

## Cancer Survivors — United States, 2007

As a result of advances in early detection and treatment, cancer has become a curable disease for some and a chronic illness for others; persons living with a history of cancer are now described as cancer survivors rather than cancer victims (1). From 1971 to 2001, the number of cancer survivors in the United States increased from 3.0 million to 9.8 million (2). To update those data, published in 2004, the National Cancer Institute (NCI) and CDC analyzed cancer incidence and follow-up information from nine Surveillance, Epidemiology, and End Results (SEER) programs to estimate the number of persons in the United States ever diagnosed with cancer who were alive on January 1, 2007. This report summarizes the results of that analysis, which indicated that the number of cancer survivors increased from 9.8 million in 2001 to 11.7 million in 2007. Breast, prostate, and colorectal cancers were the most common types of cancer among survivors, accounting for 51% of diagnoses. As of January 1, 2007, an estimated 64.8% of cancer survivors had lived  $\geq 5$  years after their diagnosis of cancer, and 59.5% of survivors were aged  $\geq 65$  years. Because many cancer survivors live long after diagnosis and the U.S. population is aging, the number of persons living with a history of cancer is expected to continue to increase. Public health and health-care professionals should understand the potential long-term needs of cancer survivors, engage in health promotion (e.g., urging cancer screening and smoking cessation), and ensure coordination of follow-up care for this growing population.

For this report, data on persons with malignant cancer diagnosed during 1975–2006 were obtained from the SEER Program at NCI. Persons who had diagnoses of in situ cancer or nonmelanoma skin cancer were excluded. The SEER Program consists of cancer registries throughout the United States and has been collecting information on tumor characteristics, patient demographics, and follow-up since January 1, 1973. The estimates in this report are based on information from

the nine SEER registries\* that have provided data continually since 1975; these registries cover approximately 10% of the U.S. population.

To estimate the number of persons in the United States ever diagnosed with cancer who were alive on January 1, 2007, a three-step analysis was performed (3). First, SEER statistical software<sup>†</sup> was used to estimate the proportion of persons enrolled in the nine registries who were alive on January 1, 2007, and who received a diagnosis of cancer during 1975–2006. Next, using NCI software,<sup>§</sup> these prevalence estimates were extrapolated to the entire U.S. population,<sup>¶</sup> while controlling for age, sex, and race. Finally, to adjust for underascertainment of cases that occurred before 1975, another NCI software\*\* was used to apply a completeness index (based on incidence and survival estimates) to the 1975–2006 prevalence estimates. The final results are estimates of the number of persons ever diagnosed with cancer who were alive on January 1, 2007, regardless of how long ago the diagnosis was made, and are characterized by patient age and sex, years since diagnosis, and cancer type.

\* Atlanta, Georgia; Connecticut; Detroit, Michigan; Hawaii; Iowa; New Mexico; San Francisco-Oakland, California; Seattle-Puget Sound, Washington; and Utah.

<sup>†</sup> Information available at <http://seer.cancer.gov/seerstat>.

<sup>§</sup> Information available at <http://srab.cancer.gov/projprev>.

<sup>¶</sup> An average of the 2006 and 2007 U.S. populations.

\*\* Information available at <http://srab.cancer.gov/compres>.

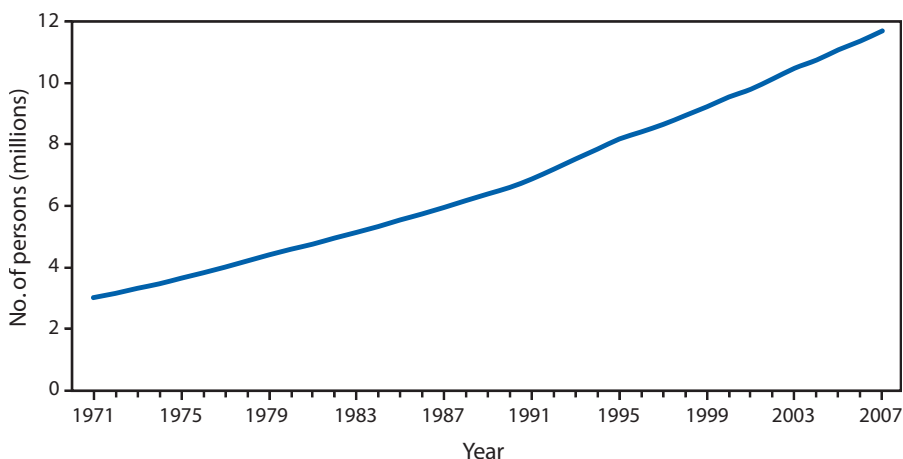
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The number of cancer survivors in the United States increased from an estimated 3.0 million in 1971 (1.5% of the U.S. population), to 9.8 million in 2001 (3.5%), and to 11.7 million in 2007 (3.9%) (Figure 1). Female breast (22.1%), prostate (19.4%), and colorectal (9.5%) cancers were the most common types of cancer diagnosed, accounting for 51.0% of diagnoses among persons who were alive on January 1, 2007

**FIGURE 1. Estimated number of living persons ever diagnosed with cancer — United States, January 1, 1971, to January 1, 2007**



**Source:** Altekruse SF, Kosary CL, Krapcho M, et al., eds. SEER cancer statistics review, 1975–2007. Bethesda, MD: National Cancer Institute; 2010 (based on November 2009 data submission). Available at [http://seer.cancer.gov/csr/1975\\_2007](http://seer.cancer.gov/csr/1975_2007).

(Table). Among all cancer survivors, 54.3% were female, and 45.7% were male.

An estimated 59.5% of cancer survivors on January 1, 2007, were aged  $\geq 65$  years; 35.2% were aged 40–64 years, 4.5% were aged 20–39 years, and  $< 1\%$  were aged  $\leq 19$  years (Table). The largest numbers of survivors with female breast cancer were aged 65–84 years (1,227,283) and 40–64 years (1,038,976).

The largest numbers of survivors with prostate (1,549,851) and colorectal cancer (625,129) were aged 65–84 years. The largest numbers of survivors with melanoma (393,133), thyroid (250,824), and cervical cancer (127,519) were aged 40–64 years. Among survivors aged 0–19 years, 33,001 (31.1%) had leukemia.

Among cancer survivors on January 1, 2007, an estimated 64.8% had lived with a diagnosis of cancer for  $\geq 5$  years; of those survivors, 57.2% were females (Figure 2). Among those who had lived with a diagnosis of cancer  $\geq 15$  years, 67.5% were females. Approximately 1.1 million of the 11.7 million cancer survivors had lived with a diagnosis of cancer for  $\geq 25$  years; of those survivors, 75.4% were females.

The *MMWR* series of publications is published by the Office of Surveillance, Epidemiology, and Laboratory Services, 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* 2011;60:[inclusive page numbers].

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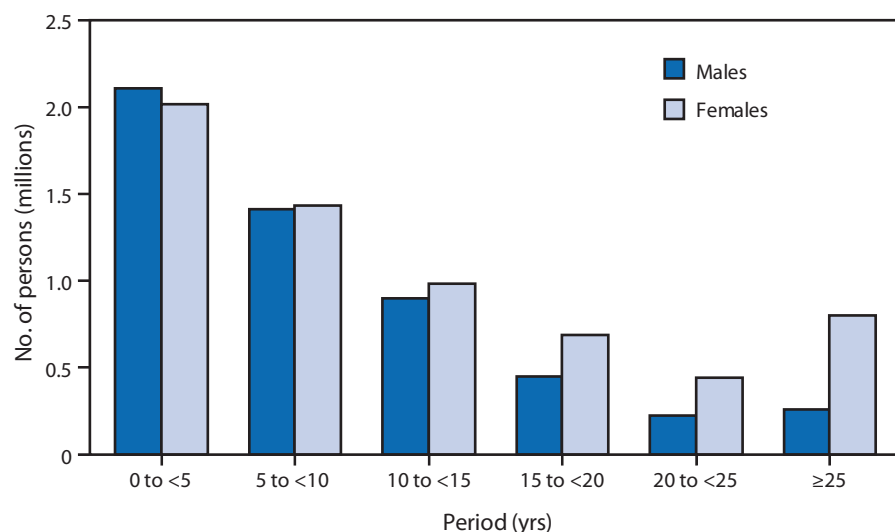
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TABLE. Estimated number of living persons ever diagnosed with cancer, by age group and cancer type — United States, January 1, 2007

Cancer type	Age group (yrs)					Overall	
	0–19	20–39	40–64	65–84	≥85	No.	(%)
<b>All types</b>	<b>106,083</b>	<b>522,000</b>	<b>4,122,070</b>	<b>5,743,200</b>	<b>1,220,382</b>	<b>11,713,736</b>	<b>(100.0)</b>
Female breast	80	37,618	1,038,976	1,227,283	287,899	2,591,855	(22.1)
Prostate	119	467	463,272	1,549,851	262,404	2,276,112	(19.4)
Colorectal	166	12,802	271,311	625,129	203,085	1,112,493	(9.5)
Gynecologic							
Cervix	92	19,885	127,519	83,923	15,761	247,180	(2.1)
Ovary	1,033	10,357	79,225	73,230	13,315	177,162	(1.5)
Corpus uteri	67	5,567	164,268	300,577	104,629	575,108	(4.9)
Hematologic							
Leukemia	33,001	38,522	70,190	85,507	17,053	244,272	(2.1)
Non-Hodgkin lymphoma	6,112	30,853	175,925	191,339	34,097	438,325	(3.7)
Hodgkin lymphoma	3,859	51,996	90,088	16,944	1,387	164,273	(1.4)
Bladder	221	4,630	121,403	327,086	81,895	535,236	(4.6)
Kidney and renal pelvis	7,915	13,357	112,029	128,644	19,544	281,490	(2.4)
Melanoma	1,907	66,091	393,133	285,249	46,901	793,283	(6.8)
Thyroid	1,778	64,155	250,824	105,996	11,502	434,256	(3.7)
Lung	174	3,084	110,065	228,806	28,488	370,617	(3.2)
Other	49,559	162,616	653,842	513,636	92,422	1,472,074	(12.6)

Source: Altekruse SF, Kosary CL, Krapcho M, et al., eds. SEER cancer statistics review, 1975–2007. Bethesda, MD: National Cancer Institute; 2010 (based on November 2009 data submission). Available at [http://seer.cancer.gov/csr/1975\\_2007](http://seer.cancer.gov/csr/1975_2007).

FIGURE 2. Estimated number of living persons ever diagnosed with cancer, by sex and period since diagnosis — United States, January 1, 2007



Source: Altekruse SF, Kosary CL, Krapcho M, et al., eds. SEER cancer statistics review, 1975–2007. Bethesda, MD: National Cancer Institute; 2010 (based on November 2009 data submission). Available at [http://seer.cancer.gov/csr/1975\\_2007](http://seer.cancer.gov/csr/1975_2007).

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### Editorial Note

Updating the 2004 report that showed an increase in cancer survivors from 1971 to 2001 (2), the findings in this report indicate that the population of cancer survivors continued to grow, both in number and as a percentage of the U.S. population, from 2001 to 2007. This growth can be attributed to multiple factors, including earlier detection, improved diagnostic methods, more effective treatment, improved clinical follow-up after treatment, and an aging U.S. population (1,4). If these trends continue, the number of cancer survivors is expected to increase further (4,5).

Similar to previous reports, this analysis found that the majority of cancer survivors are females and persons aged ≥65 years (2,6,7). Women are more likely to be survivors because cancers among women (e.g., breast or cervical cancer) usually occur at a younger age and can be detected early and treated successfully; in addition, women have a longer life expectancy than men. Among men, a substantial number of cancer survivors had prostate cancer, which is diagnosed more commonly among older men. The large proportion of cancer survivors aged ≥65 years reflects the increase in cancer risk with age (7) and the fact that more persons with diagnoses of cancer are surviving ≥5 years.

**What is already known on this topic?**

The number of persons living with a history of cancer (cancer survivors) in the United States increased from 3.0 million in 1971 to 9.8 million in 2001, as a result of earlier diagnosis through screening, more effective treatment, improved follow-up care, and an aging population.

**What is added by this report?**

As of January 1, 2007, the number of cancer survivors had increased to 11.7 million, or approximately 3.9% of the U.S. population.

**What are the implications for public health practice?**

The increasing number of cancer survivors underscores the need for medical and public health professionals to address the potential long-term and late effects of cancer on survivors' physical and psychosocial well-being, provide survivors with coordinated care, and promote the importance of 1) healthy behaviors (e.g., smoking cessation and physical activity) to reduce the risk for new or recurrent cancer and 2) early detection to increase the likelihood of survival with new or recurrent cancer.

The findings in this report are subject to at least four limitations. First, to calculate national estimates of cancer survivors, race- and age-specific proportions from SEER were extrapolated to the U.S. population, and the data do not account for other prognostic factors (e.g., smoking status or comorbidities). In addition, compared with the U.S. population, the SEER population is more urban and includes more persons who are foreign-born (8), which might limit generalizability. Second, because of the methods used, these cancer prevalence estimates might be lower than those obtained through self-reported cancer in national surveys because self-reported cancer cases in surveys tend to be overreported and are not confirmed diagnostically, whereas this study uses cancer registry data derived from medical record review (9). Third, persons with multiple primary tumors were categorized according to their first tumor; therefore, the number of survivors for certain cancer types is underestimated (10). Finally, the data do not permit specifying whether a cancer survivor is cured, in active therapy, living with a chronic cancer-related illness or disability, or dying from cancer.

Healthy behaviors such as smoking cessation, healthy eating, and regular physical activity can reduce the risk for cancer, and early detection of cancer can improve the quality of life and increase the likelihood of survival. With a steady increase in the number of cancer survivors during the past 40 years, additional research is needed to identify those survivors at risk for recurrence, secondary disease, or late effects (e.g., nerve

damage or infertility) from cancer and its treatment (e.g., chemotherapy or radiation). Further study also is needed to address the disparate burden of cancer among the medically underserved and the special needs of older cancer survivors, and to develop, test, and deliver measures to prevent or mitigate these adverse effects on survivors.

NCI and CDC are actively pursuing a better understanding of cancer survivorship. NCI's Office of Cancer Survivorship supports research to identify, examine, and prevent or control adverse effects associated with cancer and disseminates information to enhance the quality of life of survivors.<sup>††</sup> CDC works with state, territorial, tribal, and local partners to address various aspects of cancer survivorship, including development of cancer-control strategies, education of survivors and health-care providers regarding survivorship, and evaluation of the use and effectiveness of resources for cancer survivors and their families.<sup>§§</sup>

<sup>††</sup> Additional information available at <http://dccps.nci.nih.gov/ocs>.

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## Premastication of Food by Caregivers of HIV-Exposed Children — Nine U.S. Sites, 2009–2010

Premastication (i.e., chewing foods or medicines before feeding to a child) was reported recently as a route of human immunodeficiency (HIV) transmission through blood in saliva (1) and has been associated with transmission of other pathogens (2–7). Approximately 14% of caregivers in the United States report premastication (8); however, the frequency of this behavior among HIV-infected caregivers is unknown. To assess the prevalence of premastication among caregivers of children being treated in pediatric HIV clinics, which include perinatally HIV-exposed children (i.e., HIV-uninfected and HIV-infected children born to an HIV-infected mother), CDC conducted a cross-sectional survey at nine such clinics in the United States during December 2009–February 2010. This report describes the results of that survey, which indicated that among primary caregivers of children aged  $\geq 6$  months, 48 (31%) of 154 reported the children received premasticated food from themselves or someone else. Approximately 37% of black caregivers reported premastication, compared with 20% of non-black caregivers (prevalence ratio [PR] = 1.8). Premastication decreased with caregiver age and was used to feed children aged 1–36 months. Public health officials and health-care providers should educate the public about the risk for disease transmission via premastication and advise HIV-infected caregivers against the practice.

Pediatric HIV clinics with which the CDC had collaborated previously in premastication-related or longitudinal, HIV-related epidemiologic studies participated in this investigation. These clinics were located in Atlanta, Georgia; Dallas, Texas; Houston, Texas; Memphis, Tennessee; Miami, Florida; New Orleans, Louisiana; Newark, New Jersey; San Juan, Puerto Rico; and the District of Columbia. A 10-minute, self-administered paper questionnaire was distributed to primary caregivers during their child's clinic visit. A primary caregiver was defined as the person responsible for feeding, clothing, and housing the child. One survey per child with an appointment was allowed; therefore, multiple interviews were possible if a caregiver had multiple children with appointments. After completion of the survey, caregivers were provided written information and counseled about the risk for disease transmission through premastication. Of 203 primary caregivers approached, 192 (95%) were surveyed (11 declined participation).

Of the 192 primary caregivers surveyed, the majority were biologic mothers of the children (81%) and U.S.-born

(86%). Approximately 66% of caregivers were non-Hispanic black, 24% were Hispanic, and 7% were non-Hispanic white. The median age was 31 years for primary caregivers (range: 15–77 years) and 2 years for children (range: <1–18 years). Approximately 30% of caregivers had less than a high school education, and 49% had an annual household income of less than \$12,000.

Given the decreased likelihood that children are fed solid foods during the first months of life, CDC limited its analysis to caregivers of children who were aged  $\geq 6$  months at the time of investigation (155 [81%] of 192). Among primary caregivers of these children, 44 (29%) of 153 reported ever premasticating food for the child. Fourteen (10%) of 140 primary caregivers reported that someone else had given premasticated food to the child. Overall, 48 (31%) of 154 primary caregivers stated that they or someone else had premasticated food for the child, with biologic mothers representing 79% of premasticators. Black caregivers more frequently reported ever premasticating food, compared with non-blacks (37% versus 20%, respectively; PR = 1.8) (Table 1). Premastication decreased with increasing caregiver age at interview. Caregivers aged  $\leq 19$  years were significantly more likely to premasticate than those aged  $\geq 40$  years (44% versus 13%, respectively; PR = 3.5), as were those aged 20–29 years (38% versus 13%, respectively; PR = 2.9) and those aged 30–39 years (36% versus 13%, respectively; PR = 2.8). Similar prevalences of premastication were found regardless of the sex of the child and the primary caregiver's country of origin, education level, and income (Table 1).

Primary caregivers started premastication of food for children as young as age 1 month (median age: 7 months) and stopped premastication as late as age 36 months (median age: 13 months). Among 38 premasticating primary caregivers who described frequency of the behavior, 15 (39%) reported premasticating 1–3 days in a typical week, 14 (36%) reported 4 or more days, and nine (24%) reported less than once a week. The most commonly reported reasons for premastication, reported from a predetermined list, were “child wanting some of the caregiver's food” (64%), “caregiver not wanting the child to choke” (62%), and “prechewing is done in my family” (31%) (Table 2). Meat and fish (80%) and fruit (39%) were the most commonly reported food types premasticated by caregivers.

**TABLE 1. Prevalence of pre-mastication of food for HIV-exposed children\* aged ≥6 months, by selected characteristics — nine U.S. sites,† December 2009–February 2010**

Characteristic	Total	Pre-mastication		Prevalence ratio	95% CI
		No.	(%)		
<b>Sex of child</b>					
Male	75	25	(33)	1.1	(0.7–1.8)
Female	79	23	(29)	1.0	—
<b>Race of caregiver</b>					
Black	104	38	(37)	1.8	(1.0–3.3)
Non-black	49	10	(20)	1.0	—
<b>Education of caregiver</b>					
Less than high school diploma	43	16	(37)	1.0	—
High school diploma or higher	109	31	(28)	0.8	(0.5–1.2)
<b>Annual household income of caregiver</b>					
<\$12,000	55	20	(36)	1.0	—
≥\$12,000	67	19	(28)	0.8	(0.5–1.3)
<b>Age of caregiver (yrs)</b>					
0–19	9	4	(44)	3.5	(1.2–10.4)
20–29	45	17	(38)	2.9	(1.2–7.2)
30–39	55	20	(36)	2.8	(1.2–6.9)
≥40	39	5	(13)	1.0	—
<b>Country of origin of caregiver</b>					
U.S.-born	134	43	(32)	1.4	(0.6–3.5)
Non-U.S.-born	18	4	(22)	1.0	—

**Abbreviations:** HIV = human immunodeficiency virus; CI = confidence interval.

\* HIV-uninfected and HIV-infected children born to an HIV-infected mother.

† Pediatric clinics in Atlanta, Georgia; New Orleans, Louisiana; Newark, New Jersey; Memphis, Tennessee; Miami, Florida; Dallas, Texas; Houston, Texas; San Juan, Puerto Rico; and the District of Columbia.

**TABLE 2. Reasons given by primary caregivers for pre-mastication of food for HIV-exposed children\* aged ≥6 months (N = 45) — nine U.S. sites,† December 2009–February 2010**

Reason	No.	(%)
Child wanted some of the food	29	(64)
Did not want child to choke	28	(62)
Prechewing is done in my family	14	(31)
Heard about prechewing	4	(9)
Away from home with no baby food	4	(9)
Did not have store-bought baby food	2	(4)
Did not make baby food	1	(2)

**Abbreviation:** HIV = human immunodeficiency virus.

\* HIV-uninfected and HIV-infected children born to an HIV-infected mother.

† Pediatric clinics in Atlanta, Georgia; New Orleans, Louisiana; Newark, New Jersey; Memphis, Tennessee; Miami, Florida; Dallas, Texas; Houston, Texas; San Juan, Puerto Rico; and the District of Columbia.

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### Editorial Note

In 2007, an estimated 13% of 159 diagnoses of HIV and acquired immunodeficiency syndrome (AIDS) among children aged <13 years were attributed to modes other than perinatal transmission, including hemophilia, blood transfusion, and risk factors not reported or identified.\* In 2008, a case series of three pediatric HIV cases concluded that pre-mastication was the likely mode of transmission for these children, a route not reported previously (1). Bleeding gums at the time of pre-mastication were reported in caregivers of two of the three children in the case series. The third caregiver could not recall her dental condition at the time of pre-mastication. One of these transmissions was to a child whose mother was not HIV-infected. HIV transmission via pre-mastication is presumed to require blood in the mouth of the caregiver. No evidence suggests that saliva alone can transmit HIV.

In addition to HIV, transmission of hepatitis B virus (3) and group A streptococcus (6) by pre-mastication has been documented. Furthermore, pre-mastication has been found to be associated with increased risk for infection with *Helicobacter pylori* (7), *Streptococcus mutans* (2), human herpesvirus 8 (4), and Epstein Barr virus (5). Only one study has indicated that pre-mastication can be associated with decreased risk for infection; that study involved respiratory syncytial virus in Alaska Native infants aged <6 months (9).

The prevalence of pre-mastication observed in this investigation is particularly important because most of the caregivers and pre-masticators were biologic mothers; thus, most caregivers were HIV-infected, posing a potential risk for HIV transmission to children in their care who are uninfected. Furthermore, the higher prevalence of pre-mastication among black and younger caregivers suggests the need for targeted prevention messages for these populations.

\* Additional information available at <http://www.cdc.gov/hiv/surveillance/resources/reports/2008report/index.htm>.

**What is already known on this topic?**

Premastication (i.e., prechewing) of food is a risk factor for human immunodeficiency virus (HIV) transmission to children.

**What is added by this report?**

This is the first epidemiologic study to investigate the prevalence of and reasons for premastication of food by caregivers of HIV-exposed children in various geographic regions of the United States. In a convenience sample of 154 primary caregivers, 31% of HIV-exposed children aged  $\geq 6$  months received premasticated food from a caregiver; younger caregivers reporting significantly higher rates of this practice compared with older caregivers, and black caregivers reported premastication more frequently than non-black caregivers.

**What are the implications for public health practice?**

Understanding that premastication is a common behavior, particularly among certain racial/ethnic populations, public health officials and health-care providers should educate the public about the potential risk for disease transmission, including HIV, via premastication.

The reasons given by caregivers for premastication might suggest that the practice is mostly situational or in response to immediate circumstances, as opposed to reasons that reflect an inability to provide baby food or formula. Therefore, prevention messages might be effective among this population, particularly those with situational reasons for premastication. Qualitative research on premastication might be helpful to explore the reasons for premastication and to determine helpful, realistic alternatives for HIV-infected caregivers.

The findings in this report are subject to at least three limitations. First, gathering HIV status information on caregivers was not possible because surveys were completed in a setting where caregivers were accompanied by their children and other family members, some of whom might have been unaware of their caregiver's HIV status. However, given that all caregivers were surveyed in pediatric HIV clinics and 81% of primary caregivers were biologic mothers, the majority of the caregivers surveyed likely were HIV-infected. Second, the surveyed caregivers were asked to recall behaviors that might have taken place several years before survey administration; therefore, these

data might be affected by recall bias. Finally, this cross-sectional investigation included a convenience sample of caregivers of children seen in HIV clinics and is not generalizable to all HIV-infected caregivers.

Although research on the risk for HIV transmission via premastication is limited, CDC recommends that HIV-infected caregivers not premasticate food for HIV-uninfected children because of the possibility of transmitting HIV to the child. Public health officials and health-care providers should continue to educate the public about the risk for disease transmission, including HIV, via premastication.

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## Japanese Encephalitis in Two Children — United States, 2010

Japanese encephalitis virus (JEV) is the leading cause of vaccine-preventable encephalitis in Asia and the western Pacific. JEV is maintained in an enzootic cycle involving mosquitoes and amplifying vertebrate hosts, mainly pigs and wading birds. The virus is transmitted to humans primarily by *Culex* mosquitoes, which breed in flooded rice fields and pools of stagnant water and most often feed outdoors during the evening and night. JEV transmission occurs mainly in rural agricultural areas, but occasional human cases occur in urban areas. Japanese encephalitis (JE) in persons who have traveled or lived overseas is diagnosed infrequently in the United States, with only four cases identified from 1992 (when a JE vaccine was first licensed in the United States) to 2008 (1). This report describes the only cases diagnosed in the United States and reported to CDC since then. The first was a fatal case in a U.S. child who had visited relatives in the Philippines. The other occurred in a refugee who became ill while traveling from Thailand to the United States and whose diagnosis was complicated by concurrent neurocysticercosis. JE should be considered in the differential diagnosis for any patient with an acute neurologic infection who recently has been in a JE-endemic country. Travelers to JE-endemic countries should be advised of the risk for JE and the importance of personal protective measures to prevent mosquito bites (2). JE vaccine should be considered for travelers who might be at greater risk based on the season, location, and duration of their visit and their planned activities.

### Case Reports

**Case 1.** On July 18, 2010, a previously healthy girl aged 11 years was hospitalized in Nevada after 2 days of fever, headache, nausea, vomiting, and neck pain. During June 21–July 12, she had visited the Philippines with four relatives and had received numerous mosquito bites. Two of the relatives were born in the Philippines; the patient and her parents (who did not accompany her on the trip) were born in the United States. The girl had no history of JE vaccination and neither she nor her travel companions sought pretravel health advice. The travelers spent most of their time in Metro Manila, staying with relatives in a screened house in a compound in urban Quezon City. They took day trips on four occasions to coastal and rural destinations within a few hours' drive of Manila. They also took a 2-night trip to a resort on an island where they slept in air-conditioned, screened accommodations. While at the resort, they walked on the beach one evening.

On admission, the patient had fever (103.0°F [39.4°C]) and a peripheral white blood cell (WBC) count of 23,400/mm<sup>3</sup> (normal: 4,500–13,500/mm<sup>3</sup>). Cerebrospinal fluid (CSF) showed pleocytosis (403 WBCs/mm<sup>3</sup> [normal: 0–5/mm<sup>3</sup>]) with 80% neutrophils and 11% lymphocytes, slightly elevated protein (50 mg/dL [normal: 5–40 mg/dL]), and normal glucose concentrations. Healing insect bites were noted on examination. Initial management included intravenous antibiotics for presumed bacterial meningitis. The patient was alert and ambulatory until the evening of July 19, when she became somnolent and developed focal motor seizures. A computed tomography scan showed effacement of the cortical sulci. On July 20, she developed acute pulmonary edema, bradycardia, and hypotension and required mechanical ventilation. Her pupils became fixed and dilated and an electroencephalogram (EEG) showed little cerebral activity. She developed ventricular tachycardia and died July 21, 5 days after illness onset.

Formalin-fixed brain tissue collected at autopsy showed histopathologic changes indicative of meningoencephalitis, and positive immunohistochemical staining for JEV serocomplex group flavivirus antigens in multiple areas. JEV ribonucleic acid was identified in frozen brain tissue by reverse transcription–polymerase chain reaction using flavivirus consensus primers followed by nucleic acid sequencing. CSF collected on July 18 tested positive for JEV-specific immunoglobulin M (IgM) and neutralizing antibodies. Tests for other viral, bacterial, and fungal causes of meningitis and encephalitis were negative.

**Case 2.** On July 14, 2010, a boy aged 6 years was hospitalized in Texas with fever, somnolence, headache, vomiting, and refusal to walk. His illness had commenced 2 days earlier while en route to the United States from a refugee camp in north-west Thailand, where he had resided since being born there to parents from Burma. In the camp, he had lived in communal housing. Mosquito nets were available but not used regularly. Pigs were kept within the grounds of the camp, and rice fields were nearby. The boy reportedly had received childhood vaccinations in Thailand, where JE vaccine is part of the routine immunization schedule, but no records confirming his receipt of JE vaccine were available.

On admission to the hospital in Texas, the patient had fever (104.5°F [40.3°C]) and nuchal rigidity. His peripheral WBC count was 25,900/mm<sup>3</sup> with 87% neutrophils and 6% band-forms. CSF showed a WBC count of 600/mm<sup>3</sup> with 87% neutrophils, slightly elevated protein (52 mg/dL), and normal glucose concentrations. Magnetic resonance imaging (MRI) of the brain with contrast showed a lesion in the left frontal



lobe, consistent with neurocysticercosis, and abnormal signal in the left thalamus.

During the next 2 days, the patient developed reduced awareness and became nonverbal, with brief response only to his name and painful stimuli. No seizures were observed, and an EEG showed generalized slowing of cerebral activity but no seizure-related activity. On July 17, a repeat MRI also showed the left thalamic changes and abnormal signal around the lesion in the left frontal lobe. CSF collected the same day showed a WBC count of 55/mm<sup>3</sup> with lymphocytic predominance (72%), slightly elevated protein (49 mg/dL), and normal glucose concentrations.

A coinfection was suspected because the boy's clinical presentation was unusual for neurocysticercosis. CSF collected on July 17 (day 6 of illness) showed JEV-specific IgM and neutralizing antibodies. JEV neutralizing antibody titers increased more than fourfold between acute (day 3) and convalescent (day 19) serum samples. Cysticercosis serology on a serum sample was negative. CSF, blood, and urine bacterial cultures, CSF cryptococcal antigen testing, a malarial smear, dengue and human immunodeficiency virus serology, and respiratory viral testing on a nasopharyngeal aspirate also were negative.

The boy's neurologic symptoms resolved during his 24-day hospitalization. He completed a 21-day course of albendazole with corticosteroid taper for neurocysticercosis. On discharge, he was active, alert, and walking and talking normally.

#### Reported by

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#### Editorial Note

JE is an uncommon but often serious disease in travelers to JE-endemic countries. These two JE cases represent the fifth and sixth cases identified in the United States since 1992.

The Philippines and Thailand are both recognized as JE-endemic countries. Information on the incidence and

#### What is already known on the topic?

Japanese encephalitis (JE) is a mosquito-borne disease that occurs in Asia and the western Pacific. Cases among persons who have traveled or lived overseas are diagnosed infrequently in the United States.

#### What is added by this report?

Two JE cases were reported to CDC in 2010, one fatal case in a child who had visited relatives in the Philippines and the other in a refugee child from Thailand who recovered.

#### What are the implications for public health practice?

Health-care providers should advise travelers of the risk for JE virus infection and the importance of personal protective measures to prevent mosquito bites, and JE vaccine should be considered for some travelers who will be in a high-risk setting. JE should be considered in the differential diagnosis for any patient with an acute neurologic syndrome returning from a JE-endemic country.

epidemiology of JE in Thailand is more comprehensive because JE surveillance has been conducted there since 1976 (3). In the Philippines, JE studies have been conducted sporadically (4), but JE cases in the local population generally are unrecognized because JE surveillance is not conducted routinely and access to JE diagnostics is limited. Nonetheless, JEV transmission in the Philippines is clearly evident; the case in this report is the sixth travel-associated case reported worldwide since 1986 in a person from a nonendemic country traveling to the Philippines (1). Therefore, lack of reported cases in the local population should not be assumed to indicate absence of disease.

Concomitant JEV infection and neurocysticercosis is well-recognized in JE-endemic countries. Neurocysticercosis is caused by the larval stage of the pork tapeworm, *Taenia solium*. Humans are the host for the adult *T. solium* tapeworm, and neurocysticercosis is acquired by ingesting eggs excreted by an intestinal tapeworm carrier. Neurocysticercosis increases the risk for JEV neuroinvasive disease and might cause higher JE mortality rates (5,6). With coinfection, JE-related neuroimaging abnormalities tend to be more prominent on the side of the brain where the most cysts, or the solitary cyst, are located (5). Thalamic changes on the same side as the cyst and suggestive of JE (7) were noted in the boy (case 2) in this report. Negative cysticercosis serology, as occurred in this patient, is not uncommon with single cysts (8).

Case 1 of travel-associated JE occurred in a person of Asian origin (as did three of the most recent JE cases in U.S. travelers) who was visiting relatives in the Philippines. Travelers returning to their country of origin to visit friends and relatives are typically at greater risk than most tourists for travel-related infections but infrequently seek pretravel health advice (9). This limits their opportunity to receive information and

counseling on ways to reduce their risk for acquiring diseases during travel. Such risks might be reduced through targeted outreach to educate travelers who will be visiting friends and relatives about potential health risks and prevention methods, including immunizations.

The Advisory Committee on Immunization Practices recommends that all travelers to JE-endemic countries be informed of the risks for JE and use personal protective measures to reduce the risk for mosquito bites. JE vaccine is recommended for some travelers who will be in a high-risk area, based on season, location, duration, and activities (2). Two JE vaccines are licensed in the United States. In 2009, an inactivated Vero cell culture–derived JE vaccine (JE-VC) was approved for use in adults aged  $\geq 17$  years. An inactivated mouse brain–derived vaccine (JE-MB) has been licensed since 1992 for use in adults and children aged  $\geq 1$  year. However, JE-MB is no longer being produced and remaining doses will expire by May 2011. One pediatric clinical trial with JE-VC has been completed (10), but the vaccine currently is not licensed for use in U.S. children. Additional pediatric clinical trials are in progress in the Philippines and in non-JE–endemic countries, including five study sites in the United States.\* Other JE vaccines are manufactured and available for pediatric use in Asia but are not licensed in the United States. Federal agencies and the manufacturer are discussing additional options for making JE-VC available for pediatric use in the United States. If a patient who recently has been in a JE-endemic country presents with an acute neurologic syndrome (e.g., encephalitis, meningitis, or acute flaccid paralysis), clinicians should consider the diagnosis of JE. Health-care providers should contact their state or local health department or CDC's Division of Vector-Borne Diseases (telephone: 970-221-6400) for assistance with JEV diagnostic testing.

\*Additional information is available at <http://clinicaltrials.gov/ct2/show/nct01047839?term=japanese+encephalitis&rank=26>.

## Acknowledgments

This report is based, in part, on contributions by J Sejvar, MD, Div of Vector-Borne Diseases, and I McAuliffe, MS, S Montgomery, DVM, and P Wilkins, PhD, Div of Parasitic Diseases and Malaria, National Center for Emerging and Zoonotic Infectious Diseases, CDC.

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## Errata

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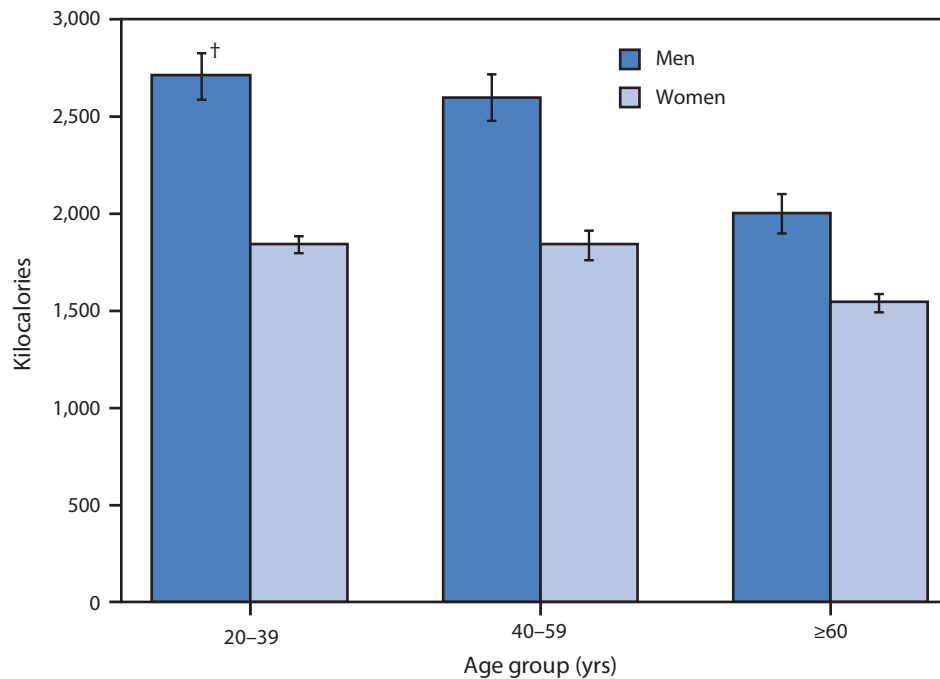
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In “Final 2009 Reports of Nationally Notifiable Infectious Diseases,” on page 1032, in Table 2, “Reported cases of notifiable diseases, by geographic division and area — United States, 2009,” for *Haemophilus influenzae*, invasive disease, age <5 yrs, certain serotype data were not included in the case counts for Upstate New York. The correct case counts and resulting totals are as follows: Serotype b: United States, **38**; Mid. Atlantic, **13**; New York (Upstate), **3**. Nonserotype b: United States, **245**; Mid. Atlantic, **22**; New York (Upstate), **9**. Unknown serotype: United States, **166**; Mid. Atlantic, **34**; New York (Upstate), **4**.

## QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

### Average Daily Intake of Kilocalories, by Sex and Age Group, for Adults Aged $\geq 20$ Years — National Health and Nutrition Examination Survey, United States, 2007–2008\*



\* Based on responses to a series of questions in the 24-hour dietary recall interview of the National Health and Nutrition Examination Survey.

† 95% confidence interval.

During 2007–2008, on average, men consumed 2,504 kilocalories daily, and women consumed 1,771 kilocalories daily. Men had a significantly higher intake of kilocalories than women in each of the three age groups: 20–39 years, 40–59 years, and  $\geq 60$  years. Men aged  $\geq 60$  years consumed fewer kilocalories than younger men, and women aged  $\geq 60$  years consumed fewer kilocalories than younger women.

**Source:** Wright JD, Wang CY. Trends in intake of energy and macronutrients in adults from 1999–2000 through 2007–2008. NCHS Data Brief no. 49. Available at <http://www.cdc.gov/nchs/data/databriefs/db49.htm>.

## Notifiable Diseases and Mortality Tables

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending March 5, 2011 (9th week)\*

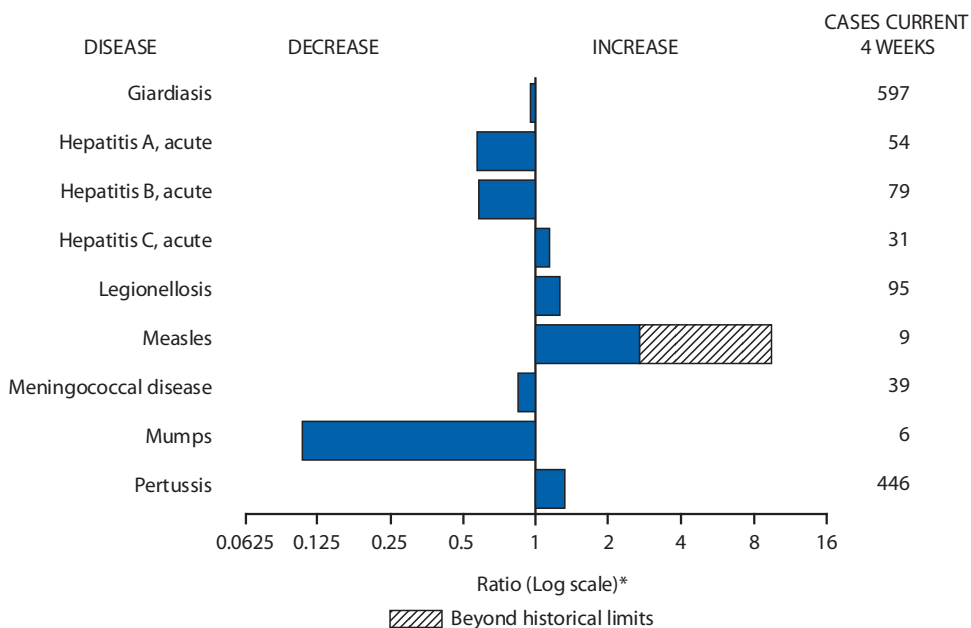
Disease	Current week	Cum 2011	5-year weekly average <sup>†</sup>	Total cases reported for previous years					States reporting cases during current week (No.)
				2010	2009	2008	2007	2006	
Anthrax	—	—	0	—	1	—	1	1	
Arboviral diseases <sup>§, ¶</sup> :									
California serogroup virus disease	—	—	0	74	55	62	55	67	
Eastern equine encephalitis virus disease	—	—	—	10	4	4	4	8	
Powassan virus disease	—	—	—	9	6	2	7	1	
St. Louis encephalitis virus disease	—	—	0	10	12	13	9	10	
Western equine encephalitis virus disease	—	—	—	—	—	—	—	—	
Babesiosis	—	3	0	NN	NN	NN	NN	NN	
Botulism, total	—	9	2	110	118	145	144	165	
foodborne	—	2	0	7	10	17	32	20	
infant	—	5	2	78	83	109	85	97	
other (wound and unspecified)	—	2	0	25	25	19	27	48	
Brucellosis	1	7	2	125	115	80	131	121	WA (1)
Chancroid	—	3	1	35	28	25	23	33	
Cholera	—	7	—	12	10	5	7	9	
Cyclosporiasis <sup>§</sup>	—	17	1	172	141	139	93	137	
Diphtheria	—	—	—	—	—	—	—	—	
<i>Haemophilus influenzae</i> , ** invasive disease (age <5 yrs):									
serotype b	—	1	1	20	35	30	22	29	
nonsertotype b	—	10	5	178	236	244	199	175	
unknown serotype	3	37	4	224	178	163	180	179	MO (1), FL (1), AR (1)
Hansen disease <sup>§</sup>	—	6	2	66	103	80	101	66	
Hantavirus pulmonary syndrome <sup>§</sup>	—	1	0	17	20	18	32	40	
Hemolytic uremic syndrome, postdiarrheal <sup>§</sup>	—	7	2	229	242	330	292	288	
Influenza-associated pediatric mortality <sup>§, ††</sup>	5	56	4	61	358	90	77	43	MI (1), KY (1), TX (1), NY (1), VA (1)
Listeriosis	5	62	10	766	851	759	808	884	PA (1), WA (3), CA (1)
Measles <sup>§§</sup>	2	20	1	34	71	140	43	55	FL (1), TX (1)
Meningococcal disease, invasive <sup>¶¶</sup> :									
A, C, Y, and W-135	3	22	10	247	301	330	325	318	ME (1), MD (1), ID (1)
serogroup B	1	15	5	115	174	188	167	193	WA (1)
other serogroup	—	1	1	10	23	38	35	32	
unknown serogroup	5	59	14	412	482	616	550	651	NY (2), OH (1), OR (2)
Novel influenza A virus infections <sup>***</sup>	—	1	0	4	43,774	2	4	NN	
Plague	—	—	0	2	8	3	7	17	
Poliomyelitis, paralytic	—	—	—	—	1	—	—	—	
Polio virus Infection, nonparalytic <sup>§</sup>	—	—	—	—	—	—	—	NN	
Psittacosis <sup>§</sup>	—	—	0	4	9	8	12	21	
Q fever, total <sup>§</sup>	—	9	3	121	113	120	171	169	
acute	—	6	1	92	93	106	—	—	
chronic	—	3	0	29	20	14	—	—	
Rabies, human	—	—	—	1	4	2	1	3	
Rubella <sup>†††</sup>	—	1	0	5	3	16	12	11	
Rubella, congenital syndrome	—	—	—	—	2	—	—	1	
SARS-CoV <sup>§</sup>	—	—	—	—	—	—	—	—	
Smallpox <sup>§</sup>	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome <sup>§</sup>	1	19	4	168	161	157	132	125	NC (1)
Syphilis, congenital (age <1 yr) <sup>§§§</sup>	—	17	7	260	423	431	430	349	
Tetanus	—	—	0	10	18	19	28	41	
Toxic-shock syndrome (staphylococcal) <sup>§</sup>	—	10	2	73	74	71	92	101	
Trichinellosis	—	3	0	5	13	39	5	15	
Tularemia	—	1	0	112	93	123	137	95	
Typhoid fever	2	38	7	417	397	449	434	353	CA (2)
Vancomycin-intermediate <i>Staphylococcus aureus</i> <sup>§</sup>	2	8	1	98	78	63	37	6	NY (2)
Vancomycin-resistant <i>Staphylococcus aureus</i> <sup>§</sup>	—	—	—	1	1	—	2	1	
Vibriosis (noncholera <i>Vibrio</i> species infections) <sup>§</sup>	3	28	3	783	789	588	549	NN	FL (2), WA (1)
Viral hemorrhagic fever <sup>¶¶¶</sup>	—	—	—	1	NN	NN	NN	NN	
Yellow fever	—	—	—	—	—	—	—	—	

See Table 1 footnotes on next page.

**TABLE I. (Continued) Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending March 5, 2011 (9th week)\***

—: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts.  
 \* Case counts for reporting years 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see <http://www.cdc.gov/ncphi/diss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf>.  
 † Calculated by summing the incidence counts for the current week, the 2 weeks preceding the current week, and the 2 weeks following the current week, for a total of 5 preceding years. Additional information is available at <http://www.cdc.gov/ncphi/diss/nndss/phs/files/5yearweeklyaverage.pdf>.  
 ‡ Not reportable in all states. Data from states where the condition is not reportable are excluded from this table except starting in 2007 for the arboviral diseases, STD data, TB data, and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at <http://www.cdc.gov/ncphi/diss/nndss/phs/infdis.htm>.  
 ¶ Includes both neuroinvasive and nonneuroinvasive. Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for West Nile virus are available in Table II.  
 \*\* Data for H. influenzae (all ages, all serotypes) are available in Table II.  
 †† Updated weekly from reports to the Influenza Division, National Center for Immunization and Respiratory Diseases. Since October 3, 2010, 60 influenza-associated pediatric deaths occurring during the 2010-11 influenza season have been reported.  
 ‡‡ The two measles cases reported for the current week were indigenous.  
 ¶¶ Data for meningococcal disease (all serogroups) are available in Table II.  
 \*\*\* CDC discontinued reporting of individual confirmed and probable cases of 2009 pandemic influenza A (H1N1) virus infections on July 24, 2009. During 2009, four cases of human infection with novel influenza A viruses, different from the 2009 pandemic influenza A (H1N1) strain, were reported to CDC. The four cases of novel influenza A virus infection reported to CDC during 2010, and the one case reported during 2011, were identified as swine influenza A (H3N2) virus and are unrelated to the 2009 pandemic influenza A (H1N1) virus. Total case counts for 2009 were provided by the Influenza Division, National Center for Immunization and Respiratory Diseases (NCIRD).  
 ††† No rubella cases were reported for the current week.  
 §§§ Updated weekly from reports to the Division of STD Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.  
 ¶¶¶ There was one case of viral hemorrhagic fever reported during week 12 of 2010. The one case report was confirmed as lassa fever. See Table II for dengue hemorrhagic fever.

**FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals March 5, 2011, 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.

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 Deborah A. Adams      Rosaline Dhara  
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Morbidity and Mortality Weekly Report

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending March 5, 2011, and March 6, 2010 (9th week)\*

Reporting area	Dengue Virus Infection									
	Dengue Fever†					Dengue Hemorrhagic Fever§				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
	Med	Max				Med	Max			
<b>United States</b>	—	6	51	5	52	—	0	2	—	—
<b>New England</b>	—	0	3	—	3	—	0	0	—	—
Connecticut	—	0	0	—	—	—	0	0	—	—
Maine¶	—	0	2	—	3	—	0	0	—	—
Massachusetts	—	0	0	—	—	—	0	0	—	—
New Hampshire	—	0	0	—	—	—	0	0	—	—
Rhode Island¶	—	0	1	—	—	—	0	0	—	—
Vermont¶	—	0	1	—	—	—	0	0	—	—
<b>Mid. Atlantic</b>	—	2	25	2	21	—	0	1	—	—
New Jersey	—	0	5	—	2	—	0	0	—	—
New York (Upstate)	—	0	5	—	1	—	0	1	—	—
New York City	—	1	17	—	13	—	0	1	—	—
Pennsylvania	—	0	3	2	5	—	0	0	—	—
<b>E.N. Central</b>	—	1	7	2	8	—	0	1	—	—
Illinois	—	0	2	—	2	—	0	0	—	—
Indiana	—	0	2	1	1	—	0	0	—	—
Michigan	—	0	2	—	—	—	0	0	—	—
Ohio	—	0	2	—	5	—	0	0	—	—
Wisconsin	—	0	2	1	—	—	0	1	—	—
<b>W.N. Central</b>	—	0	6	—	4	—	0	1	—	—
Iowa	—	0	1	—	—	—	0	0	—	—
Kansas	—	0	1	—	—	—	0	0	—	—
Minnesota	—	0	2	—	4	—	0	0	—	—
Missouri	—	0	0	—	—	—	0	0	—	—
Nebraska¶	—	0	6	—	—	—	0	0	—	—
North Dakota	—	0	1	—	—	—	0	0	—	—
South Dakota	—	0	0	—	—	—	0	1	—	—
<b>S. Atlantic</b>	—	2	19	—	10	—	0	1	—	—
Delaware	—	0	0	—	—	—	0	0	—	—
District of Columbia	—	0	0	—	—	—	0	0	—	—
Florida	—	2	14	—	8	—	0	1	—	—
Georgia	—	0	2	—	1	—	0	0	—	—
Maryland¶	—	0	0	—	—	—	0	0	—	—
North Carolina	—	0	2	—	—	—	0	0	—	—
South Carolina¶	—	0	3	—	—	—	0	0	—	—
Virginia¶	—	0	3	—	1	—	0	0	—	—
West Virginia	—	0	1	—	—	—	0	0	—	—
<b>E.S. Central</b>	—	0	2	—	—	—	0	0	—	—
Alabama¶	—	0	2	—	—	—	0	0	—	—
Kentucky	—	0	1	—	—	—	0	0	—	—
Mississippi	—	0	0	—	—	—	0	0	—	—
Tennessee¶	—	0	1	—	—	—	0	0	—	—
<b>W.S. Central</b>	—	0	1	—	—	—	0	1	—	—
Arkansas¶	—	0	0	—	—	—	0	1	—	—
Louisiana	—	0	0	—	—	—	0	0	—	—
Oklahoma	—	0	1	—	—	—	0	0	—	—
Texas¶	—	0	1	—	—	—	0	0	—	—
<b>Mountain</b>	—	0	2	—	2	—	0	0	—	—
Arizona	—	0	1	—	—	—	0	0	—	—
Colorado	—	0	0	—	—	—	0	0	—	—
Idaho¶	—	0	1	—	—	—	0	0	—	—
Montana¶	—	0	1	—	—	—	0	0	—	—
Nevada¶	—	0	1	—	1	—	0	0	—	—
New Mexico¶	—	0	0	—	1	—	0	0	—	—
Utah	—	0	0	—	—	—	0	0	—	—
Wyoming¶	—	0	0	—	—	—	0	0	—	—
<b>Pacific</b>	—	1	6	1	4	—	0	0	—	—
Alaska	—	0	1	—	—	—	0	0	—	—
California	—	0	5	—	1	—	0	0	—	—
Hawaii	—	0	0	—	—	—	0	0	—	—
Oregon	—	0	0	—	—	—	0	0	—	—
Washington	—	0	2	1	3	—	0	0	—	—
<b>Territories</b>										
American Samoa	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	105	523	116	824	—	1	18	—	17
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

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

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

\* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see <http://www.cdc.gov/ncphi/diss/nndss/pubs/files/ProvisionalNationalNotifiableDiseasesSurveillanceData20100927.pdf>. Data for TB are displayed in Table IV, which appears quarterly.

† Dengue Fever includes cases that meet criteria for Dengue Fever with hemorrhage, other clinical and unknown case classifications.

§ DHF includes cases that meet criteria for dengue shock syndrome (DSS), a more severe form of DHF.

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









TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending March 5, 2011, and March 6, 2010 (9th week)\*

Reporting area	Legionellosis					Lyme disease					Malaria				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
<b>United States</b>	26	55	123	260	366	34	406	1,671	790	2,145	5	27	82	149	202
<b>New England</b>	1	4	16	15	18	—	126	504	79	671	—	1	5	6	11
Connecticut	—	0	6	—	3	—	47	213	—	278	—	0	1	—	—
Maine†	—	0	4	1	—	—	12	67	21	26	—	0	1	—	—
Massachusetts	1	2	10	13	9	—	41	223	35	229	—	1	4	4	11
New Hampshire	—	0	5	—	1	—	24	68	17	122	—	0	2	—	—
Rhode Island†	—	0	4	—	4	—	1	40	1	6	—	0	4	—	—
Vermont†	—	0	2	1	1	—	4	27	5	10	—	0	1	2	—
<b>Mid. Atlantic</b>	3	14	48	61	77	10	181	734	494	1,001	—	7	18	42	52
New Jersey	—	1	11	1	11	—	49	220	46	295	—	0	1	—	—
New York (Upstate)	2	5	19	23	23	6	36	159	74	98	—	1	6	5	13
New York City	—	2	17	15	19	—	2	8	2	28	—	4	14	29	29
Pennsylvania	1	6	19	22	24	4	92	386	372	580	—	1	3	8	10
<b>E.N. Central</b>	8	12	44	46	86	—	26	325	6	84	—	2	9	11	19
Illinois	—	2	15	—	11	—	1	18	—	4	—	0	7	—	7
Indiana	1	2	7	6	11	—	0	7	—	10	—	0	2	1	2
Michigan	—	3	20	8	10	—	1	14	1	—	—	0	4	2	3
Ohio	7	4	15	32	34	—	0	9	3	4	—	1	5	7	7
Wisconsin	—	1	5	—	20	—	22	297	2	66	—	0	2	1	—
<b>W.N. Central</b>	—	2	9	4	10	—	1	11	—	3	—	1	4	1	14
Iowa	—	0	2	—	—	—	0	10	—	2	—	0	2	—	3
Kansas	—	0	2	—	2	—	0	1	—	1	—	0	2	—	3
Minnesota	—	0	8	—	3	—	0	0	—	—	—	0	0	—	3
Missouri	—	1	4	3	2	—	0	1	—	—	—	0	3	—	2
Nebraska†	—	0	2	—	2	—	0	2	—	—	—	0	1	1	3
North Dakota	—	0	1	—	—	—	0	5	—	—	—	0	1	—	—
South Dakota	—	0	2	1	1	—	0	1	—	—	—	0	2	—	—
<b>S. Atlantic</b>	5	10	27	45	67	20	57	175	192	347	2	7	45	59	64
Delaware	—	0	3	—	3	2	10	33	44	98	—	0	1	—	1
District of Columbia	—	0	4	—	—	—	0	4	2	1	—	0	2	1	1
Florida	4	3	9	28	25	5	2	10	14	9	2	2	7	17	22
Georgia	—	1	4	1	10	—	0	2	1	1	—	1	7	10	10
Maryland†	1	2	6	7	15	4	22	105	66	155	—	1	24	10	11
North Carolina	—	1	7	5	2	—	1	9	6	17	—	0	13	8	9
South Carolina†	—	0	2	—	1	—	0	3	—	4	—	0	1	—	—
Virginia†	—	1	10	4	10	9	18	83	59	59	—	1	5	13	10
West Virginia	—	0	3	—	1	—	0	29	—	3	—	0	1	—	—
<b>E.S. Central</b>	—	2	10	10	18	—	0	4	1	8	—	0	3	2	3
Alabama†	—	0	2	1	3	—	0	1	—	—	—	0	1	1	1
Kentucky	—	0	4	4	5	—	0	1	—	1	—	0	1	—	2
Mississippi	—	0	3	1	2	—	0	0	—	—	—	0	2	—	—
Tennessee†	—	1	6	4	8	—	0	4	1	7	—	0	2	1	—
<b>W.S. Central</b>	1	3	8	8	9	1	2	19	1	4	—	1	14	4	12
Arkansas†	—	0	2	—	1	—	0	0	—	—	—	0	1	—	1
Louisiana	—	0	2	1	1	—	0	1	—	—	—	0	1	—	1
Oklahoma	—	0	3	1	—	—	0	0	—	—	—	0	1	1	1
Texas†	1	2	7	6	7	1	2	19	1	4	—	1	13	3	9
<b>Mountain</b>	1	3	10	11	25	—	0	3	1	2	1	1	4	9	9
Arizona	1	1	7	5	6	—	0	1	—	—	—	0	3	3	2
Colorado	—	0	2	1	8	—	0	1	—	—	1	0	3	3	2
Idaho†	—	0	1	1	—	—	0	2	—	1	—	0	1	—	—
Montana†	—	0	1	—	1	—	0	1	—	—	—	0	1	—	—
Nevada†	—	0	2	1	5	—	0	1	—	—	—	0	2	2	2
New Mexico†	—	0	2	—	1	—	0	2	1	—	—	0	1	1	—
Utah	—	0	2	3	4	—	0	1	—	1	—	0	0	—	3
Wyoming†	—	0	2	—	—	—	0	0	—	—	—	0	0	—	—
<b>Pacific</b>	7	5	13	60	56	3	3	10	16	25	2	3	10	15	18
Alaska	—	0	2	—	—	—	0	1	—	1	—	0	2	2	—
California	7	4	12	53	55	3	2	7	12	12	1	2	9	7	14
Hawaii	—	0	1	1	—	N	0	0	N	N	—	0	1	—	—
Oregon	—	0	3	1	—	—	1	4	4	12	—	0	3	3	2
Washington	—	0	5	5	1	—	0	3	—	—	1	0	5	3	2
<b>Territories</b>															
American Samoa	—	0	0	—	—	N	0	0	N	N	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	N	0	0	N	N	—	0	1	—	3
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 reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.

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





TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending March 5, 2011, and March 6, 2010 (9th week)\*

Reporting area	Shigellosis					Spotted Fever Rickettsiosis (including RMSF) <sup>†</sup>									
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Confirmed					Probable				
		Med	Max			Current week	Previous 52 weeks	Cum 2011	Cum 2010	Current week	Previous 52 weeks	Cum 2011	Cum 2010		
<b>United States</b>	108	275	375	1,269	2,373	—	2	10	8	7	1	27	98	35	52
<b>New England</b>	—	4	17	30	105	—	0	0	—	—	—	0	1	—	—
Connecticut	—	0	3	3	63	—	0	0	—	—	—	0	0	—	—
Maine <sup>§</sup>	—	0	1	1	1	—	0	0	—	—	—	0	1	—	—
Massachusetts	—	3	16	25	37	—	0	0	—	—	—	0	0	—	—
New Hampshire	—	0	2	—	2	—	0	0	—	—	—	0	1	—	—
Rhode Island <sup>§</sup>	—	0	3	—	1	—	0	0	—	—	—	0	1	—	—
Vermont <sup>§</sup>	—	0	1	1	1	—	0	0	—	—	—	0	0	—	—
<b>Mid. Atlantic</b>	3	25	70	77	360	—	0	1	—	—	—	1	4	2	2
New Jersey	—	5	16	12	58	—	0	0	—	—	—	0	0	—	—
New York (Upstate)	1	3	15	18	29	—	0	1	—	—	—	0	3	—	—
New York City	—	5	14	32	57	—	0	1	—	—	—	0	4	2	2
Pennsylvania	2	10	55	15	216	—	0	0	—	—	—	0	3	—	—
<b>E.N. Central</b>	5	24	140	93	574	—	0	1	—	—	—	1	10	2	1
Illinois	—	8	126	25	434	—	0	1	—	—	—	0	5	—	—
Indiana <sup>§</sup>	—	1	4	7	6	—	0	1	—	—	—	0	5	—	1
Michigan	1	5	10	19	36	—	0	0	—	—	—	0	1	1	—
Ohio	4	5	18	42	51	—	0	0	—	—	—	0	2	1	—
Wisconsin	—	2	21	—	47	—	0	0	—	—	—	0	1	—	—
<b>W.N. Central</b>	3	25	81	70	483	—	0	4	—	—	—	4	21	2	3
Iowa	—	1	4	4	12	—	0	0	—	—	—	0	1	—	—
Kansas <sup>§</sup>	1	5	13	15	31	—	0	1	—	—	—	0	0	—	—
Minnesota	—	0	3	—	8	—	0	0	—	—	—	0	0	—	—
Missouri	2	17	66	48	426	—	0	4	—	—	—	4	20	2	3
Nebraska <sup>§</sup>	—	1	10	2	4	—	0	1	—	—	—	0	1	—	—
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	1	—	—
South Dakota	—	0	2	1	2	—	0	0	—	—	—	0	0	—	—
<b>S. Atlantic</b>	36	57	122	451	263	—	1	7	4	4	1	7	60	18	38
Delaware <sup>§</sup>	—	0	3	—	20	—	0	1	—	—	—	0	3	—	2
District of Columbia	—	0	4	2	3	—	0	1	—	—	—	0	0	—	—
Florida <sup>§</sup>	32	25	55	298	93	—	0	1	1	—	1	0	2	4	—
Georgia	4	16	26	76	77	—	0	6	1	2	—	0	0	—	—
Maryland <sup>§</sup>	—	2	8	15	17	—	0	1	1	—	—	0	5	1	1
North Carolina	—	3	36	41	23	—	0	3	1	2	—	2	48	9	32
South Carolina <sup>§</sup>	—	1	5	6	14	—	0	1	—	—	—	0	3	1	2
Virginia <sup>§</sup>	—	2	9	13	16	—	0	2	—	—	—	2	12	3	1
West Virginia	—	0	66	—	—	—	0	0	—	—	—	0	0	—	—
<b>E.S. Central</b>	6	14	40	71	74	—	0	3	—	1	—	5	29	3	3
Alabama <sup>§</sup>	4	5	14	36	11	—	0	1	—	—	—	1	8	2	1
Kentucky	2	2	28	8	29	—	0	2	—	—	—	0	0	—	—
Mississippi	—	1	4	9	4	—	0	0	—	—	—	0	3	—	—
Tennessee <sup>§</sup>	—	5	14	18	30	—	0	2	—	1	—	4	20	1	2
<b>W.S. Central</b>	28	53	128	194	258	—	0	4	—	1	—	2	43	1	4
Arkansas <sup>§</sup>	—	1	6	4	9	—	0	2	—	—	—	1	29	—	1
Louisiana	—	6	13	12	26	—	0	0	—	—	—	0	1	—	—
Oklahoma	4	4	13	15	35	—	0	3	—	—	—	0	11	—	—
Texas <sup>§</sup>	24	43	111	163	188	—	0	1	—	1	—	0	3	1	3
<b>Mountain</b>	9	15	32	106	102	—	0	5	4	—	—	0	3	7	1
Arizona	1	8	19	34	64	—	0	5	4	—	—	0	3	7	—
Colorado <sup>§</sup>	—	2	8	20	16	—	0	1	—	—	—	0	1	—	—
Idaho <sup>§</sup>	—	0	3	5	2	—	0	0	—	—	—	0	1	—	—
Montana <sup>§</sup>	8	0	3	17	2	—	0	1	—	—	—	0	1	—	—
Nevada <sup>§</sup>	—	0	6	6	3	—	0	0	—	—	—	0	0	—	—
New Mexico <sup>§</sup>	—	3	10	20	12	—	0	0	—	—	—	0	0	—	1
Utah	—	1	4	4	3	—	0	0	—	—	—	0	1	—	—
Wyoming <sup>§</sup>	—	0	0	—	—	—	0	0	—	—	—	0	1	—	—
<b>Pacific</b>	18	22	72	177	154	—	0	2	—	1	—	0	1	—	—
Alaska	—	0	1	1	—	N	0	0	N	N	N	0	0	N	N
California	12	19	58	144	137	—	0	2	—	1	—	0	0	—	—
Hawaii	1	1	4	13	7	N	0	0	N	N	N	0	0	N	N
Oregon	1	1	4	10	7	—	0	0	—	—	—	0	1	—	—
Washington	4	1	17	9	3	—	0	0	—	—	—	0	0	—	—
<b>Territories</b>															
American Samoa	—	1	1	1	—	N	0	0	N	N	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	—	—	N	0	0	N	N	N	0	0	N	N
Puerto Rico	—	0	1	—	—	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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**TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending March 5, 2011, and March 6, 2010 (9th week)\***

Reporting area	Varicella (chickenpox)					West Nile virus disease†									
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Neuroinvasive				Nonneuroinvasive‡					
		Med	Max			Current week	Previous 52 weeks	Cum 2011	Cum 2010	Current week	Previous 52 weeks	Cum 2011	Cum 2010		
<b>United States</b>	139	259	562	1,780	2,823	—	1	71	—	1	—	1	53	—	—
<b>New England</b>	3	21	45	122	166	—	0	3	—	—	—	0	2	—	—
Connecticut	—	5	20	—	37	—	0	2	—	—	—	0	2	—	—
Maine¶	—	4	16	28	46	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	5	16	58	40	—	0	2	—	—	—	0	1	—	—
New Hampshire	—	2	9	9	30	—	0	1	—	—	—	0	0	—	—
Rhode Island¶	—	0	3	1	1	—	0	0	—	—	—	0	0	—	—
Vermont¶	3	0	10	26	12	—	0	0	—	—	—	0	0	—	—
<b>Mid. Atlantic</b>	16	30	62	165	301	—	0	19	—	—	—	0	13	—	—
New Jersey	—	7	30	26	100	—	0	3	—	—	—	0	6	—	—
New York (Upstate)	N	0	0	N	N	—	0	9	—	—	—	0	7	—	—
New York City	—	0	1	—	1	—	0	7	—	—	—	0	4	—	—
Pennsylvania	16	20	41	139	200	—	0	3	—	—	—	0	3	—	—
<b>E.N. Central</b>	44	84	176	584	1,091	—	0	15	—	—	—	0	8	—	—
Illinois	2	18	45	111	272	—	0	10	—	—	—	0	5	—	—
Indiana¶	3	5	30	49	121	—	0	2	—	—	—	0	2	—	—
Michigan	8	28	62	189	348	—	0	6	—	—	—	0	1	—	—
Ohio	31	23	58	234	278	—	0	1	—	—	—	0	1	—	—
Wisconsin	—	6	22	1	72	—	0	0	—	—	—	0	1	—	—
<b>W.N. Central</b>	—	14	32	43	150	—	0	7	—	—	—	0	11	—	—
Iowa	N	0	0	N	N	—	0	1	—	—	—	0	2	—	—
Kansas¶	—	3	22	30	60	—	0	1	—	—	—	0	3	—	—
Minnesota	—	0	0	—	—	—	0	1	—	—	—	0	3	—	—
Missouri	—	7	23	10	80	—	0	1	—	—	—	0	0	—	—
Nebraska¶	N	0	0	N	N	—	0	3	—	—	—	0	7	—	—
North Dakota	—	0	10	—	7	—	0	2	—	—	—	0	2	—	—
South Dakota	—	1	7	3	3	—	0	2	—	—	—	0	3	—	—
<b>S. Atlantic</b>	18	34	100	215	364	—	0	5	—	—	—	0	4	—	—
Delaware¶	—	0	3	2	2	—	0	0	—	—	—	0	0	—	—
District of Columbia	—	0	4	2	—	—	0	1	—	—	—	0	1	—	—
Florida¶	17	16	57	162	180	—	0	3	—	—	—	0	1	—	—
Georgia	N	0	0	N	N	—	0	1	—	—	—	0	3	—	—
Maryland¶	N	0	0	N	N	—	0	3	—	—	—	0	2	—	—
North Carolina	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
South Carolina¶	—	0	35	—	44	—	0	1	—	—	—	0	0	—	—
Virginia¶	1	10	29	49	65	—	0	1	—	—	—	0	1	—	—
West Virginia	—	6	26	—	73	—	0	0	—	—	—	0	0	—	—
<b>E.S. Central</b>	7	6	22	51	36	—	0	1	—	1	—	0	3	—	—
Alabama¶	7	5	22	48	36	—	0	1	—	—	—	0	1	—	—
Kentucky	N	0	0	N	N	—	0	1	—	—	—	0	1	—	—
Mississippi	—	0	2	3	—	—	0	1	—	1	—	0	2	—	—
Tennessee¶	N	0	0	N	N	—	0	1	—	—	—	0	2	—	—
<b>W.S. Central</b>	36	45	183	328	434	—	0	16	—	—	—	0	3	—	—
Arkansas¶	3	3	32	19	21	—	0	3	—	—	—	0	1	—	—
Louisiana	—	1	4	5	18	—	0	3	—	—	—	0	1	—	—
Oklahoma	N	0	0	N	N	—	0	1	—	—	—	0	0	—	—
Texas¶	33	40	173	304	395	—	0	15	—	—	—	0	2	—	—
<b>Mountain</b>	15	18	49	224	266	—	0	18	—	—	—	0	15	—	—
Arizona	—	0	0	—	—	—	0	13	—	—	—	0	9	—	—
Colorado¶	—	8	31	97	91	—	0	5	—	—	—	0	11	—	—
Idaho¶	N	0	0	N	N	—	0	0	—	—	—	0	1	—	—
Montana¶	—	3	28	64	45	—	0	0	—	—	—	0	0	—	—
Nevada¶	N	0	0	N	N	—	0	0	—	—	—	0	1	—	—
New Mexico¶	—	1	8	9	20	—	0	6	—	—	—	0	2	—	—
Utah	15	4	12	54	108	—	0	1	—	—	—	0	1	—	—
Wyoming¶	—	0	3	—	2	—	0	1	—	—	—	0	1	—	—
<b>Pacific</b>	—	2	16	48	15	—	0	8	—	—	—	0	6	—	—
Alaska	—	1	5	16	4	—	0	0	—	—	—	0	0	—	—
California	—	0	13	23	2	—	0	8	—	—	—	0	6	—	—
Hawaii	—	1	7	9	9	—	0	0	—	—	—	0	0	—	—
Oregon	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
Washington	N	0	0	N	N	—	0	1	—	—	—	0	1	—	—
<b>Territories</b>															
American Samoa	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	2	1	1	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	8	30	32	72	—	0	0	—	—	—	0	0	—	—
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 reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.

\* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see <http://www.cdc.gov/ncphi/diss/nndss/phs/files/ProvisionalNationalNotifiableDiseasesSurveillanceData20100927.pdf>. Data for TB are displayed in Table IV, which appears quarterly.

† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for California serogroup, eastern equine, Powassan, St. Louis, and western equine diseases are available in Table I.

§ Not reportable in all states. Data from states where the condition is not reportable are excluded from this table, except starting in 2007 for the domestic arboviral diseases and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at <http://www.cdc.gov/ncphi/diss/nndss/phs/infdis.htm>.

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

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TABLE III. Deaths in 122 U.S. cities,\* week ending March 5, 2011 (9th week)

Reporting area	All causes, by age (years)						P&I†	Reporting area (Continued)	All causes, by age (years)						P&I†
	All Ages	≥65	45-64	25-44	1-24	<1			All Ages	≥65	45-64	25-44	1-24	<1	
<b>New England</b>	637	460	139	22	10	6	73	<b>S. Atlantic</b>	1,395	861	394	80	29	31	119
Boston, MA	141	97	32	7	3	2	15	Atlanta, GA	168	90	53	14	7	4	19
Bridgeport, CT	38	26	11	1	—	—	7	Baltimore, MD	226	108	87	15	10	6	20
Cambridge, MA	14	12	2	—	—	—	2	Charlotte, NC	145	86	41	11	4	3	19
Fall River, MA	31	22	7	2	—	—	4	Jacksonville, FL	191	128	53	8	—	2	5
Hartford, CT	61	33	24	3	1	—	4	Miami, FL	125	80	31	8	2	4	10
Lowell, MA	31	26	5	—	—	—	4	Norfolk, VA	49	33	10	4	—	2	4
Lynn, MA	11	7	3	1	—	—	—	Richmond, VA	79	52	24	2	1	—	4
New Bedford, MA	38	33	4	1	—	—	1	Savannah, GA	59	50	7	1	—	1	12
New Haven, CT	34	19	8	3	2	2	4	St. Petersburg, FL	48	32	8	3	—	5	6
Providence, RI	71	54	14	3	—	—	11	Tampa, FL	185	124	45	11	2	3	9
Somerville, MA	3	2	1	—	—	—	—	Washington, D.C.	109	72	30	3	3	1	10
Springfield, MA	46	32	13	—	1	—	6	Wilmington, DE	11	6	5	—	—	—	1
Waterbury, CT	33	29	2	1	1	—	4	<b>E.S. Central</b>	925	601	230	59	12	23	97
Worcester, MA	85	68	13	—	2	2	11	Birmingham, AL	187	114	51	11	2	9	20
<b>Mid. Atlantic</b>	1,978	1,407	430	86	28	27	113	Chattanooga, TN	89	62	12	9	3	3	10
Albany, NY	47	34	10	1	—	2	1	Knoxville, TN	86	63	18	3	1	1	8
Allentown, PA	30	22	5	2	—	1	1	Lexington, KY	69	44	16	4	2	3	3
Buffalo, NY	86	63	16	4	2	1	7	Memphis, TN	188	118	53	14	1	2	27
Camden, NJ	35	21	7	1	3	3	1	Mobile, AL	97	68	25	4	—	—	7
Elizabeth, NJ	16	12	4	—	—	—	2	Montgomery, AL	54	38	12	1	2	1	7
Erie, PA	63	47	13	2	—	1	4	Nashville, TN	155	94	43	13	1	4	15
Jersey City, NJ	18	12	4	2	—	—	3	<b>W.S. Central</b>	1,281	840	305	78	35	22	103
New York City, NY	1,130	807	252	43	16	12	62	Austin, TX	114	78	24	7	1	4	12
Newark, NJ	31	20	6	5	—	—	1	Baton Rouge, LA	69	33	15	14	7	—	—
Paterson, NJ	24	12	6	4	2	—	—	Corpus Christi, TX	85	56	24	5	—	—	5
Philadelphia, PA	153	94	46	6	4	3	7	Dallas, TX	190	116	53	8	8	4	19
Pittsburgh, PA <sup>§</sup>	49	35	10	3	1	—	6	El Paso, TX	106	78	21	3	3	1	11
Reading, PA	40	34	5	1	—	—	4	Fort Worth, TX	U	U	U	U	U	U	U
Rochester, NY	79	60	14	4	—	1	5	Houston, TX	99	53	33	4	1	8	5
Schenectady, NY	26	20	5	1	—	—	2	Little Rock, AR	110	82	18	6	3	1	—
Scranton, PA	26	22	1	3	—	—	—	New Orleans, LA	U	U	U	U	U	U	U
Syracuse, NY	60	47	11	1	—	1	4	San Antonio, TX	285	195	60	17	11	2	24
Trenton, NJ	32	19	10	1	—	2	—	Shreveport, LA	39	21	14	3	—	1	3
Utica, NY	13	11	2	—	—	—	1	Tulsa, OK	184	128	43	11	1	1	24
Yonkers, NY	20	15	3	2	—	—	2	<b>Mountain</b>	1,014	702	227	57	12	14	85
<b>E.N. Central</b>	2,027	1,362	469	117	41	38	167	Albuquerque, NM	111	83	18	7	1	2	23
Akron, OH	62	38	16	4	3	1	8	Boise, ID	62	53	8	1	—	—	2
Canton, OH	55	38	12	2	2	1	7	Colorado Springs, CO	65	50	12	2	1	—	4
Chicago, IL	262	188	49	21	4	—	22	Denver, CO	110	67	30	8	3	2	9
Cincinnati, OH	119	66	37	9	3	4	15	Las Vegas, NV	269	179	64	16	2	6	21
Cleveland, OH	239	160	59	12	4	4	13	Ogden, UT	28	17	9	2	—	—	5
Columbus, OH	95	69	15	7	2	2	7	Phoenix, AZ	U	U	U	U	U	U	U
Dayton, OH	140	97	35	4	4	—	6	Pueblo, CO	37	23	11	3	—	—	2
Detroit, MI	93	57	29	5	—	2	5	Salt Lake City, UT	147	97	36	7	5	2	7
Evansville, IN	50	38	9	3	—	—	5	Tucson, AZ	185	133	39	11	—	2	12
Fort Wayne, IN	93	70	16	5	1	1	9	<b>Pacific</b>	2,049	1,493	393	106	35	22	231
Gary, IN	15	9	6	—	—	—	—	Berkeley, CA	12	6	5	—	1	—	—
Grand Rapids, MI	77	46	15	4	3	9	8	Fresno, CA	159	106	33	10	7	3	25
Indianapolis, IN	252	164	59	13	6	10	25	Glendale, CA	35	27	5	1	2	—	8
Lansing, MI	48	33	10	3	2	—	4	Honolulu, HI	78	56	14	3	1	4	8
Milwaukee, WI	102	61	36	4	—	1	5	Long Beach, CA	72	50	18	4	—	—	9
Peoria, IL	53	31	12	5	3	2	9	Los Angeles, CA	288	207	56	16	7	2	37
Rockford, IL	61	41	15	4	1	—	7	Pasadena, CA	33	28	3	—	2	—	5
South Bend, IN	36	30	4	2	—	—	—	Portland, OR	146	103	28	10	1	4	4
Toledo, OH	107	66	28	9	3	1	7	Sacramento, CA	271	196	56	15	3	1	41
Youngstown, OH	68	60	7	1	—	—	5	San Diego, CA	184	138	37	4	1	4	23
<b>W.N. Central</b>	831	513	205	67	28	16	46	San Francisco, CA	136	98	26	12	—	—	17
Des Moines, IA	82	59	16	6	—	1	2	San Jose, CA	233	179	37	9	5	3	23
Duluth, MN	29	16	11	2	—	—	—	Santa Cruz, CA	49	37	10	2	—	—	5
Kansas City, KS	39	26	9	2	1	1	—	Seattle, WA	143	118	19	4	1	1	7
Kansas City, MO	111	71	28	9	2	1	8	Spokane, WA	103	72	24	5	2	—	10
Lincoln, NE	38	32	4	2	—	—	4	Tacoma, WA	107	72	22	11	2	—	9
Minneapolis, MN	71	42	18	7	2	2	6	<b>Total¶</b>	<b>12,137</b>	<b>8,239</b>	<b>2,792</b>	<b>672</b>	<b>230</b>	<b>199</b>	<b>1,034</b>
Omaha, NE	88	56	21	6	3	2	8								
St. Louis, MO	193	98	52	23	14	4	12								
St. Paul, MN	63	39	17	4	1	2	2								
Wichita, KS	117	74	29	6	5	3	4								

U: Unavailable. —: No reported cases.

\* Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of >100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Total includes unknown ages.



## Morbidity and Mortality Weekly Report

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