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National HIV Testing Day — June 27, 2005

National HIV Testing Day (NHTD) is June 27. NHTD is sponsored by the National Association of People with AIDS to encourage persons at risk to receive voluntary counseling and testing for human immunodeficiency virus (HIV). This year's theme, "Take the Test. Take Control," highlights the need for testing and counseling persons at risk to maintain their health and protect their partners. In addition, this year marks the 20th anniversary of the first commercially available HIV test (*1*), and NHTD offers an opportunity to recognize how much progress has been made in diagnosing, counseling, treatment, and care since 1985.

Approximately 1 million persons in the United States are HIV positive, and nearly one quarter of those infected are not aware of their infections (*2*). HIV testing has become easier, more accessible, and less invasive than ever before (*3*). Persons who know they are infected can benefit from advances in medical care to prolong their lives and can take action to prevent transmission of HIV to others (*4*).

Additional information about where to get tested for HIV and local events being held to encourage testing among populations at greatest risk (e.g., non-Hispanic blacks, Hispanics, and men who have sex with men) is available at http://www.hivtest.org.

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HIV Prevalence, Unrecognized Infection, and HIV Testing Among Men Who Have Sex with Men — Five U.S. Cities, June 2004–April 2005

Well into the third decade of the human immunodeficiency virus (HIV) epidemic, rates of HIV infection remain high, especially among minority populations. Of newly diagnosed HIV infections in the United States during 2003, CDC estimated that approximately 63% were among men who were infected through sexual contact with other men, 50% were among blacks, 32% were among whites, and 16% were among Hispanics (*1*). Studies of HIV infection among young men who have sex with men (MSM) in the mid to late 1990s revealed high rates of HIV prevalence, incidence, and unrecognized infection, particularly among young black MSM (*2–4*). To reassess those findings and previous HIV testing behaviors among MSM, CDC analyzed data from five of 17 cities participating in the National HIV Behavioral Surveillance (NHBS) system. This report summarizes preliminary findings from the HIV-testing component of NHBS, which indicated that, of MSM surveyed, 25% were infected with HIV, and 48% of those infected were unaware of their infection. To decrease HIV transmission, MSM should be encouraged to receive an HIV test at least annually, and prevention programs should improve means of reaching persons unaware of their HIV status, especially those in populations disproportionately at risk.

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NHBS is an ongoing behavioral surveillance system that collects cross-sectional data among populations at high risk for acquiring HIV, including MSM, injection-drug users, and heterosexuals at high risk. Men aged ≥18 years were sampled systematically from randomly selected venues where MSM congregated (e.g., bars/clubs, organizations, and street locations). Formative research was conducted to identify venues and days and times when MSM frequented these venues (*2–4*). Men eligible for the survey were aged ≥18 years and residents of the metropolitan statistical area (MSA). Using a standardized questionnaire, men were interviewed about their sexual and drug-use behaviors, HIV-testing behavior, and use of HIV-prevention services. During June 2004–April 2005, participants in five NHBS cities (Baltimore, Maryland; Los Angeles, California; Miami, Florida; New York, New York; and San Francisco, California) were also tested for HIV infection after informed consent.

The OraQuick® rapid test or an enzyme immunoassay (EIA) was used to screen blood specimens for HIV antibody, and initially reactive specimens were tested by Western blot for confirmation. To estimate HIV incidence, CDC used a serologic testing algorithm for recent HIV seroconversion (STARHS) (*5*). Specimens that were confirmed positive were tested further with the Vironostika-Less Sensitive (LS) EIA, which detects HIV infection approximately 170 days after initial infection by using a 1.0 standard optical density cutoff (95% confidence interval [CI] = 145–200 days) (*6*). A specimen confirmed positive by Western blot and nonreactive on the Vironostika-LS assay was categorized as an incident infection. Persons self-reporting a previous positive test result and HIV-positive participants reporting use of antiretroviral therapy were excluded from the incidence estimate.

Participants were asked about the date and result of their most recent HIV test before having their blood drawn as part of NHBS. Men who had not been tested during the preceding year were asked about their reasons for not being tested. MSM with unrecognized infection were defined as those who reported being HIV negative, indeterminate, or not knowing their HIV status, but who tested HIV positive at the time of their interview. Prevalence ratios and 95% CIs were calculated to evaluate characteristics associated with testing during the preceding year. Differences in reasons for not testing between HIV-negative MSM and MSM with unrecognized infection were assessed by using chi-square tests ($p<0.05$).

In the five cities, 2,261 men sampled from 258 venues participated in NHBS. The participation rate among eligible men was 83% (range by city: 69%–99%). A total of 1,767 (78%) were men who had one or more male sex partners and agreed to the survey, HIV test, and STARHS test (range by city: 222–462). Of these 1,767 participants, the median age was 32 years

(range: 18–81 years); 35% were white, 27% Hispanic, 25% black, 7% multiracial/other, and 6% Asian/Pacific Islander. Participants were recruited at bars (30%), street locations (20%), dance clubs (19%), cafes/retail stores (10%), Gay Pride events (6%), social organizations (5%), gyms (5%), sex establishments (3%), and parks (1%).

Of the 1,767 MSM, 450 (25%) tested positive for HIV (range by city: 18%–40%). HIV prevalence was 46% among blacks, 21% among whites, and 17% among Hispanics. A total of 340 (76%) of those who were HIV positive were aged ≥30 years (Table 1). Of the 449 HIV-antibody–positive specimens tested by Vironostika-LS, 80 were nonreactive; of these, 31 were considered incident infections, and 49 were excluded from the incidence estimate. HIV incidence among MSM by city was as follows: Baltimore, 8.0% (95% CI = 4.2%–11.8%); Los Angeles, 1.4% (95% CI = 0.0%–2.9%); Miami, 2.6% (95% CI = 0.0%–5.6%); New York City, 2.3% (95% CI = 0.28%–4.2%); and San Francisco, 1.2% (95% CI = 0.0%–2.6%).

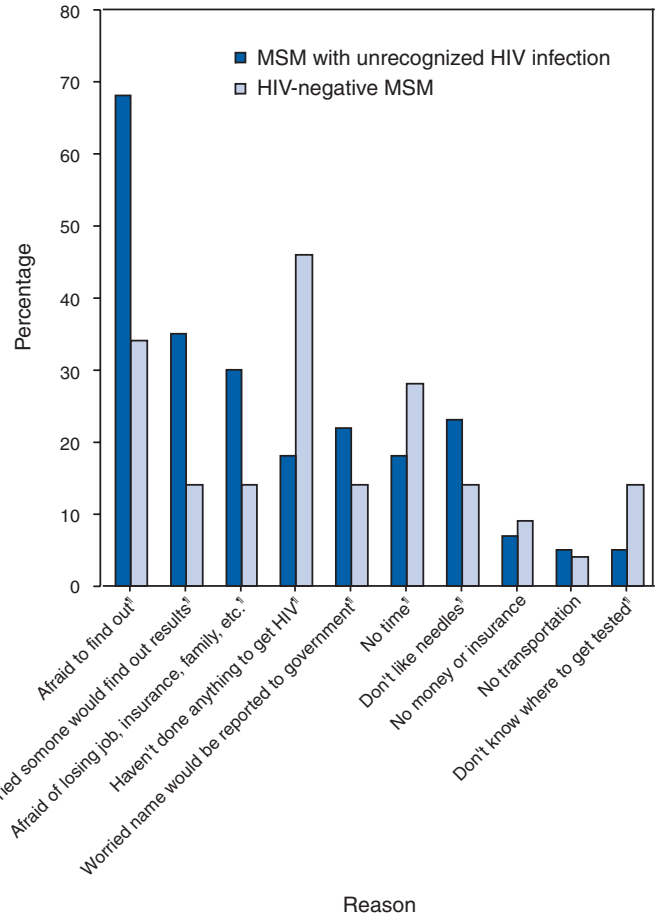
Of the 450 HIV-infected MSM, 217 (48%) were unaware of their HIV infections. The proportion of unrecognized HIV infection was highest among MSM who were aged <30 years, nonwhite, and surveyed in the four cities other than San Francisco (Table 1). Of the 217 MSM with unrecognized HIV infections, 64% were black, 18% Hispanic, 11% white, and 6% multiracial/other. The majority (184 [84%]) of the 217 MSM with unrecognized HIV infection had previously been tested for HIV; 145 (79%) reported that their most recent test result was negative, 33 (18%) were unknown, and six (3%) were indeterminate. Approximately 58% of MSM with unrecognized infections had not been tested during the preceding year. Compared with MSM who were HIV negative, proportionally more MSM with unrecognized infections had not been tested during the preceding year because they were afraid of learning they had HIV (34% versus 68%; p<0.0001) and were worried others would find out the result (14% versus 35%; p<0.0001) (Figure).

TABLE 1. HIV prevalence and proportion of unrecognized HIV infection among men who have sex with men, by city, age group, and race/ethnicity — five NHBS* cities, June 2004–April 2005

Characteristic	Total tested	HIV prevalence		Unrecognized HIV infection	
		No.	(%)	No.	(%)
City					
Baltimore	462	186	(40)	115	(62)
Los Angeles	382	73	(19)	31	(42)
Miami	222	41	(18)	19	(46)
New York City	336	62	(18)	32	(52)
San Francisco	365	88	(24)	20	(23)
Age group (yrs)					
18–24	410	57	(14)	45	(79)
25–29	303	53	(17)	37	(70)
30–39	585	171	(29)	83	(49)
40–49	367	137	(37)	41	(30)
≥50	102	32	(31)	11	(34)
Race/Ethnicity†					
White, non-Hispanic	616	127	(21)	23	(18)
Black, non-Hispanic	444	206	(46)	139	(67)
Hispanic	466	80	(17)	38	(48)
Multiracial	86	16	(19)	8	(50)
Other§	139	18	(13)	9	(50)
Total	**1,767**	**450**	**(25)**	**217**	**(48)**

* National HIV Behavioral Surveillance.
† Numbers for HIV prevalence do not add to 450 because of missing data in three records.
§ Because of small sample sizes, category includes Asian/Pacific Islander, Native American/Alaska Native, and other.

FIGURE. Reasons for not having an HIV test during the preceding 12 months among men who have sex with men (MSM), by HIV-infection status* — five NHBS† cities§, June 2004–April 2005



* HIV-negative MSM (n = 472); MSM with unrecognized infection (n = 119).
† National HIV Behavioral Surveillance.
§ Baltimore, Maryland; Los Angeles, California; Miami, Florida; New York, New York; and San Francisco, California.
¶ p<0.05 by Cochran-Mantel-Haenszel chi-square test.

Nearly all participants (92%) reported previously being tested for HIV, and 64% reported being tested during the preceding year. MSM were more likely to have been tested during the preceding year if they had visited a health-care provider and their provider recommended an HIV test (Table 2). Sexual and drug-use behaviors were not associated with testing during the preceding year.

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Editorial Note: Consistent with previous studies of young MSM conducted in the same cities using similar sampling methods (*2–4,7,8*), this study revealed that 1) prevalence and incidence of HIV infection in this population were high; 2) many HIV-infected MSM, particularly younger and black MSM, were unaware they were HIV-infected; and 3) among MSM with unrecognized infection, nearly half presumably acquired HIV during the preceding year, and many had not been tested recently because of fears of testing positive. These findings underscore the need to increase testing and improve primary prevention practices for MSM.

Although a majority of MSM had been tested during the preceding year, more than half with unrecognized infections had not had an annual test. The results of this study support CDC guidelines recommending at least annual testing for sexually active MSM (*8*), especially among younger MSM and minority populations (*7*).

The findings in this report are subject to at least four limitations. First, the date of a participant's most recent HIV test is self-reported and might be subject to reporting inaccuracies. Second, given the sensitive nature of some questions, HIV status might have been underreported during the interview, thereby inflating estimates of unrecognized infections. Third, these findings are limited to men who frequented MSM-identified venues in the five selected cities during the survey period. Although similar rates of HIV incidence were observed compared with previous surveys (*2*), the limited number of incident cases prevents comparisons by race and age. Finally, data are preliminary and have not been weighted by venue-selection probability.

TABLE 2. Prevalence of HIV testing during the preceding year among men who have sex with men, by selected characteristics — five NHBS* cities, June 2004–April 2005

Characteristic	Total previously tested	Last HIV test during preceding year No.	(%)	Prevalence ratio	(95% CI†)
City					
Baltimore	404	260	64	1.00	Referent
Los Angeles	358	231	64	1.00	(0.90–1.11)
Miami	230	136	67	1.04	(0.92–1.17)
New York City	306	202	66	1.03	(0.92–1.14)
San Francisco	351	206	59	0.91	(0.81–1.02)
Age group (yrs)					
18–24	350	285	81	1.00	Referent
25–29	285	200	70	0.86	(0.79–0.94)
30–39	547	330	60	0.74	(0.68–0.81)
40–49	346	180	52	0.64	(0.57–0.72)
≥50	94	40	43	0.52	(0.41–0.66)
Race/Ethnicity					
White, non-Hispanic	589	345	58	1.00	Referent
Black, non-Hispanic	391	254	65	1.11	(1.00–1.23)
Hispanic	422	289	68	1.17	(1.06–1.28)
Asian/Pacific Islander	85	55	65	1.10	(0.93–1.31)
Native American/ Alaska Native	7	6	86	1.46	(1.07–2.00)
Multiracial	79	52	66	1.12	(0.95–1.34)
Other	34	25	74	1.26	(0.36–1.13)
Education					
<High school	142	97	68	1.00	Referent
High school or equivalent	343	227	66	0.97	(0.85–1.11)
>High school	1,135	709	62	0.91	(0.81–1.03)
Sexual identity					
Homosexual	1,256	787	63	1.00	Referent
Bisexual	320	219	68	1.09	(1.00–1.19)
Health-insurance status					
Private physician or HMO§	954	616	65	1.00	Referent
Public	149	91	61	0.95	(0.83–1.08)
None	495	312	63	0.98	(0.90–1.06)
Health-care use					
Visited provider during preceding year					
No	317	156	49	1.00	Referent
Yes	1,305	879	67	1.37	(1.22–1.54)
Provider recommended HIV test¶					
No	809	476	59	1.00	Referent
Yes	496	403	81	1.38	(1.29–1.48)
Most recent HIV test result**					
Negative	1,285	874	68	1.00	Referent
Unknown	95	72	76	0.90	(0.80–1.01)
Total	**1,622**	**1,035**	**64**	—	—

* National HIV Behavioral Surveillance.
† Confidence interval.
§ Health maintenance organization.
¶ Among those who visited a health-care provider during the preceding year.
** Result of last HIV test before participation in NHBS.

The 2004 NHBS system was conducted in 17 MSAs with the highest AIDS prevalence. Although this report focuses on testing results from five selected cities, behavioral data are forthcoming from all participating cities. NHBS is an important tool for monitoring the impact of the HIV epidemic and informing prevention efforts.

HIV incidence and prevalence are high among MSM, and many are unaware they are HIV positive. The high level of unrecognized HIV infections among MSM is a public health concern. Persons aware of their HIV infection often take steps to reduce their risk behaviors, which could reduce HIV transmission (*9*). To increase the proportion of HIV-positive persons who know they are infected, sexually active MSM should be encouraged to have an HIV test at least annually. Corresponding efforts should be developed to address barriers to testing, particularly those related to fear, and to increase the availability of testing in clinical and nonclinical settings (*10*). Testing programs should target both younger MSM and black MSM to reach populations disproportionately unaware they are HIV positive.

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Use of Social Networks to Identify Persons with Undiagnosed HIV Infection — Seven U.S. Cities, October 2003–September 2004

An estimated 250,000 persons living with human immunodeficiency virus (HIV) in the United States are not aware of their infections and their risk for transmitting HIV (*1*). As part of CDC's Advancing HIV Prevention Initiative, identifying persons with undiagnosed HIV infection and linking them to medical care and prevention services is a national priority (*2*). In 2003, a 2-year demonstration project was begun with nine community-based organizations (CBOs) in seven cities to evaluate the effectiveness of using a social network strategy (*3*) at multiple sites to identify persons at risk for HIV infection and direct them to HIV counseling, testing, and referral (CTR). In this strategy, HIV-positive persons and HIV-negative persons at high risk (i.e., recruiters) are enlisted to recruit for CTR persons from their social, sexual, and drug-use networks (i.e., network associates [NAs]) believed to be at risk for HIV infection (*4*). This report summarizes preliminary results from the first year of this 2-year project, which indicated that 133 persons recruited 814 NAs, resulting in 46 newly identified HIV infections (approximately 6% of all persons tested). Health departments and CBOs should consider this strategy as an effective method for recruiting persons for CTR and identifying those with undiagnosed HIV infection.

The nine CBOs participating in the social network project provided HIV-related services in seven cities*. Although details differed among sites (e.g., identification of recruiters or use of incentives), all CBOs used the same basic methods. First, CBO staff members invited clients who were HIV positive to recruit NAs, including sex and needle-sharing partners the recruiters believed did not know their HIV status and might have been at risk for HIV infection. Certain CBOs also received referrals of recruiters from collaborating agencies. Next, recruiters were interviewed to elicit information about their networks and were coached by CBO staff members on strategies for discussing HIV and CTR with NAs. Although CBO interviewers talked with recruiters about their NAs in detail, information on the specific nature of the recruiter-NA relationship (e.g., sex or needle-sharing partners) was not

* San Francisco, California; Washington, DC; Orlando, Florida; Lafayette, Louisiana; Boston, Massachusetts; New York, New York; and Philadelphia, Pennsylvania.

requested. Typically, recruiters then contacted their NAs and accompanied or referred them to a designated CTR site (on certain occasions, at a recruiter's request, NAs were contacted by CBO outreach staff). Those NAs not accompanied to a CTR site received referral cards to present to CTR staff members to indicate who recruited them for testing.

NAs with positive tests were referred for medical care, HIV risk-reduction services, partner counseling and referral services (PCRS), and other services as needed (e.g., sexually transmitted disease [STD] screening, substance abuse treatment, and mental health treatment). NAs with negative HIV tests were assessed to determine HIV behavioral risks[†] and the need for follow-up testing, and referred for HIV risk-reduction and other appropriate services.

CBOs typically provided a small incentive (e.g., gift card) to recruiters for each NA successfully recruited and tested; some provided incentives to NAs who completed HIV testing. At the discretion of CBO staff, HIV-positive NAs and HIV-negative NAs at high risk (tested during the project) were invited to become recruiters, enabling identification and testing of additional NAs in a recruiter's network. Recruiter and NA data were collected during October 2003–September 2004. Pearson chi square or Fisher's exact tests were used to test associations between selected characteristics of recruiters and NAs and prevalence of newly identified HIV-positive NAs. For outcomes significant at the $p<0.05$ level, pairwise comparisons were performed by using an adjustment for multiple comparisons.

During October 2003–September 2004, a total of 133 recruiters (Table 1) were enlisted from the nine CBO sites (range: three to 29 recruiters). A total of 814 NAs were recruited for HIV testing, including 737 (90%) by recruiters on their own; 67 (8%) by CBO outreach workers, based on information provided by recruiters; and five (1%) by recruiters and outreach workers together. Recruitment method was not available for five (1%) NAs. Of the 133 recruiters, 80 (60%) were male, 43 (32%) were female, and 10 (8%) were transgender[§] persons. Most recruiters were either HIV positive (77%) or HIV negative but at high risk (16%). A total of 113 (85%) were aged ≥35 years; and 125 (94%) were from racial/ethnic minorities, including 88 (66%) who were non-Hispanic black and 34 (26%) who were Hispanic. Fifty-four (41%) were heterosexuals at high risk, 39 (29%) were men who have sex with men (MSM), 15 (11%) were men who have sex with men and were injection-drug users (MSM/IDUs), and 12 (9%) were IDUs.

Recruiter proficiency was assessed by calculating a network index (i.e., number of NAs recruited divided by number of recruiters) and by calculating prevalence of newly identified HIV infection among NAs; recruitment information was not available for 59 (7%) NAs (Table 1). The network index was highest for recruiters who were aged 25–34 years, Hispanic, IDUs, and MSM/IDUs, indicating that recruiters with these characteristics were most proficient at recruiting NAs for testing. However, the prevalence of newly identified HIV infection was highest among NAs recruited by transgender persons and MSM.

Of the 814 NAs tested, 669 (82%) were HIV negative and at high risk, 79 (10%) were HIV negative at low or unknown risk, 46 (6%) had newly identified HIV infections, 12 (2%) had HIV diagnosed previously, and eight (1%) did not have test results available (Table 2). Information on referral to care was incomplete in these preliminary data. A total of 677 (83%) NAs were aged ≥25 years, 544 (67%) were male, 477 (59%) were heterosexuals at high risk, 383 (47%) were non-Hispanic blacks, and 310 (38%) were Hispanics. A total of 748 (92%) NAs were identified directly by a recruiter; 66 (8%) were identified through another NA.

Prevalence of newly identified HIV infections among NAs varied significantly by sex/gender and HIV risk group; the highest prevalences were recorded among MSM/IDU (26%), transgender persons (20%), and MSM (16%) (Table 2). Prevalence of newly identified HIV infections for NAs identified directly by recruiters (6%) was similar to that for NAs identified indirectly through another NA (8%). At each site, recruiters also identified venues they frequented (e.g., substance abuse centers, bars/clubs, and homeless shelters) where they believed NAs at high risk could be reached; 110 (14%) NAs received CTR at these venues, but none were HIV positive.

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[†] Persons were considered at high risk for HIV if, during the preceding year, they had unprotected sex (i.e., oral, vaginal, or anal) with a person with HIV or AIDS, or a person with unknown HIV status (with or without known risk for HIV); shared drug-injection equipment; had sex in exchange for money or drugs; or had an STD.

[§] Persons who identify with or express a gender and/or sex different from their biologic sex.

TABLE 1. Number and percentage of recruiters enlisted and network associates recruited and tested for HIV, by selected recruiter characteristics — seven U.S. cities*, October 2003–September 2004

Recruiter characteristic	Recruiters		Network associates recruited and tested		Network index†	Network associates with newly identified HIV infection			
	No.	(%)	No.	(%)		No.	(%)	Prevalence§	p value¶
No recruiter specified**	—	—	59	(7.2)	—	3	(6.5)	—	
HIV serostatus									0.88
Positive	103	(77.4)	461	(56.6)	4.5	31	(67.4)	6.7	
Negative, at high risk††	21	(15.8)	155	(19.0)	7.4	11	(23.9)	7.1	
Negative, at low or unknown risk	3	(2.3)	0	—	0	0	—	0	
Unknown	6	(4.5)	139	(17.1)	—	1	(2.2)	—	
Sex/Gender									0.03
Female	43	(32.3)	183	(22.5)	4.3	9	(19.6)	4.9	
Male	80	(60.2)	547	(67.2)	6.8	29	(63.0)	5.3	
Transgender§§	10	(7.5)	25	(3.1)	2.5	5	(10.9)	20.0	
Age group (yrs)									0.08
13–24	5	(3.8)	18	(2.2)	3.6	0	—	0	
25–34	14	(10.5)	222	(27.3)	15.9	9	(19.6)	4.1	
35–44	61	(45.9)	285	(35.0)	4.7	19	(41.3)	6.7	
≥45	52	(39.1)	229	(28.1)	4.4	15	(32.6)	6.6	
Unknown	1	(0.8)	1	(0.1)	—	0	—	—	
Race/Ethnicity									0.21
White, non-Hispanic	8	(6.0)	9	(1.1)	1.1	0	—	0	
Black, non-Hispanic	88	(66.2)	356	(43.7)	4.0	26	(56.5)	7.3	
Hispanic	34	(25.6)	386	(47.4)	11.4	17	(37.0)	4.4	
Other¶¶	3	(2.3)	4	(0.5)	1.3	0	—	0	
HIV risk group									0.008
Men who have sex with men***	39	(29.3)	74	(9.1)	1.9	11	(23.9)	14.9	
Men who have sex with men and are injection-drug users	15	(11.3)	154	(18.9)	10.3	4	(8.7)	2.6	
Injection-drug users	12	(9.0)	230	(28.3)	19.2	13	(28.3)	5.7	
Heterosexuals at high risk††	54	(40.6)	258	(31.7)	4.8	14	(30.4)	5.4	
Other risk factors†††	13	(9.8)	39	(4.8)	3.0	1	(2.2)	2.6	
Total	**133**	**(100.0)**	**814**	**(100.0)**	**6.1**	**46**	**(100.0)**	**5.7**	

* San Francisco, California; Washington, DC; Orlando, Florida; Lafayette, Louisiana; Boston, Massachusetts; New York, New York; and Philadelphia, Pennsylvania.
† Number of network associates recruited and tested divided by number of recruiters.
§ Number of network associates with newly identified HIV infections divided by total number of network associates recruited and tested.
¶ For chi-square tests assessing the association between recruiter characteristics and prevalence of network associates with newly identified HIV infection. Characteristics described as unknown or other were excluded.
** Network associates not linked to specific recruiters.
†† Persons were considered at high risk for HIV if, during the preceding year, they had unprotected sex (i.e., oral, vaginal, or anal) with a person with HIV or AIDS, or a person with unknown HIV status (with or without known risk for HIV); shared drug-injection equipment; had sex in exchange for money or drugs; or had a sexually transmitted disease.
§§ Persons who identify with or express a gender and/or sex different from their biologic sex.
¶¶ American Indian/Alaska Native (two) and other race (one).
*** Includes bisexuals.
††† Certain risk factors (e.g., recent unprotected sex or general drug use) specified for recruiters instead of a primary risk group.

Editorial Note: Preliminary findings described in this report suggest that programs can target testing to persons at high risk for HIV infection by enlisting persons who are HIV positive or HIV negative and at high risk to recruit NAs in their social, sexual, and drug-using networks. The approximate 6% prevalence of HIV infection among NAs tested in this project was five times the average prevalence reported by publicly funded CTR sites (*5*). In addition, the findings indicate that transgender and MSM recruiters were particularly effective in recruiting persons who tested positive for HIV, suggesting that transgender and MSM networks might be more likely to include persons with undiagnosed HIV infection.

In this project, CBO interviewers did not ask recruiters to provide information on the specific nature of their relationship with each NA. CBO staff members reported that this contributed substantially to the willingness of recruiters to provide information about their networks and recruit NAs for CTR. Recruiters contacted most NAs themselves and, when coached and supported by CBO staff members, successfully recruited NAs for CTR. This strategy appears to make efficient use of CBO staff members, enabling them to focus on in-depth network interviews with recruiters, establishing rapport and trust, and coaching recruiters on how to effectively

TABLE 2. Results of testing network associates for HIV infection, by selected network associate characteristics — seven U.S. cities*, October 2003–September 2004

Network associate characteristic	Total†		Network associates: HIV negative, at high risk§		HIV negative, at low or unknown risk		Newly identified as HIV positive			
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	Prevalence¶	p value**
Sex/Gender										0.01
Female	**252**	**(31.0)**	218	(32.6)	16	(20.3)	8	(17.4)	3.2	
Male	**544**	**(66.8)**	438	(65.5)	62	(78.5)	35	(76.1)	6.4	
Transgender††	**15**	**(1.8)**	11	(1.6)	0	—	3	(6.5)	20.0	
Unknown	**3**	**(0.4)**	2	(0.3)	1	(1.3)	0	—	—	
Age group (yrs)										0.91
13–24	**132**	**(16.2)**	114	(17.4)	10	(12.7)	7	(15.2)	5.3	
25–34	**229**	**(28.1)**	200	(29.9)	13	(16.5)	12	(26.1)	5.2	
35–44	**210**	**(25.8)**	172	(25.7)	16	(20.3)	14	(30.4)	6.7	
≥45	**238**	**(29.2)**	179	(26.8)	40	(50.6)	13	(28.3)	5.5	
Unknown	**5**	**(0.6)**	4	(0.6)	0	—	0	—	—	
Race/Ethnicity										0.02
White, non-Hispanic	**91**	**(11.2)**	76	(11.4)	12	(15.2)	1	(2.2)	1.1	
Black, non-Hispanic	**383**	**(47.1)**	292	(43.6)	48	(60.8)	30	(65.2)	7.8	
Hispanic	**310**	**(38.1)**	282	(42.2)	11	(13.9)	13	(28.3)	4.2	
Other§§	**30**	**(3.7)**	19	(2.8)	8	(10.1)	2	(4.3)	6.7	
HIV risk group										<0.0001
Men who have sex with men¶¶	**63**	**(7.7)**	52	(7.8)	0	—	10	(21.7)	15.9	
Men who have sex with men and are injection-drug users	**27**	**(3.3)**	16	(2.4)	1	(1.3)	7	(15.2)	25.9	
Injection-drug users	**124**	**(15.2)**	111	(16.6)	3	(3.8)	6	(13.0)	4.8	
Heterosexuals at high risk§	**477**	**(58.6)**	427	(63.8)	18	(22.8)	22	(47.8)	4.6	
Other risk factors***	**95**	**(11.7)**	54	(8.1)	40	(50.6)	0	—	0	
Risk unknown	**28**	**(3.4)**	9	(1.3)	17	(21.5)	1	(2.2)	—	
Type of recruitment†††										0.48
Direct	**748**	**(91.9)**	626	(93.6)	65	(82.3)	41	(89.1)	5.5	
Indirect	**66**	**(8.1)**	43	(6.4)	14	(17.7)	5	(10.9)	7.6	
Total	**814**	**(100.0)**	**669**	**(100.0)**	**79**	**(100.0)**	**46**	**(100.0)**	**5.7**	

* San Francisco, California; Washington, DC; Orlando, Florida; Lafayette, Louisiana; Boston, Massachusetts; New York, New York; and Philadelphia, Pennsylvania.
† Eight network associates did not have test results available, and 12 had been identified as HIV positive before the project; therefore, the number of network associates by HIV-test status might not sum to the total for that characteristic.
§ Persons were considered at high risk for HIV if, during the preceding year, they had unprotected sex (i.e., oral, vaginal, or anal) with a person with HIV or AIDS, or a person with unknown HIV status (with or without known risk for HIV); shared drug-injection equipment; had sex in exchange for money or drugs; or had a sexually transmitted disease.
¶ Number of network associates with newly identified HIV infections divided by total number of network associates recruited and tested.
** For chi-square tests assessing the association between network associate characteristics and prevalence of network associates with newly identified HIV infection. Characteristics described as unknown or other were excluded.
†† Persons who identify with or express a gender and/or sex different from their biologic sex.
§§ American Indian/Alaska Native (11), Asian (three), Native Hawaiian/Pacific Islander (three), and other race (12).
¶¶ Includes bisexuals.
*** Certain risk factors (e.g., recent unprotected sex or general drug use) specified for network associates instead of a primary risk group.
††† Direct: network associate recruited directly by a recruiter; indirect: network associate recruited indirectly through another associate.

refer NAs for CTR. During October 2003–September 2004, CBO staff members in this project interviewed approximately three persons to identify each new case of HIV infection (133 recruiters/46 NAs). For comparison, during 2001, a survey of 22 jurisdictions indicated that health departments, on average, interviewed approximately 14 persons to identify each new case of HIV infection through PCRS (*6*). Cost data were collected but not analyzed for the project described in this report; further assessment of the effectiveness and cost-effectiveness of the social network strategy is needed.

The findings in this report are subject to at least two limitations. First, few recruiters were enlisted who tested positive for HIV during this project and were previously unaware of their status. Whether this reflects reluctance of newly diagnosed HIV-positive clients to participate in the project or reluctance of CBO staff to suggest participation to persons who have just learned they are HIV positive is unclear. Second, data on linking newly identified HIV-positive persons to medical evaluation, care, and other services are incomplete because of difficulty in tracking and documenting referrals to other agencies.

CDC guidelines recommend that HIV-positive persons be offered PCRS to identify potentially exposed partners on an ongoing basis, rather than limit such efforts to the time of initial diagnosis (*7,8*). In this project, most HIV-positive recruiters were not newly diagnosed; nevertheless, they were able to recruit a substantial number of NAs with a high rate of newly diagnosed HIV infection, and to do so efficiently. This finding supports the potential efficacy of working with HIV-positive persons on an ongoing basis to identify and offer CTR to others at high risk for HIV infection. However, the finding further suggests that a broader approach, which targets not only sex partners but also others in the HIV-positive person's social, sexual, or drug-using network, might be more cost-effective for identifying persons with HIV infection. Although results are preliminary, further assessment of the social network strategy is warranted.

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Human Tuberculosis Caused by *Mycobacterium bovis* — New York City, 2001–2004

In March 2004, a U.S.-born boy aged 15 months in New York City (NYC) died of peritoneal tuberculosis (TB) caused by *Mycobacterium bovis* infection. *M. bovis*, a bacterial species of the *M. tuberculosis* complex, is a pathogen that primarily infects cattle. However, humans also can become infected, most commonly through consumption of unpasteurized milk products from infected cows. In industrialized nations, human TB caused by *M. bovis* is rare because of milk pasteurization and culling of infected cattle herds (*1*). This report summarizes an ongoing, multiagency* investigation that has identified 35 cases of human *M. bovis* infection in NYC. Preliminary findings indicate that fresh cheese (e.g., queso fresco) brought to NYC from Mexico was a likely source of infection. No evidence of human-to-human transmission has been found. Products from unpasteurized cow's milk have been associated with certain infectious diseases and carry the risk of transmitting *M. bovis* if imported from countries where the bacterium is common in cattle. All persons should avoid consuming products from unpasteurized cow's milk†.

TB Surveillance

Since January 1, 2001, spoligotyping of *M. tuberculosis*–complex isolates from patients with newly diagnosed TB has been conducted routinely in NYC. This rapid genotyping method is primarily used for epidemiologic monitoring; however, spoligotyping also differentiates *M. bovis* from *M. tuberculosis*. Of 4,524 TB cases reported in NYC during 2001–2004, a total of 3,417 (76%) were culture-confirmed; 3,123 (91%) of these had spoligotype results, of which 35 (1%) were *M. bovis*. Twelve (34%) of the *M. bovis* cases were in children aged <15 years (median age: 5 years), and five of the 35 cases (14%) were in children aged <5 years (range: 1–4 years). Of the 35 patients, 20 (57%) were born in Mexico, 11 (31%) in the United States, two (6%) in the Dominican Republic, and one (3%) each in Guatemala and Guyana. Of 23 adult patients (median age: 27 years; range: 16–76 years), 22 (96%) were born abroad; of the 12 patients aged <15 years, 10 (83%) were born in the United States, all of Mexican-born parents. Of the five patients aged <5 years, all had extrapulmonary disease (i.e., three lymphatic and two peritoneal). All five were born in the United States of Mexican-born parents. None had traveled outside of the United States, and no epidemiologic link to other TB cases was discovered.

Twenty-six of the 35 patients received inpatient hospital care. The anatomical site of disease was extrapulmonary in 21 (60%) patients, pulmonary in nine (26%), and both pulmonary and

* The investigation is led by the NYC Department of Health and Mental Hygiene, in collaboration with the New York State Department of Agriculture and Markets, CDC, the U.S. Department of Agriculture, and the Food and Drug Administration.

† The Food and Drug Administration permits sale of imported or domestic, aged cheeses from unpasteurized milk under certain conditions. (Cheeses and related cheese products, 21 C.F.R. Part 133 [2005]).

extrapulmonary in five (14%) patients. The sputum-smear microscopy results were positive for acid-fast bacilli, indicating potential contagiousness, for eight (57%) of the 14 patients with pulmonary disease. Twenty-five (seven children and 18 adults) of the 35 patients were tested for antibodies to human immunodeficiency virus (HIV). Seven (28%) of those tested had positive HIV results; all were adults, aged 23–51 years (median: 35 years).

The only fatal *M. bovis* case was in the boy aged 15 months. He was treated for diarrhea and fever and received inpatient and outpatient care for 4 weeks, until abdominal distension and tenderness led to laparotomy for presumed ruptured appendicitis. Tuberculous peritonitis was diagnosed on the basis of surgical and microbiologic findings, and treatment for TB was begun. However, the boy died after 4 days of treatment.

During 1995–2004, the number of TB cases reported annually in NYC among Mexican-born persons ranged from 28 to 64. During 2001–2004, a total of 20 (13%) of 155 culture-confirmed TB cases in Mexican-born patients were caused by *M. bovis* infection, compared with 15 (<1%) of 2,925 TB cases (with spoligotype results) in all others. During 2001–2004, a total of 101 TB cases in children aged <5 years were reported; 32 (32%) of the cases were culture-confirmed, and five (16%) of the 32 culture isolates were *M. bovis*.

The standard four-drug regimen for TB consists of isoniazid, rifampin, pyrazinamide, and ethambutol. Since 2003, a fifth drug, streptomycin, is no longer recommended as a first-line alternative to ethambutol (*2*). Whereas isolates of other species belonging to the *M. tuberculosis* complex usually are susceptible to pyrazinamide, *M. bovis* isolates typically are resistant. In this investigation, of the 35 isolates, 17 (49%) were resistant to pyrazinamide only; 14 (40%) were resistant to pyrazinamide and streptomycin; two (6%) were resistant to pyrazinamide, isoniazid, and streptomycin; one (3%) was resistant to pyrazinamide and isoniazid; and one (3%) had no resistance.

Laboratory Investigation

Identification of the 35 *M. bovis* isolates was confirmed by genetic deletion analysis. Genotyping determined nine different patterns by spoligotype, three patterns (1–7 bands) by IS6110-based restriction fragment length polymorphism (RFLP), and six patterns by mycobacterial interspersed repetitive units (MIRU). A cluster of 13 cases had identical RFLP (BE4), spoligotype (octal designation 264073777777600) (*3*), and MIRU (232224253322) (Figure). Genotyping with polymorphic guanine- and cytosine-rich repeat sequences (PGRS) did not reveal additional clusters. The interpretation of *M. bovis* genotypes for investigating paths of transmission has not been determined.

Epidemiologic Investigation

Of the 35 patients, 23 (66%) patients (or parents of patients) were interviewed regarding exposures associated with *M. bovis* infection. Among the 12 not interviewed, two had died, three had moved back to Mexico, five had their telephones disconnected and attempts to visit them at home were unsuccessful, and two lacked usable locating information. Parents of the 10 U.S.-born children and one of the two children born abroad were interviewed, as were 12 of 22 adults. No linkages that might allow airborne, person-to-person transmission of *M. bovis* were discovered among any of the patients.

Nineteen (83%) of the 23 interviewed reported eating cheeses produced in Mexico while they were living in the United States, including parents of four (80%) of the five children aged <5 years. The cheeses were believed obtained from one or more of the following sources: a courier agency delivering Mexican products, a visitor carrying food in luggage, a Mexican-specialty grocery, or a door-to-door vendor in NYC. Eighteen (78%) of the 23 interviewed did not know whether milk products they consumed were pasteurized. Samples of cheeses produced in Mexico and acquired in NYC are being tested for presence of *M. bovis*.

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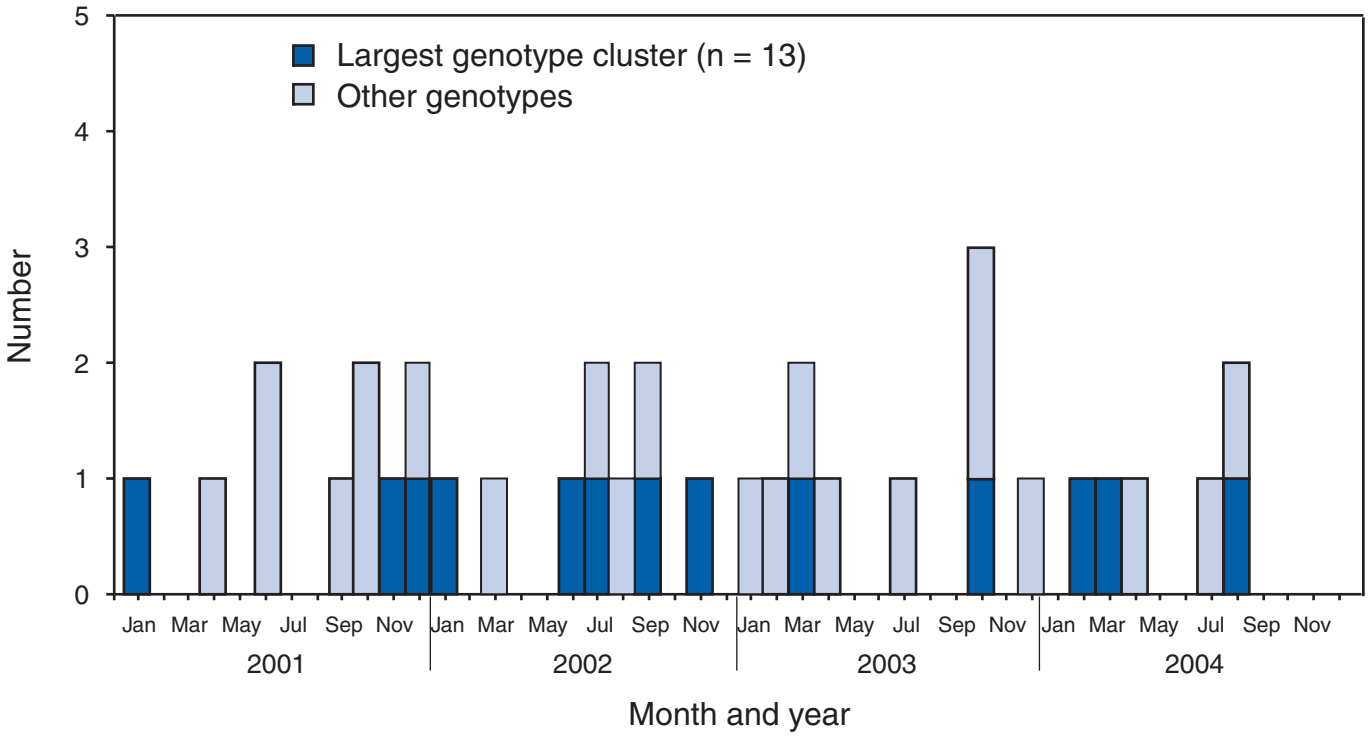
Editorial Note: *M. bovis* transmission from cattle to humans was once common in the United States, but human infections were virtually eliminated by decades of disease control in cattle herds and by routine pasteurization of cow's milk (*1*). Now the majority of persons who have *M. bovis* TB come from countries where the infection is prevalent in cattle and where they presumably acquired infection. However, in San Diego, California, during 1980–1997, 34% of culture-confirmed TB cases in children aged <15 years were caused by *M. bovis*; approximately 90% of these children were U.S. born and of Hispanic ethnicity (*4*). Fresh cheese brought from Mexico is suspected to be one source of infections in these

FIGURE. Number* of reported *Mycobacterium bovis* cases, by month and largest genotype cluster† — New York City, 2001–2004§



* N = 35.
† Cases had identical restriction fragment length polymorphism (BE4), spoligotype (octal designation 264073777777600), and mycobacterial interspersed repetitive units (232224253322).
§ Data as of October 2004.

children. The investigation in NYC, where the Mexican population tripled to 186,872 during 1990–2000, suggests that fresh cheese from Mexico might account for a high percentage of the 35 cases described in this report; however, further epidemiologic investigations and laboratory results are needed for confirmation.

M. bovis causes disease in cattle, deer, and other mammals. In humans, consumption of unpasteurized infected cow's milk products can cause infection. Although human disease caused by *M. bovis* and other species of *M. tuberculosis* complex are similar, the anatomic site of *M. bovis* disease is more often extrapulmonary. Epidemiologic evidence supports the likelihood of human-to-human, airborne *M. bovis* transmission from patients who have pulmonary disease, but its relative contribution to new infections in humans is unknown (*5*).

The frequency of isoniazid resistance in the cases described in this report was comparable to that previously reported for *M. bovis* in San Diego. Streptomycin resistance, which had not been examined previously for *M. bovis* in the United States, was approximately six times more frequent among the cases in NYC (16 of 35 isolates) than that reported for *M. tuberculosis* complex previously (*6*). Continued surveillance for drug resistance is needed to ensure effective treatment.

TB disease is a reportable condition in all U.S. jurisdictions; however, speciation of *M. tuberculosis* complex is not reported nationally. Approximately 80% of cases in the United States are culture confirmed. Systematic speciation was not feasible until the advent of comprehensive genotyping. *M. bovis* also can be distinguished from other species of *M. tuberculosis* complex by its pyrazinamide resistance and by biochemical tests available in reference laboratories; genetic deletion analysis identifies *M. bovis* definitively. The CDC national genotyping program for TB isolates incorporates spoligotype and MIRU, with IS6110 RFLP upon special request. However, RFLP is poorly discriminatory for *M. bovis* because isolates usually have a low number of IS6110 copies. Spoligotype variability among *M. bovis* isolates from the same cattle herd and similar spoligotype patterns from cattle in different regions have been observed (*7*). MIRU can yield more patterns than RFLP (*8*). PGRS has been recommended as the method of choice for strain typing of isolates with low copy numbers of IS6110

(*9*); however, in the NYC investigation, PGRS did not further differentiate clusters among the cases. The matching genotypes that defined the cluster of 13 cases might imply a transmission linkage; however, the significance of genotype clustering among *M. bovis* isolates is undetermined. The ongoing investigation in NYC has determined that human-to-human transmission was an unlikely explanation.

New York and surrounding states are accredited as TB free for *M. bovis* in cattle[§]. Cow's milk products approved for sale in New York state are pasteurized with a few regulated exceptions[¶]. In contrast, a previous study determined that 17% of cattle sampled at meat-processing plants in Mexico were infected with *M. bovis* (*10*). An estimated 20% of cow's milk in Mexico destined for production of fresh cheese and similar products is not pasteurized. Other pathogens potentially acquired by consuming unpasteurized cow's milk products include *Listeria monocytogenes, Salmonella* spp., *Brucella* spp., *Staphylococcus aureus,* and *Escherichia coli*. To prevent infections with these bacteria, consumption of unpasteurized cow's milk products should be avoided[**].

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[§] Accredited-free states or zones, 9 C.F.R. Sect. 77.7 (2003).

[¶] New York Codes, Rules, and Regulations. Title 1, Department of Agriculture and Markets; chapter I, milk control; subchapter A, dairy products; part 2, requirement for the production, processing, manufacturing, and distribution of milk and milk products.

[**] 21 C.F.R. Part 133 (2005).

Erratum: Vol. 54, No. 23

In the report, "Seroprevalence of Poliovirus Antibodies Among Children in a Dominican Community — Puerto Rico, 2002," an error occurred in the second sentence of the final paragraph of the Editorial Note on page 581. The sentence should read, "The study described in this report included children who were vaccinated with OPV and children who were vaccinated after the all-IPV schedule was implemented in Puerto Rico on January 1, 2001."

Errata: Vol. 53, No. SS-2

In the *MMWR Surveillance Summary*, "Youth Risk Behavior Surveillance — United States, 2003," the following errors occurred in the overweight and at risk for overweight data.

On page 1, the last sentence of the abstract under "Results and Interpretation" should read, "In 2003, a total of 21.9% of high school students had smoked cigarettes during the 30 days preceding the survey; 78% had not eaten >5 servings/day of fruits and vegetables during the 7 days preceding the survey; 33.4% had participated in an insufficient amount of physical activity; and 12.1% were overweight.

On page 25, the text should read as follows:

Overweight and Weight Control

At Risk for Overweight

Nationwide, 14.8% of students were at risk for becoming overweight (Table 58). Overall, the prevalence of being at risk for overweight was higher among black (18.2%) and Hispanic (17.4%) than white (13.3%) students; higher among black female (21.2%) than white female (12.4%) and Hispanic female (15.7%) students; and higher among Hispanic male (19.1%) than white male (14.0%) students. Overall, the prevalence of being at risk for overweight was higher among 11th grade (16.5%) than 12th grade (13.7%) students and higher among 11th grade female (16.1%) than 12th grade female (12.0%) students. Prevalence of being at risk for overweight ranged from 11.0% to 16.7% across state surveys (median: 14.5%) and from 14.2% to 20.9% across local surveys (17.4%) (Table 59).

Overweight

Nationwide, 12.1% of students were overweight (Table 58). Overall, the prevalence of being overweight was higher among male (15.7%) than female (8.3%) students; higher among white male (14.0%) and Hispanic male (21.3%) than white female (6.5%) and Hispanic female (11.5%) students, respectively; and higher among 9th grade male (17.8%), 10th grade male (15.6%), 11th grade male (15.4%), and 12th grade male (13.0%) than 9th grade female (10.5%), 10th grade female (8.2%), 11th grade female (7.4%), and 12th grade female (6.7%) students, respectively. Overall, the prevalence of being overweight was higher among black (16.2%) and Hispanic (16.4%) than white (10.4%) students; higher among black female (14.2%) and Hispanic female (11.5%) than white female (6.5%) students; and higher among black male (18.2%) and Hispanic male (21.3%) than white male (14.0%) students. Overall, the prevalence of being overweight was higher among 9th grade (14.3%) and 10th grade (12.0%) than 12th grade (9.9%) students; higher among 9th grade (14.3%) than 11th grade (11.5%) students; higher among 9th grade female (10.5%) than 11th grade female (7.4%) and 12th grade female (6.7%) students; and higher among 9th grade male (17.8%) than 12th grade male (13.0%) students. Prevalence of being overweight ranged from 7.0% to 15.7% across state surveys (median: 11.1%) and from 9.3% to 20.5% across local surveys (median: 13.8%) (Table 59) (Figure 8).

On page 28, the last sentence of the first paragraph under "Discussion" should read, "In addition, 6.6 million high school students had ever had sexual intercourse, and 1.7 million were overweight.

On page 87, Table 58 should be replaced by the following table:

TABLE 58. Percentage of high school students who were at risk for becoming* or were overweight,† by sex, race/ethnicity, and grade — United States, Youth Risk Behavior Survey, 2003

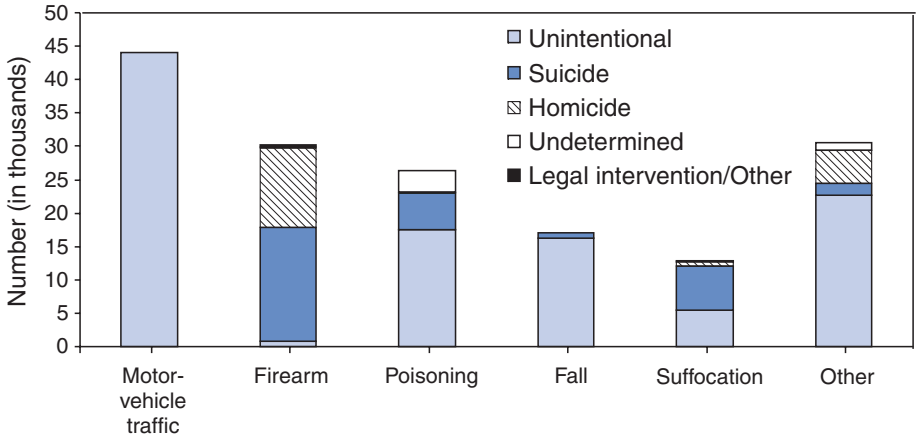
	At risk for becoming overweight						Overweight					
	Female		Male		Total		Female		Male		Total	
Category	%	CI§ (±)	%	CI (±)	%	CI (±)	%	CI (±)	%	CI (±)	%	CI (±)
Race/Ethnicity												
White¶	12.4	1.7	14.0	1.8	**13.3**	**1.2**	6.5	1.7	14.0	2.2	**10.4**	**1.8**
Black¶	21.2	4.3	15.1	3.0	**18.2**	**2.0**	14.2	2.4	18.2	2.5	**16.2**	**1.4**
Hispanic	15.7	2.5	19.1	2.9	**17.4**	**2.0**	11.5	2.9	21.3	3.2	**16.4**	**2.5**
Grade												
9	14.5	2.0	14.3	2.7	**14.4**	**1.7**	10.5	2.0	17.8	2.9	**14.3**	**2.3**
10	14.8	2.5	14.8	2.0	**14.8**	**1.6**	8.2	2.4	15.6	1.8	**12.0**	**1.7**
11	16.1	2.7	16.8	2.5	**16.5**	**1.5**	7.4	1.5	15.4	3.1	**11.5**	**1.9**
12	12.0	2.4	15.5	2.0	**13.7**	**1.2**	6.7	1.7	13.0	2.2	**9.9**	**1.5**
Total	**14.4**	**1.2**	**15.2**	**1.3**	**14.8**	**0.7**	**8.3**	**1.4**	**15.7**	**1.5**	**12.1**	**1.3**

* Students who were ≥85th percentile but <95th percentile for body mass index, by age and sex, based on reference data.
† Students who were ≥95th percentile for body mass index, by age and sex, based on reference data.
§ 95% confidence interval.
¶ Non-Hispanic.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

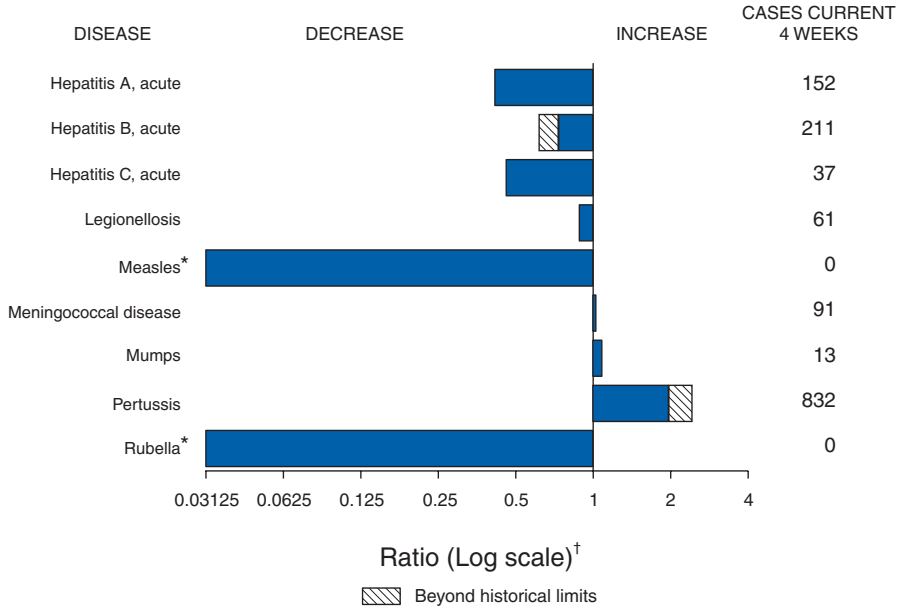
Number of Injury Deaths, by Mechanism and Intent — United States, 2002



In 2002, the five leading mechanisms of injury death accounted for 81% of all 161,629 injury deaths: motor-vehicle traffic (MVT) (27%), firearm (19%), poisoning (16%), fall (11%), and suffocation (8%). All MVT-related and nearly all fall deaths were classified as unintentional. Of the firearm deaths, 57% were suicides, and 39% were homicides. Two thirds of poisonings were unintentional. Half of suffocations were suicides, and 43% were unintentional. Additional information is available at http://www.cdc.gov/nchs/injury.htm.

Source: Kochanek KD, Murphy SL, Anderson RN. Deaths: final data for 2002. Natl Vital Stat Rep 2004;53(5).

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals June 18, 2005, with historical data



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

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending June 18, 2005 (24th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	56	46
Botulism:			HIV infection, pediatric†¶	150	160
foodborne	5	6	Influenza-associated pediatric mortality†**	36	—
infant	24	35	Measles	16††	17§§
other (wound & unspecified)	10	4	Mumps	122	103
Brucellosis	41	42	Plague	2	—
Chancroid	11	22	Poliomyelitis, paralytic	—	—
Cholera	1	4	Psittacosis†	9	6
Cyclosporiasis†	487	98	Q fever†	39	33
Diphtheria	—	—	Rabies, human	1	—
Domestic arboviral diseases			Rubella	4	9
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	1	—
California serogroup†§	—	7	SARS†**	—	—
eastern equine†§	—	—	Smallpox†	—	—
Powassan†§	—	—	*Staphylococcus aureus*:		
St. Louis†§	—	1	Vancomycin-intermediate (VISA)†	—	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	—	1
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome†	75	86
human granulocytic (HGE)†	49	78	Tetanus	8	9
human monocytic (HME)†	45	54	Toxic-shock syndrome	43	43
human, other and unspecified †	13	9	Trichinellosis¶¶	5	—
Hansen disease†	30	46	Tularemia†	30	27
Hantavirus pulmonary syndrome†	8	6	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 May 29, 2005.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of 16 cases reported, 10 were indigenous and six were imported from another country.
§§ Of 17 cases reported, five were indigenous and 12 were imported from another country.
¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending June 18, 2005, and June 19, 2004 (24th 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	16,504	17,900	403,105	420,887	1,937	2,489	836	1,104
NEW ENGLAND	673	598	14,119	14,015	—	—	45	67
Maine	8	5	938	893	N	N	6	13
N.H.	10	23	856	771	—	—	7	14
Vt.¶	4	13	464	530	—	—	10	7
Mass.	331	184	6,461	6,178	—	—	15	22
R.I.	68	66	1,415	1,661	—	—	1	2
Conn.	252	307	3,985	3,982	N	N	6	9
MID. ATLANTIC	3,059	4,097	48,827	52,097	—	—	120	180
Upstate N.Y.	318	472	10,242	10,223	N	N	32	36
N.Y. City	1,725	2,310	16,654	15,970	—	—	28	55
N.J.	472	672	5,227	8,368	N	N	7	14
Pa.	544	643	16,704	17,536	N	N	53	75
E.N. CENTRAL	1,387	1,470	61,254	75,761	4	5	175	278
Ohio	209	229	15,572	19,608	N	N	62	65
Ind.	198	194	9,156	8,384	N	N	11	31
Ill.	664	702	18,381	21,459	—	—	12	45
Mich.	246	263	10,835	17,899	4	5	28	51
Wis.	70	82	7,310	8,411	N	N	62	86
W.N. CENTRAL	394	327	24,167	25,525	3	4	127	130
Minn.	104	78	3,856	5,370	3	N	37	51
Iowa	48	26	2,951	3,082	N	N	20	18
Mo.	163	127	10,209	9,358	—	3	47	20
N. Dak.	5	13	472	895	N	N	—	6
S. Dak.	9	5	1,283	1,124	—	—	11	16
Nebr.¶	18	21	2,393	2,370	—	1	1	7
Kans.	47	57	3,003	3,326	N	N	11	12
S. ATLANTIC	5,315	5,616	77,582	78,700	—	—	169	197
Del.	81	80	1,508	1,348	N	N	—	—
Md.	637	684	8,242	8,540	—	—	11	9
D.C.	407	332	1,727	1,666	—	—	2	4
Va.¶	273	282	9,241	9,924	—	—	13	23
W. Va.	30	30	1,121	1,288	N	N	4	2
N.C.	399	295	15,218	13,236	N	N	24	36
S.C.¶	287	328	9,699	8,451	—	—	7	9
Ga.	896	779	11,345	14,809	—	—	42	59
Fla.	2,305	2,806	19,481	19,438	N	N	66	55
E.S. CENTRAL	896	815	28,417	26,326	—	3	23	46
Ky.	118	68	4,852	2,500	N	N	8	14
Tenn.¶	369	365	10,108	10,314	N	N	4	13
Ala.¶	244	202	4,062	6,380	—	—	10	11
Miss.	165	180	9,395	7,132	—	3	1	8
W.S. CENTRAL	1,896	2,355	51,088	53,812	—	2	22	43
Ark.	71	88	3,982	3,756	—	1	1	7
La.	370	444	8,664	12,040	—	1	3	—
Okla.	113	87	4,795	4,991	N	N	10	11
Tex.¶	1,342	1,736	33,647	33,025	N	N	8	25
MOUNTAIN	643	612	24,493	23,248	1,283	1,507	51	49
Mont.	4	—	972	1,185	N	N	8	10
Idaho¶	7	10	1,054	1,343	N	N	3	4
Wyo.	1	6	501	491	2	—	2	2
Colo.	127	133	6,336	6,071	N	N	18	23
N. Mex.	60	88	1,945	3,961	3	10	2	2
Ariz.	258	198	8,842	6,254	1,245	1,461	4	6
Utah	33	31	1,864	1,555	2	6	7	1
Nev.¶	153	146	2,979	2,388	31	30	7	1
PACIFIC	2,241	2,010	73,158	71,403	647	968	104	114
Wash.	196	165	8,768	8,058	N	N	5	—
Oreg.¶	117	110	3,966	3,693	—	—	18	14
Calif.	1,865	1,676	56,517	55,262	647	968	81	98
Alaska	10	13	1,782	1,781	—	—	—	—
Hawaii	53	46	2,125	2,609	—	—	—	2
Guam	1	—	—	660	—	—	—	—
P.R.	335	208	2,029	1,657	N	N	N	N
V.I.	8	5	32	173	—	—	—	—
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 May 29, 2005.

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 18, 2005, and June 19, 2004 (24th 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	546	629	73	106	77	58	6,528	7,329	134,461	145,875
NEW ENGLAND	40	44	21	25	9	7	587	677	2,690	3,248
Maine	5	2	5	—	—	—	68	63	57	120
N.H.	4	7	1	5	—	—	27	18	72	59
Vt.	3	1	—	—	—	—	69	53	24	42
Mass.	16	23	6	8	9	7	245	308	1,236	1,393
R.I.	1	5	—	—	—	—	35	54	229	427
Conn.	11	6	9	12	—	—	143	181	1,072	1,207
MID. ATLANTIC	60	77	3	14	9	11	1,234	1,620	13,908	16,573
Upstate N.Y.	24	28	3	5	3	3	424	494	2,865	3,342
N.Y. City	2	12	—	—	—	—	321	506	4,290	5,126
N.J.	12	15	—	3	—	4	166	211	1,960	3,111
Pa.	22	22	—	6	6	4	323	409	4,793	4,994
E.N. CENTRAL	95	125	9	19	4	7	957	1,113	24,113	31,226
Ohio	37	26	1	4	2	6	273	332	7,196	9,937
Ind.	10	12	—	—	—	—	N	N	3,554	2,866
Ill.	14	31	1	1	—	1	183	352	7,330	9,073
Mich.	17	22	—	4	2	—	277	255	4,052	7,259
Wis.	17	34	7	10	—	—	224	174	1,981	2,091
W.N. CENTRAL	78	103	15	16	10	12	819	806	7,691	7,542
Minn.	9	28	4	7	2	2	409	276	1,098	1,337
Iowa	14	24	—	—	—	—	87	107	643	560
Mo.	28	18	7	7	3	3	172	229	4,145	3,831
N. Dak.	1	3	—	—	—	4	1	11	24	62
S. Dak.	3	5	1	—	—	—	36	28	175	121
Nebr.	7	13	3	2	3	—	42	57	576	494
Kans.	16	12	—	—	2	3	72	98	1,030	1,137
S. ATLANTIC	81	61	12	11	36	10	947	1,131	33,033	34,882
Del.	—	—	N	N	N	N	11	23	368	430
Md.	14	16	2	2	—	2	69	42	3,076	3,634
D.C.	—	1	—	—	—	—	20	32	924	1,139
Va.	8	6	6	6	8	—	225	162	3,166	3,989
W. Va.	1	1	—	—	—	—	13	12	329	380
N.C.	—	—	—	—	19	6	N	N	7,478	6,955
S.C.	1	5	—	—	—	—	31	41	4,141	4,133
Ga.	11	14	2	1	—	—	220	358	4,980	6,294
Fla.	46	18	2	2	9	2	358	461	8,571	7,928
E.S. CENTRAL	35	43	—	2	5	7	164	162	10,461	11,368
Ky.	8	10	—	1	4	4	N	N	1,515	1,091
Tenn.	15	13	—	—	1	3	82	80	3,592	3,691
Ala.	11	12	—	—	—	—	82	82	2,455	3,653
Miss.	1	8	—	1	—	—	—	—	2,899	2,933
W.S. CENTRAL	17	37	2	1	3	4	96	124	20,208	20,131
Ark.	3	8	—	—	—	—	36	53	2,049	1,862
La.	3	2	2	—	2	—	14	21	4,766	5,443
Okla.	4	5	—	—	—	—	46	50	1,974	2,094
Tex.	7	22	—	1	1	4	N	N	11,419	10,732
MOUNTAIN	54	58	10	17	1	—	493	546	5,025	5,037
Mont.	3	3	—	—	—	—	16	18	53	47
Idaho	7	14	5	3	—	—	39	75	40	35
Wyo.	—	—	1	1	—	—	10	7	27	25
Colo.	15	14	1	1	—	—	181	179	1,263	1,452
N. Mex.	2	6	3	3	—	—	16	33	349	462
Ariz.	11	6	N	N	N	N	67	80	1,871	1,731
Utah	8	7	—	8	—	—	132	112	294	228
Nev.	8	8	—	1	1	—	32	42	1,128	1,057
PACIFIC	86	81	1	1	—	—	1,231	1,150	17,332	15,868
Wash.	21	26	—	—	—	—	116	115	1,620	1,230
Oreg.	21	12	1	1	—	—	105	173	716	468
Calif.	37	39	—	—	—	—	951	796	14,364	13,243
Alaska	4	1	—	—	—	—	33	27	241	293
Hawaii	3	3	—	—	—	—	26	39	391	634
Guam	N	N	—	—	—	—	—	2	—	106
P.R.	—	—	—	—	—	—	11	81	192	128
V.I.	—	—	—	—	—	—	—	—	2	62
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 June 18, 2005, and June 19, 2004 (24th 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	1,077	1,052	2	8	58	57	108	102
NEW ENGLAND	78	102	—	1	6	6	4	1
Maine	4	7	—	—	—	—	1	—
N.H.	3	12	—	—	—	2	—	—
Vt.	6	5	—	—	—	—	2	1
Mass.	33	52	—	1	1	2	1	—
R.I.	6	3	—	—	2	—	—	—
Conn.	26	23	—	—	3	2	—	—
MID. ATLANTIC	214	214	—	1	—	3	26	27
Upstate N.Y.	60	70	—	1	—	3	5	4
N.Y. City	36	46	—	—	—	—	8	9
N.J.	43	38	—	—	—	—	7	2
Pa.	75	60	—	—	—	—	6	12
E.N. CENTRAL	144	198	1	—	1	8	9	28
Ohio	74	64	—	—	—	2	7	10
Ind.	39	30	—	—	1	4	1	1
Ill.	13	63	—	—	—	—	1	14
Mich.	11	12	1	—	—	2	—	3
Wis.	7	29	—	—	—	—	—	—
W.N. CENTRAL	58	54	—	2	3	3	8	5
Minn.	21	24	—	1	3	3	—	—
Iowa	—	1	—	1	—	—	—	—
Mo.	28	18	—	—	—	—	6	4
N. Dak.	1	3	—	—	—	—	1	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	4	2	—	—	—	—	1	—
Kans.	4	6	—	—	—	—	—	1
S. ATLANTIC	253	238	—	—	16	15	13	16
Del.	—	—	—	—	—	—	—	—
Md.	38	40	—	—	4	3	—	—
D.C.	—	2	—	—	—	—	—	1
Va.	26	21	—	—	—	—	—	1
W. Va.	14	10	—	—	1	3	2	—
N.C.	41	30	—	—	5	4	—	—
S.C.	10	6	—	—	—	—	1	—
Ga.	53	70	—	—	—	—	6	14
Fla.	71	59	—	—	6	5	4	—
E.S. CENTRAL	66	40	—	—	1	—	12	7
Ky.	6	3	—	—	1	—	1	—
Tenn.	46	26	—	—	—	—	7	5
Ala.	14	11	—	—	—	—	4	2
Miss.	—	—	—	—	—	—	—	—
W.S. CENTRAL	63	39	1	1	4	5	6	1
Ark.	2	1	—	—	—	—	—	—
La.	26	9	1	—	2	—	6	1
Okla.	35	28	—	—	2	5	—	—
Tex.	—	1	—	1	—	—	—	—
MOUNTAIN	152	119	—	3	15	13	24	12
Mont.	—	—	—	—	—	—	—	—
Idaho	3	5	—	—	—	—	1	2
Wyo.	2	—	—	—	—	—	—	—
Colo.	28	29	—	—	—	—	5	3
N. Mex.	13	25	—	—	4	4	1	4
Ariz.	82	43	—	—	9	6	9	1
Utah	11	8	—	2	—	1	6	1
Nev.	13	9	—	1	2	2	2	1
PACIFIC	49	48	—	—	12	4	6	5
Wash.	—	1	—	—	—	—	—	1
Oreg.	20	25	—	—	—	—	4	2
Calif.	21	15	—	—	12	4	1	1
Alaska	3	3	—	—	—	—	1	1
Hawaii	5	4	—	—	—	—	—	—
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 June 18, 2005, and June 19, 2004 (24th 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	1,695	2,613	2,567	2,655	299	327
NEW ENGLAND	219	383	135	171	6	6
Maine	—	8	8	1	—	—
N.H.	32	10	5	22	—	—
Vt.	2	7	2	2	6	1
Mass.	155	317	101	81	—	5
R.I.	5	10	1	3	—	—
Conn.	25	31	18	62	U	—
MID. ATLANTIC	270	324	540	345	48	57
Upstate N.Y.	42	38	45	35	11	2
N.Y. City	134	124	45	72	—	—
N.J.	45	71	348	92	—	—
Pa.	49	91	102	146	37	55
E.N. CENTRAL	168	211	171	252	61	37
Ohio	26	26	66	64	1	3
Ind.	22	20	10	16	15	2
Ill.	37	67	14	28	—	11
Mich.	69	75	81	120	45	21
Wis.	14	23	—	24	—	—
W.N. CENTRAL	54	76	178	167	17	4
Minn.	3	23	10	20	1	4
Iowa	14	23	62	11	—	—
Mo.	27	11	78	109	15	—
N. Dak.	—	1	—	1	1	—
S. Dak.	—	2	—	—	—	—
Nebr.	3	9	14	15	—	—
Kans.	7	7	14	11	—	—
S. ATLANTIC	245	470	671	849	66	85
Del.	—	5	30	23	2	3
Md.	27	61	86	71	16	2
D.C.	2	4	4	12	—	1
Va.	40	38	84	94	7	8
W. Va.	3	1	18	2	5	14
N.C.	33	32	68	80	8	6
S.C.	8	27	41	63	1	7
Ga.	41	180	90	257	4	7
Fla.	91	122	250	247	23	37
E.S. CENTRAL	115	73	173	220	43	35
Ky.	6	11	36	24	3	15
Tenn.	83	48	68	105	9	9
Ala.	13	6	32	35	8	2
Miss.	13	8	37	56	23	9
W.S. CENTRAL	104	363	162	126	17	53
Ark.	3	47	19	55	—	1
La.	34	19	23	27	7	3
Okla.	3	16	7	31	—	2
Tex.	64	281	113	13	10	47
MOUNTAIN	164	205	257	200	17	19
Mont.	7	4	3	1	—	2
Idaho	15	10	5	6	—	1
Wyo.	—	2	—	6	—	—
Colo.	19	20	22	22	8	4
N. Mex.	8	9	7	10	—	U
Ariz.	96	134	177	101	—	2
Utah	13	20	26	17	6	2
Nev.	6	6	17	37	3	8
PACIFIC	356	508	280	325	24	31
Wash.	21	29	33	26	4	9
Oreg.	21	38	44	52	9	9
Calif.	302	425	196	235	11	12
Alaska	3	3	5	8	—	—
Hawaii	9	13	2	4	—	1
Guam	—	1	—	10	—	8
P.R.	4	20	3	34	—	—
V.I.	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U
C.N.M.I.	—	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 June 18, 2005, and June 19, 2004 (24th 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	505	610	209	244	2,742	4,895	448	564
NEW ENGLAND	32	18	6	11	166	786	18	51
Maine	1	—	—	2	13	29	3	4
N.H.	4	—	1	1	23	21	3	—
Vt.	—	1	—	—	3	12	—	3
Mass.	19	10	2	3	95	481	10	29
R.I.	2	2	1	1	3	47	2	2
Conn.	6	5	2	4	29	196	—	13
MID. ATLANTIC	146	134	44	56	1,908	3,250	120	139
Upstate N.Y.	38	27	13	17	358	1,006	22	15
N.Y. City	17	18	7	8	—	109	51	69
N.J.	32	21	8	16	835	943	30	31
Pa.	59	68	16	15	715	1,192	17	24
E.N. CENTRAL	101	139	20	40	38	309	26	49
Ohio	48	62	8	15	23	20	7	12
Ind.	6	12	1	6	3	3	—	6
Ill.	11	21	—	8	—	37	7	15
Mich.	28	37	6	9	4	3	9	9
Wis.	8	7	5	2	8	246	3	7
W.N. CENTRAL	14	15	11	4	94	63	24	35
Minn.	1	1	2	1	72	25	11	16
Iowa	2	3	4	1	13	13	2	1
Mo.	8	7	2	2	8	19	10	8
N. Dak.	1	1	2	—	—	—	—	2
S. Dak.	—	1	—	—	—	—	—	1
Nebr.	—	1	—	—	—	4	—	2
Kans.	2	1	1	—	1	2	1	5
S. ATLANTIC	112	134	49	34	449	417	95	135
Del.	1	2	N	N	117	57	—	3
Md.	33	20	6	5	233	266	34	29
D.C.	2	5	—	—	3	2	2	7
Va.	12	8	5	4	39	16	11	11
W. Va.	4	2	1	1	4	2	1	—
N.C.	12	15	9	8	22	45	13	9
S.C.	2	4	1	1	7	4	3	7
Ga.	7	21	10	7	—	8	13	24
Fla.	39	57	17	8	24	17	18	45
E.S. CENTRAL	21	26	10	13	15	21	12	17
Ky.	7	6	1	4	1	10	3	1
Tenn.	7	10	5	7	14	8	6	3
Ala.	7	9	3	1	—	3	3	10
Miss.	—	1	1	1	—	—	—	3
W.S. CENTRAL	9	84	9	21	29	14	33	57
Ark.	1	—	—	1	2	2	2	6
La.	4	5	3	2	3	1	2	3
Okla.	1	2	—	—	—	—	2	2
Tex.	3	77	6	18	24	11	27	46
MOUNTAIN	41	34	2	11	3	5	25	17
Mont.	3	1	—	—	—	—	—	—
Idaho	1	3	—	1	1	2	—	1
Wyo.	2	4	—	—	—	2	1	—
Colo.	10	6	1	3	—	—	14	7
N. Mex.	1	1	—	—	—	—	—	1
Ariz.	12	5	—	—	—	1	5	3
Utah	5	11	—	1	2	—	4	3
Nev.	7	3	1	6	—	—	1	2
PACIFIC	29	26	58	54	40	30	95	64
Wash.	—	4	4	6	—	2	7	3
Oreg.	N	N	4	4	4	14	2	10
Calif.	29	22	50	44	35	14	79	49
Alaska	—	—	—	—	1	—	3	—
Hawaii	—	—	—	—	N	N	4	2
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 June 18, 2005, and June 19, 2004 (24th 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	649	683	50	50	31	27	—	—	568	606
NEW ENGLAND	48	35	1	4	—	4	—	—	47	27
Maine	2	8	—	—	—	1	—	—	2	7
N.H.	6	3	—	—	—	—	—	—	6	3
Vt.	4	1	—	—	—	—	—	—	4	1
Mass.	24	21	—	4	—	3	—	—	24	14
R.I.	2	1	—	—	—	—	—	—	2	1
Conn.	10	1	1	—	—	—	—	—	9	1
MID. ATLANTIC	87	102	25	30	4	5	—	—	58	67
Upstate N.Y.	22	30	3	5	3	3	—	—	16	22
N.Y. City	12	17	—	—	—	—	—	—	12	17
N.J.	24	19	—	—	—	—	—	—	24	19
Pa.	29	36	22	25	1	2	—	—	6	9
E.N. CENTRAL	58	69	15	11	5	5	—	—	38	53
Ohio	28	40	—	3	5	4	—	—	23	33
Ind.	8	10	—	—	—	1	—	—	8	9
Ill.	2	1	—	—	—	—	—	—	2	1
Mich.	15	8	15	8	—	—	—	—	—	—
Wis.	5	10	—	—	—	—	—	—	5	10
W.N. CENTRAL	43	44	2	—	1	3	—	—	40	41
Minn.	6	13	1	—	—	—	—	—	5	13
Iowa	11	9	—	—	1	2	—	—	10	7
Mo.	15	13	1	—	—	1	—	—	14	12
N. Dak.	—	1	—	—	—	—	—	—	—	1
S. Dak.	2	1	—	—	—	—	—	—	2	1
Nebr.	3	2	—	—	—	—	—	—	3	2
Kans.	6	5	—	—	—	—	—	—	6	5
S. ATLANTIC	117	137	3	2	4	2	—	—	110	133
Del.	2	2	—	—	—	—	—	—	2	2
Md.	11	7	1	—	2	—	—	—	8	7
D.C.	—	5	—	2	—	—	—	—	—	3
Va.	16	9	—	—	—	—	—	—	16	9
W. Va.	5	4	1	—	—	—	—	—	4	4
N.C.	11	20	1	—	2	2	—	—	8	18
S.C.	11	13	—	—	—	—	—	—	11	13
Ga.	11	9	—	—	—	—	—	—	11	9
Fla.	50	68	—	—	—	—	—	—	50	68
E.S. CENTRAL	33	30	—	—	3	—	—	—	30	30
Ky.	11	3	—	—	3	—	—	—	8	3
Tenn.	15	10	—	—	—	—	—	—	15	10
Ala.	3	7	—	—	—	—	—	—	3	7
Miss.	4	10	—	—	—	—	—	—	4	10
W.S. CENTRAL	49	40	1	1	4	1	—	—	44	38
Ark.	9	10	—	—	—	—	—	—	9	10
La.	21	24	—	1	2	—	—	—	19	23
Okla.	10	4	1	—	2	1	—	—	7	3
Tex.	9	2	—	—	—	—	—	—	9	2
MOUNTAIN	57	37	2	—	5	3	—	—	50	34
Mont.	—	2	—	—	—	—	—	—	—	2
Idaho	1	4	—	—	—	—	—	—	1	4
Wyo.	—	3	—	—	—	—	—	—	—	3
Colo.	12	11	2	—	—	—	—	—	10	11
N. Mex.	1	4	—	—	—	2	—	—	1	2
Ariz.	31	6	—	—	2	—	—	—	29	6
Utah	7	2	—	—	2	—	—	—	5	2
Nev.	5	5	—	—	1	1	—	—	4	4
PACIFIC	157	189	1	2	5	4	—	—	151	183
Wash.	29	16	1	2	4	4	—	—	24	10
Oreg.	23	37	—	—	—	—	—	—	23	37
Calif.	98	129	—	—	—	—	—	—	98	129
Alaska	1	2	—	—	—	—	—	—	1	2
Hawaii	6	5	—	—	1	—	—	—	5	5
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	4	9	—	—	—	—	—	—	4	9
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	—	—	—	—	—	—	—	—	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—

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* 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 June 18, 2005, and June 19, 2004 (24th 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	7,600	5,248	2,238	2,793	323	354	11,926	13,165	4,431	5,415
NEW ENGLAND	429	707	324	231	1	7	750	651	87	111
Maine	13	3	26	28	N	N	60	35	4	2
N.H.	18	22	4	9	—	—	54	40	4	5
Vt.	49	40	25	9	—	—	43	21	4	2
Mass.	320	610	190	95	—	6	409	371	50	70
R.I.	11	9	8	13	1	1	23	48	4	8
Conn.	18	23	71	77	—	—	161	136	21	24
MID. ATLANTIC	676	1,070	266	344	21	33	1,513	1,731	469	573
Upstate N.Y.	248	769	209	175	—	1	411	396	118	267
N.Y. City	38	75	14	7	1	11	345	505	187	163
N.J.	119	77	N	N	6	8	244	307	131	92
Pa.	271	149	43	162	14	13	513	523	33	51
E.N. CENTRAL	1,641	1,366	44	26	5	14	1,440	1,898	305	411
Ohio	658	198	22	8	3	5	418	446	30	74
Ind.	146	40	4	3	—	3	141	170	33	89
Ill.	179	278	11	8	1	5	273	650	55	149
Mich.	106	51	7	5	1	1	322	321	123	48
Wis.	552	799	—	2	—	—	286	311	64	51
W.N. CENTRAL	1,068	300	165	272	41	36	869	886	450	167
Minn.	271	52	32	22	—	—	201	212	28	22
Iowa	314	40	31	31	—	—	123	182	41	34
Mo.	206	165	27	8	38	31	285	243	313	71
N. Dak.	48	8	6	29	—	—	11	15	2	1
S. Dak.	1	11	27	57	2	—	60	35	15	6
Nebr.	97	5	—	64	—	5	72	58	27	7
Kans.	131	19	42	61	1	—	117	141	24	26
S. ATLANTIC	501	272	761	1,124	172	168	3,146	2,816	759	1,327
Del.	13	—	—	9	1	2	16	24	4	3
Md.	90	55	141	130	18	12	266	237	30	49
D.C.	4	6	—	—	—	—	17	16	7	21
Va.	91	59	255	213	9	1	347	301	43	44
W. Va.	27	4	19	32	3	—	48	50	—	—
N.C.	27	43	236	310	118	103	494	341	72	137
S.C.	161	46	5	68	6	18	161	184	35	239
Ga.	14	14	102	157	8	26	434	531	200	309
Fla.	74	45	3	205	9	6	1,363	1,132	368	525
E.S. CENTRAL	220	66	64	63	42	47	691	800	626	279
Ky.	58	11	6	11	—	—	130	127	95	34
Tenn.	104	37	21	22	31	25	255	235	345	118
Ala.	40	8	37	25	10	12	218	217	150	98
Miss.	18	10	—	5	1	10	88	221	36	29
W.S. CENTRAL	208	251	461	597	14	41	846	1,401	782	1,554
Ark.	109	15	16	27	7	19	260	166	28	20
La.	16	8	—	—	2	3	231	259	53	156
Okla.	—	14	48	68	5	19	126	124	328	235
Tex.	83	214	397	502	—	—	229	852	373	1,143
MOUNTAIN	1,870	496	94	51	22	5	804	884	261	334
Mont.	365	13	—	5	1	1	35	59	3	4
Idaho	64	17	—	—	1	1	47	64	2	6
Wyo.	15	3	11	—	1	—	18	22	—	1
Colo.	686	255	8	6	2	1	199	208	42	55
N. Mex.	62	70	—	2	—	1	62	96	31	60
Ariz.	465	95	75	38	13	1	267	270	139	172
Utah	189	33	—	—	4	—	117	89	19	16
Nev.	24	10	—	—	—	—	59	76	25	20
PACIFIC	987	720	59	85	5	3	1,867	2,098	692	659
Wash.	234	208	—	—	—	—	176	167	35	43
Oreg.	319	223	—	—	—	2	128	179	32	32
Calif.	356	270	58	74	5	1	1,431	1,556	608	556
Alaska	20	10	1	11	—	—	19	29	5	5
Hawaii	58	9	—	—	—	—	113	167	12	23
Guam	—	—	—	—	—	—	—	41	—	33
P.R.	—	—	28	23	N	N	37	151	—	10
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 18, 2005, and June 19, 2004 (24th 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	2,294	2,600	1,273	1,264	432	432	3,321	3,460	108	194
NEW ENGLAND	86	188	12	72	48	66	98	84	—	—
Maine	5	5	N	N	—	2	1	—	—	—
N.H.	7	13	—	—	3	N	5	3	—	—
Vt.	7	6	6	6	3	1	—	—	—	—
Mass.	61	88	—	18	42	39	71	50	—	—
R.I.	6	17	6	7	—	5	2	9	—	—
Conn.	—	59	U	41	U	19	19	22	—	—
MID. ATLANTIC	532	451	128	96	72	61	432	445	11	22
Upstate N.Y.	172	140	49	42	42	40	35	38	5	1
N.Y. City	88	74	U	U	U	U	278	263	5	9
N.J.	112	95	N	N	13	5	62	80	1	11
Pa.	160	142	79	54	17	16	57	64	—	1
E.N. CENTRAL	451	612	345	302	119	108	279	414	17	27
Ohio	120	148	221	217	51	52	92	114	2	1
Ind.	48	68	118	85	31	22	33	27	1	1
Ill.	94	173	6	—	33	—	112	163	3	3
Mich.	181	176	—	N	—	N	32	92	9	22
Wis.	8	47	N	N	4	34	10	18	2	—
W.N. CENTRAL	150	188	32	12	50	42	106	85	1	2
Minn.	53	89	—	—	29	25	26	14	—	1
Iowa	N	N	N	N	—	N	1	4	—	—
Mo.	45	42	27	9	5	8	64	48	1	1
N. Dak.	2	8	—	—	1	1	—	—	—	—
S. Dak.	16	8	3	3	—	—	—	—	—	—
Nebr.	11	13	2	—	5	5	3	5	—	—
Kans.	23	28	N	N	10	3	12	14	—	—
S. ATLANTIC	465	510	514	648	51	31	860	853	22	33
Del.	—	2	1	4	—	N	6	3	—	1
Md.	121	79	—	—	34	20	165	164	7	4
D.C.	6	5	13	5	2	4	56	24	—	1
Va.	40	40	N	N	—	N	45	48	3	1
W. Va.	11	16	67	66	15	7	2	3	—	—
N.C.	72	73	N	N	U	U	107	72	7	3
S.C.	11	43	—	72	—	N	29	59	—	9
Ga.	81	131	109	161	—	N	112	151	—	2
Fla.	123	121	324	340	—	N	338	329	5	12
E.S. CENTRAL	108	138	114	81	5	9	173	183	12	9
Ky.	23	43	21	20	N	N	16	23	—	1
Tenn.	85	95	93	59	—	N	78	64	8	1
Ala.	—	—	—	—	—	N	63	77	3	5
Miss.	—	—	—	2	5	9	16	19	1	2
W.S. CENTRAL	92	200	84	38	55	87	576	527	27	37
Ark.	8	7	12	5	13	7	24	15	—	3
La.	6	2	72	33	17	20	118	122	3	3
Okla.	67	38	N	N	16	26	18	13	1	2
Tex.	11	153	N	N	9	34	416	377	23	29
MOUNTAIN	362	269	44	14	32	28	182	185	14	27
Mont.	—	—	—	—	—	—	5	—	—	—
Idaho	1	4	N	N	—	N	19	13	1	2
Wyo.	2	6	18	5	—	—	—	1	—	—
Colo.	133	57	N	N	31	28	19	32	—	—
N. Mex.	23	62	—	N	—	—	23	48	1	2
Ariz.	154	116	N	N	—	N	67	79	12	23
Utah	48	23	25	7	1	—	4	3	—	—
Nev.	1	1	1	2	—	—	45	9	—	—
PACIFIC	48	44	—	1	—	—	615	684	4	37
Wash.	N	N	N	N	N	N	64	42	—	—
Oreg.	N	N	N	N	—	N	16	15	—	—
Calif.	—	—	N	N	N	N	529	624	4	37
Alaska	—	—	—	—	—	N	4	—	—	—
Hawaii	48	44	—	1	—	—	2	3	—	—
Guam	—	—	—	—	—	—	—	1	—	—
P.R.	N	N	N	N	—	N	91	64	6	3
V.I.	—	—	—	—	—	—	—	4	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 18, 2005, and June 19, 2004 (24th 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	4,247	5,781	91	120	12,475	12,223	—	63	—
NEW ENGLAND	136	188	11	14	891	1,728	—	—	—
Maine	7	11	1	—	200	176	—	—	—
N.H.	4	7	—	—	124	—	—	—	—
Vt.	—	—	—	—	29	392	—	—	—
Mass.	90	105	7	12	538	36	—	—	—
R.I.	14	22	—	1	—	—	—	—	—
Conn.	21	43	3	1	U	1,124	—	—	—
MID. ATLANTIC	900	852	24	33	2,716	36	—	2	—
Upstate N.Y.	111	104	4	2	—	—	—	—	—
N.Y. City	458	432	5	12	—	—	—	1	—
N.J.	210	183	8	11	—	—	—	—	—
Pa.	121	133	7	8	2,716	36	—	1	—
E.N. CENTRAL	557	504	5	12	3,778	3,863	—	1	—
Ohio	117	89	—	2	855	955	—	—	—
Ind.	59	58	—	—	120	N	—	—	—
Ill.	258	228	1	5	24	1	—	—	—
Mich.	85	94	2	4	2,524	2,444	—	1	—
Wis.	38	35	2	1	255	463	—	—	—
W.N. CENTRAL	202	193	1	3	184	128	—	2	—
Minn.	85	73	1	2	—	—	—	—	—
Iowa	17	15	—	—	N	N	—	—	—
Mo.	53	58	—	1	110	2	—	1	—
N. Dak.	2	3	—	—	10	71	—	—	—
S. Dak.	5	5	—	—	64	55	—	1	—
Nebr.	16	11	—	—	—	—	—	—	—
Kans.	24	28	—	—	—	—	—	—	N
S. ATLANTIC	947	1,104	13	12	989	1,428	—	1	—
Del.	2	12	—	—	6	4	—	—	—
Md.	106	110	3	3	—	—	—	—	—
D.C.	27	4	—	—	16	17	—	—	—
Va.	111	86	3	3	177	343	—	—	—
W. Va.	10	10	—	—	613	788	—	—	N
N.C.	92	110	2	3	—	N	—	—	—
S.C.	93	90	—	—	177	276	—	—	—
Ga.	132	297	2	1	—	—	—	—	—
Fla.	374	385	3	2	—	—	—	1	—
E.S. CENTRAL	236	255	1	4	—	—	—	1	—
Ky.	47	42	1	2	N	N	—	—	—
Tenn.	106	96	—	2	—	—	—	—	—
Ala.	83	84	—	—	—	—	—	1	—
Miss.	—	33	—	—	—	—	—	—	—
W.S. CENTRAL	347	977	3	8	2,306	3,569	—	2	—
Ark.	41	60	—	—	—	—	—	—	—
La.	—	—	—	—	97	44	—	—	—
Okla.	61	75	—	—	—	—	—	—	—
Tex.	245	842	3	8	2,209	3,525	—	2	—
MOUNTAIN	150	242	3	6	1,611	1,471	—	52	—
Mont.	6	—	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—	—
Wyo.	—	1	—	—	42	21	—	—	—
Colo.	27	64	—	1	1,149	1,156	—	1	—
N. Mex.	8	18	—	—	97	U	—	—	—
Ariz.	98	99	1	2	—	—	—	51	—
Utah	11	20	1	1	323	294	—	—	—
Nev.	—	40	1	2	—	—	—	—	—
PACIFIC	772	1,466	30	28	—	—	—	2	—
Wash.	98	106	2	2	N	N	—	—	—
Oreg.	46	38	2	—	—	—	—	—	—
Calif.	564	1,257	21	20	—	—	—	2	—
Alaska	13	14	—	—	—	—	—	—	—
Hawaii	51	51	5	6	—	—	—	—	—
Guam	—	36	—	—	—	75	—	—	—
P.R.	—	21	—	—	77	242	—	—	—
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 June 18, 2005 (24th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
NEW ENGLAND	502	337	105	40	13	7	46
Boston, Mass.	109	61	31	11	4	2	16
Bridgeport, Conn.	28	16	10	2	—	—	2
Cambridge, Mass.	19	18	1	—	—	—	2
Fall River, Mass.	21	12	5	3	1	—	2
Hartford, Conn.	58	41	8	5	4	—	6
Lowell, Mass.	17	14	3	—	—	—	2
Lynn, Mass.	4	2	2	—	—	—	—
New Bedford, Mass.	24	14	5	4	1	—	1
New Haven, Conn.	39	24	11	2	1	1	3
Providence, R.I.	66	46	11	6	1	2	4
Somerville, Mass.	1	—	—	—	1	—	—
Springfield, Mass.	34	27	6	—	—	1	4
Waterbury, Conn.	27	21	2	3	—	1	1
Worcester, Mass.	55	41	10	4	—	—	3
MID. ATLANTIC	2,110	1,467	448	118	46	30	128
Albany, N.Y.	59	43	13	2	—	1	4
Allentown, Pa.	24	21	3	—	—	—	1
Buffalo, N.Y.	96	65	20	8	2	1	10
Camden, N.J.	23	17	5	—	1	—	1
Elizabeth, N.J.	14	11	3	—	—	—	—
Erie, Pa.	33	25	3	2	2	1	2
Jersey City, N.J.	40	29	8	2	1	—	—
New York City, N.Y.	1,084	758	237	58	21	9	64
Newark, N.J.	77	39	26	7	2	3	—
Paterson, N.J.	U	U	U	U	U	U	U
Philadelphia, Pa.	299	189	74	19	9	8	16
Pittsburgh, Pa.§	41	28	6	2	2	3	3
Reading, Pa.	22	18	3	—	1	—	1
Rochester, N.Y.	111	86	17	5	1	2	10
Schenectady, N.Y.	16	12	1	2	—	1	—
Scranton, Pa.	31	23	4	2	2	—	7
Syracuse, N.Y.	84	64	13	4	2	1	9
Trenton, N.J.	25	15	7	3	—	—	—
Utica, N.Y.	15	13	1	1	—	—	—
Yonkers, N.Y.	16	11	4	1	—	—	—
E.N. CENTRAL	1,970	1,277	466	129	49	49	145
Akron, Ohio	43	28	11	3	1	—	2
Canton, Ohio	21	15	5	—	1	—	2
Chicago, Ill.	325	187	91	25	11	11	27
Cincinnati, Ohio	76	51	15	5	1	4	1
Cleveland, Ohio	238	170	49	13	2	4	13
Columbus, Ohio	200	123	50	16	6	5	22
Dayton, Ohio	128	94	27	5	2	—	13
Detroit, Mich.	158	83	46	17	7	5	12
Evansville, Ind.	40	34	5	—	1	—	5
Fort Wayne, Ind.	62	39	15	4	1	3	1
Gary, Ind.	19	11	5	1	1	1	—
Grand Rapids, Mich.	48	25	18	—	1	4	3
Indianapolis, Ind.	186	121	41	16	5	3	14
Lansing, Mich.	34	28	2	3	1	—	2
Milwaukee, Wis.	105	69	25	5	2	4	11
Peoria, Ill.	45	31	12	1	—	1	5
Rockford, Ill.	52	35	9	2	5	1	5
South Bend, Ind.	49	33	10	6	—	—	3
Toledo, Ohio	93	60	26	5	1	1	3
Youngstown, Ohio	48	40	4	2	—	2	1
W.N. CENTRAL	512	317	126	37	18	14	31
Des Moines, Iowa	0	0	0	0	0	0	0
Duluth, Minn.	24	16	6	2	—	—	1
Kansas City, Kans.	20	14	3	2	1	—	2
Kansas City, Mo.	80	46	20	6	7	1	5
Lincoln, Nebr.	39	32	7	—	—	—	4
Minneapolis, Minn.	52	25	18	4	2	3	6
Omaha, Nebr.	82	55	15	5	2	5	5
St. Louis, Mo.	93	55	22	13	—	3	3
St. Paul, Minn.	48	28	14	2	3	1	3
Wichita, Kans.	74	46	21	3	3	1	2
S. ATLANTIC	1,144	743	260	79	39	23	59
Atlanta, Ga.	133	79	35	16	3	—	6
Baltimore, Md.	146	76	45	16	7	2	10
Charlotte, N.C.	102	68	20	8	3	3	11
Jacksonville, Fla.	160	104	37	13	5	1	5
Miami, Fla.	55	35	14	2	2	2	2
Norfolk, Va.	35	25	4	1	2	3	2
Richmond, Va.	56	35	14	3	4	—	8
Savannah, Ga.	44	28	11	4	1	—	1
St. Petersburg, Fla.	59	38	12	3	3	3	2
Tampa, Fla.	205	146	39	8	6	6	10
Washington, D.C.	101	68	23	4	3	3	1
Wilmington, Del.	48	41	6	1	—	—	1
E.S. CENTRAL	884	582	189	64	30	19	67
Birmingham, Ala.	149	105	30	9	3	2	17
Chattanooga, Tenn.	74	53	18	1	2	—	3
Knoxville, Tenn.	84	64	14	4	1	1	5
Lexington, Ky.	67	44	11	10	1	1	6
Memphis, Tenn.	202	128	40	13	14	7	11
Mobile, Ala.	72	43	24	3	1	1	2
Montgomery, Ala.	59	39	9	5	4	2	5
Nashville, Tenn.	177	106	43	19	4	5	18
W.S. CENTRAL	1,646	1,020	396	136	55	39	87
Austin, Tex.	82	44	21	12	4	1	5
Baton Rouge, La.	16	12	4	—	—	—	1
Corpus Christi, Tex.	64	36	17	6	3	2	2
Dallas, Tex.	199	122	48	18	4	7	14
El Paso, Tex.	99	71	18	5	3	2	3
Ft. Worth, Tex.	155	103	37	7	6	2	8
Houston, Tex.	326	187	80	37	8	14	22
Little Rock, Ark.	64	42	15	5	1	1	1
New Orleans, La.	240	130	63	23	19	5	10
San Antonio, Tex.	198	129	47	13	6	3	9
Shreveport, La.	73	44	23	5	—	1	4
Tulsa, Okla.	130	100	23	5	1	1	8
MOUNTAIN	954	590	219	82	33	26	72
Albuquerque, N.M.	100	50	36	4	6	4	4
Boise, Idaho	54	39	5	4	1	5	5
Colo. Springs, Colo.	64	43	14	5	—	2	4
Denver, Colo.	99	61	19	9	5	5	7
Las Vegas, Nev.	269	175	69	16	7	1	35
Ogden, Utah	28	22	3	2	1	—	2
Phoenix, Ariz.	203	102	47	36	8	7	6
Pueblo, Colo.	30	18	11	1	—	—	1
Salt Lake City, Utah	107	80	15	5	5	2	8
Tucson, Ariz.	U	U	U	U	U	U	U
PACIFIC	1,615	1,102	353	104	32	23	148
Berkeley, Calif.	12	11	1	—	—	—	—
Fresno, Calif.	129	89	31	8	1	—	8
Glendale, Calif.	19	16	3	—	—	—	2
Honolulu, Hawaii	82	61	13	6	1	1	6
Long Beach, Calif.	62	39	17	2	3	1	8
Los Angeles, Calif.	416	290	89	25	8	4	56
Pasadena, Calif.	26	20	4	2	—	—	1
Portland, Oreg.	118	75	26	13	3	1	8
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	187	123	45	9	5	4	20
San Francisco, Calif.	120	76	27	9	4	4	6
San Jose, Calif.	169	121	34	10	2	2	14
Santa Cruz, Calif.	29	25	3	1	—	—	3
Seattle, Wash.	114	72	29	7	3	3	5
Spokane, Wash.	52	38	10	2	1	1	7
Tacoma, Wash.	80	46	21	10	1	2	4
TOTAL	11,337¶	7,435	2,562	789	315	230	783

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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