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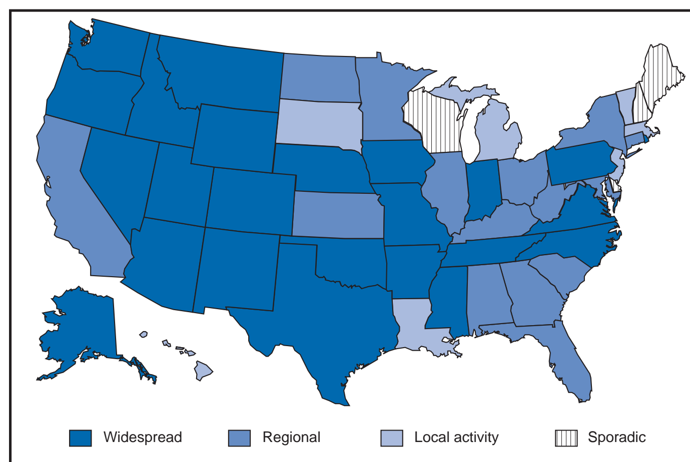
Update: Influenza Activity — United States, 2003–04 Season

Influenza began circulating in the United States unusually early this season, and influenza activity nationwide is expected to increase. Cases of severe disease, including deaths, have been reported in children. This report summarizes influenza activity in the United States during the weeks ending October 4–December 6, 2003*. During the week ending December 6, influenza activity was reported to CDC as widespread in 24 states (Figure). The early season and the unusually high and persistent demand for vaccine have resulted in a decreasing supply of trivalent inactivated vaccine. Emphasis should be placed on vaccinating persons at high risk for complications from influenza, including healthy children aged 6–23 months. Healthy persons aged 5–49 years who wish to receive vaccine should consider being vaccinated with the intranasally administered live, attenuated influenza vaccine (LAIV), a substantial supply of which remains available.

* Data reported as of December 5.

FIGURE. States in which estimated influenza activity has been reported by state epidemiologists, by level of activity* — United States, November 23–29, 2003



* Levels of activity are 1) *no activity*, 2) *sporadic*—small numbers of laboratory-confirmed influenza cases or a single influenza outbreak reported but no increase in cases of ILI, 3) *local*—outbreaks of influenza or increases in influenza-like illness (ILI) cases and recent laboratory-confirmed influenza in a single region of a state 4) *regional*—outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least two but less than half the regions of a state, and 5) *widespread*—outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of a state.

National Surveillance

CDC conducts national influenza surveillance by monitoring 1) viruses through a system of approximately 120 World Health Organization (WHO) and National Respiratory and Enteric Virus Surveillance System (NREVSS) laboratories, 2) visits for influenza-like illness (ILI)[†] through the U.S. Influenza Sentinel Providers Surveillance Network, 3) the percentage of U.S. deaths attributable to pneumonia and influenza (P&I) reported through the 122 Cities Mortality Reporting System, and 4) estimated levels of influenza activity reported to CDC by state and territorial epidemiologists. CDC also receives reports from clinicians and local health officials on influenza outbreaks and cases nationwide.

† Temperature of >100.0° F (37.8° C) and cough and/or sore throat in the absence of a known cause other than influenza.

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

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Influenza Virus Surveillance

For the weeks ending October 4–December 6, WHO and NREVSS collaborating laboratories in the United States tested 24,906 respiratory specimens for influenza viruses; 6,751 (27.1%) were positive. During the same period, the weekly percentages of respiratory specimens testing positive for influenza viruses increased from 1.4% to 37.1%. During the 2000–01, 2001–02, and 2002–03 influenza seasons, the peak percentages of specimens testing positive for influenza ranged from 23.2% to 26.4%. During the 1999–00 influenza season, when influenza A (H3N2) viruses predominated, the peak weekly percentage of specimens testing positive was 30.9% (*1*; CDC, unpublished data, 2003).

Of the 6,751 positive isolates, 6,716 (99.5%) were influenza A viruses, and 35 (0.5%) were influenza B viruses. Of the 6,716 influenza A viruses, 1,255 (18.7%) have been subtyped; 1,254 (99.9%) were influenza A (H3N2) viruses, and one (0.1%) was an influenza A (H1) virus. As of December 6, a total of 47 states and all nine surveillance regions had reported laboratory-confirmed influenza.

CDC has characterized antigenically 215 influenza viruses that were collected and submitted by U.S. laboratories since October 1. Of these, 212 were influenza A (H3N2) viruses, and one was an influenza A (H1) virus. Of the 212 influenza A (H3N2) viruses, 54 (25%) were similar antigenically to the vaccine strain A/Panama/2007/99 (H3N2), which is contained in this season's vaccine, whereas 158 (75%) were similar antigenically to A/Fujian/411/2002, a drift variant of A/Panama/2007/99.

ILI Surveillance

During the weeks ending October 4–December 6, the weekly percentages of patient visits[§] to approximately 1,000 sentinel providers nationwide for ILI increased from 0.9% to 5.1%, which is above the national baseline[¶] of 2.5%. During the 2000–01, 2001–02, and 2002–03 influenza seasons, the peak weekly percentages of patient visits for ILI ranged from 3.3% to 4.4%. During the 1999–00 season, the peak weekly percentage for patient visits for ILI was 7.1% (*1*; CDC, unpublished data, 2003).

P&I Mortality Surveillance

During the week ending December 6, P&I accounted for 7.0% of all deaths reported through the 122 Cities Mortality

[§] National and regional percentages of patient visits for ILI are weighted on the basis of state population.

[¶] Calculated as the mean percentage of visits for ILI during noninfluenza weeks, plus two standard deviations. Wide variability in regional data precludes calculating region-specific baselines and makes it inappropriate to apply the national baseline to regional data.

Reporting System. The epidemic threshold** for that week was 7.6%. Since the week ending October 4, the weekly percentage of P&I deaths has been below the epidemic threshold. The percentage of P&I deaths exceeded the epidemic threshold for zero weeks during the 2002–03 influenza season, for 9 weeks during the 2001–02 season, and for 10 weeks during the 2000–01 influenza season. During the 1999–00 influenza season, the percentage of P&I deaths exceeded the epidemic threshold for 15 weeks (*1*; CDC, unpublished data, 2003).

Activity Reported by State and Territorial Epidemiologists

During the week ending December 6, influenza activity†† was reported as widespread in 24 states (Alaska, Arizona, Arkansas, Colorado, Idaho, Indiana, Iowa, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Virginia, Washington, and Wyoming), regional in 15 states (Alabama, California, Connecticut, Florida, Georgia, Illinois, Kansas, Kentucky, Maryland, Minnesota, New York, North Dakota, Ohio, South Carolina, and West Virginia) and New York City, and local in six states (Louisiana, Massachusetts, Michigan, New Jersey, South Dakota, and Vermont) and the District of Columbia. Sporadic influenza activity was reported in five states (Delaware, Hawaii, Maine, New Hampshire, and Wisconsin) and Guam.

Reports of Severe Illness and Deaths

Pediatric cases. CDC has received reports of severe complications of influenza occurring in young infants, school-age children, and adolescents. Complications have included encephalopathy, seizures, dehydration with severe hypotension, respiratory failure requiring mechanical ventilation, and secondary bacterial pneumonia, including necrotizing pneumonia with community-associated methicillin-resistant *Staphylococcus aureus* (CA-MRSA). Three deaths (an infant aged 20 months with underlying reactive airways disease, a previously healthy infant aged 22 months, and a previously healthy child aged 16 years) have been associated with secondary pneumonia caused by CA-MRSA. Other influenza-related deaths not related to CA-MRSA in children have occurred. Fatal cases reported to CDC are being investigated by local and state health authorities. Laboratory testing has confirmed influenza A virus infection in these fatal cases; antigenic characterization is pending. The vaccination status of the majority of the deceased children has not been determined.

Pregnant women. In Texas, 88 pregnant women had laboratory-confirmed influenza A infections. Symptoms included fever, cough, and profound sinus tachycardia (i.e., 150–170 beats per minute) that resolved subsequently. One patient required intensive care for bilateral pneumonia and myocarditis. Of the 88 patients, two (2.3%) had been vaccinated 2 and 10 days before admission, respectively. No influenza-associated maternal deaths occurred; one case of fetal loss occurred but was not attributed to maternal influenza infection. The majority of the 88 cases were associated with influenza A infection; however, influenza B viruses also were detected.

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Editorial Note: Influenza seasons can vary substantially in terms of timing and pattern of onset, peaking, decline, and overall severity. In the United States, the 2003–04 influenza season began unusually early, with community activity first reported in early October, followed by continued spread of influenza activity during the weeks ending October 4–December 6. National activity levels have not yet peaked, and neither the duration of activity nor the season's eventual magnitude is known. As of December 6, influenza A (H3N2) viruses predominated in the United States, but different influenza viruses might predominate later in the season. Influenza seasons dominated by A (H3N2) viruses (e.g., those in 1996–97, 1997–98, and 1998–99) typically are associated with high levels of severe illness and deaths (*3*). No evidence exists to indicate that the A/Fujian-like viruses in circulation are more virulent than other influenza A (H3N2) viruses. However, reports of severe pediatric illnesses and deaths underscore the severe consequences that influenza infections can cause in children (*4*).

Cases of sudden death associated with influenza in previously healthy children also were reported in the United States during the 2002–03 season (*4*; CDC unpublished data, 2003). Although the pathophysiology of sudden deaths associated

** The expected baseline proportion of P&I deaths reported by the 122 Cities Mortality Reporting System is projected by using a robust regression procedure that applies a periodic regression model to the observed percentage of deaths from P&I during the previous 5 years; the epidemic threshold is 1.645 standard deviations above the seasonal baseline percentage (*2*).

†† Levels of activity are 1) *no activity*, 2) *sporadic*—small numbers of laboratory-confirmed influenza cases or a single influenza outbreak reported but no increase in cases of ILI, 3) *local*—outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in a single region of a state, 4) *regional*—outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least two but less than half the regions of a state, and 5) *widespread*—outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of a state.

with influenza in children is unknown, atypical symptoms (e.g., abdominal pain, absence of fever, and mild respiratory symptoms) have been reported.

Encephalopathy is another severe and potentially underrecognized complication of influenza in children (*5*). One case so far this season has resulted in the death of a patient (CDC, unpublished data, 2003). Patients might report high fevers, seizures, headaches, abnormal mental status, and/or confusion and do not always exhibit classic influenza symptoms. Cases have been reported among young children and school-aged children, including adolescents. Suspected cases should be reported to CDC at telephone, 404-639-0277 or 404-639-2893; fax, 404-639-3866; or e-mail, tmu0@cdc.gov or nib9@cdc.gov.

Although secondary bacterial pneumonia is a common complication of influenza infection, *S. aureus* typically occurs in a minority of such cases. Clinical and laboratory features of *S. aureus* pneumonia are similar to other types of community-acquired pneumonia (*6,7*). Clinicians should be aware that CA-MRSA can be a cause of community-acquired pneumonia. Treatment for pneumonia after influenza infection should be guided by bacterial culture results when possible. Aspirin and other salicylate-containing medications should not be administered to children with fever and respiratory illness (*1*).

Pregnant women are at higher risk than nonpregnant women for having complications secondary to influenza. Pregnant women who will be in their second or third trimester during influenza season should be vaccinated against influenza (*8*).

So far this season, influenza A/Fujian/411/2002-like viruses are predominating in the United States. This strain differs from the influenza A (H3N2) virus contained in the 2003–04 vaccine (i.e., A/Panama/2007/99). The A/Fujian-like viruses are antigenic drift variants of the A/Panama strain and were detected by global surveillance early this year but too late for inclusion in the current influenza vaccine. Hemagglutination inhibition testing using postinfection ferret sera indicates that antibodies to the A/Panama vaccine virus cross-react with A/Fujian-like viruses; therefore, current influenza vaccines should provide some protection against A/Fujian-like viruses. However, the level of protection remains uncertain until vaccine effectiveness studies are completed. The vaccine also contains A/New Caledonia/20/99 (H1N1)-like and B/Hong Kong/330/2001-like viruses and should protect persons who are vaccinated against these viruses if they circulate more widely later in the season.

Approximately 83.4 million doses of influenza vaccine, including inactivated influenza vaccine made by two manufacturers and LAIV made by a third manufacturer, were produced for the 2003–04 influenza season. All doses of trivalent inactivated vaccine appear to have been sold by the manufacturers and their major distributors. Trivalent inactivated vaccine remains available from physicians' offices and in other settings. As of December 9, a total of 3.9 million doses of LAIV were available from the manufacturer (Wyeth Pharmaceuticals, Collegeville, Pennsylvania, telephone 800-358-7443).

To ascertain the availability of influenza vaccine, CDC conducted a survey of state and urban area immunization programs. As of December 3, a total of 28 states had redistributed influenza vaccine from health-care providers and public immunization clinics that had excess supplies to those that needed vaccine. In addition, 34 states had influenza vaccine inventory that had not been distributed. However, in an average year, <10% of influenza vaccine is purchased by state health departments.

Influenza antiviral medications are available for use in adults and children. Four prescription antiviral medications (i.e., amantadine, rimantadine, oseltamivir, and zanamivir) are approved for treatment of influenza A virus infections. Oseltamivir and zanamivir also are approved for treatment of influenza B. The costs, routes of administration, adverse effects, contraindications, approved ages, and potential for antiviral resistance differ among the four drugs. When administered within 48 hours of symptom onset, antiviral treatment of influenza can reduce the duration of illness by approximately 1 day in healthy adults (*9*). Data on the use of any of the four antiviral agents during pregnancy are not available. Amantadine, rimantadine, and oseltamivir also are approved for chemoprophylaxis of influenza A virus infections and can be used for control of institutional influenza outbreaks. When used for chemoprophylaxis, antivirals can be approximately 70%–90% effective in preventing illness in healthy adults (*9,10*). To obtain information about approved age groups, dosing, and adverse effects, clinicians should consult antiviral drug package inserts (available from the Food and Drug Administration at http://www.fda.gov/cder/drug/antivirals/influenza/default.htm#drugs).

CDC has published recommendations for prevention and control of influenza (available at http://www.cdc.gov/mmwr/PDF/rr/rr5208.pdf). Supplemental recommendations have been released for the 2003–04 influenza season (Box). Influenza surveillance reports for the United States are published weekly during October–May and are available from CDC at http://www.cdc.gov/flu or through CDC's voice (telephone, 888-232-3228) and fax (telephone, 888-232-3299, document number 361100) information systems.

Acknowledgments

This report is based on data contributed by A Tulu, K Hankins, Dallas County Health and Human Svcs Office; G Wendell,

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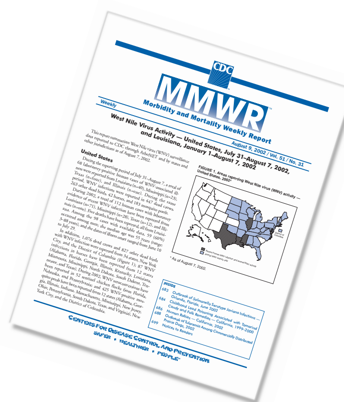
(ə-ˈrij-ən-ᵊl) 1 : being the first instance or source from which a copy, reproduction, or translation can be made; see also *MMWR*.



know what matters.

BOX. CDC recommendations to prevent influenza

Vaccination
- Emphasis should be placed on targeting trivalent inactivated vaccine to persons at high risk for complications from influenza: healthy children aged 6–23 months, adults aged ≥65 years, pregnant women in their second or third trimester during influenza season, and persons aged ≥2 years with underlying chronic conditions.
- Persons at high risk should be encouraged to search locally for vaccine if their usual health-care provider no longer has vaccine available.
- All children at high risk, including those aged 6–23 months, who report for vaccination should be vaccinated with a first or second dose, depending on vaccination status. Doses should not be held in reserve to ensure that two doses will be available.
- Next priority should be given to vaccinating those persons at greatest risk for transmission of disease to persons at high risk, including household contacts and health-care workers.
- Healthy persons aged 5–49 years should be encouraged to be vaccinated with intranasally administered live, attenuated influenza vaccine.
- Decisions about vaccinating healthy persons, including adults aged 50–64 years, with inactivated influenza vaccine should be made on a case-by-case basis, depending on local disease activity, vaccine coverage, feasibility, and supply.
- Health departments should work with their health-care providers to reallocate influenza vaccine to health-care providers in need when possible.

Hygiene
- Good respiratory hygiene should be encouraged, including cleaning of hands, and staying at home when symptomatic with fever and respiratory illness.

Medication
- Antiviral medications with specific activity against influenza A viruses should be considered either for treatment or chemoprophylaxis for influenza A, especially in persons at high risk for complications from influenza.

J Sheffield, Parkland Memorial Hospital, Dallas; J Siegel, Children's Medical Center, Dallas; N Pascoe, S Avashia, Texas Dept of Health. K Gershman, Colorado State Dept of Public Health and Environment. Participating state and territorial epidemiologists and state public health laboratory directors. WHO collaborating laboratories. National Respiratory and Enteric Virus Surveillance System collaborating laboratories, U.S. Influenza Sentinel Provider Surveillance System. Div of Public Health Surveillance and Informatics, Epidemiology Program Office; DJ O'Mara, Immunization Svcs Div, National Immunization Program, CDC.

References

1. CDC. Update: influenza activity—United States and worldwide, 2002–03 season, and composition of the 2003–04 influenza vaccine. MMWR 2003;52:516–21.
2. CDC. Surveillance for influenza—United States 1997–98, 1998–99, and 1999–00 seasons. In: CDC Surveillance Summaries (October 25). MMWR 2002;51(No. SS-7).
3. Thompson WW, Shay DK, Weintraub E, et al. Mortality associated with influenza and respiratory syncytial virus in the United States. JAMA 2003;289:179–86.
4. CDC. Severe morbidity and mortality associated with influenza in children and young adults—Michigan, 2003. MMWR 2003;52:837–40.
5. Morishima T, Togashi T, Yokata S, et al. Encephalitis and encephalopathy associated with an influenza epidemic in Japan. Clin Infect Dis 2002;35:512–7.
6. Mandell LA, Bartlett JG, Dowell SF, File TM, Musher DM, Whitney C. Update of practice guidelines for the management of community-acquired pneumonia in immunocompetent adults. Clin Infect Dis 2003;37:1405–33.
7. Johnston BL. Methicillin-resistant *Staphylococcus aureus* as a cause of community-acquired pneumonia—a critical review. Semin Respir Infect 1994;9:199–206.
8. CDC. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2003;52(No. RR-8).
9. Demicheli V, Jefferson T, Rivetti, Deeks J. Prevention and early treatment of influenza in healthy adults. Vaccine 2000;18:957–1030.
10. Hayden FG, Atmar RL, Schilling M, et al. Use of the selective oral neuraminidase inhibitor oseltamivir to prevent influenza. N Engl J Med 1999;341:1336–43.

Revised U.S. Surveillance Case Definition for Severe Acute Respiratory Syndrome (SARS) and Update on SARS Cases — United States and Worldwide, December 2003

During the 2003 epidemic of severe acute respiratory syndrome (SARS), CDC and the Council of State and Territorial Epidemiologists (CSTE) developed surveillance criteria to identify persons with SARS. The surveillance case definition changed throughout the epidemic as understanding of the clinical, laboratory, and transmission characteristics of SARS-associated coronavirus (SARS-CoV) increased (*1–5*). On June 26, CSTE adopted a position statement to add SARS-CoV disease to the National Notifiable Disease Surveillance System (NNDSS). The position statement included criteria for defining a SARS case for national reporting. On November 3, CSTE issued a new interim position statement* with a revised SARS case definition. This report summarizes the new

* The interim position statement must be ratified by the entire membership at the 2004 annual CSTE meeting. The statement is available from CSTE at http://www.cste.org/ps/2003pdfs/2003finalpdf/cstesarscasedefrevision2003-10-30.pdf.

U.S. surveillance case definition for SARS and updates reported cases of SARS worldwide and in the United States.

Summary of Changes to Case Definition

The revised SARS case definition (Box) modifies the clinical, epidemiologic, laboratory, and case-exclusion criteria in the U.S. surveillance case definition used during the 2003 epidemic. In the clinical criteria, "early" illness replaces "asymptomatic" or "mild" illness. The epidemiologic criteria include the following new categories: 1) possible exposure to SARS-CoV and 2) likely exposure to SARS-CoV. Laboratory criteria for evidence of SARS-CoV infection reflect advances in testing technology. The case-exclusion criteria have been changed to allow for exclusion when a serum sample collected >28 days after onset of symptoms is negative for antibody to SARS-CoV.

The revised case definition also classifies each SARS case as either a SARS report under investigation (SARS RUI) or SARS-CoV disease. SARS RUI is a sensitive, nonspecific case classification based solely on clinical or epidemiologic criteria and includes cases classified previously as probable or suspect. SARS-CoV disease is a more specific case classification based on selected clinical and epidemiologic criteria or laboratory confirmation. SARS RUIs might subsequently meet the definition for SARS-CoV disease based on results from laboratory testing (Tables 1 and 2).

Update on SARS Cases

During November 2002–July 2003, a total of 8,098 probable SARS cases were reported to the World Health Organization (WHO) from 29 countries, including 29 cases from the United States; 774 SARS-related deaths (case-fatality rate: 9.6%) were reported, none of which occurred in the United States (*6*). Eight U.S. cases had serologic evidence of SARS-CoV infection; these eight cases have been described previously (*7–10*). A total of 156 reported U.S. SARS cases from the 2003 epidemic remain under investigation, with 137 (88%) cases classified according to previous surveillance criteria as suspect SARS and 19 (12%) classified as probable SARS. Because convalescent serum specimens have not been obtained from the 19 probable and 137 suspect cases that remain under investigation, whether these persons had SARS-CoV disease is unknown.

Reported by: *SARS Team and Executive Committee, Council of State and Territorial Epidemiologists. SARS Investigative Team, CDC.*

Editorial Note: The revised surveillance case definition for SARS reflects an improved understanding of the clinical and laboratory characteristics of SARS-CoV. The revision differentiates patients with nonspecific clinical illness or less definitive epidemiologic associations (i.e., SARS RUIs) from those with laboratory-confirmed SARS-CoV infection or more definitive epidemiologic links (i.e., cases of SARS-CoV disease). Local and state health departments will monitor SARS RUIs to ensure implementation of prompt public health measures for preventing disease transmission if SARS-CoV is confirmed subsequently. Numerous SARS RUIs probably will be excluded as SARS cases as laboratory results become available during the course of illness. Surveillance data for cases meeting the SARS-CoV disease case definition will be reported to NNDSS and included in the weekly statistical summary of notifiable infectious diseases in the United States published in *MMWR* (Table 1. Summary of provisional cases of selected notifiable diseases, United States).

Reporting of cases meeting previous SARS definitions ended in late July 2003. However, case numbers continue to change as new clinical information or results of additional laboratory testing on cases reported previously become available. Updated case counts reflecting these changes are available from CDC at http://www.cdc.gov/od/oc/media/sars/cases.htm.

Efforts are under way to prepare for a possible reappearance of SARS-CoV. CDC, in collaboration with other federal partners, state and local health officials, professional organizations and societies, and representatives of the health-care industry, has developed a guidance document to help public health and health-care officials detect the reappearance of SARS-CoV in the United States quickly and implement a decisive and effective public health response. The document, "Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS)," is available at http://www.cdc.gov/ncidod/sars/sarsprepplan.htm.

References

1. CDC. Outbreak of severe acute respiratory syndrome—worldwide, 2003. MMWR 2003;52:226–8.
2. CDC. Updated interim surveillance case definition for severe acute respiratory syndrome (SARS)—United States, April 29, 2003. MMWR 2003;52:391–3.
3. CDC. Update: severe acute respiratory syndrome—United States, May 21, 2003. MMWR 2003;52:466–8.
4. CDC. Update: severe acute respiratory syndrome—United States, June 4, 2003. MMWR 2003;52:525–6.
5. CDC. Update: severe acute respiratory syndrome—worldwide and United States, 2003. MMWR 2003;52:664–5.
6. World Health Organization. Summary table of SARS cases by country, November 1, 2002–August 7, 2003. Available at http://www.who.int/csr/sars/country/2003_08_15/en/.
7. CDC. Severe acute respiratory syndrome (SARS) and coronavirus testing—United States, 2003. MMWR 2003;52:297–302.
8. CDC. Update: severe acute respiratory syndrome—United States, 2003. MMWR 2003;52:357–60.
9. CDC. Update: severe acute respiratory syndrome—United States, May 28, 2003. MMWR 2003;52:500–1.
10. CDC. Update: severe acute respiratory syndrome—United States, June 11, 2003. MMWR 2003;52:550.

BOX. Revised Council of State and Territorial Epidemiologists surveillance case definition for severe acute respiratory syndrome (SARS), December 2003

Clinical Criteria

Early illness

- Presence of two or more of the following features: fever (might be subjective), chills, rigors, myalgia, headache, diarrhea, sore throat, or rhinorrhea

Mild-to-moderate respiratory illness

- Temperature of >100.4° F (>38° C)* **and**
- One or more clinical findings of lower respiratory illness (e.g., cough, shortness of breath, or difficulty breathing)

Severe respiratory illness

- Meets clinical criteria of mild-to-moderate respiratory illness **and**
- One or more of the following findings:
  - — Radiographic evidence of pneumonia, **or**
  - — Acute respiratory distress syndrome, **or**
  - — Autopsy findings consistent with pneumonia or acute respiratory distress syndrome without an identifiable cause

Epidemiologic Criteria

Possible exposure to SARS-associated coronavirus (SARS-CoV)

One or more of the following exposures in the 10 days before onset of symptoms:

- Travel to a foreign or domestic location with documented or suspected recent transmission of SARS-CoV[†] or
- Close contact[§] with a person with mild-to-moderate or severe respiratory illness and history of travel in the 10 days before onset of symptoms to a foreign or domestic location with documented or suspected recent transmission of SARS-CoV[†]

Likely exposure to SARS-CoV

One or more of the following exposures in the 10 days before onset of symptoms:

- Close contact[§] with a person with confirmed SARS-CoV disease or
- Close contact[§] with a person with mild-to-moderate or severe respiratory illness for whom a chain of transmission can be linked to a confirmed case of SARS-CoV disease in the 10 days before onset of symptoms

Laboratory Criteria

Tests to detect SARS-CoV are being refined and their performance characteristics assessed[¶]; therefore, criteria for laboratory diagnosis of SARS-CoV are changing. The following are general criteria for laboratory confirmation of SARS-CoV:

- Detection of serum antibody to SARS-CoV by a test validated by CDC (e.g., enzyme immunoassay), or
- Isolation in cell culture of SARS-CoV from a clinical specimen, or
- Detection of SARS-CoV RNA by a reverse transcription polymerase chain reaction test validated by CDC and with subsequent confirmation in a reference laboratory (e.g., CDC).

Information about the current criteria for laboratory diagnosis of SARS-CoV is available at http://www.cdc.gov/ncidod/sars/labdiagnosis.htm.

Exclusion Criteria

A case may be excluded as a SARS report under investigation (SARS RUI), including as a CDC-defined probable SARS-CoV case, if any of the following apply:

- An alternative diagnosis can explain the illness fully**, **or**
- Antibody to SARS-CoV is undetectable in a serum specimen obtained >28 days after onset of illness[††], **or**
- The case was reported on the basis of contact with a person who was excluded subsequently as a case of SARS-CoV disease; then the reported case also is excluded, provided other epidemiologic or laboratory criteria are not present.

Case Classification

SARS RUI

Reports in persons from areas where SARS is not known to be active

- SARS RUI-1: Cases compatible with SARS in groups likely to be first affected by SARS-CoV[§§] if SARS-CoV is introduced from a person without clear epidemiologic links to known cases of SARS-CoV disease or places with known ongoing transmission of SARS-CoV

BOX. (*Continued*) Revised Council of State and Territorial Epidemiologists surveillance case definition for severe acute respiratory syndrome (SARS), December 2003

Reports in persons from areas where SARS activity is occurring

- SARS RUI-2: Cases meeting the clinical criteria for mild-to-moderate illness and the epidemiologic criteria for possible exposure (spring 2003 CDC definition for suspect cases[¶¶])
- SARS RUI-3: Cases meeting the clinical criteria for severe illness and the epidemiologic criteria for possible exposure (spring 2003 CDC definition for probable cases[¶¶])
- SARS RUI-4: Cases meeting the clinical criteria for early or mild-to-moderate illness and the epidemiologic criteria for likely exposure to SARS-CoV

SARS-CoV disease

- Probable case of SARS-CoV disease: meets the clinical criteria for severe respiratory illness and the epidemiologic criteria for likely exposure to SARS-CoV
- Confirmed case of SARS-CoV disease: clinically compatible illness (i.e., early, mild-to-moderate, or severe) that is laboratory confirmed

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* A measured documented temperature of >100.4° F (>38° C) is expected. However, clinical judgment may allow a small proportion of patients without a documented fever to meet this criterion. Factors that might be considered include patient's self-report of fever, use of antipyretics, presence of immunocompromising conditions or therapies, lack of access to health care, or inability to obtain a measured temperature. Initial case classification based on reported information might change, and reclassification might be required.

† Types of locations specified will vary (e.g., country, airport, city, building, or floor of building). The last date a location may be a criterion for exposure is 10 days (one incubation period) after removal of that location from CDC travel alert status. The patient's travel should have occurred on or before the last date the travel alert was in place. Transit through a foreign airport meets the epidemiologic criteria for possible exposure in a location for which a CDC travel advisory is in effect. Information about CDC travel alerts and advisories and assistance in determining appropriate dates are available at http://www.cdc.gov/ncidod/sars/travel.htm.

§ Close contact is defined as having cared for or lived with a person with SARS or having a high likelihood of direct contact with respiratory secretions and/or body fluids of a person with SARS (during encounters with the patient or through contact with materials contaminated by the patient) either during the period the person was clinically ill or within 10 days of resolution of symptoms. Examples of close contact include kissing or embracing, sharing eating or drinking utensils, close (i.e., <3 feet) conversation, physical examination, and any other direct physical contact between persons. Close contact does not include activities such as walking by a person or sitting across a waiting room or office for a brief time.

¶ The identification of the etiologic agent of SARS (i.e., SARS-CoV) led to the rapid development of enzyme immunoassays and immunofluorescence assays for serologic diagnosis and reverse transcription polymerase chain reaction assays for detection of SARS-CoV RNA in clinical samples. These assays can be very sensitive and specific for detecting antibody and RNA, respectively, in the later stages of SARS-CoV disease. However, both are less sensitive for detecting infection early in illness. The majority of patients in the early stages of SARS-CoV disease have a low titer of virus in respiratory and other secretions and require time to mount an antibody response. SARS-CoV antibody tests might be positive as early as 8–10 days after onset of illness and often by 14 days after onset of illness, but sometimes not until 28 days after onset of illness. Information about the current criteria for laboratory diagnosis of SARS-CoV is available at http://www.cdc.gov/ncidod/sars/labdiagnosis.htm.

** Factors that may be considered in assigning alternate diagnoses include the strength of the epidemiologic exposure criteria for SARS-CoV disease, the specificity of the alternate diagnostic test, and the compatibility of the clinical presentation and course of illness with the alternative diagnosis.

†† Current data indicate that >95% of patients with SARS-CoV disease mount an antibody response to SARS-CoV. However, health officials may choose not to exclude a case on the basis of lack of a serologic response if reasonable concern exists that an antibody response could not be mounted.

§§ Consensus guidance is in development between CDC and CSTE on which groups are most likely to be affected first by SARS-CoV if it reemerges. SARS-CoV disease should be considered at a minimum in the differential diagnoses for persons requiring hospitalization for pneumonia confirmed radiographically or acute respiratory distress syndrome without identifiable etiology and who have one of the following risk factors in the 10 days before the onset of illness:

- Travel to mainland China, Hong Kong, or Taiwan, or close contact with an ill person with a history of recent travel to one of these areas, or
- Employment in an occupation associated with a risk for SARS-CoV exposure (e.g., health-care worker with direct patient contact or worker in a laboratory that contains live SARS-CoV), or
- Part of a cluster of cases of atypical pneumonia without an alternative diagnosis.

Guidelines for the identification, evaluation, and management of these patients are available at http://www.cdc.gov/ncidod/sars/absenceofsars.htm.

¶¶ During the 2003 SARS epidemic, CDC case definitions were the following:

Suspect case

- Meets the clinical criteria for mild-to-moderate respiratory illness and the epidemiologic criteria for possible exposure to SARS-CoV but does not meet any of the laboratory criteria and exclusion criteria or
- Unexplained acute respiratory illness that results in death of a person on whom an autopsy was not performed and that meets the epidemiologic criteria for possible exposure to SARS-CoV but does not meet any of the laboratory criteria and exclusion criteria

Probable case

- Meets the clinical criteria for severe respiratory illness and the epidemiologic criteria for possible exposure to SARS-CoV but does not meet any of the laboratory criteria and exclusion criteria.

TABLE 1. Severe acute respiratory syndrome–associated coronavirus (SARS-CoV) case classification before laboratory testing, by clinical and epidemiologic criteria

Epidemiologic criteria	Clinical criteria for degree of illness		
	Early	Mild to moderate	Severe
Unknown	—	—	SARS RUI*-1
Possible	—	SARS RUI-2	SARS RUI-3
Likely	SARS RUI-4	SARS RUI-4	Probable case of SARS-CoV disease

* Report under investigation.

TABLE 2. Severe acute respiratory syndrome–associated coronavirus (SARS-CoV) case classification after laboratory testing, by initial report category

Initial report category	Laboratory testing results		
	Negative*	Positive	Not performed
SARS RUI†-1 to SARS RUI-4	Excluded	Confirmed case of SARS-CoV disease	Undetermined§
Probable case of SARS-CoV disease	Excluded	Confirmed case of SARS-CoV disease	Probable case of SARS-CoV disease

* Negative test as defined by negative antibody titer taken >28 days after the onset of symptoms. A negative polymerase chain reaction result does not rule out SARS-CoV disease.
† Report under investigation.
§ Collection and/or laboratory testing of specimen was not completed.

Reptile-Associated Salmonellosis — Selected States, 1998–2002

During 1998–2002, CDC received reports from state health departments regarding *Salmonella* infections in persons who had contact with reptiles (e.g., lizards, snakes, and turtles). *Salmonella* infections usually cause gastroenteritis but can result in invasive illness (e.g., septicemia and meningitis), especially in infants and immunocompromised persons. For decades, reptiles have been known as a source for salmonellosis (*1*); however, numerous reptile owners remain unaware that reptile contact places them and other household members, including children, at greater risk for salmonellosis (*2*). Increasing evidence suggests that amphibians (e.g., frogs, toads, newts, and salamanders) also can pose risks for salmonellosis in humans (*3,4*). This report describes cases of reptile-associated salmonellosis in six states*, offers recommendations on preventing transmission of *Salmonella* from reptiles and amphibians to humans (Box), and provides an update on state regulations mandating education at pet stores about salmonellosis.

* California, Connecticut, Florida, North Dakota, Ohio, and Wisconsin. At least six other states (Kansas, Maine, Maryland, Oklahoma, Washington, and Wyoming) reported similar cases.

BOX. Recommendations for preventing transmission of *Salmonella* from reptiles and amphibians to humans

- Pet-store owners, health-care providers, and veterinarians should provide information to owners and potential purchasers of reptiles and amphibians about the risks for and prevention of salmonellosis from these pets.
- Persons at increased risk for infection or serious complications from salmonellosis (e.g., children aged <5 years and immunocompromised persons) should avoid contact with reptiles and amphibians and any items that have been in contact with reptiles and amphibians.
- Reptiles and amphibians should be kept out of households that include children aged <5 years or immunocompromised persons. A family expecting a child should remove any pet reptile or amphibian from the home before the infant arrives.
- Reptiles and amphibians should not be allowed in child-care centers.
- Persons always should wash their hands thoroughly with soap and water after handling reptiles and amphibians or their cages.
- Reptiles and amphibians should not be allowed to roam freely throughout a home or living area.
- Pet reptiles and amphibians should be kept out of kitchens and other food-preparation areas. Kitchen sinks should not be used to bathe reptiles and amphibians or to wash their dishes, cages, or aquariums. If bathtubs are used for these purposes, they should be cleaned thoroughly and disinfected with bleach.
- Reptiles and amphibians in public settings (e.g., zoos and exhibits) should be kept from direct or indirect contact with patrons except in designated animal-contact areas equipped with adequate hand-washing facilities. Food and drink should not be allowed in animal-contact areas.

Case Reports

California. During December 2001, an infant aged 3 months was taken to an emergency department (ED) after 1 day of bloody diarrhea and fever. The infant was sent home with no therapy and recovered in 2 days; a stool specimen yielded *Salmonella* serotype Nima. Although no reptiles lived in the home, the infant's father was a high school biology teacher who handled reptiles in the classroom, including a large snake (i.e., a boa) that he often draped over his shoulders. A stool culture from the snake grew *S.* Nima. When interviewed, the father indicated that he knew reptiles carry *Salmonella* and was careful to wash his hands after handling them or their containers. However, he did not change clothing when he came home from work before holding his child.

Connecticut. During June 2002, a child aged 21 months was admitted to a hospital with fever, abdominal cramps, and bloody diarrhea. The child received no antibiotic therapy and was discharged the next day. Blood and stool cultures yielded *Salmonella* serotype Poona. A sibling aged 6 years also had fever and bloody diarrhea and a stool culture that yielded *S.* Poona. The family had purchased an iguana approximately 1 month earlier. The children had cleaned the iguana's cage and handled the iguana 2 days before their illness onsets. A stool culture from the iguana grew *S.* Poona; isolates from the iguana and the two siblings were indistinguishable by pulsed-field gel electrophoresis (PFGE).

Florida. During January 2000, an infant aged 1 month visited a clinic with fever and diarrhea; the infant was not hospitalized. A stool specimen yielded *Salmonella* serotype Tennessee. One week before illness onset, the infant's family moved into a household that contained a bearded dragon (i.e., *Pogona vitticeps*). The pet reptile's cage had been washed in the kitchen near the infant's bottle nipples. A stool culture from the bearded dragon yielded *S.* Tennessee. Isolates from the infant and the bearded dragon were indistinguishable by PFGE. An adult in the house reported being aware that turtles and iguanas are reservoirs for *Salmonella* but unaware that all reptiles can carry *Salmonella*. The bearded dragon was placed outside the home and later donated to a zoo.

North Dakota. During March 1998, twin infants aged 2 weeks were admitted to a hospital after 1 day of poor feeding, diarrhea, and fever. They were treated intravenously with ampicillin for 6 days. The infants' mother and a child aged 3 years in the home also had diarrhea. Stool specimens from one of the twins, the mother, and the older child yielded *Salmonella* with the partial serotype O group 44, 45, 47, 48, or 50, H antigen G complex. The family recently had acquired an iguana, which was not allowed out of its cage. Only the mother handled the reptile and cleaned the cage. When the family learned that the iguana was the probable source of *Salmonella* infections, the iguana was euthanized. Culture of intestinal contents from the iguana yielded *Salmonella* with the same partial serotype as the patients' isolates. The clinical isolate from the twin was sent to CDC for complete serotyping and found to be *Salmonella* serotype IV 48:g,z_{51}:- (known formerly as *S.* Marina).

Ohio. During August–October 2000, local health departments reported seven gastrointestinal illnesses associated with iguanas or turtles acquired at county fairs. In one incident, two siblings aged 11 and 13 years with diarrhea and abdominal cramping visited an ED. No stool specimens were collected from the children. However, stool specimens from a turtle that the siblings received at a county fair yielded *Salmonella* serotype Sandiego. During the same period, a stool specimen from a man aged 20 years with diarrhea also yielded *S.* Sandiego; he recently had won a turtle at a county fair. Isolates from the children's turtle and the man were indistinguishable by PFGE.

Wisconsin. During November 2002, an infant aged 24 days was admitted to a hospital after 1 day of bloody diarrhea. The infant was hospitalized for 3 days and received intravenous fluids and supportive care. A stool culture yielded *Salmonella* serotype IV 44:z_4z_{23}:-. The infant was treated for 14 days with oral amoxicillin. An iguana was reported living in the home of the infant's father; however, attempts to collect stool samples from the iguana were unsuccessful.

Two weeks later, an infant aged 4 months in a neighboring county visited a hospital after 8 days of fever of 100.3° F (37.9° C) and 3 days of decreased range of motion in the left hip. *Salmonella* serotype IV 44:z_4z_{23}:- was isolated from both left hip aspirate and blood cultures. The infant was hospitalized for 6 days and treated intravenously with cefotaxime and gentamicin. An iguana was reported living in the infant's home, but the reptile was removed before it could be tested. Both iguanas associated with the infants were traced back by the state health department to the same distributor in Florida.

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Editorial Note: Salmonellosis associated with reptiles is a continuing public health concern (*5,6*). During the 1970s, small pet turtles were a major source of *Salmonella* infections in the United States (*1*). In 1975, the Food and Drug Administration banned commercial distribution of small (i.e., <4 in. long) turtles; the majority of states prohibited the sale of such turtles. These measures prevented an estimated 100,000 cases of salmonellosis among children each year (*1*). However, reptiles remain popular pets in the United States; during 1991–2001, the estimated number of households with reptiles doubled from approximately 850,000 to 1.7 million (*7*). The increase in pet reptile popularity has been paralleled by an increase in the number of reptile-related *Salmonella* serotypes isolated from humans (*2,6*).

Reptiles are commonly colonized with *Salmonella* and shed the organism intermittently in their feces (*6*). Attempts to treat reptiles with antibiotics to eliminate *Salmonella* carriage

have been unsuccessful and might lead to increased antibiotic resistance (*5*). *Salmonella* survives well in the environment and can be isolated for prolonged periods from surfaces contaminated by reptile feces (*8*). For this reason, even minimal indirect contact with reptiles can result in illness (*2,5*).

Increasing evidence suggests that amphibians also are a source for salmonellosis (*3,4*). Frogs and toads are frequent carriers of *Salmonella* and have been linked by epidemiologic evidence to outbreaks (*3,4*). In a population-based, case-control study, housing an amphibian was associated independently with *Salmonella* infection (*3*). Overall, reptile and amphibian contacts are estimated to account for 74,000 (6%) of the approximately 1.2 million sporadic *Salmonella* infections that occur each year in the United States (*3*).

Gaps remain in the public's understanding of amphibian- and reptile-associated salmonellosis. In one study, fewer than half the families with salmonellosis and known iguana exposure suspected their iguanas might have been the cause of illness (*2*). Pet-store owners, health-care providers, and veterinarians should provide information and prevention messages about salmonellosis to owners and potential purchasers of reptiles and amphibians. Educational materials are available from the Pet Industry Joint Advisory Council, telephone 800-553-7387.

In 1999, the National Association of State Public Health Veterinarians and the Council of State and Territorial Epidemiologists recommended that state and local agencies adopt regulations to prohibit the sale or gift of reptiles without written point-of-sale education to consumers about the risks for and prevention of reptile-associated salmonellosis (*9*). In February 2003, CDC polled health departments in all 50 states and New York City (NYC) to determine whether such regulations existed. Among the 49 health departments responding, four states (Colorado, Illinois, Kansas, and Texas) required pet stores to provide information about salmonellosis to persons purchasing any reptile; five (California, Connecticut, Maryland, Michigan, and New York) required providing salmonellosis information to persons purchasing a turtle but not other reptiles. Tennessee prohibited sale of all turtles. NYC prohibited sale of certain reptiles, including iguanas, small turtles, and boas, and required posting of information about reptile-associated salmonellosis where other reptiles were sold.

Evaluation of the effectiveness of mandated point-of-sale education in reducing amphibian- and reptile-associated salmonellosis could help guide future prevention efforts. In the meantime, areas such as NYC have adopted restrictions on the sale of certain reptiles similar to those for small turtles.

"The important thing is not to stop questioning."

Albert Einstein

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References

1. Cohen ML, Potter M, Pollard R, Feldman RA. Turtle-associated salmonellosis in the United States: effect of public health action, 1970 to 1976. JAMA 1980;243:1247–9.
2. Mermin J, Hoar B, Angulo FJ. Iguanas and *Salmonella* Marina infection in children: a reflection of the increasing incidence of reptile-associated salmonellosis in the United States. Pediatrics 1997;99: 399–402.
3. Mermin J, Hutwagner L, Vugia D, et al. Reptiles, amphibians, and human *Salmonella* infection: a population-based, case-control study. Clin Infect Dis Suppl (in press).
4. Srikantiah P, Lay JC, Crump JA, et al. An outbreak of *Salmonella* Javiana associated with amphibian contact—Mississippi, 2001. Presented at the International Conference on Emerging Infectious Diseases, Atlanta, Georgia, 2002.
5. CDC. Reptile-associated salmonellosis—selected states, 1994–1995. MMWR 1995;44:347–50.
6. CDC. Reptile-associated salmonellosis—selected states, 1996–1998. MMWR 1999;48:1009–13.
7. Wise JK, Heathcott BL, Gonzalez ML. Results of the AVMA survey on companion animal ownership in U.S. pet-owning households. J Am Vet Med Assoc 2002;221:1572–3.
8. Friedman CR, Torigian C, Shillam PJ, et al. An outbreak of salmonellosis among children attending a reptile exhibit at a zoo. J Pediatr 1998; 132:802–7.
9. Council of State and Territorial Epidemiologists. Reptile-associated salmonellosis and prevention education. CSTE position statement 1999-ID 13. Available at http://www.cste.org/ps/1999/1999-id-13.htm.

Public Health Dispatch

Tuberculosis Outbreak Among Homeless Persons — King County, Washington, 2002–2003

The Public Health–Seattle and King County (PH-SKC) Tuberculosis Control Program, with assistance from the Washington State Department of Health and CDC, is continuing to investigate an ongoing outbreak of tuberculosis (TB) disease among homeless persons in Seattle (*1*). This report describes patient characteristics, methods used to identify active TB cases and contacts at highest risk for exposure, and control measures under way to prevent further transmission of this outbreak strain of *Mycobacterium tuberculosis*.

During 1999–2001, PH-SKC reported an annual average of 13 cases of TB among the homeless population. In 2002, diagnosis of TB in 30 homeless patients prompted an investigation. As of September 30, 2003, PH-SKC had identified 44 outbreak-associated TB patients with dates of diagnosis during May 2002–September 2003. Outbreak-associated TB patients have been defined according to the following criteria: 1) having an *M. tuberculosis* isolate with a matching 15-band restriction fragment length polymorphism (RFLP) pattern (*2*) (n = 39) or 2) if RFLP analysis is pending, having an epidemiologic link to a patient whose isolate matched the outbreak pattern (n = five). All but three of the outbreak-associated patients were homeless at the time of diagnosis; 43 (98%) were born in the United States, 34 (77%) were male, 21 (48%) were American Indian/Alaska Native, and 17 (39%) were black. Of the 38 (86%) patients with pulmonary disease, 23 (61%) had acid-fast bacilli identified on sputum smear at diagnosis. Seven (16%) outbreak-associated patients also were infected with human immunodeficiency virus (HIV).

In January 2003, an investigation conducted by PH-SKC assisted in identifying contacts at highest risk for exposure. Investigators reinterviewed outbreak patients and health-care providers serving homeless facilities to identify additional patient contacts. Sites of transmission were determined by review of homeless facility intake registries for the presence of infectious patients and the rates of positive tuberculin skin testing (TST) results among staff and clients. Exposed cohorts were identified at three sites of transmission. The cohort prioritized for intensive screening included 385 contacts from three homeless facilities and 86 other contacts named by patients or health-care providers.

In February 2003, PH-SKC began an intensive effort to screen the high-priority cohort for TB disease and latent TB infection (LTBI) in the TB clinic and at homeless facilities, which included symptom review, chest radiograph, sputum examination and culture, TST, and voluntary HIV counseling and testing. During February 1–September 30, PH-SKC screened approximately 380 contacts with a chest radiograph and/or sputum culture. Of the 44 outbreak-associated patients, 20 were reported during this time, and 11 (55%) were identified through PH-SKC screening efforts, limiting the amount of time these patients were exposing others in the community. As of December 9, all homeless outbreak-associated patients with TB disease and some contacts with LTBI were receiving directly observed therapy.

Focused, intensified screening efforts for early detection and treatment of both TB disease and LTBI are under way to control transmission in the King County community (*3*). TB controllers, particularly those from western states, should consider the possibility of unrecognized TB outbreaks involving homeless persons in their communities.

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References

1. Public Health Seattle and King County. Recent increase in tuberculosis among homeless persons in King County. Epi-Log Communicable Disease and Epidemiology News 2002;42:11. Available at http://www.metrokc.gov/health/phnr/prot_res/epilog/vol4211.htm#tb.

2. van Embden JD, Cave MD, Crawford JT, et al. Strain identification of *Mycobacterium tuberculosis* by DNA fingerprinting: recommendations for a standardized methodology. J Clin Microbiol 1993;31:406–9.
3. CDC. Prevention and control of tuberculosis among homeless persons: recommendations of the Advisory Council for the Elimination of Tuberculosis. MMWR 1992;41(No. RR-5).

Notice to Readers

Request for Information About Acute Encephalopathy Associated with Influenza Virus Infection in U.S. Children

Since the mid-1990s, several hundred cases of acute encephalopathy have been reported in Japanese children with influenza virus infection (*1,2*). These cases have been characterized by fever and rapid onset of encephalopathy, resulting in a high frequency of neurologic sequelae and mortality. The majority of the children have had laboratory-confirmed evidence of influenza.

Reports of influenza-associated encephalopathy have been uncommon in the United States (*3,4*). To determine if a similar pattern is occurring in the United States, CDC is requesting information on any case meeting certain criteria. The criteria include a person aged <18 years with altered mental status or personality change lasting >24 hours and occurring within 5 days of onset of an acute febrile respiratory illness, laboratory or rapid diagnostic test evidence of acute influenza virus infection associated with the respiratory illness, and diagnosis of the condition in the United States. Cases meeting these criteria should be reported to CDC (telephone, 404-639-0277 or 404-639-2893; fax, 404-639-3866; or e-mail, tmu0@cdc.gov or nib9@cdc.gov).

References

1. Morishima T, Togashi T, Yokata S, et al. Encephalitis and encephalopathy associated with an influenza epidemic in Japan. Clin Infect Dis 2002;35:512–7.
2. Sugaya N. Influenza-associated encephalopathy in Japan. Semin Pediatr Infect Dis 2002;13:79–84.
3. McCullers JA, Facchini S, Chesney PJ, Webster RG. Influenza B virus encephalitis. Clin Infect Dis 1999;28:898–900.
4. Straumanis JP, Tapia MD, King JC. Influenza B infection associated with encephalitis: treatment with oseltamivir. Pediatr Infect Dis J 2002;21:173–5.

Notice to Readers

Inclusion of Official Counts of SARS-CoV Disease in National Notifiable Diseases Surveillance System Data Presentation

Beginning with this issue of *MMWR*, severe acute respiratory syndrome–associated coronavirus (SARS-CoV) disease incidence data are being added to Table I, Summary of provisional cases of selected notifiable diseases, United States. Effective July 1, 2003, SARS-CoV disease was added to the list of nationally notifiable conditions as designated by the Council of State and Territorial Epidemiologists and with concurrence from CDC (*1*). The National Notifiable Diseases Surveillance System (NNDSS) is the official source of SARS-CoV disease case counts.

No SARS-CoV disease cases were reported in the United States from July 1, 2003 (27th week) through December 6, 2003 (49th week). However, as an aid to future data interpretation and comparison, SARS-CoV incidence data were included in NNDSS for the first half of the year (week ending January 4, 2003, [first week] through week ending June 28, 2003 [26th week]). Cumulative SARS-CoV disease incidence data for *MMWR* weeks 1–49 (week ending December 6, 2003) are presented in Table I.

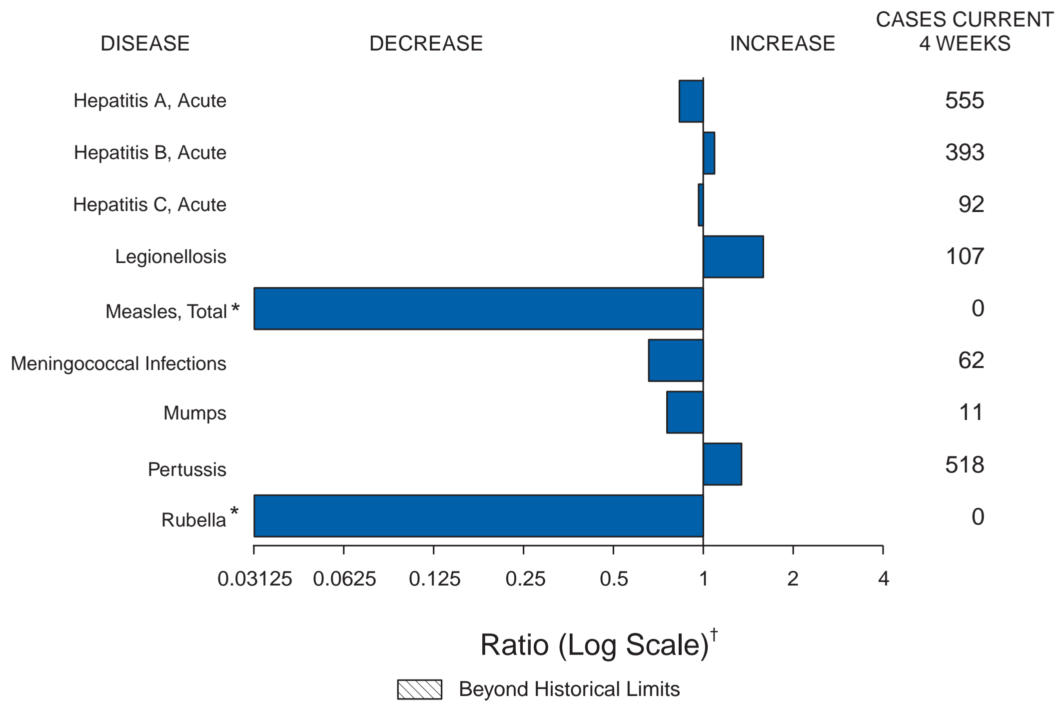
Reference

1. CDC. Revised U.S. surveillance case definition for severe acute respiratory syndrome (SARS) and update on SARS cases—United States and worldwide, December 2003. MMWR 2003;52:1202–6.

Erratum: Vol. 52, No. 41

In the report, "Infants Tested for Hearing Loss—United States, 1999–2001," an error occurred in the fourth paragraph on page 982. The paragraph should read, "For 1999, five states/areas reported that 179 infants were identified with HL; 108 (60.3%) were enrolled in early intervention programs by age 6 months. In 2001, a total of 24 states/areas reported that 1,306 infants were identified with HL; 831 (63.6%) were enrolled in early intervention programs. Of these 831 enrolled infants, 579 (69.7%) reportedly were enrolled by age 6 months."

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals December 6, 2003, with historical data



* No measles or rubella cases were reported for the current 4-week period yielding a ratio for week 49 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 December 6, 2003 (49th Week)*

	Cum. 2003	Cum. 2002		Cum. 2003	Cum. 2002
Anthrax	-	2	Hansen disease (leprosy)†	54	82
Botulism:	-	-	Hantavirus pulmonary syndrome†	17	17
foodborne	17	26	Hemolytic uremic syndrome, postdiarrheal†	143	197
infant	60	64	HIV infection, pediatric†§	204	152
other (wound & unspecified)	30	18	Measles, total	43¶	39**
Brucellosis†	80	111	Mumps	183	248
Chancroid	43	64	Plague	1	2
Cholera	1	2	Poliomyelitis, paralytic	-	-
Cyclosporiasis†	62	157	Psittacosis†	14	16
Diphtheria	1	1	Q fever†	66	55
Ehrlichiosis:	-	-	Rabies, human	3	3
human granulocytic (HGE)†	332	312	Rubella	8	16
human monocytic (HME)†	192	192	Rubella, congenital	-	1
other and unspecified	41	22	SARS-associated coronavirus disease††	8	NA
Encephalitis/Meningitis:	-	-	Streptococcal toxic-shock syndrome†	132	105
California serogroup viral†	83	144	Tetanus	13	22
eastern equine†	10	8	Toxic-shock syndrome	121	99
Powassan†	-	1	Trichinosis	4	14
St. Louis†	36	20	Tularemia†	76	72
western equine†	5	-	Yellow fever	-	-

-: No reported cases.
* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update November 30, 2003.
¶ Of 43 cases reported, 32 were indigenous, and 11 were imported from another country.
** Of 39 cases reported, 24 were indigenous, and 15 were imported from another country.
†† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (notifiable as of July 2003).

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending December 6, 2003, and December 7, 2002 (49th Week)*

Reporting area	AIDS		Chlamydia[†]		Coccidiodomycosis		Cryptosporidiosis		Encephalitis/Meningitis West Nile	
	Cum. 2003[§]	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	41,832	38,707	771,602	780,541	3,993	3,834	3,111	2,833	1,785	2,621
NEW ENGLAND	1,436	1,486	25,536	26,111	-	-	163	187	6	27
Maine	52	28	1,652	1,649	N	N	19	11	-	-
N.H.	36	35	1,037	1,466	-	-	11	29	-	-
Vt.	16	12	1,001	881	-	-	31	33	-	-
Mass.	599	753	10,845	10,319	-	-	69	76	-	18
R.I.	102	97	2,767	2,612	-	-	16	21	-	-
Conn.	631	561	8,234	9,184	N	N	17	17	6	9
MID. ATLANTIC	9,714	9,061	105,938	87,844	-	-	385	397	186	131
Upstate N.Y.	1,007	1,022	18,877	15,738	N	N	129	134	7	44
N.Y. City	5,201	5,280	32,452	28,619	-	-	94	142	-	28
N.J.	1,448	1,306	13,679	13,396	-	-	7	15	31	23
Pa.	2,058	1,453	40,930	30,091	N	N	155	106	148	36
E.N. CENTRAL	3,863	4,216	130,427	143,967	7	22	943	931	119	1,505
Ohio	757	757	29,145	36,052	-	-	169	118	106	326
Ind.	514	483	15,499	16,368	N	N	105	56	1	18
Ill.	1,718	2,092	41,303	45,610	-	2	85	119	2	554
Mich.	703	706	29,796	29,875	7	20	135	128	10	556
Wis.	171	178	14,684	16,062	-	-	449	510	-	51
W.N. CENTRAL	768	712	44,295	44,264	1	1	550	403	369	192
Minn.	162	149	9,115	9,612	N	N	144	194	49	17
Iowa	82	81	3,344	5,397	N	N	118	45	78	-
Mo.	365	335	16,971	15,148	-	-	48	38	34	107
N. Dak.	2	3	1,294	1,131	N	N	13	24	9	-
S. Dak.	14	10	2,492	2,083	-	-	40	35	65	14
Nebr.[¶]	52	66	4,550	4,397	1	1	18	51	47	35
Kans.	91	68	6,529	6,496	N	N	169	16	87	19
S. ATLANTIC	11,498	11,380	145,550	148,216	5	4	385	311	180	69
Del.	202	181	2,824	2,513	N	N	4	3	12	-
Md.	1,441	1,670	15,837	15,658	5	4	23	19	51	21
D.C.	863	769	3,016	3,165	-	-	17	5	-	-
Va.	856	811	15,969	17,271	-	-	45	24	17	-
W. Va.	86	79	2,427	2,330	N	N	4	2	1	2
N.C.	1,060	952	24,319	23,309	N	N	49	35	-	-
S.C.[¶]	756	777	15,303	13,801	-	-	8	6	2	1
Ga.	1,825	1,543	28,339	30,913	-	-	124	117	46	21
Fla.	4,409	4,598	37,516	39,256	N	N	111	100	51	24
E.S. CENTRAL	1,879	1,829	48,413	49,062	N	N	114	119	44	274
Ky.	200	287	7,483	8,310	N	N	24	8	11	42
Tenn.	800	745	19,057	15,140	N	N	38	55	17	8
Ala.	441	389	11,245	14,863	-	-	42	46	16	34
Miss.	438	408	10,628	10,749	N	N	10	10	-	190
W.S. CENTRAL	4,566	3,834	95,166	101,461	4	12	88	62	495	420
Ark.	172	224	7,251	6,903	-	-	17	8	22	12
La.	610	898	16,682	17,749	N	N	2	10	47	204
Okla.	202	180	10,358	10,345	N	N	19	16	25	-
Tex.	3,582	2,532	60,875	66,464	4	12	50	28	401	204
MOUNTAIN	1,461	1,307	41,610	48,631	2,461	2,378	129	153	382	3
Mont.	13	11	2,080	2,138	N	N	18	6	216	1
Idaho	24	28	2,374	2,364	N	N	27	28	-	1
Wyo.	7	8	908	875	1	-	5	9	94	-
Colo.	343	283	10,031	13,385	N	N	34	57	-	-
N. Mex.	102	81	6,284	6,921	8	8	10	19	68	-
Ariz.	646	551	11,818	14,063	2,399	2,315	6	16	1	1
Utah	72	62	3,274	3,257	19	11	21	14	1	-
Nev.	254	283	4,841	5,628	34	44	8	4	2	-
PACIFIC	6,647	4,882	134,667	130,985	1,514	1,416	354	270	4	-
Wash.	491	441	15,610	13,975	N	N	59	36	-	-
Oreg.	242	310	6,940	6,515	-	-	38	39	4	-
Calif.	5,802	3,993	105,254	102,727	1,514	1,416	256	192	-	-
Alaska	15	30	3,412	3,507	-	-	1	1	-	-
Hawaii	97	108	3,451	4,261	-	-	-	2	-	-
Guam	6	2	-	606	-	-	-	-	-	-
P.R.	1,025	1,042	1,761	2,390	N	N	N	N	-	-
V.I.	33	70	208	125	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	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 2002 and 2003 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 November 30, 2003.
[¶] Contains data reported through National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 6, 2003, and December 7, 2002 (49th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	2,438	3,606	258	183	126	51	17,130	19,593	293,826	331,185
NEW ENGLAND	154	258	54	46	16	6	1,319	1,666	6,754	7,296
Maine	10	37	3	8	1	-	178	198	170	130
N.H.	12	33	2	-	-	-	22	41	76	116
Vt.	18	14	-	1	-	1	116	138	83	94
Mass.	64	117	8	19	15	5	677	901	2,879	3,071
R.I.	1	12	-	1	-	-	106	145	892	864
Conn.	49	45	41	17	-	-	220	243	2,654	3,021
MID. ATLANTIC	230	403	19	1	35	7	3,392	3,997	40,725	40,024
Upstate N.Y.	92	165	11	-	17	-	1,015	1,177	7,415	8,119
N.Y. City	5	18	-	-	-	-	1,075	1,369	12,794	11,970
N.J.	22	62	1	-	-	1	351	455	7,634	7,374
Pa.	111	158	7	1	18	6	951	996	12,882	12,561
E.N. CENTRAL	550	834	25	31	23	6	2,836	3,433	58,576	70,335
Ohio	130	152	17	11	22	5	864	898	16,108	20,757
Ind.	89	76	-	1	-	-	-	-	6,210	7,052
Ill.	112	189	-	6	-	-	721	982	18,623	22,913
Mich.	89	133	-	3	-	1	722	882	12,869	13,640
Wis.	130	284	8	10	1	-	529	671	4,766	5,973
W.N. CENTRAL	423	501	54	31	20	7	1,918	2,029	15,702	17,051
Minn.	132	158	23	26	1	-	755	785	2,608	2,921
Iowa	102	120	-	-	-	-	256	300	775	1,290
Mo.	87	68	18	-	1	-	477	482	8,067	8,389
N. Dak.	13	18	4	-	8	2	38	31	72	71
S. Dak.	28	40	4	2	-	-	82	80	222	259
Nebr.	33	66	4	3	-	-	109	172	1,544	1,455
Kans.	28	31	1	-	10	5	201	179	2,414	2,666
S. ATLANTIC	148	413	70	36	11	1	2,653	2,787	72,361	84,136
Del.	11	9	N	N	N	N	46	54	1,064	1,503
Md.	14	27	-	-	-	-	113	109	7,565	8,645
D.C.	1	3	-	-	-	-	49	43	2,388	2,518
Va.	37	67	11	10	-	-	344	307	7,311	9,885
W. Va.	5	9	-	-	-	1	49	57	801	921
N.C.	4	191	30	-	-	-	N	N	14,014	14,867
S.C.	2	5	-	-	-	-	134	135	8,212	8,816
Ga.	31	43	5	8	-	-	879	868	14,321	16,905
Fla.	43	59	24	18	11	-	1,039	1,214	16,685	20,076
E.S. CENTRAL	80	106	2	-	7	10	331	380	23,963	28,398
Ky.	27	30	2	-	7	10	N	N	3,333	3,571
Tenn.	34	46	-	-	-	-	172	181	7,949	8,868
Ala.	13	19	-	-	-	-	159	199	7,211	9,618
Miss.	6	11	-	-	-	-	-	-	5,470	6,341
W.S. CENTRAL	92	108	4	2	9	9	280	246	39,186	45,460
Ark.	12	12	-	-	-	-	138	166	3,664	4,371
La.	3	4	-	-	-	-	10	6	9,891	10,970
Okla.	28	22	-	-	-	-	128	71	4,264	4,449
Tex.	49	70	4	2	9	9	4	3	21,367	25,670
MOUNTAIN	319	331	26	29	5	5	1,532	1,601	8,974	10,675
Mont.	16	30	-	-	-	-	106	92	104	108
Idaho	81	42	16	18	-	-	195	127	69	90
Wyo.	4	14	1	2	-	-	22	29	42	57
Colo.	71	97	3	6	5	5	418	548	2,408	3,323
N. Mex.	10	12	5	3	-	-	48	146	1,007	1,391
Ariz.	39	33	N	N	N	N	253	189	3,241	3,499
Utah	75	75	-	-	-	-	355	316	344	341
Nev.	23	28	1	-	-	-	135	154	1,759	1,866
PACIFIC	442	652	4	7	-	-	2,869	3,454	27,585	27,810
Wash.	112	139	1	-	-	-	330	414	2,562	2,742
Oreg.	98	204	3	7	-	-	382	427	924	836
Calif.	220	265	-	-	-	-	1,989	2,417	22,759	22,946
Alaska	4	7	-	-	-	-	83	111	512	591
Hawaii	8	37	-	-	-	-	85	85	828	695
Guam	N	N	-	-	-	-	-	7	-	45
P.R.	-	1	-	-	36	-	129	81	188	327
V.I.	-	-	-	-	-	-	-	-	55	31
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 6, 2003, and December 7, 2002 (49th Week)*

	Haemophilus influenzae, invasive†								Hepatitis (viral, acute), by type	
	All ages		Age <5 years							
	All serotypes		Serotype b		Non-serotype b		Unknown serotype		A	
Reporting area	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	1,560	1,558	20	29	87	132	174	143	6,857	8,323
NEW ENGLAND	114	116	1	-	5	11	5	2	307	286
Maine	4	2	-	-	-	-	1	-	18	8
N.H.	11	10	1	-	-	-	-	-	11	11
Vt.	9	7	-	-	-	-	-	-	6	4
Mass.	50	43	-	-	5	4	3	2	186	141
R.I.	9	10	-	-	-	-	1	-	15	30
Conn.	31	44	-	-	-	7	-	-	71	92
MID. ATLANTIC	347	284	-	3	2	15	50	23	1,699	1,070
Upstate N.Y.	126	109	-	2	2	4	13	8	141	174
N.Y. City	57	66	-	-	-	-	10	9	422	431
N.J.	60	54	-	-	-	-	10	6	149	178
Pa.	104	55	-	1	-	11	17	-	987	287
E.N. CENTRAL	226	301	4	3	12	14	32	42	670	1,006
Ohio	67	75	-	-	-	1	11	9	161	291
Ind.	48	41	1	1	8	8	-	-	75	48
Ill.	69	117	-	-	-	-	15	20	191	259
Mich.	21	17	3	2	4	5	1	-	200	215
Wis.	21	51	-	-	-	-	5	13	43	193
W.N. CENTRAL	118	71	2	1	7	3	15	6	186	280
Minn.	52	47	2	1	7	3	2	4	45	42
Iowa	-	1	-	-	-	-	-	-	30	64
Mo.	40	13	-	-	-	-	12	2	69	82
N. Dak.	3	4	-	-	-	-	-	-	1	3
S. Dak.	1	1	-	-	-	-	-	-	-	3
Nebr.	3	-	-	-	-	-	-	-	13	17
Kans.	19	5	-	-	-	-	1	-	28	69
S. ATLANTIC	363	344	3	5	17	16	20	27	1,717	2,310
Del.	-	-	-	-	-	-	-	-	7	15
Md.	87	89	1	2	7	4	1	1	169	295
D.C.	-	-	-	-	-	-	-	-	43	75
Va.	52	32	-	-	-	-	6	5	107	150
W. Va.	15	17	-	-	-	1	-	1	15	20
N.C.	36	31	-	-	3	3	2	-	105	203
S.C.	4	13	-	-	-	-	1	2	38	60
Ga.	60	78	-	-	-	-	5	12	836	476
Fla.	109	84	2	3	7	8	5	6	397	1,016
E.S. CENTRAL	73	65	1	1	2	5	10	13	246	257
Ky.	6	7	-	-	2	1	-	2	31	41
Tenn.	45	32	-	-	-	1	6	7	185	115
Ala.	20	16	1	1	-	3	3	1	15	39
Miss.	2	10	-	-	-	-	1	3	15	62
W.S. CENTRAL	65	58	2	2	8	11	5	3	366	993
Ark.	7	1	-	-	1	-	-	-	19	68
La.	12	9	-	-	-	-	5	3	54	82
Okla.	43	46	-	-	7	11	-	-	22	48
Tex.	3	2	2	2	-	-	-	-	271	795
MOUNTAIN	156	182	4	6	19	39	22	15	466	511
Mont.	-	-	-	-	-	-	-	-	8	13
Idaho	5	2	-	-	-	-	2	1	17	30
Wyo.	2	2	-	-	-	-	-	-	1	3
Colo.	37	33	-	-	-	-	7	3	68	73
N. Mex.	17	26	-	-	4	6	1	1	20	29
Ariz.	72	89	4	4	6	27	8	6	257	261
Utah	13	18	-	1	5	4	4	1	46	53
Nev.	10	12	-	1	4	2	-	3	49	49
PACIFIC	98	137	3	8	15	18	15	12	1,200	1,610
Wash.	11	3	-	2	7	1	3	-	63	145
Oreg.	44	53	-	-	-	-	5	3	57	60
Calif.	20	43	3	6	8	17	4	4	1,059	1,370
Alaska	2	2	-	-	-	-	2	2	9	10
Hawaii	21	36	-	-	-	-	1	3	12	25
Guam	-	-	-	-	-	-	-	-	-	1
P.R.	-	1	-	-	-	-	-	-	50	222
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).
† Non-serotype b: nontypeable and type other than b; Unknown serotype: type unknown or not reported. Previously, cases reported without type information were counted as non-serotype b.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 6, 2003, and December 7, 2002 (49th Week)*

Reporting area	Hepatitis (viral, acute), by type B Cum. 2003	B Cum. 2002	C Cum. 2003	C Cum. 2002	Legionellosis Cum. 2003	Legionellosis Cum. 2002	Listeriosis Cum. 2003	Listeriosis Cum. 2002	Lyme disease Cum. 2003	Lyme disease Cum. 2002
UNITED STATES	6,409	6,988	1,772	1,703	1,888	1,208	585	614	17,101	21,182
NEW ENGLAND	238	287	8	20	97	110	43	60	3,275	6,908
Maine	1	12	1	-	2	4	7	5	216	102
N.H.	11	22	-	-	6	7	3	4	95	245
Vt.	4	6	7	13	6	35	1	3	43	35
Mass.	182	152	-	6	40	44	14	33	1,064	1,796
R.I.	18	28	-	1	15	5	-	1	564	335
Conn.	22	67	U	U	28	15	18	14	1,293	4,395
MID. ATLANTIC	823	1,468	157	105	540	342	111	183	11,113	10,874
Upstate N.Y.	125	116	41	44	151	99	33	56	4,353	4,719
N.Y. City	275	714	-	-	51	62	19	39	5	58
N.J.	160	318	-	5	70	33	15	35	1,967	2,307
Pa.	263	320	116	56	268	148	44	53	4,788	3,790
E.N. CENTRAL	391	663	152	115	377	284	69	86	800	1,248
Ohio	138	103	12	2	216	116	24	23	75	72
Ind.	36	56	9	-	25	21	10	12	22	20
Ill.	1	141	17	23	3	27	8	22	33	47
Mich.	185	314	114	86	116	83	19	21	12	26
Wis.	31	49	-	4	17	37	8	8	658	1,083
W.N. CENTRAL	321	221	272	627	62	67	22	18	445	442
Minn.	33	35	9	2	3	17	11	3	321	344
Iowa	11	20	1	1	9	13	-	2	48	42
Mo.	228	111	259	608	33	19	5	9	62	40
N. Dak.	2	5	-	-	1	1	-	1	-	1
S. Dak.	2	2	-	1	2	4	-	1	1	2
Nebr.	27	26	3	15	4	13	4	1	2	6
Kans.	18	22	-	-	10	-	2	1	11	7
S. ATLANTIC	2,019	1,645	149	199	501	213	130	80	1,192	1,367
Del.	8	13	-	-	27	10	N	N	181	186
Md.	130	123	17	13	129	50	27	19	602	712
D.C.	12	21	-	-	19	6	-	-	15	22
Va.	186	196	9	15	91	30	11	7	154	204
W. Va.	37	18	4	3	17	-	6	-	27	17
N.C.	150	216	11	26	37	11	17	6	121	127
S.C.	148	118	24	5	7	10	5	8	15	24
Ga.	746	440	5	64	32	19	32	14	17	2
Fla.	602	500	79	73	142	77	32	26	60	73
E.S. CENTRAL	409	364	78	131	92	48	31	21	61	71
Ky.	71	51	17	4	43	22	9	4	15	22
Tenn.	193	129	18	26	33	18	8	12	17	26
Ala.	57	96	7	10	13	8	12	4	5	11
Miss.	88	88	36	91	3	-	2	1	24	12
W.S. CENTRAL	818	1,000	777	346	61	33	42	35	77	138
Ark.	59	109	3	10	2	-	1	-	-	3
La.	108	132	108	94	1	4	3	4	6	5
Okla.	41	76	2	5	7	3	3	9	-	-
Tex.	610	683	664	237	51	26	35	22	71	130
MOUNTAIN	582	562	52	51	72	48	30	29	19	17
Mont.	16	9	2	1	4	3	2	-	-	-
Idaho	8	7	1	1	4	1	2	2	3	4
Wyo.	31	17	-	5	2	2	-	-	2	2
Colo.	79	75	17	6	15	8	10	6	4	1
N. Mex.	33	145	-	3	3	2	2	3	1	1
Ariz.	274	199	7	4	11	12	10	14	3	3
Utah	61	48	-	4	23	14	-	3	3	5
Nev.	80	62	25	27	10	6	4	1	3	1
PACIFIC	808	778	127	109	86	63	107	102	119	117
Wash.	71	69	15	24	10	5	6	8	3	10
Oreg.	101	121	16	12	N	N	5	9	17	12
Calif.	602	568	85	72	76	55	91	77	96	92
Alaska	11	9	1	-	-	2	-	-	3	3
Hawaii	23	11	10	1	-	1	5	8	N	N
Guam	-	1	-	-	-	-	-	-	-	-
P.R.	81	175	-	-	-	-	-	2	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 6, 2003, and December 7, 2002 (49th Week)*

Reporting area	Malaria		Meningococcal disease		Pertussis		Rabies, animal		Rocky Mountain spotted fever	
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	1,090	1,321	1,460	1,674	7,305	8,144	5,284	7,323	899	998
NEW ENGLAND	41	78	68	89	1,005	821	544	880	-	7
Maine	3	6	6	5	12	17	64	57	-	-
N.H.	4	7	3	14	60	43	13	48	-	-
Vt.	2	4	3	4	64	159	37	89	-	-
Mass.	11	33	42	47	826	560	206	294	-	3
R.I.	2	7	2	5	20	13	57	72	-	4
Conn.	19	21	12	14	23	29	167	320	-	-
MID. ATLANTIC	276	360	181	201	1,007	502	914	1,259	37	59
Upstate N.Y.	59	44	50	50	640	338	408	676	2	-
N.Y. City	134	226	33	35	-	22	6	21	13	10
N.J.	40	42	25	27	84	2	62	182	11	16
Pa.	43	48	73	89	283	140	438	380	11	33
E.N. CENTRAL	84	157	204	255	670	945	159	162	15	32
Ohio	22	23	55	73	287	414	53	39	9	13
Ind.	3	14	42	32	67	139	29	31	1	4
Ill.	26	61	43	56	-	161	24	31	-	12
Mich.	23	45	43	45	112	60	46	46	5	3
Wis.	10	14	21	49	204	171	7	15	-	-
W.N. CENTRAL	48	57	127	145	435	707	541	460	70	104
Minn.	22	17	26	35	141	357	38	37	2	-
Iowa	6	4	26	25	128	129	101	77	2	3
Mo.	5	15	54	49	98	139	54	50	54	96
N. Dak.	1	1	1	3	6	7	53	54	-	-
S. Dak.	3	2	1	2	5	7	67	91	5	1
Nebr.	-	5	8	23	15	8	73	-	3	4
Kans.	11	13	11	8	42	60	155	151	4	-
S. ATLANTIC	306	309	250	271	653	396	2,374	2,550	565	475
Del.	3	5	9	7	8	3	59	53	1	1
Md.	72	104	26	9	82	62	256	376	106	40
D.C.	14	21	-	-	3	2	-	-	1	2
Va.	38	32	24	42	90	133	477	562	30	40
W. Va.	4	3	6	4	24	31	81	168	5	2
N.C.	23	22	35	32	126	43	743	679	287	285
S.C.	3	8	21	29	182	45	234	142	39	72
Ga.	64	49	30	31	32	27	346	395	82	19
Fla.	85	65	99	117	106	50	178	175	14	14
E.S. CENTRAL	22	19	80	92	137	249	171	213	109	131
Ky.	9	7	19	15	45	94	37	26	3	5
Tenn.	7	3	27	36	70	113	100	108	65	83
Ala.	3	4	15	22	16	33	33	75	12	16
Miss.	3	5	19	19	6	9	1	4	29	27
W.S. CENTRAL	69	77	169	206	647	1,589	215	1,204	92	171
Ark.	4	3	13	23	37	488	25	99	39	97
La.	4	4	34	44	6	7	-	-	-	-
Okla.	4	10	17	22	88	35	190	118	42	61
Tex.	57	60	105	117	516	1,059	-	987	11	13
MOUNTAIN	50	48	74	90	899	1,276	166	306	10	14
Mont.	-	2	5	2	5	9	21	19	1	1
Idaho	1	-	7	4	75	143	15	38	2	-
Wyo.	1	-	2	-	125	11	6	18	2	5
Colo.	22	23	22	25	340	433	38	59	2	2
N. Mex.	3	3	11	4	67	192	5	10	1	1
Ariz.	16	12	15	30	126	339	63	138	-	-
Utah	5	5	4	5	126	102	14	13	2	-
Nev.	2	3	8	20	35	47	4	11	-	5
PACIFIC	194	216	307	325	1,852	1,659	200	289	1	5
Wash.	26	24	37	62	677	437	-	-	-	-
Oreg.	11	11	58	46	422	181	6	14	-	3
Calif.	149	172	199	204	735	1,007	186	249	1	2
Alaska	1	2	3	4	7	5	8	26	-	-
Hawaii	7	7	10	9	11	29	-	-	-	-
Guam	-	-	-	1	-	2	-	-	-	-
P.R.	1	1	5	7	1	3	68	86	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 6, 2003, and December 7, 2002 (49th Week)*

Reporting area	Salmonellosis		Shigellosis		Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive: Drug resistant, all ages		*Streptococcus pneumoniae*, invasive: Age <5 years	
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	38,592	41,237	20,602	20,422	4,919	4,272	1,933	2,300	427	360
NEW ENGLAND	1,941	2,112	303	334	350	305	40	111	9	3
Maine	131	138	6	10	27	20	-	-	-	-
N.H.	100	133	5	12	21	35	-	-	N	N
Vt.	70	74	8	1	19	10	6	5	5	2
Mass.	1,139	1,180	199	198	166	103	N	N	N	N
R.I.	125	163	20	17	15	15	10	13	4	1
Conn.	376	424	65	96	102	122	24	93	U	U
MID. ATLANTIC	4,313	5,570	2,169	1,740	860	672	124	113	93	83
Upstate N.Y.	1,096	1,469	545	321	342	266	69	84	71	69
N.Y. City	1,208	1,340	378	480	122	150	U	U	U	U
N.J.	539	1,023	272	599	143	142	N	N	N	N
Pa.	1,470	1,738	974	340	253	114	55	29	22	14
E.N. CENTRAL	5,052	5,322	1,632	2,125	998	926	413	239	173	149
Ohio	1,282	1,335	287	618	280	196	269	81	95	27
Ind.	565	537	178	108	105	49	144	156	49	64
Ill.	1,604	1,737	820	1,035	182	271	-	2	-	-
Mich.	751	841	232	181	346	289	N	N	N	N
Wis.	850	872	115	183	85	121	N	N	29	58
W.N. CENTRAL	2,417	2,516	784	1,035	313	234	155	430	61	59
Minn.	543	555	100	210	155	114	-	292	51	55
Iowa	369	484	86	120	N	N	N	N	N	N
Mo.	944	803	367	190	68	42	14	5	3	1
N. Dak.	37	41	6	18	15	3	3	1	7	3
S. Dak.	115	109	16	157	21	14	1	1	-	-
Nebr.	135	181	100	249	25	24	-	26	N	N
Kans.	274	343	109	91	29	37	137	105	N	N
S. ATLANTIC	10,586	10,856	6,860	6,853	853	688	978	1,058	18	35
Del.	89	100	154	356	6	2	1	3	N	N
Md.	819	889	556	1,146	258	115	-	-	-	25
D.C.	50	76	71	60	14	9	2	-	7	3
Va.	1,041	1,160	418	922	94	73	N	N	N	N
W. Va.	123	146	-	12	33	19	70	43	11	7
N.C.	1,301	1,480	944	422	102	113	N	N	U	U
S.C.	775	821	507	128	36	38	137	188	N	N
Ga.	2,138	1,881	1,572	1,671	111	123	227	266	N	N
Fla.	4,250	4,303	2,638	2,136	199	196	541	558	N	N
E.S. CENTRAL	2,526	3,138	887	1,456	195	110	137	124	-	-
Ky.	372	376	125	188	43	19	18	17	N	N
Tenn.	718	797	356	144	152	91	119	107	N	N
Ala.	498	826	242	787	-	-	-	-	N	N
Miss.	938	1,139	164	337	-	-	-	-	-	-
W.S. CENTRAL	4,580	4,512	4,335	3,110	333	278	58	177	68	27
Ark.	760	1,036	95	192	5	8	8	9	-	-
La.	522	778	297	480	1	1	50	168	8	9
Okla.	448	489	825	562	88	43	N	N	38	6
Tex.	2,850	2,209	3,118	1,876	239	226	N	N	22	12
MOUNTAIN	2,174	2,118	1,206	885	435	526	25	48	5	4
Mont.	108	87	2	4	2	-	-	-	-	-
Idaho	170	147	33	15	19	11	N	N	N	N
Wyo.	74	106	8	8	2	7	7	13	-	-
Colo.	443	575	277	205	126	117	-	-	-	-
N. Mex.	255	304	240	220	110	105	18	34	-	-
Ariz.	736	515	530	352	163	256	-	-	N	N
Utah	216	176	50	32	11	30	-	-	5	4
Nev.	172	208	66	49	2	-	-	1	-	-
PACIFIC	5,003	5,093	2,426	2,884	582	533	3	-	-	-
Wash.	547	494	150	170	70	60	-	-	N	N
Oreg.	399	327	209	107	N	N	N	N	N	N
Calif.	3,746	3,936	2,014	2,534	387	372	N	N	N	N
Alaska	95	79	10	5	-	-	-	-	N	N
Hawaii	216	257	43	68	125	101	3	-	-	-
Guam	-	40	-	36	-	-	-	4	-	-
P.R.	325	526	8	30	N	N	N	N	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.

* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 6, 2003, and December 7, 2002 (49th Week)*

Reporting area	Syphilis				Tuberculosis		Typhoid fever		Varicella (Chickenpox)
	Primary & secondary		Congenital						
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003
UNITED STATES	6,318	6,352	346	406	10,517	12,079	297	306	12,261
NEW ENGLAND	192	140	1	1	295	405	23	13	1,722
Maine	7	2	1	-	5	20	-	-	776
N.H.	14	7	-	-	7	17	2	-	-
Vt.	1	2	-	-	7	7	-	-	790
Mass.	128	93	-	1	194	219	12	7	151
R.I.	18	9	-	-	32	48	2	-	5
Conn.	24	27	-	-	50	94	7	6	-
MID. ATLANTIC	809	691	61	65	2,027	2,073	54	76	37
Upstate N.Y.	43	31	15	4	266	294	11	9	N
N.Y. City	454	407	31	25	1,066	1,002	21	41	-
N.J.	161	154	15	35	400	468	16	18	-
Pa.	151	99	-	1	295	309	6	8	37
E.N. CENTRAL	800	1,146	67	64	1,067	1,241	23	33	5,591
Ohio	192	152	3	3	186	213	2	6	1,118
Ind.	47	60	11	3	123	117	4	2	-
Ill.	314	448	20	37	505	601	7	17	-
Mich.	235	460	33	21	201	248	10	4	3,624
Wis.	12	26	-	-	52	62	-	4	849
W.N. CENTRAL	137	119	4	2	440	495	4	10	73
Minn.	41	57	-	1	182	211	-	4	N
Iowa	7	4	-	-	25	31	2	-	N
Mo.	51	32	4	1	103	126	1	2	-
N. Dak.	2	-	-	-	4	6	-	-	73
S. Dak.	2	-	-	-	16	11	-	-	-
Nebr.	11	6	-	-	18	25	1	4	-
Kans.	23	20	-	-	92	85	-	-	-
S. ATLANTIC	1,681	1,644	67	89	2,116	2,452	51	41	2,010
Del.	6	11	-	-	23	20	-	-	28
Md.	284	205	10	15	220	267	8	8	-
D.C.	52	53	-	1	-	-	-	-	28
Va.	70	65	1	1	246	249	12	7	494
W. Va.	2	2	-	-	20	28	-	-	1,204
N.C.	143	267	19	19	315	333	9	2	N
S.C.	93	127	7	13	161	146	-	-	256
Ga.	442	357	11	13	340	501	8	5	-
Fla.	589	557	19	27	791	908	14	19	N
E.S. CENTRAL	302	437	11	30	628	704	6	4	2
Ky.	32	86	1	3	122	124	1	4	N
Tenn.	128	160	3	11	198	270	3	-	N
Ala.	110	146	5	10	220	192	2	-	-
Miss.	32	45	2	6	88	118	-	-	2
W.S. CENTRAL	878	793	67	84	1,403	1,737	32	30	2,169
Ark.	49	32	2	11	88	118	-	-	-
La.	156	146	-	-	-	-	-	-	13
Okla.	61	64	1	2	137	159	1	2	N
Tex.	612	551	64	71	1,178	1,460	31	28	2,156
MOUNTAIN	277	313	22	16	344	411	6	9	657
Mont.	-	-	-	-	5	6	-	-	N
Idaho	12	8	-	-	8	14	1	-	N
Wyo.	-	-	-	-	4	3	-	-	86
Colo.	24	64	3	2	64	92	3	4	-
N. Mex.	57	36	1	-	6	34	-	1	3
Ariz.	167	184	18	14	200	217	2	-	4
Utah	7	6	-	-	35	31	-	2	564
Nev.	10	15	-	-	22	14	-	2	-
PACIFIC	1,242	1,069	46	55	2,197	2,561	98	90	-
Wash.	75	58	-	2	224	228	3	6	-
Oreg.	42	23	-	-	95	104	5	2	-
Calif.	1,123	980	46	52	1,757	2,048	89	77	-
Alaska	-	-	-	-	53	46	-	-	-
Hawaii	2	8	-	1	68	135	1	5	-
Guam	-	6	-	-	-	64	-	-	-
P.R.	183	274	1	23	86	104	-	-	402
V.I.	1	1	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,* week ending December 6, 2003 (49th Week)

	All causes, by age (years)						
Reporting Area	All Ages	≥65	45-64	25-44	1-24	<1	P&I† Total
NEW ENGLAND	532	372	106	38	10	6	60
Boston, Mass.	133	85	29	12	5	2	8
Bridgeport, Conn.	4	2	2	-	-	-	-
Cambridge, Mass.	31	27	3	1	-	-	4
Fall River, Mass.	28	24	2	2	-	-	5
Hartford, Conn.	52	26	20	4	1	1	13
Lowell, Mass.	21	18	2	1	-	-	3
Lynn, Mass.	14	8	4	1	1	-	-
New Bedford, Mass.	35	23	5	6	1	-	3
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	72	50	12	6	2	2	7
Somerville, Mass.	6	5	1	-	-	-	-
Springfield, Mass.	45	34	8	3	-	-	6
Waterbury, Conn.	33	25	7	1	-	-	4
Worcester, Mass.	58	45	11	1	-	1	7
MID. ATLANTIC	2,695	1,876	550	173	49	40	157
Albany, N.Y.	55	41	9	4	1	-	4
Allentown, Pa.	20	18	2	-	-	-	2
Buffalo, N.Y.	93	65	19	6	2	1	11
Camden, N.J.	33	22	6	3	2	-	-
Elizabeth, N.J.	27	19	7	1	-	-	1
Erie, Pa.	47	34	10	3	-	-	2
Jersey City, N.J.	35	19	14	2	-	-	-
New York City, N.Y.	1,515	1,064	303	94	31	16	67
Newark, N.J.	72	29	24	14	-	5	5
Paterson, N.J.	25	14	8	3	-	-	-
Philadelphia, Pa.	225	134	57	19	8	7	11
Pittsburgh, Pa.[§]	36	21	6	5	-	4	-
Reading, Pa.	27	24	3	-	-	-	7
Rochester, N.Y.	187	139	33	6	4	5	22
Schenectady, N.Y.	34	28	6	-	-	-	3
Scranton, Pa.	36	28	7	1	-	-	3
Syracuse, N.Y.	153	120	25	6	-	2	9
Trenton, N.J.	30	21	6	3	-	-	1
Utica, N.Y.	20	19	-	-	1	-	3
Yonkers, N.Y.	25	17	5	3	-	-	6
E.N. CENTRAL	2,350	1,582	497	160	51	59	151
Akron, Ohio	56	31	16	4	2	3	5
Canton, Ohio	44	33	8	3	-	-	11
Chicago, Ill.	401	242	104	35	11	9	20
Cincinnati, Ohio	72	49	14	4	2	3	4
Cleveland, Ohio	254	191	47	10	2	4	11
Columbus, Ohio	221	151	39	17	10	4	18
Dayton, Ohio	144	99	35	7	3	-	11
Detroit, Mich.	227	127	65	22	4	8	14
Evansville, Ind.	57	45	11	-	-	1	3
Fort Wayne, Ind.	75	52	12	7	2	2	4
Gary, Ind.	16	6	5	4	1	-	1
Grand Rapids, Mich.	71	53	13	4	-	1	7
Indianapolis, Ind.	197	132	39	13	4	9	15
Lansing, Mich.	48	30	12	2	2	2	3
Milwaukee, Wis.	143	94	31	10	3	5	7
Peoria, Ill.	50	36	3	6	2	3	1
Rockford, Ill.	61	47	10	3	1	-	5
South Bend, Ind.	36	28	6	2	-	-	-
Toledo, Ohio	94	68	15	5	2	4	6
Youngstown, Ohio	83	68	12	2	-	1	5
W.N. CENTRAL	509	357	96	31	11	14	42
Des Moines, Iowa	46	35	7	3	1	-	3
Duluth, Minn.	47	33	10	1	2	1	4
Kansas City, Kans.	13	8	3	2	-	-	2
Kansas City, Mo.	66	40	16	6	3	1	4
Lincoln, Nebr.	58	49	6	3	-	-	7
Minneapolis, Minn.	67	43	12	2	2	8	4
Omaha, Nebr.	71	46	17	5	2	1	10
St. Louis, Mo.	U	U	U	U	U	U	U
St. Paul, Minn.	61	47	11	2	-	1	4
Wichita, Kans.	80	56	14	7	1	2	4
S. ATLANTIC	1,376	823	330	139	42	42	80
Atlanta, Ga.	124	73	28	20	2	1	6
Baltimore, Md.	173	92	46	20	9	6	12
Charlotte, N.C.	116	79	22	9	2	4	16
Jacksonville, Fla.	154	92	38	13	3	8	2
Miami, Fla.	117	68	35	10	3	1	4
Norfolk, Va.	63	41	12	7	2	1	4
Richmond, Va.	73	40	22	8	1	2	5
Savannah, Ga.	59	38	15	3	2	1	3
St. Petersburg, Fla.	43	27	12	2	1	1	3
Tampa, Fla.	245	161	48	24	6	6	17
Washington, D.C.	196	101	51	22	11	11	6
Wilmington, Del.	13	11	1	1	-	-	2
E.S. CENTRAL	880	582	200	54	21	22	67
Birmingham, Ala.	162	107	39	6	5	4	25
Chattanooga, Tenn.	74	47	18	9	-	-	4
Knoxville, Tenn.	122	85	25	4	4	4	-
Lexington, Ky.	77	57	11	5	3	1	8
Memphis, Tenn.	137	87	34	8	2	6	6
Mobile, Ala.	105	69	27	8	-	1	5
Montgomery, Ala.	51	36	8	4	1	2	10
Nashville, Tenn.	152	94	38	10	6	4	9
W.S. CENTRAL	1,585	1,002	361	132	39	51	108
Austin, Tex.	103	79	11	7	4	2	9
Baton Rouge, La.	39	25	13	1	-	-	-
Corpus Christi, Tex.	68	42	12	9	2	3	6
Dallas, Tex.	233	133	58	26	8	8	9
El Paso, Tex.	112	75	26	6	2	3	2
Ft. Worth, Tex.	121	74	32	9	3	3	5
Houston, Tex.	418	252	111	24	9	22	49
Little Rock, Ark.	83	58	16	5	1	3	4
New Orleans, La.	41	16	15	7	3	-	-
San Antonio, Tex.	194	129	36	20	3	6	13
Shreveport, La.	30	22	6	1	1	-	3
Tulsa, Okla.	143	97	25	17	3	1	8
MOUNTAIN	1,079	695	171	59	25	19	92
Albuquerque, N.M.	151	105	34	8	1	3	17
Boise, Idaho	59	42	8	4	4	1	9
Colo. Springs, Colo.	65	46	13	3	1	2	4
Denver, Colo.	100	62	19	7	6	6	12
Las Vegas, Nev.	191	131	44	12	3	1	9
Ogden, Utah	53	45	4	4	-	-	9
Phoenix, Ariz.	112	2	-	-	-	-	5
Pueblo, Colo.	43	38	4	1	-	-	2
Salt Lake City, Utah	168	119	26	10	7	6	17
Tucson, Ariz.	137	105	19	10	3	-	8
PACIFIC	1,725	1,201	359	104	39	22	129
Berkeley, Calif.	16	9	7	-	-	-	3
Fresno, Calif.	74	47	16	5	2	4	6
Glendale, Calif.	21	11	7	2	1	-	2
Honolulu, Hawaii	75	56	13	3	1	2	4
Long Beach, Calif.	96	69	18	6	1	2	7
Los Angeles, Calif.	374	267	77	18	11	1	42
Pasadena, Calif.	U	U	U	U	U	U	U
Portland, Oreg.	110	75	25	4	2	4	5
Sacramento, Calif.	185	119	43	16	6	1	7
San Diego, Calif.	172	123	34	9	5	1	16
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	188	132	38	12	3	3	9
Santa Cruz, Calif.	43	35	6	2	-	-	2
Seattle, Wash.	193	116	49	20	5	3	13
Spokane, Wash.	72	59	12	-	-	1	8
Tacoma, Wash.	106	83	14	7	2	-	5
TOTAL	12,731[¶]	8,490	2,670	890	287	275	886

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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