

MMWRTM
**MORBIDITY AND MORTALITY
WEEKLY REPORT**

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Update: Investigation of Bioterrorism-Related Anthrax and Adverse Events from Antimicrobial Prophylaxis

CDC and state and local public health authorities continue to investigate cases of bioterrorism-related anthrax. As of November 7, a total of 22 cases of anthrax have been identified according to the CDC surveillance case definition; 10 were confirmed inhalational anthrax cases and 12 cases (seven confirmed and five suspected) were cutaneous anthrax (Table 1). The majority of cases have occurred in persons working at postal facilities in New Jersey (NJ) and the District of Columbia (DC) in which letters contaminated with anthrax were handled or processed using high-speed sorting machines, or at media companies in New York City (NYC) or Florida (FL) where letters, either confirmed or presumed to be contaminated with anthrax, were opened or handled. The probable exposures for a case of cutaneous anthrax in NJ and a case of inhalational anthrax in NYC remain unknown. Epidemiologic investigations of these cases and surveillance to detect new cases of bioterrorism-associated anthrax continue. This report updates the investigation of these cases and describes adverse events associated with antimicrobial prophylaxis.

Since the last report (1), one additional case of confirmed cutaneous anthrax has been identified in a 38-year-old man who worked at a media company in NYC. This is the third case of cutaneous anthrax reported among employees at the media company and is probably associated with a contaminated letter postmarked September 18 that was handled during October 12–15. On October 23, the patient noted a small nonerythematous, nonpruritic, and painless lesion on his forehead. On October 28, a physician evaluated

TABLE 1. Number of cases of anthrax, by site — September–October 2001

Site	Florida	New York City	District of Columbia	New Jersey*	Total
Inhalational					
Confirmed	2	1	5	2	10
Suspected	0	0	0	0	0
Total	2	1	5	2	10
Cutaneous					
Confirmed	0	4	0	3	7
Suspected	0	3	0	2	5
Total	0	7	0	5	12

*Includes one case each from Pennsylvania and Delaware.

Update: Investigation of Bioterrorism-Related Anthrax — Continued

the patient and described a lesion 1.4 cm in diameter, the center of which was depressed and dark gray; the same day, he was started on ciprofloxacin. A biopsy was positive for *Bacillus anthracis* by culture and immunohistochemical staining. No other new cases have been identified from investigations in FL, DC, NJ, NYC, or other areas.

Recommendations for antimicrobial prophylaxis to prevent inhalational anthrax have been directed by epidemiologic and laboratory findings. Approximately 300 postal and other facilities have been tested for *B. anthracis* spores and approximately 32,000 persons have initiated antimicrobial prophylaxis following potential exposure to *B. anthracis* at workplaces in FL, DC, NJ, and NYC. Clean-up at contaminated sites and surveillance for new anthrax cases are ongoing.

Adverse Events from Antimicrobial Prophylaxis

During October 8–10, a total of 1,132 persons from company A in Boca Raton, Florida, received initial antimicrobial prophylaxis for presumed exposure to *B. anthracis*; 970 (86%) persons received ciprofloxacin. After 14 days of prophylaxis, of 1,000 persons for whom information was available, 797 (80%) were still taking antibiotics.

A questionnaire was administered on approximately day 7 or day 14 of prophylaxis to assess adverse events in 490 (62%) persons who reported taking antibiotics. Of 490 persons, 95 (19%) reported one or more of the following symptoms: itching; breathing problems; swelling of face, neck, or throat; or seeking medical attention for any adverse events related to taking the antibiotic. Clinic record review and telephone interviews of the 95 indicated that six persons reported seeking medical attention and did not continue taking their original medication, possibly because of adverse events. A detailed questionnaire was administered to these six persons to determine the temporal association between initiation of antimicrobial prophylaxis and symptom onset, medical care received, and underlying illnesses. Two persons had been seen by a physician as outpatients, two had been seen in emergency departments, and two had been hospitalized. None of the persons had documented objective findings or clinical history attributable to adverse events, including anaphylaxis (2). Similar screening for adherence to and adverse events associated with antimicrobial prophylaxis has been initiated in DC, NJ, and NYC.

Public Health Response

CDC and local health departments continue to respond to public concern and bioterrorism threats. During October 8–31, CDC's Emergency Operations Center received 8,860 telephone inquiries from all 50 states, Puerto Rico, Guam, and 22 foreign countries. Of these, 590 (6.7%) calls were thought to represent a potential threat as defined by a report of exposure to a substance possibly associated with bioterrorism or symptoms consistent with an illness associated with bioterrorism. The 590 calls regarding potential threats were from physicians or other health-care workers (40%); local or state health departments (14%); private citizens (14%); and police, fire, or emergency response departments (7%). In response to the calls, CDC has provided information; referred to appropriate local, state, or federal agencies; assisted with clinical diagnosis or management; or initiated additional epidemiologic investigations of illnesses compatible with bioterrorism.

State and local public health agencies also are addressing public concerns and investigating potential bioterrorist threats. CDC has established a secured web-based system for states to report weekly summaries of their bioterrorism-related activities. For the week of October 21–27, Colorado, Connecticut, Louisiana, Maryland, Montana, North

Update: Investigation of Bioterrorism-Related Anthrax — Continued

Dakota, Tennessee, Wisconsin, and Wyoming reported 2,817 bioterrorism-related calls (mean per state: 313; range: 23–800) and approximately 25 investigations of bioterrorism threats in each state. From eight to 30 full-time personnel are engaged in these responses in each state.

For the same period, public health laboratories in 46 states participating in the Laboratory Response Network reported receiving approximately 7,500 specimens and isolates for *B. anthracis* testing. These specimens were primarily from environmental samples and nasal swabs.

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Editorial Note: Since the last report, one new case of confirmed cutaneous anthrax has been identified in a media company employee resulting from exposure to a previously known contaminated letter. The probable source of exposure for two cases reported last week (one cutaneous and one inhalational) has yet to be determined. Although these two cases ultimately might be attributed to letter handling, the lack of a discernable link to previous cases or workplaces raises the possibility of new routes of exposure or new target populations.

Since October 8, approximately 32,000 persons with potential exposure to *B. anthracis* in FL, NJ, NYC, and DC have initiated antimicrobial prophylaxis to prevent anthrax infection, and for approximately 5,000 persons, a 60-day course of antibiotics has been recommended. The Code of Federal Regulations* defines a serious adverse event associated with using a biologic product in humans as any of the following: death, life-threatening adverse event, inpatient hospitalization or prolongation of an existing hospitalization, persistent or substantial disability/incapacity, congenital anomaly/birth defect, or an important medical event that requires medical or surgical intervention to avert one of these outcomes. Although two persons were hospitalized in FL, their illnesses were not associated with antimicrobial prophylaxis. Efforts to contact persons who have not yet received followup are ongoing.

Adverse events associated with ciprofloxacin and doxycycline have been well-described among patients taking these medications for short-term treatment of bacterial infections. Anaphylactoid reactions caused by drug reaction have been reported rarely (3). However, few data exist regarding the use of these antimicrobials for longer periods. Because many persons are receiving antimicrobial prophylaxis, enhanced surveillance programs are essential to detect and monitor adverse events associated with these medications. Moreover, these programs will monitor adherence to the full 60-day regimen, enabling the design of better programs to promote completion of recommended prophylactic regimens.

CDC and state and local public health agencies are continuing epidemiologic and laboratory investigations of bioterrorism-related anthrax. Even without confirmed cases of anthrax, state and local health departments have responded to public concerns and

* 21 CFR 600.80.

Update: Investigation of Bioterrorism-Related Anthrax — Continued

have applied substantial personnel and laboratory resources to address anthrax issues in recent weeks. Recent cases of anthrax are attributed to intentional infection of persons and represent criminal acts that are being investigated by federal law enforcement agencies. Because new cases of anthrax may occur, public health authorities and clinicians should remain vigilant.

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Nationwide Campaign for Vaccination of Adults Against Rubella and Measles — Costa Rica, 2001

In 1999 in Costa Rica, a large rubella outbreak occurred among persons aged 15–45 years. In response, the Ministry of Health adopted the goal of eliminating rubella and congenital rubella syndrome (CRS). In 2001, a nationwide vaccination campaign reached approximately 1.6 million (>95%) persons aged 15–39 years. This report highlights successful aspects of the campaign, including effective planning, cooperation among government ministries, social mobilization, the use of house-to-house vaccination teams, daily coverage reports from local staff, vaccine safety monitoring, and strategies for ensuring a sufficient national blood supply. This campaign will strengthen measles eradication and lead to rubella and CRS elimination in Costa Rica.

In Costa Rica, measles vaccine was introduced in 1967, the combined measles-rubella (MR) vaccine in 1972, and measles-mumps-rubella (MMR) in 1986 as a single dose for children at age 12 months. Since 1992, a second dose of MMR vaccine has been recommended for children aged 7 years, and nationwide campaigns were conducted in 1992 (targeting children aged 1–4 years), 1997 (targeting children aged 1–14 years), and 1999 (targeting children aged 7–14 years) (Figure 1) (1). In 1996, a nationwide serosurvey indicated that rubella immunity was lowest (46%) among persons aged 15–24 years (2). In 1999, a rubella outbreak, in which 906 (84%) of 1,083 cases occurred among persons aged 15–45 years, prompted an MMR campaign among children aged 7–14 years (Figure 2).

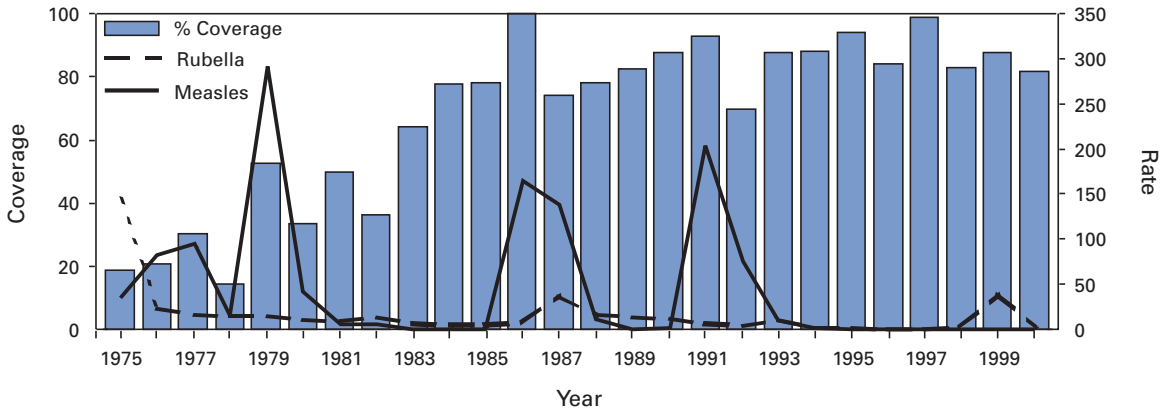
On the basis of age-specific data on the incidence of rubella, age-specific fertility rates, and the risk for CRS during pregnancy, 30 CRS cases were projected to occur following the 1999 outbreak. In response, the Ministry of Health implemented a national rubella and CRS elimination program that included MR vaccination* for persons aged 15–39 years, in accordance with World Health Organization recommendations (3–5). Measles-containing vaccine was used in this campaign to maintain elimination of measles in Costa Rica. The last confirmed case of measles was reported in September 1999.

During May 2001, the Ministry of Health and the Social Security System collaborated to vaccinate >95% of the adult population. The ministries of education and labor, worker's unions, religious leaders, community associations, student federations, university representatives, entrepreneurs, and local governments assisted with communication and

*MR vaccine manufactured by Serum Institute of India.

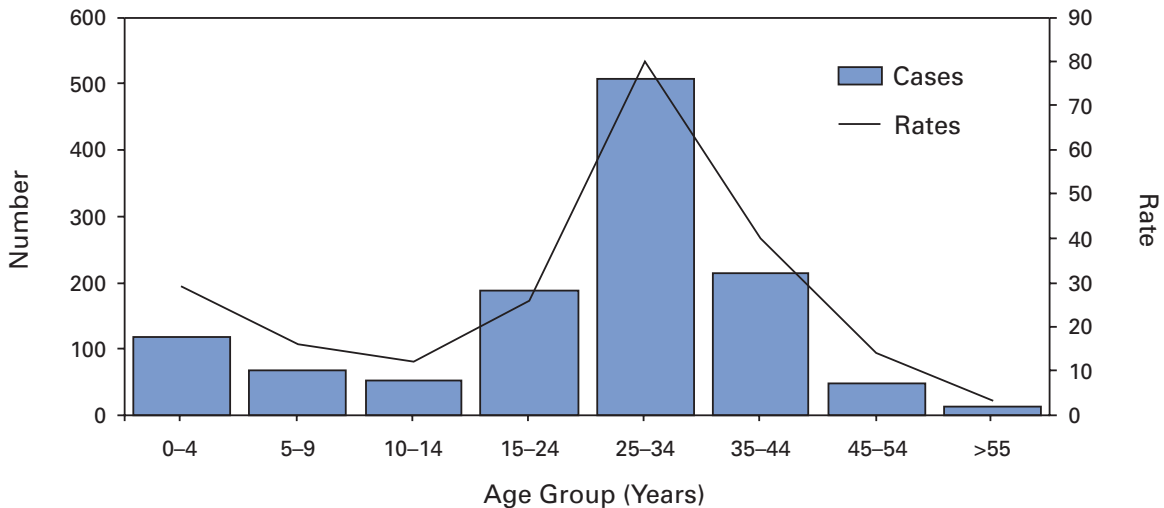
Rubella and Measles — Continued

FIGURE 1. Percentage of vaccination coverage with measles- and rubella-containing vaccines among children aged 1 year and reported measles and rubella rate*, by year — Costa Rica, 1975–2000



* Per 100,000 population.

FIGURE 2. Number and rate* of reported rubella cases, by age group — Costa Rica, 1999



* Per 100,000 population.

social mobilization. During the 2 weeks preceding the vaccination campaign, newspapers, radio, and television stations informed the targeted adults about the importance of vaccination.

During the campaign, vaccine was offered at health units and locations convenient for the target populations (e.g., malls, universities, and workplaces). In addition, mobile teams went house-to-house from sparsely populated areas to densely populated areas. Reports of doses administered were submitted daily by health units and periodically by selected workplace vaccination programs. These reports were used to estimate regional and national vaccination coverage by age group, sex, and canton (i.e., district) of residence.

Rubella and Measles — Continued

During the 4 weeks of the campaign, coverage of persons aged 15–45 years increased from 30% at the end of week 1, to 61%, 80%, and 98% for subsequent weeks, respectively. A total of 1,635,445 persons were vaccinated, representing 42% of the country's population (6,7). Vaccination coverage[†] by age group was 111% (aged 15–19 years), 92% (aged 20–24 years), 93% (aged 25–29 years), 87% (aged 30–34 years), and 106% (aged 35–39 years). Coverage was >100% in the youngest and oldest targeted age groups because of the inclusion of vaccinated persons either younger or older than the targeted age. Vaccination coverage was at least 80% in all 81 cantons and ≥95% in 60 cantons.

Vaccine safety surveillance conducted by the Social Security System using a passive reporting system detected 981 events (rate: 60 per 100,000 vaccinated persons) possibly related to vaccination, including rash (26%), lymphadenopathy (16%), fever (15%), headache (10%), and arthralgias or arthritis (10%). Of >1.6 million doses administered, health-care workers reported five needlestick injuries at the time of vaccine preparation out . Women aged 15–40 years known to be pregnant (56,634 [7%]) at the time of the campaign were not vaccinated and will be vaccinated after delivery.

Vaccinated persons were not eligible to donate blood for 1 month after vaccination, and blood donations decreased 52% in May compared with the previous 12 months. To maintain the blood supply, information about blood donation was distributed to persons not targeted for vaccination; persons aged ≥40 years had accounted for approximately 25% of blood donations before the campaign. During and immediately after the campaign, this group accounted for approximately 95% of donations. Blood donations returned to normal in July.

Surveillance for measles and rubella in Costa Rica is integrated with the surveillance of febrile rash illnesses, including dengue fever and leptospirosis. In conjunction with the MR vaccination campaign, rubella and CRS surveillance protocols were updated, laboratory capabilities for isolating and identifying rubella virus were upgraded, and training programs were conducted for staff at the national epidemiologic surveillance unit.

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Editorial Note: Adults are difficult to reach with mass vaccination campaigns possibly because vaccination usually is not considered part of adult health care. Aspects of the design and implementation of this vaccination campaign can serve as a model for other countries that want to eliminate CRS and rubella.

Complete demographic information about the target population obtained through an up-to-date census or registry is useful in assuring adequate vaccine and staff, targeting the campaign to appropriate areas, and estimating coverage. Supplemental outreach activities can reach immigrants and persons residing in remote areas.

Coordination between national authorities and local campaign organizers can avoid the occurrence of dangerously lowering blood reserves. Strategies include conducting a blood drive before the vaccination campaign, selecting a pool of donors to be vaccinated after the campaign, and offering incentives for blood donation among persons aged 40–60 years. Safety data should be gathered in a timely fashion to ensure the safety of

[†] Measured by the number of doses of rubella-containing vaccine administered to persons in the age group divided by the total population in that age group and multiplied by 100.

Rubella and Measles — Continued

vaccine and to address concerns about adverse events. The low number of needlestick injuries reflects the appropriate biosafety training given to vaccinators before the campaign.

To maintain the goals of measles, rubella, and CRS elimination, Costa Rica will need to 1) achieve and maintain coverage $\geq 95\%$ with measles- and rubella-containing vaccine at both scheduled vaccination opportunities or conduct periodic mass vaccination campaigns; 2) continue surveillance for measles, rubella, and CRS; and 3) adjust their vaccination strategy in response to new surveillance information.

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State Medicaid Coverage for Tobacco-Dependence Treatments — United States, 1998 and 2000

The *Guide to Community Preventive Services* (1) recommends reducing the cost of tobacco-dependence treatments because these interventions increase both the use of treatment by smokers during attempts to stop smoking and the number of smokers who actually stop. The *Public Health Service (PHS) Clinical Practice Guideline* (2) supports insurance coverage for tobacco-dependence treatment (i.e., individual, group, and telephone counseling, and Food and Drug Administration-approved pharmacotherapy) (2). One of the 2010 national health objectives (3) is to provide coverage in the 50 states and District of Columbia (DC) for nicotine-dependence treatment by Medicaid (objective 27.8b) (3). In 2000, approximately 32 million low-income persons in the United States received their health insurance coverage through the federal-state Medicaid program (4); approximately 11.5 million (36%) of these persons smoked (CDC, unpublished data, 2000). Medicaid recipients have approximately 50% greater smoking prevalence than the overall U.S. population. To assess the amount and type of coverage for tobacco dependence offered by Medicaid, the Center for Health and Public Policy Studies at the University of California, Berkeley, conducted state surveys in 1998 and 2000. In 1998, 24 states and DC offered some coverage for tobacco-dependence treatment; in 2000, nine started offering some coverage. In 1998 and 2000, one state offered coverage for all the

Tobacco-Dependence Treatments — Continued

counseling and pharmacotherapy treatments recommended by PHS. These findings indicate that states can reduce smoking prevalence among Medicaid recipients by implementing more extensive Medicaid coverage for treatment of tobacco dependence.

To obtain and update information on Medicaid coverage of specific tobacco-dependence treatments, a survey was faxed to the 50 states and DC Medicaid programs during 1998 and 2000. State Medicaid program directors were asked to identify staff members most knowledgeable about tobacco-dependence treatment coverage and programs. A 10-page survey was faxed to the identified staff member in each state. Additional followup was conducted; the final response rate in both 1998 and 2000 was 100%. The survey included 26 questions about coverage of tobacco-dependence treatments, awareness of clinical practice guidelines for treatment of tobacco dependence, and state activities to document and support providers and health plans in delivering tobacco-dependence treatment services to Medicaid recipients. The only difference in the two surveys was that on the 2000 survey form, a question was asked about bupropion, the generic name for Wellbutrin® and Zyban® (GlaxoSmithKline, Research Triangle Park, North Carolina).

To validate state Medicaid program responses to survey questions, all reporting areas were asked to submit a written copy of their coverage policies for tobacco-dependence treatment. Of the 34 Medicaid programs that reported offering coverage in 2000, 39 states and DC (91%) provided supporting documentation; 11 noted that pharmacotherapy was covered under standard drug benefits; three states (9%) did not provide a coverage policy statement.

In 2000, a total of 33 states and DC offered some coverage for tobacco-dependence treatments; one state offered coverage for all treatments recommended by PHS. In 2000, some pharmacotherapy coverage was offered by 31 states, an increase of 35% from 1998. Sixteen states offered coverage for all recommended pharmacotherapy treatments in 2000. In 1998, a total of 23 states offered some coverage for prescription drugs and 17 for over-the-counter drugs; in 2000, a total of 31 states offered coverage for prescription drugs and 23 for over-the-counter drugs. In 2000, a total of 13 states offered special tobacco-dependence treatment programs for pregnant women; in two states, counseling services were covered for pregnant women only. In 2000, two states covered some form of counseling services without coverage for any drug treatments. During 1998–2000, one state dropped Medicaid coverage for bupropion and one state stopped Medicaid coverage for counseling. In 2000, a total of 11 states covered at least one type of pharmacotherapy and one type of counseling. In 2000, a total of 17 state Medicaid programs reported no coverage for tobacco-dependence treatments (Table 1).

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Editorial Note: Coverage of tobacco-use treatment under Medicaid remains low despite available and effective treatments for tobacco dependence (2) and evidence that decreasing the cost of treatment increases successful cessation (1). Two major barriers to using treatment for low-income smokers are the lack of access to and cost of effective treatment (5). In 2000, a total of 17 states offered no coverage for tobacco-use treatment and only Oregon provided coverage for all cessation interventions recommended by

TABLE 1. Changes in state Medicaid program coverage of pharmacotherapy and counseling for tobacco dependence — United States*, 1998 and 2000

State	Any treatment	Over-the-counter medication		Prescription medication						Counseling			
		Gum	Patch	Any	Spray	Inhaler	Zyban	Wellbutrin	Bupropion [†]	Any	Group	Individual	Telephone
Arizona	YES [§]	+ [¶]	+	-**	—	—	—	—	—	+	+	+	—
Arkansas	+	—	—	+	—	—	+	+	—	—	—	—	—
California ^{††}	YES	YES	YES	YES	YES	YES	YES	+	+	—	—	—	—
Colorado ^{††}	YES	YES	YES	YES	YES	YES	YES	+	+	—	—	—	—
Delaware ^{††}	YES	+	+	YES	YES	YES	YES	+	+	—	—	—	—
District of Columbia	YES	—	—	YES	YES	—	YES	+	+	—	—	—	—
Florida	YES	YES	YES	YES	—	—	YES	—	—	—	—	—	—
Hawaii	+	—	—	+	+	+	+	+	+	—	—	—	—
Illinois ^{††}	+	+	+	+	+	+	+	+	+	—	—	—	—
Indiana ^{††}	+	+	+	+	+	+	+	+	+	+	—	+	—
Kansas	YES	—	+	YES	—	—	YES	+	+	+	+	+	—
Louisiana	YES	—	—	YES	YES	YES	YES	+	+	—	—	—	—
Maine ^{††}	YES	YES	YES	YES	YES	YES	YES	+	+	YES	YES	YES	—
Maryland	YES	—	—	YES	YES	YES	YES	+	+	X ^{§§}	X	X	—
Massachusetts	+	—	—	—	—	—	—	—	—	+	+	+	—
Michigan	YES	YES	YES	+	—	—	+	+	—	—	—	—	—
Minnesota ^{††}	YES	YES	YES	YES	YES	YES	YES	+	+	YES	YES	YES	—
Montana	YES	YES	YES	YES	—	—	YES	—	—	—	—	—	—
Nevada ^{††}	YES	YES	YES	YES	YES	YES	YES	+	+	—	—	—	—
New Hampshire ^{††}	YES	YES	YES	YES	YES	YES	YES	+	+	+	+	+	—
New Jersey ^{††}	YES	+	+	YES	YES	YES	YES	+	+	—	—	—	—
New Mexico ^{††}	YES	YES	YES	YES	YES	YES	YES	+	+	X	X	X	X
New York ^{††}	+	+	+	+	+	+	+	+	+	—	—	—	—
North Carolina	YES	—	—	YES	YES	YES	YES	+	+	—	—	—	—
North Dakota	YES	YES	YES	YES	—	—	YES	+	+	—	—	—	—
Ohio	YES	YES	YES	YES	—	YES	YES	+	+	—	—	—	—
Oklahoma	YES	—	—	YES	—	—	YES	+	+	—	—	—	—
Oregon ^{¶¶}	YES	YES	YES	YES	YES	YES	YES	+	+	YES	YES	YES	YES
Rhode Island	+	—	—	—	—	—	—	—	—	+	+	+	—
Texas ^{††}	YES	YES	YES	YES	YES	YES	YES	+	+	—	—	—	—
Vermont ^{††}	YES	YES	YES	YES	YES	YES	YES	+	+	—	—	—	—
Virginia	+	—	—	+	+	+	+	+	+	—	—	—	—
West Virginia ^{††}	+	+	+	+	+	+	+	+	+	+	—	+	+
Wisconsin	YES	—	—	YES	YES	YES	YES	+	+	YES	—	YES	—
No. states in 2000	34	22	23	31	23	23	31	29	27	13	10	11	3
% states in 2000	67%	43%	45%	61%	45%	45%	61%	57%	53%	26%	20%	24%	6%

* States offering no coverage were Alabama, Alaska, Connecticut, Georgia, Idaho, Iowa, Kentucky, Mississippi, Missouri, Nebraska, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, Washington, and Wyoming.

[†] Bupropion question added in 2000.

[§] Offered coverage in 1998 and 2000.

[¶] Added coverage in 2000.

** Dropped coverage in 2000.

^{††} Offered all pharmacotherapy recommended in *Public Health Service Clinical Practice Guideline for Treating Tobacco Use and Dependence*.

^{§§} Covered pregnant women only.

^{¶¶} Offered all treatments.

Tobacco-Dependence Treatments — Continued

PHS. Strategies to increase access include incorporating tobacco-use treatment into routine health-care visits, and offering coverage of treatment costs and access to telephone quit lines (1).

Tobacco-use treatment is one of the most cost-effective prevention services (2,6,7). Based on disease impact, intervention effectiveness, and cost effectiveness, a recent study ranked tobacco-use treatment second (after childhood vaccination) among 30 prevention services recommended by the *Guide to Clinical Preventive Services*. Because the current provision of service is low, tobacco-use treatment was also the service that had the potential for the greatest improvement (8).

The findings in this report are subject to at least one limitation. The data were self-reported. Among the 34 Medicaid programs reporting coverage in 2000, three could not document coverage. The absence of written policy increases the likelihood of reporting errors. These results might differ from other ratings of coverage as the result of interpretations of unwritten policies.

Tobacco use is the leading preventable cause of death in the United States (9). Because smoking prevalence is high among Medicaid recipients, they are affected disproportionately by tobacco and tobacco-related disease and disability. CDC supports efforts to assist state Medicaid programs in meeting the PHS and Community Preventive Services Task Force recommendations and the national health objective for tobacco-dependence treatment coverage. Substantial action to improve coverage will be needed if the United States is to reach the 2010 national health objective to reduce from 24% in 1998 to 12% the prevalence of current cigarette smoking among persons aged ≥ 18 years. States are encouraged to cover all recommended pharmacotherapy and counseling for Medicaid populations.

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Weekly Update: West Nile Virus Activity — United States, October 31–November 6, 2001

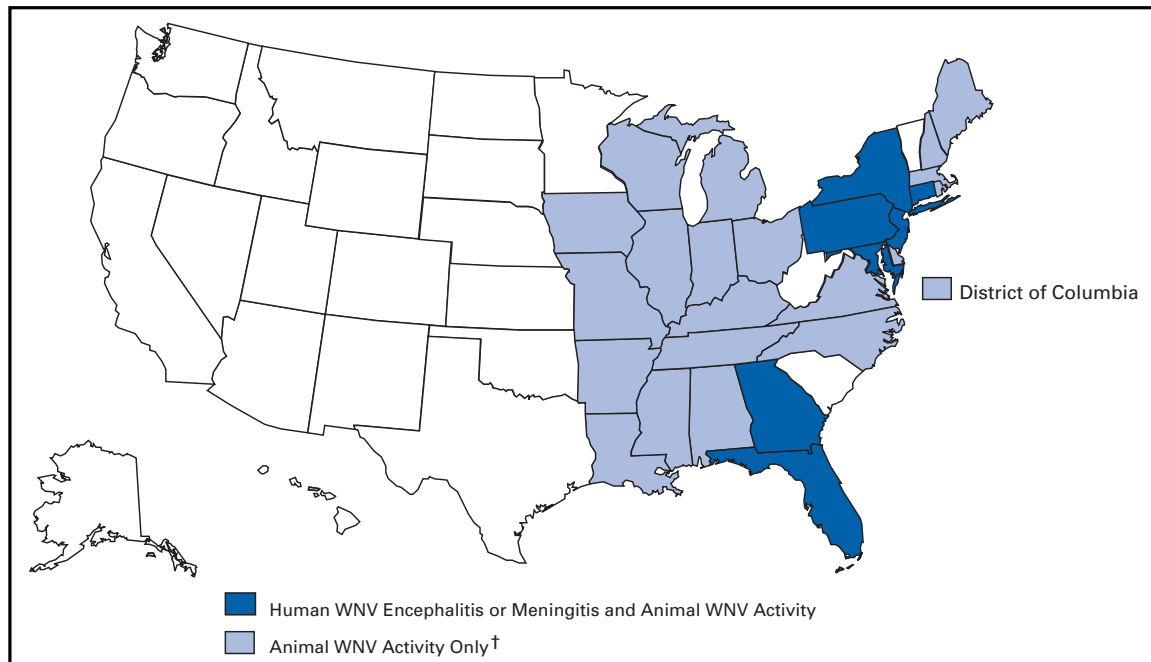
The following report summarizes West Nile virus (WNV) surveillance data reported to CDC through ArboNET and verified by states and other jurisdictions as of November 6, 2001.

During the week of October 31–November 6, five human cases of WNV encephalitis or meningitis were reported in New York (four) and Connecticut (one). During the same period, WNV infections were reported in 255 crows, 22 other birds, and 11 horses. No WNV-positive mosquito pools were reported.

During 2001, a total of 42 human cases of WNV encephalitis or meningitis have been reported in Florida (10), New York (10), Connecticut (six), Maryland (six), New Jersey (six), Pennsylvania (three), and Georgia (one). Among the 42 cases, 22 (52%) were in males; the median age was 70.5 years (range: 36–90 years); dates of illness onset ranged from July 13 to October 7; and two persons died. A total of 4,251 crows and 1,459 other birds with WNV infection were reported from 26 states and the District of Columbia (Figure 1); 170 WNV infections in other animals (all horses) were reported from 14 states (Alabama, Connecticut, Florida, Georgia, Indiana, Kentucky, Louisiana, Massachusetts, Mississippi, New York, North Carolina, Pennsylvania, Tennessee, and Virginia); and 736 WNV-positive mosquito pools were reported from 15 states (Connecticut, Florida, Georgia, Illinois, Kentucky, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, and Virginia).

Additional information about WNV activity is available at <http://www.cdc.gov/ncidod/dvbid/westnile/index.htm> and http://cindi.usgs.gov/hazard/event/west_nile/west_nile.html.

FIGURE 1. Areas reporting West Nile virus (WNV) activity — United States, 2001*



* As of November 6, 2001.

[†] Mississippi reported WNV infection in a horse but no birds.

Notice to Readers

Considerations for Distinguishing Influenza-Like Illness from Inhalational Anthrax

CDC has issued guidelines on the evaluation of persons with a history of exposure to *Bacillus anthracis* spores or who have an occupational or environmental risk for anthrax exposure (1). This notice describes the clinical evaluation of persons who are not known to be at increased risk for anthrax but who have symptoms of influenza-like illness (ILI). Clinicians evaluating persons with ILI should consider a combination of epidemiologic, clinical, and, if indicated, laboratory and radiographic test results to evaluate the likelihood that inhalational anthrax is the basis for ILI symptoms.

ILI is a nonspecific respiratory illness characterized by fever, fatigue, cough, and other symptoms. The majority of ILI cases is not caused by influenza but by other viruses (e.g., rhinoviruses and respiratory syncytial virus [RSV]), adenoviruses, and parainfluenza viruses). Less common causes of ILI include bacteria such as *Legionella spp.*, *Chlamydia pneumoniae*, *Mycoplasma pneumoniae*, and *Streptococcus pneumoniae*. Influenza, RSV, and certain bacterial infections are particularly important causes of ILI because these infections can lead to serious complications requiring hospitalization (2–4). Yearly, adults and children can average one to three and three to six ILI, respectively (5).

Epidemiologic Considerations

To date, 10 confirmed cases of inhalational anthrax have been identified (1). The epidemiologic profile of these 10 cases caused by bioterrorism can guide the assessment of persons with ILI. All but one case have occurred among postal workers, persons exposed to letters or areas known to be contaminated by anthrax spores, and media employees. The 10 confirmed cases have been identified in a limited number of communities. Inhalational anthrax is not spread from person-to-person. In comparison, millions of ILI cases associated with other respiratory pathogens occur each year and in all communities. Respiratory infections associated with bacteria can occur throughout the year; pneumococcal disease peaks during the winter, and mycoplasma and legionellosis are more common during the summer and fall (4). Cases of ILI resulting from influenza and RSV infection generally peak during the winter; rhinoviruses and parainfluenza virus infections usually peak during the fall and spring; and adenoviruses circulate throughout the year. All of these viruses are highly communicable and spread easily from person to person.

Clinical Considerations

Although many different illnesses might present with ILI symptoms, the presence of certain signs and symptoms might help to distinguish other causes of ILI from inhalational anthrax. Nasal congestion and rhinorrhea are features of most ILI cases not associated with anthrax (Table 1) (6,7). In comparison, rhinorrhea was reported in one of the 10 persons who had inhalational anthrax diagnosed since September 2001. All 10 persons with inhalational anthrax had abnormal chest radiographs on initial presentation; seven had mediastinal widening, seven had infiltrates, and eight had pleural effusion. Findings might be more readily discernable on posteroanterior with lateral views, compared with anteroposterior views (i.e., portable radiograph alone) (1). Most cases of ILI are not associated with radiographic findings of pneumonia, which occurs most often

Notices to Readers — Continued

TABLE 1. Symptoms and signs of inhalational anthrax, laboratory-confirmed influenza, and influenza-like illness (ILI) from other causes

Symptom/Sign	Inhalational anthrax (n=10)	Laboratory-confirmed influenza	ILI from other causes
Elevated temperature	70%	68%–77%	40%–73%
Fever or chills	100%	83%–90%	75%–89%
Fatigue/malaise	100%	75%–94%	62%–94%
Cough (minimal or nonproductive)	90%	84%–93%	72%–80%
Shortness of breath	80%	6%	6%
Chest discomfort or pleuritic chest pain	60%	35%	23%
Headache	50%	84%–91%	74%–89%
Myalgias	50%	67%–94%	73%–94%
Sore throat	20%	64%–84%	64%–84%
Rhinorrhea	10%	79%	68%
Nausea or vomiting	80%	12%	12%
Abdominal pain	30%	22%	22%

among the very young, elderly, or those with chronic lung disease (2,3). Influenza associated pneumonia occurs in approximately 1%–5% of community-dwelling adults with influenza and can occur in >20% of influenza-infected elderly (2). Influenza-associated pneumonia might be caused by the primary virus infection or, more commonly, by bacterial infection occurring coincident with or following influenza illness (2).

Testing

No rapid screening test is available to diagnose inhalational anthrax in the early stages. Blood cultures grew *B. anthracis* in all seven patients with inhalational anthrax who had not received previous antimicrobial therapy. However, blood cultures should not be obtained routinely on all patients with ILI symptoms who have no probable exposure to anthrax but should be obtained for persons in situations in which bacteremia is suspected.

Rapid tests for influenza and RSV are available, and, if used, should be conducted within the first 3–4 days of a person's illness when viral shedding is most likely. RSV antigen detection tests have a peak sensitivity of 75%–95% in infants but do not have enough sensitivity to warrant their routine use among adults (8).

Among the influenza tests available for point-of-care testing, the reported sensitivities and specificities range from 45%–90% and 60%–95%, respectively (9). Two tests (Quidel Quickvue Influenza test and ZymeTx Zstatflu test[®]) can be performed in any physician's office, and three are classified as moderately complex tests (Biostar FLU OIA; Becton-Dickinson Directigen Flu A+B; and Becton-Dickinson Directigen Flu A[™]).

The clinical usefulness of rapid influenza tests for the diagnosis of influenza in individual patients is limited because the sensitivity of the influenza rapid tests is relatively low (45%–90%), and a large proportion of persons with influenza might be missed with these tests. Therefore, the rapid influenza tests should not be done on every person presenting with ILI. However, rapid influenza testing used with viral culture can help indicate whether influenza viruses are circulating among specific populations, (e.g., nursing home residents or patients attending a clinic). This type of epidemiologic information on specific populations can aid in diagnosing ILI.

Notices to Readers — Continued

Vaccination against influenza is the best means to prevent influenza and its severe complications. The influenza vaccine is targeted towards persons aged ≥ 65 years and to persons aged 6 months to 64 years who have a high risk medical condition because these groups are at increased risk for influenza-related complications. The vaccine also is targeted towards health-care workers to prevent transmission of influenza to high-risk persons. In addition, vaccination is recommended for household members of high-risk persons and for healthy persons aged 50–64 years. The vaccine can prevent 70%–90% of influenza infections in healthy adults. However, the vaccine does not prevent ILI caused by infectious agents other than influenza, and many persons vaccinated against influenza will still get ILI. Therefore, receipt of vaccine will not definitely exclude influenza from the differential diagnosis of ILI or increase the probability of inhalational anthrax as a cause, especially among persons who have no probable exposure to anthrax. Frequent hand washing can reduce the number of respiratory illnesses (10) and pneumococcal polysaccharide vaccine can reduce the risk for serious pneumococcal disease.

Additional information about anthrax is available at <http://www.hhs.gov/hottopics/healing/biological.html> and <http://www.bt.cdc.gov/DocumentsApp/FactsAbout/FactsAbout.asp>. Additional information about influenza, RSV and other viral respiratory infections, and pneumococcal disease is available at <http://www.cdc.gov/ncidod/diseases/flu/fluvirus.htm>, <http://www.cdc.gov/nip/flu/default.htm>, <http://www.cdc.gov/ncidod/dvrd/revb/index.htm>, http://www.cdc.gov/ncidod/dbmd/diseaseinfo/streppneum_t.htm, and <http://www.cdc.gov/nip/diseases/Pneumo/vac-chart.htm>.

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Notices to Readers — Continued

Notice to Readers

Interim Guidelines for Investigation of and Response to *Bacillus Anthracis* Exposures

Environmental Sampling. Environmental testing to detect *B. anthracis* on surfaces or in the air can be used to investigate known or suspected exposure events. The highest priority of an investigation is to evaluate the risk for exposure to aerosolized *B. anthracis* spores. Persons collecting and testing samples should 1) obtain adequate samples, 2) avoid cross-contamination during processing, and 3) ensure proficient laboratory testing and interpretation of test results. A positive laboratory test for *B. anthracis* from a sample of an environmental surface may be caused by cross-contamination from an exposure vehicle (e.g., contact with an envelope containing *B. anthracis*), background occurrence of *B. anthracis* spores in the environment, or previously aerosolized *B. anthracis* that has settled onto environmental surfaces. Laboratory test results of environmental surface samples should not be the only criterion for starting, continuing, or stopping antimicrobial prophylaxis for inhalational disease.

Environmental sampling can be directed, prospective, or random. In directed sampling, air and/or surface samples are obtained as part of an investigation of a specific threat, a known exposure, or of persons with bioterrorism-related anthrax. Directed environmental sampling may play a critical role in characterizing potential exposures and guiding public health action (Box 1).

Prospective environmental sampling is defined as ongoing sampling and testing of air or surfaces for *B. anthracis* spores. The value of prospective sampling is not known. Current technologies for monitoring air for *B. anthracis* and other agents are not validated and their performance has not been assessed during bioterrorism events. Prospective environmental sampling of surfaces may have a role in detecting *B. anthracis* contamination, especially at facilities or events determined to be at high risk for bioterrorism (Box 1).

The testing of random environmental samples (i.e., sampling air or surfaces of facilities that are not directly associated with confirmed anthrax disease or a known *B. anthracis* exposure) is of uncertain utility in detecting past exposures. Random positive tests for *B. anthracis* spores may represent cross-contamination from an exposure vehicle (e.g., letter) that poses negligible risks for inhalational anthrax. These positive test results may prompt more extensive evaluation to direct cleanup, if needed.

Nasal Swab Cultures. Nasal swab cultures should not be used to diagnose cases of anthrax or to evaluate whether a person had been exposed. Nasal swab cultures may be useful in the investigation of known or suspected airborne *B. anthracis* (Box 1). Because the sensitivity of nasal swab cultures decreases over time, cultures should be obtained within 7 days of the exposure. The presence of *B. anthracis* from a nasal swab culture cannot be determined by gram stain or colony characteristics alone and requires confirmatory testing by qualified laboratories.

Antimicrobial Prophylaxis. Antimicrobial prophylaxis is used to prevent cases of inhalational anthrax (Box 1). Public health authorities often start prophylaxis before the extent of exposure is known. Subsequent epidemiologic and laboratory test data may indicate that some persons started on prophylaxis were not exposed. These persons should stop antimicrobial prophylaxis. Persons who were exposed should complete 60

*Notices to Readers — Continued***BOX 1. Interim guidelines for investigation of and response to *B. anthracis* exposures****Environmental Sampling**

Directed sampling of environmental surfaces may be indicated:

- To identify a site or source of *Bacillus anthracis* exposure that has resulted in a case(s) of anthrax
- To trace the route of an exposure vehicle (e.g., a powder-containing letter)
- To obtain the *B. anthracis* strain when isolates from patients are not available
- To guide clean-up activities in a contaminated area or building
- To assess biosafety procedures in laboratories processing *B. anthracis* specimens

Prospective sampling of environmental surfaces may be indicated:

- To identify receipt of a contaminated exposure vehicle in high risk facilities (e.g., mailrooms of targeted persons or groups)
- To detect aerosolized *B. anthracis* in high risk areas or events

Laboratory testing of environmental surface samples should not be the only means to determine the need for antimicrobial prophylaxis.

Nasal Swab Cultures

Collection of nasal swabs for culture of *B. anthracis* may be useful:

- To help define an area of exposure to aerosolized *B. anthracis*
- To help ascertain where a person with inhalational anthrax was exposed if the time and place of exposure are not already known

Collection of nasal swabs for culture of *B. anthracis* is not indicated:

- To diagnose anthrax
- To determine a person's risk of exposure and the need for antimicrobial prophylaxis
- To determine when antimicrobial prophylaxis should be stopped
- To supplement random environmental sampling

Antimicrobial Prophylaxis

Antimicrobial prophylaxis may be initiated pending additional information when:

- A person is exposed to an air space where a suspicious material may have been aerosolized (e.g., near a suspicious powder-containing letter during opening)
- A person has shared the air space likely to be the source of an inhalational anthrax case

Notices to Readers — Continued

Antimicrobial prophylaxis should be continued for 60 days for:

- Persons exposed to an air space known to be contaminated with aerosolized *B. anthracis*
- Persons exposed to an air space known to be the source of an inhalational anthrax case
- Persons along the transit path of an envelope or other vehicle containing *B. anthracis* that may have been aerosolized (e.g., a postal sorting facility in which an envelope containing *B. anthracis* was processed)
- Unvaccinated laboratory workers exposed to confirmed *B. anthracis* cultures

Antimicrobial prophylaxis is not indicated:

- For prevention of cutaneous anthrax
- For autopsy personnel examining bodies infected with anthrax when appropriate isolation precautions and procedures are followed
- For hospital personnel caring for patients with anthrax
- For persons who routinely open or handle mail in the absence of a suspicious letter or credible threat

A positive test for *B. anthracis* from a randomly collected specimen does not require implementation of antimicrobial prophylaxis or the closing of a facility.

Closing a Facility

Closing a facility or a part of a facility may be indicated:

- After an inhalational anthrax case is detected and a probable site of exposure in the facility is identified
- When there is a known aerosolization of *B. anthracis* in the facility
- When evidence strongly suggests an aerosolization of *B. anthracis* in the facility
- As determined by law enforcement authorities in a criminal investigation

Closing a facility is not indicated:

- Based only on the identification of *B. anthracis* from samples of environmental surfaces
- Based only on the identification of a cutaneous anthrax cases

Notices to Readers — Continued

days of therapy. No shorter course of antimicrobial prophylaxis exists. The choice of an antimicrobial agent should be based on antimicrobial susceptibility, the drug's effectiveness, adverse events, and cost. *B. anthracis* isolates from patients with bioterrorism-related anthrax have been susceptible to ciprofloxacin, doxycycline, and other agents; the use of doxycycline may be preferable to prevent development of ciprofloxacin resistance in more common bacteria (1). Respiratory transmission of *B. anthracis* from person-to-person does not occur; no antimicrobial prophylaxis is indicated.

Closing Facilities. The decision to close a facility is made to prevent cases of inhalational anthrax (Box 1). The facility should remain closed until the risk for inhalational disease is eliminated.

Reference

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*Notice to Readers***Great American Smokeout — November 15, 2001**

During 1977–1999, the proportion of persons who had ever smoked and had quit increased from 35.8% to 49.5% (1,2). On November 15, the American Cancer Society (ACS) will host the 25th annual Great American Smokeout to encourage smokers to quit tobacco use for at least 24 hours. In 2000, 19% of smokers participated in the Great American Smokeout; of these, 4% had not resumed smoking 1–5 days after the smokeout (ACS, unpublished data, 2000).

Smokers who use effective therapy to reduce their dependence on tobacco can approximately double the likelihood of quitting permanently (3). Pharmacotherapy, counseling, and behavioral tobacco-dependence treatments are effective clinically and are cost-effective compared with medical and disease prevention interventions (3,4). Although reducing cost to smokers for such therapies improves the likelihood of quitting (5), public and private insurance coverage for these treatments remains low (6). One of the 2010 national health objectives is to increase insurance coverage of evidence-based treatments for nicotine dependence (7) (objective 27.8). In addition, in 2001, the Office of Personnel Management encouraged an expansion of health insurance coverage for federal employees to include comprehensive coverage of tobacco-use treatment (8). Because insurance coverage for government employees often is an indicator of future trends, the new federal provision represents a major step in improved access to effective treatment.

Additional information is available by contacting ACS, telephone (800) 227-2345, <<http://www.cancer.org>>; or CDC, telephone (800) 232-1311, <<http://www.cdc.gov/tobacco>>.

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Notice to Readers**National Epilepsy Month — November 2001**

November is National Epilepsy Month. Epilepsy, a central nervous system disorder characterized by unprovoked recurrent seizures, affects approximately 2.3 million persons in the United States. Of the 181,000 new cases of epilepsy and seizures every year, approximately one third begins during childhood.

Teenagers face challenges as they navigate the physiologic and social changes of their lives and as they try to achieve independence. Teenagers who have epilepsy bear the added burden of the disorder. Seizures can lead to isolation, limit independence, and leave them vulnerable to teasing and ridicule from their peers. To help alleviate this burden, the Epilepsy Foundation and its affiliates, in collaboration with CDC, have launched the “Entitled to Respect” campaign as the focus of this year’s National Epilepsy Month activities. During November, the Epilepsy Foundation will begin activities to educate the teenage population about epilepsy and to promote peer understanding and acceptance of teenagers with the disorder.

Additional information about epilepsy or the “Entitled to Respect” campaign is available from the National Epilepsy Foundation, telephone (800) 332-1000 ([800] EFA-1000), or from <<http://www.epilepsyfoundation.org>>.

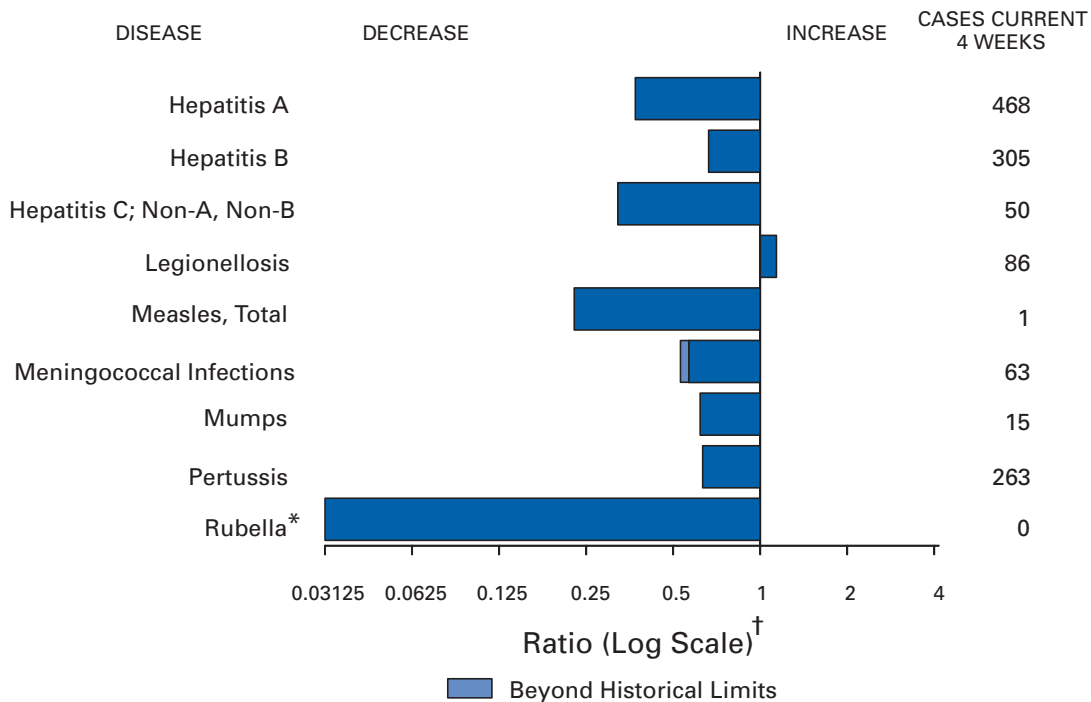
Clarification: Vol. 50, No. 43

In the article, “Update: Investigation of Bioterrorism-Related Anthrax and Interim Guidelines for Clinical Evaluation of Persons with Possible Anthrax,” on page 945 in Figure 2, the fifth bullet of the box marked “yes” should read, “Consider chest computerized tomography (CT) if CR *diagnosis is uncertain.*”

Errata: Vol. 50, Nos. 42 and 43

In the articles, “Weekly Update: West Nile Virus Activity — United States, October 17–23, 2001, and October 24–30, 2001,” the maps on pages 927 and 959 both incorrectly show Virginia as having reported human and animal West Nile virus activity. Virginia has not reported human West Nile virus activity.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending November 3, 2001, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 44 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 November 3, 2001 (44th Week)*

	Cum. 2001		Cum. 2001
Anthrax	15	Poliomyelitis, paralytic	-
Brucellosis†	74	Psittacosis†	19
Cholera	3	Q fever†	18
Cyclosporiasis†	134	Rabies, human	1
Diphtheria	2	Rocky Mountain spotted fever (RMSF)	510
Ehrlichiosis: human granulocytic (HGE)†	173	Rubella, congenital syndrome	-
human monocytic (HME)†	73	Streptococcal disease, invasive, group A	3,000
Encephalitis: California serogroup viral†	91	Streptococcal toxic-shock syndrome†	41
eastern equine†	7	Syphilis, congenital†	190
St. Louis†	1	Tetanus	22
western equine†	-	Toxic-shock syndrome	98
Hansen disease (leprosy)†	71	Trichinosis	21
Hantavirus pulmonary syndrome†	7	Tularemia†	92
Hemolytic uremic syndrome, postdiarrheal†	127	Typhoid fever	235
HIV infection, pediatric‡§	181	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 update October 30, 2001.

§ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending November 3, 2001, and November 4, 2000 (44th Week)*

Reporting Area	AIDS		Chlamydia [§]		Cryptosporidiosis		Escherichia coli O157:H7 [†]			
	Cum. 2001 [†]	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	NETSS		PHLIS	
							Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	33,013	32,692	596,587	589,077	2,835	2,685	2,609	3,999	2,025	3,269
NEW ENGLAND	1,276	1,673	19,707	19,758	110	127	204	346	209	359
Maine	40	28	1,132	1,240	17	20	25	27	26	28
N.H.	31	28	1,104	933	14	21	32	31	26	37
Vt.	13	29	515	455	31	26	13	33	8	33
Mass.	661	1,049	8,318	8,444	44	33	110	155	106	162
R.I.	85	81	2,484	2,270	4	3	14	19	11	18
Conn.	446	458	6,154	6,416	-	24	10	81	32	81
MID. ATLANTIC	7,683	7,090	63,315	54,996	225	339	187	396	180	281
Upstate N.Y.	823	665	11,777	2,085	91	109	145	263	136	63
N.Y. City	3,788	3,755	24,359	22,462	75	154	11	22	10	15
N.J.	1,537	1,423	8,936	8,978	7	16	31	111	34	111
Pa.	1,535	1,247	18,243	21,471	52	60	N	N	-	92
E.N. CENTRAL	2,513	3,164	98,532	101,866	1,291	888	674	989	471	697
Ohio	482	475	20,886	26,418	146	246	174	240	145	206
Ind.	306	320	12,924	11,289	73	57	74	109	39	83
Ill.	1,115	1,596	28,326	28,350	373	112	151	186	128	149
Mich.	459	601	25,412	21,951	164	87	82	132	73	104
Wis.	151	172	10,984	13,858	535	386	193	322	86	155
W.N. CENTRAL	719	762	30,261	33,468	359	340	482	578	409	549
Minn.	121	153	6,226	6,918	137	123	232	155	186	175
Iowa	78	73	3,944	4,568	77	73	76	170	60	141
Mo.	347	349	10,826	11,362	36	27	48	100	81	94
N. Dak.	2	2	767	739	13	15	18	15	31	20
S. Dak.	23	7	1,473	1,570	6	15	40	53	40	57
Nebr.	63	64	2,175	3,136	88	78	51	59	-	46
Kans.	85	114	4,850	5,175	2	9	17	26	11	16
S. ATLANTIC	10,366	9,072	112,692	111,573	299	410	203	328	126	266
Del.	218	182	2,309	2,418	6	5	4	3	7	1
Md.	1,529	1,127	9,547	12,129	35	9	23	31	1	2
D.C.	738	694	2,533	2,721	10	13	-	1	U	U
Va.	803	580	15,401	13,546	24	17	48	63	36	59
W. Va.	73	54	2,005	1,816	2	3	10	14	8	12
N.C.	807	585	16,660	18,882	26	22	46	81	33	66
S.C.	623	682	9,374	8,165	-	-	10	21	11	16
Ga.	1,239	1,049	24,814	23,574	127	151	30	36	15	36
Fla.	4,336	4,119	30,049	28,322	69	190	32	78	15	74
E.S. CENTRAL	1,554	1,618	40,689	43,205	39	45	116	122	98	100
Ky.	299	168	7,415	6,841	4	5	57	39	47	31
Tenn.	507	684	11,962	12,548	12	11	36	51	38	48
Ala.	378	418	11,430	13,216	13	15	16	8	6	9
Miss.	370	348	9,882	10,600	10	14	7	24	7	12
W.S. CENTRAL	3,488	3,366	88,934	88,953	33	153	86	216	86	265
Ark.	178	158	6,043	5,673	6	14	13	54	-	37
La.	711	587	14,824	15,639	7	12	4	14	25	44
Okla.	203	294	8,850	8,044	13	17	27	19	24	17
Tex.	2,396	2,327	59,217	59,597	7	110	42	129	37	167
MOUNTAIN	1,172	1,211	33,513	32,765	203	161	258	387	128	288
Mont.	15	12	1,542	1,174	33	10	19	30	-	-
Idaho	19	19	1,613	1,529	21	21	63	65	-	39
Wyo.	3	9	690	676	6	5	6	17	1	10
Colo.	248	294	7,022	8,866	34	66	84	147	52	105
N. Mex.	129	126	4,830	4,385	26	19	13	22	10	18
Ariz.	459	386	12,157	10,836	7	10	27	44	22	37
Utah	101	113	1,512	1,951	71	26	31	49	42	69
Nev.	198	252	4,147	3,348	5	4	15	13	1	10
PACIFIC	4,242	4,736	108,944	102,493	276	222	399	637	318	464
Wash.	435	428	11,531	11,005	43	U	115	208	62	197
Oreg.	177	145	6,261	5,829	44	17	61	127	57	110
Calif.	3,552	4,042	85,637	80,500	185	205	202	259	192	142
Alaska	18	22	2,236	2,117	1	-	4	29	1	4
Hawaii	60	99	3,279	3,042	3	-	17	14	6	11
Guam	12	13	-	432	-	-	N	N	U	U
P.R.	1,021	1,133	2,193	U	-	-	1	6	U	U
V.I.	2	31	53	-	-	-	-	-	U	U
Amer. Samoa	1	-	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	103	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 October 30, 2001.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending November 3, 2001, and November 4, 2000 (44th 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	273,861	301,906	2,704	2,701	846	935	384	10,708	14,695
NEW ENGLAND	5,683	5,561	14	26	57	52	34	3,386	4,620
Maine	113	80	-	2	8	2	2	-	-
N.H.	154	93	-	-	10	2	4	130	60
Vt.	55	56	6	4	5	5	3	14	36
Mass.	2,634	2,306	8	15	15	17	19	654	1,108
R.I.	707	549	-	5	10	9	1	436	457
Conn.	2,020	2,477	-	-	9	17	5	2,152	2,959
MID. ATLANTIC	32,033	32,969	1,311	603	166	258	59	5,383	7,706
Upstate N.Y.	7,155	6,230	49	34	59	75	26	3,064	3,321
N.Y. City	10,256	9,836	-	-	17	42	9	2	172
N.J.	5,856	6,086	1,214	528	8	21	10	927	2,360
Pa.	8,766	10,817	48	41	82	120	14	1,390	1,853
E.N. CENTRAL	51,474	60,700	148	202	239	240	49	591	751
Ohio	11,624	16,153	5	11	116	101	12	105	56
Ind.	5,707	5,284	1	-	20	32	8	22	22
Ill.	15,588	17,789	13	19	-	28	1	21	34
Mich.	14,586	15,561	129	172	70	42	21	13	23
Wis.	3,969	5,913	-	-	33	37	7	430	616
W.N. CENTRAL	12,900	15,152	616	506	47	54	15	344	362
Minn.	2,021	2,700	9	5	9	7	-	285	267
Iowa	1,016	1,056	-	2	8	13	2	31	31
Mo.	6,741	7,452	595	488	20	24	8	23	45
N. Dak.	34	60	-	-	1	-	-	-	1
S. Dak.	234	257	-	-	3	2	-	-	-
Nebr.	710	1,259	3	4	5	4	1	3	3
Kans.	2,144	2,368	9	7	1	4	4	2	15
S. ATLANTIC	69,836	78,983	97	92	174	172	63	755	1,011
Del.	1,398	1,452	-	2	12	9	-	49	167
Md.	5,183	8,324	16	12	33	64	11	483	590
D.C.	2,292	2,203	-	3	7	5	-	12	7
Va.	9,210	8,930	-	3	20	31	12	114	135
W. Va.	575	549	9	14	N	N	5	11	29
N.C.	14,017	15,451	19	14	9	14	5	38	43
S.C.	6,293	7,245	6	2	10	4	5	5	7
Ga.	13,635	15,332	1	3	10	6	11	-	-
Fla.	17,233	19,497	46	39	73	39	14	43	33
E. S. CENTRAL	26,362	31,068	170	400	50	33	19	53	47
Ky.	2,967	3,018	8	31	11	18	5	22	11
Tenn.	8,054	9,968	58	87	25	10	8	22	28
Ala.	8,838	10,230	4	9	12	3	6	8	5
Miss.	6,503	7,852	100	273	2	2	-	1	3
W.S. CENTRAL	43,370	47,057	173	647	5	22	17	80	82
Ark.	3,646	3,304	4	8	-	-	1	-	5
La.	10,127	11,549	85	393	2	7	-	2	7
Okla.	4,045	3,580	3	8	3	3	2	-	-
Tex.	25,552	28,624	81	238	-	12	14	78	70
MOUNTAIN	8,391	8,936	61	66	46	37	32	13	12
Mont.	86	41	1	4	-	1	-	-	-
Idaho	64	72	2	3	3	5	1	6	2
Wyo.	68	41	8	2	1	-	1	1	3
Colo.	2,412	2,736	19	12	13	13	7	2	-
N. Mex.	815	960	11	13	2	1	7	-	-
Ariz.	3,297	3,590	9	18	18	7	7	1	-
Utah	119	187	3	1	5	10	2	1	3
Nev.	1,530	1,309	8	13	4	-	7	2	4
PACIFIC	23,812	21,480	114	159	62	67	96	103	104
Wash.	2,565	1,956	20	29	9	16	9	8	9
Oreg.	978	833	12	25	N	N	8	8	12
Calif.	19,410	17,996	82	103	49	50	73	85	81
Alaska	358	297	-	-	-	-	-	2	2
Hawaii	501	398	-	2	4	1	6	N	N
Guam	-	46	-	3	-	-	-	-	-
P.R.	531	432	1	1	2	1	-	N	N
V.I.	6	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	-	U	U
C.N.M.I.	U	U	-	U	-	U	-	-	U

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

* Incidence data for reporting year 2001 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 November 3, 2001, and November 4, 2000 (44th Week)*

Reporting Area	Malaria		Rabies, Animal		Salmonellosis [†]			
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	NETSS		PHLIS	
					Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	998	1,270	5,716	6,127	31,058	33,564	25,140	28,193
NEW ENGLAND	68	65	641	714	2,098	1,936	1,998	1,969
Maine	4	6	63	116	159	111	150	88
N.H.	2	1	20	21	154	125	142	131
Vt.	1	2	58	54	71	101	63	97
Mass.	29	30	234	237	1,158	1,110	1,054	1,122
R.I.	9	8	62	51	123	123	158	136
Conn.	23	18	204	235	433	366	431	395
MID. ATLANTIC	264	335	1,053	1,147	3,583	4,388	3,483	4,634
Upstate N.Y.	59	66	690	719	1,060	1,061	1,213	1,141
N.Y. City	137	192	24	15	923	1,067	1,192	1,160
N.J.	34	43	165	171	652	1,024	657	896
Pa.	34	34	174	242	948	1,236	421	1,437
E.N. CENTRAL	93	125	117	148	4,084	4,624	3,691	3,145
Ohio	20	17	42	48	1,082	1,265	1,062	1,271
Ind.	16	6	-	-	461	569	426	543
Ill.	1	60	24	22	1,119	1,345	1,049	145
Mich.	37	29	45	67	711	770	710	840
Wis.	19	13	6	11	711	675	444	346
W.N. CENTRAL	31	61	313	490	2,001	2,101	2,127	2,265
Minn.	6	27	43	79	581	477	609	604
Iowa	6	2	73	70	308	317	295	312
Mo.	12	15	40	50	556	628	833	773
N. Dak.	-	2	35	107	56	55	77	70
S. Dak.	-	1	42	88	140	86	111	95
Nebr.	2	8	4	2	125	197	-	135
Kans.	5	6	76	94	235	341	202	276
S. ATLANTIC	261	294	1,985	2,102	7,662	6,953	5,151	5,235
Del.	2	5	30	47	80	106	98	116
Md.	105	104	323	363	713	693	770	618
D.C.	13	15	-	-	72	57	U	U
Va.	44	48	411	497	1,175	882	747	831
W. Va.	1	4	127	106	116	139	125	136
N.C.	16	33	514	506	1,158	972	1,083	1,003
S.C.	6	2	103	142	768	655	660	501
Ga.	30	22	311	302	1,513	1,269	1,210	1,542
Fla.	44	61	166	139	2,067	2,180	458	488
E.S. CENTRAL	31	42	186	189	2,267	2,103	1,668	1,596
Ky.	12	17	26	19	328	335	210	232
Tenn.	11	11	97	97	556	562	713	713
Ala.	6	13	61	72	632	585	474	535
Miss.	2	1	2	1	751	621	271	116
W.S. CENTRAL	12	67	877	799	3,311	4,316	2,068	2,632
Ark.	3	3	20	20	806	632	92	516
La.	5	11	1	4	325	764	566	645
Okla.	3	8	57	52	419	343	292	262
Tex.	1	45	799	723	1,761	2,577	1,118	1,209
MOUNTAIN	49	44	225	250	1,882	2,372	1,546	2,235
Mont.	3	1	36	62	68	82	-	-
Idaho	3	3	28	9	124	104	4	98
Wyo.	-	-	20	50	52	58	52	50
Colo.	20	21	-	-	527	628	531	611
N. Mex.	3	-	14	19	246	206	215	189
Ariz.	9	7	112	91	545	613	532	675
Utah	3	6	14	10	189	438	189	432
Nev.	8	6	1	9	131	243	23	180
PACIFIC	189	237	319	288	4,170	4,771	3,408	4,482
Wash.	9	28	-	-	456	500	491	590
Oreg.	11	36	3	7	207	261	271	320
Calif.	159	163	279	255	3,151	3,750	2,335	3,328
Alaska	1	-	37	26	37	53	28	33
Hawaii	9	10	-	-	319	207	283	211
Guam	-	2	-	-	-	23	U	U
P.R.	4	5	83	67	510	585	U	U
V.I.	-	-	-	-	-	-	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	11	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 November 3, 2001, and November 4, 2000 (44th Week)*

Reporting Area	Shigellosis [†]				Syphilis (Primary & Secondary)		Tuberculosis	
	NETSS		PHLIS		Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000				
UNITED STATES	15,140	19,133	6,885	10,990	4,901	5,193	10,219	11,996
NEW ENGLAND	229	368	249	346	51	75	345	360
Maine	6	10	2	11	-	1	8	16
N.H.	6	6	3	8	1	2	14	17
Vt.	7	4	5	-	2	-	4	4
Mass.	179	254	170	233	29	53	198	206
R.I.	17	30	24	30	9	4	29	27
Conn.	14	64	45	64	10	15	92	90
MID. ATLANTIC	1,109	2,287	693	1,484	429	242	1,962	1,899
Upstate N.Y.	433	668	113	205	23	9	296	250
N.Y. City	310	873	331	596	229	102	1,003	1,025
N.J.	185	475	184	409	116	61	418	458
Pa.	181	271	65	274	61	70	245	166
E.N. CENTRAL	3,633	3,644	1,609	1,100	861	1,067	1,119	1,217
Ohio	2,484	325	1,058	274	71	64	230	240
Ind.	190	1,361	38	144	145	307	88	122
Ill.	435	1,063	288	82	278	359	514	581
Mich.	272	600	198	548	345	294	222	200
Wis.	252	295	27	52	22	43	65	74
W.N. CENTRAL	1,665	2,168	1,126	1,806	80	60	386	435
Minn.	388	704	384	787	27	15	195	132
Iowa	339	468	281	316	4	11	34	33
Mo.	286	606	192	424	21	26	113	161
N. Dak.	21	42	28	49	-	-	3	2
S. Dak.	506	7	206	4	-	-	12	16
Nebr.	63	130	-	107	5	2	29	21
Kans.	62	211	35	119	23	6	-	70
S. ATLANTIC	2,175	2,599	664	1,030	1,680	1,722	2,025	2,420
Del.	14	22	11	20	9	8	15	14
Md.	136	181	82	102	203	263	182	211
D.C.	51	67	U	U	32	34	51	26
Va.	327	407	124	324	92	118	215	225
W. Va.	8	4	8	3	4	3	26	27
N.C.	309	334	156	240	387	418	291	292
S.C.	227	118	119	83	203	198	153	238
Ga.	366	227	130	161	314	329	388	524
Fla.	737	1,239	34	97	436	351	704	863
E.S. CENTRAL	1,398	998	518	516	543	765	686	789
Ky.	646	416	264	101	40	73	102	99
Tenn.	88	326	95	352	270	459	253	302
Ala.	185	72	130	57	108	107	222	257
Miss.	479	184	29	6	125	126	109	131
W.S. CENTRAL	1,993	3,003	1,098	965	610	705	763	1,740
Ark.	506	180	155	53	31	94	129	159
La.	128	250	137	155	141	186	-	146
Okla.	71	107	17	41	59	101	122	130
Tex.	1,288	2,466	789	716	379	324	512	1,305
MOUNTAIN	850	1,040	615	766	212	206	411	439
Mont.	8	7	-	-	-	-	6	14
Idaho	37	44	-	25	1	1	8	7
Wyo.	3	5	5	3	1	1	3	3
Colo.	211	230	239	188	36	8	99	72
N. Mex.	111	142	75	102	18	15	24	38
Ariz.	364	424	240	305	140	175	187	180
Utah	50	73	48	77	8	1	32	41
Nev.	66	115	8	66	8	5	52	84
PACIFIC	2,088	3,026	313	2,977	435	351	2,522	2,697
Wash.	183	406	167	377	42	55	199	215
Oreg.	76	152	91	100	13	11	85	86
Calif.	1,766	2,428	-	2,468	370	284	2,071	2,187
Alaska	6	7	6	3	-	-	43	92
Hawaii	57	33	49	29	10	1	124	117
Guam	-	35	U	U	-	3	-	47
P.R.	8	29	U	U	227	133	76	135
V.I.	-	-	U	U	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	4	U	U	U	4	U	23	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 November 3, 2001, and November 4, 2000 (44th Week)*

Reporting Area	<i>H. influenzae</i> , Invasive		Hepatitis (Viral), By Type				Measles (Rubeola)					
	Cum. 2001 [†]	Cum. 2000	A		B		Indigenous		Imported [‡]		Total	
			Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	2001	Cum. 2001	2001	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	1,080	1,100	8,643	11,255	5,534	5,982	-	49	1	44	93	73
NEW ENGLAND	78	94	552	343	85	96	-	4	-	1	5	6
Maine	2	1	10	19	5	5	-	-	-	-	-	-
N.H.	4	12	16	18	14	15	-	-	-	-	-	3
Vt.	3	7	14	10	4	6	-	1	-	-	1	3
Mass.	35	37	241	122	6	13	-	2	-	1	3	-
R.I.	5	4	59	22	25	19	-	-	-	-	-	-
Conn.	29	33	212	152	31	38	-	1	-	-	1	-
MID. ATLANTIC	163	199	803	1,321	865	1,003	-	5	-	11	16	21
Upstate N.Y.	63	84	222	220	112	116	-	1	-	4	5	10
N.Y. City	41	54	242	450	367	488	-	3	-	1	4	10
N.J.	39	36	159	252	169	154	-	-	-	1	1	-
Pa.	20	25	180	399	217	245	-	1	-	5	6	1
E.N. CENTRAL	137	158	993	1,462	757	623	-	-	-	10	10	7
Ohio	50	47	175	230	84	93	-	-	-	3	3	2
Ind.	43	27	93	103	45	42	-	-	-	4	4	-
Ill.	10	55	380	626	124	108	-	-	-	3	3	3
Mich.	12	9	289	428	504	344	-	-	-	-	-	2
Wis.	22	20	56	75	-	36	-	-	-	-	-	-
W.N. CENTRAL	55	64	365	602	172	252	-	4	1	1	5	2
Minn.	33	35	38	167	21	34	-	2	1	1	3	1
Iowa	-	-	32	61	22	31	-	-	-	-	-	-
Mo.	13	19	101	243	91	122	-	2	-	-	2	-
N. Dak.	7	2	3	3	1	2	-	-	-	-	-	-
S. Dak.	-	1	2	1	1	1	-	-	-	-	-	-
Nebr.	1	3	30	30	19	38	-	-	-	-	-	-
Kans.	1	4	159	97	17	24	-	-	-	-	-	1
S. ATLANTIC	325	243	2,080	1,261	1,308	1,083	-	4	-	1	5	4
Del.	-	-	-	15	-	14	-	-	-	-	-	-
Md.	74	74	234	181	124	111	-	2	-	1	3	-
D.C.	-	-	47	23	11	28	-	-	-	-	-	-
Va.	27	35	113	136	150	140	-	1	-	-	1	2
W. Va.	14	8	18	53	20	13	-	-	-	-	-	-
N.C.	44	22	198	125	173	208	-	-	-	-	-	-
S.C.	6	7	65	72	28	21	-	-	-	-	-	-
Ga.	87	61	853	256	442	197	-	1	-	-	1	-
Fla.	73	36	552	400	360	351	-	-	-	-	-	2
E.S. CENTRAL	65	41	338	355	367	397	-	2	-	-	2	-
Ky.	2	12	117	46	40	66	U	2	U	-	2	-
Tenn.	35	17	137	125	199	187	-	-	-	-	-	-
Ala.	26	10	68	46	74	50	-	-	-	-	-	-
Miss.	2	2	16	138	54	94	-	-	-	-	-	-
W.S. CENTRAL	41	61	1,155	2,095	575	974	-	-	-	1	1	-
Ark.	1	2	62	123	85	87	-	-	-	-	-	-
La.	3	16	56	77	41	137	-	-	-	-	-	-
Okla.	36	41	107	226	70	135	-	-	-	-	-	-
Tex.	1	2	930	1,669	379	615	-	-	-	1	1	-
MOUNTAIN	123	104	649	786	432	453	-	1	-	1	2	12
Mont.	-	1	11	7	3	6	-	-	-	-	-	-
Idaho	1	4	54	26	11	6	-	-	-	1	1	-
Wyo.	-	1	7	4	2	3	-	-	-	-	-	-
Colo.	32	27	79	176	95	86	-	-	-	-	-	2
N. Mex.	20	21	35	67	125	121	-	-	-	-	-	-
Ariz.	54	35	347	389	130	169	-	1	-	-	1	-
Utah	6	11	64	51	26	20	-	-	-	-	-	3
Nev.	10	4	52	66	40	42	-	-	-	-	-	7
PACIFIC	93	136	1,708	3,030	973	1,101	-	29	-	18	47	21
Wash.	5	5	127	254	123	94	-	13	-	2	15	3
Oreg.	17	31	68	155	91	100	-	4	-	-	4	-
Calif.	43	34	1,496	2,595	734	886	-	10	-	11	21	14
Alaska	6	43	14	13	9	10	-	-	-	-	-	1
Hawaii	22	23	3	13	16	11	-	2	-	5	7	3
Guam	-	1	-	1	-	9	-	-	-	-	-	-
P.R.	1	4	119	221	173	251	-	-	-	-	-	2
V.I.	-	-	-	-	-	-	U	-	U	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	28	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).

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

[‡] Of 235 cases among children aged <5 years, serotype was reported for 117, and of those, 20 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending November 3, 2001, and November 4, 2000 (44th 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	1,762	1,878	5	189	279	93	3,951	5,872	-	21	165
NEW ENGLAND	98	113	-	-	4	-	346	1,525	-	-	12
Maine	4	8	-	-	-	-	21	41	-	-	-
N.H.	13	11	-	-	-	-	27	111	-	-	2
Vt.	5	3	-	-	-	-	27	210	-	-	-
Mass.	50	65	-	-	1	-	249	1,103	-	-	8
R.I.	4	9	-	-	1	-	5	18	-	-	1
Conn.	22	17	-	-	2	-	17	42	-	-	1
MID. ATLANTIC	184	215	-	20	23	-	256	580	-	5	9
Upstate N.Y.	53	64	-	3	10	-	124	292	-	1	1
N.Y. City	34	38	-	10	6	-	44	78	-	3	8
N.J.	43	43	-	3	3	-	18	30	-	1	-
Pa.	54	70	-	4	4	-	70	180	-	-	-
E.N. CENTRAL	223	338	1	18	21	17	552	677	-	3	1
Ohio	67	79	-	1	7	15	218	288	-	-	-
Ind.	35	38	1	3	1	-	78	93	-	1	-
Ill.	22	77	-	11	6	1	66	98	-	2	1
Mich.	57	103	-	3	6	1	123	86	-	-	-
Wis.	42	41	-	-	1	-	67	112	-	-	-
W.N. CENTRAL	127	134	-	7	17	46	293	513	-	3	2
Minn.	18	20	-	3	-	41	146	314	-	-	1
Iowa	26	31	-	-	7	5	26	47	-	1	-
Mo.	46	61	-	-	4	-	90	74	-	1	-
N. Dak.	6	2	-	-	1	-	4	6	-	-	-
S. Dak.	5	5	-	-	-	-	4	7	-	-	-
Nebr.	12	6	-	1	2	-	4	26	-	-	1
Kans.	14	9	-	3	3	-	19	39	-	1	-
S. ATLANTIC	334	259	2	36	40	6	224	438	-	7	112
Del.	4	1	-	-	-	-	-	8	-	1	1
Md.	37	26	-	6	9	-	32	111	-	-	-
D.C.	-	-	-	-	-	-	1	3	-	-	-
Va.	36	37	2	8	9	5	41	97	-	-	-
W. Va.	12	13	-	-	-	1	3	1	-	-	-
N.C.	61	36	-	5	6	-	63	96	-	-	82
S.C.	31	21	-	5	10	-	31	28	-	2	27
Ga.	46	43	-	7	2	-	27	37	-	1	-
Fla.	107	82	-	5	4	-	26	57	-	3	2
E.S. CENTRAL	119	124	-	8	5	-	128	103	-	-	6
Ky.	20	26	U	3	1	U	34	52	U	-	1
Tenn.	56	52	-	1	2	-	55	31	-	-	1
Ala.	30	33	-	-	2	-	35	17	-	-	4
Miss.	13	13	-	4	-	-	4	3	-	-	-
W.S. CENTRAL	195	199	-	11	29	13	415	323	-	1	8
Ark.	18	12	-	1	1	4	43	34	-	-	1
La.	59	43	-	2	5	-	2	19	-	-	1
Okla.	27	26	-	-	-	-	18	27	-	-	-
Tex.	91	118	-	8	23	9	352	243	-	1	6
MOUNTAIN	81	80	-	11	18	11	1,164	674	-	1	2
Mont.	4	4	-	1	1	4	35	35	-	-	-
Idaho	7	7	-	1	-	-	169	57	-	-	-
Wyo.	5	-	-	1	1	-	1	4	-	-	-
Colo.	29	29	-	1	-	6	238	397	-	1	1
N. Mex.	10	8	-	2	1	-	132	85	-	-	-
Ariz.	13	22	-	1	4	-	498	63	-	-	1
Utah	7	7	-	1	5	-	74	21	-	-	-
Nev.	6	3	-	3	6	1	17	12	-	-	-
PACIFIC	401	416	2	78	122	-	573	1,039	-	1	13
Wash.	60	51	1	2	9	-	136	352	-	-	7
Oreg.	38	58	N	N	N	-	45	106	-	-	-
Calif.	289	291	1	39	85	-	353	523	-	-	6
Alaska	2	8	-	1	8	-	8	20	-	-	-
Hawaii	12	8	-	36	20	-	31	38	-	1	-
Guam	-	-	-	-	14	-	-	3	-	-	1
P.R.	4	9	-	-	-	-	2	7	-	-	-
V.I.	-	-	U	U	U	U	-	-	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	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
November 3, 2001 (44th Week)**

Reporting Area	All Causes, By Age (Years)						P&I† Total	Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1			All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	396	299	62	24	2	9	40	S. ATLANTIC	1,278	833	275	98	35	37	84
Boston, Mass.	U	U	U	U	U	U	U	Atlanta, Ga.	186	127	32	14	7	6	4
Bridgeport, Conn.	41	26	8	5	-	2	3	Baltimore, Md.	192	114	50	21	3	4	18
Cambridge, Mass.	13	10	2	1	-	-	2	Charlotte, N.C.	124	84	23	13	2	2	8
Fall River, Mass.	33	24	5	3	1	-	4	Jacksonville, Fla.	129	85	34	4	1	5	10
Hartford, Conn.	34	20	7	2	-	5	4	Miami, Fla.	91	56	20	10	3	2	8
Lowell, Mass.	22	21	-	1	-	-	5	Norfolk, Va.	41	33	4	3	-	1	1
Lynn, Mass.	1	1	-	-	-	-	1	Richmond, Va.	68	46	13	2	6	1	3
New Bedford, Mass.	21	15	5	1	-	-	4	Savannah, Ga.	62	37	16	6	3	-	5
New Haven, Conn.	38	30	6	1	-	1	4	St. Petersburg, Fla.	68	53	12	1	2	-	8
Providence, R.I.	62	50	9	3	-	-	-	Tampa, Fla.	184	124	39	12	4	5	16
Somerville, Mass.	5	4	-	-	-	1	-	Washington, D.C.	108	57	27	10	4	10	1
Springfield, Mass.	48	37	8	2	1	-	4	Wilmington, Del.	25	17	5	2	-	1	2
Waterbury, Conn.	23	18	3	2	-	-	3	E.S. CENTRAL	841	574	164	58	20	24	71
Worcester, Mass.	55	43	9	3	-	-	6	Birmingham, Ala.	179	127	37	8	2	4	18
MID. ATLANTIC	2,844	1,575	638	538	53	38	113	Chattanooga, Tenn.	84	61	17	5	-	1	6
Albany, N.Y.	43	32	6	2	1	2	3	Knoxville, Tenn.	107	80	19	4	2	2	6
Allentown, Pa.	18	15	3	-	-	-	2	Lexington, Ky.	43	31	8	-	3	1	2
Buffalo, N.Y.	U	U	U	U	U	U	U	Memphis, Tenn.	187	112	40	19	7	9	17
Camden, N.J.	16	11	3	1	-	1	-	Mobile, Ala.	51	32	13	4	1	1	4
Elizabeth, N.J.	U	U	U	U	U	U	U	Montgomery, Ala.	42	33	6	2	-	1	3
Erie, Pa.‡	39	30	7	2	-	-	1	Nashville, Tenn.	148	98	24	16	5	5	15
Jersey City, N.J.	31	23	5	1	2	-	-	W.S. CENTRAL	1,315	832	278	116	49	39	83
New York City, N.Y.	1,915	882	486	489	38	18	48	Austin, Tex.	U	U	U	U	U	U	U
Newark, N.J.	U	U	U	U	U	U	U	Baton Rouge, La.	90	59	22	4	5	-	5
Paterson, N.J.	19	13	4	2	-	-	2	Corpus Christi, Tex.	49	34	8	3	-	4	3
Philadelphia, Pa.	369	259	69	25	8	8	18	Dallas, Tex.	184	115	39	19	5	6	10
Pittsburgh, Pa.‡	31	22	5	3	1	-	2	El Paso, Tex.	U	U	U	U	U	U	U
Reading, Pa.	21	17	3	1	-	-	1	Ft. Worth, Tex.	120	78	28	5	2	7	4
Rochester, N.Y.	131	101	22	6	-	2	12	Houston, Tex.	357	182	81	53	29	12	18
Schenectady, N.Y.	22	14	6	2	-	-	2	Little Rock, Ark.	75	50	15	4	3	2	4
Scranton, Pa.‡	33	31	2	-	-	-	3	New Orleans, La.	U	U	U	U	U	U	U
Syracuse, N.Y.	101	81	9	3	3	5	16	San Antonio, Tex.	204	136	45	15	4	4	10
Trenton, N.J.	31	22	6	1	-	2	3	Shreveport, La.	88	69	12	5	1	1	15
Utica, N.Y.	24	22	2	-	-	-	-	Tulsa, Okla.	148	109	28	8	-	3	14
Yonkers, N.Y.	U	U	U	U	U	U	U	MOUNTAIN	1,125	766	226	78	32	23	81
E.N. CENTRAL	1,718	1,244	291	110	26	47	123	Albuquerque, N.M.	149	107	23	10	5	4	19
Akron, Ohio	42	30	6	1	1	4	3	Boise, Idaho	46	33	11	1	-	1	1
Canton, Ohio	43	31	10	2	-	-	6	Colo. Springs, Colo.	73	53	13	4	3	-	4
Chicago, Ill.	U	U	U	U	U	U	U	Denver, Colo.	102	60	25	5	2	10	5
Cincinnati, Ohio	113	76	19	11	2	5	10	Las Vegas, Nev.	293	190	73	27	3	-	13
Cleveland, Ohio	130	83	33	9	1	4	4	Ogden, Utah	41	33	7	1	-	-	2
Columbus, Ohio	196	143	36	8	5	5	10	Phoenix, Ariz.	118	69	27	11	7	4	6
Dayton, Ohio	118	84	22	7	3	2	10	Pueblo, Colo.	42	34	6	1	1	-	2
Detroit, Mich.	160	86	37	22	4	11	13	Salt Lake City, Utah	108	75	17	8	4	4	13
Evansville, Ind.	59	49	8	2	-	-	4	Tucson, Ariz.	153	112	24	10	7	-	16
Fort Wayne, Ind.	85	66	14	4	1	-	4	PACIFIC	1,488	1,009	303	108	29	38	117
Gary, Ind.	26	12	6	7	1	-	1	Berkeley, Calif.	15	9	3	1	-	2	1
Grand Rapids, Mich.	66	50	7	5	1	3	8	Fresno, Calif.	97	67	22	6	2	-	2
Indianapolis, Ind.	188	120	43	18	2	5	13	Glendale, Calif.	19	14	5	-	-	-	3
Lansing, Mich.	51	43	6	1	1	-	8	Honolulu, Hawaii	73	50	13	5	4	1	6
Milwaukee, Wis.	119	100	13	2	1	3	12	Long Beach, Calif.	74	50	12	7	2	3	6
Peoria, Ill.	57	45	6	2	2	2	2	Los Angeles, Calif.	381	248	80	38	5	10	28
Rockford, Ill.	62	55	1	5	-	1	7	Pasadena, Calif.	24	14	6	3	-	1	2
South Bend, Ind.	44	39	3	1	1	-	6	Portland, Oreg.	113	74	21	11	4	3	5
Toledo, Ohio	93	74	15	3	-	1	5	Sacramento, Calif.	205	134	50	13	3	5	17
Youngstown, Ohio	66	58	7	-	-	1	2	San Diego, Calif.	159	114	25	8	3	8	14
W.N. CENTRAL	902	623	165	68	22	24	68	San Francisco, Calif.	U	U	U	U	U	U	U
Des Moines, Iowa	114	84	21	7	-	2	20	San Jose, Calif.	U	U	U	U	U	U	U
Duluth, Minn.	28	22	4	1	-	1	1	Santa Cruz, Calif.	27	18	7	2	-	-	3
Kansas City, Kans.	31	18	6	6	1	-	1	Seattle, Wash.	129	86	30	7	5	1	12
Kansas City, Mo.	88	59	16	6	4	3	6	Spokane, Wash.	59	47	7	3	1	1	11
Lincoln, Nebr.	37	31	3	1	2	-	-	Tacoma, Wash.	113	84	22	4	-	3	7
Minneapolis, Minn.	197	141	38	15	1	2	20	TOTAL	11,907†	7,755	2,402	1,198	268	279	780
Omaha, Nebr.	94	60	20	9	2	3	11								
St. Louis, Mo.	107	66	25	7	5	4	3								
St. Paul, Minn.	74	64	5	3	1	1	4								
Wichita, Kans.	132	78	27	13	6	8	2								

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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