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Cigarette Smoking Among Adults — United States, 1998

One of the national health objectives for 2010 is to reduce the prevalence of cigarette smoking among adults to no more than 12% (objective 21.1a) (*1*). To assess progress toward meeting this objective, CDC analyzed self-reported data from the 1998 National Health Interview Survey (NHIS) Sample Adult Core Questionnaire about cigarette smoking among U.S. adults. This report summarizes the findings of this analysis, which indicate that, in 1998, 24.1% of adults were current smokers.

The 1998 NHIS Core Questionnaire was administered to a nationally representative sample (n=32,440) of the U.S. noninstitutionalized civilian population aged ≥18 years; the overall response rate for the survey was 73.9%. Participants were asked, "Have you smoked at least 100 cigarettes in your entire life?" and "Do you now smoke cigarettes every day, some days, or not at all?" Current smokers were persons who reported both having smoked ≥100 cigarettes during their lifetime and having smoked every day or some days at the time of the interview. Former smokers were those who had smoked ≥100 cigarettes during their lifetime but did not currently smoke. Attempts to quit were determined by asking current smokers, "During the past 12 months, have you stopped smoking for one day or longer because you were trying to stop smoking?" Data were adjusted for nonresponse and weighted to provide national estimates. Confidence intervals (CIs) were calculated using SUDAAN.

In 1998, an estimated 47.2 million adults (24.1%), comprising 24.8 million men (26.4%) and 22.4 million women (22.0%), were current smokers (Table 1). Overall, 19.7% (95% CI=±0.6) of adults were every-day smokers, and 4.2% (95% CI=±0.3) were some-day smokers (every-day smokers constituted 82.4% [95% CI=±1.0] of all smokers). Prevalence of smoking was highest among persons aged 18–24 years (27.9%) and aged 25–44 years (27.5%), and lowest among persons aged ≥65 years (10.9%). Prevalence of current smoking was highest among American Indians/Alaska Natives (40.0%), intermediate among non-Hispanic whites (25.0%) and non-Hispanic blacks (24.7%), and lowest among Hispanics (19.1%) and Asians/Pacific Islanders (13.7%). Adults with ≥16 years of education had the lowest smoking prevalence (11.3%), achieving the 2010 goal of reducing smoking rates to no more than 12%. Current smoking prevalence was highest among persons with 9–11 years of education (36.8%). Smoking prevalence was higher among persons living below the poverty level* (32.3%) than among those living at or above the poverty level (23.5%).

*1997 poverty thresholds from the Bureau of the Census, Economics and Statistics Administration, U.S. Department of Commerce, were used in these calculations.

Cigarette Smoking — Continued

TABLE 1. Percentage of persons aged ≥18 years who were current smokers*, by selected characteristics — National Health Interview Survey, United States, 1998

	Men (n=14,202)		Women (n=18,238)		Total (n=32,440)	
Characteristic	**%**	**(95% CI†)**	**%**	**(95% CI)**	**%**	**(95% CI)**
Race/Ethnicity§						
White, non-Hispanic	26.5	(± 1.0)	23.6	(± 0.9)	**25.0**	(±**0.7**)
Black, non-Hispanic	29.0	(± 2.5)	21.3	(± 2.0)	**24.7**	(±**1.6**)
Hispanic	24.7	(± 2.1)	13.3	(± 1.4)	**19.1**	(±**1.3**)
American Indian/ Alaska Native¶	41.7	(±13.8)	38.1	(±11.9)	**40.0**	(±**9.8**)
Asian/Pacific Islander	17.9	(± 4.6)	9.9	(± 4.2)	**13.7**	(±**3.0**)
Education**						
≤8	27.7	(± 3.0)	16.7	(± 2.4)	**21.9**	(±**2.0**)
9–11	39.7	(± 3.3)	34.3	(± 2.8)	**36.8**	(±**2.2**)
12	31.5	(± 1.8)	24.1	(± 1.4)	**27.4**	(±**1.1**)
13–15	26.6	(± 1.8)	22.8	(± 1.5)	**24.6**	(±**1.1**)
≥16	11.5	(± 1.2)	11.2	(± 1.2)	**11.3**	(±**0.9**)
Age group (yrs)						
18–24	31.3	(± 2.9)	24.5	(± 2.6)	**27.9**	(±**1.9**)
25–44	29.4	(± 1.3)	25.6	(± 1.2)	**27.5**	(±**0.9**)
45–64	27.7	(± 1.6)	22.5	(± 1.3)	**25.0**	(±**1.0**)
≥65	10.4	(± 1.3)	11.2	(± 1.2)	**10.9**	(±**0.8**)
Poverty level††						
At or above	25.7	(± 1.0)	21.3	(± 0.9)	**23.5**	(±**0.7**)
Below	37.0	(± 3.2)	29.3	(± 2.1)	**32.3**	(±**1.8**)
Unknown	25.3	(± 2.0)	20.2	(± 1.6)	**22.5**	(±**1.3**)
Total	**26.4**	(± **0.9**)	**22.0**	(± **0.8**)	**24.1**	(±**0.6**)

* Persons who reported having ≥100 cigarettes during their lifetime and who reported now smoking every day or some days. Excludes 285 respondents for whom smoking status was unknown.
† Confidence Interval.
§ Excludes 79 respondents of unknown, multiple, or other racial/ethnic categories.
¶ Wide variances on estimates reflect the small sample sizes.
** Persons aged ≥25 years. Excludes 1021 persons with unknown years of education.
†† 1997 poverty thresholds from the Bureau of the Census, Economics and Statistics Administration, U.S. Department of Commerce, were used in these calculations.

In 1998, an estimated 44.8 million adults (22.9% [95% CI=±0.6]) were former smokers, comprising 25.7 million men and 19.1 million women. Former smokers constituted 48.7% (95% CI=±1.0) of persons who had ever smoked ≥100 cigarettes. Among current daily smokers in 1998, an estimated 15.2 million (39.2% [95% CI=±1.4]) had stopped smoking for at least 1 day during the preceding 12 months because they were trying to stop smoking.

Reported by: Epidemiology Br, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: The findings in this report suggest that the goal of reducing the prevalence of cigarette smoking among adults to ≤12% by 2010 will require aggressive public health efforts to implement comprehensive tobacco-control programs nationwide (*2*). The 1998 NHIS data also demonstrate substantial differences in smoking prevalence across populations.

Cigarette Smoking — Continued

In 1998, smoking prevalence among persons aged 18–24 years was as high as the prevalence among persons aged 25–44 years. Historically, smoking prevalence has been highest among persons aged 25–44 years and significantly lower among persons aged 18–24 years. Recent increases among persons aged 18–24 years may reflect the aging of the cohort of high school students among whom current smoking rates were high during the 1990s (*3*). In addition, the increase may indicate increased initiation of smoking among young adults. The high prevalence of smoking among young adults indicates a need to focus tobacco-use prevention and treatment programs on both adolescents and young adults.

Smoking prevalence reported for racial/ethnic subgroups showed few changes from 1997 (*4*) to 1998. Prevalence of current smoking among American Indians/Alaska Natives remained the highest. State and regional surveys indicate that the prevalence of smoking cessation among American Indians/Alaska Natives remains relatively low (*5*). Although many factors contribute to the high prevalence of smoking among American Indians/Alaska Natives, it is important to develop culturally appropriate prevention and control measures that distinguish between the use of manufactured tobacco products and the ceremonial use of tobacco.

National health objectives for 2010 that are focused on eliminating population disparities reinforce the need for greater surveillance and culturally responsive approaches to tobacco use across communities (*1*). In the United States, population disparities in smoking prevalence have been consistent from 1993 through 1998. For example, in 1993, an 8.3 (95% CI=±2.5) percentage-point difference in smoking prevalence existed between those at or above the poverty level and those below (23.8% and 32.1%, respectively). In 1998, the difference was 8.8 (95% CI=±1.9) percentage points (23.5% and 32.3%, respectively). Similarly, differences in prevalence among various educational groups have not been reduced. In 1993, the difference between those with 9–11 years of education and those with ≥16 years was 23.3 (95% CI=±3.0) percentage points (36.8% and 13.5%, respectively). In 1998, the difference was 25.5 (95% CI=±2.3) percentage points (36.8% and 11.3%, respectively). The relation between tobacco use and increased risk for failing or dropping out of high school demonstrates the necessity of reaching these students (*6*) through school-based programs (*7,8*) before they leave school. Differences in prevalence among racial/ethnic subgroups have not been reduced. For example, in 1993, the difference between non-Hispanic whites and American Indians/Alaska Natives was 13.3 (95% CI=±8.7) percentage points (25.4% and 38.7%, respectively). In 1998, the difference between non-Hispanic whites and American Indians/Alaska Natives was 15.0 (95% CI=±9.8) percentage points (25.0% and 40.0%, respectively). The reduction of tobacco-related health disparities requires communities, states, and national organizations to take a multidisciplinary approach to tobacco prevention and control (*7,8*).

The findings in this report are subject to at least two limitations. Because the questionnaire for the 1997 NHIS was redesigned completely, trend analysis or comparison with data from years before 1997 should be conducted with caution. Second, the sample size of certain subgroups (e.g., American Indians/Alaska Natives) was small, possibly resulting in unstable estimates.

Although comprehensive programs are critical in reducing the burden of tobacco use, short-term decreases in tobacco-related morbidity and mortality can be achieved only by helping current smokers quit. To assist in this process, the U.S. Department of Health and Human Services has released guidelines (*9*) with specific evidence-based recommendations for tobacco-use treatment. Recommended interventions include individual,

Cigarette Smoking — Continued

group, or telephone counseling that offers practical advice about and support for quitting; support from family and friends also improves success rates. In addition, all smokers trying to quit should be encouraged to use a medication approved by the Food and Drug Administration, either nicotine replacement therapy (gum, inhaler, nasal spray, or patch) or a non-nicotine pharmacologic aid (buproprion). To ensure that smokers interested in quitting receive appropriate treatment, health-care systems must make routine screening of tobacco use the standard of care and monitor (through quality assurance processes) the provision of appropriate interventions to smokers. Improving access to treatment by reducing cost barriers also increases the number of quitters.

A comprehensive approach to tobacco control will require treatment for nicotine dependence and efforts at national, state, and local levels to reduce youth smoking, promote smoke-free environments, support countermarketing efforts, enforce laws and regulations, and eliminate disparities in tobacco use among population subgroups (*7,8*). Increased attention must be focused on groups that show no decline in smoking prevalence, including persons aged 18–24 years, adults with low education levels, and American Indians/Alaska Natives. Approaches with the widest scope (i.e., economic, regulatory, and comprehensive) are likely to have the greatest long-term population impact (*10*).

References

1. US Department of Health and Human Services. Healthy people 2010 (conference ed., 2 vols). Washington, DC: US Department of Health and Human Services, 2000.
2. Green LW, Ericksen MP, Bailey L, Husten C. Achieving the implausible in the next decades: tobacco control objectives. Am J Public Health 2000;90:337–9.
3. Kann L, Kinchen SA, Williams BI, et al. Youth risk behavior surveillance—United States, 1999. In: CDC surveillance summaries (June). MMWR 2000;49(no. SS-5).
4. CDC. Cigarette smoking among adults—United States, 1997. MMWR 1999;48:993–6.
5. US Department of Health and Human Services. Tobacco use among U.S. racial/ethnic minority groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: a report of the Surgeon General. Atlanta, Georgia: US Department of Health and Human Services, CDC, 1998.
6. CDC. Youth risk behavior surveillance—national Alternative High School Youth Risk Behavior Survey, United States, 1998. In: CDC Surveillance Summaries (October). MMWR 1999;48(no. SS-7).
7. CDC. Best practices of comprehensive tobacco control programs. Atlanta, Georgia: US Department of Health and Human Services, CDC, 1999.
8. National Association of County and City Health Officials. Program and funding guidelines for comprehensive local tobacco control programs. Washington, DC: National Association of County and City Health Officials, April 2000.
9. Fiore MC, Bailey WC, Cohen SJ, et al. Treating tobacco use and dependence: a clinical practice guideline. Rockville, Maryland: US Department of Health and Human Services, June 2000.
10. US Department of Health and Human Services. Reducing tobacco use: a report of the Surgeon General. Atlanta, Georgia: US Department of Health and Human Services, CDC, 2000.

Consequences of Delayed Diagnosis of Rocky Mountain Spotted Fever in Children — West Virginia, Michigan, Tennessee, and Oklahoma, May–July 2000

Patients with Rocky Mountain spotted fever (RMSF), a tickborne infection caused by *Rickettsia rickettsii*, respond quickly to tetracycline-class antibiotics (e.g., doxycycline) when therapy is started within the first few days of illness; however, untreated RMSF may result in severe illness and death. Persons aged <10 years have the highest age-specific incidence of RMSF (*1,2*). This report summarizes the clinical course and outcome of RMSF in four children from four regions of the United States and underscores the need for clinicians throughout the United States to consider RMSF in children with rash and fever, particularly those with a history of tick bite or who present during April–September when approximately 90% of RMSF cases occur (*1,2*).

West Virginia

On May 12, a child aged 15 months presented to a physician with a 2-day history of maculopapular rash and fever. A tick had been removed from the patient's scalp 1 week before onset of symptoms. The patient was thought to have a viral illness. On May 16, the patient returned to the physician with continued fever and irritability; an allergy to a sulfa-containing antimicrobial prescribed on the previous visit was suspected, and treatment was switched to an oral penicillin-class antibiotic. On May 17, the patient was seen twice at a local emergency department (ED) and, by the second visit, exhibited lethargy, seizures, a generalized petechial rash, hyponatremia (131 mmol of sodium/L) (normal range: 135–145 mmol/L), and thrombocytopenia (8 x 10^9 platelets/L) (normal range: 150–350 x 10^9/L). The patient was transported to a tertiary medical center with a differential diagnosis of bacterial sepsis, meningitis, or a rickettsial disease and immediately was started on intravenous doxycycline. Shortly after admission, the patient required intubation for respiratory distress and anticonvulsant therapy for seizures. On May 19, the patient died. Paired serum samples demonstrated a four-fold increase (from 80 to 320) in reciprocal IgM antibody titers reactive with *R. rickettsii* when tested using an indirect immunofluorescence assay (IFA). When stained by using an immunohistochemical (IHC) technique, tissue samples obtained at autopsy demonstrated spotted fever group rickettsiae.

Michigan

On June 1, a child aged 3 years presented to a physician with a 4-day history of rash and a temperature of 101.3 F (38.5 C). On clinical examination, the patient had a fine red-purple rash on the cheeks, trunk, upper extremities, and palms, thrombocytopenia (102 x 10^9/L), and a normal white blood cell (WBC) count (5.8 cells x 10^9/L). The patient's mother reported that she recently had found a tick on the patient's scalp. The patient was diagnosed with a viral exanthem. On June 2, the patient was still febrile but the rash had faded, and the patient was given an oral cephalosporin-class antibiotic. On June 5, the patient developed vomiting, decreased appetite, persistent crying, and disorientation. The patient's mother reported that she had removed a second tick that day. Clinical examination revealed generalized petechiae, hepatosplenomegaly, dry mucous membranes, and pallor. Laboratory findings included thrombocytopenia (38 x 10^9/L), an elevated WBC count (19 x 10^9/L), hyponatremia (124 mmol/L), elevated aspartate aminotransferase (AST 7.20 μkat/L) (normal range: 0.17–0.67 μkat/L), and alanine aminotransferase (ALT 1.63 μkat/L) (normal range: 0.17–0.92 μkat/L). The patient was admitted to a hospital, and within several hours the patient became cyanotic, developed seizures, and

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died. Using an IHC stain, tissue samples obtained at autopsy revealed spotted fever group rickettsiae. Using a polymerase chain reaction assay, a whole blood sample was positive for DNA of *R. rickettsii*.

Tennessee

On June 15, a child aged 11 years presented to an ED with a 1-day history of severe headache and a temperature of 102.4 F (39.1 C). On clinical examination, an injected tympanic membrane was found, and the patient received an oral penicillin for otitis media and released. No history of tick bite was reported. On June 16, the patient developed a diffuse maculopapular rash, and on June 20, the patient was hospitalized because of persistent fever, headache, and vomiting; a viral exanthem or an allergic reaction to the antibiotic was suspected. Laboratory findings included elevated AST (0.96 μkat/L) and ALT (1.52 μkat/L). On June 24, the patient was treated intravenously with a cephalosporin and sent home; however, the patient continued to have fever and headache. On June 30, IFA results from a serum sample obtained June 21 revealed positive IgG and IgM antibody titers (64 and 64, respectively) reactive with *R. rickettsii*. The patient received oral doxycycline and the symptoms resolved over the next 7 days. On July 6, IFA results of a serum specimen demonstrated an eight-fold increase in the IgG antibody titer to 512, confirming the diagnosis of RMSF.

Oklahoma

On July 7, a child aged 6 years presented to a physician with a 1-day history of a temperature of 102.2 F (39.0 C), headache, myalgia, diarrhea, and a macular rash on the arms, legs, palms, and soles. On July 1, a tick had been removed from the back of the patient's neck. On July 10, the patient was diagnosed with a viral illness. When the symptoms worsened, the patient was given an oral cephalosporin. On July 11, the patient was hospitalized with dehydration, irritability, confusion, and thrombocytopenia (26×10^9/L). On July 12, the patient was transferred to a tertiary care medical center with disseminated intravascular coagulation. Laboratory results included an elevated WBC count (20×10^9/L) and AST (3.65 μkat/L), and thrombocytopenia (9×10^9/L). On July 13, therapy with intravenous doxycycline for possible RMSF was initiated. The patient subsequently developed gangrene, requiring limb amputation and removal of the upper stomach and distal esophagus. On August 19, the patient died. Using an enzyme immunoassay, a serum sample collected on July 12 tested positive for IgG antibodies reactive with *R. rickettsii*. Serum obtained on August 3 and tested using an IFA demonstrated a high positive IgG antibody titer of 1024 reactive with *R. rickettsii*.

Reported by: L Minnich, MS, JE McJunkin, MD, Charleston Area Medical Center, Charleston; D Bixler, MD, C Slemp, MD, L Haddy, MA, State Epidemiologist, West Virginia Dept of Health and Human Resources. F Busse, MD, M Harrison, MD, Lakeland Medical Center, Lakeland; MG Stobierski, DVM, ML Boulton, MD, State Epidemiologist, Michigan Dept of Community Health. T Jones, MD, W Moore, MD, State Epidemiologist, Tennessee Dept of Public Health. P Barton, MD, St. Francis Hospital, Tulsa; K Bradley, DVM, M Crutcher, MD, State Epidemiologist, Oklahoma State Dept of Health. State Br, Div of Applied Public Health Training, Epidemiology Program Office; Infectious Disease Pathology Activity, and Viral and Rickettsial Zoonoses Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; and EIS officers, CDC.

Editorial Note: Despite its name, RMSF has been reported throughout the continental United States (except in Maine and Vermont) (*1*,*2*). During 1990–1998, approximately 4800 RMSF cases were reported to CDC. Approximately 20% of the cases and 15% of

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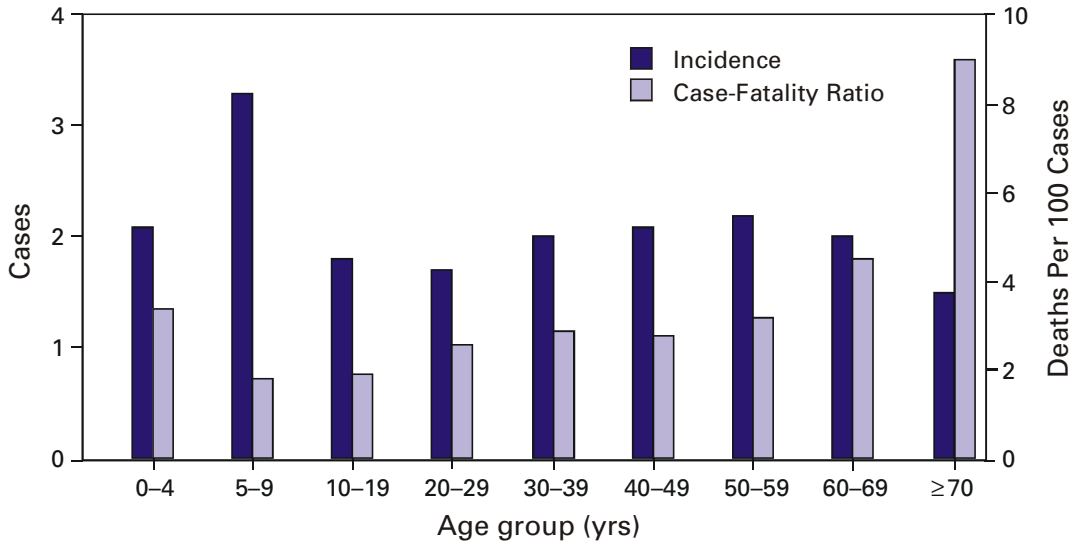
reported deaths were in persons aged <10 years. Because of RMSF's rapid course, half the RMSF deaths in this age group occurred within 9 days of illness onset, leaving no more than several days to establish the diagnosis and initiate specific antibiotic therapy. Before the discovery of effective antirickettsial drugs, 13% of children with RMSF died (*3*). Despite the availability of treatment and advances in supportive medical care, the case-fatality ratio is 2%–3% for patients aged <10 years with RMSF (Figure 1).

In its early stages, RMSF may resemble other infectious and noninfectious conditions and can be difficult to diagnose even for physicians familiar with the disease (*4,5*). Because only 3%–18% of patients present with rash, fever, and a history of tick exposure on their first visit (*4–6*), physicians should consider RMSF in infants and children even when one feature is lacking. The absence of tick exposure should not dissuade the clinician from suspecting RMSF. Laboratory abnormalities such as thrombocytopenia and hyponatremia should also raise the possibility of RMSF (*5*).

Delayed diagnosis and late initiation of specific antirickettsial therapy (e.g., on or after day 5 of the illness) is associated with substantially greater risk for a fatal outcome (*1,4,5*). Treatment never should be delayed pending a laboratory diagnosis. Most broad-spectrum antibiotics, including penicillins, cephalosporins, and sulfa-containing antimicrobials, are ineffective treatments for RMSF. In almost all clinical situations, including disease in children aged <8 years, the antibiotic of choice is doxycycline (*7*). However, this drug is used infrequently as initial therapy even for children who present with signs and symptoms of a rickettsial illness (*6*). The use of tetracyclines in young children has been discouraged because of the potential for tooth discoloration and should be

FIGURE 1. Age-specific incidence of Rocky Mountain spotted fever (RMSF)* and case-fatality ratio, by age group — United States, 1990–1998†



*Per million population.

† Incidence rates were calculated using data from the National Electronic Telecommunications System for Surveillance and from 1990–1998 U.S. Bureau of the Census data. Case-fatality ratios were calculated from laboratory-confirmed cases of RMSF reported to CDC through RMSF case report forms.

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reserved for patients in whom a rickettsial illness is strongly suspected; however, tetracycline staining of teeth is dose related and available data suggest that one course of doxycycline for presumed RMSF does not cause clinically significant staining of permanent teeth (*8*).

The most effective ways to reduce the risk for RMSF in children are for supervising adults to 1) limit the child's exposure to ticks, especially during April–September; 2) thoroughly inspect the head, body, and clothes for ticks after time spent in wooded or grassy areas, especially along the edges of trails, roads, or yards; and 3) immediately remove attached ticks by grasping the tick with tweezers or forceps close to the skin and pulling gently with steady pressure. More information about RMSF is available on the World-Wide Web, http://www.cdc.gov/ncidod/dvrd/rmsf.

References

1. Dalton MJ, Clarke MJ, Holman RC, et al. National surveillance for Rocky Mountain spotted fever, 1981–1992: epidemiologic summary and evaluation of risk factors for fatal outcome. Am J Trop Med Hyg 1995;52:405–13.
2. Treadwell TA, Holman RC, Clarke MJ, et al. Rocky Mountain spotted fever in the United States, 1993 through 1996. Am J Trop Med Hyg 2000;62(in press).
3. Topping NH. Rocky Mountain spotted fever: a note on some aspects of its epidemiology. Public Health Rep 1941;56:1699–703.
4. Kirkland KB, Wilkinson WE, Sexton DJ. Therapeutic delay and mortality in cases of Rocky Mountain spotted fever. Clin Infect Dis 1995;20:1118–21.
5. Helmick CG, Bernard KW, D'Angelo LJ. Rocky Mountain spotted fever: clinical, laboratory, and epidemiological features of 262 cases. J Infect Dis 1984;150:480.
6. Purvis JJ, Edwards MS. Doxycycline use for rickettsial disease in pediatric patients. Pediatr Infect Dis J 2000;19:871–4.
7. American Academy of Pediatrics. Rocky Mountain spotted fever. In: Pickering LK, ed. 2000 Red Book: Report of the Committee on Infectious Diseases. 25th ed. Elk Grove Village, Illinois: American Academy of Pediatrics, 2000:491–3.
8. Lochary ME, Lockhart PB, Williams WT. Doxycycline and staining of permanent teeth. Pediatr Infect Dis J 1998;17:429–31.

Notice to Readers

Updated Recommendations From the Advisory Committee on Immunization Practices in Response to Delays in Supply of Influenza Vaccine for the 2000–01 Season

On July 14, CDC reported a substantial delay in the availability of a proportion of influenza vaccine for the 2000–01 season and the possibility of a vaccine shortage (*1*). Since then, resolution of manufacturing problems and improved yields of the influenza A (H3N2) vaccine component have averted a shortage. Although safe and effective influenza vaccine will be available in similar quantities as last year, much of the vaccine will be distributed later in the season than usual. This update provides information on the influenza vaccine supply situation and updated influenza vaccination recommendations by the Advisory Committee on Immunization Practices (ACIP) for the 2000–01 influenza season.

For the 1999–2000 influenza season, approximately 77 million doses of vaccine were

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distributed, of which 3 million doses were returned. On the basis of information provided by manufacturers, distribution of approximately 75 million doses is anticipated for the 2000–01 season, including 9 million doses that CDC has contracted with Aventis Pasteur (Swiftwater, Pennsylvania) to produce. Most vaccine doses usually become available to providers by October, with 99% of distributed doses available before December; this year, approximately 18 million doses are expected to be distributed in December.

The optimal time to administer influenza vaccine is October through mid-November (*2*) to assure that vaccination occurs before there is substantial influenza activity. In any influenza season, vaccine should continue to be offered after November to persons at high risk for influenza complications; this will be particularly important in this season in which vaccine delivery is delayed. The effectiveness of this approach is supported by surveillance data from the past 18 years, indicating that seasonal activity peaked four times in December, four times in January, seven times in February, and three times in March.

Vaccination of persons aged ≥65 years substantially reduces influenza morbidity and mortality. For each additional million elderly persons vaccinated, CDC estimates that approximately 900 deaths and 1300 hospitalizations would be averted during the average influenza season (CDC, unpublished data, 2000). The health impact of individual seasons can vary widely on the basis of the size of the susceptible population, the prevalence of influenza infections, the type and strain of the predominating virus(es), and the match between the vaccine strains and those circulating in the community. The primary goal of influenza vaccination is to prevent severe illness and death from influenza infection and its complications. Although the severity of influenza seasons varies, an annual average of approximately 20,000 deaths and 110,000 pneumonia and influenza (P&I) hospitalizations result from influenza infections (*3–5*). More than 18,000 (>90%) of these deaths and approximately 48,000 of the P&I hospitalizations per year occur among persons aged ≥5 years who are at highest risk for influenza-related complications.

Because of the potential health impact of delayed influenza vaccine availability, CDC and ACIP updated recommendations for the 2000–01 season. The goal of these recommendations is to minimize the adverse health impact of delays on high-risk persons. Minimizing the adverse impact on this group will require an effective response by the private and public sectors, including actions that have not been undertaken during past seasons.

Updated ACIP Recommendations for the 2000–01 Influenza Season

Persons at high risk for complications from influenza are:

1. persons aged ≥65 years;
2. residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions;
3. children and adults who have chronic disorders of the pulmonary or cardiovascular systems, including asthma;
4. children and adults who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (e.g., caused by medications or human immunodeficiency virus);
5. persons aged 6 months–18 years who are receiving long-term aspirin therapy and therefore might be at risk for developing Reye syndrome after influenza; and
6. women who will be in the second or third trimester of pregnancy during the influenza season.

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- When influenza vaccine becomes available, vaccination efforts should be focused on persons at high risk for complications associated with influenza disease and on health-care workers who care for these persons.
- Temporary shortages because of delayed or partial shipments may require decisions on how to prioritize use of vaccine available early in the season among high-risk persons and health-care workers; such decisions are best made by those familiar with the local situation. Vaccine available early in the season should be used to maximize protection of high-risk persons. Because vaccine supplies are expected to increase substantially in November and December, plans should be made to continue vaccination of high-risk persons and health-care workers into December and later.
- Mass vaccination campaigns should be scheduled later in the season as availability of vaccine is assured. Based on projected vaccine distribution, in most areas campaigns will be scheduled in November or later. Efforts should be made to increase participation by high-risk persons and their household contacts, but other persons should not be turned away.
- Groups implementing mass vaccination efforts should seek to enhance coverage among those at greatest risk for complications of influenza and their household contacts. Strategies for targeting mass vaccination efforts at high-risk persons include 1) targeting announcements in publications and other media focused toward the elderly and those with high-risk medical conditions; 2) establishing liaisons with community groups representing the elderly and those with chronic diseases; and 3) offering vaccination to elderly relatives of persons in the workplace and employees.
- Special efforts should be made in December and later to vaccinate persons aged 50–64 years, including those who are not at high risk and are not household contacts of high-risk persons. Persons in this age group with high-risk conditions should be vaccinated along with other high-risk persons. However, special efforts to vaccinate healthy persons in this age group should begin in December and continue as long as vaccine is available.
- Vaccination efforts for all groups should continue into December and later as long as influenza vaccine is available. Production of influenza vaccine will continue through December, and providers should plan for how vaccine provided late in the season can be used effectively. Vaccination providers who administer all of their available influenza vaccine supply early in the season and who still have unvaccinated high-risk patients should order additional vaccine that will become available in December. To minimize wastage of influenza vaccine, providers whose initial vaccine orders are delayed or partially filled should not seek replacement vaccine from other manufacturers or distributors unless use of all vaccine doses ordered can be assured during the 2000–01 season.
- Pneumococcal vaccines are recommended by ACIP for many of the same high-risk persons for whom influenza vaccine is recommended (*6,7*). Assuring pneumococcal vaccination of high-risk persons in accordance with ACIP recommendations early in the season will confer substantial protection from a major complication of influenza (pneumococcal pneumonia).
- Annual influenza vaccination provides an opportunity to review the pneumococcal vaccination status of persons for whom pneumococcal vaccination is recommended by ACIP. This season, pneumococcal vaccine should be administered

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when indicated even if influenza vaccine is not yet available. Providers should emphasize to patients or their caregivers that pneumococcal vaccination is not a substitute for influenza vaccination and that patients need to return for influenza vaccine when it is available.

Role of Health-Care Organizations and Health-Care Providers

ACIP encourages health-care organizations and providers to undertake special efforts to maximize influenza vaccine coverage among high-risk persons. Health-care organizations and medical providers that can identify elderly and high-risk patients from computerized administrative databases or clinical records should evaluate their capacity to send reminders directly to these patients. Reminder-recall systems have been proven effective in increasing vaccination coverage and are recommended by the Task Force on Community Preventive Services (*8*). In addition, ACIP recommends use of standing orders in long-term–care facilities and other settings (e.g., inpatient and outpatient facilities, managed-care organizations, assisted-living facilities, correctional facilities, adult workplaces, and home health-care agencies) to ensure the administration of recommended vaccinations for adults, including influenza vaccine (*9*). Assuring that elderly and high-risk patients receive vaccine before hospital discharge throughout the influenza season will provide protection for a large number of high-risk persons.

Role of State and Local Health Departments

State and local health departments can play a critical role in promoting vaccination of high-risk persons and in promoting ongoing vaccination through December and later. Because only a small proportion of influenza vaccine is delivered by the public sector, the greatest impact may be achieved through the formation of coalitions that include community and provider organizations to promote the strategies recommended by ACIP. Key coalition partners include professional societies, Health Care Financing Administration peer review organizations that have an existing focus on influenza vaccination through the National Pneumonia Project, and community groups that focus on high-risk populations. Many states already may have an active coalition for adult vaccination that could serve as a focus for state and local efforts. Health departments also can play a key role in disseminating timely and accurate local information on influenza activity and communicating local availability of vaccine to high-risk groups and monitoring and promoting vaccination of residents of long-term–care facilities.

Update on Use of Influenza Vaccine in Children

Early vaccination of young children with high-risk conditions is a priority because two doses of vaccine administered at least 1 month apart are recommended for children aged <9 years who are receiving influenza vaccine for the first time. Two influenza vaccines (Flushield™, Wyeth Laboratories, Inc. [Marietta, Pennsylvania], and Fluzone® split, Aventis Pasteur, Inc.) are licensed and recommended for use in high-risk children aged ≥6 months. One other influenza vaccine, Fluvirin™ (Medeva Pharma Ltd., Leatherhead, England), is labeled in the United States for use only in persons aged ≥4 years because its efficacy in younger persons has not been demonstrated. Because Fluvirin™ is not indicated for children aged 6 months–3 years, providers should use other approved influenza vaccines for vaccination of children in this age group.

CDC will provide information material to assist state health departments and other organizations in their communication and education efforts. This material and updates on the influenza vaccine supply will be posted on CDC's World-Wide Web site,

Notices to Readers — Continued

http://www.cdc.gov/nip. Additional information and assistance can be obtained by contacting CDC's National Immunization Program by e-mail, nipinfo@cdc.gov, or the National Immunization Information Hotline, telephone (800) 232-2522.

References

1. CDC. Delayed supply of influenza vaccine and adjunct ACIP influenza vaccine recommendations for the 2000–01 influenza season. MMWR 2000;49:619–22.
2. CDC. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2000;49(no. RR-3).
3. Simonsen L, Schonberger LB, Stroup DF, Arden NH, Cox NJ. The impact of influenza on mortality in the USA. In: Brown LE, Hampson AW, Webster RB, eds. Options for the control of influenza III. Amsterdam, The Netherlands: Elsevier Science BV, 1996:26–33.
4. Lui K-J, Kendal AP. Impact of influenza epidemics on mortality in the United States from October 1972 to May 1985. Am J Public Health 1987;77:712–6.
5. Simonsen L, Fukuda K, Schonberger LB, Cox NJ. The impact of influenza epidemics on hospitalizations. J Infect Dis 2000;181:831–7.
6. CDC. Prevention of pneumococcal disease: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1997;46(no. RR-8).
7. CDC. Preventing pneumococcal disease among infants and young children, MMWR 2000;49(no RR-9).
8. Task Force for Community Preventive Services. Recommendations regarding interventions to improve vaccination coverage in children, adolescents, and adults. Am J Prev Med 2000;18:92–6.
9. CDC. Adult immunization programs in nontraditional settings: quality standards and guidance for program evaluation—a report of the National Vaccine Advisory Committee and use of standing orders programs to increase adult vaccination rates: recommendations of the Advisory Committee on Immunization Practices. MMWR 2000;49(no. RR-1).

Notice to Readers

Changes in National Notifiable Diseases Data Presentation

This issue of *MMWR* incorporates modifications to Tables I and II, Cases of Notifiable Diseases, United States. The modifications will add diseases designated nationally notifiable by the Council of State and Territorial Epidemiologists and CDC. As of January 1, 2000, 60 infectious diseases were designated as notifiable at the national level (Table 1). Except where otherwise indicated, the data presented in the notifiable disease tables are transmitted to CDC through the National Electronic Telecommunications System for Surveillance (NETSS).

For the infectious diseases added to the list of nationally notifiable diseases that were reportable in <40 states in 2000, data now will be included in Table I; these diseases are Q fever and tularemia. Because not all nationally notifiable diseases are reportable in every state or territory, the reported numbers of cases of some diseases in Table I represent only the totals from states or territories in which the diseases are reportable. Cumulative totals of the number of reported cases of listeriosis by state and territory in 2000 were added to Table II.

Reported by: Council of State and Territorial Epidemiologists. Div of Public Health Surveillance and Informatics, Epidemiology Program Office, CDC.

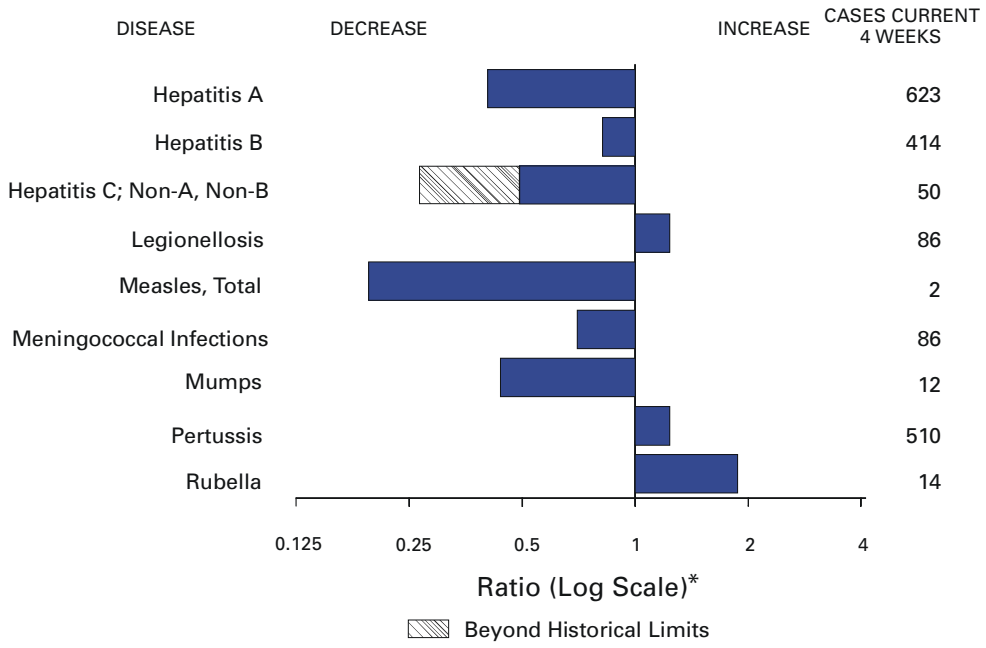
Notices to Readers — Continued

TABLE 1. Infectious diseases designated as notifiable at the national level — United States, 2000*

Acquired Immunodeficiency Syndrome (AIDS)	Listeriosis
Anthrax	Lyme disease
Botulism	Malaria
Brucellosis	Measles
Chancroid	Meningococcal disease
Chlamydia trachomatis, genital infections	Mumps
Cholera	Pertussis
Coccidioidomycosis	Plague
Cryptosporidiosis	Poliomyelitis, paralytic
Cyclosporiasis	Psittacosis
Diphtheria	Q fever
Ehrlichiosis, human granulocytic	Rabies, animal
Ehrlichiosis, human monocytic	Rabies, human
Encephalitis, California serogroup viral	Rocky Mountain spotted fever
Encephalitis, eastern equine	Rubella
Encephalitis, St. Louis	Rubella, congenital syndrome
Encephalitis, western equine	Salmonellosis
Escherichia coli O157:H7	Shigellosis
Gonorrhea	Streptococcal disease, invasive, Group A
Haemophilus influenzae, invasive disease	*Streptococcus pneumoniae,* drug resistant
Hansen disease (leprosy)	Streptococcal toxic-shock syndrome
Hantavirus pulmonary syndrome	Syphilis
Hemolytic uremic syndrome, postdiarrheal	Syphilis, congenital
Hepatitis A	Tetanus
Hepatitis B	Toxic-shock syndrome
Hepatitis, C/non A, non B	Trichinosis
HIV infection, adult (≥13 years)	Tuberculosis
HIV infection, pediatric (<13 years)	Tularemia
Legionellosis	Typhoid fever
	Varicella (deaths only)
	Yellow fever

*Although not a nationally notifiable disease, the Council of State and Territorial Epidemiologists recommends reporting cases of varicella (chickenpox) through the National Notifiable Diseases Surveillance System.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending September 30, 2000, with historical data



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

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending September 30, 2000 (39th Week)

	Cum. 2000		Cum. 2000
Anthrax	-	Poliomyelitis, paralytic	-
Brucellosis*	52	Psittacosis*	8
Cholera	1	Q fever*	14
Cyclosporiasis*	35	Rabies, human	-
Diphtheria	1	Rocky Mountain spotted fever (RMSF)	342
Ehrlichiosis: human granulocytic (HGE)*	139	Rubella, congenital syndrome	6
human monocytic (HME)*	80	Streptococcal disease, invasive, group A	2,208
Encephalitis: California serogroup viral*	83	Streptococcal toxic-shock syndrome*	62
eastern equine*	-	Syphilis, congenital¶	172
St. Louis*	1	Tetanus	19
western equine*	-	Toxic-shock syndrome	118
Hansen disease (leprosy)*	47	Trichinosis	7
Hantavirus pulmonary syndrome*†	27	Tularemia*	100
Hemolytic uremic syndrome, postdiarrheal*	134	Typhoid fever	264
HIV infection, pediatric*§	170	Yellow fever	-
Plague	5		

-: No reported cases.
*Not notifiable in all states.
† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID).
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update September 24, 2000.
¶ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending September 30, 2000, and October 2, 1999 (39th Week)

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7*			
							NETSS		PHLIS	
	Cum. 2000§	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	30,346	33,919	478,874	489,450	1,748	1,970	3,429	2,729	2,321	2,118
NEW ENGLAND	1,599	1,676	15,743	15,786	72	144	311	331	289	307
Maine	27	55	1,080	780	17	20	24	31	25	-
N.H.	28	38	751	733	17	11	30	26	28	26
Vt.	22	13	393	355	23	32	30	25	30	15
Mass.	1,006	1,094	6,729	6,734	12	58	132	146	126	159
R.I.	78	77	1,871	1,723	3	2	14	24	12	25
Conn.	438	399	4,919	5,461	-	21	81	79	68	82
MID. ATLANTIC	6,780	8,675	41,815	49,945	117	386	324	213	196	98
Upstate N.Y.	692	957	N	N	81	113	225	154	38	-
N.Y. City	3,619	4,588	19,384	20,816	8	187	10	16	9	16
N.J.	1,336	1,608	5,929	9,205	8	27	89	43	89	54
Pa.	1,133	1,522	16,502	19,924	20	59	N	N	60	28
E.N. CENTRAL	2,871	2,304	77,775	81,775	570	522	758	803	443	412
Ohio	427	376	20,659	22,400	192	43	211	163	165	164
Ind.	286	257	9,556	8,985	49	33	110	69	69	50
Ill.	1,569	1,104	20,080	24,370	7	77	149	474	-	81
Mich.	437	454	18,854	15,942	81	41	107	97	82	71
Wis.	152	113	8,626	10,078	241	328	181	N	127	46
W.N. CENTRAL	681	762	26,307	27,866	203	167	539	428	403	462
Minn.	130	138	5,234	5,648	23	61	137	135	139	150
Iowa	70	68	3,540	3,277	64	50	155	94	76	67
Mo.	316	370	8,609	9,829	21	19	110	35	81	55
N. Dak.	2	6	352	686	9	16	15	16	17	16
S. Dak.	7	13	1,318	1,161	13	6	46	38	46	55
Nebr.	53	57	2,723	2,624	65	13	54	85	32	107
Kans.	103	110	4,531	4,641	8	2	22	25	12	12
S. ATLANTIC	8,394	9,346	96,426	103,318	344	279	295	244	175	153
Del.	156	128	2,153	2,034	5	-	1	6	1	3
Md.	1,060	1,113	10,080	9,740	10	12	26	21	1	2
D.C.	570	408	2,474	N	14	7	1	-	U	U
Va.	574	600	12,026	10,743	15	19	55	60	44	50
W. Va.	47	53	1,379	1,358	3	3	13	10	7	6
N.C.	529	632	16,860	17,096	21	15	70	54	58	48
S.C.	660	790	7,966	13,881	-	-	18	18	13	14
Ga.	983	1,377	19,203	24,884	120	114	38	26	26	1
Fla.	3,815	4,245	24,285	23,582	156	109	73	49	25	29
E.S. CENTRAL	1,533	1,530	35,819	34,933	38	27	105	108	80	82
Ky.	160	220	5,966	5,690	5	6	32	32	27	22
Tenn.	657	585	10,830	10,676	10	9	48	47	38	36
Ala.	397	398	11,520	9,625	12	10	8	21	7	20
Miss.	319	327	7,503	8,942	11	2	17	8	8	4
W.S. CENTRAL	3,049	3,507	73,315	68,575	79	71	155	87	188	115
Ark.	150	131	4,219	4,469	10	1	55	11	30	10
La.	510	663	13,792	12,362	10	22	9	12	42	12
Okla.	257	102	6,172	6,053	13	7	14	19	11	19
Tex.	2,132	2,611	49,132	45,691	46	41	77	45	105	74
MOUNTAIN	1,131	1,339	27,681	25,369	131	78	350	227	189	178
Mont.	12	8	1,023	1,099	10	10	29	17	-	-
Idaho	19	19	1,380	1,309	12	7	58	35	-	21
Wyo.	7	10	571	572	5	1	14	13	2	13
Colo.	258	235	8,045	5,186	59	11	129	85	80	67
N. Mex.	116	74	3,286	3,842	14	32	19	9	15	5
Ariz.	367	694	9,058	9,387	11	10	42	25	31	16
Utah	112	116	1,578	1,580	17	N	49	29	61	41
Nev.	240	183	2,740	2,394	3	7	10	14	-	15
PACIFIC	4,308	4,780	83,993	81,883	194	296	592	288	358	311
Wash.	394	281	9,388	8,790	N	N	177	119	173	143
Oreg.	113	151	3,754	4,627	15	86	127	55	99	62
Calif.	3,693	4,274	66,880	64,624	179	210	250	102	75	96
Alaska	15	13	1,810	1,435	-	-	24	1	1	1
Hawaii	93	61	2,161	2,407	-	-	14	11	10	9
Guam	15	11	-	355	-	-	N	N	U	U
P.R.	1,028	1,013	2,996	U	-	-	6	5	U	U
V.I.	27	25	U	U	U	U	U	U	U	U
Amer. Samoa	-	-	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	U	U	U	U	U	U	U	U

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

* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

† Chlamydia refers to genital infections caused by *C. trachomatis*. Totals reported to the Division of STD Prevention, NCHSTP.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update September 24, 2000.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending September 30, 2000, and October 2, 1999 (39th Week)

Reporting Area	Gonorrhea		Hepatitis C; Non-A, Non-B		Legionellosis		Listeriosis	Lyme Disease	
	Cum. 2000§	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 2000	Cum. 1999
UNITED STATES	249,741	267,797	2,358	2,097	699	724	520	9,737	11,808
NEW ENGLAND	4,437	4,899	13	13	39	61	39	3,142	3,592
Maine	68	55	2	2	2	3	2	-	34
N.H.	81	89	-	-	2	6	2	50	8
Vt.	48	36	3	5	4	12	3	20	16
Mass.	1,843	1,863	3	3	11	24	19	882	665
R.I.	463	438	5	3	5	6	-	318	350
Conn.	1,934	2,418	-	-	15	10	13	1,872	2,519
MID. ATLANTIC	25,752	30,048	430	97	137	172	122	5,027	6,189
Upstate N.Y.	5,241	5,058	53	48	58	46	67	2,836	2,932
N.Y. City	8,368	9,589	-	-	-	28	21	14	129
N.J.	4,454	5,828	352	-	10	13	20	1,208	1,404
Pa.	7,689	9,573	25	49	69	85	14	969	1,724
E.N. CENTRAL	47,193	51,344	171	728	187	206	86	292	537
Ohio	12,307	13,562	9	2	88	59	43	70	37
Ind.	4,493	4,784	1	1	33	29	7	30	17
Ill.	13,640	17,179	10	41	9	27	11	11	17
Mich.	13,216	11,414	151	668	35	55	22	-	11
Wis.	3,537	4,405	-	16	22	36	3	181	455
W.N. CENTRAL	11,602	12,348	468	168	51	40	13	235	238
Minn.	2,088	2,130	5	7	3	6	5	156	135
Iowa	781	889	1	-	12	11	3	21	21
Mo.	5,428	5,988	447	158	27	15	4	39	58
N. Dak.	15	68	-	-	-	1	1	1	1
S. Dak.	220	130	-	-	2	2	-	-	-
Nebr.	1,057	1,140	6	3	3	5	-	4	10
Kans.	2,013	2,003	9	-	4	-	-	14	13
S. ATLANTIC	71,392	77,979	101	139	149	100	85	827	1,004
Del.	1,269	1,273	-	-	8	11	1	140	83
Md.	6,941	7,241	18	19	51	22	18	449	723
D.C.	1,978	2,812	3	1	3	3	-	4	3
Va.	7,766	7,069	3	10	27	25	5	123	94
W. Va.	451	435	14	17	N	N	3	26	15
N.C.	13,767	15,092	13	32	13	13	-	41	63
S.C.	10,114	10,396	2	21	4	7	9	5	4
Ga.	12,210	16,831	3	1	6	1	21	-	-
Fla.	16,896	16,830	45	38	37	18	28	39	19
E.S. CENTRAL	26,144	27,975	343	223	26	40	14	39	82
Ky.	2,634	2,577	30	15	14	14	2	8	16
Tenn.	8,679	8,619	74	82	10	21	9	25	45
Ala.	8,972	8,608	7	1	2	3	3	6	18
Miss.	5,859	8,171	232	125	-	2	-	-	3
W.S. CENTRAL	38,388	39,286	403	421	15	9	14	36	42
Ark.	2,343	2,295	9	23	-	1	1	4	4
La.	10,181	9,847	289	249	6	4	-	3	7
Okla.	2,731	2,975	7	15	2	3	6	-	7
Tex.	23,133	24,169	98	134	7	1	7	29	24
MOUNTAIN	7,481	7,273	274	146	31	37	24	25	13
Mont.	31	33	4	5	1	-	-	-	-
Idaho	64	65	3	6	4	1	-	3	3
Wyo.	40	22	207	38	2	-	1	9	3
Colo.	2,375	1,857	20	28	11	11	5	9	2
N. Mex.	727	758	13	27	1	1	1	-	1
Ariz.	3,022	3,388	14	28	7	5	11	-	-
Utah	163	156	1	6	5	13	3	1	2
Nev.	1,059	994	12	8	-	6	3	3	2
PACIFIC	17,352	16,645	155	162	64	59	123	114	111
Wash.	1,666	1,519	24	13	15	11	5	7	6
Oreg.	525	665	25	13	N	N	4	8	12
Calif.	14,621	13,888	104	136	49	47	112	97	93
Alaska	254	235	-	-	-	1	-	2	-
Hawaii	286	338	2	-	-	-	2	N	N
Guam	-	41	-	1	-	-	-	-	-
P.R.	525	260	1	-	1	-	-	N	N
V.I.	U	U	U	U	U	U	-	U	U
Amer. Samoa	U	U	U	U	U	U	-	U	U
C.N.M.I.	U	U	U	U	U	U	-	U	U

N: Not notifiable. U: Unavailable. - : No reported cases.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending September 30, 2000, and October 2, 1999 (39th Week)

Reporting Area	Malaria		Rabies, Animal		Salmonellosis*			
					NETSS		PHLIS	
	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	871	1,086	4,479	5,074	26,516	28,437	21,699	25,690
NEW ENGLAND	40	47	621	672	1,695	1,721	1,619	1,770
Maine	5	3	104	126	101	110	77	89
N.H.	1	2	9	40	104	111	98	110
Vt.	2	4	48	83	95	77	102	67
Mass.	10	14	208	158	949	949	891	957
R.I.	6	4	49	73	106	80	114	132
Conn.	16	20	203	192	340	394	337	415
MID. ATLANTIC	156	307	804	975	2,854	3,816	3,194	4,021
Upstate N.Y.	55	54	548	693	915	995	883	1,044
N.Y. City	53	178	U	U	682	1,143	723	1,147
N.J.	29	43	148	145	612	749	444	888
Pa.	19	32	108	137	645	929	1,144	942
E.N. CENTRAL	96	131	132	146	3,843	4,122	2,468	3,673
Ohio	16	18	46	31	1,088	961	1,004	856
Ind.	4	19	-	12	501	395	427	372
Ill.	42	55	20	9	1,072	1,298	1	1,244
Mich.	24	32	58	75	684	765	720	766
Wis.	10	7	8	19	498	703	316	435
W.N. CENTRAL	38	58	439	592	1,835	1,775	1,769	1,964
Minn.	13	30	72	82	402	475	498	591
Iowa	3	12	66	125	288	197	185	182
Mo.	7	11	41	24	558	558	676	706
N. Dak.	2	-	103	119	48	40	61	51
S. Dak.	-	-	75	151	79	75	84	102
Nebr.	7	1	1	3	178	155	44	138
Kans.	6	4	81	88	282	275	221	194
S. ATLANTIC	245	267	1,807	1,647	5,946	6,196	3,781	5,029
Del.	4	1	41	47	89	110	106	126
Md.	79	77	323	311	652	670	581	695
D.C.	15	16	-	-	50	64	U	U
Va.	44	55	416	415	770	1,014	615	859
W. Va.	3	2	91	91	131	128	114	120
N.C.	27	24	438	341	829	927	806	1,067
S.C.	2	11	118	119	537	454	411	385
Ga.	16	21	255	178	1,051	1,012	1,052	1,281
Fla.	55	60	125	145	1,837	1,817	96	496
E.S. CENTRAL	37	21	159	208	1,629	1,569	1,152	1,121
Ky.	13	7	18	32	294	311	199	210
Tenn.	10	7	82	76	435	432	482	461
Ala.	13	6	59	100	483	451	401	372
Miss.	1	1	-	-	417	375	70	78
W.S. CENTRAL	17	14	70	367	2,331	2,784	2,794	2,083
Ark.	3	2	20	14	524	487	329	138
La.	7	10	-	-	243	590	461	455
Okla.	7	2	50	79	313	355	205	282
Tex.	-	-	-	274	1,251	1,352	1,799	1,208
MOUNTAIN	39	36	207	174	2,219	2,324	1,629	2,076
Mont.	1	4	57	52	71	47	-	1
Idaho	3	3	9	-	98	80	-	77
Wyo.	-	1	47	39	51	48	14	46
Colo.	21	15	-	1	596	605	534	590
N. Mex.	-	2	18	8	186	312	167	249
Ariz.	6	4	63	62	616	682	538	634
Utah	4	4	11	7	395	398	376	430
Nev.	4	3	2	5	206	152	-	49
PACIFIC	203	205	240	293	4,164	4,130	3,293	3,953
Wash.	23	19	-	-	424	482	547	672
Oreg.	33	17	7	3	245	351	285	386
Calif.	142	157	212	283	3,263	2,981	2,271	2,642
Alaska	-	1	21	7	49	39	23	25
Hawaii	5	11	-	-	183	277	167	228
Guam	-	-	-	-	-	31	U	U
P.R.	4	-	63	58	448	423	U	U
V.I.	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending September 30, 2000, and October 2, 1999 (39th Week)

Reporting Area	Shigellosis* NETSS Cum. 2000	Shigellosis* NETSS Cum. 1999	Shigellosis* PHLIS Cum. 2000	Shigellosis* PHLIS Cum. 1999	Syphilis (Primary & Secondary) Cum. 2000	Syphilis (Primary & Secondary) Cum. 1999	Tuberculosis Cum. 2000	Tuberculosis Cum. 1999
UNITED STATES	14,624	12,000	7,579	7,248	4,472	5,043	9,230	11,681
NEW ENGLAND	302	635	270	600	56	47	307	318
Maine	11	4	12	-	1	-	12	13
N.H.	4	14	8	14	1	1	15	10
Vt.	4	6	-	4	-	3	4	2
Mass.	211	542	176	513	37	26	183	180
R.I.	22	18	28	17	4	2	27	32
Conn.	50	51	46	52	13	15	66	81
MID. ATLANTIC	1,548	796	1,029	569	205	223	1,694	1,942
Upstate N.Y.	601	222	177	58	11	17	219	244
N.Y. City	595	270	426	190	99	93	922	1,009
N.J.	228	175	235	174	35	53	400	399
Pa.	124	129	191	147	60	60	153	290
E.N. CENTRAL	3,088	2,211	892	1,201	865	889	935	1,232
Ohio	289	339	213	113	63	67	205	190
Ind.	1,296	219	126	79	291	313	72	104
Ill.	778	884	2	696	257	323	459	627
Mich.	539	326	504	253	218	152	133	236
Wis.	186	443	47	60	36	34	66	75
W.N. CENTRAL	1,713	939	1,343	631	48	107	356	366
Minn.	508	185	614	198	9	9	113	142
Iowa	406	35	217	36	10	9	27	33
Mo.	524	595	384	300	22	73	146	132
N. Dak.	14	3	30	2	-	-	2	6
S. Dak.	6	11	3	6	-	-	14	12
Nebr.	100	68	9	54	2	6	17	15
Kans.	155	42	86	35	5	10	37	26
S. ATLANTIC	2,154	1,825	757	420	1,478	1,637	1,984	2,366
Del.	17	12	19	7	8	7	-	22
Md.	163	129	86	42	217	299	192	204
D.C.	63	45	U	U	38	37	22	37
Va.	341	96	241	50	105	121	326	221
W. Va.	4	7	3	4	2	3	22	34
N.C.	162	163	201	72	387	388	228	348
S.C.	99	96	74	52	148	206	104	206
Ga.	191	178	71	68	283	319	423	456
Fla.	1,114	1,099	62	125	290	257	667	838
E.S. CENTRAL	752	973	362	587	670	885	572	789
Ky.	286	206	56	134	63	79	83	142
Tenn.	270	583	269	390	404	491	250	269
Ala.	52	97	34	53	98	176	239	236
Miss.	144	87	3	10	105	139	-	142
W.S. CENTRAL	1,617	1,980	1,995	851	618	809	849	1,575
Ark.	164	68	44	23	72	55	139	129
La.	133	157	133	91	171	237	74	U
Okla.	89	452	31	143	101	152	102	135
Tex.	1,231	1,303	1,787	594	274	365	534	1,179
MOUNTAIN	913	775	486	530	181	179	377	399
Mont.	7	7	-	-	-	1	10	10
Idaho	43	20	-	9	1	1	10	12
Wyo.	5	3	2	1	1	-	2	3
Colo.	199	142	124	113	9	2	55	54
N. Mex.	110	93	67	71	19	8	29	47
Ariz.	376	388	222	279	145	161	163	174
Utah	67	47	71	51	1	2	37	30
Nev.	106	75	-	6	5	4	71	69
PACIFIC	2,537	1,866	445	1,859	351	267	2,156	2,694
Wash.	365	87	339	82	51	50	180	191
Oreg.	143	67	79	67	5	5	25	82
Calif.	1,987	1,687	-	1,683	294	209	1,783	2,248
Alaska	8	-	3	2	-	1	70	42
Hawaii	34	25	24	25	1	2	98	131
Guam	-	11	U	U	-	-	-	52
P.R.	23	120	U	U	125	126	238	161
V.I.	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.
*Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending September 30, 2000, and October 2, 1999 (39th Week)

Reporting Area	*H. influenzae*, Invasive		Hepatitis (Viral), By Type				Measles (Rubeola)					
			A		B		Indigenous		Imported*		Total	
	Cum. 2000†	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	2000	Cum. 2000	2000	Cum. 2000	Cum. 2000	Cum. 1999
UNITED STATES	877	913	8,936	12,362	5,138	5,237	-	54	-	18	72	79
NEW ENGLAND	74	67	268	241	78	119	-	2	-	4	6	11
Maine	1	5	15	8	5	1	-	-	-	-	-	-
N.H.	12	13	18	13	15	13	-	2	-	1	3	1
Vt.	6	5	8	15	6	3	-	-	-	3	3	-
Mass.	36	28	100	87	9	40	-	-	-	-	-	8
R.I.	4	1	21	14	15	26	-	-	-	-	-	-
Conn.	15	15	106	104	28	36	-	-	-	-	-	2
MID. ATLANTIC	143	157	835	900	714	661	-	14	-	5	19	5
Upstate N.Y.	77	64	166	206	103	143	-	9	-	-	9	2
N.Y. City	28	49	245	293	337	203	-	5	-	4	9	3
N.J.	29	39	158	107	105	100	-	-	-	-	-	-
Pa.	9	5	266	294	169	215	-	-	-	1	1	-
E.N. CENTRAL	117	151	1,032	2,315	530	545	-	8	-	-	8	2
Ohio	44	51	217	513	88	74	-	2	-	-	2	-
Ind.	26	20	76	84	40	34	-	-	-	-	-	1
Ill.	40	61	375	590	91	46	-	4	-	-	4	-
Mich.	7	14	351	1,066	310	364	-	2	-	-	2	1
Wis.	-	5	13	62	1	27	-	-	-	-	-	-
W.N. CENTRAL	53	57	681	603	552	208	-	2	-	1	3	-
Minn.	29	36	171	59	30	40	-	-	-	1	1	-
Iowa	-	2	61	114	27	34	-	2	-	-	2	-
Mo.	15	6	330	362	439	111	-	-	-	-	-	-
N. Dak.	1	1	3	2	2	-	-	-	-	-	-	-
S. Dak.	1	2	1	8	1	1	-	-	-	-	-	-
Nebr.	3	4	29	42	32	15	-	-	-	-	-	-
Kans.	4	6	86	16	21	7	-	-	-	-	-	-
S. ATLANTIC	233	198	1,104	1,432	946	871	-	3	-	-	3	14
Del.	-	-	-	2	-	1	-	-	-	-	-	-
Md.	62	51	178	241	90	119	-	-	-	-	-	-
D.C.	-	4	20	54	27	21	-	-	-	-	-	-
Va.	33	15	118	124	124	70	-	2	-	-	2	12
W. Va.	7	6	52	32	10	22	-	-	-	-	-	-
N.C.	20	28	116	125	182	185	-	-	-	-	-	-
S.C.	12	5	48	38	13	59	-	-	-	-	-	-
Ga.	56	54	199	369	155	123	-	-	-	-	-	-
Fla.	43	35	373	447	345	271	-	1	-	-	1	2
E.S. CENTRAL	39	53	309	312	350	362	-	-	-	-	-	2
Ky.	12	6	36	58	57	35	-	-	-	-	-	2
Tenn.	18	29	114	125	168	178	-	-	-	-	-	-
Ala.	8	15	47	44	44	72	-	-	-	-	-	-
Miss.	1	3	112	85	81	77	-	-	-	-	-	-
W.S. CENTRAL	54	53	1,406	2,460	611	916	-	-	-	-	-	9
Ark.	2	2	104	37	71	57	-	-	-	-	-	2
La.	11	12	55	183	86	147	-	-	-	-	-	-
Okla.	39	35	216	411	120	116	-	-	-	-	-	-
Tex.	2	4	1,031	1,829	334	596	-	-	-	-	-	7
MOUNTAIN	79	80	758	989	393	457	-	11	-	1	12	1
Mont.	1	2	5	17	7	17	-	-	-	-	-	-
Idaho	3	1	21	35	7	24	-	-	-	-	-	-
Wyo.	1	1	39	7	24	12	-	-	-	-	-	-
Colo.	11	13	163	184	71	78	-	1	-	1	2	-
N. Mex.	18	18	60	40	77	148	-	-	-	-	-	-
Ariz.	37	37	380	554	153	112	-	-	-	-	-	1
Utah	7	5	41	38	19	26	-	3	-	-	3	-
Nev.	1	3	49	114	35	40	U	7	U	-	7	-
PACIFIC	85	97	2,543	3,110	964	1,098	-	14	-	7	21	35
Wash.	5	3	219	261	81	55	-	2	-	1	3	5
Oreg.	23	32	143	204	83	84	-	-	-	-	-	12
Calif.	28	49	2,159	2,617	782	931	-	11	-	3	14	17
Alaska	6	5	9	9	8	15	-	1	-	-	1	-
Hawaii	23	8	13	19	10	13	-	-	-	3	3	1
Guam	-	-	-	1	-	2	-	-	-	-	-	1
P.R.	3	2	198	246	193	174	-	-	-	-	-	-
V.I.	U	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. - : No reported cases.
*For imported measles, cases include only those resulting from importation from other countries.
†Of 179 cases among children aged <5 years, serotype was reported for 76 and of those, 20 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending September 30, 2000, and October 9, 1999 (39th Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999
UNITED STATES	1,601	1,853	2	272	277	162	4,565	4,647	1	125	233
NEW ENGLAND	102	85	-	4	6	12	1,002	557	-	12	7
Maine	9	5	-	-	-	2	35	-	-	-	-
N.H.	11	11	-	-	1	3	86	78	-	2	-
Vt.	2	4	-	-	1	-	179	53	-	-	-
Mass.	57	48	-	1	4	6	648	387	-	8	7
R.I.	8	4	-	1	-	-	14	24	-	1	-
Conn.	15	13	-	2	-	1	40	15	-	1	-
MID. ATLANTIC	152	173	1	20	35	31	421	757	-	9	30
Upstate N.Y.	50	50	1	9	7	30	216	593	-	2	18
N.Y. City	31	49	-	4	10	-	44	45	-	7	5
N.J.	35	39	-	3	1	1	35	22	-	-	4
Pa.	36	35	-	4	17	-	126	97	-	-	3
E.N. CENTRAL	268	332	-	28	36	9	513	401	-	1	2
Ohio	71	114	-	7	11	-	265	156	-	-	-
Ind.	37	48	-	1	4	3	78	54	-	-	1
Ill.	64	86	-	6	9	5	59	67	-	1	1
Mich.	76	51	-	14	8	1	56	43	-	-	-
Wis.	20	33	-	-	4	-	55	81	-	-	-
W.N. CENTRAL	140	185	1	19	10	38	409	307	-	1	126
Minn.	17	42	-	-	1	26	243	140	-	-	5
Iowa	26	32	-	7	5	-	43	47	-	-	30
Mo.	76	67	-	5	1	8	57	58	-	-	2
N. Dak.	2	3	-	-	-	3	6	4	-	-	-
S. Dak.	5	11	-	-	-	1	4	5	-	-	-
Nebr.	7	10	1	4	-	-	25	4	-	1	89
Kans.	7	20	-	3	3	-	31	49	-	-	-
S. ATLANTIC	258	310	-	40	41	11	363	330	-	73	35
Del.	-	9	-	-	-	-	8	4	-	-	-
Md.	25	45	-	10	3	4	87	106	-	-	1
D.C.	-	3	-	-	2	-	3	-	-	-	-
Va.	36	41	-	8	9	5	71	19	-	-	-
W. Va.	12	5	-	-	-	-	1	2	-	-	-
N.C.	32	35	-	5	8	-	77	86	-	64	34
S.C.	19	39	-	10	4	-	23	15	-	7	-
Ga.	39	51	-	2	4	-	34	33	-	-	-
Fla.	95	82	-	5	11	2	59	65	-	2	-
E.S. CENTRAL	111	128	-	7	11	2	88	79	-	5	2
Ky.	24	26	-	1	-	-	41	23	-	1	-
Tenn.	46	53	-	2	-	2	28	34	-	1	-
Ala.	31	30	-	2	8	-	18	19	-	3	2
Miss.	10	19	-	2	3	-	1	3	-	-	-
W.S. CENTRAL	110	183	-	24	37	10	280	167	-	5	11
Ark.	12	31	-	2	-	-	31	19	-	-	3
La.	33	55	-	4	10	-	12	9	-	1	-
Okla.	24	27	-	-	1	-	14	32	-	-	1
Tex.	41	70	-	18	26	10	223	107	-	4	7
MOUNTAIN	111	115	-	19	18	31	615	576	-	2	16
Mont.	4	2	-	1	-	2	35	2	-	-	-
Idaho	7	8	-	-	1	1	53	132	-	-	-
Wyo.	-	4	-	2	-	-	6	2	-	-	-
Colo.	30	31	-	1	5	27	348	213	-	1	1
N. Mex.	8	13	-	1	N	1	78	80	-	-	-
Ariz.	52	37	-	4	4	-	69	87	-	1	13
Utah	7	13	-	4	3	-	16	55	-	-	1
Nev.	3	7	U	6	5	U	10	5	U	-	1
PACIFIC	349	342	-	111	83	18	874	1,473	1	17	4
Wash.	43	57	-	10	2	8	293	580	-	7	-
Oreg.	56	59	N	N	N	1	102	41	-	-	-
Calif.	234	214	-	80	68	9	431	815	1	10	4
Alaska	8	6	-	7	1	-	19	4	-	-	-
Hawaii	8	6	-	14	12	-	29	33	-	-	-
Guam	-	1	-	-	1	-	-	2	-	-	-
P.R.	9	10	-	-	-	-	4	21	-	-	-
V.I.	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. - : No reported cases.

TABLE IV. Deaths in 122 U.S. cities,* week ending September 30, 2000 (39th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	517	370	88	37	11	11	47
Boston, Mass.	142	95	25	13	2	7	10
Bridgeport, Conn.	46	36	8	1	1	-	4
Cambridge, Mass.	13	9	2	1	-	1	1
Fall River, Mass.	40	31	7	2	-	-	4
Hartford, Conn.	77	48	15	8	4	2	2
Lowell, Mass.	20	18	1	-	1	-	2
Lynn, Mass.	8	6	2	-	-	-	-
New Bedford, Mass.	17	12	2	3	-	-	4
New Haven, Conn.	37	22	7	6	1	1	2
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	2	2	-	-	-	-	1
Springfield, Mass.	36	22	10	3	1	-	6
Waterbury, Conn.	33	28	4	-	1	-	6
Worcester, Mass.	46	41	5	-	-	-	5
MID. ATLANTIC	2,085	1,452	411	135	43	42	96
Albany, N.Y.	52	40	7	3	1	1	1
Allentown, Pa.	9	7	1	1	-	-	-
Buffalo, N.Y.	85	60	18	4	1	2	12
Camden, N.J.	42	25	8	7	-	2	1
Elizabeth, N.J.	15	11	2	1	1	-	-
Erie, Pa.§	35	27	3	3	2	-	-
Jersey City, N.J.	24	12	9	2	-	1	-
New York City, N.Y.	1,156	800	234	79	20	21	36
Newark, N.J.	24	9	5	4	2	4	2
Paterson, N.J.	22	14	7	1	-	-	2
Philadelphia, Pa.	244	168	46	18	7	5	18
Pittsburgh, Pa.§	69	40	20	4	3	2	4
Reading, Pa.	26	18	7	1	-	-	-
Rochester, N.Y.	121	93	21	3	4	-	7
Schenectady, N.Y.	25	20	4	1	-	-	2
Scranton, Pa.§	35	28	6	1	-	-	4
Syracuse, N.Y.	77	61	9	1	2	4	5
Trenton, N.J.	12	8	3	1	-	-	1
Utica, N.Y.	12	11	1	-	-	-	1
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	2,098	1,376	428	165	68	60	141
Akron, Ohio	47	31	12	3	1	-	1
Canton, Ohio	34	22	9	2	-	1	4
Chicago, Ill.	397	230	86	37	24	19	40
Cincinnati, Ohio	128	83	24	11	5	5	8
Cleveland, Ohio	151	87	40	15	4	5	1
Columbus, Ohio	172	123	27	15	6	1	17
Dayton, Ohio	141	107	22	10	1	1	5
Detroit, Mich.	214	112	56	31	6	9	14
Evansville, Ind.	50	34	11	3	1	1	5
Fort Wayne, Ind.	63	45	11	3	3	1	5
Gary, Ind.	24	11	6	3	4	-	1
Grand Rapids, Mich.	59	44	11	1	-	3	3
Indianapolis, Ind.	148	100	32	10	4	2	10
Lansing, Mich.	44	29	7	3	1	4	6
Milwaukee, Wis.	119	83	25	9	1	1	11
Peoria, Ill.	52	40	6	3	-	3	5
Rockford, Ill.	57	42	12	1	1	1	-
South Bend, Ind.	31	20	6	2	1	2	-
Toledo, Ohio	103	81	16	2	4	-	5
Youngstown, Ohio	64	52	9	1	1	1	-
W.N. CENTRAL	841	601	144	47	19	29	59
Des Moines, Iowa	70	51	11	4	-	4	5
Duluth, Minn.	40	31	5	2	-	2	2
Kansas City, Kans.	32	19	5	6	1	1	4
Kansas City, Mo.	93	64	15	7	5	2	6
Lincoln, Nebr.	36	24	5	5	-	1	3
Minneapolis, Minn.	202	140	37	12	7	6	12
Omaha, Nebr.	85	66	11	2	1	5	9
St. Louis, Mo.	115	77	29	1	4	4	4
St. Paul, Minn.	94	72	17	2	1	2	9
Wichita, Kans.	74	57	9	6	-	2	5
S. ATLANTIC	1,025	647	219	90	34	35	78
Atlanta, Ga.	U	U	U	U	U	U	U
Baltimore, Md.	166	97	46	13	5	5	16
Charlotte, N.C.	116	81	20	8	5	2	16
Jacksonville, Fla.	127	79	28	10	6	4	7
Miami, Fla.	99	66	21	9	2	1	9
Norfolk, Va.	51	30	12	5	2	2	2
Richmond, Va.	68	39	16	10	1	2	5
Savannah, Ga.	53	35	10	6	1	1	1
St. Petersburg, Fla.	55	37	5	7	4	2	7
Tampa, Fla.	175	122	32	12	4	5	12
Washington, D.C.	100	51	27	8	4	10	1
Wilmington, Del.	15	10	2	2	-	1	2
E.S. CENTRAL	810	524	186	65	20	15	48
Birmingham, Ala.	167	101	42	19	1	4	13
Chattanooga, Tenn.	67	42	13	6	4	2	5
Knoxville, Tenn.	84	60	15	5	3	1	-
Lexington, Ky.	38	23	11	4	-	-	2
Memphis, Tenn.	159	97	42	9	7	4	8
Mobile, Ala.	78	60	9	5	1	3	1
Montgomery, Ala.	62	45	13	4	-	-	12
Nashville, Tenn.	155	96	41	13	4	1	7
W.S. CENTRAL	1,426	966	255	115	68	22	87
Austin, Tex.	87	69	12	5	1	-	7
Baton Rouge, La.	63	40	20	1	2	-	-
Corpus Christi, Tex.	41	26	12	3	-	-	1
Dallas, Tex.	202	126	47	11	14	4	18
El Paso, Tex.	96	74	12	8	1	1	1
Ft. Worth, Tex.	113	82	17	9	2	3	2
Houston, Tex.	354	214	59	43	29	9	23
Little Rock, Ark.	54	35	13	3	1	2	4
New Orleans, La.	47	27	2	7	11	-	-
San Antonio, Tex.	200	140	33	21	4	2	18
Shreveport, La.	50	38	7	4	1	-	5
Tulsa, Okla.	119	95	21	-	2	1	8
MOUNTAIN	990	642	205	80	37	24	64
Albuquerque, N.M.	116	64	32	15	3	2	4
Boise, Idaho	39	26	10	2	-	1	2
Colo. Springs, Colo.	69	40	20	5	3	1	6
Denver, Colo.	102	66	15	13	3	3	7
Las Vegas, Nev.	180	121	44	9	4	2	10
Ogden, Utah	36	32	3	-	-	1	6
Phoenix, Ariz.	158	90	29	22	10	7	10
Pueblo, Colo.	26	15	8	1	2	-	-
Salt Lake City, Utah	120	81	21	10	5	3	10
Tucson, Ariz.	144	107	23	3	7	4	9
PACIFIC	1,448	1,009	286	88	34	27	119
Berkeley, Calif.	20	12	7	-	-	1	4
Fresno, Calif.	133	99	27	5	1	1	7
Glendale, Calif.	20	17	2	-	1	-	-
Honolulu, Hawaii	70	55	15	-	-	-	7
Long Beach, Calif.	78	60	12	1	3	2	6
Los Angeles, Calif.	317	214	60	26	12	5	23
Pasadena, Calif.	24	17	4	2	-	1	4
Portland, Oreg.	U	U	U	U	U	U	U
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	167	100	38	17	5	6	18
San Francisco, Calif.	118	80	25	10	-	2	10
San Jose, Calif.	188	132	39	9	2	6	20
Santa Cruz, Calif.	36	25	7	3	-	1	3
Seattle, Wash.	118	84	18	10	6	-	13
Spokane, Wash.	53	41	8	3	-	1	3
Tacoma, Wash.	106	73	24	2	4	1	1
TOTAL	11,240¶	7,587	2,222	822	334	265	739

U: Unavailable. -:No reported cases.

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

†Pneumonia and influenza.

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

¶Total includes unknown ages.

Contributors to the Production of the *MMWR* (Weekly)

Weekly Notifiable Disease Morbidity Data and 122 Cities Mortality Data

Samuel L. Groseclose, D.V.M., M.P.H.

State Support Team
Robert Fagan
Jose Aponte
Gerald Jones
David Nitschke
Scott Noldy
Carol A. Worsham

CDC Operations Team
Carol M. Knowles
Deborah A. Adams
Willie J. Anderson
Patsy A. Hall
Suzette A. Park
Felicia J. Perry
Pearl Sharp

Informatics

T. Demetri Vacalis, Ph.D.

Michele D. Renshaw
Erica R. Shaver

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