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***Acinetobacter baumannii* Infections Among Patients at Military Medical Facilities Treating Injured U.S. Service Members, 2002–2004**

Acinetobacter baumannii is a well known but relatively uncommon cause of health-care–associated infections. Because the organism has developed substantial antimicrobial resistance, treatment of infections attributed to *A. baumannii* has become increasingly difficult (1). This report describes an increasing number of *A. baumannii* bloodstream infections in patients at military medical facilities in which service members injured in the Iraq/Kuwait region during Operation Iraqi Freedom (OIF) and in Afghanistan during Operation Enduring Freedom (OEF) were treated. The number of these infections and their resistance to multiple antimicrobial agents underscore 1) the importance of infection control during treatment in combat and health-care settings and 2) the need to develop new antimicrobial drugs to treat these infections.

During January 1, 2002–August 31, 2004, military health officials identified 102 patients with blood cultures that grew *A. baumannii* at military medical facilities treating service members injured in Afghanistan and the Iraq/Kuwait region. All of these cases met the criteria for *A. baumannii* bloodstream infection on the basis of criteria established by CDC's National Nosocomial Infection Surveillance (NNIS) system (2). Of these 102 cases, 85 (83%) were associated with activities during OIF and OEF. Most of the infections were reported from Landstuhl Regional Medical Center (LRMC), Germany (33 patients: 32 OIF/OEF casualties, one non-OIF/OEF), and Walter Reed Army Medical Center (WRAMC), District of Columbia (45 patients: 29 OIF/OEF casualties, 16 non-OIF/OEF). In both facilities, the number of patients with *A. baumannii* bloodstream infections in 2003 and 2004 exceeded those reported in previous years (one case during 2000–2002 at LRMC; two cases during 2001–2002 at WRAMC).

Of the 33 patients with *A. baumannii* bloodstream infections at LRMC, 32 (97%) were men; the median age was 30 years (range: 19–72 years). Thirty (91%) patients sustained

traumatic injuries in either the Iraq/Kuwait region (25) or in Afghanistan (five). The majority (67%) were active-duty members of the U.S. Armed Forces. Thirty-two (97%) were transferred directly to the LRMC intensive care unit (ICU) from a combat theater military medical facility. In 22 (67%) of these patients, bloodstream infections were detected from blood cultures obtained within 48 hours of ICU admission.

Of the 45 patients with *A. baumannii* bloodstream infections at WRAMC, 39 (87%) were males; the median age was 39 years (range: 6–86 years). Twenty-nine (64%) patients sustained traumatic injuries in the Iraq/Kuwait region. Of these, 18 (62%) had bloodstream infections detected from blood cultures obtained within 48 hours of hospital admission after transfer from a combat theater medical or other military medical facility.

Antimicrobial susceptibility testing (AST) was performed by using microdilution. Results of 33 *A. baumannii* isolates from LRMC and 45 isolates from WRAMC indicated widespread resistance to antimicrobial agents commonly used to

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treat infections with this organism. AST results, expressed as a percentage of susceptible isolates, were as follows: imipenem (LRMC: 87%; WRAMC: 82%), amikacin (LRMC: 80%; WRAMC: 48%), ampicillin/sulbactam (LRMC: 8%; WRAMC: 35%), piperacillin/tazobactam (LRMC: 0%; WRAMC: 27%), cefepime (LRMC: 0%; WRAMC: 22%), and ciprofloxacin (LRMC: 3%; WRAMC: 20%).

Among the WRAMC isolates, 13 (35%) were susceptible to imipenem only, and two (4%) were resistant to all drugs tested. One antimicrobial agent, colistin (polymyxin E), has been used to treat infections with multidrug-resistant *A. baumannii*; however, AST for colistin was not performed on isolates described in this report.

In addition to LRMC and WRAMC, three other military treatment facilities have identified *A. baumannii* bloodstream infections in service members injured in Iraq, Kuwait, and Afghanistan: U.S. Navy hospital ship (USNS) Comfort (11 patients), National Naval Medical Center (NNMC), Bethesda, Maryland (eight), and Brooke Army Medical Center (BAMC), San Antonio, Texas (five).

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Editorial Note: *A. baumannii* are a species of gram-negative bacteria commonly found in water and soil. During 1963–2003, *A. baumannii* became an increasingly important cause of nosocomial infections, particularly in ICUs (3). Treatment of infections attributed to *A. baumannii* can be difficult because the organism has intrinsic resistance to certain antimicrobial agents and has acquired resistance to many others (3). In health-care settings, colonized and infected patients are often the sources of *A. baumannii* infections; however, the ability of the organism to survive for prolonged periods on environmental surfaces also has contributed to protracted outbreaks in these settings (1).

In a recent national survey of hospital laboratories, *A. baumannii* infections accounted for only 1.3% of health-care-associated bloodstream infections (4). However, the findings in this report indicate an increase in the number of reported *A. baumannii* bloodstream infections in patients at military medical facilities in which service members injured in Iraq, Kuwait, and Afghanistan are treated.

The sources of the *A. baumannii* that led to the infections described in this report are under investigation. During the Vietnam War, *A. baumannii* was reported to be the most common gram-negative bacillus recovered from traumatic injuries to extremities, and more recent reports have identified *A. baumannii* infections in patients who suffered traumatic injuries, suggesting environmental contamination of wounds as a potential source (5–8). Although some of the patients identified in this report had evidence of bloodstream infections at the time of admission to military medical facilities, whether the infections were acquired from environmental sources in the field or during treatment at (or evacuation from) other military medical facilities (e.g., field hospitals) is unknown. Information on patients described in this report is being reviewed to examine potential risk factors for *A. baumannii* bloodstream infection. In addition to exploring traditionally reported risk factors such as antimicrobial exposure, ICU admission, vascular access, and mechanical ventilation, this investigation will involve detailed reviews of geographic locations where injuries occurred and reviews of the movement of injured patients through treatment facilities. An environmental microbiology survey of both indigenous soil samples and treatment facilities is also under way to explore the potential contribution of environmental contamination to this outbreak. Molecular analysis with pulsed-field gel electrophoresis of patient and environmental isolates will be performed to further characterize the potential contribution of environmental contamination.

The bacterial isolates described in this report demonstrated antimicrobial-resistance patterns similar to multidrug-resistant *A. baumannii* from ICUs in the United States and Europe (3,4). Data from the NNIS system also indicate that resistance among *Acinetobacter* isolates is increasing (CDC, unpublished data, 2004). The high level of antimicrobial resistance is a challenge to clinicians treating *A. baumannii* infections. In some cases, the only effective antimicrobial agent is colistin (polymyxin E); however, this agent is seldom used because of its high toxicity (9). Use of colistin, possibly in combination with other agents, might be effective; however, new agents active against multidrug-resistant *A. baumannii* are needed. Treatment of patients infected with *A. baumannii* is being monitored to determine factors predictive of success and failure, to better understand the impact of antimicrobial

resistance on therapy, and to monitor the potential toxicities of treatment regimens that include colistin.

Identification of colonized and infected patients, combined with implementation of infection-control measures such as hand-hygiene and contact-isolation precautions, might help prevent transmission of this organism within medical facilities (1). Interventions recommended by military medical officials have included 1) institution of active surveillance of groin, axillary, and/or wound cultures for *A. baumannii* for all patients; 2) use of contact precautions for colonized or infected patients; and 3) increased availability and use of alcohol-based hand rubs. Laboratory surveillance for *A. baumannii* has been initiated at LRMC, NNMC, WRAMC, and BAMC, and, as much as possible, at each forward-deployed combat support hospital and medical treatment facility in Iraq, Kuwait, and Afghanistan.

Clinicians who treat patients who have recently been hospitalized (especially in ICUs) at the military hospitals described in this report should be aware of the potential for colonization and infection with *A. baumannii*. Additional information on *A. baumannii* is available at <http://www.cdc.gov/ncidod/hip>. Clinical management and wound-care guidelines have been developed to help prevent and mitigate *A. baumannii* infections in military treatment facilities (10). Clinicians with specific questions about *A. baumannii* among U.S. service members should contact the U.S. Army Center for Health Promotion and Preventive Medicine, telephone 800-222-9698.

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Prevalence of Overweight and Obesity Among Adults with Diagnosed Diabetes — United States, 1988–1994 and 1999–2002

Obesity in persons with diabetes is associated with poorer control of blood glucose levels, blood pressure, and cholesterol (1), placing persons with diabetes at higher risk for both cardiovascular and microvascular disease (2). Conversely, intentional weight loss is associated with reduced mortality among overweight persons with diabetes (3). CDC analyzed the prevalence of overweight and obesity among U.S. adults aged ≥ 20 years with previously diagnosed diabetes by using data from two surveys: the Third National Health and Nutrition Examination Survey (NHANES III), 1988–1994, and NHANES 1999–2002. This report summarizes the results of that analysis, which indicated that most adults with diagnosed diabetes were overweight or obese. During 1999–2002, the

prevalence of overweight or obesity was 85.2%, and the prevalence of obesity was 54.8%. Encouraging patients to achieve and maintain a healthy weight should be a priority for all diabetes-care programs.

NHANES is a continuous survey of the health and nutritional status of the U.S. civilian, noninstitutionalized population; samples are selected through a complex, multistage probability design. Diabetes status was determined in household interviews with participants aged ≥ 20 years. In NHANES III, 1988–1994, participants were asked, “Have you ever been told by a doctor that you have diabetes or sugar diabetes?” For women, the question was preceded by “other than during pregnancy.” In NHANES 1999–2002, the same questions were asked, but “doctor” was replaced with “doctor or health-care professional.” Participants who responded “yes” were categorized as having diagnosed diabetes. The body mass index (BMI) of each participant was calculated as weight in kilograms divided by height in meters squared. Overweight was defined as a BMI of 25.0–29.9 and obesity as a BMI of ≥ 30.0 (4,5). Pregnant women were excluded from the analysis.

Data were analyzed with sample weights to account for differential probabilities in the sample selection, nonresponses, and sample noncoverage. Two sample t-tests were used to test differences in proportions and determine the statistical significance ($p < 0.05$) of differences in results by age, racial/ethnic population, and survey period. Percentages of racial/ethnic populations and persons aged ≥ 20 years were age-standardized to the 2000 U.S. standard population.

Among all survey participants with diagnosed diabetes, the prevalence of obesity was similar for the periods 1988–1994 (45.7%) and 1999–2002 (54.8%) (Table 1). In the 1999–2002 survey, the prevalence of obesity among adults with diagnosed diabetes was 57.9% for non-Hispanic whites, 63.0% for non-Hispanic blacks, and 59.5% for Mexican Americans. Similar prevalences of overweight and obesity were observed in these racial/ethnic populations during 1988–1994.

Among men in the 1999–2002 survey, the prevalence of overweight or obesity was 86.3%, and the prevalence of obesity was 53.0% (Table 2). Both the prevalence of overweight or obesity and the prevalence of obesity were similar among men aged 20–64 years and ≥ 65 years. Among women in the 1999–2002 survey, the prevalence of overweight or obesity was 84.2%, and the prevalence of obesity was 58.0%. Compared with women aged ≥ 65 years, women aged 20–64 years had a significantly higher prevalence of obesity (64.7% versus 47.4%) ($p < 0.05$).

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TABLE 1. Prevalence of overweight and obesity among adults with diagnosed diabetes*, by race/ethnicity — Third National Health and Nutrition Examination Survey (NHANES III), 1988–1994, and NHANES 1999–2002, United States

Body mass index (BMI) [†] group	Race/Ethnicity	NHANES III 1988–1994			NHANES 1999–2002		
		No. surveyed	%	(95% CI) [§]	No. surveyed	%	(95% CI)
Overweight or obese (BMI: ≥ 25.0)	White, non-Hispanic	463	78.1	(69.1–87.1)	295	85.9	(77.5–94.3)
	Black, non-Hispanic	363	79.4	(72.3–86.5)	213	86.1	(79.2–93.0)
	Mexican American	398	84.0	(77.3–90.7)	240	86.9	(79.5–94.3)
	Total[¶]	1,260	78.5	(72.2–84.8)	827	85.2	(80.5–89.9)
Obese (BMI: ≥ 30.0)	White, non-Hispanic	463	45.4	(32.7–58.1)	295	57.9	(47.1–68.7)
	Black, non-Hispanic	363	45.0	(38.3–51.7)	213	63.0	(51.0–75.0)
	Mexican American	398	47.0	(34.3–59.7)	240	59.5	(49.3–69.7)
	Total[¶]	1,260	45.7	(36.7–54.7)	827	54.8	(46.0–63.6)

* Pregnant females were excluded; results were age-standardized to the 2000 U.S. standard population, by using age groups 20–39 years, 40–59 years, and ≥ 60 years.

[†] Calculated from participant weight and height (BMI = kg/m²) and rounded to the nearest tenth.

[§] Confidence interval.

[¶] Includes racial/ethnic populations not shown separately.

TABLE 2. Prevalence of overweight and obesity among adults with diagnosed diabetes*, by sex and age group — Third National Health and Nutrition Examination Survey (NHANES III), 1988–1994, and NHANES 1999–2002, United States

Body mass index (BMI) [†] group	Sex	Age group (yrs)	NHANES III 1988–1994			NHANES 1999–2002		
			No. surveyed	%	(95% CI) [§]	No. surveyed	%	(95% CI)
Overweight or obese (BMI: ≥ 25.0)	Men	≥ 20	556	77.6	(66.2–89.0)	406	86.3	(78.7–93.9)
		20–64	272	85.6	(79.1–92.1)	216	84.2	(77.1–91.3)
		≥ 65	284	75.9 [¶]	(69.8–82.0)	190	84.3	(79.8–88.8)
	Women	≥ 20	704	79.8	(72.7–86.9)	421	84.2	(78.5–89.9)
		20–64	355	82.0	(75.7–88.3)	221	84.3	(78.6–90.0)
		≥ 65	349	73.7 [¶]	(67.2–80.2)	200	79.9	(72.6–87.2)
	Total	≥ 20	1,260	78.5	(72.2–84.8)	827	85.2	(80.5–89.9)
		20–64	627	83.7	(79.4–88.0)	437	84.2	(79.1–89.3)
		≥ 65	633	74.6[¶]	(69.9–79.3)	390	81.8	(76.7–86.9)
Obese (BMI: ≥ 30.0)	Men	≥ 20	556	38.2	(29.0–47.4)	406	53.0	(41.6–64.4)
		20–64	272	51.8	(42.8–60.8)	216	51.5	(40.1–62.9)
		≥ 65	284	22.4 [¶]	(15.7–29.1)	190	38.9	(30.3–47.5)
	Women	≥ 20	704	53.5	(44.7–62.3)	421	58.0	(46.4–69.6)
		20–64	355	54.1	(46.7–61.5)	221	64.7	(55.5–73.9)
		≥ 65	349	38.2 [¶]	(31.1–45.3)	200	47.4 [¶]	(38.6–56.2)
	Total	≥ 20	1,260	45.7	(36.7–54.7)	827	54.8	(46.0–63.6)
		20–64	627	53.0	(46.3–59.7)	437	57.5	(49.3–65.7)
		≥ 65	633	31.6[¶]	(26.5–36.7)	390	43.8[¶]	(37.5–50.1)

* Pregnant females were excluded; results for the groups aged ≥ 20 years were age-standardized to the 2000 U.S. standard population, by using age groups 20–39 years, 40–59 years, and ≥ 60 years.

[†] Calculated from participant weight and height (BMI = kg/m²) and rounded to the nearest tenth.

[§] Confidence interval.

[¶] Significantly different from persons aged 20–64 years ($p < 0.05$).

Editorial Note: The prevalence of obesity among adults overall in the United States increased from 22.9% during 1988–1994 to 30.5% during 1999–2002 (5,6); the prevalence of obesity among adults with diagnosed diabetes remained high, at 45.7% during 1988–1994 and 54.8% during 1999–2002. Weight management, through healthy eating and physical

activity, can help reduce the number of persons at risk for diabetes and reduce the risk for complications and premature mortality among those who already have diabetes.

The findings in this report are subject to at least three limitations. First, the NHANES surveys exclude institutionalized persons, including those in nursing homes, a population with

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a high rate of diabetes (7). Second, the number of persons with diagnosed diabetes surveyed limited the power of the analysis and precluded stratifying the results by multiple demographic groups. Finally, greater clinical vigilance of overweight or obese persons might have resulted in a greater proportion receiving diagnoses of diabetes.

The National Diabetes Education Program (NDEP), cosponsored by CDC and the National Institutes of Health (NIH), has an ongoing community campaign to reduce morbidity and mortality, Control Your Diabetes for Life, which educates persons about healthy eating and weight control. Information about the campaign is available from NDEP at http://www.ndep.nih.gov/campaigns/controlforlife/controlforlife_index.htm. Research into the effects of obesity on diabetes includes a multicenter clinical trial, sponsored by NIH and CDC, to determine the long-term health benefits of an intensive lifestyle intervention designed to achieve and maintain weight loss (8).

The health consequences of diabetes are compounded by overweight and obesity. However, the prevalence of overweight and obesity among persons with diabetes has not been monitored regularly. Findings in this report provide baseline data to track future trends that will enable public health agencies to assess the scope of this public health concern, target programs, and allocate resources accordingly.

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Prevalence of Visual Impairment and Selected Eye Diseases Among Persons Aged ≥ 50 Years With and Without Diabetes — United States, 2002

Visual impairment and blindness* affect an estimated 3.4 million U.S. adults aged ≥ 40 years (1). The leading causes of visual impairment and blindness are diabetic retinopathy and age-related eye diseases (e.g., cataracts, macular degeneration, and glaucoma) (2). Diabetes affects approximately 18 million U.S. adults, of whom an estimated 30% have undiagnosed diabetes, and imposes an increased risk for eye disease (3). To characterize the prevalence of visual impairment and selected eye diseases (i.e., diabetic retinopathy, cataracts, macular degeneration, and glaucoma) among persons aged ≥ 50 years with and without diabetes, CDC analyzed data from the 2002 National Health Interview Survey (NHIS). This report summarizes the findings of that analysis, which identified a substantially higher prevalence of visual impairment and eye disease among those with diabetes compared with those without diabetes. Measures are needed to increase comprehensive eye examinations, especially among adults at high risk for blindness and visual impairment (e.g., persons aged ≥ 65 years and those with diabetes).

NHIS is a stratified, multistage probability sample survey representing the U.S. civilian, noninstitutionalized population. For this analysis, respondents were classified as having diabetes if they answered "yes" to the question, "Have you ever been told by a doctor or health professional that you have diabetes or sugar diabetes?" Women who had diabetes only during pregnancy and persons who reported having borderline diabetes were classified as not having diabetes. Respondents were classified as having visual impairment (including blindness) if they answered "yes" to the question, "Do you have any trouble seeing even when wearing glasses or contact lenses?" Respondents were classified as having diabetic retinopathy, cataracts, glaucoma, or macular degeneration if they answered "yes" to the question, "Have you ever been told by a doctor or other health-care professional that you had diabetic retinopathy, cataracts, glaucoma, or macular degeneration?" The prevalence of visual impairment and selected eye diseases was determined for adults with and without diabetes and for specific characteristics (i.e., age, sex, race/ethnicity, education, and health insurance status).

Logistic regression analysis was used to assess the association between diabetes status and prevalence of visual impairment or selected eye diseases while adjusting for demographic characteristics. Chi-square analysis was used to test for statistical significance. All data were weighted to reflect the age, sex, and racial/ethnic distribution of the adult population, and analyses were conducted by using statistical software. Data were age-adjusted to the 2000 U.S. standard population. All results are statistically significant ($p < 0.05$) unless otherwise noted.

In 2002, among persons aged ≥ 50 years with and without diabetes, the age-adjusted prevalence of visual impairment was 23.5% and 12.4%, respectively. The age-adjusted prevalence of diabetic retinopathy among persons aged ≥ 50 years with diabetes was 10.2%. The age-adjusted prevalence for cataracts among those with and without diabetes was 31.8% and 21.2%, respectively; for glaucoma, 8.0% and 4.3%; and for macular degeneration, 2.8% and 2.9% (Table).

The prevalence of visual impairment, cataracts, and glaucoma was higher among persons aged ≥ 50 years with diabetes than among those without diabetes, overall, and for most groups examined (Table). Among persons with diabetes, the age-adjusted prevalence of visual impairment was higher among women than men (28.5% versus 19.2%) and higher among those with less than high school education than among those with high school or more education (30.5% versus 20.9%). Among persons without diabetes, the prevalence of visual impairment was higher among persons aged ≥ 65 years than persons aged 50–64 years (16.1% versus 9.2%), higher among women than men (13.6% versus 10.9%), higher among other racial/ethnic populations than non-Hispanic whites (14.1% versus 12.0%), and higher among those with less than a high school education than among those with at least a high school education (18.0% versus 11.0%).

Among persons with diabetes, the prevalence of cataracts was higher among persons aged ≥ 65 years than persons aged 50–64 years (50.3% versus 16.1%), higher among women than men (37.3% versus 26.7%), and higher among non-Hispanic whites than those of other racial/ethnic populations (34.8% versus 24.1%). The prevalence of glaucoma was higher among persons aged ≥ 65 years than persons aged 50–64 years (11.7% versus 4.9%) and higher among other racial/ethnic populations than non-Hispanic whites (11.4% versus 6.8%). The prevalence of macular degeneration was higher among persons aged ≥ 65 years than persons aged 50–64 years (4.7% versus 1.1%), higher among non-Hispanic whites than other racial/ethnic populations (3.2% versus 1.4%), and higher among those with at least a high school education than those with less than a high school education (3.3% versus 1.7%). No statistically significant differences in the prevalence of

*Visual impairment is defined as best-corrected visual acuity of $\leq 20/40$ in the better-seeing eye. Blindness is defined as best-corrected visual acuity of $\leq 20/200$ in the better-seeing eye.

TABLE. Prevalence of visual impairment and selected eye diseases among persons aged ≥ 50 years with and without diagnosed diabetes, by selected characteristics — National Health Interview Survey, United States, 2002*

Characteristic	Visual impairment†				Cataracts			
	Diabetes		No diabetes		Diabetes		No diabetes	
	%	(95% CI)‡	%	(95% CI)	%	(95% CI)	%	(95% CI)
Age group (yrs)								
50–64	22.5	(18.9–26.2)	9.2	(8.4–10.1)	16.1	(13.0–19.3)	6.0	(5.3–6.7)
≥ 65	24.7	(21.6–27.8)	16.1	(15.0–17.3)	50.3	(46.7–54.0)	39.2	(37.7–40.8)
Total (unadjusted)	23.7	(21.3–26.0)	12.1	(11.4–12.8)	34.0	(31.4–36.6)	19.9	(19.1–20.7)
Sex								
Men	19.2	(16.0–22.3)	10.9	(9.8–11.9)	26.7	(23.5–29.9)	18.4	(17.1–19.6)
Women	28.5	(24.8–32.2)	13.6	(12.6–14.5)	37.3	(33.7–41.0)	23.3	(22.2–24.3)
Race/Ethnicity								
White, non-Hispanic	23.0	(20.0–26.0)	12.0	(11.2–12.8)	34.8	(31.7–37.8)	22.4	(21.5–23.3)
Other††	24.9	(20.7–29.2)	14.1	(12.3–15.8)	24.1	(20.6–27.6)	14.9	(13.3–16.5)
Education level								
<High school	30.5	(25.5–35.4)	18.0	(16.1–19.9)	35.1	(30.2–40.1)	22.9	(21.2–24.7)
\geq High school	20.9	(18.1–23.7)	11.0	(10.2–11.8)	30.9	(28.1–33.7)	21.1	(20.1–22.0)
Health insurance								
Yes	22.6	(20.1–25.1)	12.1	(11.4–12.8)	32.3	(29.8–34.8)	21.4	(20.6–22.3)
No	33.3	(20.9–45.7)	19.5	(10.8–28.3)	24.4	(13.2–35.6)	11.9	(5.7–18.1)
Total (age-adjusted)	23.5	(21.1–25.9)	12.4	(11.7–13.1)	31.8	(29.4–34.2)	21.2	(20.4–22.0)

TABLE. (Continued) Prevalence of visual impairment and selected eye diseases among persons aged ≥ 50 years with and without diagnosed diabetes, by selected characteristics — National Health Interview Survey, United States, 2002

Characteristic	Glaucoma				Macular degeneration				Diabetic retinopathy**	
	Diabetes		No diabetes		Diabetes		No diabetes		Diabetes	
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Age group (yrs)										
50–64	4.9	(3.0–6.8)	1.9	(1.5–2.3)	1.1	(0.4–1.8)	0.7	(0.4–0.9)	9.7	(7.3–12.1)
≥ 65	11.7	(9.4–13.9)	7.0	(6.2–7.8)	4.7	(3.2–6.2)	5.6	(4.8–6.3)	10.8	(8.6–13.0)
Total (unadjusted)	8.4	(6.9–9.9)	4.1	(3.7–4.5)	3.0	(2.1–3.8)	2.7	(2.4–3.0)	10.3	(8.6–11.9)
Sex										
Men	7.0	(5.0–8.9)	4.0	(3.3–4.7)	2.7	(1.6–3.9)	2.3	(1.8–2.8)	8.7	(6.4–11.0)
Women	9.1	(6.9–11.2)	4.5	(3.9–5.0)	2.8	(1.8–3.9)	3.4	(2.9–3.8)	11.8	(9.5–14.1)
Race/Ethnicity										
White, non-Hispanic	6.8	(5.1–8.5)	4.1	(3.6–4.5)	3.2	(2.2–4.1)	3.2	(2.8–3.7)	9.4	(7.5–11.2)
Other	11.4	(8.4–14.4)	5.2	(4.2–6.2)	1.4	(0.4–2.4)	1.1	(0.5–1.8)	12.0	(8.8–15.2)
Education level										
<High school	9.3	(6.6–12.0)	5.3	(4.2–6.3)	1.7	(0.8–2.6)	2.6	(2.0–3.3)	12.1	(8.8–15.4)
\geq High school	7.3	(5.6–9.1)	4.0	(3.5–4.5)	3.3	(2.2–4.5)	3.0	(2.6–3.5)	9.4	(7.5–11.3)
Health insurance										
Yes	8.3	(6.7–9.8)	4.3	(3.9–4.8)	2.8	(2.0–3.6)	2.9	(2.6–3.3)	10.2	(8.5–11.9)
No	6.6	(-0.9–14.1)	0.6	(0.2–0.9)	3.3	(-2.9–9.4)	1.1	(-0.2–2.3)	9.9	(2.4–17.5)
Total (age-adjusted)	8.0	(6.5–9.5)	4.3	(3.8–4.7)	2.8	(2.0–3.5)	2.9	(2.5–3.3)	10.2	(8.5–11.8)

* Sex, race/ethnicity, education level, and health insurance status were age-adjusted according to the 2000 U.S. standard population.

† Visual impairment, including blindness.

‡ Confidence interval.

†† Numbers for racial/ethnic populations other than non-Hispanic white were combined because, when analyzed separately, data were too small for meaningful analysis.

** Not applicable for persons without diabetes.

diabetic retinopathy between age, sex, race/ethnicity, education, and health insurance status were observed.

After data were adjusted for all demographic characteristics, persons with diabetes reported having more visual impairment (odds ratio [OR] = 2.1; 95% confidence interval

[CI] = 1.8–2.5), cataracts (OR = 2.1; 95% CI = 1.8–2.4), and glaucoma (OR = 1.9; 95% CI = 1.5–2.4), compared with persons without diabetes; however, differences in prevalence of age-related macular degeneration were not statistically significant (OR = 1.0; 95% CI = 0.8–1.5).

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Editorial Note: The findings in this report suggest a higher prevalence of visual impairment and eye disease among persons aged ≥ 50 years with diagnosed diabetes than among those without diabetes. Although diabetic retinopathy is a major cause of visual impairment among persons with diabetes, other causes (e.g., cataracts, glaucoma, and macular degeneration) are frequently responsible for visual impairment in persons with diabetes (4,5). The prevalence of diabetes mellitus is increasing in the United States (6). With the aging of the U.S. population, the number of older persons with diabetes is likely to increase, which suggests that a smaller proportion of visual impairment among persons with diabetes will be attributed to diabetic retinopathy. Health-care professionals should check for eye diseases and diabetic retinopathy when evaluating persons with diabetes. Yearly dilated eye examinations should be part of diabetes management in addition to managing hyperglycemia, hypertension, and lipid abnormalities.

The findings in this report are subject to at least four limitations. First, self-reported visual impairment might not represent measured vision impairment; however, it does represent the perceived vision quality of a population (7). Second, the prevalence of visual impairment and eye disease documented in this report is limited to persons with diagnosed diabetes; approximately 30% of persons have undiagnosed diabetes, and a substantial proportion of persons with undiagnosed diabetes might have diabetes-related vision disorders. Third, self-reported eye diseases could be misclassified; persons might mistake their disease for other conditions, and self-reported diabetic retinopathy might not include the early stages of the disease because patients might not count it as retinopathy. Finally, the increased prevalence of visual impairment and eye disease among older persons (i.e., aged ≥ 65 years) might also be attributed to detection bias associated with higher rates of insurance coverage among persons aged ≥ 65 years versus persons aged 50–64 years (98.5% versus 88.7%; $p < 0.05$) and, thus, higher rates of health-care use. Moreover, the high prevalence of visual impairment and eye disease among persons with diabetes in these findings might be related to more frequent use of their health-care system.

Reducing visual impairment, increasing preventive eye care, and increasing use of vision rehabilitation services are public health priorities. CDC has made progress in vision health for persons with diabetes. For example, increasing comprehensive eye examination is a national objective for diabetes prevention and control programs. Although the percentage of annual comprehensive eye examinations has increased (e.g.,

from 58.9% in 1995 to 65.9% in 2001), the percentage is still below the 2010 national health objective of 75% (8). CDC also collaborates with the National Eye Institute through the National Eye Health Education Program (NEHEP) to increase public and professional awareness activities related to diabetic eye disease. NEHEP materials designed to educate the public and health-care providers are available at <http://www.nei.nih.gov/publications/publications.htm>.

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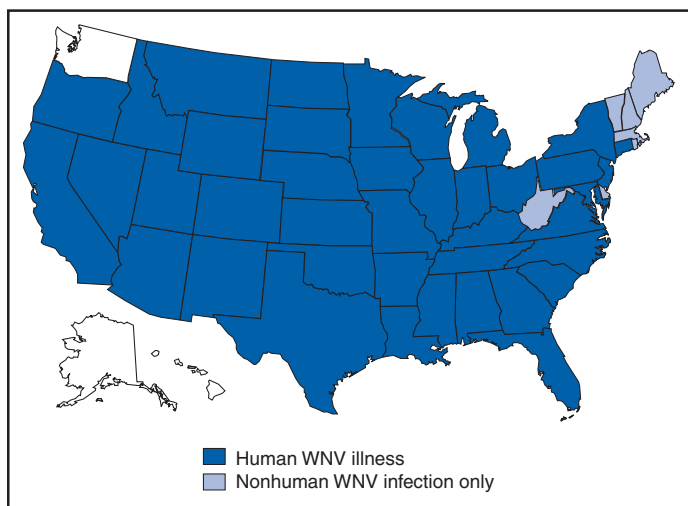
West Nile Virus Activity — United States, November 9–16, 2004

During November 9–16, a total of 31 cases of human West Nile virus (WNV) illness were reported from eight states (Arizona, Georgia, Maryland, Michigan, Missouri, New York, Pennsylvania, and Texas).

During 2004, 40 states and the District of Columbia (DC) have reported 2,313 cases of human WNV illness to CDC through ArboNET (Figure and Table). Of these, 737 (32%) cases were reported in California, 390 (17%) in Arizona, and 276 (12%) in Colorado. A total of 1,339 (59%) of the 2,282 cases for which such data were available occurred in males; the median age of patients was 52 years (range: 1 month–99 years). Date of illness onset ranged from April 23 to November 4; a total of 79 cases were fatal.

A total of 192 presumptive West Nile viremic blood donors (PVDs) have been reported to ArboNET in 2004. Of these, 68 (35%) were reported in California; 35 (18%) in Arizona; 16 in Texas; 15 in New Mexico; seven in Colorado; six each in Louisiana and Oklahoma; five in Nevada; four in Georgia and Iowa; three each in Florida, Michigan, and South

FIGURE. Areas reporting West Nile virus (WNV) activity — United States, 2004*



* As of 3 a.m., Mountain Standard Time, November 16, 2004.

Dakota; two each in Minnesota, Mississippi, Missouri, and Wisconsin; and one each in Delaware, Kentucky, Maryland, Nebraska, New Jersey, New York, North Dakota, Oregon, and Pennsylvania. Of the 192 PVDs, three persons aged 35, 69, and 77 years subsequently had neuroinvasive illness, and 55 persons (median age: 52 years; range: 17–73 years) subsequently had West Nile fever.

In addition, 5,660 dead corvids and 1,414 other dead birds with WNV infection have been reported from 46 states and New York City during 2004. WNV infections have been reported in horses in 37 states; one bat in Wisconsin; nine dogs in Nevada, New Mexico, and Wisconsin; seven squirrels in Arizona and Wyoming; and 14 unidentified animal species in nine states (Arizona, Idaho, Illinois, Iowa, Kentucky, Missouri, Nevada, New York, and South Carolina). WNV seroconversions have been reported in 1,429 sentinel chicken flocks in 14 states (Alabama, Arizona, Arkansas, California, Delaware, Florida, Iowa, Louisiana, Nebraska, Nevada, North Carolina, Pennsylvania, South Dakota, and Utah) and in 31 wild hatchling birds in Missouri and Ohio. Four seropositive sentinel horses were reported in Minnesota and Puerto Rico. A total of 8,263 WNV-positive mosquito pools have been reported in 38 states, DC, and New York City.

Additional information about national WNV activity is available from CDC at <http://www.cdc.gov/ncidod/dvbid/westnile/index.htm> and at <http://westnilemaps.usgs.gov>.

TABLE. Number of human cases of West Nile virus (WNV) illness, by area — United States, 2004*

Area	Neuro-invasive disease [†]	West Nile fever [§]	Other clinical/unspecified [¶]	Total reported to CDC**	Deaths
Alabama	13	0	0	13	0
Arizona	128	77	185	390	11
Arkansas	12	9	1	22	0
California	150	256	331	737	20
Colorado	39	237	0	276	3
Connecticut	0	1	0	1	0
District of Columbia	1	0	0	1	0
Florida	29	8	0	37	2
Georgia	12	6	0	18	0
Idaho	0	0	2	2	0
Illinois	28	27	1	56	3
Indiana	5	0	2	7	1
Iowa	11	7	4	22	2
Kansas	18	25	0	43	2
Kentucky	1	6	0	7	0
Louisiana	68	17	0	85	7
Maryland	7	7	1	15	0
Michigan	11	2	0	13	0
Minnesota	13	21	0	34	2
Mississippi	23	5	2	30	3
Missouri	26	9	2	37	2
Montana	2	3	1	6	0
Nebraska	4	26	0	30	0
Nevada	25	19	0	44	0
New Jersey	1	0	0	1	0
New Mexico	30	50	4	84	4
New York	7	3	0	10	0
North Carolina	3	0	0	3	0
North Dakota	2	18	0	20	1
Ohio	11	1	0	12	2
Oklahoma	10	6	0	16	1
Oregon	0	3	0	3	0
Pennsylvania	9	4	1	14	2
South Carolina	0	1	0	1	0
South Dakota	6	45	0	51	1
Tennessee	13	1	0	14	0
Texas	89	34	0	123	8
Utah	6	5	0	11	0
Virginia	4	0	1	5	1
Wisconsin	4	6	0	10	1
Wyoming	2	5	2	9	0
Total	823	950	540	2,313	79

* As of November 16, 2004.

[†] Cases with neurologic manifestations (i.e., West Nile meningitis, West Nile encephalitis, and West Nile myelitis).

[§] Cases with no evidence of neuroinvasion.

[¶] Illnesses for which sufficient clinical information was not provided.

** Total number of human cases of WNV illness reported to ArboNet by state and local health departments.

Recommended Adult Immunization Schedule — United States, October 2004–September 2005

MMWRTM
QuickGuide

Weekly

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CDC's Advisory Committee on Immunization Practices (ACIP) annually reviews the recommended Adult Immunization Schedule to ensure that the schedule reflects current recommendations for the use of licensed vaccines. In June 2004, ACIP approved the Adult Immunization Schedule for October 2004–September 2005. This schedule has also been approved by the American Academy of Family Physicians and the American College of Obstetricians and Gynecologists.

Changes in the Schedule for October 2004–September 2005

The 2004–2005 schedule differs from the previous schedule as follows:

- Both figures now provide a separate row for each vaccine (Figures 1 and 2).
- Health-care workers have been added to the figure that provides immunization recommendations by medical indications and other conditions (Figure 2).
- The special note regarding influenza vaccination of pregnant women reflects the revised ACIP recommendations that all pregnant women should receive influenza vaccination regardless of preexisting chronic conditions (1).

Health-care workers were added to the Adult Immunization Schedule in response to provider requests; this change should facilitate assessment of the vaccination status of health-care workers and administration of needed vaccinations. In 2002, 38.4% of health-care workers reported influenza vaccination, and 62.3% reported having completed hepatitis B

vaccination series (National Health Interview Survey, CDC, unpublished data, 2003). Influenza vaccination of health-care workers is an important preventive measure for persons at high risk for complications from influenza infection. Health-care workers involved in direct patient care are among the priority groups recommended to receive influenza vaccination for the 2004–05 influenza season, despite the vaccine shortage (2).

The Adult Immunization Schedule is available in English and Spanish at <http://www.cdc.gov/nip/recs/adult-schedule.htm>. General information about adult immunization, including recommendations concerning vaccination of persons with human immunodeficiency virus (HIV) and other immunosuppressive conditions, is available from state and local health departments and from the National Immunization Program at <http://www.cdc.gov/nip>. Vaccine information statements are available at <http://www.cdc.gov/nip/publications/vis>. ACIP statements for each recommended vaccine can be viewed, downloaded, and printed from CDC's National Immunization Program at <http://www.cdc.gov/nip/publications/acip-list.htm>. Instructions for reporting adverse events after vaccination to the Vaccine Adverse Event Reporting System (VAERS) are available at <http://www.vaers.org> or by telephone, 800-822-7967.

References

1. CDC. Prevention and control of influenza: recommendations of the Advisory Committee for Immunization Practices (ACIP). *MMWR* 2004;53(No. RR-6).
2. CDC. Interim influenza vaccination recommendations, 2004–05 influenza season. *MMWR* 2004;53:923–4.

The Recommended Adult Immunization Schedule has been approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians. The standard *MMWR* footnote format has been modified for publication of this schedule.

Suggested citation: Centers for Disease Control and Prevention. Recommended Adult Immunization Schedule—United States, October 2004–September 2005. *MMWR* 2004;53:Q1–4.

FIGURE 1. Recommended adult immunization schedule, by vaccine and age group — United States, October 2004–September 2005

Vaccine	Age group (yrs)		
	19–49	50–64	≥65
Tetanus, Diphtheria (Td)*	1 dose booster every 10 years ¹		
Influenza	1 dose annually ²		1 dose annually
Pneumococcal (polysaccharide)	1 dose ^{3,4}		1 dose ^{3,4}
Hepatitis B*	3 doses (0, 1–2, 4–6 mos) ⁵		
Hepatitis A*	2 doses (0, 6–12 mos) ⁶		
Measles, mumps, rubella (MMR)*	1 or 2 doses ⁷		
Varicella*	2 doses (0, 4–8 wks) ⁸		
Meningococcal (polysaccharide)	1 dose ⁹		

For all persons in this group
 For persons lacking documentation of vaccination or evidence of disease
 For persons at risk (i.e., with medical/exposure indications)

* Covered by the Vaccine Injury Compensation Program.

1. Tetanus and diphtheria (Td). Adults, including pregnant women with uncertain history of a complete primary vaccination series, should receive a primary series of Td. A primary series for adults is 3 doses; administer the first 2 doses at least 4 weeks apart and the 3rd dose 6–12 months after the second. Administer 1 dose if the person received the primary series and if the last vaccination was received ≥ 10 years previously. Consult recommendations for administering Td as prophylaxis in wound management (see *MMWR* 1991;40[No. RR-10]). The American College of Physicians Task Force on Adult Immunization supports a second option for Td use in adults: a single Td booster at age 50 years for persons who have completed the full pediatric series, including the teenage/young adult booster.

2. Influenza vaccination. The Advisory Committee on Immunization Practices (ACIP) recommends inactivated influenza vaccination for the following indications, when vaccine is available. *Medical indications:* chronic disorders of the cardiovascular or pulmonary systems, including asthma; chronic metabolic diseases, including diabetes mellitus, renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications or by human immunodeficiency virus [HIV]); and pregnancy during the influenza season. *Occupational indications:* health-care workers and employees of long-term-care and assisted living facilities. *Other indications:* residents of nursing homes and other long-term-care facilities; persons likely to transmit influenza to persons at high risk (i.e., in-home caregivers to persons with medical indications, household/close contacts and out-of-home caregivers of children aged 0–23 months,

household members and caregivers of elderly persons and adults with high-risk conditions); and anyone who wishes to be vaccinated. For healthy persons aged 5–49 years without high-risk conditions who are not contacts of severely immunocompromised persons in special care units, either the inactivated vaccine or the intranasally administered influenza vaccine (FluMist[®]) may be administered (see *MMWR* 2004;53[No. RR-6]). **Note:** Because of the vaccine shortage for the 2004–05 influenza season, CDC has recommended that vaccination be restricted to the following priority groups, which are considered to be of equal importance: all children aged 6–23 months; adults aged ≥ 65 years; persons aged 2–64 years with underlying chronic medical conditions; all women who will be pregnant during the influenza season; residents of nursing homes and long-term-care facilities; children aged 6 months–18 years on chronic aspirin therapy; health-care workers involved in direct patient care; and out-of-home caregivers and household contacts of children aged < 6 months. For the 2004–05 season, intranasally administered, live, attenuated influenza vaccine, if available, should be encouraged for healthy persons who are aged 5–49 years and are not pregnant, including health-care workers (except those who care for severely immunocompromised patients in special care units) and persons caring for children aged < 6 months (see *MMWR* 2004;53:923–4).

3. Pneumococcal polysaccharide vaccination. *Medical indications:* chronic disorders of the pulmonary system (excluding asthma); cardiovascular diseases; diabetes mellitus; chronic liver diseases, including liver disease as

This schedule indicates the recommended age groups for routine administration of currently licensed vaccines for persons aged ≥ 19 years. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. Providers should consult manufacturers' package inserts for detailed recommendations. Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available by telephone, 800-822-7967, or from the VAERS website at <http://www.vaers.org>.

Information on how to file a Vaccine Injury Compensation Program claim is available at <http://www.hrsa.gov/osp/vicp> or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, DC 20005, telephone 202-219-9657.

Additional information about the vaccines listed above and contraindications for immunization is available at <http://www.cdc.gov/nip> or from the National Immunization Hotline, 800-232-2522 (English) or 800-232-0233 (Spanish). Approved by the **Advisory Committee on Immunization Practices (ACIP)**, the **American College of Obstetricians and Gynecologists (ACOG)**, and the **American Academy of Family Physicians (AAFP)**.

FIGURE 2. Recommended adult immunization schedule, by vaccine and medical and other indications — United States, October 2004–September 2005

Vaccine	Indication						
	Pregnancy	Diabetes, heart disease, chronic pulmonary disease, chronic liver disease (including chronic alcoholism)	Congenital immunodeficiency, cochlear implants, leukemia, lymphoma, generalized malignancy, therapy with alkylating agents, antimetabolites, CSF [†] leaks, radiation, or large amounts of corticosteroids	Renal failure/end-stage renal disease, recipients of hemodialysis or clotting factor concentrates	Asplenia (including elective splenectomy and terminal complement deficiencies)	HIV [§] infection	Health-care workers
Tetanus, Diphtheria (Td)*,1	Yellow						Green
Influenza ²	Yellow	A, B	Yellow		C	Yellow	Green
Pneumococcal (polysaccharide) ^{3,4}	Purple	B	D	D, E, F		D, G	Purple
Hepatitis B*, ⁵	Purple			H	Purple	Yellow	Green
Hepatitis A*, ⁶	Purple						
Measles, mumps, rubella (MMR)*, ⁷	Red	Green	Red	Green		J	Green
Varicella*, ⁸	Red	Green	K	Green		Red	Green

For all persons in this group
 For persons lacking documentation of vaccination or evidence of disease
 For persons at risk (i.e., with medical/exposure indications)
 Contraindicated

* Covered by the Vaccine Injury Compensation Program.

[†] Cerebrospinal fluid.

[§] Human immunodeficiency virus.

Special Notes for Medical and Other Indications

- A. Although chronic liver disease and alcoholism are not indications for influenza vaccination, administer 1 dose annually if the patient is aged ≥ 50 years, has other indications for influenza vaccine, or requests vaccination.
- B. Asthma is an indication for influenza vaccination but not for pneumococcal vaccination.
- C. No data exist specifically on the risk for severe or complicated influenza infections among persons with asplenia. However, influenza is a risk factor for secondary bacterial infections that can cause severe disease among persons with asplenia.
- D. For persons aged < 65 years, revaccinate once after ≥ 5 years have elapsed since initial vaccination.
- E. Administer meningococcal vaccine and consider *Haemophilus influenzae* type b vaccine.
- F. For persons undergoing elective splenectomy, vaccinate ≥ 2 weeks before surgery.
- G. Vaccinate as soon after diagnosis as possible.
- H. For hemodialysis patients, use special formulation of vaccine (40 $\mu\text{g}/\text{mL}$) or two 20 $\mu\text{g}/\text{mL}$ doses administered at one body site. Vaccinate early in the course of renal disease. Assess antibody titers to hepatitis B surface antigen (anti-HB) levels annually. Administer additional doses if anti-HB levels decline to < 10 mIU/mL.
- I. For all persons with chronic liver disease.
- J. Withhold MMR or other measles-containing vaccines from HIV-infected persons with evidence of severe immunosuppression (see *MMWR* 1998;47[No. RR-8]:21–2 and *MMWR* 2002;51[No. RR-2]:22–4).
- K. Persons with impaired humoral immunity but intact cellular immunity may be vaccinated (see *MMWR* 1999;48[No. RR-6]).

a result of alcohol abuse (e.g., cirrhosis); chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy); immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection, leukemia, lymphoma, multiple myeloma, Hodgkins disease, generalized malignancy, or organ or bone marrow transplantation); chemotherapy with alkylating agents, antimetabolites, or long-term systemic corticosteroids; or cochlear implants. *Geographic/other indications:* Alaska Natives and certain American Indian populations. *Other indications:* residents of nursing homes and other long-term-care facilities (see *MMWR* 1997;46[No. RR-8] and *MMWR* 2003;52:739–40).

4. Revaccination with pneumococcal polysaccharide vaccine. One-time revaccination after 5 years for persons with chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy); immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection, leukemia, lymphoma, multiple myeloma, Hodgkins disease, generalized malignancy, or organ or bone marrow transplantation); or chemotherapy with alkylating agents, antimetabolites, or long-term systemic corticosteroids. For persons aged ≥ 65 years, one-time revaccination if they were vaccinated ≥ 5 years previously and were aged < 65 years at the time of primary vaccination (see *MMWR* 1997;46[No. RR-8]).

5. Hepatitis B vaccination. *Medical indications:* hemodialysis patients or patients who receive clotting factor concentrates. *Occupational indications:* health-care workers and public-safety workers who have exposure to blood in the workplace; and persons in training in schools of medicine, dentistry, nursing, laboratory technology, and other allied health professions. *Behavioral indications:* injection-drug users; persons with more than one sex partner during the previous 6 months; persons with a recently acquired sexually transmitted disease (STD); all clients in STD clinics; and men who have sex with men. *Other indications:* household contacts and sex partners of persons with chronic hepatitis B virus (HBV) infection; clients and staff members of institutions for the developmentally disabled; inmates of correctional facilities; or international travelers who will be in countries with high or intermediate prevalence of chronic HBV infection for >6 months (<http://www.cdc.gov/travel/diseases/hbv.htm>) (see *MMWR* 1991;40[No. RR-13]).

6. Hepatitis A vaccination. *Medical indications:* persons with clotting factor disorders or chronic liver disease. *Behavioral indications:* men who have sex with men or users of illegal drugs. *Occupational indications:* persons working with hepatitis A virus (HAV)-infected primates or with HAV in a research laboratory setting. *Other indications:* persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A. If the combined Hepatitis A and Hepatitis B vaccine is used, administer 3 doses at 0, 1, and 6 months (<http://www.cdc.gov/travel/diseases/hav.htm>) (see *MMWR* 1999;48[No. RR-12]).

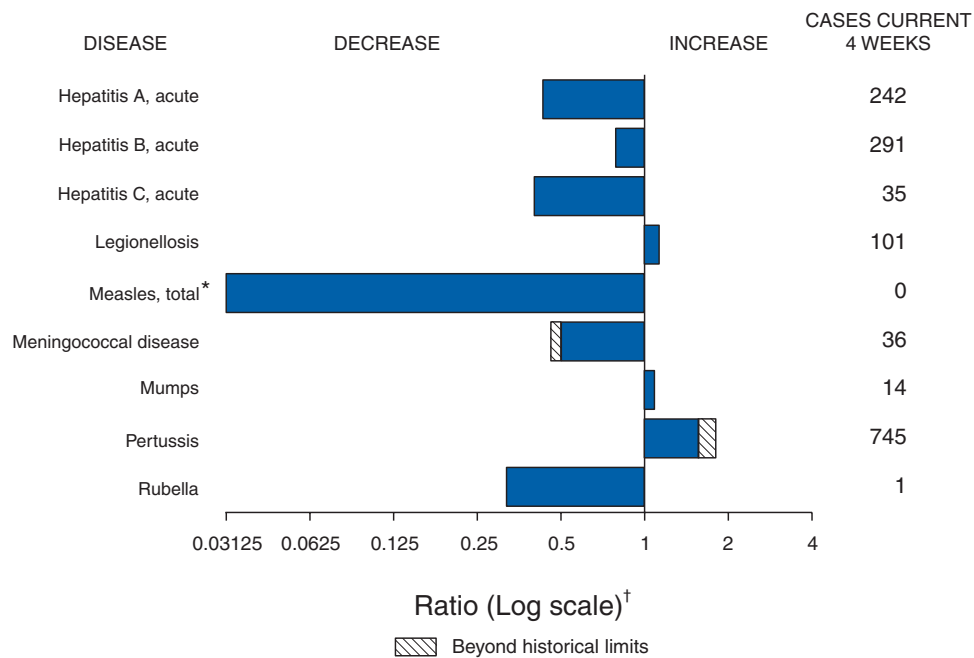
7. Measles, mumps, rubella (MMR) vaccination. *Measles component:* adults born before 1957 can be considered immune to measles. Adults born during or after 1957 should receive ≥ 1 dose of MMR unless they have a medical contraindication, documentation of ≥ 1 dose, or other acceptable evidence of immunity. A second dose of MMR is recommended for adults who 1) were recently exposed to measles or in an outbreak setting, 2) were previously vaccinated with killed measles vaccine, 3) were vaccinated with an unknown vaccine during 1963–1967, 4) are students in postsecondary educational institutions, 5) work in health-care facilities, or 6) plan to travel internationally. *Mumps component:* 1 dose of MMR vaccine should be adequate for protection. *Rubella component:* Administer 1 dose of MMR vaccine to women whose rubella vaccination history is unreliable and counsel women to avoid becoming pregnant for 4 weeks after vaccination. For women of childbearing age, regardless of birth year,

routinely determine rubella immunity and counsel women regarding congenital rubella syndrome. Do not vaccinate pregnant women or those planning to become pregnant during the next 4 weeks. For women who are pregnant and susceptible, vaccinate as early in the postpartum period as possible (see *MMWR* 1998;47[No. RR-8] and *MMWR* 2001;50:1117).

8. Varicella vaccination. Recommended for all persons lacking a reliable clinical history of varicella infection or serologic evidence of varicella zoster virus (VZV) infection who might be at high risk for exposure or transmission. This includes health-care workers and family contacts of immunocompromised persons; persons who live or work in environments where transmission is likely (e.g., teachers of young children, child care employees, and residents and staff members in institutional settings); persons who live or work in environments where VZV transmission can occur (e.g., college students, inmates, and staff members of correctional institutions, and military personnel); adolescents aged 11–18 years and adults living in households with children; women who are not pregnant but who might become pregnant; and international travelers who are not immune to infection. **Note:** Approximately 95% of U.S.-born adults are immune to VZV. Do not vaccinate pregnant women or those planning to become pregnant during the next 4 weeks. For women who are pregnant and susceptible, vaccinate as early in the postpartum period as possible (see *MMWR* 1999;48[No. RR-6]).

9. Meningococcal vaccine (quadrivalent polysaccharide for serogroups A, C, Y, and W 135). *Medical indications:* adults with terminal complement component deficiencies or those with anatomic or functional asplenia. *Other indications:* travelers to countries in which meningococcal disease is hyperendemic or epidemic (e.g., the “meningitis belt” of sub-Saharan Africa and Mecca, Saudi Arabia). Revaccination after 3–5 years might be indicated for persons at high risk for infection (e.g., persons residing in areas where disease is epidemic). Counsel college freshmen, especially those who live in dormitories, regarding meningococcal disease and availability of the vaccine to enable them to make an educated decision about receiving the vaccination (see *MMWR* 2000;49[No. RR-7]). The American Academy of Family Physicians recommends that colleges should take the lead on providing education on meningococcal infection and availability of vaccination and offer it to students who are interested. Physicians need not initiate discussion of meningococcal quadrivalent polysaccharide vaccine as part of routine medical care.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals November 13, 2004, with historical data



* No measles cases were reported for the current 4-week period yielding a ratio for week 45 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 November 13, 2004 (45th Week)*

	Cum. 2004	Cum. 2003		Cum. 2004	Cum. 2003
Anthrax	-	-	HIV infection, pediatric ^{¶¶}	140	179
Botulism:	-	-	Influenza-associated pediatric mortality ^{**}	-	NA
foodborne	11	11	Measles, total	23 ^{††}	52 ^{§§}
infant	61	62	Mumps	187	189
other (wound & unspecified)	9	26	Plague	1	1
Brucellosis [†]	95	86	Poliomyelitis, paralytic	-	-
Chancroid	33	51	Psittacosis [†]	9	12
Cholera	4	1	Q fever [†]	62	59
Cyclosporiosis [†]	206	63	Rabies, human	3	2
Diphtheria	-	1	Rubella	11	7
Ehrlichiosis:	-	-	Rubella, congenital syndrome	-	1
human granulocytic (HGE) [†]	289	290	SARS-associated coronavirus disease ^{† **}	-	8
human monocytic (HME) [†]	266	240	Smallpox ^{† ¶¶}	-	NA
human, other and unspecified	30	39	<i>Staphylococcus aureus</i> :	-	-
Encephalitis/Meningitis:	-	-	Vancomycin-intermediate (VISA) ^{† ¶¶}	-	NA
California serogroup viral ^{† §}	78	108	Vancomycin-resistant (VRSA) ^{† ¶¶}	1	NA
eastern equine ^{† §}	4	13	Streptococcal toxic-shock syndrome [†]	90	141
Powassan ^{† §}	-	-	Tetanus	15	17
St. Louis ^{† §}	8	40	Toxic-shock syndrome	109	107
western equine ^{† §}	-	-	Trichinosis	4	3
Hansen disease (leprosy) [†]	70	70	Tularemia [†]	78	79
Hantavirus pulmonary syndrome [†]	17	19	Yellow fever	-	-
Hemolytic uremic syndrome, postdiarrheal [†]	125	154			

-: No reported cases.

* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

† Not notifiable in all states.

§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).

¶ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update October 24, 2004.

** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.

†† Of 23 cases reported, 10 were indigenous, and 13 were imported from another country.

§§ Of 52 cases reported, 31 were indigenous, and 21 were imported from another country.

¶¶ Not previously notifiable.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending November 13, 2004, and November 8, 2003 (45th Week)*

Reporting area	AIDS		Chlamydia [†]		Coccidiomycosis		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	34,915	38,111	754,264	747,021	5,109	3,345	2,921	3,001	823	2,849
NEW ENGLAND	1,149	1,276	25,700	24,025	-	-	155	170	-	30
Maine	23	49	1,805	1,711	N	N	18	18	-	-
N.H.	41	34	1,521	1,358	-	-	30	20	-	2
Vt.	14	15	890	928	-	-	23	29	-	-
Mass.	435	518	11,594	9,579	-	-	53	73	-	12
R.I.	115	89	2,895	2,565	-	-	4	15	-	5
Conn.	521	571	6,995	7,884	N	N	27	15	-	11
MID. ATLANTIC	7,373	8,995	92,314	92,709	-	-	477	380	17	223
Upstate N.Y.	792	825	19,212	17,210	N	N	165	112	5	-
N.Y. City	4,086	4,987	28,684	30,109	-	-	97	108	2	57
N.J.	1,230	1,362	12,881	13,768	-	-	30	16	1	21
Pa.	1,265	1,821	31,537	31,622	N	N	185	144	9	145
E.N. CENTRAL	2,858	3,543	129,724	136,418	15	7	819	900	59	150
Ohio	561	717	31,294	37,001	N	N	207	135	11	84
Ind.	339	482	15,850	14,779	N	N	80	87	5	15
Ill.	1,279	1,597	35,364	41,636	-	-	77	93	28	30
Mich.	537	584	31,959	27,696	15	7	143	126	11	14
Wis.	142	163	15,257	15,306	-	-	312	459	4	7
W.N. CENTRAL	727	687	45,878	43,280	5	2	358	533	80	696
Minn.	193	140	8,719	9,240	N	N	118	141	13	48
Iowa	58	75	5,293	4,348	N	N	80	114	11	81
Mo.	307	320	17,879	15,853	3	1	65	43	26	39
N. Dak.	15	3	1,285	1,388	N	N	10	12	2	94
S. Dak.	8	10	2,238	2,251	-	-	37	38	6	151
Nebr.**	41	49	4,260	4,051	2	1	23	23	4	194
Kans.	105	90	6,204	6,149	N	N	25	162	18	89
S. ATLANTIC	11,003	10,557	147,743	140,991	-	5	478	331	56	187
Del.	137	192	2,526	2,613	N	N	-	4	-	12
Md.	1,292	1,281	16,226	14,259	-	5	17	23	7	49
D.C.	785	858	2,875	2,722	-	-	12	12	1	3
Va.	567	813	18,550	16,866	-	-	57	40	4	19
W. Va.	73	78	2,435	2,252	N	N	6	4	-	1
N.C.	1,031	989	24,942	22,771	N	N	72	44	3	16
S.C.**	641	713	17,374	12,409	-	-	15	8	-	3
Ga.	1,407	1,665	26,585	30,812	-	-	181	101	12	26
Fla.	5,070	3,968	36,230	36,287	N	N	118	95	29	58
E.S. CENTRAL	1,654	1,699	48,613	47,985	4	1	114	122	50	90
Ky.	215	175	5,059	7,066	N	N	42	22	1	11
Tenn.**	684	733	19,288	17,661	N	N	29	38	13	21
Ala.	388	391	9,675	12,570	-	-	20	52	13	25
Miss.	367	400	14,591	10,688	4	1	23	10	23	33
W.S. CENTRAL	4,027	4,058	91,798	91,629	2	-	68	107	179	600
Ark.	182	164	6,330	6,904	1	-	16	17	12	23
La.	812	520	19,227	17,276	1	-	3	4	68	94
Okla.	173	177	9,116	9,900	N	N	20	16	10	56
Tex.**	2,860	3,197	57,125	57,549	N	N	29	70	89	427
MOUNTAIN	1,294	1,327	42,098	41,767	3,249	2,006	152	122	232	871
Mont.	6	13	2,001	1,728	N	N	34	18	2	75
Idaho	16	22	2,380	2,159	N	N	26	26	-	-
Wyo.	15	6	917	834	2	1	3	5	2	92
Colo.	288	327	10,491	11,269	N	N	53	33	39	621
N. Mex.	169	98	4,333	6,346	20	9	12	10	30	74
Ariz.	496	576	14,087	11,273	3,137	1,954	17	6	128	7
Utah	55	60	3,145	3,217	34	8	5	17	6	-
Nev.	249	225	4,744	4,941	56	34	2	7	25	2
PACIFIC	4,830	5,969	130,396	128,217	1,834	1,324	300	336	150	2
Wash.	352	420	15,267	14,332	N	N	36	43	-	-
Oreg.	250	229	7,248	6,462	-	-	31	36	-	-
Calif.	4,061	5,214	100,239	99,442	1,834	1,324	231	256	150	2
Alaska	51	18	3,203	3,273	-	-	-	1	-	-
Hawaii	116	88	4,439	4,708	-	-	2	-	-	-
Guam	2	5	-	527	-	-	-	-	-	-
P.R.	617	940	2,923	2,344	N	N	N	N	-	-
V.I.	17	31	272	367	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	32	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 weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).

[¶] Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update October 31, 2004.

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending November 13, 2004, and November 8, 2003 (45th Week)*

Reporting area	<i>Escherichia coli</i> , 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	2,135	2,344	235	220	151	137	15,631	16,602	267,958	285,927
NEW ENGLAND	141	136	46	39	16	13	1,493	1,396	5,936	6,285
Maine	10	10	-	1	-	-	112	164	191	186
N.H.	21	17	5	3	-	-	41	36	112	108
Vt.	12	15	-	-	-	-	150	110	76	77
Mass.	58	60	15	8	16	13	645	708	2,708	2,505
R.I.	9	1	1	-	-	-	107	95	729	831
Conn.	31	33	25	27	-	-	438	283	2,120	2,578
MID. ATLANTIC	250	228	50	22	29	33	3,274	3,302	29,906	35,581
Upstate N.Y.	114	84	35	11	14	17	1,175	911	6,245	6,742
N.Y. City	34	7	-	-	-	-	846	1,055	9,242	11,785
N.J.	38	31	4	2	5	-	356	444	5,142	6,974
Pa.	64	106	11	9	10	16	897	892	9,277	10,080
E.N. CENTRAL	384	535	37	30	28	17	2,123	2,846	55,064	61,006
Ohio	90	125	10	16	21	17	707	791	16,190	19,514
Ind.	51	75	-	-	-	-	-	-	5,848	5,780
Ill.	58	117	2	2	1	-	384	830	15,606	18,755
Mich.	77	87	8	-	6	-	646	671	13,481	12,078
Wis.	108	131	17	12	-	-	386	554	3,939	4,879
W.N. CENTRAL	451	419	29	51	16	20	1,807	1,830	14,509	15,132
Minn.	107	126	15	21	1	1	674	696	2,623	2,629
Iowa	121	97	-	-	-	-	267	243	938	1,066
Mo.	81	77	11	17	7	1	479	452	7,638	7,556
N. Dak.	14	13	-	4	6	8	21	36	87	85
S. Dak.	31	27	2	4	-	-	58	70	253	193
Nebr.	60	48	1	5	-	-	117	130	861	1,340
Kans.	37	31	-	-	2	10	191	203	2,109	2,263
S. ATLANTIC	154	131	39	42	51	38	2,424	2,373	66,847	70,251
Del.	2	9	N	N	N	N	39	41	766	1,001
Md.	20	12	5	3	4	1	114	102	6,974	6,747
D.C.	1	1	-	-	-	-	60	44	2,164	2,160
Va.	35	35	16	11	-	-	469	312	7,405	7,821
W. Va.	2	5	-	-	-	-	34	37	799	754
N.C.	-	-	-	-	35	30	N	N	12,946	13,126
S.C.	7	2	-	-	-	-	51	128	8,478	7,262
Ga.	23	26	11	7	-	-	702	754	11,709	15,289
Fla.	64	41	7	21	12	7	955	955	15,606	16,091
E.S. CENTRAL	80	76	4	2	9	6	329	352	21,225	24,126
Ky.	24	25	2	2	6	6	N	N	2,302	3,143
Tenn.	31	33	2	-	3	-	157	164	7,343	7,365
Ala.	18	14	-	-	-	-	172	188	5,926	8,092
Miss.	7	4	-	-	-	-	-	-	5,654	5,526
W.S. CENTRAL	66	84	2	4	2	4	281	269	35,714	37,923
Ark.	14	10	1	-	-	-	111	135	3,174	3,673
La.	4	3	-	-	-	-	41	11	9,074	9,990
Okla.	17	26	-	-	-	-	129	123	3,879	4,087
Tex.	31	45	1	4	2	4	N	N	19,587	20,173
MOUNTAIN	228	288	27	26	-	6	1,336	1,403	9,171	8,992
Mont.	16	16	-	-	-	-	73	95	60	99
Idaho	49	76	16	15	-	-	166	179	81	65
Wyo.	9	3	3	1	-	-	22	20	55	39
Colo.	50	64	2	4	-	6	462	400	2,298	2,474
N. Mex.	9	10	2	5	-	-	62	46	603	1,022
Ariz.	23	33	N	N	N	N	158	219	3,419	3,130
Utah	48	63	3	-	-	-	287	315	485	339
Nev.	24	23	1	1	-	-	106	129	2,170	1,824
PACIFIC	381	447	1	4	-	-	2,564	2,831	29,586	26,631
Wash.	134	105	-	1	-	-	336	324	2,361	2,389
Oreg.	66	98	1	3	-	-	411	369	1,092	863
Calif.	170	232	-	-	-	-	1,669	1,986	24,617	21,845
Alaska	1	4	-	-	-	-	80	77	463	482
Hawaii	10	8	-	-	-	-	68	75	1,053	1,052
Guam	N	N	-	-	-	-	-	2	-	59
P.R.	1	1	-	-	-	-	119	287	214	241
V.I.	-	-	-	-	-	-	-	-	80	79
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	3	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 November 13, 2004, and November 8, 2003 (45th Week)*

Reporting area	<i>Haemophilus influenzae</i> , invasive								Hepatitis (viral, acute), by type	
	All ages		Age <5 years						A	
	All serotypes		Serotype b		Non-serotype b		Unknown serotype			
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	1,578	1,598	13	25	91	98	152	174	4,825	6,274
NEW ENGLAND	137	119	1	2	6	5	3	3	887	284
Maine	12	4	-	-	-	-	-	1	11	13
N.H.	17	12	-	1	2	-	-	-	25	16
Vt.	8	8	-	-	-	-	1	-	8	6
Mass.	52	57	1	1	-	5	2	1	761	159
R.I.	6	6	-	-	1	-	-	1	21	14
Conn.	42	32	-	-	3	-	-	-	61	76
MID. ATLANTIC	341	339	1	3	4	3	39	42	602	1,364
Upstate N.Y.	109	121	1	3	4	3	6	8	95	118
N.Y. City	72	60	-	-	-	-	14	11	235	403
N.J.	66	63	-	-	-	-	4	10	129	190
Pa.	94	95	-	-	-	-	15	13	143	653
E.N. CENTRAL	231	268	-	3	6	5	35	47	482	563
Ohio	89	63	-	-	2	-	15	11	44	104
Ind.	41	42	-	-	4	-	1	5	93	61
Ill.	50	97	-	-	-	-	11	21	161	166
Mich.	19	22	-	3	-	5	6	1	133	188
Wis.	32	44	-	-	-	-	2	9	51	44
W.N. CENTRAL	93	102	2	2	3	7	10	12	154	150
Minn.	40	44	1	2	3	7	1	2	32	37
Iowa	1	-	1	-	-	-	-	-	48	25
Mo.	33	36	-	-	-	-	6	9	38	50
N. Dak.	4	4	-	-	-	-	-	-	1	1
S. Dak.	-	1	-	-	-	-	-	-	3	-
Nebr.	8	2	-	-	-	-	1	-	10	12
Kans.	7	15	-	-	-	-	2	1	22	25
S. ATLANTIC	391	355	1	2	21	16	30	21	932	1,541
Del.	-	-	-	-	-	-	-	-	5	8
Md.	53	84	-	1	4	7	-	1	100	163
D.C.	-	1	-	-	-	-	-	-	7	38
Va.	35	49	-	-	-	-	1	6	119	92
W. Va.	15	15	-	-	1	-	3	-	6	13
N.C.	54	36	1	-	6	3	1	2	99	98
S.C.	4	6	-	-	-	-	-	2	24	35
Ga.	127	65	-	-	-	-	22	6	317	724
Fla.	103	99	-	1	10	6	3	4	255	370
E.S. CENTRAL	59	72	1	1	-	3	8	8	140	247
Ky.	5	6	-	-	-	2	-	-	29	29
Tenn.	38	43	-	-	-	1	6	5	80	180
Ala.	13	21	1	1	-	-	2	3	8	23
Miss.	3	2	-	-	-	-	-	-	23	15
W.S. CENTRAL	64	71	1	2	7	10	2	4	331	598
Ark.	3	6	-	-	-	1	1	-	56	30
La.	11	20	-	-	-	2	1	4	49	43
Okla.	49	42	-	-	7	7	-	-	19	18
Tex.	1	3	1	2	-	-	-	-	207	507
MOUNTAIN	171	141	4	6	25	22	18	16	399	416
Mont.	-	-	-	-	-	-	-	-	6	8
Idaho	5	4	-	-	-	-	2	1	19	15
Wyo.	1	1	-	-	1	-	-	-	5	1
Colo.	42	34	-	-	-	-	5	6	47	62
N. Mex.	34	16	1	-	7	4	5	1	20	20
Ariz.	61	64	-	6	12	9	2	4	242	228
Utah	15	12	2	-	2	5	3	4	47	35
Nev.	13	10	1	-	3	4	1	-	13	47
PACIFIC	91	131	2	4	19	27	7	21	898	1,111
Wash.	3	11	2	-	-	7	1	3	55	60
Oreg.	42	34	-	-	-	-	3	3	61	53
Calif.	34	56	-	4	19	20	1	9	755	978
Alaska	4	19	-	-	-	-	1	6	5	8
Hawaii	8	11	-	-	-	-	1	-	22	12
Guam	-	-	-	-	-	-	-	-	-	2
P.R.	-	1	-	-	-	-	-	1	24	74
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 November 13, 2004, and November 8, 2003 (45th 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	5,515	6,089	738	923	1,618	1,871	570	587	15,676	18,218
NEW ENGLAND	319	315	11	8	53	108	39	46	2,394	3,572
Maine	2	1	-	-	-	2	7	7	53	142
N.H.	36	16	-	-	10	9	3	4	197	155
Vt.	5	4	6	8	5	6	2	1	46	41
Mass.	185	199	4	-	8	54	11	17	850	1,475
R.I.	5	13	-	-	15	14	1	-	189	529
Conn.	86	82	1	-	15	23	15	17	1,059	1,230
MID. ATLANTIC	1,098	665	131	110	469	542	133	119	10,513	12,037
Upstate N.Y.	82	82	15	13	101	134	44	31	3,568	3,994
N.Y. City	98	170	-	-	47	64	17	22	-	196
N.J.	657	164	-	-	91	79	23	22	2,986	2,726
Pa.	261	249	116	97	230	265	49	44	3,959	5,121
E.N. CENTRAL	480	455	107	130	428	394	88	78	800	882
Ohio	104	123	6	9	200	203	38	22	66	65
Ind.	38	33	7	8	67	27	16	8	16	21
Ill.	71	62	12	18	20	43	5	20	1	70
Mich.	235	194	82	90	126	103	26	19	31	7
Wis.	32	43	-	5	15	18	3	9	686	719
W.N. CENTRAL	280	284	44	216	45	61	16	15	533	374
Minn.	46	31	17	8	7	3	5	4	430	253
Iowa	14	11	-	1	5	9	2	-	43	49
Mo.	169	196	27	205	23	31	6	6	49	65
N. Dak.	4	2	-	-	2	1	-	-	-	-
S. Dak.	-	2	-	-	4	2	1	-	-	1
Nebr.	33	26	-	2	1	5	2	4	7	2
Kans.	14	16	-	-	3	10	-	1	4	4
S. ATLANTIC	1,679	1,755	147	133	347	471	102	115	1,242	1,095
Del.	28	10	-	-	12	25	N	N	137	191
Md.	145	116	15	8	69	118	15	23	717	645
D.C.	19	10	3	-	8	17	-	1	9	8
Va.	237	158	16	7	47	88	17	9	162	82
W. Va.	34	29	23	4	9	16	4	6	23	22
N.C.	153	148	11	11	35	36	22	16	112	95
S.C.	65	145	6	24	3	7	3	4	12	8
Ga.	556	593	17	13	39	33	16	29	13	10
Fla.	442	546	56	66	125	131	25	27	57	34
E.S. CENTRAL	383	408	86	75	82	94	21	29	44	59
Ky.	61	65	23	15	35	38	4	8	15	15
Tenn.	174	174	35	18	33	32	10	8	17	15
Ala.	62	88	4	6	11	19	5	11	3	8
Miss.	86	81	24	36	3	5	2	2	9	21
W.S. CENTRAL	263	966	109	144	56	69	27	48	34	89
Ark.	67	73	2	3	-	2	2	1	8	-
La.	58	109	63	95	4	1	3	4	4	6
Okla.	47	52	3	2	5	7	-	3	-	-
Tex.	91	732	41	44	47	59	22	40	22	83
MOUNTAIN	435	496	34	45	75	60	25	31	29	14
Mont.	2	16	2	2	2	4	-	2	-	-
Idaho	10	7	-	1	9	3	1	2	6	3
Wyo.	7	29	2	-	5	2	-	-	3	2
Colo.	55	69	-	11	18	9	12	9	-	-
N. Mex.	12	32	7	-	4	3	1	2	1	1
Ariz.	239	225	5	7	11	11	-	10	6	3
Utah	44	43	5	-	22	20	3	2	13	2
Nev.	66	75	13	24	4	8	8	4	-	3
PACIFIC	578	745	69	62	63	72	119	106	87	96
Wash.	45	66	21	18	10	10	9	7	13	3
Oreg.	99	98	14	13	N	N	6	4	32	14
Calif.	409	555	28	29	52	61	100	90	40	76
Alaska	15	5	-	-	1	-	-	-	2	3
Hawaii	10	21	6	2	-	1	4	5	N	N
Guam	-	9	-	5	-	-	-	-	-	-
P.R.	50	116	-	-	1	-	-	-	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 November 13, 2004, and November 8, 2003 (45th 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	1,121	1,166	1,109	1,428	13,021	7,989	4,910	6,146	1,314	824
NEW ENGLAND	67	59	61	67	1,415	1,320	587	534	18	8
Maine	6	2	9	6	2	12	39	63	-	-
N.H.	5	6	7	4	83	90	27	24	-	-
Vt.	4	2	3	3	63	60	33	30	-	-
Mass.	34	29	33	41	1,224	1,080	260	190	15	8
R.I.	4	2	2	2	31	17	34	62	1	-
Conn.	14	18	7	11	12	61	194	165	2	-
MID. ATLANTIC	285	315	133	173	2,463	978	509	819	88	40
Upstate N.Y.	41	48	31	43	1,685	460	469	380	4	-
N.Y. City	146	170	24	39	154	130	11	6	20	13
N.J.	54	59	31	23	206	146	-	62	33	16
Pa.	44	38	47	68	418	242	29	371	31	11
E.N. CENTRAL	94	99	151	226	3,056	897	149	162	26	19
Ohio	28	19	61	53	509	237	72	51	14	8
Ind.	14	4	23	39	212	60	10	27	5	1
Ill.	22	42	12	67	351	81	47	24	2	5
Mich.	20	23	44	40	268	106	16	46	5	5
Wis.	10	11	11	27	1,716	413	4	14	-	-
W.N. CENTRAL	62	44	80	115	1,639	398	449	597	113	62
Minn.	25	20	22	26	314	141	81	36	3	1
Iowa	4	5	16	24	157	126	100	97	1	2
Mo.	19	6	19	45	277	72	57	40	93	49
N. Dak.	3	1	2	1	702	7	55	53	-	-
S. Dak.	1	3	2	1	43	3	10	124	4	5
Nebr.	3	-	4	7	43	11	53	94	12	4
Kans.	7	9	15	11	103	38	93	153	-	1
S. ATLANTIC	303	287	198	240	602	589	1,737	2,389	684	478
Del.	6	2	3	8	8	9	9	57	4	1
Md.	67	66	10	24	107	76	281	318	66	101
D.C.	13	13	4	5	4	3	-	-	-	1
Va.	48	34	19	24	196	91	430	470	30	30
W. Va.	2	4	5	5	18	18	59	79	4	5
N.C.	19	21	28	32	79	118	535	716	477	234
S.C.	9	4	11	21	42	146	125	210	17	33
Ga.	55	63	21	28	32	29	290	351	66	64
Fla.	84	80	97	93	116	99	8	188	20	9
E.S. CENTRAL	28	27	56	78	249	140	129	201	171	119
Ky.	4	8	11	17	65	45	21	37	2	2
Tenn.	7	5	15	23	135	63	36	100	88	63
Ala.	12	7	15	20	35	18	61	60	47	21
Miss.	5	7	15	18	14	14	11	4	34	33
W.S. CENTRAL	92	118	102	158	691	673	979	1,058	184	88
Ark.	7	4	16	14	63	43	46	25	105	31
La.	5	4	34	37	11	10	-	2	5	1
Okla.	7	4	9	15	33	78	96	181	71	42
Tex.	73	106	43	92	584	542	837	850	3	14
MOUNTAIN	45	38	58	77	1,388	830	202	170	25	9
Mont.	-	-	3	5	51	5	25	20	3	1
Idaho	1	1	7	7	36	72	7	15	4	2
Wyo.	-	1	3	2	28	124	6	6	5	2
Colo.	15	21	14	22	747	296	43	38	1	2
N. Mex.	3	3	7	9	130	65	5	5	2	1
Ariz.	13	7	12	23	200	118	105	67	2	-
Utah	8	4	5	1	158	116	8	14	8	1
Nev.	5	1	7	8	38	34	3	5	-	-
PACIFIC	145	179	270	294	1,518	2,164	169	216	5	1
Wash.	16	24	30	30	655	672	-	-	-	-
Oreg.	16	9	54	51	400	409	6	6	3	-
Calif.	108	139	177	194	430	1,007	155	201	2	1
Alaska	2	1	3	7	11	66	8	9	-	-
Hawaii	3	6	6	12	22	10	-	-	-	-
Guam	-	1	-	-	-	1	-	-	-	-
P.R.	-	2	8	9	6	4	56	65	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 November 13, 2004, and November 8, 2003 (45th Week)*

Reporting area	Salmonellosis		Shigellosis		Streptococcal disease, invasive, group A		<i>Streptococcus pneumoniae</i> , invasive			
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Drug resistant, all ages		Age <5 years	
							Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	34,918	37,659	10,424	20,285	4,038	4,924	1,878	1,728	596	607
NEW ENGLAND	1,779	1,875	256	296	159	419	54	88	59	8
Maine	79	116	4	6	8	27	2	-	3	-
N.H.	124	129	8	8	17	29	-	-	N	N
Vt.	55	65	3	7	8	19	7	6	3	4
Mass.	1,020	1,096	162	200	105	183	28	N	46	N
R.I.	107	114	18	14	21	14	17	10	7	4
Conn.	394	355	61	61	-	147	-	72	U	U
MID. ATLANTIC	4,860	4,325	1,011	2,091	631	853	117	113	107	86
Upstate N.Y.	1,096	1,009	385	451	209	322	51	61	76	65
N.Y. City	1,072	1,203	328	363	90	131	U	U	U	U
N.J.	854	717	209	323	143	160	-	-	6	2
Pa.	1,838	1,396	89	954	189	240	66	52	25	19
E.N. CENTRAL	4,317	5,030	952	1,647	766	1,155	416	379	139	268
Ohio	1,140	1,214	152	269	202	269	293	245	67	85
Ind.	531	499	189	148	88	110	123	134	34	26
Ill.	1,168	1,764	278	890	161	298	-	-	-	108
Mich.	769	701	183	226	266	330	N	N	N	N
Wis.	709	852	150	114	49	148	N	N	38	49
W.N. CENTRAL	2,093	2,203	368	710	270	303	17	17	92	66
Minn.	537	486	62	93	131	145	-	-	59	45
Iowa	392	347	61	73	N	N	N	N	N	N
Mo.	549	812	141	334	57	68	12	13	13	3
N. Dak.	41	36	3	7	11	16	-	3	4	7
S. Dak.	112	105	10	16	17	22	5	1	-	-
Nebr.	130	150	22	86	14	25	-	-	6	5
Kans.	332	267	69	101	40	27	N	N	10	6
S. ATLANTIC	9,787	9,487	2,389	6,022	870	813	970	927	50	18
Del.	81	93	6	161	3	6	4	1	N	N
Md.	729	763	134	535	146	200	-	21	37	-
D.C.	57	39	35	69	10	8	5	-	3	7
Va.	1,094	937	148	396	67	93	N	N	N	N
W. Va.	200	117	8	-	22	31	97	64	10	11
N.C.	1,432	1,193	310	883	118	93	N	N	U	U
S.C.	765	653	275	435	37	38	69	126	N	N
Ga.	1,746	1,816	618	1,078	264	162	283	207	N	N
Fla.	3,683	3,876	855	2,465	203	182	512	508	N	N
E.S. CENTRAL	2,266	2,613	697	870	189	173	120	125	5	-
Ky.	307	350	65	120	57	41	26	16	N	N
Tenn.	522	677	327	299	132	132	93	109	N	N
Ala.	653	664	259	287	-	-	-	-	N	N
Miss.	784	922	46	164	-	-	1	-	5	-
W.S. CENTRAL	2,934	5,515	2,353	5,221	224	250	54	68	106	98
Ark.	505	740	69	99	16	6	8	20	8	7
La.	697	796	250	422	2	1	46	48	24	19
Okla.	360	426	408	754	60	79	N	N	39	48
Tex.	1,372	3,553	1,626	3,946	146	164	N	N	35	24
MOUNTAIN	2,131	1,962	736	1,090	440	403	35	7	38	63
Mont.	177	96	4	2	-	1	-	-	-	-
Idaho	140	159	13	29	8	18	N	N	N	N
Wyo.	49	73	5	8	8	2	10	6	-	-
Colo.	489	441	142	290	117	118	-	-	35	47
N. Mex.	243	245	114	229	70	99	5	-	-	11
Ariz.	664	587	363	427	196	132	N	N	N	N
Utah	220	198	44	44	38	31	18	1	3	5
Nev.	149	163	51	61	3	2	2	-	-	-
PACIFIC	4,751	4,649	1,662	2,338	489	555	95	4	-	-
Wash.	511	505	99	149	53	56	-	-	N	N
Oreg.	377	375	69	202	N	N	N	N	N	N
Calif.	3,482	3,509	1,445	1,934	327	381	N	N	N	N
Alaska	53	64	6	10	-	-	-	-	N	N
Hawaii	328	196	43	43	109	118	95	4	-	-
Guam	-	40	-	33	-	-	-	-	-	-
P.R.	268	631	8	27	N	N	N	N	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	3	U	-	U	-	U	-	U	-	U

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

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TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending November 13, 2004, and November 8, 2003 (45th Week)*

Reporting area	Syphilis				Tuberculosis		Typhoid fever		Varicella (Chickenpox)	
	Primary & secondary		Congenital		Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003						
UNITED STATES	6,385	6,086	295	382	8,988	10,733	253	315	15,428	14,337
NEW ENGLAND	161	186	5	1	316	365	19	26	607	2,844
Maine	2	7	-	-	-	19	-	-	180	769
N.H.	4	16	3	-	14	11	-	2	-	-
Vt.	-	1	-	-	-	9	-	-	427	651
Mass.	104	118	-	-	211	193	13	15	-	147
R.I.	21	20	1	-	29	43	1	2	-	5
Conn.	30	24	1	1	62	90	5	7	-	1,272
MID. ATLANTIC	836	747	39	59	1,781	1,910	58	72	77	36
Upstate N.Y.	84	34	6	9	226	249	8	12	-	-
N.Y. City	518	427	13	31	899	980	20	34	-	-
N.J.	127	151	19	19	373	376	15	21	-	-
Pa.	107	135	1	-	283	305	15	5	77	36
E.N. CENTRAL	730	787	55	68	1,015	990	17	32	5,046	4,937
Ohio	195	177	1	3	175	171	5	2	1,191	1,057
Ind.	50	39	9	12	112	113	-	4	-	-
Ill.	296	331	14	20	457	477	-	16	-	-
Mich.	160	225	31	32	194	175	10	10	3,463	3,051
Wis.	29	15	-	1	77	54	2	-	392	829
W.N. CENTRAL	133	132	5	4	371	404	9	6	130	52
Minn.	15	40	1	-	148	164	5	2	-	-
Iowa	5	8	-	-	33	30	-	2	N	N
Mo.	86	52	2	4	94	100	2	1	5	-
N. Dak.	-	2	-	-	4	-	-	-	82	52
S. Dak.	-	2	-	-	8	16	-	-	43	-
Nebr.	5	5	-	-	27	24	2	1	-	-
Kans.	22	23	2	-	57	70	-	-	-	-
S. ATLANTIC	1,664	1,601	45	75	1,612	2,139	42	46	1,941	1,909
Del.	8	6	-	-	-	23	-	-	4	29
Md.	301	272	7	12	203	210	11	9	-	1
D.C.	74	43	1	-	68	-	-	-	21	27
Va.	89	72	3	1	223	223	8	14	487	478
W. Va.	2	2	-	-	17	19	-	-	1,175	1,144
N.C.	168	138	10	16	244	285	7	9	N	N
S.C.	101	88	7	13	158	145	-	-	254	230
Ga.	283	419	1	13	11	446	6	5	-	-
Fla.	638	561	16	20	688	788	10	9	-	-
E. S. CENTRAL	346	285	19	12	482	595	7	6	-	-
Ky.	42	31	1	1	101	103	3	1	-	-
Tenn.	115	119	8	2	195	198	4	2	-	-
Ala.	142	104	8	7	153	197	-	3	-	-
Miss.	47	31	2	2	33	97	-	-	-	-
W. S. CENTRAL	1,041	811	48	70	925	1,578	19	30	5,388	4,032
Ark.	38	45	-	2	98	78	-	-	-	-
La.	243	148	-	1	-	-	-	-	47	16
Okla.	24	57	2	1	135	129	1	1	-	-
Tex.	736	561	46	66	692	1,371	18	29	5,341	4,016
MOUNTAIN	309	278	48	30	420	391	7	6	2,239	527
Mont.	-	-	-	-	4	5	-	-	-	-
Idaho	21	10	2	2	4	8	-	1	-	-
Wyo.	3	-	-	-	4	4	-	-	45	45
Colo.	37	32	-	3	86	89	2	3	1,716	-
N. Mex.	46	56	1	7	18	41	-	-	87	3
Ariz.	161	163	45	18	189	189	2	2	-	-
Utah	7	7	-	-	35	33	1	-	391	479
Nev.	34	10	-	-	80	22	2	-	-	-
PACIFIC	1,165	1,259	31	63	2,066	2,361	75	91	-	-
Wash.	119	69	-	-	196	211	6	3	-	-
Oreg.	25	40	-	-	74	93	2	4	-	-
Calif.	1,014	1,143	30	61	1,665	1,910	61	83	-	-
Alaska	1	1	-	-	34	49	-	-	-	-
Hawaii	6	6	1	2	97	98	6	1	-	-
Guam	-	1	-	-	-	48	-	-	-	131
P.R.	141	182	5	14	84	95	-	-	265	522
V.I.	4	1	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	-	U	10	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 November 13, 2004 (45th Week)

Reporting Area	All causes, by age (years)							Reporting Area	All causes, by age (years)							P&I [†] Total
	All Ages	≥65	45-64	25-44	1-24	<1	P&I [†] Total		All Ages	≥65	45-64	25-44	1-24	<1		
NEW ENGLAND	490	353	67	24	12	6	47	S. ATLANTIC	1,186	734	295	94	25	38	76	
Boston, Mass.	122	80	1	7	4	2	13	Atlanta, Ga.	187	103	53	19	4	8	6	
Bridgeport, Conn.	34	20	11	2	1	-	1	Baltimore, Md.	196	111	53	17	7	8	22	
Cambridge, Mass.	18	16	2	-	-	-	2	Charlotte, N.C.	111	67	26	8	3	7	10	
Fall River, Mass.	25	22	2	1	-	-	4	Jacksonville, Fla.	116	79	22	12	2	1	7	
Hartford, Conn.	49	36	8	3	2	-	3	Miami, Fla.	82	53	18	7	2	2	4	
Lowell, Mass.	20	17	2	1	-	-	3	Norfolk, Va.	54	36	11	5	-	2	-	
Lynn, Mass.	4	3	-	-	1	-	-	Richmond, Va.	54	32	14	4	1	3	4	
New Bedford, Mass.	26	20	4	1	1	-	3	Savannah, Ga.	42	31	10	-	-	1	1	
New Haven, Conn.	41	24	12	1	2	2	7	St. Petersburg, Fla.	42	23	12	5	2	-	3	
Providence, R.I.	49	35	9	4	1	-	7	Tampa, Fla.	172	127	34	7	1	3	14	
Somerville, Mass.	1	1	-	-	-	-	-	Washington, D.C.	112	57	40	9	3	3	4	
Springfield, Mass.	29	21	4	3	-	1	1	Wilmington, Del.	18	15	2	1	-	-	1	
Waterbury, Conn.	26	22	4	-	-	-	2	E.S. CENTRAL	857	541	209	62	22	23	56	
Worcester, Mass.	46	36	8	1	-	1	1	Birmingham, Ala.	196	128	43	15	6	4	14	
MID. ATLANTIC	1,862	1,335	370	106	30	21	84	Chattanooga, Tenn.	76	46	18	3	3	6	4	
Albany, N.Y.	32	25	3	2	2	-	3	Knoxville, Tenn.	71	51	12	5	3	-	1	
Allentown, Pa.	29	21	4	1	2	1	-	Lexington, Ky.	45	28	11	4	1	1	2	
Buffalo, N.Y.	86	62	14	6	1	3	8	Memphis, Tenn.	271	165	72	20	6	8	15	
Camden, N.J.	34	16	10	3	4	1	1	Mobile, Ala.	41	28	9	3	1	-	6	
Elizabeth, N.J.	22	17	1	4	-	-	1	Montgomery, Ala.	21	13	7	1	-	-	4	
Erie, Pa.	31	27	4	-	-	-	-	Nashville, Tenn.	136	82	37	11	2	4	10	
Jersey City, N.J.	45	31	11	3	-	-	-	W.S. CENTRAL	1,175	743	270	104	23	34	68	
New York City, N.Y.	873	612	185	58	12	6	36	Austin, Tex.	81	49	16	8	3	5	9	
Newark, N.J.	58	24	21	8	1	4	1	Baton Rouge, La.	41	31	7	3	-	-	2	
Paterson, N.J.	U	U	U	U	U	U	U	Corpus Christi, Tex.	49	34	7	4	1	3	1	
Philadelphia, Pa.	269	208	54	5	2	-	9	Dallas, Tex.	186	97	49	26	6	8	8	
Pittsburgh, Pa. [§]	21	14	4	1	-	2	2	El Paso, Tex.	75	59	11	4	1	-	6	
Reading, Pa.	17	15	1	1	-	-	2	Ft. Worth, Tex.	109	68	26	10	2	2	7	
Rochester, N.Y.	102	82	15	1	3	1	4	Houston, Tex.	316	183	84	34	6	9	20	
Schenectady, N.Y.	26	16	8	2	-	-	2	Little Rock, Ark.	U	U	U	U	U	U	U	
Scranton, Pa.	21	18	-	3	-	-	1	New Orleans, La.	49	26	17	6	-	-	-	
Syracuse, N.Y.	131	98	24	5	2	2	6	San Antonio, Tex.	110	78	22	6	2	2	4	
Trenton, N.J.	18	14	1	2	-	1	1	Shreveport, La.	59	47	9	1	1	1	6	
Utica, N.Y.	23	19	3	-	1	-	1	Tulsa, Okla.	100	71	22	2	1	4	5	
Yonkers, N.Y.	24	16	7	1	-	-	6	MOUNTAIN	826	536	179	69	20	21	48	
E.N. CENTRAL	1,923	1,336	396	114	38	39	128	Albuquerque, N.M.	121	73	34	7	5	2	7	
Akron, Ohio	54	44	5	1	2	2	7	Boise, Idaho	46	35	9	-	2	-	6	
Canton, Ohio	37	33	3	1	-	-	5	Colorado Springs, Colo.	68	39	17	10	-	2	1	
Chicago, Ill.	297	181	78	26	6	6	16	Denver, Colo.	101	71	18	10	-	2	8	
Cincinnati, Ohio	45	30	12	1	-	2	2	Las Vegas, Nev.	217	138	52	18	2	7	9	
Cleveland, Ohio	234	169	46	10	3	6	6	Ogden, Utah	31	23	3	3	1	1	2	
Columbus, Ohio	223	149	49	12	11	2	20	Phoenix, Ariz.	122	83	23	8	4	3	5	
Dayton, Ohio	104	79	17	7	-	1	7	Pueblo, Colo.	U	U	U	U	U	U	U	
Detroit, Mich.	158	96	36	18	4	4	9	Salt Lake City, Utah	120	74	23	13	6	4	10	
Evansville, Ind.	54	42	10	2	-	-	6	Tucson, Ariz.	U	U	U	U	U	U	U	
Fort Wayne, Ind.	51	33	14	1	-	3	4	PACIFIC	1,340	949	284	57	32	17	145	
Gary, Ind.	16	9	4	2	1	-	1	Berkeley, Calif.	10	7	2	1	-	-	2	
Grand Rapids, Mich.	64	48	9	6	1	-	4	Fresno, Calif.	146	110	26	6	3	1	9	
Indianapolis, Ind.	188	139	32	7	6	4	13	Glendale, Calif.	18	16	1	1	-	-	2	
Lansing, Mich.	36	26	9	-	-	1	2	Honolulu, Hawaii	75	57	13	1	3	1	10	
Milwaukee, Wis.	92	57	25	7	1	2	7	Long Beach, Calif.	51	33	15	1	1	1	7	
Peoria, Ill.	43	32	8	-	-	3	1	Los Angeles, Calif.	243	163	59	13	6	2	34	
Rockford, Ill.	53	34	13	3	2	1	6	Pasadena, Calif.	U	U	U	U	U	U	U	
South Bend, Ind.	50	42	4	3	1	-	2	Portland, Oreg.	91	65	20	4	-	2	5	
Toledo, Ohio	69	46	17	5	-	1	3	Sacramento, Calif.	U	U	U	U	U	U	U	
Youngstown, Ohio	55	47	5	2	-	1	7	San Diego, Calif.	120	90	22	3	2	2	15	
W.N. CENTRAL	508	343	109	35	7	13	31	San Francisco, Calif.	100	67	20	9	3	1	16	
Des Moines, Iowa	56	46	7	1	1	1	4	San Jose, Calif.	208	145	40	8	11	4	24	
Duluth, Minn.	16	15	-	1	-	-	1	Santa Cruz, Calif.	31	24	5	2	-	-	3	
Kansas City, Kans.	26	13	9	3	1	-	1	Seattle, Wash.	84	55	22	5	1	1	4	
Kansas City, Mo.	58	40	9	7	-	2	3	Spokane, Wash.	52	39	11	-	1	1	6	
Lincoln, Nebr.	42	25	12	3	1	1	2	Tacoma, Wash.	111	78	28	3	1	1	8	
Minneapolis, Minn.	58	34	15	3	1	5	3	TOTAL	10,167 [¶]	6,870	2,179	665	209	212	683	
Omaha, Nebr.	80	56	19	2	-	3	4									
St. Louis, Mo.	45	27	10	5	1	1	3									
St. Paul, Minn.	57	44	11	2	-	-	3									
Wichita, Kans.	70	43	17	8	2	-	7									

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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