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Racial/Ethnic and Socioeconomic Disparities in Multiple Risk Factors for Heart Disease and Stroke — United States, 2003

Heart disease and stroke are the first and third leading causes of death, respectively, in the United States (*1*). Certain modifiable risk factors, including high blood pressure, high cholesterol, diabetes, tobacco use, obesity, and lack of exercise, are the main targets for primary and secondary prevention of heart disease and stroke. A substantial proportion of the population has multiple risk factors, increasing their likelihood of cardiovascular disease (*2,3*). To assess the prevalence of multiple risk factors for heart disease and stroke and to identify disparities in risk status among population subgroups, CDC analyzed data from the 2003 Behavioral Risk Factor Surveillance System (BRFSS) survey. This report summarizes the results of that analysis, which indicated that approximately 37% of the survey population had two or more risk factors for heart disease and stroke and that considerable disparities in risk factors existed among socioeconomic groups and racial/ethnic populations. To decrease morbidity and mortality from heart disease and stroke, public health programs should improve identification of persons with multiple risk factors and focus interventions on those populations disproportionately affected.

BRFSS is a state-based, random-digit–dialed telephone survey of the noninstitutionalized, U.S. civilian population aged ≥18 years. CDC analyzed self-reported data from the 2003 BRFSS survey, which included 256,155 participants from 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. In 2003, the median CASRO response rate among states/territories was 53.2% (range: 34.4% [New Jersey] to 80.5% [Puerto Rico]). These rates reflect both telephone sampling efficiency and the degree of participation among eligible respondents who were contacted.

This analysis examined six risk factors for heart disease and stroke: high blood pressure, high cholesterol, diabetes, current smoking, physical inactivity, and obesity. Persons reported whether they were ever told by a doctor or other health professional that they had high blood pressure, high cholesterol, or diabetes. Current smoking was defined as having smoked at least 100 cigarettes during one's lifetime and still smoking by the date of the survey. Physical inactivity was assessed by a "no" response to the question, "During the past month, other than your regular job, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?" Obesity was defined as having a body mass index ≥30.0 kg/m^2 on the basis of self-reported height and weight (*4*). Multiple-risk–factor status was defined as having two or more of the six risk factors. Differences in the prevalence of multiple risk factors were examined by age, sex, race/ethnicity, education, income, and employment status; pregnant women were excluded from analysis. Data were weighted to reflect the noninstitutionalized, civilian population of each state/territory. Statistical software was used to account for the complex sampling design. Data were age-standardized to the 2000 U.S. standard population. Age-specific and age-adjusted prevalences are reported. For this report, references to white and black populations mean non-Hispanic whites and non-Hispanic blacks, respectively.

In 2003, 25.6% (95% confidence interval [CI] = ±0.3) of respondents reported having high blood pressure, 25.3%

INSIDE

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(CI = ±0.3) reported having high blood cholesterol, 25.0% (CI = ±0.3) were obese, 24.1% (CI = ±0.3) were physically inactive, 22.6% (CI = ±0.3) were current smokers, and 7.4% (CI = ±0.2) reported having diabetes. Overall, 29.8% (CI = ±0.4) reported having no risk factors, 33.1% (CI = ±0.4) reported one risk factor, and 37.2% (CI = ±0.3) reported two or more risk factors.

The percentage of respondents reporting two or more risk factors increased among successive age groups (Table 1). The prevalence of having two or more risk factors was highest among blacks (48.7%) and American Indians/Alaska Natives (46.7%) and lowest among Asians (25.9%); prevalences were similar in women (36.4%) and men (37.8%). The prevalence of multiple risk factors ranged from 25.9% among those who graduated from college to 52.5% among those with less than a high school diploma (or equivalent). Household income followed a similar pattern, with persons reporting ≥$50,000 annual income having the lowest prevalence (28.8%) and those reporting <$10,000 having the highest prevalence (52.5%) of two or more risk factors. Household income was not provided by 12.3% of respondents; these persons reported a 36.9% prevalence of multiple risk factors. The occurrence of two or more risk factors also varied by employment status. Adults who reported being unable to work had the highest prevalence (69.3%) of two or more risk factors, followed by retired persons (45.1%), adults who reported being unemployed (43.4%), homemakers (34.3%), and employed persons (34.0%) (Table 1).

The prevalence of two or more heart disease and stroke risk factors also varied by state/territory and ranged from 27.0% (Hawaii) to 46.2% (Kentucky) (Table 2; Figure). Twelve states and two territories had a multiple-risk–factor prevalence of ≥40% (Alabama, Arkansas, Georgia, Indiana, Kentucky, Louisiana, Mississippi, North Carolina, Ohio, Oklahoma, Tennessee, West Virginia, Guam, and Puerto Rico).

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Editorial Note: This report indicates that, in 2003, a high proportion of the U.S. population had multiple risk factors for heart disease and stroke, particularly certain population subgroups defined by race/ethnicity and socioeconomic status (i.e., education, family income, and employment). Prevalence of multiple risk factors also varied considerably by state/territory. A better understanding of the reasons for these differences could guide public health prevention programs. Furthermore, the small proportion of the population that reports no risk factors demonstrates the substantial public health burden of heart disease and stroke.

TABLE 1. Prevalence of multiple risk factors* for heart disease and stroke among adults aged ≥18 years, by selected characteristics — Behavioral Risk Factor Surveillance System, United States†, 2003

Characteristic	No. of respondents§	(%)¶	(95% CI**)
Age group (yrs)			
18–34	11,422	(20.3)	(±0.6)
35–49	26,485	(34.6)	(±0.6)
50–64	34,156	(51.1)	(±0.7)
≥65	31,128	(56.4)	(±0.8)
Race/Ethnicity			
White, non-Hispanic	79,891	(35.5)	(±0.4)
Black, non-Hispanic	10,016	(48.7)	(±1.2)
Hispanic	6,858	(39.6)	(±1.5)
Asian	1,070	(25.9)	(±3.1)
American Indian/Alaska Native	1,914	(46.7)	(±3.3)
Other/Multiple race	3,442	(38.7)	(±2.1)
Sex			
Men	40,631	(37.8)	(±0.5)
Women	62,560	(36.4)	(±0.4)
Education			
<High school	16,440	(52.5)	(±1.3)
High school graduate or equivalent	37,341	(43.8)	(±0.6)
Some college	27,314	(36.9)	(±0.6)
College graduate	21,901	(25.9)	(±0.5)
Annual household income			
<$10,000	8,351	(52.5)	(±1.7)
$10,000–19,999	17,694	(49.3)	(±1.1)
$20,000–34,999	24,658	(42.8)	(±0.8)
$35,000–49,999	14,934	(37.0)	(±0.8)
≥$50,000	23,358	(28.8)	(±0.6)
No answer	14,196	(36.9)	(±1.0)
Employment status			
Employed	49,978	(34.0)	(±0.5)
Unemployed	5,315	(43.4)	(±2.2)
Homemaker	7,577	(34.3)	(±1.1)
Student	1,028	(31.0)	(±4.3)
Retired	28,656	(45.1)	(±7.4)
Unable to work	10,421	(69.3)	(±2.2)
No answer	216	(38.7)	(±6.8)
Total	**103,191**	**(37.2)**	**(±0.3)**

* Two or more of the following: high blood pressure, high cholesterol, diabetes, obesity, current smoking, or physical inactivity.
† Includes all 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands.
§ Unweighted number of survey respondents with multiple-risk–factor status. Total sample size = 256,155.
¶ Weighted percentages, except for age groups, are age-standardized to the 2000 U.S. standard population.
** Confidence interval.

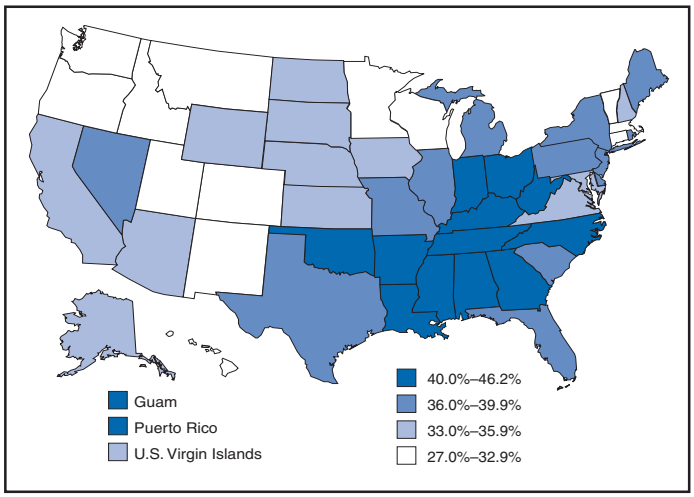
In this study, 37.2% of respondents reported having two or more of the six heart disease and stroke risk factors examined. A previous study that used BRFSS examined five risk factors and observed an 18% increase in the prevalence of multiple risk factors from 1991 to 1999, with 27.9% of the population reporting two or more risk factors in 1999 (*5*). If physical inactivity is excluded from the 2003 BRFSS survey analysis, the prevalence of multiple risk factors is 28.8%; thus, the

TABLE 2. Prevalence of multiple risk factors* for heart disease and stroke among adults aged ≥18 years, by state/territory — Behavioral Risk Factor Surveillance System, United States, 2003

State/Territory	No. of respondents†	(%)§	(95% CI¶)
Alabama	3,240	(45.6)	(±1.9)
Alaska	2,573	(33.7)	(±2.5)
Arizona	3,102	(33.6)	(±2.4)
Arkansas	4,108	(42.4)	(±1.7)
California	4,210	(33.5)	(±1.7)
Colorado	3,954	(28.9)	(±1.5)
Connecticut	5,098	(31.4)	(±1.4)
Delaware	3,943	(39.2)	(±1.9)
District of Columbia	1,943	(36.0)	(±2.6)
Florida	4,860	(38.0)	(±2.0)
Georgia	7,434	(40.0)	(±1.5)
Hawaii	4,158	(27.0)	(±1.6)
Idaho	4,869	(32.3)	(±1.5)
Illinois	5,053	(37.9)	(±1.8)
Indiana	5,327	(41.0)	(±1.4)
Iowa	4,903	(34.5)	(±1.5)
Kansas	4,504	(34.4)	(±1.5)
Kentucky	7,445	(46.2)	(±1.7)
Louisiana	4,927	(41.6)	(±1.5)
Maine	2,325	(36.0)	(±2.1)
Maryland	4,248	(35.7)	(±1.8)
Massachusetts	7,263	(32.5)	(±1.3)
Michigan	3,490	(39.8)	(±1.8)
Minnesota	3,809	(31.9)	(±1.6)
Mississippi	4,298	(45.8)	(±1.7)
Missouri	4,150	(38.9)	(±2.0)
Montana	3,927	(29.9)	(±1.8)
Nebraska	4,823	(33.7)	(±1.5)
Nevada	2,842	(36.7)	(±2.4)
New Hampshire	4,878	(33.6)	(±1.5)
New Jersey	10,819	(36.0)	(±1.0)
New Mexico	5,298	(30.1)	(±1.4)
New York	5,318	(37.3)	(±1.5)
North Carolina	9,109	(40.4)	(±1.5)
North Dakota	2,947	(34.1)	(±1.8)
Ohio	3,685	(40.3)	(±1.9)
Oklahoma	7,457	(41.0)	(±1.3)
Oregon	3,890	(32.6)	(±1.6)
Pennsylvania	3,586	(37.9)	(±1.7)
Rhode Island	3,914	(36.5)	(±1.7)
South Carolina	5,753	(39.8)	(±1.4)
South Dakota	5,139	(34.4)	(±1.4)
Tennessee	2,539	(43.2)	(±2.1)
Texas	5,741	(39.2)	(±1.4)
Utah	3,893	(29.0)	(±1.8)
Vermont	4,156	(30.7)	(±1.5)
Virginia	5,286	(35.8)	(±1.6)
Washington	18,089	(32.9)	(±0.8)
West Virginia	3,295	(44.9)	(±1.9)
Wisconsin	3,966	(32.8)	(±1.6)
Wyoming	3,924	(35.8)	(±1.6)
Guam	766	(43.6)	(±4.0)
Puerto Rico	3,934	(42.7)	(±1.9)
U.S. Virgin Islands	1,947	(35.0)	(±2.7)
Total	**256,155**	**(37.2)**	**(±0.3)**

* Two or more of the following: high blood pressure, high cholesterol, diabetes, obesity, current smoking, or physical inactivity.
† Unweighted number of survey respondents for each state and territory.
§ Weighted percentages are age-standardized to the 2000 U.S. standard population.
¶ Confidence interval.

FIGURE. Prevalence* of multiple risk factors for heart disease and stroke among adults aged ≥18 years, by state/territory — Behavioral Risk Factor Surveillance System, United States, 2003



* Age adjusted to the 2000 U.S. standard population.

greater prevalence determined by the current study is probably attributable to the inclusion of physical inactivity as an additional risk factor.

Changes in self-reported risk-factor status might also be attributable either to an increasing prevalence of risk factors overall or to better detection and awareness of certain risk factors. For example, in a study using data from the National Health and Nutrition Examination Survey, hypertension based on actual blood pressure measurements increased from 24.5% during 1988–1994 to 28.4% during 1999–2000 (*6*), suggesting an increase in prevalence. High blood pressure based on self-reports (i.e., BRFSS survey) also increased, from 23.8% in 1991 to 25.4% in 1999 (*5*), suggesting a greater awareness of the risk factor. However, for the same period, self-reports of high blood cholesterol increased (*5*), whereas the prevalence based on actual measurement of blood cholesterol changed minimally (*7*). Regardless of the differences between actual measurements and self-reports, the results indicate that a substantial proportion of the adult population has multiple risk factors for heart disease and stroke.

The findings in this report are subject to at least five limitations. First, BRFSS data are based on self-reported information and are subject to recall and social desirability bias (e.g., underreporting of actual weight) (*8*). Second, this study did not examine the degree of individual cardiovascular risk factors nor their control through lifestyle, behavioral, or pharmacologic means. Third, those respondents who had not been screened for high cholesterol, diabetes, or high blood pressure might not have been aware they had these risk factors, an obstacle possibly attributable to unequal access to health-care services. Fourth, the low response rate might have influenced the results; however, when compared with other surveys, data from BRFSS have been demonstrated to be reliable and valid (*9*). Finally, this study only examined modifiable risk factors and did not include other established risk factors (e.g., family history of premature coronary heart disease) (*5*).

Many modifiable risk factors for heart disease and stroke can be addressed through prevention, early recognition, and treatment. Policy and environmental changes (e.g., workplace smoking cessation programs and health-care provider adherence to primary care guidelines) also are essential in influencing persons to live heart-healthy and stroke-free lives. CDC has formed multiple local, national, and global partnerships to address the burden of heart disease and stroke. One example is the Public Health Action Plan to Prevent Heart Disease and Stroke, which is being implemented by the National Forum for Heart Disease and Stroke Prevention (*10*). Through one of its eight task groups, this forum is assessing existing research agendas and gaps in policy development for preventing heart disease, stroke, and associated risk factors. Another task group is examining current data systems and identifying gaps in surveillance, including incidence of risk factors for heart disease and stroke, incidence and case fatality of acute events, and disability among survivors.

CDC funds health departments in 32 states and the District of Columbia to promote heart-healthy and stroke-free communities. These programs emphasize the use of education, environmental strategies, and system changes to address heart disease and stroke among diverse populations. For example, Oregon's program uses population-based public health approaches to raise public awareness of the urgency of addressing cardiovascular disease, the symptoms of heart disease and stroke, and the need to call 911. To decrease the disproportionate burden of multiple risk factors on minority populations, public health programs should focus on improving identification and treatment of affected persons and promoting policy and lifestyle changes conducive to cardiovascular health.

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Disparities in Screening for and Awareness of High Blood Cholesterol — United States, 1999–2002

High blood cholesterol is a major modifiable risk factor for atherosclerotic cardiovascular disease (*1*). Two national health objectives for 2010 are to reduce to 17% the proportion of adults with high total blood cholesterol levels and to increase to 80% the proportion of adults who had their blood cholesterol checked during the preceding 5 years (objectives 12-14 and 12-15) (*2*). In addition, an overall national health objective is to eliminate racial/ethnic and other disparities in all health outcomes (*2*). During 1960–1994, total blood cholesterol levels among the overall U.S. population declined; however, levels have changed little since then (*3,4*), despite increases in cholesterol screening and awareness (*5*). To assess racial/ethnic and other disparities among persons who were screened for high blood cholesterol during the preceding 5 years and among persons who were aware of their high blood cholesterol, CDC analyzed data from the 1999–2000 and 2001–2002 National Health and Nutrition Examination Surveys (NHANES). This report summarizes the results of that analysis, which indicated that Mexican Americans, blacks, and younger adults were less likely to be screened for high blood cholesterol, and persons in those populations who had high cholesterol were less likely to be aware of their condition. Efforts are needed to encourage persons, especially among these populations, to seek screening and gain awareness of high blood cholesterol.

The 1999–2000 and 2001–2002 NHANES conducted by CDC were designed to be nationally representative of the noninstitutionalized, U.S. civilian population on the basis of a complex, multistage probability sample. Persons with low incomes, persons aged ≥60 years, blacks, and Mexican Americans were oversampled. For this analysis, data from the two surveys were aggregated to increase sample size. For this report, only participants classified as Mexican American, non-Hispanic white, or non-Hispanic black were included. All persons in this report referred to as white or black are non-Hispanic; Mexican Americans might be of any race. Interviews were conducted both in English and Spanish. For 1999–2002, the examined response rate among persons in the sample was 78.1%. Data were collected from 8,112 survey participants aged ≥20 years who were interviewed in their homes and subsequently provided blood samples for cholesterol level determination in mobile examination centers. Participants were considered to have high blood cholesterol if 1) testing indicated their total cholesterol level was ≥240 mg/dL or 2) they reported currently taking cholesterol-lowering medication, regardless of their test result. Subjects were asked whether they had their blood cholesterol checked during the preceding 5 years and whether they had ever been told by a health professional that they had high blood cholesterol.

Estimated population numbers, prevalences, and 95% confidence intervals (CIs) were calculated by using statistical analysis software to account for nonresponse and complex sampling design. The percentages of persons in various populations with high cholesterol levels or who had undergone blood cholesterol screening were age-standardized to the 2000 U.S. standard population (*6*). Odds ratios (ORs) and CIs were obtained by using logistic regression models that included age, sex, and race/ethnicity. All results in this report are statistically significant ($p<0.05$) unless otherwise indicated.

During 1999–2002, the overall age-adjusted prevalence of cholesterol screening was 63.0%, corresponding to approximately 106 million (CI = 102 million–109 million) persons in the United States. Disparities in cholesterol screening were observed by age, sex, and race/ethnicity (Table). The likelihood of having had blood cholesterol screening within the preceding 5 years increased with age. Women were more likely than men (adjusted OR [AOR] = 1.20; CI = 1.03–1.39) to have had their cholesterol checked during the preceding 5 years. Blacks were less likely than whites (AOR = 0.70; CI = 0.57–0.84) and Mexican Americans were less likely than whites (AOR = 0.43; CI = 0.35–0.53) to have had their cholesterol checked during the preceding 5 years.

The percentage of U.S. adults with high blood cholesterol levels increased with age (Table). On the basis of test results only, the age-adjusted prevalence of high blood cholesterol levels overall was 17.2%, which corresponds to approximately 29 million (CI = 27 million–31 million) persons in the United States. On the basis of either test results or use of cholesterol-

TABLE. Percentage* of adults aged ≥20 years who were screened for high blood cholesterol levels during the preceding 5 years, whose test results indicated high blood cholesterol levels or who were using cholesterol-lowering medication, and who were aware they had high blood cholesterol, by selected characteristics — National Health and Nutrition Examination Surveys, United States, 1999–2002

Characteristic	Screened for high blood cholesterol level during the preceding 5 years		Test results indicated high blood cholesterol level†		Test results indicated high blood cholesterol or used cholesterol-lowering medication§		Were aware of high blood cholesterol level¶	
	%	(95% CI**)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Age group (yrs)								
20–39	40.7	(37.7–43.8)	10.6	(9.0–12.3)	11.4	(9.7–13.1)	30.3	(25.5–35.1)
40–59	72.9	(70.4–75.4)	20.9	(18.5–23.4)	28.3	(25.8–30.8)	65.4	(60.4–70.4)
≥60	85.1	(83.1–87.1)	22.3	(20.7–23.9)	41.2	(39.6–42.9)	76.4	(72.8–79.9)
Sex								
Men	61.2	(59.1–63.3)	16.0	(14.4–17.6)	24.7	(23.2–26.1)	65.2	(61.0–69.4)
Women	64.8	(62.1–67.4)	17.9	(16.3–19.4)	24.2	(22.6–25.7)	61.6	(57.5–65.7)
Race/Ethnicity								
White, non-Hispanic	65.2	(62.8–67.6)	17.7	(16.1–19.2)	25.5	(24.1–26.9)	65.5	(62.1–68.9)
Black, non-Hispanic	57.7	(54.5–60.8)	15.4	(13.2–17.6)	20.9	(18.4–23.4)	54.0	(48.8–59.1)
Mexican American	47.6	(44.9–50.3)	15.4	(13.6–17.2)	19.9	(17.8–22.0)	41.8	(35.1–48.5)
Total	**63.0**	**(61.0–65.0)**	**17.2**	**(15.9–18.4)**	**24.6**	**(23.4–25.8)**	**63.3**	**(60.3–66.4)**

* Percentages for the total population and populations by sex and race/ethnicity are age-standardized to the 2000 U.S. standard population.
† A high blood cholesterol level was defined as a total blood cholesterol level ≥240 mg/dL, as determined by test results.
§ Includes all persons whose test results indicated high blood cholesterol, plus any persons not in that group who used cholesterol-lowering medication.
¶ Percentage ever told by a health professional that their cholesterol level was high, among those with a high blood cholesterol test result, and those who used cholesterol-lowering medication.
** Confidence interval.

lowering medication, the overall prevalance of high blood cholesterol was 24.6%, which corresponds to approximately 41 million (CI = 39 million–43 million) persons. Prevalence of measured high blood cholesterol or use of cholesterol-lowering medication was lower among blacks (AOR = 0.74; CI = 0.60–0.91) and Mexican Americans, respectively, when compared with whites (AOR = 0.70; CI = 0.59–0.84), after adjustment for age and sex.

Overall, 63.3% of participants whose test results indicated high blood cholesterol or who were on a cholesterol-lowering medication had been told by a health professional they had high cholesterol before the survey. The likelihood of this awareness increased with age. Women were less likely than men (AOR = 0.68; CI = 0.50–0.91) to be aware of their condition. Blacks were less likely than whites (AOR = 0.67; CI = 0.51–0.89), and Mexican Americans were less likely than whites (AOR = 0.47; CI = 0.33–0.67) to be aware of their condition; less than half (42%) of Mexican Americans with high cholesterol were aware of their condition.

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Editorial Note: This analysis indicates that, in 1999–2002 the proportions of blacks and Mexican Americans who had been screened for high blood cholesterol during the preceding 5 years was lower than the proportion for whites. The proportions of blacks and Mexican Americans with high blood cholesterol who had been told by a health professional of their condition also was lower than the proportion for whites. In addition, younger adults were less likely than older persons to be screened for and aware of their high cholesterol condition. Although women participants were more likely than men to have had their cholesterol checked during the preceding 5 years, those women whose test results indicated high cholesterol or who were on cholesterol-lowering medication were less likely than men to be aware of their high cholesterol condition. A previous study determined that women were only half as likely as men to have their total blood cholesterol controlled at <200 mg/dL, the level considered desirable (*4*).

Participants in the study described in this report were defined as having high cholesterol if they had a measured total blood cholesterol level ≥240 mg/dL or reported taking cholesterol-lowering medication; this combination resulted in a higher prevalence estimate (24.6%) than the measured results alone (17.2%). NHANES data have previously indicated that the prevalence of high blood cholesterol levels among U.S. adults aged 20–74 years, as determined by testing only, decreased from 27.8% during 1976–1980 to 19.7% during 1988–1994 (*3*). The prevalence for the same age range obtained from NHANES 1999–2002 was 17.4%; however, the mean serum total cholesterol of U.S. adults has changed little since the 1988–1994 survey (*4*). The decreasing prevalence of high blood cholesterol as measured by laboratory tests likely reflects increased use of cholesterol-lowering medication. Persons who have lowered their cholesterol by using medication might have other cardiovascular risk factors (e.g.,

high blood pressure) that place them at higher risk than persons with naturally lower cholesterol levels (*7*). Determining the prevalence of high blood cholesterol by accounting for persons using cholesterol-lowering medication, in addition to testing, might provide a more complete estimate of the health burden related to high blood cholesterol.

The findings in this report are subject to at least two limitations. First, data were only collected from persons in the noninstitutionalized population; persons residing in nursing homes or other institutions were not included. Second, only non-Hispanic blacks and Mexican Americans were oversampled in NHANES 1999–2002; consequently, estimates could not be calculated for other minority populations (e.g., Asians, Pacific Islanders, American Indians, Alaska Natives, and other Hispanic subpopulations).

The National Cholesterol Education Program (NCEP) recommends that all adults aged ≥20 years have their cholesterol checked at least every 5 years (*8*). The data in this analysis indicated that approximately 63% of U.S. adults had their cholesterol checked during the preceding 5 years, below the national health objective of 80% for 2010. Public health campaigns to raise awareness of the cardiovascular disease risk associated with high blood cholesterol levels should focus particularly on blacks, Mexican Americans, younger adults, and women. Ongoing campaigns conducted by the American College of Cardiology; National Heart, Lung, and Blood Institute; and American Heart Association are aimed at raising awareness of this risk among women (*9*). NCEP provides guidelines on therapeutic lifestyle changes in nutrition, physical activity, weight control, and drug therapy, to achieve desirable cholesterol levels (*8*). Physician adherence to guidelines that emphasize more intensive cholesterol-lowering treatment for patients at higher cardiovascular risk can also help lower the U.S. health burden related to high blood cholesterol (*10*).

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Racial/Ethnic Differences in the Prevalence and Impact of Doctor-Diagnosed Arthritis — United States, 2002

Arthritis is among the most prevalent chronic conditions in the United States, diagnosed in approximately 21% of adults (*1*). In addition, arthritis is the most common reported cause of disability (*2*) and the third leading cause of work limitation in the United States (*3*). Racial/ethnic differences have been documented in the prevalence of arthritis and in the prevalence of limitations caused by arthritis (*4*). To examine racial/ethnic differences in the prevalence and impact of arthritis, CDC analyzed data from the 2002 National Health Interview Survey (NHIS). This report summarizes the results of that analysis, which indicated that, when compared with whites, a higher proportion of blacks had arthritis-attributable activity limitations, work limitations, and severe joint pain, and a higher proportion of Hispanics had arthritis-attributable work limitations and severe joint pain. Examining racial/ethnic disparities in the prevalence and impact of arthritis is important to identify priority populations for public health interventions.

The 2002 NHIS sample adult questionnaire was administered by personal interview in English or Spanish to a nationally representative sample (n = 31,044) of the U.S. civilian, noninstitutionalized population aged ≥18 years; the survey response rate for this component was 74.3%. Respondents were asked about their health conditions and limitations and were considered to have self-reported, doctor-diagnosed arthritis if they answered "yes" to the question, "Have you ever been told by a doctor or other health professional that you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?" Those who answered "yes" were asked about limitation of usual activities caused by arthritis and if arthritis affected whether they worked or the type or amount of work they did. Responses to the work limitation question were analyzed only for the typical working age population (i.e., ages 18–64 years).

Respondents were also asked if they had joint pain (excluding the neck or back) during the preceding 30 days and to rate their average pain on a scale of 0 (no pain) to 10 (extreme pain). Severe joint pain was defined as a reported level of 7 or higher. Approximately 27.9% of those with doctor-diagnosed arthritis reported no joint pain, were therefore not asked the question about pain severity, and were classified as not having severe joint pain.

For this study, data are presented only for white, black, Hispanic, and other/multiple races combined because the sample sizes for other racial/ethnic populations, when analyzed separately, were too small for meaningful analysis. In this report, persons who are white, black, and other/multiple races are all non-Hispanic. Because different racial/ethnic populations have different age distributions, both crude and age-adjusted prevalence estimates were calculated. Data were adjusted for nonresponse and weighted to provide national estimates. Confidence intervals (CIs) were calculated by using statistical analysis software to account for the multistage probability sample. Estimates were age-adjusted to the standard 2000 U.S. population. All differences noted are statistically significant ($p<0.05$) with nonoverlapping 95% CIs.

In 2002, an estimated 20.8% (42.7 million) of adults aged ≥18 years had self-reported, doctor-diagnosed arthritis* (Table 1). Women had higher prevalence of arthritis than men, and prevalence among all respondents increased with age (Table 1). Of all adults reporting arthritis, approximately one in three (37.6%) reported activity limitations caused by arthritis or joint symptoms, which corresponds to 7.8% (16.0 million) of the total U.S. adult population (Table 2). Nearly one in four (24.6%) adults with arthritis reported severe joint pain during the preceding 30 days. Among persons aged 18–64 years with arthritis, 30.6% reported work limitations attributable to arthritis, which corresponds to 4.8% (8.2 million) of the total U.S. adult population aged 18–64 years.

Age-adjusted estimates indicated that blacks had a prevalence of arthritis similar to that of whites (Table 1), but a higher proportion had activity limitations attributable to arthritis (44.2% versus 34.1%) and thus a higher prevalence of arthritis-attributable activity limitations (10.1% versus 7.9%) (Table 2). Similarly, among respondents aged 18–64 years, blacks had a higher proportion with work limitations (39.5% versus 28.0%) and thus a higher prevalence of arthritis-attributable work limitation (6.6% versus 4.6%). Overall, blacks with doctor-diagnosed arthritis had a higher prevalence of severe pain attributable to arthritis, compared with whites (34.0% versus 22.6%).

Compared with whites, Hispanics had a lower prevalence of doctor-diagnosed arthritis (21.9% versus 15.8%) (Table 1) but a similar proportion with activity limitations attributed to arthritis (34.1% versus 39.7%), resulting in a lower prevalence of arthritis-attributable activity limitations (7.9% versus 6.5%) (Table 2). Among respondents aged 18–64 years, Hispanics had a higher proportion of work limitations than whites (38.8% versus 28.0%), resulting in a similar prevalence of arthritis-attributable work limitations (4.1% versus 4.6%). A higher proportion of Hispanics with doctor-

*An additional 11.3% (23.2 million) of adults had possible arthritis (data not shown). Respondents with possible arthritis reported chronic joint pain but no doctor-diagnosed arthritis.

TABLE 1. Number and percentage of adults aged ≥18 years with doctor-diagnosed arthritis*, by selected characteristics — National Health Interview Survey, United States, 2002

Characteristic	Unweighted no. of respondents	No. (in thousands)	Prevalence of doctor-diagnosed arthritis			
			Crude		Age-adjusted†	
			%	(95% CI§)	%	(95% CI)
Age group (yrs)						
18–44	15,693	8,469	7.9	(7.4–8.4)		—
45–64	9,434	18,523	28.8	(27.7–29.9)		—
≥65	5,821	15,713	47.8	(46.3–49.3)		—
Sex						
Women	17,481	25,869	24.3	(23.5–25.1)	23.7	(23.0–24.4)
Men	13,467	16,835	17.1	(16.3–17.9)	17.8	(17.1–18.6)
Race/Ethnicity¶						
White, non-Hispanic	20,235	34,325	23.0	(22.3–23.8)	21.9	(21.3–22.6)
Black, non-Hispanic	4,100	4,464	19.4	(18.0–21.0)	22.3	(20.8–23.8)
Hispanic	5,255	2,648	11.7	(10.7–12.8)	15.8	(14.6–17.1)
Other/Multiple race¶	1,358	1,267	12.1	(10.2–14.3)	14.4	(12.3–16.9)
Total	**30,948**	**42,704**	**20.8**	**(20.2–21.4)**	**20.9**	**(20.4–21.5)**

*Respondents with doctor-diagnosed arthritis were defined as those answering "yes" to the question, "Have you ever been told by a doctor or other health professional that you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?"
†Age-adjusted to the standard 2000 U.S. population.
§Confidence interval.
¶Data for other/multiple racial/ethnic populations are combined because, when analyzed separately, numbers were too small for meaningful analysis. Persons in this category are non-Hispanic.

TABLE 2. Estimated number, prevalence, and proportion of adults with doctor-diagnosed arthritis* reporting activity limitations, work limitations, and severe joint pain attributed to arthritis or joint symptoms, by race/ethnicity† — United States, 2002

Characteristic	White, non-Hispanic		Black, non-Hispanic		Hispanic		Other Multiple race†		Total	
	%	(95% CI§)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
No. and prevalence of adults reporting activity limitations attributable to arthritis¶										
No. in 1,000s		12,343		1,996		1,070		629		**16,038**
Unadjusted	8.3	(7.8–8.8)	8.7	(7.8–9.7)	4.7	(4.1–5.5)	6.0	(4.8–7.6)	**7.8**	**(7.5–8.2)**
Adjusted**	7.9	(7.4–8.3)	10.1	(9.1–11.1)	6.5	(5.7–7.5)	7.5	(6.0–9.4)	**7.9**	**(7.5–8.3)**
Proportion of adults†† reporting activity limitations attributable to arthritis										
Unadjusted	36.0	(34.3–37.8)	44.9	(41.2–48.6)	40.6	(36.0–45.3)	49.6	(42.1–57.2)	**37.6**	**(36.2–39.2)**
Adjusted**	34.1	(32.1–36.2)	44.2	(39.7–48.9)	39.7	(34.3–45.3)	44.0	(36.1–52.2)	**35.9**	**(34.1–37.7)**
No. and prevalence of adults aged 18–64 years reporting work limitations attributable to arthritis§§										
No. in 1,000s		5.918		1,260		697		363		**8,237**
Unadjusted	4.9	(4.5–5.3)	6.2	(5.4–7.1)	3.4	(2.9–4.1)	3.8	(2.7–5.4)	**4.8**	**(4.5–5.1)**
Adjusted**	4.6	(4.3–5.0)	6.6	(5.7–7.5)	4.1	(3.4–4.8)	4.2	(3.0–5.8)	**4.7**	**(4.4–5.0)**
Proportion of adults†† aged 18–64 years reporting work limitations attributable to arthritis§§										
Unadjusted	28.0	(26.1–29.9)	41.3	(36.7–46.1)	39.5	(33.9–45.5)	38.5	(28.7–49.3)	**30.6**	**(29.0–32.3)**
Adjusted**	28.0	(25.7–30.3)	39.5	(33.9–45.4)	38.8	(32.9–45.1)	35.1	(25.7–45.7)	**30.3**	**(28.3–32.3)**
No. and proportion of adults†† reporting severe joint pain¶¶ during preceding 30 days										
No. in 1,000s		7,675		1,584		926		329		**10,515**
Unadjusted	22.4	(21.0–23.8)	35.5	(31.6–39.5)	35.0	(30.6–39.6)	26.0	(19.7–33.5)	**24.6**	**(23.4–25.9)**
Adjusted**	22.6	(20.8–24.5)	34.0	(29.0–39.5)	32.5	(28.0–37.3)	25.5	(18.5–33.9)	**24.6**	**(23.0–26.3)**

* Respondents with doctor-diagnosed arthritis were defined as those answering "yes" to the question, "Have you ever been told by a doctor or other health professional that you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?"

† Data for other/multiple racial/ethnic populations are combined because, when analyzed separately, numbers were too small for meaningful analysis. Persons in this category are non-Hispanic.

§ Confidence interval.

¶ Estimate is based on respondents answering "yes" to the question, "Are you now limited in any way in any of your usual activities because of arthritis or joint symptoms?"

** Age-adjusted to the standard 2000 U.S. population.

†† Refers only to those with doctor-diagnosed arthritis.

§§ Work limitation is estimated among the working-age population (ages 18–64 years) from the question, "In this next question, we are referring to work for pay. Do arthritis or joint symptoms now affect whether you work, the type of work you do, or the amount of work you do?"

¶¶ Pain level was estimated from the question, "During the past 30 days, how bad was your joint pain on average? Please answer on a scale of 0–10, where 0 is no pain or aching and 10 is pain or aching as bad as it can be." Pain levels of 7–10 were considered severe. Approximately 27.9% of those with doctor-diagnosed arthritis did not report joint pain during the preceding 30 days and were not asked the question about pain severity. For this analysis, these respondents were classified as not having severe joint pain and were included in the denominator.

diagnosed arthritis reported severe joint pain, compared with whites (32.5% versus 22.6%).

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Editorial Note: The findings in this report indicate that, in 2002, approximately 21% of U.S. adults had self-reported, doctor-diagnosed arthritis, more than one third of those with arthritis had activity limitations attributable to arthritis, and nearly one third of working-age adults with arthritis also had arthritis-attributable work limitations. Compared with whites, blacks had a similar prevalence of doctor-diagnosed arthritis but a higher proportion of arthritis-attributable activity limitations, work limitations, and severe joint pain, and Hispanics had a lower prevalence of arthritis but a higher proportion with arthritis-attributable work limitations and severe joint pain.

The reasons for these racial/ethnic differences are not understood, but might be related to differences in health-care access, use of available health-care services, and language barriers (*5*). A higher prevalence of activity limitations attributable to arthritis among blacks could also be related to a higher prevalence of obesity, a condition known to be related to arthritis prevalence and poor physical functioning. The higher

proportion of work limitations attributable to arthritis among blacks and Hispanics might also reflect certain racial/ethnic differences in the type of work activities the respondents perform. Those who engage in more physically demanding work (e.g., work that requires frequent knee-bending and lifting) might also experience limitations sooner because specific work tasks can exacerbate joint symptoms and because adapting certain job tasks to accommodate joint problems is difficult.

The findings in this report are subject to at least two limitations. First, data were from self-reports of survey participants; thus, the presence of doctor-diagnosed arthritis were not confirmed by a health-care provider. However, this case-finding question appears valid for surveillance purposes (*6*). Second, this analysis did not take into account other factors (e.g., socioeconomic status, body mass index, or comorbid conditions) that might be related to a person's risk for activity and work limitation and that might differ by race/ethnicity (*7*).

Arthritis is a common illness with a major impact on all racial/ethnic populations. However, the disabling effects of arthritis (e.g., arthritis-attributable activity limitations, work limitations, and severe pain) affect racial/ethnic minorities disproportionately. Evidence-based arthritis interventions should increase among all persons with arthritis, especially these high-need populations. For example, physical activity and weight reduction programs can reduce the disabling effects of arthritis; these interventions should be made more available and accessible to all persons with arthritis, especially to blacks and Hispanics. The Arthritis Self Help Course (ASHC) is a self-management education program that has been shown to reduce pain and physician visits among persons with arthritis (*8*). A Spanish version of ASHC, also shown to be effective (*9*), should be made available to all Spanish-speaking persons with arthritis. Because the number of persons with arthritis is expected to increase during the next 25 years as the population ages (*10*) and the number of persons limited by arthritis symptoms is likely to increase, expansion of these programs is key. Increased attention should be given to implementing and evaluating evidence-based interventions in different populations, as well as adapting the interventions as necessary. Additional research is also needed to clarify reasons for racial/ethnic disparities in the occurrence of arthritis and arthritis-attributable limitations.

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Japanese Encephalitis in a U.S. Traveler Returning from Thailand, 2004

Japanese encephalitis (JE) virus is a mosquito-borne flavivirus that is closely related to the West Nile and St. Louis encephalitis viruses endemic to North America. JE virus is a leading cause of viral encephalitis in Asia (*1*) but is rarely reported among travelers to countries where JE is endemic (*2*). This report describes a case of an unvaccinated Washington resident who had JE after traveling to northern Thailand. The Advisory Committee on Immunization Practices (ACIP) recommends JE vaccine for travelers to JE-endemic areas of Asia during the transmission season, especially those spending ≥1 month in those areas and whose travel itineraries include rural settings (*2*). JE vaccine should also be considered for travelers visiting areas with epidemic transmission or those engaging in extensive outdoor activity in rural settings in areas where JE is endemic, regardless of the duration of their visit. In addition, health-care providers and organized international travel programs should ensure that travelers obtain appropriate preventive health guidance before travel.

Case Report

In late June 2004, a previously healthy woman aged 22 years was admitted to a Seattle hospital within hours of returning from a 32-day visit to Thailand. She had become ill 2 days earlier with fever (101.5°F [38.6°C]), nausea, headache, photophobia, and stiff neck that had worsened over time. A lumbar puncture was performed; her cerebrospinal fluid (CSF) revealed a white blood cell count of 47 cells/μL (97% polymorphonuclear leukocytes), glucose 60 mg/dL, and protein 37 mg/dL. The patient was presumptively treated for herpes encephalitis with acyclovir and for cerebral malaria with quinidine and corticosteroids.

Two days later, the patient had dysarthria, dysphagia, profound lethargy, and fever (104.0°F [40.0°C]); as a result, she was sedated and endotracheally intubated. A nonenhanced magnetic resonance image revealed edema in the hypothalamus. Polymerase chain reaction studies of CSF for herpes simplex virus and enteroviruses were negative, and peripheral blood smears were negative for plasmodia. The patient improved clinically and was extubated after 2 days but had onset of Bell's palsy on hospital day 11. After 14 days of hospitalization, she was discharged and underwent outpatient rehabilitation for 6 weeks. The patient had no apparent neurologic sequelae. CSF and serum collected 4 days after illness onset and serum collected 21 days after illness onset had JE virus–specific IgM antibodies and neutralizing antibodies confirming a recent JE viral infection.

In May 2004, the patient had traveled with 21 other students to Chiang Mai City, Thailand, on a university-affiliated study-abroad program. Although the program did not require students to consult a health-care provider before travel, the patient consulted her primary-care physician. She did not receive any vaccinations or malaria prophylaxis. During her month-long stay, the patient slept in a dormitory, where her room did not have screened windows or bed nets. She also spent one night in a poorly screened cabin in the rural Chiang Mai Valley. The patient reported receiving mosquito bites in both the dormitory and cabin.

Cohort Survey

Approximately 6 weeks after hospital admission, a telephone survey of the patient's travel cohort was performed. Of 22 students, 20 (91%) participated in the survey; none had a similar illness. Mean age of respondents was 22 years (range: 19–30 years), and the median time spent in Asia during the study-abroad program was 6.5 weeks (range: 4.5–16.0 weeks). In preparation for the trip, five (25%) students consulted a travel medicine specialist, seven (35%) consulted a primary-care provider or a parent in the health-care field, and eight (40%) did not consult a health-care provider. One student was vaccinated against JE. All students participated in outdoor activities in Thailand, and 19 (95%) reported receiving mosquito bites. Three (15%) students reported having screens or bed nets at the dormitory; however, 15 (75%) reported "sometimes" or "always" using insect repellent while in Chiang Mai City.

On the basis of the cohort survey results, the Washington State Department of Health recommended that the univer-

sity study-abroad program 1) require all students traveling to areas outside of North America or Western Europe to consult a knowledgeable health-care provider for advice on appropriate vaccinations, malaria prophylaxis, and other health precautions before travel, and 2) develop a formal curriculum on travelers' health topics to be presented during predeparture orientation.

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Editorial Note: JE virus is a leading cause of viral encephalitis in Asia; JE has a case-fatality rate of approximately 30% (*1,3*). No virus-specific treatment exists, and survivors commonly have neurologic sequelae (*1,3*). Although JE is a substantial public health problem in Asian countries, transmission to short-term travelers to JE-endemic countries rarely has been reported (*2,4*). This report describes the first reported case in a U.S. traveler since 1992.

Less than 1% of JE virus–infected persons have onset of encephalitis (*3*); however, because an effective JE vaccine is available, vaccination should be considered for use in travelers to Asia. Although the risk for infection among travelers is low overall, risk varies substantially by season (e.g., risk is highest in the rainy season), geographic location, duration of travel, outbreak presence, and activities of the traveler (*2,5*). Risk estimates based on JE incidence among residents of countries where the disease is endemic are often inaccurate because JE surveillance is not conducted in many Asian countries. In countries with childhood vaccination programs or where the majority of persons aged <15 years have developed immunity after a natural, asymptomatic JE viral infection, the low incidence among residents can be misleading. Despite a history of JE outbreaks in rural Chiang Mai Valley (*6,7*) and ≥1 month's stay for all 22 travelers described in this report, 40% received no pre-travel medical advice from a health-care provider, and only one was vaccinated against JE.

The specific ecologic setting in which the patient described in this report was infected is unknown. Swine production and flood-irrigated rice farming provide a hospitable environment for both the proliferation of the principal mosquito vector, *Culex tritaeniorhynchus*, and amplification of JE virus in swine. Mosquito infection rates can be as high as 10% in areas where virus transmission to vertebrates is high (*8*). The virus can also be transmitted in urban and other ecologic settings, although the intensity of transmission is often much less than in endemic, rice-producing areas. JE cases have been reported among urban residents and travelers to Asian cities who had little or no rural exposure and were likely infected by urban *Culex* species (*2*). In addition, because wading birds (e.g., egrets) and large mammals other than swine can serve as amplifying hosts, JE virus transmission can occur in areas where swine are not raised. JE virus–infected persons do not have high-titer viremia and are therefore considered "dead-end" hosts.

A single, formalin-inactivated, mouse brain–derived, JE vaccine is licensed for use in the United States in persons aged ≥1 year. The preferred primary vaccination series consists of 3 doses administered at 0, 7, and 30 days, but an accelerated schedule consisting of 3 doses administered at 0, 7, and 14 days can be used when the longer schedule is impractical or inconvenient because of time constraints. With either schedule, the primary series should be completed at least 10 days before travel to allow an adequate immune response and monitoring of adverse events (AE) after vaccination; therefore, JE vaccination should begin at least 24 days before travel abroad. In addition to a moderate rate of local side effects (*2*), rare and more serious neurologic (e.g., encephalitis) and allergic AE (e.g., urticaria or angioedema) have been reported (*9*).

JE vaccine is not recommended for all travelers to Asia. For each traveler, careful consideration of the potential risks and benefits of vaccination should be made by a health-care provider familiar with the person's itinerary, the vaccine, and current CDC recommendations for its use (*2*). In general, vaccine should be offered to persons spending ≥1 month in JE-endemic areas during the transmission season, especially if travel will include rural areas. Under specific circumstances, vaccine should be considered for persons spending <1 month in JE-endemic areas (e.g., travelers to areas experiencing epidemic transmission and persons whose activities, such as extensive outdoor activities in rural areas, place them at high risk for exposure). In all instances, travelers should be advised to take personal precautions to reduce exposure to mosquito bites (e.g., avoidance of mosquitoes and use of repellents and protective clothing).

To determine a traveler's need for vaccination and prophylaxis, health-care providers and travelers can review regularly updated CDC travel recommendations for JE, malaria, other vector-borne diseases, and endemic infectious diseases at http://www.cdc.gov/travel. In addition, health-care providers can call the CDC Division of Vector-Borne Infectious Diseases, telephone 970-221-6400, or Division of Global Migration and Quarantine, telephone 404-498-1600. Finally, organized international travel programs should ensure that their clients obtain appropriate preventive health guidance before travel.

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Notice to Readers

Caution Regarding Testing for Lyme Disease

CDC and the Food and Drug Administration (FDA) have become aware of commercial laboratories that conduct testing for Lyme disease by using assays whose accuracy and clinical usefulness have not been adequately established. These tests include urine antigen tests, immunofluorescent staining for cell wall–deficient forms of *Borrelia burgdorferi*, and lymphocyte transformation tests. In addition, some laboratories perform polymerase chain reaction tests for *B. burgdorferi* DNA on inappropriate specimens such as blood and urine or interpret Western blots using criteria that have not been validated and published in peer-reviewed scientific literature. These inadequately validated tests and criteria also are being used to evaluate patients in Canada and Europe, according to reports from the National Microbiology Laboratory, Public Health Agency of Canada; the British Columbia Centres for Disease Control, Canada; the German National Reference Center for Borreliae; and the Health Protection Agency Lyme Borreliosis Unit of the United Kingdom.

In the United States, FDA has cleared 70 serologic assays to aid in the diagnosis of Lyme disease. Recommendations for the use and interpretation of serologic tests have been published previously (*1*). Initial testing should use an enzyme immunoassay (EIA) or immunofluorescent assay (IFA); specimens yielding positive or equivocal results should be tested further by using a standardized Western immunoblot assay. Specimens negative by a sensitive EIA or IFA do not need further testing. Similar assays and recommendations are used in Canada (*2*). In the European Union, a minimum standard for commercial diagnostic kits is provided by Conformité Européene (CE) marking; application and interpretation guidelines appropriate for Europe have been published (*3,4*).

Health-care providers are reminded that a diagnosis of Lyme disease should be made after evaluation of a patient's clinical presentation and risk for exposure to infected ticks, and, if indicated, after the use of validated laboratory tests. Patients are encouraged to ask their physicians whether their testing for Lyme disease was performed using validated methods and whether results were interpreted using appropriate guidelines.

References
1. CDC. Recommendations for test performance and interpretation from the Second National Conference on Serologic Diagnosis of Lyme Disease. MMWR 1995;44:590–1.
2. Consensus Conference on Lyme Disease. Can Dis Wkly Rep 1991; 17:63–70.
3. Wilske B, Zöller L, Brade V, et al. MIQ 12 Lyme-Borreliose. Qualitätsstandards in der mikrobiologisch-infektiologischen Diagnostik. Munich, Germany: Urban & Fischer Verlag; 2000;1–59. Guidelines available in English at http://nrz-borrelien.lmu.de/miq-lyme/index.html.
4. Robertson J, Guy E, Andrews N, et al. A European multicenter study of immunoblotting in serodiagnosis of Lyme borreliosis. J Clin Microbiol 2000;38:2097–102.

Notice to Readers

National Child Passenger Safety Week, February 12–18, 2005

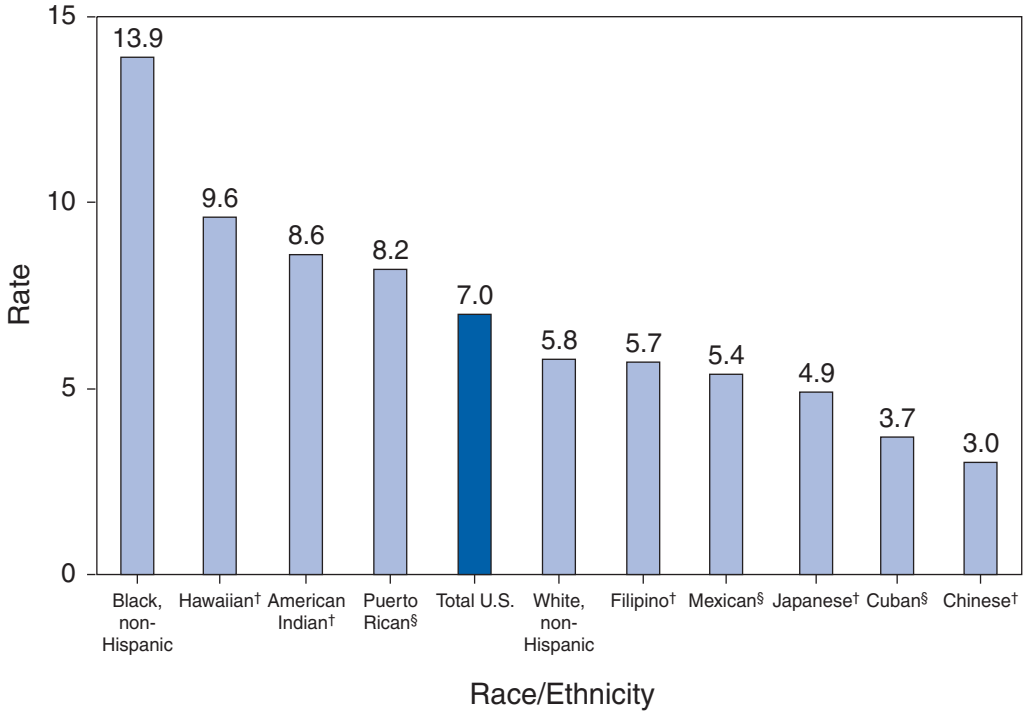
Each day during 2003, an average of six children aged <15 years were killed and another 694 were injured in motor vehicle crashes, which are a leading cause of death and disability for children in the United States (*1,2*). This year's theme for National Child Passenger Safety Week, February 12–18, 2005, will highlight the importance of booster seat use.

Recent findings suggest that children aged 4–7 years who use belt-positioning booster seats are 59% less likely to be injured in a motor-vehicle crash, compared with their counterparts using adult safety belts (*3*). The National Highway Traffic Safety Administration (NHTSA) and CDC recommend the use of booster seats for children who weigh at least 40 pounds, are aged 4–8 years, and are less than 4 feet 9 inches tall (*4*). In a recent national telephone survey conducted by NHTSA, only 21% of children aged 4–8 years used booster seats at least occasionally (*5*). Although all states have enacted legislation requiring child passenger restraints for infants and toddlers, only 22 states and the District of Columbia have enacted booster seat laws, the majority of which do not cover all children who should be in booster seats (*6*).

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Infant Mortality Rates*, by Selected Racial/Ethnic Populations — United States, 2002



* Per 1,000 live births.
† Can include persons of Hispanic and non-Hispanic origin.
§ Persons of Hispanic origin might be of any race.

In 2002, the infant mortality rate was highest for infants of non-Hispanic black mothers. Infants of Hawaiian, American Indian, and Puerto Rican mothers also had high rates. The lowest rates were observed for infants of Cuban and Chinese mothers. Additional birth data are available at http://www.cdc.gov/nchs/births.htm.

SOURCE: Mathews TJ, Menacker F, MacDorman MF. Infant mortality statistics from the 2002 period linked birth/infant death data set. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_10.pdf.

Information about child passenger safety and Child Passenger Safety Week activities is available from NHTSA, Office of Communications and Outreach, 400 Seventh St., SW, NTS-21, Washington, DC 20590; telephone 202-366-9742; fax 202-366-6916; and at http://www.nhtsa.dot.gov, and http://www.cdc.gov/ncipc.

References

1. National Highway Traffic Safety Administration. Traffic safety facts 2003: children. Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration; 2004. Available at http://www-nrd.nhtsa.dot.gov/pdf/nrd-30/NCSA/TSF2003/809762.pdf.
2. CDC. Ten leading causes of death, United States, 2001. Atlanta, GA: US Department of Health and Human Services, CDC; 2004. Available at http://webapp.cdc.gov/sasweb/ncipc/leadcaus.html.
3. Durbin DR, Elliott MR, Winston FK. Belt-positioning booster seats and reduction in risk of injury among children in vehicle crashes. JAMA 2003;289:2835–40.
4. CDC. National Child Passenger Safety Week—February 14–20, 1999. MMWR 1999;48:83–4.
5. National Highway Traffic Safety Administration. Traffic safety facts traffic tech. No. 294. Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration; September 2004. Available at http://www.nhtsa.dot.gov/people/injury/traffic_tech/2004/TrafficTech294/index.html.
6. Advocates for Highway and Auto Safety. Child passenger safety. Washington, DC: Advocates for Highway and Auto Safety; November 2004. Available at http://www.saferoads.org/issues/fs-boosterseat.htm.

Errata: Volume 54, No. 3

In the report, "Outbreaks of Pertussis Associated with Hospitals — Kentucky, Pennsylvania, and Oregon, 2003," an error occurred in the last sentence on page 70 (continuing to page 71). The text should read as follows: "A recent study that compared azithromycin administered as 10 mg/kg (maximum: 500 mg) on day 1 followed by 5 mg/kg (maximum: 250 mg) on days 2–5 with a 10-day treatment of erythromycin (40 mg/kg/day in 3 divided doses; maximum 1 g/day) demonstrated equivalence between the two treatments (*9*)."

In addition, on page 69, the first sentence of the third full paragraph should read as follows: "In late September 2003, physician C treated an infant aged 2 months with PCR-confirmed pertussis in the pediatric ICU."

Also on page 69, the first sentence of the Editorial Note should read as follows:

"Despite high childhood coverage for pertussis vaccination (*4*), reported pertussis incidence in the United States has increased from a low of 1,248 cases (0.54 per 100,000 population) in 1981 to an annual average of 9,431 cases during 1996–2004 (average annual rate: 3.3 per 100,000 population) (*5*)."

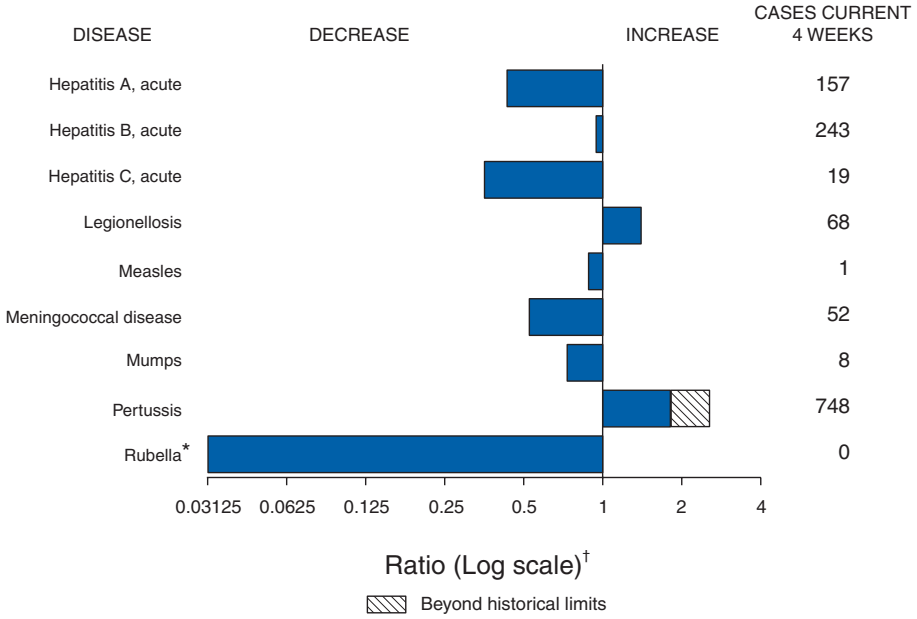
Errata: Vol. 54, No. 4

In Table III, "Deaths in 122 U.S. Cities, Week Ending January 29, 2005 (4th Week)," on page 111, total deaths attributable to pneumonia and influenza (P&I) for San Francisco, California; the Pacific Region; and across all reporting cities were incorrectly reported. The correct mortality data are as follows:

Reporting Area	All causes, by age (years)						P&I Total
	All Ages	≥65	45–64	25–44	1–24	<1	
PACIFIC	2,020	1,443	400	108	34	35	193
San Francisco, Calif.	133	87	32	8	2	4	22
TOTAL	12,710	8,668	2,765	785	253	233	1,022

Corrected data are available at http://www.cdc.gov/mmwr/distrnds.html, select "Search Mortality Tables" and *MMWR* year 2005 and *MMWR* week 4.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals February 5, 2005, with historical data



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

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending February 5, 2005 (5th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	5	5
Botulism:			HIV infection, pediatric†¶	31	22
foodborne	3	1	Influenza-associated pediatric mortality†**	6	—
infant	2	9	Measles	2††	2§§
other (wound & unspecified)	2	—	Mumps	19	20
Brucellosis	7	9	Plague	—	—
Chancroid	4	3	Poliomyelitis, paralytic	—	—
Cholera	—	1	Psittacosis†	—	—
Cyclosporiasis†	1	7	Q fever†	4	5
Diphtheria	—	—	Rabies, human	—	—
Domestic arboviral diseases			Rubella	—	4
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	—	—
California serogroup†§	—	—	SARS†**	—	—
eastern equine†§	—	—	Smallpox†	—	—
Powassan†§	—	—	*Staphylococcus aureus*:		
St. Louis†§	—	—	Vancomycin-intermediate (VISA)†	—	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	—	—
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome†	4	24
human granulocytic (HGE)†	3	6	Tetanus	—	1
human monocytic (HME)†	4	5	Toxic-shock syndrome	7	12
human, other and unspecified †	2	1	Trichinellosis¶¶	—	—
Hansen disease†	4	6	Tularemia†	—	2
Hantavirus pulmonary syndrome†	—	2	Yellow fever	—	—

—: No reported cases.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
¶ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update January 30, 2005.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of two cases reported, two were indigenous and none were imported from another country.
§§ Of two cases reported, one was indigenous and one was imported from another country.
¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending February 5, 2005, and February 7, 2004 (5th Week)*

Reporting area	AIDS		Chlamydia†		Coccidioidomycosis		Cryptosporidiosis	
	Cum. 2005§	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	2,989	2,511	61,867	82,225	344	138	122	241
NEW ENGLAND	133	50	2,509	2,908	—	—	2	14
Maine	3	1	228	176	N	N	—	4
N.H.	2	4	150	170	—	—	—	3
Vt.¶	—	7	96	96	—	—	1	2
Mass.	47	1	1,253	1,329	—	—	1	5
R.I.	14	16	308	429	—	—	—	—
Conn.	67	21	474	708	N	N	—	—
MID. ATLANTIC	447	459	7,801	9,693	—	—	20	35
Upstate N.Y.	39	24	1,047	1,377	N	N	3	7
N.Y. City	221	281	2,648	3,231	—	—	4	14
N.J.	87	98	1,043	1,758	N	N	1	2
Pa.	100	56	3,063	3,327	N	N	12	12
E.N. CENTRAL	275	307	6,495	15,225	—	—	17	57
Ohio	59	96	95	3,653	N	N	13	15
Ind.	37	53	1,955	1,597	N	N	—	2
Ill.	147	125	2,651	4,399	—	—	—	13
Mich.	26	15	854	3,954	—	—	2	11
Wis.	6	18	940	1,622	N	N	2	16
W.N. CENTRAL	85	60	2,229	5,235	—	1	20	16
Minn.	35	12	216	1,151	N	N	5	2
Iowa	16	5	—	658	N	N	3	1
Mo.	17	12	1,203	1,982	—	—	7	5
N. Dak.	—	5	105	134	N	N	—	—
S. Dak.	3	—	278	247	—	—	2	4
Nebr.¶	—	5	—	442	—	1	—	—
Kans.	14	21	427	621	N	N	3	4
S. ATLANTIC	1,108	715	14,322	14,206	—	—	30	46
Del.	—	12	301	263	N	N	—	—
Md.	82	10	1,415	1,659	—	—	4	2
D.C.	28	21	165	291	—	—	—	1
Va.	58	3	2,322	2,118	—	—	—	2
W. Va.	12	8	235	277	N	N	—	—
N.C.	127	1	3,554	1,951	N	N	5	10
S.C.¶	42	27	1,679	907	—	—	—	1
Ga.	231	192	989	3,427	—	—	10	17
Fla.	528	441	3,662	3,313	N	N	11	13
E.S. CENTRAL	141	98	4,509	5,091	—	—	6	18
Ky.	25	20	867	602	N	N	1	5
Tenn.¶	59	33	1,487	2,115	N	N	1	7
Ala.¶	54	26	223	1,284	—	—	3	4
Miss.	3	19	1,932	1,090	—	—	1	2
W.S. CENTRAL	331	383	9,100	11,321	—	—	1	11
Ark.	35	15	696	713	—	—	—	4
La.	39	28	1,034	3,220	—	—	—	—
Okla.	43	5	1,118	890	N	N	1	2
Tex.¶	214	335	6,252	6,498	N	N	—	5
MOUNTAIN	112	70	4,368	5,137	272	16	8	9
Mont.	—	—	156	26	N	N	—	—
Idaho¶	1	1	209	232	N	N	—	—
Wyo.	—	—	116	93	—	—	—	1
Colo.	12	1	621	1,089	N	N	1	7
N. Mex.	17	—	422	759	—	4	1	—
Ariz.	57	64	1,937	1,976	265	2	2	—
Utah	8	3	323	333	1	3	1	—
Nev.¶	17	1	584	629	6	7	3	1
PACIFIC	357	369	10,534	13,409	72	121	18	35
Wash.	28	22	1,772	1,442	N	N	—	—
Oreg.¶	32	16	759	676	—	—	1	3
Calif.	291	318	7,606	10,407	72	121	17	32
Alaska	5	—	214	266	—	—	—	—
Hawaii	1	13	183	618	—	—	—	—
Guam	1	—	—	125	—	—	—	—
P.R.	1	47	174	198	N	N	N	N
V.I.	3	—	—	50	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

† Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update January 30, 2005.

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 5, 2005, and February 7, 2004 (5th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	62	92	4	13	15	11	944	1,344	22,167	30,708
NEW ENGLAND	7	4	—	3	3	1	62	95	488	686
Maine	—	—	—	—	—	—	8	14	11	27
N.H.	—	1	—	—	—	—	—	3	12	13
Vt.	—	—	—	—	—	—	4	5	3	4
Mass.	3	—	—	2	3	1	49	70	252	282
R.I.	—	—	—	—	—	—	—	3	43	98
Conn.	4	3	—	1	—	—	1	—	167	262
MID. ATLANTIC	5	10	—	—	1	1	195	288	2,486	3,331
Upstate N.Y.	2	1	—	—	—	—	45	51	429	557
N.Y. City	—	4	—	—	—	—	52	105	787	1,077
N.J.	1	—	—	—	—	1	34	37	344	623
Pa.	2	5	—	—	1	—	64	95	926	1,074
E.N. CENTRAL	11	24	1	4	4	1	99	233	2,521	6,639
Ohio	7	9	—	—	3	1	54	81	37	2,119
Ind.	—	4	—	—	—	—	N	N	807	649
Ill.	—	3	—	—	—	—	—	76	1,015	1,930
Mich.	3	5	—	—	1	—	30	49	354	1,539
Wis.	1	3	1	4	—	—	15	27	308	402
W.N. CENTRAL	11	11	—	3	1	6	68	104	762	1,808
Minn.	2	5	—	—	—	—	1	26	58	472
Iowa	5	—	—	—	—	—	20	20	—	113
Mo.	2	3	—	3	1	1	23	36	507	836
N. Dak.	—	—	—	—	—	3	—	1	5	10
S. Dak.	2	—	—	—	—	—	3	3	37	23
Nebr.	—	1	—	—	—	—	9	7	—	125
Kans.	—	2	—	—	—	2	12	11	155	229
S. ATLANTIC	9	5	1	2	6	2	153	201	6,739	6,783
Del.	—	—	N	N	N	N	—	1	70	103
Md.	3	1	1	—	—	—	15	12	640	792
D.C.	—	—	—	—	—	—	—	7	107	210
Va.	—	—	—	1	1	—	15	18	885	974
W. Va.	—	—	—	—	—	—	—	1	80	79
N.C.	—	—	—	—	4	2	N	N	1,947	1,144
S.C.	—	—	—	—	—	—	5	1	807	453
Ga.	2	1	—	—	—	—	54	76	533	1,561
Fla.	4	3	—	1	1	—	64	85	1,670	1,467
E.S. CENTRAL	3	3	—	—	—	—	20	24	1,666	2,483
Ky.	—	1	—	—	—	—	N	N	303	275
Tenn.	1	—	—	—	—	—	2	10	575	860
Ala.	2	1	—	—	—	—	18	14	172	775
Miss.	—	1	—	—	—	—	—	—	616	573
W.S. CENTRAL	2	6	—	—	—	—	14	27	3,934	4,450
Ark.	1	—	—	—	—	—	6	12	369	331
La.	—	—	—	—	—	—	—	6	643	1,480
Okla.	1	1	—	—	—	—	8	9	471	417
Tex.	—	5	—	—	—	—	N	N	2,451	2,222
MOUNTAIN	3	10	2	—	—	—	87	113	1,078	1,342
Mont.	—	1	—	—	—	—	5	1	3	8
Idaho	1	1	—	—	—	—	13	18	12	5
Wyo.	—	—	1	—	—	—	1	1	7	3
Colo.	1	2	1	—	—	—	28	56	227	325
N. Mex.	—	1	—	—	—	—	4	5	64	94
Ariz.	1	1	N	N	N	N	19	—	450	595
Utah	—	2	—	—	—	—	13	23	53	31
Nev.	—	2	—	—	—	—	4	9	262	281
PACIFIC	11	19	—	1	—	—	246	259	2,493	3,186
Wash.	2	3	—	—	—	—	9	13	240	267
Oreg.	—	2	—	1	—	—	21	48	116	89
Calif.	6	11	—	—	—	—	201	188	2,071	2,634
Alaska	1	—	—	—	—	—	3	5	33	48
Hawaii	2	3	—	—	—	—	12	5	33	148
Guam	N	N	—	—	—	—	—	—	—	26
P.R.	—	—	—	—	—	—	—	—	21	9
V.I.	—	—	—	—	—	—	—	—	—	18
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 5, 2005, and February 7, 2004 (5th Week)*

Reporting area	*Haemophilus influenzae*, invasive							
	All ages		Age <5 years					
	All serotypes		Serotype b		Non-serotype b		Unknown serotype	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	154	225	—	3	5	7	13	27
NEW ENGLAND	11	25	—	—	1	2	2	1
Maine	—	1	—	—	—	—	—	—
N.H.	—	6	—	—	—	1	—	—
Vt.	4	1	—	—	—	—	2	—
Mass.	3	10	—	—	—	—	—	1
R.I.	—	1	—	—	—	—	—	—
Conn.	4	6	—	—	1	1	—	—
MID. ATLANTIC	36	46	—	—	—	—	2	7
Upstate N.Y.	10	11	—	—	—	—	—	1
N.Y. City	5	9	—	—	—	—	—	3
N.J.	6	9	—	—	—	—	—	1
Pa.	15	17	—	—	—	—	2	2
E.N. CENTRAL	25	47	—	—	—	1	2	11
Ohio	19	16	—	—	—	—	2	3
Ind.	3	1	—	—	—	—	—	1
Ill.	—	15	—	—	—	—	—	4
Mich.	3	5	—	—	—	1	—	2
Wis.	—	10	—	—	—	—	—	1
W.N. CENTRAL	5	7	—	—	—	—	1	1
Minn.	—	—	—	—	—	—	—	—
Iowa	—	—	—	—	—	—	—	—
Mo.	5	3	—	—	—	—	1	1
N. Dak.	—	—	—	—	—	—	—	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	—	4	—	—	—	—	—	—
Kans.	—	—	—	—	—	—	—	—
S. ATLANTIC	50	48	—	—	1	—	3	2
Del.	—	—	—	—	—	—	—	—
Md.	9	16	—	—	1	—	1	—
D.C.	—	—	—	—	—	—	—	—
Va.	—	6	—	—	—	—	—	—
W. Va.	—	1	—	—	—	—	—	—
N.C.	13	1	—	—	—	—	—	—
S.C.	1	—	—	—	—	—	—	—
Ga.	13	14	—	—	—	—	2	2
Fla.	14	10	—	—	—	—	—	—
E.S. CENTRAL	4	10	—	—	—	—	—	1
Ky.	—	—	—	—	—	—	—	—
Tenn.	3	4	—	—	—	—	—	—
Ala.	1	6	—	—	—	—	—	1
Miss.	—	—	—	—	—	—	—	—
W.S. CENTRAL	5	6	—	—	—	1	1	—
Ark.	—	—	—	—	—	—	—	—
La.	2	3	—	—	—	—	1	—
Okla.	3	3	—	—	—	1	—	—
Tex.	—	—	—	—	—	—	—	—
MOUNTAIN	13	28	—	1	3	3	1	2
Mont.	—	—	—	—	—	—	—	—
Idaho	1	1	—	—	—	—	—	—
Wyo.	1	—	—	—	—	—	—	—
Colo.	2	10	—	—	—	—	—	1
N. Mex.	1	8	—	—	—	1	—	1
Ariz.	4	5	—	—	1	1	1	—
Utah	1	1	—	1	—	—	—	—
Nev.	3	3	—	—	2	1	—	—
PACIFIC	5	8	—	2	—	—	1	2
Wash.	—	3	—	2	—	—	—	1
Oreg.	3	3	—	—	—	—	1	—
Calif.	—	2	—	—	—	—	—	1
Alaska	1	—	—	—	—	—	—	—
Hawaii	1	—	—	—	—	—	—	—
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	—	—	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 5, 2005, and February 7, 2004 (5th Week)*

Reporting area	Hepatitis (viral, acute), by type					
	A		B		C	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	247	569	393	484	38	83
NEW ENGLAND	45	85	18	33	—	—
Maine	—	4	—	—	—	—
N.H.	2	1	—	4	—	—
Vt.	—	3	—	1	—	—
Mass.	35	68	18	15	—	—
R.I.	—	—	—	—	—	—
Conn.	8	9	—	13	—	—
MID. ATLANTIC	26	85	85	84	1	14
Upstate N.Y.	5	4	5	2	—	1
N.Y. City	8	31	3	17	—	—
N.J.	2	17	59	36	—	—
Pa.	11	33	18	29	1	13
E.N. CENTRAL	18	55	29	28	11	5
Ohio	3	6	17	11	1	—
Ind.	4	7	1	—	—	—
Ill.	4	24	—	—	—	—
Mich.	5	15	11	12	10	5
Wis.	2	3	—	5	—	—
W.N. CENTRAL	7	13	14	28	4	8
Minn.	—	—	—	1	—	—
Iowa	2	3	1	1	—	—
Mo.	2	2	8	23	4	8
N. Dak.	—	—	—	—	—	—
S. Dak.	—	—	—	—	—	—
Nebr.	2	5	3	1	—	—
Kans.	1	3	2	2	—	—
S. ATLANTIC	41	109	132	159	12	18
Del.	—	—	—	1	—	—
Md.	3	19	15	12	5	2
D.C.	—	—	—	—	—	—
Va.	—	5	6	5	—	1
W. Va.	—	—	1	—	—	1
N.C.	3	5	15	23	1	1
S.C.	—	—	—	1	—	—
Ga.	17	53	46	62	—	3
Fla.	18	27	49	55	6	10
E.S. CENTRAL	3	17	14	32	2	7
Ky.	—	—	1	3	—	2
Tenn.	1	10	2	8	—	2
Ala.	2	2	10	5	2	—
Miss.	—	5	1	16	—	3
W.S. CENTRAL	4	85	5	24	—	24
Ark.	—	10	—	9	—	—
La.	3	2	2	13	—	17
Okla.	—	4	—	2	—	—
Tex.	1	69	3	—	—	7
MOUNTAIN	35	7	50	20	5	2
Mont.	4	—	—	—	—	—
Idaho	3	1	2	1	—	—
Wyo.	—	—	—	1	—	—
Colo.	3	2	3	5	—	—
N. Mex.	2	—	—	2	—	—
Ariz.	21	—	38	—	—	1
Utah	2	3	5	5	4	—
Nev.	—	1	2	6	1	1
PACIFIC	68	113	46	76	3	5
Wash.	4	4	1	4	—	1
Oreg.	6	12	6	17	1	1
Calif.	58	95	38	54	2	2
Alaska	—	—	—	—	—	—
Hawaii	—	2	1	1	—	1
Guam	—	—	—	—	—	—
P.R.	—	3	1	1	—	—
V.I.	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 5, 2005, and February 7, 2004 (5th Week)*

Reporting area	Legionellosis		Listeriosis		Lyme disease		Malaria	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	99	142	28	44	301	723	79	115
NEW ENGLAND	2	2	—	1	5	45	2	10
Maine	—	—	—	—	—	—	—	—
N.H.	—	—	—	—	4	—	—	—
Vt.	—	—	—	—	—	—	—	—
Mass.	2	1	—	—	1	41	2	8
R.I.	—	—	—	—	—	—	—	—
Conn.	—	1	—	1	—	4	—	2
MID. ATLANTIC	33	29	5	13	236	585	17	27
Upstate N.Y.	8	3	—	1	21	117	2	3
N.Y. City	—	—	—	2	—	—	4	15
N.J.	4	12	2	6	106	149	9	4
Pa.	21	14	3	4	109	319	2	5
E.N. CENTRAL	19	46	5	4	12	18	5	7
Ohio	12	24	2	3	11	4	2	1
Ind.	5	5	—	—	—	—	—	1
Ill.	—	9	—	—	—	—	—	1
Mich.	2	6	1	—	1	—	3	1
Wis.	—	2	2	1	U	14	—	3
W.N. CENTRAL	2	4	3	—	1	7	3	8
Minn.	—	—	—	—	—	—	1	4
Iowa	—	—	2	—	1	2	2	—
Mo.	2	3	—	—	—	5	—	3
N. Dak.	—	—	1	—	—	—	—	—
S. Dak.	—	1	—	—	—	—	—	—
Nebr.	—	—	—	—	—	—	—	—
Kans.	—	—	—	—	—	—	—	1
S. ATLANTIC	23	26	6	9	41	52	17	35
Del.	—	—	N	N	—	4	—	—
Md.	7	5	2	2	29	38	7	10
D.C.	—	2	—	—	—	—	—	—
Va.	—	1	—	—	—	—	—	—
W. Va.	—	—	—	1	—	—	—	—
N.C.	4	4	2	3	5	5	2	1
S.C.	—	1	—	—	—	—	—	2
Ga.	3	2	—	1	—	2	5	7
Fla.	9	11	2	2	7	3	3	15
E.S. CENTRAL	—	5	—	2	2	—	3	3
Ky.	—	—	—	1	—	—	—	—
Tenn.	—	2	—	1	2	—	2	—
Ala.	—	3	—	—	—	—	1	2
Miss.	—	—	—	—	—	—	—	1
W.S. CENTRAL	—	11	1	2	—	7	1	13
Ark.	—	—	—	—	—	—	—	1
La.	—	1	1	—	—	—	—	2
Okla.	—	1	—	—	—	—	—	—
Tex.	—	9	—	2	—	7	1	10
MOUNTAIN	7	7	—	3	—	1	8	2
Mont.	—	—	—	—	—	—	—	—
Idaho	—	1	—	—	—	—	—	—
Wyo.	2	2	—	—	—	—	1	—
Colo.	—	1	—	1	—	—	3	—
N. Mex.	—	—	—	—	—	—	—	1
Ariz.	3	—	—	—	—	—	2	—
Utah	1	2	—	—	—	1	2	—
Nev.	1	1	—	2	—	—	—	1
PACIFIC	13	12	8	10	4	8	23	10
Wash.	—	2	2	1	—	1	—	—
Oreg.	N	N	—	4	—	3	1	1
Calif.	13	10	6	5	4	4	21	9
Alaska	—	—	—	—	—	—	1	—
Hawaii	—	—	—	—	N	N	—	—
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 5, 2005, and February 7, 2004 (5th Week)*

Reporting area	Meningococcal disease									
	All serogroups		Serogroup A, C, Y, and W-135		Serogroup B		Other serogroup		Serogroup unknown	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	85	198	10	15	5	6	—	—	70	177
NEW ENGLAND	11	7	—	—	—	—	—	—	11	7
Maine	1	2	—	—	—	—	—	—	1	2
N.H.	1	—	—	—	—	—	—	—	1	—
Vt.	3	1	—	—	—	—	—	—	3	1
Mass.	5	4	—	—	—	—	—	—	5	4
R.I.	—	—	—	—	—	—	—	—	—	—
Conn.	1	—	—	—	—	—	—	—	1	—
MID. ATLANTIC	17	27	5	8	2	2	—	—	10	17
Upstate N.Y.	5	7	—	2	1	—	—	—	4	5
N.Y. City	1	6	—	—	—	—	—	—	1	6
N.J.	3	3	—	—	—	—	—	—	3	3
Pa.	8	11	5	6	1	2	—	—	2	3
E.N. CENTRAL	6	22	2	5	1	1	—	—	3	16
Ohio	2	15	—	3	1	1	—	—	1	11
Ind.	2	2	—	—	—	—	—	—	2	2
Ill.	—	—	—	—	—	—	—	—	—	—
Mich.	2	2	2	2	—	—	—	—	—	—
Wis.	—	3	—	—	—	—	—	—	—	3
W.N. CENTRAL	6	7	1	—	—	1	—	—	5	6
Minn.	—	—	—	—	—	—	—	—	—	—
Iowa	1	1	—	—	—	1	—	—	1	—
Mo.	4	3	1	—	—	—	—	—	3	3
N. Dak.	—	—	—	—	—	—	—	—	—	—
S. Dak.	—	1	—	—	—	—	—	—	—	1
Nebr.	—	1	—	—	—	—	—	—	—	1
Kans.	1	1	—	—	—	—	—	—	1	1
S. ATLANTIC	16	36	1	—	1	1	—	—	14	35
Del.	—	—	—	—	—	—	—	—	—	—
Md.	2	3	—	—	1	—	—	—	1	3
D.C.	—	1	—	—	—	—	—	—	—	1
Va.	—	2	—	—	—	—	—	—	—	2
W. Va.	—	3	—	—	—	—	—	—	—	3
N.C.	3	3	1	—	—	1	—	—	2	2
S.C.	2	4	—	—	—	—	—	—	2	4
Ga.	3	5	—	—	—	—	—	—	3	5
Fla.	6	15	—	—	—	—	—	—	6	15
E.S. CENTRAL	1	9	—	—	—	—	—	—	1	9
Ky.	—	2	—	—	—	—	—	—	—	2
Tenn.	1	4	—	—	—	—	—	—	1	4
Ala.	—	1	—	—	—	—	—	—	—	1
Miss.	—	2	—	—	—	—	—	—	—	2
W.S. CENTRAL	5	26	1	1	—	—	—	—	4	25
Ark.	1	3	—	—	—	—	—	—	1	3
La.	3	8	—	1	—	—	—	—	3	7
Okla.	1	1	1	—	—	—	—	—	—	1
Tex.	—	14	—	—	—	—	—	—	—	14
MOUNTAIN	3	8	—	—	—	1	—	—	3	7
Mont.	—	—	—	—	—	—	—	—	—	—
Idaho	—	1	—	—	—	—	—	—	—	1
Wyo.	—	1	—	—	—	—	—	—	—	1
Colo.	2	3	—	—	—	—	—	—	2	3
N. Mex.	—	—	—	—	—	—	—	—	—	—
Ariz.	1	1	—	—	—	—	—	—	1	1
Utah	—	—	—	—	—	—	—	—	—	—
Nev.	—	2	—	—	—	1	—	—	—	1
PACIFIC	20	56	—	1	1	—	—	—	19	55
Wash.	4	3	—	1	1	—	—	—	3	2
Oreg.	7	11	—	—	—	—	—	—	7	11
Calif.	9	40	—	—	—	—	—	—	9	40
Alaska	—	—	—	—	—	—	—	—	—	—
Hawaii	—	2	—	—	—	—	—	—	—	2
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	—	—	—	—	—	—
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	—	—	—	—	—	—	—	—	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 5, 2005, and February 7, 2004 (5th Week)*

Reporting area	Pertussis		Rabies, animal		Rocky Mountain spotted fever		Salmonellosis		Shigellosis	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,191	726	223	592	52	55	1,617	2,364	568	1,007
NEW ENGLAND	59	206	50	18	—	4	79	100	13	25
Maine	3	—	4	1	N	N	4	4	—	—
N.H.	—	3	2	1	—	—	2	4	1	1
Vt.	10	8	—	3	—	—	8	3	1	—
Mass.	46	190	34	8	—	4	47	71	10	18
R.I.	—	—	—	—	—	—	—	4	—	—
Conn.	—	5	10	5	—	—	18	14	1	6
MID. ATLANTIC	169	202	21	48	—	5	145	338	63	113
Upstate N.Y.	46	98	18	18	—	—	26	40	8	35
N.Y. City	—	14	3	1	—	2	42	114	38	36
N.J.	12	34	N	N	—	—	25	91	12	24
Pa.	111	56	—	29	—	3	52	93	5	18
E.N. CENTRAL	346	120	3	1	3	—	141	370	30	105
Ohio	266	50	1	1	3	—	71	87	7	24
Ind.	3	—	1	—	—	—	13	17	1	2
Ill.	1	2	1	—	—	—	2	136	—	56
Mich.	15	10	—	—	—	—	34	60	19	12
Wis.	61	58	—	—	—	—	21	70	3	11
W.N. CENTRAL	148	47	19	39	2	—	124	135	55	40
Minn.	30	—	6	6	—	—	23	31	1	9
Iowa	—	12	6	6	—	—	34	22	9	2
Mo.	48	31	3	2	2	—	38	42	31	10
N. Dak.	9	—	—	5	—	—	2	3	1	1
S. Dak.	1	—	—	9	—	—	4	5	5	1
Nebr.	25	—	—	—	—	—	12	11	5	1
Kans.	35	4	4	11	—	—	11	21	3	16
S. ATLANTIC	39	34	64	348	43	38	534	504	113	262
Del.	—	—	—	1	—	—	—	2	—	1
Md.	20	15	17	21	1	—	54	42	9	16
D.C.	—	4	—	—	—	—	—	—	—	5
Va.	—	5	6	26	—	—	11	36	1	7
W. Va.	—	—	3	6	—	—	—	1	—	—
N.C.	—	—	36	49	35	35	118	64	6	24
S.C.	7	2	—	7	1	2	14	11	—	15
Ga.	2	—	—	31	4	1	118	94	49	64
Fla.	10	8	2	207	2	—	219	254	48	130
E.S. CENTRAL	15	10	3	45	1	7	71	141	23	46
Ky.	5	1	—	1	—	—	12	12	2	1
Tenn.	1	5	—	36	1	2	12	38	8	23
Ala.	9	1	3	5	—	1	47	56	13	12
Miss.	—	3	—	3	—	4	—	35	—	10
W.S. CENTRAL	8	5	43	78	—	—	74	234	58	225
Ark.	1	2	6	4	—	—	23	18	7	5
La.	—	2	—	—	—	—	20	28	6	20
Okla.	—	1	6	6	—	—	19	21	32	28
Tex.	7	—	31	68	—	—	12	167	13	172
MOUNTAIN	329	62	16	8	2	—	136	143	53	62
Mont.	109	4	—	—	—	—	6	6	—	1
Idaho	17	6	—	—	—	—	8	23	—	—
Wyo.	5	2	—	—	—	—	4	2	—	1
Colo.	165	35	—	—	—	—	31	48	8	22
N. Mex.	2	8	—	—	—	—	6	19	4	19
Ariz.	12	2	16	8	—	—	58	17	32	6
Utah	16	4	—	—	2	—	7	15	2	7
Nev.	3	1	—	—	—	—	16	13	7	6
PACIFIC	78	40	4	7	1	1	313	399	160	129
Wash.	19	12	—	—	—	—	11	20	5	5
Oreg.	53	20	—	—	—	—	10	37	5	9
Calif.	—	7	4	7	1	1	261	301	146	108
Alaska	1	1	—	—	—	—	5	15	1	—
Hawaii	5	—	—	—	—	—	26	26	3	7
Guam	—	—	—	—	—	—	—	—	—	3
P.R.	—	—	7	7	N	N	3	14	—	1
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 5, 2005, and February 7, 2004 (5th Week)*

Reporting area	Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive disease				Syphilis			
			Drug resistant, all ages		Age <5 years		Primary & secondary		Congenital	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	353	517	187	313	44	75	398	656	8	50
NEW ENGLAND	15	30	—	1	4	8	19	9	—	—
Maine	1	1	N	N	—	—	—	—	—	—
N.H.	1	3	—	—	—	N	—	1	—	—
Vt.	2	—	—	—	—	—	—	—	—	—
Mass.	11	24	—	—	4	8	19	4	—	—
R.I.	—	2	—	1	—	—	—	1	—	—
Conn.	—	—	—	—	U	U	—	3	—	—
MID. ATLANTIC	67	80	20	19	7	6	46	89	1	9
Upstate N.Y.	27	20	4	5	2	2	2	2	1	1
N.Y. City	4	21	U	U	U	U	31	57	—	2
N.J.	11	16	N	N	1	—	11	16	—	5
Pa.	25	23	16	14	4	4	2	14	—	1
E.N. CENTRAL	35	127	37	88	14	23	16	68	—	10
Ohio	15	38	31	76	11	15	4	15	—	—
Ind.	5	—	6	12	3	3	5	6	—	1
Ill.	—	37	—	—	—	—	3	35	—	2
Mich.	15	39	—	N	—	N	3	9	—	7
Wis.	—	13	N	N	—	5	1	3	—	—
W.N. CENTRAL	17	27	3	1	3	6	10	19	—	—
Minn.	—	—	—	—	—	—	1	2	—	—
Iowa	N	N	N	N	—	N	—	1	—	—
Mo.	9	10	3	1	—	3	8	14	—	—
N. Dak.	1	2	—	—	1	—	—	—	—	—
S. Dak.	3	3	—	—	—	—	—	—	—	—
Nebr.	3	3	—	—	1	2	—	2	—	—
Kans.	1	9	N	N	1	1	1	—	—	—
S. ATLANTIC	86	89	98	148	8	8	131	147	1	8
Del.	—	—	—	—	—	N	—	1	—	—
Md.	29	18	—	—	8	6	20	25	—	2
D.C.	—	—	—	2	—	2	7	4	—	—
Va.	2	5	N	N	—	N	5	3	1	1
W. Va.	—	1	—	4	—	—	—	2	—	—
N.C.	11	11	N	N	U	U	24	12	—	—
S.C.	—	1	—	9	—	N	5	7	—	2
Ga.	17	27	33	47	—	N	—	25	—	—
Fla.	27	26	65	86	—	N	70	68	—	3
E.S. CENTRAL	5	29	6	16	—	—	30	34	2	2
Ky.	1	13	—	4	N	N	1	6	—	—
Tenn.	4	16	6	12	—	N	7	16	1	1
Ala.	—	—	—	—	—	N	20	7	1	1
Miss.	—	—	—	—	—	—	2	5	—	—
W.S. CENTRAL	9	46	11	12	2	16	77	102	3	14
Ark.	2	1	3	1	—	—	3	6	—	—
La.	2	1	8	11	1	5	12	17	—	—
Okla.	5	6	N	N	1	2	8	3	—	2
Tex.	—	38	N	N	—	9	54	76	3	12
MOUNTAIN	85	31	8	7	6	8	23	31	1	1
Mont.	—	—	—	—	—	—	—	—	—	—
Idaho	—	1	N	N	—	N	—	3	—	—
Wyo.	1	2	1	3	—	—	—	1	—	—
Colo.	29	11	N	N	5	8	—	5	—	—
N. Mex.	7	15	—	2	—	—	6	9	—	1
Ariz.	43	—	N	N	—	N	12	9	1	—
Utah	5	2	6	1	1	—	—	2	—	—
Nev.	—	—	1	1	—	—	5	2	—	—
PACIFIC	34	58	4	21	—	—	46	157	—	6
Wash.	N	N	N	N	N	N	6	9	—	—
Oreg.	N	N	N	N	—	N	—	5	—	—
Calif.	20	39	N	N	—	N	39	142	—	6
Alaska	—	—	—	—	—	N	—	—	—	—
Hawaii	14	19	4	21	—	—	1	1	—	—
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	N	N	N	N	—	N	5	10	—	—
V.I.	—	—	—	—	—	—	—	2	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 5, 2005, and February 7, 2004 (5th Week)*

Reporting area	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease†		
							Neuroinvasive		Non-neuroinvasive§
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	303	749	13	26	1,632	1,589	—	1	—
NEW ENGLAND	4	16	—	2	39	119	—	—	—
Maine	—	—	—	—	37	5	—	—	—
N.H.	1	—	—	—	—	—	—	—	—
Vt.	—	—	—	—	1	114	—	—	—
Mass.	3	6	—	2	1	—	—	—	—
R.I.	—	4	—	—	—	—	—	—	—
Conn.	—	6	—	—	—	—	—	—	—
MID. ATLANTIC	103	125	4	7	141	6	—	—	—
Upstate N.Y.	2	6	—	—	—	—	—	—	—
N.Y. City	54	97	—	3	—	—	—	—	—
N.J.	26	21	1	3	—	—	—	—	—
Pa.	21	1	3	1	141	6	—	—	—
E.N. CENTRAL	89	61	—	2	896	711	—	—	—
Ohio	17	9	—	1	126	204	—	—	—
Ind.	8	17	—	—	N	N	—	—	—
Ill.	59	22	—	—	—	—	—	—	—
Mich.	—	7	—	1	734	427	—	—	—
Wis.	5	6	—	—	36	80	—	—	—
W.N. CENTRAL	18	19	—	—	9	22	—	—	—
Minn.	4	8	—	—	—	—	—	—	—
Iowa	—	—	—	—	N	N	—	—	—
Mo.	8	10	—	—	—	—	—	—	—
N. Dak.	—	—	—	—	—	11	—	—	—
S. Dak.	—	—	—	—	9	11	—	—	—
Nebr.	1	—	—	—	—	—	—	—	—
Kans.	5	1	—	—	—	—	—	—	N
S. ATLANTIC	15	172	3	2	126	168	—	—	—
Del.	—	2	—	—	—	—	—	—	—
Md.	—	6	1	—	—	—	—	—	—
D.C.	—	4	—	—	—	4	—	—	—
Va.	—	1	—	1	—	—	—	—	—
W. Va.	6	2	—	—	121	156	—	—	N
N.C.	2	2	1	1	—	N	—	—	—
S.C.	7	11	—	—	5	8	—	—	—
Ga.	—	72	—	—	—	—	—	—	—
Fla.	—	72	1	—	—	—	—	—	—
E.S. CENTRAL	6	33	—	—	—	—	—	—	—
Ky.	6	4	—	—	N	N	—	—	—
Tenn.	—	9	—	—	—	—	—	—	—
Ala.	—	14	—	—	—	—	—	—	—
Miss.	—	6	—	—	—	—	—	—	—
W.S. CENTRAL	17	167	—	4	87	399	—	1	—
Ark.	8	4	—	—	—	—	—	1	—
La.	—	—	—	—	2	9	—	—	—
Okla.	9	4	—	—	—	—	—	—	—
Tex.	—	159	—	4	85	390	—	—	—
MOUNTAIN	3	19	—	2	334	164	—	—	—
Mont.	—	—	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—	—
Wyo.	—	—	—	—	14	9	—	—	—
Colo.	—	5	—	—	243	69	—	—	—
N. Mex.	—	4	—	—	16	8	—	—	—
Ariz.	2	6	—	—	—	—	—	—	—
Utah	1	4	—	1	61	78	—	—	—
Nev.	—	—	—	1	—	—	—	—	—
PACIFIC	48	137	6	7	—	—	—	—	—
Wash.	22	18	—	—	N	N	—	—	—
Oreg.	3	7	1	—	—	—	—	—	—
Calif.	9	101	3	5	—	—	—	—	—
Alaska	—	1	—	—	—	—	—	—	—
Hawaii	14	10	2	2	—	—	—	—	—
Guam	—	8	—	—	—	13	—	—	—
P.R.	—	—	—	—	5	32	—	—	—
V.I.	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	—
C.N.M.I.	—	U	—	U	—	U	—	U	—

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

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

§ Not previously notifiable.

TABLE III. Deaths in 122 U.S. cities,* week ending February 5, 2005 (5th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
NEW ENGLAND	685	508	121	37	5	14	74
Boston, Mass.	182	127	33	9	4	9	20
Bridgeport, Conn.	49	44	5	—	—	—	5
Cambridge, Mass.	25	19	4	2	—	—	5
Fall River, Mass.	41	34	4	3	—	—	7
Hartford, Conn.	85	59	15	9	—	2	15
Lowell, Mass.	22	15	7	—	—	—	1
Lynn, Mass.	14	9	4	1	—	—	—
New Bedford, Mass.	44	35	4	4	1	—	5
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	85	66	13	3	—	3	3
Somerville, Mass.	3	3	—	—	—	—	—
Springfield, Mass.	40	24	13	3	—	—	3
Waterbury, Conn.	37	28	8	1	—	—	3
Worcester, Mass.	58	45	11	2	—	—	7
MID. ATLANTIC	2,751	1,976	574	141	40	20	200
Albany, N.Y.	52	42	9	1	—	—	2
Allentown, Pa.	24	20	3	1	—	—	5
Buffalo, N.Y.	118	82	28	4	3	1	12
Camden, N.J.	26	15	7	—	1	3	1
Elizabeth, N.J.	28	19	6	3	—	—	3
Erie, Pa.	52	43	7	2	—	—	2
Jersey City, N.J.	51	39	8	3	1	—	—
New York City, N.Y.	1,478	1,052	321	74	18	13	95
Newark, N.J.	59	30	22	6	1	—	6
Paterson, N.J.	26	17	8	1	—	—	—
Philadelphia, Pa.	377	257	80	26	12	2	14
Pittsburgh, Pa.§	32	21	8	3	—	—	3
Reading, Pa.	31	24	6	1	—	—	6
Rochester, N.Y.	160	130	24	5	1	—	26
Schenectady, N.Y.	U	U	U	U	U	U	U
Scranton, Pa.	31	26	5	—	—	—	—
Syracuse, N.Y.	119	97	15	5	1	1	19
Trenton, N.J.	37	24	9	3	1	—	2
Utica, N.Y.	20	17	1	1	1	—	1
Yonkers, N.Y.	30	21	7	2	—	—	3
E.N. CENTRAL	2,394	1,632	534	126	53	47	190
Akron, Ohio	39	27	11	1	—	—	8
Canton, Ohio	41	23	14	3	1	—	2
Chicago, Ill.	361	242	81	26	5	5	35
Cincinnati, Ohio	89	63	15	3	3	5	7
Cleveland, Ohio	221	165	38	11	4	3	—
Columbus, Ohio	220	148	50	14	3	5	16
Dayton, Ohio	143	101	28	9	2	3	17
Detroit, Mich.	240	131	79	17	9	4	19
Evansville, Ind.	59	51	6	1	1	—	5
Fort Wayne, Ind.	83	55	21	6	1	—	6
Gary, Ind.	28	18	10	—	—	—	—
Grand Rapids, Mich.	70	58	8	2	—	2	8
Indianapolis, Ind.	238	136	62	17	12	11	15
Lansing, Mich.	55	38	11	2	3	1	2
Milwaukee, Wis.	131	92	31	7	—	1	15
Peoria, Ill.	85	61	16	2	4	2	10
Rockford, Ill.	81	61	15	—	3	2	7
South Bend, Ind.	57	38	15	3	—	1	4
Toledo, Ohio	98	74	19	1	2	2	8
Youngstown, Ohio	55	50	4	1	—	—	6
W.N. CENTRAL	664	453	140	31	21	19	56
Des Moines, Iowa	106	75	20	6	2	3	9
Duluth, Minn.	32	27	3	2	—	—	2
Kansas City, Kans.	3	1	1	—	—	1	—
Kansas City, Mo.	99	68	25	5	—	1	6
Lincoln, Nebr.	39	30	7	2	—	—	4
Minneapolis, Minn.	81	55	17	1	5	3	14
Omaha, Nebr.	88	57	19	2	4	6	7
St. Louis, Mo.	136	78	35	10	8	5	7
St. Paul, Minn.	71	55	11	3	2	—	7
Wichita, Kans.	9	7	2	—	—	—	—
S. ATLANTIC	1,321	840	318	92	43	27	80
Atlanta, Ga.	210	119	65	15	7	4	9
Baltimore, Md.	190	116	45	20	3	5	19
Charlotte, N.C.	103	71	19	6	5	2	14
Jacksonville, Fla.	195	129	47	11	3	5	7
Miami, Fla.	85	55	19	6	3	2	6
Norfolk, Va.	71	50	15	3	2	1	6
Richmond, Va.	66	43	20	1	—	2	5
Savannah, Ga.	60	40	12	6	1	1	3
St. Petersburg, Fla.	U	U	U	U	U	U	U
Tampa, Fla.	221	154	43	13	8	3	6
Washington, D.C.	105	51	31	10	11	2	3
Wilmington, Del.	15	12	2	1	—	—	2
E.S. CENTRAL	1,032	705	224	53	32	18	81
Birmingham, Ala.	219	151	48	10	8	2	19
Chattanooga, Tenn.	93	68	14	4	5	2	7
Knoxville, Tenn.	102	74	18	6	3	1	4
Lexington, Ky.	78	48	18	7	1	4	5
Memphis, Tenn.	171	108	42	11	5	5	10
Mobile, Ala.	137	99	29	3	5	1	11
Montgomery, Ala.	69	47	16	4	2	—	7
Nashville, Tenn.	163	110	39	8	3	3	18
W.S. CENTRAL	1,689	1,106	384	127	42	30	104
Austin, Tex.	110	67	30	7	4	2	9
Baton Rouge, La.	19	16	1	2	—	—	—
Corpus Christi, Tex.	71	48	17	4	—	2	5
Dallas, Tex.	224	138	47	27	9	3	6
El Paso, Tex.	78	53	19	6	—	—	5
Ft. Worth, Tex.	135	85	39	7	3	1	8
Houston, Tex.	414	253	101	33	14	13	34
Little Rock, Ark.	96	70	20	3	1	2	7
New Orleans, La.	49	28	15	6	—	—	—
San Antonio, Tex.	235	178	35	14	6	2	19
Shreveport, La.	123	82	26	10	2	3	4
Tulsa, Okla.	135	88	34	8	3	2	7
MOUNTAIN	1,109	722	242	78	35	28	80
Albuquerque, N.M.	124	82	26	10	5	1	11
Boise, Idaho	40	33	5	—	1	1	5
Colo. Springs, Colo.	72	53	10	5	2	2	4
Denver, Colo.	105	60	27	6	7	5	3
Las Vegas, Nev.	246	153	63	20	6	4	21
Ogden, Utah	39	24	10	2	—	3	—
Phoenix, Ariz.	181	97	51	18	7	4	11
Pueblo, Colo.	28	21	4	2	1	—	3
Salt Lake City, Utah	107	75	17	7	5	3	8
Tucson, Ariz.	167	124	29	8	1	5	14
PACIFIC	1,864	1,320	347	115	42	39	188
Berkeley, Calif.	16	8	5	2	—	1	2
Fresno, Calif.	130	94	18	12	5	1	15
Glendale, Calif.	17	11	3	2	1	—	1
Honolulu, Hawaii	89	72	14	2	—	1	7
Long Beach, Calif.	85	60	13	6	2	4	9
Los Angeles, Calif.	346	246	59	29	6	6	51
Pasadena, Calif.	15	11	3	1	—	—	1
Portland, Oreg.	135	92	21	10	2	10	5
Sacramento, Calif.	230	149	52	16	7	6	19
San Diego, Calif.	172	127	31	6	2	5	20
San Francisco, Calif.	132	92	28	6	6	—	12
San Jose, Calif.	166	123	28	8	6	1	24
Santa Cruz, Calif.	34	26	6	2	—	—	4
Seattle, Wash.	138	99	28	7	2	2	5
Spokane, Wash.	67	44	18	2	2	1	6
Tacoma, Wash.	92	66	20	4	1	1	7
TOTAL	13,509¶	9,262	2,884	800	313	242	1,053

U: Unavailable. —: No reported cases.

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

† Pneumonia and influenza.

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

¶ Total includes unknown ages.

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