MMWR™
Morbidity and Mortality Weekly Report
Weekly March 1, 2002 / Vol. 51 / No. 8

Rashes Among Schoolchildren — 14 States, October 4, 2001–February 27, 2002

Fourteen states (Arizona, Connecticut, Florida, Georgia, Indiana, Mississippi, New York, Ohio, Oregon, Pennsylvania, Texas, Virginia, Washington, and West Virginia) have reported investigations of multiple schoolchildren who have developed rashes. This report summarizes the investigation by state and local health departments of these rashes, which have occurred during October 2001 through February 2002, and provides examples for four states. Preliminary findings indicate that further investigation is needed to determine whether a common etiology for these rashes exists.

UNITED STATES

The first reported incident occurred October 4, 2001, in Indiana, followed by cases in Virginia that began November 20. Subsequent cases of rashes began in late January and occurred as recently as February 21. Rashes have been reported primarily from elementary schools but also among students in a few middle and high schools. The number of affected students in each state ranges from <10 to approximately 600. A few teachers and school staff have been affected, but rarely parents or siblings.

Characteristics of the rashes vary, but onset has generally been acute, typically with maculopapular erythematous lesions—possibly in a reticulated pattern—on the face, neck, hands, or arms; duration of the rash varied but in most reports it was highly pruritic. The rashes were not attributed to a defined environmental exposure or infectious agent. Children with rashes were afebrile and usually had no other associated signs or symptoms. The rashes lasted from a few hours to 2 weeks and appeared to be self-limiting. Secondary transmission has not been reported, but in-school "sympathy" cases have reportedly occurred. Diagnoses by clinicians who have examined children have included viral exanthem, contact or atopic dermatitis, eczema, chemical exposure, impetigo, and poison ivy. Approximately 40 serum samples collected in four states have been PCR or IgM negative for parvovirus B19 (*1*); 22 nasal swab samples have been negative for enterovirus. Environmental assessments have not identified environmental causes.

CASE REPORTS

Indiana. During October 4–November 2, 2001, rashes appeared among 18 third-grade students in an elementary school of 390 students; one substitute teacher also developed rash. No rashes among family members were reported. The rash most often began on the face, then spread to the upper extremities; most rashes occurred on exposed skin. Clinical signs—including reddish welt-type itchy rash on face and upper extremities, swollen eyes, and smooth pink cheeks—degrees of coloration, and prominence of rash varied among the children. Diagnoses in the few children examined by family physicians varied and included contact dermatitis, chemical exposure, impetigo, and poison ivy. Because parvovirus B19 infection was diagnosed in one third-grade student on August 30, 2001, the Indiana State Department of Health collected serum specimens from four students with rashes to

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

SUGGESTED CITATION
Centers for Disease Control and Prevention. [Article Title]. MMWR 2002;51:[inclusive page numbers].

assess whether they had parvovirus B19 infection. All specimens tested negative for the presence of IgM antibodies. Laboratory data analysis, interviews, a building survey, and examination of the children did not identify a cause for the rashes.

Pennsylvania. The initial report of rash occurred on January 31, 2002, among 54 elementary school students who had contact dermatitis diagnosed by a local health-care provider. To date, approximately 575 cases of rashes have been reported to the Pennsylvania Department of Health; 58 schools and child-care centers have reported cases (range: one–168 cases per facility). Most cases are in elementary and middle school students, with female cases outnumbering males. The rash has been characterized as bright-red, itchy or burning, and macular, occasionally with an urticarial or papular component. The rash may be evanescent, or remain for as long as 2 weeks; recurrent cases have been reported. There have been no other associated symptoms. Among the 54 students reported initially, serologies for parvovirus B19 were drawn on 13 cases; all were negative for IgM. PCR for parvovirus B19 was negative for 10 cases; results are pending for the remainder. Another health-care provider reported that results of nonserological (biopsy) specimens from his patients were consistent with viral exanthem. Environmental investigations at five schools have not yet identified an environmental source of the rashes. These investigations have included sampling for dust mite and cockroach allergens, solvents and cleaners, and fungal or bacterial culture growth. Air and surface cultures are still pending.

Oregon. During February 2002, outbreaks of rashes of acute onset and short duration occurred among students in two Oregon schools. Starting February 4, rashes were reported in 53 children and 11 adults in an elementary school of 589 students in southwestern Oregon; 54 (84%) were female. The rash, which appeared on cheeks and arms, was itchy and had a sunburned appearance but no systemic symptoms. A panel of dermatologists who examined 28 of the affected children reported that the rash resembled fifth disease but that several characteristics were not compatible with that diagnosis. Testing for parvovirus in two children was negative. Extensive questioning and environmental inspection did not uncover a source of the rash. Beginning February 21, rashes were reported by 84 children and seven adults in a middle school of 314 students in northwestern Oregon; 67 (74%) affected persons were female. No known links existed between the two schools. Rashes were characterized in a variety of ways, including eczema, and as a sunburned, itchy rash on face, arms, neck, and back; no other symptoms were reported. Tests for parvovirus in six persons were negative. An environmental evaluation of the school found no explanation for the rash.

In both schools, rash improved in several children when they left school but recurred when they returned to school.

Connecticut. On February 20, the Connecticut Department of Public Health was notified of nine elementary schoolchildren with rashes. On February 21, an additional 16 children were identified with a similar rash. The children, all fourth-graders, represented four classrooms in a school of 253 students and 12 classrooms. The acute rash appeared on the trunk and extremities and was characterized by erythema and pruritis. The children were afebrile and had no other symptoms. The illness lasted 24–72 hours. A dermatologist who examined three children attributed the rashes to an allergic reaction to an environmental exposure. Rashes were not reported among parents or siblings of affected children. The local health director and the state Environmental Epidemiology Program are collaborating to identify potential environmental causes. The school was closed for 1 day to clean the classrooms, check air-handling units, and replace air filters.

PUBLIC HEALTH RESPONSE

CDC is working with state and local health and education agencies in these investigations to determine if affected children within and between schools have developed rash as a result of a common etiology. CDC is systematically compiling information about 1) date of onset and duration of rash; 2) settings of and circumstances surrounding the rash's appearance; 3) the number, age, and sex of affected persons; 4) the appearance and characteristics of the rash; 5) additional signs or symptoms, diagnoses, and treatments; and 6) investigational methods used (e.g., interviews or questionnaires, biologic sampling, and environmental sampling). To facilitate the collection of standardized information, CDC has developed and distributed to health departments a document with suggested approaches for investigating reports of rashes among groups of schoolchildren. In addition, CDC requests that dermatologists and other health-care providers who have examined affected children share their clinical observations, diagnoses, and photographs with a CDC dermatologist (bdt1@cdc.gov). This information will help CDC assess whether affected children within and between schools developed rash caused by a common etiology. Local health and school officials with information about rashes among groups of schoolchildren in their jurisdiction are asked to report this information to their state health department.

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Editorial Note: With 53 million young people attending 117,000 schools each school day in the United States, it is expected that rashes from a wide range of causes will be observed. Environmental factors or infectious agents can cause rashes among groups of school-aged children. Rashes caused by infectious agents usually are preceded or accompanied by symptoms such as headache or fever. However, in these reports, none of the children showed signs of systemic illness, and the rash appeared to be self-limiting.

Potential environmental causes of rashes include biologic contaminants (e.g., bacteria and fungi), chemical agents (e.g., cleaning products and pesticide residues), physical agents (e.g., fiberglass), insects (e.g., biting flies and moths), and allergens (e.g., dust mites) (*2–4*). If one of these environmental causes is suspected, appropriate environmental experts should be consulted.

The most commonly identified viral agent associated with rashes in school-aged children is parvovirus B19, which causes erythema infectiosum (i.e., fifth disease). Fifth disease is a mild rash illness characterized by a "slapped-cheek" rash on the face and a lacy red rash on the trunk and limbs, which may itch; it usually resolves within 7–10 days. Low-grade fever, malaise, or upper respiratory symptoms usually precede the rash. Other manifestations of parvovirus B19 infection include arthritis and arthralgia (especially in adults), transient crisis of aplastic anemia (in persons with certain hematologic disorders such as sickle-cell anemia), neutropenia, and thrombocytopenia. In pregnant women, parvovirus B19 infection may be associated with miscarriage or nonimmune hydrops fetalis (*1*).

Public health response to rashes of unknown etiology involves an epidemiologic investigation that includes consultation with facilities and maintenance staff familiar with the physical plant, examination of the rash by a dermatologist, and, when appropriate, collection and analysis of biologic specimens. To date, reports from states do not document a common cause or demonstrate that all children are experiencing the same rash. State and local health departments, in collaboration with CDC, continue to investigate these and other reports of rashes among groups of schoolchildren.

Acknowledgements

This report is based on data contributed by C McRill, MD, K Komatsu, MPH, W Humble, MPH, Arizona Dept of Health Svcs; L Sands, DO, MPH, Maricopa County Dept of Public Health, Phoenix, Arizona. T Wegrzyn, MPH, J Hadler, MD, Connecticut Dept of Public Health. S Wiersma, MD, Florida Dept of Health. P Blake, MD, S Lance-Parker, PhD, C Morin, MD, Georgia Dept of Human Resources, Div of Public Health. R Teclaw, DVM, M Wilkinson, Indiana State Dept of Health. M Currier, MD, S Slavinski, DVM, Mississippi Dept of Health. H Mackley, MPH, B Asante, MD, New York City Dept of Health. M Kohn, MD, E DeBess, DVM, L Davidoff, MD, M Scott, M Heumann, MA, Oregon Health Div; G Stevens, V Barbour, MSN, J Baures, J Manwaring, B Thomas, G Chakarun, Jackson County Public Health Dept, Medford; R Parlier, M Jaqua, M Breedlove, MBA, Yamhill County Health Dept, McMinnville, Oregon. J Rankin, Jr., DVM, C Coventon, MD, Pennsylvania Dept of Health, Bureau of Epidemiology. F Sassano, Bucks County Dept of Health, Doylestown; J Maher, MD, E Walls, Chester County Health Dept,Westchester; C Baysinger, M Supplee, MS, Montgomery County Human Svcs Center, Norristown; J Jahre, MD, St. Luke's Hospital Network, Bethlehem; N Sykes, MD, Jefferson Medical College, Philadelphia, Pennsylvania. R Stroube, MD, E Barrett, DMD, S Jenkins, VMD, Virginia Health Dept; J Florance MD, A Ansher MD, L Estrada MPH, B Bradshaw, Prince William Health Dept, Manassas, Virginia. J Hofmann, MD, J Van Eenwyk, PhD, Washington Dept of Health. L Haddy, MA, D Bixler, MD, West Virginia Dept of Health and Human Resources, Bur for Public Health; P Gordon, MD, Harrison-Clarksburg Health Dept Clarksburg, West Virginia. J Perdue, Texas Dept of Health; and other state and local health and education departments and schools. A Henderson, PhD, Div of Environmental Hazards and Health Effects, National Center for Environmental Health. A Adija, MD, K Griffith, MD, EIS officers, CDC.

References

1. Brown KE. Human parvovirus B19 epidemiology and clinical manifestations. In: Anderson LJ, Young NS, eds. Human parvovirus B19 (monographs in virology. vol 20). Basel, Switzerland: Karger 1997:42–60.
2. Environmental Protection Agency. Indoor air pollution: an introduction for health professionals. Washington, DC: Environmental Protection Agency, 1994. Available at http://www.epa.gov/iaq/pubs/hpguide.htm. Accessed February 2002.
3. CDC. Moth-associated dermatitis—Cozumel, Mexico. MMWR 1990;39:219–20.
4. CDC. Rash illness associated with gypsy moth caterpillars—Pennsylvania. MMWR 1982;31:169–70.

Congenital Malaria as a Result of *Plasmodium malariae* — North Carolina, 2000

Congenitally acquired malaria is rare in the United States; ≤10 cases are reported each year (*1*). Congenital infection with *Plasmodium malariae* is particularly uncommon because distribution of this parasite is focal and sparse in areas where *P. falciparum* is endemic (*2*). The last case of congenital *P. malariae* infection in the United States was reported in 1992 (*3*). This report describes the investigation of a case of *P. malariae* in an infant with no travel history outside of the United States and suggests that health-care providers suspect malaria when treating a neonate or young infant with fever if the mother has traveled or lived in a malarious area.

In September 2000, a previously healthy female infant aged 10 weeks who resided in Raleigh, North Carolina, developed fever and dark urine. A pediatrician examined the infant and found a temperature of 103.7 F (39.8 C) but no other abnormalities. Laboratory evaluation included a white blood cell count of 4,600 μ/L (normal range: 9,000–30,000 μ/L]) and hemoglobin of 8.7 g/dL (normal range: 10.0–14.0 g/dL). The same day, she was admitted to a local hospital for treatment and further evaluation. Laboratory studies were performed, including cultures of blood, urine, and cerebrospinal fluid (CSF). A repeated complete blood count (CBC) demonstrated hemoglobin (6.6 g/dL) and platelets (109,000 μ/L). Intravenous antibiotic therapy was begun with ampicillin and cefotaxime.

Two days after admission, blood films for malaria obtained the previous day were reported to contain *Plasmodium malariae* parasites; treatment with chloroquine was initiated. Over the next 2 days, the infant received two transfusions of packed red blood cells for anemia. Bacterial cultures of urine, blood, and CSF obtained on admission remained negative.The infant's clinical status improved, and she was discharged home after having completed chloroquine treatment. She had a negative malaria smear on specimens obtained 2 days and 15 days post-therapy.

In July 2000, approximately 42 days before admission, the infant was seen at a local hospital emergency department because her parents were concerned about her breathing pattern; however, physical exam and chest radiograph were normal and no treatment or follow-up was required. The infant had not traveled outside the city or received any blood products before hospitalization.

Both parents had emigrated to the United States from the Democratic Republic of the Congo; the father arrived in 1995

and the mother in 1996. The mother reported being treated for malaria with chloroquine shortly before leaving the Congo and presumptively completed a full course of therapy. Both parents denied any episodes of malaria, febrile illness, foreign travel, or blood transfusion following arrival in the United States. The family lived in a screened apartment in Raleigh, although some mosquitoes were noted indoors during August 2000. A friend from Kinshasa, Congo, stayed with the family during August; he reportedly was well during the visit.

Pretreatment malaria testing of the mother with thick and thin blood films prepared four times over a 2-week period was negative for malaria parasites. Subsequent serologic testing revealed positive IgG titers against *P. falciparum* and *P. malariae* (1:16,384), and against *P. vivax* and *P. ovale* (1:1,024). Polymerase chain reaction (PCR) analysis on pretreatment blood collected September 22 was negative for these four *Plasmodium* species. However, the mother was presumptively treated with chloroquine.

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Editorial Note: Although the infant in this report could have been infected by the bite of a mosquito that had bitten a *P. malariae*-infected person (e.g., one of the parents or the visitor from Kinshasa), congenital transmission is a much more likely source of infection. *P. malariae* can persist in humans as an asymptomatic erythrocytic disease for many years following an untreated or incompletely treated primary infection. Symptomatic recrudescence has been reported for up to 70 years following primary infection (*4*). Unlike *P. vivax* and *P. ovale*, no dormant form exists in the liver. Recrudescence should not occur following completed treatment with chloroquine; therefore, additional treatment with primaquine as is required for radical cure of *P. vivax* and *P. ovale* is not necessary.

Pregnancy can make women more susceptible to infection with malaria and might allow a sufficient increase in the density of parasitemia for passage of parasites through the placenta to the fetus (*5*). Suspected malaria in the neonate should be confirmed using Giemsa-stained thick and thin blood smears. If the infant's smear is positive for malaria parasites, the mother's smears also should be examined for malaria parasites. If the mother's smears are negative, then serologic analysis of her blood for *Plasmodium*-specific antibodies should be conducted. Negative results demonstrate an absence of current or previous malaria infection and would rule out maternal transmission of malaria. Positive results indicate infection at some time but cannot be used to differentiate current from previous infection or to determine the infecting *Plasmodium* species. In persons with negative blood films and positive serology, PCR might be useful to detect low-level parasitemia and to determine the infecting species.

In this case, the mother's serology demonstrates previous infection with malaria parasites at some time. The pattern of elevated titers to *P. falciparum* and *P. malariae* commonly is seen in persons who have had long-term exposure to malaria in areas of Africa where the disease is endemic. The failure to detect *P. malariae* in the mother by smear or the more sensitive PCR is expected because most women spontaneously clear parasitemia in the hours following delivery (*6*). The mother in this report was not tested until 10 weeks after delivery, well past the expected period for detecting parasitemia.

U.S. health-care providers should be alert to the diagnosis of malaria in ill neonates and young infants, particularly those with fever. During evaluation, health-care providers should obtain a complete and accurate travel and residency history on the patient and close relatives. Patients should be asked about transfusion of blood products. However, the absence of recent foreign travel or a long interval between immigration of the mother and the birth of the infant being examined should not dissuade clinicians from obtaining blood films on the patient to rule out a potentially life-threatening but easily treatable infection.

Additional information about malaria and its distribution is available from CDC at http://www.cdc.gov/travel. Information about the diagnosis of malaria and the preparation of blood films is available at http://www.dpd.cdc.gov/dpdx.

References

1. Hubert TV. Congenital malaria in the United States: report of a case and review. Clin Infect Dis 1992;14:922–6.
2. Gilles HM, Warrel DA. Bruce-Chwatt's Essential Malariology, 3rd ed. London: Arnold, 1996.
3. Zucker JR, Barber AM, Paxton, LA, et al. Malaria Surveillance—United States, 1992. In: CDC Surveillance summaries. MMWR 1995;44(No. SS-5).
4. Vinetz JM, Li J, McCutchan TF, et al. *Plasmodium malariae* infection in an asymptomatic 74-year-old Greek woman with splenomegaly. N Eng J Med 1998;2:367–71.
5. Brabin BJ. An analysis of malaria in pregnancy in Africa. Bull World Health Organ 1983;61:1005–16.
6. Nguyen-Dinh P, Steketee RW, Greenberg AE, et al. Rapid spontaneous postpartum clearance of *Plasmodium falciparum* parasitaemia in African women. Lancet 1988;2:751–2.

Health-Related Quality of Life — Puerto Rico, 1996–2000

Although a number of studies have been made to determine the health-related quality of life (HRQOL) of persons living in the United States, no overall assessment of HRQOL has been conducted previously for residents of Puerto Rico (*1*). To determine the HRQOL of adults living in Puerto Rico, during 1996–2000, as part of the Behavioral Risk Factor Surveillance System (BRFSS), interviews were conducted in Spanish with a representative sample of Puerto Rican adults (*2*). Older women, persons with less education or lower income, persons unable to work, and those who were overweight or who had diabetes or high blood pressure reported more days for which they were physically or mentally unhealthy during the 30 days preceding the survey. Interventions designed to reach these vulnerable, demographic, socioeconomic, and behavioral risk groups might help adults in Puerto Rico increase their quality and years of healthy life and eliminate health disparities.

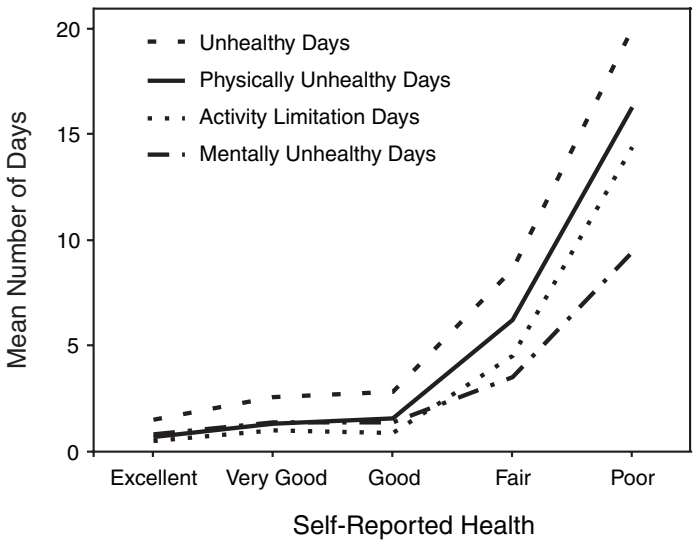
BRFSS is an ongoing, random-digit–dialed telephone survey of the noninstitutionalized civilian population aged ≥18 years that is conducted in the 50 U.S. states, the District of Columbia, and Puerto Rico. Data were weighted to reflect the age and sex distribution of Puerto Rico's estimated population during each survey year. In Puerto Rico, a Spanish-language version of the English-language BRFSS survey was administered (*2*). HRQOL items included self-rated health status (i.e., excellent, very good, good, fair, or poor) and the number of days during the 30 days preceding the survey when physical health (i.e., physical illness or injury) or mental health (i.e., stress, depression, or emotional problems) was not good and usual activity (i.e., self-care, work, or recreation) was limited as a result of poor physical or mental health. Unhealthy days were defined as the total number of days for which the respondent reported feeling either physically or mentally unhealthy, up to a maximum of 30 days per respondent. Means and 95% confidence intervals (CIs) were calculated using SUDAAN to account for the complex BRFSS survey design.

During 1996–2000, a total of 13,686 adults in Puerto Rico participated in BRFSS. The average response rate was 91.8% (range: 89.4%–93.2%)*. An estimated 34% (95% CI=33.1%–35.0%) of adults in Puerto Rico reported fair or poor health. Levels of self-rated health in adults in Puerto Rico did not differ by sex. On average, adults with fair or poor health reported substantially more days for which they were either physically or mentally unhealthy or limited in activity than those whose health status was good, very good, or excellent (Figure 1). Among persons rating their health status as fair or poor, younger adults were more likely than older adults to report mentally unhealthy days.

Men aged 18–44 years living in the island's metropolitan or eastern regions reported the fewest (2.9) unhealthy days, and women aged ≥65 years living in the northern region reported the most (9.8) unhealthy days (Table 1). The number of self-reported unhealthy days peaked in 1998 and 1999 but did not change substantially. Overall, the mean number of activity limitation days was substantially higher during 1998–2000 (2.7 days; 95% CI=2.5–2.9) than during 1996–1997 (1.7 days; 95% CI=1.5–1.9). The number of unhealthy days reported was significantly higher for women aged 18–44 years, 45–64 years, and ≥65 years than for men in the same three age groups by 1.4 days, 1.7 days, and 2.2 days, respectively (Table 1).

Fewer unhealthy days were reported by respondents with higher education, income, and employment levels than less educated, poorer, and unemployed respondents. By educational attainment, mean unhealthy days ranged from 2.7 days for men aged 18–44 years with a high school education to 9.5 days for women aged ≥65 years who did not complete high school. By household income, the lowest mean for unhealthy days was 1.9 days for men aged 18–44 years with household incomes of $35,000–$49,999; the highest mean for unhealthy days was 9.4 days for women aged ≥65 years with incomes <$15,000 per year. By employment status, the lowest mean (1.7 days) was for self-employed men aged ≥65 years, and the

FIGURE 1. Self-reported health status, by mean number of days — Behavioral Risk Factor Surveillance System, Puerto Rico, 1996–2000



* This rate is the upper bound response rate, which includes completed interviews, refusals, and terminations. The resulting estimate reflects the cooperation of respondents contacted and is not affected by difference in telephone sampling efficiency. The response rates for 1996 and 2000 are unavailable. Council of American Survey Research Organizations response rates were 88.9% in 1997, 76.7% in 1998, and 69.5% in 1999 (Source: BRFSS 1998 and 1999, Summary Quality Control Report).

TABLE 1. Mean number of unhealthy days among adults,* by selected demographic and risk factors, Behavioral Risk Factor Surveillance System — Puerto Rico, 1996–2000

	Age group (yrs)									
	18–44				45–64				≥65	
	Men (n=2,451)		Women (n=3,826)		Men (n=1,548)		Women (n=2,740)		Men (n=1,004)	Women (n=1,585)
Characteristic	Mean	(95% CI†)	Mean	(95% CI)	Mean	(95% CI)	Mean	(95% CI)	Mean (95% CI)	Mean (95% CI)
Geographic region§										
Metro	2.9	(2.4– 3.4)	4.4	(3.9– 4.9)	4.2	(3.4– 5.1)	5.9	(5.1– 6.6)	5.8 (4.6– 7.0)	8.0 (6.9– 9.1)
East	2.9	(2.1– 3.7)	4.9	(3.9– 5.8)	5.1	(3.5– 6.7)	8.6	(7.2–10.0)	5.7 (3.7– 7.7)	8.2 (6.3–10.1)
South	3.2	(2.3– 4.0)	4.3	(3.5– 5.0)	4.0	(2.6– 5.4)	5.2	(4.3– 6.1)	6.9 (4.7– 9.1)	7.4 (5.7– 9.0)
West	3.0	(2.2– 3.8)	4.3	(3.5– 5.0)	5.5	(3.9– 7.1)	8.0	(6.8– 9.1)	7.1 (5.1– 9.1)	9.2 (7.5–11.0)
Central	4.0	(2.9– 5.0)	4.8	(4.0– 5.7)	6.8	(5.2– 8.4)	7.8	(6.5– 9.1)	7.4 (5.0– 9.8)	8.9 (6.9–10.8)
North	3.2	(2.3– 4.2)	4.6	(3.6– 5.6)	5.4	(3.5– 7.3)	6.9	(5.6– 8.2)	5.0 (2.7– 7.3)	9.8 (7.4–12.2)
Year										
1996	3.0	(2.3– 3.7)	4.6	(3.9– 5.3)	4.9	(3.4– 6.4)	6.4	(5.3– 7.5)	7.4 (5.4– 9.4)	8.7 (6.8–10.6)
1997	2.6	(2.0– 3.2)	3.7	(3.0– 4.3)	4.0	(3.0– 5.1)	5.8	(4.9– 6.8)	5.6 (4.0– 7.1)	7.1 (5.6– 8.5)
1998	3.2	(2.6– 3.9)	5.4	(4.7– 6.1)	6.3	(4.8– 7.7)	6.6	(5.6– 7.7)	6.6 (4.7– 8.5)	9.2 (7.5–10.9)
1999	3.5	(2.8– 4.2)	5.1	(4.4– 5.8)	5.6	(4.3– 6.8)	7.7	(6.8– 8.6)	6.2 (4.7– 7.7)	8.2 (7.0– 9.5)
2000	3.0	(2.3– 3.8)	3.7	(3.0– 4.3)	4.5	(3.6– 5.4)	7.0	(6.1– 7.8)	5.2 (3.9– 6.6)	9.0 (7.8–10.3)
Education level										
<High school	3.7	(2.8– 4.6)	5.2	(4.2– 6.1)	5.7	(4.7– 6.7)	8.1	(7.4– 8.8)	7.0 (5.9– 8.1)	9.5 (8.6–10.3)
High school graduate	2.7	(2.1– 3.2)	4.7	(4.1– 5.3)	5.5	(4.4– 6.6)	6.7	(5.8– 7.5)	6.4 (4.6– 8.2)	7.2 (5.6– 8.9)
Some college	3.4	(2.8– 3.9)	4.8	(4.2– 5.3)	4.4	(3.1– 5.7)	5.7	(4.6– 6.7)	4.8 (2.8– 6.8)	5.6 (3.4– 7.8)
College graduate	2.9	(2.2– 3.5)	3.7	(3.2– 4.2)	3.6	(2.6– 4.7)	4.7	(3.8– 5.6)	4.4 (2.7– 6.0)	5.5 (3.7– 7.3)
Annual household income										
<$15,000	3.8	(3.2– 4.3)	5.0	(4.5– 5.5)	6.9	(6.0– 7.8)	8.0	(7.4– 8.6)	7.8 (6.8– 8.8)	9.4 (8.6–10.2)
$15,000–$24,999	3.0	(2.4– 3.7)	4.9	(4.2– 5.5)	3.7	(2.7– 4.8)	4.9	(3.9– 5.8)	2.5 (1.1– 4.0)	5.4 (3.5– 7.3)
$25,000–$34,999	2.8	(1.9– 3.7)	3.3	(2.5– 4.0)	5.2	(3.3– 7.1)	5.1	(3.4– 6.8)	4.4 (1.2– 7.6)	¶
$35,000–$49,999	1.9	(1.1– 2.8)	5.2	(3.7– 6.7)	3.4	(1.5– 5.3)	3.2	(1.6– 4.8)	¶	¶
≥$50,000	2.0	(0.8– 3.2)	2.1	(1.1– 3.0)	2.5	(1.0– 4.1)	3.4	(1.3– 5.5)	¶	¶
Employment status										
Employed for wages	2.7	(2.3– 3.1)	4.4	(3.9– 4.9)	2.7	(2.1– 3.3)	4.4	(3.7– 5.1)	3.2 (1.3– 5.1)	¶
Self-employed	2.3	(1.8– 2.9)	4.6	(3.2– 6.1)	2.6	(1.7– 3.5)	4.1	(2.7– 5.5)	1.7 (0. 0– 3.4)	¶
Out of work	4.9	(3.5– 6.4)	6.6	(4.8– 8.4)	6.2	(3.9– 8.4)	8.9	(6.0–11.8)	¶	¶
Homemaker	¶		4.6	(4.1– 5.2)	¶		7.2	(6.6– 7.9)	¶	8.9 (8.2– 9.7)
Student	2.2	(1.5– 3.0)	3.3	(2.6– 4.0)	¶		¶		¶	¶
Retired	¶		¶		5.0	(3.5– 6.5)	6.7	(4.9– 8.5)	5.5 (4.7– 6.3)	6.2 (4.8 –7.6)
Unable to work	14.1	(10.9–17.2)	¶		15.7	(13.6–17.7)	16.1	(13.3–18.9)	12.6 (9.9–15.2)	12.2 (7.9–16.5)
Marital status										
Married	3.2	(2.8– 3.7)	4.5	(4.1– 4.9)	5.1	(4.4– 5.7)	6.1	(5.6– 6.7)	6.3 (5.4– 7.2)	7.3 (6.2– 8.3)
Divorced	3.8	(2.5– 5.1)	6.3	(5.2– 7.4)	4.6	(3.1– 6.1)	8.1	(7.0– 9.2)	5.3 (2.7– 7.9)	7.5 (5.4– 9.6)
Widowed	¶		6.8	(3.4–10.3)	¶		7.8	(6.4– 9.1)	6.2 (4.3– 8.0)	9.1 (8.1–10.1)
Separated	4.9	(2.4– 7.4)	4.6	(3.4– 5.8)	¶		8.1	(5.9–10.3)	¶	¶
Never married	2.6	(2.1– 3.1)	3.8	(3.2– 4.4)	5.4	(2.8– 8.0)	5.8	(4.2– 7.4)	¶	11.6 (8.1–15.1)
Unmarried couple	4.3	(2.2– 6.4)	5.3	(3.7– 6.9)	¶		¶		¶	¶
Any exercise in last month**										
Yes	2.7	(2.2– 3.1)	4.1	(3.5– 4.6)	4.1	(3.1– 5.1)	5.8	(5.0– 6.7)	4.9 (3.8– 6.1)	6.6 (5.2– 8.0)
No	3.7	(3.0– 4.4)	5.0	(4.4– 5.6)	6.1	(5.0– 7.3)	7.3	(6.5– 8.0)	7.8 (6.1– 9.4)	10.1 (8.9–11.3)
Cigarette smoking										
Never smoked	2.7	(2.3– 3.0)	4.2	(3.9– 4.6)	4.9	(4.1– 5.7)	6.5	(6.0– 7.0)	6.0 (4.9– 7.1)	7.8 (7.1– 8.5)
Former smoker	4.2	(3.2– 5.1)	5.4	(4.4– 6.5)	5.6	(4.6– 6.6)	7.7	(6.4– 9.0)	6.6 (5.5– 7.8)	10.8 (8.9–12.6)
Current smoker	3.7	(2.9– 4.4)	5.8	(4.8– 6.8)	4.6	(3.4– 5.8)	6.9	(5.5– 8.4)	5.0 (2.6– 7.4)	10.1 (6.5–13.8)
BMI††										
Normal	2.7	(2.2– 3.2)	4.0	(3.6– 4.4)	5.7	(4.5– 6.9)	5.2	(4.4– 5.9)	6.4 (5.0– 7.7)	8.5 (7.1–10.0)
Overweight	3.0	(2.5– 3.5)	5.2	(4.5– 5.9)	4.7	(3.9– 5.6)	6.5	(5.8– 7.3)	5.7 (4.6– 6.8)	7.9 (6.6– 9.3)
Obese class I, II, III	4.3	(3.4– 5.2)	5.6	(4.7– 6.5)	4.9	(3.7– 6.2)	8.3	(7.3– 9.4)	6.8 (4.7– 9.0)	10.5 (8.5–12.5)
Diabetes										
Yes	3.8	(1.9– 5.7)	8.3	(5.7–10.9)	7.1	(5.5– 8.7)	8.8	(7.6–10.1)	9.3 (7.5–11.1)	11.9 (10.5–13.3)
No	3.1	(2.7– 3.4)	4.4	(4.1– 4.7)	4.6	(4.0– 5.2)	6.3	(5.9– 6.8)	5.2 (4.5– 6.0)	7.1 (6.4– 7.8)
High blood pressure§§										
Never told s/he has	2.8	(2.3– 3.3)	4.0	(3.6– 4.5)	3.7	(2.8– 4.5)	5.5	(4.7– 6.2)	4.2 (2.9– 5.4)	6.6 (5.3– 7.9)
Told more than once	6.2	(4.0– 8.3)	7.4	(5.2– 9.5)	8.1	(6.1–10.1)	9.4	(8.1–10.6)	8.3 (6.3–10.2)	8.7 (7.4–10.1)
Could not afford to see physician										
Yes	7.1	(5.6– 8.7)	7.4	(6.4– 8.4)	10.6	(8.3–12.9)	11.6	(10.3–12.9)	10.4 (7.5–13.3)	12.9 (10.7–15.2)
No	2.7	(2.4– 3.0)	4.1	(3.8– 4.5)	4.5	(3.9– 5.0)	5.9	(5.4– 6.3)	5.7 (4.9– 6.4)	7.9 (7.2– 8.6)
Health care coverage										
Yes	3.3	(2.9– 3.6)	4.4	(4.1– 4.7)	5.2	(4.6– 5.8)	6.7	(6.2– 7.1)	6.2 (5.4– 6.9)	8.5 (7.8– 9.2)
No	2.3	(1.6– 3.0)	5.2	(4.1– 6.2)	3.6	(2.4– 4.9)	7.1	(5.5– 8.7)	¶	¶
Total	**3.1**	**(2.8– 3.4)**	**4.5**	**(4.2– 4.8)**	**5.0**	**(4.4– 5.6)**	**6.7**	**(6.3– 7.1)**	**6.2 (5.4– 6.9)**	**8.4 (7.8– 9.1)**

* Percentages based on self-reported data and weights applied to represent population.
† Confidence interval.
§ Does not include islands of Vieques or Culebras (insufficient sample).
¶ Sample <50.
** From 1996, 1998, and 2000 data only.
†† BMI (kg/m^2) categories: normal (18.5–24.9), overweight (25.0–29.9), obese class I (30.0–34.9), obese class II (35.0–39.9), and obese class III (≥40). The underweight category had <50 respondents and was excluded.
§§ From 1997 and 1999 data only.

highest (16.1 days) was for women aged 45–64 years who were unable to work.

Respondents who exercised during the month preceding the survey or who had never smoked cigarettes reported fewer unhealthy days than those who did not exercise or who had smoked. Those with normal body mass index (BMI) usually had fewer unhealthy days than those who were obese (BMI [kg/m^2] ≥30). Persons in all age groups with diabetes had significantly more unhealthy days than those without diabetes. Persons who had been told two or more times by a health-care provider that they had high blood pressure reported significantly more unhealthy days in all age groups than those who not been told they had high blood pressure. Those who could not afford to see a health-care provider reported more unhealthy days than those who could afford to see one, but the 9% without health-care coverage had about the same mean number of unhealthy days as those with health-care coverage.

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Editorial Note: The findings in this report indicate that there are substantial differences in HRQOL among subgroups in Puerto Rico. Socioeconomic and health indicators for Puerto Rico have improved substantially since 1970 as economic development has transformed a primarily agricultural economy to one based on manufacturing and services (*3*). Since 1993, Puerto Rico also has privatized public health facilities and instituted managed competition to extend health insurance coverage to the uninsured. However, the continued low per capita income in Puerto Rico adversely affects Puerto Ricans' mental and physical health and their overall quality of life (*3*). The findings in this report reflect the impact of lower socioeconomic status on HRQOL. In some cases, low HRQOL might affect socioeconomic status (e.g., by reducing one's productivity and associated earnings).

Puerto Rican adults reported having fewer unhealthy days but substantially worse self-rated health than U.S. adults (*2,4*). Lower self-reported health status among Puerto Ricans, both those living in Puerto Rico and those living on the U.S. mainland, has in part been attributed to somatization (i.e., reported physical symptoms in the absence of physical pathology as a method of expressing psychosocial problems) (*5*), the stresses of acculturation (6), or *ataque de nervios* (a culturally meaningful expression addressing the experience of suffering either personal or social loss) (*7*).

Persons with fair or poor health status reported more days for which they were physically and/or mentally unhealthy or limited in activity than did persons whose health status was good, very good, or excellent. This supports the construct validity of the HRQOL measures in the Puerto Rican population: the two constructs—self-rated health and reported unhealthy days—were associated in a consistent and expected manner (*8*).

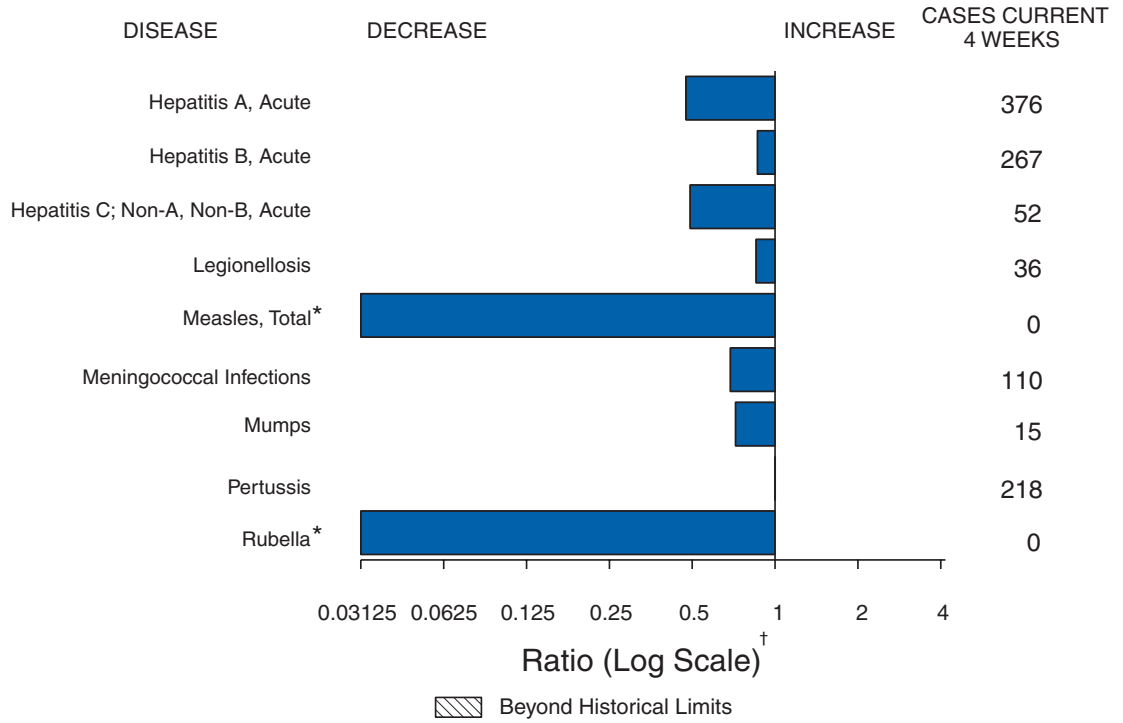
The findings in this report are subject to at least four limitations. First, households without telephones and those with only cellular phones were excluded from the sampling frame (*2*). Second, BRFSS excludes an unknown number of persons in institutions and all persons aged <18 years. Third, BRFSS might underrepresent those with a severe impairment because time and functional capacity are required to participate in BRFSS. Finally, the reasons why persons reported worse health status are unclear because BRFSS does not assess the effects of cultural expressions of distress, acculturative stress, or other sociocultural and environmental factors that influence health.

The results of this analysis indicate that the Spanish-language HRQOL questions might be useful for other Spanish-speaking groups in the U.S. and in other Spanish-speaking countries. Differences in HRQOL in demographic, socioeconomic, and behavioral risk subgroups in Puerto Rico reflect the influence of individual biology and behavior, as well as social and environmental factors, on HRQOL (*9*). Policy makers can track HRQOL to identify groups with unmet health needs (*10*). Public health interventions designed to reach vulnerable demographic, socioeconomic, and behavioral risk groups with poor HRQOL might help adults in Puerto Rico to increase their quality and years of healthy life and eliminate health disparities (*9*).

References

1. CDC. Health-related quality of life. Available at http://www.cdc.gov/hrqol. Accessed February 2002.
2. CDC. Behavioral Risk Factor Surveillance System. Available at http://www.cdc.gov/nccdphp/brfss. Accessed February 2002.
3. Pan American Health Organization. Health sector reform: the case of Puerto Rico. Washington, DC: Division of Health Systems and Services Development, World Health Organization, September 1998.
4. CDC. Measuring healthy days: population assessment of health-related quality of life. Atlanta, Georgia: US Department of Health and Human Services, Public Health Service, CDC, November 2000.
5. Angel R, Guarnaccia PJ. Mind, body, and culture: somatization among Hispanics. Soc Sci Med 1989;28:1229–38.
6. Cortes DE, Rogler LH. Health status and acculturation among Puerto Ricans in New York City. J Gen Cult Health 1996;1:267–76.
7. Guarnaccia PJ, Rivera M, Franco F, Neighbors C. The experiences of ataques de nervios: towards an anthropology of emotions in Puerto Rico. Cult Med Psychiatry 1996;20:343–67.
8. Spector PE. Summated rating scale construction. Newbury Park, California: Sage University. Sage University paper series on Qualitative Applications in the Social Sciences, (no. 82).
9. US Department of Health and Human Services. Healthy people 2010, understanding and improving health 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000, 6.
10. Broyles RW, McAnley WJ, Baird-Holmes D. The medically vulnerable: their health risks, health status, and use of physician care. Journal of Health Care for the Poor and Underserved 1999;10(2):186–200.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending February 23, 2002, with historical data



* No measles or rubella cases were reported for the current 4-week period yielding a ratio for week 8 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 February 23, 2002 (8th Week)*

		Cum. 2002	Cum. 2001		Cum. 2002	Cum. 2001
Anthrax		-	-	Encephalitis: West Nile†	4	-
Botulism:	foodborne	5	5	Hansen disease (leprosy)†	3	13
	infant	7	9	Hantavirus pulmonary syndrome†	-	1
	other (wound & unspecified)	2	-	Hemolytic uremic syndrome, postdiarrheal†	11	16
Brucellosis†		8	6	HIV infection, pediatric †§	4	24
Chancroid		6	8	Plague	-	-
Cholera		-	-	Poliomyelitis, paralytic	-	-
Cyclosporiasis†		13	29	Psittacosis†	7	1
Diphtheria		-	-	Q fever†	3	-
Ehrlichiosis:	human granulocytic (HGE)†	7	5	Rabies, human	-	-
	human monocytic (HME)†	1	3	Streptococcal toxic-shock syndrome†	7	16
	other and unspecified	-	-	Tetanus	1	5
Encephalitis:	California serogroup viral†	8	1	Toxic-shock syndrome	14	17
	eastern equine†	-	-	Trichinosis	2	5
	Powassan†	-	-	Tularemia†	4	1
	St. Louis†	-	-	Yellow fever	-	-
	western equine†	-	-			

-:No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update January 27, 2002.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending February 23, 2002, and February 24, 2001 (8th Week)*

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7		*Escherichia coli* Shiga Toxin Positive, Serogroup non-O157	
	Cum. 2002§	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	3,550	5,651	87,913	107,985	244	229	143	152	7	5
NEW ENGLAND	119	164	3,387	3,450	7	4	6	11	-	1
Maine	1	3	199	189	-	-	-	-	-	-
N.H.	2	12	227	181	2	-	-	2	-	-
Vt.	2	9	97	97	-	2	-	-	-	-
Mass.	83	116	1,552	1,354	1	1	4	9	-	1
R.I.	6	9	401	471	3	1	2	-	-	-
Conn.	25	15	911	1,158	1	-	-	-	-	-
MID. ATLANTIC	874	2,448	6,837	9,756	16	36	7	14	-	-
Upstate N.Y.	52	494	900	1,346	3	4	7	9	-	-
N.Y. City	600	1,576	3,965	4,066	8	22	-	1	-	-
N.J.	163	214	263	1,176	-	2	-	4	-	-
Pa.	59	164	1,709	3,168	5	8	N	N	-	-
E.N. CENTRAL	375	300	14,310	20,864	72	87	44	30	-	-
Ohio	106	37	2,888	5,849	26	16	11	11	-	-
Ind.	53	26	2,059	2,141	9	8	3	4	-	-
Ill.	175	123	3,622	6,227	5	8	12	8	-	-
Mich.	31	97	4,426	4,051	16	17	8	2	-	-
Wis.	10	17	1,315	2,596	16	38	10	5	-	-
W.N. CENTRAL	47	87	3,805	5,801	16	6	22	16	3	-
Minn.	9	7	1,031	1,278	7	-	8	8	3	-
Iowa	15	9	461	491	2	2	7	2	-	-
Mo.	22	37	1,212	2,085	5	1	3	2	-	-
N. Dak.	-	1	37	149	-	-	-	-	-	-
S. Dak.	-	-	328	277	-	-	1	1	-	-
Nebr.	-	15	-	560	-	3	-	-	-	-
Kans.	1	18	736	961	2	-	3	3	-	-
S. ATLANTIC	1,156	1,240	18,391	20,434	65	34	27	21	2	2
Del.	23	37	394	437	-	-	1	-	-	-
Md.	143	115	2,166	2,208	2	2	-	-	-	-
D.C.	19	63	460	457	1	2	-	-	-	-
Va.	113	127	2,219	2,427	1	2	1	2	-	1
W. Va.	8	6	355	334	-	-	-	-	-	-
N.C.	64	73	3,104	2,401	9	4	4	13	-	-
S.C.	112	128	2,071	3,297	-	-	-	1	-	-
Ga.	377	104	2,896	4,437	40	12	17	3	1	1
Fla.	297	587	4,726	4,436	12	12	4	2	1	-
E.S. CENTRAL	158	211	6,939	7,467	14	4	1	5	-	-
Ky.	16	18	1,151	1,324	1	-	-	-	-	-
Tenn.	86	87	2,415	2,276	2	-	1	2	-	-
Ala.	20	25	2,422	1,887	10	2	-	3	-	-
Miss.	36	81	951	1,980	1	2	-	-	-	-
W.S. CENTRAL	401	563	14,950	16,383	4	5	-	18	-	-
Ark.	14	45	409	1,377	2	2	-	-	-	-
La.	75	149	2,740	2,707	1	1	-	-	-	-
Okla.	7	35	1,366	1,591	1	1	-	2	-	-
Tex.	305	334	10,435	10,708	-	1	-	16	-	-
MOUNTAIN	121	183	5,433	6,085	11	14	13	9	1	1
Mont.	3	1	399	246	-	-	2	-	-	-
Idaho	1	5	359	292	2	2	1	2	-	-
Wyo.	1	-	128	117	-	-	-	-	1	-
Colo.	21	52	724	1,936	5	6	2	3	-	1
N. Mex.	6	18	755	908	-	3	2	-	-	-
Ariz.	52	37	1,254	1,718	1	1	1	4	-	-
Utah	7	12	992	68	2	2	3	-	-	-
Nev.	30	58	822	800	1	-	2	-	-	-
PACIFIC	299	455	13,861	17,745	39	39	23	28	1	1
Wash.	-	28	2,093	2,120	10	U	4	3	-	-
Oreg.	76	19	-	941	7	4	7	1	1	1
Calif.	220	398	10,816	13,687	22	35	12	20	-	-
Alaska	-	1	510	360	-	-	-	-	-	-
Hawaii	3	9	442	637	-	-	-	4	-	-
Guam	1	1	-	-	-	-	N	N	-	-
P.R.	68	48	-	441	-	-	-	-	-	-
V.I.	33	1	-	27	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	25	U	-	U	-	U	-	U

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

* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

† Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update January 27, 2002.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 23, 2002, and February 24, 2001 (8th Week)*

Reporting Area	*Escherichia coli* Shiga Toxin Positive, Not Serogrouped		Giardiasis	Gonorrhea		*Haemophilus influenzae*, Invasive			
						All Ages, All Serotypes		Age <5 Years Serotype B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	1	1	1,546	40,679	51,558	210	246	1	3
NEW ENGLAND	-	-	159	1,061	941	14	9	-	1
Maine	-	-	25	13	25	1	-	-	-
N.H.	-	-	10	14	17	2	-	-	-
Vt.	-	-	16	13	14	2	-	-	-
Mass.	-	-	60	570	402	8	9	-	1
R.I.	-	-	18	142	123	-	-	-	-
Conn.	-	-	30	309	360	1	-	-	-
MID. ATLANTIC	-	-	262	3,328	4,813	32	42	-	-
Upstate N.Y.	-	-	60	501	753	16	8	-	-
N.Y. City	-	-	121	1,784	1,811	11	13	-	-
N.J.	-	-	-	225	620	2	16	-	-
Pa.	-	-	81	818	1,629	3	5	-	-
E.N. CENTRAL	1	-	330	7,493	10,813	29	44	-	-
Ohio	1	-	132	1,640	3,196	21	16	-	-
Ind.	-	-	-	946	981	6	5	-	-
Ill.	-	-	38	2,078	3,302	-	15	-	-
Mich.	-	-	115	2,411	2,380	1	3	-	-
Wis.	-	-	45	418	954	1	5	-	-
W.N. CENTRAL	-	-	162	1,851	2,552	3	3	-	-
Minn.	-	-	58	347	427	-	-	-	-
Iowa	-	-	40	134	134	1	-	-	-
Mo.	-	-	38	977	1,291	2	3	-	-
N. Dak.	-	-	-	-	4	-	-	-	-
S. Dak.	-	-	9	40	32	-	-	-	-
Nebr.	-	-	-	-	212	-	-	-	-
Kans.	-	-	17	353	452	-	-	-	-
S. ATLANTIC	-	-	295	11,442	13,379	61	79	-	1
Del.	-	-	10	269	251	-	-	-	-
Md.	-	-	18	1,202	1,287	16	17	-	-
D.C.	-	-	8	403	472	-	-	-	-
Va.	-	-	10	1,390	1,416	2	5	-	-
W. Va.	-	-	2	142	60	-	3	-	1
N.C.	-	-	-	2,496	2,041	7	14	-	-
S.C.	-	-	1	1,224	2,864	-	1	-	-
Ga.	-	-	110	1,715	2,451	23	19	-	-
Fla.	-	-	136	2,601	2,537	13	20	-	-
E.S. CENTRAL	-	1	38	4,188	5,038	5	9	1	-
Ky.	-	1	-	478	566	-	-	-	-
Tenn.	-	-	12	1,461	1,623	3	4	-	-
Ala.	-	-	26	1,597	1,605	2	4	1	-
Miss.	-	-	-	652	1,244	-	1	-	-
W.S. CENTRAL	-	-	9	6,845	8,315	10	3	-	-
Ark.	-	-	9	253	938	-	-	-	-
La.	-	-	-	1,833	1,893	-	1	-	-
Okla.	-	-	-	570	784	10	2	-	-
Tex.	-	-	-	4,189	4,700	-	-	-	-
MOUNTAIN	-	-	147	1,374	1,498	32	39	-	-
Mont.	-	-	6	25	10	-	-	-	-
Idaho	-	-	3	16	17	-	1	-	-
Wyo.	-	-	1	9	12	-	-	-	-
Colo.	-	-	59	504	551	7	8	-	-
N. Mex.	-	-	10	146	153	8	7	-	-
Ariz.	-	-	12	354	474	13	22	-	-
Utah	-	-	31	69	9	3	-	-	-
Nev.	-	-	25	251	272	1	1	-	-
PACIFIC	-	-	144	3,097	4,209	24	18	-	1
Wash.	-	-	30	466	484	-	-	-	-
Oreg.	-	-	83	-	172	19	-	-	-
Calif.	-	-	-	2,465	3,402	-	13	-	1
Alaska	-	-	13	107	42	-	1	-	-
Hawaii	-	-	18	59	109	5	4	-	-
Guam	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	155	-	-	-	-
V.I.	-	-	-	-	4	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	3	U	-	U	-	U

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

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 23, 2002, and February 24, 2001 (8th Week)*

Reporting Area	*Haemophilus influenzae*, Invasive, Age <5 Years, Non-Serotype B		*Haemophilus influenzae*, Invasive, Age <5 Years, Unknown Serotype		Hepatitis (Viral, Acute), By Type, A		B		C; Non-A, Non-B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	34	46	1	5	1,024	2,073	553	867	160	810
NEW ENGLAND	1	4	-	-	51	76	17	22	3	11
Maine	-	-	-	-	1	1	-	1	-	-
N.H.	-	-	-	-	3	2	3	1	-	-
Vt.	-	-	-	-	-	1	1	1	3	2
Mass.	1	4	-	-	23	31	12	4	-	9
R.I.	-	-	-	-	4	3	1	4	-	-
Conn.	-	-	-	-	20	38	-	11	-	-
MID. ATLANTIC	3	6	-	-	78	190	75	213	24	385
Upstate N.Y.	2	-	-	-	14	17	4	8	4	9
N.Y. City	1	3	-	-	24	63	43	97	-	-
N.J.	-	-	-	-	1	83	8	75	18	366
Pa.	-	3	-	-	39	27	20	33	2	10
E.N. CENTRAL	4	8	-	-	107	621	92	82	14	51
Ohio	3	2	-	-	42	40	12	17	1	1
Ind.	1	-	-	-	4	6	3	2	-	-
Ill.	-	5	-	-	27	487	2	2	1	19
Mich.	-	-	-	-	30	75	75	61	12	31
Wis.	-	1	-	-	4	13	-	-	-	-
W.N. CENTRAL	-	-	1	1	50	83	19	33	51	178
Minn.	-	-	-	-	3	1	2	1	-	-
Iowa	-	-	-	-	15	6	5	5	1	-
Mo.	-	-	1	1	8	27	9	19	50	176
N. Dak.	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	2	-	-	1	-	-
Nebr.	-	-	-	-	-	17	-	4	-	1
Kans.	-	-	-	-	22	32	3	3	-	1
S. ATLANTIC	11	12	-	2	337	228	189	169	14	9
Del.	-	-	-	-	-	1	1	3	3	1
Md.	-	1	-	-	70	43	16	18	3	3
D.C.	-	-	-	-	12	3	2	2	-	-
Va.	1	2	-	-	3	20	13	11	-	-
W. Va.	-	-	-	-	1	-	2	1	-	-
N.C.	-	-	-	2	57	10	34	29	3	2
S.C.	-	-	-	-	8	9	3	-	1	-
Ga.	6	5	-	-	52	77	71	74	1	1
Fla.	4	4	-	-	134	65	47	31	3	2
E.S. CENTRAL	1	1	-	1	29	50	25	72	21	13
Ky.	-	-	-	-	9	5	4	10	1	-
Tenn.	-	-	-	-	-	24	-	25	4	10
Ala.	1	-	-	1	5	19	10	20	2	-
Miss.	-	1	-	-	15	2	11	17	14	3
W.S. CENTRAL	4	1	-	-	16	382	14	47	1	136
Ark.	-	-	-	-	5	16	12	15	-	1
La.	-	-	-	-	3	16	-	20	1	58
Okla.	4	1	-	-	7	27	1	11	-	-
Tex.	-	-	-	-	1	323	1	1	-	77
MOUNTAIN	7	5	-	1	72	149	32	66	12	10
Mont.	-	-	-	-	2	2	-	-	-	-
Idaho	-	-	-	-	-	17	-	2	-	1
Wyo.	-	-	-	-	2	1	2	-	4	2
Colo.	1	-	-	-	19	22	13	15	6	2
N. Mex.	3	2	-	1	4	4	2	17	-	5
Ariz.	2	3	-	-	24	73	7	24	-	-
Utah	-	-	-	-	8	9	3	-	-	-
Nev.	1	-	-	-	13	21	5	8	2	-
PACIFIC	3	9	-	-	284	294	90	163	20	17
Wash.	-	-	-	-	10	7	5	10	2	2
Oreg.	3	-	-	-	21	2	18	3	6	1
Calif.	-	8	-	-	252	274	67	146	12	14
Alaska	-	-	-	-	1	10	-	1	-	-
Hawaii	-	1	-	-	-	1	-	3	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	7	-	15	-	1
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	4	U	-	U

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

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 23, 2002, and February 24, 2001 (8th Week)*

Reporting Area	Legionellosis		Listeriosis		Lyme Disease		Malaria		Measles Total	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	84	114	39	62	383	653	119	182	-	28†
NEW ENGLAND	5	2	5	5	20	99	8	16	-	4
Maine	-	-	1	-	-	-	1	-	-	-
N.H.	1	-	2	-	9	2	4	-	-	-
Vt.	-	1	-	-	-	1	-	-	-	1
Mass.	2	1	1	5	8	32	-	8	-	3
R.I.	-	-	-	-	3	-	-	-	-	-
Conn.	2	-	1	-	-	64	3	8	-	-
MID. ATLANTIC	12	24	5	6	264	447	13	45	-	-
Upstate N.Y.	3	1	3	1	166	113	3	4	-	-
N.Y. City	-	2	1	1	-	5	6	24	-	-
N.J.	-	4	-	2	16	92	2	10	-	-
Pa.	9	17	1	2	82	237	2	7	-	-
E.N. CENTRAL	38	39	6	9	9	24	11	32	-	2
Ohio	26	15	5	1	9	8	7	4	-	-
Ind.	2	2	-	-	-	-	-	7	-	-
Ill.	-	7	-	2	-	3	-	10	-	2
Mich.	10	9	1	4	-	-	4	11	-	-
Wis.	-	6	-	2	U	13	-	-	-	-
W.N. CENTRAL	2	8	1	2	7	5	8	5	-	2
Minn.	-	-	-	-	2	3	-	1	-	-
Iowa	-	2	-	-	3	-	2	1	-	-
Mo.	2	3	1	1	2	2	3	3	-	2
N. Dak.	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	-	-	-	-
Nebr.	-	2	-	-	-	-	-	-	-	-
Kans.	-	1	-	1	-	-	3	-	-	-
S. ATLANTIC	15	13	6	6	63	53	45	38	-	3
Del.	3	-	-	-	5	4	-	1	-	-
Md.	4	5	1	1	40	44	17	14	-	3
D.C.	-	-	-	-	3	1	2	2	-	-
Va.	-	2	-	1	-	2	-	8	-	-
W. Va.	N	N	-	1	-	-	-	-	-	-
N.C.	2	2	-	-	3	2	5	1	-	-
S.C.	-	-	2	-	1	-	2	-	-	-
Ga.	3	1	2	1	-	-	11	9	-	-
Fla.	3	3	1	2	11	-	8	3	-	-
E.S. CENTRAL	-	6	2	4	1	2	3	6	-	-
Ky.	-	2	-	1	-	2	-	1	-	-
Tenn.	-	-	1	2	1	-	1	3	-	-
Ala.	-	2	1	1	-	-	1	2	-	-
Miss.	-	2	-	-	-	-	1	-	-	-
W.S. CENTRAL	-	2	-	7	2	12	2	2	-	-
Ark.	-	-	-	-	-	-	-	-	-	-
La.	-	1	-	-	1	-	2	1	-	-
Okla.	-	-	-	-	-	-	-	-	-	-
Tex.	-	1	-	7	1	12	-	1	-	-
MOUNTAIN	4	4	3	5	2	-	5	9	-	1
Mont.	-	-	-	-	-	-	-	1	-	-
Idaho	-	-	-	-	-	-	-	1	-	1
Wyo.	-	-	-	-	-	-	-	-	-	-
Colo.	1	3	1	1	1	-	2	3	-	-
N. Mex.	1	-	-	1	1	-	-	1	-	-
Ariz.	-	1	2	1	-	-	-	1	-	-
Utah	2	-	-	-	-	-	2	1	-	-
Nev.	-	-	-	2	-	-	1	1	-	-
PACIFIC	8	16	11	18	15	11	24	29	-	16
Wash.	-	3	-	-	-	-	1	1	-	12
Oreg.	N	N	1	1	1	1	-	2	-	2
Calif.	8	13	10	17	14	10	20	23	-	1
Alaska	-	-	-	-	-	-	1	1	-	-
Hawaii	-	-	-	-	N	N	2	2	-	1
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	2	-	-	N	N	-	-	-	-
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Of 28 cases reported, 22 were indigenous and six were imported from another country.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 23, 2002, and February 24, 2001 (8th Week)*

Reporting Area	Meningococcal Disease		Mumps		Pertussis		Rabies, Animal	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	229	558	28	24	539	743	427	817
NEW ENGLAND	20	36	2	-	131	119	70	66
Maine	2	-	-	-	3	-	5	11
N.H.	2	3	2	-	1	11	1	1
Vt.	3	2	-	-	18	17	20	13
Mass.	10	21	-	-	109	87	19	16
R.I.	2	-	-	-	-	-	4	8
Conn.	1	10	-	-	-	4	21	17
MID. ATLANTIC	19	72	4	2	29	39	71	119
Upstate N.Y.	4	13	1	1	22	31	54	66
N.Y. City	4	14	1	1	3	6	4	1
N.J.	1	28	-	-	-	-	-	17
Pa.	10	17	2	-	4	2	13	35
E.N. CENTRAL	34	61	2	2	75	103	2	6
Ohio	19	16	1	1	50	69	1	-
Ind.	6	-	-	-	5	1	1	1
Ill.	-	14	1	1	10	6	-	-
Mich.	6	20	-	-	9	11	-	2
Wis.	3	11	-	-	1	16	-	3
W.N. CENTRAL	10	30	2	1	76	30	24	49
Minn.	-	-	-	-	10	-	4	11
Iowa	3	9	-	-	31	5	4	10
Mo.	4	13	-	-	22	15	1	2
N. Dak.	-	-	-	-	-	-	-	8
S. Dak.	2	1	-	-	2	2	-	8
Nebr.	-	2	-	-	-	-	-	-
Kans.	1	5	2	1	11	8	15	10
S. ATLANTIC	47	86	4	1	50	31	190	226
Del.	1	-	-	-	1	-	3	-
Md.	1	14	1	1	9	10	38	43
D.C.	-	-	-	-	-	-	-	-
Va.	2	10	1	-	15	-	63	43
W. Va.	-	-	-	-	-	-	10	15
N.C.	7	20	1	-	9	10	64	56
S.C.	6	5	1	-	14	4	8	7
Ga.	8	16	-	-	-	6	-	41
Fla.	22	21	-	-	2	1	4	21
E.S. CENTRAL	14	34	3	-	19	22	13	111
Ky.	2	5	1	-	6	6	1	2
Tenn.	3	10	-	-	10	11	8	106
Ala.	8	13	1	-	3	2	4	3
Miss.	1	6	1	-	-	3	-	-
W.S. CENTRAL	11	124	2	-	36	3	16	152
Ark.	5	6	-	-	5	2	-	-
La.	1	19	-	-	-	-	-	2
Okla.	4	7	-	-	1	1	16	11
Tex.	1	92	2	-	30	-	-	139
MOUNTAIN	25	25	-	3	87	318	15	38
Mont.	-	-	-	-	2	-	-	4
Idaho	-	3	-	-	6	49	-	-
Wyo.	-	-	-	1	1	-	1	12
Colo.	9	11	-	-	49	98	-	-
N. Mex.	-	4	-	2	14	8	-	1
Ariz.	7	3	-	-	9	159	14	21
Utah	4	2	-	-	5	4	-	-
Nev.	5	2	-	-	1	-	-	-
PACIFIC	49	90	9	15	36	78	26	50
Wash.	9	12	-	-	19	8	-	-
Oreg.	12	2	N	N	11	2	-	-
Calif.	26	71	9	8	4	61	10	26
Alaska	1	1	-	-	2	-	16	24
Hawaii	1	4	-	7	-	7	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	-	1	-	-	-	-	12	17
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U

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

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 23, 2002, and February 24, 2001 (8th Week)*

Reporting Area	Rocky Mountain Spotted Fever		Rubella				Salmonellosis	
			Rubella		Congenital Rubella			
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	39	11	-	-	-	-	3,130	3,572
NEW ENGLAND	-	-	-	-	-	-	173	190
Maine	-	-	-	-	-	-	29	9
N.H.	-	-	-	-	-	-	5	13
Vt.	-	-	-	-	-	-	8	10
Mass.	-	-	-	-	-	-	94	143
R.I.	-	-	-	-	-	-	5	11
Conn.	-	-	-	-	-	-	32	4
MID. ATLANTIC	4	1	-	-	-	-	210	583
Upstate N.Y.	-	-	-	-	-	-	42	69
N.Y. City	-	-	-	-	-	-	84	144
N.J.	-	-	-	-	-	-	2	213
Pa.	4	1	-	-	-	-	82	157
E.N. CENTRAL	3	2	-	-	-	-	559	507
Ohio	3	-	-	-	-	-	224	152
Ind.	-	1	-	-	-	-	35	29
Ill.	-	1	-	-	-	-	163	153
Mich.	-	-	-	-	-	-	95	95
Wis.	-	-	-	-	-	-	42	78
W.N. CENTRAL	1	1	-	-	-	-	244	200
Minn.	-	-	-	-	-	-	48	67
Iowa	-	-	-	-	-	-	43	23
Mo.	1	1	-	-	-	-	111	50
N. Dak.	-	-	-	-	-	-	-	1
S. Dak.	-	-	-	-	-	-	13	13
Nebr.	-	-	-	-	-	-	-	16
Kans.	-	-	-	-	-	-	29	30
S. ATLANTIC	29	5	-	-	-	-	978	823
Del.	-	-	-	-	-	-	8	9
Md.	4	1	-	-	-	-	79	90
D.C.	-	-	-	-	-	-	9	13
Va.	-	-	-	-	-	-	73	76
W. Va.	-	-	-	-	-	-	3	3
N.C.	22	4	-	-	-	-	144	153
S.C.	2	-	-	-	-	-	60	55
Ga.	-	-	-	-	-	-	312	268
Fla.	1	-	-	-	-	-	290	156
E.S. CENTRAL	2	2	-	-	-	-	187	201
Ky.	-	-	-	-	-	-	23	35
Tenn.	2	1	-	-	-	-	54	45
Ala.	-	1	-	-	-	-	70	83
Miss.	-	-	-	-	-	-	40	38
W.S. CENTRAL	-	-	-	-	-	-	62	385
Ark.	-	-	-	-	-	-	27	30
La.	-	-	-	-	-	-	1	66
Okla.	-	-	-	-	-	-	32	15
Tex.	-	-	-	-	-	-	2	274
MOUNTAIN	-	-	-	-	-	-	219	198
Mont.	-	-	-	-	-	-	3	7
Idaho	-	-	-	-	-	-	11	6
Wyo.	-	-	-	-	-	-	6	10
Colo.	-	-	-	-	-	-	73	50
N. Mex.	-	-	-	-	-	-	36	27
Ariz.	-	-	-	-	-	-	34	66
Utah	-	-	-	-	-	-	21	19
Nev.	-	-	-	-	-	-	35	13
PACIFIC	-	-	-	-	-	-	498	485
Wash.	-	-	-	-	-	-	21	18
Oreg.	-	-	-	-	-	-	43	6
Calif.	-	-	-	-	-	-	392	403
Alaska	-	-	-	-	-	-	10	5
Hawaii	-	-	-	-	-	-	32	53
Guam	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	6	103
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	1	U

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

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 23, 2002, and February 24, 2001 (8th Week)*

Reporting Area	Shigellosis		Streptococcal Disease, Invasive, Group A		*Streptococcus pneumoniae*, Drug Resistant, Invasive		*Streptococcus pneumoniae*, Invasive (<5 Years)	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	1,659	1,870	515	600	322	444	12	15
NEW ENGLAND	33	24	17	20	1	2	6	1
Maine	2	-	4	5	-	-	-	-
N.H.	2	-	5	3	-	-	-	-
Vt.	-	-	1	3	1	2	6	1
Mass.	26	22	7	9	-	-	-	-
R.I.	-	-	-	-	-	-	-	-
Conn.	3	2	-	-	-	-	-	-
MID. ATLANTIC	50	252	64	122	10	25	2	9
Upstate N.Y.	6	70	26	32	10	24	2	9
N.Y. City	28	67	25	50	-	-	-	-
N.J.	-	66	6	36	-	-	-	-
Pa.	16	49	7	4	-	1	-	-
E.N. CENTRAL	233	283	91	153	16	27	2	5
Ohio	150	67	34	38	-	-	1	-
Ind.	10	35	4	-	16	27	1	5
Ill.	39	99	1	54	-	-	-	-
Mich.	27	58	52	52	-	-	-	-
Wis.	7	24	-	9	-	-	-	-
W.N. CENTRAL	161	220	19	39	28	5	-	-
Minn.	22	101	-	-	-	-	-	-
Iowa	8	26	-	-	-	-	-	-
Mo.	21	49	11	19	1	-	-	-
N. Dak.	-	8	-	2	-	1	-	-
S. Dak.	92	2	1	2	1	-	-	-
Nebr.	-	12	-	4	-	2	-	-
Kans.	18	22	7	12	26	2	-	-
S. ATLANTIC	729	238	130	79	227	293	2	-
Del.	2	2	-	-	3	-	-	-
Md.	64	16	16	8	-	-	-	-
D.C.	3	8	2	-	2	1	2	-
Va.	161	12	7	22	-	-	-	-
W. Va.	1	2	-	1	3	6	-	-
N.C.	41	51	32	14	-	-	-	-
S.C.	9	12	3	1	27	51	-	-
Ga.	337	67	47	17	81	94	-	-
Fla.	111	68	23	16	111	141	-	-
E.S. CENTRAL	105	127	18	13	28	55	-	-
Ky.	21	47	1	4	1	6	-	-
Tenn.	9	13	17	9	27	48	-	-
Ala.	37	26	-	-	-	1	-	-
Miss.	38	41	-	-	-	-	-	-
W.S. CENTRAL	47	324	8	83	2	26	-	-
Ark.	16	31	-	-	2	7	-	-
La.	2	32	-	-	-	19	-	-
Okla.	28	1	7	7	-	-	-	-
Tex.	1	260	1	76	-	-	-	-
MOUNTAIN	54	103	73	70	10	10	-	-
Mont.	-	-	-	-	-	-	-	-
Idaho	2	4	1	1	-	-	-	-
Wyo.	1	-	1	1	5	-	-	-
Colo.	16	17	49	41	-	-	-	-
N. Mex.	8	23	22	21	5	10	-	-
Ariz.	13	51	-	5	-	-	-	-
Utah	7	2	-	1	-	-	-	-
Nev.	7	6	-	-	-	-	-	-
PACIFIC	247	299	95	21	-	1	-	-
Wash.	5	25	16	-	-	-	-	-
Oreg.	25	1	-	-	-	-	-	-
Calif.	206	265	67	13	-	-	-	-
Alaska	1	1	-	-	-	-	-	-
Hawaii	10	7	12	8	-	1	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	-	4	-	-	-	-	-	-
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	-	-	U	U
C.N.M.I.	-	U	-	U	-	-	-	U

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

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 23, 2002, and February 24, 2001 (8th Week)*

Reporting Area	Syphilis				Tuberculosis		Typhoid Fever	
	Primary & Secondary		Congenital†					
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	715	733	2	69	664	1,170	27	39
NEW ENGLAND	10	4	-	-	31	41	3	4
Maine	-	-	-	-	-	-	-	-
N.H.	-	-	-	-	1	1	-	-
Vt.	-	-	-	-	-	1	-	-
Mass.	6	1	-	-	8	25	2	4
R.I.	1	-	-	-	6	3	-	-
Conn.	3	3	-	-	16	11	1	-
MID. ATLANTIC	60	69	-	9	144	178	2	17
Upstate N.Y.	4	3	-	7	2	23	-	3
N.Y. City	43	42	-	-	107	75	2	1
N.J.	11	9	-	2	-	56	-	13
Pa.	2	15	-	-	35	24	-	-
E.N. CENTRAL	145	96	-	13	114	111	6	3
Ohio	19	6	-	1	21	23	2	1
Ind.	8	16	-	-	13	11	1	-
Ill.	36	44	-	11	53	57	-	1
Mich.	79	25	-	1	21	9	2	1
Wis.	3	5	-	-	6	11	1	-
W.N. CENTRAL	5	19	-	1	58	42	-	1
Minn.	2	12	-	-	27	28	-	-
Iowa	-	-	-	-	-	-	-	-
Mo.	3	3	-	-	28	8	-	1
N. Dak.	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	3	1	-	-
Nebr.	-	-	-	-	-	5	-	-
Kans.	-	4	-	1	-	-	-	-
S. ATLANTIC	179	260	-	20	66	194	7	7
Del.	2	1	-	-	-	-	-	-
Md.	11	42	-	1	13	11	-	2
D.C.	8	6	-	-	-	16	-	-
Va.	5	24	-	-	7	21	-	-
W. Va.	-	-	-	-	5	6	-	-
N.C.	55	63	-	2	28	11	-	1
S.C.	18	38	-	7	2	21	-	-
Ga.	22	30	-	4	11	47	5	3
Fla.	58	56	-	6	-	61	2	1
E.S. CENTRAL	94	83	-	3	60	72	-	-
Ky.	4	7	-	-	14	7	-	-
Tenn.	34	43	-	1	20	14	-	-
Ala.	49	19	-	2	22	36	-	-
Miss.	7	14	-	-	4	15	-	-
W.S. CENTRAL	106	106	2	13	6	223	-	3
Ark.	-	10	-	2	3	15	-	-
La.	22	17	-	-	-	-	-	-
Okla.	11	13	-	1	3	3	-	-
Tex.	73	66	2	10	-	205	-	3
MOUNTAIN	41	28	-	2	25	48	2	1
Mont.	-	-	-	-	-	-	-	-
Idaho	1	-	-	-	-	-	-	-
Wyo.	-	-	-	-	1	-	-	-
Colo.	-	2	-	-	5	15	1	-
N. Mex.	6	2	-	-	4	5	-	-
Ariz.	32	19	-	2	11	15	-	-
Utah	2	4	-	-	2	1	1	-
Nev.	-	1	-	-	2	12	-	1
PACIFIC	75	68	-	8	160	261	7	3
Wash.	7	13	-	-	20	26	-	-
Oreg.	-	2	-	-	8	10	1	-
Calif.	67	50	-	8	102	193	6	2
Alaska	-	-	-	-	14	9	-	-
Hawaii	1	3	-	-	16	23	-	1
Guam	-	-	-	-	-	-	-	-
P.R.	-	41	-	1	-	-	-	-
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	-	U	11	U	-	U

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

TABLE III. Deaths in 122 U.S. cities,* week ending February 23, 2002 (8th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	597	458	95	25	9	10	106
Boston, Mass.	160	114	31	8	5	2	29
Bridgeport, Conn.	U	U	U	U	U	U	U
Cambridge, Mass.	19	17	1	1	-	-	7
Fall River, Mass.	39	36	3	-	-	-	11
Hartford, Conn.	43	33	8	-	-	2	5
Lowell, Mass.	36	33	2	1	-	-	7
Lynn, Mass.	21	15	5	1	-	-	5
New Bedford, Mass.	43	38	3	1	1	-	3
New Haven, Conn.	50	37	8	3	1	1	7
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	8	8	-	-	-	-	3
Springfield, Mass.	61	41	15	3	2	-	3
Waterbury, Conn.	37	28	8	1	-	-	7
Worcester, Mass.	80	58	11	6	-	5	19
MID. ATLANTIC	2,262	1,645	411	146	41	19	131
Albany, N.Y.	49	33	12	2	1	1	4
Allentown, Pa.	24	19	2	1	2	-	3
Buffalo, N.Y.	83	59	17	6	1	-	12
Camden, N.J.	44	37	6	-	1	-	2
Elizabeth, N.J.	23	17	4	2	-	-	-
Erie, Pa.	44	37	5	1	1	-	1
Jersey City, N.J.	53	36	11	4	1	1	-
New York City, N.Y.	1,231	877	244	86	14	10	58
Newark, N.J.	U	U	U	U	U	U	U
Paterson, N.J.	37	22	8	1	3	3	1
Philadelphia, Pa.	287	193	60	22	10	2	17
Pittsburgh, Pa.§	51	39	5	6	1	-	4
Reading, Pa.	19	14	3	1	1	-	2
Rochester, N.Y.	136	109	16	7	2	2	16
Schenectady, N.Y.	25	23	2	-	-	-	2
Scranton, Pa.	37	31	6	-	-	-	1
Syracuse, N.Y.	58	47	6	3	2	-	6
Trenton, N.J.	34	28	2	3	1	-	1
Utica, N.Y.	27	24	2	1	-	-	1
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,635	1,157	291	102	41	43	115
Akron, Ohio	52	36	7	6	1	2	6
Canton, Ohio	40	37	2	-	-	1	3
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	U	U	U	U	U	U	U
Cleveland, Ohio	158	106	34	8	6	3	6
Columbus, Ohio	201	140	36	16	7	2	5
Dayton, Ohio	134	107	19	6	2	-	9
Detroit, Mich.	152	75	42	19	5	11	11
Evansville, Ind.	50	34	9	2	1	4	4
Fort Wayne, Ind.	48	36	9	3	-	-	3
Gary, Ind.	27	13	5	6	1	2	-
Grand Rapids, Mich.	66	51	8	3	2	2	7
Indianapolis, Ind.	192	152	23	6	5	6	14
Lansing, Mich.	66	43	14	4	3	2	2
Milwaukee, Wis.	124	79	25	12	2	6	13
Peoria, Ill.	50	34	13	3	-	-	6
Rockford, Ill.	60	44	12	1	3	-	6
South Bend, Ind.	79	61	15	1	2	-	8
Toledo, Ohio	77	60	12	4	-	1	8
Youngstown, Ohio	59	49	6	2	1	1	4
W.N. CENTRAL	627	455	108	40	11	12	39
Des Moines, Iowa	65	51	8	2	1	3	5
Duluth, Minn.	U	U	U	U	U	U	U
Kansas City, Kans.	27	20	5	1	1	-	3
Kansas City, Mo.	119	90	16	10	1	1	3
Lincoln, Nebr.	58	49	5	3	-	1	5
Minneapolis, Minn.	2	1	1	-	-	-	-
Omaha, Nebr.	77	62	12	2	-	1	7
St. Louis, Mo.	97	65	21	6	3	2	1
St. Paul, Minn.	69	52	16	1	-	-	5
Wichita, Kans.	113	65	24	15	5	4	10
S. ATLANTIC	1,302	871	257	95	27	52	99
Atlanta, Ga.	134	75	35	15	3	6	3
Baltimore, Md.	266	163	69	21	5	8	27
Charlotte, N.C.	103	71	16	10	3	3	17
Jacksonville, Fla.	184	136	32	11	3	2	18
Miami, Fla.	175	125	30	13	6	1	9
Norfolk, Va.	49	28	9	4	4	4	-
Richmond, Va.	71	40	21	4	3	3	4
Savannah, Ga.	58	44	10	2	-	2	2
St. Petersburg, Fla.	56	50	2	3	-	1	5
Tampa, Fla.	155	116	26	10	-	3	14
Washington, D.C.	35	7	7	2	-	19	-
Wilmington, Del.	16	16	-	-	-	-	-
E.S. CENTRAL	639	437	130	43	17	9	46
Birmingham, Ala.	169	109	37	14	3	3	13
Chattanooga, Tenn.	91	64	18	4	3	2	9
Knoxville, Tenn.	118	86	21	7	4	-	2
Lexington, Ky.	90	62	20	5	2	1	8
Memphis, Tenn.	U	U	U	U	U	U	U
Mobile, Ala.	126	81	28	10	4	3	7
Montgomery, Ala.	45	35	6	3	1	-	7
Nashville, Tenn.	U	U	U	U	U	U	U
W.S. CENTRAL	1,776	1,162	383	143	50	38	144
Austin, Tex.	101	69	23	6	3	-	5
Baton Rouge, La.	121	84	25	10	2	-	-
Corpus Christi, Tex.	55	39	11	2	3	-	9
Dallas, Tex.	220	139	50	19	4	8	19
El Paso, Tex.	101	77	16	6	1	1	11
Ft. Worth, Tex.	151	109	30	7	1	4	16
Houston, Tex.	516	275	134	64	30	13	36
Little Rock, Ark.	U	U	U	U	U	U	U
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	245	178	40	17	3	7	18
Shreveport, La.	109	83	16	8	1	1	15
Tulsa, Okla.	157	109	38	4	2	4	15
MOUNTAIN	1,147	805	216	67	30	25	112
Albuquerque, N.M.	161	113	32	11	4	1	23
Boise, Idaho	61	49	10	-	-	2	9
Colo. Springs, Colo.	82	60	15	4	3	-	1
Denver, Colo.	106	66	21	11	2	6	8
Las Vegas, Nev.	245	178	49	11	3	4	22
Ogden, Utah	29	25	-	2	1	1	3
Phoenix, Ariz.	147	90	34	8	9	2	17
Pueblo, Colo.	42	33	7	1	1	-	4
Salt Lake City, Utah	113	69	24	8	3	9	14
Tucson, Ariz.	161	122	24	11	4	-	11
PACIFIC	1,640	1,143	336	90	47	24	153
Berkeley, Calif.	19	15	4	-	-	-	3
Fresno, Calif.	83	61	13	3	5	1	8
Glendale, Calif.	16	11	3	2	-	-	2
Honolulu, Hawaii	81	68	9	3	-	1	4
Long Beach, Calif.	77	56	14	6	1	-	10
Los Angeles, Calif.	281	173	64	29	10	5	16
Pasadena, Calif.	33	29	3	1	-	-	4
Portland, Oreg.	158	104	37	10	3	4	9
Sacramento, Calif.	237	160	57	11	5	4	16
San Diego, Calif.	142	103	26	4	6	3	19
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	188	144	38	-	6	-	29
Santa Cruz, Calif.	31	22	6	2	1	-	3
Seattle, Wash.	127	82	27	11	7	-	14
Spokane, Wash.	59	43	9	3	-	4	12
Tacoma, Wash.	108	72	26	5	3	2	4
TOTAL	11,625¶	8,133	2,227	751	273	232	945

U: Unavailable. -:No reported cases.

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

† Pneumonia and influenza.

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

¶ Total includes unknown ages.

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