



MMWRTM

Morbidity and Mortality Weekly Report

Weekly

November 11, 2005 / Vol. 54 / No. 44

Great American Smokeout — November 17, 2005

Approximately 20.9% of U.S. adults are current smokers (1), and an estimated 70% of smokers want to quit smoking (2). Since 1977, the American Cancer Society (ACS) has sponsored the Great American Smokeout each year on the third Thursday in November. Smokers are encouraged to quit for 24 hours straight in the hope they might quit permanently.

Effective interventions for increasing cessation success rates include sustained media campaigns; price increases for tobacco products; increased insurance coverage for treatment; individual, group, or telephone counseling; and approved medications. Telephone quitlines are a cost-effective and accessible way to provide smokers with counseling about cessation strategies (3,4). The National Network of Quitlines, a collaborative effort of CDC, the National Cancer Institute, state quitlines, and the North American Quitline Consortium, maintains a national telephone number (800-QUIT-NOW) that links callers to free quitlines serving their areas.

Information about the Great American Smokeout is available from ACS at telephone, 800-227-2345, or from a local ACS office. Information on smoking cessation is also available at <http://smokefree.gov>.

References

1. CDC. Cigarette smoking among adults—United States, 2004. *MMWR* 2005;54:1121–4.
2. CDC. Cigarette smoking among adults—United States, 2000. *MMWR* 2002;51:642–5.
3. CDC. Strategies for reducing exposure to environmental tobacco smoke, increasing tobacco-use cessation, and reducing initiation in communities and health-care systems. *MMWR* 2000;49(No. RR-12).
4. Fiore MC, Bailey WC, Cohen SJ, et al. Treating tobacco use and dependence: clinical practice guideline. Rockville, MD: US Department of Health and Human Services, Public Health Service; 2000.

Cigarette Smoking Among Adults — United States, 2004

One of the national health objectives for 2010 is to reduce the prevalence of cigarette smoking among adults to $\leq 12\%$ (objective no. 27-1a) (1). To assess progress toward this objective, CDC analyzed self-reported data from the 2004 National Health Interview Survey (NHIS) sample adult core questionnaire. This report describes the results of that analysis, which indicated that, in 2004, approximately 20.9% of U.S. adults were current smokers. This prevalence is lower than the 21.6% prevalence among U.S. adults in 2003 and is significantly lower than the 22.5% prevalence among adults in 2002 (2). The prevalence of heavy smoking (≥ 25 cigarettes per day) has also declined during the past 11 years, from 19.1% of smokers in 1993 to 12.1% of smokers in 2004. Tobacco-use prevention and control measures appear to be decreasing both the prevalence of cigarette smoking and the proportion of heavy smokers, who are at high risk for tobacco-related morbidity and mortality. However, to further decrease smoking prevalence among adults and to meet the national health objective, effective comprehensive tobacco-control programs that address both initiation and cessation of smoking should be fully implemented in every state and territory.

INSIDE

- 1124 State-Specific Prevalence of Cigarette Smoking and Quitting Among Adults — United States, 2004
- 1127 Outbreak of Mesotherapy-Associated Skin Reactions — District of Columbia Area, January–February 2005
- 1130 Prevalence of Receiving Multiple Preventive-Care Services Among Adults with Diabetes — United States, 2002–2004
- 1133 Update: West Nile Virus Activity — United States, 2005
- 1135 Notice to Readers
- 1135 QuickStats

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].

Centers for Disease Control and Prevention

Julie L. Gerberding, MD, MPH
Director

Dixie E. Snider, MD, MPH
Chief Science Officer

Tanja Popovic, MD, PhD
Associate Director for Science

Coordinating Center for Health Information and Service

Steven L. Solomon, MD
Director

National Center for Health Marketing

Jay M. Bernhardt, PhD, MPH
Director

Division of Scientific Communications

Maria S. Parker
(Acting) Director

Mary Lou Lindegren, MD
Editor, MMWR Series

Suzanne M. Hewitt, MPA
Managing Editor, MMWR Series

Douglas W. Weatherwax
(Acting) Lead Technical Writer-Editor

Stephanie M. Neitzel
Jude C. Rutledge
Writers-Editors

Lynda G. Cupell
Malbea A. LaPete
Visual Information Specialists

Quang M. Doan, MBA
Erica R. Shaver

Information Technology Specialists

Notifiable Disease Morbidity and 122 Cities Mortality Data

Patsy A. Hall	Felicia J. Connor
Deborah A. Adams	Rosaline Dhara
Lenee Blanton	Pearl C. Sharp

The 2004 NHIS adult core questionnaire was administered by personal interview to a nationally representative sample ($n = 31,326$) of the noninstitutionalized U.S. civilian population aged ≥ 18 years; the overall survey response rate for the sample was 72.5%. Respondents were asked, "Have you smoked at least 100 cigarettes in your entire life?" and "Do you now smoke cigarettes every day, some days, or not at all?" Ever smokers were defined as those who reported having smoked ≥ 100 cigarettes during their lifetime. Current smokers were defined as those reporting having smoked ≥ 100 cigarettes during their lifetime and currently smoking every day or some days. Current smokers who reported that they smoked every day also reported the average number of cigarettes smoked per day. Former smokers were defined as those who reported smoking ≥ 100 cigarettes during their lifetime but who currently did not smoke. Data were adjusted for nonresponse and weighted to provide national estimates of cigarette smoking prevalence and the number of cigarettes smoked per day. Confidence intervals were calculated using statistical analysis software to account for the survey's multi-stage probability sample design.

In 2004, an estimated 20.9% (44.5 million) of U.S. adults were current smokers; of these, 81.3% (36.1 million) smoked every day, and 18.7% (8.3 million) smoked some days. Among those who currently smoked every day, 40.5% (14.6 million) reported that they had stopped smoking for at least 1 day during the preceding 12 months because they were trying to quit. Among the estimated 42.4% (90.2 million) of persons who had ever smoked, 50.6% (45.6 million) were former smokers.

The prevalence of current cigarette smoking varied substantially across population subgroups (Table). Current smoking was higher among men (23.4%) than women (18.5%). Among racial/ethnic populations, Asians (11.3%) and Hispanics (15.0%) had the lowest prevalence of current smoking; American Indians/Alaska Natives had the highest prevalence (33.4%), followed by non-Hispanic whites (22.2%) and non-Hispanic blacks (20.2%). By education level, current smoking prevalence was highest among adults who had earned a General Educational Development (GED) diploma (39.6%) and among those with a 9th–11th grade education (34.0%) and generally decreased with increasing years of education. Persons aged ≥ 65 years had the lowest prevalence of current cigarette smoking (8.8%) among all adults. Current smoking prevalence was higher among adults living below the poverty level (29.1%) than among those at or above the poverty level (20.6%).

Hispanic (10.9%) and Asian (4.8%) women, women with less than an 8th-grade education (10.5%), women with undergraduate (10.1%) or graduate (8.1%) degrees, men with

TABLE. Percentage of persons aged ≥ 18 years who were current smokers,* by sex and selected characteristics — National Health Interview Survey, United States, 2004

Characteristic	Men	Women	Total
	(n = 13,903) % (95% CI) [†]	(n = 17,423) % (95% CI)	(n = 31,326) % (95% CI)
Race/Ethnicity[§]			
White, non-Hispanic	24.1 (±1.1)	20.4 (±0.9)	22.2 (±0.8)
Black, non-Hispanic	23.9 (±2.4)	17.2 (±2.1)	20.2 (±1.7)
Hispanic	18.9 (±1.9)	10.9 (±1.3)	15.0 (±1.2)
American Indian/ Alaska Native [¶]	37.3 (±12.1)	28.5 (±11.4)	33.4 (±8.3)
Asian ^{**}	17.8 (±4.4)	4.8 (±2.1)	11.3 (±2.4)
Education^{††}			
0–12 yrs (no diploma)	31.5 (±2.4)	21.2 (±2.0)	26.2 (±1.6)
<8 yrs	23.5 (±3.2)	10.5 (±2.0)	16.7 (±2.0)
9–11 yrs	38.3 (±3.7)	29.8 (±3.1)	34.0 (±2.4)
12 yrs (no diploma)	29.9 (±6.5)	21.9 (±4.6)	25.5 (±3.8)
GED ^{§§} diploma	42.1 (±5.9)	36.6 (±5.9)	39.6 (±4.4)
High school graduate	27.2 (±1.8)	21.1 (±1.4)	24.0 (±1.1)
Associate degree	24.6 (±3.1)	18.0 (±2.1)	20.9 (±1.9)
Some college	24.6 (±1.8)	20.3 (±1.3)	22.2 (±1.1)
Undergraduate degree	13.5 (±1.7)	10.1 (±1.4)	11.7 (±1.1)
Graduate degree	7.9 (±1.5)	8.1 (±1.5)	8.0 (±1.0)
Age group (yrs)			
18–24	25.6 (±2.9)	21.5 (±2.3)	23.6 (±2.0)
25–44	26.3 (±1.5)	21.4 (±1.2)	23.8 (±1.0)
45–64	25.0 (±1.6)	19.8 (±1.2)	22.4 (±1.0)
≥ 65	9.8 (±1.4)	8.1 (±1.0)	8.8 (±0.8)
Poverty status^{¶¶}			
At or above	23.5 (±1.1)	17.7 (±0.9)	20.6 (±0.7)
Below	31.9 (±3.3)	27.1 (±2.2)	29.1 (±2.0)
Unknown	20.8 (±1.6)	17.4 (±1.4)	19.0 (±1.1)
Total	23.4 (±0.9)	18.5 (±0.7)	20.9 (±0.6)

* Persons who reported smoking ≥ 100 cigarettes during their lifetime and at the time of interview reported smoking every day or some days. Excludes 349 respondents whose smoking status was unknown.

[†] Confidence interval.

[§] Excludes 332 respondents of unknown or multiple racial/ethnic category or whose racial/ethnic category was unknown.

[¶] Wide variances in estimates reflect small sample sizes.

^{**} Does not include native Hawaiians or other Pacific Islanders.

^{††} Among persons aged ≥ 25 years. Excludes 345 persons whose education level was unknown.

^{§§} General Educational Development.

^{¶¶} Based on family income reported by respondents and 2003 poverty thresholds published by the U.S. Census Bureau.

graduate degrees (7.9%), men aged ≥ 65 years (9.8%), and women aged ≥ 65 years (8.1%) all had smoking prevalence rates below the national health objective of $\leq 12\%$ (Table).

From 1993 through 2004, the percentage of daily smokers who smoked ≥ 25 cigarettes per day (cpd) (i.e., heavy smokers) decreased steadily, from 19.1% to 12.1% (Figure). During the same period, the percentage of daily smokers who smoked 1–4 cpd and 5–14 cpd increased, from 2.9% to 4.8% and from 20.6% to 28.4%, respectively. The mean number of cpd among daily smokers in 1993 was 19.6 (21.3 cpd for men and 17.8 cpd for women) and in 2004 was 16.8 (18.1 cpd for men and 15.3 cpd for women). Among current smokers, the overall percentage of some-day smokers remained stable at approximately 18%–19% during the same period.

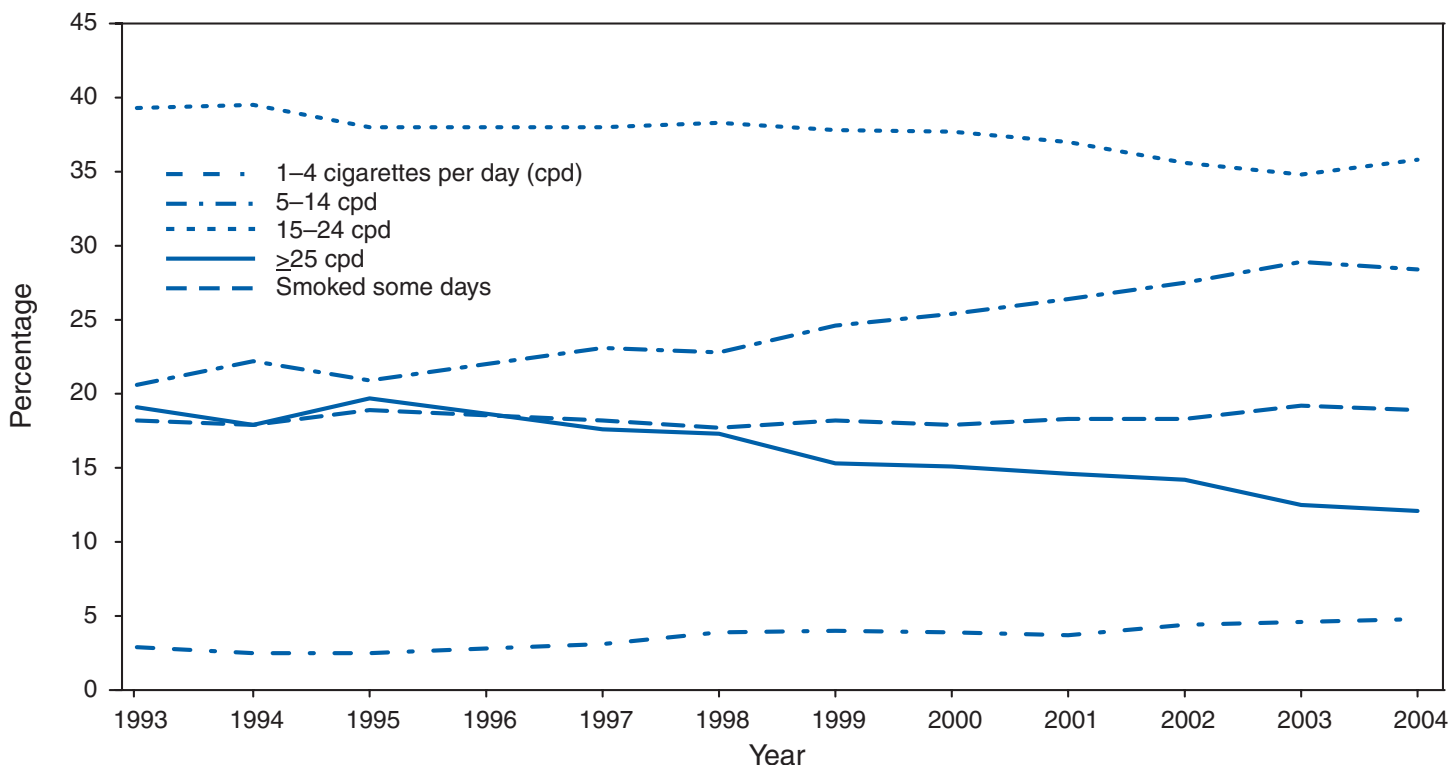
Reported by: E Maurice, MS, A Trosclair, MS, R Merritt, MA, R Caraballo, PhD, A Malarcher, PhD, C Husten, MD, T Pechacek, PhD, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: The findings in this report indicate that cigarette smoking continues to decrease among U.S. adults overall. Nationally and in 34 states, Puerto Rico, and the U.S. Virgin Islands (3), the majority of adults who ever smoked have now quit smoking. However, the rate of decrease in cigarette smoking among adults is not sufficient to meet the national health objective for 2010, which is to reduce the prevalence of cigarette smoking to $\leq 12\%$. Furthermore, although the decline in smoking has been observed nationally, smoking prevalence remains high among certain segments of the population. For example, in 2004, the smoking prevalence among persons with a GED diploma was approximately 40%, and approximately one in three persons with a 9th–11th grade education smoked.

The findings in this report are subject to at least three limitations. First, estimates for cigarette smoking are based on self-reports and are not validated by biochemical tests. However, self-reported data on current smoking status have high validity (4). Second, the NHIS questionnaire is administered only in English and Spanish, which might result in imprecise estimates of smoking prevalence for racial/ethnic populations unable to respond to the survey because of language barriers. Finally, the small sample sizes in NHIS for certain population subgroups (e.g., Asians and American Indians/Alaska Natives) result in unstable single-year estimates for those groups.

In addition to the reduction in smoking prevalence in the adult U.S. population, the number of cigarettes smoked by daily smokers and the proportion of adults who were heavy smokers have also declined during the past 11 years. This study did not assess what proportion of the decline in the prevalence of heavy smokers was attributable to 1) smokers reducing their number of cigarettes per day, 2) smokers quitting, or 3) changes in cohorts of smokers over time in terms of their cigarette consumption. A recent longitudinal study in Denmark reported that smokers who reduced their smoking from an average of 20 to 10 cpd during a 5–10 year interval reduced their lung cancer risk by 25% (5). The risk for lung cancer declines steadily in persons who quit smoking. After 10 years of abstinence, the risk for lung cancer is approximately 30%–50% of the risk for continuing smokers (6). After 15 years of abstinence, the risk for coronary heart disease is similar to that of persons who have never smoked (7). Reduced consumption has not, however, reduced the risk for other diseases with substantial public health burdens, such as chronic obstructive pulmonary disease and coronary heart disease (6); in addition, some long-term studies have failed to show a decrease in overall mortality after cigarette reduction (8).

FIGURE. Percentage of daily* and some-day† smokers among persons aged ≥18 years, by number of cigarettes smoked per day and year — National Health Interview Survey, United States, 1993–2004



* Current smokers who reported smoking every day.

† Current smokers who reported smoking some days.

No level of tobacco use is safe; the best option for any smoker is to quit completely (6). Effective smoking cessation interventions are available, including brief clinical counseling, pharmacotherapy, and state quitlines (available by telephone, 800-QUIT NOW). Comprehensive tobacco-control programs must be fully implemented in every state and territory to accelerate the reduction in smoking prevalence among U.S. adults and decrease the public health burden of smoking-related disease (7,9).

References

1. US Department of Health and Human Services. Healthy people 2010: understanding and improving health. 2nd ed. Washington, DC: US Department of Health and Human Services; 2000. Available at <http://www.healthypeople.gov>.
2. CDC. Cigarette smoking among adults—United States, 2003. MMWR 2005;54:509–13.
3. CDC. State-specific prevalence of cigarette smoking and quitting among adults—United States, 2004. MMWR 2005;54:1124–7.
4. Patrick DL, Cheadle A, Thompson DC, Diehr P, Koepsell T, Kinne S. The validity of self-reported smoking: a review and meta-analysis. Am J Public Health 1994;84:1086–93.
5. Godtfredsen NS, Prescott E, Osler M. Effect of smoking reduction on lung cancer risk. JAMA 2005;294:1505–10.
6. US Department of Health and Human Services. The health benefits of smoking cessation: a report of the Surgeon General. Rockville, MD: US Department of Health and Human Services, CDC;1990.

7. CDC. Best practices for comprehensive tobacco control programs. Atlanta, GA: US Department of Health and Human Services, CDC; 1999.
8. Godtfredsen NS, Holst C, Prescott E, Vestbo J, Osler M. Smoking reduction, smoking cessation, and mortality: a 16-year follow-up of 19,732 men and women from The Copenhagen Centre for Prospective Population Studies. Am J Epidemiol 2002;156:994–1001.
9. Task Force on Community Preventive Services. The guide to community preventive services: tobacco use prevention and control. Am J Prev Med 2001;20(2 Suppl 1):1–87.

State-Specific Prevalence of Cigarette Smoking and Quitting Among Adults — United States, 2004

After stagnating in the early 1990s, cigarette smoking prevalence among adults in the United States declined during the late 1990s and early 2000s (1). In 2002, for the first time, more than half of those who had ever smoked had quit smoking (1). To assess the prevalence of current and never cigarette smoking and the proportion of ever smokers who had quit smoking, CDC analyzed state/area data from the 2004

Behavioral Risk Factor Surveillance System (BRFSS). This report summarizes the results of that analysis, which indicated substantial variation in current cigarette smoking prevalence among 49 states, the District of Columbia (DC), Puerto Rico (PR), and the U.S. Virgin Islands (USVI) (range: 9.5%–27.6%). In 44 states, DC, PR, and USVI, the majority of persons had never smoked. In 34 states, PR, and USVI, more than 50% of ever smokers had quit smoking. Effective, comprehensive tobacco-use prevention and control programs should be continued and expanded to further reduce initiation among young persons and to ensure that smokers have access to effective smoking-cessation services, including proactive telephone quitline counseling (2,3).

BRFSS is a state-based, random-digit-dialed, telephone health survey of the noninstitutionalized, civilian U.S. population aged ≥ 18 years. Estimates were weighted by age and sex distributions of each state/area population, and 95% confidence intervals were calculated using statistical analysis software. Because BRFSS data are state-specific, median prevalences are reported instead of national averages. The median response rate across 49 states and DC was 52.7% (range: 32.2% [New Jersey]–66.6% [Nebraska]).

Respondents were asked, “Have you smoked at least 100 cigarettes in your entire life?” and “Do you now smoke cigarettes every day, some days, or not at all?” Ever smokers were defined as those who reported having smoked ≥ 100 cigarettes during their lifetime. Current smokers were defined as those who reported having smoked ≥ 100 cigarettes during their lifetime and who currently smoked every day or some days. Never smokers were defined as those who reported not having smoked ≥ 100 cigarettes during their lifetime. Former smokers were defined as those who reported having smoked ≥ 100 cigarettes during their lifetime and who currently did not smoke at all. The percentage of ever smokers who had quit smoking was calculated by dividing the number of former smokers by the number of ever smokers.

Current Cigarette Smoking Prevalence

In 2004, the median adult smoking prevalence among 49 states and DC was 20.9%, with a nearly three-fold difference between the lowest and highest prevalence (range: 10.5% [Utah]–27.6% [Kentucky]) (Table 1). Current smoking prevalence was highest in Kentucky (27.6%), West Virginia (26.9%), Oklahoma (26.1%), and Tennessee (26.1%), and was lowest in Utah (10.5%), California (14.8%), and Idaho (17.5%). Smoking prevalence was 9.5% in USVI and 12.7% in PR. Men generally had a higher smoking prevalence (median: 23.2% [range: 11.7%–29.3%]) than women (median: 19.2% [range: 9.4%–26.4%]) in 49 states and DC.

Never Cigarette Smoking Prevalence

In 2004, the median adult never smoking prevalence among 49 states and DC was 54.6% (Table 2). Never smoking prevalence was highest in Utah (73.7%) and California (61.1%) and lowest in Maine (47.7%) and West Virginia (48.0%). Never smoking prevalence was 72.2% in PR and 80.5% in USVI. Women had a higher never smoking prevalence (median: 59.5% [range: 52.1%–78.9%]) than men (median: 48.4% [range: 41.3%–68.4%]).

Percentage of Ever Smokers Who Have Quit Smoking

In 2004, the median percentage of adult ever smokers who had quit among 49 states and DC was 52.4% (Table 2). Among all states/areas surveyed, 36 had percentages of ever smokers who had quit at $\geq 50\%$. Four states had percentages of ever smokers who had quit at $\geq 60\%$: Connecticut (62.5%), California (62.0%), Vermont (60.5%), and Utah (60.1%). The five states with the lowest percentages of ever smokers who had quit were Kentucky (42.5%), Mississippi (44.0%), Alabama (45.6%), Louisiana (45.9%), and Tennessee (45.9%).

Reported by: *N Kuiper, MPH, A Malarcher, PhD, J Bombard, MSPH, E Maurice, MS, K Jackson, MSPH, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

Editorial Note: One of the *Healthy People 2010* objectives (objective no. 27-1a) is to reduce cigarette smoking prevalence to $\leq 12\%$ (4). As of 2004, Utah and USVI achieved this goal in the population overall and among both men and women; California women also achieved this goal. The findings in this report indicate that in the majority of states, most adults have never been smokers and, among those who have ever smoked, the majority have quit. However, the rate of decline in current smoking is not rapid enough for most states to achieve the 2010 objective. Comprehensive tobacco-control programs are effective in preventing and reducing tobacco use, and the more funds states spend on such programs, the greater the reduction in smoking (5). Many states have reduced funding in recent years, and only four states (Colorado, Delaware, Maine, and Mississippi) funded their programs in fiscal year 2005 at even the minimum levels recommended by CDC (3,6).

The findings in this report are subject to at least three limitations. First, BRFSS does not survey persons in households without telephones, a population that might be more likely to smoke (7). BRFSS estimates that 97.6% of the U.S. population had telephones in 2003; however, noncoverage ranged from 1.1% in Connecticut and New Hampshire to 6.6% in Mississippi and 23.8% in Puerto Rico (8). Second, estimates

TABLE 1. Prevalence of current cigarette smoking among adults,* by state/area and sex — Behavioral Risk Factor Surveillance System, 49 states,† District of Columbia, Puerto Rico, and the U.S. Virgin Islands, 2004

State/Area	Men		Women		Total	
	% (95% CI) [§]	% (95% CI)	% (95% CI)	% (95% CI)	% (95% CI)	% (95% CI)
Alabama	29.0	(±3.0)	21.2	(±1.9)	24.9	(±1.8)
Alaska	26.4	(±3.6)	23.3	(±3.0)	24.9	(±2.4)
Arizona	19.7	(±3.8)	17.6	(±2.4)	18.6	(±2.2)
Arkansas	28.1	(±2.7)	23.4	(±2.0)	25.7	(±1.7)
California	18.5	(±2.3)	11.1	(±1.3)	14.8	(±1.3)
Colorado	22.3	(±2.5)	17.8	(±1.7)	20.1	(±1.5)
Connecticut	20.1	(±2.1)	16.2	(±1.5)	18.1	(±1.3)
Delaware	28.4	(±3.3)	20.9	(±2.1)	24.5	(±1.9)
District of Columbia	25.1	(±3.6)	17.3	(±2.2)	21.0	(±2.1)
Florida	23.3	(±2.5)	17.7	(±1.6)	20.4	(±1.5)
Georgia	22.4	(±2.6)	17.9	(±1.8)	20.1	(±1.6)
Idaho	19.2	(±2.1)	15.7	(±1.5)	17.5	(±1.3)
Illinois	26.1	(±2.7)	18.6	(±1.9)	22.2	(±1.6)
Indiana	26.8	(±2.0)	23.2	(±1.5)	25.0	(±1.2)
Iowa	22.8	(±2.3)	19.0	(±1.6)	20.8	(±1.4)
Kansas	22.1	(±1.7)	17.6	(±1.2)	19.8	(±1.0)
Kentucky	29.3	(±3.0)	25.9	(±2.0)	27.6	(±1.8)
Louisiana	26.9	(±2.0)	20.5	(±1.3)	23.6	(±1.1)
Maine	22.6	(±2.7)	19.5	(±2.1)	21.0	(±1.7)
Maryland	22.7	(±2.9)	16.9	(±1.8)	19.7	(±1.7)
Massachusetts	19.7	(±2.0)	17.4	(±1.4)	18.5	(±1.2)
Michigan	25.0	(±2.4)	21.8	(±1.8)	23.4	(±1.5)
Minnesota	22.0	(±2.2)	19.5	(±1.9)	20.7	(±1.4)
Mississippi	29.1	(±2.5)	20.5	(±1.6)	24.6	(±1.5)
Missouri	26.1	(±2.6)	22.3	(±2.1)	24.1	(±1.7)
Montana	20.6	(±2.4)	20.2	(±1.9)	20.4	(±1.5)
Nebraska	23.1	(±1.9)	17.7	(±1.4)	20.3	(±1.2)
Nevada	24.7	(±3.2)	21.7	(±3.0)	23.2	(±2.2)
New Hampshire	24.0	(±2.3)	19.7	(±1.8)	21.8	(±1.4)
New Jersey	20.1	(±1.5)	17.8	(±1.1)	18.9	(±0.9)
New Mexico	22.8	(±2.1)	17.9	(±1.5)	20.3	(±1.3)
New York	21.2	(±2.1)	19.0	(±1.5)	20.0	(±1.3)
North Carolina	26.6	(±1.6)	20.0	(±1.0)	23.2	(±0.9)
North Dakota	24.1	(±2.8)	15.8	(±2.0)	19.9	(±1.7)
Ohio	27.3	(±3.6)	24.7	(±2.7)	25.9	(±2.2)
Oklahoma	28.1	(±2.2)	24.2	(±1.6)	26.1	(±1.3)
Oregon	21.9	(±2.2)	18.2	(±1.6)	20.0	(±1.4)
Pennsylvania	23.0	(±2.1)	22.5	(±1.6)	22.7	(±1.3)
Rhode Island	23.7	(±2.8)	19.2	(±2.0)	21.3	(±1.7)
South Carolina	28.1	(±2.2)	21.2	(±1.5)	24.5	(±1.3)
South Dakota	22.0	(±2.0)	18.7	(±1.7)	20.3	(±1.3)
Tennessee	27.1	(±3.2)	25.3	(±2.3)	26.1	(±1.9)
Texas	23.7	(±2.1)	17.5	(±1.5)	20.6	(±1.3)
Utah	11.7	(±1.6)	9.4	(±1.4)	10.5	(±1.0)
Vermont	21.8	(±1.9)	18.3	(±1.4)	20.0	(±1.2)
Virginia	22.4	(±2.4)	19.5	(±1.9)	20.9	(±1.5)
Washington	20.1	(±1.2)	18.3	(±0.9)	19.2	(±0.8)
West Virginia	27.4	(±2.8)	26.4	(±2.2)	26.9	(±1.8)
Wisconsin	25.0	(±2.5)	19.1	(±1.8)	22.0	(±1.5)
Wyoming	21.6	(±2.3)	21.9	(±1.9)	21.7	(±1.5)
Median	23.2	—	19.2	—	20.9	—
Puerto Rico	17.4	(±2.5)	8.4	(±1.4)	12.7	(±1.4)
U.S. Virgin Islands	11.9	(±2.5)	7.4	(±1.4)	9.5	(±1.4)

* Persons aged ≥18 years who reported having smoked ≥100 cigarettes during their lifetime and who currently smoke every day or some days.

† Hawaii completed 3 of 12 months of interviews in 2004; these data are not available in the aggregate 2004 dataset.

§ Confidence interval.

TABLE 2. Prevalence of never* smoking cigarettes and percentage of ever smokers who have quit† among adults, by state/area — Behavioral Risk Factor Surveillance System, 49 states,‡ District of Columbia, Puerto Rico, and the U.S. Virgin Islands, 2004

State/Area	Prevalence of never smoking cigarettes		Percentage of ever smokers who have quit	
	% (95% CI) [¶]	% (95% CI)	% (95% CI)	% (95% CI)
Alabama	54.3	(±2.0)	45.6	(±2.9)
Alaska	51.1	(±2.8)	49.1	(±3.9)
Arizona	57.0	(±2.7)	56.7	(±4.1)
Arkansas	49.7	(±1.8)	48.9	(±2.6)
California	61.1	(±1.8)	62.0	(±2.8)
Colorado	55.5	(±1.8)	54.9	(±2.7)
Connecticut	51.8	(±1.5)	62.5	(±2.2)
Delaware	50.4	(±2.1)	50.7	(±3.1)
District of Columbia	59.9	(±2.3)	47.7	(±3.6)
Florida	53.8	(±1.7)	55.9	(±2.5)
Georgia	58.9	(±1.9)	51.1	(±2.9)
Idaho	59.1	(±1.7)	57.3	(±2.6)
Illinois	56.3	(±1.8)	49.2	(±2.8)
Indiana	52.4	(±1.4)	47.5	(±2.0)
Iowa	57.8	(±1.6)	50.6	(±2.5)
Kansas	58.5	(±1.2)	52.3	(±1.9)
Kentucky	52.1	(±2.0)	42.5	(±2.7)
Louisiana	56.5	(±1.3)	45.9	(±2.0)
Maine	47.7	(±2.0)	59.9	(±2.7)
Maryland	57.1	(±1.9)	54.1	(±3.0)
Massachusetts	54.5	(±1.5)	59.4	(±2.2)
Michigan	51.5	(±1.7)	51.9	(±2.4)
Minnesota	52.5	(±1.7)	56.4	(±2.5)
Mississippi	56.1	(±1.7)	44.0	(±2.5)
Missouri	51.7	(±1.9)	50.1	(±2.8)
Montana	54.6	(±1.8)	55.1	(±2.7)
Nebraska	58.4	(±1.4)	51.1	(±2.1)
Nevada	52.3	(±2.7)	51.3	(±3.7)
New Hampshire	49.8	(±1.6)	56.7	(±2.3)
New Jersey	56.7	(±1.1)	56.4	(±1.7)
New Mexico	55.6	(±1.5)	54.3	(±2.3)
New York	55.9	(±1.6)	54.6	(±2.3)
North Carolina	55.5	(±1.1)	47.8	(±1.6)
North Dakota	56.5	(±2.0)	54.3	(±3.1)
Ohio	51.9	(±2.4)	46.1	(±3.5)
Oklahoma	51.3	(±1.4)	46.4	(±2.1)
Oregon	55.3	(±1.6)	55.3	(±2.4)
Pennsylvania	53.3	(±1.5)	51.3	(±2.1)
Rhode Island	49.9	(±2.0)	57.4	(±2.7)
South Carolina	53.7	(±1.4)	47.1	(±2.1)
South Dakota	56.0	(±1.6)	53.8	(±2.3)
Tennessee	51.7	(±2.2)	45.9	(±3.1)
Texas	59.1	(±1.5)	49.7	(±2.4)
Utah	73.7	(±1.5)	60.1	(±3.2)
Vermont	49.5	(±1.4)	60.5	(±2.0)
Virginia	55.8	(±1.9)	52.8	(±2.7)
Washington	55.5	(±0.9)	56.9	(±1.4)
West Virginia	48.0	(±2.0)	48.3	(±2.7)
Wisconsin	53.7	(±1.8)	52.5	(±2.6)
Wyoming	53.4	(±1.8)	53.4	(±2.5)
Median	54.6	—	52.4	—
Puerto Rico	72.2	(±1.8)	54.4	(±3.9)
U.S. Virgin Islands	80.5	(±1.8)	51.3	(±5.1)

* Persons aged ≥18 years who reported not having smoked ≥100 cigarettes during their lifetime.

† Percentage of ever smokers aged ≥18 years who reported having quit smoking.

‡ Hawaii completed 3 of 12 months of interviews in 2004; these data are not available in the aggregate 2004 dataset.

¶ Confidence interval.

for cigarette smoking are based on self-reports and are not validated by biochemical tests. However, self-reported data on current smoking status have high validity (7). Third, the median response rate was 52.7% (range: 32.2%–66.6%); lower response rates indicate a potential for response bias. However, BRFSS estimates for current cigarette smoking are generally comparable with smoking estimates from other surveys with higher response rates (7). Moreover, evidence suggests that telephone surveys with low response rates might not contain differential response bias compared with those with higher response rates (9).

In more than half of states, the majority of ever smokers have quit smoking; however, for every smoker who successfully quits each year, many more make attempts but do not succeed (10). Tobacco dependence is a chronic condition that often requires repeated intervention (10). Patients who are willing to quit should be provided with effective interventions, including brief interventions by clinicians at every patient visit (i.e., the five “A”s: ask about tobacco use, advise to quit, assess willingness to make a quit attempt, assist in the quit attempt, and arrange for follow-up) and pharmacotherapies for smoking cessation, including bupropion (sustained release), nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, and nicotine patch (10). Patients who are not ready to quit should be provided messages to increase the motivation to quit (10).

Although minimal clinical interventions (i.e., those lasting <3 minutes) increase overall tobacco cessation rates, a strong dose-response relation has been demonstrated between session length and successful cessation (10). Proactive telephone counseling is effective in increasing successful cessation and can reach substantial numbers of tobacco users. In November 2004, CDC, in partnership with the National Cancer Institute Cancer Information Service (NCI/CIS), created a new national network of quitlines. Through the network, states received funding as part of CDC’s National Tobacco Control Program either to establish a quitline or to enhance existing quitline services, in addition to training and technical assistance from the North American Quitline Consortium. A national telephone number sponsored by NCI/CIS (800-QUIT-NOW) links callers to the free quitline serving the area where they live and is designed to ensure that proactive counseling services are available to all smokers who want to quit. These cessation interventions, combined with other elements of comprehensive programs, such as creating smoke-free worksites and public places, increasing tobacco excise taxes, implementing countermarketing campaigns, and increasing insurance coverage for tobacco-use treatment, all work to encourage cessation and prevent initiation (2,3). Implementing comprehensive state tobacco-control programs at

CDC-recommended funding levels (3) should accelerate progress in reducing tobacco use.

References

1. CDC. Cigarette smoking among adults — United States, 2003. *MMWR* 2005;54:509–13.
2. Task Force on Community Preventive Services. Guide to community preventive services: tobacco use prevention and control. *Am J Prev Med* 2001;20(2 Suppl 1):1–87. Available at <http://www.thecommunityguide.org/tobacco>.
3. CDC. Best practices for comprehensive tobacco control programs. Atlanta, GA: US Department of Health and Human Services, CDC; 1999.
4. US Department of Health and Human Services. Healthy people 2010: understanding and improving health. 2nd ed. Washington, DC: US Department of Health and Human Services; 2000. Available at <http://www.healthypeople.gov>.
5. Farrelly MC, Pechacek TP, Chaloupka FJ. The impact of tobacco control program expenditures on aggregate cigarette sales: 1981–2000. *Health Econ* 2003;22:843–9.
6. Campaign for Tobacco-Free Kids. State tobacco settlement: status of funding, 2004. Available at <http://tobaccofreekids.org/reports/settlements>.
7. Nelson DE, Holtzman D, Bolen J, Stanwyck CA, Mack KA. Reliability and validity of measures from the Behavioral Risk Factor Surveillance System (BRFSS). *Social Prev Med* 2001;46:S3–S42.
8. CDC. Behavioral Risk Factor Surveillance System. Notes for data users; 2003 data limitations. Available at <http://www.cdc.gov/brfss/prevdata/usernote2003.htm>.
9. Keeter S, Miller C, Kohut A, Groves RM, Presser S. Consequences of reducing nonresponse in a national telephone survey. *Public Opin Q* 2000;64:125–48.
10. Fiore MC, Bailey WC, Cohen SJ, et al. Treating tobacco use and dependence: clinical practice guideline. Rockville, MD: US Department of Health and Human Services, Public Health Service; 2000.

Outbreak of Mesotherapy-Associated Skin Reactions — District of Columbia Area, January–February 2005

Mesotherapy is a treatment involving local subcutaneous injections of minute quantities of various substances (e.g., vitamins or plant extracts) for cosmetic purposes (e.g., fat and wrinkle reduction or body contouring) or relief of musculoskeletal pain. In February 2005, the Virginia Department of Health and CDC were notified of a cluster of skin reactions unresponsive to antimicrobial therapy among patients who had been administered mesotherapy by an unlicensed practitioner in the District of Columbia (DC) area. This report 1) summarizes the subsequent investigation by CDC and state and local health departments in Virginia, Maryland, and DC, which identified prolonged skin reactions in 14 patients, and 2) provides recommendations for practices related to mesotherapy. Patients should accept medical therapy only from licensed practitioners and should not permit

injection of substances that have not been approved by the Food and Drug Administration (FDA)*. Licensed practitioners should follow safe-injection practices when practicing mesotherapy and patients should observe that safe-injection practices are followed.

During January–February 2005, an infectious diseases physician reported visits by several patients with skin reactions at the sites on their bodies where they had received mesotherapy injections. The injections had been administered in a private home by a person who told patients he was a physician from Colombia. When no diagnosis could be made and the lesions failed to respond to standard antimicrobial therapy, the physician sought assistance from the Virginia Department of Health and CDC. Because the patients said they knew of others with similar skin reactions after mesotherapy injections from the same practitioner, a joint press release was issued by the health departments of DC, Maryland, and Virginia, asking that any person who had received injections from the practitioner call a designated hotline.

Twenty persons were interviewed by respective state and local health departments in Virginia and DC regarding their experiences with the practitioner. Sixteen (80%) patients reported reactions at one or more sites of injection. Fourteen patients reported prolonged (i.e., lasting ≥ 3 days) skin reactions consistent with the case definition. The majority of patients had redness and swelling, and certain patients had drainage or ulceration at the sites of mesotherapy injections received during October–November 2004; a total of 11 had persistent lesions at the time of interview, 10–16 weeks after their injections. All 14 patients with conditions consistent with the case definition were female; median age was 41 years (range: 18–63 years). Reactions occurred primarily on the torso and legs; no reactions occurred in the face, even though six patients had received facial injections. Fourteen patients reported breaches in safe-injection practices by the practitioner, including 1) failure to practice hand hygiene, 2) failure to prepare the skin with an antiseptic, 3) failure to wipe vials with alcohol before injection, and 4) failure to wear gloves. Of 11 patients who could recall, all reported use of a new needle; however, nine patients reported use of a multidose vial. Patients reported being told their injections contained various substances (e.g., plant extracts from artichoke and thuja, liquid “graphites,” and procaine). With the exception of procaine, none of the substances reported by patients have been approved for subcutaneous injection by the FDA.

Lesion aspirates from seven patients were cultured for mycobacteria at the Virginia Division of Consolidated Laboratory Services; culture sensitivity was limited by small specimen volume. To maximize mycobacterial recovery and preserve viability of aerobic actinomycetes, specimens were processed without decontamination. In addition, cultures included media to support growth of *Mycobacterium haemophilum* and were incubated at both 86°F (30°C) and 98.6°F (37°C). One specimen grew three colonies of *M. chelonae*; specimens from the other six patients had no growth at 12 weeks. Aspirates from four patients had sufficient volume for bacterial and fungal cultures, but no growth was detected. Histopathologic examination of four biopsy samples was performed at CDC. Some samples had evidence of fat necrosis and inflammation in subcutaneous tissues, but special stains did not detect bacteria, fungi, or mycobacteria in any sample.

At the time of the investigation, none of the vials of injected substances could be obtained for analysis, and the practitioner could not be reached for questioning. Patients reported that the practitioner told them he had traveled back and forth from Colombia to provide mesotherapy to more than 100 patients in Florida, New York, New Jersey, and the DC area. However, the practitioner was not licensed to practice medicine in DC, Maryland, or Virginia. FDA is conducting an investigation with assistance from Virginia authorities.

Reported by: W Furlong, MD, Arlington, Virginia; BA Cunanan, Arlington County Public Health Div; LA Weymouth, PhD, D(ABMM), JL Pearson, DrPH, Virginia Div of Consolidated Laboratory Svcs; DC Sockwell, MSPH, SR Jenkins, VMD, J Marr, MD, M Tipple, MD, Virginia Dept of Health. DD Shah, MPH, D Blythe, MD, Maryland Dept of Health and Mental Hygiene. GR Lum, MPH, AC Glymph, MPH, JO Davies-Cole, PhD, District of Columbia Dept of Health. A Srinivasan, MD, Div of Healthcare Quality Promotion, National Center for Infectious Diseases, E Meites, RH Sunenshine, MD, EIS Officer, CDC.

Editorial Note: The findings from this investigation determined that 14 women had prolonged skin reactions after mesotherapy injections of non-FDA–approved products administered by an unlicensed practitioner in the DC area. Cause of the reactions is unknown. Both infectious and non-infectious complications of mesotherapy have been described previously; however, injection-site infections with nontuberculous mycobacteria were the problem reported most commonly (1–5). In this investigation, clinical findings of prolonged skin reactions that were unresponsive to antimicrobial therapy and histopathology were consistent with nontuberculous mycobacterial infection in almost all cases; however, only one sample grew colonies of *M. chelonae*. Inadequate aseptic measures have been cited as the most likely cause of mesotherapy-related infections (1,2), and multiple

*Center for Drug Evaluation and Research, Food and Drug Administration. Index to drug-specific information. Available at <http://www.fda.gov/cder/drug/drugsafety/drugindex.htm>.

breaches in safe-injection practices were reported by the majority of patients in this investigation. These lapses increased the risk for infectious complications.

The histopathology in these cases also is consistent with a chemical or allergic reaction, and certain substances (e.g., cosmetic fillers and a mixture of aminophylline, xantinol nicotinate, and lidocaine) have been reported to cause reactions following mesotherapy injections (5,6). Investigators could not fully assess the potential for chemical or allergic reactions in these cases because injected materials were not available for testing.

Mesotherapy has been practiced extensively in Europe since 1945 and in South America since 1986 (7) and appears to be gaining in popularity in the United States (8). Laws governing who may provide the injections and what may be injected vary by country. In 2003, the Brazilian government banned the use of phosphatidylcholine in mesotherapy injections for cosmetic fat reduction because of safety concerns and the lack of efficacy (8,9). The practice had become so common in Brazil that lay persons in nonmedical locations such as gyms and beauty salons were administering the injections (9). In the United States, laws governing medical procedures vary by state; however, in Virginia, mesotherapy is considered a medical procedure that must be practiced by a licensed provider. To minimize the risk for infectious complications from mesotherapy, providers should adhere to recommended standard precautions, follow safe-injection practices with appropriate aseptic techniques (Box), and inject only FDA-approved products that are prepared following guidelines to ensure sterility, as described in the FDA's good manufacturing practices (10).

References

1. Nagore E, Ramos P, Botella-Estrada R, Ramos-Níguez JA, Sanmartín O, Castejón P. Cutaneous infection with *Mycobacterium fortuitum* after localized microinjections (mesotherapy) treated successfully with a triple drug regimen. *Acta Derm Venereol* 2001;81:291–3.
2. Paul C, Burguiere AM, Vincent V, Susbielle P, Bonvalet D, Dubertret L. BCG-induced mycobacterium infection induced by alternative medicine [French]. *Ann Dermatol Venereol* 1997;124:710–2.
3. Marco-Bonnet J, Beylot-Barry M, Texier-Maugein J, et al. *Mycobacterium bovis* BCG cutaneous infections following mesotherapy: 2 cases [French]. *Ann Dermatol Venereol* 2002;129:728–31.
4. Friedel J, Piedmont Y, Truchetet F, Cattan E. Mesotherapy and cutaneous mycobacteriosis caused by *Mycobacterium fortuitum*: alternative medicine at risk [French]. *Ann Dermatol Venereol* 1987;114:845–9.
5. Lombardi T, Samson J, Plantier F, Husson C, Küffer R. Orofacial granulomas after injection of cosmetic fillers: histopathologic and clinical study of 11 cases. *J Oral Pathol Med* 2004;33:115–20.
6. Rosina P, Chieragato C, Miccolis D, D'Onghia FS. Psoriasis and side-effects of mesotherapy. *Int J Dermatol* 2001;40:581–3.
7. Bryant R. Controversial mesotherapy: Could it be the next botox? *Dermatology Times*; December 1, 2004.

BOX. Infection-control and safe-injection practices

Injections

- Inject only substances approved by the Food and Drug Administration.*
- Use a sterile, single-use, disposable needle and syringe for each patient and discard intact in an appropriate sharps container after use.
- Use single-dose medication vials, prefilled syringes, and ampules when possible.
- Do not administer medications from single-dose vials to multiple patients or combine leftover contents for later use.
- If multiple-dose vials are used, restrict them to a centralized medication area or for single-patient use. Never reenter a vial with a needle or syringe used on one patient if that vial will be used to withdraw medication for another patient. Store vials in accordance with manufacturer's recommendations and discard if sterility is compromised.
- Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients.
- Use aseptic techniques to avoid contamination of sterile injection equipment and medications.

Patient-care equipment

- Handle patient-care equipment, including medications that might be contaminated with blood or body fluids, in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other patients and surfaces.
- Evaluate equipment and devices for potential cross-contamination of blood and body fluids. Establish procedures for safe handling during and after use, including cleaning and disinfection or sterilization as indicated.

Work environment

- Dispose of used syringes and needles at the point of use in a sharps container that is puncture-resistant and leak-proof and that can be sealed before completely full.
- Maintain physical separation between clean and contaminated equipment and supplies.
- Clean and disinfect equipment and surfaces after use in accordance with recommended guidelines.

Hand hygiene and gloves

- Perform proper hand hygiene (e.g., hand washing with soap and water or use of an alcohol-based hand rub) before preparing and administering an injection, before and after donning gloves, and between patients.
- Wear gloves for procedures that might involve contact with blood and change gloves between patients.

* Center for Drug Evaluation and Research, Food and Drug Administration. Index to drug-specific information. Available at <http://www.fda.gov/cder/drug/drugsafety/drugindex.htm>.

8. Rotunda AM, Suzuki H, Moy RL, Kolodney MS. Detergent effects of sodium deoxycholate are a major feature of an injectable phosphatidylcholine formulation used for localized fat dissolution. *Dermatol Surg* 2004;30:1001–8.
9. Hexsel D, Serra M, Mazzuco R, Dal'Forno T, Zechmeister D. Phosphatidylcholine in the treatment of localized fat. *J Drugs Dermatol* 2003;2:511–8.
10. Food and Drug Administration. Current good manufacturing practice for finished pharmaceuticals. Rockville, MD: US Department of Health and Human Services, Food and Drug Administration; 1996. Available at <http://www.fda.gov/cder/dmpq/cgmpregs.htm>.

Prevalence of Receiving Multiple Preventive-Care Services Among Adults with Diabetes — United States, 2002–2004

An estimated 7% of the U.S. population has diabetes; however, only 70% of these persons have had the disease diagnosed (1). Recommended preventive-care services such as annual foot and eye examinations can prevent or delay amputation and blindness (2,4). Measurement of glycosylated hemoglobin (A1C) two or more times per year is important for glycemic control and diabetes management (3,4). Three national health objectives for 2010 are to increase the proportion of adults with diabetes who have an annual dilated eye examination (objective no. 5-13; target: 75%), an annual foot examination (objective no. 5-14; target: 75%), and A1C measurements at least twice each year (objective no. 5-12; target: 50%) (5). To determine the percentage of U.S. adults with diabetes receiving each of these three preventive-care services and the percentage receiving all three services, CDC analyzed data from Behavioral Risk Factor Surveillance System (BRFSS) surveys for 2002–2004. This report summarizes the results of that analysis, which determined that four in 10 U.S. adults with diabetes reported receiving all three preventive-care services; persons with recently diagnosed diabetes and current smokers were least likely to receive all three preventive-care services. Increased understanding of barriers to receiving multiple preventive-care services and continued interventions to ensure their delivery can improve the health status of persons with diabetes.

BRFSS is an ongoing, state-based, random-digit-dialed telephone survey of noninstitutionalized civilian adults aged ≥ 18 years. Median response rates among the state surveys were 58.3% (range: 42.2%–80.5%) in 2002, 53.2% (range: 34.4%–80.5%) in 2003, and 52.7% (range: 32.2%–66.6%) in 2004. Persons with diabetes were defined as respondents who answered “yes” to the core question, “Has a doctor ever told you that you have diabetes?” Those with prediabetes or

borderline diabetes and women who were told they had diabetes but only during pregnancy were classified as not having diabetes. Among persons with diabetes, 70% responded to the following three diabetes module questions and were included in the analyses: “When was the last time you had an eye exam in which the pupils were dilated?” , “About how many times in the last year has a health professional checked your feet for any sores or irritations?” (persons who indicated having bilateral amputations were not asked this question), and “About how many times in the last year has a doctor, nurse, or other health professional checked you for glycated hemoglobin or hemoglobin A1c?” Those who reported one or more eye examinations, one or more foot examinations, and two or more A1C tests during the preceding year were defined as having received multiple preventive-care services. Data were available from 47 states and Puerto Rico for the analysis. Persons with missing data and areas with < 2 years of data were excluded from the analysis.

Data were weighted to reflect the age, sex, and racial/ethnic distribution of noninstitutionalized U.S. adults, and all estimates were age-adjusted to the 2000 U.S. adult population. *T*-tests were used to determine statistically significant differences between groups and populations. Multiple logistic regression analysis was used to determine whether selected characteristics (e.g., age, race/ethnicity, income, and health insurance) were associated significantly with receipt of multiple preventive-care services.

Of 807,771 survey respondents, 65,441 reported diabetes. Among those responding, the overall age-adjusted weighted prevalence of those receiving multiple preventive-care services was 39.5% (Table 1), ranging from 20.7% in Puerto Rico to 64.0% in Hawaii (median: 44.7%) (Table 2). The following six states/areas reported prevalence of $\geq 50\%$ for receipt of multiple preventive-care services: Hawaii (64.0%), New Hampshire (56.7%), Minnesota (55.3%), Massachusetts (54.3%), South Dakota (52.1%), and Wisconsin (50.3%) (Table 2).

Prevalence of receiving multiple preventive-care services was significantly lower ($p \leq 0.001$) among persons aged 18–44 years than among those aged ≥ 45 years, lower among Hispanics than non-Hispanic whites, and lower among current smokers than among nonsmokers or former smokers (Table 1). Prevalence was significantly higher ($p < 0.001$) among persons with the following characteristics: having more than a high school education, annual income of $\geq \$50,000$, duration of diabetes of > 4 years, insulin use, receiving diabetes-management education, and having health insurance coverage (Table 1).

Multivariate analyses determined that the following characteristics were significantly associated with the likelihood of receiving multiple preventive-care services: aged ≥ 75 years

TABLE 1 Age-adjusted prevalence* of receiving multiple preventive-care services† among adults aged ≥18 years with diabetes, by selected characteristics — Behavioral Risk Factor Surveillance System, United States,§ 2002–2004

Characteristic	%	(95% CI) [¶]	p-value**	OR ^{††}	(95% CI)
Crude total	43.2	(42.3–44.2)			
Age-adjusted total	39.5	(38.2–40.8)			
Age group (yrs)					
18–44 ^{§§}	34.9	(32.5–37.2)			
45–64	43.2	(41.8–44.5)	<0.001	1.4	(1.6–1.4)
65–74	48.6	(46.7–50.5)	<0.001	1.6	(1.4–1.9)
≥75	46.0	(43.6–48.4)	<0.001	1.6	(1.4–1.9)
Sex					
Men	38.9	(36.9–40.9)	0.413	1.0	(0.9–1.0)
Women ^{§§}	40.0	(38.3–41.8)			
Race/Ethnicity					
White, non-Hispanic ^{§§}	40.8	(39.3–42.2)			
Black, non-Hispanic	44.3	(41.1–47.4)	0.048	1.3	(1.1–1.5)
Hispanic	33.3	(29.0–37.4)	0.001	0.9	(0.7–1.0)
Education level					
<High school ^{§§}	32.7	(28.1–37.3)			
High school	36.8	(34.6–38.9)	0.16	1.1	(0.9–1.2)
>High school	43.5	(41.8–45.2)	<0.001	1.2	(1.1–1.4)
Annual income					
<\$25,000 ^{§§}	36.3	(34.0–38.6)			
\$25,000–49,999	39.1	(36.9–41.2)	0.08	1.1	(1.0–1.2)
≥\$50,000	45.3	(42.7–48.0)	<0.001	1.2	(1.0–1.3)
Marital status					
Married/Cohabiting ^{§§}	40.4	(38.6–42.1)			
Widowed/Divorced/Separated	36.1	(33.6–38.6)	0.006	0.9	(0.8–1.0)
Never married	40.9	(37.4–44.3)	0.802	1.0	(0.8–1.1)
Years with diabetes					
0–4 ^{§§}	32.9	(30.9–34.9)			
5–9	38.8	(36.2–41.4)	<0.001	1.2	(1.1–1.3)
10–19	45.8	(42.7–48.9)	<0.001	1.5	(1.3–1.6)
≥20	53.7	(49.8–57.5)	<0.001	1.4	(1.2–1.6)
Insulin use					
Yes	54.2	(51.8–56.6)	<0.001	1.7	(1.5–1.9)
No ^{§§}	33.4	(31.8–34.9)			
Current smoking					
Yes	34.0	(31.4–36.6)	<0.001	0.8	(0.7–0.9)
No ^{§§}	41.0	(39.4–42.6)			
Diabetes-management education					
Yes	47.7	(45.9–49.5)	<0.001	1.9	(1.7–2.0)
No ^{§§}	28.2	(26.5–30.0)			
Health insurance coverage					
Yes	42.4	(40.9–43.9)	<0.001	1.9	(1.6–2.2)
No ^{§§}	25.9	(22.8–28.9)			

* Age-adjusted for persons aged 18–44, 45–64, 65–74, and ≥75 years, on the basis of the 2000 U.S. standard population.

† Receiving one or more eye examinations, one or more foot examinations, and two or more glycosylated hemoglobin (A1C) tests during the preceding year were defined as having received multiple preventive-care services.

§ Excludes Guam, U.S. Virgin Islands, and states/areas with <2 years of data.

¶ Confidence interval.

** T-test for difference from reference group.

†† Odds ratio.

§§ Referent for characteristic.

(odds ratio [OR] = 1.6), non-Hispanic black (OR = 1.3), more than a high school education (OR = 1.2), duration of diabetes of 10–19 years (OR = 1.5), insulin use (OR = 1.7), receiving diabetes-management education (OR = 1.9), and having health insurance coverage (OR = 1.9) (Table 1). Current

smoking (OR = 0.8) was negatively associated with receiving multiple preventive-care services.

Reported by: Q Mukhtar, PhD, L Pan, MD, L Jack Jr, PhD, DL Murphy, MPH, Div of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC.

TABLE 2. Age-adjusted prevalence* of receiving individual and multiple preventive-care services† among adults aged ≥18 years with diabetes, by state/area§ — Behavioral Risk Factor Surveillance System, United States, 2002–2004

State/Area	Annual eye examination		Annual foot examination		≥2 A1C tests per year¶		Multiple preventive-care services	
	%	(95% CI**)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Alabama	68.1	(64.3–71.8)	68.8	(65.0–72.6)	74.1	(70.4–77.8)	41.1	(37.0–45.2)
Alaska	63.3	(55.8–70.8)	61.9	(54.5–69.3)	65.7	(58.4–73.1)	35.7	(28.0–43.5)
Arizona	65.0	(59.0–70.9)	64.4	(58.6–70.2)	71.9	(66.0–77.8)	41.9	(35.7–48.1)
Arkansas	61.5	(57.8–65.2)	57.8	(54.1–61.6)	70.6	(66.9–74.4)	32.1	(28.4–35.8)
California	57.4	(52.9–61.9)	59.1	(54.7–63.5)	60.0	(55.3–64.6)	34.7	(30.3–39.1)
Colorado	65.6	(60.7–70.4)	74.1	(69.9–78.2)	72.1	(67.5–76.7)	45.1	(40.1–50.2)
Connecticut	74.7	(70.9–78.5)	71.9	(68.0–75.9)	76.8	(72.9–80.7)	49.6	(45.0–54.2)
Delaware	74.5	(70.0–79.0)	79.6	(76.1–83.2)	69.9	(65.1–74.7)	49.7	(44.6–54.8)
District of Columbia	—	—	—	—	—	—	—	—
Florida	74.1	(70.5–77.7)	67.8	(64.0–71.7)	69.2	(64.8–73.5)	45.1	(40.4–49.7)
Georgia	64.2	(60.7–67.7)	71.4	(68.1–74.7)	70.4	(66.7–74.1)	43.0	(39.0–47.0)
Hawaii	79.4	(74.6–84.3)	83.3	(79.2–87.4)	86.4	(82.7–90.2)	64.0	(58.3–69.8)
Idaho	57.9	(53.6–62.1)	62.6	(58.6–66.7)	62.4	(58.1–66.8)	32.1	(28.0–36.2)
Illinois	—	—	—	—	—	—	—	—
Indiana	61.3	(58.1–64.5)	69.4	(66.5–72.4)	71.4	(68.3–74.5)	38.8	(35.5–42.1)
Iowa	74.9	(71.1–78.6)	69.7	(65.4–74.0)	78.1	(74.4–81.8)	49.3	(44.7–53.9)
Kansas	70.1	(65.7–74.5)	68.3	(63.9–72.7)	73.0	(68.6–77.3)	44.3	(39.3–49.3)
Kentucky	68.2	(64.9–71.5)	62.7	(59.1–66.2)	71.8	(68.5–75.1)	39.9	(36.2–43.7)
Louisiana	69.2	(66.0–72.4)	71.6	(68.5–74.7)	64.0	(60.5–67.6)	42.2	(38.4–46.1)
Maine	67.1	(62.2–71.9)	77.5	(73.2–81.8)	74.7	(69.8–79.6)	48.4	(43.1–53.6)
Maryland	76.4	(72.3–80.6)	74.1	(70.0–78.3)	73.7	(69.1–78.2)	49.6	(44.7–54.5)
Massachusetts	77.5	(73.4–81.7)	76.8	(72.9–80.7)	76.1	(72.0–80.2)	54.3	(49.1–59.5)
Michigan	—	—	—	—	—	—	—	—
Minnesota	77.7	(73.8–81.7)	82.4	(78.9–85.9)	75.0	(70.9–79.1)	55.3	(50.6–60.1)
Mississippi	61.9	(58.0–65.8)	66.4	(62.6–70.3)	67.5	(63.2–71.7)	37.3	(32.9–41.7)
Missouri	64.6	(59.6–69.6)	72.5	(67.9–77.2)	73.8	(69.1–78.5)	43.9	(38.5–49.4)
Montana	67.6	(62.8–72.4)	76.9	(72.9–80.9)	68.5	(63.7–73.3)	45.2	(40.2–50.3)
Nebraska	71.7	(66.8–76.6)	70.6	(65.8–75.4)	71.6	(66.7–76.5)	45.3	(39.6–50.9)
Nevada	58.8	(52.7–65.0)	65.2	(59.3–71.1)	64.0	(57.6–70.4)	32.0	(25.9–38.2)
New Hampshire	75.7	(72.1–79.2)	79.4	(76.2–82.7)	77.3	(73.8–80.9)	56.7	(52.5–60.8)
New Jersey	69.9	(66.5–73.4)	68.5	(64.8–72.3)	73.6	(69.9–77.2)	43.6	(39.7–47.5)
New Mexico	70.2	(66.6–73.7)	76.3	(73.3–79.4)	68.8	(64.8–72.7)	49.2	(44.9–53.6)
New York	67.9	(63.3–72.4)	76.2	(72.2–80.2)	78.1	(73.9–82.4)	47.6	(42.4–52.9)
North Carolina	73.6	(70.9–76.3)	76.6	(74.0–79.2)	73.1	(70.1–76.1)	48.1	(44.7–51.5)
North Dakota	69.5	(63.6–75.4)	80.1	(75.4–84.9)	73.6	(68.0–79.2)	47.9	(41.4–54.4)
Ohio	62.6	(58.0–67.2)	68.3	(63.8–72.7)	74.6	(70.3–78.9)	43.1	(38.2–48.1)
Oklahoma	64.4	(61.5–67.3)	66.0	(63.2–68.9)	68.9	(65.9–71.9)	38.6	(35.6–41.7)
Oregon	—	—	—	—	—	—	—	—
Pennsylvania	66.9	(62.2–71.6)	77.6	(73.7–81.4)	78.7	(74.5–82.8)	46.8	(41.7–51.9)
Rhode Island	75.0	(69.8–80.2)	66.7	(60.8–72.6)	77.0	(71.4–82.6)	49.0	(42.6–55.5)
South Carolina	61.3	(57.9–64.6)	74.4	(71.5–77.3)	72.2	(69.0–75.4)	41.5	(38.1–45.0)
South Dakota	76.1	(72.5–79.6)	76.3	(73.0–79.5)	77.8	(74.4–81.2)	52.1	(47.9–56.3)
Tennessee	74.9	(71.2–78.5)	68.8	(64.8–72.8)	75.8	(72.0–79.6)	47.8	(43.3–52.4)
Texas	60.5	(57.3–63.6)	65.0	(61.9–68.1)	67.5	(64.1–70.8)	36.6	(33.3–39.9)
Utah	63.9	(58.7–69.1)	70.7	(65.3–76.2)	74.3	(69.7–78.9)	42.3	(36.4–48.1)
Vermont	68.5	(64.5–72.4)	71.7	(68.0–75.5)	76.3	(72.6–79.9)	45.9	(41.6–50.2)
Virginia	63.0	(59.0–67.1)	72.2	(68.1–76.2)	71.7	(67.4–76.1)	42.7	(38.3–47.0)
Washington	68.2	(65.3–71.2)	74.1	(71.3–77.0)	73.6	(70.6–76.5)	45.7	(42.7–48.8)
West Virginia	64.2	(60.6–67.9)	65.9	(62.4–69.5)	76.2	(72.6–79.8)	41.0	(37.0–44.9)
Wisconsin	70.1	(66.5–75.6)	74.4	(70.3–78.5)	75.6	(71.2–80.0)	50.3	(45.2–55.4)
Wyoming	62.8	(58.4–67.2)	66.6	(62.3–70.9)	64.6	(60.1–69.1)	37.0	(32.5–41.4)
Puerto Rico	50.4	(46.8–53.9)	46.1	(42.6–49.7)	66.6	(62.8–70.4)	20.7	(17.6–23.7)

* Age-adjusted for persons aged <65 and ≥65 years on the basis of the 2000 U.S. standard population.

† Receiving one or more eye examinations, one or more foot examinations, and two or more glycosylated hemoglobin (A1C) tests during the preceding year were defined as having received multiple preventive-care services.

§ Excludes Guam, U.S. Virgin Islands, and states/areas with <2 years of data.

¶ The A1C (glycosylated hemoglobin) test determines a person's average blood glucose level for the 2–3 months before the test and helps determine how well a person's diabetes is being controlled over time.

** Confidence interval.

Editorial Note: This report is the first population-based assessment of the receipt of multiple preventive-care services among persons with diabetes. Although the percentage of persons with diabetes receiving individual preventive-care services (e.g., foot or eye examinations and A1C tests) in certain states is close to or above the national targets (75% for foot and eye examinations and 50% for A1C tests) (5), more than half of those with diabetes reported they had not received all three preventive-care services. This prevalence is low even among those with favorable characteristics (e.g., having health insurance coverage, receiving diabetes-management education, and being in high education or income groups).

Possible barriers to not receiving all three recommended preventive-care services might include lack of awareness, inadequate health insurance coverage, and inability to make co-payments or visit specialists. Effective management of diabetes requires persons with diabetes and health-care providers to be aware of the need for multiple preventive-care services and a multidisciplinary approach to care. Expansion of preventive-care services available through health plans might be needed to improve the affordability and availability of multiple services (6). However, further research is needed to increase understanding of individual, social, and environmental barriers to persons with diabetes receiving multiple preventive-care services.

The findings in this report are subject to at least three limitations. First, persons living in long-term-care facilities or in households with no telephone or only a cellular telephone are not included in BRFSS surveys; thus, these results do not reflect the entire U.S. population. Second, BRFSS data are self-reported and subject to recall bias; further investigation is needed particularly to assess the reliability and validity of self-reports for foot examinations and A1C tests. Nonetheless, validation studies have indicated that self-reported diabetes and dilated eye examinations are accurate (7,8). Finally, only three of the preventive-care services recommended to persons with diabetes were evaluated; incorporating additional recommended services (e.g., influenza and pneumococcal vaccination) likely would yield even lower prevalence of multiple preventive-care services.

CDC supports 59 diabetes prevention and control programs, one in each state and territory, to 1) increase awareness about diabetes and diabetes management, 2) work with health systems to improve the quality of diabetes care, 3) encourage early detection of diabetes and diabetes-related complications, and 4) monitor trends in the burden of diabetes and quality of care received by persons with diabetes. In addition, CDC partners with the Health Disparities Collaborative,* and CDC and the National Institutes of Health jointly sponsor the

National Diabetes Education Program,† which develops educational tools and community-based interventions and establishes public- and private-sector partnerships to improve diabetes prevention, treatment, and outcomes and to promote early detection.

References

1. CDC. National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2005. Atlanta, GA: US Department of Health and Human Services, CDC; 2005. Available at <http://www.cdc.gov/diabetes/pubs/factsheet05.htm>.
2. Allen BT, DeLong ER, Feussner JR. Impact of glucose self-monitoring on non-insulin treated patients with type II diabetes mellitus. Randomized controlled trial comparing blood and urine testing. *Diabetes Care* 1990;13:1044–50.
3. The Diabetes Control and Complications Trial Research Group. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. *N Engl J Med* 1993;329:977–86.
4. Stratton IM, Adler AI, Neil HA, et al. Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study. *BMJ* 2000;321:405–12.
5. US Department of Health and Human Services. Healthy people 2010: understanding and improving health. 2nd ed. Washington, DC: US Department of Health and Human Services; 2000. Available at <http://www.health.gov/healthypeople>.
6. Cooksey C, Lanza AP. Examining diabetes health benefits in health plans of large employers. *J Public Health Manag Pract* 2003;(Suppl):S30–5.
7. Will JC, German RR, Schuman E, Michael S, Kurth DM, Deeb L. Patient adherence to guidelines for diabetic eye care: results from the Diabetic Eye Disease Follow-up Study. *Am J Public Health* 1994;4:1669–71.
8. Fowles JB, Rosheim K, Fowler EJ, Craft C, Arrichiello L. The validity of self-reported diabetes quality of care measures. *Int J Qual Health Care* 1999;11:407–12.

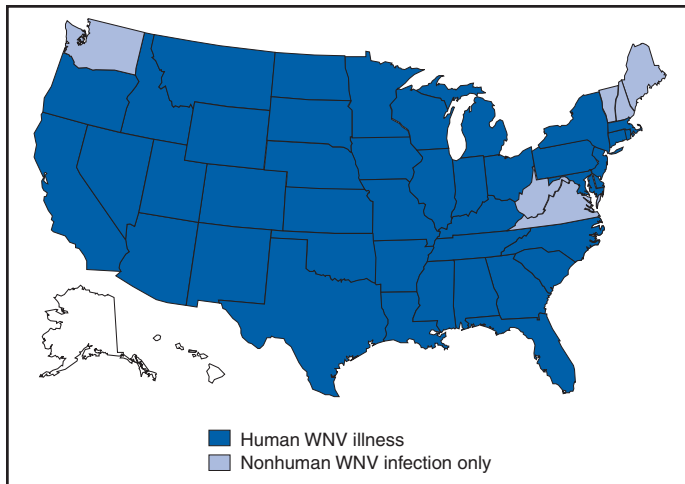
* Available at <http://www.healthdisparities.net/hdc/html/collaboratives.topics.diabetes.aspx>.

† Available at <http://www.ndep.nih.gov>.

Update: West Nile Virus Activity — United States, 2005

This report summarizes West Nile virus (WNV) surveillance data reported to CDC through ArboNET as of 3 a.m. Mountain Standard Time, November 8, 2005. A total of 42 states have reported 2,653 cases of human WNV illness in 2005 (Figure and Table 1). By comparison, a total of 2,282 WNV cases had been reported as of November 8, 2004 (Table 2). A total of 1,405 (56%) of the 2,490 cases for which such data were available in 2005 occurred in males; the median age of patients was 51 years (range: 3 months–98 years). Dates of illness onset ranged from January 2 to October 21; a total of 86 cases were fatal.

FIGURE. Areas reporting West Nile virus (WNV) activity — United States, 2005*



* As of November 8, 2005.

A total of 381 presumptive West Nile viremic blood donors (PVDs) have been reported to ArboNET during 2005. Of these, 88 were reported from California; 57 from Texas; 53 from Nebraska; 22 from Louisiana; 20 from Arizona; 19 from Kansas; 18 from Iowa; 17 from South Dakota; 13 from Oklahoma; 11 from Minnesota; 10 from Illinois; five each from Michigan, New Mexico, and North Dakota; four each from Alabama, Pennsylvania, and Utah; three each from Nevada and Wisconsin; two each from Colorado, Indiana, Maryland, Mississippi, Montana, and Ohio; and one each from Florida, Idaho, Kentucky, Missouri, New York, North Carolina, Oregon, and South Carolina. Of the 381 PVDs, three persons aged 53, 56, and 72 years subsequently had neuroinvasive illness; seven persons (median age: 41 years [range: 17–64 years]) subsequently had other illnesses; and 84 persons (median age: 46 years [range: 17–78 years]) subsequently had West Nile fever.

In addition, 4,227 dead corvids and 902 other dead birds with WNV infection have been reported from 45 states. WNV infections have been reported in horses in 34 states; five dogs in Idaho, Minnesota, and Nebraska; six squirrels in Arizona; and five unidentified animal species in four states (Arizona, Illinois, North Carolina, and Texas). WNV seroconversions have been reported in 1,534 sentinel chicken flocks from 16 states. Eight seropositive sentinel birds have been reported in Michigan. One seropositive sentinel horse was reported in Minnesota. A total of 11,095 WNV-positive mosquito pools have been reported from 43 states and the District of Columbia.

Additional information about national WNV activity is available from CDC at <http://www.cdc.gov/ncidod/dvbid/westnile/index.htm> and at <http://westnilemaps.usgs.gov>.

TABLE 1. Number of human cases of West Nile virus (WNV) illness reported, by state — United States, 2005*

State	Neuroinvasive disease [†]	West Nile fever [§]	Other clinical/unspecified [¶]	Total**	Deaths
Alabama	6	3	0	9	2
Arizona	41	42	19	102	4
Arkansas	11	15	0	26	0
California	273	487	80	840	18
Colorado	19	72	0	91	2
Connecticut	4	2	0	6	1
Delaware	1	0	1	2	0
Florida	8	13	0	21	1
Georgia	9	6	4	19	1
Idaho	2	7	4	13	0
Illinois	130	86	25	241	8
Indiana	10	1	11	22	1
Iowa	12	18	6	36	2
Kansas	12	5	0	17	1
Kentucky	4	0	0	4	1
Louisiana	78	33	0	111	6
Maryland	4	1	0	5	0
Massachusetts	4	2	0	6	0
Michigan	35	4	12	51	4
Minnesota	16	26	0	42	3
Mississippi	39	31	0	70	6
Missouri	14	12	0	26	1
Montana	8	17	0	25	0
Nebraska	35	78	0	113	2
Nevada	14	15	2	31	0
New Jersey	2	2	0	4	0
New Mexico	18	13	0	31	2
New York	10	4	0	14	1
North Carolina	2	2	0	4	0
North Dakota	12	74	0	86	0
Ohio	45	13	0	58	2
Oklahoma	12	9	0	21	0
Oregon	0	5	0	5	0
Pennsylvania	14	11	0	25	0
Rhode Island	1	0	0	1	0
South Carolina	4	0	0	4	1
South Dakota	35	196	4	235	2
Tennessee	13	3	0	16	1
Texas	97	47	0	144	10
Utah	21	30	0	51	1
Wisconsin	8	6	0	14	1
Wyoming	5	6	0	11	1
Total	1,088	1,397	168	2,653	86

* As of November 8, 2005.

[†] Cases with neurologic manifestations (i.e., West Nile meningitis, West Nile encephalitis, and West Nile myelitis).

[§] Cases with no evidence of neuroinvasion.

[¶] Illnesses for which sufficient clinical information was not provided.

** Total number of human cases of WNV illness reported to ArboNET by state and local health departments.

TABLE 2. Comparison of human cases and deaths from West Nile virus — United States, 2002–2005

Year	Human cases	Deaths
2002*	3,507	187
2003 [†]	8,219	182
2004 [§]	2,282	77
2005 [¶]	2,653	86

* As of November 6, 2002.

[†] As of November 5, 2003.

[§] As of November 8, 2004.

[¶] As of November 8, 2005.

*Notice to Readers***Fifth International Conference
on Emerging Infectious Diseases**

CDC, the American Society for Microbiology, the Council of State and Territorial Epidemiologists, the Association of Public Health Laboratories, and the World Health Organization will cosponsor the Fifth International Conference on Emerging Infectious Diseases, March 19–22, 2006, at the Marriott Marquis Hotel in Atlanta, Georgia. The conference will explore current research, surveillance, and prevention and control programs addressing all aspects of emerging infectious diseases. Attendance is limited to 2,500 participants.

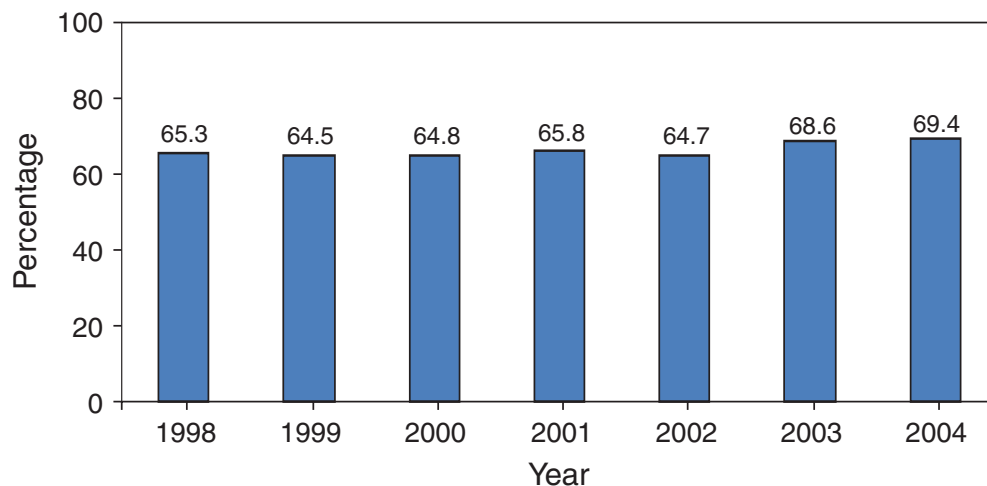
The conference will include general and plenary sessions, symposia, panels of speakers, oral and poster presentations, and exhibits. The deadline for submitting abstracts for presentations is December 2, 2005. Abstracts should address new, reemerging, or drug-resistant infectious diseases that affect human health. The deadline for late-breaker abstracts is February 1, 2006.

Information about abstract submission is available at <http://www.iceid.org/abstractsubmission.htm>. Registration information is available at <http://www.iceid.org> and by e-mail at meetinginfo@asmusa.org or thj0@cdc.gov.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

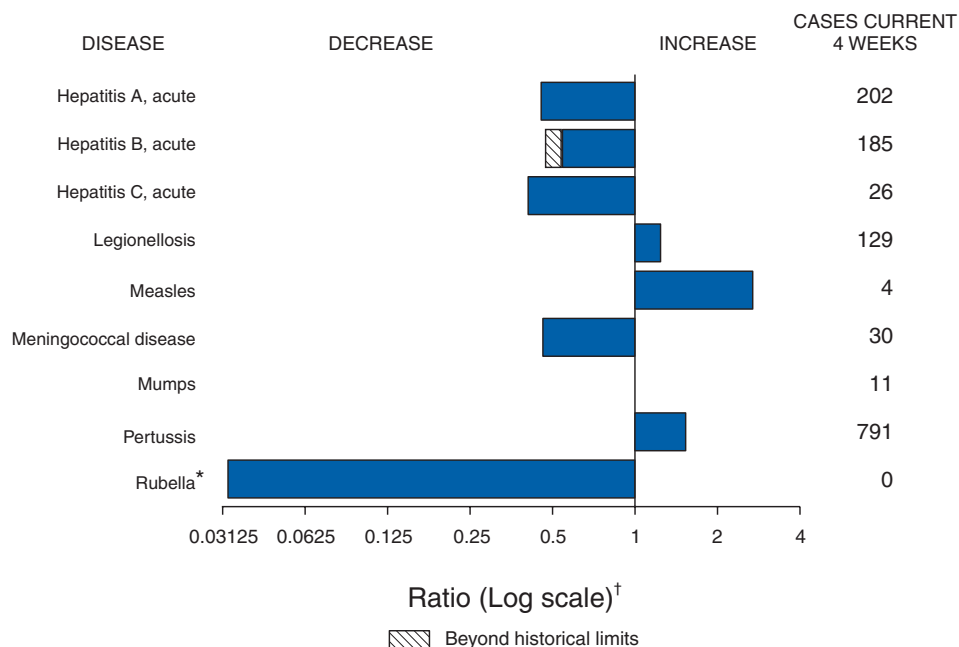
Percentage of Young Adults Aged 18–24 Years Who Never Smoked Cigarettes — United States, 1998–2004



The percentage of young adults aged 18–24 years who never smoked cigarettes increased in 2003 and remained at this level during 2004. In 2004, approximately seven of every 10 young adults had never smoked cigarettes.

SOURCE: National Health Interview Survey, 1998–2004. Available at <http://www.cdc.gov/nchs/nhis.htm>.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals November 5, 2005, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 44 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 November 5, 2005 (44th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	152	147
Botulism:			HIV infection, pediatric†¶	181	322
foodborne	12	8	Influenza-associated pediatric mortality†**	44	—
infant	69	73	Measles	64††	25§§
other (wound & unspecified)	25	14	Mumps	232	190
Brucellosis	89	82	Plague	3	2
Chancroid	4	23	Poliomyelitis, paralytic	1	—
Cholera	16	4	Psittacosis†	19	11
Cyclosporiasis†	707	199	Q fever†	126	55
Diphtheria	—	—	Rabies, human	2	6
Domestic arboviral diseases			Rubella	15	9
(neuroinvasive & non-neuroinvasive):			Rubella, congenital syndrome	1	—
California serogroup†§	—	116	SARS†**	—	—
eastern equine†§	—	4	Smallpox†	—	—
Powassan†§	—	1	<i>Staphylococcus aureus</i> :		
St. Louis†§	—	13	Vancomycin-intermediate (VISA)†	1	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	—	1
Ehrlichiosis:			Streptococcal toxic-shock syndrome†	95	116
human granulocytic (HGE)†	471	363	Tetanus	17	21
human monocytic (HME)†	387	268	Toxic-shock syndrome	84	77
human, other and unspecified †	67	63	Trichinellosis¶¶	16	2
Hansen disease†	66	86	Tularemia†	129	94
Hantavirus pulmonary syndrome†	21	19	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 64 cases reported, 53 were indigenous and 11 were imported from another country.

§§ Of 25 cases reported, eight were indigenous and 17 were imported from another country.

¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending November 5, 2005, and November 6, 2004 (44th 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	34,502	774,093	779,488	3,904	4,967	6,294	3,142
NEW ENGLAND	778	1,129	26,634	25,519	—	—	301	161
Maine	11	23	1,900	1,774	N	N	25	18
N.H.	20	39	1,538	1,478	—	—	30	30
Vt.¶	4	14	779	955	—	—	35	23
Mass.	368	425	12,055	11,260	—	—	126	59
R.I.	68	114	2,732	2,890	—	—	11	4
Conn.	307	514	7,630	7,162	N	N	74	27
MID. ATLANTIC	4,352	7,360	97,536	95,193	—	—	2,760	510
Upstate N.Y.	800	837	19,618	19,138	N	N	2,362	159
N.Y. City	2,327	4,039	30,639	29,396	—	—	116	122
N.J.	574	1,229	15,503	15,002	N	N	48	42
Pa.	651	1,255	31,776	31,657	N	N	234	187
E.N. CENTRAL	1,938	2,816	126,008	137,771	10	13	1,349	946
Ohio	312	540	33,584	33,782	N	N	727	198
Ind.	236	326	16,692	15,765	N	N	73	69
Ill.	983	1,274	38,170	40,505	—	—	128	146
Mich.	322	535	21,743	31,449	10	13	92	137
Wis.	85	141	15,819	16,270	N	N	329	396
W.N. CENTRAL	463	710	47,993	48,133	5	6	531	361
Minn.	123	190	9,335	10,025	3	N	127	119
Iowa	50	57	6,072	5,915	N	N	102	78
Mo.	198	296	18,979	17,746	1	3	238	64
N. Dak.	5	15	995	1,533	N	N	1	10
S. Dak.	10	8	2,340	2,140	—	—	24	37
Nebr.¶	18	44	4,350	4,447	1	3	7	26
Kans.	59	100	5,922	6,327	N	N	32	27
S. ATLANTIC	6,473	10,881	147,767	146,952	2	—	606	464
Del.	100	131	2,892	2,490	N	N	3	—
Md.	812	1,292	15,512	15,998	2	—	33	19
D.C.	467	785	3,269	3,038	—	—	10	14
Va.¶	307	565	17,750	18,960	—	—	60	54
W. Va.	36	71	2,271	2,376	N	N	13	6
N.C.	531	1,014	26,366	24,877	N	N	77	70
S.C.¶	386	640	17,809	16,015	—	—	16	21
Ga.	1,103	1,375	25,798	27,440	—	—	101	164
Fla.	2,731	5,008	36,100	35,758	N	N	293	116
E.S. CENTRAL	1,093	1,646	58,129	51,063	—	5	187	126
Ky.	135	212	7,534	4,880	N	N	129	39
Tenn.¶	434	684	20,349	19,022	N	N	37	38
Ala.¶	295	381	12,954	11,560	—	—	17	21
Miss.	229	369	17,292	15,601	—	5	4	28
W.S. CENTRAL	2,206	4,000	89,705	94,883	1	3	173	120
Ark.	72	183	7,416	6,814	—	1	5	15
La.	436	799	13,997	18,979	1	2	76	5
Okla.	167	169	9,236	9,258	N	N	40	21
Tex.¶	1,531	2,849	59,056	59,832	N	N	52	79
MOUNTAIN	789	1,233	44,123	47,577	2,653	3,103	112	149
Mont.	4	5	1,765	2,106	N	N	16	34
Idaho¶	9	17	1,826	2,321	N	N	11	24
Wyo.	2	14	970	898	3	2	3	3
Colo.	163	278	11,521	12,283	N	N	43	50
N. Mex.	72	164	4,394	7,601	13	20	5	16
Ariz.	329	454	14,712	13,743	2,600	3,006	10	15
Utah	33	53	3,609	3,145	5	22	15	5
Nev.¶	177	248	5,326	5,480	32	53	9	2
PACIFIC	2,313	4,727	136,198	132,397	1,233	1,837	275	305
Wash.	229	348	15,781	14,899	N	N	43	33
Oreg.¶	136	249	6,327	7,095	—	—	64	29
Calif.	1,874	3,981	108,012	102,548	1,233	1,837	164	241
Alaska	14	43	3,369	3,273	—	—	3	—
Hawaii	60	106	2,709	4,582	—	—	1	2
Guam	1	1	—	803	—	—	—	—
P.R.	537	614	3,193	2,878	N	N	N	N
V.I.	10	18	155	298	—	—	—	—
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 November 5, 2005, and November 6, 2004 (44th 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	2,051	2,185	299	255	275	161	15,278	16,573	267,656	276,683
NEW ENGLAND	147	147	47	41	29	14	1,410	1,549	4,798	5,859
Maine	14	14	11	—	—	—	182	128	117	187
N.H.	12	21	2	5	—	—	46	40	145	107
Vt.	13	13	3	—	—	—	165	151	47	73
Mass.	59	62	7	13	29	14	602	685	2,138	2,655
R.I.	7	9	—	1	—	—	105	107	365	720
Conn.	42	28	24	22	—	—	310	438	1,986	2,117
MID. ATLANTIC	268	257	33	55	26	34	2,809	3,457	28,283	30,900
Upstate N.Y.	121	114	16	36	9	17	1,032	1,163	5,778	6,320
N.Y. City	13	35	—	—	—	—	706	945	8,291	9,513
N.J.	47	45	3	6	8	6	342	447	4,721	5,740
Pa.	87	63	14	13	9	11	729	902	9,493	9,327
E.N. CENTRAL	402	423	25	44	17	30	2,406	2,758	51,411	58,593
Ohio	130	87	10	9	10	18	698	688	15,754	17,690
Ind.	59	47	—	—	—	—	N	N	6,637	5,761
Ill.	45	95	1	7	1	7	507	706	15,479	17,686
Mich.	70	75	2	10	6	5	670	602	8,989	13,228
Wis.	98	119	12	18	—	—	531	762	4,552	4,228
W.N. CENTRAL	369	446	37	34	50	20	1,855	1,761	15,459	14,616
Minn.	125	103	20	13	31	4	857	619	2,659	2,481
Iowa	74	115	—	—	—	—	233	258	1,349	1,066
Mo.	76	85	11	15	8	6	426	484	7,993	7,647
N. Dak.	6	13	—	—	1	6	12	21	69	96
S. Dak.	26	31	3	2	—	—	85	58	303	238
Nebr.	24	61	3	4	4	—	83	127	986	936
Kans.	38	38	—	—	6	4	159	194	2,100	2,152
S. ATLANTIC	180	153	78	29	105	44	2,216	2,524	64,763	66,908
Del.	7	3	N	N	N	N	48	43	752	758
Md.	30	21	29	5	9	3	171	123	5,926	6,876
D.C.	—	1	—	—	—	—	42	63	1,811	2,249
Va.	39	33	27	15	21	—	478	451	6,482	7,512
W. Va.	2	2	—	—	1	—	41	34	629	781
N.C.	—	—	—	—	58	34	N	N	12,715	13,300
S.C.	6	12	—	—	1	—	89	102	7,892	7,934
Ga.	28	19	18	6	—	—	511	771	11,965	12,120
Fla.	68	62	4	3	15	7	836	937	16,591	15,378
E.S. CENTRAL	122	90	8	5	29	15	358	362	23,304	22,516
Ky.	46	24	5	1	19	9	N	N	2,624	2,240
Tenn.	41	36	2	2	10	6	184	196	7,507	7,236
Ala.	28	19	—	—	—	—	174	166	7,438	7,019
Miss.	7	11	1	2	—	—	—	—	5,735	6,021
W.S. CENTRAL	45	78	13	3	9	4	280	284	36,455	37,037
Ark.	7	16	—	—	—	—	74	112	3,880	3,582
La.	3	4	11	1	3	—	50	43	7,752	8,945
Okla.	22	17	1	—	2	—	156	129	3,666	3,946
Tex.	13	41	1	2	4	4	N	N	21,157	20,564
MOUNTAIN	198	218	52	43	10	—	1,228	1,292	9,532	10,127
Mont.	15	16	—	—	—	—	63	69	111	69
Idaho	22	49	11	12	7	—	85	163	76	80
Wyo.	6	8	2	5	—	—	23	22	66	54
Colo.	61	50	3	1	1	—	462	446	2,545	2,587
N. Mex.	10	10	9	6	—	—	67	64	864	1,052
Ariz.	38	19	N	N	N	N	133	143	3,238	3,291
Utah	36	42	25	18	—	—	346	278	580	490
Nev.	10	24	2	1	2	—	49	107	2,052	2,504
PACIFIC	320	373	6	1	—	—	2,716	2,586	33,651	30,127
Wash.	96	125	—	—	—	—	313	325	3,126	2,246
Oreg.	76	65	6	1	—	—	335	394	1,094	1,076
Calif.	126	172	—	—	—	—	1,923	1,714	28,468	25,251
Alaska	12	1	—	—	—	—	90	83	469	489
Hawaii	10	10	—	—	—	—	55	70	494	1,065
Guam	N	N	—	—	—	—	—	2	—	125
P.R.	2	1	—	—	—	—	145	254	290	211
V.I.	—	—	—	—	—	—	—	—	39	82
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 November 5, 2005, and November 6, 2004 (44th 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	1,768	1,680	4	12	94	103	159	154
NEW ENGLAND	141	159	—	1	10	9	3	1
Maine	6	12	—	—	—	—	1	—
N.H.	8	17	—	—	—	2	—	—
Vt.	10	8	—	—	—	—	—	1
Mass.	66	74	—	1	3	4	1	—
R.I.	7	3	—	—	2	—	—	—
Conn.	44	45	—	—	5	3	1	—
MID. ATLANTIC	362	349	—	2	—	4	39	36
Upstate N.Y.	104	110	—	2	—	4	9	5
N.Y. City	65	78	—	—	—	—	10	15
N.J.	75	66	—	—	—	—	10	3
Pa.	118	95	—	—	—	—	10	13
E.N. CENTRAL	253	316	1	—	4	8	17	46
Ohio	97	87	—	—	—	2	7	15
Ind.	56	42	—	—	4	4	—	1
Ill.	59	114	—	—	—	—	7	21
Mich.	18	18	1	—	—	2	2	4
Wis.	23	55	—	—	—	—	1	5
W.N. CENTRAL	95	92	—	2	3	3	8	11
Minn.	38	40	—	1	3	3	2	1
Iowa	1	1	—	1	—	—	—	—
Mo.	32	36	—	—	—	—	5	7
N. Dak.	2	4	—	—	—	—	1	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	9	5	—	—	—	—	—	2
Kans.	13	6	—	—	—	—	—	1
S. ATLANTIC	415	376	1	1	26	24	25	26
Del.	—	—	—	—	—	—	—	—
Md.	60	56	—	—	5	5	—	—
D.C.	—	3	—	—	—	—	—	1
Va.	40	39	—	—	—	—	—	5
W. Va.	25	16	—	—	1	4	6	—
N.C.	69	52	1	1	8	6	—	1
S.C.	26	12	—	—	—	—	—	1
Ga.	82	97	—	—	—	—	13	17
Fla.	113	101	—	—	12	9	6	1
E.S. CENTRAL	99	63	—	1	1	1	6	8
Ky.	8	7	—	—	1	1	2	—
Tenn.	73	41	—	—	—	—	—	6
Ala.	18	13	—	1	—	—	4	2
Miss.	—	2	—	—	—	—	—	—
W.S. CENTRAL	91	65	1	1	8	8	7	1
Ark.	5	2	—	—	1	1	—	—
La.	30	13	1	—	2	—	7	1
Okla.	54	49	—	—	5	7	—	—
Tex.	2	1	—	1	—	—	—	—
MOUNTAIN	196	168	—	4	14	25	39	18
Mont.	—	—	—	—	—	—	—	—
Idaho	4	5	—	—	—	—	1	2
Wyo.	6	1	—	—	—	1	1	—
Colo.	39	41	—	—	1	—	9	5
N. Mex.	18	37	—	1	4	8	2	6
Ariz.	98	58	—	—	7	11	15	2
Utah	17	14	—	2	—	2	8	2
Nev.	14	12	—	1	2	3	3	1
PACIFIC	116	92	1	—	28	21	15	7
Wash.	4	1	—	—	—	—	3	1
Oreg.	29	40	—	—	—	—	5	3
Calif.	50	38	1	—	28	21	2	1
Alaska	25	5	—	—	—	—	5	1
Hawaii	8	8	—	—	—	—	—	1
Guam	—	—	—	—	—	—	—	—
P.R.	3	2	—	—	—	—	1	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 November 5, 2005, and November 6, 2004 (44th 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	3,509	5,055	4,647	5,011	598	681
NEW ENGLAND	465	880	247	331	16	15
Maine	4	13	16	5	—	—
N.H.	74	24	23	32	—	—
Vt.	6	8	5	6	13	7
Mass.	321	749	172	183	—	7
R.I.	14	21	3	5	—	—
Conn.	46	65	28	100	3	1
MID. ATLANTIC	590	693	896	654	90	127
Upstate N.Y.	94	92	80	71	17	11
N.Y. City	263	293	103	131	—	—
N.J.	144	165	531	187	—	—
Pa.	89	143	182	265	73	116
E.N. CENTRAL	330	442	438	469	112	97
Ohio	47	43	115	98	7	5
Ind.	48	52	44	39	23	7
Ill.	79	137	99	71	—	13
Mich.	127	129	149	225	82	72
Wis.	29	81	31	36	—	—
W.N. CENTRAL	80	137	231	284	29	20
Minn.	3	32	29	44	5	17
Iowa	20	42	19	14	—	—
Mo.	37	28	135	171	22	3
N. Dak.	—	1	—	4	1	—
S. Dak.	—	3	3	1	—	—
Nebr.	4	12	21	36	1	—
Kans.	16	19	24	14	—	—
S. ATLANTIC	614	902	1,165	1,553	128	166
Del.	4	6	44	45	7	29
Md.	65	96	134	136	22	3
D.C.	4	7	10	19	—	4
Va.	72	109	125	224	12	13
W. Va.	5	5	32	35	19	22
N.C.	78	98	150	139	19	11
S.C.	33	40	122	122	3	15
Ga.	102	293	135	398	7	14
Fla.	251	248	413	435	39	55
E. S. CENTRAL	223	139	301	422	74	80
Ky.	24	29	55	61	9	23
Tenn.	144	88	123	200	16	29
Ala.	35	8	70	66	14	4
Miss.	20	14	53	95	35	24
W.S. CENTRAL	238	593	425	336	71	95
Ark.	13	60	43	103	1	2
La.	60	44	60	59	11	3
Okla.	4	19	34	58	6	3
Tex.	161	470	288	116	53	87
MOUNTAIN	306	367	475	408	39	38
Mont.	8	6	3	1	1	2
Idaho	17	17	12	10	1	1
Wyo.	—	5	1	7	1	2
Colo.	37	45	51	53	19	11
N. Mex.	22	23	9	16	—	U
Ariz.	193	220	332	215	—	5
Utah	19	35	39	37	8	4
Nev.	10	16	28	69	9	13
PACIFIC	663	902	469	554	39	43
Wash.	41	54	57	45	U	U
Oreg.	38	60	88	99	15	15
Calif.	559	760	312	390	23	27
Alaska	4	4	7	11	—	—
Hawaii	21	24	5	9	1	1
Guam	—	1	—	12	—	9
P.R.	55	42	38	70	—	—
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 November 5, 2005, and November 6, 2004 (44th 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	1,644	1,740	665	622	18,010	16,213	1,061	1,222
NEW ENGLAND	102	81	47	45	2,158	2,927	59	83
Maine	6	1	3	8	182	29	4	7
N.H.	8	10	6	3	176	183	5	5
Vt.	7	5	2	2	41	47	1	4
Mass.	37	35	12	16	956	1,444	31	49
R.I.	19	15	6	1	32	187	2	4
Conn.	25	15	18	15	771	1,037	16	14
MID. ATLANTIC	583	499	173	147	11,472	9,877	291	325
Upstate N.Y.	162	105	54	42	3,499	3,450	44	41
N.Y. City	82	65	32	25	—	333	154	178
N.J.	88	83	33	31	3,118	2,479	62	65
Pa.	251	246	54	49	4,855	3,615	31	41
E.N. CENTRAL	309	426	65	107	1,321	1,266	87	109
Ohio	166	197	29	38	66	47	24	28
Ind.	18	41	4	16	29	24	3	13
Ill.	15	45	2	22	—	87	29	38
Mich.	92	123	23	26	50	26	20	18
Wis.	18	20	7	5	1,176	1,082	11	12
W.N. CENTRAL	80	51	38	16	831	477	40	63
Minn.	16	7	11	4	724	394	11	24
Iowa	6	5	8	2	78	47	8	4
Mo.	32	24	6	6	23	24	16	19
N. Dak.	2	2	4	—	—	—	—	3
S. Dak.	21	4	—	1	1	1	—	1
Nebr.	1	3	5	3	2	8	1	4
Kans.	2	6	4	—	3	3	4	8
S. ATLANTIC	327	345	138	105	1,993	1,466	253	298
Del.	16	13	N	N	575	296	3	6
Md.	94	74	19	15	1,026	787	92	68
D.C.	9	10	—	5	8	12	8	13
Va.	37	40	14	17	219	156	27	44
W. Va.	16	10	4	4	16	28	1	2
N.C.	25	29	27	21	44	109	30	19
S.C.	11	11	9	10	19	22	7	10
Ga.	22	39	21	14	5	12	39	58
Fla.	97	119	44	19	81	44	46	78
E.S. CENTRAL	70	89	28	23	32	43	26	30
Ky.	24	35	4	4	5	15	9	4
Tenn.	31	39	12	12	26	23	13	10
Ala.	12	12	8	5	1	5	4	11
Miss.	3	3	4	2	—	—	—	5
W.S. CENTRAL	25	123	27	37	56	65	78	120
Ark.	4	1	2	3	4	8	6	8
La.	1	7	8	3	4	2	2	6
Okla.	7	5	3	—	—	—	9	7
Tex.	13	110	14	31	48	55	61	99
MOUNTAIN	79	70	16	23	21	17	47	48
Mont.	5	2	—	—	—	—	—	—
Idaho	3	7	—	1	2	6	—	1
Wyo.	4	6	—	—	3	3	2	—
Colo.	21	18	7	12	3	—	23	18
N. Mex.	2	4	4	1	1	1	2	4
Ariz.	23	11	—	—	8	6	10	13
Utah	13	18	3	1	2	1	8	7
Nev.	8	4	2	8	2	—	2	5
PACIFIC	69	56	133	119	126	75	180	146
Wash.	—	9	9	9	8	12	13	15
Oreg.	N	N	10	6	17	25	9	16
Calif.	66	46	113	100	98	36	139	109
Alaska	—	1	—	—	3	2	5	2
Hawaii	3	—	1	4	N	N	14	4
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	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 November 5, 2005, and November 6, 2004 (44th 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	985	1,028	78	79	48	39	—	1	859	909
NEW ENGLAND	66	63	1	6	—	6	—	1	65	50
Maine	2	10	—	—	—	1	—	—	2	9
N.H.	12	7	—	—	—	—	—	—	12	7
Vt.	6	3	—	—	—	—	—	—	6	3
Mass.	31	34	—	5	—	5	—	—	31	24
R.I.	3	2	—	1	—	—	—	—	3	1
Conn.	12	7	1	—	—	—	—	1	11	6
MID. ATLANTIC	126	139	34	37	7	5	—	—	85	97
Upstate N.Y.	33	36	4	5	4	3	—	—	25	28
N.Y. City	18	24	—	—	—	—	—	—	18	24
N.J.	32	30	—	—	—	—	—	—	32	30
Pa.	43	49	30	32	3	2	—	—	10	15
E.N. CENTRAL	108	115	29	27	10	6	—	—	69	82
Ohio	36	58	—	4	6	5	—	—	30	49
Ind.	18	17	—	1	4	1	—	—	14	15
Ill.	15	1	—	—	—	—	—	—	15	1
Mich.	29	22	29	22	—	—	—	—	—	—
Wis.	10	17	—	—	—	—	—	—	10	17
W.N. CENTRAL	65	71	3	—	1	4	—	—	61	67
Minn.	13	22	1	—	—	—	—	—	12	22
Iowa	15	16	—	—	1	2	—	—	14	14
Mo.	22	18	1	—	—	1	—	—	21	17
N. Dak.	—	2	—	—	—	—	—	—	—	2
S. Dak.	3	2	1	—	—	1	—	—	2	1
Nebr.	5	4	—	—	—	—	—	—	5	4
Kans.	7	7	—	—	—	—	—	—	7	7
S. ATLANTIC	189	195	6	2	9	3	—	—	174	190
Del.	4	5	—	—	—	—	—	—	4	5
Md.	20	10	3	—	2	—	—	—	15	10
D.C.	—	5	—	2	—	—	—	—	—	3
Va.	30	19	—	—	—	—	—	—	30	19
W. Va.	6	5	1	—	—	—	—	—	5	5
N.C.	28	27	2	—	7	3	—	—	19	24
S.C.	14	14	—	—	—	—	—	—	14	14
Ga.	15	13	—	—	—	—	—	—	15	13
Fla.	72	97	—	—	—	—	—	—	72	97
E.S. CENTRAL	51	59	1	1	3	1	—	—	47	57
Ky.	16	11	—	1	3	1	—	—	13	9
Tenn.	24	20	—	—	—	—	—	—	24	20
Ala.	6	15	1	—	—	—	—	—	5	15
Miss.	5	13	—	—	—	—	—	—	5	13
W.S. CENTRAL	86	62	1	2	5	2	—	—	80	58
Ark.	14	15	—	—	—	1	—	—	14	14
La.	26	31	—	1	2	—	—	—	24	30
Okla.	13	9	1	1	3	1	—	—	9	7
Tex.	33	7	—	—	—	—	—	—	33	7
MOUNTAIN	78	58	2	1	6	5	—	—	70	52
Mont.	—	3	—	—	—	—	—	—	—	3
Idaho	4	7	—	—	—	—	—	—	4	7
Wyo.	—	4	—	—	—	—	—	—	—	4
Colo.	17	14	1	—	1	—	—	—	15	14
N. Mex.	3	7	—	1	—	3	—	—	3	3
Ariz.	36	11	—	—	2	1	—	—	34	10
Utah	10	5	1	—	2	—	—	—	7	5
Nev.	8	7	—	—	1	1	—	—	7	6
PACIFIC	216	266	1	3	7	7	—	—	208	256
Wash.	41	28	1	3	4	7	—	—	36	18
Oreg.	28	50	—	—	—	—	—	—	28	50
Calif.	132	177	—	—	—	—	—	—	132	177
Alaska	3	4	—	—	—	—	—	—	3	4
Hawaii	12	7	—	—	3	—	—	—	9	7
Guam	—	1	—	—	—	—	—	—	—	1
P.R.	6	15	—	—	—	—	—	—	6	15
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	1	1	—	—	—	—	—	—	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 November 5, 2005, and November 6, 2004 (44th 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	17,055	17,362	4,692	5,681	1,499	1,358	35,520	35,885	11,527	11,485
NEW ENGLAND	1,027	1,615	615	598	3	18	1,855	1,805	258	264
Maine	29	8	48	49	N	N	136	94	9	7
N.H.	59	72	12	28	1	—	145	124	7	8
Vt.	79	66	52	33	—	1	92	55	16	3
Mass.	790	1,384	303	254	1	13	976	1,031	162	167
R.I.	29	31	20	40	1	1	82	107	14	18
Conn.	41	54	180	194	—	3	424	394	50	61
MID. ATLANTIC	1,133	2,451	848	858	96	69	4,235	4,977	1,085	1,045
Upstate N.Y.	451	1,714	482	472	5	1	1,100	1,075	242	380
N.Y. City	85	175	27	11	7	21	971	1,133	351	357
N.J.	175	169	N	N	29	14	721	954	268	216
Pa.	422	393	339	375	55	33	1,443	1,815	224	92
E.N. CENTRAL	2,997	6,652	191	177	35	33	4,529	4,482	814	1,047
Ohio	995	504	67	72	25	9	1,173	1,081	94	148
Ind.	286	174	11	10	2	6	531	420	148	180
Ill.	572	1,194	50	48	1	14	1,323	1,441	242	360
Mich.	253	252	35	40	6	2	773	735	202	164
Wis.	891	4,528	28	7	1	2	729	805	128	195
W.N. CENTRAL	2,749	1,862	380	565	154	114	2,171	2,083	1,333	361
Minn.	966	314	65	81	2	—	504	521	82	62
Iowa	547	343	98	96	4	2	340	387	71	59
Mo.	410	306	74	55	133	94	728	542	875	138
N. Dak.	130	698	24	54	—	—	37	39	4	3
S. Dak.	109	52	48	91	5	4	130	112	41	10
Nebr.	172	45	—	94	4	14	117	152	62	21
Kans.	415	104	71	94	6	—	315	330	198	68
S. ATLANTIC	1,149	659	1,397	1,966	773	715	10,562	9,708	1,963	2,538
Del.	15	2	—	9	3	5	110	100	11	8
Md.	149	123	278	291	84	65	709	742	88	135
D.C.	7	8	—	—	2	—	45	54	11	35
Va.	301	170	460	424	99	29	1,000	1,030	114	141
W. Va.	43	22	52	59	6	5	154	205	1	8
N.C.	98	79	415	528	443	460	1,436	1,405	179	306
S.C.	319	122	5	146	54	58	1,129	878	85	491
Ga.	32	19	182	304	65	77	1,601	1,719	498	573
Fla.	185	114	5	205	17	16	4,378	3,575	976	841
E. S. CENTRAL	433	258	129	135	260	187	2,544	2,357	1,065	755
Ky.	127	64	16	20	3	2	428	296	273	61
Tenn.	189	144	43	46	194	103	666	611	499	396
Ala.	76	34	68	58	59	54	643	630	208	251
Miss.	41	16	2	11	4	28	807	820	85	47
W.S. CENTRAL	1,489	803	761	989	139	197	3,056	3,705	2,329	3,096
Ark.	256	70	33	48	109	114	658	496	58	69
La.	34	15	—	4	5	5	691	833	117	272
Okla.	—	38	69	99	7	71	356	354	576	404
Tex.	1,199	680	659	838	18	7	1,351	2,022	1,578	2,351
MOUNTAIN	3,442	1,363	211	205	31	21	1,929	2,013	761	702
Mont.	542	47	15	25	1	3	93	177	5	4
Idaho	131	34	—	7	3	4	90	133	11	13
Wyo.	46	29	17	6	2	5	77	47	5	5
Colo.	1,176	713	16	46	5	4	508	478	142	136
N. Mex.	122	144	7	5	2	2	211	251	101	125
Ariz.	871	200	128	107	14	2	569	568	428	329
Utah	522	158	15	6	4	1	296	209	41	40
Nev.	32	38	13	3	—	—	85	150	28	50
PACIFIC	2,636	1,699	160	188	8	4	4,639	4,755	1,919	1,677
Wash.	726	627	U	U	—	—	458	477	110	94
Oreg.	561	411	6	6	1	2	330	387	111	71
Calif.	1,104	624	153	171	7	2	3,546	3,511	1,662	1,462
Alaska	112	13	1	11	—	—	47	55	7	6
Hawaii	133	24	—	—	—	—	258	325	29	44
Guam	—	—	—	—	—	—	—	50	—	42
P.R.	5	4	55	55	N	N	375	422	4	31
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 November 5, 2005, and November 6, 2004 (44th 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	3,651	3,764	1,808	1,858	614	677	6,685	6,627	214	333
NEW ENGLAND	154	240	107	135	50	93	178	165	1	4
Maine	10	11	N	N	—	7	1	2	—	—
N.H.	14	17	—	—	4	N	14	4	—	3
Vt.	9	8	11	6	—	3	1	—	—	—
Mass.	112	108	80	43	45	50	108	101	—	—
R.I.	9	18	16	18	1	6	19	23	—	1
Conn.	U	78	U	68	U	27	35	35	1	—
MID. ATLANTIC	755	626	171	129	120	104	833	851	25	32
Upstate N.Y.	226	206	66	55	52	72	75	81	6	4
N.Y. City	143	104	U	U	20	U	506	532	5	14
N.J.	150	131	N	N	22	8	113	127	14	13
Pa.	236	185	105	74	26	24	139	111	—	1
E.N. CENTRAL	725	853	487	415	177	157	701	757	26	53
Ohio	168	199	310	292	67	66	187	195	1	2
Ind.	90	86	165	123	45	33	54	52	1	3
Ill.	157	226	12	—	53	9	358	322	10	18
Mich.	275	260	—	N	—	N	71	159	12	30
Wis.	35	82	N	N	12	49	31	29	2	—
W.N. CENTRAL	230	274	39	18	67	91	208	139	5	5
Minn.	90	129	—	—	42	59	52	22	1	1
Iowa	N	N	N	N	—	N	4	5	—	—
Mo.	61	58	32	13	9	13	127	84	4	2
N. Dak.	9	11	2	—	4	3	1	—	—	—
S. Dak.	20	17	3	5	—	—	2	—	—	—
Nebr.	18	19	2	—	—	8	4	6	—	—
Kans.	32	40	N	N	12	8	18	22	—	2
S. ATLANTIC	792	764	707	935	70	52	1,669	1,678	37	55
Del.	5	3	1	4	—	N	10	8	—	1
Md.	177	127	—	—	45	37	258	303	13	9
D.C.	9	9	15	8	3	4	84	51	—	1
Va.	77	64	N	N	—	N	114	89	4	3
W. Va.	22	24	103	98	22	11	4	3	—	—
N.C.	111	115	N	N	U	U	213	164	8	10
S.C.	27	51	—	83	—	N	64	101	4	11
Ga.	154	178	111	239	—	N	309	330	1	4
Fla.	210	193	477	503	—	N	613	629	7	16
E.S. CENTRAL	151	192	144	133	13	15	381	351	18	21
Ky.	31	55	25	26	N	N	44	41	—	1
Tenn.	120	137	119	105	—	N	187	110	12	8
Ala.	—	—	—	—	—	N	115	148	5	10
Miss.	—	—	—	2	13	15	35	52	1	2
W.S. CENTRAL	230	294	99	66	62	130	1,081	1,060	61	65
Ark.	18	16	12	8	14	8	43	46	—	3
La.	6	2	87	58	24	29	206	274	11	5
Okla.	100	61	N	N	24	38	32	25	1	2
Tex.	106	215	N	N	—	55	800	715	49	55
MOUNTAIN	523	415	54	26	46	33	328	337	17	44
Mont.	—	—	—	—	—	—	5	1	—	—
Idaho	2	8	N	N	—	N	20	21	1	2
Wyo.	4	8	22	10	—	—	—	3	—	—
Colo.	177	93	N	N	45	33	33	55	1	1
N. Mex.	41	85	—	N	—	—	38	72	2	2
Ariz.	225	182	N	N	—	N	148	139	12	38
Utah	73	35	30	14	1	—	6	11	—	1
Nev.	1	4	2	2	—	—	78	35	1	—
PACIFIC	91	106	—	1	9	2	1,306	1,289	24	54
Wash.	N	N	N	N	N	N	126	116	—	—
Oreg.	N	N	N	N	6	N	22	24	—	—
Calif.	—	—	N	N	N	N	1,148	1,141	24	54
Alaska	—	—	—	—	—	N	6	1	—	—
Hawaii	91	106	—	1	3	2	4	7	—	—
Guam	—	—	—	—	—	—	—	1	—	—
P.R.	N	N	N	N	—	N	179	137	8	5
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 November 5, 2005, and November 6, 2004 (44th 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	9,741	11,113	228	280	20,152	23,661	—	1,132	—
NEW ENGLAND	295	365	22	20	1,079	2,697	—	—	—
Maine	12	16	1	—	213	226	—	—	—
N.H.	6	13	—	—	255	—	—	—	—
Vt.	4	2	—	—	73	413	—	—	—
Mass.	197	210	13	14	538	530	—	—	—
R.I.	24	44	1	1	—	—	—	—	—
Conn.	52	80	7	5	U	1,528	—	—	—
MID. ATLANTIC	1,726	1,742	39	67	3,923	80	—	17	—
Upstate N.Y.	210	232	5	9	—	—	—	5	—
N.Y. City	849	871	15	27	—	—	—	2	—
N.J.	404	385	11	16	—	—	—	1	—
Pa.	263	254	8	15	3,923	80	—	9	—
E.N. CENTRAL	1,042	1,010	19	32	5,309	10,100	—	66	—
Ohio	211	168	2	6	1,224	1,209	—	11	—
Ind.	108	111	1	—	482	N	—	8	—
Ill.	488	454	6	15	68	5,031	—	29	—
Mich.	170	203	5	9	3,191	3,283	—	13	—
Wis.	65	74	5	2	344	577	—	5	—
W.N. CENTRAL	366	384	6	8	407	161	—	86	—
Minn.	158	148	5	4	—	—	—	13	—
Iowa	38	40	—	—	N	N	—	13	—
Mo.	80	97	—	2	295	5	—	27	—
N. Dak.	2	4	—	—	25	82	—	2	—
S. Dak.	11	8	—	—	87	74	—	6	—
Nebr.	28	27	—	2	—	—	—	7	—
Kans.	49	60	1	—	—	—	—	18	—
S. ATLANTIC	2,117	2,315	47	40	1,872	2,024	—	65	—
Del.	14	17	1	—	28	5	—	—	—
Md.	226	233	10	11	—	—	—	10	—
D.C.	42	72	—	—	34	21	—	1	—
Va.	252	231	17	8	471	481	—	4	—
W. Va.	21	18	—	—	916	1,149	—	—	N
N.C.	232	254	5	7	—	N	—	3	—
S.C.	187	156	—	—	423	368	—	—	—
Ga.	331	494	3	4	—	—	—	14	—
Fla.	812	840	11	10	—	—	—	33	—
E.S. CENTRAL	475	558	5	8	—	45	—	60	—
Ky.	87	96	2	3	N	N	—	1	—
Tenn.	224	197	—	5	—	—	—	13	—
Ala.	164	164	1	—	—	45	—	15	—
Miss.	—	101	2	—	—	—	—	31	—
W.S. CENTRAL	1,194	1,645	16	26	5,382	6,494	—	227	—
Ark.	91	100	—	—	11	—	—	15	—
La.	—	—	1	—	110	50	—	80	—
Okla.	123	143	1	1	—	—	—	16	—
Tex.	980	1,402	14	25	5,261	6,444	—	116	—
MOUNTAIN	321	437	9	7	2,180	2,060	—	322	—
Mont.	8	4	—	—	—	—	—	2	—
Idaho	—	3	—	—	—	—	—	1	—
Wyo.	—	4	—	—	52	40	—	2	—
Colo.	46	106	5	2	1,556	1,641	—	41	—
N. Mex.	14	24	—	—	149	U	—	31	—
Ariz.	196	179	2	2	—	—	—	214	—
Utah	26	33	1	1	423	379	—	6	—
Nev.	31	84	1	2	—	—	—	25	—
PACIFIC	2,205	2,657	65	72	—	—	—	289	—
Wash.	202	193	5	6	N	N	—	—	—
Oreg.	54	85	3	1	—	—	—	—	—
Calif.	1,812	2,249	45	59	—	—	—	289	—
Alaska	38	32	—	—	—	—	—	—	—
Hawaii	99	98	12	6	—	—	—	—	—
Guam	—	46	—	—	—	189	—	—	—
P.R.	—	98	—	—	540	352	—	—	—
V.I.	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	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 November 5, 2005 (44th 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	581	413	119	26	12	11	59	S. ATLANTIC	1,232	757	298	100	47	30	66		
Boston, Mass.	144	88	41	8	4	3	20	Atlanta, Ga.	146	85	35	19	5	2	1		
Bridgeport, Conn.	27	23	3	1	—	—	2	Baltimore, Md.	177	93	51	14	12	7	17		
Cambridge, Mass.	14	13	—	1	—	—	1	Charlotte, N.C.	105	71	21	11	2	—	7		
Fall River, Mass.	24	19	5	—	—	—	3	Jacksonville, Fla.	134	83	33	12	4	2	4		
Hartford, Conn.	71	53	11	4	1	2	4	Miami, Fla.	86	56	21	5	2	2	3		
Lowell, Mass.	17	15	1	—	1	—	2	Norfolk, Va.	51	34	13	1	1	2	4		
Lynn, Mass.	14	10	2	2	—	—	—	Richmond, Va.	57	34	15	4	2	2	5		
New Bedford, Mass.	30	21	8	—	—	1	5	Savannah, Ga.	52	35	10	4	3	—	4		
New Haven, Conn.	61	40	11	6	1	3	7	St. Petersburg, Fla.	73	41	16	5	2	9	1		
Providence, R.I.	47	37	6	—	2	2	1	Tampa, Fla.	239	152	62	13	8	4	17		
Somerville, Mass.	5	2	2	1	—	—	—	Washington, D.C.	100	64	19	11	6	—	2		
Springfield, Mass.	37	27	10	—	—	—	5	Wilmington, Del.	12	9	2	1	—	—	1		
Waterbury, Conn.	28	21	4	1	2	—	6	E.S. CENTRAL	718	420	186	59	30	23	44		
Worcester, Mass.	62	44	15	2	1	—	3	Birmingham, Ala.	130	73	31	9	9	8	7		
MID. ATLANTIC	2,162	1,524	444	126	41	27	124	Chattanooga, Tenn.	83	58	15	5	2	3	7		
Albany, N.Y.	40	25	11	3	1	—	2	Knoxville, Tenn.	74	51	16	2	3	2	2		
Allentown, Pa.	16	12	2	2	—	—	2	Lexington, Ky.	48	30	12	4	—	2	3		
Buffalo, N.Y.	80	49	23	7	1	—	7	Memphis, Tenn.	120	67	36	14	1	2	9		
Camden, N.J.	24	14	8	1	1	—	4	Mobile, Ala.	84	49	19	8	6	2	7		
Elizabeth, N.J.	10	7	3	—	—	—	—	Montgomery, Ala.	44	20	15	5	3	1	1		
Erie, Pa.	54	36	15	2	1	—	2	Nashville, Tenn.	135	72	42	12	6	3	8		
Jersey City, N.J.	40	28	7	3	2	—	—	W.S. CENTRAL	1,513	994	337	105	34	43	91		
New York City, N.Y.	1,092	764	226	58	26	18	48	Austin, Tex.	70	42	19	5	—	4	11		
Newark, N.J.	59	27	19	10	3	—	3	Baton Rouge, La.	47	33	12	1	1	—	1		
Paterson, N.J.	17	8	5	3	1	—	3	Corpus Christi, Tex.	45	36	5	2	2	—	2		
Philadelphia, Pa.	325	249	56	19	1	—	18	Dallas, Tex.	199	111	56	22	4	6	9		
Pittsburgh, Pa. [§]	27	18	5	2	—	2	—	El Paso, Tex.	81	60	16	3	2	—	7		
Reading, Pa.	31	21	6	2	1	1	3	Ft. Worth, Tex.	132	87	26	9	4	6	2		
Rochester, N.Y.	141	116	20	2	—	3	18	Houston, Tex.	409	258	96	31	12	12	37		
Schenectady, N.Y.	22	17	5	—	—	—	—	Little Rock, Ark.	83	58	15	3	2	5	—		
Scranton, Pa.	27	18	9	—	—	—	2	New Orleans, La. [¶]	U	U	U	U	U	U	U		
Syracuse, N.Y.	95	65	17	9	2	2	6	San Antonio, Tex.	228	164	40	20	1	3	11		
Trenton, N.J.	20	15	2	2	—	1	2	Shreveport, La.	100	63	24	4	4	5	11		
Utica, N.Y.	16	13	2	1	—	—	2	Tulsa, Okla.	119	82	28	5	2	2	—		
Yonkers, N.Y.	26	22	3	—	1	—	2	MOUNTAIN	1,080	721	224	85	29	20	65		
E.N. CENTRAL	2,007	1,322	431	148	53	51	134	Albuquerque, N.M.	119	79	22	15	2	1	5		
Akron, Ohio	28	18	5	2	2	1	—	Boise, Idaho	44	32	9	2	—	1	3		
Canton, Ohio	39	27	8	3	—	1	3	Colorado Springs, Colo.	73	57	10	5	—	1	6		
Chicago, Ill.	298	181	69	29	10	7	26	Denver, Colo.	83	49	17	7	8	2	5		
Cincinnati, Ohio	80	55	14	6	3	2	8	Las Vegas, Nev.	261	178	62	14	6	1	9		
Cleveland, Ohio	216	155	37	18	2	4	13	Ogden, Utah	28	21	3	2	2	—	4		
Columbus, Ohio	170	107	43	9	8	3	12	Phoenix, Ariz.	171	107	34	15	6	8	13		
Dayton, Ohio	103	79	14	6	3	1	15	Pueblo, Colo.	24	18	5	1	—	—	3		
Detroit, Mich.	166	82	50	22	5	7	10	Salt Lake City, Utah	120	77	22	11	4	6	9		
Evansville, Ind.	50	37	10	3	—	—	3	Tucson, Ariz.	157	103	40	13	1	—	8		
Fort Wayne, Ind.	79	53	18	4	1	3	5	PACIFIC	1,572	1,100	288	90	50	24	126		
Gary, Ind.	22	12	7	3	—	—	—	Berkeley, Calif.	20	10	7	1	1	1	—		
Grand Rapids, Mich.	61	45	8	3	1	4	9	Fresno, Calif.	130	92	20	10	6	—	14		
Indianapolis, Ind.	231	118	72	24	7	10	11	Glendale, Calif.	16	11	5	—	—	—	—		
Lansing, Mich.	50	33	14	1	1	1	2	Honolulu, Hawaii	165	128	28	1	4	4	7		
Milwaukee, Wis.	101	73	22	3	1	2	8	Long Beach, Calif.	60	40	14	6	—	—	6		
Peoria, Ill.	62	53	4	—	4	1	3	Los Angeles, Calif.	155	108	24	12	7	4	18		
Rockford, Ill.	56	40	8	5	1	2	2	Pasadena, Calif.	39	28	9	—	1	1	7		
South Bend, Ind.	66	53	8	3	2	—	1	Portland, Oreg.	108	81	18	5	1	3	6		
Toledo, Ohio	81	62	14	3	—	2	1	Sacramento, Calif.	174	122	28	15	8	1	10		
Youngstown, Ohio	48	39	6	1	2	—	2	San Diego, Calif.	160	114	29	14	2	1	14		
W.N. CENTRAL	632	394	155	37	26	20	32	San Francisco, Calif.	103	72	20	6	5	—	5		
Des Moines, Iowa	59	46	11	1	1	—	9	San Jose, Calif.	134	85	34	10	4	1	20		
Duluth, Minn.	31	18	11	1	—	—	—	Santa Cruz, Calif.	19	16	3	—	—	—	4		
Kansas City, Kans.	30	18	8	1	3	—	1	Seattle, Wash.	103	68	21	6	3	5	2		
Kansas City, Mo.	97	58	22	6	8	3	4	Spokane, Wash.	57	29	6	1	2	1	5		
Lincoln, Nebr.	39	27	7	2	2	1	1	Tacoma, Wash.	129	96	22	3	6	2	8		
Minneapolis, Minn.	55	28	22	1	3	1	2	TOTAL	11,497**	7,645	2,482	776	322	249	741		
Omaha, Nebr.	81	51	16	9	2	3	9										
St. Louis, Mo.	98	61	19	8	3	7	2										
St. Paul, Minn.	56	40	12	2	1	1	2										
Wichita, Kans.	86	47	27	6	3	3	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.

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

**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 material in the *MMWR* Series is in the public domain and may be used and reprinted without permission; citation as to source, however, is appreciated.

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.