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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

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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.

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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.

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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 trace-back 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.

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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.

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** 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

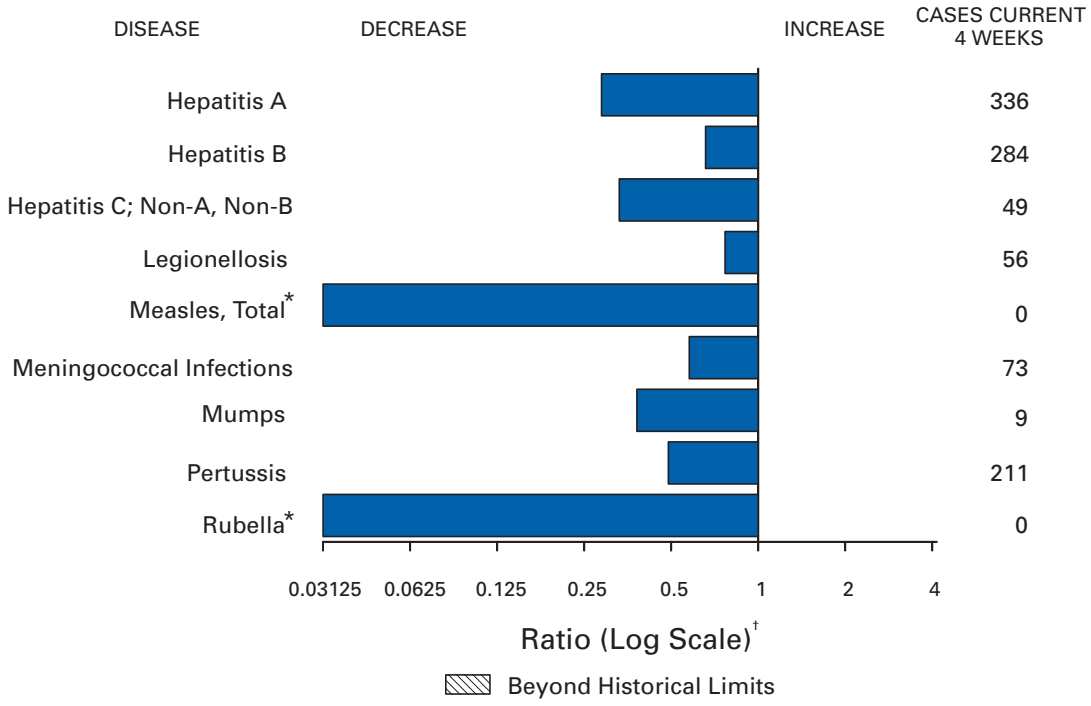
The recent bioterrorist attacks represent a national emergency that requires action by all of those responsible for public health and safety. In October and November in response to these attacks, CDC developed guidelines for anthrax treatment, prophylaxis, and exposure management that required immediate 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		Chlamydia§		Cryptosporidiosis		*Escherichia coli* O157:H7†			
							NETSS		PHLIS	
	Cum. 2001¶	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	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		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)*

Reporting Area	*H. influenzae*, Invasive		Hepatitis (Viral), By Type				Measles (Rubeola)					
			A		B		Indigenous		Imported†		Total	
	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		Mumps			Pertussis			Rubella		
	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	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
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.

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