex. | 1,402 | 2,721 | 789 | 801 | 435 | 365 | 512 | 1,408 |
| MOUNTAIN | 906 | 1,175 | 675 | 814 | 216 | 215 | 467 | 473 |
| Mont. | 8 | 7 | - | - | - | - | 14 | 17 |
| Idaho | 40 | 44 | - | 25 | 1 | 1 | 8 | 8 |
| Wyo. | 3 | 5 | 5 | 3 | 1 | 1 | 3 | 4 |
| Colo. | 233 | 252 | 255 | 205 | 22 | 8 | 112 | 74 |
| N. Mex. | 115 | 157 | 79 | 108 | 17 | 16 | 24 | 40 |
| Ariz. | 383 | 514 | 275 | 326 | 159 | 183 | 210 | 199 |
| Utah | 58 | 76 | 53 | 81 | 8 | 1 | 33 | 41 |
| Nev. | 66 | 120 | 8 | 66 | 8 | 5 | 63 | 90 |
| PACIFIC | 2,231 | 3,271 | 333 | 3,216 | 520 | 378 | 2,720 | 3,002 |
| Wash. | 202 | 434 | 167 | 399 | 43 | 60 | 220 | 235 |
| Oreg. | 86 | 163 | 104 | 109 | 13 | 11 | 103 | 90 |
| Calif. | 1,876 | 2,633 | - | 2,673 | 452 | 305 | 2,214 | 2,451 |
| Alaska | 7 | 7 | 6 | 3 | - | - | 47 | 101 |
| Hawaii | 60 | 34 | 56 | 32 | 12 | 2 | 136 | 125 |
| Guam | - | 38 | U | U | - | 3 | - | 50 |
| P.R. | 8 | 33 | U | U | 249 | 154 | 76 | 152 |
| V.I. | - | - | U | U | - | - | - | - |
| Amer. Samoa | U | U | U | U | U | U | U | U |
| C.N.M.I. | 7 | U | U | U | 10 | U | 32 | U |

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

† Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

# TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending December 1, 2001, and December 2, 2000 (48th Week)*

| | *H. influenzae,* Invasive | | Hepatitis (Viral), By Type | | | | Measles (Rubeola) | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | A | | B | | Indigenous | | Imported† | | Total | |
| Reporting Area | Cum. 2001§ | Cum. 2000 | Cum. 2001 | Cum. 2000 | Cum. 2001 | Cum. 2000 | 2001 | Cum. 2001 | 2001 | Cum. 2001 | Cum. 2001 | Cum. 2000 |
| UNITED STATES | 1,229 | 1,194 | 9,310 | 12,070 | 5,962 | 6,520 | - | 52 | - | 43 | 95 | 75 |
| NEW ENGLAND | 88 | 100 | 642 | 368 | 95 | 105 | - | 4 | - | 1 | 5 | 6 |
| Maine | 2 | 1 | 11 | 21 | 5 | 5 | - | - | - | - | - | - |
| N.H. | 6 | 12 | 18 | 18 | 16 | 16 | - | - | - | - | - | 3 |
| Vt. | 4 | 9 | 16 | 10 | 4 | 6 | - | 1 | - | - | 1 | 3 |
| Mass. | 41 | 40 | 307 | 128 | 11 | 15 | - | 2 | - | 1 | 3 | - |
| R.I. | 5 | 4 | 66 | 24 | 28 | 22 | - | - | - | - | - | - |
| Conn. | 30 | 34 | 224 | 167 | 31 | 41 | - | 1 | - | - | 1 | - |
| MID. ATLANTIC | 179 | 217 | 886 | 1,421 | 917 | 1,082 | - | 5 | - | 11 | 16 | 21 |
| Upstate N.Y. | 71 | 93 | 256 | 240 | 121 | 123 | - | 1 | - | 4 | 5 | 10 |
| N.Y. City | 46 | 59 | 281 | 479 | 397 | 527 | - | 3 | - | 1 | 4 | 10 |
| N.J. | 42 | 38 | 159 | 273 | 169 | 168 | - | - | - | 1 | 1 | - |
| Pa. | 20 | 27 | 190 | 429 | 230 | 264 | - | 1 | - | 5 | 6 | 1 |
| E.N. CENTRAL | 202 | 167 | 1,086 | 1,564 | 833 | 691 | - | - | - | 10 | 10 | 8 |
| Ohio | 56 | 51 | 213 | 245 | 84 | 98 | - | - | - | 3 | 3 | 2 |
| Ind. | 46 | 28 | 95 | 111 | 47 | 46 | - | - | - | 4 | 4 | - |
| Ill. | 62 | 56 | 403 | 666 | 149 | 108 | - | - | - | 3 | 3 | 3 |
| Mich. | 13 | 11 | 308 | 461 | 553 | 400 | - | - | - | - | - | 3 |
| Wis. | 25 | 21 | 67 | 81 | - | 39 | - | - | - | - | - | - |
| W.N. CENTRAL | 64 | 74 | 385 | 622 | 201 | 274 | - | 4 | - | 1 | 5 | 2 |
| Minn. | 39 | 42 | 41 | 171 | 28 | 35 | - | 2 | - | 1 | 3 | 1 |
| Iowa | - | - | 37 | 63 | 25 | 32 | - | - | - | - | - | - |
| Mo. | 15 | 22 | 103 | 248 | 103 | 134 | - | 2 | - | - | 2 | - |
| N. Dak. | 7 | 2 | 3 | 3 | 1 | 2 | - | - | - | - | - | - |
| S. Dak. | - | 1 | 3 | 2 | 1 | 1 | - | - | - | - | - | - |
| Nebr. | 2 | 3 | 32 | 32 | 25 | 44 | - | - | - | - | - | - |
| Kans. | 1 | 4 | 166 | 103 | 18 | 26 | - | - | - | - | - | 1 |
| S. ATLANTIC | 348 | 260 | 2,174 | 1,341 | 1,364 | 1,189 | - | 4 | - | 1 | 5 | 4 |
| Del. | - | - | - | 15 | - | 14 | - | - | - | - | - | - |
| Md. | 84 | 75 | 276 | 186 | 132 | 114 | - | 2 | - | 1 | 3 | - |
| D.C. | - | - | 52 | 24 | 11 | 29 | - | - | - | - | - | - |
| Va. | 27 | 37 | 127 | 147 | 170 | 156 | - | 1 | - | - | 1 | 2 |
| W. Va. | 14 | 8 | 25 | 53 | 20 | 19 | - | - | - | - | - | - |
| N.C. | 44 | 23 | 206 | 131 | 200 | 236 | - | - | - | - | - | - |
| S.C. | 9 | 7 | 71 | 77 | 29 | 21 | - | - | - | - | - | - |
| Ga. | 97 | 65 | 865 | 283 | 442 | 220 | - | 1 | - | - | 1 | - |
| Fla. | 73 | 45 | 552 | 425 | 360 | 380 | - | - | - | - | - | 2 |
| E.S. CENTRAL | 70 | 47 | 366 | 369 | 390 | 439 | - | 2 | - | - | 2 | - |
| Ky. | 2 | 12 | 123 | 47 | 41 | 73 | - | 2 | - | - | 2 | - |
| Tenn. | 40 | 21 | 145 | 133 | 216 | 204 | - | - | - | - | - | - |
| Ala. | 26 | 12 | 71 | 48 | 79 | 60 | - | - | - | - | - | - |
| Miss. | 2 | 2 | 27 | 141 | 54 | 102 | - | - | - | - | - | - |
| W.S. CENTRAL | 47 | 63 | 1,273 | 2,272 | 661 | 1,026 | - | - | - | 1 | 1 | - |
| Ark. | 1 | 2 | 66 | 127 | 95 | 92 | - | - | - | - | - | - |
| La. | 6 | 16 | 61 | 90 | 45 | 144 | - | - | - | - | - | - |
| Okla. | 39 | 43 | 113 | 245 | 106 | 148 | - | - | - | - | - | - |
| Tex. | 1 | 2 | 1,033 | 1,810 | 415 | 642 | - | - | - | 1 | 1 | - |
| MOUNTAIN | 133 | 123 | 687 | 870 | 449 | 496 | - | 2 | - | - | 2 | 12 |
| Mont. | - | 1 | 11 | 7 | 3 | 6 | - | - | - | - | - | - |
| Idaho | 2 | 4 | 57 | 33 | 11 | 6 | - | 1 | - | - | 1 | - |
| Wyo. | - | 1 | 7 | 4 | 3 | 3 | - | - | - | - | - | - |
| Colo. | 37 | 31 | 86 | 196 | 99 | 95 | - | - | - | - | - | 2 |
| N. Mex. | 22 | 24 | 37 | 69 | 128 | 131 | - | - | - | - | - | - |
| Ariz. | 54 | 45 | 365 | 424 | 136 | 184 | - | 1 | - | - | 1 | - |
| Utah | 8 | 11 | 68 | 59 | 26 | 24 | - | - | - | - | - | 3 |
| Nev. | 10 | 6 | 56 | 78 | 43 | 47 | - | - | - | - | - | 7 |
| PACIFIC | 98 | 143 | 1,811 | 3,243 | 1,052 | 1,218 | - | 31 | - | 18 | 49 | 22 |
| Wash. | 5 | 7 | 140 | 268 | 133 | 107 | - | 13 | - | 2 | 15 | 3 |
| Oreg. | 19 | 32 | 74 | 161 | 111 | 113 | - | 4 | - | - | 4 | - |
| Calif. | 44 | 35 | 1,580 | 2,788 | 782 | 975 | - | 12 | - | 11 | 23 | 15 |
| Alaska | 6 | 45 | 14 | 13 | 9 | 11 | - | - | - | - | - | 1 |
| Hawaii | 24 | 24 | 3 | 13 | 17 | 12 | - | 2 | - | 5 | 7 | 3 |
| Guam | - | 1 | - | 1 | - | 10 | - | - | - | - | - | - |
| P.R. | 1 | 4 | 119 | 234 | 176 | 275 | - | - | - | - | - | 2 |
| V.I. | - | - | - | - | - | - | - | - | - | - | - | - |
| Amer. Samoa | U | U | U | U | U | U | U | U | U | U | U | U |
| C.N.M.I. | - | U | - | U | 35 | U | U | - | U | - | - | U |

N: Not notifiable. U: Unavailable. - : No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

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

§ Of 257 cases among children aged <5 years, serotype was reported for 121, and of those, 21 were type b.

**TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending December 1, 2001, and December 2, 2000 (48th Week)***

| Reporting Area | Meningococcal Disease Cum. 2001 | Meningococcal Disease Cum. 2000 | Mumps 2001 | Mumps Cum. 2001 | Mumps Cum. 2000 | Pertussis 2001 | Pertussis Cum. 2001 | Pertussis Cum. 2000 | Rubella 2001 | Rubella Cum. 2001 | Rubella Cum. 2000 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| UNITED STATES | 2,041 | 2,009 | 3 | 201 | 299 | 82 | 4,394 | 6,600 | - | 20 | 165 |
| NEW ENGLAND | 106 | 118 | - | - | 4 | 4 | 415 | 1,789 | - | - | 12 |
| Maine | 4 | 8 | - | - | - | - | 21 | 45 | - | - | - |
| N.H. | 13 | 12 | - | - | - | - | 38 | 126 | - | - | 2 |
| Vt. | 6 | 3 | - | - | - | 3 | 36 | 236 | - | - | - |
| Mass. | 54 | 68 | - | - | 1 | - | 297 | 1,318 | - | - | 8 |
| R.I. | 6 | 9 | - | - | 1 | 1 | 6 | 19 | - | - | 1 |
| Conn. | 23 | 18 | - | - | 2 | - | 17 | 45 | - | - | 1 |
| MID. ATLANTIC | 203 | 238 | - | 20 | 26 | 2 | 265 | 654 | - | 5 | 9 |
| Upstate N.Y. | 59 | 72 | - | 3 | 10 | 2 | 133 | 326 | - | 1 | 1 |
| N.Y. City | 40 | 41 | - | 10 | 7 | - | 44 | 82 | - | 3 | 8 |
| N.J. | 49 | 49 | - | 3 | 3 | - | 18 | 30 | - | 1 | - |
| Pa. | 55 | 76 | - | 4 | 6 | - | 70 | 216 | - | - | - |
| E.N. CENTRAL | 295 | 362 | - | 19 | 22 | 7 | 605 | 774 | - | 3 | 1 |
| Ohio | 75 | 87 | - | 1 | 7 | 2 | 235 | 318 | - | - | - |
| Ind. | 37 | 41 | - | 3 | 1 | 1 | 80 | 111 | - | 1 | - |
| Ill. | 70 | 82 | - | 11 | 6 | 2 | 71 | 113 | - | 2 | 1 |
| Mich. | 66 | 110 | - | 4 | 6 | 2 | 132 | 111 | - | - | - |
| Wis. | 47 | 42 | - | - | 2 | - | 87 | 121 | - | - | - |
| W.N. CENTRAL | 145 | 146 | 1 | 11 | 17 | 23 | 345 | 564 | - | 3 | 2 |
| Minn. | 22 | 21 | - | 3 | - | 21 | 167 | 343 | - | - | 1 |
| Iowa | 29 | 34 | - | - | 7 | 1 | 43 | 56 | - | 1 | - |
| Mo. | 49 | 66 | - | 2 | 4 | - | 92 | 85 | - | 1 | - |
| N. Dak. | 6 | 2 | - | - | 1 | - | 5 | 6 | - | - | - |
| S. Dak. | 5 | 5 | - | - | - | - | 4 | 7 | - | - | - |
| Nebr. | 20 | 7 | - | 1 | 2 | - | 7 | 27 | - | - | 1 |
| Kans. | 14 | 11 | 1 | 5 | 3 | 1 | 27 | 40 | - | 1 | - |
| S. ATLANTIC | 347 | 268 | 1 | 37 | 44 | 9 | 247 | 478 | - | 7 | 112 |
| Del. | 5 | 1 | - | - | - | - | - | 9 | - | 1 | 1 |
| Md. | 40 | 26 | 1 | 7 | 9 | - | 38 | 114 | - | - | - |
| D.C. | - | - | - | - | - | - | 1 | 3 | - | - | - |
| Va. | 38 | 39 | - | 8 | 10 | 8 | 49 | 106 | - | - | - |
| W. Va. | 13 | 13 | - | - | - | - | 4 | 1 | - | - | - |
| N.C. | 62 | 36 | - | 5 | 7 | 1 | 70 | 108 | - | - | 82 |
| S.C. | 34 | 22 | - | 5 | 11 | - | 32 | 35 | - | 2 | 27 |
| Ga. | 48 | 45 | - | 7 | 2 | - | 27 | 40 | - | 1 | - |
| Fla. | 107 | 86 | - | 5 | 5 | - | 26 | 62 | - | 3 | 2 |
| E.S. CENTRAL | 123 | 127 | - | 9 | 5 | 2 | 149 | 108 | - | - | 6 |
| Ky. | 21 | 26 | - | 3 | 1 | 2 | 52 | 55 | - | - | 1 |
| Tenn. | 56 | 53 | - | 1 | 2 | - | 57 | 32 | - | - | 1 |
| Ala. | 31 | 34 | - | - | 2 | - | 36 | 18 | - | - | 4 |
| Miss. | 15 | 14 | - | 5 | - | - | 4 | 3 | - | - | - |
| W.S. CENTRAL | 322 | 214 | 1 | 14 | 32 | 14 | 470 | 351 | - | 1 | 8 |
| Ark. | 19 | 13 | - | 1 | 3 | - | 45 | 36 | - | - | 1 |
| La. | 65 | 43 | - | 2 | 5 | - | 3 | 20 | - | - | 1 |
| Okla. | 28 | 27 | - | - | - | - | 27 | 47 | - | - | - |
| Tex. | 210 | 131 | 1 | 11 | 24 | 14 | 395 | 248 | - | 1 | 6 |
| MOUNTAIN | 88 | 94 | - | 13 | 21 | 19 | 1,248 | 755 | - | - | 2 |
| Mont. | 4 | 4 | - | 1 | 1 | - | 37 | 35 | - | - | - |
| Idaho | 7 | 7 | - | 1 | 1 | - | 170 | 61 | - | - | - |
| Wyo. | 5 | 1 | - | 1 | 1 | - | 1 | 4 | - | - | - |
| Colo. | 34 | 32 | - | 3 | 1 | 11 | 283 | 453 | - | - | 1 |
| N. Mex. | 10 | 11 | - | 2 | 1 | 2 | 137 | 88 | - | - | - |
| Ariz. | 13 | 29 | - | 1 | 4 | - | 509 | 75 | - | - | 1 |
| Utah | 8 | 7 | - | 1 | 6 | - | 76 | 24 | - | - | - |
| Nev. | 7 | 3 | - | 3 | 6 | 6 | 35 | 15 | - | - | - |
| PACIFIC | 412 | 442 | - | 78 | 128 | 2 | 650 | 1,127 | - | 1 | 13 |
| Wash. | 60 | 56 | - | 2 | 10 | 2 | 161 | 391 | - | - | 7 |
| Oreg. | 41 | 66 | N | N | N | - | 51 | 106 | - | - | - |
| Calif. | 295 | 303 | - | 39 | 87 | - | 395 | 569 | - | - | 6 |
| Alaska | 3 | 9 | - | 1 | 8 | - | 11 | 21 | - | - | - |
| Hawaii | 13 | 8 | - | 36 | 23 | - | 32 | 40 | - | 1 | - |
| Guam | - | - | - | - | 16 | - | - | 4 | - | - | 1 |
| P.R. | 4 | 10 | - | - | - | - | 2 | 9 | - | - | - |
| V.I. | - | - | - | - | - | - | - | - | - | - | - |
| Amer. Samoa | U | U | U | U | U | U | U | U | U | U | U |
| C.N.M.I. | - | U | U | - | U | U | - | U | U | - | U |

N: Not notifiable. U: Unavailable. - : No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

# TABLE IV. Deaths in 122 U.S. cities,* week ending December 1, 2001 (48th Week)

| Reporting Area | All Causes, By Age (Years) | | | | | | P&I† Total |
|---|---|---|---|---|---|---|---|
| | All Ages | ≥65 | 45-64 | 25-44 | 1-24 | <1 | |
| NEW ENGLAND | 417 | 327 | 56 | 23 | 8 | 3 | 27 |
| Boston, Mass. | U | U | U | U | U | U | U |
| Bridgeport, Conn. | 34 | 28 | 4 | 2 | - | - | 3 |
| Cambridge, Mass. | 18 | 14 | 3 | 1 | - | - | - |
| Fall River, Mass. | 30 | 28 | 2 | - | - | - | 2 |
| Hartford, Conn. | U | U | U | U | U | U | U |
| Lowell, Mass. | 19 | 12 | 6 | - | 1 | - | - |
| Lynn, Mass. | 16 | 9 | 2 | 5 | - | - | 1 |
| New Bedford, Mass. | 42 | 38 | 3 | 1 | - | - | 4 |
| New Haven, Conn. | 54 | 42 | 5 | 4 | 1 | 2 | 4 |
| Providence, R.I. | 67 | 48 | 12 | 6 | 1 | - | - |
| Somerville, Mass. | 7 | 6 | 1 | - | - | - | - |
| Springfield, Mass. | 27 | 18 | 4 | 2 | 3 | - | - |
| Waterbury, Conn. | 24 | 22 | 1 | 1 | - | - | 5 |
| Worcester, Mass. | 79 | 62 | 13 | 1 | 2 | 1 | 8 |
| MID. ATLANTIC | 2,556 | 1,699 | 532 | 227 | 62 | 33 | 123 |
| Albany, N.Y. | 51 | 33 | 11 | 5 | 1 | 1 | 8 |
| Allentown, Pa. | 21 | 17 | 4 | - | - | - | 1 |
| Buffalo, N.Y. | 94 | 62 | 23 | 6 | 2 | 1 | 8 |
| Camden, N.J. | 42 | 28 | 8 | 5 | 1 | - | 1 |
| Elizabeth, N.J. | 16 | 11 | 5 | - | - | - | - |
| Erie, Pa.§ | 51 | 40 | 5 | 6 | - | - | - |
| Jersey City, N.J. | 29 | 16 | 8 | 4 | - | 1 | - |
| New York City, N.Y. | 1,449 | 918 | 324 | 149 | 37 | 18 | 51 |
| Newark, N.J. | U | U | U | U | U | U | U |
| Paterson, N.J. | 19 | 11 | 4 | 3 | - | 1 | 1 |
| Philadelphia, Pa. | 364 | 238 | 72 | 35 | 14 | 5 | 21 |
| Pittsburgh, Pa.§ | 42 | 31 | 9 | 1 | - | 1 | 1 |
| Reading, Pa. | 23 | 18 | 5 | - | - | - | 2 |
| Rochester, N.Y. | 192 | 149 | 28 | 7 | 6 | 2 | 15 |
| Schenectady, N.Y. | 27 | 20 | 5 | 2 | - | - | 2 |
| Scranton, Pa.§ | 36 | 32 | 3 | 1 | - | - | 1 |
| Syracuse, N.Y. | 66 | 48 | 13 | 2 | 1 | 2 | 10 |
| Trenton, N.J. | 15 | 10 | 3 | 1 | - | 1 | - |
| Utica, N.Y. | 19 | 17 | 2 | - | - | - | 1 |
| Yonkers, N.Y. | U | U | U | U | U | U | U |
| E.N. CENTRAL | 2,032 | 1,423 | 389 | 124 | 41 | 55 | 137 |
| Akron, Ohio | 63 | 43 | 16 | 3 | - | 1 | 8 |
| Canton, Ohio | 47 | 33 | 9 | 1 | 3 | 1 | 5 |
| Chicago, Ill. | U | U | U | U | U | U | U |
| Cincinnati, Ohio | 119 | 84 | 24 | 8 | 2 | 1 | 9 |
| Cleveland, Ohio | 146 | 96 | 34 | 11 | 3 | 2 | 11 |
| Columbus, Ohio | 211 | 139 | 45 | 15 | 4 | 8 | 7 |
| Dayton, Ohio | 160 | 127 | 20 | 9 | 3 | 1 | 12 |
| Detroit, Mich. | 236 | 135 | 58 | 22 | 5 | 16 | 14 |
| Evansville, Ind. | 55 | 42 | 9 | 3 | 1 | - | 3 |
| Fort Wayne, Ind. | 82 | 62 | 11 | 5 | 2 | 2 | 4 |
| Gary, Ind. | 39 | 21 | 8 | 5 | 4 | 1 | 2 |
| Grand Rapids, Mich. | 82 | 55 | 14 | 4 | 1 | 8 | 4 |
| Indianapolis, Ind. | 239 | 169 | 50 | 9 | 3 | 8 | 18 |
| Lansing, Mich. | 62 | 43 | 10 | 6 | 2 | 1 | 5 |
| Milwaukee, Wis. | 127 | 89 | 23 | 9 | 4 | 2 | 11 |
| Peoria, Ill. | 54 | 38 | 11 | 3 | 1 | 1 | 8 |
| Rockford, Ill. | 77 | 61 | 10 | 4 | 2 | - | 6 |
| South Bend, Ind. | 75 | 66 | 8 | 1 | - | - | 2 |
| Toledo, Ohio | 87 | 62 | 18 | 4 | 1 | 2 | 7 |
| Youngstown, Ohio | 71 | 58 | 11 | 2 | - | - | 1 |
| W.N. CENTRAL | 797 | 580 | 127 | 42 | 22 | 26 | 46 |
| Des Moines, Iowa | 49 | 42 | 7 | - | - | - | 8 |
| Duluth, Minn. | 37 | 32 | 4 | 1 | - | - | 4 |
| Kansas City, Kans. | 53 | 30 | 15 | 4 | 2 | 2 | 2 |
| Kansas City, Mo. | 58 | 43 | 7 | 5 | 1 | 2 | 2 |
| Lincoln, Nebr. | 50 | 38 | 7 | 3 | 1 | 1 | 1 |
| Minneapolis, Minn. | 149 | 109 | 26 | 8 | 3 | 3 | 12 |
| Omaha, Nebr. | 93 | 73 | 9 | 1 | 5 | 5 | 5 |
| St. Louis, Mo. | 116 | 70 | 24 | 10 | 7 | 5 | - |
| St. Paul, Minn. | 87 | 76 | 6 | 2 | 1 | 2 | 6 |
| Wichita, Kans. | 105 | 67 | 22 | 8 | 2 | 6 | 6 |

| Reporting Area | All Causes, By Age (Years) | | | | | | P&I† Total |
|---|---|---|---|---|---|---|---|
| | All Ages | ≥65 | 45-64 | 25-44 | 1-24 | <1 | |
| S. ATLANTIC | 1,304 | 851 | 280 | 115 | 26 | 32 | 84 |
| Atlanta, Ga. | 143 | 79 | 34 | 19 | 4 | 7 | 3 |
| Baltimore, Md. | 131 | 83 | 28 | 17 | 1 | 2 | 13 |
| Charlotte, N.C. | 142 | 96 | 29 | 12 | 2 | 3 | 15 |
| Jacksonville, Fla. | 203 | 132 | 39 | 18 | 8 | 6 | 20 |
| Miami, Fla. | 163 | 116 | 28 | 17 | 1 | 1 | 12 |
| Norfolk, Va. | 61 | 43 | 11 | 3 | 1 | 3 | 1 |
| Richmond, Va. | 61 | 35 | 16 | 3 | 2 | 5 | 4 |
| Savannah, Ga. | 47 | 34 | 8 | 2 | 1 | 2 | 4 |
| St. Petersburg, Fla. | 61 | 45 | 10 | 4 | 1 | 1 | 5 |
| Tampa, Fla. | 180 | 124 | 40 | 11 | 3 | 2 | 7 |
| Washington, D.C. | 100 | 55 | 34 | 9 | 2 | - | - |
| Wilmington, Del. | 12 | 9 | 3 | - | - | - | - |
| E.S. CENTRAL | 937 | 645 | 200 | 50 | 21 | 20 | 75 |
| Birmingham, Ala. | 162 | 109 | 37 | 8 | 3 | 4 | 18 |
| Chattanooga, Tenn. | 73 | 55 | 13 | 3 | 2 | - | 3 |
| Knoxville, Tenn. | 107 | 78 | 20 | 5 | 3 | 1 | 7 |
| Lexington, Ky. | 101 | 66 | 26 | 3 | - | 6 | 13 |
| Memphis, Tenn. | 152 | 103 | 32 | 9 | 7 | 1 | 14 |
| Mobile, Ala. | 148 | 96 | 34 | 12 | 4 | 2 | 6 |
| Montgomery, Ala. | 40 | 31 | 7 | 2 | - | - | 7 |
| Nashville, Tenn. | 154 | 107 | 31 | 8 | 2 | 6 | 7 |
| W.S. CENTRAL | 1,794 | 1,115 | 412 | 151 | 70 | 46 | 104 |
| Austin, Tex. | 133 | 79 | 29 | 13 | 5 | 7 | 5 |
| Baton Rouge, La. | 128 | 88 | 26 | 4 | 8 | 2 | 5 |
| Corpus Christi, Tex. | 57 | 36 | 16 | 1 | 1 | 3 | 1 |
| Dallas, Tex. | 283 | 161 | 77 | 24 | 9 | 12 | 15 |
| El Paso, Tex. | 97 | 71 | 16 | 8 | 2 | - | 6 |
| Ft. Worth, Tex. | 121 | 77 | 22 | 9 | 9 | 4 | 5 |
| Houston, Tex. | 407 | 241 | 101 | 40 | 17 | 8 | 26 |
| Little Rock, Ark. | 65 | 37 | 18 | 4 | 5 | 1 | 2 |
| New Orleans, La. | U | U | U | U | U | U | U |
| San Antonio, Tex. | 285 | 184 | 60 | 28 | 7 | 6 | 16 |
| Shreveport, La. | 65 | 49 | 10 | 3 | 3 | - | 9 |
| Tulsa, Okla. | 153 | 92 | 37 | 17 | 4 | 3 | 14 |
| MOUNTAIN | 1,203 | 804 | 255 | 87 | 26 | 24 | 84 |
| Albuquerque, N.M. | 175 | 110 | 40 | 14 | 4 | 3 | 12 |
| Boise, Idaho | 41 | 33 | 7 | 1 | - | - | 3 |
| Colo. Springs, Colo. | 51 | 42 | 5 | 3 | - | 1 | 4 |
| Denver, Colo. | 100 | 60 | 23 | 11 | 3 | 3 | 9 |
| Las Vegas, Nev. | 314 | 217 | 79 | 15 | 3 | - | 19 |
| Ogden, Utah | 47 | 35 | 9 | 2 | - | 1 | 6 |
| Phoenix, Ariz. | 142 | 78 | 36 | 13 | 7 | 5 | 8 |
| Pueblo, Colo. | 31 | 22 | 6 | 2 | 1 | - | 2 |
| Salt Lake City, Utah | 141 | 88 | 25 | 17 | 4 | 7 | 14 |
| Tucson, Ariz. | 161 | 119 | 25 | 9 | 4 | 4 | 7 |
| PACIFIC | 1,922 | 1,345 | 354 | 133 | 42 | 48 | 150 |
| Berkeley, Calif. | 12 | 11 | 1 | - | - | - | 2 |
| Fresno, Calif. | 131 | 86 | 26 | 17 | - | 2 | 5 |
| Glendale, Calif. | 28 | 20 | 5 | 3 | - | - | 3 |
| Honolulu, Hawaii | 86 | 62 | 15 | 5 | 2 | 2 | 7 |
| Long Beach, Calif. | 77 | 58 | 14 | 1 | 3 | 1 | 13 |
| Los Angeles, Calif. | 461 | 320 | 89 | 32 | 12 | 8 | 34 |
| Pasadena, Calif. | 20 | 12 | 6 | 2 | - | - | 3 |
| Portland, Oreg. | 181 | 133 | 25 | 13 | 4 | 6 | 6 |
| Sacramento, Calif. | 142 | 88 | 34 | 7 | 5 | 8 | 10 |
| San Diego, Calif. | 176 | 119 | 33 | 15 | 3 | 6 | 15 |
| San Francisco, Calif. | U | U | U | U | U | U | U |
| San Jose, Calif. | 216 | 157 | 36 | 17 | 1 | 5 | 10 |
| Santa Cruz, Calif. | 37 | 31 | 4 | 2 | - | - | 5 |
| Seattle, Wash. | 166 | 113 | 31 | 7 | 9 | 6 | 17 |
| Spokane, Wash. | 71 | 52 | 11 | 4 | 2 | 2 | 9 |
| Tacoma, Wash. | 118 | 83 | 24 | 8 | 1 | 2 | 11 |
| TOTAL | 12,962¶ | 8,789 | 2,605 | 952 | 318 | 287 | 830 |

U: Unavailable. -:No reported cases.

* Mortality data in this table are reported voluntarily 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.

## Contributors to the Production of the *MMWR* (Weekly)

### Weekly Notifiable Disease Morbidity Data and 122 Cities Mortality Data

Samuel L. Groseclose, D.V.M., M.P.H.
Wayne S. Brathwaite

***State Support Team***
Robert Fagan
Jose Aponte
Gerald Jones
David Nitschke
Scott Noldy
Jim Vaughan
Carol A. Worsham

***CDC Operations Team***
Carol M. Knowles
Deborah A. Adams
Willie J. Anderson
Lateka M. Dammond
Patsy A. Hall
Mechele A. Hester
Felicia J. Connor
Pearl Sharp

### Informatics

T. Demetri Vacalis, Ph.D.
Michele D. Renshaw
Erica R. Shaver

**The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format and on a paid subscription basis for paper copy. To receive an electronic copy on Friday of each week, send an e-mail message to *listserv@listserv.cdc.gov*. The body content should read *SUBscribe mmwr-toc*. Electronic copy also is available from CDC's World-Wide Web server at *http://www.cdc.gov/mmwr* or from CDC's file transfer protocol server at *ftp://ftp.cdc.gov/pub/Publications/mmwr*. To subscribe for paper copy, contact Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone (202) 512-1800.**

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