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World TB Day — March 24, 2005

World TB Day is March 24, 2005. This annual event commemorates the date in 1882 when Dr. Robert Koch announced his discovery of the tuberculosis (TB) bacillus. TB remains one of the leading causes of death from infectious disease worldwide. An estimated 2 billion persons (i.e., one third of the world's population) are infected with the bacteria that cause TB. Each year, approximately 9 million persons become ill from TB; of these, 2 million die. World TB Day provides an opportunity for TB programs, nongovernmental organizations, and other partners to describe TB-related problems and possible solutions and to support global TB-control efforts.

During 1985–1992, after years of decline, the number of TB cases reported in the United States increased 20%. A renewed emphasis on TB control and prevention during the 1990s reversed this trend. Provisional data indicate that the rate of TB in 2004 was the lowest recorded in the United States since reporting began in 1953. However, the rate of decline has slowed in the past 2 years, and disparities persist for certain racial, ethnic, and foreign-born populations.

CDC and its partners are committed to eliminating TB in the United States. Educational programs convened by local TB coalitions will be held in many states on World TB Day. These programs will feature presentations from TB experts and from leaders of communities at highest risk for the disease. For example, the Metropolitan Chicago Tuberculosis Coalition World TB Day observance will have the theme, "TB: Educate to Eliminate." Progress in international collaborative efforts to combat TB will be acknowledged at numerous events, including a meeting of the United States–Mexico Binational Health Card Project, a comprehensive TB-referral and case-management system for the United States and Mexico. Additional information about World TB Day and CDC TB-elimination activities is available at http://www.cdc.gov/nchstp/tb/worldtbday/2005/default.htm.

Trends in Tuberculosis — United States, 2004

During 2004, a total of 14,511 confirmed tuberculosis (TB) cases (4.9 cases per 100,000 population) were reported in the United States, representing a 3.3% decline in the rate from 2003. Slightly more than half (53.7%) of U.S. cases were in foreign-born persons. This report summarizes data from the national TB surveillance system for 2004 and describes trends since 1993. Findings indicate that although the 2004 TB rate was the lowest recorded in the United States since national reporting began in 1953, the declines in rates for 2003 (2.3%) and 2004 (3.3%) were the smallest since 1993. In addition, TB rates greater than the U.S. average continue to be reported in certain racial/ethnic populations*; in 2004, Hispanics, blacks, and Asians had TB rates 7.5, 8.3, and 20.0 times higher than whites, respectively. Essential elements for controlling TB in the United States include sufficient local resources, interventions targeted to populations with the highest TB rates, and continued collaborative efforts with other nations to reduce TB globally.

The 50 states and the District of Columbia (DC) report cases to the national TB surveillance system at CDC by using a standard case definition and report form (*1*). Provisional reports, updated as of February 16, 2005, were used for this analysis. U.S. census population estimates were used to

* For this report, persons identified as white, black, Asian, and of other/unknown races are all non-Hispanic. Persons identified as Hispanic might be of any race.

INSIDE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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calculate national and state TB rates (*2*) and rates for racial/ethnic populations (*3*) and for foreign-born and U.S.-born† persons (*5*).

During 2004, a total of 30 (58.8%) states§ reported a decline in cases from 2003. Seventeen states¶ and DC reported an increase in cases, and three states** reported the same number of cases as in 2003. Seven states reported more than 400 cases each in 2004; collectively these states accounted for 8,689 cases, or 59.9% of the national case total. Of these seven states, two reported increases for 2004 (Texas, 4.0% and Florida, 1.0%); the other five states reported decreases (California, 8.4%; Georgia, 2.5%; Illinois, 10.9%; New Jersey, 3.3%; and New York, 7.3%).

States with the largest numbers of TB cases also had the highest TB rates, with certain exceptions. Illinois and New Jersey each had more than 400 cases but were not among the top 20% of rates (i.e., ≥5.6 per 100,000 population) (Figure 1). The number of cases reported by Alaska (43 cases), DC (81), and Hawaii (116) were less than the median of 127, but each area reported rates of ≥5.6. Many of the states reporting the lowest TB rates were in the Rocky Mountains area, the upper Midwest, or the Northeast.

In 2004, among U.S.-born persons, 6,637 cases were reported, a decrease of 3.7% compared with 2003 and 61.9% compared with 1993 (Figure 2). The 2004 TB rate for U.S.-born persons was 2.6 per 100,000 population, a decrease of 4.3% from 2003 and 64.6% from 1993. In 2004, among foreign-born persons, 7,701 cases were reported. In contrast to the substantial decline in cases among U.S.-born persons

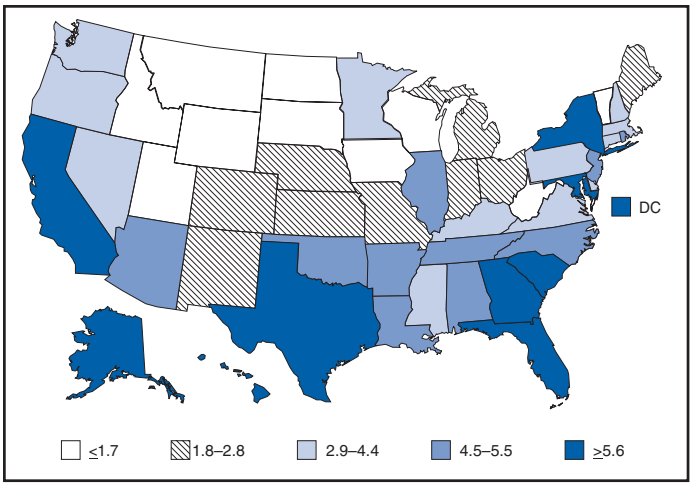
† A U.S.-born person is defined as someone born in the United States or its associated jurisdictions or someone born in a foreign country but having at least one U.S.-born parent. All other persons not meeting this definition were classified as foreign-born (*4*). For 2004, patients with unknown origin of birth represented 1.2% (173) of total cases.

§ States reporting declines in cases in 2004 (cases, % decrease from 2003 to 2004): California (2,988, 8.4%), New York (1,364, 7.3%), Illinois (568, 10.9%), Georgia (528, 2.5%), New Jersey (482, 3.3%), Virginia (329, 2.7%), Pennsylvania (327, 3.0%), Tennessee (279, 3.4%), Arizona (272, 10.4%), Louisiana (249, 4.3%), Washington (244, 3.5%), South Carolina (234, 9.0%), Ohio (219, 4.5%), Alabama (211, 18.7%), Minnesota (199, 7.7%), Indiana (129, 10.3%), Kentucky (127, 8.6%), Missouri (127, 3.7%), Mississippi (119, 7.7%), Connecticut (101, 9.4%), Nevada (95, 13.9%), Kansas (62, 17.7%), Alaska (43, 25.4%), New Mexico (42, 15.4%), Utah (36, 9.1%), Maine (20, 17.2%), Idaho (11, 17.0%), South Dakota (11, 45.4%), Vermont (six, 33.6%), and North Dakota (four, 33.4%).

¶ States/areas reporting an increase in cases in 2004 (cases, % increase from 2003 to 2004): Texas (1,683, 4.0%), Florida (1,076, 1.0%), North Carolina (382, 0.7%), Maryland (314, 16.2%), Massachusetts (284, 8.9%), Michigan (273, 12.0%), Oklahoma (179, 9.3%), Arkansas (132, 2.2%), Colorado (127, 13.1%), Wisconsin (95, 43.0%), DC (81, 3.3%), Rhode Island (51, 10.4%), Iowa (47, 17.0%), Nebraska (39, 38.5%), New Hampshire (24, 58.7%), West Virginia (24, 14.0%), Montana (15, 112.3%), and Wyoming (five, 23.9%).

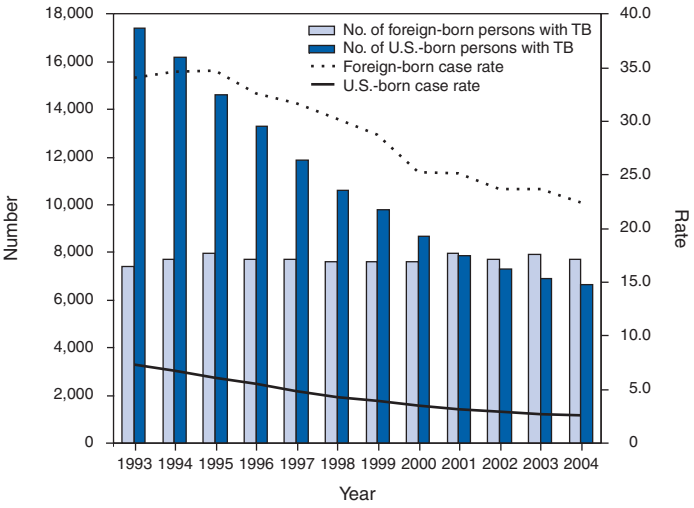
** States reporting the same number of cases in 2003 and 2004 include Hawaii (116), Oregon (106), and Delaware (32).

FIGURE 1. Rate* of tuberculosis cases, by state — United States, 2004†



* Per 100,000 population.
† Data for 2004 are provisional.

FIGURE 2. Number and rate* of persons with tuberculosis (TB), by origin of birth and year — United States, 1993–2004†



* Per 100,000 population.
† Data for 2004 are provisional.

since 1993, the number of cases reported among foreign-born persons has not changed substantially. From 1996 to 2000, the TB rate for foreign-born persons decreased 22.4%, from 32.6 to 25.3; from 2000 to 2004, the rate decreased 11.2%, from 25.3 to 22.5. During these periods, the growth of the foreign-born population in the United States ranged from a 26.6% increase during 1996–2000 to a 14.2% increase during 2000–2004.

In 2004, for the first time, TB was reported more frequently among Hispanics than among any other racial/ethnic population (Table). The number of cases in Hispanics increased 1.2%, from 4,109 in 2003 to 4,160 in 2004. However, the TB rate for Hispanics decreased, from 10.3 in 2003 to 10.1 in 2004. The increase in case counts, but decrease in rates, reflects a 3.6% increase in the 2004 U.S. population of Hispanics compared with 2003. For blacks, whites, and Asians, the case numbers and rates both decreased. Of 3,221 Asians with TB and known origin of birth, 3,074 (95.4%) were foreign born; of 4,105 Hispanics with TB, 3,037 (74.0%) were foreign born; and, of 3,981 blacks with TB, 1,055 (26.5%) were foreign born.

The recommended length of drug therapy for most types of TB is 6–9 months. In 2001, the latest year for which completion-of-therapy data are available, the percentage of patients who completed therapy within 1 year†† was 81.4% for U.S.-born patients and 80.4% for foreign-born patients. In 2003, the most recent year for which drug-susceptibility data are available, 114 cases of multidrug-resistant (MDR) TB§§ were reported. These MDR TB cases represent 1.0% of the 11,040 cases for which drug-susceptibility test results were reported in 2003 and a 76.5% decline from the 486 MDR TB cases reported in 1993. In 2003, a total of 0.6% (28 cases) of U.S.-born and 1.4% (86 cases) of foreign-born persons had MDR TB, a 91.6% and 42.7% decline, respectively, in MDR TB cases from 1993.

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Editorial Note: During 1993–2002, the United States reported steady declines in annual TB rates, with an average decline of 6.6% (*4*). However, annual declines in rates for 2003 and 2004 were the smallest since 1993, raising concerns that the progress toward eliminating TB might be slowing. Steep declines have occurred in TB rates among U.S.-born persons; since 1993, the TB rate among U.S.-born persons has declined 64.6%, to an all-time low of 2.6 per 100,000 population in 2004. Smaller declines have occurred among foreign-born persons; since 1993, the TB rate among those foreign born has declined 33.9%, to a rate of 22.5, approximately 8.7 times higher than the rate for those born in the United States.

In 2001, the percentages of both U.S.-born (81.4%) and foreign-born (80.4%) patients who completed therapy within 1 year were similar but fell short of the 2010 national health target of 90% (objective no. 14.12) (*6*). A greater percentage of foreign-born than U.S.-born patients had MDR TB, reflecting likely exposure to TB in countries where rates of MDR TB are higher than in the United States.

†† Completion-of-therapy data exclude persons who died during therapy, persons with initial isolate resistant to rifampin, and pediatric patients (i.e., aged <15 years) with meningeal, bone or joint, or miliary disease.
§§ Defined as resistant to at least isoniazid and rifampin.

TABLE. Number and rate* of tuberculosis cases and percentage change, by race/ethnicity and year — United States, 2003 and 2004†

Race/Ethnicity	2003		2004		% change 2003–2004		U.S. population	
	No.	Rate	No.	Rate	No.	Rate	2003	2004
Hispanic	4,109	10.3	4,160	10.1	+1.2%	-2.3%	39,898,889	41,329,556
Non-Hispanic								
Black	4,153	11.7	4,006	11.1	-3.5%	-4.6%	35,593,148	35,980,588
Asian	3,441	29.5	3,253	26.9	-5.5%	-8.6%	11,673,494	12,080,429
White	2,797	1.4	2,638	1.3	-5.7%	-5.9%	197,326,272	197,768,300
Other/Unknown§	358		454					
Total	**14,858**	**5.1**	**14,511**	**4.9**	**-2.3%**	**-3.3%**	**290,809,777**	**293,622,764**

* Per 100,000 population.
† Data for 2004 are provisional.
§ Persons included in this category are American Indian/Alaska Native (2004, n = 159, rate: 7.2 per 100,000 population; 2003, n = 177, rate: 8.1), Native Hawaiian or other Pacific Islander, multiple race (2004, n = 47, rate: 1.2; 2003, n = 36, rate: 1.0), and unknown race. The race category for Native Hawaiian or other Pacific Islander was first introduced in 2003, and the rates are not listed using provisional data.

To address the high rate of TB among foreign-born persons, CDC is collaborating with other national and international public health organizations to 1) improve overseas screening of immigrants and refugees by systematically monitoring and evaluating the screening process, 2) strengthen the current notification system that alerts local health departments about the arrival of immigrants or refugees who have suspected TB, 3) improve coordination of TB-control activities between the United States and Mexico to ensure completion of treatment among TB patients who cross the border, 4) test recent arrivals from high-incidence countries for latent TB infection and treat them to completion, and 5) survey foreign-born TB patients in the United States to determine opportunities for improving prevention and control interventions. In addition, CDC continues to strengthen collaborations with international partners, including the Stop TB Partnership of the World Health Organization (http://www.stoptb.org), to improve TB control in high-incidence countries.

A disproportionately large number of TB cases are reported among blacks, most of whom were born in the United States; in 2004, the TB rate for blacks was 8.3 times greater than that for whites. In southeastern states, blacks with TB are more likely than whites to have certain risk factors, such as human immunodeficiency virus infection, incarceration, or excess alcohol or drug use, which suggests that differences in socioeconomic status, health status, and opportunity for TB exposure, underlie increased risk for TB (*7*). However, the percentages of blacks receiving directly observed therapy (81.0%) and completing treatment on time (81.6%) were similar to the percentages among whites (74.7% and 82.2%, respectively).

To address the high rate of TB in blacks in the United States, CDC has funded three U.S. demonstration projects (in Chicago, Illinois; Georgia; and South Carolina), in collaboration with state and local health departments, to identify innovative strategies for improving TB diagnosis, screening, and treatment adherence in communities with black persons at high risk. CDC is also conducting a formative research and intervention study in collaboration with the Research Triangle Institute. This study will 1) examine barriers to health-seeking behaviors and treatment adherence for blacks with or at risk for TB, 2) determine barriers to TB guideline adherence among providers who serve this population, 3) develop and test interventions to overcome identified barriers, and 4) improve partnerships and collaborations among TB programs and providers and organizations serving this population.

Despite these targeted efforts to control TB, the recent deceleration of the decline in TB cases indicates the need for increased measures (e.g., improved case management and contact investigation, intensified testing of populations at high risk, better treatments and diagnostic tools, improved understanding of TB transmission, and continued collaborative efforts with other nations to reduce TB globally). These measures are required for complete implementation of the Institute of Medicine's recommendations for eliminating TB in the United States (*8*). Final data for 2004 will be published in fall 2005 in the CDC surveillance report, *Reported Tuberculosis in the United States*.

Acknowledgments

The findings in this report are based on surveillance data contributed by TB-control officials in state and local health departments.

References

1. CDC. Report of verified case of tuberculosis (RVCT) in the United States. OMB No. 0920-0020. Atlanta, GA: US Department of Health and Human Services, CDC; 2003.
2. US Census Bureau. Annual estimates of the population for the United States and states, and for Puerto Rico: April 1, 2000 to July 1, 2004 (NST-ST2004-01), release date December 22, 2004. Available at http://www.census.gov/popest/states/tables/NST-EST2004-01.xls.

3. US Census Bureau. Resident population: national population estimates for the 2000s. July 1, 2004, estimate. Available at http://www.census.gov/popest/national/asrh/2003_nat_res.html.
4. CDC. Reported tuberculosis in the United States, 2003. Atlanta, GA: US Department of Health and Human Services, CDC; 2004. Available at http://www.cdc.gov/nchstp/tb/surv/surv2003/default.htm.
5. US Census Bureau. United States foreign-born population. Washington, DC: US Department of Commerce, US Census Bureau. Available at http://www.census.gov/population/www/socdemo/foreign.html.
6. US Department of Health and Human Services. Healthy people 2010 (conference ed, in 2 vols). Washington, DC: US Department of Health and Human Services; 2000.
7. CDC. Racial disparities in tuberculosis—selected southeastern states, 1991–2002. MMWR 2004;53:556–9.
8. Geiter L, ed. Ending neglect: the elimination of tuberculosis in the United States. Washington, DC: National Academies Press; 2000.

Congenital Pulmonary Tuberculosis Associated with Maternal Cerebral Tuberculosis — Florida, 2002

In 2002, congenital tuberculosis (TB), a rare disease with nonspecific signs and symptoms, was diagnosed in an infant in Florida. If untreated, congenital TB is fatal, which underscores the importance of suspecting congenital TB in newborns and infants who are at risk and who have unexplained febrile illnesses (*1*). This report summarizes the investigation of the case in Florida. Health-care practitioners should administer a tuberculin skin test to women who have risks for *Mycobacterium tuberculosis* infection and treat those who have latent TB infection (LTBI) to prevent maternal and congenital TB disease (*2*).

In May 2002, a U.S.-born male infant aged 44 days was brought to hospital A after 3 days of respiratory distress and fever. Examination revealed a fever of 103.2°F (39.6°C), nasal congestion, and bibasilar wheezing. The neck was supple, and no superficial lymphadenopathy was palpable. The abdomen was soft, no hepatosplenomegaly was detected, and ultrasound images of the liver were normal. The chest radiograph showed left lower lobe infiltrates, and the infant was admitted to the hospital for presumptive bacterial pneumonia. The fever continued despite administration of broad-spectrum antibiotics; on hospital day 9, physicians learned that the mother had cerebral TB diagnosed at hospital B approximately 20 days earlier. Gastric aspirates and bronchial washings from the infant yielded acid-fast bacilli (AFB) on smear microscopy and *M. tuberculosis* by rRNA amplification (Amplified™ Mycobacterium Tuberculosis Direct Test, Gen-Probe, San Diego, California) and by culture. Serology results for human immunodeficiency virus (HIV) antibody were negative. The infant subsequently was administered isoniazid, rifampin, pyrazinamide, and streptomycin. The streptomycin was discontinued when drug-susceptibility studies showed resistance to it. The infant responded favorably to treatment and was discharged after 8 weeks in hospital A. Investigation of potential sources of *M. tuberculosis* infection other than the mother (i.e., the father, a grandmother, and hospital staff) did not reveal any additional cases of TB disease.

The mother, aged 30 years, was born in Haiti, where TB is prevalent, and had moved to the United States in 1995; she had no children previously. After an uneventful pregnancy, during which she received prenatal care and had negative serology results for HIV antibody, the mother reported having a seizure 1 week before delivery; however, she did not seek medical care. The baby was born at hospital A at full term, with 1-minute and 5-minute Apgar scores of 6 and 9, respectively (normal: 7–10 at 5 minutes), clear amniotic fluid, and a grossly normal placenta. The mother began breastfeeding without difficulty and had no signs or symptoms of mastitis. From the day after delivery, she felt feverish; 3 days later, she had seizures lasting 15 minutes. She was admitted to hospital B, and magnetic resonance imaging showed five inflammatory cortical brain lesions. Histology of a brain biopsy specimen from the mother, obtained 10 days before her infant was admitted to hospital A with respiratory distress and fever, revealed necrotic granulomata and AFB. Cerebrospinal fluid from a lumbar puncture had no white blood cells and normal concentrations of glucose and protein; the results of Gram stain and culture (not performed for mycobacteria) were negative. Culture of her brain tissue yielded *M. tuberculosis* susceptible to isoniazid, rifampin, and pyrazinamide but resistant to streptomycin. A chest radiograph was normal; the results of AFB smear and culture on the mother's sputum were negative. The uterus was not curetted. The mother recovered fully while receiving isoniazid, rifampin, pyrazinamide, and the anticonvulsant oxcarbazepine. *M. tuberculosis* isolates from mother and infant were subsequently determined to have identical genotype patterns by IS6110-based restriction fragment length polymorphism.

Two years before her pregnancy, the mother had been administered a preemployment tuberculin skin test with a positive result of 20 mm of induration (≥10 mm is positive for persons from countries with high incidence of TB). A chest radiograph was normal, and treatment for LTBI was not prescribed at that time.

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Editorial Note: The results of the investigation described in this report emphasize the importance of considering congenital TB in a newborn or infant with pneumonia who fails to respond to conventional treatment, particularly if the mother is at risk for TB (e.g., because she emigrated from a country where the disease is prevalent) (*2*). Congenital TB is rare, but fatal if untreated, and is difficult to diagnose in time to treat successfully without knowledge of a maternal history of TB (*3*). Two possible routes of *M. tuberculosis* infection in utero are postulated: 1) hematogenous infection through the umbilical vein, with primary lesions in the liver and sometimes with porta hepatis lymphadenopathy; and 2) prenatal aspiration of infected fluid, with pulmonary and gastrointestinal disease predominating (*3,4*).

M. tuberculosis infection in utero can be indistinguishable from perinatal or early postpartum infection. The most recent set of criteria for congenital TB requires the infant to have a tuberculous lesion (e.g., infiltrates on the chest radiograph or granulomas) and at least one of the following: 1) onset during the first week of life, 2) a primary hepatic TB complex or caseating hepatic granulomas, 3) infection of the placenta or maternal genital tract, or 4) exclusion of postnatal transmission by a contact investigation (*3*). In this case, transmission linkage from the mother to the infant was corroborated by the matching drug-resistance and genotype patterns of the *M. tuberculosis* isolates. The likeliest explanation is that infection was congenital, because the mother had TB during pregnancy and the contact investigation found no alternative sources of infection. The infant came to medical attention at 44 days, later than the typical 1–3 weeks, but still within the widest reported range (1–84 days) for congenital TB (*3,4*). The mother was not examined for uterine TB, and the placenta was discarded before the infant became ill; no gross abnormalities were noted by physicians. The lack of pulmonary disease in the mother makes airborne spread from her to the infant unlikely. Transmission via breast milk was unlikely because the mother lacked findings of TB mastitis.

The missed opportunity to prevent the infant's TB by treating the mother's LTBI at the time it was diagnosed underscores the need to incorporate treatment plans for persons at risk into preemployment and other health screenings that identify LTBI. Strategies for preventing TB in foreign-born persons are especially important (*5*). TB-control officials should use epidemiologic history for identifying persons at risk and collaborate with the medical community in finding and treating LTBI to prevent TB disease.

References

1. Popli MB, Mehta N, Nijhavan VS, Popli V. Congenital tuberculosis. Australas Radiol 1998;43:256–7.
2. CDC. Targeted tuberculin testing and treatment of latent tuberculosis infection. MMWR 2000;49(No. RR-6).
3. Cantwell MF, Shehab ZM, Costello AM, et al. Brief report: congenital tuberculosis. N Engl J Med 1994;330:1051–4.
4. Li CK, Chan YF, Har CY. Congenital tuberculosis. Aust Paediatr J 1989;25:366–7.
5. CDC. Recommendations for prevention and control of tuberculosis among foreign-born persons: report of the Working Group on Tuberculosis Among Foreign-Born Persons. MMWR 1998;47(No. RR-16).

Preemptive State Smoke-Free Indoor Air Laws — United States, 1999–2004

Exposure to secondhand smoke results in approximately 3,000 lung cancer deaths and 35,000 heart disease deaths in the United States each year (*1*). Policies establishing smoke-free environments are the most effective method for reducing exposure to secondhand smoke (*2*). Restrictions on where smoking is allowed are also associated with decreased cigarette consumption and possibly with increased cessation rates among workers and the general public (*3*). Local laws often impose more stringent smoking restrictions than state laws (*3*). Preemptive legislation prohibits communities from enacting laws that are more stringent than or vary from the state law. One of the national health objectives for 2010 is to eliminate laws that preempt stronger tobacco-control laws (objective no. 27-19) (*4*). In 1999, CDC published a list of states that, as of December 31, 1998, had laws that preempted stronger local smoking restrictions in one or more of three environments: government worksites, private-sector worksites, and restaurants (*5*). This report updates that list and summarizes changes in preemptive state smoke-free indoor air laws during 1999–2004 for these three environments. The findings indicate that almost no progress is being made toward the 2010 goal of eliminating all preemptive state smoke-free indoor air laws, resulting in the potential for lesser health protection.

The status of smoke-free indoor air preemption provisions in state laws, as of December 31, 2004 (Table), is based on data from the CDC State Tobacco Activities Tracking and Evaluation (STATE) System database, which contains tobacco-related epidemiologic and economic data and information on state tobacco-related legislation (*6*). The legislative data are identified quarterly from an online legal research database, coded, verified, and then entered into the STATE System. The system tracks smoke-free indoor air policies at government and private-sector worksites; restaurants; commercial and home-based child care centers; and other sites, including bars, malls, grocery stores, enclosed arenas, public transportation facilities, hospitals, prisons, hotels, and motels; however, it

TABLE. States with preemption provisions in state laws* governing smoking at government worksites, private-sector worksites, and restaurants

State	Any preemption	Preemption involving government worksites	Preemption involving private-sector worksites	Preemption involving restaurants
Alabama				
Alaska				
Arizona				
Arkansas				
California†				
Colorado				
Connecticut†	X	X		X
Delaware				
Florida	X	X	X	X
Georgia				
Hawaii				
Idaho				
Illinois	X	X	X	X
Indiana				
Iowa	X	X	X	X
Kansas				
Kentucky				
Louisiana	X			X
Maine				
Maryland				
Massachusetts				
Michigan	X			X
Minnesota				
Mississippi	X	X		
Missouri				
Montana				
Nebraska				
Nevada	X	X	X	X
New Hampshire	X			X
New Jersey†	X	X	X	X
New Mexico				
New York				
North Carolina	X	X	X	X
North Dakota				
Ohio				
Oklahoma†	X	X	X	X
Oregon	X	X	X	X
Pennsylvania§	X	X	X	X
Rhode Island				
South Carolina†	X	X	X	X
South Dakota	X	X	X	X
Tennessee	X	X	X	X
Texas				
Utah	X	X	X	X
Vermont				
Virginia	X	X	X	X
Washington				
West Virginia				
Wisconsin				
Wyoming				
Total	**19**	**16**	**14**	**18**

* As of December 31, 2004. The type of smoke-free indoor air law for each environment is available for each state on the State Tobacco Activities Tracking and Evaluation (STATE) System at http://www.cdc.gov/tobacco/STATEsystem.

† Correction from 1999 report. Connecticut was previously listed as having preemptive provisions affecting private-sector worksites. South Carolina was listed as not having preemptive provisions affecting private-sector worksites and restaurants, and Oklahoma was listed as not having preemptive provisions affecting private-sector worksites. New Jersey was listed as not having any preemptive provisions, and California was listed as having preemptive provisions in all three areas.

§ Preemptive legal status is under review.

only tracks preemptive provisions concerning government and private-sector worksites and restaurants (*6*). State smoke-free indoor air policies for each environment can range from prohibiting all smoking, to allowing designated smoking areas with separate ventilation, to requiring or allowing designated smoking areas, to having no smoking restrictions. States were coded as having preemption if they had a law indicating that local jurisdictions were prevented from enacting smoking restrictions that were more stringent than or different from state law by virtue of a provision that preempts local ordinances in all settings or a location-specific preemptive provision (e.g., one only applying to government worksites). The opinions of state attorneys general and court decisions that affected whether state tobacco-control laws preempt local laws are reflected in these results. Tobacco-control personnel in state health departments reviewed and commented on the preemption codes. Preemptive provisions of state smoke-free indoor air laws that were enacted before, but became effective after December 31, 2004, were not included in this report. For example, Rhode Island adopted a preemptive provision during the period covered by this analysis, but the provision did not take effect until March 2005. This provision is scheduled to expire in October 2006, when another phase of the law takes effect.

As of December 31, 1998, a total of 17 states had preemptive provisions in smoke-free indoor air laws governing at least one of the three settings considered (16 for government worksites, 15 for private-sector worksites, and 17 for restaurants) (*5*). During 1999–2004, state-level smoke-free indoor air laws lost preemptive provisions in two states; Delaware became the first state to repeal preemptive provisions in state smoke-free laws governing all sites and environments, and Louisiana repealed some of its preemptive language. During this period, smoke-free indoor air laws also acquired preemptive status in three states; Mississippi and Oregon adopted preemptive provisions, and ambiguous provisions in New Hampshire were held to be preemptive by the state court in 2003. During 1999–2004, two states (Delaware and Louisiana) repealed, and two states (Mississippi and Oregon) adopted preemption provisions in laws for government worksites; two states (Delaware and Louisiana) repealed, and one state (Oregon) adopted preemption provisions in laws for private-sector worksites; and one state (Delaware) repealed, and two states (New Hampshire and Oregon) gained preemptive provisions in laws for restaurants. Montana also adopted preemptive provisions during this period for all businesses with video-gambling licenses, but this legislation was later deemed unconstitutional*. As of December 31, 2004, a total of 19

* American Cancer Society, et al. v. State of Montana, 325 Mont. 70, 103 P.3d 1085 (2004).

states had at least one type of preemptive provision for smoke-free indoor air legislation.

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Editorial Note: The findings of this analysis indicate that preemption provisions in state smoke-free indoor air laws remain common. States without such preemptive provisions may set minimum requirements and, therefore, allow the continued passage and enforcement of local ordinances that can establish a greater level of protection of public health.

The findings in this report are subject to at least two limitations. First, because the study only tracks preemptive provisions affecting three specific areas, it does not completely describe state efforts to repeal or add to preemption in all settings. For example, in 2003, Nevada rescinded preemptive provisions in laws for public schools, and North Carolina rescinded preemptive provisions in laws for public schools and some college campus buildings. Second, because the language of potentially preemptive tobacco-control provisions in state law can be ambiguous, state laws classified as preemptive by the STATE System might not have actually prevented local communities from adopting stricter tobacco-control regulations, and state laws that are not classified as preemptive might have been interpreted as being so, preventing local action; the STATE System would not have identified such instances. In addition, court rulings can affect how a law is interpreted and enforced. Numerous state and local courts have issued rulings in cases contesting preemptive provisions in state smoke-free indoor air laws. In certain cases, the court rulings affirmed the prevailing view of the state law. For example, the state supreme courts of West Virginia[†] and Kentucky[§], in 2003 and 2004, respectively, found that state tobacco-control laws did not preempt more stringent local smoke-free laws. In other instances, however, court decisions have found state laws that were widely regarded as not being preemptive to be so. A 1990 New Hampshire law regulating smoking in enclosed workplaces and public places was generally viewed as not preempting more stringent local smoke-free ordinances, and at least three municipalities subsequently adopted ordinances that were stronger than the state law. In 2002, a legal challenge was filed against one of these municipal ordinances on the grounds that the local ordinance was preempted by state law. Although a county superior court upheld the ordinance, the restaurant appealed the ruling and, in 2003, the New Hampshire Supreme Court reversed the lower court's decision and held that the state law preempted the municipal ordinance[¶]. In February 2005, beyond the timeframe captured in this analysis, the Washington State Supreme Court ruled that state law preempted more stringent local smoke-free ordinances[**].

New legal developments continue to clarify the extent to which state laws can preempt stricter local laws. In January 2005, Mecklenburg County, North Carolina, formally asked the state legislature to exempt the county from a provision in state law preventing communities from adopting new smoke-free ordinances more stringent than state tobacco-control laws.

Comprehensive, population-based policy interventions are effective in reducing tobacco use, and the establishment of smoke-free environments is the most effective method for reducing secondhand smoke exposure (*2,3*). For example, during the 6 months after Helena, Montana, prohibited smoking in all workplaces and public places in 2002, the number of hospital admissions for acute myocardial infarctions declined 40% but then rebounded when the ordinance was suspended (*7*). In addition, other findings suggest that passive exposure to tobacco smoke for as little as 30 minutes compromises coronary circulation in nonsmokers and that nonsmokers who are exposed to typical levels of secondhand smoke incur approximately one third the tobacco-related increased heart disease risk of someone who smokes 20 cigarettes a day (*8*). Whereas increased restrictions on smoking in public places have afforded expanded protection for certain persons, others continue to be exposed to secondhand smoke in the workplace. For example, a CDC study found that of all occupations surveyed, nonsmoking waiters and waitresses had the highest levels of workplace exposure to secondhand smoke, a known human carcinogen (*9*).

The importance of smoke-free laws and policies in comprehensive tobacco-control interventions is reflected by their inclusion in national health objectives for 2010 and in CDC surveillance efforts (*3,4*). The tracking of state legislative data is an important form of public health surveillance, and the STATE System is a well-established example of tracking and reporting on laws with a public health impact. CDC will continue to monitor progress toward achieving the national health objectives to reduce tobacco-related morbidity and mortality.

[†] Foundation for Independent Living, Inc. et al. v. The Cabell-Huntington Board of Health, 214 W. Va. 818, 591 S.E.2d 744 (2003).

[§] Lexington Fayette County Food and Beverage Association v. Lexington Fayette Urban County Government, 131 S.W.3d 745 (2004).

[¶] JTR Colebrook, Inc. v. Town of Colebrook, 149 N.H. 767, 829 A.2d 1089 (2003).

[**] Entertainment Industry Coalition v. Tacoma-Pierce County Health Department and the Tacoma-Pierce County Board of Health, 2005 WL 310431 (Wash.).

Acknowledgments

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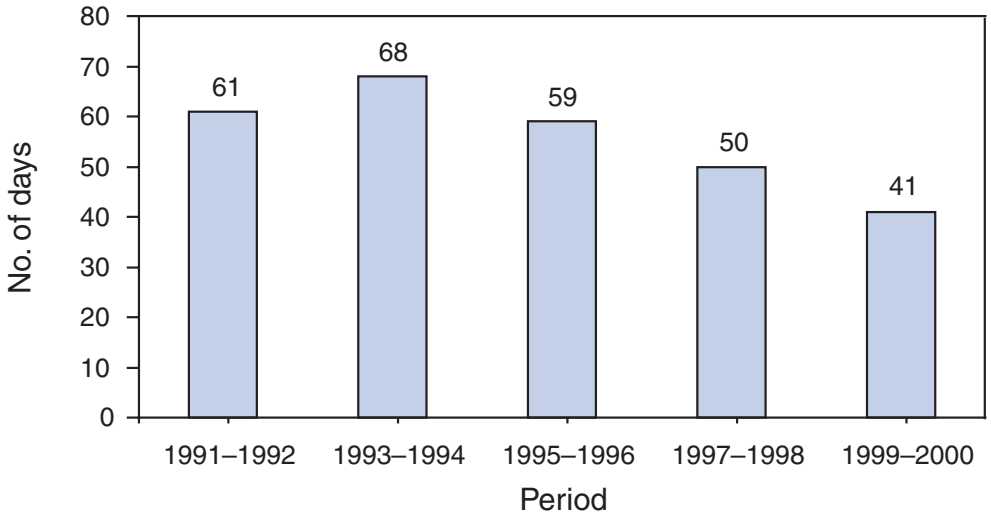
References

1. CDC. Annual smoking-attributable mortality, years of potential life lost, and economic costs—United States, 1995–1999. MMWR 2002;51:300–3.
2. Task Force on Community Preventive Services. Guide to community preventive services: tobacco use prevention and control. Am J Prev Med 2001;20(2 Suppl 1):1–87.
3. US Department of Health and Human Services. Reducing tobacco use: a report of the Surgeon General. Rockville, MD: US Department of Health and Human Services, Public Health Service, Office of the Surgeon General; 2000.
4. US Department of Health and Human Services. Healthy People 2010, 2nd ed. With understanding and improving health and objectives for improving health (2 vols.). Washington, DC: US Department of Health and Human Services; November 2000.
5. Fishman JA, Allison H, Knowles SB, et al. State laws on tobacco control—United States, 1998. MMWR 1999;48(No. SS-3).
6. CDC. State Tobacco Activities Tracking and Evaluation (STATE) System. Available at http://www.nccd.cdc.gov/tobacco/STATEsystem.
7. Sargent RP, Shepard RM, Glantz SA. Reduced incidence of admissions for myocardial infarction associated with public smoking ban: before and after study. BMJ 2004;328:977–80.
8. Pechacek TF, Babb S. How acute and reversible are the cardiovascular risks of secondhand smoke? BMJ 2004;328:980–3.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Average Length of Service Provided to U.S. Home Health-Care Patients, by Selected Period — United States, 1991–2000



From 1993–1994 to 1999–2000, the overall length of service provided to patients in home health care declined. Several factors have contributed to this decline, including a special initiative implemented in 1995 to identify fraud and abuse in home health care and the Balanced Budget Act of 1997, which changed the Medicare payment system for home health care. Medicare covers approximately two thirds of those receiving home health care. Length of service did not decline among home health-care patients with Medicaid or private health insurance during this period. Additional information is available at http://www.cdc.gov/nchs/about/major/nhhcsd/nhhcsd.htm.

SOURCES: Han B, Remsburg R, Lubitz J, Goulding M. Payment source and length of use among home health agency discharges. Medical Care 2004;42:1081–90.

National Center for Health Statistics. National Home and Hospice Care Surveys, 1992, 1994, 1996, 1998, and 2000. Hyattsville, MD: US Department of Health and Human Services, CDC, National Center for Health Statistics.

9. Wortley PM, Caraballo RS, Pederson LL, et al. Exposure to secondhand smoke in the workplace: serum cotinine by occupation. J Occup Environ Med 2002;44:503–9.

Notice to Readers

World Water Day — March 22, 2005

World Water Day, March 22, 2005, marks the start of the Water for Life Decade, 2005–2015, a new United Nations International Decade for Action (*1*). The decade-long effort will improve the chances of achieving international water-related goals, including that of the United Nations Millennium Declaration: by 2015, to reduce by 50% the proportion of persons without sustainable access to safe drinking water and basic sanitation.

An estimated 1.1 billion persons lack access to an improved water source*, and 2.6 billion persons lack access to adequate sanitation (*2*). Waterborne diseases account for approximately 4 billion episodes of illness and 2.2 million deaths every year, disproportionately affecting young children (*3*). Safe water, adequate sanitation, and hygiene education can substantially reduce morbidity and mortality from diarrheal diseases (*4*).

The Safe Water System (SWS) program uses simple, inexpensive technologies to empower families to treat and safely store drinking water in their homes (http://www.cdc.gov/safewater). Promotion of hand washing with soap, an intervention proven to reduce diarrhea (*5*), is an integral component of SWS projects. SWS programs operate in 19 countries and were a critical tool in responding to contamination of water sources in Indonesia, India, and Myanmar after the December 2004 tsunamis. *Safe Water Systems for the Developing World: A Handbook for Implementing Household-Based Water Treatment and Safe Storage Projects* is a guide for program managers, technical staff, and other personnel in organizations involved in water and sanitation projects (*6*). The guide is available in English, French, Spanish, and Arabic. CDC, the World Health Organization, the United Nations Children's Fund, and other public and private partners are members of the International Network to Promote Household Water Treatment and Safe Storage (http://www.who.int/household_water/en). Additional information about World Water Day is available at http://www.worldwaterday.org.

References

1. World Health Organization. Celebrating water for life: the International Decade for Action 2005–2015. Geneva, Switzerland: World Health Organization; 2005. Available at http://www.who.int/water_sanitation_health/2005advocguide/en/index.html.
2. World Health Organization. Meeting the MDG drinking-water and sanitation target: a mid-term assessment of progress. Geneva, Switzerland: World Health Organization; 2004. Available at http://www.who.int/water_sanitation_health/monitoring/jmp2004/en.
3. Prüss A, Kay D, Fewtrell L, Bartram J. Estimating the burden of disease from water, sanitation, and hygiene at a global level. Environ Health Perspect 2002;110:537–42.
4. World Health Organization and United Nations Children's Fund. Global water supply and sanitation assessment 2000 report. Geneva, Switzerland: World Health Organization; 2000. Available at http://www.who.int/docstore/water_sanitation_health/globassessment/globaltoc.htm.
5. Curtis V, Cairncross S. Effect of washing hands with soap on diarrhoea risk in the community: a systematic review. Lancet Infect Dis 2003;3:275–81.
6. CDC. Safe water systems for the developing world: a handbook for implementing household-based water treatment and safe storage projects. Atlanta, GA: US Department of Health and Human Services, CDC; 2001. Available at http://www.cdc.gov/safewater/manual/1_toc.htm.

Notice to Readers

National Colorectal Cancer Awareness Month — March 2005

March is National Colorectal Cancer Awareness Month, a health observance created to increase awareness about the importance of regular screening for colorectal cancer (i.e., cancer of the colon or rectum), the second leading cause of cancer-related death in the United States (*1*). During 2005, approximately 56,290 Americans will die from colorectal cancer, and an additional 145,290 new cases will be diagnosed (*1*). Colorectal cancer screening rates in the United States remain low, even though regular screening for colorectal cancer has been shown to reduce the incidence and the number of deaths from this disease (*2,3*).

Regular screening beginning at age 50 years is considered the key to preventing colorectal cancer (*4*). CDC and other public health agencies encourage all persons aged ≥50 years to discuss screening with their health-care providers. According to current screening guidelines, including those from the U.S. Preventive Services Task Force, persons aged ≥50 years should be screened for colorectal cancer with one or more of the following tests:

- Annual fecal occult blood test (FOBT), which should be performed at home;
- Flexible sigmoidoscopy every 5 years;
- Colonoscopy every 10 years; and
- Double-contrast barium enema every 5 years.

Health-care professionals can help control colorectal cancer by recommending regular and appropriate colorectal cancer screening to all patients aged ≥50 years (*5*). An estimated 50%–60% of colorectal cancer deaths could be prevented if all persons aged ≥50 years were routinely screened (*6*).

* Defined as water supply via a household connection, public standpipe, borehole well, protected dug well, protected spring, or rainwater collection.

Despite the established effectiveness of screening, findings from CDC's 2000 National Health Interview Survey indicate that only 45% of men and 41% of women aged ≥50 years in the United States had undergone a flexible sigmoidoscopy or colonoscopy within the previous 10 years or had used a FOBT home test kit within the preceding year (*7*). Furthermore, findings from CDC's national Survey of Endoscopic Capacity demonstrate that approximately 41.8 million average-risk persons aged ≥50 years have not been screened for colorectal cancer according to national guidelines (*8*). An immediate capacity exists to screen the unscreened population with annual FOBT followed by a diagnostic colonoscopy for those with a positive FOBT result (*9*).

The public can learn more about preventing colorectal cancer through CDC's Screen for Life: National Colorectal Cancer Action Campaign, which promotes colorectal cancer screening among adults aged ≥50 years by using several communication strategies, including patient education materials, public service announcements, airport dioramas, and Internet advertising. Additional information is available at http://www.cdc.gov/screenforlife. Information about CDC's colorectal cancer–control efforts is available at http://www.cdc.gov/cancer.

References

1. American Cancer Society. Cancer facts and figures, 2005. Atlanta, GA: American Cancer Society; 2005. Publication no. 5008.05.
2. Mandel JS, Church TR, Bond JH, et al. The effect of fecal occult-blood screening on the incidence of colorectal cancer. N Engl J Med 2000;343:1603–7.
3. Mandel JS, Bond JH, Church TR, et al. Reducing mortality from colorectal cancer by screening for fecal occult blood. Minnesota Colon Cancer Control Study. N Engl J Med 1993;328:1365–71.
4. Pignone M, Rich M, Teutsch SM, Berg AO, Lohr KN. Screening for colorectal cancer in adults at average risk: a summary of the evidence for the U.S. Preventive Services Task Force. Ann Intern Med 2002;137:132–41.
5. Nadel MR, Shapiro JA, Klabunde CN, et al. National survey of primary care physicians' methods for screening for fecal occult blood. Ann Intern Med 2005;142:86–94.
6. Selby JV, Friedman GD, Quesenberry CP Jr, Weiss NS. A case control study of screening sigmoidoscopy and mortality from colorectal cancer. N Engl J Med 1992;326:653–7.
7. Swan J, Breen N, Coates RJ, Rimer BK, Lee NC. Progress in cancer screening practices in the United States: results from the National Health Interview Survey. Cancer 2003;97:1528–40.
8. Seeff LC, Manninen DL, Dong FB, et al. Is there endoscopic capacity to provide colorectal cancer screening to the unscreened population of the United States? Gastroenterol 2004;127:1661–9.
9. Seeff LC, Richards TB, Shapiro JA, et al. How many endoscopies are performed for colorectal cancer screening? Results from CDC's Survey of Endoscopic Capacity. Gastroenterol 2004;127:1670–7.

Notice to Readers

National Poison Prevention Week — March 20–26, 2005

National Poison Prevention Week, March 20–26, is organized each year in the United States by the National Poison Prevention Week Council, a coalition of national organizations working to prevent poisonings. This year, the central theme is "Children Act Fast . . . So Do Poisons!" For 2005, a primary focus is public education about the products most often involved in poisonings.

In 2003, U.S. poison-control centers reported an estimated 2.3 million exposures to poisonous substances (*1*). Approximately 90% of these occurred at a residence, and the majority occurred in children aged ≤5 years (*1*). Poisonous agents most often implicated in pediatric exposures include cosmetics, personal-care products, cleaning substances, analgesics, cough and cold preparations, and other products usually found in the home (*1*). The highest fatality rates among all poison exposures occurred in persons aged 30–39 years (19.4%) and 40–49 years (22.4%).

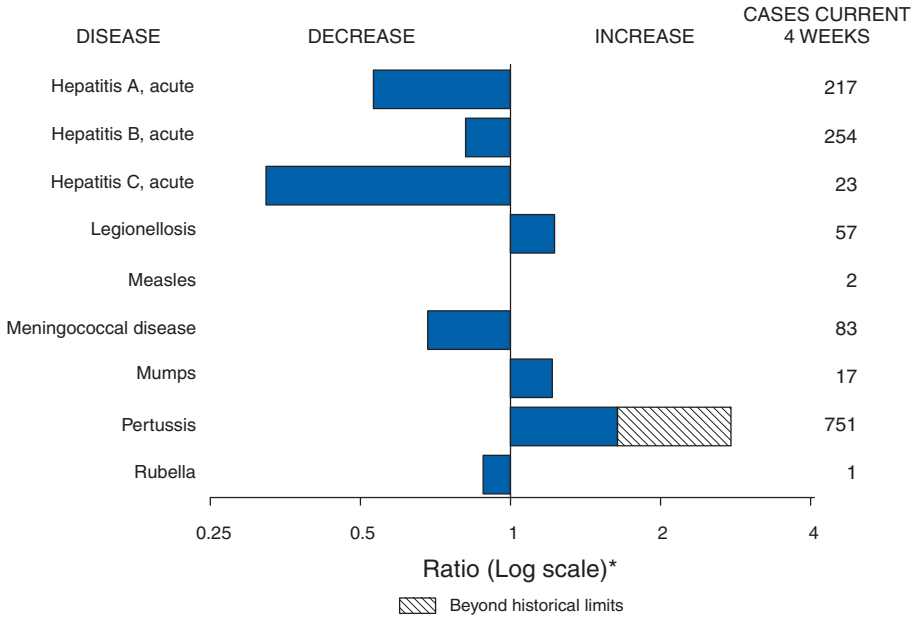
Resources for consumer education on poisoning and its prevention are available at http://www.cdc.gov/ncipc/factsheets/poisoning.htm and http://www.poisonprevention.org. A Consumer Product Safety Commission checklist is also available to educate consumers about identifying and correcting situations in the home that could lead to poisoning. This checklist is available at http://www.cpsc.gov/cpscpub/pubs/383.html.

Additional information about National Poison Prevention Week is available at http://www.cdc.gov/injury. The national toll-free telephone number for poison-control centers is 1-800-222-1222.

Reference

1. Watson WA, Litovitz TL, Klein-Schwartz W, et al. 2003 annual report of the American Association of Poison Control Centers Toxic Exposures Surveillance System. Am J Emerg Med 2003;22:335–404.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals March 12, 2005, with historical data



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

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending March 12, 2005 (10th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	13	10
Botulism:			HIV infection, pediatric†¶	31	49
foodborne	3	1	Influenza-associated pediatric mortality†**	18	—
infant	8	15	Measles	6††	11§§
other (wound & unspecified)	4	1	Mumps	51	41
Brucellosis	17	14	Plague	—	—
Chancroid	6	8	Poliomyelitis, paralytic	—	—
Cholera	—	2	Psittacosis†	3	2
Cyclosporiasis†	3	61	Q fever†	7	9
Diphtheria	—	—	Rabies, human	1	—
Domestic arboviral diseases			Rubella	4	7
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	1	—
California serogroup†§	—	1	SARS†**	—	—
eastern equine†§	—	—	Smallpox†	—	—
Powassan†§	—	—	*Staphylococcus aureus*:		
St. Louis†§	—	—	Vancomycin-intermediate (VISA)†	—	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	—	—
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome†	17	37
human granulocytic (HGE)†	11	10	Tetanus	2	1
human monocytic (HME)†	12	13	Toxic-shock syndrome	24	26
human, other and unspecified †	4	1	Trichinellosis¶¶	4	—
Hansen disease†	7	12	Tularemia†	2	4
Hantavirus pulmonary syndrome†	2	2	Yellow fever	—	—

—: No reported cases.
* Incidence data for reporting years 2004 and 2005 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, National Center for HIV, STD, and TB Prevention. Last update January 30, 2005.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of six cases reported, four were indigenous and two were imported from another country.
§§ Of 11 cases reported, three were indigenous and eight were imported from another country.
¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending March 12, 2005, and March 13, 2004 (10th Week)*

Reporting area	AIDS		Chlamydia†		Coccidioidomycosis		Cryptosporidiosis	
	Cum. 2005§	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	2,989	5,431	147,234	171,662	846	1,003	280	532
NEW ENGLAND	133	180	4,957	5,839	—	—	18	29
Maine	3	5	411	355	N	N	1	5
N.H.	2	5	295	344	—	—	4	7
Vt.¶	—	7	204	229	—	—	5	3
Mass.	47	49	2,855	2,657	—	—	4	10
R.I.	14	22	643	725	—	—	1	—
Conn.	67	92	549	1,529	N	N	3	4
MID. ATLANTIC	447	626	17,903	20,792	—	—	44	90
Upstate N.Y.	39	78	3,489	3,526	N	N	15	14
N.Y. City	221	300	5,370	6,936	—	—	9	25
N.J.	87	186	1,984	3,388	N	N	1	8
Pa.	100	62	7,060	6,942	N	N	19	43
E.N. CENTRAL	275	614	19,303	32,236	1	3	45	127
Ohio	59	155	2,416	7,981	N	N	21	33
Ind.	37	83	3,867	3,578	N	N	4	17
Ill.	147	278	6,322	9,091	—	—	—	21
Mich.	26	61	3,633	8,152	1	3	8	23
Wis.	6	37	3,065	3,434	N	N	12	33
W.N. CENTRAL	85	176	8,105	10,876	—	1	39	49
Minn.	35	33	1,416	2,232	N	N	9	16
Iowa	16	9	643	1,372	N	N	8	7
Mo.	17	82	3,721	4,000	—	—	14	14
N. Dak.	—	8	227	308	N	N	—	—
S. Dak.	3	—	543	451	—	—	2	4
Nebr.¶	—	8	404	1,025	—	1	—	—
Kans.	14	36	1,151	1,488	N	N	6	8
S. ATLANTIC	1,108	1,966	31,090	32,089	—	—	63	107
Del.	—	29	592	589	N	N	—	—
Md.	82	193	3,359	3,783	—	—	5	6
D.C.	28	96	709	687	—	—	1	2
Va.	58	76	4,871	4,337	—	—	6	8
W. Va.	12	23	501	571	N	N	4	—
N.C.	127	173	6,972	4,926	N	N	8	24
S.C.¶	42	135	3,787	3,501	—	—	—	3
Ga.	231	324	2,116	6,308	—	—	16	38
Fla.	528	917	8,183	7,387	N	N	23	26
E.S. CENTRAL	141	266	10,951	9,989	—	2	7	26
Ky.	25	39	2,544	1,110	N	N	1	5
Tenn.¶	59	109	3,503	4,156	N	N	2	11
Ala.¶	54	75	465	2,524	—	—	3	7
Miss.	3	43	4,439	2,199	—	2	1	3
W.S. CENTRAL	331	788	18,987	21,933	—	—	7	24
Ark.	35	42	1,606	1,466	—	—	—	8
La.	39	147	1,034	4,868	—	—	—	—
Okla.	43	27	2,044	1,730	N	N	4	7
Tex.¶	214	572	14,303	13,869	N	N	3	9
MOUNTAIN	112	191	9,360	9,666	535	649	17	22
Mont.	—	—	421	26	N	N	—	—
Idaho¶	1	2	275	647	N	N	—	1
Wyo.	—	—	220	213	—	—	—	2
Colo.	12	28	1,998	2,294	N	N	6	12
N. Mex.	17	19	537	1,332	1	7	2	1
Ariz.	57	104	4,199	3,494	519	625	3	5
Utah	8	9	742	574	2	4	3	—
Nev.¶	17	29	968	1,086	13	13	3	1
PACIFIC	357	624	26,578	28,242	310	348	40	58
Wash.	28	63	3,654	3,282	N	N	—	3
Oreg.¶	32	17	1,734	1,493	—	—	5	6
Calif.	291	514	19,803	21,678	310	348	35	48
Alaska	5	5	650	623	—	—	—	—
Hawaii	1	25	737	1,166	—	—	—	1
Guam	1	—	—	190	—	—	—	—
P.R.	1	141	694	404	N	N	N	N
V.I.	3	2	32	90	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	2	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 2004 and 2005 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, National Center for HIV, STD, and TB Prevention. Last update January 30, 2005.

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 12, 2005, and March 13, 2004 (10th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	163	155	19	31	24	20	2,497	2,941	49,250	61,883
NEW ENGLAND	12	7	2	8	4	2	182	241	936	1,381
Maine	—	—	—	—	—	—	26	22	24	59
N.H.	—	1	—	—	—	—	7	8	22	21
Vt.	1	—	—	—	—	—	24	16	5	11
Mass.	4	2	1	3	4	2	107	131	589	582
R.I.	1	—	—	—	—	—	17	9	90	183
Conn.	6	4	1	5	—	—	1	55	206	525
MID. ATLANTIC	21	16	1	—	1	4	448	658	5,128	6,930
Upstate N.Y.	12	3	1	—	—	2	144	163	1,087	1,244
N.Y. City	1	5	—	—	—	—	108	231	1,381	2,270
N.J.	4	—	—	—	—	1	61	78	686	1,296
Pa.	4	8	—	—	1	1	135	186	1,974	2,120
E.N. CENTRAL	42	42	3	9	3	3	328	476	7,472	13,528
Ohio	19	11	1	—	2	3	109	139	1,255	4,226
Ind.	3	12	—	—	—	—	N	N	1,511	1,292
Ill.	5	6	1	—	—	—	20	168	2,595	3,834
Mich.	7	8	—	1	1	—	115	104	1,240	3,313
Wis.	8	5	1	8	—	—	84	65	871	863
W.N. CENTRAL	26	20	4	6	3	6	278	269	2,626	3,582
Minn.	3	9	1	2	—	—	112	89	429	869
Iowa	5	2	—	—	—	—	41	36	116	242
Mo.	11	3	2	4	1	1	62	92	1,523	1,632
N. Dak.	—	1	—	—	—	3	—	2	15	29
S. Dak.	2	—	—	—	—	—	16	10	64	42
Nebr.	3	2	1	—	1	—	20	19	106	244
Kans.	2	3	—	—	1	2	27	21	373	524
S. ATLANTIC	20	10	3	3	13	4	467	472	13,637	14,752
Del.	—	—	N	N	N	N	8	11	139	199
Md.	4	2	1	—	—	1	31	18	1,361	1,611
D.C.	—	—	—	—	—	—	11	13	430	456
Va.	1	—	—	2	2	—	80	59	1,851	1,887
W. Va.	—	—	—	—	—	—	6	7	145	168
N.C.	—	—	—	—	9	3	N	N	3,606	2,869
S.C.	—	1	—	—	—	—	13	6	1,667	1,714
Ga.	5	2	1	—	—	—	162	142	926	2,795
Fla.	10	5	1	1	2	—	156	216	3,512	3,053
E.S. CENTRAL	8	6	—	—	—	1	59	58	3,779	4,726
Ky.	—	2	—	—	—	1	N	N	773	500
Tenn.	5	2	—	—	—	—	24	23	1,282	1,582
Ala.	3	1	—	—	—	—	35	35	390	1,511
Miss.	—	1	—	—	—	—	—	—	1,334	1,133
W.S. CENTRAL	4	15	—	—	—	—	38	53	7,358	8,292
Ark.	1	—	—	—	—	—	16	24	862	674
La.	—	1	—	—	—	—	6	8	643	2,339
Okla.	1	3	—	—	—	—	16	21	956	785
Tex.	2	11	—	—	—	—	N	N	4,897	4,494
MOUNTAIN	10	16	6	4	—	—	208	252	2,103	2,245
Mont.	1	1	—	—	—	—	9	5	23	7
Idaho	1	3	4	1	—	—	19	38	14	12
Wyo.	—	—	1	—	—	—	1	1	11	10
Colo.	3	3	1	1	—	—	64	86	517	578
N. Mex.	—	2	—	1	—	—	8	11	100	164
Ariz.	3	2	N	N	N	N	44	50	891	948
Utah	2	2	—	—	—	—	54	44	126	60
Nev.	—	3	—	1	—	—	9	17	421	466
PACIFIC	20	23	—	1	—	—	489	462	6,211	6,447
Wash.	5	2	—	—	—	—	28	27	622	544
Oreg.	—	2	—	1	—	—	42	81	296	188
Calif.	11	16	—	—	—	—	391	333	5,054	5,313
Alaska	2	—	—	—	—	—	12	8	90	110
Hawaii	2	3	—	—	—	—	16	13	149	292
Guam	N	N	—	—	—	—	—	—	—	42
P.R.	—	—	—	—	—	—	6	4	70	30
V.I.	—	—	—	—	—	—	—	—	2	28
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 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 12, 2005, and March 13, 2004 (10th Week)*

Reporting area	*Haemophilus influenzae*, invasive							
	All ages		Age <5 years					
	All serotypes		Serotype b		Non-serotype b		Unknown serotype	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	407	449	—	3	16	23	35	49
NEW ENGLAND	29	45	—	1	1	4	2	—
Maine	1	3	—	—	—	—	—	—
N.H.	—	9	—	—	—	1	—	—
Vt.	5	3	—	—	—	—	2	—
Mass.	13	22	—	1	—	2	—	—
R.I.	2	1	—	—	—	—	—	—
Conn.	8	7	—	—	1	1	—	—
MID. ATLANTIC	83	88	—	—	—	1	9	13
Upstate N.Y.	23	27	—	—	—	1	1	1
N.Y. City	14	16	—	—	—	—	2	4
N.J.	17	18	—	—	—	—	3	3
Pa.	29	27	—	—	—	—	3	5
E.N. CENTRAL	57	87	—	—	1	6	2	14
Ohio	34	30	—	—	—	2	2	4
Ind.	14	11	—	—	1	3	—	1
Ill.	2	22	—	—	—	—	—	5
Mich.	7	7	—	—	—	1	—	3
Wis.	—	17	—	—	—	—	—	1
W.N. CENTRAL	22	17	—	1	1	1	2	2
Minn.	9	7	—	—	1	1	—	—
Iowa	—	1	—	1	—	—	—	—
Mo.	11	5	—	—	—	—	2	2
N. Dak.	—	—	—	—	—	—	—	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	1	4	—	—	—	—	—	—
Kans.	1	—	—	—	—	—	—	—
S. ATLANTIC	119	99	—	—	4	1	9	7
Del.	—	—	—	—	—	—	—	—
Md.	19	23	—	—	1	1	2	—
D.C.	—	—	—	—	—	—	—	—
Va.	6	9	—	—	—	—	—	—
W. Va.	7	6	—	—	—	—	2	3
N.C.	21	7	—	—	2	—	—	—
S.C.	2	2	—	—	—	—	—	—
Ga.	41	25	—	—	—	—	4	4
Fla.	23	27	—	—	1	—	1	—
E.S. CENTRAL	19	17	—	—	—	—	3	4
Ky.	—	—	—	—	—	—	—	—
Tenn.	16	10	—	—	—	—	1	3
Ala.	3	7	—	—	—	—	2	1
Miss.	—	—	—	—	—	—	—	—
W.S. CENTRAL	20	22	—	—	1	3	5	—
Ark.	—	—	—	—	—	—	—	—
La.	9	7	—	—	—	—	5	—
Okla.	11	15	—	—	1	3	—	—
Tex.	—	—	—	—	—	—	—	—
MOUNTAIN	44	56	—	1	7	6	2	7
Mont.	—	—	—	—	—	—	—	—
Idaho	1	2	—	—	—	—	—	1
Wyo.	1	—	—	—	—	—	—	—
Colo.	11	11	—	—	—	—	1	1
N. Mex.	6	16	—	—	2	2	—	4
Ariz.	17	26	—	—	3	4	1	1
Utah	3	1	—	1	—	—	—	—
Nev.	5	—	—	—	2	—	—	—
PACIFIC	14	18	—	—	1	1	1	2
Wash.	—	1	—	—	—	—	—	1
Oreg.	7	10	—	—	—	—	1	—
Calif.	4	5	—	—	1	1	—	1
Alaska	1	—	—	—	—	—	—	—
Hawaii	2	2	—	—	—	—	—	—
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	—	—	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 12, 2005, and March 13, 2004 (10th Week)*

Reporting area	Hepatitis (viral, acute), by type					
	A		B		C	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	679	1,210	948	1,095	94	168
NEW ENGLAND	92	194	44	73	2	3
Maine	—	6	2	1	—	—
N.H.	6	3	2	8	—	—
Vt.	—	5	—	1	2	1
Mass.	73	160	36	36	—	2
R.I.	1	—	—	—	—	—
Conn.	12	20	4	27	—	—
MID. ATLANTIC	103	154	191	200	15	28
Upstate N.Y.	22	14	18	9	2	—
N.Y. City	42	56	10	37	—	—
N.J.	12	34	120	91	—	—
Pa.	27	50	43	63	13	28
E.N. CENTRAL	50	116	64	83	21	10
Ohio	16	12	32	34	—	2
Ind.	9	17	5	2	1	—
Ill.	5	44	—	—	—	1
Mich.	16	30	27	36	20	7
Wis.	4	13	—	11	—	—
W.N. CENTRAL	21	23	45	64	6	16
Minn.	—	1	—	6	—	—
Iowa	4	5	3	1	—	—
Mo.	12	5	30	49	6	16
N. Dak.	—	—	—	1	—	—
S. Dak.	—	2	—	—	—	—
Nebr.	2	7	7	5	—	—
Kans.	3	3	5	2	—	—
S. ATLANTIC	128	211	323	313	25	35
Del.	2	2	4	3	—	2
Md.	11	42	36	32	8	2
D.C.	—	2	—	4	—	1
Va.	15	12	37	26	—	4
W. Va.	3	1	3	—	—	1
N.C.	22	13	34	24	4	1
S.C.	3	3	9	11	—	2
Ga.	33	84	92	105	—	5
Fla.	39	52	108	108	13	17
E.S. CENTRAL	28	33	55	81	11	18
Ky.	3	2	17	6	—	7
Tenn.	19	22	22	29	5	5
Ala.	3	2	15	14	3	—
Miss.	3	7	1	32	3	6
W.S. CENTRAL	16	172	33	45	1	44
Ark.	1	21	10	19	—	—
La.	4	7	5	18	1	28
Okla.	1	9	—	7	—	—
Tex.	10	135	18	1	—	16
MOUNTAIN	77	82	91	72	5	4
Mont.	6	—	—	—	—	—
Idaho	4	4	3	2	—	—
Wyo.	—	—	—	1	—	—
Colo.	7	7	7	10	—	—
N. Mex.	4	3	3	3	—	1
Ariz.	49	56	67	38	—	2
Utah	5	11	9	10	4	—
Nev.	2	1	2	8	1	1
PACIFIC	164	225	102	164	8	10
Wash.	12	11	9	13	1	1
Oreg.	9	16	18	33	2	3
Calif.	138	192	74	115	5	4
Alaska	1	2	—	2	—	—
Hawaii	4	4	1	1	—	2
Guam	—	1	—	—	—	—
P.R.	—	6	2	5	—	—
V.I.	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 12, 2005, and March 13, 2004 (10th Week)*

Reporting area	Legionellosis		Listeriosis		Lyme disease		Malaria	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	204	233	85	78	864	1,488	168	224
NEW ENGLAND	5	4	2	2	24	102	4	18
Maine	—	—	—	—	5	6	—	—
N.H.	1	—	1	1	9	—	2	—
Vt.	—	—	—	—	—	2	—	1
Mass.	4	3	—	—	6	75	2	13
R.I.	—	—	—	—	1	4	—	1
Conn.	—	1	1	1	3	15	—	3
MID. ATLANTIC	64	49	17	19	643	1,187	35	47
Upstate N.Y.	15	10	3	3	79	277	5	6
N.Y. City	2	—	3	3	—	—	14	24
N.J.	12	19	4	7	277	345	11	10
Pa.	35	20	7	6	287	565	5	7
E.N. CENTRAL	42	67	13	10	23	33	11	17
Ohio	24	31	4	4	21	8	3	3
Ind.	9	10	—	2	1	—	—	3
Ill.	—	13	—	—	—	—	1	2
Mich.	8	11	4	2	1	—	6	4
Wis.	1	2	5	2	U	25	1	5
W.N. CENTRAL	9	4	7	2	24	11	7	13
Minn.	1	—	2	1	22	3	1	6
Iowa	—	—	2	—	1	2	2	1
Mo.	7	3	2	1	1	6	3	4
N. Dak.	1	—	1	—	—	—	—	—
S. Dak.	—	1	—	—	—	—	—	—
Nebr.	—	—	—	—	—	—	—	—
Kans.	—	—	—	—	—	—	1	2
S. ATLANTIC	50	50	22	14	130	120	40	67
Del.	—	1	N	N	25	14	—	—
Md.	13	8	3	3	71	72	11	19
D.C.	1	2	—	—	1	1	—	4
Va.	3	4	2	—	3	2	5	4
W. Va.	4	2	—	1	—	—	1	—
N.C.	6	7	5	4	11	21	5	3
S.C.	—	1	—	—	3	1	—	4
Ga.	6	4	3	2	—	2	11	8
Fla.	17	21	9	4	16	7	7	25
E.S. CENTRAL	1	9	4	3	3	4	6	7
Ky.	—	2	—	1	—	—	1	1
Tenn.	—	4	2	2	3	1	4	1
Ala.	1	3	2	—	—	—	1	4
Miss.	—	—	—	—	—	3	—	1
W.S. CENTRAL	1	23	1	8	5	12	15	21
Ark.	—	—	—	—	—	—	1	1
La.	1	1	1	—	—	—	—	2
Okla.	—	2	—	—	—	—	—	1
Tex.	—	20	—	8	5	12	14	17
MOUNTAIN	13	13	—	2	—	4	11	7
Mont.	—	—	—	—	—	—	—	—
Idaho	—	1	—	1	—	1	—	—
Wyo.	2	2	—	—	—	1	1	—
Colo.	2	2	—	1	—	—	6	3
N. Mex.	1	—	—	—	—	—	—	1
Ariz.	3	2	—	—	—	1	2	1
Utah	2	5	—	—	—	1	2	1
Nev.	3	1	—	—	—	—	—	1
PACIFIC	19	14	19	18	12	15	39	27
Wash.	1	2	2	3	—	1	—	1
Oreg.	N	N	1	4	1	7	1	3
Calif.	18	12	16	11	10	7	36	23
Alaska	—	—	—	—	1	—	1	—
Hawaii	—	—	—	—	N	N	1	—
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 12, 2005, and March 13, 2004 (10th Week)*

Reporting area	Meningococcal disease									
	All serogroups		Serogroup A, C, Y, and W-135		Serogroup B		Other serogroup		Serogroup unknown	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	247	364	19	26	17	11	—	—	211	327
NEW ENGLAND	25	16	1	2	—	—	—	—	24	14
Maine	1	3	—	—	—	—	—	—	1	3
N.H.	2	2	—	—	—	—	—	—	2	2
Vt.	3	1	—	—	—	—	—	—	3	1
Mass.	11	10	—	2	—	—	—	—	11	8
R.I.	2	—	—	—	—	—	—	—	2	—
Conn.	6	—	1	—	—	—	—	—	5	—
MID. ATLANTIC	34	54	8	15	2	4	—	—	24	35
Upstate N.Y.	9	18	1	3	1	2	—	—	7	13
N.Y. City	4	12	—	—	—	—	—	—	4	12
N.J.	10	6	—	—	—	—	—	—	10	6
Pa.	11	18	7	12	1	2	—	—	3	4
E.N. CENTRAL	19	38	6	7	3	2	—	—	10	29
Ohio	7	18	—	3	2	2	—	—	5	13
Ind.	4	8	—	—	1	—	—	—	3	8
Ill.	—	1	—	—	—	—	—	—	—	1
Mich.	6	4	6	4	—	—	—	—	—	—
Wis.	2	7	—	—	—	—	—	—	2	7
W.N. CENTRAL	20	14	1	—	1	1	—	—	18	13
Minn.	4	3	1	—	—	—	—	—	3	3
Iowa	6	2	—	—	1	1	—	—	5	1
Mo.	6	6	—	—	—	—	—	—	6	6
N. Dak.	—	—	—	—	—	—	—	—	—	—
S. Dak.	—	1	—	—	—	—	—	—	—	1
Nebr.	1	1	—	—	—	—	—	—	1	1
Kans.	3	1	—	—	—	—	—	—	3	1
S. ATLANTIC	40	64	2	1	4	1	—	—	34	62
Del.	—	1	—	—	—	—	—	—	—	1
Md.	6	4	1	—	2	—	—	—	3	4
D.C.	—	4	—	1	—	—	—	—	—	3
Va.	1	2	—	—	—	—	—	—	1	2
W. Va.	1	3	—	—	—	—	—	—	1	3
N.C.	6	7	1	—	2	1	—	—	3	6
S.C.	4	5	—	—	—	—	—	—	4	5
Ga.	7	5	—	—	—	—	—	—	7	5
Fla.	15	33	—	—	—	—	—	—	15	33
E.S. CENTRAL	14	16	—	—	1	—	—	—	13	16
Ky.	5	3	—	—	1	—	—	—	4	3
Tenn.	6	6	—	—	—	—	—	—	6	6
Ala.	—	3	—	—	—	—	—	—	—	3
Miss.	3	4	—	—	—	—	—	—	3	4
W.S. CENTRAL	17	38	1	1	2	—	—	—	14	37
Ark.	5	5	—	—	—	—	—	—	5	5
La.	7	12	—	1	2	—	—	—	5	11
Okla.	3	1	1	—	—	—	—	—	2	1
Tex.	2	20	—	—	—	—	—	—	2	20
MOUNTAIN	17	22	—	—	1	2	—	—	16	20
Mont.	—	1	—	—	—	—	—	—	—	1
Idaho	—	2	—	—	—	—	—	—	—	2
Wyo.	—	2	—	—	—	—	—	—	—	2
Colo.	7	7	—	—	—	—	—	—	7	7
N. Mex.	—	3	—	—	—	1	—	—	—	2
Ariz.	6	4	—	—	1	—	—	—	5	4
Utah	2	1	—	—	—	—	—	—	2	1
Nev.	2	2	—	—	—	1	—	—	2	1
PACIFIC	61	102	—	—	3	1	—	—	58	101
Wash.	10	5	—	—	3	1	—	—	7	4
Oreg.	14	25	—	—	—	—	—	—	14	25
Calif.	34	68	—	—	—	—	—	—	34	68
Alaska	—	1	—	—	—	—	—	—	—	1
Hawaii	3	3	—	—	—	—	—	—	3	3
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	—	1	—	—	—	—	—	—	—	1
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	—	—	—	—	—	—	—	—	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 12, 2005, and March 13, 2004 (10th Week)*

Reporting area	Pertussis		Rabies, animal		Rocky Mountain spotted fever		Salmonellosis		Shigellosis	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	2,900	1,629	683	1,020	109	94	3,889	4,724	1,559	2,152
NEW ENGLAND	143	327	118	56	—	3	195	213	35	45
Maine	6	—	8	10	N	N	10	9	—	—
N.H.	—	7	2	4	—	—	14	13	3	3
Vt.	40	12	7	4	—	—	15	7	2	—
Mass.	97	298	83	20	—	3	115	134	24	31
R.I.	—	—	2	—	—	—	5	7	1	—
Conn.	—	10	16	18	—	—	36	43	5	11
MID. ATLANTIC	348	457	94	104	3	9	412	645	151	230
Upstate N.Y.	105	279	45	50	—	—	104	113	45	82
N.Y. City	5	39	6	1	1	3	105	215	57	70
N.J.	39	59	N	N	—	—	69	142	41	50
Pa.	199	80	43	53	2	6	134	175	8	28
E.N. CENTRAL	786	253	5	3	2	—	373	771	90	202
Ohio	443	90	3	2	2	—	130	172	12	43
Ind.	64	7	1	1	—	—	38	61	13	15
Ill.	4	2	1	—	—	—	17	272	4	94
Mich.	35	23	—	—	—	—	90	123	48	26
Wis.	240	131	—	—	—	—	98	143	13	24
W.N. CENTRAL	346	81	43	71	5	2	299	252	124	57
Minn.	92	14	12	9	—	—	75	54	6	11
Iowa	20	22	11	9	—	—	61	46	16	3
Mo.	97	38	4	2	5	2	86	76	72	20
N. Dak.	12	1	1	11	—	—	3	6	1	1
S. Dak.	1	—	5	11	—	—	23	11	6	1
Nebr.	54	—	—	12	—	—	22	22	18	3
Kans.	70	6	10	17	—	—	29	37	5	18
S. ATLANTIC	197	87	227	535	79	66	1,200	1,073	288	583
Del.	1	—	—	1	—	2	1	6	—	2
Md.	36	28	52	59	5	1	94	80	14	22
D.C.	—	4	—	—	—	—	6	4	1	9
Va.	40	19	92	74	—	—	100	104	15	19
W. Va.	3	—	2	13	1	—	14	16	—	—
N.C.	19	16	75	106	59	56	243	162	26	91
S.C.	62	5	5	16	2	3	62	60	14	55
Ga.	6	3	—	59	9	3	211	166	87	123
Fla.	30	12	1	207	3	1	469	475	131	262
E.S. CENTRAL	74	22	14	53	3	10	208	254	162	122
Ky.	18	2	—	2	—	—	28	34	13	16
Tenn.	33	13	—	36	2	3	83	74	90	50
Ala.	17	3	14	11	1	1	78	97	46	40
Miss.	6	4	—	4	—	6	19	49	13	16
W.S. CENTRAL	42	23	137	174	1	1	235	421	310	495
Ark.	2	7	9	8	—	—	41	40	12	11
La.	1	2	—	—	1	1	48	46	17	47
Okla.	—	1	12	17	—	—	33	41	69	75
Tex.	39	13	116	149	—	—	113	294	212	362
MOUNTAIN	671	163	33	14	14	—	270	347	96	161
Mont.	192	4	—	1	—	—	17	14	—	3
Idaho	25	13	—	—	—	—	11	30	—	—
Wyo.	6	2	4	—	—	—	7	5	—	1
Colo.	308	83	—	—	—	—	73	87	13	29
N. Mex.	18	21	—	—	—	—	16	39	9	38
Ariz.	48	23	29	13	12	—	105	121	49	69
Utah	71	17	—	—	2	—	24	32	8	8
Nev.	3	—	—	—	—	—	17	19	17	13
PACIFIC	293	216	12	10	2	3	697	748	303	257
Wash.	58	53	—	—	—	—	55	39	9	10
Oreg.	156	35	—	—	—	2	31	57	13	13
Calif.	50	124	11	10	2	1	558	577	272	219
Alaska	10	1	1	—	—	—	11	20	3	3
Hawaii	19	3	—	—	—	—	42	55	6	12
Guam	—	—	—	—	—	—	—	5	—	10
P.R.	—	1	15	14	N	N	20	34	—	1
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. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 12, 2005, and March 13, 2004 (10th Week)*

Reporting area	Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive disease				Syphilis			
			Drug resistant, all ages		Age <5 years		Primary & secondary		Congenital	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	946	1,070	554	562	134	157	1,108	1,334	37	88
NEW ENGLAND	33	58	2	2	13	18	37	21	—	—
Maine	2	2	N	N	—	—	1	—	—	—
N.H.	3	6	—	—	—	N	3	1	—	—
Vt.	4	—	2	1	1	—	—	—	—	—
Mass.	21	48	—	—	12	17	32	10	—	—
R.I.	3	2	—	1	—	1	—	1	—	—
Conn.	—	—	—	—	U	U	1	9	—	—
MID. ATLANTIC	175	183	57	35	28	15	127	180	9	16
Upstate N.Y.	64	56	20	13	18	8	11	7	6	1
N.Y. City	15	37	U	U	U	U	87	115	1	5
N.J.	33	40	N	N	2	—	19	31	1	9
Pa.	63	50	37	22	8	7	10	27	1	1
E.N. CENTRAL	124	236	111	128	31	43	95	140	2	21
Ohio	38	60	79	99	20	23	45	41	—	1
Ind.	26	17	32	29	6	6	10	8	—	5
Ill.	2	71	—	—	2	—	28	62	1	2
Mich.	54	68	—	N	—	N	8	23	—	13
Wis.	4	20	N	N	3	14	4	6	1	—
W.N. CENTRAL	60	84	12	3	14	14	27	35	—	—
Minn.	22	36	—	—	6	7	1	5	—	—
Iowa	N	N	N	N	—	N	—	1	—	—
Mo.	18	17	11	3	—	3	23	21	—	—
N. Dak.	1	3	—	—	1	—	—	—	—	—
S. Dak.	4	5	1	—	—	—	—	—	—	—
Nebr.	7	6	—	—	2	2	1	5	—	—
Kans.	8	17	N	N	5	2	2	3	—	—
S. ATLANTIC	211	191	265	280	17	10	322	329	8	12
Del.	—	—	—	1	—	N	2	1	—	—
Md.	72	47	—	—	15	7	68	48	4	3
D.C.	2	2	2	3	1	3	24	13	—	1
Va.	7	11	N	N	—	N	15	3	2	1
W. Va.	6	7	13	20	1	—	2	2	—	—
N.C.	19	22	N	N	U	U	50	30	1	—
S.C.	2	2	—	17	—	N	14	26	—	2
Ga.	41	50	102	83	—	N	12	58	—	1
Fla.	62	50	148	156	—	N	135	148	1	4
E.S. CENTRAL	35	52	41	39	—	—	72	73	3	3
Ky.	9	20	7	8	N	N	5	14	—	—
Tenn.	26	32	34	31	—	N	23	32	1	1
Ala.	—	—	—	—	—	N	38	18	2	1
Miss.	—	—	—	—	—	—	6	9	—	1
W.S. CENTRAL	29	91	30	24	21	41	198	208	12	20
Ark.	6	3	6	3	1	2	11	13	—	2
La.	3	1	24	21	6	10	12	42	—	—
Okla.	20	13	N	N	8	15	11	5	1	2
Tex.	—	74	N	N	6	14	164	148	11	16
MOUNTAIN	191	65	20	11	10	16	55	67	3	1
Mont.	—	—	—	—	—	—	4	—	—	—
Idaho	1	1	N	N	—	N	6	5	—	—
Wyo.	1	3	6	4	—	—	—	1	—	—
Colo.	81	22	N	N	9	15	1	12	—	—
N. Mex.	13	28	—	5	—	—	6	21	—	1
Ariz.	80	3	N	N	—	N	29	24	3	—
Utah	15	8	13	1	1	1	1	2	—	—
Nev.	—	—	1	1	—	—	8	2	—	—
PACIFIC	88	110	16	40	—	—	175	281	—	15
Wash.	N	N	N	N	N	N	30	12	—	—
Oreg.	N	N	N	N	—	N	2	9	—	—
Calif.	67	85	N	N	—	N	141	257	—	15
Alaska	—	—	—	—	—	N	—	—	—	—
Hawaii	21	25	16	40	—	—	2	3	—	—
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	N	N	N	N	—	N	23	22	3	1
V.I.	—	—	—	—	—	—	—	4	—	—
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 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 12, 2005, and March 13, 2004 (10th Week)*

Reporting area	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease†		
							Neuroinvasive		Non-neuroinvasive§
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	1,072	1,736	29	47	4,064	3,936	—	—	—
NEW ENGLAND	44	50	—	6	79	172	—	—	—
Maine	—	—	—	—	66	17	—	—	—
N.H.	3	—	—	—	—	—	—	—	—
Vt.	—	—	—	—	12	155	—	—	—
Mass.	30	27	—	6	1	—	—	—	—
R.I.	—	9	—	—	—	—	—	—	—
Conn.	11	14	—	—	—	—	—	—	—
MID. ATLANTIC	293	292	8	11	775	9	—	—	—
Upstate N.Y.	29	30	1	—	—	—	—	—	—
N.Y. City	163	169	1	5	—	—	—	—	—
N.J.	62	56	3	4	—	—	—	—	—
Pa.	39	37	3	2	775	9	—	—	—
E.N. CENTRAL	191	155	1	2	1,610	1,506	—	—	—
Ohio	36	32	—	1	259	401	—	—	—
Ind.	20	32	1	—	N	N	—	—	—
Ill.	101	69	—	—	2	—	—	—	—
Mich.	19	10	—	1	1,227	947	—	—	—
Wis.	15	12	—	—	122	158	—	—	—
W.N. CENTRAL	67	52	1	1	24	41	—	—	—
Minn.	20	20	1	1	—	—	—	—	—
Iowa	7	5	—	—	N	N	—	—	—
Mo.	24	17	—	—	2	—	—	—	—
N. Dak.	1	—	—	—	3	22	—	—	—
S. Dak.	4	2	—	—	19	19	—	—	—
Nebr.	1	2	—	—	—	—	—	—	—
Kans.	10	6	—	—	—	—	—	—	N
S. ATLANTIC	232	352	4	8	387	362	—	—	—
Del.	—	4	—	—	1	—	—	—	—
Md.	37	26	1	2	—	—	—	—	—
D.C.	20	4	—	—	2	5	—	—	—
Va.	—	22	—	2	28	41	—	—	—
W. Va.	6	5	—	—	317	257	—	—	N
N.C.	24	22	1	2	—	N	—	—	—
S.C.	20	16	—	—	39	59	—	—	—
Ga.	3	127	1	—	—	—	—	—	—
Fla.	122	126	1	2	—	—	—	—	—
E.S. CENTRAL	59	84	2	—	—	—	—	—	—
Ky.	20	6	1	—	N	N	—	—	—
Tenn.	39	31	1	—	—	—	—	—	—
Ala.	—	30	—	—	—	—	—	—	—
Miss.	—	17	—	—	—	—	—	—	—
W.S. CENTRAL	35	354	2	5	431	1,295	—	—	—
Ark.	15	20	—	—	—	—	—	—	—
La.	—	—	—	—	4	33	—	—	—
Okla.	20	24	—	—	—	—	—	—	—
Tex.	—	310	2	5	427	1,262	—	—	—
MOUNTAIN	18	55	1	2	758	551	—	—	—
Mont.	—	—	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—	—
Wyo.	—	—	—	—	32	11	—	—	—
Colo.	—	13	—	—	534	387	—	—	—
N. Mex.	1	5	—	—	36	21	—	—	—
Ariz.	15	21	1	1	—	—	—	—	—
Utah	2	9	—	1	156	132	—	—	—
Nev.	—	7	—	—	—	—	—	—	—
PACIFIC	133	342	10	12	—	—	—	—	—
Wash.	36	41	—	1	N	N	—	—	—
Oreg.	21	12	1	—	—	—	—	—	—
Calif.	50	257	5	8	—	—	—	—	—
Alaska	2	7	—	—	—	—	—	—	—
Hawaii	24	25	4	3	—	—	—	—	—
Guam	—	12	—	—	—	16	—	—	—
P.R.	—	5	—	—	38	81	—	—	—
V.I.	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	—
C.N.M.I.	—	U	—	U	—	U	—	U	—

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

* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

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

§ Not previously notifiable.

TABLE III. Deaths in 122 U.S. cities,* week ending March 12, 2005 (10th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
NEW ENGLAND	521	353	116	34	11	7	60
Boston, Mass.	158	101	38	12	4	3	17
Bridgeport, Conn.	53	38	13	2	—	—	5
Cambridge, Mass.	13	10	3	—	—	—	3
Fall River, Mass.	24	17	6	—	—	1	4
Hartford, Conn.	68	38	19	7	3	1	5
Lowell, Mass.	30	24	4	1	—	1	3
Lynn, Mass.	11	4	7	—	—	—	—
New Bedford, Mass.	29	27	2	—	—	—	7
New Haven, Conn.	9	5	1	1	2	—	3
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	4	2	2	—	—	—	—
Springfield, Mass.	35	24	5	4	1	1	4
Waterbury, Conn.	20	15	4	1	—	—	3
Worcester, Mass.	67	48	12	6	1	—	6
MID. ATLANTIC	2,249	1,599	444	143	34	29	153
Albany, N.Y.	61	42	8	7	2	2	5
Allentown, Pa.	17	14	2	1	—	—	1
Buffalo, N.Y.	88	65	18	2	1	2	7
Camden, N.J.	43	23	10	8	1	1	5
Elizabeth, N.J.	21	14	4	3	—	—	2
Erie, Pa.	62	50	9	3	—	—	5
Jersey City, N.J.	41	26	11	3	—	1	—
New York City, N.Y.	1,114	798	228	65	12	11	66
Newark, N.J.	52	29	15	6	1	1	4
Paterson, N.J.	U	U	U	U	U	U	U
Philadelphia, Pa.	402	276	84	28	7	7	20
Pittsburgh, Pa.§	39	21	13	2	2	1	3
Reading, Pa.	30	26	1	1	2	—	4
Rochester, N.Y.	158	125	23	5	4	1	21
Schenectady, N.Y.	24	20	2	1	1	—	4
Scranton, Pa.	39	35	2	2	—	—	—
Syracuse, N.Y.	U	U	U	U	U	U	U
Trenton, N.J.	27	10	10	5	—	2	3
Utica, N.Y.	10	8	2	—	—	—	—
Yonkers, N.Y.	21	17	2	1	1	—	3
E.N. CENTRAL	2,462	1,733	490	143	39	56	227
Akron, Ohio	59	43	12	1	—	3	17
Canton, Ohio	48	37	8	2	—	1	8
Chicago, Ill.	386	245	85	36	7	12	33
Cincinnati, Ohio	121	73	35	8	—	5	10
Cleveland, Ohio	291	219	48	20	1	3	9
Columbus, Ohio	214	160	36	8	6	4	32
Dayton, Ohio	164	119	30	7	4	4	22
Detroit, Mich.	173	94	60	11	3	5	12
Evansville, Ind.	56	47	6	—	1	2	4
Fort Wayne, Ind.	83	66	12	4	1	—	5
Gary, Ind.	14	4	6	3	—	1	—
Grand Rapids, Mich.	74	57	10	6	1	—	9
Indianapolis, Ind.	223	153	40	13	8	9	19
Lansing, Mich.	45	34	9	1	—	1	8
Milwaukee, Wis.	139	106	17	13	1	2	14
Peoria, Ill.	58	36	18	1	1	2	3
Rockford, Ill.	70	51	14	3	—	2	3
South Bend, Ind.	75	62	11	1	1	—	10
Toledo, Ohio	105	71	26	5	3	—	5
Youngstown, Ohio	64	56	7	—	1	—	4
W.N. CENTRAL	615	427	130	27	17	14	46
Des Moines, Iowa	125	94	27	2	2	—	11
Duluth, Minn.	36	25	10	—	1	—	1
Kansas City, Kans.	U	U	U	U	U	U	U
Kansas City, Mo.	100	74	23	2	1	—	6
Lincoln, Nebr.	36	27	7	1	1	—	3
Minneapolis, Minn.	61	43	8	4	2	4	5
Omaha, Nebr.	89	65	14	3	2	5	14
St. Louis, Mo.	100	47	30	11	8	4	5
St. Paul, Minn.	67	52	10	4	—	1	1
Wichita, Kans.	1	—	1	—	—	—	—
S. ATLANTIC	1,291	858	294	90	36	13	89
Atlanta, Ga.	160	96	44	15	5	—	11
Baltimore, Md.	233	136	64	25	7	1	21
Charlotte, N.C.	116	85	22	—	7	2	13
Jacksonville, Fla.	146	95	32	11	6	2	4
Miami, Fla.	98	67	22	7	1	1	6
Norfolk, Va.	47	29	13	1	1	3	1
Richmond, Va.	62	41	17	3	1	—	5
Savannah, Ga.	52	39	10	3	—	—	9
St. Petersburg, Fla.	64	48	9	6	—	1	2
Tampa, Fla.	202	142	40	12	5	3	13
Washington, D.C.	100	69	21	7	3	—	2
Wilmington, Del.	11	11	—	—	—	—	2
E.S. CENTRAL	993	688	218	47	19	21	85
Birmingham, Ala.	230	168	40	12	4	6	25
Chattanooga, Tenn.	96	65	25	4	2	—	5
Knoxville, Tenn.	92	64	26	2	—	—	8
Lexington, Ky.	63	45	16	1	1	—	6
Memphis, Tenn.	203	130	50	11	7	5	7
Mobile, Ala.	61	47	8	5	—	1	5
Montgomery, Ala.	61	45	10	4	1	1	7
Nashville, Tenn.	187	124	43	8	4	8	22
W.S. CENTRAL	1,708	1,166	361	100	46	35	144
Austin, Tex.	103	85	13	3	2	—	14
Baton Rouge, La.	19	13	2	3	—	1	—
Corpus Christi, Tex.	66	45	11	6	1	3	6
Dallas, Tex.	211	129	52	14	7	9	15
El Paso, Tex.	112	79	23	6	2	2	6
Ft. Worth, Tex.	175	118	35	9	7	6	12
Houston, Tex.	440	285	96	40	12	7	42
Little Rock, Ark.	104	67	28	3	3	3	—
New Orleans, La.	12	9	3	—	—	—	12
San Antonio, Tex.	290	209	61	10	7	3	22
Shreveport, La.	53	36	12	2	3	—	9
Tulsa, Okla.	123	91	25	4	2	1	6
MOUNTAIN	1,137	780	222	73	31	28	100
Albuquerque, N.M.	151	108	27	8	6	2	17
Boise, Idaho	53	43	4	2	1	3	5
Colo. Springs, Colo.	108	75	23	4	2	4	5
Denver, Colo.	108	79	18	7	—	4	15
Las Vegas, Nev.	281	181	74	18	4	4	20
Ogden, Utah	38	32	6	—	—	—	3
Phoenix, Ariz.	209	122	41	21	13	9	18
Pueblo, Colo.	23	17	4	1	1	—	—
Salt Lake City, Utah	U	U	U	U	U	U	U
Tucson, Ariz.	166	123	25	12	4	2	17
PACIFIC	2,112	1,546	389	109	36	32	243
Berkeley, Calif.	17	10	6	1	—	—	—
Fresno, Calif.	206	158	33	9	5	1	20
Glendale, Calif.	25	22	—	3	—	—	4
Honolulu, Hawaii	97	71	16	6	2	2	9
Long Beach, Calif.	66	45	13	6	1	1	7
Los Angeles, Calif.	424	309	88	16	5	6	51
Pasadena, Calif.	34	24	7	1	1	1	6
Portland, Oreg.	111	78	23	8	1	1	14
Sacramento, Calif.	201	146	41	6	3	5	22
San Diego, Calif.	180	125	36	13	2	4	14
San Francisco, Calif.	140	99	23	10	7	1	23
San Jose, Calif.	180	136	31	7	4	2	27
Santa Cruz, Calif.	34	25	6	3	—	—	2
Seattle, Wash.	159	114	30	9	2	4	19
Spokane, Wash.	82	61	15	3	1	2	16
Tacoma, Wash.	156	123	21	8	2	2	9
TOTAL	13,088¶	9,150	2,664	766	269	235	1,147

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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