



MMWRTM

Morbidity and Mortality Weekly Report

Weekly

September 2, 2005 / Vol. 54 / No. 34

The Role of Public Health in Mental Health Promotion

Mental illness contributes a substantial burden of disease worldwide. Globally, approximately 450 million persons suffer from mental disorders (1), and one fourth of the world's population will develop a mental or behavioral disorder at some point during their lives (2). Mental disorders account for approximately 25% of disability in the United States, Canada, and Western Europe and are a leading cause of premature death (1,3). In the United States, approximately 22% of the U.S. adult population has one or more diagnosable mental disorders in a given year (3). The estimated lifetime prevalences for mental disorders among the U.S. adult population are approximately 29% for anxiety disorders, 25% for impulse-control disorders, 21% for mood disorders, 15% for substance-use disorders, and 46% for any of these disorders (4). In addition, an estimated one in 10 children in the United States has a mental disorder that causes some level of impairment (5). The effects of mental illness are evident across the life span, among all ethnic, racial, and cultural groups, and among persons of every socioeconomic level (6). Moreover, mental illness costs the United States an estimated \$150 billion annually, excluding the costs of research (7).

Mental health is integral to overall health and well-being and should be treated with the same urgency as physical health (3,7). Mental illness can influence the onset, progression, and outcome of other illnesses and often correlates with health risk behaviors such as substance abuse, tobacco use, and physical inactivity (8). Depression has emerged as a risk factor for such chronic illnesses as hypertension, cardiovascular disease, and diabetes and can adversely affect the course and management of these conditions (8).

Treatment for mental disorders is available and effective (3,5). However, the majority of persons with diagnosed mental disorders do not receive treatment (4). The challenges for public health are to identify risk factors, increase awareness about mental disorders and the effectiveness of treatment,

remove the stigma associated with receiving treatment, eliminate health disparities, and improve access to mental health services for all persons, particularly among populations that are disproportionately affected (1,3). Public health agencies can incorporate mental health promotion into chronic disease prevention efforts, conduct surveillance and research to improve the evidence base about mental health in the United States, and collaborate with partners to develop comprehensive mental health plans to enhance coordination of care.

CDC has mobilized multiple efforts to assess and address mental health and well-being. Data on mental health, risk behaviors, and comorbidity of mental illness and chronic disease are collected through various national surveillance initiatives. CDC also collaborates with the World Federation for Mental Health to address stigma, a pervasive barrier to seeking treatment, through promotion of public awareness campaigns, such as World Mental Health Day. As the nation's premier public health agency, CDC is well-positioned to expand its role in safeguarding mental health by supporting the efforts of other health agencies, such as the Substance Abuse and Mental Health Services Administration and the National Institute of Mental Health, through continued surveillance of mental illness and risk behaviors in the U.S. population and promotion of mental health across the life span.

INSIDE

- 842 Prevalence of Diagnosis and Medication Treatment for Attention-Deficit/Hyperactivity Disorder — United States, 2003
- 848 Children and Teens Told by Doctors That They Were Overweight — United States, 1999–2002
- 850 Update: Influenza Vaccine Supply and Recommendations for Prioritization During the 2005–06 Influenza Season
- 851 Update: West Nile Virus Activity — United States, 2005
- 852 QuickStats

The *MMWR* series of publications is published by the Coordinating Center for Health Information and Service, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

SUGGESTED CITATION

Centers for Disease Control and Prevention. [Article Title]. *MMWR* 2005;54:[inclusive page numbers].

Centers for Disease Control and Prevention

Julie L. Gerberding, MD, MPH
Director

Dixie E. Snider, MD, MPH
Chief Science Officer

Tanja Popovic, MD, PhD
Associate Director for Science

Coordinating Center for Health Information and Service

Blake Caldwell, MD, MPH, and Edward J. Sondik, PhD
(Acting) Directors

National Center for Health Marketing*

Jay M. Bernhardt, PhD, MPH
Director

Division of Scientific Communications*

Maria S. Parker
(Acting) Director

Mary Lou Lindegren, MD
Editor, MMWR Series

Suzanne M. Hewitt, MPA
Managing Editor, MMWR Series

Douglas W. Weatherwax
(Acting) Lead Technical Writer-Editor

Stephanie M. Neitzel
Jude C. Rutledge
Writers-Editors

Lynda G. Cupell
Malbea A. LaPete
Visual Information Specialists

Quang M. Doan, MBA
Erica R. Shaver
Information Technology Specialists

Notifiable Disease Morbidity and 122 Cities Mortality Data

Patsy A. Hall	Donna Edwards
Deborah A. Adams	Tambra McGee
Felicia J. Connor	Pearl C. Sharp
Rosaline Dhara	

* Proposed.

This issue of *MMWR* begins a series of occasional reports on mental health in the United States and includes a report on attention-deficit/hyperactivity disorder in children.

Reported by: *S Marshall Williams, PhD, D Chapman, PhD, J Lando, MD, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

References

1. World Health Organization. The world health report 2001: mental health: new understanding, new hope. Geneva, Switzerland: World Health Organization; 2001.
2. Murray CL, Lopez AD, eds. The global burden of disease and injury series. Vol 1: a comprehensive assessment of mortality and disability from diseases injuries and risk factors in 1990 and projected to 2020. Cambridge, MA: Harvard University Press; 1996.
3. US Department of Health and Human Services. Mental health: a report of the Surgeon General. Rockville, MD: US Department of Health and Human Services; 1999.
4. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psych* 2005;62:593–602.
5. National Institute of Mental Health. Treatment of children with mental disorders. Bethesda, MD: National Institute of Mental Health; 2000. Available at <http://www.nimh.nih.gov/publicat/childqa.cfm>.
6. US Department of Health and Human Services. Mental health: culture, race, and ethnicity—a supplement to mental health: a report of the Surgeon General. Rockville, MD: US Department of Health and Human Services; 2001.
7. President's New Freedom Commission on Mental Health. Achieving the promise: transforming mental health care in America. Rockville, MD: US Department of Health and Human Services; 2003.
8. Chapman DP, Perry SG, Strine TW. The vital link between chronic disease and depressive disorders. *Prevent Chronic Dis* 2005;2 [serial pub online]. Available at <http://www.cdc.gov/pcd/issues/2005>.

Mental Health in the United States

Prevalence of Diagnosis and Medication Treatment for Attention-Deficit/Hyperactivity Disorder — United States, 2003

Attention-deficit/hyperactivity disorder (ADHD), previously known as attention deficit disorder, is a neurobehavioral disorder characterized by pervasive inattention and hyperactivity-impulsivity that often results in substantial functional impairment (Box). Prevalence estimates of ADHD in school-aged children have ranged from 2% to 18% in community samples (1). Although stimulant medications are an effective first-line treatment for ADHD (2), concern persists regarding the possible side effects and long-term health outcomes associated with stimulant consumption (1). Estimating the number of children who have had ADHD diagnosed and are currently taking medication for the disorder is an important step toward understanding the overall burden of ADHD in the United States. Previously, population-based estimates of medication treatment for ADHD were not available or were limited by their lack of generalizability (3–5). To

BOX. Diagnostic criteria for attention-deficit/hyperactivity disorder (ADHD)

A. Either (1) or (2):

- (1) six or more of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention

- (a) often fails to give close attention to details or makes careless mistakes in school work, work, or other activities
- (b) often has difficulty sustaining attention in tasks or play activities
- (c) often does not seem to listen when spoken to directly
- (d) often does not follow through on instructions and fails to finish school work, chores, or duties in the workplace (not because of oppositional behavior or failure to understand instructions)
- (e) often has difficulty organizing tasks and activities
- (f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as school work or homework)
- (g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
- (h) is often easily distracted by extraneous stimuli
- (i) is often forgetful in daily activities

- (2) six or more of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

- (a) often fidgets with hands or feet or squirms in seat
- (b) often leaves seat in classroom or in other situations in which remaining seated is expected

- (c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, might be limited to subjective feelings of restlessness)

- (d) often has difficulty playing or engaging in leisure activities quietly

- (e) is often “on the go” or often acts as if “driven by a motor”

- (f) often talks excessively

Impulsivity

- (g) often blurts out answers before questions have been completed

- (h) often has difficulty awaiting turn

- (i) often interrupts or intrudes on others (e.g., butts into conversations or games)

- B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

- C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

- D. Clear evidence of clinically significant impairment in social, academic, or occupational functioning.

- E. Symptoms do not occur exclusively during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder and are not better accounted for by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, or personality disorder).

ADHD Subtypes

Attention-deficit/hyperactivity disorder, combined type: if both criteria A1 and A2 are met for the preceding 6 months.

Attention-deficit/hyperactivity disorder, predominantly inattentive type: if criterion A1 is met but criterion A2 is not met for the preceding 6 months.

Attention-deficit/hyperactivity disorder, predominantly hyperactive-impulsive type: if criterion A2 is met but criterion A1 is not met for the preceding 6 months.

SOURCE: American Psychiatric Association. Diagnostic and statistical manual—text revision (DSM-IV-TR™, 2000). Arlington, VA: American Psychiatric Association; 2000.

estimate rates of parent-reported ADHD diagnosis and medication treatment for ADHD, CDC analyzed data from the 2003 National Survey of Children's Health (NSCH). This report describes the results of that analysis, which indicated that, in 2003, approximately 4.4 million children aged 4–17 years were reported to have a history of ADHD diagnosis; of these, 2.5 million (56%) were reported to be taking medication for the disorder. Because both substantial health risks

and benefits might be associated with medication treatment for ADHD, further study of this population of children with ADHD is needed.

NSCH is a survey about the physical and emotional health of civilian, noninstitutionalized, U.S. children aged ≤17 years (6). CDC conducted the 2003 NSCH during January 2003–July 2004 by using the State and Local Area Integrated Telephone Survey (SLAITS). SLAITS allows for sampling from

the National Immunization Survey sampling frame. One child was randomly selected from households with at least one child aged ≤ 17 years. Parents or guardians responded to survey items on behalf of 102,353 sample children (completion rate: 68.8%). NSCH data were weighted to estimate national and state-specific rates of ADHD diagnosis and medication treatment among children aged 4–17 years.

As a proxy for ADHD diagnosis, respondents were asked, "Has a doctor or health professional ever told you that [child] has attention-deficit disorder or attention-deficit/hyperactivity disorder, that is, ADD or ADHD?" If an ADHD diagnosis was indicated, respondents were asked, "Is [child] currently taking medication for ADD or ADHD?" Estimates of reported ADHD diagnosis, current medication treatment among those with ADHD, and current medication treatment for ADHD among all children aged 4–17 years were calculated. Rates of medication treatment for ADHD among all children aged 4–17 years were calculated by using the number of children

currently receiving medication as the numerator and all families who responded to the ADHD diagnosis question (affirmatively or negatively) as the denominator. Statistical software was used to adjust for the complex sampling design of NSCH. Statistical significance was concluded for those comparisons yielding an alpha level < 0.05 . Seventy-four sample children were excluded from sociodemographic comparisons because of missing data on their sex.

Prevalence and national population estimates of parent-reported ADHD diagnosis were calculated and compared by selected sociodemographic characteristics (Table). In 2003, approximately 7.8% (4,418,000; 95% confidence interval [CI] = 4,234,000–4,602,000) of U.S. children aged 4–17 years had ever had ADHD diagnosed. ADHD diagnosis was reported approximately 2.5 times more frequently among males than females (Figure 1). Prevalence of reported ADHD increased with age and was significantly lower among children aged 4–8 years compared with children aged ≥ 9 years

TABLE. Weighted prevalence estimates of ADHD* ever diagnosed and current medication treatment for ADHD among children aged 4–17 years,† by sex and sociodemographic characteristics — United States, 2003

Characteristic	Reported ADHD diagnosis						Currently taking medication for ADHD					
	Male		Female		Total		Male		Female		Total	
	%	95% CI [§]	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
National prevalence[¶]	11.0	(10.4–11.5)	4.4	(4.1–4.8)	7.8	(7.4–8.1)	6.2	(5.8–6.6)	2.4	(2.2–2.7)	4.3	(4.1–4.6)
Age group (yrs)												
4–8	6.0	(5.3–6.7)	2.1	(1.7–2.5)	4.1	(3.7–4.5)	3.6	(3.1–4.2)	1.5	(1.2–1.8)	2.6	(2.3–2.9)
9–12	13.5	(12.5–14.5)	5.9	(5.1–6.7)	9.7	(9.1–10.4)	8.8	(8.0–9.6)	3.6	(3.0–4.3)	6.2	(5.7–6.7)
13–17	13.8	(12.9–14.8)	5.4	(4.9–6.0)	9.7	(9.2–10.3)	6.7	(6.1–7.4)	2.4	(2.0–2.8)	4.6	(4.2–5.0)
Highest education in family												
Less than high school	9.5	(7.5–11.8)	3.3	(2.3–4.8)	6.5	(5.3–7.9)	4.6	(3.3–6.4)	2.0	(1.2–3.4)	3.4	(2.6–4.4)
High school graduate	12.9	(11.8–14.1)	4.2	(3.6–5.0)	8.6	(7.9–9.3)	6.8	(6.1–7.7)	2.3	(1.9–2.9)	4.6	(4.1–5.1)
More than high school	10.4	(9.8–11.0)	4.6	(4.2–5.1)	7.6	(7.2–8.0)	6.1	(5.7–6.6)	2.5	(2.2–2.8)	4.4	(4.1–4.6)
Race												
White	12.0	(11.4–12.6)	5.0	(4.6–5.4)	8.6	(8.2–9.0)	7.1	(6.6–7.6)	2.8	(2.5–3.2)	5.0	(4.7–5.3)
Black	12.0	(10.4–13.8)	3.6	(2.7–4.6)	7.7	(6.8–8.7)	6.0	(4.9–7.4)	1.5	(1.1–2.1)	3.7	(3.1–4.5)
Multiracial	13.5	(10.1–17.9)	5.8	(4.1–8.2)	9.7	(7.7–12.2)	6.5	(4.8–8.7)	3.0	(1.7–5.3)	4.8	(3.6–6.2)
Other	6.6	(4.6–9.2)	2.3	(1.0–5.0)	4.5	(3.3–6.2)	3.0	(1.9–4.7)	1.3	(0.4–4.6)	2.2	(1.4–3.6)
Ethnicity												
Hispanic	4.8	(3.9–5.9)	2.5	(1.8–3.4)	3.7	(3.1–4.4)	2.1	(1.6–2.7)	1.0	(0.6–1.7)	1.6	(1.3–2.0)
Non-Hispanic	12.2	(11.6–12.8)	4.8	(4.4–5.2)	8.6	(8.2–8.9)	7.0	(6.6–7.5)	2.7	(2.4–3.0)	4.9	(4.6–5.2)
Primary language in home												
English	12.3	(11.7–12.8)	4.9	(4.5–5.3)	8.6	(8.3–9.0)	7.0	(6.6–7.4)	2.7	(2.4–3.0)	4.9	(4.6–5.2)
Other	1.6	(1.1–2.2)	0.9	(0.5–1.8)	1.3	(0.9–1.7)	0.5	(0.3–0.8)	—**	—	0.3	(0.2–0.5)
Poverty^{††}												
<100%	14.8	(13.1–16.8)	4.2	(3.4–5.1)	9.6	(8.6–10.7)	7.4	(6.2–8.8)	2.1	(1.6–2.8)	4.8	(4.1–5.6)
100%–199%	11.2	(10.0–12.5)	4.7	(4.0–5.6)	8.0	(7.3–8.8)	6.6	(5.6–7.6)	2.8	(2.2–3.5)	4.7	(4.1–5.3)
$\geq 200\%$	10.2	(9.7–10.8)	4.5	(4.0–5.0)	7.4	(7.1–7.8)	6.1	(5.7–6.6)	2.5	(2.1–2.9)	4.3	(4.1–4.6)
Any health-care coverage												
Yes	11.4	(10.9–12.0)	4.5	(4.2–4.9)	8.1	(7.7–8.4)	6.7	(6.3–7.1)	2.5	(2.3–2.8)	4.6	(4.4–4.9)
No	6.5	(5.1–8.2)	3.2	(2.3–4.4)	4.9	(4.0–5.9)	1.7	(1.3–2.4)	1.3	(0.7–2.1)	1.5	(1.1–2.0)

* Attention-deficit/hyperactivity disorder.

† Estimates do not include children aged 2–3 years with reported ADHD diagnosis (n = 32) because small sample size yields substantial (>30%) relative standard errors.

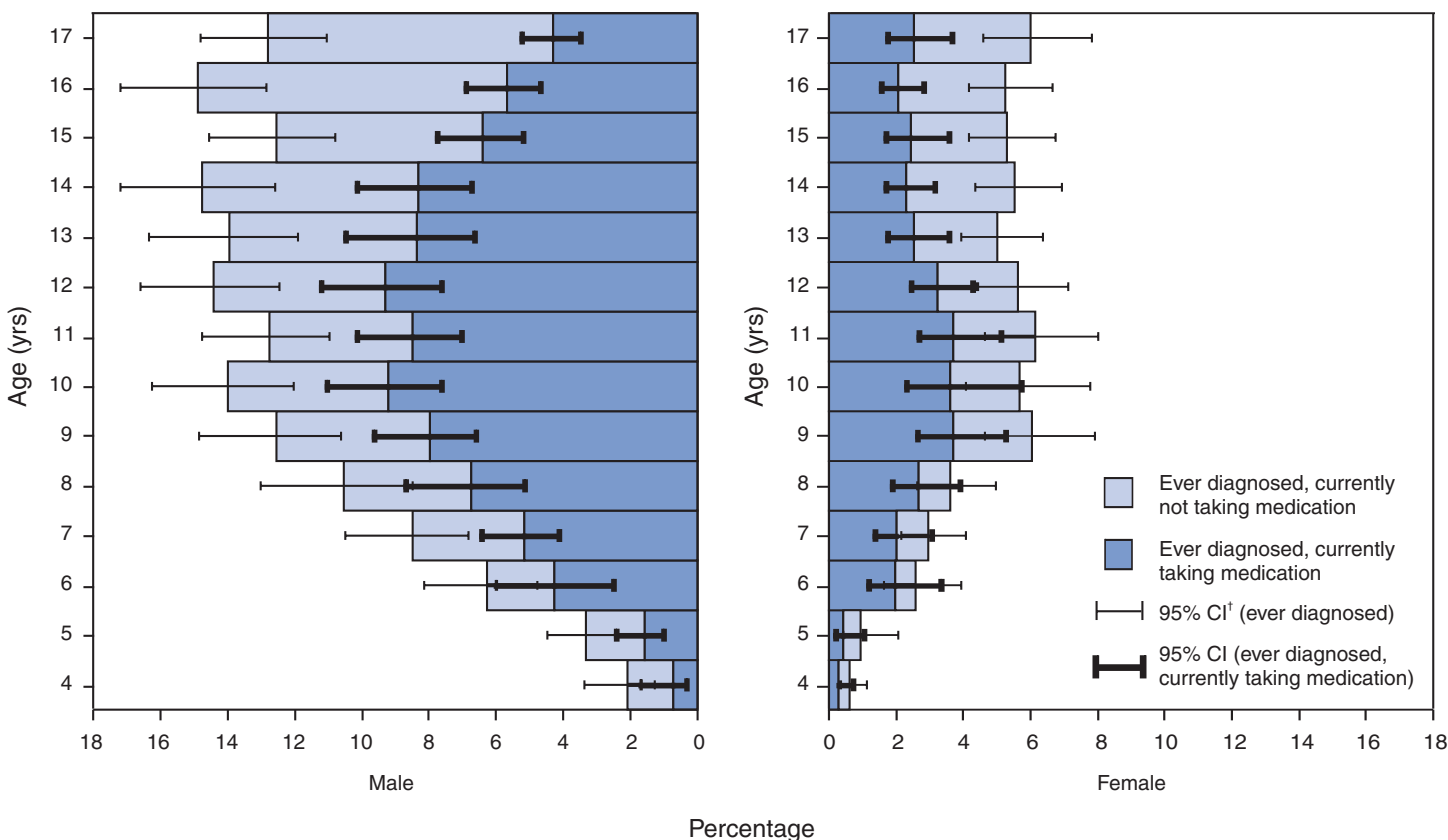
§ Confidence interval.

¶ Sociodemographic estimates included data from 46,104 males and 43,680 females aged 4–17 years for a total of 89,784.

** Relative standard error >30%.

†† Federal poverty level.

FIGURE 1. Percentage of children aged 4–17 years ever diagnosed with ADHD,* by age, sex, and medication treatment status — United States, 2003



* Attention-deficit/hyperactivity disorder.
† Confidence interval.

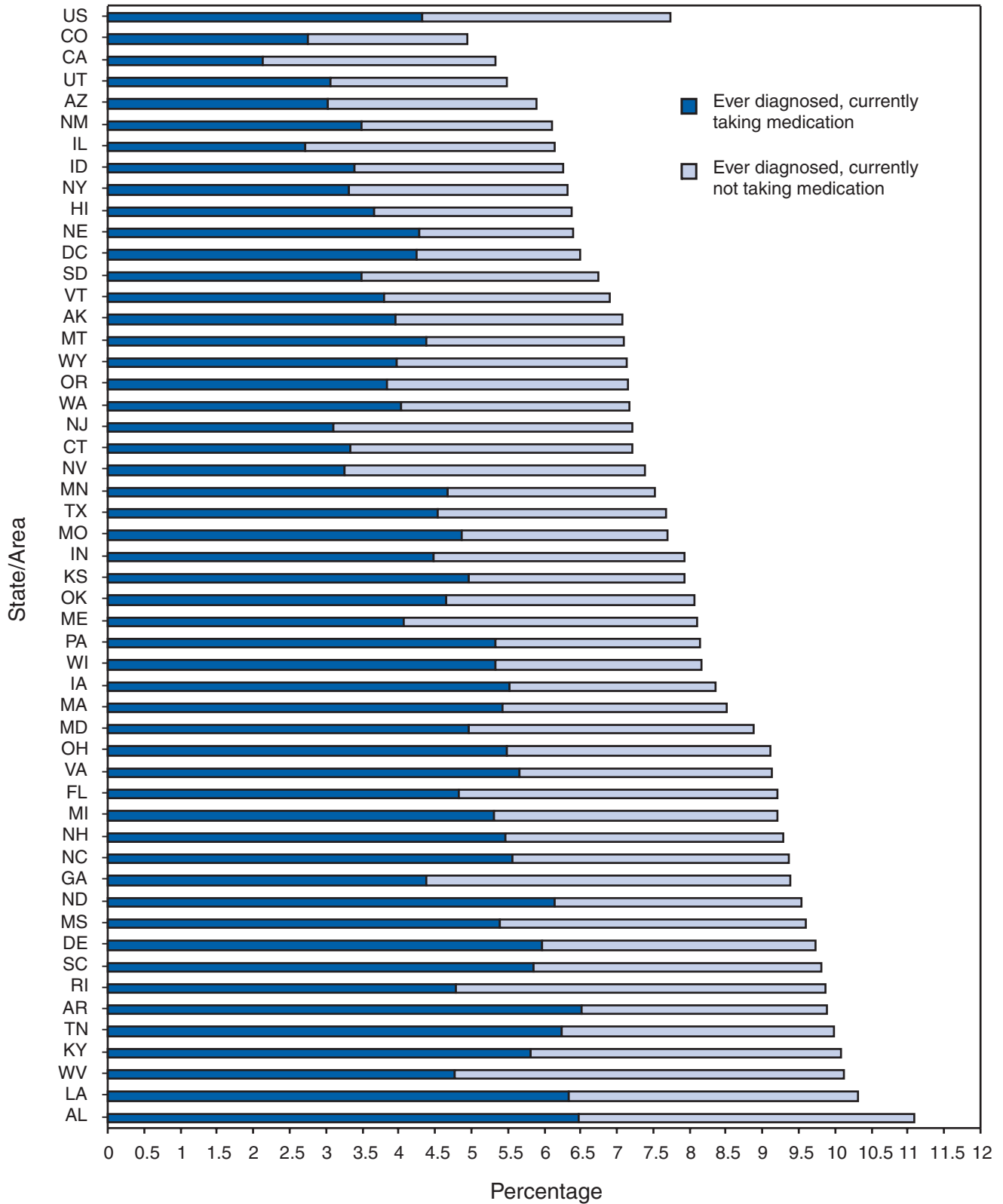
(Table). The greatest prevalence was noted among males aged 16 years (14.9%) and females aged 11 years (6.1%). The prevalence of reported ADHD diagnosis was significantly higher among non-Hispanic, primarily English-speaking, and insured children. Moreover, prevalence rates were significantly higher for children in families in which the most highly educated adult was a high school graduate (or had completed 12 years of education), compared with children in families in which the most highly educated adult had a higher or lower level of education. ADHD diagnosis among males was reported significantly more often in families with incomes below the poverty threshold (<100%) than in families with incomes at or above the poverty threshold. Rates of reported diagnosis among females were not significantly different across the three levels of poverty. Prevalence varied substantially by state, from a low of 5.0% in Colorado to a high of 11.1% in Alabama (Figure 2).

In 2003, an estimated 4.3% (2,473,000; 95% CI = 2,338,000–2,607,000) of children aged 4–17 years were reported to have ever had an ADHD diagnosis and were taking medication for the disorder. Rates of medication treatment for ADHD varied by age and sex and ranged from 0.3% to 9.3% (Figure 1). Regardless of sex, the overall medication-

by-age patterns were curvilinear, with prevalence of medication treatment for ADHD highest among children aged 9–12 years, compared with younger or older children (Table). Rates of medication treatment for ADHD followed the same pattern noted for ADHD diagnosis, such that males of all ages were more likely to have a reported history of ADHD diagnosis and to currently take medication for the disorder (Table). More males aged 6 years were taking medication for ADHD (4.3%) than females at any age (Figure 1). The highest rates of medication treatment for ADHD by sex and age were reported among males aged 12 years (9.3%) and among females aged 11 years (3.7%). Medication treatment rates were significantly higher among non-Hispanic, primarily English-speaking, and insured children. Geographic variability in prevalence of medication treatment ranged from a low of 2.1% in California to a high of 6.5% in Arkansas (Figure 2).

Nationally, 56.3% of children with reported ADHD diagnoses were being treated with medication at the time of the survey. The frequency of medication treatment among males and females with reported ADHD diagnoses was not significantly different (56.8% versus 55.0%, respectively). Rates of medication treatment among those with a reported diagnosis

FIGURE 2. Percentage of children aged 4–17 years ever diagnosed with ADHD,* by medication treatment status and state/area — United States, 2003



* Attention-deficit/hyperactivity disorder.

varied by state, ranging from 40.6% in California to 68.5% in Nebraska (median: [57.6%]).

Reported by: SN Visser, MS, CA Lesesne, PhD, Div of Human Development and Disability, National Center on Birth Defects and Developmental Disabilities, CDC.

Editorial Note: This report provides the most recent national and state-specific estimates of the prevalence of children aged 4–17 years ever diagnosed with ADHD. The findings indicate considerable variability in ADHD diagnosis by state of residence and certain sociodemographic characteristics. Certain state variation in ADHD diagnosis might be attributed to underlying state differences in diagnostic practice, sociodemographic characteristics, or both.

This report is also the first to document national and state-specific prevalence of medication treatment for ADHD using national survey data. Although ADHD is considered a chronic condition, to what extent the “ever” diagnosed rate reflects current levels of clinical symptomatology is unclear. However, because children with ADHD often are not treated with medication, current medication treatment prevalence can serve as a minimum estimate of overall ADHD prevalence.

Several factors affect determination of the most appropriate ADHD therapy for children; however, clinical treatment guidelines exist that recommend efficacious pharmacologic and behavioral interventions (7–8). NSCH does not assess use of ADHD treatments other than medication. Thus, the number of children with reported ADHD diagnoses who received other types of treatments is not known. Children in racial/ethnic minority populations and uninsured children were less likely than others to be taking medication for ADHD. Additional research is warranted to investigate differential patterns in diagnosis and treatment of ADHD across demographic and geographic strata.

The findings in this report are subject to at least four limitations. First, because the data are based on parental reports of ADHD diagnosis and medication treatment, the accuracy of these reports are subject to recall bias, telephone survey selection biases, and other types of response errors. Second, the survey sampling design excluded institutionalized persons, who might have higher rates of ADHD and medication treatment. Third, the survey was only administered in English or Spanish and therefore excluded families speaking neither language. Finally, these data do not include undiagnosed ADHD or children without an ADHD diagnosis who are taking medication for similar symptoms.

This analysis was limited to two relevant NSCH questions pertaining to ADHD and cannot fully characterize current ADHD treatment patterns. No known national survey currently assesses ADHD-related impairment or the nature and extent of treatment for ADHD. Such data are necessary

to characterize community care and might inform future public health action.

ADHD poses substantial costs both to families and society. The disorder has been associated with strained familial and peer relationships, suboptimal educational achievement, and increased risk for unintentional injuries (1,7,8). Health-care costs associated with ADHD are conservatively estimated at \$3.3 billion annually (9). Moreover, persistent and negative side effects of stimulants have been documented, including sleep disturbances, reduced appetite, and suppressed growth, which might have important health implications for the millions of children who are currently taking medication for ADHD. Continued monitoring and community-based research activities that focus on sociodemographic and geographic variation in ADHD diagnosis and treatment are needed (10).

Acknowledgments

This report is based, in part, on contributions from Maternal Child Health Bur, Health Resources and Svcs Admin, US Dept of Health and Human Svcs. C Kennedy, MPH, R Perou, PhD, Div of Human Development and Disability, National Center on Birth Defects and Developmental Disabilities, CDC.

References

- Rowland AS, Lesesne CA, Abramowitz AJ. The epidemiology of attention-deficit/hyperactivity disorder (ADHD): a public health view. *Mental Retardation Developmental Disability Research Review* 2002;8:162–70.
- Jensen PS, Arnold LE, Richters JE, et al. A 14-month randomized clinical trial of treatment strategies for children with attention-deficit/hyperactivity disorder. *Arch Gen Psychiatry* 1999;56:1073–86.
- Cox ER, Mothel BR, Henderson RR, Mager D. Geographic variation in the prevalence of stimulant medication use among children 5–14 years old: results from a commercially insured US sample. *Pediatrics* 2003;111:237–43.
- Safer DJ, Malever M. Stimulant treatment in Maryland public schools. *Pediatrics* 2000;106:533–9.
- Rowland AS, Umbach DM, Stallone L, Naftel AJ, Bohlig EM, Sandler DP. Prevalence of medication treatment for attention-deficit/hyperactivity disorder among elementary school children in Johnston County, North Carolina. *Am J Public Health* 2002;92:231–4.
- Blumberg SJ, Olson L, Frankel MR, Osborn L, Srinath KP, Giambo P. Design and operation of the National Survey of Children's Health, 2003. *Vital Health Stat* 2005;1(43).
- American Academy of Child and Adolescent Psychiatry. Practice parameters for the assessment and treatment of children, adolescents, and adults with attention-deficit/hyperactivity disorder. *J Am Acad Child Adolesc Psychiatry* 1997;36(10 Suppl).
- American Academy of Pediatrics, Committee on Quality Improvement, Subcommittee on Attention-Deficit/Hyperactivity Disorder. Clinical practice guideline: treatment of the school-aged child with attention-deficit/hyperactivity disorder. *Pediatrics* 2001;105:1158–70.
- Birnbaum HG, Kessler RC, Lowe SW, et al. Costs of attention deficit-hyperactivity disorder (ADHD) in the US: excess costs of persons with ADHD and their family members in 2000. *Curr Med Res Opin* 2005;21:195–205.
- Lesesne C, Abramowitz A, Perou R, Brann E. Attention deficit/hyperactivity disorder: a public health research agenda. Atlanta, GA: US Department of Health and Human Services, CDC; 2000. Available at <http://www.cdc.gov/ncbddd/adhd/dadphra.htm>.

Children and Teens Told by Doctors That They Were Overweight — United States, 1999–2002

The percentage of children and teens aged 6–19 years in the United States who are overweight nearly tripled to 16% during 1980–2002 (1). Overweight and obese children and teens are at greater risk for many comorbid conditions, both immediate and long-term (2). Their risk is approximately 10 times greater than that of normal weight children for hypertension in young adulthood, three to eight times greater for dyslipidemias, and more than twice as great for diabetes mellitus (2). To determine what percentage of overweight children (or their parents) and teens were ever told their weight status by doctors or other health-care professionals, CDC analyzed data from the 1999–2002 National Health and Nutrition Examination Survey (NHANES). This report summarizes the results of that analysis, which determined that 36.7% of overweight children and teens aged 2–19 years had been told by a doctor or other health-care professional that they were overweight, and teens aged 16–19 years were more likely to be told than parents of children aged 2–11 years. By discussing weight status with overweight patients and their parents, pediatric health-care providers might help these patients implement lifelong improvements in diet and physical activity.

NHANES is an ongoing series of cross-sectional surveys on health and nutrition designed to be nationally representative of the noninstitutionalized, U.S. civilian population by using a complex, multistage probability design.* During 1999–2002, populations of persons aged 12–19 years, non-Hispanic blacks, and Mexican Americans were among those oversampled. The analyses described in this report include data from 1,473 children and teens aged 2–19 years who were determined to be overweight. This sample represented the approximately 10.3% of U.S. children aged 2–5 years and 16.0% of children and teens aged 6–19 years who were overweight. Overweight was defined as having a body mass index (BMI) (calculated as weight in kilograms divided by height in meters squared) ≥ 95 th percentile on the BMI-for-age, sex-specific 2000 CDC growth charts for the United States.†

Parents of overweight children aged 2–11 years were asked, “Has a doctor or health professional ever told you that [child] was overweight?” Parents of those aged 12–15 years were asked, “Has a doctor or health professional ever told [child] that he/she was overweight?” Teens aged 16–19 years were asked, “Has a doctor or health professional ever told you that you were overweight?”

Results were stratified by sex and age and by sex and race/ethnicity. Pregnant females were excluded from analysis. Weighted prevalence estimates were calculated. A chi-square test for trend was performed to evaluate the effect of age. Individual *t*-tests were performed to test differences between racial/ethnic populations. The cutoff for statistical significance was $p = 0.05$. Bonferroni adjustments were used to account for multiple comparisons between racial/ethnic populations.

Among all overweight children and teens aged 2–19 years (or their parents), 36.7% reported having ever been told by a doctor or health-care professional that they were overweight (Table). A significant increasing trend ($p < 0.05$) by age group was observed in the percentage of the overall sample told that they were overweight (17.4% for ages 2–5 years, 32.6% for ages 6–11 years, 39.6% for ages 12–15 years, and 51.6% for ages 16–19 years). Similar trends by age group were observed among males and females. Among racial/ethnic populations, overweight non-Hispanic black females were significantly more likely to be told that they were overweight than non-Hispanic white females (47.4% versus 31.0%). Among those informed of overweight status, 39% of non-Hispanic black females were severely overweight (BMI ≥ 99 th percentile for age and sex), compared with 17% of non-Hispanic white females.

Reported by: CL Ogden, PhD, National Center for Health Statistics; CJ Tabak, MD, EIS Officer, CDC.

Editorial Note: Annual well-child visits to health-care professionals should include measurement of BMI to determine weight status, as recommended by the American Academy of Pediatrics (3). Without intervention, many overweight children will grow up to be overweight or obese adults (4,5). The following four behavioral strategies are recommended for families with overweight children: controlling the environment, monitoring behavior, setting goals, and rewarding successful changes in behavior (6). Families with overweight children might be more motivated to make these changes if they are recommended by a doctor or health-care professional.

In a study of adults who had visited their physicians for routine checkups during the preceding 12 months, fewer than half of those classified as obese (i.e., BMI > 30 kg/m²) reported being advised by their health-care professionals to lose weight (7). A study of 473 children in Kentucky determined that overweight condition had been diagnosed in only 29% of 93 overweight children (i.e., BMI ≥ 95 th percentile); however, that study did not report whether the diagnoses were shared with children and parents (8).

In the study described in this report, significant differences in being informed of overweight status were observed by age group and race/ethnicity. For example, 51.6% of teens aged 16–19 years were informed of their overweight status, but

* Available at <http://www.cdc.gov/nchs/nhanes.htm>.

† Available at <http://www.cdc.gov/growthcharts>

TABLE. Number and percentage of overweight* children and teens aged 2–19 years ever told by a doctor or health professional that they were overweight, by age group and race/ethnicity — National Health and Nutrition Examination Survey, United States, 1999–2002

Age group (yrs) [§]	No. in sample	Total		Males		Females		
		%	(95% CI) [†]	%	(95% CI)	%	(95% CI)	
2–5	161	17.4	(10.8–26.9)	17.0	(9.0–29.8)	17.8	(8.7–32.9)	
6–11	411	32.6	(24.9–41.3)	33.8	(25.8–42.9)	31.1	(21.1–43.2)	
12–15	511	39.6	(31.9–47.8)	36.0	(26.2–47.2)	43.2	(33.1–54.0)	
16–19	390	51.6	(41.7–61.3)	50.7	(37.1–64.1)	52.8	(42.1–63.2)	
Race/Ethnicity								
White, non-Hispanic	280	34.7	(28.0–42.0)	37.9	(28.8–47.9)	31.0	(23.4–39.7)	
Black, non-Hispanic	456	43.4	(38.1–48.8)	38.4	(30.1–47.4)	47.4	(40.8–54.2) [¶]	
Mexican American	608	37.3	(31.5–43.4)	37.2	(30.6–44.3)	37.3	(29.3–46.1)	
Total**	1,473	36.7	(31.9–41.9)	36.5	(30.0–43.4)	37.1	(31.8–42.6)	

* Defined as having a body mass index (BMI) (calculated as weight in kilograms divided by height in meters squared) \geq 95th percentile on the BMI-for-age, sex-specific 2000 CDC growth charts for the United States.

[†] Confidence interval.

[§] Statistically significant ($p < 0.05$) by increasing age group, by chi-square test for trend.

[¶] Statistically significant ($p < 0.05$) difference from non-Hispanic whites, with Bonferroni adjustment.

** Includes persons of all races and ethnicities (including all Hispanic origins), not just non-Hispanic whites, non-Hispanic blacks, and Mexican Americans.

only 17.4% of parents of children aged 2–5 years were informed, possibly suggesting reluctance by health-care providers to inform parents of the weight status of very young overweight children. In addition, non-Hispanic black females were more likely to be told that they were overweight than were non-Hispanic white females. However, 39% of non-Hispanic black females informed of overweight status were severely overweight, compared with 17% of non-Hispanic white females. Health-care providers might have been more likely to discuss weight status with patients who were severely overweight.

The findings in this report are subject to at least three limitations. First, NHANES data are cross-sectional and therefore cannot capture information about duration of overweight in these children and teens; a longer duration of overweight might have made a provider more likely to inform a child or parent of the child's overweight status. Second, teens might have had more visits to a health-care professional than young children and therefore more opportunities to be told of their overweight status; however, multiple logistic regression controlling for number of health-care visits during the preceding year produced similar results. Third, the question regarding being told of overweight status was asked of parents for children and teens ages 2–15 years and of teens themselves for those aged 16–19 years. Overweight teens might answer this question differently than parents of overweight children, resulting in either a lesser or greater difference among age groups in reports of being told of overweight status.

Among overweight children who become obese adults, earlier onset of childhood overweight is associated with higher BMI in adulthood (9). Previous findings suggest that children begin to respond to environmental cues regarding

dietary patterns by age 5 years (10). Thus, early recognition and discussion of overweight status is a necessary first step to developing healthier lifelong behaviors. Addressing overweight among children and teens requires recognition by health-care providers, discussion of potential consequences with families, acknowledgment of those consequences by families of affected children, and a commitment to work together toward attaining a healthier lifestyle (6).

References

1. CDC. Prevalence of overweight among children and adolescents: United States, 1999–2002. National Health and Nutrition Examination Survey. Hyattsville, MD: US Department of Health and Human Services, CDC, National Center for Health Statistics. Available at <http://www.cdc.gov/nchs/products/pubs/pubd/hestats/overwght99.htm>.
2. Must A, Strauss RS. Risks and consequences of childhood and adolescent obesity. *Int J Obes Relat Metab Disord* 1999;23(Suppl 2):S2–S11.
3. Krebs NF, Jacobson MS; American Academy of Pediatrics Committee on Nutrition. Prevention of pediatric overweight and obesity. *Pediatrics* 2003;112:424–30.
4. Serdula MK, Ivery D, Coates RJ, Freedman DS, Williamson DF, Byers T. Do obese children become obese adults? A review of the literature. *Prev Med* 1993;22:167–77.
5. Guo SS, Wu W, Chumlea WC, Roche AF. Predicting overweight and obesity in adulthood from body mass index values in childhood and adolescence. *Am J Clin Nutr* 2002;76:653–8.
6. Dietz WH, Robinson TN. Overweight children and adolescents. *N Engl J Med* 2005;352:2100–9.
7. Galuska DA, Will JC, Serdula MK, Ford ES. Are health care professionals advising obese patients to lose weight? *JAMA* 1999;282:1576–8.
8. Louthan MV, Lafferty-Oza MJ, Smith ER, Hornung CA, Franco S, Theriot JA. Diagnosis and treatment frequency for overweight children and adolescents at well child visits. *Clinical Pediatr (Phila)* 2005;44:57–61.
9. Freedman DS, Khan LK, Dietz WH, Srinivasan SR, Berenson GS. Relationship of childhood obesity to coronary heart disease risk factors in adulthood: the Bogalusa Heart Study. *Pediatrics* 2001;108:712–8.
10. Rolls BJ, Engell D, Birch LL. Serving portion size influences 5-year-old but not 3-year-old children's food intakes. *J Am Diet Assoc* 2000;100:232–4.

Update: Influenza Vaccine Supply and Recommendations for Prioritization During the 2005–06 Influenza Season

Influenza vaccine distribution delays or vaccine supply shortages have occurred in the United States in three of the last five influenza seasons (1,2). In response, prioritization has been implemented in previous years to ensure that enough vaccine is available for those at the highest risk for complications from influenza (3). The information in this report updates projections of influenza vaccine supply and previous recommendations for priority use of trivalent inactivated influenza vaccine (TIV) during the 2005–06 influenza season (4).

Four manufacturers now expect to provide influenza vaccine to the U.S. population during the 2005–06 influenza season (Table). Sanofi Pasteur, Inc., projects production of 60 million doses of TIV. Chiron Corporation projects production of 18–26 million doses of TIV. GlaxoSmithKline (GSK), Inc., whose license application was approved by the Food and Drug Administration on August 31, 2005, projects production of 8 million doses of TIV. MedImmune Vaccines, Inc., producer of live attenuated influenza vaccine (LAIV), projects production of approximately 3 million doses. However, because of the uncertainties regarding production of influenza vaccine, the exact number of available doses and timing of vaccine distribution for the 2005–06 influenza season remain unknown.

Given the uncertainties in doses and distribution, CDC recommends that the following priority groups receive TIV until October 24, 2005:

- persons aged ≥ 65 years with comorbid conditions
- residents of long-term-care facilities
- persons aged 2–64 years with comorbid conditions
- persons aged ≥ 65 years without comorbid conditions
- children aged 6–23 months
- pregnant women
- health-care personnel who provide direct patient care
- household contacts and out-of-home caregivers of children aged < 6 months

These groups correspond to tiers 1A–1C in the table of TIV priority groups that was published previously in the event of vaccination supply disruption (4). Beginning October 24, 2005, all persons will be eligible for vaccination.

The tiered use of prioritization is not recommended for LAIV administration. LAIV may be administered at any time for vaccination of nonpregnant healthy persons aged 5–49 years, including most health-care personnel, other persons in close contact with groups at high risk for influenza-related complications, and others desiring protection against influenza (5). Additional information is available at <http://www.cdc.gov/flu>.

References

1. CDC. Updated recommendations from the Advisory Committee on Immunization Practices in response to delays in supply of influenza vaccine for the 2000–01 season. *MMWR* 2000;49:888–92.
2. CDC. Delayed influenza vaccine availability for 2001–02 season and supplemental recommendations of the Advisory Committee on Immunization Practices. *MMWR* 2001;50:582–5.
3. CDC. Interim influenza vaccination recommendations, 2004–05 influenza season. *MMWR* 2004;53:923–4.
4. CDC. Tiered use of inactivated influenza vaccine in the event of a vaccine shortage. *MMWR* 2005;54:749–50.
5. CDC. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR* 2005;54(No. RR-8).

TABLE. Influenza vaccine manufacturers and projected supplies for the 2005–06 influenza season

Manufacturer	Vaccine	Formulation	Contains thimerosal preservative	Age indication	No. of projected doses
Sanofi Pasteur, Inc.	Fluzone® trivalent inactivated influenza vaccine (TIV)	Multidose vial	Yes	≥ 6 mos	60 million*
		Single-dose prefilled 0.5 mL syringe or vial	No	≥ 36 mos	
		Single-dose prefilled 0.25 mL syringe	No	6–35 mos	
Chiron Corporation	Fluvirin™ TIV	Multidose vial	Yes	≥ 4 yrs	18–26 million†
		Single-dose prefilled 0.5 mL syringe	No§	≥ 4 yrs	
GlaxoSmithKline, Inc.	Fluarix™ TIV	Single-dose prefilled 0.5 mL syringe	No§	≥ 18 yrs	8 million
MedImmune Vaccines, Inc.	FluMist™ live, attenuated influenza vaccine (LAIV)	Single-dose nasal sprayer	No	Healthy, nonpregnant persons aged 5–49 yrs	3 million

* Approximately 6–8 million of the 60 million doses are projected to be distributed in single-dose prefilled syringes or vials.

† Chiron projects that the majority of its vaccine doses will be distributed by the end of October 2005; the exact timing of distribution was uncertain as of August 30, 2005. A minimal number of doses of Chiron thimerosal-free formulation might be available in late season.

§ These preparations contain traces of thimerosal from the production process.

Update: West Nile Virus Activity — United States, 2005

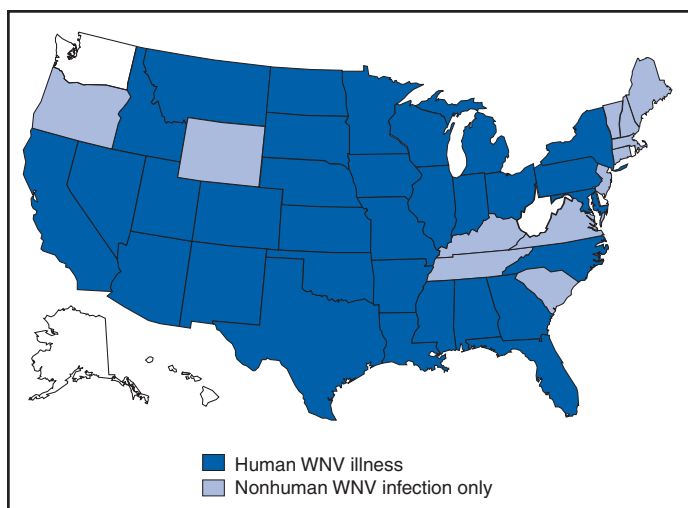
This report summarizes West Nile virus (WNV) surveillance data reported to CDC through ArboNET as of 3 a.m. Mountain Daylight Time, August 30, 2005.

Thirty-one states have reported 689 cases of human WNV illness (Figure and Table 1) in 2005. By comparison, in 2004, a total of 1,053 WNV cases had been reported, as of August 31, 2004 (Table 2). A total of 367 (57%) of the 640 cases for which such data were available occurred in males; the median age of patients was 50 years (range: 3 months—92 years). Date of illness onset ranged from January 2 through August 24; a total of 16 cases were fatal.

A total of 145 presumptive West Nile viremic blood donors (PVDs) have been reported to ArboNET during 2005. Of these, 49 were reported from California; 30 from Texas; 22 from Nebraska; 12 from South Dakota; 10 from Louisiana; four from Arizona; two each from Alabama, Colorado, Iowa, Minnesota, Mississippi, and New Mexico; and one each from Illinois, Michigan, North Carolina, North Dakota, Pennsylvania, and Utah. Of the 145 PVDs, two persons aged 53 and 56 years subsequently had neuroinvasive illness, and 35 persons (median age: 46 years [range: 17–77 years]) subsequently had West Nile fever.

In addition, 2,290 dead corvids and 483 other dead birds with WNV infection have been reported from 37 states. WNV infections have been reported in horses from 27 states, three dogs from Minnesota and Nebraska, four squirrels from Arizona, and three unidentified animal species in three states (Arizona, Illinois, and South Dakota). WNV seroconversions have been reported in 540 sentinel chicken flocks from

FIGURE. Areas reporting West Nile virus (WNV) activity — United States, 2005*



* As of August 30, 2005.

TABLE 1. Number of human cases of West Nile virus (WNV) illness reported, by state — United States, 2005*

State	Neuroinvasive disease [†]	West Nile fever [§]	Other clinical/ unspecified [¶]	Total**	Deaths
Alabama	2	0	0	2	0
Arizona	7	9	3	19	0
Arkansas	0	5	0	5	0
California	93	155	20	268	7
Colorado	2	19	0	21	0
Florida	4	5	1	10	0
Georgia	0	1	1	2	0
Idaho	0	1	0	1	0
Illinois	29	16	1	46	0
Indiana	1	0	0	1	0
Iowa	1	1	0	2	0
Kansas	1	2	0	3	0
Louisiana	40	12	0	52	4
Maryland	1	0	0	1	0
Michigan	2	1	1	4	0
Minnesota	5	8	0	13	1
Mississippi	5	5	0	10	1
Missouri	1	2	2	5	1
Montana	1	1	0	2	0
Nebraska	11	18	0	29	0
Nevada	3	2	0	5	0
New Mexico	6	3	0	9	0
North Carolina	1	1	0	2	0
North Dakota	2	14	0	16	0
Ohio	9	2	0	11	0
Oklahoma	1	0	0	1	0
Pennsylvania	3	4	0	7	0
South Dakota	19	90	1	110	1
Texas	21	2	0	23	1
Utah	3	4	0	7	0
Wisconsin	1	1	0	2	0
Total	275	384	30	689	16

* As of August 30, 2005.

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

[§] Cases with no evidence of neuroinvasion.

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

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

TABLE 2. Comparison of human cases and deaths from West Nile virus — United States, 2002–2005

Year	Human cases	Deaths
2002*	480	24
2003 [†]	1,442	21
2004 [§]	1,053	28
2005 [¶]	689	16

* As of August 28, 2002.

[†] As of August 27, 2003.

[§] As of August 31, 2004.

[¶] As of August 30, 2005.

12 states. One seropositive sentinel horse was reported from Minnesota. A total of 6,290 WNV-positive mosquito pools have been reported from 35 states (Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland,

Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Wisconsin).

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

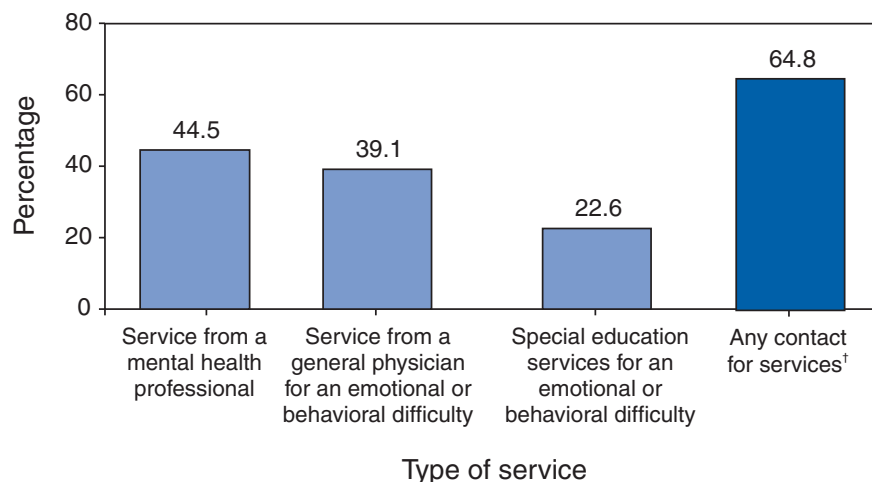
Erratum: Vol. 54, No. 32

In the report, “Atypical Reactions Associated With Heroin Use — Five States, January–April 2005,” an error occurred in the Figure. Among the 26 suspected, probable, or confirmed cases of heroin-related clenbuterol poisoning, the case with a date of exposure of March 14, 2005, occurred in New York, not in North Carolina.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Children Aged 4–17 Years with Emotional or Behavioral Difficulties* Who Used Mental Health Services, by Type of Service — United States, 2003



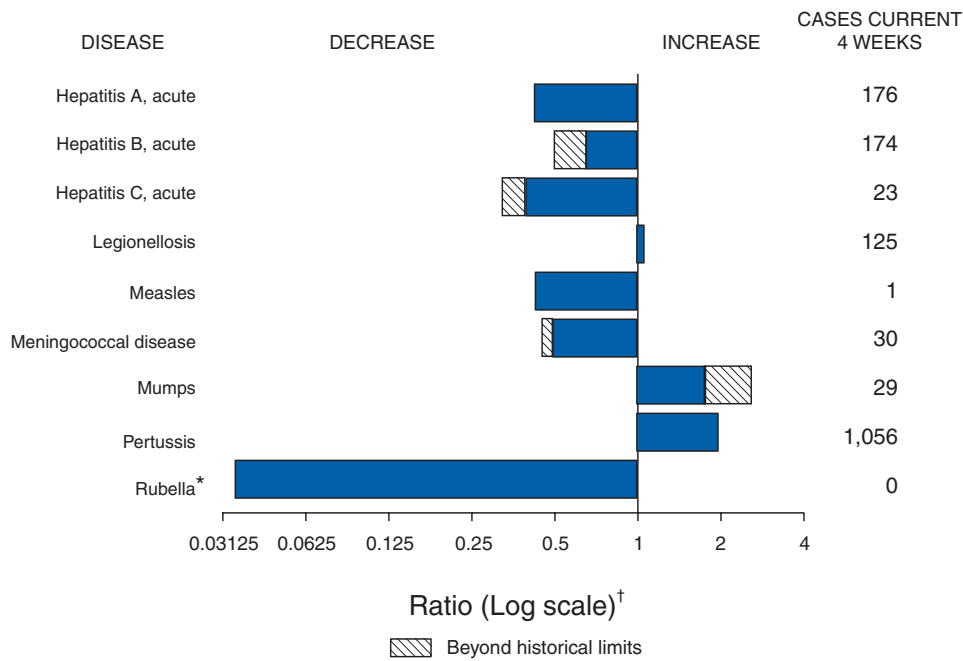
* Includes children whose parents reported that they had “definite or severe difficulties,” based on response to the question, “Overall, do you think that [child] has a difficulty with emotions, concentration, behavior, or being able to get along with others?”

† Includes contact or visit with a mental health professional (i.e., psychiatrist, psychologist, clinical social worker, or psychiatric nurse) during the preceding 12 months, visit with a general physician (i.e., a physician in general practice, pediatrics, family medicine, or internal medicine) for an emotional or behavioral difficulty during the preceding 12 months, or receipt of special education services for an emotional or behavioral difficulty. A child might have received more than one type of service.

In 2003, among the 2.7 million U.S. children aged 4–17 years for whom parents reported definite or severe emotional or behavioral difficulties (5% of all children in that age group), nearly two thirds had had contact with a mental health professional or general physician or had used special education services for those difficulties.

SOURCE: Simpson GA, Bloom B, Cohen RA, Blumberg S, Bourdon KH. U.S. children with emotional and behavioral difficulties: data from the 2001, 2002, and 2003 National Health Interview Surveys. Advance data from vital and health statistics; no. 360. Hyattsville, MD: US Department of Health and Human Services, CDC, National Center for Health Statistics; 2005. Available at <http://www.cdc.gov/nchs/data/ad/ad360.pdf>.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals August 27, 2005, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 34 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 August 27, 2005 (34th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal [†]	96	108
Botulism:			HIV infection, pediatric [¶]	181	271
foodborne	8	6	Influenza-associated pediatric mortality ^{†**}	43	—
infant	49	50	Measles	56 ^{††}	25 ^{§§}
other (wound & unspecified)	18	8	Mumps	183	136
Brucellosis	68	62	Plague	3	1
Chancroid	17	18	Poliomyelitis, paralytic	—	—
Cholera	2	4	Psittacosis [†]	14	8
Cyclosporiasis [†]	668	177	Q fever [†]	76	42
Diphtheria	—	—	Rabies, human	1	4
Domestic arboviral diseases			Rubella	8	9
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	1	—
California serogroup ^{†§}	9	71	SARS ^{†**}	—	—
eastern equine ^{†§}	7	2	Smallpox [†]	—	—
Powassan ^{†§}	—	1	<i>Staphylococcus aureus</i> :		
St. Louis ^{†§}	2	8	Vancomycin-intermediate (VISA) [†]	—	—
western equine ^{†§}	—	—	Vancomycin-resistant (VRSA) [†]	—	1
Ehrlichiosis:			Streptococcal toxic-shock syndrome [†]	91	102
human granulocytic (HGE) [†]	286	255	Tetanus	14	12
human monocytic (HME) [†]	214	188	Toxic-shock syndrome	65	59
human, other and unspecified [†]	36	46	Trichinellosis ^{¶¶}	12	1
Hansen disease [†]	52	66	Tularemia [†]	84	68
Hantavirus pulmonary syndrome [†]	16	17	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 June 26, 2005.
 ** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
 †† Of 56 cases reported, 46 were indigenous and 10 were imported from another country.
 §§ Of 25 cases reported, eight were indigenous and 17 were imported from another country.
 ¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending August 27, 2005, and August 28, 2004 (34th 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	20,405	25,815	583,867	599,290	2,952	3,705	2,200	2,118
NEW ENGLAND	778	849	20,947	19,609	—	—	106	116
Maine	11	20	1,412	1,298	N	N	12	16
N.H.	20	29	1,200	1,101	—	—	16	20
Vt.¶	4	13	637	749	—	—	20	18
Mass.	368	283	9,359	8,687	—	—	42	44
R.I.	68	82	2,133	2,230	—	—	3	4
Conn.	307	422	6,206	5,544	N	N	13	14
MID. ATLANTIC	4,352	5,775	72,927	73,856	—	—	666	300
Upstate N.Y.	800	723	14,654	14,667	N	N	495	65
N.Y. City	2,327	3,242	23,051	22,852	—	—	45	80
N.J.	574	977	11,413	11,690	N	N	12	31
Pa.	651	833	23,809	24,647	N	N	114	124
E.N. CENTRAL	1,938	2,176	88,832	106,316	5	9	399	674
Ohio	312	464	21,954	26,065	N	N	129	150
Ind.	236	264	12,922	11,896	N	N	30	52
Ill.	983	944	26,018	30,924	—	—	34	119
Mich.	322	383	15,797	25,211	5	9	52	105
Wis.	85	121	12,141	12,220	N	N	154	248
W.N. CENTRAL	463	502	36,264	36,465	6	5	344	252
Minn.	123	141	6,551	7,638	3	N	68	82
Iowa	50	37	4,410	4,446	N	N	61	50
Mo.	198	202	14,597	13,397	2	3	170	46
N. Dak.	5	15	778	1,184	N	N	—	9
S. Dak.	10	7	1,825	1,598	—	—	16	23
Nebr.¶	18	21	3,678	3,362	1	2	4	23
Kans.	59	79	4,425	4,840	N	N	25	19
S. ATLANTIC	6,473	7,926	114,975	112,058	1	—	314	329
Del.	100	105	2,151	1,859	N	N	—	—
Md.	812	986	12,236	12,483	1	—	21	13
D.C.	467	523	2,421	2,302	—	—	7	10
Va.¶	307	465	13,397	14,339	—	—	22	38
W. Va.	36	55	1,713	1,836	N	N	7	4
N.C.	531	416	21,763	18,654	N	N	37	52
S.C.¶	386	495	14,688	11,786	—	—	9	14
Ga.	1,103	1,015	18,836	21,089	—	—	60	112
Fla.	2,731	3,866	27,770	27,710	N	N	151	86
E.S. CENTRAL	1,093	1,321	42,356	38,740	—	4	61	91
Ky.	135	157	6,320	3,718	N	N	23	29
Tenn.¶	434	532	15,560	14,774	N	N	21	27
Ala.¶	295	305	7,235	8,904	—	—	15	15
Miss.	229	327	13,241	11,344	—	4	2	20
W.S. CENTRAL	2,206	3,150	69,565	75,110	1	2	57	68
Ark.	72	135	5,154	5,311	—	1	2	13
La.	436	638	12,572	15,335	1	1	3	2
Okla.	167	130	7,250	7,373	N	N	32	15
Tex.¶	1,531	2,247	44,589	47,091	N	N	20	38
MOUNTAIN	789	933	34,495	36,462	2,037	2,353	78	116
Mont.	4	4	1,166	1,596	N	N	12	31
Idaho¶	9	16	1,655	1,886	N	N	6	15
Wyo.	2	13	720	693	2	1	2	2
Colo.	163	162	8,862	8,985	N	N	26	39
N. Mex.	72	138	3,272	5,829	6	16	3	10
Ariz.	329	356	11,903	10,922	1,994	2,284	10	15
Utah	33	51	2,696	2,426	4	11	11	2
Nev.¶	177	193	4,221	4,125	31	41	8	2
PACIFIC	2,313	3,183	103,506	100,674	902	1,332	175	172
Wash.	229	215	12,234	11,513	N	N	28	14
Oreg.¶	136	216	5,429	5,229	—	—	36	25
Calif.	1,874	2,656	80,531	77,808	902	1,332	110	131
Alaska	14	29	2,603	2,479	—	—	—	—
Hawaii	60	67	2,709	3,645	—	—	1	2
Guam	1	1	—	749	—	—	—	—
P.R.	537	396	2,406	2,474	N	N	N	N
V.I.	10	6	119	245	—	—	—	—
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 June 26, 2005.

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending August 27, 2005, and August 28, 2004 (34th Week)*

Reporting area	<i>Escherichia coli</i> , Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped		Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004				
UNITED STATES	1,221	1,498	176	177	157	113	10,284	11,632	198,282	209,747
NEW ENGLAND	93	105	33	38	23	9	922	1,037	3,916	4,543
Maine	11	8	6	—	—	—	123	86	85	152
N.H.	11	14	2	5	—	—	38	26	108	79
Vt.	10	10	3	—	—	—	103	102	34	59
Mass.	35	47	6	13	23	9	383	488	1,708	2,037
R.I.	3	6	—	1	—	—	62	68	300	570
Conn.	23	20	16	19	—	—	213	267	1,681	1,646
MID. ATLANTIC	153	167	16	25	23	26	1,902	2,487	20,675	23,758
Upstate N.Y.	66	69	10	11	7	13	665	801	4,130	4,793
N.Y. City	7	33	—	—	—	—	498	713	6,040	7,335
N.J.	26	31	2	5	3	6	231	317	3,465	4,492
Pa.	54	34	4	9	13	7	508	656	7,040	7,138
E.N. CENTRAL	246	291	15	36	7	18	1,605	1,827	35,723	44,106
Ohio	70	62	2	7	3	10	454	508	10,363	13,367
Ind.	34	31	—	—	—	—	N	N	5,173	4,219
Ill.	45	63	1	5	1	6	316	528	10,755	13,330
Mich.	53	54	—	7	3	2	446	422	6,040	10,066
Wis.	44	81	12	17	—	—	389	369	3,392	3,124
W.N. CENTRAL	204	324	24	25	22	19	1,223	1,253	11,628	10,955
Minn.	49	76	7	10	11	3	560	437	1,855	1,901
Iowa	43	87	—	—	—	—	150	179	983	790
Mo.	61	53	11	12	4	6	281	348	6,028	5,689
N. Dak.	2	11	—	—	—	6	5	18	49	77
S. Dak.	12	26	3	—	—	—	59	40	246	170
Nebr.	13	49	3	3	4	—	56	90	857	690
Kans.	24	22	—	—	3	4	112	141	1,610	1,638
S. ATLANTIC	116	111	45	20	60	25	1,489	1,848	49,503	50,507
Del.	3	2	N	N	N	N	31	32	532	586
Md.	21	20	18	3	4	3	110	75	4,588	5,328
D.C.	—	1	—	—	—	—	32	44	1,345	1,678
Va.	19	23	16	9	12	—	323	309	4,819	5,810
W. Va.	1	2	—	—	1	—	28	24	465	585
N.C.	—	—	—	—	35	16	N	N	10,301	9,890
S.C.	4	9	—	—	—	—	66	73	6,432	5,745
Ga.	17	15	7	6	—	—	299	575	8,559	9,188
Fla.	51	39	4	2	8	6	600	716	12,462	11,697
E.S. CENTRAL	80	69	1	3	15	12	250	232	16,089	16,867
Ky.	23	17	—	1	12	7	N	N	2,072	1,623
Tenn.	33	29	1	—	3	5	129	131	5,560	5,437
Ala.	19	14	—	—	—	—	121	101	4,245	5,390
Miss.	5	9	—	2	—	—	—	—	4,212	4,417
W.S. CENTRAL	30	57	4	3	3	4	176	195	28,256	28,712
Ark.	6	10	—	—	—	—	51	77	2,660	2,708
La.	3	3	3	1	2	—	27	34	6,950	7,103
Okla.	13	13	—	—	—	—	98	84	2,968	3,123
Tex.	8	31	1	2	1	4	N	N	15,678	15,778
MOUNTAIN	112	143	32	26	4	—	809	940	7,460	7,600
Mont.	11	12	—	—	—	—	34	39	62	53
Idaho	10	32	8	6	2	—	53	110	68	55
Wyo.	1	5	2	1	—	—	13	15	48	38
Colo.	24	39	1	1	1	—	305	336	1,988	1,924
N. Mex.	5	10	4	5	—	—	41	53	628	759
Ariz.	25	13	N	N	N	N	93	123	2,615	2,555
Utah	27	22	17	12	—	—	229	187	414	373
Nev.	9	10	—	1	1	—	41	77	1,637	1,843
PACIFIC	187	231	6	1	—	—	1,908	1,813	25,032	22,699
Wash.	46	78	—	—	—	—	223	208	2,364	1,710
Oreg.	43	46	6	1	—	—	218	287	958	684
Calif.	77	101	—	—	—	—	1,362	1,212	20,853	19,044
Alaska	12	1	—	—	—	—	63	52	363	408
Hawaii	9	5	—	—	—	—	42	54	494	853
Guam	N	N	—	—	—	—	—	2	—	119
P.R.	—	1	—	—	—	—	40	165	225	180
V.I.	—	—	—	—	—	—	—	—	35	73
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 August 27, 2005, and August 28, 2004 (34th Week)*

Reporting area	<i>Haemophilus influenzae</i> , 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	1,445	1,361	3	9	78	75	141	131
NEW ENGLAND	112	122	—	1	10	8	4	1
Maine	5	10	—	—	—	—	1	—
N.H.	5	14	—	—	—	2	—	—
Vt.	6	5	—	—	—	—	2	1
Mass.	52	59	—	1	3	3	1	—
R.I.	7	3	—	—	2	—	—	—
Conn.	37	31	—	—	5	3	—	—
MID. ATLANTIC	281	282	—	1	—	4	35	32
Upstate N.Y.	79	96	—	1	—	4	7	5
N.Y. City	51	64	—	—	—	—	10	12
N.J.	54	52	—	—	—	—	9	2
Pa.	97	70	—	—	—	—	9	13
E.N. CENTRAL	212	250	1	—	3	8	14	38
Ohio	91	73	—	—	—	2	9	12
Ind.	51	37	—	—	3	4	—	1
Ill.	35	87	—	—	—	—	3	20
Mich.	14	15	1	—	—	2	1	3
Wis.	21	38	—	—	—	—	1	2
W.N. CENTRAL	84	74	—	2	3	3	10	7
Minn.	33	34	—	1	3	3	1	—
Iowa	1	1	—	1	—	—	—	—
Mo.	35	26	—	—	—	—	7	5
N. Dak.	1	3	—	—	—	—	1	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	7	4	—	—	—	—	1	1
Kans.	7	6	—	—	—	—	—	1
S. ATLANTIC	345	310	1	—	21	20	20	22
Del.	—	—	—	—	—	—	—	—
Md.	49	49	—	—	5	5	—	—
D.C.	—	2	—	—	—	—	—	1
Va.	34	30	—	—	—	—	1	3
W. Va.	22	12	—	—	1	3	4	—
N.C.	60	41	1	—	7	5	—	1
S.C.	20	10	—	—	—	—	1	1
Ga.	69	87	—	—	—	—	10	16
Fla.	91	79	—	—	8	7	4	—
E.S. CENTRAL	84	57	—	1	1	—	14	7
Ky.	8	5	—	—	1	—	2	—
Tenn.	58	38	—	—	—	—	8	5
Ala.	18	12	—	1	—	—	4	2
Miss.	—	2	—	—	—	—	—	—
W.S. CENTRAL	79	52	1	1	5	6	6	1
Ark.	4	1	—	—	1	—	—	—
La.	28	10	1	—	2	—	6	1
Okla.	46	40	—	—	2	6	—	—
Tex.	1	1	—	1	—	—	—	—
MOUNTAIN	167	144	—	3	13	17	29	17
Mont.	—	—	—	—	—	—	—	—
Idaho	3	5	—	—	—	—	1	2
Wyo.	4	—	—	—	—	—	1	—
Colo.	34	35	—	—	—	—	9	4
N. Mex.	15	30	—	—	4	5	1	6
Ariz.	84	51	—	—	7	7	8	2
Utah	14	12	—	2	—	2	7	2
Nev.	13	11	—	1	2	3	2	1
PACIFIC	81	70	—	—	22	9	9	6
Wash.	1	1	—	—	—	—	1	1
Oreg.	29	32	—	—	—	—	5	2
Calif.	39	24	—	—	22	9	2	1
Alaska	4	5	—	—	—	—	1	1
Hawaii	8	8	—	—	—	—	—	1
Guam	—	—	—	—	—	—	—	—
P.R.	1	2	—	—	—	—	—	2
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 August 27, 2005, and August 28, 2004 (34th 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	2,397	3,824	3,516	3,836	531	492
NEW ENGLAND	314	639	186	236	8	11
Maine	1	11	10	1	—	—
N.H.	65	14	13	26	—	—
Vt.	4	8	2	5	8	4
Mass.	205	532	132	118	—	7
R.I.	6	17	1	3	—	—
Conn.	33	57	28	83	U	—
MID. ATLANTIC	412	482	699	499	67	81
Upstate N.Y.	66	55	56	49	12	4
N.Y. City	194	204	67	104	—	—
N.J.	80	107	434	141	—	—
Pa.	72	116	142	205	55	77
E.N. CENTRAL	230	305	302	363	87	65
Ohio	34	35	95	80	3	4
Ind.	32	33	25	31	16	4
Ill.	55	101	70	50	—	13
Mich.	92	100	112	172	68	44
Wis.	17	36	—	30	—	—
W.N. CENTRAL	67	116	197	230	35	15
Minn.	3	28	20	31	5	12
Iowa	14	34	17	14	—	—
Mo.	35	24	119	143	28	3
N. Dak.	—	1	—	4	1	—
S. Dak.	—	3	3	1	—	—
Nebr.	4	10	19	24	1	—
Kans.	11	16	19	13	—	—
S. ATLANTIC	401	704	907	1,205	167	118
Del.	4	5	38	29	82	6
Md.	41	82	100	106	16	3
D.C.	2	4	8	13	—	2
Va.	53	70	99	155	10	12
W. Va.	3	3	26	27	11	17
N.C.	57	69	105	129	9	8
S.C.	22	36	92	94	2	13
Ga.	66	241	106	318	6	11
Fla.	153	194	333	334	31	46
E. S. CENTRAL	171	113	235	329	69	65
Ky.	23	25	47	40	13	23
Tenn.	113	72	87	165	12	20
Ala.	19	6	55	48	9	3
Miss.	16	10	46	76	35	19
W.S. CENTRAL	119	467	248	226	39	69
Ark.	5	58	27	81	—	2
La.	44	33	31	40	9	3
Okla.	4	18	22	45	—	3
Tex.	66	358	168	60	30	61
MOUNTAIN	222	295	358	299	31	33
Mont.	7	4	3	1	1	2
Idaho	15	13	7	9	1	1
Wyo.	—	4	1	7	—	2
Colo.	26	33	33	39	15	8
N. Mex.	16	17	6	12	—	U
Ariz.	135	184	254	154	—	5
Utah	16	28	32	26	7	3
Nev.	7	12	22	51	7	12
PACIFIC	461	703	384	449	28	35
Wash.	29	40	50	38	U	U
Oreg.	32	48	64	77	13	13
Calif.	381	591	261	317	15	21
Alaska	3	4	7	10	—	—
Hawaii	16	20	2	7	—	1
Guam	—	1	—	12	—	9
P.R.	17	30	13	58	—	—
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 August 27, 2005, and August 28, 2004 (34th 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	1,042	1,208	425	437	12,125	12,061	748	934
NEW ENGLAND	66	41	32	25	1,324	2,136	46	67
Maine	3	1	1	5	54	29	5	6
N.H.	6	1	4	2	119	145	4	3
Vt.	3	3	1	1	18	33	1	3
Mass.	24	21	9	9	700	1,192	24	40
R.I.	9	2	3	1	25	152	2	2
Conn.	21	13	14	7	408	585	10	13
MID. ATLANTIC	351	321	111	104	8,453	7,520	201	247
Upstate N.Y.	93	55	34	28	2,256	2,364	31	29
N.Y. City	37	47	21	18	—	260	95	124
N.J.	74	50	25	24	2,857	2,024	49	57
Pa.	147	169	31	34	3,340	2,872	26	37
E.N. CENTRAL	175	290	44	85	532	1,010	61	83
Ohio	83	125	19	31	49	36	15	22
Ind.	13	30	2	15	18	15	—	7
Ill.	12	33	1	18	—	75	23	29
Mich.	54	86	16	19	27	14	17	15
Wis.	13	16	6	2	438	870	6	10
W.N. CENTRAL	45	35	20	8	408	260	32	48
Minn.	11	3	4	2	330	194	11	18
Iowa	3	3	7	1	51	33	6	3
Mo.	18	17	4	3	22	23	12	15
N. Dak.	1	2	2	—	—	—	—	3
S. Dak.	9	3	—	—	—	—	—	1
Nebr.	1	2	—	2	—	7	—	2
Kans.	2	5	3	—	5	3	3	6
S. ATLANTIC	231	256	84	66	1,262	1,006	182	216
Del.	12	8	N	N	406	158	3	6
Md.	67	55	14	9	638	595	68	41
D.C.	6	7	—	—	7	6	7	9
Va.	30	30	7	13	113	94	17	31
W. Va.	10	6	3	2	7	15	1	—
N.C.	19	25	15	15	35	80	21	14
S.C.	9	7	3	4	10	16	5	9
Ga.	14	35	16	10	2	12	27	45
Fla.	64	83	26	13	44	30	33	61
E.S. CENTRAL	48	65	19	19	27	31	17	26
Ky.	15	22	3	4	3	12	4	4
Tenn.	22	29	7	10	24	16	9	6
Ala.	9	12	7	3	—	3	4	11
Miss.	2	2	2	2	—	—	—	5
W.S. CENTRAL	19	99	20	29	39	29	48	102
Ark.	4	—	—	3	4	4	4	7
La.	4	7	7	2	4	2	2	4
Okla.	3	3	2	—	—	—	3	7
Tex.	8	89	11	24	31	23	39	84
MOUNTAIN	62	58	8	15	11	13	32	33
Mont.	5	1	—	—	—	—	—	—
Idaho	3	7	—	1	1	5	—	1
Wyo.	3	5	—	—	2	3	1	—
Colo.	16	13	3	6	3	—	18	13
N. Mex.	2	3	3	—	1	—	1	2
Ariz.	16	10	—	—	1	5	6	8
Utah	10	15	—	1	2	—	4	5
Nev.	7	4	2	7	1	—	2	4
PACIFIC	45	43	87	86	69	56	129	112
Wash.	—	8	7	8	3	8	10	11
Oreg.	N	N	5	5	14	19	6	13
Calif.	44	35	75	70	49	27	97	85
Alaska	—	—	—	—	3	2	3	—
Hawaii	1	—	—	3	N	N	13	3
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	1	—
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 August 27, 2005, and August 28, 2004 (34th 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	828	846	59	68	43	35	—	1	726	742
NEW ENGLAND	58	51	1	5	—	6	—	1	57	39
Maine	2	9	—	—	—	1	—	—	2	8
N.H.	9	3	—	—	—	—	—	—	9	3
Vt.	6	2	—	—	—	—	—	—	6	2
Mass.	27	30	—	5	—	5	—	—	27	20
R.I.	2	1	—	—	—	—	—	—	2	1
Conn.	12	6	1	—	—	—	—	1	11	5
MID. ATLANTIC	112	119	29	34	5	5	—	—	78	80
Upstate N.Y.	29	33	4	5	3	3	—	—	22	25
N.Y. City	15	20	—	—	—	—	—	—	15	20
N.J.	30	24	—	—	—	—	—	—	30	24
Pa.	38	42	25	29	2	2	—	—	11	11
E.N. CENTRAL	82	94	16	21	9	6	—	—	57	67
Ohio	29	48	—	3	5	5	—	—	24	40
Ind.	15	15	—	1	4	1	—	—	11	13
Ill.	12	1	—	—	—	—	—	—	12	1
Mich.	16	17	16	17	—	—	—	—	—	—
Wis.	10	13	—	—	—	—	—	—	10	13
W.N. CENTRAL	56	60	2	—	1	4	—	—	53	56
Minn.	9	18	1	—	—	—	—	—	8	18
Iowa	13	13	—	—	1	2	—	—	12	11
Mo.	20	16	1	—	—	1	—	—	19	15
N. Dak.	—	2	—	—	—	—	—	—	—	2
S. Dak.	2	2	—	—	—	1	—	—	2	1
Nebr.	4	4	—	—	—	—	—	—	4	4
Kans.	8	5	—	—	—	—	—	—	8	5
S. ATLANTIC	156	157	4	2	8	2	—	—	144	153
Del.	3	2	—	—	—	—	—	—	3	2
Md.	15	8	2	—	2	—	—	—	11	8
D.C.	—	5	—	2	—	—	—	—	—	3
Va.	21	12	—	—	—	—	—	—	21	12
W. Va.	5	5	1	—	—	—	—	—	4	5
N.C.	24	24	1	—	6	2	—	—	17	22
S.C.	14	13	—	—	—	—	—	—	14	13
Ga.	14	9	—	—	—	—	—	—	14	9
Fla.	60	79	—	—	—	—	—	—	60	79
E.S. CENTRAL	40	41	1	1	3	1	—	—	36	39
Ky.	14	8	—	1	3	1	—	—	11	6
Tenn.	17	13	—	—	—	—	—	—	17	13
Ala.	5	10	1	—	—	—	—	—	4	10
Miss.	4	10	—	—	—	—	—	—	4	10
W.S. CENTRAL	63	49	1	1	5	1	—	—	57	47
Ark.	11	12	—	—	—	—	—	—	11	12
La.	25	27	—	1	2	—	—	—	23	26
Okla.	12	7	1	—	3	1	—	—	8	6
Tex.	15	3	—	—	—	—	—	—	15	3
MOUNTAIN	67	51	4	1	5	5	—	—	58	45
Mont.	—	3	—	—	—	—	—	—	—	3
Idaho	2	6	—	—	—	—	—	—	2	6
Wyo.	—	3	—	—	—	—	—	—	—	3
Colo.	15	12	3	—	—	—	—	—	12	12
N. Mex.	2	6	—	1	—	3	—	—	2	2
Ariz.	34	10	—	—	2	1	—	—	32	9
Utah	9	4	1	—	2	—	—	—	6	4
Nev.	5	7	—	—	1	1	—	—	4	6
PACIFIC	194	224	1	3	7	5	—	—	186	216
Wash.	38	21	1	3	4	5	—	—	33	13
Oreg.	28	43	—	—	—	—	—	—	28	43
Calif.	116	152	—	—	—	—	—	—	116	152
Alaska	1	3	—	—	—	—	—	—	1	3
Hawaii	11	5	—	—	3	—	—	—	8	5
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	4	13	—	—	—	—	—	—	4	13
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	1	1	—	—	—	—	—	—	1	1
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 August 27, 2005, and August 28, 2004 (34th 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	12,198	10,503	3,359	4,255	1,001	929	23,719	25,934	7,816	8,260
NEW ENGLAND	680	1,132	481	396	3	12	1,392	1,377	185	190
Maine	16	4	37	39	N	N	98	77	8	5
N.H.	41	39	10	16	1	—	113	97	5	6
Vt.	73	56	39	16	—	—	73	37	13	2
Mass.	509	974	258	164	1	10	738	806	116	122
R.I.	15	16	13	28	1	1	66	75	11	13
Conn.	26	43	124	133	—	1	304	285	32	42
MID. ATLANTIC	850	1,764	402	604	59	56	2,913	3,893	747	817
Upstate N.Y.	331	1,247	342	323	3	1	748	774	190	332
N.Y. City	47	124	17	11	4	19	647	892	250	249
N.J.	147	125	N	N	23	10	477	739	209	161
Pa.	325	268	43	270	29	26	1,041	1,488	98	75
E.N. CENTRAL	2,278	3,322	125	110	33	28	3,260	3,453	551	731
Ohio	798	353	49	44	27	8	870	839	68	111
Ind.	192	60	16	7	2	5	363	326	101	133
Ill.	443	644	17	33	1	11	924	1,097	117	295
Mich.	142	103	26	22	3	2	557	559	154	73
Wis.	703	2,162	17	4	—	2	546	632	111	119
W.N. CENTRAL	1,984	1,122	303	436	156	92	1,586	1,572	968	277
Minn.	868	154	52	54	2	—	360	387	54	38
Iowa	375	84	80	63	2	1	243	320	54	56
Mo.	305	251	53	36	138	76	522	417	666	111
N. Dak.	77	568	17	48	—	—	19	29	2	2
S. Dak.	1	15	43	79	4	4	101	72	24	9
Nebr.	147	9	—	77	2	11	96	101	42	14
Kans.	211	41	58	79	8	—	245	246	126	47
S. ATLANTIC	869	451	1,078	1,559	463	434	6,395	6,635	1,233	1,955
Del.	5	—	—	9	2	4	56	67	8	6
Md.	115	85	198	216	57	43	510	555	56	91
D.C.	7	6	—	—	2	—	36	31	8	26
Va.	237	107	359	326	35	17	615	747	75	101
W. Va.	36	16	28	43	3	4	94	158	—	4
N.C.	64	62	337	421	278	238	905	828	111	201
S.C.	251	77	5	110	27	46	702	654	56	366
Ga.	27	17	150	229	46	68	948	1,201	288	435
Fla.	127	81	1	205	13	14	2,529	2,394	631	725
E. S. CENTRAL	359	207	94	95	188	133	1,609	1,615	893	531
Ky.	101	41	7	18	15	2	281	226	213	48
Tenn.	164	132	29	32	134	79	460	448	439	267
Ala.	60	21	56	36	35	30	456	403	188	175
Miss.	34	13	2	9	4	22	412	538	53	41
W.S. CENTRAL	719	445	614	792	65	154	1,995	2,445	1,737	2,214
Ark.	193	45	26	37	44	78	464	327	44	47
La.	30	13	—	—	5	5	458	565	83	216
Okla.	—	17	61	87	7	70	239	255	469	315
Tex.	496	370	527	668	9	1	834	1,298	1,141	1,636
MOUNTAIN	2,669	839	155	131	26	16	1,443	1,513	430	502
Mont.	478	31	9	19	1	3	60	108	5	4
Idaho	94	24	—	2	1	3	70	114	2	9
Wyo.	28	14	14	2	2	4	58	37	2	3
Colo.	880	418	14	32	5	3	395	381	71	99
N. Mex.	100	116	4	3	—	2	126	181	48	85
Ariz.	740	148	102	67	13	1	433	438	244	253
Utah	321	76	7	3	4	—	225	144	32	26
Nev.	28	12	5	3	—	—	76	110	26	23
PACIFIC	1,790	1,221	107	132	8	4	3,126	3,431	1,072	1,043
Wash.	528	440	U	U	—	—	338	326	58	73
Oreg.	504	304	3	5	1	2	246	300	78	52
Calif.	606	451	103	116	7	2	2,324	2,526	909	878
Alaska	54	11	1	11	—	—	38	38	7	6
Hawaii	98	15	—	—	—	—	180	241	20	34
Guam	—	—	—	—	—	—	—	48	—	38
P.R.	1	2	41	40	N	N	142	262	1	18
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 August 27, 2005, and August 28, 2004 (34th 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	3,032	3,227	1,589	1,538	559	529	5,043	5,054	160	258
NEW ENGLAND	117	221	80	98	45	75	137	130	—	4
Maine	9	9	N	N	—	4	1	2	—	—
N.H.	12	15	—	—	3	N	10	3	—	3
Vt.	9	8	10	6	4	1	1	—	—	—
Mass.	80	100	57	24	38	41	89	80	—	—
R.I.	7	17	13	14	—	6	8	18	—	1
Conn.	—	72	U	54	U	23	28	27	—	—
MID. ATLANTIC	681	558	153	109	107	78	652	654	19	27
Upstate N.Y.	204	182	59	47	48	53	55	60	4	1
N.Y. City	118	88	U	U	19	U	404	398	5	12
N.J.	149	121	N	N	19	7	92	106	10	13
Pa.	210	167	94	62	21	18	101	90	—	1
E.N. CENTRAL	604	752	423	351	156	125	513	588	24	31
Ohio	148	175	266	244	60	59	144	152	2	2
Ind.	79	77	147	107	41	26	43	42	1	2
Ill.	116	206	10	—	48	1	248	243	8	5
Mich.	232	226	—	N	—	N	55	128	11	22
Wis.	29	68	N	N	7	39	23	23	2	—
W.N. CENTRAL	205	223	35	17	64	70	159	113	1	3
Minn.	77	111	—	—	39	48	45	17	—	1
Iowa	N	N	N	N	—	N	2	5	—	—
Mo.	57	46	29	12	6	9	94	67	1	1
N. Dak.	7	10	1	—	2	2	—	—	—	—
S. Dak.	18	12	3	5	—	—	—	—	—	—
Nebr.	14	15	2	—	6	6	3	6	—	—
Kans.	32	29	N	N	11	5	15	18	—	1
S. ATLANTIC	631	638	630	794	63	36	1,286	1,260	27	41
Del.	1	3	1	4	—	N	8	6	—	1
Md.	142	100	—	—	41	24	223	236	9	6
D.C.	7	5	15	7	2	4	70	39	—	1
Va.	60	59	N	N	—	N	84	69	3	2
W. Va.	21	19	92	86	20	8	3	3	—	—
N.C.	89	85	N	N	U	U	178	121	8	6
S.C.	24	48	—	78	—	N	40	83	2	10
Ga.	116	156	109	192	—	N	214	220	—	2
Fla.	171	163	413	427	—	N	466	483	5	13
E.S. CENTRAL	127	170	125	105	7	11	275	275	16	19
Ky.	27	51	24	22	N	N	28	27	—	1
Tenn.	100	119	101	81	—	N	134	88	12	7
Ala.	—	—	—	—	—	N	88	122	3	9
Miss.	—	—	—	2	7	11	25	38	1	2
W.S. CENTRAL	144	253	94	45	72	105	800	789	44	53
Ark.	14	15	12	6	13	7	32	34	—	3
La.	6	2	82	39	22	23	176	193	6	3
Okla.	83	48	N	N	18	30	26	19	1	2
Tex.	41	188	N	N	19	45	566	543	37	45
MOUNTAIN	453	344	49	18	37	29	259	263	15	32
Mont.	—	—	—	—	—	—	5	1	—	—
Idaho	1	8	N	N	—	N	20	13	1	2
Wyo.	3	7	21	6	—	—	—	1	—	—
Colo.	171	69	N	N	36	29	28	48	—	—
N. Mex.	34	74	—	N	—	—	32	62	2	2
Ariz.	184	156	N	N	—	N	97	112	12	27
Utah	59	28	27	10	1	—	4	7	—	1
Nev.	1	2	1	2	—	—	73	19	—	—
PACIFIC	70	68	—	1	8	—	962	982	14	48
Wash.	N	N	N	N	N	N	95	76	—	—
Oreg.	N	N	N	N	6	N	19	21	—	—
Calif.	—	—	N	N	N	N	839	880	14	48
Alaska	—	—	—	—	—	N	5	—	—	—
Hawaii	70	68	—	1	2	—	4	5	—	—
Guam	—	—	—	—	—	—	—	1	—	—
P.R.	N	N	N	N	—	N	121	87	8	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

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 August 27, 2005, and August 28, 2004 (34th Week)*

Reporting area	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease†		
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Neuroinvasive		Non-neuroinvasive‡
							Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	6,862	8,550	147	205	15,795	19,182	275	831	385
NEW ENGLAND	216	274	16	17	985	2,011	—	—	—
Maine	9	13	1	—	210	180	—	—	—
N.H.	4	10	—	—	201	—	—	—	—
Vt.	4	2	—	—	36	413	—	—	—
Mass.	131	156	9	14	538	141	—	—	—
R.I.	18	35	1	1	—	—	—	—	—
Conn.	50	58	5	2	U	1,277	—	—	—
MID. ATLANTIC	1,276	1,312	31	48	3,119	72	3	6	4
Upstate N.Y.	163	183	5	6	—	—	—	1	—
N.Y. City	619	660	9	19	—	—	—	2	—
N.J.	303	282	9	13	—	—	—	—	—
Pa.	191	187	8	10	3,119	72	3	3	4
E.N. CENTRAL	835	767	11	25	4,458	8,338	42	37	20
Ohio	161	129	1	5	993	1,030	9	5	2
Ind.	85	83	—	—	482	N	1	2	—
Ill.	398	340	2	10	50	4,270	29	18	16
Mich.	135	154	4	8	2,637	2,538	2	8	1
Wis.	56	61	4	2	296	500	1	4	1
W.N. CENTRAL	286	297	3	7	283	135	40	52	136
Minn.	126	111	2	3	—	—	5	10	8
Iowa	26	23	—	—	N	N	1	7	1
Mo.	65	81	1	2	195	5	1	19	2
N. Dak.	2	3	—	—	12	75	2	2	14
S. Dak.	9	8	—	—	76	55	19	5	90
Nebr.	19	21	—	2	—	—	11	1	18
Kans.	39	50	—	—	—	—	1	8	3
S. ATLANTIC	1,541	1,771	24	30	1,381	1,675	6	43	7
Del.	7	17	—	—	21	4	—	—	—
Md.	182	176	7	10	—	—	1	6	—
D.C.	33	60	—	—	23	19	—	1	—
Va.	191	147	5	5	284	393	—	2	—
W. Va.	17	14	—	—	703	949	—	—	N
N.C.	164	188	2	3	—	N	1	1	1
S.C.	143	127	—	—	350	310	—	—	—
Ga.	241	391	2	4	—	—	—	8	1
Fla.	563	651	8	8	—	—	4	25	5
E. S. CENTRAL	345	419	5	6	—	5	7	44	5
Ky.	67	68	2	2	N	N	—	—	—
Tenn.	161	146	—	4	—	—	—	7	—
Ala.	117	125	1	—	—	5	2	14	—
Miss.	—	80	2	—	—	—	5	23	5
W.S. CENTRAL	773	1,304	10	18	3,822	5,374	62	135	19
Ark.	69	80	—	—	—	—	—	9	5
La.	—	—	—	—	107	48	40	49	12
Okla.	90	104	—	1	—	—	1	10	—
Tex.	614	1,120	10	17	3,715	5,326	21	67	2
MOUNTAIN	235	341	7	6	1,747	1,572	22	281	39
Mont.	8	4	—	—	—	—	1	1	1
Idaho	—	3	—	—	—	—	—	—	1
Wyo.	—	2	—	—	43	26	—	2	—
Colo.	47	81	2	1	1,235	1,243	2	35	19
N. Mex.	8	20	—	—	121	U	6	22	3
Ariz.	142	139	3	2	—	—	7	196	9
Utah	19	27	1	1	348	303	3	4	4
Nev.	11	65	1	2	—	—	3	21	2
PACIFIC	1,355	2,065	40	48	—	—	93	233	155
Wash.	153	144	4	4	N	N	—	—	—
Oreg.	54	65	2	1	—	—	—	—	—
Calif.	1,056	1,751	28	37	—	—	93	233	155
Alaska	18	26	—	—	—	—	—	—	—
Hawaii	74	79	6	6	—	—	—	—	—
Guam	—	41	—	—	—	106	—	—	—
P.R.	—	74	—	—	126	284	—	—	—
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 August 27, 2005 (34th Week)

Reporting Area	All causes, by age (years)							P&I [†] Total	Reporting Area	All causes, by age (years)							P&I [†] Total
	All Ages	≥65	45-64	25-44	1-24	<1	All Ages			≥65	45-64	25-44	1-24	<1			
NEW ENGLAND	418	301	78	27	6	6	36	S. ATLANTIC	1,103	685	274	96	23	25	53		
Boston, Mass.	129	86	24	13	2	4	12	Atlanta, Ga.	145	82	39	19	2	3	4		
Bridgeport, Conn.	35	27	7	1	—	—	3	Baltimore, Md.	139	77	42	15	4	1	12		
Cambridge, Mass.	18	15	2	1	—	—	2	Charlotte, N.C.	96	68	21	6	—	1	4		
Fall River, Mass.	21	18	3	—	—	—	1	Jacksonville, Fla.	126	74	33	10	3	6	7		
Hartford, Conn.	U	U	U	U	U	U	U	Miami, Fla.	111	74	24	8	4	1	3		
Lowell, Mass.	21	14	6	1	—	—	1	Norfolk, Va.	47	30	7	5	3	2	—		
Lynn, Mass.	12	9	2	1	—	—	1	Richmond, Va.	54	29	14	7	2	2	5		
New Bedford, Mass.	18	12	5	1	—	—	—	Savannah, Ga.	47	35	9	3	—	—	2		
New Haven, Conn.	U	U	U	U	U	U	U	St. Petersburg, Fla.	44	37	4	1	—	2	3		
Providence, R.I.	52	41	8	2	1	—	7	Tampa, Fla.	174	115	43	11	2	3	6		
Somerville, Mass.	3	1	2	—	—	—	—	Washington, D.C.	100	52	30	11	3	4	6		
Springfield, Mass.	30	18	9	3	—	—	3	Wilmington, Del.	20	12	8	—	—	—	1		
Waterbury, Conn.	23	17	4	—	1	1	1	E.S. CENTRAL	812	479	217	65	26	25	42		
Worcester, Mass.	56	43	6	4	2	1	5	Birmingham, Ala.	149	82	46	12	6	3	8		
MID. ATLANTIC	1,934	1,310	431	116	44	33	83	Chattanooga, Tenn.	82	52	21	5	1	3	3		
Albany, N.Y.	47	39	3	3	2	—	3	Knoxville, Tenn.	81	56	12	4	4	5	—		
Allentown, Pa.	20	15	4	1	—	—	—	Lexington, Ky.	57	34	12	7	2	2	4		
Buffalo, N.Y.	77	42	26	6	1	2	5	Memphis, Tenn.	171	91	50	19	3	8	9		
Camden, N.J.	27	16	7	1	—	3	—	Mobile, Ala.	73	48	18	5	1	1	2		
Elizabeth, N.J.	16	10	4	1	1	—	2	Montgomery, Ala.	66	38	21	4	2	1	5		
Erie, Pa.	35	28	4	3	—	—	3	Nashville, Tenn.	133	78	37	9	7	2	11		
Jersey City, N.J.	75	48	18	4	3	2	—	W.S. CENTRAL	1,245	800	284	84	34	43	66		
New York City, N.Y.	965	667	218	54	18	8	34	Austin, Tex.	62	37	18	5	1	1	1		
Newark, N.J.	45	20	16	7	—	2	—	Baton Rouge, La.	U	U	U	U	U	U	U		
Paterson, N.J.	11	6	2	1	2	—	—	Corpus Christi, Tex.	U	U	U	U	U	U	U		
Philadelphia, Pa.	226	131	56	20	11	8	11	Dallas, Tex.	179	101	47	10	5	16	9		
Pittsburgh, Pa. [‡]	27	17	6	—	1	3	—	El Paso, Tex.	98	58	19	16	4	1	6		
Reading, Pa.	18	13	4	—	1	—	1	Ft. Worth, Tex.	112	62	25	11	5	9	5		
Rochester, N.Y.	124	94	22	4	3	1	14	Houston, Tex.	312	193	79	24	8	8	18		
Schenectady, N.Y.	17	11	6	—	—	—	—	Little Rock, Ark.	70	47	19	2	1	1	5		
Scranton, Pa.	27	20	4	3	—	—	1	New Orleans, La.	U	U	U	U	U	U	U		
Syracuse, N.Y.	127	97	20	6	—	4	5	San Antonio, Tex.	243	181	41	10	6	5	16		
Trenton, N.J.	23	15	7	1	—	—	1	Shreveport, La.	41	32	6	—	3	—	3		
Utica, N.Y.	7	5	1	—	1	—	1	Tulsa, Okla.	128	89	30	6	1	2	3		
Yonkers, N.Y.	20	16	3	1	—	—	2	MOUNTAIN	921	559	240	65	28	27	57		
E.N. CENTRAL	1,804	1,192	409	121	48	34	80	Albuquerque, N.M.	104	65	25	8	4	2	5		
Akron, Ohio	48	28	13	6	1	—	3	Boise, Idaho	64	40	19	1	2	2	4		
Canton, Ohio	31	25	5	—	1	—	4	Colo. Springs, Colo.	50	34	12	1	—	3	2		
Chicago, Ill.	333	205	78	30	7	13	15	Denver, Colo.	98	66	17	8	3	4	8		
Cincinnati, Ohio	49	39	9	1	—	—	7	Las Vegas, Nev.	249	149	74	15	7	4	16		
Cleveland, Ohio	223	143	48	18	9	5	4	Ogden, Utah	28	21	5	1	—	1	2		
Columbus, Ohio	182	113	47	15	5	2	10	Phoenix, Ariz.	179	85	58	18	9	8	8		
Dayton, Ohio	123	88	22	7	5	1	4	Pueblo, Colo.	29	21	4	3	—	—	3		
Detroit, Mich.	147	77	52	12	5	1	5	Salt Lake City, Utah	120	78	26	10	3	3	9		
Evansville, Ind.	52	39	10	1	2	—	4	Tucson, Ariz.	U	U	U	U	U	U	U		
Fort Wayne, Ind.	54	33	14	4	2	1	2	PACIFIC	1,233	818	271	90	30	24	71		
Gary, Ind.	10	6	4	—	—	—	—	Berkeley, Calif.	19	15	3	—	—	1	3		
Grand Rapids, Mich.	50	36	7	3	3	1	2	Fresno, Calif.	132	90	28	9	3	2	7		
Indianapolis, Ind.	203	133	47	13	5	5	3	Glendale, Calif.	4	4	—	—	—	—	1		
Lansing, Mich.	33	22	9	1	—	1	—	Honolulu, Hawaii	94	68	20	5	1	—	3		
Milwaukee, Wis.	U	U	U	U	U	U	U	Long Beach, Calif.	U	U	U	U	U	U	U		
Peoria, Ill.	57	44	7	1	1	4	6	Los Angeles, Calif.	139	97	31	9	1	1	14		
Rockford, Ill.	44	32	9	2	1	—	3	Pasadena, Calif.	19	14	4	1	—	—	1		
South Bend, Ind.	35	27	6	2	—	—	1	Portland, Oreg.	146	102	28	12	2	2	5		
Toledo, Ohio	82	61	16	4	1	—	3	Sacramento, Calif.	187	109	47	17	9	5	12		
Youngstown, Ohio	48	41	6	1	—	—	4	San Diego, Calif.	132	89	27	10	1	5	5		
W.N. CENTRAL	668	454	137	45	16	16	34	San Francisco, Calif.	106	69	23	6	4	4	7		
Des Moines, Iowa	89	68	13	4	2	2	6	San Jose, Calif.	U	U	U	U	U	U	U		
Duluth, Minn.	48	34	10	3	1	—	2	Santa Cruz, Calif.	30	26	3	1	—	—	—		
Kansas City, Kans.	27	16	4	6	1	—	3	Seattle, Wash.	86	52	25	7	1	1	4		
Kansas City, Mo.	93	56	24	8	2	3	5	Spokane, Wash.	48	24	13	6	3	2	3		
Lincoln, Nebr.	49	42	6	—	1	—	3	Tacoma, Wash.	91	59	19	7	5	1	6		
Minneapolis, Minn.	54	33	13	5	1	2	4	TOTAL	10,138 [¶]	6,598	2,341	709	255	233	522		
Omaha, Nebr.	88	66	13	3	2	4	1										
St. Louis, Mo.	81	40	32	5	3	1	7										
St. Paul, Minn.	46	35	6	4	—	1	2										
Wichita, Kans.	93	64	16	7	3	3	1										

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.

The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format and on a paid subscription basis for paper copy. To receive an electronic copy each week, send an e-mail message to listserv@listserv.cdc.gov. The body content should read *SUBscribe mmwr-toc*. Electronic copy also is available from CDC's World-Wide Web server at <http://www.cdc.gov/mmwr> or from CDC's file transfer protocol server at <ftp://ftp.cdc.gov/pub/publications/mmwr>. To subscribe for paper copy, contact Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone 202-512-1800.

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Address inquiries about the *MMWR* Series, including material to be considered for publication, to Editor, *MMWR* Series, Mailstop K-95, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone 888-232-3228.

All material in the *MMWR* Series is in the public domain and may be used and reprinted without permission; citation as to source, however, is appreciated.

All *MMWR* references are available on the Internet at <http://www.cdc.gov/mmwr>. Use the search function to find specific articles.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

References to non-CDC sites on the Internet are provided as a service to *MMWR* readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of these sites. URL addresses listed in *MMWR* were current as of the date of publication.