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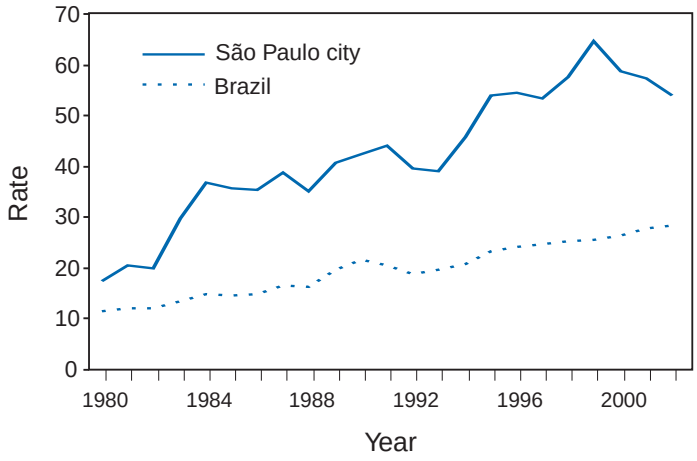
Homicide Trends and Characteristics — Brazil, 1980–2002

Brazil is the largest and most populous country in South America (2002 population: approximately 175 million) (Brazilian Geography and Statistics Institute [BGSI], unpublished data, 2004). Although life expectancy in Brazil has increased and rates of infant mortality have decreased as a result of reductions in infectious disease mortality, homicide and other forms of injury-related mortality have increased as a proportion of overall mortality (*1,2*). Homicide is now the leading cause of death for persons aged 15–44 years. To describe trends and characteristics of homicides countrywide and in São Paulo city (2000 population: approximately 10.4 million) (BGSI, unpublished data, 2004), the State Health Department of São Paulo (SHDSP) analyzed vital statistics and census data for 1980–2002. This report summarizes the results of that analysis, which indicated that the homicide rate in Brazil more than doubled during this period (Figure 1). Since 2001, Brazilian authorities have implemented several initiatives to reduce the number of homicides, including a law that controls gun ownership and prohibits anyone other than police and members of the armed forces from carrying guns. However, homicides among adolescents and young adults remain a substantial public health problem in Brazil, and additional prevention strategies that target young persons are needed.

Data were obtained from the Mortality Information System operated by Brazil's Ministry of Health. This database includes information from death certificates for all states in Brazil. Additional data for São Paulo city were obtained from the Program for Quality Improvement of Mortality Information. Homicide was defined as a death resulting from an injury that was inflicted purposefully by another (including legal intervention) for which the underlying cause listed on the death certificate corresponds to codes E960–E978 and E970–E978 of the *International Classification of Diseases, Ninth Revision* for 1980–1996, and codes X85–Y09 and Y35 of the *Tenth Revision* for 1997–2002. Population data for Brazil and São Paulo city were obtained from BGSI. Crude, age-, and sex-specific rates were calculated per 100,000 population. To examine the association between socioeconomic status and homicide rates in São Paulo city, SHDSP obtained data on the monthly average income of heads of households in all 96 city districts from the 2000 Brazil Population Census. Pearson correlation analysis was used to test this association.

FIGURE 1. Homicide rates*, by year — Brazil and São Paulo city, 1980–2002



* Per 100,000 population.

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During 1980–2002, the homicide rate in Brazil more than doubled, from 11.4 per 100,000 population to 28.4. In São Paulo city, the rate more than tripled, from 17.5 in 1980 to 53.9 in 2002 (Figure 1). In 2002, a total of 49,570 homicides were documented in Brazil. Firearms and sharp objects were the weapons used in 34,085 (68.8%) and 6,728 (13.6%) of all incidents, respectively. In 2002, the homicide rate was 53.1 among males and 4.3 among females, and adolescent (aged 15–19 years) and young adult (aged 20–29 years) males accounted for 52.2% of homicide victims. By age group, the homicide rate was highest among young adult males (121.0).

In 2002, a total of 5,719 homicides occurred in São Paulo city. Firearms and sharp objects were used in 62.0% and 4.7% of all incidents, respectively. The homicide rate for males (105.1 per 100,000 population) was nearly 15 times that for females (7.2). Adolescent and young adult males accounted for the largest proportion (59.8%) of homicide victims, and age-specific homicide rates were highest among males aged 20–29 years (227.4) (Figure 2). The risk for homicide varied substantially by city district. In 2002, crude homicide rates ranged from 1.2 in the Jardim Paulista District to 115.8 in the Guaianazes District. In some districts, homicide rates for males aged 15–29 years were >400. A negative correlation was observed between the average monthly income of heads of households and homicide rates in these districts (Pearson correlation coefficient = -0.58; $p<0.05$).

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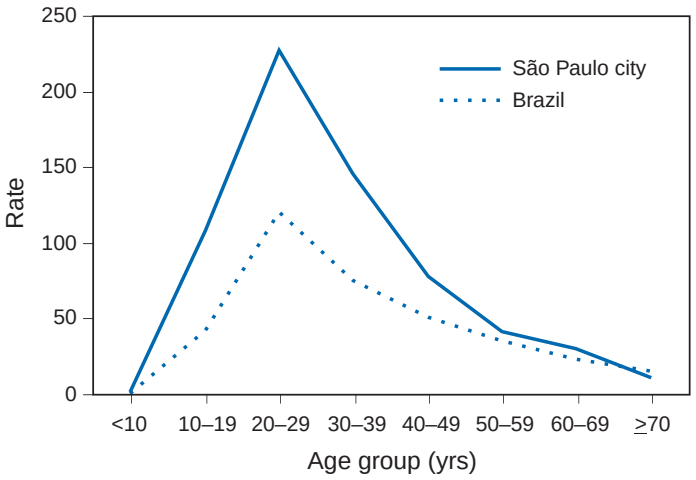
Editorial Note: The findings in this report indicate that homicide rates in Brazil and São Paulo city increased

FIGURE 2. Homicides rates* among males, by age group — Brazil and São Paulo city, 2002



* Per 100,000 population.

markedly during 1980–2002. Other countries in the Americas have experienced similar increases in homicide rates during this period (*3*). In 2002, Brazil had one of the world's highest homicide rates, nearly four times higher than that for the United States (*4*). In 2000, Brazil accounted for an estimated 28% of all the homicides that occurred in the Americas, a region that has the highest homicide rate (*4*).

Factors that might have contributed to increased violence include increasing urbanization, expansion of illegal drug and firearms trafficking, a lengthy economic crisis, increased unemployment, and widening income inequality (*5–7*). The strong negative correlation between monthly average income and homicide rates in São Paulo city described in this report is consistent with homicide research in other urban areas worldwide (*8*). Further research is needed to better understand the association between violence and poverty so appropriate interventions can be developed. This association might be attributed to income inequality and disparities in job and education prospects.

Brazil has adopted measures to reduce the number of homicides. In 2001, the Brazil Ministry of Health issued a national policy to reduce injury-related morbidity and mortality and, in 2002, Brazil issued guidelines for the reporting of child maltreatment by health professionals. In December 2003, the Brazilian Congress passed a law that controls gun ownership and prohibits anyone other than police and members of the armed forces from carrying guns. The law also established tougher penalties for international firearms trafficking. The country also plans to implement an emergency department–based registry for injuries. In 2002, the government of São Paulo state passed legislation to establish an injury surveillance system. Improved surveillance data can help guide program and policy design and monitor progress toward reducing levels of violence (*4*).

Several violence-prevention initiatives have been developed in Brazil. In Rio de Janeiro, Viva Rio (http://www.vivario.org.br), a nongovernment organization, directs projects for 1) promoting awareness about the risks of using or carrying firearms, 2) reducing firearm injuries, 3) promoting peace, and 4) providing vocational training for youths who live in impoverished communities. In São Paulo state, a coalition of private sector investor groups, state banking organizations, advertising and media companies, and research centers established the São Paulo Institute Against Violence (http://www.spcv.org.br) to support projects for violence prevention. In addition, the local government of São Paulo city implemented the Renda Minima Program, which provides financial support to low-income families, and the Bolsa Trabalho Program, which promotes youth employment; both programs might help reduce the homicide rate. The impact of these efforts should be evaluated to guide development of interventions in other communities.

The findings in this report are subject to at least two limitations. First, data from death certificates might underestimate the proportion of firearm-related homicides. Studies based on medical examiners' records have documented that, in large Brazilian cities like Recife, >90% of homicides involve firearms, whereas death certificates indicate that <70% of deaths were firearm related (*9*). Second, information is lacking about perpetrator characteristics or circumstances of these deaths (e.g., place of occurrence, relationship between victim and offender, and the use of alcohol and other substances). A homicide surveillance system is being planned for São Paulo city that will link information from death certificates with medical examiner and police records to guide public policies.

Homicides among adolescents and young adults constitute a substantial public health problem in Brazil, and additional prevention strategies that target young persons are needed. These strategies should include partnerships among the government, universities, the private sector, nongovernment organizations, and communities.

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Hypothermia-Related Deaths — United States, 2003

Hypothermia, a preventable lowering of the core body temperature to <95° F (<35° C) (*1*), causes approximately 600 deaths each year in the United States (*2*). Exposure to excessive cold (or excessive exposure to cold) slows enzymatic activity throughout the body, leading to potentially fatal rhabdomyolysis, coagulopathy, renal failure, and dysrhythmias (*3*). Alcohol intake, activity level, and type of clothing are among the modifiable factors associated with hypothermia (*4*). Understanding the epidemiology and pathophysiology of hypothermia is important to preventing hypothermia-related mortality. This report describes three cases of fatal hypothermia that occurred during 2003, reviews national statistics on mortality from cold exposure in 2001, and provides recommendations for the diagnosis, treatment, and prevention of hypothermia. Public health strategies tailored to U.S. populations at increased risk for exposure to excessive cold can help reduce mortality and morbidity from hypothermia.

Case Reports

Case 1. In the fall of 2003, a man aged 44 years was found dead outdoors in Vermont. He wore a T-shirt, long-sleeved shirt, two sweatshirts, underpants, pants, socks, and boots. His clothes were wet, and an empty vodka bottle was nearby. Local investigators reported that he looked as though he "lay down and went to sleep." Overnight, the temperature had dropped to <32° F (<0° C). Autopsy findings were unremarkable except for a fatty liver. A toxicology screen was negative except for an elevated blood alcohol concentration (BAC) of 0.30 g/dL, nearly four times the legal intoxication limit of 0.08 g/dL in Vermont. Cause of death was certified as hypothermia, with alcohol intoxication as a contributing factor.

Case 2. In the spring of 2003, a man aged 76 years with Alzheimer's disease was reported missing from his home in Vermont. The next day, a farmer found the man lying in a swampy area where his car had become stuck in the mud. Overnight, the temperature had dropped to <32° F (<0° C). The man was pronounced dead at the scene; cause of death was hypothermia precipitated by a cold, wet environment.

Case 3. In the fall of 2003, Alaska state troopers reported that a hiker aged 35 years was found dead alongside a highway. The hiker was not clothed from the waist up and was missing a shoe. The overnight temperature was 44° F (6.7° C), but conditions were wet and windy. The hiker's BAC was 0.28 g/dL, nearly four times the legal intoxication limit of 0.08 g/dL in Alaska; his toxicology screen was positive for cocaine and marijuana. Cause of death was hypothermia, with drug and alcohol intoxication as contributing factors.

United States

In the United States, certain populations (e.g., alcoholics; drug users; elderly, homeless, and chronically ill persons; and those with preexisting heart disease) are at increased risk for dying from hypothermia. During 2001, a total of 599 persons in the United States (*2*) died from "exposure to excessive natural cold" (code X31), as categorized in the *International Classification of Diseases, Tenth Revision*. Of these victims, 67% were male, and 51% were aged >65 years. As persons age, their risk for dying from hypothermia increases (Figure). Approximately 71% of the hypothermia-related deaths in 2001 occurred during November–February. The three states with the highest rates of death from hypothermia were Montana (1.44 persons per 100,000 population), Alaska (1.42), and New Mexico (1.04).

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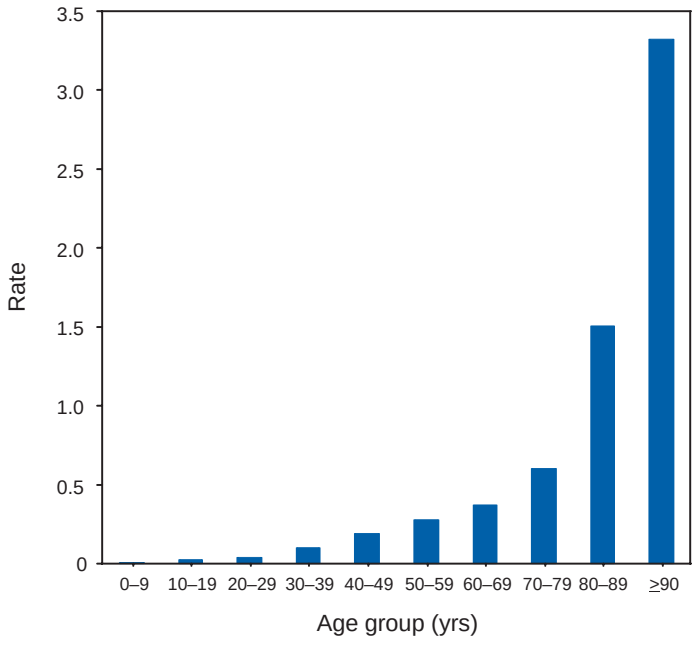
Editorial Note: Hypothermia causes multiple dysfunctions, including cardiac arrhythmias, renal insufficiency, and hemoconcentration. In late stages of hypothermia, brain function

FIGURE. Age-adjusted rate* of hypothermia-associated death, by age group — United States, 2001



* Per 100,000 population.

deteriorates, predisposing persons to poor judgment and increasing their risk for further exposure to excessive cold.

Improper clothing and comorbidities can interfere with the balance between the body's heat production and cooling. Wet clothing cannot retain body heat; warm clothing keeps the body dry and helps to decrease heat loss, which can save a person's life during excessively cold weather. Advanced age, immobility, and existing medical conditions can increase the risk for hypothermia and death during cold weather. Certain medical conditions (e.g., hypothyroidism, congestive heart failure, and diabetes) can affect a person's ability to recognize warning symptoms of hypothermia, compensate for the cold, or to seek shelter from the cold.

Use of alcohol or other mood-altering drugs often is associated with cases of hypothermia. The vasodilatation caused by alcohol provides a sensation of warmth but also increases heat loss through radiation. In addition, alcohol and other drugs impair hand coordination, mobility, and decision-making abilities.

Treatment of hypothermia focuses on returning the core body temperature to normal while providing supportive care. The method chosen to rewarm a patient depends on the severity of the hypothermia (Box). With rewarming and supportive care, even persons who appear to be dead might survive hypothermia (*5*).

Prevention of hypothermia requires public health strategies that target persons at greatest risk. Such strategies can include creating community programs for checking on the well-being of elderly persons, opening temporary shelters for the homeless, and urging persons with cardiovascular disease to avoid outdoor exercise during cold weather (*6*).

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BOX. Epidemiology, diagnosis, treatment, prevention, and reporting of hypothermia

Epidemiology

- Hypothermia is caused by exposure to excessive cold (or excessive exposure to cold).
- Hypothermia can occur in temperatures above freezing.
- Hypothermia disproportionately affects the elderly, homeless, and chronically ill, and persons with preexisting heart disease.
- Immersion in water, wearing wet clothing, and exposure to wind can accelerate body heat loss.
- Mood-altering substances (e.g., alcohol and drugs) impair judgment and are associated with mortality from hypothermia.

Clinical findings

- Symptoms of hypothermia include sensation of cold, exhaustion, and numbness.
- Signs of hypothermia include shivering, pallor in adults, flushed skin in children, decreased hand coordination, confusion, and slurred speech.
- Diagnosis is made when the core body temperature is <95.0° F (<35.0° C).
- Hypothermia can be mild (90.0° F–<95.0° F [32.2° C–<35.0° C]), moderate (82.5° F–90.0° F [28.0° C–32.2° C]), or severe (<82.5° F [<28.0° C]).

Treatment

- Mild hypothermia can be treated with passive rewarming by using blankets.
- Moderate hypothermia requires active rewarming with warm intravenous fluids, oxygen, lavage, or immersion baths.
- Severe hypothermia might require both active rewarming and cardiopulmonary bypass.
- The core body temperature should be rewarmed by 2–4° F (1–2° C) per hour.
- As needed, cardiopulmonary resuscitation and supportive care should be provided, cardiac rhythm monitored, and electrolytes replenished.

Prevention and reporting

- The public should be educated about the danger of using alcohol and drugs in excessive cold.
- During cold weather, infants, elderly neighbors, and homeless populations should be monitored.
- Instructions should be provided on how to prepare emergency kits for homes and cars and how to safely use an alternate heat source (http://www.cdc.gov/nceh/hsb/extremecold).
- Any cases of hypothermia should be reported to the local health department.

Alcohol Use Among Adolescents and Adults — New Hampshire, 1991–2003

Alcohol abuse is the third leading preventable cause of death in the United States (*1*). Because binge and heavy drinking increase the risk for cirrhosis, cancer, heart disease, stroke, injury, and depression (*2,3*), public health efforts have focused on reducing these patterns of alcohol use. The Council of State and Territorial Epidemiologists, the Association of State and Territorial Chronic Disease Program Directors, and CDC developed *Indicators for Chronic Disease Surveillance* (*4*), which provides a standard set of measures for alcohol surveillance. The New Hampshire Department of Health and Human Services used these measures to facilitate statewide trend analysis of alcohol use among adolescents and adults. This report summarizes the results of that analysis, which indicated that, in 2003, a total of 30.6% of adolescents reported binge drinking. In 2001, a total of 15.8% of adults reported binge drinking, and 6.3% reported heavy drinking. Interventions are needed to prevent adolescent drinking and to reduce excessive alcohol use among adults.

Three data sources were used to examine trends in alcohol use: New Hampshire (NH) Youth Risk Behavior Survey (NHYRBS), NH Behavioral Risk Factor Surveillance System (NHBRFSS), and NH Vital Records (NHVR). NHYRBS is a biennial, self-administered, school-based survey of students in grades 9–12; NHYRBS was conducted in odd-numbered years during 1995–2003. Because the statewide response rate was <60% during 1997–2001, analysis of NHYRBS data was restricted to 1995 and 2003 (response rate: 65% and 62%, respectively). NHBRFSS is an annual population-based, random-digit–dialed telephone survey of the noninstitutionalized, civilian population aged ≥18 years. Alcohol-related questions were asked annually during 1991–1993 and in odd-numbered years during 1995–2001 (response rate: 42.5%–70.9%). NHVR maintains and analyzes death-related data that are reported according to state law. The cause of death reported is the underlying cause of death or the specific disease, condition, or injury that leads to death.

For this analysis, seven public health indicators of alcohol-related impact were assessed: binge drinking among adults, women of child-bearing age (i.e., aged 18–44 years), and adolescents (indicators 1–3); heavy drinking among adult men and women (indicators 4–5); alcohol use among adolescents (indicator 6); and mortality from chronic liver disease (indicator 7). Binge drinking was defined as having five or more drinks on one or more occasions during the 30 days preceding the survey. Heavy drinking was defined as an average daily consumption of greater than two drinks for men and one drink for women. Alcohol use among adolescents was defined as having one or more drinks during the 30 days preceding the survey. Mortality from chronic liver disease was determined by using the underlying primary cause of death from *International Classification of Diseases, Tenth Revision* codes K70 or K73–K74 or, for years before 1999, *Ninth Revision* code 571. Age-standardized prevalence estimates were calculated by using the 2000 U.S. standard population for all indicators except those that were age specific.

In the 2003 NHYRBS, 47.1% of high school students reported alcohol use, and 30.6% reported binge drinking; in comparison with 1995 results, changes were not statistically significant (Table 1). Both alcohol use and binge drinking among students increased significantly in grades 9 and 12 in 1995 and 2003.

In the 2001 NHBRFSS, 15.8% of adults reported binge drinking. During 1991–2001, men were two to three times more likely than women to report binge drinking (Table 2). In 2001, women of child-bearing age were six times more likely to report binge drinking than women aged ≥45 years (14.2% [95% confidence interval (CI) = 11.8%–16.6%] versus 2.3% [95% CI = 1.4%– 3.2%]). In 2001, a total of 6.3% of adults reported heavy drinking (Table 3). No statistically significant differences were observed in heavy drinking between men and women during 1991–2001.

According to the 2001 NHVR, 9.7 deaths per 100,000 New Hampshire residents were attributable to chronic liver disease.

TABLE 1. Prevalence of alcohol use* and binge drinking† among high school students, by sex and grade — New Hampshire Youth Risk Behavior Survey, 1995 and 2003

	Male		Female		9th grade		10th grade		11th grade		12th grade		Total	
Category	%	(95% CI§)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Alcohol use														
1995	55.1	(51.0–59.2)	51.1	(47.9–54.3)	41.4	(36.7–46.1)	53.1	(48.3–57.9)	57.4	(52.9–61.9)	63.5	(56.4–70.6)	**53.1**	**(50.2–56.0)**
2003	47.1	(40.4–53.8)	46.9	(41.1–52.7)	29.6	(23.8–35.5)	46.4	(42.2–50.6)	56.9	(48.1–65.7)	60.9	(52.4–69.4)	**47.1**	**(41.8–52.4)**
Binge drinking														
1995	37.6	(33.8–41.4)	28.1	(25.1–31.1)	20.3	(17.0–23.6)	33.2	(29.3–37.1)	36.9	(32.5–41.3)	44.7	(37.1–52.3)	**32.9**	**(30.2–35.6)**
2003	33.5	(27.4–39.6)	27.9	(23.1–32.6)	18.2	(13.1–23.3)	24.2	(19.0–29.3)	39.1	(29.4–48.8)	46.5	(37.0–56.0)	**30.6**	**(25.9–35.3)**

* Defined as having one or more drinks during the 30 days preceding the survey.
† Defined as having five or more drinks on one or more occasions during the 30 days preceding the survey.
§ Confidence interval.

TABLE 2. Prevalence of binge drinking* among adults, by sex, age, and year — New Hampshire Behavioral Risk Factor Surveillance System, 1991–2001

Year	Men		Women		Women aged 18–44 yrs		Total	
	%	(95% CI†)	%	(95% CI)	%	(95% CI)	%	(95% CI)
1991	27.6	(24.1–31.1)	9.8	(7.6–12.0)	18.1	(13.9–22.2)	**18.6**	**(16.5–20.8)**
1992	25.2	(21.7–28.6)	10.2	(7.7–12.6)	18.0	(13.3–22.6)	**17.4**	**(15.3–19.6)**
1993	27.7	(24.3–31.2)	10.1	(7.9–12.3)	17.9	(13.7–22.0)	**18.8**	**(16.7–20.9)**
1995	24.7	(21.1–28.2)	7.7	(5.7–9.7)	11.5	(8.3–14.8)	**16.1**	**(14.0–18.1)**
1997	24.1	(20.5–27.7)	7.9	(6.0–9.9)	12.4	(8.9–15.8)	**15.8**	**(13.8–17.9)**
1999	27.7	(23.3–32.1)	12.0	(9.1–14.8)	20.4	(14.8–25.9)	**19.8**	**(17.2–22.5)**
2001	23.1	(20.9–25.3)	8.6	(7.3–9.9)	14.2	(11.8–16.6)	**15.8**	**(14.5–17.1)**

* Defined as having five or more drinks on one or more occasions during the 30 days preceding the survey.
† Confidence interval.

TABLE 3. Prevalence of heavy drinking* among adults, by sex and year — New Hampshire Behavioral Risk Factor Surveillance System, 1991–2001

Year	Men		Women		Total	
	%	(95% CI†)	%	(95% CI)	%	(95% CI)
1991	8.0	(5.6–10.3)	5.5	(3.9–7.2)	**6.8**	**(5.3–8.2)**
1992	5.6	(3.8–7.4)	5.8	(3.8–7.8)	**5.7**	**(4.3–7.0)**
1993	6.0	(4.1–7.9)	6.6	(4.7–8.6)	**6.3**	**(5.0–7.6)**
1995	5.0	(3.2–6.8)	3.7	(2.2–5.3)	**4.4**	**(3.2–5.5)**
1997	4.2	(2.5–5.9)	3.3	(1.9–4.7)	**3.7**	**(2.6–4.8)**
1999	7.1	(4.2–9.9)	6.0	(3.5–8.4)	**6.5**	**(4.6–8.4)**
2001	6.7	(5.4–8.0)	5.9	(4.8–7.0)	**6.3**	**(5.5–7.2)**

* Defined as an average daily consumption of greater than two drinks for men and one drink for women.
† Confidence interval.

In 2001, males were significantly more likely than females to die from chronic liver disease (14.6 [95% CI = 11.5–17.8] versus 5.3 [95% CI = 3.6–7.1]). During 1991–2001, trends in mortality from chronic liver disease remained stable.

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Editorial Note: The findings in this report indicate that adolescents and adults in New Hampshire use alcohol in ways that place them at increased risk for alcohol-related health problems. New Hampshire is the only state in the northeast with no alcoholic beverage sales tax, which contributes to low alcohol prices and the highest per-capita alcohol sales in the United States (*5*). Compliance checks of New Hampshire alcohol vendors indicate that approximately 30% of attempts to purchase alcohol by adolescents are successful (*6*).

The findings in this report are subject to at least four limitations. First, because approximately half of all adults and high school students reported no alcohol use, the prevalence of binge drinking among current drinkers was underestimated. Second, a trend analysis of alcohol use among high school students could not be performed because weighted data from NHYRBS during 1997–2001 were unavailable. Third, analysis of annual data at the substate level was not possible because of sample size limitations. Finally, the full burden of alcohol-related disease and death, including injuries, violence, and other health impacts, could not be determined because analysis of alcohol-related health effects was limited to deaths caused by chronic liver disease.

New Hampshire was one of 12 states that included a module on binge drinking in its 2003 BRFSS survey, which will provide more recent and comprehensive information on adult binge drinking, including the type and quantity of alcohol consumed, the location of consumption, and alcohol-impaired driving that might have resulted from binge drinking. Alcohol surveillance information in New Hampshire was published for the first time in 2003 (*6*); the report will be updated annually to help policymakers and public health authorities implement programs to prevent adolescent drinking and excessive alcohol use among adults.

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Acknowledgment

The findings in this report are based on data contributed by K Vandole, New Hampshire Dept of Health and Human Svcs.

Brief Report

Exposure to Tear Gas from a Theft-Deterrent Device on a Safe — Wisconsin, December 2003

On December 4, 2003, a hazardous materials (HazMat) release occurred at a jewelry store in Beloit, Wisconsin, when the store owner tightened a screw on the door of an old safe outfitted with a chemical theft-deterrent device. The device included a metal housing containing a glass vial of liquid, which cracked as the screw tightened, releasing approximately 4 ounces of tear gas. The store owner sustained eye and skin irritation and was treated at a hospital and released. Twelve persons in the building and persons in adjacent businesses were evacuated for 3 hours while a certified Level A HazMat team*, city firefighters, and emergency medical technicians responded to the release. This report summarizes the response to this event and underscores the need for persons who use old safes and vaults to know how to identify these devices and avoid tampering with them.

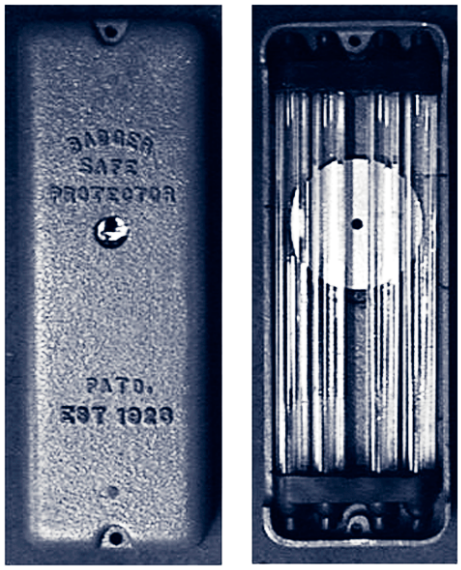
Beginning in the 1920s, certain safes and vaults included (or were fitted with) theft-deterrent devices containing chemical vials (Figure). Chloropicrin† was used commonly in these devices. Other tear gas agents reportedly were used in similar theft-deterrent devices. The metal casing of these devices usually is approximately 3 inches wide and 6–8 inches tall; the device is fastened to the back of a safe door with screws. A major manufacturer of these devices was located in Wisconsin during the 1920s–1950s, and other companies sold similar devices. One such device was found in an Iowa bank in 1999 after a vial shattered, releasing chloropicrin and causing a pregnant bank employee to suffer eye, skin, and throat irritation (*2*). The number of these devices sold or still in circulation is unknown.

Chloropicrin was used as a chemical weapon during World War I (*2*). Documented symptoms of chloropicrin exposure include 1) irritation of the eyes, skin, and respiratory system; 2) lacrimation (i.e., tearing); 3) cough; 4) pulmonary edema; and 5) nausea and vomiting (*1*).

The 2003 chloropicrin release was reported to the Hazardous Substances Emergency Events Surveillance (HSEES) system operated by the Wisconsin Department of Health and Family Services. Created and funded by the Agency for Toxic Substances and Disease Registry (*3*), HSEES is a multistate§ health department surveillance system that tracks morbidity and mortality resulting from events¶ involving the release or potential release of a hazardous substance**. However, because reporting HazMat events to HSEES is not mandatory, participating state health departments might not be informed about every event. In addition, how many chemical releases from theft-deterrent devices occur in nonparticipating states is unknown.

Persons who use or are around older safes and vaults (e.g., bankers, jewelers, locksmiths, and vault technicians) should know how to identify these devices and should avoid tampering with them. If a device is identified, only trained persons (e.g., experienced locksmiths or HazMat personnel) should attempt to remove or neutralize these devices. In addition, appropriate personal protective equipment should be used when attempting to dismantle these devices (*4*). If the contents of a device are released, the area should be evacuated immediately. Persons who have adverse health effects (e.g., eye, skin, or respiratory irritation) should seek medical attention immediately.

FIGURE. Chemical theft-deterrent device used on a safe



Front view Rear view

Photo/Charles Eastwood

* Equipped typically with supplied-air respirator, pressure-demand, and self-contained breathing apparatus; fully encapsulating chemical-resistant suit; coveralls; long cotton underwear; chemical-resistant gloves (inner); chemical-resistant boots with steel toe and shank; hard hat; disposable gloves and boot covers; cooling unit; and two-way radio communications.

† Also called nitrochloroform, nitrotrichloromethane, and trichloronitromethane. The chemical abstracts service number is 76-06-2 (*1*).

§ Alabama, Colorado, Iowa, Louisiana, Minnesota, Mississippi, Missouri, New Jersey, New York, North Carolina, Oregon, Texas, Utah, Washington, and Wisconsin.

¶ An event is the release or threatened release of a hazardous substance(s) in an amount requiring removal, cleaning up, or neutralizing according to federal, state, or local law (*3*).

** A substance that can reasonably be expected to cause an adverse health effect.

Reported by: *J Drew, W Otto, H Nehls-Lowe, MPH, Wisconsin Dept of Health and Family Svcs. DK Horton, MSPH, WE Kaye, PhD, Div of Health Studies, Agency for Toxic Substances and Disease Registry.*

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Notice to Readers

Updated Recommendations on the Use of Pneumococcal Conjugate Vaccine: Suspension of Recommendation for Third and Fourth Dose

On March 2, this notice was posted on the MMWR *website* (http://www.cdc.gov/mmwr).

On February 13, 2004, CDC recommended that health-care providers temporarily suspend routine use of the fourth dose of 7-valent pneumococcal conjugate vaccine (PCV7) when vaccinating healthy children (*1*). This action was taken to conserve vaccine and minimize the likelihood of shortages until Wyeth Vaccines, the only U.S. supplier of PCV7 (marketed as Prevnar®), restores sufficient production capacity to meet the national need. Since that recommendation, PCV7 production has been much less than expected because of continuing problems with the PCV7 vial-filling production line. Shipments have been delayed, resulting in spot shortages that might continue beyond summer 2004 and become widespread. Effective immediately, to further conserve vaccine, CDC recommends that all health-care providers temporarily suspend routine administration of both the third and fourth doses to healthy children.

Approximately 1.3 million doses of PCV7 are needed each month to provide every infant in the United States with the full, 4-dose vaccination series. For January–April 2004, total shipments are estimated to be ≤55% of the amount needed. Limiting healthy children to 2 doses of PCV7 will conserve vaccine and permit more children to receive at least 2 doses. More vaccine is expected to become available for distribution in May and June, but availability cannot be guaranteed. CDC will continue to update health-care providers on the status of vaccine supplies while the shortage persists.

PCV7 is highly effective. The routinely recommended 4-dose series has been 97% (95% confidence interval [CI] = 76%–100%) effective against invasive disease caused by serotypes represented in the vaccine; effectiveness in children who received 3 doses before age 1 year has been 87% (95% CI = 71%–94%), and effectiveness in children who received 2 doses has been 94% (95% CI = 84%–98%) (CDC, unpublished data, 2004). Efficacy data from a randomized, controlled trial suggest that 1–2 doses of pneumococcal conjugate vaccine are protective during the 2-month interval before the next dose, with 86% effectiveness (but a 95% CI that includes zero) (*2*). Although limited data support a 2-dose schedule among infants, this regimen is preferable to vaccinating certain children with 3 doses and not vaccinating others. Because PCV7 is a new vaccine, no long-term data on vaccine effectiveness are available. However, the incidence of invasive pneumococcal disease declines rapidly after age 2 years, even in unvaccinated children. In 1998, before PCV7 was licensed, the incidence of invasive disease was 203 per 100,000 infants aged 1 year and 63 per 100,000 children aged 2 years (*3*).

To ensure that every child is protected against pneumococcal disease despite the PCV7 shortage, CDC, in consultation with the American Academy of Family Physicians, the American Academy of Pediatrics, and the Advisory Committee on Immunization Practices, recommends that all health-care providers temporarily discontinue administering the third and fourth dose of PCV7 to healthy children. Health-care providers should continue to administer the routine 4-dose series to children at increased risk for severe disease*. Unvaccinated, healthy children aged 12–23 months should receive a single dose of PCV7. For children aged ≥2 years, PCV7 is not recommended routinely.

This recommendation reflects CDC's assessment of the existing national PCV7 supply and will be changed if the supply changes. Updated information about the national PCV7 supply is available from CDC at http://www.cdc.gov/nip/news/shortages/default.htm.

* Including children with sickle cell disease and other hemoglobinopathies, anatomic asplenia, chronic diseases (e.g., chronic cardiac and pulmonary disease and diabetes), cerebrospinal fluid leak, human immunodeficiency virus infection and other immunocompromising conditions, immunosuppressive chemotherapy or long-term systemic corticosteroid use; children who have undergone solid organ transplantation, and children who either have received or will receive cochlear implants (*4*). All these children have been identified as being at either "high risk" or "presumed high risk" for severe invasive pneumoccocal disease (*5*).

Health-care providers should maintain lists of children for whom conjugate vaccine has been deferred so it can be administered when the supply allows. The highest priority for vaccination among children who have been deferred is children vaccinated with ≤2 doses who are aged <1 year.

Because data on the long-term efficacy of 3-dose or 2-dose vaccine regimens are limited, health-care providers should consider the diagnosis of invasive pneumococcal disease in incompletely vaccinated children and are encouraged to report invasive pneumococcal disease after any regimen of pneumococcal conjugate vaccine to CDC through state health departments. If a pneumococcal isolate is available from a vaccinated child, CDC will perform serotyping to determine whether the type is included in the vaccine. Additional information is available from CDC at http://www.cdc.gov/nip/home-hcp.htm and by telephone, 404-639-2215 or fax, 404-639-3970.

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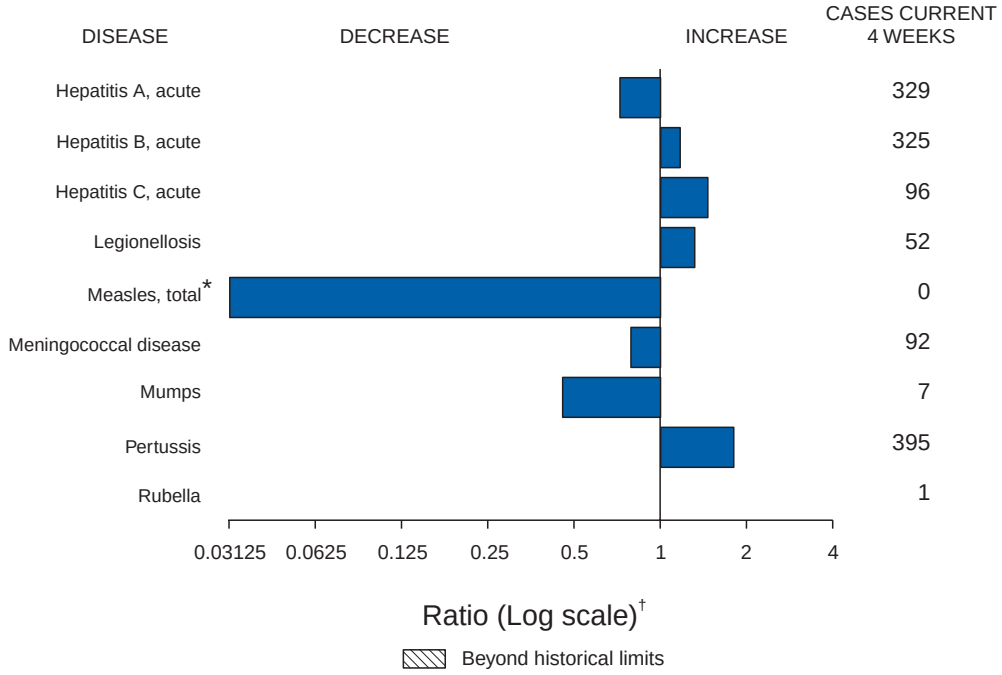
Notice to Readers

Satellite Broadcast on HIV Prevention

CDC and the Public Health Training Network will present a satellite broadcast and webcast, "Prevention with Positives: HIV Risk Reduction Strategies for Health Care Providers," on Thursday, April 29, 2004, beginning at 1 p.m., EDT. The 2-hour forum will discuss evidence-based behavioral interventions and ongoing research about HIV prevention with persons living with HIV (PLWH), describe examples of behavior interventions for PLWH in community-based organizations and clinical settings, and identify opportunities and methods for health-care providers to link PLWH to local HIV-prevention resources. A panel of experts will address viewers' questions, which can be sent via fax before, during, and after the program.

Additional information and instructions for continuing education are available at http://www.cdcnpin.org/broadcast and through the CDC Fax Information System, telephone 888-232-3299, by entering document number 130039 and a return fax number. Organizations are responsible for setting up their own viewing sites and are encouraged to register their sites as soon as possible so persons who want to view the broadcast can access information online. Directions for establishing and registering a viewing site are available on the website. The broadcast also can be viewed live or later on computers with Internet and RealPlayer® capability through a link at http://www.phppo.cdc.gov/phtn. Videotapes and CD-ROMs of the broadcast can be ordered by telephone, 800-458-5231.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals February 28, 2004, with historical data



* No measles cases were reported for the current 4-week period yielding a ratio for week 8 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 February 28, 2004 (8th Week)*

	Cum. 2004	Cum. 2003		Cum. 2004	Cum. 2003
Anthrax	-	-	Hemolytic uremic syndrome, postdiarrheal†	5	22
Botulism:	-	-	HIV infection, pediatric†§	-	27
foodborne	3	1	Measles, total	2¶	3**
infant	8	13	Mumps	21	33
other (wound & unspecified	3	1	Plague	-	-
Brucellosis†	6	21	Poliomyelitis, paralytic	-	-
Chancroid	4	8	Psittacosis†	2	5
Cholera	1	-	Q fever†	5	14
Cyclosporiasis†	4	20	Rabies, human	-	-
Diphtheria	-	-	Rubella	4	1
Ehrlichiosis:	-	-	Rubella, congenital syndrome	-	-
human granulocytic (HGE)†	3	12	SARS-associated coronavirus disease† ††	-	-
human monocytic (HME)†	3	18	Smallpox† §§	-	NA
human, other and unspecified	-	1	*Staphylococcus aureus*:	-	-
Encephalitis/Meningitis:	-	-	Vancomycin-intermediate (VISA)† §§	2	NA
California serogroup viral†	-	-	Vancomycin-resistant (VRSA)† §§	-	NA
eastern equine†	-	2	Streptococcal toxic-shock syndrome†	17	33
Powassan†	-	-	Tetanus	1	4
St. Louis†	1	2	Toxic-shock syndrome	19	13
western equine†	-	-	Trichinosis	1	-
Hansen disease (leprosy)†	7	16	Tularemia†	2	3
Hantavirus pulmonary syndrome†	2	5	Yellow fever	-	-

-: No reported cases.
* Incidence data for reporting years 2003 and 2004 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. Last update December 28, 2003.
¶ Of two cases reported, one was indigenous, and one was imported from another country.
** Of three cases reported, two were indigenous, and one was imported from another country.
†† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (notifiable as of July 2003).
§§ Not previously notifiable.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending February 28, 2004, and February 22, 2003 (8th Week)*

Reporting area	AIDS		Chlamydia†		Coccidiodomycosis		Cryptosporidiosis		Encephalitis/Meningitis West Nile	
	Cum. 2004§	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	-	5,273	105,298	127,443	1,043	502	348	370	4	57
NEW ENGLAND	-	192	4,060	4,127	-	-	20	21	-	-
Maine	-	-	181	273	N	N	4	1	-	-
N.H.	-	3	267	239	-	-	5	2	-	-
Vt.	-	5	123	172	-	-	2	2	-	-
Mass.	-	111	2,284	1,574	-	-	7	11	-	-
R.I.	-	16	646	412	-	-	-	3	-	-
Conn.	-	57	559	1,457	N	N	2	2	-	-
MID. ATLANTIC	-	1,540	16,088	18,357	-	-	56	33	1	-
Upstate N.Y.	-	77	2,644	1,768	N	N	13	7	-	-
N.Y. City	-	941	4,717	5,012	-	-	8	14	-	-
N.J.	-	170	1,452	2,391	-	-	1	2	-	-
Pa.	-	352	7,275	9,186	N	N	34	10	1	-
E.N. CENTRAL	-	632	16,391	23,775	-	2	72	53	-	-
Ohio	-	95	1,779	6,405	-	-	26	7	-	-
Ind.	-	84	2,546	2,768	N	N	7	3	-	-
Ill.	-	290	4,412	7,639	-	-	4	11	-	-
Mich.	-	143	6,040	4,389	-	2	18	12	-	-
Wis.	-	20	1,614	2,574	-	-	17	20	-	-
W.N. CENTRAL	-	60	5,921	6,716	-	-	36	17	1	-
Minn.	-	9	755	1,640	N	N	8	8	-	-
Iowa	-	17	-	396	N	N	5	3	-	-
Mo.	-	26	2,917	2,600	-	-	10	2	1	-
N. Dak.	-	-	140	138	N	N	-	-	-	-
S. Dak.	-	1	332	358	-	-	4	4	-	-
Nebr.¶	-	-	582	542	-	-	-	-	-	-
Kans.	-	7	1,195	1,042	N	N	9	-	-	-
S. ATLANTIC	-	1,118	16,556	22,125	-	-	64	156	1	57
Del.	-	30	447	466	N	N	-	1	-	-
Md.	-	103	2,844	2,358	-	-	6	6	-	-
D.C.	-	179	367	497	-	-	1	-	-	-
Va.	-	176	1,245	2,079	-	-	7	-	-	-
W. Va.	-	6	404	368	N	N	-	-	-	-
N.C.	-	123	3,294	3,802	N	N	14	3	-	-
S.C.¶	-	45	2,412	1,940	-	-	-	1	-	-
Ga.	-	309	554	4,598	-	-	20	16	-	-
Fla.	-	147	4,989	6,017	N	N	16	129	1	57
E.S. CENTRAL	-	80	7,451	8,302	N	N	19	16	-	-
Ky.	-	28	911	1,335	N	N	5	1	-	-
Tenn.	-	21	2,853	2,612	N	N	10	7	-	-
Ala.	-	12	2,025	2,269	-	-	2	6	-	-
Miss.	-	19	1,662	2,086	N	N	2	2	-	-
W.S. CENTRAL	-	698	14,519	15,709	-	-	12	8	1	-
Ark.	-	14	1,133	952	-	-	7	2	-	-
La.	-	15	3,924	2,911	N	N	-	-	1	-
Okla.	-	16	1,041	1,050	N	N	4	1	-	-
Tex.	-	653	8,421	10,796	-	-	1	5	-	-
MOUNTAIN	-	204	6,034	7,626	820	403	22	11	-	-
Mont.	-	7	27	270	N	N	1	1	-	-
Idaho	-	1	477	383	N	N	-	4	-	-
Wyo.	-	1	156	181	-	-	2	-	-	-
Colo.	-	23	534	2,051	N	N	14	2	-	-
N. Mex.	-	14	861	1,198	2	-	1	-	-	-
Ariz.	-	112	2,841	2,275	805	395	3	1	-	-
Utah	-	6	365	322	4	1	-	3	-	-
Nev.	-	40	773	946	9	7	1	-	-	-
PACIFIC	-	749	18,278	20,706	223	97	47	55	-	-
Wash.	-	72	2,560	2,274	N	N	-	-	-	-
Oreg.	-	47	1,180	897	-	-	7	3	-	-
Calif.	-	618	14,059	16,189	223	97	39	52	-	-
Alaska	-	6	468	526	-	-	-	-	-	-
Hawaii	-	6	11	820	-	-	1	-	-	-
Guam	-	1	-	-	-	-	-	-	-	-
P.R.	-	145	135	98	N	N	N	N	-	-
V.I.	-	2	-	52	-	-	-	-	-	-
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. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Incidence data for reporting years 2003 and 2004 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 December 28, 2003.

¶ Contains data reported through National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 28, 2004, and February 22, 2003 (8th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	128	180	19	43	14	19	1,894	3,226	38,166	50,479
NEW ENGLAND	4	9	2	1	2	2	166	134	944	1,131
Maine	-	-	-	-	-	-	15	16	36	18
N.H.	1	2	-	1	-	-	5	13	17	18
Vt.	-	-	-	-	-	-	11	13	6	16
Mass.	-	3	1	-	2	2	72	83	534	443
R.I.	-	-	-	-	-	-	9	9	160	144
Conn.	3	4	1	-	-	-	54	-	191	492
MID. ATLANTIC	10	15	1	1	3	2	381	465	5,418	7,546
Upstate N.Y.	3	3	1	-	1	-	113	82	1,000	833
N.Y. City	3	1	-	-	-	-	114	193	1,603	2,034
N.J.	-	3	-	-	1	-	22	65	614	1,506
Pa.	4	8	-	1	1	2	132	125	2,201	3,173
E.N. CENTRAL	27	39	4	4	1	2	258	401	6,464	11,037
Ohio	12	10	-	1	1	2	121	122	876	3,371
Ind.	3	3	-	-	-	-	-	-	956	1,057
Ill.	2	6	-	-	-	-	36	120	1,774	3,477
Mich.	6	6	-	-	-	-	74	99	2,379	2,180
Wis.	4	14	4	3	-	-	27	60	479	952
W.N. CENTRAL	15	20	4	3	6	2	167	227	2,119	2,418
Minn.	6	9	-	3	-	-	53	48	342	447
Iowa	-	1	-	-	-	-	30	33	-	52
Mo.	5	3	4	-	1	-	58	85	1,154	1,324
N. Dak.	-	1	-	-	3	1	2	5	13	4
S. Dak.	-	2	-	-	-	-	4	7	29	18
Nebr.	1	3	-	-	-	-	7	27	151	170
Kans.	3	1	-	-	2	1	13	22	430	403
S. ATLANTIC	9	53	5	28	1	10	303	1,333	8,345	11,395
Del.	-	-	N	N	N	N	7	8	173	217
Md.	2	-	-	-	-	-	13	17	1,260	1,195
D.C.	-	-	-	-	-	-	6	-	263	354
Va.	-	2	1	-	-	-	43	17	472	1,111
W. Va.	-	-	-	-	-	-	1	-	128	117
N.C.	-	-	3	3	-	-	N	N	2,325	2,189
S.C.	-	-	-	-	-	-	1	9	1,204	1,152
Ga.	3	4	-	-	-	-	80	147	374	2,272
Fla.	4	47	1	25	1	10	152	1,135	2,146	2,788
E.S. CENTRAL	5	7	1	-	-	-	29	43	3,598	4,292
Ky.	1	1	1	-	-	-	N	N	414	587
Tenn.	2	4	-	-	-	-	16	18	1,105	1,235
Ala.	1	2	-	-	-	-	13	25	1,200	1,442
Miss.	1	-	-	-	-	-	-	-	879	1,028
W.S. CENTRAL	3	4	-	2	-	1	41	27	5,619	6,624
Ark.	-	1	-	-	-	-	22	19	532	571
La.	-	-	-	-	-	-	4	-	1,901	1,696
Okla.	3	-	-	-	-	-	15	8	497	426
Tex.	-	3	-	2	-	1	-	-	2,689	3,931
MOUNTAIN	31	15	1	3	1	-	233	200	1,611	1,754
Mont.	1	-	-	-	-	-	5	3	8	20
Idaho	2	4	-	2	-	-	30	27	10	12
Wyo.	-	-	-	-	-	-	1	3	7	9
Colo.	15	4	1	-	1	-	77	55	310	510
N. Mex.	-	-	-	1	-	-	5	9	112	201
Ariz.	8	5	N	N	N	N	63	44	787	683
Utah	2	2	-	-	-	-	40	42	39	36
Nev.	3	-	-	-	-	-	12	17	338	283
PACIFIC	24	18	1	1	-	-	316	396	4,048	4,282
Wash.	4	5	-	-	-	-	26	19	451	419
Oreg.	4	1	1	1	-	-	55	52	138	135
Calif.	12	12	-	-	-	-	220	299	3,378	3,491
Alaska	-	-	-	-	-	-	6	11	80	83
Hawaii	4	-	-	-	-	-	9	15	1	154
Guam	N	N	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	-	9	10	10
V.I.	-	-	-	-	-	-	-	-	-	11
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 years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 28, 2004, and February 22, 2003 (8th Week)*

Reporting area	*Haemophilus influenzae*, invasive								Hepatitis (viral, acute), by type	
	All ages		Age <5 years							
	All serotypes		Serotype b		Non-serotype b		Unknown serotype		A	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	300	348	3	6	22	18	26	36	780	1,231
NEW ENGLAND	28	24	-	1	2	2	1	-	141	28
Maine	3	-	-	-	-	-	-	-	5	1
N.H.	9	3	-	-	1	-	-	-	2	2
Vt.	2	5	-	-	-	-	-	-	4	2
Mass.	7	12	-	1	-	2	1	-	116	15
R.I.	1	-	-	-	-	-	-	-	-	1
Conn.	6	4	-	-	1	-	-	-	14	7
MID. ATLANTIC	57	39	-	-	1	-	8	5	96	161
Upstate N.Y.	21	7	-	-	1	-	1	2	10	14
N.Y. City	7	10	-	-	-	-	2	2	34	67
N.J.	8	7	-	-	-	-	2	-	11	23
Pa.	21	15	-	-	-	-	3	1	41	57
E.N. CENTRAL	42	37	-	1	9	2	4	10	68	100
Ohio	24	8	-	-	2	-	3	3	11	16
Ind.	8	3	-	-	3	1	1	-	4	4
Ill.	-	17	-	-	-	-	-	7	19	39
Mich.	7	5	-	1	4	1	-	-	29	30
Wis.	3	4	-	-	-	-	-	-	5	11
W.N. CENTRAL	8	20	-	-	1	2	-	3	20	27
Minn.	6	7	-	-	1	2	-	-	-	4
Iowa	-	-	-	-	-	-	-	-	6	6
Mo.	1	10	-	-	-	-	-	3	6	6
N. Dak.	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	1	-	-	-	-	-	-	1	-
Nebr.	1	-	-	-	-	-	-	-	3	3
Kans.	-	2	-	-	-	-	-	-	4	8
S. ATLANTIC	89	152	-	1	1	8	6	11	172	570
Del.	-	-	-	-	-	-	-	-	-	2
Md.	20	12	-	-	-	1	1	-	32	29
D.C.	-	-	-	-	-	-	-	-	1	-
Va.	8	5	-	-	-	-	-	1	14	10
W. Va.	4	1	-	-	-	-	2	-	1	2
N.C.	5	3	-	-	-	-	-	-	8	5
S.C.	-	1	-	-	-	-	-	-	-	9
Ga.	34	7	-	-	-	-	3	1	68	102
Fla.	18	123	-	1	1	7	-	9	48	411
E.S. CENTRAL	11	22	-	-	-	-	2	3	21	29
Ky.	-	2	-	-	-	-	-	-	1	5
Tenn.	6	9	-	-	-	-	1	2	15	15
Ala.	5	10	-	-	-	-	1	1	-	6
Miss.	-	1	-	-	-	-	-	-	5	3
W.S. CENTRAL	9	13	-	-	2	1	-	-	16	78
Ark.	-	1	-	-	-	-	-	-	6	2
La.	1	4	-	-	-	-	-	-	-	9
Okla.	8	8	-	-	2	1	-	-	5	2
Tex.	-	-	-	-	-	-	-	-	5	65
MOUNTAIN	46	24	1	1	6	2	4	3	94	44
Mont.	-	-	-	-	-	-	-	-	-	-
Idaho	1	-	-	-	-	-	1	-	3	2
Wyo.	-	-	-	-	-	-	-	-	1	-
Colo.	15	5	-	-	-	-	2	1	8	2
N. Mex.	4	2	-	-	1	-	-	-	2	3
Ariz.	22	11	-	1	4	-	1	1	70	23
Utah	1	4	1	-	-	1	-	1	8	5
Nev.	3	2	-	-	1	1	-	-	2	9
PACIFIC	10	17	2	2	-	1	1	1	152	194
Wash.	3	-	2	-	-	-	1	-	8	3
Oreg.	6	9	-	-	-	-	-	1	14	17
Calif.	-	6	-	2	-	1	-	-	127	171
Alaska	-	-	-	-	-	-	-	-	1	1
Hawaii	1	2	-	-	-	-	-	-	2	2
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	-	-	1	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 years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 28, 2004, and February 22, 2003 (8th Week)*

Reporting area	Hepatitis (viral, acute), by type				Legionellosis		Listeriosis		Lyme disease	
	B		C							
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	665	1,607	201	398	153	299	53	103	727	1,142
NEW ENGLAND	28	46	-	-	2	8	1	4	10	50
Maine	-	-	-	-	-	-	-	-	1	-
N.H.	6	1	-	-	-	-	-	1	-	1
Vt.	1	1	-	-	-	1	-	-	-	3
Mass.	21	33	-	-	1	3	-	2	2	44
R.I.	-	-	-	-	-	1	-	-	-	2
Conn.	-	11	U	U	1	3	1	1	7	-
MID. ATLANTIC	60	182	24	19	29	34	9	15	607	873
Upstate N.Y.	5	7	2	2	5	6	2	2	199	266
N.Y. City	2	85	-	-	-	5	1	4	-	-
N.J.	23	43	-	-	6	4	3	2	57	159
Pa.	30	47	22	17	18	19	3	7	351	448
E.N. CENTRAL	41	76	11	21	43	43	7	7	16	27
Ohio	22	25	2	1	27	18	3	1	11	4
Ind.	1	-	-	-	2	1	1	1	-	2
Ill.	-	1	-	5	-	9	-	3	-	-
Mich.	18	34	9	15	12	12	2	2	-	-
Wis.	-	16	-	-	2	3	1	-	5	21
W.N. CENTRAL	55	45	94	34	4	2	1	2	9	3
Minn.	5	2	-	-	-	-	-	1	3	-
Iowa	1	2	-	-	-	1	-	-	2	2
Mo.	45	35	94	34	3	-	1	-	3	1
N. Dak.	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	1	-	-	-	-	-
Nebr.	4	3	-	-	-	-	-	1	-	-
Kans.	-	3	-	-	-	1	-	-	1	-
S. ATLANTIC	244	853	27	88	38	175	14	46	68	148
Del.	1	2	-	-	2	-	N	N	-	19
Md.	20	18	1	3	6	11	2	2	47	40
D.C.	3	-	-	-	-	-	-	-	1	-
Va.	14	15	3	-	3	4	-	1	-	2
W. Va.	-	-	1	-	-	-	1	-	-	-
N.C.	24	16	1	1	6	5	4	1	12	6
S.C.	-	6	-	-	-	-	-	2	1	-
Ga.	89	160	5	4	5	4	4	2	-	1
Fla.	93	636	16	80	16	151	3	38	7	80
E.S. CENTRAL	37	50	30	15	6	2	2	4	-	7
Ky.	5	8	4	2	2	-	1	-	-	-
Tenn.	19	7	25	2	3	1	1	-	-	1
Ala.	2	15	-	2	1	1	-	3	-	-
Miss.	11	20	1	9	-	-	-	1	-	6
W.S. CENTRAL	8	142	7	206	4	16	1	8	-	19
Ark.	3	15	-	1	-	-	-	-	-	-
La.	4	23	6	31	-	-	-	-	-	2
Okla.	1	7	-	-	1	2	-	1	-	-
Tex.	-	97	1	174	3	14	1	7	-	17
MOUNTAIN	87	86	3	5	12	8	6	8	3	2
Mont.	-	2	-	-	-	-	-	1	-	-
Idaho	1	2	-	-	1	1	-	-	-	1
Wyo.	1	2	-	-	2	1	-	-	1	-
Colo.	10	10	-	2	2	1	1	5	-	-
N. Mex.	2	5	-	-	-	-	-	-	-	-
Ariz.	56	49	2	2	2	3	4	2	1	-
Utah	7	4	-	-	4	1	-	-	1	-
Nev.	10	12	1	1	1	1	1	-	-	1
PACIFIC	105	127	5	10	15	11	12	9	14	13
Wash.	9	4	1	1	3	-	2	-	1	-
Oreg.	17	24	1	2	N	N	3	-	3	3
Calif.	77	94	2	6	12	11	7	9	10	10
Alaska	2	2	-	-	-	-	-	-	-	-
Hawaii	-	3	1	1	-	-	-	-	N	N
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	1	15	-	-	-	-	-	-	N	N
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 years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 28, 2004, and February 22, 2003 (8th Week)*

Reporting area	Malaria		Meningococcal disease		Pertussis		Rabies, animal		Rocky Mountain spotted fever	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	136	233	282	355	1,009	936	387	686	64	52
NEW ENGLAND	10	7	7	13	301	106	34	59	4	-
Maine	-	1	-	1	-	-	2	4	-	-
N.H.	-	2	-	-	6	4	4	4	-	-
Vt.	-	-	1	-	10	17	3	4	-	-
Mass.	6	4	6	10	283	84	14	23	4	-
R.I.	1	-	-	-	-	-	-	1	-	-
Conn.	3	-	-	2	2	1	11	23	-	-
MID. ATLANTIC	18	33	35	31	271	91	73	99	5	6
Upstate N.Y.	4	5	9	3	196	36	44	37	-	-
N.Y. City	7	17	7	8	-	-	-	1	1	1
N.J.	-	3	3	3	18	15	-	24	-	4
Pa.	7	8	16	17	57	40	29	37	4	1
E.N. CENTRAL	11	17	37	40	136	76	1	4	-	1
Ohio	3	5	20	15	82	52	1	-	-	1
Ind.	-	-	3	4	1	3	-	2	-	-
Ill.	-	8	1	8	-	-	-	-	-	-
Mich.	5	3	11	9	17	6	-	2	-	-
Wis.	3	1	2	4	36	15	-	-	-	-
W.N. CENTRAL	9	4	11	18	50	26	49	69	1	2
Minn.	5	2	1	3	6	3	7	3	-	-
Iowa	1	2	2	4	9	6	8	6	-	1
Mo.	2	-	3	9	28	11	2	-	1	1
N. Dak.	-	-	-	-	1	-	7	10	-	-
S. Dak.	-	-	1	-	-	1	-	6	-	-
Nebr.	-	-	-	1	-	-	11	7	-	-
Kans.	1	-	4	1	6	5	14	37	-	-
S. ATLANTIC	58	116	53	132	59	170	187	401	48	39
Del.	-	-	1	4	2	-	1	-	-	-
Md.	18	12	4	4	14	12	13	40	3	4
D.C.	3	-	-	-	1	-	-	-	-	-
Va.	4	3	2	3	10	1	15	49	-	1
W. Va.	-	2	3	-	-	-	9	8	-	-
N.C.	1	4	5	4	16	28	78	81	43	16
S.C.	1	-	1	5	2	1	11	19	-	-
Ga.	7	3	10	5	-	14	60	36	2	-
Fla.	24	92	27	107	14	114	-	168	-	18
E.S. CENTRAL	2	5	16	15	17	19	9	17	5	2
Ky.	1	1	2	1	1	3	2	3	-	-
Tenn.	-	2	7	3	12	7	5	12	2	1
Ala.	1	2	2	4	1	7	2	2	1	-
Miss.	-	-	5	7	3	2	-	-	2	1
W.S. CENTRAL	4	15	28	39	4	16	14	12	-	2
Ark.	1	-	5	2	2	1	5	-	-	-
La.	2	1	8	12	2	1	-	-	-	-
Okla.	1	-	1	3	-	2	9	12	-	-
Tex.	-	14	14	22	-	12	-	-	-	2
MOUNTAIN	7	5	18	12	117	135	13	12	-	-
Mont.	-	-	1	-	4	-	-	1	-	-
Idaho	-	1	1	-	13	7	-	-	-	-
Wyo.	-	-	1	-	2	-	-	-	-	-
Colo.	3	3	9	3	69	62	-	-	-	-
N. Mex.	1	-	1	2	1	14	-	-	-	-
Ariz.	1	1	4	4	12	36	13	11	-	-
Utah	1	-	1	-	16	11	-	-	-	-
Nev.	1	-	-	3	-	5	-	-	-	-
PACIFIC	17	31	77	55	54	297	7	13	1	-
Wash.	2	4	4	2	32	17	-	-	-	-
Oreg.	1	5	16	11	21	43	-	-	-	-
Calif.	14	22	54	40	-	236	7	12	1	-
Alaska	-	-	1	-	1	-	-	1	-	-
Hawaii	-	-	2	2	-	1	-	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	1	-	-	11	7	N	N
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 years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 28, 2004, and February 22, 2003 (8th Week)*

Reporting area	Salmonellosis		Shigellosis		Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive			
							Drug resistant, all ages		Age <5 years	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	3,331	8,078	1,351	5,431	739	1,170	448	899	49	77
NEW ENGLAND	146	145	35	53	33	82	1	22	1	-
Maine	6	6	-	3	1	1	-	-	-	-
N.H.	5	9	2	-	5	4	-	-	N	N
Vt.	6	4	-	1	-	3	-	3	-	-
Mass.	92	96	26	35	25	43	N	N	N	N
R.I.	7	6	-	2	2	-	1	-	1	-
Conn.	30	24	7	12	-	31	-	19	U	U
MID. ATLANTIC	362	468	131	268	95	179	24	19	11	15
Upstate N.Y.	67	52	50	32	40	50	9	9	5	13
N.Y. City	112	152	37	62	5	29	U	U	U	U
N.J.	53	95	20	69	15	43	N	N	N	N
Pa.	130	169	24	105	35	57	15	10	6	2
E.N. CENTRAL	464	540	121	225	111	249	102	75	23	43
Ohio	146	147	36	46	46	55	83	64	16	29
Ind.	31	27	4	9	6	12	19	11	6	2
Ill.	117	216	46	114	2	72	-	-	-	-
Mich.	89	72	20	33	54	73	N	N	N	N
Wis.	81	78	15	23	3	37	N	N	1	12
W.N. CENTRAL	192	196	51	117	61	59	38	50	5	10
Minn.	42	52	11	11	24	24	-	-	5	8
Iowa	33	50	3	2	N	N	N	N	N	N
Mo.	58	47	17	45	10	16	2	1	-	-
N. Dak.	4	4	1	-	3	1	-	1	-	2
S. Dak.	9	10	1	8	4	5	-	-	-	-
Nebr.	15	11	2	39	3	6	-	-	N	N
Kans.	31	22	16	12	17	7	36	48	N	N
S. ATLANTIC	897	5,318	396	3,659	222	309	242	692	2	2
Del.	4	8	2	61	-	1	1	-	N	N
Md.	55	88	19	107	43	35	-	1	-	-
D.C.	4	-	8	-	-	-	-	-	2	-
Va.	97	50	15	31	7	8	N	N	N	N
W. Va.	5	2	-	-	6	1	8	10	-	2
N.C.	112	179	47	121	17	17	N	N	U	U
S.C.	47	59	15	21	1	3	17	28	N	N
Ga.	186	263	94	469	108	13	112	42	N	N
Fla.	387	4,669	196	2,849	40	231	104	611	N	N
E.S. CENTRAL	167	244	71	125	38	22	22	13	-	-
Ky.	23	40	7	22	19	5	6	-	N	N
Tenn.	48	81	37	32	19	17	16	13	N	N
Ala.	60	81	15	49	-	-	-	-	N	N
Miss.	36	42	12	22	-	-	-	-	-	-
W.S. CENTRAL	178	335	165	460	25	93	11	23	6	6
Ark.	30	40	10	3	2	2	2	5	1	2
La.	15	51	14	61	-	-	9	18	2	2
Okla.	29	26	58	88	12	14	N	N	2	2
Tex.	104	218	83	308	11	77	N	N	1	-
MOUNTAIN	375	220	194	129	62	97	8	5	1	1
Mont.	10	13	3	-	-	-	-	-	-	-
Idaho	27	16	-	2	1	5	N	N	N	N
Wyo.	4	3	1	1	3	-	4	-	-	-
Colo.	87	68	37	25	38	26	-	-	-	-
N. Mex.	20	20	23	25	10	23	3	5	-	-
Ariz.	184	65	113	68	4	41	-	-	N	N
Utah	26	17	8	4	6	2	-	-	1	1
Nev.	17	18	9	4	-	-	1	-	-	-
PACIFIC	550	612	187	395	92	80	-	-	-	-
Wash.	36	36	8	8	-	-	-	-	N	N
Oreg.	45	35	11	10	N	N	N	N	N	N
Calif.	409	503	160	369	69	64	N	N	N	N
Alaska	18	16	-	2	-	-	-	-	N	N
Hawaii	42	22	8	6	23	16	-	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	9	60	1	2	N	N	N	N	N	N
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 years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 28, 2004, and February 22, 2003 (8th Week)*

Reporting area	Syphilis: Primary & secondary		Syphilis: Congenital		Tuberculosis		Typhoid fever		Varicella (Chickenpox)	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	839	1,046	23	73	646	1,028	29	51	1,685	2,524
NEW ENGLAND	11	24	-	-	23	27	2	2	147	462
Maine	-	-	-	-	-	-	-	-	7	242
N.H.	1	2	-	-	-	2	-	-	-	-
Vt.	-	-	-	-	-	1	-	-	140	177
Mass.	7	18	-	-	19	8	2	1	-	43
R.I.	2	2	-	-	3	6	-	-	-	-
Conn.	1	2	-	-	1	10	-	1	-	-
MID. ATLANTIC	116	139	5	10	187	212	3	9	8	3
Upstate N.Y.	5	3	2	1	9	16	-	-	-	-
N.Y. City	73	60	3	3	154	112	1	5	-	-
N.J.	19	31	-	6	-	32	1	3	-	-
Pa.	19	45	-	-	24	52	1	1	8	3
E.N. CENTRAL	73	149	10	15	133	108	2	4	817	1,230
Ohio	29	27	-	1	18	12	1	-	141	269
Ind.	9	5	-	5	13	18	-	2	-	-
Ill.	18	53	-	8	86	57	-	1	-	-
Mich.	14	62	10	1	8	17	1	1	644	787
Wis.	3	2	-	-	8	4	-	-	32	174
W.N. CENTRAL	17	34	-	-	46	59	-	-	25	3
Minn.	1	12	-	-	13	16	-	-	-	-
Iowa	-	2	-	-	-	3	-	-	N	N
Mo.	12	13	-	-	11	16	-	-	-	-
N. Dak.	-	-	-	-	-	-	-	-	12	3
S. Dak.	-	-	-	-	-	4	-	-	13	-
Nebr.	3	-	-	-	-	-	-	-	-	-
Kans.	1	7	-	-	22	20	-	-	-	-
S. ATLANTIC	242	234	1	12	93	239	6	21	239	413
Del.	1	1	-	-	-	-	-	-	-	1
Md.	44	36	-	3	18	14	2	2	1	-
D.C.	12	3	-	-	-	-	-	-	4	-
Va.	1	10	-	1	6	15	1	4	20	75
W. Va.	-	-	-	-	4	1	-	-	207	326
N.C.	27	24	-	-	12	18	2	-	-	-
S.C.	21	17	-	3	15	16	-	-	7	11
Ga.	21	49	-	4	-	56	-	-	-	-
Fla.	115	94	1	1	38	119	1	15	-	-
E.S. CENTRAL	49	58	1	2	41	73	-	-	-	-
Ky.	10	11	-	1	5	6	-	-	-	-
Tenn.	23	24	1	1	22	20	-	-	-	-
Ala.	12	20	-	-	14	37	-	-	-	-
Miss.	4	3	-	-	-	10	-	-	-	-
W.S. CENTRAL	146	122	6	12	28	222	1	-	-	399
Ark.	8	9	-	-	12	9	-	-	-	-
La.	29	13	-	-	-	-	-	-	-	3
Okla.	5	7	-	-	16	10	-	-	-	-
Tex.	104	93	6	12	-	203	1	-	-	396
MOUNTAIN	55	40	-	12	27	27	5	2	449	14
Mont.	-	-	-	-	-	-	-	-	-	-
Idaho	4	-	-	-	-	-	-	-	-	-
Wyo.	1	-	-	-	-	1	-	-	11	2
Colo.	-	8	-	2	2	16	-	2	306	-
N. Mex.	13	9	-	4	-	-	-	-	12	-
Ariz.	34	20	-	6	16	9	3	-	-	-
Utah	1	1	-	-	9	1	1	-	120	12
Nev.	2	2	-	-	-	-	1	-	-	-
PACIFIC	130	246	-	10	68	61	10	13	-	-
Wash.	11	10	-	-	36	26	1	-	-	-
Oreg.	9	9	-	-	9	10	-	2	-	-
Calif.	110	223	-	10	-	-	7	11	-	-
Alaska	-	-	-	-	4	7	-	-	-	-
Hawaii	-	4	-	-	19	18	2	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	10	13	-	1	-	11	-	-	36	72
V.I.	-	1	-	-	-	-	-	-	-	-
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 years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,* week ending February 28, 2004 (8th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	590	420	124	34	7	5	76
Boston, Mass.	153	102	34	11	3	3	27
Bridgeport, Conn.	42	34	6	1	-	1	6
Cambridge, Mass.	17	11	5	-	1	-	1
Fall River, Mass.	34	25	8	1	-	-	2
Hartford, Conn.	56	34	15	6	-	1	12
Lowell, Mass.	24	21	1	-	2	-	1
Lynn, Mass.	13	10	1	2	-	-	1
New Bedford, Mass.	24	21	3	-	-	-	3
New Haven, Conn.	19	13	5	1	-	-	4
Providence, R.I.	64	45	15	4	-	-	4
Somerville, Mass.	5	4	1	-	-	-	2
Springfield, Mass.	40	24	11	4	1	-	4
Waterbury, Conn.	29	26	3	-	-	-	4
Worcester, Mass.	70	50	16	4	-	-	5
MID. ATLANTIC	2,725	1,917	542	173	37	51	175
Albany, N.Y.	50	41	6	1	1	1	5
Allentown, Pa.	19	10	9	-	-	-	1
Buffalo, N.Y.	84	59	11	9	4	1	17
Camden, N.J.	29	9	15	2	2	1	-
Elizabeth, N.J.	16	8	3	3	-	2	-
Erie, Pa.	46	37	7	1	1	-	4
Jersey City, N.J.	60	43	12	5	-	-	-
New York City, N.Y.	1,361	985	271	68	17	15	73
Newark, N.J.	70	35	14	13	1	7	6
Paterson, N.J.	30	14	7	7	-	2	1
Philadelphia, Pa.	499	340	98	42	7	12	30
Pittsburgh, Pa.§	26	22	2	2	-	-	1
Reading, Pa.	25	19	3	1	-	2	1
Rochester, N.Y.	153	114	28	6	1	4	13
Schenectady, N.Y.	27	19	5	2	1	-	2
Scranton, Pa.	31	26	1	4	-	-	1
Syracuse, N.Y.	90	61	27	2	-	-	12
Trenton, N.J.	62	38	18	3	1	2	2
Utica, N.Y.	24	20	2	1	-	1	3
Yonkers, N.Y.	23	17	3	1	1	1	3
E.N. CENTRAL	2,329	1,592	493	153	39	49	148
Akron, Ohio	53	39	10	4	-	-	3
Canton, Ohio	37	29	7	1	-	-	7
Chicago, Ill.	404	253	91	38	8	11	23
Cincinnati, Ohio	94	62	18	6	5	3	8
Cleveland, Ohio	261	175	65	17	2	2	6
Columbus, Ohio	251	175	54	13	6	3	27
Dayton, Ohio	150	110	26	6	2	6	11
Detroit, Mich.	183	104	57	15	3	4	11
Evansville, Ind.	63	48	12	2	-	1	6
Fort Wayne, Ind.	71	56	12	2	-	1	3
Gary, Ind.	20	11	4	3	2	-	1
Grand Rapids, Mich.	56	40	9	3	2	2	8
Indianapolis, Ind.	193	130	37	14	8	4	10
Lansing, Mich.	48	35	9	2	-	2	1
Milwaukee, Wis.	116	78	27	7	-	4	13
Peoria, Ill.	40	31	5	2	-	2	1
Rockford, Ill.	48	44	4	-	-	-	5
South Bend, Ind.	66	46	13	6	-	1	-
Toledo, Ohio	91	59	22	7	-	3	4
Youngstown, Ohio	84	67	11	5	1	-	-
W.N. CENTRAL	628	445	112	31	22	15	44
Des Moines, Iowa	44	34	7	2	1	-	2
Duluth, Minn.	32	28	2	1	1	-	2
Kansas City, Kans.	41	24	11	5	1	-	3
Kansas City, Mo.	98	68	16	4	6	4	2
Lincoln, Nebr.	33	29	3	1	-	-	-
Minneapolis, Minn.	65	47	11	1	4	2	10
Omaha, Nebr.	114	84	14	6	5	5	12
St. Louis, Mo.	19	8	6	1	-	1	2
St. Paul, Minn.	67	49	13	2	2	1	2
Wichita, Kans.	115	74	29	8	2	2	9
S. ATLANTIC	1,229	795	265	110	27	32	80
Atlanta, Ga.	167	113	35	13	3	3	5
Baltimore, Md.	214	125	55	29	1	4	18
Charlotte, N.C.	92	62	18	5	-	7	7
Jacksonville, Fla.	124	71	31	16	3	3	5
Miami, Fla.	112	73	23	9	5	2	9
Norfolk, Va.	47	33	12	1	1	-	3
Richmond, Va.	67	44	10	6	3	4	7
Savannah, Ga.	62	43	12	3	4	-	-
St. Petersburg, Fla.	59	42	9	5	2	1	4
Tampa, Fla.	225	164	36	15	4	6	19
Washington, D.C.	34	11	19	2	-	2	-
Wilmington, Del.	26	14	5	6	1	-	3
E.S. CENTRAL	863	603	191	39	12	16	79
Birmingham, Ala.	167	128	24	5	4	4	22
Chattanooga, Tenn.	96	75	16	3	-	2	9
Knoxville, Tenn.	99	74	18	4	-	3	7
Lexington, Ky.	93	53	30	3	4	3	5
Memphis, Tenn.	129	78	41	9	-	1	7
Mobile, Ala.	51	30	16	3	1	1	1
Montgomery, Ala.	51	40	7	3	1	-	10
Nashville, Tenn.	177	125	39	9	2	2	18
W.S. CENTRAL	1,585	1,050	326	121	37	35	109
Austin, Tex.	80	52	19	5	3	1	2
Baton Rouge, La.	58	24	10	6	2	1	-
Corpus Christi, Tex.	66	40	18	4	4	-	9
Dallas, Tex.	207	142	41	16	5	3	21
El Paso, Tex.	62	49	11	2	-	-	1
Ft. Worth, Tex.	152	102	37	9	1	3	8
Houston, Tex.	398	248	83	41	10	16	32
Little Rock, Ark.	90	59	16	8	4	3	2
New Orleans, La.	31	21	7	2	1	-	-
San Antonio, Tex.	250	180	40	20	4	5	27
Shreveport, La.	56	37	15	2	-	2	4
Tulsa, Okla.	135	96	29	6	3	1	3
MOUNTAIN	1,031	714	205	59	29	21	75
Albuquerque, N.M.	129	97	21	5	2	4	11
Boise, Idaho	54	37	11	4	1	1	4
Colo. Springs, Colo.	72	48	14	8	2	-	6
Denver, Colo.	106	64	26	4	6	6	7
Las Vegas, Nev.	247	181	44	14	6	2	17
Ogden, Utah	34	22	9	2	1	-	3
Phoenix, Ariz.	92	57	15	9	3	5	5
Pueblo, Colo.	37	24	8	2	3	-	4
Salt Lake City, Utah	111	71	29	6	2	3	9
Tucson, Ariz.	149	113	28	5	3	-	9
PACIFIC	2,827	1,988	558	177	62	42	277
Berkeley, Calif.	19	13	5	-	-	1	1
Fresno, Calif.	130	93	25	7	2	3	12
Glendale, Calif.	91	72	16	2	-	1	9
Honolulu, Hawaii	85	55	24	5	-	1	6
Long Beach, Calif.	85	52	23	4	3	3	14
Los Angeles, Calif.	1,582	1,119	298	105	38	22	154
Pasadena, Calif.	44	31	7	5	1	-	5
Portland, Oreg.	99	69	21	5	3	1	7
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	151	111	21	11	6	2	22
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	205	143	52	9	1	-	19
Santa Cruz, Calif.	28	20	6	2	-	-	1
Seattle, Wash.	139	84	32	15	2	6	20
Spokane, Wash.	53	38	8	4	1	2	3
Tacoma, Wash.	116	88	20	3	5	-	4
TOTAL	13,807¶	9,524	2,816	897	272	266	1,063

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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