MMWR™
Morbidity and Mortality Weekly Report
Weekly
November 4, 2005 / Vol. 54 / No. 43

National Diabetes Awareness Month — November 2005

In 2005, an estimated 20.8 million persons in the United States, approximately 7% of the population, have diabetes; however, only 14.6 million of these persons have had the disease diagnosed (*1*). Persons with diabetes have a risk for premature death approximately twice that of persons of similar ages without diabetes. In 2002, diabetes was the sixth leading cause of death in the United States, with associated direct and indirect costs totaling an estimated $132 billion (*1*).

November is National Diabetes Awareness Month; throughout the month, *MMWR* will publish reports on diabetes. CDC is working in conjunction with the 50 states, eight territories, and the District of Columbia to reach populations at greatest risk for diabetes, including American Indians/Alaska Natives (AI/ANs) and Hispanics. AI/ANs are 2.2 times more likely to have diabetes than non-Hispanic whites of similar ages (*1*). The CDC Native Diabetes Wellness Program is developing books to teach children and parents about healthy eating and physical activity, two important factors in diabetes prevention. In addition, the CDC National Diabetes Education Program is working with a Spanish-language television network to introduce a diabetes prevention and care theme into a telenovela (serial drama). Additional information about diabetes is available from CDC at http://www.cdc.gov/diabetes.

Reference

1. CDC. National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2005. Atlanta, GA: US Department of Health and Human Services, CDC; 2005. Available at http://www.cdc.gov/diabetes/pubs/factsheet05.htm.

Incidence of End-Stage Renal Disease Among Persons With Diabetes — United States, 1990–2002

Diabetes mellitus is the leading cause of end-stage renal disease (ESRD) (i.e., kidney failure requiring dialysis or transplantation) in the United States, accounting for 44% of new cases of treated ESRD in 2002 (*1*). To examine trends in ESRD attributed to diabetes mellitus (ESRD-DM) in the United States, CDC analyzed 1990–2002 data from the United States Renal Data System (USRDS) and the National Health Interview Survey (NHIS). This report summarizes the findings of that analysis, which indicated that, although the number of new cases of ESRD-DM increased overall, the incidence of ESRD-DM among persons with diabetes is not increasing among blacks,* Hispanics, men, and persons aged 65–74 years, and is declining among persons aged <65 years, women, and whites. Continued interventions to reduce the prevalence of risk factors for kidney disease and improve diabetes care are needed to sustain and improve these trends.

USRDS, which is funded by the National Institute of Diabetes and Digestive and Kidney Diseases of the National

*For this report, race and ethnicity were considered independently. The only racial populations considered were black and white; persons who identified themselves as black or white might be Hispanic or non-Hispanic. Persons who identified themselves as Hispanic might be of any race.

INSIDE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

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].

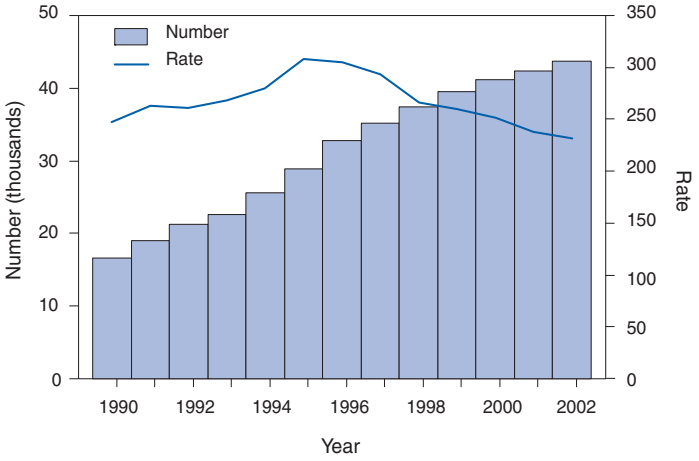
Institutes of Health (NIH), collects, analyzes, and distributes information from clinical and claims data reports to the Centers for Medicare and Medicaid Services (CMS) regarding patients being treated for ESRD. With the ESRD entitlement program, the CMS Medicare program reimburses most of the total cost of ESRD treatment in the United States (*1*). USRDS collects demographic data and ESRD-related information, such as the date patients were first treated and the primary cause of their renal failure. CDC determined the number of persons who began treatment (i.e., dialysis or kidney transplantation) for ESRD in the United States during 1990–2002 for whom diabetes was the primary cause of renal failure. Incidence was calculated from 3-year moving averages of the annual number of U.S. residents with diabetes, as estimated by NHIS data for a weighted sample of the civilian noninstitutionalized population and age-adjusted on the basis of the 2000 U.S. standard population. In 1996, the NHIS estimate of the number of U.S. residents with diabetes was unusually low[†] (*2*), resulting in ESRD-DM incidence that was higher than expected. Beginning in 1997, data on Hispanics were collected, and the NHIS survey methodology was changed; instead of asking a one-sixth subsample of respondents whether (during the preceding 12 months) a family member had diabetes, all respondents were asked whether a health professional had ever told them they had diabetes (*3*). All analyses were conducted using statistical analysis software to account for the complex NHIS survey design. Regression analyses of annual data were used to test for trends; these analyses were performed both with and without the 1996 data.

The number of persons who began treatment for ESRD-DM increased 162%, from 16,649 in 1990 to 43,638 in 2002 (Figure 1). The age-adjusted incidence of ESRD-DM increased from 247 per 100,000 persons with diabetes in 1990 to 305 in 1996, before declining 21%, from 293 in 1997 to 232 in 2002 ($p<0.01$) (Figure 1). However, the magnitude of this decline in ESRD-DM incidence varied by age group (Figure 2). During 1997–2002, incidence decreased for persons aged <65 years (by 28% for those aged <45 years [$p<0.01$] and by 19% for those aged 45–64 years [$p<0.05$]); however, incidence did not change significantly for those aged 65–74 years, and increased 10% for those aged ≥75 years ($p<0.05$).

The magnitude of change in ESRD-DM incidence also differed by sex and by race/ethnicity (Figure 3). During 1990–2002, age-adjusted ESRD-DM incidence was greater among men than women and higher among blacks than whites. During 1997–2002, age-adjusted ESRD-DM incidence decreased

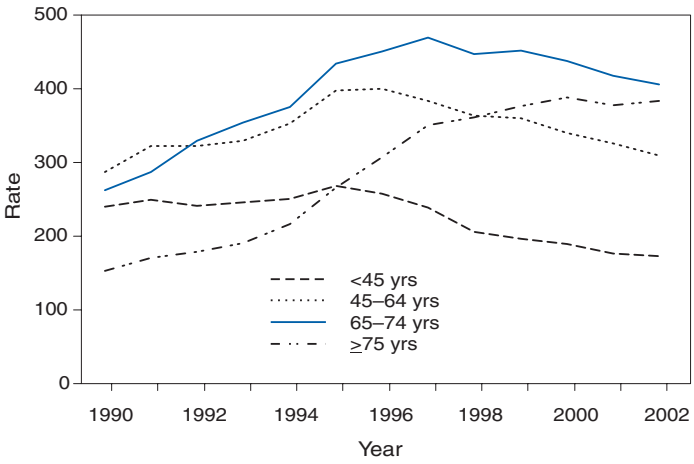
[†] Relative to 1995, the 1996 NHIS sample size was reduced by approximately 25% in the first and second quarters and by approximately 50% in the third and fourth quarters.

FIGURE 1. Number of persons who began treatment for end-stage renal disease associated with diabetes mellitus (ESRD-DM) and age-adjusted rate* of ESRD-DM among persons with diabetes — United States Renal Data System, 1990–2002



* Per 100,000 persons with diabetes, age-adjusted on the basis of the 2000 U.S. standard population.

FIGURE 2. Rate* of end-stage renal disease associated with diabetes mellitus among persons with diabetes, by age group — United States Renal Data System, 1990–2002



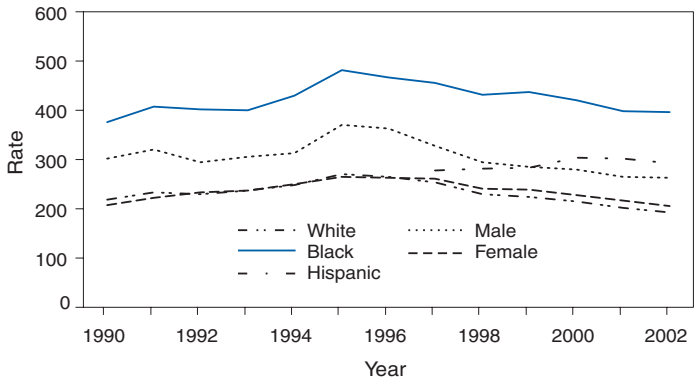
* Per 100,000 persons with diabetes.

significantly among women ($p<0.05$) but not among men. Incidence also decreased significantly among whites ($p<0.01$) but not among blacks; the trend among Hispanics did not change significantly.

Reported by: *NR Burrows, MPH, J Wang, LS Geiss, MA, KM Venkat Narayan, MD, MM Engelgau, MD, Div of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

Editorial Note: ESRD is a costly and disabling condition that disproportionately affects racial/ethnic minority populations

FIGURE 3. Age-adjusted rate* of end-stage renal disease associated with diabetes mellitus among persons with diabetes, by sex and race/ethnicity† — United States Renal Data System, 1990–2002



* Per 100,000 persons with diabetes, age-adjusted on the basis of the 2000 U.S. standard population.
† Race and ethnicity were considered independently. The only racial populations considered were black and white; persons who identified themselves as black or white might be Hispanic or non-Hispanic. Persons who identified themselves as Hispanic might be of any race.

and is associated with a high mortality rate (*1*). Risk factors for ESRD-DM include familial and genetic factors, the length of time a person has had diabetes, and hyperglycemia, hypertension, and hyperlipidemia (*4*). The findings in this report indicate encouraging trends in ESRD-DM incidence. After increasing from 1990 to 1996, ESRD-DM incidence decreased during 1997–2002 among persons aged <65 years, women, and whites; stopped increasing among persons aged 65–74 years, men, and blacks; and remained level among Hispanics. The reasons for improvement cannot be determined from these surveillance data; however, they might include a reduction in the prevalence of cardiovascular disease risk factors such as high blood pressure and high cholesterol (*5*), improvements in diabetes care practices (*6*), or development of new pharmacologic agents to reduce the prevalence of kidney disease risk factors (*7*). Continued interventions (e.g., blood sugar and blood pressure control [*8–10*]) to reduce the prevalence of these risk factors and improve care among persons with diabetes are needed to sustain and improve trends in ESRD-DM incidence.

During 1997–2002, ESRD-DM incidence among men, blacks, persons aged 65–74 years, and Hispanics did not decrease as it did among certain other populations; among persons aged ≥75 years, ESRD-DM incidence increased during 1990–2002. Additional strategies are needed to reduce these disparities. Reducing incidence of ESRD-DM among persons aged ≥75 years likely will be difficult because persons with diabetes are surviving longer and ESRD typically occurs

15–20 years after onset of diabetes (*4*). Moreover, the number of ESRD cases in the United States is likely to continue to increase as the U.S. population ages and the number of persons with diabetes continues to increase. The downward trend in ESRD incidence in the population with diabetes might reverse if persons have diabetes at younger ages or live with the disease for a longer time, thus increasing their risk for developing ESRD.

The findings in this report are subject to at least four limitations. First, data were collected for patients whose ESRD treatment was reported to CMS and do not include patients who died from ESRD before receiving treatment, persons who refused treatment, or patients whose treatment was not reported to CMS. Second, the 1996 NHIS estimate of the number of U.S. residents with diabetes was unusually low (*2*); however, exclusion of 1996 data did not substantially affect incidence trends. Third, because incidence of ESRD-DM was defined as the percentage of persons with diabetes who began ESRD treatment in a given year, changes in incidence might have been caused by other factors, such as changes in diabetes treatment and care practices, greater recognition of the etiologic role of diabetes in ESRD, changes in access to treatment or acceptance of ESRD treatment, or a combination of these factors. Finally, the correlation between the length of time diabetes patients had the disease and their risk for developing ESRD-DM was not assessed because of a lack of data on duration of diabetes.

CDC provides resources and technical assistance to state and territorial diabetes-control programs to help them 1) educate persons regarding diabetes, 2) improve and monitor the quality of diabetes care, and 3) promote early detection of diabetic complications. The National Diabetes Education Program (NDEP), sponsored by CDC and NIH, aims to educate the public about controlling diabetes and preventing its complications. The NDEP campaign, "Know your ABCs,"[§] addresses risk factors for ESRD-DM, such as hyperglycemia, hypertension, and hyperlipidemia. In addition, the National Kidney Disease Education Program,[¶] sponsored by NIH, seeks to raise public awareness about the seriousness of kidney disease, the importance of testing for kidney disease among those at risk, and the availability of treatment to prevent or slow kidney failure. Similarly, the National Kidney Foundation offers the Kidney Early Evaluation Program,[**] a free health-screening program for persons at increased risk for kidney disease.

CDC will continue to work with public and private partners to reduce rates of diabetes and other risk factors for kidney disease and to improve care for persons with diabetes. Continued surveillance of ESRD-DM, its risk factors, and the level of care received by patients with diabetes will help public health officials monitor and assess progress in reducing the incidence of this serious complication of diabetes.

[§] Available at http://www.cdc.gov/diabetes/ndep/campaigns.htm.
[¶] Available at http://www.nkdep.nih.gov.
[**] Available at http://www.kidney.org/keep.

References

1. United States Renal Data System. Annual data report, 2004. Minneapolis, MN: USRDS Coordinating Center; 2004. Available at http://www.usrds.org/adr_2004.htm.
2. Engelgau MM, Geiss LS, Saaddine JB, et al. The evolving diabetes burden in the United States. Ann Intern Med 2004;140:945–50.
3. CDC. 1997 National Health Interview Survey (NHIS) public use data release: NHIS survey description. Hyattsville, MD: US Department of Health and Human Services, CDC; 2000. Available at ftp://ftp.cdc.gov/pub/health_statistics/nchs/dataset_documentation/nhis/1997/srvydesc.pdf.
4. Nelson RG, Knowler WC, Pettitt DJ, Bennett PH. Kidney diseases in diabetes. In: Diabetes in America. 2nd ed. Harris MI, Cowie CC, Stern MP, Boyko EJ, Reiber GE, Bennett PH, eds. Washington, DC: US Department of Health and Human Services, National Institutes of Health; 1995. DHHS publication no. (NIH)95-1468; 361–6.
5. Imperatore G, Cadwell BL, Geiss L, et al. Thirty-year trends in cardiovascular risk factor levels among US adults with diabetes: National Health and Nutrition Examination Surveys, 1971–2000. Am J Epidemiol 2004;160:531–9.
6. Geiss L, Engelgau M, Pogach L, et al. A national progress report on diabetes: successes and challenges. Diabetes Technol Ther 2005; 7:198–203.
7. Parving HH, Lehnert H, Brochner-Mortensen J, Gomis R, Andersen S, Arner P; Irbesartan in Patients with Type 2 Diabetes and Microalbuminuria Study Group. The effect of irbesartan on the development of diabetic nephropathy in patients with type 2 diabetes. N Engl J Med 2001;345:870–8.
8. The Diabetes Control and Complications Trial Research Group. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. N Engl J Med 1993;329:977–86.
9. UK Prospective Diabetes Study Group. Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33). Lancet 1998;352:837–53.
10. UK Prospective Diabetes Study Group. Tight blood pressure control and risk of macrovascular and microvascular complications in type 2 diabetes (UKPDS 38). BMJ 1998;317:703–13.

Global Measles and Rubella Laboratory Network, January 2004–June 2005

Measles continues to be a leading cause of childhood morbidity and mortality in developing countries and an outbreak threat in the majority of countries. In 2000, measles was considered the fifth leading cause of childhood mortality, and the World Health Organization (WHO) estimated that approximately 777,000 measles-associated deaths occurred worldwide. In 2001, WHO and the United Nations Children's Fund (UNICEF) developed a 5-year strategic plan, endorsed by the World Health Assembly in 2003, to reduce measles mortality

by 50% by 2005 (relative to 1999 estimates) and to achieve and maintain interruption of indigenous measles transmission in large geographic areas with established measles elimination goals. This plan included strengthening routine vaccination coverage, providing a second opportunity for measles immunization to children, improving measles case management, and improving surveillance with laboratory confirmation of suspected measles cases (*1*). To date, four of six WHO regions have established measles elimination targets: the Americas Region (AMR) by 2000, the European Region (EUR) by 2010, the Eastern Mediterranean Region (EMR) by 2010, and the Western Pacific Region (WPR) by 2012. The remaining two WHO regions, the African (AFR) and South East Asian (SEAR) regions, are continuing work toward the measles mortality reduction goal. Likewise, to reduce the burden of disease from congenital rubella syndrome (CRS), currently estimated at 100,000 cases per year worldwide, several countries have developed or continue to develop rubella control programs, and AMR and EUR have established regional rubella elimination and CRS reduction goals, respectively. Because improved global surveillance is essential for monitoring progress toward mortality reduction and elimination of these diseases, WHO established the Measles and Rubella Laboratory Network (LabNet) in 2003 to promote case identification and confirmation. This report provides an update on the development of LabNet during January 2004–June 2005 and describes the geographic distribution of measles and rubella virus genotypes as of June 2005.

LabNet

On the basis of the model provided by the WHO Polio Laboratory Network, WHO established the Global Measles Laboratory Network (GMLN) in 2000 to 1) provide laboratory confirmation of initial measles cases during outbreaks, 2) collect baseline measles genotype information on the regional distribution of circulating viruses useful in establishing transmission pathways of disease spread, and 3) monitor the success of vaccination campaigns and the integrity of elimination programs (*2*). Because of the similar nature of clinical surveillance and diagnostic assay procedures, GMLN also provided diagnostic support for rubella control programs and has since evolved into LabNet.

Clinical recognition of cases has low positive predictive value when the incidence of measles and rubella is low. Thus, LabNet selected highly sensitive and specific, commercially available, IgM enzyme immunoassays (EIAs) for laboratory confirmation of suspected cases of measles and rubella. LabNet includes IgM testing laboratories serving 162 countries and is still expanding. A total of 705 laboratories participate in the network, which consists of three global specialized laboratories, 16 regional reference laboratories, 178 national laboratories, and 508 subnational laboratories. More than 86,000 serum samples were tested for IgM for measles and rubella in 2004, often meeting result-reporting targets of at least 80% within 7 days of receiving the sample (Table).

The network has expanded in all WHO regions since 2003 but particularly in the WPR and AFR regions. In September 2005, WPR adopted the goal of measles elimination, with strengthening of laboratory testing as a key component of its measles surveillance strategy. AFR has implemented strategies for measles mortality reduction and has established laboratory-based surveillance before, or at times coincident with, countries beginning measles supplementary immunization activities. Thirty-six of 46 AFR countries have established measles laboratories as part of LabNet, with staff who have received training from regional or global laboratories. LabNet has been developed with a long-term objective of responsiveness to developing public health priorities in the WHO regions. For example, the laboratory network established in AMR supports 1) pursuing regional elimination goals for rubella and CRS and 2) continuing case-based investigations of measles now that elimination of indigenous measles from the region has been achieved.

TABLE. LabNet workload and performance, by World Health Organization (WHO) region — worldwide, January 2004–June 2005

WHO region	January–December 2004						January–June 2005					
	No. of serum specimens received	IgM positive				% reported within 7 days*	No. of serum specimens received	IgM positive				% reported within 7 days*
		Measles		Rubella				Measles		Rubella		
		No.	(%)	No.	(%)			No.	(%)	No.	(%)	
African	15,896	2,715	(17.0)	4,601	(28.9)	80%	8,893	2,282	(25.7)	1,278	(14.4)	91%
Americas	26,830	108	(0.4)	3,103	(11.6)	86%	14,413	26	(0.2)	955	(6.6)	79%
Eastern Mediterranean	6,784	2,747	(40.5)	1,092	(16.1)	90%	2,136	428	(2.0)	324	(15.2)	86%
European	34,161	2,886	(8.4)	3,091	(9.0)	40%	17,593	2,616	(14.9)	1,771	(10.1)	57%
South East Asian	2,534	1,589	(62.7)	199	(7.9)	>80%	2,372	962	(40.6)	747	(31.5)	>80%
Western Pacific	NA†	NA	NA	NA	NA	—	5,764	333	(5.8)	2,547	(44.2)	63%
Total	**86,205**	**10,045**	**(11.7)**	**12,086**	**(14.0)**	**—**	**51,171**	**6,647**	**(13.0)**	**7,622**	**(14.9)**	**—**

* Within 5 days for the Americas Region.
† Not available.

Performance Monitoring

A comprehensive system for monitoring indicators of laboratory performance, including proficiency testing and annual laboratory accreditation by WHO and/or regional laboratories, has been implemented in all regions. Six quality indicators* are monitored during the 12-month review period, and a comprehensive onsite review of laboratory activities, procedures, and communication links is performed every 2–3 years. All regions have begun this process, with priority given to regions with a high burden of measles, such as AFR, SEAR, and EMR. Sixty-two (43%) of 144 national and regional reference laboratories in these three regions have been assessed, with only one failing to receive accreditation.

The IgM proficiency testing program is in its fifth year, and more than 160 panels of 20 sera will be distributed in 2005. Analysis of the 2004 measles proficiency panel resulted in 90% of 100 national laboratories achieving the pass score of at least 90%. Laboratories that fail the test are visited by WHO laboratory program officials. Problems usually are identified rapidly, deficiencies are corrected, and the laboratories are permitted to attempt the proficiency tests again.

Alternative Specimen Collection

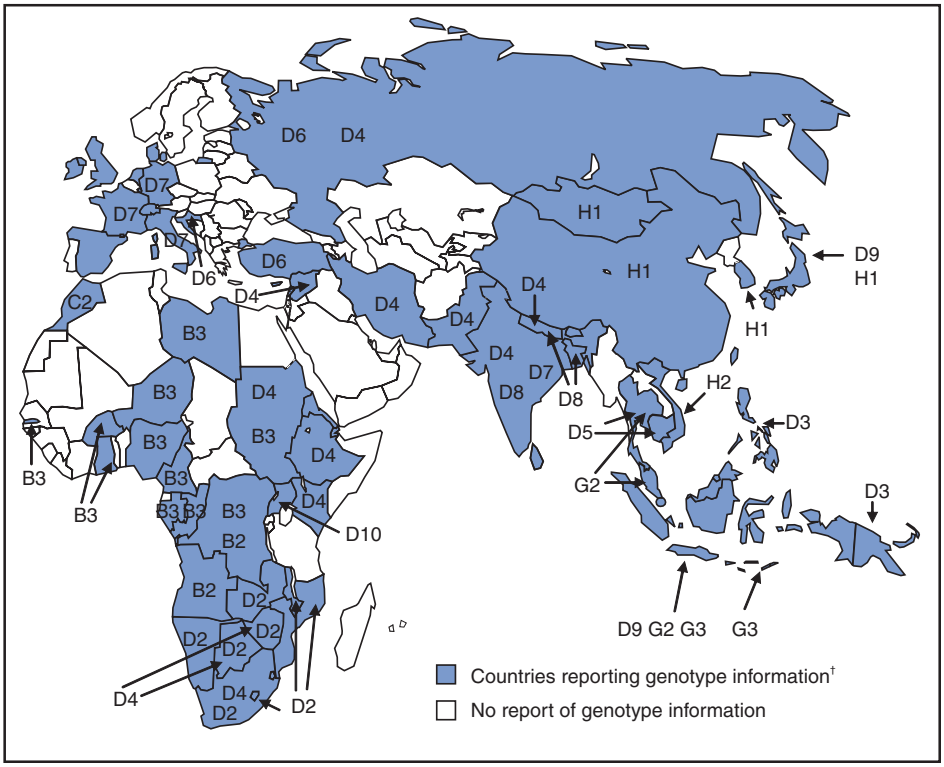
LabNet is active in developing new techniques to improve laboratory surveillance. Dried blood and oral fluid samples as an alternative to serum have been evaluated recently for measles and rubella testing. These sampling techniques might be useful when countries have difficulty in collecting venepuncture blood from infants or transporting samples under conditions of reverse cold chain to a testing laboratory. Good concordance of both oral fluid and dried blood samples with parallel serum samples was documented for measles using commercially available assays (WHO, unpublished data, 2005); however, limited data are available for rubella. IgM in dried blood and oral fluid is stable at (68°F [20°C]) for up to 1 week; however, additional data are needed regarding stability at higher temperatures.

Virus Characterization

Because molecular epidemiologic techniques provide an important tool for tracking viral transmission pathways, LabNet also supports genetic characterization of currently circulating strains of measles and rubella viruses. LabNet has standardized the nomenclature and laboratory procedures used to describe the genetic characteristics of wild-type measles (*3–6*) and rubella viruses (*7,8*); these protocols are included in all WHO-sponsored laboratory training courses. This standardization has allowed sharing of virologic surveillance data among laboratories and permitted efficient communication of these data throughout the measles and rubella control programs.

WHO currently recognizes 23 genotypes of measles virus. Although virologic surveillance for measles is still incomplete, a pattern for the global distribution of genotypes within disease-endemic regions is emerging (Figure 1). In countries

FIGURE 1. Geographic distribution of measles virus genotypes for regions that have not yet eliminated measles transmission,* 1995–2005



* The countries in the western hemisphere and Australia have eliminated measles and are not shown.
† In western Europe, genotype D7 was the most commonly reported genotype. Australia, Spain, the United Kingdom, and the countries of the western hemisphere have reported multiple genotypes attributed to importation.

* Annual accreditation requires meeting the following six criteria: 1) test results are reported on at least 80% of received samples within 7 days of receipt, 2) serologic/reverse-transcriptase polymerase chain reaction (RT-PCR) tests are performed on at least 100 specimens annually, 3) accuracy of diagnostic assays for measles and rubella IgM or RT-PCR identification is at least 90%, 4) internal quality control procedures for IgM assays are in place, 5) proficiency test score of at least 90% on WHO-distributed serum panel is achieved, and 6) the score from the annual onsite review of laboratory operating procedures and practices is at least 80%.

that have not yet interrupted measles transmission, the sequence analysis of measles isolates has revealed a limited geographic distribution of genotypes, whereas in countries that have eliminated measles, several genotypes have been detected in association with limited outbreaks, reflecting the various imported sources of these viruses.

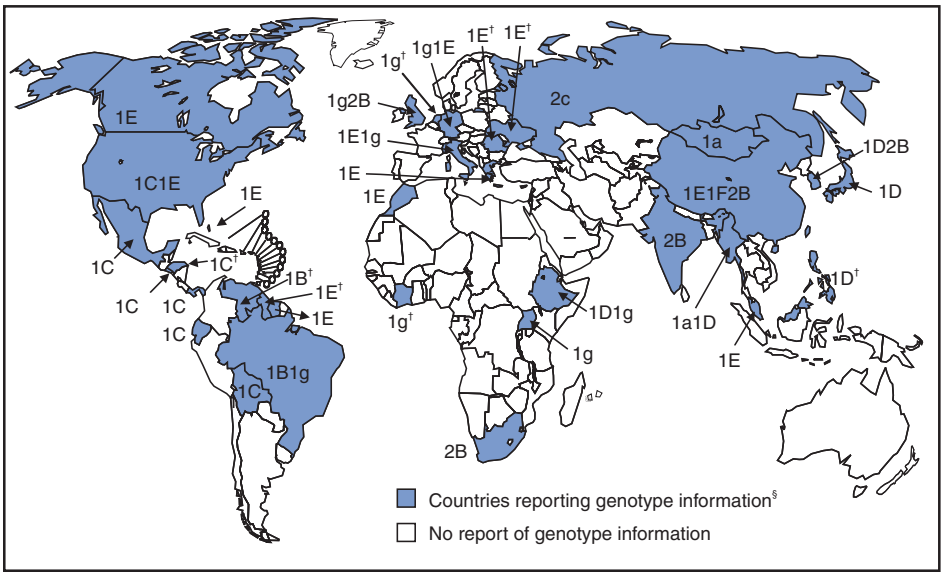
The systematic nomenclature for wild-type rubella viruses developed in 2004 and 2005 is an important advance in virologic surveillance for rubella. Seven genotypes and three additional provisional genotypes of rubella virus are recognized by WHO (Figure 2). These genotypes are classified into two clades (i.e., groups of similar genotypes), designated 1 and 2; clade 2 viruses have not been found circulating in the western hemisphere. Although knowledge concerning the geographic distribution of rubella genotypes has progressed substantially since 2003, the genotypes of rubella viruses present in many countries and regions remain unknown. LabNet encourages the collection and storage of viruses for genetic characterization.

Reported by: *PA Rota, PhD, JP Icenogle, PhD, JS Rota, MPH, WJ Bellini, PhD, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases, CDC.*

Editorial Note: Measles and rubella elimination and control programs depend on effective global surveillance. LabNet promotes case identification and confirmation, thus improving the quality of disease surveillance and furthering progress toward elimination of these diseases. The development of LabNet has progressed rapidly during the past 5 years. More than 190 national and regional reference laboratories have been equipped and trained to perform IgM ELISA procedures, and the number of measles serum samples tested in 2004 has increased 32% compared with 2003. Many countries have taken the opportunity to use this capability and expand their laboratory-based surveillance by testing for diseases endemic in their respective regions that have similar clinical features (e.g., dengue, parvovirus B19, and HHV-6) or where similar diagnostic assays might be used (e.g., yellow fever and Japanese encephalitis). Virologic surveillance data, when analyzed in conjunction with standard epidemiologic data, can help document viral transmission pathways and aid in case classification. If baseline information regarding circulating genotypes is available, molecular epidemiologic data can also help to document the elimination of endemic transmission and, therefore, provide a means to measure the effectiveness of control programs. Virologic surveillance has provided evidence of the interruption of endemic transmission of measles virus in the western hemisphere (*9*) and rubella virus in the United States (*10*). However, epidemiologic and molecular surveillance activities, coupled with active vaccination programs, must be continued as long as the threat of disease importation exists.

As new laboratories are established, surveillance improves, and laboratory workloads increase, important challenges remain in maintaining quality and meeting the resource needs of the measles and rubella LabNet. These challenges include identifying funding resources for laboratory supplies for measles and rubella testing and encouraging countries to integrate these costs into national surveillance budgets whenever possible. In addition, partners must pursue a means of 1) gaining access to data from laboratories in countries with extensive private laboratory structures for measles and/or rubella surveillance and 2) expanding the quality-assurance program for all laboratories within LabNet, including those at the subnational level.[†]

FIGURE 2. Geographic distribution of rubella virus genotypes — worldwide, 1995–2005*



* Genotype data represent a summary of information from several laboratories that was made available in July 2005.
† Viruses were characterized after importation into another country.
§ Certain countries reduced indigenous rubella to low levels or have eliminated it during this period (e.g., Canada, Cuba, the United Kingdom, and the United States).

Acknowledgments

This report is based on data contributed by the member laboratories of the WHO Global Measles and Rubella Laboratory

† In accordance with the consensus of the Third WHO Global Measles and Rubella Laboratory Network Meeting held in Geneva, Switzerland, on August 25–26, 2005. The meeting was attended by representatives from all the global specialized and regional reference laboratories in LabNet, laboratory coordinators from all six WHO regions, and key partners.

Network. PM Strebel, MBChB, DA Featherstone, Immunization, Vaccines, and Biologicals, WHO, Geneva, Switzerland. L Cairns, MD, V Dietz, MD, Global Measles Br, Global Immunization Div, National Immunization Program, CDC.

References

1. World Health Organization. Measles mortality reduction and regional elimination strategic plan 2001–2005. Geneva, Switzerland: World Health Organization; 2001. WHO/V&B/01/13.
2. Featherstone D, Brown D, Sanders R. Development of the Global Measles Laboratory Network. J Infect Dis 2003;187(Suppl 1):S264–9.
3. World Health Organization. Standardization of the nomenclature for describing the genetic characteristics of wild-type measles viruses. Wkly Epidemiol Rec 1998;73:265–9.
4. World Health Organization. Nomenclature for describing the genetic characteristics of wild-type measles viruses (update), part I. Wkly Epidemiol Rec 2001;76:241–7.
5. World Health Organization. Nomenclature for describing the genetic characteristics of wild-type measles viruses (update), part II. Wkly Epidemiol Rec 2001;76:249–51.
6. World Health Organization. New genotype of measles virus and update on global distribution of measles genotypes. Wkly Epidemiol Rec 2005;80:347–51.
7. World Health Organization. Standardization of the nomenclature for genetic characteristics of wild-type rubella viruses. Wkly Epidemiol Rec 2005;80:126–32.
8. World Health Organization. Rubella nomenclature meeting recommendations. Geneva, Switzerland: World Health Organization; 2004. Available at http://www.mayeticvillage.com/who-rubellagenotype. User name: rubella; password: rubella.
9. CDC. Progress toward measles elimination—Region of the Americas, 2002–2003. MMWR 2004;53:304–6.
10. CDC. Achievements in public health: elimination of rubella and congenital rubella syndrome—United States, 1969–2004. MMWR 2005; 54:279–82.

Update: *Ralstonia* Species Associated with Vapotherm Oxygen Delivery Devices — United States, 2005

This report updates information on *Ralstonia* species associated with Vapotherm™ oxygen delivery devices (Vapotherm Inc., Stevensville, Maryland) (*1*). CDC has obtained new information from a test developed by CDC and performed by The Children's Hospital of Philadelphia (Pennsylvania) to assess the efficacy of the new chlorine dioxide disinfection protocol recommended by Vapotherm. Although limited, this information suggests that the new protocol for disinfecting Vapotherm devices and cartridges might not achieve sustained bacterial control in certain situations. At this time, the optimal protocol to disinfect machines and cartridges that might contain very heavy biofilms is not known.

Before development of the new disinfection protocol in October 2005, certain institutions had reported no growth of *Ralstonia* spp. in samples obtained from machines and cartridges disinfected according to the previous protocol. In addition, in an experiment conducted by an independent laboratory contracted by Vapotherm, a laboratory-generated biofilm (consisting of a mix of organisms) was grown in a Vapotherm device and cartridge for 3 weeks. The device and cartridge were then subjected to the new chlorine dioxide disinfection protocol. Results from this trial revealed no growth during the 4 days after disinfection.

However, in a single trial designed by CDC and involving one machine, The Children's Hospital of Philadelphia subjected a Vapotherm device and used filter cartridge to the new chlorine dioxide disinfection protocol. The device and cartridge were known to be contaminated with *Ralstonia* spp., and the unit had been out of service and not disinfected for multiple weeks. Samples obtained immediately after disinfection grew no organisms. The trial was initially designed to run for 30 days; however, after 7 days of continuous operation of the unit with no patient contact, samples from both the vapor condensate and the filter cartridge grew *Ralstonia* spp. in culture at CDC.

Whether the presence of an unusually heavy biofilm in the machine and cartridge in the hospital experiment resulted in the failure to eradicate *Ralstonia* spp. is unknown. Similarly, the impact of testing a laboratory-generated biofilm instead of a use-generated biofilm is not known. The varying results achieved with the new disinfection protocol might indicate that its efficacy depends on the maturity of any biofilm contained within Vapotherm machines or cartridges.

Testing is being conducted by a private laboratory and CDC to further assess the efficacy of and possible improvements to the new disinfection protocol; CDC continues to search for the source of *Ralstonia* spp. contamination in Vapotherm devices. Clinicians should continue to weigh the potential risks for *Ralstonia* spp. contamination of Vapotherm devices against the benefits of using the device in patients requiring humidified oxygen therapy.

Clinicians are encouraged to report findings of *Ralstonia* spp. in patients using any Vapotherm 2000 respiratory gas administration device directly to the device manufacturer, local or state health departments, or CDC by telephone, 800-893-0485. Cases or any other adverse events related to medical devices should be reported to MedWatch, the Food and Drug Administration's voluntary reporting program online at http://www.accessdata.fda.gov/scripts/medwatch; by telephone, 800-FDA-1088; by fax, 800-FDA-0178; or by mail, MedWatch, Food and Drug Administration, HF-2, 5600 Fishers Lane, Rockville, MD 20857.

Reported by: *The Children's Hospital of Philadelphia, Pennsylvania. Div of Healthcare Quality Promotion, National Center for Infectious Diseases, CDC.*

Reference

1. CDC. *Ralstonia* associated with Vapotherm oxygen delivery device—United States, 2005. MMWR 2005;54:1052–3.

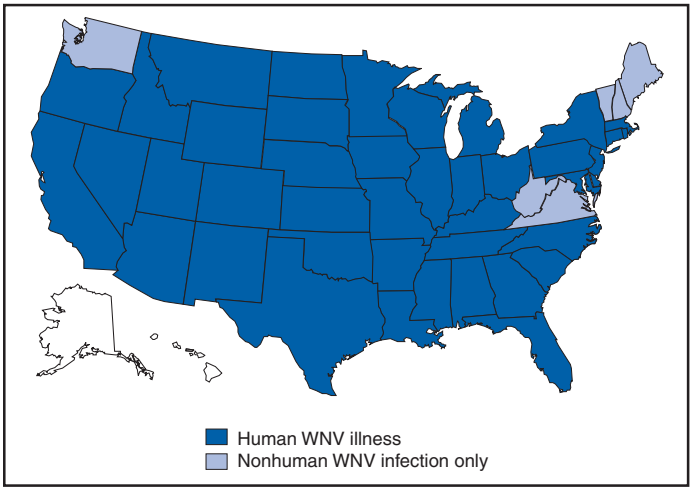
Update: West Nile Virus Activity — United States, 2005

This report summarizes West Nile virus (WNV) surveillance data reported to CDC through ArboNET as of 3 a.m. Mountain Standard Time, November 1, 2005.

Forty-two states have reported 2,581 cases of human WNV illness in 2005 (Figure and Table 1). By comparison, a total of 2,241 WNV cases had been reported as of November 2, 2004 (Table 2). A total of 1,359 (56%) of the 2,419 cases for which such data were available in 2005 occurred in males; the median age of patients was 51 years (range: 3 months–98 years). Dates of illness onset ranged from January 2 to October 21; a total of 83 cases were fatal.

A total of 374 presumptive West Nile viremic blood donors (PVDs) have been reported to ArboNET during 2005. Of these, 87 were reported from California; 57 from Texas; 53 from Nebraska; 22 from Louisiana; 20 from Arizona; 19 from Kansas; 17 from Iowa; 16 from South Dakota; 13 from Oklahoma; 11 from Minnesota; 10 from Illinois; five each from Michigan, New Mexico, and North Dakota; four each from Alabama, Pennsylvania, and Utah; three each from Nevada and Wisconsin; two each from Colorado, Indiana, Mississippi, Montana, and Ohio; and one each from Idaho, Kentucky,

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



* As of November 1, 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	6	3	0	**9**	2
Arizona	41	42	19	**102**	4
Arkansas	8	13	0	**21**	0
California	269	476	79	**824**	18
Colorado	19	72	0	**91**	2
Connecticut	4	2	0	**6**	1
Delaware	1	0	0	2	0
Florida	8	13	0	**21**	1
Georgia	7	6	5	**17**	1
Idaho	2	7	4	**13**	0
Illinois	130	86	25	**241**	8
Indiana	10	1	11	**22**	1
Iowa	12	18	6	**36**	2
Kansas	8	4	0	**12**	1
Kentucky	4	0	0	**4**	1
Louisiana	78	33	0	**111**	6
Maryland	4	1	0	**5**	0
Massachusetts	4	1	0	**5**	0
Michigan	34	4	10	**48**	4
Minnesota	17	26	0	**43**	3
Mississippi	39	31	0	**70**	6
Missouri	13	12	0	**25**	1
Montana	8	17	0	**25**	0
Nebraska	26	64	0	**90**	1
Nevada	13	15	2	**30**	0
New Jersey	2	2	0	**4**	0
New Mexico	18	13	0	**31**	2
New York	10	4	0	**14**	1
North Carolina	2	1	0	**3**	0
North Dakota	12	74	0	**86**	0
Ohio	44	12	0	**56**	1
Oklahoma	9	7	0	**16**	0
Oregon	0	5	0	**5**	0
Pennsylvania	14	11	0	**25**	0
Rhode Island	1	0	0	**1**	0
South Carolina	4	0	0	**4**	1
South Dakota	35	196	4	**235**	2
Tennessee	12	1	0	**13**	1
Texas	92	47	0	**139**	9
Utah	21	30	0	**51**	1
Wisconsin	8	6	0	**14**	1
Wyoming	4	7	0	**11**	1
Total	**1,053**	**1,363**	**165**	**2,581**	**83**

* As of November 1, 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*	3,419	180
2003†	7,718	166
2004§	2,241	76
2005¶	2,581	83

* As of October 30, 2002.
† As of October 29, 2003.
§ As of November 2, 2004.
¶ As of November 1, 2005.

Missouri, New York, North Carolina, and Oregon. Of the 374 PVDs, three persons aged 53, 56, and 72 years subsequently had neuroinvasive illness; seven persons (median age: 41 years [range: 17–64 years]) subsequently had other illnesses; and 82 persons (median age: 46 years [range: 17–78 years]) subsequently had West Nile fever.

In addition, 4,179 dead corvids and 892 other dead birds with WNV infection have been reported from 45 states. WNV infections have been reported in horses in 34 states; five dogs in Idaho, Minnesota, and Nebraska; six squirrels in Arizona; and five unidentified animal species in four states (Arizona, Illinois, North Carolina, and Texas). WNV seroconversions have been reported in 1,365 sentinel chicken flocks from 16 states. Eight seropositive sentinel birds have been reported in Michigan. One seropositive sentinel horse was reported in Minnesota. A total of 11,061 WNV-positive mosquito pools have been reported from 43 states and the District of Columbia.

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.

Notice to Readers

Availability of Maxi-Vac Alternative

Maxi-Vac Alternative, a public use software program, is now available. Maxi-Vac Alternative was developed by CDC to help public health officials plan smallpox vaccination clinics in the event of a bioterrorist attack. Maxi-Vac Alternative allows planners to refine human resource allocations (e.g., physicians and nurses) at clinics, with the goal of maximizing patient flow-through. Maxi-Vac Alternative is a companion program to Maxi-Vac 1.0, which was released in 2003. The two programs differ in terms of the time patients will require at each station (e.g., pre-vaccination screening and vaccination) and the selections the user can make for number of personnel, size of patient pre-vaccination orientation rooms, and the need for vaccination witnesses. Because no one scenario can describe all contingencies of an emergency mass smallpox vaccination campaign, users should examine both versions before deciding which version to use.

Both Maxi-Vac Alternative and Maxi-Vac 1.0 and their manuals can be downloaded from http://www.bt.cdc.gov/agent/smallpox/vaccination/maxi-vac. Both programs and manuals are in the public domain and may be used and copied without permission; however, citation as to source (provided in the manuals and in online help functions) is appreciated.

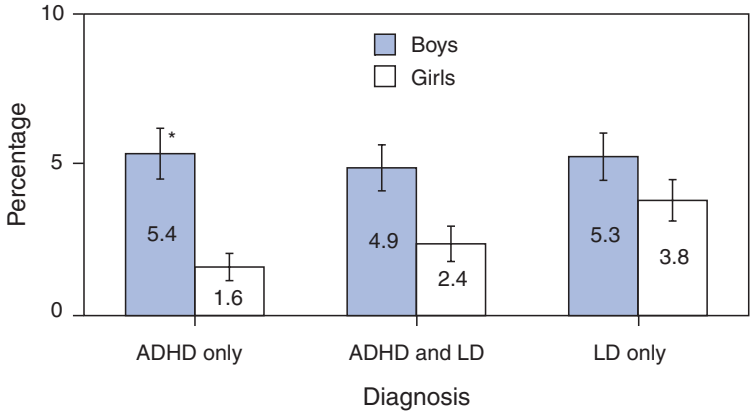
Erratum: Vol. 54, No. 40

In the *Recommended Adult Immunization Schedule — United States, October 2005–September 2006*, on page Q4, an error occurred in the first sentence under footnote 10, "Selected conditions for which *Haemophilus influenzae* type b (Hib) vaccine may be used." The sentence should read as follows: "Hib conjugate vaccines are licensed for children aged **6 weeks**–71 months."

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Children Aged 5–17 Years Ever Having Diagnoses of Attention Deficit/Hyperactivity Disorder (ADHD) or Learning Disability (LD), by Sex and Diagnosis — United States, 2003

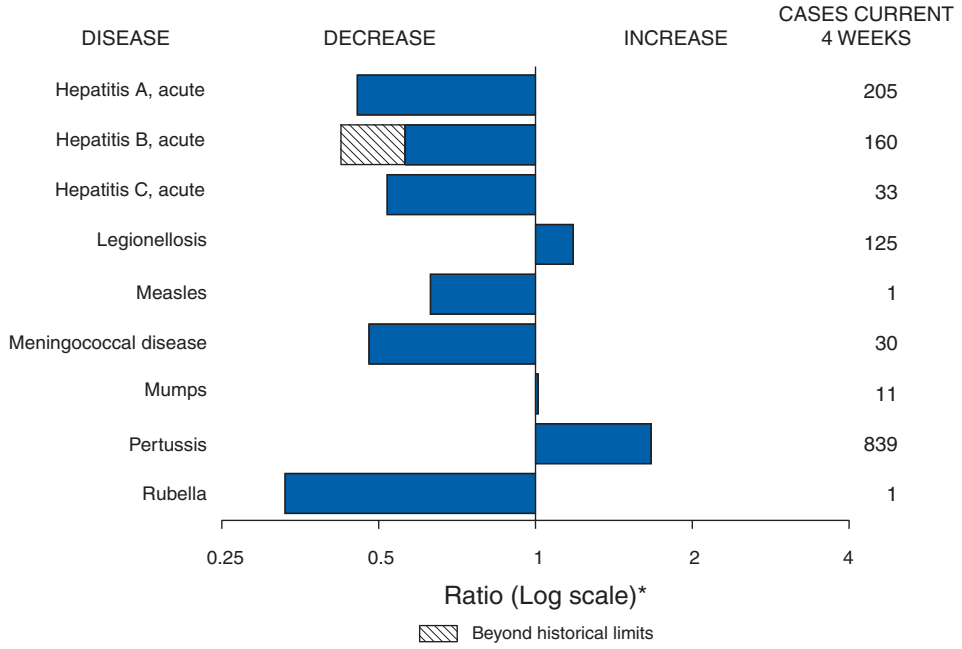


* 95% confidence interval.

In 2003, approximately 16% of boys and 8% of girls aged 5–17 years had ever had diagnoses of ADHD or LD, according to parental reports. Boys were three times more likely than girls to have diagnoses of ADHD without LD. Boys were also more likely than girls to have LD diagnosed, either with or without ADHD.

SOURCE: National Health Interview Survey, 2003. Available at http://www.cdc.gov/nchs/nhis.htm.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals October 29, 2005, with historical data



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

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending October 29, 2005 (43rd Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	146	143
Botulism:			HIV infection, pediatric†¶	181	322
foodborne	12	8	Influenza-associated pediatric mortality†**	44	—
infant	67	71	Measles	61††	25§§
other (wound & unspecified)	22	14	Mumps	229	182
Brucellosis	84	80	Plague	3	2
Chancroid	24	21	Poliomyelitis, paralytic	1	—
Cholera	4	4	Psittacosis†	19	11
Cyclosporiasis†	705	198	Q fever†	120	55
Diphtheria	—	—	Rabies, human	2	6
Domestic arboviral diseases			Rubella	14	9
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	1	—
California serogroup†§	46	115	SARS†**	—	—
eastern equine†§	20	4	Smallpox†	—	—
Powassan†§	—	1	*Staphylococcus aureus*:		
St. Louis†§	7	13	Vancomycin-intermediate (VISA)†	—	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	—	1
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome†	95	115
human granulocytic (HGE)†	463	346	Tetanus	17	19
human monocytic (HME)†	375	260	Toxic-shock syndrome	82	75
human, other and unspecified †	67	63	Trichinellosis¶¶	15	2
Hansen disease†	63	84	Tularemia†	126	93
Hantavirus pulmonary syndrome†	19	19	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 61 cases reported, 51 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 October 29, 2005, and October 30, 2004 (43rd 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	34,502	753,433	761,851	3,774	4,864	6,061	3,067
NEW ENGLAND	778	1,129	25,775	25,080	—	—	291	158
Maine	11	23	1,845	1,717	N	N	24	18
N.H.	20	39	1,530	1,442	—	—	30	29
Vt.¶	4	14	779	939	—	—	35	23
Mass.	368	425	11,475	11,036	—	—	118	57
R.I.	68	114	2,732	2,832	—	—	11	4
Conn.	307	514	7,414	7,114	N	N	73	27
MID. ATLANTIC	4,352	7,360	95,943	92,944	—	—	2,627	493
Upstate N.Y.	800	837	19,012	18,845	N	N	2,251	152
N.Y. City	2,327	4,039	30,639	28,513	—	—	103	118
N.J.	574	1,229	15,344	14,695	N	N	48	41
Pa.	651	1,255	30,948	30,891	N	N	225	182
E.N. CENTRAL	1,938	2,816	122,268	134,636	8	13	1,321	931
Ohio	312	540	32,532	32,738	N	N	711	198
Ind.	236	326	16,371	15,435	N	N	64	69
Ill.	983	1,274	36,987	39,492	—	—	128	144
Mich.	322	535	21,007	31,118	8	13	89	133
Wis.	85	141	15,371	15,853	N	N	329	387
W.N. CENTRAL	463	710	46,843	47,064	5	6	523	348
Minn.	123	190	9,157	9,797	3	N	122	118
Iowa	50	57	5,882	5,771	N	N	101	72
Mo.	198	296	18,477	17,382	1	3	236	63
N. Dak.	5	15	995	1,518	N	N	1	10
S. Dak.	10	8	2,305	2,096	—	—	24	33
Nebr.¶	18	44	4,260	4,294	1	3	7	26
Kans.	59	100	5,767	6,206	N	N	32	26
S. ATLANTIC	6,473	10,881	144,948	143,941	1	—	575	459
Del.	100	131	2,824	2,436	N	N	3	—
Md.	812	1,292	15,288	15,744	1	—	33	19
D.C.	467	785	3,085	2,953	—	—	10	14
Va.¶	307	565	17,354	18,549	—	—	57	53
W. Va.	36	71	2,226	2,320	N	N	13	6
N.C.	531	1,014	26,211	24,286	N	N	70	70
S.C.¶	386	640	17,428	15,860	—	—	15	21
Ga.	1,103	1,375	25,246	26,934	—	—	98	161
Fla.	2,731	5,008	35,286	34,859	N	N	276	115
E.S. CENTRAL	1,093	1,646	56,749	49,828	—	5	186	124
Ky.	135	212	7,321	4,728	N	N	129	39
Tenn.¶	434	684	19,816	18,498	N	N	36	36
Ala.¶	295	381	12,347	11,281	—	—	17	21
Miss.	229	369	17,265	15,321	—	5	4	28
W.S. CENTRAL	2,206	4,000	86,520	92,834	1	3	168	115
Ark.	72	183	7,248	6,651	—	1	4	13
La.	436	799	12,572	18,586	1	2	73	3
Okla.	167	169	9,236	9,108	N	N	39	21
Tex.¶	1,531	2,849	57,464	58,489	N	N	52	78
MOUNTAIN	789	1,233	43,334	46,462	2,645	3,038	108	148
Mont.	4	5	1,709	2,101	N	N	16	34
Idaho¶	9	17	1,826	2,277	N	N	11	24
Wyo.	2	14	953	872	3	2	3	3
Colo.	163	278	11,322	11,855	N	N	40	50
N. Mex.	72	164	4,394	7,442	13	20	4	16
Ariz.	329	454	14,414	13,490	2,592	2,943	10	15
Utah	33	53	3,609	3,088	5	21	15	4
Nev.¶	177	248	5,107	5,337	32	52	9	2
PACIFIC	2,313	4,727	131,053	129,062	1,114	1,799	262	291
Wash.	229	348	15,402	14,553	N	N	43	33
Oreg.¶	136	249	6,327	6,963	—	—	61	29
Calif.	1,874	3,981	103,342	99,867	1,114	1,799	154	227
Alaska	14	43	3,273	3,178	—	—	3	—
Hawaii	60	106	2,709	4,501	—	—	1	2
Guam	1	1	—	803	—	—	—	—
P.R.	537	614	3,193	2,809	N	N	N	N
V.I.	10	18	119	290	—	—	—	—
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 October 29, 2005, and October 30, 2004 (43rd 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	1,976	2,140	284	248	272	157	14,823	16,161	259,801	270,274
NEW ENGLAND	142	138	46	41	28	14	1,374	1,517	4,649	5,788
Maine	14	14	11	—	—	—	180	126	116	183
N.H.	12	18	2	5	—	—	44	37	140	106
Vt.	13	12	3	—	—	—	161	149	47	73
Mass.	55	57	6	13	28	14	581	669	2,030	2,608
R.I.	7	9	—	1	—	—	105	107	365	708
Conn.	41	28	24	22	—	—	303	429	1,951	2,110
MID. ATLANTIC	262	247	31	54	27	34	2,748	3,365	27,845	30,089
Upstate N.Y.	115	109	16	35	10	17	1,007	1,122	5,646	6,195
N.Y. City	13	35	—	—	—	—	682	925	8,291	9,187
N.J.	47	41	3	6	8	6	342	439	4,667	5,596
Pa.	87	62	12	13	9	11	717	879	9,241	9,111
E.N. CENTRAL	392	416	25	44	15	28	2,356	2,690	49,794	57,306
Ohio	123	84	11	9	8	17	675	677	15,217	17,150
Ind.	56	47	—	—	—	—	N	N	6,505	5,667
Ill.	45	92	1	7	1	7	507	689	14,990	17,231
Mich.	70	75	1	10	6	4	643	592	8,665	13,122
Wis.	98	118	12	18	—	—	531	732	4,417	4,136
W.N. CENTRAL	356	440	28	32	57	20	1,776	1,723	15,043	14,269
Minn.	120	102	11	13	38	4	810	619	2,606	2,434
Iowa	72	113	—	—	—	—	228	249	1,307	1,036
Mo.	75	84	11	15	8	6	405	472	7,765	7,461
N. Dak.	6	13	—	—	1	6	12	20	69	96
S. Dak.	23	31	3	—	—	—	85	50	298	234
Nebr.	23	61	3	4	4	—	81	124	954	898
Kans.	37	36	—	—	6	4	155	189	2,044	2,110
S. ATLANTIC	176	152	75	29	102	42	2,142	2,467	63,309	65,365
Del.	7	3	N	N	N	N	46	42	731	742
Md.	31	21	28	5	9	3	163	114	5,798	6,754
D.C.	—	1	—	—	—	—	42	62	1,739	2,196
Va.	37	33	25	15	20	—	460	438	6,339	7,403
W. Va.	1	2	—	—	1	—	35	34	623	762
N.C.	—	—	—	—	56	32	N	N	12,575	12,778
S.C.	6	12	—	—	1	—	83	102	7,688	7,859
Ga.	28	19	18	6	—	—	496	748	11,620	11,879
Fla.	66	61	4	3	15	7	817	927	16,196	14,992
E.S. CENTRAL	115	89	8	5	26	15	354	351	22,701	21,948
Ky.	39	24	5	1	16	9	N	N	2,528	2,156
Tenn.	41	36	2	2	10	6	181	187	7,309	6,997
Ala.	28	18	—	—	—	—	173	164	7,134	6,870
Miss.	7	11	1	2	—	—	—	—	5,730	5,925
W.S. CENTRAL	44	75	13	3	8	4	271	275	34,786	36,171
Ark.	7	15	—	—	—	—	72	107	3,792	3,518
La.	3	4	11	1	3	—	48	43	6,950	8,734
Okla.	21	17	1	—	1	—	151	125	3,666	3,875
Tex.	13	39	1	2	4	4	N	N	20,378	20,044
MOUNTAIN	188	216	52	39	9	—	1,182	1,269	9,298	9,878
Mont.	14	16	—	—	—	—	62	68	97	69
Idaho	20	49	11	12	6	—	79	163	76	79
Wyo.	6	8	2	3	—	—	21	21	64	54
Colo.	60	49	3	1	1	—	447	438	2,485	2,506
N. Mex.	10	10	9	5	—	—	62	61	864	1,025
Ariz.	32	19	N	N	N	N	129	139	3,171	3,235
Utah	36	42	25	17	—	—	333	274	580	480
Nev.	10	23	2	1	2	—	49	105	1,961	2,430
PACIFIC	301	367	6	1	—	—	2,620	2,504	32,376	29,460
Wash.	96	125	—	—	—	—	299	309	3,015	2,246
Oreg.	69	65	6	1	—	—	333	386	1,094	1,043
Calif.	114	166	—	—	—	—	1,845	1,659	27,320	24,652
Alaska	12	1	—	—	—	—	90	81	453	480
Hawaii	10	10	—	—	—	—	53	69	494	1,039
Guam	N	N	—	—	—	—	—	2	—	125
P.R.	2	1	—	—	—	—	145	252	290	204
V.I.	—	—	—	—	—	—	—	—	35	81
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 October 29, 2005, and October 30, 2004 (43rd 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	1,731	1,646	4	11	92	103	151	153
NEW ENGLAND	138	151	—	1	10	9	3	1
Maine	6	12	—	—	—	—	1	—
N.H.	8	16	—	—	—	2	—	—
Vt.	9	7	—	—	—	—	—	1
Mass.	65	71	—	1	3	4	1	—
R.I.	7	3	—	—	2	—	—	—
Conn.	43	42	—	—	5	3	1	—
MID. ATLANTIC	358	339	—	1	—	4	38	36
Upstate N.Y.	103	108	—	1	—	4	8	5
N.Y. City	63	75	—	—	—	—	10	15
N.J.	75	64	—	—	—	—	10	3
Pa.	117	92	—	—	—	—	10	13
E.N. CENTRAL	241	309	1	—	4	8	15	46
Ohio	96	85	—	—	—	2	6	15
Ind.	55	42	—	—	4	4	—	1
Ill.	49	110	—	—	—	—	6	21
Mich.	18	18	1	—	—	2	2	4
Wis.	23	54	—	—	—	—	1	5
W.N. CENTRAL	95	92	—	2	3	3	8	11
Minn.	38	40	—	1	3	3	2	1
Iowa	1	1	—	1	—	—	—	—
Mo.	32	36	—	—	—	—	5	7
N. Dak.	2	4	—	—	—	—	1	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	9	5	—	—	—	—	—	2
Kans.	13	6	—	—	—	—	—	1
S. ATLANTIC	404	370	1	1	25	24	22	25
Del.	—	—	—	—	—	—	—	—
Md.	59	55	—	—	5	5	—	—
D.C.	—	3	—	—	—	—	—	1
Va.	39	38	—	—	—	—	—	5
W. Va.	24	16	—	—	1	4	5	—
N.C.	68	52	1	1	8	6	—	1
S.C.	23	12	—	—	—	—	—	1
Ga.	81	95	—	—	—	—	11	16
Fla.	110	99	—	—	11	9	6	1
E.S. CENTRAL	98	63	—	1	1	1	6	8
Ky.	8	7	—	—	1	1	2	—
Tenn.	72	41	—	—	—	—	—	6
Ala.	18	13	—	1	—	—	4	2
Miss.	—	2	—	—	—	—	—	—
W.S. CENTRAL	91	63	1	1	8	8	7	1
Ark.	5	2	—	—	1	1	—	—
La.	30	13	1	—	2	—	7	1
Okla.	54	47	—	—	5	7	—	—
Tex.	2	1	—	1	—	—	—	—
MOUNTAIN	193	167	—	4	14	25	38	18
Mont.	—	—	—	—	—	—	—	—
Idaho	3	5	—	—	—	—	1	2
Wyo.	6	1	—	—	—	1	1	—
Colo.	39	41	—	—	1	—	9	5
N. Mex.	18	37	—	1	4	8	2	6
Ariz.	97	58	—	—	7	11	15	2
Utah	16	13	—	2	—	2	7	2
Nev.	14	12	—	1	2	3	3	1
PACIFIC	113	92	1	—	27	21	14	7
Wash.	3	1	—	—	—	—	2	1
Oreg.	29	40	—	—	—	—	5	3
Calif.	48	38	1	—	27	21	2	1
Alaska	25	5	—	—	—	—	5	1
Hawaii	8	8	—	—	—	—	—	1
Guam	—	—	—	—	—	—	—	—
P.R.	3	2	—	—	—	—	1	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 October 29, 2005, and October 30, 2004 (43rd 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	3,399	4,931	4,539	4,853	584	670
NEW ENGLAND	448	852	236	320	15	15
Maine	3	12	16	4	—	—
N.H.	74	19	21	30	—	—
Vt.	6	8	5	5	12	7
Mass.	305	727	163	177	—	7
R.I.	14	21	3	5	—	—
Conn.	46	65	28	99	3	1
MID. ATLANTIC	576	674	887	637	88	126
Upstate N.Y.	91	91	78	71	17	11
N.Y. City	257	283	100	129	—	—
N.J.	144	162	531	184	—	—
Pa.	84	138	178	253	71	115
E.N. CENTRAL	319	425	419	461	111	93
Ohio	46	40	112	98	7	5
Ind.	45	52	42	39	23	7
Ill.	78	135	94	71	—	13
Mich.	121	126	140	218	81	68
Wis.	29	72	31	35	—	—
W.N. CENTRAL	79	134	228	277	30	20
Minn.	3	32	29	42	5	17
Iowa	20	39	19	14	—	—
Mo.	37	28	132	166	23	3
N. Dak.	—	1	—	4	1	—
S. Dak.	—	3	3	1	—	—
Nebr.	4	12	21	36	1	—
Kans.	15	19	24	14	—	—
S. ATLANTIC	596	884	1,138	1,508	122	166
Del.	4	6	43	45	7	29
Md.	64	93	132	134	20	3
D.C.	4	7	10	19	—	4
Va.	70	108	122	215	11	13
W. Va.	5	5	32	35	19	22
N.C.	71	93	138	138	18	11
S.C.	32	39	120	118	2	15
Ga.	98	292	133	388	7	14
Fla.	248	241	408	416	38	55
E.S. CENTRAL	221	138	292	406	73	78
Ky.	24	29	55	60	9	23
Tenn.	143	87	116	188	15	28
Ala.	35	8	68	64	14	4
Miss.	19	14	53	94	35	23
W.S. CENTRAL	236	585	422	324	68	93
Ark.	12	60	43	99	1	2
La.	59	44	58	57	11	3
Okla.	4	19	33	57	6	3
Tex.	161	462	288	111	50	85
MOUNTAIN	296	362	459	380	38	38
Mont.	7	6	3	1	1	2
Idaho	17	17	12	10	1	1
Wyo.	—	5	1	7	—	2
Colo.	35	43	50	53	19	11
N. Mex.	22	22	9	16	—	U
Ariz.	186	218	317	191	—	5
Utah	19	35	39	35	8	4
Nev.	10	16	28	67	9	13
PACIFIC	628	877	458	540	39	41
Wash.	40	53	57	45	U	U
Oreg.	38	60	87	96	15	15
Calif.	525	738	302	380	23	25
Alaska	4	4	7	10	—	—
Hawaii	21	22	5	9	1	1
Guam	—	1	—	12	—	9
P.R.	55	38	36	67	—	—
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 October 29, 2005, and October 30, 2004 (43rd 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	1,580	1,684	644	606	17,617	15,904	1,032	1,201
NEW ENGLAND	100	80	47	42	2,101	2,859	59	83
Maine	6	1	3	8	182	29	4	7
N.H.	8	10	6	3	173	179	5	5
Vt.	7	5	2	2	40	46	1	4
Mass.	35	35	12	13	947	1,422	31	49
R.I.	19	14	6	1	32	187	2	4
Conn.	25	15	18	15	727	996	16	14
MID. ATLANTIC	563	474	171	146	11,261	9,696	280	320
Upstate N.Y.	153	96	53	42	3,347	3,375	44	40
N.Y. City	77	63	32	25	—	328	143	174
N.J.	88	79	33	30	3,118	2,444	62	65
Pa.	245	236	53	49	4,796	3,549	31	41
E.N. CENTRAL	300	414	63	104	1,315	1,259	83	106
Ohio	161	194	28	37	66	47	24	26
Ind.	16	41	4	16	24	24	1	13
Ill.	15	42	1	22	—	87	28	38
Mich.	90	118	23	24	49	26	19	17
Wis.	18	19	7	5	1,176	1,075	11	12
W.N. CENTRAL	69	50	34	15	801	471	40	63
Minn.	16	7	10	4	698	388	11	24
Iowa	5	5	8	2	77	47	8	4
Mo.	27	23	4	5	21	24	16	19
N. Dak.	2	2	4	—	—	—	—	3
S. Dak.	16	4	—	1	1	1	—	1
Nebr.	1	3	4	3	2	8	1	4
Kans.	2	6	4	—	2	3	4	8
S. ATLANTIC	314	337	130	103	1,919	1,427	248	288
Del.	14	13	N	N	564	287	3	6
Md.	88	73	18	14	985	772	92	66
D.C.	9	10	—	5	8	11	8	11
Va.	36	40	14	16	198	149	26	42
W. Va.	15	10	4	4	16	26	1	2
N.C.	24	29	26	21	44	105	28	18
S.C.	11	11	9	10	19	22	7	10
Ga.	22	38	20	14	5	12	38	58
Fla.	95	113	39	19	80	43	45	75
E.S. CENTRAL	66	89	28	22	33	40	26	30
Ky.	23	35	4	4	5	15	9	4
Tenn.	28	39	12	11	27	20	13	10
Ala.	12	12	8	5	1	5	4	11
Miss.	3	3	4	2	—	—	—	5
W.S. CENTRAL	25	120	27	35	56	60	78	120
Ark.	4	1	2	3	4	8	6	8
La.	1	7	8	3	4	2	2	6
Okla.	7	5	3	—	—	—	9	7
Tex.	13	107	14	29	48	50	61	99
MOUNTAIN	78	68	16	23	21	17	47	46
Mont.	5	2	—	—	—	—	—	—
Idaho	3	7	—	1	2	6	—	1
Wyo.	4	5	—	—	3	3	2	—
Colo.	21	18	7	12	3	—	23	18
N. Mex.	2	4	4	1	1	1	2	4
Ariz.	22	11	—	—	8	6	10	11
Utah	13	17	3	1	2	1	8	7
Nev.	8	4	2	8	2	—	2	5
PACIFIC	65	52	128	116	110	75	171	145
Wash.	—	9	9	9	7	12	13	15
Oreg.	N	N	10	6	17	25	9	16
Calif.	63	43	108	97	83	36	130	109
Alaska	—	—	—	—	3	2	5	1
Hawaii	2	—	1	4	N	N	14	4
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	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 October 29, 2005, and October 30, 2004 (43rd 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	963	1,008	75	78	48	39	—	1	840	890
NEW ENGLAND	65	61	1	6	—	6	—	1	64	48
Maine	2	10	—	—	—	1	—	—	2	9
N.H.	12	5	—	—	—	—	—	—	12	5
Vt.	6	3	—	—	—	—	—	—	6	3
Mass.	30	34	—	5	—	5	—	—	30	24
R.I.	3	2	—	1	—	—	—	—	3	1
Conn.	12	7	1	—	—	—	—	1	11	6
MID. ATLANTIC	126	137	34	37	7	5	—	—	85	95
Upstate N.Y.	33	34	4	5	4	3	—	—	25	26
N.Y. City	18	24	—	—	—	—	—	—	18	24
N.J.	32	30	—	—	—	—	—	—	32	30
Pa.	43	49	30	32	3	2	—	—	10	15
E.N. CENTRAL	102	113	27	26	10	6	—	—	65	81
Ohio	34	57	—	4	6	5	—	—	28	48
Ind.	18	17	—	1	4	1	—	—	14	15
Ill.	13	1	—	—	—	—	—	—	13	1
Mich.	27	21	27	21	—	—	—	—	—	—
Wis.	10	17	—	—	—	—	—	—	10	17
W.N. CENTRAL	63	69	3	—	1	4	—	—	59	65
Minn.	13	22	1	—	—	—	—	—	12	22
Iowa	15	15	—	—	1	2	—	—	14	13
Mo.	21	17	1	—	—	1	—	—	20	16
N. Dak.	—	2	—	—	—	—	—	—	—	2
S. Dak.	3	2	1	—	—	1	—	—	2	1
Nebr.	4	4	—	—	—	—	—	—	4	4
Kans.	7	7	—	—	—	—	—	—	7	7
S. ATLANTIC	186	194	5	2	9	3	—	—	172	189
Del.	4	5	—	—	—	—	—	—	4	5
Md.	19	10	2	—	2	—	—	—	15	10
D.C.	—	5	—	2	—	—	—	—	—	3
Va.	28	18	—	—	—	—	—	—	28	18
W. Va.	6	5	1	—	—	—	—	—	5	5
N.C.	28	27	2	—	7	3	—	—	19	24
S.C.	14	14	—	—	—	—	—	—	14	14
Ga.	15	13	—	—	—	—	—	—	15	13
Fla.	72	97	—	—	—	—	—	—	72	97
E.S. CENTRAL	50	55	1	1	3	1	—	—	46	53
Ky.	16	9	—	1	3	1	—	—	13	7
Tenn.	23	19	—	—	—	—	—	—	23	19
Ala.	6	14	1	—	—	—	—	—	5	14
Miss.	5	13	—	—	—	—	—	—	5	13
W.S. CENTRAL	83	59	1	2	5	2	—	—	77	55
Ark.	13	15	—	—	—	1	—	—	13	14
La.	26	31	—	1	2	—	—	—	24	30
Okla.	13	9	1	1	3	1	—	—	9	7
Tex.	31	4	—	—	—	—	—	—	31	4
MOUNTAIN	77	57	2	1	6	5	—	—	69	51
Mont.	—	3	—	—	—	—	—	—	—	3
Idaho	3	7	—	—	—	—	—	—	3	7
Wyo.	—	4	—	—	—	—	—	—	—	4
Colo.	17	13	1	—	1	—	—	—	15	13
N. Mex.	3	7	—	1	—	3	—	—	3	3
Ariz.	36	11	—	—	2	1	—	—	34	10
Utah	10	5	1	—	2	—	—	—	7	5
Nev.	8	7	—	—	1	1	—	—	7	6
PACIFIC	211	263	1	3	7	7	—	—	203	253
Wash.	41	27	1	3	4	7	—	—	36	17
Oreg.	28	50	—	—	—	—	—	—	28	50
Calif.	128	175	—	—	—	—	—	—	128	175
Alaska	3	4	—	—	—	—	—	—	3	4
Hawaii	11	7	—	—	3	—	—	—	8	7
Guam	—	1	—	—	—	—	—	—	—	1
P.R.	6	13	—	—	—	—	—	—	6	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 October 29, 2005, and October 30, 2004 (43rd 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	16,539	16,748	4,600	5,580	1,447	1,310	34,292	35,080	11,185	11,170
NEW ENGLAND	957	1,560	602	580	3	17	1,815	1,787	252	261
Maine	27	8	48	49	N	N	133	93	9	7
N.H.	58	71	12	26	1	—	144	123	7	8
Vt.	79	65	52	33	—	—	92	54	16	2
Mass.	727	1,332	295	244	1	13	949	1,019	157	166
R.I.	29	31	20	38	1	1	82	107	14	18
Conn.	37	53	175	190	—	3	415	391	49	60
MID. ATLANTIC	1,102	2,410	817	843	94	68	4,162	4,908	1,073	1,030
Upstate N.Y.	437	1,689	473	464	5	1	1,080	1,051	237	377
N.Y. City	76	175	27	11	7	21	952	1,120	345	350
N.J.	175	163	N	N	29	14	721	944	268	212
Pa.	414	383	317	368	53	32	1,409	1,793	223	91
E.N. CENTRAL	2,909	6,405	191	171	35	33	4,485	4,418	793	1,020
Ohio	965	485	67	69	25	9	1,163	1,059	92	145
Ind.	257	170	11	10	2	6	518	420	134	180
Ill.	558	1,162	50	47	1	14	1,323	1,418	242	357
Mich.	238	243	35	39	6	2	752	724	197	147
Wis.	891	4,345	28	6	1	2	729	797	128	191
W.N. CENTRAL	2,648	1,751	377	560	153	112	2,099	2,049	1,286	356
Minn.	966	303	64	81	2	—	482	515	79	61
Iowa	507	259	97	91	3	2	331	382	67	59
Mo.	387	303	73	55	132	92	700	535	849	135
N. Dak.	130	691	24	54	—	—	37	38	4	3
S. Dak.	91	49	48	91	5	4	126	112	39	10
Nebr.	170	42	—	94	4	14	117	144	61	21
Kans.	397	104	71	94	7	—	306	323	187	67
S. ATLANTIC	1,134	640	1,371	1,928	725	681	10,034	9,435	1,895	2,489
Del.	15	2	—	9	3	5	108	99	10	7
Md.	146	120	273	283	79	65	679	732	84	132
D.C.	7	7	—	—	2	—	45	53	11	33
Va.	301	170	446	410	92	29	945	1,004	111	136
W. Va.	42	21	52	57	6	5	146	200	1	8
N.C.	98	72	410	518	416	427	1,343	1,376	174	293
S.C.	311	118	5	144	51	58	1,079	847	81	489
Ga.	32	19	182	302	61	76	1,524	1,681	480	557
Fla.	182	111	3	205	15	16	4,165	3,443	943	834
E.S. CENTRAL	429	246	122	131	259	184	2,481	2,301	1,045	721
Ky.	124	57	11	20	3	2	415	293	264	60
Tenn.	189	142	41	45	194	101	658	598	492	377
Ala.	76	31	68	55	58	53	614	617	206	237
Miss.	40	16	2	11	4	28	794	793	83	47
W.S. CENTRAL	1,434	779	760	976	139	190	2,909	3,592	2,298	2,996
Ark.	248	70	32	48	109	107	648	480	57	67
La.	33	14	—	4	5	5	644	806	112	258
Okla.	—	33	69	98	7	71	349	347	561	396
Tex.	1,153	662	659	826	18	7	1,268	1,959	1,568	2,275
MOUNTAIN	3,361	1,314	206	204	31	21	1,872	1,974	725	690
Mont.	535	45	15	25	1	3	86	176	5	4
Idaho	125	34	—	7	3	4	87	133	9	13
Wyo.	46	28	16	6	2	5	75	47	5	5
Colo.	1,141	680	15	46	5	4	500	468	137	136
N. Mex.	120	137	7	5	2	2	203	246	92	124
Ariz.	851	194	125	106	14	2	547	557	408	322
Utah	511	158	15	6	4	1	289	201	41	39
Nev.	32	38	13	3	—	—	85	146	28	47
PACIFIC	2,565	1,643	154	187	8	4	4,435	4,616	1,818	1,607
Wash.	709	602	U	U	—	—	451	468	110	94
Oreg.	555	390	6	6	1	2	322	381	109	69
Calif.	1,074	616	147	170	7	2	3,366	3,391	1,563	1,394
Alaska	108	12	1	11	—	—	48	53	7	6
Hawaii	119	23	—	—	—	—	248	323	29	44
Guam	—	—	—	—	—	—	—	50	—	42
P.R.	5	4	54	53	N	N	370	398	4	29
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 October 29, 2005, and October 30, 2004 (43rd 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	3,560	3,718	1,764	1,815	601	654	6,533	6,467	200	323
NEW ENGLAND	148	238	92	129	46	90	175	163	1	4
Maine	10	11	N	N	—	4	1	2	—	—
N.H.	13	17	—	—	4	N	14	4	—	3
Vt.	9	8	11	6	—	3	1	—	—	—
Mass.	107	108	65	38	41	50	106	100	—	—
R.I.	9	17	16	18	1	6	19	23	—	1
Conn.	U	77	U	67	U	27	34	34	1	—
MID. ATLANTIC	748	618	167	125	118	97	828	841	22	32
Upstate N.Y.	225	205	64	52	51	67	74	81	6	4
N.Y. City	140	103	U	U	20	U	506	526	5	14
N.J.	150	130	N	N	22	8	112	126	11	13
Pa.	233	180	103	73	25	22	136	108	—	1
E.N. CENTRAL	694	844	480	404	176	154	680	739	26	51
Ohio	165	196	306	281	65	65	183	190	1	2
Ind.	89	86	162	123	46	33	53	52	1	2
Ill.	142	224	12	—	53	7	347	315	10	17
Mich.	263	258	—	N	—	N	67	153	12	30
Wis.	35	80	N	N	12	49	30	29	2	—
W.N. CENTRAL	227	271	38	18	66	87	201	137	5	5
Minn.	90	129	—	—	42	55	52	20	1	1
Iowa	N	N	N	N	—	N	4	5	—	—
Mo.	59	57	31	13	9	13	122	84	4	2
N. Dak.	9	11	2	—	4	3	1	—	—	—
S. Dak.	20	16	3	5	—	—	1	—	—	—
Nebr.	17	19	2	—	—	8	4	6	—	—
Kans.	32	39	N	N	11	8	17	22	—	2
S. ATLANTIC	770	756	695	920	68	51	1,630	1,630	36	53
Del.	5	3	1	4	—	N	10	8	—	1
Md.	173	123	—	—	44	36	254	297	13	8
D.C.	9	9	15	8	3	4	86	50	—	1
Va.	75	64	N	N	—	N	111	88	4	3
W. Va.	22	23	101	97	21	11	4	3	—	—
N.C.	104	115	N	N	U	U	213	161	8	10
S.C.	26	51	—	83	—	N	59	99	4	11
Ga.	152	176	111	233	—	N	290	317	1	4
Fla.	204	192	467	495	—	N	603	607	6	15
E.S. CENTRAL	150	191	140	131	11	15	371	345	18	20
Ky.	31	55	25	26	N	N	41	40	—	1
Tenn.	119	136	115	103	—	N	181	108	12	8
Ala.	—	—	—	—	—	N	115	147	5	9
Miss.	—	—	—	2	11	15	34	50	1	2
W.S. CENTRAL	226	289	98	62	61	125	1,041	1,038	55	63
Ark.	17	16	12	8	14	8	43	45	—	3
La.	6	2	86	54	23	28	176	268	6	5
Okla.	99	57	N	N	24	36	32	24	1	2
Tex.	104	214	N	N	—	53	790	701	48	53
MOUNTAIN	510	407	54	25	46	33	327	323	16	41
Mont.	—	—	—	—	—	—	5	1	—	—
Idaho	2	8	N	N	—	N	20	18	1	2
Wyo.	4	8	22	10	—	—	—	3	—	—
Colo.	174	91	N	N	45	33	33	53	1	1
N. Mex.	41	84	—	N	—	—	38	71	2	2
Ariz.	217	177	N	N	—	N	148	133	12	35
Utah	71	35	30	13	1	—	6	11	—	1
Nev.	1	4	2	2	—	—	77	33	—	—
PACIFIC	87	104	—	1	9	2	1,280	1,251	21	54
Wash.	N	N	N	N	N	N	120	109	—	—
Oreg.	N	N	N	N	6	N	22	24	—	—
Calif.	—	—	N	N	N	N	1,128	1,111	21	54
Alaska	—	—	—	—	—	N	6	1	—	—
Hawaii	87	104	—	1	3	2	4	6	—	—
Guam	—	—	—	—	—	—	—	1	—	—
P.R.	N	N	N	N	—	N	179	137	8	5
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 October 29, 2005, and October 30, 2004 (43rd 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	9,595	10,910	220	275	19,567	22,821	1,030	1,128	1,352
NEW ENGLAND	278	355	22	20	1,055	2,546	9	—	3
Maine	14	16	1	—	213	185	—	—	—
N.H.	6	13	—	—	241	—	—	—	—
Vt.	4	2	—	—	63	413	—	—	—
Mass.	179	204	13	14	538	452	4	—	1
R.I.	24	44	1	1	—	—	1	—	—
Conn.	51	76	7	5	U	1,496	4	—	2
MID. ATLANTIC	1,678	1,713	36	67	3,803	78	26	17	17
Upstate N.Y.	208	231	5	9	—	—	—	5	—
N.Y. City	821	852	12	27	—	—	10	2	4
N.J.	396	376	11	16	—	—	2	1	2
Pa.	253	254	8	15	3,803	78	14	9	11
E.N. CENTRAL	1,035	980	18	32	5,144	9,773	221	66	108
Ohio	209	163	2	6	1,181	1,148	44	11	12
Ind.	108	110	1	—	482	N	7	8	—
Ill.	483	433	5	15	68	4,922	128	29	86
Mich.	170	203	5	9	3,069	3,136	34	13	4
Wis.	65	71	5	2	344	567	8	5	6
W.N. CENTRAL	494	373	6	8	394	159	123	86	395
Minn.	156	147	5	4	—	—	17	13	26
Iowa	170	33	—	—	N	N	12	13	18
Mo.	79	97	—	2	282	5	13	27	12
N. Dak.	2	3	—	—	25	82	12	2	74
S. Dak.	11	8	—	—	87	72	35	6	196
Nebr.	28	26	—	2	—	—	26	7	64
Kans.	48	59	1	—	—	—	8	18	5
S. ATLANTIC	2,030	2,287	45	38	1,769	2,008	26	65	21
Del.	12	17	1	—	28	5	1	—	—
Md.	221	232	9	11	—	—	4	10	1
D.C.	42	72	—	—	34	21	—	1	—
Va.	246	226	17	7	401	481	—	4	—
W. Va.	19	18	—	—	887	1,135	—	—	N
N.C.	232	254	4	6	—	N	2	3	1
S.C.	180	151	—	—	419	366	4	—	—
Ga.	324	477	3	4	—	—	7	14	6
Fla.	754	840	11	10	—	—	8	33	13
E.S. CENTRAL	404	520	5	8	—	42	60	60	35
Ky.	84	94	2	3	N	N	4	1	—
Tenn.	161	165	—	5	—	—	11	13	1
Ala.	159	161	1	—	—	42	6	15	3
Miss.	—	100	2	—	—	—	39	31	31
W.S. CENTRAL	1,189	1,610	16	25	5,259	6,226	187	224	100
Ark.	88	98	—	—	2	—	8	15	13
La.	—	—	1	—	109	49	78	79	33
Okla.	121	140	1	1	—	—	9	16	7
Tex.	980	1,372	14	24	5,148	6,177	92	114	47
MOUNTAIN	286	423	10	7	2,143	1,989	109	322	192
Mont.	8	4	—	—	—	—	8	2	17
Idaho	—	3	—	—	—	—	2	1	7
Wyo.	—	4	—	—	49	35	4	2	6
Colo.	46	106	5	2	1,524	1,598	19	41	72
N. Mex.	14	23	—	—	149	U	17	31	12
Ariz.	174	169	3	2	—	—	25	214	33
Utah	26	32	1	1	421	356	21	6	30
Nev.	18	82	1	2	—	—	13	25	15
PACIFIC	2,201	2,649	62	70	—	—	269	288	481
Wash.	202	190	5	6	N	N	—	—	—
Oreg.	54	83	3	1	—	—	—	—	5
Calif.	1,812	2,249	42	57	—	—	269	288	476
Alaska	36	32	—	—	—	—	—	—	—
Hawaii	97	95	12	6	—	—	—	—	—
Guam	—	46	—	—	—	189	—	—	—
P.R.	—	83	—	—	533	342	—	—	—
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 October 29, 2005 (43rd Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
NEW ENGLAND	506	371	87	27	10	11	37
Boston, Mass.	130	86	29	9	2	4	8
Bridgeport, Conn.	37	33	2	1	—	1	1
Cambridge, Mass.	23	20	3	—	—	—	4
Fall River, Mass.	22	18	1	3	—	—	4
Hartford, Conn.	50	34	11	3	1	1	4
Lowell, Mass.	16	13	2	1	—	—	2
Lynn, Mass.	15	8	5	2	—	—	—
New Bedford, Mass.	24	22	1	1	—	—	—
New Haven, Conn.	36	23	8	1	2	2	4
Providence, R.I.	49	41	5	3	—	—	1
Somerville, Mass.	4	2	2	—	—	—	—
Springfield, Mass.	29	19	6	1	3	—	3
Waterbury, Conn.	20	16	3	—	1	—	2
Worcester, Mass.	51	36	9	2	1	3	4
MID. ATLANTIC	2,063	1,393	474	118	31	46	121
Albany, N.Y.	50	35	12	2	—	1	3
Allentown, Pa.	31	24	6	—	—	1	1
Buffalo, N.Y.	65	43	17	3	1	1	9
Camden, N.J.	21	11	4	—	1	5	—
Elizabeth, N.J.	16	11	5	—	—	—	2
Erie, Pa.	48	38	8	1	1	—	4
Jersey City, N.J.	33	16	13	4	—	—	—
New York City, N.Y.	1,051	703	240	72	12	23	60
Newark, N.J.	49	25	14	5	2	3	2
Paterson, N.J.	32	16	8	3	3	2	1
Philadelphia, Pa.	315	199	85	16	8	7	14
Pittsburgh, Pa.§	24	18	5	—	1	—	1
Reading, Pa.	27	21	4	2	—	—	—
Rochester, N.Y.	120	94	17	7	1	1	13
Schenectady, N.Y.	22	21	1	—	—	—	2
Scranton, Pa.	27	23	3	1	—	—	1
Syracuse, N.Y.	85	61	21	2	—	1	5
Trenton, N.J.	22	13	8	—	—	1	2
Utica, N.Y.	10	8	2	—	—	—	—
Yonkers, N.Y.	15	13	1	—	1	—	1
E.N. CENTRAL	1,701	1,130	390	109	31	39	122
Akron, Ohio	66	39	14	9	2	2	4
Canton, Ohio	37	26	11	—	—	—	5
Chicago, Ill.	263	173	62	21	1	4	16
Cincinnati, Ohio	88	56	21	5	3	3	11
Cleveland, Ohio	194	146	34	7	2	5	9
Columbus, Ohio	191	118	49	19	—	5	16
Dayton, Ohio	108	84	17	7	—	—	5
Detroit, Mich.	135	62	51	12	9	1	9
Evansville, Ind.	49	33	9	3	2	2	2
Fort Wayne, Ind.	55	41	10	2	2	—	7
Gary, Ind.	9	5	2	—	1	1	—
Grand Rapids, Mich.	55	38	13	2	1	1	8
Indianapolis, Ind.	U	U	U	U	U	U	U
Lansing, Mich.	34	25	5	2	1	1	5
Milwaukee, Wis.	107	66	26	8	1	6	12
Peoria, Ill.	55	38	9	5	2	1	3
Rockford, Ill.	63	47	13	—	1	2	—
South Bend, Ind.	36	26	8	—	1	1	1
Toledo, Ohio	99	67	23	5	1	3	7
Youngstown, Ohio	57	40	13	2	1	1	2
W.N. CENTRAL	625	414	149	34	15	13	39
Des Moines, Iowa	48	35	10	—	1	2	2
Duluth, Minn.	35	28	7	—	—	—	5
Kansas City, Kans.	31	15	14	1	—	1	2
Kansas City, Mo.	80	50	17	7	5	1	1
Lincoln, Nebr.	59	46	10	2	1	—	2
Minneapolis, Minn.	44	23	11	9	1	—	5
Omaha, Nebr.	103	75	26	1	1	—	7
St. Louis, Mo.	66	36	20	5	2	3	7
St. Paul, Minn.	52	30	16	4	1	1	5
Wichita, Kans.	107	76	18	5	3	5	3
S. ATLANTIC	1,026	607	254	104	29	32	59
Atlanta, Ga.	156	77	35	21	7	16	9
Baltimore, Md.	143	64	44	25	9	1	15
Charlotte, N.C.	108	66	32	7	1	2	6
Jacksonville, Fla.	159	95	44	14	4	2	6
Miami, Fla.	67	44	14	7	2	—	3
Norfolk, Va.	41	27	8	1	1	4	—
Richmond, Va.	60	40	13	6	1	—	4
Savannah, Ga.	43	25	12	4	1	1	—
St. Petersburg, Fla.	23	19	2	1	—	1	4
Tampa, Fla.	113	81	21	8	1	2	5
Washington, D.C.	100	59	27	9	2	3	4
Wilmington, Del.	13	10	2	1	—	—	3
E.S. CENTRAL	955	602	233	59	27	34	48
Birmingham, Ala.	214	149	41	6	3	15	15
Chattanooga, Tenn.	57	35	15	3	2	2	3
Knoxville, Tenn.	105	66	31	6	1	1	3
Lexington, Ky.	78	51	17	3	3	4	3
Memphis, Tenn.	215	129	53	20	6	7	12
Mobile, Ala.	83	50	22	5	5	1	1
Montgomery, Ala.	80	50	21	4	2	3	5
Nashville, Tenn.	123	72	33	12	5	1	6
W.S. CENTRAL	1,588	1,018	377	119	41	33	97
Austin, Tex.	77	49	19	5	2	2	5
Baton Rouge, La.	29	21	3	5	—	—	3
Corpus Christi, Tex.	57	37	11	8	—	1	3
Dallas, Tex.	209	127	54	14	7	7	9
El Paso, Tex.	77	48	18	7	2	2	8
Ft. Worth, Tex.	129	85	28	11	2	3	5
Houston, Tex.	438	265	113	35	15	10	32
Little Rock, Ark.	78	39	23	8	6	2	4
New Orleans, La.¶	U	U	U	U	U	U	U
San Antonio, Tex.	231	161	50	13	5	2	11
Shreveport, La.	135	100	28	4	—	3	8
Tulsa, Okla.	128	86	30	9	2	1	9
MOUNTAIN	1,051	672	241	83	29	25	69
Albuquerque, N.M.	128	78	32	14	2	2	10
Boise, Idaho	51	36	9	4	2	—	4
Colo. Springs, Colo.	72	53	11	4	1	3	4
Denver, Colo.	86	50	22	7	4	3	3
Las Vegas, Nev.	258	163	65	19	5	6	21
Ogden, Utah	26	16	8	2	—	—	4
Phoenix, Ariz.	142	81	30	16	7	7	6
Pueblo, Colo.	28	21	5	2	—	—	4
Salt Lake City, Utah	113	75	27	5	4	2	6
Tucson, Ariz.	147	99	32	10	4	2	7
PACIFIC	1,085	744	210	75	30	25	69
Berkeley, Calif.	11	9	1	1	—	—	—
Fresno, Calif.	86	55	18	7	5	—	2
Glendale, Calif.	—	—	—	—	—	—	—
Honolulu, Hawaii	64	52	7	—	3	2	1
Long Beach, Calif.	65	53	10	1	1	—	8
Los Angeles, Calif.	46	24	15	2	3	2	7
Pasadena, Calif.	14	10	4	—	—	—	1
Portland, Oreg.	126	88	22	10	2	4	4
Sacramento, Calif.	201	137	36	18	3	7	16
San Diego, Calif.	140	92	23	15	6	4	10
San Francisco, Calif.	21	15	2	3	1	—	1
San Jose, Calif.	U	U	U	U	U	U	U
Santa Cruz, Calif.	27	20	5	2	—	—	1
Seattle, Wash.	143	86	43	8	4	2	9
Spokane, Wash.	53	39	7	5	—	2	5
Tacoma, Wash.	88	64	17	3	2	2	4
TOTAL	10,600**	6,951	2,415	728	243	258	661

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.

¶Because of Hurricane Katrina, weekly reporting of deaths has been temporarily disrupted.

**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 *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.

☆U.S. Government Printing Office: 2006-523-142/00125 Region IV ISSN: 0149-2195