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WEEKLY REPORT

Influenza Activity — United States, 2000–01 Season

This report summarizes influenza activity in the United States during October 1–November 25, 2000 (*1*)*. Influenza activity was low during this period, and influenza virus isolates were reported from 11 states. The viruses most frequently isolated were influenza A (H1N1) and were well matched by the 2000–01 influenza vaccine strains.

During October 1–November 25, 1% of patient visits to U.S. sentinel physicians were for influenza-like illness (ILI)†. During the week ending November 25 (week 47), among each of the nine surveillance regions, patient visits for ILI were at baseline levels (0–3%); 24 state and territorial health departments reported no influenza activity, 24 reported sporadic activity, and two (Kentucky and Texas) reported regional activity (*1*)§. No states reported widespread activity. The 122 Cities Mortality Reporting System attributed 6.5% of total deaths to pneumonia and influenza (P&I). This percentage was below the epidemic threshold of 7.9% for week 47. Deaths attributed to P&I have remained below the epidemic threshold for each week since October 1 (*1*)¶.

During October 1–November 25, World Health Organization (WHO) collaborating laboratories and National Respiratory and Enteric Virus Surveillance System laboratories in the United States tested 8511 specimens for influenza; 118 (1.4%) were positive for laboratory-confirmed influenza. Of these, 101 (86%) were influenza A and 17 (14%) were influenza B. The percentage of positive influenza infections identified each week, an important early indicator of influenza activity, increased from zero for the week ending October 21 to 4% for the week ending November 25. Typically, during peak influenza activity, approximately 30%–34% of specimens submitted for respiratory virus testing

*The four components of the influenza surveillance system have been described (*1*). Information reported as of November 30, 2000.

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

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

¶Before the 1999–2000 season, the case definition for P&I deaths was modified. CDC analysis estimated that the revised case definition resulted in an average increase in baseline P&I mortality estimates of 0.8% for 1999–2000. Thus, the 122 cities P&I mortality baseline and epidemic threshold for the 2000–01 season have been adjusted upward. The epidemic threshold is 1.645 standard deviations above the seasonal baseline. The expected seasonal baseline is projected using a robust regression procedure in which a periodic regression model is applied to observed percentages of deaths from P&I since 1983.

Influenza Activity — Continued

have tested positive for influenza viruses. Of the 101 influenza A isolates collected, 86 (85%) have been subtyped; 79 (92%) were A (H1N1) and seven (8%) were A (H3N2). Of the three influenza A isolates that were characterized antigenically at CDC, two were A/New Caledonia/20/99-like (H1N1) viruses, the H1N1 component of the 2000–01 vaccine strain, and one was an A/Panama/2007/99-like (H3N2) virus, the H3N2 component of the 2000–01 vaccine strain. One influenza B isolate collected since October 1 was similar to the recommended vaccine strain B/Beijing/184/93.

Reported by: Participating state and territorial epidemiologists and state public health laboratory directors. WHO collaborating laboratories. National Respiratory and Enteric Virus Surveillance System laboratories. Sentinel Physicians Influenza Surveillance System. Surveillance Systems Br, Div of Public Health Surveillance and Informatics, Epidemiology Program Office; Mortality Statistics Br, Div of Vital Statistics, National Center for Health Statistics; WHO Collaborating Center for Reference and Research on Influenza, Respiratory and Enteric Virus Br, and Influenza Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases, CDC.

Editorial Note: All four influenza surveillance system components indicated that influenza activity was low during October–November 25 in the United States, and lower than the same period in 1999. However, the percentage of respiratory specimens that were laboratory-confirmed influenza each week began to increase during this period, and influenza activity is expected to increase during the next few weeks to months. Both influenza A and influenza B viruses were isolated. So far this season, the viruses isolated most frequently were influenza A (H1N1); however, it is too early to know what strain(s) will predominate. Seasonal epidemics caused by influenza A (H1N1) viruses have been less severe than seasons in which influenza A (H3N2) viruses predominated (*2*). Although a very small number of influenza isolates have been characterized antigenically so far this season, all were well matched to the 2000–01 influenza vaccine strains.

The best prevention against influenza is vaccination. This season, a quantity of influenza vaccine similar to 1999–2000 will be available; however, vaccine distribution has been delayed (*3,4*). This delay may have limited the opportunity for vaccination of persons at high risk for complications from influenza, household contacts of high-risk persons, and health-care providers who care for high-risk persons; therefore, vaccination efforts for these groups should continue during December, January, and beyond, if necessary. Efforts also should be made to vaccinate persons aged 50–64 years. Unvaccinated persons can benefit from influenza vaccination even after influenza activity has begun in their community.

As of December 4, approximately 51.2 million (68%) of the 75 million doses of influenza vaccine projected to be produced this year had been distributed. CDC has contracted with Aventis Pasteur to produce 9 million of the 75 million doses, and this vaccine will be available for distribution beginning in mid-December (*5*). Information on vaccine prices and ordering procedures is available on the World-Wide Web, http://www.cdc.gov/nip/flu-vac-supply. The deadline for placing applications for orders is December 15, 2000. As of December 4, applications had been received for approximately 46% of this vaccine.

Four prescription antiviral medications are approved for treating uncomplicated influenza: Amantadine is approved to treat influenza A in persons aged ≥1 year, rimantadine for treating influenza A in adults, Zanamivir for treating influenza A and B in persons aged ≥7 years, and Oseltamivir for treating influenza A and B in persons aged ≥18 years.

Influenza Activity — Continued

These four antiviral agents can reduce the duration of influenza symptoms by approximately 1 day if treatment is started within 48 hours of symptom onset, but the agents differ in routes of administration, contraindications, adverse effects, and cost. Three antiviral medications are approved for chemoprophylaxis of influenza but are not substitutes for influenza vaccination. Amantadine and rimantadine are approved for chemoprophylaxis of influenza A in persons aged ≥1 year. Oseltamivir recently was approved for chemoprophylaxis of influenza A and B in persons aged ≥13 years. Chemoprophylactic use of antiviral drugs can be helpful in controlling influenza outbreaks in specific situations (e.g., in long-term–care facilities). Long-term antiviral chemoprophylaxis also might be indicated for high-risk institutionalized persons or persons at high risk for complications from influenza if vaccine is unavailable, ineffective (e.g., in severely immunocompromised persons), or contraindicated. Widespread use of antiviral drugs as chemoprophylaxis for influenza is not recommended.

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

References

1. CDC. Influenza activity—United States, 1999–2000 season. MMWR 1999;48:1039–42.
2. Simonsen L, Fukuda K, Schonberger LB, Cox NJ. The impact of influenza epidemics on hospitalizations. J Infect Dis 2000;181:831–7.
3. CDC. Updated recommendations from the Advisory Committee on Immunization Practices in response to delays in supply of influenza vaccine for the 2000–01 season. MMWR 2000;49:888–92.
4. CDC. Delayed supply of influenza vaccine and adjunct ACIP influenza vaccine recommendations for the 2000–01 influenza season. MMWR 2000;49:619–22.
5. CDC. CDC contract for additional 9 million doses of influenza vaccine for the 2000–01 season. MMWR 2000;49:999.

Pseudomonas Dermatitis/Folliculitis Associated With Pools and Hot Tubs — Colorado and Maine, 1999–2000

During 1999–2000, outbreaks of *Pseudomonas aeruginosa* dermatitis and otitis externa associated with swimming pool and hot tub use occurred in Colorado and Maine. This report summarizes these outbreaks and provides recommendations for swimming pool and hot tub operation and maintenance, particularly when using offsite monitoring of water disinfectant and pH levels or when cyanuric acid is added to pools as a chlorine stabilizer.

Colorado

In February 1999, the Colorado Department of Public Health and Environment (CDPHE) was notified of approximately 15 persons with folliculitis after they had used a hotel pool and hot tub. The cases occurred among children and adults attending two birthday parties at the hotel and among community residents who entered the pool on a pay-to-swim basis. The patients were treated for suspected *Pseudomonas* skin infections; one patient tested positive for *Pseudomonas* sp. by culture of a skin lesion.

Pseudomonas *Dermatitis/Folliculitis — Continued*

Twenty-five community residents who used the pool and/or hot tub during February 5–7, were identified through discussions with area physicians, hotel management, and other swimmers. These community residents were interviewed by CDPHE using a telephone questionnaire. Case-patients were defined as persons who developed dermatitis/folliculitis, with or without other symptoms, within 3 days of using either the pool or hot tub at the hotel during February 5–7. Questionnaires were completed for 22 (88%) of the 25 persons identified. Of the 20 persons who used the hot tub, 19 developed a rash and met the case definition. Fourteen (74%) of the 19 case-patients had more severe illness (rash ≥2 weeks or rash and one other symptom) (Table 1), some lasting >6 weeks.

Specimens collected during the environmental inspection in May from the hot tub filter and hand rail base were positive for *Pseudomonas aeruginosa* and other *Pseudomonas* species. The pool and hot tub used separate filtration systems; each had an automated chlorination system that relied on an onsite probe to measure free chlorine and pH levels and deliver set levels of chlorine using calcium hypochlorite tablets and muriatic acid for pH control. A printout of the hourly free chlorine and pH levels in the pool and hot tub revealed that free chlorine levels dropped below state-required levels (1 mg/L) on the evening of February 4 and remained below recommended levels for approximately 69 hours. The decline in pool chlorine levels was the result of a faulty chlorine pellet dispenser. Hotel staff did not perform routine onsite water testing for the pool or hot tub.

Maine

The Maine Bureau of Health (MBOH) was notified of several cases of dermatitis/folliculitis among persons who had stayed at Hotel A in Bangor, Maine, during February 18–27, 2000. To characterize the illness and determine exposures associated with illness, MBOH conducted a case-control study among persons connected with a high school basketball tournament who stayed at hotels with swimming pools and/or hot tubs in Bangor during the outbreak. Case-patients had a rash for ≤7 days or draining otitis externa with onset during February 18–March 3. Case-patients were matched by age and high school with healthy controls. Results from two (12.5%) schools were available for analysis. Nine persons were identified with rash, including one with otitis externa. Onset of symptoms occurred during February 20–March 1. Four of the nine persons were seen by a health-care provider. Case-patients ranged in age from 6–18 years

TABLE 1. Number and percentage of case-patients with *Pseudomonas* dermatitis/folliculitis* associated with pool and hot tub use, by symptom — Colorado, 1999

Symptom	No.	%
Rash	19	(100)
Fatigue	11	(58)
Lymphadenopathy	10	(53)
Fever	8	(42)
Joint pain	7	(37)
Muscle aches	6	(32)
Nodules on feet	5	(26)
Nodules on hands	5	(26)
Chest pain	4	(21)

* n=19.

Pseudomonas *Dermatitis/Folliculitis — Continued*

(median age: 15 years); five were female (Table 2). The nine case-patients stayed at hotel A and spent time in either the hot tub or pool; seven spent time in both. Case-patients were more likely than controls to have spent time in the hot tub (odds ratio [OR]= 8.9; p=0.04) or to have used the pool (OR=7.4; p=0.06).

The indoor pool and hot tub were located within 5 feet of each other and had separate filtration systems. Pool disinfectant and pH levels were monitored by an offsite contractor. The pool had an automated chlorination system that relied on an onsite probe to measure chlorine and pH levels and to deliver a set level of chlorine using calcium hypochlorite tablets and muriatic acid for pH control. Chlorine and pH levels were maintained manually in the hot tub. To stabilize chlorine levels, 40–60 mg/L cyanurates were used. During the outbreak, free chlorine levels were tested daily and repeatedly registered <1.0 mg/L, less than the state-required level of 1–3 mg/L, in the pool and hot tub. The pool and hot tub were crowded during the outbreak, and free chlorine levels were very low to zero after the February 25–26 weekend; no measurements were recorded over the weekend.

The facilities had been cleaned thoroughly before the environmental investigation in March. *Pseudomonas aeruginosa* was isolated from the top of the pool filter and from the draining ear of a child aged 6 years who used the pool. Although the pulsed field gel electrophoresis patterns of the two isolates did not match, the pool isolate was obtained after the facilities had been cleaned and may not have reflected the bacterial environment of the pool during the outbreak.

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Editorial Note: *Pseudomonas aeruginosa*, a gram negative rod, is ubiquitous and can cause various mild to severe symptoms (*1*). *Pseudomonas* dermatitis and otitis externa outbreaks associated with swimming pool and hot tub use are well described (*2,3*); at least 75 cases during six outbreaks occurred during 1997–1998 (*4*). Dermatitis outbreaks

TABLE 2. Characteristics and symptoms of case-patients* and controls† with *Pseudomonas* dermatitis/folliculitis associated with pool and hot tub use — Maine, 2000

Characteristic	Case-patients	Controls
Female	5	12
Median age (yrs)	15	16
Age range (yrs)	6–18	6–18
Symptom		
Rash	9	0
Raised (not pustule)	5	—
Pustule	3	—
Pruritic	5	—
Headache	6	4
Sore throat	4	3
Earache	3	1
Fever	2	1
Fatigue	2	2

* n=9.
† n=25.

Pseudomonas *Dermatitis/Folliculitis — Continued*

usually occur as a result of low water disinfectant levels (*2,3*), a condition that also increases the risk for transmission of other chlorine-sensitive pathogens (e.g., *Escherichia coli* O157:H7 and *Shigella sonnei*) that may cause severe health consequences.

In this report, factors that may have resulted in inadequate disinfectant levels included the use of an offsite contractor who could monitor and alert pool staff to low free chlorine or pH levels but could not change free chlorine or pH levels, and hotel employees with a minimal understanding of the offsite monitoring and alert system, pool maintenance, and the link between inadequate water disinfection and disease transmission. In addition, pools and hot tubs were not monitored routinely onsite to adjust to high bather loads that can lower free chlorine levels. In Maine, cyanuric acid was added to the indoor pool and hot tub. However, cyanuric acid, which is used to reduce chlorine loss as a result of ultraviolet light exposure, is not recommended for indoor pools or hot tubs (*5,6*) and is prohibited in two states (*7*); adding this chemical reduces the antimicrobial capacity of free chlorine (*8*).

To reduce the risk for *Pseudomonas* dermatitis and the transmission of other waterborne pathogens, pool and hot tub operators should 1) adhere to pool and hot tub recommendations and regulatory requirements for pH and disinfectant levels (*6,9,10*); 2) have a thorough knowledge of basic aquatic facility operation; 3) provide training for pool staff on system capabilities, maintenance, and emergency alert procedures of remote monitoring systems; 4) closely monitor pool and hot tub free chlorine measurements during periods of heavy bather loading; 5) monitor hot tub disinfectant levels closely because the higher temperatures maintained serve to dissipate chlorine rapidly; and 6) understand appropriate use and effects of cyanurates on disinfection and testing. In addition, remote-monitoring companies should be timely in notifying swimming-facility staff about low disinfectant levels. Swimmers should be educated about the potential for waterborne disease transmission in pools and hot tubs, which could increase advocacy for improved maintenance and monitoring by pool operators.

References

1. Pollack M. *Pseudomonas aeruginosa*. In: Mandell D, ed. Principles and practice of infectious diseases. New York, New York: Churchill Livingstone, 1995:1980–2003.
2. Gustafson TL, Band JD, Hutcheson RH Jr, Schaffner W. *Pseudomonas* folliculitis: an outbreak and review. Rev Infect Dis 1983;5:1–8.
3. Ratnam S, Hogan K, March SB, Butler RW. Whirlpool-associated folliculitis caused by *Pseudomonas aeruginosa*: report of an outbreak and review. J Clin Microbiol 1986;23:655–9.
4. Barwick RS, Levy DA, Beach MJ, Craun GF, Calderon RL. Surveillance for waterborne-disease outbreaks—United States, 1997–1998. In: CDC surveillance summaries (May). MMWR 2000;49(no. SS-4).
5. Williams KG. The aquatic facility operator manual. Hoffman Estates, Illinois: National Recreation and Park Association, 1995.
6. CDC. Suggested health and safety guidelines for public spas and hot tubs. Washington, DC: US Department of Health and Human Services, Public Health Service, 1985, DHHS publication no. (CDC)99-960.
7. Johnson K, Bittenbring C, Bruya L, Richwine M, Youngblood S. The encyclopedia of aquatic codes and standards. Ashburn, Virginia: National Recreation and Park Association, 1999.
8. Fitzgerald GP, DerVartanian ME. *Pseudomonas aeruginosa* for the evaluation of swimming pool chlorination and algicides. Appl Microbiol 1969;17:415–21.
9. CDC. Swimming pools: safety and disease control through proper design and operation. Washington, DC: US Department of Health and Human Services, Public Health Service, 1988; DHHS publication no. (CDC)88-8319.

Pseudomonas *Dermatitis/Folliculitis — Continued*

10. American Public Health Association. Public swimming pools: recommended regulations for design and construction, operation and maintenance. Washington, DC: American Public Health Association, 1981.

Respiratory Syncytial Virus Activity — United States, 1999–2000 Season

Respiratory syncytial virus (RSV) is the leading cause of lower respiratory tract illness (LRTI) among infants and children worldwide (*1*) and is an important cause of LRTI among older children and adults (*2*). Despite the presence of maternal antibodies, most hospitalizations occur among infants aged <6 months, and nearly all children are infected by age 2 years (*3*). Although primary infection is usually most severe, reinfection throughout life is common (*4*). In temperate climates, RSV infections occur primarily during annual outbreaks, which peak during winter months (*5*). In the United States, RSV activity is monitored by the National Respiratory and Enteric Virus Surveillance System (NREVSS), a voluntary, laboratory-based system. This report summarizes trends in RSV activity reported to NREVSS from July 1999 through June 2000 and presents preliminary surveillance data from July 8 through November 21, 2000, which indicate that RSV community outbreaks are becoming widespread.

Clinical and public health laboratories report weekly to CDC the number of specimens tested for RSV by antigen-detection or virus-isolation methods and the number of positive results. RSV activity is considered widespread by NREVSS when 1) >50% of participating laboratories report one or more RSV detections for at least 2 consecutive weeks, and 2) >10% of all specimens tested for RSV during a surveillance week are positive. Of the laboratories reporting data for the week ending November 4, 2000, 32 (53%) detected >10% of specimens positive for RSV for at least 2 consecutive weeks, indicating the onset of widespread RSV activity for the 2000–01 season.

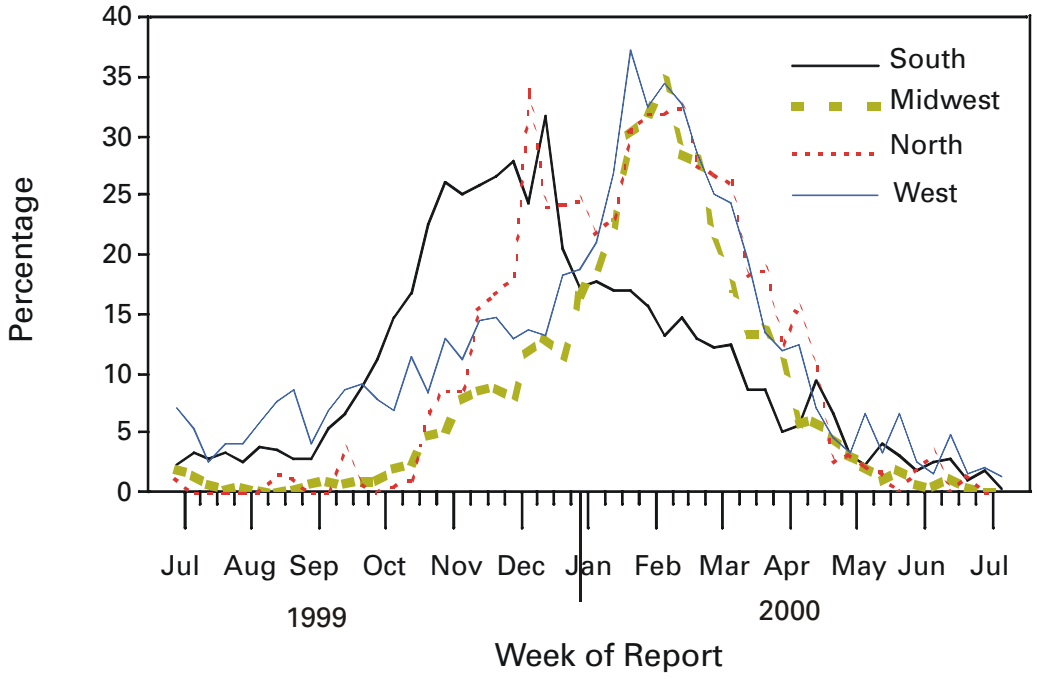
From July 1999 through June 2000, 72 laboratories in 45 states reported 123,769 tests for RSV; 18,981 (15%) were positive for RSV (Figure 1). In the United States, widespread RSV activity began during the week of October 30, 1999, and continued for 26 weeks, until the week of March 25, 2000. The timing of the onsets and conclusions of RSV regional outbreaks varied by state: range at onset was September 18 to January 29 and range at conclusions was January 29 to May 6. Regional RSV outbreaks occurred earliest in the South (23 sites; median weeks of onset and conclusion: October 16 and March 11, respectively), later in the Northeast (10 sites; November 27 and April 15), and latest in the Midwest (11 sites; December 28 and April 1) and West (12 sites; November 13 and April 8).*

Although 92% of positive tests were reported for the week ending October 30 through the week ending March 25, RSV was detected throughout the year. For example, during July–August 1999, sporadic RSV isolates were reported from laboratories in California, Colorado, Florida, Hawaii, Louisiana, Texas, Virginia, and Washington.

**Northeast*=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; *Midwest*=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin; *South*=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; *West*=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

Respiratory Syncytial Virus — Continued

FIGURE 1. Percentage* of specimens testing positive for respiratory syncytial virus, by region† and week of report — United States, July 1999–July 2000



* Weekly laboratory average smoothed using a 3-week running interval.

† *Northeast*=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; *Midwest*=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin; *South*=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; *West*=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

For the July 1999–June 2000 surveillance period, the number of specimens that tested positive for RSV, average months of peak activity, and regional trends were similar to trends observed during previous years. The duration of the 1999–2000 RSV season also was consistent with that of previous years, including the typical earlier onset of RSV outbreaks reported by southern laboratories.

Reported by: National Respiratory and Enteric Virus Surveillance System collaborating laboratories. Respiratory and Enteric Viruses Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases, CDC.

Editorial Note: Severe manifestations of RSV infection (e.g., pneumonia and bronchiolitis) most commonly occur among infants aged 2–6 months, and hospitalization rates for these diagnoses have been used as an indicator for severe RSV disease among young children. In the United States, bronchiolitis hospitalization rates among children aged <1 year were 31.2 per 1000 in 1996 (*6*) and were 61.8 per 1000 children aged <1 year among American Indian/Alaska Native children receiving care through the Indian Health Service (*7*).

Respiratory Syncytial Virus — Continued

NREVSS consists of 84 widely distributed laboratories and permits characterization of geographic and temporal trends of RSV infections in the United States. NREVSS data can alert public health officials and physicians to the timing of seasonal RSV activity. Although no RSV vaccine is available, RSV immune globulin intravenous and a humanized murine anti-RSV monoclonal antibody are recommended as prophylaxis for some high-risk infants and young children (e.g., those born prematurely or with chronic lung disease) to prevent serious RSV disease (*8*). Nosocomial transmission of RSV can be controlled by using contact isolation procedures.

The findings in this report are subject to at least three limitations. First, laboratory data serve as an indicator of when RSV is circulating in a community; however, the correlation of these data to disease burden in the population is uncertain. Second, some regions are represented by few laboratories. Finally, results may not be confirmed in some laboratories.

Symptomatic RSV disease can recur throughout life because of limited protective immunity induced by natural infection. As a result, health-care providers should consider RSV as a cause of acute respiratory disease in children and adults during community outbreaks. Persons with underlying cardiac or pulmonary disease or compromised immune systems and the elderly are at increased risk for serious complications of RSV infection, such as pneumonia and death (*9*). RSV infection among recipients of bone marrow transplants has resulted in high mortality rates (83%) (*10*). Additional information and updated data on RSV trends are available on the CDC World-Wide Web site at http://www.cdc.gov/ncidod/dvrd/nrevss.

References

1. Institute of Medicine. Prospects for immunizing against respiratory syncytial virus. In: Institute of Medicine. New vaccine development: establishing priorities. Vol II. Disease importance in developing countries. Washington, DC: National Academy Press, 1986: 299–307.
2. Falsey AR, Walsh EE. Respiratory syncytial virus infection in adults. Clin Micro Reviews 2000;13:371–84.
3. Glezen WP, Taber LH, Frank AL, Kasel JA. Risk of primary infection and reinfection with respiratory syncytial virus. Am J Dis Child 1996;140:543–6.
4. Henderson FW, Collier AM, Clyde WA Jr, Denny FW. Respiratory syncytial virus infections: reinfections and immunity. N Engl J Med 1979;300:530–4.
5. Gilchrist S, Török TJ, Gary HE Jr, Alexander JP, Anderson LJ. National surveillance for respiratory syncytial virus, United States, 1985–1990. J Infect Dis 1994;170:986–90.
6. Shay DK, Holman RC, Newman RD, Liu LL, Stout JW, Anderson LJ. Bronchiolitis-associated hospitalizations among U.S. children, 1980–1996. JAMA 1999;282;15:1440–6.
7. Lowther SA, Shay DK, Holman RC, Clarke MJ, Kaufman SF, Anderson LJ. Bronchiolitis-associated hospitalizations among American Indian and Alaska Native children. Pediatr Infect Dis J 2000;19:11–17.
8. Committee on Infectious Diseases, Committee on Fetus and Newborn, American Academy of Pediatrics. Prevention of respiratory syncytial virus infections: indications for the use of palivizumab and update on the use of RSV-IGIV. Pediatrics 1998;102:1211–6.
9. Dowell SF, Anderson LJ, Gary HE Jr, et al. Respiratory syncytial virus is an important cause of community-acquired lower respiratory infection among hospitalized adults. J Pediatr 1996;174:456–62.
10. Whimbey E, Couch RB, Englund JA, et al. Respiratory syncytial virus pneumonia in hospitalized adult patients with leukemia. Clin Infect Dis 1995;21:376–9.

Public Health Dispatch

Outbreak of Poliomyelitis — Dominican Republic and Haiti, 2000

During July 12–November 18, 2000, 19 persons with acute flaccid paralysis (AFP) were identified in the Dominican Republic, including six laboratory-confirmed cases with poliovirus type 1 isolates. Of the 19 case-patients, 16 (84%) were aged ≤6 years (range: 9 months–21 years). All case-patients were either unvaccinated (n=14) or inadequately vaccinated (n=5). In Haiti, a single laboratory-confirmed poliovirus type 1 case was reported in an inadequately vaccinated child aged 2 years; paralysis onset was August 30. Despite intensive case-finding activities, no additional cases have been identified.

The outbreak virus is unusual because it is derived from oral poliovirus vaccine (OPV) and has 97% genetic similarity to the parental OPV strain (normally vaccine-derived isolates are >99.5% similar to the parent strain) and appears to have recovered the neurovirulence and transmissibility characteristics of wild poliovirus type 1. In comparison, wild polioviruses normally have <82% genetic similarity to OPV (*1*). The differences in nucleotide sequences among the outbreak isolates suggest that the virus has been circulating for approximately 2 years in an area where vaccination coverage is very low and that the virus had accumulated genetic changes that restored the essential properties of wild poliovirus.

The ministries of health of the Dominican Republic and Haiti, with the assistance of the Pan American Health Organization and CDC, are investigating the outbreak to determine the extent of spread, evaluate the reasons for the outbreak, and initiate appropriate control measures. The Dominican Republic has started a nationwide mass vaccination campaign with OPV, and three nationwide vaccination rounds with OPV are planned for January, February, and March 2001 in Haiti.

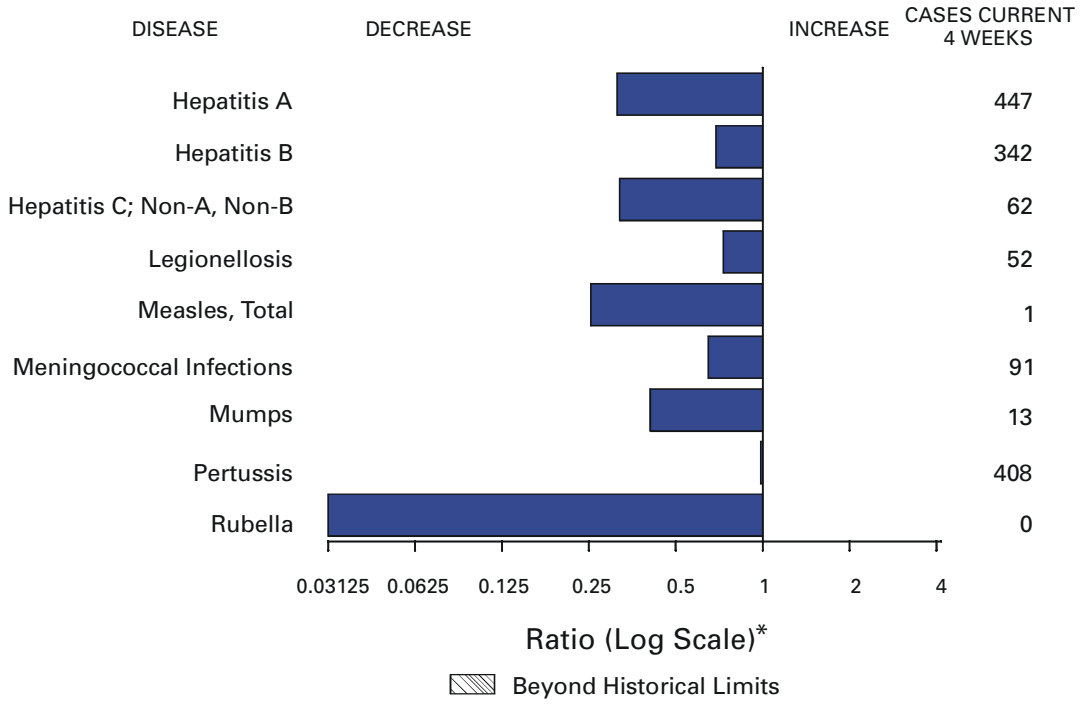
Circulation of OPV-derived polioviruses in areas with very low OPV coverage has been documented in one other setting—type 2 OPV-derived virus circulated in Egypt for an estimated 10 years (1983–1993) and was associated with >30 reported cases (*2*). Vaccination coverage was very low in the affected areas, and circulation of a vaccine-derived poliovirus stopped when OPV coverage increased. The key factor in controlling circulating OPV-derived viruses and wild polioviruses is achieving and maintaining high vaccination coverage. No evidence for circulation of OPV-derived virus has been found in areas with high coverage.

Since 1991, no cases of polio attributed to wild poliovirus have been detected in the Western Hemisphere. The current outbreak underscores the need for polio-free areas to maintain high coverage with polio vaccine until global polio eradication has been achieved. OPV is safe and effective and recommended for the eradication of polio. All countries should maintain high quality AFP and poliovirus surveillance and accelerate current activities to complete the global eradication of wild polioviruses.

Health-care providers should consider polio as a diagnosis in case-patients with a history of travel to other countries of the Western Hemisphere from the Dominican Republic and Haiti who present with AFP usually accompanied by fever. These possible cases should be investigated properly, including collection of stool samples. Suspected cases should be reported immediately to state and local health departments.

(Continued on page 1103)

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending December 2, 2000, with historical data



* Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending December 2, 2000 (48th Week)

	Cum. 2000		Cum. 2000
Anthrax	-	Poliomyelitis, paralytic	-
Brucellosis*	60	Psittacosis*	10
Cholera	2	Q fever*	21
Cyclosporiasis*	38	Rabies, human	1
Diphtheria	2	Rocky Mountain spotted fever (RMSF)	403
Ehrlichiosis: human granulocytic (HGE)*	170	Rubella, congenital syndrome	6
human monocytic (HME)*	95	Streptococcal disease, invasive, group A	2,553
Encephalitis: California serogroup viral*	104	Streptococcal toxic-shock syndrome*	67
eastern equine*	2	Syphilis, congenital¶	257
St. Louis*	3	Tetanus	24
western equine*	-	Toxic-shock syndrome	122
Hansen disease (leprosy)*	59	Trichinosis	14
Hantavirus pulmonary syndrome*†	30	Tularemia*	109
Hemolytic uremic syndrome, postdiarrheal*	179	Typhoid fever	301
HIV infection, pediatric*§	203	Yellow fever	-
Plague	6		

-: No reported cases.
*Not notifiable in all states.
† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID).
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update November 26, 2000.
¶ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending December 2, 2000, and December 4, 1999 (48th Week)

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7*			
							NETSS		PHLIS	
	Cum. 2000§	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	36,091	40,781	594,772	603,238	2,431	2,495	4,168	3,534	3,085	2,613
NEW ENGLAND	1,884	2,070	19,300	19,491	101	180	372	396	362	358
Maine	38	75	1,309	979	20	29	31	38	28	-
N.H.	31	46	923	905	22	19	36	35	35	33
Vt.	37	16	493	447	26	35	33	32	34	21
Mass.	1,137	1,319	8,136	8,226	30	69	158	174	164	183
R.I.	95	96	2,357	2,159	3	6	19	27	18	26
Conn.	546	518	6,082	6,775	-	22	95	90	83	95
MID. ATLANTIC	7,705	10,462	53,288	60,685	173	569	388	354	275	143
Upstate N.Y.	705	1,196	N	N	119	165	280	278	66	8
N.Y. City	3,929	5,574	22,457	24,880	11	243	11	17	13	17
N.J.	1,592	1,922	7,858	11,403	12	46	97	59	109	65
Pa.	1,479	1,770	22,973	24,402	31	115	N	N	87	53
E.N. CENTRAL	3,442	2,810	96,641	102,035	776	613	963	952	565	513
Ohio	546	462	23,202	27,108	255	64	261	238	209	216
Ind.	352	317	11,481	11,079	57	39	132	98	83	64
Ill.	1,693	1,345	26,321	30,088	7	87	183	494	14	86
Mich.	652	552	23,516	20,772	94	49	137	122	104	80
Wis.	199	134	12,121	12,988	363	374	250	N	155	67
W.N. CENTRAL	813	934	32,919	34,844	352	197	656	514	573	536
Minn.	160	177	6,812	6,941	131	75	198	166	190	184
Iowa	86	75	4,579	4,480	75	55	180	108	147	78
Mo.	368	449	10,486	12,323	30	25	114	45	96	66
N. Dak.	3	6	677	857	15	18	20	16	20	18
S. Dak.	7	15	1,697	1,459	15	7	55	47	58	62
Nebr.	68	62	3,260	3,211	77	15	63	101	45	113
Kans.	121	150	5,408	5,573	9	2	26	31	17	15
S. ATLANTIC	10,157	11,255	117,456	127,330	457	359	358	318	265	182
Del.	199	158	2,651	2,551	6	-	1	6	1	3
Md.	1,197	1,339	12,081	12,112	10	17	32	41	1	4
D.C.	785	636	2,980	N	19	7	1	1	U	U
Va.	764	777	14,780	13,144	17	27	72	71	61	59
W. Va.	60	64	1,442	1,693	3	3	15	15	13	9
N.C.	667	741	20,009	20,314	26	29	87	72	65	52
S.C.	755	917	8,929	17,381	-	-	21	19	14	14
Ga.	1,117	1,585	24,305	30,645	170	128	42	31	36	2
Fla.	4,613	5,038	30,279	29,490	206	148	87	62	74	39
E.S. CENTRAL	1,809	1,788	44,879	42,302	47	36	125	137	100	102
Ky.	186	256	7,431	6,898	7	7	40	47	32	34
Tenn.	771	704	13,616	13,099	11	12	55	55	45	43
Ala.	457	444	13,324	11,774	15	12	11	27	9	21
Miss.	395	384	10,508	10,531	14	5	19	8	14	4
W.S. CENTRAL	3,708	4,159	92,076	86,084	123	88	178	139	229	147
Ark.	172	186	5,355	5,583	14	2	57	15	38	14
La.	649	814	16,686	15,287	10	24	9	14	49	14
Okla.	320	125	8,208	7,593	17	12	19	37	17	28
Tex.	2,567	3,034	61,827	57,621	82	50	93	73	125	91
MOUNTAIN	1,322	1,605	33,724	30,564	171	96	423	321	282	240
Mont.	14	13	1,264	1,450	10	13	30	25	-	-
Idaho	20	22	1,682	1,632	23	8	73	64	35	43
Wyo.	9	11	725	713	5	1	19	15	10	16
Colo.	300	290	8,461	5,840	71	12	160	112	110	88
N. Mex.	140	82	4,237	4,559	21	41	23	13	16	7
Ariz.	427	816	11,817	11,501	11	12	53	36	41	23
Utah	137	141	2,043	1,992	26	N	52	35	70	48
Nev.	275	230	3,495	2,877	4	9	13	21	-	15
PACIFIC	5,251	5,698	104,489	99,903	231	357	705	403	434	392
Wash.	480	336	11,583	11,104	N	N	221	161	200	176
Oreg.	171	208	4,798	5,657	21	93	154	67	114	68
Calif.	4,479	5,047	83,129	78,450	210	264	287	161	108	136
Alaska	22	14	2,187	1,711	-	-	28	1	1	1
Hawaii	99	93	2,792	2,981	-	-	15	13	11	11
Guam	15	17	-	432	-	-	N	N	U	U
P.R.	1,245	1,180	3,027	U	-	-	7	7	U	U
V.I.	32	35	U	U	U	U	U	U	U	U
Amer. Samoa	-	-	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	U	U	U	U	U	U	U	U

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

* 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*. Totals reported to the Division of STD Prevention, NCHSTP.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update November 26, 2000.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending December 2, 2000, and December 4, 1999 (48th Week)

Reporting Area	Gonorrhea		Hepatitis C; Non-A, Non-B		Legionellosis		Listeriosis	Lyme Disease	
	Cum. 2000[§]	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 2000	Cum. 1999
UNITED STATES	310,863	332,617	2,789	2,680	887	957	628	12,397	14,598
NEW ENGLAND	5,383	6,067	15	16	51	77	52	4,229	4,330
Maine	80	70	2	2	2	3	2	-	41
N.H.	94	104	-	-	3	8	4	62	22
Vt.	60	46	4	7	5	14	3	37	23
Mass.	2,211	2,280	4	4	16	27	26	1,098	768
R.I.	594	543	5	3	8	11	1	550	464
Conn.	2,344	3,024	-	-	17	14	16	2,482	3,012
MID. ATLANTIC	33,351	36,734	610	120	196	233	148	6,256	7,841
Upstate N.Y.	6,625	6,293	64	56	86	58	81	3,455	3,713
N.Y. City	9,825	11,268	-	-	-	43	27	85	134
N.J.	5,303	7,252	510	-	15	18	21	1,448	1,656
Pa.	11,598	11,921	36	64	95	114	19	1,268	2,338
E.N. CENTRAL	58,182	64,386	203	870	231	258	107	315	574
Ohio	14,009	16,741	12	4	107	77	54	82	43
Ind.	5,435	5,816	1	1	39	43	8	32	18
Ill.	17,579	21,407	18	47	9	31	11	11	17
Mich.	16,024	14,493	172	802	49	64	29	-	11
Wis.	5,135	5,929	-	16	27	43	5	190	485
W.N. CENTRAL	14,953	15,358	452	287	57	55	13	420	301
Minn.	2,678	2,611	5	10	7	13	5	322	188
Iowa	1,086	1,141	2	-	13	13	2	32	22
Mo.	7,138	7,611	429	273	26	18	5	44	64
N. Dak.	40	76	-	1	-	2	1	1	1
S. Dak.	263	186	-	-	2	3	-	-	-
Nebr.	1,287	1,347	6	3	4	6	-	4	11
Kans.	2,461	2,386	10	-	5	-	-	17	15
S. ATLANTIC	86,698	97,717	118	152	185	135	102	937	1,244
Del.	1,598	1,562	-	-	10	18	2	140	148
Md.	8,538	9,278	18	21	63	33	22	506	847
D.C.	2,558	3,385	3	1	6	4	-	10	6
Va.	9,584	8,869	3	10	33	32	8	143	114
W. Va.	465	531	15	17	N	N	5	32	18
N.C.	16,330	18,140	17	33	15	14	-	44	72
S.C.	10,919	13,818	3	22	6	11	9	13	6
Ga.	15,992	21,059	3	1	7	2	21	-	-
Fla.	20,714	21,075	56	47	45	21	35	49	33
E.S. CENTRAL	32,260	33,719	407	296	32	48	20	47	97
Ky.	3,248	3,113	34	23	18	20	3	12	17
Tenn.	10,844	10,527	91	114	10	22	13	28	56
Ala.	10,345	10,448	8	1	3	4	4	6	20
Miss.	7,823	9,631	274	158	1	2	-	1	4
W.S. CENTRAL	48,777	49,137	430	519	18	30	15	44	56
Ark.	2,920	3,076	9	28	-	1	1	4	4
La.	12,406	12,147	296	292	6	8	-	3	9
Okla.	3,667	3,725	10	16	5	3	6	1	7
Tex.	29,784	30,189	115	183	7	18	8	36	36
MOUNTAIN	9,272	8,920	385	199	46	45	36	30	16
Mont.	48	53	5	5	2	-	-	-	-
Idaho	83	80	3	7	5	2	-	3	3
Wyo.	46	30	302	64	2	-	1	9	3
Colo.	2,641	2,339	28	32	16	12	9	11	3
N. Mex.	953	909	13	34	1	1	2	-	1
Ariz.	3,921	4,082	19	43	8	7	15	-	2
Utah	208	212	2	6	12	17	4	3	2
Nev.	1,372	1,215	13	8	-	6	5	4	2
PACIFIC	21,987	20,579	169	221	71	76	135	119	139
Wash.	2,110	1,946	31	21	18	20	7	9	10
Oreg.	712	822	27	19	N	N	6	15	15
Calif.	18,491	17,117	109	181	53	54	119	93	114
Alaska	311	272	-	-	-	1	-	2	-
Hawaii	363	422	2	-	-	1	3	N	N
Guam	-	48	-	1	-	-	-	-	-
P.R.	559	309	1	-	1	-	-	N	N
V.I.	U	U	U	U	U	U	-	U	U
Amer. Samoa	U	U	U	U	U	U	-	U	U
C.N.M.I.	U	U	U	U	U	U	-	U	U

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

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending December 2, 2000, and December 4, 1999 (48th Week)

Reporting Area	Malaria		Rabies, Animal		Salmonellosis*			
					NETSS		PHLIS	
	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	1,137	1,354	5,399	6,221	34,436	36,270	29,444	31,039
NEW ENGLAND	64	61	782	839	2,048	2,085	2,088	2,114
Maine	6	3	129	166	120	125	91	100
N.H.	1	2	21	45	136	134	135	131
Vt.	3	4	57	87	104	88	113	81
Mass.	27	22	256	211	1,149	1,128	1,166	1,146
R.I.	8	5	60	93	123	121	149	153
Conn.	19	25	259	237	416	489	434	503
MID. ATLANTIC	224	397	952	1,227	3,786	5,043	4,333	4,929
Upstate N.Y.	78	66	650	865	1,139	1,288	1,237	1,273
N.Y. City	80	235	U	U	910	1,385	852	1,427
N.J.	36	54	184	172	772	1,116	821	1,056
Pa.	30	42	118	190	965	1,254	1,423	1,173
E.N. CENTRAL	115	161	145	166	4,842	5,131	3,247	4,433
Ohio	21	18	50	35	1,483	1,229	1,329	1,029
Ind.	6	21	-	13	601	511	551	450
Ill.	46	72	22	10	1,334	1,527	129	1,480
Mich.	31	40	67	87	823	945	864	922
Wis.	11	10	6	21	601	919	374	552
W.N. CENTRAL	60	73	505	690	2,229	2,127	2,351	2,296
Minn.	27	41	88	104	495	547	626	679
Iowa	2	13	75	146	347	239	312	221
Mo.	14	13	50	30	691	705	860	840
N. Dak.	2	-	113	135	55	44	74	62
S. Dak.	1	-	89	174	94	92	100	115
Nebr.	7	1	2	4	209	182	94	161
Kans.	7	5	88	97	338	318	285	218
S. ATLANTIC	305	328	2,222	2,021	7,696	8,276	5,214	6,161
Del.	5	1	49	55	109	157	130	147
Md.	101	90	387	378	742	806	714	847
D.C.	16	18	-	-	61	72	U	U
Va.	49	69	539	543	945	1,180	839	983
W. Va.	4	3	109	106	161	165	143	147
N.C.	34	30	536	416	1,076	1,247	1,072	1,256
S.C.	2	15	146	132	701	633	540	489
Ga.	30	28	306	222	1,469	1,434	1,549	1,611
Fla.	64	74	150	169	2,432	2,582	227	681
E.S. CENTRAL	45	24	194	249	2,244	2,037	1,570	1,405
Ky.	18	7	20	35	360	393	249	277
Tenn.	12	8	99	92	637	543	679	564
Ala.	14	7	75	120	632	571	521	469
Miss.	1	2	-	2	615	530	121	95
W.S. CENTRAL	19	15	73	466	3,823	3,553	3,965	2,666
Ark.	3	3	20	14	691	635	587	241
La.	7	10	-	-	248	697	708	581
Okla.	9	2	53	90	373	433	265	338
Tex.	-	-	-	362	2,511	1,788	2,405	1,506
MOUNTAIN	51	42	241	211	2,685	2,830	2,139	2,443
Mont.	1	4	64	57	90	78	-	1
Idaho	4	3	9	5	121	121	97	97
Wyo.	-	1	55	43	67	67	44	58
Colo.	25	17	-	1	684	685	646	671
N. Mex.	-	3	20	9	223	353	182	283
Ariz.	9	6	74	80	784	851	719	768
Utah	6	4	10	8	477	487	451	516
Nev.	6	4	9	8	239	188	-	49
PACIFIC	254	253	285	352	5,083	5,188	4,537	4,592
Wash.	32	26	-	-	560	640	670	792
Oreg.	41	21	7	4	295	399	348	443
Calif.	170	193	255	341	3,944	3,779	3,270	3,064
Alaska	-	1	23	7	59	53	23	31
Hawaii	11	12	-	-	225	317	226	262
Guam	-	-	-	-	-	36	U	U
P.R.	5	-	76	69	603	593	U	U
V.I.	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U

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

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

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending December 2, 2000, and December 4, 1999 (48th Week)

Reporting Area	Shigellosis* NETSS Cum. 2000	Shigellosis* NETSS Cum. 1999	Shigellosis* PHLIS Cum. 2000	Shigellosis* PHLIS Cum. 1999	Syphilis (Primary & Secondary) Cum. 2000	Syphilis (Primary & Secondary) Cum. 1999	Tuberculosis Cum. 2000	Tuberculosis Cum. 1999
UNITED STATES	19,303	15,442	10,075	9,359	5,479	6,192	11,379	14,047
NEW ENGLAND	368	838	353	816	70	54	375	397
Maine	10	5	12	-	1	-	12	16
N.H.	6	18	8	16	2	1	17	15
Vt.	4	6	-	4	-	3	4	3
Mass.	256	721	233	702	45	32	225	220
R.I.	26	23	35	27	4	2	30	39
Conn.	66	65	65	67	18	16	87	104
MID. ATLANTIC	1,896	1,031	1,321	699	244	274	2,035	2,379
Upstate N.Y.	719	262	211	70	14	19	259	298
N.Y. City	696	335	466	227	110	120	1,078	1,232
N.J.	296	241	384	223	42	62	504	489
Pa.	185	193	260	179	78	73	194	360
E.N. CENTRAL	3,649	3,012	1,120	1,654	1,059	1,153	1,241	1,480
Ohio	386	401	291	138	68	88	251	238
Ind.	1,484	314	143	107	334	406	105	129
Ill.	931	1,232	76	922	319	389	613	721
Mich.	622	467	555	417	295	230	199	298
Wis.	226	598	55	70	43	40	73	94
W.N. CENTRAL	2,228	1,134	1,849	756	57	124	417	487
Minn.	679	221	824	241	13	9	128	186
Iowa	510	62	316	53	11	9	32	50
Mo.	631	677	450	339	25	88	179	164
N. Dak.	42	3	49	2	-	-	2	6
S. Dak.	7	18	4	10	-	-	16	17
Nebr.	142	80	84	64	2	6	23	16
Kans.	217	73	122	47	6	12	37	48
S. ATLANTIC	2,821	2,304	1,073	517	1,840	1,977	2,345	2,784
Del.	23	15	23	10	8	8	14	25
Md.	191	154	109	56	275	332	228	247
D.C.	77	51	U	U	47	43	35	50
Va.	438	126	331	63	124	146	255	268
W. Va.	18	8	9	5	2	5	28	37
N.C.	363	198	249	90	449	441	303	434
S.C.	129	117	87	61	203	244	110	218
Ga.	247	221	167	83	358	412	505	555
Fla.	1,335	1,414	98	149	374	346	867	950
E.S. CENTRAL	1,092	1,118	502	663	812	1,075	802	955
Ky.	480	228	108	146	80	99	114	164
Tenn.	338	638	339	445	486	603	280	329
Ala.	90	110	49	61	116	196	279	287
Miss.	184	142	6	11	130	177	129	175
W.S. CENTRAL	2,811	2,492	2,591	1,107	771	976	892	1,719
Ark.	200	73	52	26	94	78	158	158
La.	134	208	177	127	201	289	74	219
Okla.	118	509	42	155	118	169	126	163
Tex.	2,359	1,702	2,320	799	358	440	534	1,179
MOUNTAIN	1,241	1,077	723	734	223	221	444	494
Mont.	7	9	-	-	-	1	17	13
Idaho	44	25	25	12	1	1	11	12
Wyo.	5	3	3	1	1	-	4	3
Colo.	264	194	189	153	11	2	68	69
N. Mex.	158	134	99	103	21	11	36	58
Ariz.	569	556	327	394	183	200	196	212
Utah	77	61	80	65	1	2	41	39
Nev.	117	95	-	6	5	4	71	88
PACIFIC	3,197	2,436	543	2,413	403	338	2,828	3,352
Wash.	436	119	405	107	60	64	227	228
Oreg.	163	91	105	86	6	7	25	101
Calif.	2,553	2,190	-	2,185	336	263	2,364	2,804
Alaska	8	3	3	3	-	1	91	52
Hawaii	37	33	30	32	1	3	121	167
Guam	-	17	U	U	-	-	-	62
P.R.	32	136	U	U	152	140	119	178
V.I.	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.
*Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending December 2, 2000, and December 4, 1999 (48th Week)

Reporting Area	*H. influenzae*, Invasive		Hepatitis (Viral), By Type				Measles (Rubeola)					
			A		B		Indigenous		Imported*		Total	
	Cum. 2000†	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	2000	Cum. 2000	2000	Cum. 2000	Cum. 2000	Cum. 1999
UNITED STATES	1,115	1,108	11,536	15,227	6,144	6,384	-	60	-	18	78	93
NEW ENGLAND	96	90	345	327	88	138	-	3	-	4	7	11
Maine	1	8	21	14	5	1	-	-	-	-	-	-
N.H.	12	17	18	17	16	16	-	2	-	1	3	1
Vt.	9	5	10	19	6	4	-	-	-	3	3	-
Mass.	36	37	119	131	12	43	-	1	-	-	1	8
R.I.	4	6	24	21	21	33	-	-	-	-	-	-
Conn.	34	17	153	125	28	41	-	-	-	-	-	2
MID. ATLANTIC	174	187	1,032	1,108	808	818	-	14	-	5	19	5
Upstate N.Y.	94	74	215	252	128	170	-	9	-	-	9	2
N.Y. City	38	57	348	371	416	246	-	5	-	4	9	3
N.J.	32	50	100	143	57	130	-	-	-	-	-	-
Pa.	10	6	369	342	207	272	-	-	-	1	1	-
E.N. CENTRAL	137	185	1,416	2,751	663	651	-	9	-	-	9	4
Ohio	51	57	249	613	98	87	-	2	-	-	2	-
Ind.	28	23	114	99	46	38	-	-	-	-	-	2
Ill.	48	79	592	772	110	52	-	4	-	-	4	1
Mich.	7	19	448	1,196	408	445	-	3	-	-	3	1
Wis.	3	7	13	71	1	29	-	-	-	-	-	-
W.N. CENTRAL	70	70	689	929	516	324	-	3	-	1	4	1
Minn.	42	45	183	95	36	52	-	-	-	1	1	1
Iowa	1	2	64	137	31	40	-	2	-	-	2	-
Mo.	17	10	305	587	381	194	-	-	-	-	-	-
N. Dak.	2	1	3	3	2	2	-	-	-	-	-	-
S. Dak.	1	2	2	9	1	1	-	-	-	-	-	-
Nebr.	3	4	33	48	42	20	-	-	-	-	-	-
Kans.	4	6	99	50	23	15	-	1	-	-	1	-
S. ATLANTIC	284	233	1,400	1,752	1,233	1,045	-	4	-	-	4	20
Del.	-	-	-	2	-	1	-	-	-	-	-	-
Md.	74	66	199	281	113	144	-	-	-	-	-	-
D.C.	-	5	24	58	29	25	-	-	-	-	-	-
Va.	37	19	147	168	156	91	-	2	-	-	2	18
W. Va.	9	7	53	40	15	23	-	-	-	-	-	-
N.C.	23	31	131	152	236	212	-	-	-	-	-	-
S.C.	15	5	76	44	21	63	-	-	-	-	-	-
Ga.	67	62	284	447	220	149	-	-	-	-	-	-
Fla.	59	38	486	560	443	337	-	2	-	-	2	2
E.S. CENTRAL	48	65	367	383	422	444	-	-	-	-	-	2
Ky.	12	7	45	66	70	45	-	-	-	-	-	2
Tenn.	23	37	132	147	202	207	-	-	-	-	-	-
Ala.	12	18	53	54	51	83	-	-	-	-	-	-
Miss.	1	3	137	116	99	109	-	-	-	-	-	-
W.S. CENTRAL	58	60	2,172	2,884	699	1,074	-	-	-	-	-	12
Ark.	2	2	109	69	75	80	-	-	-	-	-	5
La.	11	15	58	209	91	166	-	-	-	-	-	-
Okla.	43	39	250	478	152	145	-	-	-	-	-	-
Tex.	2	4	1,755	2,128	381	683	-	-	-	-	-	7
MOUNTAIN	111	102	947	1,186	527	537	-	12	-	1	13	2
Mont.	1	3	7	17	6	17	-	-	-	-	-	-
Idaho	4	1	34	42	6	28	-	-	-	-	-	-
Wyo.	1	1	45	8	38	14	-	-	-	-	-	-
Colo.	20	14	200	210	105	92	-	2	-	1	3	-
N. Mex.	23	18	69	50	107	172	-	-	-	-	-	-
Ariz.	47	52	457	661	196	129	-	-	-	-	-	1
Utah	11	9	61	58	24	33	-	3	-	-	3	-
Nev.	4	4	74	140	45	52	-	7	-	-	7	1
PACIFIC	137	116	3,168	3,907	1,188	1,353	-	15	-	7	22	36
Wash.	7	8	268	369	111	75	-	2	-	1	3	5
Oreg.	29	38	171	233	116	107	-	-	-	-	-	12
Calif.	33	53	2,705	3,269	940	1,140	-	12	-	3	15	17
Alaska	44	9	11	13	10	16	-	1	-	-	1	-
Hawaii	24	8	13	23	11	15	-	-	-	3	3	2
Guam	-	-	-	1	-	4	-	-	-	-	-	1
P.R.	4	2	227	327	249	226	-	-	-	-	-	-
V.I.	U	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. - : No reported cases.
*For imported measles, cases include only those resulting from importation from other countries.
†Of 233 cases among children aged <5 years, serotype was reported for 99 and of those, 23 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending December 2, 2000, and December 4, 1999 (48th Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999
UNITED STATES	1,897	2,169	4	300	336	77	6,064	6,044	-	150	246
NEW ENGLAND	121	105	-	4	8	15	1,477	805	-	13	7
Maine	8	5	-	-	-	-	45	-	-	-	-
N.H.	12	12	-	-	1	9	125	91	-	2	-
Vt.	3	5	-	-	1	6	233	71	-	-	-
Mass.	71	60	-	1	4	-	1,012	578	-	9	7
R.I.	9	7	-	1	2	-	17	33	-	1	-
Conn.	18	16	-	2	-	-	45	32	-	1	-
MID. ATLANTIC	177	214	-	23	41	5	595	959	-	9	35
Upstate N.Y.	61	67	-	10	11	-	299	712	-	2	21
N.Y. City	34	53	-	4	12	-	51	58	-	7	7
N.J.	40	50	-	3	1	-	35	27	-	-	4
Pa.	42	44	-	6	17	5	210	162	-	-	3
E.N. CENTRAL	332	384	-	30	46	13	700	564	-	1	2
Ohio	89	128	-	7	18	9	321	224	-	-	-
Ind.	44	58	-	1	5	4	111	73	-	-	1
Ill.	72	103	-	6	11	-	78	91	-	1	1
Mich.	101	59	-	16	8	-	109	63	-	-	-
Wis.	26	36	-	-	4	-	81	113	-	-	-
W.N. CENTRAL	166	214	-	18	13	14	563	460	-	3	129
Minn.	21	48	-	-	1	13	347	209	-	1	5
Iowa	34	37	-	7	7	1	54	90	-	-	30
Mo.	88	84	-	4	1	-	79	71	-	1	2
N. Dak.	2	4	-	-	1	-	6	18	-	-	-
S. Dak.	5	11	-	-	-	-	7	7	-	-	-
Nebr.	8	10	-	4	-	-	32	9	-	1	91
Kans.	8	20	-	3	3	-	38	56	-	-	1
S. ATLANTIC	289	366	1	46	48	6	469	413	-	94	35
Del.	1	10	-	-	-	1	9	5	-	1	-
Md.	26	52	-	10	6	-	106	118	-	-	1
D.C.	-	4	-	-	2	-	3	1	-	-	-
Va.	39	50	-	10	10	-	106	51	-	-	-
W. Va.	12	8	-	-	-	-	1	3	-	-	-
N.C.	36	42	-	7	8	-	108	93	-	82	34
S.C.	21	43	-	11	4	-	32	17	-	9	-
Ga.	46	59	-	2	4	2	40	40	-	-	-
Fla.	108	98	1	6	14	3	64	85	-	2	-
E.S. CENTRAL	123	150	-	7	14	-	104	100	-	5	2
Ky.	26	32	-	1	-	-	53	34	-	1	-
Tenn.	53	60	-	2	-	-	31	42	-	1	-
Ala.	32	36	-	2	10	-	19	21	-	3	2
Miss.	12	22	-	2	4	-	1	3	-	-	-
W.S. CENTRAL	127	204	-	30	40	2	330	211	-	6	15
Ark.	14	35	-	5	-	1	35	24	-	-	5
La.	35	65	-	4	11	-	12	9	-	1	-
Okla.	27	33	-	-	1	-	40	40	-	-	1
Tex.	51	71	-	21	28	1	243	138	-	5	9
MOUNTAIN	154	132	2	25	26	21	755	741	-	2	16
Mont.	4	4	-	1	-	-	35	2	-	-	-
Idaho	7	11	1	1	3	2	61	144	-	-	-
Wyo.	3	4	-	4	-	-	6	2	-	-	-
Colo.	34	34	1	2	6	14	450	275	-	1	1
N. Mex.	12	14	-	1	N	3	85	139	-	-	-
Ariz.	84	41	-	4	8	2	82	110	-	1	13
Utah	7	16	-	6	4	-	24	57	-	-	1
Nev.	3	8	-	6	5	-	12	12	-	-	1
PACIFIC	408	400	1	117	100	1	1,071	1,791	-	17	5
Wash.	59	63	1	11	2	-	395	632	-	7	-
Oreg.	73	74	N	N	N	-	113	58	-	-	-
Calif.	260	250	-	85	82	-	509	1,047	-	10	5
Alaska	8	7	-	7	3	-	22	5	-	-	-
Hawaii	8	6	-	14	13	1	32	49	-	-	-
Guam	-	1	-	-	3	-	-	2	-	-	-
P.R.	9	13	-	-	-	-	6	25	-	-	-
V.I.	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U	U	U	U

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

TABLE IV. Deaths in 122 U.S. cities,* week ending December 2, 2000 (48th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	620	440	109	46	12	13	45
Boston, Mass.	179	111	34	22	6	6	16
Bridgeport, Conn.	70	48	19	2	-	1	1
Cambridge, Mass.	26	23	3	-	-	-	1
Fall River, Mass.	30	27	2	1	-	-	-
Hartford, Conn.	63	44	11	4	3	1	2
Lowell, Mass.	14	14	-	-	-	-	1
Lynn, Mass.	13	12	-	1	-	-	1
New Bedford, Mass.	32	28	4	-	-	-	4
New Haven, Conn.	40	26	10	2	1	1	2
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	9	5	3	1	-	-	1
Springfield, Mass.	48	31	10	2	2	3	4
Waterbury, Conn.	25	18	4	3	-	-	2
Worcester, Mass.	71	53	9	8	-	1	10
MID. ATLANTIC	2,333	1,677	422	151	38	45	142
Albany, N.Y.	43	36	5	-	-	2	3
Allentown, Pa.	34	26	6	1	-	1	3
Buffalo, N.Y.	83	66	9	7	-	1	12
Camden, N.J.	31	23	7	-	-	1	4
Elizabeth, N.J.	17	16	-	1	-	-	-
Erie, Pa.§	66	53	10	1	1	1	5
Jersey City, N.J.	50	33	6	7	3	1	-
New York City, N.Y.	1,162	816	237	80	13	16	50
Newark, N.J.	U	U	U	U	U	U	U
Paterson, N.J.	27	16	8	1	2	-	-
Philadelphia, Pa.	344	230	60	33	10	11	24
Pittsburgh, Pa.§	61	41	11	4	2	3	5
Reading, Pa.	24	20	4	-	-	-	3
Rochester, N.Y.	176	136	20	9	5	6	17
Schenectady, N.Y.	20	16	1	2	-	1	-
Scranton, Pa.§	45	36	8	-	1	-	2
Syracuse, N.Y.	101	78	19	2	1	1	8
Trenton, N.J.	23	18	5	-	-	-	5
Utica, N.Y.	26	17	6	3	-	-	1
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	2,425	1,666	472	172	54	59	174
Akron, Ohio	72	50	17	4	-	1	6
Canton, Ohio	50	37	11	2	-	-	6
Chicago, Ill.	389	250	76	41	14	6	16
Cincinnati, Ohio	122	76	23	8	8	7	9
Cleveland, Ohio	154	110	29	12	1	2	8
Columbus, Ohio	186	130	37	13	1	5	14
Dayton, Ohio	161	125	23	6	3	4	14
Detroit, Mich.	227	118	63	28	8	10	17
Evansville, Ind.	45	35	7	2	1	-	8
Fort Wayne, Ind.	64	45	13	4	1	1	3
Gary, Ind.	19	6	6	3	2	2	-
Grand Rapids, Mich.	75	61	6	4	1	3	9
Indianapolis, Ind.	250	172	48	15	4	11	23
Lansing, Mich.	54	36	14	4	-	-	5
Milwaukee, Wis.	164	121	30	10	1	2	12
Peoria, Ill.	58	43	13	-	1	1	5
Rockford, Ill.	71	51	11	6	1	2	6
South Bend, Ind.	74	58	11	3	-	2	5
Toledo, Ohio	106	75	23	4	4	-	6
Youngstown, Ohio	84	67	11	3	3	-	2
W.N. CENTRAL	850	614	144	49	25	18	68
Des Moines, Iowa	158	114	25	9	8	2	22
Duluth, Minn.	40	28	11	1	-	-	5
Kansas City, Kans.	38	24	9	4	1	-	2
Kansas City, Mo.	73	53	14	2	1	3	3
Lincoln, Nebr.	57	47	6	1	2	1	1
Minneapolis, Minn.	228	155	46	16	2	9	14
Omaha, Nebr.	85	64	9	7	4	1	11
St. Louis, Mo.	U	U	U	U	U	U	U
St. Paul, Minn.	69	59	4	4	1	1	4
Wichita, Kans.	102	70	20	5	6	1	6
S. ATLANTIC	1,244	817	263	89	35	39	78
Atlanta, Ga.	173	93	51	14	5	10	4
Baltimore, Md.	132	84	23	16	2	7	11
Charlotte, N.C.	139	89	37	8	2	3	12
Jacksonville, Fla.	164	120	26	9	4	5	11
Miami, Fla.	85	47	20	8	8	2	9
Norfolk, Va.	62	45	11	4	-	2	1
Richmond, Va.	85	59	14	7	3	1	7
Savannah, Ga.	38	28	6	1	1	2	2
St. Petersburg, Fla.	65	50	11	2	2	-	7
Tampa, Fla.	186	132	36	10	4	4	10
Washington, D.C.	100	55	28	10	4	3	4
Wilmington, Del.	15	15	-	-	-	-	-
E.S. CENTRAL	767	529	151	50	19	16	65
Birmingham, Ala.	143	105	22	7	2	5	15
Chattanooga, Tenn.	88	62	18	5	2	1	3
Knoxville, Tenn.	101	69	18	10	2	2	4
Lexington, Ky.	71	45	16	7	1	2	12
Memphis, Tenn.	95	64	20	5	6	-	3
Mobile, Ala.	69	51	11	3	2	2	4
Montgomery, Ala.	53	41	10	1	1	-	12
Nashville, Tenn.	147	92	36	12	3	4	12
W.S. CENTRAL	1,375	888	255	138	60	32	88
Austin, Tex.	104	64	24	13	2	1	7
Baton Rouge, La.	1	-	-	-	-	-	-
Corpus Christi, Tex.	73	52	15	5	-	1	4
Dallas, Tex.	237	147	42	24	17	7	24
El Paso, Tex.	70	47	18	2	3	-	5
Ft. Worth, Tex.	134	92	27	7	2	6	-
Houston, Tex.	472	299	86	60	23	4	28
Little Rock, Ark.	98	65	17	5	1	10	4
New Orleans, La.	63	33	9	12	8	-	14
San Antonio, Tex.	U	U	U	U	U	U	U
Shreveport, La.	U	U	U	U	U	U	U
Tulsa, Okla.	123	89	17	10	4	3	2
MOUNTAIN	1,082	739	212	72	34	22	79
Albuquerque, N.M.	113	77	20	8	5	3	11
Boise, Idaho	47	40	6	1	-	-	4
Colo. Springs, Colo.	75	58	7	4	2	4	3
Denver, Colo.	104	60	22	11	7	4	7
Las Vegas, Nev.	198	131	52	10	3	2	12
Ogden, Utah	36	27	7	1	-	1	3
Phoenix, Ariz.	197	114	45	21	8	7	14
Pueblo, Colo.	45	37	8	-	-	-	6
Salt Lake City, Utah	94	69	11	11	2	-	12
Tucson, Ariz.	173	126	34	5	7	1	7
PACIFIC	1,696	1,225	302	113	28	25	156
Berkeley, Calif.	23	14	6	2	1	-	3
Fresno, Calif.	70	55	7	6	1	1	4
Glendale, Calif.	17	14	2	1	-	-	1
Honolulu, Hawaii	91	66	15	4	2	4	10
Long Beach, Calif.	93	70	20	2	-	1	11
Los Angeles, Calif.	395	277	67	35	9	7	23
Pasadena, Calif.	29	20	-	5	2	2	4
Portland, Oreg.	U	U	U	U	U	U	U
Sacramento, Calif.	159	115	31	11	-	2	12
San Diego, Calif.	200	144	37	10	6	3	24
San Francisco, Calif.	100	76	20	1	-	2	16
San Jose, Calif.	171	118	35	15	3	-	10
Santa Cruz, Calif.	49	37	7	4	-	1	7
Seattle, Wash.	116	76	24	13	2	1	14
Spokane, Wash.	81	64	12	3	1	1	11
Tacoma, Wash.	102	79	19	1	1	-	6
TOTAL	12,392¶	8,595	2,330	880	305	269	895

U: Unavailable. -:No reported cases.

*Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. 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.

Public Health Dispatch — Continued

Travelers to the Dominican Republic and Haiti who are not vaccinated adequately should be considered at risk for polio. All travelers should be vaccinated fully against polio according to national vaccination policies (*3*).*

Reported by: Ministry of Health, Pan American Health Organization, Santo Domingo, Dominican Republic. Ministry of Health, Pan American Health Organization, Port-au-Prince, Haiti. Caribbean Epidemiology Center Laboratory, Pan American Health Organization, Trinidad and Tobago. Div of Vaccines and Immunization, Pan American Health Organization, Washington, DC. Respiratory and Enteric Viruses Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases, and Vaccine Preventable Disease Eradication Div, National Immunization Program, CDC.

References

1. Kew OM, Mulders MN, Lipskaya GY, et al. Molecular epidemiology of polioviruses. Sem Virol 1995;6:401–14.
2. Naguib T, Yang SJ, Pallansch M, Kew O. Prolonged circulation of Sabin 2-derived polioviruses. In: Program and abstracts of progress in polio eradication: vaccination strategies for the end game. Geneva, Switzerland: International Association for Biologicals, 2000.
3. CDC. Poliomyelitis prevention in the United States: updated recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2000;49(no. RR-5).

*Current recommendations for children in the United States include a 4-dose vaccination series with inactivated poliovirus vaccine (IPV) at ages 2, 4, 6–18 months, and 4–6 years. Unvaccinated adults should receive three doses of IPV, the first two doses at intervals of 4–8 weeks and the third dose 6–12 months after the second. If three doses cannot be administered within the recommended intervals before protection is needed, alternative schedules are proposed. For incompletely vaccinated persons, additional IPV doses are recommended to complete a series. Booster doses of IPV may be considered for persons who previously have completed a primary series of polio vaccination and who may be traveling to areas where polio is endemic.

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