



MMWRTM

Morbidity and Mortality Weekly Report

Weekly

July 28, 2006 / Vol. 55 / No. 29

Investigation of a New Diagnosis of Multidrug-Resistant, Dual-Tropic HIV-1 Infection — New York City, 2005

In December 2004, infection with a strain of multidrug-resistant (MDR), dual-tropic* human immunodeficiency virus (HIV)-1 was newly diagnosed in a man aged 46 years in New York City (NYC). The man (i.e., the index patient) had no history of antiretroviral treatment and reported having sex with multiple named and anonymous male partners, using crystal methamphetamine, and engaging in unprotected insertive and receptive anal intercourse. He had rapid progression to acquired immunodeficiency syndrome (AIDS) after experiencing signs and symptoms of acute HIV infection. The case was reported to the New York City Department of Health and Mental Hygiene (NYCDOH) in late January 2005 and has been described previously (1). This report describes the public health investigation of the index patient's reported contacts and a review of viral genetic sequencing (genotype) results from other HIV-infected patients in the NYC region to estimate the prevalence of this strain of HIV. The investigation, conducted by NYCDOH, Connecticut Department of Public Health, Aaron Diamond AIDS Research Center, New York State Department of Health, and CDC, identified three other patients with similar risk factors who engaged in high-risk sexual activity at the same time and in the same venues as the index patient and who were infected with a genotypically homologous strain of HIV. The findings demonstrate the usefulness of population-based reporting of HIV genotyping data to identify exact matches of new HIV mutations associated with drug resistance and to determine their characteristics and public health importance. The findings also demonstrate the continued risk for HIV transmission among men who have sex with men (MSM)

through high-risk behaviors and the need to find effective methods to prevent HIV transmission in this population.

Case Report

The index patient had tested negative for HIV infection in May 2003 and reported no history of treatment with antiretroviral drugs (ARVs). In early November 2004, he experienced onset of persistent fever, fatigue, and pharyngitis. In mid-December 2004, he tested positive for HIV-1 by enzyme-linked immunosorbent assay (ELISA) and Western blot. The patient's HIV infection progressed rapidly to AIDS during a period of 4–20 months (1); his exact date of infection was unknown. His CD4 T lymphocyte count decreased from 80 cells/ μ L on December 29, 2004, to 28 cells/ μ L on January 19, 2005. His plasma HIV RNA levels ranged from 100,000 to 650,000 copies/mL during January 2005 (2).

Genotypic analysis of the viral polymerase (*pol*) gene predicted that the patient's virus was resistant to most agents in three classes of ARVs: nucleoside or nucleotide analogue reverse transcriptase inhibitors, non-nucleoside reverse transcriptase inhibitors, and protease inhibitors. Phenotypic drug-resistance testing indicated that the strain was susceptible to enfuvirtide and efavirenz. The virus was subtype B; the viral population was relatively homogeneous, with an average intrasample diversity for the p17 and V3 regions ranging from 0.4% to 1.7%. The virus was dual tropic and had replication

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*Virus has capacity to use both CCR5 and CXCR4 coreceptors for attachment and entry into CD4 lymphocytes.

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* 2006;55:[inclusive page numbers].

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capacity 36% greater than wild-type HIV strains. The patient tested negative for all known genetic host-susceptibility factors associated with rapid AIDS progression (e.g., presence of $\Delta 32$ homo- or heterozygosity, HLA A-B-C homozygosity, or specific Class I and Class II alleles) (2,3).

Contact Investigation

After the case was reported to NYCDOH, the index patient provided the names and contact information for 14 sex partners during a standard, voluntary, confidential interview. The named partners were contacted by NYCDOH in February 2005 and were offered HIV testing. Ten of the 14 named partners had been reported previously to the NYCDOH HIV/AIDS registry as seropositive. Eight of these 10 partners either had a recent blood test for HIV genotype (i.e., within 1 year of the index diagnosis) or consented to a new blood draw for genotyping. Chart review indicated that all 10 named partners were clinically stable, and none had a genotype matching that of the index patient. Of the four partners who had not been previously reported to NYCDOH, one could not be reached despite multiple attempts; the three others all either reported a recent negative HIV test or refused testing.

Laboratory Reporting

In response to this case, on February 11, 2005, NYCDOH requested that all physicians and laboratories in NYC report patients with newly diagnosed MDR HIV-1 and rapidly progressive disease. Laboratories conducting genotypic drug-resistance testing were asked to report all genotypes identified during June 1, 2004–June 30, 2005, that exhibited resistance to four or more nucleoside/nucleotide analogue reverse transcriptase inhibitors, one or more non-nucleoside reverse transcriptase inhibitors, or four or more protease inhibitors. In response, laboratories reported 189 MDR genotypes, representing 134 persons, of whom 121 had medical records available for review in NYC. An attempt to match each person to those in the HIV/AIDS registry confirmed that 116 persons had diagnoses of HIV infection before January 1, 2000; five had infections diagnosed during 2000–2004. Two of these patients (with infections diagnosed in 2001 and 2003, respectively) had no record of ARV therapy in their charts; two others were on ARV therapy before the MDR HIV-1 genotype was identified in the index patient in December 2004.

During February 11–June 30, 2005, health-care providers were encouraged to perform genotyping on all patients who tested newly HIV positive and to report by telephone any patients with newly diagnosed MDR HIV-1 infection who had never been treated with ARVs.

In February–March 2005, the 28 laboratories conducting HIV genotyping on NYC residents were asked to match the *pol* genotype of the index patient against the nucleotide sequences in their sequence databases. The index patient's *pol* genotype also was matched against sequence libraries at CDC, the New York State Department of Health Wadsworth Center, three large commercial laboratories in the United States, two laboratories in Canada, and one in Europe. Three male patients, one in Connecticut and two in NYC, had nucleotide sequences with >95% homology to the index patient's *pol* sequence. The three patients with matching genotypes were interviewed either by their primary-care providers or by NYCDOH. Information from the interviews indicated a strong likelihood that the index patient and Connecticut patient had been sex partners. Although none of the three patients with matching genotypes identified each other or the index patient by name, all reported engaging in sexual activity at the same events or venues or at similar events attended by the index patient during the preceding 2 years. Both the Connecticut patient and the index patient described a sex partner attending at least one of these events who resembled the other in terms of general appearance, occupation, and serostatus (self-reported). All three men with genotypes that matched the index patient's genotype were clinically stable on ARV regimens at the time of their interviews. Sufficient data were not available to determine the rate of disease progression before diagnosis of HIV infection or initiation of ARV therapy in any of the three patients with matching genotypes.

Sequencing

Confirmatory sequencing of *pol* and additional portions of the genome was conducted by three independent laboratories on new blood samples from the index patient and the three patients with matching genotypes. This testing confirmed the *pol* homology of the viruses and homology of other genomic regions. However, because of the incomplete epidemiologic information, a definite chain of transmission among these four genotypically related cases could not be established.

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Editorial Note: This report describes the public health investigation surrounding a previously reported case of MDR

HIV-1 infection (1). The investigation was conducted to identify contacts of the index patient, to offer HIV testing and partner notification, and to search for other persons with diagnosed HIV infection who shared the index patient's HIV genotype. Data obtained from interviews, laboratory matching, and supplemental laboratory testing identified only three persons as infected with strains of HIV similar to that of the index patient. As of July 21, 2006, the index patient and two of the patients with matching genotypes were clinically stable and responding to ARVs. The third patient with a matching genotype was clinically stable and responding to ARVs through April 2005 but has since been lost to follow-up; he had not been matched to the New York City Death Registry as of June 30, 2006.

Investigators were not able to determine exactly when or how, during May 2003–December 2004, the index patient was infected, whether transmission of the HIV strain to the index patient was direct from one of the three patients with matching genotypes or indirect (i.e., passed through an unknown intermediate person), or whether the index patient's viral genotype was from a single viral infection or from recombination or superinfection. The index patient had multiple partners, many anonymous, during the period in which he became infected. The cluster of three patients with matching genotypes represents only cases detected through laboratory matching and only through June 30, 2005. At least 6,400 HIV-infected MSM in NYC have never been tested for HIV,[†] and many other persons with diagnosed HIV infection have never had genotyping. Therefore, the actual prevalence of this or a similar MDR HIV genotype in NYC is unknown.

The index patient's HIV infection progressed to AIDS in ≤20 months; the median period for transition to AIDS without treatment is 8–10 years (4). Available laboratory and medical records data were not sufficient to establish whether this viral genotype was associated with rapid progression to AIDS. Accelerated progression to AIDS and transmission of MDR HIV-1 have been reported previously, although not with this combination of high-level resistance and rapid progression (5,6). Newly diagnosed MDR HIV in a sexually active MSM who had never received ARV treatment raises several public health concerns. Approximately 70% of the named partners of the index patient had HIV infection, and the majority had other recent sexually transmitted disease infections, indicating substantial potential for transmission of HIV and possi-

[†] Torian LV, Bennani Y, Frieden TR. What is the true prevalence of HIV in New York City: estimating the number of undiagnosed and unreported persons living with HIV and AIDS, 2003 [Poster]. Presented at the 12th Conference on Retroviruses and Opportunistic Infections, Boston, MA; February 22–25, 2005. Available at <http://www.nyc.gov/html/doh/downloads/pdf/dires/epi-presentation-croi2005-970.pdf>.

bly also MDR HIV. The findings in this report, along with increasing syphilis rates, continuing gonorrhea transmission, and the emergence of lymphogranuloma venereum in HIV-positive MSM, reflects a resurgence of unsafe sex among MSM. This behavior also has been associated with increasing use of methamphetamine (7).

The genotype data collected by NYCDOH indicated a low prevalence of MDR genotypes among persons who had not been treated with ARVs and who had HIV infections diagnosed during June 1, 2004–June 30, 2005. Drug-resistant HIV compromises the effectiveness of standard ARV regimens and can limit the treatment options available to persons with newly diagnosed HIV infection (6). Therefore, CDC has provided funding to four city and 17 state health departments to conduct drug-resistance surveillance on remnant sera obtained from all patients with newly diagnosed HIV infection (8). Provisional data from these areas indicate that as many as 15% of these patients are infected with an HIV strain that has mutations associated with resistance to ARVs, and 3.2% have mutations associated with resistance to two or more classes of such medications.[§]

Case reports such as the one described here and results from surveillance of newly diagnosed, drug-resistant HIV infections contributed to recent changes in HIV-1 treatment guidelines issued by the U.S. Department of Health and Human Services (9). These guidelines now recommend performing drug-resistance testing before initiation of therapy in patients who have never received ARV treatment. To reduce HIV-associated morbidity and mortality in the United States, public health officials should intensify measures to improve early diagnosis, partner notification, and prevention counseling for persons (particularly MSM) who are HIV positive and should conduct population-based genotype surveillance to monitor the emergence of unusual strains of HIV, particularly those with mutations associated with ARV resistance (8,10).

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Heat-Related Deaths — United States, 1999–2003

Heat-related illnesses (e.g., heat cramps, heat exhaustion, heat syncope, or heatstroke) can occur when high ambient temperatures overcome the body's natural ability to dissipate heat (1). Older adults, young children, and persons with chronic medical conditions are particularly susceptible to these illnesses and are at high risk for heat-related mortality (2). Previous analyses of the risk factors associated with heat-related deaths* have been based on the underlying cause[†] entered on the death certificate (4,5) and have not included decedents for whom hyperthermia was listed as a contributing factor but not the underlying cause of death. This report describes an analysis in which number of heat-related deaths were counted, including deaths in which hyperthermia was listed as a contributing factor on the death certificate. The analysis revealed that including these deaths increased the number of heat-related deaths by 54% and suggested that the number of heat-related deaths is underestimated.

CDC uses information from death certificates categorized by codes from the *International Classification of Diseases* to estimate national mortality trends. These data, collected and submitted by states, were used to determine the number of deaths in the United States during 1999–2003 that had expo-

* Defined as a death in which exposure to high ambient temperatures either caused the death or contributed to it substantially, the decedent had a body temperature at the time of collapse >105°F (>40.6°C), the decedent had a history of exposure to high ambient temperature, and other causes of hyperthermia could reasonably be excluded (3).

[†] The underlying cause of death is defined as the disease or injury that initiated the chain of events that lead directly and inevitably to death. Contributing conditions, or factors, are defined as diseases, injuries, or complications that directly caused the death. A sample death certificate, showing underlying and contributing causes of death, is available at <http://www.cdc.gov/nchs/data/dvs/death11-03final-acc.pdf>.

[§] Bennett D, McCormick L, Kline R, et al. U.S. surveillance of HIV drug resistance at diagnosis using HIV diagnostic sera [Poster Abstract 674]. Presented at the 12th Conference on Retroviruses and Opportunistic Infections, Boston, MA; February 22–25, 2005. Available at <http://www.retroconference.org/2005/cd/abstracts/24184.htm>.

sure to excessive natural heat[§] recorded as the underlying cause (code X30 from ICD, tenth revision [ICD-10]), hyperthermia[¶] recorded as a contributing factor (ICD-10 code T67) (6), or both.

During 1999–2003, a total of 3,442 deaths resulting from exposure to extreme heat were reported (annual mean: 688). For 2,239 (65%) of these deaths, the underlying cause of death was recorded as exposure to excessive heat; for the remaining 1,203 (35%), hyperthermia was recorded as a contributing factor. Deaths among males accounted for 66% of deaths and outnumbered deaths among females in all age groups (Figure). Of the 3,401 decedents for whom age information was available, 228 (7%) were aged <15 years, 1,810 (53%) were aged 15–64 years, and 1,363 (40%) were aged ≥65 years. The state with the highest average annual hyperthermia-related death rate during 1999–2003 was Arizona (1.7 deaths per 100,000 population), followed by Nevada (0.8) and Missouri (0.6).

Cardiovascular disease was recorded as the underlying cause of death in 681 (57%) of cases in which hyperthermia was a contributing factor (Table). Approximately 70% of these heat-related cardiovascular deaths occurred among persons with reported chronic ischemic heart disease. External causes (e.g., unintentional poisonings) were documented as the underlying cause of 345 (29%) deaths in which hyperthermia was a contributing factor. Endocrine, nutritional, and metabolic

TABLE. Selected underlying causes of death with hyperthermia* as a contributing factor† — United States, 1999–2003

Underlying cause of death	No.	(%)
Cardiovascular diseases	681	(56.6)
Chronic ischemic heart disease	473	(39.3)
Acute ischemic heart disease	63	(5.2)
Hypertensive heart disease without congestive heart failure	60	(5.0)
Other cardiovascular diseases	85	(7.1)
External causes of morbidity and mortality	345	(28.7)
Accidental poisoning by and exposure to noxious substances	51	(4.2)
Assault	63	(5.2)
Other external causes of morbidity and mortality	231	(19.2)
Diseases of the respiratory system	37	(3.1)
Chronic obstructive pulmonary disease, unspecified	27	(2.2)
Other diseases of the respiratory system	10	(0.8)
Endocrine, nutritional, and metabolic disorders	38	(3.2)
Unspecified diabetes mellitus	26	(2.2)
Other endocrine, nutritional, and metabolic disorders	12	(1.0)
Mental and behavioral disorders	29	(2.4)
Mental and behavioral disorders due to alcoholism	21	(1.7)
Other mental and behavioral disorders	8	(0.7)
Diseases of the digestive system	22	(1.8)
Fibrosis and cirrhosis of the liver	15	(1.2)
Other diseases of the digestive system	7	(0.6)
Other diseases of the nervous, infectious, immune, and genitourinary systems and neoplasms	51	(4.2)

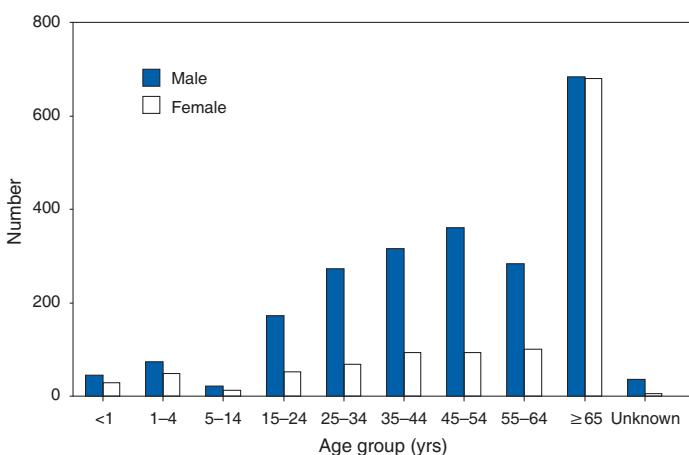
* Abnormally high body temperature caused by the body's inability to dissipate heat.

† N = 1,203.

[§] Heat-related deaths can also be caused by exposure to excessive heat of man-made origin (e.g., from saunas or furnace malfunctions; *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision* [ICD-10] code W92) and can include homicides and suicides involving exposure to excessive heat. Deaths from these causes were not included in this analysis.

[¶] Abnormally high body temperature caused by the body's inability to dissipate heat.

FIGURE. Number of heat-related deaths,* by sex and age group — United States, 1999–2003



* Exposure to extreme heat is reported as the underlying cause of or a contributing factor to death (N = 3,442).

disorders (e.g., diabetes mellitus) were the underlying causes in 38 (3%) of total deaths. All other underlying causes, including infection and psychiatric disorders, accounted for 139 (11%) deaths.

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Editorial Note: In this analysis, the inclusion of hyperthermia as a contributing cause of death increased by 54% the total number of heat-related deaths during 1999–2003 that would have been counted through inclusion of a heat-related underlying cause alone. Because heat-related illnesses can exacerbate existing medical conditions and death from heat exposure can be preceded by various symptoms, heat-related deaths can be difficult to identify when illness onset or death is not witnessed by a clinician. In addition, the criteria used to determine heat-related causes of death vary among states. This can lead to underreporting heat-related deaths or to reporting heat as a factor contributing to death rather than the underlying cause (3). The demographics (e.g., sex, age group, and state) of the decedents described in this report are

consistent with previous descriptions of persons at risk for heat-related deaths (4,5).

This analysis also provides additional information on the underlying causes of death in which hyperthermia was a contributing factor. Although this report might still underestimate the extent of overall heat-related morbidity and mortality, the inclusion of hyperthermia as a contributing factor to death provides a more comprehensive view of the actual effects of heat-related illnesses. The association between cardiovascular disease and heat-related death is well established (7); this analysis suggests the need for additional investigations of the association between noncardiovascular conditions, such as endocrine and respiratory diseases, and the risk for heat-related death.

Continued exposure to excessive heat can lead to hyperthermia or death. Of the heat-related illnesses, heat exhaustion and heatstroke are the most serious. Heat exhaustion is characterized by muscle cramps, fatigue, headache, nausea or vomiting, and dizziness or fainting. The skin is often cool and moist, indicating that the body's mechanism for cooling itself (i.e., sweating) is still functioning. The pulse rate is typically fast and weak, and breathing is rapid and shallow. If untreated, heat exhaustion can progress to heatstroke (1). Heatstroke is a serious, life-threatening condition characterized by a high body temperature ($>103^{\circ}\text{F}$ [$>39.4^{\circ}\text{C}$]); red, hot, and dry skin (no sweating); rapid, strong pulse; throbbing headache; dizziness; nausea; confusion; and unconsciousness. Symptoms can progress to encephalopathy, liver and kidney failure, coagulopathy, and multiple organ system dysfunction (2). Prompt treatment of heat-related illnesses with aggressive fluid replacement and cooling of core body temperature is critical to reducing morbidity and mortality (2).

Many heat-related deaths, regardless of whether they are associated with chronic medical conditions, are preventable. During periods of extreme heat, heat-related illnesses can be prevented by avoiding strenuous outdoor activities, drinking adequate amounts of fluid, avoiding alcohol consumption, wearing lightweight clothing, and using air-conditioning. Groups at high risk include young children, persons aged >65 years, persons who do strenuous activities outdoors, and persons with chronic (particularly cardiovascular) medical conditions (8).

During heat waves, young children, older adults, and chronically ill persons should be checked frequently by relatives, neighbors, and caretakers to evaluate their heat exposure, recognize symptoms of heat-related illness, and take appropriate preventive action. Regardless of the outdoor temperature, parents and other child-care providers should never leave children alone in cars and should ensure that children cannot

lock themselves inside enclosed spaces, such as the trunks of automobiles.

Communities can prepare for heat-related illnesses by creating well-defined heat response plans (HRPs) (9). Both governmental and nongovernmental organizations, each with specific roles and responsibilities, can be involved in this planning. HRP protocols and communication tools should be reviewed annually, before the summer months begin. The HRPs should identify populations at high risk for heat-related illness and death and determine which strategies will be used to reach them during heat emergencies. The HRP should also include specific criteria for activation and deactivation of the plan. Postemergency evaluations of HRPs are necessary to make appropriate revisions and improve plan effectiveness.

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Chagas Disease After Organ Transplantation — Los Angeles, California, 2006

Chagas disease is an infection caused by the parasite *Trypanosoma cruzi*. Reduviids (i.e., “kissing bugs”) transmit the parasite through infected feces. *T. cruzi* also can be transmitted congenitally and through blood transfusion or organ transplantation. The infection is lifelong if left untreated; the majority of infected persons are asymptomatic, and their disease remains undiagnosed. Although routine serologic testing of organ and blood donors is performed in areas of Latin

America where Chagas disease is endemic, no *T. cruzi* screening test is licensed in the United States. However, seroprevalence studies using research tests have documented the presence of *T. cruzi* antibodies in U.S. blood (1) and organ donor populations (2). This report describes two cases of acute Chagas disease in heart transplant recipients reported by two Los Angeles County hospitals in February 2006. In the United States, one previous report documented *T. cruzi* transmission through solid organ transplantation, in which three organ recipients were infected (3).

Case Reports

Case 1. In December 2005, a man aged 64 years with idiopathic cardiomyopathy received a heart transplant. In January 2006, he was treated with enhanced immunosuppression for suspected organ rejection. In February 2006, he was readmitted to the hospital with anorexia, fever, and diarrhea of 2 weeks' duration. A peripheral blood smear revealed *T. cruzi* trypomastigotes, blood cultures were positive for *T. cruzi*, and endomyocardial biopsy specimens contained amastigotes. The patient was interviewed about natural exposures, and organ procurement and transplantation records were reviewed. He had no identifiable risk factors for *T. cruzi* infection (e.g., travel to a country endemic for Chagas disease). He was seronegative for *T. cruzi* antibodies but positive for *T. cruzi* DNA by polymerase chain reaction (PCR), indicating recent infection. After initiation of nifurtimox therapy, his parasitemia rapidly cleared. However, in April 2006, the patient died from complications attributed to acute rejection of the transplanted organ.

To identify the source of infection, a traceback was conducted on all blood products transfused to the heart donor and recipient. All available blood donors tested negative for *T. cruzi* antibodies by immunofluorescence assay (IFA) and radioimmunoprecipitation assay (RIPA). However, blood from the organ donor tested seropositive for *T. cruzi* antibodies by RIPA and tested borderline-positive by IFA. The organ donor had been born in the United States but had traveled to a *T. cruzi*-endemic area of Mexico.

Three additional patients received a liver and both kidneys from the same donor. These patients are *T. cruzi*-seronegative by IFA and have no evidence of parasitemia by PCR. They continue to be monitored.

Case 2. In January 2006, a man aged 73 years with ischemic cardiomyopathy received a heart transplant. The patient was readmitted to the hospital in February 2006 with fever, fatigue, and an abdominal rash. A thin blood smear revealed *T. cruzi* trypomastigotes, and blood cultures were positive for *T. cruzi*. Organ procurement and transplantation records were reviewed.

The patient had no identifiable risk factors for *T. cruzi* infection. He was seronegative but PCR-positive for *T. cruzi*, indicating recent infection.

The patient's rash and parasitemia resolved after 10 days of nifurtimox treatment. Serial endomyocardial biopsies did not reveal trypanosomes, and he remained seronegative by IFA for *T. cruzi*. The patient died in June 2006. The primary cause of death was cardiac failure; no autopsy was performed.

The source of infection was investigated with the same methods used for case 1. All available blood donors tested seronegative for *T. cruzi*. The organ donor, who had been born in El Salvador and was residing in Los Angeles at the time of his death, tested positive for *T. cruzi* antibodies by RIPA but had a negative IFA. Three other patients received solid organs from the same donor. These patients are *T. cruzi*-seronegative by IFA and have no evidence of parasitemia by PCR. They continue to be monitored. No record of previous blood donations by either organ donor was found.

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Editorial Note: The two cases described in this report are the fourth and fifth cases of reported *T. cruzi* transmission through solid organ transplantation in the United States. The prevalence of infection with *T. cruzi* in the United States varies by region and might now be higher than previously thought, especially in geographic areas such as Los Angeles County, where a substantial proportion of blood and organ donors have emigrated from Chagas-endemic countries. Because organ donors frequently receive blood transfusions, infection can be transmitted to recipients either by transfusion or transplant. Currently, no policies recommend laboratory screening for *T. cruzi*. Diagnostic tests available for research studies have variable sensitivities and specificities, and no licensed screening test exists.

Physicians and laboratorians should maintain a high index of suspicion for *T. cruzi* infection in transplant and transfusion recipients who exhibit complications of an unknown etiology when more common sources have been excluded. Acute Chagas disease in severely immunocompromised patients is of special concern because the clinical course is often severe and rapidly progressive. If Chagas is suspected, manual microscopic examination of peripheral blood smears should

be performed. Patients with acute Chagas disease should be treated as early as possible in the course of the infection. Available treatments include nifurtimox (available from CDC Drug Service, telephone 404-639-3670) or benznidazole (only distributed outside of the United States).

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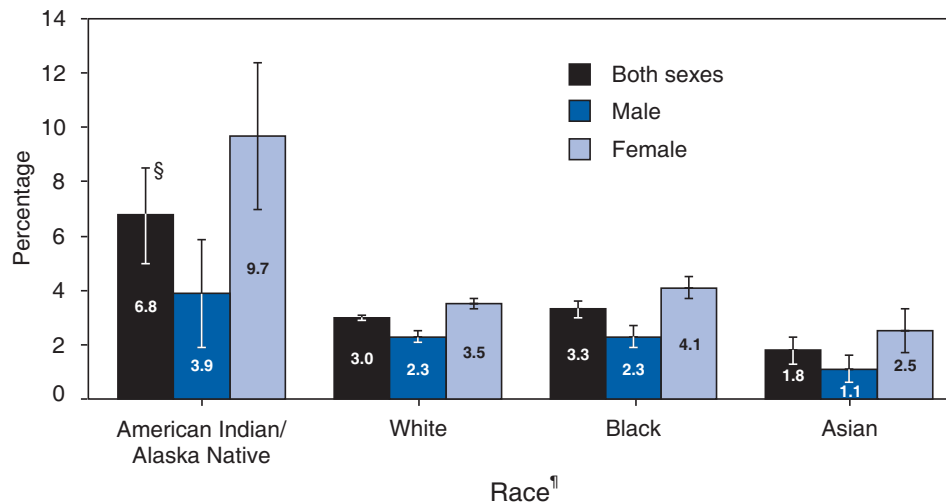
Erratum: Vol. 55, No. RR-10

In the *MMWR Recommendations and Reports*, “Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP),” in Table 4, on page 15, the mercury content (mcg Hg/0.5-mL dose) for FLUARIX™ should read <1.0.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Adults with Self-Assessed Symptoms of Serious Psychological Distress,* by Sex and Race — United States, 2000–2004†



* Six psychological distress questions were included in the adult component of the National Health Interview Survey. These questions asked: "During the past 30 days, how often did you feel 1) so sad that nothing could cheer you up, 2) nervous, 3) restless or fidgety, 4) hopeless, 5) that everything was an effort, or 6) worthless?" Response codes (0–4) for the six items for each person were summed to yield a point value on a 0–24 point scale. A value of 13 or more was used to define serious psychological distress.

† Estimates are age adjusted to the 2000 projected U.S. standard population aged ≥ 18 years using four age groups: 18–24 years, 25–44 years, 45–64 years, and ≥ 65 years. Estimates are based on household interviews of a sample of the civilian, noninstitutionalized U.S. population.

§ 95% confidence interval.

¶ Persons who indicated a single racial group.

During 2000–2004, American Indian/Alaska Native (AI/AN) adults were most likely to have self-assessed symptoms of serious psychological distress, and Asian adults were least likely. Overall, the percentage was highest for AI/AN women, who were at least twice as likely as white women and black women and nearly four times as likely as Asian women to have self-assessed symptoms of serious psychological distress. AI/AN men were more than three times as likely as Asian men to have symptoms.

SOURCES: National Health Interview Surveys, 2000–2004. Available at <http://www.cdc.gov/nchs/nhis.htm>.

Barnes PM, Adams PF, Powell-Griner E. Health characteristics of the American Indian and Alaska Native adult population: United States 1999–2003. Advance data from vital and health statistics; no. 356. Hyattsville, MD: US Department of Health and Human Services, CDC; 2005. Available at <http://www.cdc.gov/nchs/data/ad/ad356.pdf>.

Kessler RC, Barker PR, Colpe LJ, et al. Screening for serious mental illness in the general population. *Arch Gen Psychiatry* 2003;60:184–9.

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending July 22, 2006 (29th Week)*

Disease	Current week	Cum 2006	5-year weekly average†	Total cases reported for previous years					States reporting cases during current week (No.)
				2005	2004	2003	2002	2001	
Anthrax	—	1	0	—	—	—	2	23	
Botulism:									
foodborne	—	3	1	19	16	20	28	39	
infant	1	36	1	90	87	76	69	97	TX (1)
other (wound & unspecified)	2	30	1	33	30	33	21	19	CA (2)
Brucellosis	1	55	2	122	114	104	125	136	CA (1)
Chancroid	—	18	0	17	30	54	67	38	
Cholera	—	3	0	8	5	2	2	3	KS (1)
Cyclosporiasis§	4	49	8	734	171	75	156	147	FL (2), TN (2)
Diphtheria	—	—	—	—	—	1	1	2	
Domestic arboviral diseases§¶:									
California serogroup	—	1	5	78	112	108	164	128	
eastern equine	—	—	1	21	6	14	10	9	
Powassan	—	—	0	1	1	—	1	N	
St. Louis	—	1	1	10	12	41	28	79	
western equine	—	—	—	—	—	—	—	—	
Ehrlichiosis§:									
human granulocytic	13	115	20	790	537	362	511	261	NY (11), MN (1), CA (1)
human monocytic	11	115	12	522	338	321	216	142	NY (3), MO (5), FL (1), KY (1), TN (1)
human (other & unspecified)	1	28	3	122	59	44	23	6	AR (1)
<i>Haemophilus influenzae</i> **,									
invasive disease (age <5 yrs):									
serotype b	—	4	0	9	19	32	34	—	
nonserotype b	2	48	2	135	135	117	144	—	IN (1), NC (1)
unknown serotype	1	100	2	217	177	227	153	—	MA (1)
Hansen disease§	—	33	2	88	105	95	96	79	
Hantavirus pulmonary syndrome§	1	15	1	29	24	26	19	8	CO (1)
Hemolytic uremic syndrome, postdiarrheal§	4	74	5	221	200	178	216	202	MN (1), MO (1), FL (1), TN (1)
Hepatitis C viral, acute	8	437	31	771	713	1,102	1,835	3,976	NY (1), MI (1), MO (1), NC (2), KY (1), AL (1), WA (1)
HIV infection, pediatric (age <13 yrs)§,††	—	52	5	380	436	504	420	543	
Influenza-associated pediatric mortality§,§§,¶¶	1	40	0	49	—	N	N	N	KY (1)
Listeriosis	10	281	19	892	753	696	665	613	ME (1), IN (1), MN (2), MO (1), MD (2), WV (2), CA (1)
Measles	—***	24	2	66	37	56	44	116	
Meningococcal disease,††† invasive:									
A, C, Y, & W-135	—	130	4	297	—	—	—	—	
serogroup B	—	87	3	157	—	—	—	—	
other serogroup	—	12	0	27	—	—	—	—	
Mumps	16	5,331	5	314	258	231	270	266	NH (1), NY (1), OH (1), WI (2), IA (1), SD (1), KS (9)
Plague	—	4	0	8	3	1	2	2	
Poliomyelitis, paralytic	—	—	—	1	—	—	—	—	
Psittacosis§	—	10	0	19	12	12	18	25	
Q fever§	4	75	2	139	70	71	61	26	CO (1), CA (3)
Rabies, human	—	1	0	2	7	2	3	1	
Rubella	—	4	0	11	10	7	18	23	
Rubella, congenital syndrome	—	1	—	1	—	1	1	3	
SARS-CoV§,§§	—	—	—	—	—	8	N	N	
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	—	64	1	129	132	161	118	77	
<i>Streptococcus pneumoniae</i> §									
invasive disease (age <5 yrs)	7	626	10	1,257	1,162	845	513	498	MN (2), OK (1), TX (4)
Syphilis, congenital (age <1 yr)	1	117	8	361	353	413	412	441	AZ (1)
Tetanus	2	13	1	27	34	20	25	37	OH (2)
Toxic-shock syndrome (other than streptococcal)§	3	54	2	96	95	133	109	127	NC (2), AL (1)
Trichinellosis	1	9	0	19	5	6	14	22	MN (1)
Tularemia§	2	38	4	154	134	129	90	129	MT (1), CA (1)
Typhoid fever	3	131	7	324	322	356	321	368	NY (1), DC (1), CA (1)
Vancomycin-intermediate <i>Staphylococcus aureus</i> §	—	2	—	2	—	N	N	N	
Vancomycin-resistant <i>Staphylococcus aureus</i> §	—	—	—	3	1	N	N	N	
Yellow fever	—	—	—	—	—	—	1	—	

—: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts.

* Incidence data for reporting years 2005 and 2006 are provisional, whereas data for 2001, 2002, 2003, and 2004 are finalized.

† Calculated by summing the incidence counts for the current week, the two weeks preceding the current week, and the two weeks following the current week, for a total of 5 preceding years. Additional information is available at <http://www.cdc.gov/epo/dphsi/phs/files/5yearweeklyaverage.pdf>.

§ Not notifiable in all states.

¶ Includes both neuroinvasive and non-neuroinvasive. Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNET Surveillance).

** Data for *H. influenzae* (all ages, all serotypes) are available in Table II.

†† Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV/AIDS, STD and TB Prevention. Implementation of HIV reporting influences the number of cases reported. Data for HIV/AIDS are available in Table IV quarterly.

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

¶¶ A total of 37 cases were reported for the 2005-06 flu season (October 2, 2005 [week 40]–May 20, 2006 [week 20]).

*** No measles cases were reported for the current week.

††† Data for meningococcal disease (all serogroups and unknown serogroups) are available in Table II.

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending July 22, 2006, and July 23, 2005 (29th Week)*

Reporting area	Hepatitis (viral, acute), by type										Legionellosis				
	A					B									
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
	Med	Max				Med	Max				Med	Max			
United States	21	75	245	1,773	2,082	43	85	597	2,107	2,897	26	41	127	854	861
New England	2	5	22	104	237	—	2	9	36	81	2	2	12	46	47
Connecticut	—	1	3	21	29	—	0	3	—	29	1	0	8	17	15
Maine†	1	0	2	5	1	—	0	2	11	6	—	0	1	3	3
Massachusetts	—	3	14	50	142	—	1	5	14	26	—	1	6	15	19
New Hampshire	1	0	7	16	55	—	0	2	7	17	—	0	1	1	5
Rhode Island	—	0	4	5	5	—	0	2	4	1	1	0	10	8	3
Vermont†	—	0	2	7	5	—	0	1	—	2	—	0	3	2	2
Mid. Atlantic	1	9	24	161	345	—	9	55	191	379	11	13	53	241	283
New Jersey	—	2	9	32	63	—	3	10	47	140	—	1	11	9	61
New York (Upstate)	1	1	14	46	54	—	1	43	35	34	11	5	29	118	60
New York City	—	2	10	53	172	—	1	5	28	78	—	1	20	13	55
Pennsylvania	—	1	6	30	56	—	3	9	81	127	—	6	17	101	107
E.N. Central	—	6	15	147	187	10	8	24	185	327	2	9	25	176	154
Illinois	—	1	11	24	57	—	0	6	7	94	—	1	5	14	22
Indiana	—	0	5	17	11	5	0	17	28	17	1	0	6	13	12
Michigan	—	2	8	55	63	2	3	7	76	108	1	2	6	43	42
Ohio	—	1	4	39	31	2	2	7	68	81	—	4	19	87	64
Wisconsin	—	1	5	12	25	1	0	4	6	27	—	0	5	19	14
W.N. Central	1	2	30	78	51	2	4	22	92	147	—	1	12	23	38
Iowa	—	0	2	4	13	—	0	3	9	14	—	0	1	2	3
Kansas	—	0	5	21	10	—	0	2	6	19	—	0	1	1	2
Minnesota	—	0	29	6	3	—	0	13	10	14	—	0	10	—	11
Missouri	1	1	4	31	22	2	3	7	61	79	—	0	3	13	12
Nebraska†	—	0	3	9	3	—	0	1	6	18	—	0	2	3	2
North Dakota	—	0	2	—	—	—	0	0	—	—	—	0	1	—	1
South Dakota	—	0	3	7	—	—	0	1	—	3	—	0	6	4	7
S. Atlantic	6	11	34	261	327	8	23	66	625	824	7	9	19	195	190
Delaware	—	0	2	9	4	—	1	4	19	19	—	0	2	3	10
District of Columbia	—	0	2	2	2	—	0	2	4	6	—	0	2	8	3
Florida	2	5	18	95	113	7	8	19	236	283	3	3	8	82	55
Georgia	—	1	6	29	68	—	3	8	89	128	—	0	4	9	16
Maryland†	2	1	6	32	29	1	2	9	84	92	4	1	6	39	49
North Carolina	2	0	20	53	41	—	0	23	91	92	—	0	5	20	16
South Carolina†	—	1	3	10	18	—	2	7	42	94	—	0	1	2	10
Virginia†	—	1	11	27	49	—	1	18	20	86	—	1	7	28	23
West Virginia	—	0	3	4	3	—	0	18	40	24	—	0	3	4	8
E.S. Central	3	2	15	62	139	9	6	18	192	205	1	2	9	44	42
Alabama†	1	0	9	8	14	4	2	7	70	49	—	0	1	7	9
Kentucky	1	0	5	24	11	—	1	5	40	41	—	0	4	11	11
Mississippi	—	0	1	4	13	—	0	3	8	33	—	0	1	1	2
Tennessee†	1	1	7	26	101	5	2	12	74	82	1	1	7	25	20
W.S. Central	—	7	77	116	221	7	13	315	335	299	1	1	32	28	17
Arkansas	—	0	9	29	8	—	1	4	21	39	—	0	3	1	4
Louisiana	—	0	4	1	37	—	0	3	5	47	—	0	1	—	—
Oklahoma	—	0	2	4	4	4	0	17	17	28	—	0	3	1	2
Texas†	—	5	73	82	172	3	11	295	292	185	1	0	26	26	11
Mountain	1	6	18	130	166	1	6	39	148	284	2	1	7	46	56
Arizona	—	2	16	64	85	—	4	27	86	173	—	0	3	14	12
Colorado	—	1	4	24	19	1	1	5	21	33	2	0	1	5	15
Idaho†	—	0	2	7	18	—	0	2	7	7	—	0	2	6	3
Montana	—	0	2	6	7	—	0	7	—	3	—	0	1	3	4
Nevada†	—	0	2	6	9	—	0	4	13	30	—	0	2	3	11
New Mexico†	—	0	3	10	14	—	0	3	2	12	—	0	1	2	2
Utah	—	0	2	11	13	—	0	5	19	25	—	0	2	13	6
Wyoming	1	0	1	2	1	—	0	1	—	1	—	0	1	—	3
Pacific	7	19	163	714	409	6	10	61	303	351	—	2	9	55	34
Alaska	—	0	1	—	3	—	0	1	2	7	—	0	1	—	—
California	7	15	162	653	342	6	7	41	239	240	—	2	9	55	33
Hawaii	—	0	2	8	16	—	0	1	4	2	—	0	1	—	1
Oregon†	—	0	5	26	24	—	1	6	33	59	N	0	0	N	N
Washington	—	1	13	27	24	—	0	18	25	43	—	0	0	—	—
American Samoa	U	0	0	U	1	U	0	0	U	—	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	2	—	0	2	—	16	—	0	0	—	—
Puerto Rico	—	0	3	9	46	—	1	8	17	29	—	0	1	1	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
 U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
 * Incidence data for reporting years 2005 and 2006 are provisional.
 † Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending July 22, 2006, and July 23, 2005 (29th Week)*

Reporting area	Lyme disease					Malaria				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max		
United States	426	247	2,153	5,451	9,600	13	24	125	576	702
New England	212	37	780	945	1,667	—	1	12	39	31
Connecticut	184	8	753	725	157	—	0	10	10	—
Maine†	8	2	26	47	118	—	0	1	3	2
Massachusetts	—	3	163	26	1,305	—	0	3	17	22
New Hampshire	17	5	29	128	68	—	0	3	8	4
Rhode Island	—	0	12	—	4	—	0	8	—	2
Vermont†	3	1	5	19	15	—	0	1	1	1
Mid. Atlantic	153	151	1,176	3,121	5,441	1	4	15	86	192
New Jersey	13	25	229	749	2,296	—	1	7	13	45
New York (Upstate)	140	76	1,150	1,450	963	1	1	11	20	25
New York City	—	0	25	1	215	—	2	8	37	101
Pennsylvania	—	34	376	921	1,967	—	1	2	16	21
E.N. Central	2	13	136	407	1,151	—	2	8	53	81
Illinois	—	0	13	—	88	—	1	5	15	43
Indiana	1	0	4	8	12	—	0	3	6	3
Michigan	1	1	7	21	13	—	0	2	9	15
Ohio	—	1	5	17	26	—	0	3	18	14
Wisconsin	—	10	116	361	1,012	—	0	3	5	6
W.N. Central	11	11	98	174	203	1	0	32	28	29
Iowa	—	1	8	32	56	—	0	1	1	4
Kansas	—	0	2	3	2	1	0	2	4	3
Minnesota	10	6	96	121	137	—	0	30	14	11
Missouri	1	0	3	10	7	—	0	2	4	11
Nebraska†	—	0	2	7	—	—	0	2	3	—
North Dakota	—	0	3	—	—	—	0	1	1	—
South Dakota	—	0	1	1	1	—	0	1	1	—
S. Atlantic	27	28	124	634	1,016	3	6	16	169	152
Delaware	—	8	34	235	386	—	0	1	5	2
District of Columbia	7	0	2	18	4	—	0	2	2	4
Florida	4	1	5	18	14	2	1	6	29	25
Georgia	—	0	1	—	4	—	1	6	50	33
Maryland†	16	15	87	283	495	—	1	9	36	57
North Carolina	—	0	5	15	27	—	0	8	13	16
South Carolina†	—	0	3	5	8	1	0	2	5	3
Virginia†	—	3	22	57	74	—	1	9	28	11
West Virginia	—	0	44	3	4	—	0	2	1	1
E.S. Central	—	0	4	4	15	1	0	3	14	13
Alabama†	—	0	1	1	—	—	0	2	7	3
Kentucky	—	0	2	—	2	—	0	2	1	4
Mississippi	—	0	0	—	—	—	0	1	3	—
Tennessee†	—	0	4	3	13	1	0	2	3	6
W. S. Central	—	0	5	5	51	1	2	31	39	51
Arkansas	—	0	1	—	3	—	0	2	1	3
Louisiana	—	0	0	—	3	—	0	1	—	2
Oklahoma	—	0	0	—	—	—	0	6	3	3
Texas†	—	0	5	5	45	1	1	29	35	43
Mountain	—	0	4	7	9	—	0	9	23	31
Arizona	—	0	4	2	—	—	0	9	4	5
Colorado	—	0	1	1	—	—	0	2	9	17
Idaho†	—	0	1	—	1	—	0	0	—	—
Montana	—	0	0	—	—	—	0	1	1	—
Nevada†	—	0	1	—	2	—	0	1	1	2
New Mexico†	—	0	1	—	2	—	0	1	1	2
Utah	—	0	1	4	1	—	0	2	7	4
Wyoming	—	0	1	—	3	—	0	1	—	1
Pacific	21	4	14	154	47	6	4	13	125	122
Alaska	—	0	1	1	3	2	0	4	16	3
California	20	3	14	150	27	4	3	10	86	90
Hawaii	N	0	0	N	N	—	0	1	1	12
Oregon†	—	0	2	2	15	—	0	2	7	6
Washington	1	0	3	1	2	—	0	5	15	11
American Samoa	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	N	0	0	N	N	—	0	1	—	2
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.

U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.

* Incidence data for reporting years 2005 and 2006 are provisional.

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending July 22, 2006, and July 23, 2005 (29th Week)*

Reporting area	Meningococcal disease, invasive										Pertussis				
	All serogroups					Serogroup unknown									
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	6	20	85	683	798	6	13	58	454	488	111	290	2,877	6,667	11,758
New England	1	1	3	31	52	1	0	2	23	19	17	30	83	687	691
Connecticut	—	0	2	8	10	—	0	2	2	1	—	1	5	23	40
Maine†	—	0	1	3	2	—	0	1	3	2	—	1	5	23	18
Massachusetts	—	0	2	13	25	—	0	2	13	5	—	23	43	468	519
New Hampshire	1	0	2	5	9	1	0	2	5	9	17	2	36	96	36
Rhode Island	—	0	1	—	2	—	0	0	—	—	—	0	17	—	12
Vermont†	—	0	1	2	4	—	0	0	—	2	—	1	14	77	66
Mid. Atlantic	1	3	13	102	96	1	2	11	76	74	6	30	137	891	756
New Jersey	—	0	2	10	24	—	0	2	10	24	—	4	13	129	108
New York (Upstate)	1	0	7	27	27	1	0	5	5	10	6	12	123	348	282
New York City	—	1	5	31	14	—	1	5	31	14	—	2	7	35	50
Pennsylvania	—	1	5	34	31	—	1	5	30	26	—	11	26	379	316
E.N. Central	1	3	11	75	98	1	1	6	53	83	21	52	133	980	2,154
Illinois	—	0	4	17	23	—	0	4	17	23	—	11	35	206	497
Indiana	1	0	5	15	13	1	0	2	6	6	—	4	75	118	172
Michigan	—	1	3	16	17	—	0	3	9	11	11	6	23	224	129
Ohio	—	1	5	27	28	—	0	4	21	26	10	15	30	327	717
Wisconsin	—	0	2	—	17	—	0	2	—	17	—	8	41	105	639
W.N. Central	—	1	4	39	51	—	0	3	14	23	9	46	552	698	1,642
Iowa	—	0	2	9	12	—	0	1	3	1	—	12	63	158	410
Kansas	—	0	1	1	9	—	0	1	1	9	5	11	28	181	147
Minnesota	—	0	2	10	8	—	0	1	3	3	1	0	485	106	458
Missouri	—	0	2	12	16	—	0	1	3	7	3	9	42	182	253
Nebraska†	—	0	2	5	4	—	0	1	3	3	—	4	10	58	168
North Dakota	—	0	1	—	—	—	0	1	1	—	—	0	26	4	77
South Dakota	—	0	1	1	2	—	0	0	—	—	—	1	7	9	129
S. Atlantic	—	3	14	118	146	—	2	7	50	58	8	22	92	529	778
Delaware	—	0	1	4	2	—	0	1	4	2	—	0	1	3	14
District of Columbia	—	0	1	—	4	—	0	1	—	3	—	0	3	3	4
Florida	—	1	6	45	55	—	1	5	18	17	1	4	14	119	102
Georgia	—	0	3	9	14	—	0	3	9	14	—	0	3	8	31
Maryland†	—	0	2	7	14	—	0	1	2	1	1	3	9	74	128
North Carolina	—	0	11	22	21	—	0	3	6	4	4	0	21	109	64
South Carolina†	—	0	2	13	12	—	0	1	5	8	2	4	22	82	238
Virginia†	—	0	4	14	19	—	0	3	6	7	—	1	73	109	165
West Virginia	—	0	2	4	5	—	0	0	—	2	—	0	9	22	32
E.S. Central	—	1	4	26	38	—	1	4	21	29	7	7	17	169	325
Alabama†	—	0	1	4	4	—	0	1	4	3	—	1	4	42	45
Kentucky	—	0	2	7	14	—	0	2	7	14	—	1	7	22	88
Mississippi	—	0	1	1	4	—	0	1	1	4	—	1	4	22	40
Tennessee†	—	0	2	14	16	—	0	2	9	8	7	2	10	83	152
W. S. Central	1	1	23	38	82	1	0	6	15	19	7	21	360	311	1,226
Arkansas	1	0	3	7	10	1	0	2	5	2	1	2	21	41	179
Louisiana	—	0	1	1	25	—	0	1	1	4	—	0	3	2	33
Oklahoma	—	0	4	8	13	—	0	0	—	2	6	0	124	16	—
Texas†	—	1	16	22	34	—	0	4	9	11	—	20	215	252	1,014
Mountain	—	1	4	39	62	—	0	4	17	16	30	64	230	1,636	2,417
Arizona	—	0	4	11	29	—	0	4	11	9	—	12	177	266	638
Colorado	—	0	2	14	13	—	0	1	2	—	12	23	40	536	785
Idaho†	—	0	2	1	3	—	0	2	1	3	2	2	13	48	118
Montana	—	0	1	3	—	—	0	1	1	—	2	3	19	77	457
Nevada†	—	0	2	2	6	—	0	1	—	1	—	0	9	35	36
New Mexico†	—	0	1	2	3	—	0	1	—	2	—	2	6	46	130
Utah	—	0	1	4	8	—	0	1	—	1	10	18	39	579	228
Wyoming	—	0	2	2	—	—	0	2	2	—	4	1	8	49	25
Pacific	2	5	29	215	173	2	5	25	185	167	6	50	1,334	766	1,769
Alaska	—	0	1	1	1	—	0	1	1	1	3	2	15	40	23
California	2	3	14	134	112	2	3	14	134	112	—	25	1,136	389	713
Hawaii	—	0	1	4	10	—	0	1	4	5	—	2	7	44	108
Oregon†	—	1	7	51	31	—	1	4	35	31	—	3	16	77	519
Washington	—	0	25	25	19	—	0	11	11	18	3	10	195	216	406
American Samoa	U	0	0	—	—	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	—	—	U	0	0	U	U	U	0	0	U	U
Guam	—	0	1	—	1	—	0	1	—	1	—	0	0	—	2
Puerto Rico	—	0	1	4	6	—	0	1	4	6	—	0	1	—	4
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
 U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
 * Incidence data for reporting years 2005 and 2006 are provisional.
 † Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending July 22, 2006, and July 23, 2005 (29th Week)*

Reporting area	Rabies, animal					Rocky Mountain spotted fever					Salmonellosis				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	49	106	158	2,973	3,376	17	35	246	757	665	617	737	2,291	17,009	19,594
New England	6	12	26	311	413	—	0	2	2	4	26	34	196	917	1,133
Connecticut	2	3	13	82	89	—	0	0	—	—	—	0	188	188	227
Maine†	1	1	5	41	40	N	0	0	N	N	7	2	7	48	103
Massachusetts	2	4	17	142	226	—	0	2	1	2	8	19	40	544	615
New Hampshire	—	0	3	9	9	—	0	1	1	1	5	2	10	72	89
Rhode Island	—	0	4	1	11	—	0	2	—	1	5	0	17	45	47
Vermont†	1	1	4	36	38	—	0	0	—	—	1	1	10	20	52
Mid. Atlantic	20	18	46	557	495	1	1	7	23	42	34	76	272	1,888	2,445
New Jersey	N	0	0	N	N	—	0	3	4	11	—	14	41	329	473
New York (Upstate)	20	11	24	282	261	1	0	1	2	1	34	22	233	520	569
New York City	—	0	3	2	17	—	0	1	4	5	—	18	44	397	594
Pennsylvania	—	7	35	273	217	—	1	5	13	25	—	27	61	642	809
E.N. Central	2	2	12	59	109	—	0	7	20	22	82	94	219	2,306	2,891
Illinois	—	0	4	12	21	—	0	4	1	7	—	24	53	493	1,054
Indiana	—	0	3	5	5	—	0	1	3	—	42	12	67	341	274
Michigan	2	1	5	27	13	—	0	1	—	2	6	16	35	456	484
Ohio	—	0	6	15	70	—	0	7	15	11	33	23	50	616	638
Wisconsin	N	0	0	N	N	—	0	1	1	2	1	15	44	400	441
W.N. Central	3	5	20	157	200	5	2	12	95	86	42	44	100	1,239	1,259
Iowa	1	0	5	27	—	—	0	2	1	2	3	7	18	193	206
Kansas	1	1	5	44	54	—	0	1	1	4	5	7	17	170	181
Minnesota	—	1	6	25	41	—	0	1	1	—	20	10	60	349	288
Missouri	1	1	6	27	38	5	2	12	86	74	13	15	40	377	370
Nebraska†	—	0	0	—	—	—	0	2	6	2	—	3	12	91	108
North Dakota	—	0	7	13	17	—	0	1	—	—	1	0	46	8	15
South Dakota	—	0	4	21	50	—	0	1	—	4	—	2	8	51	91
S. Atlantic	14	36	118	1,106	1,278	4	18	94	472	339	222	200	514	4,427	5,047
Delaware	—	0	0	—	—	—	0	1	6	4	—	2	9	49	52
District of Columbia	—	0	0	—	—	—	0	1	—	—	3	1	7	35	24
Florida	—	0	99	99	201	—	0	3	12	10	143	96	230	2,007	1,875
Georgia	—	4	9	98	161	—	0	4	11	62	—	25	87	563	783
Maryland†	—	8	14	200	199	3	1	6	22	36	25	12	39	295	386
North Carolina	14	8	18	243	293	—	15	87	384	176	33	32	114	665	659
South Carolina†	—	3	11	79	117	1	1	6	10	27	18	19	73	379	728
Virginia†	—	10	27	333	281	—	2	10	26	20	—	20	66	390	461
West Virginia	—	1	13	54	26	—	0	2	1	3	—	2	19	44	79
E.S. Central	1	4	16	139	80	5	4	18	95	116	57	54	115	1,152	1,217
Alabama†	1	1	7	48	46	—	0	8	22	29	12	13	41	378	296
Kentucky	—	0	5	7	7	—	0	1	—	1	14	8	27	198	191
Mississippi	—	0	2	4	—	—	0	3	1	5	6	13	62	257	330
Tennessee†	—	2	9	80	27	5	3	18	72	81	25	14	41	319	400
W.S. Central	1	14	34	462	567	—	1	161	30	33	33	76	922	1,379	1,865
Arkansas	1	0	3	20	23	—	0	32	21	21	15	14	43	396	341
Louisiana	—	0	0	—	—	—	0	1	—	5	3	6	43	50	444
Oklahoma	—	1	9	44	56	—	0	154	6	5	15	7	48	199	187
Texas†	—	12	29	398	488	—	0	8	3	2	—	44	839	734	893
Mountain	—	4	16	81	143	1	0	6	15	21	26	46	110	1,060	1,133
Arizona	—	2	11	63	105	—	0	6	2	12	—	12	67	197	315
Colorado	—	0	2	—	13	1	0	1	1	2	15	12	45	357	265
Idaho†	—	0	12	—	—	—	0	2	1	1	2	2	9	81	95
Montana	—	0	2	7	3	—	0	2	2	1	5	2	16	80	49
Nevada†	—	0	2	—	5	—	0	0	—	—	—	3	17	65	100
New Mexico†	—	0	2	6	4	—	0	2	4	3	—	4	13	90	127
Utah	—	0	5	3	1	—	0	2	3	—	4	5	30	157	147
Wyoming	—	0	2	2	12	—	0	1	2	2	—	1	12	33	35
Pacific	2	4	15	101	91	1	0	1	5	2	95	109	426	2,641	2,604
Alaska	—	0	4	13	1	—	0	0	—	—	4	1	7	44	27
California	2	3	15	85	87	1	0	1	4	—	75	86	292	2,022	1,959
Hawaii	—	0	0	—	—	—	0	0	—	—	1	5	15	119	153
Oregon†	—	0	1	3	3	—	0	1	1	2	4	7	25	213	221
Washington	U	0	0	U	U	N	0	0	N	N	11	9	124	243	244
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	2	U	1
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	3	—	26
Puerto Rico	—	2	6	57	42	N	0	0	N	N	—	7	35	81	307
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.

* Incidence data for reporting years 2005 and 2006 are provisional.

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending July 22, 2006, and July 23, 2005 (29th Week)*

Reporting area	Shiga toxin-producing <i>E. coli</i> (STEC) [†]					Shigellosis					Streptococcal disease, invasive, group A				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	45	51	297	907	1,172	115	212	1,013	4,884	6,924	36	87	283	3,011	2,952
New England	4	3	23	73	107	2	5	31	130	142	3	5	15	142	182
Connecticut	—	0	22	22	27	—	0	25	25	25	U	0	3	U	71
Maine [§]	—	0	5	—	17	1	0	3	3	7	2	0	2	12	9
Massachusetts	2	1	7	38	42	1	4	11	89	91	—	3	6	86	76
New Hampshire	2	0	2	9	10	—	0	4	5	4	1	0	9	31	10
Rhode Island	—	0	2	2	2	—	0	6	5	9	—	0	3	4	7
Vermont [§]	—	0	2	2	9	—	0	4	3	6	—	0	2	9	9
Mid. Atlantic	5	4	107	63	136	10	16	72	396	672	6	15	43	575	631
New Jersey	—	0	7	3	31	—	5	16	145	197	—	2	7	84	129
New York (Upstate)	—	1	103	19	56	10	4	60	125	154	6	4	32	216	182
New York City	—	0	3	8	7	—	4	14	82	258	—	2	10	71	126
Pennsylvania	—	0	8	—	42	—	2	48	44	63	—	5	13	204	194
E.N. Central	2	10	38	188	233	4	20	96	450	507	3	16	42	555	628
Illinois	—	1	10	20	62	—	7	26	123	138	—	4	10	111	210
Indiana	—	1	6	27	29	3	2	56	76	45	2	2	11	82	61
Michigan	2	1	8	34	48	—	3	10	94	139	1	3	11	151	155
Ohio	—	3	14	62	49	1	3	11	91	48	—	4	19	175	133
Wisconsin	—	2	15	45	45	—	3	10	66	137	—	1	4	36	69
W.N. Central	6	7	35	149	175	12	39	78	731	665	—	5	57	225	183
Iowa	—	2	10	53	42	—	1	7	36	46	N	0	0	N	N
Kansas	—	0	4	—	18	—	4	20	64	62	—	1	5	43	30
Minnesota	6	3	19	77	28	2	2	8	52	40	—	0	52	106	64
Missouri	4	2	9	82	49	7	19	70	466	454	—	1	5	44	50
Nebraska [§]	—	1	5	19	24	—	2	11	39	43	—	0	4	19	17
North Dakota	—	0	15	—	1	3	0	2	7	2	—	0	5	7	6
South Dakota	—	0	5	16	13	—	2	17	67	18	—	0	3	6	16
S. Atlantic	5	7	39	158	164	49	52	122	1,323	1,015	12	21	41	702	564
Delaware	—	0	1	1	2	—	0	2	2	8	—	0	2	7	1
District of Columbia	—	0	1	—	—	—	0	2	6	8	—	0	2	9	7
Florida	2	1	29	49	60	43	26	66	655	496	4	5	12	162	149
Georgia	—	1	6	28	19	—	15	38	429	253	—	4	12	134	115
Maryland [§]	3	1	5	20	27	5	2	8	44	40	1	3	12	124	112
North Carolina	3	1	11	42	21	—	1	22	95	99	6	0	26	112	81
South Carolina [§]	—	0	2	4	3	1	1	9	60	55	1	1	6	47	27
Virginia [§]	—	0	8	—	31	—	1	9	32	56	—	2	11	86	54
West Virginia	—	0	2	—	1	—	0	1	—	—	—	0	6	21	18
E.S. Central	13	2	11	68	63	4	14	35	344	792	4	3	11	138	121
Alabama [§]	—	0	3	8	15	—	3	14	99	161	N	0	0	N	N
Kentucky	3	1	8	22	20	—	6	23	148	151	1	0	5	30	25
Mississippi	—	0	2	—	2	—	1	6	36	47	—	0	0	—	—
Tennessee [§]	—	1	4	25	26	4	3	11	61	433	3	3	9	108	96
W.S. Central	—	1	52	13	49	2	27	596	393	1,892	6	6	58	235	194
Arkansas	—	0	2	6	8	2	1	7	46	32	2	0	5	20	11
Louisiana	—	0	2	—	14	—	0	11	1	83	—	0	1	1	4
Oklahoma	—	0	8	7	12	—	4	286	54	409	—	2	14	67	75
Texas [§]	1	1	44	38	15	—	23	308	292	1,368	4	4	43	147	104
Mountain	3	4	15	77	125	10	17	47	309	339	2	10	78	383	390
Arizona	—	0	4	16	13	—	8	29	131	174	—	3	57	180	168
Colorado	3	1	6	33	29	4	3	18	67	51	—	3	8	92	127
Idaho [§]	2	1	7	27	20	3	0	4	9	6	—	0	2	8	2
Montana	—	0	2	—	8	—	0	1	4	5	—	0	0	—	—
Nevada [§]	—	0	3	7	12	—	1	8	28	30	—	0	6	—	1
New Mexico [§]	—	0	3	4	14	—	2	9	36	50	1	1	7	49	54
Utah	3	1	7	33	27	3	1	4	33	22	1	1	6	51	36
Wyoming	—	0	3	6	2	—	0	1	1	1	—	0	1	3	2
Pacific	7	7	55	118	120	22	41	148	808	900	—	2	9	56	59
Alaska	—	0	2	—	8	—	0	2	7	10	—	0	0	—	—
California	7	4	18	81	52	21	32	104	632	778	—	0	0	—	—
Hawaii	—	0	4	6	4	1	0	4	22	14	—	2	9	56	59
Oregon [§]	—	2	47	32	37	—	2	31	76	45	N	0	0	N	N
Washington	—	2	32	31	19	—	2	43	71	53	N	0	0	N	N
American Samoa	U	0	0	U	U	U	0	2	U	3	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	3	—	9	—	0	0	—	—
Puerto Rico	—	0	1	—	—	—	0	2	4	3	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.

* Incidence data for reporting years 2005 and 2006 are provisional.

† Includes *E. coli* O157:H7; Shiga toxin positive, serogroup non-O157; and Shiga toxin positive, not serogrouped.

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending July 22, 2006, and July 23, 2005 (29th Week)*

Reporting area	<i>Streptococcus pneumoniae</i> , invasive disease Drug resistant, all ages					Syphilis, primary and secondary					Varicella (chickenpox)				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	12	51	334	1,595	1,722	65	166	334	4,459	4,606	106	800	3,204	27,113	16,960
New England	—	1	24	16	154	3	4	17	112	113	3	43	144	992	3,520
Connecticut	U	0	7	U	65	—	0	11	22	24	U	0	58	U	993
Maine†	N	0	0	N	N	—	0	2	8	1	—	5	20	151	209
Massachusetts	—	0	6	—	67	3	2	5	71	76	—	11	54	92	1,581
New Hampshire	—	0	0	—	—	—	0	2	6	7	1	5	43	261	200
Rhode Island	—	0	11	6	14	—	0	6	3	5	—	0	0	—	—
Vermont†	—	0	2	10	8	—	0	1	2	—	2	12	50	488	537
Mid. Atlantic	—	3	15	102	151	14	21	35	604	572	—	103	183	3,051	3,087
New Jersey	N	0	0	N	N	3	2	7	86	81	—	0	0	—	—
New York (Upstate)	—	1	10	39	62	5	2	14	87	38	—	0	0	—	—
New York City	U	0	0	U	U	6	10	23	301	356	—	0	0	—	—
Pennsylvania	—	2	9	63	89	—	5	9	130	97	—	103	183	3,051	3,087
E.N. Central	—	11	41	387	426	4	18	38	457	492	23	213	585	9,920	3,747
Illinois	—	1	3	13	17	2	9	23	218	264	—	1	5	13	59
Indiana	—	2	21	103	136	—	1	4	32	38	N	0	347	N	70
Michigan	—	0	4	15	28	2	2	19	64	48	4	102	174	2,990	2,372
Ohio	—	6	32	256	245	—	4	8	115	122	19	82	420	6,347	947
Wisconsin	N	0	0	N	N	—	1	4	28	20	—	12	52	570	299
W.N. Central	—	1	191	32	28	1	4	9	130	154	9	22	84	993	246
Iowa	N	0	0	N	N	—	0	3	9	4	N	0	0	N	N
Kansas	N	0	0	N	N	—	0	2	12	13	—	0	0	—	—
Minnesota	—	0	191	—	—	—	1	3	16	50	—	0	0	—	—
Missouri	—	1	3	32	22	1	3	8	92	84	7	17	82	934	157
Nebraska†	—	0	0	—	2	—	0	1	1	3	—	0	0	—	—
North Dakota	—	0	1	—	1	—	0	1	—	—	2	0	25	27	12
South Dakota	—	0	0	—	3	—	0	1	—	—	—	1	12	32	77
S. Atlantic	10	24	53	855	706	21	43	186	1,035	1,071	36	90	860	2,875	1,307
Delaware	—	0	2	—	1	—	0	2	14	6	—	1	5	43	22
District of Columbia	—	0	3	20	12	—	1	9	57	64	—	0	5	21	20
Florida	10	13	36	468	376	14	14	29	400	388	—	0	0	—	—
Georgia	—	7	29	281	232	—	8	147	132	191	—	0	0	—	—
Maryland†	—	0	0	—	—	—	5	19	163	174	—	0	0	—	—
North Carolina	N	0	0	N	N	5	5	17	155	139	—	0	0	—	—
South Carolina†	—	0	0	—	—	—	1	7	38	31	3	16	53	730	350
Virginia†	N	0	0	N	N	2	2	12	75	76	28	27	812	1,077	243
West Virginia	—	1	14	86	85	—	0	1	1	2	5	26	70	1,004	672
E.S. Central	1	3	13	124	122	8	11	21	350	258	1	0	70	68	7
Alabama†	N	0	0	N	N	—	3	12	136	92	1	0	70	68	7
Kentucky	—	0	5	23	22	1	1	8	36	22	N	0	0	N	N
Mississippi	—	0	0	—	1	—	0	6	31	28	—	0	0	—	—
Tennessee†	1	2	13	101	99	7	5	13	147	116	N	0	0	N	N
W.S. Central	—	0	4	13	96	6	25	40	770	701	27	206	1,757	7,428	3,303
Arkansas	—	0	3	11	12	—	0	6	38	30	—	6	110	553	—
Louisiana	—	0	4	2	84	4	4	17	113	153	—	0	8	33	108
Oklahoma	N	0	0	N	N	1	1	6	40	21	—	0	0	—	—
Texas†	N	0	0	N	N	1	18	29	579	497	27	201	1,647	6,842	3,195
Mountain	1	1	27	66	39	4	7	17	207	241	7	52	138	1,786	1,743
Arizona	N	0	0	N	N	4	4	13	101	82	—	0	0	—	—
Colorado	N	0	0	N	N	—	1	3	23	26	7	33	76	946	1,186
Idaho†	N	0	0	N	N	—	0	1	2	19	—	0	0	—	—
Montana	—	0	1	—	—	—	0	1	1	5	—	0	0	—	—
Nevada†	—	0	27	4	2	—	1	12	44	71	—	0	2	4	—
New Mexico†	—	0	1	1	—	—	1	5	34	31	—	3	34	280	150
Utah	—	0	8	28	17	—	0	1	2	7	—	10	55	526	362
Wyoming	1	0	3	33	20	—	0	0	—	—	—	0	8	30	45
Pacific	—	0	0	—	—	4	32	49	794	1,004	—	0	0	—	—
Alaska	—	0	0	—	—	—	0	4	5	5	—	0	0	—	—
California	N	0	0	N	N	4	28	42	659	900	—	0	0	—	—
Hawaii	—	0	0	—	—	—	0	2	12	4	N	0	0	N	N
Oregon†	N	0	0	N	N	—	0	6	9	17	N	0	0	N	N
Washington	N	0	0	N	N	—	3	11	109	78	N	0	0	N	N
American Samoa	—	0	0	—	—	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	—	0	0	—	—	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	3	—	2	12	—	375
Puerto Rico	N	0	0	N	N	—	3	10	54	135	—	7	47	178	457
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.

U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.

* Incidence data for reporting years 2005 and 2006 are provisional.

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending July 22, 2006, and July 23, 2005 (29th Week)*

Reporting area	West Nile virus disease [†]									
	Neuroinvasive					Non-neuroinvasive				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max		
United States	—	1	155	9	129	—	0	203	6	227
New England	—	0	3	—	—	—	0	2	—	—
Connecticut	—	0	2	—	—	—	0	1	—	—
Maine [§]	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	3	—	—	—	0	1	—	—
New Hampshire	—	0	0	—	—	—	0	0	—	—
Rhode Island	—	0	1	—	—	—	0	0	—	—
Vermont [§]	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	—	0	10	—	2	—	0	4	—	3
New Jersey	—	0	1	—	—	—	0	2	—	—
New York (Upstate)	—	0	7	—	—	—	0	2	—	—
New York City	—	0	2	—	—	—	0	2	—	—
Pennsylvania	—	0	3	—	2	—	0	2	—	3
E.N. Central	—	0	39	—	12	—	0	18	—	4
Illinois	—	0	25	—	4	—	0	16	—	3
Indiana	—	0	2	—	1	—	0	1	—	—
Michigan	—	0	14	—	—	—	0	3	—	—
Ohio	—	0	9	—	5	—	0	4	—	—
Wisconsin	—	0	3	—	2	—	0	2	—	1
W.N. Central	—	0	26	3	15	—	0	80	5	44
Iowa	—	0	3	—	—	—	0	5	1	—
Kansas	—	0	3	—	1	—	0	1	1	N
Minnesota	—	0	5	—	3	—	0	5	—	4
Missouri	—	0	4	1	1	—	0	3	—	1
Nebraska [§]	—	0	9	1	2	—	0	24	1	4
North Dakota	—	0	4	—	2	—	0	15	—	7
South Dakota	—	0	7	1	6	—	0	33	2	28
S. Atlantic	—	0	6	—	3	—	0	4	—	4
Delaware	—	0	1	—	—	—	0	0	—	—
District of Columbia	—	0	1	—	—	—	0	1	—	—
Florida	—	0	2	—	2	—	0	4	—	3
Georgia	—	0	3	—	—	—	0	3	—	1
Maryland [§]	—	0	2	—	—	—	0	1	—	—
North Carolina	—	0	1	—	1	—	0	1	—	—
South Carolina [§]	—	0	1	—	—	—	0	0	—	—
Virginia [§]	—	0	0	—	—	—	0	1	—	—
West Virginia	—	0	0	—	—	N	0	0	N	N
E.S. Central	—	0	10	2	3	—	0	5	—	4
Alabama [§]	—	0	1	—	—	—	0	2	—	—
Kentucky	—	0	1	—	—	—	0	0	—	—
Mississippi	—	0	9	2	3	—	0	5	—	4
Tennessee [§]	—	0	3	—	—	—	0	1	—	—
W.S. Central	—	0	32	2	39	—	0	22	—	19
Arkansas	—	0	3	—	—	—	0	2	—	3
Louisiana	—	0	20	—	18	—	0	9	—	8
Oklahoma	—	0	6	—	1	—	0	3	—	—
Texas [§]	—	0	16	2	20	—	0	13	—	8
Mountain	—	0	16	1	7	—	0	39	1	30
Arizona	—	0	8	—	4	—	0	8	—	10
Colorado	—	0	5	1	1	—	0	13	—	16
Idaho [§]	—	0	2	—	—	—	0	3	1	—
Montana	—	0	3	—	—	—	0	9	—	—
Nevada [§]	—	0	3	—	1	—	0	8	—	2
New Mexico [§]	—	0	3	—	1	—	0	4	—	2
Utah	—	0	6	—	—	—	0	8	—	—
Wyoming	—	0	2	—	—	—	0	1	—	—
Pacific	—	0	50	1	48	—	0	90	—	119
Alaska	—	0	0	—	—	—	0	0	—	—
California	—	0	50	1	48	—	0	89	—	116
Hawaii	—	0	0	—	—	—	0	0	—	—
Oregon [§]	—	0	1	—	—	—	0	2	—	3
Washington	—	0	0	—	—	—	0	0	—	—
American Samoa	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.

U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.

* Incidence data for reporting years 2005 and 2006 are provisional.

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

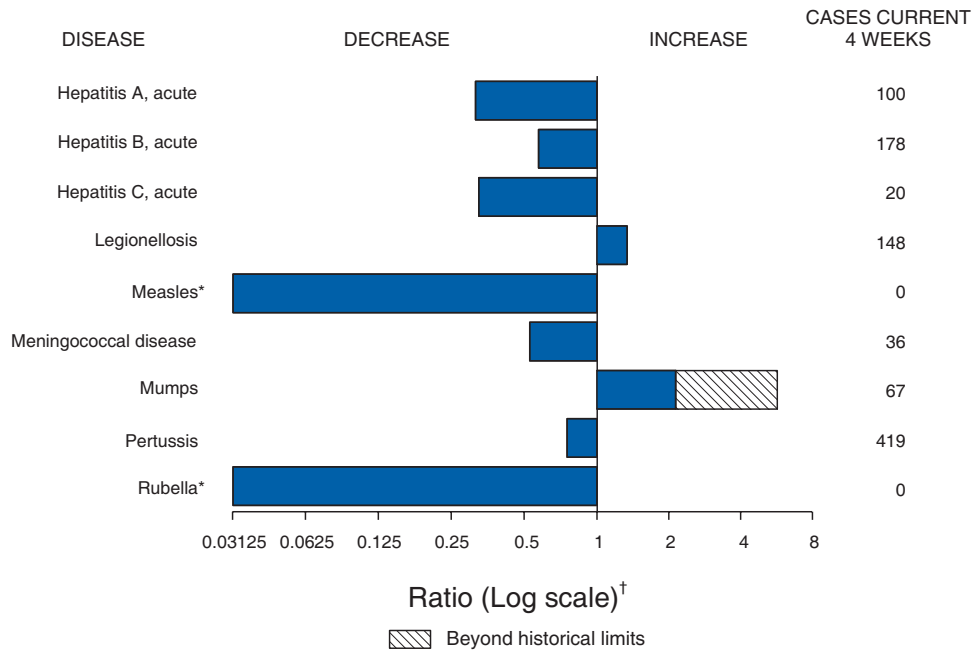
[§] Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE III. Deaths in 122 U.S. cities,* week ending July 22, 2006 (29th Week)

Table with columns for Reporting Area, All causes, by age (years), and P&I Total. Includes sub-sections for New England, Mid-Atlantic, E.N. Central, W.N. Central, S. Atlantic, E.S. Central, W.S. Central, Mountain, Pacific, and Total.

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.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals July 22, 2006, with historical data



* No measles or rubella cases were reported for the current 4-week period yielding a ratio for week 29 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.

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