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Nonoxynol-9 Spermicide Contraception Use — United States, 1999

Most women in the United States with human immunodeficiency virus (HIV) become infected through sexual transmission, and a woman's choice of contraception can affect her risk for HIV transmission during sexual contact with an infected partner. Most contraceptives do not protect against transmission of HIV and other sexually transmitted diseases (STDs) (*1*), and the use of some contraceptives containing nonoxynol-9 (N-9) might increase the risk for HIV sexual transmission. Three randomized, controlled trials of the use of N-9 contraceptives by commercial sex workers (CSWs) in Africa failed to demonstrate any protection against HIV infection (*2–4*); one trial showed an increased risk (*3*). N-9 contraceptives also failed to protect against infection with *Neisseria gonorrhoeae* and *Chlamydia trachomatis* in two randomized trials (*5*,*6*), one among African CSWs and one among U.S. women recruited from an STD clinic. Because most women in the African studies had frequent sexual activity, had high-level exposure to N-9, and probably were exposed to a population of men with a high prevalence of HIV/STDs, the implications of these studies for U.S. women are uncertain. To determine the extent of N-9 contraceptive use among U.S. women, CDC assessed data provided by U.S. family planning clinics for 1999. This report summarizes the results of that assessment, which indicate that some U.S. women are using N-9 contraceptives. Sexually active women should consider their individual HIV/STD infection risk when choosing a method of contraception. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections.

CDC collected information on types of N-9 contraceptives purchased and family planning program (FPP) guidelines for N-9 contraceptive use. The national FPP, authorized by Title X of the Public Health Service Act, serves approximately 4.5 million predominantly low-income women each year. Program data for 1999 were obtained from all 10 U.S. Department of Health and Human Services (HHS) regions on the number of female clients and the number of female clients who reported use of N-9 contraceptives or condoms as their primary method of contraception. CDC obtained limited purchase data for 1999 for specific N-9 contraceptives and program guidelines from eight state/territorial FPPs within six HHS regions. State health departments, family planning grantees, and family planning councils were contacted to request assistance in collecting data on purchasing patterns of the 91 Title X grantees; of the 12 FPPs that responded, eight provided sufficient data for analysis.

In 1999, a total of 7%–18% of women attending Title X clinics reported using condoms as their primary method of contraception. Data on the percentage of condoms lubricated with N-9 were not available. A total of 1%–5% of all women attending Title X clinics reported using N-9 contraceptives (other than condoms) as their primary method of contraception (Table 1). Among the eight FPPs that provided purchase data, most (87%) condoms were N-9–lubricated (Table 2). All eight FPPs purchased N-9 contraceptives (i.e., vaginal films

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and suppositories, jellies, creams, and foams) to be used either alone or in combination with diaphragms or other contraceptive products. Four of the eight clinics had protocols or program guidance stating that N-9–containing foam should be dispensed routinely with condoms; two additional programs reported that despite the absence of a clinic protocol, the practice was common. Data for the other two programs were not available.

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Editorial Note: The findings in this report indicate that in 1999, before the release of recent publications on N-9 and HIV/STDs (*4,6,7*), Title X family planning clinics in the U.S. purchased and distributed N-9 contraceptives. Among at least eight family planning clinics, most of the condoms purchased were N-9–lubricated; this is consistent with trends in condom purchases among the general public (*8*). The 2002 STD treatment guidelines state that condoms lubricated with spermicides are no more effective than other lubricated condoms in protecting against the transmission of HIV infection and other STDs (*7*). CDC recommends that previously purchased condoms lubricated with N-9 spermicide continue to be distributed provided the condoms have not passed their expiration date. The amount of N-9 on a spermicide-lubricated condom is small relative to the doses tested in the studies in Africa and the use of N-9–lubricated condoms is preferable to using no condom at all. In the future, purchase of condoms lubricated with N-9 is not recommended because of their increased cost, shorter shelf life, association with urinary tract infections in young women, and lack of apparent benefit compared with other lubricated condoms (*7*).

Spermicidal gel is used in conjunction with diaphragms (*1*); only diaphragms combined with the use of spermicide are approved as contraceptives. The respective contributions of the physical barrier (diaphragm) and chemical barrier (spermicide) are unknown, but the combined use prevents approximately 460,000 pregnancies in the United States each year (*1*).

The findings in this report are subject to at least two limitations. First, data on specific products and patterns of contraceptive use were limited; CDC used a nonrepresentative sample of regions and states that voluntarily provided data, and specific use patterns of the contraceptives could not be extrapolated from these data. Second, data correlating use of N-9 contraceptives with individual HIV risk were not available.

Prevention of both unintended pregnancy and HIV/STD infection among U.S. women is needed. In 1994, a total of

TABLE 1. Number of women using male condoms or nonoxynol-9 (N-9) products as their primary method of contraception, by Title X Family Planning Region — United States, 1999

Region*	No. of women served	Male condoms		N-9 products†	
		No.	(%)	No.	(%)
I	179,705	27,726	(15)	1,251	(1)
II	404,325	73,069	(18)	21,515	(5)
III	487,502	73,088	(15)	4,807	(1)
IV	1,011,126	93,011	(9)	29,630	(3)
V	522,312	61,756	(12)	2,489	(1)
VI	478,533	40,520	(8)	11,212	(2)
VII	238,971	15,949	(7)	1,386	(1)
VIII	133,735	15,131	(11)	4,885	(4)
IX	672,362	109,678	(17)	14,547	(2)
X	186,469	17,320	(9)	1,275	(2)
Total	**4,315,040**	**527,248**	**(12)**	**92,997**	**(2)**

* Region I=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont; Region II=New Jersey, New York, Puerto Rico, Virgin Islands; Region III=Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia; Region IV=Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee; Region V=Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin; Region VI=Arkansas, Louisiana, New Mexico, Oklahoma, Texas; Region VII=Iowa, Kansas, Missouri, Nebraska; Region VIII=Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming; Region IX=Arizona, California, Hawaii, Nevada, American Samoa, Guam, Mariana Islands, Marshall Islands, Micronesia, Palau; Region X=Alaska, Idaho, Oregon, Washington.

† Primary method of contraception reported by these women was one of the following: spermicidal foam, cream, jelly (with and without diaphragm), film, or suppositories.

TABLE 2. Number of nonoxynol-9 (N-9) contraceptives purchased by Title X Family Planning Programs in selected states/territories, 1999

State/territory	No. of clients served	Physical barrier method		N-9 chemical barrier methods				
		Condoms with N-9	Condoms without N-9	Gel	Vaginal		Jelly	Foam
					Film	Insert		
Puerto Rico	15,103	148,072	5,000	12,900	0	NA*	12,841	2,400
New York†	283,200	1,936,084	NA	0	73,788	NA	3,112	23,830
West Virginia	60,899	1,300,000	9,360	0	0	NA	1,200	9,900
Florida	193,784	3,920,000	560,000	0	468,720	NA	5,760	25,920
Tennessee	111,223	2,865,160§	717,088	0	94,500	12,528	756	2,758
Michigan	166,893	631,000	254,000	0	0	NA	1,000	1,200
Oklahoma	58,392	708,480	0	0	394,560	NA	1,200	0
Oregon	57,099	151,900	276,000	345	25,764	2,074	272	3,007

* Not available.

† 41 of 61 grantees responded.

§ Purchasing by family planning and sexually transmitted disease programs are combined and cannot be separated.

49% of all pregnancies were unintended (*9*). Furthermore, 26% of women experience an unintended pregnancy during the first year of typical use of spermicide products (*1*). In 1999, a total of 10,780 AIDS cases, 537,003 chlamydia cases, and 179,534 gonorrhea cases were reported among U.S. women. Contraceptive options should provide both effective fertility control and protection from HIV/STDs; however, the optimal choice is probably not the same for every woman.

N-9 alone is not an effective means to prevent infection with HIV or cervical gonorrhea and chlamydia (*2*,*7*). Sexually active women and their health-care providers should consider risk for infection with HIV and other STDs and risk for unintended pregnancy when considering contraceptive options. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections. In addition, women seeking a family planning method should be informed that latex condoms, when used consistently and correctly, are effective in preventing transmission of HIV and can reduce the risk for other STDs.

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Assessment of Susceptibility Testing Practices for *Streptococcus pneumoniae* — United States, February 2000

Streptococcus pneumoniae is the leading cause of community-acquired pneumonia, otitis media, and meningitis in the United States. Antimicrobial susceptibility results are important for guiding therapy decisions and monitoring emerging resistance patterns. Appropriate methods for pneumococcal susceptibility testing are recommended by the National Committee for Clinical Laboratory Standards (NCCLS) (*1–3*). Recommendations for pneumococcal susceptibility testing are reviewed annually and were the same in 2000 and 2001. To assess laboratory practices for *Streptococcus pneumoniae* susceptibility testing on sterile site isolates, in February 2000, CDC conducted a multistate survey of clinical laboratories. This report summarizes the survey results, which found that most practices of clinical laboratories were consistent with NCCLS recommendations; however, some inconsistencies were noted. As antimicrobial resistance in pneumococci continues to worsen, clinical laboratories should be aware of emerging resistance patterns and follow new recommendations to provide clinicians with precise information about antimicrobial susceptibility.

Laboratories were selected on the basis of their participation in CDC's Emerging Infections Program/Active Bacterial Core Surveillance (*4*), through which, since 1995, state and local health departments and universities have conducted active population- and laboratory-based surveillance for invasive pneumococcal disease (defined as isolates from sterile sites such as blood and cerebrospinal fluid [CSF]) in seven to nine geographic areas in the United States. The survey was designed to assess 1) which susceptibility testing practices were being used by clinical laboratories, 2) whether practices followed current NCCLS guidelines, 3) which antimicrobials were being tested routinely, and 4) how microbiology laboratories were reporting susceptibility results to clinicians.

A standardized survey was sent to 659 laboratories, and 547 (83%) laboratories responded. A total of 452 (83%) laboratories reported that they tested susceptibility of pneumococcal isolates either in their own laboratory (in-house) or at a reference laboratory, 353 (78%) of which reported doing some in-house testing. Of these 353 laboratories, 188 (53%) performed in-house oxacillin screening on sterile site isolates (Table 1); of these, 187 (99%) followed positive screens with confirmatory minimum inhibitory concentrations (MICs) or had disk diffusion (DD) testing for antimicrobials other than oxacillin. Of the 165 laboratories that bypassed initial oxacillin screening as recommended by NCCLS for blood and CSF isolates, 145 (88%) laboratories performed MICs or DD testing in-house, and the remaining 20 laboratories used a combination of testing in-house and at a reference laboratory.

Of the 250 (71%) laboratories that performed MICs or DD testing in-house, 232 (93%) tested sterile site pneumococcal isolates for resistance to penicillin, and 227 (91%) tested a third-generation cephalosporin (cefotaxime or ceftriaxone) (Table 2). In addition, 190 (76%) laboratories tested the three antimicrobials (penicillin, cefotaxime/ceftriaxone, and vancomycin) recommended by NCCLS for blood and CSF isolates, and seven laboratories tested meropenem in addition to these three antimicrobials. Most laboratories also tested sterile site isolates against erythromycin (79%), trimethoprim-sulfamethoxazole (62%), tetracycline (57%), and chloramphenicol (53%); 98 (39%) laboratories tested for resistance to one or more fluoroquinolones. Most laboratories reported using the Etest® (Solna, Sweden) for penicillin (52%) and cefotaxime/ceftriaxone (51%) and disk diffusion for fluoroquinolones (51%); the broth microdilution method was used more frequently (43%–71%) for other antimicrobials.

Of the 250 laboratories that performed MICs or DD testing in-house, 207 (83%) laboratories reported susceptibility

TABLE 1. Number and percentage of laboratories performing oxacillin disk diffusion screening, other disk diffusion (DD) or minimum inhibitory concentrations (MICs) of sterile site pneumococcal isolates — Active Bacterial Core Surveillance, United States, February 2000

Testing Procedure	No.	(%)
Oxacillin screening performed	**188**	**(53%)**
Screening and MICs/DD both performed in-house	103	(55%)
Screening performed in-house, with MICs or DD performed at reference laboratory	84	(45%)
Screening performed in-house but no other definitive testing performed	1	(<1%)
No oxacillin screening performed	**165**	**(47%)**
MICs or DD performed in-house	145	(88%)
MICs or DD performed in-house or at reference laboratory	20	(12%)

TABLE 2. Number and percentage* of laboratories testing sterile site pneumococcal isolates for susceptibility to selected antimicrobials, by testing method — Active Bacterial Core Surveillance, United States, February 2000

	Broth microdilution		Etest®		Disk diffusion†		Any method§	
Antimocrobial	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**
Penicillin	101	(44%)	121	(52%)	14	(6%)	**232**	**(93%)**
Cefotaxime/Ceftriaxone	103	(45%)	116	(51%)	15	(7%)	**227**	**(91%)**
Vancomycin	102	(49%)	45	(22%)	66	(32%)	**209**	**(84%)**
Meropenem	6	(60%)	2	(20%)	0	0	**10**	**(4%)**
Erythromycin	96	(48%)	30	(15%)	74	(37%)	**198**	**(79%)**
Fluoroquinolones	12	(12%)	41	(42%)	50	(51%)	**98**	**(39%)**
Clindamycin	96	(66%)	10	(7%)	42	(29%)	**146**	**(58%)**
Trimethoprim-sulfamethoxazole	95	(61%)	11	(7%)	52	(34%)	**155**	**(62%)**
Tetracycline	92	(64%)	5	(3%)	43	(30%)	**143**	**(57%)**
Chloramphenicol	94	(71%)	6	(5%)	29	(22%)	**133**	**(53%)**
Rifampin	12	(52%)	0	0	5	(22%)	**23**	**(9%)**
Cefuroxime	15	(43%)	12	(34%)	5	(14%)	**35**	**(14%)**
Quinupristin-dalfopristin¶	3	(43%)	1	(14%)	1	(14%)	**7**	**(3%)**

* Some laboratories reported using more than one type of testing method, and others reported methods not listed here.
† Disks other than oxacillin.
§ N=250.
¶ Synercid.

results to clinicians as interpretations (i.e., susceptible, intermediate, or resistant [S/I/R]), 175 (70%) laboratories reported an exact MIC value, 12 (5%) laboratories reported by zone diameter, and 142 (57%) laboratories used a combination of these reporting methods. A total of 137 (55%) laboratories reported both interpretations and exact MIC values as recommended by NCCLS; however, 66 (26%) laboratories reported only the interpretations, and 35 (14%) laboratories reported only the exact MIC values.

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Editorial Note: This survey assessed consistency between reported practices in surveyed laboratories and NCCLS recommendations about oxacillin disk screening, acceptable MIC testing methods and reporting, and antimicrobial agents tested. Most clinical laboratories surveyed were using appropriate methods for pneumococcal susceptibility testing; however, some inconsistencies with NCCLS guidelines were found.

In the United States, *Streptococcus pneumoniae* causes an estimated 63,000 invasive infections and 6,100 deaths per year (*4*). Since the emergence of penicillin-resistant isolates in the United States in the early 1990s, a high proportion of pneumococci has become resistant to multiple antimicrobial agents. In 1998, approximately 25% of pneumococcal isolates had decreased susceptibility to penicillin, and 14% were resistant to three or more classes of antimicrobial agents (*5*). The increase in resistance to antimicrobials used to treat pneumococcal infections has resulted in changes in recommended empiric treatment regimens for otitis media, meningitis, and pneumococcal pneumonia (*6*–*8*).

Initial oxacillin disk screening for pneumococcal isolates is not recommended when isolates come from patients with a potentially life-threatening infection (e.g., meningitis or sepsis). This survey found that 53% of laboratories conducted oxacillin screening on isolates from sterile sites. In the absence of information about the clinical severity of a patient's illness, laboratories should test all isolates from CSF and blood by bypassing oxacillin disk screening and using a more reliable MIC method. Otherwise, definitive MIC results will be delayed by >24 hours, which might prolong use of broad-spectrum antimicrobials chosen for initial empiric treatment. For isolates from other sites (e.g., respiratory), initial oxacillin disk screening is acceptable; however, if the oxacillin zone size is <20 mm, MICs for penicillin and other agents should be determined.

Acceptable MIC methods differ for different classes of antimicrobial agents. For ß-lactam agents other than oxacillin, reliable MIC methods include broth microdilution or Etest®. Disk diffusion testing is unreliable for ß-lactam agents including penicillins, cephalosporins, and carbapenems.

Either MIC (broth microdilution, Etest®) or disk diffusion should be used for other antimicrobials (e.g., vancomycin, macrolides, trimethoprim-sulfamethoxazole, clindamycin, tetracycline, and fluoroquinolones). If an MIC is determined for an isolate, the exact MIC results should be reported in combination with interpretations (i.e., S/I/R) to assist clinicians with therapeutic decisions, which might vary based on clinical syndrome and severity of illness (*3*).

Antimicrobial choices used for susceptibility testing should include the agents that clinicians use to treat common pneumococcal syndromes. Laboratories should conduct susceptibility testing of all isolates from blood or CSF directly against penicillin, cefotaxime or ceftriaxone, and vancomycin. Meropenem testing also might be performed depending on local clinician preferences and institutional formularies. Because many clinicians use fluoroquinolones as first-line treatment for community-acquired pneumonia or bacteremia, laboratories should perform susceptibility testing against fluoroquinolones. For isolates from patients whose diseases are not life-threatening, such as from middle ear fluid or joint fluid, NCCLS recommends that laboratories perform susceptibility testing for macrolides, trimethoprim-sulfamethoxazole, clindamycin, tetracycline, and fluoroquinolones. Other authorities have recommended that laboratories test against a more extensive primary antimicrobial panel comprising penicillin, cefotaxime or ceftriaxone, and erythromycin, doxycycline or tetracycline, clindamycin, and fluoroquinolones, with trimethoprim-sulfamethoxazole and vancomycin as optional (*7*).

The findings in this report are subject to at least four limitations. First, the survey did not address testing methods used for nonsterile site isolates. Second, the survey assessed laboratory practices in 2000, which might not reflect current practices. Third, the survey assessed reported rather than actual practices. Finally, these laboratories were part of an ongoing surveillance system and might be more likely than other laboratories to be aware of and follow current recommendations.

As the problem of antimicrobial resistance for pneumococci worsens, recommendations for susceptibility testing will change, and having precise information on antimicrobial susceptibility will be even more important to clinicians. Clinical laboratories should be aware of new recommendations and emerging resistance patterns. Conducting comprehensive susceptibility testing will enhance the work of public health agencies in tracking emerging resistance patterns in their communities.

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Public Health Dispatch

Pertussis in an Infant Adopted from Russia — May 2002

On May 2, 2002, the North Carolina Department of Health and Human Services notified CDC about an infant aged 10 months adopted from Russia who had culture-confirmed pertussis diagnosed. On April 8, the adoptive parents picked him up in the orphan ward at hospital A in Bryansk and noticed that the child had upper respiratory congestion and cough. The adoptive parents reported that the infant had not received any vaccinations and that another infant living in the same room in hospital A had a severe cough. The adopted infant subsequently was examined by a local physician, who

diagnosed his condition as a "cold," and the infant was taken to the U.S. Embassy in Moscow, where the parents were interviewed for an immigrant visa for the child.

On April 24, the infant and his parents traveled from Moscow to Raleigh, North Carolina, through New York on commercial airline flights. On April 26, the infant was seen as an outpatient at a local clinic; a culture of a nasopharyngeal swab confirmed infection with *Bordetella pertussis*. The infant improved after treatment with clarithromycin and was administered the first dose of diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). The parents were placed on azithromycin for prophylaxis.

CDC is collaborating with the U.S. Embassy, adoption agencies, visa applicant medical clinics in Moscow, and the airline to identify and notify persons who might have been exposed to the infant during his communicable period. The airline is working to identify those passengers who might have been exposed to the infant during his flights to North Carolina. CDC is collaborating with state health departments, who are notifying and ensuring appropriate chemoprophylaxis and vaccination for exposed passengers in their jurisdiction.

Health-care providers and public health officials are advised to consider pertussis when evaluating or notified of a person with an acute illness characterized by cough with paroxysms, whoop, or post-tussive gagging or vomiting. Following are CDC guidelines on the management of patients with pertussis and their contacts:

- For symptomatic patients, test by culture of nasopharyngeal aspirate or swab; a nasopharyngeal Dacron™ swab should be used. Swabs or aspirate should be placed in Regan Lowe transport media if direct inoculation of selective media is not possible.
- For hospitalized patients, respiratory isolation (droplet precautions) is recommended for at least the first 5 days of antimicrobial treatment.
- For symptomatic patients, the treatment of choice for pertussis is erythromycin for 14 days. Trimethoprim-sulfamethoxozole is an alternative antibiotic. Limited clinical data suggest that newer macrolides, such as azithromycin for 5–7 days or clarithromycin for 14 days, might be as effective as erythromycin in the treatment of pertussis and are alternatives for patients who cannot tolerate erythromycin.
- For exposed persons, chemoprophylaxis is recommended to limit secondary transmission. Exposure is defined as having face-to-face contact, having direct contact with respiratory, oral, or nasal secretions, or being in the same room with a coughing pertussis case-patient. The recommended chemoprophylaxis regimen is erythromycin for 14 days. Alternative therapies are the same as for symptomatic patients.
- Pertussis vaccination should be initiated or continued according to the recommended schedule for exposed children aged <7 years who are undervaccinated or who have received <4 DTaP doses. Exposed children may receive DTaP dose 2 or 3 if 4 weeks have elapsed after dose 1 or 2, respectively. Children may receive DTaP dose 4 as early as age 12 months, and preferably 6 months after dose 3. Children should be administered DTaP dose 5 unless a dose was given within the last 3 years or they are aged ≥7 years.

Additional information about pertussis is available at http://www.cdc.gov/nip/publications/pertussis/guide.htm.

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Notice to Readers

Potential Shortage of Supplemental Test Kits for Detecting HIV-1 Antibodies

The Public Health Service has become aware of a potential shortage of supplemental test kits used for confirmatory testing of human immunodeficiency virus (HIV) antibodies in specimens obtained from either patients or blood and plasma donors. On April 17, 2002, Calypte Biomedical Corporation (Alameda, California) announced the company might stop manufacturing the Cambridge Biotech HIV-1 Western blot kit. The distributor, bioMérieux, Inc. (Durham, North Carolina), immediately notified customers that it no longer would be able to distribute the Cambridge Biotech HIV-1 Western blot kit.

The Cambridge kit is one of two HIV-1 Western blot (WB) kits licensed by the Food and Drug Administration (FDA) for supplemental testing of serum, plasma, and dried whole-blood spot specimens obtained for medical diagnosis or blood and plasma donor screening. The other WB test used for these purposes is the Genetic Systems Western blot kit made by BioRad Laboratories, Inc. (Hercules, California). A third, OraSure® HIV-1 Western blot kit made by OraSure Technologies, Inc. (Bethlehem, Pennsylvania) and distributed by bioMérieux, Inc., is approved for supplemental testing of oral fluid samples found reactive for antibodies to HIV-1 in

screening tests performed on oral fluids. However, use of oral fluid specimens is not approved for screening and supplemental testing of blood and plasma donors.

The algorithm for HIV testing in the United States begins with an initial screening enzyme immunoassay (EIA). If reactive, the EIA is repeated in duplicate on the same specimen. If repeatedly reactive, the specimen is tested with a more specific supplemental test to validate the true-positive EIA results and to prevent notification based on false-positive results that might occur during the screening tests. Supplemental tests include the WB test or the indirect immunofluorescence assay (IFA). This algorithm is used with serum, plasma, dried whole-blood spots, and oral fluid specimens (*1–9*).

Some laboratories are experiencing delays in obtaining WB supplemental test kits, and the potential exists for future delays in supplemental testing. Persons being tested for HIV might need to be counseled that they might experience delays in receiving their HIV test results.

If the Cambridge Biotech HIV-1 Western blot kit is unavailable, three options exist for supplemental testing to detect HIV antibodies using manufactured test kits approved by FDA:

1. Supplemental testing can be performed on serum, plasma, and dried whole-blood spots using the Genetic Systems Western blot kit. Information about the availability of the test kit is available by telephone, 800-224-6723, or at http://www.biorad.com.
2. Supplemental testing can be performed on serum, plasma, and dried whole-blood spots using the Fluorognost™ HIV-1 IFA kit made by Sanochemia (Vienna, Austria) and distributed by Home Access Health (Hoffman Estates, Illinois). Information about the availability of this product is available by telephone, 203-227-6880, or at http://www.fluorognost.com. Sanochemia provides a self-taught course on performing the HIV-1 IFA and a proficiency panel free of charge.
3. Patient (but not blood or plasma donor) screening for antibodies to HIV can be performed on an oral fluid specimen collected with the OraSure® HIV-1 oral fluid collection device made by OraSure Technologies, Inc. using an approved EIA test kit (Oral Fluid Vironostika HIV-1 MicroElisa) manufactured by bioMérieux, Inc. Repeatedly EIA reactive oral fluid samples can be tested further with the supplemental OraSure® HIV-1 Western blot kit. Information about the availability of the OraSure® HIV-1 collection device is available by telephone, 800-869-3538, or at http://www.orasure.com. Information about the availability of the oral fluid EIA and WB kits can be obtained from bioMérieux, Inc., telephone 800-682-2666.

The period during which kits might be in short supply is uncertain. CDC and FDA have contacted all the companies listed above about increasing production to ensure that sufficient quantities of supplemental test kits will be available for patient and donor screening. CDC is collaborating with FDA and other private and public health partners about the evaluation of alternative strategies for HIV diagnostic testing in case shortages of supplemental test kits continue. Laboratories experiencing difficulty obtaining manufactured kits for supplemental testing can contact CDC, telephone 404-639-4581.

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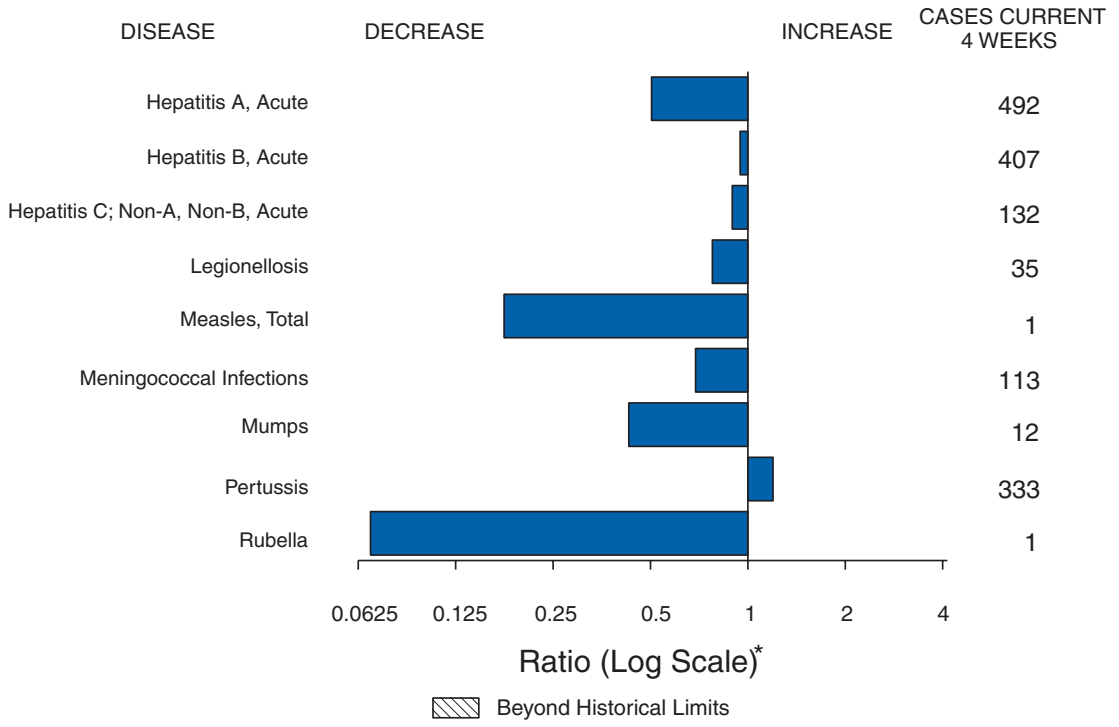
(Continued on page 407)

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending May 4, 2002, with historical data



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

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending May 4, 2002 (18th Week)*

		Cum. 2002	Cum. 2001		Cum. 2002	Cum. 2001
Anthrax		1	-	Encephalitis: West Nile†	14	-
Botulism:	foodborne	6	8	Hansen disease (leprosy)†	25	33
	infant	17	36	Hantavirus pulmonary syndrome†	1	3
	other (wound & unspecified)	7	5	Hemolytic uremic syndrome, postdiarrheal†	36	33
Brucellosis†		27	21	HIV infection, pediatric†§	31	64
Chancroid		22	14	Plague	-	-
Cholera		1	2	Poliomyelitis, paralytic	-	-
Cyclosporiasis†		37	43	Psittacosis†	9	4
Diphtheria		1	-	Q fever†	10	2
Ehrlichiosis:	human granulocytic (HGE)†	22	23	Rabies, human	-	-
	human monocytic (HME)†	7	13	Streptococcal toxic-shock syndrome†	25	36
	other and unspecified	1	1	Tetanus	2	13
Encephalitis:	California serogroup viral†	6	2	Toxic-shock syndrome	45	51
	eastern equine†	-	-	Trichinosis	5	6
	Powassan†	-	-	Tularemia†	7	11
	St. Louis†	-	-	Yellow fever	1	-
	western equine†	-	-			

-:No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update April 28, 2002.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending May 4, 2002, and May 5, 2001 (18th Week)*

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7		*Escherichia coli* Shiga Toxin Positive, Serogroup non-O157	
	Cum. 2002§	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	13,092	13,255	235,179	270,463	631	630	411	414	17	24
NEW ENGLAND	459	460	8,561	7,972	28	22	29	41	2	10
Maine	8	14	458	455	1	2	1	5	-	-
N.H.	13	13	536	441	8	-	1	6	-	2
Vt.	5	10	249	208	6	6	1	2	-	-
Mass.	243	266	3,545	3,248	5	8	16	19	2	2
R.I.	42	38	910	951	5	3	3	3	-	-
Conn.	148	119	2,863	2,669	3	3	7	6	-	6
MID. ATLANTIC	2,520	3,711	23,184	25,985	70	92	30	39	-	-
Upstate N.Y.	304	584	5,151	4,357	22	23	26	21	-	-
N.Y. City	1,397	2,043	10,035	10,185	34	42	-	2	-	-
N.J.	544	602	919	3,131	1	4	4	16	-	-
Pa.	275	482	7,079	8,312	13	23	N	N	-	-
E.N. CENTRAL	1,335	919	35,154	49,207	166	215	112	98	-	1
Ohio	269	158	5,586	13,280	49	37	19	25	-	1
Ind.	155	84	4,881	5,462	17	18	9	14	-	-
Ill.	560	436	9,095	14,571	17	17	28	19	-	-
Mich.	282	191	10,986	10,175	40	46	26	16	-	-
Wis.	69	50	4,606	5,719	43	97	30	24	-	-
W.N. CENTRAL	197	249	10,782	13,539	62	25	63	39	3	2
Minn.	45	48	2,988	2,907	21	-	21	17	3	-
Iowa	41	24	629	1,543	5	13	15	3	-	-
Mo.	66	113	3,357	4,731	11	7	14	8	-	-
N. Dak.	-	1	286	363	5	-	-	-	-	-
S. Dak.	2	-	753	640	4	2	1	3	-	1
Nebr.	22	25	537	1,236	11	3	7	-	-	1
Kans.	21	38	2,232	2,119	5	-	5	8	-	-
S. ATLANTIC	4,422	3,674	48,005	51,275	128	117	48	47	8	9
Del.	82	72	923	1,034	1	1	1	-	-	-
Md.	645	436	4,772	5,118	4	19	-	2	-	-
D.C.	202	293	1,179	1,282	3	7	-	-	-	-
Va.	281	309	5,585	6,217	1	5	7	10	-	1
W. Va.	25	26	765	811	1	-	1	1	-	-
N.C.	357	166	7,836	8,372	16	14	8	20	-	-
S.C.	335	237	4,670	5,878	2	1	-	2	-	-
Ga.	788	389	9,921	10,736	65	48	23	6	5	6
Fla.	1,707	1,746	12,354	11,827	35	22	8	6	3	2
E.S. CENTRAL	621	654	17,966	17,112	43	13	16	17	-	-
Ky.	109	121	3,010	3,052	1	1	3	3	-	-
Tenn.	270	197	5,546	5,062	21	2	10	8	-	-
Ala.	118	174	5,706	4,721	18	4	2	5	-	-
Miss.	124	162	3,704	4,277	3	6	1	1	-	-
W.S. CENTRAL	1,494	1,266	35,735	36,752	5	13	2	35	-	-
Ark.	100	81	1,365	2,719	2	2	-	1	-	-
La.	375	319	6,260	6,079	1	4	-	1	-	-
Okla.	77	67	3,645	3,369	2	2	2	8	-	-
Tex.	942	799	24,465	24,585	-	5	-	25	-	-
MOUNTAIN	449	510	14,246	14,544	40	42	41	38	3	-
Mont.	6	11	680	798	3	3	8	3	-	-
Idaho	8	7	736	640	11	5	1	5	-	-
Wyo.	2	1	302	273	2	-	-	1	1	-
Colo.	96	121	3,126	4,037	9	14	11	15	1	-
N. Mex.	28	42	2,048	2,125	5	8	3	3	1	-
Ariz.	191	189	3,984	4,604	5	1	5	6	-	-
Utah	22	47	1,714	279	2	9	7	3	-	-
Nev.	96	92	1,656	1,788	3	2	6	2	-	-
PACIFIC	1,595	1,812	41,546	54,077	89	91	70	60	1	2
Wash.	176	198	7,946	4,757	15	U	8	13	-	-
Oreg.	155	69	2,377	2,442	11	11	23	7	1	2
Calif.	1,242	1,520	28,808	44,541	62	79	29	35	-	-
Alaska	2	9	1,168	936	-	-	3	1	-	-
Hawaii	20	16	1,247	1,401	1	1	7	4	-	-
Guam	2	8	-	-	-	-	N	N	-	-
P.R.	376	406	1,306	977	-	-	-	-	-	-
V.I.	55	2	30	61	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	80	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 year 2001 and 2002 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 — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update April 28, 2002.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending May 4, 2002, and May 5, 2001 (18th Week)*

Reporting Area	*Escherichia coli* Shiga Toxin Positive, Not Serogrouped		Giardiasis	Gonorrhea		*Haemophilus influenzae*, Invasive			
						All Ages, All Serotypes		Age <5 Years Serotype B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	4	3	4,343	100,505	120,137	568	606	4	9
NEW ENGLAND	-	-	462	2,586	2,128	46	19	-	1
Maine	-	-	57	22	45	1	1	-	-
N.H.	-	-	17	42	45	4	-	-	-
Vt.	-	-	36	34	30	3	-	-	-
Mass.	-	-	205	1,166	975	20	16	-	1
R.I.	-	-	36	327	255	8	-	-	-
Conn.	-	-	111	995	778	10	2	-	-
MID. ATLANTIC	-	-	914	10,304	12,313	99	88	1	-
Upstate N.Y.	-	-	349	2,758	2,618	51	22	1	-
N.Y. City	-	-	400	4,131	4,226	27	25	-	-
N.J.	-	-	-	651	1,451	10	35	-	-
Pa.	-	-	165	2,764	4,018	11	6	-	-
E.N. CENTRAL	2	2	809	16,705	24,875	72	101	1	1
Ohio	2	2	285	3,103	6,918	42	28	-	1
Ind.	-	-	-	2,200	2,275	16	17	-	-
Ill.	-	-	132	5,083	7,743	-	42	-	-
Mich.	-	-	279	4,784	5,956	8	4	1	-
Wis.	-	-	113	1,535	1,983	6	10	-	-
W.N. CENTRAL	-	-	534	4,544	5,504	19	22	-	1
Minn.	-	-	192	930	890	14	10	-	-
Iowa	-	-	79	170	401	1	-	-	-
Mo.	-	-	154	2,302	2,739	2	10	-	-
N. Dak.	-	-	6	13	12	-	-	-	-
S. Dak.	-	-	20	91	80	-	-	-	-
Nebr.	-	-	40	135	444	-	1	-	1
Kans.	-	-	43	903	938	2	1	-	-
S. ATLANTIC	-	-	784	28,230	31,090	154	177	-	1
Del.	-	-	14	574	548	-	-	-	-
Md.	-	-	33	2,681	2,931	38	42	-	-
D.C.	-	-	16	994	1,083	-	-	-	-
Va.	-	-	54	3,646	2,985	8	10	-	-
W. Va.	-	-	9	325	183	2	4	-	1
N.C.	-	-	-	5,543	6,482	14	22	-	-
S.C.	-	-	13	2,712	4,462	3	3	-	-
Ga.	-	-	289	5,239	5,784	54	50	-	-
Fla.	-	-	356	6,516	6,632	35	46	-	-
E.S. CENTRAL	-	1	108	10,141	10,960	20	33	1	-
Ky.	-	1	-	1,180	1,183	2	1	-	-
Tenn.	-	-	49	3,038	3,303	11	12	-	-
Ala.	-	-	59	3,639	3,780	5	18	1	-
Miss.	-	-	-	2,284	2,694	2	2	-	-
W.S. CENTRAL	-	-	14	15,856	17,664	24	20	-	1
Ark.	-	-	14	873	1,744	1	-	-	-
La.	-	-	-	3,920	4,121	1	2	-	-
Okla.	-	-	-	1,612	1,587	22	17	-	-
Tex.	-	-	-	9,451	10,212	-	1	-	1
MOUNTAIN	2	-	405	3,266	3,466	77	77	1	2
Mont.	-	-	25	38	41	-	-	-	-
Idaho	-	-	19	31	31	1	1	-	-
Wyo.	-	-	6	21	19	1	-	-	-
Colo.	2	-	134	1,228	1,092	16	18	-	-
N. Mex.	-	-	49	381	343	14	12	-	-
Ariz.	-	-	57	940	1,259	35	37	1	1
Utah	-	-	69	137	26	8	2	-	-
Nev.	-	-	46	490	655	2	7	-	1
PACIFIC	-	-	313	8,873	12,137	57	69	-	2
Wash.	-	-	127	1,712	1,054	1	1	-	-
Oreg.	-	-	126	301	414	30	18	-	-
Calif.	-	-	-	6,509	10,321	9	32	-	2
Alaska	-	-	24	193	120	1	2	-	-
Hawaii	-	-	36	158	228	16	16	-	-
Guam	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	224	236	-	-	-	-
V.I.	-	-	-	17	8	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	5	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending May 4, 2002, and May 5, 2001 (18th Week)*

Reporting Area	*Haemophilus influenzae*, Invasive, Age <5 Years, Non-Serotype B		*Haemophilus influenzae*, Invasive, Age <5 Years, Unknown Serotype		Hepatitis (Viral, Acute), By Type, A		B		C; Non-A, Non-B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	99	110	6	11	2,936	3,626	2,038	2,491	689	1,736
NEW ENGLAND	5	5	-	-	134	155	65	44	13	21
Maine	-	-	-	-	4	3	1	3	-	-
N.H.	-	-	-	-	7	4	5	6	-	-
Vt.	-	-	-	-	-	3	2	3	6	5
Mass.	3	4	-	-	65	55	35	8	7	16
R.I.	-	-	-	-	18	6	10	8	-	-
Conn.	2	1	-	-	40	84	12	16	-	-
MID. ATLANTIC	15	14	1	-	388	478	497	517	222	798
Upstate N.Y.	7	2	-	-	68	82	45	38	19	11
N.Y. City	5	4	-	-	173	141	301	222	-	-
N.J.	2	4	-	-	38	193	76	155	197	761
Pa.	1	4	1	-	109	62	75	102	6	26
E.N. CENTRAL	11	19	-	1	381	406	288	221	37	88
Ohio	5	3	-	-	123	93	32	45	5	5
Ind.	5	4	-	1	21	30	9	7	-	-
Ill.	-	8	-	-	107	123	21	-	4	6
Mich.	-	-	-	-	90	130	226	167	28	77
Wis.	1	4	-	-	40	30	-	2	-	-
W.N. CENTRAL	2	1	2	2	130	142	79	85	213	471
Minn.	2	1	1	-	19	12	2	9	-	-
Iowa	-	-	-	-	30	14	9	6	1	-
Mo.	-	-	1	2	25	28	47	51	204	467
N. Dak.	-	-	-	-	1	-	1	-	-	-
S. Dak.	-	-	-	-	3	1	-	1	-	-
Nebr.	-	-	-	-	5	20	12	8	8	1
Kans.	-	-	-	-	47	67	8	10	-	3
S. ATLANTIC	25	31	-	4	930	709	549	566	55	30
Del.	-	-	-	-	7	3	4	6	3	1
Md.	1	4	-	-	112	84	46	48	8	3
D.C.	-	-	-	-	33	16	9	3	-	-
Va.	2	4	-	-	30	49	65	47	1	-
W. Va.	-	-	-	-	9	2	11	10	1	4
N.C.	2	1	-	4	105	43	77	83	8	7
S.C.	1	1	-	-	26	22	31	5	3	3
Ga.	13	13	-	-	212	309	185	237	10	1
Fla.	6	8	-	-	396	181	121	127	21	11
E.S. CENTRAL	4	6	-	1	54	111	56	138	65	91
Ky.	-	-	-	-	23	17	13	19	2	4
Tenn.	2	2	-	-	-	47	-	45	15	25
Ala.	2	3	-	1	12	40	21	39	2	1
Miss.	-	1	-	-	19	7	22	35	46	61
W.S. CENTRAL	5	4	-	-	34	659	106	287	6	168
Ark.	-	-	-	-	11	18	26	36	-	3
La.	-	-	-	-	10	40	9	39	6	82
Okla.	5	4	-	-	12	62	1	39	-	2
Tex.	-	-	-	-	1	539	70	173	-	81
MOUNTAIN	18	8	2	1	211	256	142	186	26	26
Mont.	-	-	-	-	7	4	3	1	-	-
Idaho	-	-	-	-	-	26	-	6	-	1
Wyo.	-	-	-	-	3	1	7	-	4	4
Colo.	2	-	-	-	38	27	36	40	15	5
N. Mex.	4	5	-	1	6	8	16	51	-	9
Ariz.	8	3	1	-	112	133	48	61	-	4
Utah	3	-	-	-	21	24	13	11	-	-
Nev.	1	-	1	-	24	33	19	16	7	3
PACIFIC	14	22	1	2	674	710	256	447	52	43
Wash.	1	-	-	1	54	25	20	36	6	11
Oreg.	4	3	-	-	37	47	47	58	7	6
Calif.	6	18	1	1	576	621	184	341	39	26
Alaska	1	-	-	-	7	10	3	3	-	-
Hawaii	2	1	-	-	-	7	2	9	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	25	47	15	74	-	1
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	22	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending May 4, 2002, and May 5, 2001 (18th Week)*

Reporting Area	Legionellosis		Listeriosis		Lyme Disease		Malaria		Measles Total	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	201	275	115	162	1,398	1,556	317	396	8†	63§
NEW ENGLAND	7	8	13	14	58	275	20	30	-	5
Maine	1	-	2	-	-	-	1	2	-	-
N.H.	1	2	2	-	17	2	4	2	-	-
Vt.	-	3	-	-	1	1	1	-	-	1
Mass.	3	2	6	8	33	103	8	13	-	3
R.I.	-	-	1	-	7	-	1	1	-	-
Conn.	2	1	2	6	-	169	5	12	-	1
MID. ATLANTIC	43	64	17	31	1,124	962	73	104	4	8
Upstate N.Y.	15	14	9	9	787	232	13	15	-	4
N.Y. City	10	5	4	7	48	25	48	53	4	1
N.J.	1	9	-	11	54	208	6	24	-	1
Pa.	17	36	4	4	235	497	6	12	-	2
E.N. CENTRAL	59	73	18	22	12	70	39	56	-	6
Ohio	31	32	9	3	10	5	9	7	-	2
Ind.	3	3	1	2	2	1	1	8	-	4
Ill.	-	10	-	7	-	7	7	19	-	-
Mich.	19	15	6	8	-	-	18	15	-	-
Wis.	6	13	2	2	U	57	4	7	-	-
W.N. CENTRAL	14	17	4	2	18	27	24	9	-	4
Minn.	1	1	-	-	12	16	9	1	-	2
Iowa	2	4	1	-	3	3	2	1	-	-
Mo.	6	8	1	1	3	6	5	4	-	2
N. Dak.	-	-	1	-	-	-	1	-	-	-
S. Dak.	1	-	-	-	-	-	-	-	-	-
Nebr.	4	3	-	-	-	-	3	1	-	-
Kans.	-	1	1	1	-	2	4	2	-	-
S. ATLANTIC	41	35	15	23	140	150	93	91	1	4
Del.	3	-	-	-	16	16	1	1	-	-
Md.	4	7	3	2	73	97	24	32	-	3
D.C.	-	1	-	-	6	7	2	4	-	-
Va.	2	6	1	4	6	22	7	15	-	-
W. Va.	N	N	-	2	-	1	1	-	-	-
N.C.	3	4	2	-	18	4	7	1	-	-
S.C.	4	1	2	2	1	1	2	3	-	-
Ga.	5	3	3	6	-	-	33	20	-	1
Fla.	20	13	4	7	20	2	16	15	1	-
E.S. CENTRAL	5	26	8	7	6	3	5	10	-	-
Ky.	3	6	2	1	2	2	1	2	-	-
Tenn.	-	9	3	3	1	1	1	4	-	-
Ala.	2	7	3	3	3	-	2	3	-	-
Miss.	-	4	-	-	-	-	1	1	-	-
W.S. CENTRAL	2	6	3	15	2	38	2	4	-	1
Ark.	-	-	-	1	-	-	-	1	-	-
La.	-	3	-	-	1	2	2	1	-	-
Okla.	2	1	3	-	-	-	-	1	-	-
Tex.	-	2	-	14	1	36	-	1	-	1
MOUNTAIN	16	16	11	12	8	2	13	19	-	1
Mont.	1	-	-	-	-	-	-	2	-	-
Idaho	-	-	-	-	1	1	-	2	-	1
Wyo.	3	1	-	1	-	-	-	-	-	-
Colo.	4	6	2	1	2	-	6	9	-	-
N. Mex.	1	1	-	3	1	-	-	1	-	-
Ariz.	3	5	7	2	1	-	2	1	-	-
Utah	4	1	2	1	2	-	2	2	-	-
Nev.	-	2	-	4	1	1	3	2	-	-
PACIFIC	14	30	26	36	30	29	48	73	3	34
Wash.	1	6	3	2	-	1	4	2	-	15
Oreg.	N	N	2	4	1	3	2	6	-	3
Calif.	13	20	21	30	29	25	39	59	3	12
Alaska	-	1	-	-	-	-	1	1	-	-
Hawaii	-	3	-	-	N	N	2	5	-	4
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	2	-	-	N	N	-	3	-	-
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.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Of eight cases reported, three were indigenous and five were imported from another country.
§ Of 63 cases reported, 34 were indigenous and 29 were imported from another country.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending May 4, 2002, and May 5, 2001 (18th Week)*

Reporting Area	Meningococcal Disease		Mumps		Pertussis		Rabies, Animal	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	623	1,202	97	64	1,635	1,772	1,524	2,146
NEW ENGLAND	48	60	4	-	223	185	256	199
Maine	4	1	-	-	3	-	17	28
N.H.	5	5	3	-	3	16	3	6
Vt.	3	4	-	-	37	22	50	31
Mass.	24	34	1	-	175	139	85	59
R.I.	4	1	-	-	1	1	16	23
Conn.	8	15	-	-	4	7	85	52
MID. ATLANTIC	60	129	11	5	110	136	276	130
Upstate N.Y.	21	32	2	1	74	76	179	-
N.Y. City	9	20	1	3	5	18	8	4
N.J.	6	46	1	-	3	2	32	53
Pa.	24	31	7	1	28	40	57	73
E.N. CENTRAL	83	155	12	2	227	176	11	14
Ohio	38	43	3	1	138	116	3	1
Ind.	17	11	-	1	15	12	3	1
Ill.	-	39	4	-	34	-	2	2
Mich.	18	37	5	-	27	19	3	6
Wis.	10	25	-	-	13	29	-	4
W.N. CENTRAL	64	66	9	3	196	77	118	116
Minn.	15	8	2	1	67	17	7	15
Iowa	8	15	-	-	62	10	16	18
Mo.	27	25	3	-	38	35	8	10
N. Dak.	-	3	1	-	-	-	7	17
S. Dak.	2	2	-	-	5	3	20	18
Nebr.	7	4	-	-	4	2	-	-
Kans.	5	9	3	2	20	10	60	38
S. ATLANTIC	115	193	14	8	144	92	637	785
Del.	5	-	-	-	2	-	9	12
Md.	3	24	2	4	15	12	111	167
D.C.	-	-	-	-	1	1	-	-
Va.	16	21	2	2	63	10	171	138
W. Va.	-	4	-	-	3	1	57	49
N.C.	14	40	1	-	14	30	207	208
S.C.	12	17	2	1	24	15	22	41
Ga.	16	32	3	-	11	14	59	95
Fla.	49	55	4	1	11	9	1	75
E.S. CENTRAL	30	72	8	1	42	35	52	122
Ky.	4	13	4	1	12	11	9	7
Tenn.	13	24	2	-	25	14	35	106
Ala.	9	27	1	-	5	7	8	9
Miss.	4	8	1	-	-	3	-	-
W.S. CENTRAL	27	231	6	7	176	98	29	547
Ark.	7	9	-	-	5	7	-	-
La.	10	49	1	2	2	2	-	3
Okla.	9	16	-	-	15	2	29	31
Tex.	1	157	5	5	154	87	-	513
MOUNTAIN	51	49	5	5	280	716	69	93
Mont.	2	-	-	-	2	5	4	13
Idaho	2	5	1	-	28	156	-	-
Wyo.	-	-	-	1	3	-	3	17
Colo.	15	19	1	1	129	137	-	-
N. Mex.	1	7	-	2	29	41	4	2
Ariz.	17	9	-	-	69	359	57	61
Utah	4	5	2	-	13	13	-	-
Nev.	10	4	1	1	7	5	1	-
PACIFIC	145	247	28	33	237	257	76	140
Wash.	30	33	-	-	118	31	-	-
Oreg.	21	34	N	N	21	13	-	-
Calif.	90	171	22	18	93	203	53	104
Alaska	1	1	-	1	2	-	23	36
Hawaii	3	8	6	14	3	10	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	1	2	-	-	-	2	24	37
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.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending May 4, 2002, and May 5, 2001 (18th Week)*

Reporting Area	Rocky Mountain Spotted Fever		Rubella				Salmonellosis	
			Rubella		Congenital Rubella			
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	4,063	4,367	1,569	1,709	1,026	1,291	71	87
NEW ENGLAND	80	75	38	58	4	6	1	1
Maine	2	1	14	7	-			
N.H.	4	1	19	3	-			
Vt.		2	3	7	3	6	1	
Mass.	54	50	22	34	-			
R.I.	4	6	7	1	1			1
Conn.	16	15	-	-	-			
MID. ATLANTIC	226	325	247	288	46	76	29	49
Upstate N.Y.	54	135	139	112	42	74	29	49
N.Y. City	123	135	68	32	U	U		
N.J.	19	163	24	77	-			
Pa.	30	92	16	17	4	2	-	-
E.N. CENTRAL	470	508	251	393	74	88	19	33
Ohio	274	159	102	100	-		1	
Ind.	24	85	14	27	72	88	15	7
Ill.	89	175	3	139	2			16
Mich.	52	113	132	99	-		3	10
Wis.	31	76	-	28	-			
W.N. CENTRAL	400	424	115	168	264	29	17	3
Minn.	46	170	31	35	179	2	17	2
Iowa	31	76	-	-	-			
Mo.	47	84	25	42	5	7	-	-
N. Dak.	7	9	-	1	-	2		1
S. Dak.	126	26	3	3	1	2		
Nebr.	93	26	9	15	21	3		
Kans.	50	33	15	37	58	13		
S. ATLANTIC	1,707	648	302	310	541	884	5	1
Del.	5	4	1	3	3	1		
Md.	232	40	45	24	-			
D.C.	19	19	1	3	28	3	1	
Va.	329	39	33	48	-			
W. Va.	2	4	7	3	25	26		1
N.C.	102	136	60	32	-			
S.C.	18	41	22	1	92	157	4	
Ga.	325	140	78	99	153	311		
Fla.	375	225	52	50	240	386		
E.S. CENTRAL	317	362	48	37	36	135	-	
Ky.	54	122	5	16	3	16		
Tenn.	19	34	43	21	58	118		
Ala.	137	91			-	1		
Miss.	107	115			-			
W.S. CENTRAL	143	840	16	160	11	51	-	
Ark.	24	191			2	12		
La.	26	81			9	39		
Okla.	92	10	15	24	-			
Tex.	1	558	1	136	-			
MOUNTAIN	174	231	296	186	20	21		
Mont.	1				-			
Idaho	2	8	3	3	-			
Wyo.	2		3	4	7	2		
Colo.	39	53	112	73	-			
N. Mex.	45	45	50	38	13	19		
Ariz.	60	93	125	65	-			
Utah	14	14	1	3	-			
Nev.	11	18			-			
PACIFIC	546	354	226	109	-	1		
Wash.	27	58	26	-	-			
Oreg.	31	37			-			
Calif.	469	545	178	38	-			
Alaska	2	2			-			
Hawaii	17	12	22	21	-	1		
Guam					-			
P.R.	1	8	-	-	-			
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	-		U	U
C.N.M.I.	3	U		U	-			U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending May 4, 2002, and May 5, 2001 (18th Week)*

Reporting Area	Shigellosis		Streptococcal Disease, Invasive, Group A		*Streptococcus pneumoniae*, Drug Resistant, Invasive		*Streptococcus pneumoniae*, Invasive (<5 Years)	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	4,063	4,367	1,569	1,709	1,026	1,291	71	87
NEW ENGLAND	80	75	68	58	4	6	1	1
Maine	2	1	14	7	-	-	-	-
N.H.	4	1	19	6	-	-	-	-
Vt.	-	2	6	7	3	6	1	-
Mass.	54	50	22	34	-	-	-	-
R.I.	4	6	7	4	1	-	-	1
Conn.	16	15	-	-	-	-	-	-
MID. ATLANTIC	226	525	247	288	46	76	29	49
Upstate N.Y.	54	135	139	112	42	74	29	49
N.Y. City	123	135	68	82	U	U	-	-
N.J.	19	163	24	77	-	-	-	-
Pa.	30	92	16	17	4	2	-	-
E.N. CENTRAL	470	608	251	393	74	88	19	33
Ohio	274	159	102	100	-	-	1	-
Ind.	24	85	14	27	72	88	15	7
Ill.	89	175	3	139	2	-	-	16
Mich.	52	113	132	99	-	-	3	10
Wis.	31	76	-	28	-	-	-	-
W.N. CENTRAL	400	424	115	168	264	29	17	3
Minn.	46	170	61	65	179	2	17	2
Iowa	31	76	-	-	-	-	-	-
Mo.	47	84	25	42	5	7	-	-
N. Dak.	7	9	-	4	-	2	-	1
S. Dak.	126	26	5	5	1	2	-	-
Nebr.	93	26	9	15	21	3	-	-
Kans.	50	33	15	37	58	13	-	-
S. ATLANTIC	1,707	648	302	310	541	884	5	1
Del.	5	4	1	2	3	1	-	-
Md.	232	40	45	24	-	-	-	-
D.C.	19	19	4	2	28	3	1	-
Va.	329	39	33	48	-	-	-	-
W. Va.	2	4	7	9	25	26	-	1
N.C.	102	136	60	62	-	-	-	-
S.C.	18	41	22	4	92	157	4	-
Ga.	625	140	78	99	153	311	-	-
Fla.	375	225	52	60	240	386	-	-
E.S. CENTRAL	317	362	48	37	66	135	-	-
Ky.	54	122	5	16	8	16	-	-
Tenn.	19	34	43	21	58	118	-	-
Ala.	137	91	-	-	-	1	-	-
Miss.	107	115	-	-	-	-	-	-
W.S. CENTRAL	143	840	16	160	11	51	-	-
Ark.	24	191	-	-	2	12	-	-
La.	26	81	-	-	9	39	-	-
Okla.	92	10	15	24	-	-	-	-
Tex.	1	558	1	136	-	-	-	-
MOUNTAIN	174	231	296	186	20	21	-	-
Mont.	1	-	-	-	-	-	-	-
Idaho	2	8	5	3	-	-	-	-
Wyo.	2	-	3	4	7	2	-	-
Colo.	39	53	112	73	-	-	-	-
N. Mex.	45	45	50	38	13	19	-	-
Ariz.	60	93	125	65	-	-	-	-
Utah	14	14	1	3	-	-	-	-
Nev.	11	18	-	-	-	-	-	-
PACIFIC	546	654	226	109	-	1	-	-
Wash.	27	58	26	-	-	-	-	-
Oreg.	31	37	-	-	-	-	-	-
Calif.	469	545	178	88	-	-	-	-
Alaska	2	2	-	-	-	-	-	-
Hawaii	17	12	22	21	-	1	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	1	6	-	-	-	-	-	-
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	-	-	U	U
C.N.M.I.	3	U	-	U	-	-	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending May 4, 2002, and May 5, 2001 (18th Week)*

Reporting Area	Syphilis				Tuberculosis		Typhoid Fever	
	Primary & Secondary		Congenital†					
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	1,919	1,939	27	160	2,756	3,593	80	107
NEW ENGLAND	29	13	-	3	113	119	8	6
Maine	-	-	-	-	5	-	-	-
N.H.	1	-	-	-	5	8	-	1
Vt.	1	-	-	-	-	3	-	-
Mass.	18	9	-	2	60	63	7	4
R.I.	2	1	-	-	12	13	-	-
Conn.	7	3	-	1	31	32	1	1
MID. ATLANTIC	196	154	3	23	662	596	20	39
Upstate N.Y.	9	4	1	14	84	-	3	6
N.Y. City	116	92	-	-	361	344	13	8
N.J.	38	27	2	7	147	164	3	24
Pa.	33	31	-	2	70	88	1	1
E.N. CENTRAL	362	304	-	27	337	187	11	13
Ohio	50	28	-	1	47	72	4	2
Ind.	20	64	-	3	33	29	1	1
Ill.	88	110	-	21	182	-	1	6
Mich.	196	92	-	2	69	63	3	2
Wis.	8	10	-	-	6	23	2	2
W.N. CENTRAL	20	26	-	4	136	141	3	6
Minn.	6	15	-	-	70	77	2	2
Iowa	-	-	-	-	-	9	-	-
Mo.	8	6	-	2	51	37	1	4
N. Dak.	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	7	4	-	-
Nebr.	4	-	-	-	1	14	-	-
Kans.	2	5	-	2	7	-	-	-
S. ATLANTIC	506	692	5	41	553	736	11	12
Del.	6	4	-	-	7	-	-	-
Md.	59	94	-	1	58	66	1	3
D.C.	39	14	-	1	-	28	-	-
Va.	11	43	-	1	35	62	-	2
W. Va.	-	-	-	-	8	11	-	-
N.C.	111	162	-	5	106	78	-	1
S.C.	41	101	-	8	42	70	-	-
Ga.	72	106	-	9	67	148	7	3
Fla.	167	168	5	16	230	273	3	3
E.S. CENTRAL	215	198	1	8	230	256	2	-
Ky.	33	15	-	-	40	33	2	-
Tenn.	87	116	-	4	89	88	-	-
Ala.	74	29	1	2	68	97	-	-
Miss.	21	38	-	2	33	38	-	-
W.S. CENTRAL	263	245	16	26	69	610	-	5
Ark.	6	18	-	2	19	47	-	-
La.	45	51	-	-	-	-	-	-
Okla.	25	31	-	1	50	34	-	-
Tex.	187	145	16	23	-	529	-	5
MOUNTAIN	90	67	1	7	77	142	8	2
Mont.	-	-	-	-	-	-	-	1
Idaho	1	-	-	-	-	3	-	-
Wyo.	-	-	-	-	2	-	-	-
Colo.	6	10	1	-	15	40	4	-
N. Mex.	14	7	-	-	7	15	-	-
Ariz.	63	42	-	7	43	45	-	-
Utah	5	6	-	-	8	5	3	-
Nev.	1	2	-	-	2	34	1	1
PACIFIC	238	240	1	21	579	806	17	24
Wash.	29	22	-	-	74	76	-	1
Oreg.	5	5	-	-	26	33	2	3
Calif.	200	210	1	21	407	629	15	19
Alaska	-	-	-	-	23	15	-	-
Hawaii	4	3	-	-	49	53	-	1
Guam	-	-	-	-	-	-	-	-
P.R.	75	101	-	7	8	30	-	-
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	11	U	-	U	19	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE III. Deaths in 122 U.S. cities,* week ending May 4, 2002 (18th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	325	240	53	23	4	5	38
Boston, Mass.	U	U	U	U	U	U	U
Bridgeport, Conn.	39	30	5	4	-	-	7
Cambridge, Mass.	18	14	1	-	2	1	3
Fall River, Mass.	22	20	1	1	-	-	2
Hartford, Conn.	40	29	6	3	-	2	5
Lowell, Mass.	23	14	8	1	-	-	1
Lynn, Mass.	12	11	1	-	-	-	-
New Bedford, Mass.	20	17	3	-	-	-	3
New Haven, Conn.	26	14	4	6	1	1	3
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	2	2	-	-	-	-	-
Springfield, Mass.	42	28	7	6	-	1	5
Waterbury, Conn.	29	25	3	1	-	-	4
Worcester, Mass.	52	36	14	1	1	-	5
MID. ATLANTIC	2,284	1,550	486	156	41	43	107
Albany, N.Y.	48	35	7	2	-	4	1
Allentown, Pa.	21	18	3	-	-	-	-
Buffalo, N.Y.	84	58	16	5	2	3	5
Camden, N.J.	25	15	6	3	1	-	1
Elizabeth, N.J.	21	13	5	1	1	1	-
Erie, Pa.	57	44	8	2	2	1	2
Jersey City, N.J.	52	36	8	6	1	1	-
New York City, N.Y.	1,110	751	242	86	17	12	47
Newark, N.J.	53	26	17	7	3	-	6
Paterson, N.J.	31	18	6	5	1	1	2
Philadelphia, Pa.	419	255	106	26	10	16	16
Pittsburgh, Pa.§	39	28	8	2	-	1	3
Reading, Pa.	21	18	3	-	-	-	2
Rochester, N.Y.	118	95	17	5	-	1	11
Schenectady, N.Y.	28	20	7	-	1	-	2
Scranton, Pa.	30	27	3	-	-	-	1
Syracuse, N.Y.	72	53	14	2	1	2	5
Trenton, N.J.	24	17	4	2	1	-	1
Utica, N.Y.	13	9	4	-	-	-	-
Yonkers, N.Y.	18	14	2	2	-	-	2
E.N. CENTRAL	1,498	1,047	282	96	31	42	96
Akron, Ohio	U	U	U	U	U	U	U
Canton, Ohio	45	35	7	1	-	2	3
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	80	54	18	3	-	5	17
Cleveland, Ohio	110	69	26	11	3	1	2
Columbus, Ohio	235	155	56	14	7	3	13
Dayton, Ohio	131	103	17	10	1	-	7
Detroit, Mich.	182	101	46	18	7	10	8
Evansville, Ind.	49	42	5	-	1	1	2
Fort Wayne, Ind.	U	U	U	U	U	U	U
Gary, Ind.	11	7	3	-	1	-	-
Grand Rapids, Mich.	52	38	8	2	1	3	8
Indianapolis, Ind.	182	131	32	9	3	7	5
Lansing, Mich.	32	28	2	2	-	-	1
Milwaukee, Wis.	114	74	25	9	3	3	9
Peoria, Ill.	50	39	5	4	-	2	6
Rockford, Ill.	56	37	8	6	2	3	4
South Bend, Ind.	U	U	U	U	U	U	U
Toledo, Ohio	95	74	13	6	2	-	9
Youngstown, Ohio	74	60	11	1	-	2	2
W.N. CENTRAL	838	547	177	55	31	28	69
Des Moines, Iowa	99	67	25	3	2	2	8
Duluth, Minn.	31	24	6	1	-	-	4
Kansas City, Kans.	84	58	15	7	3	1	9
Kansas City, Mo.	97	65	21	5	3	3	7
Lincoln, Nebr.	U	U	U	U	U	U	U
Minneapolis, Minn.	76	45	15	8	5	3	7
Omaha, Nebr.	96	72	16	3	3	2	10
St. Louis, Mo.	119	47	41	9	9	13	7
St. Paul, Minn.	45	32	7	2	2	2	3
Wichita, Kans.	191	137	31	17	4	2	14
S. ATLANTIC	1,256	801	276	105	42	29	83
Atlanta, Ga.	174	89	48	22	5	10	9
Baltimore, Md.	117	66	34	11	4	2	11
Charlotte, N.C.	108	71	21	11	3	1	14
Jacksonville, Fla.	155	103	35	8	6	3	14
Miami, Fla.	104	69	22	10	2	1	8
Norfolk, Va.	36	22	9	3	1	1	-
Richmond, Va.	59	30	17	8	1	2	2
Savannah, Ga.	64	49	10	1	3	1	8
St. Petersburg, Fla.	72	59	7	4	1	1	5
Tampa, Fla.	167	120	29	12	2	4	10
Washington, D.C.	200	123	44	15	14	3	2
Wilmington, Del.	U	U	U	U	U	U	U
E.S. CENTRAL	643	444	125	45	21	7	51
Birmingham, Ala.	200	131	48	11	7	2	23
Chattanooga, Tenn.	68	55	10	2	1	-	4
Knoxville, Tenn.	73	56	12	3	-	2	3
Lexington, Ky.	44	31	9	3	-	1	3
Memphis, Tenn.	185	120	34	20	10	1	11
Mobile, Ala.	73	51	12	6	3	1	7
Montgomery, Ala.	U	U	U	U	U	U	U
Nashville, Tenn.	U	U	U	U	U	U	U
W.S. CENTRAL	1,520	987	305	133	43	51	100
Austin, Tex.	88	46	23	11	3	5	4
Baton Rouge, La.	51	34	12	3	-	2	2
Corpus Christi, Tex.	45	33	7	3	2	-	4
Dallas, Tex.	187	104	50	18	7	8	13
El Paso, Tex.	127	88	21	12	1	5	5
Ft. Worth, Tex.	130	89	24	8	5	4	10
Houston, Tex.	248	160	55	22	4	7	16
Little Rock, Ark.	78	53	11	8	3	3	5
New Orleans, La.	52	28	12	6	5	-	-
San Antonio, Tex.	306	201	57	27	11	10	22
Shreveport, La.	57	39	13	4	-	1	8
Tulsa, Okla.	151	112	20	11	2	6	11
MOUNTAIN	769	555	135	48	17	14	59
Albuquerque, N.M.	U	U	U	U	U	U	U
Boise, Idaho	46	33	10	1	1	1	2
Colo. Springs, Colo.	70	57	4	5	4	-	7
Denver, Colo.	120	76	26	8	3	7	9
Las Vegas, Nev.	219	143	53	18	2	3	17
Ogden, Utah	32	27	4	-	-	1	-
Phoenix, Ariz.	U	U	U	U	U	U	U
Pueblo, Colo.	27	22	3	1	1	-	5
Salt Lake City, Utah	114	87	16	6	5	-	8
Tucson, Ariz.	141	110	19	9	1	2	11
PACIFIC	1,630	1,187	285	102	29	27	109
Berkeley, Calif.	15	11	4	-	-	-	-
Fresno, Calif.	91	64	17	7	3	-	4
Glendale, Calif.	18	15	2	1	-	-	-
Honolulu, Hawaii	86	64	14	5	2	1	4
Long Beach, Calif.	60	41	11	6	1	1	11
Los Angeles, Calif.	341	254	53	22	6	6	-
Pasadena, Calif.	19	16	1	-	1	1	4
Portland, Oreg.	163	127	24	9	1	2	9
Sacramento, Calif.	205	152	31	13	6	3	28
San Diego, Calif.	146	94	32	13	3	4	7
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	171	130	25	11	2	3	17
Santa Cruz, Calif.	37	26	9	1	1	-	2
Seattle, Wash.	121	80	26	11	1	3	9
Spokane, Wash.	57	39	14	2	1	1	7
Tacoma, Wash.	100	74	22	1	1	2	7
TOTAL	10,763¶	7,358	2,124	763	259	246	712

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.

(Continued from page 396)

Notice to Readers

National Women's Health Week, May 12–18, 2002

The week of May 12–18, 2002, marks the third annual National Women's Health Week. This national effort encourages women of all ages to take steps to improve their health (*1*). During the week, public and private organizations and agencies work to raise awareness of key health issues to help women make healthier choices to improve their lives.

Heart disease, cancer, stroke, diabetes, and influenza/pneumonia are the leading causes of death among women in the United States (*2*). Heart disease and cancer combined account for approximately half of all deaths in the United States (*3*). Prevention is key in reducing risk for these and other diseases.

All women can live longer and healthier lives by incorporating positive health behaviors into their daily lives. These behaviors include eating better, exercising regularly, being smoke-free, getting regular examinations and screenings, and protecting themselves from disease and injury.

Information on National Women's Health Week, staying healthy, and CDC/ATSDR women's health programs and activities is available at http://www.cdc.gov/od/spotlight/nwhw2002.htm

References

1. U.S. Department of Health and Human Services. National Women's Health Week: The National Women's Health Information Center. Available at http://www.4woman.gov.
2. Anderson RN. Deaths: leading causes for 1999. National vital statistics reports; vol 49 no 11. Hyattsville,Maryland: National Center for Health Statistics. 2001.
3. CDC. The burden of chronic diseases and their risk factors: national and state perspectives. February 2002. Available at http://www.cdc.gov/nccdphp/burdenbook2002/index.htm.

Erratum: Vol. 51, No. 16

In the article "Factors Associated with Pilot Fatalities in Work-Related Aircraft Crashes—Alaska, 1990–1999," an error occurred on page 349 in Table 1. The odds ratio for light conditions should be *1.0* for daylight and *1.8*†† for darkness.

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