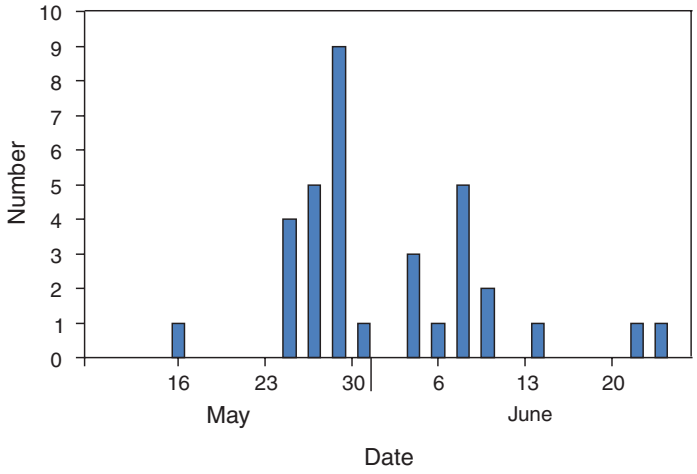
MMWR™
Morbidity and Mortality Weekly Report
Weekly October 28, 2005 / Vol. 54 / No. 42

Import-Associated Measles Outbreak — Indiana, May–June 2005

On May 29, 2005, the Indiana State Department of Health (ISDH) was notified of suspected measles in a female Indiana resident aged 6 years who was hospitalized in Cincinnati, Ohio, where she had been visiting relatives. Serologic analyses performed by the Ohio State Department of Health Laboratory and a private reference laboratory confirmed the diagnosis of measles. The hospital in Cincinnati and the girl's parents told ISDH she had been at a church gathering in northwestern Indiana on May 15 where a fellow attendee had been ill. This fellow attendee was an adolescent girl aged 17 years, an Indiana resident who had not been vaccinated for measles and who had worked during May 4–14 as a missionary in an orphanage and hospital in Bucharest, Romania, where a large measles outbreak was subsequently reported. The teen had returned to the United States with prodromal fever, cough, conjunctivitis, and coryza, traveling on international and domestic commercial airliners on May 14. The next day the teen attended the church gathering along with others who had not been vaccinated because of nonmedical exemptions. Family members recalled that the teen had a rash on May 16; measles was diagnosed retrospectively, and the teen was identified as the index patient. An outbreak investigation was conducted by ISDH and CDC. This report summarizes 1) the results of that investigation, which identified 34 persons with measles, including three who required hospitalization, 2) the measures taken to control and prevent measles transmission, and 3) recommendations to prevent future cases of measles.

Persons with measles were defined as having generalized maculopapular rash, fever of ≥101°F (≥38.3°C), and at least one of the following: cough, coryza, or conjunctivitis. Measles cases were either laboratory-confirmed or met the clinical case definition and were linked epidemiologically to a patient with confirmed measles. Onset of rash for the 34 persons identified with measles occurred during May 16–June 24 (Figure). Of the 34 cases, 33 (97%) were in church members who acquired disease either through direct exposure to the index patient or household exposure to a person with measles who had been exposed to the index patient. The remaining case was in a phlebotomist, with rash onset on June 24, who worked in an Indiana hospital where one of the measles patients had

FIGURE. Number* of measles cases by date of rash onset — Indiana, May–June 2005



* N = 34.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

The *MMWR* series of publications is published by the Coordinating Center for Health Information and Service, 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 2005;54:[inclusive page numbers].

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been admitted; however, exposure of the phlebotomist to any of the patients in the outbreak was not identified. The phlebotomist had received 1 dose of measles-containing vaccine (MCV) as a child, according to a school record.

Among the measles patients, 33 were residents of Indiana and one resided in Illinois. Patients ranged in age from 9 months to 49 years (median age: 12 years); vaccination with MCV was documented for two (6%) persons, one who had received 1 dose, and one who had received 2 doses. Of the 34 cases, 14 (41%) were laboratory confirmed either by serologic testing that detected measles-specific IgM antibodies, polymerase chain reaction analysis of urine specimens, or both; the other 20 cases were in patients with rash illness who were linked epidemiologically to the confirmed cases. Three (9%) of the 34 patients were hospitalized, two (aged 6 and 45 years) with dehydration and one (aged 34 years) with pneumonia who required 6 days of ventilator support. Among the 31 nonhospitalized patients, complications included 16 cases of diarrhea and two cases of otitis media.

The outbreak was controlled by multiple actions taken by state and local health departments in Indiana, Ohio, and Illinois. These measures included 1) voluntary isolation of patients, 2) tracing of potentially exposed patient contacts by local and state health departments in all three states and by staff members at hospitals in Indiana and Ohio, 3) administering vaccine and immunoglobulin to susceptible contacts, 4) voluntary home quarantine among those who refused vaccination, 5) checking immune status of health-care workers, 6) alerting hospitals to the measles outbreak and urging physicians to report all suspected cases, and 7) increasing media attention to health risks posed to the community by persons who refuse vaccination.

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Editorial Note: The measles outbreak described in this report was the largest in Indiana since 1990 and the largest in the United States since 1996 (*1,2*). The outbreak resulted from a gathering of church members who had not been vaccinated for measles and could have been prevented if the index patient had been adequately vaccinated before traveling to Romania.

Measles is a highly infectious acute viral illness that can cause severe pneumonia, diarrhea, encephalitis, and death. Although an effective vaccine has been available since 1963, an estimated 30–40 million measles cases and 530,000 deaths from measles occur annually worldwide (*3*). Ongoing measles transmission has been eliminated in the United States by high vac-

cination levels (*4*). Of 540 measles cases in the United States during 1997–2001, 362 (67%) were linked to imports (i.e., 196 imported cases, 138 cases epidemiologically linked to imported cases, and 28 cases associated with an imported measles virus genotype), and most measles cases could have been prevented (*5*).

Because the disease is endemic or epidemic in many parts of the world (*6*), the Advisory Committee on Immunization Practices (ACIP) recommends that all persons who travel internationally be vaccinated for measles to reduce the risk for infection among travelers (*7*). ACIP further recommends that all preschool children in the United States receive 1 dose of MCV and all school-aged children receive 2 doses of MCV. Although all states require 2 doses of MCV for children attending school, nonmedical exemptions are permitted by certain states, including Indiana. Persons choosing a nonmedical exemption from vaccination are approximately 22 times more likely to acquire measles than persons who are vaccinated (*8*). Parents and persons who opt out of vaccination should be aware of the risk that this practice places upon their children and their community. Communities of persons who have not been vaccinated can make intensive measles-containment activities necessary (*9*).

ACIP also recommends that persons who work in medical facilities be vaccinated for measles (*10*). The Indiana outbreak, in which a hospital worker contracted measles, demonstrates the need for health-care facilities to be aware of the vaccination status of their workers and require written documentation of vaccination history.

The Indiana outbreak could have been prevented by adherence to long-standing ACIP recommendations calling for measles vaccination of 1) international travelers, 2) children, and 3) health-care workers. The serious illnesses that resulted from this outbreak and the size and scope of activities and resources required to contain it underscore the need to adhere to these recommendations to sustain elimination of measles in the United States.

Acknowledgments

This report is based, in part, on contributions by the Tippecanoe County Health Dept, Lafayette, Indiana; Immunology and Virology Laboratories, Epidemiology Resource Center, Immunization Program, Indiana State Dept of Health. Hamilton County General Health District, Cincinnati Health Dept, Ohio. Illinois Dept of Health.

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Progress Toward Global Eradication of Dracunculiasis, January 2004–July 2005

In 1986, an estimated 3.5 million cases of dracunculiasis occurred in 20 countries, and 120 million persons were at risk for the disease (*1*). That year, the World Health Assembly adopted a resolution calling for the eradication of dracunculiasis, also known as Guinea worm disease (*2*). This report describes the status of the global dracunculiasis eradication program as of July 2005 (*3,4*), indicating that, during January–July 2005, a total of 8,191 indigenous cases of dracunculiasis were reported from nine countries, with at least 150 million persons at risk. Despite the substantial reductions in dracunculiasis cases since 1986, eradication of dracunculiasis will require international commitment and ongoing surveillance and intensified interventions at national, state, and local levels.

At the end of 2004, Asia was free from dracunculiasis. The remaining countries where dracunculiasis was endemic, all in Africa, had reported 50% reductions in the number of cases from 2003 to 2004 (from 32,193 to 16,026), and 11 (Benin, Cameroon, Central African Republic, Chad, India, Kenya, Mauritania, Pakistan, Senegal, Uganda, and Yemen) of the original 20 countries with endemic disease had interrupted

transmission. Uganda reported zero cases for an entire calendar year for the first time in 2004. Moreover, Benin and Mauritania reported zero indigenous cases for 16 and 13 consecutive months, respectively, as of July 2005. The overall number of villages with endemic disease decreased 33%, from 4,659 in 2003 to 3,109 in 2004 (compared with 23,735 villages in 1993). During January–July 2005, the number of indigenous cases worldwide decreased 31%, from 11,865 to 8,191, compared with the same period for 2004 (Table), and the number of cases exported from one country to another decreased 65%, from 69 to 24.

Ghana and Sudan have reported 95% of the world's cases so far in 2005. Ghana reported slightly more cases than Sudan in 2004 (7,275 versus 7,266, respectively), but Sudan has reported more cases than Ghana in 2005 (5,008 versus 2,811). Ghana reduced its reported cases by 53% during the first half of 2005, compared with a reduction of 12% from 2003 to 2004. Ghana's Nkwanta District, which was the district with the highest endemic disease in the country in 2004 (reporting 1,266 [17%] of all cases in Ghana), reduced its cases of dracunculiasis by 88% (from 1,199 to 144) from January–July 2004 to January–July 2005.

Sudan reported the last indigenous cases in its northern states in 2001. From 2003 to 2004, reported cases in the disease-endemic southern states declined by 67% (from 20,299 to 7,266), with respective reporting rates of 70% and 65%, despite the civil war in Sudan, which formally ended in January 2005. The uncertainties and continued lack of security in certain areas have delayed reporting of cases and implementation of interventions against the disease in 2005 after the peace agreement in Sudan.

Nigeria reported 495 cases in 2004 and has reduced its cases by an additional 70% in 2005. The remaining disease-endemic areas of Mali and Niger, where dracunculiasis primarily affects the nomadic Tuareg populations, were accessed later than other areas because of political insecurity. An infestation of locusts in 2004 and drought in 2005 have caused additional migrations in Niger in 2005. Drilling of new borehole wells to provide safe drinking water in 14, 12, and 14 villages of Mali, Niger, and Togo, respectively, is under way; four of these wells are already functioning in Mali. By using containment centers to voluntarily isolate a substantial share of its cases, Togo reduced its indigenous cases by 63% from 2003 to 2004 and by another 66% in 2005, despite a substantial number of cases imported from neighboring Ghana in 2004.

TABLE. Indigenous cases of dracunculiasis during January–July, by country — worldwide, 2004 and 2005

Country	No. of cases reported during January–July		% change
	2004	2005	
Sudan	5,232	5,008	-4%
Ghana	5,953	2,811	-53%
Nigeria	383	115	-70%
Mali	46	139	202%
Togo	154	53	-66%
Ethiopia	3	26	767%
Niger	57	23	-60%
Côte d'Ivoire	16	8	-50%
Burkina Faso	15	8	-47%
Benin	3	0	-100%
Mauritania	3	0	-100%
Total	**11,865**	**8,191**	**-31%**

With 40 indigenous cases in 2004 and a 47% reduction in cases in 2005, Burkina Faso is approaching interruption of transmission of dracunculiasis. Côte d'Ivoire reported an outbreak of eight cases in a village in the rebel-held area of the country; those cases were not reported to the program in time to meet a strict criterion to enable case containment (i.e., detection within 24 hours of emergence of the worm) and thus prevent transmission.

Reported by: *The Carter Center, Atlanta, Georgia; World Health Organization Collaborating Center for Research, Training, and Eradication of Dracunculiasis; Div of Parasitic Diseases, National Center for Infectious Diseases, CDC.*

Editorial Note: Dracunculiasis is a parasitic infection caused by *Dracunculus medinensis*. Persons become infected by drinking water from ponds contaminated by copepods (water fleas) that contain immature forms of the parasite. One year later, adult worms approximately 1 meter (40 inches) in length emerge through skin lesions, usually on the lower limbs, which frequently develop severe secondary bacterial infections. No effective treatment or vaccine for the disease exists, and infected persons do not become immune to future infections by the parasite. However, dracunculiasis can be prevented by 1) filtering drinking water through a finely woven cloth, 2) treating contaminated water with the larvicide ABATE® (temephos) (BASF, Ludwigshafen, Germany), 3) providing clean water from borehole or hand-dug wells (*5*), and 4) educating persons to avoid entering water sources when Guinea worms are emerging from their bodies.

Momentum toward eradication of dracunculiasis is accelerating, with substantial reductions in cases in 2004 and through July 2005. The reduction in dracunculiasis cases observed during 2005 in Nkwanta District of Ghana demonstrates what can be achieved when a program focuses attention on case detection and containment and on implementation of interventions against disease transmission, including supervision of program staff. Ensuring adequate surveillance in areas of Ghana that no longer have endemic disease is also critical to preventing reintroduction of the disease.

The reduction in cases exported from southern Sudan to the northern states and to neighboring countries indicates that the recent decline in cases in Sudan is real. The reductions in cases within southern Sudan are a net result of underreporting (e.g., poor surveillance in some areas with endemic disease), overreporting (e.g., poor surveillance resulting from failure to adhere to the case definition or reporting of fictitious cases), inaccessibility to disease-endemic areas with ongoing civil conflicts, access to newly secure areas, and the effects of interventions by Sudan's Guinea Worm Eradication Program. A challenge grant provided by the Bill & Melinda Gates Foundation in support of the dracunculiasis eradication program and the recent peace agreement should remove major obstacles to eradication in southern Sudan.

The increased rate of reduction of cases, the reduction in cases exported to other countries during 2004–2005, and the peace agreement in Sudan indicate that the final phase of the global dracunculiasis eradication program might be executed without further delays and be concluded by the target date of 2009 (*6*). Recent development of a reliable means to distinguish *D. medinensis* from other species of *Dracunculus* (i.e., by sequence analysis of the 18S RNA) (*7*) will facilitate investigation of sporadic cases at this stage by eliminating false positives in areas now free from dracunculiasis transmission and in areas reporting few cases of disease. Successful completion of the global campaign will require attention to the quality of surveillance, supervision of national eradication program staff, and implementation of interventions in each of the remaining disease-endemic countries, especially Ghana and Sudan.

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Estimated Exposure of Adolescents to State-Funded Anti-Tobacco Television Advertisements — 37 States and the District of Columbia, 1999–2003

The majority of persons who become regular smokers begin smoking during adolescence, making this period critical for preventing tobacco use (*1*). Evidence suggests that anti-tobacco mass media campaigns that include paid television advertising reduce youth smoking (*1–3*). With development of anti-tobacco programs in all 50 states during the 1990s, spurred by funding from the 1998 Master Settlement Agreement with major cigarette manufacturers, CDC, and other sources (*4*), an increasing number of states instituted anti-tobacco media campaigns. This report summarizes trends in median state estimates for the average number of state-funded anti-tobacco television advertisements to which adolescents aged 12–17 years were exposed per month in 37 states* and the District of Columbia (DC) during 1999–2003. The findings indicate that the median state estimate of the number of advertisement exposures per month increased from 0.04 in 1999 to 0.80 in 2002 but declined to 0.63 in 2003. The decline in estimated exposure from 2002 to 2003 is consistent with cutbacks in funding for state tobacco-prevention and -control programs during this period (*4*). Reduced exposure to state-funded anti-tobacco advertising might be contributing to the recent lack of substantial change in youth smoking prevalence from 2002 to 2004, which had been declining substantially since 1997 (*5*). The majority of states need to implement additional measures to ensure that adolescents are adequately exposed to effective paid anti-tobacco advertisements as part of tobacco-prevention activities.

The monthly advertisement-exposure data used in this analysis were based on target ratings points (TRPs) for adolescents aged 12–17 years obtained from Nielsen Media Research (*6*). TRPs are typically used as a mass-media exposure measure for a specific population during a defined period within a geographic media market, with 100 TRPs equaling an average of one exposure. Thus, if a television advertisement received 200

* Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin.

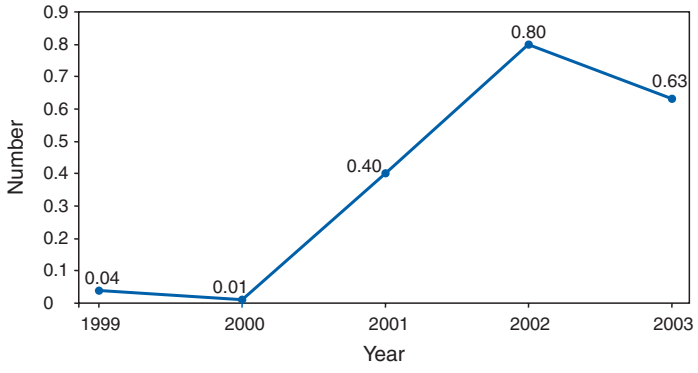
TRPs for adolescents for a given month, the average adolescent viewer in that market saw the advertisement two times. Data were available for state anti-tobacco advertisements appearing on network and cable television in the 75 largest media markets (i.e., designated market areas [DMAs]) in the United States during 1999–2003. These 75 DMAs were in 37 states and DC and accounted for 78% of television-viewing households in the United States.

DMAs are television broadcasting geographic regions with a predominantly, but not exclusively, metropolitan audience. For states with only one DMA, exposure estimates for that DMA were applied to the state as a whole. For states with multiple DMAs, estimates were averaged for all DMAs within a state to produce state-level estimates. Exposure estimates for DMAs that crossed state boundaries were assigned to the state in which the largest metropolitan area was located. Annual state estimates and 95% confidence intervals for the average number of advertisement exposures per month were calculated on the basis of means of TRPs for all 12 months. Median state estimates were calculated on the basis of average annual state estimates of monthly exposures.

The median average monthly exposure of adolescents to state-funded anti-tobacco television advertisements increased from 0.04 in 1999 to 0.80 in 2002 but decreased to 0.63 in 2003 (Figure). State advertisement exposure estimates in 2003 ranged from no exposure in Louisiana, Maryland, and South Carolina to more than two exposures per month in Indiana, Minnesota, Ohio, Utah, Virginia, and Washington (Table).

Research has demonstrated the effectiveness of several long-running programs in reducing youth smoking that used extensive state-funded media advertising and began before 1999 (*1,2*). From 1999 to 2003, estimated adolescent exposure to state-funded advertisements declined by 78%–88% in Florida, Massachusetts, and Arizona. The largest 1-year declines resulting from cutbacks in state program funding occurred in Florida from 2002 to 2003 (from 3.72 to 1.07) and in Massachusetts from 2001 to 2002 (from 1.83 to 0.40); however, the largest decline in exposure occurred in Arizona from 1999 to 2000 (from 10.25 to 4.36) after state program officials decided to adopt programs targeting a wider population in place of youth-oriented campaigns. In California, where

FIGURE. Median state estimates of the average number of state-funded anti-tobacco television advertisements to which adolescents aged 12–17 years were exposed per month, by year — 37 states* and the District of Columbia, 1999–2003



* Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin.

TABLE. Estimated average monthly number of state-funded anti-tobacco television advertisements to which adolescents aged 12–17 years were exposed, by state/area — 37 states and the District of Columbia, 2003

State/Area	Average no. of advertisements per month	(95% CI*)
Utah	10.0	(6.9–13.1)
Washington	3.1	(2.4–3.9)
Ohio	3.0	(2.5–3.5)
Indiana	2.7	(1.7–3.7)
Minnesota	2.7	(2.0–3.4)
Virginia	2.3	(1.9–2.8)
District of Columbia	1.9	(1.6–2.3)
Arkansas	1.7	(0.2–3.1)
Arizona	1.4	(0.9–1.9)
California	1.3	(1.1–1.6)
Wisconsin	1.3	(0.8–1.8)
New York	1.3	(0.7–1.8)
Colorado	1.1	(0.1–2.2)
Florida	1.1	(0.7–1.5)
West Virginia	1.0	(0.3–1.7)
Iowa	1.0	(0.4–1.5)
Hawaii	0.9	(0.5–1.3)
Nebraska	0.8	(0.6–1.0)
Georgia	0.7	(0.4–0.9)
New Mexico	0.6	(0.3–0.9)
Oregon	0.6	(0.2–1.0)
Connecticut	0.6	(0.2–1.0)
Oklahoma	0.6	(0.1–1.0)
Texas	0.5	(0.2–0.8)
Pennsylvania	0.5	(0.2–0.7)
Massachusetts	0.3	(0.0–0.6)
Michigan	0.3	(0.1–0.4)
Alabama	0.1	(0.0–0.2)
Tennessee	0.1	(0.0–0.2)
Illinois	0.1	(0.0–0.2)
Nevada	0.1	(0.0–0.1)
Kansas	0.0†	(0.0–0.1)
Missouri	0.0†	(0.0–0.1)
Kentucky	0.0†	(0.0–0.0)
North Carolina	0.0†	(0.0–0.0)
Louisiana	0.0	(0.0–0.0)
Maryland	0.0	(0.0–0.0)
South Carolina	0.0	(0.0–0.0)
Median	0.6	—
Range	0.0–10.0	—

* Confidence interval.
† Less than 0.05 advertisements per month.

the state anti-tobacco program had relatively stable funding during 1999–2003, the level of estimated youth exposure to state-funded anti-tobacco advertisements remained consistent during this period, with the annual estimated monthly exposures ranging from 1.15 to 1.79. Indiana was the only other state that maintained an estimated exposure level greater than 1.0 for all 5 years.

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Editorial Note: From 1999 to 2002, the overall estimated average monthly exposure of adolescents to state-funded anti-tobacco television advertising increased substantially. The Task Force on Community Preventive Services and CDC's *Best Practices for Comprehensive Tobacco Control Programs* both recommend that states use such paid advertising as part of their countermarketing activities (*2,7*), given that research has consistently demonstrated the role of such advertisements in preventing tobacco use (*1–3*). Moreover, sustained exposure of adolescents to such advertisements over time is important for prevention, as demonstrated in California and Indiana.

Despite these findings, the results of this report also indicate that exposure of adolescents to state-funded anti-tobacco advertisements decreased in 2003, coinciding with reduced funding for state tobacco-prevention and -control programs in response to state budget crises (*4*). From fiscal years 2002 to 2004, overall state spending on tobacco-prevention and -control programs declined by 28% in the United States. State program cuts have exceeded 75% in some states, such as Florida and Massachusetts (*4,8*). In Minnesota, program reductions were associated with reduced awareness of the state anti-tobacco campaign and a substantial increase in youth smoking susceptibility (*8*). Downward trends in adolescent exposure to state-funded anti-tobacco ads in Arizona, California, Florida, and Massachusetts were particularly noteworthy, given their long-term use of state-funded anti-tobacco advertising.

Comprehensive state tobacco-prevention and -control programs have a key role in preventing tobacco use (*1–3*). Components of effective state programs include paid anti-tobacco television advertisements as part of countermarketing activities, community-based programs, school programs, cessation-assistance efforts, and enforcement activities (*7*). An additional challenge to effective tobacco countermarketing is that adolescents were exposed to more "anti-tobacco" advertisements sponsored by the tobacco industry than to state-funded anti-tobacco advertisements (*9*). Research has indicated that tobacco industry-sponsored ads are not effective in preventing youth from smoking (*10*).

State-funded anti-tobacco advertisements, however, cannot be effective on a populationwide basis if they do not achieve adequate exposure among target audiences. At a minimum, states should make every effort to ensure that adolescents are exposed to, on average, at least one state-funded anti-tobacco television advertisement per month, given that even this low level of exposure has been shown to be associated with higher anti-tobacco sentiment and reduced smoking prevalence (*9*). Retaining sufficient levels of exposure consistently is especially important now that funding for the nationally aired and effective anti-tobacco advertisements produced by the American Legacy Foundation has been reduced (*4*).

The findings in this report are subject to at least five limitations. First, because Nielsen Media Research ratings measure the availability of audiences for advertising exposure, they do not guarantee actual viewing or recall of advertisements by adolescents. Nevertheless, Nielsen ratings are the standard approach used by corporations and others to estimate population exposure to television programs and advertising. Furthermore, research has demonstrated a dose-response relationship between estimated exposure of adolescents to anti-tobacco advertisements and their ability to recall seeing such advertisements (*9*). Second, this study did not examine the actual content of anti-tobacco advertisements. Third, the estimated exposure levels did not reflect adolescent exposure to nationally aired anti-tobacco advertisements. Fourth, these data are not nationally representative, given that no data were available from 13 states. Finally, DMAs, although they cover the majority of the population in the 37 states and DC, might not be fully representative of estimated adolescent exposure throughout each state.

Tobacco use remains the leading preventable cause of death in the United States (*1*). However, reductions in state-funded anti-tobacco television advertisements might be contributing to the recent absence of a substantial change in adolescent cigarette smoking prevalence from 2002 to 2004 (i.e., from 22.5% to 21.8% among high school students, and from 9.8% to 8.3% among middle school students; neither difference was statistically significant) (*5*). If these reductions continue, the *Healthy People 2010* goal of reducing youth smoking prevalence to 16% by 2010 might not be achieved, and the short-term cost savings that states gain by reducing their support for televised anti-tobacco advertising campaigns might produce long-term increased costs from smoking-related health effects.

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Prevalence of Epilepsy and Health-Related Quality of Life and Disability Among Adults with Epilepsy — South Carolina, 2003 and 2004

Epilepsy is a common neurologic disorder and poses substantial burdens on physical and mental health. Epilepsy can interfere with social functioning by limiting employment, educational opportunities, and interpersonal relationships and can increase the risk for death (*1*). The annual cost of cases of epilepsy in the United States, including direct medical costs and productivity losses, was estimated at $12.5 billion in 1995 (*2*). Depending on case definitions and populations studied, epilepsy affects an estimated 0.4%–1.0% of the population (*3,4*) with a lifetime prevalence of 1.8%–2.6% in certain state populations (*5,6*). This report analyzes data from the 2003 and 2004 South Carolina Behavioral Risk Factor Surveillance System (BRFSS) surveys, which included questions on epilepsy, health-related quality of life (HRQOL), and disability. This report summarizes the results of that analysis, which determined that 2.2% of adults in South Carolina had ever been told they had epilepsy, 1.1% had active epilepsy, and both groups reported worse HRQOL and higher prevalence of disability than those who had never had epilepsy. Healthcare providers should screen epilepsy patients for cognitive, emotional, and physical health problems that might negatively affect HRQOL (*6–8*). Patients with active epilepsy and recent seizures should be targeted with interventions that will decrease the risk for adverse physical (e.g., injury) and psychosocial (e.g., unemployment) outcomes that accompany continued seizures (*8*).

BRFSS is a state-based, random-digit-dialed telephone survey of the noninstitutionalized, U.S. civilian population aged ≥18 years. Data were weighted by sex, race, and age to adjust for differences between the survey population and the South Carolina population. A total of 5,926 respondents participated in the 2003 survey and 7,114 in the 2004 survey, for response rates of 41.6% and 43.8%, respectively. Results were considered significantly different if 95% confidence intervals (CIs) did not overlap.

BRFSS includes standard questions on key health-related behaviors and demographic characteristics; states can choose to add optional questions. In 2003 and 2004, South Carolina added four questions regarding epilepsy. The first question was "Have you ever been told by a doctor that you have a seizure disorder or epilepsy?" The lifetime prevalence of self-reported epilepsy was based on responses to this question, which had a response rate of 90.3%. Participants who answered yes to this question were also asked (where appropriate), "Are you currently taking any medicine to control your seizure disorder or epilepsy?", "How many seizures have you had in the last 3 months?", and "During the past 30 days, to what extent has epilepsy or its treatment interfered with your normal activities like working, school, or socializing with family or friends?" Respondents were considered to have active epilepsy if they 1) reported ever having been told by a doctor that they had a seizure disorder or epilepsy and 2) either were currently taking medicine to control epilepsy or had had one or more episodes of seizure during the preceding 3 months. Active epilepsy was categorized further by whether the respondent had had one or more seizures during the preceding 3 months.

In addition, all respondents, with and without epilepsy, were asked the following BRFSS core questions on HRQOL and activity limitation: "Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?", "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many

days during the past 30 days was your mental health not good?", and "During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?" CDC methods for calculating HRQOL were used (*9*). Finally, to determine whether respondents were disabled, they were asked the BRFSS core question, "Are you limited in any way in any activities because of physical, mental, or emotional problems?"

Results indicated that an estimated 2.2% (95% CI = 1.8%–2.5%) of South Carolina adults had ever had epilepsy and that 1.1% (CI = 0.9%–1.4%) had active epilepsy (Table). Among those with active epilepsy, an estimated 50.5% (CI = 38.9%–62.1%) had had one or more seizures during the preceding 3 months.

Adults who had ever had epilepsy had more mentally, physically, and overall unhealthy days and more activity-limitation days than those without epilepsy. Nearly half (46.7%) of those who had ever had epilepsy and 63.5% of those with active epilepsy reported some form of disability, compared with 17.9% of those without epilepsy. HRQOL factors were worse for those taking medicine to control their epilepsy than for those not taking medicine. Adults with active epilepsy had more than twice as many physically, mentally, and overall unhealthy days and activity-limitation days than those without epilepsy, and more overall unhealthy days and activity-limitation days than those with inactive epilepsy (Table). Finally, a larger proportion of adults with active epilepsy reporting a seizure during the preceding 3 months reported disability than those without epilepsy, those with inactive epilepsy, or those with active epilepsy but no seizures during the preceding 3 months.

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Editorial Note: The 2.2% estimated lifetime prevalence of epilepsy in South Carolina is similar to recent estimated lifetime prevalence rates calculated from BRFSS data in Texas, Georgia, and Tennessee (*5,6*), and the 1.1% prevalence of active epilepsy is similar to that reported for Georgia in 2002 (*6*). Results of the South Carolina BRFSS also confirm previous results indicating worse HRQOL (*5*) and indicate higher rates of disability among adults who have ever had epilepsy than among those without epilepsy. Results from the 2002 National Health Interview Survey indicated that adults who reported having seizures met criteria for serious mental illness more than four times as often as those who did not report having seizures (*7*). Nonetheless, persons with epilepsy often remain undiagnosed and untreated for depression (*1,8,10*).

Most of the overall cost of epilepsy results from treatment of persons with continuing seizures (*2*); approximately half of those in this study with active epilepsy reported seizures during the preceding 3 months. The goal of epilepsy treatment is to eliminate seizures and treatment side effects (*1*); continuing seizures might indicate inadequate treatment.

The findings in this report are subject to at least four limitations. First, all data are self-reported and not based on

TABLE. Estimated frequency* of health-related quality of life indicators and prevalence of disability, by epilepsy status — Behavioral Risk Factor Surveillance System, South Carolina, 2003–2004

	Participants			Indicators									
				Mentally unhealthy days		Physically unhealthy days		Overall unhealthy days		Activity-limitation days		Disability†	
Epilepsy status	No.	(%)	(95% CI§)	No.¶	(95% CI)	No.	(95% CI)	No.	(95% CI)	No.	(95% CI)	(%)	(95% CI)
Does not have epilepsy	11,549	(97.8)	(97.5–98.2)	3.4	(3.3–3.6)	3.7	(3.5–3.8)	6.1	(5.9–6.3)	2.4	(2.2–2.5)	(17.9)	(17.1–18.8)
Has or had epilepsy	228	(2.2)	(1.8–2.5)	7.5	(6.0–9.0)	6.9	(5.3–8.6)	11.4	(9.4–13.4)	5.8	(4.2–7.4)	(46.7)	(38.5–55.1)
Taking medicine	111	(45.2)	(36.9–53.5)	9.7	(7.6–11.8)	9.3	(6.5–12.0)	14.8	(12.1–17.6)	8.7	(5.9–11.4)	(59.8)	(48.7–70.0)
Not taking medicine	117	(54.8)	(46.5–63.1)	5.7	(3.7–7.6)	5.0	(3.2–6.8)	8.5	(6.1–10.9)	3.4	(2.0–4.9)	(35.8)	(25.3–47.9)
Had seizure during preceding 3 mos	53	(26.3)	(18.3–34.3)	10.5	(7.1–14.0)	11.7	(7.2–16.2)	16.8	(11.8–21.8)	10.1	(5.7–14.5)	(85.7)	(72.8–93.1)
No seizures during preceding 3 mos	162	(70.4)	(62.3–78.5)	6.5	(4.7–8.2)	5.1	(3.6–6.6)	9.4	(7.3–11.4)	4.2	(2.7–5.7)	(32.4)	(24.6–41.4)
No longer has epilepsy	10	(3.3)	(1.1–5.4)	—**	—	—	—	—	—	—	—	—	—
Epilepsy, inactive	105	(1.0)	(0.8–1.3)	5.4	(3.4–7.3)	4.9	(3.0–6.7)	8.3	(5.9–10.8)	3.1	(1.6–4.6)	(28.2)	(19.6–38.7)
Epilepsy, active	122	(1.1)	(0.9–1.4)	9.4	(7.2–11.6)	8.8	(6.2–11.4)	14.1	(11.2–17.0)	8.2	(5.7–10.8)	(63.5)	(52.8–73.1)
Active, no seizure during preceding 3 mos	*66*	*(49.5)*	*(37.9–61.1)*	*8.3*	*(5.3–11.2)*	*5.8*	*(3.2–8.4)*	*11.3*	*(8.0–14.5)*	*6.4*	*(3.6–9.2)*	*(41.0)*	*(27.8–55.7)*
Active, seizure during preceding 3 mos	*53*	*(50.5)*	*(38.9–62.1)*	*10.5*	*(7.1–14.0)*	*11.7*	*(7.2–16.2)*	*16.8*	*(11.8–21.8)*	*10.1*	*(5.7–14.5)*	*(85.7)*	*(72.8–93.1)*

* Adjusted for race, sex, and age to the South Carolina adult population.
† Participants responding yes to the question: "Are you limited in any way in any activities because of physical, mental, or emotional problems?"
§ Confidence interval.
¶ Mean number of days during preceding 30 days.
** Data excluded because of small sample size.

clinical diagnoses; self-reporting of epilepsy is subject to potential bias. Prevalence might be overestimated by persons reporting nonepileptic seizures, childhood febrile seizures, or seizures associated with alcohol abuse. Prevalence might be underestimated because of reluctance to disclose a stigmatizing condition (*1*) or because misdiagnosis occurred with symptoms associated with other conditions (e.g., dementia). However, the follow-up questions (e.g., regarding medication and number of seizures) tend to increase the likelihood that epilepsy prevalence data are accurate. Second, BRFSS data exclude children and adolescents, for whom prevalence is high (*1*), and also exclude persons with no telephone or only cellular phones and those who are institutionalized. Thus, findings are not generalizable to the entire state population. Third, response rates were low (41.6% and 43.8%) for the surveys described in this report. Finally, the cross-sectional design of the study prevents causal relationships (e.g., between epilepsy and mental health) from being assigned.

CDC, the National Epilepsy Foundation, and 19 state health departments are working together to expand BRFSS surveillance to assess the burden of epilepsy.* In addition, CDC and the Epilepsy Foundation are working to help educate school staff, clinicians, and the public about epilepsy and its treatment, and three CDC Prevention Research Centers are evaluating self-management programs designed to improve health outcomes in persons with epilepsy.†

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*Additional information is available at http://www.cdc.gov/epilepsy/state_activities.htm.

†Additional information is available at http://www.cdc.gov/epilepsy/research_projects.htm.

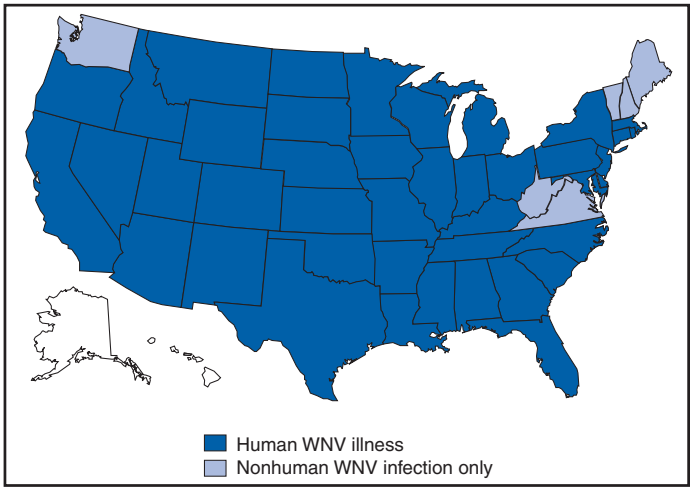
Update: West Nile Virus Activity — United States, 2005

This report summarizes West Nile virus (WNV) surveillance data reported to CDC through ArboNET as of 3 a.m. Mountain Daylight Time, October 25, 2005.

Forty-two states have reported 2,435 cases of human WNV illness in 2005 (Figure and Table 1). By comparison, a total of 2,231 WNV cases had been reported as of October 26, 2004 (Table 2). A total of 1,284 (56%) of the 2,282 cases for which such data were available in 2005 occurred in males; the median age of patients was 51 years (range: 3 months–98 years). Dates of illness onset ranged from January 2 to October 14; a total of 73 cases were fatal.

A total of 372 presumptive West Nile viremic blood donors (PVDs) have been reported to ArboNET during 2005. Of these, 85 were reported from California; 57 from Nebraska; 54 from Texas; 22 from Louisiana; 20 from Arizona; 19 from Kansas; 17 from Iowa; 16 from South Dakota; 12 from Oklahoma; 11 from Minnesota; 10 from Illinois; five each from Michigan, New Mexico, and North Dakota; four each from Alabama, Pennsylvania, and Utah; three each from Nevada and Wisconsin; two each from Colorado, Indiana, Mississippi, Montana, and Ohio; and one each from Idaho, Kentucky,

FIGURE. Areas reporting West Nile virus (WNV) activity — United States, 2005*



* As of October 25, 2005.

TABLE 1. Number of human cases of West Nile virus (WNV) illness reported, by state — United States, 2005*

State	Neuroinvasive disease†	West Nile fever§	Other clinical/ unspecified¶	Total**	Deaths
Alabama	6	2	0	**8**	1
Arizona	25	33	30	**88**	3
Arkansas	8	13	0	**21**	0
California	247	448	76	**771**	16
Colorado	14	61	0	**75**	1
Connecticut	4	2	0	**6**	1
Delaware	1	0	0	**1**	0
Florida	7	13	0	**20**	1
Georgia	7	5	5	**17**	1
Idaho	2	7	4	**13**	0
Illinois	126	84	23	**233**	6
Indiana	7	0	8	**15**	1
Iowa	12	15	8	**35**	2
Kansas	9	3	0	**12**	1
Kentucky	4	0	0	**4**	1
Louisiana	78	33	0	**111**	6
Maryland	4	1	0	**5**	0
Massachusetts	4	1	0	**5**	0
Michigan	34	4	10	**48**	4
Minnesota	17	26	0	**43**	3
Mississippi	37	31	0	**68**	4
Missouri	13	12	0	**25**	1
Montana	8	17	0	**25**	0
Nebraska	26	64	0	**90**	1
Nevada	12	15	2	**29**	0
New Jersey	2	2	0	**4**	0
New Mexico	17	12	0	**29**	2
New York	10	4	0	**14**	1
North Carolina	2	1	0	**3**	0
North Dakota	11	72	0	**83**	0
Ohio	44	12	0	**56**	1
Oklahoma	7	5	0	**12**	0
Oregon	0	5	0	**5**	0
Pennsylvania	14	11	0	**25**	0
Rhode Island	1	0	0	**1**	0
South Carolina	4	0	0	**4**	1
South Dakota	34	192	4	**230**	2
Tennessee	11	1	0	**12**	1
Texas	75	42	0	**117**	8
Utah	21	30	0	**51**	1
Wisconsin	7	5	0	**12**	1
Wyoming	4	5	0	**9**	1
Total	**976**	**1,289**	**170**	**2,435**	**73**

* As of October 25, 2005.
† Cases with neurologic manifestations (i.e., West Nile meningitis, West Nile encephalitis, and West Nile myelitis).
§ Cases with no evidence of neuroinvasion.
¶ Illnesses for which sufficient clinical information was not provided.
** Total number of human cases of WNV illness reported to ArboNET by state and local health departments.

Missouri, New York, North Carolina, and Oregon. Of the 372 PVDs, three persons aged 53, 56, and 72 years subsequently had neuroinvasive illness; seven persons (median age: 41 years [range: 17–64 years]) subsequently had other illnesses; and 78 persons (median age: 46 years [range: 17–78 years]) subsequently had West Nile fever.

TABLE 2. Comparison of human cases and deaths from West Nile virus — United States, 2002–2005

Year	Human cases	Deaths
2002*	3,296	165
2003†	7,386	155
2004§	2,231	73
2005¶	2,435	73

* As of October 23, 2002.
† As of October 22, 2003.
§ As of October 26, 2004.
¶ As of October 25, 2005.

In addition, 3,988 dead corvids and 845 other dead birds with WNV infection have been reported from 45 states. WNV infections have been reported in horses in 32 states; five dogs in Idaho, Minnesota, and Nebraska; six squirrels in Arizona; and five unidentified animal species in four states (Arizona, Illinois, North Carolina, and Texas). WNV seroconversions have been reported in 1,200 sentinel chicken flocks from 16 states. Eight seropositive sentinel birds have been reported in Michigan. One seropositive sentinel horse was reported in Minnesota. A total of 10,787 WNV-positive mosquito pools have been reported from 41 states and the District of Columbia.

Additional information about national WNV activity is available from CDC at http://www.cdc.gov/ncidod/dvbid/westnile/index.htm and at http://westnilemaps.usgs.gov.

Notice to Readers

National Epilepsy Awareness Month — November 2005

November is National Epilepsy Awareness Month. Epilepsy affects approximately 2.7 million persons in the United States and is characterized by unprovoked seizures. Delayed recognition of seizures and inadequate treatment greatly increase the risk for subsequent seizures, brain damage, disability, decreased health-related quality of life, and death from injuries incurred during a seizure. Epilepsy most often affects young children and older adults, although persons can have epilepsy at any age. The effects of epilepsy on children can be especially burdensome as they transition into adulthood (e.g., driving and working). The number of cases among older adults is increasing as the U.S. population ages. Outside the medical community, epilepsy is a poorly understood condition, even among families and friends of affected persons.

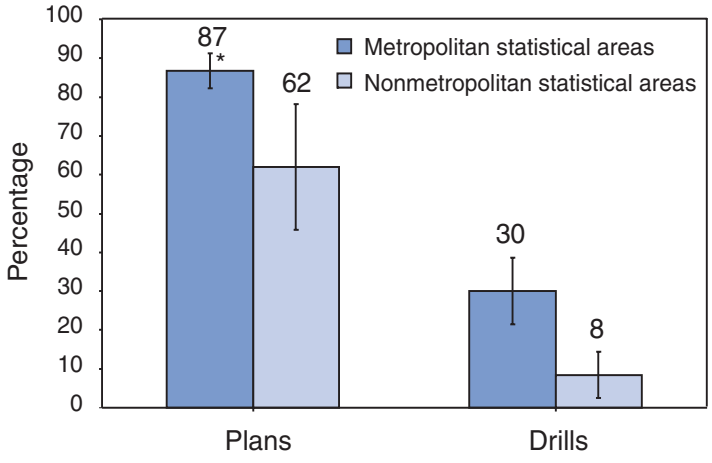
To improve social acceptance and understanding of epilepsy and to increase support for persons living with it, the Epilepsy Foundation, in partnership with CDC, is expanding its campaign to focus on providing information about epilepsy to the Hispanic community through national and local partnerships, including Hispanic Radio Network, local affiliates

of the National Council of La Raza, and local groups of the Community Health Workers (Promotoras) National Network. Information about epilepsy and the campaign is available from the Epilepsy Foundation, telephone 800-332-1000, or at http://www.epilepsyfoundation.org and in Spanish at telephone 866-748-8008 or at http://www.fundacionparalaepilepsia.org.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Hospitals Having Plans or Conducting Drills for Attack by Explosion or Fire, by Urbanization of Area — United States, 2003

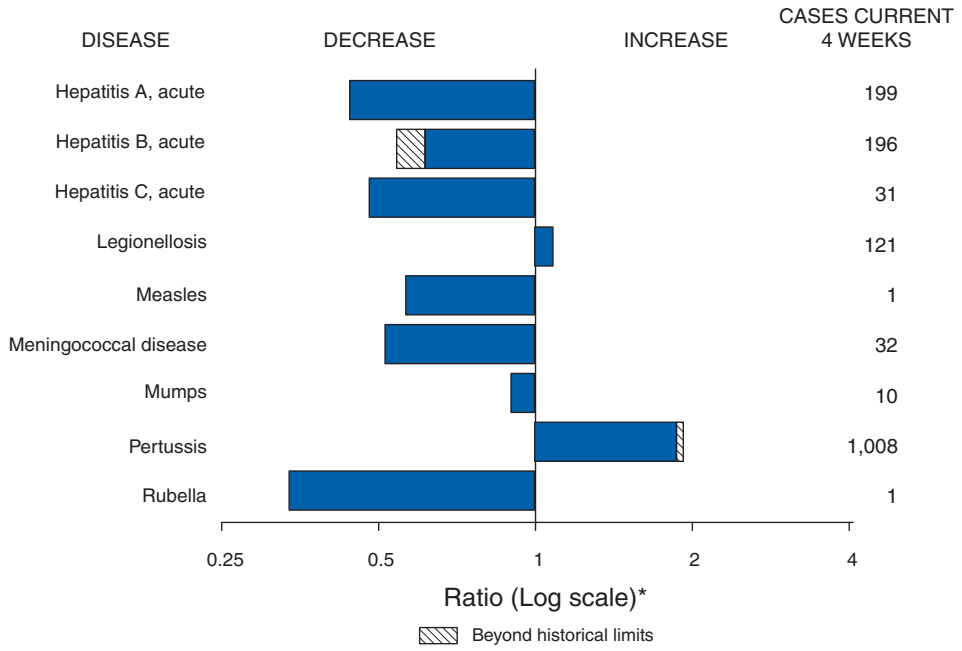


* 95% confidence interval.

Overall, approximately three fourths of hospital emergency response plans address explosive or incendiary attacks; however, only approximately one fifth of hospitals conduct drills to prepare for these types of attacks. Hospitals in metropolitan statistical areas are more likely to have such plans and to conduct drills than are hospitals in nonmetropolitan statistical areas.

SOURCE: Niska RW, Burt CW. Bioterrorism and mass casualty preparedness in hospitals: United States, 2003. Advance data from vital and health statistics; no. 364. Hyattsville, MD: US Department of Health and Human Services, CDC, National Center for Health Statistics; 2005. Available at http://www.cdc.gov/nchs/data/ad/ad364.pdf.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals October 22, 2005, with historical data



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

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending October 22, 2005 (42nd Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	142	141
Botulism:			HIV infection, pediatric†¶	181	304
foodborne	12	8	Influenza-associated pediatric mortality†**	44	—
infant	65	71	Measles	61††	25§§
other (wound & unspecified)	22	14	Mumps	228	175
Brucellosis	82	76	Plague	3	2
Chancroid	24	20	Poliomyelitis, paralytic	1	—
Cholera	4	4	Psittacosis†	20	11
Cyclosporiasis†	704	197	Q fever†	100	53
Diphtheria	—	—	Rabies, human	2	6
Domestic arboviral diseases			Rubella	14	9
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	1	—
California serogroup†§	44	115	SARS†**	—	—
eastern equine†§	20	3	Smallpox†	—	—
Powassan†§	—	1	*Staphylococcus aureus*:		
St. Louis†§	7	13	Vancomycin-intermediate (VISA)†	—	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	—	1
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome†	93	110
human granulocytic (HGE)†	444	336	Tetanus	16	19
human monocytic (HME)†	364	252	Toxic-shock syndrome	80	73
human, other and unspecified †	67	61	Trichinellosis¶¶	15	2
Hansen disease†	59	78	Tularemia†	122	93
Hantavirus pulmonary syndrome†	19	19	Yellow fever	—	—

—: No reported cases.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
¶ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update June 26, 2005.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of 61 cases reported, 51 were indigenous and 10 were imported from another country.
§§ Of 25 cases reported, eight were indigenous and 17 were imported from another country.
¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending October 22, 2005, and October 23, 2004 (42nd Week)*

Reporting area	AIDS		Chlamydia†		Coccidioidomycosis		Cryptosporidiosis	
	Cum. 2005§	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	20,405	31,825	736,813	741,868	3,669	4,685	5,812	2,966
NEW ENGLAND	778	1,087	25,406	24,568	—	—	279	154
Maine	11	20	1,798	1,672	N	N	23	18
N.H.	20	36	1,446	1,401	—	—	29	27
Vt.¶	4	14	779	918	—	—	33	22
Mass.	368	389	11,475	10,809	—	—	114	56
R.I.	68	114	2,654	2,775	—	—	7	4
Conn.	307	514	7,254	6,993	N	N	73	27
MID. ATLANTIC	4,352	7,087	91,901	90,645	—	—	2,476	445
Upstate N.Y.	800	776	18,281	18,269	N	N	2,114	113
N.Y. City	2,327	4,032	29,431	27,934	—	—	95	112
N.J.	574	1,188	14,105	14,332	N	N	47	41
Pa.	651	1,091	30,084	30,110	N	N	220	179
E.N. CENTRAL	1,938	2,673	119,261	131,081	8	12	1,288	911
Ohio	312	504	32,199	32,021	N	N	702	194
Ind.	236	285	16,371	15,037	N	N	64	69
Ill.	983	1,267	35,310	38,576	—	—	108	138
Mich.	322	485	20,389	29,996	8	12	86	130
Wis.	85	132	14,992	15,451	N	N	328	380
W.N. CENTRAL	463	626	45,613	45,835	5	6	506	341
Minn.	123	148	9,063	9,582	3	N	114	118
Iowa	50	50	5,696	5,615	N	N	100	68
Mo.	198	267	18,060	16,944	1	3	228	62
N. Dak.	5	15	921	1,489	N	N	1	10
S. Dak.	10	8	2,227	2,032	—	—	24	33
Nebr.¶	18	44	4,041	4,173	1	3	7	25
Kans.	59	94	5,605	6,000	N	N	32	25
S. ATLANTIC	6,473	9,843	142,540	139,462	1	—	560	450
Del.	100	118	2,737	2,365	N	N	3	—
Md.	812	1,286	15,103	15,320	1	—	33	18
D.C.	467	625	3,085	2,876	—	—	10	14
Va.¶	307	507	16,983	18,103	—	—	52	52
W. Va.	36	71	2,096	2,286	N	N	13	5
N.C.	531	472	26,211	22,926	N	N	70	70
S.C.¶	386	639	17,055	15,478	—	—	15	20
Ga.	1,103	1,299	24,631	26,307	—	—	94	157
Fla.	2,731	4,826	34,639	33,801	N	N	270	114
E.S. CENTRAL	1,093	1,546	55,232	48,618	—	5	176	119
Ky.	135	183	7,163	4,591	N	N	124	38
Tenn.¶	434	617	19,334	18,235	N	N	32	33
Ala.¶	295	381	11,855	10,899	—	—	16	21
Miss.	229	365	16,880	14,893	—	5	4	27
W.S. CENTRAL	2,206	3,870	85,271	90,815	1	3	166	113
Ark.	72	175	7,049	6,529	—	1	4	13
La.	436	704	12,572	18,248	1	2	73	3
Okla.	167	147	9,236	8,960	N	N	37	20
Tex.¶	1,531	2,844	56,414	57,078	N	N	52	77
MOUNTAIN	789	1,127	42,615	45,129	2,556	2,918	107	145
Mont.	4	5	1,656	1,955	N	N	16	34
Idaho¶	9	16	1,826	2,252	N	N	11	23
Wyo.	2	14	928	849	3	2	2	3
Colo.	163	247	11,068	11,561	N	N	40	50
N. Mex.	72	148	4,394	7,242	12	20	4	14
Ariz.	329	403	14,118	13,133	2,504	2,823	10	15
Utah	33	51	3,518	3,012	5	21	15	4
Nev.¶	177	243	5,107	5,125	32	52	9	2
PACIFIC	2,313	3,966	128,974	125,715	1,098	1,741	254	288
Wash.	229	309	15,024	14,093	N	N	41	33
Oreg.¶	136	236	6,327	6,725	—	—	59	29
Calif.	1,874	3,284	101,687	97,382	1,098	1,741	150	224
Alaska	14	43	3,227	3,110	—	—	3	—
Hawaii	60	94	2,709	4,405	—	—	1	2
Guam	1	1	—	803	—	—	—	—
P.R.	537	613	2,901	2,724	N	N	N	N
V.I.	10	11	119	285	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	2	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 2004 and 2005 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, National Center for HIV, STD, and TB Prevention. Last update June 26, 2005.

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 22, 2005, and October 23, 2004 (42nd Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,884	2,086	267	224	256	153	14,261	15,651	254,187	262,529
NEW ENGLAND	138	132	46	40	27	14	1,301	1,454	4,589	5,654
Maine	14	14	11	—	—	—	171	118	114	178
N.H.	12	16	2	5	—	—	44	33	130	100
Vt.	13	11	3	—	—	—	150	144	47	72
Mass.	53	56	6	13	27	14	547	651	2,030	2,549
R.I.	5	8	—	1	—	—	86	101	360	689
Conn.	41	27	24	21	—	—	303	407	1,908	2,066
MID. ATLANTIC	249	242	28	36	27	34	2,655	3,275	26,648	29,273
Upstate N.Y.	113	105	15	17	9	17	966	1,085	5,407	5,932
N.Y. City	11	35	—	—	—	—	665	910	7,950	9,005
N.J.	42	41	3	6	7	6	331	429	4,325	5,467
Pa.	83	61	10	13	11	11	693	851	8,966	8,869
E.N. CENTRAL	385	406	21	44	15	28	2,258	2,606	48,447	55,425
Ohio	120	84	7	9	8	17	654	660	14,993	16,753
Ind.	56	47	—	—	—	—	N	N	6,505	5,515
Ill.	45	90	1	7	1	7	449	679	14,281	16,822
Mich.	70	72	1	10	6	4	624	575	8,384	12,310
Wis.	94	113	12	18	—	—	531	692	4,284	4,025
W.N. CENTRAL	344	429	26	31	52	20	1,640	1,671	14,695	13,875
Minn.	115	100	9	12	33	4	698	589	2,574	2,377
Iowa	71	111	—	—	—	—	227	245	1,271	1,000
Mo.	73	79	11	15	8	6	391	464	7,586	7,261
N. Dak.	6	12	—	—	1	6	12	20	64	95
S. Dak.	23	31	3	—	—	—	85	50	285	227
Nebr.	23	61	3	4	4	—	81	119	915	872
Kans.	33	35	—	—	6	4	146	184	2,000	2,043
S. ATLANTIC	166	151	71	28	92	38	2,107	2,397	62,393	63,326
Del.	6	2	N	N	N	N	45	42	706	726
Md.	31	21	28	5	9	3	163	110	5,720	6,574
D.C.	—	1	—	—	—	—	42	60	1,739	2,130
Va.	33	33	23	14	20	—	453	417	6,233	7,125
W. Va.	1	2	—	—	1	—	35	32	578	750
N.C.	—	—	—	—	46	28	N	N	12,575	12,189
S.C.	6	12	—	—	1	—	78	97	7,559	7,674
Ga.	24	19	16	6	—	—	492	732	11,417	11,640
Fla.	65	61	4	3	15	7	799	907	15,866	14,518
E.S. CENTRAL	110	87	7	5	26	15	336	342	22,057	21,394
Ky.	36	23	4	1	16	9	N	N	2,473	2,078
Tenn.	41	36	2	2	10	6	178	183	7,128	6,882
Ala.	26	17	—	—	—	—	158	159	6,862	6,680
Miss.	7	11	1	2	—	—	—	—	5,594	5,754
W.S. CENTRAL	43	72	13	3	8	4	262	268	34,344	35,305
Ark.	6	15	—	—	—	—	72	105	3,700	3,444
La.	3	4	11	1	3	—	48	41	6,950	8,545
Okla.	21	16	1	—	1	—	142	122	3,666	3,810
Tex.	13	37	1	2	4	4	N	N	20,028	19,506
MOUNTAIN	157	206	49	36	9	—	1,141	1,218	9,193	9,573
Mont.	14	16	—	—	—	—	63	64	93	65
Idaho	19	43	11	9	6	—	76	143	76	79
Wyo.	6	8	2	3	—	—	20	21	63	52
Colo.	33	47	1	1	1	—	425	420	2,470	2,432
N. Mex.	10	10	8	5	—	—	62	60	864	992
Ariz.	32	19	N	N	N	N	124	138	3,102	3,138
Utah	33	42	25	17	—	—	322	269	564	471
Nev.	10	21	2	1	2	—	49	103	1,961	2,344
PACIFIC	292	361	6	1	—	—	2,561	2,420	31,821	28,704
Wash.	92	124	—	—	—	—	295	302	2,965	2,120
Oreg.	67	65	6	1	—	—	326	377	1,094	998
Calif.	111	161	—	—	—	—	1,801	1,601	26,822	24,099
Alaska	12	1	—	—	—	—	86	73	446	470
Hawaii	10	10	—	—	—	—	53	67	494	1,017
Guam	N	N	—	—	—	—	—	2	—	125
P.R.	2	1	—	—	—	—	143	238	267	199
V.I.	—	—	—	—	—	—	—	—	35	80
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. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 22, 2005, and October 23, 2004 (42nd Week)*

Reporting area	*Haemophilus influenzae*, invasive							
	All ages		Age <5 years					
	All serotypes		Serotype b		Non-serotype b		Unknown serotype	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,684	1,587	4	10	91	91	146	150
NEW ENGLAND	137	142	—	1	10	8	3	1
Maine	6	12	—	—	—	—	1	—
N.H.	7	16	—	—	—	2	—	—
Vt.	8	6	—	—	—	—	—	1
Mass.	65	66	—	1	3	3	1	—
R.I.	7	3	—	—	2	—	—	—
Conn.	44	39	—	—	5	3	1	—
MID. ATLANTIC	343	331	—	1	—	4	37	36
Upstate N.Y.	101	106	—	1	—	4	8	5
N.Y. City	59	74	—	—	—	—	10	15
N.J.	72	63	—	—	—	—	9	3
Pa.	111	88	—	—	—	—	10	13
E.N. CENTRAL	226	299	1	—	4	8	12	43
Ohio	95	83	—	—	—	2	6	15
Ind.	55	41	—	—	4	4	—	1
Ill.	35	106	—	—	—	—	3	20
Mich.	18	18	1	—	—	2	2	4
Wis.	23	51	—	—	—	—	1	3
W.N. CENTRAL	94	89	—	2	3	3	8	11
Minn.	38	40	—	1	3	3	2	1
Iowa	1	1	—	1	—	—	—	—
Mo.	32	34	—	—	—	—	5	7
N. Dak.	2	3	—	—	—	—	1	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	9	5	—	—	—	—	—	2
Kans.	12	6	—	—	—	—	—	1
S. ATLANTIC	396	357	1	—	25	24	21	25
Del.	—	—	—	—	—	—	—	—
Md.	57	55	—	—	5	5	—	—
D.C.	—	3	—	—	—	—	—	1
Va.	39	35	—	—	—	—	—	5
W. Va.	24	16	—	—	1	4	5	—
N.C.	68	47	1	—	8	6	—	1
S.C.	23	11	—	—	—	—	—	1
Ga.	79	92	—	—	—	—	11	16
Fla.	106	98	—	—	11	9	5	1
E.S. CENTRAL	95	63	—	1	1	1	6	8
Ky.	8	7	—	—	1	1	2	—
Tenn.	69	41	—	—	—	—	—	6
Ala.	18	13	—	1	—	—	4	2
Miss.	—	2	—	—	—	—	—	—
W.S. CENTRAL	91	63	1	1	8	8	7	1
Ark.	5	2	—	—	1	1	—	—
La.	30	13	1	—	2	—	7	1
Okla.	54	47	—	—	5	7	—	—
Tex.	2	1	—	1	—	—	—	—
MOUNTAIN	190	164	—	4	13	25	38	18
Mont.	—	—	—	—	—	—	—	—
Idaho	3	5	—	—	—	—	1	2
Wyo.	6	1	—	—	—	1	1	—
Colo.	37	41	—	—	—	—	9	5
N. Mex.	17	37	—	1	4	8	2	6
Ariz.	97	56	—	—	7	11	15	2
Utah	16	12	—	2	—	2	7	2
Nev.	14	12	—	1	2	3	3	1
PACIFIC	112	79	1	—	27	10	14	7
Wash.	3	1	—	—	—	—	2	1
Oreg.	29	40	—	—	—	—	5	3
Calif.	47	25	1	—	27	10	2	1
Alaska	25	5	—	—	—	—	5	1
Hawaii	8	8	—	—	—	—	—	1
Guam	—	—	—	—	—	—	—	—
P.R.	3	2	—	—	—	—	1	2
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 22, 2005, and October 23, 2004 (42nd Week)*

Reporting area	Hepatitis (viral, acute), by type					
	A		B		C	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	3,289	4,795	4,385	4,711	566	643
NEW ENGLAND	418	835	227	303	14	14
Maine	2	12	16	4	—	—
N.H.	72	16	20	27	—	—
Vt.	6	8	4	5	11	6
Mass.	284	716	158	165	—	7
R.I.	10	20	1	5	—	—
Conn.	44	63	28	97	3	1
MID. ATLANTIC	560	650	874	618	84	121
Upstate N.Y.	90	85	77	66	15	11
N.Y. City	249	279	96	123	—	—
N.J.	138	154	526	182	—	—
Pa.	83	132	175	247	69	110
E.N. CENTRAL	309	413	407	458	108	91
Ohio	43	40	108	98	6	4
Ind.	45	52	42	39	23	7
Ill.	76	133	86	71	—	13
Mich.	119	125	140	216	79	67
Wis.	26	63	31	34	—	—
W.N. CENTRAL	76	132	223	270	31	19
Minn.	3	32	29	41	5	16
Iowa	19	39	17	14	—	—
Mo.	36	26	132	166	24	3
N. Dak.	—	1	—	4	1	—
S. Dak.	—	3	3	1	—	—
Nebr.	4	12	21	31	1	—
Kans.	14	19	21	13	—	—
S. ATLANTIC	582	853	1,110	1,466	113	157
Del.	4	6	41	42	7	27
Md.	63	93	128	129	20	3
D.C.	4	7	10	15	—	2
Va.	68	99	121	211	11	13
W. Va.	5	5	32	35	16	20
N.C.	71	76	128	138	17	10
S.C.	32	39	114	115	2	14
Ga.	95	290	132	382	7	14
Fla.	240	238	404	399	33	54
E.S. CENTRAL	219	137	285	401	73	78
Ky.	22	29	54	60	9	23
Tenn.	143	86	115	186	15	28
Ala.	35	8	64	63	14	4
Miss.	19	14	52	92	35	23
W.S. CENTRAL	231	577	353	295	68	85
Ark.	8	60	36	98	1	2
La.	58	43	57	54	11	3
Okla.	4	19	34	57	6	3
Tex.	161	455	226	86	50	77
MOUNTAIN	295	357	452	378	38	38
Mont.	7	6	3	1	1	2
Idaho	17	17	12	10	1	1
Wyo.	—	5	1	7	—	2
Colo.	38	43	43	52	19	11
N. Mex.	20	22	7	16	—	U
Ariz.	185	215	319	191	—	5
Utah	18	34	39	35	8	4
Nev.	10	15	28	66	9	13
PACIFIC	599	841	454	522	37	40
Wash.	38	53	57	42	U	U
Oreg.	38	59	85	94	14	15
Calif.	498	703	300	367	22	24
Alaska	4	4	7	10	—	—
Hawaii	21	22	5	9	1	1
Guam	—	1	—	12	—	9
P.R.	55	37	35	67	—	—
V.I.	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U

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* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 22, 2005, and October 23, 2004 (42nd Week)*

Reporting area	Legionellosis		Listeriosis		Lyme disease		Malaria	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,496	1,648	612	588	16,860	15,431	1,009	1,175
NEW ENGLAND	78	78	46	41	1,894	2,765	57	80
Maine	4	1	2	8	172	29	4	7
N.H.	7	9	6	3	166	175	5	5
Vt.	7	5	2	1	38	44	1	4
Mass.	22	35	12	13	913	1,397	29	47
R.I.	16	13	6	1	32	179	2	4
Conn.	22	15	18	15	573	941	16	13
MID. ATLANTIC	529	464	162	142	10,940	9,434	273	311
Upstate N.Y.	146	94	50	40	3,253	3,219	44	39
N.Y. City	65	62	28	25	—	328	138	167
N.J.	84	75	33	29	3,043	2,407	61	64
Pa.	234	233	51	48	4,644	3,480	30	41
E.N. CENTRAL	289	404	62	100	1,232	1,245	82	105
Ohio	154	189	28	37	62	47	23	26
Ind.	16	40	4	16	24	24	1	13
Ill.	15	42	1	20	—	87	28	37
Mich.	87	114	22	22	47	26	19	17
Wis.	17	19	7	5	1,099	1,061	11	12
W.N. CENTRAL	63	49	35	15	722	424	40	62
Minn.	16	7	10	4	619	343	11	24
Iowa	5	5	8	2	76	46	8	4
Mo.	27	22	4	5	21	23	16	19
N. Dak.	2	2	4	—	—	—	—	3
S. Dak.	10	4	—	1	1	1	—	1
Nebr.	1	3	4	3	2	8	1	4
Kans.	2	6	5	—	3	3	4	7
S. ATLANTIC	309	329	124	99	1,855	1,377	239	280
Del.	13	13	N	N	560	276	3	6
Md.	88	72	18	14	939	744	92	66
D.C.	9	10	—	5	8	11	8	11
Va.	36	39	14	15	190	141	26	37
W. Va.	15	9	4	3	16	26	1	2
N.C.	24	29	22	19	44	104	25	18
S.C.	11	9	9	10	18	22	6	10
Ga.	21	37	20	14	4	12	34	56
Fla.	92	111	37	19	76	41	44	74
E.S. CENTRAL	65	89	27	22	33	39	25	30
Ky.	23	35	4	4	5	15	8	4
Tenn.	28	39	11	11	27	19	13	10
Ala.	11	12	8	5	1	5	4	11
Miss.	3	3	4	2	—	—	—	5
W.S. CENTRAL	25	115	27	35	56	56	78	118
Ark.	4	—	2	3	4	8	6	8
La.	1	7	8	3	4	2	2	5
Okla.	7	5	3	—	—	—	9	7
Tex.	13	103	14	29	48	46	61	98
MOUNTAIN	76	68	15	23	22	17	45	46
Mont.	5	2	—	—	—	—	—	—
Idaho	3	7	—	1	2	6	—	1
Wyo.	4	5	—	—	3	3	2	—
Colo.	19	18	6	12	5	—	21	18
N. Mex.	2	4	4	1	1	1	2	4
Ariz.	22	11	—	—	7	6	10	11
Utah	13	17	3	1	2	1	8	7
Nev.	8	4	2	8	2	—	2	5
PACIFIC	62	52	114	111	106	74	170	143
Wash.	—	9	9	9	7	12	13	15
Oreg.	N	N	10	6	17	24	8	16
Calif.	60	43	94	92	79	36	130	107
Alaska	—	—	—	—	3	2	5	1
Hawaii	2	—	1	4	N	N	14	4
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	2	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 22, 2005, and October 23, 2004 (42nd Week)*

Reporting area	Meningococcal disease									
	All serogroups		Serogroup A, C, Y, and W-135		Serogroup B		Other serogroup		Serogroup unknown	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	952	988	77	76	46	38	—	1	829	873
NEW ENGLAND	64	56	1	6	—	6	—	1	63	43
Maine	2	10	—	—	—	1	—	—	2	9
N.H.	12	4	—	—	—	—	—	—	12	4
Vt.	6	2	—	—	—	—	—	—	6	2
Mass.	29	32	—	5	—	5	—	—	29	22
R.I.	3	2	—	1	—	—	—	—	3	1
Conn.	12	6	1	—	—	—	—	1	11	5
MID. ATLANTIC	123	135	34	36	7	5	—	—	82	94
Upstate N.Y.	31	34	4	5	4	3	—	—	23	26
N.Y. City	17	24	—	—	—	—	—	—	17	24
N.J.	32	29	—	—	—	—	—	—	32	29
Pa.	43	48	30	31	3	2	—	—	10	15
E.N. CENTRAL	98	111	26	25	9	6	—	—	63	80
Ohio	32	57	—	4	5	5	—	—	27	48
Ind.	18	17	—	1	4	1	—	—	14	15
Ill.	12	1	—	—	—	—	—	—	12	1
Mich.	26	20	26	20	—	—	—	—	—	—
Wis.	10	16	—	—	—	—	—	—	10	16
W.N. CENTRAL	63	67	3	—	1	4	—	—	59	63
Minn.	13	22	1	—	—	—	—	—	12	22
Iowa	15	14	—	—	1	2	—	—	14	12
Mo.	21	17	1	—	—	1	—	—	20	16
N. Dak.	—	2	—	—	—	—	—	—	—	2
S. Dak.	3	2	1	—	—	1	—	—	2	1
Nebr.	4	4	—	—	—	—	—	—	4	4
Kans.	7	6	—	—	—	—	—	—	7	6
S. ATLANTIC	185	189	5	2	9	2	—	—	171	185
Del.	4	4	—	—	—	—	—	—	4	4
Md.	18	10	2	—	2	—	—	—	14	10
D.C.	—	5	—	2	—	—	—	—	—	3
Va.	28	17	—	—	—	—	—	—	28	17
W. Va.	6	5	1	—	—	—	—	—	5	5
N.C.	28	26	2	—	7	2	—	—	19	24
S.C.	14	14	—	—	—	—	—	—	14	14
Ga.	15	12	—	—	—	—	—	—	15	12
Fla.	72	96	—	—	—	—	—	—	72	96
E.S. CENTRAL	49	55	1	1	3	1	—	—	45	53
Ky.	16	9	—	1	3	1	—	—	13	7
Tenn.	22	19	—	—	—	—	—	—	22	19
Ala.	6	14	1	—	—	—	—	—	5	14
Miss.	5	13	—	—	—	—	—	—	5	13
W.S. CENTRAL	82	59	1	2	5	2	—	—	76	55
Ark.	13	15	—	—	—	1	—	—	13	14
La.	26	31	—	1	2	—	—	—	24	30
Okla.	13	9	1	1	3	1	—	—	9	7
Tex.	30	4	—	—	—	—	—	—	30	4
MOUNTAIN	77	56	5	1	5	5	—	—	67	50
Mont.	—	3	—	—	—	—	—	—	—	3
Idaho	3	6	—	—	—	—	—	—	3	6
Wyo.	—	4	—	—	—	—	—	—	—	4
Colo.	17	13	4	—	—	—	—	—	13	13
N. Mex.	3	7	—	1	—	3	—	—	3	3
Ariz.	36	11	—	—	2	1	—	—	34	10
Utah	10	5	1	—	2	—	—	—	7	5
Nev.	8	7	—	—	1	1	—	—	7	6
PACIFIC	211	260	1	3	7	7	—	—	203	250
Wash.	41	27	1	3	4	7	—	—	36	17
Oreg.	28	49	—	—	—	—	—	—	28	49
Calif.	128	173	—	—	—	—	—	—	128	173
Alaska	3	4	—	—	—	—	—	—	3	4
Hawaii	11	7	—	—	3	—	—	—	8	7
Guam	—	1	—	—	—	—	—	—	—	1
P.R.	6	13	—	—	—	—	—	—	6	13
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	1	1	—	—	—	—	—	—	1	1
C.N.M.I.	—	—	—	—	—	—	—	—	—	—

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 22, 2005, and October 23, 2004 (42nd Week)*

Reporting area	Pertussis		Rabies, animal		Rocky Mountain spotted fever		Salmonellosis		Shigellosis	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	16,101	16,165	4,517	5,464	1,393	1,283	33,220	34,235	10,810	10,827
NEW ENGLAND	907	1,510	586	565	3	17	1,768	1,751	249	256
Maine	26	8	47	49	N	N	128	92	9	7
N.H.	57	68	12	24	1	—	140	121	7	7
Vt.	77	62	50	31	—	—	87	53	16	2
Mass.	681	1,288	291	236	1	13	921	1,002	154	163
R.I.	29	31	20	36	1	1	82	99	14	18
Conn.	37	53	166	189	—	3	410	384	49	59
MID. ATLANTIC	1,081	2,360	801	820	90	65	4,022	4,819	1,040	1,017
Upstate N.Y.	425	1,657	457	450	3	1	1,048	1,023	233	375
N.Y. City	76	167	27	11	7	21	895	1,105	320	341
N.J.	171	159	N	N	28	13	698	924	267	210
Pa.	409	377	317	359	52	30	1,381	1,767	220	91
E.N. CENTRAL	2,861	6,133	185	169	35	33	4,362	4,350	755	972
Ohio	947	474	67	67	25	9	1,138	1,043	90	141
Ind.	257	146	11	10	2	6	518	420	134	180
Ill.	544	1,123	46	47	1	14	1,255	1,393	218	350
Mich.	235	228	35	39	6	2	740	713	190	114
Wis.	878	4,162	26	6	1	2	711	781	123	187
W.N. CENTRAL	2,574	1,682	369	550	153	111	2,062	2,019	1,260	340
Minn.	966	299	64	78	2	—	471	505	75	58
Iowa	481	235	96	91	4	2	323	381	66	59
Mo.	375	299	69	54	131	91	682	529	832	131
N. Dak.	130	685	24	54	—	—	36	38	4	3
S. Dak.	85	34	48	88	5	4	126	111	39	10
Nebr.	170	33	—	93	4	14	117	138	61	19
Kans.	367	97	68	92	7	—	307	317	183	60
S. ATLANTIC	1,105	620	1,351	1,892	687	672	9,651	9,161	1,826	2,451
Del.	15	2	—	9	3	5	107	97	10	7
Md.	140	115	266	275	80	64	679	713	84	129
D.C.	7	7	—	—	2	—	45	53	11	33
Va.	295	170	440	406	89	24	921	979	109	132
W. Va.	37	18	50	57	6	5	139	191	1	7
N.C.	98	67	404	509	385	427	1,229	1,314	163	293
S.C.	302	114	5	141	50	56	1,053	824	77	484
Ga.	32	19	182	290	57	76	1,447	1,644	442	544
Fla.	179	108	4	205	15	15	4,031	3,346	929	822
E.S. CENTRAL	423	244	119	129	255	176	2,379	2,229	1,024	688
Ky.	122	57	11	20	3	2	405	288	263	59
Tenn.	188	142	41	45	191	94	643	586	482	356
Ala.	73	29	65	53	57	52	577	597	199	226
Miss.	40	16	2	11	4	28	754	758	80	47
W.S. CENTRAL	1,411	732	750	956	131	184	2,854	3,464	2,277	2,868
Ark.	226	68	32	47	102	102	623	460	55	62
La.	33	14	—	4	5	5	620	783	109	252
Okla.	—	33	69	96	7	71	343	340	546	382
Tex.	1,152	617	649	809	17	6	1,268	1,881	1,567	2,172
MOUNTAIN	3,272	1,271	204	198	31	21	1,863	1,944	714	678
Mont.	526	45	15	24	1	3	85	176	5	4
Idaho	125	33	—	7	3	4	87	129	9	12
Wyo.	44	28	16	5	2	5	72	46	5	5
Colo.	1,080	648	14	46	5	4	511	463	136	132
N. Mex.	118	133	7	4	2	2	199	237	92	120
Ariz.	851	190	125	103	14	2	539	551	401	321
Utah	496	156	14	6	4	1	285	199	38	37
Nev.	32	38	13	3	—	—	85	143	28	47
PACIFIC	2,467	1,613	152	185	8	4	4,259	4,498	1,665	1,557
Wash.	697	594	U	U	—	—	431	456	98	93
Oreg.	552	378	6	6	1	2	311	376	103	66
Calif.	994	607	145	168	7	2	3,224	3,297	1,428	1,348
Alaska	105	12	1	11	—	—	45	51	7	6
Hawaii	119	22	—	—	—	—	248	318	29	44
Guam	—	—	—	—	—	—	—	50	—	42
P.R.	5	4	54	52	N	N	367	380	3	26
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. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 22, 2005, and October 23, 2004 (42nd Week)*

Reporting area	Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive disease				Syphilis			
			Drug resistant, all ages		Age <5 years		Primary & secondary		Congenital	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	3,515	3,666	1,743	1,781	590	635	6,387	6,287	201	314
NEW ENGLAND	142	238	90	124	43	85	169	161	1	4
Maine	10	11	N	N	—	4	1	2	—	—
N.H.	13	17	—	—	4	N	14	4	—	3
Vt.	9	8	10	6	—	3	1	—	—	—
Mass.	101	108	64	35	38	46	106	98	—	—
R.I.	9	17	16	18	1	6	13	23	—	1
Conn.	U	77	U	65	U	26	34	34	1	—
MID. ATLANTIC	745	612	165	121	115	94	814	813	23	32
Upstate N.Y.	225	201	63	49	50	64	73	77	7	4
N.Y. City	139	102	U	U	20	U	496	506	5	14
N.J.	150	130	N	N	22	8	111	122	11	13
Pa.	231	179	102	72	23	22	134	108	—	1
E.N. CENTRAL	664	835	469	402	175	152	650	722	26	47
Ohio	162	196	296	280	65	65	175	184	1	2
Ind.	89	85	162	122	46	33	53	52	1	2
Ill.	116	220	11	—	52	5	328	306	10	15
Mich.	262	256	—	N	—	N	65	152	12	28
Wis.	35	78	N	N	12	49	29	28	2	—
W.N. CENTRAL	225	265	38	17	66	85	197	135	5	5
Minn.	89	126	—	—	42	55	52	20	1	1
Iowa	N	N	N	N	—	N	4	5	—	—
Mo.	57	56	31	12	9	13	120	82	4	2
N. Dak.	9	11	2	—	4	2	—	—	—	—
S. Dak.	20	15	3	5	—	—	1	—	—	—
Nebr.	17	18	2	—	—	7	4	6	—	—
Kans.	33	39	N	N	11	8	16	22	—	2
S. ATLANTIC	758	736	692	908	67	47	1,608	1,568	36	50
Del.	5	3	1	4	—	N	10	8	—	1
Md.	173	118	—	—	44	33	254	292	13	8
D.C.	8	9	15	8	2	4	86	48	—	1
Va.	73	64	N	N	—	N	108	84	4	2
W. Va.	22	23	101	96	21	10	4	3	—	—
N.C.	104	105	N	N	U	U	213	150	8	9
S.C.	26	51	—	83	—	N	57	97	4	11
Ga.	150	174	111	225	—	N	281	309	1	4
Fla.	197	189	464	492	—	N	595	577	6	14
E.S. CENTRAL	149	190	139	126	11	15	363	335	18	20
Ky.	31	55	25	25	N	N	41	34	—	1
Tenn.	118	135	114	99	—	N	178	107	12	8
Ala.	—	—	—	—	—	N	112	146	5	9
Miss.	—	—	—	2	11	15	32	48	1	2
W.S. CENTRAL	221	289	98	59	61	124	1,019	1,007	55	62
Ark.	17	16	12	8	14	8	42	43	—	3
La.	6	2	86	51	23	28	176	254	6	5
Okla.	96	57	N	N	24	36	32	24	1	2
Tex.	102	214	N	N	—	52	769	686	48	52
MOUNTAIN	524	400	52	23	43	33	320	322	16	40
Mont.	—	—	—	—	—	—	5	1	—	—
Idaho	2	8	N	N	—	N	20	18	1	2
Wyo.	4	8	22	9	—	—	—	3	—	—
Colo.	190	88	N	N	42	33	31	53	1	—
N. Mex.	41	83	—	N	—	—	38	71	2	2
Ariz.	215	174	N	N	—	N	143	133	12	35
Utah	71	35	28	12	1	—	6	10	—	1
Nev.	1	4	2	2	—	—	77	33	—	—
PACIFIC	87	101	—	1	9	—	1,247	1,224	21	54
Wash.	N	N	N	N	N	N	120	106	—	—
Oreg.	N	N	N	N	6	N	22	24	—	—
Calif.	—	—	N	N	N	N	1,095	1,087	21	54
Alaska	—	—	—	—	—	N	6	1	—	—
Hawaii	87	101	—	1	3	—	4	6	—	—
Guam	—	—	—	—	—	—	—	1	—	—
P.R.	N	N	N	N	—	N	156	127	8	5
V.I.	—	—	—	—	—	—	—	4	—	—
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. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 22, 2005, and October 23, 2004 (42nd Week)*

Reporting area	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease†		
							Neuroinvasive		Non-neuroinvasive§
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	9,009	10,694	212	273	19,025	22,202	946	1,126	1,279
NEW ENGLAND	267	349	22	20	1,040	2,422	9	—	3
Maine	14	16	1	—	213	185	—	—	—
N.H.	6	13	—	—	230	—	—	—	—
Vt.	4	2	—	—	59	413	—	—	—
Mass.	168	202	13	14	538	368	4	—	1
R.I.	24	42	1	1	—	—	1	—	—
Conn.	51	74	7	5	U	1,456	4	—	2
MID. ATLANTIC	1,635	1,668	38	67	3,688	77	26	17	17
Upstate N.Y.	201	221	5	9	—	—	—	5	—
N.Y. City	802	836	12	27	—	—	10	2	4
N.J.	389	367	11	16	—	—	2	1	2
Pa.	243	244	10	15	3,688	77	14	9	11
E.N. CENTRAL	1,020	939	18	32	5,011	9,498	213	66	105
Ohio	206	159	2	6	1,136	1,102	44	11	12
Ind.	106	102	1	—	482	N	7	8	—
Ill.	478	416	5	15	67	4,809	126	29	84
Mich.	166	191	5	9	2,984	3,042	29	13	4
Wis.	64	71	5	2	342	545	7	5	5
W.N. CENTRAL	480	362	6	7	390	149	122	86	384
Minn.	148	140	5	3	—	—	17	13	26
Iowa	170	32	—	—	N	N	12	13	15
Mo.	75	94	—	2	278	5	13	27	11
N. Dak.	2	3	—	—	25	81	11	2	72
S. Dak.	11	8	—	—	87	63	34	6	192
Nebr.	28	26	—	2	—	—	26	7	64
Kans.	46	59	1	—	—	—	9	18	4
S. ATLANTIC	1,997	2,253	41	38	1,694	1,984	24	65	20
Del.	12	17	1	—	28	5	1	—	—
Md.	217	225	9	11	—	—	4	10	1
D.C.	42	72	—	—	28	21	—	1	—
Va.	235	213	15	7	377	481	—	4	—
W. Va.	19	16	—	—	858	1,121	—	—	N
N.C.	228	254	3	6	—	N	2	3	1
S.C.	179	151	—	—	403	356	4	—	—
Ga.	318	465	2	4	—	—	7	14	5
Fla.	747	840	11	10	—	—	6	33	13
E.S. CENTRAL	397	508	5	8	—	41	58	60	34
Ky.	84	92	2	3	N	N	4	1	—
Tenn.	161	165	—	5	—	—	11	13	1
Ala.	152	157	1	—	—	41	6	15	2
Miss.	—	94	2	—	—	—	37	31	31
W.S. CENTRAL	1,042	1,566	15	25	5,112	6,089	145	223	83
Ark.	88	94	—	—	1	—	8	14	13
La.	—	—	1	—	109	48	58	79	23
Okla.	115	136	—	1	—	—	4	16	5
Tex.	839	1,336	14	24	5,002	6,041	75	114	42
MOUNTAIN	286	409	9	7	2,090	1,942	102	321	180
Mont.	8	4	—	—	—	—	8	2	17
Idaho	—	3	—	—	—	—	2	1	7
Wyo.	—	3	—	—	48	34	3	2	5
Colo.	46	100	4	2	1,501	1,555	14	41	61
N. Mex.	14	23	—	—	143	U	17	31	12
Ariz.	174	166	3	2	—	—	25	213	33
Utah	26	32	1	1	398	353	21	6	30
Nev.	18	78	1	2	—	—	12	25	15
PACIFIC	1,885	2,640	58	69	—	—	247	288	453
Wash.	196	185	5	6	N	N	—	—	—
Oreg.	54	83	3	1	—	—	—	—	5
Calif.	1,502	2,249	38	56	—	—	247	288	448
Alaska	36	30	—	—	—	—	—	—	—
Hawaii	97	93	12	6	—	—	—	—	—
Guam	—	46	—	—	—	181	—	—	—
P.R.	—	83	—	—	529	336	—	—	—
V.I.	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	—
C.N.M.I.	—	U	—	U	—	U	—	U	—

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

* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).

§ Not previously notifiable.

TABLE III. Deaths in 122 U.S. cities,* week ending October 22, 2005 (42nd Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
NEW ENGLAND	506	343	108	31	8	16	47
Boston, Mass.	124	78	24	12	1	9	17
Bridgeport, Conn.	31	24	5	1	1	—	—
Cambridge, Mass.	9	6	2	1	—	—	—
Fall River, Mass.	26	18	4	3	1	—	3
Hartford, Conn.	62	42	15	1	3	1	5
Lowell, Mass.	28	14	12	2	—	—	2
Lynn, Mass.	11	9	1	1	—	—	1
New Bedford, Mass.	20	15	5	—	—	—	—
New Haven, Conn.	26	16	4	3	1	2	1
Providence, R.I.	43	28	10	2	—	3	—
Somerville, Mass.	5	4	1	—	—	—	1
Springfield, Mass.	31	24	5	2	—	—	4
Waterbury, Conn.	26	18	5	1	1	1	2
Worcester, Mass.	64	47	15	2	—	—	11
MID. ATLANTIC	2,109	1,407	473	157	36	36	112
Albany, N.Y.	38	30	7	—	1	—	2
Allentown, Pa.	20	16	4	—	—	—	—
Buffalo, N.Y.	72	51	12	2	2	5	1
Camden, N.J.	23	15	4	2	2	—	1
Elizabeth, N.J.	17	9	5	3	—	—	—
Erie, Pa.	47	34	10	3	—	—	5
Jersey City, N.J.	47	32	6	8	1	—	—
New York City, N.Y.	1,075	737	234	71	14	19	47
Newark, N.J.	54	22	22	9	—	1	1
Paterson, N.J.	25	18	4	—	1	2	3
Philadelphia, Pa.	307	166	87	38	8	8	17
Pittsburgh, Pa.§	28	23	4	1	—	—	2
Reading, Pa.	20	15	3	—	2	—	—
Rochester, N.Y.	131	92	27	9	3	—	14
Schenectady, N.Y.	24	19	4	1	—	—	3
Scranton, Pa.	27	20	6	1	—	—	1
Syracuse, N.Y.	92	67	19	4	1	1	10
Trenton, N.J.	26	13	8	4	1	—	2
Utica, N.Y.	18	16	2	—	—	—	1
Yonkers, N.Y.	18	12	5	1	—	—	2
E.N. CENTRAL	2,031	1,318	501	127	43	41	130
Akron, Ohio	41	24	14	2	—	1	—
Canton, Ohio	41	31	6	3	1	—	1
Chicago, Ill.	288	167	77	22	12	9	16
Cincinnati, Ohio	69	43	18	3	3	2	9
Cleveland, Ohio	241	167	55	14	3	2	6
Columbus, Ohio	203	129	54	15	3	2	20
Dayton, Ohio	104	76	24	3	1	—	7
Detroit, Mich.	155	74	54	17	3	7	10
Evansville, Ind.	46	33	11	2	—	—	3
Fort Wayne, Ind.	71	42	22	4	1	2	3
Gary, Ind.	12	4	5	1	1	1	1
Grand Rapids, Mich.	57	44	8	2	2	1	7
Indianapolis, Ind.	225	140	59	13	8	5	10
Lansing, Mich.	48	30	14	2	1	1	4
Milwaukee, Wis.	109	76	24	6	—	3	13
Peoria, Ill.	58	44	10	3	1	—	9
Rockford, Ill.	51	31	12	3	2	3	1
South Bend, Ind.	45	37	6	1	—	1	1
Toledo, Ohio	107	76	19	10	1	1	3
Youngstown, Ohio	60	50	9	1	—	—	6
W.N. CENTRAL	686	438	154	44	24	26	50
Des Moines, Iowa	51	33	10	3	1	4	4
Duluth, Minn.	23	18	4	1	—	—	2
Kansas City, Kans.	23	10	12	1	—	—	—
Kansas City, Mo.	106	62	25	11	3	5	7
Lincoln, Nebr.	38	30	3	5	—	—	6
Minneapolis, Minn.	57	34	16	3	2	2	5
Omaha, Nebr.	87	57	23	2	4	1	5
St. Louis, Mo.	137	76	32	14	9	6	11
St. Paul, Minn.	76	53	13	2	2	6	5
Wichita, Kans.	88	65	16	2	3	2	5
S. ATLANTIC	1,072	641	278	95	32	24	52
Atlanta, Ga.	142	81	45	10	3	3	8
Baltimore, Md.	211	120	58	22	8	3	15
Charlotte, N.C.	96	61	20	10	1	4	7
Jacksonville, Fla.	158	95	43	11	8	1	2
Miami, Fla.	U	U	U	U	U	U	U
Norfolk, Va.	54	25	13	12	3	—	3
Richmond, Va.	63	36	18	6	1	2	6
Savannah, Ga.	50	30	14	3	1	2	2
St. Petersburg, Fla.	24	16	5	2	—	1	3
Tampa, Fla.	159	106	29	12	7	5	4
Washington, D.C.	100	63	29	5	—	3	2
Wilmington, Del.	15	8	4	2	—	—	—
E.S. CENTRAL	739	468	187	47	14	23	43
Birmingham, Ala.	131	79	38	7	3	4	6
Chattanooga, Tenn.	74	44	25	3	—	2	4
Knoxville, Tenn.	71	50	16	4	—	1	4
Lexington, Ky.	67	46	16	4	—	1	6
Memphis, Tenn.	151	98	35	8	2	8	15
Mobile, Ala.	79	49	25	5	—	—	1
Montgomery, Ala.	51	33	11	4	2	1	—
Nashville, Tenn.	115	69	21	12	7	6	7
W.S. CENTRAL	1,483	943	333	128	42	37	81
Austin, Tex.	85	55	18	7	—	5	3
Baton Rouge, La.	54	39	6	8	—	1	—
Corpus Christi, Tex.	57	39	12	5	1	—	3
Dallas, Tex.	184	107	42	18	12	5	12
El Paso, Tex.	107	74	22	8	2	1	4
Ft. Worth, Tex.	122	79	23	11	2	7	7
Houston, Tex.	420	245	105	45	17	8	25
Little Rock, Ark.	61	36	18	4	1	2	2
New Orleans, La.¶	U	U	U	U	U	U	U
San Antonio, Tex.	238	160	50	14	7	7	13
Shreveport, La.	63	48	12	2	—	1	2
Tulsa, Okla.	92	61	25	6	—	—	10
MOUNTAIN	1,060	681	261	64	33	20	78
Albuquerque, N.M.	108	72	25	2	7	2	8
Boise, Idaho	67	51	13	1	1	1	5
Colo. Springs, Colo.	63	40	13	4	3	3	2
Denver, Colo.	78	48	23	3	—	4	4
Las Vegas, Nev.	247	142	75	18	10	2	16
Ogden, Utah	41	30	7	3	1	—	2
Phoenix, Ariz.	175	100	46	15	7	6	16
Pueblo, Colo.	26	19	4	3	—	—	2
Salt Lake City, Utah	101	67	25	7	1	1	12
Tucson, Ariz.	154	112	30	8	3	1	11
PACIFIC	1,583	1,070	342	112	32	27	133
Berkeley, Calif.	17	13	2	—	—	2	2
Fresno, Calif.	146	99	32	10	3	2	6
Glendale, Calif.	7	7	—	—	—	—	3
Honolulu, Hawaii	63	44	14	1	1	3	4
Long Beach, Calif.	79	52	15	10	—	2	13
Los Angeles, Calif.	133	76	32	18	5	2	20
Pasadena, Calif.	18	11	4	3	—	—	—
Portland, Oreg.	155	110	31	7	4	3	7
Sacramento, Calif.	193	136	35	13	5	4	10
San Diego, Calif.	165	116	31	8	6	4	12
San Francisco, Calif.	138	79	45	13	1	—	14
San Jose, Calif.	171	115	42	7	5	2	19
Santa Cruz, Calif.	26	20	5	1	—	—	7
Seattle, Wash.	112	75	27	8	2	—	6
Spokane, Wash.	48	31	10	7	—	—	6
Tacoma, Wash.	112	86	17	6	—	3	4
TOTAL	11,269**	7,309	2,637	805	264	250	726

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.

¶ Because of Hurricane Katrina, weekly reporting of deaths has been temporarily disrupted.

** Total includes unknown ages.

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☆U.S. Government Printing Office: 2006-523-142/00124 Region IV ISSN: 0149-2195