CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

March 9, 2001 / Vol. 50 / No. 9

MMWR™
MORBIDITY AND MORTALITY
WEEKLY REPORT

National Colorectal Cancer Awareness Month — March 2001

The U.S. Congress designated March as "National Colorectal Cancer Awareness Month" in 2000 to increase public awareness about the disease and to encourage persons aged ≥50 years to reduce their risk for colorectal cancer through regular screening tests. Colorectal cancer is the second leading cause of cancer-related deaths in the United States. During 2001, approximately 56,700 deaths will be attributed to colorectal cancer. Although effective screening is available, only 44% of U.S. adults aged ≥50 years have been screened recently with at least one of two tests. Routine screening has proven effective in reducing the number of cases of and deaths from colorectal cancer.

CDC supports National Colorectal Cancer Awareness Month through the Colorectal Cancer Prevention and Control Initiative, which includes "Screen for Life: A National Colorectal Cancer Action Campaign," and "A Call to Action," emphasizing to the public and to health-care providers the importance of early detection and regular screening among persons aged ≥50 years. CDC also supports training and education programs for health-care providers; conducts epidemiologic and behavioral research; oversees national cancer surveillance; and provides leadership by working with partners, health organizations, and state health departments.

States are increasing their focus on colorectal cancer prevention. For example, in Massachusetts, activities stress public and professional awareness of colorectal cancer. In New York, programs offer educational activities and access to screening services to the uninsured population. In North Carolina, surveys have been conducted to describe screening practices, to define barriers to screening, to assess public attitudes toward screening, and to assess screening insurance coverage. CDC's education and training materials are available on the World-Wide Web, http://www.cdc.gov/cancer/screenforlife and http://www.cdc.gov/cancer/colorctl/calltoaction.

Trends in Screening for Colorectal Cancer — United States, 1997 and 1999

Colorectal cancer is the second leading cause of cancer-related death in the United States (*1*). An estimated 135,400 new cases and 56,700 deaths from colorectal cancer are expected during 2001 (*1*). Since the mid-1990s, national guidelines have recommended that persons aged ≥50 years at average risk for colorectal cancer should have screening tests regularly. To estimate rates for the use of colorectal cancer screening tests and to evaluate trends in test use, CDC analyzed data from the 1999 Behavioral Risk Factor Surveillance System (BRFSS) on the use of a home administered fecal occult blood test (FOBT) and sigmoidoscopy/colonoscopy, and then compared them with similar data from 1997. The findings in this report indicate that the proportion of the U.S. population that has been screened remains low. In 1999, 44% of BRFSS respondents reported receiving FOBT and/or sigmoidoscopy/colonoscopy within the recommended period compared with approximately 41% reporting FOBT and/or sigmoidoscopy/proctoscopy within the recommended period in 1997 (*2*). Efforts to address barriers and to promote the use of colorectal cancer screening should be intensified.

In 1999, the 50 states, District of Columbia, and Puerto Rico participated in BRFSS, an ongoing, state-based, random-digit–dialed telephone survey of the civilian, noninstitutionalized population aged ≥18 years. A total of 63,555 respondents aged ≥50 years were asked whether they ever had FOBT using a home kit, whether they ever had sigmoidoscopy or colonoscopy, and when the last test had been performed. Responses coded as "don't know/not sure" or "refused" were excluded from analyses (<2%). Aggregated and state-specific proportions, standard errors, 95% confidence intervals, and p-values were calculated using SAS and SUDAAN.

Data in this analysis were weighted to the age, sex, and race/ethnicity distribution of each state's adult population using intercensal estimates and were age standardized to the 1999 BRFSS population. The median state response rate of 56.7% (range: 38.4%–83.9%) was calculated using the cooperation rate formula (i.e., the number of completed interviews divided by the number of potential respondents [households with a resident aged ≥18 years]). The 1999 questions about the use of sigmoidoscopy were modified from the 1997 questions. In 1997, respondents were asked whether they had received sigmoidoscopy or proctoscopy. Proctoscopy is performed with a shorter instrument than sigmoidoscope and is not recommended as a colorectal cancer screening test. In 1999, "sigmoidoscopy/proctoscopy" was replaced with "sigmoidoscopy/colonoscopy." Colonoscopy evaluates the entire colon and is recommended once every 10 years in some guidelines (*3,4*). For this report, "sigmoidoscopy/proctoscopy" and "sigmoidoscopy/colonoscopy" are referred to as "sigmoidoscopy" unless otherwise specified.

In 1999, 40.3% (25,263 of approximately 63,000) of respondents reported ever having FOBT, and 43.8% (26,388) of the respondents reported ever having sigmoidoscopy. For tests received within the recommended period, 20.6% (12,518) had FOBT within the year preceding the survey, 33.6% (19,535) had sigmoidoscopy within the preceding 5 years (Table 1), and 44.0% (25,871) had either FOBT within the year preceding the survey or sigmoidoscopy within the preceding 5 years (Figure 1). In 1997, 19.6% (9832 of approximately 51,000) of the respondents had FOBT within the year preceding the survey, and 30.3% (14,678) had sigmoidoscopy within the preceding 5 years (Table 1). Although these rate changes in testing use were statistically significant ($p<0.05$), actual increases were small. By state, the proportion of respondents who had FOBT within the preceding year ranged from 8.2% (112 of 1366) in Puerto Rico to 36.4% (187 of

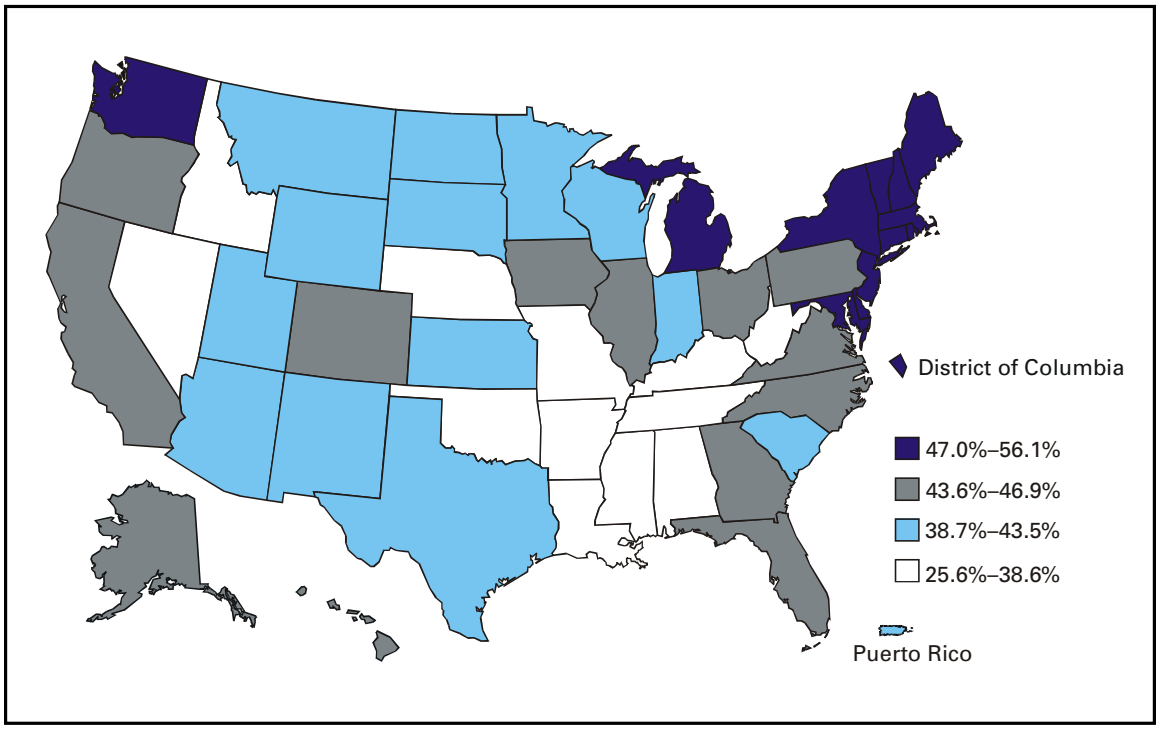
Screening for Colorectal Cancer — Continued

TABLE 1. Number and percentage of respondents aged ≥50 years who reported colorectal cancer screening tests within recommended period, by test type — Behavioral Risk Factor Surveillance System (BRFSS), United States, 1997 and 1999*

Test	1997			1999		
	No.	(%)	(95% CI†)	No.	(%)	(95%CI)
Fecal occult blood test within 1 year	9,832	(19.6)	(±0.5%)	12,518	(20.6)	(±0.5%)
Sigmoidoscopy§ within 5 years	14,678	(30.3)	(±0.6%)	19,535	(33.6)	(±0.6%)

*1997 and 1999 estimates age adjusted to the 1999 BRFSS population.
† Confidence interval.
§ For 1997 data, "sigmoidoscopy" refers to "sigmoidoscopy/proctoscopy." For 1999 data, "sigmoidoscopy" refers to "sigmoidoscopy/colonoscopy."

FIGURE 1. Proportion of respondents using fecal occult blood test and/or sigmoidoscopy within recommended period, by state — Behavioral Risk Factor Surveillance System, United States, 1999



500) in the District of Columbia; the proportion that had sigmoidoscopy/colonoscopy within the preceding 5 years ranged from 20.4% (275 of 1357) in Puerto Rico to 46.1% (410 of 981) in Delaware (Table 2).

Reported by the following state BRFSS coordinators: S Reese, MPH, Alabama; P Owen, Alaska; B Bender, MBA, Arizona; G Potts, MBA, Arkansas; B Davis, PhD, California; M Leff, MSPH, Colorado; M Adams, MPH, Connecticut; F Breukelman, Delaware; I Bullo, District of Columbia; S Hoecherl, Florida; L Martin, MS, Georgia; F Reyes-Salvail, MS, Hawaii; J Aydelotte, MA, Idaho; B Steiner, MS, Illinois; L Stemnock, Indiana; J Davila, Iowa; C Hunt, Kansas; T Sparks, Kentucky; B Bates, MSPH, Louisiana; D Maines, Maine; A Weinstein, MA, Maryland; D Brooks, MPH,

Screening for Colorectal Cancer — Continued

TABLE 2. Number and percentage of respondents aged ≥50 years who reported colorectal cancer screening tests within recommended period, by state — Behavioral Risk Factor Surveillance System (BRFSS), United States, 1999*

State	Fecal occult blood test within 1 year			Sigmoidoscopy/Colonoscopy within 5 years		
	No.†	(%)	(95% CI§)	No.	(%)	(95% CI)
Alabama	108	(11.5)	(±2.2%)	277	(29.9)	(±3.1%)
Alaska	68	(14.3)	(±5.0%)	181	(39.4)	(±6.3%)
Arizona	187	(21.2)	(±3.8%)	266	(30.0)	(±4.2%)
Arkansas	187	(15.3)	(±2.2%)	356	(28.9)	(±2.8%)
California	261	(17.0)	(±2.2%)	555	(38.8)	(±2.9%)
Colorado	245	(21.8)	(±3.4%)	335	(32.2)	(±3.8%)
Connecticut	334	(28.9)	(±3.3%)	452	(39.1)	(±3.5%)
Delaware	210	(21.6)	(±3.4%)	410	(46.1)	(±3.9%)
District of Columbia	187	(36.4)	(±4.4%)	215	(42.5)	(±4.6%)
Florida	561	(22.4)	(±1.9%)	819	(33.9)	(±2.3%)
Georgia	140	(17.3)	(±3.0%)	261	(36.9)	(±4.1%)
Hawaii	171	(20.1)	(±3.4%)	277	(35.7)	(±4.3%)
Idaho	302	(15.7)	(±1.9%)	544	(30.0)	(±2.5%)
Illinois	110	(20.2)	(±3.7%)	163	(33.7)	(±4.6%)
Indiana	139	(16.3)	(±3.9%)	248	(31.5)	(±5.1%)
Iowa	384	(23.6)	(±2.4%)	498	(30.7)	(±2.6%)
Kansas	316	(19.1)	(±2.1%)	449	(28.7)	(±2.5%)
Kentucky	586	(17.6)	(±1.8%)	867	(25.8)	(±2.0%)
Louisiana	115	(17.9)	(±3.2%)	177	(28.7)	(±3.8%)
Maine	208	(27.1)	(±3.5%)	230	(31.9)	(±3.6%)
Maryland	395	(29.1)	(±3.0%)	553	(41.2)	(±3.2%)
Massachusetts	513	(29.0)	(±2.6%)	595	(34.7)	(±2.7%)
Michigan	232	(24.5)	(±2.9%)	375	(40.0)	(±3.4%)
Minnesota	348	(18.4)	(±1.9%)	684	(36.5)	(±2.3%)
Mississippi	104	(13.4)	(±2.5%)	230	(28.5)	(±3.3%)
Missouri	305	(17.5)	(±2.4%)	494	(26.7)	(±2.7%)
Montana	149	(18.8)	(±2.8%)	233	(30.6)	(±3.4%)
Nebraska	251	(19.5)	(±2.4%)	295	(21.7)	(±2.4%)
Nevada	118	(14.2)	(±3.3%)	210	(28.9)	(±4.6%)
New Hampshire	135	(33.1)	(±4.9%)	153	(36.7)	(±5.0%)
New Jersey	282	(25.9)	(±3.0%)	391	(35.4)	(±3.2%)
New Mexico	247	(18.2)	(±2.3%)	438	(32.2)	(±2.7%)
New York	215	(23.7)	(±3.0%)	323	(35.0)	(±3.3%)
North Carolina	309	(30.1)	(±3.2%)	309	(31.3)	(±3.2%)
North Dakota	149	(17.4)	(±2.7%)	259	(30.1)	(±3.3%)
Ohio	175	(22.7)	(±3.5%)	243	(32.7)	(±3.8%)
Oklahoma	205	(15.4)	(±2.1%)	362	(28.4)	(±2.7%)
Oregon	156	(21.4)	(±3.2%)	239	(33.2)	(±3.7%)
Pennsylvania	332	(23.3)	(±2.4%)	409	(30.2)	(±2.7%)
Rhode Island	384	(24.9)	(±2.4%)	558	(38.8)	(±2.8%)
South Carolina	252	(20.0)	(±2.5%)	393	(31.8)	(±2.8%)
South Dakota	311	(18.7)	(±2.0%)	539	(31.7)	(±2.4%)
Tennessee	215	(17.3)	(±2.4%)	346	(29.7)	(±2.8%)
Texas	282	(17.5)	(±2.1%)	525	(32.8)	(±2.6%)
Utah	148	(15.2)	(±2.8%)	343	(32.2)	(±3.6%)
Vermont	379	(30.1)	(±2.7%)	385	(32.3)	(±2.8%)
Virginia	258	(18.7)	(±2.7%)	459	(35.9)	(±3.5%)
Washington	329	(26.0)	(±2.9%)	451	(36.9)	(±3.0%)
West Virginia	170	(13.5)	(±2.0%)	307	(26.0)	(±2.7%)
Wisconsin	123	(14.8)	(±2.6%)	296	(36.0)	(±3.6%)
Wyoming	116	(13.8)	(±2.5%)	283	(34.0)	(±3.4%)
Puerto Rico	112	(8.2)	(±1.7%)	275	(20.4)	(±2.4%)
Total	**12,518**	**(20.6)**	**(±0.5%)**	**19,535**	**(33.6)**	**(±0.6%)**

*1999 estimates age adjusted to the 1999 BRFSS population.

† Number responding "yes."

§ Confidence interval.

Screening for Colorectal Cancer — Continued

Massachusetts; H McGee, MPH, Michigan; N Salem, PhD, Minnesota; D Johnson, MS, Mississippi; J Jackson-Thompson, PhD, Missouri; P Feigley, PhD, Montana; L Andelt, PhD, Nebraska; E DeJan, MPH, Nevada; L Powers, MA, New Hampshire; G Boeselager, MS, New Jersey; W Honey, MPH, New Mexico; C Baker, New York; Z Gizlice, PhD, North Carolina; L Shireley, MPH, North Dakota; P Pullen, Ohio; K Baker, MPH, Oklahoma; K Pickle, MPH, Oregon; L Mann, Pennsylvania; Y Cintron, MPH, Puerto Rico; J Hesser, PhD, Rhode Island; M Wu, MD, South Carolina; M Gildemaster, South Dakota; D Ridings, Tennessee; K Condon, MS, Texas; K Marti, Utah; C Roe, MS, Vermont; K Carswell, MPH, Virginia; K Wynkoop Simmons, PhD, Washington; F King, West Virginia; K Pearson, Wisconsin; M Futa, MA, Wyoming. Epidemiology and Health Svcs Research Br, Div of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: Since 1997, the proportion of the U.S. population that reported having had FOBT and sigmoidoscopy has increased slightly but remains low. Various factors may contribute to the continued underuse of these tests, including lack of knowledge by the public and health-care providers of the effectiveness of screening and low reimbursement rates for health-care providers who perform screening tests (*5,6*).

The findings in this report are subject to at least four limitations. First, because of the wording change in the BRFSS questionnaire from "sigmoidoscopy/proctoscopy" in 1997 to "sigmoidoscopy/colonoscopy" in 1999, comparing endoscopic procedures for these years must be interpreted with caution. Data on the use of colonoscopy were collected only in 1999; however, some tests reported as sigmoidoscopies/proctoscopies in 1997 probably were colonoscopies because some respondents may have been unable to distinguish among the three tests. It is unknown whether the reported increase from 1997 to 1999 represents a true increase in sigmoidoscopy use or previously unmeasured rates of colonoscopy use. Second, because the survey was administered over the telephone, only persons who own telephones were represented in this analysis. Third, 43.3% of the eligible respondents were contacted but did not complete the telephone interview or could not be reached for an interview. Finally, responses were self-reported and were not validated through medical record review.

For persons aged ≥50 years at average risk for colorectal cancer, recommended screening options include one or more of the following tests: annual FOBT, sigmoidoscopy every 5 years, colonoscopy every 10 years, or double-contrast barium enema every 5–10 years (*3,4,7*). Despite their efficacy in reducing incidence and mortality from colorectal cancer (*8*), screening tests are underused. To draw attention to this disease, the U.S. Congress designated March as "National Colorectal Cancer Awareness Month." During March 2001, CDC and the Health Care Financing Administration launched the third annual "Screen for Life: A National Colorectal Cancer Action Campaign." Using print, television, and radio announcements and brochures and fact sheets, the campaign was designed to raise awareness of colorectal cancer and to encourage persons aged ≥50 years to discuss screening with their health-care provider and select the appropriate test(s). CDC also produced "A Call to Action: Prevention and Early Detection of Colorectal Cancer," a slide presentation for health-care providers. All material is available on the World-Wide Web, http://www.cdc.gov/cancer/screenforlife and http://www.cdc.gov/cancer/colorctl/calltoaction.

References

1. American Cancer Society. Cancer facts and figures, 2001. Atlanta, Georgia: American Cancer Society, 2001 (publication no. 5008.01).
2. CDC. Screening for colorectal cancer—United States, 1997. MMWR 1999;48:116–21.
3. Winawer SJ, Fletcher RH, Miller L, et al. Colorectal cancer screening: clinical guidelines and rationale. Gastroenterology 1997;112:594–642.

Screening for Colorectal Cancer — Continued

4. Smith RA, von Eschenbach AC, Wender R, et al. American Cancer Society guidelines for the early detection of cancer: update of early detection guidelines for prostate, colorectal, and endometrial cancers. CA Cancer J Clin 2001;51:38–75.
5. Peterson SK, Vernon SW. A review of patient and physician adherence to colorectal cancer screening guidelines. Seminars in Colon and Rectal Surgery 2000;11:58–72.
6. Lewis JD, Asch DA. Barriers to office-based screening sigmoidoscopy: does reimbursement cover costs? Ann Intern Med 1999;130:525–30.
7. US Preventive Services Task Force. Guide to clinical preventive services. 2nd ed. Baltimore, Maryland: Williams and Wilkins, 1996.
8. Mandel JS, Church TR, Bond JH, et al. The effect of fecal occult-blood screening on the incidence of colorectal cancer. N Engl J Med 2000;343:1603–7.

Physical Activity Trends — United States, 1990–1998

Physical activity is associated with numerous health benefits (*1*), and increased participation in various types of leisure-time physical activity had been encouraged during the 1990s (*2*). To determine national estimates of leisure-time physical activity during 1990–1998, data were obtained from the Behavioral Risk Factor Surveillance System (BRFSS). This report summarizes the results of that analysis, which indicate that leisure-time physical activity trends have remained unchanged.

BRFSS is a population-based, random-digit–dialed telephone survey of the civilian, noninstitutionalized U.S. population aged ≥18 years. Forty-three states and the District of Columbia collected data about physical activity for 1990, 1991, 1992, 1994, 1996, and 1998. Data were not collected by all states during 1993, 1995, and 1997. Respondents were asked about the two physical activities or exercises they engage in most often and about the frequency, duration, and distance (as appropriate) of each activity. Responses were then classified as one of 56 selected activities (Table 1). Moderate activity was defined as any of the 56 selected activities, and vigorous activity was defined as aerobic physical activity classified as vigorous-intensity based on estimated metabolic expenditure (MET) (Table 1). To classify an activity as vigorous, it must be aerobic with an assigned MET value (*3*) that is at least 60% of a person's maximal cardiorespiratory capacity (MCC). MET values are determined using two regression equations for MCC (*4*): one for men ($METS_{60\%MCC}$ = [0.6 x (60 - 0.55 x age)]/ 3.5) and one for women ($METS_{60\%MCC}$ = [0.6 x (48 - 0.37 x age)]/ 3.5).

To have achieved recommended levels of physical activity, a person must have reported engaging in moderate-intensity physical activity ≥5 times per week for ≥30 minutes each time, vigorous-intensity physical activity ≥3 times per week for ≥20 minutes each time, or both during the preceding month. Persons reporting some activity during the preceding month but not enough to be classified as moderate or vigorous were classified as insufficient. Persons classified as inactive reported no physical activity outside of their occupation during the preceding month. Data were analyzed using SUDAAN to obtain prevalence estimates for recommended levels of physical activity. All data were age adjusted to the 2000 standard population.

The prevalence of those who engaged in recommended levels of activity increased slightly from 24.3% in 1990 to 25.4% in 1998, and the prevalence of those reporting insufficient activity increased from 45.0% in 1990 to 45.9% in 1998 (Figure 1). Those reporting no physical activity decreased from 30.7% in 1990 to 28.7% in 1998. The components of recommended activity remained relatively stable (Figure 2).

Physical Activity Trends — Continued

TABLE 1. Metabolic expenditure values used for calculating intensity of leisure-time physical activity and aerobic classification of activitiy, by activity — Behavioral Risk Factor Surveillance System, United States, 1990–1998

Activity	Metabolic expenditure	Aerobic activity	Activity	Metabolic expenditure	Aerobic activity
Aerobics class	6.5	Yes	Painting, papering	3.0	No
Backpacking	7.0	Yes	Racquetball	7.0	Yes
Badminton	4.5	Yes	Raking lawn	4.3	Yes
Basketball	6.0	Yes	Rope skipping	10.0	Yes
Bicycle machine	7.0	Yes	Rowing machine	7.0	Yes
Biking (pleasure)	6.0	Yes	Running	8.0	Yes
Boating (pleasure)	2.5	No	Scuba diving	7.0	Yes
Bowling	3.0	No	Skating (any)	7.0	Yes
Boxing	9.0	Yes	Sledding	7.0	Yes
Calisthenics	3.5	Yes	Snorkeling	5.0	Yes
Canoeing (competitive)	3.5	Yes	Snow blowing	4.5	Yes
Carpentry	3.0	No	Snow shoeing	8.0	Yes
Dancing	4.5	Yes	Snow shoveling	6.0	Yes
Fishing (bank or boat)	3.5	No	Snow skiing	7.0	Yes
Gardening	4.0	No	Soccer	7.0	Yes
Golf	4.5	No	Softball	5.0	No
Handball	10.0	Yes	Squash	12.0	Yes
Health club exercise	5.5	Yes	Stair climbing	8.0	Yes
Hiking	6.0	Yes	Stream fishing	6.0	No
Home exercise	5.5	Yes	Surfing	3.0	No
Horseback riding	4.0	No	Swimming laps	6.0	Yes
Hunting	5.0	Yes	Table tennis	4.0	Yes
Jogging	7.0	Yes	Tennis	7.0	Yes
Judo, Karate	10.0	No	Touch football	8.0	Yes
Mountain climbing	8.0	Yes	Volleyball	4.0	No
Mowing lawn	5.5	Yes	Walking	3.5	Yes
Other	4.5	No	Water skiing	6.0	No
Paddleball	6.0	Yes	Weightlifting	3.0	No

Reported by: Physical Activity and Health Br, Div of Nutrition and Physical Activity, and Cardiovascular Health Br, Div of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion; and an EIS Officer, CDC.

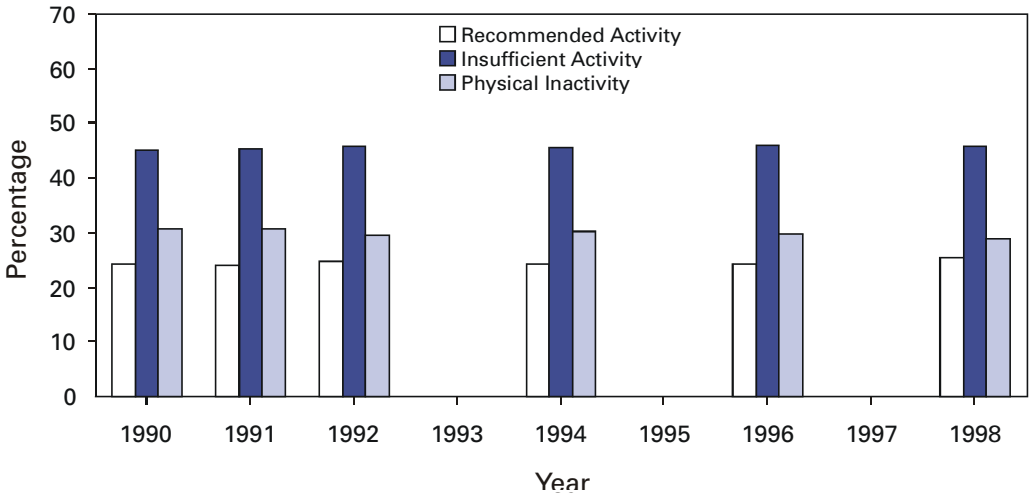
Editorial Note: The findings in this report indicate that trends in physical activity remained stable during 1990–1998. Classifying persons according to their main pair of nonoccupational activities during the preceding month suggests that only approximately one fourth of U.S. adults meet recommended levels of physical activity.

During 1990–1998, the BRFSS formula for calculating vigorous intensity changed. In 1992, vigorous intensity was calculated as 50% of MCC; before 1992, it was calculated as 60% of MCC, the generally accepted threshold for vigorous activity. The data reported here vary from previous reports (*1*) because all years of data were calculated using the same formula for vigorous intensity (60% MCC). Therefore, the slight increase in vigorous physical activity that might have appeared after 1992 in previous reports was attributed to differences in calculating vigorous physical activity rather than an actual increase among the population.

The findings in this report are subject to at least four limitations. First, these data are self-reported and are subject to recall bias. Second, because these data do not include information on nonleisure-time physical activities, total activity may be underestimated.

Physical Activity Trends — Continued

FIGURE 1. Percentage of persons reporting level* of leisure-time physical activity, by year — Behavioral Risk Factor Surveillance System, United States, 1990–1998†



*Recommended level=moderate-intensity activity ≥5 times per week for ≥30 minutes each time, vigorous-intensity ≥3 times per week for ≥20 minutes each time, or both; insufficient=some activity but not enough to be classified as moderate or vigorous; inactive=no leisure-time physical activity during the preceding month.

† Data were not collected by all states during 1993, 1995, and 1997.

Third, only the two most common activities the respondents engaged in during the preceding month are reported. Finally, these data are limited by coverage- and nonresponse-related errors.

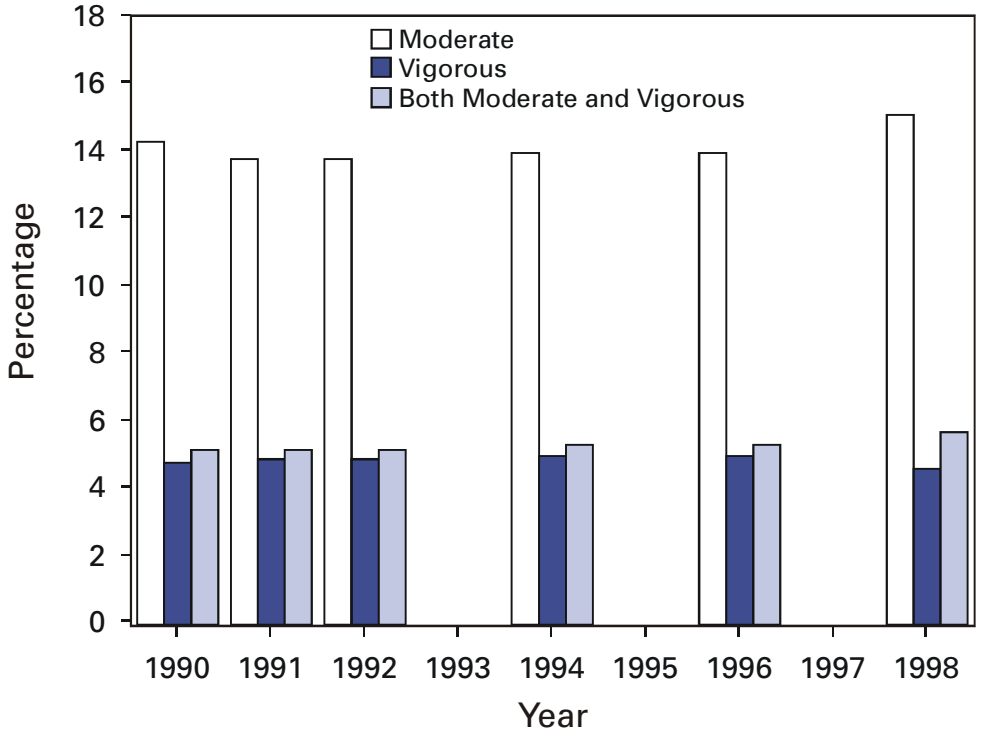
Moderate-intensity physical activity has substantial health benefits (*1*). Moderate-intensity activities include housework, childcare activities, occupational activity, or walking for transportation, which may be more prevalent among women and certain subgroups of the population. However, surveillance systems that primarily are based on sports-related vigorous activities may miss a substantial portion of this type of activity. Also, systems based on only two reported activities may miss less intense or moderate-intensity activities. Public health programs usually encourage participation in moderate-intensity rather than vigorous-intensity activities for sedentary persons. Surveillance systems should be updated so that a broader range of physical activities can be measured. A more extensive measurement system would enable determination of whether the trends in this report are an accurate reflection of physical activity trends in the United States.

References

1. US Department of Health and Human Services. Physical activity and health: report of the Surgeon General. Atlanta, Georgia: US Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, 1996.
2. US Department of Health and Human Services. Healthy people 2000—full report, with commentary. Washington, DC: US Department of Health and Human Services, Public Health Service, 1991; DHHS publication no. (PHS) 91-50212.

Physical Activity Trends — Continued

FIGURE 2. Percentage of persons participating in recommended level of leisure-time physical activity, by intensity* of activity and year — Behavioral Risk Factor Surveillance System, United States, 1990–1998†



*Moderate=engaging in moderate-intensity physical activity ≥5 times per week for ≥30 minutes each time; vigorous=engaging in vigorous intensity physical activity ≥3 times per week for ≥20 minutes each time.

† Data were not collected by all states during 1993, 1995, and 1997.

3. Ainsworth BE, Haskell WL, Whitt MC, et al. Compendium of physical activities: an update of activity codes and MET intensities. Med Sci Sports Exerc 2000;9:S498–S516.
4. Pereria MA, Fitzgerald SJ, Gregg EW, et al. A collection of physical activity questionnaires for health-related research. Med Sci Sports Exerc 1997;29:S146–S52.

Sudden Death in a Traveler Following Halofantrine Administration — Togo, 2000

On July 17, 2000, a previously healthy 22-year-old U.S. student collapsed and died suddenly while leading a teenage exchange group in West Africa. This report summarizes the results of the investigations of this incident, which implicate use of halofantrine for treatment of malaria as the cause of death. Travelers should be warned that halofantrine treatment may be dangerous in persons with cardiac abnormalities or in those taking mefloquine for malaria prophylaxis.

The student began taking mefloquine for malaria prophylaxis approximately 1 week before departure on July 5. On July 12, he developed fever of 102 F (39 C), chills, headache, and cough, and was seen at a clinic in Togo 2 days later. He was diagnosed with

Halofantrine Administration — Continued

malaria and bronchopneumonia and treated orally with halofantrine, dirithromycin, and acetylcysteine. The patient defervesced over the following 24 hours and resumed normal activities on July 13.

On July 14, following a 2-hour car ride, he stepped from the car, complained of a "head rush," and collapsed. Cardiopulmonary resuscitation was unsuccessful, and he was later pronounced dead at a local medical center. On July 24, an autopsy was performed at Yale-New Haven Medical Center, which revealed a previously undiagnosed atypical asymmetric hypertrophic cardiomyopathy.

Reported by: D Irons, MD, Tufts Univ School of Medicine, Boston, Massachusetts. J Morrow, MD, Yale Univ Medical Center, New Haven, Connecticut. Malaria Epidemiology Br, Div of Parasitic Diseases, National Center for Infectious Diseases; and an EIS Officer, CDC.

Editorial Note: This report underscores precautions about halofantrine use for treating malaria, especially among travelers who are taking mefloquine prophylaxis. In the case of this traveler, who had been taking mefloquine for prophylaxis and had been in a malarious area for only 1 week, the diagnosis of malaria probably was erroneous. The patient in this report also received dirithromycin, a macrolide antibiotic that may have exacerbated the cardiac effects of mefloquine and halofantrine (*1*).

Halofantrine is a synthetic phenanthrene-methanol antimalarial and is chemically related to quinine and mefloquine. The drug has been approved for use in the United States and is marketed internationally but not in the United States. Although halofantrine is an efficacious treatment for *Plasmodium falciparum* malaria (*2*), the drug can cause rare but serious cardiac complications (*3*). The drug has been associated with lengthening of the QT interval in patients without known cardiac abnormalities (*4–6*) and with fatal or near-fatal arrhythmias in some persons (*6,7*). Although this patient had no family history of heart disease, hypertrophic cardiomyopathy, which has been associated with QT prolongation and an increased risk for sudden cardiac death (*8*), was discovered at autopsy.

QT prolongation may occur more frequently when halofantrine is administered following mefloquine (*6*), and prescribing information for halofantrine warns against its use in those taking mefloquine (*9*). The manufacturer and others also recommend that halofantrine be used for treatment only in persons who have a normal electrocardiogram, which makes its use in many less-developed settings impractical (*4,9*).

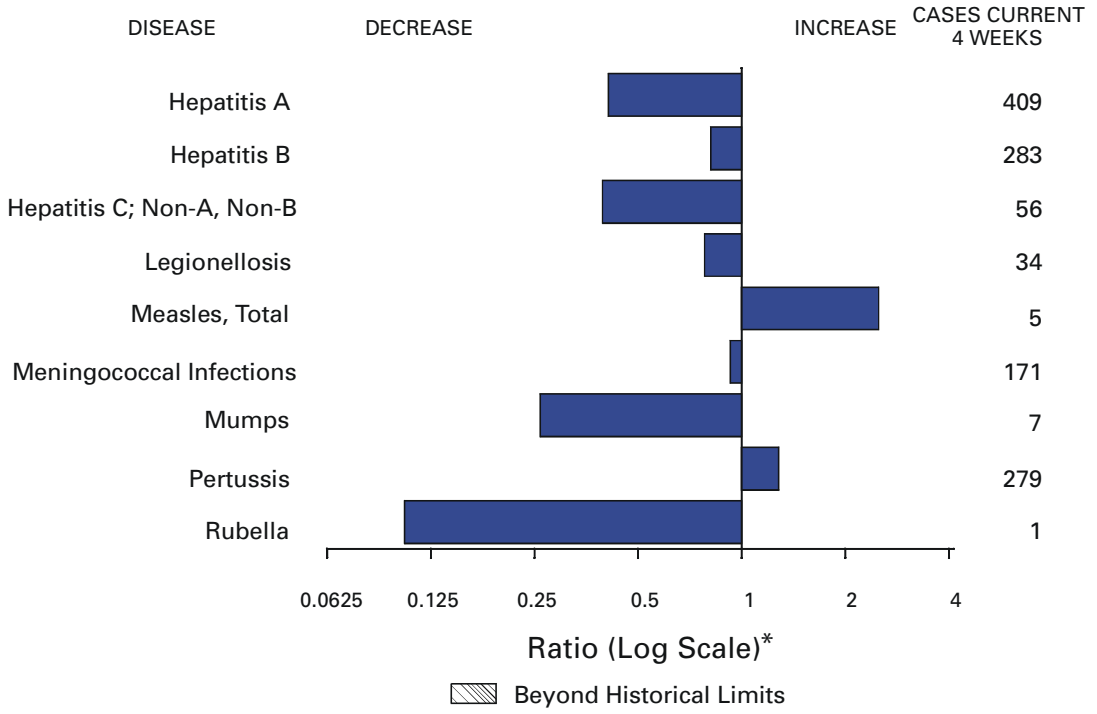
Travelers to remote areas should consider carrying antimalarials for presumptive self-treatment should they become ill with symptoms of malaria and are unable to obtain prompt medical care. Both sulfadoxine-pyrimethamine (Fansidar*, Roche Laboratories, Nutley, New Jersey), and atovaquone-proguanil (Malarone, Glaxo Wellcome, Research Triangle Park, North Carolina) are acceptable options for presumptive self-treatment, depending on local drug resistance patterns (*10*). However, all travelers should be cautioned that presumptive self-treatment for malaria is not a substitute for a prompt medical evaluation.

Halofantrine treatment may be dangerous in those with cardiac abnormalities or in those taking mefloquine for malaria prophylaxis. However, because *P. falciparum* malaria is a potentially life-threatening illness, the benefit of halofantrine treatment may outweigh the risks in the case of laboratory-confirmed *P. falciparum* infection if no other effective therapies are available. Additional information about malaria prophylaxis and treatment is available from CDC by telephone, (888) 232-3228, fax, (888) 232-3299, or on the World-Wide Web, http://www.cdc.gov/travel.

*Use of trade names is for identification only and does not imply endorsement by CDC or the U.S. Department of Health and Human Services.

(Continued on Page 179)

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending March 3, 2001, with historical data



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

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending March 3, 2001 (9th Week)

	Cum. 2001		Cum. 2001
Anthrax	-	Poliomyelitis, paralytic	-
Brucellosis*	4	Psittacosis*	2
Cholera	-	Q fever*	1
Cyclosporiasis*	6	Rabies, human	-
Diphtheria	-	Rocky Mountain spotted fever (RMSF)	9
Ehrlichiosis: human granulocytic (HGE)*	3	Rubella, congenital syndrome	-
human monocytic (HME)*	2	Streptococcal disease, invasive, group A	456
Encephalitis: California serogroup viral*	-	Streptococcal toxic-shock syndrome*	14
eastern equine*	-	Syphilis, congenital¶	1
St. Louis*	-	Tetanus	1
western equine*	-	Toxic-shock syndrome	18
Hansen disease (leprosy)*	2	Trichinosis	2
Hantavirus pulmonary syndrome*†	1	Tularemia*	2
Hemolytic uremic syndrome, postdiarrheal*	9	Typhoid fever	22
HIV infection, pediatric*§	37	Yellow fever	-
Plague	-		

-: No reported cases.
*Not notifiable in all states.
† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID).
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update February 27, 2001.
¶ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending March 3, 2001, and March 5, 2000 (9th Week)

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7*			
							NETSS		PHLIS	
	Cum. 2001§	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	5,820	6,226	89,907	109,373	156	192	130	227	76	183
NEW ENGLAND	200	500	3,190	3,933	5	12	13	17	11	22
Maine	3	6	140	231	-	1	-	1	-	2
N.H.	12	6	172	190	-	-	4	3	2	4
Vt.	9	-	96	102	2	4	-	1	-	2
Mass.	118	360	1,405	1,654	-	3	9	7	7	5
R.I.	24	17	524	393	1	1	-	-	-	-
Conn.	34	111	853	1,363	2	3	-	5	2	9
MID. ATLANTIC	1,180	1,591	3,981	8,523	12	15	10	26	6	39
Upstate N.Y.	29	65	N	N	6	8	10	24	6	32
N.Y. City	740	985	1,870	4,250	6	4	-	1	-	-
N.J.	241	387	676	2,283	-	-	-	1	-	2
Pa.	170	154	1,435	1,990	-	3	N	N	-	5
E.N. CENTRAL	463	591	11,638	19,987	48	48	24	40	12	10
Ohio	77	91	218	5,390	20	11	12	7	6	3
Ind.	45	56	1,898	2,164	9	3	4	1	-	2
Ill.	226	354	3,168	5,750	-	6	4	16	4	-
Mich.	97	67	5,104	3,759	19	5	2	7	-	2
Wis.	18	23	1,250	2,924	-	23	2	9	2	3
W.N. CENTRAL	110	147	4,219	6,523	5	6	14	41	10	38
Minn.	29	31	933	1,436	-	-	3	5	4	16
Iowa	15	10	509	576	3	1	2	8	-	4
Mo.	38	67	1,185	2,356	-	1	6	20	3	9
N. Dak.	1	-	109	184	-	1	-	2	-	2
S. Dak.	-	2	321	317	-	1	1	-	1	-
Nebr.	9	7	201	598	2	2	-	3	-	4
Kans.	18	30	961	1,056	-	-	2	3	2	3
S. ATLANTIC	1,673	1,508	19,778	20,695	32	24	23	21	6	16
Del.	37	25	508	500	-	-	-	-	-	-
Md.	131	154	2,063	1,877	3	1	-	5	-	1
D.C.	166	113	527	475	2	-	-	-	U	U
Va.	137	113	2,863	2,270	3	-	3	4	3	5
W. Va.	12	7	358	373	-	-	2	1	-	1
N.C.	101	74	3,479	3,040	6	3	13	6	1	2
S.C.	171	153	1,698	3,064	-	-	1	-	-	-
Ga.	187	180	3,384	4,252	7	12	1	2	-	3
Fla.	731	689	4,898	4,844	11	8	3	3	2	4
E.S. CENTRAL	360	279	7,649	7,280	3	7	6	10	3	7
Ky.	51	37	1,449	1,331	-	-	-	4	2	2
Tenn.	132	104	2,553	2,060	-	-	3	3	1	5
Ala.	95	91	1,764	2,162	2	6	3	1	-	-
Miss.	82	47	1,883	1,727	1	1	-	2	-	-
W.S. CENTRAL	629	532	16,633	17,119	4	11	8	13	8	20
Ark.	45	20	1,568	760	2	1	-	3	-	3
La.	188	91	3,045	3,322	1	-	-	-	5	6
Okla.	36	17	1,801	1,461	1	1	2	3	2	3
Tex.	360	404	10,219	11,576	-	9	6	7	1	8
MOUNTAIN	241	210	4,382	6,370	16	11	13	24	7	9
Mont.	5	3	237	193	-	-	-	5	-	-
Idaho	5	3	343	324	2	1	2	3	-	-
Wyo.	-	1	134	129	-	1	-	2	-	2
Colo.	40	52	315	1,637	8	3	7	9	4	3
N. Mex.	15	25	664	808	3	1	-	-	-	-
Ariz.	93	55	2,092	2,200	1	2	4	3	2	3
Utah	23	28	67	388	2	3	-	1	1	1
Nev.	60	43	530	691	-	-	-	1	-	-
PACIFIC	964	868	18,437	18,943	31	58	19	35	13	22
Wash.	117	101	2,219	2,256	N	U	3	3	5	7
Oreg.	38	22	943	783	7	1	3	6	1	5
Calif.	798	721	14,470	14,914	24	57	13	22	5	7
Alaska	2	-	326	368	-	-	-	-	-	-
Hawaii	9	24	479	622	-	-	-	4	2	3
Guam	5	7	-	-	-	-	N	N	U	U
P.R.	158	150	577	U	-	-	-	1	U	U
V.I.	1	5	U	U	U	U	U	U	U	U
Amer. Samoa	-	-	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	U	U	U	U	U	U	U	U

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

* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

† Chlamydia refers to genital infections caused by *C. trachomatis*. Totals reported to the Division of STD Prevention, NCHSTP.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update February 27, 2001.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 3, 2001, and March 5, 2000 (9th Week)

Reporting Area	Gonorrhea		Hepatitis C; Non-A, Non-B		Legionellosis		Listeriosis	Lyme Disease	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	42,775	57,745	255	579	84	109	48	312	675
NEW ENGLAND	889	1,163	2	3	1	9	5	85	114
Maine	19	12	-	-	-	2	-	-	-
N.H.	20	17	-	-	-	1	-	42	15
Vt.	14	7	2	-	1	-	-	1	-
Mass.	430	463	-	3	-	5	3	7	21
R.I.	133	95	-	-	-	-	-	-	-
Conn.	273	569	-	-	-	1	2	35	78
MID. ATLANTIC	2,888	4,674	14	94	5	16	2	143	460
Upstate N.Y.	929	781	11	3	4	6	2	118	128
N.Y. City	925	1,818	-	-	-	-	-	-	15
N.J.	409	1,257	-	86	-	-	-	-	69
Pa.	625	818	3	5	1	10	-	25	248
E.N. CENTRAL	5,927	12,318	35	54	27	37	7	10	15
Ohio	175	3,108	3	-	15	16	2	10	2
Ind.	871	1,002	-	-	3	4	-	-	1
Ill.	1,489	3,960	-	5	-	3	-	-	1
Mich.	2,937	2,987	32	49	9	7	5	-	-
Wis.	455	1,261	-	-	-	7	-	U	11
W.N. CENTRAL	1,841	2,737	37	84	8	4	2	5	8
Minn.	320	538	-	-	1	1	-	3	2
Iowa	154	136	-	-	2	1	-	-	-
Mo.	844	1,379	36	81	3	2	1	2	2
N. Dak.	4	6	-	-	-	-	-	-	-
S. Dak.	36	48	-	-	-	-	-	-	-
Nebr.	43	199	-	1	1	-	-	-	-
Kans.	440	431	1	2	1	-	1	-	4
S. ATLANTIC	12,386	16,701	11	13	16	21	7	54	64
Del.	280	261	-	1	-	1	-	-	10
Md.	1,331	1,256	3	2	7	7	1	49	45
D.C.	540	400	-	-	-	-	-	1	-
Va.	1,666	1,692	-	-	2	3	1	2	1
W. Va.	72	98	-	1	N	N	1	-	4
N.C.	2,311	2,786	4	5	2	2	-	2	4
S.C.	1,620	3,888	-	-	-	2	-	-	-
Ga.	1,777	2,775	-	-	-	-	2	-	-
Fla.	2,789	3,545	4	4	5	6	2	-	-
E.S. CENTRAL	5,076	5,399	33	86	5	2	4	2	-
Ky.	619	564	-	6	2	-	1	2	-
Tenn.	1,791	1,656	9	18	2	1	2	-	-
Ala.	1,495	1,807	-	3	1	1	1	-	-
Miss.	1,171	1,372	24	59	-	-	-	-	-
W.S. CENTRAL	8,447	9,007	92	196	1	4	1	-	2
Ark.	998	378	1	1	-	-	1	-	-
La.	2,098	2,402	44	107	1	2	-	-	2
Okla.	889	672	-	-	-	-	-	-	-
Tex.	4,462	5,555	47	88	-	2	-	-	-
MOUNTAIN	1,326	1,801	14	17	4	8	5	-	-
Mont.	11	-	-	-	-	-	-	-	-
Idaho	18	19	1	-	-	1	-	-	-
Wyo.	13	12	3	-	-	-	-	-	-
Colo.	412	642	5	8	3	4	1	-	-
N. Mex.	125	148	5	4	-	-	1	-	-
Ariz.	551	691	-	4	1	-	1	-	-
Utah	9	53	-	-	-	3	-	-	-
Nev.	187	236	-	1	-	-	2	-	-
PACIFIC	3,995	3,945	17	32	17	8	15	13	12
Wash.	503	419	2	3	3	2	-	-	-
Oreg.	172	84	3	9	N	N	2	2	1
Calif.	3,204	3,331	12	20	14	6	13	11	11
Alaska	35	34	-	-	-	-	-	-	-
Hawaii	81	77	-	-	-	-	-	N	N
Guam	-	-	-	-	-	-	-	-	-
P.R.	179	78	-	1	2	-	-	N	N
V.I.	U	U	U	U	U	U	-	U	U
Amer. Samoa	U	U	U	U	U	U	-	U	U
C.N.M.I.	U	U	U	U	U	U	-	U	U

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

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 3, 2001, and March 5, 2000 (9th Week)

Reporting Area	Malaria		Rabies, Animal		Salmonellosis*			
					NETSS		PHLIS	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	121	144	636	769	2,830	3,866	2,251	3,449
NEW ENGLAND	10	3	70	73	202	229	193	260
Maine	-	-	11	17	9	22	7	12
N.H.	-	-	2	2	17	14	12	17
Vt.	-	-	17	4	13	5	11	7
Mass.	3	3	16	25	121	149	106	155
R.I.	-	-	8	4	11	3	18	17
Conn.	7	-	16	21	31	36	39	52
MID. ATLANTIC	9	27	99	128	205	551	361	619
Upstate N.Y.	5	8	79	100	92	81	64	149
N.Y. City	3	11	1	U	86	156	141	181
N.J.	-	4	19	14	-	187	55	109
Pa.	1	4	-	14	27	127	101	180
E.N. CENTRAL	22	17	3	6	437	596	389	302
Ohio	4	2	-	2	165	151	85	107
Ind.	7	-	1	-	31	46	36	62
Ill.	-	10	-	-	110	207	144	1
Mich.	11	5	2	-	94	83	89	90
Wis.	-	-	-	4	37	109	35	42
W.N. CENTRAL	3	8	51	65	179	185	174	217
Minn.	1	2	12	18	31	39	71	69
Iowa	1	-	12	6	28	15	2	19
Mo.	1	1	3	2	63	63	68	62
N. Dak.	-	-	8	8	1	2	5	15
S. Dak.	-	-	9	18	14	7	9	13
Nebr.	-	2	-	-	9	22	-	15
Kans.	-	3	7	13	33	37	19	24
S. ATLANTIC	31	36	260	287	771	597	408	574
Del.	1	-	-	10	15	10	8	11
Md.	13	19	55	63	108	107	96	107
D.C.	2	-	-	-	13	-	U	U
Va.	8	11	57	67	90	66	66	70
W. Va.	-	-	19	18	3	19	13	12
N.C.	1	4	69	70	170	132	45	85
S.C.	-	-	7	14	76	55	50	58
Ga.	-	-	24	28	110	66	130	173
Fla.	6	2	29	17	186	142	-	58
E.S. CENTRAL	6	4	5	28	203	194	94	146
Ky.	-	1	2	5	38	32	27	22
Tenn.	3	-	3	20	44	45	56	70
Ala.	3	3	-	3	91	70	-	46
Miss.	-	-	-	-	30	47	11	8
W.S. CENTRAL	3	1	70	126	160	364	154	271
Ark.	-	-	-	-	32	31	13	22
La.	1	1	-	-	22	45	55	65
Okla.	1	-	11	8	16	28	15	32
Tex.	1	-	59	118	90	260	71	152
MOUNTAIN	9	9	29	28	252	317	177	274
Mont.	1	-	5	9	8	11	-	-
Idaho	1	-	-	-	7	21	4	18
Wyo.	-	-	10	14	9	6	6	3
Colo.	3	4	-	-	66	78	48	65
N. Mex.	1	-	1	1	30	30	28	33
Ariz.	1	2	13	4	91	89	64	102
Utah	1	2	-	-	28	52	27	53
Nev.	1	1	-	-	13	30	-	-
PACIFIC	28	39	49	28	421	833	301	786
Wash.	1	2	-	-	29	32	37	102
Oreg.	4	5	-	-	38	48	34	60
Calif.	22	31	28	22	349	697	177	578
Alaska	1	-	21	6	5	12	-	10
Hawaii	-	1	-	-	-	44	53	36
Guam	-	-	-	-	-	-	U	U
P.R.	-	2	19	10	23	51	U	U
V.I.	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U

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

* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 3, 2001, and March 5, 2000 (9th Week)

Reporting Area	Shigellosis* NETSS Cum. 2001	Shigellosis* NETSS Cum. 2000	Shigellosis* PHLIS Cum. 2001	Shigellosis* PHLIS Cum. 2000	Syphilis (Primary & Secondary) Cum. 2001	Syphilis (Primary & Secondary) Cum. 2000	Tuberculosis Cum. 2001	Tuberculosis Cum. 2000
UNITED STATES	1,402	2,432	750	1,059	699	1,046	906	1,553
NEW ENGLAND	20	58	22	46	6	12	41	41
Maine	-	2	-	-	-	-	-	1
N.H.	-	1	-	1	-	-	2	1
Vt.	-	1	-	-	-	-	-	-
Mass.	16	43	16	32	4	10	25	25
R.I.	-	4	-	6	-	1	3	2
Conn.	4	7	6	7	2	1	11	12
MID. ATLANTIC	115	173	114	145	33	42	216	220
Upstate N.Y.	72	59	2	34	3	1	23	19
N.Y. City	30	57	55	53	20	21	91	135
N.J.	-	41	14	26	7	10	65	59
Pa.	13	16	43	32	3	10	37	7
E.N. CENTRAL	242	413	145	148	66	208	120	130
Ohio	77	20	28	10	7	12	17	24
Ind.	37	46	7	9	17	78	13	4
Ill.	64	161	68	2	15	82	60	89
Mich.	60	150	40	122	25	23	15	6
Wis.	4	36	2	5	2	13	15	7
W.N. CENTRAL	192	131	146	100	6	21	39	70
Minn.	66	33	94	42	4	3	25	25
Iowa	32	18	2	22	-	6	-	7
Mo.	51	64	41	24	1	10	8	27
N. Dak.	8	-	1	-	-	-	-	-
S. Dak.	3	1	1	-	-	-	1	3
Nebr.	9	10	-	8	-	1	5	1
Kans.	23	5	7	4	1	1	-	7
S. ATLANTIC	219	210	59	96	292	323	187	250
Del.	2	-	-	1	1	1	-	-
Md.	19	19	4	7	34	61	15	24
D.C.	8	-	U	U	7	15	9	-
Va.	13	12	6	12	27	22	13	17
W. Va.	2	1	6	1	-	1	6	7
N.C.	65	13	19	6	81	84	13	32
S.C.	13	3	7	1	46	25	14	18
Ga.	22	14	13	42	23	53	50	55
Fla.	75	148	4	26	73	61	67	97
E.S. CENTRAL	122	113	34	83	101	149	57	104
Ky.	51	23	15	14	8	8	7	12
Tenn.	13	52	16	63	50	103	-	22
Ala.	29	7	-	4	21	22	39	49
Miss.	29	31	3	2	22	16	11	21
W.S. CENTRAL	118	432	100	139	115	167	27	285
Ark.	40	38	10	3	10	11	19	12
La.	11	63	28	24	19	44	-	6
Okla.	1	8	-	5	14	39	8	8
Tex.	66	323	62	107	72	73	-	259
MOUNTAIN	124	187	70	71	32	30	28	77
Mont.	-	-	-	-	-	-	-	-
Idaho	4	22	-	15	-	-	3	-
Wyo.	-	1	-	1	-	-	-	-
Colo.	26	33	17	15	2	1	12	8
N. Mex.	25	20	20	13	3	3	1	14
Ariz.	60	65	28	21	22	24	10	22
Utah	3	5	5	6	4	-	2	5
Nev.	6	41	-	-	1	2	-	28
PACIFIC	250	715	60	231	48	94	191	376
Wash.	34	141	37	180	13	8	25	33
Oreg.	18	78	16	44	2	1	-	1
Calif.	197	485	-	-	31	85	159	323
Alaska	1	2	-	1	-	-	7	7
Hawaii	-	9	7	6	2	-	-	12
Guam	-	-	U	U	-	-	-	-
P.R.	1	8	U	U	41	29	-	17
V.I.	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U

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

*Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending March 3, 2001, and March 5, 2000 (9th Week)

Reporting Area	*H. influenzae*, Invasive		Hepatitis (Viral), By Type				Measles (Rubeola)					
			A		B		Indigenous		Imported*		Total	
	Cum. 2001†	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	2001	Cum. 2001	2001	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	207	232	1,182	2,172	677	921	1	8	-	5	13	12
NEW ENGLAND	8	22	51	56	11	15	-	3	-	1	4	-
Maine	-	-	1	1	1	1	U	-	U	-	-	-
N.H.	-	3	3	7	4	3	-	-	-	-	-	-
Vt.	-	3	2	2	1	2	-	1	-	-	1	-
Mass.	8	16	11	23	1	1	U	2	U	1	3	-
R.I.	-	-	3	-	4	-	-	-	-	-	-	-
Conn.	-	-	31	23	-	8	-	-	-	-	-	-
MID. ATLANTIC	21	36	49	137	52	150	1	1	-	-	1	4
Upstate N.Y.	9	14	23	47	13	11	-	-	-	-	-	-
N.Y. City	7	12	22	70	31	84	-	-	-	-	-	4
N.J.	4	8	-	6	-	8	-	-	-	-	-	-
Pa.	1	2	4	14	8	47	1	1	-	-	1	-
E.N. CENTRAL	23	34	148	323	97	95	-	-	-	2	2	3
Ohio	16	11	45	73	18	21	-	-	-	-	-	2
Ind.	5	3	4	5	2	1	-	-	-	-	-	-
Ill.	-	16	25	134	2	2	-	-	-	2	2	-
Mich.	2	3	74	98	75	70	-	-	-	-	-	1
Wis.	-	1	-	13	-	1	-	-	-	-	-	-
W.N. CENTRAL	4	4	89	193	42	61	-	-	-	-	-	-
Minn.	-	-	3	18	1	-	-	-	-	-	-	-
Iowa	1	-	7	19	5	10	-	-	-	-	-	-
Mo.	3	3	28	124	29	44	-	-	-	-	-	-
N. Dak.	-	1	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	1	-	1	-	-	-	-	-	-	-
Nebr.	-	-	17	5	4	4	-	-	-	-	-	-
Kans.	-	-	33	27	2	3	-	-	-	-	-	-
S. ATLANTIC	79	53	200	180	129	135	-	2	-	1	3	-
Del.	-	-	-	4	-	1	-	-	-	-	-	-
Md.	20	20	49	27	18	28	-	2	-	1	3	-
D.C.	-	-	5	-	2	-	-	-	-	-	-	-
Va.	6	11	25	32	13	25	-	-	-	-	-	-
W. Va.	3	1	-	19	1	-	-	-	-	-	-	-
N.C.	16	3	16	50	41	55	-	-	-	-	-	-
S.C.	1	1	9	3	-	1	-	-	-	-	-	-
Ga.	14	14	30	17	19	2	-	-	-	-	-	-
Fla.	19	3	66	28	35	23	-	-	-	-	-	-
E.S. CENTRAL	12	13	51	94	59	72	-	-	-	-	-	-
Ky.	-	8	7	4	3	8	-	-	-	-	-	-
Tenn.	5	3	28	29	24	34	-	-	-	-	-	-
Ala.	6	2	16	15	21	5	-	-	-	-	-	-
Miss.	1	-	-	46	11	25	-	-	-	-	-	-
W.S. CENTRAL	3	18	166	430	40	94	-	-	-	-	-	-
Ark.	-	-	16	31	16	12	-	-	-	-	-	-
La.	-	6	11	19	11	30	-	-	-	-	-	-
Okla.	3	12	30	67	12	9	-	-	-	-	-	-
Tex.	-	-	109	313	1	43	-	-	-	-	-	-
MOUNTAIN	48	27	166	134	80	72	-	-	-	1	1	-
Mont.	-	-	3	1	1	2	-	-	-	-	-	-
Idaho	1	1	18	6	3	3	-	-	-	1	1	-
Wyo.	-	-	1	1	-	-	-	-	-	-	-	-
Colo.	9	9	24	38	19	21	-	-	-	-	-	-
N. Mex.	8	9	4	19	17	21	-	-	-	-	-	-
Ariz.	28	6	85	49	31	19	-	-	-	-	-	-
Utah	1	1	10	10	1	3	-	-	-	-	-	-
Nev.	1	1	21	10	8	3	-	-	-	-	-	-
PACIFIC	9	25	262	625	167	227	-	2	-	-	2	5
Wash.	-	2	9	29	12	6	-	-	-	-	-	2
Oreg.	8	7	21	45	28	18	-	2	-	-	2	-
Calif.	-	5	224	544	126	198	-	-	-	-	-	3
Alaska	1	1	8	3	1	2	-	-	-	-	-	-
Hawaii	-	10	-	4	-	3	-	-	-	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	1	67	8	36	-	-	-	-	-	-
V.I.	U	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. - : No reported cases.
*For imported measles, cases include only those resulting from importation from other countries.
† Of 37 cases among children aged <5 years, serotype was reported for 13 and of those, 2 was type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending March 3, 2001, and March 5, 2000 (9th Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000
UNITED STATES	466	495	2	20	85	131	802	868	1	3	9
NEW ENGLAND	37	29	-	-	-	3	152	238	-	-	4
Maine	-	2	U	-	-	U	-	7	U	-	-
N.H.	4	3	-	-	-	3	14	34	-	-	1
Vt.	3	1	-	-	-	-	17	42	-	-	-
Mass.	20	16	U	-	-	U	117	149	U	-	3
R.I.	-	1	-	-	-	-	-	4	-	-	-
Conn.	10	6	-	-	-	-	4	2	-	-	-
MID. ATLANTIC	38	38	-	-	5	17	44	73	1	1	2
Upstate N.Y.	15	8	-	-	1	11	36	33	1	1	-
N.Y. City	8	12	-	-	2	-	-	19	-	-	2
N.J.	14	8	-	-	-	-	-	-	-	-	-
Pa.	1	10	-	-	2	6	8	21	-	-	-
E.N. CENTRAL	31	86	-	3	11	11	99	157	-	2	-
Ohio	20	12	-	1	4	8	78	108	-	-	-
Ind.	1	13	-	-	-	2	3	5	-	-	-
Ill.	-	29	-	1	1	-	5	8	-	1	-
Mich.	10	22	-	1	6	1	12	6	-	1	-
Wis.	-	10	-	-	-	-	1	30	-	-	-
W.N. CENTRAL	31	32	-	3	5	-	29	20	-	-	-
Minn.	-	1	-	-	-	-	-	6	-	-	-
Iowa	12	8	-	-	3	-	3	6	-	-	-
Mo.	10	18	-	-	1	-	15	2	-	-	-
N. Dak.	-	1	-	-	-	-	-	1	-	-	-
S. Dak.	1	2	-	-	-	-	2	1	-	-	-
Nebr.	3	1	-	-	1	-	-	-	-	-	-
Kans.	5	1	-	3	-	-	9	4	-	-	-
S. ATLANTIC	95	73	1	2	10	4	29	46	-	-	1
Del.	-	-	-	-	-	-	-	1	-	-	-
Md.	15	5	-	1	3	-	11	14	-	-	-
D.C.	-	-	-	-	-	-	-	-	-	-	-
Va.	12	12	1	1	1	1	1	3	-	-	-
W. Va.	2	1	-	-	-	1	1	-	-	-	-
N.C.	22	13	-	-	2	-	10	15	-	-	-
S.C.	5	6	-	-	3	-	4	9	-	-	-
Ga.	12	16	-	-	-	-	-	2	-	-	-
Fla.	27	20	-	-	1	2	2	2	-	-	1
E.S. CENTRAL	37	23	-	-	1	-	24	26	-	-	-
Ky.	6	6	-	-	-	-	5	19	-	-	-
Tenn.	13	9	-	-	-	-	16	2	-	-	-
Ala.	14	7	-	-	1	-	2	4	-	-	-
Miss.	4	1	-	-	-	-	1	1	-	-	-
W.S. CENTRAL	68	65	-	-	10	-	3	9	-	-	2
Ark.	7	2	-	-	-	-	2	3	-	-	-
La.	19	19	-	-	2	-	-	2	-	-	-
Okla.	10	7	-	-	-	-	1	-	-	-	-
Tex.	32	37	-	-	8	-	-	4	-	-	2
MOUNTAIN	27	25	1	4	3	96	411	166	-	-	-
Mont.	-	-	-	-	-	2	2	1	-	-	-
Idaho	3	2	-	-	-	29	78	24	-	-	-
Wyo.	-	-	-	1	-	-	-	-	-	-	-
Colo.	11	9	1	1	-	5	96	104	-	-	-
N. Mex.	5	4	-	2	N	1	11	22	-	-	-
Ariz.	4	6	-	-	-	58	219	9	-	-	-
Utah	2	3	-	-	-	1	5	4	-	-	-
Nev.	2	1	-	-	2	-	-	2	-	-	-
PACIFIC	102	124	-	8	40	-	11	133	-	-	-
Wash.	18	6	-	-	1	-	8	19	-	-	-
Oreg.	14	14	N	N	N	-	3	16	-	-	-
Calif.	69	100	-	8	36	-	-	90	-	-	-
Alaska	1	1	-	-	-	-	-	2	-	-	-
Hawaii	-	3	-	-	3	-	-	6	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-	-
P.R.	1	2	-	-	-	-	-	-	-	-	-
V.I.	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U	U	U	U

TABLE IV. Deaths in 122 U.S. cities,* week ending March 3, 2001 (9th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	545	389	102	38	8	8	75
Boston, Mass.	166	113	34	11	1	7	25
Bridgeport, Conn.	48	30	10	6	2	-	4
Cambridge, Mass.	37	28	7	1	1	-	2
Fall River, Mass.	42	33	7	1	1	-	3
Hartford, Conn.	U	U	U	U	U	U	U
Lowell, Mass.	26	18	6	2	-	-	6
Lynn, Mass.	12	10	2	-	-	-	2
New Bedford, Mass.	41	32	6	3	-	-	4
New Haven, Conn.	32	20	5	6	-	1	5
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	8	6	2	-	-	-	-
Springfield, Mass.	31	23	6	2	-	-	8
Waterbury, Conn.	32	21	5	5	1	-	4
Worcester, Mass.	70	55	12	1	2	-	12
MID. ATLANTIC	2,259	1,648	420	129	39	23	107
Albany, N.Y.	54	43	10	1	-	-	4
Allentown, Pa.	21	20	1	-	-	-	2
Buffalo, N.Y.	116	83	19	8	-	6	6
Camden, N.J.	28	16	8	1	2	1	-
Elizabeth, N.J.	26	16	8	2	-	-	-
Erie, Pa.§	56	48	5	2	1	-	2
Jersey City, N.J.	47	31	12	4	-	-	-
New York City, N.Y.	1,230	879	236	76	26	13	35
Newark, N.J.	U	U	U	U	U	U	U
Paterson, N.J.	U	U	U	U	U	U	U
Philadelphia, Pa.	352	250	76	18	7	1	26
Pittsburgh, Pa.§	U	U	U	U	U	U	U
Reading, Pa.	U	U	U	U	U	U	U
Rochester, N.Y.	115	90	18	5	1	1	10
Schenectady, N.Y.	U	U	U	U	U	U	U
Scranton, Pa.§	46	42	4	-	-	-	3
Syracuse, N.Y.	119	94	15	7	2	1	12
Trenton, N.J.	28	19	5	4	-	-	2
Utica, N.Y.	U	U	U	U	U	U	U
Yonkers, N.Y.	21	17	3	1	-	-	5
E.N. CENTRAL	2,196	1,472	464	152	59	46	145
Akron, Ohio	62	41	13	4	2	2	6
Canton, Ohio	40	31	8	-	1	-	8
Chicago, Ill.	428	253	112	38	16	7	26
Cincinnati, Ohio	106	77	19	7	2	1	4
Cleveland, Ohio	142	101	33	6	2	-	7
Columbus, Ohio	230	160	46	12	4	8	14
Dayton, Ohio	128	89	23	13	2	1	10
Detroit, Mich.	200	105	56	20	6	13	9
Evansville, Ind.	74	54	12	7	1	-	4
Fort Wayne, Ind.	78	43	24	4	4	3	4
Gary, Ind.	23	11	7	1	-	3	1
Grand Rapids, Mich.	45	34	6	2	3	-	4
Indianapolis, Ind.	232	152	45	18	13	4	14
Lansing, Mich.	42	28	8	6	-	-	1
Milwaukee, Wis.	111	88	14	6	1	2	16
Peoria, Ill.	52	41	9	1	-	1	3
Rockford, Ill.	62	51	7	3	-	1	6
South Bend, Ind.	63	50	9	2	2	-	3
Toledo, Ohio	U	U	U	U	U	U	U
Youngstown, Ohio	78	63	13	2	-	-	5
W.N. CENTRAL	737	540	118	43	16	20	62
Des Moines, Iowa	90	69	13	1	2	5	14
Duluth, Minn.	24	20	2	2	-	-	1
Kansas City, Kans.	35	19	13	-	3	-	5
Kansas City, Mo.	U	U	U	U	U	U	U
Lincoln, Nebr.	43	34	5	3	-	1	5
Minneapolis, Minn.	206	156	29	13	4	4	15
Omaha, Nebr.	U	U	U	U	U	U	U
St. Louis, Mo.	116	73	25	8	4	6	-
St. Paul, Minn.	100	81	10	5	1	3	12
Wichita, Kans.	123	88	21	11	2	1	10
S. ATLANTIC	1,073	679	243	97	33	21	64
Atlanta, Ga.	201	116	48	25	9	3	-
Baltimore, Md.	226	141	52	25	4	4	18
Charlotte, N.C.	105	69	21	10	-	5	12
Jacksonville, Fla.	179	117	33	21	6	2	6
Miami, Fla.	U	U	U	U	U	U	U
Norfolk, Va.	U	U	U	U	U	U	U
Richmond, Va.	75	46	20	5	2	2	4
Savannah, Ga.	13	7	4	1	1	-	2
St. Petersburg, Fla.	61	40	11	1	6	3	4
Tampa, Fla.	188	131	41	9	5	2	18
Washington, D.C.	U	U	U	U	U	U	U
Wilmington, Del.	25	12	13	-	-	-	-
E.S. CENTRAL	887	589	193	67	15	23	76
Birmingham, Ala.	210	150	43	10	3	4	10
Chattanooga, Tenn.	82	61	17	4	-	-	8
Knoxville, Tenn.	109	75	21	8	2	3	5
Lexington, Ky.	87	47	22	9	2	7	9
Memphis, Tenn.	180	113	46	14	3	4	21
Mobile, Ala.	34	20	8	4	2	-	2
Montgomery, Ala.	32	24	6	1	1	-	6
Nashville, Tenn.	153	99	30	17	2	5	15
W.S. CENTRAL	1,618	1,075	349	102	61	31	114
Austin, Tex.	95	67	18	6	3	1	8
Baton Rouge, La.	77	55	17	4	1	-	1
Corpus Christi, Tex.	64	48	10	2	3	1	6
Dallas, Tex.	204	119	57	12	8	8	19
El Paso, Tex.	69	54	8	5	1	1	7
Ft. Worth, Tex.	126	87	30	8	1	-	7
Houston, Tex.	407	236	94	39	31	7	25
Little Rock, Ark.	71	46	16	3	3	3	4
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	252	177	53	9	7	6	18
Shreveport, La.	124	92	23	4	1	4	9
Tulsa, Okla.	129	94	23	10	2	-	10
MOUNTAIN	1,145	766	236	82	27	33	93
Albuquerque, N.M.	127	88	23	10	5	-	16
Boise, Idaho	51	32	13	3	1	2	4
Colo. Springs, Colo.	63	41	16	2	3	1	5
Denver, Colo.	122	76	26	12	1	7	10
Las Vegas, Nev.	250	163	56	23	4	4	14
Ogden, Utah	28	20	6	-	1	1	-
Phoenix, Ariz.	206	119	52	17	9	9	13
Pueblo, Colo.	20	17	2	-	-	1	-
Salt Lake City, Utah	100	72	19	3	2	4	16
Tucson, Ariz.	178	138	23	12	1	4	15
PACIFIC	1,156	855	206	48	18	23	115
Berkeley, Calif.	28	19	5	1	1	2	5
Fresno, Calif.	145	112	26	5	2	-	11
Glendale, Calif.	U	U	U	U	U	U	U
Honolulu, Hawaii	71	56	13	1	-	1	2
Long Beach, Calif.	70	52	11	5	2	-	12
Los Angeles, Calif.	U	U	U	U	U	U	U
Pasadena, Calif.	34	25	6	3	-	-	5
Portland, Oreg.	121	88	26	4	-	3	13
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	210	146	40	11	6	6	19
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	209	154	34	9	3	7	22
Santa Cruz, Calif.	37	36	-	1	-	-	7
Seattle, Wash.	57	37	12	3	1	4	4
Spokane, Wash.	57	44	11	2	-	-	6
Tacoma, Wash.	117	86	22	3	3	-	9
TOTAL	11,616¶	8,013	2,331	758	276	228	851

U: Unavailable. -:No reported cases.
*Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.
†Pneumonia and influenza.
§Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.
¶Total includes unknown ages.

Halofantrine Administration — Continued

References

1. Drici MD, Knollmann BC, Wang W-X, Woosley RL. Cardiac actions of erythromycin: influence of female sex. JAMA 1998;280:1774–6.
2. ter Kuile FO, Dolan G, Nosten F, et al. Halofantrine versus mefloquine in treatment of multidrug-resistant falciparum malaria. Lancet 1993;341:1044–9.
3. Touze JE, Fourcade L, Peyron F, Heno P, Deharo JC. Is halofantrine still advisable in malaria attacks? Ann Trop Med Parasitol 1997;91:867–73.
4. Monlun E, LeMetayer P, Szwandt S, et al. Cardiac complications of halofantrine: a prospective study of 20 patients. Trans Roy Soc Trop Med Hyg 1995;89:430–3.
5. Touze JE, Bernard J, Keundjian A, et al. Electrocardiographic changes and halofantrine plasma level during acute falciparum malaria. Am J Trop Med Hyg 1996;54:225–8.
6. Nosten F, ter Kuile FO, Luxemburger C, et al. Cardiac effects of antimalarial treatment with halofantrine. Lancet 1993;341:1054–5.
7. Akhtar T, Imran M. Sudden deaths while on halofantrine treatment—a report of two cases from Peshawar. J Pak Med Assoc 1994;44:120–1.
8. Yetman AT, Hamilton RM, Benson LN, McCrindle BW. Long-term outcome and prognostic determinants in children with hypertrophic cardiomyopathy. J Am Coll Cardiol 1998;32:1943–50.
9. Prescribing information: Halfan® brand of halofantrine hydrochloride tablets [package insert]. Philadelphia, Pennsylvania: SmithKline Beecham Pharmaceuticals, 1997.
10. CDC. Information for health care providers: Malarone for malaria treatment and prophylaxis. Available at http://www.cdc.gov/travel/diseases/malaria/malarone.htm. Accessed January 2001.

Notice to Readers

Availability of Diabetes Postage Stamp

The U.S. Postal Service will issue a diabetes stamp on March 16, 2001, in Boston, Massachusetts, at the Joslin Diabetes Center. The stamp will go on sale nationwide the same day. The Diabetes Awareness Commemorative Stamp ceremony will feature celebrities and officials from CDC, the U.S. Postal Service, the American Diabetes Association, the Juvenile Diabetes Research Foundation International, and the National Institutes of Health.

This event will offer presentations on diabetes, opportunities for eye examinations for persons with diabetes, and information booths on diabetes care and prevention. The diabetes stamp encourages everyone to "Know More About Diabetes" and will help promote awareness about the need for early detection, quality preventive care, and continued research and education to help find a cure for this disease.

Additional information about the diabetes stamp is available from CDC's Diabetes Public Health Resource World-Wide Web site, http://www.cdc.gov/diabetes, or from the U.S. Postal Service, telephone (800) 782-6724 ([800] STAMP-24). Additional information about diabetes is available from CDC's Division of Diabetes Translation, toll-free telephone, (877) 232-3422 ([877] CDC-DIAB).

The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format and on a paid subscription basis for paper copy. To receive an electronic copy on Friday of each week, send an e-mail message to *listserv@listserv.cdc.gov*. The body content should read *SUBscribe mmwr-toc*. Electronic copy also is available from CDC's World-Wide Web server at *http://www.cdc.gov/mmwr* or from CDC's file transfer protocol server at *ftp://ftp.cdc.gov/pub/Publications/mmwr*. To subscribe for paper copy, contact Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone (202) 512-1800.

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Address inquiries about the *MMWR* Series, including material to be considered for publication, to: Editor, *MMWR* Series, Mailstop C-08, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone (888) 232-3228.

☆U.S. Government Printing Office: 2001-633-173/48212 Region IV