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National Stroke Awareness Month — May 2005

May is National Stroke Awareness Month. During 2005, an estimated 700,000 persons in the United States will have a stroke, approximately 160,000 persons will die from stroke, and 15%–30% of stroke survivors will be disabled permanently (1). Preventing and controlling stroke risk factors, such as high blood pressure, atherosclerosis, atrial fibrillation, tobacco use, and diabetes, are the most important measures for preventing a stroke. Recognition of the warning signs of stroke and immediate calls for emergency medical care by bystanders are critical first steps toward obtaining appropriate emergency treatment that might prevent death and disability for persons having a stroke. The warning signs of stroke are 1) sudden numbness or weakness of the face, arm, or leg, especially on one side of the body; 2) sudden confusion, including trouble speaking or understanding; 3) sudden trouble seeing in one or both eyes; 4) sudden trouble walking, dizziness, or loss of balance or coordination; and 5) sudden, severe headache with no known cause.

CDC supports programs in 32 states and the District of Columbia that emphasize multiple strategies for targeting stroke and its risk factors in various settings and ensuring that patients receive quality care. CDC also funds stroke-care registries in several states that monitor the quality of care for stroke. Additional information about state programs and the national stroke registry is available at <http://www.cdc.gov/cvh>. Information about stroke prevention and care is also available at <http://www.strokeassociation.org>, <http://www.stroke.org>, and <http://www.ninds.nih.gov>.

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Disparities in Deaths from Stroke Among Persons Aged <75 Years — United States, 2002

Despite declines in deaths from stroke, stroke remained the third leading cause of death in the United States in 2002, and age-adjusted death rates for stroke remained higher among blacks than whites (1). In 1997, excess deaths from stroke occurred among persons aged <65 years in most racial/ethnic minority groups, compared with whites (2). A younger age distribution among Hispanics and other racial/ethnic groups compared with whites might partly explain the disproportionate burden in deaths at younger ages. To examine disparities in stroke mortality among persons aged <75 years, CDC assessed several characteristics of mortality at younger ages by using death certificate data for 2002. This report summarizes the results of that assessment. Overall, 11.9% of all stroke deaths in 2002 occurred among persons aged <65 years; the proportion of stroke decedents who were aged <65 years was higher among blacks, American Indians/Alaska Natives, and Asians/Pacific Islanders, compared with whites. In addition, the mean ages of stroke decedents were statistically significantly lower in these racial groups than among whites. Blacks had more than twice the age-specific death rates from stroke than whites aged <75 years. Approximately 3,400 excess stroke deaths would not have occurred among blacks in 2002 if blacks had had the same death rates for stroke as whites aged <65 years. Moreover, age-adjusted estimates of years of potential

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Notifiable Disease Morbidity and 122 Cities Mortality Data

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life lost (YPLL) before age 75 years from stroke were more than twice as high for blacks than for all other racial groups. Reducing premature death from stroke in these groups will require early prevention, detection, treatment, and control of risk factors for stroke in young and middle-aged adults.

National and state mortality statistics used in this assessment were based on information from death certificates from all 50 states and the District of Columbia (DC). Demographic data (e.g., race/ethnicity, sex, and age) on death certificates were provided by funeral directors or family members. Stroke-related deaths were defined as those for which the underlying causes reported on the death certificate by a physician, medical examiner, or coroner were classified according to *International Classification of Diseases, Tenth Revision* (ICD-10) codes I60-I69. Age-specific excess deaths for racial groups were calculated by subtracting the expected number of deaths (i.e., the population number in a racial group multiplied by the death rate of whites) from the observed number of deaths within each age-specific group (2). YPLL before age 75 years was calculated as the sum of the differences between age 75 years and the midpoint of each of eight age groups <75 years (3). Age-adjusted estimates for YPLL before age 75 years (per 100,000 persons aged <75 years) in 2002 were calculated by using the 2000 U.S. standard population (3). The mean age at death for all stroke decedents was also calculated. Age-adjusted death rates (per 100,000 population) and 95% confidence intervals (CIs) were calculated by using the 2000 U.S. standard population (1).

Among U.S. residents, 162,672 stroke deaths occurred in 2002, with an age-adjusted death rate of 56.2 per 100,000 population (Table 1). Age-adjusted rates were higher among blacks (76.3) than whites (54.2) ($p < 0.05$). The overall mean age of a stroke decedent was 79.6 years; however, males had a younger mean age at stroke death than females ($p < 0.05$). Blacks, American Indians/Alaska Natives, and Asians/Pacific Islanders had younger mean ages than whites ($p < 0.05$), and the mean age at stroke death was also younger among Hispanics than among non-Hispanics ($p < 0.05$). Of all stroke deaths in 2002, a total of 19,376 (11.9%) occurred among persons aged <65 years. The proportion of stroke decedents aged <65 was higher among men than women, higher in other racial groups than among whites, and higher among Hispanics than among non-Hispanics. Overall, 568,575 YPLL occurred before age 75 years from stroke in 2002; this number resulted in an age-adjusted estimate of 208.5 per 100,000 population aged <75 years. Higher age-adjusted estimates of YPLL were observed in males (227.9) compared with females

TABLE 1. Total number of stroke deaths, age-adjusted death rate*, mean age at death, percentage of stroke decedents aged <65 years, and years of potential life lost (YPLL) before age 75 years, by selected characteristics — United States, 2002

Characteristic	Total	Rate		Mean age (yrs)		Aged <65 years (%)	YPLL from stroke before age 75 years	
		No.	(95% CI) [†]	No.	(95% CI)		No.	Rate [§]
Sex								
Men	62,622	56.5	(56.0–57.1)	76.3	(76.2–76.4)	16.7	300,442	227.9
Women	100,050	55.2	(54.8–55.6)	81.6	(80.8–82.4)	8.9	268,133	190.7
Race								
White	139,719	54.2	(53.9–54.6)	80.7	(80.6–80.7)	9.5	397,680	173.7
Black	18,856	76.3	(74.9–77.8)	72.6	(72.3–72.8)	27.8	145,543	475.3
American Indian/Alaska Native	567	37.5	(33.7–41.3)	71.4	(70.1–72.8)	29.6	4,835	202.6
Asian/Pacific Islander	3,530	29.4	(27.5–31.3)	75.4	(74.9–75.8)	20.5	20,518	187.4
Hispanic origin[¶]								
Hispanic	6,451	41.3	(40.0–42.6)	72.6	(72.2–73.0)	26.3	50,516	195.5
Non-Hispanic	155,852	56.8	(56.4–57.1)	79.9	(79.8–79.9)	11.3	516,540	209.3
Total	162,672	56.2	(55.9–56.5)	79.6	(79.5–79.6)	11.9	568,575	208.5

* Per 100,000 population; adjusted to the standard 2000 U.S. population.

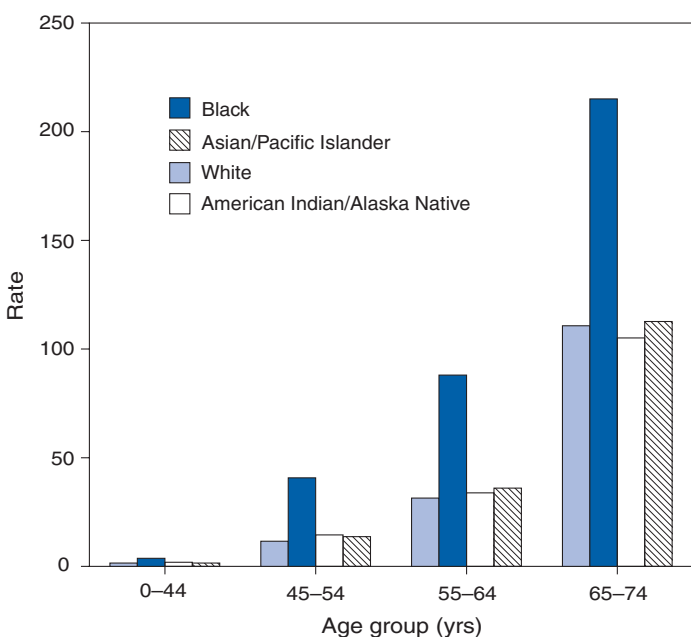
[†] Confidence interval.

[§] Age-adjusted estimated rate per 100,000 population aged <75 years; adjusted to the standard 2000 U.S. population aged <75 years.

[¶] Hispanics and non-Hispanics include members of any race. Decedents with missing information about Hispanic origin were excluded from this category.

(190.7) and were more than doubled in blacks (475.3) compared with whites (173.7) (Table 1).

Compared with whites, age-specific death rates for blacks were 2.5 times, 3.5 times, 2.8 times, and 1.9 times higher ($p<0.05$) at ages 0–44, 45–54, 55–64, and 65–74 years, respectively (Figure). This resulted in 3,453.9 excess stroke deaths among blacks at age <65 years (606.5 at age 0–44 years,

FIGURE. Age-specific death rates* for stroke among persons aged <75 years, by race and age group — United States, 2002

* Per 100,000 population.

1,352.5 at age 45–54 years, and 1,494.9 at age 55–64 years). Age-specific death rates among American Indians/Alaskan Natives and Asians/Pacific Islanders were slightly higher than among whites ($p<0.05$ for age 55–64 years only). Compared with non-Hispanics, Hispanics had lower or similar age-specific death rates for stroke (CDC, unpublished data, 2005).

Age-adjusted death rates, mean age at stroke death, and the proportion of stroke deaths that occurred at age <65 years varied among states and DC (Table 2). In 2002, the age-adjusted death rate for stroke ranged from 37.4 per 100,000 population in New York to 74.3 in Arkansas. The mean age of stroke decedents ranged from 75.5 years in Alaska to 83.4 years in North Dakota. The proportion of stroke deaths occurring at age <65 years ranged from 6.3% in Iowa to 18.2% in Louisiana and 18.3% in DC. Age-adjusted estimates of YPLL from stroke before age 75 years (per 100,000 population aged <75 years) ranged from 132.7 in Vermont to 361.0 in Mississippi in 2002.

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Editorial Note: The findings in this report demonstrate racial and ethnic disparities in stroke mortality at age <75 years. In 2002, the mean age of stroke decedents was 79.6 years, and only 11.9% of all stroke deaths occurred among persons aged <65 years. However, considerable differences by race/ethnicity and by area of residence occurred in the proportion of deaths at age <65 years and by race/ethnicity in age-specific mortality rates, excess deaths, and YPLL before age 75 years. Whereas a younger age distribution among Hispanics and other racial groups compared with whites might explain some of the higher

TABLE 2. Total number of stroke deaths, age-adjusted death rate*, mean age at death, percentage of stroke decedents aged <65 years, and years of potential life lost (YPLL) before age 75 years, by state/area — United States, 2002

State/Area	Total	Rate		Mean age (yrs)		Aged <65 years (%)	YPLL from stroke before age 75 years	
		No.	(95% CI) [†]	No.	(95% CI)		No.	Rate [§]
Alabama	3,201	69.6	(67.2–72.0)	77.9	(77.4–78.3)	15.9	14,240	325.3
Alaska	158	55.1	(46.0–64.2)	75.5	(73.3–77.7)	17.7	855	157.6
Arizona	2,535	47.6	(45.8–49.5)	79.6	(79.1–80.1)	11.2	8,264	165.7
Arkansas	2,232	74.3	(71.3–77.4)	78.9	(78.3–79.4)	13.2	8,693	330.5
California	17,626	58.0	(57.2–58.9)	79.5	(79.3–79.7)	11.9	62,252	200.1
Colorado	1,915	54.4	(52.0–56.9)	79.6	(79.0–80.2)	12.3	6,911	170.1
Connecticut	1,861	45.6	(43.5–47.7)	80.5	(79.9–81.1)	10.9	6,180	183.3
Delaware	405	50.4	(45.5–55.3)	79.5	(78.2–80.9)	13.1	1,493	189.4
District of Columbia	279	48.7	(43.0–54.5)	77.2	(75.6–78.9)	18.3	1,352	250.2
Florida	10,269	46.0	(45.1–46.9)	79.5	(79.2–79.7)	12.2	35,790	212.0
Georgia	4,261	65.3	(63.3–67.3)	76.9	(76.4–77.3)	17.6	21,125	274.7
Hawaii	812	60.6	(56.5–64.8)	79.9	(79.0–80.8)	12.0	2,781	227.0
Idaho	736	59.4	(55.1–63.7)	81.6	(80.7–82.4)	8.0	1,784	146.7
Illinois	7,183	57.2	(55.9–58.6)	80.0	(79.7–80.2)	11.3	24,072	206.7
Indiana	3,717	60.1	(58.2–62.0)	79.7	(79.3–80.2)	12.0	13,048	224.9
Iowa	2,226	57.9	(55.5–60.3)	82.7	(82.2–83.2)	6.3	4,537	159.5
Kansas	1,845	59.5	(56.7–62.2)	82.1	(81.6–82.7)	8.2	4,483	178.7
Kentucky	2,554	63.5	(61.0–66.0)	79.6	(79.1–80.1)	11.6	8,657	216.5
Louisiana	2,595	63.0	(60.6–65.4)	76.6	(76.0–77.1)	18.2	13,675	327.6
Maine	823	53.7	(50.1–57.4)	82.1	(81.3–82.9)	7.4	1,839	137.6
Maryland	2,811	56.7	(54.6–58.8)	78.6	(78.1–79.1)	14.1	11,535	218.5
Massachusetts	3,559	48.1	(46.5–49.7)	81.6	(81.2–82.0)	8.1	8,885	143.8
Michigan	5,814	58.1	(56.6–59.6)	79.5	(79.2–79.9)	12.6	21,041	219.6
Minnesota	2,706	51.3	(49.4–53.3)	82.0	(81.5–82.4)	7.7	6,333	135.7
Mississippi	1,926	69.5	(66.4–72.6)	76.7	(76.0–77.3)	18.0	9,646	361.0
Missouri	3,885	62.5	(60.5–64.4)	80.4	(80.0–80.7)	10.1	11,958	218.8
Montana	639	62.4	(57.6–67.3)	81.8	(80.9–82.7)	8.5	1,447	150.8
Nebraska	1,103	54.6	(51.4–57.9)	81.8	(81.0–82.5)	9.0	3,071	191.9
Nevada	976	56.8	(53.1–60.4)	75.8	(74.9–76.8)	17.5	5,211	251.0
New Hampshire	627	50.1	(46.2–54.0)	80.8	(79.9–81.8)	8.6	1,750	139.6
New Jersey	4,016	43.5	(42.1–44.8)	79.0	(78.6–79.4)	12.7	14,995	179.0
New Mexico	715	41.5	(38.4–44.5)	78.3	(77.3–79.3)	15.1	2,910	165.0
New York	7,625	37.4	(36.6–38.2)	79.0	(78.7–79.3)	13.1	29,034	156.6
North Carolina	5,259	67.8	(65.9–69.6)	79.0	(78.6–79.3)	12.6	19,261	242.4
North Dakota	469	54.6	(49.6–59.6)	83.4	(82.5–84.4)	6.8	928	150.5
Ohio	7,252	59.4	(58.1–60.8)	79.9	(79.6–80.2)	10.7	23,140	208.9
Oklahoma	2,427	66.2	(63.6–68.9)	78.9	(78.3–79.4)	12.8	9,380	279.5
Oregon	2,645	69.5	(66.8–72.1)	81.2	(80.8–81.7)	8.7	6,511	190.7
Pennsylvania	8,579	54.4	(53.2–55.5)	80.7	(80.5–81.0)	9.2	24,004	194.7
Rhode Island	605	45.8	(42.1–49.5)	80.9	(79.9–81.8)	8.6	1,583	154.9
South Carolina	2,822	72.7	(70.0–75.3)	77.2	(76.7–77.7)	16.7	13,250	330.3
South Dakota	518	54.2	(49.4–58.9)	82.7	(81.6–83.8)	6.8	1,245	176.6
Tennessee	3,980	70.1	(67.9–72.2)	78.8	(78.4–79.2)	13.4	15,307	268.8
Texas	10,548	61.8	(60.6–63.0)	78.6	(78.4–78.9)	14.0	43,320	228.2
Utah	903	56.8	(53.1–60.5)	80.6	(79.8–81.5)	8.9	2,530	137.0
Vermont	335	50.9	(45.4–56.4)	81.6	(80.3–82.8)	7.2	799	132.7
Virginia	3,960	61.2	(59.3–63.1)	79.4	(79.0–79.8)	12.0	13,866	197.6
Washington	3,753	65.2	(63.1–67.3)	81.7	(81.4–82.1)	8.1	9,011	158.9
West Virginia	1,260	58.3	(55.1–61.5)	79.7	(79.0–80.4)	10.2	4,008	208.4
Wisconsin	3,479	57.7	(55.7–59.6)	81.1	(80.7–81.5)	9.6	9,902	191.0
Wyoming	243	51.5	(45.0–58.0)	80.4	(78.9–81.9)	9.9	695	141.0
Total	162,672	56.2	(55.9–56.5)	79.6	(79.5–79.6)	11.9	568,575	208.5

* Per 100,000 population; adjusted to the standard 2000 U.S. population.

† Confidence interval.

§ Age-adjusted estimated rate per 100,000 population aged <75 years; adjusted to the standard 2000 U.S. population aged <75 years.

proportions of deaths at age <65 years, stroke decedents in these groups die at a younger age than non-Hispanics and whites. Stroke death at younger ages contributes to 8% of the lower life expectancy in blacks compared with whites after accounting for heart disease (27.4%), cancer (19.4%), and homicide (9.7%) (4). Racial and ethnic disparities might also be explained by differences in stroke risk factors among population subgroups and younger adults. For example, among adults aged 45–54 years, during 1998–2002, a statistically higher prevalence of self-reported diabetes was observed for Hispanics than non-Hispanic whites in several states with the highest proportions of Hispanics (5). Hispanics and non-Hispanic blacks also have a higher prevalence of overweight, obesity, and physical inactivity than non-Hispanics whites (3,6), whereas self-reported high blood pressure is higher in blacks than whites (3,6). In certain communities, the prevalence of hypertension, diabetes, and obesity among American Indians and blacks is considerably higher than in the general population (7). Cigarette smoking tends to be more common in American Indian communities than in other racial or ethnic communities (7). To eliminate these disparities in stroke mortality among persons aged <75 years, public health strategies should focus on detecting and reducing stroke risk factors and improving access to health-care and preventive-care services among young and middle-aged adults in racial and ethnic subgroups at high risk.

Variations among states might reflect differences in lifestyle and stroke risk factors (6). States with the highest proportion of stroke deaths occurring at age <65 years are in the southern region of the United States, which includes a higher percentage of adults with stroke risk factors, such as hypertension, smoking, obesity, and physical inactivity (6). The disproportionate number of stroke deaths among persons aged <65 years in Alaska, Nevada, and New Mexico might reflect the demographics of those states, which have greater proportions of American Indian/Alaska Native communities and a high prevalence of stroke risk factors.

The findings in this report are subject to at least two limitations. First, death certificate data are subject to error in the certification of underlying causes of death (1). Second, underreporting of American Indian/Alaska Native, Asian/Pacific Islander, and Hispanic origin on death certificates might lead to underestimates of the proportion of stroke deaths among persons aged <65 years among these populations (1,8).

Premature death is only part of the health impact of strokes in young and middle-aged adults. An estimated 942,000 hospitalizations for stroke occurred in 2002; of these, 28% occurred among patients aged <65 years (9). Approximately 2.3% of whites and 2.7% of blacks living in U.S. households in 2000–2001 reported a history of stroke; approximately half of

black stroke survivors and one third of white stroke survivors were aged <65 years (10). Black stroke survivors experienced more limitations of activities than white survivors (10). The elimination of stroke risk is crucial for reducing not only death but also stroke disability, thereby improving both the quality of life and life expectancy. Campaigns that increase awareness of stroke warning signs and symptoms should be continued, particularly among young adults who might perceive stroke as a health condition limited to the aging population.

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Regional and Racial Differences in Prevalence of Stroke — 23 States and District of Columbia, 2003

Higher stroke mortality in the United States has long been evidenced among blacks and residents of southeastern states (1). A greater proportion of blacks live in the southeastern states that make up the so-called stroke belt than elsewhere in the country (2); however, variations in socioeconomic characteristics and risk factors have also been associated with disparities in stroke, and these variations have been associated with region and race (3). To more closely examine these associations, CDC analyzed data from the 2003 Behavioral Risk Factor Surveillance System (BRFSS) survey. This report

describes the results of that analysis, which indicated that although the prevalence of stroke was higher in 10 southeastern states than in 13 other states and the District of Columbia (DC) and higher among blacks than among whites, differences in education level and certain risk factors (i.e., having diabetes or high blood pressure, smoking, and not having health-care coverage) might account for most of the differences in stroke prevalence by region and race. These findings reinforce the importance of primary and secondary prevention of known risk factors for stroke.

BRFSS is a state-based, random-digit-dialed cross-sectional telephone survey of the U.S. civilian, noninstitutionalized population aged ≥ 18 years conducted in all 50 states, DC, and three U.S. territories. In the 2003 cardiovascular module of the BRFSS survey, data on stroke were collected from 109,629 respondents in 23 states and DC. Response rates ranged from 38.3% in Maryland to 64.6% in Nebraska; median response rate was 53.2%. A total of 6,086 respondents who had missing data for stroke, age, race, diabetes, high blood pressure, smoking status, or health-care coverage status were excluded from this analysis; also excluded were 7,945 respondents whose racial identity was other than black or white (and who might be of any ethnicity). The final sample consisted of 95,598 respondents.

The 23 states were divided into two categories: southeastern and nonsoutheastern states. Ten states (Alabama, Arkansas, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia) were categorized as southeastern, and 13 states (Alaska, Colorado, Connecticut, Hawaii, Maine, Maryland, Minnesota, Montana, Nebraska, New York, North Dakota, Ohio, and West Virginia) plus DC were categorized as nonsoutheastern. Respondents were considered to have had a stroke if they answered "yes" to the question: "Has a doctor, nurse, or other health professional ever told you that you had a stroke?" Persons were considered to have diabetes if they answered "yes" to the question: "Have you ever been told by a doctor that you have diabetes?" They were considered to have high blood pressure if they reported having been told by a doctor, nurse, or other health professional that they had high blood pressure. Respondent smoking status was categorized as follows: never smoked (fewer than 100 cigarettes in lifetime), formerly smoked (at least 100 cigarettes in lifetime but not currently smoking), or currently smoke (smoked at least 100 cigarettes in lifetime and currently smoke every day or some days). Respondents were considered to have health-care coverage if they answered "yes" to the question: "Do you have any kind of health-care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?" Respondents were also asked about the highest grade or year of school they had com-

pleted and were placed into one of four education-level categories on the basis of their response: less than high school graduate, high school graduate, some college, and college graduate.

Estimates of stroke prevalence were standardized to the sex and age distribution of the 2000 U.S. population. Logistic regression analysis was used to examine the independent effects of region and race on stroke prevalence after adjustments for other factors, expressed as adjusted odds ratios (AORs). Statistical software was used to account for the complex sampling design and to calculate standard errors and 95% confidence intervals (CIs). Of the 95,598 respondents in the study, 41,059 were southeastern whites, and 9,448 were southeastern blacks; 42,175 were nonsoutheastern whites, and 2,916 were nonsoutheastern blacks. Blacks represented 21.0% of the population in southeastern states and 10.5% of the population in nonsoutheastern states. Blacks had a lower mean age than their white counterparts both in southeastern states (42.0 years versus 46.7 years) and nonsoutheastern states (44.1 years versus 47.0 years). The highest age-adjusted prevalence of stroke was among southeastern blacks (3.4% [CI = 3.0%–3.9%]), followed by nonsoutheastern blacks (2.8% [CI = 2.1%–3.8%]), southeastern whites (2.5% [CI = 2.3%–2.7%]), and nonsoutheastern whites (1.8% [CI = 1.7%–2.0%]). Therefore, by race, prevalence of stroke was higher in the southeastern states than in the nonsoutheastern states and, within both groups of states, prevalence of stroke was higher among blacks than among whites.

Among all participants, blacks had greater proportions in younger age groups and higher percentages of females than did whites (Table 1). Persons in the southeastern states had lower education levels than those in the nonsoutheastern states, and blacks had lower education levels than whites. Prevalence of diabetes and high blood pressure was higher in the southeastern states and among blacks; however, a higher percentage of blacks never smoked. Blacks and residents of southeastern states were less likely to have health-care coverage than were whites and residents of nonsoutheastern states (Table 1).

The age- and sex-adjusted AOR comparing stroke prevalence among southeastern residents with prevalence among nonsoutheastern residents was 1.43 (CI = 1.26–1.61) (Table 2). After additional adjustment for race, the AOR was reduced to 1.37 (CI = 1.21–1.55). Finally, the AOR was calculated as 1.23 (CI = 1.08–1.40), a reduction of 47% from the age- and sex-adjusted AOR, after additional adjustment for five other factors (i.e., education level, having diabetes, having high blood pressure, smoking status, and having health-care coverage). The age- and sex-adjusted AOR comparing stroke prevalence among blacks in both regions with prevalence among whites in both regions was 1.61 (CI = 1.37–1.88). That AOR was reduced to 1.52 (CI = 1.29–1.78) after additional adjustment for region.

TABLE 1. Estimated percentage of adults aged ≥18 years with selected characteristics, by region and race — Behavioral Risk Factor Surveillance System, 23 states and District of Columbia (DC), 2003

Characteristic	Southeastern states*				Nonsoutheastern states† and DC			
	Black		White		Black		White	
	%	(95% CI) [§]	%	(95% CI)	%	(95% CI)	%	(95% CI)
Age group (yrs)								
18–34	38.9	(37.4–40.4)	28.5	(27.8–29.2)	31.1	(28.4–33.9)	27.8	(27.0–28.6)
35–44	21.2	(20.0–22.3)	20.1	(19.6–20.7)	23.6	(21.3–26.1)	20.2	(19.6–20.9)
45–54	17.8	(16.8–18.8)	18.9	(18.3–19.4)	19.3	(17.2–21.7)	19.3	(18.7–19.9)
55–64	10.5	(9.8–11.3)	14.8	(14.3–15.2)	12.6	(10.8–14.7)	14.3	(13.8–14.8)
≥65	11.6	(10.9–12.4)	17.7	(17.3–18.2)	13.3	(11.3–15.6)	18.4	(17.8–18.9)
Sex								
Men	44.4	(42.9–45.9)	48.3	(47.6–49.0)	43.8	(40.9–46.8)	48.1	(47.3–48.9)
Women	55.6	(54.1–57.1)	51.7	(51.0–52.4)	56.2	(53.2–59.1)	51.9	(51.1–52.7)
Education level								
Less than high school graduate	18.9	(17.9–20.0)	11.8	(11.4–12.2)	13.3	(11.2–15.7)	8.1	(7.6–8.6)
High school graduate	36.9	(35.5–38.4)	31.4	(30.8–32.0)	35.9	(33.1–38.8)	30.3	(29.6–31.1)
Some college	26.0	(24.7–27.3)	27.3	(26.7–27.9)	25.4	(23.0–27.9)	25.9	(25.2–26.6)
College graduate	18.2	(17.1–19.3)	29.5	(28.9–30.1)	25.4	(23.1–27.9)	35.7	(34.9–36.4)
Has diabetes	12.1	(11.2–12.9)	7.6	(7.2–7.9)	10.7	(9.1–12.6)	6.8	(6.4–7.2)
Has high blood pressure	33.8	(32.5–35.1)	28.3	(27.7–28.8)	30.0	(27.5–32.8)	24.9	(24.3–25.6)
Smoking status[¶]								
Never smoked	63.4	(62.0–64.8)	49.4	(48.7–50.1)	59.7	(56.8–62.5)	49.9	(49.1–50.6)
Formerly smoked	14.1	(13.2–15.1)	25.0	(24.5–25.6)	17.0	(15.0–19.3)	28.2	(27.5–28.9)
Currently smokes	22.5	(21.3–23.8)	25.5	(24.9–26.2)	23.3	(21.0–25.8)	22.0	(21.3–22.7)
Has health-care coverage	77.4	(76.1–78.6)	86.4	(85.9–86.9)	83.9	(81.7–86.0)	89.2	(88.7–89.8)

* Alabama, Arkansas, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia.

† Alaska, Colorado, Connecticut, Hawaii, Maine, Maryland, Minnesota, Montana, Nebraska, New York, North Dakota, Ohio, and West Virginia.

§ Confidence interval.

¶ Categorized as follows: never smoked (fewer than 100 cigarettes in lifetime), formerly smoked (at least 100 cigarettes in lifetime but not currently smoking), or currently smoke (smoked at least 100 cigarettes in lifetime and currently smoke every day or some days).

TABLE 2. Comparison of diagnosed stroke in adults aged ≥18 years among residents of southeastern states* and residents of nonsoutheastern states† and among blacks and whites — Behavioral Risk Factor Surveillance System, 23 states and the District of Columbia (DC), 2003

Adjustments	Southeastern states versus nonsoutheastern states and DC		Blacks versus whites	
	AOR [§]	(95% CI) [¶]	AOR	(95% CI)
Age- and sex-adjusted	1.43	(1.26–1.61)	1.61	(1.37–1.88)
Age-, sex-, and race-adjusted	1.37	(1.21–1.55)	—	—
Age-, sex-, and region-adjusted	—	—	1.52	(1.29–1.78)
Fully adjusted model**	1.23	(1.08–1.40)	1.13	(0.96–1.33)

* Alabama, Arkansas, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia.

† Alaska, Colorado, Connecticut, Hawaii, Maine, Maryland, Minnesota, Montana, Nebraska, New York, North Dakota, Ohio, and West Virginia.

§ Adjusted odds ratio.

¶ Confidence interval.

** In addition to adjusting for age, sex, and race or region, the fully adjusted model was adjusted for education level, having diabetes, having high blood pressure, smoking status, and having a health-care plan.

Finally, the AOR comparing blacks and whites in both regions was reduced to 1.13 (CI = 0.96–1.33) when adjusted for all factors, a 79% reduction from the age- and sex-adjusted AOR.

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Editorial Note: The findings in this report indicate higher prevalence of stroke in 10 southeastern states than in 13 nonsoutheastern states and DC. Blacks living in the southeastern states had the highest prevalence of stroke. The greater proportion of blacks in the southeastern states accounted for some of the higher prevalence in this group of states. However, differences in education level and prevalence of risk factors such as diabetes and high blood pressure accounted for approximately half of the difference in stroke prevalence between southerners and nonsoutherners and approximately three fourths of the difference in prevalence between blacks and whites. These findings reinforce the importance of primary and secondary prevention of known risk factors (e.g., diabetes, high blood pressure, and smoking) for stroke.

Stroke death rates have been higher in the southeastern region of the United States than in other regions for approximately 50 years (1); the 10 southeastern states in this report,

plus Indiana, make up the stroke belt (4). The reasons for persistence of high stroke mortality in this region are not entirely known; in one study, socioeconomic status was not a major factor (5). In other studies, higher rates of high blood pressure, diabetes, smoking, and certain other stroke risk factors did not fully explain the higher stroke risk among residents of southeastern states (6). Regional variations might be attributable to risk factors other than those considered in this report, such as lower intake of animal protein, potassium, and calcium, and higher intake of sodium and grain-derived complex carbohydrates among residents of southeastern states (7).

The findings in this report are subject to at least three limitations. First, because BRFSS data are collected through a cross-sectional telephone survey, institutionalized persons and persons not able to answer questions because of stroke-related disability were not included. This exclusion might result in underestimates of the stroke burden and create certain biases in survey data. Second, although 10 of the 11 previously named stroke belt states (all except Indiana) were included in this report as the southeastern states, the 13 nonsoutheastern states plus DC might not be representative of the entire remainder of the United States. This analysis also did not include certain states with a high stroke mortality (e.g., Washington and Oregon) that have been described as the new "satellites" of the stroke belt (8). Finally, because the prevalence of stroke is estimated at only 2%–4% in the general population, not enough stroke patients were among survey participants to permit the analyses by age group performed in previous studies (9,10).

This report confirms that blacks and others residing in the southeastern United States are disproportionately affected by stroke. Other attempts have been made to understand the elevated stroke risk among blacks. A report based on data from the first National Health and Nutrition Examination Survey Epidemiologic Follow-up Study determined that the risk for cerebral infarction among black persons aged 34–44 years compared with whites in the same age group attenuated only from 2.6 to 2.1 after accounting for differences in demographic, education, and stroke risk factors (9). In an analysis of data from the Atherosclerosis Risk in Communities cohort, blacks aged 45–64 years still had a 38% greater risk for stroke than whites even after accounting for established risk factors (10). While researchers examine causes for this excess stroke burden, programs to prevent stroke should continue to focus on disproportionately affected regions (e.g., southeastern states) and disproportionately affected subpopulations (e.g., blacks) and prevention of known risk factors for stroke.

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Monitoring Progress in Arthritis Management — United States and 25 States, 2003

Arthritis is a chronic disease affecting an estimated 43 million (20.8%) U.S. adults and is the leading cause of disability in the United States (1,2). Arthritis results in activity and work limitations, decreased quality of life, and substantial burden to the U.S. health-care system (2–4). Promotion of arthritis self-management through weight counseling, physical activity counseling, and arthritis education can reduce pain, improve function and quality of life, and delay disability among persons with arthritis (5). To encourage arthritis self-management, three objectives were added to the national health objectives for 2010 (6). To monitor progress toward achieving these objectives and assess that progress by selected characteristics, CDC analyzed data from the 2003 National Health Interview Survey (NHIS) and the state-based 2003 Behavioral Risk Factor Surveillance System (BRFSS) survey. This report summarizes the results of those analyses, which indicated no statistically significant progress toward reaching the targets for weight counseling, physical activity counseling, and arthritis education. To meet these targets by 2010, public health and health-care agencies should increase efforts to improve awareness of these three factors among both health-care providers and patients. Such interventions will enable persons with arthritis to better self-manage their disease.

NHIS is an annual, in-person survey of persons of all ages in the United States. In 2003, approximately 31,000 adults were selected as a nationally representative sample of the U.S. civilian, noninstitutionalized adult population aged ≥ 18 years; response rate for the adult sample was 74.2% (7). Respondents were considered to have doctor-diagnosed arthritis if they answered “yes” to the question: “Have you ever been told by a doctor or other health professional that you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?” Those who answered “yes” were asked three questions designed to monitor progress toward meeting the national arthritis management objectives for 2010 regarding weight counseling (objective 2-4a), physical activity counseling (objective 2-4b), and arthritis education (objective 2-8) (Table 1) (6).

BRFSS is a state-based, random-digit-dialed telephone survey of the U.S. civilian, noninstitutionalized population aged ≥ 18 years conducted in all 50 states, the District of Columbia, and three U.S. territories. In the arthritis management module of the 2003 BRFSS survey administered in 25 states, the same questions were asked as in the NHIS survey to identify persons with arthritis and to monitor progress toward meeting the national arthritis management objectives for 2010. Response rates among the 25 states ranged from 28.8% in Connecticut to 65.5% in Utah; median response rate was 42.7% (8). Because NHIS and BRFSS both use complex sample designs, statistical weighting was used to calculate estimates and 95% confidence intervals; both NHIS and BRFSS estimates were age-adjusted to the standard 2000 U.S. population.

For both surveys, prevalence estimates for physical activity counseling and arthritis education objectives were calculated from the total number of respondents who reported doctor-diagnosed arthritis. Prevalence estimates for the weight counseling objective were calculated from the total number of respondents with doctor-diagnosed arthritis who were also overweight (i.e., their self-reported height and weight produced a body mass index [BMI]* of 25.0–29.9) or obese (i.e., BMI of ≥ 30.0). In NHIS, physically inactive was defined as no participation in any leisure-time physical activity. Persons with doctor-diagnosed arthritis were considered to have activity limitations attributable to arthritis if they responded “yes” to the question: “Are you now limited in any way in any of your usual activities because of arthritis or joint symptoms?”

When compared with baseline data for the national objectives collected on the NHIS in 2002, NHIS data for 2003 indicated no statistically significant progress toward meeting the targets for the three arthritis management objectives (Table 1). Age-adjusted data for 2003 indicated that 21.5% of U.S. adults had doctor-diagnosed arthritis (Table 2). Among overweight or obese persons with arthritis, weight counseling was reported by 37.3% overall; among obese persons with arthritis, 56.1% reported weight counseling. Among all adults with arthritis, 55.5% reported receiving physical activity counseling. The percentage of persons receiving physical activity counseling who were obese (64.9%) was significantly higher ($p < 0.05$) than for persons who were overweight (52.5%).

* Calculated as weight in kilograms divided by height in meters squared.

TABLE 1. Estimated age-adjusted*, weighted prevalence of adults aged ≥ 18 years with doctor-diagnosed arthritis who met national arthritis management objectives, compared with national targets for 2010 — National Health Interview Survey, United States, 2002–2003

Arthritis management objective [§]	Survey question	Age-adjusted prevalence				2010 target %
		2002 [†]		2003		
		%	(95% CI) [¶]	%	(95% CI)	
Weight counseling (objective 2-4a) Increase the proportion of adults with doctor-diagnosed arthritis who receive health-care–provider counseling for weight reduction among overweight and obese persons.**	Has a doctor or other health professional ever suggested losing weight to help your arthritis or joint symptoms?	35.0	(32.8–37.2)	37.3	(35.0–39.6)	46
Physical activity counseling (objective 2-4b) Increase the proportion of adults with doctor-diagnosed arthritis who receive health-care–provider counseling for physical activity or exercise.	Has a doctor or other health professional ever suggested physical activity or exercise to help your arthritis or joint symptoms?	51.9	(50.0–53.8)	55.5	(53.7–57.4)	67
Arthritis education (objective 2-8) Increase the proportion of persons with doctor-diagnosed arthritis who have had effective, evidence-based arthritis education as an integral part of the management of their condition.	Have you ever taken an educational course or class to teach you how to manage problems related to your arthritis or joint symptoms?	11.2	(10.0–12.3)	10.8	(9.6–12.0)	13

* Age-adjusted to the standard 2000 U.S. population.

[†] Baseline data for national arthritis management objectives.

[§] Not yet finalized; under consideration as part of the *Healthy People 2010 Midcourse Review*.

[¶] Confidence interval.

** Defined as body mass index (BMI) of ≥ 25.0 ; BMI calculated as weight in kilograms divided by height in meters squared.

TABLE 2. Estimated age-adjusted*, weighted prevalence of adults aged ≥18 years with doctor-diagnosed arthritis and percentage who met national arthritis management objectives, by selected characteristics — National Health Interview Survey, United States, 2003

Characteristic	Arthritis management objective†							
	U.S. adults with arthritis		Weight counseling (objective 2-4a)§		Physical activity counseling (objective 2-4b)		Arthritis education (objective 2-8)	
	%	(95% CI¶)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Age group (yrs)								
18–44	7.8	(7.3–8.4)	32.8	(29.0–36.9)	54.7	(51.4–57.9)	10.6	(8.7–12.9)
45–64	30.2	(29.1–31.3)	44.4	(42.0–46.8)	58.3	(56.4–60.2)	12.1	(10.8–13.5)
≥65	48.9	(47.5–50.3)	38.8	(36.2–41.3)	53.2	(51.0–55.3)	8.9	(7.8–10.2)
Sex								
Men	17.9	(17.2–18.6)	32.0	(28.7–35.5)	49.5	(46.3–52.7)	10.0	(8.3–12.0)
Women	24.7	(23.9–25.4)	41.7	(38.7–44.9)	59.4	(57.1–61.7)	11.3	(9.7–13.0)
Race/Ethnicity								
White, non-Hispanic	22.7	(22.0–23.3)	34.4	(32.0–36.9)	54.6	(52.6–56.6)	10.9	(9.6–12.3)
Black, non-Hispanic	22.1	(20.6–23.7)	51.7	(46.1–57.2)	60.9	(55.0–66.5)	9.5	(7.1–12.5)
Hispanic	16.2	(14.9–17.6)	41.9	(35.2–49.0)	56.9	(50.8–62.8)	12.0	(8.7–16.4)
Other	17.0	(14.8–19.4)	39.2	(27.1–52.8)	57.1	(47.0–66.7)	9.3	(4.5–18.5)
Education level								
Less than high school graduate	23.0	(21.7–24.2)	32.3	(27.0–38.0)	48.7	(43.2–54.2)	5.4	(3.6–8.1)
At least high school graduate	21.3	(20.7–21.8)	37.9	(35.4–40.4)	57.0	(55.0–58.9)	11.6	(10.4–13.1)
Body mass index								
<25.0	17.4	(16.7–18.1)	—		48.8	(45.5–52.1)	9.8	(8.1–11.9)
25.0–29.9 (overweight)	20.7	(19.9–21.5)	19.4	(17.0–22.1)	52.5	(49.3–55.8)	12.1	(10.0–14.6)
≥30.0 (obese)	29.4	(28.3–30.6)	56.1	(52.5–59.6)	64.9	(61.5–68.2)	10.7	(8.7–13.1)
Physical activity level								
Inactive	22.3	(21.6–23.1)	39.0	(35.4–42.8)	52.9	(49.4–56.3)	9.8	(8.0–12.0)
Active	21.0	(20.3–21.6)	35.9	(33.1–38.7)	57.5	(55.3–59.6)	11.4	(10.0–13.0)
Arthritis-attributable activity limitation								
Yes	64.8	(62.5–67.0)	46.2	(42.5–49.9)	64.4	(61.4–67.2)	17.1	(14.5–20.0)
No	45.1	(43.8–46.5)	31.7	(29.0–34.6)	50.8	(48.5–53.2)	7.4	(6.4–8.7)
Total	21.5	(21.0–22.0)	37.3	(35.0–39.6)	55.5	(53.7–57.4)	10.8	(9.6–12.0)

* Age-adjusted to the standard 2000 U.S. population.

† Not yet finalized; under consideration as part of the *Healthy People 2010 Midcourse Review*.

§ Includes only persons with a body mass index of ≥25.0 (calculated as weight in kilograms divided by height in meters squared).

¶ Confidence interval.

Overall, arthritis education was reported by 10.8%. Adults with activity limitations attributable to arthritis were more likely to have met all three objectives than were those without such limitations. Differences within age, sex, racial/ethnic, and education groups were minimal for all three objectives.

In the 2003 BRFSS, among the 25 states that administered the arthritis management questions, the age-adjusted percentage of overweight and obese persons with arthritis who received weight counseling ranged from 23.4% to 35.9%, with no state reaching the 2010 target (Table 3). Among all persons with arthritis, the percentage receiving physical activity counseling ranged from 42.6% to 57.9%, with no state reaching the 2010 target; the percentage receiving arthritis education ranged from 5.8% to 15.7%, with seven states reaching the 2010 target.

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Editorial Note: The findings in this report indicate that, from 2002 to 2003, no statistically significant progress occurred toward reaching the targets for the three 2010 national health objectives for arthritis management, although for two of the objectives (i.e., weight counseling and physical activity counseling), results suggested movement in the right direction. However, only 37.3% of persons categorized as overweight or obese and only 56.1% of those categorized as obese received weight counseling. The results suggest that opportunities are being missed by health-care providers and persons with arthritis to employ nonpharmacologic arthritis management techniques that have been determined to reduce pain, improve function and mental health, and delay disability (5).

Health-care-provider counseling for behavior change might have a priming effect, making patients more likely to practice beneficial behaviors. Although the evidence is insufficient to suggest that physical activity counseling alone leads to long-term increases in physical activity levels, such counseling has resulted in short-term improvement (9). Provider counseling coupled with promotion of self management; medical, social,

TABLE 3. Estimated age-adjusted*, weighted prevalence of adults aged ≥18 years with doctor-diagnosed arthritis who met national arthritis management objectives†, by state — Behavioral Risk Factor Surveillance Survey (BRFSS)§, 25 states, 2003

State	Weight counseling [¶] (objective 2-4a)		Physical activity counseling (objective 2-4b)		Arthritis education (objective 2-8)	
	%	(95% CI**)	%	(95% CI)	%	(95% CI)
Arizona	32.7	(24.9–41.7)	52.9	(46.1–59.5)	15.5	(11.3–20.8)
Arkansas	33.1	(28.6–37.9)	42.6	(38.7–46.6)	6.7	(5.1–8.8)
California	35.6	(30.1–41.4)	54.4	(49.7–59.0)	13.2	(10.5–16.3)
Connecticut	26.2	(22.0–30.9)	44.4	(40.4–48.5)	9.5	(7.4–12.1)
Florida	35.4	(29.0–42.5)	56.5	(50.7–62.2)	15.7	(12.1–20.1)
Georgia	32.9	(28.2–37.8)	49.0	(45.1–53.0)	9.6	(7.2–12.6)
Idaho	26.8	(22.7–31.3)	48.4	(44.2–52.7)	13.3	(10.7–16.5)
Indiana	30.9	(27.3–34.7)	48.2	(44.9–51.5)	9.8	(7.9–12.1)
Iowa	27.1	(23.0–31.6)	50.4	(46.1–54.6)	11.5	(8.9–14.6)
Kansas	35.3	(30.3–40.7)	49.3	(45.1–53.6)	8.9	(7.0–11.4)
Maryland	32.4	(27.9–37.3)	46.4	(42.0–50.8)	10.3	(7.9–13.3)
Minnesota	25.9	(21.7–30.5)	48.7	(44.0–53.4)	12.5	(10.2–15.4)
Missouri	29.0	(24.4–34.0)	49.7	(44.8–54.6)	13.7	(10.2–18.3)
Nebraska	29.5	(25.3–34.1)	44.4	(40.5–48.5)	11.5	(9.0–14.6)
Nevada	23.4	(18.3–29.4)	45.0	(39.1–51.0)	10.1	(6.9–14.5)
New Mexico	35.9	(31.1–41.0)	55.8	(51.6–59.9)	11.3	(9.1–14.0)
New York	33.1	(28.7–37.9)	48.7	(44.7–52.6)	9.7	(7.6–12.4)
Ohio	32.2	(26.6–38.3)	49.4	(44.6–54.1)	8.8	(6.6–11.7)
Oklahoma	30.1	(26.7–33.6)	50.6	(47.4–53.8)	10.3	(8.4–12.6)
Pennsylvania	31.6	(27.1–36.5)	54.7	(50.6–58.8)	13.5	(10.9–16.7)
Rhode Island	29.4	(24.5–34.7)	54.4	(49.5–59.3)	5.8	(4.4–7.7)
South Carolina	30.5	(26.7–34.5)	47.6	(44.1–51.0)	10.5	(8.3–13.1)
Utah	24.4	(19.9–29.5)	52.6	(47.5–57.6)	15.6	(11.8–20.4)
Vermont	31.0	(25.9–36.5)	57.9	(53.5–62.1)	12.4	(9.4–16.1)
Virginia	29.3	(25.2–33.6)	49.2	(44.9–53.5)	12.8	(9.6–17.0)
Median	30.9		49.4		11.3	
Range	23.4–35.9		42.6–57.9		5.8–15.7	

* Age adjusted to the standard 2000 U.S. population.

† Not yet finalized; under consideration as part of the *Healthy People 2010 Midcourse Review*.

§ Although survey questions in the 2003 BRFSS survey were identical to those asked in the 2003 National Health Interview Survey, the latter survey is the official data source for monitoring progress toward the national arthritis management objectives. BRFSS data can be used to monitor progress toward meeting state-specific health objectives for 2010, but these data are not recommended for deriving national estimates.

¶ Includes only persons with a body mass index of ≥25.0 (calculated as weight in kilograms divided by height in meters squared).

** Confidence interval.

and community support systems; community-based arthritis programs; and interventions that address behavioral factors (e.g., readiness to change behavior, belief in ability to change behavior, or depression) might help persons with arthritis attempt and maintain desirable self-management behaviors.

The CDC Arthritis Program is addressing arthritis self-management objectives by funding 36 state programs that partner with local chapters of the Arthritis Foundation and others to increase availability of evidence-based community self-management programs such as People with Arthritis Can Exercise[®], the Arthritis Foundation Aquatics Program, and the Arthritis Self-Help Course. CDC is also evaluating additional community-based physical activity programs and investigating new methods to decrease barriers by delivering self-management education classes through the mail or

Internet. The CDC health communications campaign, Physical Activity. The Arthritis Pain Reliever, has been implemented in 35 states; a similar campaign for Spanish-speaking persons with arthritis is under development. The goal of all these activities is to increase availability and access to self-management programs at the community level for persons with arthritis.

The findings in this report are subject to at least three limitations. First, data are based on self-reports. Certain persons who reported doctor-diagnosed arthritis might not actually have the disease or might not have accurately reported whether they received provider counseling; however, the arthritis case-finding question used has been determined appropriately sensitive for public health surveillance (10). Second, this analysis did not adjust for factors such as sociodemographic characteristics of participants or access to health care, which might have affected likelihood of receiving arthritis counseling or education. Finally, BRFSS findings for individual states are limited in their comparability to national data from NHIS because of 1) different sampling schemes, 2) different modes of survey administration (telephone interview in BRFSS versus in-person interview in NHIS), 3) different ordering of questions, and 4) lower response rates and state-specific sample sizes in the BRFSS survey.

As the U.S. population ages, the personal and societal burdens of arthritis will continue to increase. Evidence-based, self-management interventions for arthritis have been underutilized. Further research to understand and overcome barriers to use of these interventions might help persons with arthritis. Systematic efforts to encourage persons to self-manage their arthritis also might help reduce the burden of arthritis on the health-care system. Efforts to increase health-care-provider counseling for weight control and physical activity and referral to arthritis education programs are a first step toward increasing self-management behavior in persons with arthritis.

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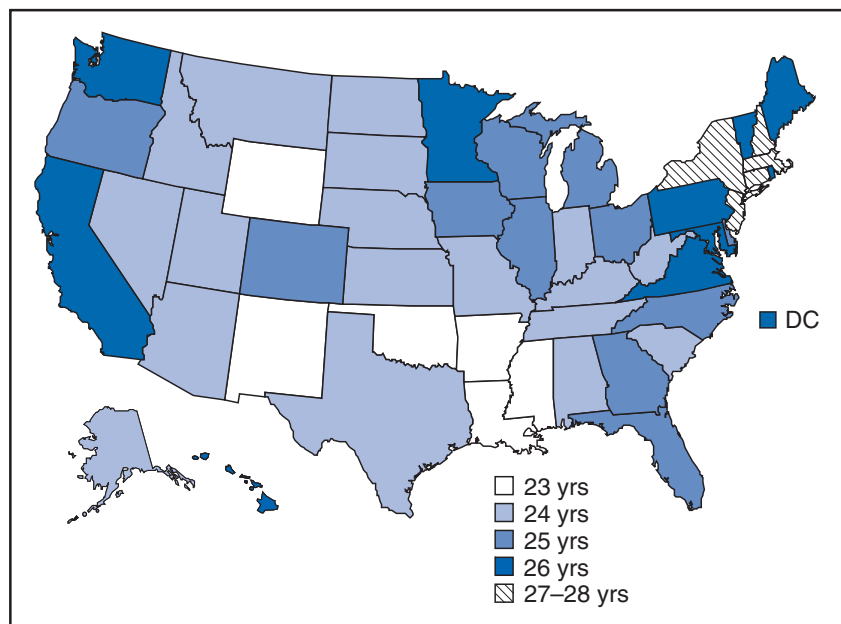
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QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Average Age of Mothers at First Birth, by State — United States, 2002



The average age of mothers at first birth increased steadily during the preceding 30 years, to 25.1 years in 2002, an all-time high for the nation. In 2002, by state, the average age of mothers at first birth ranged from 23 years to 28 years. Mothers living in northeastern states were the oldest at first birth; mothers living in Arkansas, Louisiana, Mississippi, New Mexico, Oklahoma, and Wyoming were the youngest. Additional information is available at http://www.cdc.gov/nchs/data/nvsr/nvsr52/nvsr52_19acc.pdf.

SOURCE: National Vital Statistics System, annual file; 2003. Available at <http://www.cdc.gov/nchs/births.htm>.

Notice to Readers

National Arthritis Month — May 2005

May is National Arthritis Month. This year, the Arthritis Foundation is urging persons with arthritis to get active for better health. Regular moderate physical activity improves the health and function of joints and reduces the risk for other chronic conditions. Physical activity helps protect joints by strengthening muscles and improving balance and joint nutrition, which leads to better flexibility, joint motion, and physical function. Long-term benefits include reduced pain, improved mental health, and delayed disability (1).

Walking is an ideal activity for most persons with arthritis because it is low impact, can be incorporated into usual daily activities, and does not require special equipment or facilities. A free copy of the *Arthritis Today* Walking Guide is available at <http://www.arthritis.org> or by telephone, 1-800-568-4045. CDC, along with 36 state arthritis programs, the Arthritis Foundation, and other organizations, continue to implement the *National Arthritis Action Plan: A Public Health Strategy* (1) to promote progress toward achieving the arthritis-related objectives in *Healthy People 2010* (2).

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Notice to Readers

Recreational Water Illness Prevention Week — May 23–30, 2005

The first National Recreational Water Illness Prevention Week will be held May 23–30, 2005, at the start of the annual swimming season, to raise awareness of the potential for spread of infectious disease at swimming venues and to help improve prevention efforts. An estimated 8.1 million swimming pools are in residential or public use in the United States (1). Each year, U.S. residents make an estimated 360 million visits to recreational water venues such as swimming pools, spas, lakes, and oceans, making swimming the second-most popular physical activity (walking is first) in the country and the most popular among children (2). However, recreational water use also can be associated with drowning, injury, and the spread of infectious diseases.

Recreational water illnesses (RWIs) are spread by swallowing, breathing, or having contact with contaminated water from swimming pools, spas, lakes, rivers, or oceans (3). The most commonly reported RWI is diarrhea caused by pathogens such as *Cryptosporidium*, *Giardia*, *Shigella*, and *Escherichia coli* O157:H7. Children, pregnant women, and persons with compromised immune systems are at greatest risk from infection with these pathogens. Infection with *Cryptosporidium* can be life threatening in persons with weakened immune systems (4). Other RWIs can cause various symptoms, including skin, ear, eye, respiratory, and neurologic infections.

A steady increase in reported diarrheal RWI outbreaks during 1984–2002 has resulted in approximately 19,000 illnesses (5). This increase is likely the result of a combination of increased water usage, improved outbreak detection, and increased disease transmission. The spread of RWIs is facilitated by emergence of chlorine-resistant pathogens such as *Cryptosporidium* (5), poor pool maintenance (6), and low public awareness of the problem (7). Recommendations for public swimming pools include improved operation, training, and public education to protect swimmers from infectious disease transmission. Additional information for public health professionals, aquatics staff members, and the general public is available at <http://www.cdc.gov/healthyswimming>.

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Notice to Readers

FDA Rule for Current Good Tissue Practice for Human Cells, Tissues, and Cellular and Tissue-Based Products

On May 25, 2005, the Food and Drug Administration (FDA) will issue its Current Good Tissue Practice (CGTP) for Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/Ps), representing the last of three FDA rules* that have been developed to improve the safety of HCT/Ps by preventing the introduction, transmission, and spread of communicable disease.

The CGTP regulations will require HCT/P establishments to recover, process, store, label, package, and distribute HCT/Ps in a way that prevents the introduction, transmission, or spread of communicable diseases. HCT/P establishments must also maintain complaint files and evaluate each complaint relating to core CGTP requirements. Such establishments will also be required to 1) investigate any adverse reaction involving a communicable disease related to an HCT/P they made available for distribution and 2) report to FDA any serious adverse reactions involving a communicable disease. Serious adverse reactions are defined by FDA as fatal, life-threatening, resulting in permanent impairment of a body function or permanent damage to body structure, or necessitating medical or surgical intervention, including hospitalization. The establishments will be required to use the FDA MedWatch mandatory reporting form (Form FDA-3500A) and submit each report to FDA within 15 days of initial receipt of the information. This will be the first federal requirement for reporting of adverse reactions from transplanted HCT/Ps.

Nearly simultaneously with the CGTP rule, the Joint Commission on Accreditation of Healthcare Organizations

(JCAHO) revised its standards for the Laboratory Accreditation Program (revised standards QC.5.300, QC.5.310, and QC.5.320) and adopted these standards for the Ambulatory Care, Office-Based Surgery, Critical Access Hospital, and Hospital Accreditation programs (new standards PC.17.10, PC.17.20, and PC.17.30) (1,2). Effective July 1, 2005, these standards will apply to accredited organizations that store or issue tissue. These new standards will require that organizations assign oversight responsibility for a tissue program, use standardized procedures in all tissue handling, maintain traceability of all tissues, and have a process for investigating and reporting adverse events. All adverse events involving tissues, including disease transmission or other complications suspected of being directly related to tissue use, are to be investigated and reported to the HCT/P establishment from which the tissue was received.

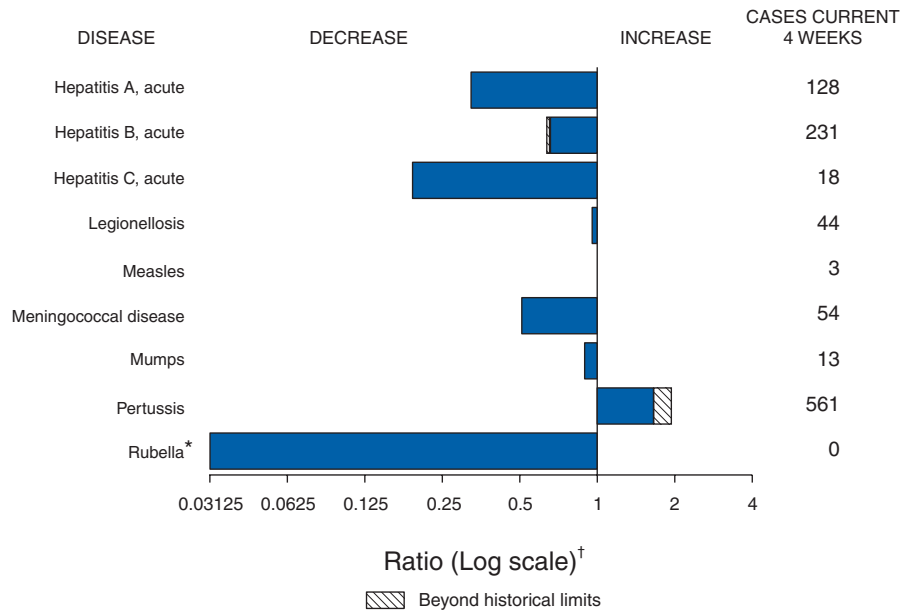
Improved HCT/P adverse event surveillance from these two mandatory reporting rules is anticipated to improve the overall safety of HCT/Ps and reduce risk to HCT/P recipients. A successful surveillance system will be contingent upon reporting by physicians, infection-control practitioners, risk managers, and others who identify adverse events. Along with receiving mandatory reports from establishments, FDA continues to encourage direct voluntary reports through its MedWatch program by using MedWatch Form FDA-3500, available at <http://www.fda.gov/medwatch>. Additional information about FDA and HCT/Ps is available at <http://www.fda.gov/cber/tiss.htm>.

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* Federal Register 66 FR 5447, January 19, 2001; 66 FR 29786, May 25, 2004; and 69 FR 68612, November 24, 2004.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals May 14, 2005, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 19 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.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending May 14, 2005 (19th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	42	24
Botulism:			HIV infection, pediatric†¶	116	117
foodborne	5	4	Influenza-associated pediatric mortality†**	33	—
infant	27	26	Measles	15††	14§§
other (wound & unspecified)	8	3	Mumps	94	76
Brucellosis	26	34	Plague	—	—
Chancroid	10	13	Poliomyelitis, paralytic	—	—
Cholera	1	3	Psittacosis†	11	3
Cyclosporiasis†	242	86	Q fever†	22	19
Diphtheria	—	—	Rabies, human	1	—
Domestic arboviral diseases			Rubella	4	7
(neuroinvasive & non-neuroinvasive):			Rubella, congenital syndrome	1	—
California serogroup†§	—	3	SARS†**	—	—
eastern equine†§	—	—	Smallpox†	—	—
Powassan†§	—	—	<i>Staphylococcus aureus</i> :		
St. Louis†§	—	—	Vancomycin-intermediate (VISA)†	3	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	1	—
Ehrlichiosis:			Streptococcal toxic-shock syndrome†	56	66
human granulocytic (HGE)†	30	34	Tetanus	3	4
human monocytic (HME)†	30	22	Toxic-shock syndrome	45	35
human, other and unspecified †	15	4	Trichinellosis¶¶	7	—
Hansen disease†	14	43	Tularemia†	12	12
Hantavirus pulmonary syndrome†	4	3	Yellow fever	—	—

—: No reported cases.

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

† Not notifiable in all states.

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

¶ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update April 24, 2005.

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

†† Of 15 cases reported, nine were indigenous and six were imported from another country.

§§ Of 14 cases reported, six were indigenous and eight were imported from another country.

¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending May 14, 2005, and May 15, 2004 (19th Week)*

Reporting area	AIDS		Chlamydia [†]		Coccidioidomycosis		Cryptosporidiosis	
	Cum. 2005 [§]	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	13,232	12,150	335,024	333,050	1,457	1,783	679	893
NEW ENGLAND	532	370	9,243	10,972	—	—	34	52
Maine	4	5	789	718	N	N	3	8
N.H.	7	19	678	632	—	—	5	13
Vt. [¶]	3	10	370	430	—	—	9	6
Mass.	275	119	5,320	4,909	—	—	12	18
R.I.	47	44	1,240	1,283	—	—	1	1
Conn.	196	173	846	3,000	N	N	4	6
MID. ATLANTIC	2,558	2,414	61,658	41,471	—	—	154	144
Upstate N.Y.	253	186	7,585	7,865	N	N	20	27
N.Y. City	1,476	1,134	11,458	13,004	—	—	20	46
N.J.	413	524	4,108	6,708	N	N	7	10
Pa.	416	570	38,507	13,894	N	N	107	61
E.N. CENTRAL	1,204	1,276	48,884	60,559	2	5	114	232
Ohio	185	231	13,714	15,535	N	N	44	51
Ind.	165	164	7,019	6,610	N	N	11	30
Ill.	661	606	13,284	17,217	—	—	—	39
Mich.	138	207	8,280	14,614	2	5	19	47
Wis.	55	68	6,587	6,583	N	N	40	65
W.N. CENTRAL	318	300	18,621	20,416	3	4	90	93
Minn.	88	66	3,030	4,149	3	N	26	39
Iowa	41	19	2,450	2,514	N	N	16	14
Mo.	132	125	7,756	7,582	—	3	32	17
N. Dak.	5	12	412	719	N	N	—	—
S. Dak.	9	5	1,030	937	—	—	7	10
Nebr. [¶]	5	20	1,498	1,916	—	1	1	3
Kans.	38	53	2,445	2,599	N	N	8	10
S. ATLANTIC	4,263	4,145	60,044	62,742	—	—	144	167
Del.	70	55	1,228	1,091	N	N	—	—
Md.	513	475	6,496	7,074	—	—	7	9
D.C.	276	149	1,401	1,348	—	—	2	4
Va. [¶]	223	209	7,635	8,234	—	—	12	22
W. Va.	22	29	886	1,024	N	N	4	2
N.C.	350	237	12,702	9,815	N	N	19	31
S.C. [¶]	215	267	7,522	6,630	—	—	7	7
Ga.	741	690	6,629	12,289	—	—	40	47
Fla.	1,853	2,034	15,545	15,237	N	N	53	45
E.S. CENTRAL	770	555	21,777	19,688	—	3	15	38
Ky.	91	68	4,158	2,033	N	N	5	9
Tenn. [¶]	313	208	8,017	8,283	N	N	3	12
Ala. [¶]	213	167	2,576	4,449	—	—	6	10
Miss.	153	112	7,026	4,923	—	3	1	7
W.S. CENTRAL	1,513	1,707	40,452	42,055	—	2	17	40
Ark.	71	88	3,248	2,945	—	1	1	7
La.	278	337	6,706	9,367	—	1	2	—
Okla.	112	68	3,911	3,829	N	N	7	8
Tex. [¶]	1,052	1,214	26,587	25,914	N	N	7	25
MOUNTAIN	537	485	19,668	18,532	940	1,126	34	34
Mont.	3	—	722	754	N	N	4	3
Idaho [¶]	5	3	731	1,144	N	N	2	4
Wyo.	—	5	404	411	—	—	2	2
Colo.	107	97	4,757	4,786	N	N	11	17
N. Mex.	56	51	1,478	3,098	2	9	2	1
Ariz.	227	197	7,672	5,344	906	1,085	4	5
Utah	25	29	1,538	1,213	2	12	4	1
Nev. [¶]	114	103	2,366	1,782	30	20	5	1
PACIFIC	1,537	898	54,677	56,615	512	643	77	93
Wash.	144	165	7,101	6,345	N	N	5	—
Oreg. [¶]	90	90	3,213	2,837	—	—	14	9
Calif.	1,250	592	41,313	43,835	512	643	58	83
Alaska	9	10	1,396	1,453	—	—	—	—
Hawaii	44	41	1,654	2,145	—	—	—	1
Guam	1	—	—	351	—	—	—	—
P.R.	335	208	1,537	956	N	N	N	N
V.I.	7	4	32	145	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	—	U	—	U	—	U

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

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

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

[§] Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update April 24, 2005.

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending May 14, 2005, and May 15, 2004 (19th Week)*

Reporting area	<i>Escherichia coli</i> , Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped		Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004				
UNITED STATES	381	374	46	65	66	43	5,703	5,737	110,598	115,242
NEW ENGLAND	26	19	8	16	10	4	464	503	1,642	2,556
Maine	2	—	2	—	—	—	44	47	50	98
N.H.	2	4	1	1	—	—	21	16	57	52
Vt.	1	—	—	—	—	—	59	35	15	32
Mass.	10	10	—	5	10	4	201	253	1,029	1,134
R.I.	1	2	—	—	—	—	30	37	184	345
Conn.	10	3	5	10	—	—	109	115	307	895
MID. ATLANTIC	63	34	3	8	10	10	1,408	1,272	17,634	13,350
Upstate N.Y.	14	9	3	2	1	3	305	369	2,234	2,633
N.Y. City	1	7	—	—	—	—	270	400	2,742	4,218
N.J.	11	6	—	2	—	4	126	162	1,516	2,482
Pa.	37	12	—	4	9	3	707	341	11,142	4,017
E.N. CENTRAL	69	75	7	13	3	4	740	874	19,278	24,714
Ohio	27	18	1	2	2	4	218	262	6,414	7,947
Ind.	7	12	—	—	—	—	N	N	2,686	2,258
Ill.	7	19	1	—	—	—	126	290	5,347	7,176
Mich.	14	11	—	2	1	—	223	192	3,019	5,716
Wis.	14	15	5	9	—	—	173	130	1,812	1,617
W.N. CENTRAL	50	57	10	11	9	9	678	633	5,915	5,969
Minn.	5	22	2	6	2	2	335	206	865	1,063
Iowa	10	10	—	—	—	—	72	86	534	451
Mo.	19	5	5	4	2	2	143	193	3,189	3,029
N. Dak.	1	2	—	—	—	3	1	11	19	51
S. Dak.	2	2	—	—	—	—	33	19	134	100
Nebr.	5	8	3	1	2	—	38	53	349	390
Kans.	8	8	—	—	3	2	56	65	825	885
S. ATLANTIC	62	41	8	8	26	7	891	897	25,423	27,925
Del.	—	—	N	N	N	N	8	19	295	355
Md.	6	5	2	—	—	2	50	33	2,449	2,955
D.C.	—	1	—	—	—	—	17	29	735	889
Va.	2	1	3	6	6	—	195	130	2,695	3,310
W. Va.	1	1	—	—	—	—	11	9	258	294
N.C.	—	—	—	—	13	4	N	N	6,138	5,550
S.C.	1	4	—	—	—	—	30	31	3,222	3,187
Ga.	7	11	1	1	—	—	299	271	2,891	5,140
Fla.	45	18	2	1	7	1	281	375	6,740	6,245
E.S. CENTRAL	23	17	—	1	5	6	141	119	7,976	8,552
Ky.	4	6	—	1	4	4	N	N	1,316	842
Tenn.	11	3	—	—	1	2	74	58	2,847	2,933
Ala.	8	3	—	—	—	—	67	61	1,705	2,535
Miss.	—	5	—	—	—	—	—	—	2,108	2,242
W.S. CENTRAL	6	35	1	3	2	3	78	99	15,836	15,581
Ark.	1	5	—	1	—	—	30	44	1,657	1,376
La.	—	1	1	—	2	—	8	15	3,687	4,265
Okla.	2	4	—	—	—	—	40	40	1,658	1,645
Tex.	3	25	—	2	—	3	N	N	8,834	8,295
MOUNTAIN	39	42	9	4	1	—	382	429	4,067	4,003
Mont.	2	3	—	—	—	—	11	14	37	23
Idaho	3	11	5	1	—	—	31	60	31	32
Wyo.	—	—	1	—	—	—	7	5	23	21
Colo.	10	7	1	1	—	—	124	143	1,000	1,144
N. Mex.	—	5	2	1	—	—	14	23	260	370
Ariz.	9	6	N	N	N	N	58	71	1,605	1,517
Utah	7	6	—	—	—	—	109	91	245	159
Nev.	8	4	—	1	1	—	28	22	866	737
PACIFIC	43	54	—	1	—	—	921	911	12,827	12,592
Wash.	9	14	—	—	—	—	61	83	1,260	981
Oreg.	5	8	—	1	—	—	79	145	595	353
Calif.	23	28	—	—	—	—	734	625	10,491	10,488
Alaska	3	1	—	—	—	—	25	26	180	255
Hawaii	3	3	—	—	—	—	22	32	301	515
Guam	N	N	—	—	—	—	—	—	—	66
P.R.	—	—	—	—	—	—	10	20	137	89
V.I.	—	—	—	—	—	—	—	—	2	52
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending May 14, 2005, and May 15, 2004 (19th Week)*

Reporting area	<i>Haemophilus influenzae</i> , invasive							
	All ages		Age <5 years					
	All serotypes		Serotype b		Non-serotype b		Unknown serotype	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	954	849	2	4	47	45	92	91
NEW ENGLAND	58	82	—	1	4	6	3	—
Maine	3	7	—	—	—	—	1	—
N.H.	3	12	—	—	—	2	—	—
Vt.	6	4	—	—	—	—	2	—
Mass.	23	40	—	1	—	2	—	—
R.I.	6	2	—	—	2	—	—	—
Conn.	17	17	—	—	2	2	—	—
MID. ATLANTIC	272	175	—	—	—	3	30	25
Upstate N.Y.	46	59	—	—	—	3	4	4
N.Y. City	26	34	—	—	—	—	6	8
N.J.	35	33	—	—	—	—	5	2
Pa.	165	49	—	—	—	—	15	11
E.N. CENTRAL	111	151	—	—	1	7	6	23
Ohio	58	54	—	—	—	2	5	9
Ind.	34	21	—	—	1	4	1	1
Ill.	4	46	—	—	—	—	—	10
Mich.	10	9	—	—	—	1	—	3
Wis.	5	21	—	—	—	—	—	—
W.N. CENTRAL	39	43	—	—	2	2	6	5
Minn.	17	14	—	—	2	2	—	—
Iowa	—	1	—	—	—	—	—	1
Mo.	17	17	—	—	—	—	4	4
N. Dak.	1	3	—	—	—	—	1	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	3	4	—	—	—	—	1	—
Kans.	1	4	—	—	—	—	—	—
S. ATLANTIC	230	198	—	—	13	10	14	14
Del.	—	—	—	—	—	—	—	—
Md.	32	38	—	—	4	2	—	—
D.C.	—	—	—	—	—	—	—	—
Va.	18	17	—	—	—	—	—	1
W. Va.	14	8	—	—	1	3	2	—
N.C.	37	24	—	—	5	3	—	—
S.C.	10	5	—	—	—	—	1	—
Ga.	59	56	—	—	—	—	6	13
Fla.	60	50	—	—	3	2	5	—
E.S. CENTRAL	45	28	—	—	1	—	10	6
Ky.	4	—	—	—	1	—	1	—
Tenn.	32	19	—	—	—	—	6	4
Ala.	9	9	—	—	—	—	3	2
Miss.	—	—	—	—	—	—	—	—
W.S. CENTRAL	47	35	1	1	3	4	5	1
Ark.	—	—	—	—	—	—	—	—
La.	18	9	1	—	1	—	5	1
Okla.	29	25	—	—	2	4	—	—
Tex.	—	1	—	1	—	—	—	—
MOUNTAIN	113	97	—	2	14	9	15	12
Mont.	—	—	—	—	—	—	—	—
Idaho	3	4	—	—	—	—	1	2
Wyo.	1	—	—	—	—	—	—	—
Colo.	24	22	—	—	—	—	3	2
N. Mex.	12	21	—	—	4	3	—	4
Ariz.	51	40	—	—	8	5	3	1
Utah	10	8	—	2	—	1	6	2
Nev.	12	2	—	—	2	—	2	1
PACIFIC	39	40	1	—	9	4	3	5
Wash.	—	1	—	—	—	—	—	1
Oreg.	17	22	—	—	—	—	3	2
Calif.	16	11	1	—	9	4	—	1
Alaska	1	2	—	—	—	—	—	1
Hawaii	5	4	—	—	—	—	—	—
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	—	—	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending May 14, 2005, and May 15, 2004 (19th Week)*

Reporting area	Hepatitis (viral, acute), by type					
	A		B		C	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,415	2,234	2,173	2,079	285	273
NEW ENGLAND	203	309	109	138	6	4
Maine	—	7	4	1	—	—
N.H.	18	8	5	19	—	—
Vt.	1	5	1	2	6	1
Mass.	159	255	84	65	—	3
R.I.	5	6	—	1	—	—
Conn.	20	28	15	50	—	—
MID. ATLANTIC	275	266	608	281	96	44
Upstate N.Y.	31	31	45	33	10	2
N.Y. City	101	98	37	64	—	—
N.J.	29	58	308	72	—	—
Pa.	114	79	218	112	86	42
E.N. CENTRAL	134	171	134	185	43	26
Ohio	24	19	54	57	2	2
Ind.	19	18	8	9	7	2
Ill.	27	57	9	—	—	6
Mich.	51	59	63	99	34	16
Wis.	13	18	—	20	—	—
W.N. CENTRAL	45	53	101	131	14	1
Minn.	3	10	8	12	—	1
Iowa	8	16	9	7	—	—
Mo.	25	8	60	92	13	—
N. Dak.	—	1	—	1	1	—
S. Dak.	—	2	—	—	—	—
Nebr.	2	10	13	11	—	—
Kans.	7	6	11	8	—	—
S. ATLANTIC	202	375	600	653	49	71
Del.	—	4	26	15	—	2
Md.	19	57	67	57	12	1
D.C.	2	3	—	9	—	2
Va.	28	24	74	69	6	7
W. Va.	5	1	14	2	5	8
N.C.	29	25	57	57	7	6
S.C.	8	19	41	46	1	6
Ga.	37	151	111	206	2	7
Fla.	74	91	210	192	16	32
E.S. CENTRAL	85	68	123	182	27	31
Ky.	4	9	27	20	1	12
Tenn.	60	40	56	78	7	5
Ala.	9	6	23	25	7	1
Miss.	12	13	17	59	12	13
W.S. CENTRAL	79	423	96	94	24	61
Ark.	2	43	17	49	—	—
La.	20	11	15	23	5	3
Okla.	3	15	7	20	—	2
Tex.	54	354	57	2	19	56
MOUNTAIN	140	163	196	150	9	15
Mont.	6	3	2	—	—	2
Idaho	12	10	5	6	—	—
Wyo.	—	—	—	3	—	—
Colo.	14	13	10	21	—	4
N. Mex.	7	6	5	8	—	5
Ariz.	83	106	143	69	—	2
Utah	12	23	20	21	6	—
Nev.	6	2	11	22	3	2
PACIFIC	252	406	206	265	17	20
Wash.	16	21	17	22	3	3
Oreg.	15	31	36	40	8	7
Calif.	209	343	149	193	6	10
Alaska	3	2	3	8	—	—
Hawaii	9	9	1	2	—	—
Guam	—	1	—	4	—	—
P.R.	2	11	3	19	—	—
V.I.	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U

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

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending May 14, 2005, and May 15, 2004 (19th Week)*

Reporting area	Legionellosis		Listeriosis		Lyme disease		Malaria	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	445	446	172	180	2,970	2,746	349	424
NEW ENGLAND	20	7	5	11	97	320	17	31
Maine	1	—	—	2	2	13	—	2
N.H.	3	—	1	1	17	13	2	—
Vt.	—	—	—	—	2	10	—	1
Mass.	12	3	1	3	67	201	13	19
R.I.	1	1	1	1	3	25	2	2
Conn.	3	3	2	4	6	58	—	7
MID. ATLANTIC	184	78	45	39	2,409	1,938	104	102
Upstate N.Y.	28	17	7	10	199	704	17	13
N.Y. City	8	8	7	6	—	63	39	51
N.J.	22	13	7	13	567	431	21	20
Pa.	126	40	24	10	1,643	740	27	18
E.N. CENTRAL	71	90	19	26	36	98	16	27
Ohio	34	38	7	8	24	14	3	7
Ind.	3	9	1	5	2	1	—	3
Ill.	8	15	—	5	—	13	3	7
Mich.	22	24	6	6	2	—	8	6
Wis.	4	4	5	2	8	70	2	4
W.N. CENTRAL	11	9	11	3	57	33	15	23
Minn.	1	—	2	1	45	12	5	9
Iowa	—	3	4	1	6	6	2	1
Mo.	8	4	2	1	5	13	7	4
N. Dak.	1	1	2	—	—	—	—	2
S. Dak.	—	1	—	—	—	—	—	1
Nebr.	—	—	—	—	—	2	—	1
Kans.	1	—	1	—	1	—	1	5
S. ATLANTIC	80	96	37	24	315	287	81	110
Del.	1	2	N	N	77	38	—	2
Md.	18	14	4	5	158	174	24	26
D.C.	1	3	—	—	3	5	2	5
Va.	5	6	1	3	28	10	8	10
W. Va.	4	2	—	1	3	1	1	—
N.C.	9	8	9	4	18	34	13	5
S.C.	2	2	1	—	7	3	3	6
Ga.	6	14	8	5	—	6	14	18
Fla.	34	45	14	6	21	16	16	38
E.S. CENTRAL	10	20	9	9	11	11	11	11
Ky.	2	4	1	2	—	4	2	1
Tenn.	3	9	4	5	11	2	6	3
Ala.	5	5	3	1	—	—	3	5
Miss.	—	2	1	1	—	5	—	2
W.S. CENTRAL	10	98	4	28	12	26	22	53
Ark.	1	—	—	1	2	—	1	2
La.	3	5	2	1	—	1	—	3
Okla.	1	2	—	—	—	—	2	1
Tex.	5	91	2	26	10	25	19	47
MOUNTAIN	36	24	—	3	2	9	15	15
Mont.	2	—	—	—	—	—	—	—
Idaho	1	1	—	1	—	2	—	1
Wyo.	2	4	—	—	—	2	1	—
Colo.	7	3	—	1	—	—	8	6
N. Mex.	1	—	—	—	—	—	—	1
Ariz.	11	5	—	—	—	1	2	2
Utah	5	9	—	—	2	4	4	3
Nev.	7	2	—	1	—	—	—	2
PACIFIC	23	24	42	37	31	24	68	52
Wash.	—	4	2	5	—	2	3	1
Oreg.	N	N	2	4	2	12	1	8
Calif.	23	20	38	28	28	10	58	42
Alaska	—	—	—	—	1	—	2	—
Hawaii	—	—	—	—	N	N	4	1
Guam	—	—	—	—	—	—	—	—
P.R.	—	1	—	—	N	N	—	—
V.I.	U	—	U	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	—	U	—	U	—	U

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending May 14, 2005, and May 15, 2004 (19th Week)*

Reporting area	Meningococcal disease									
	All serogroups		Serogroup A, C, Y, and W-135		Serogroup B		Other serogroup		Serogroup unknown	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	532	595	67	38	28	19	1	—	436	538
NEW ENGLAND	37	27	1	4	—	—	—	—	36	23
Maine	1	7	—	—	—	—	—	—	1	7
N.H.	3	3	—	—	—	—	—	—	3	3
Vt.	3	1	—	—	—	—	—	—	3	1
Mass.	19	16	—	4	—	—	—	—	19	12
R.I.	2	—	—	—	—	—	—	—	2	—
Conn.	9	—	1	—	—	—	—	—	8	—
MID. ATLANTIC	109	83	46	23	6	5	—	—	57	55
Upstate N.Y.	17	25	1	4	3	3	—	—	13	18
N.Y. City	10	14	—	—	—	—	—	—	10	14
N.J.	19	16	—	—	—	—	—	—	19	16
Pa.	63	28	45	19	3	2	—	—	15	7
E.N. CENTRAL	47	56	13	8	4	4	—	—	30	44
Ohio	21	34	—	3	4	4	—	—	17	27
Ind.	8	8	—	—	—	—	—	—	8	8
Ill.	—	1	—	—	—	—	—	—	—	1
Mich.	13	5	13	5	—	—	—	—	—	—
Wis.	5	8	—	—	—	—	—	—	5	8
W.N. CENTRAL	28	36	2	—	1	1	—	—	25	35
Minn.	5	9	1	—	—	—	—	—	4	9
Iowa	9	8	—	—	1	—	—	—	8	8
Mo.	7	11	1	—	—	1	—	—	6	10
N. Dak.	—	—	—	—	—	—	—	—	—	—
S. Dak.	1	1	—	—	—	—	—	—	1	1
Nebr.	2	3	—	—	—	—	—	—	2	3
Kans.	4	4	—	—	—	—	—	—	4	4
S. ATLANTIC	91	116	2	2	4	2	—	—	85	112
Del.	—	1	—	—	—	—	—	—	—	1
Md.	8	5	1	—	2	—	—	—	5	5
D.C.	—	5	—	2	—	—	—	—	—	3
Va.	11	7	—	—	—	—	—	—	11	7
W. Va.	4	3	—	—	—	—	—	—	4	3
N.C.	11	18	1	—	2	2	—	—	8	16
S.C.	11	11	—	—	—	—	—	—	11	11
Ga.	8	7	—	—	—	—	—	—	8	7
Fla.	38	59	—	—	—	—	—	—	38	59
E.S. CENTRAL	27	27	—	—	2	—	—	—	25	27
Ky.	8	3	—	—	2	—	—	—	6	3
Tenn.	13	10	—	—	—	—	—	—	13	10
Ala.	2	6	—	—	—	—	—	—	2	6
Miss.	4	8	—	—	—	—	—	—	4	8
W.S. CENTRAL	37	54	1	1	3	1	—	—	33	52
Ark.	8	10	—	—	—	—	—	—	8	10
La.	15	18	—	1	2	—	—	—	13	17
Okla.	6	3	1	—	1	1	—	—	4	2
Tex.	8	23	—	—	—	—	—	—	8	23
MOUNTAIN	39	29	1	—	3	3	1	—	34	26
Mont.	—	1	—	—	—	—	—	—	—	1
Idaho	1	4	—	—	—	—	—	—	1	4
Wyo.	—	2	—	—	—	—	—	—	—	2
Colo.	10	9	1	—	—	—	1	—	8	9
N. Mex.	1	4	—	—	—	2	—	—	1	2
Ariz.	19	5	—	—	2	—	—	—	17	5
Utah	5	2	—	—	1	—	—	—	4	2
Nev.	3	2	—	—	—	1	—	—	3	1
PACIFIC	117	167	1	—	5	3	—	—	111	164
Wash.	20	11	1	—	4	3	—	—	15	8
Oreg.	23	35	—	—	—	—	—	—	23	35
Calif.	67	114	—	—	—	—	—	—	67	114
Alaska	1	2	—	—	—	—	—	—	1	2
Hawaii	6	5	—	—	1	—	—	—	5	5
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	3	4	—	—	—	—	—	—	3	4
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	—	—	—	—	—	—	—	—	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—

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

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending May 14, 2005, and May 15, 2004 (19th Week)*

Reporting area	Pertussis		Rabies, animal		Rocky Mountain spotted fever		Salmonellosis		Shigellosis	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	6,113	3,530	1,821	2,495	226	198	8,749	9,859	3,382	4,668
NEW ENGLAND	321	554	270	174	1	5	497	458	66	82
Maine	12	1	19	18	N	N	26	28	2	1
N.H.	11	21	3	6	—	—	35	28	4	3
Vt.	46	35	22	6	—	—	33	18	4	2
Mass.	230	473	171	73	—	5	282	249	39	52
R.I.	8	9	6	10	1	—	19	31	2	4
Conn.	14	15	49	61	—	—	102	104	15	20
MID. ATLANTIC	1,010	821	277	257	30	16	1,534	1,243	404	429
Upstate N.Y.	183	595	139	121	—	—	253	291	94	175
N.Y. City	28	58	9	5	1	7	277	365	154	130
N.J.	93	52	N	N	4	—	171	217	98	77
Pa.	706	116	129	131	25	9	833	370	58	47
E.N. CENTRAL	1,367	717	32	12	5	9	834	1,345	197	306
Ohio	617	151	17	5	4	3	279	320	21	61
Ind.	123	22	2	2	—	1	108	137	33	49
Ill.	74	137	8	4	—	4	37	410	6	128
Mich.	98	39	5	1	1	1	218	242	90	33
Wis.	455	368	—	—	—	—	192	236	47	35
W.N. CENTRAL	783	190	120	194	16	7	606	610	246	125
Minn.	136	29	25	17	—	—	150	153	21	17
Iowa	265	29	26	19	—	—	95	121	38	29
Mo.	160	105	18	5	15	7	184	164	145	40
N. Dak.	48	5	6	21	—	—	11	12	2	1
S. Dak.	1	8	12	38	—	—	45	23	8	6
Nebr.	72	4	—	52	1	—	48	45	20	7
Kans.	101	10	33	42	—	—	73	92	12	25
S. ATLANTIC	449	188	592	922	130	112	2,360	2,025	592	1,076
Del.	12	—	—	9	1	2	13	17	4	3
Md.	72	38	103	109	11	5	176	168	23	40
D.C.	3	5	—	—	—	—	13	16	6	21
Va.	74	48	200	166	4	—	255	222	33	31
W. Va.	22	2	13	27	1	—	33	43	—	—
N.C.	27	33	178	240	87	78	357	247	63	129
S.C.	161	30	5	58	6	9	161	121	35	190
Ga.	13	9	86	108	12	15	391	343	171	236
Fla.	65	23	7	205	8	3	961	848	257	426
E.S. CENTRAL	157	44	45	66	14	29	461	531	484	207
Ky.	45	7	6	7	—	—	85	94	38	26
Tenn.	65	25	15	36	11	11	173	155	302	86
Ala.	34	6	24	19	3	5	144	157	111	71
Miss.	13	6	—	4	—	13	59	125	33	24
W.S. CENTRAL	143	115	386	771	8	16	517	1,391	641	1,693
Ark.	74	12	12	22	2	—	117	94	18	17
La.	7	5	—	—	1	3	111	155	36	116
Okla.	—	12	41	47	5	13	85	86	264	150
Tex.	62	86	333	702	—	—	204	1,056	323	1,410
MOUNTAIN	1,305	371	61	38	18	1	578	682	205	255
Mont.	285	7	—	4	1	—	29	51	2	3
Idaho	46	15	—	—	—	—	30	53	—	5
Wyo.	10	3	9	—	1	—	12	20	—	1
Colo.	546	201	1	2	—	1	139	155	32	43
N. Mex.	52	54	—	—	—	—	46	68	27	46
Ariz.	204	63	51	32	13	—	204	220	105	123
Utah	144	27	—	—	3	—	65	76	14	16
Nev.	18	1	—	—	—	—	53	39	25	18
PACIFIC	578	530	38	61	4	3	1,362	1,574	547	495
Wash.	135	133	—	—	—	—	106	101	22	24
Oreg.	231	169	—	—	—	2	91	127	23	24
Calif.	156	211	37	50	4	1	1,072	1,203	487	427
Alaska	15	9	1	11	—	—	17	28	5	4
Hawaii	41	8	—	—	—	—	76	115	10	16
Guam	—	—	—	—	—	—	—	14	—	16
P.R.	—	1	28	17	N	N	29	71	—	1
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending May 14, 2005, and May 15, 2004 (19th Week)*

Reporting area	Streptococcal disease, invasive, group A		Streptococcus pneumoniae, invasive disease				Syphilis			
			Drug resistant, all ages		Age <5 years		Primary & secondary		Congenital	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	2,000	2,173	1,231	1,107	345	353	2,504	2,724	92	138
NEW ENGLAND	69	102	11	18	29	40	66	61	—	—
Maine	2	3	N	N	—	1	1	—	—	—
N.H.	5	9	—	—	1	N	4	1	—	—
Vt.	7	4	5	5	3	1	—	—	—	—
Mass.	49	70	—	6	25	35	55	37	—	—
R.I.	6	16	6	7	—	3	2	5	—	—
Conn.	—	—	—	—	U	U	4	18	—	—
MID. ATLANTIC	611	367	249	83	79	49	387	365	15	18
Upstate N.Y.	143	113	44	37	35	31	25	28	11	1
N.Y. City	56	65	U	U	U	U	205	216	3	7
N.J.	78	74	N	N	11	4	40	71	1	9
Pa.	334	115	205	46	33	14	117	50	—	1
E.N. CENTRAL	313	497	271	254	86	87	198	315	13	21
Ohio	95	124	179	191	40	43	74	94	2	1
Ind.	40	48	90	63	22	17	23	20	1	1
Ill.	18	154	2	—	20	—	62	120	1	1
Mich.	152	136	—	N	—	N	31	66	7	18
Wis.	8	35	N	N	4	27	8	15	2	—
W.N. CENTRAL	123	160	27	9	38	32	67	73	—	1
Minn.	44	72	—	—	19	18	12	12	—	1
Iowa	N	N	N	N	—	N	1	3	—	—
Mo.	38	39	25	8	4	8	46	41	—	—
N. Dak.	2	6	—	—	1	—	—	—	—	—
S. Dak.	9	8	2	1	—	—	—	—	—	—
Nebr.	9	10	—	—	4	4	2	5	—	—
Kans.	21	25	N	N	10	2	6	12	—	—
S. ATLANTIC	384	417	483	560	41	24	644	674	18	24
Del.	—	2	1	3	—	N	6	2	—	—
Md.	102	64	—	—	27	18	119	124	7	3
D.C.	5	4	13	6	2	4	40	20	—	1
Va.	27	35	N	N	—	N	32	22	3	1
W. Va.	9	12	49	55	12	2	2	3	—	—
N.C.	63	56	N	N	U	U	86	56	3	1
S.C.	11	40	—	57	—	N	25	51	—	7
Ga.	72	106	155	144	—	N	69	122	—	1
Fla.	95	98	265	295	—	N	265	274	5	10
E.S. CENTRAL	77	107	86	70	3	—	135	139	11	5
Ky.	17	34	13	17	N	N	12	21	—	—
Tenn.	60	73	73	52	—	N	57	52	8	1
Ala.	—	—	—	—	—	N	55	51	3	2
Miss.	—	—	—	1	3	—	11	15	—	2
W.S. CENTRAL	80	253	66	36	43	96	443	409	20	30
Ark.	7	5	8	5	9	5	20	16	—	3
La.	4	1	58	31	9	18	90	91	2	2
Okla.	58	29	N	N	16	23	15	9	1	2
Tex.	11	218	N	N	9	50	318	293	17	23
MOUNTAIN	303	234	38	19	26	25	132	143	11	8
Mont.	—	—	—	—	—	—	5	—	—	—
Idaho	1	4	N	N	—	N	9	9	—	1
Wyo.	1	5	16	4	—	—	—	1	—	—
Colo.	114	45	N	N	25	23	15	25	—	—
N. Mex.	23	49	—	5	—	—	18	38	1	2
Ariz.	125	108	N	N	—	N	54	61	10	5
Utah	38	23	21	8	1	2	2	2	—	—
Nev.	1	—	1	2	—	—	29	7	—	—
PACIFIC	40	36	—	58	—	—	432	545	4	31
Wash.	N	N	N	N	N	N	56	31	—	—
Oreg.	N	N	N	N	—	N	12	14	—	—
Calif.	—	—	N	N	N	N	359	497	4	31
Alaska	—	—	—	—	—	N	3	—	—	—
Hawaii	40	36	—	58	—	—	2	3	—	—
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	N	N	N	N	—	N	45	48	5	3
V.I.	—	—	—	—	—	—	—	4	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending May 14, 2005, and May 15, 2004 (19th Week)*

Reporting area	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease [†]		
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Neuroinvasive		Non-neuroinvasive [‡]
							Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	3,078	4,318	78	93	11,981	9,444	—	4	—
NEW ENGLAND	92	134	5	10	170	364	—	—	—
Maine	6	8	—	—	101	43	—	—	—
N.H.	3	6	—	—	45	—	—	—	—
Vt.	—	—	—	—	23	307	—	—	—
Mass.	63	75	4	9	1	14	—	—	—
R.I.	6	15	—	1	—	—	—	—	—
Conn.	14	30	1	—	—	—	—	—	—
MID. ATLANTIC	874	657	29	24	5,348	28	—	—	—
Upstate N.Y.	84	78	3	2	—	—	—	—	—
N.Y. City	365	336	2	8	—	—	—	—	—
N.J.	155	141	3	10	—	—	—	—	—
Pa.	270	102	21	4	5,348	28	—	—	—
E.N. CENTRAL	423	376	3	11	2,882	3,181	—	—	—
Ohio	85	63	—	2	719	833	—	—	—
Ind.	47	47	—	—	N	N	—	—	—
Ill.	203	180	1	5	12	1	—	—	—
Mich.	62	61	1	3	1,930	2,020	—	—	—
Wis.	26	25	1	1	221	327	—	—	—
W.N. CENTRAL	158	135	1	2	72	119	—	1	—
Minn.	63	50	1	1	—	—	—	—	—
Iowa	14	15	—	—	N	N	—	—	—
Mo.	42	38	—	1	3	2	—	—	—
N. Dak.	2	2	—	—	10	68	—	—	—
S. Dak.	5	4	—	—	59	49	—	1	—
Nebr.	15	6	—	—	—	—	—	—	—
Kans.	17	20	—	—	—	—	—	—	N
S. ATLANTIC	652	869	9	8	856	1,163	—	—	—
Del.	2	8	—	—	6	4	—	—	—
Md.	71	75	1	2	—	—	—	—	—
D.C.	26	6	—	—	15	17	—	—	—
Va.	94	67	2	2	141	316	—	—	—
W. Va.	8	9	—	—	517	579	—	—	N
N.C.	67	85	1	2	—	N	—	—	—
S.C.	72	68	—	—	177	247	—	—	—
Ga.	48	238	2	—	—	—	—	—	—
Fla.	264	313	3	2	—	—	—	—	—
E. S. CENTRAL	169	169	1	4	—	—	—	—	—
Ky.	37	25	1	2	N	N	—	—	—
Tenn.	76	46	—	2	—	—	—	—	—
Ala.	56	65	—	—	—	—	—	—	—
Miss.	—	33	—	—	—	—	—	—	—
W.S. CENTRAL	78	666	3	9	1,342	3,283	—	1	—
Ark.	32	48	—	—	—	—	—	—	—
La.	—	—	—	—	90	41	—	—	—
Okla.	46	52	—	—	—	—	—	—	—
Tex.	—	566	3	9	1,252	3,242	—	1	—
MOUNTAIN	59	178	3	3	1,311	1,306	—	2	—
Mont.	—	—	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—	—
Wyo.	—	1	—	—	40	16	—	—	—
Colo.	8	46	—	1	909	986	—	—	—
N. Mex.	3	14	—	—	78	34	—	—	—
Ariz.	43	71	1	1	—	—	—	2	—
Utah	5	15	1	1	284	270	—	—	—
Nev.	—	31	1	—	—	—	—	—	—
PACIFIC	573	1,134	24	22	—	—	—	—	—
Wash.	76	72	1	1	N	N	—	—	—
Oreg.	36	33	2	—	—	—	—	—	—
Calif.	405	980	17	15	—	—	—	—	—
Alaska	11	11	—	—	—	—	—	—	—
Hawaii	45	38	4	6	—	—	—	—	—
Guam	—	14	—	—	—	42	—	—	—
P.R.	—	21	—	—	76	122	—	—	—
V.I.	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	—
C.N.M.I.	—	U	—	U	—	U	—	U	—

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

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

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

‡ Not previously notifiable.

TABLE III. Deaths in 122 U.S. cities,* week ending May 14, 2005 (19th Week)

Reporting Area	All causes, by age (years)							P&I [†] Total	Reporting Area	All causes, by age (years)							P&I [†] Total
	All Ages	≥65	45-64	25-44	1-24	<1	All Ages			≥65	45-64	25-44	1-24	<1			
NEW ENGLAND	510	357	96	38	14	5	54	S. ATLANTIC	1,257	777	306	102	44	28	80		
Boston, Mass.	129	85	28	11	—	5	12	Atlanta, Ga.	176	105	49	11	7	4	3		
Bridgeport, Conn.	26	19	5	2	—	—	4	Baltimore, Md.	169	91	45	22	6	5	20		
Cambridge, Mass.	19	17	1	1	—	—	1	Charlotte, N.C.	98	69	21	5	2	1	12		
Fall River, Mass.	18	16	1	1	—	—	3	Jacksonville, Fla.	209	133	48	16	7	5	13		
Hartford, Conn.	62	35	14	9	4	—	7	Miami, Fla.	67	43	15	5	3	1	4		
Lowell, Mass.	22	15	5	1	1	—	1	Norfolk, Va.	44	27	8	5	2	2	—		
Lynn, Mass.	13	9	2	2	—	—	—	Richmond, Va.	75	37	23	7	6	2	4		
New Bedford, Mass.	21	18	2	1	—	—	4	Savannah, Ga.	60	40	15	1	2	2	8		
New Haven, Conn.	26	12	10	4	—	—	3	St. Petersburg, Fla.	27	19	6	—	1	1	1		
Providence, R.I.	58	45	10	—	3	—	9	Tampa, Fla.	204	139	40	15	5	5	13		
Somerville, Mass.	4	3	1	—	—	—	—	Washington, D.C.	102	53	32	14	3	—	1		
Springfield, Mass.	31	21	6	1	3	—	6	Wilmington, Del.	26	21	4	1	—	—	1		
Waterbury, Conn.	20	15	3	—	2	—	1	E.S. CENTRAL	932	587	228	66	31	20	83		
Worcester, Mass.	61	47	8	5	1	—	3	Birmingham, Ala.	209	124	56	12	6	11	17		
MID. ATLANTIC	2,105	1,427	457	124	51	44	110	Chattanooga, Tenn.	52	41	8	1	2	—	6		
Albany, N.Y.	50	38	8	1	1	2	4	Knoxville, Tenn.	97	60	23	9	4	1	7		
Allentown, Pa.	23	21	2	—	—	—	2	Lexington, Ky.	71	43	16	7	2	3	10		
Buffalo, N.Y.	88	58	25	5	—	—	6	Memphis, Tenn.	152	88	45	12	4	3	18		
Camden, N.J.	27	17	7	1	—	2	2	Mobile, Ala.	136	94	31	9	2	—	6		
Elizabeth, N.J.	14	10	3	1	—	—	1	Montgomery, Ala.	177	48	21	3	5	—	7		
Erie, Pa.	52	42	6	2	1	1	2	Nashville, Tenn.	138	89	28	13	6	2	12		
Jersey City, N.J.	49	31	12	5	1	—	—	W.S. CENTRAL	2,011	1,300	484	144	43	40	130		
New York City, N.Y.	1,050	696	246	58	21	27	39	Austin, Tex.	85	55	17	8	2	3	5		
Newark, N.J.	56	33	18	3	2	—	5	Baton Rouge, La.	18	15	3	—	—	—	—		
Paterson, N.J.	10	7	2	—	1	—	—	Corpus Christi, Tex.	61	38	15	3	—	5	8		
Philadelphia, Pa.	315	191	67	27	21	9	13	Dallas, Tex.	214	138	48	16	5	7	15		
Pittsburgh, Pa. [§]	27	16	7	3	1	—	2	El Paso, Tex.	93	62	17	10	2	2	—		
Reading, Pa.	26	21	2	3	—	—	2	Ft. Worth, Tex.	117	78	28	8	—	3	1		
Rochester, N.Y.	137	108	21	5	1	2	9	Houston, Tex.	382	230	102	30	11	9	27		
Schenectady, N.Y.	22	17	3	2	—	—	4	Little Rock, Ark.	72	51	11	6	2	2	—		
Scranton, Pa.	27	21	4	2	—	—	2	New Orleans, La.	527	332	135	38	15	7	37		
Syracuse, N.Y.	80	58	17	5	—	—	13	San Antonio, Tex.	253	176	59	13	4	1	26		
Trenton, N.J.	33	26	4	1	1	1	4	Shreveport, La.	46	29	14	2	—	1	3		
Utica, N.Y.	19	16	3	—	—	—	—	Tulsa, Okla.	143	96	35	10	2	—	8		
Yonkers, N.Y.	0	0	0	0	0	0	0	MOUNTAIN	996	659	214	77	22	23	63		
E.N. CENTRAL	2,075	1,440	420	128	44	42	130	Albuquerque, N.M.	97	66	23	3	2	3	6		
Akron, Ohio	59	38	15	2	2	2	2	Boise, Idaho	50	35	11	2	—	2	6		
Canton, Ohio	44	32	11	1	—	—	5	Colo. Springs, Colo.	69	48	13	4	1	3	3		
Chicago, Ill.	325	203	85	21	7	8	23	Denver, Colo.	95	57	20	9	4	5	2		
Cincinnati, Ohio	81	54	16	4	3	4	7	Las Vegas, Nev.	236	157	50	17	8	4	13		
Cleveland, Ohio	224	172	34	9	6	3	10	Ogden, Utah	30	23	4	3	—	—	—		
Columbus, Ohio	198	136	36	16	5	5	8	Phoenix, Ariz.	150	87	37	19	3	3	13		
Dayton, Ohio	124	96	22	4	—	2	14	Pueblo, Colo.	35	20	10	5	—	—	2		
Detroit, Mich.	175	102	51	14	2	6	6	Salt Lake City, Utah	104	77	17	5	2	3	10		
Evansville, Ind.	67	45	16	4	2	—	5	Tucson, Ariz.	130	89	29	10	2	—	8		
Fort Wayne, Ind.	77	50	10	9	5	3	8	PACIFIC	1,671	1,152	352	88	38	38	163		
Gary, Ind.	12	5	5	1	—	1	1	Berkeley, Calif.	20	14	6	—	—	—	2		
Grand Rapids, Mich.	52	44	5	3	—	—	3	Fresno, Calif.	72	47	19	1	3	2	7		
Indianapolis, Ind.	164	111	41	7	4	1	6	Glendale, Calif.	9	7	2	—	—	—	2		
Lansing, Mich.	44	36	4	4	—	—	2	Honolulu, Hawaii	80	60	14	4	1	1	9		
Milwaukee, Wis.	125	89	22	8	2	4	12	Long Beach, Calif.	83	57	19	4	2	1	4		
Peoria, Ill.	51	34	8	7	2	—	1	Los Angeles, Calif.	287	188	68	18	8	5	31		
Rockford, Ill.	54	40	9	4	—	1	3	Pasadena, Calif.	38	27	8	1	—	2	5		
South Bend, Ind.	50	38	8	3	1	—	4	Portland, Oreg.	139	96	22	10	5	6	12		
Toledo, Ohio	98	72	16	6	2	2	6	Sacramento, Calif.	194	131	37	15	6	5	16		
Youngstown, Ohio	51	43	6	1	1	—	4	San Diego, Calif.	118	84	23	8	2	1	11		
W.N. CENTRAL	706	478	149	53	12	12	52	San Francisco, Calif.	122	83	30	4	1	4	16		
Des Moines, Iowa	95	73	12	7	1	2	12	San Jose, Calif.	186	144	30	6	3	3	16		
Duluth, Minn.	27	21	6	—	—	—	5	Santa Cruz, Calif.	31	20	10	1	—	—	9		
Kansas City, Kans.	29	18	9	2	—	—	—	Seattle, Wash.	136	86	33	12	2	3	9		
Kansas City, Mo.	62	33	18	5	5	1	4	Spokane, Wash.	67	41	15	2	3	3	6		
Lincoln, Nebr.	32	21	6	5	—	—	3	Tacoma, Wash.	89	67	16	2	2	2	8		
Minneapolis, Minn.	51	33	14	2	1	1	4	TOTAL	12,263 [¶]	8,177	2,706	820	299	252	865		
Omaha, Nebr.	87	63	16	5	2	1	6										
St. Louis, Mo.	160	98	39	13	3	5	13										
St. Paul, Minn.	64	48	9	7	—	—	5										
Wichita, Kans.	99	70	20	7	—	2	—										

U: Unavailable. —: No reported cases.

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

† Pneumonia and influenza.

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

¶ Total includes unknown ages.

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