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World TB Day — March 24, 2004

World TB Day is March 24, 2004. This annual event commemorates the date in 1882 when Dr. Robert Koch announced his discovery of the tuberculosis (TB) bacillus. Worldwide, TB remains a leading cause of death from infectious disease. An estimated 2 billion persons (i.e., one third of the world's population) are infected with the bacteria that cause TB. Each year, approximately 8 million persons become ill from TB; of these, 2 million die. World TB Day provides an opportunity for TB programs, nongovernment organizations, and other partners to describe TB-related problems and solutions and to support TB-control efforts.

During 1985–1992, after years of decline, the number of TB cases reported in the United States increased 20%. This resurgence was associated with 1) deterioration of the infrastructure for TB services; 2) immigration of persons from TB-endemic countries; and 3) a combination of the human immunodeficiency virus epidemic, TB transmission in congregate settings (e.g., prisons), and outbreaks of multidrug-resistant TB.

Renewed emphasis on TB control and prevention has produced substantial gains in the United States. However, provisional data indicate that 2003 marked the smallest annual decline in new TB cases since 1992. These data raise concerns that increased efforts might be required to maintain the progress made in controlling TB.

CDC is committed to eliminating TB in the United States. Achieving this goal demands targeted interventions for populations at high risk, active involvement in the global fight against TB, and strong local programs. Additional information about World TB Day and CDC's TB-elimination activities is available at http://www.cdc.gov/nchstp/tb/worldtb2004/default.htm.

Trends in Tuberculosis — United States, 1998–2003

During 2003, a total of 14,871 tuberculosis (TB) cases (5.1 cases per 100,000 population) were reported in the United States, representing a 1.4% decrease in cases and a 1.9% decline in the rate from 2002. This decline is the smallest since 1992, when TB incidence peaked after a 7-year resurgence. In addition, the rate remains higher than the national interim goal of 3.5 cases per 100,000 population that was set for 2000 (*1*). This report summarizes data from the national TB surveillance system for 2003 and describes trends during a 5-year period, with comparison to 1998 and 2002. Despite a decline in TB nationwide, rates have increased in certain states, and elevated TB rates continue to be reported in certain populations (e.g., foreign-born persons and racial/ethnic minorities). Targeted interventions for these at-risk populations, continued collaborative efforts toward the global fight against TB, and adequate local resources are essential to eliminating TB in the United States.

The 50 states and the District of Columbia (DC) report cases to the national TB surveillance system at CDC by using a standard case definition and report form (*2*). Data were analyzed for cases reported during 1998–2003 by using reports updated as of February 24, 2004. A U.S.-born person was defined as someone born in the United States or its associated jurisdictions, or someone born in a foreign country but

INSIDE

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having at least one U.S.-born parent; other persons were classified as foreign-born. U.S. Census population estimates were used to calculate national and state TB rates for 2003 (*3*), and the Current Population Survey (March 2002) was used to extrapolate the total U.S.-born and foreign-born populations for 2003 (*4*). The 2002 U.S. Census population estimates were used to extrapolate and calculate race/ethnicity TB rates for 2003 (*5,6*). U.S. Census Bureau national population estimates were used to calculate the U.S.-born, foreign-born, and racial/ethnic populations for 1998 (*7,8*).

During 2003, a total of 12 states and DC reported rates above the national average (5.1 cases per 100,000 population), and 24 states met the definition for low incidence (≤3.5 cases per 100,000 population) (Table 1). Among the 19 states that reported increases in cases during 2002–2003, California, New York, and Texas accounted for 42.4% of the 2003 national case total. Among those areas reporting <100 cases in 2003, only Alaska and DC had rates higher than the national average (Table 1).

In 2003, foreign-born persons accounted for 53.3% (7,845 cases) of the national case total, and 25 states reported ≥50% of their cases among foreign-born persons. The foreign-born prevalence represents an increase from 1998, when foreign-born persons accounted for 41.7% (7,598) of TB cases nationwide, and 13 states reported ≥50% of their cases among foreign-born persons. The 2003 TB rate among foreign-born persons (23.4 cases per 100,000 population) was 8.7 times greater than that among U.S.-born persons (2.7 cases per 100,000 population), representing an increased rate ratio from 1998 (7.0) and from 2002 (8.0). For the top three reporting states (California, New York, and Texas), the 1998–2003 decrease in cases among U.S.-born persons (32.2%; from 3,179 to 2,155) was four times greater than the decrease among foreign-born persons (7.6%; from 4,420 to 4,086).

In 2003, the five birth countries of foreign-born patients with TB reported most commonly were Mexico (25.6%), the Philippines (11.6%), Vietnam (8.4%), India (7.7%), and China (4.8%). TB patients from certain countries were concentrated in certain states. For example, New York reported 56.1% of the national total born in Ecuador, Minnesota reported 55.2% of patients born in Somalia, California reported 52.3% of patients born in the Philippines, and Florida reported 49.4% of patients born in Haiti. Among 6,429 foreign-born TB patients aged ≥15 years, 3,410 (53.0%) had resided in the United States ≥5 years before TB diagnosis, 1,778 (27.7%) resided in the United States 1–4 years, and 1,241 (19.3%) resided in the United States <1 year.

Disparities in TB rates persist among racial/ethnic minority populations. In 2003, two modifications were made to the

TABLE 1. Number and rate* of reported tuberculosis cases, percentage change in number of cases and rate, and rank according to rate, by area and year — United States, 2002 and 2003†

Area	2003		2002		% change 2002–2003		2003
	No.	Rate	No.	Rate	No.	Rate	Rank by rate
≥400 cases in 2003							
California	3,230	9.1	3,169	9.0	1.9	1.1	3
Texas	1,594	7.2	1,550	7.1	2.8	1.4	6
New York	1,477	7.7	1,434	7.5	3.0	2.7	5
Florida	1,046	6.1	1,086	6.5	-3.7	-6.2	7
Illinois	633	5.0	680	5.4	-6.9	-7.4	14
Georgia	521	6.0	524	6.1	-0.6	-1.6	9
New Jersey	495	5.7	530	6.2	-6.6	-8.1	11
100–399 cases in 2003							
North Carolina	374	4.4	434	5.2	-13.8	-15.4	21
Pennsylvania	336	2.7	353	2.9	-4.8	-6.9	32
Virginia	332	4.5	315	4.3	5.4	4.7	20
Arizona	295	5.3	263	4.8	12.2	10.4	13
Tennessee	285	4.9	308	5.3	-7.5	-7.5	15
Maryland	268	4.9	306	5.6	-12.4	-12.5	15
Massachusetts	261	4.1	271	4.2	-3.7	-2.4	25
Louisiana	260	5.8	230	5.1	13.0	13.7	10
Alabama	258	5.7	233	5.2	10.7	9.6	11
South Carolina	254	6.1	256	6.2	-0.8	-1.6	7
Washington	251	4.1	252	4.2	-0.4	-2.4	25
Michigan	243	2.4	315	3.1	-22.9	-22.6	35
Ohio	229	2.0	257	2.3	-10.9	-13.0	39
Minnesota	214	4.2	237	4.7	-9.7	-10.6	24
Oklahoma	163	4.6	190	5.4	-14.2	-14.8	19
Indiana	143	2.3	128	2.1	11.7	9.5	37
Kentucky	139	3.4	146	3.6	-4.8	-5.6	28
Missouri	131	2.3	136	2.4	-3.7	-4.2	37
Mississippi	128	4.4	134	4.7	-4.5	-6.4	21
Arkansas	127	4.7	136	5.0	-6.6	-6.0	18
Hawaii	117	9.3	148	11.9	-20.9	-21.8	2
Connecticut	111	3.2	104	3.0	6.7	6.7	29
Colorado	111	2.4	104	2.3	6.7	4.3	35
Nevada	107	4.8	85	3.9	25.9	23.1	17
Oregon	106	3.0	111	3.2	-4.5	-6.3	30
<100 cases in 2003							
District of Columbia	79	14.0	82	14.4	-3.7	-2.8	1
Kansas	75	2.8	89	3.3	-15.7	-15.2	31
Wisconsin	66	1.2	78	1.4	-15.4	-14.3	45
Alaska	57	8.8	49	7.6	16.3	15.8	4
New Mexico	49	2.6	57	3.1	-14.0	-16.1	33
Rhode Island	46	4.3	49	4.6	-6.1	-6.5	23
Iowa	40	1.4	34	1.2	17.6	16.7	44
Utah	39	1.7	31	1.3	25.8	30.8	41
Delaware	33	4.0	25	3.1	32.0	29.0	27
Nebraska	28	1.6	28	1.6	0.0	0.0	42
Maine	25	1.9	23	1.8	8.7	5.6	40
West Virginia	21	1.2	30	1.7	-30.0	-29.4	45
South Dakota	20	2.6	13	1.7	53.8	52.9	33
New Hampshire	15	1.2	19	1.5	-21.1	-20.0	45
Idaho	13	1.0	14	1.0	-7.1	0.0	48
Vermont	9	1.5	8	1.3	12.5	15.4	43
Montana	7	0.8	12	1.3	-41.7	-38.5	50
North Dakota	6	0.9	6	0.9	0.0	0.0	49
Wyoming	4	0.8	3	0.6	33.3	33.3	50
Total	**14,871**	**5.1**	**15,075**	**5.2**	**-1.4**	**-1.9**	

* Per 100,000 population.
† Data for 2002 are final; data for 2003 are provisional.

TB report form: 1) multiple race entries were allowed, with 0.3% selecting more than one race, and 2) the previous category of Asian/Pacific Islander was divided into "Asian" and "Native Hawaiian or Other Pacific Islander." During 2003, the highest rates were reported among racial/ethnic minority populations (Table 2). The non-Hispanic black population had the largest number of TB cases (3,041 cases, 45.0%).

During 2003, drug resistance among initial isolates of *Mycobacterium tuberculosis* in persons with no previous TB episodes was more common in foreign-born patients than in U.S.-born patients. With 82.3% of data on drug-susceptibility testing complete, multidrug resistance (i.e., resistance to at least isoniazid and rifampin) among foreign-born persons was 1.2% (U.S.-born: 0.6%). During the preceding 5 years, the proportion of multidrug-resistant TB has been stable (1998: foreign-born, 1.3% and U.S.-born, 0.7%). In 2000, a total of 80.8% of reported TB patients completed therapy in ≤1 year, and 92.2% completed therapy overall.

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Editorial Note: During 1993–2002, the average year-to-year decrease in TB rate was 6.8%. However, 2003 had the smallest annual decrease (1.9%), raising concern about a possible slowing of the progress against TB. During the preceding decade, certain key challenges to TB control were identified, including 1) an increasing proportion of TB among persons born in countries with high rates of TB, 2) disparities among racial/ethnic minority populations, and 3) unique TB epidemiologic trends found in localized areas throughout the United States.

Birthplace data were first collected by the national TB surveillance system in 1986, when 21.8% of TB cases occurred among foreign-born persons. Since then, the proportion has increased steadily, with the highest proportion being reported in 2003, a trend enhanced by the decrease in TB cases among U.S.-born persons. Foreign-born TB patients also are more likely to have multidrug-resistant TB than U.S.-born patients, and the cost of caring for patients with multidrug-resistant TB is high (*9*). CDC is collaborating with partners (e.g., U.S. Agency for International Development, International Union Against TB and Lung Disease, Royal Netherlands TB Association, and World Health Organization) to assist countries with high burdens of TB. CDC collaborations have focused on operational research and programmatic evaluation to address problems such as TB/human immunodeficiency virus coinfection and drug resistance in approximately 20 countries. CDC also is contributing to improvements in TB screening among immigrant and refugee visa applicants, both overseas and in the United States, through the development of innovative tracking mechanisms, new diagnostic tools, and updated medical screening guidelines. A CDC-sponsored assessment of TB prevention among foreign-born persons is under way in 22 locations in the United States and Canada.

The elimination of disparities among racial/ethnic minority populations is a priority for TB control. CDC continues to work with the Advisory Council for the Elimination of TB and public health partners to identify contributing factors and develop strategies to eliminate existing disparities.

Epidemiologic profiles for individual states often are varied and distinct. Changing immigration patterns, proximity to

TABLE 2. Number and rate* of tuberculosis cases and percentage change in rate in U.S.-born and foreign-born persons, by race/ethnicity — United States, 1998 and 2003†

	U.S.-born					Foreign-born					Total§				
	1998		2003		% change 1998–2003	1998		2003		% change 1998–2003	1998		2003		% change 1998–2003
Race/Ethnicity	No.	Rate	No.	Rate		No.	Rate	No.	Rate		No.	Rate	No.	Rate	
Hispanic	1,282	6.6	1,025	4.4	-33.3	2,785	26.0	3,035	19.3	-25.8	**4,091**	**13.5**	**4,108**	**10.5**	**-22.2**
Non-Hispanic															
Black	4,968	16.0	3,041	9.1	-43.1	841	48.5	1,033	51.3	5.8	**5,816**	**17.8**	**4,099**	**11.5**	**-35.4**
Asian/Pacific Islander¶	213	5.8	201	5.3	-8.6	3,411	55.4	3,241	40.6	-26.7	**3,637**	**36.9**	**3,466**	**29.4**	**-20.3**
Asian	—	—	154	4.4	—	—	—	3,205	40.5	—	**—**	**—**	**3,383**	**29.7**	**—**
Native Hawaiian or Other Pacific Islander	—	—	47	15.1	—	—	—	36	48.6	—	**—**	**—**	**83**	**21.5**	**—**
White	3,914	2.1	2,328	1.2	-42.9	550	8.5	437	6.3	-25.9	**4,473**	**2.3**	**2,784**	**1.4**	**-39.1**
American Indian/ Alaska Native	248	12.6	169	7.9	-37.3	—	—	—	—	—	**254**	**12.7**	**175**	**8.0**	**-37.0**
Total**	**10,633**	**4.3**	**6,873**	**2.7**	**-37.2**	**7,598**	**30.2**	**7,845**	**23.4**	**-22.5**	**18,287**	**6.8**	**14,871**	**5.1**	**-25.0**

* Per 100,000 population.
† Data for 2003 are provisional.
§ Includes persons for whom country of birth was unknown: 56 in 1998 and 153 in 2003.
¶ For comparison with 1998, data for 2003 for Asian/Pacific Islanders include Asians plus Native Hawaiians or Other Pacific Islanders.
** Includes persons for whom race/ethnicity was unknown: 16 for total, eight for U.S-born, and five for foreign-born persons in 1998; 201 for total, 99 for U.S-born, and 66 for foreign-born persons in 2003. In 2003, persons were included who selected multiple races: 38 for total, 10 for U.S.-born, and 28 for foreign-born persons.

a•ware: *adj*

(ə-'wâr) 1 : marked by comprehension, cognizance, and perception; see also *MMWR*.

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the U.S.-Mexico border, drug resistance, and outbreaks can affect TB incidence. Tailored TB-control strategies and continued monitoring of TB epidemiology are needed to identify emerging populations at high risk.

The data described in this report reflect key challenges to TB control and the need for sustained efforts to eliminate TB in the United States. Targeted interventions for populations at high risk, active involvement in the global effort against TB, and adequate local resources are essential to eliminate TB in the United States (*10*).

Acknowledgments

The findings in this report are based on surveillance data contributed by TB control officials in state and local health departments.

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Tuberculosis Outbreak in a Community Hospital — District of Columbia, 2002

After declining for nearly 30 years, during 1985–1992, tuberculosis (TB) rates in the United States experienced a resurgence, and several large nosocomial TB outbreaks occurred (*1*). Although data on such outbreaks are not collected systematically by CDC, the occurrence of nosocomial TB is believed to have declined sharply since the issuance and widespread implementation of infection-control guidelines in 1994 (*2–4*). During April 2–September 12, 2002, TB was diagnosed in six persons who either had been patients or had worked in a large community hospital (hospital A) in March or early April. This report describes the results of an investigation of the presumed source patient, who had spent 3 weeks on two general medical wards of hospital A before being placed in respiratory isolation and having TB diagnosed on April 2. To prevent transmission of *Mycobacterium tuberculosis*, hospital staff should remain vigilant to identify and treat suspected TB cases promptly.

In July 2002, after five patients at hospital A had been diagnosed with TB, the District of Columbia Department of Health requested epidemiologic assistance from CDC. An investigative team, consisting of CDC staff, the local health department TB-control program, and the infection-control department of hospital A was formed. The team conducted a contact and case-finding investigation by reviewing hospital and health department records of all six patients. Three patients were interviewed, including the index patient. An expanded contact investigation extended to persons possibly exposed to patients with TB disease at the hospital. Patients who spent ≥1 day on the same medical ward with the index patient were identified through the hospital A admission database and medical ward logs. Hospital staff contacts who were determined from the index patient's medical record and from hospital employment records were categorized as 1) direct-care providers, 2) workers assigned to the same ward but not involved in the patient's medical care, or 3) other workers who spent time on the medical ward but were not assigned there.

Latent TB infection (LTBI) was diagnosed in anyone with a tuberculin skin test (TST) reaction of ≥5 mm induration who did not have evidence of TB disease on the basis of symptom and chest radiographic evaluation. Among staff contacts, a positive TST was defined as induration of ≥5 mm during the investigation in a person with a documented negative TST during the preceding 2 years (*5*). *M. tuberculosis* isolates from all six patients were sent to CDC for genotyping.

Index Patient

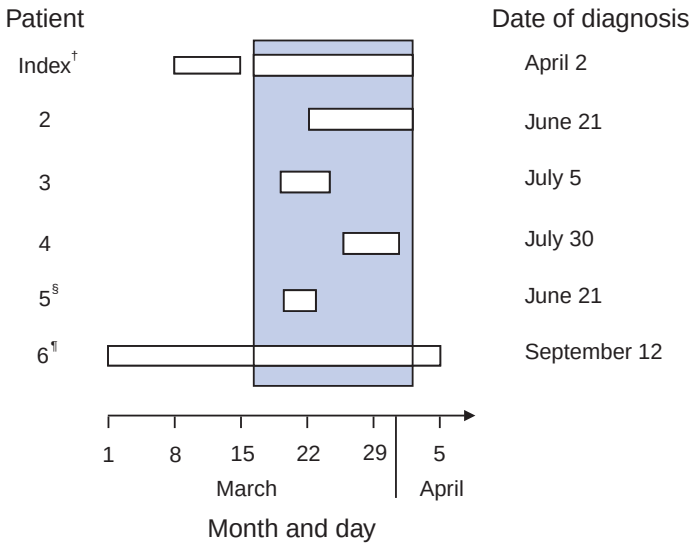
The index patient was a man aged 42 years with schizophrenia and acquired immunodeficiency syndrome (AIDS). The mental illness contributed to patient-care problems because of inability of the patient to understand questions and follow instructions. He was admitted twice to a different hospital (hospital B) in late February 2002 for fever and nonproductive cough. His chest radiographs were interpreted as normal. He produced one sputum specimen, which was negative for acid-fast bacilli (AFB), before leaving the hospital against medical advice. In early March, he was admitted to hospital A with similar symptoms, treated with intravenous vancomycin for a presumed central line infection, and released after a 6-day hospital stay. Three days later, he returned to the hospital. His CD4 T-lymphocyte count was 30 cells/μL. A chest radiograph revealed hilar adenopathy, and a computerized tomography scan of the chest revealed a questionable left upper lobe infiltrate thought to represent pneumonia; ceftriaxone was administered. On April 2, the hospital staff learned that a stool culture obtained during the patient's first admission had grown *M. tuberculosis*. The patient was placed in isolation that day. Three subsequent sputum specimens were 4+ AFB smear-positive, indicative of a high degree of infectiousness, and a contact investigation was initiated. The index patient was ambulatory and was in contact with several patients and medical personnel. This contact continued even after the patient was placed in isolation.

Secondary Patients

During June 21–September 12, five secondary TB patients were identified. Four were men aged 35–49 years who had been hospitalized in different rooms on the same medical ward as the index patient. All four had at least one condition associated with increased risk for progression to TB disease (one had human immunodeficiency virus [HIV] infection and diabetes, one had diabetes, and two had end-stage renal disease) (*1*). The fifth secondary patient was a phlebotomist on the same medical ward as the index patient. She had been evaluated in May and found to have a TST of 50 mm induration. She was asymptomatic at that time. Because of slightly elevated serum liver enzyme concentrations, she was not treated for LTBI and was monitored only for development of symptoms. In September, she had TB diagnosed.

All five secondary patients received diagnoses 3–6 months after exposure to the index patient (Figure). *M. tuberculosis* isolates from all six patients had matching genotypes by three methods (i.e., identical spoligotyping, mycobacterial interspersed repetitive units, and a 6-band pattern on restriction fragment-length polymorphism). All strains were susceptible to isoniazid and rifampin.

FIGURE. Days of overlap* on hospital A ward, by date of tuberculosis diagnosis — District of Columbia, 2002



* All five secondary patients spent time on the medical ward with the index patient during his last admission to hospital A. The area within the box indicates the period of overlap. All secondary patients had tuberculosis (TB) diagnosed within 6 months of the exposure.
† The index patient was treated at hospital B during March 4–6. He was placed in respiratory isolation in hospital A on April 2.
§ Patient 5 had TB diagnosed posthumously when a sputum culture grew *Mycobacterium tuberculosis*. His specimen was collected on May 9, and he died on May 20 from acute respiratory failure secondary to a stroke. His specimen was confirmed on June 21.
¶ Patient 6 worked as a phlebotomist for hospital A and was assigned to the patient ward.

Contact Investigation

Of the 1,045 contacts who were identified as having been exposed to the index patient during March 9–April 2 at hospital A, 261 (25%) were patients, and 784 (75%) were staff. All staff contacts with positive TST reactions were evaluated for disease by symptom assessment and chest radiograph. Among the 784 staff members, 106 (14%) provided direct care to the index patient, 49 (6%) were ward-based staff, and 629 (80%) were other staff who had spent some time on the ward during the admissions of the index patient. Of 261 patient-contacts, 173 (66%) received TSTs, and 39 (23%) had a positive reaction. In addition, 495 (63%) of 784 staff members were evaluated with TSTs; 56 staff members tested positive, of whom 21 (38%) were direct-care providers, six (11%) were ward-based staff, and 29 (52%) were other staff (Table).

During the investigation, hospital A engineers and the infection-control staff determined that the index patient's room

TABLE. Tuberculin skin test (TST) results among staff at hospital A, by type of work assignment — District of Columbia, April–September 2002

Assignment	No. workers	No. evaluated	TST-positive* No.	(%)	RR†	(95% CI§)
Direct care	106	65	21	(32)	4.5	(2.7–7.4)
Ward-based	49	26	6	(23)	3.2	(1.5–7.0)
Other	629	404	29	(7)		Referent
Total	**784**	**495**	**56**	**(11)**		

* A TST of ≥5 mm during the investigation in a person with a documented negative TST during the preceding 2 years.
† Relative risk.
§ Confidence interval.

met specifications for an airborne infection isolation room. Infection-control staff at hospital B also were notified about the index patient so that a contact investigation could be initiated there.

Contacts with HIV and a negative TST were recommended for therapy with isoniazid for 9 months (*1*). Staff contacts who did not know their HIV status were offered voluntary HIV counseling and testing. Foreign-born persons and contacts with a previous positive TST reaction were offered treatment if they had no past history of treatment.

Reported by: *MA Tipple, MD, W Heirendt, Virginia Dept of Health. B Metchock, DrPH, K Ijaz, MD, PD McElroy, PhD, Div of TB Elimination, National Center for HIV, STD, and TB Prevention; AM Andre, MD, EIS Officer, CDC.*

Editorial Note: This report describes recent nosocomial transmission of *M. tuberculosis* in a community hospital. The index patient spent 3 weeks hospitalized with unrecognized TB, possibly masked by HIV infection. AIDS patients can have atypical presentations of TB disease resulting in diagnostic delays (*6*). Because TB was not initially a diagnostic consideration, the patient was not placed immediately in respiratory isolation.

Although the incidence of TB continues to decline (*7*), heightened awareness and vigilance is required by hospital staff to identify and treat persons with suspected TB promptly. Patients with suspected TB should be placed in respiratory isolation until infectious TB is ruled out. When the patient is transported for medical procedures that cannot be performed in the isolation room, the patient should wear a surgical mask. Hospital infection-control programs are encouraged to develop protocols and implement administrative procedures for HIV-infected patients with pulmonary symptoms suggestive of TB. Finally, local TB-control programs can assist hospital infection-control staff in investigating community contacts of persons hospitalized with TB (*2*).

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School-Associated Pertussis Outbreak — Yavapai County, Arizona, September 2002–February 2003

On September 21, 2002, a pertussis case (confirmed by isolation of *Bordetella pertussis*) was reported to the Yavapai County Health Department (YCHD). The patient was a child aged 13 years in the 8th grade at a middle school in Yavapai County; the child had attended school during the illness. A case consistent with the clinical definition of pertussis had been reported in another student in the same classroom 2 weeks earlier. On September 22, a second culture-confirmed case was reported from the same classroom. Subsequent investigation identified five additional persons (two students in the same classroom, two 8th-grade teachers, and one parent of an ill student) with prolonged cough illnesses. In comparison, during the previous 10 years, an average of four pertussis cases were reported annually from this county. On September 26, YCHD, in conjunction with the Arizona Department of Health Services (ADHS) and school officials, notified the community of the pertussis outbreak in the middle school and initiated control measures. This report summarizes the epidemiology of the outbreak and the control measures used to contain it. Health-care providers should consider pertussis in persons of any age with acute cough illnesses and consider obtaining nasopharyngeal (NP) specimens for *B. pertussis* culture.

A probable case of pertussis was defined as an acute cough illness lasting ≥14 days (*1*). In a person with ≥1 day of cough, cases were confirmed by isolation of *B. pertussis* from an NP specimen. In persons with cough of ≥14 days, cases were confirmed by either 1) a positive polymerase chain reaction (PCR)

test result for *B. pertussis* DNA from an NP specimen or 2) epidemiologic linkage to a person with a laboratory-confirmed case. Epidemiologic linkage was defined as close contact with a person with laboratory-confirmed pertussis or attendance at the same school as a person with a laboratory-confirmed case.

Public health and school officials implemented an aggressive control strategy requiring the exclusion of any coughing student or staff member from the school through the fifth day of treatment with an antibiotic recommended for pertussis (*1*). Parents of excluded students were given letters advising them to contact their health-care providers for medical examination, to contact YCHD to have an NP specimen collected for culture, and to stay at home and away from others (particularly infants and young children) through the fifth day of treatment. Health-care providers were alerted to the pertussis outbreak through an existing e-mail and facsimile network and were urged to send patients with suspected pertussis to YCHD for NP specimen collection. To attempt isolation of *B. pertussis*, YCHD forwarded all NP specimens collected to Arizona's Bureau of State Laboratory Services (BSLS). If identified at another laboratory, *B. pertussis* isolates were forwarded to BSLS in accordance with Arizona administrative code. All *B. pertussis* isolates were forwarded to CDC for pulsed-field gel electrophoresis (PFGE) profiling. A sample of NP specimens collected by YCHD was forwarded from BSLS to CDC for PCR testing. PCR testing targeted genes coding for an insertion element (IS*481*) and for pertussis toxin subunit 1 (*ptxS1*).

On October 24, YCHD and ADHS recommended initiation of an accelerated pertussis vaccination schedule for infants because of the increasing numbers of pertussis cases identified throughout six communities in Yavapai County. On the accelerated schedule, the first 3 doses of the diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine are administered at ages 6, 10, and 14 weeks rather than at the usual recommended ages of 2, 4, and 6 months (*2*). Other vaccinations recommended according to the childhood immunization schedule (*2,3*) also were administered on the accelerated schedule.

A total of 485 pertussis cases were reported from six communities (2000 population: 83,550) in the county (580.5 per 100,000 population): 218 confirmed cases (16 by isolation of *B. pertussis* and 202 by epidemiologic linkage) and 267 probable cases (Figures 1 and 2). Of the 485 cases, 203 (42%) were associated with schools; 113 (56%) were in students, eight (4%) were in school staff, and 82 (40%) were in family members (including the nine infants with cases confirmed by epidemiologic linkage) or close contacts of ill students or staff members. Cases were identified in an elementary school, a middle school, and a high school (Table). The highest attack rate was among students in the 8th grade of the middle school; of 198 students in this grade, 20 (10%) were confirmed to have pertussis. Males accounted for 193 (54%) of 357 persons aged ≤19 years and 24 (19%) of 128 persons aged ≥20 years. The median age of persons with pertussis was 13 years (range: 0–83 years). Among the 29 infants aged <1 year, 20 (69%) had onset before October 24, when the accelerated schedule was recommended; of the nine cases that occurred after October 24, one infant was too young to be vaccinated, seven were aged ≥14 weeks and were ineligible for the accelerated schedule, and one was eligible but did not receive

FIGURE 1. Number of reported pertussis cases, by week of cough onset and classification status — Yavapai County, Arizona, September 2002–February 2003

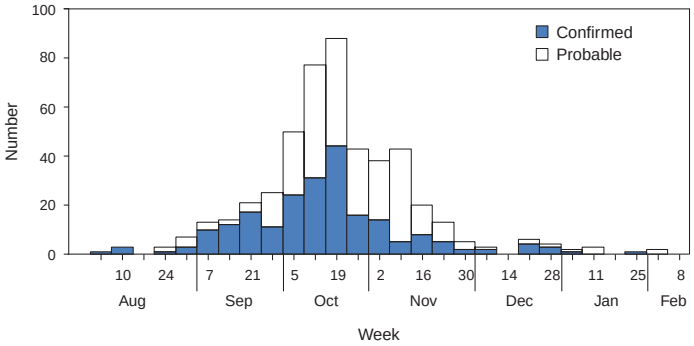
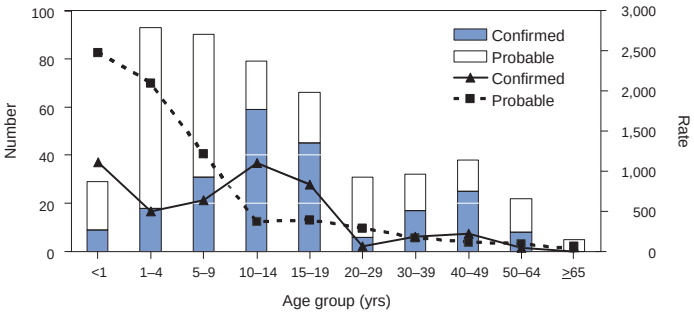


FIGURE 2. Number and rate* of reported pertussis cases, by age group — Yavapai County, Arizona, September 2002–February 2003



* Per 100,000 population.

TABLE. Number of reported pertussis cases in students and attack rate, by school — Yavapai County, Arizona, September 2002–February 2003

School	No. culture-positive cases	Total no. confirmed cases	Attack rate
Elementary (n = 685)	1	**27**	3.9%
Middle (n = 614)	8	**38**	6.2%
High (n = 1,599)	2	**48**	3.0%

vaccine according to the accelerated schedule. DTaP vaccination data were available for 24 (83%) infants: three (13%) infants were not vaccinated; eight (33%) received 1 DTaP vaccination; five (21%) received 2 DTaP vaccinations; and eight (33%) received 3 DTaP vaccinations. Although 15 (52%) of the 29 infants were aged <6 months, no infants were hospitalized for pertussis.

Of 1,047 NP samples sent to BSLS, CDC tested 569 (54%) by PCR. Of these 569 samples, 11 (2%) had positive PCR results for *B. pertussis* DNA, 462 (81%) had negative results, and 96 (17%) could not be tested because of improper specimen processing or were indeterminate because of contamination. Of the 11 persons with positive PCR results, 10 (91%) also had *B. pertussis* isolated at BSLS. The one case with a positive PCR result and a negative culture result was in a person in close contact with a person from whom *B. pertussis* was isolated.

All 16 *B. pertussis* isolates were profiled genetically by PFGE, and four profiles were identified: profile 10 (63%), profile 160 (25%), profile 13 (6%), and profile 55 (6%). Profile 10 was identified in *B. pertussis* isolates from epidemiologically linked patients attending the middle and high school. Seven of the eight isolates from middle school students were profile 10; these seven students were linked epidemiologically and had cough onset within 1 month of each other. The eighth student had onset of pertussis 3 months later, and the isolate was PFGE profile 55.

The outbreak peaked in mid-October and lasted 6 months. The last culture-positive case occurred in a person who had cough onset on January 10, 2003.

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Editorial Note: Middle and high school–associated pertussis outbreaks are recognized increasingly and reported to state health departments, but few outbreak investigation results are published (*1,4*). The Yavapai outbreak shared features of many of these outbreaks, including a substantial number of cases among older children and adolescents (i.e., persons aged 10–19 years) and subsequent spread to the community, with cases among infants aged <1 year. In the United States, cases in older children and adolescents are reported most commonly in the fall, when students return to school (*5*). Because of waning immunity, older children and adolescents can become susceptible to pertussis 5–15 years after the last DTaP dose (*6*). In 2002, pertussis cases in persons aged 10–19 years constituted 29% (7.0 per 100,000 population) of 9,771 nationally reported cases (CDC, unpublished data, 2003). In the six affected communities in Yavapai County, the incidence of confirmed and probable pertussis among older children and adolescents was 1,348 per 100,000 population.

Attack rates among children in the three schools differed by school and grade. The outbreak was recognized first among students in the 8th grade of the middle school, which had higher attack rates than either the elementary or the high school. Although control measures implemented when the outbreak was identified appear to have contributed to lower attack rates in the elementary and high schools, differences in susceptibility, efficiency of transmission, or mixing patterns also might have been factors. The coverage level for ≥4 DTaP doses among children entering elementary school was >90% (ADHS, unpublished data, 2003); these children probably had immunity from recent DTaP vaccination. Although high school students can be susceptible to pertussis, and high attack rates have been documented (*1,4*), immunity boosted by exposure to *B. pertussis* before this outbreak might account for the low attack rate at this school.

In this outbreak, CDC's PCR testing was as specific as *B. pertussis* isolation but not more sensitive in confirming *B. pertussis* infection. The concordance of results was high and probably reflects the use of two sets of primers and a stringent quality-assurance program that detected false-positive results. In other pertussis outbreaks in which different PCR primers and protocols were used, cases with PCR-positive but culture-negative results were identified. Although they are widely used in the United States, PCR assays have not been standardized, and their predictive value for pertussis is unknown. Exclusive use of nonstandardized PCR assays can result in either underestimation or overestimation of pertussis (*1,7*).

As in other school outbreaks (*8*), a single PFGE profile predominated among the middle school isolates, indicating student-to-student spread. Communitywide outbreaks have been associated with an increase in *B. pertussis* infections with PFGE profiles that predominated before the epidemic (*9*). Although minimal data are available on the profiles of strains circulating in Yavapai County before the outbreak, outbreak PFGE profiles 10 and 13 were identified among 165 sporadic isolates recovered in Arizona during 1999–2003 (CDC, unpublished data, 2003).

The data described in this report are subject to at least two limitations. First, because persons can have cough of ≥14 days from other illnesses, the use of the probable case definition and epidemiologic linkage to confirm cases in Yavapai County might have led to an overestimation of the size of the outbreak.

However, although pertussis is challenging to confirm, studies of pertussis incidence have documented that passive reporting underestimates pertussis incidence (*1,5,6*). The absence of severe illness among infants could have resulted from the lack of specificity of the case definition used; milder illness also is consistent with DTaP vaccine–induced protection. Second, because the epidemic peak coincided with the time that the accelerated DTaP vaccination schedule was recommended, the impact of this recommendation could not be evaluated. Additional studies are needed to evaluate the effectiveness of the accelerated schedule.

Although infants with pertussis can become severely ill and die (*5,10*), no pertussis-associated hospitalizations or deaths were reported during this outbreak. In contrast to disease severity observed commonly among infants, older persons with pertussis often have a mild illness. As a result, older persons might not visit a health-care provider until several weeks after cough onset, when recovery of the fastidious *B. pertussis* bacterium is unlikely and diagnosis might not be confirmed (*6*). Recognizing pertussis outbreaks in schools is challenging for several reasons, including 1) patients usually do not seek medical care early, 2) a diagnosis of pertussis might be delayed or not considered, and 3) the sensitivity and specificity of diagnostic tests will be low if NP specimens are not obtained and transported to the laboratory under optimal conditions. Health-care providers should consider pertussis in persons of any age with an acute cough illness and consider obtaining NP specimens for *B. pertussis* culture. Early recognition, treatment, and chemoprophylaxis can help prevent transmission to others; because of its severity in young unvaccinated infants, preventing pertussis in this population is of greatest importance (*1,4,5,10*).

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Evaluation of an Association Between Loratadine and Hypospadias — United States, 1997–2001

Hypospadias is a birth defect that affects approximately seven in 1,000 male infants in the United States. In affected infants, the urethral opening is located along the underside of the penis, scrotum, or perineum; the condition usually is corrected by surgery. Hypospadias is classified in order of increasing severity as first, second, or third degree. In 2002, a study in Sweden noted that among male infants born to women who while pregnant had taken loratadine (Claritin®), a nonsedating antihistamine commonly used for seasonal allergies, hypospadias prevalence was twice that of the general population (*1*). However, insufficient data were available to determine the severity of the hypospadias cases, and the study did not control for confounding variables (e.g., family history of hypospadias or maternal age). In 2003, a prospective study using data from four countries indicated that five of 142 pregnancies in women exposed to loratadine resulted in infants with major malformations, a prevalence consistent with that of the general population; none had hypospadias (*2*). To further assess any potential association between loratadine and hypospadias, CDC analyzed data from the National Birth Defects Prevention Study (NBDPS). This report summarizes the results of that analysis, which determined that no increased risk for second- or third-degree hypospadias existed among women who used loratadine in early pregnancy (Table). These results might be useful for women and health-care providers to address concerns about loratadine use and hypospadias.

NBDPS is an ongoing, multistate, case-control study of environmental and genetic risk factors for major birth defects that can be used in response to public health concerns regarding rare drug exposures and birth defects (*3,4*). Infants are identified through birth defect surveillance systems in eight states; mothers undergo a detailed interview by telephone in English or Spanish. For this analysis, the case population was defined as male infants with second- or third-degree hypospadias. Infants with first-degree hypospadias are not included in NBDPS because the mildest form of hypospadias is much

TABLE. Risk for hypospadias in male infants associated with exposure to loratadine and nonsedating and sedating antihistamines — National Birth Defects Prevention Study, United States, October 1997–June 2001

Medication	Exposed*		Not exposed†					
	Cases	Controls	Cases	Controls	OR§	(95% CI¶)	AOR**	(95% CI)
Loratadine	11	22	547	1,410	1.29††	(0.62–2.68)	0.96	(0.41–2.22)
Nonsedating antihistamines (including loratadine)	17	33	541	1,392	1.33	(0.73–2.40)	0.95	(0.48–1.89)
Sedating antihistamines	43	104	489	1,258	1.06	(0.73–1.54)	1.02	(0.68–1.53)

* Infants whose mothers reported using the medication during the period from 1 month before pregnancy through the first trimester.
† Infants whose mothers did not report using the medication during the period from 3 months before pregnancy until delivery.
§ Odds ratio.
¶ Confidence interval.
** Adjusted odds ratio. Adjusted for birth month, maternal age, maternal race/ethnicity, and state of residency at delivery.
†† This analysis had 80% power to detect OR of ≥2.3, using a one-sided test.

less completely ascertained by routine surveillance. Infants were excluded if they had 1) known or suspected chromosome abnormalities, 2) single gene conditions, or 3) other recognized multiple congenital anomaly phenotypes. The control population consisted of live-born male infants with no major birth defects, selected at random from the same populations as the case group. Excluded from the analysis were 86 infants whose mothers had incomplete interviews and 30 infants (28 in the case population and two in the control population) who had fathers or brothers with hypospadias. The study populations consisted of 563 male infants with hypospadias and 1,444 male infant controls; all were born during October 1, 1997–June 30, 2001.

Exposure was defined as any maternal use of loratadine from 1 month before pregnancy through the first trimester. To control for confounding by indication, exposure to other nonsedating or sedating antihistamines during the same period also was assessed. Potential confounding factors tested by multivariate logistic regression analysis included maternal age, maternal race/ethnicity (i.e., non-Hispanic white, non-Hispanic black, Hispanic, and other), birth month, and state of residence at delivery.

Of 563 male infants with hypospadias, 46 (8.2%) had multiple major birth defects that were not recognized phenotypes, and 517 (91.8%) had hypospadias with no other major birth defects. Among the 1,957 mothers of infants in the case and control populations, 33 (1.7%) reported using loratadine during the exposure period. Univariate analyses showed no association between this use of loratadine and hypospadias (Table). Use of nonsedating antihistamines (including loratadine) and sedating antihistamines also were not associated with hypospadias. Multivariate adjusted odds ratio estimates did not vary significantly from the univariate estimates. In addition, no association between loratadine use and hypospadias was determined when cases with multiple major defects were excluded or when different exposure periods were examined.

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Editorial Note: The findings in this report indicated that hypospadias was not associated with use of loratadine during the period from 1 month before pregnancy through the first 3 months of pregnancy. During 1998–1999, loratadine was the drug most advertised directly to consumers (*5*) and was used by 3% of women of childbearing age (*6*). In November 2002, loratadine was approved by the Food and Drug Administration for over-the-counter use (*7*). Antihistamines are used widely by the general population, including women of childbearing age, 20%–30% of whom have allergic conditions, primarily rhinitis and sinusitis (*8*). Because an estimated 50% of all pregnancies in the United States are unintended (*9*), women frequently are exposed inadvertently to medications before learning they are pregnant.

This report is subject to at least two limitations. First, NBDPS does not track all birth defects. Because first-degree hypospadias is excluded, the potential association between this mildest form of hypospadias and loratadine could not be assessed. Second, women are interviewed about their pregnancy exposures after delivery, and recall of drug use might be different among mothers of infants with major birth defects compared with mothers of infants without major birth defects.

The results of this analysis might be useful for women and health-care providers to address concerns about loratadine use and hypospadias. These results do not provide definitive information on the overall safety of loratadine. Women should continue to consult their health-care providers before using any medications during pregnancy. Future studies of medications and birth defects, possibly using NBDPS, are needed to address some of the current knowledge gaps on the effects of medication use during pregnancy.

Acknowledgments

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Notice to Readers

National Colorectal Cancer Awareness Month

March is National Colorectal Cancer Awareness Month. This national health observance serves to increase public awareness about the importance of regular testing to decrease the burden of colorectal cancer (i.e., cancer of the colon or rectum) and to encourage persons aged ≥50 years to reduce their risk for colorectal cancer through regular screening examinations.

Colorectal cancer is the second leading cause of cancer-related death in the United States; during 2004, an estimated 56,730 such deaths will occur, and 146,940 new cases will be diagnosed (*1*). Regular testing beginning at age 50 years is the key to preventing colorectal cancer (*2*). However, despite recommendations for screening, the majority of persons who are at risk for colorectal cancer are not being screened. In 2000, only 45% of men and 41% of women aged ≥50 years had had a flexible sigmoidoscopy or colonoscopy during the preceding 10 years or had used a home-fecal occult blood test during the preceding 1 year. Screening rates were particularly low among persons who had no health insurance, had no usual source of health care, or had not visited a doctor during the preceding 1 year (*3*).

To reduce the colorectal cancer death rate, CDC has implemented a broad-based initiative to 1) promote colorectal cancer screening nationwide through the "Screen for Life" campaign; 2) build national and state partnerships that focus on colorectal cancer awareness; 3) support education and training efforts for the public and health professionals; 4) conduct surveillance and research to evaluate screening test prevalence, barriers to screening, and the safety and availability of screening tests; and 5) fund comprehensive cancer-control programs that promote colorectal cancer screening. Additional information about colorectal cancer is available at http://www.cdc.gov/cancer. Information about CDC's "Screen for Life" campaign is available at http://www.cdc.gov/screenforlife.

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Notice to Readers

Protocols for Confirmation of Reactive Rapid HIV Tests

On November 7, 2002, the Food and Drug Administration (FDA) announced approval of the OraQuick® Rapid HIV-1 Antibody Test (OraSure Technologies, Inc., Bethlehem, Pennsylvania) for use by trained personnel as a point-of-care test to aid in the diagnosis of infection with human immunodeficiency virus type 1 (HIV-1). Subsequently, two other rapid HIV tests have been approved by FDA: the Reveal™ HIV-1 Antibody Test (MedMira Laboratories, Halifax, Nova Scotia) and the Uni-Gold Recombigen™ HIV Test (Trinity Biotech, Wicklow, Ireland).

All reactive rapid HIV test results require confirmatory testing. CDC described protocols for confirming reactive rapid HIV tests based on a consultation convened in January 2003 with expert laboratory scientists, FDA, and the Centers for Medicare and Medicaid Services (*1*). These protocols recommend 1) confirmation of all reactive rapid HIV test results with either Western blot (WB) or immunofluorescent assay (IFA), even if an enzyme immunoassay (EIA) screening test is negative, and 2) follow-up testing for persons with negative or indeterminate confirmatory test results, with a blood

specimen collected 4 weeks after the initial reactive rapid test result.

In September 2003, CDC initiated postmarketing surveillance in 14 state and local health departments to monitor the performance of the OraQuick® test. Follow-up was attempted for all persons with reactive OraQuick® tests who had either nonreactive EIAs or negative or indeterminate WB or IFA results. For the 21 such persons who were identified through the surveillance system (Table), follow-up testing was initiated at the testing sites' reference laboratories only as a result of postmarketing surveillance; test results are available for 13 of these persons.

At least five HIV-infected persons were informed incorrectly that their rapid HIV test results were false-positive. Several public health and commercial laboratories contacted during this same period also indicated that they did not perform WB or IFA on OraQuick®-reactive specimens if the laboratory EIA was nonreactive. Additional persons might have received erroneous results from incomplete confirmatory testing.

CDC emphasizes that reactive rapid HIV tests must be confirmed with WB or IFA, even if a subsequent EIA is nonreactive. If such confirmatory testing yields negative or indeterminate results, follow-up testing should be performed on a blood specimen collected 4 weeks after the initial reactive rapid HIV test result.

Reference

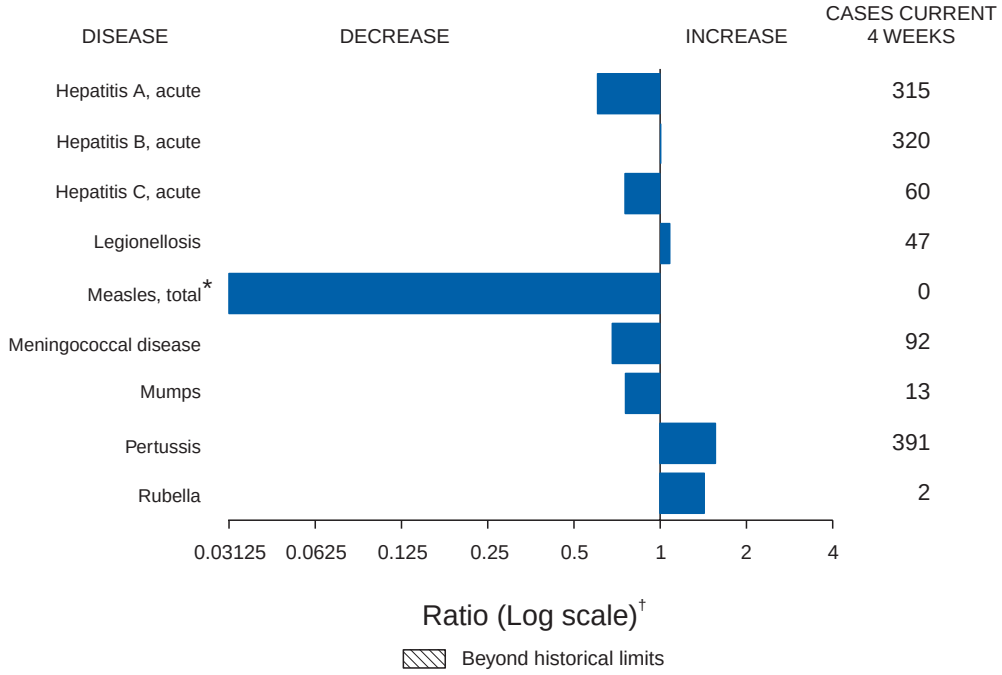
1. CDC. Quality Assurance Guidelines for Testing Using the OraQuick® Rapid HIV-1 Antibody Test. Available at http://www.cdc.gov/hiv/rapid_testing/materials/qa-guide.htm.

TABLE. Test results for persons with reactive OraQuick® tests and discordant confirmatory test results

	Initial specimen			Follow-up specimen			
OraQuick	EIA*	Confirmatory test		EIA	Supplemental test		Interpretation
Reactive	ND†	IFA	neg§	neg	IFA¶	pos**	Initial EIA or confirmatory test false-negative
Reactive	neg	—	ND	ND	Viral load	>750,000 copies	
Reactive	neg	WB††,§§	Indeterm¶¶	pos	WB	Pos	
Reactive	neg	WB§§	pos	ND	ND	—	
Reactive	neg	WB§§	pos	ND	ND	—	
Reactive	pos	IFA	indeterm	pos	WB	Pos	Early infection, evolving confirmatory test
Reactive	pos	WB	indeterm	pos	WB	Pos	
Reactive	pos	WB	indeterm	ND	Viral load	>750,000 copies	
Reactive	pos	WB	indeterm	pos	WB	Pos	
Reactive	neg	WB	neg	ND	Viral load	neg	False-positive OraQuick®
Reactive	neg	WB	indeterm	ND	WB	neg	
Reactive	neg	WB	neg	neg	WB	neg	
Reactive	neg	WB	neg	neg	WB	neg	
Reactive	pos	WB	neg	—	—	—	Unsuccessful follow-up, HIV status unconfirmed
Reactive	neg	WB	indeterm	—	—	—	
Reactive	neg	WB	indeterm	—	—	—	
Reactive	neg	WB	neg	—	—	—	
Reactive	neg	WB	neg	—	—	—	
Reactive	neg	WB	neg	—	—	—	
Reactive	neg	WB	neg	—	—	—	
Reactive	neg	WB	neg	—	—	—	

* Enzyme immunoassay.
† Not done.
§ Negative.
¶ Immunoflourescent assay.
** Positive.
†† Western blot.
§§ Not performed until after surveillance follow-up was initiated.
¶¶ Indeterminate.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals March 13, 2004, with historical data



* No measles cases were reported for the current 4-week period yielding a ratio for week 10 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 March 13, 2004 (10th Week)*

	Cum. 2004	Cum. 2003		Cum. 2004	Cum. 2003
Anthrax	-	-	Hemolytic uremic syndrome, postdiarrheal†	9	28
Botulism:	-	-	HIV infection, pediatric†§	-	48
foodborne	2	2	Measles, total	1¶	3**
infant	13	14	Mumps	31	38
other (wound & unspecified	4	4	Plague	-	-
Brucellosis†	12	25	Poliomyelitis, paralytic	-	-
Chancroid	7	9	Psittacosis†	2	5
Cholera	1	-	Q fever†	4	14
Cyclosporiasis†	5	21	Rabies, human	-	-
Diphtheria	-	-	Rubella	7	1
Ehrlichiosis:	-	-	Rubella, congenital syndrome	1	-
human granulocytic (HGE)†	4	17	SARS-associated coronavirus disease† ††	-	2
human monocytic (HME)†	6	19	Smallpox† §§	-	NA
human, other and unspecified	-	1	*Staphylococcus aureus*:	-	-
Encephalitis/Meningitis:	-	-	Vancomycin-intermediate (VISA)† §§	3	NA
California serogroup viral†	-	-	Vancomycin-resistant (VRSA)† §§	-	NA
eastern equine†	-	2	Streptococcal toxic-shock syndrome†	21	46
Powassan†	-	-	Tetanus	2	4
St. Louis†	1	2	Toxic-shock syndrome	26	22
western equine†	-	-	Trichinosis	1	-
Hansen disease (leprosy)†	8	19	Tularemia†	3	4
Hantavirus pulmonary syndrome†	2	5	Yellow fever	-	-

-: No reported cases.
* Incidence data for reporting years 2003 and 2004 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. Last update December 28, 2003.
¶ Of one case reported, one was indigenous, and none were imported from another country.
** Of three cases reported, two were indigenous, and one was imported from another country.
†† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (notifiable as of July 2003).
§§ Not previously notifiable.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending March 13, 2004, and March 8, 2003 (10th Week)*

Reporting area	AIDS		Chlamydia†		Coccidiodomycosis		Cryptosporidiosis		Encephalitis/Meningitis West Nile	
	Cum. 2004§	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	-	8,321	140,132	157,427	1,364	657	488	454	5	57
NEW ENGLAND	-	279	5,532	5,261	-	-	28	25	-	-
Maine	-	8	213	347	N	N	4	1	-	-
N.H.	-	3	330	290	-	-	7	3	-	-
Vt.	-	5	220	207	-	-	3	3	-	-
Mass.	-	111	2,822	2,011	-	-	10	13	-	-
R.I.	-	21	704	526	-	-	-	3	-	-
Conn.	-	131	1,243	1,880	N	N	4	2	-	-
MID. ATLANTIC	-	2,163	20,739	17,663	-	-	87	50	1	-
Upstate N.Y.	-	92	3,563	2,776	N	N	18	10	-	-
N.Y. City	-	1,272	6,286	6,316	-	-	14	22	-	-
N.J.	-	296	2,331	2,854	-	-	4	2	-	-
Pa.	-	503	8,559	5,717	N	N	51	16	1	-
E.N. CENTRAL	-	856	21,469	30,078	3	2	100	77	-	-
Ohio	-	128	2,561	8,210	-	-	35	11	-	-
Ind.	-	119	3,426	3,419	N	N	14	4	-	-
Ill.	-	365	5,470	9,531	-	-	8	13	-	-
Mich.	-	202	8,152	5,628	3	2	21	17	-	-
Wis.	-	42	1,860	3,290	-	-	22	32	-	-
W.N. CENTRAL	-	136	7,983	8,988	-	1	56	28	1	-
Minn.	-	23	1,223	2,090	N	N	19	16	-	-
Iowa	-	23	-	783	N	N	7	5	-	-
Mo.	-	73	3,665	3,407	-	1	13	2	1	-
N. Dak.	-	-	207	200	N	N	-	-	-	-
S. Dak.	-	4	456	437	-	-	4	4	-	-
Nebr.¶	-	6	943	779	-	-	1	1	-	-
Kans.	-	7	1,489	1,292	N	N	12	-	-	-
S. ATLANTIC	-	1,814	22,388	27,804	-	-	98	163	2	57
Del.	-	49	589	573	N	N	-	1	-	-
Md.	-	187	3,805	2,941	-	-	6	6	-	-
D.C.	-	233	633	649	-	-	1	-	-	-
Va.	-	264	1,245	2,694	-	-	9	4	-	-
W. Va.	-	13	404	490	N	N	-	-	-	-
N.C.	-	192	4,926	4,500	N	N	24	4	-	-
S.C.¶	-	169	3,354	2,577	-	-	2	1	1	-
Ga.	-	415	743	5,720	-	-	30	18	-	-
Fla.	-	292	6,689	7,660	N	N	26	129	1	57
E.S. CENTRAL	-	324	8,972	10,587	N	N	19	19	-	-
Ky.	-	38	1,110	1,637	N	N	5	2	-	-
Tenn.	-	145	3,654	3,492	N	N	10	9	-	-
Ala.	-	64	2,025	2,838	-	-	2	6	-	-
Miss.	-	77	2,183	2,620	N	N	2	2	-	-
W.S. CENTRAL	-	940	19,879	19,801	-	1	19	8	1	-
Ark.	-	23	1,460	1,171	-	-	8	2	-	-
La.	-	49	4,870	3,849	N	N	-	-	1	-
Okla.	-	40	1,481	1,553	N	N	8	1	-	-
Tex.	-	828	12,068	13,228	-	1	3	5	-	-
MOUNTAIN	-	312	8,552	10,010	1,035	501	26	15	-	-
Mont.	-	7	27	399	N	N	1	1	-	-
Idaho	-	4	647	490	N	N	1	4	-	-
Wyo.	-	2	215	208	-	-	2	-	-	-
Colo.	-	72	1,191	2,571	N	N	15	3	-	-
N. Mex.	-	27	1,245	1,544	2	-	1	-	-	-
Ariz.	-	145	3,675	3,154	1,020	493	5	1	-	-
Utah	-	14	498	476	4	1	-	4	-	-
Nev.	-	41	1,054	1,168	9	7	1	2	-	-
PACIFIC	-	1,497	24,618	27,235	326	152	55	69	-	-
Wash.	-	117	3,285	2,833	N	N	3	-	-	-
Oreg.	-	66	1,312	1,296	-	-	6	5	-	-
Calif.	-	1,294	19,388	21,402	326	152	45	64	-	-
Alaska	-	7	622	674	-	-	-	-	-	-
Hawaii	-	13	11	1,030	-	-	1	-	-	-
Guam	-	1	-	-	-	-	-	-	-	-
P.R.	-	235	298	199	N	N	N	N	-	-
V.I.	-	6	-	60	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	32	U	-	U	-	U	-	U

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

* Incidence data for reporting years 2003 and 2004 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 December 28, 2003.

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 13, 2004, and March 8, 2003 (10th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	168	228	29	51	19	20	2,525	3,816	49,234	61,175
NEW ENGLAND	9	9	2	1	2	2	213	217	1,357	1,414
Maine	-	-	-	-	-	-	20	20	46	23
N.H.	1	2	-	1	-	-	8	14	20	21
Vt.	-	-	-	-	-	-	16	16	10	20
Mass.	1	3	1	-	2	2	105	105	658	522
R.I.	-	-	-	-	-	-	9	18	178	180
Conn.	7	4	1	-	-	-	55	44	445	648
MID. ATLANTIC	16	21	2	1	2	2	543	569	6,929	7,504
Upstate N.Y.	4	3	2	-	-	-	168	110	1,254	1,127
N.Y. City	4	3	-	-	-	-	173	233	2,051	2,569
N.J.	-	4	-	-	1	-	41	75	993	1,710
Pa.	8	11	-	1	1	2	161	151	2,631	2,098
E.N. CENTRAL	38	48	6	6	3	2	330	515	8,360	13,745
Ohio	11	13	-	3	3	2	139	161	1,154	4,286
Ind.	10	4	-	-	-	-	-	-	1,273	1,308
Ill.	4	8	-	-	-	-	51	151	2,098	4,194
Mich.	8	9	-	-	-	-	96	125	3,314	2,772
Wis.	5	14	6	3	-	-	44	78	521	1,185
W.N. CENTRAL	21	29	6	3	6	2	243	283	2,762	3,140
Minn.	9	12	2	3	-	-	88	70	456	526
Iowa	1	3	-	-	-	-	36	38	-	158
Mo.	5	6	4	-	1	-	73	104	1,478	1,696
N. Dak.	1	1	-	-	3	1	2	8	24	6
S. Dak.	-	2	-	-	-	-	10	8	43	22
Nebr.	2	4	-	-	-	-	16	31	235	239
Kans.	3	1	-	-	2	1	18	24	526	493
S. ATLANTIC	11	52	8	33	2	10	428	1,373	10,622	14,120
Del.	-	-	N	N	N	N	11	11	199	263
Md.	2	-	-	-	-	-	18	21	1,624	1,481
D.C.	-	-	-	-	-	-	7	-	424	489
Va.	-	2	2	-	-	-	59	35	472	1,356
W. Va.	-	-	-	-	-	-	1	4	128	158
N.C.	-	-	3	6	-	-	N	N	2,869	2,582
S.C.	-	-	-	-	-	-	4	12	1,578	1,497
Ga.	5	3	2	2	-	-	108	154	495	2,795
Fla.	4	47	1	25	2	10	220	1,136	2,833	3,499
E.S. CENTRAL	6	10	1	-	3	-	36	54	4,226	5,338
Ky.	2	1	1	-	3	-	N	N	500	697
Tenn.	2	5	-	-	-	-	23	24	1,393	1,593
Ala.	1	3	-	-	-	-	13	30	1,200	1,747
Miss.	1	1	-	-	-	-	-	-	1,133	1,301
W.S. CENTRAL	8	8	-	2	-	2	53	40	7,466	8,205
Ark.	-	1	-	-	-	-	25	26	667	687
La.	-	-	-	-	-	-	7	3	2,336	2,144
Okla.	3	-	-	-	-	-	21	11	690	631
Tex.	5	7	-	2	-	2	-	-	3,773	4,743
MOUNTAIN	35	19	3	4	1	-	272	249	2,083	2,190
Mont.	1	-	-	-	-	-	5	4	8	28
Idaho	3	5	1	3	-	-	37	30	12	16
Wyo.	-	-	-	-	-	-	1	3	10	10
Colo.	17	4	1	-	1	-	87	68	399	617
N. Mex.	1	-	-	1	-	-	10	11	152	255
Ariz.	8	8	N	N	N	N	71	53	996	880
Utah	2	2	-	-	-	-	44	55	51	43
Nev.	3	-	-	-	-	-	17	25	455	341
PACIFIC	24	32	1	1	-	-	407	516	5,429	5,519
Wash.	4	9	-	-	-	-	35	25	540	537
Oreg.	2	4	1	1	-	-	67	61	159	169
Calif.	14	19	-	-	-	-	284	398	4,619	4,522
Alaska	-	-	-	-	-	-	8	14	110	102
Hawaii	4	-	-	-	-	-	13	18	1	189
Guam	N	N	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	2	12	24	27
V.I.	-	-	-	-	-	-	-	-	-	16
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	3	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 13, 2004, and March 8, 2003 (10th Week)*

Reporting area	*Haemophilus influenzae*, invasive								Hepatitis (viral, acute), by type	
	All ages		Age <5 years							
	All serotypes		Serotype b		Non-serotype b		Unknown serotype		A	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	392	429	4	6	25	28	37	44	1,026	1,461
NEW ENGLAND	35	28	-	1	2	2	1	-	196	36
Maine	3	1	-	-	-	-	-	-	7	1
N.H.	9	3	-	-	1	-	-	-	3	3
Vt.	3	5	-	-	-	-	-	-	4	2
Mass.	12	14	-	1	-	2	1	-	164	19
R.I.	1	-	-	-	-	-	-	-	-	2
Conn.	7	5	-	-	1	-	-	-	18	9
MID. ATLANTIC	72	58	-	-	1	-	10	7	119	212
Upstate N.Y.	23	17	-	-	1	-	1	3	14	16
N.Y. City	11	10	-	-	-	-	3	2	39	87
N.J.	14	9	-	-	-	-	2	-	17	33
Pa.	24	22	-	-	-	-	4	2	49	76
E.N. CENTRAL	55	46	-	1	9	2	6	10	80	128
Ohio	30	12	-	-	2	-	4	3	12	25
Ind.	10	5	-	-	3	1	1	-	5	5
Ill.	-	19	-	-	-	-	-	7	26	49
Mich.	8	5	-	1	4	1	1	-	31	35
Wis.	7	5	-	-	-	-	-	-	6	14
W.N. CENTRAL	14	23	1	-	1	3	-	3	26	32
Minn.	7	8	-	-	1	3	-	-	1	4
Iowa	1	-	1	-	-	-	-	-	6	9
Mo.	2	10	-	-	-	-	-	3	7	7
N. Dak.	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	1	-	-	-	-	-	-	2	-
Nebr.	4	-	-	-	-	-	-	-	7	3
Kans.	-	4	-	-	-	-	-	-	3	9
S. ATLANTIC	111	162	-	1	2	8	9	11	219	603
Del.	1	-	-	-	-	-	1	-	2	2
Md.	21	13	-	-	1	1	-	-	36	35
D.C.	-	-	-	-	-	-	-	-	2	-
Va.	9	5	-	-	-	-	-	1	20	10
W. Va.	4	2	-	-	-	-	2	-	1	4
N.C.	7	3	-	-	-	-	-	-	13	15
S.C.	-	1	-	-	-	-	-	-	3	12
Ga.	41	15	-	-	-	-	5	1	87	114
Fla.	28	123	-	1	1	7	1	9	55	411
E.S. CENTRAL	14	25	-	-	-	1	4	3	28	34
Ky.	-	3	-	-	-	1	-	-	2	5
Tenn.	9	10	-	-	-	-	3	2	20	16
Ala.	5	11	-	-	-	-	1	1	-	8
Miss.	-	1	-	-	-	-	-	-	6	5
W.S. CENTRAL	15	15	-	-	2	1	-	-	28	97
Ark.	-	2	-	-	-	-	-	-	6	4
La.	1	4	-	-	-	-	-	-	-	16
Okla.	14	9	-	-	2	1	-	-	9	3
Tex.	-	-	-	-	-	-	-	-	13	74
MOUNTAIN	61	47	1	1	7	8	5	5	112	64
Mont.	-	-	-	-	-	-	-	-	-	-
Idaho	1	-	-	-	-	-	1	-	4	4
Wyo.	-	-	-	-	-	-	-	-	1	-
Colo.	18	7	-	-	-	-	3	1	12	3
N. Mex.	7	4	-	-	1	2	-	-	3	5
Ariz.	31	28	-	1	5	3	1	3	80	38
Utah	1	5	1	-	-	1	-	1	10	5
Nev.	3	3	-	-	1	2	-	-	2	9
PACIFIC	15	25	2	2	1	3	2	5	218	255
Wash.	3	2	2	-	-	1	1	1	11	9
Oreg.	7	10	-	-	-	-	-	2	15	19
Calif.	2	11	-	2	1	2	1	2	188	223
Alaska	-	-	-	-	-	-	-	-	2	2
Hawaii	3	2	-	-	-	-	-	-	2	2
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	-	-	3	5
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 13, 2004, and March 8, 2003 (10th Week)*

Reporting area	Hepatitis (viral, acute), by type				Legionellosis		Listeriosis		Lyme disease	
	B		C							
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	909	1,901	242	471	188	327	65	117	1,018	1,399
NEW ENGLAND	38	61	-	-	2	8	2	4	34	67
Maine	1	-	-	-	-	-	-	-	6	-
N.H.	8	2	-	-	-	-	1	1	-	1
Vt.	1	1	-	-	-	1	-	-	-	3
Mass.	28	44	-	-	1	3	-	2	10	60
R.I.	-	-	-	-	-	1	-	-	4	3
Conn.	-	14	U	U	1	3	1	1	14	-
MID. ATLANTIC	107	210	31	26	40	40	12	16	825	1,062
Upstate N.Y.	11	8	3	2	10	8	3	2	269	305
N.Y. City	3	102	-	-	-	6	1	5	-	-
N.J.	49	50	-	-	11	4	4	3	144	225
Pa.	44	50	28	24	19	22	4	6	412	532
E.N. CENTRAL	63	93	12	32	50	50	8	7	20	30
Ohio	37	29	2	3	31	22	4	1	14	5
Ind.	1	-	-	-	2	2	1	1	-	2
Ill.	-	1	-	9	-	9	-	3	-	-
Mich.	25	45	10	20	15	14	2	2	-	-
Wis.	-	18	-	-	2	3	1	-	6	23
W.N. CENTRAL	72	55	112	42	4	5	1	2	14	18
Minn.	6	3	-	-	-	-	-	1	3	13
Iowa	1	4	-	-	-	2	-	-	2	2
Mo.	59	40	112	42	3	1	1	-	8	2
N. Dak.	1	-	-	-	-	1	-	-	-	-
S. Dak.	-	-	-	-	1	-	-	-	-	-
Nebr.	5	5	-	-	-	-	-	1	-	-
Kans.	-	3	-	-	-	1	-	-	1	1
S. ATLANTIC	322	961	30	96	49	180	14	53	98	170
Del.	1	2	-	-	2	-	N	N	7	25
Md.	29	20	1	5	8	12	2	3	57	51
D.C.	4	-	1	-	-	-	-	-	1	-
Va.	27	15	3	-	4	4	-	1	2	2
W. Va.	-	1	1	-	1	-	1	-	-	-
N.C.	24	17	1	3	7	5	4	5	21	9
S.C.	8	12	-	2	-	2	-	2	1	-
Ga.	110	258	5	6	5	6	3	4	-	3
Fla.	119	636	18	80	22	151	4	38	9	80
E.S. CENTRAL	56	66	33	15	7	4	2	4	1	9
Ky.	7	11	7	2	2	-	1	-	-	-
Tenn.	29	13	25	2	4	2	1	-	1	2
Ala.	2	20	-	2	1	1	-	3	-	-
Miss.	18	22	1	9	-	1	-	1	-	7
W.S. CENTRAL	15	196	13	244	6	18	2	8	3	23
Ark.	4	20	-	1	-	-	-	-	-	-
La.	5	28	7	35	-	-	-	-	1	2
Okla.	6	7	-	-	2	2	-	1	-	-
Tex.	-	141	6	208	4	16	2	7	2	21
MOUNTAIN	96	106	4	5	14	10	7	9	3	3
Mont.	-	4	-	-	-	-	-	1	-	-
Idaho	2	2	-	-	1	1	1	-	-	1
Wyo.	1	2	-	-	2	1	-	-	1	-
Colo.	13	12	-	2	3	2	1	5	-	-
N. Mex.	2	8	-	-	-	-	-	-	-	-
Ariz.	59	57	2	2	2	3	4	3	1	-
Utah	8	6	-	-	5	2	-	-	1	1
Nev.	11	15	2	1	1	1	1	-	-	1
PACIFIC	140	153	7	11	16	12	17	14	20	17
Wash.	13	8	2	1	3	1	3	-	2	-
Oreg.	20	29	2	3	N	N	3	1	6	5
Calif.	105	112	2	6	13	11	11	13	12	12
Alaska	2	1	-	-	-	-	-	-	-	-
Hawaii	-	3	1	1	-	-	-	-	N	N
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	4	19	-	-	-	-	-	-	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 13, 2004, and March 8, 2003 (10th Week)*

Reporting area	Malaria		Meningococcal disease		Pertussis		Rabies, animal		Rocky Mountain spotted fever	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	171	254	359	453	1,355	1,231	548	876	86	67
NEW ENGLAND	12	7	13	17	402	126	54	77	4	-
Maine	-	1	-	1	-	-	10	6	-	-
N.H.	-	2	2	1	7	7	4	5	-	-
Vt.	1	-	1	-	10	17	4	6	-	-
Mass.	7	4	10	13	382	101	18	29	4	-
R.I.	1	-	-	-	-	-	-	1	-	-
Conn.	3	-	-	2	3	1	18	30	-	-
MID. ATLANTIC	29	41	45	40	386	125	87	137	7	9
Upstate N.Y.	7	7	12	5	276	47	58	46	1	-
N.Y. City	12	22	9	10	-	-	-	1	1	4
N.J.	3	4	5	6	31	21	-	33	-	4
Pa.	7	8	19	19	79	57	29	57	5	1
E.N. CENTRAL	14	18	43	56	156	89	3	4	2	1
Ohio	3	5	18	19	90	56	2	-	2	1
Ind.	-	-	6	6	7	4	1	2	-	-
Ill.	1	8	1	11	-	-	-	-	-	-
Mich.	5	3	15	12	22	10	-	2	-	-
Wis.	5	2	3	8	37	19	-	-	-	-
W.N. CENTRAL	11	4	17	22	64	73	69	81	2	2
Minn.	6	2	3	4	14	27	9	5	-	-
Iowa	1	2	3	5	10	28	9	9	-	1
Mo.	3	-	5	11	33	12	2	-	2	1
N. Dak.	-	-	-	-	1	-	11	12	-	-
S. Dak.	-	-	1	-	-	1	10	7	-	-
Nebr.	-	-	1	1	-	-	12	9	-	-
Kans.	1	-	4	1	6	5	16	39	-	-
S. ATLANTIC	69	120	66	148	72	173	276	499	61	51
Del.	-	-	1	6	2	1	1	-	-	-
Md.	19	16	4	6	22	14	50	57	2	4
D.C.	4	-	-	-	1	-	-	-	-	-
Va.	4	3	2	6	16	1	15	76	-	1
W. Va.	-	2	3	1	-	1	13	10	-	-
N.C.	3	4	7	5	16	36	106	104	56	27
S.C.	3	-	5	6	3	2	16	25	-	-
Ga.	10	3	10	11	-	4	64	57	2	1
Fla.	26	92	34	107	12	114	11	170	1	18
E.S. CENTRAL	4	5	16	21	20	21	11	28	8	2
Ky.	1	1	3	2	2	3	2	4	-	-
Tenn.	1	2	7	3	13	8	7	19	2	1
Ala.	1	2	2	5	1	8	2	5	1	-
Miss.	1	-	4	11	4	2	-	-	5	1
W.S. CENTRAL	5	16	35	51	18	28	26	18	-	2
Ark.	1	1	5	2	2	2	8	-	-	-
La.	2	1	9	19	2	4	-	-	-	-
Okla.	1	-	1	3	-	2	18	18	-	-
Tex.	1	14	20	27	14	20	-	-	-	2
MOUNTAIN	8	6	23	15	150	193	14	12	-	-
Mont.	-	-	1	-	4	-	1	1	-	-
Idaho	-	1	2	-	13	7	-	-	-	-
Wyo.	-	-	2	-	2	28	-	-	-	-
Colo.	3	4	10	4	79	77	-	-	-	-
N. Mex.	1	-	2	2	8	16	-	-	-	-
Ariz.	2	1	5	6	27	44	13	11	-	-
Utah	1	-	1	-	17	16	-	-	-	-
Nev.	1	-	-	3	-	5	-	-	-	-
PACIFIC	19	37	101	83	87	403	8	20	2	-
Wash.	2	4	7	8	60	29	-	-	-	-
Oreg.	1	5	22	21	26	49	-	-	-	-
Calif.	16	28	67	51	-	324	8	19	2	-
Alaska	-	-	1	-	1	-	-	1	-	-
Hawaii	-	-	4	3	-	1	-	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	1	1	-	14	10	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 13, 2004, and March 8, 2003 (10th Week)*

Reporting area	Salmonellosis		Shigellosis		Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive			
							Drug resistant, all ages		Age <5 years	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	4,280	8,858	1,769	5,841	957	1,512	573	1,091	74	92
NEW ENGLAND	189	200	43	64	43	112	1	26	1	1
Maine	8	11	-	3	2	4	-	-	-	-
N.H.	13	13	3	-	6	7	-	-	N	N
Vt.	6	4	-	1	-	6	-	3	-	1
Mass.	112	129	29	44	33	58	N	N	N	N
R.I.	7	10	-	2	2	-	1	-	1	-
Conn.	43	33	11	14	-	37	-	23	U	U
MID. ATLANTIC	522	593	189	325	140	236	33	27	16	18
Upstate N.Y.	113	72	82	41	56	69	15	14	10	14
N.Y. City	148	196	51	88	14	35	U	U	U	U
N.J.	93	119	30	81	23	62	N	N	N	N
Pa.	168	206	26	115	47	70	18	13	6	4
E.N. CENTRAL	605	677	160	282	163	320	123	93	32	52
Ohio	172	196	44	56	60	77	96	73	23	32
Ind.	56	37	12	14	13	12	27	20	6	3
Ill.	157	256	59	141	16	89	-	-	-	-
Mich.	114	90	27	41	66	91	N	N	N	N
Wis.	106	98	18	30	8	51	N	N	3	17
W.N. CENTRAL	247	258	56	138	80	73	54	63	7	10
Minn.	54	69	11	14	36	24	-	-	7	8
Iowa	48	65	3	6	N	N	N	N	N	N
Mo.	70	62	20	54	14	22	3	3	-	-
N. Dak.	6	5	1	-	3	3	-	2	-	2
S. Dak.	11	13	1	8	5	8	-	-	-	-
Nebr.	19	14	2	43	6	7	-	-	N	N
Kans.	39	30	18	13	16	9	51	58	N	N
S. ATLANTIC	1,133	5,304	580	3,546	260	381	304	818	2	2
Del.	5	12	2	74	-	2	1	-	N	N
Md.	81	110	22	122	49	57	-	1	-	-
D.C.	4	-	8	-	2	-	-	-	2	-
Va.	112	71	19	42	10	8	N	N	N	N
W. Va.	10	3	-	-	6	3	13	12	-	2
N.C.	162	225	91	158	22	22	N	N	U	U
S.C.	59	64	54	23	2	4	17	40	N	N
Ga.	224	150	122	278	118	54	128	154	N	N
Fla.	476	4,669	262	2,849	51	231	145	611	N	N
E.S. CENTRAL	201	290	89	159	44	32	32	24	-	-
Ky.	35	51	16	29	20	5	8	1	N	N
Tenn.	63	97	42	42	24	27	24	23	N	N
Ala.	60	92	15	59	-	-	-	-	N	N
Miss.	43	50	16	29	-	-	-	-	-	-
W.S. CENTRAL	236	398	210	627	32	120	18	30	15	7
Ark.	40	52	11	6	3	2	3	7	2	2
La.	24	59	17	68	-	1	15	23	2	3
Okla.	41	33	69	110	13	18	N	N	8	2
Tex.	131	254	113	443	16	99	N	N	3	-
MOUNTAIN	414	318	206	201	76	126	8	9	1	2
Mont.	14	15	3	-	-	-	-	-	-	-
Idaho	29	20	-	3	1	7	N	N	N	N
Wyo.	5	4	1	1	3	-	4	-	-	-
Colo.	99	90	38	27	40	29	-	-	-	-
N. Mex.	23	29	26	34	20	34	3	9	-	-
Ariz.	193	114	120	122	4	54	-	-	N	N
Utah	30	25	8	6	8	2	-	-	1	2
Nev.	21	21	10	8	-	-	1	-	-	-
PACIFIC	733	820	236	499	119	112	-	1	-	-
Wash.	54	55	11	24	10	-	-	-	N	N
Oreg.	50	49	11	11	N	N	N	N	N	N
Calif.	555	671	203	454	84	94	N	N	N	N
Alaska	22	18	2	2	-	-	-	-	N	N
Hawaii	52	27	9	8	25	18	-	1	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	21	80	1	2	N	N	N	N	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	3	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 13, 2004, and March 8, 2003 (10th Week)*

Reporting area	Syphilis: Primary & secondary		Syphilis: Congenital		Tuberculosis		Typhoid fever		Varicella (Chickenpox)	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	1,111	1,284	35	98	975	1,735	36	62	2,567	3,130
NEW ENGLAND	15	29	-	-	29	40	4	3	172	549
Maine	-	-	-	-	-	-	-	-	17	292
N.H.	1	4	-	-	-	5	-	-	-	-
Vt.	-	-	-	-	-	1	-	-	155	207
Mass.	8	21	-	-	25	11	4	2	-	48
R.I.	2	2	-	-	3	7	-	-	-	2
Conn.	4	2	-	-	1	16	-	1	-	-
MID. ATLANTIC	162	143	5	14	229	332	4	12	8	4
Upstate N.Y.	9	3	2	1	18	27	-	1	-	-
N.Y. City	84	68	3	5	174	170	1	7	-	-
N.J.	29	40	-	8	-	56	2	3	-	-
Pa.	40	32	-	-	37	79	1	1	8	4
E.N. CENTRAL	95	177	13	19	170	174	2	4	1,119	1,533
Ohio	36	34	-	2	31	31	1	-	273	353
Ind.	10	6	-	5	13	22	-	2	-	-
Ill.	23	69	-	9	107	82	-	1	-	-
Mich.	23	66	13	3	8	31	1	1	814	972
Wis.	3	2	-	-	11	8	-	-	32	208
W.N. CENTRAL	23	42	-	-	39	84	-	-	40	5
Minn.	2	15	-	-	18	26	-	-	-	-
Iowa	-	2	-	-	4	5	-	-	N	N
Mo.	14	16	-	-	11	21	-	-	-	-
N. Dak.	-	-	-	-	-	-	-	-	21	5
S. Dak.	-	-	-	-	2	8	-	-	19	-
Nebr.	4	-	-	-	-	2	-	-	-	-
Kans.	3	9	-	-	4	22	-	-	-	-
S. ATLANTIC	296	302	2	17	213	290	7	23	344	482
Del.	1	1	-	-	-	-	-	-	-	1
Md.	48	47	-	4	26	26	2	2	1	-
D.C.	15	4	-	-	-	-	-	-	5	-
Va.	1	13	-	1	6	24	1	4	42	101
W. Va.	-	-	-	-	5	2	-	-	257	358
N.C.	30	29	-	1	20	22	2	1	-	-
S.C.	25	27	-	3	16	17	-	-	39	22
Ga.	34	67	-	5	11	72	-	1	-	-
Fla.	142	114	2	3	129	127	2	15	-	-
E.S. CENTRAL	59	75	1	6	50	112	-	-	1	-
Ky.	14	14	-	1	6	16	-	-	-	-
Tenn.	27	28	1	1	30	32	-	-	-	-
Ala.	12	25	-	4	14	49	-	-	-	-
Miss.	6	8	-	-	-	15	-	-	1	-
W.S. CENTRAL	202	151	12	14	41	283	2	1	333	543
Ark.	11	9	-	-	20	11	-	-	-	-
La.	42	15	-	-	-	-	-	-	-	5
Okla.	6	8	2	-	21	14	-	-	-	-
Tex.	143	119	10	14	-	258	2	1	333	538
MOUNTAIN	84	57	2	14	32	38	5	2	550	14
Mont.	-	-	-	-	-	-	-	-	-	-
Idaho	5	-	-	-	-	-	-	-	-	-
Wyo.	1	-	-	-	-	1	-	-	11	2
Colo.	-	8	-	2	2	17	-	2	386	-
N. Mex.	20	15	-	4	-	1	-	-	18	-
Ariz.	54	31	2	8	21	18	3	-	-	-
Utah	2	1	-	-	9	1	1	-	135	12
Nev.	2	2	-	-	-	-	1	-	-	-
PACIFIC	175	308	-	14	172	382	12	17	-	-
Wash.	11	12	-	-	41	43	1	-	-	-
Oreg.	9	12	-	-	12	15	-	2	-	-
Calif.	155	280	-	14	87	289	8	15	-	-
Alaska	-	-	-	-	7	14	-	-	-	-
Hawaii	-	4	-	-	25	21	3	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	20	26	-	1	-	11	-	-	69	86
V.I.	-	1	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	-	U	10	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,* week ending March 13, 2004 (10th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	508	370	87	31	12	8	65
Boston, Mass.	135	89	27	11	4	4	16
Bridgeport, Conn.	33	27	3	3	-	-	5
Cambridge, Mass.	19	14	4	1	-	-	3
Fall River, Mass.	27	23	2	2	-	-	-
Hartford, Conn.	41	27	9	3	2	-	2
Lowell, Mass.	20	14	6	-	-	-	3
Lynn, Mass.	10	7	3	-	-	-	1
New Bedford, Mass.	23	19	2	1	-	1	4
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	64	51	8	5	-	-	3
Somerville, Mass.	4	4	-	-	-	-	-
Springfield, Mass.	57	39	9	2	5	2	17
Waterbury, Conn.	34	25	5	3	1	-	3
Worcester, Mass.	41	31	9	-	-	1	8
MID. ATLANTIC	2,934	2,049	576	190	56	59	187
Albany, N.Y.	55	40	9	4	1	1	7
Allentown, Pa.	18	17	1	-	-	-	-
Buffalo, N.Y.	87	62	17	4	2	2	12
Camden, N.J.	32	21	8	-	-	3	-
Elizabeth, N.J.	9	4	5	-	-	-	-
Erie, Pa.	49	39	7	1	1	1	2
Jersey City, N.J.	45	25	11	9	-	-	-
New York City, N.Y.	1,808	1,263	365	115	33	28	114
Newark, N.J.	41	22	10	9	-	-	3
Paterson, N.J.	15	8	4	2	-	1	-
Philadelphia, Pa.	382	241	80	30	12	19	18
Pittsburgh, Pa.§	28	17	7	1	3	-	-
Reading, Pa.	26	22	3	-	-	1	3
Rochester, N.Y.	137	114	16	5	1	1	10
Schenectady, N.Y.	26	19	6	1	-	-	2
Scranton, Pa.	32	29	3	-	-	-	1
Syracuse, N.Y.	63	45	12	4	2	-	9
Trenton, N.J.	33	23	7	2	-	1	-
Utica, N.Y.	22	17	3	2	-	-	3
Yonkers, N.Y.	26	21	2	1	1	1	3
E.N. CENTRAL	2,121	1,437	427	163	50	38	162
Akron, Ohio	47	35	5	4	1	2	3
Canton, Ohio	35	25	8	1	1	-	5
Chicago, Ill.	344	192	80	47	10	9	21
Cincinnati, Ohio	105	67	22	6	8	2	11
Cleveland, Ohio	226	181	36	5	3	1	11
Columbus, Ohio	207	136	47	15	6	3	17
Dayton, Ohio	104	73	19	9	2	1	5
Detroit, Mich.	177	105	50	15	5	2	20
Evansville, Ind.	48	38	7	2	-	1	2
Fort Wayne, Ind.	82	54	14	7	6	1	1
Gary, Ind.	18	10	7	-	1	-	2
Grand Rapids, Mich.	58	41	14	3	-	-	9
Indianapolis, Ind.	176	114	38	14	3	7	16
Lansing, Mich.	42	26	8	7	-	1	2
Milwaukee, Wis.	105	79	15	4	2	5	9
Peoria, Ill.	60	43	9	8	-	-	4
Rockford, Ill.	62	49	10	2	1	-	5
South Bend, Ind.	58	40	13	4	1	-	5
Toledo, Ohio	89	68	13	6	-	2	8
Youngstown, Ohio	78	61	12	4	-	1	6
W.N. CENTRAL	676	460	132	43	18	22	60
Des Moines, Iowa	88	61	20	3	-	4	10
Duluth, Minn.	33	29	3	1	-	-	6
Kansas City, Kans.	16	10	4	-	1	1	1
Kansas City, Mo.	103	69	16	10	1	6	6
Lincoln, Nebr.	37	25	6	2	2	2	1
Minneapolis, Minn.	66	47	9	4	5	1	4
Omaha, Nebr.	96	71	19	3	1	2	16
St. Louis, Mo.	138	75	33	17	7	6	7
St. Paul, Minn.	43	34	8	1	-	-	6
Wichita, Kans.	56	39	14	2	1	-	3
S. ATLANTIC	1,498	951	371	105	39	32	78
Atlanta, Ga.	192	109	53	18	7	5	7
Baltimore, Md.	157	93	38	20	4	2	12
Charlotte, N.C.	113	67	31	11	1	3	8
Jacksonville, Fla.	166	109	39	11	4	3	6
Miami, Fla.	158	94	44	14	1	5	6
Norfolk, Va.	50	35	11	1	1	2	4
Richmond, Va.	63	31	25	4	2	1	7
Savannah, Ga.	63	47	15	1	-	-	3
St. Petersburg, Fla.	53	34	11	6	1	1	2
Tampa, Fla.	169	128	27	7	2	5	11
Washington, D.C.	298	192	73	12	16	5	9
Wilmington, Del.	16	12	4	-	-	-	3
E.S. CENTRAL	919	626	203	49	17	21	60
Birmingham, Ala.	189	135	41	5	4	1	15
Chattanooga, Tenn.	69	50	12	3	2	2	5
Knoxville, Tenn.	110	73	29	6	1	1	1
Lexington, Ky.	67	40	16	7	1	3	4
Memphis, Tenn.	207	135	45	14	2	11	14
Mobile, Ala.	104	72	22	5	4	1	4
Montgomery, Ala.	31	20	9	1	-	1	5
Nashville, Tenn.	142	101	29	8	3	1	12
W.S. CENTRAL	1,459	926	334	121	34	44	86
Austin, Tex.	100	65	22	12	-	1	5
Baton Rouge, La.	68	49	13	6	-	-	2
Corpus Christi, Tex.	U	U	U	U	U	U	U
Dallas, Tex.	258	141	73	22	9	13	20
El Paso, Tex.	64	51	10	1	2	-	3
Ft. Worth, Tex.	133	78	29	14	5	7	6
Houston, Tex.	325	195	82	26	9	13	15
Little Rock, Ark.	64	43	13	5	1	2	5
New Orleans, La.	27	23	2	2	-	-	-
San Antonio, Tex.	268	170	58	28	6	6	23
Shreveport, La.	35	23	9	1	-	2	3
Tulsa, Okla.	117	88	23	4	2	-	4
MOUNTAIN	1,101	755	229	70	22	25	85
Albuquerque, N.M.	143	91	31	13	6	2	12
Boise, Idaho	67	47	13	5	-	2	8
Colo. Springs, Colo.	88	68	17	2	-	1	6
Denver, Colo.	104	64	24	6	4	6	4
Las Vegas, Nev.	284	187	65	25	3	4	23
Ogden, Utah	30	25	5	-	-	-	3
Phoenix, Ariz.	39	28	6	2	2	1	3
Pueblo, Colo.	38	29	8	1	-	-	4
Salt Lake City, Utah	111	70	26	6	6	3	9
Tucson, Ariz.	197	146	34	10	1	6	13
PACIFIC	2,485	1,769	494	133	53	35	227
Berkeley, Calif.	14	12	2	-	-	-	-
Fresno, Calif.	155	112	34	5	1	2	11
Glendale, Calif.	51	39	9	2	-	1	3
Honolulu, Hawaii	90	63	19	6	-	2	5
Long Beach, Calif.	94	59	23	4	4	4	14
Los Angeles, Calif.	882	623	173	55	23	8	83
Pasadena, Calif.	U	U	U	U	U	U	U
Portland, Oreg.	163	122	31	4	6	-	10
Sacramento, Calif.	226	171	40	10	3	2	28
San Diego, Calif.	164	118	30	9	1	6	20
San Francisco, Calif.	146	90	37	12	4	3	11
San Jose, Calif.	191	144	31	8	5	3	25
Santa Cruz, Calif.	47	39	7	1	-	-	2
Seattle, Wash.	112	71	31	6	2	2	8
Spokane, Wash.	53	35	11	5	1	1	4
Tacoma, Wash.	97	71	16	6	3	1	3
TOTAL	13,701¶	9,343	2,853	905	301	284	1,010

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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