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National HIV Testing Day — June 27, 2006

June 27 is National HIV Testing Day. Initiated in 1995 by the National Association of People with AIDS, National HIV Testing Day serves to increase awareness of HIV/AIDS and to encourage all persons in the United States to get tested for human immunodeficiency virus (HIV). Locations of HIV test sites by postal code are available at National HIV Testing Resources at http://www.hivtest.org/index.htm.

Persons who know they have HIV infection often can receive antiretroviral treatment at an early stage of disease, when more treatment options are available. Knowing HIV status also has the potential to reduce transmission. Persons who learn they are infected with HIV usually take steps to reduce their risk for transmitting the virus (*1*).

In 2003, CDC began its Advancing HIV Prevention initiative (*2*), which aims to increase the prevalence of persons who know their HIV status by making HIV testing more available and by encouraging more people to take advantage of the tests. *MMWR* will publish CDC's revised *Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings* later this year.

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2. CDC. Advancing HIV prevention: new strategies for a changing epidemic—United States, 2003. MMWR 2003;52:329–2.

Rapid HIV Test Distribution — United States, 2003–2005

At the end of 2003, an estimated 1 million persons in the United States were living with human immunodeficiency virus (HIV) infection, including those with acquired immunodeficiency syndrome (AIDS); approximately one fourth of these persons had not had their infections diagnosed (*1*). In 2003, CDC implemented a new initiative, Advancing HIV Prevention (AHP) (*2*), focused, in part, on reducing the prevalence of undiagnosed HIV infection by expanding HIV testing (*2*) and taking advantage of rapid HIV tests that enable persons to receive results within 30 minutes, instead of the 2 weeks typically associated with conventional tests (*3*). In support of AHP strategies, during September 2003–December 2005, CDC purchased and distributed rapid HIV tests to expand testing and assess the feasibility of using rapid tests in new environments (e.g., outreach settings or emergency departments). This report summarizes the results of this rapid HIV-test distribution program (RTDP), in which CDC distributed tests to 230 organizations in the United States and identified 4,650 (1.2%) HIV infections among 372,960 rapid tests administered. The results suggest that RTDP helped scale up rapid HIV-testing programs in the United States and enabled diagnosis of HIV in persons who might not have had their infections diagnosed otherwise.

INSIDE

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

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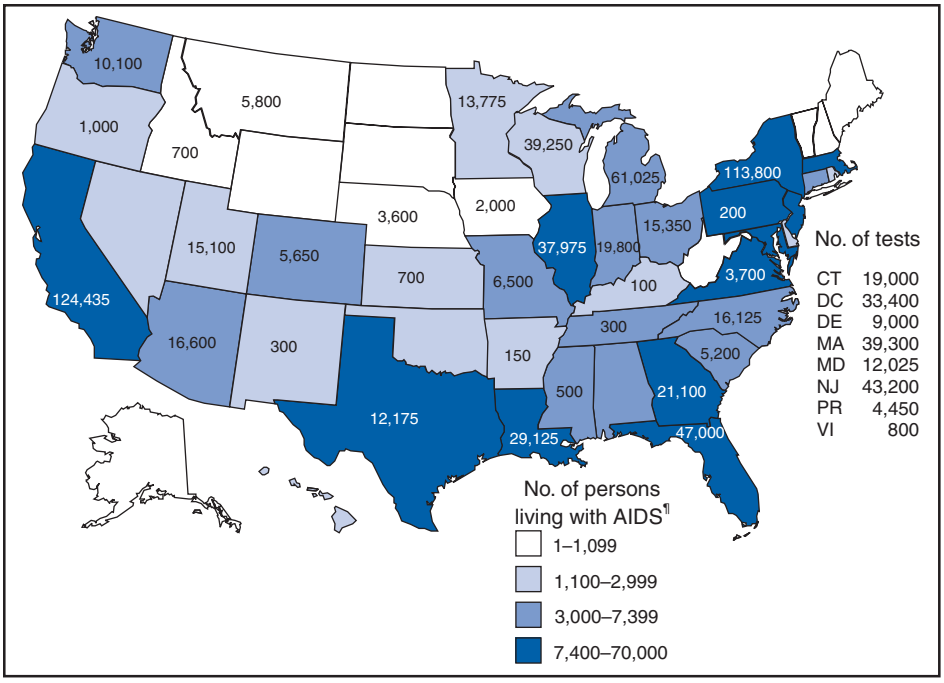
During 2003–2004, any publicly funded organization providing HIV testing was eligible to participate in RTDP. During 2005, participation was limited to organizations in 21 states and the District of Columbia (DC) funded by the CDC AHP initiative. In all 3 years, participating organizations were required to 1) have appropriate quality-assurance plans and Clinical Laboratory Improvement Amendments (CLIA) certification, 2) run periodic external quality controls, and 3) use either Western blot or immunofluorescent assays to confirm all reactive (i.e., preliminary positive) rapid HIV test results. Clients with test results that were confirmed positive were referred to HIV-care clinics.

During September 2003–December 2005, CDC distributed 790,310 OraQuick® Advance™ Rapid HIV-1/2 Antibody Tests (OraSure Technologies, Bethlehem, Pennsylvania) to 107 coordinators representing 230 organizations (121 state and local health departments, 101 medical centers and community-based organizations, and eight correctional facilities) in 37 states, DC, Puerto Rico, and the Virgin Islands. RTDP generally distributed more rapid tests to states and territories with higher estimated numbers of persons aged ≥13 years living with AIDS (Figure). Evaluation of RTDP was performed using two methods. First, coordinators of participating organizations were asked to submit quarterly reports regarding the number of rapid HIV tests used for training, external controls, and diagnostic purposes and the number of confirmed results (i.e., positive, negative, or indeterminate) for clients with preliminary positive rapid HIV test results. Quarterly reports also included data on the total number of conventional HIV tests administered, and of these, the number that were confirmed positive. Second, 52 RTDP coordinators, representing a random sample of all 107 coordinators, were telephoned during February 23–April 6, 2006, to assess challenges to implementing rapid HIV testing and the impact of RTDP on HIV testing services overall.

Of the 230 organizations, 128 (56%) submitted quarterly reports that accounted for 606,951 (76.8%) of the rapid tests distributed. Of these tests, 372,960 (61.4%) were administered for diagnostic purposes, 60,294 (9.9%) were used for external quality control, and 25,378 (4.2%) were used for training. The remaining 148,319 (24.4%) tests either had not yet been used at the time the reports were submitted, had been returned to CDC and redistributed to other organizations, or had expired before they could be administered. On average, approximately one rapid test was used for external quality control for every six rapid tests used for diagnostic purposes (60,294 versus 372,960). Among tests administered, results from 5,385 (1.4%) were preliminary positive for HIV,

FIGURE. Number of rapid HIV* tests distributed by CDC during September 2003–December 2005 and estimated number of persons† living with AIDS§ at the end of 2004, by state/territory — United States



* Human immunodeficiency virus.
† Aged ≥13 years.
§ Acquired immunodeficiency syndrome.
¶ CDC. HIV/AIDS surveillance report, 2004. Vol. 16. Atlanta, GA: US Department of Health and Human Services, CDC; 2005:22. Available at http://www.cdc.gov/hiv/stats/2004surveillancereport.pdf.

and 4,650 (1.2%) were confirmed as HIV positive from samples drawn at the rapid testing sites; similarly, during 2003–2005, the same 230 organizations reported that 1.5% of results from 600,732 conventional tests were confirmed positive. Of preliminary HIV-positive rapid tests, 4,262 confirmed positive, negative, or indeterminate results (79.1%) were provided to clients; data were not collected on the number of clients who refused confirmatory testing or left the site before confirmatory specimens could be drawn, or on other reasons clients did not receive results of confirmed tests.

Of the 52 coordinators telephoned for interview, four were no longer employed by the organization and could not be contacted; 48 (92%) participated, representing 97 organizations from 27 different states. Forty-six (96%) reported one or more challenges that delayed the start of their rapid-test programs, including training of staff (63%); meeting local, state, or federal regulations (48%); and creating operating procedures and quality-assurance protocols (35%). A total of 22 (46%) coordinators reported one or more expired test kits. The most commonly reported reasons for expiration were receipt of rapid tests from the manufacturer too near their expiration dates or unexpected expiration date changes by the manufacturer (i.e., because annual stability testing suggested the shelf life should be reduced [*4*]) (cited by 11 [50%] coordinators); overestimating demand for rapid testing (nine coordinators [41%]); delay in starting programs (nine [41%]); and inadequate inventory control (e.g., tracking of expiration dates or test supplies) (eight [36%]). Of the 22 coordinators, 15 (68%) reported using expired tests for training purposes.

Of the 48 coordinators interviewed, 43 (90%) said RTDP enabled their organizations to screen more clients for HIV because the program provided them with additional tests (cited by 35 coordinators [81%]) or because clients did not have to make a second visit to the clinic and meet with staff members a second time to receive their results (33 [79%]), increasing client acceptance of testing and increasing staff availability for testing additional clients. During 2005, when participation was limited to AHP-funded organizations, 26 (54%) of the interviewed coordinators were not eligible to participate in RTDP. Four (15%) of these coordinators said their rapid testing was discontinued at one or more test sites because of lack of funding, and one reported that a rapid test site was closed for other reasons; however, 21 (80%) reported continuing rapid testing by using non-RTDP federal, state, or local resources.

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Editorial Note: The findings in this report suggest that HIV testing might be increased by using rapid tests and that RTDP might have enabled diagnosis of HIV infection in persons who would not have known their HIV status otherwise. Although follow-up client data were not collected on the 4,650 confirmed HIV-positive test results, previous research has indicated that the majority of persons who learn they are infected with HIV take steps to prevent transmission to others (*5*) and obtain health care that can prolong the quality and duration of their lives (*6*). Previous research also has suggested that many

providers and clients prefer rapid HIV tests, which allow clients to receive test results in <30 minutes (*6*–*8*), eliminating for those with negative results the 2-week waiting period typically associated with conventional tests. Rapid tests also are simple to use and accurate. For example, the sensitivity of the OraQuick Advance test is 99.3% using oral fluid specimens and 99.6% using whole blood specimens; the specificity is 99.8% and 100.0%, respectively (*3*).

Despite the considerable utilization of rapid HIV tests provided through RTDP, nearly all coordinators identified challenges to implementing their programs, including receipt of tests with a short shelf life or notices of reduction in the shelf life of devices that had already been distributed. The short shelf life of OraQuick Advance (currently 6 months [*4*]) and lack of programmatic experience in rapid testing resulted in some devices expiring before their use. To help prevent expiration of tests, RTDP organizations also should ensure that comprehensive inventory-control mechanisms are in place and that initial orders for rapid HIV tests are based on accurate estimates.

The results of this assessment, combined with other CDC data, suggest that an excessive number of rapid tests might have been used for external quality control. External controls for rapid HIV tests should be run 1) by a new operator before performing testing, 2) when opening a new test lot or when a new shipment of rapid tests is received, 3) if the temperature in the test storage or testing area falls outside of specified ranges, or 4) at periodic intervals as dictated by the user facility (*3*). Many of the RTDP recipient organizations participated in another CDC evaluation of rapid HIV test quality-control procedures, which documented that rapid HIV tests were rarely exposed to temperatures outside of specified ranges (CDC, unpublished data, 2006). Thus, the high ratio of controls to tests in RTDP likely reflects running periodic controls at short user-defined intervals (e.g., daily). With increased experience in using rapid HIV tests, the New York State Department of Health, in March 2006, reduced its minimum requirement for periodic external controls from daily to monthly and with change in lot number and receipt of new shipments.*

The findings in this report are subject to at least four limitations. First, because 44% of participating organizations did not submit any reports, the number of tests reported as administered, expired, and used for training or external control should be considered minimum estimates. Second, some organizations that submitted quarterly reports operated multiple testing sites; the quality of test utilization data might not have been consistent among these multiple sites. Third, the organizations used different data collection methods that might have changed over time and might not have been able to distinguish rapid tests provided by RTDP from those purchased by the organizations. Finally, although organizations used RTDP devices on both oral fluid and whole blood specimens, RTDP quarterly reports did not differentiate between the two specimen types.

Despite obstacles associated with implementing a new diagnostic technology, RTDP has helped initiate rapid HIV testing at sites throughout the United States. Many organizations, although no longer associated with RTDP in 2005, continued to offer rapid HIV testing. CDC will procure an additional 211,800 OraQuick Advance rapid HIV tests for RTDP distribution during June 2006–June 2007. Currently, a total of six rapid HIV tests have been approved by the Food and Drug Administration (FDA) and are available in the United States; two of these tests are CLIA waived and can be used in nonlaboratory settings. However, OraQuick Advance remains the only FDA-approved, CLIA-waived rapid test for use on oral fluid (*3*). CDC will continue to work with federal, state, and local partners to increase the efficient use of rapid HIV tests, providing more access to HIV testing in settings and communities in which many HIV infections are undiagnosed.

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Methicillin-Resistant *Staphylococcus aureus* Skin Infections Among Tattoo Recipients — Ohio, Kentucky, and Vermont, 2004–2005

Community-associated methicillin-resistant *Staphylococcus aureus* (CA-MRSA) infections have emerged as a major cause of skin disease in the United States (*1*). Outbreaks of CA-MRSA have occurred among athletes, inmates at correctional facilities, and military recruits (*2–4*). This report summarizes investigations of six unlinked clusters of skin and soft tissue infections caused by CA-MRSA among 44 recipients of tattoos from 13 unlicensed tattooists in three states (Ohio, Kentucky, and Vermont); use of nonsterile equipment and suboptimal infection-control practices were identified as potential causes of the infections. Clinicians should consider CA-MRSA in their differential diagnosis for staphylococcus diseases, including skin infections. Clinicians can contact their local health departments to determine the prevalence of CA-MRSA in their community and whether the disease is reportable. MRSA infections should be added to education and prevention campaigns highlighting the risks of unlicensed tattooing.

CA-MRSA outbreaks among tattoo recipients were identified by hospital infection-control practitioners and reported to local health departments in six separate communities in Ohio, Kentucky, and Vermont during June 2004–August 2005 (Table). CA-MRSA is reportable in Ohio, Kentucky, and Vermont during outbreaks or when clusters have been identified. CDC was notified independently of the clusters in Ohio (four clusters) and Kentucky (one) by the state health departments; the Vermont Department of Health notified public authorities nationally of one tattoo-associated CA-MRSA cluster in August 2005 by using the Epidemic Information Exchange (*Epi-X*). After this notification, CDC contacted the Vermont Department of Health to share information on the clusters. Separate investigations of each cluster were conducted by local and state health departments, assisted by CDC, to identify the sources of exposure. A primary case of tattoo-associated CA-MRSA skin infection was defined as a skin infection consistent with staphylococcal infection (e.g., boil, folliculitis, erythema, or abscess) that occurred near or at the site of a recent tattoo in a person from whom a culture from that site yielded MRSA. A secondary case was defined as a skin infection consistent with staphylococcal disease that occurred in a person who had not received a recent tattoo, had provided a specimen that yielded MRSA, and had been in close contact with an MRSA patient who had received a tattoo.

A total of 34 primary cases and 10 secondary cases were identified in the three states. Patients ranged in age from 15 to 42 years. The majority were male (73%) and white (63%); 35% were black. Except for one Ohio patient with hepatitis C, no underlying diseases or risk factors were identified. Among all 34 primary cases, the time from tattoo to symptom onset was 4–22 days; no incubation period was recorded for the

TABLE. Characteristics of tattoo-associated methicillin-resistant *Staphylococcus aureus* skin infection clusters — Ohio, Kentucky, and Vermont, 2004–2005

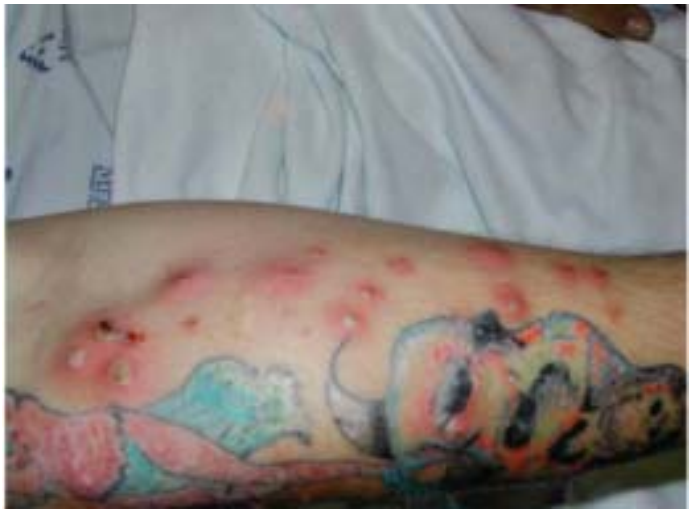
Characteristic	Ohio				Kentucky	Vermont
	Cluster 1	Cluster 2	Cluster 3	Cluster 4		
Month and year of outbreak*	June 2004	November 2004	April 2005	April 2005	May 2005	August 2005
Primary cases	13	4	4	4	4	5†
Median time to onset (days)	22	21	13	15	4	12
Secondary cases	6	0	1	1	0	2
Age range (yrs)	15–36	19–34	15–30	22–42	16–32	17–24
Percentage male	62	100	60	80	100	40
Unlicensed tattooists§	4	1	4	1	2	1
PFGE¶ matches	10 of 13 primary cases	Test not performed	1 of 4 primary cases, 1 of 1 secondary case	3 of 3 primary cases	Test not performed	3 of 3 primary cases
Antimicrobial resistance	Test not performed	Test not performed	Oxacillin, erythromycin	Oxacillin, erythromycin	Test not performed	Oxacillin, erythromycin
Personal protective equipment use reported	None	Gloves, mask	Gloves	None	Gloves	Gloves
Professional tattoo gun use reported	No	Yes	Unknown	Yes	Yes	Yes
Persons hospitalized	0	0	0	0	2	2

* Defined as month of first diagnosed case.
† Two of five cases had signs of infection observed at the tattoo site, but cultures were obtained from other infected skin.
§ All the tattooists (n = 13) implicated in all six clusters were unlicensed; no licensed tattooists were involved with any of the cases.
¶ Pulsed-field gel electrophoresis results for all cases tested.

secondary cases described in this report. Most infections were mild to moderate, ranging from cellulitis and small pustules (Figure) to larger abscesses that required surgical incision and drainage (n = 20). Most infections improved with surgical drainage (n = 16) and/or oral antimicrobials (n = 24), including trimethoprim-sulfamethoxazole, levofloxacin, and clindamycin. Four patients had bacteremia and required hospitalization for intravenous vancomycin.

During interviews regarding the circumstances of their tattoos, 34 patients with primary MRSA identified a total of 13 unlicensed tattooists. Investigations were performed by local health departments in coordination with law enforcement officials; seven tattooists who could be located were interviewed. Although gloves were reportedly worn by all tattooists in four of the six clusters (defined by spatial and temporal relationships), adherence to other infection-control measures (e.g., changing gloves between clients and performing appropriate hand hygiene, skin antisepsis, and disinfection of equipment and surfaces) was not practiced. Investigators determined that three of the tattooists in Ohio had recently been incarcerated in correctional facilities, a potential site for exposure to MRSA infection (*4*). However, none of the tattooists from Kentucky or Vermont reported previous incarceration. None of the 34 persons with primary cases were incarcerated when they received their tattoos. Five patients reported seeing lesions on the hands of tattooists that were consistent in description with MRSA skin infection, and one tattooist reported a pustule on his finger; however, no specimens from tattooists were cultured. All 13 primary patients in the first of the four Ohio clusters reported receiving their tattoos in public places (e.g., parks or private residences) from tattooists who used homemade tattooing equipment consisting of guitar-string tattoo needles and computer ink-jet printer cartridges for dye. The persons with secondary cases were exposed to persons with primary cases by direct contact because they were living in the same house or had close personal contact.

FIGURE. Pustules resulting from a methicillin-resistant *Staphylococcus aureus* skin infection in a tattoo recipient — Ohio, 2005



Photo/Toledo-Lucas County Health Department

Isolates from four of the six clusters also were characterized by pulsed-field gel electrophoresis (PFGE). Analysis of PFGE results revealed that isolates were indistinguishable within each cluster and all were USA300, a common CA-MRSA type (Table). Antimicrobial susceptibilities were characterized for infections in two of the Ohio clusters and the Vermont cluster. *S. aureus* isolates in all three clusters were resistant to oxacillin and erythromycin.

Interventions initiated by local health departments included educational forums targeting local infection-control professionals and medical providers. Students also were targeted in one Ohio community because many of the cases occurred in persons who attended one local high school and the educational forums provided them with information regarding the dangers of illegal tattoos. In addition, public service announcements were issued on the radio and in local newspapers, discussing the risks of acquiring tattoos from unlicensed tattooists and the possibility of skin infections with CA-MRSA.

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Editorial Note: CA-MRSA skin infections are usually transmitted from person to person by direct contact with a draining lesion or by contact with an asymptomatic carrier of *S. aureus*. Transmission also can occur indirectly through contact with contaminated items or environmental surfaces (*3,5*). In 2001, CDC initiated population-based surveillance for CA-MRSA at three Emerging Infection Program (EIP) sites using the Active Bacterial Core surveillance (ABCs) program (*1*). Currently, nine EIP sites participate in ABCs invasive MRSA surveillance, which represents a population of 16.3 million persons.* The annual incidence for all MRSA infections varied from 18.0 to 25.7 cases per 100,000 population. The majority of these were skin and soft tissue infections, accounting for 75% of cases (*1*).

* Available at http://www.cdc.gov/ncidod/dhqp/ar_mrsa_CDCactions.html.

Limited data are available on the morbidity and mortality of CA-MRSA. Most infections are mild skin and soft tissue infections, but more severe invasive disease such as pneumonia and necrotizing fasciitis has been reported (*6,7*). The cases in this report involved persons who received services from unlicensed tattooists who reportedly did not follow proper infection-control precautions recommended by tattoo industry groups and local and state regulators. These recommendations include following infection-control standard precautions† and using sterilized or single-use equipment, including needles, tattoo guns, and ink supplies. Persons considering getting a tattoo should be aware of the potential for CA-MRSA infection associated with unlicensed tattooists.

Laws and regulating authorities for tattooing vary by state. In Ohio, tattooing is regulated by local health departments,§ in Vermont by the Office of the Secretary of State,¶ and in Kentucky by the State Cabinet for Health Services.** Statutes or regulations have been in place in these three states since the mid-1990s. For example, under Ohio law, the operator of a tattoo establishment must ensure that tattooists follow standard infection-control procedures, are trained adequately, and have completed required first aid and bloodborne pathogen courses.

Certain states have reported an increase in CA-MRSA infections in their prisons (*4*). In this report, three of the tattooists associated with outbreaks in Ohio had been incarcerated recently. However, the prevalence of unlicensed tattooists in Ohio and other states is unknown; similarly, any association between CA-MRSA infection and tattooists who have been incarcerated is unknown.

In response to the outbreaks described in this report, local health departments rapidly targeted members of the affected population and health-care providers with CA-MRSA prevention messages and provided recommendations for early treatment of infections. Since implementation of the campaigns, no new CA-MRSA clusters have been reported in the affected areas. Persons considering a tattoo should be aware of the potential for CA-MRSA infection and should only use the services of a licensed tattooist who follows proper infection-control procedures.

† Available at http://www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html.

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Progress Toward Poliomyelitis Eradication — Pakistan and Afghanistan, January 2005–May 2006

As of March 2006, wild poliovirus (WPV) remained indigenous in four countries: Afghanistan, India, Nigeria, and Pakistan (*1*). Since 2005, WPV-endemic countries in Asia have intensified their polio eradication measures through use of type 1 monovalent oral polio vaccine (mOPV1)* and implementation of innovative social mobilization, communication, and vaccine-delivery strategies (*2,3*). This report describes polio eradication strategies in Afghanistan and Pakistan during January 2005–May 2006.

Immunization Activities

Routine vaccination coverage with oral polio vaccine (OPV) remains low in Afghanistan and in much of Pakistan (*2*). The most recent available estimates (2004) for national vaccination coverage of infants with 3 doses of OPV are 66% for Afghanistan and 65% for Pakistan (*4*). However, population figures for Afghanistan are uncertain, and coverage in both countries varies among provinces and districts.

During 2005–2006, both countries continued to vaccinate children aged <5 years with additional OPV doses during large-scale, closely synchronized, house-to-house immunization

* mOPV1 contains polio vaccine virus against type 1 WPV (WPV1) only and does not provide protection against other WPV types; mOPV1 provides greater immunity to WPV1 than does trivalent OPV using the same number of doses.

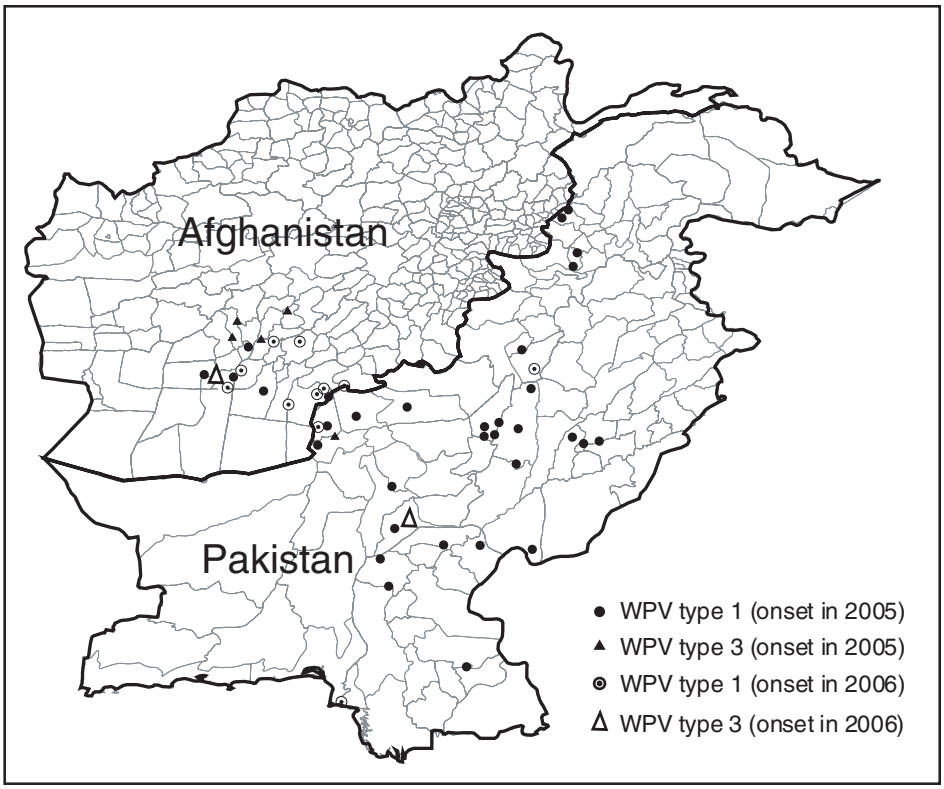
campaigns, or supplementary immunization activities (SIAs). In 2005, Pakistan conducted eight SIAs (seven national immunization days [NIDs] and one subnational immunization day [SNID]), and Afghanistan conducted 10 SIAs (four NIDs, three SNIDs and three mop-up campaigns[†]). In 2006, both countries conducted an SIA in January (NID in Pakistan and SNID in Afghanistan), March (NID in each country), and April (NID in each country), followed in early May by the first of two mop-up SIAs targeting the region stretching from central Pakistan into southern Afghanistan (Figure). A second SIA targeting the same area was held in early June 2006.

Pakistan used mOPV1 in the September 2005 NID and in all subsequent rounds through April 2006. The extent of mOPV1 use varied by round but always included known areas of high risk in Northwest Frontier Province (NWFP) and Punjab and Sindh provinces. Because of WPV type 3 (WPV3) circulation in Balochistan, mOPV1 use in that province was delayed until the December 2005 SNID. In Afghanistan, mOPV1 was used in three rounds: in October 2005 in two provinces in the eastern region, during the April 2006 NID round in the southern region, and in the May 2006 mop-up in the southern, southeastern, and eastern regions.

Both countries deployed additional partner staff members from areas at lower risk to areas at higher risk. Since January 2005, SIA staff members have targeted mobile groups (e.g., nomads, seasonal migrants and persons seeking temporary employment in harvesting, Afghan refugees moving between countries, and groups moving out of areas with ongoing military conflict) throughout the region with high virus transmission between central Pakistan and southern Afghanistan.

Polio teams in both countries had difficulties gaining access to children and effectively implementing SIAs in several areas affected by conflict. In Pakistan, these areas included the North Waziristan, South Waziristan, and Bajaur agencies in the tribal area of NWFP, and, since mid-2005, two districts in eastern Balochistan (Dera Bugti and Kohlu). Worsening security had the greatest impact on the effectiveness of the vaccination campaign in the southern region of Afghanistan, despite strategies to overcome the problems (e.g., recruitment of additional local staff members).

FIGURE. Wild poliovirus (WPV) cases,* by district — Afghanistan and Pakistan, January–May 31, 2006



* Excludes viruses detected from environmental surveillance and vaccine-derived polio viruses. Data reported to the World Health Organization as of May 31, 2006.

Acute Flaccid Paralysis (AFP) Surveillance

AFP reporting increased in both countries in 2005 compared with 2004; nonpolio AFP reporting rates were more than five cases per 100,000 population aged <15 years, and adequate stool specimens[§] were collected from 89% and 92% of persons with AFP in Pakistan and Afghanistan, respectively. AFP surveillance remained above certification-standard levels[¶] at the national level in both countries, provincial level in Pakistan, and regional level in Afghanistan. However, genetic analysis in 2005 and 2006 identified WPV chains of transmission in both countries that might have existed for 2–3 years without being detected by AFP surveillance. The primary gaps in surveillance are in southern Afghanistan.

[†] SIAs in a targeted geographic area of known virus transmission.

[§] Two stool specimens that are collected at an interval of at least 24 hours within 14 days of paralysis onset and properly shipped to the laboratory.

[¶] Nonpolio AFP rate of at least two cases per 100,000 population aged <15 years and collection of two adequate stool specimens from at least 80% of all AFP cases.

AFP surveillance in Pakistan and Afghanistan continues to receive laboratory support from the National Institutes of Health in Islamabad, Pakistan. In 2005, the laboratory isolated nonpolio enteroviruses from 19% and 22% of specimens from Pakistan and Afghanistan, respectively.

Polio Incidence

In Pakistan, 28 polio cases were confirmed with onset in 2005 (Table), compared with 53 cases in 2004. Twenty-seven of the 2005 cases were WPV1, and one was WPV3 (from Quetta district in the Balochistan province). For the first time, no high-season (August–October) transmission peak occurred; 13 cases were reported during this period in 2005. In 2006, as of May 31, four cases (three WPV1 and one WPV3) had been confirmed: one WPV1 case from Killa Abdullah in the Balochistan province (February 23 onset of paralysis); one WPV1 case from Dera Ismail Khan district in NWFP (February 23 onset of paralysis); one WPV1 case from Karachi in the Sindh province (April 28 onset of paralysis); and one WPV3 case from Jafarabad in the Balochistan province (May 15 onset of paralysis).

In Afghanistan, nine polio cases with onset in 2005 were confirmed (five WPV1 and four WPV3), all from three provinces in the southern region: three WPV1 and two WPV3 cases from Helmand, two WPV3 cases from Oruzgan, and two WPV1 cases from Kandahar. In 2006, WPV1 transmission is continuing in the southern region. As of May 31, eight WPV1 cases had been reported, including seven from Kandahar (three from Spin Boldak district and four cases from districts near the city of Kandahar) and one from Helmand. A WPV3 case with onset of paralysis on May 4 was also reported from Helmand province. During 2005–2006, confirmed WPV cases (both WPV1 and WPV3) in Afghanistan have been limited to three provinces of the southern region: Helmand, Oruzgan, and Kandahar. Only one case in 2004 and one positive contact (i.e., a person who is excreting WPV but has no paralysis) in 2005 were reported from the eastern region.

During 2005 and 2006, WPV detection in Afghanistan and Pakistan has been limited to five zones known for endemic transmission in preceding years: 1) Peshawar Valley and surrounding districts in NWFP, Pakistan; 2) southern Punjab, Pakistan; 3) northern Sindh, Pakistan; 4) eastern Balochistan and the Quetta area (including Pishin and Killa Abdullah districts) of Balochistan, Pakistan; and 5) the southern region of Afghanistan, particularly Kandahar, Helmand, and Oruzgan provinces.

Genetic data indicate close links between viruses found in zones 2 through 5 and confirm that these zones form a transmission corridor. All cases in Afghanistan since January 2005 and 24 of the 31 cases reported in Pakistan during the same period occurred in zones along this corridor. Genetic analysis indicates that the biodiversity of endemic WPVs has continued to decrease in Pakistan; the number of type-1 lineage

TABLE. Acute flaccid paralysis (AFP) surveillance indicators and reported wild poliovirus (WPV) cases, by quarter and type — Pakistan and Afghanistan, January 2005–May 31, 2006

Country/Province or region	AFP reporting (2005)			Reported WPV cases (2005)							Reported WPV cases by type (January–May 31, 2006)	
	No. AFP cases	Nonpolio AFP rate*	% persons with AFP with adequate specimens†	Quarter 1	2	3	4	Total cases by WPV type P1	P3	Total cases	P1	P3
Pakistan	4,025	5.4	88	6	6	8	8	27	1	28	3	1
NWFP§	868	7.6	83	1	1	1	2	5	—	5	1	—
Balochistan	220	6.3	85	1	—	4	3	7	1	8	1	1
Punjab	1,965	4.9	91	2	5	1	2	10	—	10	—	—
Sindh	884	5.5	88	2	—	2	1	5	—	5	1	—
Other areas¶	88	3.5	91	—	—	—	—	—	—	—	—	—
Afghanistan	827	5.2	92	—	4	—	5	5	4	9	8	1
South	123	4.1	86	—	4	—	5	5	4	9	8	1
Southeast	53	3.3	85	—	—	—	—	—	—	—	—	—
East	95	6.6	92	—	—	—	—	—	—	—	—	—
West	128	5.0	94	—	—	—	—	—	—	—	—	—
Central, including Bamian	165	5.6	96	—	—	—	—	—	—	—	—	—
North, including Mazar and Badakhshan	263	5.9	93	—	—	—	—	—	—	—	—	—

* Per 100,000 children aged <15 years.
† Two stool specimens that are collected at an interval of at least 24 hours within 14 days of paralysis onset and properly shipped to the laboratory.
§ Northwest Frontier Province.
¶ Other areas include Azad, Jammu, Kashmir (AJK), the Federally Administered Northern Areas (FANA), and Islamabad.

clusters (substrains) decreased from six in 2004 to three in 2005; one cluster of WPV1 has been identified in 2006.

Reported by: *Immunization, Vaccines, and Biologicals Dept, World Health Organization (WHO), Geneva, Switzerland. WHO Pakistan, Islamabad. Global Immunization Div, National Center for Immunization and Respiratory Diseases, CDC.*

Editorial Note: Pakistan and Afghanistan continue to progress toward polio eradication. Approximately 50% fewer cases were reported in Pakistan in 2005 than in 2004. For the first time since polio eradication measures began in Pakistan, no seasonal peak of cases was recorded during the 2005 autumn high-transmission season, indicating a decrease in WPV circulation after the SIAs. As of May 31, 2006, four cases had been reported in Pakistan, fewer than the number reported during any previous first quarter.** Epidemiologic findings suggest that the geographic extent of WPV transmission narrowed at the end of 2005; therefore, transmission is now confined to a corridor linking central Pakistan with southern Afghanistan through Balochistan. The reduction in the biodiversity of viral isolates indicates that previous transmission chains have been interrupted.

Although the number of WPV cases in Afghanistan increased from five in 2004 to nine in 2005, transmission was confined to three (9.4%) of 32 provinces, all in the southern region; transmission in 2004 also was confined to three provinces (although different from the 2005 provinces). Three genetically different clusters of WPV3 circulated in the south in 2005, and at least one WPV3 strain persisted in 2006. Cross-border transmission of WPV1, particularly in Kandahar, increased toward the end of 2005. The likely reason for continued transmission in southern Afghanistan is the lack of security in that area, which hinders planning, implementation, and evaluation of SIAs.

Cultural ties between southeastern Afghanistan and bordering areas of Pakistan are close, particularly between the Kandahar area and Balochistan, where cross-border migration is common. Unless transmission is stopped in this region, preventing continued transmission will be difficult in other parts of the high-risk corridor of districts from Afghanistan to central Pakistan.

Stopping WPV transmission in Afghanistan and Pakistan calls for additional improvements in SIA quality, particularly higher coverage of mobile persons (e.g., nomads or migrants) in areas of Pakistan at high risk and improved access to children in southern Afghanistan. These improvements will require increased deployment of local health workers and volunteers and an appeal to those in the southern Afghanistan conflict to reinstitute immediately a cease-fire to allow vaccinators to do their work undisturbed.

Progress in polio eradication has resulted from support from the international polio partnership†† and political and health leaders at the national, provincial, and district levels. The goal of polio eradication can be achieved only if health and political leaders remain committed to and supportive of their national programs.

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** As of May 31, 2006; laboratory data were complete through mid-April.

†† Polio eradication programs in Afghanistan and Pakistan are supported by Rotary International; WHO; UNICEF; CDC; the governments of Japan, Netherlands, and the United Kingdom; the United States Agency for International Development; the International Committee of the Red Cross; the International Federation of Red Cross and Red Crescent Societies; and the Bill & Melinda Gates Foundation.

Notice to Readers

International Standards for Tuberculosis Care and *The Patients' Charter for Tuberculosis Care*

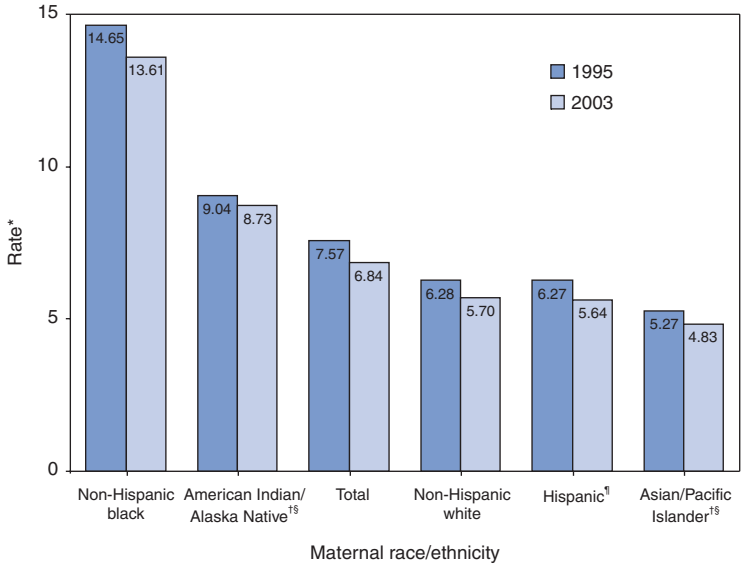
The Tuberculosis Coalition for Technical Assistance, funded by the U.S. Agency for International Development, has released the *International Standards for Tuberculosis Care (ISTC)* and *The Patients' Charter for Tuberculosis Care*. The publications were developed by partner health agencies, including CDC, for providers of tuberculosis care and their patients.

The *ISTC* describes the level of care that practitioners should strive to achieve while treating patients who have or are suspected of having tuberculosis. The standards were endorsed by leading international health agencies. The patients' charter outlines the rights and responsibilities of persons with tuberculosis and was designed to create a mutually beneficial relationship between patients and their health-care providers. The *ISTC* and charter are available at http://www.stoptb.org/resource_center/documents.asp. Additional information is available from Philip C. Hopewell, MD, Division of Pulmonary and Critical Care Medicine, San Francisco General Hospital, 1001 Potrero Ave, San Francisco, CA 94110; telephone, 415-206-3510; e-mail, phopewell@medsfgh.ucsf.edu.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Infant Mortality Rates, by Maternal Race/Ethnicity — United States, 1995 and 2003



* Deaths of infants aged <1 year per 1,000 live births.
† Includes persons of Hispanic and non-Hispanic origin.
§ Difference not significant at p<0.05 (*z* test).
¶ Persons of Hispanic origin might be of any race.

Infant mortality rates decreased significantly (p<0.05, *z* test) in the United States from 1995 to 2003. The rate for non-Hispanic black mothers was significantly higher than for all other groups for both years; the rate for American Indian/Alaska Native mothers was significantly higher than for non-Hispanic whites, Hispanics, and Asians/Pacific Islanders for both years.

SOURCE: Mathews TJ, MacDorman MF. Infant mortality statistics from the 2003 period linked birth/infant death data set. Natl Vital Stat Rep 2006;54(15).

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending June 17, 2006 (24th 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	—	1	0	—	—	—	2	23	
Botulism:									
foodborne	—	1	0	19	16	20	28	39	
infant	—	32	2	90	87	76	69	97	
other (wound & unspecified)	—	22	0	33	30	33	21	19	
Brucellosis	—	42	2	122	114	104	125	136	
Chancroid	1	14	1	17	30	54	67	38	MD (1)
Cholera	—	—	0	6	5	2	2	3	
Cyclosporiasis§	—	26	11	734	171	75	156	147	
Diphtheria	—	—	0	—	—	1	1	2	
Domestic arboviral diseases§¶:									
California serogroup	—	—	1	78	112	108	164	128	
eastern equine	—	—	0	21	6	14	10	9	
Powassan	—	—	0	1	1	—	1	N	
St. Louis	—	—	0	10	12	41	28	79	
western equine	—	—	—	—	—	—	—	—	
Ehrlichiosis§:									
human granulocytic	—	37	11	790	537	362	511	261	
human monocytic	4	69	7	522	338	321	216	142	MO (1), NC (1), TN (2)
human (other & unspecified)	3	12	2	121	59	44	23	6	MO (1), TN (2)
Haemophilus influenzae,**									
invasive disease (age <5 yrs):									
serotype b	—	3	0	9	19	32	34	—	
nonserotype b	1	43	3	135	135	117	144	—	OK (1)
unknown serotype	2	82	2	217	177	227	153	—	NY (1), DC (1)
Hansen disease§	5	26	2	88	105	95	96	79	HI (5)
Hantavirus pulmonary syndrome§	—	8	1	22	24	26	19	8	
Hemolytic uremic syndrome, postdiarrheal§	—	50	4	219	200	178	216	202	
Hepatitis C viral, acute	7	354	33	771	713	1,102	1,835	3,976	PA (1), MI (3), MO (2), OR (1)
HIV infection, pediatric (age <13 yrs)§††	—	52	6	380	436	504	420	543	
Influenza-associated pediatric mortality§,§§,¶¶	1	35	0	49	—	N	N	N	AZ (1)
Listeriosis	6	209	13	893	753	696	665	613	PA (1), OH (2), MD (1), VA (2)
Measles	1	22***	1	65	37	56	44	116	NY (1)
Meningococcal disease,††† invasive:									
A, C, Y, & W-135	3	122	5	294	—	—	—	—	CT (2), FL (1)
serogroup B	3	72	3	153	—	—	—	—	NC (3)
other serogroup	—	12	1	27	—	—	—	—	
Mumps	47	4,219	5	310	258	231	270	266	NY (1), PA (3), IN (1), IA (4), MO (3), NE (4), KS (13), DC (1), VA (2), TN (1), AL (8), TX (2), ID (2), CO (1), AZ (1)
Plague	—	1	0	7	3	1	2	2	
Poliomyelitis, paralytic	—	—	—	1	—	—	—	—	
Psittacosis§	—	9	0	19	12	12	18	25	
Q fever§	—	56	2	139	70	71	61	26	
Rabies, human	—	—	—	2	7	2	3	1	
Rubella	—	4	0	11	10	7	18	23	
Rubella, congenital syndrome	—	1	—	1	—	1	1	3	
SARS-CoV§,§§	—	—	—	—	—	8	N	N	
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	1	58	3	129	132	161	118	77	OH (1)
Streptococcus pneumoniae,§									
invasive disease (age <5 yrs)	9	551	14	1,224	1,162	845	513	498	NY (1), PA (1), OH (2), IN (1), MD (2), OK (1), CO (1)
Syphilis, congenital (age <1 yr)	1	95	8	361	353	413	412	441	LA (1)
Tetanus	1	9	1	26	34	20	25	37	IN (1)
Toxic-shock syndrome (other than streptococcal)§	—	45	2	95	95	133	109	127	
Trichinellosis	1	5	0	20	5	6	14	22	MD (1)
Tularemia§	—	18	4	154	134	129	90	129	
Typhoid fever	2	108	6	324	322	356	321	368	OH (1), NC (1)
Vancomycin-intermediate *Staphylococcus aureus*§	—	2	—	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 2005 and 2006 are provisional, whereas data for 2001, 2002, 2003, and 2004 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/AIDS, 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 40 cases reported since October 2, 2005 (week 40), only 36 occurred during the current 2005–06 season.

*** One measles case was reported from another country 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 June 17, 2006, and June 18, 2005 (24th 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	8,826	18,815	35,170	414,236	440,009	7	126	1,643	3,506	1,803	43	70	860	1,101	945
New England	401	634	1,550	14,112	14,308	—	0	0	—	—	3	4	35	59	48
Connecticut	—	169	1,214	3,405	4,129	N	0	0	N	N	—	0	14	8	6
Maine	42	41	74	970	955	N	0	0	N	N	—	0	3	11	10
Massachusetts	247	290	432	6,817	6,370	—	0	0	—	—	1	2	15	23	16
New Hampshire	10	34	64	809	858	—	0	0	—	—	—	1	3	11	7
Rhode Island	80	65	99	1,570	1,531	—	0	0	—	—	2	0	6	3	1
Vermont§	22	19	43	541	465	N	0	0	N	N	—	0	5	3	8
Mid. Atlantic	1,160	2,296	3,696	52,405	53,676	—	0	0	—	—	8	11	597	156	128
New Jersey	—	366	526	7,095	8,669	N	0	0	N	N	—	0	8	6	9
New York (Upstate)	446	497	1,727	10,638	10,840	N	0	0	N	N	3	3	561	46	33
New York City	233	691	1,619	16,897	17,389	N	0	0	N	N	—	2	15	20	34
Pennsylvania	481	718	1,073	17,775	16,778	N	0	0	N	N	5	4	21	84	52
E.N. Central	1,586	3,103	12,578	67,692	73,452	2	0	3	21	4	8	14	162	247	217
Illinois	562	919	1,536	20,820	22,896	—	0	0	—	—	—	2	16	31	29
Indiana	196	393	552	8,306	9,200	N	0	0	N	N	4	1	13	24	12
Michigan	664	558	9,888	14,381	11,787	2	0	3	17	4	1	2	7	37	28
Ohio	60	805	1,445	15,658	20,243	—	0	1	4	—	3	5	109	95	62
Wisconsin	104	397	531	8,527	9,326	N	0	0	N	N	—	4	38	60	86
W.N. Central	709	1,124	1,457	25,795	26,918	—	0	12	—	3	2	9	52	175	135
Iowa	110	150	225	3,747	3,209	N	0	0	N	N	—	1	11	16	25
Kansas	170	154	269	3,735	3,352	N	0	0	N	N	1	1	5	26	12
Minnesota	—	233	298	4,987	5,714	—	0	12	—	3	—	3	22	70	36
Missouri	305	429	525	9,172	10,322	—	0	1	—	—	1	2	37	33	47
Nebraska§	66	96	176	2,275	2,367	N	0	1	N	N	—	0	3	7	4
North Dakota	3	32	54	665	693	N	0	0	N	N	—	0	4	3	—
South Dakota	55	52	117	1,214	1,261	N	0	0	N	N	—	0	4	20	11
S. Atlantic	2,041	3,324	4,905	78,420	81,896	—	0	1	2	—	17	15	54	294	176
Delaware	85	68	92	1,653	1,508	N	0	0	N	N	—	0	2	1	—
District of Columbia	55	58	101	1,159	1,785	—	0	0	—	—	1	0	3	8	2
Florida	763	898	1,090	21,354	19,986	N	0	0	N	N	6	6	28	112	66
Georgia	43	609	2,142	10,793	13,715	—	0	0	—	—	9	3	12	102	47
Maryland§	288	357	519	8,278	8,198	—	0	1	2	—	—	0	4	9	9
North Carolina	527	584	1,772	16,199	15,218	N	0	0	N	N	—	1	10	29	24
South Carolina§	259	281	1,306	7,941	9,256	N	0	0	N	N	1	0	4	14	10
Virginia§	—	423	840	9,434	11,066	N	0	0	N	N	—	1	8	17	14
West Virginia	21	58	226	1,609	1,164	N	0	0	N	N	—	0	3	2	4
E.S. Central	624	1,380	2,188	32,708	31,567	—	0	0	—	—	2	3	29	38	25
Alabama§	110	370	1,048	9,272	5,569	N	0	0	N	N	1	0	5	16	11
Kentucky	153	148	336	4,297	4,852	N	0	0	N	N	1	1	25	10	9
Mississippi	—	378	647	7,779	10,490	—	0	0	—	—	—	0	1	1	—
Tennessee§	361	489	614	11,360	10,656	N	0	0	N	N	—	1	4	11	5
W.S. Central	1,139	2,160	3,605	49,782	51,980	—	0	1	—	—	1	4	30	63	28
Arkansas	—	162	340	3,453	4,051	—	0	0	—	—	—	0	2	7	1
Louisiana	115	285	761	7,258	8,654	—	0	1	—	N	—	0	21	9	3
Oklahoma	249	234	2,159	5,574	4,922	N	0	0	N	N	—	1	10	14	10
Texas§	775	1,391	1,802	33,497	34,353	N	0	0	N	N	1	1	19	33	14
Mountain	660	1,102	1,839	21,852	29,350	5	92	452	2,401	1,109	1	2	9	39	53
Arizona	490	365	642	8,257	10,535	5	91	448	2,359	1,056	—	0	1	4	4
Colorado	68	226	482	2,898	6,845	N	0	0	N	N	1	1	3	15	17
Idaho§	2	52	235	1,427	1,058	N	0	0	N	N	—	0	2	4	5
Montana	99	39	195	961	1,061	N	0	0	N	N	—	0	2	7	8
Nevada§	—	87	432	1,795	3,389	—	1	4	20	36	—	0	1	3	7
New Mexico§	—	164	338	4,016	3,957	—	0	2	2	10	—	0	3	—	6
Utah	1	89	136	1,870	2,004	—	0	3	18	5	—	0	3	6	4
Wyoming	—	25	55	628	501	—	0	2	2	2	—	0	1	—	2
Pacific	506	3,243	5,079	71,470	76,862	—	33	1,179	1,082	687	1	4	52	30	135
Alaska	46	83	152	1,887	1,868	—	0	0	—	—	—	0	2	1	—
California	—	2,505	4,231	54,615	59,620	—	33	1,179	1,082	687	—	2	14	—	94
Hawaii	—	106	135	2,306	2,483	N	0	0	N	N	—	0	1	—	—
Oregon§	—	178	315	4,237	4,105	N	0	0	N	N	1	1	20	29	22
Washington	460	357	604	8,425	8,786	N	0	0	N	N	—	0	38	—	19
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	—	17	37	—	348	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	77	162	1,877	2,041	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	2	7	6	97	—	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).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 17, 2006, and June 18, 2005 (24th 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	148	327	1,028	6,194	7,286	2,741	6,506	14,136	139,284	146,178	35	37	142	938	1,205
New England	7	25	75	453	630	62	105	288	2,399	2,701	1	3	19	69	81
Connecticut	—	0	37	119	150	—	41	241	843	1,101	—	0	9	20	25
Maine	3	3	11	37	70	2	2	6	56	59	—	0	2	6	5
Massachusetts	1	11	34	192	280	44	48	76	1,146	1,207	1	1	5	31	37
New Hampshire	—	1	8	10	29	3	4	9	104	72	—	0	1	2	4
Rhode Island	3	0	25	37	35	13	7	19	224	238	—	0	7	2	6
Vermont†	—	3	9	58	66	—	1	4	26	24	—	0	2	8	4
Mid. Atlantic	28	64	254	1,062	1,345	304	649	1,014	13,772	14,811	7	7	30	174	222
New Jersey	—	8	18	97	183	—	110	150	2,138	2,558	—	2	4	26	41
New York (Upstate)	26	22	227	438	435	133	123	455	2,773	2,936	6	2	27	58	64
New York City	—	15	32	250	389	55	180	402	3,846	4,455	—	1	4	14	41
Pennsylvania	2	16	29	277	338	116	218	391	5,015	4,862	1	3	8	76	76
E.N. Central	15	56	110	874	1,245	497	1,278	7,047	26,857	28,575	4	5	14	134	214
Illinois	—	10	32	62	328	167	379	567	7,775	8,770	—	1	6	30	67
Indiana	N	0	0	N	N	65	157	228	3,471	3,613	1	1	7	34	39
Michigan	6	14	29	281	304	177	235	5,880	5,710	4,482	—	0	3	14	12
Ohio	9	16	34	318	269	38	391	681	7,169	9,197	3	1	6	44	73
Wisconsin	—	16	40	213	344	50	122	172	2,732	2,513	—	0	4	12	23
W.N. Central	8	35	259	702	869	225	358	461	7,742	8,399	1	2	15	51	55
Iowa	2	5	14	94	103	29	31	54	748	704	—	0	0	—	1
Kansas	2	3	9	68	84	31	48	124	1,017	1,138	1	0	3	10	5
Minnesota	—	5	238	280	407	—	63	88	1,172	1,590	—	0	9	23	21
Missouri	3	10	32	190	179	125	178	240	4,045	4,187	—	0	7	13	20
Nebraska†	—	2	6	34	52	27	21	56	561	566	—	0	2	4	7
North Dakota	—	0	7	5	2	—	2	7	36	39	—	0	3	1	1
South Dakota	1	2	7	31	42	13	6	13	163	175	—	0	0	—	—
S. Atlantic	48	55	107	1,131	1,071	707	1,470	2,334	32,773	34,730	19	10	24	268	283
Delaware	—	1	3	10	27	37	23	44	678	368	—	0	1	1	—
District of Columbia	4	1	5	31	20	16	36	66	724	922	1	0	1	2	3
Florida	18	19	39	398	356	401	413	512	10,000	8,776	5	3	9	87	71
Georgia	7	14	67	371	300	12	288	1,014	4,592	5,970	1	2	5	57	68
Maryland†	—	4	10	81	75	115	137	231	3,177	3,030	3	1	5	34	40
North Carolina	N	0	0	N	N	—	274	766	7,111	7,477	8	0	11	23	41
South Carolina†	3	1	9	43	52	119	125	748	3,486	4,085	1	1	3	21	17
Virginia†	16	10	50	187	228	—	142	288	2,593	3,790	—	1	8	33	29
West Virginia	—	0	6	10	13	7	16	42	412	312	—	0	4	10	14
E.S. Central	12	8	18	178	165	241	548	868	12,817	11,856	1	2	6	53	72
Alabama†	9	4	14	93	76	52	184	491	4,228	3,272	—	0	4	12	14
Kentucky	N	0	0	N	N	48	55	116	1,491	1,515	—	0	1	2	9
Mississippi	—	0	0	—	—	—	133	203	2,885	3,208	—	0	1	2	—
Tennessee†	3	4	12	85	89	141	181	279	4,213	3,861	1	1	4	37	49
W.S. Central	4	6	31	106	100	428	898	1,430	20,998	20,640	1	1	15	43	69
Arkansas	—	2	6	31	36	—	86	186	1,924	2,071	—	0	2	4	5
Louisiana	—	1	6	29	18	70	171	461	4,331	4,766	—	0	2	8	28
Oklahoma	4	3	24	46	46	93	86	764	2,016	2,035	1	1	14	31	34
Texas†	N	0	0	N	N	265	527	734	12,727	11,768	—	0	1	—	2
Mountain	19	29	57	521	528	137	230	552	4,628	6,200	1	3	8	94	143
Arizona	—	2	36	33	65	64	94	201	1,959	2,310	—	1	7	42	74
Colorado	8	9	33	183	180	65	54	90	831	1,446	—	0	4	27	29
Idaho†	4	2	11	50	57	—	3	10	85	42	—	0	1	2	3
Montana	2	1	7	29	16	8	2	14	55	67	—	0	0	—	—
Nevada†	—	2	6	28	37	—	39	194	634	1,320	—	0	1	—	13
New Mexico†	—	1	6	16	25	—	29	64	672	688	—	0	4	11	15
Utah	5	7	19	175	136	—	16	23	328	300	—	0	4	10	5
Wyoming	—	0	2	7	12	—	2	6	64	27	1	0	2	2	4
Pacific	7	58	202	1,167	1,333	140	809	946	17,298	18,266	—	2	20	52	66
Alaska	1	1	7	18	39	8	11	23	240	252	—	0	19	4	4
California	—	43	105	833	1,020	—	667	806	14,040	15,198	—	0	9	10	27
Hawaii	—	1	6	24	31	—	20	36	427	450	—	0	1	8	5
Oregon†	3	8	21	162	139	—	28	58	620	742	—	1	6	29	30
Washington	3	7	90	130	104	132	73	142	1,971	1,624	—	0	4	1	—
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	3	—	3	—	1	15	—	52	—	0	2	—	—
Puerto Rico	—	3	20	13	69	—	6	16	127	191	—	0	1	—	2
U.S. Virgin Islands	—	0	0	—	—	—	0	2	4	50	—	0	0	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 17, 2006, and June 18, 2005 (24th 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	20	74	243	1,497	1,749	51	87	594	1,693	2,386	25	41	127	584	544
New England	2	6	22	88	182	—	2	9	32	67	2	2	12	25	28
Connecticut	2	1	3	16	25	—	0	3	—	27	2	0	8	11	7
Maine	—	0	2	4	1	—	0	2	9	4	—	0	1	3	1
Massachusetts	—	4	14	44	116	—	1	5	14	22	—	1	6	9	13
New Hampshire	—	1	12	15	33	—	0	3	5	11	—	0	1	1	4
Rhode Island	—	0	4	3	5	—	0	2	4	1	—	0	10	—	3
Vermont†	—	0	2	6	2	—	0	1	—	2	—	0	3	1	—
Mid. Atlantic	5	9	24	109	291	1	9	55	157	316	4	12	53	146	152
New Jersey	—	2	9	17	53	—	3	10	40	114	—	1	13	6	26
New York (Upstate)	5	1	14	40	41	—	1	43	27	28	3	4	29	63	39
New York City	—	2	10	26	149	—	1	5	19	70	—	1	20	11	20
Pennsylvania	—	1	6	26	48	1	3	9	71	104	1	5	17	66	67
E.N. Central	4	7	15	128	160	9	8	24	150	260	9	8	25	122	113
Illinois	—	1	11	17	49	—	1	7	6	76	—	1	5	11	16
Indiana	1	0	7	18	9	3	0	17	19	10	1	0	6	5	10
Michigan	3	2	8	51	53	1	3	7	63	89	1	2	6	27	29
Ohio	—	1	4	35	26	5	2	8	57	66	7	3	19	61	48
Wisconsin	—	0	5	7	23	—	0	6	5	19	—	1	5	18	10
W.N. Central	1	2	29	70	46	—	5	19	64	115	—	1	12	17	17
Iowa	—	0	2	4	12	—	0	2	5	12	—	0	1	1	3
Kansas	—	0	5	20	7	—	0	2	5	16	—	0	1	1	2
Minnesota	—	0	29	6	3	—	0	13	6	10	—	0	10	—	1
Missouri	1	1	4	26	21	—	3	7	45	63	—	0	3	10	9
Nebraska†	—	0	3	9	3	—	0	2	3	13	—	0	2	3	1
North Dakota	—	0	2	—	—	—	0	0	—	—	—	0	1	—	1
South Dakota	—	0	3	5	—	—	0	1	—	1	—	0	6	2	—
S. Atlantic	7	12	34	224	265	20	23	66	531	686	9	9	19	148	126
Delaware	—	0	2	8	4	—	0	4	18	18	—	0	4	2	8
District of Columbia	—	0	2	2	2	—	0	2	4	4	—	0	2	5	2
Florida	1	4	18	79	91	4	9	19	199	237	6	3	8	70	35
Georgia	—	1	6	26	52	2	3	9	74	113	—	0	4	6	13
Maryland†	—	1	6	29	26	—	2	9	78	78	1	2	9	27	36
North Carolina	5	0	20	45	32	11	0	23	85	68	—	0	3	14	12
South Carolina†	—	1	3	10	14	1	2	7	28	71	—	0	2	2	4
Virginia†	1	1	11	24	41	2	1	18	18	78	2	1	7	21	12
West Virginia	—	0	1	1	3	—	0	18	27	19	—	0	3	1	4
E.S. Central	1	3	15	49	112	5	6	18	139	180	—	2	9	35	25
Alabama†	—	0	9	3	14	4	1	7	44	45	—	0	1	5	8
Kentucky	—	0	5	22	7	—	1	5	35	39	—	0	4	9	9
Mississippi	—	0	2	2	11	—	0	3	5	25	—	0	1	—	1
Tennessee†	1	1	7	22	80	1	2	12	55	71	—	1	7	21	7
W.S. Central	—	8	77	104	189	14	13	315	272	220	—	1	32	11	11
Arkansas	—	0	9	26	7	—	1	4	14	32	—	0	3	—	3
Louisiana	—	0	4	4	31	—	1	3	10	37	—	0	1	4	—
Oklahoma	—	0	2	4	3	7	0	17	12	20	—	0	3	1	1
Texas†	—	5	73	70	148	7	11	295	236	131	—	0	26	6	7
Mountain	—	5	18	110	142	1	7	39	131	253	1	2	8	38	44
Arizona	—	2	16	64	69	—	5	27	86	161	—	0	3	14	11
Colorado	—	1	4	17	18	—	1	5	15	24	—	0	3	2	10
Idaho†	—	0	2	5	18	—	0	2	5	5	—	0	2	5	1
Montana	—	0	2	5	7	—	0	7	—	3	1	0	1	3	3
Nevada†	—	0	2	5	7	—	1	4	13	24	—	0	2	3	9
New Mexico†	—	0	3	5	9	—	0	3	1	12	—	0	1	—	2
Utah	—	0	2	8	13	1	0	4	11	23	—	0	2	10	5
Wyoming	—	0	1	1	1	—	0	1	—	1	—	0	1	1	3
Pacific	—	16	163	615	362	1	10	61	217	289	—	2	9	42	28
Alaska	—	0	1	—	3	—	0	1	1	6	—	0	1	—	—
California	—	14	162	563	303	—	7	41	163	202	—	2	9	42	27
Hawaii	—	0	2	7	12	—	0	1	4	2	—	0	1	—	1
Oregon†	—	1	5	25	23	1	1	6	33	49	N	0	0	N	N
Washington	—	1	13	20	21	—	0	18	16	30	—	0	0	—	—
American Samoa	U	0	1	U	1	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	—	2	—	0	2	—	15	—	0	0	—	—
Puerto Rico	—	0	4	7	39	2	1	8	13	14	—	0	1	1	—
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 June 17, 2006, and June 18, 2005 (24th 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	105	236	2,153	2,595	4,061	11	25	125	452	545
New England	5	51	780	181	656	—	1	12	24	25
Connecticut	—	9	753	95	43	—	0	10	4	—
Maine	—	2	26	29	35	—	0	1	2	2
Massachusetts	—	10	205	11	539	—	0	3	13	17
New Hampshire	5	5	21	38	32	—	0	1	4	3
Rhode Island	—	0	12	—	3	—	0	8	—	2
Vermont†	—	1	5	8	4	—	0	1	1	1
Mid. Atlantic	83	151	1,176	1,680	2,193	—	5	15	69	151
New Jersey	—	21	312	300	963	—	1	7	13	35
New York (Upstate)	60	74	1,150	796	407	—	1	11	11	22
New York City	—	3	33	—	104	—	3	8	33	76
Pennsylvania	23	34	376	584	719	—	1	2	12	18
E.N. Central	—	10	160	138	406	—	3	8	46	55
Illinois	—	0	13	—	40	—	1	5	11	31
Indiana	—	0	4	3	3	—	0	3	6	3
Michigan	—	1	7	9	4	—	0	2	8	10
Ohio	—	1	5	17	19	—	1	3	16	6
Wisconsin	—	9	145	109	340	—	0	3	5	5
W.N. Central	1	9	98	74	110	—	0	32	21	27
Iowa	—	0	8	10	32	—	0	1	1	4
Kansas	—	0	2	3	2	—	0	1	—	2
Minnesota	—	6	96	52	71	—	0	30	14	11
Missouri	—	0	2	4	5	—	0	2	3	10
Nebraska†	1	0	2	5	—	—	0	2	1	—
North Dakota	—	0	3	—	—	—	0	1	1	—
South Dakota	—	0	1	—	—	—	0	1	1	—
S. Atlantic	14	28	124	412	609	9	6	16	146	107
Delaware	—	9	37	163	248	—	0	1	3	1
District of Columbia	1	0	2	8	3	—	0	2	—	2
Florida	—	1	5	14	10	—	1	6	23	18
Georgia	—	0	1	—	2	4	1	6	47	20
Maryland†	8	16	87	184	275	—	1	9	34	38
North Carolina	—	0	5	9	22	—	0	8	11	13
South Carolina†	1	0	3	4	8	—	0	2	4	3
Virginia†	4	3	22	30	40	5	1	9	23	11
West Virginia	—	0	44	—	1	—	0	2	1	1
E.S. Central	1	0	4	2	10	1	0	3	11	10
Alabama†	—	0	1	—	—	1	0	2	6	3
Kentucky	—	0	2	—	1	—	0	2	1	3
Mississippi	—	0	0	—	—	—	0	1	2	—
Tennessee†	1	0	4	2	9	—	0	2	2	4
W.S. Central	—	0	5	3	38	1	2	31	30	41
Arkansas	—	0	1	—	2	—	0	2	1	3
Louisiana	—	0	0	—	3	—	0	1	—	2
Oklahoma	—	0	0	—	—	—	0	6	2	2
Texas†	—	0	5	3	33	1	1	29	27	34
Mountain	—	0	4	4	3	—	1	9	18	27
Arizona	—	0	4	2	—	—	0	9	4	5
Colorado	—	0	0	—	—	—	0	2	6	14
Idaho†	—	0	1	—	1	—	0	0	—	—
Montana	—	0	0	—	—	—	0	1	1	—
Nevada†	—	0	2	—	—	—	0	1	—	2
New Mexico†	—	0	1	—	—	—	0	1	—	1
Utah	—	0	1	2	1	—	0	2	7	4
Wyoming	—	0	1	—	1	—	0	1	—	1
Pacific	1	3	19	101	36	—	4	12	87	102
Alaska	—	0	1	—	2	—	0	2	8	3
California	—	3	19	100	25	—	3	10	61	80
Hawaii	N	0	0	N	N	—	0	4	—	9
Oregon†	1	0	3	1	9	—	0	2	6	3
Washington	—	0	3	—	—	—	0	5	12	7
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	—	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 June 17, 2006, and June 18, 2005 (24th 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	12	20	84	600	717	8	13	58	394	440	129	400	2,867	5,204	9,260
New England	2	1	3	24	47	—	0	2	17	17	—	30	83	558	547
Connecticut	2	0	2	8	10	—	0	2	2	1	—	1	5	16	36
Maine	—	0	1	3	2	—	0	1	3	2	—	1	5	22	15
Massachusetts	—	0	2	10	22	—	0	2	10	5	—	23	43	391	411
New Hampshire	—	0	2	2	7	—	0	2	2	7	—	2	36	71	20
Rhode Island	—	0	1	—	2	—	0	0	—	—	—	0	17	—	11
Vermont†	—	0	1	1	4	—	0	1	—	2	—	1	10	58	54
Mid. Atlantic	2	3	13	82	90	4	2	11	62	69	16	27	137	737	654
New Jersey	—	0	2	5	23	—	0	2	5	23	—	4	10	95	90
New York (Upstate)	—	0	7	20	26	2	0	5	4	10	12	11	123	281	244
New York City	—	0	5	23	12	—	0	5	23	12	—	2	6	25	42
Pennsylvania	2	1	5	34	29	2	1	5	30	24	4	11	26	336	278
E.N. Central	—	3	10	68	92	—	2	6	50	78	18	48	133	589	1,853
Illinois	—	0	4	16	22	—	0	4	16	22	—	11	35	20	419
Indiana	—	0	5	12	11	—	0	2	6	5	3	4	75	87	146
Michigan	—	1	3	14	16	—	0	3	7	10	4	5	23	156	114
Ohio	—	1	5	26	28	—	0	4	21	26	11	16	30	284	658
Wisconsin	—	0	2	—	15	—	0	2	—	15	—	10	41	42	516
W.N. Central	—	1	4	36	45	—	1	3	15	21	3	61	542	605	1,218
Iowa	—	0	2	9	12	—	0	2	3	4	—	11	55	137	321
Kansas	—	0	1	1	7	—	0	1	1	7	1	11	28	160	130
Minnesota	—	0	2	8	6	—	0	1	3	1	—	0	485	75	273
Missouri	—	0	2	12	14	—	0	2	4	6	—	10	42	165	197
Nebraska†	—	0	2	5	4	—	0	1	3	3	2	4	15	55	129
North Dakota	—	0	1	1	—	—	0	1	1	—	—	0	26	4	66
South Dakota	—	0	1	—	2	—	0	0	—	—	—	1	8	9	102
S. Atlantic	8	3	14	109	123	4	2	7	46	50	18	23	92	441	573
Delaware	—	0	1	4	2	—	0	1	4	2	—	0	1	2	13
District of Columbia	—	0	1	—	4	—	0	1	—	3	—	0	3	3	4
Florida	3	1	6	42	50	2	0	5	16	15	6	4	14	100	74
Georgia	—	0	3	11	12	—	0	3	11	12	—	0	3	8	22
Maryland†	1	0	2	7	12	1	0	1	2	—	1	3	9	69	113
North Carolina	4	0	11	19	11	1	0	3	4	2	—	0	21	87	27
South Carolina†	—	0	2	11	11	—	0	1	4	8	—	5	22	63	200
Virginia†	—	0	4	12	16	—	0	3	5	6	11	1	73	98	91
West Virginia	—	0	2	3	5	—	0	0	—	2	—	0	5	11	29
E.S. Central	—	1	4	19	34	—	1	4	15	25	5	7	22	105	250
Alabama†	—	0	1	4	3	—	0	1	4	2	3	1	7	29	37
Kentucky	—	0	2	5	12	—	0	2	5	12	—	1	10	6	66
Mississippi	—	0	1	1	4	—	0	1	1	4	—	1	4	13	32
Tennessee†	—	0	2	9	15	—	0	2	5	7	2	2	14	57	115
W.S. Central	—	2	23	53	74	—	1	6	23	18	10	36	360	272	929
Arkansas	—	0	3	5	9	—	0	2	4	2	—	3	21	36	142
Louisiana	—	0	4	24	25	—	0	3	13	4	—	0	3	7	24
Oklahoma	—	0	4	8	11	—	0	0	—	2	—	0	124	10	—
Texas†	—	1	16	16	29	—	0	4	6	10	10	30	215	219	763
Mountain	—	1	4	34	60	—	0	4	16	16	53	68	230	1,413	1,972
Arizona	—	0	4	11	28	—	0	4	11	9	—	14	177	266	458
Colorado	—	0	2	12	12	—	0	1	2	—	8	23	40	475	681
Idaho†	—	0	2	1	3	—	0	2	1	3	8	2	13	32	97
Montana	—	0	1	2	—	—	0	0	—	—	3	3	19	58	390
Nevada†	—	0	2	2	6	—	0	1	—	1	—	0	9	33	31
New Mexico†	—	0	1	1	3	—	0	1	—	2	—	2	6	22	112
Utah	—	0	1	3	8	—	0	1	—	1	34	15	38	496	187
Wyoming	—	0	2	2	—	—	0	2	2	—	—	1	5	31	16
Pacific	—	4	29	175	152	—	4	25	150	146	6	64	1,334	484	1,264
Alaska	—	0	1	1	1	—	0	1	1	1	—	2	15	33	21
California	—	2	14	109	98	—	2	14	109	98	—	31	1,136	168	485
Hawaii	—	0	1	4	8	—	0	1	4	3	—	2	10	36	78
Oregon†	—	1	7	39	26	—	1	4	28	26	—	3	26	73	432
Washington	—	0	25	22	19	—	0	11	8	18	6	10	195	174	248
American Samoa	U	0	0	—	—	U	0	0	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	1	—	—	—	0	1	—	—	—	0	0	—	2
Puerto Rico	—	0	1	4	6	—	0	1	4	6	—	0	1	—	4
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.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 17, 2006, and June 18, 2005 (24th 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	58	108	190	2,436	2,828	33	35	246	509	392	438	810	2,287	12,545	14,211
New England	13	12	26	267	338	—	0	2	1	2	10	34	157	641	827
Connecticut	9	3	13	68	73	—	0	0	—	—	—	6	149	149	160
Maine	—	1	5	32	31	N	0	0	N	N	—	2	7	31	79
Massachusetts	4	4	17	128	192	—	0	2	1	1	4	19	41	366	453
New Hampshire	—	0	3	6	4	—	0	1	—	—	2	2	12	45	69
Rhode Island	—	0	4	1	11	—	0	2	—	1	4	0	17	36	27
Vermont†	—	1	7	32	27	—	0	0	—	—	—	1	10	14	39
Mid. Atlantic	4	19	46	480	404	—	1	7	16	30	33	73	272	1,370	1,748
New Jersey	N	0	0	N	N	—	0	3	—	10	—	11	41	191	341
New York (Upstate)	4	11	24	207	210	—	0	1	1	—	15	22	233	363	405
New York City	—	0	3	—	14	—	0	2	3	2	—	20	44	318	444
Pennsylvania	—	8	35	273	180	—	1	5	12	18	18	28	61	498	558
E.N. Central	4	2	9	30	98	—	0	7	8	12	48	94	219	1,731	2,125
Illinois	—	0	4	—	15	—	0	4	1	6	—	26	53	403	842
Indiana	3	0	3	6	4	—	0	1	1	—	6	11	69	224	184
Michigan	1	1	4	18	9	—	0	1	—	2	9	17	35	323	362
Ohio	—	0	2	6	70	—	0	3	6	3	33	25	52	501	403
Wisconsin	N	0	2	N	N	—	0	1	—	1	—	15	44	280	334
W.N. Central	4	5	15	115	158	10	2	14	63	45	22	45	90	873	917
Iowa	1	0	4	22	—	—	0	2	—	1	—	7	18	133	159
Kansas	—	1	5	34	45	—	0	1	1	2	6	7	17	127	126
Minnesota	—	1	5	13	31	—	0	1	1	—	—	10	30	206	210
Missouri	3	1	6	12	26	8	2	13	56	39	12	15	40	278	258
Nebraska†	—	0	0	—	—	2	0	2	5	—	4	4	12	81	87
North Dakota	—	0	7	13	11	—	0	1	—	—	—	0	46	4	12
South Dakota	—	1	4	21	45	—	0	1	—	3	—	2	9	44	65
S. Atlantic	29	36	97	890	1,076	20	17	94	346	214	194	252	514	3,319	3,684
Delaware	—	0	0	—	—	—	0	2	5	—	—	2	9	31	34
District of Columbia	—	0	0	—	—	—	0	1	—	—	3	1	7	27	20
Florida	—	0	23	76	201	—	0	3	11	8	81	96	230	1,453	1,360
Georgia	—	2	42	85	137	—	1	7	20	43	23	35	87	507	526
Maryland†	—	8	14	154	168	1	1	6	18	15	8	11	39	201	265
North Carolina	13	8	20	176	236	18	6	87	272	118	45	28	114	507	494
South Carolina†	—	3	11	66	96	—	1	6	4	18	19	20	73	277	572
Virginia†	16	10	27	290	219	1	2	10	15	9	15	20	66	283	361
West Virginia	—	1	13	43	19	—	0	2	1	3	—	3	19	33	52
E.S. Central	2	4	16	130	65	3	5	24	50	53	38	54	115	764	812
Alabama†	2	1	7	36	37	—	0	9	14	12	20	14	41	299	200
Kentucky	—	0	5	7	6	—	0	1	—	—	7	8	27	142	124
Mississippi	—	0	1	—	—	—	0	3	—	2	—	11	62	94	185
Tennessee†	—	1	10	87	22	3	3	18	36	39	11	14	41	229	303
W.S. Central	1	14	34	382	495	—	1	161	19	17	43	83	922	1,181	1,284
Arkansas	—	0	3	16	16	—	0	32	16	7	—	14	67	301	263
Louisiana	—	0	0	—	—	—	0	1	—	5	—	9	43	139	295
Oklahoma	—	1	9	30	48	—	0	154	1	5	11	7	48	138	126
Texas†	1	12	29	336	431	—	0	8	2	—	32	45	839	603	600
Mountain	1	4	16	64	118	—	0	6	4	18	43	50	110	829	861
Arizona	—	2	11	54	95	—	0	6	2	12	—	13	67	197	250
Colorado	—	0	2	—	10	—	0	1	—	1	18	12	45	271	198
Idaho†	—	0	12	—	—	—	0	2	—	1	5	2	8	51	72
Montana	1	0	3	7	—	—	0	0	—	1	10	2	16	61	36
Nevada†	—	0	2	—	—	—	0	0	—	—	—	3	8	41	75
New Mexico†	—	0	1	—	2	—	0	1	—	2	—	3	13	53	92
Utah	—	0	5	2	—	—	0	0	—	—	9	5	30	127	117
Wyoming	—	0	2	1	11	—	0	1	2	1	1	1	12	28	21
Pacific	—	3	15	78	76	—	0	1	2	1	7	104	426	1,837	1,953
Alaska	—	0	4	12	1	—	0	0	—	—	—	1	7	35	21
California	—	3	15	64	74	—	0	1	2	—	—	84	292	1,368	1,482
Hawaii	—	0	0	—	—	—	0	0	—	—	1	5	15	91	122
Oregon†	—	0	1	2	1	—	0	1	—	1	—	8	25	170	175
Washington	U	0	0	U	U	N	0	0	N	N	6	10	124	173	153
American Samoa	U	0	0	U	U	U	0	0	U	U	U	1	2	U	1
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	4	—	18
Puerto Rico	2	2	6	52	38	N	0	0	N	N	4	9	35	53	220
U.S. Virgin Islands	—	0	0	—	—	—	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.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 17, 2006, and June 18, 2005 (24th 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	31	54	296	541	782	84	292	1,009	3,917	5,422	80	82	283	2,578	2,550
New England	—	3	15	43	71	—	5	27	109	101	—	5	9	102	157
Connecticut	—	0	14	14	19	—	0	21	21	21	U	0	3	U	63
Maine	—	0	5	—	14	—	0	3	2	5	—	0	2	10	6
Massachusetts	—	1	7	24	27	—	4	11	76	61	—	3	6	64	64
New Hampshire	—	0	2	5	5	—	0	4	4	4	—	0	3	18	8
Rhode Island	—	0	2	—	2	—	0	6	4	4	—	0	3	3	7
Vermont§	—	0	2	2	4	—	0	4	2	6	—	0	2	7	9
Mid. Atlantic	3	5	107	29	87	1	16	72	250	516	14	13	43	433	554
New Jersey	—	1	7	—	24	—	4	15	58	145	—	1	6	13	115
New York (Upstate)	—	2	103	20	29	1	4	60	95	118	11	4	32	177	165
New York City	—	0	3	8	6	—	4	14	61	220	—	2	8	56	106
Pennsylvania	—	1	8	—	28	—	2	48	36	33	3	5	13	187	168
E.N. Central	10	10	38	133	139	7	20	96	388	408	7	16	41	502	560
Illinois	—	1	10	15	37	—	7	26	108	107	—	4	10	101	189
Indiana	2	1	7	19	17	2	1	56	61	40	1	2	11	68	53
Michigan	1	1	8	25	23	1	3	10	80	125	—	3	11	134	135
Ohio	7	2	14	46	38	4	3	11	79	29	6	4	19	166	120
Wisconsin	—	3	15	28	24	—	3	10	60	107	—	1	4	33	63
W.N. Central	2	7	35	83	111	14	45	78	582	428	3	5	57	192	155
Iowa	2	1	10	27	27	1	1	7	20	45	N	0	0	N	N
Kansas	—	0	4	—	15	1	4	20	42	25	1	1	5	38	26
Minnesota	—	3	19	52	17	—	2	8	39	28	—	0	52	83	53
Missouri	3	2	7	44	29	12	23	70	402	280	—	1	5	40	42
Nebraska§	2	1	5	14	17	—	2	11	38	33	—	0	4	18	14
North Dakota	—	0	15	—	1	—	0	2	4	2	2	0	5	7	4
South Dakota	—	0	5	3	5	—	2	17	37	15	—	0	3	6	16
S. Atlantic	6	7	39	94	135	40	52	122	1,097	783	37	20	41	631	479
Delaware	—	0	2	1	—	—	0	2	—	5	—	0	2	5	—
District of Columbia	—	0	1	—	—	1	0	2	6	7	1	0	2	8	6
Florida	—	1	29	38	55	22	27	66	497	368	3	5	12	134	123
Georgia	—	0	6	—	15	7	14	34	382	212	2	4	16	144	99
Maryland§	3	1	5	10	19	—	2	8	37	27	1	3	12	116	96
North Carolina	2	1	11	31	18	8	2	22	90	72	26	0	21	93	72
South Carolina§	—	0	2	4	3	1	2	9	59	49	1	0	6	37	25
Virginia§	—	1	8	—	24	1	2	9	26	43	3	2	11	79	45
West Virginia	—	0	2	—	1	—	0	1	—	—	—	0	6	15	13
E.S. Central	6	2	11	33	43	14	14	35	284	685	1	3	10	119	109
Alabama§	—	0	3	7	12	10	3	14	82	143	N	0	0	N	N
Kentucky	—	1	8	14	11	—	7	23	132	95	—	0	5	27	23
Mississippi	—	0	2	—	2	—	1	6	26	41	—	0	0	—	—
Tennessee§	—	1	4	27	18	4	3	13	44	406	1	3	9	92	86
W.S. Central	—	1	52	8	29	1	59	596	374	1,495	5	7	58	211	149
Arkansas	—	0	2	3	3	—	1	7	34	27	—	0	5	18	8
Louisiana	—	0	2	—	11	—	2	11	43	62	—	0	2	7	4
Oklahoma	—	0	8	5	4	1	6	286	44	328	1	2	14	61	65
Texas§	2	1	44	26	11	—	44	308	253	1,078	4	4	43	125	72
Mountain	4	5	15	48	83	5	17	47	265	265	13	10	78	348	335
Arizona	—	0	4	16	10	—	9	29	131	128	2	4	57	180	149
Colorado	—	1	6	16	22	4	3	18	47	40	5	3	8	83	107
Idaho§	3	1	7	15	14	—	0	4	5	5	—	0	2	6	1
Montana	—	0	2	—	3	—	0	1	3	3	—	0	0	—	—
Nevada§	—	0	3	7	10	—	1	7	25	27	—	0	6	—	1
New Mexico§	—	0	3	3	7	—	2	9	27	43	1	1	7	31	42
Utah	2	1	7	15	15	1	1	4	25	19	5	1	6	46	33
Wyoming	2	0	3	5	2	—	0	1	2	—	—	0	1	2	2
Pacific	—	7	55	70	84	2	38	148	568	741	—	2	9	40	52
Alaska	—	0	2	—	4	—	0	2	6	9	—	0	0	—	—
California	—	4	18	47	38	—	32	104	420	649	—	0	0	—	—
Hawaii	—	0	4	4	3	—	0	4	17	12	—	2	9	40	52
Oregon§	—	2	47	26	28	—	1	31	64	37	N	0	0	N	N
Washington	—	2	32	19	11	2	2	43	61	34	N	0	0	N	N
American Samoa	U	0	0	U	U	U	0	2	U	3	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	3	—	9	—	0	0	—	—
Puerto Rico	—	0	1	—	—	—	0	2	2	1	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	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.
† 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).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 17, 2006, and June 18, 2005 (24th Week)*

Reporting area	*Streptococcus pneumoniae*, invasive disease Drug resistant, all ages					Syphilis, primary and 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	51	334	1,470	1,552	74	166	334	3,545	3,775	562	804	3,204	24,717	15,092
New England	—	1	24	13	135	2	3	17	85	94	49	45	172	859	3,194
Connecticut	U	0	7	U	58	—	0	11	19	19	U	11	58	U	918
Maine	N	0	0	N	N	—	0	2	5	1	—	5	20	151	202
Massachusetts	—	0	6	—	62	2	2	5	51	65	—	16	61	92	1,403
New Hampshire	—	0	0	—	—	—	0	2	5	4	2	6	42	181	137
Rhode Island	—	0	11	4	7	—	0	6	3	5	—	0	0	—	—
Vermont†	—	0	2	9	8	—	0	1	2	—	47	9	35	435	534
Mid. Atlantic	3	3	15	90	141	5	21	35	506	467	45	102	183	2,831	2,878
New Jersey	N	0	0	N	N	—	2	7	79	64	—	0	0	—	—
New York (Upstate)	2	1	10	31	57	3	2	14	74	32	—	0	0	—	—
New York City	U	0	0	U	U	—	10	22	239	292	—	0	0	—	—
Pennsylvania	1	2	9	59	84	2	5	9	114	79	45	102	183	2,831	2,878
E.N. Central	10	11	41	360	382	6	17	38	355	400	146	213	577	9,272	3,572
Illinois	—	1	3	11	15	2	8	23	169	224	—	1	5	11	51
Indiana	7	2	21	90	120	1	1	4	31	33	N	0	347	N	70
Michigan	—	0	4	15	27	—	1	19	36	32	51	102	174	2,796	2,286
Ohio	3	6	32	244	220	1	4	11	98	96	95	70	421	6,045	882
Wisconsin	N	0	0	N	N	2	1	3	21	15	—	10	41	420	283
W.N. Central	1	1	191	27	27	4	4	9	100	124	9	20	84	900	200
Iowa	N	0	0	N	N	—	0	3	7	4	N	0	0	N	N
Kansas	N	0	0	N	N	—	0	2	11	11	—	0	0	—	—
Minnesota	—	0	191	—	—	—	1	4	14	37	—	0	0	—	—
Missouri	1	1	3	27	22	4	3	8	67	69	8	15	82	844	124
Nebraska†	—	0	0	—	2	—	0	1	1	3	—	0	0	—	—
North Dakota	—	0	1	—	—	—	0	1	—	—	1	0	25	25	10
South Dakota	—	0	1	—	3	—	0	1	—	—	—	1	12	31	66
S. Atlantic	11	25	53	762	622	31	43	186	869	873	78	84	860	2,512	1,168
Delaware	—	0	2	—	1	—	0	2	12	6	—	1	5	37	17
District of Columbia	—	0	3	19	11	3	2	9	51	53	1	0	5	19	16
Florida	10	14	36	411	324	13	14	29	330	339	—	0	0	—	—
Georgia	1	8	22	264	216	3	8	147	98	137	—	0	0	—	—
Maryland†	—	0	0	—	—	5	6	19	146	146	—	0	0	—	—
North Carolina	N	0	0	N	N	6	5	17	138	107	—	0	0	—	—
South Carolina†	—	0	0	—	—	1	1	7	34	28	4	17	50	647	304
Virginia†	N	0	0	N	N	—	2	12	59	55	67	21	812	943	216
West Virginia	—	1	14	68	70	—	0	1	1	2	6	25	70	866	615
E.S. Central	5	3	13	112	116	7	10	19	261	201	—	0	70	27	1
Alabama†	N	0	0	N	N	3	3	12	113	79	—	0	70	27	1
Kentucky	1	0	5	23	21	—	1	8	32	16	N	0	0	N	N
Mississippi	—	0	0	—	1	—	0	5	15	23	—	0	0	—	—
Tennessee†	4	2	13	89	94	4	4	11	101	83	N	0	0	N	N
W.S. Central	—	1	9	55	94	9	24	39	601	582	226	206	1,757	6,708	2,394
Arkansas	—	0	3	7	12	—	1	6	33	26	—	5	110	413	—
Louisiana	—	1	7	48	82	—	4	17	64	119	—	0	17	90	105
Oklahoma	N	0	0	N	N	—	1	6	34	19	—	0	0	—	—
Texas†	N	0	0	N	N	9	17	29	470	418	226	202	1,647	6,205	2,289
Mountain	3	1	27	51	35	5	7	17	178	199	9	47	136	1,608	1,685
Arizona	N	0	0	N	N	5	3	13	86	68	—	0	0	—	—
Colorado	N	0	0	N	N	—	1	3	17	21	7	30	76	826	1,147
Idaho†	N	0	0	N	N	—	0	3	2	18	—	0	0	—	—
Montana	—	0	1	—	—	—	0	1	1	5	—	0	0	—	—
Nevada†	—	0	27	4	2	—	1	12	43	55	—	0	2	4	—
New Mexico†	—	0	1	1	—	—	1	5	27	25	—	3	32	235	144
Utah	—	0	8	19	15	—	0	1	2	7	2	11	55	515	350
Wyoming	3	0	3	27	18	—	0	0	—	—	—	0	8	28	44
Pacific	—	0	0	—	—	5	32	47	590	835	—	0	0	—	—
Alaska	—	0	0	—	—	—	0	4	5	4	—	0	0	—	—
California	N	0	0	N	N	—	27	42	480	749	—	0	0	—	—
Hawaii	—	0	0	—	—	—	0	2	8	2	N	0	0	N	N
Oregon†	N	0	0	N	N	—	0	6	8	16	N	0	0	N	N
Washington	N	0	0	N	N	5	2	11	89	64	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	—	3	—	2	12	—	361
Puerto Rico	N	0	0	N	N	—	3	16	54	91	4	8	47	136	392
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.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 17, 2006, and June 18, 2005 (24th 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	—	1	155	4	12	—	0	203	—	34
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	10	—	—	—	0	4	—	—
New Jersey	—	0	1	—	—	—	0	2	—	—
New York (Upstate)	—	0	7	—	—	—	0	2	—	—
New York City	—	0	2	—	—	—	0	2	—	—
Pennsylvania	—	0	3	—	—	—	0	2	—	—
E.N. Central	—	0	39	—	2	—	0	18	—	—
Illinois	—	0	25	—	—	—	0	16	—	—
Indiana	—	0	2	—	1	—	0	1	—	—
Michigan	—	0	14	—	—	—	0	3	—	—
Ohio	—	0	9	—	1	—	0	4	—	—
Wisconsin	—	0	3	—	—	—	0	2	—	—
W.N. Central	—	0	26	—	2	—	0	80	—	6
Iowa	—	0	3	—	—	—	0	5	—	—
Kansas	—	0	3	—	—	N	0	3	N	N
Minnesota	—	0	5	—	—	—	0	5	—	—
Missouri	—	0	4	—	1	—	0	3	—	—
Nebraska§	—	0	9	—	—	—	0	24	—	1
North Dakota	—	0	4	—	—	—	0	15	—	—
South Dakota	—	0	7	—	1	—	0	33	—	5
S. Atlantic	—	0	6	—	—	—	0	4	—	1
Delaware	—	0	1	—	—	—	0	0	—	—
District of Columbia	—	0	1	—	—	—	0	1	—	—
Florida	—	0	2	—	—	—	0	4	—	—
Georgia	—	0	3	—	—	—	0	3	—	1
Maryland§	—	0	2	—	—	—	0	1	—	—
North Carolina	—	0	1	—	—	—	0	1	—	—
South Carolina§	—	0	1	—	—	—	0	0	—	—
Virginia§	—	0	0	—	—	—	0	1	—	—
West Virginia	—	0	0	—	—	N	0	0	N	N
E.S. Central	—	0	10	1	1	—	0	5	—	1
Alabama§	—	0	1	—	—	—	0	2	—	—
Kentucky	—	0	1	—	—	—	0	0	—	—
Mississippi	—	0	9	1	1	—	0	5	—	1
Tennessee§	—	0	3	—	—	—	0	1	—	—
W.S. Central	—	0	32	2	2	—	0	22	—	6
Arkansas	—	0	3	—	—	—	0	2	—	2
Louisiana	—	0	20	—	—	—	0	9	—	2
Oklahoma	—	0	6	—	—	—	0	3	—	—
Texas§	—	0	16	2	2	—	0	13	—	2
Mountain	—	0	16	1	2	—	0	39	—	7
Arizona	—	0	8	—	1	—	0	8	—	1
Colorado	—	0	5	1	—	—	0	13	—	5
Idaho§	—	0	2	—	—	—	0	3	—	—
Montana	—	0	3	—	—	—	0	9	—	—
Nevada§	—	0	3	—	—	—	0	8	—	—
New Mexico§	—	0	3	—	1	—	0	4	—	1
Utah	—	0	6	—	—	—	0	8	—	—
Wyoming	—	0	2	—	—	—	0	1	—	—
Pacific	—	0	50	—	3	—	0	90	—	13
Alaska	—	0	0	—	—	—	0	0	—	—
California	—	0	50	—	3	—	0	89	—	13
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	—	—

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.
† 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).

TABLE III. Deaths in 122 U.S. cities,* week ending June 17, 2006 (24th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
New England	431	295	83	30	17	6	29
Boston, MA	110	64	28	10	7	1	12
Bridgeport, CT	28	20	4	4	—	—	2
Cambridge, MA	10	8	1	1	—	—	—
Fall River, MA	14	12	1	1	—	—	2
Hartford, CT	39	24	7	4	3	1	2
Lowell, MA	17	13	3	—	1	—	2
Lynn, MA	8	7	1	—	—	—	—
New Bedford, MA	18	15	3	—	—	—	1
New Haven, CT	29	23	1	2	2	1	1
Providence, RI	42	25	14	1	—	2	1
Somerville, MA	2	—	2	—	—	—	—
Springfield, MA	43	27	10	4	2	—	2
Waterbury, CT	22	19	2	1	—	—	2
Worcester, MA	49	38	6	2	2	1	2
Mid. Atlantic	1,925	1,320	403	140	30	30	89
Albany, NY	43	34	4	4	1	—	2
Allentown, PA	25	21	1	3	—	—	—
Buffalo, NY	85	59	17	6	1	2	5
Camden, NJ	26	11	9	4	2	—	3
Elizabeth, NJ	19	9	6	4	—	—	1
Erie, PA	33	25	7	1	—	—	3
Jersey City, NJ	33	19	8	5	1	—	—
New York City, NY	1,014	704	211	69	12	16	44
Newark, NJ	59	31	17	5	1	5	3
Paterson, NJ	11	6	1	2	2	—	1
Philadelphia, PA	240	147	60	22	6	5	12
Pittsburgh, PA§	22	13	6	2	1	—	—
Reading, PA	30	24	6	—	—	—	2
Rochester, NY	122	99	17	4	1	1	8
Schenectady, NY	31	23	4	3	1	—	—
Scranton, PA	22	18	3	—	—	1	1
Syracuse, NY	59	40	14	4	1	—	3
Trenton, NJ	25	17	7	1	—	—	—
Utica, NY	13	10	3	—	—	—	—
Yonkers, NY	13	10	2	1	—	—	1
E.N. Central	2,063	1,326	471	154	58	54	142
Akron, OH	36	17	14	3	1	1	1
Canton, OH	33	21	6	4	2	—	5
Chicago, IL	345	205	90	29	14	7	24
Cincinnati, OH	77	39	23	8	4	3	10
Cleveland, OH	236	163	46	18	5	4	14
Columbus, OH	181	114	38	15	8	6	14
Dayton, OH	115	84	23	6	2	—	10
Detroit, MI	172	95	52	17	4	4	8
Evansville, IN	44	34	9	1	—	—	2
Fort Wayne, IN	62	49	9	3	1	—	6
Gary, IN	12	5	3	3	—	1	1
Grand Rapids, MI	53	30	19	1	2	1	4
Indianapolis, IN	234	137	55	23	10	9	18
Lansing, MI	44	35	6	1	—	2	3
Milwaukee, WI	98	60	27	5	3	3	8
Peoria, IL	43	31	7	2	—	3	4
Rockford, IL	46	33	7	4	—	2	2
South Bend, IN	68	57	9	—	—	2	2
Toledo, OH	112	78	23	5	1	5	4
Youngstown, OH	52	39	5	6	1	1	2
W.N. Central	686	435	168	40	22	20	53
Des Moines, IA	101	79	17	3	—	2	9
Duluth, MN	31	21	10	—	—	—	3
Kansas City, KS	25	16	9	—	—	—	3
Kansas City, MO	89	54	24	5	2	4	4
Lincoln, NE	37	25	8	—	4	—	3
Minneapolis, MN	67	40	16	8	—	3	6
Omaha, NE	91	61	23	4	2	1	11
St. Louis, MO	122	65	31	11	9	5	8
St. Paul, MN	67	39	17	2	4	5	3
Wichita, KS	56	35	13	7	1	—	3
S. Atlantic	1,331	785	337	113	56	40	81
Atlanta, GA	179	91	58	20	8	2	7
Baltimore, MD	196	100	63	23	7	3	17
Charlotte, NC	103	67	19	8	2	7	5
Jacksonville, FL	193	109	51	15	14	4	11
Miami, FL	133	89	27	7	6	4	2
Norfolk, VA	50	35	8	3	1	3	2
Richmond, VA	54	32	11	7	3	1	2
Savannah, GA	60	45	11	3	1	—	6
St. Petersburg, FL	53	37	9	4	2	1	7
Tampa, FL	172	106	41	12	7	6	16
Washington, D.C.	120	67	32	8	5	8	3
Wilmington, DE	18	7	7	3	—	1	3
E.S. Central	833	536	205	53	20	19	64
Birmingham, AL	169	121	35	6	3	4	14
Chattanooga, TN	83	54	19	5	2	3	5
Knoxville, TN	91	49	28	5	5	4	5
Lexington, KY	59	38	16	2	—	3	1
Memphis, TN	159	92	40	21	4	2	14
Mobile, AL	82	55	21	2	4	—	4
Montgomery, AL	64	47	14	2	1	—	9
Nashville, TN	126	80	32	10	1	3	12
W.S. Central	1,487	945	365	108	40	29	66
Austin, TX	103	64	28	7	2	2	9
Baton Rouge, LA	56	42	8	4	—	2	—
Corpus Christi, TX	69	47	15	7	—	—	2
Dallas, TX	188	100	61	21	5	1	11
El Paso, TX	76	57	15	3	—	1	2
Fort Worth, TX	111	74	29	3	1	4	5
Houston, TX	383	237	91	31	14	10	7
Little Rock, AR	79	39	19	10	8	3	1
New Orleans, LA¶	U	U	U	U	U	U	U
San Antonio, TX	251	166	53	17	9	6	15
Shreveport, LA	66	46	19	1	—	—	8
Tulsa, OK	105	73	27	4	1	—	6
Mountain	744	489	157	56	21	21	48
Albuquerque, NM	101	60	24	13	2	2	7
Boise, ID	54	42	5	1	3	3	4
Colorado Springs, CO	105	74	20	9	2	—	9
Denver, CO	84	49	20	9	1	5	7
Las Vegas, NV	236	162	48	16	7	3	9
Ogden, UT	25	22	2	—	—	1	1
Phoenix, AZ	U	U	U	U	U	U	U
Pueblo, CO	24	17	5	—	2	—	2
Salt Lake City, UT	115	63	33	8	4	7	9
Tucson, AZ	U	U	U	U	U	U	U
Pacific	1,501	1,056	282	93	39	30	123
Berkeley, CA	14	7	6	1	—	—	1
Fresno, CA	107	76	26	3	—	2	7
Glendale, CA	17	17	—	—	—	—	3
Honolulu, HI	36	26	5	4	—	1	—
Long Beach, CA	66	47	12	3	3	1	11
Los Angeles, CA	235	169	39	18	8	1	22
Pasadena, CA	30	26	4	—	—	—	7
Portland, OR	127	86	19	12	2	8	6
Sacramento, CA	197	139	36	13	8	1	16
San Diego, CA	147	102	24	10	3	7	10
San Francisco, CA	U	U	U	U	U	U	U
San Jose, CA	222	156	42	11	7	6	20
Santa Cruz, CA	31	23	6	2	—	—	2
Seattle, WA	117	74	31	8	2	2	7
Spokane, WA	59	39	11	6	3	—	6
Tacoma, WA	96	69	21	2	3	1	5
Total	11,001**	7,187	2,471	787	303	249	695

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.

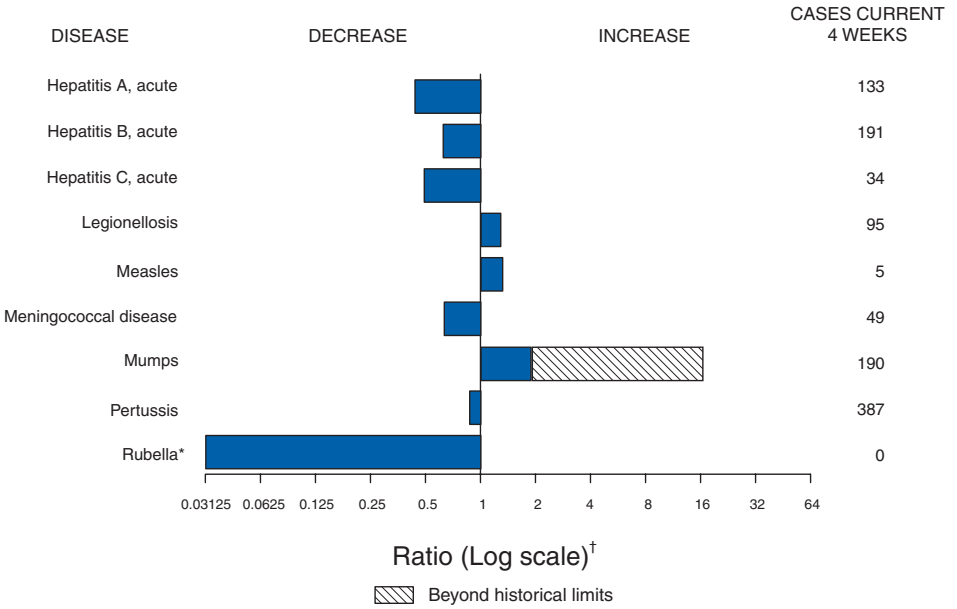
† Pneumonia and influenza.

§ 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 June 17, 2006, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 24 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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