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Mortality Patterns — United States, 1993

In 1993, a total of 2,268,553 deaths were registered in the United States—92,940 more than in 1992 and the highest number ever recorded (*1*). In addition, life expectancy at birth declined for the first time since 1980. This report characterizes mortality patterns in 1993 (the most recent year for which complete data were available) (*1*) and compares these with patterns in 1992.

National mortality statistics are based on information from death certificates filed in state vital statistics offices as required by state law and are compiled by CDC into a national database. Cause-of-death statistics are based on the underlying cause of death*, which is recorded on the death certificate by the attending physician, medical examiner, or coroner in a manner specified by the World Health Organization (WHO) and endorsed by CDC. Data are presented only for blacks and whites because of inconsistent reporting of other racial/ethnic groups on death certificates.

From 1992 to 1993, the crude death rate increased 3.2% (from 852.9 to 880.0 deaths per 100,000 population); the age-adjusted death rate† increased 1.7% (from 504.5 to 513.3 per 100,000 population). The 10 leading causes of death and their rankings were unchanged during this period; mortality decreased only for cancer (–0.4%) (Table 1)§. The largest increase in age-adjusted death rate (9.5%) was for human immunodeficiency virus (HIV) infection (*International Classification of Diseases, Ninth Revision* [ICD-9], codes 042–044¶); this rate (13.8) was the highest ever recorded for HIV infection (*1*).

From 1992 to 1993, age-adjusted death rates increased 1.6% for whites** (from 477.5 to 485.1) and 2.3% for blacks (from 767.5 to 785.2). Rates were higher for blacks

* Defined by the World Health Organization's *International Classification of Diseases, Ninth Revision*, as "(a) the disease or injury which initiated the train of morbid events leading directly to death, or (b) the circumstances of the accident or violence which produced the fatal injury."

† Age-adjusted to the 1940 U.S. population. Age-adjusted death rates indicate the risk for death relative to a standard population and are more effective than crude death rates for comparing mortality of population groups with different age structures.

§ "Motor-vehicle accidents" and "all other accidents and adverse effects" are not included as causes of death for which the rate has decreased because these causes are subcategories of the leading cause "accidents and adverse effects." When a death occurs under "accidental" circumstances, the preferred term within the public health community is "unintentional injury."

¶ These codes are from addenda to the ICD-9 (*2*).

** Hispanics and non-Hispanics are included in totals for both whites and blacks.

Mortality — Continued

TABLE 1. Age-adjusted death rates* for 1993 and percentage changes in age-adjusted death rates for the 10 leading causes of death from 1992 to 1993 and from 1979 to 1993 — United States

Rank†	Cause of death (ICD-9§ code)	1993 Age-adjusted death rate	% Change 1992 to 1993	% Change 1979 to 1993
1	Diseases of heart (390–398, 402, 404–429)	145.3	0.7	–27.2
2	Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues (140–208)	132.6	–0.4	1.4
3	Cerebrovascular diseases (430–438)	26.5	1.1	–36.3
4	Chronic obstructive pulmonary diseases and allied conditions (490–496)	21.4	7.5	46.6
5	Accidents¶ and adverse effects (E800–E949)	30.3	3.1	–29.4
	Motor-vehicle accidents (E810–E825)	16.0	1.3	–31.0
	All other accidents and adverse effects (E800–E807, E826–E949)	14.4	5.1	–26.5
6	Pneumonia and influenza (480–487)	13.5	6.3	20.5
7	Diabetes mellitus (250)	12.4	4.2	26.5
8	Human immunodeficiency virus infection (042–044)**	13.8	9.5	—
9	Suicide (E950–E959)	11.3	1.8	– 3.4
10	Homicide and legal intervention (E960–E978)	10.7	1.9	4.9

* Per 100,000 population, age-adjusted to the 1940 U.S. population.
† Based on number of deaths.
§ *International Classification of Diseases, Ninth Revision*.
¶ When a death occurs under "accidental" circumstances, the preferred term within the public health community is "unintentional injury."
** These codes are from addenda to the ICD-9 (*2*).

than for whites for eight of the 10 leading causes (Table 2). Race-specific ratios were greatest for homicide (6.8) and HIV infection (4.0). Death rates for blacks were lower for chronic obstructive pulmonary diseases and allied conditions (COPD) (ICD-9 codes 490–496; 0.8) and suicide (ICD-9 codes E950–E959; 0.6).

From 1992 to 1993, age-adjusted death rates increased 1.3% for males (from 656.0 to 664.9) and 2.1% for females (from 380.3 to 388.3). Rates were higher for males than females for all 10 leading causes (Table 2). Sex-specific ratios were greatest for HIV infection (6.3), suicide (4.4), and homicide (3.8). Compared with 1992, sex-specific ratios decreased for HIV infection and homicide. The sex-specific ratio was lowest for diabetes mellitus (ICD-9 code 250; 1.2).

In 1993, a total of 302 women were reported to have died from causes associated with pregnancy and childbirth (i.e., deaths assigned to complications of pregnancy, childbirth, and the puerperium [ICD-9 codes 630–676]). The overall maternal mortality rate was 7.5 deaths per 100,000 live-born infants. However, this rate was approximately four times higher for blacks than for whites (20.5 versus 4.8).

From 1992 to 1993, overall life expectancy (LE) at birth declined from 75.8 years to 75.5 years. As in 1992, LE at birth continued to be highest among white females (79.5 years), followed by black females (73.7 years), white males (73.1 years), and black males (64.6 years). Although LE declined for all four racial-sex groups during 1992–1993, the overall race-specific difference in LE for blacks and whites increased slightly, from 6.9 years in 1992 to 7.1 years in 1993.

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Mortality — Continued

TABLE 2. Ratio of age-adjusted death rates* from the 10 leading causes of death, by sex and race of decedent — United States, 1993

Rank†	Cause of death (ICD-9§ code)	Male:Female	Black:White¶
1	Diseases of heart (390–398, 402, 404–429)	1.9	1.5
2	Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues (140–208)	1.5	1.4
3	Cerebrovascular diseases (430–438)	1.2	1.8
4	Chronic obstructive pulmonary diseases and allied conditions (490–496)	1.6	0.8
5	Accidents** and adverse effects (E800–E949)	2.6	1.3
	Motor-vehicle accidents (E810–E825)	2.3	1.0
	All other accidents and adverse effects (E800–E807, E826–E949)	2.9	1.6
6	Pneumonia and influenza (480–487)	1.6	1.4
7	Diabetes mellitus (250)	1.2	2.4
8	Human immunodeficiency virus infection (042–044)††	6.3	4.0
9	Suicide (E950–E959)	4.4	0.6
10	Homicide and legal intervention (E960–E978)	3.8	6.8

* Per 100,000 population, age-adjusted to the 1940 U.S. population.
† Based on number of deaths.
§ *International Classification of Diseases, Ninth Revision*.
¶ Both groups include Hispanics. Numbers for other racial/ethnic groups were too small for meaningful analysis.
** When a death occurs under "accidental" circumstances, the preferred term within the public health community is "unintentional injury."
†† These codes are from addenda to the ICD-9 (*2*).

Editorial Note: LE summarizes death rates by age into a single measure used as an indicator of the nation's health. Death rates and LE can be used to monitor health status and progress toward national health objectives and to identify groups at increased risk for specific diseases and injuries. The findings in this report indicate that, in 1993, crude and age-adjusted death rates increased and LE decreased from 1992. The decline in LE most likely reflects increases in death rates for 1) chronic diseases during the two influenza outbreaks of 1993, 2) pneumonia and influenza, and 3) HIV infection and unintentional injuries. Race-specific variation in death rates are accounted for, in part, by differences in factors such as socioeconomic status, access to medical care, and risk behaviors. The increases in both the crude and age-adjusted rates in 1993 are the first since 1988 and 1975, respectively; however, preliminary analysis of provisional data for 1994 suggest small, but statistically significant, decreases in these rates (*3*).

In 1993, death rates for some chronic diseases—heart disease, stroke, COPD, and diabetes—and for pneumonia and influenza accounted for nearly 75% of all deaths during the year. This analysis especially highlights the role of heart disease and cancer as leading causes of death in the United States; these two causes accounted for approximately 56% of deaths in 1993. Although increases in the rates for HIV infection and unintentional injuries among younger persons contributed to the decline in LE, most increases in mortality were among persons aged ≥65 years.

Mortality — Continued

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Animal Rabies — South Dakota, 1995

On July 28, 1995, the South Dakota Public Health Laboratory diagnosed rabies in an 8-week-old puppy; on July 23, the puppy had had onset of neurologic signs (e.g., head tilt, ataxia, and somnolence) that culminated in seizures, and the puppy was euthanized. A clinically normal littermate owned by a neighboring family was euthanized on July 31 and tested positive for rabies. This report summarizes the epidemiologic investigation and follow-up management by the South Dakota Department of Health (SDDH), with assistance from CDC, of persons and domestic animals potentially exposed to rabies.

On July 8, the neighboring families acquired the two puppies from a private owner near Summit, South Dakota. The puppies were from a litter of nine born on May 29. On June 13 or 14, a skunk attacked the litter in a garage where they were kept. The skunk was killed by the owner of the puppies but was not tested for rabies. All the puppies were free of clinical signs consistent with rabies when given away between July 8 and July 27. However, the original owner of the puppies was uncertain of the identity of all the persons who had adopted them. Through announcements in the local news media and distribution of flyers door-to-door by the Aberdeen Area Indian Health Service in Sisseton, by August 4 the remaining seven puppies were identified to be in private residences located throughout eastern South Dakota. Six of the puppies tested negative for rabies at the South Dakota Public Health Laboratory; the seventh puppy had been killed by the owner because it was part of the exposed litter, and it was unavailable for testing. The dam of the litter and another contact dog—neither of which were currently vaccinated against rabies—were euthanized and tested negative for rabies. Two other potentially exposed pet dogs, past due for rabies vaccination, were identified; they were managed by home quarantine and booster vaccination according to the 1995 animal rabies compendium (*1*) and remained symptom-free.

The SDDH initiated efforts to identify persons with potential exposure to the two puppies and determine their risk for rabies infection. In response to the alert, the state health department and four major health-care facilities screened by phone or personal interview approximately 150 persons possibly exposed during July 13–31 (the established period of potential rabies transmission). In addition, SDDH conducted town meetings and provided briefings to health-care providers, the news media, and animal-control authorities. Of the 150 persons, 22 (15%) (including nine persons from the veterinary clinic in which the ill puppy had been treated and euthanized and seven persons who had had contact with the puppy that had been destroyed and was un-

Rabies — Continued

available for rabies testing) met the criteria used to determine the need for rabies postexposure treatment (PET) for either a bite or nonbite exposure as defined by the Immunization Practices Advisory Committee (*2*). Specific antirabies treatment was initiated for 31 persons; the other nine persons requested and received PET despite reassurance they were at low risk for rabies infection.

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Editorial Note: In the United States, the most frequently reported rabid wild animals are raccoons, skunks, bats, and foxes (*3*). Although the exposure for the two rabid puppies in this report was not confirmed, the skunk that attacked the litter in mid-June was probably the source of infection. Measures for preventing pets from contacting wild animals include keeping them indoors, on leashes, or in fenced outdoor areas. If pets are wounded by wild animals, wounds should be washed immediately with soap and water, and the pet should be evaluated by a veterinarian. Wildlife that attacks persons or pets should be apprehended by trained personnel, euthanized, and tested for rabies. Wild and stray domestic animals exhibiting signs of neurologic illness or of abnormal behavior (signs of rabies among wild animals cannot be interpreted reliably) should be reported to appropriate local health authorities, especially if the animal bites or scratches a person. Only trained personnel should attempt to trap or capture these animals and submit them for rabies testing.

The economic burden of the exposures in South Dakota was minimized because of the small number of persons requiring PET and as a result of efforts to inform and reassure persons who unnecessarily were seeking medical services for exposures not associated with true risk (e.g., petting a rabid puppy, handling a noninfected littermate, or having contact with a human who had been exposed to a rabid puppy). Nonetheless, substantial resources were required to educate potentially exposed persons about rabid animals and to conduct the prompt and standardized assessment of persons who received PET (*4*). The estimated cost associated with the public health response, assessment, and PET was $115,000: $97,900 for chemoprophylaxis and provider services, $16,500 for the investigation by public health officials, and $600 for laboratory testing of animals. In South Dakota, from 1990 through 1995, an estimated $1.4 million was spent for PET for 632 persons exposed to approximately 704 rabies-positive animals. Although this estimate is for a 5-year period, it is similar to the cost ($1.5 million) associated with the single-point source exposure to a rabid kitten in New Hampshire, in which PET was initiated for 665 persons (*5*). To facilitate efforts to investigate rabies exposures such as those described in this report, persons involved in the private sale or adoption of pets are encouraged to maintain records of buyers' or adoptees' names and addresses.

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Rabies — Continued

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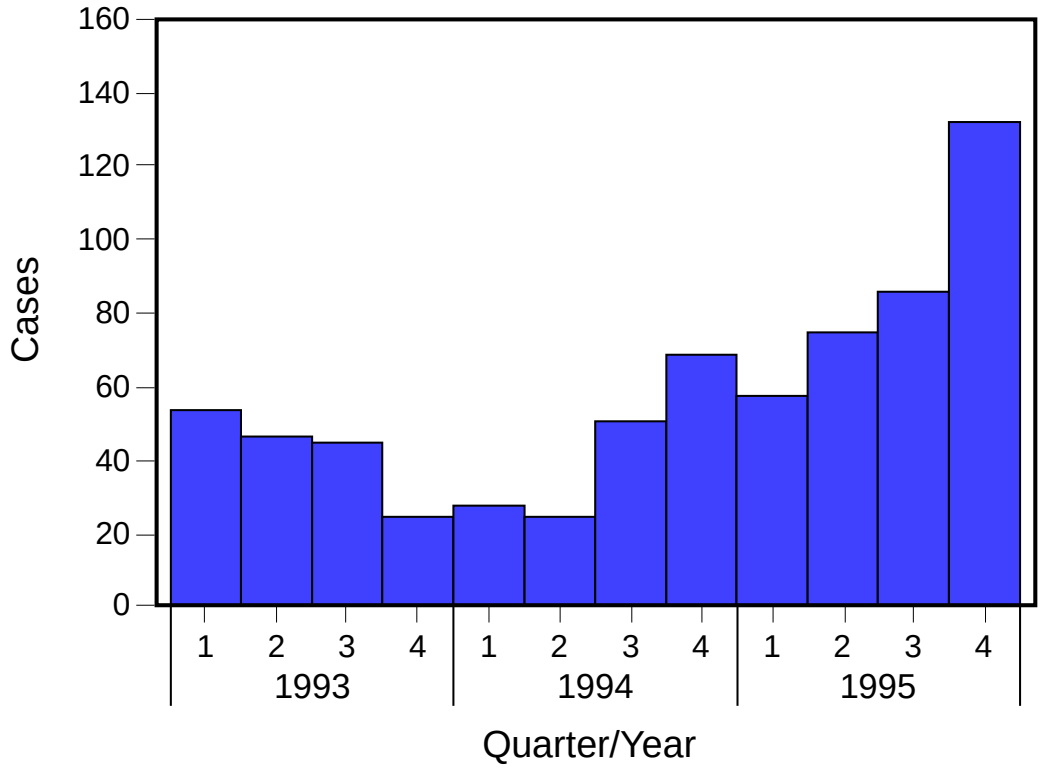
Outbreak of Primary and Secondary Syphilis — Baltimore City, Maryland, 1995

From 1993 to 1995, the number of primary and secondary syphilis cases reported in Baltimore City (1990 population: 736,014) increased 97%, from 179 to 352 cases per year (Figure 1). To identify potential reasons for this increase, CDC, in collaboration with the Baltimore City Health Department (BCHD) and the Maryland Department of Health and Mental Hygiene, analyzed data about primary and secondary syphilis cases during 1992–1995 and about temporal trends in factors that may affect syphilis rates (e.g., partner-notification results, access to medical care, and community illicit-drug use). In addition, data were analyzed from the two public sexually transmitted disease (STD) clinics in Baltimore City. BCHD collects demographic data for all cases of reported syphilis among patients who reside in Baltimore City and attempts to

FIGURE 1. Number of cases of primary and secondary syphilis, by quarter and year of report — Baltimore City, Maryland, 1993–1995



Syphilis — Continued

interview and provide partner notification and treatment for these patients. This report summarizes the results of the analysis, which suggest the outbreak has been associated with decreases in partner notification and health department clinical services and a substantial increase in community cocaine use.

Epidemiology

Of 344 patients with primary or secondary syphilis reported in 1995 and for whom demographic information was available, 196 (57%) were non-Hispanic black males; 120 (35%), non-Hispanic black females; 16 (5%), non-Hispanic white males; nine (3%), non-Hispanic white females; and three (1%), Hispanic (two males and one female). The mean age of males was 37.3 years (range: 13–69 years) and of females, 30.3 years (range: 14–58 years). Among persons with primary or secondary syphilis reported in 1995 and for whom self-reported sexual orientation was known, 16 (8%) of 206 men and nine (7%) of 123 women reported same-sex sexual contact since 1978; in addition, 56 (27%) men and 18 (15%) women reported exchanging money or drugs for sex.

During 1995 at one of the two STD clinics, cocaine use was reported by 18 (26%) of 70 male patients with a presumptive diagnosis of primary or secondary syphilis, compared with 663 (14%) of 4780 without a presumptive diagnosis ($p<0.01$). Among female patients, cocaine use was reported by 27 (28%) of 97 with a presumptive diagnosis of primary or secondary syphilis, compared with 299 (13%) of 2281 without a presumptive diagnosis ($p<0.01$). In addition, among female patients with a presumptive diagnosis of primary or secondary syphilis, prostitution was reported by nine (35%) of 26 who reported cocaine use, compared with one (1%) of 69 who did not use cocaine ($p<0.01$).

During January–September 1995, tests for human immunodeficiency virus (HIV) were positive for 22 (8%) of 265 STD clinic patients with early syphilis (i.e., primary, secondary, or early latent) who were tested for HIV at the time syphilis was diagnosed; in comparison, HIV-antibody tests were positive for 243 (3%) of 7079 STD clinic patients without early syphilis ($p<0.01$). Based on analysis of interview records, of 293 persons with early syphilis in 1995 for whom current HIV serostatus was known (including persons who were HIV-infected before their syphilis infection), 54 (18%) were HIV-infected.

From 1993 to 1994, the number of clinicians at the two BCHD STD clinics decreased from 12 to eight and, from 1993 to 1995, the number of public health workers conducting partner notification decreased from 14 to eight. The contact index (i.e., the number of sex partners for whom information was sufficient to initiate efforts to locate that person divided by the number of persons with early syphilis interviewed), progressively declined from 1.3 in 1992 to 1.0 in 1995. The treatment index (i.e., the number of persons treated as a result of partner notification divided by the number of persons interviewed) declined from 0.6 in 1992 and 1.0 in 1993 to 0.4 in 1995.

From 1993 to 1995, the number of self-referred patients that visited the two public STD clinics declined 12% (from 17,190 to 15,197). In comparison, during each year from 1990 through 1994, the proportion of gonorrhea cases reported from private health-care providers, a potential marker for access to private provider STD care, remained nearly constant (57% to 59%).

Syphilis — Continued

Community Cocaine Use

Based on data from the Drug Abuse Warning Network (DAWN), from 1990 through 1994, the annual number of listings of cocaine by medical examiners in drug-abuse–death cases in Baltimore City increased 737% (*1*) (Figure 2), and the annual number of cocaine-related emergency department episodes increased 239% (from 3023 to 10,243) (*2*). In addition, DAWN data indicated that the crack cocaine epidemic began in Baltimore City later than in other east coast cities. From 1990 through 1995, annual listings of crack cocaine use by Baltimore City residents entering drug treatment increased 196% (from 2131 to 6312) (Maryland Alcohol and Drug Abuse Administration, unpublished data).

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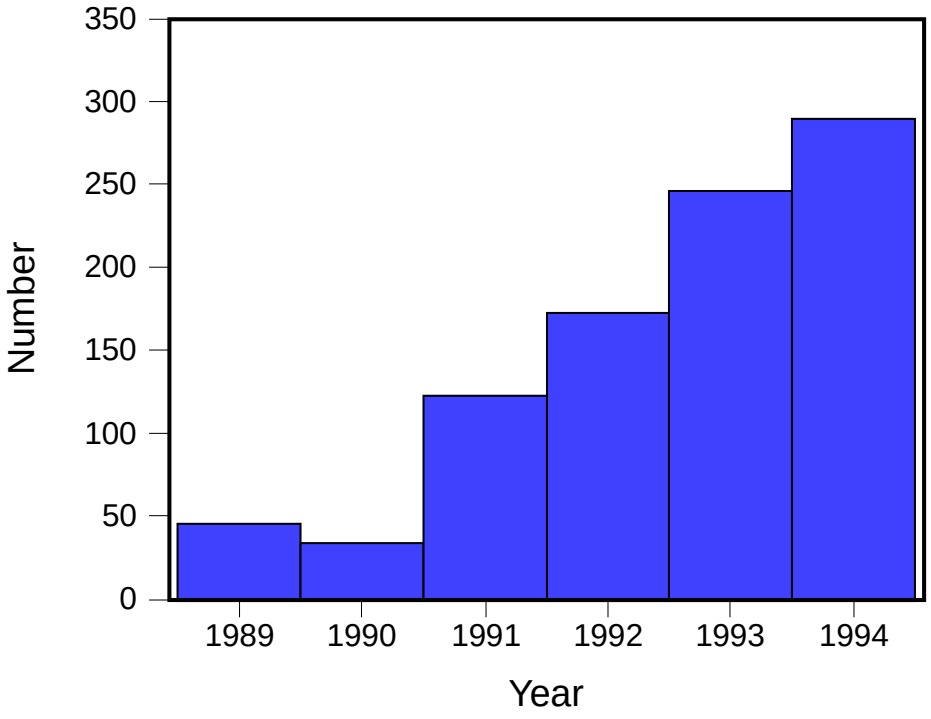
Editorial Note: During 1990, the rate for primary and secondary syphilis in the United States (20.3 per 100,000 population) was the highest since the 1940s and approximately 10-fold higher than in other industrialized countries (*3*). Use of crack cocaine and the exchange of sex for drugs were identified as major contributors to this epidemic (*4*). Although the national rate had declined to 8.1 by 1994, endemic disease at high rates persists in some communities and outbreaks continue to occur.

The investigation of primary and secondary syphilis in Baltimore City identified epidemiologic patterns consistent with other urban areas of the United States: most cases occurred among blacks, and cocaine use and the exchange of money or drugs

FIGURE 2. Number of drug-abuse–related deaths with mentions of cocaine by medical examiners — Drug Abuse Warning Network, Baltimore City, Maryland, 1989–1994



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for sex were frequently reported risk behaviors; the predominance of cases among blacks may reflect factors including area of residence, socioeconomic status, and access to health services. A communitywide expansion in crack cocaine use preceded the increase in Baltimore City and most likely was the primary contributing factor. In addition, a decline in clinical and partner-notification service staffing may have limited the public health response to the increase in cases, although cocaine-associated syphilis outbreaks may be characterized by lower partner notification indices independent of available personnel (*5*).

At least three potential intersecting epidemics may be associated with the increased occurrence of early syphilis in Baltimore City, including crack-cocaine use, congenital syphilis, and HIV infection. Because the numbers of syphilis-infected pregnant women in Baltimore City may increase, efforts to prevent congenital syphilis must be intensified (*6*). HIV transmission in Baltimore City may be increasing because HIV infection is associated with the use of crack cocaine (*7*) and because genital ulcers directly facilitate HIV transmission (*8*). In a previous syphilis epidemic, 18% of all documented HIV seroconversion in STD clinic patients was attributable to syphilis infection (*9*). Because of the duration of the incubation period of HIV and its effect on recognition of HIV transmission patterns, additional efforts should assess whether early syphilis rates are useful indicators of risk for HIV transmission.

To control the increase in syphilis cases, BCHD is alerting the medical community about the syphilis outbreak (e.g., letters to and teleconferences with health-care providers), filling STD program personnel vacancies, and expanding case-finding and surveillance activities.

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Adult Blood Lead Epidemiology and Surveillance — United States, Third Quarter, 1995

CDC's National Institute for Occupational Safety and Health Adult Blood Lead Epidemiology and Surveillance program (ABLES) monitors elevated blood lead levels (BLLs) among adults in the United States (*1*). This report presents ABLES data for the third quarter of 1995.

During July–September 1995, the 5410 reports of BLLs ≥25 μg/dL represented a 14% decrease from the 6298 reports for the third quarter of 1994 (*2*). Compared with the third quarter of 1994, the number of reports for the same period in 1995 decreased 11% at the 25–39 μg/dL level, 29% at the 40–49 μg/dL level, and 11% at the 50–59 μg/dL level; they increased 23% at the ≥60 μg/dL level. For the first three quarters of 1995, cumulative reports of BLLs ≥25 μg/dL decreased by 4% from reports for the same period of 1994 (Table 1). The number of reports increased only at the lowest reporting level (25–39 μg/dL) and decreased at all higher reporting levels (40–49 μg/dL, 50–59 μg/dL, and ≥60 μg/dL).

Compared with quarterly data for 1994, the number of reports increased at the highest blood lead level (≥60 μg/dL) by 4% (from 112 to 117) in the second quarter (*3*) and again by 23% (from 90 to 111) in the third quarter of 1995. Reports at all lower BLLs decreased in both quarters.

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TABLE 1. Number of reports of elevated blood lead levels (BLLs) among adults, number of adults with elevated BLLs, and percentage change in number of reports — 23 states,* third quarter, 1995

Reported BLL (μg/dL)	Third quarter, 1995		Cumulative reports, 1995	Cumulative reports, 1994¶	% Change 1994 to 1995
	No. reports†	No. persons§			
25–39	4,151	3,318	13,458	13,311	+ 1%
40–49	941	702	3,290	4,077	–19%
50–59	207	141	660	773	–15%
≥60	111	72	310	319	– 3%
Total	**5,410**	**4,233**	**17,718**	**18,480**	**– 4%**

*Alabama, Arizona, California, Connecticut, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Utah, Vermont, Washington, and Wisconsin.

†Data for Alabama, Arizona, and South Carolina were missing; third quarter 1994 data were used as an estimate.

§Individual reports are categorized according to the highest reported BLL for the person during the given quarter. Pennsylvania provides the number of reports but not the number of persons; the numbers of persons for Pennsylvania in this table are estimates based on the proportions from the other 22 states combined and the number of reports received from Pennsylvania. Data for Alabama, Arizona, and South Carolina were missing; third quarter 1994 data were used as an estimate.

¶Data for the third quarter of 1994 include data for Maine, which were not previously included in the published report (*2*).

Adult Blood Lead Epidemiology and Surveillance — Continued

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Editorial Note: In contrast to previous reports, which documented a pattern of an increasing number of BLLs at lower levels and a decreasing number at higher levels, the findings in this report indicate a decrease at lower levels and an increase at higher levels. Variation in national quarterly reporting totals may result from 1) changes in the number of participating states; 2) timing of receipt of laboratory BLL reports by state-based surveillance programs; 3) changes in staffing and funding in state-based surveillance programs; and 4) interstate differences in worker BLL testing by lead-using industries. Variation from these sources reduces the capability to confidently identify trends in the actual data reported.

The findings in this report document the continuing hazard of work-related lead exposures as an occupational health problem in the United States. ABLES enhances surveillance for this preventable condition by expanding the number of participating states, reducing variability in reporting, and distinguishing between new and recurring elevated BLLs in adults.

References

1. CDC. Surveillance of elevated blood lead levels among adults—United States, 1992. MMWR 1992;41:285–8.
2. CDC. Adult blood lead epidemiology and surveillance—United States, third quarter, 1994. MMWR 1994;44:36–7.
3. CDC. Adult blood lead epidemiology and surveillance—United States, second quarter, 1995. MMWR 1995;44,801–2.

Notice to Readers

Availability of *Case Definitions for Public Health Surveillance* on Internet

In response to high demand from state and local health departments, the 1990 *MMWR Recommendations and Reports* entitled *Case Definitions for Public Health Surveillance* (*1*) is now available electronically on the Internet. This document provides case definitions for use by health-care providers, laboratories, and other public health personnel who report the occurrences of notifiable diseases to state and local health departments. The reported numbers of cases of selected notifiable diseases are printed each week in Tables I–III of *MMWR*.

Notice to Readers — Continued

Case definitions for specific conditions can be accessed individually as World-Wide Web (WWW) pages. To access these pages, use WWW browser software to connect to the CDC home page at **http://www.cdc.gov/**, then select ***MMWR* — Morbidity and Mortality Weekly Reports**; go to the "new" item titled **Case Definitions for Public Health Surveillance**. To access the *Case Definitions* directly, connect to **http://www.cdc.gov/epo/mmwr/other/case_def/about.html.**

Users can download the complete document as a .pdf file (Adobe® Acrobat®* portable document format) from the **Case Definitions for Public Health Surveillance** WWW page and from CDC's file transfer protocol server at **ftp.cdc.gov/**. When prompted for user name enter **anonymous**, and give your Internet e-mail address when prompted for the password. Select **pub/publications/mmwr/rr/rr3913.pdf** and download the file (309,488 bytes). Because of changes in software used for processing the file, the page numbers for this file do not correspond to those in the original document.

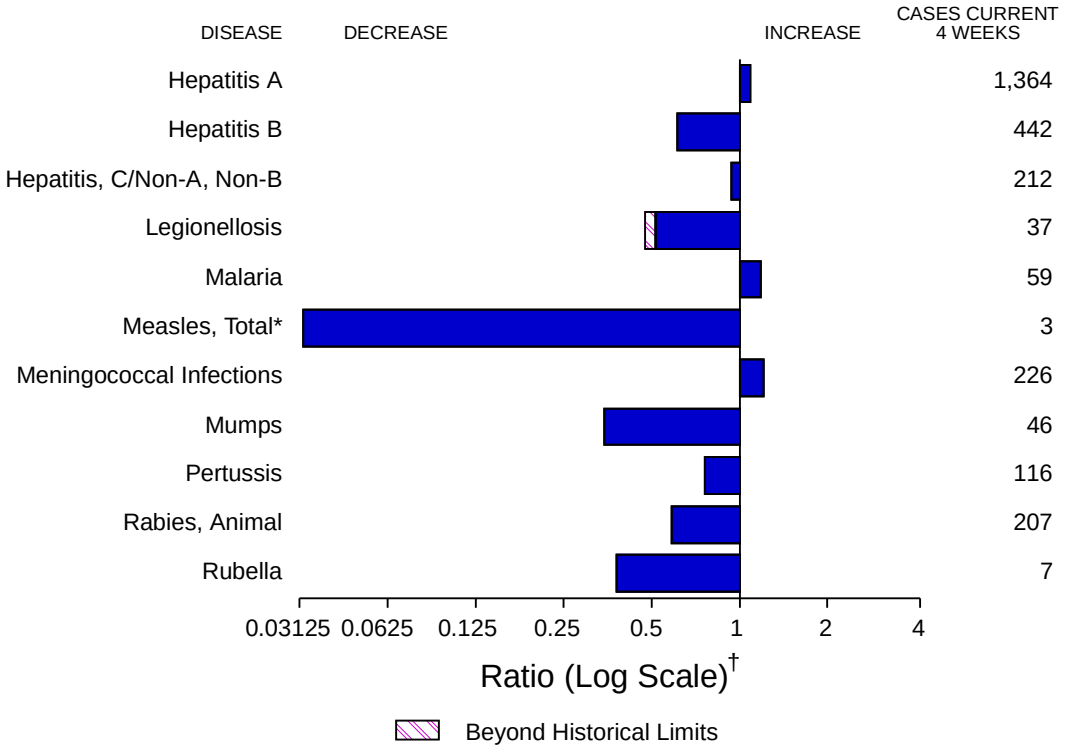
Case definitions for conditions recently made nationally reportable and newly revised case definitions will be included in a supplement to this 1990 publication, which will be added to this website at a later date. The Council of State and Territorial Epidemiologists and CDC are revising the entire case definitions document for publication in late 1996.

Reference

1. CDC. Case definitions for public health surveillance. MMWR 1990;39(no. RR-13).

*Use of trade names and commercial sources is for identification only and does not imply endorsement by the Public Health Service or the U.S. Department of Health and Human Services.

FIGURE I. Selected notifiable disease reports, comparison of 4-week totals ending February 24, 1996, with historical data — United States



*The large apparent decrease in the number of reported cases of measles (total) reflects dramatic fluctuations in the historical baseline.

†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 — cases of selected notifiable diseases, United States, cumulative, week ending February 24, 1996 (8th Week)

	Cum. 1996		Cum. 1996
Anthrax	-	HIV infection, pediatric*§	26
Brucellosis	6	Plague	-
Cholera	-	Poliomyelitis, paralytic¶	-
Congenital rubella syndrome	-	Psittacosis	2
Cryptosporidiosis*	136	Rabies, human	-
Diphtheria	1	Rocky Mountain spotted fever (RMSF)	8
Encephalitis: California*	-	Streptococcal toxic-shock syndrome*	1
eastern equine*	-	Syphilis, congenital**	-
St. Louis*	-	Tetanus	2
western equine*	-	Toxic-shock syndrome	18
Hansen Disease	9	Trichinosis	4
Hantavirus pulmonary syndrome*†	-	Typhoid fever	22

*Not notifiable in all states.
†Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID).
§Updated monthly to the Division of HIV/AIDS Prevention, National Center for Prevention Services (NCPS), last update January 30, 1996.
¶No suspected cases of polio reported for 1996.
**Updated quarterly from reports to the Division of STD Prevention, NCPS. First quarter 1996 is not yet available.
-: no reported cases

TABLE II. Cases of selected notifiable diseases, United States, weeks ending February 24, 1996, and February 25, 1995 (8th Week)

Reporting Area	AIDS*		Chlamydia	*Escherichia coli* O157:H7		Gonorrhea		Hepatitis C/NA,NB		Legionellosis	
				NETSS†	PHLIS§						
	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1996	Cum. 1996	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995
UNITED STATES	4,357	10,759	22,189	86	20	39,244	60,560	463	594	96	157
NEW ENGLAND	208	510	1,494	13	3	957	910	7	8	4	-
Maine	7	15	-	2	-	3	8	-	-	1	-
N.H.	3	12	98	1	1	18	17	-	1	-	-
Vt.	-	1	-	3	2	15	4	3	-	-	-
Mass.	135	285	1,045	4	-	362	512	4	7	2	-
R.I.	9	28	351	2	-	82	92	-	-	1	-
Conn.	54	169	-	1	-	477	277	-	-	N	N
MID. ATLANTIC	1,235	2,832	1,124	11	3	2,875	6,578	29	49	15	18
Upstate N.Y.	158	248	N	7	3	-	1,013	25	20	4	3
N.Y. City	696	1,571	-	-	-	713	2,124	1	1	-	1
N.J.	244	626	1,124	2	-	481	739	-	21	2	5
Pa.	137	387	-	N	-	1,681	2,702	3	7	9	9
E.N. CENTRAL	419	981	5,940	11	2	7,119	12,857	55	51	37	58
Ohio	143	125	907	8	-	566	4,460	2	1	17	24
Ind.	50	80	1,304	2	-	1,132	1,228	-	-	8	7
Ill.	156	531	-	1	1	2,783	2,990	1	18	-	12
Mich.	37	216	3,392	-	1	2,355	3,102	52	32	12	7
Wis.	33	29	337	N	-	283	1,077	-	-	-	8
W.N. CENTRAL	145	235	2,322	10	6	1,917	3,279	57	13	6	16
Minn.	20	64	-	1	4	-	492	-	-	-	-
Iowa	17	14	183	2	1	83	220	34	2	1	2
Mo.	53	98	1,585	1	-	1,357	1,854	23	7	1	14
N. Dak.	-	-	-	1	1	-	5	-	-	-	-
S. Dak.	2	-	166	-	-	24	28	-	1	1	-
Nebr.	15	20	388	1	-	57	173	-	1	3	-
Kans.	38	39	-	4	-	396	507	-	2	-	-
S. ATLANTIC	880	2,666	6,779	9	-	16,038	18,347	19	48	10	32
Del.	32	69	-	-	-	227	322	-	-	-	-
Md.	69	348	723	N	-	2,126	2,543	-	2	1	8
D.C.	64	140	N	-	-	700	972	-	-	1	1
Va.	36	233	1,631	N	-	1,192	1,686	1	-	2	-
W. Va.	7	13	-	N	-	95	106	4	14	1	3
N.C.	1	160	-	4	-	3,136	4,227	6	12	3	7
S.C.	13	165	-	1	-	2,037	1,951	1	1	1	3
Ga.	215	383	1,165	1	-	3,620	3,297	-	6	-	4
Fla.	443	1,155	3,260	-	-	2,905	3,243	7	13	1	6
E.S. CENTRAL	152	381	1,121	5	-	4,074	7,225	66	263	9	7
Ky.	43	38	-	-	-	637	808	1	2	2	2
Tenn.	56	167	1,101	N	-	1,201	1,807	65	260	3	3
Ala.	35	103	-	1	-	2,109	3,150	-	1	-	1
Miss.	18	73	20	2	-	127	1,460	-	-	4	1
W.S. CENTRAL	495	904	990	3	1	2,432	4,500	49	12	-	3
Ark.	19	45	-	2	-	438	560	-	-	-	-
La.	113	168	-	N	1	1,322	1,975	8	3	-	1
Okla.	1	57	990	1	-	672	58	32	7	-	2
Tex.	362	634	-	-	-	-	1,907	9	2	-	-
MOUNTAIN	120	408	757	8	1	986	1,442	111	57	5	18
Mont.	2	7	-	-	-	2	19	3	2	-	1
Idaho	1	15	229	2	-	12	26	43	8	-	1
Wyo.	-	4	102	-	-	6	8	29	22	-	-
Colo.	54	187	-	3	1	304	467	4	15	4	10
N. Mex.	8	34	-	-	-	146	194	20	5	-	1
Ariz.	37	88	-	N	-	385	448	8	2	-	1
Utah	17	5	68	2	-	26	31	4	3	-	2
Nev.	1	68	358	1	-	105	249	-	-	1	2
PACIFIC	703	1,842	1,662	16	4	2,846	5,422	70	93	10	5
Wash.	65	145	1,470	3	4	394	408	11	11	-	-
Oreg.	48	59	-	5	-	46	60	2	5	-	-
Calif.	580	1,547	-	6	-	2,280	4,700	31	69	10	3
Alaska	3	29	N	-	-	66	156	-	-	-	-
Hawaii	7	62	192	N	-	60	98	25	8	-	2
Guam	-	-	-	N	-	-	12	-	-	-	-
P.R.	255	494	N	N	U	28	75	8	12	-	-
V.I.	1	-	N	N	U	-	3	-	-	-	-
Amer. Samoa	-	-	-	N	U	-	6	-	-	-	-
C.N.M.I.	-	-	N	N	U	-	4	-	-	-	-

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

*Updated monthly to the Division of HIV/AIDS Prevention, National Center for Prevention Services, last update January 30, 1996.
†National Electronic Telecommunications System for Surveillance.
§Public Health Laboratory Information System.

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending February 24, 1996, and February 25, 1995 (8th Week)

Reporting Area	Lyme Disease		Malaria		Meningococcal Disease		Syphilis (Primary & Secondary)		Tuberculosis		Rabies, Animal	
	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995
UNITED STATES	367	626	116	143	575	499	1,441	2,436	1,605	1,771	418	810
NEW ENGLAND	22	24	4	7	23	31	24	30	43	29	53	226
Maine	-	-	1	-	6	2	-	-	4	-	-	-
N.H.	-	1	-	1	1	7	-	1	-	1	5	33
Vt.	-	1	1	-	1	2	-	-	-	-	11	28
Mass.	4	2	2	-	7	10	12	13	16	11	14	108
R.I.	13	-	-	2	-	-	-	-	7	6	7	-
Conn.	5	20	-	4	8	10	12	16	16	11	16	57
MID. ATLANTIC	305	504	35	31	40	50	47	164	173	287	72	194
Upstate N.Y.	89	200	9	3	9	17	-	13	23	30	23	117
N.Y. City	124	27	17	14	5	8	18	92	67	144	-	-
N.J.	-	78	6	10	14	16	16	31	62	59	20	37
Pa.	92	199	3	4	12	9	13	28	21	54	29	40
E.N. CENTRAL	6	5	12	21	68	76	308	402	298	229	4	1
Ohio	4	3	3	1	32	20	128	121	48	38	2	1
Ind.	2	1	1	1	5	12	41	39	20	8	-	-
Ill.	-	1	2	15	21	27	83	143	193	135	-	-
Mich.	-	-	5	2	4	10	32	62	30	44	-	-
Wis.	-	-	1	2	6	7	24	37	7	4	2	-
W.N. CENTRAL	13	11	2	5	50	26	58	139	43	50	42	42
Minn.	-	-	-	3	3	1	-	6	11	10	3	4
Iowa	9	-	1	-	15	7	4	10	5	15	25	10
Mo.	-	4	1	2	19	12	51	121	16	15	3	7
N. Dak.	-	-	-	-	1	-	-	-	-	-	4	5
S. Dak.	-	-	-	-	2	-	-	-	5	-	7	11
Nebr.	-	-	-	-	5	2	3	2	-	-	-	-
Kans.	4	7	-	-	5	4	-	-	6	10	-	5
S. ATLANTIC	17	65	23	33	88	87	473	638	157	299	207	240
Del.	-	8	2	1	1	1	9	4	-	9	10	11
Md.	12	47	10	6	11	1	70	65	27	66	62	58
D.C.	-	-	1	3	2	1	15	26	10	16	-	1
Va.	-	1	5	6	5	10	56	85	1	6	52	44
W. Va.	2	5	-	-	3	-	1	-	11	13	3	11
N.C.	3	3	3	4	15	11	157	186	36	16	35	51
S.C.	-	1	-	-	16	11	71	90	31	43	6	16
Ga.	-	-	2	3	26	27	46	112	-	40	34	39
Fla.	-	-	-	10	9	25	48	70	41	90	5	9
E.S. CENTRAL	-	5	-	1	44	26	370	578	138	135	8	34
Ky.	-	-	-	-	7	9	32	37	31	17	-	3
Tenn.	-	3	-	-	3	5	84	123	-	53	-	18
Ala.	-	-	-	1	17	8	108	109	58	65	8	13
Miss.	-	2	-	-	17	4	146	309	49	-	-	-
W.S. CENTRAL	-	-	1	-	76	52	141	324	82	73	3	22
Ark.	-	-	-	-	9	5	41	70	10	23	-	12
La.	-	-	-	-	16	5	78	174	-	-	-	8
Okla.	-	-	-	-	3	7	22	26	9	25	3	2
Tex.	-	-	1	-	48	35	-	54	63	25	-	-
MOUNTAIN	-	1	8	8	44	39	19	45	65	60	6	7
Mont.	-	-	-	1	1	1	-	2	-	-	-	3
Idaho	-	-	1	-	4	2	1	-	2	2	-	-
Wyo.	-	-	-	-	4	1	-	-	-	-	4	-
Colo.	-	-	4	5	4	10	9	21	12	3	-	-
N. Mex.	-	-	1	2	10	6	-	8	2	13	1	-
Ariz.	-	-	1	-	14	17	6	9	39	38	1	4
Utah	-	-	1	-	3	1	-	1	-	3	-	-
Nev.	-	1	-	-	4	1	3	4	10	1	-	-
PACIFIC	4	11	31	37	142	112	1	116	606	609	23	44
Wash.	-	-	-	4	9	10	-	1	37	34	-	-
Oreg.	2	-	4	3	26	25	1	1	15	4	-	-
Calif.	2	11	26	28	103	76	-	114	525	532	20	42
Alaska	-	-	-	1	2	-	-	-	11	13	3	2
Hawaii	-	-	1	1	2	1	-	-	18	26	-	-
Guam	-	-	-	-	-	1	-	1	-	4	-	-
P.R.	-	-	-	-	-	9	29	44	-	-	4	11
V.I.	-	-	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-	2	-	-
C.N.M.I.	-	-	-	-	-	-	-	-	-	5	-	-

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

TABLE III. Cases of selected notifiable diseases preventable by vaccination, United States, weeks ending February 24, 1996, and February 25, 1995 (8th Week)

Reporting Area	*H. influenzae*, invasive		Hepatitis (viral), by type				Measles (Rubeola)			
			A		B		Indigenous		Imported†	
	Cum. 1996*	Cum. 1995	Cum. 1996	Cum. 1995	Cum. 1996	Cum. 1995	1996	Cum. 1996	1996	Cum. 1996
UNITED STATES	176	220	3,157	3,429	891	1,167	1	6	-	1
NEW ENGLAND	4	8	29	23	3	39	-	3	-	-
Maine	-	-	5	6	-	1	-	-	-	-
N.H.	4	-	2	1	-	3	-	-	-	-
Vt.	-	1	-	-	1	1	-	-	-	-
Mass.	-	1	13	3	1	5	-	3	-	-
R.I.	-	-	2	6	1	6	-	-	-	-
Conn.	-	6	7	7	-	23	U	-	U	-
MID. ATLANTIC	26	23	194	144	146	119	-	1	-	-
Upstate N.Y.	9	6	36	21	32	35	-	-	-	-
N.Y. City	2	4	138	69	100	21	-	1	-	-
N.J.	8	5	-	28	-	40	-	-	-	-
Pa.	7	8	20	26	14	23	-	-	-	-
E.N. CENTRAL	26	48	285	599	96	183	-	-	-	-
Ohio	18	25	165	347	19	13	-	-	-	-
Ind.	-	3	57	29	9	37	-	-	-	-
Ill.	8	17	13	123	7	56	-	-	-	-
Mich.	-	3	43	59	58	69	-	-	-	-
Wis.	-	-	7	41	3	8	-	-	-	-
W.N. CENTRAL	10	5	256	144	85	90	-	-	-	-
Minn.	-	-	3	9	2	1	-	-	-	-
Iowa	6	1	82	8	35	11	-	-	-	-
Mo.	4	4	121	109	35	70	-	-	-	-
N. Dak.	-	-	2	1	-	-	-	-	-	-
S. Dak.	-	-	10	-	-	-	-	-	-	-
Nebr.	-	-	14	9	2	4	-	-	-	-
Kans.	-	-	24	8	11	4	-	-	-	-
S. ATLANTIC	34	53	106	142	148	153	1	1	-	-
Del.	-	-	1	2	-	1	U	-	U	-
Md.	11	20	31	30	48	37	1	1	-	-
D.C.	-	-	3	1	1	7	-	-	-	-
Va.	2	6	10	33	17	13	U	-	U	-
W. Va.	-	-	4	5	6	11	-	-	-	-
N.C.	5	10	19	17	57	43	-	-	-	-
S.C.	1	-	11	3	6	3	-	-	-	-
Ga.	15	7	-	5	-	5	-	-	-	-
Fla.	-	10	27	46	13	33	-	-	-	-
E.S. CENTRAL	4	3	104	162	12	153	-	-	-	-
Ky.	1	1	4	15	1	17	-	-	-	-
Tenn.	-	-	19	113	6	116	-	-	-	-
Ala.	3	2	26	23	5	20	-	-	-	-
Miss.	-	-	55	11	-	-	-	-	-	-
W.S. CENTRAL	7	6	548	239	63	54	-	-	-	-
Ark.	-	1	94	12	6	1	-	-	-	-
La.	-	-	9	10	6	5	-	-	-	-
Okla.	7	5	283	83	19	11	-	-	-	-
Tex.	-	-	162	134	32	37	-	-	-	-
MOUNTAIN	13	21	481	634	135	89	-	-	-	-
Mont.	-	-	10	10	-	4	-	-	-	-
Idaho	1	1	70	74	17	14	-	-	-	-
Wyo.	3	1	5	25	4	1	-	-	-	-
Colo.	1	2	24	94	9	20	-	-	-	-
N. Mex.	4	4	92	132	66	30	-	-	-	-
Ariz.	2	6	125	148	12	13	-	-	-	-
Utah	1	2	124	128	20	2	-	-	-	-
Nev.	1	5	31	23	7	5	-	-	-	-
PACIFIC	52	53	1,154	1,342	203	287	-	1	-	1
Wash.	-	3	65	43	11	12	-	1	-	-
Oreg.	7	6	183	257	13	19	-	-	-	-
Calif.	43	42	875	1,022	176	252	-	-	-	-
Alaska	-	-	12	13	2	1	-	-	-	-
Hawaii	2	2	19	7	1	3	-	-	-	1
Guam	-	-	-	-	-	-	U	-	U	-
P.R.	-	3	12	3	33	19	-	-	-	-
V.I.	-	-	-	-	-	1	U	-	U	-
Amer. Samoa	-	-	-	4	-	-	U	-	U	-
C.N.M.I.	-	-	-	5	-	-	U	-	U	-

*Of 33 cases among children aged <5 years, serotype was reported for 8 and of those, 1 was type B.
†For imported measles, cases include only those resulting from importation from other countries.
N: Not notifiable U: Unavailable -: no reported cases

TABLE III. (Cont'd.) Cases of selected notifiable diseases preventable by vaccination, United States, weeks ending February 24, 1996, and February 25, 1995 (8th Week)

Reporting Area	Measles (Rubeola), cont'd. Total		Mumps			Pertussis			Rubella		
	Cum. 1996	Cum. 1995	1996	Cum. 1996	Cum. 1995	1996	Cum. 1996	Cum. 1995	1996	Cum. 1996	Cum. 1995
UNITED STATES	7	47	10	85	105	29	218	394	2	19	11
NEW ENGLAND	3	3	-	-	-	8	35	41	-	2	2
Maine	-	-	-	-	-	-	2	5	-	-	-
N.H.	-	-	-	-	-	2	6	5	-	-	1
Vt.	-	-	-	-	-	-	5	2	-	-	-
Mass.	3	1	-	-	-	6	22	26	-	-	1
R.I.	-	2	-	-	-	-	-	-	-	-	-
Conn.	-	-	U	-	-	U	-	3	U	2	-
MID. ATLANTIC	1	-	3	12	13	2	30	33	-	-	-
Upstate N.Y.	-	-	3	5	3	1	23	19	-	-	-
N.Y. City	1	-	-	2	2	1	5	9	-	-	-
N.J.	-	-	-	-	-	-	-	3	-	-	-
Pa.	-	-	-	5	8	-	2	2	-	-	-
E.N. CENTRAL	-	-	4	24	16	7	40	49	-	-	-
Ohio	-	-	3	13	7	7	31	23	-	-	-
Ind.	-	-	-	1	2	-	2	3	-	-	-
Ill.	-	-	-	-	-	-	-	-	-	-	-
Mich.	-	-	1	10	7	-	5	21	-	-	-
Wis.	-	-	-	-	-	-	2	2	-	-	-
W.N. CENTRAL	-	1	-	2	9	-	1	18	-	-	-
Minn.	-	-	-	-	-	-	1	-	-	-	-
Iowa	-	-	-	-	1	-	-	1	-	-	-
Mo.	-	1	-	-	8	-	-	7	-	-	-
N. Dak.	-	-	-	2	-	-	-	1	-	-	-
S. Dak.	-	-	-	-	-	-	-	2	-	-	-
Nebr.	-	-	-	-	-	-	-	1	-	-	-
Kans.	-	-	-	-	-	-	-	6	-	-	-
S. ATLANTIC	1	-	2	8	15	2	18	41	-	-	1
Del.	-	-	U	-	-	U	-	1	U	-	-
Md.	1	-	1	2	4	2	13	-	-	-	-
D.C.	-	-	-	-	-	-	-	1	-	-	-
Va.	-	-	U	2	4	U	-	-	U	-	-
W. Va.	-	-	-	-	-	-	-	-	-	-	-
N.C.	-	-	-	-	3	-	-	30	-	-	-
S.C.	-	-	1	3	1	-	2	7	-	-	-
Ga.	-	-	-	1	-	-	1	-	-	-	-
Fla.	-	-	-	-	3	-	2	2	-	-	1
E.S. CENTRAL	-	-	-	3	4	1	6	9	-	-	-
Ky.	-	-	-	-	-	-	4	-	-	-	-
Tenn.	-	-	-	-	-	-	-	-	-	-	-
Ala.	-	-	-	3	2	-	1	9	-	-	-
Miss.	-	-	-	-	2	1	1	-	N	N	N
W.S. CENTRAL	-	-	-	3	7	-	3	8	-	-	-
Ark.	-	-	-	-	2	-	2	-	-	-	-
La.	-	-	-	3	1	-	1	-	-	-	-
Okla.	-	-	-	-	-	-	-	-	-	-	-
Tex.	-	-	-	-	4	-	-	8	-	-	-
MOUNTAIN	-	43	-	8	4	1	22	135	-	-	2
Mont.	-	-	-	-	-	-	2	2	-	-	-
Idaho	-	-	-	-	-	-	2	47	-	-	-
Wyo.	-	-	-	-	-	-	-	-	-	-	-
Colo.	-	17	-	-	-	-	-	30	-	-	-
N. Mex.	-	21	N	N	N	-	9	4	-	-	-
Ariz.	-	5	-	-	-	-	2	51	-	-	2
Utah	-	-	-	-	1	1	1	-	-	-	-
Nev.	-	-	-	8	3	-	6	1	-	-	-
PACIFIC	2	-	1	25	37	8	63	60	2	17	6
Wash.	1	-	-	2	1	1	6	9	-	-	-
Oreg.	-	-	N	N	N	-	13	1	-	-	-
Calif.	-	-	-	15	33	6	42	48	2	17	6
Alaska	-	-	-	1	2	-	-	-	-	-	-
Hawaii	1	-	1	7	1	1	2	2	-	-	-
Guam	-	-	U	-	-	U	-	-	U	-	-
P.R.	-	-	-	-	-	-	-	1	-	-	-
V.I.	-	-	U	-	1	U	-	-	U	-	-
Amer. Samoa	-	-	U	-	-	U	-	-	U	-	-
C.N.M.I.	-	-	U	-	-	U	-	-	U	-	-

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

TABLE IV. Deaths in 121 U.S. cities,* week ending February 24, 1996 (8th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	619	447	105	47	12	8	34
Boston, Mass.	188	126	34	18	8	2	7
Bridgeport, Conn.	48	33	12	3	-	-	-
Cambridge, Mass.	24	19	3	2	-	-	2
Fall River, Mass.	28	24	3	1	-	-	1
Hartford, Conn.	U	U	U	U	U	U	U
Lowell, Mass.	37	29	7	1	-	-	4
Lynn, Mass.	16	12	3	1	-	-	2
New Bedford, Mass.	30	25	3	2	-	-	1
New Haven, Conn.	38	22	7	4	2	3	1
Providence, R.I.	55	47	5	3	-	-	3
Somerville, Mass.	2	2	-	-	-	-	-
Springfield, Mass.	48	34	8	4	1	1	5
Waterbury, Conn.	38	27	7	4	-	-	2
Worcester, Mass.	67	47	13	4	1	2	6
MID. ATLANTIC	2,584	1,709	494	275	57	49	141
Albany, N.Y.	46	40	3	2	1	-	7
Allentown, Pa.	16	15	1	-	-	-	1
Buffalo, N.Y.	70	53	12	2	2	1	2
Camden, N.J.	33	23	6	-	2	2	2
Elizabeth, N.J.	17	10	6	1	-	-	2
Erie, Pa.§	38	30	5	-	3	-	3
Jersey City, N.J.	63	34	14	12	1	2	-
New York City, N.Y.	1,374	873	283	176	25	17	60
Newark, N.J.	55	25	12	13	1	4	5
Paterson, N.J.	50	30	7	8	2	3	5
Philadelphia, Pa.	400	275	75	32	8	10	21
Pittsburgh, Pa.§	57	37	13	4	2	1	4
Reading, Pa.	26	18	3	2	-	3	9
Rochester, N.Y.	126	87	20	14	4	1	2
Schenectady, N.Y.	34	30	1	2	-	1	1
Scranton, Pa.§	21	18	3	-	-	-	4
Syracuse, N.Y.	78	54	19	1	1	3	5
Trenton, N.J.	26	20	4	1	1	-	-
Utica, N.Y.	23	18	2	1	1	1	1
Yonkers, N.Y.	31	19	5	4	3	-	7
E.N. CENTRAL	2,356	1,587	424	210	70	64	167
Akron, Ohio	60	45	9	5	1	-	-
Canton, Ohio	58	47	9	1	1	-	7
Chicago, Ill.	511	289	114	72	17	18	43
Cincinnati, Ohio	77	53	12	7	4	1	8
Cleveland, Ohio	177	108	40	13	4	12	5
Columbus, Ohio	190	132	29	16	2	11	24
Dayton, Ohio	134	96	27	6	3	2	9
Detroit, Mich.	157	88	37	20	9	3	7
Evansville, Ind.	44	32	7	3	1	1	2
Fort Wayne, Ind.	68	46	12	4	6	-	6
Gary, Ind.	17	10	4	3	-	-	-
Grand Rapids, Mich.	55	45	2	5	3	-	6
Indianapolis, Ind.	292	193	60	24	10	5	10
Madison, Wis.	60	45	9	5	1	-	3
Milwaukee, Wis.	128	100	14	6	4	4	11
Peoria, Ill.	46	36	4	2	-	4	3
Rockford, Ill.	55	44	7	2	2	-	8
South Bend, Ind.	45	38	3	4	-	-	3
Toledo, Ohio	113	82	20	7	1	3	9
Youngstown, Ohio	69	58	5	5	1	-	3
W.N. CENTRAL	900	642	149	63	17	20	42
Des Moines, Iowa	106	76	19	9	1	1	4
Duluth, Minn.	20	14	4	2	-	-	2
Kansas City, Kans.	61	43	10	8	-	-	-
Kansas City, Mo.	129	75	22	13	7	3	10
Lincoln, Nebr.	37	26	9	2	-	-	1
Minneapolis, Minn.	197	150	28	9	3	7	12
Omaha, Nebr.	78	56	14	5	2	1	3
St. Louis, Mo.	118	84	20	8	2	4	-
St. Paul, Minn.	57	50	4	1	-	2	5
Wichita, Kans.	97	68	19	6	2	2	5

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
S. ATLANTIC	1,508	913	352	157	49	34	82
Atlanta, Ga.	217	127	51	25	10	4	6
Baltimore, Md.	249	144	55	35	6	8	19
Charlotte, N.C.	191	115	51	13	9	3	14
Jacksonville, Fla.	138	100	29	6	3	-	2
Miami, Fla.	111	58	29	16	6	2	1
Norfolk, Va.	61	38	14	2	3	4	2
Richmond, Va.	84	49	23	7	2	3	3
Savannah, Ga.	53	33	12	5	1	2	7
St. Petersburg, Fla.	61	44	12	3	1	1	4
Tampa, Fla.	182	132	36	7	3	3	20
Washington, D.C.	151	67	38	36	5	4	4
Wilmington, Del.	10	6	2	2	-	-	-
E.S. CENTRAL	734	501	132	67	14	9	54
Birmingham, Ala.	141	91	28	11	-	-	7
Chattanooga, Tenn.	37	26	7	4	-	-	1
Knoxville, Tenn.	76	52	14	10	-	-	9
Lexington, Ky.	70	52	13	5	-	-	1
Memphis, Tenn.	182	123	30	16	11	2	21
Mobile, Ala.	53	38	9	1	1	4	3
Montgomery, Ala.	60	44	11	4	-	1	4
Nashville, Tenn.	115	75	20	16	2	2	8
W.S. CENTRAL	1,481	976	297	137	39	32	96
Austin, Tex.	60	43	11	6	-	-	7
Baton Rouge, La.	43	32	11	-	-	-	-
Corpus Christi, Tex.	57	46	3	4	1	3	5
Dallas, Tex.	209	125	50	21	8	5	8
El Paso, Tex.	85	60	14	4	4	3	3
Ft. Worth, Tex.	114	71	19	12	5	7	-
Houston, Tex.	392	234	100	43	11	4	43
Little Rock, Ark.	60	41	10	5	3	1	7
New Orleans, La.	103	61	23	13	5	1	-
San Antonio, Tex.	206	147	35	19	1	4	12
Shreveport, La.	42	29	4	5	-	4	4
Tulsa, Okla.	110	87	17	5	1	-	7
MOUNTAIN	1,026	696	181	91	34	23	82
Albuquerque, N.M.	116	78	18	16	2	2	5
Colo. Springs, Colo.	60	33	17	4	4	2	8
Denver, Colo.	124	86	19	12	2	5	11
Las Vegas, Nev.	230	149	49	23	6	2	17
Ogden, Utah	29	24	2	1	1	1	3
Phoenix, Ariz.	184	119	32	15	10	8	21
Pueblo, Colo.	32	24	5	2	-	1	2
Salt Lake City, Utah	90	66	13	7	2	2	5
Tucson, Ariz.	161	117	26	11	7	-	10
PACIFIC	1,718	1,171	304	159	44	40	145
Berkeley, Calif.	18	11	2	4	1	-	1
Fresno, Calif.	95	64	18	7	4	2	7
Glendale, Calif.	16	14	2	-	-	-	-
Honolulu, Hawaii	65	50	10	4	-	1	6
Long Beach, Calif.	86	55	21	4	2	4	11
Los Angeles, Calif.	392	257	64	41	15	15	12
Pasadena, Calif.	30	25	3	1	-	1	4
Portland, Oreg.	150	101	30	13	2	4	15
Sacramento, Calif.	135	96	25	5	6	3	20
San Diego, Calif.	130	74	30	20	5	1	22
San Francisco, Calif.	138	85	30	19	1	3	10
San Jose, Calif.	176	140	22	11	1	2	24
Santa Cruz, Calif.	34	23	4	3	2	2	2
Seattle, Wash.	111	72	21	15	2	1	3
Spokane, Wash.	48	37	6	3	2	-	3
Tacoma, Wash.	94	67	16	9	1	1	5
TOTAL	12,926¶	8,642	2,438	1,206	336	279	843

*Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.
†Pneumonia and influenza.
§Because of changes in reporting methods in these 3 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.
¶Total includes unknown ages.
U: Unavailable -: no reported cases

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