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National Nutrition Month — March 2007

March is National Nutrition Month. A healthy diet is high in fruits and vegetables, and evidence indicates that eating more fruits and vegetables can lower a person's risk for chronic diseases such as certain cancers and cardiovascular disease (*1*). *Healthy People 2010* objectives include increasing the proportion of persons who eat adequate amounts of fruit and vegetables every day (objectives 19-5 and 19-6) (*2*).

In March, the Produce for Better Health Foundation, a nonprofit consumer education organization, introduced the Fruit & Veggies — More Matters health initiative, which provides nutritional information, cooking advice, and shopping tips to help members of the public increase consumption of fruits and vegetables. CDC, the foundation, and other partners are collaborating through research, education, and environmental and policy strategies to encourage persons in the United States to eat more fruits and vegetables. Additional information on National Nutrition Month is available at http://www.eatright.org and on the Produce for Better Health Foundation's health initiative at http://www.fruitsandveggiesmorematters.org. Information regarding 5 A Day for Better Health, a CDC-led program (including several public and private partners) to increase fruit and vegetable consumption, is available at http://www.5aday.gov.

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1. US Department of Health and Human Services, US Department of Agriculture. Dietary guidelines for Americans, 2005. 6th ed. Washington, DC: US Government Printing Office; 2005. Available at http://www.health.gov/dietaryguidelines.
2. US Department of Health and Human Services. Healthy people 2010 (conference ed, in 2 vols). Washington, DC: US Department of Health and Human Services; 2000. Available at http://www.healthypeople.gov.

Fruit and Vegetable Consumption Among Adults — United States, 2005

A diet high in fruits and vegetables is associated with decreased risk for chronic diseases (*1*). In addition, because fruits and vegetables have low energy density (i.e., few calories relative to volume), eating them as part of a reduced-calorie diet can be beneficial for weight management (*2*). *Healthy People 2010* health objectives include increasing to 75% the percentage of persons aged ≥2 years who eat at least two daily servings* of fruit (objective 19-5) and increasing to 50% the proportion of persons aged ≥2 years who eat at least three daily servings of vegetables, with at least one third being dark green or orange vegetables (objective 19-6) (*3*). To assess the level of fruit and vegetable consumption among adults by state and demographic characteristics, data from the 2005 Behavioral Risk Factor Surveillance System (BRFSS) were analyzed. This report describes the results of that analysis, which indicated that 32.6% of adults consumed fruit two or more times per day and 27.2% ate vegetables three or more times per day. The results underscore the need for continued interventions that encourage greater fruit and vegetable consumption among U.S. adults.

*Information regarding recommended serving sizes based on U.S. Dietary Guidelines for Americans is available at http://www.health.gov/dietaryguidelines/dga2005/document/html/appendixa.htm.

INSIDE

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

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BRFSS is an ongoing, state-based, random-digit–dialed telephone survey of the noninstitutionalized, U.S. civilian population aged ≥18 years. BRFSS data are used to provide information regarding health behaviors that relate to the leading causes of death among U.S. adults and to monitor state progress toward health objectives. BRFSS data are weighted to the respondents' probabilities of being selected and to the age-, race/ethnicity-, and sex-specific populations from annually adjusted census reports in the state. In 2005, response rates[†] among the states ranged from 34.6% to 67.4% (median: 51.1%) when calculated by the guidelines of the Council of American Survey and Research Organizations. Cooperation rates[§] ranged from 58.7% to 85.3% (median: 75.1%). City- and county-level 2005 data on health behaviors, including consumption of fruits and vegetables, for more than 153 cities are available as part of the BRFSS Selected Metropolitan/Micropolitan Area Risk Trends project.[¶]

The BRFSS module on fruits and vegetables included six questions that were preceded by the following statement: "These next questions are about the foods you usually eat or drink. Please tell me how often you eat or drink each one, for example, twice a week, three times a month, and so forth." The six questions were as follows: 1) "How often do you drink fruit juices such as orange, grapefruit, or tomato?" 2) "Not counting juice, how often do you eat fruit?" 3) "How often do you eat green salad?" 4) "How often do you eat potatoes, not including French fries, fried potatoes, or potato chips?" 5) "How often do you eat carrots?" 6) "Not counting carrots, potatoes, or salad, how many servings of vegetables do you usually eat? (Example: a serving of vegetables at both lunch and dinner would be two servings.)" Participants were not given a definition of serving size. Total daily fruit consumption was calculated based on responses to questions 1 and 2, and total daily vegetable consumption was based on responses to questions 3–6. The percentage of adults who consumed fruit two or more times per day and vegetables three or more times per day was calculated for the overall population and by selected characteristics. To calculate consumption in times per day, weekly frequencies were divided by seven, monthly frequencies were divided by 30, and yearly frequencies were divided by 365. To be consistent with past analyses, the answer to question 6 was treated as times per day.

Data from all 50 states and the District of Columbia (DC) were included. A total of 347,278 persons completed the

[†] The percentage of persons who completed interviews among all eligible persons, including those who were not successfully contacted. Rates available at http://www.cdc.gov/brfss/technical_infodata/2005qualityreport.htm.

[§] The percentage of persons who completed interviews among all eligible persons who were contacted.

[¶] Additional information available at http://www.cdc.gov/brfss/smart.

interview. After excluding persons who did not report selected demographic or behavioral risk-factor information (n = 38,317), persons who did not answer all six questions in the fruit and vegetable module (n = 14,179), and persons who reported consumption of fruits and vegetables ≥25 times per day (an unlikely frequency of consumption) (n = 61), 305,504 persons were included in the final sample.

In 2005, approximately 32.6% of the U.S. adult population surveyed consumed fruit two or more times per day, and 27.2% ate vegetables three or more times per day. The prevalence of consuming fruit two or more times per day was 28.7% among women and 36.4% among men. By age, prevalence of consuming fruit two or more times per day ranged from 27.9% among persons aged 35–44 years to 45.9% among persons aged ≥65 years. Among racial/ethnic populations, Hispanics had the highest prevalence (37.2%) of consuming fruit two or more times per day, and non-Hispanic whites had the lowest prevalence (31.2%). College graduates had the highest level of fruit consumption (37.4%) compared with lower levels of education, as did persons who earned ≥$50,000 per year (32.4%) compared with those who earned less. Persons who were not overweight or obese (i.e., body mass index [BMI] <25) had the highest prevalence of consuming fruit two or more times per day (36.0%), and obese persons (BMI ≥30) had the lowest prevalence (28.1%) (Table).

The prevalence of eating vegetables three or more times per day was 22.1% among men and 32.2% among women and ranged from 20.9% among persons aged 18–24 years to 33.7% among persons aged ≥65 years. Among racial/ethnic populations, whites had the highest prevalence (28.6%) of eating vegetables three or more times per day, and Hispanics had the lowest prevalence (20.4%). College graduates had the highest level of vegetable consumption (33.3%) compared with lower education levels, as did persons earning ≥$50,000 per year (30.3%) compared with those earning less. Persons who were not overweight or obese had the highest prevalence of eating vegetables three or more times per day (28.9%), and overweight persons had the lowest prevalence (26.0%).

TABLE. Percentage of adults aged ≥18 years who consumed fruit two or more times per day and vegetables three or more times per day, by selected demographic characteristics — Behavioral Risk Factor Surveillance System, United States, 2005

Characteristic	No. of respondents	Fruit, two or more times per day (%)	Fruit, two or more times per day (99% CI*)	Vegetables, three or more times per day (%)	Vegetables, three or more times per day (99% CI)
Sex					
Men	120,952	28.7	(28.0–29.4)	22.1	(21.5–22.7)
Women	184,552	36.4	(35.8–37.0)	32.2	(31.7–32.7)
Age group (yrs)					
18–24	15,823	30.1	(28.4–31.9)	20.9	(19.5–22.4)
25–34	40,876	29.5	(28.4–30.6)	24.3	(23.3–25.3)
35–44	55,939	27.9	(26.9–28.8)	26.2	(25.3–27.0)
45–54	64,535	30.5	(29.5–31.4)	28.3	(27.4–29.1)
55–64	56,078	33.4	(32.4–34.4)	29.5	(28.6–30.5)
≥65	72,253	45.9	(44.9–46.8)	33.7	(32.8–34.6)
Race/Ethnicity					
Black, non-Hispanic	22,083	35.1	(33.5–36.7)	23.7	(22.3–25.1)
Hispanic	17,404	37.2	(35.3–39.2)	20.4	(18.9–22.0)
White, non-Hispanic	247,985	31.2	(30.8–31.7)	28.6	(28.2–29.1)
Other†	18,032	35.5	(33.3–37.6)	29.3	(27.4–31.4)
Education					
Less than high school diploma	28,767	32.0	(30.3–33.7)	20.5	(19.2–21.9)
High school graduate	92,748	29.4	(28.5–30.2)	22.3	(21.6–23.0)
Some college	81,822	30.6	(29.8–31.4)	27.9	(27.1–28.7)
College graduate	102,167	37.4	(36.7–38.1)	33.3	(32.6–34.0)
Annual income					
<$25,000	78,013	33.0	(31.9–34.0)	23.0	(22.2–23.9)
$25,000–$49,999	83,839	31.5	(30.6–32.3)	26.0	(25.3–26.8)
≥$50,000	109,488	32.4	(31.8–33.1)	30.3	(29.7–31.0)
Unknown	34,164	35.1	(33.7–36.5)	27.2	(26.1–28.5)
Body mass index (kg/m^2)					
<25.0	116,201	36.0	(35.3–36.8)	28.9	(28.2–29.6)
25.0–29.9 (overweight)	111,214	32.0	(31.2–32.7)	26.0	(25.3–26.7)
≥30.0 (obese)	78,089	28.1	(27.3–29.0)	26.3	(25.5–27.1)
Total	**305,504**	**32.6**	**(32.2–33.1)**	**27.2**	**(26.8–27.6)**

* Confidence interval.
† Sample sizes for remaining racial/ethnic populations were too small for meaningful analysis.

Twenty-six states reported that ≥30% of the adults consumed fruit two or more times per day (Figure 1), and 10 states reported that ≥30% of adults ate vegetables three or more times per day (Figure 2). By state, the prevalence of eating fruit two or more times per day ranged from 19.2% to 37.8%, and the prevalence of eating vegetables three or more times per day ranged from 20.9% to 39.0%. No state reached the *Healthy People 2010* national objectives for fruit and vegetable consumption.

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FIGURE 1. Percentage of adults aged ≥18 years who consumed fruit two or more times per day — Behavioral Risk Factor Surveillance System, United States, 2005

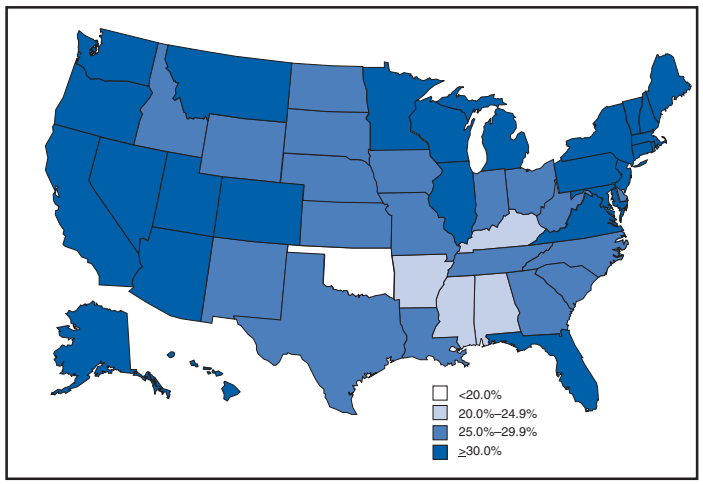
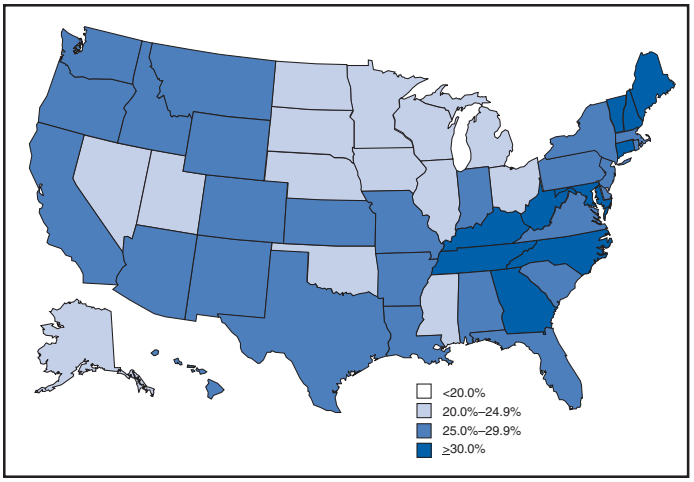


FIGURE 2. Percentage of adults aged ≥18 years who ate vegetables three or more times per day — Behavioral Risk Factor Surveillance System, United States, 2005



Editorial Note: The findings in this report indicate that adults in the 50 states and DC have not achieved national objectives for fruit and vegetable consumption. A separate midcourse review of *Healthy People 2010* determined that data were not yet available to update estimates toward meeting fruit and vegetable consumption goals; however, existing data were used to make interim analyses, which indicated that the average fruit intake among persons aged ≥2 years remained the same from 1994–1996 to 1999–2002 (1.6 servings) and that average vegetable consumption declined from 3.4 to 3.2 servings during the same period, with no noted change in the daily consumption of dark green or orange vegetables (0.3 servings).**

To meet the 2010 national objectives, a more sustained and effective public health response is needed, including continued surveillance, identification of barriers to eating more fruits and vegetables, and environmental changes (e.g., increasing the proportion of fruits and vegetables in vending machines and promoting healthful food advertising and the availability of healthful foods). Interventions that increase fruit and vegetable consumption by changing behaviors should be promoted, as should those that increase public awareness of the overall benefits of fruits and vegetables in the diet (*4*). The 2005 U.S. Dietary Guidelines suggest eating more fruits and vegetables than have been recommended in the past (*1*). The most recently recommended numbers of daily servings of fruits and vegetables are related to sex, age, and physical activity level; for adults, recommended levels are three to five servings of fruit and four to eight servings of vegetables per day†† (*1*).

In 1991, Produce for Better Health (a nonprofit organization that promotes the consumption of fruits and vegetables) and the National Cancer Institute initiated the 5 A Day for Better Health program to promote healthy eating through fruit and vegetable consumption. In 2005, CDC became the lead federal agency for the program, which is a partnership of government, nonprofit, business, and community organizations. The program has encouraged behaviors that increase fruit and vegetable intake (*5*).

** US Department of Health and Human Services. *Healthy People 2010* midcourse review. Available at http://www.healthypeople.gov/data/midcourse/default.htm.

†† Additional information regarding recommendations, which vary based on caloric level of the diet, are available at http://www.health.gov/dietaryguidelines/dga2005/document/html/chapter5.htm.

In addition to the 5 A Day for Better Health program, CDC's Steps to a HealthierUS Cooperative Agreement Program and the Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases support various state and local programs that have effectively increased fruit and vegetable consumption. These programs include school-based interventions such as the Fresh Fruit and Vegetable Program; during an evaluation of this program, parents reported that their children were requesting more fruits and vegetables at home, and many children described positive changes in their eating habits and a greater willingness to try fruits and vegetables (*6*). A healthy-eating program for preschoolers, Color Me Healthy, resulted in 79% of child-care providers reporting that children were more willing to try new foods, and 82% reporting that the program had improved fruit and vegetable recognition (*7*). Participants in Body & Soul, a health program for churches serving the black community, had greater fruit and vegetable intake when compared with controls (*8*).[§§] CDC programs also support state initiatives that provide nutritional education and increase access to fruits and vegetables through community gardens, farmers' markets, and restaurants (*5*).

The findings in this report are subject to at least five limitations. First, although the retest consistency of participant responses has been validated in multiple populations, estimates of fruit and vegetable intake from abbreviated food questionnaires such as the BRFSS fruit and vegetable module are lower than other methods of dietary assessment (*9,10*). Second, BRFSS does not include persons without landline telephones or those residing in institutions, so the results might not be representative of certain U.S. populations. Third, the BRFSS survey has low response rates, which might result in an overestimation or underestimation of fruit and vegetable consumption. Fourth, BMI data are based on self-reported measures, which might lead to an underestimation of BMI. Finally, this analysis reports fruit and vegetable consumption according to number of times per day the foods were eaten, whereas *Healthy People 2010* objectives are based on number of servings per day. This difference in intake measurement might lead to misclassification of participants, resulting in an overestimation or underestimation of persons meeting national fruit and vegetable consumption objectives.

The lack of success in meeting national goals for fruit and vegetable consumption indicates a need for additional measures to educate and motivate persons to make healthier dietary choices. Nutritional interventions should go beyond increasing individual awareness and target the family, local community, and overall society to eliminate barriers to healthy eating, provide support for persons who are making healthy changes, increase resources for populations with greater need, and emphasize nutritional policies that have an impact on society.

[§§] Additional information regarding these programs is available at the following websites: 5 A Day: http://www.5aday.gov, Steps to a HealthierUS Cooperative Agreement Program: http://www.cdc.gov/steps, the Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases: http://www.cdc.gov/nccdphp/dnpa/obesity/state_programs/index.htm, Color Me Healthy: http://www.colormehealthy.com, and Body & Soul: http://www.bodyandsoul.nih.gov.

Acknowledgment

The findings in this report are based, in part, on data provided by BRFSS state coordinators.

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Postmarketing Monitoring of Intussusception After RotaTeq™ Vaccination — United States, February 1, 2006–February 15, 2007

Rotavirus is the leading cause of severe gastroenteritis in children aged <5 years worldwide. In February 2006, a new rotavirus vaccine, RotaTeq™ (Merck and Co., West Point, Pennsylvania), was licensed in the United States, and the Advisory Committee on Immunization Practices (ACIP) recommended it for routine vaccination of U.S. infants with 3 doses, administered orally at ages 2, 4, and 6 months (*1*). Because a previous rotavirus vaccine, Rotashield™ (Wyeth Laboratories, Marietta, Pennsylvania), was withdrawn from the U.S. market in 1999 after postmarketing surveillance identified an association* with intussusception (a rare type of bowel obstruction) (*2*), the safety of RotaTeq was evaluated in a prelicensure clinical trial involving 71,725 infants who received either vaccine or placebo (*3*). In this controlled trial, no statistically significant elevated risk for intussusception was observed within a 42-day period after RotaTeq vaccination. However, postmarketing monitoring for intussusception after RotaTeq vaccination is necessary because of possible differences in the characteristics of infants who received the vaccine in routine use compared with the infants in the clinical trials. Also, the large numbers of infants being vaccinated provides an opportunity to detect intussusception occurring at a low rate after vaccination. This report presents data from the first year of postmarketing monitoring for intussusception after RotaTeq vaccination in the United States, with particular focus on all intussusception reports received by the Vaccine Adverse Event Reporting System (VAERS) during February 1, 2006–February 15, 2007. As of February 15, 2007, postmarketing surveillance did not suggest association of RotaTeq vaccination with intussusception. CDC reaffirms vaccine policy recommendations to routinely vaccinate U.S. infants with RotaTeq at ages 2, 4, and 6 months.

In the United States, the postmarketing safety of RotaTeq is being monitored jointly by CDC and the Food and Drug Administration (FDA) through both evaluation of reports to VAERS and active surveillance using data from the Vaccine Safety Datalink (VSD) (*4,5*). Merck and Co. also is conducting a postmarketing observational study, which will monitor for occurrence of intussusception within 30 days of RotaTeq vaccination in 44,000 infants in the United States. VAERS is a passive national surveillance system that receives reports of adverse events after vaccination from various sources, including vaccine manufacturers, health-care providers, immunization programs, and vaccine recipients (*4*). VAERS reports of serious adverse events after RotaTeq vaccination are reviewed daily by staff physicians and epidemiologists at CDC and FDA. Health-care providers are contacted to verify diagnoses and obtain additional clinical information and vaccination history. VSD is a collaborative project between CDC and several large U.S. health maintenance organizations (HMOs) in which computerized vaccination data can be linked to medical outcomes (*5*). Because of the limited number of administered doses of RotaTeq vaccine reported in VSD to date, this analysis focused on VAERS data.

To assess a potential association between intussusception and RotaTeq vaccination, the number of intussusception reports to VAERS after RotaTeq vaccination was compared with the number of intussusception cases expected to occur by chance alone (i.e., the background cases of intussusception). Because the background rates of natural intussusception and number of vaccine doses administered vary substantially by age, the analysis was stratified into three age groups (6–14 weeks, 15–23 weeks, and 24–35 weeks). The observed reports of intussusception were compared with the expected number of cases of intussusception for the three age groups within 1–21 days and 1–7 days after RotaTeq vaccination. These periods were selected on the basis of the potential risk periods identified from experience with Rotashield and the hypothesis that any possible risk of intussusception requires replication of the vaccine virus in the intestinal tract, which might occur 1–15 days after vaccination, on the basis of the RotaTeq clinical trials (*1–3*).

The background rates of intussusception for the three age groups were determined from hospital discharges coded with the *International Classification of Diseases, Ninth Revision* code for intussusception (560.0) at the VSD study sites for 2000–2004, when no rotavirus vaccine was in use. The expected number of background cases for risk periods of 1–21 days and 1–7 days were calculated by multiplying the VSD background rates of intussusception for each age group by the estimated number of vaccine doses administered to that age group. For these calculations, the following was assumed: 1) administered doses of vaccine approximated the total number of doses of RotaTeq distributed by the manufacturer during February 1, 2006–January 31, 2007; and 2) the national distribution of vaccine doses to infants in these three age groups approximated the distribution of vaccine doses administered in each of the three age groups in VSD. Observed versus expected reporting rate ratios (RRs) with 95% confidence intervals (CIs) were calculated using the exact age-stratified Poisson test.

* The odds of intussusception were 37 times higher among vaccine recipients than among unvaccinated infants during the 3–7 days after dose 1 of Rotashield.

VAERS Reports

During February 1, 2006–February 15, 2007, VAERS received 567 reports of adverse events after RotaTeq vaccination, including 35 reports of intussusception (Figure 1) that were confirmed using the Brighton Collaboration case definition (*6*). Of these 35 reports, 17 (49%) occurred in infants within 1–21 days of vaccination, including 11 (31%) that occurred within 1–7 days of vaccination. Among the other 18 reports, onset of intussusception ranged from 22–73 days, with the exception of one report, with onset on the same day as vaccination (Figure 1).

All 17 intussusception reports occurring within 1–21 days of vaccination were radiographically confirmed (i.e., by barium enema or ultrasonogram). Of these 17 cases, nine (53%) occurred in vaccinees after dose 1, eight (47%) after dose 2, and none after dose 3 of vaccine (Figure 2). Ten (59%) infants required surgery (including five who needed intestinal resection); for seven (41%) infants, intussusception was resolved by enema reduction or resolved spontaneously (Table 1).

Observed Versus Expected Calculations

As of January 31, 2007, the manufacturer had distributed 3.6 million doses of RotaTeq (Merck, unpublished data, 2007). According to VSD data, an estimated 57%, 31%, and 12% of these doses had been distributed among infants aged 6–14, 15–23, and 24–35 weeks, respectively; an estimated 61% were dose 1, 30% were dose 2, and 9% were dose 3. Using VSD data for 2000–2004, the background rate of intussusception was 18.1 per 100,000 person years (PY) at ages 6–14 weeks, 32.5 per 100,000 PY at ages 15–23 weeks, and 42.5 per 100,000 PY at ages 24–35 weeks. By applying these background intussusception rates to the estimated distributed doses per age group, an expected number of 52 intussusception cases was calculated for the period 1–21 days after vaccination; 17 of these cases would be expected to occur at 1–7 days after vaccination. In contrast, 17 intussusception cases were reported to VAERS that occurred within 1–21 days after vaccination, including 11 that occurred 1–7 days after vaccination. Thus, the number of cases of intussusception reported through VAERS was not elevated above the age-adjusted background rates of intussusception for either 1–21 days (RR = 0.32; CI = 0.17–0.55) or 1–7 days (RR = 0.61; CI = 0.29–1.18) after RotaTeq vaccination (Table 2).

VSD Results

During February 1, 2006–February 15, 2007, a total of 28,377 doses of RotaTeq were administered to infants in VSD-monitored HMOs. No cases of intussusception within 30 days of vaccination were reported among these recipients. In contrast, during the same period, within 30 days of vaccination, eight cases of intussusception were reported among approximately 240,110 infants of the same age group who received vaccines other than RotaTeq.

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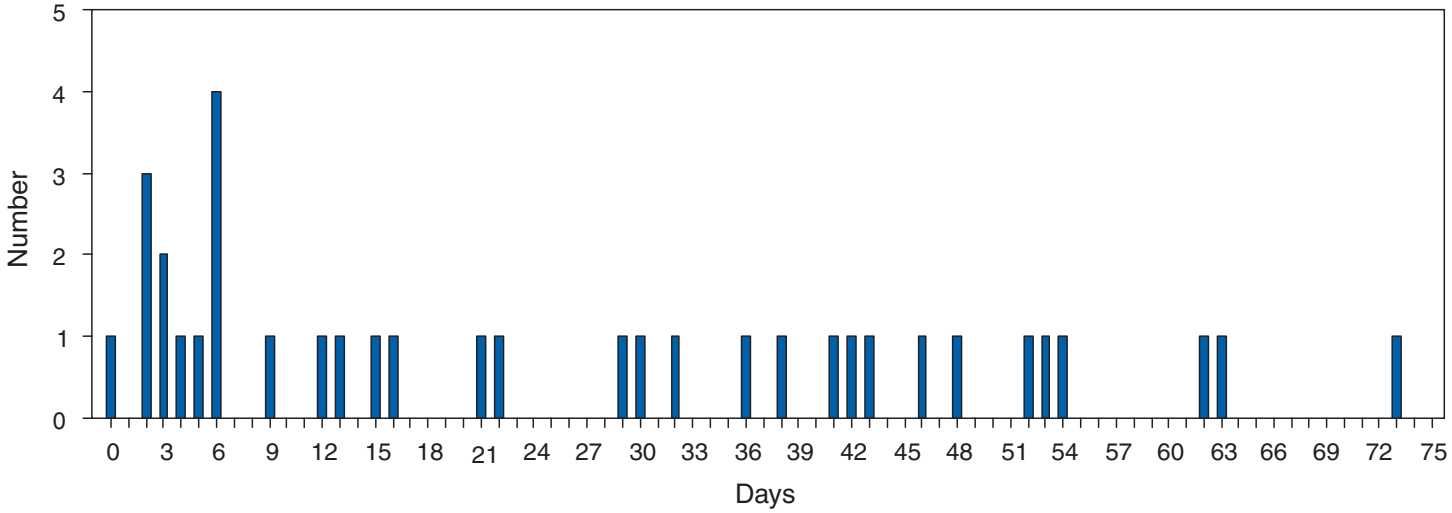
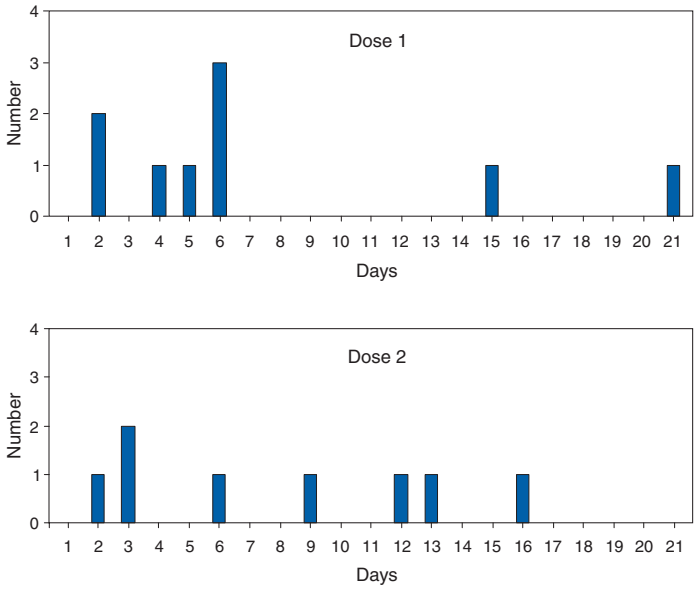
FIGURE 1. Number of intussusception reports to VAERS* after RotaTeq™ vaccination, by onset interval in days — United States, February 1, 2006–February 15, 2007



* Vaccine Adverse Event Reporting System.

FIGURE 2. Number of intussusception reports to VAERS* 1–21 days after RotaTeq™ vaccination, by dose number† and onset interval in days — United States, February 1, 2006–February 15, 2007



* Vaccine Adverse Event Reporting System.
† Denotes vaccination dose immediately before onset of intussusception. No cases were reported after dose 3 within 1–21 days of vaccination.

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Editorial Note: Intussusception is the most common cause of acute intestinal obstruction in infants aged <1 year. Although many etiologies have been associated with intussusception (e.g., adenovirus infection or Meckel's diverticulum), the cause is often unknown. In the United States, approximately 1,200–1,400 cases of intussusception occur annually, even in the absence of rotavirus vaccination (*7*). Using surveillance data to ascertain whether RotaTeq is associated with intussusception requires careful assessment of the observed number of cases after vaccination compared with the number that would have been expected to occur based on the background rate of natural intussusception.

Postmarketing surveillance data available to date do not suggest that RotaTeq is associated with intussusception. The reported number of VAERS intussusception cases among infants vaccinated with RotaTeq does not exceed the number of expected background cases for either the 1–7 day period or the 1–21 day period after vaccination.Within each age group, which corresponds to the risk after each of the 3 doses of RotaTeq, the observed number of reports also is within the expected range (Table 2). In addition, no cases of intussusception were detected within 30 days of vaccination in more than 28,000 VSD infants reported to have received RotaTeq vaccination. However, because of possible underreporting to VAERS and the limited number of infants in VSD vaccinated

TABLE 1. Number of intussusception reports to VAERS* after RotaTeq™ vaccination, by selected characteristics and onset interval in days — United States, February 1, 2006 — February 15, 2007

Characteristic	Total no. of reports (N = 35)	(%)	1–21 days after vaccination (n = 17)	(%)	>21 days after vaccination† (n = 18)	(%)
Sex						
Male	**15**	**(43)**	6	(35)	9	(50)
Female	**16**	**(46)**	11	(65)	5	(28)
Unknown	**4**	**(11)**	0		4	(22)
Dose number§						
1	**15**	**(43)**	9	(53)	6	(33)
2	**14**	**(40)**	8	(47)	6	(33)
3	**6**	**(17)**	0		6	(33)
Treatment						
Barium enema	**13**	**(37)**	7	(41)	6	(33)
Surgical reduction	**12**	**(34)**	5	(29)	7	(39)
Surgical resection	**8**	**(23)**	5	(29)	3	(17)
Spontaneous resolution	**2**	**(6)**	0		2	(11)
Age (wks)						
Mean age at vaccination	**17**		16		18	
Mean age at intussusception onset	**21**		17		24	

* Vaccine Adverse Event Reporting System.
† Includes one report of onset on the day of vaccination.
§ Denotes vaccination dose immediately before onset of intussusception.

TABLE 2. Number of intussusception reports to VAERS* after RotaTeq™ vaccination and expected number† of intussusception cases, by onset period and age group — United States, February 1, 2006–February 15, 2007

Age group (wks)§	1–7 days after vaccination		1–21 days after vaccination	
	No. of VAERS cases	No. of expected cases	No. of VAERS cases	No. of expected cases
6–14	5	7	7	21
15–23	6	7	9	21
24–35	0	3	1	10
Total	11¶	17	17¶	52

* Vaccine Averse Event Reporting System.
† Based on Vaccine Safety Datalink background rates for intussusception during 2000–2004 and Merck and Co. distribution data for RotaTeq.
§ Age at symptom onset.
¶ Reporting rate ratios (RRs) of VAERS cases to expected cases: 1–7 days after vaccination, RR = 0.61 (95% confidence interval [CI] = 0.29–1.18); 1–21 days after vaccination, RR = 0.32 (CI = 0.17–0.55).

with RotaTeq to date, the possibility cannot be excluded that an increased risk for intussusception (or any other adverse event) might be observed over time.

Although the 17 intussusception cases occurring in infants within 1–21 days of RotaTeq vaccination do not exceed the expected number for this risk period, a majority of these cases (11 [65%]) occurred within 1–7 days of vaccination. Of these 11 infants, five had onset in October 2006. The apparent clustering of reported intussusception cases in the week after vaccination might be explained by characteristics of VAERS reporting, which is generally more complete for severe adverse events that occur close to the time of vaccination (*4*). The reason for the large number of reports in the first 7 days after vaccination during the month of October is unclear. This temporal pattern is not consistent with the pattern of vaccine distribution data by month. As more data become available, the significance of the apparent clustering of intussusception cases in the week after RotaTeq vaccination will be examined further.

VAERS data merit cautious interpretation because of the inherent limitations of passive surveillance. Underreporting is a limitation of VAERS; however, the high level of awareness of the association of the previous Rotashield vaccine with intussusception among U.S. pediatricians and family practitioners (*8*) likely has improved reporting of RotaTeq-related adverse events to VAERS. This conclusion is supported by the response to a vaccine label change to RotaTeq issued by Merck (and an accompanying public health notification issued by FDA [available at http://www.fda.gov/cber/safety/phnrota021307.htm] that received extensive media coverage and was widely distributed among pediatricians) on February 13, 2007, adding intussusception as a reported adverse event after vaccination. Although the initial public health alert for Rotashield published on July 16, 1999, resulted in approximately 42 additional reports (i.e., historical cases that occurred prior to the label change) of intussusception to VAERS, the recent RotaTeq label change had generated reports of only five additional cases as of March 2, 2007. Only one of these reports occurred within 1–21 days of RotaTeq vaccination. Inclusion of this case in the analysis will not affect the conclusions of this report.

The findings in this report are subject to at least two additional limitations. First, the proportion of distributed doses of RotaTeq that had been administered could not be determined. If the number of doses administered was overestimated, the expected background number of cases would decrease and the potential for an association between vaccine and risk for intussusception would increase. Second, although the most robust data available were used to estimate background rates for intussusception hospitalizations, the accuracy and completeness of these data have not been verified. A preliminary study suggests that hospital discharge diagnoses might not include some intussusception cases, such as those managed in non-inpatient settings (e.g., emergency departments, short-stay units, or 23-hour observation units) (*9*); thus, the background incidence of intussusception might have been underestimated. In addition, electronically coded data on intussusception might not represent true cases (*10*). The likelihood of finding an association between vaccine and intussusception might increase or decrease depending on the effect of these factors.

The number of reports to VAERS of intussusception after administration of RotaTeq has not exceeded the number expected to occur based on background rates. RotaTeq vaccine is recommended for all infants at ages 2, 4, and 6 months. Health-care providers are reminded that the first dose should be administered to infants only between ages 6 and 12 weeks, and the full series should be completed before age 32 weeks (*1*). CDC and FDA will continue to monitor adverse events reported after RotaTeq vaccination. All persons are encouraged to report cases of intussusception or any adverse events after RotaTeq or any other vaccination to VAERS. Reports may be submitted securely online at http://www.vaers.hhs.gov or by fax at 877-721-0366. Reporting forms and additional information are available by telephone at 800-822-7967.

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Increases in Gonorrhea — Eight Western States, 2000–2005

Neisseria gonorrhoeae infection is the second most commonly reported notifiable disease in the United States (*1*). Gonorrhea increases the risk for pelvic inflammatory disease, infertility, ectopic pregnancy, and acquisition and transmission of human immunodeficiency virus (HIV) (*2*). Nationally, reported gonorrhea incidence rates have been either declining or stable since 1996, although, in 2005, the national rate (115.6 cases per 100,000 population) increased for the first time since 1999 (*3*). In recent decades, western states have had lower gonorrhea rates than other U.S. regions; however, from 2000 to 2005, rates in the West* increased 42%, from 57.2 cases to 81.5 cases per 100,000 population (Figure). During that period, rates in the three other U.S. regions decreased (South: -22%, Northeast: -16%, and Midwest: -5%). This report describes the epidemiology of gonorrhea in eight western states that reported large increases in gonorrhea incidence rates from 2000 to 2005. The results indicated that both sexes and all specified age and racial/ethnic groups experienced increases in gonorrhea rates. Causes for these increases remain unclear; however, data suggest they likely resulted from a combination of increases in the number of tests performed, trends in the types of test performed, and actual increases in disease occurrence. CDC is collaborating with state and local health departments to further investigate and respond to these increases. Public health agencies should remain vigilant for early signs of increases in gonorrhea incidence in their areas.

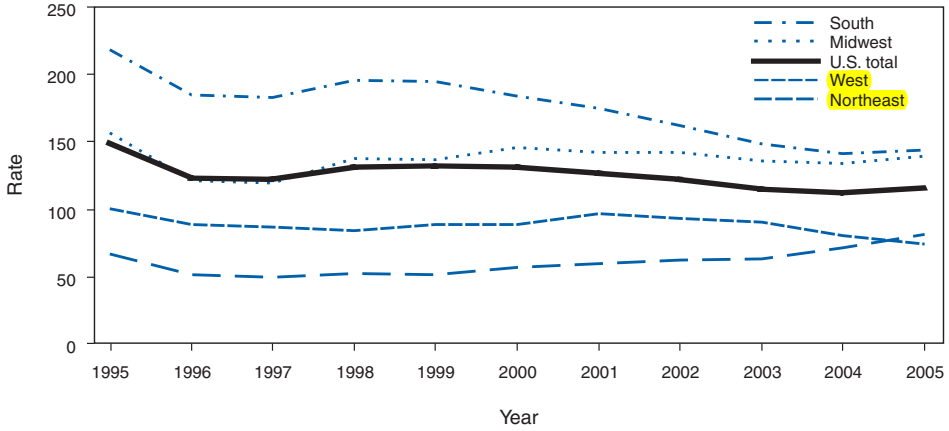
This analysis focused on U.S. states that reported ≥25% increases in the rate of gonorrhea from 2000 to 2005 and reported ≥500 cases of gonorrhea in 2005. Eight states met those criteria, all in the West: Alaska, California, Hawaii, Nevada, New Mexico, Oregon, Utah, and Washington. Data also were examined for two western cities, Los Angeles and San Francisco. Case report data received via the National Electronic Telecommunications System for Surveillance were examined to identify demographic trends. For each reporting area, unknown, missing, or invalid demographic data (e.g., age group or race/ethnicity) were imputed on the basis of proportions from case reports that contained known data. To assess trends in the number of males with symptomatic gonorrhea (i.e., gonococcal urethritis), during 2000–2005, clinical reports were analyzed from two of the western states (Oregon and Washington) and three cities (Honolulu, Los Angeles, and San Francisco), the only states and cities with available data on symptoms.

To examine possible causes of the increase in the gonorrhea rate in the eight states studied, data from surveys of Association of Public Health Laboratories (APHL) members conducted in 2000 and 2004 were evaluated for changes in test volume and testing technologies (i.e., the use of nucleic acid amplification tests [NAATs]). These tests detect the presence of *N. gonorrhoeae* DNA in cervical, vaginal, urethral, and urine samples and are more sensitive than older methods of gonorrhea detection, such as culture or nonamplified tests (*4*). Approximately 80% of APHL members participated in both the 2000 and 2004 surveys. The total number of gonorrhea tests and the percentage performed using NAATs in the eight western states were compared with data from the eight nonwestern states that reported the highest gonorrhea rates in 2005 (Florida, Georgia, Illinois, Michigan, New York, North Carolina, Ohio, and Texas).

The overall gonorrhea rate for the eight western states increased 52.0%, from 56.3 cases per 100,000 population in 2000 to 85.6 cases per 100,000 in 2005. The greatest increase (195.1%) was reported from Utah, where the gonorrhea rate increased from 10.3 per 100,000 population in 2000 to 30.4 in 2005. The next largest increase (103.8%) was reported from Hawaii; three other states (Alaska, California, and Nevada) had increases ≥50% (Table 1).

* One of four U.S. Census regions. *West:* Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming. *South:* Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia. *Northeast:* Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont. *Midwest:* Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin.

FIGURE. Gonorrhea rates,* by U.S. Census region† — United States, 1995–2005



* Per 100,000 population.
† *West:* Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming. *South:* Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia. *Northeast:* Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont. *Midwest:* Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin.

In the eight western states, increases in gonorrhea rates were observed among both sexes, in all specified age groups, and among all specified racial/ethnic populations. The gonorrhea rate among males in the eight states increased 46.7%, from 64.3 per 100,000 in 2000 to 94.5 in 2005. The gonorrhea rate among females increased 58.5%, from 52.3 per 100,000 in 2000 to 82.9 in 2005. All specified age groups had substantial increases, ranging from 43% to 64%, with the largest percentage increase among those aged 20–29 years. Although the highest gonorrhea rate in 2005 was reported among blacks (537.6 per 100,000 population in 2005), the increase among blacks from 2000 to 2005 (17.5%) was less than that for whites and Hispanics. The gonorrhea rate for whites in 2005 was 50.4 per 100,000 population, an increase of 77.5% from 2000; the rate for Hispanics in 2005 was 91.1 per 100,000 population, an increase of 80.8% from 2000.

Among 21 public health laboratories in the eight western states, the number of gonorrhea tests increased 87.1%, from 334,171 in 2000 to 625,381 in 2004. At 15 public health laboratories in the eight nonwestern states used for comparison, the number of tests increased 13.8%, from 641,068 in 2000 to 729,456 in 2004. The percentage of samples tested using NAATs increased from 49% in 2000 to 86% in 2004 in the eight western states and from 9% to 35% in the eight nonwestern states.

In Honolulu, Los Angeles, Oregon, and Washington, the number of males with symptomatic gonorrhea increased from 2000 to 2005; in San Francisco, the number declined from 2000 to 2003, but increased from 2003 to 2005 (Table 2). Changes in the numbers of males with symptomatic gonorrhea, during 2000–2005 roughly paralleled changes in the overall number of reported cases in all areas (Table 1).

TABLE 1. Number of reported gonorrhea cases and incidence rates* — selected western states† and cities, 2000–2005

State/City	No.						Rate						% change in rate, 2000 to 2005
	2000	2001	2002	2003	2004	2005	2000	2001	2002	2003	2004	2005	
Alaska	361	457	641	573	567	600	57.5	72.1	99.6	88.3	87.4	91.5	59.1
California§	21,619	23,296	24,606	25,963	30,155	34,338	63.6	67.3	70.1	73.2	85.0	95.7	50.5
Los Angeles	7,307	7,747	7,765	8,174	9,689	10,485	81.7	85.5	84.6	88.5	104.9	112.7	37.9
San Francisco	2,161	2,053	2,136	1,809	2,142	2,463	275.6	264.6	279.6	240.7	285.0	330.9	20.1
Hawaii	483	604	740	1,263	1,193	1,024	39.8	49.2	59.4	100.4	94.9	81.1	103.8
Nevada	1,553	1,756	1,988	2,221	3,078	2,880	76.9	83.7	91.5	99.1	137.3	123.4	60.5
New Mexico	1,152	1,040	1,462	1,169	1,306	1,552	63.2	56.8	78.8	62.4	69.7	81.5	29.0
Oregon	1,038	1,144	909	1,000	1,302	1,562	30.3	32.9	25.8	28.1	36.6	43.5	43.6
Utah	231	219	374	412	603	727	10.3	9.6	16.1	17.5	25.6	30.4	195.1
Washington	2,418	2,991	2,925	2,753	2,810	3,739	40.9	49.9	48.2	44.9	45.8	60.3	47.4
Eight-state total	**28,855**	**31,507**	**33,645**	**35,354**	**41,014**	**46,422**	**56.3**	**60.4**	**63.6**	**66.0**	**75.6**	**85.6**	**52.0**
Other 42 states¶	334,281	330,198	318,207	299,750	289,118	293,171	144.7	141.6	135.2	126.3	120.8	122.5	-15.3
U.S. total	**363,136**	**361,705**	**351,852**	**335,104**	**330,132**	**339,593**	**128.7**	**126.8**	**122.0**	**115.2**	**113.5**	**115.6**	**-10.2**

* Per 100,000 population.
† Selected states all reported ≥25% increases in the gonorrhea rate from 2000 to 2005 and reported ≥500 cases in 2005.
§ Includes Los Angeles and San Francisco.
¶ Includes the District of Columbia.

TABLE 2. Number of males reported with symptomatic gonorrhea — selected western states and cities,* 2000–2005

State/City	No. of males with symptomatic gonorrhea†						% change,
	2000	2001	2002	2003	2004	2005	2000 to 2005
California							
Los Angeles	2,808	2,918	2,775	2,816	3,816	4,159	48
San Francisco	566	489	434	366	421	470	-17
Hawaii							
Honolulu	39	70	84	120	101	91	133
Oregon	451	574	483	474	488	596	32
Washington	1,025	1,468	1,405	1,305	1,281	1,638	60

* The only states and cities with data on symptoms available.
† Data source varied by state/city. San Francisco: municipal sexually transmitted disease (STD) clinic; Los Angeles: case reports; Honolulu: STD clinic; Oregon: case reports; Washington: case reports.

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Editorial Note: This report documents increases in reported gonorrhea cases among all ages, racial/ethnic populations, and both sexes in eight western states during 2000–2005. These increases likely resulted, in part, from increased testing and use of more sensitive tests; however, increases in the number of males with symptomatic gonorrhea, a population that generally seeks medical care spontaneously, suggest that actual increases in gonorrhea morbidity also occurred. National policies promoting increased testing for *Chlamydia trachomatis* infection might have increased gonorrhea testing through combined screening for both infections; however, such policies are national and would not be expected to produce greater increases in the West than in other regions of the United States. Spread of gonorrhea into high-risk networks, (e.g., methamphetamine users or incarcerated populations) (*5,6*), reduced disease-control efforts, and changes in the organism (e.g., increasing antibiotic resistance or transmissibility) also are possible causes. Although the increases were most evident in the West, gonorrhea rates increased slightly in the Midwest and South from 2004 to 2005 (by 4.0% and 1.6%, respectively), suggesting that a similar pattern of increases might be occurring in other regions (Figure).

Data from public health laboratories indicate that changes in gonorrhea rates might have resulted from increased screening; a greater increase in testing volume was reported in the eight western states than in the eight nonwestern states with the highest gonorrhea rates. Furthermore, in 2000 and 2004, the western states used the more sensitive NAATs to a greater extent than the eight comparison states. However, other data sources suggest that changes in testing procedures and screening practices do not account for all of the observed increase. The Infertility Prevention Project (IPP) is a national program that funds the screening of chlamydia and gonorrhea in sexually active women; the majority of IPP screening occurs in family planning clinics. Washington experienced a significant increase in overall gonorrhea test positivity from 2003 (0.35% testing positive) to 2005 (0.49%) among females screened through the IPP; only NAATs were used during this period, and no major changes in screening volume or clinic participation occurred (Washington State Department of Public Health, unpublished data, 2006). IPP data for females aged 15–24 years in California and Utah also demonstrated increases in the percentage testing positive, from 0.9% in 2003 to 1.3% in 2005 in California and from 0.5% in 2003 to 0.8% in 2005 in Utah. In California, mostly NAATs were used and no major changes were observed in test technology or screening volume (California STD Control Branch and Utah Department of Health; unpublished data; 2007). IPP data from the other five western states either were unavailable (Alaska, Nevada, New Mexico, Oregon) or indicated a slight decline in gonorrhea test positivity (Hawaii).

Males with symptomatic gonorrhea generally visit healthcare facilities for treatment and are less likely to be affected by changes in screening or testing practices. Although the number of males with symptomatic gonorrhea did not increase every year during 2000–2005 and the available data were limited to two states and three cities, the overall increases suggest actual increases in gonorrhea morbidity.

Unlike recent increases in syphilis (*7*), case report data indicate that the increases in reported gonorrhea rates do not appear to be confined predominantly to increases among men who have sex with men (MSM). The increase in reported rates has been similar in men and women, suggesting involvement of the heterosexual population. Available data from Honolulu,

Oregon, San Francisco, Seattle, and Utah demonstrate marked increases in gonorrhea in both MSM and heterosexual populations (Hawaii Department of Health, Oregon Department of Human Services, San Francisco Department of Public Health, Public Health, Seattle & King County, and Utah Department of Health; unpublished data; 2006).

The findings in this report are subject to at least three limitations. First, complete surveillance data on gonorrhea were not consistently available in all states; for example, data on symptoms were only available from two states and three cities. Second, data on trends in laboratory testing, specifically test type and testing volume, were not available for private laboratories; whether trends in testing at public health laboratories were similar to trends in private laboratories is uncertain. Third, gonorrhea historically has been underreported (*3*); whether changes in reporting practices might have resulted in increased gonorrhea incidence rates is unclear. However, state health officials in several of the eight western states were not aware of any changes in policies that might have increased reporting during 2000–2005 (California Department of Health Services, Hawaii Department of Health, New Mexico Department of Health, Oregon Department of Human Services, Utah Department of Health, Washington State Department of Health; unpublished data; 2006).

CDC and health departments in affected areas continue to investigate whether the increases in each of the eight western states are related to similar or different phenomena. Even if the precise reason for increases in gonorrhea rates cannot be determined, these data should prompt public health departments in all states to review their gonorrhea control programs. STD program officials should remain vigilant for early signs of increases and consider improved surveillance for gonorrhea. Clinicians should screen and treat persons according to local, state, and national guidelines (*8,9*).[†] Partners of patients with gonorrhea should be treated, and delivery of antibiotic therapy by patients directly to their partners (i.e., expedited partner therapy) should be considered where appropriate and permissible (*9*). Patients with gonorrhea should be retested 3 months after diagnosis because of a high frequency of reinfection (*9*). Laboratories should maintain a high level of quality control for gonorrhea testing. Increased resources for gonorrhea control programs should be considered because such increases have been associated with reductions in gonorrhea rates (*10*). Greater emphasis on gonorrhea control programs will be important for limiting increases in western states and preventing increases in currently unaffected areas.

[†] Available at http://www.cdc.gov/std/treatment.

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Kidney Disease Mortality — Michigan, 1989–2005

Kidney disease was the ninth leading cause of death in Michigan in 2005 (*1*) and in the United States in 2004 (*2*). In 2004, the incidence rate for kidney failure (i.e., end-stage renal disease) was higher in Michigan than in the United States (365 versus 353 per 1 million population) (*3*). A total of 3,695 Michigan residents started treatment (i.e., dialysis or transplant) for kidney failure in 2004; by the end of that year, 11,002 Michigan residents were receiving dialysis, and 614 had received a transplant (*3*). Many of these persons had a

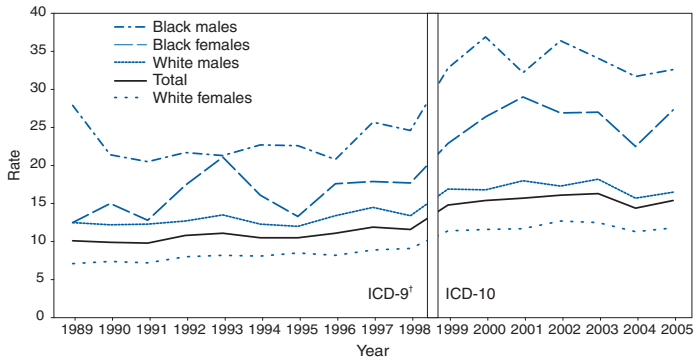
diagnosis of diabetes (40%) or hypertension (30%) as the primary cause of kidney failure (*3*). To examine recent trends in kidney disease mortality, the Michigan Department of Community Health (MDCH) analyzed vital statistics data from the period 1989–2005. This report describes the results of that analysis, which indicated that kidney disease mortality is a growing public health problem in Michigan and that blacks were more likely than whites to die from kidney disease. Continued disease-prevention and health-promotion activities, including targeted interventions among populations at greatest risk, are needed by MDCH and other organizations to reduce the burden of kidney disease in Michigan.

Vital statistics data from the period 1989–2005 were analyzed to determine the number of deaths in Michigan with kidney disease as the underlying cause. For 1999–2005, kidney disease deaths were classified using *International Classification of Diseases, Tenth Revision* (ICD-10) codes N00–N07, N17–N19, and N25–N27. For 1989–1998, kidney disease deaths were classified using *International Classification of Diseases, Ninth Revision* codes 580–589. Kidney disease mortality rates were calculated by selected demographic variables (i.e., age, sex, and race) using annual U.S. Census population estimates for Michigan for 1989–2005 and were age adjusted by the direct method on the basis of the 2000 U.S. standard population with bridged-race categories (*4*). Standard methodology assuming a Poisson distribution was used to estimate 95% confidence intervals (CIs) (*5*).

From 1989 to 1998, kidney disease mortality rates increased by 14.9%, from 10.1 (CI = 9.4–10.8) per 100,000 population to 11.6 (CI = 10.9–12.3) (Figure). After implementation of ICD-10 coding in 1999, kidney disease mortality rates increased by 4.1%, from 14.8 (CI = 14.0–15.6) in 1999 to 15.4 (CI = 14.7–16.1) in 2005. The kidney disease mortality rate was significantly higher among persons aged ≥75 years than among younger age groups. In 2005, age-specific mortality rates were 173.6 (CI = 163.5–183.7) per 100,000 population for persons aged ≥75 years, compared with 19.0 (CI = 17.2–20.8) for those aged 50–74 years and 1.1 (CI = 0.9–1.3) for those aged <50 years.

During 1989–2005, the age-adjusted kidney disease mortality rate in Michigan was consistently higher among black males and females than among white males and females (Figure). In 2005, the age-adjusted death rate among males was approximately 2.0 times higher among blacks than whites (32.6 [CI = 27.1–38.1] per 100,000 population versus 16.5 [CI = 15.2–17.8]). Among females, the age-adjusted rate was 2.3 times higher among blacks than whites (27.3 [CI = 23.3–31.3] versus 11.8 [CI = 10.9–12.7]).

FIGURE. Age-adjusted kidney disease mortality rates,* by race and sex — Michigan, 1989–2005



* Death rates per 100,000 population are for kidney disease as the underlying cause of death, age adjusted by the direct method on the basis of the 2000 U.S. standard population with bridged-race categories.

† Before January 1, 1999, kidney disease deaths were classified using *International Classification of Diseases, Ninth Revision* (ICD-9) codes 580–589. Beginning January 1, 1999, kidney disease deaths were classified using *International Classification of Diseases, Tenth Revision* (ICD-10) codes N00–N07, N17–N19, and N25–N27.

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Editorial Note: Kidney disease mortality is a growing public health problem in Michigan. The findings in this report indicate that kidney disease mortality rates increased during 1989–2005 and that blacks were more likely than whites to die from kidney disease. The increased kidney disease mortality rate might be explained, in part, by the increasing prevalence of kidney failure in Michigan (*6*). The prevalence of diabetes and hypertension, two risk factors for kidney failure, also has increased among adults in Michigan, and self-reported diabetes and hypertension are more prevalent among blacks than whites (*7*). The results described in this report identify population groups in Michigan that need targeted interventions to reduce the prevalence of kidney disease risk factors and ultimately reduce morbidity and mortality from kidney disease.

The findings in this report are subject to at least three limitations. First, the change in ICD classification in 1999 resulted in a new coding structure that classified more deaths with kidney disease as the underlying cause of death (*8*). During 1998–1999, an apparent increase occurred in age-adjusted kidney disease mortality rates; part of this increase likely can be attributed to changes in ICD coding. Second, mortality

rates were estimated using only kidney disease as the underlying cause of death (i.e., not including deaths with kidney disease listed as a contributing cause), which underestimates the overall burden of mortality associated with kidney disease. Finally, kidney disease mortality among Hispanics was not analyzed; however, less than 4% of the population in Michigan in 2005 was Hispanic (*9*).

The number of persons living with chronic kidney disease (CKD) in Michigan is expected to increase with the increasing prevalence of diabetes and hypertension, major risk factors for kidney disease (*7*). In 2002, MDCH and the National Kidney Foundation of Michigan (NKFM) developed a plan for key health-care and community interventions to promote early identification and appropriate management of Michigan residents with CKD. Interventions in health-care settings include educating physicians regarding CKD management, developing a common CKD guideline for health plans across Michigan, and implementing mandatory reporting of the estimated glomerular filtration rate (GFR) by laboratories.* Estimated GFR (eGFR) is calculated using serum creatinine levels and is accepted as the best overall measure of kidney function (*10*). Substantial kidney dysfunction can be present despite a normal serum creatinine level, and an estimate of GFR detects more cases of CKD than does the serum creatinine level alone (*10*). In 2002, guidelines for the diagnosis and management of CKD were established to provide a definition and a classification scheme for staging kidney disease patients according to levels of GFR (*10*). In 2006, legislation was passed in Michigan mandating eGFR reporting by laboratories when an outpatient serum creatinine test is performed for adults covered by Medicaid, alerting health-care providers of early loss of kidney function and prompting action to reduce disease progression. Five other states have mandated eGFR reporting (Connecticut, Louisiana, New Jersey, Pennsylvania, and Tennessee), and eGFR legislation has been proposed in four more states (Alabama, Mississippi, North Carolina, and South Carolina).

Because blacks in Michigan are affected disproportionately by kidney disease, interventions have focused on reaching blacks in community-based settings, such as beauty salons, barber shops, schools, preschools, and Head Start programs. These interventions include lay health education programs about kidney disease and its risk factors. In one program, Healthy Hair Starts with a Healthy Body™, 20,433 beauty salon clients have received educational materials since 1999; 47% have reported taking a prevention step related to diet or exercise (e.g., limiting salt intake or increasing number of days they exercise ≥30 minutes), and 38% have visited a doctor or planned to do so. In another program, Dodge the Punch: Live Right™, 2,853 barber shop clients have received educational materials since 2005, and 37% have tried to eat more fruits and vegetables. In addition, MDCH and NKFM are working with CDC grantees at the University of Michigan and John Hopkins University to develop and test a national surveillance system for kidney disease in the United States.

*Mandate covers patients on Medicaid only. However, a survey of Michigan laboratories conducted by the MDCH Bureau of Laboratories in August 2006 indicated that 67% of laboratories are routinely providing estimated GFR results, compared with 22% in 2004.

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Notice to Readers

National Colorectal Cancer Awareness Month — March 2007

Colorectal cancer (i.e., cancer of the colon or rectum) is the second leading cause of cancer-related deaths in the United States. In 2003 (the most recent year for which data are available), 55,783 adults died of colorectal cancer (27,990 men and 27,793 women) in the United States, according to CDC's

U.S. Cancer Statistics: 2003 Incidence and Mortality report (*1*). In 2003, colorectal cancer, the third most commonly diagnosed cancer in the United States, was diagnosed in 143,945 adults (73,182 men and 70,763 women) (*1*). An estimated 50%–60% of colorectal cancer deaths would be prevented if all adults aged ≥50 years were routinely screened (*2*). However, approximately one half of U.S. residents at average risk in that age group have not been screened for colorectal cancer, according to national guidelines (*3*).

March is National Colorectal Cancer Awareness Month. CDC conducts research, monitors national data, and supports various programs to promote increased screening for this largely preventable disease. Among programs to increase screening rates for colorectal cancer, CDC has implemented a colorectal cancer screening demonstration program to provide screening and diagnostic follow-up to low-income and underinsured or uninsured populations. The demonstration program currently is conducted at five sites in the United States. In addition, CDC educates the public about the benefits of colorectal cancer screening through its multiyear, multimedia Screen for Life: National Colorectal Cancer Action Campaign. Additional information is available at http://www.cdc.gov/cancer/colorectal.

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Notice to Readers

World Water Day — March 22, 2007

In 1992, the United Nations (UN) Conference on Environment and Development designated March 22 as World Water Day. The objective of World Water Day is to promote activities related to the conservation and development of water resources, such as the publication and distribution of related documents and the organization of conferences and seminars (*1*). The theme for World Water Day 2007 is Coping with Water Scarcity.

Approximately 1.1 billion persons lack access to an improved water source,* and 2.4 billion persons lack access to adequate sanitation. As a result of infectious diseases related to unsafe water and inadequate sanitation, an estimated 3 million people in developing regions of the world die each year, primarily children aged <5 years (*2*). One of the UN's millennium development goals is, by 2015, to decrease by half the proportion of persons without sustainable access to safe drinking water and basic sanitation. According to a recent assessment, some regions, including sub-Saharan Africa, will not meet their targets if current trends continue (*3*).

Diarrhea accounts for approximately 4 billion episodes of illness and 1.8 million deaths every year, disproportionately affecting young children (*4*). Likewise, developing regions are disproportionately affected by illnesses and deaths from waterborne pathogens. The World Health Organization (WHO) estimates that 94% of diarrheal disease episodes are preventable through environmental modifications, including interventions to increase the availability of clean water and to improve sanitation and hygiene (*5*).

Families without access to improved water sources or who might be using unsafe water can improve the quality of their drinking water through simple, inexpensive technologies to treat and safely store drinking water in their homes. Studies have documented a reduced risk for diarrhea in families who treat their household drinking water through solar disinfection or by chlorination, filtration, combined chlorination, and flocculation (*6*). Additional information on household water treatment is available from CDC at http://www.cdc.gov/safewater and from WHO at http://www.who.int/household_water.

In the United States, improved water quality has dramatically enhanced the health of the population. However, new challenges have developed, including the emergence of chlorine-resistant pathogens, chemical contamination of water sources, aging infrastructure, increased recreational water contamination, exposure to water from cooling towers and other nontraditional water sources, and increasing water reuse. These challenges are reflected in increasing numbers of disease outbreaks associated with 1) small or individual water systems, 2) recreational water, 3) building distribution systems, and 4) other water sources (e.g., cooling towers). An

* Water that is supplied through a household connection, public standpipe, borehole well, protected dug well, protected spring, or rain water collection.

estimated 4 million to 33 million cases of gastrointestinal illness associated with public drinking water systems in the United States occur annually (*7*). However, these estimates are imprecise and do not include illnesses in the 45 million persons served by small or individual water systems, the >60 million persons who swim each year, other water exposures, or illnesses other than gastrointestinal illness.

Water-related activities throughout CDC address the relationship between water and public health from various perspectives, including the public health effects from contaminated drinking water and recreational water, global issues regarding safe water, waterborne disease outbreak surveillance and investigations, support for local and state health departments delivering water-related programs, and terrorism related to waterborne pathogens.

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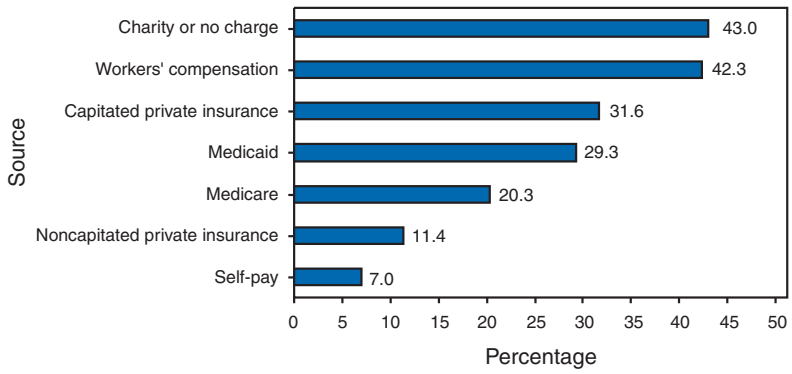
QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Office-Based Primary-Care Physicians Who Did Not Accept New Patients, by Expected Payment Source — National Ambulatory Medical Care Survey, United States, 2003–2004



Although 94.2% of primary-care physicians reported in 2003–2004 that they were accepting new patients, acceptance varied by the patient's expected payment source. Among the physicians, 43.0% did not accept new charity cases, 29.3% did not accept new Medicaid patients, and 20.3% did not accept new Medicare patients. Only 7.0% did not accept new patients who self-paid.

SOURCE: Hing E, Burt CW. Characteristics of office-based physicians and their practices: United States, 2003–04. Vital Health Stat 13 2007;164.

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending March 10, 2007 (10th 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	—	—	0	1	—	—	—	2	
Botulism:									
foodborne	—	—	0	19	19	16	20	28	
infant	1	12	2	92	85	87	76	69	KY (1)
other (wound & unspecified)	—	2	0	46	31	30	33	21	
Brucellosis	1	15	2	115	120	114	104	125	CA (1)
Chancroid	—	1	1	34	17	30	54	67	
Cholera	—	—	—	6	8	5	2	2	
Cyclosporiasis§	—	9	4	134	543	171	75	156	
Diphtheria	—	—	—	—	—	—	1	1	
Domestic arboviral diseases§,¶:									
California serogroup	—	—	0	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	2	11	1	556	786	537	362	511	NY (2)
human monocytic	2	19	1	493	506	338	321	216	NY (1), PA (1)
human (other & unspecified)	—	6	0	201	112	59	44	23	
Haemophilus influenzae,**									
invasive disease (age <5 yrs):									
serotype b	—	1	0	9	9	19	32	34	
nonserotype b	1	9	3	100	135	135	117	144	FL (1)
unknown serotype	2	60	5	247	217	177	227	153	NY (1), UT (1)
Hansen disease§	—	9	2	75	87	105	95	96	
Hantavirus pulmonary syndrome§	—	2	0	36	26	24	26	19	
Hemolytic uremic syndrome, postdiarrheal§	1	14	2	271	221	200	178	216	NY (1)
Hepatitis C viral, acute	7	107	21	833	652	713	1,102	1,835	CT (1), NY (1), TX (1), CA (4)
HIV infection, pediatric (age <13 yrs)††	—	—	6	52	380	436	504	420	
Influenza-associated pediatric mortality§,§§	7	32	1	41	45	—	N	N	AZ (1), SD (1), MN (1), GA (1), CA (3)
Listeriosis	4	78	9	802	896	753	696	665	VA (1), TX (2), WA (1)
Measles¶¶	—	1	1	51	66	37	56	44	
Meningococcal disease, invasive***:									
A, C, Y, & W-135	5	31	7	224	297	—	—	—	OH (1), TX (1), WA (3)
serogroup B	1	13	3	137	156	—	—	—	WA (1)
other serogroup	—	4	1	24	27	—	—	—	
unknown serogroup	10	120	23	721	765	—	—	—	NY (1), NYC (1), PA (1), OH (1), MN (2), FL (2), TN (1), WA (1)
Mumps	14	134	20	6,504	314	258	231	270	NY (1), PA (3), MO (1), KS (3), FL (2), AZ (1), WA (2), CA (1)
Plague	—	—	0	16	8	3	1	2	
Poliomyelitis, paralytic	—	—	—	—	1	—	—	—	
Poliovirus infection, nonparalytic§	—	—	—	N	N	N	N	N	
Psittacosis§	—	3	0	20	16	12	12	18	
Q fever§	—	19	1	164	136	70	71	61	
Rabies, human	—	—	—	3	2	7	2	3	
Rubella†††	—	5	0	8	11	10	7	18	
Rubella, congenital syndrome	—	—	0	1	1	—	1	1	
SARS-CoV§,§§§	—	—	0	—	—	—	8	N	
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	—	9	4	101	129	132	161	118	
Syphilis, congenital (age <1 yr)	—	25	7	323	329	353	413	412	
Tetanus	—	1	0	32	27	34	20	25	
Toxic-shock syndrome (staphylococcal)§	2	11	3	112	90	95	133	109	NY (1), PA (1)
Trichinellosis	—	1	0	14	16	5	6	14	
Tularemia	—	2	0	85	154	134	129	90	
Typhoid fever	2	41	5	307	324	322	356	321	MN (1), UT (1)
Vancomycin-intermediate *Staphylococcus aureus*§	—	—	0	4	2	—	N	N	
Vancomycin-resistant *Staphylococcus aureus*§	—	—	—	1	3	1	N	N	
Vibriosis (non-cholera *Vibrio* species infections)§	1	17	—	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 2003 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 33 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 March 10, 2007, and March 11, 2006 (10th 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	10,372	20,017	22,262	157,739	184,644	139	150	482	1,513	1,727	41	68	303	425	486
New England	699	659	1,260	5,872	5,256	—	0	0	—	—	2	3	22	20	63
Connecticut	198	185	729	1,049	867	N	0	0	N	N	—	0	5	5	38
Maine§	71	45	72	496	390	—	0	0	—	—	2	0	6	7	5
Massachusetts	321	298	604	3,146	2,793	—	0	0	—	—	—	0	14	—	14
New Hampshire	33	40	69	390	317	—	0	0	—	—	—	1	5	4	4
Rhode Island§	64	63	108	606	638	—	0	0	—	—	—	0	5	—	—
Vermont§	12	20	45	185	251	N	0	0	N	N	—	1	5	4	2
Mid. Atlantic	1,529	2,468	3,956	20,802	22,260	—	0	0	—	—	4	10	33	49	82
New Jersey	254	370	554	2,681	3,593	N	0	0	N	N	—	0	3	—	3
New York (Upstate)	705	502	2,633	3,882	3,231	N	0	0	N	N	3	3	13	12	12
New York City	—	755	1,566	6,804	7,996	N	0	0	N	N	—	2	12	8	23
Pennsylvania	570	779	1,005	7,435	7,440	N	0	0	N	N	1	4	18	29	44
E.N. Central	1,193	3,157	4,173	22,846	32,539	1	1	3	6	8	1	16	110	79	104
Illinois	596	1,021	1,267	7,769	10,753	—	0	0	—	—	—	2	22	2	15
Indiana	—	374	632	3,047	4,129	—	0	0	—	—	—	1	18	8	6
Michigan	367	749	1,225	7,122	5,228	1	0	3	4	5	—	2	9	15	19
Ohio	145	623	1,473	2,058	8,163	—	0	2	2	3	1	5	33	38	41
Wisconsin	85	371	527	2,850	4,266	N	0	0	N	N	—	5	53	16	23
W.N. Central	770	1,185	1,444	10,292	11,946	—	0	54	2	—	9	12	77	67	54
Iowa	124	161	223	1,516	1,749	N	0	0	N	N	—	2	28	11	4
Kansas	174	145	271	1,378	1,626	N	0	0	N	N	—	1	8	8	12
Minnesota	1	245	322	1,342	2,469	—	0	54	—	—	9	3	25	20	20
Missouri	276	453	628	4,359	4,317	—	0	1	2	—	—	2	21	10	12
Nebraska§	136	99	180	956	908	N	0	0	N	N	—	1	16	4	3
North Dakota	19	30	64	259	382	N	0	0	N	N	—	0	1	1	—
South Dakota	40	51	84	482	495	N	0	0	N	N	—	1	7	13	3
S. Atlantic	1,815	3,762	5,850	28,522	34,870	—	0	1	1	2	19	17	67	145	128
Delaware	27	69	107	678	719	N	0	0	N	N	—	0	3	2	—
District of Columbia	—	61	161	698	535	—	0	0	—	—	—	0	2	3	5
Florida	—	964	1,187	3,300	8,829	N	0	0	N	N	14	7	32	75	45
Georgia	—	708	2,754	5,604	5,971	N	0	0	N	N	3	5	12	43	36
Maryland§	—	343	482	3,001	3,051	—	0	1	1	2	—	0	3	3	7
North Carolina	689	613	1,772	5,456	7,693	—	0	0	—	—	2	0	11	6	23
South Carolina§	545	365	2,105	4,919	2,861	N	0	0	N	N	—	1	13	5	5
Virginia§	523	461	687	4,352	4,770	N	0	0	N	N	—	1	5	7	6
West Virginia	31	59	96	514	441	N	0	0	N	N	—	0	3	1	1
E.S. Central	1,082	1,464	2,074	14,163	13,565	—	0	0	—	—	—	3	15	15	7
Alabama§	34	424	761	3,061	4,442	N	0	0	N	N	—	1	12	6	2
Kentucky	96	139	691	1,120	1,721	N	0	0	N	N	—	1	3	7	1
Mississippi	232	385	957	4,235	2,554	N	0	0	N	N	—	0	3	—	1
Tennessee§	720	517	672	5,747	4,848	N	0	0	N	N	—	1	5	2	3
W.S. Central	751	2,182	3,023	16,165	20,391	—	0	1	—	—	5	5	45	16	19
Arkansas§	232	154	337	1,630	1,566	N	0	0	N	N	1	0	2	2	1
Louisiana	126	301	610	1,037	3,285	—	0	1	—	—	—	1	9	4	—
Oklahoma	393	248	423	2,391	1,866	N	0	0	N	N	4	0	4	9	8
Texas§	—	1,447	1,904	11,107	13,674	N	0	0	N	N	—	2	36	1	10
Mountain	572	1,274	2,043	8,129	12,532	77	107	202	1,012	1,297	1	3	39	23	16
Arizona	238	457	1,017	2,140	3,929	77	105	200	995	1,267	—	0	3	6	3
Colorado	—	315	418	1,309	3,021	N	0	0	N	N	1	1	7	9	3
Idaho§	—	50	253	549	628	N	0	0	N	N	—	0	5	1	1
Montana§	39	51	143	481	401	N	0	0	N	N	—	0	26	1	2
Nevada§	188	103	397	1,461	1,309	—	1	3	3	13	—	0	1	—	1
New Mexico§	18	187	314	1,270	2,038	—	0	3	3	4	—	0	5	5	1
Utah	60	96	182	788	932	—	1	4	11	11	—	0	3	1	5
Wyoming§	29	27	54	131	274	—	0	0	—	2	—	0	11	—	—
Pacific	1,961	3,381	4,017	30,948	31,285	61	51	299	492	420	—	1	5	11	13
Alaska	64	82	156	833	787	N	0	0	N	N	—	0	1	—	—
California	1,338	2,681	3,185	24,050	24,122	61	51	299	492	420	—	0	0	—	—
Hawaii	2	107	133	851	1,136	N	0	0	N	N	—	0	1	—	—
Oregon§	204	167	394	1,836	1,773	N	0	0	N	N	—	1	4	11	13
Washington	353	351	548	3,378	3,467	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	217	106	236	1,576	947	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	U	4	15	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 March 10, 2007, and March 11, 2006 (10th 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	123	318	531	2,064	2,783	3,334	6,785	8,663	51,371	64,475	32	43	133	423	450
New England	6	19	44	79	174	100	110	228	943	902	—	2	12	20	28
Connecticut	—	5	25	28	22	48	42	172	237	233	—	0	7	15	8
Maine§	5	4	15	32	12	—	2	8	16	28	—	0	4	2	4
Massachusetts	—	3	18	—	95	42	47	96	553	487	—	0	7	—	14
New Hampshire	—	0	9	1	6	1	3	9	25	48	—	0	2	3	—
Rhode Island§	—	0	17	—	11	8	9	19	99	95	—	0	3	—	1
Vermont§	1	3	12	18	28	1	1	5	13	11	—	0	2	—	1
Mid. Atlantic	23	65	120	363	538	387	638	1,323	5,786	6,265	5	9	25	91	106
New Jersey	—	7	16	—	90	94	103	158	948	1,021	—	1	4	6	18
New York (Upstate)	19	25	101	144	128	107	122	865	1,038	995	4	3	14	21	18
New York City	1	17	33	117	174	—	176	377	1,591	1,970	1	2	6	25	27
Pennsylvania	3	15	34	102	146	186	224	336	2,209	2,279	—	3	8	39	43
E.N. Central	19	41	96	279	513	452	1,272	2,225	8,832	13,360	2	6	14	44	65
Illinois	—	9	27	20	119	165	368	488	2,709	4,119	—	1	5	3	19
Indiana	N	0	0	N	N	—	154	287	1,259	1,830	—	1	10	5	9
Michigan	1	13	38	101	148	204	300	880	3,127	2,139	—	0	5	6	10
Ohio	18	15	32	125	143	55	306	718	666	3,789	2	2	6	30	15
Wisconsin	—	9	24	33	103	28	132	179	1,071	1,483	—	0	3	—	12
W.N. Central	11	23	117	152	265	255	383	509	3,446	3,604	7	2	22	25	17
Iowa	3	6	16	38	48	28	37	63	327	363	—	0	1	—	—
Kansas	2	3	11	22	33	50	43	91	441	458	—	0	2	5	3
Minnesota	1	0	87	7	75	—	65	87	390	586	7	0	17	7	—
Missouri	5	9	28	70	76	133	196	268	2,002	1,901	—	0	5	10	11
Nebraska§	—	2	9	8	13	34	26	56	216	207	—	0	2	2	3
North Dakota	—	0	4	—	4	2	2	6	13	25	—	0	2	1	—
South Dakota	—	1	6	7	16	8	6	15	57	64	—	0	0	—	—
S. Atlantic	18	50	88	388	396	825	1,616	2,542	11,490	15,395	9	11	26	116	118
Delaware	—	0	4	5	5	10	28	44	293	276	—	0	1	1	—
District of Columbia	—	1	4	13	12	—	35	63	320	362	—	0	2	1	—
Florida	18	22	44	196	162	—	446	549	1,564	4,104	6	3	9	40	31
Georgia	—	12	28	83	74	—	351	1,344	2,325	2,772	3	2	6	38	29
Maryland§	—	4	11	28	39	—	121	160	1,038	1,290	—	1	5	21	17
North Carolina	—	0	0	—	—	466	310	571	2,907	4,059	—	0	8	8	14
South Carolina§	—	2	8	8	18	174	163	1,135	1,995	1,177	—	0	3	5	11
Virginia§	—	9	28	54	84	171	117	238	905	1,233	—	1	7	—	12
West Virginia	—	0	6	1	2	4	19	43	143	122	—	0	4	2	4
E.S. Central	1	11	42	63	76	338	588	877	5,160	5,505	2	2	9	27	27
Alabama§	—	6	30	28	37	16	193	313	1,282	2,097	—	0	5	7	6
Kentucky	N	0	0	N	N	27	55	268	398	625	—	0	1	—	2
Mississippi	N	0	0	N	N	79	149	434	1,526	1,033	—	0	1	—	—
Tennessee§	1	4	12	35	39	216	194	239	1,954	1,750	2	1	6	20	19
W.S. Central	5	7	21	54	29	390	959	1,477	6,832	8,643	—	1	26	17	19
Arkansas§	—	3	13	26	12	79	80	142	763	941	—	0	2	1	2
Louisiana	—	1	6	7	—	78	179	366	859	1,865	—	0	3	2	1
Oklahoma	5	2	11	21	17	233	92	184	1,019	624	—	1	24	14	15
Texas§	N	0	0	N	N	—	583	925	4,191	5,213	—	0	2	—	1
Mountain	17	27	69	205	254	102	279	466	1,720	2,831	7	4	14	64	52
Arizona	4	3	11	41	28	41	116	231	477	970	2	2	9	34	24
Colorado	7	10	26	77	91	—	71	92	456	729	2	1	4	13	16
Idaho§	1	3	12	19	33	—	2	20	25	36	1	0	1	2	2
Montana§	—	2	11	10	12	—	3	20	20	20	—	0	0	—	—
Nevada§	—	1	8	4	7	51	30	135	363	494	—	0	1	1	—
New Mexico§	—	1	6	10	12	3	31	65	239	358	—	0	2	5	7
Utah	5	7	25	41	66	5	17	26	128	183	2	0	4	9	3
Wyoming§	—	0	4	3	5	2	2	5	12	41	—	0	1	—	—
Pacific	23	59	132	481	538	485	786	971	7,162	7,970	—	2	7	19	18
Alaska	1	1	17	13	4	7	10	27	88	96	—	0	2	4	2
California	20	43	71	365	420	391	650	833	6,079	6,607	—	0	5	—	4
Hawaii	—	1	4	11	12	1	15	30	92	198	—	0	1	—	3
Oregon§	—	8	14	62	77	23	26	46	207	291	—	1	5	15	8
Washington	2	7	55	30	25	63	77	131	696	778	—	0	1	—	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	1	5	19	17	11	12	5	16	76	77	—	0	2	—	—
U.S. Virgin Islands	U	0	0	U	U	U	0	4	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 March 10, 2007, and March 11, 2006 (10th 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	25	61	103	404	725	31	87	244	546	727	18	49	108	246	245
New England	—	2	20	3	58	1	2	4	7	36	—	1	12	2	15
Connecticut	—	1	3	2	7	—	0	3	—	16	—	0	9	1	3
Maine§	—	0	2	—	2	—	0	2	1	3	—	0	2	—	2
Massachusetts	—	0	4	—	33	—	0	1	—	11	—	0	4	—	8
New Hampshire	—	0	16	1	11	1	0	1	2	4	—	0	1	—	1
Rhode Island§	—	0	2	—	1	—	0	4	4	1	—	0	6	—	—
Vermont§	—	0	2	—	4	—	0	1	—	1	—	0	2	1	1
Mid. Atlantic	5	7	19	49	64	4	8	18	59	94	8	15	53	62	75
New Jersey	—	1	4	3	22	—	2	6	12	31	—	2	11	11	12
New York (Upstate)	3	1	11	13	10	2	1	14	10	5	6	5	30	19	18
New York City	2	2	11	21	20	—	2	6	7	20	—	2	20	3	15
Pennsylvania	—	1	4	12	12	2	3	7	30	38	2	5	19	29	30
E.N. Central	2	6	13	52	56	2	9	18	71	85	1	9	28	53	47
Illinois	—	1	4	15	14	—	2	9	4	29	—	1	7	—	9
Indiana	1	0	8	2	4	—	0	12	2	1	—	0	5	3	3
Michigan	—	2	8	23	18	2	3	9	32	34	1	3	10	23	7
Ohio	1	1	4	12	16	—	3	10	29	19	—	4	19	26	18
Wisconsin	—	0	4	—	4	—	0	3	4	2	—	0	3	1	10
W.N. Central	—	2	8	12	26	1	3	13	22	26	—	1	15	10	7
Iowa	—	0	1	4	1	—	0	2	5	4	—	0	3	1	—
Kansas	—	0	1	—	15	—	0	2	1	3	—	0	2	—	—
Minnesota	—	0	7	—	1	—	0	12	1	1	—	0	11	1	—
Missouri	—	1	3	5	5	1	1	6	12	15	—	0	2	6	5
Nebraska§	—	0	2	1	2	—	0	3	2	3	—	0	2	1	2
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	3	2	2	—	0	1	1	—	—	0	1	1	—
S. Atlantic	4	8	26	70	120	3	23	42	153	214	6	9	23	68	54
Delaware	—	0	2	—	3	—	1	4	3	7	—	0	2	1	1
District of Columbia	—	0	5	8	1	—	0	2	—	1	—	0	5	—	—
Florida	3	3	13	31	47	3	7	16	60	84	2	3	10	30	22
Georgia	—	1	5	11	8	—	3	8	25	19	2	1	5	11	1
Maryland§	—	1	6	5	19	—	2	7	13	40	—	2	8	13	16
North Carolina	—	0	11	1	31	—	1	23	21	42	2	0	5	6	7
South Carolina§	—	0	3	3	5	—	2	5	8	12	—	0	2	3	1
Virginia§	1	1	7	11	6	—	2	5	16	5	—	1	5	3	5
West Virginia	—	0	3	—	—	—	0	7	7	4	—	0	4	1	1
E.S. Central	—	2	8	17	25	—	8	23	40	66	—	2	9	11	9
Alabama§	—	0	3	2	3	—	2	13	10	26	—	0	2	1	2
Kentucky	—	0	4	2	10	—	1	5	1	16	—	1	5	4	1
Mississippi	—	0	4	4	1	—	1	7	7	6	—	0	2	—	—
Tennessee§	—	1	5	9	11	—	3	7	22	18	—	1	7	6	6
W.S. Central	1	6	20	20	44	8	18	110	85	92	2	1	12	9	3
Arkansas§	—	0	9	2	4	—	1	4	6	10	1	0	1	1	1
Louisiana	—	0	4	3	1	—	1	5	9	3	—	0	2	—	—
Oklahoma	—	0	3	—	3	5	1	14	7	—	—	0	6	—	—
Texas§	1	5	15	15	36	3	15	90	63	79	1	1	12	8	2
Mountain	4	5	14	60	72	2	3	8	19	39	1	2	8	20	10
Arizona	4	3	13	53	44	—	0	2	—	13	1	1	4	6	1
Colorado	—	1	3	5	12	2	0	4	4	7	—	0	2	3	2
Idaho§	—	0	2	—	3	—	0	2	2	4	—	0	3	1	2
Montana§	—	0	3	—	1	—	0	0	—	—	—	0	1	—	—
Nevada§	—	0	1	1	3	—	0	4	5	9	—	0	2	2	3
New Mexico§	—	0	2	1	5	—	0	2	3	4	—	0	2	2	—
Utah	—	0	2	—	4	—	0	5	5	2	—	1	6	5	2
Wyoming§	—	0	1	—	—	—	0	1	—	—	—	0	1	1	—
Pacific	9	15	53	121	260	10	11	36	90	75	—	1	10	11	25
Alaska	—	0	1	1	1	—	0	3	2	1	—	0	0	—	—
California	7	13	48	111	244	8	8	26	68	56	—	1	10	11	25
Hawaii	—	0	2	1	5	—	0	1	—	1	—	0	0	—	—
Oregon§	—	1	3	4	5	—	2	5	15	11	—	0	0	—	—
Washington	2	1	4	4	5	2	1	10	5	6	—	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	10	7	10	2	1	9	7	1	—	0	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.
† 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 March 10, 2007, and March 11, 2006 (10th 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	33	249	1,017	981	952	8	25	45	108	235	18	19	44	168	259
New England	5	20	260	61	72	—	0	6	—	8	—	1	3	3	11
Connecticut	2	9	227	20	29	—	0	3	—	1	—	0	2	1	3
Maine§	—	2	39	20	12	—	0	1	—	—	—	0	3	1	2
Massachusetts	—	0	3	—	15	—	0	3	—	5	—	0	2	—	5
New Hampshire	3	3	95	17	14	—	0	3	—	1	—	0	2	—	1
Rhode Island§	—	0	93	—	1	—	0	1	—	—	—	0	1	—	—
Vermont§	—	1	15	4	1	—	0	0	—	1	—	0	1	1	—
Mid. Atlantic	19	153	570	493	622	1	5	18	20	64	3	2	11	17	35
New Jersey	—	26	187	92	192	—	1	7	—	20	—	0	2	—	3
New York (Upstate)	17	59	392	116	159	1	1	7	5	6	1	0	4	3	4
New York City	—	3	24	2	10	—	3	9	10	31	1	1	4	4	14
Pennsylvania	2	44	237	283	261	—	1	4	5	7	1	0	4	10	14
E.N. Central	—	12	158	12	48	1	3	10	20	33	2	2	12	23	27
Illinois	—	0	1	—	—	—	1	6	6	12	—	0	3	3	9
Indiana	—	0	3	—	—	—	0	2	1	5	—	0	5	6	1
Michigan	—	1	5	4	2	1	0	2	4	4	—	0	4	6	6
Ohio	—	0	5	2	5	—	0	2	4	9	2	1	4	8	7
Wisconsin	—	11	154	6	41	—	0	3	5	3	—	0	2	—	4
W.N. Central	2	5	169	17	20	3	0	14	11	5	4	1	4	17	11
Iowa	—	1	8	1	4	—	0	1	1	1	—	0	2	4	—
Kansas	—	0	2	1	—	—	0	2	—	—	1	0	1	1	—
Minnesota	2	3	167	15	15	3	0	12	7	2	3	0	3	2	—
Missouri	—	0	2	—	—	—	0	1	1	1	—	0	3	7	7
Nebraska§	—	0	2	—	1	—	0	1	2	—	—	0	1	1	4
North Dakota	—	0	0	—	—	—	0	1	—	—	—	0	1	1	—
South Dakota	—	0	1	—	—	—	0	0	—	1	—	0	1	1	—
S. Atlantic	4	41	131	363	169	—	5	15	32	61	2	4	10	24	45
Delaware	—	7	28	59	55	—	0	1	1	—	—	0	1	—	2
District of Columbia	—	0	7	—	5	—	0	2	1	—	—	0	1	—	—
Florida	2	1	5	9	5	—	1	4	8	6	2	1	7	10	17
Georgia	—	0	1	—	1	—	1	6	4	16	—	0	3	5	2
Maryland§	—	20	88	258	96	—	1	4	8	18	—	0	2	5	4
North Carolina	—	0	4	—	7	—	0	4	4	8	—	0	6	—	11
South Carolina§	—	0	2	1	—	—	0	2	—	2	—	0	2	2	5
Virginia§	2	6	36	36	—	—	1	4	6	11	—	0	4	2	4
West Virginia	—	0	10	—	—	—	0	1	—	—	—	0	2	—	—
E.S. Central	—	1	4	4	—	1	0	3	6	6	1	1	3	10	11
Alabama§	—	0	3	1	—	—	0	2	—	2	—	0	2	2	2
Kentucky	—	0	2	—	—	—	0	1	1	1	—	0	1	—	1
Mississippi	—	0	1	—	—	—	0	1	1	1	—	0	3	3	2
Tennessee§	—	0	2	3	—	1	0	2	4	2	1	0	2	5	6
W.S. Central	—	0	5	2	1	—	1	7	2	5	1	1	5	12	14
Arkansas§	—	0	0	—	—	—	0	2	—	—	—	0	1	—	3
Louisiana	—	0	1	—	—	—	0	1	1	—	—	0	2	3	1
Oklahoma	—	0	0	—	—	—	0	2	1	1	—	0	3	4	4
Texas§	—	0	5	2	1	—	1	6	—	4	1	0	5	5	6
Mountain	—	0	4	2	2	—	1	6	2	13	—	1	4	14	21
Arizona	—	0	2	—	2	—	0	3	—	1	—	0	2	2	9
Colorado	—	0	1	—	—	—	0	2	1	6	—	0	2	3	9
Idaho§	—	0	2	—	—	—	0	1	—	—	—	0	1	1	—
Montana§	—	0	1	1	—	—	0	1	—	—	—	0	1	1	—
Nevada§	—	0	1	1	—	—	0	1	—	—	—	0	0	—	—
New Mexico§	—	0	1	—	—	—	0	1	—	1	—	0	1	1	—
Utah	—	0	1	—	—	—	0	2	1	5	—	0	2	6	3
Wyoming§	—	0	1	—	—	—	0	0	—	—	—	0	2	—	—
Pacific	3	3	17	27	18	2	4	13	15	40	5	5	10	48	84
Alaska	—	0	1	2	—	—	0	4	2	2	—	0	1	1	2
California	3	2	15	23	18	2	2	6	9	31	—	3	8	33	57
Hawaii	N	0	0	N	N	—	0	2	—	—	—	0	2	2	1
Oregon§	—	0	1	2	—	—	0	3	3	4	—	0	3	5	12
Washington	—	0	2	—	—	—	0	6	1	3	5	0	5	7	12
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	1	—
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 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 March 10, 2007, and March 11, 2006 (10th 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	115	258	743	1,206	2,675	26	107	173	480	858	2	32	118	65	252
New England	1	21	53	41	290	6	11	26	75	79	—	0	1	—	—
Connecticut	—	1	9	—	17	2	4	14	35	20	—	0	0	—	—
Maine†	—	2	14	19	17	3	2	8	14	11	N	0	0	N	N
Massachusetts	—	3	28	—	221	—	2	17	—	34	—	0	1	—	—
New Hampshire	1	2	27	7	2	—	1	5	8	2	—	0	1	—	—
Rhode Island†	—	0	17	—	11	—	0	3	4	2	—	0	1	—	—
Vermont†	—	1	14	15	22	1	2	5	14	10	—	0	0	—	—
Mid. Atlantic	26	37	156	274	315	—	17	57	38	108	—	1	6	7	9
New Jersey	—	4	11	8	85	—	0	0	—	—	—	0	1	—	1
New York (Upstate)	20	20	150	194	72	—	0	0	—	—	—	0	2	—	—
New York City	—	0	8	—	18	—	1	5	8	—	—	0	3	1	2
Pennsylvania	6	10	25	72	140	—	16	56	30	108	—	1	4	6	6
E.N. Central	8	41	78	267	442	1	2	18	1	4	—	1	6	1	3
Illinois	—	10	23	35	115	—	0	7	—	1	—	0	4	—	1
Indiana	—	3	34	1	21	—	0	2	—	—	—	0	1	—	—
Michigan	1	11	39	64	88	—	0	5	—	2	—	0	1	1	—
Ohio	7	12	56	163	149	1	0	9	1	1	—	0	4	—	2
Wisconsin	—	2	7	4	69	—	0	0	—	—	—	0	1	—	—
W.N. Central	—	18	97	84	347	2	6	20	24	28	—	3	14	9	3
Iowa	—	5	16	26	97	—	1	7	2	4	—	0	1	—	—
Kansas	—	4	13	38	93	1	2	5	15	10	—	0	1	—	—
Minnesota	—	0	80	—	—	1	0	6	3	2	—	0	2	—	—
Missouri	—	5	10	9	109	—	1	6	1	2	—	2	12	9	3
Nebraska†	—	1	9	1	43	—	0	0	—	—	—	0	5	—	—
North Dakota	—	0	9	1	4	—	0	7	3	2	—	0	0	—	—
South Dakota	—	0	4	9	1	—	0	4	—	8	—	0	0	—	—
S. Atlantic	40	17	136	160	187	15	39	62	277	469	1	13	68	34	227
Delaware	—	0	1	—	1	—	0	0	—	—	—	0	3	1	2
District of Columbia	—	0	2	1	2	—	0	0	—	—	—	0	1	—	—
Florida	17	4	20	65	48	—	0	7	27	176	1	0	5	2	5
Georgia	—	0	3	—	7	—	5	16	36	40	—	1	5	1	2
Maryland†	—	2	6	20	46	—	6	13	18	61	—	1	7	6	11
North Carolina	23	0	94	43	27	8	9	22	72	46	—	5	61	18	206
South Carolina†	—	3	11	15	28	—	3	11	19	24	—	0	5	2	1
Virginia†	—	2	19	16	26	7	12	27	97	106	—	2	13	4	—
West Virginia	—	0	9	—	2	—	2	7	8	16	—	0	2	—	—
E.S. Central	4	6	28	53	61	—	4	13	19	32	1	6	31	12	7
Alabama†	—	2	19	16	15	—	1	8	—	11	—	2	11	5	2
Kentucky	—	0	5	—	12	—	0	4	5	1	—	0	1	—	—
Mississippi	—	0	5	5	9	—	0	2	—	—	—	0	1	—	—
Tennessee†	4	3	11	32	25	—	2	8	14	20	1	4	22	7	5
W.S. Central	—	17	123	36	104	—	4	34	12	98	—	1	27	—	3
Arkansas†	—	1	13	—	6	—	0	5	3	1	—	0	10	—	3
Louisiana	—	0	2	2	3	—	0	0	—	—	—	0	1	—	—
Oklahoma	—	0	9	—	1	—	1	9	9	8	—	0	18	—	—
Texas†	—	14	110	34	94	—	0	29	—	89	—	0	5	—	—
Mountain	27	40	87	237	652	—	3	28	9	20	—	0	5	2	—
Arizona	7	6	28	47	122	—	2	10	8	19	—	0	2	—	—
Colorado	7	9	26	76	298	—	0	0	—	—	—	0	1	1	—
Idaho†	—	1	7	9	18	—	0	24	—	—	—	0	3	1	—
Montana†	—	1	8	9	25	—	0	2	—	—	—	0	2	—	—
Nevada†	—	0	6	—	6	—	0	0	—	—	—	0	0	—	—
New Mexico†	—	2	8	6	12	—	0	2	—	1	—	0	2	—	—
Utah	13	13	39	81	161	—	0	1	1	—	—	0	2	—	—
Wyoming†	—	1	8	9	10	—	0	2	—	—	—	0	1	—	—
Pacific	9	29	227	54	277	2	4	12	25	20	—	0	1	—	—
Alaska	—	1	8	8	24	1	0	6	16	7	N	0	0	N	N
California	—	21	224	—	152	1	3	11	9	13	—	0	1	—	—
Hawaii	—	1	6	4	29	N	0	0	N	N	N	0	0	N	N
Oregon†	—	2	8	16	38	—	0	4	—	—	—	0	1	—	—
Washington	9	4	46	26	34	—	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	6	15	21	N	0	0	N	N
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

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* Incidence data for reporting years 2006 and 2007 are provisional.
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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending March 10, 2007, and March 11, 2006 (10th Week)*

Reporting area	Salmonellosis					Shiga toxin-producing *E. coli* (STEC)†					Shigellosis				
	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	290	830	1,371	4,436	5,348	9	74	173	230	351	171	258	520	1,642	1,862
New England	2	18	82	103	698	—	2	16	6	100	—	2	14	10	107
Connecticut	—	0	54	54	503	—	0	0	—	84	—	0	7	7	67
Maine§	—	2	13	21	12	—	0	8	4	1	—	0	2	2	—
Massachusetts	—	9	53	—	156	—	0	9	—	11	—	0	11	—	33
New Hampshire	2	3	25	13	17	—	0	3	2	2	—	0	2	1	3
Rhode Island§	—	1	10	8	8	—	0	2	—	1	—	0	3	—	3
Vermont§	—	1	6	7	2	—	0	4	—	1	—	0	2	—	1
Mid. Atlantic	43	90	191	607	587	1	8	62	27	26	5	15	47	66	166
New Jersey	—	15	49	43	108	—	1	15	1	7	—	3	35	2	56
New York (Upstate)	28	27	92	185	96	—	3	14	13	7	4	4	43	19	47
New York City	2	24	50	141	174	—	0	4	1	3	—	5	14	35	47
Pennsylvania	13	30	67	238	209	1	2	47	12	9	1	1	6	10	16
E.N. Central	20	105	197	422	693	—	10	59	40	45	13	22	67	72	181
Illinois	—	27	60	25	193	—	1	7	2	5	—	9	49	9	65
Indiana	6	15	55	65	64	—	1	8	1	6	1	2	17	10	20
Michigan	1	18	35	95	134	—	1	6	8	11	—	2	5	6	48
Ohio	13	23	56	163	189	—	3	18	27	9	12	3	14	36	28
Wisconsin	—	17	27	74	113	—	2	39	2	14	—	3	10	11	20
W.N. Central	26	47	109	338	308	1	11	45	26	46	37	36	77	306	191
Iowa	1	8	26	45	49	—	1	38	—	9	—	2	14	6	4
Kansas	2	7	16	53	52	1	0	4	4	—	—	2	11	6	17
Minnesota	10	11	60	65	59	—	3	26	12	18	5	4	24	52	17
Missouri	12	14	35	118	89	—	2	13	5	15	31	10	69	223	114
Nebraska§	—	4	9	18	34	—	1	11	5	3	—	1	14	3	23
North Dakota	1	0	5	7	2	—	0	0	—	—	1	0	18	4	2
South Dakota	—	3	11	32	23	—	0	5	—	1	—	6	24	12	14
S. Atlantic	115	223	396	1,547	1,285	3	11	32	66	51	88	65	143	675	424
Delaware	—	2	10	7	13	—	0	3	3	—	—	0	2	2	—
District of Columbia	—	1	4	8	13	—	0	1	—	—	—	0	5	3	3
Florida	41	95	176	641	559	3	2	9	21	10	67	32	76	402	187
Georgia	26	34	67	311	171	—	1	7	8	8	21	24	54	233	132
Maryland§	—	13	33	94	88	—	2	9	13	9	—	1	10	11	26
North Carolina	47	29	130	278	272	—	2	11	10	16	—	1	14	9	49
South Carolina§	—	19	51	95	63	—	0	3	—	2	—	0	9	6	20
Virginia§	1	21	58	106	97	—	2	11	11	6	—	2	9	9	7
West Virginia	—	1	16	7	9	—	0	5	—	—	—	0	2	—	—
E.S. Central	17	63	153	261	298	—	4	21	13	25	7	13	84	107	133
Alabama§	—	22	95	63	123	—	0	5	1	2	—	5	75	32	26
Kentucky	6	8	23	63	55	—	1	12	4	6	—	2	15	12	71
Mississippi	—	12	42	18	48	—	0	0	—	—	—	2	15	13	20
Tennessee§	11	17	32	117	72	—	3	9	8	17	7	3	13	50	16
W.S. Central	6	84	185	142	375	1	3	46	11	8	7	37	182	104	181
Arkansas§	3	15	45	38	141	—	0	7	4	1	2	2	10	12	9
Louisiana	—	16	42	54	37	—	0	1	—	—	1	2	24	22	3
Oklahoma	3	8	40	43	38	1	0	17	2	—	—	2	9	8	15
Texas§	—	46	107	7	159	—	2	42	5	7	4	30	169	62	154
Mountain	21	51	87	317	362	1	7	34	21	34	8	26	87	122	141
Arizona	5	18	45	125	128	1	1	13	9	10	3	11	35	61	77
Colorado	12	12	30	86	83	—	1	8	1	10	5	3	15	19	16
Idaho§	2	3	9	21	26	—	2	8	2	4	—	0	3	1	4
Montana§	—	2	10	13	14	—	0	0	—	—	—	0	13	2	—
Nevada§	—	2	20	11	21	—	0	4	—	3	—	1	20	8	12
New Mexico§	—	4	15	23	37	—	1	5	5	3	—	2	15	16	22
Utah	2	5	15	28	41	—	1	14	4	3	—	1	6	4	9
Wyoming§	—	1	4	10	12	—	0	3	—	1	—	0	19	11	1
Pacific	40	117	288	699	742	2	4	20	20	16	6	33	90	180	338
Alaska	—	1	4	11	20	N	0	0	N	N	—	0	2	5	1
California	39	89	218	568	578	1	0	5	10	N	4	29	81	150	250
Hawaii	—	5	16	39	37	—	0	2	1	1	—	1	3	6	10
Oregon§	—	7	16	36	63	—	1	9	3	10	—	1	6	8	50
Washington	1	10	69	45	44	1	2	19	6	5	2	2	13	11	27
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	—	13	65	39	37	—	0	0	—	—	—	0	6	2	2
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

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† 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 March 10, 2007, and March 11, 2006 (10th 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	100	83	214	838	1,210	30	24	84	264	257
New England	1	2	15	16	51	2	1	4	8	11
Connecticut	—	0	0	—	—	—	0	0	—	—
Maine§	—	0	2	5	5	—	0	2	—	—
Massachusetts	—	0	5	—	35	—	0	4	—	9
New Hampshire	—	0	9	4	8	2	0	4	4	2
Rhode Island§	—	0	4	—	2	—	0	3	3	—
Vermont§	1	0	2	7	1	—	0	1	1	—
Mid. Atlantic	18	15	40	152	235	2	3	17	28	40
New Jersey	1	2	8	17	51	—	1	4	—	12
New York (Upstate)	14	5	26	60	50	2	2	14	28	25
New York City	—	3	8	19	47	—	0	2	—	3
Pennsylvania	3	6	13	56	87	N	0	0	N	N
E.N. Central	8	16	46	149	277	1	6	14	45	79
Illinois	—	4	11	31	104	—	1	6	4	18
Indiana	1	2	13	18	28	—	0	10	4	8
Michigan	3	3	11	34	54	—	1	5	18	21
Ohio	4	4	19	66	59	1	1	7	18	17
Wisconsin	—	1	7	—	32	—	1	2	1	15
W.N. Central	29	5	57	73	53	5	2	10	17	13
Iowa	—	0	0	—	—	—	0	0	—	—
Kansas	—	1	3	10	23	—	0	3	2	4
Minnesota	29	0	52	29	—	5	1	7	5	—
Missouri	—	2	6	28	16	—	0	2	7	5
Nebraska§	—	0	2	1	10	—	0	2	2	3
North Dakota	—	0	2	3	4	—	0	1	1	1
South Dakota	—	0	2	2	—	—	0	0	—	—
S. Atlantic	20	20	45	201	270	5	2	11	59	16
Delaware	—	0	2	—	1	—	0	0	—	—
District of Columbia	—	0	2	1	4	—	0	1	—	—
Florida	6	5	16	47	64	—	0	5	12	—
Georgia	9	5	11	68	69	5	0	5	23	—
Maryland§	—	4	12	34	57	—	1	5	19	12
North Carolina	—	0	26	14	28	—	0	0	—	—
South Carolina§	1	1	6	12	19	—	0	2	4	—
Virginia§	4	2	9	22	22	—	0	1	1	—
West Virginia	—	0	6	3	6	—	0	2	—	4
E.S. Central	3	4	11	37	52	—	0	6	17	5
Alabama§	N	0	0	N	N	N	0	0	N	N
Kentucky	—	0	5	8	13	—	0	0	—	—
Mississippi	N	0	0	N	N	—	0	2	2	5
Tennessee§	3	3	9	29	39	—	0	6	15	—
W.S. Central	9	6	50	50	80	10	3	39	37	35
Arkansas§	1	0	5	5	2	1	0	2	5	7
Louisiana	—	0	2	3	1	—	0	1	3	—
Oklahoma	2	2	6	21	32	1	1	12	13	12
Texas§	6	3	45	21	45	8	1	24	16	16
Mountain	12	11	42	140	171	5	4	12	44	56
Arizona	5	5	34	57	97	2	2	9	26	35
Colorado	3	3	8	39	31	3	1	4	12	14
Idaho§	1	0	1	4	3	—	0	1	—	1
Montana§	N	0	0	N	N	N	0	0	N	N
Nevada§	—	0	3	3	—	—	0	0	—	—
New Mexico§	1	1	5	9	20	—	0	3	6	6
Utah	2	1	7	27	18	—	0	0	—	—
Wyoming§	—	0	1	1	2	—	0	0	—	—
Pacific	—	2	9	20	21	—	0	4	9	2
Alaska	—	0	2	5	N	—	0	2	7	—
California	N	0	0	N	N	N	0	0	N	N
Hawaii	—	2	9	15	21	—	0	2	2	2
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 March 10, 2007, and March 11, 2006 (10th 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	51	43	105	567	611	8	6	19	79	76	68	181	252	1,300	1,601
New England	2	0	4	13	7	—	0	1	—	1	5	4	13	32	35
Connecticut	—	0	0	—	—	—	0	0	—	—	—	0	10	4	4
Maine§	—	0	2	3	2	—	0	1	—	—	—	0	1	—	3
Massachusetts	—	0	0	—	—	—	0	0	—	—	4	2	7	21	22
New Hampshire	—	0	0	—	—	—	0	0	—	—	1	0	2	4	4
Rhode Island§	—	0	3	4	1	—	0	1	—	—	—	0	3	3	1
Vermont§	2	0	2	6	4	—	0	1	—	1	—	0	1	—	1
Mid. Atlantic	4	3	8	38	28	—	0	5	9	2	9	24	38	264	184
New Jersey	—	0	0	—	—	—	0	0	—	—	4	3	8	30	29
New York (Upstate)	3	1	5	13	6	—	0	4	5	—	4	3	14	25	21
New York City	—	0	0	—	—	—	0	0	—	—	—	12	29	167	94
Pennsylvania	1	2	6	25	22	—	0	2	4	2	1	5	12	42	40
E.N. Central	10	10	40	153	126	3	1	8	19	21	16	15	32	106	178
Illinois	—	0	2	—	7	—	0	1	—	2	6	7	13	21	99
Indiana	4	2	29	24	18	—	0	5	3	6	—	1	5	5	18
Michigan	—	0	3	—	7	—	0	1	—	1	3	2	10	23	15
Ohio	6	5	38	129	94	3	1	5	16	12	7	4	9	49	37
Wisconsin	N	0	0	N	N	—	0	0	—	—	—	1	4	8	9
W.N. Central	2	1	51	19	11	—	0	10	3	1	2	5	14	40	41
Iowa	—	0	0	—	—	—	0	0	—	—	—	0	3	—	3
Kansas	—	0	1	2	—	—	0	0	—	—	—	0	3	4	5
Minnesota	—	0	50	—	—	—	0	10	—	—	—	1	5	15	11
Missouri	2	1	3	17	11	—	0	2	2	1	2	3	9	21	20
Nebraska§	—	0	1	—	—	—	0	0	—	—	—	0	2	—	2
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	1	—	—
South Dakota	—	0	3	—	—	—	0	1	1	—	—	0	3	—	—
S. Atlantic	31	21	49	273	358	4	3	8	36	31	7	42	132	254	344
Delaware	—	0	0	—	—	—	0	1	1	—	—	0	3	2	6
District of Columbia	—	0	3	2	8	—	0	2	—	—	—	2	7	23	29
Florida	17	12	29	146	148	4	2	8	31	30	—	14	23	68	137
Georgia	14	7	17	118	181	—	0	1	—	1	—	7	101	7	20
Maryland§	—	0	0	—	—	—	0	0	—	—	—	5	14	45	52
North Carolina	—	0	0	—	—	—	0	0	—	—	2	5	21	52	61
South Carolina§	—	0	0	—	—	—	0	0	—	—	—	1	5	15	16
Virginia§	N	0	0	N	N	—	0	0	—	—	5	3	17	42	23
West Virginia	—	1	14	7	21	—	0	1	4	—	—	0	2	—	—
E.S. Central	1	3	11	33	51	1	0	2	5	7	14	14	29	129	101
Alabama§	N	0	0	N	N	—	0	0	—	—	2	5	17	36	52
Kentucky	—	0	3	8	11	—	0	2	—	—	1	1	9	19	6
Mississippi	—	0	0	—	—	—	0	0	—	—	4	1	8	23	14
Tennessee§	1	2	10	25	40	1	0	2	5	7	7	5	12	51	29
W.S. Central	—	1	5	28	6	—	0	2	4	2	10	29	57	256	251
Arkansas§	—	0	3	1	4	—	0	0	—	2	1	1	7	22	16
Louisiana	—	0	2	8	2	—	0	1	1	—	8	5	30	56	34
Oklahoma	—	0	4	19	—	—	0	2	3	—	1	1	4	15	15
Texas§	—	0	0	—	—	—	0	0	—	—	—	21	32	163	186
Mountain	1	1	7	10	24	—	0	5	3	11	1	8	27	36	78
Arizona	—	0	0	—	—	—	0	0	—	—	—	3	16	11	34
Colorado	—	0	0	—	—	—	0	0	—	—	—	1	5	1	12
Idaho§	N	0	0	N	N	—	0	0	—	—	—	0	1	—	1
Montana§	—	0	0	—	—	—	0	0	—	—	—	0	1	—	—
Nevada§	—	0	2	5	2	—	0	1	1	—	1	1	12	11	21
New Mexico§	—	0	0	—	—	—	0	0	—	—	—	1	5	11	8
Utah	1	0	7	4	14	—	0	4	2	8	—	0	2	1	2
Wyoming§	—	0	3	1	8	—	0	2	—	3	—	0	1	1	—
Pacific	—	0	0	—	—	—	0	0	—	—	4	37	52	183	389
Alaska	—	0	0	—	—	—	0	0	—	—	—	0	4	1	1
California	N	0	0	N	N	—	0	0	—	—	3	34	45	161	333
Hawaii	—	0	0	—	—	—	0	0	—	—	—	0	2	1	5
Oregon§	N	0	0	N	N	—	0	0	—	—	—	0	6	3	4
Washington	N	0	0	N	N	—	0	0	—	—	1	2	11	17	46
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	—	—	3	2	11	20	28
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 March 10, 2007, and March 11, 2006 (10th 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	775	770	1,431	7,861	9,746	—	1	178	—	2	—	1	399	—	1
New England	8	25	72	114	363	—	0	3	—	—	—	0	2	—	—
Connecticut	—	0	0	—	—	—	0	3	—	—	—	0	1	—	—
Maine¶	—	3	17	—	70	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	1	—	92	—	0	1	—	—	—	0	1	—	—
New Hampshire	5	5	47	40	70	—	0	0	—	—	—	0	0	—	—
Rhode Island¶	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Vermont¶	3	12	66	74	131	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	94	105	190	1,140	1,260	—	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	94	105	190	1,140	1,260	—	0	2	—	—	—	0	1	—	—
E.N. Central	114	256	587	2,620	4,069	—	0	43	—	—	—	0	33	—	—
Illinois	—	1	7	1	19	—	0	23	—	—	—	0	23	—	—
Indiana	—	0	0	—	—	—	0	7	—	—	—	0	12	—	—
Michigan	32	100	258	1,047	1,196	—	0	11	—	—	—	0	2	—	—
Ohio	82	128	449	1,346	2,475	—	0	11	—	—	—	0	3	—	—
Wisconsin	—	16	64	226	379	—	0	2	—	—	—	0	2	—	—
W.N. Central	47	29	131	441	539	—	0	36	—	—	—	0	79	—	—
Iowa	N	0	0	N	N	—	0	3	—	—	—	0	4	—	—
Kansas	12	5	52	230	101	—	0	3	—	—	—	0	3	—	—
Minnesota	—	0	0	—	—	—	0	6	—	—	—	0	7	—	—
Missouri	15	17	82	167	411	—	0	14	—	—	—	0	2	—	—
Nebraska¶	N	0	0	N	N	—	0	9	—	—	—	0	38	—	—
North Dakota	18	0	49	24	13	—	0	5	—	—	—	0	28	—	—
South Dakota	2	1	15	20	14	—	0	7	—	—	—	0	22	—	—
S. Atlantic	68	85	187	821	948	—	0	2	—	—	—	0	7	—	—
Delaware	—	1	6	7	26	—	0	0	—	—	—	0	0	—	—
District of Columbia	—	0	5	—	5	—	0	0	—	—	—	0	1	—	—
Florida	37	0	42	272	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¶	2	20	71	246	242	—	0	1	—	—	—	0	0	—	—
Virginia¶	—	26	78	1	253	—	0	0	—	—	—	0	2	—	—
West Virginia	29	25	61	295	422	—	0	1	—	—	—	0	0	—	—
E.S. Central	—	4	43	63	—	—	0	15	—	2	—	0	16	—	—
Alabama¶	—	4	43	61	—	—	0	2	—	—	—	0	0	—	—
Kentucky	N	0	0	N	N	—	0	2	—	—	—	0	1	—	—
Mississippi	—	0	2	2	—	—	0	10	—	2	—	0	16	—	—
Tennessee¶	N	0	0	N	N	—	0	4	—	—	—	0	2	—	—
W.S. Central	374	204	875	2,009	1,729	—	0	58	—	—	—	0	26	—	1
Arkansas¶	16	10	92	88	160	—	0	4	—	—	—	0	2	—	—
Louisiana	—	1	9	16	9	—	0	13	—	—	—	0	9	—	1
Oklahoma	—	0	0	—	—	—	0	6	—	—	—	0	4	—	—
Texas¶	358	175	782	1,905	1,560	—	0	38	—	—	—	0	16	—	—
Mountain	69	58	137	634	838	—	0	61	—	—	—	1	228	—	—
Arizona	—	0	0	—	—	—	0	9	—	—	—	0	15	—	—
Colorado	29	23	59	253	485	—	0	10	—	—	—	0	51	—	—
Idaho¶	N	0	0	N	N	—	0	30	—	—	—	0	157	—	—
Montana¶	12	0	11	73	N	—	0	3	—	—	—	0	8	—	—
Nevada¶	—	0	3	—	1	—	0	9	—	—	—	0	16	—	—
New Mexico¶	4	4	34	57	133	—	0	1	—	—	—	0	1	—	—
Utah	24	18	65	251	212	—	0	8	—	—	—	0	17	—	—
Wyoming¶	—	0	11	—	7	—	0	7	—	—	—	0	10	—	—
Pacific	1	0	9	19	—	—	0	15	—	—	—	0	51	—	—
Alaska	1	0	9	19	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	6	12	30	87	81	—	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 2003 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 March 10, 2007 (10th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
New England	572	431	97	26	11	7	45
Boston, MA	150	115	22	5	5	3	13
Bridgeport, CT	20	12	6	2	—	—	3
Cambridge, MA	24	21	2	1	—	—	7
Fall River, MA	39	30	4	4	—	1	3
Hartford, CT	38	27	5	5	—	1	3
Lowell, MA	25	19	5	1	—	—	4
Lynn, MA	10	10	—	—	—	—	—
New Bedford, MA	24	20	3	1	—	—	—
New Haven, CT	42	29	10	2	—	1	7
Providence, RI	56	45	9	—	2	—	1
Somerville, MA	6	1	3	2	—	—	—
Springfield, MA	46	27	16	—	3	—	2
Waterbury, CT	27	21	5	—	—	1	1
Worcester, MA	65	54	7	3	1	—	1
Mid. Atlantic	2,064	1,448	425	126	32	31	135
Albany, NY	43	31	5	3	3	1	2
Allentown, PA	21	17	2	2	—	—	1
Buffalo, NY	79	58	13	4	1	2	5
Camden, NJ	30	15	7	4	3	1	2
Elizabeth, NJ	25	16	4	4	—	1	5
Erie, PA	40	25	12	2	1	—	2
Jersey City, NJ	26	13	12	1	—	—	3
New York City, NY	1,095	773	232	66	10	13	54
Newark, NJ	57	33	10	10	2	2	3
Paterson, NJ	21	11	6	3	1	—	1
Philadelphia, PA	181	118	47	10	4	2	13
Pittsburgh, PA§	33	24	7	2	—	—	4
Reading, PA	34	26	5	1	1	1	1
Rochester, NY	151	115	23	6	2	5	20
Schenectady, NY	U	U	U	U	U	U	U
Scranton, PA	35	25	7	1	—	2	1
Syracuse, NY	139	107	24	4	3	1	13
Trenton, NJ	19	13	4	1	1	—	1
Utica, NY	22	18	3	1	—	—	2
Yonkers, NY	13	10	2	1	—	—	2
E.N. Central	2,198	1,430	531	144	41	52	155
Akron, OH	76	53	14	8	1	—	5
Canton, OH	32	21	7	3	—	1	4
Chicago, IL	349	191	102	31	9	16	30
Cincinnati, OH	103	63	21	11	2	6	18
Cleveland, OH	246	170	58	12	1	5	7
Columbus, OH	231	144	64	15	4	4	16
Dayton, OH	133	98	29	5	—	1	5
Detroit, MI	204	112	65	13	11	3	12
Evansville, IN	58	41	8	8	1	—	7
Fort Wayne, IN	70	46	18	2	—	4	4
Gary, IN	10	6	4	—	—	—	—
Grand Rapids, MI	59	46	10	—	—	3	10
Indianapolis, IN	193	130	37	16	7	3	12
Lansing, MI	49	35	11	1	1	1	2
Milwaukee, WI	88	55	26	5	1	1	9
Peoria, IL	54	40	12	—	1	1	2
Rockford, IL	49	34	11	4	—	—	2
South Bend, IN	44	38	5	—	—	1	3
Toledo, OH	116	80	23	9	2	2	2
Youngstown, OH	34	27	6	1	—	—	5
W.N. Central	675	483	144	19	12	16	45
Des Moines, IA	81	53	20	5	2	1	5
Duluth, MN	32	25	5	2	—	—	3
Kansas City, KS	17	14	2	—	—	1	2
Kansas City, MO	94	64	18	3	5	4	3
Lincoln, NE	46	39	5	—	—	2	3
Minneapolis, MN	62	44	14	1	1	2	4
Omaha, NE	103	82	17	1	—	3	11
St. Louis, MO	79	49	26	2	—	1	3
St. Paul, MN	55	39	14	1	1	—	4
Wichita, KS	106	74	23	4	3	2	7
S. Atlantic	1,360	840	342	107	36	35	91
Atlanta, GA	197	119	53	13	8	4	14
Baltimore, MD	204	120	57	18	6	3	26
Charlotte, NC	123	75	33	8	3	4	7
Jacksonville, FL	179	107	46	19	5	2	10
Miami, FL	83	52	21	9	—	1	7
Norfolk, VA	52	37	11	2	1	1	—
Richmond, VA	72	38	22	8	2	2	1
Savannah, GA	65	44	13	5	2	1	8
St. Petersburg, FL	67	48	15	—	1	3	5
Tampa, FL	193	133	32	12	8	8	7
Washington, D.C.	100	50	32	12	—	6	1
Wilmington, DE	25	17	7	1	—	—	5
E.S. Central	947	625	220	61	22	19	84
Birmingham, AL	156	105	33	9	4	5	11
Chattanooga, TN	101	65	27	6	2	1	9
Knoxville, TN	115	83	21	7	2	2	10
Lexington, KY	74	50	16	5	2	1	9
Memphis, TN	201	129	50	15	4	3	17
Mobile, AL	87	55	22	4	2	4	3
Montgomery, AL	56	38	9	4	4	1	8
Nashville, TN	157	100	42	11	2	2	17
W.S. Central	1,700	1,075	395	143	48	39	115
Austin, TX	90	54	26	6	3	1	9
Baton Rouge, LA	66	43	16	6	—	1	—
Corpus Christi, TX	56	29	22	2	3	—	3
Dallas, TX	198	122	38	27	6	5	22
El Paso, TX	157	124	19	10	2	2	10
Fort Worth, TX	100	71	22	4	1	2	8
Houston, TX	387	206	104	45	17	15	18
Little Rock, AR	73	42	23	6	1	1	2
New Orleans, LA¶	U	U	U	U	U	U	U
San Antonio, TX	324	216	70	21	9	8	27
Shreveport, LA	116	78	23	10	3	2	12
Tulsa, OK	133	90	32	6	3	2	4
Mountain	1,048	692	238	73	24	20	78
Albuquerque, NM	U	U	U	U	U	U	U
Boise, ID	48	36	6	2	3	1	5
Colorado Springs, CO	83	51	21	6	1	4	4
Denver, CO	98	60	23	9	3	3	5
Las Vegas, NV	255	170	56	22	6	1	15
Ogden, UT	37	31	4	2	—	—	3
Phoenix, AZ	179	102	52	14	6	4	15
Pueblo, CO	22	16	6	—	—	—	1
Salt Like City, UT	163	106	35	13	3	6	14
Tucson, AZ	163	120	35	5	2	1	16
Pacific	1,343	925	288	75	28	27	107
Berkeley, CA	15	14	1	—	—	—	4
Fresno, CA	U	U	U	U	U	U	U
Glendale, CA	U	U	U	U	U	U	U
Honolulu, HI	90	60	25	1	2	2	6
Long Beach, CA	70	48	15	2	4	1	7
Los Angeles, CA	U	U	U	U	U	U	U
Pasadena, CA	33	26	4	3	—	—	3
Portland, OR	136	82	38	12	2	2	9
Sacramento, CA	192	138	33	12	4	5	11
San Diego, CA	146	99	27	8	4	8	13
San Francisco, CA	135	88	33	12	2	—	12
San Jose, CA	185	136	35	9	3	2	15
Santa Cruz, CA	38	23	10	5	—	—	3
Seattle, WA	138	91	31	6	5	5	16
Spokane, WA	64	53	9	2	—	—	3
Tacoma, WA	101	67	27	3	2	2	5
Total	11,907**	7,949	2,680	774	254	246	855

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.

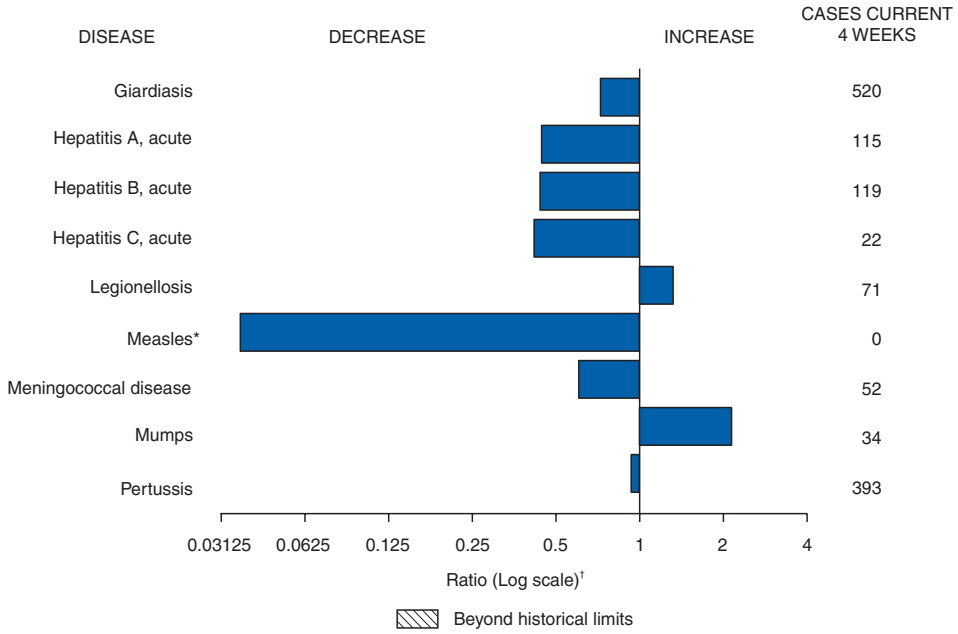
† Pneumonia and influenza.

§ 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 March 10, 2007, with historical data



* No measles cases reported for the current 4-week period, yielding a ratio for week 10 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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