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Outbreaks of Aseptic Meningitis Associated with Echoviruses 9 and 30 and Preliminary Surveillance Reports on Enterovirus Activity — United States, 2003

Aseptic or viral meningitis is the most common type of meningitis and is associated with an estimated 26,000–42,000 hospitalizations each year in the United States (*1*). Enteroviruses are the most common cause of aseptic meningitis (*2*). Echovirus 9 (E9) and echovirus 30 (E30) have been associated frequently with outbreaks of aseptic meningitis (*3*–*5*). During March 2003, several state public health departments noted increased reports of aseptic meningitis and, as of August 7, seven states (Arizona, California, Georgia, Idaho, Oregon, South Carolina, and Texas) had reported outbreaks associated with either E9 or E30. This report summarizes the epidemiologic features of the aseptic meningitis outbreaks in five states (Arizona, California, Georgia, Idaho, and South Carolina) and provides an overview of enterovirus activity in the United States during January 1–August 7. Enteroviruses, E9 and E30 in particular, should be considered in the differential diagnosis of persons with aseptic meningitis.

Aseptic meningitis is not a nationally notifiable disease, and no nationally accepted case definition exists for this condition (*6*). Therefore, cases of aseptic meningitis described in this report represent physician diagnoses based on clinical presentation and laboratory findings. The enterovirus surveillance data were obtained from reports to the National Enterovirus Surveillance System (NESS), a passive voluntary surveillance system based on reporting by state public health and private laboratories of enterovirus detections by serotype and basic demographic information, specimen type, and date of collection.

Aseptic Meningitis Outbreaks

Arizona. During January 1–July 31, a total of 465 cases of aseptic meningitis (rate: 8.6 per 100,000 population) were reported to the Arizona Department of Health Services, compared with 104 cases (rate: 1.9) reported for the same period in 2002. The highest rate during January 1–July 31 was reported in Maricopa County (rate: 12.7, compared with 2.7 during the same period in 2002). As of July 31, the Arizona State Health Laboratory had reported 62 enterovirus isolates, the majority (66%) from cerebrospinal fluid (CSF) specimens. Of the 62 isolates, E30 accounted for 47 (76%) isolates and E9 for one (2%) isolate.

California. As of August 5, a total of 1,753 cases of aseptic meningitis (rate: 8.0 per 100,000 population) had been reported to the California Department of Health Services (CDHS). During 1999–2003, the annual reported rate of aseptic meningitis in California ranged from 4.5 to 7.3. Specimens from 148 patients with aseptic meningitis were submitted to CDHS for diagnostic testing from 24 counties throughout the state (Table). Serum and CSF specimens from all patients were tested for enteroviruses and arboviruses (i.e., West Nile virus [WNV], St. Louis encephalitis, and western equine encephalitis) at CDHS. Of the 148 patients, 82 (55%) had evidence of enterovirus infection by polymerase chain reaction (PCR) or culture; E30 was identified from 29 (85%) of the 82 culture-positive cases, and E9 was identified from four (12%) cases.

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Georgia. During March, an outbreak of aseptic meningitis associated with E9 infection began in Augusta, Georgia. During March 10–July 23, a total of 320 cases were reported from 50 of Georgia's 159 counties, compared with 227 cases reported statewide during 2002. E9 has been isolated from CSF, throat swab, and/or rectal swab specimens of 24 patients. Enteroviruses (untyped) were isolated from an additional 24 CSF specimens, and 52 CSF specimens tested positive for enteroviruses by PCR. Patients commonly reported headache, fever, nausea or vomiting, stiff neck, and photophobia (Table). As of August 7, the outbreak was ongoing.

Idaho. During May 21–July 17, an outbreak of viral meningitis occurred in north central Idaho, with 38 cases from three adjacent counties reported to the Idaho Division of Health, compared with four cases reported statewide during the previous year. Of the 32 patients for whom clinical information was available, 17 (53%) were hospitalized with clinical signs and symptoms consistent with aseptic meningitis (Table). E30 was isolated from two of four patients who underwent virologic investigation. Two cases of aseptic meningitis reported subsequently from the same area are under investigation by the North Central District Health Department.

South Carolina. During April 6–July 31, a total of 82 cases of viral meningitis were identified by the Aiken County Health Department. The outbreak peaked during May, when 38 cases were reported. E9 was isolated from CSF of two of these patients. At the same time, adjacent counties in Georgia also experienced an outbreak of aseptic meningitis associated with E9. In June, cases began to appear in multiple counties. The number of reports and CSF specimen submissions to the South Carolina State Laboratory continued to increase in July. As of July 31, a total of 130 cases of aseptic meningitis had been reported; E9 was isolated from 20 specimens (18 CSF and two throat washings) from eight different counties, and no other enteroviruses were identified. Because viral meningitis is not a notifiable disease in South Carolina, comparative data are not available for previous years.

Enterovirus Surveillance Data

As of August 7, NESS had received reports of 365 enterovirus detections in 25 states; source specimens for these isolates were collected during January 5–July 30. The most commonly detected serotypes were E9 and E30, with E30 accounting for 132 (36%) and E9 accounting for 108 (30%) reports. E9 was isolated in 14 states, predominantly in the East (e.g., Georgia, Florida, New Jersey, and South Carolina), and E30 was isolated in 10 states, predominantly in the West (e.g., Arizona, California, Colorado, and Texas). For both serotypes, CSF

TABLE. Number and percentage of persons with aseptic meningitis, by demographic and clinical characteristics — Arizona, California, Georgia, Idaho, and South Carolina, 2003

Characteristic	Arizona January 1–July 31 (n = 465)*		California April 1–July 31 (n = 148)		Georgia March 10–July 23 (n = 320)†		Idaho May 21–July 17 (n = 38)§		South Carolina April 6–July 31 (n = 82)¶	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Sex										
Male	237	(51)	81	(55)	157	(60)	12	(32)	51	(62)
Female	227	(49)	67	(45)	104	(40)	26	(68)	31	(38)
Age group										
≤3 mos	—		6	(4)	39	(15)	0	—	1	(1)
4–11 mos	—		1	(1)	13	(5)	0	—	0	—
1–14 yrs	244	(52)	61	(41)	114	(44)	16	(42)	61	(78)
≥15 yrs	221	(48)	80	(54)	95	(36)	22	(58)	16	(21)
Clinical signs										
Fever	NA**		91	(61)	63	(80)	25	(78)	NA	
Headache	NA		NA		64	(64)	32	(100)	NA	
Stiff neck	NA		73	(49)	32	(41)	24	(75)	NA	
Photophobia	NA		NA		14	(18)	26	(81)	NA	
Nausea/Vomiting		NA		NA		41	(52)	29	(91)	NA

* Data for sex were unavailable for one person.
† Demographic information was available for 261 cases and clinical information for 79 cases.
§ Demographic information was available for 38 cases and clinical information for 32 cases.
¶ On the basis of the 82 cases reported in Aiken County. Information on age was available for 78 cases.
** Not available.

was the source specimen in the majority of cases (72 [67%] for E9 and 107 [81%] for E30).

Other enterovirus serotypes reported most frequently include coxsackievirus B1 (29 [8%] of all reports), echovirus 7 (10 [3%]), coxsackievirus A9 (10 [3%]), enterovirus 71 (nine [3%]), coxsackievirus B4 (12 [4%]), and echovirus 5 (seven [2%]).

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Editorial Note: Aseptic meningitis is a central nervous system infection characterized by fever and meningeal symptoms with moderate, predominantly lymphocytic CSF pleocytosis and the absence of bacterial pathogens in CSF. The disease occurs both sporadically and in outbreaks, and >90% of cases with an identified cause are associated with enteroviruses (*2*). Many aseptic meningitis outbreaks occurring during the current enterovirus season reflect high levels of E9 and E30 activity. In 2003, E9 has been involved predominantly in the outbreaks in the East, and E30 has been linked exclusively with outbreaks in the West.

During 1970–2001, both E9 and E30 were among the 15 enteroviruses reported most commonly each year, accounting for 10.2% and 8.2% of all enterovirus isolates reported to CDC, respectively (CDC, unpublished data, 2003). However, these enteroviruses have been relatively quiescent in recent years; E9 has not been the predominant enterovirus isolated from clinical specimens since 1995, and E30 has not been widespread since 1998 (*7,8*). This probably has resulted in an accumulation of cohorts of susceptible persons who have not been exposed previously to these agents. The increase in aseptic meningitis cases associated with high activity of E9 and E30 is consistent with the historic data; during 1988–1999, peak years for viral meningitis hospitalizations in the United States coincided with periods of high activity of either E9 or E30 (*1*).

Although the majority of cases of enterovirus infections are asymptomatic or result in mild febrile illnesses, aseptic meningitis is the predominant diagnosis reported with the current E9 and E30 activity in the United States because patients with meningitis are more likely to be tested for enteroviruses than those with less severe manifestations. In a small proportion of cases, more severe, life-threatening diseases (e.g., encephalitis, paralysis, myopericarditis, and neonatal enteroviral sepsis) might occur.

Enteroviruses typically demonstrate a marked seasonality in temperate climates, with a typical enterovirus season in the United States occurring during June–October (*9*). In 2003, the enterovirus season appears to have started early, with the first isolations of E9 reported in January (in Louisiana), the first outbreaks of E9-associated aseptic meningitis reported in March, and the first isolations of E30 reported in April (in Arizona).

WNV has the same seasonal pattern as enteroviruses, and is also associated with neurologic signs and symptoms of aseptic meningitis. However, WNV-associated meningitis tends to occur among older persons (median age: 46 years) (*10*), whereas children and young adults (median age: 13 years) are at highest risk for enteroviral meningitis (*1*). The investigation of an aseptic meningitis outbreak in an area of high WNV epizootic activity in 2001 indicated that enteroviruses were the leading cause of aseptic meningitis in this area, and no evidence of WNV infection was detected (*10*). For this reason, diagnostic testing of specimens from younger patients with aseptic meningitis should include testing for enteroviruses, even during a documented WNV outbreak (*10*).

Early etiologic diagnosis of aseptic meningitis helps to avoid unnecessary antibiotic treatment and additional testing. Although virus culture is the standard technique for enterovirus detection, it consumes time and resources and has limited clinical use. Molecular methods of enterovirus detection (e.g., PCR and typing based on genomic sequences) are increasingly becoming available. Serotype-specific PCR primers have been developed by CDC for several enteroviruses, including E30 (*5*). These serotype-specific primers are useful for rapid differentiation of cases in patients infected with the outbreak strain from sporadic infections with other enteroviruses.

Aseptic meningitis is a benign, self-limiting illness, and severe illness and death are uncommon. The treatment is symptomatic and the majority of patients recover in approximately 1 week. Enteroviruses typically are spread person to person through the fecal-oral or oral-oral routes and through respiratory droplets and fomites. No specific prevention or control measures are available for nonpolio enteroviruses including E9 and E30. Adherence to good hygienic practices, such as frequent and thorough hand washing (especially after diaper changes), disinfection of contaminated surfaces by household cleaners (e.g., diluted bleach solution), and avoidance of shared utensils and drinking containers, are recommended to help interrupt transmission.

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Prevalence of Physical Activity, Including Lifestyle Activities Among Adults — United States, 2000–2001

Regular physical activity helps prevent obesity, heart disease, hypertension, diabetes, colon cancer, and premature mortality (*1*). During 1986–2000, the Behavioral Risk Factor Surveillance System (BRFSS) included questions that measured leisure-time physical activity (primarily exercise or sports-related activities). Previous guidelines for appropriate physical activity to increase cardiorespiratory fitness included participating in vigorous-intensity activity (i.e., ≥20 minutes per day, ≥3 days per week) (*2*). BRFSS questions used to measure this level of activity were developed a decade before CDC and the American College of Sports Medicine concluded that health-related benefits could accrue from a minimum of 30 minutes of moderate-intensity activity on most days of the week (*3*). Various household and transportation-related physical activities and some leisure-time activities, therefore, can be important to measure (*4*). In response to expanded activity recommendations designed to include health-related lifestyle activities, new BRFSS physical activity questions have been developed. After cognitive, validity, and reliability testing, the new lifestyle activity questions were used in the 2001 BRFSS. A separate question allowed tracking of physical inactivity during leisure time across years and was used in the

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('trəst-"wər-thē) 1 : worthy of belief

2 : capable of being depended upon;

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2000 and 2001 BRFSS questionnaires (*5*). This report presents data from responses to the 2000 BRFSS leisure-time activity questions and the updated lifestyle activity questions of the 2001 BRFSS to compare overall U.S. and state-specific prevalence estimates for adults who engaged in physical activities consistent with recommendations from both survey years. The findings indicate that even with a more complete measure of physical activity than used previously, the majority of U.S. adults are not physically active at levels that can promote health.

BRFSS is a population-based, random-digit–dialed telephone survey of the civilian, noninstitutionalized U.S. population aged ≥18 years in the 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands. Physical activity data were analyzed from the 2000 (n = 180,244; response rate: 48.9%) and 2001 BRFSS (n = 205,140; response rate: 51.1%) (*6,7*). In 2000, BRFSS respondents were asked to report frequency and duration of the two most common leisure-time physical activities or exercise in which they participated during the preceding month (Table 1). Vigorous-intensity activities were defined as activities consistent with the metabolic equivalent of ≥60% VO_{2max} (*5*); all other activities were classified as moderate-intensity.

In 2001, BRFSS respondents were asked to recall overall frequency and duration of time spent in household, transportation, and leisure-time activities of moderate-intensity (e.g., vacuuming, gardening, brisk walking, or bicycling) and of vigorous intensity (e.g., running, aerobics, or heavy yard work) in a usual week (Table 1). Intensity was self-ascribed and defined by using a lead-in statement to the questions. Respondents were asked whether activities in which they participated caused "large" (vigorous) or "small" (moderate) changes in breathing and heart rate. Respondents were classified as active at the recommended level if they reported sufficient physical activities of moderate intensity (i.e., ≥30 minutes per day, ≥5 days per week) or of vigorous intensity (i.e., ≥20 minutes per day, ≥3 days per week). The 2001 BRFSS estimates provide the current baseline for states.

TABLE 1. Physical activity- and inactivity-tracking questions to assess the prevalence of persons who engaged in activities consistent with physical activity recommendations — Behavioral Risk Factor Surveillance System, 2000 and 2001

Category	2000	2001
Inactivity		
	During the past month, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?	During the past 30 days, other than your regular job, did you participate in any physical activities or exercise such as running, calisthenics, golf, gardening, or walking for exercise?
Physical activity		
	What type of physical activity or exercise did you spend the most time doing during the past month? (Choose from list of activities)	**Lead in:** We are interested in two types of physical activity, vigorous and moderate. Vigorous activities cause large increases in breathing or heart rate while moderate activities cause small increases in breathing or heart rate.
	If answered walk/run/jog/swim: How far did you usually walk/run/jog/swim?	
	How many times per week or per month did you take part in this activity during the past month?	Now thinking about the moderate physical activities you do (when you are not working) in a usual week, do you do moderate activities for at least 10 minutes at a time, such as brisk walking, bicycling, vacuuming, gardening, or anything else that causes small increases in breathing or heart rate?
	And when you took part in this activity, for how many minutes or hours did you usually keep at it?	
	Was there another physical activity or exercise that you participated in during the last month?	How many days per week do you do these moderate activities for at least 10 minutes at a time?
	What other type of physical activity gave you the next most exercise during the past month? (Choose from list of activities)	On days when you do moderate activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities?
	If answered walk/run/jog/swim: How far did you usually walk/run/jog/swim?	Now thinking about the vigorous physical activities you do (when you are not working) in a usual week, do you do vigorous activities for at least 10 minutes at a time, such as running, aerobics, heavy yard work, or anything else that causes large increases in breathing or heart rate?
	How many times per week or per month did you take part in this activity during the past month?	
	And when you took part in this activity, for how many minutes or hours did you usually keep at it?	How many days per week do you do these vigorous activities for at least 10 minutes at a time?
		On days when you do vigorous activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities?

In 2000 and 2001, a tracking question was used to quantify physical inactivity (Table 1). In the 2000 BRFSS, the inactivity question immediately preceded other physical activity questions and specifically referred to leisure-time activities. In the 2001 BRFSS, the inactivity question was asked separately and earlier in the survey (i.e., several sections before the lifestyle physical activity questions) to reduce recall bias. Because of its placement, the wording was changed to include the phrase "other than your regular job."

Data were adjusted for nonresponses, age-adjusted to the 2000 U.S. standard population, and weighted to provide state and overall estimates. Confidence intervals were calculated by using SUDAAN to adjust for the complex survey sample design.

The new 2001 lifestyle activity questions classified more persons in the United States as physically active than did the 2000 leisure-time activity questions. In 2000, a total of 26.2% of adults engaged in activities consistent with the physical activity recommendations, compared with 45.4% in 2001 (Table 2). Physical inactivity, measured by the same tracking question, was similar in 2000 (27.4%) and in 2001 (26.0%) (Table 3).

In 2001, the state-specific percentage of adults who engaged in activities consistent with the physical activity recommendations ranged from 28.9% to 55.8%. State-specific estimates for physical inactivity remained similar during 2000–2001; absolute differences ranged from 0.1% to 12.0%.

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Editorial Note: The findings in this report indicate that the majority of U.S. adults were not physically active on a regular basis in 2000 or 2001. Because of changes to the 2001 BRFSS survey, the difference in the proportion of adults who engaged in activities consistent with physical activity recommendations during 2000–2001 might not reflect an actual increase in physical activity. The percentage of adults who obtained the recommended level of physical activity, as indicated by responses to the 2001 questions, increased for several reasons. First, the new 2001 lifestyle activity questions covered more activity domains (e.g., household, transportation, and leisure-time); the 2000 questions covered only the leisure-time domain. Second, the new 2001 lifestyle activity questions attempted to profile the activities in a usual week rather than reporting the top two activities during the preceding month; therefore, less frequent activities that might not have been mentioned in the 2000 question format could be included in the 2001 overall activity profile. Finally, in 2001, respondents were

TABLE 2. Age-adjusted percentage of respondents aged ≥18 years who engaged in activities consistent with physical activity recommendations, by state/area — Behavioral Risk Factor Surveillance System (BRFSS), United States, 2000 and 2001

State/Area	2000 BRFSS recommended physical activity* %	2000 BRFSS recommended physical activity* (95% CI§)	2001 BRFSS recommended physical activity† %	2001 BRFSS recommended physical activity† (95% CI)
Alabama	25.0	(22.9–27.1)	42.4	(40.3–44.5)
Alaska	31.7	(28.7–34.7)	54.6	(51.6–57.6)
Arizona	25.9	(23.1–28.7)	51.2	(48.7–53.7)
Arkansas	24.7	(22.9–26.5)	45.4	(43.3–47.5)
California	28.8	(27.2–30.4)	45.8	(43.9–47.7)
Colorado	30.1	(27.8–32.4)	53.0	(50.5–55.5)
Connecticut	29.5	(27.8–31.2)	48.6	(47.2–50.0)
Delaware	26.3	(24.0–28.6)	41.4	(39.2–43.6)
District of Columbia	34.9	(32.3–37.5)	49.7	(46.9–52.5)
Florida	26.9	(25.5–28.3)	45.5	(43.7–47.3)
Georgia	24.7	(23.0–26.4)	39.2	(37.3–41.1)
Hawaii	34.8	(33.1–36.5)	50.4	(48.4–52.4)
Idaho	29.9	(28.4–31.4)	54.3	(52.5–56.1)
Illinois	26.5	(24.1–28.9)	45.6	(43.0–48.2)
Indiana	25.8	(24.0–27.6)	45.9	(44.1–47.7)
Iowa	23.7	(22.1–25.3)	43.8	(41.8–45.8)
Kansas	22.0	(20.6–23.4)	44.1	(42.4–45.8)
Kentucky	17.7	(16.4–19.0)	28.9	(27.3–30.5)
Louisiana	18.3	(17.1–19.5)	35.1	(33.5–36.7)
Maine	24.6	(22.6–26.6)	50.3	(48.0–52.6)
Maryland	28.4	(26.7–30.1)	45.0	(43.1–46.9)
Massachusetts	29.1	(27.9–30.3)	51.4	(50.1–52.7)
Michigan	29.1	(27.1–31.1)	45.5	(43.7–47.3)
Minnesota	26.6	(24.7–28.5)	48.5	(46.7–50.3)
Mississippi	21.3	(19.3–23.3)	37.6	(35.5–39.7)
Missouri	24.3	(22.5–26.1)	39.9	(37.8–42.0)
Montana	29.4	(27.1–31.7)	51.5	(49.1–53.9)
Nebraska	24.4	(22.6–26.2)	34.2	(32.3–36.1)
Nevada	29.0	(26.2–31.8)	49.8	(46.9–52.7)
New Hampshire	26.3	(24.1–28.5)	50.7	(48.9–52.5)
New Jersey	26.7	(25.0–28.4)	44.0	(42.3–45.7)
New Mexico	28.2	(26.5–29.9)	50.0	(48.0–52.0)
New York	25.5	(23.8–27.2)	44.8	(42.9–46.7)
North Carolina	21.5	(19.8–23.2)	42.3	(40.4–44.2)
North Dakota	26.1	(23.9–28.3)	46.8	(44.6–49.0)
Ohio	23.0	(20.9–25.1)	46.1	(44.0–48.2)
Oklahoma	22.6	(21.0–24.2)	38.9	(37.0–40.8)
Oregon	32.4	(30.7–34.1)	52.9	(50.7–55.1)
Pennsylvania	27.7	(26.0–29.4)	46.8	(44.9–48.7)
Rhode Island	29.8	(28.0–31.6)	48.7	(46.8–50.6)
South Carolina	24.4	(22.7–26.1)	45.3	(43.2–47.4)
South Dakota	25.0	(23.6–26.4)	44.5	(42.9–46.1)
Tennessee	18.4	(16.7–20.1)	36.9	(34.7–39.1)
Texas	25.3	(23.9–26.7)	42.9	(41.4–44.4)
Utah	29.8	(27.6–32.0)	53.1	(51.0–55.2)
Vermont	30.4	(28.7–32.1)	55.0	(53.3–56.7)
Virginia	27.4	(25.1–29.7)	47.6	(45.4–49.8)
Washington	32.4	(30.7–34.1)	55.5	(53.7–57.3)
West Virginia	21.5	(19.6–23.4)	48.4	(46.3–50.5)
Wisconsin	27.1	(25.1–29.1)	52.3	(50.3–54.3)
Wyoming	30.5	(28.4–32.6)	55.8	(53.8–57.8)
Total	**26.2**	**(25.8–26.6)**	**45.4**	**(45.0–45.8)**

* Reported any physical activity for ≥30 minutes per day, ≥5 days per week or vigorous-intensity activity (metabolic equivalent ≥60% VO_{2max}) for ≥20 minutes per day, ≥3 days per week.

† Reported moderate-intensity activities (i.e., brisk walking, bicycling, vacuuming, gardening, or anything else that causes small increases in breathing or heart rate) for ≥30 minutes per day, ≥5 days per week or vigorous-intensity activities (i.e., running, aerobics, heavy yard work, or anything else that causes large increases in breathing or heart rate) for ≥20 minutes per day, ≥3 days per week.

§ Confidence interval.

TABLE 3. Age-adjusted percentage of respondents aged ≥18 years who reported no leisure-time physical activity, by state/area — Behavioral Risk Factor Surveillance System (BRFSS), United States, 2000 and 2001

State/Area	2000 BRFSS physical inactivity* %	2000 BRFSS physical inactivity* (95% CI†)	2001 BRFSS physical inactivity %	2001 BRFSS physical inactivity (95% CI)
Alabama	31.8	(29.5–34.1)	31.1	(29.2–33.0)
Alaska	21.0	(18.5–23.5)	22.4	(20.1–24.7)
Arizona	33.9	(30.5–37.3)	21.9	(19.8–24.0)
Arkansas	27.8	(26.0–29.6)	31.1	(29.2–33.0)
California	26.5	(24.7–28.3)	26.6	(24.8–28.4)
Colorado	20.0	(17.9–22.1)	19.4	(17.5–21.3)
Connecticut	25.0	(23.5–26.5)	23.8	(22.6–25.0)
Delaware	27.9	(25.7–30.1)	25.6	(23.8–27.4)
District of Columbia	20.8	(18.6–23.0)	24.3	(21.9–26.7)
Florida	28.3	(26.8–29.8)	27.1	(25.6–28.6)
Georgia	29.4	(27.7–31.1)	27.6	(26.0–29.2)
Hawaii	23.2	(21.7–24.7)	18.8	(17.3–20.3)
Idaho	19.8	(18.5–21.1)	20.9	(19.5–22.3)
Illinois	29.3	(26.8–31.8)	26.6	(24.3–28.9)
Indiana	25.2	(23.4–27.0)	26.1	(24.6–27.6)
Iowa	27.0	(25.3–28.7)	25.5	(23.9–27.1)
Kansas	30.1	(28.5–31.7)	26.4	(25.0–27.8)
Kentucky	41.1	(39.4–42.8)	33.3	(31.8–34.8)
Louisiana	36.4	(34.9–37.9)	35.8	(34.3–37.3)
Maine	26.9	(24.7–29.1)	22.9	(21.2–24.6)
Maryland	24.2	(22.7–25.7)	24.3	(22.7–25.9)
Massachusetts	24.5	(23.4–25.6)	22.7	(21.7–23.7)
Michigan	22.9	(21.1–24.7)	23.3	(21.8–24.8)
Minnesota	24.7	(22.8–26.6)	17.1	(15.8–18.4)
Mississippi	33.7	(31.4–36.0)	33.5	(31.6–35.4)
Missouri	28.5	(26.7–30.3)	27.2	(25.4–29.0)
Montana	22.9	(20.9–24.9)	21.5	(19.7–23.3)
Nebraska	29.0	(27.2–30.8)	31.2	(29.4–33.0)
Nevada	24.9	(22.1–27.7)	22.7	(20.4–25.0)
New Hampshire	26.7	(24.4–29.0)	19.6	(18.2–21.0)
New Jersey	28.4	(26.7–30.1)	26.4	(24.9–27.9)
New Mexico	24.5	(22.9–26.1)	25.9	(24.3–27.5)
New York	29.1	(27.2–31.0)	28.6	(26.9–30.3)
North Carolina	30.6	(28.7–32.5)	26.3	(24.6–28.0)
North Dakota	24.2	(22.1–26.3)	23.0	(21.2–24.8)
Ohio	31.2	(28.9–33.5)	26.1	(24.3–27.9)
Oklahoma	34.2	(32.4–36.0)	32.5	(30.7–34.3)
Oregon	19.9	(18.4–21.4)	20.6	(18.9–22.3)
Pennsylvania	22.5	(20.9–24.1)	24.1	(22.5–25.7)
Rhode Island	27.2	(25.5–28.9)	24.6	(23.1–26.1)
South Carolina	28.1	(26.3–29.9)	26.6	(24.8–28.4)
South Dakota	26.2	(24.8–27.6)	25.0	(23.7–26.3)
Tennessee	32.5	(30.6–34.4)	34.7	(32.7–36.7)
Texas	28.7	(27.2–30.2)	27.3	(26.0–28.6)
Utah	15.9	(14.2–17.6)	17.1	(15.5–18.7)
Vermont	23.2	(21.7–24.7)	20.4	(19.1–21.7)
Virginia	25.1	(23.0–27.2)	23.4	(21.7–25.1)
Washington	16.8	(15.5–18.1)	17.1	(15.8–18.4)
West Virginia	33.5	(31.4–35.6)	31.3	(29.5–33.1)
Wisconsin	22.0	(20.2–23.8)	20.6	(19.0–22.2)
Wyoming	22.6	(20.7–24.5)	21.3	(19.7–22.9)
Total	**27.4**	**(27.0–27.8)**	**26.0**	**(25.7–26.3)**

* No reported leisure-time physical activities (i.e., any physical activities or exercises such as running, calisthenics, golf, gardening, or walking).
† Confidence interval.

asked specifically to recall moderate- and vigorous-intensity activities separately, thereby increasing the potential to recall less intense lifestyle activities.

The findings in this report are subject to at least five limitations. First, BRFSS is based on self-reported data and is subject to recall bias. Second, although the new 2001 lifestyle activity questions covered more activity domains than previous BRFSS questions, the domains cannot be considered separately with these few questions. Third, expanding the scope of questions to include more activities and intensity levels provides less information about particular activities. For example, time spent specifically walking or running was not determined. Fourth, the 2001 questionnaire is not designed to assess whether a combination of moderate- and vigorous-physical activity might classify persons as active, because it was not possible to determine whether the moderate and vigorous activities occurred on different days. Therefore, a small proportion of active persons might have been misclassified as not participating in activities consistent with physical activity recommendations. Finally, response rates might have affected estimates. The number of interviews completed in 2001 ranged from 8,628 in Massachusetts to 871 in Guam; the Council of American Survey Research Organizations response rates for states and territories in the 2001 BRFSS ranged from 81.5% in Puerto Rico to 33.3% in New Jersey (*6*). The median response rate for the 2001 BRFSS was 51.1%. However, BRFSS data have minimal bias compared with census data. In addition, BRFSS data for select health behaviors and health status measures have moderate-to-high reliability and validity (*8*).

The majority of persons in the United States do not engage in physical activities consistent with the recommendation of a minimum of 30 minutes of moderate-intensity activity on most days of the week. In 2001, a total of 54.6% of persons were not active enough to meet these recommendations. By incorporating lifestyle physical activity measurements in the 2001 BRFSS, states have an updated baseline for evaluating the effectiveness of public health physical activity interventions.

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Detection of West Nile Virus in Blood Donations — United States, 2003

During the 2002 epidemic of West Nile virus (WNV) in the United States, a total of 23 persons were reported to have acquired WNV infection after receipt of blood components from 16 WNV-viremic blood donors (*1*), and an estimated 500 viremic donations might have been collected (B. Biggerstaff, M.D., CDC, personal communication, 2003). Because of the possibility of recurrent WNV epidemics in the United States, blood collection agencies (BCAs) recently implemented WNV nucleic acid–amplification tests (NATs) to screen all donations and quarantine and retrieve potentially infectious blood components. In addition to NAT screening, the Food and Drug Administration (FDA) recommended that BCAs enhance donor deferral questions by specifically asking about fever with headache occurring in the week before donation and defer persons reporting such symptoms (*2*). This report describes the NAT screening process for two WNV-viremic donors and presents data summarizing the testing results for approximately 95% of the civilian blood donations collected during late June to early August. These preliminary data suggest that investigational screening tests are effective in identifying viremic donations and preventing the implicated blood components from entering the blood supply.

Screening Procedures

Two commercial WNV-screening NATs have been distributed under phase III investigational new drug (IND) approval by FDA. The Roche assay is based on a real-time, quantitative reverse transcriptase polymerase chain reaction (PCR) format (Taqman®), and the GenProbe-Chiron assay is based on a transcription-mediated amplification format. Both assays identify highly conserved regions of the WNV genome. Depending on the test format, aliquots of the donation are combined with aliquots from other donors into pools of six (Roche assay) or 16 (GenProbe-Chiron assay) for NAT. If the pool is NAT-reactive, the individual samples that had been combined are

tested separately by using the same NAT-screening format. Some laboratories test individual donations with no pooling. When an individual donation is NAT-reactive, all blood components associated with that donation are quarantined; unused components from any donation given by the same donor within the preceding 14–28 days are retrieved. As part of the test evaluation under the investigational status, a series of additional NATs are performed on alternate samples from the implicated donation (i.e., an aliquot from the donated plasma). Additional amplification testing is usually performed by a second laboratory using a different amplification format or primers that are reactive with a different part of the WNV genome. The original donation sample and blood samples collected after the donation are assayed for WNV-specific IgM antibody to document seroconversion in the donor. Donor information, including recent travel history, other exposure history, and review of symptoms compatible with WNV illness before or after donation, is collected by questionnaire within 14 days of donation.

To assist with national WNV surveillance and control efforts, BCAs share WNV NAT-screening data with state health departments. Full confirmatory testing under the IND protocols might not be completed in time to serve public health needs; therefore, preliminary screening results are reported to the state health department of the donor's state of residence. Donors are presumed to be WNV viremic when samples from the initial donation are reactive in the screening NATs of the pool, reactive using the screening NAT as individual samples, and repeatedly reactive as individual samples using an additional NAT. The American Association of Blood Banks, CDC, and FDA collaborated to request BCAs to report the state of residence, age, sex, postal code, and date of donation of presumptive viremic donors (*3*).

Examples of NAT Screening Process

Donor 1. On June 25, 2003, a resident of Harris County, Texas, aged 47 years donated blood locally. A pool of six samples, including this donation, was reactive on NAT screening performed the same day. When individual donations were tested, this person's donation was the only reactive donation identified from the initially reactive pool. A sample of the plasma component (i.e., alternate sample) was tested on June 26 by using the same NAT format and was found to be reactive. On June 27, the BCA reported this case to the Harris County Public Health and Environmental Services as a presumptive WNV infection. Subsequent PCR testing using alternate primers and NAT formats at three different laboratories, including CDC, confirmed the presence of WNV RNA in the blood with an estimated viral load of 7,200 copies/mL (18 plaque-forming units [pfu]/mL). Plasma samples collected from this donor by the BCA 14 and 28 days post-donation did not contain WNV RNA; serologic testing is pending. The donor reported no symptoms suggestive of WNV illness either before donation or during the 4 weeks post-donation. On July 2, the NAT manufacturer reported having sequenced an amplicon (i.e., the amplified segment of viral genome generated by PCR) that was homologous with the 1999 New York strain of WNV. At CDC, WNV was isolated from the plasma. This donor would be eligible to donate blood again 28 days after the original donation (i.e., the most recent reactive NAT result) according to the IND protocol.

Donor 2. On July 9, a South Dakota resident aged 24 years donated blood locally. On July 10, initial screening of the pool of six samples was NAT-reactive. Testing of the individual donor's sample also was reactive on this date, and the BCA notified the South Dakota Department of Health. Aliquots of the donated plasma were tested by using alternate WNV primers and NAT formats at a second laboratory, the South Dakota Public Department of Health State Laboratory, and CDC; all tests were reactive. The viral load was estimated to be 160,000 copies/mL (400 pfu/mL). WNV-specific antibody was identified in a sample collected 14 days post-donation; the donor reported fever and malaise from the second day to the fourth day post-donation.

Status of Blood Donation Screening for WNV

Of the approximately one million donations screened as of August 5, a total of 329 (approximately 0.03%) were found reactive for WNV infection by using the NAT format. Of these 329 donations, 163 (approximately 0.015% of total donations) were repeatedly reactive when tested with an additional NAT; results of additional NATs for 28 screening test–reactive donations are pending. The more than one million donations screened represent approximately 95% of the blood collected in the United States during that period; however, testing was performed on all donations. As of August 5, state health departments have reported 38 presumptive WNV-viremic donors to ArboNET, the cooperative surveillance project between CDC and 57 state and local health departments. These presumptive WNV-viremic donors have been reported from Colorado, Florida, Louisiana, Mississippi, New Mexico, South Dakota, and Texas. The remaining donors identified by the BCA community have yet to be reported to public health officials in the donors' states of residence or have not yet been reported to ArboNET by public health departments.

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Editorial Note: On the basis of information gathered from BCAs, the investigational screening tests currently in use are successfully identifying viremic donations and preventing the implicated blood components from entering the blood supply. Follow-up testing and data collection performed by BCAs on all presumptive viremic donors identified by the initial screening tests is necessary to confirm these infections, but identification of probable infections might be valuable to surveillance efforts at the state level.

The WNV-screening NAT was commercially developed and implemented during a 9-month period, from September 2002, when the need was identified, to the initiation of donation testing in June 2003. As of July 14, all civilian blood donations collected in the United States, including Puerto Rico, have been screened for WNV by using NATs.

WNV nucleic-acid detection was identified as the most efficient means of interdicting viremic donations, as opposed to donor deferral on the basis of donor symptoms or serologic testing. In addition, since 1999, all blood donations have been screened for human immunodeficiency virus–1 and hepatitis C virus by virus detection using NAT-based methods in a pooled screening format. As a result, testing infrastructure and familiarity with these methods and formats were in place at regional blood screening laboratories. Although the technology for NAT of sample pools will probably detect the majority of viremic donations, the sensitivity of testing in field settings is still under investigation. As a result, patients who have received blood transfusions within 4 weeks preceding the development of febrile illness compatible with WNV infection should be reported to CDC through the local public health authorities to initiate an investigation.

WNV viremia in humans typically lasts an average of 6 days (*4,5*) and is thought to peak shortly before or within a few days of the onset of symptoms among persons who have WNV illness (*6*). After illness onset, the concentration of virus in the bloodstream decreases, and detectable amounts of WNV-specific IgM antibody increase. During the investigations of clinical illness resulting from transfusion of WNV-infectious blood products in 2002, the implicated donors were estimated to have had viremia as low as 0.8 pfu/mL, and many were asymptomatic in the week before or after donation. In all cases in which transfusion transmission of WNV infection was proven, the donated blood was negative for IgM. However, the possibility of transfusion transmission from donors with detectable IgM concurrent with low-level viremia has not been excluded.

After the issuance of industry-wide guidelines from the American Association of Blood Banks (*3*), which allow for protection of blood donor confidentiality, reporting to public health officials of presumed positive donors has been performed voluntarily by blood banks in several states. The current investigational screening tests are designed to be sensitive for the initial testing of pooled samples from as many as 16 donors. Because of the high sensitivity of these tests, public health officials should be cautious in the use of preliminary test result data because false-positive results can occur. As part of the protocols for evaluation of these investigational tests, all blood products from a donation found to be WNV-reactive on initial individual donation screening are excluded from the blood supply. Because the majority of WNV-infected persons remain asymptomatic, collection of data about viremic donors might serve as an essential surveillance tool in addition to screening for removal of potentially infectious products from the blood supply. State health departments receiving reports of these donors are encouraged to notify CDC through ArboNET as part of the national surveillance of human WNV infection.

Acknowledgments

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West Nile Virus Activity — United States, August 7–13, 2003

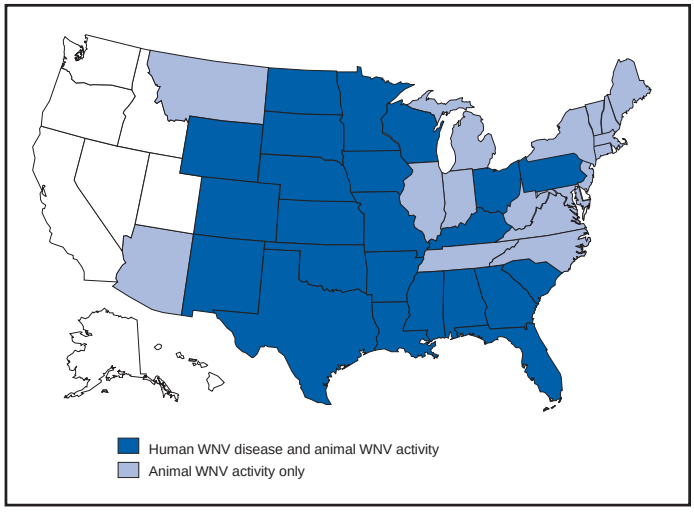
This report summarizes West Nile virus (WNV) surveillance data reported to CDC through ArboNET as of 3 a.m., Mountain Daylight Time, August 13, 2003.

During the reporting week of August 7–13, a total of 240 human cases of WNV infection were reported from 18 states (Alabama, Arkansas, Colorado, Georgia, Iowa, Kentucky, Louisiana, Minnesota, Mississippi, Missouri, New Mexico, North Dakota, Oklahoma, Pennsylvania, South Dakota, Texas, Wisconsin, and Wyoming), including five fatal cases from two states (Alabama and Colorado). During the same period, WNV infections were reported in 492 dead birds, 212 horses, one squirrel, and 430 mosquito pools.

During 2003, a total of 393 human cases of WNV infection have been reported from Colorado (n = 195), South Dakota (n = 51), Texas (n = 39), Louisiana (n = 21), Mississippi (n = 14), Pennsylvania (n = 12), Alabama (n = 10), Minnesota (n= seven), Ohio (n = seven), Nebraska (n = six), North Dakota (n= six), Florida (n = four), Iowa (n = four), Kentucky (n = three), New Mexico (n = three), Wyoming (n = three), Oklahoma (n = two), Arkansas (n = one), Georgia (n = one), Kansas (n = one), Missouri (n = one), South Carolina (n = one), and Wisconsin (n = one) (Figure). Among 383 (97%) cases for which demographic data were available, 213 (54%) occurred among men; the median age was 46 years (range: 17 months–89 years). Of the 393 cases, nine fatal cases were reported from Colorado (n = five), Alabama (n = two), and Texas (n = two). In addition, 2,262 dead birds with WNV infection were reported from 38 states and New York City; 403 WNV infections in horses have been reported from 27 states (Alabama, Arkansas, Colorado, Delaware, Florida, Georgia, Iowa, Kansas, Kentucky, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Mexico, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, Wisconsin, and Wyoming), three WNV infections were reported in dogs, one infection was reported in a squirrel, and five infections were reported in unidentified animal species. During 2003, WNV seroconversions have been reported in 261 sentinel chicken flocks from 10 states (Colorado, Delaware, Florida, Georgia, Iowa, Louisiana, Nebraska, North Carolina, Pennsylvania, and Virginia). Louisiana and South Dakota each reported three seropositive sentinel horses. A total of 1,468 WNV-positive mosquito pools have been reported from 28 states (Arkansas, Arizona, Colorado, Connecticut, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Maryland, Michigan, Minnesota, Missouri, Mississippi, Montana, Nebraska, New Jersey, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, Virginia, and Wisconsin) and New York City.

Additional information about WNV activity is available from CDC at http://www.cdc.gov/ncidod/dvbid/westnile/index.htm and http://www.cindi.usgs.gov/hazard/event/west_nile/west_nile.html.

FIGURE. Areas reporting West Nile virus (WNV) activity — United States, 2003*



* As of 3 a.m., Mountain Daylight Time, August 13, 2003.

Notice to Readers

National Syndromic Surveillance Conference and Workshop

The National Syndromic Surveillance Conference will be held October 23–24, 2003, at the New York Academy of Medicine in New York City. The conference is sponsored by the New York City Department of Health and Mental Hygiene, the New York Academy of Medicine, and CDC with the support of the Alfred P. Sloan Foundation. A workshop for public health practitioners at state and local health departments will be conducted during October 20–22. The workshop will be a hands-on opportunity to learn the New York City syndromic surveillance system and the SaTScan software.

Bioterrorism events have highlighted the need for improved public health surveillance systems to detect outbreaks. Systems using real-time electronic surveillance of nonspecific disease indicators (i.e., syndromic surveillance) might provide early warning of large outbreaks, whether intentional or occurring naturally. The conference will provide public, private, and academic entities with a forum to evaluate syndromic surveillance critically and will assist public health entities in defining their needs and priorities. Posters and presentations will define the goals and objectives of syndromic surveillance and describe the evaluation of systems, findings from model operational systems, national resources under development, and discuss the usefulness of syndromic surveillance. Work in research and development and lessons from public health practice will be discussed in concurrent sessions. In the research session, aberration detection algorithms, the use of simulated data sets, and syndrome coding will be discussed. In the practitioner session, presenters will describe their experiences and challenges, how they have managed relations with data providers, and signal investigation.

Registration and information are available at http://www.nyam.org/events/syndromicconference. Deadlines are September 15 to submit abstracts for the poster session or for oral presentations and October 6 to register online. Additional information is available by e-mail, ssc@nyam.org, by telephone, 212-822-7303, or by fax, 212-987-4735.

Notice to Readers

Satellite Broadcast on Immunization

Immunization Update 2003, a live satellite broadcast and webcast, will be presented on August 21 from 9 a.m. to 11:30 a.m. and rebroadcast from 12 p.m. to 2:30 p.m. Both broadcasts will feature a live question-and-answer session in which participants can interact with the course instructors through toll-free telephone lines. Both broadcasts will have a webcast and also will be available for viewing after August 21 at http://www.phppo.cdc.gov/PHTN/webcast/imm-up2003.

The program will provide up-to-date information on the field of immunization. Anticipated topics include influenza

vaccine, including recommendations for the use of the new live attenuated intranasal vaccine; pneumococcal conjugate vaccine; hepatitis B vaccine; recommendations for the use of new pediatric combination vaccines; an update on the smallpox vaccination program, including recommendations for the use of smallpox vaccine for the prevention of monkeypox; and an update on global poliomyelitis eradication.

The broadcast is designed for physicians, nurses, nurse practitioners, physician assistants, Department of Defense paraprofessionals, pharmacists, and their colleagues who either administer vaccinations or set policy for their offices, clinics, or communicable disease or infection-control programs. Continuing education credit will be offered for several professions based on 2.5 hours of instruction. Continuing Education credit will be available only through the CDC/ATSDR Training and Continuing Education Online System at http://www.phppo.cdc.gov/phtnonline. Participants must use the online system to register and receive continuing education credits. Information about registration is available by telephone, 800-418-7246.

Notice to Readers

Satellite Broadcast on HIV Prevention

CDC and the Public Health Training Network will present a satellite broadcast and webcast, "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV," on Thursday, November 13, 2003, at 1 p.m., EST. The 2-hour forum will discuss *Recommendations for Incorporating HIV Prevention into the Medical Care of Persons Living with HIV*, an update guidance document developed by CDC, the Health Resources and Services Administration, and the National Institutes of Health in partnership with the HIV Medicine Association of the Infectious Diseases Society of America. The document is available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.html.

The broadcast will identify roles, resources, and training for organizations, individual providers, and persons with acquired immunodeficiency syndrome about planning and delivering strategies and interventions. A panel of experts will address viewers' questions, which can be faxed before, during, and after the program.

Additional information and instructions for continuing education are available at http://www.cdcnpin.org/broadcast and through the CDC Fax Information System, telephone 888-232-3299, by entering document number 130042 and a return fax number. Organizations are responsible for setting up their own viewing sites and are encouraged to register their sites as soon as possible so persons who want to view the broadcast can access information online. Directions for establishing and registering a viewing site are available on the website. The broadcast also can be viewed live or later on computers with Internet and Real Player capability through a link at http://www.phppo.cdc.gov/phtn. Videotapes of the broadcast can be ordered by telephone, 800-458-5231.

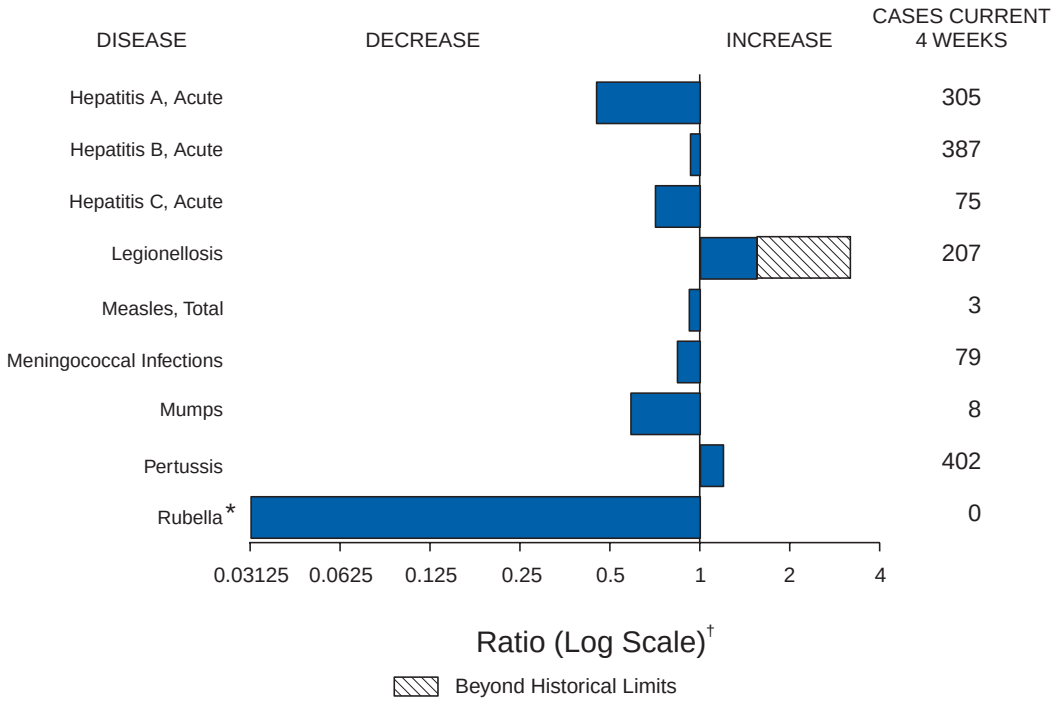
Notice to Readers

New Telephone Number to Report Botulism Cases and Request Antitoxin

CDC's 24-hour telephone number for state health departments to report suspected botulism cases, obtain clinical consultation on botulism cases, and request botulinum antitoxin release has changed. State health departments should call 770-488-7100. The call will be taken by the CDC Emergency Operations Center, which will page the Foodborne and Diarrheal Diseases Branch medical officer on call. All other aspects of the botulism emergency response system will remain unchanged.

Medical care providers who suspect a diagnosis of botulism in a patient should immediately call their state health department's emergency 24-hour telephone number. The state health department will contact CDC to arrange for a clinical consultation by telephone and, if indicated, release of botulinum antitoxin.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals August 9, 2003, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 32 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 August 9, 2003 (32nd Week)*

	Cum. 2003	Cum. 2002		Cum. 2003	Cum. 2002
Anthrax	-	2	Hansen disease (leprosy)†	30	62
Botulism:	-	-	Hantavirus pulmonary syndrome†	12	14
foodborne	7	18	Hemolytic uremic syndrome, postdiarrheal†	66	111
infant	32	44	HIV infection, pediatric†§	144	104
other (wound & unspecified)	17	9	Measles, total	31¶	22**
Brucellosis†	43	70	Mumps	129	179
Chancroid	27	46	Plague	1	-
Cholera	1	1	Poliomyelitis, paralytic	-	-
Cyclosporiasis†	44	126	Psittacosis†	11	12
Diphtheria	-	1	Q fever†	44	33
Ehrlichiosis:	-	-	Rabies, human	-	1
human granulocytic (HGE)†	137	169	Rubella	6	10
human monocytic (HME)†	65	105	Rubella, congenital	-	1
other and unspecified	15	13	Streptococcal toxic-shock syndrome†	118	79
Encephalitis/Meningitis:	-	-	Tetanus	7	16
California serogroup viral†	4	27	Toxic-shock syndrome	82	71
eastern equine†	4	1	Trichinosis	1	12
Powassan†	-	1	Tularemia†	39	48
St. Louis†	-	7	Yellow fever	-	-
western equine†	4	-			

-: No reported cases.
* Incidence data for reporting years 2002 and 2003 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 July 27, 2003.
¶ Of 31 cases reported, 24 were indigenous and seven were imported from another country.
** Of 22 cases reported, 12 were indigenous and 10 were imported from another country.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending August 9, 2003, and August 10, 2002 (32nd Week)*

Reporting area	AIDS		Chlamydia†		Coccidiodomycosis		Cryptosporidiosis		Encephalitis/Meningitis West Nile	
	Cum. 2003§	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	26,605	24,521	484,079	497,286	2,156	2,735	1,235	1,449	55	310
NEW ENGLAND	905	1,003	16,425	16,342	-	-	81	88	-	-
Maine	49	23	1,200	950	N	N	8	3	-	-
N.H.	22	20	895	973	-	-	8	16	-	-
Vt.	11	8	620	508	-	-	18	16	-	-
Mass.	371	514	6,579	6,467	-	-	32	34	-	-
R.I.	69	70	1,638	1,684	-	-	10	13	-	-
Conn.	383	368	5,493	5,760	N	N	5	6	-	-
MID. ATLANTIC	6,223	5,658	53,873	55,266	-	-	164	193	4	1
Upstate N.Y.	665	466	11,603	9,999	N	N	50	49	1	-
N.Y. City	3,189	3,202	20,018	18,823	-	-	47	79	-	1
N.J.	1,044	922	7,774	7,644	-	-	4	12	-	-
Pa.	1,325	1,068	14,478	18,800	N	N	63	53	3	-
E.N. CENTRAL	2,625	2,488	82,104	91,164	6	18	284	458	7	46
Ohio	466	447	20,432	23,481	-	-	53	79	7	-
Ind.	345	345	9,607	9,887	N	N	33	26	-	-
Ill.	1,238	1,170	24,525	28,977	-	2	33	70	-	40
Mich.	451	401	18,554	18,594	6	16	61	66	-	-
Wis.	125	125	8,986	10,225	-	-	104	217	-	6
W.N. CENTRAL	486	419	27,329	27,490	1	1	160	162	18	3
Minn.	95	91	6,012	6,418	N	N	61	66	2	-
Iowa	55	50	2,676	2,972	N	N	32	16	-	-
Mo.	230	187	9,402	9,272	-	-	14	19	-	-
N. Dak.	2	1	700	760	N	N	11	10	-	-
S. Dak.	8	3	1,565	1,281	-	-	22	5	9	3
Nebr.¶	35	43	2,769	2,522	1	1	6	35	6	-
Kans.	61	44	4,205	4,265	N	N	14	11	1	-
S. ATLANTIC	7,717	7,404	95,151	93,971	3	3	191	175	6	5
Del.	149	130	1,858	1,598	N	N	3	2	-	-
Md.	882	1,062	10,015	9,431	3	3	10	10	-	-
D.C.	725	371	1,779	2,002	-	-	8	4	-	-
Va.	627	535	10,632	10,536	-	-	21	7	-	-
W. Va.	54	57	1,540	1,475	N	N	3	2	-	-
N.C.	799	536	15,822	15,018	N	N	19	23	-	-
S.C.¶	504	533	8,626	8,760	-	-	3	2	1	-
Ga.	1,202	1,161	20,383	19,500	-	-	69	69	1	5
Fla.	2,775	3,019	24,496	25,651	N	N	55	56	4	-
E.S. CENTRAL	1,144	1,105	32,431	32,084	N	N	59	82	1	93
Ky.	98	172	5,006	5,234	N	N	14	3	1	-
Tenn.	517	467	11,716	9,856	N	N	20	43	-	-
Ala.	271	194	8,245	10,048	-	-	22	32	-	-
Miss.	258	272	7,464	6,946	N	N	3	4	-	93
W.S. CENTRAL	2,737	2,677	61,980	66,601	-	6	17	39	18	162
Ark.	107	164	4,533	4,646	-	-	4	7	-	-
La.	402	685	11,061	11,630	N	N	2	8	-	115
Okla.	139	130	6,828	6,998	N	N	7	8	-	-
Tex.	2,089	1,698	39,558	43,327	-	6	4	16	18	47
MOUNTAIN	967	777	28,744	30,789	1,486	1,861	68	89	1	-
Mont.	10	8	1,283	1,321	N	N	13	4	-	-
Idaho	15	18	1,479	1,510	N	N	15	18	-	-
Wyo.	6	6	597	549	1	-	2	6	-	-
Colo.	215	156	6,583	8,511	N	N	15	27	-	-
N. Mex.	75	53	4,143	4,612	4	6	3	15	1	-
Ariz.	432	315	8,542	9,070	1,451	1,825	3	11	-	-
Utah	40	43	2,827	1,566	7	9	11	5	-	-
Nev.	174	178	3,290	3,650	23	21	6	3	-	-
PACIFIC	3,801	2,990	86,042	83,579	659	845	211	163	-	-
Wash.	290	299	9,856	8,945	N	N	25	9	-	-
Oreg.	165	213	4,378	4,195	-	-	28	25	-	-
Calif.	3,271	2,394	67,978	65,508	659	845	158	128	-	-
Alaska	13	17	2,287	2,221	-	-	-	-	-	-
Hawaii	62	67	1,543	2,710	-	-	-	1	-	-
Guam	6	1	-	370	-	-	-	-	-	-
P.R.	724	667	1,158	1,558	N	N	N	N	-	-
V.I.	22	62	142	119	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	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 2002 and 2003 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 July 27, 2003.

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 9, 2003, and August 10, 2002 (32nd Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	1,025	1,618	114	97	72	24	9,217	10,952	183,541	211,719
NEW ENGLAND	67	139	22	25	8	3	633	1,003	4,124	4,590
Maine	6	19	1	3	-	-	88	99	127	74
N.H.	9	17	1	-	-	-	18	29	66	73
Vt.	6	5	-	-	-	-	56	76	48	64
Mass.	24	64	3	14	8	3	267	533	1,643	1,974
R.I.	1	5	-	-	-	-	67	77	520	521
Conn.	21	29	17	8	-	-	137	189	1,720	1,884
MID. ATLANTIC	113	186	7	1	20	2	1,793	2,294	21,766	25,473
Upstate N.Y.	46	85	3	-	10	-	520	640	4,500	5,119
N.Y. City	3	9	-	-	-	-	628	874	7,735	7,655
N.J.	5	33	-	-	-	-	157	268	4,923	4,722
Pa.	59	59	4	1	10	2	488	512	4,608	7,977
E.N. CENTRAL	241	384	13	21	11	3	1,498	1,851	37,035	44,278
Ohio	51	69	10	7	10	2	509	491	11,393	13,063
Ind.	47	36	-	-	-	-	-	-	3,698	4,327
Ill.	40	106	-	6	-	-	366	549	10,901	14,753
Mich.	39	66	-	2	-	1	394	473	7,951	8,481
Wis.	64	107	3	6	1	-	229	338	3,092	3,654
W.N. CENTRAL	188	236	15	15	16	3	996	1,037	9,230	10,673
Minn.	58	77	9	12	1	-	387	368	1,600	1,869
Iowa	41	54	-	-	-	-	135	150	607	698
Mo.	48	37	3	-	1	-	267	275	4,419	5,262
N. Dak.	6	4	-	-	7	-	22	13	30	41
S. Dak.	13	20	3	1	-	-	25	40	127	155
Nebr.	8	28	-	2	-	-	67	95	905	900
Kans.	14	16	-	-	7	3	93	96	1,542	1,748
S. ATLANTIC	81	130	42	17	3	-	1,560	1,622	46,837	54,229
Del.	1	5	N	N	N	N	18	30	721	974
Md.	2	13	-	-	-	-	66	62	4,736	5,380
D.C.	1	-	-	-	-	-	25	28	1,399	1,624
Va.	22	29	5	2	-	-	208	126	4,926	6,101
W. Va.	3	2	-	-	-	-	24	27	524	608
N.C.	5	23	12	-	-	-	N	N	9,031	10,029
S.C.	-	2	-	-	-	-	68	50	4,671	5,522
Ga.	18	34	2	7	-	-	543	531	10,098	10,584
Fla.	29	22	23	8	3	-	608	768	10,731	13,407
E.S. CENTRAL	44	60	-	-	5	7	185	199	15,768	18,385
Ky.	13	14	-	-	5	7	N	N	2,179	2,116
Tenn.	18	26	-	-	-	-	85	91	4,747	5,627
Ala.	10	13	-	-	-	-	100	108	5,086	6,487
Miss.	3	7	-	-	-	-	-	-	3,756	4,155
W.S. CENTRAL	29	64	1	-	3	2	164	112	25,582	29,815
Ark.	4	5	-	-	-	-	88	79	2,427	2,847
La.	2	2	-	-	-	-	5	2	6,613	7,247
Okla.	13	13	-	-	-	-	71	30	2,691	2,990
Tex.	10	44	1	-	3	2	-	1	13,851	16,731
MOUNTAIN	129	157	11	13	6	4	803	842	6,020	6,619
Mont.	4	10	-	-	-	-	42	52	68	55
Idaho	26	12	6	5	-	-	90	61	43	51
Wyo.	2	5	-	1	-	-	11	17	28	36
Colo.	35	58	2	4	6	4	225	277	1,530	2,080
N. Mex.	4	4	3	3	-	-	23	94	692	914
Ariz.	19	18	N	N	N	N	148	113	2,297	2,168
Utah	29	35	-	-	-	-	190	151	264	145
Nev.	10	15	-	-	-	-	74	77	1,098	1,170
PACIFIC	133	262	3	5	-	-	1,585	1,992	17,179	17,657
Wash.	37	63	1	-	-	-	146	216	1,692	1,746
Oreg.	24	53	1	5	-	-	205	242	581	512
Calif.	68	114	-	-	-	-	1,150	1,414	14,251	14,621
Alaska	1	5	-	-	-	-	47	55	321	379
Hawaii	3	27	1	-	-	-	37	65	334	399
Guam	N	N	-	-	-	-	-	6	-	32
P.R.	-	1	-	-	-	-	30	38	123	232
V.I.	-	-	-	-	-	-	-	-	36	31
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 years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 9, 2003, and August 10, 2002 (32nd Week)*

Reporting area	*Haemophilus influenzae*, invasive†								Hepatitis (viral, acute), by type	
	All ages		Age <5 years							
	All serotypes		Serotype b		Non-serotype b		Unknown serotype		A	
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	1,077	1,101	8	20	61	88	119	102	3,525	5,687
NEW ENGLAND	86	71	1	-	6	7	5	1	171	201
Maine	2	1	-	-	-	-	1	-	9	6
N.H.	11	6	1	-	-	-	-	-	8	11
Vt.	6	5	-	-	-	-	-	-	5	1
Mass.	42	31	-	-	6	3	3	1	95	88
R.I.	4	10	-	-	-	-	1	-	11	28
Conn.	21	18	-	-	-	4	-	-	43	67
MID. ATLANTIC	235	201	-	2	1	11	32	20	679	722
Upstate N.Y.	88	77	-	2	1	4	9	6	79	120
N.Y. City	41	48	-	-	-	-	8	9	221	259
N.J.	40	42	-	-	-	-	6	5	85	118
Pa.	66	34	-	-	-	7	9	-	294	225
E.N. CENTRAL	144	224	1	2	5	9	23	30	395	707
Ohio	50	62	-	-	-	1	8	7	83	203
Ind.	32	33	-	1	3	7	-	-	42	33
Ill.	41	82	-	-	-	-	11	15	115	185
Mich.	15	9	1	1	2	1	2	-	123	151
Wis.	6	38	-	-	-	-	2	8	32	135
W.N. CENTRAL	82	48	-	1	6	2	9	3	120	204
Minn.	31	29	-	1	6	2	1	1	33	28
Iowa	-	1	-	-	-	-	-	-	19	46
Mo.	34	10	-	-	-	-	8	2	43	58
N. Dak.	1	4	-	-	-	-	-	-	-	1
S. Dak.	1	1	-	-	-	-	-	-	-	3
Nebr.	2	-	-	-	-	-	-	-	5	13
Kans.	13	3	-	-	-	-	-	-	20	55
S. ATLANTIC	253	246	-	4	9	13	14	19	852	1,574
Del.	-	-	-	-	-	-	-	-	4	10
Md.	58	63	-	1	5	2	-	1	91	185
D.C.	-	-	-	-	-	-	-	-	26	55
Va.	38	22	-	-	-	-	5	3	48	57
W. Va.	11	9	-	-	-	-	-	1	13	12
N.C.	22	23	-	-	1	3	1	-	46	146
S.C.	3	9	-	-	-	-	-	2	25	45
Ga.	50	55	-	-	-	-	5	9	329	325
Fla.	71	65	-	3	3	8	3	3	270	739
E.S. CENTRAL	49	45	1	1	-	4	6	7	98	179
Ky.	2	4	-	-	-	1	-	-	20	39
Tenn.	29	21	-	-	-	-	4	5	54	71
Ala.	16	13	1	1	-	3	1	1	11	25
Miss.	2	7	-	-	-	-	1	1	13	44
W.S. CENTRAL	43	39	-	2	5	7	3	2	166	607
Ark.	6	1	-	-	1	-	-	-	15	36
La.	7	4	-	-	-	-	2	2	38	57
Okla.	28	32	-	-	4	7	1	-	10	31
Tex.	2	2	-	2	-	-	-	-	103	483
MOUNTAIN	124	126	4	4	17	19	19	11	294	354
Mont.	-	-	-	-	-	-	-	-	4	10
Idaho	3	2	-	-	-	-	1	1	-	22
Wyo.	1	2	-	-	-	-	-	-	1	2
Colo.	23	25	-	-	-	-	5	2	42	53
N. Mex.	15	20	-	-	4	4	2	1	11	11
Ariz.	64	56	4	2	6	12	8	5	177	197
Utah	11	14	-	1	4	3	3	-	23	25
Nev.	7	7	-	1	3	-	-	2	36	34
PACIFIC	61	101	1	4	12	16	8	9	750	1,139
Wash.	6	2	-	1	4	1	1	-	37	112
Oreg.	32	39	-	-	-	-	3	3	40	44
Calif.	16	32	1	3	8	15	4	2	662	959
Alaska	-	1	-	-	-	-	-	1	7	7
Hawaii	7	27	-	-	-	-	-	3	4	17
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	1	-	-	-	-	-	-	24	135
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 years 2002 and 2003 are provisional and cumulative (year-to-date).

† Non-serotype b: nontypeable and type other than b; Unknown serotype: type unknown or not reported. Previously, cases reported without type information were counted as non-serotype b.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 9, 2003, and August 10, 2002 (32nd Week)*

Reporting area	Hepatitis (viral, acute), by type				Legionellosis		Listeriosis		Lyme disease	
	B		C							
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	3,729	4,521	862	1,144	933	601	309	319	7,001	10,218
NEW ENGLAND	143	161	2	18	34	52	23	34	1,154	2,106
Maine	1	5	-	-	1	2	5	2	105	49
N.H.	11	12	-	-	4	4	2	2	41	109
Vt.	2	3	2	12	2	18	-	2	15	18
Mass.	113	89	-	6	13	20	10	19	188	1,412
R.I.	8	17	-	-	2	1	-	1	141	113
Conn.	8	35	U	U	12	7	6	8	664	405
MID. ATLANTIC	575	967	105	58	205	154	55	72	4,671	6,071
Upstate N.Y.	65	73	33	27	62	41	16	24	2,174	2,534
N.Y. City	246	488	-	-	15	27	10	19	2	49
N.J.	109	190	-	4	4	20	7	11	544	1,708
Pa.	155	216	72	27	124	66	22	18	1,951	1,780
E.N. CENTRAL	250	398	132	67	204	159	37	46	280	909
Ohio	88	59	9	-	131	64	14	12	33	40
Ind.	22	30	1	-	11	11	2	6	9	11
Ill.	1	80	9	12	3	19	5	12	-	39
Mich.	116	193	113	52	48	38	13	12	1	16
Wis.	23	36	-	3	11	27	3	4	237	803
W.N. CENTRAL	192	130	138	510	42	29	9	10	151	151
Minn.	26	12	7	2	3	2	3	-	105	89
Iowa	4	12	1	1	9	7	-	1	15	24
Mo.	131	68	129	499	19	9	3	6	24	30
N. Dak.	-	4	-	-	1	-	-	1	-	-
S. Dak.	2	-	-	-	1	2	-	-	-	-
Nebr.	16	19	1	8	2	9	3	1	2	4
Kans.	13	15	-	-	7	-	-	1	5	4
S. ATLANTIC	1,193	1,094	113	127	293	110	70	46	616	782
Del.	5	12	-	-	12	6	N	N	85	113
Md.	78	87	10	7	65	20	12	9	376	484
D.C.	6	13	-	-	8	5	-	-	5	15
Va.	104	127	4	2	57	10	7	3	44	52
W. Va.	12	14	1	1	11	-	3	-	6	8
N.C.	111	161	8	17	21	7	11	4	56	63
S.C.	94	69	23	4	5	6	2	6	1	9
Ga.	363	293	3	57	19	8	20	8	12	1
Fla.	420	318	64	39	95	48	15	16	31	37
E.S. CENTRAL	251	233	82	80	55	19	14	8	29	36
Ky.	42	38	8	4	21	9	2	2	7	13
Tenn.	116	91	41	18	22	4	4	3	9	9
Ala.	41	48	6	4	11	6	6	3	1	7
Miss.	52	56	27	54	1	-	2	-	12	7
W.S. CENTRAL	187	627	189	166	11	17	14	18	33	94
Ark.	32	82	3	10	1	-	1	-	-	2
La.	42	77	41	60	-	4	-	1	3	3
Okla.	31	29	2	4	4	3	1	5	-	-
Tex.	82	439	143	92	6	10	12	12	30	89
MOUNTAIN	381	385	43	42	43	22	18	20	10	9
Mont.	8	3	1	-	2	3	1	-	-	-
Idaho	-	6	-	-	3	-	1	2	2	2
Wyo.	22	12	-	5	2	1	-	-	-	-
Colo.	49	48	23	5	8	3	7	3	3	-
N. Mex.	19	110	-	2	2	1	2	2	-	1
Ariz.	193	141	6	4	9	6	5	9	-	2
Utah	40	25	-	4	13	7	-	3	2	3
Nev.	50	40	13	22	4	1	2	1	3	1
PACIFIC	557	526	58	76	46	39	69	65	57	60
Wash.	37	42	8	15	5	1	2	5	-	3
Oreg.	75	92	9	10	N	N	3	7	14	10
Calif.	427	380	39	51	41	38	61	47	41	46
Alaska	8	6	1	-	-	-	-	-	2	1
Hawaii	10	6	1	-	-	-	3	6	N	N
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	38	114	-	-	-	-	-	2	N	N
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 years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 9, 2003, and August 10, 2002 (32nd Week)*

Reporting area	Malaria		Meningococcal disease		Pertussis		Rabies, animal		Rocky Mountain spotted fever	
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	527	814	1,038	1,227	3,688	4,644	3,045	4,510	335	558
NEW ENGLAND	24	46	50	72	350	418	297	522	-	2
Maine	2	2	5	4	11	5	29	30	-	-
N.H.	2	6	3	9	25	9	11	25	-	-
Vt.	-	1	-	4	46	80	21	72	-	-
Mass.	9	22	32	37	260	290	110	170	-	2
R.I.	-	3	2	5	7	9	28	40	-	-
Conn.	11	12	8	13	1	25	98	185	-	-
MID. ATLANTIC	113	203	133	157	339	192	274	706	15	40
Upstate N.Y.	32	27	33	36	191	123	211	393	1	-
N.Y. City	51	124	25	27	-	11	1	10	6	9
N.J.	10	27	19	23	22	-	62	100	5	14
Pa.	20	25	56	71	126	58	-	203	3	17
E.N. CENTRAL	50	114	160	181	278	552	71	74	6	24
Ohio	11	14	46	57	143	264	31	16	4	10
Ind.	1	9	32	22	32	40	7	16	-	3
Ill.	18	48	35	42	-	99	8	14	-	9
Mich.	16	34	33	28	50	36	23	17	2	2
Wis.	4	9	14	32	53	113	2	11	-	-
W.N. CENTRAL	28	46	96	98	192	369	387	309	30	74
Minn.	15	16	20	22	59	141	22	19	1	-
Iowa	3	2	16	14	44	103	57	43	2	2
Mo.	2	12	44	37	51	74	13	29	22	68
N. Dak.	1	1	1	-	3	5	39	29	-	-
S. Dak.	2	1	1	2	3	5	67	64	2	-
Nebr.	-	5	7	18	4	5	58	-	1	4
Kans.	5	9	7	5	28	36	131	125	2	-
S. ATLANTIC	161	186	204	187	323	245	1,524	1,614	216	248
Del.	1	2	7	6	1	2	26	24	-	-
Md.	42	65	22	5	45	35	147	257	58	30
D.C.	7	15	-	-	-	1	-	-	-	-
Va.	20	17	20	28	64	96	342	346	14	17
W. Va.	4	3	4	2	6	17	58	114	4	1
N.C.	13	12	27	20	83	24	489	417	97	141
S.C.	3	5	19	18	49	28	136	74	12	36
Ga.	27	28	22	22	23	18	227	264	23	18
Fla.	44	39	83	86	52	24	99	118	8	5
E.S. CENTRAL	7	11	51	70	87	146	124	156	43	77
Ky.	1	4	11	12	28	57	27	17	-	3
Tenn.	4	2	13	28	41	56	82	108	33	41
Ala.	2	3	13	16	14	25	15	31	3	11
Miss.	-	2	14	14	4	8	-	-	7	22
W.S. CENTRAL	16	38	69	149	279	1,168	162	776	19	80
Ark.	4	1	10	20	8	445	25	-	-	21
La.	3	3	24	30	6	6	-	-	-	-
Okla.	3	4	12	16	12	34	137	76	18	49
Tex.	6	30	23	83	253	683	-	700	1	10
MOUNTAIN	24	34	52	71	617	562	85	172	6	11
Mont.	-	1	3	2	1	4	13	8	1	1
Idaho	1	-	6	3	46	46	3	16	1	-
Wyo.	1	-	2	-	119	10	1	14	2	4
Colo.	12	19	13	22	205	214	15	26	1	1
N. Mex.	-	2	6	3	35	112	5	6	-	-
Ariz.	7	5	15	21	122	98	39	96	1	-
Utah	2	4	1	2	66	47	6	3	-	-
Nev.	1	3	6	18	23	31	3	3	-	5
PACIFIC	104	136	223	242	1,223	992	121	181	-	2
Wash.	16	13	20	46	335	296	-	-	-	-
Oreg.	7	7	37	34	291	125	5	8	-	2
Calif.	76	108	158	154	588	546	113	147	-	-
Alaska	-	2	1	2	-	4	3	26	-	-
Hawaii	5	6	7	6	9	21	-	-	-	-
Guam	-	-	-	1	-	2	-	-	-	-
P.R.	-	1	2	5	-	2	47	54	N	N
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 years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 9, 2003, and August 10, 2002 (32nd Week)*

Reporting area	Salmonellosis		Shigellosis		Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive			
							Drug resistant, all ages		Age <5 years	
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	20,331	22,541	11,963	10,347	3,691	3,216	1,484	1,703	293	218
NEW ENGLAND	1,173	1,196	177	180	307	250	40	75	6	1
Maine	77	83	6	3	21	20	-	-	-	-
N.H.	81	73	5	6	19	27	-	-	N	N
Vt.	39	42	6	-	16	9	6	4	3	1
Mass.	692	690	117	121	140	84	N	N	N	N
R.I.	63	75	7	6	9	13	10	6	3	-
Conn.	221	233	36	44	102	97	24	65	U	U
MID. ATLANTIC	2,260	3,111	1,264	910	606	538	92	81	69	57
Upstate N.Y.	567	818	202	138	275	215	50	72	53	47
N.Y. City	640	804	217	270	90	125	U	U	U	U
N.J.	211	659	161	352	42	113	N	N	N	N
Pa.	842	830	684	150	199	85	42	9	16	10
E.N. CENTRAL	3,069	3,395	1,095	1,144	842	691	320	152	130	81
Ohio	887	796	245	394	247	157	210	28	77	-
Ind.	340	280	92	59	86	39	110	122	33	40
Ill.	978	1,193	517	488	179	202	-	2	-	-
Mich.	460	570	167	99	284	212	N	N	N	N
Wis.	404	556	74	104	46	81	N	N	20	41
W.N. CENTRAL	1,428	1,389	489	695	241	185	125	326	42	40
Minn.	335	328	59	141	121	95	-	220	36	36
Iowa	206	228	35	72	N	N	N	N	N	N
Mo.	536	468	249	104	49	38	9	5	2	1
N. Dak.	25	24	3	16	10	-	3	1	4	3
S. Dak.	60	52	9	150	18	10	1	1	-	-
Nebr.	87	100	87	151	21	16	-	25	N	N
Kans.	179	189	47	61	22	26	112	74	N	N
S. ATLANTIC	5,301	5,259	4,817	3,301	678	527	758	787	8	19
Del.	48	44	142	27	6	1	1	3	N	N
Md.	466	507	399	645	207	84	-	-	-	14
D.C.	21	48	41	39	10	6	2	-	4	3
Va.	572	544	262	569	85	55	N	N	N	N
W. Va.	70	68	-	4	30	13	51	34	4	2
N.C.	644	670	596	207	80	100	N	N	U	U
S.C.	281	316	268	69	30	29	106	136	N	N
Ga.	1,005	985	1,276	765	83	101	187	196	N	N
Fla.	2,194	2,077	1,833	976	147	138	411	418	N	N
E.S. CENTRAL	1,326	1,582	558	813	139	74	95	104	-	-
Ky.	236	188	68	82	32	13	12	13	N	N
Tenn.	425	403	190	42	107	61	83	91	N	N
Ala.	296	413	177	425	-	-	-	-	N	N
Miss.	369	578	123	264	-	-	-	-	-	-
W.S. CENTRAL	1,697	2,320	1,649	1,588	136	209	32	145	34	17
Ark.	344	474	59	130	5	6	8	5	-	-
La.	195	445	132	296	1	1	24	140	10	4
Okla.	239	256	515	289	62	35	N	N	24	2
Tex.	919	1,145	943	873	68	167	N	N	-	11
MOUNTAIN	1,209	1,260	570	384	344	400	19	33	4	3
Mont.	56	60	2	3	2	-	-	-	-	-
Idaho	103	76	14	2	14	5	N	N	N	N
Wyo.	59	37	1	4	2	7	4	10	-	-
Colo.	275	359	93	79	96	82	-	-	-	-
N. Mex.	111	165	108	71	85	74	15	23	-	-
Ariz.	385	334	292	184	135	205	-	-	N	N
Utah	123	98	30	18	9	27	-	-	4	3
Nev.	97	131	30	23	1	-	-	-	-	-
PACIFIC	2,868	3,029	1,344	1,332	398	342	3	-	-	-
Wash.	319	280	102	92	38	18	-	-	N	N
Oreg.	240	223	121	60	N	N	N	N	N	N
Calif.	2,150	2,320	1,098	1,143	304	282	N	N	N	N
Alaska	50	41	5	2	-	-	-	-	N	N
Hawaii	109	165	18	35	56	42	3	-	-	-
Guam	-	29	-	19	-	-	-	4	-	-
P.R.	156	264	2	20	N	N	N	N	N	N
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 years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 9, 2003, and August 10, 2002 (32nd Week)*

Reporting area	Syphilis: Primary & secondary		Syphilis: Congenital		Tuberculosis		Typhoid fever		Varicella (Chickenpox)
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003
UNITED STATES	4,055	3,944	220	245	6,319	7,628	156	178	8,054
NEW ENGLAND	127	83	1	-	184	247	15	8	1,240
Maine	6	1	1	-	5	10	-	-	633
N.H.	13	2	-	-	7	8	1	-	-
Vt.	-	1	-	-	3	4	-	-	492
Mass.	83	59	-	-	112	123	7	6	112
R.I.	12	2	-	-	24	34	2	-	3
Conn.	13	18	-	-	33	68	5	2	-
MID. ATLANTIC	462	426	43	36	1,206	1,297	18	48	16
Upstate N.Y.	24	20	12	1	148	191	3	3	N
N.Y. City	280	253	24	16	702	637	9	25	-
N.J.	82	81	7	18	215	290	5	13	-
Pa.	76	72	-	1	141	179	1	7	16
E.N. CENTRAL	570	741	41	36	693	763	12	19	3,735
Ohio	136	87	2	1	122	125	1	5	925
Ind.	31	39	7	2	86	66	4	2	-
Ill.	215	286	14	27	327	371	1	6	-
Mich.	178	313	18	6	126	159	6	3	2,259
Wis.	10	16	-	-	32	42	-	3	551
W.N. CENTRAL	92	77	2	-	277	332	2	6	37
Minn.	32	37	-	-	106	139	-	3	N
Iowa	4	2	-	-	17	17	1	-	N
Mo.	32	17	2	-	72	93	1	1	-
N. Dak.	-	-	-	-	-	4	-	-	37
S. Dak.	1	-	-	-	16	10	-	-	-
Nebr.	3	5	-	-	8	17	-	2	-
Kans.	20	16	-	-	58	52	-	-	-
S. ATLANTIC	1,081	975	38	57	1,274	1,573	35	23	1,540
Del.	4	9	-	-	-	13	-	-	18
Md.	182	115	7	10	129	170	7	5	-
D.C.	35	31	-	1	-	-	-	-	22
Va.	55	45	1	1	159	168	10	2	427
W. Va.	2	2	-	-	11	18	-	-	905
N.C.	100	180	11	15	184	195	6	1	N
S.C.	66	79	4	7	97	115	-	-	168
Ga.	254	200	3	9	186	316	6	4	-
Fla.	383	314	12	14	508	578	6	11	N
E.S. CENTRAL	193	325	12	18	389	457	5	4	-
Ky.	24	61	1	3	69	80	-	4	N
Tenn.	82	121	6	5	127	175	2	-	N
Ala.	71	109	4	7	139	129	3	-	-
Miss.	16	34	1	3	54	73	-	-	-
W.S. CENTRAL	520	504	38	51	837	1,185	6	19	1,116
Ark.	32	20	-	3	60	76	-	-	-
La.	79	88	-	-	-	-	-	-	4
Okla.	34	38	1	1	90	100	-	-	N
Tex.	375	358	37	47	687	1,009	6	19	1,112
MOUNTAIN	184	182	21	9	194	234	3	7	370
Mont.	-	-	-	-	5	6	-	-	N
Idaho	6	1	-	-	5	10	-	-	N
Wyo.	-	-	-	-	2	2	-	-	42
Colo.	12	37	3	1	43	49	3	3	-
N. Mex.	35	21	-	-	6	22	-	-	-
Ariz.	118	112	18	8	90	115	-	-	4
Utah	5	3	-	-	21	17	-	2	324
Nev.	8	8	-	-	22	13	-	2	-
PACIFIC	826	631	24	38	1,265	1,540	60	44	-
Wash.	47	32	-	1	146	150	2	4	-
Oreg.	27	10	-	-	71	65	3	2	-
Calif.	751	582	24	36	980	1,203	55	37	-
Alaska	-	-	-	-	34	32	-	-	-
Hawaii	1	7	-	1	34	90	-	1	-
Guam	-	6	-	-	-	41	-	-	-
P.R.	118	152	1	20	33	67	-	-	274
V.I.	1	1	-	-	-	-	-	-	-
Amer. Samoa	U	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 years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,* week ending August 9, 2003 (32nd Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	398	278	86	16	9	9	39
Boston, Mass.	136	82	35	8	6	5	9
Bridgeport, Conn.	12	7	3	-	-	2	1
Cambridge, Mass.	17	15	2	-	-	-	2
Fall River, Mass.	29	24	3	2	-	-	6
Hartford, Conn.	U	U	U	U	U	U	U
Lowell, Mass.	21	15	5	1	-	-	4
Lynn, Mass.	13	9	3	-	1	-	1
New Bedford, Mass.	32	25	7	-	-	-	-
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	6	5	1	-	-	-	2
Springfield, Mass.	34	23	7	2	2	-	3
Waterbury, Conn.	39	28	9	2	-	-	5
Worcester, Mass.	59	45	11	1	-	2	6
MID. ATLANTIC	1,963	1,332	412	138	43	34	113
Albany, N.Y.	40	31	8	-	-	1	5
Allentown, Pa.	17	13	3	-	1	-	1
Buffalo, N.Y.	87	63	18	5	1	-	8
Camden, N.J.	18	11	4	-	2	1	1
Elizabeth, N.J.	21	18	1	2	-	-	-
Erie, Pa.	37	27	9	1	-	-	3
Jersey City, N.J.	27	18	6	-	3	-	-
New York City, N.Y.	989	664	208	80	16	17	45
Newark, N.J.	50	16	18	11	4	1	7
Paterson, N.J.	U	U	U	U	U	U	U
Philadelphia, Pa.	310	207	65	22	7	9	12
Pittsburgh, Pa.§	37	24	12	1	-	-	3
Reading, Pa.	29	18	7	1	1	2	4
Rochester, N.Y.	128	88	28	6	5	1	12
Schenectady, N.Y.	24	15	8	1	-	-	1
Scranton, Pa.	44	36	5	3	-	-	1
Syracuse, N.Y.	43	36	4	2	1	-	6
Trenton, N.J.	11	7	1	2	-	1	2
Utica, N.Y.	29	27	2	-	-	-	2
Yonkers, N.Y.	22	13	5	1	2	1	-
E.N. CENTRAL	1,888	1,264	400	141	41	39	112
Akron, Ohio	52	36	11	2	1	2	2
Canton, Ohio	34	20	12	1	-	1	1
Chicago, Ill.	322	196	80	33	9	1	20
Cincinnati, Ohio	72	46	17	5	2	2	9
Cleveland, Ohio	124	86	24	11	3	-	3
Columbus, Ohio	165	111	41	7	3	3	11
Dayton, Ohio	120	90	22	6	2	-	11
Detroit, Mich.	193	108	54	20	7	4	11
Evansville, Ind.	44	37	6	-	-	1	-
Fort Wayne, Ind.	85	62	13	5	-	5	6
Gary, Ind.	27	15	7	3	1	1	2
Grand Rapids, Mich.	67	47	12	4	-	4	6
Indianapolis, Ind.	183	120	41	16	5	1	12
Lansing, Mich.	36	21	12	3	-	-	6
Milwaukee, Wis.	105	74	12	8	3	8	4
Peoria, Ill.	59	46	6	5	-	2	1
Rockford, Ill.	56	41	8	4	1	2	2
South Bend, Ind.	U	U	U	U	U	U	U
Toledo, Ohio	99	70	19	5	3	2	4
Youngstown, Ohio	45	38	3	3	1	-	1
W.N. CENTRAL	598	409	124	41	13	11	42
Des Moines, Iowa	112	81	23	3	3	2	11
Duluth, Minn.	52	37	10	4	1	-	3
Kansas City, Kans.	38	24	11	3	-	-	4
Kansas City, Mo.	99	62	23	9	2	3	5
Lincoln, Nebr.	39	28	10	1	-	-	2
Minneapolis, Minn.	64	44	13	3	4	-	5
Omaha, Nebr.	65	41	13	4	3	4	4
St. Louis, Mo.	U	U	U	U	U	U	U
St. Paul, Minn.	49	39	5	4	-	1	1
Wichita, Kans.	80	53	16	10	-	1	7
S. ATLANTIC	1,239	780	272	120	37	29	62
Atlanta, Ga.	192	114	47	24	5	2	6
Baltimore, Md.	208	115	55	25	8	4	13
Charlotte, N.C.	84	55	20	2	7	-	6
Jacksonville, Fla.	133	85	29	14	2	3	9
Miami, Fla.	137	82	30	16	5	4	5
Norfolk, Va.	48	33	10	3	-	2	-
Richmond, Va.	59	29	14	9	2	5	3
Savannah, Ga.	45	32	6	3	2	2	1
St. Petersburg, Fla.	43	32	5	2	1	3	4
Tampa, Fla.	172	128	25	12	3	4	8
Washington, D.C.	100	62	28	8	2	-	3
Wilmington, Del.	18	13	3	2	-	-	4
E.S. CENTRAL	824	520	197	59	28	20	48
Birmingham, Ala.	148	94	34	10	6	4	7
Chattanooga, Tenn.	96	69	19	7	1	-	4
Knoxville, Tenn.	102	69	24	4	4	1	6
Lexington, Ky.	64	40	13	6	1	4	7
Memphis, Tenn.	181	114	45	11	7	4	11
Mobile, Ala.	56	30	18	3	2	3	1
Montgomery, Ala.	50	27	12	10	1	-	6
Nashville, Tenn.	127	77	32	8	6	4	6
W.S. CENTRAL	1,235	745	277	109	61	43	74
Austin, Tex.	91	55	24	6	3	3	7
Baton Rouge, La.	56	36	13	6	1	-	-
Corpus Christi, Tex.	56	40	13	3	-	-	4
Dallas, Tex.	185	82	55	26	9	13	5
El Paso, Tex.	73	54	15	4	-	-	-
Ft. Worth, Tex.	124	79	21	14	2	8	8
Houston, Tex.	310	185	54	27	31	13	21
Little Rock, Ark.	80	47	19	9	2	3	2
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	227	145	55	11	13	3	24
Shreveport, La.	33	22	8	3	-	-	3
Tulsa, Okla.	U	U	U	U	U	U	U
MOUNTAIN	855	557	168	75	32	23	48
Albuquerque, N.M.	132	76	36	11	6	3	7
Boise, Idaho	48	33	7	3	3	2	1
Colo. Springs, Colo.	52	33	11	3	2	3	3
Denver, Colo.	83	46	16	9	4	8	2
Las Vegas, Nev.	238	161	49	21	5	2	18
Ogden, Utah	30	24	4	2	-	-	-
Phoenix, Ariz.	U	U	U	U	U	U	U
Pueblo, Colo.	32	27	4	1	-	-	2
Salt Lake City, Utah	117	62	21	21	11	2	8
Tucson, Ariz.	123	95	20	4	1	3	7
PACIFIC	1,770	1,225	364	109	39	32	140
Berkeley, Calif.	15	7	2	3	-	3	3
Fresno, Calif.	165	108	37	16	3	1	12
Glendale, Calif.	29	22	4	2	-	1	2
Honolulu, Hawaii	90	66	15	5	1	3	9
Long Beach, Calif.	83	56	19	8	-	-	14
Los Angeles, Calif.	596	407	134	35	13	7	46
Pasadena, Calif.	U	U	U	U	U	U	U
Portland, Oreg.	122	82	23	10	5	2	3
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	162	117	27	10	2	5	11
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	178	118	41	10	6	3	14
Santa Cruz, Calif.	33	26	5	-	1	1	5
Seattle, Wash.	138	93	29	9	5	2	9
Spokane, Wash.	67	55	7	-	2	3	7
Tacoma, Wash.	92	68	21	1	1	1	5
TOTAL	10,770¶	7,110	2,300	808	303	240	678

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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