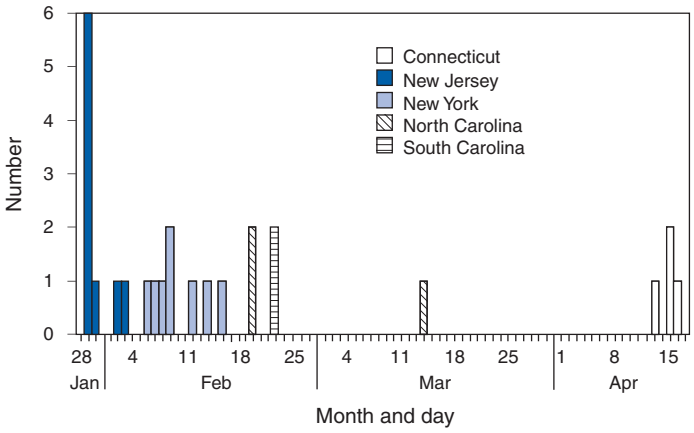
MMWR™
Morbidity and Mortality Weekly Report

Weekly August 19, 2005 / Vol. 54 / No. 32

Atypical Reactions Associated With Heroin Use — Five States, January–April 2005

Heroin use typically produces a well-recognized syndrome of euphoria, miosis, and respiratory and central nervous system depression; cardiovascular effects are not a common finding. In January 2005, a man aged 21 years in New Jersey was hospitalized with an atypical reaction (e.g., tachycardia and palpitations) after reported heroin use. During the next 3 months, 25 additional persons in five states were reported to poison control centers (PCCs) and local public health agencies with a similar reaction after reported heroin use; in all, 24 of 26 patients were hospitalized. Analysis of drug specimens or testing of urine was performed in certain cases; in eight patients, the veterinary pharmaceutical clenbuterol was detected. This report describes four representative cases and summarizes the investigation by state and local health and law enforcement authorities and CDC into the 26 cases of atypical reactions after heroin use reported in five states (Connecticut, New Jersey, New York, North Carolina, and South Carolina) during January 28–April 17, 2005 (Figure). Unintentional or intentional adulteration of illicit drugs such as cocaine or heroin is an additional potential hazard associated with their use.

FIGURE. Number of suspected, probable, or confirmed cases of heroin-related clenbuterol poisoning, by state and date of exposure — five states, January 28–April 17, 2005



New Jersey

During January 28–February 2, 2005, nine cases of atypical reactions after heroin use were reported to the New Jersey Poison Information and Education System (NJPIES). The reports originated from hospitals in four New Jersey counties. The reported route of exposure was intranasal in six patients, intravenous in two, and unknown in one. Tachycardia (89%), hyperglycemia (78%), palpitations (78%), and hypokalemia (78%) were the most common signs, symptoms, and laboratory findings; six patients (67%) had all four. In addition, multiple patients had nausea, hypotension, chest pain, venous hyperoxia, lactic acidosis, agitation, and anxiety.

Early in the investigation, cyanide was suspected as the adulterant responsible for the atypical reactions because several patients had venous hyperoxia and lactic acidosis. However, the uncharacteristic responses of the patients to antidotal therapy (i.e., sodium thiosulfate and sodium nitrite) for cyanide, presence of signs not typically associated with cyanide

INSIDE

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

The *MMWR* series of publications is published by the Coordinating Center for Health Information and Service, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

SUGGESTED CITATION
Centers for Disease Control and Prevention. [Article Title]. MMWR 2005;54:[inclusive page numbers].

poisoning (e.g., hypokalemia), and negative cyanide levels made cyanide an unlikely etiology. Law enforcement personnel with the New Jersey State Police responded to the outbreak and tested samples of the heroin involved; the presence of clenbuterol, a β_2 adrenergic receptor agonist, was reported.

Information regarding the atypical reactions to heroin use was disseminated by NJPIES and local public health agencies to the general public, public health agencies in neighboring states, national toxicology organizations, and federal agencies. One patient reported atypical symptoms on multiple occasions after using heroin but only sought medical attention after seeing a flyer informing heroin users of suspected drug adulteration.

Case 1. The first reported patient was a man aged 21 years who went to the emergency department (ED) of a New Jersey hospital January 28, 2005, complaining of chest pain, palpitations, and shortness of breath, which had begun soon after intranasal exposure to what he believed was heroin. While in the ED, his highest recorded heart rate was 137 beats per minute (bpm), and his lowest recorded systolic blood pressure was 69 mmHg. On physical examination, the patient had tachycardia, tachypnea, pale skin, and mydriasis (dilated pupils). Laboratory studies revealed the following serum values: potassium, 2.2 mmol/L (reference range: 3.5–5.3 mmol/L); glucose, 243 mg/dL (reference range: 65–115 mg/dL); CO_2, 13 mmol/L (reference range: 22–32 mmol/L); an elevated anion gap; and an elevated lactate level (*1*). An electrocardiogram (ECG) revealed ischemic changes. The patient required intravenous fluid replacement, potassium supplementation, and an intravenous calcium channel blocker for persistent tachycardia. His laboratory, ECG, and vital sign abnormalities resolved during his 4 days in the intensive care unit. The patient left against medical advice on the fifth day of hospitalization with no apparent remaining impairments.

Case 2. A man aged 23 years visited the ED at the same New Jersey hospital on January 29, 2005, a day after the patient in case 1. The man had headache, nausea, palpitations, chest pain, and anxiety after intranasal exposure to heroin the night before. He had no known connection to the patient in case 1. While in the ED, he was tachypneic and hypotensive; he had a widened pulse pressure (120/48 mmHg) and was persistently tachycardic (120–122 bpm). He was noted to have agitation and mydriasis on physical examination. Laboratory serum values included potassium, 2.9 mmol/L, and blood glucose, 157 mg/dL. The patient was admitted to the intensive care unit and discharged from the hospital on the fifth day with no known impairments.

New York

Nine cases of atypical reactions to intranasally insufflated heroin were reported to the New York City Poison Control Center during February 5–March 14, 2005. Tachycardia (89%), palpitations (78%), chest pain (67%), and hypotension (56%) were the most common abnormal findings. Of the seven patients for whom potassium and glucose measurements were available, seven (100%) were hypokalemic, and five (71%) were hyperglycemic. Clenbuterol was detected in the urine by liquid chromatography mass spectrometry in four of the patients and ranged from 1.7 to 969 ng/mL. Testing for clenbuterol was not conducted on the other five patients.

Cases 3 and 4. A man aged 43 years and a man aged 29 years visited an ED on February 8, 2005, after intranasally insufflating heroin together. Both patients noted the heroin "smelled like vanilla." Within 15 minutes of exposure, both complained of palpitations, chest pain, and shortness of breath. After arrival in the ED, both patients were noted to be tachycardic, hypotensive, and tremulous. One patient complained of tinnitus, and the other complained of "ear throbbing." A mild leukocytosis, hypokalemia, and hyperglycemia were noted on the initial laboratory results for both men. Both patients were admitted to the hospital but left against medical advice.

North Carolina, South Carolina, and Connecticut

During February 19–22, 2005, two cases of suspected adulterated heroin exposure were reported to Carolinas Poison Center in North Carolina and two cases were reported to Palmetto Poison Center in South Carolina. In April, the Connecticut Poison Control Center received information on four more patients who had developed atypical reactions after using heroin. Five patients had intranasally insufflated the heroin, and three had injected it. All eight patients complained of palpitations with maximum heart rates of 120–141 bpm in the ED and were hypokalemic with serum potassium values ranging from 1.9–2.8 mmol/L. Six of the eight patients were noted as hypotensive in the ED. Seven patients had serum glucose testing performed, and all had results higher than 150 mg/dL. Urine from all four Connecticut patients tested positive for clenbuterol. A drug sample involved in one of the Connecticut cases was tested and was found to contain heroin, procaine, and clenbuterol.

Provisional Case Definition for Future Cases

To facilitate uniform reporting of future cases of heroin adulterated with clenbuterol, a provisional case definition (Box) was created by CDC, in coordination with PCCs and public health agencies involved with this investigation. Because the assay for clenbuterol is not available in the majority of laboratories, only eight of the 26 cases described in this report were confirmed; 16 cases were classified as probable and two as suspected.

BOX. Provisional case definition* for heroin-related clenbuterol toxicity

Clinical Description

After reported heroin use, signs, symptoms, and laboratory findings† indicating clenbuterol toxicity include tachycardia, hypokalemia, palpitations, hyperglycemia, chest pain, hypotension, nausea, shortness of breath, agitation, or tremor.

Laboratory Criteria for Diagnosis

- **Biologic:** Detection of clenbuterol in urine or blood samples, as determined by a commercial laboratory.

or

- **Environmental:** Detection of clenbuterol in environmental samples (e.g., heroin), as determined by the Drug Enforcement Agency, the Federal Bureau of Investigation, or other appropriate agency.

Case Classification

- **Suspected:** A case in which a potentially exposed person is being evaluated by health-care workers or public health officials for poisoning by clenbuterol.
- **Probable:** A clinically compatible case in which a high index of suspicion for clenbuterol exposure exists (e.g., patient history regarding location and time of day), or a case with an epidemiologic link to a laboratory-confirmed case.
- **Confirmed:** A clinically compatible case in which laboratory tests of biologic or environmental samples have confirmed exposure. A case can also be considered confirmed without laboratory testing if a predominant amount of clinical and nonspecific laboratory evidence of clenbuterol was present.

* For additional information on using the provisional case definition, see CDC. Case definitions for chemical poisoning. MMWR 2005;54 (No. RR-1).

† In the 26 cases reported in five states (Connecticut, New Jersey, New York, North Carolina, and South Carolina) during January 28-April 17, 2005, the six most common signs, symptoms, and laboratory findings were as follows: tachycardia (24 of 26 patients [92%]), hypokalemia (22 of 24 [92%]), palpitations (22 of 26 [85%]), hyperglycemia (19 of 23 [83%]), chest pain (15 of 26 [58%]), and hypotension (14 of 26 [54%]).

Reported by: *RS Hoffman, MD, LS Nelson, MD, GM Chan, MD, SE Halcomb, MD, NC Bouchard, MD, BY Ginsburg, MD, New York City Poison Control Center; J Cone, MD, Y Jean-Francois, MD, S Voit, MSPH, New York City Dept of Health and Mental Hygiene. S Marcus, MD, New Jersey Poison Information and Education System, Newark. M Ford, MD, Carolinas Poison Center, Charlotte; C Sanford, MSPH, North Carolina Dept of Health and Human Svcs. JE Michels, PharmD, WH Richardson, MD, Palmetto Poison Center, Columbia; LM Bretous, MD, South Carolina Dept of Health and Environmental Control. K Johnson-Arbor, MD, Connecticut Poison Control Center, Farmington. J Thomas, MD, Div of Laboratory Sciences, C Barthold, MD, M Belson, MD, M Patel, MD, J Schier, MD, A Wolkin, MSPH, C Rubin, DVM, Div of Environmental Hazards and Health Effects, National Center for Environmental Health; Z Duprey, DVM, EIS Officer, CDC.*

Editorial Note: Clenbuterol is a β_2 adrenergic receptor agonist with a rapid onset and long duration of action approved for limited veterinary use in the United States (*2*,*3*). Clenbuterol is also used illicitly as an alternative to anabolic steroids in humans and livestock because it can increase muscle mass (*4*,*5*). Most adverse health effects are related to its stimulation of β_2 adrenergic receptors and clinical manifestations, including hypokalemia, hyperglycemia, hyperlactemia, agitation, tachycardia, and hypotension (*6*). Adverse human health effects have been reported previously in a case of clenbuterol ingestion (*7*) and from ingestion of meat from livestock fed clenbuterol (*3*). However, the 26 cases described in this report are the first published accounts of poisoning from clenbuterol associated with reported heroin use.

Whether these cases represent adulteration of a single source of heroin before widespread distribution or adulteration of multiple sources is unknown. Also unclear is whether the substance used by each patient was heroin contaminated with clenbuterol or pure clenbuterol sold as heroin. The presence of adulterants in heroin is common. In some years, substances such as caffeine were detected in more than half of samples tested (*8*). Widespread poisoning secondary to adulterated heroin has occurred before as in the case of scopolamine-adulterated heroin reported in four states during the mid-1990s (*9*).

For various reasons, the 26 cases described in this report likely represent a fraction of actual cases of clenbuterol poisoning. Patients might not have medical evaluation for fear of legal repercussions. Passive reporting to public health agencies or PCCs might not have occurred because ED physicians, hospital intensivists, and the patients themselves might have presumed that the effects were related to a known coingestant. The identification of potential cases during the PCC record review process might have been limited by each center's database classification. The etiologic agent in suspicious cases might have been coded by using words other than "heroin" or "clenbuterol," such as "unknown drug" or "presumed coingestant."

Communication and cooperation among PCCs, EDs, CDC, and local public health agencies allowed for coordination of an appropriate response to the clenbuterol incidents. Local public health agencies and PCCs (available 24 hours a day at telephone 800-222-1222) should be notified of any case of suspected or known human exposure to an adulterated product. Early and rapid collaboration among local, state, and federal public health and law enforcement agencies might be necessary to identify, respond to, and minimize the effects of unintentional or intentional adulteration of substances used by the public.

Acknowledgments

This report is based, in part, on contributions from the New Jersey State Police, West Trenton; B Ruck, PharmD, Z Vassilev, MD, New Jersey Poison and Education System, Newark; E Bresnitz, MD, New Jersey Dept of Health and Senior Svcs. N Kim, PhD, P Smith, MD, New York State Dept of Health. D Drociuk, MSPH, South Carolina Dept of Health and Environmental Control. E Tan, MBBS, EIS Officer, CDC.

References

1. Mast A. Appendix A: Barnes-Jewish Hospital laboratory reference values. In: Carey CF, Lee HH, Woeltje KF, eds. The Washington manual of medical therapeutics, 29th ed. Philadelphia, PA: Lippincott, Williams & Wilkins; 1998:527–33.
2. Center for Veterinary Medicine, Food and Drug Administration. Update on illegal compounding of clenbuterol veterinary drug products. Rockville, MD: Food and Drug Administration; 2002. Available at http://www.fda.gov/cvm/cvm_updates/clenbut.htm.
3. Brambilla G, Cenci T, Franconi F, et al. Clinical and pharmacological profile in a clenbuterol epidemic poisoning of contaminated beef meat in Italy. Toxicol Lett 2000;114:47–53.
4. Prather ID, Brown DE, North P, Wilson JR. Clenbuterol: a substitute for anabolic steroids? Med Sci Sports Exerc 1995;27:1118–21.
5. Mitchell GA, Dunnavan G. Illegal use of β-adrenergic agonists in the United States. J Anim Sci 1998;76:208–11.
6. Hoffman BB. Catecholamines, sympathomimetic drugs, and adrenergic receptor antagonists. In: Gilman AG, Hardman JG, Limbird LE, eds. Goodman & Gilman's the pharmacological basis of therapeutics. 10th ed. New York, NY: McGraw Hill; 2002:215–68.
7. Hoffman RJ, Hoffman RS, Freyberg CL, Poppenga RH, Nelson LS. Clenbuterol ingestion causing prolonged tachycardia, hypokalemia, and hypophosphatemia with confirmation by quantitative levels. J Toxicol Clin Toxicol 2001;39:339–44.
8. Kaa E. Impurities, adulterants and diluents of illicit heroin. Changes during a 12-year period. Forensic Sci Int 1994;64:171–9.
9. CDC. Scopolamine poisoning among heroin users—New York City, Newark, Philadelphia, and Baltimore, 1995 and 1996. MMWR 1996;45:457–60.

Mercury Exposure — Kentucky, 2004

In November 2004, a student aged 15 years brought a small vial of liquid mercury onto a school bus and into a high school in Kentucky. A subsequent investigation revealed that mercury had been in the student's possession for more than a year and that substantial amounts had been spilled in multiple locations. This report describes the results of that investigation, which indicated that 1) duration of exposure was associated with the amount of mercury absorbed by exposed persons and 2) extensive multiagency collaboration facilitated an efficient response. The investigation further revealed that, although mercury exposure is common, clinicians might not be aware of how to evaluate and treat patients with mercury exposure. State and federal health agencies should provide schools, clinicians, and local health department staff with readily accessible guidelines* for use in mercury spills and exposures.

On November 10, school officials at a county high school in rural Kentucky discovered approximately 15 students playing with liquid mercury in the school cafeteria. School officials separated the students, confiscated and bagged their clothes, and closed the cafeteria. Local health department and environmental protection officials were notified. Questioning revealed that a boy aged 15 years had brought a vial of mercury to school on a school bus. Parents were advised to consult their health-care providers about whether their child should be tested for mercury exposure. Several children were tested at the local hospital, but none had concentrations exceeding background levels other than the student who brought the mercury to the school.

During November 10–24, local and state health department staff coordinated a public health investigation of the mercury exposure, and the U.S. Environmental Protection Agency (EPA) conducted an environmental investigation. Law enforcement and health department staff interviewed relevant observers and persons who directly handled the mercury. Serum and 24-hour urine mercury samples (measured in micrograms per liter [μg/L]) were collected for all persons who reported substantial exposure (i.e., persons who were known to have handled the mercury on multiple occasions or who spent 1 hour or more in rooms or vehicles during periods in which those places were known to be contaminated) and were tested at a local hospital. EPA and Kentucky Department for Environmental Protection (KDEP) personnel collected environmental air samples (measured in nanograms per cubic meter [ng/m^3]) at implicated locations and conducted ongoing cleaning and environmental assessment until ambient mercury levels were brought within acceptable limits (i.e., <3,000 ng/m^3) (*2*) or the site was deemed unrecoverable.

EPA and KDEP officials assessed the student's school and home environments and initiated cleanup procedures. The school cafeteria contained mercury levels ranging from 5,280 ng/m^3 to 36,600 ng/m^3. The school was closed by the school superintendent to limit the potential for exposure of children and to facilitate cleaning of the cafeteria. After 2 days of cleanup, heating, and venting, EPA deemed the school safe for students to return.

Approximately 15 school buses were also tested and/or cleaned. The family's mobile home and possessions were deemed unrecoverable (ambient mercury was >50,000 ng/m^3 at outset of investigation and later reduced to 11,550 ng/m^3) and were removed and destroyed. The family van (14,950 ng/m^3 reduced to 1,285 ng/m^3) and an additional vehicle (>50,000 ng/m^3 reduced to 174 ng/m^3) were eventually cleaned and returned to the family. However, a third vehicle (41,275 ng/m^3 reduced to 36,610 ng/m^3), belonging to the family of a friend of the student, was determined unrecoverable and removed by EPA.

During the cleanup process, more liquid mercury was collected than could be contained in the vial that the student had carried to school. The student claimed that he had found the mercury in the trash of a dentist's office during a visit on November 9. Investigation revealed that the mercury was kept in a storage area at the dentist's office that doubled as a restroom for patients. Examination of dental office records indicated that the student had visited the dentist on August 29, 1997, August 21, 2003, and November 9, 2004. Additional evidence suggested that the student had mercury for several months before the school exposure. Under further questioning, the student admitted having obtained the mercury during a previous visit to the dentist (presumably the August 2003 visit). Investigators suspected that the student took mercury during each of the last two visits, accounting for the excess mercury recovered in the cleanup process. EPA personnel disposed of all remaining mercury in the dentist's office.

Nine family members, including the student, had lived in the mobile home during different periods preceding the incident. In addition, the student's friend and his family, including a pregnant female, indicated that they had spent considerable time in one of the contaminated vehicles. Moreover, an additional 12 persons were said to have spent substantial amounts of time in the mobile home.

Blood concentrations were obtained for the student and seven family members who were living in the mobile home. Blood mercury levels ranged from 32 μg/L to 72 μg/L (normal: 0–10 μg/L) (*3*). The 24-hour urine mercury concentrations obtained from seven of these patients ranged from 28

* Such as a toxicological profile for mercury (*1*).

μg/L to 496 μg/L (normal: 0–19 μg/L) (*4*). The student had the highest mercury levels for both blood and urine (i.e., 72 μg/L blood and 496 μg/L for initial urine concentration). Urine mercury concentrations were directly associated with amount of time spent in the mobile home. Three of the children, including the student, lived in the contaminated home for 15 months and had urinary concentrations ranging from 193 μg/L to 496 μg/L, whereas three of the children who lived in the home for only 10 weeks had urinary concentrations ranging from 28 μg/L to 68 μg/L. The additional family member, a woman who had not been in the mobile home since June 2004, had a urine mercury concentration of 241 μg/L. Three additional persons, who were exposed to the contaminated vehicle that had to be destroyed, had urinary mercury levels ranging from 4 μg/L to 8 μg/L. An infant born to one of these persons in May 2004 had no signs of mercury exposure. Five family members, including the student responsible for the initial exposure, were chelated by using succimer. The three adolescent family members with the longest exposures received chelation in multiple sessions. Final urine mercury levels were 48, 44, and 35 μg/L, for the student and the two other children, respectively.

Several of the children living in the mobile home experienced itchy rashes and headaches. In late 2003, one girl aged 13 years residing in the mobile home had experienced several months of illness consistent with mercury exposure (e.g., unexplained tachycardia, hypertension, desquamation of soles and palms, rashes, diaphoresis, muscle pain, insomnia, vomiting, and behavioral and psychiatric changes). She was hospitalized for approximately 30 days. Mercury toxicity was not considered at the time, so testing was not performed. The patient improved with a cardiac stent concurrent with removal from the exposure setting.

After the investigation, the Kentucky Department for Public Health (KDPH) held a meeting with all agencies involved to discuss lessons learned. Participants agreed to 1) better identify a lead coordinator for future investigations, 2) continue to increase coordination and communication between all agencies, and 3) increase awareness of school and local public health officials regarding mercury exposure. KDPH produced a flyer for schools that was distributed on April 15, 2005. Information related to the dangers of mercury and the proper response to a mercury spill also was sent to all local health departments.

Reported by: *L Sims, MSN, A Indukuri, MPH, Lincoln Trail District Health Dept, Elizabethtown; J Walsh, LaRue County Health Dept, Hodgenville; HA Spiller, MS, Kentucky Regional Poison Center, Louisville; C Kaelin, MSPH, Kentucky Dept for Public Health. DA Thoroughman, PhD, Career Epidemiology Field Officer Program, Div of Public Health Partnerships, National Center for Health Marketing, CDC.*

Editorial Note: Mercury spills and exposures are common. In EPA Region 4,† a total of 40 documented mercury spills occurred during September 1, 1999–March 23, 2005, with 14 of those spills occurring in fiscal year 2005 (R. Bittinger, EPA, personal communication, 2005). Kentucky experienced 15 spills during that period, 10 of which were associated with schools and five with residences only. After publicity mounted regarding the case described in this report, the local health department and the Kentucky Regional Poison Center received numerous inquiries from private citizens about quantities of mercury in their possession. Thus, local public health officials and health-care providers should be familiar with the symptoms of mercury exposure, how to respond appropriately in cases of spills, and what local resources are available for mercury cleanup and disposal.

During this investigation, a strong association was observed between the duration of exposure and remaining levels of mercury in patients. Compared with three children who had recent exposures of 10 weeks' duration, a woman who had been exposed for 8–10 months but left that setting approximately 5 months before the November incident had substantially higher levels of mercury, as evidenced by high urine concentrations. Children exposed for 15 months in the mobile home had substantially higher levels than those who had only 10 weeks' exposure. Only those children who experienced the 15-month exposure were recommended for chelation. Finally, although the family acquaintances were exposed to high levels of mercury (i.e., in their contaminated vehicle), their exposures were periodic and brief, which might have resulted in limited mercury levels.

The mercury exposures described in this report, which occurred in multiple locations and resulted in extensive property loss and intensive cleanup efforts, highlight the utility of multiagency collaboration in investigations. Collaboration of local, state, private, and federal officials improved the response time and investigation outcome. This coordination is essential to mount a public health response to exposures such as this, which quickly outstrip local resources.

The events described in this report also underscore the need for appropriate and consistent medical advice for clinicians when responding to similar events. Resources are needed at the local level to help health-care providers and public health officials recognize, evaluate, and treat patients with mercury exposures.

† Includes Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee.

References

1. CDC. Toxicological profiles: public health statement for mercury. Atlanta, GA: US Department of Health and Human Services, CDC; 2005. Available at http://www.atsdr.cdc.gov/toxprofiles/phs46.html.
2. US Environmental Protection Agency. Mercury response guidebook—suggested action levels for indoor mercury exposures in homes or businesses with indoor gas regulators (attachment E). Washington, DC: US Environmental Protection Agency; 2001. Available at http://www.epa.gov/epaoswer/hazwaste/mercury/guidebook.
3. CDC. Blood mercury levels in young children and childbearing-aged women—United States, 1999–2002. MMWR 2004;53:1018–20.
4. Hudson PJ, Vogt RL, Brondum J, Witherell L, Myers G, Paschal DC. Elemental mercury exposure among children of thermometer plant workers. Pediatr 1987;79:935–8.

Update: Interim Guidance for Minimizing Risk for Human Lymphocytic Choriomeningitis Virus Infection Associated with Pet Rodents

On August 12, this report was posted as an MMWR Dispatch *on the* MMWR *website* (http://www.cdc.gov/mmwr).

In May 2005, CDC received reports of illness in four solid-organ transplant recipients who were later determined to have been infected with lymphocytic choriomeningitis virus (LCMV) from a common organ donor (*1*). Three of the four organ recipients died, 23–27 days after transplantation. This report updates information about the ongoing investigation and provides interim measures for reducing the risk for LCMV infection from pet rodents associated with this outbreak.

Epidemiologic investigation traced the source of the virus to a pet hamster recently purchased by the organ donor from a pet store in Rhode Island. LCMV testing of other rodents at the pet store identified three other LCMV-infected rodents (two hamsters and a guinea pig). All four pet rodents had been supplied by a single distributor, MidSouth Distributors of Ohio. Preliminary test results determined that four (3.4%) of 115 hamsters sampled from the Ohio distributor had active LCMV infection. On the basis of sequence analysis, the LCMV from the transplant recipients, the donor's pet rodent, and from rodents obtained from the Rhode Island pet store and the Ohio distributor were determined to have the same lineage (i.e., likely to share a common source). Under the authority of the Ohio Department of Agriculture, the MidSouth facility was quarantined. The MidSouth owner voluntarily depopulated the facility; the premises also will be disinfected.

LCMV test results for the sampled rodents and records reviewed at the Rhode Island pet store and at MidSouth Distributors indicate that LCMV-infected pet rodents might have been transported from the Ohio facility to pet stores in the northeastern and midwestern United States as early as February 2005. Ohio authorities and CDC are working to determine which stores and states have received potentially affected shipments from the Ohio facility. CDC also is conducting an ongoing traceback investigation of the breeding facilities that supplied MidSouth Distributors.

Background Information

LCMV infection in humans with normal immune systems usually causes either asymptomatic or mild, self-limited illness. Aseptic meningitis also can occur in some patients, but the infection is rarely fatal (*2*). However, LCMV infection during the first or second trimester of pregnancy can cause severe illness or developmental defects in the fetus, including hydrocephalus, psychomotor retardation, blindness, and fetal death (*3*). The frequency with which developmental defects occur after in utero LCMV infection is not known. In addition, LCMV can be a serious infection in persons with impaired immune systems.

Pet hamsters and guinea pigs are not known to be natural reservoirs for LCMV. However, pet rodents can become infected if they have contact with wild house mice (*Mus musculus*) (e.g, in a breeding facility, pet store, or home). Although infection of other animals with LCMV might be possible, documented infections in humans have occurred only after exposure to infected mice, guinea pigs, and hamsters (*2,4*). Most human cases are associated with wild house mice, which are considered the primary reservoir (*5*).

Serologic testing of pet rodent species for antibodies against LCMV has not been reliable; the tests have not detected antibodies in animals with active infections demonstrated by other tests (i.e., immunohistochemistry staining of tissues and virus isolation). The unreliability of serologic testing is of concern because certain species of pet rodents infected with LCMV can shed virus for up to 8 months without signs of illness and thus can be a source of infection for humans (*4,6*).

A large outbreak of LCMV infection associated with pet hamsters sold by a single distributor was reported in 1974, when 181 symptomatic human cases were identified in 12 states; no deaths occurred (*7*). The outbreak was controlled by voluntary cessation of the sale of pet hamsters and subsequent destruction of the infected breeding stock. Stores were advised that all caging material be decontaminated or destroyed before receiving new animals. In addition, the public was informed of the risk for infection from hamsters purchased during the outbreak at stores supplied by the affected distributor (*8*).

Pet Stores with Potentially Infected Rodents in Stock

Two national retail chains have temporarily stopped the sale of potentially affected rodents (e.g., hamsters, guinea pigs, gerbils, rats, chinchillas, and mice) originating from MidSouth Distributors since February 2005. Pet stores that have received rodents from MidSouth Distributors since February should contact the appropriate authority in their states (i.e., state health department or state department of agriculture) for additional information and guidance.

Although LCMV is known to infect hamsters and guinea pigs, data are insufficient to determine the potential for infection of other rodent species (e.g., chinchillas, dwarf hamsters, or gerbils). However, husbandry practices in breeding facilities, distribution centers, and pet stores make cross-contamination with LCMV of other species a possibility. CDC is working with retailers in the pet industry to consider appropriate testing of these other rodent species.

Practices that can lead to cross-contamination of rodents include 1) housing healthy rodents in the same room or bin or in cages near potentially infected rodents (i.e., rodents from the MidSouth Distributors facility in Ohio); 2) handling or caring for rodents without washing hands or changing gloves after handling other rodents and between other animal-care activities, such as cleaning cages; 3) placing rodents in cages that previously housed other rodents without first decontaminating the cages with bleach or other appropriate disinfectants; and 4) reusing materials (e.g., water bottles, food dishes, bedding, or toys) that might be contaminated by potentially infected rodents.

Pet rodents that did not originate from MidSouth Distributors of Ohio and were not exposed to potential cross-contamination can be sold or distributed as normal. In addition, nonrodent species (e.g., ferrets and rabbits) can be sold or distributed as normal.

Pet stores are advised to work with state authorities to minimize the risk for transmission of LCMV from affected rodents to humans. Options considered by state authorities include 1) stopping sale or distribution of all rodents originating from MidSouth Distributors of Ohio since February, 2) stopping sale or distribution of hamsters and guinea pigs originating from MidSouth Distributors of Ohio since February, or 3) allowing distribution (i.e., sale or adoption), provided that appropriate educational material (e.g., state-approved informed consent or fact sheet) is provided to purchasers of pet rodents originating from MidSouth Distributors since February. Educational material should disclose the specific LCMV risk in this population of pet rodents and potential outcomes in humans, including birth defects and fetal deaths. If sale of rodents is allowed to continue, populations at high risk (i.e., pregnant women, women who think they might become pregnant, and persons with weakened immune systems) should be advised against purchasing a pet rodent (*9*).

Preventing LCMV Infection in New Supplies of Rodents

Efforts are under way to ensure that animal facilities and equipment in retail outlets are disinfected, that new supplies of rodents come from sources free from LCMV, and that cross-contamination between new supplies of rodents and potentially infected animals will not occur. Surfaces, cages, and any reusable equipment that has been in contact with affected animals, their waste, or bedding material should be cleaned and disinfected by using a household disinfectant according to the manufacturer's instructions. Persons who are pregnant or have compromised immune systems should not engage in cleaning and disinfection related to these affected animals or other rodents. CDC and other partners will work with breeders and retailers in the pet industry to implement quality-assurance programs to minimize the risk for LCMV infection in rodents that are sold to the public.

Previously Purchased Pet Rodents

Testing of individual pet rodents in households is not a recommended strategy to minimize risk for LCMV infection; the probability of any one rodent in the United States being infected is low. The greatest infection risk for a pet owner is likely to occur soon after purchase of a pet rodent. Thus, most exposures likely already have occurred for existing owners and substantial added risk is unlikely to result from continued ownership of the rodent. However, women who are or who plan to become pregnant and persons who are immunocompromised should avoid contact with all rodents.

To prevent any possible infection of other rodents in stores, owners should not return pet rodents from MidSouth Distributors to pet stores. For legal, ethical, and wildlife conservation considerations, owners should not release pet rodents into the wild. Persons who no longer wish to keep their pet rodent should consult a veterinarian.

CDC continues to work with state public health officials and retailers in the pet industry to educate the public regarding safe handling of pet rodents and has prepared educational material for reducing the risk for LCMV infection from pet rodents. Rodents and other pets from any pet store pose some risk for transmitting certain infectious diseases and should be handled appropriately. Additional information about reduc-

ing the risk for infectious diseases from pets is available at http://www.cdc.gov/healthypets. More detailed information about LCMV is available at http://www.cdc.gov/ncidod/dvrd/spb/mnpages/dispages/lcmv.htm.

Reported by: *Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases, CDC.*

References

1. CDC. Lymphocytic choriomeningitis virus infection in organ transplant recipients—Massachusetts, Rhode Island, 2005. MMWR 2005;54;537–9.
2. Rousseau MC, Saron MF, Brouqui P, Bourgeade A. Lymphocytic choriomeningitis virus in southern France: four case reports and a review of the literature. Eur J Epidemiol 1997;13:817–23.
3. Barton LL, Mets MB, Beauchamp CL. Lymphocytic choriomeningitis virus: emerging fetal teratogen. Am J Obstet Gynecol 2002;187:1715–6.
4. Traub E. The epidemiology of lymphocytic choriomeningitis in white mice. J Exp Med 1936;64:183–200.
5. Childs JE, Peters CJ. Ecology and epidemiology of arenaviruses and their hosts. In: Salvato MS, ed. The Arenaviridae. New York, NY: Plenum Press;1993:331–84.
6. Skinner HH, Knight EH, Buckley LS. The hamster as a secondary reservoir host of lymphocytic choriomeningitis virus. J Hyg (Lond) 1976;76:299–306.
7. Gregg MB. Recent outbreaks of lymphocytic choriomeningitis in the United States of America. Bull World Health Organ 1975;52:549–53.
8. CDC. Lymphocytic choriomeningitis associated with pet hamsters—New York. MMWR 1974;23.
9. CDC. Interim guidance for minimizing risk for human lymphocytic choriomeningitis virus infection associated with rodents. MMWR 2005;54:747–9.

Notice to Readers

"You Drink & Drive. You Lose" Program, August 19–September 5, 2005

Motor-vehicle crashes are the leading cause of death in all persons aged 1–34 years in the United States (*1*). In 2003, approximately 40% of motor-vehicle–traffic fatalities involved alcohol (*2*). The percentage of traffic fatalities involving alcohol usually increases during holiday periods. During the Labor Day holiday period in 2003, approximately 51% of traffic fatalities involved alcohol (*2*).

During August 19–September 5, 2005 (Labor Day), the National Highway Traffic Safety Administration and local traffic-safety partners nationwide will conduct the "You Drink & Drive. You Lose" program to reduce the rate of alcohol-impaired driving. The program will involve a national media campaign and increased enforcement of drinking and driving laws through such measures as sobriety checkpoints.

At sobriety checkpoints, law enforcement officers systematically stop drivers to assess their level of alcohol impairment. Legal blood alcohol levels in every state are <0.08% (0.08 g/dL). CDC has concluded that sobriety checkpoints are an effective means of reducing alcohol-related traffic fatalities (*3,4*).

Information about the "You Drink & Drive. You Lose" program is available at http://www.nhtsa.dot.gov. Information about effective strategies communities can use to prevent deaths and injuries from impaired driving is available from CDC's National Center for Injury Prevention and Control at http://www.cdc.gov/ncipc/factsheets/drving.htm.

References

1. CDC. Web-based Injury Statistics Query and Reporting System (WISQARS™). Atlanta, GA: US Department of Health and Human Services, CDC; 2005. Available at http://www.cdc.gov/ncipc/wisqars.
2. National Highway Traffic Safety Administration. Traffic safety facts, 2003. Washington, DC: US Department of Transportation; 2005. Publication no. DOT HS 809 775.
3. Elder RW, Shults RA, Sleet DA, Nichols JL, Zaza S, Thompson RS. Effectiveness of sobriety checkpoints for reducing alcohol-involved crashes. Traffic Inj Prev 2002;3:266–74.
4. Shults RA, Elder RW, Sleet DA, et al., Task Force for Community Preventive Services. Reviews of evidence regarding interventions to reduce alcohol-impaired driving. Am J Prev Med 2001;4S:66–88.

Notice to Readers

New CDC Course: Public Health Emergency Law

CDC's Public Health Law Program and CDC's Coordinating Office for Terrorism Preparedness and Emergency Response announce the availability of a new course, "Public Health Emergency Law" (PHEL). PHEL includes six PowerPoint lecture units that can be used for training nonlegal professionals in health departments, emergency management agencies, and other organizations active in public health emergency preparedness. PHEL covers relevant legal principles in the following areas: 1) basic concepts (e.g., plans under which public health and emergency management work together); 2) detecting and declaring emergencies; 3) protecting persons (e.g., use of quarantine and isolation); 4) managing property; 5) mobilizing professional resources; and 6)

advanced topics (e.g., legal implications of public communications during emergencies). The course also provides an interactive case study to reinforce learning points delivered during lectures.

Detailed information about PHEL and copies of the CD-ROM containing all of the course components are available from PHEL field coordinators at telephone, 770-220-0608, or e-mail, wbradford@mcking.com or wrushing@mcking.com.

Notice to Readers

Partners in Information Access for the Public Health Workforce Website

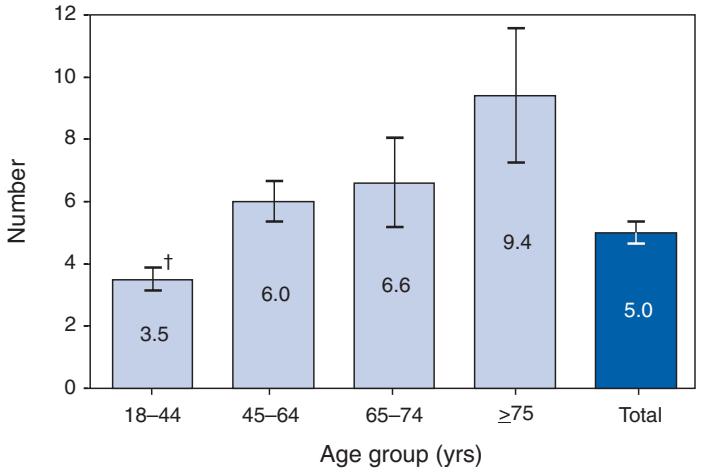
The Partners in Information Access for the Public Health Workforce is a collaboration of CDC and other federal agencies, public health organizations, and health sciences libraries. The group has created a website (http://phpartners.org) to help members of the public health workforce find and use information effectively. The content of all linked sites has been reviewed by the group's editorial board.

The website's links are organized into 10 main categories: health promotion and health education, literature and guidelines, health data tools and statistics, grants and funding, education and training, legislation, conferences and meetings, finding people, discussion and e-mail lists, and jobs and careers. In addition, the website offers news items of interest to public health practitioners and links to several initiatives supported by the group, including the *Healthy People 2010 Information Access Project*, *Public Health Information and Data: A Training Manual* (and online tutorial), and the *Resource Guide for Public Health Preparedness*.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Average Number of Bed Days* During the Preceding 12 Months Among Persons Aged ≥18 Years, by Age Group — United States, 2003

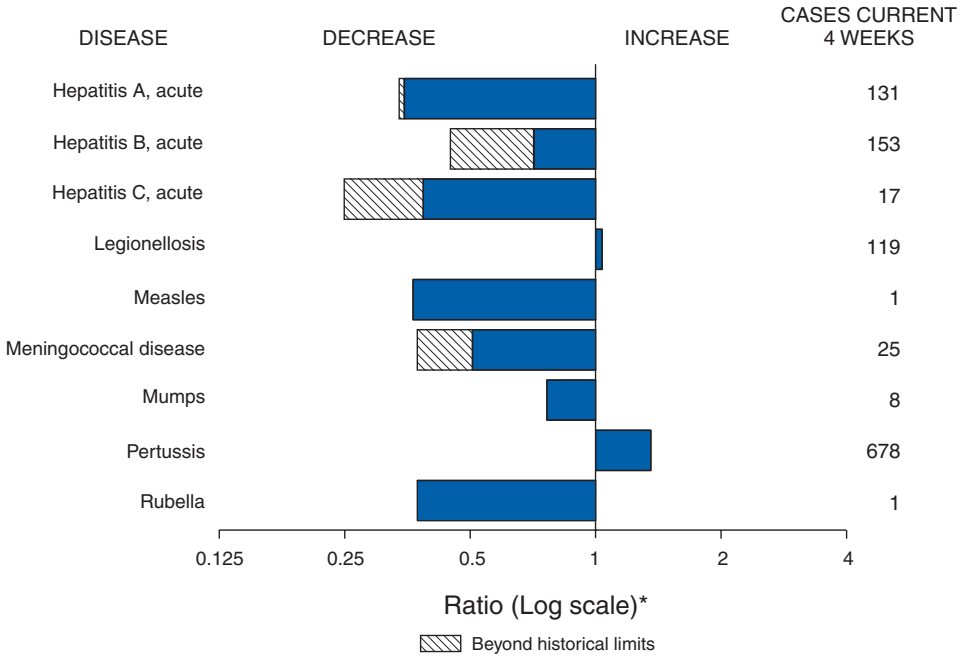


* Bed days are defined as days spent as an overnight patient in a hospital or days on which a person was kept in bed for more than half a day because of illness or injury.
† 95% confidence interval.

In 2003, U.S. adults reported spending an average of 5 days in bed during the preceding 12 months because of illness or injury. Younger adults had fewer bed days than older adults, and adults aged 18–44 years had the fewest bed days.

SOURCE: Lethbridge-Çejku M, Vickerie J. Summary health statistics for U.S. adults: National Health Interview Survey, 2003. Vital Health Stat 2005;10(225). Available at http://www.cdc.gov/nchs/data/series/sr_10/sr10_225.pdf.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals August 13, 2005, with historical data



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

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending August 13, 2005 (32nd Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	86	93
Botulism:			HIV infection, pediatric†¶	181	251
foodborne	7	6	Influenza-associated pediatric mortality†**	42	—
infant	42	47	Measles	56††	24§§
other (wound & unspecified)	17	8	Mumps	156	129
Brucellosis	60	55	Plague	3	—
Chancroid	17	17	Poliomyelitis, paralytic	—	—
Cholera	2	4	Psittacosis†	13	8
Cyclosporiasis†	654	173	Q fever†	66	41
Diphtheria	—	—	Rabies, human	1	4
Domestic arboviral diseases			Rubella	8	9
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	1	—
California serogroup†§	6	59	SARS†**	—	—
eastern equine†§	5	1	Smallpox†	—	—
Powassan†§	—	1	*Staphylococcus aureus*:		
St. Louis†§	1	6	Vancomycin-intermediate (VISA)†	—	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	—	1
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome†	88	100
human granulocytic (HGE)†	239	227	Tetanus	14	12
human monocytic (HME)†	165	154	Toxic-shock syndrome	61	54
human, other and unspecified †	34	40	Trichinellosis¶¶	11	1
Hansen disease†	46	63	Tularemia†	71	57
Hantavirus pulmonary syndrome†	16	15	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 June 26, 2005.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of 56 cases reported, 46 were indigenous and 10 were imported from another country.
§§ Of 24 cases reported, seven were indigenous and 17 were imported from another country.
¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending August 13, 2005, and August 14, 2004 (32nd 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	20,405	23,315	553,920	562,768	2,678	3,441	1,476	1,831
NEW ENGLAND	778	769	19,248	18,463	—	—	85	104
Maine	11	14	1,267	1,206	N	N	12	14
N.H.	20	28	1,144	1,035	—	—	13	19
Vt.¶	4	13	571	703	—	—	18	14
Mass.	368	232	8,629	8,143	—	—	28	42
R.I.	68	82	1,983	2,078	—	—	2	3
Conn.	307	400	5,654	5,298	N	N	12	12
MID. ATLANTIC	4,352	4,995	68,714	69,431	—	—	201	280
Upstate N.Y.	800	653	13,764	13,778	N	N	63	61
N.Y. City	2,327	2,723	22,115	21,604	—	—	42	77
N.J.	574	919	10,585	11,055	N	N	10	25
Pa.	651	700	22,250	22,994	N	N	86	117
E.N. CENTRAL	1,938	1,901	84,560	99,131	5	8	313	541
Ohio	312	229	20,890	24,363	N	N	101	102
Ind.	236	246	12,051	11,036	N	N	21	47
Ill.	983	941	25,632	28,966	—	—	28	93
Mich.	322	380	14,712	23,280	5	8	45	90
Wis.	85	105	11,275	11,486	N	N	118	209
W.N. CENTRAL	463	470	33,836	34,194	5	5	255	233
Minn.	123	118	6,318	7,190	3	N	60	76
Iowa	50	36	3,994	4,147	N	N	55	47
Mo.	198	201	13,701	12,571	2	3	107	42
N. Dak.	5	14	685	1,141	N	N	—	9
S. Dak.	10	7	1,692	1,480	—	—	13	23
Nebr.¶	18	21	3,381	3,175	—	2	3	17
Kans.	59	73	4,065	4,490	N	N	17	19
S. ATLANTIC	6,473	7,144	108,347	105,181	1	—	287	284
Del.	100	102	2,006	1,756	N	N	—	—
Md.	812	804	11,470	11,610	1	—	18	11
D.C.	467	460	2,237	2,180	—	—	5	10
Va.¶	307	393	12,428	13,678	—	—	19	30
W. Va.	36	32	1,583	1,736	N	N	4	3
N.C.	531	390	20,575	17,612	N	N	34	49
S.C.¶	386	426	13,902	11,022	—	—	9	11
Ga.	1,103	1,011	17,812	19,532	—	—	61	93
Fla.	2,731	3,526	26,334	26,055	N	N	137	77
E.S. CENTRAL	1,093	1,163	39,932	36,545	—	4	50	68
Ky.	135	129	5,887	3,502	N	N	20	23
Tenn.¶	434	461	13,579	13,916	N	N	15	19
Ala.¶	295	286	7,235	8,333	—	—	14	13
Miss.	229	287	13,231	10,794	—	4	1	13
W.S. CENTRAL	2,206	2,954	67,743	71,247	1	2	55	61
Ark.	72	131	4,672	4,993	—	1	2	12
La.	436	590	11,798	14,558	1	1	3	1
Okla.	167	120	6,684	7,075	N	N	30	15
Tex.¶	1,531	2,113	44,589	44,621	N	N	20	33
MOUNTAIN	789	828	32,698	33,805	1,862	2,172	73	97
Mont.	4	4	1,142	1,566	N	N	12	28
Idaho¶	9	11	1,554	1,749	N	N	6	9
Wyo.	2	6	675	663	2	1	2	2
Colo.	163	162	8,431	8,324	N	N	23	33
N. Mex.	72	116	2,969	5,453	6	16	3	7
Ariz.	329	309	11,259	10,241	1,820	2,104	9	14
Utah	33	41	2,651	2,268	3	11	10	2
Nev.¶	177	179	4,017	3,541	31	40	8	2
PACIFIC	2,313	3,091	98,842	94,771	804	1,250	157	163
Wash.	229	213	11,518	10,593	N	N	21	14
Oreg.¶	136	155	5,115	5,044	—	—	28	22
Calif.	1,874	2,646	77,061	73,371	804	1,250	107	125
Alaska	14	21	2,439	2,314	—	—	—	—
Hawaii	60	56	2,709	3,449	—	—	1	2
Guam	1	1	—	719	—	—	—	—
P.R.	537	394	2,274	2,284	N	N	N	N
V.I.	10	6	119	235	—	—	—	—
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 June 26, 2005.

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending August 13, 2005, and August 14, 2004 (32nd Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,048	1,297	151	162	131	100	9,445	10,562	187,524	196,188
NEW ENGLAND	86	98	32	35	21	9	848	947	3,646	4,319
Maine	11	8	6	—	—	—	113	80	78	146
N.H.	10	14	2	5	—	—	35	24	105	74
Vt.	9	9	2	—	—	—	97	87	33	53
Mass.	32	43	6	12	21	9	333	438	1,605	1,935
R.I.	3	6	—	1	—	—	57	62	286	532
Conn.	21	18	16	17	—	—	213	256	1,539	1,579
MID. ATLANTIC	133	154	13	25	19	22	1,751	2,272	19,457	22,344
Upstate N.Y.	62	64	8	11	6	9	615	715	3,901	4,496
N.Y. City	6	31	—	—	—	—	467	675	5,763	6,992
N.J.	21	28	1	5	3	6	208	290	3,242	4,210
Pa.	44	31	4	9	10	7	461	592	6,551	6,646
E.N. CENTRAL	206	257	14	33	7	16	1,459	1,679	33,932	41,043
Ohio	60	55	1	7	3	10	402	465	9,742	12,519
Ind.	27	28	—	—	—	—	N	N	4,821	3,863
Ill.	34	52	1	4	1	5	307	495	10,592	12,435
Mich.	48	47	—	6	3	1	398	395	5,635	9,305
Wis.	37	75	12	16	—	—	352	324	3,142	2,921
W.N. CENTRAL	175	267	24	23	18	18	1,143	1,130	10,765	10,248
Minn.	36	64	7	9	7	3	554	371	1,778	1,783
Iowa	40	73	—	—	—	—	135	169	876	750
Mo.	55	45	11	11	5	6	243	320	5,582	5,302
N. Dak.	1	8	—	—	—	5	5	18	38	77
S. Dak.	10	18	3	—	—	—	48	35	231	158
Nebr.	12	38	3	3	4	—	54	85	790	651
Kans.	21	21	—	—	2	4	104	132	1,470	1,527
S. ATLANTIC	109	96	34	17	49	20	1,396	1,669	46,288	47,248
Del.	3	2	N	N	N	N	31	30	494	557
Md.	19	20	10	2	4	2	99	67	4,246	4,981
D.C.	—	1	—	—	—	—	27	44	1,233	1,549
Va.	16	19	14	7	13	—	310	254	4,376	5,496
W. Va.	1	2	—	—	—	—	20	19	436	547
N.C.	—	—	—	—	24	13	N	N	9,645	9,413
S.C.	4	7	—	—	—	—	66	65	6,094	5,391
Ga.	16	15	6	6	—	—	290	525	7,977	8,437
Fla.	50	30	4	2	8	5	553	665	11,787	10,877
E.S. CENTRAL	68	62	1	3	10	11	230	213	15,245	15,859
Ky.	18	15	—	1	9	7	N	N	1,933	1,513
Tenn.	27	26	1	—	1	4	116	114	4,861	5,109
Ala.	19	12	—	—	—	—	114	99	4,245	5,042
Miss.	4	9	—	2	—	—	—	—	4,206	4,195
W.S. CENTRAL	29	55	4	3	3	4	151	177	27,330	27,046
Ark.	5	10	—	—	—	—	44	70	2,420	2,537
La.	3	2	3	1	2	—	26	32	6,493	6,695
Okla.	13	12	—	—	—	—	81	75	2,739	3,009
Tex.	8	31	1	2	1	4	N	N	15,678	14,805
MOUNTAIN	89	121	25	22	4	—	724	839	6,984	6,832
Mont.	8	11	—	—	—	—	26	30	58	51
Idaho	10	26	8	3	2	—	53	98	63	49
Wyo.	1	3	2	1	—	—	12	14	40	34
Colo.	18	35	1	1	1	—	267	297	1,840	1,823
N. Mex.	4	9	3	4	—	—	35	49	577	694
Ariz.	22	10	N	N	N	N	88	111	2,469	2,196
Utah	17	18	11	12	—	—	203	173	404	341
Nev.	9	9	—	1	1	—	40	67	1,533	1,644
PACIFIC	153	187	4	1	—	—	1,743	1,636	23,877	21,249
Wash.	35	65	—	—	—	—	203	185	2,159	1,504
Oreg.	39	35	3	1	—	—	181	254	907	659
Calif.	63	82	—	—	—	—	1,267	1,103	19,982	17,891
Alaska	11	1	—	—	—	—	53	45	335	377
Hawaii	5	4	1	—	—	—	39	49	494	818
Guam	N	N	—	—	—	—	—	2	—	116
P.R.	—	—	—	—	—	—	30	139	214	163
V.I.	—	—	—	—	—	—	—	—	35	73
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 August 13, 2005, and August 14, 2004 (32nd Week)*

Reporting area	*Haemophilus influenzae*, invasive							
	All ages		Age <5 years					
	All serotypes		Serotype b		Non-serotype b		Unknown serotype	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,396	1,303	3	9	73	73	133	122
NEW ENGLAND	107	119	—	1	9	7	4	1
Maine	5	9	—	—	—	—	1	—
N.H.	5	14	—	—	—	2	—	—
Vt.	6	5	—	—	—	—	2	1
Mass.	49	58	—	1	3	2	1	—
R.I.	7	3	—	—	2	—	—	—
Conn.	35	30	—	—	4	3	—	—
MID. ATLANTIC	268	270	—	1	—	4	33	29
Upstate N.Y.	76	91	—	1	—	4	5	4
N.Y. City	49	60	—	—	—	—	10	10
N.J.	49	51	—	—	—	—	8	2
Pa.	94	68	—	—	—	—	10	13
E.N. CENTRAL	206	242	1	—	3	8	12	37
Ohio	89	71	—	—	—	2	8	12
Ind.	48	37	—	—	3	4	—	1
Ill.	35	81	—	—	—	—	3	19
Mich.	13	15	1	—	—	2	—	3
Wis.	21	38	—	—	—	—	1	2
W.N. CENTRAL	82	66	—	2	3	3	10	5
Minn.	32	29	—	1	3	3	1	—
Iowa	—	1	—	1	—	—	—	—
Mo.	35	24	—	—	—	—	7	4
N. Dak.	1	3	—	—	—	—	1	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	6	3	—	—	—	—	1	—
Kans.	8	6	—	—	—	—	—	1
S. ATLANTIC	335	295	1	—	21	19	18	21
Del.	—	—	—	—	—	—	—	—
Md.	49	47	—	—	5	5	—	—
D.C.	—	2	—	—	—	—	—	1
Va.	32	27	—	—	—	—	1	3
W. Va.	21	10	—	—	1	3	4	—
N.C.	59	40	1	—	7	5	—	1
S.C.	20	9	—	—	—	—	1	1
Ga.	64	85	—	—	—	—	8	15
Fla.	90	75	—	—	8	6	4	—
E.S. CENTRAL	81	54	—	1	1	—	14	7
Ky.	8	5	—	—	1	—	2	—
Tenn.	56	35	—	—	—	—	8	5
Ala.	17	12	—	1	—	—	4	2
Miss.	—	2	—	—	—	—	—	—
W.S. CENTRAL	77	51	1	1	5	6	6	1
Ark.	4	1	—	—	1	—	—	—
La.	28	10	1	—	2	—	6	1
Okla.	44	39	—	—	2	6	—	—
Tex.	1	1	—	1	—	—	—	—
MOUNTAIN	166	141	—	3	13	17	28	16
Mont.	—	—	—	—	—	—	—	—
Idaho	3	5	—	—	—	—	1	2
Wyo.	4	—	—	—	—	—	1	—
Colo.	34	32	—	—	—	—	9	3
N. Mex.	15	30	—	—	4	5	1	6
Ariz.	83	51	—	—	7	7	7	2
Utah	14	12	—	2	—	2	7	2
Nev.	13	11	—	1	2	3	2	1
PACIFIC	74	65	—	—	18	9	8	5
Wash.	1	1	—	—	—	—	1	1
Oreg.	28	29	—	—	—	—	5	2
Calif.	33	24	—	—	18	9	1	1
Alaska	4	5	—	—	—	—	1	1
Hawaii	8	6	—	—	—	—	—	—
Guam	—	—	—	—	—	—	—	—
P.R.	1	2	—	—	—	—	—	2
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 August 13, 2005, and August 14, 2004 (32nd 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	2,220	3,543	3,415	3,554	479	454
NEW ENGLAND	285	575	168	227	8	9
Maine	1	9	9	1	—	—
N.H.	59	13	13	24	—	—
Vt.	4	8	2	3	8	2
Mass.	186	479	120	114	—	7
R.I.	5	13	1	3	—	—
Conn.	30	53	23	82	U	—
MID. ATLANTIC	383	457	721	467	62	79
Upstate N.Y.	62	53	56	46	13	4
N.Y. City	184	189	63	91	—	—
N.J.	72	103	471	136	—	—
Pa.	65	112	131	194	49	75
E.N. CENTRAL	208	288	289	335	80	62
Ohio	33	32	91	71	3	4
Ind.	25	30	25	31	15	4
Ill.	49	95	67	50	—	12
Mich.	84	98	106	157	62	42
Wis.	17	33	—	26	—	—
W.N. CENTRAL	65	107	175	214	33	14
Minn.	3	28	15	29	5	11
Iowa	16	33	9	14	—	—
Mo.	32	22	111	133	26	3
N. Dak.	—	1	—	4	1	—
S. Dak.	—	2	3	—	—	—
Nebr.	5	10	19	21	1	—
Kans.	9	11	18	13	—	—
S. ATLANTIC	371	640	878	1,107	155	107
Del.	4	5	38	28	82	4
Md.	37	76	98	99	15	3
D.C.	2	4	8	13	—	2
Va.	51	53	98	133	9	11
W. Va.	3	3	24	24	9	16
N.C.	57	62	98	107	9	8
S.C.	21	33	91	87	2	13
Ga.	60	226	103	303	3	8
Fla.	136	178	320	313	26	42
E.S. CENTRAL	153	104	221	306	64	57
Ky.	17	18	43	39	11	22
Tenn.	104	71	83	146	11	16
Ala.	17	6	50	48	8	3
Miss.	15	9	45	73	34	16
W.S. CENTRAL	115	447	243	208	18	66
Ark.	5	57	25	75	—	2
La.	40	26	28	38	8	3
Okla.	4	18	22	42	—	3
Tex.	66	346	168	53	10	58
MOUNTAIN	208	269	352	274	31	26
Mont.	7	4	3	1	1	2
Idaho	15	12	7	6	1	1
Wyo.	—	4	1	7	—	—
Colo.	25	28	31	37	15	7
N. Mex.	12	16	6	11	—	U
Ariz.	128	169	250	140	—	4
Utah	14	27	32	24	7	2
Nev.	7	9	22	48	7	10
PACIFIC	432	656	368	416	28	34
Wash.	28	39	47	33	U	U
Oreg.	30	43	58	70	13	13
Calif.	357	552	252	298	15	20
Alaska	3	4	7	9	—	—
Hawaii	14	18	4	6	—	1
Guam	—	1	—	12	—	9
P.R.	16	28	11	54	—	—
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 August 13, 2005, and August 14, 2004 (32nd 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	943	1,081	377	405	9,752	10,933	689	845
NEW ENGLAND	61	34	25	22	968	1,948	34	64
Maine	3	—	—	5	50	29	4	6
N.H.	6	1	3	2	90	121	4	1
Vt.	2	2	1	1	15	27	1	3
Mass.	22	18	8	8	484	1,102	23	39
R.I.	9	2	2	1	13	112	2	2
Conn.	19	11	11	5	316	557	—	13
MID. ATLANTIC	322	284	96	96	6,872	6,865	187	227
Upstate N.Y.	83	50	35	27	1,796	2,106	28	24
N.Y. City	30	36	17	16	—	241	85	114
N.J.	77	46	16	22	2,406	1,903	52	53
Pa.	132	152	28	31	2,670	2,615	22	36
E.N. CENTRAL	156	256	38	73	364	930	53	77
Ohio	74	112	16	23	53	34	15	20
Ind.	11	25	1	15	13	12	—	7
Ill.	12	31	1	16	—	73	19	26
Mich.	46	72	14	17	16	10	15	14
Wis.	13	16	6	2	282	801	4	10
W.N. CENTRAL	42	29	17	7	284	194	30	45
Minn.	11	3	3	2	219	136	11	18
Iowa	3	3	6	1	39	27	4	2
Mo.	17	14	4	3	20	22	12	13
N. Dak.	1	1	2	—	—	—	—	3
S. Dak.	7	3	—	—	—	—	—	1
Nebr.	1	1	—	1	—	7	—	2
Kans.	2	4	2	—	6	2	3	6
S. ATLANTIC	202	224	80	62	1,133	886	165	186
Del.	12	5	N	N	406	142	3	6
Md.	54	42	13	9	539	551	57	39
D.C.	4	7	—	—	7	6	6	9
Va.	26	25	6	12	101	65	17	16
W. Va.	8	4	2	2	4	8	1	—
N.C.	17	24	15	14	32	64	20	11
S.C.	9	7	3	4	8	12	4	7
Ga.	12	33	16	10	1	11	26	40
Fla.	60	77	25	11	35	27	31	58
E.S. CENTRAL	43	60	15	19	23	28	17	23
Ky.	13	20	3	4	3	12	4	3
Tenn.	20	26	6	10	20	13	10	5
Ala.	9	12	5	3	—	3	3	11
Miss.	1	2	1	2	—	—	—	4
W.S. CENTRAL	18	98	16	29	37	24	46	96
Ark.	3	—	—	3	3	4	2	7
La.	4	7	6	2	3	2	2	4
Okla.	3	3	2	—	—	—	3	4
Tex.	8	88	8	24	31	18	39	81
MOUNTAIN	59	54	7	15	10	10	32	31
Mont.	4	1	—	—	—	—	—	—
Idaho	3	6	—	1	1	2	—	1
Wyo.	3	5	—	—	2	3	1	—
Colo.	15	11	2	6	2	—	18	11
N. Mex.	2	3	3	—	1	—	1	2
Ariz.	17	10	—	—	1	5	6	8
Utah	8	15	—	1	2	—	4	5
Nev.	7	3	2	7	1	—	2	4
PACIFIC	40	42	83	82	61	48	125	96
Wash.	—	8	7	7	3	3	10	8
Oreg.	N	N	5	5	13	19	6	12
Calif.	39	34	71	67	42	25	93	73
Alaska	—	—	—	—	3	1	3	—
Hawaii	1	—	—	3	N	N	13	3
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	1	—
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 August 13, 2005, and August 14, 2004 (32nd 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	802	826	59	65	40	34	—	1	703	726
NEW ENGLAND	56	51	1	5	—	6	—	1	55	39
Maine	2	9	—	—	—	1	—	—	2	8
N.H.	9	3	—	—	—	—	—	—	9	3
Vt.	5	2	—	—	—	—	—	—	5	2
Mass.	27	30	—	5	—	5	—	—	27	20
R.I.	2	1	—	—	—	—	—	—	2	1
Conn.	11	6	1	—	—	—	—	1	10	5
MID. ATLANTIC	106	116	29	33	4	5	—	—	73	78
Upstate N.Y.	28	33	4	5	3	3	—	—	21	25
N.Y. City	14	20	—	—	—	—	—	—	14	20
N.J.	29	23	—	—	—	—	—	—	29	23
Pa.	35	40	25	28	1	2	—	—	9	10
E.N. CENTRAL	80	89	16	19	8	6	—	—	56	64
Ohio	28	45	—	3	5	5	—	—	23	37
Ind.	14	15	—	1	3	1	—	—	11	13
Ill.	12	1	—	—	—	—	—	—	12	1
Mich.	16	15	16	15	—	—	—	—	—	—
Wis.	10	13	—	—	—	—	—	—	10	13
W.N. CENTRAL	55	56	2	—	1	4	—	—	52	52
Minn.	9	17	1	—	—	—	—	—	8	17
Iowa	12	13	—	—	1	2	—	—	11	11
Mo.	20	15	1	—	—	1	—	—	19	14
N. Dak.	—	2	—	—	—	—	—	—	—	2
S. Dak.	2	2	—	—	—	1	—	—	2	1
Nebr.	4	2	—	—	—	—	—	—	4	2
Kans.	8	5	—	—	—	—	—	—	8	5
S. ATLANTIC	152	155	4	2	7	2	—	—	141	151
Del.	3	2	—	—	—	—	—	—	3	2
Md.	15	8	2	—	2	—	—	—	11	8
D.C.	—	5	—	2	—	—	—	—	—	3
Va.	20	11	—	—	—	—	—	—	20	11
W. Va.	5	5	1	—	—	—	—	—	4	5
N.C.	23	24	1	—	5	2	—	—	17	22
S.C.	14	13	—	—	—	—	—	—	14	13
Ga.	13	9	—	—	—	—	—	—	13	9
Fla.	59	78	—	—	—	—	—	—	59	78
E.S. CENTRAL	39	40	1	1	3	—	—	—	35	39
Ky.	13	7	—	1	3	—	—	—	10	6
Tenn.	17	13	—	—	—	—	—	—	17	13
Ala.	5	10	1	—	—	—	—	—	4	10
Miss.	4	10	—	—	—	—	—	—	4	10
W.S. CENTRAL	61	49	1	1	5	1	—	—	55	47
Ark.	11	12	—	—	—	—	—	—	11	12
La.	24	27	—	1	2	—	—	—	22	26
Okla.	12	7	1	—	3	1	—	—	8	6
Tex.	14	3	—	—	—	—	—	—	14	3
MOUNTAIN	65	50	4	1	5	5	—	—	56	44
Mont.	—	3	—	—	—	—	—	—	—	3
Idaho	2	6	—	—	—	—	—	—	2	6
Wyo.	—	3	—	—	—	—	—	—	—	3
Colo.	14	12	3	—	—	—	—	—	11	12
N. Mex.	1	6	—	1	—	3	—	—	1	2
Ariz.	34	9	—	—	2	1	—	—	32	8
Utah	9	4	1	—	2	—	—	—	6	4
Nev.	5	7	—	—	1	1	—	—	4	6
PACIFIC	188	220	1	3	7	5	—	—	180	212
Wash.	35	21	1	3	4	5	—	—	30	13
Oreg.	26	43	—	—	—	—	—	—	26	43
Calif.	115	149	—	—	—	—	—	—	115	149
Alaska	1	2	—	—	—	—	—	—	1	2
Hawaii	11	5	—	—	3	—	—	—	8	5
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	4	13	—	—	—	—	—	—	4	13
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	—	1	—	—	—	—	—	—	—	1
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 August 13, 2005, and August 14, 2004 (32nd 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	11,163	9,285	3,040	3,891	849	765	21,323	23,370	7,145	7,690
NEW ENGLAND	602	1,035	438	360	3	12	1,255	1,272	164	162
Maine	16	4	35	36	N	N	94	71	7	5
N.H.	36	32	10	15	1	—	99	91	4	6
Vt.	69	49	38	16	—	—	73	36	11	2
Mass.	449	895	241	146	1	10	660	736	102	97
R.I.	12	16	13	23	1	1	54	72	10	12
Conn.	20	39	101	124	—	1	275	266	30	40
MID. ATLANTIC	830	1,599	359	544	48	51	2,574	3,573	690	777
Upstate N.Y.	314	1,121	299	285	3	1	690	688	174	323
N.Y. City	47	108	17	10	4	18	546	831	236	231
N.J.	153	119	N	N	18	10	405	667	193	152
Pa.	316	251	43	249	23	22	933	1,387	87	71
E.N. CENTRAL	2,181	2,857	98	75	25	23	2,915	3,134	447	650
Ohio	770	315	41	26	22	7	792	773	59	96
Ind.	183	54	7	5	—	4	281	283	41	117
Ill.	396	542	17	25	1	11	870	997	109	259
Mich.	130	86	20	16	2	1	517	508	142	71
Wis.	702	1,860	13	3	—	—	455	573	96	107
W.N. CENTRAL	1,613	983	266	403	144	81	1,439	1,467	843	253
Minn.	585	153	48	48	1	—	332	351	51	34
Iowa	342	59	52	51	2	1	215	310	52	53
Mo.	290	229	49	30	132	65	483	391	583	104
N. Dak.	77	486	17	47	—	—	17	27	2	2
S. Dak.	1	13	43	77	3	4	89	64	19	8
Nebr.	143	8	—	74	2	11	88	91	40	11
Kans.	175	35	57	76	4	—	215	233	96	41
S. ATLANTIC	807	409	975	1,455	405	353	5,768	5,754	1,136	1,854
Del.	5	—	—	9	2	4	56	58	8	5
Md.	110	79	171	193	50	36	462	513	49	82
D.C.	4	6	—	—	1	—	32	31	8	26
Va.	203	107	317	299	35	12	601	656	71	90
W. Va.	31	5	26	42	3	3	80	133	—	4
N.C.	64	49	320	396	241	185	778	665	110	175
S.C.	245	73	5	98	25	40	651	513	55	356
Ga.	26	17	135	213	36	60	833	1,067	269	419
Fla.	119	73	1	205	12	13	2,275	2,118	566	697
E.S. CENTRAL	317	149	85	81	152	108	1,354	1,450	842	482
Ky.	81	33	7	16	13	—	225	205	184	46
Tenn.	147	87	29	28	107	58	407	398	426	240
Ala.	59	17	48	28	30	30	381	364	180	160
Miss.	30	12	1	9	2	20	341	483	52	36
W.S. CENTRAL	668	378	583	746	40	120	1,853	2,232	1,700	2,103
Ark.	146	36	25	33	21	76	399	289	35	45
La.	27	12	—	—	5	5	405	502	70	209
Okla.	—	17	60	84	5	38	216	228	454	301
Tex.	495	313	498	629	9	1	833	1,213	1,141	1,548
MOUNTAIN	2,544	742	134	109	25	13	1,302	1,371	379	469
Mont.	457	27	5	19	1	3	52	91	5	4
Idaho	94	21	—	1	1	2	70	103	2	8
Wyo.	26	12	14	—	2	3	55	32	2	2
Colo.	844	368	13	23	4	2	349	336	62	91
N. Mex.	97	107	4	3	—	2	117	154	45	80
Ariz.	712	143	90	60	13	1	387	413	210	237
Utah	286	52	3	2	4	—	198	140	27	24
Nev.	28	12	5	1	—	—	74	102	26	23
PACIFIC	1,601	1,133	102	118	7	4	2,863	3,117	944	940
Wash.	474	410	U	U	—	—	304	280	57	65
Oreg.	485	290	3	4	1	2	218	272	66	45
Calif.	519	410	98	103	6	2	2,134	2,316	798	794
Alaska	33	11	1	11	—	—	36	34	7	6
Hawaii	90	12	—	—	—	—	171	215	16	30
Guam	—	—	—	—	—	—	—	47	—	38
P.R.	1	1	35	36	N	N	113	238	1	15
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 August 13, 2005, and August 14, 2004 (32nd 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	2,889	3,123	1,549	1,492	544	506	4,798	4,723	159	247
NEW ENGLAND	105	213	79	97	44	72	124	128	—	1
Maine	8	7	N	N	—	3	1	2	—	—
N.H.	9	15	—	—	3	N	9	3	—	—
Vt.	9	8	10	6	4	1	—	—	—	—
Mass.	72	97	56	24	37	40	85	79	—	—
R.I.	7	17	13	14	—	5	5	18	—	1
Conn.	—	69	U	53	U	23	24	26	—	—
MID. ATLANTIC	643	537	147	108	105	77	617	622	18	27
Upstate N.Y.	202	179	57	47	48	52	50	55	3	1
N.Y. City	108	81	U	U	19	U	388	375	5	12
N.J.	130	115	N	N	17	7	86	104	10	13
Pa.	203	162	90	61	21	18	93	88	—	1
E.N. CENTRAL	579	726	410	344	150	121	497	542	24	30
Ohio	142	171	255	240	60	56	137	140	2	2
Ind.	69	75	145	104	38	26	41	37	1	1
Ill.	115	199	10	—	47	1	243	224	8	5
Mich.	225	216	—	N	—	N	54	120	11	22
Wis.	28	65	N	N	5	38	22	21	2	—
W.N. CENTRAL	196	219	35	16	63	60	149	110	1	3
Minn.	72	111	—	—	39	39	41	17	—	1
Iowa	N	N	N	N	—	N	1	5	—	—
Mo.	56	45	29	12	5	9	90	64	1	1
N. Dak.	6	10	1	—	2	2	—	—	—	—
S. Dak.	16	9	3	4	—	—	—	—	—	—
Nebr.	13	15	2	—	6	6	3	6	—	—
Kans.	33	29	N	N	11	4	14	18	—	1
S. ATLANTIC	602	620	614	762	62	36	1,215	1,170	27	41
Del.	1	3	1	4	—	N	8	4	—	1
Md.	137	99	—	—	40	24	212	220	9	6
D.C.	7	5	15	7	2	4	70	35	—	1
Va.	57	54	N	N	—	N	79	65	3	2
W. Va.	17	17	85	82	20	8	2	3	—	—
N.C.	85	85	N	N	U	U	161	110	8	6
S.C.	24	47	—	77	—	N	37	73	2	10
Ga.	111	154	108	183	—	N	198	212	—	2
Fla.	163	156	405	409	—	N	448	448	5	13
E.S. CENTRAL	125	163	123	102	5	10	261	258	16	19
Ky.	27	51	23	22	N	N	24	27	—	1
Tenn.	98	112	100	78	—	N	124	85	12	7
Ala.	—	—	—	—	—	N	88	114	3	9
Miss.	—	—	—	2	5	10	25	32	1	2
W.S. CENTRAL	132	244	92	44	71	101	780	737	44	49
Ark.	12	14	12	6	13	7	29	32	—	3
La.	6	2	80	38	21	22	159	181	6	3
Okla.	81	46	N	N	18	29	26	19	1	2
Tex.	33	182	N	N	19	43	566	505	37	41
MOUNTAIN	440	338	49	18	36	29	244	243	15	30
Mont.	—	—	—	—	—	—	5	1	—	—
Idaho	1	7	N	N	—	N	20	13	1	2
Wyo.	2	6	21	6	—	—	—	1	—	—
Colo.	165	65	N	N	35	29	28	46	—	—
N. Mex.	32	74	—	N	—	—	30	60	2	2
Ariz.	182	156	N	N	—	N	89	99	12	26
Utah	57	28	27	10	1	—	4	6	—	—
Nev.	1	2	1	2	—	—	68	17	—	—
PACIFIC	67	63	—	1	8	—	911	913	14	47
Wash.	N	N	N	N	N	N	86	66	—	—
Oreg.	N	N	N	N	6	N	17	21	—	—
Calif.	—	—	N	N	N	N	799	822	14	47
Alaska	—	—	—	—	—	N	5	—	—	—
Hawaii	67	63	—	1	2	—	4	4	—	—
Guam	—	—	—	—	—	—	—	1	—	—
P.R.	N	N	N	N	—	N	115	81	7	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 August 13, 2005, and August 14, 2004 (32nd Week)*

Reporting area	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease†		
							Neuroinvasive		Non-neuroinvasive§
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	6,336	7,841	142	183	15,176	14,432	131	643	181
NEW ENGLAND	187	250	16	16	983	1,970	—	—	—
Maine	9	13	1	—	210	180	—	—	—
N.H.	4	9	—	—	199	—	—	—	—
Vt.	4	1	—	—	36	413	—	—	—
Mass.	126	140	9	13	538	116	—	—	—
R.I.	18	32	1	1	—	—	—	—	—
Conn.	26	55	5	2	U	1,261	—	—	—
MID. ATLANTIC	1,216	1,228	31	41	3,049	70	2	4	4
Upstate N.Y.	153	169	5	5	—	—	—	1	1
N.Y. City	589	617	9	14	—	—	—	2	2
N.J.	293	262	9	12	—	—	—	—	—
Pa.	181	180	8	10	3,049	70	2	1	1
E.N. CENTRAL	799	714	10	22	4,061	4,060	12	22	4
Ohio	157	122	1	4	968	1,026	2	3	—
Ind.	76	75	—	—	120	N	1	2	—
Ill.	382	322	2	10	43	2	9	10	4
Mich.	130	140	3	6	2,634	2,534	—	3	—
Wis.	54	55	4	2	296	498	—	4	—
W.N. CENTRAL	264	281	3	7	267	134	17	32	53
Minn.	114	105	2	3	—	—	2	7	5
Iowa	26	23	—	—	N	N	—	4	—
Mo.	59	77	1	2	179	5	1	10	—
N. Dak.	2	3	—	—	12	74	2	1	4
S. Dak.	8	5	—	—	76	55	7	5	36
Nebr.	19	20	—	2	—	—	4	—	5
Kans.	36	48	—	—	—	—	1	5	3
S. ATLANTIC	1,390	1,622	21	25	1,357	1,629	4	37	1
Del.	7	17	—	—	21	4	—	—	—
Md.	173	156	7	9	—	—	—	5	—
D.C.	33	60	—	—	23	19	—	1	—
Va.	183	138	4	4	275	392	—	2	—
W. Va.	16	14	—	—	693	921	—	—	N
N.C.	139	175	2	3	—	N	1	1	—
S.C.	133	115	—	—	345	293	—	—	—
Ga.	225	372	2	3	—	—	—	7	—
Fla.	481	575	6	6	—	—	3	21	1
E.S. CENTRAL	325	386	5	6	—	4	5	28	3
Ky.	64	62	2	2	N	N	—	—	—
Tenn.	150	129	—	4	—	—	—	5	—
Ala.	111	117	1	—	—	4	1	10	—
Miss.	—	78	2	—	—	—	4	13	3
W.S. CENTRAL	591	1,251	10	18	3,735	5,015	35	88	12
Ark.	63	73	—	—	—	—	—	7	2
La.	—	—	—	—	104	48	26	37	10
Okla.	88	101	—	1	—	—	—	9	—
Tex.	440	1,077	10	17	3,631	4,967	9	35	—
MOUNTAIN	217	310	7	6	1,724	1,550	8	249	22
Mont.	8	4	—	—	—	—	—	—	—
Idaho	—	3	—	—	—	—	—	—	—
Wyo.	—	2	—	—	43	25	—	1	—
Colo.	45	77	2	1	1,214	1,223	—	29	11
N. Mex.	8	19	—	—	121	U	2	12	1
Ariz.	128	122	3	2	—	—	5	185	9
Utah	17	26	1	1	346	302	—	3	—
Nev.	11	57	1	2	—	—	1	19	1
PACIFIC	1,347	1,799	39	42	—	—	48	183	82
Wash.	153	141	4	3	N	N	—	—	—
Oreg.	54	62	2	1	—	—	—	—	—
Calif.	1,056	1,502	27	32	—	—	48	183	82
Alaska	15	22	—	—	—	—	—	—	—
Hawaii	69	72	6	6	—	—	—	—	—
Guam	—	38	—	—	—	94	—	—	—
P.R.	—	62	—	—	113	276	—	—	—
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 August 13, 2005 (32nd Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
NEW ENGLAND	455	321	95	22	7	10	43
Boston, Mass.	161	102	38	11	1	9	13
Bridgeport, Conn.	26	21	4	1	—	—	5
Cambridge, Mass.	9	6	2	—	1	—	1
Fall River, Mass.	21	17	3	1	—	—	3
Hartford, Conn.	43	26	11	4	2	—	4
Lowell, Mass.	20	17	3	—	—	—	3
Lynn, Mass.	8	5	3	—	—	—	—
New Bedford, Mass.	16	13	3	—	—	—	4
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	35	27	4	2	2	—	4
Somerville, Mass.	1	1	—	—	—	—	—
Springfield, Mass.	25	19	5	1	—	—	—
Waterbury, Conn.	28	22	6	—	—	—	—
Worcester, Mass.	62	45	13	2	1	1	6
MID. ATLANTIC	1,974	1,308	453	141	36	33	92
Albany, N.Y.	49	27	14	3	1	4	2
Allentown, Pa.	27	24	2	—	1	—	1
Buffalo, N.Y.	79	55	14	6	2	2	8
Camden, N.J.	29	20	3	2	1	3	3
Elizabeth, N.J.	12	5	5	2	—	—	—
Erie, Pa.	45	35	7	1	—	2	5
Jersey City, N.J.	U	U	U	U	U	U	U
New York City, N.Y.	1,029	677	243	81	11	14	43
Newark, N.J.	58	26	21	6	5	—	1
Paterson, N.J.	25	15	7	3	—	—	—
Philadelphia, Pa.	272	168	68	24	9	3	13
Pittsburgh, Pa.§	26	17	9	—	—	—	1
Reading, Pa.	20	14	6	—	—	—	—
Rochester, N.Y.	126	90	24	7	3	2	8
Schenectady, N.Y.	14	11	2	1	—	—	1
Scranton, Pa.	27	25	2	—	—	—	1
Syracuse, N.Y.	82	57	18	2	2	3	3
Trenton, N.J.	18	14	3	—	1	—	2
Utica, N.Y.	13	9	4	—	—	—	—
Yonkers, N.Y.	23	19	1	3	—	—	—
E.N. CENTRAL	1,813	1,172	421	126	57	37	112
Akron, Ohio	42	21	19	1	1	—	4
Canton, Ohio	37	21	10	6	—	—	2
Chicago, Ill.	343	201	97	26	11	8	21
Cincinnati, Ohio	U	U	U	U	U	U	U
Cleveland, Ohio	205	143	35	17	6	4	11
Columbus, Ohio	177	121	36	13	4	3	14
Dayton, Ohio	111	82	21	2	5	1	10
Detroit, Mich.	182	83	65	24	6	4	11
Evansville, Ind.	35	27	7	—	—	1	—
Fort Wayne, Ind.	56	40	15	—	1	—	1
Gary, Ind.	18	8	5	1	3	1	—
Grand Rapids, Mich.	53	46	3	1	—	3	1
Indianapolis, Ind.	165	101	35	15	9	5	13
Lansing, Mich.	48	31	8	7	1	1	5
Milwaukee, Wis.	84	62	15	3	1	3	4
Peoria, Ill.	63	42	14	6	—	1	3
Rockford, Ill.	37	24	8	2	2	1	1
South Bend, Ind.	38	26	8	1	2	1	3
Toledo, Ohio	78	56	17	1	4	—	6
Youngstown, Ohio	41	37	3	—	1	—	2
W.N. CENTRAL	561	357	114	58	18	14	37
Des Moines, Iowa	30	23	5	—	1	1	3
Duluth, Minn.	30	22	4	3	—	1	2
Kansas City, Kans.	28	17	6	4	1	—	2
Kansas City, Mo.	57	36	11	6	3	1	3
Lincoln, Nebr.	56	43	6	3	1	3	6
Minneapolis, Minn.	46	22	17	4	1	2	4
Omaha, Nebr.	68	51	8	7	1	1	7
St. Louis, Mo.	108	51	27	20	8	2	3
St. Paul, Minn.	62	47	9	4	1	1	3
Wichita, Kans.	76	45	21	7	1	2	4
S. ATLANTIC	1,016	630	219	114	37	16	50
Atlanta, Ga.	109	61	26	15	3	4	3
Baltimore, Md.	125	71	25	16	7	6	9
Charlotte, N.C.	91	57	14	14	6	—	7
Jacksonville, Fla.	140	95	25	17	3	—	5
Miami, Fla.	91	57	20	12	1	1	3
Norfolk, Va.	39	24	7	3	4	1	1
Richmond, Va.	51	26	13	10	2	—	4
Savannah, Ga.	54	35	12	3	4	—	4
St. Petersburg, Fla.	51	32	12	7	—	—	4
Tampa, Fla.	151	105	31	10	4	1	6
Washington, D.C.	102	60	31	5	3	3	3
Wilmington, Del.	12	7	3	2	—	—	1
E.S. CENTRAL	1,013	668	210	82	25	28	81
Birmingham, Ala.	192	126	36	20	3	7	19
Chattanooga, Tenn.	98	72	12	8	3	3	7
Knoxville, Tenn.	69	46	15	2	4	2	2
Lexington, Ky.	57	33	16	5	2	1	3
Memphis, Tenn.	274	183	53	26	7	5	24
Mobile, Ala.	115	86	24	2	2	1	3
Montgomery, Ala.	70	44	17	9	—	—	9
Nashville, Tenn.	138	78	37	10	4	9	14
W.S. CENTRAL	1,370	825	353	103	48	39	65
Austin, Tex.	85	49	25	6	3	1	4
Baton Rouge, La.	36	24	5	1	2	4	2
Corpus Christi, Tex.	U	U	U	U	U	U	U
Dallas, Tex.	193	113	43	17	7	13	13
El Paso, Tex.	60	47	11	1	—	1	1
Ft. Worth, Tex.	114	67	27	10	8	2	4
Houston, Tex.	297	172	87	26	8	4	23
Little Rock, Ark.	69	41	20	3	3	1	2
New Orleans, La.	140	71	42	19	6	2	8
San Antonio, Tex.	193	119	56	8	6	4	6
Shreveport, La.	60	40	13	3	—	4	2
Tulsa, Okla.	123	82	24	9	5	3	—
MOUNTAIN	914	565	230	78	24	14	50
Albuquerque, N.M.	126	83	29	11	3	—	7
Boise, Idaho	40	33	5	—	—	2	3
Colo. Springs, Colo.	75	49	14	8	2	2	6
Denver, Colo.	102	65	21	7	3	6	7
Las Vegas, Nev.	244	128	79	26	9	1	11
Ogden, Utah	22	17	4	1	—	—	2
Phoenix, Ariz.	167	92	51	15	5	2	8
Pueblo, Colo.	23	17	5	1	—	—	3
Salt Lake City, Utah	115	81	22	9	2	1	3
Tucson, Ariz.	U	U	U	U	U	U	U
PACIFIC	1,600	1,091	320	109	49	31	137
Berkeley, Calif.	2	1	1	—	—	—	—
Fresno, Calif.	119	76	29	6	6	2	2
Glendale, Calif.	12	10	2	—	—	—	2
Honolulu, Hawaii	81	48	22	6	1	4	10
Long Beach, Calif.	75	42	19	7	5	2	5
Los Angeles, Calif.	278	203	53	16	5	1	41
Pasadena, Calif.	20	17	2	1	—	—	3
Portland, Oreg.	103	76	14	7	5	1	9
Sacramento, Calif.	135	88	27	13	6	1	8
San Diego, Calif.	158	102	34	15	3	4	13
San Francisco, Calif.	127	88	24	9	2	4	13
San Jose, Calif.	180	124	25	16	11	4	14
Santa Cruz, Calif.	17	11	5	—	1	—	2
Seattle, Wash.	111	66	31	9	1	4	2
Spokane, Wash.	83	62	14	3	1	3	6
Tacoma, Wash.	99	77	18	1	2	1	7
TOTAL	10,716¶	6,937	2,415	833	301	222	667

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.

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

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Address inquiries about the *MMWR* Series, including material to be considered for publication, to Editor, *MMWR* Series, Mailstop K-95, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone 888-232-3228.

All *MMWR* references are available on the Internet at http://www.cdc.gov/mmwr. Use the search function to find specific articles.

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

References to non-CDC sites on the Internet are provided as a service to *MMWR* readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of these sites. URL addresses listed in *MMWR* were current as of the date of publication.

☆U.S. Government Printing Office: 2005-733-116/00107 Region IV ISSN: 0149-2195