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Orf Virus Infection in Humans — New York, Illinois, California, and Tennessee, 2004–2005

Orf virus is a zoonotic parapoxvirus endemic to most countries in the world and is principally associated with small ruminants (e.g., sheep and goats). Human orf infections appear as ulcerative skin lesions after contact with an infected animal or contaminated fomite. This report summarizes the epidemiologic and laboratory investigations of four sporadic cases of human orf infection, emphasizing the temporal association between human lesions and skin trauma or recent flock vaccination with live orf vaccine. This zoonotic infection shares clinical manifestations and exposure risks with other, potentially life-threatening zoonoses (e.g., cutaneous anthrax) and is likely under-recognized because of a lack of clinical suspicion and widely available diagnostics. Barrier precautions and proper hand hygiene are recommended for the prevention of orf virus infection in humans.

Case 1. On March 1, 2004, a woman aged 51 years from upstate New York noted an area of erythema approximately 4 mm in diameter on the middle finger of her right hand. During the next several days, the lesion evolved into a clear, solitary vesicle with surrounding erythema. On March 12, she visited her family physician, who prescribed penicillin and warm water soaks. The patient did not recall any trauma, including animal bites, although she regularly cared for goats on her family farm. She reported having bottle-fed a kid goat with a sore on its mouth approximately 1 week before the appearance of the lesion.

The patient did not improve and, on March 15, she went to a local hospital. The lesion on her finger had progressed to 2 cm in diameter with a 3–4 mm central white ring and umbilication. Her examination was otherwise unremarkable. At the hospital, the ulcer was debrided and a serous/gelatinous material was extracted. Routine bacterial cultures were negative. The patient was treated empirically with ciprofloxacin and amoxicillin-clavulanate.

On March 22, after discussion with local veterinarians, she contacted the New York State Department of Health to inquire about diagnostics for orf virus infection. Specimens collected on March 15 were forwarded to CDC and determined to be positive at both genus (*Parapoxvirus*) and species (orf virus) level by real-time polymerase chain reaction (PCR); standard PCR (i.e., visualization of amplicons by gel electrophoresis) (*1*) for genus and species was negative. By April 1, the lesion had spontaneously healed without scarring. No other family members or farm attendants reported similar skin lesions.

Case 2. In May 2004, an adolescent boy aged 16 years was bitten on the left hand by a healthy-appearing sheep that he was grooming for a county fair in southwestern Illinois. The sheep had been vaccinated against orf virus 1 week before the patient was bitten. Three weeks after he sustained the bite, the patient went to his primary-care physician with three nonpruritic, painless vesicular lesions on his left thumb, the largest of which was 1.5 cm in diameter. Two lesions were eroded vesicles with an erythematous base and white halo (Figure 1); the remaining periungual lesion around the nail was still intact. The patient reported no constitutional symptoms, and the rest of his physical examination was unremark-

INSIDE

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FIGURE 1. A thumb with two denuded orf lesions (eroded vesicles with an erythematous base and white halo)

Photo/CDC

able. Skin from the unroofed vesicle and dry swabs of material from the ulcer beds were submitted to CDC to confirm the diagnosis of orf virus infection. Both real-time PCR and standard PCR were positive in genus- and species-specific assays, confirming the diagnosis of orf virus infection. No treatment was administered, and the lesions healed spontaneously after 2 months. The sheep was removed from the county fair once the orf infection was evident, and active case finding failed to reveal other orf infections in county fair staff or attendees.

Case 3. On July 28, 2004, a man aged 51 years from Sonoma County, California, was referred to an infectious diseases physician because of pruritic, painless vesicles on his left hand. He had onset of these lesions 10 days after shearing young sheep, which had been purchased recently at auction and vaccinated with the live orf vaccine. The patient noted that some of the sheep had ulcers on their oral mucosa. He also recalled cutting his skin on thistles and burs embedded in the sheep wool. He reported no constitutional symptoms. His physical examination was only remarkable for five bullae (vesicles ≥1 cm in diameter), 1.0–1.5 cm in diameter, on the back of both hands. A punch biopsy specimen of one lesion was sent to the Santa Rosa Kaiser Medical Center Pathology Department, and serum was submitted to the California State Health Department Laboratory for further testing. Histopathology indicated nonspecific inflammation, but serologic evaluation revealed parapoxvirus IgM >1:160 and IgG of 1:512, consistent with current or recent parapoxvirus infection. All lesions healed spontaneously within 2 weeks.

Case 4. On May 25, 2005, a girl aged 11 years was taken to her pediatrician in Nashville, Tennessee, with a 7-mm papulovesicular lesion on the fourth finger of her left hand. Ten days before this visit, her family had vaccinated their sheep against orf virus. Five days before her clinic visit, she had cut the same finger on a lamb harness. The remainder of her physical

examination was unremarkable. The lesion was lanced in clinic, producing 3 cc of bloody discharge that was submitted to CDC for evaluation of orf virus infection. While laboratory results were pending, the patient was treated with amoxicillin-clavulanate twice a day for 10 days. Real-time PCR performed at CDC confirmed the presence of orf virus using both genus- and species-specific primers, and standard PCR assays were negative for both primer sets. The lesion healed spontaneously within 1 month. No other family members reported similar lesions to the attending physician.

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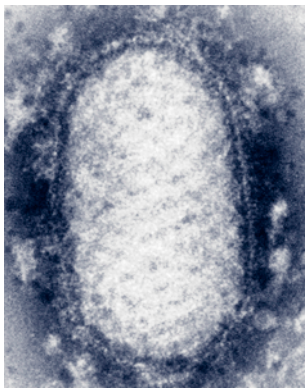
Editorial Note: Although orf virus infection is self-limiting in hosts with normal immune systems, it can resemble skin lesions associated with potentially life-threatening zoonotic infections such as tularemia, cutaneous anthrax, and erysipeloid (*2*); therefore, rapid and definitive diagnosis is critical. Tularemia and erysipeloid are generally associated with exposure to rabbits or New World sylvan rodents and swine, respectively. Both orf virus infection and naturally acquired anthrax in humans can result from exposure to domestic sheep and goats; thus, exposure history alone (i.e., animal contact) is insufficient to indicate etiology, necessitating laboratory evaluation. Histopathologic features include intraepithelial ballooning and intracytoplasmic inclusions (*3*); however, these findings are suggestive and not pathognomonic. Negative-stain electron microscopy can confirm a parapoxvirus infection by demonstrating classic ovoid cross-hatched virions (Figure 2) but cannot distinguish orf virus from other parapoxviruses such as paravaccinia (pseudocowpox) virus; serologic testing has the same limitation. Only PCR can definitively identify a parapoxvirus as orf virus. Two assays have been used by CDC: standard PCR (*1*) and real-time PCR. Cases 1 and 4 described in this report demonstrate the increased sensitivity of the newer real-time PCR technique (nearly 1,000 times more sensitive than standard PCR) (Y. Li, PhD, CDC, personal communication, November 2005). This high level of sensitivity has been observed for other poxvirus real-time PCR assays validated by CDC (*4*). These assays are ideally performed on frozen tissue specimens, vesicle material, or scab debris.

FIGURE 2. Negative-stain electron microscopic image of orf virus, a member of the genus *Parapoxvirus*



Photo/CDC

Transmission of orf virus to humans occurs after contact with infected or recently vaccinated animals and/or fomites in conjunction with skin trauma. Orf virus vaccine strains have been known to cause outbreaks among sheep (*5*), and three of the illnesses described in this report occurred soon after vaccination of the flock. Veterinary vaccines for orf virus use nonattenuated, live virus preparations and are intended to produce controlled infections in flocks (*6*). Recently vaccinated animals pose an occupational risk to humans (*7*). Infections in three of the four cases described in this report were temporally associated with orf virus vaccination; however, the vaccines used to inoculate the animals in question were not available for genetic comparison with patient isolates.

Three of the four cases described in this report were associated with concurrent skin trauma; orf virus infection is facilitated by skin trauma (*8*), and previous case series have associated skin trauma with orf virus infection (*3*). Trivial injury (e.g., pricks from thistle) or substantial trauma (e.g., bites) can facilitate transmission of orf virus. Therefore, barrier protection (e.g., nonporous gloves) and hand washing during the care of sheep and goats is recommended whenever feasible. These measures are especially important for any person with a compromised immune system or a chronic skin disorder (e.g., eczema) who has contact with overtly infected animals. Immunocompromised persons should discuss the risks of handling orf-infected animals and infection-prevention strategies with their primary-care physicians.

Human orf virus infection is a common yet preventable consequence of contact with sheep and goats. Persons who are most likely to be exposed to orf virus (e.g., farm workers) might be familiar with the infection and thus might not seek medical attention. As a result, clinicians might not be familiar with orf virus infections, leading to a delay in diagnosis and

unnecessary antibiotic use. Public health personnel should be cognizant that orf virus infection is similar in appearance and risk factors to life-threatening infections such as cutaneous anthrax and that skin trauma is a predisposing factor to infection. In addition, immunocompromised patients can have progressive, destructive lesions requiring medical interventions such as antiviral therapy (*9*) and surgical debridement (*10*). The relation between vaccination of sheep and goats for orf virus and subsequent human orf virus infection should be considered in future public health investigations. Barrier precautions and proper hand hygiene are recommended for the prevention of orf virus infection in humans. Upon request, definitive diagnostic testing for orf virus is available at CDC, telephone 404-639-4129.

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References

1. Torafson EG, Gunadottir S. Polymerase chain reaction for laboratory diagnosis of orf virus infections. J Clin Virol 2002;24:79–84.
2. CDC. Human orf mimicking cutaneous anthrax—California. MMWR 1973;22:108.
3. Uzel M, Sasmaz S, Bakaris S, et al. A viral infection of the hand commonly seen after the feast of sacrifice: human orf (orf of the hand). Epidemiol Infect 2005;133:653–7.
4. Olson VA, Laue T, Laker MT, et al. Real-time PCR system for detection of orthopoxviruses and simultaneous identification of smallpox virus. J Clin Microbiol 2004;42:1940–6.
5. Gilray JA, Nettleton PF, Pow I, et al. Restriction endonuclease profiles of orf virus isolates from the British Isles. Vet Rec 1998;143:237–40.
6. De la Concha-Bermejillo A, Ermel RW, Zhang MZ, Guo J. Contagious ecthyma (orf) virulence factors and vaccine failure. In: Proceedings of the United States Animal Health Association; Richmond, VA: United States Animal Health Association; 1999.
7. Mercer A, Fleming S, Robinson A, Nettleton P, Reid H. Molecular genetic analyses of parapoxviruses pathogenic for humans. Arch Virol Suppl 1997;13:25–34.
8. Buttner M, Rziha H-J. Parapoxviruses: from the lesion to the viral genome. J Vet Med 2002;49:7–16.
9. Geernick K, Lukito G, Snoeck R, et al. A case of human orf in an immunocompromised patient treated successfully with cidofovir cream. J Med Virol 2001;64:543–9.
10. Shelley WB, Shelley ED. Surgical treatment of farmyard pox: orf, milker's nodules, bovine papular stomatitis pox. Cutis 1983;31:191–2.

Rates of Cesarean Delivery Among Puerto Rican Women — Puerto Rico and the U.S. Mainland, 1992–2002

Cesarean delivery has been associated with greater risks for maternal morbidity (*1,2*), longer hospital stays, and rehospitalization after childbirth (*2,3*) than vaginal delivery. On the U.S. mainland (i.e., 50 states and District of Columbia), rates of total cesarean delivery and primary cesarean delivery (i.e., for women without a previous cesarean) per 100 live births decreased from 1992 to 1996 before increasing from 1996 to 2002. During 2002, among all U.S. mainland births (approximately 4 million), 26% were by cesarean delivery; among all mainland births to women without a previous cesarean delivery, 18% were by primary cesarean (*4*). Cesarean delivery rates for Puerto Rican women who delivered on the U.S. mainland were similar to those for all women on the mainland. By contrast, among all 52,747 births in Puerto Rico in 2002, 45% were by cesarean delivery; among births in Puerto Rico to women without a previous cesarean delivery, 33% were primary cesarean deliveries (*4*). In addition, during 1996–2002, annual rates of vaginal births after cesarean delivery (VBAC) (i.e., per 100 live births to women who had a previous cesarean delivery) were lower in Puerto Rico than on the U.S. mainland. To compare trends in cesarean delivery during 1992–2002 among Puerto Rican women who delivered in Puerto Rico and on the U.S. mainland, CDC and the Puerto Rico Department of Health analyzed birth certificate data from the National Vital Statistics System (NVSS). This report summarizes the results of that analysis, which determined that, during 1992–2002, total and primary cesarean rates were consistently higher in Puerto Rico than among Puerto Rican women on the mainland. From 1996 to 2002, total and primary cesarean rates increased for Puerto Rican women in both places of delivery, but rates increased more sharply for women in Puerto Rico than on the mainland. The results suggest that measures to reduce the number of cesarean deliveries in Puerto Rico should focus on lowering the rate of primary cesarean deliveries, especially among women at low risk for a cesarean delivery.*

NVSS birth certificates in Puerto Rico and on the U.S. mainland record data regarding method of delivery (i.e., vaginal, VBAC, primary cesarean, or repeat cesarean) (*4*). In Puerto Rico, during 1992–2002, approximately 82%–85% of birth certificates listed Puerto Rico as the birthplace of the mother, and 10%–13% listed the mother's birthplace as the U.S. main-

* A singleton pregnancy of ≥37 weeks' gestation with a vertex presentation (head facing downward in the birth canal). Based on *Healthy People 2010* objective 16-9a for women giving birth for the first time with a singleton pregnancy.

land; approximately 5% of mothers who were born outside of Puerto Rico or outside of the U.S. mainland were excluded from this analysis. Puerto Rican women were defined as 1) mothers delivering in Puerto Rico who were born in Puerto Rico or on the U.S. mainland and 2) mothers delivering on the U.S. mainland who were residents of the mainland and reported their Hispanic origin as Puerto Rican on their infant's birth certificate.

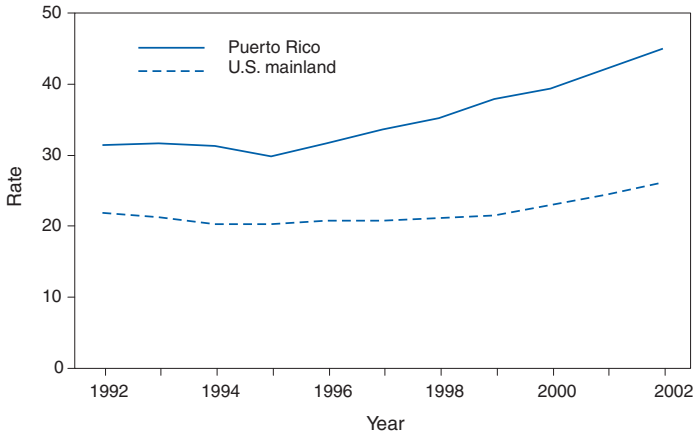
This analysis focused on differences by place of delivery (i.e., Puerto Rico versus the U.S. mainland). In addition to trends in cesarean rates during 1992–2002, certain maternal characteristics (e.g., age, level of education, and number of live births) were examined to determine any associations with rates of cesarean delivery and VBAC (*5*). Data also were analyzed to compare rates of cesarean delivery with the *Healthy People 2010* objective (no. 16-9a) to lower the rate of cesarean deliveries to 15% among women at low risk for a cesarean delivery giving birth for the first time (*6*).

Total and Primary Cesarean Deliveries and VBACs

During 2002, Puerto Rican women had 50,553 live births in Puerto Rico. From 1992 (31.4%) to 1996 (31.7%), the annual total cesarean delivery rate in Puerto Rico remained stable before increasing by 42% from 1996 to 2002 (45.0%) (Figure 1). Primary cesarean delivery rates in Puerto Rico increased by 4% from 1992 (21.3%) to 1996 (22.1%), then increased by 52% from 1996 to 2002 (33.5%) (Figure 2). The VBAC rate in Puerto Rico remained stable at 8.1% during 1992–1996 before decreasing by 56% from 1996 to 2002 (3.6%) (Figure 2).

During 2002, Puerto Rican women had 56,321 live births on the U.S. mainland. The annual total cesarean delivery rate for Puerto Rican women delivering on the mainland declined from 1992 (21.9%) to 1996 (20.8%), then increased by 26% from 1996 to 2002 (26.2%) (Figure 1). Primary cesarean delivery rates declined from 1992 (15.2%) to 1996 (14.6%), then increased by 24% from 1996 to 2002 (18.1%) (Figure 2). The VBAC rate for Puerto Rican women delivering on the mainland increased from 1992 (25.0%) to 1996 (31.2%), then decreased by 51% from 1996 to 2002 (15.2%) (Figure 2).

FIGURE 1. Cesarean delivery rates* among Puerto Rican women,† by place of delivery and year — Puerto Rico and the U.S. mainland, 1992–2002

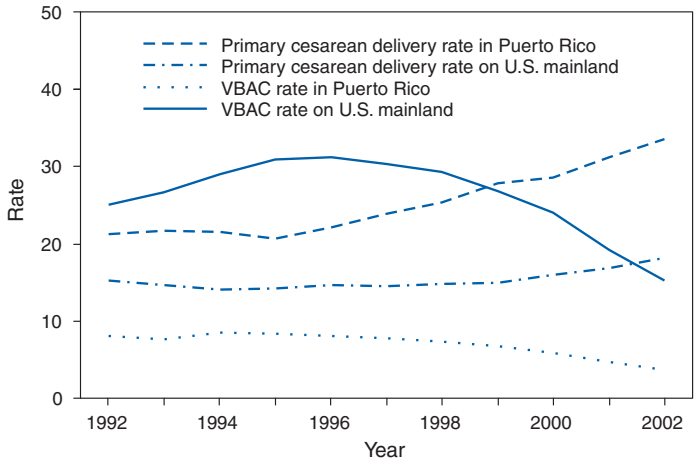


* Per 100 live births.
† For births in Puerto Rico, defined as women who were residents of Puerto Rico and born in Puerto Rico or on the U.S. mainland (50 states and the District of Columbia). For births on the U.S. mainland, defined as women who were residents of the U.S. mainland, reported Puerto Rican origin, and were born in Puerto Rico or on the mainland.

Cesarean Delivery and Maternal Characteristics

From 1992 to 2002, both in Puerto Rico and on the U.S. mainland, rates of total cesarean delivery for Puerto Rican women increased with maternal age and within age groups (Table). In Puerto Rico, the greatest increase was in the youngest group (aged <20 years), doubling from 18.5% to 37.6%. On the mainland, the greatest increase was among women aged 35–39 years, increasing 23% from 33.2% to 40.9%. During 2002, the highest rates both in Puerto Rico and on

FIGURE 2. Rates of primary cesarean delivery* and vaginal birth after cesarean delivery (VBAC)† among Puerto Rican women,§ by place of delivery and year — Puerto Rico and the U.S. mainland, 1992–2002



* Per 100 live births to women who had never had a cesarean delivery.
† Per 100 live births to women with a previous cesarean delivery.
§ For births in Puerto Rico, defined as women who were residents of Puerto Rico and born in Puerto Rico or on the U.S. mainland (50 states and the District of Columbia). For births on the U.S. mainland, defined as women who were residents of the U.S. mainland, reported Puerto Rican origin, and were born in Puerto Rico or on the mainland.

TABLE. Number and rate* of cesarean deliveries among Puerto Rican women,† by place of delivery and maternal characteristics — Puerto Rico and the U.S. mainland, 1992 and 2002

	Place of delivery							
	Puerto Rico				U.S. mainland§			
	1992		2002		1992		2002	
Characteristic	No.	(Rate)	No.	(Rate)	No.	(Rate)	No.	(Rate)
Maternal birthplace								
Puerto Rico	16,587	(31.2)	20,248	(45.0)	5,050	(23.0)	5,092	(27.5)
U.S. mainland	2,808	(32.4)	2,495	(45.2)	7,274	(21.2)	9,622	(25.6)
Total	**19,395**	**(31.4)**	**22,740**	**(45.0)**	**12,324**	**(21.9)**	**14,714**	**(26.2)**
Age group (yrs)								
<20	2,244	(18.5)	3,525	(37.6)	1,781	(14.6)	1,758	(17.6)
20–24	5,489	(27.7)	6,911	(41.7)	3,623	(19.2)	4,008	(21.9)
25–29	6,218	(37.2)	5,941	(46.5)	3,507	(24.8)	3,653	(27.0)
30–34	3,636	(40.2)	4,004	(51.2)	2,271	(29.6)	3,172	(34.6)
35–39	1,496	(44.8)	1,909	(58.8)	936	(33.2)	1,743	(40.9)
≥40	312	(46.1)	450	(63.9)	201	(37.2)	379	(44.6)
No. of live births¶								
One	8,331	(34.3)	10,184	(46.3)	4,979	(23.1)	5,697	(26.1)
Two	6,664	(34.5)	8,004	(47.4)	3,667	(22.0)	4,718	(27.2)
Three or more	4,399	(24.2)	4,549	(39.2)	3,544	(20.4)	4,276	(25.3)
Education (yrs)**								
≤8	1,406	(18.2)	1,194	(36.4)	730	(17.7)	493	(22.3)
9–11	2,408	(19.2)	3,244	(38.4)	3,280	(17.7)	3,202	(20.8)
12	5,134	(30.0)	6,501	(43.1)	4,385	(23.0)	4,934	(25.9)
13–15	5,497	(39.6)	5,933	(48.5)	2,433	(26.5)	3,670	(29.6)
≥16	4,912	(47.6)	5,830	(51.4)	1,203	(30.8)	2,275	(34.9)

* Per 100 live births.
† For births in Puerto Rico, defined as women who were residents of Puerto Rico and born in Puerto Rico or on the U.S. mainland (50 states and the District of Columbia). For births on the U.S. mainland, defined as women who were residents of the U.S. mainland, reported Puerto Rican origin, and were born in Puerto Rico or on the mainland.
§ Does not include 1992 data for New Hampshire because Puerto Rican origin of the mother was not reported on New Hampshire birth certificates that year.
¶ Includes present live birth; does not include cesarean deliveries for women with information missing on number of live births (four in 1992 and eight in 2002 in Puerto Rico; 652 in 1992 and 90 in 2002 on U.S. mainland).
** Does not include cesarean deliveries for women with information missing on education (148 in 1992 and 101 in 2002 in Puerto Rico; 1,432 in 1992 and 570 in 2002 on U.S. mainland).

the mainland were for women aged ≥40 years (63.9% and 44.6%, respectively).

Total cesarean delivery rates increased from 1992 to 2002 for women with one, two, and three or more live births (Table). In Puerto Rico, the largest increase (62%) was among women with three or more live births; however, the highest rate of cesarean delivery was for women delivering their second child (47.4%). On the U.S. mainland, the rate increased the most (24%) among women delivering their second child; these women also had the highest rate (27.2%) of cesarean delivery.

In both 1992 and 2002, total cesarean delivery rates both in Puerto Rico and on the U.S. mainland increased with education. In 2002, rates for Puerto Rican women with ≥16 years of education were 51.4% in Puerto Rico and 34.9% on the mainland (Table). Among women with ≤8 years of education, the cesarean delivery rate in Puerto Rico doubled from 1992 (18.2%) to 2002 (36.4%) and increased by 26% (from 17.7% to 22.3%) on the mainland.

The percentages of Puerto Rican women giving birth for the first time who were at low risk for a cesarean delivery were similar in Puerto Rico (16,462 [82%]) and on the U.S. mainland (14,309 [83%]). Annual rates of cesarean delivery among these women increased in Puerto Rico by 39% from 1992 (32.3%) to 2002 (44.8%). By contrast, rates for Puerto Rican women delivering on the mainland increased by 11% from 1992 (20.3%) to 2002 (22.6%).

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Editorial Note: In Puerto Rico, annual rates of total and primary cesarean delivery were stable during 1992–1996 before increasing sharply from 1996 to 2002. Nearly half of all live births in Puerto Rico in 2002 were by cesarean delivery. Rates of cesarean delivery and primary cesarean delivery were 72% and 85% higher, respectively, among Puerto Rican women in Puerto Rico than on the U.S. mainland. From 1992 to 2002, the greatest increases in rates of cesarean delivery in Puerto

Rico were among the youngest and least educated women; however, the highest rates remained among women aged ≥40 years and those with the highest levels of education.

During 2002, the rate of cesarean delivery among women at low risk for a cesarean delivery giving birth for the first time in Puerto Rico was 44.8%, nearly three times the *Healthy People 2010* target of 15% for women at low risk for a cesarean delivery and nearly double the 22.6% rate for Puerto Rican women at low risk for a cesarean delivery who delivered on the U.S. mainland. The cesarean rate (22%) for first births to all women at low risk for a cesarean delivery who delivered in the United States was similar to that for Puerto Rican women. Cesarean deliveries put women at greater risk for maternal morbidity (*1,2*) and can lengthen hospital stays and make rehospitalization more likely (*2,3*). During 2002, among women delivering in Puerto Rico with a previous cesarean delivery, approximately 96% had a repeat cesarean delivery. Whether VBAC or repeat cesarean delivery poses greater risk for a mother and infant is unresolved (*7*). According to the American College of Obstetricians and Gynecologists, most women with one previous cesarean delivery are candidates for VBAC. However, individual risk factors need to be considered; therefore, the ultimate decision regarding mode of delivery should rest with the patient and her provider (*8*). Measures to reduce the cesarean delivery rate in Puerto Rico should focus on lowering the rate of primary cesarean deliveries, especially among women at low risk for a cesarean delivery (*9*).

The findings in this report are subject to at least three limitations. First, because Hispanic ethnicity of the mother is not recorded on birth certificates in Puerto Rico, a small number of live births in Puerto Rico included in the analysis might have been to women who were born in Puerto Rico or on the U.S. mainland but were not of Puerto Rican origin. Second, certain information that might influence differences in rates of cesarean delivery and VBAC (e.g., reason for cesarean delivery, type of hospital, or type of insurance coverage) is not currently collected on birth certificates. Finally, no distinction could be made between cesarean deliveries that were elective and those resulting from medical indications or conducted as emergency procedures.

Why cesarean delivery rates in Puerto Rico are higher and increasing at a faster rate than those among Puerto Rican women delivering on the U.S. mainland is not known. High rates of cesarean delivery also have been reported among women delivering in certain Latin American countries, with rates highest in private hospitals (*10*). The higher rates in Puerto Rico might be associated with differences in maternal characteristics, attitudes toward cesarean delivery, obstetric practices, or health insurance coverage. Further research is needed to examine these factors and their potential association with rates of cesarean delivery and VBAC among Puerto Rican women.

References

1. Burrows LJ, Meyn LA, Weber AM. Maternal morbidity associated with vaginal versus cesarean delivery. Obstet Gynecol 2004;103 (5 Pt 1):907–12.
2. Webb DA, Robbins JM. Mode of delivery and risk of postpartum rehospitalization. JAMA 2003;289:46–7.
3. Kozak LJ, Owings MF, Hall MJ. National Hospital Discharge Survey: 2001 annual summary with detailed diagnosis and procedure data. Vital Health Stat 2004;13(156):1–198.
4. Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, Munson ML. Births: final data for 2002. Natl Vital Stat Rep 2003; 52(10):1–113.
5. CDC. Rates of cesarean delivery—United States, 1993. MMWR 1995;44:303–7.
6. US Department of Health and Human Services. Healthy people 2010: understanding and improving health. 2nd ed. Washington, DC: US Department of Health and Human Services; 2000. Available at http://www.health.gov/healthypeople.
7. Landon MB, Hauth JC, Leveno KJ, et al. Maternal and perinatal outcomes associated with a trial of labor after prior cesarean delivery. N Engl J Med 2004;351:2581–9.
8. ACOG Practice Bulletin No. 54: vaginal birth after previous cesarean delivery. American College of Obstetricians and Gynecologists. Obstet Gynecol 2004;104:203–12.
9. Declercq E, Menacker F, MacDorman M. Rise in "no indicated risk" primary caesareans in the United States, 1991–2001: cross sectional analysis. BMJ 2005;330:71–2.
10. Belizan JM, Althabe F, Barros FC, Alexander S. Rates and implications of cesarean sections in Latin America: ecological study. BMJ 1999;319:1397–400.

Surveillance for Early Detection of Disease Outbreaks at an Outdoor Mass Gathering — Virginia, 2005

Implementing public health surveillance at mass gatherings might help detect outbreaks or possible acts of biologic terrorism and enable prompt public health intervention. In July 2005, a daily syndromic sentinel surveillance system was implemented to monitor disease and injury among approximately 43,000 youths and adults attending a 10-day camping event held every 4 years by a national youth organization. Camp activities began on July 25, 2005, and included events such as mountain boarding, rappelling, and whittling. This report describes public health surveillance and response activities during the 10-day event and presents recommendations for health surveillance at large outdoor events. Public health surveillance should be implemented at mass gatherings to facilitate rapid detection of outbreaks and other health-related events and enable public health teams to respond with timely control measures.

Campers, predominantly young males from throughout the United States and other countries, began to arrive at the camp on July 24, 2005. The camp was held at a publicly owned site covering an area of approximately 7 square miles in Virginia. The camp was divided into 20 subcamps, each containing 31–90 groups of approximately 40 campers each. Although meals were prepared in small groups within subcamps, water was shared across subcamps for drinking and hand-hygiene purposes. Clusters of outdoor pit latrines and shower facilities were scattered throughout the subcamps. Small clinics staffed by medical personnel served each subcamp, with five additional medical clinics available to campers and guests throughout the encampment. The Virginia Department of Health and the sponsoring youth organization had requested a federal public health team to help establish and maintain public health surveillance and advise on outbreak prevention and control.

As buses arrived during the first 2 days of the event, medical and public health personnel screened persons on each incoming bus, using a standard interview form that included questions about presence of the following symptoms: vomiting, diarrhea, rash, fever, pink or red eye, and cough. If any group of campers on a single bus had at least three persons with symptoms commonly associated with communicable disease during the preceding 48 hours, the entire group was referred for in-depth screening by the public health support team. Ill campers were interviewed about the nature and timing of symptoms, travel history, and source of food and beverages consumed during the preceding 72 hours.

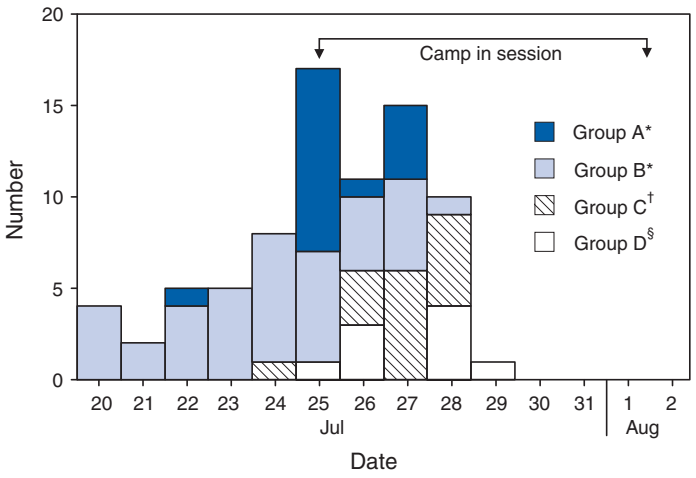
In addition to these initial screenings, a daily syndromic sentinel surveillance system was used for rapid detection of communicable disease outbreaks to enable prompt public health intervention. Medical staff at each of the 25 clinics recorded each patient's chief complaint and disposition in a log specific to that clinic. Diagnoses were categorized into one of the following 10 syndromic illness categories: gastrointestinal (GI); respiratory; infectious disease; bite (tick); bite/sting (other); heat (skin/sunburn); heat (exhaustion/stroke); injury (laceration/abrasion/puncture); cardiovascular; and other. Rate estimates for each illness and injury category were calculated by dividing the total number from each specific category by the total population. These reports were reviewed routinely and used as a guide for active surveillance and intervention.

Gastroenteritis

Initial screening on July 25 identified two groups (A and B) of campers with symptoms of gastroenteritis. Group A initially had eight (20%) of 40 members with vomiting and diarrhea when screened. By the next morning, three additional campers in group A had become ill with similar symptoms. Although only six (8%) of 80 campers in group B had symptoms on arrival day, 22 cases of GI illness were reported in group B campers 60 hours before arrival. All illnesses in groups A and B were characterized by acute onset of malaise, nausea, vomiting, and diarrhea. Symptoms typically lasted 24–48 hours. Review of cases by date of onset suggested an infectious illness that had an incubation period of approximately 24–48 hours. Attack rates were 40% (16 of 40) for group A and 48% (38 of 80) for group B. The syndromic surveillance system alerted staff within 24 hours to a third group (C) with GI illness; 15 (38%) of 40 campers from group C were ill during the entire event. A call from a physician in another camp led the team to investigate a fourth group (D) in which eight (20%) of 40 persons had symptoms similar to those of groups A and B (Figure). Overall incidence of GI disease for the entire camp throughout the event was 22.2 cases per 1,000 persons. Investigators were unable to determine whether campers from groups C and D had contact with groups A and B and were potentially exposed to previously identified GI illness clusters.

Six stool specimens (two each from groups A and D and one each from groups B and C) were tested during the event at the Virginia Division of Consolidated Laboratory Services, and four (66.7%) (two from group A and one each from groups B and D) were determined by reverse-transcription polymerase chain reaction to be positive for norovirus. The four positive specimens were subjected to nucleic acid sequencing to compare the viral strain types to each other and to those in a database of norovirus prototype sequences obtained from CDC. Viral sequences obtained from groups A and C were geneti-

FIGURE. Number of reported cases of gastrointestinal illness among attendees of a mass outdoor gathering, by group of campers and date of onset — Virginia, July 20–August 2, 2005



* Detected by initial screening.
† Detected by syndromic surveillance.
§ Detected by active surveillance.

cally similar and differed by only a single nucleotide. The group B isolate was genetically distinct from that of groups A and C; viral sequences were not able to be obtained from Group D.

Control measures implemented for GI infection clusters identified during arrival screening included isolation for 48 hours and use of separate toilet, shower, and hand-washing facilities. Persons who were symptomatic were restricted from preparing and handling food for the remainder of their stay at the encampment. Hand washing was reinforced to campers on a daily basis. In accord with public health team recommendations, any persons with new symptomatic cases from GI infection clusters were isolated in the medical clinic for up to 48 hours after resolution of symptoms.

Heat-Related Events

During July 24–August 2, a total of 14,857 injury and illness events were logged among campers, visitors, and staff at medical clinics. Of these, 3,486 (23.5%) were for heat-related conditions; cases were designated by the surveillance system in one of two illness categories: "heat (skin/sunburn)" or "heat (exhaustion/stroke)." A total of 1,624 persons were treated specifically for heat-related exhaustion/stroke, with a mean daily rate of 3.7 cases per 1,000 persons; 194 persons were transported to the onsite hospital for treatment. The daily rate of heat-related exhaustion/stroke and heat-index* measurements ranged from 0.4 to 11.5 cases per 1,000 persons and 86°F (30°C) to 121°F (49.4°C), respectively. The highest rate of heat-related exhaustion/stroke, 11.5 cases per 1,000 persons, was observed on July 27. On this day, the heat index was 121°F (49.4°C), the highest observed during the entire camping event, and attendees were exposed to other stressful conditions, such as hiking and standing in direct sunlight in a stadium for several hours awaiting a special event, without adequate water or shade structures.

The special event was rescheduled for July 31; additional shade structures and portable water reservoirs were provided and air-conditioned buses were used as cooling stations. Although the heat-index on July 31 was 90°F (32.2°C), participants at the gathering experienced one of the lowest rates of heat-related exhaustion/stroke during the 10-day event, with approximately 0.6 cases per 1,000 persons.

Other Illness and Injury Events

A total of 3,959 (26.7%) injury/illness events were classified as "other" and included such health problems as blisters, nosebleeds, and dental problems. Injuries (including lacerations and abrasions) were common during the surveillance period, accounting for 2,795 (18.8%) visits. Other reasons for seeking medical care included 1,016 (6.8%) visits for respiratory problems, 453 (3.0%) for ticks, 1,377 (9.3%) for bites/stings, 417 (2.8%) for rashes, and 96 (0.6%) for cardiovascular problems (e.g., high blood pressure or chest pain). Five adult deaths occurred during the 8-day event, one caused by myocardial infarction and four caused by electrocution.

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Editorial Note: The findings in this report underscore the utility of public health screening and surveillance at mass gatherings and the importance of implementing prevention and control measures on the basis of surveillance data. Syndromic surveillance, in conjunction with active visits with subcamp medical staff to reinforce surveillance importance and inquire about illness, alerted the epidemiology team to the GI outbreak in group C and heat-related events and enabled the public health team to monitor other injury and illness trends. By following up on illness and injury clusters identified daily by syndromic surveillance throughout the event, the public health team was able to implement control measures for the GI illness outbreak and recommend measures for preventing heat-related illness.

Initial screening detected two of four GI illness outbreaks; syndromic surveillance, in conjunction with active visits to subcamp medical personnel, alerted the team to two additional GI illness outbreaks within 24 to 36 hours. Similar findings (i.e., three laboratory-confirmed norovirus outbreaks) were detected through initial screening at a camp sponsored by the same organization in 2001; however, no additional GI illness outbreaks were identified by the syndromic surveillance system implemented at that camp (*1*). Syndromic surveillance at a smaller outdoor gathering of a different group in Pennsylvania in 1999 identified diarrheal illnesses, musculoskeletal injuries, and bites as the most common events for which participants sought care (*2*). An outbreak of shigellosis at a mass gathering in 1987 subsequently spread to the general public after the group had dispersed (*3*); that example highlights the importance not only of identifying outbreaks quickly at mass gatherings, but also of implementing control measures to prevent further transmission of illness to the community after the event.

Although no deaths associated with heat-related illness occurred during this 10-day mass gathering, 1,624 heat-related exhaustion cases were observed among approximately

* Heat index was calculated using the National Oceanic and Atmospheric Heat Index Calculation Table, which combines air temperature and relative humidity.

43,000 attendees. During 1979–2002, a total of 8,966 heat-related deaths† were documented in the United States (*4*). The annual heat-related death rate averages from 230 to 1,700 deaths per year, depending on weather conditions (*5*). Exposure to excessive heat also contributes to a range of heat-related illnesses, including heat cramps, and to more serious consequences, such as heat exhaustion and heat stroke (*6*). Risk factors for heat-related mortality and morbidity include age, socioeconomic status, urban living, and not practicing preventive behaviors (*7*). Heat-related illnesses are an important concern during prolonged exposure to heat and can be reduced at crowded outdoor events by anticipating changing environmental conditions, recognizing how persons might be at risk, and providing adequate shade structures, water, and cooling stations.

The findings in this report are subject to at least three limitations. First, misclassification of illness and injury might have occurred on the epidemiology summary form because the categories were not clearly defined or mutually exclusive. Furthermore, because different persons completed the forms each night, recording might not have been consistent. Some providers also might have reported multiple diagnoses. Second, shortage of staff time to complete the reporting form resulted in some subcamps failing to report every night; thus, data collection was incomplete. Finally, potential underreporting of heat-related illness occurred at the July 27 event when the number of ill campers overwhelmed the system; many cases were not recorded.

Because initial screening for this event was a critical component in detecting outbreaks, similar screening of participants upon arrival should be considered for comparable sites when feasible, along with syndromic surveillance. The syndromic surveillance system used for this gathering could be improved by implementation of an electronic medical record system, which would allow for immediate and real-time disease reporting and would eliminate the need for additional staff time to complete forms. In addition, clear case definitions for syndromes should improve surveillance accuracy.

Public health planning for multi-day, outdoor mass gatherings should involve the event planning staff, local and state health departments, and other agencies responsible for public health and safety. Plans should include 1) prescreening to detect disease and illness of persons before they enter the event site; 2) implementing a syndromic surveillance system with clear case definitions for injury/illness syndromes, combined with education for system users; 3) assessing the usefulness of an electronic medical record system, which would allow for immediate and real-time disease reporting; 4) estimating local response capacity for laboratory diagnosis and emergency medical treatment; and 5) preparing triage and evacuation systems.

† Underlying cause of death during 1979–1998 is classified according to the *International Classification of Diseases, Ninth Revision* (ICD-9). Excessive heat has three categories: E900.0 (due to weather conditions), E900.1 (of man-made origins), and E900.9 (of unspecified origin). The data for 1999–2002 are from ICD-10; code X30 (exposure to excessive natural heat [deaths]) was added to the 1979–1998 ICD-9 code E900.0 (excessive heat due to weather conditions [deaths]).

References

1. CDC. Norwalk-like virus–associated gastroenteritis in a large, high-density encampment—Virginia, July 2001. MMWR 2002;51:661–3.
2. CDC. Public health aspects of the Rainbow Family of Living Light annual gathering—Allegheny National Forest, Pennsylvania, 1999. MMWR 2000;49:324.
3. Wharton M, Spiegel RA, Horan JM, et al. A large outbreak of antibiotic-resistant shigellosis at a mass gathering. J Infect Dis 1990;162:1324–8.
4. CDC. About extreme heat. Atlanta, GA: US Department of Health and Human Services, CDC; 2004. Available at http://www.bt.cdc.gov/disasters/extremeheat/about.asp.
5. CDC. Heat-related illnesses and deaths: United States, 1994–1995. MMWR 1995;44:465–8.
6. CDC. Heat-related deaths—Dallas, Wichita, and Cooke counties, Texas, and United States, 1996. MMWR 1997;46:528–31.
7. McGeehin MA, Mirabelli M. The potential impacts of climate variability and change on temperature-related morbidity and mortality in the United States. Environ Health Perspect 2001;109(Suppl 2):185–9.

Update: Influenza Activity — United States, January 8–14, 2006

During January 8–14, 2006,* the number of states reporting widespread influenza activity† increased to eight. Fourteen states reported regional activity, 11 reported local activity, and 16 reported sporadic activity (Figure 1).§

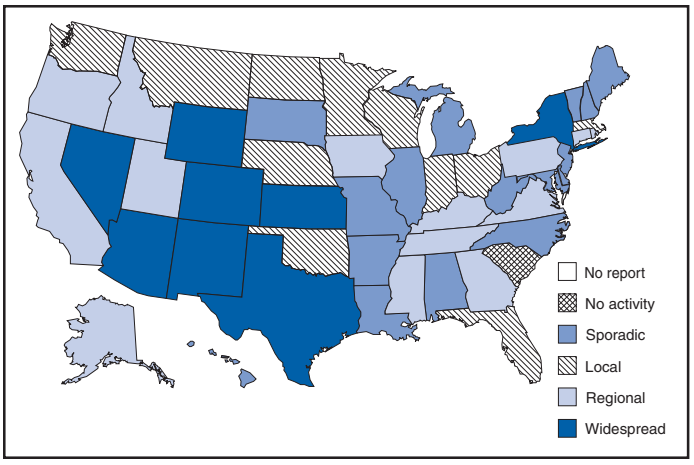
The percentage of specimens testing positive for influenza increased in the United States overall. Since October 2, 2005,

* Provisional data reported as of January 20. Additional information about influenza activity is updated each Friday and is available from CDC at http://www.cdc.gov/flu.

† Levels of activity are 1) *widespread:* outbreaks of influenza or increases in influenza-like illness (ILI) cases and recent laboratory-confirmed influenza in at least half the regions of a state; 2) *regional:* outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least two but less than half the regions of a state; 3) *local:* outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in a single region of a state; 4) *sporadic:* small numbers of laboratory-confirmed influenza cases or a single influenza outbreak reported but no increase in cases of ILI; and 5) *no activity*.

§ *Widespread:* Arizona, Colorado, Kansas, Nevada, New Mexico, New York, Texas, and Wyoming; *regional:* Alaska, California, Connecticut, Georgia, Idaho, Iowa, Kentucky, Mississippi, Oregon, Pennsylvania, Rhode Island, Tennessee, Utah, and Virginia; *local:* Florida, Indiana, Massachusetts, Minnesota, Montana, Nebraska, North Dakota, Ohio, Oklahoma, Washington, and Wisconsin; *sporadic:* Alabama, Arkansas, Delaware, Hawaii, Illinois, Louisiana, Maine, Maryland, Michigan, Missouri, New Hampshire, New Jersey, North Carolina, South Dakota, Vermont, and West Virginia; *no activity:* South Carolina; *no report:* none.

FIGURE 1. Estimated influenza activity levels reported by state epidemiologists, by state and level of activity* — United States, January 8–14, 2006



* Levels of activity are 1) *widespread:* outbreaks of influenza or increases in influenza-like illness (ILI) cases and recent laboratory-confirmed influenza in at least half the regions of a state; 2) *regional:* outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least two but less than half the regions of a state; 3) *local:* outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in a single region of a state; 4) *sporadic:* small numbers of laboratory-confirmed influenza cases or a single influenza outbreak reported but no increase in cases of ILI; and 5) *no activity*.

the largest numbers of specimens testing positive for influenza have been reported from the Mountain (754 positives) and Pacific (479 positives) regions, accounting for 36.0% and 22.9%, respectively, of positive tests reported during the 2005–06 influenza season. The percentage of outpatient visits for influenza-like illness (ILI)[¶] decreased during the week ending January 14 and is below the national baseline.** The percentage of deaths attributed to pneumonia and influenza (P&I) was below the epidemic threshold for the week ending January 14.

Laboratory Surveillance

During January 8–14, World Health Organization (WHO) collaborating laboratories and National Respiratory and Enteric Virus Surveillance System (NREVSS) laboratories in the United States reported testing 2,016 specimens for influenza viruses, of which 238 (11.8%) were positive. Of these, 105 were influenza A (H3N2) viruses, two were influenza A (H1N1) viruses, 125 were influenza A viruses that were not subtyped, and six were influenza B viruses.

Since October 2, 2005, WHO and NREVSS laboratories have tested 43,434 specimens for influenza viruses, of which 2,092 (4.8%) were positive. Of these, 2,026 (96.8%) were influenza A viruses, and 66 (3.2%) were influenza B viruses. Of the 2,026 influenza A viruses, 1,082 (53.4%) have been subtyped; 1,075 (99.4%) were influenza A (H3N2) viruses, and seven (0.6%) were influenza A (H1N1) viruses.

P&I Mortality and ILI Surveillance

During the week ending January 14, P&I accounted for 7.8% of all deaths reported through the 122 Cities Mortality Reporting System. This percentage is below the epidemic threshold[††] of 8.1% (Figure 2).

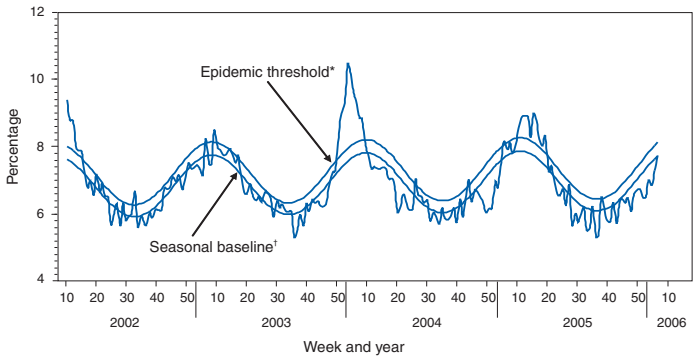
The percentage of patient visits for ILI was 2.1%, which is below the national baseline of 2.2% (Figure 3). The percentage of patient visits for ILI ranged from 1.1% in the West North Central region to 4.6% in the West South Central region.

[¶] Temperature of ≥100.0°F (≥37.8°C) and cough and/or sore throat in the absence of a known cause other than influenza.

** The national baseline was calculated as the mean percentage of visits for ILI during noninfluenza weeks for the preceding three seasons, plus two standard deviations. Noninfluenza weeks are those in which <10% of laboratory specimens are positive for influenza. Wide variability in regional data precludes calculating region-specific baselines; therefore, applying the national baseline to regional data is inappropriate.

[††] The expected seasonal baseline proportion of P&I deaths reported by the 122 Cities Mortality Reporting System is projected using a robust regression procedure in which a periodic regression model is applied to the observed percentage of deaths from P&I that occurred during the preceding 5 years. The epidemic threshold is 1.645 standard deviations above the seasonal baseline.

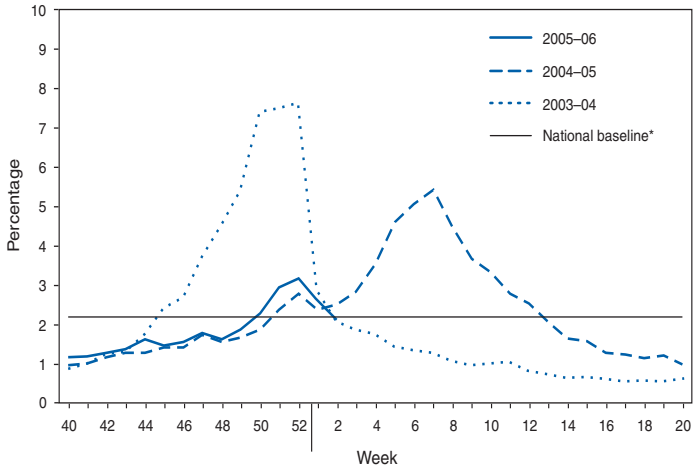
FIGURE 2. Percentage of deaths attributed to pneumonia and influenza (P&I) reported by the 122 Cities Mortality Reporting System, by week and year — United States, 2002–2006



* The epidemic threshold is 1.645 standard deviations above the seasonal baseline percentage.

† The seasonal baseline is projected using a robust regression procedure that applies a periodic regression model to the observed percentage of deaths from P&I during the preceding 5 years.

FIGURE 3. Percentage of visits for influenza-like illness (ILI) reported by the Sentinel Provider Surveillance Network, by week — United States, 2003–04, 2004–05, and 2005–06 influenza seasons



* The national baseline was calculated as the mean percentage of visits for ILI during noninfluenza weeks for the preceding three seasons, plus two standard deviations. Noninfluenza weeks are those in which <10% of laboratory specimens are positive for influenza. Wide variability in regional data precludes calculating region-specific baselines; therefore, applying the national baseline to regional data is inappropriate.

Pediatric Deaths and Hospitalizations

During October 2, 2005–January 14, 2006, CDC received reports of 10 influenza-associated deaths in U.S. residents aged <18 years. Eight of the deaths occurred during the current influenza season and two occurred during the 2004–05 influenza season.

During October 1, 2005–January 7, 2006, the preliminary influenza-associated hospitalization rate reported by the Emerging Infections Program[§§] (EIP) for children aged 0–17 years was 0.18 per 10,000. For children aged 0–4 years and 5–17 years, the rate was 0.48 per 10,000 and 0.02 per 10,000, respectively. During October 30, 2005–January 7, 2006, the New Vaccine Surveillance Network[¶¶] (NVSN) reported no laboratory-confirmed influenza-associated hospitalizations among children aged 0–4 years. EIP and NVSN hospitalization rate estimates are preliminary.

Human Cases of Avian Influenza A (H5N1)

No human case of avian influenza A (H5N1) virus infection has ever been identified in the United States. From December 2003 through January 14, 2006, a total of 151 laboratory-confirmed human cases of avian influenza A (H5N1) infections were reported to WHO from Cambodia, China, Indonesia, Thailand, Turkey, and Viet Nam.[***] Of these, 82 (54%) were fatal (Table). This represents an increase of one case and one death in China and two cases and two deaths in Indonesia reported since January 14, 2006. The majority of cases appear to have been acquired from direct contact with infected poultry. No evidence of sustained human-to-human transmission of H5N1 has been detected, although rare cases of human-to-human transmission likely have occurred (*1*).

[§§] The Emerging Infections Program (EIP) Influenza Project conducts surveillance in 60 counties associated with 12 metropolitan areas: San Francisco, California; Denver, Colorado; New Haven, Connecticut; Atlanta, Georgia; Baltimore, Maryland; Minneapolis/St. Paul, Minnesota; Albuquerque, New Mexico; Las Cruces, New Mexico; Albany, New York; Rochester, New York; Portland, Oregon; and Nashville, Tennessee.

[¶¶] The New Vaccine Surveillance Network (NVSN) conducts surveillance in Monroe County, New York; Hamilton County, Ohio; and Davidson County, Tennessee.

[***] Available at http://www.who.int/csr/disease/avian_influenza/en.

Reference

1. Ungchusak K, Auewarakul P, Dowell SF, et al. Probable person-to-person transmission of avian influenza A (H5N1). N Engl J Med 2005;352:333–40.

TABLE. Number of laboratory-confirmed human cases and deaths from avian influenza A (H5N1) infection reported to the World Health Organization — worldwide, 2003–2006*

	Cambodia		China		Indonesia		Thailand		Turkey		Viet Nam		Total	
Year of onset	No.	Deaths	No.	Deaths	No.	Deaths	No.	Deaths	No.	Deaths	No.	Deaths	No.	Deaths
2003	0	0	0	0	0	0	0	0	0	0	3	3	**3**	**3**
2004	0	0	0	0	0	0	17	12	0	0	29	20	**46**	**32**
2005	4	4	8	5	16	11	5	2	0	0	61	19	**94**	**41**
2006	0	0	1	1	3	3	0	0	4	2	0	0	**8**	**6**
Total	**4**	**4**	**9**	**6**	**19**	**14**	**22**	**14**	**4**	**2**	**93**	**42**	**151**	**82**

* As of January 23, 2006.

Notice to Readers

2006 Annual Conference on Antimicrobial Resistance, June 26–28, 2006

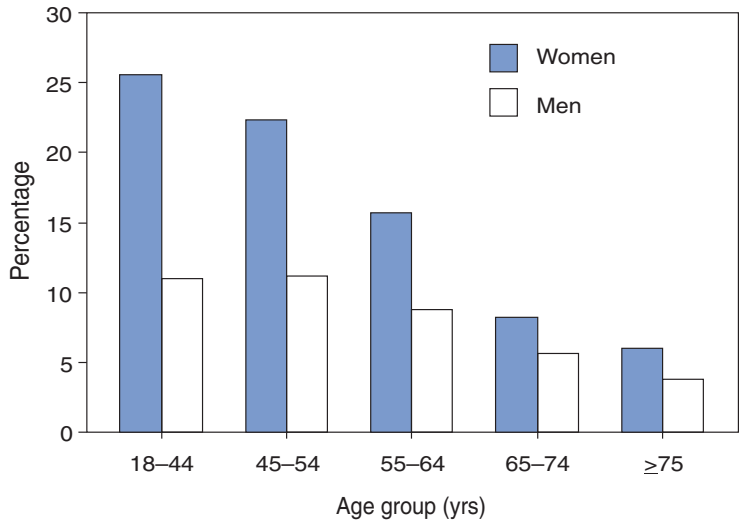
CDC and 10 other national agencies and organizations will collaborate with the National Foundation for Infectious Diseases in sponsoring the 2006 Annual Conference on Antimicrobial Resistance (including basic science, prevention, and control), June 26–28, 2006, at the Hyatt Regency Bethesda in Bethesda, Maryland. Twenty-eight invited speakers will address such topics as rapid diagnostics, community-associated methicillin-resistant *Staphylococcus aureus* infections, the reemergence of *Clostridium difficile*, controversies in antimicrobial resistance, innovations and increasing efficiency in clinical trials for infectious disease, and vaccines as a strategy for preventing and controlling drug-resistant infections.

Oral and poster presentations will be selected through peer review of submitted abstracts. Deadline for submission of abstracts is March 3, 2006. Information regarding the preliminary program, abstract submission, registration, and hotel accommodations is available at http://www.nfid.org/conferences/resistance06 and by e-mail (resistance@nfid.org), fax (301-907-0878), telephone (301-656-0003, ext. 19), or mail (NFID, Suite 750, 4733 Bethesda Avenue, Bethesda, MD 20814).

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Persons Aged ≥18 Years Reporting Severe Headache or Migraine During the Preceding 3 Months, by Sex and Age Group — United States, 2004



In 2004, the percentage of adults who experienced a severe headache or migraine during the preceding 3 months decreased with age, from 18% among persons aged 18–44 years to 6% among persons aged ≥75 years. In every age group, the proportion of women who experienced severe headache or migraine was greater than that of men.

SOURCE: 2004 National Health Interview Survey. Available at http://www.cdc.gov/nchs/nhis.htm.

Erratum: Vol. 55, No. 2

In the QuickStats, "Percentage of Persons Aged 15–44 Years Overall Tested for Human Immunodeficiency Virus (HIV) During the Preceding Year and Percentage by Number of Sex Partners of the Opposite Sex — United States, 2002," an error occurred in the first sentence of the caption. The sentence should read as follows: "In 2002, among all persons aged 15–44 years, **15.1% (approximately 18.3 million persons**) had been tested for HIV during the preceding year."

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending January 21, 2006 (3rd Week)*

Disease	Current week	Cum 2006	5-year weekly average†	Total cases reported for previous years 2005	2004	2003	2002	2001	States reporting cases during current week (No.)
Anthrax	—	—	—	—	—	—	2	23	
Botulism:									
foodborne	—	—	0	19	16	20	28	39	
infant	1	1	1	85	87	76	69	97	WA (1)
other (wound & unspecified)	—	2	0	23	30	33	21	19	
Brucellosis	1	3	1	101	114	104	125	136	NE (1)
Chancroid	—	1	1	26	30	54	67	38	
Cholera	—	—	0	6	5	2	2	3	
Cyclosporiasis§	—	2	1	731	171	75	156	147	
Diphtheria	—	—	—	—	—	1	1	2	
Domestic arboviral diseases§¶:									
California serogroup	—	—	—	65	112	108	164	128	
eastern equine	—	—	—	21	6	14	10	9	
Powassan	—	—	—	—	1	—	1	N	
St. Louis	—	—	—	9	12	41	28	79	
western equine	—	—	—	—	—	—	—	—	
Ehrlichiosis§:									
human granulocytic	—	1	1	701	537	362	511	261	
human monocytic	3	15	1	470	338	321	216	142	NE (3)
human (other & unspecified)	—	—	0	114	59	44	23	6	
Haemophilus influenzae,**									
invasive disease (age <5 yrs):									
serotype b	—	—	0	7	19	32	34	—	
nonserotype b	1	2	3	110	135	117	144	—	NE (1)
unknown serotype	1	3	3	190	177	227	153	—	NJ (1)
Hansen disease§	1	2	1	85	105	95	96	79	WI (1)
Hantavirus pulmonary syndrome§	—	—	0	22	24	26	19	8	
Hemolytic uremic syndrome, postdiarrheal§	1	3	1	192	200	178	216	202	WI (1)
Hepatitis C viral, acute	4	13	28	733	713	1,102	1,835	3,976	CO (1), IL (1), KY (1), WI (1)
HIV infection, pediatric (age <13 yrs)§††	—	—	5	255	436	504	420	543	
Influenza-associated pediatric mortality§,§§,¶¶	1	6	1	49	—	N	N	N	
Listeriosis	8	17	8	805	753	696	665	613	FL (1), KY (1), NE (4), TN (2)
Measles	—	—***	1	62	37	56	44	116	
Meningococcal disease,††† invasive:									
A, C, Y, & W-135	2	5	6	260	—	—	—	—	CT (1), KY (1)
serogroup B	1	1	4	146	—	—	—	—	WA (1)
other serogroup	—	1	1	18	—	—	—	—	
Mumps	3	5	4	271	258	231	270	266	MN (1), NE (1), WI (1)
Plague	—	—	—	7	3	1	2	2	
Poliomyelitis, paralytic	—	—	—	1	—	—	—	—	
Psittacosis§	—	—	0	19	12	12	18	25	
Q fever§	1	1	1	132	70	71	61	26	TN (1)
Rabies, human	—	—	0	2	7	2	3	1	
Rubella	—	—	0	12	10	7	18	23	
Rubella, congenital syndrome	—	—	0	1	—	1	1	3	
SARS-CoV§,§§	—	—	—	—	—	8	N	N	
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	—	1	3	101	132	161	118	77	
Streptococcus pneumoniae,§									
invasive disease (age <5 yrs)	10	22	12	963	1,162	845	513	498	AR (1), CT (1), GA (2), IL (1), MA (2), OH (1), OR (1), TN (1)
Syphilis, congenital (age <1 yr)	—	2	8	297	353	413	412	441	
Tetanus	1	1	0	20	34	20	25	37	NE (1)
Toxic-shock syndrome (other than streptococcal)§	—	—	2	88	95	133	109	127	
Trichinellosis	—	1	0	17	5	6	14	22	
Tularemia§	—	—	0	131	134	129	90	129	
Typhoid fever	—	4	4	281	322	356	321	368	
Vancomycin-intermediate *Staphylococcus aureus*§	—	—	—	2	—	N	N	N	
Vancomycin-resistant *Staphylococcus aureus*§	—	—	—	—	1	N	N	N	
Yellow fever	—	—	—	—	—	—	1	—	

—: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts.

* Incidence data for reporting years 2004, 2005, and 2006 are provisional, whereas data for 2001, 2002, and 2003 are finalized.

† Calculated by summing the incidence counts for the current week, the two weeks preceding the current week, and the two weeks following the current week, for a total of 5 preceding years. Additional information is available at http://www.cdc.gov/epo/dphsi/phs/files/5yearweeklyaverage.pdf.

§ Not notifiable in all states.

¶ Includes both neuroinvasive and non-neuroinvasive. Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNET Surveillance).

** Data for *H. influenzae* (all ages, all serotypes) are available in Table II.

†† Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Implementation of HIV reporting influences the number of cases reported. Data for HIV/AIDS are available in Table IV quarterly.

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

¶¶ Of the 11 cases reported since October 2, 2005 (week 40), only nine occurred during the current 2005–06 season.

*** No measles cases were reported for the current week.

††† Data for meningococcal disease (all serogroups and unknown serogroups) are available in Table II.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending January 21, 2006, and January 22, 2005 (3rd Week)*

Reporting area	Chlamydia†					Coccidioidomycosis					Cryptosporidiosis				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	9,379	18,509	20,410	29,524	47,531	17	88	305	133	201	12	68	865	61	87
New England	380	593	1,157	1,208	1,897	—	0	0	—	—	—	3	34	1	2
Connecticut	4	146	818	58	510	N	0	0	N	N	—	0	14	—	—
Maine	14	43	74	88	146	N	0	0	N	N	—	0	2	—	—
Massachusetts	245	276	417	712	858	—	0	0	—	—	—	1	16	—	1
New Hampshire	24	34	65	76	113	—	0	0	—	—	—	0	3	1	—
Rhode Island	57	63	99	201	215	—	0	0	—	—	—	0	4	—	—
Vermont§	36	19	43	73	55	—	0	0	—	—	—	0	5	—	1
Mid. Atlantic	1,488	2,269	3,103	3,422	5,042	—	0	0	—	—	2	9	613	9	19
New Jersey	76	359	529	166	1,062	N	0	0	N	N	—	0	11	—	—
New York (Upstate)	269	498	1,390	385	447	N	0	0	N	N	—	3	574	—	2
New York City	762	695	1,168	1,220	1,478	—	0	0	—	—	—	2	15	1	7
Pennsylvania	381	736	1,079	1,651	2,055	N	0	0	N	N	2	3	21	8	10
E.N. Central	1,652	3,069	4,043	4,989	7,627	—	0	3	1	—	—	12	162	12	18
Illinois	630	850	1,647	1,577	1,820	—	0	0	—	—	—	1	15	—	3
Indiana	255	381	558	937	1,276	N	0	0	N	N	—	1	13	—	—
Michigan	533	538	1,015	1,636	476	—	0	3	1	—	—	2	7	4	2
Ohio	117	806	1,714	435	2,871	N	0	0	N	N	—	4	109	8	8
Wisconsin	117	374	490	404	1,184	N	0	0	N	N	—	4	38	—	5
W.N. Central	618	1,110	1,292	1,792	3,123	—	0	3	—	—	4	8	51	9	8
Iowa	88	136	221	286	345	N	0	0	N	N	—	1	11	—	1
Kansas	197	136	240	199	442	N	0	0	N	N	2	0	5	4	2
Minnesota	—	225	292	11	737	—	0	3	—	—	1	2	10	2	—
Missouri	314	441	606	1,055	1,147	—	0	1	—	—	1	3	37	3	4
Nebraska§	13	97	200	121	241	—	0	1	—	—	—	0	1	—	—
North Dakota	6	23	38	55	52	N	0	0	N	N	—	0	1	—	—
South Dakota	—	51	86	65	159	—	0	0	—	—	—	0	4	—	1
S. Atlantic	1,742	3,269	4,679	6,306	8,570	1	0	1	1	—	5	11	52	22	15
Delaware	41	67	92	191	190	N	0	0	N	N	—	0	2	—	—
District of Columbia	—	71	103	101	227	—	0	0	—	—	1	0	3	1	—
Florida	473	857	1,001	1,786	2,124	N	0	0	N	N	4	5	28	11	6
Georgia	—	585	1,012	—	909	—	0	0	—	—	—	2	7	1	3
Maryland	227	358	526	953	894	1	0	1	1	—	—	0	4	2	2
North Carolina	317	510	1,741	1,395	1,798	N	0	0	N	N	—	1	10	7	4
South Carolina§	212	342	1,418	1,099	695	—	0	0	—	—	—	0	3	—	—
Virginia§	426	376	700	465	1,612	—	0	0	—	—	—	1	8	—	—
West Virginia	46	46	214	316	121	N	0	0	N	N	—	0	3	—	—
E.S. Central	640	1,356	2,189	1,845	3,155	—	0	0	—	—	—	3	20	1	6
Alabama§	—	310	1,048	—	874	—	0	0	—	—	—	0	3	1	3
Kentucky	226	157	408	632	559	N	0	0	N	N	—	1	19	—	1
Mississippi	—	395	1,077	—	591	—	0	0	—	—	—	0	1	—	1
Tennessee§	414	459	703	1,213	1,131	N	0	0	N	N	—	0	4	—	1
W.S. Central	863	1,980	2,942	2,934	6,714	—	0	1	—	—	—	2	30	4	—
Arkansas	122	171	341	347	451	—	0	0	—	—	—	0	1	—	—
Louisiana	38	276	760	99	992	—	0	1	—	—	—	0	21	—	—
Oklahoma	193	207	1,372	508	868	N	0	0	N	N	—	0	10	1	—
Texas§	510	1,339	2,255	1,980	4,403	N	0	0	N	N	—	1	8	3	—
Mountain	355	1,077	1,543	1,302	3,096	—	66	204	—	90	1	2	8	3	3
Arizona	279	331	572	895	1,129	—	64	204	—	85	—	0	1	—	1
Colorado	63	259	376	284	756	N	0	0	N	N	1	1	3	1	1
Idaho§	—	35	236	—	89	N	0	0	N	N	—	0	2	—	—
Montana	—	42	103	—	122	N	0	0	N	N	—	0	3	1	—
Nevada§	—	138	459	—	407	—	1	3	—	5	—	0	2	—	—
New Mexico§	—	116	281	—	357	—	0	2	—	—	—	0	2	—	1
Utah	13	85	130	92	182	—	0	3	—	—	—	0	3	1	—
Wyoming	—	22	43	31	54	—	0	2	—	—	—	0	2	—	—
Pacific	1,641	3,177	3,942	5,726	8,307	16	28	216	131	111	—	6	29	—	16
Alaska	18	77	120	30	133	—	0	0	—	—	—	0	2	—	—
California	1,226	2,443	3,153	4,471	6,511	16	28	216	131	111	—	3	10	—	14
Hawaii	1	105	132	108	307	—	0	0	—	—	—	0	1	—	—
Oregon§	178	166	315	399	380	—	0	0	—	—	—	1	20	—	2
Washington	218	360	501	718	976	N	0	0	N	N	—	0	7	—	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	72	141	71	125	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	5	14	—	26	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
† Chlamydia refers to genital infections caused by *Chlamydia trachomatis*.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS). Because of a technical problem with hardware, NEDSS data from these states are not included this week.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 21, 2006, and January 22, 2005 (3rd Week)*

Reporting area	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive All ages, all serotypes				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	115	314	571	405	740	3,450	6,200	7,441	11,398	17,337	13	38	67	60	126
New England	1	26	90	18	45	53	102	229	231	377	—	3	12	2	7
Connecticut	—	1	65	—	—	1	37	163	16	176	—	0	6	—	—
Maine	1	4	12	1	5	2	2	7	5	4	—	0	1	—	1
Massachusetts	—	12	34	13	38	38	50	86	145	161	—	1	5	2	4
New Hampshire	—	1	7	—	—	4	4	9	17	6	—	0	3	—	—
Rhode Island	—	0	19	—	—	6	8	25	44	27	—	0	2	—	—
Vermont†	—	3	11	4	2	2	1	4	4	3	—	0	1	—	2
Mid. Atlantic	23	67	144	58	173	450	658	967	1,204	1,624	3	8	16	12	35
New Jersey	—	7	15	—	42	51	111	166	64	334	—	2	5	1	7
New York (Upstate)	14	22	117	21	29	79	125	385	180	205	2	2	11	3	9
New York City	—	16	32	9	52	196	182	408	300	460	—	1	4	2	6
Pennsylvania	9	16	30	28	50	124	219	327	660	625	1	3	5	6	13
E.N. Central	11	52	101	43	123	754	1,237	1,792	2,560	3,283	2	6	13	10	26
Illinois	—	13	32	—	28	255	354	699	617	715	—	1	5	1	5
Indiana	N	0	0	N	N	105	153	234	447	562	—	1	6	—	1
Michigan	3	14	29	23	30	277	215	518	1,103	192	—	0	3	1	4
Ohio	8	14	34	20	26	40	375	701	216	1,454	2	2	9	8	14
Wisconsin	—	13	33	—	39	77	105	158	177	360	—	0	3	—	2
W.N. Central	11	37	142	38	48	209	362	458	662	1,033	—	2	7	9	5
Iowa	—	5	14	5	15	21	30	54	68	74	—	0	1	—	—
Kansas	2	4	9	7	11	53	47	99	53	169	—	0	2	1	—
Minnesota	7	16	113	9	—	—	63	89	—	205	—	0	5	—	—
Missouri	2	9	32	15	13	130	184	243	501	494	—	0	7	8	4
Nebraska†	—	1	7	—	8	5	21	40	22	70	—	0	1	—	1
North Dakota	—	0	3	—	—	—	2	5	4	1	—	0	2	—	—
South Dakota	—	2	7	2	1	—	6	15	14	20	—	0	0	—	—
S. Atlantic	18	49	84	87	106	923	1,441	2,199	2,926	3,873	5	8	22	16	28
Delaware	—	1	3	1	4	17	17	40	83	51	—	0	0	—	—
District of Columbia	1	1	6	1	—	—	41	67	77	129	—	0	0	—	—
Florida	11	18	40	44	38	207	386	498	866	999	2	2	12	6	8
Georgia	4	11	24	28	37	—	262	586	—	477	2	2	7	2	12
Maryland	2	4	11	13	8	125	137	242	465	417	—	1	5	5	5
North Carolina	N	0	0	N	N	413	272	730	886	863	1	1	11	2	2
South Carolina†	—	2	8	—	4	93	155	783	410	331	—	0	3	1	1
Virginia†	—	11	26	—	15	48	141	266	70	559	—	1	5	—	—
West Virginia	—	0	6	—	—	20	13	34	69	47	—	0	3	—	—
E.S. Central	—	7	19	10	13	217	519	868	696	1,574	—	2	7	4	5
Alabama†	—	4	13	10	6	—	156	491	—	660	—	0	2	1	—
Kentucky	N	0	0	N	N	78	55	107	244	223	—	0	2	—	—
Mississippi	—	0	0	—	—	—	138	299	—	245	—	0	0	—	—
Tennessee†	—	3	11	—	7	139	168	285	452	446	—	1	5	3	5
W.S. Central	—	5	23	1	5	331	827	1,195	1,149	2,817	2	2	7	2	5
Arkansas	—	1	5	—	3	58	85	188	220	257	—	0	2	—	—
Louisiana	—	1	5	1	—	29	153	461	71	578	—	0	4	—	2
Oklahoma	—	3	16	—	2	59	80	462	165	338	2	1	5	2	3
Texas†	N	0	0	N	N	185	486	843	693	1,644	—	0	1	—	—
Mountain	14	25	56	29	50	119	225	480	399	701	—	3	19	4	9
Arizona	—	3	12	—	5	86	72	166	201	252	—	1	9	—	2
Colorado	11	9	26	15	22	30	58	90	171	180	—	1	4	3	2
Idaho†	—	2	12	1	8	—	1	10	—	5	—	0	1	—	1
Montana	3	1	7	4	4	—	2	9	—	5	—	0	0	—	—
Nevada†	—	1	5	—	2	—	54	198	—	162	—	0	3	—	1
New Mexico†	—	1	6	—	2	—	24	48	—	69	—	0	4	—	1
Utah	—	7	28	8	6	3	14	22	19	27	—	0	2	1	1
Wyoming	—	0	2	1	1	—	2	6	8	1	—	0	2	—	1
Pacific	37	59	101	121	177	394	792	1,052	1,571	2,055	1	2	19	1	6
Alaska	—	2	6	1	3	5	10	23	6	22	1	0	19	1	1
California	36	42	69	104	145	309	648	806	1,299	1,768	—	1	7	—	—
Hawaii	—	1	6	2	7	1	19	36	30	45	—	0	2	—	1
Oregon†	1	7	21	14	18	49	30	58	79	59	—	0	4	—	4
Washington	—	5	26	—	4	30	71	210	157	161	—	0	4	—	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	3	14	—	2	—	6	14	10	17	—	0	1	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	20	—	2	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS). Because of a technical problem with hardware, NEDSS data from these states are not included this week.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 21, 2006, and January 22, 2005 (3rd Week)*

Reporting area	Hepatitis (viral, acute), by type: A — Current week	A — Previous 52 weeks Med	A — Previous 52 weeks Max	A — Cum 2006	A — Cum 2005	B — Current week	B — Previous 52 weeks Med	B — Previous 52 weeks Max	B — Cum 2006	B — Cum 2005	Legionellosis — Current week	Legionellosis — Previous 52 weeks Med	Legionellosis — Previous 52 weeks Max	Legionellosis — Cum 2006	Legionellosis — Cum 2005
United States	21	78	166	142	209	25	101	139	91	289	13	36	110	42	67
New England	—	8	23	1	23	—	4	12	5	11	1	2	11	2	2
Connecticut	—	1	3	1	5	—	0	5	—	2	1	0	8	1	—
Maine	—	0	1	—	—	—	0	2	—	—	—	0	1	—	—
Massachusetts	—	6	14	—	18	—	3	10	5	9	—	1	5	1	2
New Hampshire	—	1	12	—	—	—	0	3	—	—	—	0	1	—	—
Rhode Island	—	0	4	—	—	—	0	2	—	—	—	0	6	—	—
Vermont†	—	0	1	—	—	—	0	1	—	—	—	0	3	—	—
Mid. Atlantic	2	13	24	6	41	—	14	37	3	64	5	11	53	15	19
New Jersey	—	3	11	—	9	—	6	26	—	41	—	1	12	—	3
New York (Upstate)	2	2	8	2	3	—	2	7	—	1	1	3	25	2	3
New York City	—	6	12	2	21	—	2	7	—	7	—	1	20	—	—
Pennsylvania	—	2	6	2	8	—	4	9	3	15	4	5	17	13	13
E.N. Central	2	7	18	10	22	4	10	25	11	30	3	6	23	7	18
Illinois	—	1	9	—	10	—	2	7	—	9	—	0	3	—	4
Indiana	—	1	10	—	—	—	0	11	—	—	—	0	5	—	—
Michigan	—	2	11	4	7	—	4	7	2	12	—	2	6	4	5
Ohio	2	1	7	6	3	4	2	8	9	7	3	3	19	3	7
Wisconsin	—	1	4	—	2	—	0	6	—	2	—	0	2	—	2
W.N. Central	—	1	31	3	8	—	5	13	4	11	—	1	12	2	4
Iowa	—	0	2	—	1	—	0	2	—	—	—	0	1	—	—
Kansas	—	0	2	2	1	—	0	3	1	2	—	0	1	—	—
Minnesota	—	0	31	—	—	—	0	6	—	—	—	0	10	—	—
Missouri	—	0	5	1	4	—	3	7	3	5	—	0	4	2	4
Nebraska†	—	0	3	—	2	—	0	2	—	4	—	0	1	—	—
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	1	—	—
South Dakota	—	0	1	—	—	—	0	1	—	—	—	0	6	—	—
S. Atlantic	5	12	33	22	26	17	25	47	38	93	3	9	19	12	10
Delaware	—	0	1	—	—	—	1	6	—	4	—	0	4	—	—
District of Columbia	1	0	2	1	—	—	0	4	—	—	—	0	2	—	—
Florida	3	5	18	14	13	14	9	21	30	26	1	2	6	4	4
Georgia	1	2	6	1	8	1	2	9	2	25	—	1	3	—	—
Maryland	—	2	6	3	4	2	2	8	5	11	2	2	9	5	4
North Carolina	—	0	18	3	1	—	0	13	—	12	—	1	3	3	2
South Carolina†	—	1	3	—	—	—	2	9	1	4	—	0	2	—	—
Virginia†	—	1	6	—	—	—	2	10	—	11	—	1	4	—	—
West Virginia	—	0	2	—	—	—	0	11	—	—	—	0	3	—	—
E.S. Central	—	4	16	3	3	—	6	20	4	18	—	1	6	1	1
Alabama†	—	0	6	—	—	—	1	7	1	10	—	0	2	—	1
Kentucky	—	0	3	—	—	—	1	5	—	—	—	0	3	—	—
Mississippi	—	0	4	—	—	—	1	4	—	1	—	0	1	—	—
Tennessee†	—	2	13	3	3	—	2	13	3	7	—	0	4	1	—
W.S. Central	—	5	13	—	11	—	12	25	14	10	—	0	4	—	—
Arkansas	—	0	3	—	—	—	1	4	—	1	—	0	1	—	—
Louisiana	—	1	5	—	4	—	1	5	1	3	—	0	1	—	—
Oklahoma	—	0	1	—	—	—	0	5	—	—	—	0	3	—	—
Texas†	—	3	10	—	7	—	7	23	13	6	—	0	3	—	—
Mountain	—	6	21	5	21	—	10	38	3	17	—	2	8	—	6
Arizona	—	3	20	—	13	—	6	34	—	8	—	0	3	—	3
Colorado	—	1	5	3	2	—	1	4	2	1	—	0	3	—	1
Idaho†	—	0	3	1	1	—	0	2	1	1	—	0	2	—	—
Montana	—	0	2	—	2	—	0	2	—	—	—	0	1	—	—
Nevada†	—	0	2	—	—	—	0	2	—	2	—	0	2	—	—
New Mexico†	—	0	3	—	2	—	0	3	—	1	—	0	1	—	—
Utah	—	0	3	1	1	—	1	5	—	4	—	0	2	—	—
Wyoming	—	0	0	—	—	—	0	1	—	—	—	0	1	—	2
Pacific	12	15	142	92	54	4	10	24	9	35	1	1	6	3	7
Alaska	—	0	2	—	—	—	0	1	—	—	—	0	1	—	—
California	12	12	142	90	46	4	6	16	7	27	1	1	6	3	7
Hawaii	—	0	2	—	2	—	0	1	—	1	—	0	1	—	—
Oregon†	—	1	4	2	5	—	2	5	2	6	N	0	0	N	N
Washington	—	1	5	—	1	—	1	8	—	1	—	0	0	—	—
American Samoa	U	0	1	U	—	U	0	0	U	—	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	1	6	—	—	—	1	6	—	2	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 21, 2006, and January 22, 2005 (3rd Week)*

Reporting area	Lyme disease					Malaria				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max		
United States	22	291	1,316	74	457	18	23	45	32	61
New England	1	43	209	1	38	—	1	12	2	1
Connecticut	—	9	154	—	—	—	0	10	—	—
Maine	—	2	25	—	2	—	0	1	—	—
Massachusetts	—	12	141	—	36	—	1	4	2	1
New Hampshire	1	4	17	1	—	—	0	1	—	—
Rhode Island	—	0	12	—	—	—	0	1	—	—
Vermont†	—	0	5	—	—	—	0	2	—	—
Mid. Atlantic	8	179	919	34	326	1	6	14	3	19
New Jersey	—	39	307	—	105	—	1	6	—	4
New York (Upstate)	4	48	559	9	64	—	1	4	—	2
New York City	—	0	0	—	—	—	3	8	1	11
Pennsylvania	4	56	452	25	157	1	1	2	2	2
E.N. Central	—	12	155	—	18	1	2	6	3	7
Illinois	—	0	6	—	—	—	1	2	1	4
Indiana	—	0	4	—	—	—	0	1	—	—
Michigan	—	0	7	—	1	—	0	2	—	2
Ohio	—	1	5	—	5	1	0	3	1	1
Wisconsin	—	10	146	—	12	—	0	2	1	—
W.N. Central	1	13	99	1	2	2	1	5	4	3
Iowa	—	1	8	—	2	—	0	1	—	1
Kansas	1	0	3	1	—	—	0	1	—	—
Minnesota	—	9	96	—	—	2	0	3	2	—
Missouri	—	0	2	—	—	—	0	3	1	2
Nebraska†	—	0	1	—	—	—	0	2	—	—
North Dakota	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	1	—	—	—	0	1	1	—
S. Atlantic	11	31	125	32	69	5	6	15	9	9
Delaware	—	9	37	4	28	—	0	1	—	—
District of Columbia	—	0	2	—	—	—	0	2	—	—
Florida	1	1	8	1	3	1	1	6	3	1
Georgia	—	0	1	—	—	—	0	5	1	5
Maryland	8	16	86	23	33	1	1	9	2	3
North Carolina	2	0	5	4	4	3	0	8	3	—
South Carolina†	—	0	3	—	1	—	0	2	—	—
Virginia†	—	3	20	—	—	—	0	4	—	—
West Virginia	—	0	6	—	—	—	0	2	—	—
E.S. Central	—	1	4	—	1	—	0	2	—	1
Alabama†	—	0	1	—	—	—	0	1	—	1
Kentucky	—	0	1	—	—	—	0	2	—	—
Mississippi	—	0	0	—	—	—	0	0	—	—
Tennessee†	—	0	4	—	1	—	0	2	—	—
W.S. Central	—	1	8	—	—	—	1	9	1	3
Arkansas	—	0	2	—	—	—	0	2	—	—
Louisiana	—	0	2	—	—	—	0	1	—	—
Oklahoma	—	0	0	—	—	—	0	6	—	—
Texas†	—	0	7	—	—	—	1	9	1	3
Mountain	—	0	4	—	—	—	0	6	—	5
Arizona	—	0	4	—	—	—	0	4	—	2
Colorado	—	0	1	—	—	—	0	3	—	1
Idaho†	—	0	1	—	—	—	0	0	—	—
Montana	—	0	0	—	—	—	0	0	—	—
Nevada†	—	0	1	—	—	—	0	1	—	—
New Mexico†	—	0	1	—	—	—	0	1	—	—
Utah	—	0	1	—	—	—	0	2	—	1
Wyoming	—	0	1	—	—	—	0	1	—	1
Pacific	1	2	10	6	3	9	4	12	10	13
Alaska	—	0	1	—	—	1	0	1	1	—
California	1	2	10	6	2	8	2	9	9	12
Hawaii	N	0	0	N	N	—	0	4	—	—
Oregon†	—	0	2	—	1	—	0	2	—	1
Washington	—	0	3	—	—	—	0	4	—	—
American Samoa	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	N	0	0	N	N	—	0	1	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 21, 2006, and January 22, 2005 (3rd Week)*

Reporting area	Meningococcal disease, invasive: All serogroups: Current week	Previous 52 weeks: Med	Previous 52 weeks: Max	Cum 2006	Cum 2005	Meningococcal disease, invasive: Serogroup unknown: Current week	Previous 52 weeks: Med	Previous 52 weeks: Max	Cum 2006	Cum 2005	Pertussis: Current week	Previous 52 weeks: Med	Previous 52 weeks: Max	Cum 2006	Cum 2005
United States	13	19	46	36	83	10	12	30	29	47	75	424	593	347	1,386
New England	—	1	5	—	9	—	0	2	—	3	1	26	49	50	96
Connecticut	—	0	3	—	—	—	0	2	—	—	—	1	4	—	7
Maine	—	0	1	—	—	—	0	1	—	—	—	0	5	—	5
Massachusetts	—	0	3	—	7	—	0	2	—	2	1	19	39	49	75
New Hampshire	—	0	2	—	—	—	0	2	—	—	—	1	15	—	—
Rhode Island	—	0	2	—	—	—	0	0	—	—	—	0	8	—	—
Vermont†	—	0	1	—	2	—	0	1	—	1	—	1	24	1	9
Mid. Atlantic	4	3	10	9	11	3	2	9	8	7	18	24	48	45	117
New Jersey	—	0	4	—	2	—	0	4	—	2	—	4	9	—	16
New York (Upstate)	2	1	4	2	3	1	0	3	1	1	10	11	38	14	25
New York City	—	0	3	2	2	—	0	3	2	2	—	2	6	—	7
Pennsylvania	2	1	3	5	4	2	1	3	5	2	8	7	28	31	69
E.N. Central	—	2	9	3	8	—	1	6	2	7	23	63	144	54	368
Illinois	—	0	4	—	1	—	0	4	—	1	—	15	30	1	62
Indiana	—	0	3	—	1	—	0	2	—	1	—	6	23	—	—
Michigan	—	1	3	1	3	—	0	3	—	2	1	4	26	2	19
Ohio	—	1	5	2	2	—	1	4	2	2	22	20	59	51	163
Wisconsin	—	0	2	—	1	—	0	2	—	1	—	22	54	—	124
W.N. Central	1	1	5	1	6	—	0	3	—	3	15	61	205	56	179
Iowa	—	0	2	—	1	—	0	2	—	—	—	13	91	1	65
Kansas	—	0	1	—	1	—	0	1	—	1	9	10	29	32	23
Minnesota	—	0	2	—	—	—	0	1	—	—	—	2	148	—	1
Missouri	1	0	3	1	4	—	0	2	—	2	6	9	39	23	32
Nebraska†	—	0	1	—	—	—	0	1	—	—	—	2	12	—	24
North Dakota	—	0	1	—	—	—	0	1	—	—	—	0	28	—	9
South Dakota	—	0	1	—	—	—	0	0	—	—	—	3	9	—	25
S. Atlantic	2	4	11	3	14	2	2	6	2	9	15	23	90	44	70
Delaware	—	0	1	—	—	—	0	1	—	—	—	0	3	—	7
District of Columbia	—	0	0	—	—	—	0	0	—	—	—	0	3	—	—
Florida	1	1	7	2	2	1	0	6	1	1	4	4	14	15	6
Georgia	—	0	2	—	6	—	0	2	—	6	—	1	3	—	5
Maryland	1	0	2	1	2	1	0	1	1	—	2	4	8	10	22
North Carolina	—	0	6	—	1	—	0	2	—	—	9	0	21	17	—
South Carolina†	—	0	2	—	3	—	0	1	—	2	—	7	17	2	30
Virginia†	—	0	3	—	—	—	0	1	—	—	—	2	72	—	—
West Virginia	—	0	1	—	—	—	0	1	—	—	—	0	12	—	—
E.S. Central	—	1	4	1	4	—	1	4	1	2	—	8	23	2	17
Alabama†	—	0	1	—	—	—	0	1	—	—	—	1	9	2	7
Kentucky	—	0	3	—	2	—	0	3	—	2	—	3	11	—	6
Mississippi	—	0	1	—	—	—	0	1	—	—	—	1	4	—	—
Tennessee†	—	0	2	1	2	—	0	1	1	—	—	4	17	—	4
W.S. Central	—	2	6	2	6	—	0	3	2	2	1	36	114	3	4
Arkansas	—	0	3	1	1	—	0	1	1	—	1	5	19	3	1
Louisiana	—	0	3	1	3	—	0	1	1	1	—	0	3	—	1
Oklahoma	—	0	3	—	1	—	0	3	—	—	—	0	0	—	—
Texas†	—	0	4	—	1	—	0	3	—	1	—	30	99	—	2
Mountain	—	2	7	5	4	—	1	5	3	3	2	77	143	89	207
Arizona	—	0	5	—	1	—	0	5	—	—	—	15	86	—	7
Colorado	—	0	3	4	3	—	0	2	2	3	—	24	55	60	127
Idaho†	—	0	2	—	—	—	0	2	—	—	—	3	19	1	12
Montana	—	0	0	—	—	—	0	0	—	—	2	9	58	7	30
Nevada†	—	0	2	—	—	—	0	1	—	—	—	0	6	—	—
New Mexico†	—	0	2	—	—	—	0	2	—	—	—	3	9	—	16
Utah	—	0	2	1	—	—	0	1	1	—	—	12	35	18	11
Wyoming	—	0	0	—	—	—	0	0	—	—	—	0	4	3	4
Pacific	6	3	27	12	21	5	3	13	11	11	—	58	171	4	328
Alaska	—	0	1	—	—	—	0	1	—	—	—	1	11	2	1
California	5	2	11	11	9	5	2	11	11	9	—	31	146	—	236
Hawaii	—	0	2	—	2	—	0	1	—	1	—	3	10	1	12
Oregon†	—	0	6	—	10	—	0	2	—	1	—	10	30	1	76
Washington	1	0	25	1	—	—	0	11	—	—	—	12	59	—	3
American Samoa	U	0	1	—	—	U	0	1	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	—	—	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	2	—	1	—	0	2	—	1	—	0	2	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 21, 2006, and January 22, 2005 (3rd Week)*

Reporting area	Rabies, animal					Rocky Mountain spotted fever					Salmonellosis				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	29	104	160	76	420	47	30	98	124	30	259	793	1,431	879	1,229
New England	5	13	33	12	37	—	0	1	—	—	3	40	76	15	50
Connecticut	1	3	13	3	7	—	0	0	—	—	—	8	25	7	10
Maine	—	1	4	—	2	N	0	0	N	N	—	3	8	—	4
Massachusetts	2	5	22	5	22	—	0	1	—	—	1	20	38	6	31
New Hampshire	1	0	3	1	2	—	0	1	—	—	2	2	12	2	2
Rhode Island	1	0	3	1	—	—	0	1	—	—	—	0	12	—	—
Vermont†	—	1	7	2	4	—	0	0	—	—	—	1	10	—	3
Mid. Atlantic	9	18	40	17	32	—	2	8	—	3	19	92	185	69	131
New Jersey	N	0	0	N	N	—	0	6	—	1	—	14	45	—	30
New York (Upstate)	9	12	24	17	9	—	0	2	—	—	7	23	69	13	8
New York City	—	0	3	—	2	—	0	2	—	1	—	23	43	13	45
Pennsylvania	—	7	22	—	21	—	1	6	—	1	12	30	61	43	48
E.N. Central	1	2	19	2	3	—	0	3	—	—	18	92	243	75	155
Illinois	—	1	4	—	1	—	0	1	—	—	—	29	160	—	47
Indiana	—	0	3	—	1	—	0	1	—	—	—	9	71	—	2
Michigan	—	0	4	1	—	—	0	1	—	—	—	17	35	13	43
Ohio	1	0	13	1	1	—	0	3	—	—	18	22	52	57	38
Wisconsin	—	0	3	—	—	—	0	1	—	—	—	15	45	5	25
W.N. Central	—	7	23	2	9	—	1	16	—	1	14	40	90	68	73
Iowa	—	1	10	1	3	—	0	2	—	—	—	7	18	4	18
Kansas	—	1	5	1	1	—	0	2	—	—	3	7	17	10	9
Minnesota	—	1	5	—	2	—	0	1	—	—	5	10	31	13	10
Missouri	—	1	7	—	2	—	1	14	—	1	6	14	40	39	24
Nebraska†	—	0	0	—	—	—	0	2	—	—	—	2	8	—	9
North Dakota	—	0	4	—	—	—	0	0	—	—	—	0	5	—	2
South Dakota	—	1	6	—	1	—	0	2	—	—	—	2	11	2	1
S. Atlantic	10	30	49	32	292	47	15	94	123	24	129	252	514	380	358
Delaware	—	0	0	—	—	—	0	2	—	—	—	2	9	1	2
District of Columbia	—	0	0	—	—	—	0	1	—	—	1	1	7	1	—
Florida	2	0	0	2	201	1	0	1	1	2	60	99	230	155	136
Georgia	—	5	9	—	18	1	1	9	3	—	16	30	83	51	64
Maryland	—	6	16	5	18	2	2	7	3	1	13	14	39	32	27
North Carolina	2	9	19	12	20	43	5	87	115	21	39	26	114	129	97
South Carolina†	—	0	2	—	2	—	1	6	1	—	—	19	146	11	22
Virginia†	6	10	18	13	32	—	1	10	—	—	—	19	66	—	10
West Virginia	—	0	13	—	1	—	0	2	—	—	—	2	13	—	—
E.S. Central	—	2	9	1	1	—	4	25	1	1	1	52	134	40	52
Alabama†	—	1	5	1	1	—	0	9	—	—	—	12	39	18	14
Kentucky	—	0	3	—	—	—	0	1	—	—	1	6	28	6	5
Mississippi	—	0	1	—	—	—	0	2	—	—	—	13	66	—	9
Tennessee†	—	1	3	—	—	—	3	19	1	1	—	14	40	16	24
W.S. Central	2	14	42	3	37	—	1	32	—	1	12	66	140	53	71
Arkansas	—	0	3	1	6	—	0	32	—	—	9	12	67	14	11
Louisiana	—	0	0	—	—	—	0	2	—	1	—	14	42	4	28
Oklahoma	2	1	7	2	4	—	0	23	—	—	3	7	26	12	4
Texas†	—	12	39	—	27	—	0	7	—	—	—	32	84	23	28
Mountain	—	5	19	5	6	—	0	8	—	—	15	48	110	29	89
Arizona	—	3	11	5	4	—	0	8	—	—	—	13	28	—	31
Colorado	—	0	2	—	—	—	0	1	—	—	14	10	45	20	23
Idaho†	—	0	12	—	—	—	0	2	—	—	—	2	17	4	6
Montana	—	0	3	—	—	—	0	1	—	—	1	2	16	3	3
Nevada†	—	0	2	—	—	—	0	0	—	—	—	2	7	—	9
New Mexico†	—	0	1	—	1	—	0	1	—	—	—	4	11	—	8
Utah	—	0	5	—	—	—	0	2	—	—	—	6	31	1	6
Wyoming	—	0	2	—	1	—	0	1	—	—	—	1	12	1	3
Pacific	2	3	14	2	3	—	0	2	—	—	48	99	188	150	250
Alaska	—	0	1	—	—	—	0	0	—	—	1	1	5	8	4
California	2	3	14	2	3	—	0	1	—	—	42	75	148	124	186
Hawaii	—	0	0	—	—	—	0	0	—	—	2	5	33	11	46
Oregon†	—	0	1	—	—	—	0	1	—	—	—	7	23	4	12
Washington	U	0	0	U	U	—	0	0	—	—	3	9	31	3	2
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	2	U	—
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	2	4	1	4	N	0	0	N	N	—	8	23	—	11
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 21, 2006, and January 22, 2005 (3rd Week)*

Reporting area	Shiga toxin-producing *E. coli* (STEC)†					Shigellosis					Streptococcal disease, invasive, group A				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	3	46	154	6	63	85	261	445	307	436	51	77	149	155	249
New England	—	4	14	—	4	—	5	15	5	10	—	3	8	4	10
Connecticut	—	1	4	—	—	—	1	4	1	—	U	0	0	U	U
Maine	—	0	5	—	—	—	0	1	—	—	—	0	2	1	1
Massachusetts	—	2	8	—	4	—	3	9	4	9	—	2	6	3	7
New Hampshire	—	0	2	—	—	—	0	4	—	1	—	0	1	—	1
Rhode Island	—	0	2	—	—	—	0	3	—	—	—	0	3	—	—
Vermont§	—	0	2	—	—	—	0	4	—	—	—	0	2	—	1
Mid. Atlantic	—	6	24	—	6	4	22	65	10	56	9	16	38	28	58
New Jersey	—	1	6	—	—	—	5	14	—	11	—	3	9	—	16
New York (Upstate)	—	3	13	—	1	4	5	24	6	4	5	4	16	10	16
New York City	—	0	2	—	1	—	7	22	2	37	—	3	9	3	10
Pennsylvania	—	2	8	—	4	—	2	48	2	4	4	5	12	15	16
E.N. Central	—	7	28	1	16	2	17	78	9	38	10	15	41	37	50
Illinois	—	1	6	—	2	—	5	21	—	11	—	3	10	1	13
Indiana	—	1	7	—	—	—	1	56	—	—	—	1	9	—	1
Michigan	—	1	8	1	5	1	4	14	3	18	4	6	15	16	22
Ohio	—	2	14	—	6	1	2	11	5	6	6	4	14	20	9
Wisconsin	—	2	15	—	3	—	3	9	1	3	—	1	8	—	5
W.N. Central	—	7	38	—	8	17	35	64	66	36	5	4	19	10	12
Iowa	—	1	10	—	3	—	1	9	—	6	N	0	0	N	N
Kansas	—	1	4	—	—	1	4	20	4	1	4	0	4	8	—
Minnesota	—	2	23	—	—	3	2	6	4	1	—	1	15	—	—
Missouri	—	2	7	—	3	13	22	45	57	17	1	1	6	2	5
Nebraska§	—	1	4	—	1	—	1	10	—	10	—	0	2	—	3
North Dakota	—	0	2	—	—	—	0	2	—	1	—	0	3	—	1
South Dakota	—	0	5	—	1	—	1	17	1	—	—	0	2	—	3
S. Atlantic	2	7	37	2	13	29	43	119	90	61	15	17	31	45	48
Delaware	—	0	2	—	—	—	0	2	—	1	—	0	2	—	—
District of Columbia	—	0	1	—	—	—	0	2	—	—	—	0	1	—	—
Florida	2	1	31	2	3	13	20	66	47	31	8	5	12	20	14
Georgia	—	0	6	—	2	4	10	32	19	20	1	3	9	6	10
Maryland	—	1	5	—	3	1	2	8	9	5	6	3	12	12	14
North Carolina	—	1	11	—	4	11	2	22	15	3	—	1	13	5	5
South Carolina§	—	0	2	—	—	—	2	6	—	—	—	0	2	2	3
Virginia§	—	1	9	—	1	—	2	9	—	1	—	2	6	—	2
West Virginia	—	0	1	—	—	—	0	1	—	—	—	0	5	—	—
E.S. Central	—	3	11	—	1	—	21	54	10	32	—	3	11	4	6
Alabama§	—	0	3	—	—	—	3	20	4	5	—	0	0	—	—
Kentucky	—	1	8	—	—	—	5	31	6	2	—	0	3	1	1
Mississippi	—	0	2	—	—	—	2	7	—	3	—	0	0	—	—
Tennessee§	—	1	4	—	1	—	7	45	—	22	—	2	8	3	5
W.S. Central	—	1	7	—	3	3	57	119	32	49	7	4	15	7	7
Arkansas	—	0	2	—	1	1	1	3	2	4	1	0	4	1	—
Louisiana	—	0	2	—	1	—	2	11	—	9	—	0	2	—	—
Oklahoma	—	0	3	—	—	2	11	41	4	7	6	2	13	6	3
Texas§	—	0	2	—	1	—	41	110	26	29	—	2	9	—	4
Mountain	1	5	15	3	4	1	17	46	10	31	4	12	25	17	47
Arizona	—	0	4	—	—	—	9	29	—	13	—	5	16	—	23
Colorado	1	1	6	3	2	1	3	17	6	7	4	4	11	11	16
Idaho§	—	0	7	—	1	—	0	4	1	—	—	0	2	—	—
Montana	—	0	2	—	—	—	0	1	—	—	—	0	0	—	—
Nevada§	—	0	4	—	—	—	1	4	—	4	—	0	6	—	—
New Mexico§	—	0	3	—	—	—	2	8	—	5	—	1	6	—	7
Utah	—	1	7	—	—	—	1	4	2	2	—	2	6	6	—
Wyoming	—	0	3	—	1	—	0	1	1	—	—	0	1	—	1
Pacific	—	7	56	—	8	29	41	98	75	123	1	2	8	3	11
Alaska	—	0	3	—	1	—	0	1	—	1	—	0	0	—	—
California	—	3	8	—	4	28	35	86	73	115	—	0	0	—	—
Hawaii	—	0	4	—	1	1	1	4	2	2	1	2	8	3	11
Oregon§	—	1	47	—	—	—	1	23	—	4	N	0	0	N	N
Washington	—	1	12	—	2	—	2	16	—	1	N	0	0	N	N
American Samoa	U	0	0	U	U	U	0	2	U	—	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	1	—	—	—	0	1	—	—	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
† Includes *E. coli* O157:H7; Shiga toxin positive, serogroup non-0157; and Shiga toxin positive, not serogrouped.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS). Because of a technical problem with hardware, NEDSS data from these states are not included this week.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 21, 2006, and January 22, 2005 (3rd Week)*

Reporting area	*Streptococcus pneumoniae*, invasive disease Drug resistant, all ages					Syphillis, primary & secondary					Varicella (chickenpox)				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005
United States	33	45	91	106	163	83	162	212	247	369	475	517	1,768	1,569	1,156
New England	—	2	12	1	13	3	4	11	11	15	7	46	1,119	54	230
Connecticut	U	0	0	U	U	—	0	7	—	—	U	0	0	U	U
Maine	N	0	0	N	N	—	0	1	1	—	—	2	19	19	34
Massachusetts	—	1	6	—	12	3	2	6	9	15	—	32	86	—	191
New Hampshire	—	0	0	—	—	—	0	2	1	—	7	2	1,110	15	—
Rhode Island	—	0	7	—	—	—	0	6	—	—	—	0	0	—	—
Vermont†	—	0	2	1	1	—	0	1	—	—	—	1	14	20	5
Mid. Atlantic	5	3	11	7	20	5	20	31	23	50	86	110	211	345	57
New Jersey	N	0	0	N	N	2	2	7	2	11	—	0	0	—	—
New York (Upstate)	1	1	9	1	3	1	2	9	1	1	—	0	0	—	—
New York City	U	0	0	U	U	1	12	20	16	35	—	0	0	—	—
Pennsylvania	4	2	9	6	17	1	3	7	4	3	86	110	211	345	57
E.N. Central	10	11	31	38	30	14	16	40	33	24	264	124	460	753	470
Illinois	—	0	2	—	—	4	7	30	12	3	—	2	5	—	3
Indiana	—	3	16	—	3	3	1	5	5	4	—	0	245	—	—
Michigan	—	1	7	2	8	1	1	8	3	1	88	81	351	220	318
Ohio	10	7	20	36	19	6	4	11	12	15	172	27	341	513	102
Wisconsin	N	0	0	N	N	—	1	3	1	1	4	9	21	20	47
W.N. Central	1	1	15	3	5	4	5	10	10	19	31	11	70	142	5
Iowa	N	0	0	N	N	—	0	1	—	—	N	0	0	N	N
Kansas	N	0	0	N	N	1	0	2	1	—	—	0	0	—	—
Minnesota	—	0	15	—	—	—	1	5	1	1	—	0	0	—	—
Missouri	1	0	3	3	5	3	3	6	8	18	31	7	69	140	—
Nebraska†	—	0	1	—	—	—	0	1	—	—	—	0	0	—	—
North Dakota	—	0	1	—	—	—	0	1	—	—	—	0	25	—	—
South Dakota	—	0	1	—	—	—	0	1	—	—	—	1	23	2	5
S. Atlantic	16	19	40	51	72	22	39	88	61	82	46	45	194	99	113
Delaware	—	0	1	—	—	2	0	2	3	—	—	0	4	—	2
District of Columbia	3	0	4	3	—	—	2	9	2	5	—	0	6	—	—
Florida	12	11	34	41	43	10	16	29	34	52	—	0	0	—	—
Georgia	1	4	18	7	27	—	7	45	—	—	—	0	0	—	—
Maryland	—	0	0	—	—	2	6	18	9	7	—	0	0	—	—
North Carolina	N	0	0	N	N	7	4	17	11	13	—	0	0	—	—
South Carolina†	—	0	0	—	—	—	1	8	—	2	—	10	41	4	20
Virginia†	N	0	0	N	N	1	2	11	2	3	—	7	135	—	7
West Virginia	—	2	8	—	2	—	0	1	—	—	46	18	61	95	84
E.S. Central	—	3	12	3	8	3	9	18	11	18	—	0	0	—	—
Alabama†	—	0	0	—	—	—	3	10	—	11	—	0	0	—	—
Kentucky	—	0	5	—	—	—	1	4	5	—	N	0	0	N	N
Mississippi	—	0	0	—	—	—	0	5	—	—	—	0	0	—	—
Tennessee†	—	2	11	3	8	3	4	11	6	7	—	0	0	—	—
W.S. Central	—	1	13	2	12	13	24	38	58	68	7	133	322	101	82
Arkansas	—	0	2	—	3	—	1	6	1	1	7	0	11	9	—
Louisiana	—	1	11	2	9	—	3	17	1	9	—	0	32	—	2
Oklahoma	N	0	0	N	N	—	1	6	3	7	—	0	0	—	—
Texas†	N	0	0	N	N	13	18	30	53	51	—	128	322	92	80
Mountain	1	1	28	1	3	7	7	17	10	17	34	47	118	75	199
Arizona	N	0	0	N	N	6	3	13	9	8	—	0	0	—	—
Colorado	N	0	0	N	N	1	1	6	1	2	34	36	87	68	157
Idaho†	N	0	0	N	N	—	0	6	—	—	—	0	0	—	—
Montana	—	0	1	—	—	—	0	3	—	—	—	0	0	—	—
Nevada†	—	0	27	—	—	—	2	7	—	3	—	0	4	—	—
New Mexico†	—	0	0	—	—	—	1	3	—	4	—	3	15	—	9
Utah	—	0	6	—	3	—	0	1	—	—	—	7	38	5	28
Wyoming	1	0	3	1	—	—	0	0	—	—	—	0	8	2	5
Pacific	—	0	0	—	—	12	33	54	30	76	—	0	0	—	—
Alaska	—	0	0	—	—	—	0	2	—	—	—	0	0	—	—
California	N	0	0	N	N	2	28	52	11	73	—	0	0	—	—
Hawaii	—	0	0	—	—	—	0	2	—	1	—	0	0	—	—
Oregon†	N	0	0	N	N	—	0	6	1	—	—	0	0	—	—
Washington	N	0	0	N	N	10	2	11	18	2	N	0	0	N	N
American Samoa	—	0	0	—	—	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	—	0	0	—	—	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	N	0	0	N	N	—	3	15	1	3	—	9	47	—	14
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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* Incidence data for reporting years 2005 and 2006 are provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS). Because of a technical problem with hardware, NEDSS data from these states are not included this week.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 21, 2006, and January 22, 2005 (3rd Week)*

Reporting area	West Nile virus disease†									
	Neuroinvasive					Non-neuroinvasive				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max		
United States	—	0	149	—	—	—	1	199	—	1
New England	—	0	3	—	—	—	0	2	—	—
Connecticut	—	0	2	—	—	—	0	1	—	—
Maine	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	3	—	—	—	0	1	—	—
New Hampshire	—	0	0	—	—	—	0	0	—	—
Rhode Island	—	0	1	—	—	—	0	0	—	—
Vermont§	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	—	0	6	—	—	—	0	4	—	—
New Jersey	—	0	1	—	—	—	0	2	—	—
New York (Upstate)	—	0	0	—	—	—	0	0	—	—
New York City	—	0	2	—	—	—	0	2	—	—
Pennsylvania	—	0	3	—	—	—	0	2	—	—
E.N. Central	—	0	39	—	—	—	0	18	—	—
Illinois	—	0	25	—	—	—	0	16	—	—
Indiana	—	0	2	—	—	—	0	1	—	—
Michigan	—	0	12	—	—	—	0	3	—	—
Ohio	—	0	9	—	—	—	0	4	—	—
Wisconsin	—	0	3	—	—	—	0	2	—	—
W.N. Central	—	0	24	—	—	—	0	73	—	—
Iowa	—	0	3	—	—	—	0	5	—	—
Kansas	—	0	2	—	—	N	0	2	N	N
Minnesota	—	0	5	—	—	—	0	5	—	—
Missouri	—	0	4	—	—	—	0	3	—	—
Nebraska§	—	0	8	—	—	—	0	20	—	—
North Dakota	—	0	3	—	—	—	0	15	—	—
South Dakota	—	0	7	—	—	—	0	33	—	—
S. Atlantic	—	0	5	—	—	—	0	4	—	—
Delaware	—	0	1	—	—	—	0	0	—	—
District of Columbia	—	0	0	—	—	—	0	0	—	—
Florida	—	0	2	—	—	—	0	4	—	—
Georgia	—	0	3	—	—	—	0	3	—	—
Maryland	—	0	2	—	—	—	0	1	—	—
North Carolina	—	0	1	—	—	—	0	1	—	—
South Carolina§	—	0	1	—	—	—	0	0	—	—
Virginia§	—	0	0	—	—	—	0	0	—	—
West Virginia	—	0	0	—	—	N	0	0	N	N
E.S. Central	—	0	10	—	—	—	0	5	—	—
Alabama§	—	0	1	—	—	—	0	2	—	—
Kentucky	—	0	1	—	—	—	0	0	—	—
Mississippi	—	0	9	—	—	—	0	5	—	—
Tennessee§	—	0	3	—	—	—	0	1	—	—
W.S. Central	—	0	27	—	—	—	0	18	—	1
Arkansas	—	0	3	—	—	—	0	2	—	—
Louisiana	—	0	16	—	—	—	0	7	—	1
Oklahoma	—	0	6	—	—	—	0	3	—	—
Texas§	—	0	16	—	—	—	0	12	—	—
Mountain	—	0	16	—	—	—	0	38	—	—
Arizona	—	0	8	—	—	—	0	8	—	—
Colorado	—	0	5	—	—	—	0	13	—	—
Idaho§	—	0	2	—	—	—	0	3	—	—
Montana	—	0	3	—	—	—	0	9	—	—
Nevada§	—	0	3	—	—	—	0	8	—	—
New Mexico§	—	0	3	—	—	—	0	4	—	—
Utah	—	0	6	—	—	—	0	8	—	—
Wyoming	—	0	2	—	—	—	0	1	—	—
Pacific	—	0	50	—	—	—	0	89	—	—
Alaska	—	0	0	—	—	—	0	0	—	—
California	—	0	50	—	—	—	0	88	—	—
Hawaii	—	0	0	—	—	—	0	0	—	—
Oregon§	—	0	1	—	—	—	0	2	—	—
Washington	—	0	0	—	—	—	0	0	—	—
American Samoa	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS). Because of a technical problem with hardware, NEDSS data from these states are not included this week.

TABLE III. Deaths in 122 U.S. cities,* week ending January 21, 2006 (3rd Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
New England	625	448	113	45	11	8	48
Boston, MA	151	100	37	7	2	5	7
Bridgeport, CT	49	37	9	3	—	—	3
Cambridge, MA	12	9	3	—	—	—	—
Fall River, MA	33	27	5	—	1	—	4
Hartford, CT	64	47	9	6	2	—	8
Lowell, MA	29	24	2	2	1	—	1
Lynn, MA	7	6	1	—	—	—	—
New Bedford, MA	32	28	—	4	—	—	3
New Haven, CT	36	16	8	9	3	—	2
Providence, RI	54	40	6	5	1	2	9
Somerville, MA	3	2	1	—	—	—	—
Springfield, MA	39	27	9	2	1	—	2
Waterbury, CT	36	22	9	4	—	1	3
Worcester, MA	80	63	14	3	—	—	6
Mid. Atlantic	1,998	1,411	402	120	37	28	124
Albany, NY	41	27	10	—	1	3	4
Allentown, PA	27	20	5	2	—	—	—
Buffalo, NY	93	69	19	5	—	—	12
Camden, NJ	33	21	9	2	—	1	1
Elizabeth, NJ	17	11	4	1	—	1	—
Erie, PA	35	29	6	—	—	—	2
Jersey City, NJ	7	7	—	—	—	—	—
New York City, NY	1,069	747	211	74	23	14	62
Newark, NJ	68	34	24	7	2	1	1
Paterson, NJ	28	14	9	3	1	1	3
Philadelphia, PA	222	159	48	13	2	—	18
Pittsburgh, PA§	U	U	U	U	U	U	U
Reading, PA	37	27	8	2	—	—	1
Rochester, NY	123	99	15	6	2	1	7
Schenectady, NY	31	24	5	1	1	—	3
Scranton, PA	25	18	7	—	—	—	3
Syracuse, NY	82	61	13	—	3	5	6
Trenton, NJ	29	20	6	1	1	1	—
Utica, NY	10	7	1	1	1	—	—
Yonkers, NY	21	17	2	2	—	—	1
E.N. Central	2,047	1,407	438	124	39	39	129
Akron, OH	44	35	8	1	—	—	3
Canton, OH	38	27	8	2	—	1	4
Chicago, IL	370	216	104	30	9	11	26
Cincinnati, OH	83	52	19	5	2	5	12
Cleveland, OH	179	142	29	5	3	—	11
Columbus, OH	199	128	46	19	2	4	14
Dayton, OH	137	97	25	9	2	4	5
Detroit, MI	171	93	53	17	4	4	9
Evansville, IN	65	53	11	1	—	—	6
Fort Wayne, IN	63	48	12	1	1	1	2
Gary, IN	11	7	2	1	1	—	—
Grand Rapids, MI	64	53	6	3	1	1	6
Indianapolis, IN	185	137	31	9	4	4	11
Lansing, MI	31	23	5	1	2	—	1
Milwaukee, WI	105	74	24	6	1	—	2
Peoria, IL	48	41	6	1	—	—	4
Rockford, IL	43	23	14	1	4	1	1
South Bend, IN	50	36	8	4	1	1	1
Toledo, OH	111	78	25	5	1	2	8
Youngstown, OH	50	44	2	3	1	—	3
W.N. Central	605	402	133	39	17	14	44
Des Moines, IA	61	49	10	2	—	—	6
Duluth, MN	34	23	10	1	—	—	1
Kansas City, KS	12	8	3	1	—	—	—
Kansas City, MO	75	50	17	5	1	2	3
Lincoln, NE	51	36	8	5	—	2	10
Minneapolis, MN	66	41	10	7	6	2	3
Omaha, NE	96	68	16	6	4	2	7
St. Louis, MO	117	61	42	6	4	4	8
St. Paul, MN	65	47	12	4	2	—	3
Wichita, KS	28	19	5	2	—	2	3
S. Atlantic	1,464	936	369	96	37	25	68
Atlanta, GA	198	115	59	15	7	2	8
Baltimore, MD	146	97	34	12	3	—	17
Charlotte, NC	123	89	27	7	—	—	13
Jacksonville, FL	139	74	52	9	1	3	6
Miami, FL	41	35	4	—	2	—	3
Norfolk, VA	57	32	16	4	3	2	1
Richmond, VA	63	40	12	3	4	4	4
Savannah, GA	63	48	11	2	2	—	2
St. Petersburg, FL	77	54	19	—	1	3	3
Tampa, FL	245	174	49	15	3	4	8
Washington, D.C.	299	170	82	28	11	7	3
Wilmington, DE	13	8	4	1	—	—	—
E.S. Central	1,017	656	253	67	19	22	71
Birmingham, AL	167	95	52	13	3	4	17
Chattanooga, TN	122	82	31	5	—	4	8
Knoxville, TN	97	72	19	5	1	—	5
Lexington, KY	85	66	14	2	1	2	8
Memphis, TN	217	139	53	15	7	3	15
Mobile, AL	94	64	17	9	1	3	3
Montgomery, AL	66	43	18	2	1	2	6
Nashville, TN	169	95	49	16	5	4	9
W.S. Central	1,753	1,151	410	114	44	34	145
Austin, TX	124	70	40	9	2	3	15
Baton Rouge, LA	60	45	11	3	1	—	2
Corpus Christi, TX	40	26	5	5	1	3	5
Dallas, TX	217	133	54	23	4	3	18
El Paso, TX	160	109	33	8	6	4	17
Fort Worth, TX	131	81	39	5	4	2	15
Houston, TX	498	332	107	35	11	13	33
Little Rock, AR	65	39	17	5	4	—	4
New Orleans, LA¶	U	U	U	U	U	U	U
San Antonio, TX	217	157	43	10	3	4	22
Shreveport, LA	92	59	25	4	2	2	5
Tulsa, OK	149	100	36	7	6	—	9
Mountain	1,315	907	239	88	26	29	133
Albuquerque, NM	110	84	18	6	2	—	13
Boise, ID	52	41	7	3	1	—	8
Colorado Springs, CO	70	50	16	1	1	2	4
Denver, CO	102	68	24	5	2	3	11
Las Vegas, NV	325	223	66	21	7	8	26
Ogden, UT	34	24	4	4	1	1	—
Phoenix, AZ	249	149	39	24	5	6	26
Pueblo, CO	32	25	4	3	—	—	1
Salt Like City, UT	144	100	24	8	5	7	18
Tucson, AZ	197	143	37	13	2	2	26
Pacific	1,434	1,025	282	88	26	13	144
Berkeley, CA	17	16	1	—	—	—	1
Fresno, CA	U	U	U	U	U	U	U
Glendale, CA	11	8	2	1	—	—	—
Honolulu, HI	25	18	2	4	1	—	—
Long Beach, CA	80	60	14	5	1	—	14
Los Angeles, CA	318	214	60	30	9	5	35
Pasadena, CA	39	33	3	2	1	—	5
Portland, OR	99	64	26	5	3	1	6
Sacramento, CA	263	181	58	15	7	2	22
San Diego, CA	156	119	27	6	3	1	21
San Francisco, CA	102	74	23	4	—	1	14
San Jose, CA	U	U	U	U	U	U	U
Santa Cruz, CA	29	23	5	1	—	—	3
Seattle, WA	123	77	34	8	1	3	10
Spokane, WA	49	40	8	1	—	—	7
Tacoma, WA	123	98	19	6	—	—	6
Total	12,258**	8,343	2,639	781	256	212	906

U: Unavailable. —:No reported cases.

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

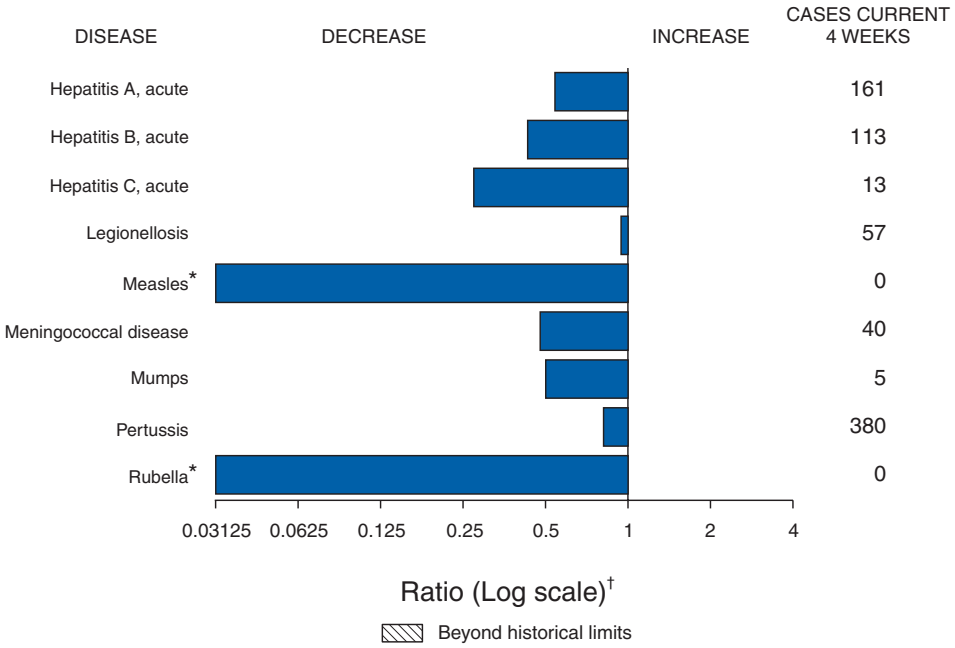
† Pneumonia and influenza.

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

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

** Total includes unknown ages.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals January 21, 2006, with historical data



* No measles or rubella cases were reported for the current 4-week period yielding a ratio for week 3 of zero (0).
† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

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