CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

February 2, 2001 / Vol. 50 / No. 4

MMWR™
MORBIDITY AND MORTALITY
WEEKLY REPORT

Hypothermia-Related Deaths — Suffolk County, New York, January 1999–March 2000, and United States, 1979–1998

Hypothermia is the unintentional lowering of core body temperature to <95 F (<35 C) (*1*). Core body temperature normally is maintained at 97.7 F (36.5 C) (*2*). Most hypothermia-related deaths occur during the winter in states that have moderate to severe cold temperatures (e.g., Alaska, Illinois, New York, and Pennsylvania) (*3*). During 1979–1998, New York had the second highest number of hypothermia-related deaths in the United States. This report presents case reports of four hypothermia-related deaths during January 1999–March 2000 in Suffolk County (1999 population: 1,383,847), the largest county in New York excluding New York City, and summarizes hypothermia-related deaths in the United States during 1979–1998. Such deaths can be prevented by educating health-care providers and the public to identify persons at risk for hypothermia.

Case Reports

Case 1. On December 15, 1998, an 89-year-old woman with a history of wandering was noticed missing from the adult home facility where she resided and was found shivering in 1 foot of water at the edge of a pond on the property. The temperature that day ranged from 23 F–54 F (–5 C–12.2 C). On admission to a hospital, her rectal temperature was 95 F (35 C). Her medical history included dementia, multiple transient ischemic attacks (TIAs), hypertension, and chronic atrial fibrillation. Her medications included digoxin, furosemide, aspirin, colchicine, and sertraline hydrochloride. On December 21, she developed adult respiratory distress syndrome; she died on January 10, 1999. The death certificate listed the cause of death as complications of environmental exposure with aspiration. Hypertension, arteriosclerotic cardiovascular disease, and dementia were contributory.

Case 2. In January 2000, a 51-year-old man wearing a rain-soaked sweater, pants, and work boots was found dead behind a dumpster. On the day he was found, the temperature ranged from 25 F–49 F (–3.9 C–9.4 C); the day before, it had been raining with temperatures in the 50s. Drug paraphernalia was found in his pockets and needle track marks were observed on his arms. According to the police report, the decedent had a history of illegal drug use. Toxicology showed 0.10% ethanol, morphine, codeine, and methadone in his body. The death certificate listed the cause of death as complications of acute and chronic drug abuse and environmental hypothermia.

Case 3. In January 2000, a 79-year-old woman who resided in an adult home facility had been missing for 40 minutes. She was found outside, unresponsive, wearing a blouse,

Hypothermia-Related Deaths — Continued

sweatshirt, and sweatpants. The temperature that day ranged from 26 F–32 F (–3.3 C–0 C). At a hospital, her rectal temperature was 81 F (27 C). She was treated with hypothermic blankets but died 1 hour later. The decedent had a history of senile dementia, syncope, and TIAs. Her medications included iron sulfate and aspirin. The cause of death was hypothermia with senile dementia and arteriosclerotic cardiovascular disease contributing.

Case 4. In March 2000, a 45-year-old homeless man was found dead next to a makeshift bed in a wooded campsite with his shirt partly covered with snow. The temperature that day ranged from 24 F–41 F (–4.4 C–4 C). He was fully clothed, including hat and gloves, and was lying partially in a sleeping bag on top of a canvass pool cover. The decedent had a history of alcohol and drug abuse, but no drugs or alcohol were found in his blood. He had been living in the woods for several years and was last seen several weeks before his death. The death certificate listed the cause of death as probable hypothermia attributed to environmental exposure with chronic alcoholism contributing.

New York

During 1979–1998, the age-adjusted death rate for hypothermia was 0.2 per 100,000 population (International Classification of Diseases, Ninth Revision [ICD-9], codes E901.0, E901.8, and E901.9; excludes man-made cold [E901.1])*, compared with the median of 0.4 for the United States. Suffolk County ranked fifth among New York's 62 counties in number of hypothermia-related deaths for persons of all ages. Age-specific death rates in Suffolk County and New York increased with age (Figure 1). Of all hypothermia-related deaths in New York and Suffolk County, 386 (53%; 95% confidence interval [CI]=±3.6%) and 25 (58%; 95% CI=±14.8%), respectively, occurred among persons aged ≥65 years. In Suffolk County, age-adjusted death rates were three times higher for men than women.

United States

During 1979–1998, 13,970 persons died from hypothermia, an average of 699 deaths per year (range: 420–1024 deaths) (Figure 2), and the age-adjusted death rates for hypothermia decreased significantly ($p<0.001$). Of all hypothermia-related deaths, 6857 (49%; 95% CI=±0.83%) occurred among persons aged ≥65 years. The age-adjusted rate for hypothermia was approximately 2.5 times higher for men (0.5 per 100,000 population) than women (0.2) during the same period.

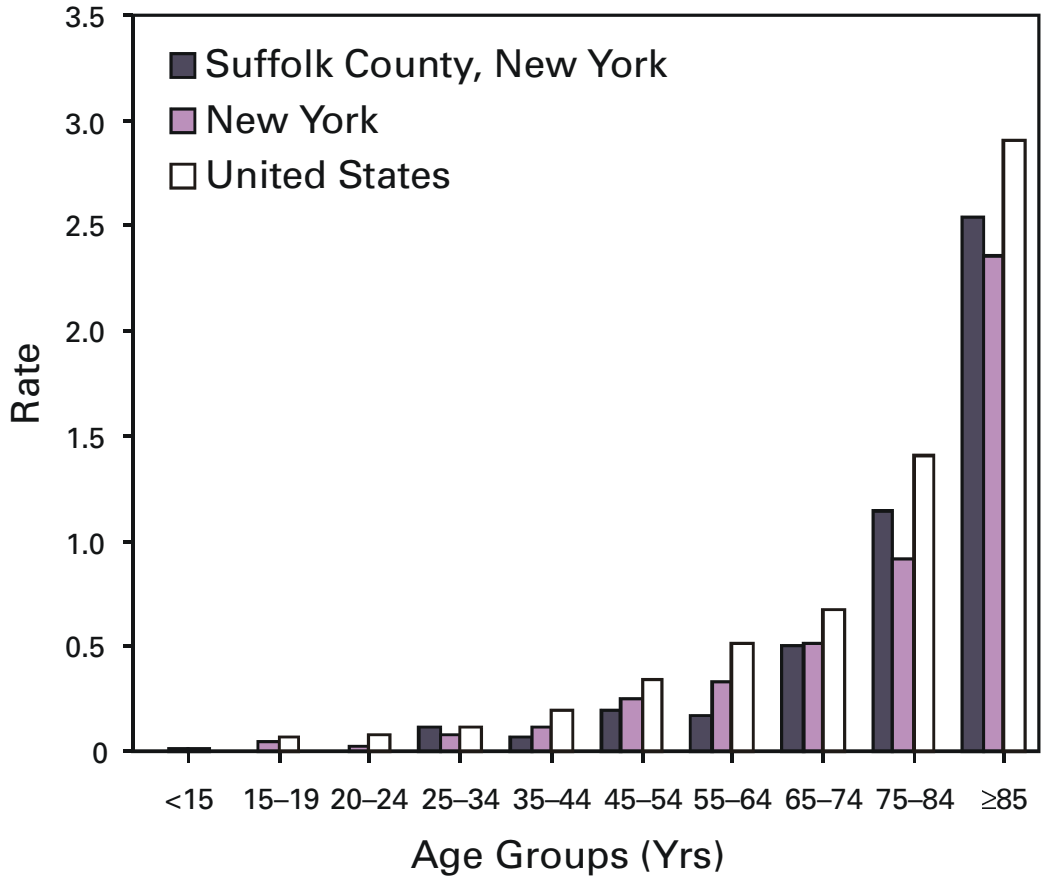
Reported by: CV Wetli, MD, Office of the Medical Examiner, Dept of Health Svcs, Suffolk County, Hauppauge; P Smith, MD, State Epidemiologist, New York State Dept of Health. Health Studies Br, Div of Environmental Hazards and Health Effects, National Center for Environmental Health; and an EIS Officer, CDC.

Editorial Note: The findings in this report indicate that hypothermia-related deaths in the United States decreased during 1979–1998. In addition, in New York and Suffolk County, hypothermia-related death rates increased by age category and were higher among men, similar to trends observed in the United States. All four case-patients in this report had one or more risk factors for hypothermia-related death (e.g., older age [≥65 years], lack of adequate housing, homelessness, mental impairment, drug overdose, and alcohol ingestion) (*4*). Contributing factors include malnutrition, lack of fitness, severe illness, and drug use or abuse (*5*).

*These data were obtained from the Compressed Mortality File (CMF), maintained by CDC's National Center for Health Statistics, and have been prepared in accordance with the external cause-of-death codes from the ICD-9. The CMF contains information from death certificates filed in the 50 states and the District of Columbia.

Hypothermia-Related Deaths — Continued

FIGURE 1. Rate* of hypothermia-related deaths, by age group — Suffolk County, New York, New York, and United States, 1979–1998



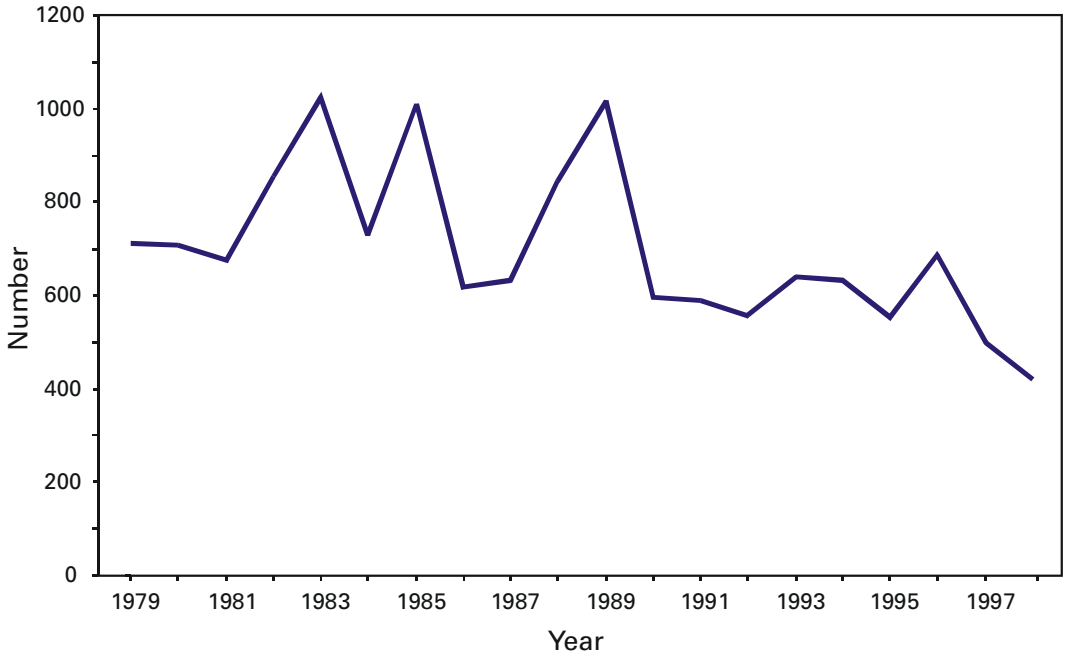
* Per 100,000 population.

Data in this report are limited by the underreporting of hypothermia in medical records and death certificates (*5*). Hypothermia-related deaths may be underreported because 1) physical signs of hypothermia may not be recognized; 2) hospitals may not use low-temperature thermometers; 3) medical personnel may be unaware of hypothermia's significance; and 4) an autopsy cannot prove hypothermia as an underlying cause of death (*6*). In addition, vital record data on hypothermia may not code hypothermia as the underlying cause of death.

Mortality estimates are 75%–90% for persons with hypothermia and underlying disease, compared with ≤10% for those with hypothermia alone (*7*). Diseases such as hypoglycemia, hypothyroidism, sepsis, and cirrhosis, or drug use (e.g., alcohol, phenothiazines, opiates, clonidine, lithium, barbiturates, and benzodiazepenes) can result in decreased heat production (*8*). Alcohol use results in central nervous system depression, vasodilation, and blunting behavioral responses to cold. Signs of hypothermia include uncontrollable shivering, confusion, memory loss, drowsiness, exhaustion, fumbling hands, and slurred speech. Severe hypothermia can result in loss of consciousness, apparent apnea, or undetectable pulse. In infants, warning signs of hypothermia include cold, bright red skin and lethargy.

Hypothermia-Related Deaths — Continued

FIGURE 2. Number of hypothermia-related deaths, by year — United States, 1979–1998



Preventive measures include wearing several layers of loosely fitting clothing with a tightly woven, wind-resistant outer layer and wool, silk, or polypropylene inner layers to hold body heat. In cold and windy climates, persons should maintain dry clothing; eat well-balanced meals; drink warm, sweet, nonalcoholic beverages; and avoid exertion because excess perspiration can cause chilling (*9*). Persons who participate in outdoor recreation should take appropriate precautions, such as wearing wet suits while participating in water-related activities or carrying emergency shelters and heat-generating devices for unexpected weather changes while hiking or camping. During winter months or in areas with low nighttime temperatures, blankets or extra clothing should be kept in vehicles when driving. Measures to prevent hypothermia-related deaths include educating the public and health-care providers (e.g., emergency department, adult home facility, and social services staff) to identify persons at risk and establishing outreach programs that provide warm shelter and adequate clothing.

References

1. Petersdorf RG. Hypothermia and hyperthermia. In: Wilson JD, Braunwald E, Isselbacher KJ, et al, eds. Harrison's principles of internal medicine. 12th ed. New York, New York: McGraw-Hill, 1991:2198–200.
2. Yoder E. Disorders due to heat and cold. In: Bennet JC, Plum F, eds. Cecil textbook of medicine. Philadelphia, Pennsylvania: WB Saunders Company, 1996:501–3.
3. CDC. Hypothermia-related deaths—Georgia, January 1996–December 1997, and United States, 1979–1995. MMWR 1998;47:1037–40.
4. Abramowicz M, ed. Treatment of hypothermia. In: The Medical Letter on Drugs and Therapeutics. New Rochelle, New York: The Medical Letter on Drugs and Therapeutics, December 1994.
5. Hector MG. Treatment of accidental hypothermia. Am Fam Physician 1992;45:785–92.

Hypothermia-Related Deaths — Continued

6. CDC. Hypothermia—United States. MMWR 1983;32:46–8.
7. Vassallo SU, Delaney KA. Thermoregulatory principles. In: Goldfrank LR, Flomenbau NE, eds. Goldfrank's toxicologic emergencies. 6th ed. Stamford, Connecticut: Appleton and Lange, 1998:285–95.
8. Fauci AS, Isselbacher KJ, Wilson JD, eds. Harrison's principles of internal medicine. 14th ed. New York, New York: McGraw-Hill, 1999:210–2.
9. CDC. Extreme cold: a prevention guide to promote your personal health and safety. Atlanta, Georgia: US Department of Health and Human Services, CDC, 1996.

Underdiagnosis of Dengue — Laredo, Texas, 1999

Dengue outbreaks have been reported in communities along the Mexico–U.S. border since 1980 (*1*); however, during 1987–July 1999, no cases were reported from Laredo, Texas (1999 population: 162,000). During January–July 1999, approximately 300–325 dengue cases were reported from Nuevo Laredo, Tamaulipas, Mexico (1999 population: 274,000), a city across the Rio Grande from Laredo. To determine whether undiagnosed or unreported dengue cases had occurred in Laredo, the Texas Department of Health (TDH) reviewed medical records from five Laredo health facilities (the two city hospitals and the three largest of five community clinics). This report summarizes the findings of the review, which indicated that during July 23–August 20, 1999, 50% of suspected case-patients had undiagnosed dengue infection. Recognition of the diagnosis of dengue can be improved through heightened surveillance, professional and public education, and prompt reporting of cases by the health-care providers to local or state health departments.

Medical records were reviewed for all patients who presented to one of the five facilities with fever, arthralgias, myalgias, rash, or headache during July 23–August 20. A case of dengue was suspected in a person aged ≥5 years with a temperature of ≥101 F (≥38.3 C) and rash of any duration or fever for ≥3 days without cough or diarrhea. During August 20–October 31, blood was drawn from suspected dengue case-patients and serum samples were tested for antidengue IgG and dengue IgM antibodies at the TDH laboratory. A confirmed case of recent dengue was defined as a positive IgM test or a fourfold or greater increase in the IgG antibody titer between acute- and convalescent-phase serum samples.

Forty-nine suspected dengue case-patients were identified from 494 records; 24 (49%) were located and interviewed. Of these, 22 (92%) agreed to provide a serum sample. Eleven case-patients had serologic evidence of recent dengue infection; 10 (91%) of the 11 tested positive for both IgM and IgG antibodies. One case-patient was negative for IgM antibodies but had a fourfold increase in IgG antibody titers over a 3-month period. Symptoms reported by the 11 confirmed case-patients included fever (100%), arthralgias (73%), headache (64%), malaise (64%), and rash (45%). Discharge diagnoses of "viral syndrome" or "viral fever" were given to nine (82%) and "flu-like illness" were given to two (18%). Nine case-patients reported a history of travel to Mexico within 2 weeks of illness onset; two had not been outside Texas.

Reported by: G Peña, City of Laredo Health Dept, Laredo; E Svenkerud, MD, Bur of Communicable Disease Control; B Liszka, Bur of Laboratories; K Hendricks, MD, J Rawlings, MPH, Infectious Diseases Epidemiology and Surveillance Div, Texas Dept of Health. Div of Applied Public Health Training, Epidemiology Program Office; Dengue Br, Div of Vectorborne Infectious Diseases, National Center for Infectious Diseases; and an EIS Officer, CDC.

Dengue — Continued

Editorial Note: Dengue is an arboviral illness of tropical and subtropical areas commonly transmitted by *Aedes aegypti* mosquitoes (*2,3*). Approximately 2.5 billion persons live in regions where dengue is endemic and 50–100 million infections occur annually (*2,4*). Although infection may result in lifelong homotypic immunity, cross-protective immunity does not occur among the four dengue virus serotypes. Infection with any dengue serotype can be asymptomatic or can cause dengue, dengue hemorrhagic fever (DHF), or dengue shock syndrome (DSS). DHF and DSS are life-threatening conditions (*5*). Since the 1970s, outbreaks of dengue, DHF, and DSS have increased in frequency and severity in the Americas and the Caribbean (*2,6*).

Dengue may present as an undifferentiated febrile illness and unless physicians retain a high level of suspicion, a dengue diagnosis may be missed easily in areas where the virus is not endemic. Laboratory testing is necessary for diagnostic confirmation. Acute- and convalescent-phase serum samples should be obtained for diagnosis and sent for confirmation to state or territorial health department laboratories. Serum samples should be accompanied by a summary of clinical and epidemiologic information, including onset date, sample collection date, and a travel history for the 3 weeks before illness onset.

An estimated two million crossings occur each month between Laredo and Nuevo Laredo, and *Ae. aegypti* is found in both cities. Movement of infected persons can introduce the virus into dengue-free areas. Travelers to regions where dengue is endemic should avoid exposure to mosquito bites by using repellents and protective clothing and by staying in well-screened or air-conditioned quarters. Residents of areas where dengue is endemic and Mexico-U.S. border communities can reduce the *Ae. aegypti* population in and around homes by changing water in bird baths or flower vases daily, tightly covering stored water receptacles, and eliminating old tires, containers, tree holes, and other potential mosquito breeding sites.

Following identification of dengue cases, the Laredo Health Department implemented mosquito reduction activities (e.g., aggressive refuse and tire disposal campaigns and insecticide fogging). Dengue alerts were sent to health-care providers, and mosquito reduction and personal protection information was distributed through health fairs and schools. Information exchange increased substantially between health officials from Laredo and Nuevo Laredo. Although no suspected cases were reported before the alerts were issued, 161 suspected dengue cases were reported during mid-August–December 1999; 18 cases tested positive for dengue. No positive cases were reported from Laredo in 2000.

When a case of dengue is confirmed in a community, the public health response should include education of health-care providers and the public, intensified surveillance, and enhanced vector-control activities. Additional information about dengue is available on the World-Wide Web, http://www.cdc.gov/ncidod/dvbid/dengue.htm.

References

1. Rawlings JA, Hendricks KA, Burgess CR, et al. Dengue surveillance in Texas, 1995. Am J Trop Med Hyg 1998;59:95–9.
2. Gubler JG. Dengue and dengue hemorrhagic fever: its history and resurgence as a global public health problem. In: Gubler DJ, Kuno G, eds. Dengue and dengue hemorrhagic fever. New York, New York: Cab International, 1997:1–22.
3. Pan American Health Organization. Dengue and dengue hemorrhagic fever in the Americas: guidelines for prevention and control. Washington, DC: Pan American Health Organization, 1994 (Scientific publication no. 548).

Dengue — Continued

4. Halstead SB. Pathogenesis of dengue: challenges to molecular biology. Science 1988;239:476–81.
5. Henchal EA, Putnak JR. Dengue viruses. Clin Microbiol Rev 1990;3:376–96.
6. Pan American Health Organization. Reemergence of dengue in the Americas. Epidemiological Bulletin of the Pan American Health Organization 1997;18:1–10.

Injection Practices Among Nurses — Vâlcea, Romania, 1998

In the early 1990s, human immunodeficiency virus (HIV) infection associated with possible reuse of syringes and needles was reported among children in Romanian orphanages (*1*). These findings led health-care workers to use new disposable syringes and needles for administering injections. By the late 1990s, reports suggested that new disposable syringes and needles had become standard for all injections. However, surveillance data collected by the Romanian Ministry of Health (MoH) during 1997–1998 indicated that acute hepatitis B virus (HBV) infection was associated with receiving injections among children aged <5 years (*2*). In Romania, injection frequently is used to administer medication, and nurses administer most injections (*3*). To identify the practices that might have resulted in injection-associated HBV transmission, selected clinic and hospital nurses were surveyed. This report summarizes the findings of the survey, which indicated that although nurses used new disposable syringes and needles, other inadequate infection-control practices might explain injection-associated HBV transmission. Results of the survey were used by the Romanian Coalition to Prevent Nosocomial Infections to prepare standards for injection safety to protect patients and health-care workers from HBV infection.

A systematic sample of every ninth nurse on the Vâlcea District nursing payroll was selected to be interviewed about knowledge and practice of infection control and bloodborne pathogen transmission during injection administration. Interviews were conducted during October 1998 using a standardized questionnaire. Information collected included demographics, work history, type of practice and injection administration knowledge, attitudes, and procedures.

Of the 1906 nurses on the payroll, 212 (11%) were included in the sample; 180 (85%) agreed to be interviewed. Of the 180, 164 (91%) were female; the mean age was 40 years (range: 23–61 years), and the mean number of years of practice was 20 (range: 1–42 years). Awareness of universal precautions to prevent bloodborne pathogen transmission was reported by 99% of respondents; 161 (91%; 95% confidence interval [CI]=86%–96%) of 177 respondents reported attending at least one training session on universal precautions. No respondent reported reusing syringes or needles on different patients; seven (4%; 95% CI=2%–8%) reported that they would reuse a syringe or needle on the same patient only in an emergency; 112 (62%; 95% CI=55%–69%) were unaware that HBV remains infectious in the environment for up to 1 week, and 78 (53%; 95% CI=44%–61%) of 148 reported that their work locations did not have an area for preparing injections that was separate from where blood and blood-contaminated objects might be handled. Seven (4%; 95% CI=2%–8%) were aware that following a needlestick the risk for transmission from an infected patient was greater for HBV infection than for HIV infection; 148 (82%; 95% CI=76%–87%) reported at least one incident of lacerating a finger while opening glass medication ampules to prepare injections. Shortages of

Infection Practices — Continued

infection-control supplies, including puncture-proof sharps containers, disinfecting solutions, and single-use gloves, were reported by 128 (72%; 95% CI=65%–79%) of 177, 95 (53%; 95% CI=45%–60%), and 84 (60%; 95% CI=51%–68%) of 141 respondents, respectively.

To validate the survey results, unannounced visits were made to four outpatient clinics and all wards of five hospitals to observe nurses' injection practices and adherence to universal precautions. In outpatient clinics, patients usually provided their own new disposable syringes and needles, and MoH provided clinics with new disposable syringes and needles for recommended vaccinations. However, this sterile equipment might have become contaminated with blood before use (e.g., blood specimens were collected in open wide-mouthed vials that were handled and placed on tables where injections were prepared, needles were placed in multidose vials to serve as access ports, and finger lacerations were left uncovered before preparing or administering injections).

Reported by: D Popesu Chisevescu, I Mihailescu, G Popaza Mihailescu, L Pasat, Vâlcea Public Health Direction, Vâlcea; N Ion-Nedelcu, Bucharest Public Health Direction, Bucharest; MI Popa, Ministry of Health, Romania. Hepatitis Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; and an EIS Officer, CDC.

Editorial Note: Overuse of injections and unsafe injection practices may lead to large-scale transmission of bloodborne pathogens (*4*). Although most injection-associated bloodborne pathogen transmission in health-care facilities can be attributed to reuse of unsterilized syringes and needles, results of this investigation suggest that this practice is likely to be rare in Romania. However, inadequate infection-control practices might explain injection-associated bloodborne pathogen transmission.

In 1998, almost all Romanian adults were aware of the risk for HIV infection associated with the reuse of syringes and needles (*3*). Patients either provided their own equipment or observed the opening of the package containing a new needle and syringe before receiving an injection (CDC, unpublished data, 1998). However, injections prepared in areas potentially contaminated with blood, multidose vial mishandling, and inadequate supplies were reported by nurses and validated by observation. In the United States, similar practices have been associated with HBV transmission in hemodialysis settings, in which frequent percutaneous exposures in a population with a high prevalence of chronic HBV infection may facilitate nosocomial HBV transmission (*5,6*). In Romania, where chronic HBV is endemic (*7*) and injections are often used to administer medication (*4*), these practices might explain injection-associated HBV transmission in the absence of syringe and needle reuse. Because most of the nurses interviewed were unaware that HBV persists in the environment for at least 1 week (*8*) and that the risk for transmitting HBV through injections can be up to 100 times greater than the risk for transmitting HIV (*9*), the nurses might not have perceived the risks for HBV transmission associated with these practices.

The findings in this report are subject to at least two limitations. First, logistic and resource constraints limited the survey to one district; however, reports suggested that nurses in Vâlcea had similar education and experience compared with nurses in other Romanian districts. Second, survey results were validated by observing nursing practice in clinics and hospitals. Because the nurses were aware they were being observed, behavior might have been modified.

In 1999, the Romanian Coalition to Prevent Nosocomial Infections held a multidisciplinary conference to define standards of injection safety. Recommendations

Infection Practices — Continued

included establishing dedicated areas for injection preparation, appropriately handling multidose vials, placing puncture-proof sharps containers in each room where injections are given, and covering lacerations. An integrated information, education, and communication campaign based on these recommendations and targeting patients and healthcare workers was launched and an evaluation of the intervention is being planned. Activities conducted by government and nongovernment organizations aimed at achieving safe and appropriate use of injections are being facilitated by the Safe Injection Global Network (SIGN). Additional information is available from the SIGN secretariat, Department of Blood Safety and Clinical Technology, World Health Organization, 20 Avenue Appia, CH 1211, Geneva 27, Switzerland, or from the World-Wide Web, http://www.injectionsafety.org.

References

1. Hersch BS, Popovici F, Jezek Z, et al. Risk factors for HIV infection among abandoned Romanian children. AIDS 1993;7:1617–24.
2. Hutin YJF, Craciun D, Ion-Nedelcu N, Mast EE, Alter MJ, Margolis HS. Using surveillance data to monitor key aspects of the epidemiology of hepatitis B virus (HBV) infection in Romania. Poster presented at the 36th annual meeting of the Infectious Disease Society of America, Denver, Colorado, November 1998.
3. CDC. Frequency of vaccine-related and therapeutic injections—Romania, 1998. MMWR 1999;48:271–4.
4. Simonsen L, Kane A, Lloyd J, Zaffran M, Kane M. Unsafe injections in the developing world and transmission of bloodborne pathogens: a review. Bul Wrld Hlth Org 1999;77:789–800.
5. Snydman DR, Bryan JA, Maon EJ, Gregg MB. Hemodialysis-associated hepatitis: report of an epidemic with further evidence on mechanisms of transmission. Am J Epidemiol 1976;104:563–70.
6. Alter MJ, Ahtone J, Maynard JE. Hepatitis B virus transmission associated with a multiple-dose vial in a hemodialysis unit. Ann Intern Med 1983;99:330–3.
7. Woodruff BA, Popovici F, Beldescu N, Shapiro CN, Hersh BS. Hepatitis B virus infection among pregnant women in northeastern Romania. Int J Epidemiol 1993;22:923–6.
8. Bond WW, Favero MS, Peterson NJ, Gravelle CR, Ebert JE, Maynard JE. Survival of hepatitis B after drying and storage for one week. Lancet 1981;1:550–1.
9. Gerberding JL. Incidence and prevalence of human immunodeficiency virus, hepatitis B virus, hepatitis C virus, and cytomegalovirus among health care personnel at risk for blood exposure: final report from a longitudinal study. J Infect Dis 1994;170:1410–7.

Notice to Readers

Publication of Report on Validation and Use of Measures of Health-Related Quality of Life

CDC recently published "Measuring Healthy Days: Population Assessment of Health-Related Quality of Life," the first comprehensive report to describe the validity and use of a set of survey measures developed by CDC and partners to track population health status and health-related quality of life (HRQOL) in states and communities (*1*). The report is intended for public health professionals involved or interested in HRQOL surveillance or measurement. The report identifies the policy and conceptual origins of a brief set of healthy days HRQOL measures developed for use as public health outcome measures and summarizes the results of studies to test the measures' accuracy and consistency.

Notice to Readers — Continued

During January 1993–December 2000, approximately 1 million U.S. adults were asked Behavioral Risk Factor Surveillance System questions on self-rated health, recent physical and mental health, and activity limitations. State and local health officials can use the measures and data to help achieve the two major goals of the national health objectives for 2010: improve the quality and years of healthy life and eliminate health disparities. States and communities are encouraged to use the measures to identify subgroups of persons with poor perceived health and to use that information to identify population health trends and disparities, define disease burden, allocate resources based on unmet needs, and evaluate disease prevention efforts. The report is available on the World-Wide Web, http://www.cdc.gov/nccdphp/hrqol.

Reference

1. CDC. Measuring healthy days: population assessment of health-related quality of life. Atlanta, Georgia: US Department of Health and Human Services, CDC, November 2000.

Notice to Readers

Availability of Applications for the Public Health Leadership Institute

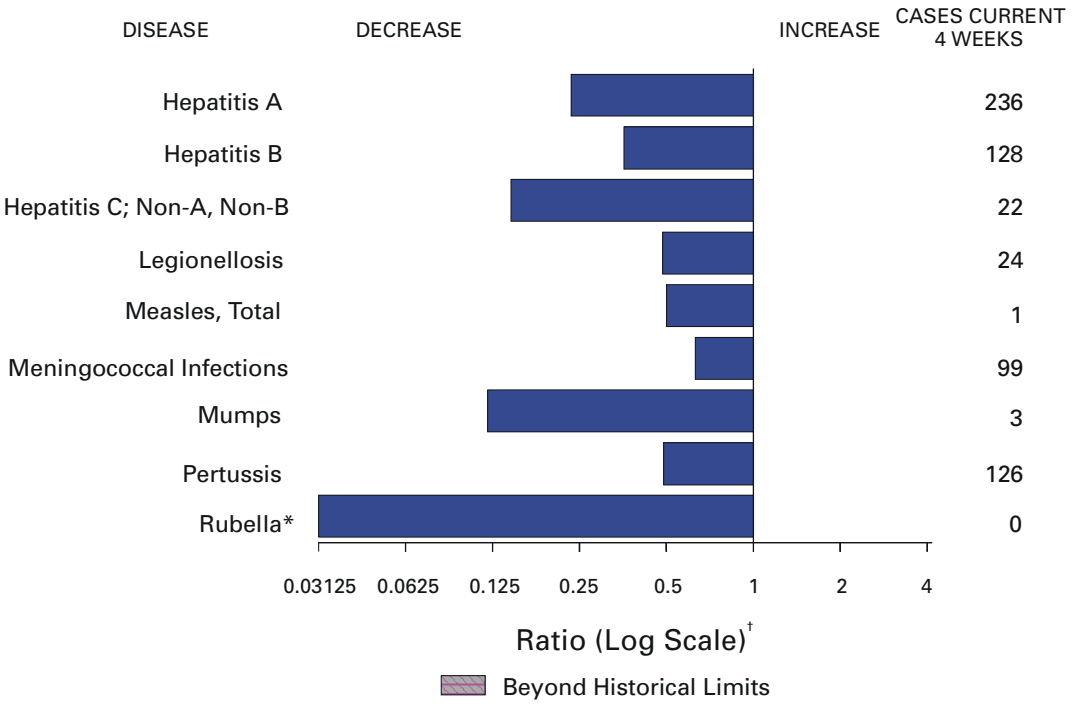
The Public Health Leadership Institute (PHLI), sponsored by CDC in partnership with the University of North Carolina at Chapel Hill School of Public Health and Kenan-Flagler Business School, and the Center for Creative Leadership in Greensboro, North Carolina, is a 2-year program that includes an intensive onsite week scheduled for May 20–25, 2001. Deadline for application is February 16.

The purpose of PHLI is to strengthen the nation's public health system by enhancing the leadership capacities of senior health officials. The program will target leading public health professionals practicing in public and private institutional settings. Because the focus of activity in the emerging public health environment occurs in a multi-institutional system, the program will be composed of leadership teams that will include at least two senior professionals from separate institutions that serve the needs of a common population.

The onsite week will be held at the Paul J. Rizzo Conference Center in Chapel Hill, North Carolina, and will include discussions of challenges facing public health leaders in the 21st century and development of skills and competencies required to face those challenges. Other parts of the curriculum will be structured around leaders' imperative to build effective teams, lead organizational change, and serve as boundary spanners to build alliances to improve the health of the public. Following the onsite week, teams will begin the distance learning phase, which includes seminars, use of LEAD (a desktop tool for on-the-job support for building leadership skills and promoting positive change), and completion of a leadership project in the population they serve. During the second year of the program, participants will work with state or regional leadership institutes in their geographic areas.

Additional information and applications are available on the World-Wide Web, http://www.phli.org. Each applicant should submit an application and list the other team member names.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending January 27, 2001, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 4 of zero (0).

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

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending January 27, 2001 (4th Week)

	Cum. 2001		Cum. 2001
Anthrax	-	Poliomyelitis, paralytic	-
Brucellosis*	-	Psittacosis*	2
Cholera	-	Q fever*	-
Cyclosporiasis*	-	Rabies, human	-
Diphtheria	-	Rocky Mountain spotted fever (RMSF)	5
Ehrlichiosis: human granulocytic (HGE)*	3	Rubella, congenital syndrome	-
human monocytic (HME)*	1	Streptococcal disease, invasive, group A	125
Encephalitis: California serogroup viral*	-	Streptococcal toxic-shock syndrome*	3
eastern equine*	-	Syphilis, congenital¶	-
St. Louis*	-	Tetanus	-
western equine*	-	Toxic-shock syndrome	4
Hansen disease (leprosy)*	-	Trichinosis	1
Hantavirus pulmonary syndrome*†	-	Tularemia*	-
Hemolytic uremic syndrome, postdiarrheal*	2	Typhoid fever	4
HIV infection, pediatric*§	-	Yellow fever	-
Plague	-		

-: 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 December 24, 2000.
¶ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending January 27, 2001, and January 29, 2000 (4th Week)

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7*			
							NETSS		PHLIS	
	Cum. 2001§	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	-	1,810	28,335	43,056	54	72	47	83	39	97
NEW ENGLAND	-	276	1,272	1,737	2	3	9	10	1	12
Maine	-	3	-	110	-	1	-	1	-	-
N.H.	-	4	51	78	-	-	3	3	1	3
Vt.	-	-	45	45	2	1	-	-	-	1
Mass.	-	228	824	725	-	1	6	2	-	2
R.I.	-	-	226	178	-	-	-	-	-	-
Conn.	-	41	126	601	-	-	-	4	-	6
MID. ATLANTIC	-	531	1,044	4,136	2	5	7	2	2	29
Upstate N.Y.	-	19	N	N	2	2	7	1	2	25
N.Y. City	-	335	3	1,809	-	2	-	1	-	-
N.J.	-	146	125	943	-	-	-	-	-	1
Pa.	-	31	916	1,384	-	1	N	N	-	3
E.N. CENTRAL	-	130	4,040	8,636	17	15	7	19	26	4
Ohio	-	24	188	2,350	8	4	5	3	1	1
Ind.	-	26	917	755	3	-	-	1	-	1
Ill.	-	59	1,126	2,664	-	3	2	7	-	-
Mich.	-	19	1,366	1,664	6	2	-	5	-	1
Wis.	-	2	443	1,203	-	6	-	3	25	1
W.N. CENTRAL	-	36	1,415	2,562	4	1	5	19	2	19
Minn.	-	11	273	637	-	-	-	-	1	10
Iowa	-	-	60	57	1	-	-	2	-	1
Mo.	-	15	352	1,027	-	-	4	14	-	6
N. Dak.	-	-	-	46	-	1	-	1	-	-
S. Dak.	-	1	147	111	-	-	1	-	1	-
Nebr.	-	-	111	230	3	-	-	-	-	1
Kans.	-	9	472	454	-	-	-	2	-	1
S. ATLANTIC	-	399	6,733	6,423	8	2	7	5	-	11
Del.	-	-	214	225	-	-	-	-	-	-
Md.	-	87	742	594	1	-	-	1	-	1
D.C.	-	5	136	169	1	-	-	-	U	U
Va.	-	29	1,074	585	2	-	-	1	-	3
W. Va.	-	1	139	140	-	-	-	1	-	1
N.C.	-	26	1,475	324	1	-	6	2	-	-
S.C.	-	6	1,064	1,333	-	-	1	-	-	-
Ga.	-	-	236	1,584	-	-	-	-	-	3
Fla.	-	245	1,653	1,469	3	2	-	-	-	3
E.S. CENTRAL	-	90	3,107	1,861	2	3	3	3	2	1
Ky.	-	20	432	498	-	-	-	1	1	-
Tenn.	-	35	983	905	-	-	2	2	1	1
Ala.	-	-	815	431	1	3	1	-	-	-
Miss.	-	35	877	27	1	-	-	-	-	-
W.S. CENTRAL	-	247	4,641	7,270	1	5	-	7	4	10
Ark.	-	8	221	234	-	1	-	2	-	1
La.	-	25	1,269	1,258	-	-	-	-	3	3
Okla.	-	10	729	515	1	-	-	1	-	2
Tex.	-	204	2,422	5,263	-	4	-	4	1	4
MOUNTAIN	-	87	1,245	2,495	4	7	4	10	2	4
Mont.	-	1	2	44	-	-	-	5	-	-
Idaho	-	3	113	148	-	1	2	-	-	-
Wyo.	-	1	66	59	-	-	-	1	-	2
Colo.	-	32	89	577	-	2	1	3	-	1
N. Mex.	-	8	174	314	2	-	-	-	-	-
Ariz.	-	21	801	788	1	2	1	-	1	1
Utah	-	-	-	266	1	2	-	-	1	-
Nev.	-	21	-	299	-	-	-	1	-	-
PACIFIC	-	14	4,838	7,936	14	31	5	8	-	7
Wash.	-	-	1,000	952	N	U	3	-	-	3
Oreg.	-	1	423	269	3	1	2	-	-	2
Calif.	-	4	3,171	6,297	11	30	-	6	-	-
Alaska	-	-	116	150	-	-	-	-	-	-
Hawaii	-	9	128	268	-	-	-	2	-	2
Guam	-	-	-	-	-	-	N	N	U	U
P.R.	-	-	305	U	-	-	-	-	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. 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 December 31, 2000.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending January 27, 2001, and January 29, 2000 (4th Week)

Reporting Area	Gonorrhea		Hepatitis C; Non-A, Non-B		Legionellosis		Listeriosis	Lyme Disease	
	Cum. 2001§	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	14,994	23,500	29	251	26	33	15	95	150
NEW ENGLAND	389	573	-	1	1	5	3	24	28
Maine	-	6	-	-	-	2	-	-	-
N.H.	4	9	-	-	-	-	-	23	7
Vt.	12	1	-	-	1	-	-	-	-
Mass.	276	230	-	1	-	3	2	1	7
R.I.	53	38	-	-	-	-	-	-	-
Conn.	44	289	-	-	-	-	1	-	14
MID. ATLANTIC	767	2,159	-	42	1	-	1	36	87
Upstate N.Y.	222	134	-	-	1	-	1	30	6
N.Y. City	1	711	-	-	-	-	-	-	7
N.J.	66	538	-	38	-	-	-	-	37
Pa.	478	776	-	4	-	-	-	6	37
E.N. CENTRAL	1,965	5,525	5	27	14	9	3	8	2
Ohio	120	1,396	-	-	10	7	1	8	-
Ind.	439	421	-	-	1	-	-	-	-
Ill.	537	1,911	-	3	-	-	-	-	1
Mich.	683	1,239	5	24	3	2	2	-	-
Wis.	186	558	-	-	-	-	-	U	1
W.N. CENTRAL	636	1,147	8	32	2	2	1	-	3
Minn.	107	251	-	-	-	-	-	-	-
Iowa	22	22	-	-	-	1	-	-	-
Mo.	246	585	7	31	1	1	-	-	1
N. Dak.	-	1	-	-	-	-	-	-	-
S. Dak.	18	8	-	-	-	-	-	-	-
Nebr.	28	84	-	-	1	-	-	-	-
Kans.	215	196	1	1	-	-	1	-	2
S. ATLANTIC	5,002	6,087	4	4	3	7	3	20	23
Del.	86	118	-	-	-	-	-	-	4
Md.	497	470	1	1	2	5	1	17	16
D.C.	163	203	-	-	-	-	-	1	-
Va.	591	756	-	-	1	-	1	1	-
W. Va.	27	46	-	-	N	N	-	-	1
N.C.	1,297	367	1	3	-	1	-	1	2
S.C.	1,208	1,850	-	-	-	1	-	-	-
Ga.	104	1,071	-	-	-	-	1	-	-
Fla.	1,029	1,206	2	-	-	-	-	-	-
E.S. CENTRAL	2,378	1,402	7	47	2	-	-	1	-
Ky.	198	241	-	2	1	-	-	1	-
Tenn.	750	770	3	6	-	-	-	-	-
Ala.	797	371	-	3	1	-	-	-	-
Miss.	633	20	4	36	-	-	-	-	-
W.S. CENTRAL	2,490	4,112	1	63	-	4	-	-	-
Ark.	206	144	1	-	-	-	-	-	-
La.	948	1,031	-	28	-	2	-	-	-
Okla.	368	237	-	-	-	-	-	-	-
Tex.	968	2,700	-	35	-	2	-	-	-
MOUNTAIN	400	768	1	20	-	4	-	-	-
Mont.	1	-	-	-	-	-	-	-	-
Idaho	7	11	-	-	-	1	-	-	-
Wyo.	9	4	1	14	-	-	-	-	-
Colo.	116	290	-	4	-	2	-	-	-
N. Mex.	39	59	-	1	-	-	-	-	-
Ariz.	228	244	-	1	-	-	-	-	-
Utah	-	43	-	-	-	1	-	-	-
Nev.	-	117	-	-	-	-	-	-	-
PACIFIC	967	1,727	3	15	3	2	4	6	7
Wash.	231	203	-	1	-	-	-	-	-
Oreg.	81	17	1	4	N	N	1	1	1
Calif.	616	1,453	2	10	3	2	3	5	6
Alaska	16	21	-	-	-	-	-	-	-
Hawaii	23	33	-	-	-	-	-	N	N
Guam	-	-	-	-	-	-	-	-	-
P.R.	71	39	-	-	2	-	-	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 January 27, 2001, and January 29, 2000 (4th Week)

Reporting Area	Malaria		Rabies, Animal		Salmonellosis*			
					NETSS		PHLIS	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	38	47	194	268	898	1,696	371	1,605
NEW ENGLAND	3	2	32	34	97	99	30	97
Maine	-	-	4	7	7	8	-	-
N.H.	-	-	-	-	7	8	4	5
Vt.	-	-	7	2	6	1	7	2
Mass.	-	2	9	14	62	64	-	58
R.I.	-	-	4	1	-	1	9	8
Conn.	3	-	8	10	15	17	10	24
MID. ATLANTIC	1	6	40	41	52	243	68	262
Upstate N.Y.	1	2	31	34	27	22	15	59
N.Y. City	-	2	U	U	24	72	51	77
N.J.	-	1	9	5	-	108	2	48
Pa.	-	1	-	2	1	41	-	78
E.N. CENTRAL	10	5	2	-	143	264	60	127
Ohio	2	1	-	-	78	68	12	54
Ind.	1	-	-	-	7	8	8	26
Ill.	-	4	-	-	28	104	-	-
Mich.	7	-	2	-	30	33	23	32
Wis.	-	-	-	-	-	51	17	15
W.N. CENTRAL	1	2	20	27	60	70	49	90
Minn.	-	-	9	9	3	1	15	31
Iowa	-	-	6	2	8	7	1	9
Mo.	1	1	2	2	27	33	27	23
N. Dak.	-	-	-	1	-	1	1	2
S. Dak.	-	-	-	7	7	4	4	6
Nebr.	-	-	-	-	7	8	-	5
Kans.	-	1	3	6	8	16	1	14
S. ATLANTIC	12	11	68	83	224	201	46	267
Del.	-	-	-	-	8	7	5	8
Md.	5	6	18	22	26	55	16	39
D.C.	1	-	-	-	6	-	U	U
Va.	4	3	19	25	31	17	-	33
W. Va.	-	-	7	8	1	8	6	5
N.C.	1	2	12	21	80	63	-	42
S.C.	-	-	3	3	14	32	19	30
Ga.	-	-	-	-	-	-	-	87
Fla.	1	-	9	4	58	19	-	23
E.S. CENTRAL	-	1	1	10	89	98	19	67
Ky.	-	-	-	1	18	16	11	10
Tenn.	-	-	1	9	9	14	7	32
Ala.	-	1	-	-	53	33	-	20
Miss.	-	-	-	-	9	35	1	5
W.S. CENTRAL	1	1	4	47	21	159	33	189
Ark.	-	-	-	-	16	10	-	13
La.	1	1	-	-	-	25	19	38
Okla.	-	-	4	5	5	8	3	13
Tex.	-	-	-	42	-	116	11	125
MOUNTAIN	1	2	7	13	59	142	36	126
Mont.	-	-	1	5	4	4	-	-
Idaho	1	-	-	-	4	13	-	8
Wyo.	-	-	-	6	2	1	1	-
Colo.	-	1	-	-	1	30	13	19
N. Mex.	-	-	-	-	17	8	10	15
Ariz.	-	-	6	2	17	34	2	54
Utah	-	1	-	-	6	35	10	30
Nev.	-	-	-	-	8	17	-	-
PACIFIC	9	17	20	13	153	420	30	380
Wash.	-	-	-	-	1	5	-	50
Oreg.	2	1	-	-	16	25	-	38
Calif.	7	15	10	13	132	358	22	268
Alaska	-	-	10	-	4	7	-	7
Hawaii	-	1	-	-	-	25	8	17
Guam	-	-	-	-	-	-	U	U
P.R.	-	1	7	2	5	14	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 January 27, 2001, and January 29, 2000 (4th Week)

Reporting Area	Shigellosis* NETSS Cum. 2001	Shigellosis* NETSS Cum. 2000	Shigellosis* PHLIS Cum. 2001	Shigellosis* PHLIS Cum. 2000	Syphilis (Primary & Secondary) Cum. 2001	Syphilis (Primary & Secondary) Cum. 2000	Tuberculosis Cum. 2001	Tuberculosis Cum. 2000
UNITED STATES	472	823	191	538	253	403	218	464
NEW ENGLAND	7	22	3	16	4	5	3	7
Maine	-	-	-	-	-	-	-	-
N.H.	-	1	-	-	-	-	-	-
Vt.	-	-	-	-	-	-	-	-
Mass.	7	19	-	11	3	3	2	2
R.I.	-	-	-	3	-	1	-	-
Conn.	-	2	3	2	1	1	1	5
MID. ATLANTIC	56	52	34	55	12	15	16	41
Upstate N.Y.	44	3	2	8	1	-	-	1
N.Y. City	11	21	32	20	5	7	-	18
N.J.	-	25	-	11	3	4	10	16
Pa.	1	3	-	16	3	4	6	6
E.N. CENTRAL	92	206	18	53	14	82	22	26
Ohio	41	13	6	-	2	11	3	4
Ind.	9	11	3	5	7	31	5	1
Ill.	14	87	-	-	4	32	12	21
Mich.	28	78	8	46	-	-	-	-
Wis.	-	17	1	2	1	8	2	-
W.N. CENTRAL	69	35	68	30	-	9	9	12
Minn.	6	4	40	12	-	1	6	6
Iowa	12	7	-	8	-	-	-	-
Mo.	32	20	24	5	-	8	2	4
N. Dak.	-	-	1	-	-	-	-	-
S. Dak.	1	1	-	-	-	-	-	-
Nebr.	5	1	-	3	-	-	1	1
Kans.	13	2	3	2	-	-	-	1
S. ATLANTIC	62	35	12	38	98	128	26	61
Del.	1	-	-	-	-	1	-	-
Md.	7	5	1	3	12	31	-	4
D.C.	3	-	U	U	2	4	3	-
Va.	4	3	-	10	5	13	-	-
W. Va.	1	-	4	-	-	-	4	4
N.C.	19	6	-	5	33	36	2	1
S.C.	6	2	7	1	17	9	-	18
Ga.	-	-	-	13	7	8	17	8
Fla.	21	19	-	6	22	26	-	26
E.S. CENTRAL	47	44	10	31	73	55	14	25
Ky.	21	10	8	4	3	3	-	1
Tenn.	-	12	1	24	12	42	-	4
Ala.	17	3	-	1	11	10	14	16
Miss.	9	19	1	2	47	-	-	4
W.S. CENTRAL	13	149	23	173	32	61	9	120
Ark.	11	2	-	1	1	1	9	1
La.	1	22	14	13	10	10	-	1
Okla.	1	2	-	2	3	14	-	1
Tex.	-	123	9	157	18	36	-	117
MOUNTAIN	40	91	23	48	5	12	2	23
Mont.	-	-	-	-	-	-	-	-
Idaho	1	2	-	11	-	-	-	-
Wyo.	-	-	-	-	-	-	-	-
Colo.	2	20	8	11	-	-	1	-
N. Mex.	16	9	7	8	-	-	-	4
Ariz.	18	46	6	16	5	10	1	6
Utah	-	2	2	2	-	-	-	4
Nev.	3	12	-	-	-	2	-	9
PACIFIC	86	189	-	94	15	36	117	149
Wash.	4	2	-	56	8	2	11	11
Oreg.	12	33	-	35	2	-	-	-
Calif.	70	148	-	-	4	34	103	131
Alaska	-	1	-	1	-	-	3	1
Hawaii	-	5	-	2	1	-	-	6
Guam	-	-	U	U	-	-	-	-
P.R.	-	2	U	U	22	19	-	-
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 January 27, 2001, and January 29, 2000 (4th Week)

Reporting Area	*H. influenzae*, Invasive		Hepatitis (Viral), By Type				Measles (Rubeola)					
			A		B		Indigenous		Imported*		Total	
	Cum. 2001†	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	2001	Cum. 2001	2001	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	54	85	322	853	174	371	1	1	-	-	1	2
NEW ENGLAND	4	8	17	21	3	12	-	-	-	-	-	-
Maine	-	-	-	1	1	1	-	-	-	-	-	-
N.H.	-	1	2	1	1	3	-	-	-	-	-	-
Vt.	-	1	-	1	-	2	-	-	-	-	-	-
Mass.	4	6	3	11	1	1	-	-	-	-	-	-
R.I.	-	-	-	-	-	-	-	-	-	-	-	-
Conn.	-	-	12	7	-	5	-	-	-	-	-	-
MID. ATLANTIC	5	9	15	39	8	68	-	-	-	-	-	-
Upstate N.Y.	4	4	9	3	1	3	-	-	-	-	-	-
N.Y. City	1	4	5	29	7	43	-	-	-	-	-	-
N.J.	-	-	-	1	-	4	-	-	-	-	-	-
Pa.	-	1	1	6	-	18	-	-	-	-	-	-
E.N. CENTRAL	7	15	55	158	40	45	-	-	-	-	-	1
Ohio	6	6	19	40	12	8	-	-	-	-	-	-
Ind.	-	1	-	2	-	1	-	-	-	-	-	-
Ill.	-	7	5	59	-	-	-	-	-	-	-	-
Mich.	1	1	31	47	28	36	-	-	-	-	-	1
Wis.	-	-	-	10	-	-	-	-	-	-	-	-
W.N. CENTRAL	1	3	28	95	10	26	-	-	-	-	-	-
Minn.	-	-	-	-	-	-	-	-	-	-	-	-
Iowa	-	-	1	3	-	3	-	-	-	-	-	-
Mo.	1	3	6	77	6	21	-	-	-	-	-	-
N. Dak.	-	-	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	1	-	-	-	-	-	-	-
Nebr.	-	-	13	3	3	2	-	-	-	-	-	-
Kans.	-	-	8	12	-	-	-	-	-	-	-	-
S. ATLANTIC	21	16	53	42	29	35	-	-	-	-	-	-
Del.	-	-	-	-	-	-	-	-	-	-	-	-
Md.	3	8	21	8	6	13	-	-	-	-	-	-
D.C.	-	-	1	-	2	-	-	-	-	-	-	-
Va.	3	6	9	3	4	6	-	-	-	-	-	-
W. Va.	1	1	-	5	-	-	-	-	-	-	-	-
N.C.	6	1	5	20	9	11	-	-	-	-	-	-
S.C.	-	-	-	1	-	1	-	-	-	-	-	-
Ga.	3	-	-	-	-	-	-	-	-	-	-	-
Fla.	5	-	17	5	8	4	-	-	-	-	-	-
E.S. CENTRAL	1	3	12	53	7	31	-	-	-	-	-	-
Ky.	-	1	1	2	2	1	-	-	-	-	-	-
Tenn.	-	2	2	10	1	13	-	-	-	-	-	-
Ala.	1	-	9	8	2	2	-	-	-	-	-	-
Miss.	-	-	-	33	2	15	-	-	-	-	-	-
W.S. CENTRAL	-	7	15	165	8	19	-	-	-	-	-	-
Ark.	-	-	6	4	4	4	-	-	-	-	-	-
La.	-	4	1	5	-	13	-	-	-	-	-	-
Okla.	-	3	8	16	4	1	-	-	-	-	-	-
Tex.	-	-	-	140	-	1	-	-	-	-	-	-
MOUNTAIN	10	13	42	52	11	20	-	-	-	-	-	-
Mont.	-	-	2	-	-	-	-	-	-	-	-	-
Idaho	-	-	-	3	-	2	-	-	-	-	-	-
Wyo.	-	-	1	-	-	-	-	-	-	-	-	-
Colo.	-	5	1	18	-	9	-	-	-	-	-	-
N. Mex.	7	2	2	8	4	7	-	-	-	-	-	-
Ariz.	3	5	28	11	4	-	-	-	-	-	-	-
Utah	-	1	1	7	-	1	-	-	-	-	-	-
Nev.	-	-	7	5	3	1	-	-	-	-	-	-
PACIFIC	5	11	85	228	58	115	1	1	-	-	1	1
Wash.	-	-	1	2	-	-	-	-	-	-	-	-
Oreg.	5	2	6	22	6	10	1	1	-	-	1	-
Calif.	-	5	71	199	51	103	-	-	-	-	-	1
Alaska	-	1	7	2	1	1	-	-	-	-	-	-
Hawaii	-	3	-	3	-	1	-	-	-	-	-	-
Guam	-	-	-	-	-	-	U	-	U	-	-	-
P.R.	-	-	-	14	1	6	-	-	-	-	-	-
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 11 cases among children aged <5 years, serotype was reported for 5 and of those, 0 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending January 27, 2001, and January 29, 2000 (4th Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000
UNITED STATES	124	210	2	7	22	72	171	339	-	-	-
NEW ENGLAND	15	8	-	-	-	1	50	88	-	-	-
Maine	-	1	-	-	-	-	-	-	-	-	-
N.H.	2	-	-	-	-	-	-	8	-	-	-
Vt.	-	1	-	-	-	-	11	22	-	-	-
Mass.	8	4	-	-	-	1	39	58	-	-	-
R.I.	-	1	-	-	-	-	-	-	-	-	-
Conn.	5	1	-	-	-	-	-	-	-	-	-
MID. ATLANTIC	6	13	-	-	1	7	9	19	-	-	-
Upstate N.Y.	3	2	-	-	-	7	9	10	-	-	-
N.Y. City	3	5	-	-	1	-	-	9	-	-	-
N.J.	-	2	-	-	-	-	-	-	-	-	-
Pa.	-	4	-	-	-	-	-	-	-	-	-
E.N. CENTRAL	10	42	-	-	5	6	27	87	-	-	-
Ohio	8	6	-	-	3	5	24	72	-	-	-
Ind.	-	4	-	-	-	-	-	-	-	-	-
Ill.	-	14	-	-	-	-	-	2	-	-	-
Mich.	2	10	-	-	2	1	2	4	-	-	-
Wis.	-	8	-	-	-	-	1	9	-	-	-
W.N. CENTRAL	8	15	-	-	2	1	11	7	-	-	-
Minn.	-	-	-	-	-	-	-	-	-	-	-
Iowa	3	3	-	-	1	-	2	3	-	-	-
Mo.	4	10	-	-	-	-	5	1	-	-	-
N. Dak.	-	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	1	-	-	-	1	1	1	-	-	-
Nebr.	1	-	-	-	1	-	-	-	-	-	-
Kans.	-	1	-	-	-	-	3	2	-	-	-
S. ATLANTIC	30	23	1	1	2	-	8	18	-	-	-
Del.	-	-	-	-	-	-	-	-	-	-	-
Md.	5	3	1	1	1	-	5	5	-	-	-
D.C.	-	-	-	-	-	-	-	-	-	-	-
Va.	3	5	-	-	-	-	-	1	-	-	-
W. Va.	-	-	-	-	-	-	-	-	-	-	-
N.C.	10	7	-	-	-	-	1	4	-	-	-
S.C.	2	4	-	-	1	-	2	8	-	-	-
Ga.	2	-	-	-	-	-	-	-	-	-	-
Fla.	8	4	-	-	-	-	-	-	-	-	-
E.S. CENTRAL	5	7	-	-	-	2	5	17	-	-	-
Ky.	-	2	-	-	-	-	-	13	-	-	-
Tenn.	-	2	-	-	-	2	4	1	-	-	-
Ala.	5	2	-	-	-	-	1	2	-	-	-
Miss.	-	1	-	-	-	-	-	1	-	-	-
W.S. CENTRAL	8	25	-	-	4	1	1	1	-	-	-
Ark.	1	1	-	-	-	1	1	1	-	-	-
La.	2	13	-	-	-	-	-	-	-	-	-
Okla.	5	-	-	-	-	-	-	-	-	-	-
Tex.	-	11	-	-	4	-	-	-	-	-	-
MOUNTAIN	8	8	1	1	-	51	56	60	-	-	-
Mont.	-	-	-	-	-	-	-	-	-	-	-
Idaho	3	1	-	-	-	-	4	1	-	-	-
Wyo.	-	-	-	-	-	-	-	-	-	-	-
Colo.	-	1	-	-	-	-	-	45	-	-	-
N. Mex.	3	1	1	1	N	1	1	10	-	-	-
Ariz.	1	4	-	-	-	50	51	1	-	-	-
Utah	1	1	-	-	-	-	-	2	-	-	-
Nev.	-	-	-	-	-	-	-	1	-	-	-
PACIFIC	34	69	-	5	8	3	4	42	-	-	-
Wash.	1	4	-	-	-	1	1	1	-	-	-
Oreg.	8	12	N	N	N	2	3	4	-	-	-
Calif.	25	51	-	5	8	-	-	33	-	-	-
Alaska	-	-	-	-	-	-	-	2	-	-	-
Hawaii	-	2	-	-	-	-	-	2	-	-	-
Guam	-	-	U	-	-	U	-	-	U	-	-
P.R.	-	2	-	-	-	-	-	-	-	-	-
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 January 27, 2001 (4th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	658	477	120	38	14	9	61
Boston, Mass.	177	122	36	11	4	4	17
Bridgeport, Conn.	46	31	6	9	-	-	2
Cambridge, Mass.	12	9	1	1	-	1	2
Fall River, Mass.	23	20	3	-	-	-	2
Hartford, Conn.	53	31	10	7	3	2	4
Lowell, Mass.	34	27	6	1	-	-	3
Lynn, Mass.	9	8	1	-	-	-	-
New Bedford, Mass.	44	36	6	2	-	-	5
New Haven, Conn.	38	21	7	5	4	1	2
Providence, R.I.	64	52	10	1	1	-	-
Somerville, Mass.	9	8	1	-	-	-	-
Springfield, Mass.	42	32	10	-	-	-	4
Waterbury, Conn.	37	23	12	1	-	1	6
Worcester, Mass.	70	57	11	-	2	-	14
MID. ATLANTIC	2,572	1,841	488	181	30	31	146
Albany, N.Y.	52	38	9	5	-	-	2
Allentown, Pa.	19	16	2	-	1	-	-
Buffalo, N.Y.	111	77	20	9	4	1	10
Camden, N.J.	39	28	7	4	-	-	5
Elizabeth, N.J.	18	13	4	1	-	-	3
Erie, Pa.§	52	42	6	3	-	1	-
Jersey City, N.J.	42	24	13	5	-	-	-
New York City, N.Y.	1,288	880	272	106	15	14	52
Newark, N.J.	59	27	19	11	1	1	3
Paterson, N.J.	20	8	8	2	1	1	-
Philadelphia, Pa.	387	287	65	20	4	11	18
Pittsburgh, Pa.§	76	63	9	2	1	1	9
Reading, Pa.	26	22	4	-	-	-	6
Rochester, N.Y.	137	108	25	3	-	1	13
Schenectady, N.Y.	26	24	1	-	1	-	5
Scranton, Pa.§	35	31	3	1	-	-	2
Syracuse, N.Y.	105	90	13	1	1	-	11
Trenton, N.J.	32	22	5	4	1	-	2
Utica, N.Y.	25	22	1	2	-	-	2
Yonkers, N.Y.	23	19	2	2	-	-	3
E.N. CENTRAL	2,036	1,432	395	129	41	39	132
Akron, Ohio	43	33	5	1	3	1	2
Canton, Ohio	40	33	6	1	-	-	4
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	111	83	20	6	2	-	10
Cleveland, Ohio	176	115	39	12	2	8	7
Columbus, Ohio	239	173	52	9	4	1	13
Dayton, Ohio	157	113	26	14	2	2	7
Detroit, Mich.	239	134	70	24	9	2	21
Evansville, Ind.	61	45	10	2	2	2	7
Fort Wayne, Ind.	77	59	11	5	2	-	6
Gary, Ind.	22	12	2	6	1	1	1
Grand Rapids, Mich.	51	40	5	2	1	3	4
Indianapolis, Ind.	265	172	57	23	8	5	21
Lansing, Mich.	57	43	10	3	-	1	5
Milwaukee, Wis.	135	99	23	8	1	4	6
Peoria, Ill.	59	39	15	2	1	2	5
Rockford, Ill.	51	33	11	4	2	1	4
South Bend, Ind.	59	50	6	1	1	1	2
Toledo, Ohio	129	106	14	5	-	4	5
Youngstown, Ohio	65	50	13	1	-	1	2
W.N. CENTRAL	957	707	147	59	23	19	68
Des Moines, Iowa	U	U	U	U	U	U	U
Duluth, Minn.	17	13	2	2	-	-	1
Kansas City, Kans.	55	31	9	11	3	1	9
Kansas City, Mo.	89	62	17	5	2	1	5
Lincoln, Nebr.	49	37	9	2	1	-	4
Minneapolis, Minn.	292	221	43	19	2	7	24
Omaha, Nebr.	119	94	13	6	4	2	14
St. Louis, Mo.	100	69	18	5	2	6	1
St. Paul, Minn.	113	100	11	1	-	1	3
Wichita, Kans.	123	80	25	8	9	1	7
S. ATLANTIC	1,603	1,055	327	135	36	49	111
Atlanta, Ga.	249	150	56	32	8	3	10
Baltimore, Md.	192	114	40	31	3	4	20
Charlotte, N.C.	146	91	29	11	4	11	23
Jacksonville, Fla.	164	106	41	13	1	3	8
Miami, Fla.	135	91	27	9	4	4	13
Norfolk, Va.	63	41	13	4	2	3	3
Richmond, Va.	84	57	19	5	-	2	9
Savannah, Ga.	80	63	10	3	3	1	10
St. Petersburg, Fla.	66	51	13	2	-	-	3
Tampa, Fla.	203	153	36	11	2	1	10
Washington, D.C.	207	126	41	14	9	17	2
Wilmington, Del.	14	12	2	-	-	-	-
E.S. CENTRAL	1,074	748	220	63	26	14	96
Birmingham, Ala.	234	168	39	16	4	4	28
Chattanooga, Tenn.	100	70	18	11	1	-	9
Knoxville, Tenn.	114	85	25	3	1	-	8
Lexington, Ky.	86	65	17	2	-	2	10
Memphis, Tenn.	231	154	55	16	5	1	15
Mobile, Ala.	111	74	27	3	3	4	6
Montgomery, Ala.	56	42	7	1	6	-	7
Nashville, Tenn.	142	90	32	11	6	3	13
W.S. CENTRAL	1,784	1,200	337	136	76	35	142
Austin, Tex.	127	95	20	11	-	1	10
Baton Rouge, La.	48	32	10	3	2	1	3
Corpus Christi, Tex.	73	59	10	1	2	1	9
Dallas, Tex.	244	160	52	17	5	10	23
El Paso, Tex.	139	100	27	8	2	2	10
Ft. Worth, Tex.	140	106	22	9	-	3	2
Houston, Tex.	442	252	92	44	45	9	31
Little Rock, Ark.	86	60	15	9	1	1	9
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	231	169	44	11	6	1	22
Shreveport, La.	87	49	20	9	5	4	8
Tulsa, Okla.	167	118	25	14	8	2	15
MOUNTAIN	1,138	809	207	70	25	27	104
Albuquerque, N.M.	132	102	17	7	3	3	13
Boise, Idaho	46	37	5	-	1	3	5
Colo. Springs, Colo.	71	49	11	5	1	5	-
Denver, Colo.	110	70	31	4	2	3	14
Las Vegas, Nev.	265	187	59	16	1	2	19
Ogden, Utah	35	27	5	1	1	1	1
Phoenix, Ariz.	173	114	29	17	9	4	15
Pueblo, Colo.	32	22	9	1	-	-	2
Salt Lake City, Utah	120	85	17	9	5	4	16
Tucson, Ariz.	154	116	24	10	2	2	19
PACIFIC	2,447	1,795	441	142	44	22	216
Berkeley, Calif.	27	19	7	1	-	-	6
Fresno, Calif.	194	135	38	15	5	1	14
Glendale, Calif.	54	44	9	-	1	-	4
Honolulu, Hawaii	73	58	13	1	-	1	7
Long Beach, Calif.	80	54	20	4	1	1	15
Los Angeles, Calif.	969	726	160	56	18	9	71
Pasadena, Calif.	30	22	4	3	1	-	4
Portland, Oreg.	210	151	40	13	3	2	14
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	213	152	39	13	4	5	34
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	210	145	43	18	4	-	14
Santa Cruz, Calif.	25	22	2	1	-	-	6
Seattle, Wash.	162	111	35	12	2	2	11
Spokane, Wash.	71	57	9	2	2	1	9
Tacoma, Wash.	129	99	22	3	3	-	7
TOTAL	14,269¶	10,064	2,682	953	315	245	1,076

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

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 and on a paid subscription basis for paper copy. To receive an electronic copy on Friday of 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 World-Wide Web server at *http://www.cdc.gov/mmwr* or from CDC's file transfer protocol server at *ftp://ftp.cdc.gov/pub/Publications/mmwr*. To subscribe for paper copy, contact 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. Address inquiries about the *MMWR* Series, including material to be considered for publication, to: Editor, *MMWR* Series, Mailstop C-08, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone (888) 232-3228.

☆U.S. Government Printing Office: 2001-633-173/48207 Region IV