MMWR
Morbidity and Mortality Weekly Report
Weekly April 20, 2007 / Vol. 56 / No. 15

Human Rabies — Indiana and California, 2006

Rabies is a viral infection that causes acute, progressive encephalitis and is considered to be universally fatal. However, during 2004, an unvaccinated Wisconsin patient received a new medical treatment and became the first documented survivor of rabies* who had not received preexposure vaccination or postexposure prophylaxis (PEP), suggesting the possibility of successful future interventions (*1*). This report describes two recent patients with rabies who were treated using therapy similar to that used for the Wisconsin patient; both treatments were unsuccessful. The report also describes the concomitant epidemiologic investigations by the Indiana State Department of Health (ISDH), California Department of Health Services (CDHS), and CDC, and the local public health responses in Marshall County, Indiana, and San Joaquin and Alameda counties in California. The findings in this report underscore the continuing need for enhanced clinical awareness of possible rabies exposure to ensure prompt PEP and timely diagnosis of rabies, especially if treatment is attempted.

Indiana

Case report. On September 30, 2006, a girl aged 10 years had pain in her right arm, and her parents noticed a skin eruption on her trunk and extremities. On October 3, she began vomiting and had increased arm pain and occasional arm numbness. During her initial visit to her family's primary health-care provider on October 4, radiographs of her arm and clavicle were normal. Three to five days after her initial symptoms began, the patient's speech became difficult to understand, and she had a decreased appetite, sore throat and neck pain, and temperature of 101°F. She became irritable and agitated. A rapid Group A streptococcal antigen test and slide heterophil antibody assay were negative on October 6. The patient was hospitalized on October 7 at a community hospital, where she was found to have difficulty swallowing secretions. Her tongue had a whitish coating and was protruding from her mouth. Her complete blood count and electrolytes were normal. She was prescribed methylprednisolone for possible glossitis and fluconazole for mucosal candidiasis.

On October 8, neurologic involvement became more evident, and the attending physician arranged for transfer to a university-affiliated tertiary care pediatric hospital. On arrival at the pediatric hospital, the patient was irritable, with intermittent moments of alertness, altered mental status, and lethargy. She had slurred speech and difficulty swallowing secretions and complained of a drowning sensation. Because of difficulty breathing, low oxygen saturation, and excess secretions, the patient was intubated and placed on a mechanical ventilator. A lumbar puncture was performed, indicating a white blood cell (WBC) count of 26 cells/mm^3 (normal: 0–7 cells/mm^3), a red blood cell (RBC) count of 1 cell/mm^3 (normal: 0 cells/mm^3), a protein level of 28 mg/dL (normal: 15–45 mg/dL), and a glucose level of 89 mg/dL (normal: 40–70 mg/dL). Vancomycin, cefotaxime, and acyclovir were administered for the presumptive diagnosis of meningoencephalitis. On the second day of hospitalization, the patient experienced episodes of lethargy, somnolence, generalized skin flushing (associated with vancomycin administration), and hypersalivation.

* The patient recovered completely.

INSIDE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

Initial interviews of family members indicated that the patient frequently was exposed to healthy-appearing household cats and dogs but to no other animals. On the third day of hospitalization, the patient's primary-care physician told staff members at the pediatric hospital that a babysitter suggested the patient might have sustained an animal scratch or bite during June 2006. Family members did not know what type of animal might have scratched her. However, in spite of her endotracheal intubation, the patient was able to indicate that a bat had scratched or bit her. On the same day, serum, saliva, cerebrospinal fluid, and a skin biopsy from the nape of the neck (nuchal sample) were sent to CDC for rabies virologic testing, and a serum rabies-virus–specific antibody test was positive. Reverse transcription–polymerase chain reaction (RT-PCR) performed on saliva and skin samples also were positive for rabies virus amplicons, and direct fluorescent antibody (DFA) staining of the skin biopsy was positive for detection of rabies virus antigens. The patient had not received a rabies vaccine or rabies PEP.

After rabies was confirmed, the Wisconsin rabies treatment protocol (*1*) was initiated, including antiexcitatory and antiviral therapy with phenobarbital, midazolam, ketamine, and amantadine with aggressive supportive care. On the sixth day of hospitalization, ribavirin was administered intravenously, under a Food and Drug Administration (FDA) emergency use investigational new drug protocol.[†] Coenzyme Q10, L-arginine, tetrahydrobiopterin, and vitamin C also were administered in an attempt to replenish neurotransmitter substrates. During hospitalization, the patient experienced multiple complications, including increased intracranial pressure, bouts of diabetes insipidus, syndrome of inappropriate secretion of antidiuretic hormone (SIADH), reversible pancreatitis secondary to ribavirin, intracranial venous sinus thrombosis, and cerebral and cerebellar herniation. In spite of a reduction in sedation drugs, the patient never regained consciousness. Because of a deteriorating clinical condition and poor prognosis, life support was withdrawn. The patient died on November 2, 2006, on the twenty-sixth day of hospitalization. Rabies virus antigen was detected in brain tissue collected postmortem.

Public health investigation. The patient's mother reported that in mid-June, the girl had awakened her during the night and said that a bird or bat had flown into her bedroom window and bitten her. The mother saw a small mark on the girl's arm, which the mother washed and treated with an over-the-counter first aid treatment. The mother then went to the girl's bedroom to see whether an animal was present. Finding none,

[†] Additional information on emergency use of investigational new drugs is available at http://www.fda.gov/cder/about/smallbiz/faq.htm.

The *MMWR* series of publications is published by the Coordinating Center for Health Information and Service, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

Suggested Citation: Centers for Disease Control and Prevention. [Article title]. MMWR 2007;56:[inclusive page numbers].

she assumed that the incident was a nightmare, not uncommon for the girl. Approximately 2–3 days later, an older sibling took a dead bat away from the family cat; however, the mother did not associate this event with the previous incident and did not seek rabies PEP for the girl. The mother later reported that at the time of the incident, a bedroom window was probably open without a screen in place.

After genetic sequencing of amplicons obtained from the patient's skin and saliva, on October 14, CDC characterized the infecting agent as a rabies virus variant associated with the silver-haired bat, *Lasionycteris noctivagans*. ISDH recommended rabies PEP for persons who had been exposed to the patient's saliva, from 7 days before onset of initial symptoms through the time of her death. A total of 66 persons received PEP, including seven members of the patient's immediate family, a health-care worker at the patient's primary-care site, nine staff members at the first hospital in which she was treated, an ambulance service worker, 17 staff members at the pediatric hospital, and 31 persons from the patient's school and community.

California

Case report. On November 15, 2006, a boy aged 11 years had sore throat, fatigue, and fever (101°F). He was taken to his pediatrician's office on November 16 for a previously scheduled childhood vaccination related to his recent immigration from the Philippines on October 2, 2006. He received a diagnosis of pharyngitis and was prescribed amoxicillin; the vaccinations were deferred. That evening, the boy was taken to a hospital emergency department (ED) with chest tightness, dysphagia, and insomnia. He had tachycardia (128 beats/min) and hypertension (148/99 mmHg) but no fever; his respiratory rate and oxygen saturation level were normal.

During the next several hours in the ED, the boy experienced irregular lip and mouth movements, hallucinations, and agitation. Rabies-associated signs such as aerophobia, hydrophobia, profuse salivation, and copious oral secretions were noted, and he was transported to a tertiary care pediatric hospital. Because the possibility of rabies was raised by providers at the referring hospital, infection-control measures were initiated at the pediatric hospital, including contact and droplet precautions.

The patient was admitted to the pediatric intensive care unit (PICU). He had profuse salivation and required tracheal intubation, and he experienced intermittent altered mental status. In the ED and subsequently in the PICU, the patient experienced hemodynamic instability associated with sedative administration, and he required cardiac resuscitation. An electrocardiogram showed sinus tachycardia with diffuse ST–T wave changes, and an echocardiogram indicated high systemic vascular resistance and secondary cardiomyopathy. A lumbar puncture indicated a WBC count of 8 cells/mm^3, RBC count of 0 cells/mm^3, a protein level of 25 mg/dL, and a glucose level of 128 mg/dL. On the basis of the patient's history, clinical signs, and symptoms, he received ketamine and midazolam infusions on the first hospital day for control of dysautonomia, as described in the Wisconsin rabies treatment protocol (*1*).[§]

Overnight, after consultation with the California Department of Health Services (CDHS), samples were obtained for rabies diagnosis, including corneal impressions, cerebrospinal fluid, serum, and saliva. On the second hospital day, the samples were sent to CDC and the CDHS Viral and Rickettsial Disease Laboratory. Rabies virus antigens were detected in the corneal impressions by DFA on November 18. After receiving this result, physicians from the hospital consulted with CDHS, CDC, and the physicians who developed the Wisconsin protocol therapy, and intravenous ribavirin and enteral amantidine, tetrahydrobiopterin, and coenzyme Q10 were administered.

The patient's family was asked about possible animal exposures. Although the parents were unaware of any specific incidents, two siblings recalled that the patient had been bitten by a dog approximately 2 years previously, when he was living in the Philippines. He did not receive rabies PEP at that time.

At CDC, rabies virus RNA was detected by RT-PCR in patient saliva samples obtained on the third hospital day. The gene sequences were similar to those of a canine rabies virus variant from the Philippines. Rabies virus antigen was detected by DFA in a nuchal biopsy that was obtained on the fourth hospital day. Serology for detection of rabies virus antibodies was performed daily by an indirect immunofluorescent assay and was negative until the twelfth hospital day, when an immunoglobulin G (IgG) titer of 1:128 was detected. The following day, the serum IgG titer increased to 1:256, and the immunoglobulin M (IgM) titer was 1:10. Rabies virus IgG was first detected in the cerebrospinal fluid on the fourteenth hospital day, with a titer of 1:8. A repeat nuchal biopsy was performed on the twentieth hospital day to assess viral clearing; rabies virus antigen was detected, but the staining intensity was less prominent and had a less organized pattern than the previous biopsy.

The patient experienced multiple complications while hospitalized, including autonomic lability, SIADH, renal insufficiency, superficial thrombophlebitis of the left lower extremity, cerebral artery spasm, subclinical seizures, mild pan-

[§] Medical College of Wisconsin. Rabies protocol. Available at http://www.mcw.edu/rabies.

creatic enzyme elevation attributed to ribavirin, and progressive heart block requiring transvenous pacing. Cerebral perfusion was monitored daily via transcranial Doppler. Additional anticonvulsant therapy was initiated on the eighteenth hospital day because of seizures. A continuous electroencephalogram (EEG) indicated bursts of electrical brain activity followed by little brain activity (i.e., burst-suppression pattern), and by the twenty-first hospital day indicated that almost no brain activity remained. Transcranial Doppler sonography results remained within normal limits.

On the twenty-fourth hospital day, the patient had diabetes insipidus, and the EEG indicated almost no electrical brain activity. A cranial computed tomography scan on the same day indicated loss of differentiation of the grey-white boundary of the brain and diffuse cerebral edema. Transcranial Doppler sonography indicated a high resistive index with no diastolic flow. Midazolam infusion was discontinued. After discussions between the family and the care team, life support was withdrawn on December 13, the twenty-seventh hospital day, and the patient died. Rabies virus antigen was detected in brain tissue collected postmortem.

Public health investigation. To identify exposures to the patient and the need for rabies PEP among identified contacts, CDHS distributed rabies assessment tools (which vary according to exposure scenario) to the public health department in San Joaquin County, where the patient first became ill, and in Alameda County, the location of the pediatric hospital. All 13 members of the patient's family were identified as potentially exposed because they had shared food and drink with the patient and reported contact with the patient's saliva; all received PEP. None of the three staff members at the primary-care physician's office or two emergency-transport personnel were determined to require PEP. Health-care workers at the hospital in San Joaquin County were interviewed, and eight of 22 elected to begin PEP because of potential contact with saliva. No additional interventions were deemed necessary in San Joaquin County. Twenty-four health-care workers were interviewed at the pediatric hospital in Alameda County. Three received PEP for potential exposure to saliva through mucous membranes or uncovered breaks in the skin.

Reported by: *JC Christenson, MD, Riley Hospital for Children; BM Holm, MD, S Lechlitner, Marshall County Health Dept; JF Howell, DVM, Mona Wenger, Indiana State Dept of Health. A Roy-Burman, MD, CJ Hsieh, MD, L LaBar, A Petru, MD, S Davis, MD, N Simons, MD, Children's Hospital and Research Center at Oakland; P Apolinario, MD, San Joaquin General Hospital; K Furst, MD, San Joaquin County Public Health Dept; B Benjamin, MD, Alameda County Public Health Dept; LJ Christie, MD, D Schnurr, PhD, CA Glaser, MD, DVM, J Rosenberg, MD, B Sun, DVM, California Dept of Health Services. RE Willoughby, MD, Children's Hospital of Wisconsin, Milwaukee. CE Rupprecht, VMD, PhD, Div of Viral and Rickettsial Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases, CDC.*

Editorial Note: During 2000–2006, a total of 19 of the 24 human rabies cases reported in the United States were acquired indigenously (*2*). The history of exposure to a bat given by the patient in Indiana described in this report and the identification of a specific bat rabies virus variant support the explanation of indigenous rabies acquisition via bat bite. In contrast, the history of a dog bite in the patient from California described in this report, even though the bite occurred years before his immigration to the United States, suggests acquisition of rabies in the Philippines; this is supported by isolation and identification of a specific canine-associated rabies virus variant found in the Philippines. Typical rabies incubation periods vary from 1 to 3 months after exposure, but longer intervals have been documented (*3*).

Human rabies is preventable with proper wound care and timely, appropriate administration of human rabies immune globulin and rabies vaccine before onset of clinical symptoms (*4*). PEP is recommended for all persons who have been bitten or scratched by an animal suspected to have rabies virus and for all persons whose mucous membranes have been exposed to the virus.

Twenty-seven health-care workers received PEP as part of the investigations in Indiana and California. Previous reports have described administration of PEP to contacts of humans with rabies (*5*). The indications for PEP among health-care workers who care for patients with rabies include exposure of mucous membranes or open wounds to infectious body fluids or tissue (e.g., saliva, tears, cerebrospinal fluid, or neurologic tissue) from the patient. Adherence to standard infection-control precautions minimizes the risk for health-care workers' exposure to rabies (*4*).

During 2004, the first documented survival of a patient who had not received preexposure vaccination or rabies PEP occurred in a patient from Wisconsin. Treatment for this patient included an intensive protocol that included drug-induced coma and administration of antiviral drugs (*1*). However, the benefits of any particular experimental regimen have not been determined, and no single specific course of therapy for rabies in humans has been demonstrated effective after clinical signs manifest (*6*).

Rabies is usually a fatal illness in humans. To consider use of the Wisconsin rabies treatment protocol, the disease must be diagnosed as early in the course as possible, which requires enhanced clinical awareness of the disease among health-care providers. Rabies should be included in the differential diagnosis of any unexplained acute, rapidly progressive viral encephalitis. Although initial signs and symptoms of rabies are nonspecific, a history of an animal bite or travel to a rabies-indigenous country, combined with clinical signs such as paresthesia, hypersalivation, dysphagia, hydrophobia or aerophobia, behavioral changes, or sudden autonomic instability, should lead to a strong suspicion of rabies. Rapid diagnosis of rabies virus infection can be beneficial to the treatment of the patient and can facilitate appropriate prophylaxis for exposed persons. In addition to current measures, other national and international interventions are needed to raise awareness, improve health education, expand diagnostic testing, and improve rabies prevention, control, and treatment.

Acknowledgments

This report is based, in part, on contributions by I Kuzmin, MD, M Niezgoda, MS, L Orciari, MS, A Velasco, MS, and P Yager, CDC.

References

1. Willoughby RE Jr, Tieves KS, Hoffman GM, et al. Survival after treatment of rabies with induction of coma. N Engl J Med 2005;352:2508–14.
2. Blanton JD, Krebs JW, Hanlon CA, Rupprecht CE. Rabies surveillance in the United States during 2005. J Am Vet Med Assoc 2006;229:1897–911.
3. Smith JS, Fishbein DB, Rupprecht CE, Clark K. Unexplained rabies in three immigrants in the United States. A virologic investigation. N Engl J Med 1991;324:205–11.
4. CDC. Human rabies prevention—United States, 1999: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1999;48(No. RR-1).
5. Noah DL, Drenzek CL, Smith JS, et al. Epidemiology of human rabies in the United States, 1980 to 1996. Ann Intern Med 1998;128:922–30.
6. Jackson AC, Warrell MJ, Rupprecht CE, et al. Management of rabies in humans. Clin Infect Dis 2003;36:60–3.

Use of Niacin in Attempts to Defeat Urine Drug Testing — Five States, January–September 2006

In addition to its use as a nutritional supplement, niacin (nicotinic acid or vitamin B3) is medically prescribed to treat hyperlipidemia and hypercholesterolemia. Use of niacin in low doses usually leads to few adverse drug reactions (ADRs); however, at larger doses, niacin can cause skin flushing, itching, and occasionally more serious effects (*1*). The 2005 annual report of the American Association of Poison Control Centers documented 3,109 reports of exposures to niacin (*2*). During 2006, the Rocky Mountain Poison and Drug Center (RMPDC) in Denver, Colorado, received multiple calls regarding ADRs after nonmedical use of niacin. A review of call records indicated various uses of niacin, including attempts to alter or mask results of urine drug tests, although no scientific evidence exists that ingestion of niacin can alter a drug test result. To determine the extent of niacin use in attempts to alter drug test results, reports to RMPDC of niacin ADRs were reviewed for the period January–September 2006. The results identified 18 persons who reported nonsuicidal, intentional, nonmedical reasons for using niacin, including eight who specified altering drug test results as their reason for using niacin. Ten other persons, among an additional 18 who offered no reason for niacin use, were categorized as possible users of niacin to try to alter drug test results because of their ages or the amount of niacin ingested. Clinicians, especially those whose patients include teens and young adults, should be aware of the potential use of niacin in attempts to defeat urine drug tests.

RMPDC serves Colorado, Hawaii, Idaho, Montana, and southern Nevada, a total population of approximately 10 million. RMPDC staff members searched their database for telephone calls reporting niacin exposures during January–September 2006. Calls regarding niacin exposures were divided into six categories: 1) unintentional dosing errors in therapeutic users, 2) ADRs after therapeutic use, 3) pediatric unintentional exposures, 4) suicide attempts, 5) ADRs with no reason given for niacin use, and 6) ADRs after nonsuicidal, intentional, nonmedical use. Data collected included the person's age, sex, circumstances of exposure, symptoms, and outcome. Persons who gave no reason for niacin use but were aged <30 years or who reported taking at least 1,000 mg or "large amounts" of niacin in one ingestion were cateogorized as possible users of niacin to defeat urine drug testing. The study was approved by RMPDC's institutional review board and granted a waiver of consent.

A total of 92 calls (72 from persons at home and 20 from health-care providers) reported exposures to niacin. Thirty calls (33%) reported dosing errors or ADRs after therapeutic use, 23 (25%) referred to unintentional pediatric exposures, and 18 (20%) reported ADRs after nonsuicidal, intentional, nonmedical use. An additional 18 calls (20%) reported niacin ADRs with no reason stated for the exposure. Three calls (3%) described attempted suicides.

Among the 18 persons who said their ADRs resulted from nonsuicidal, intentional, nonmedical use of niacin, the median age, excluding three adults of unknown ages, was 18 years (range: 15–50 years). Eight of the 18 persons said they took niacin (1,000 mg–8,000 mg) to alter or mask a drug screening; eight others said they took niacin (400 mg–5,000 mg) to "purify, cleanse, or flush" their bodies; and two said they used niacin as a diet pill. Among the 18 persons who gave no reason for niacin use, eight were aged <30 years, and two patients of unknown age reported taking a 2,000-mg dose and "large amounts" of niacin, respectively; under the case definition, those 10 persons were categorized as possible users of niacin to defeat urine drug testing.

Calls regarding the 18 persons who either said their ADRs resulted from attempts to alter drug test results or who were categorized as possible users of niacin for that purpose came from all five states covered by RMPDC. Twelve calls came from Colorado, two from Idaho, and one each from Hawaii, Montana, and southern Nevada; one call came from California via a manufacturer's hotline telephone number. Among the 28 who either gave a nonmedical reason for niacin use (18 persons) or who stated no reason but were categorized as possible users of niacin to alter drug test results (10 persons), the most common ADRs reported were tachycardia, flushed skin, rash, nausea, and vomiting. Thirteen of the 28 were treated at or referred to a health-care facility. No deaths were reported.

Reported by: *C Mendoza, MD, K Heard, MD, Rocky Mountain Poison and Drug Center, Denver Health Medical Center, Colorado.*

Editorial Note: Niacin is well established as a medical treatment for hyperlipidemia (*3*) and available by prescription in 50-mg to 500-mg tablets or capsules. The initial recommended therapeutic daily dose is 100 mg, three times a day, titrated to a maximum daily dose of 1,000 mg (*4*). Extended-release niacin tablets and capsules (at 125 mg–1,000 mg) also are available by prescription, usually in a dose of 500 mg at bedtime, to a maximum of 2,000 mg per day. The therapeutic use of niacin often is limited by dermatologic and gastrointestinal ADRs (e.g., tachycardia, flushing, rash, nausea, vomiting, or abdominal pain). These effects usually are self-limited and are more common with dosages >1,000 mg per day, but can occur at any dose. Hepatotoxicity is a rare but serious adverse effect, usually associated with chronic use (*5*).

No scientific evidence indicates that taking niacin can alter a urine drug test result. However, readily accessible information on the Internet lists ingestion of niacin as a way to prevent detection of tetrahydracannabinol (THC), the main psychoactive ingredient of marijuana. An Internet search on the words "niacin" and "marijuana" can produce tens of thousands of results.

In addition to sales as a prescription drug, niacin is sold over the counter (in 100-mg to 500-mg tablets) and generally is regarded as a safe nutritional supplement with well-known dermatologic and gastrointestinal ADRs that usually are self-limited and resolve with supportive care (*1*). Death from acute overdose has not been reported, and a minimum lethal dose has not been established (*6*). However, severe effects in some patients have been reported. A report in press on use of niacin to defeat urine drug tests describes four cases of niacin toxicity that included hepatotoxicity, metabolic acidosis, variations in blood glucose, neutropenia, and electrocardiographic effects (*7*). Two of the four patients had life-threatening ADRs; one had taken 5,500 mg of niacin during a 36-hour period, and the other had taken 2,500 mg during a 48-hour period.

The findings in this report are subject to at least four limitations. First, the data were collected retrospectively from the RMPDC database; although a specific data set was gathered for each case, persons might have misrepresented the circumstances of their niacin use, leading to misclassification, underreporting of dosages, or inaccurate reporting of symptoms. Second, persons who did not cite a reason for using niacin and were aged <30 years and persons who took more than 1,000 mg or "large amounts" of niacin were categorized as possible users of niacin to alter drug test results; however, those persons might have used niacin for other reasons, including treatment of hyperlipidemia. Third, poison center data might not be representative of all niacin exposures; patients with less severe or no symptoms from niacin use would not contact a poison center. Finally, RMPDC is a regional poison center, and the use of niacin to attempt to alter or mask drug test results might be a regional phenomenon. Further research of national poison center data can provide additional information regarding nonmedical use of niacin.

Public health measures such as school-based education and authoritative Internet communications might help prevent ADRs if directed at those who are prompted to misuse niacin by claims that are not substantiated scientifically. This report underscores the importance of taking medications in appropriate doses and for approved indications as directed by a health-care provider. With the Internet now a common source of medical information, clinicians can expect to encounter patients with unusual ADRs resulting from nonscientific drug use (*8*) and should familiarize themselves with these effects and counsel their patients accordingly.

References

1. CDC. Niacin intoxication from pumpernickel bagels—New York. MMWR 1983;32:305.
2. Lai MW, Klein-Schwartz W, Rodgers GC, et al. 2005 annual report of the American Association of Poison Control Centers' national poisoning and exposure database. Clin Toxicol 2006;44:803–932.
3. Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults. Executive summary of the third report of The National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). JAMA 2001;285:2486–97.
4. Poisondex® system. Greenwood Village, CO: Thomson Micromedex.
5. Temple BR. Vitamins. In: Dart RC, Caravati EM, McGuigan M, et al, eds. Medical toxicology. 3rd ed. Philadelphia, PA: Lippincott Williams & Wilkins, 2004:1022–3.
6. Bloomquist SE, Dart RC. Cardiovascular drugs. In: Dart RC, Caravati EM, McGuigan M, et al, eds. Medical toxicology. 3rd ed. Philadelphia, PA: Lippincott Williams & Wilkins, 2004:645–7.
7. Mittal MK, Florin T, Perrone J, Delgado JH, Osterhoudt KC. Toxicity from the use of niacin to beat urine drug screening. Ann Emerg Med. In press. 2007.
8. Cone EJ. Ephemeral profiles of prescription drug and formulation tampering: evolving pseudoscience on the Internet. Drug Alc Depend 2006;83S:S31–9.

Hypothermia-Related Mortality — Montana, 1999–2004

Hypothermia, defined as a core body temperature of <95°F (35°C), occurs in persons exposed to excessive cold. Although hypothermia can be fatal, it also is preventable. Risk factors for death from hypothermia include advanced age, substance abuse, altered mental status, and increased contact with substances that promote heat loss, such as water (*1*). Montana has an intensely cold and long winter. In December, the average daily minimum temperature is approximately 18.0°F (-7.7°C) and can remain at that level until March. For the entire year in Montana, the average daily minimum temperature is 35.9°F (2.2°C) (*2*). During the period 1999–2004, Montana had the second highest (after Alaska) average annual hypothermia-related mortality rate (1.08 deaths per 100,000 population) in the United States, approximately five times greater than the U.S. rate overall. This report describes three examples of case reports of hypothermia-related deaths in Montana during 2005–2006, summarizes hypothermia-related mortality in the state during 1999–2004 (the most recent period for which annual data were available), and discusses hypothermia risk factors and prevention measures. Enhanced education and intervention strategies, particularly targeted to older adults, might reduce the number of deaths from hypothermia in Montana.

Case Reports

Case 1. In November 2005, a man aged 88 years left home to work in the fields. When he did not return for dinner, his wife notified a neighbor, who found the man pinned at the thighs between a flatbed trailer and livestock panels. The man was in pain and said he was cold; he had diminished level of consciousness. The ambient air temperature was 47.0°F (8.3°C) with 13-mph winds. The man was extricated by the neighbor and brought to the hospital. He had moderate muscle stiffness and was unable to respond to commands. His core body temperature was 84.7°F (29.3°C). The patient died 2 days later in the hospital. Primary cause of death was severe hypothermia; secondary causes were crush injuries to the thighs and multiorgan failure.

Case 2. In November 2005, a man aged 49 years left his automobile in a wooded area to go deer hunting just before sunset. He became lost in a forest and walked 6 miles across rugged and mountainous terrain. While he was missing, ambient temperatures ranged from 28.0°F to 40.0°F (-2.2°C to 4.4°C). A mixture of wet rain and snow fell during the night and most of the next day. Search crews tracked him and found him the next night, 30 hours after he had left his vehicle. The man was found dressed in thermal underwear, jeans, wool socks, sneakers, a cotton shirt, an oil-cloth coat, and a cowboy hat. All of his clothing was wet, and he smelled of wood smoke. He was carrying his rifle and a global positioning system unit. Trackers determined that the man had stumbled and fallen several times. When found, the man was unresponsive and cyanotic; his body was stiff, and he had no detectable respiration or pulse. After several hours of backcountry transport, the man was pronounced dead. The coroner certified death as fatal arrhythmia resulting from severe hypothermia.

Case 3. In February 2006, a woman aged 43 years attempted to drive home late at night down a little-traveled road. When she did not arrive home, her husband looked for her along the road but could not find her in the dark and assumed she had spent the night in town. Ambient air temperatures that night ranged between -10.0°F and -15.0°F (-23.3°C to -26.1°C). The woman was found the next morning by a rancher who noticed her car, which had gone off the road and down a steep embankment after she had apparently missed a sharp turn. She was found dead in her car. On autopsy, she had no significant traumatic injuries but a blood alcohol concentration of 0.15 g/dL, nearly twice the state legal limit of 0.08 g/dL for drivers. Cause of death was hypothermia.

Hypothermia-Related Mortality, 1999–2004

Data on hypothermia-related deaths in Montana were obtained from the Compressed Mortality File and accessed via CDC's Wonder database.* *The International Classification of Diseases, Tenth Revision* (ICD-10) was used to identify the external cause of mortality: exposure to excessive natural cold. Hypothermia deaths were identified by ICD-10 code X31 (*3*).

During 1999–2004, Montana reported 59 hypothermia-related deaths, ranging from seven deaths in 2002 and 2004 to 13 deaths in 2001 (Table). Thirty-one (53%) victims were aged ≥65 years, and 20 (34%) were aged 45–64 years. Because fewer than 20 hypothermia deaths were recorded in Montana each year, producing statistically unreliable annual hypothermia-related death rates, an aggregate crude rate was calculated by combining data for the entire period 1999–2004. Montana's 59 deaths during that period produced a crude rate for hypothermia-related mortality of 1.08 per 100,000 population, approximately five times greater than that of the United States as a whole (3,881 deaths, for a crude rate of 0.23 per 100,000 population) (Table).

Reported by: *S Halvorson, MD, D Givens, MD, S Helgerson, MD, K Johnson, DVM, Montana Dept of Health. C Sanchez, MD, E Azziz-Baumgartner, MD, A Wolkin, MPH, D Batts, MD, M Belson, MD, C Rubin, DVM, M McGeehin, PhD, Div of Environmental Hazards*

* Available at http://www.cdc.gov/nchs/products/elec_prods/subject/mcompres.htm and at http://wonder.cdc.gov/cmf-ICD10.html, respectively.

TABLE. Hypothermia-related mortality rates,* by year — Montana and United States, 1999–2004

	Montana		United States	
Year	No. of deaths	Crude rate†	No. of deaths	Crude rate
1999	8	0.89	598	0.21
2000	12	1.33	742	0.26
2001	13	1.43	599	0.21
2002	7	0.77	646	0.22
2003	12	1.31	620	0.21
2004	7	0.76	676	0.23
Total	**59**	**1.08**	**3,881**	**0.23**

* Per 100,000 population.
† Rates based on fewer than 20 deaths are considered not statistically reliable.

and Health Effects, National Center for Environmental Health; L Hausman, MPH, EIS Officer, CDC.

Editorial Note: This report supports previous U.S. findings that persons aged >65 years and males are at greater risk for death by hypothermia (*1,4*). Older age might be a risk factor because of lower metabolic rate, which in turn might prevent maintaining a normal body temperature when indoor or outdoor temperatures fall below 64.4°F (18.0°F) (*1*). In addition, alcohol consumption is a risk factor because it triggers increased heat loss via vasodilation (*5*). Alcohol and drugs also can alter a person's mental status, impairing behavioral responses and increasing the risk for exposure to cold. Contact with cold water or other substances that promote heat loss also can cause hypothermia through conduction (the transfer of heat via contact with a cooler object) (*5*). Although only one person aged <15 years died from hypothermia in Montana during the study period, populations at risk for hypothermia also can include very young children and persons with comorbid medical conditions. These persons might have difficulty regulating their body temperature, thus increasing their risk for hypothermia (*6*).

Hypothermia is classified as mild, moderate, or severe, as determined by core body temperature (*5*). In severe cases of hypothermia, the brain is affected and victims are unable to think clearly or move well, which can further exacerbate their exposure. Warning signs of hypothermia in adults are shivering, exhaustion, confusion, fumbling hands, memory loss, slurred speech, and drowsiness (*7*).

During periods of excessively cold weather, persons can reduce their risk for hypothermia by taking the following precautions: 1) covering exposed skin and wearing a hat to prevent heat loss, 2) avoiding overexertion that might cause sweating and increased cardiac stress, 3) wearing loose-fitting layers of clothing that trap heat close to the body, 4) avoiding consumption of alcohol and other drugs that can impair judgment, and 5) staying dry by avoiding contact with cold substances that promote heat loss (*8*). In addition, persons living or traveling in cold environments can reduce their risk for hypothermia by preparing a winter storm plan, assembling a disaster supplies kit, being aware of storm warnings and the wind chill factor, leaving a travel itinerary with a friend or family member, carrying a cellular telephone, and avoiding travel during winter storms (*9*). Enhanced public health education and community intervention strategies might reduce the risk for hypothermia in persons at greatest risk.

References

1. CDC. Hypothermia-related deaths—United States, 2003–2004. MMWR 2005;54:173–5.
2. Western Regional Climate Center. Western U.S. climate historical summaries. Reno, NV: Western Regional Climate Center. Available at http://www.wrcc.dri.edu/climsum.html.
3. World Health Organization. International statistical classification of diseases and related health problems, tenth revision. Geneva, Switzerland: World Health Organization; 1992.
4. Weinberg AD. Hypothermia. Ann Emerg Med 1993;22:370–7.
5. McCullough L, Arora S. Diagnosis and treatment of hypothermia. Am Fam Physician 2004;70:2325–32.
6. CDC. Hypothermia-related deaths—United States, 1999–2002 and 2005. MMWR 2006;55:282–4.
7. CDC. Extreme cold: a prevention guide to promote your personal health and safety. Atlanta, GA: US Department of Health and Human Services, CDC; 2004. Available at http://www.bt.cdc.gov/disasters/winter/guide.asp.
8. Mayo Foundation for Medical Education and Research. Hypothermia: tools for healthier lives; 2005. Available at http://www.mayoclinic.com/health/hypothermia/ds00333/dsection=8.
9. American Red Cross. Talking about disaster: guide to standard messages. Are you ready for a winter storm? Washington, DC: American Red Cross, 1998; 147–57.

Brief Report

Gastroenteritis Among Attendees at a Summer Camp — Wyoming, June–July 2006

On July 19, 2006, the Environmental Protection Agency (EPA) notified the Wyoming Department of Health (WDH) of an *Escherichia coli*-positive well-water sample, indicating fecal contamination, that had been submitted from a Wyoming summer youth camp after the camp manager noticed cases of gastroenteritis among campers and staff members. This report describes the subsequent investigation by WDH, the Wyoming Department of Agriculture (WDA), and the Wyoming Department of Environmental Quality (WDEQ), which identified *Norovirus* and *Campylobacter* species as the etiologic agents.

WDH staff contacted camp managers on July 19; the following day, WDA, WDEQ, and WDH jointly conducted an on-site investigation of the camp, which was located in a mountainous region of southeastern Wyoming. The preliminary investigation suggested a waterborne mechanism of transmission.

The camp usually operated during May–September only, typically hosting campers for approximately 1 week. In 2006, the facility had opened in May for adult weekend retreats, and a longer adult retreat was held during mid-June. No illnesses were reported at either time. The first campers to experience illness were children who attended camp during the week of June 25–July 1, 2006 (Figure). Onset of illness for the first laboratory-confirmed case of *Norovirus* was July 1, 2006. Additional groups arrived at the camp during each of the following 3 weeks. The number of weekly camp attendees ranged from 29 to 73. The age range of attendees was 7 to 65 years,* although typical groups were composed of adult staff members and campers who were adolescent boys or girls.

Active case finding and surveillance began after WDH was notified of the *E. coli*-positive well-water sample. Activities included ascertaining the extent of the outbreak, confirming that the camp was the source of exposure, and interviewing all ill persons among camp attendees. Laboratory testing of fecal samples from symptomatic attendees was conducted to confirm the outbreak etiology. In addition, public-health nursing offices were contacted in the home towns of campers, Health Alert Network (HAN) faxes were sent to health-care providers throughout Wyoming, and both *Epi-X* and the foodborne disease listserv operated by CDC were used to identify ill campers residing in other states. The camp voluntarily closed on July 19 as recommended by WDH until improvements in the camp's water and septic systems could be implemented.

A case was defined as an illness lasting more than 24 hours that included three or more episodes of diarrhea, vomiting, or both, in a camper or staff member after arriving at or leaving the camp during June 1–July 19, 2006. Lists of camp attendees were obtained from camp managers, and a retrospective cohort study was conducted by administering a telephone questionnaire to 210 of 277 (75.8%) campers and staff members. Median age of both ill persons and those who were not ill was 12 years. A total of 141 (67.1%) cases were identified among the 210 interviewed campers. Diarrhea was reported by 102 (72.3%) persons, vomiting by 92 (65.2%), and stomach cramps by 89 (63.1%).

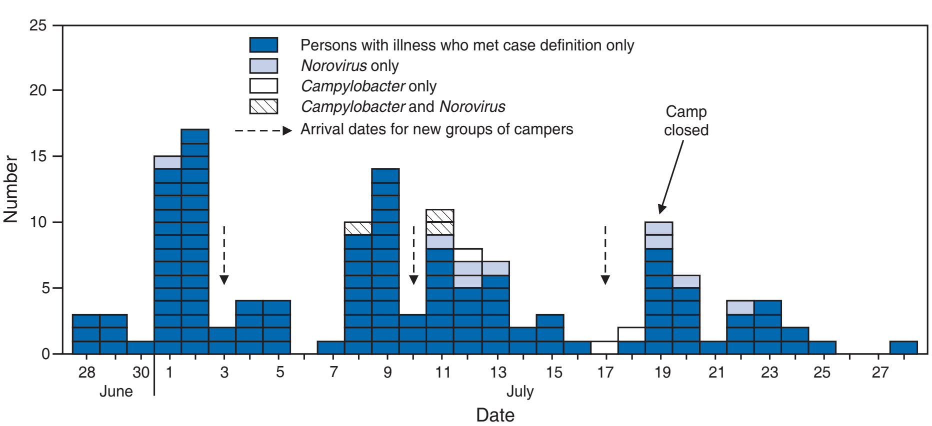
Stool samples were requested from symptomatic interviewees; 23 were obtained and tested for bacterial and viral pathogens at the Wyoming Public Health Laboratory (WPHL). Fifteen of the 23 (65.2%) stool samples were positive for *Norovirus, Campylobacter jejuni,* or both. *Norovirus* genogroup 1 alone was identified by reverse transcription–polymerase chain reaction (RT-PCR) in five samples, and genogroup 2 in four samples; *C. jejuni* alone was cultured from three samples; and both *C. jejuni* and *Norovirus* genogroup 1 were identified in three samples. All six *C. jejuni* clinical case isolates had indistinguishable DNA pulsed-field gel electrophoresis (PFGE) patterns. Persons more likely to develop gastroenteritis were those who drank camp well water from an outdoor spigot (relative risk [RR] = 1.3, 95% confidence interval [CI] = 1.00–1.66, p=0.048) and those who roomed with an ill roommate (RR = 1.50, CI = 1.13-1.98, p=0.005).

Two wells provided the camp with water, which was not treated before use. The wells were 30–50 feet deep, 25 feet apart, and approximately 120 feet from an underground metal septic tank that had been installed in the 1950s. Although these distances comply with the Wyoming State Engineer's Office guidelines for appropriate distancing of wells and septic systems, the guidelines emphasize that minimum distances are site dependent, should take into account local geology, and must be professionally evaluated before the required septic-tank construction permits are issued. The septic tank was filled to capacity when observed during site visits on July 20 and August 3 and had not been maintained adequately over the years. The system did not have a properly constructed leach field (i.e., soil absorption area), and the ground immediately downhill from the tank was damp with sewage. Food-preparation areas had been inspected by WDA before this outbreak investigation and were in compliance with WDA regulations.

Well-water samples collected on July 20 were positive for *E. coli*. WDEQ and WDH investigators inspected the camp again on August 3, approximately 2

* Excludes a child aged 2 years, who was the child of a staff member.

FIGURE. Number of persons with illness who met case definition and laboratory-confirmed cases of *Campylobacter* and *Norovirus* infection at a summer camp, by date of illness onset — Wyoming, June–July 2006



weeks after the camp's closure. Well-water samples collected from the camp at this time were tested at CDC and were negative for both *Campylobacter* and *Norovirus* by culture and PCR. However, the 2-week delay from camp closure to sample collection might have limited the laboratory's ability to isolate the pathogens from the water system because uncontaminated groundwater might have replenished the aquifer. Septic system contents tested positive for *Norovirus* genogroups 1 and 2. Five fresh fecal samples obtained from cattle kept in the area surrounding the camp also were cultured at WPHL. A *C. jejuni* isolate was identified in one of the samples; however, the PFGE patterns did not match those obtained from campers.

The investigators determined that although the camp met established EPA criteria defining community water sources and although it had not been subject previously to periodic EPA monitoring, the camp's water system should be regulated as a public water system. WDH and WDEQ advised camp directors to remove the septic tank and have a new system installed in an appropriate location, as determined through a professional site evaluation, to decrease the likelihood of future well-water contamination. Installation of either an ultraviolet or a chlorination disinfection unit also was recommended for additional protection. After system improvements have been completed and certified as compliant with EPA regulations, the camp's water system will be subject to periodic EPA testing guidelines and evaluated for coliforms, turbidity, and nitrate content.

This outbreak of gastroenteritis at a summer camp in Wyoming was caused by *Norovirus* and *C. jejuni,* which were simultaneously identified in stool samples from ill campers. The investigation emphasizes that multiple etiologic agents should be considered when waterborne disease is suspected and might be related to sewage or septic contamination. A similar outbreak of gastrointestinal illness involving *C. jejuni* and *Norovirus* was associated with sewage-contaminated groundwater in Ohio (*1*), and a waterborne outbreak of *Norovirus* was reported at a summer church camp in Norway (*2*). Other recent outbreaks at U.S. summer camps were caused by person-to-person transmission of *Norovirus* (*3*).

Investigators of the outbreak described in this report hypothesized that the large number of camp attendees overburdened the septic system and created a heavy demand for water from the wells, thereby reducing the groundwater level and allowing septic system effluent to contaminate the water that replenished the wells. The shallowness of the wells and their proximity to the septic tank, combined with the camp's location in a mountainous area with fractured rock aquifers and little topsoil, also might have facilitated contamination by allowing septic tank effluent to percolate to the wells through fissures in the underlying rock formations. An ongoing drought in the area likely was an additional contributing factor that permitted changes in groundwater levels, facilitating contamination. Such factors were identified in a similar outbreak in Wyoming (*4*), suggesting that alternative waste water treatment methods might be necessary where geologic conditions warrant.

Public health officials, health-care providers, and water-quality regulators should be aware of the potential for septic contamination of well water at rural summer camp sites that lack appropriate water and septic systems. In addition, before sending their children to a summer camp, parents should inquire about recent water-quality testing in the camp, particularly if it is located in a rural area where similar systems are more likely to be encountered.

Reported by: *C Van Houten, MS; L Baker, MSPH; K Weidenbach, MPH; K Bryan; T Murphy, MD, Wyoming Dept of Health. H Mainzer, DVM, J Sarisky, MPH, V Hill, PhD, C Fitzgerald, PhD, R Luce, DVM, EIS Officer, CDC.*

Acknowledgments

This report is based, in part, on contributions by W Manley, J Walford, and R Harris, Wyoming Public Health Laboratory; D Finkenbinder, Wyoming Dept of Agriculture; and L Harmon, Wyoming Dept of Environmental Quality.

References

1. O'Reilly CE, Bowen AB, Perez NE, et al. A waterborne outbreak of gastroenteritis with multiple etiologies among resort island visitors and residents: Ohio, 2004. Clin Infect Dis 2007;15:506–12 .
2. Nygard K, Vold L, Halvorsen E, et al. Waterborne outbreak of gastroenteritis in a religious summer camp in Norway, 2002. Epidemiol Infect 2004;132:223–9.
3. CDC. Norwalk-like virus outbreaks at two summer camps—Wisconsin, June 2001. MMWR 2001;50:642–3.
4. Gelting R, Sarisky J, Selman C, et al. Use of a systems-based approach to an environmental health assessment for a waterborne disease outbreak investigation at a snowmobile lodge in Wyoming. Int J Hygiene Environmental Health 2005;208:67–73.

Notice to Readers

United Nations Global Road Safety Week — April 23–29, 2007

Each year 1.2 million persons (vehicle drivers, passengers, and pedestrians) die on the world's roads; 40% of these deaths occur among persons aged ≤25 years. This year, the first United Nations Global Road Safety Week will be held in an attempt to improve road safety by increasing awareness of these preventable deaths and by promoting interventions that have had the greatest impact on road safety (e.g., safety belts, road design, helmets, and prohibitions on drinking and driving and speeding). The first Global Road Safety Week is dedicated to younger road users (*1*). In the United States, the focus is on teen drivers aged 16–19 years, whose risk for motor vehicle crash is four times greater than that for older drivers (*2*). Two of five deaths among U.S. teens are the result of a motor vehicle crash (*3*).

The World Health Organization has produced a toolkit to guide activities related to Global Road Safety Week (*1*). Other governmental and nongovernmental organizations are participating in various ways. Additional information is available at CDC (http://www.cdc.gov/ncipc/duip/grsw), the National Highway Traffic Safety Administration (http://www.nhtsa.dot.gov), and Make Roads Safe (http://www.makeroadssafe.org).

References

1. World Health Organization. First United Nations global road safety week: a toolkit for organizers of events. Geneva, Switzerland: World Health Organization; 2006. Available at http://www.who.int/roadsafety/week/en.
2. Insurance Institute for Highway Safety. Fatality facts 2005: teenagers. Arlington, VA: Insurance Institute for Highway Safety; 2006. Available at http://www.iihs.org/research/fatality_facts/teenagers.html.
3. CDC. Web-based Injury Statistics Query and Reporting System (WISQARS™). Atlanta, GA: US Department of Health and Human Services, CDC. Available at http://www.cdc.gov/ncipc/wisqars.

Notice to Readers

National Infant Immunization Week — April 21–28, 2007

The week of April 21–28, 2007, is National Infant Immunization Week (NIIW) and Vaccination Week in the Americas (VWA). During this week, hundreds of communities throughout the United States are expected to participate in NIIW-VWA by sponsoring activities emphasizing the importance of timely infant and childhood vaccination.

Immunization is one of the most effective ways to protect infants and children from potentially serious diseases. Approximately 11,000 infants are born each day in the United States; according to the recommended immunization schedule, each infant requires approximately 27 doses of vaccine (i.e., administered in 21 or 22 injections of combination vaccines) before age 2 years for protection from 14 vaccine-preventable diseases (*1*).

Kick-off events highlighting the need to achieve and maintain high childhood vaccination coverage rates will be hosted in Nevada; Colorado; Hidalgo County, Texas; and communities along the U.S.-Mexico border. Events will include education activities for providers, media events, and immunization clinics in collaboration with CDC, state and local health departments, the United States-Mexico Border Health Commission, and the Pan American Health Organization (PAHO).

NIIW is being held in conjunction with VWA. VWA, sponsored by PAHO, targets children and other vulnerable and underserved populations with low vaccination coverage rates in all countries in the Western hemisphere.

During NIIW-VWA, CDC has English- and Spanish-language public education campaign materials available to communities, including television public service announcements, posters, print advertisements, articles, and educational materials for parents and providers. Additional information about NIIW-VWA and childhood vaccination is available from CDC at http://www.cdc.gov/nip/events/niiw/default.htm. Information on VWA is available at http://www.paho.org/English/DD/PIN/vw_2007.htm.

References

1. CDC. Recommended immunization schedules for persons aged 0–18 years—United States, 2007. MMWR 2006;55:Q1–Q4.

Notice to Readers

Africa Malaria Day and Malaria Awareness Day — April 25, 2007

Malaria is a preventable and treatable parasitic disease that continues to cause at least 1 million deaths worldwide each year, with approximately 90% of these deaths occurring among young children in Africa (*1*). On April 25, 2000, government leaders from 44 African countries met in Abuja, Nigeria, and signed the Abuja Declaration, committing their countries to decreasing malaria deaths in Africa by 50% by 2010 (*2*). Since then, April 25 has been commemorated as Africa Malaria Day (AMD) worldwide. This year's theme, Free Africa from Malaria NOW!, is a reminder of the effects of malaria and underscores the possibility that current measures might soon reduce the burden of malaria in Africa. This year, April 25 also marks the first Malaria Awareness Day in the United States, declared at the White House Summit on Malaria in December 2006.

The fight against malaria recently received renewed commitment and resources. The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GF), founded in 2002, is the largest source of funding for malaria control, providing two thirds of all international financing. GF has approved $2.6 billion in grants over 5 years to programs in 85 countries. Of this, $698 million has been disbursed to 33 countries in sub-Saharan Africa.

On AMD 2005, the World Bank pledged $500 million in a 3-year intensive first phase to accelerate progress against malaria in Africa through its Global Strategy and Booster Program for Malaria Control, which aims to strengthen program design and implementation, increase intervention coverage, and improve outcomes. As of AMD 2007, the bank has committed $357 million, benefiting 14 countries in Africa.

In May 2005, the Malaria Control and Evaluation Partnership in Africa (MACEPA) at PATH,* an international nonprofit organization, partnered with Zambia to implement rapid scale-up of malaria interventions. These measures also were supported by other local and global partners. During 2004–2006, the percentages of households owning insecticide-treated nets and of young children and pregnant women sleeping under insecticide-treated nets doubled (*3*). During 2007, Zambia anticipates distributing approximately 3 million insecticide-treated nets, reaching more than 85% of eligible households with an indoor residual spraying program in 15 districts, and extending artemisinin-combination treatment coverage to all district health facilities. By the end of 2007, MACEPA will engage two more sub-Saharan countries and in 2008 up to three more to promote similar rapid scale-up of interventions.

In June 2005, the U.S. government launched the President's Malaria Initiative (PMI) (http://www.pmi.gov), pledging $1.2 billion over the next 5 years to support measures to reduce malaria deaths by 50% in each of the selected 15 sub-Saharan Africa countries† after 3 years of full implementation. CDC has worked with the U.S. Agency for International Development to implement PMI. PMI also collaborates with host ministries of health to support the National Malaria Control Strategy in each country and coordinates with the Global Fund to Fight AIDS, Tuberculosis, and Malaria; the World Bank; Roll Back Malaria; UNICEF; and other organizations. Approximately 1 year after implementation in the first three countries, PMI had reached more than 6 million persons with malaria prevention and control interventions (*4*).

In addition, other programs and groups (e.g., Nothing But Nets, a grassroots campaign of the United Nations Foundation and partners, and Malaria No More, a nonprofit organization) were recently created and collaborate with other organizations that address malaria in Africa.

* Information available at http://www.path.org.

† 2005–2006: Angola, Tanzania, Uganda; 2006–2007: Malawi, Mozambique, Rwanda, Senegal; 2007–2008: Benin, Ethiopia, Ghana, Kenya, Liberia, Madagascar, Mali, and Zambia.

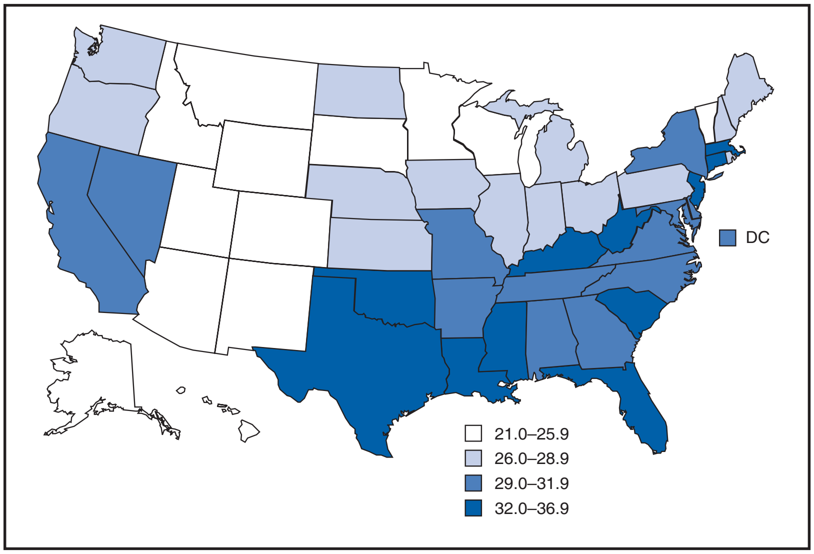
References

1. Bryce J, Boschi-Pinto C, Shibuya K, Black RE, WHO Child Health Epidemiology Reference Group. WHO estimates of the causes of death in children. Lancet 2005;365:1147–52.
2. Roll Back Malaria Partnership, World Health Organization. The Abuja Declaration and the plan of action. Geneva, Switzerland: World Health Organization; 2000. Available at http://www.rbm.who.int/docs/abuja_declaration.pdf.
3. Zambia Ministry of Health; PATH; Malaria Control and Evaluation Partnership in Africa; Zambia Central Statistical Office; CDC; World Health Organization. Zambia national malaria indicator survey 2006. Available at http://www.path.org/files/MACEPA_malaria_survey.pdf.
4. United States Agency for International Development. The President's malaria initiative. Saving the lives of mothers and children in Africa. First annual report. March 2007. Available at http://www.fightingmalaria.gov/resources/pmi_annual_report.pdf

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of All Live Births by Cesarean Delivery — National Vital Statistics System, United States, 2005



Preliminary data for 2005 indicate that 30.2% of all live births in the United States were cesarean deliveries, marking the highest U.S. total cesarean rate ever reported. Since 1996, the total cesarean rate has increased by 46%, driven by both an increase in the percentage of all women having a first cesarean and a decline in the percentage of women delivering vaginally after a previous cesarean. Cesarean rates vary considerably among states but tend to be lower in the western mountain states and upper Midwest region and higher in the Southeast and East regions.

SOURCE: National Vital Statistics System, unpublished data. Additional information is available at http://www.cdc.gov/nchs/births.htm.

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending April 14, 2007 (15th Week)*

Disease	Current week	Cum 2007	5-year weekly average[†]	Total cases reported for previous years 2006	2005	2004	2003	2002	States reporting cases during current week (No.)
Anthrax	—	—	—	1	—	—	—	2	
Botulism:									
foodborne	—	—	0	19	19	16	20	28	
infant	1	17	1	96	85	87	76	69	OH (1)
other (wound & unspecified)	2	4	1	45	31	30	33	21	AZ (1), CA (1)
Brucellosis	3	30	2	120	120	114	104	125	MN (1), FL (1), CA (1)
Chancroid	—	1	1	34	17	30	54	67	
Cholera	—	—	0	6	8	5	2	2	
Cyclosporiasis[§]	1	15	3	135	543	171	75	156	OH (1)
Diphtheria	—	—	—	—	—	—	1	1	
Domestic arboviral diseases[§,¶]:									
California serogroup	—	—	0	63	80	112	108	164	
eastern equine	—	—	—	7	21	6	14	10	
Powassan	—	—	—	1	1	1	—	1	
St. Louis	—	—	0	9	13	12	41	28	
western equine	—	—	—	—	—	—	—	—	
Ehrlichiosis[§]:									
human granulocytic	1	14	3	594	786	537	362	511	NY (1)
human monocytic	—	29	1	490	506	338	321	216	
human (other & unspecified)	1	11	1	233	112	59	44	23	CA (1)
Haemophilus influenzae,**									
invasive disease (age <5 yrs):									
serotype b	—	3	0	13	9	19	32	34	
nonserotype b	1	23	3	123	135	135	117	144	NY (1)
unknown serotype	2	77	5	223	217	177	227	153	NY (1), FL (1)
Hansen disease[§]	—	10	2	62	87	105	95	96	
Hantavirus pulmonary syndrome[§]	—	2	0	37	26	24	26	19	
Hemolytic uremic syndrome, postdiarrheal[§]	—	25	2	268	221	200	178	216	
Hepatitis C viral, acute	5	173	21	841	652	713	1,102	1,835	MI (1), MO (1), TX (1), WA (1), CA (1)
HIV infection, pediatric (age <13 yrs)[††]	—	—	6	52	380	436	504	420	
Influenza-associated pediatric mortality[§,§§]	2	43	1	41	45	—	N	N	AK (1), NY (1)
Listeriosis	3	128	10	814	896	753	696	665	PA (1), MN (1), CA (1)
Measles[¶¶]	—	5	1	52	66	37	56	44	
Meningococcal disease, invasive***:									
A, C, Y, & W-135	2	60	5	234	297	—	—	—	NY (1), FL (1)
serogroup B	1	29	3	146	156	—	—	—	WA (1)
other serogroup	1	6	1	25	27	—	—	—	FL (1)
unknown serogroup	8	214	19	703	765	—	—	—	IN (1), MN (1), TN (1), AZ (1), OR (2), CA (2)
Mumps	9	244	110	6,563	314	258	231	270	NY (1), PA (1), MN (3), AZ (1), WA (1), CA (2)
Novel influenza A virus infections	—	—	—	N	N	N	N	N	
Plague	—	—	—	17	8	3	1	2	
Poliomyelitis, paralytic	—	—	—	—	1	—	—	—	
Poliovirus infection, nonparalytic[§]	—	—	—	N	N	N	N	N	
Psittacosis[§]	—	3	0	21	16	12	12	18	
Q fever[§]	—	37	2	179	136	70	71	61	
Rabies, human	—	—	0	3	2	7	2	3	
Rubella[†††]	—	9	0	8	11	10	7	18	
Rubella, congenital syndrome	—	—	0	1	1	—	1	1	
SARS-CoV[§,§§§]	—	—	0	—	—	—	8	N	
Smallpox[§]	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome[§]	2	21	5	103	129	132	161	118	IN (2)
Syphilis, congenital (age <1 yr)	1	40	7	334	329	353	413	412	TX (1)
Tetanus	—	3	0	33	27	34	20	25	
Toxic-shock syndrome (staphylococcal)[§]	1	20	2	92	90	95	133	109	CA (1)
Trichinellosis	—	1	0	13	16	5	6	14	
Tularemia	—	2	1	89	154	134	129	90	
Typhoid fever	7	64	5	316	324	322	356	321	OH (2), NC (1), FL (1), CA (2), HI (1)
Vancomycin-intermediate *Staphylococcus aureus*[§]	—	2	—	4	2	—	N	N	
Vancomycin-resistant *Staphylococcus aureus*[§]	—	—	0	1	3	1	N	N	
Vibriosis (non-cholera *Vibrio* species infections)[§]	1	28	—	N	N	N	N	N	FL (1)
Yellow fever	—	—	—	—	—	—	—	1	

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

* Incidence data for reporting years 2006 and 2007 are provisional, whereas data for 2002, 2003, 2004, and 2005 are finalized.

† Calculated by summing the incidence counts for the current week, the 2 weeks preceding the current week, and the 2 weeks following the current week, for a total of 5 preceding years. Additional information is available at http://www.cdc.gov/epo/dphsi/phs/files/5yearweeklyaverage.pdf.

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

¶ Includes both neuroinvasive and non-neuroinvasive. Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for West Nile virus are available in Table II.

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

†† Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. Implementation of HIV reporting influences the number of cases reported. Updates of pediatric HIV data have been temporarily suspended until upgrading of the national HIV/AIDS surveillance data management system is completed. Data for HIV/AIDS, when available, are displayed in Table IV, which appears quarterly.

§§ Updated weekly from reports to the Influenza Division, National Center for Immunization and Respiratory Diseases. A total of 44 cases were reported for the 2006–07 flu season.

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

*** Data for meningococcal disease (all serogroups) are available in Table II.

††† No rubella cases were reported for the current week.

§§§ Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending April 14, 2007, and April 15, 2006 (15th Week)*

	Chlamydia†					Coccidioidomycosis					Cryptosporidiosis				
		Previous 52 weeks					Previous 52 weeks					Previous 52 weeks			
Reporting area	Current week	Med	Max	Cum 2007	Cum 2006	Current week	Med	Max	Cum 2007	Cum 2006	Current week	Med	Max	Cum 2007	Cum 2006
United States	10,239	19,778	23,524	258,982	286,168	147	151	649	2,297	2,407	27	68	301	637	746
New England	646	673	1,364	9,313	8,533	—	0	0	—	—	1	3	22	26	68
Connecticut	125	201	833	2,165	1,788	N	0	0	N	N	—	0	7	7	38
Maine§	41	47	73	751	596	—	0	0	—	—	1	0	6	7	8
Massachusetts	376	297	604	4,580	4,306	—	0	0	—	—	—	0	14	—	20
New Hampshire	31	39	69	574	508	—	0	0	—	—	—	1	5	6	—
Rhode Island§	45	63	108	970	963	—	0	0	—	—	—	0	5	—	—
Vermont§	28	20	45	273	372	N	0	0	N	N	—	1	5	6	2
Mid. Atlantic	1,773	2,509	4,163	38,940	35,173	—	0	0	—	—	8	10	33	82	122
New Jersey	—	387	543	4,311	5,524	N	0	0	N	N	—	0	1	—	9
New York (Upstate)	742	505	2,745	6,904	5,995	N	0	0	N	N	8	3	13	31	23
New York City	593	757	1,325	12,030	12,100	N	0	0	N	N	—	2	12	13	32
Pennsylvania	438	811	1,256	15,695	11,554	N	0	0	N	N	—	4	18	38	58
E.N. Central	1,279	3,201	4,484	42,154	49,464	—	1	3	10	10	9	15	110	147	173
Illinois	401	1,021	1,346	12,994	16,036	—	0	0	—	—	—	2	22	13	24
Indiana	370	376	632	6,033	6,021	—	0	0	—	—	2	1	18	12	9
Michigan	354	757	1,225	10,068	8,076	—	1	3	8	7	—	2	9	31	30
Ohio	18	642	2,265	7,898	12,978	—	0	2	2	3	7	5	33	55	63
Wisconsin	136	374	528	5,161	6,353	N	0	0	N	N	—	4	53	36	47
W.N. Central	217	1,186	1,445	14,433	18,055	—	0	54	3	—	3	12	77	95	103
Iowa	140	155	240	2,390	2,523	N	0	0	N	N	—	2	28	15	7
Kansas	—	146	270	1,861	2,397	N	0	0	N	N	—	1	8	13	15
Minnesota	—	245	314	2,598	3,836	—	0	54	—	—	3	2	25	26	43
Missouri	—	440	628	5,220	6,495	—	0	1	3	—	—	2	21	19	25
Nebraska§	—	99	180	1,260	1,487	N	0	0	N	N	—	1	16	6	5
North Dakota	26	30	64	387	572	N	0	0	N	N	—	0	1	1	—
South Dakota	51	51	84	717	745	N	0	0	N	N	—	1	7	15	8
S. Atlantic	2,472	3,671	6,115	42,029	54,126	—	0	1	1	2	3	17	68	180	176
Delaware	73	68	111	1,038	1,057	N	0	0	N	N	—	0	3	2	—
District of Columbia	—	66	161	1,331	818	—	0	0	—	—	—	0	2	3	5
Florida	—	960	1,187	3,300	13,374	N	0	0	N	N	1	8	32	90	70
Georgia	—	702	3,022	6,520	9,235	N	0	0	N	N	—	5	12	49	50
Maryland§	796	345	961	6,036	5,056	—	0	1	1	2	—	0	2	5	6
North Carolina	547	624	1,772	8,848	10,733	—	0	0	—	—	2	0	11	10	25
South Carolina§	493	390	2,105	7,323	6,102	N	0	0	N	N	—	1	14	11	5
Virginia§	563	464	685	7,081	6,955	N	0	0	N	N	—	1	5	9	13
West Virginia	—	56	96	552	796	N	0	0	N	N	—	0	3	1	2
E.S. Central	948	1,464	2,093	22,098	21,958	—	0	0	—	—	1	3	14	29	23
Alabama§	100	421	539	5,436	7,367	N	0	0	N	N	—	0	11	12	8
Kentucky	295	126	691	1,836	2,786	N	0	0	N	N	—	1	3	9	8
Mississippi	—	392	959	6,255	4,613	N	0	0	N	N	—	0	3	3	1
Tennessee§	553	528	708	8,571	7,192	N	0	0	N	N	1	1	5	5	6
W.S. Central	1,045	2,198	3,026	29,887	31,865	—	0	1	—	—	1	5	45	29	35
Arkansas§	176	157	337	2,403	2,376	N	0	0	N	N	—	0	2	2	4
Louisiana	34	303	610	3,696	4,838	—	0	1	—	—	—	1	9	11	—
Oklahoma	107	263	473	3,807	2,966	N	0	0	N	N	1	1	4	11	9
Texas§	728	1,439	1,908	19,981	21,685	N	0	0	N	N	—	2	36	5	22
Mountain	306	1,263	2,018	12,655	18,327	116	101	296	1,591	1,819	1	3	39	32	26
Arizona	105	431	993	2,959	5,442	116	99	296	1,563	1,768	—	0	3	7	3
Colorado	—	315	416	1,781	4,431	N	0	0	N	N	—	1	7	11	5
Idaho§	128	49	253	1,132	989	N	0	0	N	N	1	0	5	2	3
Montana§	21	51	144	724	687	N	0	0	N	N	—	0	26	2	5
Nevada§	—	107	397	2,234	1,914	—	1	3	12	23	—	0	1	—	3
New Mexico§	—	180	321	2,159	2,982	—	0	3	5	5	—	0	5	6	2
Utah	36	97	201	1,308	1,462	—	1	4	11	21	—	0	3	1	5
Wyoming§	16	28	54	358	420	—	0	0	—	2	—	0	11	3	—
Pacific	1,553	3,377	4,071	47,473	48,667	31	53	299	692	576	—	1	5	17	20
Alaska	60	86	157	1,165	1,187	N	0	0	N	N	—	0	1	—	—
California	1,184	2,670	3,239	37,243	37,789	31	53	299	692	576	—	0	0	—	—
Hawaii	1	107	130	1,389	1,710	N	0	0	N	N	—	0	1	—	—
Oregon§	150	161	394	2,741	2,778	N	0	0	N	N	—	1	4	17	20
Washington	158	350	548	4,935	5,203	N	0	0	N	N	—	0	0	—	—
American Samoa	U	0	46	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerto Rico	128	111	235	2,129	1,305	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	U	4	9	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional. Data for HIV/AIDS, AIDS, and TB, when available, are displayed in Table IV, which appears quarterly.
† Chlamydia refers to genital infections caused by *Chlamydia trachomatis*.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 14, 2007, and April 15, 2006 (15th Week)*

Reporting area	Giardiasis Current week	Giardiasis Previous 52 weeks Med	Giardiasis Previous 52 weeks Max	Giardiasis Cum 2007	Giardiasis Cum 2006	Gonorrhea Current week	Gonorrhea Previous 52 weeks Med	Gonorrhea Previous 52 weeks Max	Gonorrhea Cum 2007	Gonorrhea Cum 2006	*Haemophilus influenzae*, invasive All ages, all serotypes† Current week	H. influenzae Previous 52 weeks Med	H. influenzae Previous 52 weeks Max	H. influenzae Cum 2007	H. influenzae Cum 2006
United States	147	310	994	3,507	4,139	2,764	6,848	8,674	82,710	97,340	35	43	141	671	678
New England	—	19	44	120	282	102	109	259	1,459	1,419	1	2	12	22	36
Connecticut	—	5	25	48	56	25	42	203	465	461	—	0	7	15	8
Maine§	—	4	14	41	20	—	2	8	20	39	1	0	4	4	5
Massachusetts	—	0	18	—	146	60	47	96	764	698	—	0	7	—	19
New Hampshire	—	0	9	1	1	5	3	9	45	64	—	0	3	3	—
Rhode Island§	—	0	17	—	15	10	10	19	149	139	—	0	3	—	1
Vermont§	—	3	12	30	44	2	1	5	16	18	—	0	2	—	3
Mid. Atlantic	22	63	120	628	871	374	675	1,521	10,289	9,465	9	10	25	153	154
New Jersey	—	6	16	36	133	—	103	158	1,294	1,546	—	1	4	11	26
New York (Upstate)	15	25	101	233	260	139	122	1,035	1,734	1,666	6	3	14	44	36
New York City	1	16	33	197	273	116	176	376	2,658	2,950	—	2	6	35	33
Pennsylvania	6	14	35	162	205	119	239	410	4,603	3,303	3	3	10	63	59
E.N. Central	17	41	96	507	716	462	1,283	2,227	16,917	19,706	8	6	14	71	96
Illinois	—	9	27	80	162	126	359	488	4,514	5,991	—	1	5	9	29
Indiana	N	0	0	N	N	158	154	289	2,439	2,645	5	1	10	13	14
Michigan	4	12	38	165	202	125	306	880	4,488	3,034	—	0	5	9	14
Ohio	13	15	32	198	215	27	315	1,168	3,637	5,947	3	2	6	40	25
Wisconsin	—	9	24	64	137	26	136	181	1,839	2,089	—	0	3	—	14
W.N. Central	7	23	512	236	368	33	384	518	4,576	5,447	1	3	22	39	31
Iowa	—	5	16	49	67	23	38	63	555	524	—	0	1	—	—
Kansas	—	3	11	29	47	—	43	90	564	677	—	0	2	4	4
Minnesota	—	0	489	7	78	—	66	87	710	895	—	1	17	12	11
Missouri	5	9	28	117	123	—	195	269	2,354	2,863	—	1	5	17	13
Nebraska§	1	2	9	22	24	—	24	48	290	354	1	0	2	5	3
North Dakota	—	0	4	1	5	—	2	6	16	33	—	0	2	1	—
South Dakota	1	1	6	11	24	10	6	15	87	101	—	0	0	—	—
S. Atlantic	30	53	98	663	586	681	1,599	2,696	16,147	23,426	7	11	28	184	175
Delaware	—	0	4	7	7	30	28	44	409	412	—	0	3	5	1
District of Columbia	—	1	7	15	16	—	35	63	586	531	—	0	2	2	1
Florida	30	23	44	319	256	—	446	549	1,564	6,160	7	3	9	63	50
Georgia	—	12	26	154	130	—	348	1,539	2,706	4,198	—	2	6	50	43
Maryland§	—	4	12	49	34	187	119	234	1,844	1,922	—	2	5	30	25
North Carolina	—	0	0	—	—	117	314	608	4,197	5,377	—	0	8	15	15
South Carolina§	—	2	8	15	23	200	166	1,026	2,941	2,754	—	1	3	12	15
Virginia§	—	9	28	97	115	147	121	238	1,741	1,863	—	0	7	1	16
West Virginia	—	0	21	7	5	—	19	44	159	209	—	0	6	6	9
E.S. Central	8	8	34	101	102	359	579	878	7,911	8,684	4	2	9	37	46
Alabama§	2	4	22	49	49	36	192	271	2,212	3,355	—	0	3	7	10
Kentucky	N	0	0	N	N	125	48	268	624	955	1	0	1	2	4
Mississippi	N	0	0	N	N	—	154	434	2,179	1,738	—	0	1	—	3
Tennessee§	6	4	12	52	53	198	194	240	2,896	2,636	3	1	6	28	29
W.S. Central	4	7	21	88	40	337	959	1,483	12,334	13,311	—	1	26	36	25
Arkansas§	2	3	13	37	20	81	80	142	1,169	1,303	—	0	2	2	2
Louisiana	—	1	6	22	—	17	184	366	2,319	2,805	—	0	3	4	1
Oklahoma	2	2	11	29	20	36	107	237	1,600	1,000	—	1	24	28	21
Texas§	N	0	0	N	N	203	576	931	7,246	8,203	—	0	2	2	1
Mountain	15	30	68	343	373	37	269	455	2,417	3,947	3	4	14	94	85
Arizona	3	3	11	53	32	22	106	220	648	1,338	3	2	9	47	31
Colorado	—	10	26	116	131	—	71	93	524	1,016	—	1	4	20	26
Idaho§	6	3	12	32	44	10	2	20	74	61	—	0	1	3	3
Montana§	—	2	11	19	18	1	3	20	27	38	—	0	0	—	—
Nevada§	—	1	9	25	29	—	31	135	534	669	—	0	2	5	6
New Mexico§	—	1	6	21	17	—	30	65	395	501	—	0	2	9	10
Utah	6	7	27	68	96	4	16	28	197	272	—	0	3	10	9
Wyoming§	—	1	4	9	6	—	2	5	18	52	—	0	1	—	—
Pacific	44	60	147	821	801	379	783	971	10,660	11,935	2	2	8	35	30
Alaska	—	1	17	16	8	3	11	27	120	157	—	0	2	4	3
California	32	43	71	598	610	303	645	833	9,059	9,901	—	0	6	—	9
Hawaii	2	1	4	17	17	1	15	30	164	306	—	0	1	1	5
Oregon§	7	9	14	114	110	30	26	46	315	391	2	1	6	30	12
Washington	3	8	68	76	56	42	75	131	1,002	1,180	—	0	2	—	1
American Samoa	U	0	0	U	U	U	0	2	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerto Rico	3	5	19	45	26	5	6	16	106	98	—	0	2	—	—
U.S. Virgin Islands	U	0	0	U	U	U	0	3	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Data for *H. influenzae* (age <5 yrs for serotype b, nonserotype b, and unknown serotype) are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 14, 2007, and April 15, 2006 (15th Week)*

	Hepatitis (viral, acute), by type†										Legionellosis				
	A					B									
Reporting area	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006
United States	27	57	115	656	1,085	18	81	287	985	1,137	10	49	108	352	363
New England	—	1	19	6	61	—	2	4	16	37	—	2	13	3	18
Connecticut	—	1	3	4	9	—	0	4	8	19	—	0	9	2	3
Maine§	—	0	2	—	3	—	0	2	1	4	—	0	2	—	2
Massachusetts	—	0	2	—	44	—	0	1	—	12	—	0	4	—	10
New Hampshire	—	0	15	2	—	—	0	2	2	—	—	0	2	—	2
Rhode Island§	—	0	2	—	1	—	0	4	4	1	—	0	6	—	—
Vermont§	—	0	2	—	4	—	0	1	1	1	—	0	2	1	1
Mid. Atlantic	6	7	19	84	93	1	8	19	107	147	2	15	53	93	107
New Jersey	—	1	4	12	32	—	2	6	22	47	—	2	11	11	15
New York (Upstate)	5	2	12	24	16	1	1	14	19	17	—	5	30	29	33
New York City	1	2	11	34	30	—	2	6	16	32	—	2	20	12	17
Pennsylvania	—	1	4	14	15	—	3	7	50	51	2	5	19	41	42
E.N. Central	2	6	13	67	90	5	8	19	109	131	3	10	30	71	73
Illinois	—	1	4	17	21	—	1	5	14	50	—	1	11	—	12
Indiana	1	0	7	6	5	4	0	17	9	7	—	1	5	4	3
Michigan	—	2	8	23	32	1	2	8	37	43	1	3	10	27	17
Ohio	1	1	4	21	22	—	3	10	44	29	2	4	19	39	29
Wisconsin	—	0	4	—	10	—	0	3	5	2	—	0	3	1	12
W.N. Central	3	2	17	35	38	—	3	15	40	44	—	1	15	11	10
Iowa	1	0	1	6	3	—	0	3	7	6	—	0	3	1	1
Kansas	—	0	1	—	15	—	0	2	3	4	—	0	2	—	—
Minnesota	2	0	17	20	2	—	0	14	4	1	—	0	11	2	—
Missouri	—	1	3	5	9	—	1	4	21	30	—	0	2	6	6
Nebraska§	—	0	2	2	4	—	0	3	3	2	—	0	2	1	2
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	2	2	5	—	0	1	2	1	—	0	1	1	1
S. Atlantic	5	8	27	118	167	6	23	53	270	328	5	9	24	97	85
Delaware	—	0	2	—	4	—	0	4	4	13	—	0	2	1	1
District of Columbia	—	0	5	9	1	—	0	2	1	4	—	0	5	—	4
Florida	5	3	13	50	60	5	7	14	91	122	5	3	9	46	41
Georgia	—	1	5	15	11	—	3	8	36	43	—	1	5	11	2
Maryland§	—	1	7	13	25	—	2	8	22	49	—	2	8	20	12
North Carolina	—	0	11	6	38	—	1	16	49	58	—	0	5	9	11
South Carolina§	—	0	3	3	7	—	2	5	21	19	—	0	2	4	2
Virginia§	—	1	4	22	20	—	2	5	32	9	—	1	5	3	11
West Virginia	—	0	3	—	1	1	0	23	14	11	—	0	4	3	1
E.S. Central	—	2	7	22	33	2	6	20	65	98	—	2	9	15	12
Alabama§	—	0	2	2	2	—	1	10	20	26	—	0	2	1	3
Kentucky	—	0	4	4	14	1	1	5	2	25	—	1	6	7	3
Mississippi	—	0	5	5	1	—	0	7	7	10	—	0	2	—	—
Tennessee§	—	1	5	11	16	1	3	7	36	37	—	1	7	7	6
W.S. Central	—	6	18	40	101	—	18	128	148	167	—	1	12	12	8
Arkansas§	—	0	2	4	25	—	1	4	7	16	—	0	1	1	1
Louisiana	—	0	4	7	3	—	1	5	14	5	—	0	2	1	—
Oklahoma	—	0	3	—	3	—	1	14	9	1	—	0	6	—	1
Texas§	—	5	15	29	70	—	15	108	118	145	—	1	12	10	6
Mountain	4	5	17	89	97	1	3	9	63	37	—	2	8	25	16
Arizona	4	3	13	76	57	—	0	6	28	2	—	1	4	8	3
Colorado	—	1	3	6	16	—	0	4	7	11	—	0	2	5	4
Idaho§	—	0	2	1	4	1	0	2	4	4	—	0	3	1	2
Montana§	—	0	3	—	1	—	0	0	—	—	—	0	1	—	—
Nevada§	—	0	2	3	5	—	1	5	12	12	—	0	2	2	3
New Mexico§	—	0	2	1	6	—	0	2	4	5	—	0	2	2	—
Utah	—	0	2	2	7	—	0	4	8	3	—	0	2	5	4
Wyoming§	—	0	1	—	1	—	0	1	—	—	—	0	1	2	—
Pacific	7	15	52	195	405	3	12	38	167	148	—	1	11	25	34
Alaska	—	0	1	1	1	1	0	3	3	1	—	0	1	—	—
California	4	13	48	175	377	2	8	26	129	114	—	1	11	20	34
Hawaii	—	0	2	2	6	—	0	1	—	2	—	0	0	—	—
Oregon§	—	1	3	9	11	—	2	5	26	23	—	0	0	—	—
Washington	3	1	4	8	10	—	1	12	9	8	—	0	2	5	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerto Rico	1	1	10	14	13	1	1	9	12	5	—	0	1	—	—
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Data for acute hepatitis C, viral are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 14, 2007, and April 15, 2006 (15th Week)*

Reporting area	Lyme disease					Malaria					Meningococcal disease, invasive† All serogroups				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006
United States	42	252	1,026	1,485	1,647	5	25	50	177	300	12	19	40	309	437
New England	2	22	255	65	90	—	0	6	3	9	—	1	3	7	14
Connecticut	—	9	227	20	47	—	0	3	—	1	—	0	2	2	3
Maine§	—	2	39	12	17	—	0	1	3	2	—	0	3	2	2
Massachusetts	—	0	3	—	19	—	0	3	—	5	—	0	2	—	9
New Hampshire	2	5	97	27	2	—	0	3	—	—	—	0	2	—	—
Rhode Island§	—	0	93	—	1	—	0	1	—	—	—	0	1	1	—
Vermont§	—	1	15	6	4	—	0	0	—	1	—	0	1	2	—
Mid. Atlantic	26	145	571	746	1,152	1	5	18	41	85	1	2	11	31	69
New Jersey	—	26	187	102	279	—	1	7	—	24	—	0	2	—	7
New York (Upstate)	18	52	392	214	473	1	1	7	11	6	1	1	4	8	12
New York City	—	2	24	5	16	—	3	9	24	45	—	1	4	6	25
Pennsylvania	8	45	237	425	384	—	1	4	6	10	—	0	5	17	25
E.N. Central	1	12	158	20	88	—	3	10	28	40	1	2	7	38	60
Illinois	—	0	1	1	—	—	1	6	8	14	—	0	2	10	16
Indiana	—	0	3	1	2	—	0	2	1	5	1	0	4	8	8
Michigan	—	1	5	6	3	—	0	2	7	5	—	0	3	9	10
Ohio	1	0	5	3	9	—	0	2	7	11	—	1	4	11	17
Wisconsin	—	11	154	9	74	—	0	3	5	5	—	0	2	—	9
W.N. Central	8	5	191	30	35	1	1	13	13	6	1	1	5	28	20
Iowa	—	1	8	4	4	—	0	1	2	1	—	0	3	7	4
Kansas	—	0	2	1	—	—	0	2	—	—	—	0	1	1	—
Minnesota	8	2	190	23	30	—	0	12	7	2	1	0	3	8	2
Missouri	—	0	2	2	—	1	0	1	2	1	—	0	3	9	8
Nebraska§	—	0	2	—	1	—	0	1	2	—	—	0	1	1	5
North Dakota	—	0	0	—	—	—	0	1	—	1	—	0	1	1	1
South Dakota	—	0	1	—	—	—	0	0	—	1	—	0	1	1	—
S. Atlantic	2	42	135	564	248	1	5	15	45	74	2	3	9	41	75
Delaware	2	8	28	108	81	—	0	1	1	2	—	0	1	—	2
District of Columbia	—	0	7	2	6	—	0	2	1	—	—	0	1	—	—
Florida	—	0	3	9	7	1	1	4	13	10	2	1	6	15	29
Georgia	—	0	1	—	1	—	1	6	4	25	—	0	3	6	6
Maryland§	—	21	104	362	142	—	1	4	13	10	—	0	2	10	5
North Carolina	—	0	4	6	8	—	0	4	4	10	—	0	6	4	13
South Carolina§	—	0	2	3	1	—	0	2	—	3	—	0	2	4	7
Virginia§	—	6	36	70	2	—	1	4	9	13	—	0	2	2	12
West Virginia	—	0	14	4	—	—	0	1	—	1	—	0	2	—	1
E.S. Central	—	0	4	6	1	1	0	3	8	7	1	1	3	15	15
Alabama§	—	0	3	1	1	—	0	2	1	3	—	0	2	3	3
Kentucky	—	0	2	—	—	—	0	1	1	1	—	0	1	1	3
Mississippi	—	0	1	—	—	—	0	1	1	1	—	0	3	3	3
Tennessee§	—	0	2	5	—	1	0	2	5	2	1	0	2	8	6
W.S. Central	—	1	6	10	2	—	1	7	3	11	—	1	9	33	29
Arkansas§	—	0	0	—	—	—	0	2	—	—	—	0	2	5	5
Louisiana	—	0	1	2	—	—	0	1	1	1	—	0	4	9	4
Oklahoma	—	0	0	—	—	—	0	2	1	1	—	0	3	7	5
Texas§	—	1	6	8	2	—	1	6	1	9	—	0	9	12	15
Mountain	—	0	4	2	3	—	1	6	10	18	1	1	4	31	30
Arizona	—	0	2	—	3	—	0	3	4	3	1	0	3	9	9
Colorado	—	0	1	—	—	—	0	2	4	6	—	0	2	8	10
Idaho§	—	0	2	—	—	—	0	1	—	—	—	0	1	2	1
Montana§	—	0	1	1	—	—	0	1	1	1	—	0	1	1	—
Nevada§	—	0	1	1	—	—	0	1	—	—	—	0	1	3	3
New Mexico§	—	0	1	—	—	—	0	1	—	1	—	0	1	1	1
Utah	—	0	1	—	—	—	0	2	1	7	—	0	2	6	4
Wyoming§	—	0	1	—	—	—	0	0	—	—	—	0	2	1	2
Pacific	3	3	17	42	28	1	4	14	26	50	5	5	11	85	125
Alaska	—	0	1	2	—	—	0	4	2	4	—	0	1	1	2
California	3	3	14	35	28	1	2	6	19	39	2	3	9	58	83
Hawaii	N	0	0	N	N	—	0	2	—	—	—	0	2	2	4
Oregon§	—	0	2	5	—	—	0	3	4	4	2	0	3	11	18
Washington	—	0	3	—	—	—	0	11	1	3	1	0	5	13	18
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	—	—
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	—	—
Guam	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerto Rico	N	0	0	N	N	—	0	1	1	—	—	0	1	3	2
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Data for meningococcal disease, invasive caused by serogroups A, C, Y, & W-135; serogroup B; other serogroup; and unknown serogroup are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) **Provisional cases of selected notifiable diseases, United States, weeks ending April 14, 2007, and April 15, 2006 (15th Week)***

	Pertussis					Rabies, animal					Rocky Mountain spotted fever				
	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum
Reporting area	week	Med	Max	2007	2006	week	Med	Max	2007	2006	week	Med	Max	2007	2006
United States	77	245	944	1,769	3,939	12	103	173	858	1,426	2	29	116	113	290
New England	1	17	54	66	420	1	11	26	108	157	—	0	8	—	—
Connecticut	—	2	9	15	21	—	4	14	38	35	—	0	0	—	—
Maine†	1	2	15	29	22	—	2	8	21	25	N	0	0	N	N
Massachusetts	—	0	22	—	323	—	0	17	—	77	—	0	1	—	—
New Hampshire	—	2	28	7	9	1	1	5	9	—	—	0	1	—	—
Rhode Island†	—	0	30	—	11	—	0	3	9	4	—	0	8	—	—
Vermont†	—	1	14	15	34	—	2	6	31	16	—	0	0	—	—
Mid. Atlantic	8	34	156	335	494	—	16	57	115	201	—	2	6	11	14
New Jersey	—	3	11	10	111	—	0	0	—	—	—	0	2	—	2
New York (Upstate)	6	20	150	225	153	—	0	0	—	—	—	0	2	—	—
New York City	—	0	8	—	12	—	1	5	18	1	—	0	3	3	2
Pennsylvania	2	9	22	100	218	—	16	56	97	200	—	1	4	8	10
E.N. Central	10	39	79	407	626	—	2	18	5	4	—	1	6	2	3
Illinois	—	9	23	50	156	—	0	7	—	1	—	0	4	1	1
Indiana	4	3	37	7	50	—	0	2	—	—	—	0	1	—	—
Michigan	2	10	39	100	128	—	1	5	4	2	—	0	1	1	—
Ohio	4	12	56	227	205	—	0	9	1	1	—	0	4	—	2
Wisconsin	—	3	9	23	87	—	0	0	—	—	—	0	1	—	—
W.N. Central	1	18	112	124	436	—	6	20	36	56	—	3	14	16	6
Iowa	—	4	16	37	125	—	1	7	5	7	—	0	1	—	—
Kansas	—	4	13	47	113	—	1	5	20	23	—	0	1	—	—
Minnesota	—	0	96	—	—	—	0	6	3	5	—	0	2	—	1
Missouri	—	4	10	20	131	—	1	6	2	5	—	2	12	16	5
Nebraska†	1	1	4	5	57	—	0	0	—	—	—	0	5	—	—
North Dakota	—	0	9	1	4	—	0	7	6	2	—	0	0	—	—
South Dakota	—	0	4	14	6	—	0	4	—	14	—	0	0	—	—
S. Atlantic	7	18	162	255	301	9	37	62	483	667	1	10	67	64	246
Delaware	—	0	1	1	1	—	0	0	—	—	—	0	3	3	4
District of Columbia	—	0	2	2	3	—	0	0	—	—	—	0	1	—	—
Florida	—	4	18	86	68	—	0	13	36	176	—	0	4	3	4
Georgia	—	0	3	—	7	—	4	16	36	65	—	1	5	2	3
Maryland†	—	2	7	37	57	—	5	12	62	108	—	1	6	8	5
North Carolina	6	0	111	75	63	9	10	22	130	87	1	4	61	37	225
South Carolina†	—	3	11	24	45	—	3	11	33	34	—	0	5	4	3
Virginia†	1	2	19	26	53	—	11	31	163	175	—	2	13	6	2
West Virginia	—	0	19	4	4	—	2	8	23	22	—	0	2	1	—
E.S. Central	3	6	24	61	77	—	4	13	27	50	1	5	27	19	15
Alabama†	—	1	17	17	19	—	1	8	—	16	—	1	9	5	5
Kentucky	—	0	5	1	12	—	0	4	6	4	—	0	1	—	—
Mississippi	—	0	6	6	9	—	0	1	—	2	—	0	1	—	—
Tennessee†	3	3	11	37	37	—	2	7	21	28	1	4	22	14	10
W.S. Central	—	16	147	87	174	—	2	34	17	215	—	1	28	—	4
Arkansas†	—	1	13	2	14	—	0	5	7	7	—	0	10	—	3
Louisiana	—	0	2	5	3	—	0	0	—	—	—	0	1	—	—
Oklahoma	—	0	9	—	2	—	0	9	10	11	—	0	18	—	—
Texas†	—	14	134	80	155	—	0	29	—	197	—	0	6	—	1
Mountain	40	37	75	362	958	—	3	28	16	34	—	0	5	1	1
Arizona	30	6	26	91	178	—	2	10	15	31	—	0	2	—	—
Colorado	—	8	26	96	386	—	0	0	—	—	—	0	1	—	—
Idaho†	—	1	7	11	26	—	0	24	—	—	—	0	3	1	—
Montana†	—	1	8	10	35	—	0	2	—	2	—	0	2	—	—
Nevada†	—	0	9	3	15	—	0	1	—	—	—	0	1	—	—
New Mexico†	—	2	8	13	25	—	0	2	—	1	—	0	2	—	1
Utah	10	10	50	126	275	—	0	1	1	—	—	0	0	—	—
Wyoming†	—	1	8	12	18	—	0	2	—	—	—	0	1	—	—
Pacific	7	33	229	72	453	2	4	12	51	42	—	0	1	—	1
Alaska	—	1	8	8	27	1	0	6	24	7	N	0	0	N	N
California	—	22	226	—	263	1	3	11	27	35	—	0	1	—	—
Hawaii	—	1	7	7	39	N	0	0	N	N	N	0	0	N	N
Oregon†	—	1	6	18	48	—	0	4	—	—	—	0	1	—	1
Washington	7	4	46	39	76	—	0	0	—	—	N	0	0	N	N
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	—	—	—	—	—	—	—	—	—	N	—	—	N	N
Puerto Rico	—	0	1	—	—	—	1	6	15	28	N	0	0	N	N
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 14, 2007, and April 15, 2006 (15th Week)*

Reporting area	Salmonellosis					Shiga toxin-producing *E. coli* (STEC)†					Shigellosis				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006
United States	264	824	1,336	6,975	7,742	43	75	179	462	549	200	257	521	2,733	2,605
New England	—	18	82	144	779	2	2	16	19	104	—	2	14	19	122
Connecticut	—	0	68	68	503	—	0	5	5	84	—	0	8	8	67
Maine§	—	2	14	26	17	2	0	8	10	3	—	0	5	9	—
Massachusetts	—	0	53	—	237	—	0	9	—	14	—	0	11	—	50
New Hampshire	—	4	26	19	6	—	0	4	3	—	—	0	2	1	—
Rhode Island§	—	2	15	21	11	—	0	2	—	1	—	0	3	1	4
Vermont§	—	1	6	10	5	—	0	4	1	2	—	0	2	—	1
Mid. Atlantic	35	90	191	948	916	5	9	62	56	55	2	13	47	115	238
New Jersey	—	16	49	52	175	—	1	16	1	15	—	3	35	6	73
New York (Upstate)	20	27	93	295	184	2	3	14	22	15	2	3	43	30	69
New York City	—	24	50	239	249	—	0	4	4	8	—	5	14	62	67
Pennsylvania	15	30	67	362	308	3	3	47	29	17	—	1	6	17	29
E.N. Central	42	103	198	741	1,084	3	9	59	56	88	9	23	68	144	265
Illinois	—	27	61	56	316	—	1	7	2	14	—	10	50	19	95
Indiana	18	15	55	128	110	2	1	8	4	10	3	2	17	17	32
Michigan	2	18	35	155	193	1	1	6	12	19	—	2	5	10	63
Ohio	22	23	56	255	276	—	3	18	30	21	6	3	14	68	46
Wisconsin	—	17	27	147	189	—	2	39	8	24	—	3	10	30	29
W.N. Central	21	48	109	549	492	7	11	45	62	74	34	41	77	548	224
Iowa	2	8	26	82	85	—	2	38	9	13	—	2	14	16	8
Kansas	—	7	16	75	74	—	0	4	4	1	—	2	11	8	23
Minnesota	7	12	60	128	113	4	3	26	27	29	4	4	24	77	21
Missouri	11	15	35	185	136	2	2	13	14	21	30	12	69	426	123
Nebraska§	1	3	9	31	51	1	1	11	8	7	—	1	14	5	26
North Dakota	—	0	5	8	6	—	0	0	—	—	—	0	18	4	4
South Dakota	—	3	11	40	27	—	0	5	—	3	—	6	24	12	19
S. Atlantic	90	225	395	2,235	1,790	10	11	32	124	83	76	69	143	1,025	617
Delaware	—	2	10	18	21	—	0	3	4	1	—	0	2	4	—
District of Columbia	—	1	4	8	19	—	0	1	—	—	—	0	5	3	3
Florida	55	95	176	965	818	4	2	8	36	14	75	34	76	659	265
Georgia	—	34	66	386	242	—	1	7	15	15	—	24	54	294	222
Maryland§	—	14	32	146	72	—	2	9	22	5	—	1	10	18	16
North Carolina	35	29	130	370	354	6	2	11	23	20	1	1	14	17	63
South Carolina§	—	19	55	146	95	—	0	3	1	3	—	0	10	12	36
Virginia§	—	20	58	167	151	—	3	11	22	25	—	2	9	17	12
West Virginia	—	1	31	29	18	—	0	5	1	—	—	0	2	1	—
E.S. Central	17	53	138	414	392	—	4	21	21	39	2	12	75	174	168
Alabama§	—	10	70	105	133	—	0	5	3	4	—	4	66	67	35
Kentucky	2	9	23	93	77	—	1	12	7	10	1	2	15	23	86
Mississippi	—	12	42	36	73	—	0	0	—	—	—	1	25	25	24
Tennessee§	15	17	32	180	109	—	2	9	11	25	1	4	14	59	23
W.S. Central	9	84	186	284	635	2	3	52	17	26	48	37	187	244	310
Arkansas§	6	14	45	83	226	—	0	7	4	2	3	2	10	24	20
Louisiana	—	17	42	94	51	—	0	1	—	—	—	3	24	57	8
Oklahoma	3	8	40	71	49	1	0	17	5	1	1	2	9	14	20
Texas§	—	46	107	36	309	1	2	48	8	23	44	30	174	149	262
Mountain	17	52	86	542	524	9	7	36	58	54	7	26	87	179	201
Arizona	10	19	45	209	144	6	2	13	23	13	7	11	35	92	104
Colorado	—	12	30	130	147	—	1	8	9	13	—	3	15	27	27
Idaho§	4	3	9	32	35	—	2	8	4	8	—	0	3	3	5
Montana§	—	2	10	22	28	—	0	0	—	—	—	0	13	4	1
Nevada§	—	4	20	45	39	—	0	5	4	10	—	1	20	11	23
New Mexico§	—	5	15	46	46	—	1	5	9	4	—	2	15	25	29
Utah	3	4	14	44	67	3	1	14	9	5	—	1	4	5	11
Wyoming§	—	0	4	14	18	—	0	3	—	1	—	0	19	12	1
Pacific	33	116	306	1,118	1,130	5	5	24	49	26	22	32	94	285	460
Alaska	—	1	5	20	27	N	0	0	N	N	—	0	2	6	4
California	31	89	218	881	851	1	0	5	27	N	12	28	81	228	345
Hawaii	—	5	16	52	60	—	0	3	3	3	—	1	3	10	10
Oregon§	1	7	17	64	104	2	1	9	9	15	—	1	6	13	56
Washington	1	11	83	101	88	2	2	22	10	8	10	2	13	28	45
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	—	—	—	—	N	—	—	N	N	—	—	—	—	—
Puerto Rico	17	14	65	110	62	—	0	0	—	—	—	0	6	5	2
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Includes *E. coli* O157:H7; Shiga toxin-positive, serogroup non-O157; and Shiga toxin-positive, not serogrouped.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 14, 2007, and April 15, 2006 (15th Week)*

Reporting area	Streptococcal disease, invasive, group A					*Streptococcus pneumoniae*, invasive disease† Age <5 years				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006
United States	60	90	216	1,482	1,908	20	23	90	435	408
New England	1	2	15	22	68	—	1	4	9	19
Connecticut	—	0	0	—	—	—	0	0	—	—
Maine§	—	0	2	6	8	—	0	2	—	—
Massachusetts	—	0	5	—	51	—	0	4	—	19
New Hampshire	1	0	9	6	2	—	0	4	5	—
Rhode Island§	—	0	6	—	4	—	0	3	3	—
Vermont§	—	0	2	10	3	—	0	1	1	—
Mid. Atlantic	17	16	39	289	389	2	3	17	36	70
New Jersey	—	2	8	27	72	—	0	4	—	21
New York (Upstate)	11	5	26	104	115	2	2	14	36	46
New York City	—	3	8	55	74	—	0	2	—	3
Pennsylvania	6	6	11	103	128	N	0	0	N	N
E.N. Central	7	15	31	260	448	5	6	14	71	124
Illinois	—	4	11	63	143	—	1	6	9	33
Indiana	3	2	12	35	44	2	0	10	8	17
Michigan	1	3	10	66	99	2	1	5	29	29
Ohio	3	4	14	96	110	1	1	7	24	25
Wisconsin	—	1	6	—	52	—	0	2	1	20
W.N. Central	14	4	32	130	144	4	2	10	40	28
Iowa	—	0	0	—	—	—	0	0	—	—
Kansas	—	0	3	15	32	—	0	3	3	7
Minnesota	12	0	29	60	63	3	1	6	22	9
Missouri	1	2	5	38	25	—	0	3	11	7
Nebraska§	1	0	2	6	14	1	0	2	3	4
North Dakota	—	0	2	8	6	—	0	1	1	1
South Dakota	—	0	2	3	4	—	0	0	—	—
S. Atlantic	9	20	42	359	369	3	2	11	88	17
Delaware	—	0	2	—	4	—	0	0	—	—
District of Columbia	—	0	2	4	4	—	0	1	—	—
Florida	9	5	16	87	91	3	0	5	21	—
Georgia	—	5	11	87	96	—	0	5	30	—
Maryland§	—	4	10	58	42	—	1	6	25	12
North Carolina	—	0	26	45	55	—	0	0	—	—
South Carolina§	—	1	5	23	27	—	0	2	8	—
Virginia§	—	2	10	49	42	—	0	1	2	—
West Virginia	—	0	6	6	8	—	0	3	2	5
E.S. Central	1	4	11	64	84	2	0	6	25	5
Alabama§	N	0	0	N	N	N	0	0	N	N
Kentucky	—	1	4	16	25	—	0	0	—	—
Mississippi	N	0	0	N	N	—	0	2	2	5
Tennessee§	1	3	7	48	59	2	0	6	23	—
W.S. Central	3	6	61	97	144	2	4	39	80	64
Arkansas§	—	0	5	10	11	—	0	2	7	11
Louisiana	—	0	2	3	2	—	0	4	18	2
Oklahoma	—	2	5	35	46	1	1	12	21	13
Texas§	3	3	56	49	85	1	1	24	34	38
Mountain	6	11	42	226	232	2	4	11	75	79
Arizona	5	5	34	91	130	1	2	7	44	50
Colorado	—	3	9	63	45	—	1	4	19	19
Idaho§	—	0	1	5	3	1	0	1	1	1
Montana§	N	0	0	N	N	N	0	0	N	N
Nevada§	—	0	1	1	1	—	0	0	—	—
New Mexico§	—	1	4	19	30	—	0	4	11	9
Utah	1	1	7	45	21	—	0	0	—	—
Wyoming§	—	0	1	2	2	—	0	0	—	—
Pacific	2	2	9	35	30	—	0	4	11	2
Alaska	1	0	2	8	N	—	0	2	9	—
California	N	0	0	N	N	N	0	0	N	N
Hawaii	1	2	9	27	30	—	0	2	2	2
Oregon§	N	0	0	N	N	N	0	0	N	N
Washington	N	0	0	N	N	N	0	0	N	N
American Samoa	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U
Guam	—	—	—	—	—	N	—	—	N	N
Puerto Rico	—	0	0	—	—	N	0	0	N	N
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Includes cases of invasive pneumococcal disease, in children aged <5 years, caused by *S. pneumoniae*, which is susceptible or for which susceptibility testing is not available (NNDSS event code 11717).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 14, 2007, and April 15, 2006 (15th Week)*

Reporting area	*Streptococcus pneumoniae*, invasive disease, drug resistant† — All ages: Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006	*Streptococcus pneumoniae*, invasive disease, drug resistant† — Age <5 years: Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006	Syphilis, primary and secondary: Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006
United States	34	44	240	848	946	6	7	32	125	131	84	181	260	2,176	2,518
New England	—	1	7	19	12	—	0	1	—	2	—	4	13	46	62
Connecticut	—	0	0	—	—	—	0	0	—	—	—	0	10	6	15
Maine§	—	0	2	4	2	—	0	0	—	1	—	0	1	1	3
Massachusetts	—	0	0	—	—	—	0	0	—	—	—	2	7	30	32
New Hampshire	—	0	0	—	—	—	0	0	—	—	—	0	2	4	5
Rhode Island§	—	0	4	7	3	—	0	1	—	—	—	0	3	4	5
Vermont§	—	0	2	8	7	—	0	1	—	1	—	0	1	1	2
Mid. Atlantic	3	3	8	57	48	2	0	5	14	8	19	24	44	446	308
New Jersey	—	0	0	—	—	—	0	0	—	—	—	3	8	51	47
New York (Upstate)	2	1	5	20	14	1	0	4	7	3	2	3	14	33	43
New York City	—	0	0	—	—	—	0	0	—	—	13	13	35	299	146
Pennsylvania	1	2	6	37	34	1	0	2	7	5	4	5	12	63	72
E.N. Central	13	10	40	215	212	2	1	7	24	37	7	14	32	157	266
Illinois	—	0	2	3	8	—	0	1	1	3	—	6	13	33	147
Indiana	8	2	30	42	43	1	0	5	3	9	—	2	5	14	26
Michigan	—	0	3	—	9	—	0	1	—	1	1	2	10	34	22
Ohio	5	5	38	170	152	1	1	5	20	24	6	4	9	62	58
Wisconsin	N	0	0	N	N	—	0	0	—	—	—	1	4	14	13
W.N. Central	2	1	123	34	16	—	0	15	5	1	—	5	14	47	69
Iowa	—	0	0	—	—	—	0	0	—	—	—	0	3	1	6
Kansas	—	0	1	3	—	—	0	0	—	—	—	0	3	5	9
Minnesota	—	0	123	—	—	—	0	15	—	—	—	1	5	20	17
Missouri	—	1	6	26	16	—	0	2	3	1	—	3	9	21	35
Nebraska§	1	0	1	2	—	—	0	0	—	—	—	0	2	—	2
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	1	—	—
South Dakota	1	0	3	3	—	—	0	1	2	—	—	0	3	—	—
S. Atlantic	13	21	54	406	528	2	3	8	62	47	22	41	136	405	545
Delaware	—	0	1	1	—	—	0	1	1	—	1	0	3	3	8
District of Columbia	—	0	2	4	16	—	0	0	—	2	—	2	11	44	36
Florida	13	12	29	237	236	2	2	8	56	44	—	14	23	68	207
Georgia	—	7	17	147	237	—	0	1	—	1	—	6	105	13	43
Maryland§	—	0	0	—	—	—	0	0	—	—	15	5	14	90	95
North Carolina	—	0	0	—	—	—	0	0	—	—	2	5	23	100	92
South Carolina§	—	0	0	—	—	—	0	0	—	—	—	1	5	25	22
Virginia§	N	0	0	N	N	—	0	0	—	—	4	4	17	61	41
West Virginia	—	1	17	17	39	—	0	1	5	—	—	0	2	1	1
E.S. Central	3	2	7	52	80	—	0	3	9	14	15	14	29	214	162
Alabama§	N	0	0	N	N	—	0	0	—	—	8	5	17	73	79
Kentucky	1	0	2	11	20	—	0	1	1	3	1	1	9	25	20
Mississippi	—	0	0	—	—	—	0	0	—	—	—	2	8	34	17
Tennessee§	2	2	7	41	60	—	0	3	8	11	6	5	12	82	46
W.S. Central	—	1	6	47	8	—	0	2	5	3	15	29	58	402	401
Arkansas§	—	0	3	1	4	—	0	0	—	2	2	1	7	31	27
Louisiana	—	1	2	17	4	—	0	1	2	1	5	5	30	82	55
Oklahoma	—	0	5	29	—	—	0	2	3	—	—	1	5	25	22
Texas§	—	0	0	—	—	—	0	0	—	—	8	21	31	264	297
Mountain	—	1	5	18	42	—	0	5	6	19	—	8	27	58	128
Arizona	—	0	0	—	—	—	0	0	—	—	—	2	16	11	58
Colorado	—	0	0	—	—	—	0	0	—	—	—	1	5	3	22
Idaho§	N	0	0	N	N	—	0	0	—	—	—	0	1	1	2
Montana§	—	0	0	—	—	—	0	0	—	—	—	0	1	1	—
Nevada§	—	0	3	12	8	—	0	2	3	—	—	1	12	19	28
New Mexico§	—	0	0	—	—	—	0	0	—	—	—	1	5	19	16
Utah	—	0	5	4	20	—	0	4	2	13	—	0	2	3	2
Wyoming§	—	0	3	2	14	—	0	2	1	6	—	0	1	1	—
Pacific	—	0	0	—	—	—	0	0	—	—	6	37	52	401	577
Alaska	—	0	0	—	—	—	0	0	—	—	—	0	2	3	5
California	N	0	0	N	N	—	0	0	—	—	2	34	49	356	499
Hawaii	—	0	0	—	—	—	0	0	—	—	—	0	1	1	8
Oregon§	N	0	0	N	N	—	0	0	—	—	1	0	6	5	5
Washington	N	0	0	N	N	—	0	0	—	—	3	2	11	36	60
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	N	—	—	N	N	—	—	—	—	—	—	—	—	—	—
Puerto Rico	N	0	0	N	N	—	0	0	—	—	1	2	11	33	38
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Includes cases of invasive pneumococcal disease caused by drug-resistant *S. pneumoniae* (DRSP) (NNDSS event code 11720).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 14, 2007, and April 15, 2006 (15th Week)*

	Varicella (chickenpox)					West Nile virus disease† Neuroinvasive					West Nile virus disease† Non-neuroinvasive§				
Reporting area	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006
United States	830	794	1,461	12,966	16,267	—	1	178	—	5	—	1	399	—	1
New England	4	21	74	160	442	—	0	3	—	—	—	0	2	—	—
Connecticut	—	0	0	—	—	—	0	3	—	—	—	0	1	—	—
Maine¶	—	2	17	—	108	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	1	—	92	—	0	1	—	—	—	0	1	—	—
New Hampshire	4	5	43	65	16	—	0	0	—	—	—	0	0	—	—
Rhode Island¶	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Vermont¶	—	10	66	95	226	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	96	102	193	1,705	1,930	—	0	11	—	—	—	0	4	—	—
New Jersey	N	0	0	N	N	—	0	2	—	—	—	0	1	—	—
New York (Upstate)	N	0	0	N	N	—	0	5	—	—	—	0	1	—	—
New York City	—	0	0	—	—	—	0	4	—	—	—	0	2	—	—
Pennsylvania	96	102	193	1,705	1,930	—	0	2	—	—	—	0	1	—	—
E.N. Central	109	231	587	3,852	6,430	—	0	43	—	—	—	0	33	—	—
Illinois	—	1	10	54	32	—	0	23	—	—	—	0	23	—	—
Indiana	—	0	0	—	—	—	0	7	—	—	—	0	12	—	—
Michigan	28	97	258	1,539	1,844	—	0	11	—	—	—	0	2	—	—
Ohio	81	128	449	1,976	4,043	—	0	11	—	—	—	0	3	—	—
Wisconsin	—	13	64	283	511	—	0	2	—	—	—	0	2	—	—
W.N. Central	78	29	131	719	856	—	0	36	—	—	—	0	79	—	—
Iowa	N	0	0	N	N	—	0	3	—	—	—	0	4	—	—
Kansas	—	7	52	276	146	—	0	3	—	—	—	0	3	—	—
Minnesota	—	0	0	—	—	—	0	6	—	—	—	0	7	—	—
Missouri	78	15	82	333	675	—	0	14	—	—	—	0	2	—	—
Nebraska¶	N	0	0	N	N	—	0	9	—	—	—	0	38	—	—
North Dakota	—	0	60	84	15	—	0	5	—	—	—	0	28	—	—
South Dakota	—	1	15	26	20	—	0	7	—	—	—	0	22	—	—
S. Atlantic	56	89	176	1,561	1,706	—	0	2	—	—	—	0	7	—	—
Delaware	—	1	6	9	35	—	0	0	—	—	—	0	0	—	—
District of Columbia	—	0	5	—	14	—	0	0	—	—	—	0	1	—	—
Florida	24	0	42	413	N	—	0	1	—	—	—	0	0	—	—
Georgia	N	0	0	N	N	—	0	1	—	—	—	0	4	—	—
Maryland¶	N	0	0	N	N	—	0	2	—	—	—	0	2	—	—
North Carolina	—	0	0	—	—	—	0	1	—	—	—	0	0	—	—
South Carolina¶	—	22	72	452	441	—	0	1	—	—	—	0	0	—	—
Virginia¶	16	26	142	237	554	—	0	0	—	—	—	0	2	—	—
West Virginia	16	25	56	450	662	—	0	1	—	—	—	0	0	—	—
E.S. Central	3	5	43	110	7	—	0	15	—	3	—	0	16	—	—
Alabama¶	3	5	43	108	7	—	0	2	—	—	—	0	0	—	—
Kentucky	N	0	0	N	N	—	0	2	—	—	—	0	1	—	—
Mississippi	—	0	2	2	—	—	0	10	—	3	—	0	16	—	—
Tennessee¶	N	0	0	N	N	—	0	4	—	—	—	0	2	—	—
W.S. Central	461	200	966	3,833	3,652	—	0	58	—	2	—	0	26	—	1
Arkansas¶	1	11	92	170	313	—	0	4	—	—	—	0	2	—	—
Louisiana	—	2	11	41	20	—	0	13	—	—	—	0	9	—	1
Oklahoma	—	0	0	—	—	—	0	6	—	—	—	0	4	—	—
Texas¶	460	172	873	3,622	3,319	—	0	38	—	2	—	0	16	—	—
Mountain	23	57	102	1,006	1,244	—	0	61	—	—	—	1	228	—	—
Arizona	—	0	0	—	—	—	0	9	—	—	—	0	15	—	—
Colorado	—	22	51	370	646	—	0	10	—	—	—	0	51	—	—
Idaho¶	N	0	0	N	N	—	0	30	—	—	—	0	157	—	—
Montana¶	—	0	26	113	N	—	0	3	—	—	—	0	8	—	—
Nevada¶	—	0	3	—	2	—	0	9	—	—	—	0	16	—	—
New Mexico¶	—	4	19	123	236	—	0	1	—	—	—	0	1	—	—
Utah	23	19	65	390	349	—	0	8	—	—	—	0	17	—	—
Wyoming¶	—	0	11	10	11	—	0	7	—	—	—	0	10	—	—
Pacific	—	0	9	20	—	—	0	15	—	—	—	0	51	—	—
Alaska	—	0	9	20	N	—	0	0	—	—	—	0	0	—	—
California	—	0	0	—	N	—	0	15	—	—	—	0	37	—	—
Hawaii	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Oregon¶	N	0	0	N	N	—	0	2	—	—	—	0	14	—	—
Washington	N	0	0	N	N	—	0	0	—	—	—	0	2	—	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerto Rico	11	12	30	155	149	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for California serogroup, eastern equine, Powassan, St. Louis, and western equine diseases are available in Table I.
§ Not notifiable in all states. Data from states where the condition is not notifiable are excluded from this table, except in 2007 for the domestic arboviral diseases and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/epo/dphsi/phs/infdis.htm.
¶ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE III. Deaths in 122 U.S. cities,* week ending April 14, 2007 (15th Week)

Reporting Area	All causes, by age (years)						P&I†
	All Ages	≥65	45-64	25-44	1-24	<1	Total
New England	562	403	102	35	12	7	42
Boston, MA	166	104	37	14	5	3	17
Bridgeport, CT	27	18	7	2	—	—	3
Cambridge, MA	15	14	1	—	—	—	—
Fall River, MA	25	21	2	2	—	—	1
Hartford, CT	63	43	16	2	—	2	4
Lowell, MA	25	20	3	1	1	—	1
Lynn, MA	13	9	2	1	1	—	—
New Bedford, MA	29	21	4	4	—	—	3
New Haven, CT	U	U	U	U	U	U	U
Providence, RI	77	62	7	3	3	2	5
Somerville, MA	3	3	—	—	—	—	—
Springfield, MA	48	33	8	5	2	—	3
Waterbury, CT	21	17	4	—	—	—	2
Worcester, MA	50	38	11	1	—	—	3
Mid. Atlantic	2,026	1,391	434	119	36	46	109
Albany, NY	47	35	5	3	1	3	2
Allentown, PA	38	33	3	—	2	—	2
Buffalo, NY	88	56	23	6	2	1	6
Camden, NJ	10	3	4	2	—	1	—
Elizabeth, NJ	18	14	4	—	—	—	1
Erie, PA	40	33	4	2	1	—	4
Jersey City, NJ	U	U	U	U	U	U	U
New York City, NY	1,034	723	219	52	15	25	42
Newark, NJ	62	27	23	5	3	4	4
Paterson, NJ	16	8	5	3	—	—	—
Philadelphia, PA	291	177	75	28	6	5	16
Pittsburgh, PA§	32	27	4	—	1	—	3
Reading, PA	35	30	2	2	—	1	1
Rochester, NY	117	81	25	7	2	2	11
Schenectady, NY	20	19	1	—	—	—	—
Scranton, PA	30	23	4	3	—	—	5
Syracuse, NY	63	42	14	3	—	4	7
Trenton, NJ	44	32	10	—	2	—	—
Utica, NY	17	10	3	3	1	—	2
Yonkers, NY	24	18	6	—	—	—	3
E.N. Central	2,110	1,405	488	132	44	41	145
Akron, OH	56	36	16	—	2	2	1
Canton, OH	31	23	6	1	1	—	2
Chicago, IL	253	161	55	30	5	2	25
Cincinnati, OH	67	43	18	3	2	1	12
Cleveland, OH	307	218	67	11	5	6	15
Columbus, OH	201	129	52	14	1	5	13
Dayton, OH	139	108	21	8	1	1	11
Detroit, MI	177	91	58	14	8	6	16
Evansville, IN	57	38	13	4	2	—	1
Fort Wayne, IN	62	45	12	2	2	1	1
Gary, IN	17	8	6	2	1	—	2
Grand Rapids, MI	50	31	16	1	—	2	2
Indianapolis, IN	193	117	49	18	4	5	12
Lansing, MI	51	42	5	1	1	2	2
Milwaukee, WI	115	73	32	7	2	1	6
Peoria, IL	53	34	13	2	2	2	3
Rockford, IL	66	50	13	1	2	—	3
South Bend, IN	73	55	9	4	2	3	9
Toledo, OH	86	56	22	6	1	1	5
Youngstown, OH	56	47	5	3	—	1	4
W.N. Central	660	418	145	54	19	21	47
Des Moines, IA	92	64	20	5	2	1	5
Duluth, MN	35	23	9	2	1	—	3
Kansas City, KS	33	17	11	3	2	—	—
Kansas City, MO	99	59	24	7	3	6	7
Lincoln, NE	37	30	3	3	1	—	7
Minneapolis, MN	69	40	12	11	—	6	6
Omaha, NE	73	53	7	8	4	1	8
St. Louis, MO	76	33	26	7	5	2	2
St. Paul, MN	58	39	15	3	1	—	2
Wichita, KS	88	60	18	5	—	5	7

Reporting Area	All causes, by age (years)						P&I†
	All Ages	≥65	45-64	25-44	1-24	<1	Total
S. Atlantic	1,082	691	237	83	24	47	74
Atlanta, GA	—	—	—	—	—	—	—
Baltimore, MD	182	110	43	12	9	8	16
Charlotte, NC	134	90	27	10	3	4	13
Jacksonville, FL	154	106	30	13	1	4	13
Miami, FL	98	57	24	11	3	3	4
Norfolk, VA	56	33	11	6	—	6	4
Richmond, VA	76	39	19	9	1	8	2
Savannah, GA	62	37	19	3	1	2	4
St. Petersburg, FL	69	51	9	4	1	4	2
Tampa, FL	179	130	34	12	2	1	12
Washington, D.C.	50	23	15	2	3	7	1
Wilmington, DE	22	15	6	1	—	—	3
E.S. Central	906	582	228	59	19	17	66
Birmingham, AL	213	132	55	17	3	6	17
Chattanooga, TN	91	59	21	7	1	3	7
Knoxville, TN	121	87	28	5	1	—	8
Lexington, KY	55	32	17	3	—	3	2
Memphis, TN	134	74	39	13	5	3	6
Mobile, AL	84	60	19	3	2	—	3
Montgomery, AL	68	45	14	7	1	1	7
Nashville, TN	140	93	35	4	6	1	16
W.S. Central	1,456	929	351	99	37	40	90
Austin, TX	102	70	21	4	3	4	12
Baton Rouge, LA	30	25	2	1	2	—	—
Corpus Christi, TX	57	38	13	2	—	4	2
Dallas, TX	193	97	62	14	10	10	10
El Paso, TX	74	55	9	4	5	1	4
Fort Worth, TX	114	87	19	5	1	2	6
Houston, TX	374	230	97	27	11	9	19
Little Rock, AR	68	37	24	7	—	—	5
New Orleans, LA¶	U	U	U	U	U	U	U
San Antonio, TX	225	147	51	21	1	5	17
Shreveport, LA	78	47	23	5	—	3	8
Tulsa, OK	141	96	30	9	4	2	7
Mountain	1,117	755	234	71	27	29	69
Albuquerque, NM	70	50	12	5	2	—	3
Boise, ID	53	40	7	4	—	2	7
Colorado Springs, CO	96	69	14	7	2	4	2
Denver, CO	101	63	23	8	2	5	5
Las Vegas, NV	246	164	62	15	5	—	16
Ogden, UT	36	22	9	—	3	2	1
Phoenix, AZ	179	104	41	15	10	9	7
Pueblo, CO	32	25	6	1	—	—	1
Salt Like City, UT	121	78	30	7	2	4	11
Tucson, AZ	183	140	30	9	1	3	16
Pacific	1,316	905	275	75	34	27	104
Berkeley, CA	15	11	4	—	—	—	—
Fresno, CA	U	U	U	U	U	U	U
Glendale, CA	U	U	U	U	U	U	U
Honolulu, HI	80	57	16	5	—	2	10
Long Beach, CA	90	64	17	5	1	3	14
Los Angeles, CA	U	U	U	U	U	U	U
Pasadena, CA	26	20	5	1	—	—	3
Portland, OR	130	84	32	5	4	5	8
Sacramento, CA	179	134	29	5	5	6	20
San Diego, CA	156	109	30	12	4	1	14
San Francisco, CA	124	80	26	11	3	4	7
San Jose, CA	214	152	45	11	3	3	12
Santa Cruz, CA	20	15	2	2	1	—	1
Seattle, WA	105	65	22	11	4	3	9
Spokane, WA	60	39	14	3	4	—	—
Tacoma, WA	117	75	33	4	5	—	6
Total	11,235**	7,479	2,494	727	252	275	746

U: Unavailable. —:No reported cases.

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

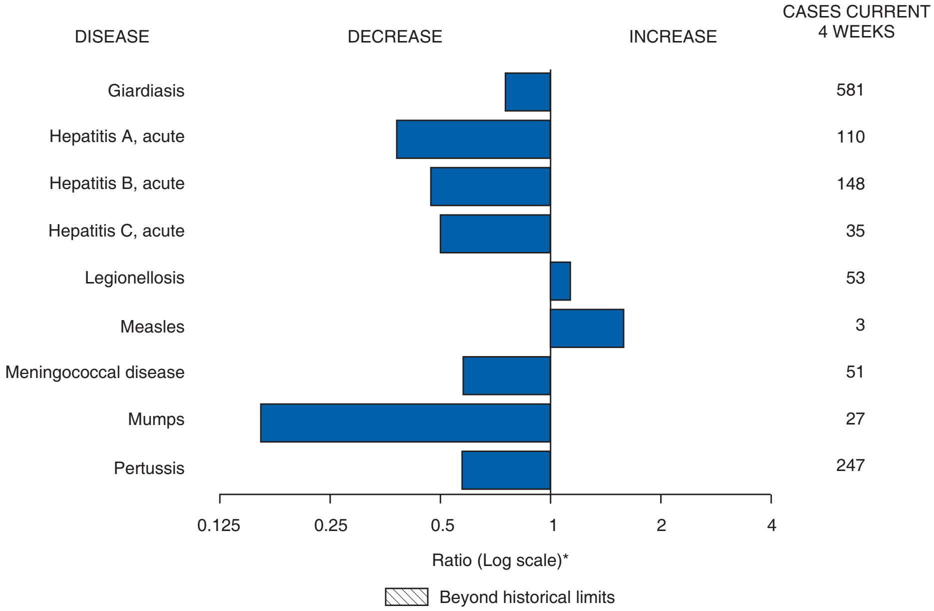
† Pneumonia and influenza.

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

¶ Because of Hurricane Katrina, weekly reporting of deaths has been temporarily disrupted.

** Total includes unknown ages.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals April 14, 2007, 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.

Notifiable Disease Data Team and 122 Cities Mortality Data Team

Patsy A. Hall

Deborah A. Adams	Rosaline Dhara
Willie J. Anderson	Vernitta Love
Lenee Blanton	Pearl C. Sharp

The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format. To receive an electronic copy each week, send an e-mail message to *listserv@listserv.cdc.gov*. The body content should read *SUBscribe mmwr-toc*. Electronic copy also is available from CDC's Internet server at *http://www.cdc.gov/mmwr* or from CDC's file transfer protocol server at *ftp://ftp.cdc.gov/pub/publications/mmwr*. Paper copy subscriptions are available through the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone 202-512-1800.

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Data are compiled in the National Center for Public Health Informatics, Division of Integrated Surveillance Systems and Services. Address all inquiries about the *MMWR* Series, including material to be considered for publication, to Editor, *MMWR* Series, Mailstop E-90, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333 or to *www.mmwrq@cdc.gov*.

☆U.S. Government Printing Office: 2007-623-038/41019 Region IV ISSN: 0149-2195