MMWR™
Morbidity and Mortality Weekly Report
Weekly November 25, 2005 / Vol. 54 / No. 46

World AIDS Day — December 1, 2005

December 1 will mark the 18th observance of World AIDS Day. Begun in 1988, this annual worldwide event was established to increase awareness and education regarding human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS).

The 2005 World AIDS Day theme in the United States, "Action Makes a Difference," addresses the importance of prevention, testing, treatment, and care programs for persons at risk for or living with HIV/AIDS. At the end of 2003, more than 1 million persons were estimated to be living in the United States with HIV infection (*1*). Approximately one fourth of these persons were believed to be unaware of their infections underscoring the need for increased efforts to reach populations at-risk with HIV testing and prevention services. Recent data from 33 states indicate that HIV/AIDS diagnoses continue to disproportionately impact non-Hispanic blacks and men who have sex with men regardless of race (*2*).

Additional information about World AIDS Day is available at http://www.worldaidscampaign.info, and information regarding other U.S. HIV/AIDS observances is available at http://www.omhrc.gov/hivaidsobservances/index.html. Information on the AIDS pandemic is available from the Joint United Nations Program on AIDS at http://www.unaids.org.

References

1. Glynn M, Rhodes P. Estimated HIV prevalence in the United States at the end of 2003 [Abstract 595]. Presented at the 2005 National HIV Prevention Conference; Atlanta, GA; June 12–15, 2005.
2. CDC. Trends in HIV/AIDS diagnoses—33 states, 2001–2004. MMWR 2005;54:1149–53.

Screening HIV-Infected Persons for Tuberculosis — Cambodia, January 2004–February 2005

Worldwide, tuberculosis (TB) is one of the most common causes of death among persons infected with human immunodeficiency virus (HIV) (*1*). The World Health Organization recommends screening HIV-infected persons for TB disease after HIV diagnosis, before initiation of highly active antiretroviral therapy (HAART), and during routine follow-up care (*1*). In 2003, health officials in Banteay Meanchey Province, Cambodia, in conjunction with CDC and the U.S. Agency for International Development (USAID), began a pilot project to increase TB screening among persons with HIV infection. Subsequently, CDC analyzed and evaluated data from the first 14 months of the project. This report summarizes the results of that analysis, which determined that, during January 2004–February 2005, among persons with HIV infection at voluntary counseling and confidential testing (VCCT) clinics, 37% were screened for TB disease, and 24% of those screened had TB disease diagnosed. On the basis of these findings, the Provincial Health Department (PHD) took action to increase awareness of the risk for TB among HIV-infected persons. During the 3 months after these measures were implemented, the TB screening rate among

INSIDE

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

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

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

persons with HIV infection increased to 61%. Evaluation of projects like the one conducted in Banteay Meanchey Province can help develop an evidence-based approach for removing barriers to screening HIV-infected persons for TB.

In Cambodia, both the prevalence of HIV infection and incidence of TB disease are high. In 2003, HIV prevalence among antenatal clinic attendees was estimated at 2.2%, the highest reported for any country in Asia (*2*). The TB case rate in Cambodia is estimated at 508 per 100,000 persons, the highest in Asia and approximately 100 times the rate in the United States (*3*). In 2003, CDC and USAID assisted the Cambodia Ministry of Health in developing a pilot project to screen HIV-infected persons living in Banteay Meanchey Province for TB disease. Banteay Meanchey is a rural province in northwestern Cambodia (estimated 2004 population: 651,000) with an HIV prevalence in antenatal clinic attendees of 4.4%, twice that of Cambodia overall (*4*). In Banteay Meanchey, 25% of HIV-infected TB patients die during TB therapy, compared with 5% of TB patients without HIV (CDC, unpublished data, 2005).

HIV-infected persons in Cambodia are directed to TB clinics for screening. Eleven of 53 TB clinics, including the three largest in the province, and three of five VCCT clinics participate in the Banteay Meanchey TB/HIV project. Screening usually includes questions about TB symptoms, testing of sputum specimens by smear microscopy (using acid-fast–bacilli staining by the Ziehl-Neelsen method), and chest radiography (depending on availability). Additional activities performed as part of the project include referral of TB patients to VCCT clinics for HIV testing, standardized recording and follow-up of referrals, and monthly on-site monitoring and training of health-care workers by PHD staff. During February–March 2005, data on TB screening rates from the first 14 months of the project were analyzed. In addition, interviews were conducted with staff members from all 11 participating TB clinics, all six counselors from the three participating VCCT clinics, and both counselors from a VCCT clinic not participating in the project to evaluate possible barriers to TB screening. Both univariate and multivariate analyses were performed. Final model terms were selected using backward stepwise variable selection. Only variables that were statistically significant ($p<0.05$) remained in the final multivariate model.

During January 2004–February 2005, participating VCCT clinics tested 8,109 persons and determined that 1,228 (15%) were HIV-infected. Median age of those with HIV infection was 33 years (range: 1 year–72 years); 52% were female, and 75% were unskilled workers (e.g., laborers, farmers, fishermen, or sex workers). Of the 1,228 with HIV infection, 450 (37%) completed TB screening. By comparison, in the VCCT

clinic not participating in the TB/HIV project, only one (2%) of 65 persons with HIV infection in 2004 was screened for TB.

All 77 persons aged <18 years were excluded from the multivariate model because they were disproportionately single and unemployed. Multivariate regression analysis of characteristics of the remaining 1,151 persons identified factors independently associated with not being screened for TB, including age <35 years, semiskilled or skilled occupation (e.g., police officers, military personnel, health-care workers, and teachers), and reporting not feeling ill at the time of the visit to VCCT (Table).

Of the 450 HIV-infected persons who completed TB screening, TB disease was diagnosed in 107 (24%) persons. TB diagnosis was reported for all subgroups of patients who were screened, including those subgroups that were less likely to be screened, such as semiskilled or skilled workers (11 of 21 [52%]), and persons who did not report feeling ill when they visited the VCCT (57 of 261 [22%]). When interviewed about their practices, VCCT counselors suggested that persons with more education (i.e., semiskilled and skilled workers) were less likely to follow their recommendation to receive TB screening or were more likely to seek TB screening in the private sector.

In March 2005, assessment of preliminary findings from the project indicated that TB screening had increased among participating VCCTs compared with the nonparticipating VCCT; nonetheless, barriers to TB screening remained. PHD took three steps to improve TB screening. First, PHD developed a standardized, written script about TB disease for HIV counselors to read to persons with newly diagnosed HIV infection. The script explains that TB disease in HIV-infected persons is common, communicable, treatable, and occasionally asymptomatic, and that screening for TB disease is required as a precondition for HAART (which became available in Banteay Meanchey in January 2005). Second, PHD began meeting monthly with TB clinic and VCCT staff members to review project data, discuss barriers to screening, and provide ongoing education about TB and HIV infection. Third, PHD began surveying persons with newly diagnosed HIV infection at VCCT sites to assess their knowledge of TB and attitudes toward the disease.

In August 2005, the impact of these interventions was assessed. During April–June 2005, a total of 267 persons had HIV infection diagnosed at the three participating VCCT sites, and 163 (61%) completed TB screening, compared with 37% who were screened before the interventions (p<0.01). Of the 163 persons completing TB screening, 37 (23%) had TB diagnosed. VCCT staff members reported that the largest remaining barrier to TB screening was limited availability of TB services. HIV-infected patients were either directed to or escorted to a TB clinic. However, the clinic was not always staffed when patients arrived. To be screened for TB in the province, persons must see a TB physician, provide sputum specimens to the laboratory, and have a chest radiograph performed. These services are usually available only for 2–3 hours per day, 3–5 days per week.

TABLE. Number and percentage of patients not screened for tuberculosis disease after a diagnosis of human immunodeficiency virus (HIV) infection, by selected characteristics — Cambodia, January 2004–February 2005

Characteristic	No.* (%)	Univariate relative risk (95% CI†)	Multivariate adjusted odds ratio§ (95% CI)
Age (yrs)			
<35	400/610 (66)	Referent	Referent
≥35	314/541 (58)	0.7 (0.6–0.9)	0.8 (0.6–1.0)
Sex			
Male	341/540 (63)	1.0 (0.9–1.1)	NS¶
Female	373/611 (61)	Referent	NS
Marital status			
Single	96/141 (68)	Referent	NS
Married	403/660 (61)	0.6 (0.4–0.8)	NS
Widowed	211/346 (61)	0.6 (0.4–0.8)	NS
Occupation**			
Unskilled	551/914 (60)	Referent	Referent
Semiskilled or skilled	66/87 (76)	2.1 (1.2–3.4)	2.1 (1.2–3.5)
Others	95/140 (68)	1.3 (0.9–1.9)	1.4 (1.0–2.1)
Reason for visit to VCCT††			
Patient feels ill	181/368 (49)	Referent	Referent
Patient does not feel ill	533/783 (68)	1.6 (1.4–1.8)	2.1 (1.6–2.7)

* N = 1,151. Seventy-seven persons aged <18 years were excluded because they were disproportionately single and unemployed.
† Confidence interval.
§ Final model terms were selected using backward stepwise variable selection. Only variables that were statistically significant (p<0.05) remained in the final multivariate model.
¶ Characteristic not selected in final multivariate model.
** Recorded as an open text variable, then reclassified as unskilled (e.g., laborers, farmers, fishermen, and sex workers), semiskilled or skilled (e.g., police officers, military personnel, health-care workers, and teachers), or others (e.g., unemployed persons and homemakers).
†† Reasons why persons visited voluntary counseling and confidential testing clinics were recorded as categorical variables (e.g., premarital testing or pregnancy). For analysis, patients reporting symptoms were classified as "patient feels ill" and all other responses as "patient does not feel ill."

Reported by: *C Vannarith, MD, Provincial Health Dept, Banteay Meanchey Province; N Kanara, MD, M Qualls, MPH, CDC Global AIDS Project, Phnom Penh, Cambodia. J Varma, MD, K Laserson, ScD, C Wells, MD, Div of Tuberculosis Elimination, National Center for HIV, STD, and TB Prevention; K Cain, MD, EIS Officer, CDC.*

Editorial Note: In Southeast Asia, the mortality rate among HIV-infected TB patients is 25%–40%, a rate 5–10 times higher than that among TB patients not infected with HIV (*5*). Most of these deaths occur within the first 2 months after TB diagnosis; the high early mortality rate might result from delayed diagnosis of TB. Screening HIV-infected persons can help identify those with TB disease earlier, potentially improving their likelihood of survival. Because HAART reduces mortality in HIV-infected TB patients, screening HIV-infected persons for TB disease might also identify a subset of patients who should be prioritized for enrollment in HAART programs (*6*).

Actively identifying and treating TB disease in persons with HIV infection also can help control communitywide TB transmission. In countries with epidemics of both TB and HIV, finding and treating patients with active TB disease was determined to be more effective in controlling TB over a 10-year period than treating persons with latent TB infection or scaling up HAART to prevent development of TB disease (*7*). Unlike the other two measures, active TB case finding directly reduces the number of infectious persons, who are those most likely to transmit TB to HIV-infected persons (*7*).

In areas where HIV and TB programs traditionally have been separate, integrating TB screening into HIV services is challenging because 1) multiple visits are required by a patient to provide a sputum specimen and receive a chest radiograph, 2) separate clinics are operated for TB screening and HIV care, 3) and operating hours for both TB and HIV services are limited. Integration of TB and HIV services might increase TB screening rates. Depending on the structure of the health system, different models might be implemented, including having TB staff members work directly in HIV clinics or training HIV clinical workers to perform TB screening. Knowledge and attitudes of health-care workers and patients might be another barrier to TB screening. In this evaluation, specific categories of HIV-infected patients (e.g., those with semiskilled and skilled occupations) were less likely to be screened for TB, possibly because health-care workers or the patients themselves believed they were not at risk for TB. However, those subgroups less likely to be screened were actually at considerable risk for TB, with TB disease rates ranging from 8% to 52%. Further research into knowledge and attitudes of patients and health-care workers might identify additional strategies for increasing TB screening rates.

The findings in this report are subject to at least three limitations. First, the study was retrospective and relied only on existing data regarding risk factors for not being screened for TB; other potential risk factors could not be assessed. Second, factors outside of the project (e.g., scale-up of HAART programs in the province) might have contributed to the increase in TB screening rates and could not be controlled for in the results. Finally, the follow-up evaluation period was relatively short in duration; whether the increased screening rates will continue is unknown.

In resource-limited countries, commonly employed diagnostic methods (e.g., sputum smear microscopy or chest radiography) for TB disease fail to identify many HIV-infected patients with TB disease (*8*). In the Cambodian population described in this report, rates of TB disease in HIV-infected persons might have been considerably higher if more sensitive techniques, such as sputum culture, had been employed (*9*). Because mycobacterial culture often is not feasible in resource-limited countries, new diagnostic methods for TB disease are needed and more research is needed to develop evidence-based clinical algorithms for TB screening of persons with HIV infection (*10*). In addition, CDC and USAID are collaborating with local and international partners in countries around the world to implement and improve upon TB/HIV projects similar to the one described in this report.

References

1. World Health Organization. Interim policy on collaborative TB/HIV activities. Geneva, Switzerland: World Health Organization; 2004. Available at http://whqlibdoc.who.int/hq/2004/who_htm_tb_2004.330.pdf.
2. Cambodia National Center for HIV/AIDS, Dermatology, and STDs. HIV sentinel surveillance 2003: results, trends, and estimates. Presented at dissemination meeting, Phnom Penh, Cambodia; December 3, 2004.
3. World Health Organization. Global tuberculosis control: surveillance, planning, financing. WHO report 2005. Geneva, Switzerland: World Health Organization; 2005.
4. Joint United Nations Programme on HIV/AIDS, World Health Organization. UNAIDS/WHO epidemiological fact sheets on HIV/AIDS and sexually transmitted infections, 2004 update. Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS, World Health Organization; 2004. Available at http://www.unaids.org/html/pub/publications/fact-sheets01/cambodia_en_pdf.pdf.
5. World Health Organization. Proceedings of the WHO HIV/TB conference for the Mekong Sub-region, Ho Chi Minh City, Viet Nam, October 10–14, 2005. Available at http://www.un.org.vn/who/docs/mekonghivtb/proceedings.pdf.
6. Dheda K, Lampe FC, Johnson MA, Lipman MC. Outcome of HIV-associated tuberculosis in the era of highly active antiretroviral therapy. J Infect Dis 2004;190:1670–6.
7. Currie CS, Williams BG, Cheng RC, Dye C. Tuberculosis epidemics driven by HIV: is prevention better than cure? AIDS 2003;17:2501–8.
8. Perkins MD, Kritski AL. Diagnostic testing in the control of tuberculosis. Bull World Health Organ 2002;80:512–3.
9. Kimerling ME, Schuchter J, Chanthol E, et al. Prevalence of pulmonary tuberculosis among HIV-infected persons in a home care program in Phnom Penh, Cambodia. Int J Tuberc Lung Dis 2002;6:988–94.
10. Siddiqi K, Lambert ML, Walley J. Clinical diagnosis of smear-negative pulmonary tuberculosis in low-income countries: the current evidence. Lancet Infect Dis 2003;3:288–96.

Dental Visits Among Dentate Adults with Diabetes — United States, 1999 and 2004

One of the major complications of diabetes is periodontal disease (*1*), a chronic infection of tissues supporting the teeth and a major cause of tooth loss. Adults with diabetes have both a higher prevalence of periodontal disease and more severe forms of the disease (*2*), contributing to impaired quality of life and substantial oral functional disability (*3*). In addition, periodontal disease has been associated with development of glucose intolerance and poor glycemic control among adults with diabetes (*4,5*). Regular dental visits provide opportunities for prevention, early detection, and treatment of periodontal disease among dentate adults (i.e., those having one or more teeth); moreover, regular dental cleaning improves glycemic control in patients with poorly controlled diabetic conditions (*6,7*). One of the national health objectives for 2010 is to increase the proportion of persons with diabetes who have an annual dental examination to 71% (revised objective 5-15) (*8*). To estimate the percentage of dentate U.S. adults aged ≥18 years with diabetes who visited a dentist within the preceding 12 months, CDC analyzed data from the Behavioral Risk Factor Surveillance System (BRFSS) surveys for 1999 and 2004. This report describes the results of that analysis, which indicated that, in 2004, age-adjusted estimates in only seven states exceeded 71% and estimated percentages for four states and District of Columbia (DC) increased significantly from their levels in 1999. The findings underscore the need to increase awareness and support for oral health care among adults with diabetes, including support for national and state diabetes care management programs.

BRFSS uses state-based telephone surveys to collect data about major health-risk behaviors, use of preventive health practices, and access to health care among a representative sample of noninstitutionalized adults aged ≥18 years in the 50 states, DC, Guam, Puerto Rico, and the U.S. Virgin Islands. In 1999, three oral health questions were included for the first time in the BRFSS rotating core questionnaire and asked of all survey participants, and two of these questions were used in this analysis: 1) "How long has it been since you last visited a dentist or a dental clinic for any reason?" and 2) "How many of your permanent teeth have been removed because of tooth decay or gum disease?" These questions were last included in the 2004 BRFSS survey. Persons with diabetes were defined as respondents who answered "yes" to the core question, "Has a doctor ever told you that you have diabetes?" Because BRFSS data are state-specific, median annual prevalences are reported instead of national averages. The median response rate in 2004 across 49 states and DC was 52.7% (range: 32.2% [New Jersey]–66.6% [Nebraska]); 25,736 respondents for whom age data were available reported having been told by a doctor they had diabetes (excluding women told so only during pregnancy). Of these, 82% were dentate. Approximately 0.01% of the survey participants provided no information on the dental visit question. All estimates were age-adjusted to the 2000 U.S. adult population. Differences in estimates were considered statistically significant if their 95% confidence intervals (CIs) did not overlap.

In 2004, among states/areas, the median estimated age-adjusted percentage of dentate adults with diabetes who had a dental visit during the preceding 12 months was 67% (range: 49.1%–83.3%). The estimated percentage, including the lower confidence limit, was ≥71% in seven states: Kansas, Minnesota, Nebraska, Pennsylvania, Rhode Island, Utah, and Wisconsin (Table 1). The lowest percentages were in Arkansas, Florida, Georgia, Louisiana, Mississippi, New York, South Carolina, Texas, West Virginia, and Wyoming. The estimated percentage increased significantly from 1999 to 2004 in Arizona, Kansas, Minnesota, Ohio, and DC, but decreased significantly in North Carolina. The lowest estimated percentage in any one state/area increased from 37% in 1999 (DC) to 49.1% in 2004 (Mississippi).

The age-adjusted estimated prevalence was significantly associated with race/ethnicity, education level, income level, smoking status, health insurance status, and having taken a course in diabetes management (Table 2). Estimated percentages were lower among non-Hispanic blacks, persons with lower education and income, those who lacked health insurance, and those who had never taken a course or class in how to manage their diabetes.

Reported by: *PI Eke, PhD, GO Thornton-Evans, DDS, Div of Oral Health; GL Beckles, MD, Div of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

Editorial Note: One of the revised national health objectives for 2010 is to increase the proportion of adults with diabetes who have an annual dental examination to at least 71% (objective 5-15). The results of this study indicate that only seven states had reached this objective as of 2004. Further research is needed to identify real or perceived barriers that might underlie the lower estimated percentage among dentate adults with diabetes in the other states.

The results also indicate that attendance at classes to manage diabetes was associated with having had a dental visit during the preceding 12 months among dentate adults with diabetes. Lack of health insurance was significantly associated with not having had a dental visit. The National Diabetes Education Program (NDEP) recommends that persons with

TABLE 1. Age-adjusted estimates* of the percentage of dentate adults with diabetes who had a dental visit during the preceding 12 months, by state/area — Behavioral Risk Factor Surveillance System, United States, 1999 and 2004

State/Area	2004 %	2004 (95% CI†)	1999 %	1999 (95% CI)	Difference in estimates§	% change in estimates¶
Alabama	64.1	(54.6–73.5)	51.3	(41.7–60.9)	12.8	24.9
Alaska	63.7	(52.9–74.5)	75.1	(61.6–81.6)	-11.4	-15.2
Arizona	64.4	(54.2–74.6)	42.5	(32.9–52.1)	21.9	51.5
Arkansas	59.2	(50.0–68.4)	45.9	(37.1–54.7)	13.3	28.9
California	65.6	(57.4–73.8)	66.5	(57.5–75.5)	-0.9	-1.4
Colorado	72.6	(66.5–78.7)	73.1	(62.5–83.7)	-0.5	-0.7
Connecticut	75.5	(67.7–83.3)	82.6	(72.6–92.6)	-7.1	-8.6
Delaware	75.9	(67.5–84.3)	65.0	(53.0–77.0)	10.9	16.7
District of Columbia	71.3	(58.6–84.0)	37.0**	(23.5–50.5)	34.3	92.7
Florida	53.5	(44.1–62.9)	56.9	(49.1–64.7)	-3.4	-5.9
Georgia	56.6	(46.4–66.8)	65.2	(54.2–76.2)	-8.6	-13.2
Hawaii††	—	—	63.7	(47.8–79.6)	—	—
Idaho	67.0	(59.6–74.4)	65.3	(54.7–75.9)	1.7	2.6
Illinois	61.7	(47.8–75.6)	73.6	(61.3–85.9)	-11.9	-16.1
Indiana	67.5	(60.8–74.1)	74.6	(62.3–86.9)	-7.1	-9.5
Iowa	70.9	(60.9–80.9)	65.5	(54.9–76.1)	5.4	8.2
Kansas	78.7	(74.6–82.8)	58.5	(52.4–64.6)	20.2	34.5
Kentucky	71.5	(65.4–77.6)	60.5	(51.9–69.1)	11.0	18.1
Louisiana	56.1	(47.9–64.3)	56.9	(43.2–70.6)	-0.8	-1.4
Maine	59.3	(51.7–66.9)	64.3	(53.1–75.5)	-5.0	-7.8
Maryland	75.0	(66.0–84.0)	70.6	(60.2–81.0)	4.4	6.2
Massachusetts	74.9	(66.1–83.7)	71.2	(60.6–81.8)	3.7	5.2
Michigan	72.1	(60.9–83.3)	73.4	(64.6–82.2)	-1.3	-1.7
Minnesota	83.3	(76.4–90.2)	54.9	(47.6–62.2)	28.4	51.7
Mississippi	49.1	(41.7–56.5)	53.0	(41.2–64.8)	-3.9	-7.4
Missouri	61.4	(53.8–69.0)	61.0	(49.6–72.4)	0.4	0.7
Montana	69.0	(57.2–80.8)	61.8	(48.5–75.1)	7.2	11.6
Nebraska	79.7	(74.6–84.8)	81.3	(71.3–91.3)	-1.6	-1.9
Nevada	76.7	(69.3–84.1)	70.2	(59.8–80.6)	6.5	9.2
New Hampshire	67.6	(59.6–75.6)	70.9**	(58.6–83.2)	-3.3	-4.6
New Jersey	74.3	(69.0–79.6)	71.0	(58.3–83.7)	3.3	4.6
New Mexico	73.9	(68.0–79.8)	71.3	(63.1–79.5)	2.6	3.6
New York	53.5	(41.7–65.3)	68.6	(56.3–80.9)	-15.1	-22.0
North Carolina	64.7	(58.8–70.6)	82.1	(76.0–88.2)	-17.4	-21.1
North Dakota	72.3	(62.5–82.1)	76.3	(64.0–88.6)	-4.0	-5.2
Ohio	73.6	(65.4–81.8)	45.6	(31.7–59.5)	28.0	61.4
Oklahoma	62.0	(52.4–71.6)	53.6	(41.8–65.4)	8.4	15.6
Oregon	73.2	(64.2–82.2)	67.0	(55.8–78.2)	6.2	9.2
Pennsylvania	78.9	(73.4–84.4)	72.9	(63.7–82.1)	6.0	8.2
Rhode Island	78.8	(71.5–86.1)	78.0	(69.4–86.6)	0.8	1.0
South Carolina	57.5	(46.9–68.1)	58.9	(49.9–67.9)	-1.4	-2.4
South Dakota	63.9	(54.5–73.3)	71.2	(61.0–81.4)	-7.3	-10.3
Tennessee	64.4	(55.6–73.2)	61.7	(52.3–71.1)	2.7	4.4
Texas	50.0	(41.6–58.4)	65.2	(56.8–73.6)	-15.2	-23.3
Utah	81.3	(75.8–86.8)	71.1	(58.8–83.4)	10.2	14.3
Vermont	63.0	(53.6–72.4)	69.7	(56.2–83.2)	-6.7	-9.6
Virginia	70.4	(62.0–78.8)	66.4	(59.5–73.3)	4.0	6.0
Washington	64.8	(59.3–70.3)	59.9	(48.7–71.1)	4.9	8.1
West Virginia	59.6	(49.0–70.2)	58.4	(42.7–74.1)	1.2	2.1
Wisconsin	79.6	(71.0–88.2)	70.4	(61.8–79.0)	9.2	13.0
Wyoming	56.7	(46.7–66.7)	68.5	(58.7–78.3)	-11.8	-17.2
Puerto Rico	59.3	(50.3–68.3)	63.8	(54.2–73.4)	-4.5	-7.0
U.S. Virgin Islands††	66.1	(56.3–75.9)	—	—	—	—
Median§§	**67.3**	**(49.1–83.3)**	**65.9**	**(37.0–82.6)**	**0.9**	**1.4**

* Estimates are age-adjusted to the 2000 U.S. standard adult population.
† Confidence interval.
§ Change in estimated percentage from 1999 to 2004.
¶ Change is estimated percentage divided by percentage in 1999.
** Because cell size is <50, data should be interpreted with caution.
†† No 2004 data were collected for Hawaii; no 1999 data were collected for the U.S. Virgin Islands.
§§ Median and range for all states/areas.

diabetes receive oral health management education, including instructions in oral self-care and oral self-examination. NDEP emphasizes that adults, even those without teeth, should receive at least one dental examination per year (*9*). In the general population, lack of health insurance, particularly dental insurance, is associated with less use of dental services and poorer oral health (*10*). Because dental insurance coverage typically is provided as an employee benefit, persons who are unemployed are less likely to have dental insurance. In addition, this report indicates that current smokers were less likely to have had a dental visit during the preceding 12 months than nonsmokers. Smoking is known to be strongly associated with periodontal disease (*3*). Measures that public health organizations can implement to increase the frequency of dental visits among persons with diabetes include 1) increasing public and professional awareness of diabetes as a risk factor for several oral conditions, 2) monitoring the oral health of persons with diabetes, 3) increasing access to dental care by providing dental coverage for adults with diabetes, 4) expanding partnerships between organizations focused on oral health and diabetes care (e.g., the American Dental Association and the American Diabetes Association), and 5) supporting tobacco-use cessation programs targeting persons with diabetes.

The findings in this report are subject to at least four limitations. First, because the BRFSS sample was drawn from a noninstitutionalized population, it excludes adults not residing in households (e.g., those in nursing homes or long-term–care facilities). Second, because the survey was conducted by telephone, it excludes persons without residential telephone service (e.g., those with lower incomes

TABLE 2. Age-adjusted estimates* of the percentage of dentate adults with diabetes who had a dental visit during the preceding 12 months, by selected characteristics — Behavioral Risk Factor Surveillance System, United States, 2004

Characteristic	%	(95% CI†)
Age group (yrs)		
18–44	62.7	(58.4–67.0)
45–64	65.7	(63.6–67.7)
65–74	67.3	(64.1–70.5)
≥75	70.6	(67.3–73.8)
Race/Ethnicity		
White, non-Hispanic	70.9	(68.6–73.2)
Black, non-Hispanic	53.4	(48.3–58.3)
Other, non-Hispanic	70.1	(60.9–79.2)
Multiracial, non-Hispanic	50.9	(37.6–64.2)
Hispanic	55.1	(48.4–61.8)
Education		
Less than high school	48.6	(41.9–55.2)
High school	63.3	(59.8–66.8)
More than high school	71.0	(67.9–74.9)
Annual household income		
<$10,000	43.8	(37.4–50.2)
$10,000–$14,999	58.4	(50.7–66.1)
$15,000–$19,999	55.7	(49.7–61.6)
$20,000–$24,999	64.2	(58.9–69.5)
$25,000–$34,999	69.6	(64.9–74.2)
$35,000–$49,999	73.1	(68.6–77.6)
$50,000–$74,999	73.0	(67.1–78.8)
≥$75,000	78.7	(71.8–85.6)
Health insurance coverage		
Yes	68.1	(65.5–70.7)
No	49.4	(43.6–55.3)
Class to manage diabetes§		
Yes	67.1	(63.7–70.4)
No	60.2	(56.2–64.2)
Smoking		
Yes (every day)	58.2	(53.1–63.3)
Yes (some days)	55.8	(48.1–63.5)
Former	64.0	(57.0–70.9)
Never	66.9	(63.8–69.9)
No. of teeth lost		
None	67.9	(64.8–70.9)
1–5	66.3	(61.5–71.0)
>5 but not all	59.8	(51.0–68.5)

* Estimates are age-adjusted to the 2000 U.S. standard adult population.
† Confidence interval.
§ Determined by response to the question, "Have you ever taken a course or class in how to manage your diabetes yourself?"

and those residing in households that use cellular telephones only). Third, the accuracy of survey participants' self-report of their dental visit was not validated against dental records, and their responses might be subject to recall bias or the tendency to give socially desirable responses during interviews. Finally, the sample size for some states/areas (e.g., DC) was small (i.e., <50) in 1999; thus, these estimates should be interpreted with caution.

Overall, in most states/areas, estimates for dental visits during the preceding 12 months among adult with diabetes 1) have not reached the targets set by the national health objectives for 2010 or 2) have not increased from estimates in 1999. These trends underscore the need to increase awareness of the importance of oral health in diabetes care management at the state and national levels. Diabetes education programs in states should emphasize personal and professional preventive dental care for all persons with diabetes, with emphasis on non-Hispanic blacks, persons with lower education and income, and those who lack health insurance.

References

1. Loe H. Periodontal disease—the sixth complication of diabetes mellitus. Diabetes Care 1993;16(Suppl 1):329–34.
2. Tomar SL, Lester A. Dental and other health care visits among U.S. adults with diabetes. Diabetes Care 2000;23:1505–10.
3. US Department of Health and Human Services. Oral health in America: a report of the Surgeon General. Rockville, MD: US National Institute of Dental and Craniofacial Research, National Institutes of Health; 2000.
4. Saito T, Shimazaki Y, Kiyohara Y, et al. The severity of periodontal disease is associated with the development of glucose intolerance in non-diabetics: the Hisayama Study. J Dent Res 2004;83:485–90.
5. Taylor G. Periodontal treatment and its effects on glycemic control, 1999. Oral Surg Oral Med Oral Pathol 1999;87:311–6.
6. Committee on Research, Science, and Therapy, American Academy of Periodontology. Diabetes and periodontal disease. J Periodontol 2000;71:664–78.
7. Grossi SG, Skrepcinski FB, DeCaro T, et al. Treatment of periodontal disease in diabetics reduces glycated hemoglobin. J Periodontol 1999;68:713–9.
8. US Department of Health and Human Services. Healthy people 2010—midcourse review. Washington, DC: US Department of Health and Human Services; 2005. Available at www.healthypeople.gov/data/midcourse.
9. National Diabetes Education Program. Working together to manage diabetes: a guide for pharmacists, podiatrists, optometrists, and dental professionals. Bethesda, MD: US Department of Health and Human Services, National Institutes of Health; 2004. Available at http://www.ndep.nih.gov/diabetes/pubs/catalog.htm.
10. Damiano PC, Shugars DA, Johnson JD. Expanding health insurance coverage and the implications for dentistry. J Public Health Dent 1992;52:52–8.

Mobility Limitation Among Persons Aged ≥40 Years With and Without Diagnosed Diabetes and Lower Extremity Disease — United States, 1999–2002

Diabetes increases the risk for mobility limitation, especially among older persons (*1,2*). Lower extremity disease (LED), which includes peripheral arterial disease (PAD) and peripheral neuropathy (PN), also increases the risk for mobility limitation (*3,4*). To assess the prevalence of mobility limitation among persons with diagnosed diabetes, persons with LED, and persons with both or neither condition, CDC analyzed data from the National Health and Nutrition Examination

Survey (NHANES) 1999–2002 for adults aged ≥40 years. This report summarizes the preliminary findings, which indicated that the national prevalence of mobility limitation is higher among persons with either diagnosed diabetes or LED than those without the conditions, and that adults with both conditions have a higher prevalence of mobility limitation than those with either condition alone. Monitoring the prevalence of diabetes, LED, and associated risk factors and identifying effective LED prevention strategies will help reduce the burden of mobility limitation in the United States.

NHANES is an ongoing, cross-sectional survey of representative samples of the U.S. civilian noninstitutionalized population. The survey uses a complex multistage probability design. Data are collected through in-person interviews and medical examinations. During 1999–2002, NHANES participants were asked, "Other than during pregnancy, have you ever been told by a doctor or health professional that you have diabetes or sugar diabetes?" Participants who answered "yes" to this question were classified as having diagnosed diabetes; if the answer was "no" or "borderline," participants were classified as not having diagnosed diabetes. LED was defined as the presence of either PAD (ankle/brachial blood pressure ratio <0.9), PN (one or more insensate areas, on the basis of monofilament testing of foot sensation), self-report of foot/leg ulcers, or technician-observed toe or foot lesion or amputation. Further details of these measures have been described previously (*5*). Mobility limitation was determined on the basis of participants' response to the questions, "How much difficulty do you have walking for a quarter of a mile; walking up 10 steps without resting; and walking from one room to another on the same level?" Participants who responded "some difficulty," "much difficulty," or "unable to do" to one or more of the three questions were classified as having mobility limitation; participants who responded "no difficulty" to all three questions were classified as having no mobility limitation. Prevalence of mobility limitation was calculated for adults with and without diagnosed diabetes and LED by age and sex for participants aged ≥40 years who had complete data in the interview and examination variables of interest (n = 4,689); of the 6,059 persons aged ≥40 years who received the health examination, 1,370 (23%) were excluded from the analysis because of missing data. All reported percentages and 95% confidence intervals (CIs) were estimated using examination weights and taking into account the complex sampling design. Data were age-adjusted to the 2000 U.S. standard population using the age groups 40–59 years, 60–74 years, and ≥75 years. Logistic regression analysis was used to assess the association of diabetes status and LED status with mobility limitation, including whether an interaction existed between diabetes status and LED status in their associations with mobility limitation, after adjusting for demographic characteristics.

The age-adjusted prevalence of mobility limitation among adults with diagnosed diabetes was greater than for those without diagnosed diabetes overall (27% and 16%, respectively) and in each age and sex group. The age-adjusted prevalence of mobility limitation among those with LED was also greater than for those without LED overall (26% and 15%, respectively) and in each age and sex group (Table).

Overall, adults with diagnosed diabetes but without LED had a similar prevalence of mobility limitation as adults with LED but without diagnosed diabetes (23% and 25%, respectively). Those with diagnosed diabetes and LED had a prevalence of mobility limitation greater than those with either condition alone and almost three times greater than those with neither condition (39% and 14%, respectively).

In a logistic regression model that included both diagnosed diabetes and LED, after data were adjusted for age, sex, and race/ethnicity, the odds of mobility limitation were greater for adults with diagnosed diabetes (odds ratio [OR] = 2.0; CI = 1.4–3.0) than adults without diagnosed diabetes; the

TABLE. Prevalence of mobility limitation among adults aged ≥40 years with and without diagnosed diabetes and lower extremity disease (LED), by age group, sex, and disease status — National Health and Nutrition Examination Survey, United States, 1999–2002

	Overall*		Age group (yrs)				Sex*			
			40–59		≥60		Men		Women	
Disease status	%	(95% CI†)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Diagnosed diabetes	27.2	(21.0–33.4)	17.2	(9.6–24.8)	41.0	(33.5–48.4)	21.7	(15.8–27.5)	34.2	(24.9–43.5)
No diagnosed diabetes	15.9	(14.4–17.4)	7.1	(5.7–8.6)	29.1	(26.4–31.9)	12.2	(10.7–13.7)	19.1	(17.7–21.0)
LED	26.4	(22.8–29.9)	17.1	(12.3–21.9)	41.5	(36.4–46.7)	21.0	(16.8–25.1)	33.8	(28.2–39.4)
No LED	14.5	(13.0–15.9)	6.5	(5.0–8.0)	26.1	(23.9–28.4)	10.1	(8.6–11.6)	17.8	(15.8–19.8)
Diagnosed diabetes with LED§	38.8	(29.4–48.2)	29.6	(14.7–44.5)	51.5	(40.3–62.8)	32.0	(19.3–44.8)	51.8	(35.2–68.3)
Diagnosed diabetes without LED§	22.6	(14.7–30.4)	13.8	(5.2–22.5)	34.8	(25.8–43.7)	15.5	(8.2–22.7)	28.9	(17.3–40.4)
LED without diagnosed diabetes §	24.7	(20.9–28.4)	15.6	(10.5–20.7)	39.6	(34.6–44.7)	19.5	(15.5–23.4)	31.5	(25.6–37.4)
No diagnosed diabetes, no LED§	13.8	(12.2–15.3)	6.0	(4.6–7.5)	25.0	(22.3–27.7)	9.6	(8.1–11.2)	16.9	(14.9–18.9)

* Overall and sex-specific estimates are age-adjusted to the 2000 U.S. standard population using age groups 40–59 years, 60–74 years, and ≥75 years.
† Confidence interval.
§ Sample sizes were as follows: diagnosed diabetes with LED: n = 181; diagnosed diabetes without LED: n = 368; LED without diagnosed diabetes: n = 859; no diagnosed diabetes and no LED: n = 3,281.

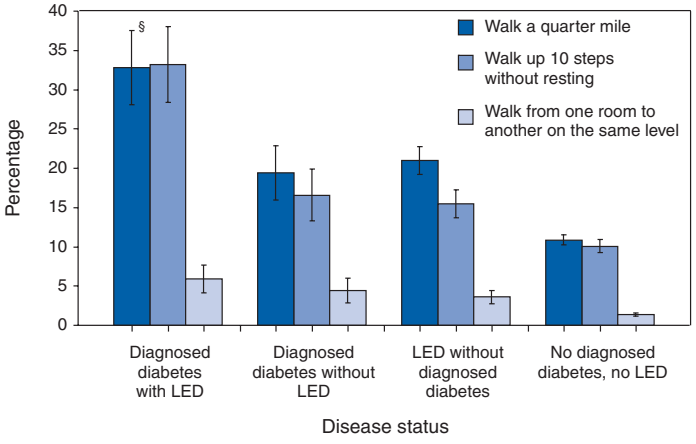
odds of mobility limitation were also increased among adults with LED (OR = 2.3; CI = 1.7–2.9) compared with adults without LED. No statistically significant interaction between diabetes status and LED status existed (i.e., the relative odds of mobility limitation for persons with diagnosed diabetes or LED were additive overall and not modified by the presence of both conditions).

Among persons with mobility limitation, the most frequently reported mobility limitations were related to walking a quarter mile and walking up 10 steps without resting (Figure). Among those who had both diagnosed diabetes and LED, 33% reported difficulty walking a quarter of a mile and difficulty walking up 10 steps; 6% reported having difficulty walking from one room to another on the same level, which is the most severe form of mobility limitation analyzed.

Reported by: *MS Eberhardt, PhD, S Saydah, PhD, R Paulose-Ram, PhD, National Center for Health Statistics; M Tao, PhD, EIS Officer, CDC.*

Editorial Note: Diabetes has long been identified as one of the major factors associated with mobility limitation (*6,7*). The findings in this report suggest a statistically significantly higher prevalence of mobility limitation among adults aged ≥40 years who had diagnosed diabetes compared with those without diagnosed diabetes. The cross-sectional design of NHANES does not permit an investigation into the causal pathway for mobility limitation; however, research has indicated that PN and PAD, as well as other diabetic complications (e.g., vision loss) or comorbidities (e.g., obesity, cardiovascular disease, or arthritis), are predictors of mobility limitation among persons with type 2 diabetes (*2*). Studies have also demonstrated that LED has an independent effect on mobility among older persons (*3,4*). Consistent with previous findings, this report indicates substantially higher percentages of mobility limitation among adults aged ≥40 years with LED but without diabetes, compared with those with neither condition.

FIGURE. Prevalence of mobility limitation* among adults aged ≥40 years with or without diagnosed diabetes and lower extremity disease (LED), by disease status and type of limitation — National Health and Nutrition Examination Survey, United States, 1999–2002†



* Estimates are age-adjusted to the 2000 U.S. standard population using age groups 40–59 years, 60–74 years, and ≥75 years.
† Participants who reported having some difficulty doing, much difficulty doing, or who were unable to perform a certain activity were classified as having mobility limitation.
§ 95% confidence interval.

In this sample of the noninstitutionalized U.S. population, only a small percentage (6%) of those with diagnosed diabetes and LED reported difficulty moving from one room to another on the same level, which can impair a person's ability to perform activities of daily living. A larger percentage reported impaired ability to walk a quarter mile or climb 10 steps without resting. Such physical limitations can affect a person's ability to live independently or participate in community life and might decrease well being.

The findings in this report are subject to at least three limitations. First, NHANES does not include institutionalized persons, such as those in long-term–care facilities, a population less healthy and more likely to have functional limitations. Second, the sample size was not sufficiently large to analyze additional factors related to mobility limitations (e.g., comorbidities) through bivariate analysis. Finally, among the 6,059 persons aged ≥40 years who received the health examination, 1,370 (23%) were excluded from the analysis because of missing data; because persons with missing data were older and more likely to have diagnosed diabetes, the prevalence of mobility limitation is probably underestimated.

As the U.S. population ages and the prevalence of diabetes increases, LED and its health consequences, including chronic ulcers in feet or legs, amputations, and mobility limitations, will become increasing public health concerns. Proper foot care is one example of preventive care that might help reduce the prevalence of LED and mobility limitations. CDC's national diabetes surveillance data for 2003 indicated that only 67% of persons with diabetes reported receiving an annual foot examination, even though 88% reported having an annual doctor visit (*8*). CDC collaborates with state health departments and communities to prevent and manage LED to minimize its impact on mobility. The National Diabetes Education Program has developed materials related to LED and foot care for persons with diabetes and their health-care providers (available at http://www.ndep.nih.gov/campaigns/feet/feet_overview.htm).

References

1. Volpato S, Ferrucci L, Blaum C, et al. Progression of lower-extremity disability in older women with diabetes: the Women's Health and Aging Study. Diabetes Care 2003;26:70–5.

2. Bruce DG, Davis WA, Davis TM. Longitudinal predictors of reduced mobility and physical disability in patients with type 2 diabetes: the Fremantle Diabetes Study. Diabetes Care 2005;28:2441–7.
3. McDermott MM, Liu K, Greenland P, et al. Functional decline in peripheral arterial disease: associations with the ankle brachial index and leg symptoms. JAMA 2004;292:453–61.
4. Resnick HE, Vinik AI, Schwartz AV, et al. Independent effects of peripheral nerve dysfunction on lower-extremity physical function in old age: the Women's Health and Aging Study. Diabetes Care 2000;23:1642–7.
5. Gregg EW, Sorlie P, Paulose-Ram R, et al. Prevalence of lower extremity disease in the U.S. adult population ≥40 years of age with and without diabetes. 1999–2000 National Health and Nutritional Examination Survey. Diabetes Care 2004;27:1591–7.
6. Gregg EW, Beckles GLA, Williamson DF, et al. Diabetes and physical disability among older US adults. Diabetes Care 2000;23:1272–7.
7. Guccione AA, Felson DT, Anderson JJ, et al. The effects of specific medical conditions on the functional limitations of elders in the Framingham study. Am J Public Health 1994;84:351–8.
8. CDC. Age-adjusted rates of annual dilated eye exam, daily self-monitoring of blood glucose, foot exam in the last year, and doctor visit for diabetes in the last year per 100 adults with diabetes, United States, 1994–2003. Atlanta, GA: US Department of Health and Human Services, CDC; 2005. Available at http://www.cdc.gov/diabetes/statistics/preventive/fX.htm.

Brief Report

Conclusions and Recommendations of the Advisory Committee on Poliomyelitis Eradication — Geneva, Switzerland, October 2005

The second meeting of the Advisory Committee on Poliomyelitis Eradication (ACPE) was convened in Geneva, Switzerland, on October 11–12, 2005, to provide the World Health Organization (WHO) and the Global Polio Eradication Initiative with advice on program policies for 1) interrupting wild poliovirus (WPV) transmission worldwide, 2) limiting the international spread of circulating polioviruses, and 3) refining the program of work for eventual cessation of immunization with oral poliovirus vaccine (OPV). This report summarizes the results of that meeting.*

Interrupting WPV Transmission

As of October 25, 2005, paralytic polio cases attributed to WPV had been reported from 16 countries, including five of the six countries that were endemic for indigenous WPV during 2004 (Table). In the disease-endemic reservoirs in India and Pakistan, transmission had been reduced by 50%, compared with the same period in 2004.

The development, licensure, and use of monovalent OPV type 1 (mOPV1) appears to have had a substantial impact on WPV circulation in polio-endemic countries. Afghanistan, Egypt, India, and Pakistan have implemented supplementary immunization activities (SIAs) using mOPV1, and Afghanistan and India might implement rounds in selected areas using monovalent OPV type 3 (mOPV3) within the first 6 months of 2006, depending upon the evolving epidemiology of types 1 and 3. Preliminary evidence suggests a positive impact of mOPV1 in restricting WPV transmission, compared with use of trivalent OPV (tOPV). ACPE recommends that 1) mOPV1 be used in polio-endemic countries with circulation of WPV type 1 only and 2) SIA vaccine strategies include mOPVs in countries where two poliovirus serotypes circulate (types 1 and 3).

For Nigeria, ACPE recommends that highest priority be placed on increasing the quality and number of routine and SIA activities in the polio-infected states and that consideration be given to introduction of mOPV1 as early as possible to complement the ongoing work to improve SIA quality. In polio-free countries bordering polio-endemic areas, mOPV should be considered for use in SIAs on a case-by-case basis. In all countries, tOPV or IPV should continue to be used in routine vaccination activities, as guided by national immunization policy.

Limiting the International Spread of Circulating Polioviruses

The impact of outbreaks attributed to importations of WPVs in polio-free areas has increased substantially in 2004 and 2005. Approximately 60% of all cases reported globally in 2005 have been from outbreaks in previously polio-free countries. Poliovirus transmission in the areas of West and Central Africa that were reinfected in 2003 and 2004 is now stopping, and Sudan has not reported any cases since June 2005. However, more recent outbreaks in Angola, Eritrea, Ethiopia, Indonesia, Somalia, and Yemen are of considerable concern.

ACPE recognizes the significance of large-scale outbreaks associated with imported polioviruses in areas of suboptimal population immunity and the risks these viruses pose to surrounding communities. Therefore, ACPE recommends that the Director-General of WHO consider declaring the following scenarios as public health emergencies of international concern (i.e., constituting a public health risk to other countries through international spread of disease, potentially requiring a coordinated international response): 1) detection of a circulating poliovirus in any previously polio-free geographic area that does not have survey-confirmed routine childhood polio vaccination coverage of >90% and has not conducted polio SIAs within the preceding 6–12 months, or 2) any poliovirus outbreak that continues to expand geographically for more than 60 days after confirmation of the index case.

* The full text of the final report is available at http://www.polioeradication.org/content/meetings/finalreport_acpe_12oct05meeting.pdf.

TABLE. Paralytic poliomyelitis cases caused by wild poliovirus, by country and type — worldwide, 2004–2005*

Country	Confirmed cases attributed to wild poliovirus: Total 2004	Jan 1–Oct 25 2004	Jan 1–Oct 25 2005	Date of most recent type 3	Date of most recent type 1	Date of most recent confirmed case
Pakistan†	53	36	19	December 4, 2004	September 25, 2005	September 25, 2005
Indonesia§	0	0	278	NA¶	September 20, 2005	September 20, 2005
India†	134	74	43	June 13, 2005	September 13, 2005	September 13, 2005
Somalia§	0	0	12	October 6, 2002	September 10, 2005	September 10, 2005
Nigeria†	782	650	522	September 4, 2005	September 3, 2005	September 4, 2005
Yemen§	0	0	473	NA	September 1, 2005	September 1, 2005
Angola§	0	0	8	NA	August 29, 2005	August 29, 2005
Niger†	25	20	5	July 14, 2005	August 18, 2005	August 18, 2005
Ethiopia§	1	0	17	NA	August 12, 2005	August 12, 2005
Nepal§	0	0	1	November 25, 2000	August 6, 2005	August 6, 2005
Sudan	127	17	26	September 7, 2004	June 17, 2005	June 17, 2005
Afghanistan†	4	3	4	June 6, 2005	February 11, 2005	June 6, 2005
Chad	24	19	1	November 30, 2004	May 6, 2005	May 6, 2005
Mali	19	2	3	NA	May 1, 2005	May 1, 2005
Eritrea§	0	0	1	NA	April 23, 2005	April 23, 2005
Cameroon§	13	2	1	August 23, 2004	February 8, 2005	February 8, 2005
Saudi Arabia§	2	0	0	NA	December 17, 2004	December 17, 2004
Guinea§	7	1	0	NA	December 6, 2004	December 6, 2004
Central African Republic	30	19	0	NA	November 10, 2004	November 10, 2004
Côte d'Ivoire	17	15	0	February 16, 1999	October 3, 2004	October 3, 2004
Burkina Faso	9	6	0	NA	September 29, 2004	September 29, 2004
Benin§	6	6	0	NA	June 1, 2004	June 1, 2004
Egypt†	1	1	0	December 7, 2000	May 3, 2004	May 3, 2004
Botswana§	1	1	0	NA	February 8, 2004	February 8, 2004
Total	**1,255**	**872**	**1,414**	—	—	—
Total in polio-endemic countries	**999**	**784**	**593**	—	—	—
Total in non–polio-endemic countries	**256**	**88**	**821**	—	—	—

* As of October 25, 2005.
† Polio-endemic in 2004.
§ Importation or under investigation.
¶ Not available. Most recent case had onset date before 1999.

Polio-free countries detecting circulating poliovirus should immediately implement ACPE's *Standing Recommendations for Responding to Circulating Polioviruses in Polio-Free Areas*, particularly completion of an expert risk assessment and large-scale response plan, immediate initiation of an in-depth epidemiologic investigation, and implementation of local control measures according to national guidelines (*1*). Moreover, in accordance with the standing recommendations, countries should plan to continue large-scale mOPV polio campaigns until at least two full rounds have been conducted after the most recent virus is detected. The need for further activities will depend on the epidemiology of the outbreak and risk for further importation.

In view of emerging evidence demonstrating the capacity of some vaccine-derived polioviruses (VDPVs) to circulate and cause outbreaks of paralytic poliomyelitis, ACPE recommends that the case definition for poliomyelitis within the WHO International Health Regulations be updated to include circulating VDPVs (*2*).

Refining the Program of Work for Cessation of the Use of OPV

ACPE reaffirms the guidance outlined in the 2003 WHO position paper (*3*) on the use of inactivated poliovirus vaccine (IPV) in OPV-using countries. The paper recommended against adoption of IPV alone or in a sequential schedule in tropical developing countries, where OPV might be more effective. A proposed supplement is currently under development, with a focus on preparations for vaccination policy decisions for the OPV-cessation era. WHO should continue investigating the potential use of newer products in the post-OPV era, including fractional doses of IPV and Sabin-strain IPV. Because assumptions regarding VDPVs underpin the strategy for OPV cessation and understanding of VDPVs continues to evolve, highest priority should be given to better characterization of the incidence and behavior of these viruses, particularly in areas of low population immunity.

Reported by: *Polio Eradication Initiative/Office of the Director-General and Dept of Immunization, Vaccines and Biologicals, World Health Organization, Geneva, Switzerland. United Nations Children's Fund, New York, New York. Rotary International, Evanston, Illinois. Div of*

Viral and Rickettsial Diseases, National Center for Infectious Diseases; Global Immunization Div, National Immunization Program, CDC.

References

1. World Health Organization. ACPE standing recommendations for responding to circulating polioviruses in polio-free areas. Wkly Epidemiol Rec 2005;80:330–1. Available at http://www.who.int/wer/2005/wer8038.pdf.
2. World Health Assembly. Revision of the International Health Regulations. 58th World Health Assembly. Geneva, Switzerland: World Health Organization; May 23, 2005. Available at http://www.who.int/gb/ebwha/pdf_files/wha58/wha58_3-en.pdf.
3. World Health Organization. Introduction of inactivated poliovirus vaccine into oral poliovirus vaccine-using countries. Wkly Epidemiol Rec 2003;78:241–50. Available at http://www.who.int/wer/2003/en/wer7828.pdf.

Notice to Readers

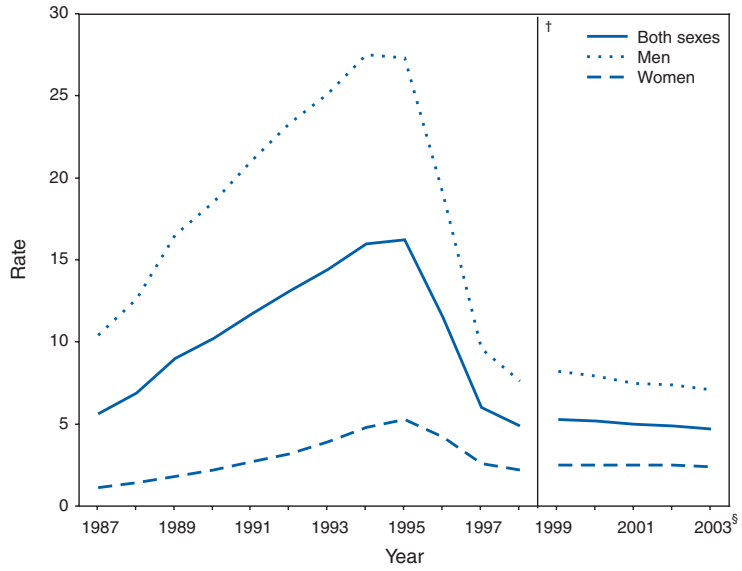
MMWR Available Via Really Simple Syndication (RSS) Feeds

MMWR now offers RSS feeds, a free, automated method to receive all *MMWR* publications. Through RSS, new reports and publications are fed to your desktop or browser-based news reader when they are posted online. Headlines are presented in the RSS feeds, with links to the full reports and publications on the *MMWR* website. RSS feeds to *MMWR* publications are available at http://www.cdc.gov/mmwr/rss/rss.html.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Age-Adjusted Death Rates* for Human Immunodeficiency Virus (HIV) Infection, by Sex — United States, 1987–2003

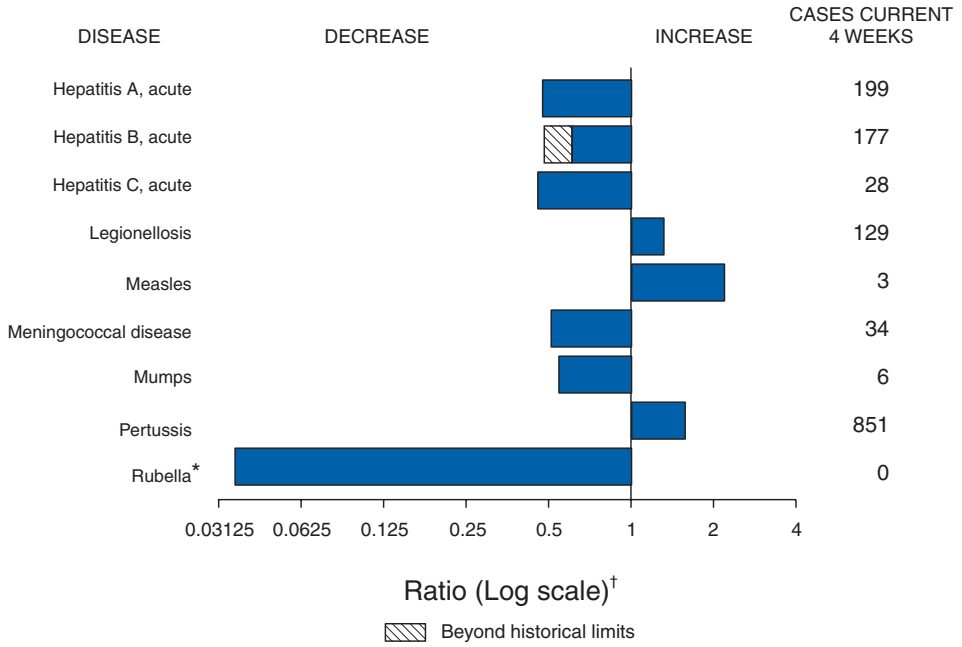


* Per 100,000 U.S. standard population.
† In 1987, a new category for HIV infection was added to the *International Classification of Diseases, Ninth Revision* (ICD-9). In 1999, ICD-10 took effect, resulting in additional deaths classified into the HIV/AIDS category; therefore, death rates for 1987–1998 are not comparable with those computed after 1998.
§ Data for 2003 are preliminary.

Mortality attributable to HIV infection and acquired immunodeficiency syndrome (AIDS) increased rapidly for both men and women during the late 1980s and early 1990s, reaching a peak in the mid-1990s. The rate then decreased sharply until 1997 before leveling off. From 1999 to 2003, men experienced a modest but steady decrease in HIV/AIDS mortality; the death rate for women was unchanged.

SOURCE: National Vital Statistics System, National Center for Health Statistics, CDC.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals November 19, 2005, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 46 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 19, 2005 (46th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	155	155
Botulism:			HIV infection, pediatric†¶	181	339
foodborne	13	8	Influenza-associated pediatric mortality†**	45	—
infant	69	76	Measles	64††	25§§
other (wound & unspecified)	25	14	Mumps	235	206
Brucellosis	94	92	Plague	3	2
Chancroid	25	25	Poliomyelitis, paralytic	1	—
Cholera	6	4	Psittacosis†	20	11
Cyclosporiasis†	711	199	Q fever†	129	57
Diphtheria	—	—	Rabies, human	2	6
Domestic arboviral diseases			Rubella	16	9
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	1	—
California serogroup†§	59	116	SARS†**	—	—
eastern equine†§	20	5	Smallpox†	—	—
Powassan†§	—	1	*Staphylococcus aureus*:		
St. Louis†§	7	13	Vancomycin-intermediate (VISA)†	1	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	—	1
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome†	97	118
human granulocytic (HGE)†	553	380	Tetanus	18	22
human monocytic (HME)†	403	284	Toxic-shock syndrome	86	80
human, other and unspecified †	80	66	Trichinellosis¶¶	16	2
Hansen disease†	69	93	Tularemia†	133	99
Hantavirus pulmonary syndrome†	22	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 the 45 cases reported, one was reported since October 2, 2005 (40th Week).
†† 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 19, 2005, and November 20, 2004 (46th 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	35,513	807,509	814,051	4,263	5,257	6,593	3,249
NEW ENGLAND	778	1,129	28,146	26,576	—	—	309	161
Maine	11	23	1,952	1,847	N	N	25	18
N.H.	20	39	1,631	1,546	—	—	32	30
Vt.¶	4	14	846	999	—	—	35	23
Mass.	368	425	12,773	11,842	—	—	128	59
R.I.	68	114	2,778	3,011	—	—	13	4
Conn.	307	514	8,166	7,331	N	N	76	27
MID. ATLANTIC	4,352	7,866	101,337	100,041	—	—	2,941	528
Upstate N.Y.	800	855	20,522	20,370	N	N	2,530	167
N.Y. City	2,327	4,452	32,570	30,473	—	—	119	127
N.J.	574	1,302	15,603	15,543	N	N	52	43
Pa.	651	1,257	32,642	33,655	N	N	240	191
E.N. CENTRAL	1,938	2,818	133,588	144,000	11	13	1,381	976
Ohio	312	541	36,299	35,397	N	N	744	208
Ind.	236	327	17,431	16,534	N	N	77	70
Ill.	983	1,274	40,235	42,313	—	—	131	150
Mich.	322	535	23,541	32,583	11	13	100	141
Wis.	85	141	16,082	17,173	N	N	329	407
W.N. CENTRAL	463	720	49,505	50,545	5	6	544	374
Minn.	123	190	9,601	10,473	3	N	131	123
Iowa	50	57	6,355	6,167	N	N	105	81
Mo.	198	297	19,364	18,741	1	3	241	65
N. Dak.	5	16	1,011	1,595	N	N	1	12
S. Dak.	10	8	2,459	2,252	—	—	24	37
Nebr.¶	18	44	4,494	4,672	1	3	9	27
Kans.	59	108	6,221	6,645	N	N	33	29
S. ATLANTIC	6,473	11,141	153,946	152,690	2	—	653	480
Del.	100	136	3,021	2,609	N	N	4	—
Md.	812	1,293	16,411	16,796	2	—	33	22
D.C.	467	785	3,322	3,148	—	—	15	14
Va.¶	307	565	18,368	19,397	—	—	60	56
W. Va.	36	71	2,426	2,480	N	N	13	6
N.C.	531	1,015	27,891	25,923	N	N	83	72
S.C.¶	386	643	18,186	16,908	—	—	17	22
Ga.	1,103	1,410	26,745	27,966	—	—	111	168
Fla.	2,731	5,223	37,576	37,463	N	N	317	120
E.S. CENTRAL	1,093	1,647	59,905	53,644	—	5	191	133
Ky.	135	212	7,724	5,333	N	N	129	42
Tenn.¶	434	684	21,125	19,793	N	N	38	41
Ala.¶	295	382	13,764	12,027	—	—	20	22
Miss.	229	369	17,292	16,491	—	5	4	28
W.S. CENTRAL	2,206	4,223	92,348	98,391	1	3	177	126
Ark.	72	183	7,718	7,124	—	1	6	15
La.	436	799	14,441	19,768	1	2	78	5
Okla.	167	169	9,506	9,428	N	N	41	22
Tex.¶	1,531	3,072	60,683	62,071	N	N	52	84
MOUNTAIN	789	1,242	46,072	49,954	2,944	3,304	121	157
Mont.	4	5	1,844	2,198	N	N	16	34
Idaho¶	9	17	2,253	2,466	N	N	15	27
Wyo.	2	14	997	944	3	2	3	3
Colo.	163	278	11,712	12,823	N	N	47	54
N. Mex.	72	164	5,135	8,035	14	21	8	17
Ariz.	329	454	14,986	14,408	2,889	3,202	9	15
Utah	33	62	3,819	3,338	6	22	14	5
Nev.¶	177	248	5,326	5,742	32	57	9	2
PACIFIC	2,313	4,727	142,662	138,210	1,300	1,926	276	314
Wash.	229	348	16,531	15,604	N	N	43	33
Oreg.¶	136	249	7,939	7,360	—	—	64	29
Calif.	1,874	3,981	111,681	107,075	1,300	1,926	165	250
Alaska	14	43	3,495	3,391	—	—	3	—
Hawaii	60	106	3,016	4,780	—	—	1	2
Guam	1	1	—	803	—	—	—	—
P.R.	537	635	3,311	3,037	N	N	N	N
V.I.	10	18	196	303	—	—	—	—
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 19, 2005, and November 20, 2004 (46th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	2,147	2,305	322	269	290	166	15,953	17,477	279,331	289,006
NEW ENGLAND	150	154	53	41	25	14	1,441	1,598	5,072	6,091
Maine	14	14	11	—	—	—	186	135	117	196
N.H.	12	21	2	5	—	—	47	44	157	114
Vt.	13	13	3	—	—	—	164	155	54	79
Mass.	61	69	13	13	25	14	627	711	2,250	2,776
R.I.	7	9	—	1	—	—	107	107	383	744
Conn.	43	28	24	22	—	—	310	446	2,111	2,182
MID. ATLANTIC	282	272	35	60	28	34	2,945	3,624	29,437	32,365
Upstate N.Y.	128	115	17	41	9	17	1,081	1,243	6,112	6,579
N.Y. City	14	35	—	—	—	—	754	987	8,855	9,801
N.J.	48	55	3	6	9	6	352	456	4,749	6,039
Pa.	92	67	15	13	10	11	758	938	9,721	9,946
E.N. CENTRAL	423	440	35	44	21	30	2,541	2,921	54,539	61,230
Ohio	138	92	9	9	13	18	727	710	17,022	18,542
Ind.	62	48	—	—	—	—	N	N	6,957	6,042
Ill.	46	101	1	7	1	7	576	740	16,330	18,469
Mich.	73	79	2	10	6	5	692	652	9,597	13,717
Wis.	104	120	23	18	1	—	546	819	4,633	4,460
W.N. CENTRAL	393	461	37	37	59	21	1,953	1,901	15,873	15,409
Minn.	125	105	20	15	33	4	898	699	2,732	2,601
Iowa	92	117	—	—	—	—	246	275	1,403	1,120
Mo.	74	92	11	16	12	6	453	509	8,136	8,110
N. Dak.	6	14	—	—	1	7	14	22	70	99
S. Dak.	26	31	3	2	—	—	85	58	309	257
Nebr.	29	62	3	4	4	—	85	139	1,012	976
Kans.	41	40	—	—	9	4	172	199	2,211	2,246
S. ATLANTIC	185	163	80	31	107	45	2,292	2,641	67,554	69,531
Del.	7	3	N	N	N	N	49	43	798	784
Md.	31	21	30	6	10	3	182	133	6,284	7,170
D.C.	1	1	—	—	—	—	51	66	1,850	2,336
Va.	39	33	27	16	21	—	478	471	6,793	7,788
W. Va.	2	2	—	—	1	—	41	40	657	812
N.C.	—	—	—	—	59	35	N	N	13,363	13,632
S.C.	6	12	1	—	1	—	91	107	8,036	8,414
Ga.	28	21	18	6	—	—	528	806	12,433	12,444
Fla.	71	70	4	3	15	7	872	975	17,340	16,151
E.S. CENTRAL	123	100	8	5	31	15	371	377	24,168	23,611
Ky.	46	25	5	1	20	9	N	N	2,715	2,388
Tenn.	41	38	2	2	11	6	188	202	7,850	7,542
Ala.	29	26	—	—	—	—	183	175	7,868	7,358
Miss.	7	11	1	2	—	—	—	—	5,735	6,323
W.S. CENTRAL	48	82	13	3	9	7	290	303	37,697	38,526
Ark.	8	17	—	—	—	—	77	117	4,036	3,773
La.	4	4	11	1	3	2	53	48	8,102	9,373
Okla.	22	18	1	—	2	—	160	138	3,828	4,012
Tex.	14	43	1	2	4	5	N	N	21,731	21,368
MOUNTAIN	213	229	53	47	10	—	1,331	1,370	9,809	10,655
Mont.	15	16	—	—	—	—	65	76	118	72
Idaho	26	52	11	13	7	—	141	179	95	83
Wyo.	6	9	2	5	—	—	25	22	71	58
Colo.	64	51	3	1	1	—	482	473	2,569	2,697
N. Mex.	12	10	9	8	—	—	74	65	985	1,134
Ariz.	42	21	N	N	N	N	135	156	3,306	3,475
Utah	38	43	26	19	—	—	360	289	613	515
Nev.	10	27	2	1	2	—	49	110	2,052	2,621
PACIFIC	330	404	8	1	—	—	2,789	2,742	35,182	31,588
Wash.	98	135	—	—	—	—	317	343	3,260	2,420
Oreg.	80	68	8	1	—	—	352	409	1,372	1,123
Calif.	128	190	—	—	—	—	1,970	1,829	29,496	26,436
Alaska	12	1	—	—	—	—	94	89	486	503
Hawaii	12	10	—	—	—	—	56	72	568	1,106
Guam	N	N	—	—	—	—	—	4	—	125
P.R.	2	2	—	—	—	—	176	260	300	219
V.I.	—	—	—	—	—	—	—	—	45	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 19, 2005, and November 20, 2004 (46th Week)*

Reporting area	*Haemophilus influenzae*, invasive							
	All ages		Age <5 years					
	All serotypes		Serotype b		Non-serotype b		Unknown serotype	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,828	1,756	4	12	96	108	179	157
NEW ENGLAND	145	163	—	1	10	10	5	2
Maine	6	12	—	—	—	—	1	—
N.H.	8	18	—	—	—	2	—	1
Vt.	9	8	—	—	—	—	2	1
Mass.	70	74	—	1	3	4	1	—
R.I.	7	6	—	—	2	1	—	—
Conn.	45	45	—	—	5	3	1	—
MID. ATLANTIC	378	368	—	2	1	5	39	36
Upstate N.Y.	109	116	—	2	—	5	9	5
N.Y. City	69	78	—	—	—	—	11	15
N.J.	77	68	—	—	—	—	10	3
Pa.	123	106	—	—	1	—	9	13
E.N. CENTRAL	263	331	1	—	4	8	19	47
Ohio	102	90	—	—	—	2	9	15
Ind.	57	48	—	—	4	4	—	1
Ill.	62	117	—	—	—	—	7	21
Mich.	19	20	1	—	—	2	2	4
Wis.	23	56	—	—	—	—	1	6
W.N. CENTRAL	99	97	—	2	3	3	9	11
Minn.	40	43	—	1	3	3	2	1
Iowa	1	1	—	1	—	—	—	—
Mo.	33	37	—	—	—	—	5	7
N. Dak.	2	4	—	—	—	—	1	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	9	5	—	—	—	—	1	2
Kans.	14	7	—	—	—	—	—	1
S. ATLANTIC	433	392	1	1	26	26	31	26
Del.	—	—	—	—	—	—	—	—
Md.	63	61	—	—	5	6	—	—
D.C.	—	3	—	—	—	—	—	1
Va.	40	39	—	—	—	—	2	5
W. Va.	25	16	—	—	1	4	6	—
N.C.	71	54	1	1	8	6	—	1
S.C.	30	13	—	—	—	—	3	1
Ga.	86	100	—	—	—	—	14	17
Fla.	118	106	—	—	12	10	6	1
E.S. CENTRAL	101	64	—	1	1	1	19	9
Ky.	8	7	—	—	1	1	2	—
Tenn.	75	42	—	—	—	—	13	7
Ala.	18	13	—	1	—	—	4	2
Miss.	—	2	—	—	—	—	—	—
W.S. CENTRAL	92	72	1	1	8	9	7	1
Ark.	5	2	—	—	1	1	—	—
La.	30	13	1	—	2	—	7	1
Okla.	55	56	—	—	5	8	—	—
Tex.	2	1	—	1	—	—	—	—
MOUNTAIN	198	174	—	4	15	25	34	18
Mont.	—	—	—	—	—	—	—	—
Idaho	5	5	—	—	—	—	—	2
Wyo.	6	1	—	—	—	1	1	—
Colo.	39	43	—	—	1	—	9	5
N. Mex.	20	37	—	1	4	8	2	6
Ariz.	97	59	—	—	7	11	12	2
Utah	17	16	—	2	1	2	7	2
Nev.	14	13	—	1	2	3	3	1
PACIFIC	119	95	1	—	28	21	16	7
Wash.	4	1	—	—	—	—	3	1
Oreg.	29	42	—	—	—	—	5	3
Calif.	50	38	1	—	28	21	2	1
Alaska	26	5	—	—	—	—	6	1
Hawaii	10	9	—	—	—	—	—	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 19, 2005, and November 20, 2004 (46th 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	3,622	5,261	4,827	5,390	633	716
NEW ENGLAND	475	918	260	339	17	16
Maine	4	13	16	5	—	—
N.H.	76	25	24	32	—	—
Vt.	6	8	5	6	13	8
Mass.	327	781	184	189	1	7
R.I.	15	21	3	5	—	—
Conn.	47	70	28	102	3	1
MID. ATLANTIC	609	732	916	681	95	133
Upstate N.Y.	97	101	84	73	18	11
N.Y. City	268	316	107	142	—	—
N.J.	152	168	533	194	—	—
Pa.	92	147	192	272	77	122
E.N. CENTRAL	349	471	458	498	123	102
Ohio	47	47	119	101	8	6
Ind.	51	55	46	39	23	8
Ill.	83	138	103	86	—	13
Mich.	137	132	159	235	92	75
Wis.	31	99	31	37	—	—
W.N. CENTRAL	84	142	239	293	26	20
Minn.	3	32	29	44	5	17
Iowa	20	45	18	14	—	—
Mo.	39	29	143	175	19	3
N. Dak.	—	1	—	4	1	—
S. Dak.	—	3	3	1	—	—
Nebr.	6	12	21	38	1	—
Kans.	16	20	25	17	—	—
S. ATLANTIC	636	930	1,205	1,656	133	176
Del.	4	6	46	48	7	31
Md.	68	100	139	144	23	9
D.C.	4	7	11	19	—	4
Va.	72	111	125	235	12	13
W. Va.	5	5	35	39	21	22
N.C.	81	98	150	168	19	11
S.C.	34	40	122	126	3	15
Ga.	103	300	140	422	8	15
Fla.	265	263	437	455	40	56
E.S. CENTRAL	224	142	316	446	75	83
Ky.	24	29	55	66	9	23
Tenn.	145	90	124	211	17	29
Ala.	35	8	84	71	14	5
Miss.	20	15	53	98	35	26
W.S. CENTRAL	241	616	456	471	81	100
Ark.	13	60	44	103	1	3
La.	63	45	63	63	14	3
Okla.	4	20	34	63	6	3
Tex.	161	491	315	242	60	91
MOUNTAIN	319	380	499	436	41	41
Mont.	8	6	3	1	1	2
Idaho	21	18	13	10	1	1
Wyo.	—	5	2	7	1	2
Colo.	38	47	52	53	21	13
N. Mex.	23	23	9	17	—	U
Ariz.	200	230	352	240	—	5
Utah	19	35	40	38	8	5
Nev.	10	16	28	70	9	13
PACIFIC	685	930	478	570	42	45
Wash.	43	56	58	47	U	U
Oreg.	39	62	91	101	17	15
Calif.	578	781	317	401	24	28
Alaska	4	4	7	11	—	—
Hawaii	21	27	5	10	1	2
Guam	—	1	—	12	—	9
P.R.	58	44	40	72	—	—
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 19, 2005, and November 20, 2004 (46th 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	1,755	1,831	709	649	18,630	16,838	1,110	1,265
NEW ENGLAND	116	84	53	47	2,276	3,047	60	83
Maine	6	1	3	8	207	29	4	7
N.H.	8	10	7	3	190	202	5	5
Vt.	9	6	2	2	46	47	1	4
Mass.	41	37	15	17	954	1,479	31	49
R.I.	19	15	6	1	32	201	2	4
Conn.	33	15	20	16	847	1,089	17	14
MID. ATLANTIC	609	514	181	155	11,817	10,268	297	342
Upstate N.Y.	169	112	56	44	3,618	3,609	47	45
N.Y. City	85	66	35	25	—	338	157	187
N.J.	89	83	33	33	3,158	2,554	62	67
Pa.	266	253	57	53	5,041	3,767	31	43
E.N. CENTRAL	331	443	76	112	1,348	1,287	88	111
Ohio	175	205	31	38	61	47	24	28
Ind.	21	44	5	17	33	27	3	13
Ill.	15	47	2	24	—	87	29	39
Mich.	102	127	27	26	53	26	21	19
Wis.	18	20	11	7	1,201	1,100	11	12
W.N. CENTRAL	92	56	40	19	877	509	43	64
Minn.	26	7	13	5	768	424	11	24
Iowa	6	6	8	3	80	49	8	4
Mo.	32	27	6	7	23	24	17	19
N. Dak.	2	2	4	—	—	—	—	3
S. Dak.	21	4	—	1	1	1	—	1
Nebr.	3	4	5	3	2	8	3	4
Kans.	2	6	4	—	3	3	4	9
S. ATLANTIC	353	374	149	108	2,068	1,522	270	312
Del.	16	13	N	N	586	310	3	6
Md.	99	76	19	16	1,084	818	96	73
D.C.	12	11	—	5	8	13	8	13
Va.	37	48	14	17	219	162	27	47
W. Va.	18	10	4	4	16	28	3	2
N.C.	30	35	32	22	44	111	30	19
S.C.	12	14	12	10	19	24	8	10
Ga.	24	41	21	14	5	12	41	58
Fla.	105	126	47	20	87	44	54	84
E.S. CENTRAL	78	92	28	23	33	43	28	31
Ky.	28	38	4	4	5	15	9	4
Tenn.	34	39	12	12	26	23	13	10
Ala.	13	12	8	5	2	5	6	12
Miss.	3	3	4	2	—	—	—	5
W.S. CENTRAL	25	129	29	39	56	67	80	122
Ark.	4	1	2	3	4	8	6	8
La.	1	8	9	3	4	2	3	6
Okla.	7	6	4	1	—	—	10	7
Tex.	13	114	14	32	48	57	61	101
MOUNTAIN	81	77	16	23	21	17	52	49
Mont.	5	2	—	—	—	—	—	—
Idaho	3	9	—	1	2	6	—	1
Wyo.	4	6	—	—	3	3	2	—
Colo.	21	20	7	12	3	—	23	18
N. Mex.	2	4	4	1	1	1	2	4
Ariz.	23	11	—	—	8	6	14	13
Utah	15	21	3	1	2	1	9	8
Nev.	8	4	2	8	2	—	2	5
PACIFIC	70	62	137	123	134	78	192	151
Wash.	—	9	9	9	8	12	15	15
Oreg.	N	N	11	7	19	25	10	16
Calif.	67	52	116	103	104	39	146	114
Alaska	—	1	—	—	3	2	5	2
Hawaii	3	—	1	4	N	N	16	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 19, 2005, and November 20, 2004 (46th 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	1,017	1,063	83	82	49	40	—	1	885	940
NEW ENGLAND	65	63	1	6	—	6	—	1	64	50
Maine	2	10	—	—	—	1	—	—	2	9
N.H.	12	7	—	—	—	—	—	—	12	7
Vt.	5	3	—	—	—	—	—	—	5	3
Mass.	31	34	—	5	—	5	—	—	31	24
R.I.	3	2	—	1	—	—	—	—	3	1
Conn.	12	7	1	—	—	—	—	1	11	6
MID. ATLANTIC	132	145	36	39	7	5	—	—	89	101
Upstate N.Y.	35	39	4	6	4	3	—	—	27	30
N.Y. City	19	25	—	—	—	—	—	—	19	25
N.J.	33	31	—	—	—	—	—	—	33	31
Pa.	45	50	32	33	3	2	—	—	10	15
E.N. CENTRAL	116	121	32	28	11	6	—	—	73	87
Ohio	41	62	—	4	7	5	—	—	34	53
Ind.	18	18	—	1	4	1	—	—	14	16
Ill.	15	1	—	—	—	—	—	—	15	1
Mich.	32	23	32	23	—	—	—	—	—	—
Wis.	10	17	—	—	—	—	—	—	10	17
W.N. CENTRAL	71	72	3	—	1	4	—	—	67	68
Minn.	14	23	1	—	—	—	—	—	13	23
Iowa	16	16	—	—	1	2	—	—	15	14
Mo.	26	18	1	—	—	1	—	—	25	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	194	203	6	2	9	4	—	—	179	197
Del.	4	6	—	—	—	—	—	—	4	6
Md.	21	10	3	—	2	—	—	—	16	10
D.C.	—	5	—	2	—	—	—	—	—	3
Va.	30	20	—	—	—	—	—	—	30	20
W. Va.	6	5	1	—	—	—	—	—	5	5
N.C.	29	28	2	—	7	4	—	—	20	24
S.C.	15	15	—	—	—	—	—	—	15	15
Ga.	15	14	—	—	—	—	—	—	15	14
Fla.	74	100	—	—	—	—	—	—	74	100
E.S. CENTRAL	52	63	1	1	3	1	—	—	48	61
Ky.	16	11	—	1	3	1	—	—	13	9
Tenn.	24	21	—	—	—	—	—	—	24	21
Ala.	6	16	1	—	—	—	—	—	5	16
Miss.	6	15	—	—	—	—	—	—	6	15
W.S. CENTRAL	87	65	1	2	5	2	—	—	81	61
Ark.	14	15	—	—	—	1	—	—	14	14
La.	26	31	—	1	2	—	—	—	24	30
Okla.	13	9	1	1	3	1	—	—	9	7
Tex.	34	10	—	—	—	—	—	—	34	10
MOUNTAIN	80	58	2	1	6	5	—	—	72	52
Mont.	—	3	—	—	—	—	—	—	—	3
Idaho	6	7	—	—	—	—	—	—	6	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	220	273	1	3	7	7	—	—	212	263
Wash.	41	28	1	3	4	7	—	—	36	18
Oreg.	28	52	—	—	—	—	—	—	28	52
Calif.	136	181	—	—	—	—	—	—	136	181
Alaska	3	4	—	—	—	—	—	—	3	4
Hawaii	12	8	—	—	3	—	—	—	9	8
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 19, 2005, and November 20, 2004 (46th 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	17,932	18,803	4,868	5,868	1,578	1,412	37,294	37,378	12,178	12,182
NEW ENGLAND	1,065	1,780	632	624	3	20	1,911	1,858	268	273
Maine	30	36	48	52	N	N	136	96	9	8
N.H.	64	90	12	30	1	—	149	129	8	8
Vt.	74	86	53	35	—	1	86	56	16	3
Mass.	822	1,478	308	266	1	15	1,014	1,066	169	171
R.I.	34	31	22	41	1	1	87	107	14	18
Conn.	41	59	189	200	—	3	439	404	52	65
MID. ATLANTIC	1,159	2,531	869	894	99	73	4,423	5,154	1,109	1,072
Upstate N.Y.	467	1,752	503	491	5	1	1,140	1,118	248	386
N.Y. City	85	180	27	12	8	22	1,051	1,171	362	369
N.J.	177	183	N	N	31	14	736	975	274	219
Pa.	430	416	339	391	55	36	1,496	1,890	225	98
E.N. CENTRAL	3,124	7,192	195	183	34	34	4,701	4,630	878	1,105
Ohio	1,042	530	69	74	21	10	1,210	1,104	107	152
Ind.	302	218	11	10	3	6	557	441	164	189
Ill.	577	1,278	50	49	1	14	1,382	1,482	267	373
Mich.	264	269	36	41	7	2	800	764	207	192
Wis.	939	4,897	29	9	2	2	752	839	133	199
W.N. CENTRAL	2,991	2,164	388	582	161	121	2,240	2,149	1,445	386
Minn.	1,025	438	66	84	3	3	523	549	86	63
Iowa	596	422	103	96	4	2	351	398	96	59
Mo.	455	336	75	58	140	97	752	554	920	151
N. Dak.	134	707	24	58	—	—	37	40	4	3
S. Dak.	153	86	48	93	5	4	130	112	45	10
Nebr.	174	50	—	96	4	15	118	157	76	28
Kans.	454	125	72	97	5	—	329	339	218	72
S. ATLANTIC	1,201	713	1,473	2,017	809	748	11,262	10,116	2,120	2,644
Del.	15	3	—	9	4	6	112	103	11	10
Md.	164	129	298	292	85	68	751	761	98	140
D.C.	8	8	—	—	2	—	53	58	13	37
Va.	314	196	460	438	99	29	1,001	1,060	114	145
W. Va.	43	22	52	59	7	5	167	221	1	9
N.C.	98	79	435	547	468	484	1,532	1,456	184	341
S.C.	337	135	5	150	61	60	1,187	893	90	497
Ga.	36	21	216	317	66	78	1,728	1,783	549	593
Fla.	186	120	7	205	17	18	4,731	3,781	1,060	872
E.S. CENTRAL	440	267	130	141	257	188	2,652	2,478	1,085	838
Ky.	127	67	16	21	3	2	440	316	283	68
Tenn.	189	147	43	47	189	104	676	636	499	437
Ala.	79	37	69	62	61	54	695	678	213	284
Miss.	45	16	2	11	4	28	841	848	90	49
W.S. CENTRAL	1,557	851	796	1,022	171	203	3,223	3,910	2,384	3,322
Ark.	262	77	33	50	118	119	685	520	59	74
La.	35	18	—	4	5	5	766	881	126	280
Okla.	—	38	71	104	29	71	361	367	585	422
Tex.	1,260	718	692	864	19	8	1,411	2,142	1,614	2,546
MOUNTAIN	3,645	1,492	217	211	36	21	2,059	2,124	831	755
Mont.	546	52	15	25	1	3	110	178	5	4
Idaho	217	37	—	8	3	4	128	141	17	13
Wyo.	46	31	17	6	2	5	79	49	5	5
Colo.	1,238	811	16	47	5	4	533	498	153	146
N. Mex.	126	148	10	5	3	2	215	263	115	132
Ariz.	893	205	131	110	18	2	605	618	465	362
Utah	547	168	15	7	4	1	303	220	43	42
Nev.	32	40	13	3	—	—	86	157	28	51
PACIFIC	2,750	1,813	168	194	8	4	4,823	4,959	2,058	1,787
Wash.	779	660	U	U	—	—	488	503	125	99
Oreg.	566	458	7	6	1	2	341	390	115	78
Calif.	1,154	657	160	177	7	2	3,674	3,670	1,779	1,559
Alaska	114	13	1	11	—	—	55	57	7	6
Hawaii	137	25	—	—	—	—	265	339	32	45
Guam	—	—	—	—	—	—	—	50	—	42
P.R.	6	5	58	56	N	N	409	444	4	32
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 19, 2005, and November 20, 2004 (46th 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	3,766	3,915	1,905	1,954	791	722	7,046	6,914	227	340
NEW ENGLAND	155	251	108	145	58	100	191	172	1	4
Maine	10	11	N	N	—	7	1	2	—	—
N.H.	14	18	—	—	4	N	14	4	—	3
Vt.	10	8	12	7	6	3	1	—	—	—
Mass.	112	110	80	46	47	57	112	105	—	—
R.I.	9	21	16	18	1	6	20	25	—	1
Conn.	U	83	U	74	U	27	43	36	1	—
MID. ATLANTIC	772	647	175	137	126	108	861	896	25	34
Upstate N.Y.	231	209	68	57	56	75	77	82	6	4
N.Y. City	145	109	U	U	20	U	530	568	5	15
N.J.	153	133	N	N	22	8	113	131	14	14
Pa.	243	196	107	80	28	25	141	115	—	1
E.N. CENTRAL	751	880	543	437	236	169	743	789	30	54
Ohio	176	205	321	302	71	70	190	205	1	2
Ind.	92	93	172	135	46	40	55	54	1	3
Ill.	168	229	14	—	57	10	394	338	11	18
Mich.	280	268	36	N	50	N	73	163	14	30
Wis.	35	85	N	N	12	49	31	29	3	1
W.N. CENTRAL	240	281	42	18	81	98	210	142	5	5
Minn.	96	134	—	—	48	65	54	23	1	1
Iowa	N	N	N	N	—	N	4	5	—	—
Mo.	61	59	35	13	9	13	128	85	4	2
N. Dak.	9	11	2	—	4	4	1	—	—	—
S. Dak.	20	17	3	5	—	—	1	—	—	—
Nebr.	20	20	2	—	7	8	4	6	—	—
Kans.	34	40	N	N	13	8	18	23	—	2
S. ATLANTIC	832	784	735	975	74	53	1,785	1,750	38	55
Del.	5	3	1	4	—	N	10	8	—	1
Md.	185	132	—	—	49	38	270	320	13	9
D.C.	10	10	15	9	3	4	86	61	—	1
Va.	77	66	N	N	—	N	123	93	4	3
W. Va.	22	24	104	99	22	11	4	3	—	—
N.C.	115	118	N	N	U	U	240	175	9	10
S.C.	29	51	—	83	—	N	72	103	4	11
Ga.	160	181	111	255	—	N	334	339	1	4
Fla.	229	199	504	525	—	N	646	648	7	16
E.S. CENTRAL	154	199	147	141	13	16	409	365	19	21
Ky.	31	58	25	27	N	N	47	44	—	1
Tenn.	123	141	122	112	—	N	191	117	12	8
Ala.	—	—	—	—	—	N	136	152	6	10
Miss.	—	—	—	2	13	16	35	52	1	2
W.S. CENTRAL	232	312	100	73	145	142	1,116	1,097	66	68
Ark.	19	16	13	9	15	8	44	46	1	3
La.	6	2	87	64	24	31	228	287	11	5
Okla.	101	63	N	N	27	44	36	25	1	2
Tex.	106	231	N	N	79	59	808	739	53	58
MOUNTAIN	534	441	55	27	49	34	346	347	17	44
Mont.	—	—	—	—	—	—	5	1	—	—
Idaho	3	9	N	N	—	N	20	22	1	2
Wyo.	4	9	23	10	—	—	—	3	—	—
Colo.	186	101	N	N	48	34	38	57	1	1
N. Mex.	41	86	—	N	—	—	44	76	2	2
Ariz.	225	196	N	N	—	N	155	141	12	38
Utah	74	36	30	15	1	—	6	11	—	1
Nev.	1	4	2	2	—	—	78	36	1	—
PACIFIC	96	120	—	1	9	2	1,385	1,356	26	55
Wash.	N	N	N	N	N	N	135	124	—	—
Oreg.	N	N	N	N	6	N	31	25	—	—
Calif.	—	—	N	N	N	N	1,204	1,199	26	55
Alaska	—	—	—	—	—	N	6	1	—	—
Hawaii	96	120	—	1	3	2	9	7	—	—
Guam	—	—	—	—	—	—	—	2	—	—
P.R.	N	N	N	N	—	N	189	149	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 19, 2005, and November 20, 2004 (46th Week)*

Reporting area	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease†		
							Neuroinvasive		Non-neuroinvasive§
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	10,098	11,831	233	287	22,407	25,073	1,112	1,138	1,414
NEW ENGLAND	305	384	23	21	2,215	2,963	9	—	4
Maine	14	18	1	—	213	226	—	—	—
N.H.	6	14	—	—	1,376	—	—	—	—
Vt.	5	3	—	—	84	413	—	—	—
Mass.	203	217	13	15	542	684	4	—	2
R.I.	25	48	1	1	—	—	1	—	—
Conn.	52	84	8	5	U	1,640	4	—	2
MID. ATLANTIC	1,781	1,830	40	71	4,142	86	26	17	17
Upstate N.Y.	224	254	5	10	—	—	—	5	—
N.Y. City	874	910	16	29	—	—	10	2	4
N.J.	412	405	11	17	—	—	2	1	2
Pa.	271	261	8	15	4,142	86	14	9	11
E.N. CENTRAL	1,080	1,040	22	33	5,627	10,881	232	66	113
Ohio	218	175	2	6	1,303	1,283	45	11	14
Ind.	109	113	1	—	482	N	10	8	1
Ill.	509	468	8	16	68	5,399	130	29	88
Mich.	177	205	6	9	3,420	3,588	36	13	4
Wis.	67	79	5	2	354	611	11	5	6
W.N. CENTRAL	378	406	6	8	469	167	139	86	416
Minn.	161	155	5	4	—	—	16	13	27
Iowa	38	42	—	—	N	N	12	13	18
Mo.	86	105	—	2	352	5	16	27	13
N. Dak.	2	4	—	—	30	82	12	2	74
S. Dak.	11	8	—	—	87	80	35	6	197
Nebr.	29	32	—	2	—	—	36	7	80
Kans.	51	60	1	—	—	—	12	18	7
S. ATLANTIC	2,183	2,512	48	40	2,035	2,081	29	65	21
Del.	14	17	1	—	28	5	1	—	—
Md.	235	248	11	11	—	—	4	10	1
D.C.	42	74	—	—	37	22	—	1	—
Va.	264	248	17	8	527	481	—	4	—
W. Va.	21	20	—	—	1,004	1,183	—	—	N
N.C.	248	283	5	7	—	N	2	3	2
S.C.	190	163	—	—	439	390	4	—	—
Ga.	335	513	3	4	—	—	9	14	6
Fla.	834	946	11	10	—	—	9	33	12
E.S. CENTRAL	500	575	5	8	—	48	63	60	38
Ky.	96	102	2	3	N	N	5	1	—
Tenn.	232	197	—	5	—	—	13	13	3
Ala.	172	173	1	—	—	48	6	15	4
Miss.	—	103	2	—	—	—	39	31	31
W.S. CENTRAL	1,307	1,710	16	26	5,644	6,633	202	233	107
Ark.	92	106	—	—	19	—	11	17	15
La.	—	—	1	—	111	53	78	81	33
Okla.	125	149	1	1	—	—	13	16	10
Tex.	1,090	1,455	14	25	5,514	6,580	100	119	49
MOUNTAIN	335	449	9	7	2,275	2,214	134	322	205
Mont.	8	4	—	—	—	—	8	2	17
Idaho	—	3	—	—	—	—	2	1	7
Wyo.	—	4	—	—	52	53	6	2	6
Colo.	51	108	5	2	1,632	1,760	19	41	72
N. Mex.	19	24	—	—	151	U	20	31	13
Ariz.	200	187	2	2	—	—	44	214	44
Utah	26	35	1	1	440	401	21	6	31
Nev.	31	84	1	2	—	—	14	25	15
PACIFIC	2,229	2,925	64	73	—	—	278	289	493
Wash.	222	203	5	6	N	N	—	—	—
Oreg.	54	90	3	1	—	—	—	—	5
Calif.	1,812	2,498	44	60	—	—	278	289	488
Alaska	38	33	—	—	—	—	—	—	—
Hawaii	103	101	12	6	—	—	—	—	—
Guam	—	49	—	—	—	209	—	—	—
P.R.	—	98	—	—	557	366	—	—	—
V.I.	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	—
C.N.M.I.	—	U	—	U	—	U	—	U	—

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

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

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

§ Not previously notifiable.

TABLE III. Deaths in 122 U.S. cities,* week ending November 19, 2005 (46th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
NEW ENGLAND	623	446	115	38	13	11	63
Boston, Mass.	148	96	29	12	4	7	16
Bridgeport, Conn.	43	28	12	3	—	—	2
Cambridge, Mass.	21	18	2	1	—	—	5
Fall River, Mass.	32	25	5	2	—	—	5
Hartford, Conn.	47	29	14	3	1	—	5
Lowell, Mass.	17	14	1	1	—	1	2
Lynn, Mass.	12	6	3	1	2	—	1
New Bedford, Mass.	25	18	7	—	—	—	5
New Haven, Conn.	64	47	12	2	2	1	9
Providence, R.I.	70	58	7	4	1	—	6
Somerville, Mass.	2	1	1	—	—	—	—
Springfield, Mass.	45	28	10	6	1	—	—
Waterbury, Conn.	33	28	3	2	—	—	2
Worcester, Mass.	64	50	9	1	2	2	5
MID. ATLANTIC	2,328	1,620	485	131	45	45	133
Albany, N.Y.	42	34	6	1	1	—	4
Allentown, Pa.	23	20	1	2	—	—	1
Buffalo, N.Y.	51	33	13	2	1	2	4
Camden, N.J.	16	9	5	—	—	2	2
Elizabeth, N.J.	20	10	9	—	1	—	—
Erie, Pa.	38	27	8	2	1	—	8
Jersey City, N.J.	33	18	13	2	—	—	—
New York City, N.Y.	1,288	923	260	64	24	15	62
Newark, N.J.	60	31	18	7	4	—	5
Paterson, N.J.	13	10	1	—	1	1	1
Philadelphia, Pa.	333	195	78	35	9	16	16
Pittsburgh, Pa.§	33	19	7	1	1	5	—
Reading, Pa.	36	30	4	2	—	—	2
Rochester, N.Y.	150	119	21	6	2	2	9
Schenectady, N.Y.	25	17	8	—	—	—	4
Scranton, Pa.	32	26	4	2	—	—	2
Syracuse, N.Y.	76	56	17	2	—	1	10
Trenton, N.J.	26	15	9	1	—	1	2
Utica, N.Y.	11	11	—	—	—	—	—
Yonkers, N.Y.	22	17	3	2	—	—	1
E.N. CENTRAL	2,241	1,475	495	161	57	53	146
Akron, Ohio	58	35	17	4	1	1	7
Canton, Ohio	30	23	4	1	1	1	1
Chicago, Ill.	370	196	104	48	10	12	22
Cincinnati, Ohio	64	37	17	3	4	3	8
Cleveland, Ohio	269	203	52	11	2	1	15
Columbus, Ohio	202	139	43	12	5	3	18
Dayton, Ohio	145	106	21	11	3	4	10
Detroit, Mich.	209	93	79	19	6	12	10
Evansville, Ind.	50	37	7	4	2	—	1
Fort Wayne, Ind.	64	47	6	9	1	1	2
Gary, Ind.	12	5	3	2	2	—	—
Grand Rapids, Mich.	52	36	14	—	1	1	8
Indianapolis, Ind.	207	135	40	14	11	7	16
Lansing, Mich.	49	37	10	2	—	—	5
Milwaukee, Wis.	111	76	24	6	4	1	7
Peoria, Ill.	73	57	9	4	2	1	4
Rockford, Ill.	46	37	7	2	—	—	3
South Bend, Ind.	54	42	9	1	—	2	—
Toledo, Ohio	109	78	21	6	1	3	5
Youngstown, Ohio	67	56	8	2	1	—	4
W.N. CENTRAL	646	426	146	44	11	18	43
Des Moines, Iowa	49	31	15	3	—	—	3
Duluth, Minn.	26	23	2	1	—	—	1
Kansas City, Kans.	23	14	8	1	—	—	—
Kansas City, Mo.	89	52	17	12	4	4	3
Lincoln, Nebr.	29	21	6	—	—	2	2
Minneapolis, Minn.	81	57	11	6	2	5	8
Omaha, Nebr.	97	70	22	2	2	1	8
St. Louis, Mo.	92	50	25	12	2	2	6
St. Paul, Minn.	73	52	17	3	—	1	6
Wichita, Kans.	87	56	23	4	1	3	6
S. ATLANTIC	1,231	748	326	95	31	31	77
Atlanta, Ga.	167	100	41	19	5	2	6
Baltimore, Md.	117	63	30	17	4	3	12
Charlotte, N.C.	110	56	35	12	4	3	9
Jacksonville, Fla.	193	117	56	10	4	6	10
Miami, Fla.	71	49	17	2	2	1	7
Norfolk, Va.	57	32	14	2	4	5	2
Richmond, Va.	48	22	21	4	1	—	5
Savannah, Ga.	73	44	24	4	—	1	3
St. Petersburg, Fla.	52	38	9	4	—	1	5
Tampa, Fla.	218	160	44	6	4	4	10
Washington, D.C.	100	50	29	13	3	5	2
Wilmington, Del.	25	17	6	2	—	—	6
E.S. CENTRAL	892	598	206	52	23	13	51
Birmingham, Ala.	177	112	43	12	3	7	15
Chattanooga, Tenn.	95	78	14	1	1	1	8
Knoxville, Tenn.	138	101	25	10	2	—	2
Lexington, Ky.	73	40	24	3	4	2	3
Memphis, Tenn.	117	74	30	9	3	1	8
Mobile, Ala.	94	66	19	6	2	1	2
Montgomery, Ala.	54	41	12	—	1	—	3
Nashville, Tenn.	144	86	39	11	7	1	10
W.S. CENTRAL	1,655	1,032	413	130	40	40	109
Austin, Tex.	96	60	25	6	3	2	7
Baton Rouge, La.	25	13	6	4	1	1	—
Corpus Christi, Tex.	59	39	16	—	1	3	5
Dallas, Tex.	198	96	61	25	9	7	14
El Paso, Tex.	53	38	10	2	1	2	4
Ft. Worth, Tex.	131	83	33	9	4	2	7
Houston, Tex.	487	289	132	48	10	8	35
Little Rock, Ark.	97	54	28	9	2	4	4
New Orleans, La.¶	U	U	U	U	U	U	U
San Antonio, Tex.	273	199	53	12	4	5	21
Shreveport, La.	67	43	16	4	4	—	4
Tulsa, Okla.	169	118	33	11	1	6	8
MOUNTAIN	1,079	721	224	80	31	22	72
Albuquerque, N.M.	115	82	23	7	2	1	13
Boise, Idaho	83	61	15	2	—	5	3
Colo. Springs, Colo.	79	65	7	3	4	—	3
Denver, Colo.	91	53	23	7	5	3	6
Las Vegas, Nev.	224	153	47	14	8	2	13
Ogden, Utah	36	23	9	2	1	1	4
Phoenix, Ariz.	180	100	48	24	5	2	14
Pueblo, Colo.	23	18	5	—	—	—	1
Salt Lake City, Utah	102	66	17	10	3	6	7
Tucson, Ariz.	146	100	30	11	3	2	8
PACIFIC	1,990	1,383	415	113	44	35	145
Berkeley, Calif.	U	U	U	U	U	U	U
Fresno, Calif.	186	125	34	16	8	3	11
Glendale, Calif.	21	16	3	—	1	1	1
Honolulu, Hawaii	84	55	17	3	1	8	8
Long Beach, Calif.	78	46	21	4	3	4	6
Los Angeles, Calif.	316	224	66	20	4	2	34
Pasadena, Calif.	30	20	7	2	—	1	1
Portland, Oreg.	139	101	29	7	2	—	5
Sacramento, Calif.	214	147	43	9	7	8	13
San Diego, Calif.	181	126	38	10	3	4	14
San Francisco, Calif.	149	94	40	8	6	1	15
San Jose, Calif.	195	135	38	16	5	1	14
Santa Cruz, Calif.	34	29	5	—	—	—	4
Seattle, Wash.	128	88	29	9	1	1	7
Spokane, Wash.	79	62	12	4	—	1	5
Tacoma, Wash.	156	115	33	5	3	—	7
TOTAL	12,685**	8,449	2,825	844	295	268	839

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

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

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

☆U.S. Government Printing Office: 2006-523-056/40005 Region IV ISSN: 0149-2195