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National Black HIV/AIDS Awareness Day — February 7, 2007

During 2001–2004, the estimated annual number of cases of human immunodeficiency virus/acquired immunodeficieny syndrome (HIV/AIDS) among blacks decreased in the 33 states with long-term, confidential, name-based HIV reporting (*1*). However, the impact of HIV among blacks remained disproportionately high compared with other racial/ethnic populations. Blacks made up approximately 13% of the population in the 33 reporting states yet accounted for approximately 49% of persons who had a diagnosis of HIV/AIDS (*1*). Of the estimated 1 million persons living with HIV/AIDS in the United States at the end of 2003, nearly half (47%) were black (*1*). AIDS is a leading cause of death for blacks, who die sooner after AIDS diagnoses than persons in other racial/ethnic populations (*1*), suggesting that blacks are more likely to receive a diagnosis late in the course of disease or to have less access to therapies that can preserve health and prolong life.

February 7 is National Black HIV/AIDS Awareness Day. To address the racial disparity in occurrence of HIV/AIDS, CDC conducts research and programs for HIV prevention among blacks. Examples include partnering with community leaders and organizations to mobilize against HIV/AIDS, expanding the reach of effective HIV-prevention programs (*2*), conducting the Minority AIDS Research Initiative, and implementing social marketing campaigns focused on the importance of HIV testing.

References

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HIV/AIDS Diagnoses Among Blacks — Florida, 1999–2004

In 2004, Florida accounted for 11% of the total number of acquired immunodeficiency syndrome (AIDS) cases in the United States, ranking third behind New York and California. Florida also had the second-highest reported AIDS diagnosis rate (behind New York) (*1*). During 2004, non-Hispanic blacks* accounted for 14% of the Florida population but 52% of the 77,421 persons in Florida living with human immunodeficiency virus (HIV)/AIDS. This report describes trends in diagnoses of HIV/AIDS cases that occurred among blacks during 1999–2004 and were reported to the Florida Department of Health.† These data indicate that, during 1999–2004, the annual rate of HIV/AIDS diagnosis among blacks decreased more than the rates among other racial/ethnic groups. To examine possible explanations for this decline, HIV/AIDS diagnosis rate trends were compared with trends in gonorrhea diagnosis and publicly funded HIV testing in Florida. The results indicated that gonorrhea diagnosis rates also

* For this report, persons identified as white, black, Asian/Pacific Islander, or American Indian/Alaska Native are all non-Hispanic; persons described as Hispanic might be of any race.

† Reporting of positive HIV tests by laboratories and of HIV cases (without AIDS) by health-care providers who diagnose or treat a case has been mandatory since mid-1997, and reporting of AIDS cases by health-care providers who diagnose or treat a case has been mandatory since 1983; cases from both the private and public sectors are reported to county health departments. A case is defined as a newly diagnosed condition; a positive test (e.g., from a publicly funded test site) does not become a reported case until it is investigated, at which time the case registry is searched for duplicate reports. Data on numbers of tests conducted at publicly funded counseling and testing clinics include both negative and positive tests and might include more than one test per person.

INSIDE

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decreased among blacks in Florida during 1999–2004, whereas the number of HIV tests increased. These findings suggest that HIV/AIDS diagnoses in blacks might be associated with a reduction in high-risk sexual behavior and that the decline was not the result of less testing.

The diagnosis date for HIV/AIDS was defined as the diagnosis date for HIV infection, regardless of whether AIDS was diagnosed subsequently. HIV/AIDS case data were adjusted for reporting delays and insufficient information to enable classification into risk-factor categories (*2*).[§] Estimated annual percentage changes (EAPCs) in diagnoses were calculated by Poisson regression. A z test for differences in two parameters was used to evaluate the statistical significance of racial/ethnic differences in EAPCs.

During 1999–2004, the HIV/AIDS diagnosis rate among blacks in Florida decreased from 224.4 cases per 100,000 population in 1999 to 134.0 in 2004 (Table 1). This decrease resulted in a decrease in the disparity in diagnosis rates between blacks and Hispanics (with 47.9 cases per 100,000 population in 1999 and 46.1 in 2004) and between blacks and whites (with 18.8 cases per 100,000 population in 1999 and 18.4 in 2004); the diagnosis rate among blacks was 11.9 times higher than that among whites in 1999 but 7.3 times higher in 2004.[¶] During 1999–2004, the rate decreased among black, Hispanic, and white females and among black males. The annual percentage decrease in the rate was greater among black women (EAPC = -10.2) than white women (EAPC = -3.3) and Hispanic women (EAPC = -2.9) ($p<0.05$) (Table 1). Among blacks, the total number of diagnoses decreased from 1999 to 2004 among men and women with a history of injection-drug use (IDU), men with a history of both male-to-male sexual contact and IDU, and men and women with a history of high-risk heterosexual contact (i.e., sexual contact with a person known to be HIV infected or at high risk for HIV infection [e.g., history of IDU or male-to-male sexual contact]) (Table 2). The EAPC decreased more among blacks than among whites and Hispanics in all risk-factor categories ($p<0.05$) except men with a history of both male-to-male sexual contact and IDU, among whom the difference between blacks and Hispanics was not significant.

Data reported to the Florida Department of Health regarding the number of diagnosed gonorrhea cases and publicly

[§] Florida Department of Health staff obtained risk information for approximately 80% of HIV/AIDS cases from medical records in hospitals and doctors' offices and from data collected by publicly funded HIV testing sites; in addition, certain patients were interviewed. The remaining cases (i.e., without an identified HIV risk factor) were statistically redistributed into categories for specified risk factors, based on expected results of follow-up investigations.

[¶] The numbers of cases among Asians/Pacific Islanders and American Indians/Alaska Natives were too small for meaningful analysis and are not included in this report.

TABLE 1. Annual rates* of newly diagnosed HIV/AIDS cases and EAPC,† by race/ethnicity and sex — Florida, 1999–2004

Characteristic	Rate of diagnosed HIV/AIDS cases						EAPC	95% CI§
	1999	2000	2001	2002	2003	2004		
Black, non-Hispanic	224.4	192.0	180.0	170.0	152.4	134.0	-9.1¶	-9.7 to -8.4
Male	263.5	224.1	212.3	203.9	184.5	163.7	-8.2¶	-9.1 to -7.4
Female	188.4	162.4	150.2	138.6	122.8	106.4	-10.2¶	-11.2 to -9.2
Hispanic**	47.9	49.2	50.8	51.3	47.0	46.1	-1.0††	-2.2 to 0.3
Male	73.1	76.5	78.5	81.4	74.4	74.1	-0.1††	-1.5 to 1.4
Female	21.7	20.9	22.5	20.7	19.7	17.9	-2.9¶††	-5.5 to -0.2
White, non-Hispanic	18.8	18.5	18.8	17.4	17.8	18.4	-0.8††	-1.8 to 0.19
Male	31.3	31.0	31.9	29.4	30.0	31.6	-0.3††	-1.4 to 0.8
Female	7.0	6.6	6.2	5.9	6.2	5.8	-3.3¶††	-5.7 to -0.9

* Per 100,000 population, as reported to the Florida Department of Health.
† Estimated annual percentage change.
§ Confidence interval.
¶ EAPC represented a significant trend (p<0.05).
** Might be of any race.
†† Significantly different from the corresponding EAPC among blacks (p<0.05).

TABLE 2. Annual number of newly diagnosed HIV/AIDS cases* and EAPC,† by race/ethnicity and risk-factor category — Florida, 1999–2004

Risk-factor category	No. of diagnosed HIV/AIDS cases						EAPC	95% CI§
	1999	2000	2001	2002	2003	2004		
Male-to-male sexual contact								
Black, non-Hispanic	957	843	1,001	1,016	910	845	-1.2	-2.7 to 0.4
Hispanic¶	632	708	737	807	759	840	5.0**††	3.2 to 6.8
White, non-Hispanic	1,283	1,350	1,424	1350	1,433	1,527	2.9**††	1.6 to 4.2
Injection-drug use (IDU)								
Black, non-Hispanic	781	665	527	461	409	386	-14.0**	-15.8 to -12.2
Male	449	428	315	291	265	264	-11.6**	-13.9 to -9.3
Female	332	237	212	170	144	122	-17.9**	-20.7 to -15.1
Hispanic	173	183	174	165	133	129	-6.5**††	-10.0 to -3.0
Male	127	140	131	136	101	89	-6.9**††	-10.8 to -2.8
Female	45	42	43	29	32	40	-5.0††	-11.9 to 2.5
White, non-Hispanic	267	266	249	227	206	187	-7.1**††	-9.9 to -4.2
Male	141	127	137	115	100	94	-7.8**	-11.7 to -3.8
Female	126	139	112	111	107	93	-6.3**††	-10.4 to -2.1
Male-to-male sexual contact and IDU								
Black, non-Hispanic	120	114	106	85	94	72	-8.9**	-13.2 to -4.5
Hispanic	39	39	46	40	38	38	-1.0	-8.1 to 6.6
White, non-Hispanic	119	94	91	92	106	110	-0.2††	-4.7 to 4.5
High-risk heterosexual contact§§								
Black, non-Hispanic	3,481	3,072	2,840	2,714	2,517	2,202	-8.0**	-8.9 to -7.2
Male	1,458	1,226	1,107	1,073	989	869	-9.0**	-10.3 to -7.7
Female	2,023	1,846	1,733	1,641	1,528	1,333	-7.4**	-8.4 to -6.3
Hispanic	388	390	452	473	465	447	3.6**††	1.3 to 6.0
Male	152	154	188	195	196	203	6.3**††	2.7 to 10.1
Female	235	236	264	279	268	244	1.8††	-1.2 to 4.8
White, non-Hispanic	400	369	390	346	392	412	0.6††	-1.7 to 3.1
Male	130	111	120	102	119	135	0.7††	-3.5 to 5.2
Female	270	257	270	244	273	277	0.6††	-2.2 to 3.6

* Diagnosed HIV/AIDS cases as reported to the Florida Department of Health, with numbers of cases reported without an HIV risk factor redistributed into categories for specified risk factors, based on expected results of follow-up investigations.
† Estimated annual percentage change.
§ Confidence interval.
¶ Might be of any race.
** EAPC represented a significant trend (p<0.05).
†† Significantly different from the corresponding EAPC among blacks (p<0.05).
§§ Sexual contact with a person known to be HIV infected or at high risk for HIV infection (e.g., history of IDU or male-to-male sexual contact).

funded HIV tests indicated that, during 1999–2004, when HIV/AIDS diagnosis rates significantly decreased among blacks, gonorrhea rates also significantly decreased among black males (EAPC = -8.7, 95% confidence interval [CI] = -9.2 to -8.2) and black females (EAPC = -7.4, CI = -7.9 to -6.8) (Table 3). Conversely, during 1999–2004, the annual number of publicly funded HIV tests in Florida increased significantly among blacks, from 81,101 tests in 1999

TABLE 3. Annual rates* of newly diagnosed gonorrhea cases and EAPC,† by race/ethnicity and sex — Florida, 1999–2004

Characteristic	Rate of diagnosed gonorrhea cases						EAPC	95% CI§
	1999	2000	2001	2002	2003	2004		
Black	657.9	642.7	586.2	559.0	473.0	439.6	-8.1¶	-8.4 to -7.7
Male	731.6	718.6	646.8	622.4	515.9	471.2	-8.7¶	-9.2 to -8.2
Female	589.9	572.7	530.1	500.4	433.4	410.3	-7.4¶	-7.9 to -6.8
Hispanic**	38.2	32.2	33.7	31.7	34.1	37.6	0.2	-1.2 to 1.7
Male	47.7	39.7	42.8	35.0	38.2	40.6	-3.1¶	-5.0 to -1.2
Female	28.4	24.5	24.5	28.3	29.9	34.5	5.4¶	3.1 to 8.1
White	33.8	33.5	31.2	33.0	32.2	33.7	-0.2	-0.9 to 0.6
Male	28.4	29.7	27.8	29.3	28.3	28.6	-0.2	-1.3 to 1.0
Female	38.9	37.1	34.4	36.6	35.8	38.5	-0.2	-1.2 to 0.8

* Per 100,000 population.
† Estimated annual percentage change.
§ Confidence interval.
¶ EAPC represented a significant trend (p<0.05).
** Might be of any race.

to 105,072 in 2004 (EAPC = 5.7, CI = 5.5–5.9), among whites, from 108,680 tests in 1999 to 114,103 in 2004 (EAPC = 1.7, CI = 1.6–1.9), and among Hispanics, from 32,050 tests in 1999 to 64,472 in 2004 (EAPC = 15.3, CI = 15.0–15.5).

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Editorial Note: In Florida, as in most of the United States (*1*), HIV/AIDS rates are higher among blacks than among any other racial/ethnic population. However, the results of this study indicate that the HIV/AIDS diagnosis rate in Florida decreased more among blacks than among other racial/ethnic populations during 1999–2004. Among blacks, rates decreased for both sexes, and the number of cases decreased in all risk-factor categories except men with a history of male-to-male sexual contact, among whom the number of cases increased significantly for whites and Hispanics.

CDC encourages health departments to use multiple data sources to develop epidemiologic profiles of populations at risk for HIV/AIDS, which can help improve prevention and treatment programs (*3*). The Florida Department of Health has analyzed data such as those described in this report by county and presented them to county health departments and the Florida public for HIV-prevention planning and community mobilization.

Trends in gonorrhea diagnosis were examined as a possible reflection of trends in high-risk sexual behavior and because gonorrhea typically is diagnosed soon after sexual transmission. Like HIV/AIDS diagnosis rates in Florida, gonorrhea diagnosis rates decreased both among black males and females. Although increases or decreases in diagnosis rates for both HIV/AIDS and gonorrhea might reflect changes in methods of diagnosis, treatment, or surveillance, rather than changes in sexual behavior, the finding that gonorrhea and HIV/AIDS diagnosis rates both decreased suggests that high-risk sexual behavior also decreased.

The possibility that decreases in HIV/AIDS diagnoses were a result of decreased HIV testing among blacks was not supported by data, which indicated a significant increase in testing among blacks at publicly funded HIV testing sites. Approximately 45% of all non-AIDS HIV diagnoses in Florida were reported from these sites.

The findings in this report are subject to at least four limitations. First, because retroactive reporting of HIV cases diagnosed before July 1997 (the implementation date of HIV reporting) was not allowed for persons without AIDS, some persons whose initial HIV diagnosis occurred before mid-1997 might have been misclassified with a later diagnosis date in this analysis if they were retested for HIV during the study period. Depending on whether the diagnosis dates were misclassified to the study period's early (1999–2001) or late (2002–2004) years, the decrease in diagnoses might have been overestimated or underestimated, respectively. Second, data on annual numbers of HIV tests were restricted to public clinics, which might have resulted in an overall underestimation of numbers of tests or a more pronounced underestimation for one racial/ethnic population compared with others. Third, persons who had multiple HIV tests in a certain year might have been counted multiple times in the annual HIV test data. Finally, the validity of the findings might be reduced by any inaccuracy of the adjustments for reporting delay and by missing risk-factor information.

Trends in the diagnosis of HIV/AIDS do not necessarily reflect trends in the transmission of HIV infection because diagnosis trends might be affected by other factors, including changes in testing behavior, clinical practice, or public health surveillance. CDC plans to address these factors by supplementing the HIV/AIDS case surveillance system with estimates of HIV incidence using a previously described serologic testing strategy (*4*). Meanwhile, examining data from other surveillance systems can assist public health professionals with interpreting HIV/AIDS diagnosis trends, as indicated by this report, in which multiple data sources support the finding

that HIV/AIDS diagnosis rates among blacks decreased in Florida and that this decrease might have been associated with a decrease in high-risk sexual behavior.

The continuing high rates of HIV/AIDS and gonorrhea diagnoses among blacks and the significantly increasing numbers of HIV/AIDS diagnoses for white and Hispanic men with a history of male-to-male sexual contact underscore the need for additional and improved prevention measures. Higher rates of HIV testing can be expected to increase the number of HIV-infected persons who are aware of their infection, decrease HIV transmission to others, link infected persons to care and counseling services earlier, and ultimately reduce progression to AIDS and death (*5*).

Acknowledgments

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Rift Valley Fever Outbreak — Kenya, November 2006–January 2007

In mid-December 2006, several unexplained fatalities associated with fever and generalized bleeding were reported to the Kenya Ministry of Health (KMOH) from Garissa District in North Eastern Province (NEP). By December 20, a total of 11 deaths had been reported. Of serum samples collected from the first 19 patients, Rift Valley fever (RVF) virus RNA or immunoglobulin M (IgM) antibodies against RVF virus were found in samples from 10 patients; all serum specimens were negative for yellow fever, Ebola, Crimean-Congo hemorrhagic fever, and dengue viruses. The outbreak was confirmed by isolation of RVF virus from six of the specimens. Humans can be infected with RVF virus from bites of mosquitoes or other arthropod vectors that have fed on animals infected with RVF virus, or through contact with viremic animals, particularly livestock. Reports of livestock deaths and unexplained animal abortions in NEP provided further evidence of an RVF outbreak. On December 20, an investigation was launched by KMOH, the Kenya Field Epidemiology and Laboratory Training Program (FELTP), the Kenya Medical Research Institute (KEMRI), the Walter Reed Project of the U.S. Army Medical Research Unit, CDC-Kenya's Global Disease Detection Center, and other partners, including the World Health Organization (WHO) and Médecins Sans Frontières (MSF). This report describes the findings from that initial investigation and the control measures taken in response to the RVF outbreak, which spread to multiple additional provinces and districts, resulting in 404 cases with 118 deaths as of January 25, 2007.

Teams of investigators conducted patient interviews and reviewed medical records from December 1 forward in major health-care facilities in the districts from which cases were first reported. The teams detected additional cases by meeting with elders, other leaders, and health-care providers in villages where cases had been reported and in adjacent villages. Blood samples from patients with suspected RVF were collected and maintained at 39.2°F (4.0°C). Samples from NEP and surrounding areas were transported to a field laboratory established at Garissa Provincial Hospital by CDC, KEMRI, and KMOH; samples from other areas were sent to KEMRI laboratories in Nairobi and to a laboratory in Malindi that was supported by a team from Health Canada.

A suspected case was defined as acute onset of fever (>99.5°F [>37.5°C]) with headache or muscle and joint pain since December 1 in a person who had no other known cause of acute febrile illness (e.g., malaria). A probable case was defined as acute onset of fever in a person with unexplained bleeding (i.e., in stool, vomit, or sputum or from gums, nose, vagina, skin, or eyes), vision deterioration, or altered consciousness. A confirmed case was defined as a suspected or probable case with laboratory confirmation of the presence in serum of anti-RVF virus IgM by enzyme-linked immunosorbent assay (ELISA) or RVF virus RNA by reverse transcription–polymerase chain reaction (RT-PCR).

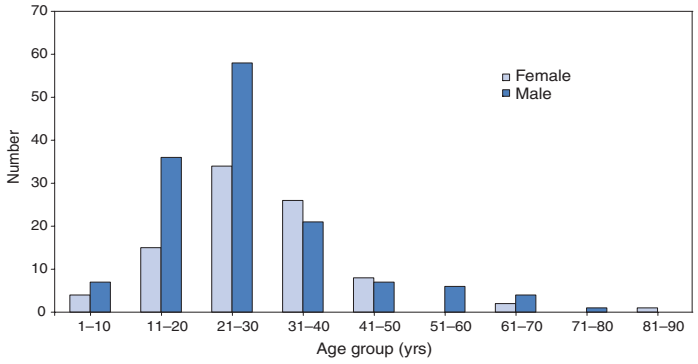
The index case was reported in Garissa District in a patient who had symptom onset on November 30, 2006. Retrospective analysis of sera collected during July–November 2006 at Garissa Provincial Hospital revealed no evidence of earlier acute RVF infections. As of January 25, 2007, a total of 404 cases of RVF had been reported in Kenya with 118 deaths, a case-fatality rate of 29%. Of the reported cases, 115 (29%) were laboratory confirmed by anti-RVF virus IgM by ELISA (64 cases, 56%) or RT-PCR (79, 69%), including 28 cases (24%) confirmed by both. Of the remaining 289 cases, 109 were classified as probable.

Of the 230 patients with available demographic information, 140 (61%) were male (Figure 1). Patients ranged in age from 4 to 85 years, with a median age of 27 years (30 years for females and 25 years for males). RVF cases were reported from three districts in NEP (Garissa [175 cases], Ijara [125], and Wajir [26]); five districts in Coast Province (Kilifi [38], Tana River [16], Malindi [eight], Isiolo [eight], and Taita Taveta [one]); two districts in Central Province (Kirinyanga [two] and Maragua [one]); one district in Rift Valley Province (Kajiado [three]); and one from Nairobi Area (Figure 2). The patient from Nairobi had traveled to NEP during the week before illness onset but was hospitalized in Nairobi. Ijara (population 79,932) and Garissa (population 420,918) districts had the highest RVF incidence rates: 156 and 42 per 100,000 population, respectively.

Among the first 97 reported cases from Garissa and Wajir districts with detailed epidemiologic information available, 71 (73%) met the probable case definition; 38 of the 62 patients who provided blood samples tested positive by IgM ELISA, RT-PCR, or both. The most frequently reported symptoms among the 97 patients were fever (100%), headache (90%), bleeding (76%), malaise (70%), muscle pain (62%), back pain (60%), vomiting (56%), and joint pain (51%).

Two thirds of the 66 patients who provided information on potential risk factors reported having an animal that was recently ill. The most frequently reported RVF risk factors during the 2 weeks preceding illness onset were drinking unboiled (raw) milk (72%); living within 100 meters of a swamp (70%); having an ill animal (67%); drinking milk from an ill animal (59%); working as a herdsman (50%); having a dead animal (50%); and slaughtering an animal (42%). Approximately 9% of patients reported contact with another ill human.

FIGURE 1. Number of reported Rift Valley fever cases (n = 230), by sex and age group — Kenya, November 2006–January 2007*



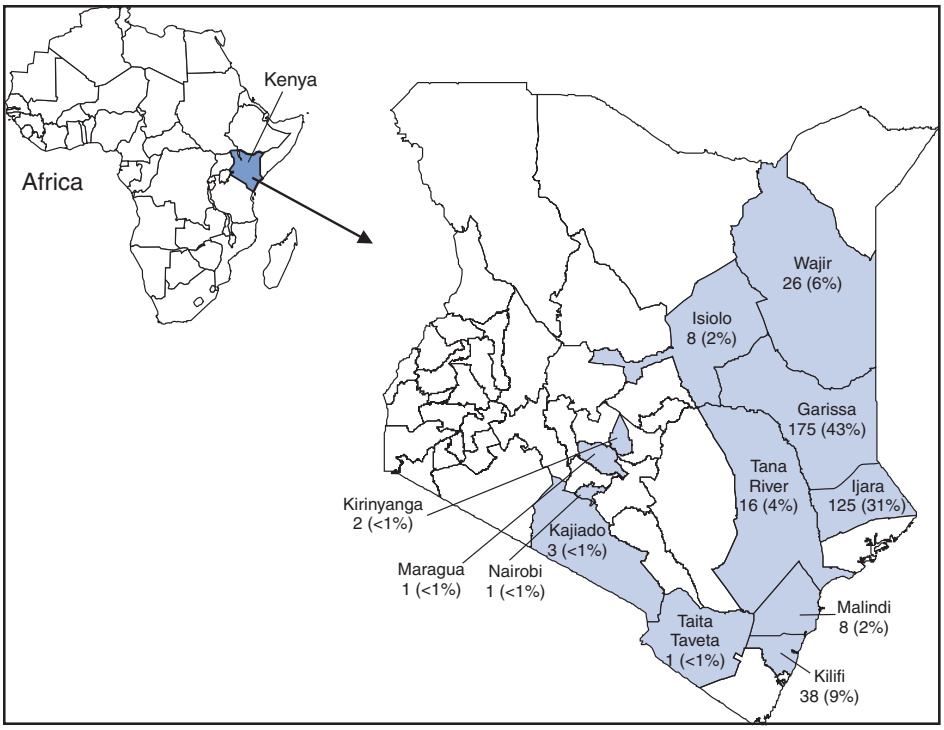
* As of January 14, 2007.

The outbreak peaked on December 24, 2006, and the number of daily cases has been declining since December 27, 2006 (Figure 3). A ban on livestock slaughtering in Garissa District went into effect on December 27 and was expanded as RVF was detected in additional districts. Vaccination of animals with live, attenuated RVF vaccine began on January 8, 2007. Prevention messages were developed in three languages (English, Kiswhali, and Somali), and public meetings (known as barazas) were held to spread information rapidly to the community. Messages also were disseminated via radio, a widely used communication medium in NEP. Village elders, chiefs, and religious leaders were consulted throughout Garissa District, leading to a district ban on the slaughter of livestock and closure of the livestock market. Health-care workers were trained to care for persons suspected to be infected with RVF virus.

Reported by: *P Nguku, S Sharif, A Omar, C Nzioka, P Muthoka, J Njau, A Dahiye, T Galgalo, J Mwihia, J Njoroge, H Limo, J Mutiso, R Kalani, A Sheikh, J Nyikal, Kenya Ministry of Health; D Mutonga, J Omollo, A Guracha, J Muindi, S Amwayi, D Langat, D Owiti, A Mohammed, Kenya Field Epidemiology and Laboratory Training Program, Kenya Ministry of Health/CDC. J Musaa, Kenya Ministry of Livestock and Fisheries Development. R Sang, Kenya Medical Research Institute. R Breiman, K Njenga, D Feikin, M Katz, H Burke, P Nyaga, M Ackers, S Gikundi, V Omballa, L Nderitu, N Wamola, R Wanjala, S Omulo, International Emerging Infections Program, Global Disease Detection Center, CDC Kenya. J Richardson, D Schnabel, S Martin, US Army Medical Research Unit-Kenya. D Hoel, H Hanafi, M Weiner, US Naval Medical Research Unit No. 3, Cairo, Egypt. J Onsongo, T Kojo, M Duale, A Hassan, M Dabaar, C Njuguna, Kenya Country Office; M Yao, African Regional Office; T Grein, P Formenty, World Health Organization, Geneva, Switzerland. B Telfer, Médecins Sans Frontières Belgium; R Lepec, Médecins Sans Frontières Epicentre, Paris, France. H Feldmann, A Grolla, Health Canada, Winnipeg, Manitoba. S Wainwright, Animal and Plant Health Inspection Svc, US Dept of Agriculture. Global Disease Detection Program, Coordinating Office for Global Health; Div of Global Migration and Quarantine, Div of Emerging Infections and Surveillance Services, National Center for Preparedness, Detection, and Control of Infectious Diseases (proposed); Special Pathogens Br, Div of Viral and Rickettisial Diseases, Div of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne and Enteric Diseases (proposed); E Lederman, E Farnon, C Rao, BK Kapella, H Gould, EIS officers, CDC.*

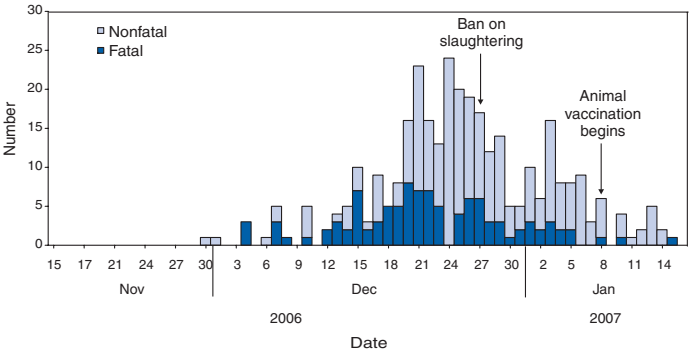
Editorial Note: RVF is an acute, febrile zoonotic disease caused by Rift Valley fever virus, which belongs to the family Bunyaviridae and genus *Phlebovirus*. The virus is primarily a vector-borne zoonotic pathogen. Humans acquire RVF through bites from infected mosquitoes or, more frequently, through exposure to the blood, body fluids, or tissues of animals that have been bitten by infected mosquitoes. Direct exposure to infected animals can occur during slaughter or through veterinary and obstetric procedures. RVF was first described in sheep in the early 20th century, and the virus was

FIGURE 2. Number and percentage of reported Rift Valley fever cases (N = 404), by district — Kenya, November 2006–January 2007*



* As of January 25, 2007.

FIGURE 3. Number of reported Rift Valley fever cases (n = 330), by date of illness onset — Kenya November 2006–January 2007*



* As of January 25, 2007, for cases with known date of onset.

first isolated in humans in Kenya in 1930 (*1,2*). In livestock, RVF causes abortion and death. Livestock epizootics can occur after heavy rainfall and flooding that result in hatching of *Aedes* mosquitoes (thought to be the initial vector and inter-epizootic reservoir of RVF) and other vectors that feed on nearby mammals (*3*). Eastern Kenya experienced unusually heavy rainfall during October–December 2006, three times the average for that period during the preceding 8 years and 13 times the rainfall in 2005 (Kenya Meteorological Department, unpublished data, 2007).

Patients with RVF usually have initial signs and symptoms of influenza-like illness; less than 8% of patients subsequently have severe disease, including generalized hemorrhagic syndrome, encephalitis, or retinitis (*2*). The overall human mortality rate from RVF has been estimated at 0.5%–1.0% of those infected, but the rate is much higher among those with severe disease. The largest reported human outbreak occurred in Kenya during 1997–1998, in which an estimated 89,000 persons (based on a systematic serosurvey) were infected and 478 died; this outbreak also was centered in NEP (*3–5*). Previous RVF outbreaks among humans were not reported outside sub-Saharan Africa until 1977–1978, when approximately 18,000 persons became ill with RVF in Egypt, and in 2000, when approximately 800 persons in Saudi Arabia and 1,000 in Yemen had severe illness (*6–8*).

Like the 1997–1998 outbreak, the current outbreak was associated with heavy rainfall, which produced massive flooding in much of Kenya, and particularly in NEP. Climatic forecasting in conjunction with satellite imaging of flooded areas has been suggested as a method for predicting where and when RVF outbreaks might occur, potentially enabling earlier interventions (*9*).

Most of the cases before December 20 occurred in young men who herded livestock, perhaps because herdsmen are the first to identify and slaughter ill animals. Later in the outbreak, the distribution of cases broadened by age and sex. Young women also were overrepresented, perhaps because they handle uncooked animal products at home as they prepare meals for the family. Cases among children aged <5 years and the elderly have been rare, probably because they rarely interact with animals or handle raw animal products.

Most patients reported to KMOH had severe illness with bleeding, which likely accounts for the 29% case-fatality rate. Judging from previous studies, many mild, undetected RVF virus infections likely occurred during this outbreak (*5*). Additional cases of severe disease also might have occurred in NEP but were not detected because of the inaccessibility of many areas of the province resulting from flooding. Many areas of NEP, including an entire division of Garissa District, were unreachable by road from early December to mid-January.

Since mid-January, RVF in livestock has been detected in districts surrounding Nairobi, signaling occurrence of the outbreak in new areas. Reports also have been received of livestock and humans with illness consistent with RVF across the border in Somalia, where disease assessment has been hampered by ongoing security concerns. Several international organizations are collaborating to control the spread of the outbreak within Kenya and to other countries. Travelers should take precautions when visiting RVF-affected areas. Generally, the risk for RVF infection among travelers to Kenya is low, unless they visit areas where an outbreak is occurring and are bitten by infected mosquitoes or come in contact with body fluids, uncooked tissue, or aerosols from infected livestock. No preventive RVF medications or licensed vaccines for humans exist. Travelers to affected areas should reduce their risk for infection by protecting themselves from mosquito bites and by avoiding direct contact with livestock. Specific recommendations for U.S. travelers are available at http://www.cdc.gov/travel/other/2006/rift_valley_fever_kenya.htm.

To control the outbreak, KMOH launched several interventions, some of which might have limited the public health impact of the outbreak. A ban on the slaughter of animals (including during Eid-ul-azha, a religious holiday) was imposed in NEP and strictly enforced. The Ministry of Livestock and Fisheries Development initiated a policy of vaccinating apparently unaffected herds of livestock in districts in which human or livestock RVF disease had been confirmed and also in adjacent districts; however, as of January 25, only a small proportion of livestock had been immunized. Other interventions included heightened disease surveillance among humans and animals, community mobilization, animal quarantines and restricted transport of livestock, and an integrated vector-control strategy, including indoor residual spraying and larviciding. RVF wards were established in which appropriate infection-control measures were encouraged.

Timely detection of this outbreak was aided by implementation of Integrated Disease Surveillance and Response* within most of the affected districts. A second factor contributing to timely detection was initiation of RVF laboratory-supported field surveillance of febrile patients at outpatient clinics in Garissa. Ongoing epidemiologic, entomologic, and veterinary studies related to this outbreak continue to 1) identify factors associated with severe forms of RVF illness and poor outcomes; 2) characterize the role of specific species of mosquitoes in transmitting, maintaining, and spreading RVF virus; 3) assess the economic impact of the outbreak; and 4) define the impact of livestock immunization with live, attenuated RVF veterinary vaccine on minimizing the spread of animal and human disease. Taking measures to decrease contact with mosquitoes through use of repellents and bednets and avoiding exposure to blood or tissues of animals that might be infected are important protective measures for preventing RVF. Livestock vaccination also can be an effective means of preventing cases of human RVF if adequate vaccination coverage and herd immunity are achieved.

*A strategy of the African Regional Office of WHO that aims to improve availability and use of surveillance and laboratory data to control infectious diseases that are the leading causes of death, disability, and illness in the region.

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West Nile Virus Transmission Through Blood Transfusion — South Dakota, 2006

West Nile virus (WNV) transmission through blood transfusion was first reported in 2002 (*1,2*), prompting rapid implementation of nationwide screening of blood donations for WNV by 2003 (*3,4*). Screening strategies were developed using minipool nucleic acid-amplification testing (MP-NAT) based on six or 16 pooled donor samples. To improve sensitivity of WNV detection, blood-collection agencies (BCAs) later implemented enhanced screening by individual donation NAT (ID-NAT), most often used when a given trigger threshold of positive MP-NAT results is reached during the WNV transmission season (*5,6*). This approach has been effective, resulting in the detection and interdiction of

approximately 1,400 potentially infectious blood donations during 2003–2005 and a reduction in recognized transfusion-transmission events (*7*). A total of 23 confirmed WNV transfusion-transmitted cases were reported in 2002, before screening was implemented; six probable or confirmed cases were detected in 2003 after MP-NAT screening was initiated, one was detected in 2004, and none were detected in 2005 (*7*). This report describes the first WNV transfusion-transmission cases detected since the initiation of enhanced screening strategies using ID-NAT triggering. In 2006, two immunosuppressed patients had onset of West Nile neuroinvasive disease (WNND) after receiving blood products from a single infected donor despite a negative MP-NAT result at the time of donation. Although risk for transmission has been substantially reduced as a result of routine MP-NAT and triggered ID-NAT screening, clinicians should be reminded that transfusion-transmitted WNV infections can still occur, and that immunosuppressed patients are more likely to have onset of WNND.

In September 2006, the South Dakota Department of Health (SDDH) was notified of WNND in a man aged 82 years with end-stage renal disease who had received a kidney transplant on August 25, 2006. Four days after the transplant surgery, the patient received a transfusion of 2 units of packed red blood cells (PRBC) for anemia. Ten days after surgery, the patient was discharged to a long-term–care facility and continued to receive immunosuppressive therapy, including 750 mg of mycophenolate mofetil twice daily, 125 mg of cyclosporin twice daily, and 20 mg of prednisone daily. Twenty-one days after surgery, he had onset of fever, lethargy, and a peri-incisional hematoma, prompting his readmission to the hospital. The patient was treated empirically with broad-spectrum antimicrobial and antifungal agents. Two days after readmission (i.e., 23 days after transplant and 19 days after PRBC transfusion), his mental status deteriorated rapidly. The next day, his cerebrospinal fluid (CSF) had four white blood cells (WBC)/mm^3, 46 red blood cells (RBC)/mm^3; a protein level of 58 mg/dL, and a glucose level of 67 mg/dL. Anti-WNV immunoglobulin M (IgM) antibody was detected in both serum and CSF by IgM antibody-capture enzyme-linked immunosorbent assay (MAC-ELISA) performed at SDDH. When the patient was discharged to a long-term–care facility (36 days after his transplant surgery), his fever had resolved, and his mental status had improved.

Because the patient had been hospitalized during the 2 weeks before onset of his WNV-related illness, WNV transmission by organ transplantation or blood transfusion was considered more likely than transmission by mosquito bite. The kidney donor's premortem serum was negative for both anti-WNV IgM and WNV RNA by MAC-ELISA and reverse transcription polymerase chain reaction (RT-PCR). One other kidney transplant recipient from the same organ donor had no symptoms of WNV disease, and serum from this recipient was negative for both anti-WNV IgM and WNV RNA. Traceback investigation revealed that the patient with WNND had received blood products from six different donors during the 8 weeks before symptom onset. No donor samples from the time of donation were available for testing. However, all donors consented to have serum collected and tested for anti-WNV IgM. One donor, the source of 1 PRBC unit transfused into the patient with WNND 4 days after transplant, was IgM positive.

The implicated blood donor was a man from a rural area of South Dakota where substantial WNV activity in birds, mosquitoes, and humans occurred during the 2006 transmission season. He had not traveled outside of South Dakota during the month before his last donation on August 4, 2006. He did not report any symptoms consistent with WNV disease during the 2 weeks before this donation or during the 3 subsequent months. Because the BCA that collected the donation did not conduct routine screening for WNV, a sample of the donor's blood was sent for screening at an out-of-state BCA, where the MP-NAT test result for six pooled samples, including his donation, was negative. The out-of-state BCA had a policy of triggering ID-NAT after two WNV-positive MP-NAT results and more than one positive in 500 results during a rolling 7-day period. Two positive MP-NAT results had been detected by the testing BCA during the month before this donation; however, the positive results occurred more than 7 days apart and therefore did not trigger ID-NAT testing.

After identification of the IgM-positive donor, the platelet and fresh frozen plasma (FFP) co-components from his whole blood donation were traced. The platelet unit had been discarded without being transfused. The FFP unit had been transfused on August 10, 2006, into a man aged 60 years who had received a kidney transplant in 2001 for end-stage renal disease attributed to insulin-dependent diabetes mellitus. On the same day as the transfusion, he had undergone surgical repair of a spinal fracture caused by a fall. He received a transfusion of 15 blood products, including 6 units of FFP, one of which was from the blood donor described in this report. One week after surgery, he was discharged to a rehabilitation facility, where he continued to receive immunosuppressive therapy, including 4 mg tacrolimus twice daily and 500 mg mycophenolate mofetil three times daily. Eleven days after the surgery, he had onset of fever and was treated empirically with antimicrobial and antifungal agents. Fifteen days after surgery, he had onset of tremors, encephalopathy, and acute left arm paralysis unexplained by his previous injury but

consistent with WNV-associated myelitis. The patient's CSF had four WBC/mm^3, zero RBC/mm^3, a protein level of 171 mg/dL, and a glucose level of 52 mg/dL. Anti-WNV IgM was detected in the CSF by MAC-ELISA at SDDH. The patient's fever, tremors, and encephalopathy resolved, but his left arm paralysis persisted at the time of transfer to an out-of-state hospital 5 days after symptom onset (20 days after surgery). Three months later, the patient remained in a long-term–care facility.

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Editorial Note: This report describes two cases of probable transfusion-transmitted WNV from a common blood donor despite a negative MP-NAT result at the time of donation. The source of infection cannot be proven because blood samples or co-components from the implicated donation were unavailable for testing; however, evidence of WNND in two recipients of blood products from a common donor with serologic evidence of recent infection makes WNV transfusion-transmission probable. Because these two transfusion recipients were hospitalized for at least 2 weeks each before onset of WNND, neither patient was likely to have acquired infection from a mosquito bite. Furthermore, for the patient who underwent transplant surgery on August 25, transmission through the transplanted kidney is unlikely, given that neither the organ donor nor the other organ recipient had evidence of WNV infection.

Nationwide blood screening for WNV has been successful in preventing transfusion-transmitted WNV (*3*). However, as with all blood donation screening, infections can be transmitted to transfusion recipients on rare occasions despite negative donor test results. Although WNV transmission by blood transfusion is rare, the cases described in this report underscore the importance of clinical recognition, effective WNV blood screening strategies, and investigation coordination.

Transfusion-transmitted WNND might be difficult to recognize, but physicians should consider the disease as a possible diagnosis, particularly when unexplained neurologic complications occur in immunosuppressed patients after transfusion. Both patients described in this report were kidney transplant recipients who were immunosuppressed when they had onset of WNND after receiving blood product transfusions. Although WNND occurs in less than 1% of WNV infections overall (the majority of which are mosquito-borne), transplant patients who acquire WNV infections have an estimated forty-fold greater risk for developing WNND compared with the general population (*8*).

The results of this investigation highlight the potential for false-negative MP-NAT results and the need to evaluate strategies for triggering ID-NAT donor screening; however, they also underscore the rarity of WNV transfusion-transmission events. Since ID-NAT triggering was fully implemented after the start of the 2004 transmission season, no transfusion-transmitted cases had been detected until the cases described in this report. Most false-negative MP-NAT results are caused by low-level viremic donor samples in which WNV is undetected by MP-NAT but is potentially identifiable by the more sensitive ID-NAT. Criteria for triggering ID-NAT differ among BCAs, but most are based on the number of positive MP-NAT results or a threshold rate for all positive results reached during a rolling 7-day period (*5*). Certain BCAs collect blood and perform NAT screening on-site; however, BCAs without the ability to screen for WNV send donor samples to remote (sometimes out-of-state) BCAs for testing. BCAs performing the testing determine when to trigger ID-NAT upon reviewing their own results.

To enhance the sensitivity of ID-NAT triggering, BCAs are considering the feasibility and utility of more standardized criteria for ID-NAT triggering and methods for enhanced communication among BCAs so that knowledge of positive screening results can be shared. BCAs face many challenges in WNV screening, including seasonal epidemics that are geographically unpredictable, limited resources for ID-NAT, and coordination of blood collection and testing that might be performed by multiple BCAs in a given geographic area. An additional tool for sharing of donor screening results might be useful to enhance ID-NAT triggering. The WNV Biovigilance Network,* currently being piloted by AABB (formerly known as the American Association of Blood Banks) to aggregate WNV blood donor screening results, is a model for successful collaboration. However, timeliness of reporting must be addressed to adapt the network for use in decisions regarding ID-NAT triggering.

Public health investigations involving patients with recent transplantation or blood transfusion are complex and often involve multiple states and local jurisdictions. Coordination among state and local health departments, clinicians, BCAs, hospital blood banks, transplant centers, and CDC often is required. Prompt reporting of suspected cases to local and state health departments, with assistance from CDC, will promote timely traceback investigations that can identify additional cases and prevent further transmission.

* Information available at http://www.aabb.org/content/programs_and_services/west_nile_virus_study/wnvstudy.htm.

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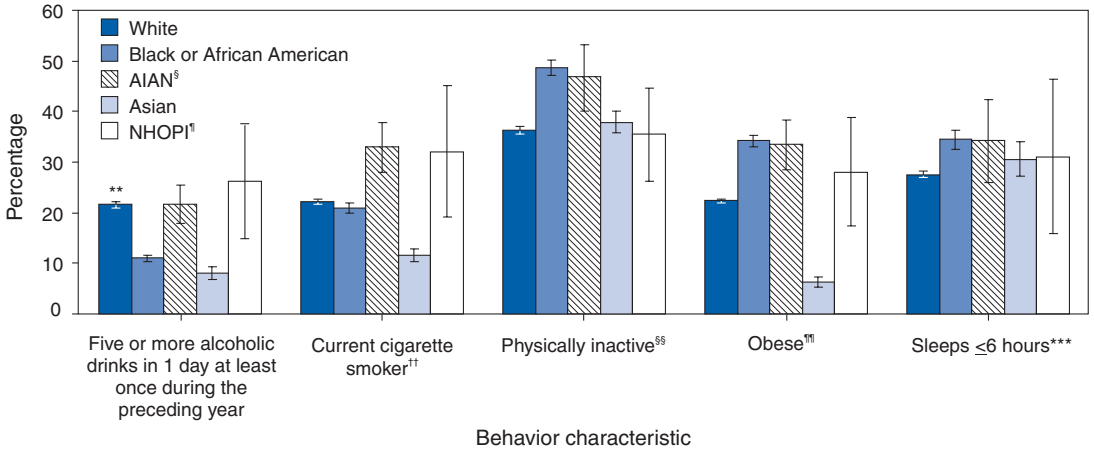
QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Prevalence of Selected Unhealthy Behavior Characteristics Among Adults Aged ≥18 Years, by Race* — National Health Interview Survey, United States, 2002–2004†



* Racial categories include persons who indicated a single race only and are consistent with the 1997 Office of Management and Budget federal guidelines for race reporting.
† Estimates are age adjusted using the 2000 projected U.S. population as the standard population and using three age groups: 18–44 years, 45–64 years, and ≥65 years. Estimates are based on household interviews of a sample of the civilian, noninstitutionalized U.S. adult population. Denominators for each percentage exclude persons with unknown health-behavior characteristics.
§ American Indian or Alaska Native.
¶ Native Hawaiian or other Pacific Islander.
** 95% confidence interval.
†† Smoked at least 100 cigarettes in lifetime and currently smoked.
§§ Never engaged in any light, moderate, or vigorous leisure-time physical activity.
¶¶ Defined as a body mass index (weight [kg] / height [m^2]) of ≥30.
*** Usual number of hours of sleep during a 24-hour period. Based on data from 2004 only.

The percentage of adults with selected unhealthy behavior characteristics varied by race during 2002–2004. Blacks and Asians had the lowest prevalence of consuming five or more alcoholic drinks in a single day; Asians also had the lowest prevalence of current cigarette smoking and obesity. AIAN had among the highest prevalences of consuming five or more drinks, current smoking, and obesity. Generally, physical inactivity was the most prevalent unhealthy behavior.

SOURCE: Adams PF, Schoenborn CA. Health behaviors of adults: United States 2002–2004. Vital Health Stat 2006;10(230). Available at http://www.cdc.gov/nchs/data/series/sr_10/sr10_230.pdf.

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending January 27, 2007 (4th Week)*

Disease	Current week	Cum 2007	5-year weekly average†	Total cases reported for previous years 2006	2005	2004	2003	2002	States reporting cases during current week (No.)
Anthrax	—	—	—	1	—	—	—	2	
Botulism:									
foodborne	—	—	0	16	19	16	20	28	
infant	—	2	2	87	85	87	76	69	
other (wound & unspecified)	—	—	0	47	31	30	33	21	
Brucellosis	—	5	2	114	120	114	104	125	
Chancroid	—	—	1	28	17	30	54	67	
Cholera	—	—	0	6	8	5	2	2	
Cyclosporiasis§	2	5	1	123	543	171	75	156	FL (2)
Diphtheria	—	—	—	—	—	—	1	1	
Domestic arboviral diseases§,¶:									
California serogroup	—	—	—	63	80	112	108	164	
eastern equine	—	—	—	7	21	6	14	10	
Powassan	—	—	—	1	1	1	—	1	
St. Louis	—	—	—	9	13	12	41	28	
western equine	—	—	—	—	—	—	—	—	
Ehrlichiosis§:									
human granulocytic	1	3	1	501	786	537	362	511	NY (1)
human monocytic	2	8	1	444	506	338	321	216	GA (1), CA (1)
human (other & unspecified)	2	4	0	191	112	59	44	23	MD (2)
Haemophilus influenzae,**									
invasive disease (age <5 yrs):									
serotype b	—	—	0	9	9	19	32	34	
nonserotype b	—	3	2	94	135	135	117	144	
unknown serotype	2	17	4	230	217	177	227	153	FL (1), AZ (1)
Hansen disease§	—	1	1	74	87	105	95	96	
Hantavirus pulmonary syndrome§	—	—	0	33	26	24	26	19	
Hemolytic uremic syndrome, postdiarrheal§	1	4	1	249	221	200	178	216	GA (1)
Hepatitis C viral, acute	3	22	18	807	652	713	1,102	1,835	OH (1), FL (2)
HIV infection, pediatric (age <13 yrs)††	—	—	4	52	380	436	504	420	
Influenza-associated pediatric mortality§,§§	—	7	1	41	45	—	N	N	
Listeriosis	10	28	8	774	896	753	696	665	NY (1), PA (1), OH (3), FL (2), CA (3)
Measles¶¶	—	—	0	51	66	37	56	44	
Meningococcal disease, invasive***:									
A, C, Y, & W-135	1	7	6	225	297	—	—	—	SD (1)
serogroup B	2	7	3	137	156	—	—	—	IN (1), FL (1)
other serogroup	—	—	1	24	27	—	—	—	
unknown serogroup	7	38	18	705	765	—	—	—	NY (1), FL (1), CA (5)
Mumps	1	21	5	6,439	314	258	231	270	CA (1)
Plague	—	—	—	16	8	3	1	2	
Poliomyelitis, paralytic	—	—	—	—	1	—	—	—	
Poliovirus infection, nonparalytic§	—	—	—	N	N	N	N	N	
Psittacosis§	—	—	0	20	16	12	12	18	
Q fever§	1	5	1	171	136	70	71	61	OR (1)
Rabies, human	—	—	0	3	2	7	2	3	
Rubella†††	—	1	0	8	11	10	7	18	
Rubella, congenital syndrome	—	—	0	1	1	—	1	1	
SARS-CoV§,§§§	—	—	—	—	—	—	8	N	
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	1	4	3	92	129	132	161	118	PA (1)
Syphilis, congenital (age <1 yr)	—	6	8	296	329	353	413	412	
Tetanus	—	—	0	32	27	34	20	25	
Toxic-shock syndrome (staphylococcal)§	1	3	2	108	90	95	133	109	PA (1)
Trichinellosis	—	1	0	13	16	5	6	14	
Tularemia	—	—	0	85	154	134	129	90	
Typhoid fever	—	8	5	268	324	322	356	321	
Vancomycin-intermediate *Staphylococcus aureus*§	—	—	—	3	2	—	N	N	
Vancomycin-resistant *Staphylococcus aureus*§	—	—	—	—	3	1	N	N	
Vibriosis (non-cholera *Vibrio* species infections)§	1	5	—	N	N	N	N	N	FL (1)
Yellow fever	—	—	—	—	—	—	—	1	

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

* Incidence data for reporting years 2006 and 2007 are provisional, whereas data for 2002, 2003, 2004, and 2005 are finalized.

† Calculated by summing the incidence counts for the current week, the 2 weeks preceding the current week, and the 2 weeks following the current week, for a total of 5 preceding years. Additional information is available at http://www.cdc.gov/epo/dphsi/phs/files/5yearweeklyaverage.pdf.

§ Not notifiable in all states. Data from states where the condition is not notifiable are excluded from this table, except in 2007 for the domestic arboviral diseases and influenza-associated pediatric mortality, and in 2004 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/epo/dphsi/phs/infdis.htm.

¶ Includes both neuroinvasive and non-neuroinvasive. Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (proposed) (ArboNET Surveillance). Data for West Nile virus are available in Table II.

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

†† Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (proposed). Implementation of HIV reporting influences the number of cases reported. Updates of pediatric HIV data have been temporarily suspended until upgrading of the national HIV/AIDS surveillance data management system is completed. Data for HIV/AIDS, when available, are displayed in Table IV, which appears quarterly.

§§ Updated weekly from reports to the Influenza Division, National Center for Immunization and Respiratory Diseases (proposed). A total of eight cases were reported for the 2006–07 flu season.

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

*** Data for meningococcal disease (all serogroups) are available in Table II.

††† No rubella cases were reported for the current week.

§§§ Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (proposed).

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending January 27, 2007, and January 28, 2006 (4th Week)*

Reporting area	Chlamydia†					Coccidioidomycosis					Cryptosporidiosis				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	13,385	19,569	21,574	49,652	65,897	205	151	367	505	393	25	67	304	128	195
New England	427	604	1,081	1,613	1,730	—	0	0	—	—	—	3	22	5	47
Connecticut	—	108	578	54	169	N	0	0	N	N	—	0	2	2	36
Maine§	—	43	65	122	145	—	0	0	—	—	—	0	6	2	4
Massachusetts	318	294	604	1,081	921	—	0	0	—	—	—	0	14	—	5
New Hampshire	24	39	71	144	127	—	0	0	—	—	—	1	5	—	1
Rhode Island§	60	57	107	167	266	—	0	0	—	—	—	0	5	—	—
Vermont§	25	20	45	45	102	N	0	0	N	N	—	0	5	1	1
Mid. Atlantic	1,936	2,414	3,341	7,027	7,819	—	0	0	—	—	2	9	31	15	36
New Jersey	177	390	562	759	1,409	N	0	0	N	N	—	0	3	—	1
New York (Upstate)	408	502	1,603	982	679	N	0	0	N	N	—	3	13	4	3
New York City	802	731	1,566	2,723	3,046	N	0	0	N	N	—	2	8	—	10
Pennsylvania	549	778	996	2,563	2,685	N	0	0	N	N	2	4	17	11	22
E.N. Central	1,594	3,104	4,094	7,210	12,550	1	1	3	3	2	7	16	110	25	34
Illinois	709	1,002	1,410	2,357	4,043	—	0	0	—	—	—	2	22	—	5
Indiana	428	389	484	1,563	1,589	—	0	0	—	—	—	1	18	—	—
Michigan	323	666	1,223	2,205	1,960	—	1	3	2	1	—	2	9	6	7
Ohio	59	658	1,424	626	3,306	1	0	2	1	1	7	5	33	18	12
Wisconsin	75	377	526	459	1,652	N	0	0	N	N	—	5	53	1	10
W.N. Central	932	1,187	1,471	3,364	4,456	—	0	1	2	—	2	12	77	20	14
Iowa	178	161	225	586	603	N	0	0	N	N	—	2	28	6	—
Kansas	284	149	284	657	495	N	0	0	N	N	1	1	8	5	4
Minnesota	—	247	321	56	1,018	—	0	0	—	—	—	3	21	1	4
Missouri	304	448	628	1,489	1,654	—	0	1	2	—	1	2	21	3	5
Nebraska§	110	102	180	350	368	N	0	0	N	N	—	1	16	3	1
North Dakota	9	32	64	46	143	N	0	0	N	N	—	0	1	—	—
South Dakota	47	51	116	180	175	N	0	0	N	N	—	1	7	2	—
S. Atlantic	3,790	3,788	5,413	11,978	11,518	—	0	1	—	2	13	17	67	50	45
Delaware	69	68	107	275	265	N	0	0	N	N	—	0	3	—	—
District of Columbia	155	58	140	327	183	—	0	0	—	—	—	0	2	—	2
Florida	967	980	1,187	3,300	2,978	N	0	0	N	N	7	7	32	26	15
Georgia	270	702	2,322	1,053	1,197	N	0	0	N	N	4	5	12	18	13
Maryland§	377	340	482	1,334	1,547	—	0	1	—	2	1	0	3	1	2
North Carolina	937	631	1,772	2,032	2,348	—	0	0	—	—	—	0	11	—	11
South Carolina§	507	347	1,452	1,911	1,099	N	0	0	N	N	1	1	13	2	—
Virginia§	463	463	712	1,597	1,793	N	0	0	N	N	—	1	5	3	2
West Virginia	45	57	97	149	108	N	0	0	N	N	—	0	3	—	—
E.S. Central	1,110	1,440	2,014	4,262	4,370	—	0	0	—	—	—	3	15	3	2
Alabama§	119	419	760	666	1,024	N	0	0	N	N	—	1	12	—	1
Kentucky	347	142	691	526	795	N	0	0	N	N	—	1	3	2	1
Mississippi	—	365	807	816	754	N	0	0	N	N	—	0	3	—	—
Tennessee§	644	512	612	2,254	1,797	N	0	0	N	N	—	1	5	1	—
W.S. Central	1,038	2,164	2,676	5,090	6,848	—	0	1	—	—	1	4	44	3	5
Arkansas§	185	154	336	630	569	N	0	0	N	N	—	0	2	—	—
Louisiana	7	190	607	135	980	—	0	1	—	—	—	0	9	1	—
Oklahoma	254	248	423	897	611	N	0	0	N	N	1	1	4	2	3
Texas§	592	1,457	1,904	3,428	4,688	N	0	0	N	N	—	1	35	—	2
Mountain	653	1,158	1,755	2,638	4,809	114	109	202	378	190	—	3	39	2	6
Arizona	467	368	881	1,541	1,411	114	105	200	378	182	—	0	3	1	2
Colorado	155	277	394	523	1,137	N	0	0	N	N	—	1	7	1	1
Idaho§	—	50	253	—	187	N	0	0	N	N	—	0	5	—	—
Montana§	—	49	143	100	70	N	0	0	N	N	—	0	26	—	1
Nevada§	—	78	397	—	666	—	1	4	—	5	—	0	1	—	—
New Mexico§	—	188	314	225	921	—	0	3	—	—	—	0	5	—	—
Utah	—	94	180	186	313	—	1	3	—	1	—	0	3	—	2
Wyoming§	31	28	54	63	104	—	0	1	—	2	—	0	11	—	—
Pacific	1,905	3,365	3,930	6,470	11,797	90	43	186	122	199	—	1	7	5	6
Alaska	68	81	152	216	249	N	0	0	N	N	—	0	1	—	—
California	1,140	2,662	3,191	4,407	9,308	90	43	186	122	199	—	0	0	—	—
Hawaii	—	105	136	32	427	N	0	0	N	N	—	0	1	—	—
Oregon§	173	177	309	552	609	N	0	0	N	N	—	1	7	5	6
Washington	524	350	604	1,263	1,204	N	0	0	N	N	—	0	0	—	—
American Samoa	U	0	46	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	236	96	198	569	270	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	U	6	16	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional. Data for HIV/AIDS, AIDS, and TB, when available, are displayed in Table IV, which appears quarterly.
† Chlamydia refers to genital infections caused by *Chlamydia trachomatis*.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 27, 2007, and January 28, 2006 (4th Week)*

Reporting area	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive All ages, all serotypes†				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	176	285	498	579	912	4,603	6,606	8,371	17,658	24,479	29	41	89	154	183
New England	2	19	44	9	57	65	97	179	279	304	—	2	12	11	7
Connecticut	—	0	25	—	—	—	26	123	17	45	—	0	8	6	—
Maine§	1	3	14	3	1	—	2	8	3	7	—	0	4	2	1
Massachusetts	—	7	18	—	42	52	46	86	200	178	—	0	7	—	6
New Hampshire	—	0	9	—	3	4	3	9	11	22	—	0	2	3	—
Rhode Island§	—	1	17	—	—	9	9	19	45	48	—	0	2	—	—
Vermont§	1	3	12	6	11	—	1	5	3	4	—	0	2	—	—
Mid. Atlantic	24	64	108	108	190	512	641	871	1,980	2,325	5	9	21	35	54
New Jersey	—	8	16	—	35	54	104	159	271	425	—	1	4	—	10
New York (Upstate)	16	25	71	49	29	123	119	286	342	245	3	3	14	6	6
New York City	3	17	30	23	64	175	175	377	686	741	1	2	6	12	17
Pennsylvania	5	15	33	36	62	160	218	299	681	914	1	3	8	17	21
E.N. Central	23	48	95	80	194	601	1,271	2,201	2,674	5,316	5	5	13	18	27
Illinois	—	9	26	—	36	224	363	521	800	1,676	—	0	6	—	6
Indiana	N	0	0	N	N	167	159	249	681	713	2	1	10	2	2
Michigan	5	14	38	36	67	136	266	880	762	813	—	0	5	1	3
Ohio	18	15	32	39	51	29	303	701	229	1,514	3	2	6	15	10
Wisconsin	—	9	24	5	40	45	130	177	202	600	—	0	3	—	6
W.N. Central	11	24	118	49	83	313	383	488	1,264	1,439	—	2	12	9	11
Iowa	2	5	15	10	15	36	37	63	138	140	—	0	1	—	—
Kansas	2	3	11	7	9	84	44	95	208	157	—	0	2	3	1
Minnesota	1	0	87	1	17	—	62	87	21	249	—	0	9	—	—
Missouri	6	9	28	24	29	151	194	264	779	785	—	0	5	5	9
Nebraska§	—	2	9	2	5	31	27	56	93	73	—	0	2	1	1
North Dakota	—	0	2	—	—	—	2	6	4	9	—	0	2	—	—
South Dakota	—	2	6	5	8	11	6	15	21	26	—	0	0	—	—
S. Atlantic	36	30	57	97	53	1,646	1,620	2,191	5,029	6,027	13	10	21	42	39
Delaware	—	0	4	1	2	36	28	44	130	110	—	0	1	1	—
District of Columbia	—	1	4	—	5	46	35	61	147	148	—	0	2	—	—
Florida	26	12	15	57	—	404	455	549	1,564	1,410	6	3	9	10	7
Georgia	4	11	28	16	12	122	351	1,037	439	525	4	2	5	14	12
Maryland§	6	4	11	13	18	128	122	183	474	677	3	1	5	14	7
North Carolina	—	0	0	—	—	571	296	766	1,139	2,357	—	0	9	—	2
South Carolina§	—	2	8	1	6	232	152	704	867	410	—	1	3	3	6
Virginia§	—	9	28	9	10	94	123	249	227	359	—	1	7	—	5
West Virginia	—	0	6	—	—	13	18	42	42	31	—	0	4	—	—
E.S. Central	—	10	42	11	26	434	576	869	1,704	1,811	—	2	7	4	11
Alabama§	—	6	30	6	12	37	193	313	331	487	—	0	5	2	2
Kentucky	N	0	0	N	N	149	55	268	230	310	—	0	1	—	1
Mississippi	N	0	0	N	N	—	146	434	294	355	—	0	1	—	—
Tennessee§	—	4	12	5	14	248	191	238	849	659	—	1	4	2	8
W.S. Central	7	6	18	15	4	400	901	1,279	2,193	3,009	2	1	25	9	6
Arkansas§	3	2	10	4	—	86	83	142	327	389	—	0	2	—	1
Louisiana	—	0	6	1	—	8	125	354	106	589	—	0	3	1	—
Oklahoma	4	2	11	10	4	107	90	184	327	209	2	1	24	8	5
Texas§	N	0	0	N	N	199	579	932	1,433	1,822	—	0	2	—	—
Mountain	24	28	68	63	92	131	245	429	615	1,160	4	4	9	17	18
Arizona	9	3	9	16	11	106	92	198	356	317	2	2	6	9	3
Colorado	10	9	33	24	25	25	72	92	157	324	2	1	4	5	9
Idaho§	1	3	12	8	14	—	2	20	—	13	—	0	1	1	1
Montana§	—	2	11	1	5	—	3	20	4	5	—	0	0	—	—
Nevada§	—	1	9	—	4	—	21	135	—	244	—	0	1	—	—
New Mexico§	—	1	6	1	5	—	31	65	53	173	—	0	2	—	3
Utah	4	7	25	12	27	—	17	26	40	65	—	0	4	2	2
Wyoming§	—	1	4	1	1	—	2	6	5	19	—	0	1	—	—
Pacific	49	57	98	147	213	501	789	971	1,920	3,088	—	2	8	9	10
Alaska	1	1	17	6	2	11	10	27	27	33	—	0	2	4	2
California	35	39	68	99	168	340	649	833	1,493	2,588	—	0	5	—	—
Hawaii	1	1	4	6	6	—	16	30	9	82	—	0	1	—	—
Oregon§	3	8	12	25	36	23	28	46	77	115	—	1	6	5	8
Washington	9	7	22	11	1	127	77	142	314	270	—	0	1	—	—
American Samoa	U	0	0	U	U	U	0	2	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	3	15	1	1	6	5	13	19	32	—	0	2	—	—
U.S. Virgin Islands	U	0	0	U	U	U	0	5	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Data for *H. influenzae* (age <5 yrs for serotype b, nonserotype b, and unknown serotype) are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 27, 2007, and January 28, 2006 (4th Week)*

Reporting area	Hepatitis (viral, acute), by type† A: Current week	A: Previous 52 weeks Med	A: Previous 52 weeks Max	A: Cum 2007	A: Cum 2006	B: Current week	B: Previous 52 weeks Med	B: Previous 52 weeks Max	B: Cum 2007	B: Cum 2006	Legionellosis: Current week	Legionellosis: Previous 52 weeks Med	Legionellosis: Previous 52 weeks Max	Legionellosis: Cum 2007	Legionellosis: Cum 2006
United States	19	63	117	76	264	29	85	130	129	266	20	47	107	75	99
New England	—	2	20	1	25	—	1	8	2	16	—	2	12	1	7
Connecticut	—	1	2	—	1	—	0	3	—	7	—	0	9	—	1
Maine§	—	0	2	—	1	—	0	2	—	1	—	0	2	—	1
Massachusetts	—	0	5	—	18	—	0	5	—	5	—	0	4	—	4
New Hampshire	—	0	16	1	4	—	0	1	—	3	—	0	1	—	—
Rhode Island§	—	0	2	—	—	—	0	4	2	—	—	0	6	—	—
Vermont§	—	0	2	—	1	—	0	1	—	—	—	0	2	1	1
Mid. Atlantic	—	7	18	6	24	1	8	20	14	46	2	14	53	18	35
New Jersey	—	1	5	—	8	—	2	8	—	17	—	2	11	2	6
New York (Upstate)	—	1	8	—	3	—	1	5	1	1	1	6	30	4	3
New York City	—	2	10	3	9	—	2	5	—	10	—	2	16	—	10
Pennsylvania	—	1	5	3	4	1	3	9	13	18	1	5	19	12	16
E.N. Central	4	6	13	9	22	7	8	16	31	31	3	8	26	17	12
Illinois	—	1	4	—	3	—	1	7	—	5	—	0	2	—	5
Indiana	—	0	8	—	1	—	0	7	—	—	1	0	5	1	—
Michigan	2	2	7	6	10	—	3	6	12	15	—	3	11	6	3
Ohio	2	0	4	3	6	7	2	10	16	10	2	3	19	10	3
Wisconsin	—	0	4	—	2	—	0	3	3	1	—	0	3	—	1
W.N. Central	1	2	8	4	8	1	3	9	8	6	3	1	15	5	4
Iowa	—	0	1	1	—	—	0	3	1	—	—	0	3	—	—
Kansas	—	0	5	—	4	—	0	2	—	2	—	0	2	—	—
Minnesota	—	0	7	—	—	—	0	5	—	—	1	0	11	1	—
Missouri	1	1	3	3	2	1	1	6	6	4	2	0	2	4	4
Nebraska§	—	0	2	—	1	—	0	3	1	—	—	0	2	—	—
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	3	—	1	—	0	1	—	—	—	0	1	—	—
S. Atlantic	3	9	29	16	34	12	23	42	38	86	8	9	21	24	21
Delaware	—	0	2	—	1	—	1	4	—	3	—	0	2	—	1
District of Columbia	—	0	1	—	1	—	0	2	—	—	—	0	5	—	—
Florida	2	4	13	11	18	10	7	16	23	34	5	3	10	11	5
Georgia	1	1	6	3	3	—	3	9	4	9	—	0	3	2	1
Maryland§	—	1	6	—	7	2	2	9	7	15	3	2	7	10	10
North Carolina	—	0	20	—	3	—	0	23	—	19	—	0	5	—	3
South Carolina§	—	0	3	1	1	—	2	4	1	6	—	0	2	—	—
Virginia§	—	1	7	1	—	—	1	4	2	—	—	1	5	1	1
West Virginia	—	0	3	—	—	—	0	7	1	—	—	0	3	—	—
E.S. Central	—	2	8	2	6	—	8	21	6	20	1	2	9	3	3
Alabama§	—	0	3	—	—	—	3	13	4	5	—	0	2	—	—
Kentucky	—	0	5	1	—	—	1	5	—	5	1	0	5	3	1
Mississippi	—	0	1	1	—	—	1	4	—	3	—	0	2	—	—
Tennessee§	—	1	5	—	6	—	2	7	2	7	—	1	7	—	2
W.S. Central	—	6	20	2	7	—	18	58	5	18	—	1	12	2	—
Arkansas§	—	0	9	—	1	—	1	4	—	3	—	0	1	—	—
Louisiana	—	0	4	2	—	—	0	5	2	1	—	0	2	—	—
Oklahoma	—	0	3	—	—	—	0	14	—	—	—	0	6	—	—
Texas§	—	5	15	—	6	—	14	39	3	14	—	1	12	2	—
Mountain	4	5	17	12	22	—	2	9	3	13	3	2	8	5	5
Arizona	3	3	16	11	8	—	0	4	—	4	1	1	4	1	—
Colorado	1	1	3	1	4	—	0	4	—	3	1	0	2	1	1
Idaho§	—	0	2	—	2	—	0	2	1	2	—	0	3	—	1
Montana§	—	0	3	—	—	—	0	0	—	—	—	0	1	—	—
Nevada§	—	0	1	—	3	—	0	5	—	2	—	0	1	—	3
New Mexico§	—	0	2	—	3	—	0	2	2	2	—	0	1	2	—
Utah	—	0	2	—	2	—	0	5	—	—	1	0	6	1	—
Wyoming§	—	0	1	—	—	—	0	1	—	—	—	0	0	—	—
Pacific	7	16	53	24	116	8	11	25	22	30	—	1	9	—	12
Alaska	—	0	0	—	—	—	0	3	1	—	—	0	0	—	—
California	7	14	48	20	109	7	8	20	16	22	—	1	9	—	12
Hawaii	—	0	3	—	2	—	0	1	—	—	—	0	0	—	—
Oregon§	—	1	4	3	3	1	1	5	4	8	—	0	0	—	—
Washington	—	1	4	1	2	—	1	6	1	—	—	0	0	—	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	1	9	—	3	1	1	9	1	1	—	0	4	—	—
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Data for acute hepatitis C, viral are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 27, 2007, and January 28, 2006 (4th Week)*

Reporting area	Lyme disease					Malaria					Meningococcal disease, invasive† All serogroups				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	36	242	1,003	291	303	8	23	39	35	90	11	20	45	52	101
New England	3	19	260	14	16	—	0	6	—	3	1	1	3	2	5
Connecticut	1	8	227	5	1	—	0	3	—	—	—	0	2	1	2
Maine§	—	2	34	5	3	—	0	1	—	—	—	0	2	1	2
Massachusetts	—	0	3	—	8	—	0	3	—	2	—	0	2	—	1
New Hampshire	1	3	95	2	3	—	0	3	—	—	1	0	2	—	—
Rhode Island§	—	0	93	—	1	—	0	1	—	—	—	0	1	—	—
Vermont§	1	1	15	2	—	—	0	1	—	1	—	0	1	—	—
Mid. Atlantic	11	142	558	174	185	—	5	14	5	21	1	3	11	7	21
New Jersey	—	27	185	3	67	—	0	3	—	7	—	0	2	—	2
New York (Upstate)	7	59	250	33	12	—	1	8	3	1	1	0	4	1	2
New York City	—	1	18	—	—	—	3	9	2	9	—	1	4	2	9
Pennsylvania	4	43	233	138	106	—	1	4	—	4	—	0	4	4	8
E.N. Central	—	11	153	1	24	1	2	7	5	12	1	2	12	6	12
Illinois	—	0	0	—	—	—	1	5	2	6	—	0	3	—	6
Indiana	—	0	3	—	—	—	0	3	—	—	1	0	5	1	—
Michigan	—	0	5	1	2	1	0	2	1	1	—	0	3	2	2
Ohio	—	0	5	—	2	—	0	3	2	2	—	1	4	3	2
Wisconsin	—	10	149	—	20	—	0	2	—	3	—	0	2	—	2
W.N. Central	—	5	169	—	—	—	0	14	3	4	1	1	4	6	4
Iowa	—	1	8	—	—	—	0	1	1	—	—	0	2	1	—
Kansas	—	0	2	—	—	—	0	2	—	—	—	0	1	—	—
Minnesota	—	2	167	—	—	—	0	12	1	2	—	0	3	—	—
Missouri	—	0	2	—	—	—	0	1	—	1	—	0	2	4	1
Nebraska§	—	0	2	—	—	—	0	1	1	—	—	0	1	—	3
North Dakota	—	0	0	—	—	—	0	1	—	—	—	0	1	—	—
South Dakota	—	0	1	—	—	—	0	0	—	1	1	0	1	1	—
S. Atlantic	19	34	124	94	73	7	6	14	18	25	2	4	14	13	9
Delaware	3	7	28	23	23	—	0	1	—	—	—	0	1	—	1
District of Columbia	—	0	7	—	2	—	0	2	—	—	—	0	1	—	—
Florida	1	1	5	4	1	3	1	4	6	3	2	2	7	7	2
Georgia	—	0	1	—	1	1	1	6	3	8	—	0	3	2	1
Maryland§	14	16	81	63	41	1	1	5	5	6	—	0	2	2	3
North Carolina	—	0	4	—	5	1	0	4	2	3	—	0	11	—	—
South Carolina§	—	0	2	—	—	—	0	2	—	—	—	0	2	2	—
Virginia§	1	4	31	4	—	1	1	4	2	5	—	0	4	—	2
West Virginia	—	0	8	—	—	—	0	1	—	—	—	0	2	—	—
E.S. Central	—	0	3	—	—	—	0	3	1	1	—	1	3	2	1
Alabama§	—	0	3	—	—	—	0	2	—	1	—	0	2	—	—
Kentucky	—	0	2	—	—	—	0	1	—	—	—	0	1	—	1
Mississippi	—	0	1	—	—	—	0	1	1	—	—	0	2	2	—
Tennessee§	—	0	2	—	—	—	0	2	—	—	—	0	2	—	—
W.S. Central	1	0	5	1	—	—	1	7	—	3	—	1	4	2	1
Arkansas§	—	0	0	—	—	—	0	2	—	—	—	0	1	—	1
Louisiana	—	0	0	—	—	—	0	1	—	—	—	0	2	1	—
Oklahoma	—	0	0	—	—	—	0	2	—	1	—	0	3	—	—
Texas§	1	0	5	1	—	—	1	6	—	2	—	0	3	1	—
Mountain	—	0	3	1	—	—	1	6	—	3	—	1	5	1	10
Arizona	—	0	2	—	—	—	0	3	—	1	—	0	3	—	2
Colorado	—	0	1	—	—	—	0	2	—	1	—	0	2	—	6
Idaho§	—	0	2	—	—	—	0	1	—	—	—	0	1	1	—
Montana§	—	0	1	1	—	—	0	1	—	—	—	0	1	—	—
Nevada§	—	0	1	—	—	—	0	1	—	—	—	0	1	—	—
New Mexico§	—	0	1	—	—	—	0	1	—	—	—	0	1	—	—
Utah	—	0	1	—	—	—	0	2	—	1	—	0	1	—	2
Wyoming§	—	0	1	—	—	—	0	0	—	—	—	0	2	—	—
Pacific	2	3	13	6	5	—	4	13	3	18	5	5	16	13	38
Alaska	—	0	1	—	—	—	0	4	—	2	—	0	1	—	1
California	2	2	13	6	5	—	3	6	—	15	5	3	10	10	20
Hawaii	N	0	0	N	N	—	0	2	—	—	—	0	2	1	—
Oregon§	—	0	2	—	—	—	0	3	3	1	—	0	4	1	13
Washington	—	0	1	—	—	—	0	4	—	—	—	0	5	1	4
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	—	—
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	—	—
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	N	0	0	N	N	—	0	1	—	—	—	0	1	—	—
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Data for meningococcal disease, invasive caused by serogroups A, C, Y, & W-135; serogroup B; other serogroup; and unknown serogroup are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 27, 2007, and January 28, 2006 (4th Week)*

Reporting area	Pertussis					Rabies, animal					Rocky Mountain spotted fever				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	70	257	488	327	957	46	112	231	127	367	1	31	118	11	143
New England	2	21	53	5	130	7	12	26	28	28	—	0	1	—	—
Connecticut	—	1	9	—	9	4	4	14	19	5	—	0	0	—	—
Maine†	2	1	12	5	9	—	2	8	2	4	N	0	0	N	N
Massachusetts	—	11	28	—	103	—	3	17	—	13	—	0	1	—	—
New Hampshire	—	2	27	—	—	1	1	5	4	1	—	0	1	—	—
Rhode Island†	—	0	11	—	—	—	0	3	1	1	—	0	1	—	—
Vermont†	—	1	14	—	9	2	1	5	2	4	—	0	0	—	—
Mid. Atlantic	35	36	126	109	96	3	17	57	8	34	—	1	6	2	2
New Jersey	—	4	13	1	34	—	0	0	—	—	—	0	1	—	—
New York (Upstate)	30	18	121	80	8	—	0	0	—	—	—	0	2	—	—
New York City	—	1	8	—	5	3	1	5	8	—	—	0	3	—	—
Pennsylvania	5	12	26	28	49	—	16	56	—	34	—	1	4	2	2
E.N. Central	4	41	77	69	182	—	2	18	—	1	—	1	6	1	1
Illinois	—	8	17	—	62	—	0	7	—	—	—	0	2	—	1
Indiana	—	4	23	—	—	—	0	2	—	—	—	0	1	—	—
Michigan	4	12	39	12	19	—	0	5	—	1	—	0	1	1	—
Ohio	—	12	25	57	70	—	0	9	—	—	—	0	4	—	—
Wisconsin	—	3	9	—	31	—	0	0	—	—	—	0	1	—	—
W.N. Central	2	21	71	30	161	6	6	20	8	9	—	2	14	3	—
Iowa	—	5	15	6	51	1	1	7	1	2	—	0	1	—	—
Kansas	2	5	16	18	50	3	1	5	4	2	—	0	1	1	—
Minnesota	—	0	56	—	—	2	0	6	2	—	—	0	2	—	—
Missouri	—	5	14	5	45	—	1	6	1	—	—	2	12	2	—
Nebraska†	—	1	9	1	15	—	0	0	—	—	—	0	5	—	—
North Dakota	—	0	9	—	—	—	0	7	—	—	—	0	0	—	—
South Dakota	—	0	4	—	—	—	0	4	—	5	—	0	0	—	—
S. Atlantic	11	17	47	37	76	27	41	183	70	236	1	13	68	4	139
Delaware	—	0	1	—	1	—	0	0	—	—	—	0	3	1	—
District of Columbia	—	0	2	—	—	—	0	0	—	—	—	0	1	—	—
Florida	7	4	20	16	19	3	0	167	11	167	—	0	5	—	1
Georgia	—	0	3	—	3	—	5	10	—	15	1	1	5	1	—
Maryland†	3	2	7	10	25	—	6	13	—	12	—	1	6	1	4
North Carolina	—	0	33	—	17	4	9	22	22	13	—	5	61	—	133
South Carolina†	1	3	11	2	11	—	3	11	3	9	—	0	5	—	1
Virginia†	—	3	19	9	—	20	11	27	30	14	—	2	13	1	—
West Virginia	—	0	9	—	—	—	2	7	4	6	—	0	2	—	—
E.S. Central	—	6	28	6	25	—	4	16	—	12	—	6	31	—	1
Alabama†	—	2	19	4	7	—	1	8	—	2	—	2	11	—	—
Kentucky	—	0	5	—	2	—	0	4	—	—	—	0	1	—	—
Mississippi	—	1	4	1	6	—	0	2	—	—	—	0	1	—	—
Tennessee†	—	3	11	1	10	—	2	9	—	10	—	4	22	—	1
W.S. Central	—	18	35	—	12	1	8	34	2	36	—	1	27	—	—
Arkansas†	—	1	7	—	3	—	0	5	—	1	—	0	10	—	—
Louisiana	—	0	2	—	1	—	0	0	—	—	—	0	1	—	—
Oklahoma	—	0	9	—	—	1	1	9	2	3	—	0	18	—	—
Texas†	—	16	32	—	8	—	7	29	—	32	—	0	4	—	—
Mountain	16	43	88	59	230	—	3	27	2	8	—	0	5	1	—
Arizona	2	7	29	5	15	—	2	10	2	8	—	0	2	—	—
Colorado	2	10	39	30	132	—	0	0	—	—	—	0	1	1	—
Idaho†	—	1	7	5	15	—	0	25	—	—	—	0	3	—	—
Montana†	1	1	9	2	12	—	0	2	—	—	—	0	2	—	—
Nevada†	—	0	9	—	9	—	0	1	—	—	—	0	1	—	—
New Mexico†	1	2	8	1	4	—	0	2	—	—	—	0	2	—	—
Utah	8	13	39	10	37	—	0	1	—	—	—	0	2	—	—
Wyoming†	2	1	8	6	6	—	0	2	—	—	—	0	1	—	—
Pacific	—	28	228	12	45	2	4	12	9	3	—	0	1	—	—
Alaska	—	1	8	8	6	1	0	4	7	1	N	0	0	N	N
California	—	21	225	—	5	1	3	11	2	2	—	0	1	—	—
Hawaii	—	1	6	—	14	N	0	0	N	N	N	0	0	N	N
Oregon†	—	2	8	3	17	—	0	4	—	—	—	0	1	—	—
Washington	—	5	46	1	3	—	0	0	—	—	N	0	0	N	N
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	N	0	0	N	N
Puerto Rico	—	0	1	—	—	1	1	6	6	6	N	0	0	N	N
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 27, 2007, and January 28, 2006 (4th Week)*

Reporting area	Salmonellosis					Shiga toxin-producing *E. coli* (STEC)†					Shigellosis				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006
United States	355	744	1,365	1,442	2,310	23	57	148	80	129	138	258	477	512	776
New England	3	20	80	40	536	1	2	16	1	77	—	3	14	4	83
Connecticut	—	0	19	19	479	—	0	0	—	72	—	0	3	3	64
Maine§	1	2	10	11	3	—	0	8	—	1	—	0	2	1	—
Massachusetts	—	15	53	—	47	—	1	9	—	3	—	2	11	—	17
New Hampshire	2	4	25	2	5	1	0	3	1	1	—	0	2	—	2
Rhode Island§	—	1	10	5	—	—	0	2	—	—	—	0	3	—	—
Vermont§	—	1	6	3	2	—	0	1	—	—	—	0	2	—	—
Mid. Atlantic	38	88	190	180	232	4	6	64	11	6	2	16	43	16	61
New Jersey	—	14	49	2	40	—	0	4	—	1	—	3	35	—	28
New York (Upstate)	20	26	70	53	20	—	0	4	—	—	1	4	36	4	11
New York City	3	23	50	39	76	—	0	4	—	—	1	4	13	9	18
Pennsylvania	15	29	67	86	96	1	2	48	6	4	—	1	6	3	4
E.N. Central	29	96	194	129	265	7	10	56	20	14	1	20	46	14	61
Illinois	—	23	57	8	95	—	1	7	—	—	—	7	34	1	30
Indiana	—	15	55	2	3	—	1	8	—	2	—	2	17	5	1
Michigan	3	18	35	22	51	—	1	6	3	3	—	3	8	—	17
Ohio	26	24	56	85	67	7	3	18	17	4	1	3	14	8	6
Wisconsin	—	16	27	12	49	—	2	39	—	5	—	3	10	—	7
W.N. Central	18	47	109	104	138	5	11	35	15	19	20	34	77	74	104
Iowa	—	8	26	11	30	—	2	22	1	4	—	2	13	3	2
Kansas	4	7	16	23	14	1	0	4	3	—	—	2	11	2	5
Minnesota	7	11	60	13	22	3	4	27	5	6	13	3	24	20	6
Missouri	7	14	35	38	48	—	0	0	—	—	7	9	69	44	68
Nebraska§	—	4	9	11	13	—	0	8	—	—	—	1	14	—	15
North Dakota	—	0	5	—	—	—	0	0	—	—	—	0	18	—	—
South Dakota	—	3	7	8	11	—	0	5	—	—	—	6	24	5	8
S. Atlantic	145	220	397	595	537	5	9	27	25	5	73	61	148	265	160
Delaware	—	3	10	5	5	—	0	3	2	—	—	0	2	1	—
District of Columbia	—	1	4	—	5	—	0	1	—	—	—	0	2	—	2
Florida	78	95	176	285	217	2	2	9	8	3	55	28	76	142	66
Georgia	19	32	72	117	94	—	1	7	3	2	16	23	59	113	53
Maryland§	12	13	33	41	44	3	2	8	9	—	1	2	10	5	12
North Carolina	29	30	130	102	129	—	2	11	—	12	—	1	21	—	18
South Carolina§	3	18	51	21	33	—	0	2	—	1	1	1	9	3	9
Virginia§	4	20	57	23	10	—	0	0	—	—	—	2	9	1	—
West Virginia	—	1	16	1	—	—	0	5	—	—	—	0	2	—	—
E.S. Central	6	60	153	68	122	—	3	21	2	3	1	14	84	30	67
Alabama§	2	24	95	23	42	—	0	5	—	—	1	5	75	12	7
Kentucky	4	8	23	28	23	—	1	12	1	3	—	3	15	5	43
Mississippi	—	12	42	5	21	—	0	0	—	—	—	2	13	1	14
Tennessee§	—	15	32	12	36	—	0	4	—	6	—	3	12	12	3
W.S. Central	8	67	179	34	79	—	1	19	2	—	10	36	138	30	43
Arkansas§	5	15	46	13	18	—	0	7	1	—	1	2	10	2	4
Louisiana	—	15	42	7	20	—	0	0	—	—	—	1	25	3	—
Oklahoma	3	8	40	14	14	—	0	17	1	—	—	2	9	2	6
Texas§	—	31	102	—	27	—	2	13	—	—	9	29	125	23	33
Mountain	29	50	88	118	130	1	4	17	3	5	15	25	87	37	52
Arizona	15	17	41	54	28	1	2	13	2	—	12	12	35	26	27
Colorado	9	12	30	35	44	—	1	8	—	5	2	3	15	5	7
Idaho§	2	3	9	10	9	—	1	7	—	3	—	0	3	—	2
Montana§	—	2	10	6	9	—	0	0	—	—	—	0	13	2	—
Nevada§	—	3	20	4	15	—	0	5	—	1	—	1	20	—	3
New Mexico§	—	4	15	1	12	—	0	1	—	1	—	2	15	3	9
Utah	2	5	15	6	11	—	1	14	1	2	1	1	6	1	3
Wyoming§	1	1	4	2	2	—	0	3	—	—	—	0	19	—	1
Pacific	79	114	181	174	271	—	4	17	1	—	16	34	87	42	145
Alaska	—	1	4	1	9	N	0	0	N	N	2	0	2	2	—
California	69	89	158	138	214	—	0	0	—	N	13	29	76	28	105
Hawaii	1	5	16	13	18	—	0	2	1	—	—	1	4	1	4
Oregon§	—	8	16	12	27	—	0	1	—	—	—	1	31	8	33
Washington	9	10	46	10	3	—	2	12	—	—	1	2	13	3	3
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	N	0	0	N	N	—	0	0	—	—
Puerto Rico	—	11	47	2	9	—	0	0	—	—	—	0	6	—	1
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Includes *E. coli* O157:H7; Shiga toxin-positive, serogroup non-O157; and Shiga toxin-positive, not serogrouped.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 27, 2007, and January 28, 2006 (4th Week)*

Reporting area	Streptococcal disease, invasive, group A					*Streptococcus pneumoniae*, invasive disease† Age <5 years				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max		
United States	62	84	216	237	398	13	24	60	68	69
New England	—	3	15	6	16	—	1	4	2	2
Connecticut	—	0	0	—	—	—	0	0	—	—
Maine§	—	0	2	1	2	—	0	2	—	—
Massachusetts	—	1	5	—	13	—	0	4	—	2
New Hampshire	—	0	9	1	1	—	0	4	1	—
Rhode Island§	—	0	2	—	—	—	0	3	—	—
Vermont§	—	0	2	4	—	—	0	1	1	—
Mid. Atlantic	8	17	40	37	84	3	3	13	12	12
New Jersey	—	2	8	—	18	—	1	4	—	6
New York (Upstate)	6	5	22	14	12	3	2	13	12	5
New York City	—	2	8	3	21	—	0	2	—	1
Pennsylvania	2	6	13	20	33	N	0	0	N	N
E.N. Central	13	13	46	51	93	3	6	14	17	20
Illinois	—	2	12	5	37	—	1	6	—	4
Indiana	2	2	11	5	2	2	0	10	2	—
Michigan	—	3	12	8	23	—	1	5	8	6
Ohio	11	4	19	33	24	1	2	7	6	6
Wisconsin	—	1	4	—	7	—	0	2	1	4
W.N. Central	6	5	57	19	23	1	2	10	6	3
Iowa	—	0	0	—	—	—	0	0	—	—
Kansas	3	1	3	5	13	—	0	3	2	2
Minnesota	—	0	52	—	—	—	1	7	—	—
Missouri	3	1	5	12	4	1	0	2	4	1
Nebraska§	—	0	4	—	6	—	0	2	—	—
North Dakota	—	0	2	—	—	—	0	1	—	—
South Dakota	—	0	2	2	—	—	0	0	—	—
S. Atlantic	18	22	45	61	96	1	1	7	15	9
Delaware	—	0	2	—	1	—	0	0	—	—
District of Columbia	—	0	2	—	3	—	0	1	—	—
Florida	7	5	16	19	26	—	0	1	1	—
Georgia	4	5	12	15	27	—	0	2	5	—
Maryland§	4	4	12	17	17	—	1	5	7	8
North Carolina	—	0	26	—	5	—	0	0	—	—
South Carolina§	—	1	6	5	9	—	0	1	1	—
Virginia§	3	2	9	5	8	1	0	0	1	—
West Virginia	—	0	6	—	—	—	0	2	—	1
E.S. Central	1	3	11	7	16	—	0	2	—	3
Alabama§	N	0	0	N	N	N	0	0	N	N
Kentucky	1	0	5	4	2	—	0	0	—	—
Mississippi	N	0	0	N	N	—	0	2	—	3
Tennessee§	—	2	9	3	14	—	0	0	—	—
W.S. Central	6	7	18	15	24	2	4	28	6	7
Arkansas§	1	0	5	2	1	1	0	2	1	2
Louisiana	—	0	2	—	—	—	0	1	1	—
Oklahoma	2	2	8	8	12	1	1	12	3	5
Texas§	3	4	14	5	11	—	2	13	1	—
Mountain	9	11	42	37	34	3	3	12	10	13
Arizona	3	5	34	12	10	2	2	9	8	8
Colorado	4	2	7	13	11	1	1	4	1	4
Idaho§	—	0	1	1	1	—	0	1	—	—
Montana§	N	0	0	N	N	N	0	0	N	N
Nevada§	—	0	3	—	—	—	0	0	—	—
New Mexico§	—	1	5	5	3	—	0	3	1	1
Utah	2	1	5	5	8	—	0	0	—	—
Wyoming§	—	0	1	1	1	—	0	0	—	—
Pacific	1	2	9	4	12	—	0	1	—	—
Alaska	—	0	1	1	N	—	0	0	—	—
California	N	0	0	N	N	N	0	0	N	N
Hawaii	1	2	9	3	12	—	0	1	—	—
Oregon§	N	0	0	N	N	N	0	0	N	N
Washington	N	0	0	N	N	N	0	0	N	N
American Samoa	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	N	0	0	N	N
Puerto Rico	—	0	0	—	—	N	0	0	N	N
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Includes cases of invasive pneumococcal disease, in children aged <5 years, caused by *S. pneumoniae*, which is susceptible or for which susceptibility testing is not available (NNDSS event code 11717).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 27, 2007, and January 28, 2006 (4th Week)*

Reporting area	*Streptococcus pneumoniae*, invasive disease, drug resistant†										Syphilis, primary and secondary				
	All ages					Age <5 years									
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	44	45	96	206	250	6	6	18	23	26	125	177	231	418	618
New England	—	0	3	2	1	—	0	1	—	1	5	3	10	11	15
Connecticut	—	0	0	—	—	—	0	0	—	—	—	0	6	—	—
Maine§	—	0	2	—	—	—	0	1	—	—	—	0	2	—	1
Massachusetts	—	0	0	—	—	—	0	0	—	—	2	2	7	7	11
New Hampshire	—	0	0	—	—	—	0	0	—	—	3	0	2	4	3
Rhode Island§	—	0	2	—	—	—	0	1	—	—	—	0	2	—	—
Vermont§	—	0	2	2	1	—	0	1	—	1	—	0	1	—	—
Mid. Atlantic	4	3	8	21	13	1	0	3	4	1	23	23	35	83	56
New Jersey	—	0	0	—	—	—	0	0	—	—	5	3	8	9	10
New York (Upstate)	1	1	5	3	2	1	0	2	1	—	—	3	9	5	4
New York City	—	0	0	—	—	—	0	0	—	—	18	11	23	52	32
Pennsylvania	3	2	6	18	11	—	0	2	3	1	—	5	12	17	10
E.N. Central	19	10	39	73	53	3	1	7	7	6	14	15	32	31	82
Illinois	—	0	2	—	4	—	0	1	—	—	—	7	13	1	54
Indiana	3	2	23	12	3	—	0	5	—	—	1	1	5	2	9
Michigan	—	0	3	—	5	—	0	1	—	—	4	2	10	10	1
Ohio	16	5	37	61	41	3	1	5	7	6	7	3	8	14	15
Wisconsin	N	0	0	N	N	—	0	0	—	—	2	1	4	4	3
W.N. Central	1	1	51	6	5	—	0	10	1	1	3	5	13	9	18
Iowa	—	0	0	—	—	—	0	0	—	—	—	0	3	—	1
Kansas	—	0	0	—	—	—	0	0	—	—	—	0	3	1	3
Minnesota	—	0	50	—	—	—	0	10	—	—	—	0	2	3	4
Missouri	1	1	2	6	5	—	0	1	—	1	3	3	8	5	10
Nebraska§	—	0	1	—	—	—	0	0	—	—	—	0	2	—	—
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	1	—	—
South Dakota	—	0	3	—	—	—	0	1	1	—	—	0	3	—	—
S. Atlantic	20	21	45	90	145	2	2	8	11	8	43	41	78	145	126
Delaware	—	0	0	—	—	—	0	0	—	—	1	0	3	1	4
District of Columbia	—	0	3	—	3	—	0	2	—	—	6	2	7	10	8
Florida	10	12	29	49	47	2	2	8	11	8	22	15	23	68	56
Georgia	10	7	28	39	93	—	0	1	—	—	—	7	48	—	—
Maryland§	—	0	0	—	—	—	0	0	—	—	6	5	14	25	19
North Carolina	—	0	0	—	—	—	0	0	—	—	1	5	20	23	24
South Carolina§	—	0	0	—	—	—	0	0	—	—	2	1	5	8	5
Virginia§	N	0	0	N	N	—	0	0	—	—	5	3	17	10	10
West Virginia	—	1	14	2	2	—	0	1	—	—	—	0	2	—	—
E.S. Central	—	2	11	4	16	—	0	2	—	3	8	14	29	37	31
Alabama§	N	0	0	N	N	—	0	0	—	—	3	6	18	12	13
Kentucky	—	0	3	2	5	—	0	2	—	—	1	1	9	7	5
Mississippi	—	0	0	—	—	—	0	0	—	—	—	1	8	—	3
Tennessee§	—	2	10	2	11	—	0	2	—	3	4	5	13	18	10
W.S. Central	—	0	5	8	2	—	0	2	—	—	16	28	54	59	94
Arkansas§	—	0	3	—	2	—	0	2	—	—	1	1	6	3	1
Louisiana	—	0	2	—	—	—	0	1	—	—	5	4	27	9	4
Oklahoma	—	0	4	8	—	—	0	0	—	—	3	1	4	9	3
Texas§	—	0	0	—	—	—	0	0	—	—	7	20	34	38	86
Mountain	—	1	7	2	15	—	0	5	—	6	9	8	26	15	25
Arizona	—	0	0	—	—	—	0	0	—	—	9	3	16	10	9
Colorado	—	0	0	—	—	—	0	0	—	—	—	1	5	—	5
Idaho§	N	0	0	N	N	—	0	0	—	—	—	0	1	—	1
Montana§	—	0	0	—	—	—	0	0	—	—	—	0	1	—	—
Nevada§	—	0	2	1	2	—	0	1	—	—	—	1	12	—	8
New Mexico§	—	0	0	—	—	—	0	0	—	—	—	1	5	5	2
Utah	—	0	7	—	11	—	0	4	—	6	—	0	2	—	—
Wyoming§	—	1	3	1	2	—	0	2	—	—	—	0	0	—	—
Pacific	—	0	0	—	—	—	0	0	—	—	4	36	50	28	171
Alaska	—	0	0	—	—	—	0	0	—	—	—	0	4	—	—
California	N	0	0	N	N	—	0	0	—	—	2	32	43	22	148
Hawaii	—	0	0	—	—	—	0	0	—	—	—	0	2	—	1
Oregon§	N	0	0	N	N	—	0	0	—	—	—	0	6	1	2
Washington	N	0	0	N	N	—	0	0	—	—	2	2	11	5	20
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
Puerto Rico	N	0	0	N	N	—	0	0	—	—	4	3	10	10	8
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Includes cases of invasive pneumococcal disease caused by drug-resistant *S. pneumoniae* (DRSP) (NNDSS event code 11720).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 27, 2007, and January 28, 2006 (4th Week)*

Reporting area	Varicella (chickenpox)					West Nile virus disease†									
						Neuroinvasive					Non-neuroinvasive§				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	427	837	1,432	2,206	3,167	—	1	178	—	2	—	1	399	—	—
New England	6	28	59	39	173	—	0	3	—	—	—	0	2	—	—
Connecticut	—	0	0	—	—	—	0	3	—	—	—	0	1	—	—
Maine¶	—	0	16	—	38	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	17	—	46	—	0	1	—	—	—	0	1	—	—
New Hampshire	4	6	47	18	28	—	0	0	—	—	—	0	0	—	—
Rhode Island¶	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Vermont¶	2	12	50	21	61	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	122	106	180	472	533	—	0	11	—	—	—	0	4	—	—
New Jersey	N	0	0	N	N	—	0	2	—	—	—	0	1	—	—
New York (Upstate)	N	0	0	N	N	—	0	5	—	—	—	0	1	—	—
New York City	—	0	0	—	—	—	0	4	—	—	—	0	2	—	—
Pennsylvania	122	106	180	472	533	—	0	2	—	—	—	0	1	—	—
E.N. Central	70	312	602	878	1,422	—	0	43	—	—	—	0	33	—	—
Illinois	—	1	7	—	8	—	0	23	—	—	—	0	23	—	—
Indiana	—	0	0	—	—	—	0	7	—	—	—	0	12	—	—
Michigan	70	111	250	395	443	—	0	11	—	—	—	0	2	—	—
Ohio	—	156	420	478	745	—	0	11	—	—	—	0	3	—	—
Wisconsin	—	15	142	5	226	—	0	2	—	—	—	0	2	—	—
W.N. Central	17	30	98	108	254	—	0	36	—	—	—	0	79	—	—
Iowa	N	0	0	N	N	—	0	3	—	—	—	0	4	—	—
Kansas	7	4	24	30	62	—	0	3	—	—	—	0	3	—	—
Minnesota	—	0	0	—	—	—	0	6	—	—	—	0	7	—	—
Missouri	9	22	82	68	182	—	0	14	—	—	—	0	2	—	—
Nebraska¶	N	0	0	N	N	—	0	9	—	—	—	0	38	—	—
North Dakota	—	0	8	—	—	—	0	5	—	—	—	0	28	—	—
South Dakota	1	1	15	10	10	—	0	7	—	—	—	0	22	—	—
S. Atlantic	45	83	223	183	225	—	0	2	—	—	—	0	7	—	—
Delaware	—	1	6	5	7	—	0	0	—	—	—	0	0	—	—
District of Columbia	—	0	5	—	1	—	0	0	—	—	—	0	1	—	—
Florida	N	0	22	N	N	—	0	1	—	—	—	0	0	—	—
Georgia	N	0	0	N	N	—	0	1	—	—	—	0	4	—	—
Maryland¶	N	0	0	N	N	—	0	2	—	—	—	0	2	—	—
North Carolina	—	0	0	—	—	—	0	1	—	—	—	0	0	—	—
South Carolina¶	4	16	53	27	68	—	0	1	—	—	—	0	0	—	—
Virginia¶	—	28	133	1	5	—	0	0	—	—	—	0	2	—	—
West Virginia	41	28	70	150	144	—	0	1	—	—	—	0	0	—	—
E.S. Central	5	4	43	29	—	—	0	15	—	2	—	0	16	—	—
Alabama¶	5	4	43	28	—	—	0	2	—	—	—	0	0	—	—
Kentucky	N	0	0	N	N	—	0	2	—	—	—	0	1	—	—
Mississippi	—	0	1	1	—	—	0	10	—	2	—	0	16	—	—
Tennessee¶	N	0	0	N	N	—	0	4	—	—	—	0	2	—	—
W.S. Central	92	194	556	307	312	—	0	58	—	—	—	0	26	—	—
Arkansas¶	—	14	88	6	41	—	0	4	—	—	—	0	2	—	—
Louisiana	2	1	8	11	1	—	0	13	—	—	—	0	9	—	—
Oklahoma	—	0	0	—	—	—	0	6	—	—	—	0	4	—	—
Texas¶	90	170	549	290	270	—	0	38	—	—	—	0	16	—	—
Mountain	70	61	137	189	248	—	0	61	—	—	—	1	228	—	—
Arizona	—	0	0	—	—	—	0	9	—	—	—	0	15	—	—
Colorado	21	28	76	69	180	—	0	10	—	—	—	0	51	—	—
Idaho¶	N	0	0	N	N	—	0	30	—	—	—	0	157	—	—
Montana¶	10	0	7	28	N	—	0	3	—	—	—	0	8	—	—
Nevada¶	—	0	3	—	1	—	0	9	—	—	—	0	16	—	—
New Mexico¶	—	4	34	12	19	—	0	1	—	—	—	0	1	—	—
Utah	39	16	65	80	46	—	0	8	—	—	—	0	17	—	—
Wyoming¶	—	1	11	—	2	—	0	7	—	—	—	0	10	—	—
Pacific	—	0	1	1	—	—	0	15	—	—	—	0	51	—	—
Alaska	—	0	1	1	N	—	0	0	—	—	—	0	0	—	—
California	—	0	0	—	N	—	0	15	—	—	—	0	37	—	—
Hawaii	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Oregon¶	N	0	0	N	N	—	0	2	—	—	—	0	14	—	—
Washington	N	0	0	N	N	—	0	0	—	—	—	0	2	—	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	10	30	3	19	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
‡ Incidence data for reporting years 2006 and 2007 are provisional.
† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (proposed) (ArboNET Surveillance). Data for California serogroup, eastern equine, Powassan, St. Louis, and western equine diseases are available in Table I.
§ Not notifiable in all states. Data from states where the condition is not notifiable are excluded from this table, except in 2007 for the domestic arboviral diseases and influenza-associated pediatric mortality, and in 2004 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/epo/dphsi/phs/infdis.htm.
¶ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE III. Deaths in 122 U.S. cities,* week ending January 27, 2007 (4th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
New England	584	414	115	22	18	15	52
Boston, MA	128	86	26	4	8	4	17
Bridgeport, CT	30	20	7	1	2	—	4
Cambridge, MA	15	13	2	—	—	—	1
Fall River, MA	30	23	4	2	1	—	1
Hartford, CT	64	50	8	2	3	1	9
Lowell, MA	24	15	7	1	—	1	1
Lynn, MA	7	5	1	1	—	—	2
New Bedford, MA	24	18	5	1	—	—	1
New Haven, CT	55	31	17	2	3	2	6
Providence, RI	72	46	16	6	1	3	5
Somerville, MA	2	2	—	—	—	—	—
Springfield, MA	36	29	4	1	—	2	—
Waterbury, CT	37	26	10	1	—	—	5
Worcester, MA	60	50	8	—	—	2	—
Mid. Atlantic	2,046	1,427	452	90	36	39	113
Albany, NY	43	35	6	1	1	—	—
Allentown, PA	21	14	4	1	1	1	—
Buffalo, NY	84	55	25	3	1	—	6
Camden, NJ	31	22	6	2	—	1	2
Elizabeth, NJ	23	16	3	2	1	1	3
Erie, PA	61	44	15	—	1	1	4
Jersey City, NJ	U	U	U	U	U	U	U
New York City, NY	1,111	761	266	50	13	19	53
Newark, NJ	33	15	9	4	1	4	—
Paterson, NJ	U	U	U	U	U	U	U
Philadelphia, PA	162	101	37	12	7	5	12
Pittsburgh, PA§	35	25	7	1	—	2	—
Reading, PA	43	31	6	2	3	1	3
Rochester, NY	159	121	25	8	2	3	15
Schenectady, NY	19	15	3	—	1	—	—
Scranton, PA	22	17	4	—	1	—	2
Syracuse, NY	126	99	21	2	3	1	7
Trenton, NJ	29	21	7	1	—	—	—
Utica, NY	22	18	4	—	—	—	3
Yonkers, NY	22	17	4	1	—	—	3
E.N. Central	2,101	1,411	464	134	45	47	161
Akron, OH	U	U	U	U	U	U	U
Canton, OH	39	26	8	4	—	1	7
Chicago, IL	369	230	82	34	13	10	36
Cincinnati, OH	79	63	11	4	1	—	13
Cleveland, OH	252	176	54	15	1	6	11
Columbus, OH	229	155	55	10	4	5	20
Dayton, OH	127	95	21	5	3	3	9
Detroit, MI	168	78	60	17	8	5	8
Evansville, IN	43	32	10	1	—	—	2
Fort Wayne, IN	53	41	9	1	1	1	6
Gary, IN	16	9	3	3	1	—	—
Grand Rapids, MI	64	44	11	6	—	3	3
Indianapolis, IN	201	128	49	16	2	6	17
Lansing, MI	55	39	11	4	—	1	3
Milwaukee, WI	94	61	26	2	2	3	8
Peoria, IL	48	35	8	1	3	1	2
Rockford, IL	62	41	15	3	3	—	3
South Bend, IN	58	47	8	1	1	1	3
Toledo, OH	101	79	17	4	—	1	8
Youngstown, OH	43	32	6	3	2	—	2
W.N. Central	683	461	137	43	20	19	51
Des Moines, IA	35	29	3	2	—	1	8
Duluth, MN	21	15	6	—	—	—	—
Kansas City, KS	24	13	5	5	1	—	1
Kansas City, MO	106	74	22	3	4	2	5
Lincoln, NE	42	30	9	2	—	1	5
Minneapolis, MN	77	48	16	8	1	4	4
Omaha, NE	110	83	17	6	1	3	9
St. Louis, MO	94	54	22	7	7	2	4
St. Paul, MN	67	44	12	5	1	5	6
Wichita, KS	107	71	25	5	5	1	9
S. Atlantic	1,505	939	369	127	41	29	82
Atlanta, GA	296	171	77	35	6	7	13
Baltimore, MD	213	122	58	20	6	7	20
Charlotte, NC	118	82	20	11	2	3	12
Jacksonville, FL	166	108	41	11	4	2	7
Miami, FL	116	78	23	7	8	—	4
Norfolk, VA	65	37	16	5	3	4	2
Richmond, VA	69	42	23	4	—	—	3
Savannah, GA	69	44	19	4	—	2	3
St. Petersburg, FL	51	32	5	4	7	3	4
Tampa, FL	199	136	46	11	5	1	12
Washington, D.C.	125	76	38	11	—	—	—
Wilmington, DE	18	11	3	4	—	—	2
E.S. Central	1,055	676	249	69	33	28	98
Birmingham, AL	213	133	52	14	6	8	25
Chattanooga, TN	82	57	16	4	2	3	6
Knoxville, TN	127	82	31	8	4	2	11
Lexington, KY	66	53	12	—	1	—	5
Memphis, TN	186	116	48	12	7	3	25
Mobile, AL	121	79	22	13	6	1	5
Montgomery, AL	80	48	24	4	1	3	4
Nashville, TN	180	108	44	14	6	8	17
W.S. Central	1,967	1,266	472	130	58	41	124
Austin, TX	100	63	23	9	3	2	8
Baton Rouge, LA	85	58	20	4	3	—	—
Corpus Christi, TX	123	77	24	11	7	4	16
Dallas, TX	270	159	79	20	8	4	23
El Paso, TX	95	71	17	4	2	1	4
Fort Worth, TX	132	98	28	2	2	2	12
Houston, TX	494	292	131	41	19	11	19
Little Rock, AR	70	45	17	5	1	2	2
New Orleans, LA¶	U	U	U	U	U	U	U
San Antonio, TX	362	238	78	26	11	9	24
Shreveport, LA	78	53	18	5	—	2	9
Tulsa, OK	158	112	37	3	2	4	7
Mountain	1,220	788	264	81	48	36	77
Albuquerque, NM	133	81	36	10	3	3	7
Boise, ID	54	39	9	5	1	—	3
Colorado Springs, CO	55	41	10	2	—	2	2
Denver, CO	123	62	36	5	6	14	5
Las Vegas, NV	289	185	61	23	11	9	16
Ogden, UT	44	23	15	4	1	1	5
Phoenix, AZ	227	143	45	17	15	4	13
Pueblo, CO	36	28	6	1	1	—	6
Salt Lake City, UT	119	78	29	7	4	1	11
Tucson, AZ	140	108	17	7	6	2	9
Pacific	1,583	1,111	339	70	33	29	147
Berkeley, CA	14	9	3	—	—	2	—
Fresno, CA	U	U	U	U	U	U	U
Glendale, CA	U	U	U	U	U	U	U
Honolulu, HI	80	58	13	1	4	4	6
Long Beach, CA	95	58	24	8	1	4	19
Los Angeles, CA	U	U	U	U	U	U	U
Pasadena, CA	27	20	2	2	1	1	6
Portland, OR	142	97	35	5	5	—	12
Sacramento, CA	263	179	65	10	5	4	24
San Diego, CA	179	126	28	10	6	9	12
San Francisco, CA	134	99	25	8	1	1	10
San Jose, CA	256	188	53	10	2	3	30
Santa Cruz, CA	36	27	9	—	—	—	3
Seattle, WA	124	79	33	8	4	—	10
Spokane, WA	81	61	17	1	1	1	8
Tacoma, WA	152	110	32	7	3	—	7
Total	12,744**	8,493	2,861	766	332	283	905

U: Unavailable. —:No reported cases.

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

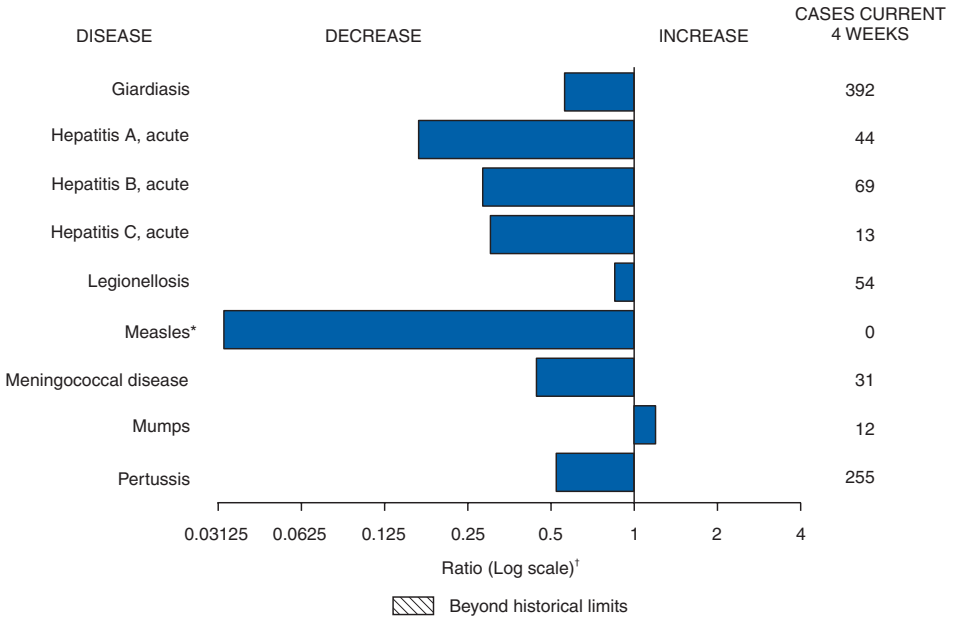
† Pneumonia and influenza.

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

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

** Total includes unknown ages.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals January 27, 2007, with historical data



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

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