

MMWRTM
**MORBIDITY AND MORTALITY
WEEKLY REPORT**

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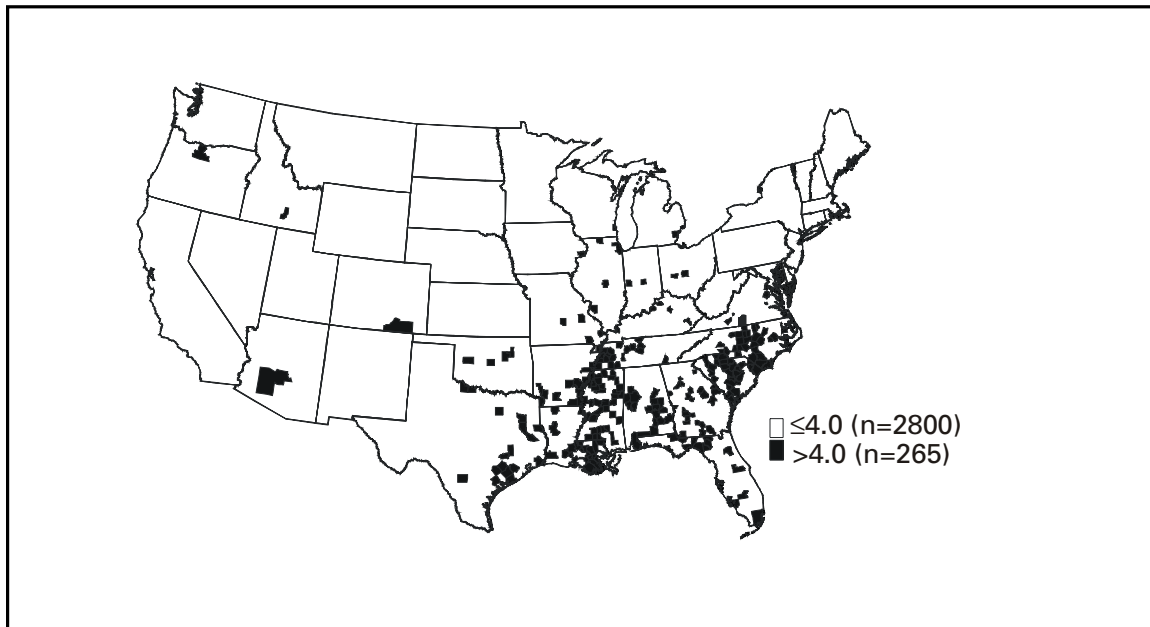
Primary and Secondary Syphilis — United States, 1999

In October 1999, CDC, in collaboration with other federal partners, launched the National Plan to Eliminate Syphilis in the United States. In 1998, Congress initiated funding for the syphilis elimination effort. Syphilis elimination is defined as the absence of sustained transmission (i.e., no transmission after 90 days of the report of an imported index case). The national goal for syphilis elimination is to reduce primary and secondary (P&S) syphilis to <1000 cases (rate: 0.4 per 100,000 population) and to increase the number of syphilis-free counties to 90% by 2005 (1). To describe the epidemiology of syphilis in the United States, CDC analyzed notifiable disease surveillance data for 1999. This report summarizes the results of that analysis, which indicate that, in 1999, P&S syphilis declined to a rate of 2.5 cases per 100,000 population, the lowest rate ever reported, and that syphilis transmission increasingly is concentrated in a few geographic areas.

Summary data for syphilis cases reported to state health departments and the District of Columbia for 1999 were sent quarterly and annually to CDC. These data included the number of syphilis cases by patients' county of residence, sex, stage of disease, racial/ethnic group, and age group. Data on reported P&S syphilis were analyzed for this report because these cases better represented incidence (i.e., newly acquired infections within the evaluated time) than reported cases of latent infection, which are usually acquired months or years before diagnosis. P&S syphilis rates were calculated by using population denominators from the U.S. Bureau of the Census (2). The 1999 rates and numbers of cases were compared with data for 1998 (3) and 1997 (4).

In 1999, 6657 cases of P&S syphilis were reported in the United States (2.5 per 100,000 population), a 5.4% decrease from the 7035 cases (rate: 2.6) reported in 1998 and a 22% decrease from the 8556 cases (rate: 3.2) reported in 1997. The South continues to have the highest rate in the country (4.5) (Figure 1)*. From 1998 to 1999, rates declined 10% in the South (from 5.0 to 4.5) and 12.5% in the Northeast (0.8 to 0.7). The rate for the West remained unchanged (1.0), and the rate for the Midwest increased from 1.9 in 1998 to 2.2 in 1999. P&S syphilis rates have declined in 28 states since 1998, and 39 states have rates below the national health objective for 2000 of 4.0. Nine of the

**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, and 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.

*Primary and Secondary Syphilis — Continued***FIGURE 1. Counties with rates above the national health objective for 2000 of 4.0 per 100,000 population — United States, 1999**

11 states that have rates above the 2000 objective are in the South. The rates for 1999 increased in 14 states; increases were largest in Indiana (from 3.6 to 7.6), Oklahoma (2.9 to 5.6), and Washington (0.8 to 1.4).

In 1999, of 3115 U.S. counties, 2473 (79.4%) reported no cases of P&S syphilis, compared with 2430 (78.0%) counties reporting no cases in 1998 and 2324 (74.6%) in 1997. In 1999, 2850 (91.5%) counties reported rates below the 2000 objective. Of the 265 counties (8.5% of all counties) with P&S syphilis rates above the 2000 objective, 243 were in the South. In 1999, 22 counties and Baltimore, Maryland; Danville, Virginia; and St. Louis, Missouri, accounted for 50% of all reported P&S syphilis cases in the United States (Table 1). The overall rate for 63 of the largest cities in the United States (population >200,000) was 5.1 cases per 100,000 persons; 24 large cities had rates higher than the 2000 objective. Cities with the highest rates of P&S syphilis were Indianapolis, Indiana (50.0); Nashville, Tennessee (46.8); and Baltimore, Maryland (38.1).

The 1999 reported rate of P&S syphilis in blacks (15.2) was 30 times the rate reported in whites (0.5); the 1999 rate for blacks declined 10% compared with 1998. The rate for Hispanics increased 20% (from 1.5 in 1998 to 1.8 in 1999). The increase in rate for Hispanics was attributed to an increased number of cases in men; the number of cases in women remained stable. Rates for American Indians/Alaska Natives and for Asians/Pacific Islanders were unchanged from 1998 (2.7 and 0.4, respectively).

Rates for P&S syphilis in 1999 were 45% higher for men (2.9) than for women (2.0). The male-to-female rate ratio in 1999 was 1.5:1, and has been increasing since 1994, when it was 1:1. The increase occurred in all racial/ethnic groups except Asians/Pacific Islanders and American Indians/Alaska Natives. The greatest increase occurred among Hispanics, from 2.3:1 in 1998 to 2.9:1 in 1999. An increase in the male-to-female rate ratio occurred in 16 (62%) of the 26 states that reported ≥ 25 cases in 1999. The male-to-female rate ratio was remarkably high in some cities, such as Seattle (38:1) and San Francisco (25:1).

*Primary and Secondary Syphilis — Continued***TABLE 1. Number and rate* of reported primary and secondary (P&S) syphilis cases, by county or city† — United States, 1998–1999**

County or City	1998		1999	
	No.	Rate	No.	Rate
Marion County, IN	161	19.8	407	50.0
Cook County, IL	364	7.0	324	6.2
Shelby County, TN	260	29.9	258	29.7
Davidson County, TN	210	39.3	250	46.8
Baltimore, MD	456	70.6	246	38.1
Fulton County, GA	151	20.4	221	29.9
Wayne County, MI	169	8.0	202	9.5
Maricopa County, AZ	173	6.2	195	7.0
Dallas County, TX	126	6.1	151	7.4
Oklahoma County, OK	71	11.2	122	19.3
Los Angeles County, CA	141	1.5	96	1.0
Dade County, FL	30	1.4	91	4.2
Harris County, TX	99	3.1	77	2.4
Philadelphia County, PA	89	6.2	69	4.8
Jefferson County, KY	91	13.5	67	10.0
King County, WA	33	2.0	65	3.9
Mecklenburg County, NC	73	11.6	55	8.7
Hinds County, MS	51	20.6	54	21.8
Guilford County, NC	98	25.3	53	13.7
Danville, VA	25	49.1	53	104.2
Orange County, FL	27	3.4	52	6.5
Oleans County, LA	105	22.6	52	11.2
St. Louis, MO	58	17.1	51	15.0
Richmond County, GA	8	4.2	50	26.1
Tulsa County, OK	14	2.6	46	8.5

*Per 100,000 population.

† Accounted for 50% of reported P&S syphilis.

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Editorial Note: The number and rate of P&S syphilis cases reported in 1999 were the lowest ever reported in the United States (1) with a 22% decline in both cases and rates since 1997, reflecting the substantial progress that has been made since efforts to eliminate syphilis began. The disease has become increasingly concentrated in a few geographic areas; in 1999, 50% of P&S syphilis cases occurred in <1% of counties; approximately 80% of counties reported no cases of syphilis. Although syphilis rates remain higher in the South than in other regions, the South had a 32% decline in the P&S syphilis rate from 1997 to 1999, illustrating that the greatest improvements in disease control have taken place where syphilis incidence has been greatest. Eliminating syphilis would reduce the likelihood of human immunodeficiency virus (HIV) transmission and improve reproductive health by preventing spontaneous abortions, stillbirths, and developmental disabilities caused by congenital syphilis. In addition, syphilis elimination would help to rebuild the capacity of communities to control infectious diseases and reduce racial disparities (1).

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Syphilis continues to disproportionately affect minority populations despite progress in reducing this racial disparity. P&S syphilis rates for blacks have remained substantially higher than those for whites. However, the magnitude of this difference has decreased 30% since 1997. The persistence of racial disparities in syphilis incidence is, in part, attributable to differences between blacks and whites regarding poverty and in access to and use of health-care services, especially in the rural South (5,6). In addition, rates increased 20% among Hispanics, due to an increase among males.

Historically, rates of syphilis have been higher for men than women. The male-to-female rate ratio peaked at 3.5:1 in 1980 during the height of syphilis transmission among men who have sex with men (MSM) and decreased to 1:1 in 1994; since then, it has increased gradually. The causes of the increasing trend in the male-to-female rate ratio are not understood completely. However, one important factor is the development since 1997 of several large outbreaks of syphilis among MSM, many of whom were co-infected with HIV (7–9). In outbreaks in King County, Washington; Chicago, Illinois; and southern California, 20%–73% of MSM with syphilis also had HIV infection. Substantial increases in syphilis among MSM also have been reported in other U.S. cities.

Despite national progress toward syphilis elimination, increases in rates have occurred in several states and cities. The increase in rates in these states may, in part, reflect improved reporting and case finding resulting from the national syphilis elimination effort; however, the increases also may be attributed to increases in populations that have been difficult to reach for purposes of syphilis prevention and control, such as MSM, who previously have not been a focus of the national syphilis elimination effort.

The findings in this report are subject to at least three limitations. First, the quality of surveillance activities and data vary at local and state levels. Second, sexually transmitted disease reporting is incomplete. Finally, cases among patients attending public sector clinics may be more likely to be reported than cases diagnosed in the private sector, which could magnify the racial/ethnic differences in reported rates; persons of minority race/ethnicity may be more likely to attend public clinics.

The variation in the demographic characteristics of syphilis patients over time and among regions highlights the need to recognize and respond to the changing epidemiology of this disease. Because increases in syphilis may emerge in areas or subpopulations that are not specifically targeted by ongoing elimination efforts, it is necessary to continually reassess and refine surveillance, prevention, and control strategies.

To sustain progress toward syphilis elimination, communities must understand local patterns of syphilis transmission and develop intervention strategies, including education, risk reduction, and screening of persons at risk for this disease. Syphilis elimination must also be viewed as an entry point for building broader public health capacity to control infectious diseases and to ensure reproductive health among historically underserved communities (1).

References

1. CDC. The national plan to eliminate syphilis from the United States. Atlanta, Georgia: US Department of Health and Human Services, CDC, National Center for HIV, STD, and TB Prevention, 1999:1–84.
2. CDC. Sexually transmitted disease surveillance, 1999. Atlanta, Georgia: US Department of Health and Human Services, CDC, 2000:25–34.
3. CDC. Primary and secondary syphilis—United States, 1998. *MMWR* 1999;48:873–8.
4. CDC. Primary and secondary syphilis—United States, 1997. *MMWR* 1997;47:493–7.

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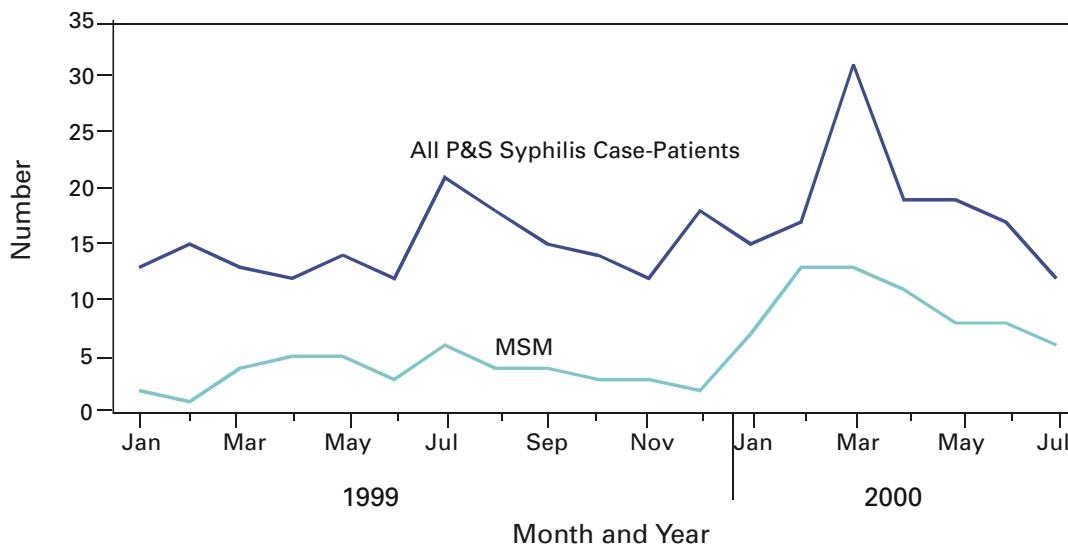
5. St. Louis ME, Wasserheit JN. Elimination of syphilis in the United States. *Science* 1998;281:353–4.
6. Kilmarx PH, Zaidi AA, Thomas JC, et al. Sociodemographic factors and the variation of syphilis rates among the US counties, 1984 through 1993: an ecological analysis. *Am J Public Health* 1997;87:1937–43.
7. Handsfield HH, Desmon S, Krekeler B, et al. Resurgent STD in gay and bisexual men: a public health crisis. Proceedings of the 2000 National STD Prevention Conference, Milwaukee, Wisconsin, December 4–7, 2000.
8. Ciesielski CA, Ramsey KS, Beidinger HA. Epidemiologic profile of early syphilis cases in a high morbidity area: implications for prevention and control. In: Proceedings of the 13th meeting of the International Society for STD Research; Denver, Colorado, July 1999.
9. CDC. Outbreak of syphilis among men who have sex with men—Southern California, 2000. *MMWR* 2001;50:117–20.

Outbreak of Syphilis Among Men Who Have Sex With Men — Southern California, 2000

Syphilis is a sexually transmitted disease (STD) caused by infection with the spirochete *Treponema pallidum*, and like other genital ulcer diseases, syphilis enhances the transmission of human immunodeficiency virus (HIV) (1). During the 1990s, syphilis occurred predominantly among heterosexual blacks in the South and in large cities. However, recent outbreaks of syphilis have occurred among men who have sex with men (MSM) (2,3). A large syphilis outbreak occurred among MSM during January–July 2000 in southern California. During the outbreak period, the proportion of primary and secondary (P&S) syphilis cases among MSM increased to 51% from 26% for the same period in 1999. This report summarizes the findings of an investigation of this syphilis outbreak, which indicate a substantial increase in the number of syphilis cases among MSM, many of whom are HIV-positive. These data suggest that concern about HIV infection may be declining among MSM and emphasize the importance of strengthening efforts to prevent HIV infection in this population in the United States.

California law requires that reactive syphilis serologic results and suspected cases of syphilis be reported to local health departments. Suspected and confirmed syphilis cases are then reported to the California Department of Health Services and CDC. Public health staff interview all persons with syphilis to collect clinical, demographic, and epidemiologic data and to assure that these persons receive appropriate treatment. The behavioral data collected include sex and number of sex partners, self-reported HIV serostatus, drug use, and location where the patient had met sex partners while the patient probably was infected. Because of the increase in the number of reported cases of syphilis in 2000, staff re-evaluated and reinterviewed syphilis case-patients reported during January 1999–July 2000. Case-patients were defined as persons with a reactive syphilis serologic test result and symptoms of P&S syphilis. Men were identified as MSM if they reported having had any male sex partners during the interview period.

During January–July 2000, 130 case-patients were reported, 66 (51%) of whom were MSM compared with 26 (26%) of 100 for the same period in 1999 (Figure 1) (4). Of the 66 MSM case-patients, 15 (23%) had primary syphilis, and 51 (77%) had secondary syphilis. MSM case-patients were from the following health jurisdictions: Los Angeles County (41), Orange County (10), City of Long Beach (eight), San Diego County (six), and

*Syphilis Outbreak — Continued***FIGURE 1. Number of primary and secondary (P&S) syphilis cases overall and among men who have sex with men (MSM), by month and year — Southern California, January 1999–July 2000**

Riverside County (one). Overall, 47% of cases were diagnosed at private medical clinics, 18% at HIV early intervention programs, and 17% at STD clinics. The median age of MSM case-patients was 35 years (range: 20–54 years); 27 (41%) were white, 24 (36%) were Hispanic, 12 (18%) were black, and two (3%) were Asian/Pacific Islander; race/ethnicity was unknown for one (2%). Of the 57 who knew their HIV serostatus, 34 (60%) reported that they were HIV positive. The year of diagnosis was known for 27 of the 34 HIV-positive MSM; the median time since diagnosis of HIV infection was 4 years (range: 0–19 years). For those whose HIV diagnosis had been made <1 year before the diagnosis of syphilis, the number of months since HIV diagnosis was not available.

Although data on behavioral risks were not collected systematically, interview records indicate that of the 66 MSM, 33 (50%) reported that they had had anonymous sex, 17 (26%) had met sex partners in bathhouses, two (3%) had met sex partners through the Internet, and four (6%) had had sex with a commercial sex worker. Overall, 13 (20%) MSM reported using a condom during the most recent sexual contact, and 26 (40%) reported using illicit drugs. Crystal methamphetamine, the drug reported most frequently, had been used by 18%.

Local response to the outbreak included a media campaign, community education, outreach, and syphilis screening. The media campaign used radio, print, and Internet advertisements to raise awareness of the outbreak and to promote syphilis testing. Local health departments and community groups used mobile vans to conduct syphilis screening at bathhouses, gay bars, HIV treatment sites, and other locations (e.g., parks and selected street corners) that MSM case-patients had identified as places for meeting sex partners.

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Editorial Note: The results of this investigation and other similar outbreaks suggest that an increasing number of MSM are participating in high-risk sexual behavior that places them at risk for syphilis and HIV infection (5,6). Similar trends have been reported internationally (7). These data are consistent with reports from behavioral surveys that indicate some MSM are participating in activities that increase their risk for acquiring and transmitting HIV and other STDs (8). Several factors may have contributed to this change, including the availability of highly active antiretroviral therapy (HAART) (9). Since the introduction of HAART in 1996, acquired immunodeficiency syndrome incidence and deaths have declined substantially, decreasing the actual and perceived threat of HIV to MSM (8). Because syphilis increases the likelihood of acquiring and transmitting HIV infection, the increase in P&S syphilis among MSM may indicate an increase in the incidence of HIV infection.

The findings in this report are subject to at least two limitations. First, information was abstracted from public health records for which data had not been collected systematically because of variations in interview style and documentation. Second, because behavioral risk data were available only for some case-patients, the proportion of case-patients with each reported behavioral risk may be inaccurate.

A high proportion of cases was identified by private providers, and communication between public health officials and HIV care and local primary-care providers was crucial in responding to the outbreak. The standard of care for MSM, regardless of HIV status, should continue to include counseling about safer sex. For MSM who are HIV positive or are at risk for HIV, voluntary screening for syphilis and other STDs is an essential component of quality care. MSM who do not know their HIV serostatus and who have an STD should be offered HIV screening to facilitate early access to care for those who are HIV positive. Partnerships with clinicians and community organizations that serve MSM will continue to be critical for the development of targeted and effective prevention messages. In this outbreak, community organizations and state and local health departments facilitated rapid outreach and education in the community. The role of outreach efforts and the media campaign in arresting the outbreak is being evaluated.

This outbreak, unlike other recent syphilis outbreaks (10), involved primarily white and Hispanic MSM with access to health care, most of whom were HIV positive. As syphilis rates decline and the epidemiology of syphilis changes, outbreak recognition through surveillance and the collection of enhanced behavioral risk data will be important in preventing syphilis and HIV transmission. State and local health departments should review HIV/STD and behavioral surveillance data on MSM and other at-risk populations to detect outbreaks and implement appropriate public health actions. Increased prevention efforts in MSM communities are critical in preventing STD and HIV transmission.

References

1. Fleming DT, Wasserheit JN. From epidemiologic synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection. *Sex Transm Infect* 1999;48:773–7.
2. CDC. Resurgent bacterial sexually transmitted disease among men who have sex with men—King County, Washington, 1997–1999. *MMWR* 1999;48:773–7.
3. CDC. Primary and secondary syphilis—United States, 1999. *MMWR* 2001;50:113–7.

Syphilis Outbreak — Continued

4. California Department of Health Services. Sexually transmitted diseases in California 1999. Sacramento, California: California Department of Health Services, 2001 (in press).
5. CDC. Gonorrhea among men who have sex with men—selected sexually transmitted disease clinics, 1993–1996. *MMWR* 1997;46:889–92.
6. CDC. Increases in unsafe sex and rectal gonorrhea among men who have sex with men—San Francisco, California, 1994–1997. *MMWR* 1999;48:45–8.
7. Stolte JG, Dukers NH, de Wit JB, Fennema JS, Goudsmit J, Coutinho RA. Increases in STDs among men who have sex with men (MSM) and in risk behavior among HIV-positive MSM in Amsterdam, possibly related to HAART-induced immunologic and virologic improvements. In: Program and abstracts of the 8th conference on Retroviruses and Opportunistic Infections; Chicago, Illinois, February 2001.
8. Stall R, Hays R, Waldo C, Ekstrand M, McFarland W. The gay '90s: a review of research in the 1990s on sexual behavior and HIV risk among men who have sex with men. *AIDS* 2000;14:S1–S14.
9. Scheer S, Chu PL, Klausner JD, Katz MH, Schwarcz SK. Effect of highly active antiretroviral therapy on diagnoses of sexually transmitted diseases in people with AIDS. *Lancet* 2001;357:432–5.
10. CDC. Outbreak of primary and secondary syphilis—Guilford County, North Carolina, 1996–1997. *MMWR* 1998;47:1070–3.

Prevalence of Disabilities and Associated Health Conditions Among Adults — United States, 1999

In the United States, the number of persons reporting disabling conditions increased from 49 million during 1991–1992 to 54 million during 1994–1995 (1–4). During 1996, direct medical costs for persons with disability were \$260 billion (5). Surveillance of disability prevalence and associated health conditions is useful in setting policy, anticipating the service needs of health systems, assisting state programs, directing health promotion and disease prevention efforts, and monitoring national health objectives (6–8). The U.S. Bureau of the Census and CDC analyzed data from the Survey of Income and Program Participation (SIPP) to determine national prevalence estimates of adults with disabilities and associated health conditions. This report summarizes findings of that analysis, which indicate that disability continues to be an important public health problem, even among working adults, and arthritis or rheumatism, back or spine problems, and heart trouble/hardening of the arteries remain the leading causes. Better health promotion and disease prevention may reduce the prevalence of disability-associated health conditions.

The 1996 SIPP panel was a multistage, stratified sample of the U.S. civilian, noninstitutionalized population based on the 1990 U.S. census. Panel members were interviewed 12 times in 4 years. During August–November 1999, the Adult Disability Topical Module of Wave 11 of the 1996 SIPP panel collected information about self-reported disability during personal interviews with persons in 36,700 households representative of the civilian, noninstitutionalized population aged ≥ 15 years. For this analysis, disability was defined as self-reported or proxy-reported difficulty with or reporting one

Disabilities and Associated Health Conditions — Continued

or more of eight measures: 1) difficulty with one or more specified functional activities*; 2) difficulty with one or more activities of daily living (ADLs)*; 3) difficulty with one or more instrumental activities of daily living (IADLs)*; 4) reporting one or more selected impairments*; 5) use of assistive aids (e.g., wheelchair, crutches, cane, or walker) for >6 months; 6) limitation in the ability to work around the house; 7) limitation in the ability to work at a job or business (data for persons aged 16–67 years); and 8) receiving federal benefits on the basis of an inability to work. A subset of persons with disability also reported the main cause of their disability from a list of 30 associated health conditions. This subset, defined before the survey was conducted, comprised persons reporting difficulty with ADLs, IADLs, selected functional activities (excluding seeing, hearing, and having their speech understood by others), or limitation in the ability to work around the house or at a job or business. National estimates were calculated using sample weights representing the inverse of the probability for selection and complex adjustments for nonresponse and subsampling (6).

The analysis focused on 53,636 adults aged ≥ 18 years (consistent with standard age categories used in other national surveys). In 1999, 44 million (22%) adults reported having a disability (Table 1). The prevalence rate of disability was 24% among women and 20% among men. Approximately 32 million adults had difficulty with one or more functional activities such as climbing a flight of stairs (19.4 million), walking three city blocks (19 million), or lifting/carrying 10 lbs (14.2 million); approximately 16.7 million adults had a limitation in the ability to work around the house; 11 million had either selected impairments or difficulty with IADLs. Two million adults used a wheelchair, and seven million used a cane, crutches, or a walker. Of the total percentage of disabilities, 63% occurred among working adults (aged 8–64 years); of these, 27.8 million (16.5%) had a disability and 17.7 million (10.5%) had a limitation in the ability to work at a job or business. Of those adults aged ≥ 65 years, 16.3 million (50%) had a disability. The age-specific prevalence rate of disability was the highest among respondents aged ≥ 65 for all functional activities, ADLs, and IADLs.

Of all adults with disabilities, 41.2 million (93.4%) reported their main health condition associated with their disability (Table 2); 7.2 million (17.5%) had arthritis and rheumatism, 6.8 million (16.5%) had back or spine problems, and 3.2 million (7.8%) had heart trouble/hardening of the arteries. Women had higher rates in the arthritis or rheumatism and “other” associated health conditions categories than men. Men had higher rates of heart trouble/hardening of the arteries and deafness or hearing problems than women.

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*Specified functional activities: ability to see words or letters in ordinary newspaper print, hear normal conversations, have speech understood by others, lift/carry 10 lbs, climb a flight of stairs without resting, and walk three city blocks. ADLs: getting around inside the home, getting in/out of a bed/chair, bathing, dressing, and toileting. IADLs: getting around outside the home, taking care of money and bills, preparing meals, doing light housework, and using the telephone. Selected impairments: learning disability, mental retardation, other developmental disability, Alzheimer disease/senility/dementia, and other mental disabilities (3).

TABLE 1. Number* and prevalence rates† of civilian noninstitutionalized persons aged ≥18 years with disability, by age group — Survey of Income Program and Participation, United States, 1999

Measure of disability	Persons with disabilities								
	≥18 Years			18–64 Years			≥65 Years		
	No.	Rate	(95% CI [§])	No.	Rate	(95% CI)	No.	Rate	(95% CI)
Difficulty with specified functional activities[¶]	32,191	16.0	(±0.5)	17,110	10.2	(±0.4)	15,081	46.3	(±1.6)
Seeing words/letters in newsprint	7,269	3.6	(±0.2)	3,542	2.1	(±0.2)	3,727	11.4	(±1.0)
Hearing normal conversation	6,932	3.5	(±0.2)	3,013	1.8	(±0.2)	3,919	12.0	(±1.0)
Having speech understood	1,982	1.0	(±0.1)	1,326	0.8	(±0.1)	656	2.0	(±0.4)
Lifting/carrying 10 lbs	14,224	7.1	(±0.3)	7,033	4.2	(±0.3)	7,191	22.1	(±1.3)
Climbing a flight of stairs	19,363	9.6	(±0.4)	9,465	5.6	(±0.3)	9,898	30.4	(±1.5)
Walking three city blocks	19,031	9.5	(±0.4)	9,087	5.4	(±0.3)	9,944	30.5	(±1.5)
Difficulty with activities of daily living[¶]	7,690	3.8	(±0.2)	3,514	2.1	(±0.2)	4,176	12.8	(±1.1)
Getting around inside home	3,471	1.7	(±0.2)	1,477	0.9	(±0.1)	1,994	6.1	(±0.8)
Getting in/out of bed/chair	5,340	2.7	(±0.2)	2,618	1.6	(±0.2)	2,722	8.4	(±0.9)
Bathing	4,371	2.2	(±0.2)	1,727	1.0	(±0.1)	2,644	8.1	(±0.9)
Dressing	3,130	1.6	(±0.2)	1,387	0.8	(±0.1)	1,743	5.4	(±0.7)
Eating	1,226	0.6	(±0.1)	566	0.3	(±0.1)	661	2.0	(±0.4)
Toileting	2,064	1.0	(±0.1)	922	0.5	(±0.1)	1,143	3.5	(±0.6)
Difficulty with instrumental activities of daily living[¶]	11,795	5.9	(±0.3)	5,370	3.2	(±0.2)	6,425	19.7	(±1.3)
Getting around outside of home	8,113	4.0	(±0.3)	3,202	1.9	(±0.2)	4,910	15.1	(±1.1)
Taking care of money and bills	4,492	2.2	(±0.2)	2,205	1.3	(±0.2)	2,286	7.0	(±0.8)
Preparing meals	4,430	2.2	(±0.2)	1,919	1.1	(±0.1)	2,511	7.7	(±0.8)
Doing light housework	6,042	3.0	(±0.2)	2,723	1.6	(±0.2)	3,319	10.2	(±1.0)
Using the telephone	2,597	1.3	(±0.1)	1,001	0.6	(±0.1)	1,597	4.9	(±0.7)
Reporting selected impairments[¶]	11,392	5.7	(±0.3)	8,706	5.2	(±0.3)	2,686	8.2	(±0.9)
A learning disability	2,660	1.3	(±0.1)	2,506	1.5	(±0.2)	154	0.5	(±0.2)
Mental retardation	1,544	0.8	(±0.1)	1,417	0.8	(±0.1)	127	0.4	(±0.2)
Other developmental disability	506	0.3	(±0.1)	456	0.3	(±0.1)	—**	—	—
Alzheimer disease/senility/dementia	1,684	0.8	(±0.1)	509	0.3	(±0.1)	1,175	3.6	(±0.6)
Other mental/emotional disability	7,932	4.0	(±0.3)	6,033	3.6	(±0.3)	1,899	5.8	(±0.7)
Use of assistive aid^{¶¶}	9,180	4.6	(±0.3)	3,415	2.0	(±0.2)	5,765	17.7	(±1.2)
Wheelchair	2,283	1.1	(±0.1)	1,012	0.6	(±0.1)	1,271	3.9	(±0.6)
Cane, crutches, or walker	6,898	3.4	(±0.2)	2,404	1.4	(±0.2)	4,494	13.8	(±1.1)
Limitation in ability to work around the house	16,755	8.3	(±0.4)	9,649	5.7	(±0.3)	7,106	21.8	(±1.3)
Limitation in ability to work at a job or business	N/A	N/A	N/A	17,689	10.5	(±0.4)	N/A	N/A	N/A
Received federal work disability benefits	N/A	N/A	N/A	7,611	4.5	(±0.3)	N/A	N/A	N/A
Total surveyed	200,668	100.0		168,105	100.0		32,563	100.0	
Total with a disability	44,088	22.0	(±0.5)	27,781	16.5	(±0.5)	16,307	50.1	(±1.6)

* In thousands.

† Per 100 persons calculated using the civilian, noninstitutionalized U.S. population on July 1, 1999.

§ Confidence interval.

¶ Number of persons reporting any subcomponent of this category. The category subtotal may be smaller than the components because these categories are not mutually exclusive.

** Estimates based on <30 unweighted cases and may not be reliable.

¶¶ Wheelchair use and use of cane/crutches/walker are mutually exclusive categories.

TABLE 2. Number* and percentage of civilian noninstitutionalized persons aged ≥ 18 years with disabilities reporting selected conditions as the main[†] cause of the disability, by sex — Survey of Income and Program Participation, United States, 1999

Main condition	All persons			Men			Women		
	No.	(%)	(95% CI [§])	No.	(%)	(95% CI)	No.	(%)	(95% CI)
Arthritis or rheumatism	7,207	17.5	(± 1.1)	1,955	11.0	(± 1.3)	5,235	22.4	(± 1.6)
Back or spine problem	6,780	16.5	(± 1.0)	2,903	16.3	(± 1.6)	3,877	16.6	(± 1.4)
Heart trouble/hardening of the arteries	3,209	7.8	(± 0.8)	1,666	9.4	(± 1.3)	1,543	6.6	(± 1.0)
Lung or respiratory problem	1,931	4.7	(± 0.6)	883	5.0	(± 1.0)	1,048	4.5	(± 0.8)
Deafness or hearing problem	1,794	4.4	(± 0.6)	1,183	6.7	(± 1.1)	611	2.6	(± 0.6)
Limb/extremity stiffness	1,747	4.2	(± 0.6)	842	4.7	(± 0.9)	905	3.9	(± 0.7)
Mental or emotional problem	1,541	3.7	(± 0.5)	733	4.1	(± 0.9)	808	3.5	(± 0.7)
Diabetes	1,399	3.4	(± 0.5)	610	3.4	(± 0.8)	789	3.4	(± 0.7)
Blindness or vision problem	1,361	3.3	(± 0.5)	629	3.5	(± 0.8)	732	3.1	(± 0.7)
Stroke	1,160	2.8	(± 0.5)	592	3.3	(± 0.8)	567	2.4	(± 0.6)
Broken bone/fracture	885	2.1	(± 0.4)	373	2.1	(± 1.5)	512	2.2	(± 0.6)
Mental retardation	827	2.0	(± 0.4)	507	2.9	(± 0.7)	320	1.4	(± 0.4)
Cancer	792	1.9	(± 0.4)	303	1.7	(± 0.6)	489	2.1	(± 0.5)
High blood pressure	692	1.7	(± 0.4)	255	1.4	(± 0.5)	437	1.9	(± 0.5)
Head or spinal cord injury	452	1.1	(± 0.3)	280	1.6	(± 1.1)	172	0.7	(± 0.3)
Learning disability	408	1.0	(± 0.3)	257	1.4	(± 0.5)	150	0.6	(± 0.3)
Alzheimer disease/senility/dementia	354	0.9	(± 0.3)	110	0.6	(± 0.3)	244	1.0	(± 0.6)
Kidney problems	348	0.8	(± 0.3)	172	1.0	(± 0.4)	177	0.8	(± 0.3)
Paralysis	310	0.8	(± 0.3)	175	1.0	(± 0.4)	135	0.6	(± 0.3)
Missing limbs	299	0.7	(± 0.2)	211	1.2	(± 0.5)	— [¶]	—	—
Stomach/digestive problems	279	0.7	(± 0.2)	112	0.6	(± 0.3)	167	0.7	(± 0.3)
Epilepsy	217	0.5	(± 0.2)	117	0.7	(± 0.4)	—	—	—
Alcohol or drug problem	210	0.5	(± 0.2)	155	0.9	(± 0.5)	—	—	—
Hernia or rupture	210	0.5	(± 0.2)	—	—	—	130	0.6	(± 0.3)
AIDS or AIDS-related condition	132	0.3	(± 0.2)	—	—	—	—	—	—
Cerebral palsy	141	0.3	(± 0.2)	—	—	—	—	—	—
Tumor/cyst/growth	116	0.3	(± 0.2)	—	—	—	—	—	—
Speech disorder	101	0.2	(± 0.1)	—	—	—	—	—	—
Thyroid problems	77	0.2	(± 0.1)	—	—	—	—	—	—
Other	6,188	15.0	(± 1.0)	2,375	13.4	(± 1.5)	3,813	16.3	(± 1.4)
Total	41,168	100.0		17,767	100.0		23,401	100.0	

* In thousands.

[†] Persons who reported difficulty with functional limitations (except vision, hearing, or speech), activities of daily living, instrumental activities of daily living, the inability to do housework or the inability to work at a job or business identified the "main" cause and up to two other causes of the disability from a list of 30 conditions.[§] Confidence interval.[¶] Estimates are based on <30 unweighted cases and may not be reliable.

Disabilities and Associated Health Conditions — Continued

Editorial Note: Disability affects more than one in five adults. Rates of disability are higher among older adults who also have higher rates of chronic diseases. However, most disability occurs during the working years, which contributes to the high cost estimates of disability. Arthritis or rheumatism, back or spine problems, and heart trouble/hardening of the arteries continue to be the leading causes of disability. This report differs from a similar 1994 report by focusing on adults only and using a broader definition of disability (4).

The strengths of SIPP include a survey design that allows nationally representative population estimates of disability. The broad definition of disability used in SIPP also provides a sensitive estimate of disability prevalence that is less likely to overlook persons with disability than other definitions (e.g., clinical or federal benefit program-based definitions). SIPP links disability with associated health conditions, providing information that usually is not available from other data sources. This information is important because many programs address disability prevention by disease or condition.

The findings in this report are subject to at least five limitations. First, despite complex statistical adjustment procedures used to address nonresponse over time, these procedures may not have completely eliminated bias that resulted from nonresponse errors, especially in subgroup analyses. Second, this report excluded persons in institutions, in the military, and aged <18 years. Third, persons with multiple disabilities may attribute the main disability to the one most disabling at the time of the interview, which may result in inconsistent survey responses. Fourth, because of questionnaire design, the main associated health condition was determined for most but not all adults with disability; 2.9 million (6.4%) persons whose only disabilities were difficulty with vision, hearing, or speech, who had selected impairments, used assistive aids, or received federal disability benefits were not asked about a main condition. Finally, the definition of disability used did not assess environmental and social barriers, discrimination as the result of disability, and effects on the workforce. These issues are addressed in the *International Classification of Functioning, Disability, and Health (ICIDH-2)*, a unified and standard framework that describes the dimensions of disability (9). *ICIDH-2* complements the *International Classification of Diseases* by organizing information around three dimensions: body level (body systems and structure), person and society level (activities and participation), and the environment. Because of the dynamic quality of disability, a limitation in one dimension does not predict a limitation in another.

These estimates demonstrate the large impact of disability in working age and older adults and the relative contributions of associated health conditions, and provide information for public health policy makers and health systems. More detailed analyses relating the eight measures of disability and associated health conditions can assist disease-specific efforts in planning, health promotion and disease prevention, and surveillance of disability-related national health objectives (10). With increasing life expectancy and the aging of the population, health issues related to disability are likely to increase in importance.

References

1. CDC. Prevalence of disabilities and associated health conditions—United States, 1991–1992. *MMWR* 1994;43:730–9.
2. Kaye H, LaPlante M, Carlson D, et al. Trends in disability rates in the United States, 1970–1994. San Francisco, California: University of California, Disability Statistics Center, 1996. Available at <http://dsc.ucsf.edu/UCSF/pub>. Accessed February 2001.
3. McNeil JM. Americans with disabilities, 1994–95. Washington, DC: US Department of Commerce, Economics and Statistics Administration, Bureau of the Census, 1997. (Current population reports; series P70, no. 61).

Disabilities and Associated Health Conditions — Continued

4. McNeil JM. Americans with disabilities: 1991–92. Washington, DC: US Department of Commerce, Economics and Statistics Administration, Bureau of the Census, 1993. (Current population reports; series P70, no. 33).
5. Hough J. Estimating the health care utilization costs associated with people with disabilities: data from the 1996 Medical Expenditure Panel Survey (MEPS). Annual meeting of the Association for Health Services Research, Los Angeles, California, 2000.
6. Income Surveys Branch, Bureau of the Census, Overview of the Survey of Income and Program Participation (SIPP). Washington, DC: US Department of Commerce, Economics and Statistics Administration, Bureau of the Census, 1999. Available at <http://www.census.gov>. Accessed December 1, 2000.
7. US Department of Health and Human Services. Healthy people 2010 (conference ed, 2 vols). Washington, DC: US Department of Health and Human Services, 2000.
8. CDC. State-specific prevalence of disability among adults—11 states and the District of Columbia, 1998. *MMWR*, 2000;49:711–4.
9. World Health Organization. ICDH-2: international classification of functioning, disability and health: prefinal draft, full version. Geneva, Switzerland: World Health Organization, 2000.
10. Arthritis Foundation, Association of State and Territorial Health Officials, and CDC. National Arthritis Action Plan: a public health strategy. Atlanta, Georgia: Arthritis Foundation, 1999.

Notice to Readers**Satellite Broadcast on HIV Prevention**

“The Impact of Stigma on HIV Prevention Programs,” a satellite broadcast, is scheduled for Wednesday, April 25, 2001, from 1–3 p.m. eastern time. CDC and the Public Health Training Network are co-sponsoring this forum, which will focus on the impact of stigma on health and human immunodeficiency virus (HIV) prevention efforts, and how public health programs may send mixed messages that contribute to stigma. Presentations and interviews will provide an update on public health resources and innovative strategies to reduce or eliminate stigmatizing attitudes.

This broadcast is designed for organizations and persons who provide HIV prevention, including health departments, HIV prevention community planning groups, national and regional minority organizations, community-based organizations, and health-care providers. Viewers can fax questions and comments before and during the broadcast.

Additional information for organizations and potential viewers is available through the World-Wide Web site, <http://www.cdcnpin.org/broadcast>, and CDC’s Fax Information System, telephone (888) 232-3299 ([888] CDC-FAXX), by entering document number 130036 and a return fax number. Organizations setting up viewing sites are encouraged to register online or by fax as early as possible so that viewers can access information about viewing locations when visiting the web site or calling the information line.

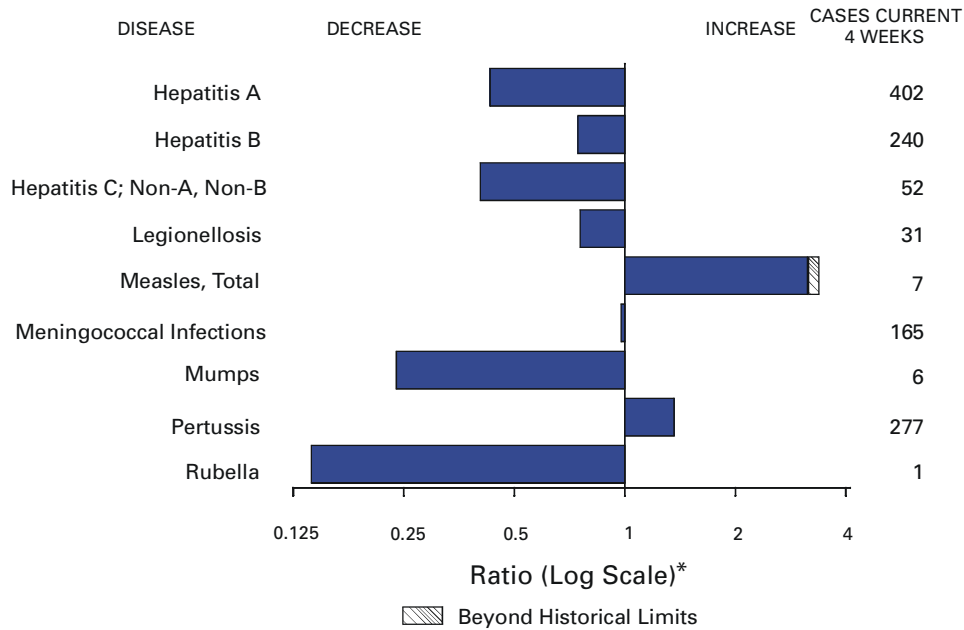
Errata: Vol. 49, No. 46

In the article “Measles, Rubella, and Congenital Rubella Syndrome — United States and Mexico, 1997–1999,” two errors appeared on page 1048 in the first paragraph under the section, “Measles in the United States.” In the fourth line, the number of cases per 100,000 population should read <0.5 , and in the last sentence of the same paragraph, the date should read March 2000.

Erratum: Vol. 49, No. 45

In the Notice to Readers, "Shortage of Tetanus and Diphtheria Toxoids," an error occurred in the next to last sentence of the second paragraph. The sentence should read, "Arthritis-type reactions may occur among persons who receive multiple doses of tetanus toxoid-containing vaccines (TT or Td), especially within short intervals (<10 years)."

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending February 17, 2001, 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 February 17, 2001 (7th Week)

	Cum. 2001		Cum. 2001
Anthrax	-	Poliomyelitis, paralytic	-
Brucellosis*	-	Psittacosis*	2
Cholera	-	Q fever*	1
Cyclosporiasis*	2	Rabies, human	-
Diphtheria	-	Rocky Mountain spotted fever (RMSF)	8
Ehrlichiosis: human granulocytic (HGE)*	3	Rubella, congenital syndrome	-
human monocytic (HME)*	1	Streptococcal disease, invasive, group A	262
Encephalitis: California serogroup viral*	-	Streptococcal toxic-shock syndrome*	10
eastern equine*	-	Syphilis, congenital†	1
St. Louis*	-	Tetanus	1
western equine*	-	Toxic-shock syndrome	10
Hansen disease (leprosy)*	2	Trichinosis	2
Hantavirus pulmonary syndrome*†	-	Tularemia*	1
Hemolytic uremic syndrome, postdiarrheal*	5	Typhoid fever	12
HIV infection, pediatric*§	10	Yellow fever	-
Plague	-		

-: 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 January 30, 2001.

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

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending February 17, 2001, and February 19, 2000 (7th Week)

Reporting Area	AIDS		Chlamydia [†]		Cryptosporidiosis		<i>Escherichia coli</i> O157:H7*			
	Cum. 2001 [§]	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	NETSS		PHLIS	
							Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	2,792	2,720	64,487	84,760	106	128	87	177	50	139
NEW ENGLAND	91	283	2,460	3,087	5	5	10	13	4	15
Maine	3	3	-	175	-	1	-	1	-	1
N.H.	5	4	130	147	-	-	3	3	2	3
Vt.	5	-	87	78	2	2	-	1	-	2
Mass.	51	228	1,189	1,289	-	2	7	4	2	3
R.I.	11	6	431	321	1	-	-	-	-	-
Conn.	16	42	623	1,077	2	-	-	4	-	6
MID. ATLANTIC	555	796	2,381	7,710	8	10	9	23	4	37
Upstate N.Y.	4	21	N	N	3	5	9	21	4	30
N.Y. City	360	495	865	3,197	5	4	-	1	-	-
N.J.	157	195	264	1,826	-	-	-	1	-	2
Pa.	34	85	1,252	2,687	-	1	N	N	-	5
E.N. CENTRAL	224	141	8,710	15,273	37	32	19	30	11	7
Ohio	46	24	204	4,111	17	6	11	5	6	3
Ind.	26	26	1,712	1,678	9	3	4	1	-	1
Ill.	121	63	2,262	4,619	-	5	3	13	3	-
Mich.	23	19	3,592	2,732	11	3	1	6	-	1
Wis.	8	9	940	2,133	-	15	-	5	2	2
W.N. CENTRAL	44	47	3,625	4,864	4	1	11	35	8	29
Minn.	12	11	667	1,119	-	-	3	3	3	11
Iowa	9	7	403	232	2	-	-	8	-	4
Mo.	7	15	1,185	1,846	-	-	6	19	2	8
N. Dak.	-	-	109	141	-	1	-	1	-	1
S. Dak.	-	1	259	242	-	-	1	-	1	-
Nebr.	6	4	177	434	2	-	-	2	-	3
Kans.	10	9	825	850	-	-	1	2	2	2
S. ATLANTIC	734	578	13,993	14,889	17	13	11	15	4	14
Del.	15	15	391	401	-	-	-	-	-	-
Md.	41	92	1,550	1,406	2	1	-	5	-	1
D.C.	62	23	391	400	2	-	-	-	U	U
Va.	48	41	2,176	1,492	2	-	2	3	3	4
W. Va.	6	4	296	262	-	-	-	1	-	1
N.C.	57	27	2,063	1,627	4	3	6	4	1	1
S.C.	61	34	1,065	2,429	-	-	1	-	-	-
Ga.	104	97	2,473	3,182	-	4	1	1	-	3
Fla.	340	245	3,588	3,690	7	5	1	1	-	4
E.S. CENTRAL	148	140	6,242	5,688	3	5	4	8	3	5
Ky.	18	20	1,104	1,000	-	-	-	2	2	2
Tenn.	80	35	2,026	1,648	-	-	2	3	1	3
Ala.	25	50	1,421	1,722	2	5	2	1	-	-
Miss.	25	35	1,691	1,318	1	-	-	2	-	-
W.S. CENTRAL	409	267	12,342	13,321	3	7	2	10	8	14
Ark.	19	8	1,279	525	1	1	-	2	-	2
La.	130	44	2,435	2,279	1	-	-	-	5	5
Okla.	20	10	1,231	1,199	1	1	2	3	2	3
Tex.	240	205	7,397	9,318	-	5	-	5	1	4
MOUNTAIN	145	100	3,147	4,753	7	8	6	21	5	7
Mont.	1	1	148	121	-	-	-	5	-	-
Idaho	-	3	249	256	1	1	2	2	-	-
Wyo.	-	1	111	110	-	-	-	2	-	2
Colo.	38	33	179	1,117	1	2	1	7	2	2
N. Mex.	7	8	585	624	3	-	-	-	-	-
Ariz.	52	21	1,437	1,623	1	2	3	3	2	2
Utah	11	12	67	344	1	3	-	1	1	1
Nev.	36	21	371	558	-	-	-	1	-	-
PACIFIC	442	368	11,587	15,175	22	47	15	22	3	11
Wash.	26	46	1,874	1,774	N	U	3	1	-	4
Oreg.	17	11	592	454	5	1	2	3	1	4
Calif.	398	302	8,519	12,168	17	46	10	14	-	-
Alaska	1	-	238	303	-	-	-	-	-	-
Hawaii	-	9	364	476	-	-	-	4	2	3
Guam	2	-	-	-	-	-	N	N	U	U
P.R.	48	75	382	U	-	-	-	-	U	U
V.I.	1	-	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 January 30, 2001.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 17, 2001, and February 19, 2000 (7th Week)

Reporting Area	Gonorrhea		Hepatitis C; Non-A, Non-B		Legionellosis		Listeriosis	Lyme Disease	
	Cum. 2001 ^s	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	31,571	44,540	162	473	55	82	30	209	406
NEW ENGLAND	719	976	2	2	1	6	5	66	38
Maine	-	8	-	-	-	2	-	-	-
N.H.	12	15	-	-	-	-	-	42	11
Vt.	14	3	2	-	1	-	-	-	-
Mass.	373	379	-	2	-	3	3	1	13
R.I.	109	79	-	-	-	-	-	-	-
Conn.	211	492	-	-	-	1	2	23	14
MID. ATLANTIC	1,612	3,997	6	70	1	8	1	86	291
Upstate N.Y.	443	339	3	-	1	2	1	63	58
N.Y. City	418	1,330	-	-	-	-	-	-	11
N.J.	188	1,015	-	65	-	-	-	-	45
Pa.	563	1,313	3	5	-	6	-	23	177
E.N. CENTRAL	4,567	9,156	20	39	25	32	5	9	9
Ohio	143	2,367	1	-	14	14	2	9	1
Ind.	814	777	-	-	3	3	-	-	-
Ill.	1,117	3,233	-	5	-	3	-	-	1
Mich.	2,124	1,814	19	34	8	6	3	-	-
Wis.	369	965	-	-	-	6	-	U	7
W.N. CENTRAL	1,655	2,043	35	68	6	3	1	3	7
Minn.	234	431	-	-	-	1	-	3	1
Iowa	110	86	-	-	1	1	-	-	-
Mo.	844	992	34	65	3	1	-	-	2
N. Dak.	4	4	-	-	-	-	-	-	-
S. Dak.	30	33	-	-	-	-	-	-	-
Nebr.	42	135	-	1	1	-	-	-	-
Kans.	391	362	1	2	1	-	1	-	4
S. ATLANTIC	9,038	12,427	7	9	8	19	4	33	49
Del.	217	220	-	-	-	1	-	-	6
Md.	902	974	4	2	5	7	2	30	37
D.C.	415	345	-	-	-	-	-	1	-
Va.	1,231	1,263	-	-	2	3	1	1	1
W. Va.	55	76	-	1	N	N	-	-	2
N.C.	1,661	1,490	1	5	-	1	-	1	3
S.C.	1,209	3,199	-	-	-	2	-	-	-
Ga.	1,287	2,119	-	-	-	-	1	-	-
Fla.	2,061	2,741	2	1	1	5	-	-	-
E. S. CENTRAL	4,182	4,152	22	73	3	1	4	2	-
Ky.	466	421	-	5	2	-	1	2	-
Tenn.	1,442	1,319	6	15	-	-	2	-	-
Ala.	1,182	1,372	-	3	1	1	1	-	-
Miss.	1,092	1,040	16	50	-	-	-	-	-
W.S. CENTRAL	6,442	7,267	51	149	1	4	-	-	2
Ark.	871	294	1	-	-	-	-	-	-
La.	1,699	1,864	3	84	1	2	-	-	2
Okla.	603	568	-	-	-	-	-	-	-
Tex.	3,269	4,541	47	65	-	2	-	-	-
MOUNTAIN	905	1,286	7	36	1	5	1	-	-
Mont.	5	-	-	-	-	-	-	-	-
Idaho	18	16	-	-	-	1	-	-	-
Wyo.	12	9	2	23	-	-	-	-	-
Colo.	231	444	1	5	-	2	-	-	-
N. Mex.	117	114	4	4	-	-	-	-	-
Ariz.	390	462	-	4	1	-	1	-	-
Utah	9	51	-	-	-	2	-	-	-
Nev.	123	190	-	-	-	-	-	-	-
PACIFIC	2,451	3,236	12	27	9	4	9	10	10
Wash.	421	331	-	2	1	1	-	-	-
Oreg.	114	56	3	7	N	N	1	2	1
Calif.	1,828	2,760	9	18	8	3	8	8	9
Alaska	26	30	-	-	-	-	-	-	-
Hawaii	62	59	-	-	-	-	-	N	N
Guam	-	-	-	-	-	-	-	-	-
P.R.	87	74	-	1	2	-	-	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 February 17, 2001, and February 19, 2000 (7th Week)

Reporting Area	Malaria		Rabies, Animal		Salmonellosis*			
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	NETSS		PHLIS	
					Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	87	107	394	521	1,903	3,029	1,421	2,818
NEW ENGLAND	8	2	55	55	164	186	73	202
Maine	-	-	10	13	8	14	5	10
N.H.	-	-	1	1	14	11	7	9
Vt.	-	-	11	3	9	4	7	4
Mass.	2	2	13	21	93	124	15	123
R.I.	-	-	7	3	9	3	11	14
Conn.	6	-	13	14	31	30	28	42
MID. ATLANTIC	3	17	76	80	139	437	176	487
Upstate N.Y.	1	6	60	63	52	53	31	108
N.Y. City	2	6	U	U	65	131	96	141
N.J.	-	2	16	8	-	161	15	89
Pa.	-	3	-	9	22	92	34	149
E.N. CENTRAL	21	14	3	5	300	456	286	225
Ohio	4	2	-	1	141	104	73	80
Ind.	6	-	1	-	26	34	19	46
Ill.	-	7	-	-	70	166	100	-
Mich.	11	5	2	-	63	66	63	69
Wis.	-	-	-	4	-	86	31	30
W.N. CENTRAL	2	7	41	56	142	136	116	156
Minn.	1	2	11	17	31	19	50	51
Iowa	-	-	10	6	16	12	1	12
Mo.	1	1	2	2	50	50	48	44
N. Dak.	-	-	8	6	1	2	1	9
S. Dak.	-	-	6	14	13	6	7	9
Nebr.	-	1	-	-	9	17	-	12
Kans.	-	3	4	11	22	30	9	19
S. ATLANTIC	22	25	160	171	496	457	330	456
Del.	1	-	-	7	11	8	5	9
Md.	9	15	36	40	78	88	67	77
D.C.	2	-	-	-	13	-	U	U
Va.	8	7	41	45	73	45	48	53
W. Va.	-	-	8	15	1	15	11	11
N.C.	1	3	45	46	133	104	45	75
S.C.	-	-	7	9	49	49	50	38
Ga.	-	-	-	-	31	53	104	148
Fla.	1	-	23	9	107	95	-	45
E.S. CENTRAL	1	4	3	22	163	163	62	116
Ky.	-	1	2	4	32	27	20	19
Tenn.	1	-	1	15	33	38	39	56
Ala.	-	3	-	3	76	55	-	34
Miss.	-	-	-	-	22	43	3	7
W.S. CENTRAL	2	1	9	87	61	271	137	326
Ark.	-	-	-	-	25	22	13	22
La.	1	1	-	-	8	37	40	60
Okla.	-	-	9	7	7	21	13	25
Tex.	1	-	-	80	21	191	71	219
MOUNTAIN	5	6	15	21	121	270	95	212
Mont.	1	-	4	6	7	11	-	-
Idaho	1	-	-	-	5	18	4	12
Wyo.	-	-	-	12	6	4	1	1
Colo.	1	2	-	-	6	57	30	45
N. Mex.	-	-	-	-	25	24	10	24
Ariz.	1	2	11	3	45	89	30	85
Utah	1	2	-	-	16	43	20	45
Nev.	-	-	-	-	11	24	-	-
PACIFIC	23	31	32	24	317	653	146	638
Wash.	-	-	-	-	14	15	-	80
Oreg.	4	4	-	-	32	43	25	50
Calif.	18	26	17	20	267	550	85	469
Alaska	1	-	15	4	4	10	-	10
Hawaii	-	1	-	-	-	35	36	29
Guam	-	-	-	-	-	-	U	U
P.R.	-	2	7	7	5	33	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 February 17, 2001, and February 19, 2000 (7th Week)

Reporting Area	Shigellosis*				Syphilis (Primary & Secondary)		Tuberculosis	
	NETSS		PHLIS		Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000				
UNITED STATES	1,007	1,747	519	1,026	500	792	578	1,046
NEW ENGLAND	16	53	6	40	6	8	19	26
Maine	-	2	-	-	-	-	-	1
N.H.	-	1	-	1	-	-	1	1
Vt.	-	-	-	-	-	-	-	-
Mass.	12	41	1	28	4	6	13	11
R.I.	-	3	-	5	-	1	-	2
Conn.	4	6	5	6	2	1	5	11
MID. ATLANTIC	87	99	59	98	23	30	131	143
Upstate N.Y.	52	14	2	13	1	1	13	11
N.Y. City	27	41	39	35	13	15	50	86
N.J.	-	33	2	24	6	7	45	39
Pa.	8	11	16	26	3	7	23	7
E.N. CENTRAL	188	313	98	110	55	164	94	92
Ohio	63	16	20	6	3	11	17	14
Ind.	34	20	5	8	15	59	10	3
Ill.	42	131	48	-	11	60	57	68
Mich.	49	119	23	93	25	23	-	3
Wis.	-	27	2	3	1	11	10	4
W.N. CENTRAL	170	81	120	73	1	20	21	38
Minn.	66	11	80	34	-	3	13	16
Iowa	18	14	-	14	-	5	-	-
Mo.	48	47	34	17	1	10	5	17
N. Dak.	8	-	1	-	-	-	-	-
S. Dak.	2	1	-	-	-	-	1	2
Nebr.	9	5	-	5	-	1	2	1
Kans.	19	3	5	3	-	1	-	2
S. ATLANTIC	145	129	49	52	197	246	75	119
Del.	2	-	-	-	1	1	-	-
Md.	17	11	2	4	26	49	8	15
D.C.	8	-	U	U	5	11	9	-
Va.	11	10	5	12	15	19	-	-
W. Va.	1	-	5	-	-	-	4	5
N.C.	45	8	19	5	55	68	9	16
S.C.	12	3	7	1	26	18	8	18
Ga.	3	5	10	19	18	32	37	39
Fla.	46	92	1	11	51	48	-	26
E.S. CENTRAL	94	82	31	52	77	107	42	73
Ky.	41	15	13	10	7	5	3	4
Tenn.	11	34	15	39	37	75	-	21
Ala.	23	5	-	1	18	17	28	35
Miss.	19	28	3	2	15	10	11	13
W.S. CENTRAL	65	304	97	317	87	124	13	221
Ark.	29	30	10	3	9	3	13	8
La.	8	46	25	19	18	30	-	6
Okla.	2	5	-	4	10	35	-	5
Tex.	26	223	62	291	50	56	-	202
MOUNTAIN	70	172	43	62	21	23	16	55
Mont.	-	-	-	-	-	-	-	-
Idaho	2	21	-	12	-	-	-	-
Wyo.	-	1	-	1	-	-	-	-
Colo.	6	30	10	12	1	1	8	7
N. Mex.	18	17	7	13	1	-	1	5
Ariz.	36	64	21	19	14	20	7	15
Utah	3	5	5	5	4	-	-	4
Nev.	5	34	-	-	1	2	-	24
PACIFIC	172	514	16	222	33	70	167	279
Wash.	24	80	-	175	13	8	22	21
Oreg.	15	71	14	42	2	1	-	1
Calif.	133	354	-	-	16	61	137	247
Alaska	-	2	-	1	-	-	8	1
Hawaii	-	7	2	4	2	-	-	9
Guam	-	-	U	U	-	-	-	-
P.R.	-	4	U	U	27	25	-	-
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 February 17, 2001, and February 19, 2000 (7th Week)

Reporting Area	<i>H. influenzae</i> , Invasive		Hepatitis (Viral), By Type				Measles (Rubeola)					
	Cum. 2001 [†]	Cum. 2000	A		B		Indigenous		Imported*		Total	
			Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	2001	Cum. 2001	2001	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	126	175	741	1,672	434	686	1	6	-	2	8	7
NEW ENGLAND	4	17	36	39	5	14	1	1	-	-	1	-
Maine	-	-	1	1	1	1	-	-	-	-	-	-
N.H.	-	2	3	6	2	3	-	-	-	-	-	-
Vt.	-	2	-	1	1	2	1	1	-	-	1	-
Mass.	4	13	8	13	1	1	-	-	-	-	-	-
R.I.	-	-	2	-	-	-	-	-	-	-	-	-
Conn.	-	-	22	18	-	7	-	-	-	-	-	-
MID. ATLANTIC	15	25	36	99	37	119	-	-	-	-	-	2
Upstate N.Y.	5	11	15	27	5	6	-	-	-	-	-	-
N.Y. City	5	8	18	56	26	70	-	-	-	-	-	2
N.J.	4	4	-	5	-	6	-	-	-	-	-	-
Pa.	1	2	3	11	6	37	-	-	-	-	-	-
E.N. CENTRAL	20	25	120	265	80	77	-	-	-	-	-	1
Ohio	16	9	35	61	15	16	-	-	-	-	-	-
Ind.	3	2	4	4	2	1	-	-	-	-	-	-
Ill.	-	11	19	109	2	1	-	-	-	-	-	-
Mich.	1	3	62	79	61	58	-	-	-	-	-	1
Wis.	-	-	-	12	-	1	-	-	-	-	-	-
W.N. CENTRAL	2	3	62	159	30	47	-	1	-	-	1	-
Minn.	-	-	1	12	1	-	-	-	-	-	-	-
Iowa	-	-	5	12	-	8	-	-	-	-	-	-
Mo.	2	3	12	111	23	33	-	-	-	-	-	-
N. Dak.	-	-	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	1	-	-	-	-	-	-	-
Nebr.	-	-	17	4	4	4	-	-	-	-	-	-
Kans.	-	-	27	20	1	2	-	1	-	-	1	-
S. ATLANTIC	42	42	105	116	66	83	-	2	-	1	3	-
Del.	-	-	-	-	-	-	-	-	-	-	-	-
Md.	10	20	39	21	12	25	-	2	-	1	3	-
D.C.	-	-	3	-	2	-	-	-	-	-	-	-
Va.	3	10	19	23	9	19	-	-	-	-	-	-
W. Va.	1	1	-	16	1	-	-	-	-	-	-	-
N.C.	6	3	5	25	26	21	-	-	-	-	-	-
S.C.	1	1	9	1	-	1	-	-	-	-	-	-
Ga.	10	6	1	6	1	-	-	-	-	-	-	-
Fla.	11	1	29	24	15	17	-	-	-	-	-	-
E.S. CENTRAL	5	8	33	76	34	59	-	-	-	-	-	-
Ky.	-	5	6	4	3	8	-	-	-	-	-	-
Tenn.	3	3	15	23	13	26	-	-	-	-	-	-
Ala.	2	-	12	11	10	4	-	-	-	-	-	-
Miss.	-	-	-	38	8	21	-	-	-	-	-	-
W.S. CENTRAL	1	13	64	336	23	74	-	-	-	-	-	-
Ark.	-	-	13	16	13	8	-	-	-	-	-	-
La.	-	5	6	14	2	25	-	-	-	-	-	-
Okla.	1	8	19	51	7	7	U	-	U	-	-	-
Tex.	-	-	26	255	1	34	-	-	-	-	-	-
MOUNTAIN	29	23	92	115	36	53	-	-	-	1	1	-
Mont.	-	-	2	1	-	1	-	-	-	-	-	-
Idaho	-	1	-	4	-	3	-	-	-	1	1	-
Wyo.	-	-	1	-	-	-	-	-	-	-	-	-
Colo.	1	6	6	31	2	15	-	-	-	-	-	-
N. Mex.	6	8	4	15	13	11	-	-	-	-	-	-
Ariz.	21	6	54	48	16	19	-	-	-	-	-	-
Utah	-	1	8	8	-	2	-	-	-	-	-	-
Nev.	1	1	17	8	5	2	-	-	-	-	-	-
PACIFIC	8	19	193	467	123	160	-	2	-	-	2	4
Wash.	-	2	5	9	5	1	-	-	-	-	-	2
Oreg.	7	4	16	33	17	14	-	2	-	-	2	-
Calif.	-	5	165	418	100	141	-	-	-	-	-	2
Alaska	1	1	7	3	1	2	-	-	-	-	-	-
Hawaii	-	7	-	4	-	2	-	-	-	-	-	-
Guam	-	-	-	-	-	-	U	-	U	-	-	-
P.R.	-	-	-	49	1	22	U	-	U	-	-	-
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 21 cases among children aged <5 years, serotype was reported for 9 and of those, 0 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending February 17, 2001, and February 19, 2000 (7th Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000
UNITED STATES	305	388	1	13	68	37	430	684	-	2	5
NEW ENGLAND	25	21	-	-	-	2	107	188	-	-	3
Maine	-	2	-	-	-	-	-	7	-	-	-
N.H.	2	2	-	-	-	2	6	29	-	-	1
Vt.	-	1	-	-	-	-	16	38	-	-	-
Mass.	15	11	-	-	-	-	83	111	-	-	2
R.I.	-	1	-	-	-	-	-	2	-	-	-
Conn.	8	4	-	-	-	-	2	1	-	-	-
MID. ATLANTIC	32	27	-	-	4	-	12	52	-	-	1
Upstate N.Y.	11	6	-	-	1	-	12	23	-	-	-
N.Y. City	6	8	-	-	1	-	-	19	-	-	1
N.J.	14	6	-	-	-	-	-	-	-	-	-
Pa.	1	7	-	-	2	-	-	10	-	-	-
E.N. CENTRAL	21	67	-	1	7	7	70	136	-	2	-
Ohio	13	9	-	1	3	2	58	97	-	-	-
Ind.	-	6	-	-	-	-	1	3	-	-	-
Ill.	-	23	-	-	1	-	-	5	-	1	-
Mich.	8	19	-	-	3	5	10	5	-	1	-
Wis.	-	10	-	-	-	-	1	26	-	-	-
W.N. CENTRAL	25	28	-	2	6	2	20	19	-	-	-
Minn.	-	1	-	-	-	-	-	6	-	-	-
Iowa	10	6	-	-	3	-	2	6	-	-	-
Mo.	8	17	-	-	1	-	7	2	-	-	-
N. Dak.	-	1	-	-	-	-	-	-	-	-	-
S. Dak.	-	1	-	-	-	-	2	1	-	-	-
Nebr.	3	1	-	-	2	-	-	-	-	-	-
Kans.	4	1	-	2	-	2	9	4	-	-	-
S. ATLANTIC	66	55	-	1	6	3	21	38	-	-	-
Del.	-	-	-	-	-	-	-	-	-	-	-
Md.	13	4	-	1	1	2	7	13	-	-	-
D.C.	-	-	-	-	-	-	-	-	-	-	-
Va.	7	10	-	-	-	-	-	1	-	-	-
W. Va.	-	1	-	-	-	-	-	-	-	-	-
N.C.	17	11	-	-	1	1	10	14	-	-	-
S.C.	4	6	-	-	3	-	4	9	-	-	-
Ga.	9	11	-	-	-	-	-	-	-	-	-
Fla.	16	12	-	-	1	-	-	1	-	-	-
E.S. CENTRAL	25	20	-	-	1	5	14	25	-	-	-
Ky.	3	3	-	-	-	-	1	18	-	-	-
Tenn.	9	9	-	-	-	5	11	2	-	-	-
Ala.	10	7	-	-	1	-	2	4	-	-	-
Miss.	3	1	-	-	-	-	-	1	-	-	-
W.S. CENTRAL	33	52	-	-	9	-	3	6	-	-	1
Ark.	6	1	-	-	-	-	2	3	-	-	-
La.	8	17	-	-	2	-	-	1	-	-	-
Okla.	6	5	U	-	-	U	1	-	U	-	-
Tex.	13	29	-	-	7	-	-	2	-	-	1
MOUNTAIN	15	18	1	2	3	16	173	122	-	-	-
Mont.	-	-	-	-	-	-	-	-	-	-	-
Idaho	3	2	-	-	-	-	18	16	-	-	-
Wyo.	-	-	1	1	-	-	-	-	-	-	-
Colo.	1	4	-	-	-	8	8	80	-	-	-
N. Mex.	4	2	-	1	N	4	8	16	-	-	-
Ariz.	3	6	-	-	-	3	135	5	-	-	-
Utah	2	3	-	-	-	1	4	3	-	-	-
Nev.	2	1	-	-	2	-	-	2	-	-	-
PACIFIC	63	100	-	7	32	2	10	98	-	-	-
Wash.	6	5	-	-	-	2	7	4	-	-	-
Oreg.	12	13	N	N	N	-	3	12	-	-	-
Calif.	45	79	-	7	30	-	-	75	-	-	-
Alaska	-	-	-	-	-	-	-	2	-	-	-
Hawaii	-	3	-	-	2	-	-	5	-	-	-
Guam	-	-	U	-	-	U	-	-	U	-	-
P.R.	-	2	U	-	-	U	-	-	U	-	-
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 February 17, 2001 (7th Week)

Reporting Area	All Causes, By Age (Years)						P&I [†] Total	Reporting Area	All Causes, By Age (Years)						P&I [†] Total
	All Ages	≥65	45-64	25-44	1-24	<1			All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	577	408	102	42	13	12	70	S. ATLANTIC	1,268	795	284	134	22	33	91
Boston, Mass.	157	96	36	11	8	6	8	Atlanta, Ga.	183	98	52	22	2	9	-
Bridgeport, Conn.	53	42	4	6	1	-	3	Baltimore, Md.	154	89	37	22	5	1	12
Cambridge, Mass.	20	18	2	-	-	-	3	Charlotte, N.C.	108	76	13	14	4	1	13
Fall River, Mass.	23	16	4	3	-	-	1	Jacksonville, Fla.	154	94	43	12	2	3	22
Hartford, Conn.	65	35	17	9	1	3	7	Miami, Fla.	124	68	32	17	1	6	15
Lowell, Mass.	25	16	6	3	-	-	7	Norfolk, Va.	64	44	11	6	-	3	3
Lynn, Mass.	8	7	1	-	-	-	1	Richmond, Va.	53	29	16	7	-	1	4
New Bedford, Mass.	26	21	5	-	-	-	6	Savannah, Ga.	52	40	6	4	-	2	2
New Haven, Conn.	45	30	9	2	2	2	8	St. Petersburg, Fla.	73	63	6	3	1	-	10
Providence, R.I.	U	U	U	U	U	U	U	Tampa, Fla.	176	121	30	14	4	7	9
Somerville, Mass.	3	2	1	-	-	-	1	Washington, D.C.	100	58	28	11	3	-	1
Springfield, Mass.	51	42	6	3	-	-	8	Wilmington, Del.	27	15	10	2	-	-	-
Waterbury, Conn.	38	31	5	2	-	-	6	E.S. CENTRAL	868	592	188	57	16	14	75
Worcester, Mass.	63	52	6	3	1	1	11	Birmingham, Ala.	188	115	46	15	5	6	20
MID. ATLANTIC	2,197	1,582	407	138	31	38	144	Chattanooga, Tenn.	91	62	24	3	1	1	8
Albany, N.Y.	54	38	9	4	3	-	6	Knoxville, Tenn.	115	78	25	10	2	-	10
Allentown, Pa.	22	17	5	-	-	-	2	Lexington, Ky.	93	63	19	9	1	1	8
Buffalo, N.Y.	92	69	13	5	3	2	13	Memphis, Tenn.	217	156	40	12	5	4	11
Camden, N.J.	26	18	1	2	2	3	4	Mobile, Ala.	105	75	22	5	1	2	9
Elizabeth, N.J.	30	21	4	1	1	3	-	Montgomery, Ala.	59	43	12	3	1	-	9
Erie, Pa.‡	42	35	3	1	-	3	4	Nashville, Tenn.	U	U	U	U	U	U	U
Jersey City, N.J.	39	24	10	5	-	-	4	W.S. CENTRAL	1,497	990	310	120	49	28	114
New York City, N.Y.	1,156	812	242	80	11	10	43	Austin, Tex.	90	64	16	7	2	1	5
Newark, N.J.	U	U	U	U	U	U	U	Baton Rouge, La.	61	45	10	3	1	2	3
Paterson, N.J.	7	7	-	-	-	-	U	Corpus Christi, Tex.	58	36	16	2	-	4	8
Philadelphia, Pa.	277	179	63	21	5	9	18	Dallas, Tex.	210	136	43	17	7	7	18
Pittsburgh, Pa.‡	49	37	7	4	1	-	3	El Paso, Tex.	86	63	16	5	2	-	4
Reading, Pa.	35	28	5	1	1	-	6	Ft. Worth, Tex.	111	72	28	8	2	1	5
Rochester, N.Y.	133	110	14	6	1	2	19	Houston, Tex.	418	263	84	40	24	7	30
Schenectady, N.Y.	23	21	2	-	-	-	2	Little Rock, Ark.	74	49	18	5	2	-	4
Scranton, Pa.‡	35	29	5	-	1	-	2	New Orleans, La.	U	U	U	U	U	U	U
Syracuse, N.Y.	100	79	14	2	-	5	17	San Antonio, Tex.	205	127	50	21	4	3	20
Trenton, N.J.	25	17	2	4	1	1	1	Shreveport, La.	53	36	8	4	3	2	6
Utica, N.Y.	33	27	4	1	1	-	3	Tulsa, Okla.	131	99	21	8	2	1	11
Yonkers, N.Y.	19	14	4	1	-	-	1	MOUNTAIN	1,006	692	190	83	23	17	91
E.N. CENTRAL	2,024	1,361	443	134	43	43	148	Albuquerque, N.M.	124	90	17	14	3	-	10
Akron, Ohio	71	46	19	5	1	-	9	Boise, Idaho	30	26	4	-	-	-	4
Canton, Ohio	33	27	5	-	-	1	7	Colo. Springs, Colo.	65	46	10	8	-	1	2
Chicago, Ill.	360	219	85	31	13	12	25	Denver, Colo.	116	78	20	7	5	6	15
Cincinnati, Ohio	84	62	11	8	1	2	7	Las Vegas, Nev.	184	117	48	14	4	1	16
Cleveland, Ohio	122	80	24	12	3	3	1	Ogden, Utah	43	34	5	4	-	-	6
Columbus, Ohio	201	139	41	15	2	4	14	Phoenix, Ariz.	175	105	37	18	8	6	11
Dayton, Ohio	120	89	18	7	5	1	11	Pueblo, Colo.	25	18	4	3	-	-	2
Detroit, Mich.	213	123	64	16	7	3	17	Salt Lake City, Utah	84	59	15	7	1	2	9
Evansville, Ind.	48	40	6	1	1	-	3	Tucson, Ariz.	160	119	30	8	2	1	16
Fort Wayne, Ind.	72	50	12	6	4	-	9	PACIFIC	1,453	1,037	278	89	30	16	113
Gary, Ind.	22	11	7	3	1	-	1	Berkeley, Calif.	19	10	5	3	-	1	1
Grand Rapids, Mich.	50	36	11	1	1	1	2	Fresno, Calif.	U	U	U	U	U	U	U
Indianapolis, Ind.	214	133	56	14	2	9	12	Glendale, Calif.	37	32	3	2	-	-	-
Lansing, Mich.	40	29	9	1	-	1	4	Honolulu, Hawaii	66	53	6	4	1	1	4
Milwaukee, Wis.	120	84	27	5	-	4	13	Long Beach, Calif.	81	61	12	6	-	2	15
Peoria, Ill.	56	38	14	2	1	1	1	Los Angeles, Calif.	531	358	118	36	17	2	37
Rockford, Ill.	55	45	9	1	-	-	5	Pasadena, Calif.	37	29	4	2	-	2	6
South Bend, Ind.	61	47	13	1	-	-	2	Portland, Oreg.	U	U	U	U	U	U	U
Toledo, Ohio	82	63	12	5	1	1	5	Sacramento, Calif.	U	U	U	U	U	U	U
Youngstown, Ohio	U	U	U	U	U	U	U	San Diego, Calif.	169	125	32	8	3	1	17
W.N. CENTRAL	779	566	134	44	12	23	65	San Francisco, Calif.	U	U	U	U	U	U	U
Des Moines, Iowa	59	43	11	3	2	-	11	San Jose, Calif.	171	131	26	6	3	5	16
Duluth, Minn.	20	12	5	2	-	1	1	Santa Cruz, Calif.	32	22	7	2	1	-	2
Kansas City, Kans.	25	16	5	3	-	1	4	Seattle, Wash.	153	101	36	14	2	-	8
Kansas City, Mo.	119	85	20	8	-	6	8	Spokane, Wash.	58	42	11	1	3	1	4
Lincoln, Nebr.	44	30	7	5	1	1	3	Tacoma, Wash.	99	73	18	5	-	1	3
Minneapolis, Minn.	182	144	25	8	1	4	10	TOTAL	11,669 [†]	8,023	2,336	841	239	224	911
Omaha, Nebr.	84	64	15	3	1	1	9								
St. Louis, Mo.	74	45	20	4	3	2	-								
St. Paul, Minn.	69	54	10	3	-	2	10								
Wichita, Kans.	103	73	16	5	4	5	9								

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.

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