MMWR™

Morbidity and Mortality Weekly Report

Weekly

November 1, 2002 / Vol. 51 / No. 43

National Diabetes Awareness Month — November 2002

November is National Diabetes Awareness Month. An estimated 17 million persons in the United States have diabetes (*1*). During 1990–2000, the prevalence of diagnosed diabetes and gestational diabetes increased 49% among U.S. adults (*2*). During November, 59 state and territorial diabetes-control programs, other partners, and CDC will highlight activities that increase awareness about diabetes in the following three areas:

Diabetes prevention: The National Diabetes Education Program, a joint initiative of CDC and the National Institutes of Health, is developing a mass-media campaign geared to health-care providers and persons at risk (http://ndep.nih.gov/get_info/dpc.htm#tactics).

Pneumonia and influenza vaccinations: Persons with diabetes should receive pneumococcal vaccinations and annual influenza vaccinations because they are more likely than other persons to die from complications of pneumonia and influenza (*3*).

Diabetes and women: In 2003, CDC will publish the *National Public Health Action Plan for Diabetes and Women* and sponsor a national partners' conference.

Additional information about diabetes is available from CDC, telephone 877-232-3422, e-mail diabetes@cdc.gov, and at http://www.cdc.gov/diabetes.

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Preventive-Care Practices Among Persons with Diabetes — United States, 1995 and 2001

Effective interventions are available to persons with diabetes that can prevent or delay the development of serious health complications such as lower limb amputation, blindness, kidney failure, and cardiovascular disease (*1–4*). However, the use of preventive-care practices is lower than recommended (*5,6*), and the national health objectives for 2010 aim to improve care for all persons with diabetes (*7*). To assess progress toward meeting these goals, CDC analyzed data on selected diabetes-related preventive-care practices, including influenza and pneumococcal vaccination coverage, from the Behavioral Risk Factor Surveillance System (BRFSS) from 1995 and 2001. This report presents the findings of these analyses, which indicate that levels of preventive-care practices among persons with diabetes in the United States increased from 1995 to 2001. Further efforts are needed to improve care among persons with diabetes, reduce the burden of diabetes-related complications, and achieve the national health objectives, including continued surveillance of diabetes-related preventive-care practices and collaboration with community-based organizations, health-care providers, public health officials, and persons with diabetes.

BRFSS is a state-based, random-digit–dialed telephone survey of the noninstitutionalized U.S. population aged $\geq$18 years.

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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].

The surveys are conducted in all 50 states, the District of Columbia, and three U.S. territories. Persons with diabetes were defined as respondents who answered "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who were told that they had diabetes only during pregnancy were not included. Persons who reported that they had diabetes were asked questions from the diabetes module on preventive-care practices, including: "When was the last time you had an eye exam in which the pupils were dilated?" (eye examination); "About how many times in the last year has a health professional checked your feet for any sores or irritations?" (foot examination); and "About how often do you check your blood for glucose or sugar?" (self-monitoring of blood glucose at least once daily [SMBG]). All BRFSS respondents were asked two additional questions: "During the past 12 months, have you had a flu shot?" (influenza vaccination) and "Have you ever had a pneumonia shot?" (pneumococcal vaccination).

A total of 35 states had information from the diabetes module for both 1995 and 2001 and were included in these analyses. The median response rate was 68.7% for 1995 (range: 48.6%–84.5%) and 52.1% for 2001 (range: 33.3%–70.8%). Data were weighted to reflect the age, sex, and racial/ethnic distribution in each of the 35 states. The percentage of persons with diabetes who received each of the preventive-care services and vaccinations was assessed by year, selected sociodemographic characteristics, and health insurance status. Age-specific rates are presented, and rates for selected characteristics are age-adjusted to the 2000 U.S. standard population. All analyses were conducted by using SAS v8 software with SUDAAN to estimate standard errors and test for significant differences in rates between 1995 and 2001.

The age-adjusted rates of all preventive-care practices increased from 1995 to 2001. The increases for rates of eye examinations and SMBG were statistically significant (Table).

Rates of eye examinations increased with age for both 1995 and 2001, and in each age group rates increased from 1995 to 2001. Among persons aged 65–74 years, the increase was statistically significant. In addition, men, non-Hispanic whites, and persons without health insurance had statistically significant increases in the age-adjusted rate of eye examinations.

Rates of annual foot examinations increased significantly from 1995 to 2001 among those aged 45–64 and 65–74 years. Statistically significant increases also were shown among men, non-Hispanic whites, non-Hispanic blacks, and persons with health insurance.

The overall rate of SMBG was lower in the older age groups in both 1995 and 2001. However, the rate of SMBG increased significantly in all age groups. In addition, the age-adjusted rate of SMBG increased significantly among both sexes, non-

TABLE. Age-specific and age-adjusted rates* and changes in diabetes-related preventive-care practices, by selected demographic characteristics — Behavioral Risk Factor Surveillance System, United States, 1995 and 2001

		Eye examination			Foot examination			Self-monitoring for glucose			Vaccinations: Influenza			Vaccinations: Pneumococcal		
Characteristic	Year	No.	(%)	% difference	No.	(%)	% difference	No.	(%)	% difference	No.	(%)	% difference	No.	(%)	% difference
Age group (yrs)																
18–44	1995	498	(51.0)	9.1	486	(55.0)	4.2	505	(44.1)	14.0†	518	(25.5)	6.3	498	(8.5)	15.8†
	2001	1,347	(60.1)		1,336	(59.2)		1,357	(58.1)		1,370	(31.8)		1,284	(24.3)	
45–64	1995	1,148	(65.1)	4.1	1,087	(57.7)	8.6†	1,146	(41.4)	12.2†	1,180	(44.2)	3.7	1,152	(26.2)	10.4†
	2001	3,958	(69.2)		3,919	(66.3)		3,958	(53.6)		4,024	(47.9)		3,884	(36.5)	
65–74	1995	872	(69.6)	7.5†	813	(56.2)	11.1†	871	(37.6)	17.0†	907	(62.6)	8.1†	872	(39.4)	23.3†
	2001	2,211	(77.0)		2,153	(67.3)		2,210	(54.6)		2,250	(70.6)		2,192	(62.7)	
≥75	1995	546	(75.4)§	3.5	504	(56.2)	6.0	553	(21.9)§	28.2†	579	(72.0)§	2.1	552	(46.0)§	22.8†
	2001	1,522	(78.9)§		1,476	(62.3)		1,523	(50.1)§		1,573	(74.1)§		1,530	(68.8)§	
Sex¶																
Men	1995	1,203	(59.4)	7.2†	1,158	(53.1)	8.6†	1,217	(38.9)	15.7†	1,251	(35.1)	9.3†	1,184	(18.3)	16.9†
	2001	3,793	(66.6)		3,757	(61.7)		3,818	(54.6)		3,879	(44.3)		3,661	(35.3)	
Women	1995	1,861	(58.4)	6.8	1,732	(58.9)	4.1	1,858	(42.8)	14.2†	1,933	(41.1)	1.7	1,890	(20.7)	14.1†
	2001	5,245	(65.2)		5,127	(63.0)		5,230	(56.9)		5,338	(42.8)		5,229	(34.7)	
Race/Ethnicity¶																
White, non-Hispanic	1995	2,418	(62.4)	5.9†	2,284	(52.7)	8.7†	2,423	(43.3)	15.8†	2,486	(42.2)	4.3	2,399	(20.6)	17.8†
	2001	6,607	(68.3)		6,512	(61.4)		6,638	(59.1)		6,755	(46.5)		6,526	(38.5)	
Black, non-Hispanic	1995	319	(69.0)	-5.2	301	(54.1)	16.2†	326	(45.4)	7.9	335	(24.3)	14.9†	328	(16.1)	13.5†
	2001	882	(63.8)		854	(70.2)		869	(53.2)		889	(39.2)		858	(29.6)	
Hispanic	1995	197	(46.1)	14.0	183	(62.9)	-8.1	197	(28.1)	17.5†	205	(28.1)	10.0	194	(15.4)	10.7†
	2001	682	(60.0)		678	(54.7)		685	(45.6)		698	(38.1)		659	(26.1)	
Education level¶																
<High school	1995	906	(50.5)	7.5	836	(58.3)	-1.3	927	(39.5)	10.3	962	(38.7)	1.5	925	(16.8)	15.9†
	2001	2,029	(58.0)		1,964	(56.9)		2,039	(49.8)		2,096	(40.2)		2,013	(32.7)	
High school	1995	1,011	(58.6)	7.2	950	(54.5)	7.5	999	(38.9)	18.6†	1,042	(34.5)	7.6†	1,018	(19.1)	17.0†
	2001	3,138	(65.8)		3,081	(62.0)		3,135	(57.5)		3,197	(42.1)		3,109	(36.1)	
>High school	1995	1,133	(62.7)	6.8	1,091	(55.8)	9.2	1,137	(43.8)	13.3†	1,169	(41.0)	5.3	1,120	(22.7)	13.1†
	2001	3,839	(69.5)		3,811	(65.0)		3,846	(57.1)		3,891	(46.3)		3,735	(35.8)	
Health insurance¶																
Yes	1995	2,790	(65.1)	5.1	2,624	(55.5)	10.1†	2,799	(44.0)	13.5†	2,895	(41.6)	4.4	2,796	(20.5)	14.9†
	2001	8,196	(70.2)		8,060	(65.7)		8,214	(57.5)		8,357	(45.9)		8,062	(35.3)	
No	1995	270	(35.8)	13.0†	262	(56.0)	-8.4	272	(28.6)	20.3†	285	(22.2)	7.1	274	(10.8)	18.7†
	2001	826	(48.8)		809	(47.6)		818	(48.9)		843	(29.3)		811	(29.5)	
Total¶	**1995**	**3,064**	**(58.9)**	**7.0†**	**2,890**	**(56.0)**	**6.3**	**3,075**	**(40.9)**	**14.9†**	**3,184**	**(38.2)**	**5.4†**	**3,074**	**(19.6)**	**15.4†**
	2001	**9,038**	**(65.9)**		**8,884**	**(62.3)**		**9,048**	**(55.8)**		**9,217**	**(43.5)**		**8,890**	**(35.0)**	

* Weighted percentage.
† p<0.05; statistically significant.
§ p<0.01; t-test for trend.
¶ Age-adjusted to the 2000 U.S. standard population.

Hispanic whites, Hispanics, persons with an education level of high school or greater, and persons with and without health insurance.

From 1995 to 2001, the age-adjusted rate increased significantly for both influenza and pneumococcal vaccinations. However, in 2001, the age-adjusted rate of influenza vaccination among persons with diabetes was higher than that for pneumococcal vaccination (43.5% versus 35.0%).

The rates of influenza vaccination increased with age for both 1995 and 2001, and rates in each age group increased from 1995 to 2001; however, the increase was statistically significant only among those aged 65–74 years. In addition, the age-adjusted rate of influenza vaccination increased significantly among men, non-Hispanic blacks, and those with a high school education.

The age-specific rate of pneumococcal vaccination increased with age in both 1995 and 2001. The rate of pneumococcal vaccination increased significantly in each age group. In addition, the age-adjusted rate increased significantly among men and women, non-Hispanic whites and non-Hispanic blacks, Hispanics, persons at each level of education, and those with and without health insurance.

In 2001, the age-adjusted rates of the three preventive-care practices and the two vaccinations were below levels recommended by the national health objectives (Figure). Rates of pneumococcal vaccination among younger persons with diabetes showed the largest difference compared with the 2010 objectives.

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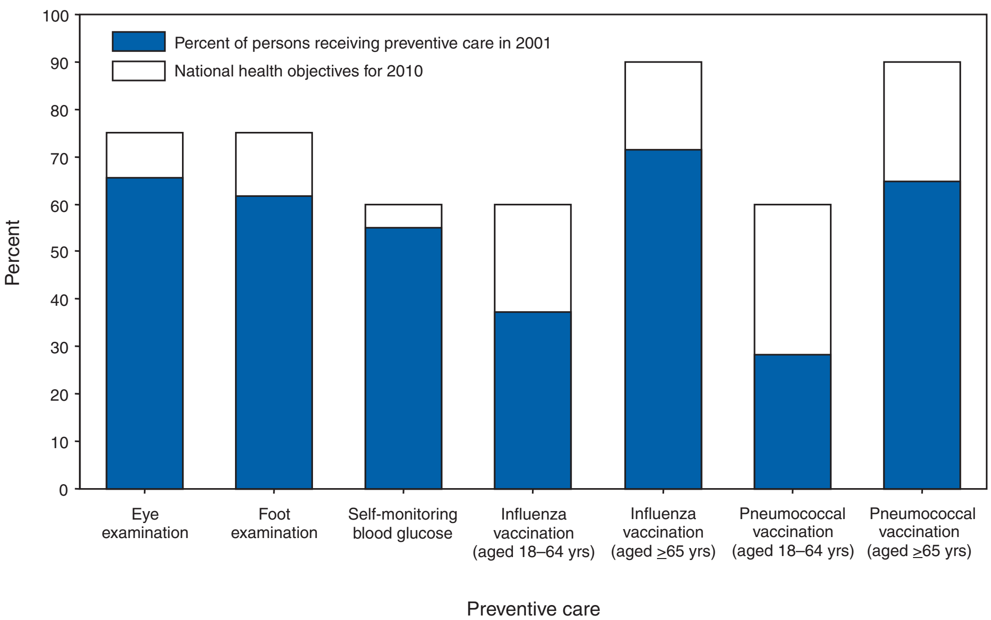
FIGURE. Age-adjusted* percentage of persons with diabetes receiving preventive care in 2001 compared with national health objectives for 2010 — United States



* Age-adjusted to the 2000 U.S. standard population.

Editorial Note: Effective interventions are available that can prevent or delay the development of diabetes complications. The findings in this report indicate that the percentage of persons with diabetes who received preventive-care services increased from 1995 to 2001.

Consistent with previous reports (*5,6*), the rate of the use of preventive-care practices and vaccination coverage among persons with diabetes in 2001 was less than recommended, and improvement is needed in all areas of diabetes care to achieve the national health objectives. Differences observed in the reported use of diabetes-related preventive-care practices among racial/ethnic populations might reflect differences in socioeconomic status, access to care, cultural or language barriers, or other factors. In addition, these analyses identified target groups who are in need of interventions to improve their preventive care, such as younger persons with diabetes who need to receive eye examinations and vaccinations, and older persons who need to practice SMBG.

The findings in this report are subject to at least five limitations. First, these analyses included only the non-institutionalized population and cannot be generalized to persons residing in nursing homes and other institutions. Second, self-reported data are subject to recall bias, and preventive-care practices or vaccination levels might be underreported or overreported. The extent to which reporting bias might affect these results is unknown. Third, BRFSS is a telephone survey, and rates of diabetes-related preventive-care practices presented in this report might be overestimated slightly because persons of low socioeconomic status are less likely to have telephones and less likely to receive preventive care. Fourth, the median response rate was 68.7% for 1995 and 52.1% for 2001; however, compared with census data, BRFSS data have minimal bias (BRFSS data quality report; available at http://www.cdc.gov/brfss). Finally, the analysis included only 35 states and might not be representative of the entire country. However, the rates of both influenza and pneumococcal vaccinations were assessed for all states in 2001 and showed little difference from the results in this report (CDC, unpublished data, 2001).

Public and private efforts to improve the level of diabetes care are ongoing (*8–10*). CDC collaborates with many partners to ensure good care and education for persons with diabetes. CDC and the National Institutes of Health cosponsor the National Diabetes Education Program (available at http://www.ndep.nih.gov), which develops educational tools and community-based interventions and establishes public and private partnerships to address the gap between current and desired levels of diabetes care and practices. CDC also is working with the Bureau of Primary Health Care of the Health Resources and Service Administration on the National Diabetes Collaborative, a partnership of public and private agencies to increase access to and improve the quality of diabetes care within federally funded health centers. As part of its national strategy, CDC provides resources and technical assistance to state diabetes-control programs to improve access to quality diabetes care. CDC also is working with managed-care partners on Project TRIAD (Translating Research into Action for Diabetes), a 5-year prospective study of the quality of diabetes care, costs, and outcomes in managed-care settings.

Continued surveillance of diabetes-related preventive-care practices using the BRFSS will be an important tool in monitoring the effectiveness of strategies designed to improve the quality of care among persons with diabetes, identify racial/ethnic health disparities, and focus interventions to eliminate such disparities.

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Tropical Diabetic Hand Syndrome — Dar es Salaam, Tanzania, 1998–2002

Patients with diabetes mellitus have impaired immunologic responses to combat infections (*1*). Infection and ulceration of the hand is a major cause of morbidity and mortality in certain populations in Africa (*2,3*); however, the condition is less well recognized than foot infections and is not classified generally as a specific diabetes complication. Hand ulceration and infection in diabetic patients was first described in the United States in 1977 (*4*) and in Africa in 1984 (*5*). Subsequently, the majority of reported cases have been from various parts of the African continent (*2,6,7*). The term "tropical diabetic hand syndrome" (TDHS) has been used to describe diabetes among patients who have progressive, fulminant hand sepsis (*3,8,9*). More recently, TDHS has been reported among patients in India (*10*). These data suggest that TDHS occurs primarily in diabetic patients who live in tropical or coastal areas and might result in loss of hand function, amputation, or death (*2*). This report describes the characteristics of 72 patients with TDHS examined at Muhimbili National Hospital (MNH) in Dar es Salaam, Tanzania. Early recognition by patients, prompt medical attention, and improved glycemic control might reduce the incidence of disability or death.

A patient with TDHS was defined as any adult diabetes patient with hand cellulitis, infection, and gangrene who sought medical attention at MNH during February 9, 1998–August 22, 2002. A total of 72 patients had illnesses that met the case definition; 36 (50%) were male, 44 (61%) had type 2 diabetes, and all had first episodes of diabetes. Median age of patients was 52 years (range: 20–89 years), median interval since diagnosis of diabetes was 5 years (range: 2 weeks–19 years), and median body mass index was 23.4 kg/m^2 (range: 15–39 kg/m^2). Patients' median blood glucose level at initial presentation was 280 mg/dL (range: 56–626 mg/dL). Peripheral neuropathy was present in 10 (14%) patients; one patient had evidence of peripheral vascular disease, which was ascertained through Doppler studies. The initial precipitating causes of TDHS varied: hand trauma was reported in 19 (26%); itching, caused possibly by insect bites, occurred in 11 (15%); boils were the precipitating cause in 10 (14%); seemingly innocuous papules were the cause in nine (13%) patients; and the cause was unknown in 23 (28%) patients. All 72 patients had hand ulcerations; 61 (85%) were purulent, 23 (32%) had a deep ulcer which involved the bone, and 17 (24%) had localized or widespread gangrene of the arm. The median time between onset of symptoms and initial clinical evaluation by a physician was 14 days (range: 2–252 days).

Superficial swab cultures of hand lesions were obtained for the majority of patients. These cultures all yielded polymicrobial growth that included *Streptococcus* spp., *Staphylococcus aureus*, *S. epidermidis*, *Klebsiella pneumoniae*, *Pseudomonas aeruginosa*, *Escherichia coli*, or *Proteus mirabilis*.

Patients for whom delay in seeking treatment was >14 days (median) from onset of symptoms were significantly more likely to undergo a surgical procedure after hospital admission (relative risk [RR]=1.8; 95% confidence interval [CI]=1.0–3.3; $p<0.05$) or to have acquired a long-term hand deformity at follow-up (RR=2.0; 95% CI=1.1–3.9; $p<0.05$). Patients who delayed seeking medical attention were twice as likely as those who did not delay to have gangrene of the hand or arm. Patients with a random blood glucose level of ≥280 mg/dL (median) were significantly more likely than those with a random blood glucose level of <280 mg/dL to undergo surgery (RR=1.7; 95% CI=1.02–2.8; $p<0.05$). Patients with random blood glucose levels above the median were twice as likely as those below the median to have gangrene (11 of 37 versus five of 35).

All 72 patients received antimicrobial therapy after initial clinical evaluation. Overall, 36 (50%) patients underwent surgery; 16 (44%) had gangrene of the hand. Of these 16 patients, seven (44%) required amputation of fingers, hand, or arm because of very rapid progression to gangrene. The remaining 29 patients who had surgery underwent incision and drainage and debridement.

Follow-up was completed for 64 (89%) patients. Of these, 51 (80%) had complete healing of their hand ulcer and resolution of inflammation; eight (13%) had ulcers that did not heal, and five (8%) died. During follow-up, 33 (52%) patients were found to have substantially impaired hand function that adversely affected their daily living activities. Damages included wasting, strictures, deformities, chronic lymphedema, or chronic pain. Of the 51 patients with healed ulcers, 20 (39%) reported chronic, severe neuropathic pain.

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Editorial Note: TDHS is a complication of diabetes that has been reported in tropical regions of Africa (*8,9*) and in India (*10*). It is both poorly understood by patients and clinicians and severe in consequence without prompt and aggressive treatment. Given its innocuous initial stages, patients and clinicians might assume that hand ulceration and infection is analogous to the more familiar and indolent diabetic foot ulcer. Previous small series or case reports indicate the severe consequences of TDHS, including permanent disability and death (*2,3,5,6,8*).

The findings in this report illustrate important characteristics that distinguish TDHS from diabetic foot ulcer syndrome. Patients with TDHS have poorly controlled blood glucose levels; neither peripheral vascular disease nor peripheral neuropathy appear to play a substantial role in the pathogenesis of TDHS. In contrast, peripheral vascular disease and peripheral neuropathy are well-known risk factors for diabetic foot ulcers and foot infections.

TDHS can develop into a rapidly progressive, synergistic gangrene (Meleney's gangrene) confined to the superficial fascia that can result in death within days of onset of symptoms (*2,3*). Although the majority of patients survive, permanent disability is likely. The most common cause of polymicrobial synergistic gangrene is a symbiotic relationship of aerobic gram-negative rods in combination with different enteric anaerobes (*3*). Culture of tissue biopsy specimens yields a single bacterial species in >75% of cases, whereas swab cultures yield polymicrobial flora in the majority of cases, probably because of contamination (*3*). Therefore, routine swabs of open, infected hands cannot guide optimal antimicrobial therapy and might not be appropriate use of resources in hospitals with limited laboratory facilities.

The likelihood of permanent disability or death might be increased because of delays in medical treatment. Such delays might occur because of limited access to medical care or because the patient is unaware of the risk for life-threatening infection. Many patients reported initial symptoms that seemed insignificant, such as itching or an insect bite. These symptoms did not alarm patients enough to seek medical care until much further into the course of the infection. Educating diabetes patients can minimize delays in seeking prompt medical attention once they recognize the initial signs and symptoms of TDHS.

Appropriate treatment for the majority of patients includes incision and drainage of the wound, debridement, or amputation. Antimicrobial therapy must be broad-spectrum because of the potential for development of polymicrobial gangrene. Physicians treating patients with diabetes should examine patients' hands and educate them about TDHS.

Prevention of permanent disability and death resulting from TDHS will require more study. The effects of demographic, socioeconomic, and behavioral factors on the occurrence of TDHS remain unknown. A case-control study is under way in Tanzania to identify risk factors for development of TDHS among diabetic patients. Poor glucose control is evident in this cohort and might be an important factor contributing to the development of TDHS, highlighting the need for improved management of glycemic levels. Further laboratory studies are needed to characterize the causative organisms, especially in coastal regions of Africa. As diabetes becomes more prevalent worldwide, especially in resource-limited tropical countries, patients and health-care providers in these regions should be educated about TDHS to prevent its life-threatening and crippling complications.

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Primary and Secondary Syphilis — United States, 2000–2001

In October 1999, CDC, in collaboration with other federal partners, initiated the National Plan to Eliminate Syphilis in the United States. Syphilis elimination is defined as the absence of sustained transmission (i.e., no transmission after 90 days of the report of an imported index case). The national goals for syphilis elimination are to reduce the annual number of primary and secondary (P&S) syphilis cases to <1,000 cases (rate: 0.4 per 100,000 population) and to increase the number of syphilis-free counties to 90% by 2005 (*1*). To characterize the epidemiology of syphilis in the United States, CDC analyzed national notifiable disease surveillance data for 2000–2001. This report summarizes the results of that analysis, which indicate that the number of reported cases of P&S syphilis increased slightly in 2001. This increase occurred only among men; the number of P&S syphilis cases continued to decline among women and among non-Hispanic blacks. The available data indicate that syphilis cases occurring among men who have sex with men (MSM) contributed to the increase in cases. The data suggest that, although efforts to reduce syphilis among women and non-Hispanic blacks appear effective and should continue, efforts to prevent and treat syphilis among MSM need to be improved.

Data for syphilis cases reported to state health departments and the District of Columbia during 2000–2001 were sent weekly to CDC. These data included information about each patient's county of residence, sex, stage of disease, racial/ethnic group, and age group. Data on reported cases of P&S syphilis were analyzed for this report because these cases represented incidence (i.e., newly acquired infections within the evaluated time) better than reported cases of latent infection, which were acquired months or years before diagnosis. P&S syphilis rates were calculated by using population denominators from the U.S. Bureau of the Census; the 2001 rates and numbers of cases were compared with 2000 data *(2)*.

After declining every year since 1990, the number of reported cases of P&S syphilis increased slightly in 2001. In 2000, the rate of P&S syphilis in the United States declined to 2.1 cases per 100,000 population, the lowest rate since reporting began in 1941 (*2*). In 2001, the rate of P&S syphilis increased slightly, to 2.2, the first annual rate increase since 1990, and 6,103 cases of P&S syphilis were reported, a 2.1% increase in reported cases compared with 2000 (Table 1).

In 2001, rates of P&S syphilis were 114.3% higher for men than for women. During 2000–2001, the rate increased 15.4% among men and decreased 17.6% among women; the male-to-female P&S syphilis case ratio increased 50% (from 1.4:1 to 2.1:1) (Figure 1). Increases in male-to-female case ratios occurred among all racial/ethnic groups.

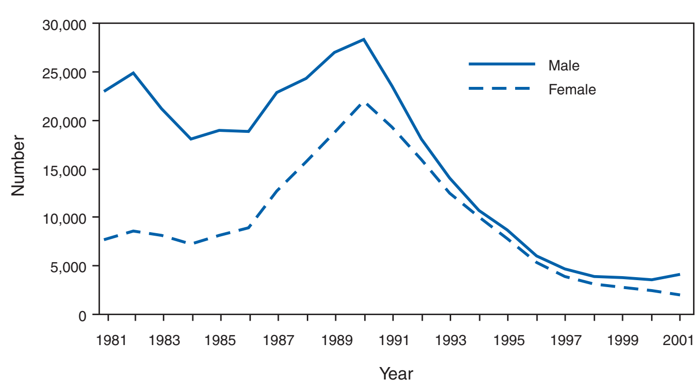
In 2001, the rate of P&S syphilis among non-Hispanic blacks was 15.7 times the rate reported among non-Hispanic whites. Non-Hispanic blacks accounted for 62.5% of cases in 2001 and 70.9% in 2000. During 2000–2001, the rate among non-Hispanic blacks declined 9.8%, reflecting a 3.5%

TABLE 1. Number and rate* of persons infected with primary and secondary syphilis, by selected demographic characteristics — United States, 2000–2001

Characteristic	2000 No.	2000 Rate	2001 No.	2001 Rate
Sex†				
Male	3,532	(2.6)	4,144	(3.0)
Female	2,445	(1.7)	1,967	(1.4)
Race/Ethnicity§				
White, non-Hispanic	1,083	(0.5)	1,387	(0.7)
Black, non-Hispanic	4,233	(12.2)	3,813	(11.0)
Hispanic	567	(1.6)	754	(2.1)
Asian/Pacific Islander	37	(0.3)	55	(0.5)
American Indian/Alaska Native	52	(2.4)	90	(4.2)
Region¶				
Northeast	371	(0.7)	613	(1.1)
Midwest	1,274	(2.0)	1,191	(1.8)
South	3,704	(3.7)	3,429	(3.4)
West	630	(1.0)	870	(1.4)
Total	**5,979**	**(2.1)**	**6,103**	**(2.2)**

* Per 100,000 population.
† Sex was not identified for two persons in 2000 and for two persons in 2001.
§ Race/ethnicity was not identified for seven persons in 2000 and for four persons in 2001
¶ *Northeast*=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; *Midwest*=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; *South*=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; *West*=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

FIGURE 1. Reported number of cases of primary and secondary syphilis, by year and sex — United States, 1981–2001



decrease in the number of cases among men (from 2,371 to 2,289) and an 18.1% decrease among women (from 1,864 to 1,523). The rate among non-Hispanic whites increased 40.0%; cases among men increased 63.0% (from 698 to 1,138), and cases among women decreased 35.3% (from 385 to 249). The rate among Hispanics increased 31.0%; cases among men increased 50.1% (from 405 to 608), and cases among women decreased 9.3% (from 162 to 147). The rate among Asians/Pacific Islanders increased 66.7%; cases among men increased 79.3% (from 29 to 52), and cases among women decreased from eight to four. The rate among American Indians/Alaska Natives increased 75.0%; cases increased among men (from 26 to 49) and women (from 26 to 41).

By region*, the South had the highest rate, accounting for 56.2% of cases occurring in 2001 and 62.0% in 2000. During 2000–2001, rates decreased 8.1% in the South and 10.0% in the Midwest but increased 40.0% in the West and 57.1% in the Northeast. Rates decreased in 16 states, remained the same in nine states, and increased in 25 states and the District of Columbia.

In 2001, no cases of P&S syphilis were reported in 2,516 (80.2%) of 3,139 U.S. counties, and 2,533 (80.7%) counties reported rates less than or equal to the national health objective for 2010 of 0.2 cases per 100,000 persons (objective no. 25-3) (Figure 2) (*3*). In 2001, 20 counties and one city accounted for 50.6% of all reported P&S syphilis cases in the United States (Table 2). During 2000–2001, the overall rate for 63 of the largest cities in the U.S. with >200,000 population increased 9.1%, from 4.4 per 100,000 persons to 4.8.

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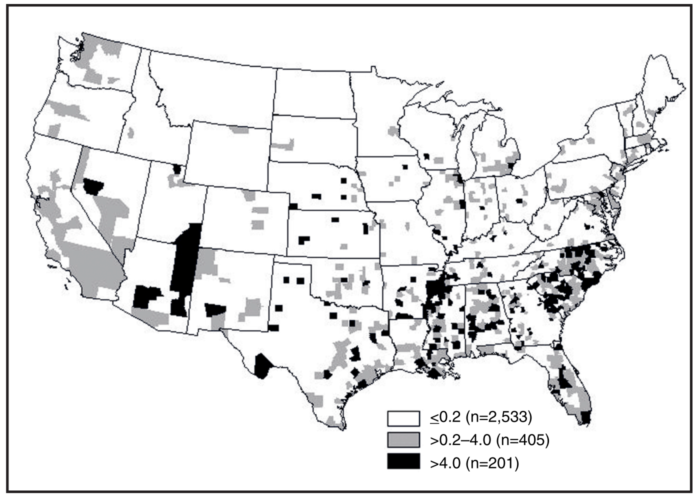
Editorial Note: The pattern of syphilis infection in the United States has changed during recent years. Although the South continues to have the highest rate of P&S syphilis, disease was less concentrated in this region. Racial/ethnic disparities in syphilis rates are decreasing because of declining rates among non-Hispanic blacks and increasing rates among non-Hispanic whites.

During 2000–2001, the number of cases of P&S syphilis increased among men, ending the decade-long trend characterized by annual declines in syphilis cases among both men and women. This increase in syphilis cases among men is associated with reports in several cities of syphilis outbreaks among MSM (*4–9*); these outbreaks were characterized by high rates of human immunodeficiency virus co-infection and high-risk sexual behavior among subpopulations of MSM. Although syphilis cases reported nationally do not include information on behavior risk, the continuing decline in syphi-

FIGURE 2. Counties with primary and secondary syphilis rates above the national health objective for 2010* — United States, 2001



* 0.2 cases per 100,000 population.

TABLE 2. Counties and independent cities accounting for ≥50% of reported cases of primary and secondary syphilis, by number and rate* of persons infected — United States, 2001

County (Major City)	No.	Rate
Wayne County, Michigan (Detroit)	379	18.4
Cook County, Illinois (Chicago)	339	6.3
Fulton County, Georgia (Atlanta)	224	27.5
Los Angeles County, California (Los Angles)	211	2.2
Shelby County, Tennessee (Memphis)	208	23.2
Dade County, Florida (Miami)	185	8.2
Baltimore, Maryland†	161	24.7
Maricopa County, Arizona (Phoenix)	148	4.8
New York County, New York (New York City)	145	9.4
San Francisco County, California (San Francisco)	138	17.8
Marion County, Indiana (Indianapolis)	128	14.9
Dallas County, Texas (Dallas)	121	5.5
Harris County, Texas (Houston)	103	3.0
Robeson County, North Carolina	90	73.0
Essex County, New Jersey (Newark)	79	10.0
Philadelphia County, Pennsylvania (Philadelphia)	78	5.1
Davidson County, Tennessee (Nashville)	76	13.3
Bexar County, Texas (San Antonio)	71	5.1
Kings County, New York (New York City)	71	2.9
Guilford County, North Carolina (Greensboro)	70	16.6
Franklin County, Ohio (Columbus)	62	5.8

* Per 100,000 population.
† Independent city.

* *Northeast*=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; *Midwest*=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; *South*=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; *West*=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

lis rates among women in conjunction with the increasing male-to-female case ratio suggests that the syphilis rate probably is increasing among MSM and decreasing among heterosexual men.

The findings in this report are subject to at least two limitations. First, the quality of surveillance data vary at local and state levels, and syphilis reporting is incomplete. Second, because cases among patients attending public-sector clinics might be more likely to be reported than cases diagnosed in the private sector and persons of minority race/ethnicity might be more likely to attend public clinics, the racial/ethnic differences in reported rates might be magnified.

The National Syphilis Elimination Plan announced by CDC in 1999 focused initially on reducing syphilis in the South and among minority populations. Rates of syphilis in the South and among non-Hispanic blacks and women have declined every year since 1997. Ensuring continued progress toward syphilis elimination will require that syphilis trends be monitored and that elimination efforts be maintained among these populations. However, the increase in cases among MSM underscores the need to modify the syphilis elimination plan to develop and implement more effective prevention activities among MSM (*7*). National efforts are under way to collect information on behavior to permit better monitoring of syphilis trends among MSM and heterosexual persons, study ethnographic and other factors associated with increases in syphilis among MSM, and improve programs to prevent and treat syphilis. To sustain progress toward syphilis elimination, communities must understand local patterns of syphilis transmission and develop effective, targeted intervention strategies that include education, risk reduction, and appropriate screening and treatment of persons at risk for this disease.

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Public Health Dispatch

Investigations of West Nile Virus Infections in Recipients of Blood Transfusions

On October 28, this report was posted on the MMWR *website* (http://www.cdc.gov/mmwr).

CDC, the Food and Drug Administration (FDA), and the Health Resources and Services Administration (HRSA), in collaboration with blood collection agencies and state and local health departments, continue to investigate West Nile virus (WNV) infections in recipients of blood transfusions. During August 28–October 26, CDC received reports of 47 persons with possible transfusion-related WNV infection. Investigations showed that 14 of these persons either did not have WNV infection or did not acquire WNV infection through transfusion. The remaining 33 cases, reported from 17 states, occurred among persons who had confirmed or probable WNV infection and had received blood components in the month before illness onset. To date, evidence that WNV can be transmitted through blood transfusion has been found in six of the 33 cases; investigations are ongoing for the other 27 cases.

Among the six cases with evidence that WNV can be transmitted through blood transfusion, three have been previously summarized (*1,2*). Two patients developed confirmed West Nile virus meningoencephalitis (WNME) after receiving different blood components derived from the same blood donation, which was subsequently found to have evidence of WNV (*2*). In follow-up testing, the donor associated with these components had WNV-specific IgM antibody. On interview, this donor reported having a fever and a rash 2 and 5 days after donation, respectively. In a third case, WNV was isolated from an untransfused unit of fresh frozen plasma (FFP) derived from the suspected donation, indicating that the virus can survive in some blood components (*1*). The donor of this unit sought medical care 4 days after donation for an illness of 1–2 weeks duration characterized by nasal congestion, sinus pain, headache, malaise, and fatigue and was treated for sinusitis. On follow-up, the donor tested positive for WNV-specific IgM antibody.

Investigations of three additional patients found evidence that these persons acquired WNV infection by transfusion. An adolescent with a hematologic malignancy who had been hospitalized continuously for 65 days developed WNME after receiving 93 blood components in the month before illness onset. Of 72 retention segments* available from these donations, one tested positive for WNV by kinetic quantitative polymerase chain reaction assay (Taqman®) and negative for WNV-specific IgM antibody. The donor of the unit associated with the Taqman®-positive retention segment reported fever, chills, headache, painful eyes, and generalized weakness beginning 2 days after donation in early September and subsequently developed WNV IgM antibody.

Two additional patients had WNME diagnosed after each had received a component derived from the same blood donation. The first patient, a man aged 60 years with a malignancy, received 4 units of red blood cells during September 18–30 and subsequently developed encephalitis. Serum and cerebrospinal fluid samples tested positive for WNV-specific IgM antibody on October 8 and 16, respectively; the patient subsequently died. One of four retention segments associated with the units the patient received tested positive for WNV by Taqman® and negative for WNV-specific IgM antibody. A unit of FFP associated with this Taqman®-positive donation had been administered on October 6 to the second patient, a woman aged 40 years with a malignancy; 3 days later, this patient had fever. Serum collected from the patient 1 day before transfusion was negative for WNV by Taqman® and WNV-specific IgM antibody. Serum collected from the patient 9 days after transfusion tested positive for WNV by reverse transcription polymerase chain reaction and negative for WNV-specific IgM antibody; serum collected 6 days later tested positive for WNV by Taqman® and positive for WNV-specific IgM antibody. The donor of the Taqman®-positive unit subsequently developed WNV IgM antibody. During follow-up interview, the donor reported having fever, chills, headache, eye pain, and myalgias 5 days before donation and a rash 4 days after donation in late August.

Cases of WNV infection in patients who have received blood transfusions within the month preceding illness onset should be reported to CDC through state and local public health authorities. Serum or tissue samples should be retained for later studies. In addition, cases of WNV infection occurring in persons who have illness onset within 2 weeks after blood donation should be reported. Prompt reporting of these cases will facilitate withdrawal of potentially infectious blood components.

FDA has issued a guidance document for deferral of donors with suspect or diagnosed WNV infection who have illness onset before or after donation (*3*). In addition, the document provides recommendations for retrieval and quarantine of blood and blood components in such donors. FDA, in collaboration with CDC, the National Institutes of Health, and HRSA, is sponsoring a workshop on development of donor-screening assays for WNV. Additional information on this workshop is available at http://www.fda.gov/cber/meetings/wnv110402.htm.

* Blood samples from tubing that had been attached to the original donor collection bag or from the packed red blood cell component prepared from the whole blood collection.

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West Nile Virus Activity — United States, October 24–30, 2002

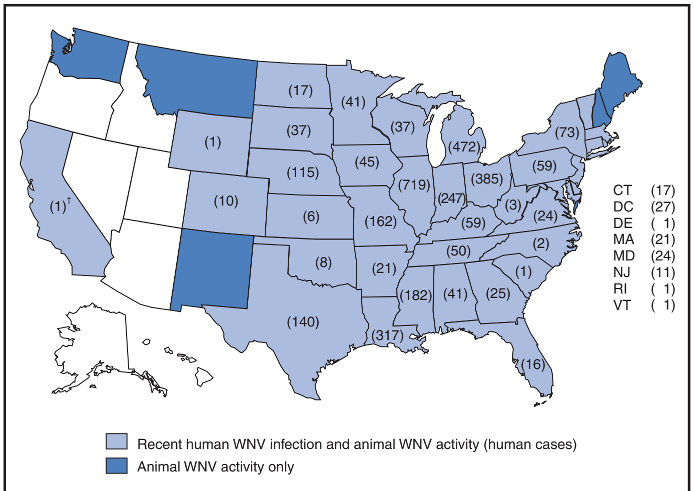
This report summarizes West Nile virus (WNV) surveillance data reported to CDC through ArboNET and by states and other jurisdictions as of 7 a.m. Mountain Standard Time, October 30, 2002.

During October 24–30, a total of 123 laboratory-positive human cases of WNV-associated illness were reported from Indiana (n=43), Illinois (n=14), Pennsylvania (n=12), Michigan (n=nine), Louisiana (n=seven), Ohio (n=seven), Colorado (n=five), Mississippi (n=four), Connecticut (n=three), Florida (n=three), Missouri (n=three), Texas (n=three), Minnesota (n=two), New York (n=two), Iowa (n=one), Maryland (n=one), Nebraska (n=one), New Jersey (n=one), Tennessee (n=one), and West Virginia (n=one). During the same period, WNV infections were reported in 519 dead crows and 424 other dead birds. A total of 272 veterinary cases and 165 WNV-positive mosquito pools were reported.

During 2002, a total of 3,419 human cases with laboratory evidence of recent WNV infection have been reported from Illinois (n=719), Michigan (n=472), Ohio (n=385), Louisiana (n=317), Indiana (n=247), Mississippi (n=182), Missouri (n=162), Texas (n=140), Nebraska (n=115), New York (n=73), Pennsylvania (n=59), Kentucky (n=59), Tennessee (n=50), Iowa (n=45), Alabama (n=41), Minnesota (n=41), South

Dakota (n=37), Wisconsin (n=37), the District of Columbia (n=27), Georgia (n=25), Maryland (n=24), Virginia (n=24), Arkansas (n=21), Massachusetts (n=21), Connecticut (n=17), North Dakota (n=17), Florida (n=16), New Jersey (n=11), Colorado (n=10), Oklahoma (n=eight), Kansas (n=six), West Virginia (n=three), North Carolina (n=two), California (n=one), Delaware (n=one), Rhode Island (n=one), South Carolina (n=one), Vermont (n=one), and Wyoming (n=one) (Figure). Among the 3,044 patients for whom data were available, the median age was 56 years (range: 1 month–99 years);

FIGURE. Areas reporting West Nile virus (WNV) activity — United States, 2002*

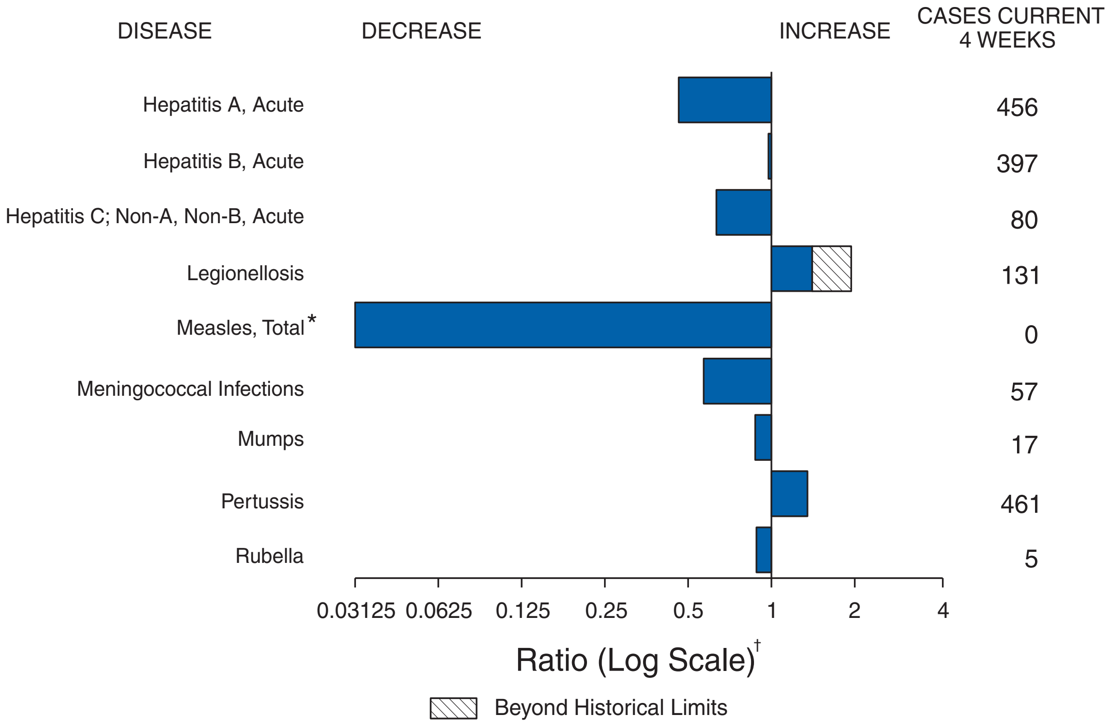


* As of 7 a.m. Mountain Standard Time, October 30, 2002.
† California has reported human WNV activity only.

1,643 (54%) were male, and the dates of illness onset ranged from June 10 to October 19. A total of 180 human deaths have been reported. The median age of decedents was 79 years (range: 24–99 years); 107 (59%) deaths were among men. In addition, 7,093 dead crows and 5,343 other dead birds with WNV infection were reported from 42 states and the District of Columbia; 7,333 WNV infections in mammals (7,320 equines, three canines, and 10 other species) have been reported from 35 states (Alabama, Arkansas, Colorado, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Wisconsin, and Wyoming). During 2002, WNV seroconversions have been reported in 365 sentinel chicken flocks from Florida, Iowa, Nebraska, Pennsylvania, Texas, and New York City; 4,782 WNV-positive mosquito pools have been reported from 26 states (Alabama, Arkansas, Connecticut, Delaware, Georgia, Illinois, Indiana, Iowa, Kentucky, Maryland, Massachusetts, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Vermont, and Virginia), New York City, and the District of Columbia.

Additional information about WNV activity is available from CDC at http://www.cdc.gov/ncidod/dvbid/westnile/index.htm and http://www.cindi.usgs.gov/hazard/event/west_nile/west_nile.html.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending October 26, 2002, with historical data



* No measles cases were reported for the current 4-week period yielding a ratio for week 43 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 October 26, 2002 (43rd Week)*

		Cum. 2002	Cum. 2001		Cum. 2002	Cum. 2001
Anthrax		2	14	Encephalitis: West Nile†	1,178	50
Botulism:	foodborne	12	33	Hansen disease (leprosy)†	58	57
	infant	47	80	Hantavirus pulmonary syndrome†	11	7
	other (wound & unspecified)	20	13	Hemolytic uremic syndrome, postdiarrheal†	161	150
Brucellosis†		64	109	HIV infection, pediatric†§	137	166
Chancroid		59	31	Plague	-	2
Cholera		4	4	Poliomyelitis, paralytic	-	-
Cyclosporiasis†		156	134	Psittacosis†	17	13
Diphtheria		1	2	Q fever†	39	22
Ehrlichiosis:	human granulocytic (HGE)†	283	189	Rabies, human	2	1
	human monocytic (HME)†	150	99	Streptococcal toxic-shock syndrome†	64	63
	other and unspecified	7	5	Tetanus	19	26
Encephalitis:	California serogroup viral†	103	100	Toxic-shock syndrome	94	97
	eastern equine†	2	8	Trichinosis	12	21
	Powassan†	-	-	Tularemia†	54	119
	St. Louis†	7	76	Yellow fever	1	-
	western equine†	2	-			

-: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 September 29, 2002.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending October 26, 2002, and October 27, 2001 (43rd Week)*

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli, Enterohemorrhagic*			
							O157:H7		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	31,555	32,310	632,482	635,920	2,380	3,241	2,935	2,705	136	123
NEW ENGLAND	1,236	1,191	22,040	19,903	157	131	238	222	31	36
Maine	27	40	1,413	1,093	10	17	33	25	5	1
N.H.	25	31	1,308	1,132	26	14	29	30	-	3
Vt.	12	13	769	511	29	30	12	13	1	1
Mass.	629	654	8,925	8,503	57	50	108	108	9	9
R.I.	82	84	2,275	2,422	19	4	13	13	-	1
Conn.	461	369	7,350	6,242	16	16	43	33	16	21
MID. ATLANTIC	7,170	8,631	72,819	68,600	286	290	205	204	-	-
Upstate N.Y.	482	1,166	14,037	11,319	110	86	150	131	-	-
N.Y. City	4,225	4,592	23,170	24,556	115	106	12	15	-	-
N.J.	1,117	1,347	10,290	10,996	10	14	43	58	-	-
Pa.	1,346	1,526	25,322	21,729	51	84	N	N	-	-
E.N. CENTRAL	3,291	2,285	106,305	118,303	758	1,457	734	705	14	10
Ohio	663	425	24,036	31,192	113	151	138	180	12	8
Ind.	422	266	13,448	12,892	39	73	55	73	-	-
Ill.	1,556	993	29,197	35,638	83	470	158	161	-	-
Mich.	500	457	26,460	24,980	96	168	128	85	2	2
Wis.	150	144	13,164	13,601	427	595	255	206	-	-
W.N. CENTRAL	507	686	35,196	32,387	358	448	449	437	31	33
Minn.	113	106	7,885	6,779	189	137	149	176	26	27
Iowa	67	73	4,452	4,145	40	77	111	73	-	-
Mo.	229	336	12,637	11,606	32	42	62	55	N	N
N. Dak.	1	2	740	839	6	12	3	18	-	2
S. Dak.	4	22	1,813	1,460	28	6	37	37	2	3
Nebr.	44	61	2,456	2,641	47	171	54	58	3	1
Kans.	49	86	5,213	4,917	16	3	33	20	-	-
S. ATLANTIC	9,368	9,799	121,688	122,451	291	321	251	211	36	24
Del.	155	217	2,215	2,331	3	6	7	4	-	1
Md.	1,412	1,510	13,564	12,569	21	34	24	27	-	-
D.C.	453	641	2,757	2,676	4	11	-	-	-	-
Va.	612	797	12,972	14,917	14	24	55	47	10	3
W. Va.	72	59	1,999	1,961	2	2	8	10	-	-
N.C.	782	776	20,551	17,860	31	24	41	46	-	-
S.C.	649	598	10,031	13,001	6	7	5	15	-	-
Ga.	1,356	1,028	24,721	26,355	126	143	52	36	10	9
Fla.	3,877	4,173	32,878	30,781	84	70	59	26	16	11
E.S. CENTRAL	1,469	1,496	39,176	40,931	107	42	93	122	-	-
Ky.	253	278	7,307	7,415	7	4	30	62	-	-
Tenn.	620	473	13,286	12,068	51	12	39	35	-	-
Ala.	298	378	10,556	11,421	42	13	17	16	-	-
Miss.	298	367	8,027	10,027	7	13	7	9	-	-
W.S. CENTRAL	3,336	3,371	88,868	88,462	35	113	58	173	-	-
Ark.	190	158	6,094	6,228	8	6	10	15	-	-
La.	815	654	16,086	15,257	5	7	2	7	-	-
Okla.	156	204	8,875	8,579	17	12	21	27	-	-
Tex.	2,175	2,355	57,813	58,398	5	88	25	124	-	-
MOUNTAIN	1,043	1,135	38,298	38,287	143	199	314	250	17	14
Mont.	9	14	1,754	1,545	5	30	27	17	-	-
Idaho	24	19	2,072	1,618	29	21	44	63	8	3
Wyo.	8	3	767	676	9	6	13	8	2	2
Colo.	212	262	11,437	10,849	50	38	83	83	3	6
N. Mex.	65	133	5,123	5,160	18	22	10	13	3	3
Ariz.	444	418	12,196	12,167	15	7	33	21	1	-
Utah	53	87	2,055	2,051	13	69	78	30	-	-
Nev.	228	199	2,894	4,221	4	6	26	15	-	-
PACIFIC	4,134	3,716	108,092	106,596	245	240	593	381	7	6
Wash.	386	385	12,053	11,263	43	U	126	108	-	-
Oreg.	260	154	5,596	6,121	35	47	212	63	7	6
Calif.	3,379	3,100	83,827	83,693	164	189	211	189	-	-
Alaska	22	17	2,971	2,193	1	1	7	4	-	-
Hawaii	87	60	3,645	3,326	2	3	37	17	-	-
Guam	2	11	-	342	-	-	N	N	-	-
P.R.	915	932	1,997	2,243	-	-	-	2	-	-
V.I.	67	2	125	125	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	138	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 September 29, 2002.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 26, 2002, and October 27, 2001 (43rd Week)*

Reporting Area	*Escherichia coli* Enterohemorrhagic — Shiga Toxin Positive, Not Serogrouped Cum. 2002	Cum. 2001	Giardiasis Cum. 2002	Gonorrhea Cum. 2002	Cum. 2001	*Haemophilus influenzae*, Invasive — All Ages, All Serotypes Cum. 2002	Cum. 2001	Age <5 Years Serotype B Cum. 2002	Cum. 2001
UNITED STATES	32	15	13,842	267,427	294,471	1,231	1,199	19	20
NEW ENGLAND	1	1	1,385	6,143	5,660	89	89	-	1
Maine	-	-	176	111	113	1	2	-	-
N.H.	-	-	36	109	152	8	4	-	-
Vt.	1	1	119	81	53	7	3	-	-
Mass.	-	-	682	2,707	2,629	48	39	-	1
R.I.	-	-	129	753	680	10	5	-	-
Conn.	-	-	243	2,382	2,033	15	36	-	-
MID. ATLANTIC	-	2	3,011	33,356	34,241	225	177	3	3
Upstate N.Y.	-	-	1,016	7,223	6,915	99	58	2	-
N.Y. City	-	-	1,108	9,677	10,335	54	46	-	-
N.J.	-	-	306	5,724	6,058	48	40	-	-
Pa.	-	2	581	10,732	10,933	24	33	1	3
E.N. CENTRAL	11	5	2,660	51,617	62,325	180	225	3	2
Ohio	10	5	779	13,397	17,393	69	59	-	1
Ind.	-	-	-	5,832	5,691	36	43	1	-
Ill.	-	-	638	15,634	19,780	57	80	-	-
Mich.	1	-	752	12,016	14,463	11	12	2	-
Wis.	-	-	491	4,738	4,998	7	31	-	1
W.N. CENTRAL	1	3	1,652	13,746	13,828	54	59	1	1
Minn.	1	-	637	2,418	2,167	39	32	1	-
Iowa	-	-	266	1,045	1,063	1	-	-	-
Mo.	N	N	400	7,199	7,180	10	16	-	-
N. Dak.	-	3	11	42	38	-	7	-	-
S. Dak.	-	-	62	222	232	-	-	-	-
Nebr.	-	-	133	713	958	1	2	-	1
Kans.	-	-	143	2,107	2,190	3	2	-	-
S. ATLANTIC	1	-	2,390	69,456	76,493	316	298	4	1
Del.	-	-	44	1,337	1,413	-	-	-	-
Md.	-	-	102	7,268	7,502	75	72	2	-
D.C.	-	-	32	2,298	2,388	-	-	-	-
Va.	-	-	235	7,792	8,938	28	27	-	-
W. Va.	1	-	48	789	561	15	14	-	1
N.C.	-	-	-	13,307	14,189	30	44	-	-
S.C.	-	-	114	6,061	9,309	12	5	-	-
Ga.	-	-	752	13,669	14,611	80	77	-	-
Fla.	-	-	1,063	16,935	17,582	76	59	2	-
E.S. CENTRAL	7	3	309	22,517	26,415	58	64	1	-
Ky.	7	3	-	3,125	2,967	4	2	-	-
Tenn.	-	-	144	7,802	8,133	29	34	-	-
Ala.	-	-	165	6,796	8,754	16	26	1	-
Miss.	-	-	-	4,794	6,561	9	2	-	-
W.S. CENTRAL	-	-	203	39,874	43,422	54	46	2	1
Ark.	-	-	143	3,861	3,813	2	-	-	-
La.	-	-	3	9,909	10,459	7	9	-	-
Okla.	-	-	57	3,825	3,895	40	36	-	-
Tex.	-	-	-	22,279	25,255	5	1	2	1
MOUNTAIN	11	1	1,368	8,145	8,647	144	126	2	7
Mont.	-	-	77	77	86	-	-	-	-
Idaho	-	-	104	77	62	2	1	-	-
Wyo.	-	-	27	54	67	1	1	-	-
Colo.	11	1	447	2,839	2,616	29	34	-	-
N. Mex.	-	-	135	1,047	828	23	21	-	1
Ariz.	-	-	178	3,006	3,282	63	52	1	4
Utah	-	-	272	208	157	16	6	-	-
Nev.	-	-	128	837	1,549	10	11	1	2
PACIFIC	-	-	864	22,573	23,440	111	115	3	4
Wash.	-	-	334	2,376	2,497	3	4	2	-
Oreg.	-	-	363	713	965	53	32	-	-
Calif.	-	-	-	18,415	19,117	22	52	1	4
Alaska	-	-	90	498	351	1	6	-	-
Hawaii	-	-	77	571	510	32	21	-	-
Guam	-	-	-	-	44	-	-	-	-
P.R.	-	-	36	292	501	1	1	-	-
V.I.	-	-	-	31	22	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	1	13	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. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 26, 2002, and October 27, 2001 (43rd Week)*

	Haemophilus influenzae, Invasive				Hepatitis (Viral, Acute), By Type					
	Age <5 Years									
	Non-Serotype B		Unknown Serotype		A		B		C; Non-A, Non-B	
Reporting Area	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	196	197	15	25	6,966	8,369	5,454	5,925	12,238	3,326
NEW ENGLAND	11	15	-	-	259	576	196	114	21	32
Maine	-	-	-	-	8	10	9	5	-	-
N.H.	-	1	-	-	11	15	19	13	-	-
Vt.	-	-	-	-	1	14	4	5	12	7
Mass.	8	7	-	-	122	272	104	25	9	25
R.I.	-	-	-	-	30	55	24	25	-	-
Conn.	3	7	-	-	87	210	36	41	-	-
MID. ATLANTIC	27	27	-	3	876	1,046	1,239	1,142	1,409	1,107
Upstate N.Y.	11	7	-	1	161	208	110	102	60	26
N.Y. City	8	9	-	-	412	364	624	533	-	-
N.J.	5	4	-	-	117	247	316	247	1,322	1,024
Pa.	3	7	-	2	186	227	189	260	27	57
E.N. CENTRAL	28	35	1	2	910	1,023	519	773	87	148
Ohio	8	10	1	-	277	194	83	88	7	8
Ind.	7	6	-	1	41	89	42	43	-	1
Ill.	11	13	-	-	246	384	121	122	13	11
Mich.	1	-	-	1	209	288	273	483	67	128
Wis.	1	6	-	-	137	68	-	37	-	-
W.N. CENTRAL	5	3	3	6	269	328	189	178	697	985
Minn.	4	2	1	2	37	34	25	19	-	9
Iowa	-	-	-	-	70	30	13	21	1	-
Mo.	-	-	2	4	75	73	103	101	678	964
N. Dak.	-	1	-	-	1	3	4	1	-	-
S. Dak.	-	-	-	-	3	2	2	1	1	-
Nebr.	1	-	-	-	17	31	22	24	13	5
Kans.	-	-	-	-	66	155	20	11	4	7
S. ATLANTIC	44	40	2	6	2,057	1,953	1,391	1,229	149	87
Del.	-	-	-	-	11	14	7	24	5	10
Md.	4	7	-	1	264	206	103	120	6	7
D.C.	-	-	-	-	65	43	18	11	-	-
Va.	4	5	-	-	121	112	164	150	11	-
W. Va.	1	1	1	1	17	18	18	20	3	9
N.C.	3	2	-	4	192	193	202	173	23	19
S.C.	2	1	-	-	54	65	102	28	4	6
Ga.	17	16	-	-	391	818	338	360	29	-
Fla.	13	8	1	-	942	484	439	343	68	36
E.S. CENTRAL	12	12	1	3	230	344	298	397	174	178
Ky.	1	-	-	1	41	119	45	47	3	9
Tenn.	6	6	-	1	104	129	114	195	25	60
Ala.	3	5	1	1	32	69	63	77	5	4
Miss.	2	1	-	-	53	27	76	78	141	105
W.S. CENTRAL	12	7	-	-	445	741	440	686	9,553	627
Ark.	1	-	-	-	41	63	75	82	7	10
La.	2	2	-	-	49	79	78	106	44	133
Okla.	7	5	-	-	48	103	43	84	5	4
Tex.	2	-	-	-	307	496	244	414	9,497	480
MOUNTAIN	34	21	7	1	496	613	517	391	57	49
Mont.	-	-	-	-	13	10	9	3	1	1
Idaho	1	-	-	-	25	51	6	11	-	2
Wyo.	-	-	-	-	3	7	17	3	5	6
Colo.	2	2	-	-	72	77	67	85	18	8
N. Mex.	6	9	1	1	26	35	128	108	1	11
Ariz.	16	8	5	-	260	312	192	118	4	9
Utah	5	2	-	-	52	61	49	22	4	3
Nev.	4	-	1	-	45	60	49	41	24	9
PACIFIC	23	37	1	4	1,424	1,745	665	1,015	91	113
Wash.	1	2	-	2	137	125	56	118	18	19
Oreg.	5	5	-	-	58	91	110	141	16	13
Calif.	13	28	1	1	1,218	1,499	490	730	57	81
Alaska	1	1	-	-	9	14	3	9	-	-
Hawaii	3	1	-	1	2	16	6	17	-	-
Guam	-	-	-	-	-	1	-	-	-	-
P.R.	-	1	-	-	89	183	77	231	-	1
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	37	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. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 26, 2002, and October 27, 2001 (43rd 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	890	890	470	496	13,734	12,978	1,054	1,250	22†	106§
NEW ENGLAND	84	58	51	45	3,942	3,764	56	81	-	5
Maine	2	7	5	1	53	-	5	4	-	-
N.H.	4	9	4	4	215	90	7	2	-	-
Vt.	36	5	3	2	30	16	4	1	-	1
Mass.	29	19	26	23	1,133	1,080	21	44	-	3
R.I.	2	9	1	1	306	436	5	7	-	-
Conn.	11	9	12	14	2,205	2,142	14	23	-	1
MID. ATLANTIC	245	207	140	92	8,143	7,081	257	382	7	19
Upstate N.Y.	83	56	51	24	4,335	2,945	38	55	1	4
N.Y. City	46	40	30	23	142	61	163	226	6	6
N.J.	22	21	30	16	1,448	1,927	28	59	-	1
Pa.	94	90	29	29	2,218	2,148	28	42	-	8
E.N. CENTRAL	207	254	53	78	71	681	116	151	3	10
Ohio	93	110	23	13	53	37	20	22	1	3
Ind.	17	17	6	8	18	22	12	16	2	4
Ill.	-	24	1	23	-	30	28	62	-	3
Mich.	69	63	17	22	-	5	44	33	-	-
Wis.	28	40	6	12	U	587	12	18	-	-
W.N. CENTRAL	45	44	16	15	234	345	52	33	3	4
Minn.	11	9	3	-	151	279	16	6	1	2
Iowa	11	8	2	2	32	29	4	6	-	-
Mo.	11	18	7	8	38	31	14	13	2	2
N. Dak.	-	1	1	-	-	-	1	-	-	-
S. Dak.	2	3	1	-	1	-	1	-	-	-
Nebr.	10	4	1	1	6	4	5	2	-	-
Kans.	-	1	1	4	6	2	11	6	-	-
S. ATLANTIC	165	150	68	64	1,123	863	310	249	2	5
Del.	7	11	-	2	147	149	4	2	-	-
Md.	37	31	16	11	600	524	100	101	-	3
D.C.	5	7	-	-	20	10	17	13	-	-
Va.	20	20	7	12	133	114	30	44	-	1
W. Va.	N	N	-	5	17	11	3	1	-	-
N.C.	11	8	6	5	117	37	20	16	-	-
S.C.	7	10	8	5	20	5	7	6	-	-
Ga.	14	11	11	11	2	-	69	40	-	1
Fla.	64	52	20	13	67	13	60	26	2	-
E.S. CENTRAL	34	54	15	21	42	61	20	35	-	2
Ky.	14	12	2	7	21	22	8	14	-	2
Tenn.	13	26	9	8	19	24	3	11	-	-
Ala.	7	12	4	6	2	8	4	6	-	-
Miss.	-	4	-	-	-	7	5	4	-	-
W.S. CENTRAL	8	21	12	31	19	80	14	77	2	1
Ark.	-	-	-	1	3	-	2	3	-	-
La.	1	6	-	-	3	8	4	6	-	-
Okla.	3	3	7	2	-	-	8	3	-	-
Tex.	4	12	5	28	13	72	-	65	2	1
MOUNTAIN	38	46	27	33	19	11	41	50	1	2
Mont.	3	-	-	-	-	-	2	3	-	-
Idaho	1	3	2	1	4	5	-	3	-	1
Wyo.	1	2	-	1	1	1	-	-	-	-
Colo.	6	13	6	9	3	-	21	21	-	-
N. Mex.	2	3	3	7	1	-	3	3	-	-
Ariz.	8	15	12	6	3	1	7	9	-	1
Utah	12	6	3	2	6	1	5	3	-	-
Nev.	5	4	1	7	1	3	3	8	1	-
PACIFIC	64	56	88	117	141	92	188	192	4	58
Wash.	7	8	8	8	10	7	21	9	-	15
Oreg.	N	N	9	11	15	10	9	14	-	3
Calif.	56	42	63	92	113	73	149	157	3	33
Alaska	-	1	-	-	3	2	2	1	-	-
Hawaii	1	5	8	6	N	N	7	11	1	7
Guam	-	-	-	-	-	-	-	1	-	-
P.R.	-	2	1	-	N	N	-	5	-	1
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 22 cases reported, 9 were indigenous and 13 were imported from another country.
§ Of 106 cases reported, 53 were indigenous and 53 were imported from another country.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 26, 2002, and October 27, 2001 (43rd Week)*

Reporting Area	Meningococcal Disease Cum. 2002	Meningococcal Disease Cum. 2001	Mumps Cum. 2002	Mumps Cum. 2001	Pertussis Cum. 2002	Pertussis Cum. 2001	Rabies, Animal Cum. 2002	Rabies, Animal Cum. 2001
UNITED STATES	1,384	1,936	220	201	6,189	4,459	5,071	6,034
NEW ENGLAND	83	92	7	1	492	417	792	627
Maine	7	4	-	-	12	21	53	60
N.H.	11	12	4	-	17	16	43	19
Vt.	4	5	-	-	107	33	86	58
Mass.	42	49	2	1	318	325	254	228
R.I.	5	4	-	-	13	5	68	59
Conn.	14	18	1	-	25	17	288	203
MID. ATLANTIC	130	215	25	24	387	292	981	1,117
Upstate N.Y.	39	56	7	3	281	125	610	686
N.Y. City	21	38	2	12	13	47	10	31
N.J.	25	35	-	3	3	18	157	165
Pa.	45	86	16	6	90	102	204	235
E.N. CENTRAL	185	304	29	24	742	714	140	132
Ohio	71	79	12	1	366	253	36	42
Ind.	29	34	2	2	103	78	31	2
Ill.	36	77	7	16	127	78	30	24
Mich.	37	67	7	3	47	129	43	46
Wis.	12	47	1	2	99	176	-	18
W.N. CENTRAL	128	130	14	7	632	262	340	326
Minn.	31	18	3	3	318	105	36	42
Iowa	18	27	1	-	129	34	67	76
Mo.	43	46	5	-	120	89	49	39
N. Dak.	-	6	1	-	-	4	12	33
S. Dak.	2	5	-	-	6	4	65	48
Nebr.	26	14	-	1	8	5	-	4
Kans.	8	14	4	3	51	21	111	84
S. ATLANTIC	249	293	23	34	360	209	2,042	2,102
Del.	7	3	-	-	3	-	24	30
Md.	8	38	5	5	56	35	199	431
D.C.	-	-	-	-	2	1	-	-
Va.	36	36	3	6	124	35	418	399
W. Va.	4	12	-	-	31	2	157	123
N.C.	30	60	2	5	38	63	618	499
S.C.	27	29	2	5	41	31	123	100
Ga.	31	43	4	8	20	20	347	352
Fla.	106	72	7	5	45	22	156	168
E.S. CENTRAL	79	122	13	9	220	140	146	196
Ky.	12	21	3	3	84	45	25	26
Tenn.	34	55	2	1	96	56	94	106
Ala.	20	30	3	-	31	35	23	60
Miss.	13	16	5	5	9	4	4	4
W.S. CENTRAL	168	288	16	11	1,461	493	106	965
Ark.	23	21	-	-	459	79	3	-
La.	30	69	1	2	7	8	-	7
Okla.	19	27	-	-	66	26	103	57
Tex.	96	171	15	9	929	380	-	901
MOUNTAIN	74	83	18	14	796	1,182	272	237
Mont.	2	4	-	1	5	30	18	31
Idaho	3	7	2	1	62	170	37	28
Wyo.	-	5	-	1	11	1	18	28
Colo.	21	31	2	3	326	268	59	-
N. Mex.	4	10	1	2	151	127	7	15
Ariz.	23	13	1	1	106	496	113	120
Utah	4	7	7	1	90	74	12	14
Nev.	17	6	5	4	45	16	8	1
PACIFIC	288	409	75	77	1,099	750	252	332
Wash.	54	58	-	1	369	134	-	-
Oreg.	41	54	N	N	172	47	13	4
Calif.	182	283	61	38	537	528	215	290
Alaska	4	2	-	1	4	9	24	38
Hawaii	7	12	14	37	17	32	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	5	5	-	1	2	-	49	82
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	1	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. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 26, 2002, and October 27, 2001 (43rd Week)*

Reporting Area	Rocky Mountain Spotted Fever		Rubella: Rubella		Rubella: Congenital Rubella		Salmonellosis	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	878	514	13	21	2	-	33,510	33,112
NEW ENGLAND	7	3	-	-	-	-	1,857	2,075
Maine	-	-	-	-	-	-	130	158
N.H.	-	1	-	-	-	-	118	150
Vt.	-	-	-	-	-	-	68	73
Mass.	4	2	-	-	-	-	1,027	1,192
R.I.	3	-	-	-	-	-	135	110
Conn.	-	-	-	-	-	-	379	392
MID. ATLANTIC	38	31	1	8	-	-	4,151	4,369
Upstate N.Y.	7	2	1	1	-	-	1,288	1,003
N.Y. City	8	2	-	6	-	-	1,161	1,098
N.J.	10	9	-	1	-	-	621	1,043
Pa.	13	18	-	-	-	-	1,081	1,225
E.N. CENTRAL	15	16	1	2	-	-	4,491	4,274
Ohio	10	2	-	-	-	-	1,207	1,138
Ind.	2	1	-	-	-	-	396	446
Ill.	-	12	-	2	-	-	1,399	1,216
Mich.	3	1	1	-	-	-	752	750
Wis.	-	-	-	-	-	-	737	724
W.N. CENTRAL	97	67	-	3	-	-	2,232	1,946
Minn.	-	-	-	-	-	-	493	532
Iowa	3	2	-	1	-	-	436	294
Mo.	89	61	-	1	-	-	747	527
N. Dak.	-	1	-	-	-	-	25	54
S. Dak.	1	2	-	-	-	-	99	139
Nebr.	4	1	-	-	-	-	150	137
Kans.	-	-	-	1	-	-	282	263
S. ATLANTIC	451	251	5	5	-	-	9,128	7,651
Del.	4	10	-	-	-	-	76	84
Md.	52	36	-	1	-	-	802	669
D.C.	1	-	-	-	-	-	62	72
Va.	34	23	-	-	-	-	963	1,143
W. Va.	2	-	-	-	-	-	124	112
N.C.	260	142	-	-	-	-	1,252	1,134
S.C.	65	27	-	2	-	-	683	762
Ga.	21	9	-	-	-	-	1,637	1,451
Fla.	12	4	5	2	-	-	3,529	2,224
E.S. CENTRAL	93	98	-	-	1	-	2,646	2,317
Ky.	5	2	-	-	-	-	319	330
Tenn.	69	69	-	-	1	-	666	553
Ala.	16	14	-	-	-	-	721	617
Miss.	3	13	-	-	-	-	940	817
W.S. CENTRAL	158	36	2	1	-	-	2,745	4,262
Ark.	97	5	-	-	-	-	914	783
La.	-	2	-	-	-	-	581	760
Okla.	61	29	-	-	-	-	427	407
Tex.	-	-	2	1	-	-	823	2,312
MOUNTAIN	13	11	1	-	-	-	1,834	1,837
Mont.	1	1	-	-	-	-	77	62
Idaho	-	1	-	-	-	-	118	120
Wyo.	4	2	-	-	-	-	59	55
Colo.	2	2	-	-	-	-	482	521
N. Mex.	1	1	-	-	-	-	273	242
Ariz.	-	-	-	-	-	-	492	496
Utah	-	3	1	-	-	-	173	192
Nev.	5	1	-	-	-	-	160	149
PACIFIC	6	1	3	2	1	-	4,426	4,381
Wash.	-	-	-	-	-	-	432	441
Oreg.	2	1	-	-	-	-	315	240
Calif.	4	-	3	1	-	-	3,390	3,357
Alaska	-	-	-	-	-	-	52	36
Hawaii	-	-	-	1	1	-	237	307
Guam	-	-	-	-	-	-	-	19
P.R.	-	-	-	3	-	-	182	797
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	25	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. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 26, 2002, and October 27, 2001 (43rd 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	14,791	15,886	3,438	3,086	1,968	2,186	205	351
NEW ENGLAND	275	270	163	193	18	105	2	37
Maine	10	6	20	10	-	-	-	-
N.H.	11	6	32	N	-	-	N	N
Vt.	1	7	9	14	5	7	1	1
Mass.	165	190	87	58	N	N	N	N
R.I.	16	17	15	12	13	4	1	3
Conn.	72	44	-	99	-	94	-	33
MID. ATLANTIC	1,137	1,289	558	564	92	141	55	90
Upstate N.Y.	251	420	256	227	80	134	55	90
N.Y. City	355	356	133	155	U	U	U	U
N.J.	332	246	118	115	N	N	N	N
Pa.	199	267	51	67	12	7	-	-
E.N. CENTRAL	1,502	3,756	596	697	186	154	86	105
Ohio	553	2,505	188	177	45	1	11	-
Ind.	84	186	46	56	136	153	50	48
Ill.	579	520	105	221	2	-	-	57
Mich.	151	269	257	192	3	-	N	N
Wis.	135	276	-	51	N	N	25	-
W.N. CENTRAL	882	1,541	211	321	409	130	46	53
Minn.	191	360	108	143	292	58	46	44
Iowa	111	332	-	-	N	N	N	N
Mo.	158	276	41	68	5	9	-	-
N. Dak.	15	20	-	17	1	6	-	9
S. Dak.	150	410	12	11	1	3	-	-
Nebr.	179	77	18	35	29	19	N	N
Kans.	78	66	32	47	81	35	N	N
S. ATLANTIC	5,453	2,197	702	508	1,044	1,163	7	5
Del.	231	14	2	4	3	6	N	N
Md.	966	130	120	N	N	N	N	N
D.C.	48	51	6	21	48	5	1	3
Va.	791	297	67	69	N	N	N	N
W. Va.	9	8	19	18	37	37	6	2
N.C.	368	305	111	131	N	N	U	U
S.C.	102	227	34	10	165	238	N	N
Ga.	1,284	378	149	161	267	354	N	N
Fla.	1,654	787	194	94	524	523	N	N
E.S. CENTRAL	1,189	1,459	98	101	116	210	-	-
Ky.	143	684	18	35	14	24	N	N
Tenn.	81	87	80	66	102	185	N	N
Ala.	657	185	-	-	-	1	N	N
Miss.	308	503	-	-	-	-	-	-
W.S. CENTRAL	1,261	2,481	108	283	65	245	5	61
Ark.	164	517	6	-	6	14	-	-
La.	336	211	-	1	59	231	2	61
Okla.	496	66	39	37	N	N	3	-
Tex.	265	1,687	63	245	N	N	-	-
MOUNTAIN	744	807	489	349	38	34	4	-
Mont.	3	5	-	-	-	-	-	-
Idaho	14	34	9	7	N	N	N	N
Wyo.	8	7	7	11	9	5	-	-
Colo.	154	218	125	135	-	-	-	-
N. Mex.	185	108	93	72	29	27	-	-
Ariz.	308	318	226	121	-	-	N	N
Utah	29	49	29	3	-	-	4	-
Nev.	43	68	-	-	-	2	-	-
PACIFIC	2,348	2,086	513	70	-	4	-	-
Wash.	140	174	65	-	-	-	N	N
Oreg.	98	98	N	N	N	N	N	N
Calif.	2,051	1,755	358	-	N	N	N	N
Alaska	6	6	-	-	-	-	N	N
Hawaii	53	53	90	70	-	4	-	-
Guam	-	42	-	1	-	-	-	-
P.R.	7	16	N	N	-	-	N	N
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	-	-	U	U
C.N.M.I.	17	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. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 26, 2002, and October 27, 2001 (43rd Week)*

	Syphilis				Tuberculosis		Typhoid Fever	
	Primary & Secondary		Congenital					
Reporting Area	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	5,157	4,942	278	412	9,611	11,380	210	300
NEW ENGLAND	118	50	-	4	307	378	14	15
Maine	2	-	-	-	10	15	-	1
N.H.	7	1	-	-	12	14	-	2
Vt.	1	2	-	-	-	4	-	-
Mass.	79	28	-	3	178	197	8	9
R.I.	6	9	-	-	30	51	-	-
Conn.	23	10	-	1	77	97	6	3
MID. ATLANTIC	555	428	53	65	1,741	1,888	47	99
Upstate N.Y.	27	16	6	4	236	293	9	15
N.Y. City	344	230	21	30	887	942	23	41
N.J.	127	104	25	31	418	417	11	36
Pa.	57	78	1	-	200	236	4	7
E.N. CENTRAL	887	854	42	57	999	1,149	18	32
Ohio	127	69	3	2	163	225	6	4
Ind.	61	136	-	8	99	81	2	2
Ill.	265	308	26	37	487	545	1	17
Mich.	412	318	13	6	209	233	4	5
Wis.	22	23	-	4	41	65	5	4
W.N. CENTRAL	87	85	-	9	443	443	8	14
Minn.	44	31	-	2	189	190	3	6
Iowa	2	4	-	-	24	34	-	-
Mo.	23	23	-	5	110	109	1	8
N. Dak.	-	-	-	-	1	3	-	-
S. Dak.	-	-	-	-	9	12	-	-
Nebr.	3	8	-	-	23	29	4	-
Kans.	15	19	-	2	87	66	-	-
S. ATLANTIC	1,385	1,696	63	100	1,883	2,142	34	38
Del.	10	12	-	-	13	15	-	1
Md.	163	225	13	4	234	184	7	10
D.C.	52	33	1	2	-	51	-	-
Va.	56	87	1	4	145	215	2	11
W. Va.	2	4	-	-	28	26	-	-
N.C.	241	385	18	12	286	287	1	2
S.C.	111	208	7	20	141	150	-	-
Ga.	292	324	9	22	315	370	8	9
Fla.	458	418	14	36	721	844	16	5
E.S. CENTRAL	397	540	17	28	597	696	4	1
Ky.	83	40	3	-	107	113	4	-
Tenn.	144	272	7	17	238	251	-	1
Ala.	136	104	4	5	169	221	-	-
Miss.	34	124	3	6	83	111	-	-
W.S. CENTRAL	699	610	62	68	1,340	1,724	5	17
Ark.	31	33	2	6	109	127	-	-
La.	129	143	-	-	-	100	-	-
Okla.	51	53	3	5	115	126	1	-
Tex.	488	381	57	57	1,116	1,371	4	17
MOUNTAIN	233	182	12	27	293	450	10	8
Mont.	-	-	-	-	6	6	-	1
Idaho	3	1	-	-	9	7	-	-
Wyo.	-	1	-	-	3	3	-	-
Colo.	33	20	1	1	48	109	5	1
N. Mex.	26	15	-	2	21	45	1	-
Ariz.	158	130	11	24	167	181	-	1
Utah	6	8	-	-	25	32	2	1
Nev.	7	7	-	-	14	67	2	4
PACIFIC	796	497	29	54	2,008	2,510	70	76
Wash.	51	42	1	-	184	199	4	4
Oreg.	17	13	1	-	92	87	2	7
Calif.	720	431	26	54	1,571	2,065	60	62
Alaska	-	-	-	-	40	42	-	1
Hawaii	8	11	1	-	121	117	4	2
Guam	-	8	-	1	-	51	-	2
P.R.	227	228	15	13	75	95	-	-
V.I.	1	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	15	U	-	U	32	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 III. Deaths in 122 U.S. cities,* week ending October 26, 2002 (43rd Week)

Reporting Area	All Causes, By Age (Years): All Ages	≥65	45-64	25-44	1-24	<1	P&I[†] Total
NEW ENGLAND	488	349	88	29	10	12	58
Boston, Mass.	155	105	31	12	3	4	29
Bridgeport, Conn.	48	34	10	2	1	1	2
Cambridge, Mass.	16	13	3	-	-	-	3
Fall River, Mass.	41	25	14	2	-	-	2
Hartford, Conn.	U	U	U	U	U	U	U
Lowell, Mass.	12	9	3	-	-	-	2
Lynn, Mass.	9	9	-	-	-	-	-
New Bedford, Mass.	23	19	4	-	-	-	3
New Haven, Conn.	50	33	9	4	1	3	6
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	4	4	-	-	-	-	-
Springfield, Mass.	38	28	4	3	1	2	1
Waterbury, Conn.	34	25	4	3	1	1	-
Worcester, Mass.	58	45	6	3	3	1	10
MID. ATLANTIC	2,063	1,450	399	147	29	38	104
Albany, N.Y.	55	41	10	2	-	2	1
Allentown, Pa.	16	11	4	-	-	1	-
Buffalo, N.Y.	92	70	15	6	-	1	9
Camden, N.J.	26	14	6	4	-	2	2
Elizabeth, N.J.	15	10	3	2	-	-	-
Erie, Pa.	52	32	15	3	1	1	3
Jersey City, N.J.	34	18	12	4	-	-	-
New York City, N.Y.	1,124	800	213	82	15	14	43
Newark, N.J.	54	26	16	8	2	2	3
Paterson, N.J.	23	12	8	-	2	1	-
Philadelphia, Pa.	199	124	42	21	4	8	7
Pittsburgh, Pa.[§]	28	21	4	1	-	2	2
Reading, Pa.	20	17	2	1	-	-	1
Rochester, N.Y.	125	98	19	4	2	2	11
Schenectady, N.Y.	U	U	U	U	U	U	U
Scranton, Pa.	34	32	2	-	-	-	2
Syracuse, N.Y.	112	90	16	3	2	1	17
Trenton, N.J.	35	20	8	6	-	1	1
Utica, N.Y.	19	14	4	-	1	-	2
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,653	1,120	352	106	31	39	109
Akron, Ohio	62	32	15	7	1	2	1
Canton, Ohio	43	35	3	3	-	2	4
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	99	70	17	5	5	2	10
Cleveland, Ohio	134	79	44	6	1	4	8
Columbus, Ohio	179	121	36	10	2	10	16
Dayton, Ohio	123	89	21	8	3	2	8
Detroit, Mich.	195	115	50	23	7	-	11
Evansville, Ind.	53	41	7	3	2	-	2
Fort Wayne, Ind.	63	46	12	4	1	-	8
Gary, Ind.	16	10	5	1	-	-	-
Grand Rapids, Mich.	48	30	10	3	1	4	1
Indianapolis, Ind.	168	113	38	9	2	6	13
Lansing, Mich.	53	29	15	5	2	2	-
Milwaukee, Wis.	130	83	34	9	2	2	11
Peoria, Ill.	42	35	6	1	-	-	2
Rockford, Ill.	60	50	8	2	-	-	10
South Bend, Ind.	40	32	3	3	-	2	-
Toledo, Ohio	94	72	16	4	1	1	2
Youngstown, Ohio	51	38	12	-	1	-	2
W.N. CENTRAL	541	375	100	30	20	16	37
Des Moines, Iowa	67	51	12	2	1	1	4
Duluth, Minn.	35	27	4	4	-	-	3
Kansas City, Kans.	26	13	9	3	1	-	-
Kansas City, Mo.	83	60	13	3	2	5	4
Lincoln, Nebr.	41	27	9	2	3	-	3
Minneapolis, Minn.	67	41	10	6	7	3	8
Omaha, Nebr.	94	69	15	4	3	3	11
St. Louis, Mo.	U	U	U	U	U	U	U
St. Paul, Minn.	57	40	10	2	2	3	2
Wichita, Kans.	71	47	18	4	1	1	2

Reporting Area	All Causes, By Age (Years): All Ages	≥65	45-64	25-44	1-24	<1	P&I[†] Total
S. ATLANTIC	1,136	690	280	103	38	25	66
Atlanta, Ga.	155	81	38	19	6	11	6
Baltimore, Md.	217	121	58	29	7	2	20
Charlotte, N.C.	113	73	28	5	2	5	15
Jacksonville, Fla.	138	91	31	10	5	1	6
Miami, Fla.	121	78	33	8	2	-	11
Norfolk, Va.	56	30	17	6	2	1	-
Richmond, Va.	56	34	14	6	2	-	-
Savannah, Ga.	61	42	10	5	2	2	3
St. Petersburg, Fla.	68	47	12	5	2	2	2
Tampa, Fla.	38	29	6	3	-	-	1
Washington, D.C.	101	58	28	7	7	1	2
Wilmington, Del.	12	6	5	-	1	-	-
E.S. CENTRAL	838	556	189	57	20	14	57
Birmingham, Ala.	214	150	43	10	4	6	13
Chattanooga, Tenn.	68	49	10	5	2	2	3
Knoxville, Tenn.	62	44	13	4	1	-	2
Lexington, Ky.	52	31	14	5	1	1	5
Memphis, Tenn.	153	86	44	16	6	1	15
Mobile, Ala.	104	71	22	6	2	3	1
Montgomery, Ala.	33	25	5	2	1	-	3
Nashville, Tenn.	152	100	38	9	3	1	15
W.S. CENTRAL	1,379	855	296	133	65	30	89
Austin, Tex.	87	53	18	12	3	1	3
Baton Rouge, La.	67	35	14	12	2	4	-
Corpus Christi, Tex.	45	31	8	2	2	2	4
Dallas, Tex.	202	123	44	20	9	6	13
El Paso, Tex.	84	58	12	11	2	1	4
Ft. Worth, Tex.	122	76	30	7	6	3	12
Houston, Tex.	303	158	73	39	29	4	20
Little Rock, Ark.	50	29	13	4	2	2	-
New Orleans, La.	35	24	6	4	1	-	-
San Antonio, Tex.	210	147	43	10	3	7	15
Shreveport, La.	60	42	12	3	3	-	9
Tulsa, Okla.	114	79	23	9	3	-	9
MOUNTAIN	936	624	183	77	35	16	57
Albuquerque, N.M.	119	83	19	13	4	-	9
Boise, Idaho	196	136	34	18	4	4	9
Colo. Springs, Colo.	50	34	11	2	2	1	2
Denver, Colo.	88	52	20	6	5	5	7
Las Vegas, Nev.	205	125	55	15	7	3	10
Ogden, Utah	19	14	2	2	1	-	2
Phoenix, Ariz.	U	U	U	U	U	U	U
Pueblo, Colo.	23	12	7	4	-	-	1
Salt Lake City, Utah	106	80	12	5	5	3	8
Tucson, Ariz.	130	88	23	12	7	-	9
PACIFIC	2,272	1,657	399	128	52	34	107
Berkeley, Calif.	20	14	5	1	-	-	1
Fresno, Calif.	123	85	27	9	1	1	11
Glendale, Calif.	54	45	7	-	-	2	-
Honolulu, Hawaii	83	68	11	-	3	1	2
Long Beach, Calif.	68	45	14	7	1	1	8
Los Angeles, Calif.	907	665	149	57	20	16	-
Pasadena, Calif.	37	30	5	1	-	1	7
Portland, Oreg.	117	84	18	7	6	2	5
Sacramento, Calif.	200	141	34	18	5	1	17
San Diego, Calif.	168	114	32	14	4	3	15
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	203	151	39	3	6	4	16
Santa Cruz, Calif.	26	22	3	1	-	-	-
Seattle, Wash.	116	86	20	7	3	-	12
Spokane, Wash.	54	40	12	1	1	-	7
Tacoma, Wash.	96	67	23	2	2	2	6
TOTAL	11,306[¶]	7,676	2,286	810	300	224	684

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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