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Brain Injury Awareness Month — March 2006

Brain Injury Awareness Month was established to increase public awareness of brain injuries and their consequences and to address the needs of persons living with brain injuries, their family members, and caregivers. Each year in the United States, approximately 1.4 million persons sustain a traumatic brain injury (TBI); of these persons, approximately 50,000 die, 235,000 are hospitalized, and 1.1 million are treated and released from emergency departments (*1*). In addition, according to a 1999 report, an estimated 5.3 million persons in the United States have a long-term or lifelong need for help in performing activities of daily living as a result of a TBI (*2*).

In recognition of Brain Injury Awareness Month, the Brain Injury Association of America, with support from CDC, is offering educational kits that include 1) a TBI fact sheet, 2) booklets on topics such as how persons with TBI can transition to life after high school and overcome loneliness, and 3) a guide on initiating TBI awareness activities and events.

Additional information regarding Brain Injury Awareness Month is available and kits can be ordered at http://www.biausa.org/Pages/biam2006.htm or at telephone, 800-444-6443. Additional information regarding CDC's TBI-related activities is available at http://www.cdc.gov/node.do?id=0900f3ec8000dbdc.

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Incidence Rates of Hospitalization Related to Traumatic Brain Injury — 12 States, 2002

Traumatic brain injury (TBI) is a major cause of death and disability in the United States. Each year, among the estimated 1.4 million persons who sustain a TBI, an estimated 80,000–90,000 experience the onset of long-term disability (*1,2*). Since the early 1990s, CDC has supported state-level, population-based surveillance of TBI associated with hospitalization or death. For 2002, 12 states* conducted TBI surveillance according to established CDC guidelines (*1*); the 2002 multistate data were finalized in December 2005 and are the most recent available. This report presents the results of TBI surveillance for 2002, which indicated that an estimated 74,517 persons (79.0 per 100,000 population) were hospitalized with TBI-related diagnoses in the 12 reporting states; unintentional falls, motor vehicle traffic (MVT) incidents, and assaults were the leading contributors to TBI-related hospitalizations. The findings underscore the need for states to continue to monitor TBI incidence and to implement effective injury-prevention programs.

* Alaska, Arizona, California, Colorado, Maryland, Minnesota, Nebraska, New Jersey, New York, Oklahoma, South Carolina, and Utah.

INSIDE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Annual incidence rates of TBI-related hospitalization were analyzed by state, sex, age group, and intent/cause of injury. Race/ethnicity was not included in the analysis because approximately 17% of case records did not provide definitive racial/ethnic data. Cases of TBI-related hospitalization were defined on the basis of administrative hospital discharge records coded in accordance with the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM)[†] and from vital statistics data. During 2002, the 12 states initially reported 79,161 probable cases of TBI-related hospitalization. Medical records were reviewed by state program staff members for a random sample of 7,930 candidate cases in seven states, allowing estimation of the predictive value positive (PVP) (estimated at 0.95 overall) of the TBI surveillance case definition. Probable TBI case counts were adjusted downward on the basis of estimated PVP to eliminate false-positive bias (*3*). U.S. Census Bureau population estimates by state, age, and sex were combined with the PVP-adjusted surveillance data to calculate age-adjusted annual incidence rates per 100,000 population.

During 2002, a PVP-adjusted total of 74,517 persons were hospitalized with a TBI-related diagnosis in the 12 reporting states (Table 1). The age-adjusted annual incidence rate of TBI-related hospitalization was 79.0 per 100,000 population; the rate was lowest in Nebraska (50.6) and highest in Arizona (96.9).

Persons aged ≥75 years had the highest TBI-related hospitalization rate (264.4 per 100,000 population), at least twice the rate for any other age group; persons aged 15–24 years had the next-highest rate (103.3) (Table 2). Persons aged ≥75 years also had the highest TBI-related hospitalization rate associated with unintentional falls (203.9 per 100,000 population), at least three times the rate for any other age group (Table 2). The rates of TBI-related hospitalization associated with MVT incidents were highest among persons aged 15–24 years, 25–34 years, and ≥75 years; for each sex, the rate for persons aged 15–24 years was approximately twice the rate for any other age group.

Overall and in most states, the rate of TBI-related hospitalizations for males was approximately twice that for females (Table 1). Among males, rates of TBI-related hospitalization

[†] ICD-9 and/or ICD-10 codes were used to identify cases. Cases identified with multiple qualifying codes were counted as single cases. TBI-related hospitalizations were identified using the following ICD-9-CM codes: 800.0–801.9, 803.0–804.9, 850.0–854.1, 950.1–950.3, 959.01, and 995.55. TBI-related hospitalizations that resulted in death and listed only a mortality code were identified using the following ICD-10 codes: S01.0–S01.9, S02.0, S02.1, S02.3, S02.7–S02.9, S04.0, S06.0–S06.9, S07.0, S07.1, S07.8, S07.9, S09.7–S09.9, T01.0, T02.0, T04.0, T06.0, T90.1, T90.2, T90.4, T90.5, T90.8, and T90.9. Although included in the case definition, T01.0, T02.0, T04.0, and T06.0 are considered invalid codes for use in the United States; however, only three cases were identified based exclusively on these four codes.

TABLE 1. Age-adjusted annual incidence rates* of hospitalization related to traumatic brain injury, by state and sex — 12 states, 2002

State	Males		Females		Total	
	No.	Rate	No.	Rate	No.	Rate
Alaska	365	113.0	206	70.8	**571**	**92.8**
Arizona	3,452	128.2	1,832	65.2	**5,284**	**96.9**
California	16,992	102.0	8,771	49.9	**25,763**	**75.8**
Colorado	2,486	116.6	1,416	65.1	**3,902**	**90.9**
Maryland	3,109	123.5	1,826	63.8	**4,935**	**92.8**
Minnesota	2,870	117.6	1,556	58.1	**4,426**	**87.7**
Nebraska	590	69.9	318	31.7	**908**	**50.6**
New Jersey	4,370	108.6	2,638	55.3	**7,008**	**81.2**
New York	9,061	100.6	5,310	49.8	**14,371**	**74.4**
Oklahoma	1,719	102.3	1,224	64.2	**2,943**	**83.4**
South Carolina	1,710	87.7	952	43.5	**2,662**	**65.2**
Utah	1,110	102.6	634	57.5	**1,744**	**79.8**
Total	**47,834**	**105.3**	**26,683**	**53.4**	**74,517**	**79.0**

* Per 100,000 population; age-adjusted rates calculated using the U.S. 2000 standard population.

TABLE 2. Annual incidence rates* of hospitalization related to traumatic brain injury, by intent/cause of injury, age group, and sex — 12 states,† 2002

Age group (yrs)	Unintentional			Intentional		
	Falls	Motor vehicle traffic§	Struck by/ against object	Assault	Other/ Unknown	Total
Both sexes						
0–4	33.7	10.1	4.0	5.8	7.6	**61.2**
5–14	11.2	16.0	4.3	1.1	9.5	**42.0**
15–24	10.5	60.4	3.9	14.5	13.9	**103.3**
25–34	8.6	32.9	1.9	10.8	8.7	**62.9**
35–64	17.9	24.3	1.7	7.3	9.8	**60.9**
65–74	58.6	21.7	2.1	2.8	12.7	**97.9**
≥75	203.9	30.3	3.5	1.9	24.8	**264.4**
Age-adjusted total	**29.6**	**28.5**	**2.7**	**7.1**	**11.1**	**79.0**
Males						
0–4	38.3	11.4	4.8	6.9	9.3	**70.8**
5–14	15.6	20.0	6.2	1.9	13.4	**57.2**
15–24	15.9	78.7	6.0	25.7	20.8	**147.2**
25–34	13.4	44.3	3.1	19.0	13.6	**93.3**
35–64	25.3	31.6	2.6	12.6	14.1	**86.2**
65–74	70.8	25.8	3.1	4.7	18.1	**122.5**
≥75	213.9	40.4	4.2	3.0	33.5	**295.0**
Age-adjusted total	**36.3**	**36.9**	**4.0**	**12.2**	**16.0**	**105.3**
Females						
0–4	28.9	8.6	3.1	4.8	5.8	**51.2**
5–14	6.5	11.8	2.2	0.3	5.3	**26.1**
15–24	4.8	40.9	1.5	2.7	6.5	**56.5**
25–34	3.7	21.2	0.7	2.2	3.7	**31.4**
35–64	10.7	17.2	0.8	2.1	5.6	**36.4**
65–74	48.5	18.3	1.3	1.2	8.2	**77.5**
≥75	197.9	24.2	3.1	1.3	19.6	**246.1**
Age-adjusted total	**23.4**	**20.1**	**1.4**	**2.0**	**6.4**	**53.4**

* Per 100,000 population; age-adjusted rates calculated by using the U.S. 2000 standard population.
† Alaska, Arizona, California, Colorado, Maryland, Minnesota, Nebraska, New Jersey, New York, Oklahoma, South Carolina, and Utah.
§ Includes drivers, passengers, pedestrians, motorcyclists, and bicyclists.

associated with assault were highest in persons aged 15–24 years, 25–34 years, and 35–64 years; rates for males in each of these age groups were at least six times as high as those for females (Table 2). Among females, rates of TBI-related hospitalization associated with assault were highest among those aged 0–4 years; females in this age group had approximately twice the rate as females in any other age group.

For all injury categories combined, 66% of patients were discharged without subsequent health-care assistance, 17% were discharged home with health services (e.g., outpatient rehabilitation) or to residential and rehabilitation facilities, 3% percent were discharged to an acute care hospital, and 1% left against medical advice. Approximately 6% of patients had no definitive coded discharge disposition, and 6% of patients died while hospitalized. The percentage of patients discharged without health-care assistance decreased with age, from 91% for persons aged 0–4 years to 32% for those aged ≥75 years. In contrast, the percentage of patients discharged to a residential facility increased with age, from 1% for persons aged 0–4 years to 31% for those aged ≥75 years, as did the percentage of those who died in the hospital (from 3% for persons aged 0–4 years to 13% for those aged ≥75 years).

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Editorial Note: The data in this report indicate that TBI continues to be a substantial public health problem, resulting in 74,517 hospitalizations in the 12 reporting states during 2002. Findings indicate that, during 2002, rates of TBI-related hospitalization varied substantially by state but were higher among males regardless of state, age group, or intent/cause of injury. Most TBI-related hospitalizations were associated with unintentional falls, MVT incidents, and assaults.

The overall age-adjusted TBI-related hospitalization rate determined by this study was lower than the annual estimates for 1994–1995 from the National Hospital Discharge Survey (NHDS) (approximately 79 versus 98 per 100,000 population) (*4*). Both studies included in-hospital deaths. Several factors might account for the difference in estimated rates: data from the CDC TBI surveillance system used in this study might not be representative of the entire United States (*5*); states participating in the surveillance system do not report cases of TBI-related hospitalization that occur among nonresidents (*1*); as a hospitalization survey, NHDS can include multiple hospitalizations for the same injury, whereas the CDC data usually do not§; and hospital admission practices for TBI

§ Data from the CDC TBI surveillance system are unduplicated by participating states and rechecked for probable duplicates at CDC.

might have changed over time. The TBI-related hospitalization rates described in this report are consistent with those of a previous CDC study based on TBI surveillance data for 1997 (*5*). However, more specific comparisons cannot be made between the 2002 and 1997 studies because 1997 surveillance data excluded in-hospital deaths from the analysis and the estimated rates were not PVP adjusted.

The substantial variability in TBI-related hospitalization rates by state might be related to hospital admission practices, administrative ICD-coding practices, or actual differences in TBI risk factors and incidence among states (*5*). The differences in rates of TBI-related hospitalization resulting from falls and MVT incidents between persons aged 65–74 years and those aged ≥75 years suggest a need to analyze incidence data using narrower age ranges for older adults. The frequently used age grouping of ≥65 years might obscure changes in risk factors with increasing age (*5,6*).

The findings in this report are subject to at least two limitations. First, findings are based on billing data that were not designed for public health surveillance purposes. Second, this study excluded persons treated in emergency departments or outpatient facilities and persons who sought no medical care.

Despite an apparent decline in the TBI-related hospitalization rate from 1994–1995 NHDS estimates, the results in this study for 2002 indicate that TBI continues to impose substantial demands on the U.S. health-care system. The findings suggest the need for ongoing and consistently defined TBI surveillance to support monitoring of general trends and to guide further development of prevention and intervention programs addressing the major age-specific causes of TBI (*7–10*).

Acknowledgment

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Deaths Associated with Hypocalcemia from Chelation Therapy — Texas, Pennsylvania, and Oregon, 2003–2005

Chelating agents bind lead in soft tissues and are used in the treatment of lead poisoning to enhance urinary and biliary excretion of lead, thus decreasing total lead levels in the body (*1*). During the past 30 years, environmental and dietary exposures to lead have decreased substantially, resulting in a considerable decrease in population blood lead levels (BLLs) (*2*) and a corresponding decrease in the number of patients requiring chelation therapy. Chelating agents also increase excretion of other heavy metals and minerals, such as zinc and, in certain cases, calcium (*1*). This report describes three deaths associated with chelation-therapy–related hypocalcemia that resulted in cardiac arrest. Several drugs are used in the treatment of lead poisoning, including edetate disodium calcium (CaEDTA), dimercaperol (British anti-Lewisite), D-penicillamine, and meso-2,3-dimercaptosuccinic acid (succimer). Health-care providers who are unfamiliar with chelating agents and are considering this treatment for lead poisoning should consult an expert in the chemotherapy of lead poisoning. Hospital pharmacies should evaluate whether continued stocking of Na_2EDTA is necessary, given the established risk for hypocalcemia, the availability of less toxic alternatives, and an ongoing safety review by the Food and Drug Administration (FDA). Health-care providers and pharmacists should ensure that Na_2EDTA is not administered to children during chelation therapy.

Chelating agents, especially those intended for use in children, should be effective in reducing lead and other heavy

metals from the body without producing substantial adverse effects on levels of critical serum electrolytes, such as calcium. The only agent recommended for intravenous (IV) chelation therapy for children is CaEDTA (*1*). However, hospital formularies usually stock multiple chelation agents. One such agent, Na_2EDTA, was formerly used for treatment of hypercalcemia, but its use has become infrequent because of concerns regarding nephrotoxicity and because of the availability of less toxic alternatives (*3*). Furthermore, Na_2EDTA contains a warning stating, "The use of this drug in any particular patient is recommended only when the severity of the clinical condition justifies the aggressive measures associated with this type of therapy." According to the package insert, Na_2EDTA is "indicated in selected patients for the emergency treatment of hypercalcemia and for the control of ventricular arrhythmias associated with digitalis toxicity." According to FDA and CDC, the safety and effectiveness of Na_2EDTA in pediatric patients has not been established, and its use is not recommended because it induces hypocalcemia and possibly fatal tetany (*1*).

In 2005, the Texas Department of Health childhood lead poisoning surveillance program reported a death attributable to chelation-associated hypocalcemia to CDC. Subsequently, CDC queried state and local lead-surveillance programs regarding chelation-related fatalities; additional deaths were identified in Pennsylvania and Oregon.

Case Reports

Texas. In February 2005, a girl aged 2 years who was tested for blood lead during routine health surveillance had a capillary BLL of 47 μg/dL. A venous BLL of 48 μg/dL obtained 12 days later confirmed the elevated BLL. A complete blood count and iron study conducted concurrently revealed low serum iron levels and borderline anemia. On February 28, 2005, the girl was admitted to a local medical center for combined oral and IV chelation therapy.

The patient's blood electrolytes at admission were within normal limits. Initial medication orders included IV Na_2EDTA and oral succimer (an agent primarily used for treatment of lead poisoning). The medication order subsequently was corrected by the pediatric resident to IV CaEDTA. At 4:00 p.m. on the day of admission, the patient received her first dose of IV CaEDTA (300 mg in 100 mL normal saline at 25 mL/hr). At 4:35 p.m., she was administered 200 mg of oral succimer. Her vital signs remained normal throughout the night. At 4:00 a.m. the next day, a dose of IV Na_2EDTA (instead of IV CaEDTA) was administered. An hour later, the patient's serum calcium had decreased to 5.2 mg/dL (normal value for pediatric patients: 8.5–10.5 mg/dL). At 7:05 a.m., the child's mother noticed that the child was limp and not breathing. Bedside procedures did not restore a normal cardiac rhythm, and a cardiac resuscitation code was called at 7:25 a.m. The child had no palpable pulse or audible heartbeat. Repeat laboratory values for serum drawn at 7:55 a.m. indicated that the serum calcium level was <5.0 mg/dL despite repeated doses of calcium chloride. All attempts at resuscitation failed, and the girl was pronounced dead at 8:12 a.m.

An autopsy revealed no results of toxicologic significance. A postmortem radiologic bone survey indicated areas of sclerosis at the metaphyses (growth arrest and recovery lines compatible with lead exposure). The cause of death was recorded as sudden cardiac arrest resulting from hypocalcemia associated with chelation therapy. The hospital's child mortality review board findings indicated that a dose of IV Na_2EDTA was unintentionally administered to the child.

Pennsylvania. In August 2005, a boy aged 5 years with autism died while receiving IV chelation therapy with Na_2EDTA in a physician's office. During the chelation procedure, the mother noted that the child was limp. The physician initiated resuscitation, and an emergency services team transported the child to the hospital. At the emergency department (ED), further resuscitation was attempted, including administration of at least 1 and possibly 2 doses of IV calcium chloride. Subsequently, the boy's blood calcium level was recorded in the ED as 6.9 mg/dL. The child did not regain consciousness. The coroner examination indicated cause of death as diffuse, acute cerebral hypoxic-ischemic injury, secondary to diffuse subendocardial necrosis. The myocardial necrosis resulted from hypocalcemia associated with administration of Na_2EDTA. The case is under investigation by the Pennsylvania State Board of Medicine.

Oregon. In August 2003, a woman aged 53 years with no evidence of coronary artery disease, intracranial disease, or injury was treated with 700 mg IV EDTA in a naturopathic practitioner's clinic. The EDTA was provided by a compounding laboratory (Creative Compounding, Wilsonville, Oregon) and was administered by the practitioner to remove heavy metals from the body. The practitioner had provided a similar treatment to the patient on three previous occasions, once in June 2003 and twice in July 2003. Approximately 10–15 minutes after treatment began, the patient became unconscious. Cardiopulmonary resuscitation was initiated, and an emergency services team was contacted. Attempts to revive the patient en route to and in the ED were unsuccessful. The medical examiner determined the cause of death to be cardiac arrhythmia resulting from hypocalcemia associated with EDTA infusion and vascuolar cardiomyopathy. The patient's ionized calcium level during code was 3.8 mg/dL (normal value for adult patients: 4.5–5.3 mg/dL) after one IV injection of calcium gluconate administered by emergency medical

technicians en route to the hospital and another IV injection of calcium chloride in the ED. The Oregon State Naturopath Licensing Board is conducting an investigation to determine whether Na_2EDTA or CaEDTA was administered to this patient.

The cases described in this report have been reported to FDA. FDA is performing a safety assessment of Na_2EDTA, including a review of the adverse event reporting system to determine whether other deaths related to use of chelating agents have been reported.

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Editorial Note: Both children and adults are subject to potentially lethal prescription errors involving "look-alike, sound-alike" substitutions (i.e., confusion of drugs with similar names). In a 1-year study of errors in a tertiary care teaching hospital, 11.4% of medication errors were found to have resulted from use of the wrong drug name, dosage form, or abbreviation (*4*). A review of medical records in the Texas case described in this report revealed that the brand names for the Na_2EDTA product, Endrate® (Hospira, Inc., Lake Forest, Illinois), and the CaEDTA product, Calcium Disodium Versenate® (3M Pharmaceuticals, St. Paul, Minnesota), were used interchangeably; this improper use of drug names likely resulted in the inappropriate administration of Na_2EDTA.

Although CaEDTA and succimer were ordered for one patient and the form of EDTA administered to another remains under investigation, these drugs singly or in combination probably were not responsible for the low calcium levels. Hypercalcemia as a result of IV administration of CaEDTA has been reported (*5*). Succimer by itself is a weak calcium binder but is not associated with a drop in essential minerals such as calcium (*6*). Moreover, the reported doses of CaEDTA and succimer in the Texas case were appropriate and within established safety limits.

Medical center records and coroner reports indicate that Na_2EDTA was administered in at least two of the cases. Na_2EDTA is often part of a standard hospital formulary; however, it should never be used for treating lead or other heavy metal poisoning in children because it induces hypocalcemia, which can lead to tetany and death (*7*). The error that caused the death in Texas most likely resulted from miscommunication between the pharmacy and the pediatric unit.

Chelation therapy with CaEDTA, dimercaperol, or succimer has been the mainstay of medical management for children with BLLs ≥45 μg/dL (*1*). The effectiveness of chelation therapy in improving renal or nervous system symptoms of chronic mercury toxicity has not been established. Nonetheless, certain health-care practitioners have used chelation therapy for autism in the belief that mercury or other heavy metals are producing the symptoms (*8*). Other practitioners have recommended chelation therapy for treatment of coronary artery disease, hoping to eliminate calcified atherosclerotic plaques that can lead to coronary artery occlusions and myocardial infarctions. These off-label uses of chelation therapy are not supported by accepted scientific evidence. The Institute of Medicine found no scientific evidence that chelation is an effective therapy for autism spectrum disorder (*8*). Because limited consistent data exist on the use of chelation therapy to treat coronary artery disease, a clinical trial to assess the safety and effectiveness of chelation therapy is being conducted by the National Institutes of Health.*

Deaths associated with lead poisoning are rare (*9*), and childhood deaths caused by cardiac arrest associated with chelation therapy have not been documented previously (*9*). As BLLs among children in the United States continue to decline (*2*), fewer children require chelation therapy. Primary care providers should consult experts in the chemotherapy of lead before using chelation drug therapy. If such an expert is not available, primary care providers should contact state or local childhood lead poisoning prevention programs or the Lead Poisoning Prevention Branch of the National Center for Environmental Health, CDC.

CDC and its state and local partners will continue to educate health-care providers and pharmacists to ensure that Na_2EDTA is never administered to children during chelation therapy. CDC recommends that hospital pharmacies evaluate the need to keep Na_2EDTA in their formularies. Case reports of cardiac arrest or symptoms of hypocalcemia during chelation therapy should be reported to the CDC Lead Poisoning Prevention Branch (770-488-3300) or to MedWatch, the FDA adverse event reporting system, at http://www.fda.gov/medwatch.

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This report is based, in part, on contributions by M Markowitz, MD, Albert Einstein College of Medicine, New York, New York; SI Fisch, MD, Valley Baptist Hospital, Harlingen, Texas; and E Strimlan, Allegheny County, Pennsylvania Office of the Coroner.

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Human Rabies — Mississippi, 2005

On September 27, 2005, a previously healthy boy aged 10 years in Mississippi died from encephalitis later attributed to rabies. This report summarizes the patient's clinical course and the subsequent epidemiologic investigation, which implicated exposure to bats at the boy's home as the likely source of rabies. The findings underscore the importance of recognizing the risk for rabies from direct contact with bats and seeking prompt medical attention when exposure occurs.

Case Report

On September 11, 2005, the boy had fever and headache. He was evaluated by a pediatrician on September 13 for a temperature of 102.4°F (39.1°C) and was noted to have sensations that the patient described as an "itchy" scalp. Viral illness was diagnosed, and the patient was advised to return if symptoms worsened. The patient was taken to a local emergency department (ED) in the early morning hours of September 15 with ongoing febrile illness. All laboratory tests and chest radiography ordered were within normal limits, and the patient was discharged home.

The patient's clinical signs worsened throughout the day, and he returned to the ED that evening with symptoms of fever, insomnia, urinary urgency, paresthesia of the right side of the scalp and right arm, dysphagia, disorientation, and ataxia. He was admitted to the hospital for suspected encephalitis. A clinical history revealed no known tick bites or contact with animals other than the family pets.

Upon admission, the patient had a temperature of 100.0°F (37.8°C) and a white blood cell (WBC) count of 12,200/μL (normal: 4,800–13,500/μL). Analysis of cerebrospinal fluid (CSF) indicated a WBC count of 226/μL (normal: 0–5/μL), protein level of 79 mg/dL (normal: 12–60 mg/dL), and glucose level of 69 mg/dL (normal: 45–75 mg/dL). Serum and CSF samples were obtained for IgG and IgM antibody testing for West Nile, St. Louis, Lacrosse, and Eastern equine encephalitis (EEE) viruses.

Shortly after admission, the patient's neurologic status deteriorated rapidly. His speech became slurred, and he began to hallucinate. He became increasingly agitated and combative and required sedation. In his agitated state, the patient bit a family member. The next morning the patient was transferred to a tertiary care facility. Within hours after transfer, he became lethargic and was intubated. Serologic tests for West Nile, St. Louis, Lacrosse, and EEE viruses, Rocky Mountain spotted fever, and *Bartonella* spp. were negative. Herpes simplex virus and enterovirus were not detected in CSF by polymerase chain reaction (PCR), and arbovirus-specific antibodies were not detected in CSF. Computed tomography scans of the head with and without contrast were within normal limits. During the next 10 days, the patient continued to worsen and experienced wide fluctuations in blood pressure and temperature. On September 26, he had onset of cerebral edema and subsequent brain herniation. Life support was withdrawn, and the patient died on September 27.

Laboratory and Public Health Investigation

The case was referred to CDC's Unexplained Deaths Project (UNEX) for additional diagnostic testing. Clinicians who had treated the patient suspected EEE and possibly rabies on the basis of the patient's rapidly progressive encephalopathy. On October 5, CDC diagnosed rabies on the basis of an increase in rabies-virus–specific IgG antibody titer from 128 to 8,192 in paired sera samples collected on September 16 and 21. Subsequent testing of CSF demonstrated the presence of rabies-virus–specific antibodies. Rabies-virus nucleic acid was not detected in CSF by reverse transcription PCR. No other clinical specimens were available to allow virus characterization and identification of a likely animal source of infection.

Family members and friends of the patient did not report a definitive animal bite when queried during the patient's illness. However, after the child's death, several persons reported that bats were commonly seen outside the home. On two occasions, dead bats also were discovered inside the home and attached garage, and a live bat was caught in an apartment above the garage during the summer of 2005. The child had removed a live bat from his bedroom and released it outdoors in the spring of 2005.

The child had attended a summer camp in Alabama for several weeks in July. The camp program included an overnight stay in a nearby cavern used for tours and special events. Interviews with the camp director and parents of children who attended the overnight camp-out with the patient revealed no

indication of direct contact with bats at the camp or in the cavern, although one bat was reportedly observed clinging to the rocky wall inside the cavern.

Postexposure prophylaxis (PEP) was administered to 23 family members and friends who possibly had contact with the patient's saliva from August 28 (14 days preceding the first clinical signs of rabies) to the patient's death on September 27. Interviews with family and friends suggested that the patient commonly shared food and drink with others, particularly children. Among 79 health-care workers evaluated for potential exposure to infectious body fluids, 32 received PEP, including 19 nurses, four physicians, five respiratory therapists, two radiology technicians, and two laboratory staff.

Reported by: *A Palmer, MD, Univ of Mississippi Medical Center, E McVey III, MD, Baptist Medical Center, Jackson; KM McNeill, MD, PhD, S Hand, Office of the State Epidemiologist, Mississippi Dept of Health. CE Rupprecht, VMD, PhD, CA Hanlon, VMD, PhD, M Watts, Div of Viral and Rickettsial Diseases; S Reagan, MPH, Div of Bacterial and Mycotic Diseases; AS Chapman, DVM, EL Yee, MD, DK Gross, DVM, PhD, EIS officers, CDC.*

Editorial Note: This report describes the only case of human rabies diagnosed in the United States in 2005 and the first case in Mississippi since 1956. On the basis of multiple reports regarding the presence of bats in and around the family home in Mississippi and the observation that the patient had handled a live bat at his home in the spring of 2005, contact with a bat at the patient's home was determined to be the likely source of rabies infection in this case. Bats are the only known reservoir of rabies in Mississippi.

Since 1995, a total of 379 deaths possibly attributed to infectious disease have been reported to CDC's UNEX. Of these, 131 (35%) have had a probable etiology identified. The case described in this report represents the first diagnosis of rabies made for a death reported to UNEX.

Thirty-two health-care workers received PEP as a result of this case. Providing health care to a patient with rabies is not an indication for PEP unless mucous membranes or an open wound are contaminated with infectious material, such as saliva, tears, CSF, or neurologic tissue. Standard precautions and adherence to infection-control measures will minimize the risk for exposure (*1*).

During 1980–2004, a total of 56 cases of human rabies were reported in the United States. Among the 55 cases for which rabies-virus variants were obtained, 35 (64%) were associated with insectivorous bats, most commonly the silver-haired and eastern pipistrelle bats (*2–6*). More than half (57%) of these human cases occurred during August–November, coincident with a seasonal increase in prevalence of rabid bats detected in the United States (*6*). Despite the substantial number of cases of human rabies attributable to bat exposure, the importance of these exposures is often overlooked or underestimated (*2*).

Human rabies is preventable with proper wound care and timely and appropriate administration of PEP after exposure (*1*). PEP is recommended for all persons with a bite, scratch, or mucous-membrane exposure to a bat unless the bat tests negative for rabies. When a bat is found in close proximity to humans, it should be submitted to a public health laboratory for diagnostic testing, if it can be captured safely. If the animal is not available for testing, PEP should be administered when a strong probability exists that exposure occurred. However, if a bat bite is unrecognized or the importance of the exposure is underestimated, medical intervention might not be sought and appropriate treatment might not be administered. Once clinical signs of rabies develop, PEP is no longer effective and a rapid, progressive, and usually fatal encephalitis ensues.

This report underscores the need for increasing public awareness of the risk for rabies after contact with bats and other wildlife. Persons bitten by a potentially rabid animal should immediately 1) wash the wound thoroughly with soap and water; 2) capture the animal, if this can be done safely (avoiding direct contact with the animal) and submit it for testing; 3) report the incident to local or state public health officials; and 4) see a physician for treatment and evaluation regarding the need for PEP. Persons should not handle nor keep bats as pets and should exclude bats from living quarters, public places, and structures adjacent to the home. Recognizing the risk for rabies from any direct exposure to bats and other wildlife is critical, and persons must seek prompt medical evaluation if exposed.

Acknowledgments

The findings in this report are based, in part, on data reported by M Niezgoda, MS, and L Orciari, MS, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases, CDC.

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A New Product (VariZIG™) for Postexposure Prophylaxis of Varicella Available Under an Investigational New Drug Application Expanded Access Protocol

On February 24, this report was posted as an MMWR Early Release *on the* MMWR *website* (http://www.cdc.gov/mmwr).

On October 27, 2004, the Advisory Committee on Immunization Practices (ACIP) was informed by the only U.S.-licensed manufacturer of varicella zoster immune globulin (VZIG) (Massachusetts Public Health Biologic Laboratories, Boston, Massachusetts) that the company had discontinued production of VZIG. The supply of the licensed VZIG product is now nearly depleted. In February 2006, an investigational (not licensed) VZIG product, VariZIG™ (Cangene Corporation, Winnipeg, Canada) became available under an investigational new drug application (IND) submitted to the Food and Drug Administration (FDA).* This product can be requested from the sole authorized U.S. distributor, FFF Enterprises (Temecula, California), for patients who have been exposed to varicella and who are at increased risk for severe disease and complications (*1*).

The investigational VariZIG, similar to licensed VZIG, is a purified human immune globulin preparation made from plasma containing high levels of anti-varicella antibodies (immunoglobulin class G [IgG]). Unlike the previous product, the investigational product is lyophilized. When properly reconstituted, VariZIG is approximately a 5% solution of IgG that can be administered intramuscularly. As with any product used under IND, patients must be informed of potential risks and benefits and must give informed consent before receiving the product.

Indications for Use of Investigational VariZIG

Patients without evidence of immunity to varicella (i.e., without history of disease or age-appropriate vaccination) who are at high risk for severe disease and complications, who have been exposed to varicella, and from whom informed consent has been obtained, are eligible to receive the IND application product under an expanded access protocol. The patient groups recommended by ACIP to receive VariZIG include the following:

- Immunocompromised patients.
- Neonates whose mothers have signs and symptoms of varicella around the time of delivery (i.e., 5 days before to 2 days after).
- Premature infants born at ≥28 weeks of gestation who are exposed during the neonatal period and whose mothers do not have evidence of immunity.
- Premature infants born at <28 weeks of gestation or who weigh ≤1,000 g at birth and were exposed during the neonatal period, regardless of maternal history of varicella disease or vaccination.
- Pregnant women.

Varicella vaccine was recommended in 1999 for postexposure prophylaxis of other persons without evidence of varicella immunity and who have no contraindications to vaccination (*2*). The vaccine should be administered preferably within 96 hours and possibly up to 120 hours postexposure. If illness occurs, with or without postexposure vaccination, antiviral treatment (e.g., acyclovir) can be considered for adolescents and adults.

Administration

Investigational VariZIG is expected to provide maximum benefit when administered as soon as possible after exposure, although it can be effective if administered as late as 96 hours after exposure; treatment after 96 hours is of uncertain value. VariZIG should be administered intramuscularly as directed by the manufacturer.

When indicated, health-care providers should make every effort to obtain and administer VariZIG. In situations in which administration of VariZIG does not appear possible within 96 hours of exposure, administration of immune globulin intravenous (IGIV) should be considered as an alternative. IGIV should also be administered within 96 hours of exposure. Although licensed IGIV preparations are known to contain anti-varicella antibody titers, the titer of any specific lot of IGIV that might be available is uncertain because IGIV is not routinely tested for anti-varicella antibodies. The recommended IGIV dose for postexposure prophylaxis of varicella is 400 mg/kg, administered once. For pregnant women who cannot receive VariZIG within 96 hours of exposure, clinicians may choose either to administer IGIV or closely monitor the women for signs and symptoms of varicella and institute treatment with acyclovir if illness occurs.

Dosage

Investigational VariZIG is supplied in 125-U vials. The recommended dose is 125 units/10 kg body weight, up to a maximum of 625 units (five vials). The minimum dose is 125 U.

*Available at http://www.fda.gov/cber/infosheets/mphvzig020806.htm.

Interval Between Administration of VariZIG and Varicella Vaccine

Any patient who receives investigational VariZIG to prevent varicella subsequently should receive varicella vaccine, provided the vaccine is not contraindicated. Varicella vaccination should be delayed until 5 months after VariZIG administration. Varicella vaccine is not needed if the patient has varicella after administration of VariZIG.

Antiviral Therapy

Any patient who receives investigational VariZIG should be observed closely for signs or symptoms of varicella for 28 days after exposure because VariZIG might prolong the incubation period by ≥1 week. Antiviral therapy should be instituted immediately if signs or symptoms of varicella disease occur. The route and duration of antiviral therapy should be determined by specific host factors, extent of infection, and initial response to therapy.

How to Obtain Investigational VariZIG

Investigational VariZIG is produced by Cangene Corporation (Winnipeg, Canada) and is distributed by FFF Enterprises (Temecula, California). An expanded access protocol under the IND application enables use of investigational VariZIG for patients who meet the protocol's enrollment criteria[†] and who choose to participate. The expanded access protocol has received central institutional review board (IRB) approval. With this central IRB review and approval, FDA does not require an additional approval by the IRB at the treatment site. However, some institutions might require that the institution's IRB be notified before the institution or its physicians participate in a study reviewed by a central IRB. In such cases, notification and any local IRB review may take place before a patient who needs the investigational product is identified. However, if a patient who needs the investigational product is identified before any required local IRB review has taken place, the investigational product may be shipped under the approval of the central IRB while coordination with the institution's IRB is addressed. In any event, all informed consent and other patient protections must still be in place.

Pharmacists and health-care providers who expect to have patients who will need VariZIG may participate in a program that allows them to acquire inventory in advance. VariZIG delivered for inventory will be accompanied by all forms required by the IND expanded access protocol (i.e., release form, protocol, informed consent form, case report forms, investigator brochure, drug accountability form, and contact information for FFF Enterprises and Cangene Corporation); IRB approval (i.e., central or local) should be in place. Providers who identify a patient for whom VariZIG is indicated should contact FFF Enterprises (24-hour telephone, 800-843-7477) and fax the completed release form. FFF Enterprises will review the form to determine patient eligibility and allot a patient number to eligible patients at the time of the call.

Alternatively, if VariZIG is not available on site to the pharmacist or health-care provider, a product release form can be requested directly from FFF Enterprises by calling the 24-hour telephone line. FFF Enterprises will transmit the product release form by e-mail or fax for completion and return. If the patient is eligible, FFF Enterprises will allot a patient number, and investigational VariZIG will be shipped with the required forms. Under normal circumstances, investigational VariZIG can be delivered from the distributor to its destination within 24 hours of request.

[†] A sample release form is available at http://www.fda.gov/cber/infosheets/mphvzig020806form.pdf.

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Update: Influenza Activity — United States, February 12–18, 2006

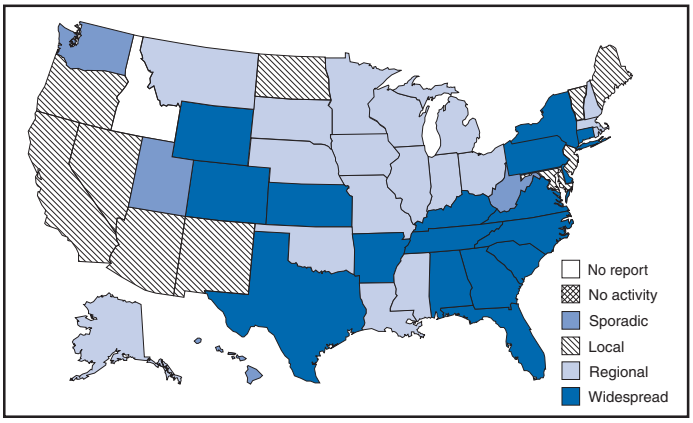
During February 12–18, 2006,* the number of states reporting widespread influenza activity[†] increased to 17. Eighteen states reported regional activity, 10 reported local activity, and four reported sporadic activity (Figure 1).[§]

* Provisional data reported as of February 24. Additional information about influenza activity is updated each Friday and is available from CDC at http://www.cdc.gov/flu.

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

[§] *Widespread:* Alabama, Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Kansas, Kentucky, New York, North Carolina, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, and Wyoming; *regional:* Alaska, Illinois, Indiana, Iowa, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, Ohio, Oklahoma, Rhode Island, South Dakota, and Wisconsin; *local:* Arizona, California, Maine, Maryland, Nevada, New Jersey, New Mexico, North Dakota, Oregon, and Vermont; *sporadic:* Hawaii, Utah, Washington, and West Virginia; *no activity:* none; *no report:* Idaho.

FIGURE 1. Estimated influenza activity levels reported by state epidemiologists, by state and level of activity* — United States, February 12–18, 2006



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

The percentage of specimens testing positive for influenza increased in the United States overall. During the preceding 3 weeks (weeks 5–7), the percentage of specimens testing positive for influenza ranged from 31.2% in the East North Central region to 10.5% in the Pacific region. The percentage of outpatient visits for influenza-like illness (ILI)[¶] increased during the week ending February 18 and remains above the national baseline.** The percentage of deaths attributed to pneumonia and influenza (P&I) was below the epidemic threshold for the week ending February 18.

Laboratory Surveillance

During February 12–18, World Health Organization (WHO) collaborating laboratories and National Respiratory and Enteric Virus Surveillance System (NREVSS) laboratories in the United States reported testing 2,864 specimens for influenza viruses, of which 437 (15.3%) were positive. Of these, 116 were influenza A (H3N2) viruses, six were influenza A (H1N1) viruses, 288 were influenza A viruses that were not subtyped, and 27 were influenza B viruses.

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

** The national baseline was calculated as the mean percentage of visits for ILI during noninfluenza weeks for the preceding three seasons, plus two standard deviations. Noninfluenza weeks are those in which <10% of laboratory specimens are positive for influenza. Wide variability in regional data precludes calculating region-specific baselines; therefore, applying the national baseline to regional data is inappropriate.

Since October 2, 2005, WHO and NREVSS laboratories have tested 73,094 specimens for influenza viruses, of which 6,174 (8.4%) were positive. Of these, 5,905 (95.6%) were influenza A viruses, and 269 (4.4%) were influenza B viruses. Of the 5,905 influenza A viruses, 2,674 (45.3%) have been subtyped; 2,640 (98.7%) were influenza A (H3N2) viruses, and 34 (1.3%) were influenza A (H1N1) viruses.

P&I Mortality and ILI Surveillance

During the week ending February 18, P&I accounted for 7.3% of all deaths reported through the 122 Cities Mortality Reporting System. This percentage is below the epidemic threshold[††] of 8.3% (Figure 2).

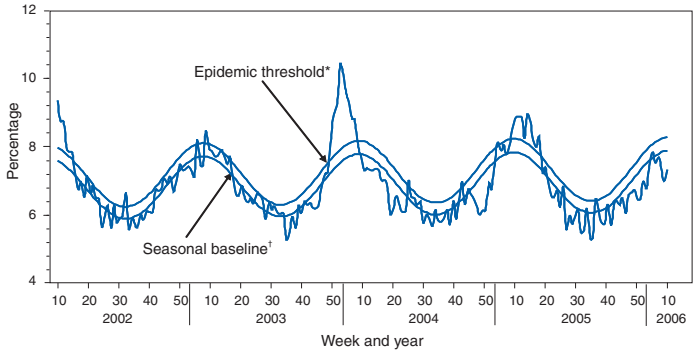
The percentage of patient visits for ILI was 2.8%, which is above the national baseline of 2.2% (Figure 3). The percentage of patient visits for ILI ranged from 1.5% in the Pacific region to 4.3% in the West South Central region.

Pediatric Deaths and Hospitalizations

During October 2, 2005–February 11, 2006, CDC received reports of 14 influenza-associated deaths in U.S. residents aged <18 years. Twelve of the deaths occurred during the current influenza season, and two occurred during the 2004–05 influenza season.

[††] The expected seasonal baseline proportion of P&I deaths reported by the 122 Cities Mortality Reporting System is projected using a robust regression procedure in which a periodic regression model is applied to the observed percentage of deaths from P&I that occurred during the preceding 5 years. The epidemic threshold is 1.645 standard deviations above the seasonal baseline.

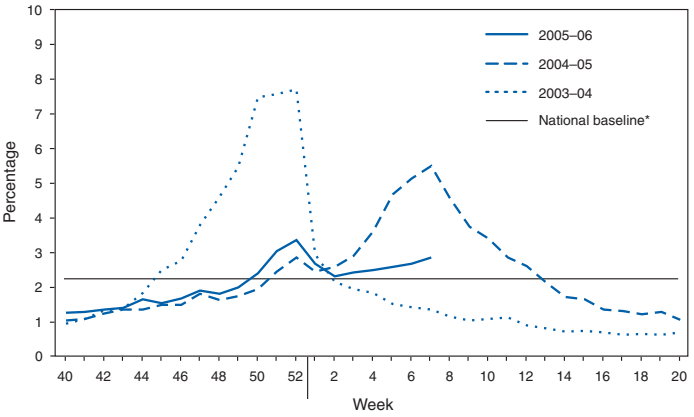
FIGURE 2. Percentage of deaths attributed to pneumonia and influenza (P&I) reported by the 122 Cities Mortality Reporting System, by week and year — United States, 2002–2006



* The epidemic threshold is 1.645 standard deviations above the seasonal baseline.

† The seasonal baseline is projected using a robust regression procedure that applies a periodic regression model to the observed percentage of deaths from P&I during the preceding 5 years.

FIGURE 3. Percentage of visits for influenza-like illness (ILI) reported by the Sentinel Provider Surveillance Network, by week — United States, 2003–04, 2004–05, and 2005–06 influenza seasons



* The national baseline was calculated as the mean percentage of visits for ILI during noninfluenza weeks for the preceding three seasons, plus two standard deviations. Noninfluenza weeks are those in which <10% of laboratory specimens are positive for influenza. Wide variability in regional data precludes calculating region-specific baselines; therefore, applying the national baseline to regional data is inappropriate.

During October 1, 2005–February 4, 2006, the preliminary laboratory-confirmed influenza-associated hospitalization rate reported by the Emerging Infections Program[§§] for children aged 0–17 years was 0.30 per 10,000. For children aged 0–4 years and 5–17 years, the rates were 0.78 per 10,000 and 0.04 per 10,000, respectively. During October 30, 2005–February 4, 2006, the preliminary laboratory-confirmed influenza-associated hospitalization rate for children aged 0–4 years in the New Vaccine Surveillance Network[¶¶] was 0.33 per 10,000.

[§§] The Emerging Infections Program Influenza Project conducts surveillance in 60 counties associated with 12 metropolitan areas: San Francisco, California; Denver, Colorado; New Haven, Connecticut; Atlanta, Georgia; Baltimore, Maryland; Minneapolis/St. Paul, Minnesota; Albuquerque, New Mexico; Las Cruces, New Mexico; Albany, New York; Rochester, New York; Portland, Oregon; and Nashville, Tennessee.

[¶¶] The New Vaccine Surveillance Network conducts surveillance in Monroe County, New York; Hamilton County, Ohio; and Davidson County, Tennessee.

Human Avian Influenza A (H5N1)

No human avian influenza A (H5N1) virus infection has ever been identified in the United States. From December 2003 through February 27, 2006, a total of 173 laboratory-confirmed human avian influenza A (H5N1) infections were reported to WHO from Cambodia, China, Indonesia, Iraq, Thailand, Turkey, and Vietnam.*** Of these, 93 (54%) were fatal (Table). This represents an increase of two cases in China and one case and one death in Indonesia since February 20, 2006. The majority of infections appear to have been acquired from direct contact with infected poultry. No evidence of sustained human-to-human transmission of H5N1 has been detected, although rare instances of human-to-human transmission likely have occurred (*1*).

Reference

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***Available at http://www.who.int/csr/disease/avian_influenza/en.

Notice to Readers

Release of Sudden, Unexplained Infant Death Investigation Reporting Form

CDC, in collaboration with other federal agencies and organizations representing medical examiners, coroners, death-scene investigators, law enforcement officials, forensic nurses, sudden infant death syndrome (SIDS) researchers, infant death review experts, and parents of infants who died from SIDS, launched an initiative in 2004 to improve the investigation and reporting of sudden, unexplained infant deaths (SUIDs). As part of this effort, on March 1, 2006, CDC released the Sudden, Unexplained Infant Death Investigation (SUIDI) Reporting Form for state and local use in infant death-scene investigations. The SUIDI Reporting Form replaces the Investigation Report Form that accompanied the 1996

TABLE. Number of laboratory-confirmed human cases and deaths from avian influenza A (H5N1) infection reported to the World Health Organization, by country — worldwide, 2003–2006*

	Year of onset									
	2003		2004		2005		2006		Total	
Country	No. of cases	Deaths	No. of cases	Deaths	No. of cases	Deaths	No. of cases	Deaths	No. of cases	Deaths
Cambodia	0	0	0	0	4	4	0	0	**4**	**4**
China	0	0	0	0	8	5	6	3	**14**	**8**
Indonesia	0	0	0	0	17	11	10	9	**27**	**20**
Iraq	0	0	0	0	0	0	1	1	**1**	**1**
Thailand	0	0	17	12	5	2	0	0	**22**	**14**
Turkey	0	0	0	0	0	0	12	4	**12**	**4**
Vietnam	3	3	29	20	61	19	0	0	**93**	**42**
Total	**3**	**3**	**46**	**32**	**95**	**41**	**29**	**17**	**173**	**93**

* As of February 27, 2006.

Guidelines for the Death Scene Investigation of Sudden, Unexplained Infant Death (*1*).

Each year in the United States, approximately 4,500 infants die suddenly of no immediately obvious cause. Half of these SUIDs are attributed to SIDS, the leading cause of SUID and of all deaths among infants aged 1–12 months. By definition, SIDS can only be diagnosed after a thorough examination of the death scene, a review of the clinical history, and an autopsy fail to find an explanation for the death (*2*).

Since 1990, SIDS rates in the United States have declined by approximately 50%, concomitant with a steady decline in the infant prone sleeping rate; prone and side sleep positions are associated with an increased risk for SIDS (*3,4*). However, studies indicate that, since 1999, certain deaths previously reported as SIDS are now reported as accidental suffocation or unknown/unspecified cause of death (*5,6*). This change in reporting of cause of death might account for part of the recent decline in SIDS rates.

The 1996 form was developed to establish a standard death-scene investigation protocol for all SUIDs. However, a 2001 national survey indicated that the form was not being used widely because it was poorly organized, lengthy, and cumbersome (*7*). Inaccurate or inconsistent cause-of-death determination and reporting hamper the ability of CDC, state and local health departments, and partners to monitor national trends, assess risk factors, and design and evaluate programs to prevent these deaths.

To address these concerns, CDC convened a national work group to revise the 1996 form. The new SUIDI Reporting Form includes questions to establish cause and manner of death, determined by a 2004 national survey of medical examiners and coroners, in addition to new questions about recently recognized risk factors for SIDS (e.g., unaccustomed prone sleep position) (S.C. Clark, Ph.D., Occupational Research Associates, Inc., unpublished data, 2004). The new form is shorter and simpler than the 1996 form. For example, most questions can be answered by checking the appropriate box or filling in the blank provided. The form is available online at http://www.cdc.gov/SIDS.

Of equal importance are well-trained death-scene investigators and certifiers. Previously, no national training materials on investigation of an infant death scene were available. In collaboration with a steering committee and a team of national advisors, CDC developed a comprehensive training curriculum and materials. CDC will use these materials to conduct five regional train-the-trainer academies during the next 2 years.

CDC plans a promotional campaign for the new form and training materials among its partners and stakeholders. Accurately collecting and reporting infant death-scene data depends on the widespread use of these tools. These measures will allow improved surveillance and research aimed at preventing infant deaths. Additional information on the SUID Initiative is available at http://www.cdc.gov/SIDS.

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Notice to Readers

Satellite Broadcast: Radiological Monitoring and Decontamination

CDC and the Public Health Training Network will present a satellite broadcast and webcast entitled "Radiological Monitoring and Decontamination," on March 9, 2006, at 1:00 p.m. EDT. CDC is developing radiological population monitoring guidelines for communities in consultation with advisors from federal, state, local, and academic organizations. This 2-hour broadcast will cover the basic components of these guidelines under development. The program will also help community leaders and public health workers prepare to conduct short- and long-term monitoring of populations affected by a nuclear or radiological terrorist incident or unintentional release of radioactive materials into the environment. A question-and-answer session will enable participants to ask questions by toll-free telephone, fax, or TTY lines. Questions may also be sent by e-mail to rsb@cdc.gov both before and during the broadcast.

Participants are responsible for setting up their own viewing locations and are encouraged to register their locations as soon as possible so that persons who wish to view the broadcast can access information online. Directions for

establishing and registering viewing locations are available at http://www.cdcnpin.org. The broadcast can be viewed live or after broadcast on computers with Internet and RealPlayer™ capability through http://www.phppo.cdc.gov/phtn.

Continuing education (CE) credit for the live satellite broadcast and webcast will be available from March 9, 2006, through April 10, 2006. CE credit for the enduring/self-study versions of the program will be available from April 9, 2006, through April 9, 2009.

Information about registration is available by telephone, 1-800-41-TRAIN, or e-mail, ce@cdc.gov. E-mail inquiries should include "Preparing for Radiological Population Monitoring and Decontamination" in the subject line.

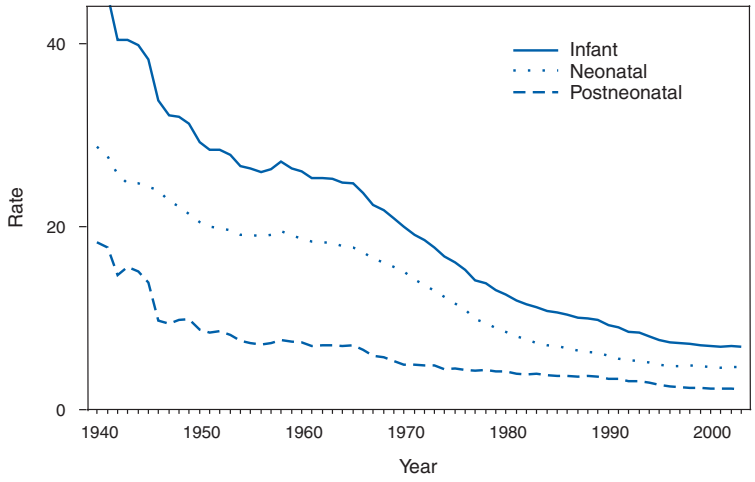
Erratum: Vol. 55, No. 6

In the report, "Assessing Capacity for Surveillance, Prevention, and Control of West Nile Virus Infection — United States, 1999 and 2004," the second sentence should read: "By the end of 2004, human WNV disease had been reported in all states except **Maine,** Washington, Hawaii, and Alaska (*3*–*8*), and WNV transmission to humans had been documented by five routes: mosquito bites (principally from *Culex* spp.), blood transfusions, organ transplantation, transplacental transfer, and breastfeeding (*1*)."

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Infant, Neonatal, and Postneonatal Annual Mortality Rates* — United States, 1940–2003



* Deaths per 1,000 live births for each group: infant (age <1 year), neonatal (age <28 days), and postneonatal (age 28 days to <1 year).

Infant, neonatal, and postneonatal annual mortality rates in the United States mostly declined during 1940–2003. The most recent data indicate that, from 2002 to 2003, the infant mortality rate declined from 6.97 per 1,000 live births to 6.85, and the postneonatal mortality rate declined from 2.31 to 2.23. The neonatal rate did not change significantly.

SOURCE: Hoyert DL, Heron M, Murphy SL, Kung HC. Deaths: final data for 2003. Health E-Stats. Hyattsville, MD: US Department of Health and Human Services, CDC; 2006. Available at http://www.cdc.gov/nchs/products/pubs/pubd/hestats/finaldeaths03/finaldeaths03.htm.

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending February 25, 2006 (8th Week)*

Disease	Current week	Cum 2006	5-year weekly average†	Total cases reported for previous years 2005	2004	2003	2002	2001	States reporting cases during current week (No.)
Anthrax	—	—	0	—	—	—	2	23	
Botulism:									
foodborne	—	—	0	20	16	20	28	39	
infant	—	2	2	87	87	76	69	97	
other (wound & unspecified)	1	9	0	24	30	33	21	19	CA (1)
Brucellosis	—	9	2	108	114	104	125	136	
Chancroid	—	3	1	27	30	54	67	38	
Cholera	—	—	0	6	5	2	2	3	
Cyclosporiasis§	1	6	4	738	171	75	156	147	FL (1)
Diphtheria	—	—	—	—	—	1	1	2	
Domestic arboviral diseases§¶:									
California serogroup	—	—	0	71	112	108	164	128	
eastern equine	—	—	—	21	6	14	10	9	
Powassan	—	—	—	1	1	—	1	N	
St. Louis	—	—	—	10	12	41	28	79	
western equine	—	—	—	—	—	—	—	—	
Ehrlichiosis§:									
human granulocytic	—	3	1	727	537	362	511	261	
human monocytic	2	29	1	478	338	321	216	142	NY (1), FL (1)
human (other & unspecified)	—	—	0	120	59	44	23	6	
Haemophilus influenzae,** invasive disease (age <5 yrs):									
serotype b	—	1	0	8	19	32	34	—	
nonserotype b	1	6	4	115	135	117	144	—	NY (1)
unknown serotype	2	27	3	205	177	227	153	—	MA (1), KS (1)
Hansen disease§	—	7	1	89	105	95	96	79	
Hantavirus pulmonary syndrome§	—	2	0	22	24	26	19	8	
Hemolytic uremic syndrome, postdiarrheal§	—	6	2	204	200	178	216	202	
Hepatitis C viral, acute	4	94	35	751	713	1,102	1,835	3,976	NY (2), PA (1), FL (1)
HIV infection, pediatric (age <13 yrs)§††	—	—	4	382	436	504	420	543	
Influenza-associated pediatric mortality§,§§,¶¶	1	10	1	49	—	N	N	N	
Listeriosis	4	53	9	824	753	696	665	613	FL (2), CA (2)
Measles	—	1***	2	63	37	56	44	116	
Meningococcal disease,††† invasive:									
A, C, Y, & W-135	2	31	8	281	—	—	—	—	FL (1), CO (1)
serogroup B	—	17	4	154	—	—	—	—	
other serogroup	1	3	1	19	—	—	—	—	OK (1)
Mumps	3	40	5	291	258	231	270	266	NY (2), IA (1)
Plague	—	—	—	7	3	1	2	2	
Poliomyelitis, paralytic	—	—	—	1	—	—	—	—	
Psittacosis§	1	1	0	21	12	12	18	25	CA (1)
Q fever§	1	11	1	133	70	71	61	26	CO (1)
Rabies, human	—	—	—	2	7	2	3	1	
Rubella	—	—	0	11	10	7	18	23	
Rubella, congenital syndrome	—	—	0	1	—	1	1	3	
SARS-CoV§,§§	—	—	0	—	—	8	N	N	
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	—	19	3	103	132	161	118	77	
Streptococcus pneumoniae,§ invasive disease (age <5 yrs)	21	128	16	1,018	1,162	845	513	498	MA (1), NY (9), OH (2), MO (1), NE (1), WV (1), AR (2), OK (1), CO (2), AZ (1)
Syphilis, congenital (age <1 yr)	—	28	9	308	353	413	412	441	
Tetanus	—	1	0	20	34	20	25	37	
Toxic-shock syndrome (other than streptococcal)§	1	10	3	90	95	133	109	127	MI (1)
Trichinellosis	—	2	0	19	5	6	14	22	
Tularemia§	—	3	0	135	134	129	90	129	
Typhoid fever	1	27	6	300	322	356	321	368	NC (1)
Vancomycin-intermediate *Staphylococcus aureus*§	—	—	—	2	—	N	N	N	
Vancomycin-resistant *Staphylococcus aureus*§	—	—	—	—	1	N	N	N	
Yellow fever	—	—	—	—	—	—	1	—	

—: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts.

* Incidence data for reporting years 2004, 2005, and 2006 are provisional, whereas data for 2001, 2002, and 2003 are finalized.

† Calculated by summing the incidence counts for the current week, the two weeks preceding the current week, and the two weeks following the current week, for a total of 5 preceding years. Additional information is available at http://www.cdc.gov/epo/dphsi/phs/files/5yearweeklyaverage.pdf.

§ Not notifiable in all states.

¶ Includes both neuroinvasive and non-neuroinvasive. Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNET Surveillance).

** Data for *H. influenzae* (all ages, all serotypes) are available in Table II.

†† Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Implementation of HIV reporting influences the number of cases reported. Data for HIV/AIDS are available in Table IV quarterly.

§§ Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.

¶¶ Of the 15 cases reported since October 2, 2005 (week 40), only 13 occurred during the current 2005–06 season.

*** No measles cases were reported for the current week.

††† Data for meningococcal disease (all serogroups and unknown serogroups) are available in Table II.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending February 25, 2006, and February 26, 2005 (8th Week)*

Reporting area	Chlamydia†					Coccidioidomycosis					Cryptosporidiosis				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	8,326	18,460	23,604	108,690	142,073	55	89	1,149	706	732	31	70	852	305	266
New England	462	604	1,513	3,886	4,237	—	0	0	—	—	—	4	34	14	14
Connecticut	108	150	1,176	507	810	N	0	0	N	N	—	0	14	2	3
Maine	37	41	74	292	337	N	0	0	N	N	—	0	2	2	1
Massachusetts	203	273	417	2,130	2,127	—	0	0	—	—	—	2	16	7	5
New Hampshire	42	34	64	264	283	—	0	0	—	—	—	0	3	2	3
Rhode Island	68	63	99	514	528	—	0	0	—	—	—	0	5	—	—
Vermont§	4	19	43	179	152	N	0	0	N	N	—	0	5	1	2
Mid. Atlantic	1,056	2,256	3,612	12,840	16,451	—	0	0	—	—	5	10	601	55	43
New Jersey	43	360	529	1,040	2,807	N	0	0	N	N	—	0	11	—	2
New York (Upstate)	309	498	1,677	2,234	2,502	N	0	0	N	N	3	3	562	11	11
New York City	256	692	1,248	4,807	5,351	N	0	0	N	N	—	2	15	13	13
Pennsylvania	448	696	1,085	4,759	5,791	N	0	0	N	N	2	4	21	31	17
E.N. Central	1,182	3,113	4,060	19,375	22,490	—	0	3	4	1	7	13	162	58	50
Illinois	154	885	1,700	4,744	5,406	—	0	0	—	—	—	1	16	5	9
Indiana	391	387	558	3,125	3,237	N	0	0	N	N	1	0	13	3	2
Michigan	388	542	1,019	5,203	3,064	—	0	3	2	1	1	2	7	12	7
Ohio	80	816	1,446	4,746	7,576	—	0	1	2	—	5	4	109	31	16
Wisconsin	169	380	520	1,557	3,207	N	0	0	N	N	—	4	38	7	16
W.N. Central	636	1,113	1,355	7,843	9,065	—	0	3	—	—	2	8	51	31	36
Iowa	167	143	221	1,293	1,067	N	0	0	N	N	—	1	11	3	7
Kansas	167	147	269	1,364	1,258	N	0	0	N	N	1	0	5	7	5
Minnesota	—	228	294	864	1,971	—	0	3	—	—	—	2	10	14	6
Missouri	198	435	525	3,013	3,446	—	0	1	—	—	1	2	37	6	16
Nebraska§	44	98	200	674	711	N	0	1	N	N	—	0	2	1	—
North Dakota	19	25	48	239	178	N	0	0	N	N	—	0	1	—	—
South Dakota	41	52	118	396	434	N	0	0	N	N	—	0	4	—	2
S. Atlantic	2,408	3,377	4,677	21,572	27,618	—	0	1	2	—	11	12	53	99	48
Delaware	67	68	92	549	474	N	0	0	N	N	—	0	2	—	—
District of Columbia	—	67	103	162	601	—	0	0	—	—	1	0	3	5	—
Florida	724	869	1,027	6,533	6,602	N	0	0	N	N	7	5	28	37	16
Georgia	—	585	1,556	627	3,923	—	0	0	—	—	—	2	12	28	12
Maryland	194	364	525	2,639	2,540	—	0	1	2	—	—	0	4	4	5
North Carolina	633	533	1,743	5,417	5,892	N	0	0	N	N	2	1	10	22	8
South Carolina§	308	323	1,418	1,611	3,631	—	0	0	—	—	—	0	4	—	—
Virginia§	424	427	841	3,243	3,627	N	0	0	N	N	—	1	8	2	3
West Virginia	58	46	354	791	328	N	0	0	N	N	1	0	3	1	4
E.S. Central	413	1,359	2,188	8,653	10,574	—	0	0	—	—	1	3	21	4	8
Alabama§	346	319	1,048	2,406	1,908	N	0	0	N	N	—	0	3	2	4
Kentucky	67	158	323	1,442	1,964	N	0	0	N	N	—	1	20	1	1
Mississippi	—	385	801	1,495	3,309	—	0	0	—	—	—	0	1	—	1
Tennessee§	—	456	624	3,310	3,393	N	0	0	N	N	1	0	4	1	2
W.S. Central	370	1,973	3,297	9,926	18,322	—	0	1	—	—	2	2	30	20	11
Arkansas	143	170	340	1,155	1,344	—	0	0	—	—	—	0	1	1	—
Louisiana	66	251	760	346	2,298	N	0	1	N	N	—	0	21	2	2
Oklahoma	161	226	2,127	1,564	1,607	N	0	0	N	N	2	0	10	9	4
Texas§	—	1,309	1,702	6,861	13,073	N	0	0	N	N	—	1	8	8	5
Mountain	307	1,048	1,563	4,873	8,952	38	66	204	384	429	3	2	8	12	14
Arizona	211	322	516	2,372	3,341	38	64	204	367	409	—	0	1	2	3
Colorado	—	251	376	991	2,242	N	0	0	N	N	—	1	3	2	5
Idaho§	—	25	236	—	275	N	0	0	N	N	—	0	2	—	—
Montana	85	42	179	85	387	N	0	0	N	N	—	0	3	1	—
Nevada§	—	138	465	808	1,127	—	1	4	10	16	—	0	2	1	3
New Mexico§	—	108	281	—	746	—	0	2	—	3	—	0	2	—	2
Utah	1	87	132	414	656	—	0	3	5	1	3	0	3	6	1
Wyoming	10	23	43	203	178	—	0	2	2	—	—	0	2	—	—
Pacific	1,492	3,161	4,566	19,722	24,364	17	28	1,060	316	302	—	6	49	12	42
Alaska	83	76	121	453	514	—	0	0	—	—	—	0	2	—	—
California	1,007	2,448	3,802	15,071	18,882	17	28	1,060	316	302	—	3	14	—	37
Hawaii	—	106	133	730	845	N	0	0	N	N	—	0	1	—	—
Oregon§	174	163	315	960	1,294	N	0	0	N	N	—	1	20	12	5
Washington	228	362	485	2,508	2,829	N	0	0	N	N	—	0	35	—	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	76	141	490	569	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	4	12	—	70	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
† Chlamydia refers to genital infections caused by *Chlamydia trachomatis*.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 25, 2006, and February 26, 2005 (8th Week)*

Reporting area	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive All ages, all serotypes				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	153	324	724	1,655	2,201	2,968	6,228	7,676	38,957	48,901	21	38	77	276	372
New England	5	29	90	104	140	58	103	280	666	781	2	3	12	15	18
Connecticut	—	1	65	17	1	21	36	233	132	278	—	0	6	—	3
Maine	—	4	11	3	21	1	2	7	21	18	—	0	1	1	1
Massachusetts	—	12	34	56	98	26	49	86	386	391	1	2	5	11	11
New Hampshire	—	1	7	5	5	7	4	9	45	22	—	0	3	1	—
Rhode Island	4	0	25	6	—	3	8	25	75	69	1	0	4	1	—
Vermont†	1	3	11	17	15	—	1	4	7	3	—	0	1	1	3
Mid. Atlantic	31	64	222	299	437	292	646	989	3,863	4,850	5	8	23	71	72
New Jersey	—	7	15	—	77	23	110	166	483	880	—	2	5	1	12
New York (Upstate)	25	22	193	115	116	79	123	424	695	809	3	2	19	17	18
New York City	1	16	33	85	124	61	185	405	1,178	1,446	—	1	6	21	14
Pennsylvania	5	16	29	99	120	129	211	340	1,507	1,715	2	3	8	32	28
E.N. Central	17	53	102	240	391	592	1,286	1,801	9,218	8,894	1	5	10	33	62
Illinois	—	13	32	14	96	51	364	729	1,941	2,104	—	1	5	3	18
Indiana	N	0	0	N	N	179	155	234	1,421	1,294	—	1	6	7	8
Michigan	9	14	29	96	107	293	231	585	3,126	1,064	1	0	3	9	7
Ohio	8	15	34	113	85	19	384	682	2,196	3,530	—	2	6	11	25
Wisconsin	—	12	33	17	103	50	109	158	534	902	—	0	3	3	4
W.N. Central	5	38	142	167	206	154	361	461	2,406	2,846	1	2	7	14	15
Iowa	—	5	14	33	41	23	30	54	226	220	—	0	1	—	—
Kansas	—	4	9	20	22	42	47	124	383	432	1	0	2	4	1
Minnesota	—	17	113	48	48	—	64	89	225	553	—	0	4	—	5
Missouri	4	9	32	51	65	81	182	240	1,367	1,387	—	0	7	9	7
Nebraska†	1	1	5	5	21	4	21	40	136	190	—	0	1	1	2
North Dakota	—	0	3	1	—	1	2	5	16	12	—	0	2	—	—
South Dakota	—	2	7	9	9	3	6	15	53	52	—	0	0	—	—
S. Atlantic	24	48	83	283	353	1,064	1,476	2,199	8,896	12,362	7	8	22	75	90
Delaware	—	1	3	3	11	23	17	40	204	123	—	0	0	—	—
District of Columbia	1	1	6	6	4	—	40	67	133	356	—	0	0	—	—
Florida	17	19	40	133	129	329	395	510	3,056	2,895	6	2	12	23	18
Georgia	2	11	25	85	104	—	262	696	298	1,738	—	1	6	15	30
Maryland	3	4	11	30	25	85	138	242	1,162	1,083	1	1	5	14	16
North Carolina	N	0	0	N	N	247	276	766	2,536	3,095	—	1	11	12	18
South Carolina†	1	2	9	9	14	108	133	783	605	1,605	—	1	3	7	2
Virginia†	—	9	38	16	62	251	148	289	745	1,368	—	1	7	4	3
West Virginia	—	0	6	1	4	21	13	37	157	99	—	0	3	—	3
E.S. Central	2	7	19	35	60	185	524	868	3,477	4,113	2	2	8	13	18
Alabama†	—	3	13	25	33	153	167	491	1,165	1,184	—	0	2	3	2
Kentucky	N	0	0	N	N	32	55	107	517	585	—	0	3	—	1
Mississippi	—	0	0	—	—	—	133	225	629	1,028	—	0	0	—	—
Tennessee†	2	4	11	10	27	—	167	284	1,166	1,316	2	1	5	10	15
W.S. Central	5	6	23	28	32	158	790	1,273	4,013	7,261	—	2	7	16	23
Arkansas	1	1	5	8	13	71	85	187	711	702	—	0	2	2	—
Louisiana	—	1	5	3	7	41	142	461	251	1,265	—	0	3	2	14
Oklahoma	4	3	16	17	12	46	85	755	523	760	—	1	5	12	9
Texas†	N	0	0	N	N	—	472	632	2,528	4,534	—	0	1	—	—
Mountain	41	27	58	181	154	50	219	480	1,336	1,924	3	4	19	30	49
Arizona	2	2	12	22	35	41	70	166	580	715	—	1	9	7	16
Colorado	33	9	26	78	54	—	57	90	319	461	2	0	4	14	14
Idaho†	—	3	12	12	18	—	1	10	—	14	—	0	1	1	1
Montana	1	1	7	9	8	5	2	13	5	23	—	0	0	—	—
Nevada†	—	2	6	4	8	—	53	195	309	456	—	0	3	—	7
New Mexico†	—	1	6	3	7	—	21	48	—	143	—	0	4	4	9
Utah	4	7	28	50	23	3	15	22	92	104	—	0	2	3	1
Wyoming	1	0	2	3	1	1	2	6	31	8	1	0	2	1	1
Pacific	23	60	187	318	428	415	785	939	5,082	5,870	—	2	20	9	25
Alaska	—	2	6	1	5	15	9	23	56	78	—	0	19	2	2
California	15	41	102	252	349	331	646	805	4,167	4,946	—	1	7	—	5
Hawaii	1	0	6	5	15	—	19	36	130	164	—	0	2	1	1
Oregon†	—	7	21	46	44	27	30	58	161	226	—	1	6	5	17
Washington	7	5	80	14	15	42	72	167	568	456	—	0	4	1	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	3	14	1	12	—	6	16	41	55	—	0	1	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	4	—	27	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 25, 2006, and February 26, 2005 (8th Week)*

Reporting area	Hepatitis (viral, acute), by type: A — Current week	A — Previous 52 weeks Med	A — Previous 52 weeks Max	A — Cum 2006	A — Cum 2005	B — Current week	B — Previous 52 weeks Med	B — Previous 52 weeks Max	B — Cum 2006	B — Cum 2005	Legionellosis — Current week	Legionellosis — Previous 52 weeks Med	Legionellosis — Previous 52 weeks Max	Legionellosis — Cum 2006	Legionellosis — Cum 2005
United States	31	78	183	489	622	35	102	197	520	878	15	38	111	147	173
New England	2	7	23	39	68	1	4	12	33	38	—	2	11	7	5
Connecticut	1	1	3	4	9	—	0	5	—	11	—	0	8	3	—
Maine	—	0	2	1	—	—	0	2	—	1	—	0	1	1	—
Massachusetts	—	5	14	24	55	—	4	10	29	23	—	1	5	2	5
New Hampshire	—	1	12	5	4	—	0	3	3	2	—	0	1	—	—
Rhode Island	—	0	4	1	—	1	0	2	1	—	—	0	7	—	—
Vermont†	1	0	2	4	—	—	0	1	—	1	—	0	3	1	—
Mid. Atlantic	1	12	23	25	112	3	13	37	37	159	5	11	53	43	54
New Jersey	—	3	11	—	20	—	5	26	7	86	—	1	12	1	8
New York (Upstate)	—	1	17	5	10	1	2	12	4	9	4	3	24	14	13
New York City	1	5	12	10	58	—	2	7	6	22	—	2	20	7	2
Pennsylvania	—	1	6	10	24	2	4	8	20	42	1	5	17	21	31
E.N. Central	2	7	18	35	67	4	10	25	41	87	3	6	23	19	43
Illinois	—	1	9	—	28	—	2	7	—	26	—	0	2	—	7
Indiana	—	1	10	2	3	1	0	11	1	1	—	0	5	1	4
Michigan	1	2	11	20	15	2	3	7	23	30	—	2	6	7	12
Ohio	1	1	4	12	15	1	2	8	15	26	3	3	19	11	17
Wisconsin	—	1	5	1	6	—	0	6	2	4	—	0	2	—	3
W.N. Central	3	2	31	22	12	2	5	13	11	37	—	1	12	2	6
Iowa	—	0	2	—	2	—	0	2	—	1	—	0	1	—	—
Kansas	3	0	4	17	2	—	0	3	2	6	—	0	1	—	—
Minnesota	—	0	31	—	—	—	0	6	—	—	—	0	10	—	—
Missouri	—	0	5	3	6	2	3	7	9	23	—	0	3	2	5
Nebraska†	—	0	3	—	2	—	0	2	—	7	—	0	1	—	—
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	1	—	1
South Dakota	—	0	1	2	—	—	0	1	—	—	—	0	6	—	—
S. Atlantic	7	13	33	86	93	13	23	52	133	260	4	9	19	44	36
Delaware	—	0	1	1	2	—	1	6	3	10	—	0	4	1	—
District of Columbia	—	0	2	1	—	—	0	4	1	—	—	0	2	—	—
Florida	6	4	18	32	31	9	9	21	64	85	1	2	6	19	11
Georgia	1	1	6	6	21	2	2	7	7	52	—	1	3	3	3
Maryland	—	2	6	14	7	1	2	8	27	33	1	2	9	14	12
North Carolina	—	0	20	28	21	—	0	19	19	32	1	0	3	4	6
South Carolina†	—	1	3	4	3	1	2	9	7	17	—	0	2	—	—
Virginia†	—	1	7	—	8	—	2	13	3	29	—	1	8	2	3
West Virginia	—	0	2	—	—	—	0	11	2	2	1	0	3	1	1
E.S. Central	—	3	16	13	29	2	7	20	29	51	—	1	6	2	2
Alabama†	—	0	6	—	3	1	1	7	11	15	—	0	2	—	2
Kentucky	—	0	3	4	3	—	1	6	7	14	—	0	4	—	—
Mississippi	—	0	2	—	6	—	1	4	4	6	—	0	1	—	—
Tennessee†	—	2	13	9	17	1	2	12	7	16	—	1	4	2	—
W.S. Central	1	6	20	9	45	—	12	46	92	72	—	0	4	2	1
Arkansas	—	0	3	—	1	—	1	3	2	12	—	0	1	—	—
Louisiana	—	1	5	1	13	—	1	5	3	12	—	0	2	2	—
Oklahoma	—	0	1	2	1	—	0	5	—	5	—	0	3	—	—
Texas†	1	4	17	6	30	—	9	44	87	43	—	0	3	—	1
Mountain	6	6	21	31	60	4	10	50	87	74	1	2	8	6	13
Arizona	2	3	20	12	35	3	5	47	69	48	—	0	3	—	3
Colorado	2	1	5	9	7	—	1	4	7	8	—	0	3	1	2
Idaho†	—	0	3	1	5	—	0	2	2	3	—	0	2	—	—
Montana	—	0	1	1	4	—	0	2	—	—	—	0	1	—	—
Nevada†	—	0	2	3	2	—	1	4	6	4	—	0	2	3	3
New Mexico†	—	0	3	2	3	—	0	3	1	4	—	0	1	—	1
Utah	2	0	3	3	4	1	0	5	2	7	1	0	2	2	2
Wyoming	—	0	0	—	—	—	0	1	—	—	—	0	1	—	2
Pacific	9	15	148	229	136	6	10	54	57	100	2	1	10	22	13
Alaska	—	0	2	—	1	—	0	2	—	—	—	0	1	—	—
California	7	13	147	216	111	4	6	39	45	74	2	1	10	22	13
Hawaii	—	0	2	4	4	—	0	1	—	1	—	0	1	—	—
Oregon†	—	1	4	3	9	—	2	5	9	20	N	0	0	N	N
Washington	2	1	11	6	11	2	1	11	3	5	—	0	0	—	—
American Samoa	U	0	1	U	—	U	0	0	U	—	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	1	6	1	8	—	1	6	1	2	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 25, 2006, and February 26, 2005 (8th Week)*

Reporting area	Lyme disease					Malaria				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max		
United States	23	293	1,336	375	1,000	20	23	47	137	170
New England	—	47	228	24	80	1	1	12	6	4
Connecticut	—	9	154	20	—	—	0	10	—	—
Maine	—	2	25	1	5	—	0	1	—	—
Massachusetts	—	16	160	—	64	1	0	4	5	4
New Hampshire	—	3	17	3	10	—	0	1	—	—
Rhode Island	—	0	12	—	—	—	0	1	—	—
Vermont†	—	0	5	—	1	—	0	2	1	—
Mid. Atlantic	18	183	924	202	675	1	6	15	24	47
New Jersey	—	35	305	16	230	—	1	7	—	14
New York (Upstate)	15	48	805	66	90	1	1	7	4	5
New York City	—	0	0	—	—	—	3	8	14	23
Pennsylvania	3	59	464	120	355	—	1	2	6	5
E.N. Central	—	13	156	9	43	3	2	6	15	15
Illinois	—	0	6	—	—	—	0	2	4	5
Indiana	—	0	4	—	1	3	0	1	3	—
Michigan	—	1	7	2	1	—	0	2	1	6
Ohio	—	1	5	2	11	—	0	3	4	2
Wisconsin	—	10	148	5	30	—	0	2	3	2
W.N. Central	—	13	99	10	8	1	0	5	5	7
Iowa	—	1	8	—	3	1	0	1	1	2
Kansas	—	0	3	1	2	—	0	1	—	1
Minnesota	—	9	96	8	3	—	0	3	2	1
Missouri	—	0	2	1	—	—	0	3	1	3
Nebraska†	—	0	1	—	—	—	0	2	—	—
North Dakota	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	1	—	—	—	0	1	1	—
S. Atlantic	2	32	125	101	179	10	6	15	45	33
Delaware	—	9	37	40	70	—	0	1	—	1
District of Columbia	—	0	2	2	1	—	0	2	—	—
Florida	—	1	8	6	7	1	1	6	5	5
Georgia	—	0	1	—	—	3	0	6	14	6
Maryland	2	16	86	48	85	5	1	9	18	11
North Carolina	—	0	5	5	11	1	0	8	4	5
South Carolina†	—	0	3	—	3	—	0	2	1	—
Virginia†	—	3	20	—	2	—	0	5	3	4
West Virginia	—	0	6	—	—	—	0	2	—	1
E.S. Central	—	1	4	—	2	1	0	2	2	5
Alabama†	—	0	1	—	—	1	0	1	1	1
Kentucky	—	0	1	—	—	—	0	2	1	1
Mississippi	—	0	0	—	—	—	0	0	—	—
Tennessee†	—	0	4	—	2	—	0	2	—	3
W.S. Central	—	1	8	—	3	—	1	9	4	16
Arkansas	—	0	2	—	—	—	0	2	—	1
Louisiana	—	0	2	—	1	—	0	1	—	1
Oklahoma	—	0	0	—	—	—	0	6	1	—
Texas†	—	0	7	—	2	—	1	9	3	14
Mountain	—	0	4	—	—	1	0	6	7	11
Arizona	—	0	4	—	—	—	0	4	—	2
Colorado	—	0	1	—	—	—	0	3	2	5
Idaho†	—	0	1	—	—	—	0	0	—	—
Montana	—	0	0	—	—	—	0	0	—	—
Nevada†	—	0	2	—	—	—	0	2	—	—
New Mexico†	—	0	1	—	—	—	0	1	—	1
Utah	—	0	1	—	—	1	0	2	5	2
Wyoming	—	0	1	—	—	—	0	1	—	1
Pacific	3	3	14	29	10	2	4	12	29	32
Alaska	—	0	1	—	1	—	0	1	1	1
California	3	2	11	29	8	1	3	9	23	29
Hawaii	N	0	0	N	N	—	0	4	—	1
Oregon†	—	0	2	—	1	—	0	2	2	1
Washington	—	0	3	—	—	1	0	4	3	—
American Samoa	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	N	0	0	N	N	—	0	1	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 25, 2006, and February 26, 2005 (8th Week)*

Reporting area	Meningococcal disease, invasive: All serogroups: Current week	Previous 52 weeks: Med	Previous 52 weeks: Max	Cum 2006	Cum 2005	Meningococcal disease, invasive: Serogroup unknown: Current week	Previous 52 weeks: Med	Previous 52 weeks: Max	Cum 2006	Cum 2005	Pertussis: Current week	Previous 52 weeks: Med	Previous 52 weeks: Max	Cum 2006	Cum 2005
United States	13	21	58	166	224	11	13	48	115	125	135	429	789	1,489	3,653
New England	1	1	5	7	18	1	1	2	7	5	—	30	51	207	225
Connecticut	—	0	3	2	3	—	0	2	2	—	—	0	4	—	14
Maine	—	0	1	2	1	—	0	1	2	1	—	0	5	—	8
Massachusetts	1	0	3	3	11	1	0	2	3	2	—	22	41	193	164
New Hampshire	—	0	2	—	1	—	0	2	—	1	—	1	15	3	—
Rhode Island	—	0	2	—	—	—	0	0	—	—	—	0	8	—	—
Vermont†	—	0	1	—	2	—	0	1	—	1	—	1	6	11	39
Mid. Atlantic	—	3	14	27	29	1	2	13	24	22	18	22	102	153	297
New Jersey	—	0	2	—	7	—	0	2	—	7	—	3	9	9	41
New York (Upstate)	—	0	6	3	7	1	0	5	2	3	9	10	93	49	82
New York City	—	0	5	11	5	—	0	5	11	5	—	2	6	—	13
Pennsylvania	—	1	3	13	10	—	1	3	11	7	9	7	16	95	161
E.N. Central	1	2	9	11	21	1	1	6	10	20	28	63	121	217	952
Illinois	—	0	4	5	5	—	0	4	5	5	—	14	31	8	168
Indiana	—	0	3	—	2	—	0	2	—	2	11	6	23	19	28
Michigan	—	0	3	2	5	—	0	3	1	4	3	4	26	35	40
Ohio	1	0	5	4	4	1	0	4	4	4	14	20	43	138	387
Wisconsin	—	0	1	—	5	—	0	1	—	5	—	21	40	17	329
W.N. Central	1	1	4	7	15	1	0	3	3	6	7	56	205	200	575
Iowa	—	0	2	—	4	—	0	2	—	—	—	9	55	33	216
Kansas	—	0	1	—	2	—	0	1	—	2	4	11	29	86	60
Minnesota	—	0	2	—	2	—	0	1	—	—	—	0	148	—	93
Missouri	1	0	3	4	5	1	0	2	1	2	3	9	39	71	99
Nebraska†	—	0	1	3	2	—	0	1	2	2	—	2	12	8	50
North Dakota	—	0	1	—	—	—	0	1	—	—	—	0	28	2	18
South Dakota	—	0	1	—	—	—	0	0	—	—	—	2	9	—	39
S. Atlantic	3	4	14	33	34	2	2	7	13	15	5	24	90	114	209
Delaware	—	0	1	1	—	—	0	1	1	—	—	0	1	1	10
District of Columbia	—	0	0	—	—	—	0	0	—	—	—	0	3	2	—
Florida	3	1	7	13	11	2	1	6	6	3	2	4	14	41	19
Georgia	—	0	2	1	7	—	0	2	1	7	1	1	3	2	6
Maryland	—	0	2	3	3	—	0	1	1	—	2	4	8	35	46
North Carolina	—	0	11	11	4	—	0	3	3	—	—	0	21	19	17
South Carolina†	—	0	1	2	7	—	0	1	—	5	—	5	21	14	81
Virginia†	—	0	3	2	2	—	0	3	1	—	—	1	72	—	27
West Virginia	—	0	1	—	—	—	0	1	—	—	—	0	12	—	3
E.S. Central	—	1	4	6	11	—	1	4	4	8	3	8	25	23	84
Alabama†	—	0	1	1	—	—	0	1	1	—	2	1	9	10	20
Kentucky	—	0	3	1	5	—	0	3	1	5	—	3	10	2	22
Mississippi	—	0	1	1	2	—	0	1	1	2	1	1	4	5	14
Tennessee†	—	0	2	3	4	—	0	1	1	1	—	3	17	6	28
W.S. Central	2	2	7	17	22	1	0	5	12	7	—	41	111	66	56
Arkansas	—	0	3	2	4	—	0	2	2	1	—	5	19	10	6
Louisiana	—	0	3	11	8	—	0	3	9	2	—	0	3	1	5
Oklahoma	2	0	3	4	3	1	0	3	1	—	—	0	1	2	—
Texas†	—	0	4	—	7	—	0	3	—	4	—	36	98	53	45
Mountain	1	2	7	16	17	—	1	5	9	10	64	74	145	441	677
Arizona	—	0	5	5	5	—	0	5	5	2	1	15	86	27	45
Colorado	1	0	2	9	8	—	0	2	2	8	33	24	41	262	325
Idaho†	—	0	2	—	—	—	0	2	—	—	—	3	16	9	43
Montana	—	0	0	—	—	—	0	0	—	—	9	8	29	25	164
Nevada†	—	0	2	—	2	—	0	1	—	—	—	0	8	8	4
New Mexico†	—	0	2	—	1	—	0	2	—	—	—	3	9	1	45
Utah	—	0	2	2	1	—	0	1	2	—	20	13	35	100	46
Wyoming	—	0	0	—	—	—	0	0	—	—	1	1	4	9	5
Pacific	4	4	28	42	57	4	3	15	33	32	10	69	410	68	578
Alaska	—	0	1	—	—	—	0	1	—	—	2	1	15	17	6
California	3	2	11	29	26	3	2	11	29	26	—	40	229	—	330
Hawaii	—	0	2	—	5	—	0	1	—	2	—	3	10	6	22
Oregon†	—	0	4	5	19	—	0	2	1	3	—	5	26	21	183
Washington	1	0	25	8	7	1	0	11	3	1	8	11	178	24	37
American Samoa	U	0	1	—	—	U	0	1	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	—	—	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	1	—	1	—	0	2	—	1	—	0	2	—	1
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 25, 2006, and February 26, 2005 (8th Week)*

Reporting area	Rabies, animal					Rocky Mountain spotted fever					Salmonellosis				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	39	105	160	369	792	54	34	98	220	89	239	858	1,449	3,305	3,463
New England	5	13	33	50	87	—	0	1	—	—	1	41	76	160	152
Connecticut	2	3	13	13	14	—	0	0	—	—	—	9	41	41	29
Maine	—	1	4	6	5	N	0	0	N	N	—	3	8	2	12
Massachusetts	3	5	22	25	59	—	0	1	—	—	—	21	40	102	93
New Hampshire	—	0	3	1	2	—	0	1	—	—	—	2	12	8	9
Rhode Island	—	0	4	1	—	—	0	1	—	—	1	0	15	5	—
Vermont†	—	1	7	4	7	—	0	0	—	—	—	1	10	2	9
Mid. Atlantic	7	18	40	73	80	—	2	8	1	5	30	94	195	317	410
New Jersey	N	0	0	N	N	—	0	6	—	1	—	16	45	2	83
New York (Upstate)	7	12	24	52	32	—	0	2	—	—	23	21	159	77	72
New York City	—	0	3	—	4	—	0	2	1	1	2	24	43	94	127
Pennsylvania	—	7	22	21	44	—	1	6	—	3	5	31	61	144	128
E.N. Central	—	3	19	2	6	—	0	6	1	2	49	93	243	370	414
Illinois	—	1	4	—	1	—	0	3	—	1	—	29	160	28	119
Indiana	—	0	3	—	1	—	0	1	—	—	23	10	71	53	18
Michigan	—	0	4	1	2	—	0	1	—	—	5	17	35	77	88
Ohio	—	0	13	1	2	—	0	3	1	1	21	23	52	152	98
Wisconsin	N	0	3	N	N	—	0	1	—	—	—	15	45	60	91
W.N. Central	—	7	23	15	34	—	2	16	4	3	18	43	91	229	215
Iowa	—	1	10	3	7	—	0	2	—	—	—	7	18	34	48
Kansas	—	1	5	3	6	—	0	2	—	—	4	7	17	35	21
Minnesota	—	1	5	1	11	—	0	1	—	—	3	10	31	49	42
Missouri	—	1	7	1	4	—	1	14	4	3	10	14	40	83	61
Nebraska†	—	0	0	—	—	—	0	2	—	—	1	2	8	14	20
North Dakota	—	0	4	2	1	—	0	0	—	—	—	0	5	—	3
South Dakota	—	1	6	5	5	—	0	2	—	—	—	2	11	14	20
S. Atlantic	26	31	54	177	433	54	16	94	211	64	69	255	511	1,022	959
Delaware	—	0	0	—	—	—	0	2	1	—	—	2	9	11	7
District of Columbia	—	0	0	—	—	—	0	1	—	—	2	1	7	9	2
Florida	3	0	14	24	201	3	0	1	5	2	40	99	230	462	382
Georgia	—	5	15	16	40	—	1	9	14	1	4	32	76	173	123
Maryland	5	6	16	30	43	1	2	7	6	1	6	14	39	73	74
North Carolina	3	8	19	26	61	50	5	87	183	57	14	30	114	236	212
South Carolina†	—	0	1	—	4	—	1	6	2	3	1	21	146	32	78
Virginia†	14	10	26	71	82	—	1	10	—	—	—	19	66	19	72
West Virginia	1	0	13	10	2	—	0	2	—	—	2	2	13	7	9
E.S. Central	1	3	9	26	16	—	5	24	1	2	9	55	134	198	206
Alabama†	1	1	5	9	14	—	0	9	—	—	—	13	39	87	65
Kentucky	—	0	3	—	—	—	0	1	—	—	—	7	26	30	24
Mississippi	—	0	1	—	—	—	0	3	—	—	—	13	66	23	27
Tennessee†	—	1	5	17	2	—	3	18	1	2	9	15	40	58	90
W.S. Central	—	13	42	8	100	—	2	32	2	1	25	80	159	308	265
Arkansas	—	0	3	1	7	—	0	32	2	—	17	12	67	67	33
Louisiana	—	0	0	—	—	—	0	2	—	1	—	15	42	24	65
Oklahoma	—	1	7	7	10	—	0	23	—	—	4	7	26	35	31
Texas†	—	12	39	—	83	—	0	7	—	—	4	43	121	182	136
Mountain	—	4	19	12	29	—	0	4	—	10	12	50	112	215	221
Arizona	—	2	11	12	25	—	0	4	—	8	1	13	28	46	76
Colorado	—	0	2	—	—	—	0	1	—	—	8	10	45	75	58
Idaho†	—	0	12	—	—	—	0	2	—	—	—	2	17	11	14
Montana	—	0	3	—	—	—	0	1	—	—	—	2	16	13	12
Nevada†	—	0	2	—	—	—	0	0	—	—	—	3	8	16	22
New Mexico†	—	0	1	—	1	—	0	1	—	—	—	5	14	12	16
Utah	—	0	5	—	—	—	0	1	—	2	3	6	31	33	17
Wyoming	—	0	2	—	3	—	0	1	—	—	—	1	12	9	6
Pacific	—	4	15	6	7	—	0	2	—	2	26	101	397	486	621
Alaska	—	0	3	2	1	—	0	0	—	—	2	1	5	14	9
California	—	3	15	4	6	—	0	1	—	2	24	77	282	399	483
Hawaii	—	0	0	—	—	—	0	0	—	—	—	5	15	31	61
Oregon†	—	0	1	—	—	—	0	1	—	—	—	7	23	28	33
Washington	U	0	0	U	U	N	0	0	N	N	—	8	107	14	35
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	2	U	1
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	1	4	11	12	N	0	0	N	N	—	8	23	5	49
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 25, 2006, and February 26, 2005 (8th Week)*

Reporting area	Shiga toxin-producing *E. coli* (STEC)†					Shigellosis					Streptococcal disease, invasive, group A				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	4	50	155	88	183	98	275	454	1,113	1,384	61	80	151	676	750
New England	—	4	13	6	16	4	5	16	32	30	—	4	8	19	30
Connecticut	—	1	4	—	8	—	1	4	4	2	U	0	0	U	U
Maine	—	0	5	—	—	—	0	1	—	—	—	0	2	3	2
Massachusetts	—	2	8	6	7	1	3	10	24	24	—	2	6	11	22
New Hampshire	—	0	2	—	—	—	0	4	1	2	—	0	2	4	2
Rhode Island	—	0	2	—	—	3	0	6	3	—	—	0	3	—	—
Vermont§	—	0	2	—	1	—	0	4	—	2	—	0	2	1	4
Mid. Atlantic	—	7	24	—	19	6	22	67	62	139	10	16	38	110	156
New Jersey	—	1	6	—	7	—	5	14	—	43	—	2	9	5	33
New York (Upstate)	3	2	16	4	7	5	4	46	35	23	8	4	24	35	47
New York City	—	0	2	—	1	—	7	22	22	65	—	3	9	17	24
Pennsylvania	—	2	8	—	4	1	2	48	5	8	2	5	12	53	52
E.N. Central	3	8	32	23	48	14	16	78	86	106	14	15	41	137	152
Illinois	—	1	7	—	11	—	5	24	13	29	—	3	10	20	42
Indiana	1	1	7	6	2	8	1	56	13	8	6	1	11	22	13
Michigan	—	1	8	3	9	3	4	14	27	47	1	6	15	37	57
Ohio	2	2	14	8	16	3	3	11	24	11	7	4	14	45	27
Wisconsin	—	2	15	6	10	—	3	9	9	11	—	1	8	13	13
W.N. Central	—	7	39	18	29	5	38	64	144	107	—	5	19	29	40
Iowa	—	1	10	4	5	—	1	9	2	15	N	0	0	N	N
Kansas	—	1	4	—	2	—	4	20	13	4	—	1	5	16	3
Minnesota	—	2	23	14	4	2	2	6	13	4	—	1	15	—	15
Missouri	—	1	7	6	11	1	22	45	94	62	—	1	6	8	10
Nebraska§	—	0	4	1	5	2	1	9	10	15	—	0	4	4	6
North Dakota	—	0	2	—	—	—	0	2	1	1	—	0	3	1	2
South Dakota	—	0	5	—	2	—	1	17	11	6	—	0	2	—	4
S. Atlantic	—	7	39	11	31	52	44	117	326	201	17	19	36	195	155
Delaware	—	0	2	—	—	—	0	2	—	1	—	0	2	1	—
District of Columbia	—	0	1	—	—	1	0	2	2	—	—	0	2	3	1
Florida	—	1	31	10	11	22	22	66	153	89	5	5	12	54	54
Georgia	—	0	6	—	5	5	12	32	99	52	6	4	9	50	28
Maryland	—	1	5	—	5	3	2	8	21	11	6	4	12	39	41
North Carolina	—	1	11	9	8	21	2	22	39	26	—	1	13	21	15
South Carolina§	—	0	2	—	—	—	2	6	12	12	—	1	3	12	9
Virginia§	—	2	9	—	2	—	2	9	—	10	—	2	11	10	5
West Virginia	—	0	1	—	—	—	0	1	—	—	—	0	5	5	2
E.S. Central	—	3	12	4	6	1	19	54	66	143	3	3	11	25	23
Alabama§	—	0	3	—	3	—	3	20	13	31	N	0	0	N	N
Kentucky	—	1	9	4	—	—	6	31	32	7	—	1	3	4	5
Mississippi	—	0	2	—	—	—	2	7	15	11	—	0	0	—	—
Tennessee§	—	1	3	3	3	1	4	47	6	94	3	3	8	21	18
W.S. Central	—	2	9	—	7	4	61	122	105	275	3	6	18	52	39
Arkansas	—	0	2	—	1	—	1	3	6	12	—	0	2	1	6
Louisiana	—	0	2	—	3	—	2	11	9	28	—	0	1	2	3
Oklahoma	—	0	3	—	1	2	10	41	19	63	3	2	13	35	18
Texas§	—	1	4	—	2	2	45	106	71	172	—	3	15	14	12
Mountain	1	5	15	7	19	6	17	47	78	89	13	12	28	95	135
Arizona	—	0	4	—	2	3	9	29	35	41	6	4	16	28	59
Colorado	1	1	6	7	4	1	3	17	13	13	4	4	11	42	47
Idaho§	—	1	8	—	5	—	0	4	3	—	—	0	2	—	1
Montana	—	0	2	—	1	1	0	1	1	—	—	0	0	—	—
Nevada§	—	0	4	—	1	—	1	6	9	17	—	0	6	—	—
New Mexico§	—	0	3	1	1	—	2	9	6	13	—	1	6	7	19
Utah	—	1	7	1	4	1	1	4	10	5	3	2	6	17	8
Wyoming	—	0	3	—	1	—	0	1	1	—	—	0	1	1	1
Pacific	—	6	52	19	8	6	40	134	214	294	1	2	8	14	20
Alaska	—	0	3	—	1	—	0	3	—	2	—	0	0	—	—
California	—	1	6	16	1	6	34	97	157	267	—	0	0	—	—
Hawaii	—	0	4	—	1	—	1	4	10	4	1	2	8	14	20
Oregon§	—	1	47	3	—	—	1	27	34	14	N	0	0	N	N
Washington	—	1	39	3	5	—	2	35	13	7	N	0	0	N	N
American Samoa	U	0	0	U	U	U	0	2	U	—	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	1	—	—	—	0	1	—	—	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
† Includes *E. coli* O157:H7; Shiga toxin positive, serogroup non-0157; and Shiga toxin positive, not serogrouped.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 25, 2006, and February 26, 2005 (8th Week)*

Reporting area	*Streptococcus pneumoniae*, invasive disease Drug resistant, all ages					Syphilis, primary & secondary					Varicella (chickenpox)				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005
United States	51	49	90	438	460	71	167	212	939	1,106	452	572	1,778	6,006	3,900
New England	1	2	12	4	25	1	4	15	26	31	3	35	1,128	170	445
Connecticut	U	0	0	U	U	—	0	11	2	1	U	0	0	U	U
Maine	N	0	0	N	N	—	0	1	1	1	—	5	20	19	58
Massachusetts	—	1	6	—	23	1	2	5	20	28	—	24	86	—	376
New Hampshire	—	0	0	—	—	—	0	2	3	1	—	5	1,110	58	—
Rhode Island	—	0	7	—	—	—	0	6	—	—	—	0	0	—	—
Vermont†	1	0	2	4	2	—	0	1	—	—	3	2	25	93	11
Mid. Atlantic	2	3	10	24	54	9	20	33	118	147	87	118	210	957	537
New Jersey	N	0	0	N	N	5	2	7	23	16	—	0	0	—	—
New York (Upstate)	1	1	9	6	15	3	2	15	16	10	—	0	0	—	—
New York City	U	0	0	U	U	—	12	21	64	98	—	0	0	—	—
Pennsylvania	1	2	9	18	39	1	4	7	15	23	87	118	210	957	537
E.N. Central	17	11	31	104	79	13	17	40	117	70	187	125	492	2,915	1,466
Illinois	—	0	2	2	—	3	8	31	34	16	—	1	5	3	13
Indiana	2	3	16	16	16	2	1	5	14	8	N	0	245	N	N
Michigan	1	1	3	7	10	5	2	8	26	5	37	82	231	811	1,060
Ohio	14	7	20	79	53	2	4	11	34	37	149	29	348	1,999	278
Wisconsin	N	0	0	N	N	1	1	3	9	4	1	9	27	102	115
W.N. Central	—	1	15	10	10	—	5	9	21	40	51	12	70	328	21
Iowa	N	0	0	N	N	—	0	1	—	2	N	0	0	N	N
Kansas	N	0	0	N	N	—	0	2	4	2	—	0	0	—	—
Minnesota	—	0	15	—	—	—	1	5	2	7	—	0	0	—	—
Missouri	—	0	3	10	9	—	3	8	15	28	50	9	69	307	1
Nebraska†	—	0	1	—	—	—	0	1	—	1	—	0	1	—	—
North Dakota	—	0	1	—	—	—	0	1	—	—	—	0	25	8	1
South Dakota	—	0	1	—	1	—	0	1	—	—	1	1	23	13	19
S. Atlantic	29	21	41	251	201	26	40	90	228	246	55	45	543	385	349
Delaware	—	0	2	—	—	1	0	2	6	2	—	0	4	4	6
District of Columbia	1	0	4	8	3	—	1	9	9	12	—	0	6	3	—
Florida	20	11	34	133	113	11	15	29	112	120	—	0	0	—	—
Georgia	8	5	19	97	76	—	7	47	—	9	—	0	0	—	—
Maryland	—	0	0	—	—	7	6	19	37	35	—	0	0	—	—
North Carolina	N	0	0	N	N	3	4	17	38	44	—	0	0	—	—
South Carolina†	—	0	0	—	—	4	1	8	11	11	3	10	41	92	82
Virginia†	N	0	0	N	N	—	3	11	15	12	1	7	533	11	22
West Virginia	—	2	8	13	9	—	0	1	—	1	51	18	61	275	239
E.S. Central	—	3	14	21	31	7	10	18	73	71	—	0	0	—	—
Alabama†	N	0	0	N	N	7	3	11	38	38	—	0	0	—	—
Kentucky	—	0	5	3	6	—	1	4	6	3	N	0	0	N	N
Mississippi	—	0	0	—	—	—	0	5	5	7	—	0	0	—	—
Tennessee†	—	3	13	18	25	—	4	11	24	23	N	0	0	N	N
W.S. Central	—	1	13	13	45	8	24	38	169	198	24	135	851	734	429
Arkansas	—	0	3	5	5	2	1	6	13	5	2	0	32	77	—
Louisiana	—	1	11	8	40	4	3	17	12	27	—	1	32	20	5
Oklahoma	N	0	0	N	N	2	0	6	10	9	—	0	0	—	—
Texas†	N	0	0	N	N	—	17	29	134	157	22	130	819	637	424
Mountain	2	1	28	11	15	1	8	17	51	54	45	47	118	517	653
Arizona	N	0	0	N	N	1	3	13	33	18	—	0	0	—	—
Colorado	N	0	0	N	N	—	1	6	4	11	33	35	87	387	458
Idaho†	N	0	0	N	N	—	0	3	—	6	—	0	0	—	—
Montana	—	0	1	—	—	—	0	3	—	—	—	0	0	—	—
Nevada†	—	0	27	—	1	—	2	7	13	9	—	0	0	—	—
New Mexico†	—	0	0	—	—	—	1	3	—	8	1	3	15	12	51
Utah	—	0	6	5	10	—	0	1	1	2	11	8	38	115	117
Wyoming	2	0	3	6	4	—	0	0	—	—	—	0	8	3	27
Pacific	—	0	0	—	—	6	33	56	136	249	—	0	0	—	—
Alaska	—	0	0	—	—	—	0	2	—	2	—	0	0	—	—
California	N	0	0	N	N	1	28	54	94	227	—	0	0	—	—
Hawaii	—	0	0	—	—	—	0	2	3	2	N	0	0	N	N
Oregon†	N	0	0	N	N	—	0	6	2	1	N	0	0	N	N
Washington	N	0	0	N	N	5	3	11	37	17	N	0	0	N	N
American Samoa	—	0	0	—	—	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	—	0	0	—	—	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	N	0	0	N	N	—	4	16	15	20	3	9	47	20	59
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 25, 2006, and February 26, 2005 (8th Week)*

Reporting area	West Nile virus disease†									
	Neuroinvasive					Non-neuroinvasive				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max		
United States	—	1	152	—	—	—	1	203	—	2
New England	—	0	3	—	—	—	0	2	—	—
Connecticut	—	0	2	—	—	—	0	1	—	—
Maine	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	3	—	—	—	0	1	—	—
New Hampshire	—	0	0	—	—	—	0	0	—	—
Rhode Island	—	0	1	—	—	—	0	0	—	—
Vermont§	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	—	0	9	—	—	—	0	3	—	—
New Jersey	—	0	1	—	—	—	0	2	—	—
New York (Upstate)	—	0	6	—	—	—	0	1	—	—
New York City	—	0	2	—	—	—	0	2	—	—
Pennsylvania	—	0	3	—	—	—	0	2	—	—
E.N. Central	—	0	39	—	—	—	0	18	—	—
Illinois	—	0	25	—	—	—	0	16	—	—
Indiana	—	0	2	—	—	—	0	1	—	—
Michigan	—	0	14	—	—	—	0	3	—	—
Ohio	—	0	9	—	—	—	0	4	—	—
Wisconsin	—	0	3	—	—	—	0	2	—	—
W.N. Central	—	0	26	—	—	—	0	78	—	—
Iowa	—	0	3	—	—	—	0	5	—	—
Kansas	—	0	2	—	—	N	0	2	N	N
Minnesota	—	0	5	—	—	—	0	5	—	—
Missouri	—	0	4	—	—	—	0	3	—	—
Nebraska§	—	0	9	—	—	—	0	22	—	—
North Dakota	—	0	4	—	—	—	0	15	—	—
South Dakota	—	0	7	—	—	—	0	33	—	—
S. Atlantic	—	0	5	—	—	—	0	4	—	—
Delaware	—	0	1	—	—	—	0	0	—	—
District of Columbia	—	0	0	—	—	—	0	0	—	—
Florida	—	0	2	—	—	—	0	4	—	—
Georgia	—	0	3	—	—	—	0	3	—	—
Maryland	—	0	2	—	—	—	0	1	—	—
North Carolina	—	0	1	—	—	—	0	1	—	—
South Carolina§	—	0	1	—	—	—	0	0	—	—
Virginia§	—	0	0	—	—	—	0	0	—	—
West Virginia	—	0	0	—	—	N	0	0	N	N
E.S. Central	—	0	10	—	—	—	0	5	—	—
Alabama§	—	0	1	—	—	—	0	2	—	—
Kentucky	—	0	1	—	—	—	0	0	—	—
Mississippi	—	0	9	—	—	—	0	5	—	—
Tennessee§	—	0	3	—	—	—	0	1	—	—
W.S. Central	—	0	32	—	—	—	0	21	—	2
Arkansas	—	0	3	—	—	—	0	2	—	—
Louisiana	—	0	20	—	—	—	0	8	—	2
Oklahoma	—	0	6	—	—	—	0	3	—	—
Texas§	—	0	16	—	—	—	0	13	—	—
Mountain	—	0	16	—	—	—	0	39	—	—
Arizona	—	0	8	—	—	—	0	8	—	—
Colorado	—	0	5	—	—	—	0	13	—	—
Idaho§	—	0	2	—	—	—	0	3	—	—
Montana	—	0	3	—	—	—	0	9	—	—
Nevada§	—	0	3	—	—	—	0	8	—	—
New Mexico§	—	0	3	—	—	—	0	4	—	—
Utah	—	0	6	—	—	—	0	8	—	—
Wyoming	—	0	2	—	—	—	0	1	—	—
Pacific	—	0	50	—	—	—	0	89	—	—
Alaska	—	0	0	—	—	—	0	0	—	—
California	—	0	50	—	—	—	0	88	—	—
Hawaii	—	0	0	—	—	—	0	0	—	—
Oregon§	—	0	1	—	—	—	0	2	—	—
Washington	—	0	0	—	—	—	0	0	—	—
American Samoa	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE III. Deaths in 122 U.S. cities,* week ending February 25, 2006 (8th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
New England	508	365	93	36	6	8	53
Boston, MA	151	94	37	16	2	2	19
Bridgeport, CT	49	39	6	4	—	—	3
Cambridge, MA	20	15	4	—	—	1	4
Fall River, MA	21	20	1	—	—	—	4
Hartford, CT	45	37	4	1	—	3	8
Lowell, MA	22	16	3	2	1	—	2
Lynn, MA	7	6	—	1	—	—	1
New Bedford, MA	26	20	4	2	—	—	2
New Haven, CT	U	U	U	U	U	U	U
Providence, RI	53	41	10	—	2	—	1
Somerville, MA	4	2	2	—	—	—	—
Springfield, MA	40	26	10	4	—	—	2
Waterbury, CT	12	7	4	—	—	1	3
Worcester, MA	58	42	8	6	1	1	4
Mid. Atlantic	2,345	1,656	486	133	40	30	138
Albany, NY	47	35	8	1	1	2	2
Allentown, PA	27	22	3	1	1	—	—
Buffalo, NY	113	75	29	5	1	3	12
Camden, NJ	37	24	7	4	—	2	1
Elizabeth, NJ	15	9	5	1	—	—	—
Erie, PA	37	29	8	—	—	—	4
Jersey City, NJ	37	28	6	2	—	1	—
New York City, NY	1,177	831	245	70	19	12	59
Newark, NJ	57	27	19	8	3	—	6
Paterson, NJ	30	19	7	4	—	—	1
Philadelphia, PA	349	224	88	25	8	4	20
Pittsburgh, PA§	31	23	5	1	1	1	3
Reading, PA	29	23	5	—	—	1	1
Rochester, NY	141	113	22	2	2	2	10
Schenectady, NY	22	22	—	—	—	—	1
Scranton, PA	27	24	3	—	—	—	3
Syracuse, NY	97	74	16	2	3	2	8
Trenton, NJ	40	29	8	3	—	—	6
Utica, NY	14	9	1	3	1	—	—
Yonkers, NY	18	16	1	1	—	—	1
E.N. Central	1,972	1,327	431	126	39	49	125
Akron, OH	33	18	14	—	1	—	1
Canton, OH	39	25	11	2	—	1	7
Chicago, IL	243	132	73	19	8	11	24
Cincinnati, OH	80	55	12	4	4	5	12
Cleveland, OH	207	154	39	9	2	3	10
Columbus, OH	215	130	58	17	4	6	12
Dayton, OH	125	87	23	13	1	1	5
Detroit, MI	181	114	41	20	6	—	7
Evansville, IN	38	28	6	3	—	1	2
Fort Wayne, IN	57	38	13	2	3	1	3
Gary, IN	14	5	6	1	—	2	—
Grand Rapids, MI	69	51	13	3	—	2	4
Indianapolis, IN	176	125	33	10	2	6	7
Lansing, MI	49	38	7	2	—	2	3
Milwaukee, WI	105	82	16	6	—	1	8
Peoria, IL	46	32	10	2	—	2	1
Rockford, IL	58	43	11	1	1	2	4
South Bend, IN	59	39	14	3	2	1	1
Toledo, OH	110	72	26	5	5	2	6
Youngstown, OH	68	59	5	4	—	—	8
W.N. Central	673	464	136	35	12	23	55
Des Moines, IA	71	57	9	4	—	—	7
Duluth, MN	32	23	6	—	2	1	1
Kansas City, KS	34	22	8	4	—	—	3
Kansas City, MO	86	64	17	1	2	2	9
Lincoln, NE	40	29	9	1	—	1	3
Minneapolis, MN	78	41	19	6	4	8	4
Omaha, NE	88	56	22	3	3	4	6
St. Louis, MO	87	53	24	7	—	1	5
St. Paul, MN	65	50	10	3	—	2	7
Wichita, KS	92	69	12	6	1	4	10
S. Atlantic	1,330	842	326	103	34	24	82
Atlanta, GA	197	103	65	17	11	1	8
Baltimore, MD	199	123	49	17	4	6	14
Charlotte, NC	112	71	30	7	3	1	11
Jacksonville, FL	160	102	39	15	2	2	10
Miami, FL	136	92	29	10	4	1	2
Norfolk, VA	54	34	12	7	1	—	3
Richmond, VA	66	36	18	6	3	3	1
Savannah, GA	80	63	14	2	1	—	10
St. Petersburg, FL	64	47	14	—	—	3	9
Tampa, FL	220	158	37	16	5	4	13
Washington, D.C.	30	6	15	5	—	3	—
Wilmington, DE	12	7	4	1	—	—	1
E.S. Central	798	534	189	44	19	12	55
Birmingham, AL	128	78	37	8	3	2	16
Chattanooga, TN	87	68	15	3	1	—	4
Knoxville, TN	96	77	14	3	1	1	6
Lexington, KY	67	48	14	2	2	1	1
Memphis, TN	119	69	33	10	5	2	7
Mobile, AL	84	57	19	6	—	2	2
Montgomery, AL	69	46	16	3	2	2	4
Nashville, TN	148	91	41	9	5	2	15
W.S. Central	1,346	879	301	86	37	43	84
Austin, TX	105	77	12	9	2	5	11
Baton Rouge, LA	56	40	14	1	1	—	7
Corpus Christi, TX	U	U	U	U	U	U	U
Dallas, TX	207	122	54	16	8	7	13
El Paso, TX	96	65	20	5	3	3	8
Fort Worth, TX	132	80	32	9	3	8	7
Houston, TX	231	129	68	18	6	10	16
Little Rock, AR	88	64	14	7	2	1	2
New Orleans, LA¶	U	U	U	U	U	U	U
San Antonio, TX	216	153	44	12	5	2	18
Shreveport, LA	97	64	21	3	4	5	1
Tulsa, OK	118	85	22	6	3	2	1
Mountain	990	616	214	94	38	25	78
Albuquerque, NM	171	106	42	11	7	5	20
Boise, ID	30	21	6	3	—	—	3
Colorado Springs, CO	65	47	10	4	1	3	2
Denver, CO	103	40	15	35	9	4	11
Las Vegas, NV	282	177	69	22	9	5	19
Ogden, UT	38	30	6	2	—	—	1
Phoenix, AZ	159	94	43	6	8	5	11
Pueblo, CO	39	32	5	2	—	—	4
Salt Lake City, UT	103	69	18	9	4	3	7
Tucson, AZ	U	U	U	U	U	U	U
Pacific	1,468	1,081	254	75	31	26	131
Berkeley, CA	16	9	5	1	—	1	2
Fresno, CA	68	48	13	4	3	—	4
Glendale, CA	9	7	2	—	—	—	2
Honolulu, HI	69	53	8	2	—	6	1
Long Beach, CA	57	38	15	1	1	2	8
Los Angeles, CA	102	70	19	8	3	2	10
Pasadena, CA	39	32	3	4	—	—	6
Portland, OR	122	88	21	6	4	2	9
Sacramento, CA	256	196	43	9	7	1	22
San Diego, CA	130	99	20	3	4	4	18
San Francisco, CA	92	60	21	5	5	1	6
San Jose, CA	218	166	36	10	1	5	26
Santa Cruz, CA	33	27	3	3	—	—	3
Seattle, WA	95	66	22	5	1	1	5
Spokane, WA	64	50	4	8	2	—	4
Tacoma, WA	98	72	19	6	—	1	5
Total	11,430**	7,764	2,430	732	256	240	801

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.

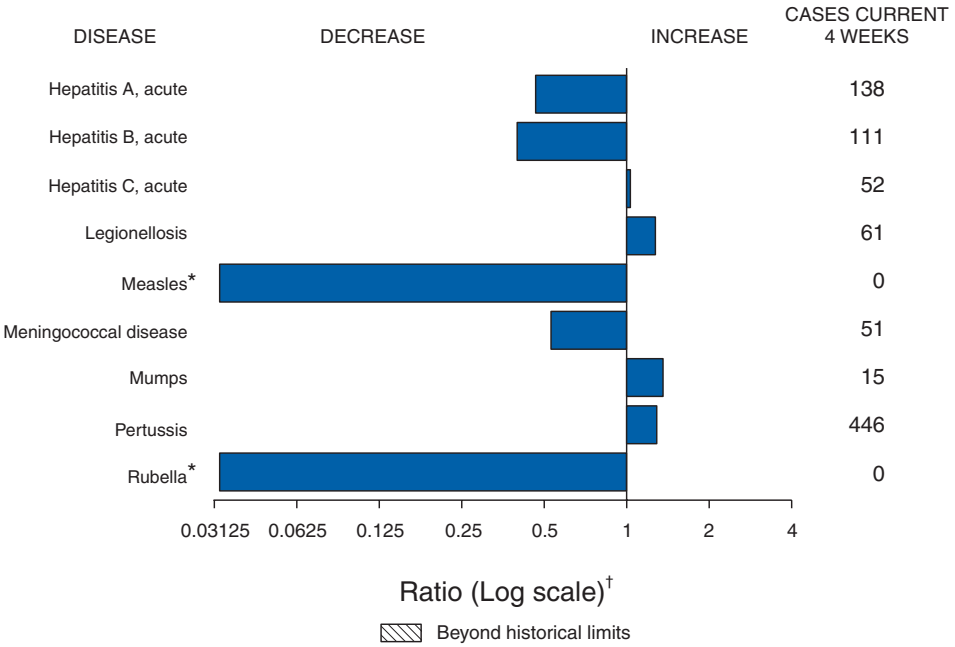
† Pneumonia and influenza.

§ 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.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals February 25, 2006, with historical data



* No measles or rubella cases were reported for the current 4-week period yielding a ratio for week 8 of zero (0).
† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

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