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Progress Toward Poliomyelitis Eradication — Pakistan and Afghanistan, January 2000–April 2002

Since 1988, when the World Health Assembly resolved to eradicate poliomyelitis worldwide, the estimated global incidence of polio has decreased 99% (*1*). Pakistan began polio eradication activities in 1994 and Afghanistan in 1997 (*2*). Although polio remains endemic in the two countries, both the incidence and the geographic distribution of poliovirus have been reduced substantially. This report summarizes progress toward eradicating polio in Pakistan and Afghanistan during January 2000–April 2002. Both countries aim to stop transmission of poliovirus by the end of 2002; however, the unstable security situation in the region might threaten this success.

Routine Vaccination

During 2000–2001 in Pakistan, reported routine coverage of infants with 3 doses of oral poliovirus vaccine (OPV3) ranged from 33% in Balochistan province to 82% in Punjab. In Afghanistan, reported national routine OPV3 coverage increased from 35% in 1999 to 45% in 2001; coverage rates in 2001 ranged from 15% in the Northeastern region to 83% in the Eastern region.

Supplemental Immunization Activities

At least two rounds of National Immunization Days (NIDs)* have been conducted annually in Pakistan since 1994 (*3*). During 1999, vaccination activities were intensified by adding a house-to-house vaccination strategy and extra rounds of NIDs. Four rounds of NIDs were conducted during 2000 and five during 2001, and an additional subnational immunization day (SNID)† was conducted in August 2001. During 2002, one SNID round was conducted in January, and two rounds of NIDs were conducted in March and April. Two additional SNID rounds will be conducted in June and July, and full NIDs are planned for September and October. Surveillance and genetic sequencing data are being used to target polio-virus reservoir districts (i.e., districts in which persistent year-round indigenous transmission occurs, particularly during the low transmission season [January–March]).

Following subnational campaigns during 1994–1996 that included OPV and other antigens, NIDs for polio began in Afghanistan in April and May 1997; since then, at least two rounds of NIDs have been conducted annually (*4*). During 2000, efforts were intensified by adding a house-to-house vaccination strategy and increasing the number of rounds of NIDs. In the spring of 2001, a house-to-house vaccination strategy was used to reach 5.8 million children; in the spring of 1999, 4.0 million children were reached by using fixed vaccination posts. Supplemental immunization activities (SIAs) have been coordinated with Afghanistan's neighbors, particularly Pakistan and Iran. During January–August 2001, three rounds of NIDs, a mop-up vaccination campaign in Kandahar and three neighboring districts, and a SNID round in high-risk provinces and districts were conducted. In September and November 2001, NIDs were conducted despite the absence of international support staff caused by armed conflict in the region.

* Nationwide mass campaigns over a short period (days to weeks) in which 2 doses of OPV are administered to all children (usually aged <5 years), regardless of vaccination history, with an interval of 4–6 weeks between doses.
† Same procedure as NIDs but in a smaller geographic area.

INSIDE

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Acute Flaccid Paralysis Surveillance

The quality of acute flaccid paralysis (AFP) surveillance is evaluated by two key WHO-established indicators: sensitivity of reporting (target: nonpolio AFP rate of ≥1 case per 100,000 children aged <15 years) and completeness of specimen collection (target: two adequate stool specimens[§] from ≥80% of all persons with AFP). Since 2001, AFP surveillance in Pakistan has met these indicators. During 2000–2001, the nonpolio AFP rate increased from 1.5 per 100,000 children aged <15 years to 2.2, and the rate for adequate stool collection increased from 67% to 83% (Table). During January–April 2002, rates remained above targets, with an annualized nonpolio AFP rate of 2.2 and an adequate stool collection rate of 88%. The nonpolio enterovirus (NPEV) isolation rate (target: ≥10%), a marker for laboratory performance and the integrity of the reverse cold chain for specimens, was 13% in 2000 and 19% in 2001.

Since Afghanistan's AFP surveillance system began in 1997, surveillance indicators have improved steadily. During 2000, the nonpolio AFP rate was 1.3, and the adequate stool collection rate was 50%; during 2001, the rates were 1.8 and 73%, respectively. In January 2001, the country switched from clinical to virologic classification of polio cases. During September–December 2001, a period marked by armed conflict, 42 AFP cases were identified (27 [64%] with adequate stool samples). AFP surveillance in the Southern region, which reported nine of the 11 polio cases in 2001, was affected more than other regions by lack of security and displacement of staff. Since January 2002, a total of 72 AFP cases has been reported nationally, with adequate specimens collected from 62 (86%) cases. The NPEV isolation rate was 19% in 2000, 16% in 2001, and 11% during January–April 2002.

The WHO-accredited Regional Reference Poliovirus Laboratory in Islamabad performs virologic testing of stool specimens from both Afghanistan and Pakistan. During 2001, laboratory results were reported within 28 days of specimen receipt for 81% of the 1,584 AFP cases in Pakistan and for 72% of the 215 AFP cases in Afghanistan (target: ≥80%).

Incidence of Polio

During 2000–2001, the number of polio cases confirmed virologically declined 42% in Pakistan, from 199 in 59 districts to 116 in 39 districts; during January–April 2002, a total of 18 cases has been confirmed virologically (Figure). Of the 116 cases in 2001, a total of 69 was caused by poliovirus type 1 (P1), 46 by poliovirus type 3 (P3), and one by a

[§] Two stool specimens collected at an interval of at least 24 hours within 14 days of paralysis onset and shipped properly to the laboratory.

TABLE. Number of reported cases of acute flaccid paralysis (AFP) and confirmed wild virus cases, and key surveillance indicators — Afghanistan and Pakistan, January 2000–April 2002*

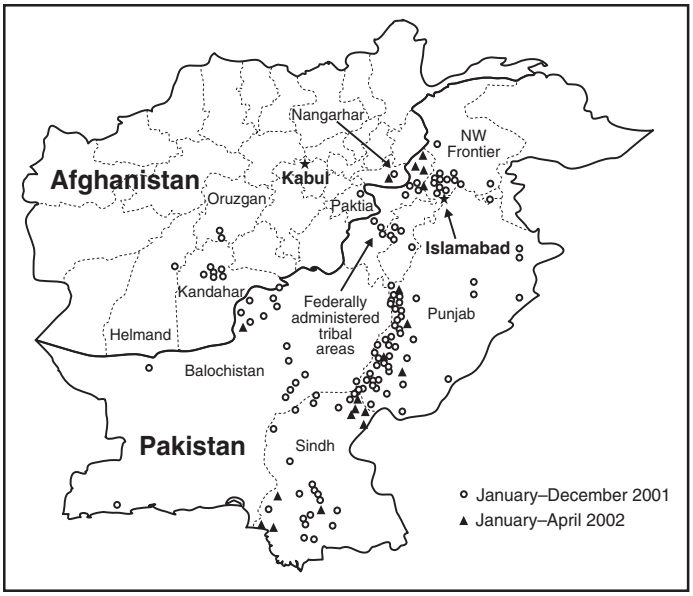
	January–December 2000				January–December 2001				January–April 2002			
	No. AFP cases	No. confirmed wild virus cases	Nonpolio AFP rate	% adequate stool specimens†	No. AFP cases	No. confirmed wild virus cases	Nonpolio AFP rate	% adequate stool specimens	No. AFP cases	No. confirmed wild virus cases	Nonpolio AFP rate	% adequate stool specimens
Afghanistan	252	27	1.3	50	214	11	1.8	73	72	1	1.8	86
Pakistan	1,152	199	1.5	67	1,573	116	2.2	83	512	18	2.2	88

*Data for 2002 annualized as of March 31, 2002.
†Two stool specimens collected at an interval of at least 24 hours within 14 days of paralysis onset and shipped properly to the laboratory.

mixture of P1 and P3. Epidemiologic data from polio cases in 2001 indicated several high-risk groups, including Afghan refugees and children whose parents are uneducated.

During 2000 in Afghanistan, 27 polio cases that were confirmed virologically were reported from 22 districts; during 2001, a total of 11 cases was reported from seven districts. During January–August 2001, nine cases of wild poliovirus were reported, of which seven were from Kandahar and three neighboring districts, and two were from a district in a neighboring province. During the same period in 2000, a total of 21 polio cases was reported. No polio cases have been reported for the Northern, Northeastern, Central, and Western regions since late 2000. Each of the 11 cases (one P3 and 10 P1) reported in 2001 came from regions that border Pakistan. As of April 2002, one case of polio (P3) was confirmed in the Eastern region, with onset in February. One case has been reported in the Southern region of Afghanistan with onset in early May 2002, indicating that transmission is ongoing in that region.

FIGURE. Distribution of wild poliovirus isolates from acute flaccid paralysis cases — Afghanistan and Pakistan, January 2001–April 2002



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Editorial Note: Pakistan and Afghanistan constitute a single epidemiologic block representing one of the three remaining major global reservoirs for poliovirus transmission (the other two being northern India and Nigeria). Improvements in the quality of SIAs and AFP surveillance since January 2000 have brought both countries closer to interrupting poliovirus transmission.

Although armed conflict in Afghanistan has posed many challenges to surveillance and vaccination activities, data from January–April 2002 indicate that progress toward eradication has resumed. The improved quality of SIAs and the addition of targeted SNID rounds in Afghanistan before September 2001 appear to have prevented a widespread resurgence of poliovirus in the country during the recent conflict. Despite continuing military and political instability, public health staff in Afghanistan and Pakistan succeeded in implementing NIDs in late September and November and continued essential surveillance activities.

The AFP surveillance system in Pakistan provides reliable data on which to base programmatic decisions. AFP surveillance quality in Afghanistan appears to be recovering from a decline during the recent conflict. Rapid restoration of the system in the remaining regions bordering Pakistan where polio is endemic is a top program priority. Both countries will conduct intense SIAs targeting high-risk populations during the summer of 2002 followed by NIDs in September and October. Mop-up vaccination activities to terminate the final chains of transmission will be implemented in 2003 in response to any isolation of wild poliovirus. Vaccination and surveillance activities are coordinated closely between the two countries and include synchronization of SIAs, establishment of border vaccination posts, and regular exchange of data.

A number of risks might threaten the interruption of virus transmission by the end of 2002, including armed conflict and deterioration of security throughout the region, sudden large population movements that might spread the virus to areas where it is now absent, persistence of virus transmission in reservoirs shared between the two countries, failure to reach high-risk groups in SIAs, shortfall in human and financial resources, increasing complacency, and inability to balance competing priorities. In Afghanistan, the new interim administration is committed to polio eradication, and in Pakistan, political commitment from the newly formed district governments to the federal government is high. Close collaboration between local governments and their global partners[¶] has been critical in sustaining eradication activities in both countries and will continue to be essential to achieve polio eradication.

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[¶]Polio eradication efforts in Pakistan and Afghanistan are supported by the governments of both countries, Japan, the United Kingdom, and the Netherlands; the Bill and Melinda Gates Foundation, the United Nations Foundation; the United Nations Children's Fund (UNICEF); the International Committee of the Red Cross; the International Federation of Red Cross and Red Crescent Societies; Rotary International; the U.S. Agency for International Development; WHO; and CDC.

Update: Rashes Among Schoolchildren — 27 States, October 4, 2001– June 3, 2002

Since October 2001, a total of 27 states has reported investigations of multiple groups of schoolchildren who have developed rashes. Rash illnesses among schoolchildren in 14 states were reported in March (*1*); since the initial report, rashes have been reported in 13 additional states (Alabama, Alaska, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Hampshire, and New Jersey). Rashes also have been reported among schoolchildren in Canada. The investigations have not identified a common source for the reported cases of rashes among U.S. schoolchildren. This report summarizes available data on these rashes and provides examples for three states. CDC is continuing to monitor reports of rashes and is providing technical assistance to state and local health departments investigating these reports.

United States

Although rashes among schoolchildren are common, public concern has been growing because of the number of simultaneous cases reported in schools across the United States. During October 2001–May 2002, rashes among groups of students were reported in approximately 110 U.S. elementary, middle, and high schools. The number of students affected in each school ranged from five to 274; the proportion of students affected ranged from <1% to 47%. The sex distribution of cases varied among the schools, ranging from 33% to 100% female. Rashes varied by presentation, location on the body, and duration. Most affected children were reported as having 1) a pruritic, sunburn-like rash that appeared on the cheeks and arms, 2) a burning sensation on the skin that might be associated with pruritis, or 3) a hive- or nettle-like reaction that was observed moving from one part of the body to another. Rashes tended to be self-limiting and ranged in duration from <1 hour to >1 month. Because of the transient nature of the rashes, most children who were evaluated were seen by school nurses; some children who had recurring or persistent rashes were seen by dermatologists. Accompanying signs and symptoms such as conjunctivitis, fever, vomiting, sore throat, or headaches were absent in all but a few cases. The etiology of the rash illnesses remains unknown in several states. Alaska, Illinois, Kentucky, Minnesota, Mississippi, and New York have received reports of cases associated with parvovirus B19, and other states have investigated small reports of rash illness that appear to be primarily psychogenic in response to a child with a diagnosed rash or infection.

Case Reports

New York. On March 8, 2002, the New York State Department of Health (NYSDOH) sent a notice to local health units and school superintendents across the state to increase awareness and reporting of outbreaks of rash illness. At the time, NYSDOH and a county health department were following an ongoing outbreak of rash illness, which began in January and by April 2 involved 242 (7%) elementary- and middle-school students in a school district with 3,371 children. No fevers or other major signs and symptoms were reported to accompany the rashes, and no rash illness was reported among employees in affected schools. To assess the outbreak, school nurses selected a sample of affected students with active rashes from five elementary schools and one middle school; 17 children with rashes were interviewed on April 2

and evaluated by a team of health-care providers by physical examination, serology for parvovirus B19, and viral cultures of throat and stool specimens. Dates of rash onset for these 17 children ranged from March 11 to April 1. Of the 17 children interviewed, 12 (71%) were females. The ages of the students ranged from 5–13 years (mean: 9 years). Five (29%) children reported having had symptoms (e.g., fatigue, stuffy nose, and sore throat) that occurred within 4 days before rash onset. Of six (35%) children who reported that another family member had a rash, four (67%) had family members whose rashes occurred before the child's rash onset, and two (33%) had family members whose onset followed the child's rash. Fifteen (88%) children reported their rashes to be itchy; of these, nine (60%) children reported no association with time of day or place. Three (18%) of the 17 children that were interviewed reported having a low-grade fever (i.e., <100.3º F [37.9º C]), nine (53%) children reported that the rashes were warm to the touch, eight (47%) children associated the rashes with a burning sensation, and 13 (77%) children reported that the rashes reappeared; information for one child was not recorded. Five (29%) children had rashes that began on the face and nine (53%) children rashes that began on the extremities or stomach before spreading; two (12%) children had rashes that did not spread. On examination, health-care providers described the rashes as maculopapular in 13 (77%) cases, lacy and reticular in 14 (82%) cases, and morbilliform in six (35%) cases. All 17 children submitted specimens for viral studies; 16 (94%) had negative viral throat cultures, and one was positive for influenza A. Stool specimens were submitted by nine children; all were negative on viral culture. Human parvovirus B19 antibody assays were performed on 14 children; 13 (93%) were positive for IgM antibodies, and 14 (100%) were positive for IgG antibodies. The results of this investigation support the conclusion that the outbreak was due to parvovirus B19, which causes erythema infectiosum (i.e., fifth disease).

Georgia. During January, the Georgia Division of Public Health received a report that 12 students from an elementary school had developed pruritic rashes in a single day; 10 children were in the same class. Dermatologists who examined all 12 children diagnosed the rashes as contact dermatitis. The rashes resolved by the next day, and no additional cases occurred. The school cleaned the classroom on the day the rashes occurred, including vacuuming the carpet, washing table tops, and wet dusting all surfaces. The school nurse determined that the pruritic rashes were the only sign or symptom; one child had a history of a preceding illness (a cold the previous week). The onset of rash illnesses began after one child developed a pruritic eczematic rash on one arm. After several minutes, a second child complained that her arm was itching; within the hour, eight children seated at the same table also were scratching their arms and complaining about rashes. A child from another classroom reported a pruritic rash after sitting with the other children at lunch; another child, also from another class, reported a rash after seeing the index child in the school clinic. Although environmental or allergic exposure cannot be ruled out, the school nurse's description suggests that all the rashes (with the exception of the index case) were caused by scratching secondary to observing, encountering, or interacting with the child with the eczematic rash.

Missouri. During February 5–March 19, a total of 33 (21%) students with rash illness was reported in a rural elementary school with 161 students; 12 (36%) of the 33 affected students sought medical care. The illnesses were mild and lasted a median of 4 days (range: 6 hours–14 days). Of the 71 children in kindergarten through fourth grade, 25 (35%) were affected. Most affected students had rashes limited to the hands and forearms, but five (15%) children had rashes that were generalized or involved the face; five (15%) children had pruritic rashes. Dates of rash onset were February 19 for six cases and February 28 for 12 cases; these 18 cases accounted for 55% of cases among students. However, single cases continued to be reported as late as March 19. Of the 33 cases reported, 23 (70%) occurred among girls. Two siblings developed rashes 4 days apart; no other rashes among family members were reported to the school nurse. Contact dermatitis was the most likely explanation for most cases, possibly from frequent use of hand cleaners and alcohol-based sanitizers or from surfaces cleaned with ammonia-based products. Other possible etiologies offered by clinicians for these rashes included scabies, dry skin, and parvovirus B19 infection; however, none of these diagnoses was confirmed.

Public Health Response

Despite public perceptions that all rash cases are interrelated, even in a single school, children's rashes can result from a variety of etiologies, including medications, dry or sensitive skin, eczema, allergies, viral infections, and psychogenic or environmental factors. Investigations have identified cases for some of the rashes reported. In other cases, the etiology remains unknown.

CDC is continuing to monitor reports of groups of schoolchildren with rashes and is providing technical assistance to state and local health departments investigating these reports. In addition, CDC is receiving public inquiries from adults (with or without exposure to children) who suspect they might have a related rash. These public inquiries are forwarded to state or local health departments for follow-up.

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Editorial Note: Rashes reported in schools have affected school policies and practices. Normal school operations were disrupted when students were moved or evacuated from their classrooms, and the costs of conducting environmental assessments have added a financial burden. In the absence of an identifiable etiology for the rashes, many school administrators and board members had to consider whether short-term school closures were warranted and to decide if children with rashes should be excluded from school or if children without rashes should be permitted to stay home from school.

Schools that identify groups of students and/or staff with rashes should report cases to their state or local health department to determine what kind of investigation should be conducted to ensure that no identifiable hazards exist within the school setting. To assist with these efforts, CDC has developed and distributed to health departments a document with suggested approaches for investigating reports of rashes among groups of schoolchildren. In particular, efforts should be made to 1) collect uniform information from affected persons so cases of rashes reportedly associated with school settings can be differentiated from rashes occurring from other causes; 2) monitor reported cases to ensure that the rashes have resolved; 3) determine whether similar rashes are occurring among household members who have not been exposed to the school setting; and 4) confirm that no other associated signs and symptoms are occurring or developing subsequent to the rashes.

At least five challenges might impede the investigation of reported rashes among schoolchildren and the identification of the underlying causes. First, school mechanisms for reporting and tracking students' health vary. Second, because many rashes are of short duration, health-care providers other than school nurses usually do not observe them. Third, parents and health-care providers might be reluctant to collect biologic specimens that would assist with determining an infectious etiology from otherwise healthy children. Fourth, the logistics of organizing an environmental assessment can delay collection of timely and complete information. Finally, inconclusive and possibly misleading data might be collected if a methodical environmental sampling plan is not followed (*2*).

When accompanied by other signs and symptoms, rashes can be an important indicator of serious health conditions; however, few schoolchildren with rashes had any accompanying signs and symptoms. The level of parental concern and media attention elicited by reports of rashes among schoolchildren underscores the need for continuing investigation.

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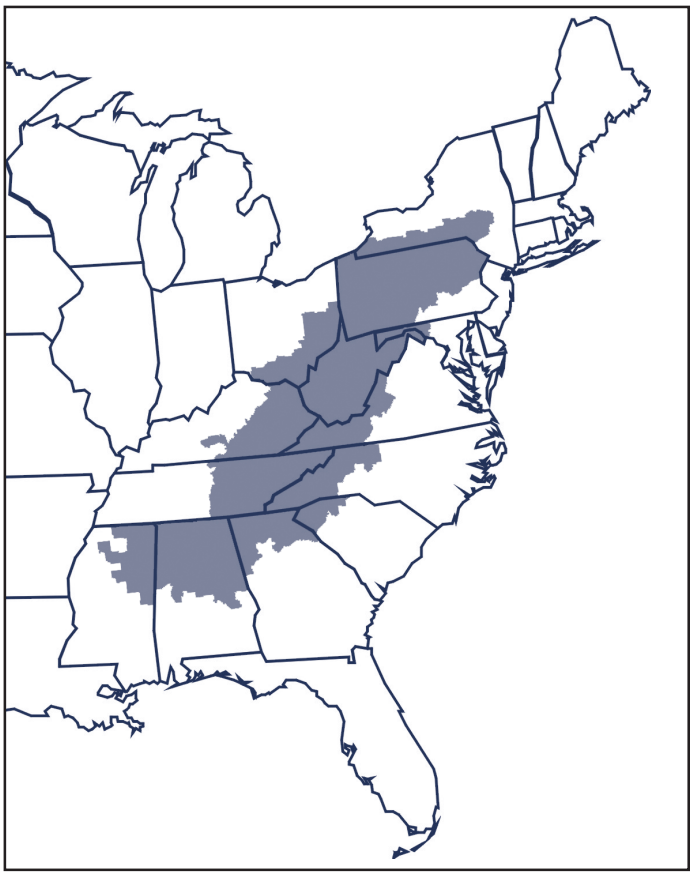
Cancer Death Rates — Appalachia, 1994–1998

Cancer is the second leading cause of death in the United States (*1*). Although descriptive analyses of mortality data are used often to identify variations by time and person, analyses that focus on regional variations are less common. Appalachia* is a U.S. region with a high prevalence of risk factors for cancer (e.g., tobacco use, physical inactivity, and inadequate access to medical care). Analyses that focus on Appalachia provide valuable information for cancer control, research, and intervention (*2*). To assess the impact of cancer in Appalachia, researchers from the University of Kentucky and Pennsylvania State University, in collaboration with CDC, analyzed mortality data from CDC's National Center for Health Statistics for 1994–1998. This report summarizes the results of that analysis, which indicate elevated cancer mortality, underscoring the need for ongoing cancer prevention and control programs as a major public health priority in this region.

Appalachia encompasses 406 counties in 13 states along the spine of the Appalachian mountains ranging from New York to Mississippi (Figure). The population of Appalachia (1994–1998 average population: 21,927,337) is approximately 8.3% of the total U.S. population. Cancer death rates were age-adjusted by using the 1970 U.S. standard million population; this standard was used instead of the 2000 standard effective with data for 1999 to allow comparability of rates with earlier internal state reports. Rates were calculated by sex and by selected anatomic sites for the United States, all Appalachia, rural Appalachia, and the Appalachian regions of each of the 13 states (*3*). Rural Appalachian counties were identified according to urban-rural continuum codes (1994–1998 average rural population: 6,835,378) (*4,5*). Population files from the National Cancer Institute (NCI) Surveillance, Epidemiology, and End Results (SEER) program were used to calculate the age-adjusted death rates (*6*). Cancers were

FIGURE. Location of Appalachia*



* Includes the 406 counties comprising Appalachia, as determined by the Appalachian Regional Commission.

* As determined by the Appalachian Regional Commission, which was mandated federally in 1965 to support economic and social development in the Appalachian region. The Commission is a partnership composed of the governors of the 13 Appalachian states and a presidential appointee representing the federal government.

classified by anatomic site by using the *International Classification of Disease* (ICD-9). Death rates and 95% confidence intervals (CIs) were calculated for the four anatomic sites associated with the leading causes of cancer deaths: lung, colon-rectum, female breast, and prostate. Rates for cervical cancer also were calculated because of the historically high death rates from this cancer in Appalachia.

The death rates for all cancers for rural Appalachia (176.3 per 100,000 population; 95% CI=±1.2) and all Appalachia (173.1; 95% CI=±0.7) were significantly higher than the corresponding U.S. death rate for this period (166.7; 95% CI=±0.2) (Table). The death rates for lung cancer were significantly higher in rural Appalachia and in Appalachia as a whole than in the United States overall, and the rural Appalachian cervical cancer death rate and the Appalachian colorectal cancer death rate were significantly higher than the corresponding overall U.S. rate.

The death rates for all cancers, and for lung cancer in particular, for the Appalachian regions of nine of the 13 states were significantly higher than the corresponding U.S. rates (Table). Cervical cancer death rates for the Appalachian regions of three states (Kentucky, Ohio, and West Virginia) were significantly higher than the overall U.S. cervical cancer death rate. The colorectal cancer death rates for the Appalachian regions of six of the 13 states were significantly higher than the corresponding overall U.S. rate. The Appalachian region of Kentucky had the highest death rates for all cancers (196.6; 95% CI=±3.5), lung cancer (73.7; 95% CI=±2.2), and cervical cancer (3.8; 95% CI=±0.7).

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Editorial Note: Residents of Appalachia and other rural regions in the United States have higher rates of poverty, lower education levels, and more limited access to health care (*7*). Because these factors place these populations at high risk for death from many diseases, including cancer, NCI designated any rural population as a "special population" (*8*). The high all-cancer death rate in Appalachia reflect higher death rates for males in that region. Elevated lung cancer death rates, which are attributable to a high prevalence of smoking (*9*), have the greatest impact on Appalachia's all-cancer death rate.

The cervical cancer death rate in this region has been higher historically than the U.S. rate. CDC, NCI, and academic and community partners are collaborating to develop research and intervention priorities to address the elevated cervical cancer death rate in this region. In addition, CDC's National Breast and Cervical Cancer Early Detection Program provides screening services for low-income and underserved women in the United States, including Appalachia (*10*). The high colorectal cancer death rates in parts of Appalachia highlight the need for increased public health attention to this cancer. CDC's National Colorectal Cancer Action Campaign provides information to promote screening for persons aged ≥50 years (*10*). The findings in this report underscore the need for a

TABLE. Age-adjusted cancer death rates* — Appalachia† and United States, 1994–1998

	Lung									
	Female		Male		Total		Female breast		Cervix	
Area	Rate	(95% CI§)	Rate	(95% CI)	Rate	(95% CI)	Rate	(95% CI)	Rate	(95% CI)
Alabama	31.2	(±1.2)	81.3	(±2.1)	**52.2**	**(±1.1)**	21.2	(±1.0)	2.7	(±0.3)
Georgia	33.4	(±1.6)	82.5	(±2.9)	**54.3**	**(±1.5)**	22.6	(±1.3)	2.3	(±0.4)
Kentucky	46.5	(±2.4)	108.1	(±3.9)	**73.7**	**(±2.2)**	23.8	(±1.7)	3.8	(±0.7)
Maryland	35.0	(±4.0)	72.3	(±6.4)	**50.7**	**(±3.6)**	21.6	(±3.2)	3.5	(±1.4)
Mississippi	28.1	(±2.5)	94.5	(±5.2)	**55.9**	**(±2.6)**	22.1	(±2.2)	3.2	(±0.9)
New York	34.7	(±2.0)	67.4	(±3.0)	**48.8**	**(±1.7)**	24.4	(±1.7)	2.7	(±0.6)
North Carolina	31.2	(±1.5)	77.6	(±2.7)	**51.3**	**(±1.5)**	22.4	(±1.3)	2.1	(±0.4)
Ohio	37.7	(±1.7)	84.9	(±2.9)	**58.4**	**(±1.6)**	25.6	(±1.4)	3.6	(±0.6)
Pennsylvania	31.5	(±0.7)	68.6	(±1.2)	**47.1**	**(±0.7)**	25.0	(±0.7)	2.6	(±0.2)
South Carolina	30.6	(±1.9)	76.7	(±3.5)	**49.9**	**(±1.9)**	22.9	(±1.7)	2.5	(±0.6)
Tennessee	37.1	(±1.3)	93.4	(±2.4)	**61.1**	**(±1.3)**	22.9	(±1.1)	3.0	(±0.4)
Virginia	35.4	(±2.6)	86.9	(±4.4)	**57.7**	**(±2.4)**	24.9	(±2.2)	2.6	(±0.7)
West Virginia	41.8	(±1.6)	86.9	(±2.5)	**60.7**	**(±1.4)**	22.9	(±1.2)	3.6	(±0.5)
Total	**34.4**	**(±0.4)**	**80.2**	**(±0.7)**	**53.9**	**(±0.4)**	**23.7**	**(±0.4)**	**2.8**	**(±0.1)**
Rural Appalachia¶	35.1	(±0.8)	85.8	(±1.3)	**57.2**	**(±0.7)**	22.8	(±0.6)	3.1	(±0.2)
United States	34.3	(±0.1)	68.2	(±0.2)	**48.9**	**(±0.1)**	24.2	(±0.1)	2.7	(±0.0)

* Per 100,000 population, adjusted to 1970 U.S. population.
† As determined by the Appalachian Regional Commission.
§ Confidence interval.
¶ Based on rural-urban continuum codes, as determined by U.S. Department of Agriculture.

strengthened focus on cancer prevention and control programs as major public health priorities for communities, health-care providers, and public health agencies throughout this region.

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Notice to Readers

Change in Reporting Congenital Syphilis

Beginning with this issue, congenital syphilis incidence data in Table 2, "Provisional cases of selected notifiable diseases, United States," will no longer be provided through updated reports to the Division of STD Prevention, National Center for HIV, STD and TB Prevention (NCHSTP), as noted by previously published footnotes in Table 2. Congenital syphilis incidence data presented in Table 2 will be based on incidence data reported from state health departments to the National Notifiable Disease Surveillance System each week. Additional information about this change is available from the Statistics and Data Management Branch, Division of STD Prevention, NCHSTP, telephone 404-639-8356.

Notice to Readers

Resumption of Routine Schedule for Tetanus and Diphtheria Toxoids

The supply of adult tetanus and diphtheria toxoids (Td) in the United States has become sufficient to permit the resumption of the routine schedule for Td use as recommended by the Advisory Committee on Immunization Practices (*1,2*). Adolescents and adults for whom routine Td booster doses were deferred should be recalled by their health-care providers to receive the delayed dose. School attendance provisions requiring students to have received a Td booster at age ≥11 years can be reinstituted.

TABLE. (*Continued*) Age-adjusted cancer death rates — Appalachia and United States, 1994–1998

	Colorectal								All cancers					
	Female		Male		Total		Prostate		Female		Male		Total	
Area	Rate	(95% CI)	Rate	(95% CI)	Rate	(95% CI)	Rate	(95% CI)	Rate	(95% CI)	Rate	(95% CI)	Rate	(95% CI)
Alabama	12.1	(±0.7)	17.9	(±1.0)	**14.5**	**(±0.6)**	26.0	(±1.2)	**135.3**	**(±2.4)**	**230.4**	**(±3.5)**	**173.3**	**(±2.0)**
Georgia	12.1	(±0.9)	18.2	(±1.3)	**14.8**	**(±0.8)**	23.1	(±1.6)	**130.1**	**(±3.1)**	**215.1**	**(±4.6)**	**164.9**	**(±2.6)**
Kentucky	16.1	(±1.3)	21.5	(±1.7)	**18.4**	**(±1.0)**	22.5	(±1.7)	**155.3**	**(±4.2)**	**251.6**	**(±5.9)**	**196.6**	**(±3.5)**
Maryland	16.2	(±2.7)	26.4	(±3.8)	**20.3**	**(±2.2)**	20.8	(±3.3)	**134.0**	**(±7.8)**	**206.5**	**(±10.8)**	**163.2**	**(±6.3)**
Mississippi	12.6	(±1.6)	17.7	(±2.2)	**14.9**	**(±1.3)**	25.0	(±2.5)	**128.9**	**(±5.3)**	**235.5**	**(±8.2)**	**171.8**	**(±4.6)**
New York	15.7	(±1.2)	22.0	(±1.7)	**18.5**	**(±1.0)**	24.3	(±1.7)	**142.7**	**(±3.9)**	**206.2**	**(±5.1)**	**168.6**	**(±3.1)**
North Carolina	12.6	(±0.9)	18.8	(±1.3)	**15.3**	**(±0.8)**	23.0	(±1.4)	**128.1**	**(±3.1)**	**208.3**	**(±4.4)**	**161.6**	**(±2.6)**
Ohio	17.2	(±1.1)	24.6	(±1.5)	**20.4**	**(±0.9)**	22.0	(±1.4)	**149.9**	**(±3.4)**	**226.6**	**(±4.6)**	**182.2**	**(±2.8)**
Pennsylvania	15.7	(±0.5)	22.9	(±0.7)	**18.8**	**(±0.4)**	23.3	(±0.7)	**140.0**	**(±1.5)**	**212.4**	**(±2.1)**	**169.1**	**(±1.3)**
South Carolina	12.5	(±1.2)	19.4	(±1.8)	**15.4**	**(±1.0)**	25.0	(±2.0)	**128.6**	**(±3.9)**	**211.1**	**(±5.8)**	**161.9**	**(±3.3)**
Tennessee	13.1	(±0.8)	19.8	(±1.1)	**15.9**	**(±0.6)**	23.6	(±1.2)	**139.9**	**(±2.6)**	**233.4**	**(±3.7)**	**178.2**	**(±2.1)**
Virginia	13.8	(±1.5)	19.5	(±2.1)	**16.3**	**(±1.3)**	21.0	(±2.1)	**141.0**	**(±5.1)**	**222.9**	**(±7.1)**	**175.2**	**(±4.2)**
West Virginia	15.7	(±0.9)	21.5	(±1.2)	**18.2**	**(±0.7)**	22.6	(±1.2)	**150.4**	**(±2.9)**	**229.9**	**(±4.1)**	**182.5**	**(±2.4)**
Total	**14.5**	**(±0.3)**	**21.0**	**(±0.4)**	**17.2**	**(±0.2)**	**23.5**	**(±0.4)**	**139.8**	**(±0.8)**	**221.4**	**(±1.2)**	**173.1**	**(±0.7)**
Rural Appalachia	14.1	(±0.5)	20.3	(±0.6)	**16.8**	**(±0.4)**	22.6	(±0.6)	**140.3**	**(±1.5)**	**225.5**	**(±2.1)**	**176.3**	**(±1.2)**
United States	14.1	(±0.1)	20.6	(±0.1)	**16.9**	**(±0.1)**	23.8	(±0.1)	**139.0**	**(±0.3)**	**206.7**	**(±0.3)**	**166.7**	**(±0.2)**

The Td shortage began in the last quarter of 2000 and resulted from 1) decreased production in 2000 by both U.S. manufacturers (Wyeth Lederle [Pearl River, New York] and Aventis Pasteur [Swiftwater, Pennsylvania]), 2) the decision by Wyeth Lederle to cease Td production in 2001, and 3) the 11-month period required for vaccine production, which led to a lag before increased Td supplies were available from the remaining manufacturer distributing vaccine nationally (Aventis Pasteur) (*3*–*5*). The amount of Td distributed nationally decreased 40% during 2001–2002, compared with preshortage distribution levels (Biological Surveillance System, unpublished data, 2002). To ensure vaccine availability for priority indications (*3*), CDC recommended in May 2001 that all routine Td boosters in adolescents and adults be deferred and that health-care providers record the names of patients whose booster doses were delayed for call-back once Td supplies are restored (*5*). Health-care providers should review the vaccination status of their patients and administer Td and other indicated vaccines as appropriate.

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Notice to Readers

National Immunization Program and Public Health Training Network Satellite Broadcast and Webcast

CDC will present "The Immunization Encounter: Critical Issues," a live satellite broadcast and webcast, on June 27, 2002, from 12:30 to 2:30 p.m. (EST). This program will address issues related to a routine vaccination clinic encounter, including recommended standards of practice for patient intake and screening, vaccine administration, vaccine management, documentation, vaccine adverse events management and reporting, and resources for staff orientation and development. The broadcast is targeted toward vaccination clinic managers, staff supervisors, and staff who administer vaccines (e.g., physicians, nurse practitioners, pharmacists, physicians' assistants, medical assistants, and students).

Online registration is available at http://www.phppo.cdc.gov/phtnonline. Information about registration also is available at 800-418-7246 or 404-639-1292.

Notice to Readers

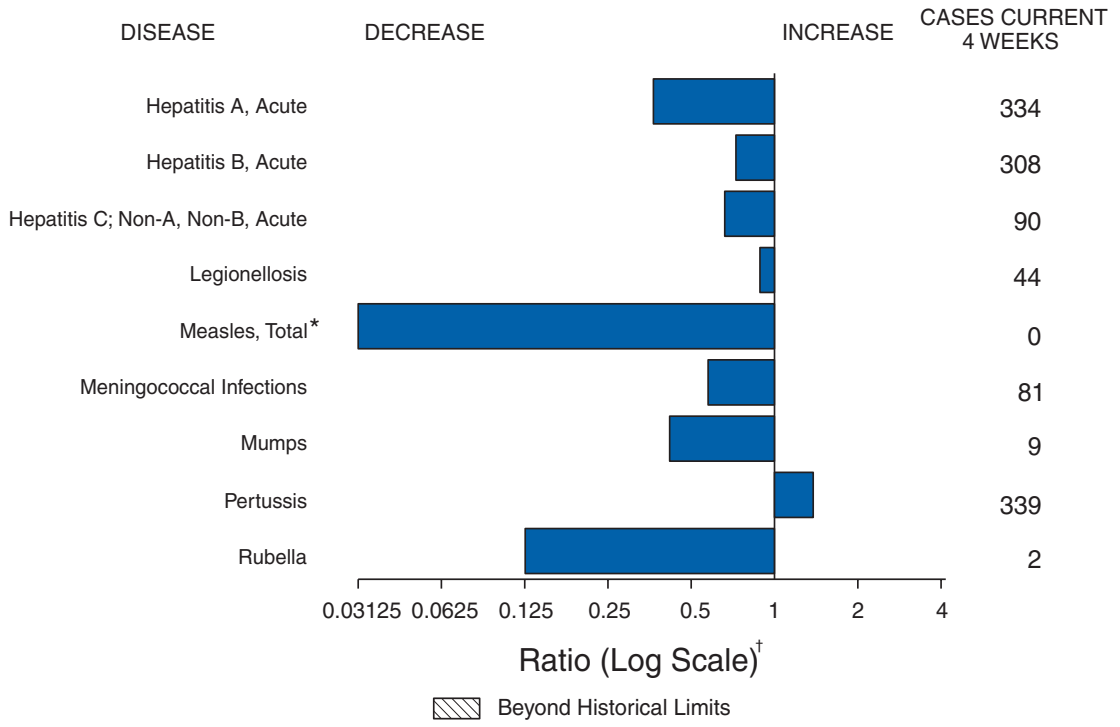
National HIV Testing Day, June 27, 2002

The National Association of People with AIDS will sponsor the eighth annual National HIV Testing Day on June 27. Testing Day is a nationwide campaign promoting human immunodeficiency virus (HIV) education and voluntary HIV counseling, testing, and referral to encourage persons at risk for HIV infection to know their status and to reduce their risks for HIV transmission.

Public health departments and other partners are encouraged to support community HIV education and testing efforts during June 23–29. Activities can include sponsoring mobile HIV counseling, testing, and referral units; participating in health fairs at which HIV education, counseling, testing, and referral services are offered; and partnering with local media to promote HIV prevention and testing messages.

Additional information about HIV counseling, testing, and referral services is available at http://www.hivtest.org.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending June 15, 2002, with historical data



* No measles cases were reported for the current 4-week period yielding a ratio for week 24 of zero (0).
† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending June 15, 2002 (24th Week)*

		Cum. 2002	Cum. 2001		Cum. 2002	Cum. 2001
Anthrax		1	-	Encephalitis: West Nile†	1	-
Botulism:	foodborne	7	9	Hansen disease (leprosy)†	36	31
	infant	27	47	Hantavirus pulmonary syndrome†	5	4
	other (wound & unspecified)	9	5	Hemolytic uremic syndrome, postdiarrheal†	54	43
Brucellosis†		32	48	HIV infection, pediatric†§	31	75
Chancroid		28	21	Plague	-	1
Cholera		2	2	Poliomyelitis, paralytic	-	-
Cyclosporiasis†		66	40	Psittacosis†	11	5
Diphtheria		-	1	Q fever†	15	5
Ehrlichiosis:	human granulocytic (HGE)†	59	30	Rabies, human	1	-
	human monocytic (HME)†	28	31	Streptococcal toxic-shock syndrome†	38	47
	other and unspecified	2	1	Tetanus	5	21
Encephalitis:	California serogroup viral†	5	2	Toxic-shock syndrome	52	62
	eastern equine†	-	-	Trichinosis	8	5
	Powassan†	-	-	Tularemia†	18	34
	St. Louis†	-	-	Yellow fever	1	-
	western equine†	-	-			

-:No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update May 26, 2002.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending June 15, 2002, and June 16, 2001 (24th Week)*

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7		*Escherichia coli* Shiga Toxin Positive, Serogroup non-O157	
	Cum. 2002§	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	16,795	16,721	331,759	347,702	875	852	696	700	27	34
NEW ENGLAND	637	575	11,550	10,065	39	40	55	71	5	14
Maine	19	18	653	592	2	3	2	10	-	-
N.H.	17	14	731	603	10	1	4	10	-	2
Vt.	6	10	317	278	8	13	2	2	-	-
Mass.	318	325	4,913	3,905	9	16	28	35	2	4
R.I.	50	42	1,191	1,267	5	3	5	4	-	-
Conn.	227	166	3,745	3,420	5	4	14	10	3	8
MID. ATLANTIC	3,498	4,575	33,472	36,694	98	118	50	52	-	-
Upstate N.Y.	259	668	7,306	5,850	28	34	39	32	-	-
N.Y. City	1,838	2,617	13,520	13,597	46	52	2	4	-	-
N.J.	668	712	2,363	5,978	7	3	9	16	-	-
Pa.	733	578	10,283	11,269	17	29	N	N	-	-
E.N. CENTRAL	1,779	1,155	52,419	64,754	218	290	179	173	1	2
Ohio	316	190	9,708	16,760	61	51	31	41	1	1
Ind.	207	117	7,521	7,257	20	28	17	28	-	-
Ill.	815	562	14,613	19,264	29	25	58	44	-	-
Mich.	358	224	14,930	14,028	47	63	32	23	-	1
Wis.	83	62	5,647	7,445	61	123	41	37	-	-
W.N. CENTRAL	270	353	16,515	17,793	106	48	95	81	3	2
Minn.	56	65	4,296	3,651	46	-	32	34	3	-
Iowa	42	40	629	2,120	11	18	20	12	-	-
Mo.	117	161	6,296	6,261	16	14	17	14	-	-
N. Dak.	-	1	469	485	6	4	3	1	-	-
S. Dak.	2	9	1,015	834	5	4	7	6	-	1
Nebr.	23	34	589	1,589	16	8	9	6	-	1
Kans.	30	43	3,221	2,853	6	-	7	8	-	-
S. ATLANTIC	5,478	4,854	65,116	66,759	150	148	72	69	13	11
Del.	96	83	1,257	1,335	1	1	1	-	-	-
Md.	822	591	6,758	6,947	5	26	3	4	-	-
D.C.	266	357	1,486	1,608	3	9	-	-	-	-
Va.	350	426	7,698	7,973	2	8	18	20	-	2
W. Va.	41	33	1,077	1,085	1	-	2	2	-	-
N.C.	418	189	10,585	10,595	18	14	9	24	-	-
S.C.	433	327	6,051	7,664	2	1	-	2	-	-
Ga.	922	575	12,840	13,408	79	58	29	12	9	6
Fla.	2,130	2,273	17,364	16,144	39	31	10	5	4	3
E.S. CENTRAL	768	813	23,717	22,871	59	16	35	38	-	-
Ky.	122	181	4,007	4,020	1	1	8	16	-	-
Tenn.	341	227	7,476	6,788	27	3	19	13	-	-
Ala.	144	182	7,448	6,325	27	5	4	6	-	-
Miss.	161	223	4,786	5,738	4	7	4	3	-	-
W.S. CENTRAL	1,834	1,587	48,632	49,308	9	24	7	49	-	-
Ark.	123	89	2,682	3,490	4	2	2	2	-	-
La.	442	392	8,603	8,222	2	7	-	2	-	-
Okla.	95	90	4,795	4,940	3	5	5	11	-	-
Tex.	1,174	1,016	32,552	32,656	-	10	-	34	-	-
MOUNTAIN	565	634	20,809	20,108	65	51	67	69	3	1
Mont.	6	12	743	1,046	4	5	8	5	-	-
Idaho	10	14	1,141	802	17	6	8	10	-	-
Wyo.	2	1	410	367	6	1	2	2	1	-
Colo.	108	139	5,200	5,499	18	16	17	27	1	1
N. Mex.	34	53	2,600	2,697	6	8	4	5	1	-
Ariz.	247	243	6,644	6,655	6	2	9	10	-	-
Utah	30	52	2,086	701	5	10	11	6	-	-
Nev.	128	120	1,985	2,341	3	3	8	4	-	-
PACIFIC	1,966	2,175	59,529	59,350	131	117	136	98	2	4
Wash.	235	241	6,467	6,369	24	U	16	20	-	-
Oreg.	181	102	3,058	3,195	18	11	38	18	2	4
Calif.	1,509	1,800	46,751	46,751	88	104	60	53	-	-
Alaska	9	10	1,564	1,255	-	-	4	1	-	-
Hawaii	32	22	1,689	1,780	1	2	18	6	-	-
Guam	2	8	-	186	-	-	N	N	-	-
P.R.	503	533	1,595	1,348	-	-	-	-	-	-
V.I.	57	2	30	81	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	90	U	-	U	-	U	-	U

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

* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

† Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update April 28, 2002.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 15, 2002, and June 16, 2001 (24th Week)*

Reporting Area	*Escherichia coli* Shiga Toxin Positive, Not Serogrouped		Giardiasis	Gonorrhea		*Haemophilus influenzae*, Invasive			
						All Ages, All Serotypes		Age <5 Years Serotype B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	10	4	6,077	140,041	155,911	784	776	11	13
NEW ENGLAND	-	1	628	3,408	2,705	56	47	-	1
Maine	-	-	69	45	63	1	1	-	-
N.H.	-	-	22	58	61	4	-	-	-
Vt.	-	1	49	44	39	3	2	-	-
Mass.	-	-	297	1,550	1,174	26	28	-	1
R.I.	-	-	52	431	326	9	2	-	-
Conn.	-	-	139	1,280	1,042	13	14	-	-
MID. ATLANTIC	-	-	1,359	15,541	16,701	142	108	2	3
Upstate N.Y.	-	-	471	3,747	3,529	65	32	2	-
N.Y. City	-	-	547	5,496	5,667	32	30	-	-
N.J.	-	-	121	2,327	2,050	31	25	-	-
Pa.	-	-	220	3,971	5,455	14	21	-	3
E.N. CENTRAL	4	2	1,128	24,782	32,938	127	134	2	1
Ohio	4	2	358	5,300	8,948	48	41	-	1
Ind.	-	-	-	3,255	3,003	28	22	1	-
Ill.	-	-	253	7,941	10,303	36	49	-	-
Mich.	-	-	348	6,498	8,088	9	8	1	-
Wis.	-	-	169	1,788	2,596	6	14	-	-
W.N. CENTRAL	-	-	731	6,725	7,278	26	32	-	1
Minn.	-	-	266	1,265	1,149	17	15	-	-
Iowa	-	-	102	170	529	1	-	-	-
Mo.	-	-	203	3,704	3,686	6	12	-	-
N. Dak.	-	-	11	27	16	-	3	-	-
S. Dak.	-	-	28	113	132	-	-	-	-
Nebr.	-	-	52	137	545	-	1	-	1
Kans.	-	-	69	1,309	1,221	2	1	-	-
S. ATLANTIC	-	-	1,030	37,883	40,235	201	195	1	1
Del.	-	-	19	760	729	-	-	-	-
Md.	-	-	42	3,722	3,992	46	48	1	-
D.C.	-	-	19	1,256	1,352	-	-	-	-
Va.	-	-	91	4,774	4,000	13	16	-	-
W. Va.	-	-	16	436	278	4	5	-	1
N.C.	-	-	-	7,361	7,646	21	28	-	-
S.C.	-	-	30	3,558	5,796	11	4	-	-
Ga.	-	-	400	6,910	7,281	63	53	-	-
Fla.	-	-	413	9,106	9,161	43	41	-	-
E.S. CENTRAL	-	1	142	13,461	14,628	25	50	1	-
Ky.	-	1	-	1,572	1,571	2	2	-	-
Tenn.	-	-	65	4,221	4,429	14	23	-	-
Ala.	-	-	77	4,752	4,963	6	23	1	-
Miss.	-	-	-	2,916	3,665	3	2	-	-
W.S. CENTRAL	-	-	59	21,279	23,769	32	28	2	1
Ark.	-	-	56	1,501	2,175	1	-	-	-
La.	-	-	-	5,312	5,644	2	5	-	-
Okla.	-	-	3	2,085	2,231	27	22	-	-
Tex.	-	-	-	12,381	13,719	2	1	2	1
MOUNTAIN	6	-	570	4,455	4,733	107	93	2	2
Mont.	-	-	32	40	57	-	-	-	-
Idaho	-	-	31	39	35	2	1	-	-
Wyo.	-	-	10	28	29	1	-	-	-
Colo.	6	-	187	1,474	1,429	19	26	-	-
N. Mex.	-	-	69	493	436	17	13	-	-
Ariz.	-	-	80	1,613	1,844	54	40	1	1
Utah	-	-	103	165	61	10	5	-	-
Nev.	-	-	58	603	842	4	8	1	1
PACIFIC	-	-	430	12,507	12,924	68	89	1	3
Wash.	-	-	173	1,282	1,365	2	1	1	-
Oreg.	-	-	174	373	529	36	30	-	-
Calif.	-	-	-	10,358	10,583	9	39	-	3
Alaska	-	-	39	259	159	1	3	-	-
Hawaii	-	-	44	235	288	20	16	-	-
Guam	-	-	-	-	22	-	-	-	-
P.R.	-	-	1	233	306	-	1	-	-
V.I.	-	-	-	17	14	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	7	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 15, 2002, and June 16, 2001 (24th Week)*

Reporting Area	*Haemophilus influenzae*, Invasive, Age <5 Years, Non-Serotype B		*Haemophilus influenzae*, Invasive, Age <5 Years, Unknown Serotype		Hepatitis (Viral, Acute), By Type, A		B		C; Non-A, Non-B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	125	134	11	14	3,865	4,085	2,875	3,115	1,395	1,905
NEW ENGLAND	6	10	-	-	160	212	92	62	18	25
Maine	-	-	-	-	6	5	3	5	-	-
N.H.	-	-	-	-	10	4	11	9	-	-
Vt.	-	-	-	-	-	5	2	4	11	6
Mass.	3	7	-	-	73	77	49	11	7	19
R.I.	-	-	-	-	21	8	14	10	-	-
Conn.	3	3	-	-	50	113	13	23	-	-
MID. ATLANTIC	20	17	1	2	481	529	640	608	618	520
Upstate N.Y.	8	5	-	1	92	113	73	55	27	15
N.Y. City	6	4	-	-	205	198	364	301	-	-
N.J.	4	2	-	-	51	125	114	112	580	473
Pa.	2	6	1	1	133	93	89	140	11	32
E.N. CENTRAL	17	25	-	1	518	492	378	371	52	101
Ohio	5	6	-	-	163	111	45	58	5	5
Ind.	6	4	-	1	27	38	16	15	-	1
Ill.	5	10	-	-	152	148	33	49	7	8
Mich.	-	-	-	-	116	156	284	228	40	87
Wis.	1	5	-	-	60	39	-	21	-	-
W.N. CENTRAL	2	1	3	2	164	175	98	99	428	605
Minn.	2	1	1	-	23	14	7	10	-	1
Iowa	-	-	-	-	41	18	10	10	1	-
Mo.	-	-	2	2	41	37	57	58	419	599
N. Dak.	-	-	-	-	1	1	1	-	-	-
S. Dak.	-	-	-	-	3	1	-	1	-	-
Nebr.	-	-	-	-	5	22	14	11	6	2
Kans.	-	-	-	-	50	82	9	9	2	3
S. ATLANTIC	29	27	1	4	1,156	724	727	552	76	28
Del.	-	-	-	-	8	4	7	10	3	2
Md.	1	4	-	-	136	104	62	61	9	3
D.C.	-	-	-	-	44	21	8	7	-	-
Va.	2	4	-	-	41	62	102	62	1	-
W. Va.	-	-	1	-	10	6	13	14	1	6
N.C.	3	1	-	4	122	55	106	98	14	8
S.C.	4	1	-	-	42	27	39	10	4	3
Ga.	13	13	-	-	281	393	235	178	17	-
Fla.	6	4	-	-	472	52	155	112	27	6
E.S. CENTRAL	7	10	-	2	134	165	161	199	87	119
Ky.	-	-	-	1	31	33	23	24	2	5
Tenn.	5	5	-	-	55	69	70	91	17	31
Ala.	2	4	-	1	23	52	35	44	3	2
Miss.	-	1	-	-	25	11	33	40	65	81
W.S. CENTRAL	6	4	-	-	56	482	174	398	12	411
Ark.	-	-	-	-	22	29	53	49	1	4
La.	1	-	-	-	11	53	12	62	11	98
Okla.	5	4	-	-	22	78	1	48	-	3
Tex.	-	-	-	-	1	322	108	239	-	306
MOUNTAIN	24	12	5	1	309	364	226	234	40	30
Mont.	-	-	-	-	9	5	3	2	-	-
Idaho	1	-	-	-	20	34	3	7	-	1
Wyo.	-	-	-	-	2	2	9	-	5	4
Colo.	2	-	-	-	50	35	45	53	18	5
N. Mex.	4	6	1	1	8	14	39	63	-	10
Ariz.	12	4	3	-	164	191	84	71	3	6
Utah	4	2	-	-	30	37	18	15	2	1
Nev.	1	-	1	-	26	46	25	23	12	3
PACIFIC	14	28	1	2	887	942	379	592	64	66
Wash.	1	-	-	1	86	46	30	49	12	15
Oreg.	4	5	-	-	43	62	72	74	11	10
Calif.	6	21	1	1	750	813	271	455	41	41
Alaska	1	1	-	-	7	12	3	4	-	-
Hawaii	2	1	-	-	1	9	3	10	-	-
Guam	-	-	-	-	-	1	-	-	-	-
P.R.	-	1	-	-	47	83	31	116	-	1
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	26	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 15, 2002, and June 16, 2001 (24th Week)*

Reporting Area	Legionellosis		Listeriosis		Lyme Disease		Malaria		Measles Total	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	292	371	173	220	2,190	2,711	469	556	9†	74§
NEW ENGLAND	14	16	20	23	121	618	28	38	-	5
Maine	2	1	2	-	-	-	1	3	-	-
N.H.	2	3	2	-	26	12	5	2	-	-
Vt.	1	4	-	-	3	3	1	-	-	1
Mass.	5	3	13	13	70	272	10	17	-	3
R.I.	-	1	1	1	22	47	2	3	-	-
Conn.	4	4	2	9	-	284	9	13	-	1
MID. ATLANTIC	66	79	30	39	1,648	1,472	103	146	5	9
Upstate N.Y.	18	21	13	12	1,102	398	18	19	-	4
N.Y. City	14	7	8	9	68	35	64	89	5	1
N.J.	10	5	3	6	144	386	13	21	-	1
Pa.	24	46	6	12	334	653	8	17	-	3
E.N. CENTRAL	75	100	22	32	25	221	56	73	-	10
Ohio	35	43	9	5	22	8	11	9	-	3
Ind.	6	5	3	3	3	2	1	11	-	4
Ill.	-	13	1	9	-	15	15	29	-	3
Mich.	26	20	7	13	-	1	22	16	-	-
Wis.	8	19	2	2	U	195	7	8	-	-
W.N. CENTRAL	21	25	8	6	45	53	35	16	-	4
Minn.	2	6	-	-	25	30	12	6	-	2
Iowa	4	5	1	-	6	9	2	1	-	-
Mo.	10	8	5	3	12	11	9	5	-	2
N. Dak.	-	1	1	-	-	-	1	-	-	-
S. Dak.	1	1	-	-	-	-	-	-	-	-
Nebr.	4	3	-	1	-	1	5	2	-	-
Kans.	-	1	1	2	2	2	6	2	-	-
S. ATLANTIC	63	49	26	27	270	242	139	110	1	4
Del.	5	-	-	1	30	30	1	1	-	-
Md.	7	12	4	2	147	150	36	44	-	3
D.C.	2	2	-	-	9	7	5	4	-	-
Va.	6	7	2	5	17	45	11	24	-	-
W. Va.	N	N	-	4	3	1	2	1	-	-
N.C.	5	5	3	-	38	6	8	2	-	-
S.C.	5	1	3	2	3	2	4	4	-	-
Ga.	8	7	8	7	1	-	50	19	-	1
Fla.	25	15	6	6	22	1	22	11	1	-
E.S. CENTRAL	8	31	8	8	15	14	8	11	-	2
Ky.	5	7	2	2	7	5	2	2	-	2
Tenn.	-	12	3	3	3	5	2	5	-	-
Ala.	3	8	3	3	5	2	3	3	-	-
Miss.	-	4	-	-	-	2	1	1	-	-
W.S. CENTRAL	3	15	3	19	2	48	3	39	-	1
Ark.	-	-	-	1	-	-	1	3	-	-
La.	1	6	-	-	1	2	2	2	-	-
Okla.	2	3	3	1	-	-	-	1	-	-
Tex.	-	6	-	17	1	46	-	33	-	1
MOUNTAIN	19	24	17	20	11	4	18	23	-	1
Mont.	1	-	-	-	-	-	-	2	-	-
Idaho	-	1	2	1	2	2	-	2	-	1
Wyo.	3	2	-	1	-	1	-	-	-	-
Colo.	4	9	2	5	3	-	8	12	-	-
N. Mex.	1	1	2	3	1	-	1	1	-	-
Ariz.	3	7	8	4	1	-	3	2	-	-
Utah	6	2	3	1	3	-	3	2	-	-
Nev.	1	2	-	5	1	1	3	2	-	-
PACIFIC	23	32	39	46	53	39	79	100	3	38
Wash.	3	6	3	2	-	1	9	3	-	15
Oreg.	N	N	2	4	4	4	3	8	-	2
Calif.	20	21	30	39	48	34	59	82	3	15
Alaska	-	1	-	-	1	-	2	1	-	-
Hawaii	-	4	4	1	N	N	6	6	-	6
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	2	1	-	N	N	-	3	-	-
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Of nine cases reported, three were indigenous and six were imported from another country.
§ Of 74 cases reported, 34 were indigenous and 40 were imported from another country.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 15, 2002, and June 16, 2001 (24th Week)*

Reporting Area	Meningococcal Disease		Mumps		Pertussis		Rabies, Animal	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	836	1,389	134	107	2,610	2,338	2,329	3,173
NEW ENGLAND	56	67	5	-	276	215	342	283
Maine	4	1	-	-	3	-	22	34
N.H.	5	8	3	-	5	8	11	6
Vt.	4	4	-	-	49	23	58	35
Mass.	28	39	2	-	213	171	113	96
R.I.	4	2	-	-	1	1	25	28
Conn.	11	13	-	-	5	12	113	84
MID. ATLANTIC	79	146	12	9	129	166	414	483
Upstate N.Y.	28	42	2	2	90	96	245	303
N.Y. City	10	25	1	4	7	26	10	12
N.J.	11	25	1	-	3	8	61	70
Pa.	30	54	8	3	29	36	98	98
E.N. CENTRAL	127	197	15	15	315	265	27	29
Ohio	48	57	3	1	182	143	5	8
Ind.	23	22	1	1	22	20	7	1
Ill.	20	45	6	10	48	29	6	3
Mich.	24	43	5	2	33	25	9	11
Wis.	12	30	-	1	30	48	-	6
W.N. CENTRAL	79	92	10	5	247	103	177	162
Minn.	20	13	2	2	70	31	11	18
Iowa	11	20	-	-	95	11	27	32
Mo.	31	32	3	-	51	42	18	13
N. Dak.	-	5	1	-	-	-	11	21
S. Dak.	2	4	-	-	5	3	20	24
Nebr.	10	9	-	1	4	2	-	1
Kans.	5	9	4	2	22	14	90	53
S. ATLANTIC	142	200	17	17	184	108	1,039	1,106
Del.	6	-	-	-	2	-	9	22
Md.	4	27	3	4	18	16	138	230
D.C.	-	-	-	-	1	1	-	-
Va.	21	25	3	2	83	12	237	204
W. Va.	-	6	-	-	6	1	79	60
N.C.	16	48	1	1	19	39	301	278
S.C.	14	19	2	1	26	18	36	57
Ga.	21	31	4	7	14	12	132	163
Fla.	60	44	4	2	15	9	107	92
E.S. CENTRAL	50	87	9	3	67	42	76	132
Ky.	8	15	4	1	22	12	13	10
Tenn.	20	33	2	-	35	17	46	106
Ala.	15	29	2	-	10	10	17	16
Miss.	7	10	1	2	-	3	-	-
W.S. CENTRAL	48	221	10	9	572	209	49	676
Ark.	20	12	-	-	272	8	-	-
La.	13	55	1	2	2	4	-	4
Okla.	14	18	-	-	27	3	49	39
Tex.	1	136	9	7	271	194	-	633
MOUNTAIN	57	68	7	8	377	862	87	118
Mont.	2	2	-	-	2	6	4	16
Idaho	3	7	1	-	42	162	-	1
Wyo.	-	4	-	1	6	-	12	20
Colo.	18	25	1	2	158	162	-	-
N. Mex.	1	8	-	2	44	45	4	4
Ariz.	18	11	-	1	89	456	66	75
Utah	4	7	4	1	26	22	-	1
Nev.	11	4	1	1	10	9	1	1
PACIFIC	198	311	49	41	443	368	118	184
Wash.	38	39	-	1	174	53	-	-
Oreg.	31	37	N	N	64	19	-	-
Calif.	123	225	42	23	196	278	94	148
Alaska	1	2	-	1	2	1	24	36
Hawaii	5	8	7	16	7	17	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	2	4	-	-	1	-	39	54
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 15, 2002, and June 16, 2001 (24th Week)*

Reporting Area	Rocky Mountain Spotted Fever		Rubella				Salmonellosis	
			Rubella		Congenital Rubella			
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	217	117	6	11	2	-	11,978	13,013
NEW ENGLAND	-	-	-	-	-	-	728	945
Maine	-	-	-	-	-	-	64	96
N.H.	-	-	-	-	-	-	43	68
Vt.	-	-	-	-	-	-	29	35
Mass.	-	-	-	-	-	-	412	524
R.I.	-	-	-	-	-	-	36	49
Conn.	-	-	-	-	-	-	144	173
MID. ATLANTIC	12	6	2	4	-	-	1,502	1,795
Upstate N.Y.	2	-	1	1	-	-	481	404
N.Y. City	2	1	-	2	-	-	536	483
N.J.	1	2	1	1	-	-	184	407
Pa.	7	3	-	-	-	-	301	501
E.N. CENTRAL	2	7	-	2	-	-	1,993	1,820
Ohio	2	1	-	-	-	-	571	575
Ind.	-	-	-	-	-	-	164	164
Ill.	-	6	-	2	-	-	587	497
Mich.	-	-	-	-	-	-	353	305
Wis.	-	-	-	-	-	-	318	279
W.N. CENTRAL	24	24	-	3	-	-	924	796
Minn.	-	-	-	-	-	-	204	251
Iowa	1	1	-	1	-	-	145	126
Mo.	22	21	-	1	-	-	362	188
N. Dak.	-	-	-	-	-	-	22	15
S. Dak.	-	2	-	-	-	-	29	49
Nebr.	-	-	-	-	-	-	51	61
Kans.	1	-	-	1	-	-	111	106
S. ATLANTIC	142	41	2	1	-	-	2,899	2,769
Del.	1	-	-	-	-	-	15	30
Md.	18	7	1	-	-	-	293	280
D.C.	-	-	-	-	-	-	31	32
Va.	4	3	-	-	-	-	330	443
W. Va.	1	-	-	-	-	-	41	41
N.C.	75	16	-	-	-	-	443	421
S.C.	28	7	-	-	-	-	189	297
Ga.	14	5	-	-	-	-	695	480
Fla.	1	3	1	1	-	-	862	745
E.S. CENTRAL	21	27	-	-	1	-	752	717
Ky.	1	1	-	-	-	-	123	132
Tenn.	15	22	-	-	1	-	201	189
Ala.	5	1	-	-	-	-	229	215
Miss.	-	3	-	-	-	-	199	181
W.S. CENTRAL	13	7	1	-	-	-	413	1,395
Ark.	-	4	-	-	-	-	205	174
La.	-	1	-	-	-	-	75	264
Okla.	13	2	-	-	-	-	131	106
Tex.	-	-	1	-	-	-	2	851
MOUNTAIN	3	5	-	-	-	-	887	843
Mont.	1	1	-	-	-	-	42	30
Idaho	-	1	-	-	-	-	56	47
Wyo.	1	1	-	-	-	-	22	27
Colo.	-	-	-	-	-	-	224	234
N. Mex.	-	-	-	-	-	-	116	106
Ariz.	-	-	-	-	-	-	273	232
Utah	-	2	-	-	-	-	63	89
Nev.	1	-	-	-	-	-	91	78
PACIFIC	-	-	1	1	1	-	1,880	1,933
Wash.	-	-	-	-	-	-	179	188
Oreg.	-	-	-	-	-	-	167	117
Calif.	-	-	1	-	-	-	1,394	1,455
Alaska	-	-	-	-	-	-	32	22
Hawaii	-	-	-	1	1	-	108	151
Guam	-	-	-	-	-	-	-	4
P.R.	-	-	-	3	-	-	69	393
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	17	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 15, 2002, and June 16, 2001 (24th Week)*

Reporting Area	Shigellosis		Streptococcal Disease, Invasive, Group A		*Streptococcus pneumoniae*, Drug Resistant, Invasive		*Streptococcus pneumoniae*, Invasive (<5 Years)	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	5,697	6,424	2,168	2,046	1,277	1,693	115	292
NEW ENGLAND	105	111	107	149	6	80	11	67
Maine	3	4	14	10	-	-	-	-
N.H.	4	2	23	9	-	-	-	-
Vt.	-	3	9	9	3	7	1	-
Mass.	74	75	53	46	-	-	10	40
R.I.	5	7	8	6	3	-	-	1
Conn.	19	20	-	69	-	73	-	26
MID. ATLANTIC	321	720	387	348	71	99	40	65
Upstate N.Y.	70	273	192	151	64	97	40	65
N.Y. City	179	196	95	108	U	U	-	-
N.J.	24	127	71	59	-	-	-	-
Pa.	48	124	29	30	7	2	-	-
E.N. CENTRAL	595	946	319	489	111	117	32	74
Ohio	315	364	130	125	4	-	-	-
Ind.	35	117	20	39	102	117	24	36
Ill.	141	229	4	163	2	-	-	26
Mich.	63	140	165	119	3	-	8	12
Wis.	41	96	-	43	-	-	-	-
W.N. CENTRAL	528	630	149	209	228	81	25	25
Minn.	103	220	74	79	135	40	25	24
Iowa	45	133	-	-	-	-	-	-
Mo.	61	120	32	51	5	9	-	-
N. Dak.	15	13	-	7	1	2	-	1
S. Dak.	147	67	9	7	1	3	-	-
Nebr.	104	36	13	23	23	7	-	-
Kans.	53	41	21	42	63	20	-	-
S. ATLANTIC	2,247	891	410	365	730	893	6	4
Del.	6	4	1	2	3	2	-	-
Md.	375	49	62	26	-	-	-	-
D.C.	25	24	5	3	33	3	1	3
Va.	411	71	43	54	-	-	-	-
W. Va.	2	4	9	13	34	32	-	1
N.C.	132	170	80	85	-	-	-	-
S.C.	42	102	25	6	120	189	5	-
Ga.	777	120	119	117	240	263	-	-
Fla.	477	347	66	59	300	404	-	-
E.S. CENTRAL	543	637	60	45	84	164	-	-
Ky.	60	236	8	18	10	18	-	-
Tenn.	26	43	52	27	74	145	-	-
Ala.	263	122	-	-	-	1	-	-
Miss.	194	236	-	-	-	-	-	-
W.S. CENTRAL	301	1,232	30	195	22	229	1	57
Ark.	89	292	4	-	5	12	-	-
La.	53	130	-	-	17	187	1	57
Okla.	158	18	25	26	-	30	-	-
Tex.	1	792	1	169	-	-	-	-
MOUNTAIN	259	350	384	220	25	29	-	-
Mont.	1	-	-	-	-	-	-	-
Idaho	2	16	5	3	-	-	-	-
Wyo.	3	2	6	5	8	5	-	-
Colo.	51	70	138	87	-	-	-	-
N. Mex.	49	53	62	46	17	22	-	-
Ariz.	123	159	173	76	-	-	-	-
Utah	15	23	-	3	-	-	-	-
Nev.	15	27	-	-	-	2	-	-
PACIFIC	798	907	322	26	-	1	-	-
Wash.	52	75	36	-	-	-	-	-
Oreg.	40	49	-	-	-	-	-	-
Calif.	682	759	252	-	-	-	-	-
Alaska	2	3	-	-	-	-	-	-
Hawaii	22	21	34	26	-	1	-	-
Guam	-	25	-	1	-	-	-	-
P.R.	1	10	-	-	-	-	-	-
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	-	-	U	U
C.N.M.I.	7	U	-	U	-	-	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 15, 2002, and June 16, 2001 (24th Week)*

Reporting Area	Syphilis				Tuberculosis		Typhoid Fever	
	Primary & Secondary		Congenital					
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	2,725	2,586	133	250	4,939	5,659	107	137
NEW ENGLAND	50	20	-	3	150	209	10	7
Maine	-	-	-	-	5	7	-	1
N.H.	1	1	-	-	7	10	-	1
Vt.	1	2	-	-	-	4	-	-
Mass.	36	10	-	2	89	106	8	4
R.I.	2	2	-	-	15	30	-	-
Conn.	10	5	-	1	34	52	2	1
MID. ATLANTIC	307	218	21	35	946	986	27	41
Upstate N.Y.	19	5	2	1	133	141	4	9
N.Y. City	188	125	10	18	494	503	13	14
N.J.	50	40	9	16	224	224	9	17
Pa.	50	48	-	-	95	118	1	1
E.N. CENTRAL	485	442	23	39	496	583	12	19
Ohio	69	43	-	2	82	111	4	2
Ind.	33	80	-	5	49	40	1	2
Ill.	122	138	18	25	248	305	1	9
Mich.	253	165	5	4	111	94	3	3
Wis.	8	16	-	3	6	33	3	3
W.N. CENTRAL	44	33	-	5	226	233	4	6
Minn.	17	17	-	1	99	99	3	2
Iowa	-	1	-	-	14	18	-	-
Mo.	13	7	-	3	67	56	1	4
N. Dak.	-	-	-	-	-	3	-	-
S. Dak.	-	-	-	-	9	6	-	-
Nebr.	4	-	-	-	9	17	-	-
Kans.	10	8	-	1	28	34	-	-
S. ATLANTIC	684	933	25	65	969	1,051	12	19
Del.	8	7	-	-	7	9	-	-
Md.	75	119	2	2	104	91	2	5
D.C.	41	14	1	1	-	34	-	-
Va.	33	60	1	3	75	106	-	5
W. Va.	-	-	-	-	10	15	-	-
N.C.	147	217	9	8	132	144	-	1
S.C.	57	134	3	18	68	92	-	-
Ga.	100	145	1	12	167	188	6	6
Fla.	223	237	8	21	406	372	4	2
E.S. CENTRAL	259	273	8	21	320	361	2	-
Ky.	41	22	-	-	57	43	2	-
Tenn.	103	151	3	13	110	131	-	-
Ala.	87	48	4	4	107	128	-	-
Miss.	28	52	1	4	46	59	-	-
W.S. CENTRAL	374	324	39	42	689	878	-	9
Ark.	12	20	1	4	54	63	-	-
La.	57	62	-	-	-	-	-	-
Okla.	30	34	2	3	61	65	-	-
Tex.	275	208	36	35	574	750	-	9
MOUNTAIN	144	91	8	12	130	220	8	5
Mont.	-	-	-	-	4	-	-	1
Idaho	7	-	1	-	-	3	-	-
Wyo.	-	-	-	-	2	1	-	-
Colo.	10	14	1	-	21	58	4	-
N. Mex.	21	9	-	-	8	32	-	-
Ariz.	97	59	6	12	80	82	-	1
Utah	6	6	-	-	13	8	3	-
Nev.	3	3	-	-	2	36	1	3
PACIFIC	378	252	9	28	1,013	1,138	32	31
Wash.	22	30	1	-	106	99	3	2
Oreg.	5	7	-	-	43	47	2	3
Calif.	346	209	8	28	772	895	27	24
Alaska	-	-	-	-	26	21	-	-
Hawaii	5	6	-	-	66	76	-	2
Guam	-	2	-	-	-	33	-	1
P.R.	109	118	10	2	8	47	-	-
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	13	U	-	U	26	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,* week ending June 15, 2002 (24th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	466	316	97	32	8	13	50
Boston, Mass.	143	86	35	14	1	7	13
Bridgeport, Conn.	30	23	4	3	-	-	3
Cambridge, Mass.	19	14	4	1	-	-	-
Fall River, Mass.	31	28	2	1	-	-	8
Hartford, Conn.	50	35	7	4	1	3	5
Lowell, Mass.	19	12	6	1	-	-	1
Lynn, Mass.	8	5	3	-	-	-	2
New Bedford, Mass.	23	16	4	1	-	2	-
New Haven, Conn.	30	21	6	2	1	-	5
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	2	2	-	-	-	-	-
Springfield, Mass.	33	24	7	1	1	-	4
Waterbury, Conn.	23	18	3	1	1	-	2
Worcester, Mass.	55	32	16	3	3	1	7
MID. ATLANTIC	2,192	1,502	422	185	41	40	121
Albany, N.Y.	38	25	6	2	3	2	3
Allentown, Pa.	20	16	3	1	-	-	1
Buffalo, N.Y.	70	58	6	4	1	1	12
Camden, N.J.	34	18	10	5	-	1	2
Elizabeth, N.J.	24	17	3	3	-	1	-
Erie, Pa.	49	41	5	3	-	-	4
Jersey City, N.J.	39	27	6	4	1	1	-
New York City, N.Y.	1,049	718	216	89	15	11	42
Newark, N.J.	63	33	13	10	-	7	5
Paterson, N.J.	19	12	2	3	-	2	1
Philadelphia, Pa.	393	250	75	43	14	9	31
Pittsburgh, Pa.§	33	20	11	1	1	-	1
Reading, Pa.	17	14	1	-	-	2	1
Rochester, N.Y.	122	93	17	9	2	1	2
Schenectady, N.Y.	20	17	3	-	-	-	2
Scranton, Pa.	33	21	9	1	2	-	3
Syracuse, N.Y.	129	91	27	7	2	2	10
Trenton, N.J.	20	13	7	-	-	-	1
Utica, N.Y.	20	18	2	-	-	-	-
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,622	1,130	313	94	30	54	104
Akron, Ohio	55	41	6	4	-	4	2
Canton, Ohio	37	27	7	3	-	-	8
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	83	58	13	2	1	8	6
Cleveland, Ohio	115	67	31	11	1	5	3
Columbus, Ohio	182	121	44	7	5	5	10
Dayton, Ohio	137	102	26	6	1	2	11
Detroit, Mich.	184	116	46	10	4	8	16
Evansville, Ind.	36	30	5	-	-	1	2
Fort Wayne, Ind.	51	39	7	2	2	1	4
Gary, Ind.	24	12	7	4	1	-	-
Grand Rapids, Mich.	64	45	7	6	3	3	9
Indianapolis, Ind.	184	134	34	7	2	7	11
Lansing, Mich.	61	46	10	1	1	3	3
Milwaukee, Wis.	117	76	26	10	3	2	7
Peoria, Ill.	41	30	7	3	-	1	1
Rockford, Ill.	53	39	9	3	1	1	3
South Bend, Ind.	59	50	4	4	1	-	2
Toledo, Ohio	78	54	10	8	3	3	5
Youngstown, Ohio	61	43	14	3	1	-	1
W.N. CENTRAL	570	399	100	48	14	9	46
Des Moines, Iowa	48	40	6	2	-	-	7
Duluth, Minn.	40	30	7	2	-	1	5
Kansas City, Kans.	27	17	6	-	4	-	2
Kansas City, Mo.	88	61	16	8	3	-	10
Lincoln, Nebr.	29	14	11	2	2	-	-
Minneapolis, Minn.	56	42	6	6	1	1	5
Omaha, Nebr.	67	55	9	1	1	1	10
St. Louis, Mo.	86	49	18	13	2	4	-
St. Paul, Minn.	52	40	7	3	1	1	2
Wichita, Kans.	77	51	14	11	-	1	5
S. ATLANTIC	1,120	685	260	119	31	25	62
Atlanta, Ga.	179	101	46	22	6	4	9
Baltimore, Md.	204	110	51	32	4	7	16
Charlotte, N.C.	115	80	19	10	4	2	8
Jacksonville, Fla.	U	U	U	U	U	U	U
Miami, Fla.	102	65	21	8	4	4	4
Norfolk, Va.	50	32	8	7	2	1	4
Richmond, Va.	45	28	13	3	1	-	1
Savannah, Ga.	68	41	14	8	2	3	5
St. Petersburg, Fla.	85	63	16	5	1	-	3
Tampa, Fla.	165	109	34	14	6	2	12
Washington, D.C.	101	54	34	10	1	2	-
Wilmington, Del.	6	2	4	-	-	-	-
E.S. CENTRAL	698	470	149	52	13	14	45
Birmingham, Ala.	200	139	47	14	-	-	13
Chattanooga, Tenn.	71	49	13	4	1	4	7
Knoxville, Tenn.	100	71	22	5	1	1	2
Lexington, Ky.	70	44	19	4	-	3	3
Memphis, Tenn.	U	U	U	U	U	U	U
Mobile, Ala.	66	40	16	7	2	1	1
Montgomery, Ala.	63	42	10	4	4	3	7
Nashville, Tenn.	128	85	22	14	5	2	12
W.S. CENTRAL	1,557	988	347	130	50	42	101
Austin, Tex.	82	51	22	7	2	-	3
Baton Rouge, La.	67	39	17	7	-	4	2
Corpus Christi, Tex.	52	35	14	2	-	1	4
Dallas, Tex.	215	118	53	25	9	10	11
El Paso, Tex.	85	54	14	13	4	-	2
Ft. Worth, Tex.	118	63	27	11	8	9	8
Houston, Tex.	390	261	78	33	10	8	31
Little Rock, Ark.	57	32	15	6	1	3	3
New Orleans, La.	37	26	7	-	3	1	-
San Antonio, Tex.	218	145	46	17	9	1	15
Shreveport, La.	94	60	22	6	2	4	8
Tulsa, Okla.	142	104	32	3	2	1	14
MOUNTAIN	841	567	176	71	14	13	53
Albuquerque, N.M.	130	81	35	11	3	-	9
Boise, Idaho	39	25	8	3	1	2	1
Colo. Springs, Colo.	53	34	12	6	-	1	-
Denver, Colo.	104	64	23	11	2	4	8
Las Vegas, Nev.	226	147	57	18	3	1	19
Ogden, Utah	21	17	3	1	-	-	2
Phoenix, Ariz.	U	U	U	U	U	U	U
Pueblo, Colo.	25	19	3	2	1	-	1
Salt Lake City, Utah	97	76	12	6	2	1	11
Tucson, Ariz.	146	104	23	13	2	4	2
PACIFIC	1,244	886	223	78	28	29	90
Berkeley, Calif.	14	9	5	-	-	-	1
Fresno, Calif.	108	72	22	8	4	2	7
Glendale, Calif.	U	U	U	U	U	U	U
Honolulu, Hawaii	84	66	13	3	1	1	3
Long Beach, Calif.	67	50	10	4	2	1	10
Los Angeles, Calif.	U	U	U	U	U	U	U
Pasadena, Calif.	21	17	2	2	-	-	3
Portland, Oreg.	108	85	12	6	2	3	6
Sacramento, Calif.	218	152	45	13	7	1	18
San Diego, Calif.	151	111	26	5	2	7	15
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	181	133	29	9	3	7	10
Santa Cruz, Calif.	30	20	7	2	1	-	2
Seattle, Wash.	114	68	23	15	3	5	11
Spokane, Wash.	50	35	8	6	-	1	2
Tacoma, Wash.	98	68	21	5	3	1	2
TOTAL	10,310¶	6,943	2,087	809	229	239	672

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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