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Tobacco Use, Access, and Exposure to Tobacco in Media Among Middle and High School Students — United States, 2004

Two of the national health objectives for 2010 are to reduce the prevalence of any tobacco use during the preceding month to ≤21% and the prevalence of current cigarette use to ≤16% among high school students (objectives 27-2a and 27-2b) (*1*). The National Youth Tobacco Survey (NYTS), conducted by CDC in 2004, provided estimates of current use of tobacco products and selected indicators related to tobacco use, including youth exposure to tobacco-related media and access to cigarettes. This report summarizes data from the 2004 NYTS and describes changes in tobacco use and indicators related to tobacco use since 2002 (*2*). During 2002–2004, middle school students reported decreases in pipe use, seeing actors using tobacco on television or in movies, and seeing advertisements for tobacco products on the Internet. Among high school students, no changes were observed in the use of tobacco or in access to tobacco products; however, seeing actors using tobacco on television or in movies declined slightly, and seeing advertisements for tobacco products on the Internet increased. The lack of substantial decreases in the use of almost all tobacco products among middle and high school students underscores the need to fully implement evidence-based strategies (e.g., increasing the retail price of tobacco products, implementing smoking-prevention media campaigns, and decreasing minors' access as part of comprehensive tobacco-control programs) that are effective in preventing youth tobacco use (*3*).

Similar to the 2002 NYTS (*2*), the sampling frame for the 2004 NYTS consisted of all U.S. public and private schools and was stratified by U.S. Census Bureau data by region and urbanicity; non-Hispanic black, Hispanic, and Asian students were oversampled. A total of 91 primary sampling units (PSUs) (i.e., large counties or groups of counties) were selected in the first stage of sampling, and 288 schools were selected from these PSUs in the second stage of sampling. Of these 288 eligible schools, 267 (93%) participated in the survey. In each school, typically five classes (approximately 125 students) were selected randomly from a required subject area (e.g., English) or a particular class period (e.g., all 2nd period classes). Participation was voluntary and anonymous, and school parental permission procedures were followed; students recorded their responses in a computer-scannable booklet.

Of 31,774 students who were sampled from the participating schools, 27,933 (88%) completed the survey (14,034 middle school students [grades 6–8], 13,738 high school students [grades 9–12], and 161 students unclassified with respect to grade). Data were weighted to be nationally representative. Statistical software was used to compute 95% confidence intervals for prevalence estimates. Differences in tobacco use estimates during 2002–2004 were assessed by using t-tests at two-tailed significance level. All statistically significant results were $p<0.05$. Current use of specific tobacco products (i.e., cigarettes, cigars, smokeless tobacco, pipes, bidis [leaf-wrapped, flavored cigarettes from India], or kreteks [clove cigarettes]) was defined as having used that product on at least 1 day during the 30 days preceding the survey. Current use of

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any tobacco product was defined as having used any of the listed products on at least 1 day during the 30 days preceding the survey. Students were asked how often they saw actors using tobacco on television or in movies or saw advertisements for tobacco products on the Internet, whether they were asked for proof of age when they bought or tried to buy cigarettes in a store during the preceding 30 days, and whether anyone ever refused to sell them cigarettes because of their age during the preceding 30 days.

In 2004, a total of 11.7% of middle school students reported current use of any tobacco product (Table 1). Cigarettes (8.1%) were the most commonly used product, followed by cigars (5.2%), smokeless tobacco (2.9%), pipes (2.6%), bidis (2.3%), and kreteks (1.5%). During 2002–2004, no significant changes were observed among middle school students in use of any tobacco or cigarettes (in 2002, a total of 13.3% of middle school students reported current use of any tobacco product, and 9.8% reported current use of cigarettes), cigars, smokeless tobacco, bidis, or kreteks. Pipe use declined significantly, from 3.5% to 2.6%. Among males, cigarette smoking and use of pipes and kreteks declined, from 9.8% to 7.7%, 5.1% to 3.3%, and 2.7% to 1.9%, respectively. Among Asians, use of any tobacco, cigarettes, cigars, pipes, bidis, and kreteks decreased. Among non-Hispanic blacks, use of pipes decreased. Among Hispanics, use of cigars and bidis increased significantly.

In 2004, a total of 28.0% of high school students reported current use of any tobacco product (Table 2). Cigarettes (22.3%) were the most commonly used product, followed by cigars (12.8%), smokeless tobacco (6.0%), pipes (3.1%), bidis (2.6%), and kreteks (2.3%). During 2002–2004, no significant decreases were observed in use of any tobacco or use of a specific tobacco product (in 2002, a total of 28.2% of high school students reported current use of any tobacco product, and 22.5% reported current use of cigarettes). Among non-Hispanic blacks, use of any tobacco product and pipes decreased, from 21.7% to 17.1% and 3.7% to 1.8%, respectively. Among Hispanics, cigar use increased, from 10.8% to 13.3%.

In 2004, a total of 77.9% of middle school students reported seeing actors using tobacco on television or in movies, and 34.1% reported seeing advertisements for tobacco products on the Internet (Table 3), compared with 89.9% and 42.7% in 2002, respectively. In addition, in 2004, a total of 70.6% of current cigarette smokers in middle school said they were not asked to show proof of age when they purchased or attempted to purchase cigarettes from a store, and 66.4% said they were not refused purchase of cigarettes because of their age. No significant differences were observed from 2002.

TABLE 1. Percentage of students in middle school (grades 6–8) who were current users* of any tobacco product, by product type, sex, and race/ethnicity — National Youth Tobacco Survey, United States, 2002 and 2004

Characteristic	Any tobacco† %	Any tobacco† (95% CI§)	Cigarettes %	Cigarettes (95% CI)	Cigars %	Cigars (95% CI)	Smokeless tobacco %	Smokeless tobacco (95% CI)	Pipes %	Pipes (95% CI)	Bidis %	Bidis (95% CI)	Kreteks %	Kreteks (95% CI)
Middle school, 2004														
Sex														
Male	12.7	(±1.7)	7.7¶	(±1.3)	6.6	(±1.1)	3.9	(±1.0)	3.3¶	(±0.8)	2.8	(±0.7)	1.9¶	(±0.4)
Female	10.7	(±1.8)	8.6	(±1.9)	3.8	(±0.5)	1.9	(±0.5)	1.8	(±0.5)	1.7	(±0.4)	1.2	(±0.4)
Race/Ethnicity														
White, non-Hispanic	11.2	(±1.9)	8.3	(±1.8)	4.4	(±0.8)	3.1	(±0.9)	2.2	(±0.6)	1.8	(±0.5)	1.2	(±0.4)
Black, non-Hispanic	12.3	(±2.5)	7.5	(±1.9)	6.9	(±1.8)	1.8	(±0.8)	2.0¶	(±0.8)	2.7	(±0.9)	1.6	(±0.6)
Hispanic	14.8	(±1.9)	9.4	(±1.5)	8.0¶	(±1.2)	3.7	(±0.9)	5.3	(±1.2)	4.3¶	(±0.8)	3.0	(±0.7)
Asian	3.4¶	(±1.8)	2.2¶	(±1.5)	0.7¶	(±0.6)	1.0	(±0.7)	0.7¶	(±0.7)	0.5¶	(±0.6)	0.7¶	(±0.7)
Total	**11.7**	**(±1.6)**	**8.1**	**(±1.5)**	**5.2**	**(±0.7)**	**2.9**	**(±0.6)**	**2.6¶**	**(±0.6)**	**2.3**	**(±0.5)**	**1.5**	**(±0.3)**
Middle school, 2002														
Sex														
Male	14.7	(±1.6)	9.8	(±1.3)	7.9	(±1.1)	5.3	(±1.3)	5.1	(±0.8)	3.1	(±0.6)	2.7	(±0.6)
Female	11.7	(±1.4)	9.7	(±1.4)	4.1	(±0.7)	1.6	(±0.5)	1.9	(±0.4)	1.7	(±0.4)	1.1	(±0.3)
Race/Ethnicity														
White, non-Hispanic	13.2	(±1.9)	10.1	(±1.6)	5.5	(±1.0)	3.8	(±1.1)	2.8	(±0.6)	1.8	(±0.4)	1.5	(±0.4)
Black, non-Hispanic	13.5	(±2.4)	9.0	(±2.3)	7.3	(±1.7)	2.3	(±0.9)	3.9	(±1.4)	3.1	(±1.0)	2.3	(±0.9)
Hispanic	12.5	(±1.9)	8.7	(±1.5)	6.3	(±1.1)	2.7	(±0.7)	4.3	(±0.9)	2.9	(±0.7)	2.6	(±0.7)
Asian	8.6	(±3.3)	7.4	(±3.3)	5.0	(±2.8)	3.5	(±2.7)	4.6	(±2.7)	3.1	(±2.2)	3.8	(±2.9)
Total	**13.3**	**(±1.4)**	**9.8**	**(±1.2)**	**6.0**	**(±0.7)**	**3.5**	**(±0.7)**	**3.5**	**(±0.5)**	**2.4**	**(±0.3)**	**2.0**	**(±0.4)**

* Used tobacco on at least 1 day during the 30 days preceding the survey.
† Cigarettes, cigars, smokeless tobacco, pipes, bidis (leaf-wrapped, flavored cigarettes from India), or kreteks (clove cigarettes).
§ Confidence interval.
¶ Significant difference ($p<0.05$), 2004 versus 2002.

TABLE 2. Percentage of students in high school (grades 9–12) who were current users* of any tobacco product, by product type, sex, and race/ethnicity — National Youth Tobacco Survey, United States, 2002 and 2004

Characteristic	Any tobacco† %	Any tobacco† (95% CI§)	Cigarettes %	Cigarettes (95% CI)	Cigars %	Cigars (95% CI)	Smokeless tobacco %	Smokeless tobacco (95% CI)	Pipes %	Pipes (95% CI)	Bidis %	Bidis (95% CI)	Kreteks %	Kreteks (95% CI)
High school, 2004														
Sex														
Male	31.5	(±3.0)	22.1	(±2.7)	18.4	(±1.8)	10.8	(±2.2)	4.6	(±0.9)	3.6	(±0.7)	3.2	(±0.8)
Female	24.7	(±3.1)	22.4	(±3.1)	7.5	(±1.4)	1.4	(±0.6)	1.6	(±0.6)	1.6	(±0.5)	1.5	(±0.5)
Race/Ethnicity														
White, non-Hispanic	31.5	(±4.1)	25.4	(±3.8)	13.6	(±2.1)	7.5	(±1.6)	2.9	(±0.8)	2.2	(±0.5)	2.3	(±0.7)
Black, non-Hispanic	17.1¶	(±3.3)	11.4	(±3.1)	10.5	(±2.1)	1.7	(±1.2)	1.8¶	(±0.8)	2.1	(±0.8)	1.3	(±0.5)
Hispanic	26.2	(±2.9)	21.6	(±3.1)	13.3¶	(±1.7)	3.5	(±1.1)	5.0	(±1.0)	4.6	(±0.9)	3.3	(±0.7)
Asian	13.1	(±3.3)	11.2	(±2.6)	5.7	(±2.4)	2.1	(±1.7)	2.0	(±1.1)	2.1	(±1.2)	1.4	(±1.0)
Total	**28.0**	**(±2.9)**	**22.3**	**(±2.7)**	**12.8**	**(±1.5)**	**6.0**	**(±1.2)**	**3.1**	**(±0.6)**	**2.6**	**(±0.5)**	**2.3**	**(±0.5)**
High school, 2002														
Sex														
Male	32.6	(±2.3)	23.9	(±2.1)	16.9	(±1.4)	10.5	(±2.0)	5.0	(±0.9)	3.7	(±0.8)	3.5	(±0.7)
Female	23.7	(±1.8)	21.0	(±1.9)	6.2	(±0.9)	1.2	(±0.3)	1.4	(±0.4)	1.5	(±0.4)	1.8	(±0.5)
Race/Ethnicity														
White, non-Hispanic	30.9	(±2.0)	25.2	(±1.8)	11.8	(±1.0)	7.3	(±1.4)	2.8	(±0.6)	2.2	(±0.5)	2.7	(±0.6)
Black, non-Hispanic	21.7	(±2.9)	13.8	(±2.8)	12.0	(±1.9)	1.8	(±0.8)	3.7	(±1.2)	3.4	(±1.1)	1.9	(±0.8)
Hispanic	24.1	(±2.7)	19.8	(±2.5)	10.8	(±1.5)	3.3	(±1.1)	4.6	(±1.1)	3.5	(±0.9)	3.0	(±0.8)
Asian	14.6	(±3.8)	12.2	(±3.4)	5.4	(±2.3)	2.1	(±1.5)	2.7	(±1.5)	2.9	(±1.6)	2.1	(±1.7)
Total	**28.2**	**(±1.7)**	**22.5**	**(±1.6)**	**11.6**	**(±0.9)**	**5.9**	**(±1.1)**	**3.2**	**(±0.6)**	**2.6**	**(±0.5)**	**2.7**	**(±0.4)**

* Used tobacco on at least 1 day during the 30 days preceding the survey.
† Cigarettes, cigars, smokeless tobacco, pipes, bidis (leaf-wrapped, flavored cigarettes from India), or kreteks (clove cigarettes).
§ Confidence interval.
¶ Significant difference ($p<0.05$), 2004 versus 2002.

TABLE 3. Percentage of students in middle school (grades 6–8) and high school (grades 9–12) who reported being exposed to tobacco-related media and advertising, and current smokers aged <18 years who tried to buy cigarettes in a store, by sex and race/ethnicity — National Youth Tobacco Survey, United States, 2004

	All students				Current cigarette smokers* aged <18 years			
	Saw actors on television or in movies using tobacco		Saw advertisements for tobacco products on the Internet		Were not asked to show proof of age when purchasing cigarettes		Were not refused purchase because of age	
Characteristic	%	(95% CI†)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Middle school								
Sex								
Male	78.6§	(±1.9)	33.8§	(±2.1)	67.9	(±7.8)	62.8	(±9.7)
Female	77.2§	(±2.1)	34.3§	(±2.7)	73.3	(±9.4)	70.1	(±7.2)
Race/Ethnicity								
White, non-Hispanic	78.5§	(±2.3)	34.4§	(±1.9)	79.9	(±8.7)	69.8	(±8.9)
Black, non-Hispanic	77.1§	(±2.4)	31.2§	(±2.5)	65.7	(±14.9)	63.6	(±12.5)
Hispanic	78.1§	(±2.1)	35.7§	(±2.5)	60.5	(±14.1)	63.4	(±11.0)
Asian	72.7§	(±4.6)	29.1§	(±6.6)	—¶	—¶	—¶	—¶
Total	**77.9§**	**(±1.9)**	**34.1§**	**(±2.0)**	**70.6**	**(±6.8)**	**66.4**	**(±6.8)**
High school								
Sex								
Male	85.9§	(±1.4)	38.8§	(±1.9)	57.8	(±5.4)	52.6	(±4.8)
Female	87.1§	(±1.7)	39.6§	(±2.2)	71.6§	(±7.1)	73.2§	(±5.6)
Race/Ethnicity								
White, non-Hispanic	86.9§	(±1.6)	38.5§	(±1.9)	63.1	(±7.3)	62.1	(±4.5)
Black, non-Hispanic	84.6§	(±2.1)	38.4	(±2.8)	77.2	(±10.6)	74.8§	(±10.6)
Hispanic	86.5§	(±1.5)	44.1§	(±2.8)	60.6	(±6.9)	55.1	(±6.5)
Asian	86.4§	(±3.6)	41.0	(±4.9)	—¶	—¶	—¶	—¶
Total	**86.5§**	**(±1.2)**	**39.2§**	**(±1.5)**	**63.9**	**(±5.7)**	**62.1**	**(±3.8)**

* Smoked cigarettes on at least 1 day during the 30 days preceding the survey and bought or tried to buy cigarettes in a store.
† Confidence interval.
§ Significant difference (p<0.05), 2004 versus 2002.
¶ Unstable estimate because of small sample size.

During 2002–2004, a significant overall decline, from 91.3% to 86.5%, was observed among high school students who reported seeing actors using tobacco on television or in movies. However, a significant increase was observed, from 33.5% to 39.2%, in seeing tobacco products on the Internet. Among current smokers aged <18 years in high school, 63.9% said they were not asked to show proof of age when they purchased or attempted to purchase cigarettes from a store, and 62.1% said they were not refused purchase of cigarettes because of their age. No significant differences were documented from 2002.

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Editorial Note: Preventing smoking initiation and use among adolescents is critical to ending the epidemic of tobacco use in the United States. In assessing state and national tobacco-control efforts, multiple indicators are needed to evaluate progress in reducing tobacco use among adolescents, in particular, measures of exposure to influences that promote or discourage tobacco use. NYTS serves as a national evaluation tool and as a benchmark for the 29 states that implemented a comparable state Youth Tobacco Survey in 2003 and 2004. Data from two of the multiple indicators in NYTS indicated no change occurred in minors' access to cigarettes, whereas declines in seeing actors using tobacco on television or in movies occurred among both middle and high school students. Although the levels of exposure to seeing actors using tobacco decreased from 91.3% in 2002 to 86.5% in 2004 among high school students and from 89.9% in 2002 to 77.9% in 2004 among middle school students, approximately three fourths of middle and high school students are still exposed to these images. Parental monitoring of and limitations on minors' access to media sources might reduce exposures (*4*); however, reductions in exposure large enough to effectively prevent smoking initiation might require different industry practices on smoking images in movies (*5*).

Because the overall prevalence of any tobacco use or cigarette smoking did not change during 2002–2004 (*2*), data from future surveys will be important in determining whether progress toward meeting the national health objectives for 2010 is slowing. Several factors might be related to this lack of change in prevalence. From winter 1997 to spring 2002, the retail price of cigarettes increased approximately 80%, but from

spring 2002 to spring 2004, the price increased only 4% (*6*). Although smoking-prevention media campaigns are effective in preventing youth smoking initiation (*7*), funding for these campaigns has declined substantially (*8*). In addition, during the preceding 3 fiscal years (FYs), a 28% decline in the total investment in statewide comprehensive tobacco-prevention and -control programs occurred, from $749.7 million in FY 2002 to $542.6 in FY 2004 (*8*). Finally, whereas factors preventing tobacco use (e.g., increasing the retail price of tobacco products, implementing smoking-prevention media campaigns, and funding for comprehensive state tobacco-prevention and -control programs) declined from 2002 to 2004, tobacco industry expenditures on tobacco advertising and promotion increased from $5.7 billion in 1997 to $12.5 billion in 2002 (*9*).

The findings in this report are subject to at least three limitations. First, these data apply only to youths who attended middle school or high school. Among persons aged 16–17 years in the United States, approximately 5% were not enrolled in a high school program and had not completed high school in 2000 (*2*). Second, the questionnaire was offered only in English. Thus, comprehension might have been limited for students with English as a second language. Third, significance testing did not control for possible changes in demographics from 2002 to 2004.

The decline in youth smoking prevalence since the late 1990s has been a public health success, reversing the pattern of increase in the early 1990s (*2*). However, the lack of substantial change among middle and high school students during the preceding 2 years emphasizes the need for sustained, comprehensive, evidence-based programs that demonstrate the ability to reduce adolescent smoking prevalence (*10*).

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Inadvertent Laboratory Exposure to *Bacillus anthracis* — California, 2004

On June 9, 2004, the California Department of Health Services (CDHS) was notified of possible inadvertent exposure to *Bacillus anthracis* spores at Children's Hospital Oakland Research Institute (CHORI), where workers were evaluating the immune response of mice to *B. anthracis*. This report summarizes the subsequent investigation by CDHS and CDC, including assessment of exposures, administration of postexposure chemoprophylaxis, and serologic testing of potentially exposed workers. The findings underscore the importance of using appropriate biosafety practices and performing adequate sterility testing when working with material believed to contain inactivated *B. anthracis* organisms.

On May 28, 2004, CHORI staff members injected 10 mice with a suspension believed to contain nonviable vegetative cells of *B. anthracis* Ames strain. The suspension was centrifuged and drawn into syringes on an open bench in the laboratory. The mice were injected in a separate animal-handling facility at CHORI. By May 30, all of the injected animals had unexpectedly died. The carcasses were removed from the cages, placed into a plastic biohazard bag, and frozen. The bedding was discarded as standard animal waste. The cages were sanitized in an automated washer.

On June 4, an additional 40 mice were injected with the same suspension. By June 7, all but one of these mice had died. All subsequent work was performed under a biological safety cabinet (BSC), and additional personal protective equipment (PPE) was used (e.g., protective clothing and gloves). Animal cages were brought into the BSC, and the surviving

animal was euthanized. The carcasses were removed, placed into double biohazard bags, and frozen. The bedding and cages were autoclaved.

On June 8, a sample of the original suspension was cultured; one mouse that died after the second experiment was necropsied and samples for cultures were obtained from its liver and peritoneal cavity. Within 24 hours, these cultures grew nonhemolytic gram-positive rods. Colony morphology was consistent with *B. anthracis*.

Suspension material and cultures were transported to a California Laboratory Response Network (LRN) reference laboratory for further identification. The California LRN confirmed that the organisms isolated were *B. anthracis* by using polymerase chain reaction and gamma phage lysis assay. At CDC, antimicrobial susceptibility testing revealed that the isolates were susceptible to penicillin, ciprofloxacin, and doxycycline. Multiple-locus variable-number tandem repeat analysis confirmed that the isolates were genotype 62, consistent with *B. anthracis* Ames strain (*1*).

On June 9, CDHS personnel visited the laboratory and animal-handling facility at CHORI to review the incident and laboratory procedures. No spills, puncture wounds, animal bites, or scratches were identified; however, initial handling of the suspension included snapping lids of microtubes, ejection of pipette tips, and centrifuging. The centrifuge tubes had snap-down tops, and the rotor was covered with a gasket. The laboratory procedures might have potentially expelled small drops of suspension but were considered unlikely to have released infectious aerosols. Because staff members believed they were working with inactive organisms, they had performed these activities on an open bench, and appropriate PPE was not consistently used until after the deaths of the second group of mice.

As part of routine laboratory procedure, horizontal surfaces had been cleaned with a buffered bleach solution (1:10 dilution) at the end of each day. After laboratory workers recognized the possibility of exposure to viable *B. anthracis* spores, all laboratory surfaces and hoods were cleaned twice more with the bleach solution. The animal facility was also sanitized with bleach and a quaternary ammonium disinfectant.

Twelve persons were involved in either the laboratory or its animal-handling facilities. Three of these persons had direct contact with the bacterial suspensions, cultures, or infected animals. Although at low risk for inhalation of *B. anthracis* spores, to further reduce their risk, the three workers with direct contact were recommended for postexposure chemoprophylaxis for prevention of inhalational anthrax (i.e., either ciprofloxacin 500 mg or doxycycline 100mg, orally twice daily for 60 days) (*2*). The nine persons who worked in the laboratory or animal-handling facility but who did not have direct contact were offered the same chemoprophylaxis regimen. All 12 were additionally offered, but declined, anthrax vaccine under an Investigational New Drug (IND) protocol for postexposure prophylaxis (*3*).

Eight of the 12 potentially exposed persons opted to take chemoprophylaxis, including the three persons for whom the regimen was recommended. One person subsequently had a rash consistent with adverse reaction to ciprofloxacin; doxycycline was substituted. No other adverse effects from chemoprophylaxis were reported. None of the potentially exposed persons had symptoms consistent with anthrax.

Serum specimens collected from nine (75%) of the 12 exposed persons 3–6 weeks after exposure were negative for IgG antibodies to *B. anthracis* protective antigen (PA) by enzyme-linked immunosorbent assay (*4*). Three persons did not provide sera for evaluation, including one person who had direct exposure to the bacterial suspensions and cultures.

Further investigation revealed that the suspension had been prepared by a separate contract laboratory in March 2004 and contained an estimated 1.5×10^9 vegetative organisms per 1 mL of phosphate-buffered saline solution. After heating the suspension at 140°F (60°C) for 2 hours, the contractor reported that the suspension revealed no spores and had no growth after 48 hours of incubation on sheep blood agar.

A sealed, screw-top tube containing the suspension was shipped to CHORI in a double-compartment package on wet ice and arrived intact. The tube of suspension was stored in a refrigerator until used. The suspension had been prepared specifically for the research laboratory and was not distributed to other facilities. All contractor laboratory personnel had received anthrax vaccine, and the suspension was prepared under biosafety level 3 (BSL-3) conditions.

Leftover suspension from the incidents at the research laboratory were provided to CDC for quantification of viable organisms and to confirm the presence of *B. anthracis* spores. Sample dilutions were plated in duplicate on sheep blood agar. Approximately 2.0×10^6 colony-forming units (CFU) were enumerated per milliliter of suspension after 24 hours of incubation at 98.6°F (37.0°C). Comparisons of heat-shocked (149°F [65°C] for 30 minutes) and non–heat-shocked samples at CDC indicated that the suspension primarily contained *B. anthracis* spores.

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Editorial Note: The findings in this investigation indicate that workers in a research laboratory unknowingly received and used a suspension from a contract laboratory that likely contained viable *B. anthracis* organisms. Manipulation of the suspension at the research laboratory was determined unlikely to have expelled infectious aerosols, and exposed workers were considered at low risk for inhalation of spores. CDC continues to work with state agencies and other federal agencies to investigate processing procedures at the contractor facility to determine why the suspension contained viable *B. anthracis* organisms.

B. anthracis spores are highly resistant to the effects of heat and chemical disinfection (*5*). Although the heat-killing procedures used by the contractor might have been lethal to vegetative cells, the procedures were not lethal to spores. Modifying suspension preparations by increasing the temperature and duration of heat-killing procedures or using formalin will increase the probability that spores are inactivated (*5,6*).

Inactivated suspensions of *B. anthracis* should be cultured both at the preparing laboratory before shipment and at the research laboratory several days before use to ensure sterility. Sensitivity of sterility testing might be enhanced by increasing the inoculum size and incubation time, and by inoculating in multiple media, including both solid and broth media. Such procedures would increase the probability of detecting even a small number of viable *B. anthracis* spores. CHORI staff members did not perform sterility testing on the suspension received in March 2004.

Because inhalation of viable *B. anthracis* spores can result in fatal infection, CDC recommends that laboratory personnel who routinely perform activities with clinical materials and diagnostic quantities of infectious cultures implement BSL-2 practices (*7*). These practices include use of appropriate PPE (e.g., gloves, gowns, or laboratory coats) and a BSC for procedures with the potential to expel infectious aerosols (e.g., centrifuging or ejection of pipette tips). Face protection (e.g., goggles, face shield, or splatter guard) should be used against anticipated splashes or sprays when potentially infectious materials require handling outside of the BSC. In the incidents described in this report, because CHORI staff members believed they were working with nonviable organisms, they did not fully implement BSL-2 practices until after the deaths in the second group of mice.

Research laboratory workers should assume that all inactivated *B. anthracis* suspension materials are infectious until inactivation is adequately confirmed. BSL-2 procedures should be applied to all suspension manipulations performed before confirming sterility. After sterility is confirmed, laboratory personnel should continue to use BSL-2 procedures while performing activities with a high potential for expelling aerosolized spores.

The Advisory Committee on Immunization Practices recommends routine anthrax vaccination of persons who work with production quantities or concentrations of *B. anthracis* cultures or perform other activities with a high potential for producing infectious aerosols (*8*). Facilities performing such work should have appropriate biosafety precautions in place to prevent exposure to *B. anthracis* spores; however, anthrax vaccination can be an additional layer of protection in the event of an unrecognized breach in practices or equipment failure. Because of the small potential for inadvertent exposure to aerosolized *B. anthracis* spores before or after sterility testing, vaccination might also be considered for researchers who routinely work with inactivated *B. anthracis* suspensions.

In addition, laboratories working with inactivated *B. anthracis* organisms should develop and implement training activities and incident-response protocols to ensure appropriate actions are taken in the event of a potential exposure. These protocols should describe mechanisms for offering counseling and postexposure chemoprophylaxis and obtaining paired sera from potentially exposed persons. Training at animal research facilities should emphasize prompt communication between animal handlers and researchers if animals are unexpectedly found dead and any special handling procedures are needed for carcasses and bedding. Finally, institutional biosafety committees should routinely review protocols and procedures to ensure that appropriate safety precautions are always in place.

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Estimated Influenza Vaccination Coverage Among Adults and Children — United States, September 1, 2004–January 31, 2005

In response to the unexpected shortfall in the 2004–05 influenza vaccine supply, CDC recommended in October 2004 that vaccine be reserved for persons in certain priority groups, including persons aged ≥65 years and 6–23 months, persons aged 2–64 years with conditions that increased their risk for influenza complications, residents of chronic-care facilities, close contacts of infants aged <6 months, and health-care workers with direct patient contact (*1*). In late December 2004, based on declining demand among these groups, two additional groups (i.e., healthy persons aged 50–64 years and household contacts of all persons at high risk) were added to the list of vaccination priority groups (*2*). To monitor influenza vaccination coverage during the 2004–05 season, the Behavioral Risk Factor Surveillance System (BRFSS), an ongoing, state-based, telephone survey of civilian, noninstitutionalized persons, added new questions to collect information on priority status and the month and year of vaccination for adults and children (*3*). This report is based on analysis of data collected during February 1–27, 2005, regarding respondent-reported receipt of influenza vaccination during September 1, 2004–January 31, 2005. The results of this analysis indicated that influenza vaccination coverage levels through January 2005 among adults in priority groups nearly reached those in recent years, whereas coverage levels among adults not in priority groups were approximately half of levels in 2003, in part because 9.3% of those unvaccinated persons in nonpriority groups declined vaccination this season. The results further suggested that designation of the priority groups successfully directed the nation's influenza vaccine supply to those at highest risk. In addition, vaccination coverage among children aged 6–23 months was notable (48.4%), given that 2004–05 was the first year this group was recommended for influenza vaccination (*4*).

In previous years, BRFSS asked adult respondents whether they had been vaccinated against influenza during the preceding 12 months. No influenza vaccination questions were asked regarding children, and the only questions related to high-risk medical conditions referred to diabetes and asthma. To more closely monitor coverage during this shortfall season, influenza vaccination questions were added during November 2004–February 2005 regarding children, priority group status, and month and year of vaccination. For comparison with the 2004–05 season, data from the 2003 National Health Interview Survey (NHIS) were used. Similar to the BRFSS survey question, NHIS routinely asks adult respondents if they received a "flu shot" during the preceding 12 months; NHIS also collects information on occupations and high-risk medical conditions. NHIS was conducted during 2003 and consisted of in-person interviews; the household response rate was 89.2%. For children, the only previous available national data on influenza vaccine coverage were collected in the 2003 National Immunization Survey (NIS), which reported on vaccination coverage during the 2002–03 season for children aged 6–23 months with an overall response rate among eligible households of 62.7% (*5*).

Because BRFSS data collection is ongoing, final response rates for February were not yet available. Preliminary estimates indicate that the median state-level response rate for February was 51.7% (range: 33.4%–69.8%), based on CASRO guidelines. Analysis was based on 26,868 interviews from 50 states and the District of Columbia.

Vaccination Coverage Among Adults

Among adults, influenza vaccination coverage through January of the 2004–05 season was highest among persons aged ≥65 years (62.7%), followed by health-care workers with patient contact (35.7%) and those aged 18–64 years with high-risk conditions (25.5%) (Table 1). In comparison, the 2003 NHIS indicated coverage of 65.6% for persons aged ≥65 years, 40.1% for health-care workers, and 34.2% for adults aged 18–64 years with high-risk conditions. In contrast, influenza vaccination coverage among healthy persons aged 18–64 years who were not health-care workers or contacts of children aged <6 months was lower than in the previous season (8.8% compared with 17.8%) (CDC, unpublished data, 2005). Among the reasons cited by respondents for not receiving vaccination, was "saving vaccine for people who need it more," cited by 9.3% of those who were not in priority groups and were not vaccinated. This represents approximately 17.5 million doses of vaccine potentially made available to persons in priority groups.

Vaccination uptake was higher in October and November and tapered off during December and January (Figure). Among the adults in the priority groups established in October,

TABLE 1. Percentage of adults reporting influenza vaccination,* by vaccination priority status† — Behavioral Risk Factor Surveillance System, United States, 2004–05 influenza season

Vaccination priority status	September 2004–January 2005 No. surveyed	%	(95% CI§)
Persons aged 18–64 years with high-risk conditions¶	4,339	25.5	(±2.6)
Persons aged ≥65 years	6,345	62.7	(±2.1)
Health-care workers with patient contact**	1,750	35.7	(±4.0)
Total adults in initial priority groups††§§	**12,134**	**42.0**	**(±1.7)**
Healthy persons aged 18–49 years	9,316	6.9	(±1.0)
Healthy persons aged 50–64 years	5,528	16.5	(±1.8)
Total nonpriority group adults aged 18–64 years	**14,392**	**8.8**	**(±0.9)**

* Interviews were conducted during February 1–27, 2005.
† Does not include persons in the following additional vaccination priority groups: residents of nursing homes and long-term–care facilities and out-of-home caregivers for children aged <6 months.
§ Confidence interval.
¶ Asthma, other lung problems, heart problems, diabetes, kidney problems, weakened immune system, anemia, or pregnancy.
** Self-reported description might include doctors, nurses, laboratory workers, and office receptionists.
†† Persons can be included in more than one priority group.
§§ Includes persons with an infant aged <6 months in the household; stable estimates for this group could not be estimated separately because of its small sample size.

2% of the vaccinations through January occurred in September, 40% in October, 32% in November, 17% in December, and 9% in January.

Vaccination Coverage Among Children

Influenza vaccination coverage (≥1 doses) among children aged 6–23 months (48.4%) and among children aged 2–17 years with high-risk conditions (34.8%) was substantially higher than among children not in priority groups (12.3%) (Table 2). Of the vaccinations received through January, 17% occurred in September, 23% in October, 28% in November, 20% in December, and 12% in January (Figure). In comparison, the 2003 NIS data indicated that coverage among children aged 6–23 months for the 2002–03 influenza season, before they were recommended for vaccination by the Advisory Committee on Immunization Practices (ACIP), was 7.4% (*5*).

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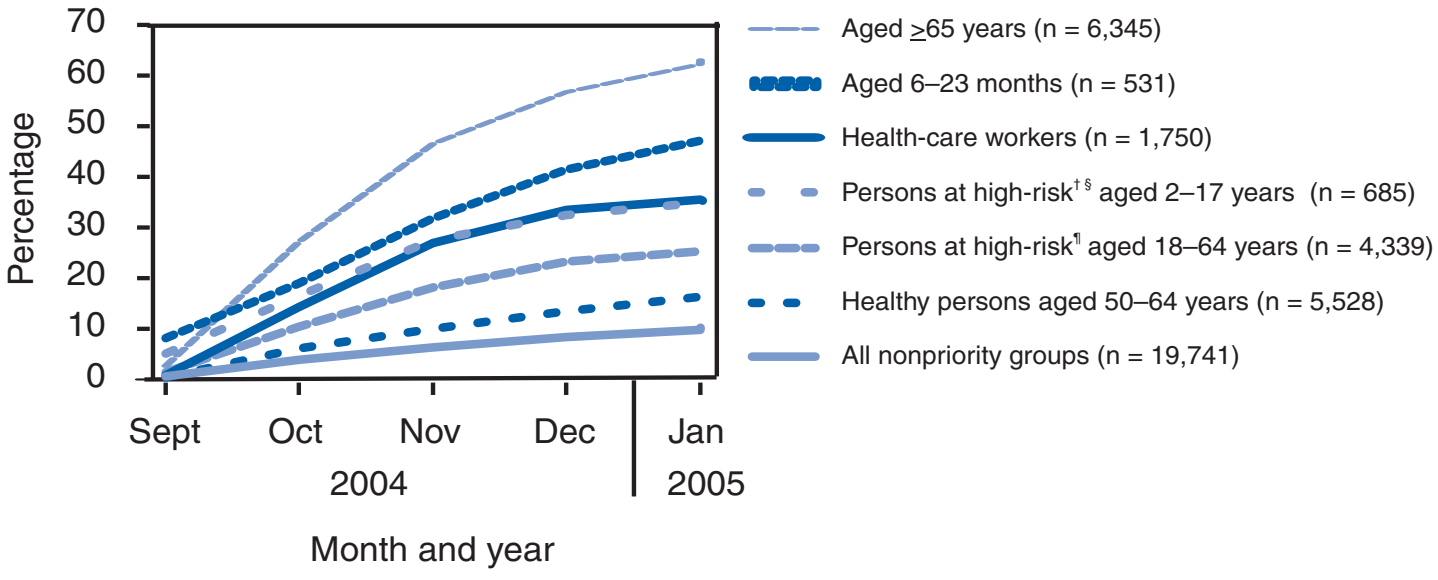
FIGURE. Monthly influenza vaccination coverage among selected priority populations, by month — Behavioral Risk Factor Surveillance System, United States, 2004–05 influenza season*



* Interviews were conducted during February 1–27, 2005.
† Does not include persons in households with infants aged <6 months, out-of-home caregivers of infants aged <6 months, or others with rare, high-risk conditions.
§ Asthma; other lung, heart, or kidney problems; diabetes; weakened immune system; anemia; or aspirin therapy for chronic conditions.
¶ Asthma; other lung, heart, or kidney problems; diabetes; weakened immune system; anemia; or pregnancy.

TABLE 2. Percentage of children aged 6 months–17 years reported to have received influenza vaccination,* by vaccination priority status — Behavioral Risk Factor Surveillance System, United States, 2004–05 influenza season

Vaccination priority status	September 2004–January 2005 No. surveyed	%	(95% CI†)
Children aged 6–23 months	531	48.4	(±8.8)
Children aged 2–17 years with high-risk conditions§	685	34.8	(±7.1)
Total children in priority groups	**1,216**	**42.2**	**(±5.9)**
Nonpriority group children and others aged 2–17 years¶	5,349	12.3	(±1.8)

* Interviews with household members were conducted during February 1–27, 2005.
† Confidence interval.
§ Asthma, other lung problems, heart problems, diabetes, kidney problems, weakened immune system, anemia, or aspirin therapy for chronic conditions.
¶ Includes children aged 2–17 years who might be in additional priority groups, such as those with rare conditions not included in the survey and household contacts or out-of-home caregivers for infants <6 months.

Editorial Note: During September 1, 2004–January 31, 2005, estimates of influenza vaccination coverage indicate that despite an unexpected and substantial vaccine shortfall, coverage levels among adults in the original influenza vaccine priority groups were similar to historical demand based on the 2003 NHIS (*3*), thereby suggesting the effectiveness of prioritization. This resulted, in part, from the estimated 17.5 million persons not in priority groups whose primary reported reason for not being vaccinated was to save vaccine for people who needed it more. According to the February 2005 BRFSS, approximately two thirds of the administered vaccine doses through January went to persons in the initial priority groups identified in October whereas, during 2003, only approximately one half of all doses of influenza vaccine were administered to persons in these groups.

The provision of ≥1 doses of influenza vaccination to 48.4% of children aged 6–23 months during this first influenza season following implementation of the ACIP recommendations suggests how quickly physicians and parents can adopt a new disease-prevention guideline (*4–6*). Because the Chiron vaccine was not licensed for use in children aged <4 years, the supply of influenza vaccine for children aged 6–23 months was not affected by the shortfall.

For the first time, a nationwide, state-based surveillance system (i.e., BRFSS) was used to assess influenza vaccination coverage by month of vaccination and provided the capability to report at intervals as brief as 1 week. This surveillance system also provided the first national influenza vaccination coverage estimates for children aged 2–17 years with high-risk conditions. Having national and state population-based estimates of vaccination coverage by month and priority status from early in the influenza season afforded policy makers, health-care providers, public health leaders, and the public timely information to make decisions regarding distribution and usage of the limited supply of vaccine.

The findings in this report are subject to at least four limitations. First, BRFSS is a land-line telephone–based survey and excludes those segments of the population without telephones or who use only cellular telephones. Second, data are self-reported and subject to recall bias, particularly for questions that require recall over a longer period; therefore, for certain behaviors, prevalence estimates might be under- or overreported. Third, certain influenza vaccine priority groups were not considered in the survey, including institutionalized adults and adult caretakers of children aged <6 months outside of the home (e.g., child care workers). Finally, these results do not include all of the vaccinations received during the 2004–05 influenza season. However, based on reports of vaccination, estimated 2004–05 coverage appeared to increase by less than one percentage point during February among all the priority and nonpriority groups except those aged 6–23 months, among whom coverage appeared to increase nearly four percentage points, from 48.4% to 52.2%.

Comparability of findings from the BRFSS survey with results of the 2003 NHIS is limited because of differences in the survey designs and timeframes. First, the 2003 NHIS is conducted throughout the entire 2003 calendar year. Thus, the results reflect vaccinations received anytime during the entire 2002–03 influenza season and vaccinations received during parts of both the 2001–02 and 2003–04 seasons. Second, the interviews are conducted in person, rather than by telephone. Analysis of 2005 NHIS data, when they become available, will be helpful to further assess the impact of the 2004–05 vaccine shortfall and to provide comparisons with results from the February 2005 BRFSS survey.

Vaccination patterns during the 2004–05 influenza season have been affected by several factors. Although an unexpected and substantial reduction of vaccine supply occurred at the beginning of the season, prioritization was quickly recommended and followed. The 2004–05 influenza season was less severe than the 2003–04 season and did not peak until mid-February (*7*). In addition, this was the first full season following the ACIP recommendation to vaccinate all children aged 6–23 months.

Despite the shortfall of inactivated influenza vaccine, the level of coverage achieved among those groups prioritized in 2004–05 appears to be similar to historical coverage. Additional guidelines for prioritization of influenza vaccination in the event of a future influenza vaccine shortfall are in development and should assist with efforts to maximize use of available vaccine.

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Influenza Vaccine Prebooking and Distribution Strategies for the 2005–06 Influenza Season

For the 2004–05 influenza season, CDC, in coordination with the Advisory Committee on Immunization Practices (ACIP), issued interim influenza vaccine use recommendations after Chiron Corporation announced that none of its inactivated influenza vaccine (Fluvirin®) would be available in the United States (*1*). To plan for the upcoming 2005–06 influenza season, CDC has met with influenza vaccine manufacturers, including those intending to apply for approval to sell in the United States, to develop supply projections and distribution strategies, including prebooking (i.e., advance ordering of vaccine) and partial shipment of orders to those customers who prebook. As of March 25, 2005, the supply of inactivated influenza vaccine projected for the 2005–06 season appeared adequate to meet the historical demand from persons in the priority groups established by ACIP during the 2004–05 season. If more vaccine becomes available, additional groups can also be targeted for vaccination.

Projected Vaccine Supply for the 2005–06 Influenza Season

During 2004–2005, Aventis Pasteur (now Sanofi Pasteur, after the merger of Aventis Pasteur and Sanofi) and MedImmune produced approximately 61 million doses of influenza vaccine for distribution in the United States. These two manufacturers anticipate producing approximately the same amount or slightly more doses for the upcoming season. How much, if any, influenza vaccine will be supplied by Chiron to the U.S. market is not known. On March 2, 2005, the British Medicines and Healthcare products Regulatory Agency (MHRA) lifted its October 5, 2004, suspension of Chiron's license to manufacture influenza vaccine (announcement available at http://www.fda.gov/bbs/topics/news/2005/new01160.html). The Food and Drug Administration (FDA) must also give its approval before this vaccine can be distributed in the United States. In addition, other manufacturers are discussing with FDA the possible licensure of influenza vaccine for the 2005–06 influenza season and beyond.

Prebooking and Distribution of Inactivated Influenza Vaccine

The primary method for reducing infections and complications from influenza is immunoprophylaxis with vaccine. The 2010 national health target for influenza vaccine coverage in noninstitutionalized adults aged ≥65 years is 90% (objective 14-29a); for noninstitutionalized adults at high risk aged 18–64 years, the coverage target is 60% (objective 14-29c) (*2*). Neither objective has been achieved. Based on data from the Behavioral Risk Factor Surveillance System (BRFSS) survey for the 2004–05 influenza season, influenza vaccination coverage was estimated at 62.7% for persons aged ≥65 years. For persons aged 18–64 with high-risk conditions, coverage was estimated at 25.5%, and for health-care workers with patient contact coverage was estimated at 35.7%. For children aged 6–23 months, coverage was estimated at 48.4% and for children aged 2–17 years with high-risk conditions, coverage was estimated at 34.8% (*3*). When combined with population estimates for these priority groups, the coverage estimates correspond to a total of approximately 40 million doses of influenza vaccine. To achieve 90% coverage in adults aged ≥65 years and 60% coverage for all other priority groups, approximately 70 million doses of vaccine would be needed (CDC, unpublished data, 2005). The supply of influenza vaccine projected from Sanofi Pasteur and MedImmune for the 2005–06 influenza season appears sufficient to meet the historical demand for vaccine by persons in all the priority groups established by ACIP during the 2004–05 influenza season. If additional vaccine becomes available above these levels (e.g., as a result of licensure of one or more additional manufacturers), additional groups can also be targeted for vaccination during the 2005–06 season.

Given the uncertainty about the number of doses of inactivated influenza vaccine that might be available for the 2005–06 season, CDC encourages implementation of a two-tiered prebooking strategy by manufacturers, distributors, and customers of inactivated vaccine. This prebooking strategy requires customers of inactivated vaccine to provide two requests for supplies, using 1) the number of doses needed

based on anticipated demand among persons in the priority groups, in the event vaccine supply is limited, and 2) the number of doses needed based on priority group use, plus other groups, if supplies prove sufficient to meet demand from other persons seeking vaccination.

Whenever feasible, CDC also encourages a distribution strategy in which partial shipments are first shipped to all prebooked customers, early in the vaccination season, followed by additional shipments later in the season. This strategy will enable all providers to administer vaccine initially to those persons at high risk, even when supplies are limited.

Priority Groups for Prebooking of Inactivated Influenza Vaccine

The following priority groups should be used as a guide for prebooking orders for inactivated influenza vaccine:

- Persons aged ≥65 years.
- Persons aged 2–64 years with underlying chronic medical conditions.
- All women who will be pregnant during the influenza season.
- All children aged 6–23 months.
- Health-care workers involved in direct patient care.
- Out-of-home caregivers and household contacts of children aged <6 months.
- Residents of nursing homes and long-term–care facilities.
- Children aged 6 months–18 years on chronic aspirin therapy.

These strategies for prebooking and distribution do not apply to live, attenuated influenza vaccine (LAIV), manufactured by MedImmune, which can be ordered in the usual manner for those persons for whom LAIV is indicated. LAIV can be administered to healthy persons aged 5–49 years who are not pregnant, including health-care workers who are not caring for severely immunocompromised patients in special care units. Further details regarding CDC influenza vaccination recommendations will be published in April 2005 in the annual Prevention and Control of Influenza *MMWR Recommendations and Reports*. In addition, updated information on inactivated influenza vaccine supply for the 2005–06 influenza season will be provided as it becomes available.

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Brief Report

Outbreak of Marburg Virus Hemorrhagic Fever — Angola, October 1, 2004–March 29, 2005

On March 30, this report was posted as an MMWR Dispatch *on the* MMWR *website* (http://www.cdc.gov/mmwr).

On March 23, 2005, the World Health Organization (WHO) confirmed Marburg virus (family Filoviridae, which includes Ebola virus) as the causative agent of an outbreak of viral hemorrhagic fever (VHF) in Uige Province in northern Angola. Testing conducted by CDC's Special Pathogens Branch detected the presence of virus in nine of 12 clinical specimens from patients who died during the outbreak.

During October 1, 2004–March 29, 2005, a total of 124 cases were identified; of these, 117 were fatal (*1*). Approximately 75% of the reported cases occurred in children aged <5 years; cases also have occurred in adults, including health-care workers. Predominant symptoms have included fever, hemorrhage, vomiting, cough, diarrhea, and jaundice.

WHO and international partners in the Global Outbreak Alert and Response Network (GOARN) are working with the Ministry of Health in Angola in conducting an investigation and public health response to the outbreak. Outbreak-control efforts are directed at providing technical support for case management, strengthening infection control in hospitals, improving surveillance and contact tracing, and educating local residents about the disease and its modes of transmission.

As part of the public health response, CDC will be sending personnel to join the WHO-coordinated GOARN response team to assist with epidemiologic investigation, infection control, and laboratory diagnosis. In addition, CDC will continue to provide laboratory and other scientific and logistical support. On March 25, CDC posted a notice on its website to inform travelers about the outbreak (available at http://www.cdc.gov/travel/other/marburg_vhf_angola_2005.htm). This website will be updated as new information becomes available. No U.S. travel restrictions to the affected area are recommended at this time.

Marburg virus disease presents as an acute febrile illness and can progress within 6–8 days to severe hemorrhagic manifestations. After an incubation period of 5–10 days, onset of the disease is sudden and is marked by fever, chills, headache, and myalgia. Approximately the fifth day after onset of symptoms, a maculopapular rash might occur, after which nausea, vomiting, chest pain, sore throat, abdominal pain, and diarrhea might appear. Signs and symptoms become increasingly severe and can include jaundice, inflammation of the pancreas,

severe weight loss, delirium, shock, liver failure, massive hemorrhaging, and multi-organ dysfunction.

Fatality rates for outbreaks of Marburg VHF have ranged from approximately 25% to 80%; mortality has been higher in outbreaks in which effective case management was lacking. No vaccine or curative treatment is available, and supportive treatment should be used. The virus can be spread to humans through direct contact with body fluids (e.g., blood, saliva, and urine) of an infected person or animal. Thus, the best protection for persons in or traveling to the outbreak area is to avoid direct contact with body fluids from potentially infected persons. Virus transmission also might be possible through contact with objects (e.g., medical equipment) that have been contaminated with infectious material. The virus has been reported to survive for as long as several days on contaminated surfaces (*2*). Hospital infection-control practices for infected patients should include contact and droplet precautions, in addition to wearing eye protection or a face shield. U.S. clinicians caring for patients with suspected Marburg virus infection should contact CDC or local public health officials for additional information about VHF infection control.

Clinicians should consider the diagnosis of Marburg VHF among febrile patients who, within 10 days before onset of fever, have either 1) traveled in northern Angola; 2) had direct contact with blood, other body fluids, secretions, or excretions of a person or animal suspected of having VHF; or 3) worked in a laboratory or animal facility that handles hemorrhagic fever viruses (*3*). The likelihood of acquiring VHF is considered extremely low in persons who do not meet any of these criteria. The cause of fever in persons who have traveled to areas where VHF is endemic is more likely to be a different infectious disease.

Reports of Marburg virus disease are rare, and its occurrence has been limited to countries in sub-Saharan Africa. The environmental reservoir of the virus is unknown. The current outbreak in Angola is the first report of Marburg virus disease since 1998–2000, when the largest known outbreak occurred in the Democratic Republic of Congo, resulting in 149 cases and 123 deaths (*4*).

Additional information is available at the following websites:

- WHO information about the outbreak in Angola: http://www.who.int;
- CDC information about Marburg virus and VHFs: http://www.cdc.gov/ncidod/dvrd/spb/mnpages/dispages/marburg.htm;
- CDC information on infection control for VHFs in the African health-care setting: http://www.cdc.gov/ncidod/dvrd/spb/mnpages/vhfmanual.htm; and
- CDC information about travelers' health: http://www.cdc.gov/travel/index.htm.

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Notice to Readers

World Health Day — April 7, 2005

The World Health Organization (WHO) has designated April 7, 2005, as World Health Day. The theme for this year's World Health Day is, "Make Every Mother and Child Count," with a focus on efforts to decrease mortality from pregnancy-related causes and in early childhood. Maternal and early childhood mortality persists as a major problem around the world, especially in developing regions. Approximately half a million women die each year from pregnancy-related causes (*1*). Approximately one in every 12 children throughout the world will not survive to age 5 years; in the least developed countries of the world, this figure is approximately one in six (*2*). Implementation of existing low cost, effective interventions could substantially close the gap and provide opportunity to reduce excessive maternal, perinatal, infant, and child mortality.

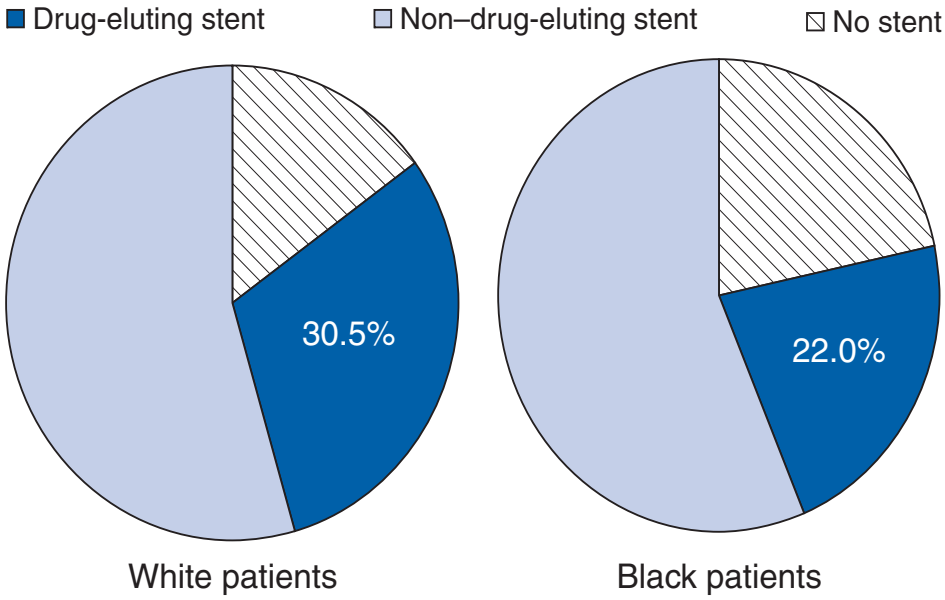
"Make Every Mother and Child Count" aims to account for every mother and child through the collection, analysis, and use of public health data. These data are often critical in helping organizations and governments to 1) design, support, and evaluate interventions; 2) identify emerging threats to maternal and child health needs; and 3) monitor the quality of services delivered to women and children. Toward this end, CDC continues to be a partner in domestic and global activities, providing the infrastructure needed to conduct surveillance and special studies to count every woman and child affected by a disease, disorder, or event.

Additional information on World Health Day and associated activities is available from WHO at http://www.who.int/world-health-day/2005/en and from the Pan American Health Organization at http://www.paho.org/english/dd/pin/whd05.htm.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Use of Stents* Among Hospitalized Patients Undergoing Coronary Angioplasty, by Race — United States, 2003



* Coronary angioplasty was identified by *International Classification of Diseases, Ninth Revision*, clinical modification codes 36.01–36.03 and 36.05–36.09. Discharges with drug-eluting stents had code 36.07.Those with non–drug-eluting stents had code 36.06 but not 36.07. Those with no stents had neither code 36.06 nor 36.07. Data are for patients whose race was reported as either white or black (including persons with and without Hispanic ethnicity). Four percent of patients with angioplasty had other races reported, and 23% had no race reported.

In 2003, approximately 84% of the 660,000 hospitalized patients who underwent a coronary angioplasty received a stent, a wire mesh tube inserted during angioplasty to reduce future narrowing of arteries. Drug-eluting stents have been determined to reduce the probability of future narrowing of arteries. Black and white angioplasty patients were equally likely to receive a stent. However, white patients were more likely than black patients to receive a drug-eluting stent.

SOURCE: CDC. National Hospital Discharge Survey (NHDS), 2003 data file. Available at http://www.cdc.gov/nchs/about/major/hdasd/nhds.htm.

References

1. United Nations Population Fund. State of world population 2004, the Cairo Consensus at ten: population, reproductive health, and the global effort to reduce poverty. New York, NY: United Nations Population Fund; 2004.
2. United Nations Children's Fund. Childhood under threat: the state of the world's children 2005. New York, NY: United Nations Children's Fund; 2004.

Notice to Readers

Sexual Assault Awareness Month — April 2005

April is Sexual Assault Awareness Month (SAAM). During this month, activities will focus on sexual violence and increasing awareness regarding its devastating effects. One in six women and one in 33 men in the United States have been victims of rape or attempted rape during their lifetimes (*1*); eight out of 10 victims knew their perpetrators (*1*).

Rape is one of the most underreported crimes, making it difficult to accurately count the number of cases. The National Women's Study documented that 84% of women in their sample did not report their rapes to the police (*2*). A primary reason for the underreporting was cultural norms that stigmatize and blame women for their assaults.

Several myths about rape persist (*3*). Some of the most prevalent rape myths are that women lead men on and therefore deserve to be raped, women often make false accusations of rape, no woman can be raped against her will, and most rapists are strangers (*4–6*). For these and other reasons, rape survivors often do not disclose experiences of rape and other sexual violence.

Additional information about sexual violence is available at http://www.cdc.gov/injury. Materials are available from the National Sexual Violence Resource Center, 123 North Enola Drive, Enola, PA 17025; telephone, 877-739-3895; or at http://www.nsvrc.org.

References

1. Tjaden P, Thoennes N. Full report of the prevalence, incidence, and consequences of violence against women: findings from the National Violence Against Women Survey. Washington, DC: National Institute of Justice; 2000. Report no. NCJ 183781.
2. Kilpatrick DG, Edmunds C, Seymour A. Rape in America: a report to the nation. Charleston, SC: National Victim Center & the Crime Victims Research and Treatment Center, Medical University of South Carolina; 1992.
3. Lonsway KA, Fitzgerald LF. Rape myths: In review. Psychology of Women Quarterly 1994;18:133–64.
4. Brownmiller S. Against our will. New York, NY: Simon & Schuster; 1975.
5. Burt MR. Cultural myths and support for rape. J Pers Soc Psychol 1980;38:217–30.
6. Ward CA. Attitudes toward rape: feminist and social psychological perspectives. London, England: Sage; 1995.

Errata: Vol. 53, Supplement, September 24, 2004

In the *MMWR Supplement*, "Syndromic Surveillance: Reports from a National Conference, 2003," errors occurred in the report, "Should We Be Worried? Investigation of Signals Generated by an Electronic Syndromic Surveillance System — Westchester County, New York."

On page 191, in the second paragraph under the section "Westchester County's Syndromic Surveillance System," the first sentence should read, "For each syndrome category, the daily rate, defined as the number of visits grouped in a particular syndrome divided by the number of total visits in all hospital EDs for that day, was analyzed to identify any statistically significant increases." Thereafter in this paragraph, the phrase, "number of visits," should read, "rate."

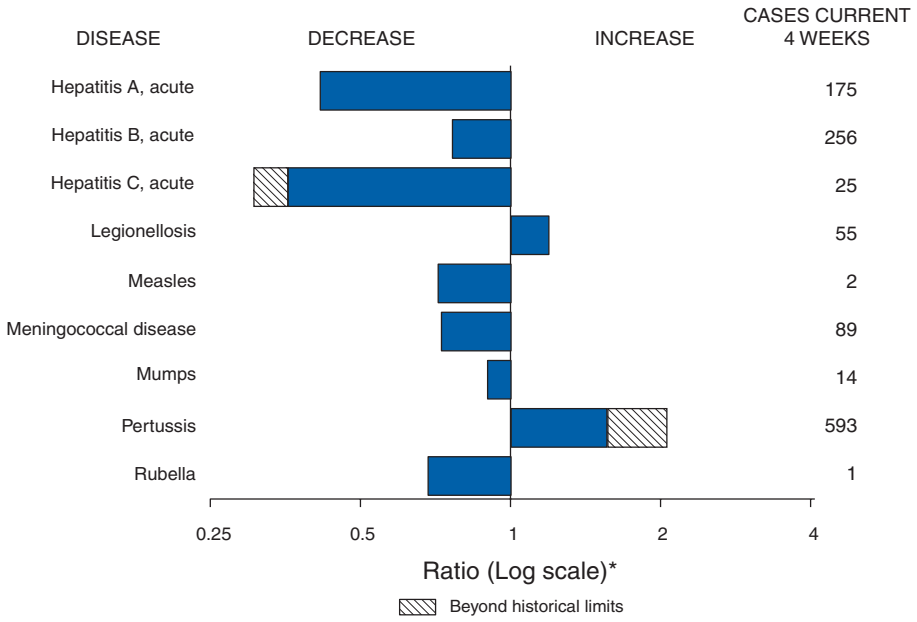
On page 191, in the second paragraph, the definition of a C3 signal should read, "A C3 signal is generated when the sum of all syndrome rates minus the baseline mean plus one standard deviation is greater than two standard deviations of the baseline for the previous 3 days. The C3 signal is illustrated as follows: "Σ [syndrome rate – (baseline mean + 1 standard deviation) > 2 standard deviations of the baseline], when >1 day exists when the syndrome rate is greater than the baseline mean + 1 standard deviation."

On page 192, in the second paragraph under the section "Terms Used To Identify and Classify Complaints into Syndrome Categories," information on monitoring for false-negative signals should include, "In addition, all chief complaints that are excluded from classification into a syndrome category should be reviewed periodically to ensure that key regional or facility-specific terminology is not being underrepresented in the search filter."

Erratum: Vol. 53, No. RR-15

In the *MMWR Recommendations and Reports*, "Treating Opportunistic Infections Among HIV-Infected Adults and Adolescents," an error occurred on page 97 in Table 6. In the second column "Preferred therapy and duration" for *Cryptococcus neoformans* meningitis, the first bulleted recommendation should read "Amphotericin B deoxycholate 0.7 mg/kg body weight IV QD with or without flucytosine 25 mg/kg PO QID for 2 weeks (AI)."

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals March 26, 2005, with historical data



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

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending March 26, 2005 (12th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	16	13
Botulism:			HIV infection, pediatric†¶	74	58
foodborne	3	1	Influenza-associated pediatric mortality†**	24	—
infant	9	19	Measles	6††	11§§
other (wound & unspecified)	4	1	Mumps	60	46
Brucellosis	19	19	Plague	—	—
Chancroid	7	8	Poliomyelitis, paralytic	—	—
Cholera	—	2	Psittacosis†	3	2
Cyclosporiasis†	5	71	Q fever†	13	9
Diphtheria	—	—	Rabies, human	1	—
Domestic arboviral diseases			Rubella	4	7
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	1	—
California serogroup†§	—	—	SARS†**	—	—
eastern equine†§	—	—	Smallpox†	—	—
Powassan†§	—	—	*Staphylococcus aureus*:		
St. Louis†§	—	—	Vancomycin-intermediate (VISA)†	—	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	—	—
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome†	19	44
human granulocytic (HGE)†	13	14	Tetanus	2	1
human monocytic (HME)†	17	14	Toxic-shock syndrome	25	32
human, other and unspecified †	5	1	Trichinellosis¶¶	5	—
Hansen disease†	9	18	Tularemia†	3	4
Hantavirus pulmonary syndrome†	3	2	Yellow fever	—	—

—: No reported cases.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
¶ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update February 27, 2005.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of six cases reported, four were indigenous and two were imported from another country.
§§ Of 11 cases reported, five were indigenous and six were imported from another country.
¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending March 26, 2005, and March 27, 2004 (12th Week)*

Reporting area	AIDS		Chlamydia†		Coccidioidomycosis		Cryptosporidiosis	
	Cum. 2005§	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	5,673	6,450	179,783	207,563	947	1,172	350	620
NEW ENGLAND	171	230	5,873	6,893	—	—	24	32
Maine	3	5	517	448	N	N	1	5
N.H.	2	10	429	402	—	—	4	8
Vt.¶	—	8	225	271	—	—	8	3
Mass.	61	82	3,328	3,066	—	—	7	10
R.I.	14	33	776	843	—	—	1	1
Conn.	91	92	598	1,863	N	N	3	5
MID. ATLANTIC	1,105	1,059	21,692	25,678	—	—	53	108
Upstate N.Y.	103	78	4,398	4,683	N	N	16	19
N.Y. City	637	304	6,467	8,388	—	—	11	34
N.J.	196	285	2,414	4,223	N	N	3	8
Pa.	169	392	8,413	8,384	N	N	23	47
E.N. CENTRAL	534	627	23,871	38,006	1	4	50	151
Ohio	83	157	3,073	9,330	N	N	25	39
Ind.	84	81	4,657	4,324	N	N	4	21
Ill.	273	279	7,620	11,064	—	—	—	23
Mich.	72	61	4,850	9,106	1	4	9	27
Wis.	22	49	3,671	4,182	N	N	12	41
W.N. CENTRAL	117	199	11,387	12,944	3	2	46	59
Minn.	52	44	1,886	2,672	N	N	11	24
Iowa	18	9	2,083	1,621	N	N	10	8
Mo.	20	82	4,741	4,817	—	1	17	14
N. Dak.	—	11	254	404	N	N	—	—
S. Dak.	3	—	639	549	—	—	2	5
Nebr.¶	—	8	404	1,174	—	1	—	—
Kans.	24	45	1,380	1,707	N	N	6	8
S. ATLANTIC	2,033	2,263	37,374	39,364	—	—	77	123
Del.	16	41	715	698	N	N	—	—
Md.	205	335	3,953	4,582	—	—	5	7
D.C.	80	99	869	851	—	—	1	2
Va.¶	104	133	5,775	5,224	—	—	9	9
W. Va.	16	24	591	679	N	N	4	2
N.C.	219	226	8,181	6,488	N	N	10	24
S.C.¶	60	160	5,134	4,134	—	—	1	4
Ga.	364	327	2,336	7,437	—	—	21	42
Fla.	969	918	9,820	9,271	N	N	26	33
E.S. CENTRAL	397	353	12,982	12,417	—	2	8	31
Ky.	48	40	2,963	1,368	N	N	1	6
Tenn.¶	157	148	4,808	5,187	N	N	2	12
Ala.¶	121	75	721	3,254	—	—	4	9
Miss.	71	90	4,490	2,608	—	2	1	4
W.S. CENTRAL	672	797	22,353	26,724	—	2	12	24
Ark.	41	42	1,975	1,829	—	1	—	7
La.	60	148	1,034	5,880	—	1	2	—
Okla.	71	36	2,361	2,182	N	N	6	7
Tex.¶	500	571	16,983	16,833	N	N	4	10
MOUNTAIN	246	254	11,946	11,018	600	739	23	27
Mont.	3	—	421	39	N	N	—	2
Idaho¶	3	2	391	751	N	N	1	1
Wyo.	—	3	256	242	—	—	2	2
Colo.	14	47	2,656	2,817	N	N	7	15
N. Mex.	35	20	748	1,450	2	7	1	1
Ariz.	113	104	5,004	3,939	575	713	3	5
Utah	12	19	917	591	2	4	4	—
Nev.¶	66	59	1,553	1,189	21	15	5	1
PACIFIC	398	668	32,305	34,519	343	423	57	65
Wash.	58	65	4,528	3,933	N	N	5	3
Oreg.¶	32	50	1,734	1,833	—	—	6	7
Calif.	297	515	24,308	26,573	343	423	46	54
Alaska	6	7	847	788	—	—	—	—
Hawaii	5	31	888	1,392	—	—	—	1
Guam	1	—	—	208	—	—	—	—
P.R.	1	141	899	474	N	N	N	N
V.I.	4	2	32	102	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	—	U	—	U	—	U

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

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

† Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update February 27, 2005.

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 26, 2005, and March 27, 2004 (12th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	199	195	26	35	34	28	3,063	3,596	59,629	73,857
NEW ENGLAND	15	9	5	9	5	2	235	298	1,091	1,605
Maine	—	—	1	—	—	—	32	27	35	69
N.H.	—	2	1	—	—	—	7	9	33	28
Vt.	1	—	—	—	—	—	30	16	6	17
Mass.	5	2	1	3	5	2	128	168	670	672
R.I.	1	1	—	—	—	—	17	23	120	220
Conn.	8	4	2	6	—	—	21	55	227	599
MID. ATLANTIC	25	20	1	1	1	8	562	803	6,321	8,428
Upstate N.Y.	12	6	1	1	—	3	184	208	1,436	1,581
N.Y. City	1	5	—	—	—	—	141	280	1,602	2,729
N.J.	6	1	—	—	—	3	72	100	817	1,561
Pa.	6	8	—	—	1	2	165	215	2,466	2,557
E.N. CENTRAL	51	49	3	9	3	4	399	565	9,075	15,713
Ohio	22	12	1	—	2	4	125	173	1,577	4,867
Ind.	6	13	—	—	—	—	N	N	1,804	1,544
Ill.	6	8	1	—	—	—	57	194	3,083	4,595
Mich.	8	8	—	1	1	—	133	124	1,596	3,657
Wis.	9	8	1	8	—	—	84	74	1,015	1,050
W.N. CENTRAL	27	36	4	6	5	6	368	349	3,596	4,203
Minn.	3	18	1	2	2	—	162	115	562	1,015
Iowa	5	4	—	—	—	—	50	44	427	279
Mo.	11	3	2	4	1	1	79	112	1,970	1,964
N. Dak.	—	2	—	—	—	3	1	6	15	41
S. Dak.	2	—	—	—	—	—	19	12	74	58
Nebr.	3	4	1	—	1	—	22	31	106	259
Kans.	3	5	—	—	1	2	35	29	442	587
S. ATLANTIC	23	14	5	4	15	5	552	562	16,320	17,796
Del.	—	—	N	N	N	N	8	12	176	236
Md.	4	3	1	—	—	1	35	22	1,575	1,929
D.C.	—	—	—	—	—	—	12	18	498	553
Va.	1	—	2	3	2	—	114	70	2,187	2,199
W. Va.	—	1	—	—	—	—	7	7	179	185
N.C.	—	—	—	—	9	3	N	N	4,229	3,662
S.C.	—	1	—	—	—	—	20	15	2,230	2,005
Ga.	5	3	1	—	—	—	168	166	1,030	3,250
Fla.	13	6	1	1	4	1	188	252	4,216	3,777
E.S. CENTRAL	9	8	—	—	3	2	78	72	4,513	5,693
Ky.	—	3	—	—	2	2	N	N	906	589
Tenn.	6	2	—	—	1	—	35	31	1,738	1,946
Ala.	3	1	—	—	—	—	43	41	520	1,822
Miss.	—	2	—	—	—	—	—	—	1,349	1,336
W.S. CENTRAL	5	16	1	1	1	1	54	65	8,460	10,031
Ark.	1	1	—	1	—	—	18	31	1,009	846
La.	—	1	1	—	1	—	8	11	643	2,789
Okla.	1	3	—	—	—	—	28	23	1,091	968
Tex.	3	11	—	—	—	1	N	N	5,717	5,428
MOUNTAIN	20	18	7	4	1	—	265	292	2,654	2,551
Mont.	1	2	—	—	—	—	9	6	23	7
Idaho	3	3	4	1	—	—	25	46	19	14
Wyo.	—	—	1	—	—	—	3	1	12	11
Colo.	3	3	1	1	—	—	87	89	642	685
N. Mex.	—	3	1	1	—	—	9	16	141	171
Ariz.	5	2	N	N	N	N	49	60	1,051	1,098
Utah	2	2	—	—	—	—	66	55	153	63
Nev.	6	3	—	1	1	—	17	19	613	502
PACIFIC	24	25	—	1	—	—	550	590	7,599	7,837
Wash.	5	3	—	—	—	—	28	38	787	651
Oreg.	1	2	—	1	—	—	46	106	296	231
Calif.	14	17	—	—	—	—	443	419	6,229	6,460
Alaska	2	—	—	—	—	—	13	10	113	138
Hawaii	2	3	—	—	—	—	20	17	174	357
Guam	N	N	—	—	—	—	—	—	—	47
P.R.	—	—	—	—	—	—	7	4	94	44
V.I.	—	—	—	—	—	—	—	—	2	34
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 26, 2005, and March 27, 2004 (12th Week)*

Reporting area	*Haemophilus influenzae*, invasive							
	All ages		Age <5 years					
	All serotypes		Serotype b		Non-serotype b		Unknown serotype	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	521	529	—	3	27	26	48	54
NEW ENGLAND	39	50	—	1	3	4	2	—
Maine	2	5	—	—	—	—	—	—
N.H.	—	9	—	—	—	1	—	—
Vt.	5	4	—	—	—	—	2	—
Mass.	16	23	—	1	—	2	—	—
R.I.	4	1	—	—	2	—	—	—
Conn.	12	8	—	—	1	1	—	—
MID. ATLANTIC	99	108	—	—	—	1	10	14
Upstate N.Y.	28	33	—	—	—	1	1	2
N.Y. City	15	21	—	—	—	—	3	4
N.J.	20	21	—	—	—	—	3	2
Pa.	36	33	—	—	—	—	3	6
E.N. CENTRAL	71	100	—	—	1	6	2	15
Ohio	39	34	—	—	—	2	2	4
Ind.	17	13	—	—	1	3	—	1
Ill.	2	26	—	—	—	—	—	6
Mich.	8	7	—	—	—	1	—	3
Wis.	5	20	—	—	—	—	—	1
W.N. CENTRAL	30	22	—	1	2	1	5	2
Minn.	13	9	—	—	2	1	—	—
Iowa	—	1	—	1	—	—	—	—
Mo.	12	8	—	—	—	—	2	2
N. Dak.	1	—	—	—	—	—	1	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	2	4	—	—	—	—	1	—
Kans.	2	—	—	—	—	—	1	—
S. ATLANTIC	145	119	—	—	5	2	10	8
Del.	—	—	—	—	—	—	—	—
Md.	22	27	—	—	2	1	1	—
D.C.	—	—	—	—	—	—	—	—
Va.	13	9	—	—	—	—	—	—
W. Va.	9	6	—	—	—	1	3	2
N.C.	24	11	—	—	2	—	—	—
S.C.	4	2	—	—	—	—	1	—
Ga.	46	31	—	—	—	—	4	6
Fla.	27	33	—	—	1	—	1	—
E.S. CENTRAL	24	19	—	—	—	—	4	5
Ky.	—	—	—	—	—	—	—	—
Tenn.	19	11	—	—	—	—	2	4
Ala.	5	8	—	—	—	—	2	1
Miss.	—	—	—	—	—	—	—	—
W.S. CENTRAL	27	23	—	—	2	3	5	—
Ark.	—	—	—	—	—	—	—	—
La.	10	8	—	—	—	—	5	—
Okla.	17	15	—	—	2	3	—	—
Tex.	—	—	—	—	—	—	—	—
MOUNTAIN	67	67	—	1	10	8	8	8
Mont.	—	—	—	—	—	—	—	—
Idaho	2	2	—	—	—	—	1	1
Wyo.	1	—	—	—	—	—	—	—
Colo.	14	12	—	—	—	—	2	1
N. Mex.	6	19	—	—	2	3	—	4
Ariz.	29	31	—	—	6	5	1	1
Utah	5	1	—	1	—	—	2	—
Nev.	10	2	—	—	2	—	2	1
PACIFIC	19	21	—	—	4	1	2	2
Wash.	—	1	—	—	—	—	—	1
Oreg.	9	11	—	—	—	—	2	—
Calif.	7	6	—	—	4	1	—	1
Alaska	1	—	—	—	—	—	—	—
Hawaii	2	3	—	—	—	—	—	—
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	—	—	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 26, 2005, and March 27, 2004 (12th Week)*

Reporting area	Hepatitis (viral, acute), by type					
	A		B		C	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	821	1,436	1,254	1,341	121	184
NEW ENGLAND	123	223	66	89	3	3
Maine	—	6	2	1	—	—
N.H.	9	6	2	10	—	—
Vt.	—	5	—	1	3	1
Mass.	95	177	53	44	—	2
R.I.	5	5	—	—	—	—
Conn.	14	24	9	33	—	—
MID. ATLANTIC	129	180	319	188	20	33
Upstate N.Y.	26	16	28	10	3	1
N.Y. City	54	67	13	49	—	—
N.J.	20	40	222	49	—	—
Pa.	29	57	56	80	17	32
E.N. CENTRAL	70	138	78	113	24	12
Ohio	18	15	38	41	—	2
Ind.	12	21	5	3	1	—
Ill.	9	51	2	—	—	1
Mich.	25	35	33	56	23	9
Wis.	6	16	—	13	—	—
W.N. CENTRAL	31	23	51	82	9	1
Minn.	3	1	—	8	—	1
Iowa	6	5	3	3	—	—
Mo.	15	5	35	60	9	—
N. Dak.	—	—	—	1	—	—
S. Dak.	—	2	—	—	—	—
Nebr.	3	7	7	6	—	—
Kans.	4	3	6	4	—	—
S. ATLANTIC	139	253	381	415	37	48
Del.	2	3	4	8	—	2
Md.	11	47	40	39	10	3
D.C.	1	3	—	5	—	1
Va.	17	18	45	37	5	8
W. Va.	—	1	7	1	2	2
N.C.	23	16	42	43	6	3
S.C.	4	5	21	18	—	4
Ga.	36	99	93	131	—	5
Fla.	45	61	129	133	14	20
E.S. CENTRAL	30	45	66	110	12	21
Ky.	3	3	20	11	—	8
Tenn.	20	26	27	43	5	5
Ala.	4	5	16	18	4	—
Miss.	3	11	3	38	3	8
W.S. CENTRAL	24	198	49	53	1	49
Ark.	1	26	11	24	—	—
La.	11	8	8	20	1	31
Okla.	1	11	4	8	—	—
Tex.	11	153	26	1	—	18
MOUNTAIN	95	110	112	89	6	5
Mont.	6	—	—	—	—	1
Idaho	7	4	3	3	—	—
Wyo.	—	—	—	1	—	—
Colo.	8	7	7	12	—	—
N. Mex.	5	5	4	4	—	1
Ariz.	58	75	81	48	—	2
Utah	8	18	10	11	4	—
Nev.	3	1	7	10	2	1
PACIFIC	180	266	132	202	9	12
Wash.	13	11	10	17	1	1
Oreg.	9	20	26	38	3	5
Calif.	153	228	95	141	5	4
Alaska	1	1	—	4	—	—
Hawaii	4	6	1	2	—	2
Guam	—	1	—	1	—	—
P.R.	—	8	2	7	—	—
V.I.	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 26, 2005, and March 27, 2004 (12th Week)*

Reporting area	Legionellosis		Listeriosis		Lyme disease		Malaria	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	239	264	103	94	1,078	1,684	214	255
NEW ENGLAND	8	5	2	4	25	140	4	22
Maine	—	—	—	1	2	13	—	—
N.H.	2	—	1	1	12	6	2	—
Vt.	—	—	—	—	—	5	—	1
Mass.	4	3	—	1	7	86	2	14
R.I.	—	1	—	—	1	13	—	2
Conn.	2	1	1	1	3	17	—	5
MID. ATLANTIC	73	49	21	24	800	1,291	51	54
Upstate N.Y.	17	11	5	5	119	400	9	9
N.Y. City	3	3	4	3	—	—	24	26
N.J.	16	7	5	8	326	255	12	10
Pa.	37	28	7	8	355	636	6	9
E.N. CENTRAL	47	75	14	12	31	40	12	19
Ohio	26	32	5	5	19	8	3	3
Ind.	9	13	—	2	2	—	—	3
Ill.	—	14	—	—	—	—	2	4
Mich.	9	14	4	3	2	—	6	4
Wis.	3	2	5	2	8	32	1	5
W.N. CENTRAL	10	4	8	3	30	16	9	17
Minn.	1	—	2	2	27	6	1	6
Iowa	—	—	3	—	2	3	2	1
Mo.	7	3	2	1	1	7	5	4
N. Dak.	1	—	1	—	—	—	—	1
S. Dak.	—	1	—	—	—	—	—	1
Nebr.	—	—	—	—	—	—	—	1
Kans.	1	—	—	—	—	—	1	3
S. ATLANTIC	55	59	26	15	169	159	55	73
Del.	—	1	N	N	25	19	—	1
Md.	15	9	3	3	97	85	17	22
D.C.	1	2	—	—	1	4	1	4
Va.	4	4	2	—	13	3	7	4
W. Va.	3	2	—	1	—	1	1	—
N.C.	7	7	6	4	12	30	7	3
S.C.	—	1	—	—	4	1	—	4
Ga.	6	4	4	3	—	5	11	9
Fla.	19	29	11	4	17	11	11	26
E.S. CENTRAL	3	11	4	5	4	4	8	8
Ky.	1	3	—	1	—	—	2	1
Tenn.	—	5	2	4	4	1	5	1
Ala.	2	3	2	—	—	—	1	5
Miss.	—	—	—	—	—	3	—	1
W.S. CENTRAL	2	26	2	11	5	14	19	23
Ark.	1	—	—	1	—	—	1	1
La.	1	1	1	—	—	—	—	2
Okla.	—	2	—	—	—	—	2	1
Tex.	—	23	1	10	5	14	16	19
MOUNTAIN	21	20	—	2	—	4	11	10
Mont.	1	—	—	—	—	—	—	—
Idaho	1	1	—	1	—	1	—	—
Wyo.	2	4	—	—	—	1	1	—
Colo.	3	3	—	1	—	—	6	4
N. Mex.	1	—	—	—	—	—	—	1
Ariz.	5	5	—	—	—	1	2	1
Utah	3	6	—	—	—	1	2	2
Nev.	5	1	—	—	—	—	—	2
PACIFIC	20	15	26	18	14	16	45	29
Wash.	1	2	2	3	—	1	—	1
Oreg.	N	N	1	4	1	7	1	3
Calif.	19	13	23	11	12	8	41	25
Alaska	—	—	—	—	1	—	2	—
Hawaii	—	—	—	—	N	N	1	—
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 26, 2005, and March 27, 2004 (12th Week)*

Reporting area	Meningococcal disease									
	All serogroups		Serogroup A, C, Y, and W-135		Serogroup B		Other serogroup		Serogroup unknown	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	319	422	23	28	20	12	—	—	276	382
NEW ENGLAND	26	21	1	2	—	—	—	—	25	19
Maine	1	6	—	—	—	—	—	—	1	6
N.H.	2	2	—	—	—	—	—	—	2	2
Vt.	3	1	—	—	—	—	—	—	3	1
Mass.	11	12	—	2	—	—	—	—	11	10
R.I.	2	—	—	—	—	—	—	—	2	—
Conn.	7	—	1	—	—	—	—	—	6	—
MID. ATLANTIC	40	60	10	16	2	4	—	—	28	40
Upstate N.Y.	9	19	1	3	1	2	—	—	7	14
N.Y. City	5	13	—	—	—	—	—	—	5	13
N.J.	13	7	—	—	—	—	—	—	13	7
Pa.	13	21	9	13	1	2	—	—	3	6
E.N. CENTRAL	27	41	7	8	4	3	—	—	16	30
Ohio	11	20	—	3	3	3	—	—	8	14
Ind.	4	8	—	—	1	—	—	—	3	8
Ill.	—	1	—	—	—	—	—	—	—	1
Mich.	7	5	7	5	—	—	—	—	—	—
Wis.	5	7	—	—	—	—	—	—	5	7
W.N. CENTRAL	25	18	1	—	1	1	—	—	23	17
Minn.	5	5	1	—	—	—	—	—	4	5
Iowa	9	3	—	—	1	1	—	—	8	2
Mo.	6	6	—	—	—	—	—	—	6	6
N. Dak.	—	—	—	—	—	—	—	—	—	—
S. Dak.	1	1	—	—	—	—	—	—	1	1
Nebr.	1	1	—	—	—	—	—	—	1	1
Kans.	3	2	—	—	—	—	—	—	3	2
S. ATLANTIC	53	77	2	1	4	1	—	—	47	75
Del.	—	1	—	—	—	—	—	—	—	1
Md.	6	5	1	—	2	—	—	—	3	5
D.C.	—	4	—	1	—	—	—	—	—	3
Va.	4	2	—	—	—	—	—	—	4	2
W. Va.	—	3	—	—	—	—	—	—	—	3
N.C.	6	9	1	—	2	1	—	—	3	8
S.C.	8	6	—	—	—	—	—	—	8	6
Ga.	7	5	—	—	—	—	—	—	7	5
Fla.	22	42	—	—	—	—	—	—	22	42
E.S. CENTRAL	16	21	—	—	1	—	—	—	15	21
Ky.	5	3	—	—	1	—	—	—	4	3
Tenn.	8	6	—	—	—	—	—	—	8	6
Ala.	—	6	—	—	—	—	—	—	—	6
Miss.	3	6	—	—	—	—	—	—	3	6
W.S. CENTRAL	26	45	1	1	3	—	—	—	22	44
Ark.	5	7	—	—	—	—	—	—	5	7
La.	9	13	—	1	2	—	—	—	7	12
Okla.	4	1	1	—	1	—	—	—	2	1
Tex.	8	24	—	—	—	—	—	—	8	24
MOUNTAIN	22	23	—	—	2	2	—	—	20	21
Mont.	—	1	—	—	—	—	—	—	—	1
Idaho	1	2	—	—	—	—	—	—	1	2
Wyo.	—	2	—	—	—	—	—	—	—	2
Colo.	7	8	—	—	—	—	—	—	7	8
N. Mex.	—	3	—	—	—	1	—	—	—	2
Ariz.	10	4	—	—	2	—	—	—	8	4
Utah	2	1	—	—	—	—	—	—	2	1
Nev.	2	2	—	—	—	1	—	—	2	1
PACIFIC	84	116	1	—	3	1	—	—	80	115
Wash.	16	5	1	—	3	1	—	—	12	4
Oreg.	16	28	—	—	—	—	—	—	16	28
Calif.	45	78	—	—	—	—	—	—	45	78
Alaska	2	1	—	—	—	—	—	—	2	1
Hawaii	5	4	—	—	—	—	—	—	5	4
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	—	1	—	—	—	—	—	—	—	1
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	—	—	—	—	—	—	—	—	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 26, 2005, and March 27, 2004 (12th Week)*

Reporting area	Pertussis		Rabies, animal		Rocky Mountain spotted fever		Salmonellosis		Shigellosis	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	3,445	1,992	888	1,265	129	115	4,886	5,630	1,983	2,628
NEW ENGLAND	168	364	155	90	1	4	279	252	44	52
Maine	7	—	11	11	N	N	15	9	—	—
N.H.	—	10	2	5	—	—	15	17	3	3
Vt.	41	16	12	5	—	—	19	11	3	—
Mass.	115	319	107	34	—	4	154	157	27	36
R.I.	5	7	2	4	1	—	11	12	1	1
Conn.	—	12	21	31	—	—	65	46	10	12
MID. ATLANTIC	401	546	115	133	9	10	555	743	209	279
Upstate N.Y.	140	361	65	61	—	—	140	148	68	105
N.Y. City	5	45	7	1	1	3	164	246	77	84
N.J.	52	50	N	N	2	—	78	140	52	57
Pa.	204	90	43	71	6	7	173	209	12	33
E.N. CENTRAL	946	312	8	3	2	—	467	923	110	245
Ohio	471	106	4	2	2	—	164	202	14	43
Ind.	72	11	1	1	—	—	54	81	16	43
Ill.	39	7	2	—	—	—	18	323	4	104
Mich.	41	28	1	—	—	—	115	148	61	30
Wis.	323	160	—	—	—	—	116	169	15	25
W.N. CENTRAL	402	99	52	97	6	3	358	328	152	67
Minn.	92	14	12	9	—	—	90	77	9	11
Iowa	50	24	13	10	—	—	70	65	29	11
Mo.	107	50	5	3	6	3	100	94	83	22
N. Dak.	14	3	1	11	—	—	6	8	2	1
S. Dak.	1	1	5	19	—	—	28	13	6	1
Nebr.	55	—	—	24	—	—	25	30	18	3
Kans.	83	7	16	21	—	—	39	41	5	18
S. ATLANTIC	253	116	290	613	91	81	1,471	1,237	346	735
Del.	1	—	—	9	—	2	1	8	—	2
Md.	41	30	66	71	5	2	114	89	17	25
D.C.	—	4	—	—	—	—	10	9	3	12
Va.	56	29	80	88	—	—	166	126	22	22
W. Va.	14	2	2	15	1	—	18	26	—	—
N.C.	21	22	92	134	70	66	275	162	29	111
S.C.	76	12	5	20	2	3	76	78	23	101
Ga.	7	4	44	69	9	6	247	200	106	137
Fla.	37	13	1	207	4	2	564	539	146	325
E.S. CENTRAL	89	26	17	59	2	12	256	315	204	142
Ky.	20	3	—	4	—	—	34	48	17	21
Tenn.	39	15	—	36	1	3	98	94	112	55
Ala.	23	4	17	15	1	2	93	113	59	46
Miss.	7	4	—	4	—	7	31	60	16	20
W.S. CENTRAL	61	32	191	231	1	2	312	508	417	604
Ark.	13	8	10	11	—	—	49	48	14	11
La.	1	2	—	—	1	2	67	62	27	60
Okla.	—	2	20	22	—	—	50	48	104	87
Tex.	47	20	161	198	—	—	146	350	272	446
MOUNTAIN	811	220	39	19	15	—	351	419	129	189
Mont.	204	4	—	3	—	—	18	20	—	3
Idaho	35	13	—	—	—	—	12	38	—	1
Wyo.	7	2	5	—	—	—	8	9	—	1
Colo.	367	107	—	—	—	—	88	97	18	29
N. Mex.	33	30	—	—	—	—	21	43	15	39
Ariz.	68	45	34	16	13	—	138	145	63	92
Utah	86	19	—	—	2	—	34	45	11	10
Nev.	11	—	—	—	—	—	32	22	22	14
PACIFIC	314	277	21	20	2	3	837	905	372	315
Wash.	69	64	—	—	—	—	62	42	11	12
Oreg.	162	57	—	—	—	2	40	72	14	17
Calif.	50	151	20	19	2	1	672	702	337	270
Alaska	11	1	1	1	—	—	11	23	3	3
Hawaii	22	4	—	—	—	—	52	66	7	13
Guam	—	—	—	—	—	—	—	7	—	12
P.R.	—	1	16	14	N	N	25	38	—	1
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 26, 2005, and March 27, 2004 (12th Week)*

Reporting area	Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive disease				Syphilis			
			Drug resistant, all ages		Age <5 years		Primary & secondary		Congenital	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,148	1,406	709	721	177	204	1,346	1,662	51	98
NEW ENGLAND	39	68	2	6	15	27	43	33	—	—
Maine	2	2	N	N	—	—	1	—	—	—
N.H.	3	7	—	—	—	N	3	1	—	—
Vt.	5	1	2	2	1	1	—	—	—	—
Mass.	26	56	—	2	14	24	37	18	—	—
R.I.	3	2	—	2	—	2	1	1	—	—
Conn.	—	—	—	—	U	U	1	13	—	—
MID. ATLANTIC	234	226	70	45	34	27	160	222	12	18
Upstate N.Y.	88	68	28	17	21	16	15	10	9	1
N.Y. City	24	46	U	U	U	U	106	135	2	6
N.J.	48	47	N	N	3	3	22	44	1	10
Pa.	74	65	42	28	10	8	17	33	—	1
E.N. CENTRAL	153	289	153	169	41	54	111	180	2	19
Ohio	49	75	102	132	24	28	50	53	—	1
Ind.	28	20	51	37	7	8	10	9	—	1
Ill.	2	82	—	—	6	—	34	73	1	3
Mich.	67	90	—	N	—	N	13	37	—	14
Wis.	7	22	N	N	4	18	4	8	1	—
W.N. CENTRAL	69	106	13	5	23	16	35	39	—	—
Minn.	25	48	—	—	12	7	2	6	—	—
Iowa	N	N	N	N	—	N	1	2	—	—
Mo.	21	21	12	4	1	4	29	23	—	—
N. Dak.	1	3	—	—	1	—	—	—	—	—
S. Dak.	5	7	1	1	—	—	—	—	—	—
Nebr.	7	7	—	—	2	3	1	5	—	—
Kans.	10	20	N	N	7	2	2	3	—	—
S. ATLANTIC	241	264	328	363	25	14	381	423	10	14
Del.	—	1	—	2	—	N	2	2	—	—
Md.	77	61	—	—	19	10	78	66	4	3
D.C.	2	2	4	3	2	4	28	17	—	1
Va.	10	14	N	N	—	N	20	7	3	1
W. Va.	7	9	19	34	4	—	2	3	—	—
N.C.	25	33	N	N	U	U	51	37	1	1
S.C.	6	18	—	33	—	N	16	31	—	2
Ga.	50	65	131	104	—	N	18	73	—	1
Fla.	64	61	174	187	—	N	166	187	2	5
E.S. CENTRAL	43	65	46	52	—	—	87	87	10	4
Ky.	12	23	7	10	N	N	6	14	—	—
Tenn.	31	42	39	42	—	N	33	38	8	1
Ala.	—	—	—	—	—	N	41	26	2	2
Miss.	—	—	—	—	—	—	7	9	—	1
W.S. CENTRAL	52	109	45	25	24	48	232	252	12	23
Ark.	6	3	6	3	2	4	12	14	—	3
La.	4	1	39	22	6	12	12	51	—	—
Okla.	33	18	N	N	10	15	11	6	1	2
Tex.	9	87	N	N	6	17	197	181	11	18
MOUNTAIN	216	152	29	12	15	18	69	84	5	3
Mont.	—	—	—	—	—	—	4	—	—	—
Idaho	1	3	N	N	—	N	6	7	—	—
Wyo.	1	4	11	4	—	—	—	1	—	—
Colo.	95	25	N	N	14	16	4	14	—	—
N. Mex.	14	31	—	5	—	—	7	22	1	1
Ariz.	85	79	N	N	—	N	28	36	4	2
Utah	20	10	17	1	1	2	1	2	—	—
Nev.	—	—	1	2	—	—	19	2	—	—
PACIFIC	101	127	23	44	—	—	228	342	—	17
Wash.	N	N	N	N	N	N	36	21	—	—
Oreg.	N	N	N	N	—	N	2	10	—	—
Calif.	75	99	N	N	—	N	188	307	—	17
Alaska	—	—	—	—	—	N	—	—	—	—
Hawaii	26	28	23	44	—	—	2	4	—	—
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	N	N	N	N	—	N	27	24	3	2
V.I.	—	—	—	—	—	—	—	4	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 26, 2005, and March 27, 2004 (12th Week)*

Reporting area	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease†		
							Neuroinvasive		Non-neuroinvasive§
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	1,404	2,401	38	56	5,363	4,910	—	—	—
NEW ENGLAND	56	64	1	7	95	201	—	—	—
Maine	—	—	—	—	79	25	—	—	—
N.H.	3	—	—	—	—	—	—	—	—
Vt.	—	—	—	—	15	176	—	—	—
Mass.	41	36	—	6	1	—	—	—	—
R.I.	—	11	—	1	—	—	—	—	—
Conn.	12	17	1	—	—	—	—	—	—
MID. ATLANTIC	407	362	12	15	1,090	12	—	—	—
Upstate N.Y.	41	41	2	—	—	—	—	—	—
N.Y. City	222	204	1	6	—	—	—	—	—
N.J.	85	67	3	6	—	—	—	—	—
Pa.	59	50	6	3	1,090	12	—	—	—
E.N. CENTRAL	265	216	1	3	1,916	1,872	—	—	—
Ohio	50	41	—	1	387	466	—	—	—
Ind.	25	35	1	—	N	N	—	—	—
Ill.	139	99	—	—	3	—	—	—	—
Mich.	36	25	—	2	1,404	1,222	—	—	—
Wis.	15	16	—	—	122	184	—	—	—
W.N. CENTRAL	75	67	1	1	40	87	—	—	—
Minn.	25	25	1	1	—	—	—	—	—
Iowa	7	7	—	—	N	N	—	—	—
Mo.	26	23	—	—	2	2	—	—	—
N. Dak.	1	2	—	—	9	63	—	—	—
S. Dak.	4	2	—	—	29	22	—	—	—
Nebr.	1	2	—	—	—	—	—	—	—
Kans.	11	6	—	—	—	—	—	—	N
S. ATLANTIC	267	486	7	8	485	508	—	—	—
Del.	—	5	—	—	1	1	—	—	—
Md.	47	39	1	2	—	—	—	—	—
D.C.	21	6	—	—	5	7	—	—	—
Va.	—	28	—	2	37	87	—	—	—
W. Va.	7	5	—	—	371	337	—	—	N
N.C.	30	29	1	2	—	N	—	—	—
S.C.	32	23	—	—	71	76	—	—	—
Ga.	5	152	2	—	—	—	—	—	—
Fla.	125	199	3	2	—	—	—	—	—
E.S. CENTRAL	96	104	1	—	—	—	—	—	—
Ky.	24	10	1	—	N	N	—	—	—
Tenn.	58	36	—	—	—	—	—	—	—
Ala.	14	30	—	—	—	—	—	—	—
Miss.	—	28	—	—	—	—	—	—	—
W.S. CENTRAL	43	431	3	5	834	1,508	—	—	—
Ark.	19	24	—	—	—	—	—	—	—
La.	—	—	—	—	6	33	—	—	—
Okla.	24	32	—	—	—	—	—	—	—
Tex.	—	375	3	5	828	1,475	—	—	—
MOUNTAIN	36	86	2	2	903	722	—	—	—
Mont.	—	—	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—	—
Wyo.	—	—	—	—	37	13	—	—	—
Colo.	8	20	—	—	626	510	—	—	—
N. Mex.	1	5	—	—	48	25	—	—	—
Ariz.	24	42	1	1	—	—	—	—	—
Utah	3	12	1	1	192	174	—	—	—
Nev.	—	7	—	—	—	—	—	—	—
PACIFIC	159	585	10	15	—	—	—	—	—
Wash.	51	44	—	1	N	N	—	—	—
Oreg.	21	16	1	1	—	—	—	—	—
Calif.	50	490	5	8	—	—	—	—	—
Alaska	9	7	—	—	—	—	—	—	—
Hawaii	28	28	4	5	—	—	—	—	—
Guam	—	13	—	—	—	17	—	—	—
P.R.	—	12	—	—	47	88	—	—	—
V.I.	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	—
C.N.M.I.	—	U	—	U	—	U	—	U	—

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

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

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

§ Not previously notifiable.

TABLE III. Deaths in 122 U.S. cities,* week ending March26, 2005 (12th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
NEW ENGLAND	522	369	97	37	11	8	44
Boston, Mass.	153	90	35	15	7	6	12
Bridgeport, Conn.	33	25	8	—	—	—	5
Cambridge, Mass.	20	15	3	2	—	—	2
Fall River, Mass.	27	24	2	1	—	—	3
Hartford, Conn.	49	35	8	2	4	—	6
Lowell, Mass.	32	23	5	3	—	1	2
Lynn, Mass.	6	4	1	1	—	—	—
New Bedford, Mass.	25	19	5	1	—	—	3
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	39	30	5	4	—	—	—
Somerville, Mass.	7	3	3	1	—	—	—
Springfield, Mass.	26	15	5	5	—	1	1
Waterbury, Conn.	32	30	1	1	—	—	1
Worcester, Mass.	73	56	16	1	—	—	9
MID. ATLANTIC	2,354	1,656	506	123	33	35	154
Albany, N.Y.	51	41	6	1	1	2	5
Allentown, Pa.	29	22	5	2	—	—	1
Buffalo, N.Y.	102	66	27	3	3	3	8
Camden, N.J.	27	18	8	—	—	1	2
Elizabeth, N.J.	21	14	7	—	—	—	—
Erie, Pa.	55	45	3	4	1	2	2
Jersey City, N.J.	34	19	8	4	1	2	—
New York City, N.Y.	1,142	793	254	63	12	19	73
Newark, N.J.	39	21	9	8	—	1	2
Paterson, N.J.	U	U	U	U	U	U	U
Philadelphia, Pa.	419	284	107	15	11	2	28
Pittsburgh, Pa.§	39	27	8	4	—	—	4
Reading, Pa.	26	23	2	1	—	—	2
Rochester, N.Y.	129	98	22	7	2	—	8
Schenectady, N.Y.	29	23	4	2	—	—	1
Scranton, Pa.	25	18	6	1	—	—	3
Syracuse, N.Y.	110	88	14	5	1	2	10
Trenton, N.J.	29	18	10	—	1	—	—
Utica, N.Y.	23	20	2	—	—	1	2
Yonkers, N.Y.	25	18	4	3	—	—	3
E.N. CENTRAL	2,328	1,644	460	139	37	45	242
Akron, Ohio	71	49	17	1	1	3	13
Canton, Ohio	45	39	4	2	—	—	8
Chicago, Ill.	439	257	113	46	11	9	39
Cincinnati, Ohio	81	57	14	4	1	5	9
Cleveland, Ohio	257	203	44	7	1	2	20
Columbus, Ohio	258	180	58	18	—	2	36
Dayton, Ohio	147	108	28	7	2	2	15
Detroit, Mich.	148	94	33	16	1	4	10
Evansville, Ind.	41	31	6	3	—	1	4
Fort Wayne, Ind.	62	49	12	—	1	—	6
Gary, Ind.	16	9	4	1	2	—	2
Grand Rapids, Mich.	49	40	3	1	3	2	5
Indianapolis, Ind.	228	174	35	10	5	4	24
Lansing, Mich.	55	36	12	—	4	3	7
Milwaukee, Wis.	116	73	24	12	3	4	17
Peoria, Ill.	57	43	10	2	—	2	7
Rockford, Ill.	54	42	9	3	—	—	3
South Bend, Ind.	41	37	4	—	—	—	4
Toledo, Ohio	98	75	21	1	1	—	6
Youngstown, Ohio	65	48	9	5	1	2	7
W.N. CENTRAL	674	456	144	40	19	15	69
Des Moines, Iowa	39	30	7	2	—	—	7
Duluth, Minn.	33	25	7	1	—	—	2
Kansas City, Kans.	34	18	10	2	4	—	2
Kansas City, Mo.	98	71	14	1	7	5	9
Lincoln, Nebr.	48	42	6	—	—	—	5
Minneapolis, Minn.	54	34	13	2	1	4	4
Omaha, Nebr.	106	75	23	6	—	2	16
St. Louis, Mo.	132	75	34	14	5	4	12
St. Paul, Minn.	41	25	10	4	2	—	2
Wichita, Kans.	89	61	20	8	—	—	10
S. ATLANTIC	1,261	832	281	96	30	21	82
Atlanta, Ga.	125	87	14	16	5	3	—
Baltimore, Md.	242	140	77	20	4	1	21
Charlotte, N.C.	74	49	18	3	3	1	5
Jacksonville, Fla.	167	113	39	7	4	4	12
Miami, Fla.	60	40	13	4	3	—	5
Norfolk, Va.	66	49	8	7	1	1	8
Richmond, Va.	70	44	20	3	2	1	2
Savannah, Ga.	66	54	8	4	—	—	5
St. Petersburg, Fla.	71	52	10	5	2	2	3
Tampa, Fla.	209	143	37	19	6	3	18
Washington, D.C.	99	54	34	6	—	5	3
Wilmington, Del.	12	7	3	2	—	—	—
E.S. CENTRAL	864	553	221	57	14	19	90
Birmingham, Ala.	187	122	44	13	2	6	24
Chattanooga, Tenn.	81	58	17	4	1	1	7
Knoxville, Tenn.	70	41	22	2	2	3	4
Lexington, Ky.	47	35	8	3	1	—	5
Memphis, Tenn.	211	126	60	16	4	5	28
Mobile, Ala.	99	62	28	6	2	1	7
Montgomery, Ala.	46	28	11	4	2	1	4
Nashville, Tenn.	123	81	31	9	—	2	11
W.S. CENTRAL	2,756	1,796	597	190	86	67	195
Austin, Tex.	103	70	20	5	6	2	11
Baton Rouge, La.	22	16	5	1	—	—	2
Corpus Christi, Tex.	57	39	11	4	2	1	5
Dallas, Tex.	203	104	60	20	10	9	15
El Paso, Tex.	87	60	17	4	3	3	6
Ft. Worth, Tex.	126	84	24	7	9	2	10
Houston, Tex.	388	252	90	28	10	8	32
Little Rock, Ark.	94	68	4	—	1	1	—
New Orleans, La.	1,295	833	289	102	38	33	72
San Antonio, Tex.	223	158	49	10	3	3	24
Shreveport, La.	58	44	9	1	1	3	4
Tulsa, Okla.	100	68	19	8	3	2	14
MOUNTAIN	1,295	912	268	66	25	23	94
Albuquerque, N.M.	229	160	48	14	3	4	18
Boise, Idaho	47	33	12	1	1	—	3
Colo. Springs, Colo.	78	50	18	4	5	1	5
Denver, Colo.	109	74	25	5	1	4	10
Las Vegas, Nev.	326	204	91	20	6	5	18
Ogden, Utah	37	31	4	—	1	1	3
Phoenix, Ariz.	122	88	21	7	5	—	11
Pueblo, Colo.	36	29	4	3	—	—	5
Salt Lake City, Utah	141	106	23	7	2	3	10
Tucson, Ariz.	170	137	22	5	1	5	11
PACIFIC	1,637	1,127	350	90	36	34	203
Berkeley, Calif.	14	5	7	1	—	1	1
Fresno, Calif.	200	138	44	13	3	2	25
Glendale, Calif.	18	13	4	—	—	1	3
Honolulu, Hawaii	76	60	13	1	—	2	3
Long Beach, Calif.	61	42	9	4	4	2	9
Los Angeles, Calif.	377	239	91	26	15	6	53
Pasadena, Calif.	39	27	10	2	—	—	4
Portland, Oreg.	125	88	26	9	1	1	13
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	151	106	25	10	5	5	16
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	199	136	41	13	4	5	26
Santa Cruz, Calif.	36	31	3	1	—	1	5
Seattle, Wash.	154	99	41	9	1	4	20
Spokane, Wash.	71	54	13	—	2	2	12
Tacoma, Wash.	116	89	23	1	1	2	13
TOTAL	13,691¶	9,345	2,924	838	291	267	1,173

U: Unavailable. —: No reported cases.

* Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Total includes unknown ages.

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