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Increased Transmission and Outbreaks of Measles — European Region, 2011

During 2003–2009, substantial progress was made toward the previous goal of measles elimination in the World Health Organization (WHO) European Region (EUR) by 2010 (*1,2*). However, since late 2009, measles virus transmission has increased, and outbreaks have become widespread. In 2011, measles outbreaks have been reported in 36 of 53 EUR member states; a total of 26,074 measles cases had been reported regionwide as of October 26. France reported the largest number of cases (approximately 14,000), predominantly among older children and young adults who had not been vaccinated or whose vaccination history was unknown. Overall, the primary reason for the increased transmission and outbreaks of measles in EUR is failure to vaccinate susceptible populations. Eliminating measles by 2015, a new measles elimination target date set in September 2010 by the 60th Regional Committee for Europe, will require 1) increasing demand for and delivery of vaccination to achieve and sustain ≥95% coverage with 2 doses of measles-containing vaccine (MCV) across a wide age range, 2) implementing effective outbreak control measures, and 3) further strengthening surveillance to identify cases and outbreaks promptly, and in the future, to validate elimination (*3*).

Measles is a notifiable disease in all 53 EUR member states,* and all states recommend 2 doses of MCV. Clinically diagnosed measles cases are reported annually from member states to the WHO Regional Office for Europe (WHO/Europe), using the WHO and United Nations Children's Fund (UNICEF) Joint Reporting Form.† Countries also are requested to report monthly individual case information (e.g., laboratory confirmation status and demographic, clinical, and vaccination data) and to report outbreaks as they occur. MCV coverage is reported to WHO/Europe annually using the Joint Reporting Form.

After 3 years of historically low measles incidence (*1*), the number of reported measles cases increased sharply in late 2009. In 2010, 30,639 measles cases were reported, the most since 2006. As of October 26, a total of 26,074 cases had been reported in EUR in 2011. The western European subregion (WE) reported 21,724 (83.3%) cases, the central and eastern European subregion (CEE) 3,570 (13.7%) cases, and the newly independent states (NIS) of the former Soviet Union 780 (3.0%) cases. Since 2008, WE has accounted for the largest proportion of measles cases in the region, with the exception of 2010, when most cases occurred in CEE because of a large outbreak in Bulgaria (24,401 reported cases during 2009–2011) (Figure).

As of October 26, 2011, a total of 12,882 (49.4%) cases had occurred among persons aged ≥15 years, 6,527 (25.0%) among children aged <5 years, and 6,423 (24.7%) among

* In 2011, the European Region of WHO included 53 member states, grouped for the purpose of this report into the western European subregion (Andorra, Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, Netherlands, Norway, Portugal, San Marino, Spain, Sweden, Switzerland, and the United Kingdom), the central and eastern European subregion (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Montenegro, Poland, Romania, Serbia, Slovakia, Slovenia, the former Yugoslav Republic of Macedonia, and Turkey), and the newly independent states of the former Soviet Union subregion (Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan).

† Available at http://www.who.int/immunization_monitoring/routine/joint_reporting/en/index.html.

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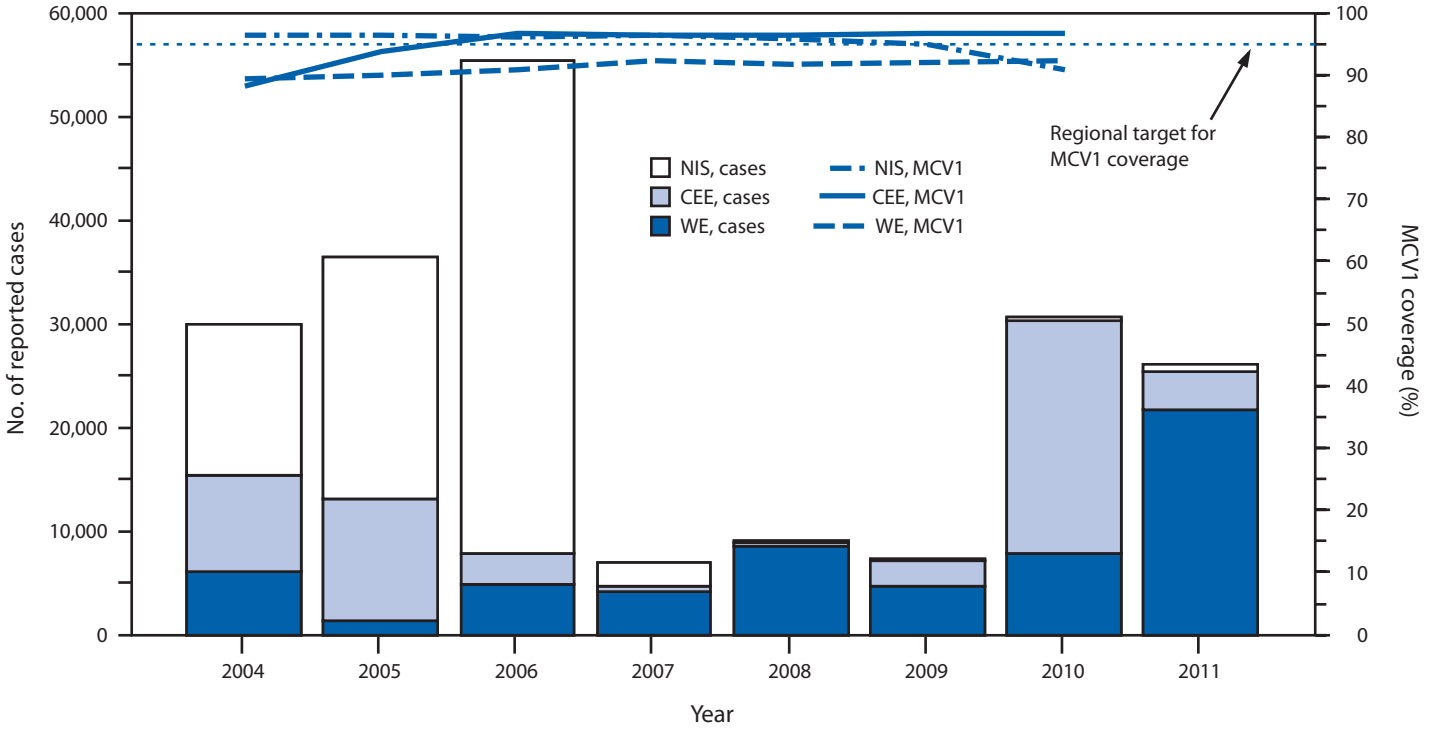
FIGURE. Total number of reported measles cases, and coverage with 1 dose of measles-containing vaccine (MCV1) among children aged 13–24 months, by subregion* — European Region of the World Health Organization (WHO), 2004–2011



Sources: Annual WHO/UNICEF Joint Reporting Forms and, for 2011, monthly surveillance reports submitted to WHO as of October 26, 2011; MCV1 coverage data for 2011 is not yet available.
* Subregions: WE = western European, CEE = central and eastern European, NIS = newly independent states of the former Soviet Union.

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children aged 5–14 years (Table 1). The median age of patients was 15 years. Overall, 11,763 (45.1%) patients were unvaccinated, and vaccination histories of 11,825 (45.4%) were unknown (Table 1). A total of 7,288 (28.0%) measles patients were hospitalized, including 4,293 (58.9%) in WE, 2,609 (35.8%) in CEE, and 386 (5.3%) in NIS. The proportion of hospitalized patients was higher in CEE and NIS (73.1% and 49.5%, respectively), where hospitalization of measles patients is a long-standing routine practice, than in WE (19.8%), where only patients with severe cases usually are hospitalized. Nine measles-associated deaths were reported, including six in France, one in Germany, one in Kyrgyzstan, and one in Romania. Seven deaths occurred among persons aged >10 years. Four decedents were unvaccinated, and the vaccination histories of the remaining five, all adults, were unknown.

A total of 115 measles outbreaks, accounting for 21,177 (81.2%) cases, were reported in 36 countries from January 1 to October 26, 2011. The outbreak in France is the largest ongoing outbreak in the region, with 14,025 cases reported as of October 26. Cases have been reported nationwide, including 2,593 (18.5%) cases in the province of Rhône-Alpes; 2,167 (15.5%) in Provence-Alpes-Côte d'Azur; 1,191 (8.5%) in Languedoc-Roussillon; 1,158 (8.3%) in Limousin; and 1,080 (7.7%) in Île-de-France. In Spain, cases have been reported in 16 of the country's 17 autonomous communities (regional governments) and in the two autonomous cities, including 1,381 (50.3%) cases in Andalucia; 439 (16.0%) in Catalonia; and 329 (12.0%) in Madrid. In Romania, cases have been reported in 34 of 42 provinces, with six northwestern provinces (Arad, Bihor, Cluj, Maramures, Salaj, and Satu Mare) reporting 1,860 (86.3%) cases.

Overall, transmission settings in the region varied and included communities as a whole, groups with religious or philosophical objections to vaccination, underserved populations with limited health-care access, health-care facilities, and schools. Within specific countries, settings also included vacation camps (France) and rural populations (Romania); settings were not reported for Uzbekistan.

Measles virus genotypes detected by molecular sequencing from specimens from patients in EUR in 2011 included D4, B3, G3, D8, D9, and H1. Genotype D4, detected in 24 countries during 2011, was the predominant genotype. This genotype has been associated with outbreaks in EUR member states since 2008 (*4,5*), including outbreaks during 2011 in France, Spain, the former Yugoslav Republic of Macedonia, Romania, and Uzbekistan. Genotype G3 also was detected in France, and genotype B3 also was detected in Spain.

In response to measles outbreaks, a wide range of control measures have been implemented, including 1) activities to strengthen surveillance for timely identification and monitoring

TABLE 1. Characteristics of reported measles cases in the European Region* and selected countries† — World Health Organization (WHO) European Region, 2011§

	European Region		France		Spain		Romania		Former Yugoslav Republic of Macedonia		Uzbekistan	
Characteristic	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**
Reported cases	**26,074**	**(100.0)**	**14,025**	**(100.0)**	**2,745**	**(100.0)**	**2,156**	**(100.0)**	**727**	**(100.0)**	**316**	**(100.0)**
Age group (yrs)												
<1	2,343	(9.0)	955	(6.8)	349	(12.7)	338	(15.7)	127	(17.5)	95	(30.1)
1–4	4,184	(16.0)	1,791	(12.8)	484	(17.6)	902	(41.9)	109	(15.0)	61	(19.3)
5–9	3,013	(11.6)	1,502	(10.7)	201	(7.3)	461	(21.4)	27	(3.7)	37	(11.7)
10–14	3,410	(13.1)	2,068	(14.7)	190	(6.9)	199	(9.2)	30	(4.1)	25	(7.9)
15–19	3,700	(14.2)	2,461	(17.5)	214	(7.8)	115	(5.3)	81	(11.1)	11	(3.5)
≥20	9,182	(35.2)	5,156	(36.8)	1,307	(47.6)	140	(6.5)	351	(48.3)	87	(27.5)
Unknown	242	(0.9)	92	(0.7)	0	(0)	1	(<0.1)	2	(0.3)	0	(0)
Median age (yrs)	15		16		18		4		17		7	
Vaccination status												
0 doses	11,763	(45.1)	3,594	(25.6)	1,508	(55.0)	1,560	(72.4)	589	(81.0)	134	(42.4)
1 dose	1,936	(7.4)	708	(5.1)	248	(9.0)	490	(22.7)	58	(8.0)	77	(24.4)
≥2 doses	550	(2.1)	203	(1.4)	67	(2.4)	105	(4.8)	27	(3.7)	31	(9.8)
Unknown	11,825	(45.4)	9,520	(67.9)	922	(33.6)	1	(<0.1)	53	(7.3)	74	(23.4)

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† Countries were selected from each subregion based on the high number of cases and availability of detailed information about the outbreak and control measures undertaken.

§ Data as of October 26, 2011, based on monthly reports and outbreak reports submitted by member states to WHO.

of cases and outbreaks, 2) social mobilization and advocacy for immunization among the general population and among health-care providers, 3) modifying immunization schedules and vaccination policies, and 4) implementing supplementary immunization activities (SIAs) of various scales, from offering free vaccination to persons not covered by routine vaccination programs to nationwide or subnational campaigns (Table 2).

During 2004–2010, overall coverage with 1 dose of MCV (MCV1) for the entire region was 92%–94%; WE had lower MCV1 coverage (90%–92%) than CEE (88%–97%) and NIS (91%–96%) (Figure). MCV1 coverage in France during 2004–2010 was 87%–90%.

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Editorial Note

The increase in measles virus transmission in EUR poses a serious challenge to achieving the regional measles elimination goal by 2015. Despite overall high coverage with MCV in the region, MCV1 coverage remains below the target of 95%, particularly in WE. These data confirm the existence of susceptible groups, which can include older children and adults, and vaccination coverage <95% can support ongoing virus transmission, leading to large-scale outbreaks (*1,6*). Additional measures targeting susceptible populations to achieve ≥95% coverage with 2 doses of MCV are needed to increase immunity levels in the EUR population.

Principal factors contributing to decreased demand for measles vaccination in EUR include lack of knowledge of the seriousness of the disease, resulting in a reluctance to be vaccinated; skepticism about the benefits of vaccination; fear of adverse effects from being vaccinated; and limited health-care access for some underserved populations (*6*). Religious or philosophical objections to vaccination are serious barriers to increasing population immunity in certain communities in EUR, particularly in WE (*6*).

The accumulation of susceptible persons among older children and young adults because of low coverage in the past and the decline in natural exposure to measles virus because of successful vaccination programs has resulted in an increase in the median age of measles patients in EUR (*1,7*). This change in measles epidemiology requires strategies tailored to older age groups and strategies to prevent transmission among infants too young to be vaccinated. To prevent further spread of the virus, effective surveillance, outbreak prevention, and control measures need to be continued, especially before mass gatherings (e.g., the European Football Championship in Poland and Ukraine in 2012). Implementation of the revised *Guidelines for Measles and Rubella Surveillance in the European Region* (*8*), beginning in 2012, will help to further strengthen surveillance capacity in the member states.

Measles in EUR is causing preventable death, illness, and financial costs and has global implications. The nine deaths and thousands of measles-associated hospitalizations in EUR during 2011 are reminders that measles is a serious disease that can lead to death in all age groups, even in countries with high-quality health care and minimal incidence of malnutrition. The substantial financial and human costs of responding to these outbreaks impose an additional burden on already limited resources. In addition, EUR has become a source of virus introduction into other areas, such as the measles-free WHO Region of the Americas. Importations from EUR have accounted for most measles importations in the United States since 2008, with 20 importations in 2011 alone, including 11–13 cases from France (*9*). During 2011, approximately 1,000 measles cases were reported in the Region of the Americas, necessitating extensive and costly public health responses (*10*).

What is already known on this topic?

During 2003–2009, substantial progress toward the goal of measles elimination in the World Health Organization (WHO) European Region by 2010 was achieved. However, after 3 years of historic low measles incidence, the number of reported measles cases increased sharply, beginning in late 2009.

What is added by this report?

As of October 26, a total of 26,074 measles cases with onset in 2011 have been reported regionwide, with outbreaks in 36 of 53 member states and nine measles-associated deaths. France reported the largest number of cases (approximately 14,000). Approximately half (49.4%) of patients in the region were aged ≥15 years, and the majority were unvaccinated (45.1%) or had unknown vaccination status (45.4%).

What are the implications for public health practice?

Failure to vaccinate, leading to the existence of susceptible populations across a wide age range, particularly in the western European subregion, has contributed to increased transmission and outbreaks of measles in the European Region. Eliminating measles by the WHO regional target of 2015 will require 1) increasing and sustaining ≥95% coverage with 2 doses of measles-containing vaccine across a wide age range, 2) implementing effective outbreak control measures, and 3) further strengthening surveillance to identify cases and outbreaks quickly, and to validate measles elimination.

TABLE 2. Response activities in selected countries with measles outbreaks — World Health Organization European Region, 2011

Subregion /Country	Response activities
Western Europe	
France	• Modification of the national immunization schedule to include: 1) 2 measles-mumps-rubella (MMR) vaccine doses for all persons born since 1980 (previous recommendation was 1 dose for adults born during 1980–1991) and 2) recommendation for children in child care or in daily close contact with other children to receive the first MMR dose at age 9 months instead of 12 months. • Nationwide communication campaign launched in October 2011 targeting health-care professionals, young adults, and mothers aged 40–60 years to provide information about the outbreak and measles vaccine recommendations, and to encourage vaccination of persons without documentation of receipt of 2 MMR doses. • Recommendation for verification of schoolchildren's vaccination status by schools, including notification of parents of students who have not received 2 MMR doses. • Revised recommendations for postexposure prophylaxis, including use of monovalent measles vaccine for exposed children aged 6–8 months, and immunoglobulin for exposed infants aged <1 year, immunocompromised patients, and pregnant women.
Spain	• Efforts directed toward strengthening vaccination programs at the regional level and increasing immunity among health-care workers, persons aged 20–39 years, and other vulnerable groups. • Modification of the national immunization schedule to recommend the first MMR dose at age 12 months, instead of at age 12–15 months. • Implementation of national communication strategies directed to health-care workers and the general population. • Strengthening links between health-care and public health services, including informing health-care workers about the current measles situation in Spain and Europe and increasing their awareness of the importance of early detection of measles and implementation of control measures. • Recommendation to introduce reporting of local level coverage data to central level.
Central and Eastern Europe	
Romania	• A supplementary immunization activity (SIA) with MMR under way in the affected areas targeting all children aged 7 months–7 years, regardless of measles vaccination status. • Active case-finding and contact tracing in hospitals and in the community. • Efforts by national public health authorities to increase awareness of the ongoing outbreak among health-care professionals and the general population.
The former Yugoslav Republic of Macedonia	• SIA vaccinating approximately 40,000 persons. • Mediators from the Roma community involved in social mobilization. • Outreach activities conducted by immunization teams.
Newly independent states of the former Soviet Union	
Uzbekistan	• Nationwide SIA with measles-rubella vaccine in September 2011; target: 7.55 million children aged 1–14 years; SIA coverage: administrative, 99.5%; post-campaign lot quality assessment survey estimate, 98.4%. • Government funding secured for procurement of the second routine dose of MCV in 2011. • Centralization of vaccine procurement in 2012.

To increase demand for measles vaccination in EUR, innovative strategies and tools are needed to effectively communicate the seriousness of measles and the benefits of vaccination to the general public and to health-care professionals. Reaching the EUR measles elimination target by 2015 is achievable. However, reaching the target will require ongoing, high-level political commitment to routine childhood immunization throughout EUR. Additional measures also are warranted, including SIAs to reduce susceptibility among older cohorts and strategies to ensure access to health care among underserved populations.

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Immunization program staff members in all 53 World Health Organization European Region member states.

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Progress in the Introduction of Rotavirus Vaccine — Latin America and the Caribbean, 2006–2010

Rotavirus disease is the leading cause of childhood morbidity and mortality related to diarrhea in Latin America and the Caribbean (LAC), where an estimated 8,000 deaths related to rotavirus diarrhea occur annually among children aged <5 years (*1*). After two safe and effective rotavirus vaccines became available, the World Health Organization (WHO) in 2007 recommended inclusion of rotavirus vaccine in the immunization programs of Europe and the Americas, and in 2009 expanded the recommendation to all infants aged <32 weeks worldwide (*2*). This report describes progress in the introduction of rotavirus vaccine in LAC, where it was first introduced in 2006 in Brazil, El Salvador, Mexico, Nicaragua, Panama, and Venezuela; by January 2011, it was included in the national immunization schedules of 14 countries in LAC. Estimated national rotavirus vaccine coverage (2 doses of the monovalent vaccine or 3 doses of the pentavalent vaccine) among children aged <1 year in 2010 ranged from 49% to 98% (median: 89%) in the 11 LAC countries with vaccine introduction before 2010. Of the 14 countries that had introduced rotavirus vaccine into their national immunization programs, 13 participate in a hospital-based rotavirus surveillance network. Data from some countries in this network and from other monitoring efforts in LAC countries (*3*–*6*) have shown declines in hospitalizations and deaths related to severe diarrhea after rotavirus vaccine introduction. The rapid introduction of rotavirus vaccine in LAC demonstrates the benefits of the early commitment of national decision makers to introduce these vaccines in low-income and middle-income countries at the same time as in high-income countries.

WHO recommends two rotavirus vaccines: a 2-dose monovalent vaccine (Rotarix, GlaxoSmithKline Biologicals, Rixensart, Belgium) and a 3-dose pentavalent vaccine (RotaTeq, Merck & Co. Inc., West Point, Pennsylvania). WHO recommends that the first dose of either vaccine be administered at age 6–15 weeks. The maximum age for administering the last dose of either vaccine should be 32 weeks, with an interval of at least 4 weeks between doses. This report summarizes 2010 WHO and United Nations Children's Fund (UNICEF) estimates of national vaccination coverage with the complete rotavirus series (2 doses of the monovalent vaccine or 3 doses of the pentavalent vaccine) and with the complete 3-dose series of diphtheria-tetanus-pertussis vaccine (DTP3) among children aged <1 year for the 14 countries with a rotavirus vaccine program. These estimates were derived through a country-by-country review of the best available data, including reports from Pan American Health Organization (PAHO) member states on the annual standardized Joint Reporting Form, and were supplemented by special coverage surveys and other published and unpublished data (*7*). As with national coverage reporting for other vaccines, age of administration for each dose was not reported. Countries were grouped on the basis of child and adult mortality rates, according to WHO mortality strata.*

Before rotavirus vaccine introduction in LAC, PAHO implemented a surveillance network for hospitalizations of children with rotavirus using standardized case definitions and laboratory methods. Any child aged <5 years hospitalized for treatment of acute diarrhea at a sentinel hospital conducting surveillance was eligible for enrollment, which required having stool specimens collected and tested for rotavirus using enzyme immunoassays. A child who tested positive for rotavirus was defined as having rotavirus diarrhea. Of the 14 countries that had introduced rotavirus vaccine into their national immunization programs (Table 1), surveillance data on the prevalence of rotavirus infection among children hospitalized with diarrhea were available from six of 14 countries during January–December 2006, before the introduction of vaccine, and from 12 of 14 countries during January–December 2010, after the introduction of vaccine. This report summarizes the surveillance data from the six countries in 2006 and from the 12 countries in 2010. This report also highlights data from El Salvador and Venezuela, where rotavirus surveillance was in place from 2006 to 2010 and vaccine was introduced in 2006, thus providing an opportunity for approximately four birth cohorts to be vaccinated before 2010.

As of June 1, 2011, rotavirus vaccine had been introduced into the national childhood immunization programs of 14 (44%) of 32 countries in LAC. Five of the 14 countries had high child mortality (WHO stratum D), and nine had low child mortality (WHO stratum B). In 2010, coverage with rotavirus vaccines among children aged <1 year in the 11 LAC countries that had introduced rotavirus vaccine before 2010 ranged from 49% to 98% (median: 89%), representing approximately 7 million infants (66% of the 10.6 million surviving infants in the 2010 birth cohort in LAC) (Table 1).

* Countries are assigned to WHO mortality strata based on both child and adult mortality (additional information available at http://www.who.int/whr/2003/en/member_states_182-184_en.pdf). Rotavirus vaccine efficacy in different countries has been found to correlate with WHO mortality strata with higher efficacy in countries in low mortality strata, such as stratum B, and lower efficacy in countries in high mortality strata, such as stratum D (*2*).

TABLE 1. Rotavirus (RV) vaccine coverage in 14 countries in Latin America and the Caribbean that have introduced RV vaccine into their national immunization programs, by World Health Organization (WHO) mortality stratum, 2010

Countries with RV vaccine programs	Year RV vaccine was introduced	2010 coverage with RV vaccine (%)*	2010 coverage with DTP3 (%)†
WHO mortality stratum D (high child mortality)			
Bolivia	2008	76	80
Ecuador	2007	97	99
Guatemala	2010	38	94
Nicaragua	2006	98	98
Peru	2009	75	93
WHO mortality stratum B (low child mortality)			
Brazil	2006	83	98
Colombia	2009	74	88
El Salvador	2006	92	92
Guyana	2010	39	95
Honduras	2009	98	98
Mexico	2006	90	95
Panama	2006	89	94
Paraguay	2010	56	90
Venezuela	2006	49	78

* WHO and United Nations Children's Fund (UNICEF) estimates of coverage of RV vaccine by country are the proportion of the birth cohort that received the complete 2-dose or 3-dose vaccine series by age 1 year (recommended age for last dose is by 32 weeks). All countries use the 2-dose monovalent RV vaccine except Nicaragua and Guyana, which use the 3-dose pentavalent RV vaccine.

† WHO/UNICEF estimates of national vaccination coverage for the full series of the third dose of diphtheria-tetanus-pertussis vaccine by age 1 year.

DTP3 coverage ranged from 78% to 99% in these countries (Table 1).

In 2010, among 14,354 children aged <5 years who were hospitalized for diarrhea and tested for rotavirus, 4,266 (30%) had laboratory-confirmed rotavirus disease (Table 2). In El Salvador, where vaccine coverage was 92% during 2010, rotavirus prevalence was 43% (1,025 rotavirus-positive stool specimens out of 2,370 stool specimens from children aged <5 years hospitalized with diarrhea) in 2006 and 24% in 2010 (524 of 2,191). In Venezuela, where rotavirus vaccine coverage was 49% during 2010, rotavirus prevalence was similar at 32% (258 of 808) in 2006 and 31% (76 of 242) in 2010.

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Editorial Note

Since 2006, countries in LAC have made substantial progress in implementing rotavirus vaccination. All low-income LAC countries eligible for vaccine financing through the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization), except Haiti, have introduced rotavirus vaccine. In total, an estimated 7 million infants (or 66% of all infants) in LAC were fully vaccinated against rotavirus during 2010, providing an opportunity to reduce the burden of rotavirus hospitalizations and deaths in this region. Coverage with rotavirus vaccine in some of these countries was lower than DTP3 coverage, with a coverage gap between the two vaccines exceeding 15 percentage points in Brazil, Colombia, Peru, and Venezuela. Factors that might explain this coverage gap might include differences in timeliness of routine vaccination in countries, differences in how countries implement WHO's recommendation to initiate rotavirus vaccination at age 6–15 weeks and to complete the full 2-dose or 3-dose series by age 32 weeks, vaccine shortages, or logistical challenges resulting from the relatively large rotavirus vaccine cold chain volume and the need for additional vaccine carriers to deliver rotavirus vaccines (*8*). Evaluating the reasons for the coverage gap between DTP3 and rotavirus vaccine and addressing them will be important to gain the full benefit of rotavirus vaccine. Possible strategies for narrowing this gap in vaccine coverage could include improvements in the timeliness of vaccination and in the tracking of infants who miss vaccination, and assessment of the benefits and risks of the WHO age restriction policy (*9*).

Although rotavirus vaccines were studied extensively before licensure, insight into the important aspects of the vaccine's performance often is better determined after a vaccine has been used widely, particularly in settings with established prevaccine disease surveillance. El Salvador and Venezuela established sentinel surveillance by 2006 and maintained the surveillance for several years after introducing rotavirus vaccine into their national immunization programs. This allows assessment of trends in rotavirus positivity before and after vaccine introduction in these countries. A substantial decrease in the percentage of rotavirus diarrhea cases in 2010 compared with 2006 was observed in El Salvador, where national rotavirus vaccine coverage was 92%, and was not observed in Venezuela, where coverage was 49%. All sentinel surveillance data should be interpreted cautiously because changes in surveillance and clinical practices over time can influence the results. Therefore, the actual impact of rotavirus vaccine introduction on rotavirus disease is best interpreted by a combination of data from sentinel surveillance and special studies. A study in El Salvador documented that vaccine introduction in 2006 resulted in substantial declines in 2008 and 2009 in rotavirus

TABLE 2. Rotavirus (RV) surveillance in 12 countries in Latin America and the Caribbean that have introduced RV vaccines and have sentinel surveillance programs for hospitalizations related to RV infection, by World Health Organization (WHO) mortality stratum, 2006 and 2010

Countries with RV vaccine programs	Year of RV vaccine introduction	2006			2010		
		Diarrhea patients tested for RV	RV positive		Diarrhea patients tested for RV	RV positive	
			No.	(%)		No.	(%)
WHO mortality stratum D (high child mortality)							
Bolivia	2008	1,170	455	(39)	1,509	439	(29)
Ecuador	2007	N/A*	—	—	2,276	449	(20)
Guatemala	2010	1,228	642	(52)	1,618	777	(48)
Nicaragua†	2006	N/A	—	—	1,493	358	—
Peru	2009	N/A	—	—	1,170	504	(43)
WHO mortality stratum B (low child mortality)							
Brazil	2006	N/A	—	—	852	191	(22)
Colombia	2009	N/A	—	—	697	106	(15)
El Salvador	2006	2,370	1,025	(43)	2,191	524	(24)
Guyana†	2010	N/A	—	—	33	7	—
Honduras	2009	2,699	1,193	(44)	1,994	696	(35)
Paraguay	2010	256	92	(36)	279	139	(50)
Venezuela	2006	808	258	(32)	242	76	(31)

* Not available (i.e., no sentinel RV surveillance system exists).

† To account for seasonal variation in RV disease, the annual percentages of tested diarrhea patients that were positive for rotavirus infection are reported only for countries that tested ≥100 stool specimens and reported the number of specimens tested for all 12 months. Nicaragua reported on 1,493 specimens during 6 months (January–June). Guyana reported on 33 specimens during 12 months.

hospitalizations at sentinel hospitals and in health-care visits for childhood diarrhea, compared with prevaccine rates in 2005 and 2006 (*3*). Furthermore, vaccination has prevented approximately 140,000 diarrhea-related hospitalizations and 1,300 diarrhea-related deaths annually among children aged <5 years in Brazil and Mexico, two large countries that introduced the vaccine early but were not part of the PAHO surveillance network when vaccine was introduced (*4,10*). These findings underscore the value of conducting sentinel surveillance for several years before and after vaccine introduction and highlight that rotavirus vaccine is an important tool for improving children's survival.

Recent data from Mexico and Brazil indicate that rotavirus vaccines might be associated with a low-level increased risk for intussusception, a form of intestinal obstruction in infants (*10*). However, recognizing that the benefits far outweigh the risks, regulatory agencies and immunization advisory committees have favored continuing rotavirus vaccination (*10*). This experience has highlighted the need that ministries of health have for reliable data on the health impact and safety of rotavirus vaccine. Surveillance systems are crucial for collecting such data, and systems such as the PAHO network can be used to conduct timely assessments of rotavirus vaccine impact and safety assessments. For example, case-control studies in El Salvador (*5*) and Nicaragua (*6*), where PAHO initiated surveillance in 2006 and 2007, respectively, have offered convincing evidence of successes in vaccine programs. In addition, these studies have generated questions for future research by demonstrating that vaccine effectiveness is lower in high child-mortality settings compared with low child-mortality settings (*5,6*).

The findings in this report are subject to at least three limitations. First, the administrative methods used to determine vaccine coverage might be inaccurate as a result of imprecise data on the size of the target population and the number of doses administered. Second, because of potential changes in the catchment population and because prevalence of rotavirus can be affected by incidence of acute diarrhea caused by nonrotavirus pathogens, hospital-based surveillance systems are less robust in quantifying the impact of vaccine than population-based systems. Finally, the absence of surveillance data from before the vaccines were introduced could pose a challenge for some countries in interpreting postvaccination trends in rotavirus disease; this challenge could be overcome by using these sites to conduct case-control studies to monitor effectiveness.

In total, approximately 7 million infants in LAC were vaccinated against rotavirus in 2010. Although coverage with rotavirus vaccine already exceeds 70% in most countries, coverage is lower than DTP3 coverage in some countries, and this discrepancy warrants attention. The existing rotavirus surveillance network in LAC provides an opportunity to collect valuable data on the benefits of vaccination for decision-makers, health-care providers, and parents. The rapid introduction of rotavirus vaccine in low-income and middle-income countries in the region demonstrates that challenges to introducing new vaccines can be overcome; this is particularly encouraging for countries in Asia and Africa, where most rotavirus deaths occur. The vaccine will be introduced into countries in Asia and Africa

What is already known on this topic?

Rotavirus infection is the leading cause of diarrhea-related death and hospitalization among children aged <5 years worldwide. To prevent morbidity and mortality related to rotavirus infection, the World Health Organization (WHO) recommends rotavirus vaccine for all infants worldwide.

What is added by this report?

Rotavirus vaccines have been included in the national immunization schedules of 14 countries in Latin America and the Caribbean. In 2010, the median rotavirus vaccine coverage was 89%, amounting to an estimated 7 million infants being vaccinated against rotavirus infection in these countries.

What are the implications for public health practice?

The successful introduction of rotavirus vaccines in low-income and middle-income countries of Latin America and the Caribbean demonstrates that new vaccines can successfully reach the target populations in a timely manner after introduction. This successful experience with the introduction of rotavirus vaccines and the lessons learned by these countries can be helpful for countries in Africa and Asia, where vaccine introduction will occur in the next few years.

during the next 3–5 years; already, a total of 16 countries, 12 of which are in Africa, have secured funding from the GAVI Alliance for introducing rotavirus vaccine in 2012 and 2013. Given the successful experience with rotavirus vaccines both in developing and developed regions of LAC, the global use of rotavirus vaccines should have a substantial impact on diarrheal morbidity and mortality, thus accelerating progress towards reaching the fourth Millennium Development Goal of reducing mortality among children.

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Limited Human-to-Human Transmission of Novel Influenza A (H3N2) Virus — Iowa, November 2011

On November 23, 2011, this report was posted as an MMWR *Dispatch on the* MMWR *website (http://www.cdc.gov/mmwr).*

On November 20, 2011, CDC confirmed three cases of swine-origin triple reassortant influenza A (H3N2) (S-OtrH3N2) virus infection in children in two counties in Iowa. None of the children were hospitalized, and each has recovered from a mild episode of febrile respiratory illness. All three were in contact with one another, and none had a known recent exposure to swine. No additional human infections with this virus have been detected in Iowa, and no evidence of sustained human-to-human transmission of this S-OtrH3N2 virus exists; surveillance is ongoing.

Eighteen human infections with swine-origin influenza A (H3N2) viruses have been identified since 2009 (*1,2*). The most recent 10 cases, including the three Iowa cases described in this report, were infections with S-OtrH3N2 viruses containing the matrix (M) gene from the pandemic 2009 influenza A (H1N1) virus (pH1N1). These viruses are considered reassortant viruses between a swine-origin influenza A (H3N2) virus circulating in North American swine and a pH1N1 virus. All cases of human infection with S-OtrH3N2 virus containing the M gene from the pH1N1 virus have occurred in 2011 and have been reported from four states: Pennsylvania (three cases), Maine (two), Indiana (two), and Iowa (three) (*3*).

Case Reports

Patient A. In the second week of November 2011, patient A, a previously healthy female child, experienced acute onset of influenza-like illness (ILI). Three days after her illness onset (illness day four), she was seen by a health-care provider, who obtained a respiratory specimen and performed a rapid influenza diagnostic test, which was positive. As part of routine influenza surveillance, the respiratory specimen was forwarded to the University of Iowa State Hygienic Laboratory (SHL) for further evaluation. Patient A's brother experienced onset of ILI 1 day before patient A's date of illness onset. Patient A's brother was not tested for influenza but was treated with oseltamivir by a health-care provider and has recovered. During her illness days two and three, patient A was in contact with her father, who subsequently developed ILI 2 days after his most recent contact with patient A. He was not tested for influenza. No other household member has reported respiratory illness. No family member reported exposure to swine before their illness onset. On her illness day one, patient A attended a small gathering of children.

Patients B and C. Patient B is a previously healthy male child who developed ILI 2 days after patient A's first day of illness. He is the sibling of patient C, a previously healthy male child who developed ILI 1 day after patient B's illness onset. Both children were seen by a health-care provider 2 days after patient B's illness onset; rapid influenza diagnostic testing was positive for both patients. As part of routine influenza surveillance, respiratory specimens were forwarded to SHL for further evaluation. The mother of patients B and C reported that no other household member had a respiratory illness and none had been exposed to swine before patient B became ill. On patient A's illness day one, patients B and C attended the same small gathering of children as patient A.

Epidemiologic and Laboratory Investigations

An investigation by the Iowa Department of Public Health (IDPH) determined that the families of patients A, B, and C reported no recent travel or attendance at community events. To date, the only epidemiologic link among patients A, B, and C that has been identified is attendance at a gathering of children on patient A's illness day one. No illnesses were reported among adults or among the five other children who were present at this gathering on that day. No swine exposures have been identified among adults or children attending this gathering. IDPH has detected no increase in absenteeism or reports of respiratory illness in the community where patients A, B, and C reside or in the schools in the community. Enhanced surveillance for ILI has been implemented in health-care facilities in the communities where patients A, B, and C reside. IDPH has instructed health-care providers to obtain respiratory specimens from patients with ILI for influenza diagnostic testing at SHL. Thus far, no additional cases of S-OtrH3N2 infection have been identified, and surveillance data from the state have shown low levels of influenza activity currently and at the time of all these patients' illnesses.

Eight days after patient A's illness onset, real-time reverse transcription–polymerase chain reaction (rRT-PCR) testing of respiratory specimens from patients A, B, and C at SHL indicated possible S-OtrH3N2 influenza virus. At CDC, preliminary rRT-PCR diagnostic results were inconclusive but indicated probable infection with a swine-origin influenza A

(H3N2) virus. Subsequent complete genome sequencing at CDC confirmed all three specimens as S-OtrH3N2 with the M gene from the pH1N1 virus. The viruses from these three patients are resistant to amantadine and rimantadine but are expected to be susceptible to the neuraminidase inhibitor drugs oseltamivir and zanamivir based on their genetic sequence. Because these viruses carry a unique combination of genes, little information currently is available regarding the capacity of this virus to transmit efficiently in swine, humans, or between swine and humans.

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Editorial Note

Since July 2011, a total of 10 cases of human infection with S-OtrH3N2 viruses have been identified in the United States, all containing the M gene from the pH1N1 virus. Seven of these 10 cases resulted in mild illness, but three of the infected persons were hospitalized for influenza; all patients have recovered. In all seven earlier cases, exposure to swine was identified in the patient or in a close contact of the patient (*4*). The lack of known exposure to swine in the three cases described in this report, combined with the known epidemiologic links, suggests that limited human-to-human transmission of this novel influenza virus might have occurred. Transmission of swine-origin influenza A (H3N2) viruses not containing the M gene from the pH1N1 virus to humans from close contact with an infected person has been reported previously and has not resulted in sustained human-to-human transmission (*5*). Preliminary evidence from the investigation of these cases in Iowa shows no evidence of ongoing transmission among humans. Swine influenza viruses are spread from pig to pig but are not known to spread through human contact with pork or pork products.

What is already known on this topic?

Swine influenza viruses have been reported sporadically to infect humans. In the United States, seven cases of swine-origin triple reassortant influenza A (H3N2) (S-OtrH3N2) virus infection have been reported in 2011. Cases usually occur after exposure to swine.

What is added by this report?

This report summarizes an investigation of three confirmed cases of human infection with S-OtrH3N2 virus in Iowa associated with limited person-to-person transmission. Cases occurred among children in contact with one another, and all cases were mild and self-limited. No child had known exposure to swine. The viruses identified are similar to seven previous cases reported in 2011, but these are the first cases reported from Iowa.

What are the implications for public health practice?

State health departments are advised to report suspect novel influenza viruses detected through influenza surveillance promptly to CDC. Persons with influenza-like illnesses who have had contact with swine are encouraged to be tested for influenza.

Although the vast majority of human infections with animal influenza viruses do not result in human-to-human transmission (*6*), each case should be investigated fully to ascertain if these viruses are transmitted among humans and to limit further exposure of humans to infected animals, if infected animals are suspected. Such investigations require close collaboration among state, local, and federal public and animal health officials. As part of routine preparedness measures to counter possible pandemic threats posed by novel influenza viruses in the event that they gain the ability to spread easily from person-to-person, CDC has developed a candidate vaccine virus that could be used to produce a human influenza vaccine against these S-OtrH3N2 viruses and has provided this candidate virus to manufacturers.

Although swine exposure was not associated with the three cases described in this report, because most previous cases of human infection with S-OtrH3N2 viruses have occurred in patients who reported swine exposure before illness onset, clinicians should consider swine-origin influenza A virus infection in the differential diagnosis of patients with febrile respiratory illness who have had contact with swine. It is anticipated that commercially available diagnostic tests, including point-of-care rapid tests, will detect infection with the S-OtrH3N2 virus; however, these tests will not differentiate S-OtrH3N2 from seasonal influenza A viruses. Clinicians who suspect swine influenza virus infections in humans should treat with oseltamivir when indicated (*7*), obtain a nasopharyngeal swab from the patient, place the swab in viral transport medium, and contact their state

or local health department to facilitate transport and timely diagnosis at a state public health laboratory, using the CDC RT-PCR assay cleared by the Food and Drug Administration. CDC requests that state public health laboratories send all suspected novel influenza A specimens, such as these S-OtrH3N2 viruses, to the CDC Influenza Division's Virus Surveillance and Diagnostics Branch Laboratory.

The 2011–12 seasonal influenza vaccine is expected to provide limited protection from this virus for adults but none for young children. Enhanced surveillance, including surveillance for ILI and diagnostic testing of respiratory specimens, is being conducted in Iowa and surrounding states as part of the ongoing investigation of these cases. Additional information about swine influenza is available at http://www.cdc.gov/flu/swineflu.

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Vital Signs: HIV Prevention Through Care and Treatment — United States

On November 29, 2011, this report was posted as an MMWR *Early Release on the* MMWR *website (http://www.cdc.gov/mmwr).*

Abstract

Background: An estimated 1.2 million persons in the United States were living with human immunodeficiency virus (HIV) infection in 2008. Improving survival of persons with HIV and reducing transmission involve a continuum of services that includes diagnosis (HIV testing), linkage to and retention in HIV medical care, and ongoing HIV prevention interventions, including appropriately timed antiretroviral therapy (ART).

Methods: CDC used three surveillance datasets to estimate recent HIV testing and HIV prevalence among U.S. adults by state, and the percentages of HIV-infected adults receiving HIV care for whom ART was prescribed, who achieved viral suppression, and who received prevention counseling from health-care providers. Published data were used to estimate the numbers of persons in the United States living with and diagnosed with HIV and, based on viral load and CD4 laboratory reports, linked to and retained in HIV care.

Results: In 2010, 9.6% of adults had been tested for HIV during the preceding 12 months (range by state: 4.9%–29.8%). Of the estimated 942,000 persons with HIV who were aware of their infection, approximately 77% were linked to care, and 51% remained in care. Among HIV-infected adults in care, 45% received prevention counseling, and 89% were prescribed ART, of whom 77% had viral suppression. Thus, an estimated 28% of all HIV-infected persons in the United States have a suppressed viral load.

Conclusions: Prevalence of HIV testing and linkage to care are high but warrant continued effort. Increasing the percentages of HIV-infected persons who remain in HIV care, achieve viral suppression, and receive prevention counseling requires additional effort.

Implications for Public Health Practice: Public health officials and HIV care providers should improve engagement at each step in the continuum of HIV care and monitor progress in every community using laboratory reports of viral load and CD4 test results.

Introduction

Human immunodeficiency virus (HIV) causes a chronic infection that leads to a progressive disease. Without treatment, most persons with HIV develop acquired immunodeficiency syndrome (AIDS) within 10 years of infection, which results in substantial morbidity and premature death (*1*). Approximately 50,000 persons in the United States were infected with HIV annually during 2006–2009 (*2*). Approximately 16,000 persons with AIDS die each year (*3*). A consistently suppressed HIV viral load is associated with reduced morbidity and mortality and a lower probability of transmitting HIV to sex partners (*4*). Testing identifies infected persons and is the entry point to a continuum of HIV health-care and social services that improve health outcomes, including survival. This continuum includes diagnosis (HIV testing), linkage to and retention in continuous medical care for HIV, prevention counseling and other services that reduce transmission, and appropriately timed and consistent antiretroviral therapy (ART) for viral suppression. This report estimates the number of HIV-infected persons who received selected services along the continuum of HIV care in the United States and the overall percentage of persons with HIV who had a suppressed viral load.

Methods

Data reported through June 2010 to the National HIV Surveillance System were used to calculate rates* by state per 100,000 population among persons aged 18–64 years living with diagnosed HIV infection (prevalence) at the end of 2008. Behavioral Risk Factor Surveillance System† data from 2010

* Diagnosed HIV prevalence rates were not adjusted for reporting delays to allow inclusion of all 50 states and the District of Columbia. By June 2010, only 40 states had implemented confidential name-based HIV infection reporting for long enough (since at least January 2006) to allow for stabilization of data collection and adjustment for reporting delays.

† The Behavioral Risk Factor Surveillance System is a state-based, random-digit-dialed telephone survey of the civilian, noninstitutionalized adult population that collects information on preventive health practices and risk behaviors in the United States (*5*).

were used to estimate percentages by state of persons aged 18–64 years who reported testing for HIV during the 12 months preceding the interview. Medical Monitoring Project (MMP)[§] data were used to estimate numbers and nationally representative percentages of adults aged ≥18 years receiving medical care who reported receiving prevention counseling in a clinical setting[¶] during the 12 months preceding the interview, and whose medical record documented that they 1) were prescribed ART during the 12 months preceding the interview and 2) had a suppressed viral load (defined as ≤200 copies/mL) at their most recent test.

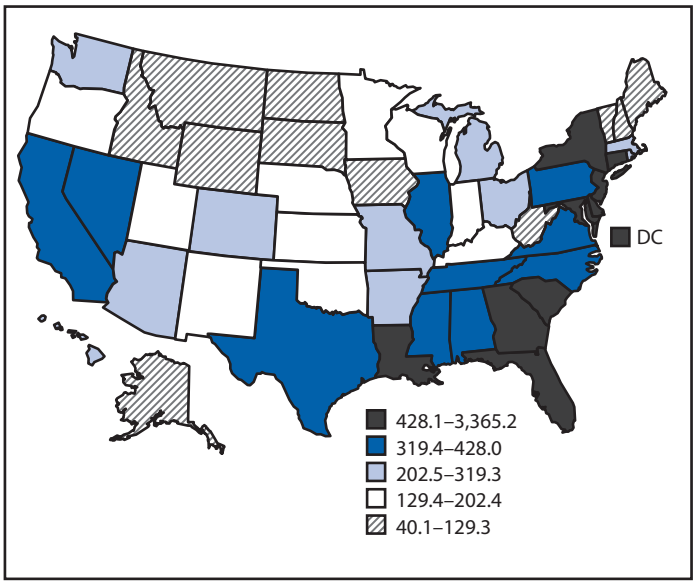
Using these surveillance data and published information, CDC assessed the estimated number of persons with HIV infection (*7*) and the numbers and percentages of persons who were 1) aware of their infection (*7*), 2) linked to care (*8,9*), 3) retained in care (*8–11*), 4) prescribed ART, and 5) virally suppressed. From these analyses, CDC developed a national estimate of the percentage of all HIV-infected persons with viral suppression.

Results

In 2008, an estimated 1.2 million persons were living with HIV in the United States, of whom 80% had been diagnosed (*7*). The prevalence rate for persons aged 18–64 years with an HIV diagnosis ranged by state from 40.1 to 3,365.2 per 100,000 population (Figure 1). In 2010, an estimated 9.6% of persons aged 18–64 years reported recent HIV testing (range by state: 4.9%–29.8%) (Figure 2). In general, recent HIV testing percentages were higher in states with higher HIV prevalence rates.

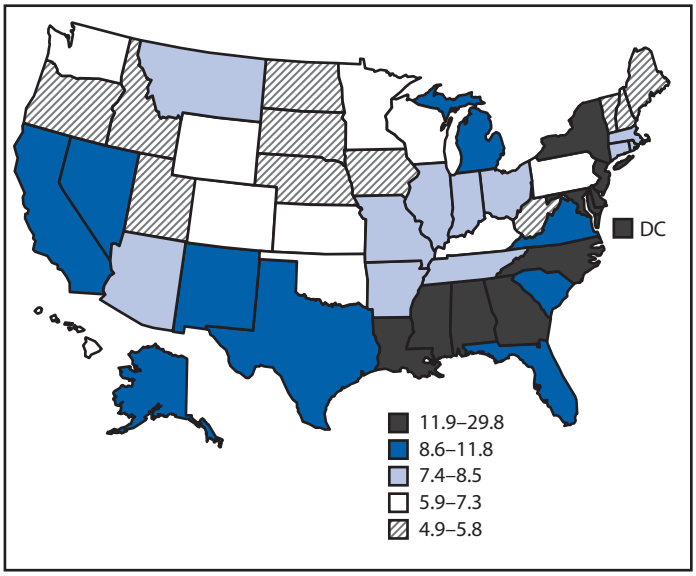
According to published studies, approximately 77% of persons diagnosed with HIV were linked to care within 3–4 months of diagnosis (*8,9*), and 51% were retained in ongoing care (*8–11*). Among adults aged ≥18 years in MMP representing persons receiving HIV medical care, 89% had been prescribed ART. Of these, 77% had a suppressed viral load at their most recent test (Table). CDC synthesized these findings to determine the number of persons in selected categories of the continuum of HIV care (Figure 3), and estimated that

FIGURE 1. Rates of persons aged 18–64 years living with a diagnosis of HIV infection* — National HIV Surveillance System, United States, year-end 2008



Abbreviation: HIV = human immunodeficiency virus.
* Rates are per 100,000 population and are not adjusted for reporting delays. Rates are categorized into quintiles. Overall rate: 417.5 per 100,000 population.

FIGURE 2. Percentages of persons aged 18–64 years tested for HIV infection during the preceding 12 months — Behavioral Risk Factor Surveillance System, United States, 2010



Abbreviation: HIV = human immunodeficiency virus.
* Percentages are categorized into quintiles. Overall percentage: 9.6%.

[§] MMP collects behavioral and clinical information from a nationally representative sample of adults receiving medical care for HIV infection in outpatient facilities in the United States and Puerto Rico (*6*). A total of 23 project areas were funded to conduct data collection activities for the 2009–2010 MMP data collection cycle: California; Chicago, Illinois; Delaware; Florida; Georgia; Houston, Texas; Illinois; Indiana; Los Angeles County, California; Michigan; Mississippi; New Jersey; the state of New York; New York City, New York; North Carolina; Oregon; Pennsylvania; Philadelphia, Pennsylvania; Puerto Rico; San Francisco, California; Texas; Virginia; and Washington. Patients who received medical care during January–April 2009 at an MMP participating facility were interviewed once during June 2009–April 2010 regarding all medical visits during the 12 months preceding the interview. In addition, patients' medical records were abstracted for documentation of medical care (including prescription of ART and HIV viral load) for the 12 months preceding the interview. All percentages were weighted for the probability of selection and adjusted for nonresponse bias.

[¶] Based on self-reported information from the patient interview about discussions with a physician, nurse, or other health-care worker. Topics might have included condom negotiation, how to practice safer sexual behavior or injection use, or how to talk with partners about safe sex. Discussion occurring during sessions that were part of HIV testing and counseling encounters were not included.

TABLE. Receipt of treatment and prevention counseling during the preceding 12 months among HIV-infected adults aged ≥18 years who received HIV medical care, by selected characteristics — Medical Monitoring Project (MMP), United States, 2008–2010*

Characteristic	Prescription of ART				Among those prescribed ART, most recent HIV viral load test indicating ≤200 copies/mL†				Prevention counseling by a health-care provider§			
	No.	No. in sample	Weighted %¶	(95% CI)¶	No.	No. in sample	Weighted %¶	(95% CI)¶	No.	No. in sample	Weighted %¶	(95% CI)¶
Age group (yrs)												
18–24	84	107	76	(64–87)	62	84	78	(69–87)	77	107	73	(63–84)
25–34	395	500	79	(72–83)	268	395	69	(64–75)	302	500	59	(52–66)
35–44	986	1,121	88	(86–91)	712	986	72	(67–76)	546	1,121	47	(42–52)
45–54	1,490	1,641	91	(90–93)	1,168	1,490	79	(75–82)	712	1,641	42	(36–47)
≥55	782	848	92	(90–94)	661	782	85	(82–87)	309	848	36	(31–41)
Sex												
Male	2,755	3,067	90	(88–92)	2,171	2,755	79	(76–82)	1,338	3,067	43	(37–48)
Female	980	1,148	86	(83–89)	698	980	71	(68–75)	607	1,148	50	(46–54)
Race/Ethnicity												
Black or African American	1,489	1,734	86	(83–88)	1,046	1,489	70	(66–74)	975	1,734	54	(49–60)
Hispanic or Latino**	783	878	89	(86–92)	611	783	79	(75–82)	457	878	52	(48–56)
White	1,270	1,384	92	(91–94)	1,067	1,270	84	(80–87)	420	1,384	29	(25–33)
Other	195	221	87	(81–94)	147	195	77	(72–83)	94	221	44	(37–52)
Sexual risk behavior												
Men who have sex with men††	1,771	1,980	89	(87–91)	1,448	1,771	81	(79–84)	797	1,980	39	(34–44)
Men who have sex with women only§§	901	997	91	(89–93)	662	901	75	(71–79)	503	997	50	(44–56)
Women who have sex with men¶¶	954	1,118	86	(83–89)	679	954	71	(68–75)	593	1,118	50	(46–54)
Total* **	**3,737**	**4,217**	**89**	**(87–91)**	**2,871**	**3,737**	**77**	**(74–80)**	**1,946**	**4,217**	**45**	**(40–50)**

Abbreviations: HIV = human immunodeficiency virus; ART = antiretroviral therapy; CI = confidence interval.

* A total of 23 project areas were funded to conduct data collection activities for the 2009–2010 MMP data collection cycle: California; Chicago, Illinois; Delaware; Florida; Georgia; Houston, Texas; Illinois; Indiana; Los Angeles County, California; Michigan; Mississippi; New Jersey; the state of New York; New York City, New York; North Carolina; Oregon; Pennsylvania; Philadelphia, Pennsylvania; Puerto Rico; San Francisco, California; Texas; Virginia; and Washington. Information regarding prescription of ART and HIV viral load was abstracted from the patient's medical record. Patients who received medical care during January–April 2009 at an MMP participating facility were interviewed once during June 2009–April 2010 regarding all medical visits during the 12 months preceding the interview. In addition, patients' medical records were abstracted for documentation of medical care for the 12 months preceding the interview.

† Represents only those patients who remained engaged in care.

§ Based on self-reported information from the patient interview about discussions with a physician, nurse, or other health-care worker. Topics might have included condom negotiation, how to practice safer sexual behavior or injection use, or how to talk with partners about safe sex. Discussion occurring during sessions that were part of HIV testing and counseling encounters were not included.

¶ All percentages are weighted for probability of selection and nonresponse bias adjustment. Computation of 95% CIs accounts for weighting and complex sample survey design.

** Hispanics or Latinos can be of any race.

†† Refers to males who reported oral or anal sex with a man, or who self-identify as gay or bisexual.

§§ Refers to males who only reported oral, anal, or vaginal sex with a woman, or who self-identify as heterosexual.

¶¶ Refers to females who reported oral, anal, or vaginal sex with a man, or who self-identify as heterosexual or bisexual.

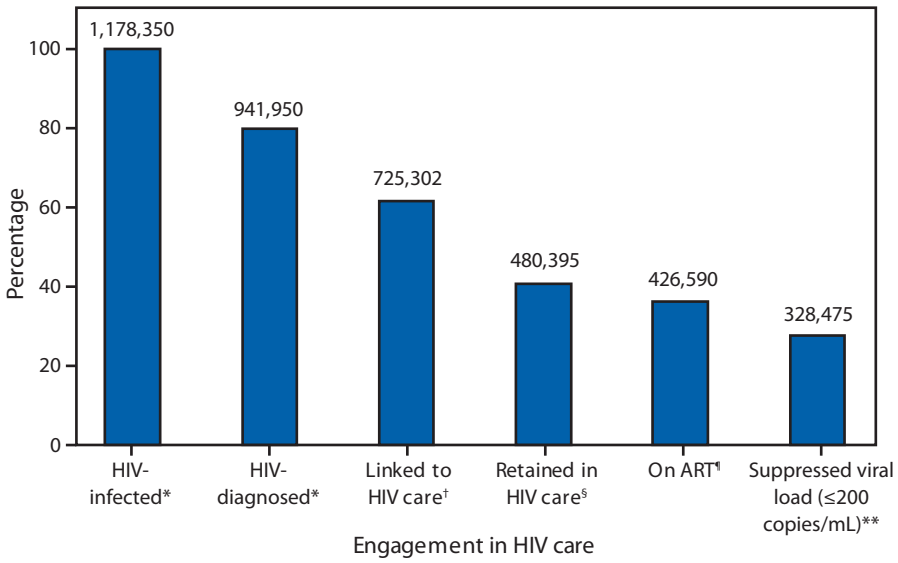
*** Numbers may not add to total because of missing data.

328,475 (35%) of 941,950 persons diagnosed with HIV (or 28% of all 1,178,350 persons with HIV) in the United States are virally suppressed.

The percentages of patients in MMP who were prescribed ART, had documented viral suppression, and received prevention counseling from a health-care provider during the preceding 12 months varied by age group, race/ethnicity, and reported sexual behavior (Table). Prescription of ART ranged from 76% for patients aged 18–24 years to 92% for those aged ≥55 years; of those prescribed ART, viral suppression was lowest among patients aged 25–34 years (69%) and highest in those aged ≥55 years (85%). Among the 92% of whites, 89% of Hispanics or Latinos, and 86% of blacks or African Americans who were prescribed ART, 84% of whites and 79% of Hispanics or Latinos had documented viral suppression, compared with 70% of blacks or African Americans. ART prescriptions were documented for 91% of men who have sex with women only (MSW), 89% of men who have sex with men (MSM), and 86% of women who have sex with men (WSM). By sex, 79% of males (81% of MSM and 75% of MSW) had viral suppression, compared with 71% of females.

Among persons in MMP, 45% had received prevention counseling during the preceding year, ranging from 36% among persons aged ≥55 years to 73% among persons aged 18–24 years. By race/ethnicity, 54% of blacks or African Americans and 52% of Hispanics or Latinos received prevention counseling, compared with 29% of whites. Prevention counseling was received by 50% of MSW and WSM, but only 39% of MSM.

FIGURE 3. Number and percentage of HIV-infected persons engaged in selected stages of the continuum of HIV care — United States



Abbreviations: HIV = human immunodeficiency virus; ART = antiretroviral therapy.

* HIV-infected, N = 1,178,350; HIV-diagnosed, n=941,950. **Source:** CDC. HIV surveillance—United States, 1981–2008. MMWR 2011;60:689–93.

† Calculated as estimated number diagnosed (941,950) × estimated percentage linked to care (77%); n = 725,302. **Sources:** Marks G, Gardner LI, Craw J, Crepaz N. Entry and retention in medical care among HIV-diagnosed persons: a meta-analysis. AIDS 2010;24:2665–78; Torian LV, Wiewel EW. Continuity of HIV-related medical care, New York City, 2005–2009: do patients who initiate care stay in care? AIDS Patient Care STDS 2011;25:79–88.

§ Calculated as estimated number diagnosed (941,950) × estimated percentage retained in care (51%); n = 480,395. **Sources:** Marks G, Gardner LI, Craw J, Crepaz N. Entry and retention in medical care among HIV-diagnosed persons: a meta-analysis. AIDS 2010;24:2665–78; Torian LV, Wiewel EW. Continuity of HIV-related medical care, New York City, 2005–2009: do patients who initiate care stay in care? AIDS Patient Care STDS 2011;25:79–88; Hall IH, Mahle KC, Tang T, Li J, Johnson AS, Shouse L. Retention in care of HIV-infected adults and adolescents in 13 U.S. areas. Presented at the National HIV Prevention Conference, Atlanta, GA, August 14–17, 2011; Tripathi A, Youmans E, Gibson JJ, Duffus WA. The impact of retention in early HIV medical care on viro-immunological parameters and survival: a statewide study. AIDS Res Hum Retroviruses 2011;27:751–8.

¶ Calculated as estimated number retained in HIV care (480,395) × percentage prescribed ART in MMP (88.8%); n = 426,590. **Source:** Data from the Medical Monitoring Project.

** Calculated as estimated number on ART (426,590) × percentage with suppressed viral load in MMP (77.0%); n = 328,475 (28% of the estimated 1,178,350 persons in the United States who are infected with HIV). **Source:** Data from the Medical Monitoring Project.

Conclusions and Comment

Among MMP participants (representing adults aged ≥18 years receiving medical care for HIV infection), 89% had been prescribed ART, of whom 77% had a suppressed viral load. However, only 28% of all persons living with HIV infection in the United States are estimated to be virally suppressed, in large part because only approximately 41% are both aware of their infection and receiving ongoing HIV care.

The observed higher percentages of persons who were recently tested in areas with higher HIV prevalence are encouraging. These findings are consistent with the recommendations of the 2010 National HIV/AIDS Strategy to intensify efforts in communities where HIV is concentrated most heavily, but continued effort is necessary to achieve the goal of increasing the proportion of persons aware of their infection from 80% to 90% (*12*). CDC's comprehensive HIV testing strategy includes 1) routine HIV screening in health-care settings with prevalence of undiagnosed infection ≥0.1%, 2) targeted testing of persons with risk factors associated with increased HIV prevalence, and 3) retesting at least annually for HIV-negative persons at increased risk for HIV (*13*).

Although the percentage of persons with HIV who are linked to care after diagnosis is 77%, more effort is needed to ensure that those patients remain in care and to eliminate disparities among subgroups who are prescribed ART and subsequently achieve viral suppression. In MMP, compared with whites, smaller percentages of blacks or African Americans and Hispanics or Latinos were prescribed ART and were virally suppressed. Differences in rates of ART prescription and viral suppression might reflect differences in insurance coverage, prescription drug costs, health-care providers' perceptions of patients' probability of adherence, or other factors associated with adherence.

Ongoing prevention interventions for persons with HIV infection are key components to reduce HIV transmission. Prevention counseling is recommended as an ongoing part of HIV care for all patients (*14*), but fewer than half of patients in MMP had received prevention counseling from their health-care provider during the preceding year. These low percentages, especially among MSM, who account for the most new HIV infections in the United States (*2*), indicate a need for health-care providers to deliver HIV prevention services more consistently.

The findings in this report are subject to at least two limitations. First, documentation of a recent suppressed viral load might not be indicative of consistent viral suppression. Second, the percentage of persons with viral suppression might be overestimated or underestimated and not representative of all persons with HIV in the United States because 1) not all states have implemented routine reporting of CD4 and viral load test results, so estimates of percentages of persons retained in care are based on a limited number of states; 2) MMP data might include persons more likely to be retained in care or adhere to ART; and 3) the estimate assumed no viral suppression among

Key Points

- About 1.2 million persons in the United States are infected with HIV; 80% are aware of their infection, and 20% have not been diagnosed.
- After diagnosis, 77% of HIV-infected adults are linked to HIV medical care, but only 51% of diagnosed persons stay in medical care; fewer than half of the patients getting care receive prevention counseling from their health-care provider.
- A suppressed HIV viral load can lead to better health outcomes and a much lower chance of passing HIV on to partners; however, only 28% of all persons with HIV have a suppressed viral load because the best possible levels have not been reached for 1) testing, 2) ongoing HIV medical care, and 3) adherence to medicine.
- Additional information is available at http://www.cdc.gov/vitalsigns.

persons not in care, although a small percentage of persons demonstrate viral suppression without taking ART.

CDC's estimate that 28% of all HIV-infected persons are virally suppressed is higher than the 19% reported in a recent review (*15*). CDC used more recent data and different methods that did not depend on estimates of the proportion of persons in care who need ART. The previous estimate calculated that 80% of persons in care need ART, of whom 75% receive it (*15*).

The 2010 National HIV/AIDS Strategy goals of reducing HIV incidence, increasing access to care and improving health outcomes for persons living with HIV, and reducing HIV-related disparities and health inequities are interdependent. Reducing national HIV incidence and improving individual health outcomes require increased access to care and elimination of disparities in the quality of care received. To meet these goals and break the cycle of HIV transmission in the United States, achieving high levels of engagement at every stage in the continuum of care is essential. Currently, a substantial proportion of HIV-infected persons have been tested and initially linked to care, and of those retained in care, 89% are prescribed ART, and 77% achieve viral suppression. However, only an estimated 28% of all HIV-infected persons in the United States are virally suppressed, largely because even among those with diagnosed infection, only 51% are receiving regular HIV care (*8–11*). Without substantial improvement in these percentages, 1.2 million new HIV infections would be expected to occur in the United States over the next 20 years (*16*). Based on estimated lifetime HIV treatment costs of $367,000 per person (2009 dollars) (*17*) caring for persons who become infected could cost as much as $450 billion in health-care expenditures (*16*).

CDC supports state and local health department programs to expand and monitor HIV testing and linkage to medical care, especially in high prevalence areas. Because ensuring that persons with HIV infection receive continuous medical care is important, CDC is working with health departments throughout the nation to expand their efforts to collect laboratory reports on all CD4 and viral load test results for persons diagnosed with HIV. Local programs can use these data (in accordance with privacy and confidentiality policies, laws, and regulations) to identify persons not in care and to facilitate efforts to ensure they receive appropriate care. CDC will continue using MMP to monitor receipt of ART and prevention services among persons in care and identify opportunities for improvement. CDC will share this information with grantees, partners, health-care providers, and other federal agencies (e.g., the Health Resources and Services Administration) to improve the delivery of care, treatment, and prevention services for all persons with HIV infection.

The results in this report indicate that progress has been made; however, continued and intensified efforts are needed. Only with success at each step in the continuum of HIV care (i.e., identifying those with HIV, linking them to and retaining them in care, and ensuring they receive optimal treatment and prevention services) can the ultimate goals of improving health, extending lives, and preventing further HIV transmission be achieved.

Reported by

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Announcement

National Influenza Vaccination Week — December 4–10, 2011

National Influenza Vaccination Week (NIVW) is a national observance established to highlight the importance of continuing influenza vaccination and to foster greater use of influenza vaccine through the holiday season into January and beyond. The U.S. Department of Health and Human Services, CDC, and other partners are conducting related activities during NIVW (December 4–10, 2011).

Approximately 128 million doses of influenza vaccine had been delivered in the United States as of mid-November (*2*). During NIVW, CDC will highlight the importance of preventing influenza by vaccination. The Advisory Committee on Immunization Practices (ACIP) recommends influenza vaccination for all persons aged ≥6 months (*1*). However, certain groups are at higher risk for influenza-related complications. These high-risk groups include children aged <5 years, but especially children aged <2 years; persons with certain chronic health conditions, such as heart disease, asthma, and diabetes (types 1 and 2); pregnant women; and adults aged ≥65 years. Children aged 6 months–8 years who did not receive at least 1 dose of the 2010–11 influenza vaccine will need 2 doses this season to be fully protected.

Posters, educational materials, and web tools for NIVW are available at http://www.cdc.gov/flu/freeresources/ and http://www.cdc.gov/flu/nivw/index.htm. Additional influenza information for health-care professionals and patients is available at http://www.cdc.gov/flu and http://www.flu.gov. Information about NIVW partnership opportunities is available by e-mail (fluinbox@cdc.gov). Influenza vaccination coverage estimates are available at http://www.cdc.gov/flu/professionals/vaccination/vaccinecoverage.htm.

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Errata

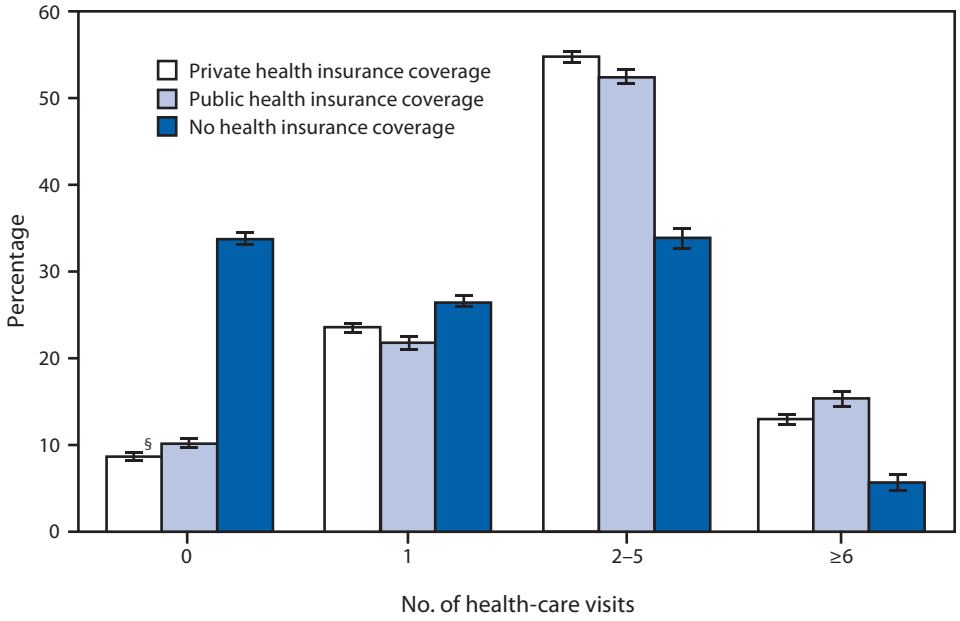
Vol. 60, No. 30

In the report, "Notes from the Field: Malnutrition and Mortality—Southern Somalia, July 2011," irregularities in data quality were found on further examination of two of the 15 survey datasets and in the under-5 mortality data. Consequently, anthropometric and mortality estimates from the Bakool Agropastoral and pastoral surveys and estimates of under-5 mortality rates from all survey areas should be disregarded. This does not change the broader conclusion that a severe nutrition crisis with high mortality exists in most of the areas assessed, and famine conditions are present in at least two areas surveyed. It also highlights the challenges of analyzing data collected remotely from insecure regions.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Health-Care Visits* for Children Aged 1–17 Years, by Health Insurance Status† — National Health Interview Survey, United States, 2006–2010



* Estimates are based on household interviews of a sample of the civilian, noninstitutionalized U.S. population. One child aged <18 years was randomly selected per family; a parent or other knowledgeable adult provided information for the child. The number of health-care visits was based on response to the question, "During the past 12 months, how many times has [child] seen a doctor or other health-care professional about [his/her] health at a doctor's office, a clinic, or some other place? Do not include times [child] was hospitalized overnight, visits to hospital emergency rooms, home visits, telephone calls, or dental visits." Children aged <1 year were not included in this analysis. In addition, unknowns with respect to office visits and health insurance coverage were excluded from the denominators.

† Health insurance status indicates coverage at the time of interview. Public coverage includes Medicaid, Children's Health Insurance Program (SCHIP), state-sponsored or other government-sponsored health plans, Medicare (disability), or military health plans (TRICARE, VA, or CHAMP-VA). Children with both public and private insurance coverage were included in the private coverage category.

§ 95% confidence interval.

The percentage of children aged 1–17 years who did not see a doctor or other health-care professional during the past 12 months was higher for children without health insurance coverage (33.8%) than for children with public health insurance coverage (10.3%) or those with private health insurance (8.7%). Children without health insurance also were more likely than children with public or private health insurance coverage to have had only one health-care visit during the past 12 months. Children with private health insurance coverage were more likely to have two to five health-care visits during the past 12 months than children with public health insurance coverage or children without health insurance coverage, but children with public health insurance coverage were more likely to have had six or more health-care visits during the past 12 months than children with private health insurance coverage or children without health insurance coverage.

Source: National Health Interview Survey, 2006–2010. Available at http://www.cdc.gov/nchs/nhis.htm.

Notifiable Diseases and Mortality Tables

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending November 26, 2011 (47th week)*

Disease	Current week	Cum 2011	5-year weekly average†	Total cases reported for previous years					States reporting cases during current week (No.)
				2010	2009	2008	2007	2006	
Anthrax	—	1	0	—	1	—	1	1	
Arboviral diseases§,¶:									
California serogroup virus disease	—	120	0	75	55	62	55	67	
Eastern equine encephalitis virus disease	—	3	—	10	4	4	4	8	
Powassan virus disease	—	14	0	8	6	2	7	1	
St. Louis encephalitis virus disease	—	3	0	10	12	13	9	10	
Western equine encephalitis virus disease	—	—	—	—	—	—	—	—	
Babesiosis	3	609	0	NN	NN	NN	NN	NN	NY (3)
Botulism, total	—	104	3	112	118	145	144	165	
foodborne	—	8	0	7	10	17	32	20	
infant	—	67	2	80	83	109	85	97	
other (wound and unspecified)	—	29	1	25	25	19	27	48	
Brucellosis	1	69	2	115	115	80	131	121	FL (1)
Chancroid	—	26	0	24	28	25	23	33	
Cholera	—	29	0	13	10	5	7	9	
Cyclosporiasis§	2	145	1	179	141	139	93	137	FL (2)
Diphtheria	—	—	—	—	—	—	—	—	
Haemophilus influenzae,** invasive disease (age <5 yrs):									
serotype b	—	6	0	23	35	30	22	29	
nonserotype b	—	96	4	200	236	244	199	175	
unknown serotype	4	206	4	223	178	163	180	179	MI (1), ND (1), FL (1), KY (1)
Hansen disease§	—	43	1	98	103	80	101	66	
Hantavirus pulmonary syndrome§	—	19	0	20	20	18	32	40	
Hemolytic uremic syndrome, postdiarrheal§	4	180	4	266	242	330	292	288	OH (1), NC (1), TX (1), OR (1)
Influenza-associated pediatric mortality§,††	2	116	4	61	358	90	77	43	CA (2)
Listeriosis	9	673	15	821	851	759	808	884	NY (2), OH (1), ND (2), NC (4)
Measles§§	—	205	0	63	71	140	43	55	
Meningococcal disease, invasive¶¶:									
A, C, Y, and W-135	—	168	6	280	301	330	325	318	
serogroup B	—	90	3	135	174	188	167	193	
other serogroup	1	11	0	12	23	38	35	32	NE (1)
unknown serogroup	1	338	9	406	482	616	550	651	OH (1)
Novel influenza A virus infections***	—	8	0	4	43,774	2	4	NN	
Plague	—	2	—	2	8	3	7	17	
Poliomyelitis, paralytic	—	—	—	—	1	—	—	—	
Polio virus Infection, nonparalytic§	—	—	—	—	—	—	—	NN	
Psittacosis§	—	2	0	4	9	8	12	21	
Q fever, total§	—	94	2	131	113	120	171	169	
acute	—	71	1	106	93	106	—	—	
chronic	—	23	0	25	20	14	—	—	
Rabies, human	—	2	0	2	4	2	1	3	
Rubella†††	—	5	0	5	3	16	12	11	
Rubella, congenital syndrome	—	—	—	—	2	—	—	1	
SARS-CoV§	—	—	—	—	—	—	—	—	
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	1	101	2	142	161	157	132	125	OH (1)
Syphilis, congenital (age <1 yr)§§§	—	207	7	377	423	431	430	349	
Tetanus	—	8	1	26	18	19	28	41	
Toxic-shock syndrome (staphylococcal)§	—	64	1	82	74	71	92	101	
Trichinellosis	—	9	0	7	13	39	5	15	
Tularemia	—	137	1	124	93	123	137	95	
Typhoid fever	2	322	4	467	397	449	434	353	NC (1), NV (1)
Vancomycin-intermediate *Staphylococcus aureus*§	1	59	1	91	78	63	37	6	FL (1)
Vancomycin-resistant *Staphylococcus aureus*§	—	—	—	2	1	—	2	1	
Vibriosis (noncholera *Vibrio* species infections)§	5	684	8	846	789	588	549	NN	FL (3), MS (1), OR (1)
Viral hemorrhagic fever¶¶¶	—	—	—	1	NN	NN	NN	NN	
Yellow fever	—	—	—	—	—	—	—	—	

See Table 1 footnotes on next page.

TABLE I. (*Continued*) Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending November 26, 2011 (47th week)*

—: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts.

* Case counts for reporting year 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/osels/ph_surveillance/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf.

† Calculated by summing the incidence counts for the current week, the 2 weeks preceding the current week, and the 2 weeks following the current week, for a total of 5 preceding years. Additional information is available at http://www.cdc.gov/osels/ph_surveillance/nndss/phs/files/5yearweeklyaverage.pdf.

§ Not reportable in all states. Data from states where the condition is not reportable are excluded from this table except starting in 2007 for the arboviral diseases, STD data, TB data, and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/osels/ph_surveillance/nndss/phs/infdis.htm.

¶ Includes both neuroinvasive and nonneuroinvasive. Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for West Nile virus are available in Table II.

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

†† Updated weekly from reports to the Influenza Division, National Center for Immunization and Respiratory Diseases. Since October 2, 2011, no influenza-associated pediatric deaths occurring during the 2011-12 influenza season have been reported.

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

¶¶ Data for meningococcal disease (all serogroups) are available in Table II.

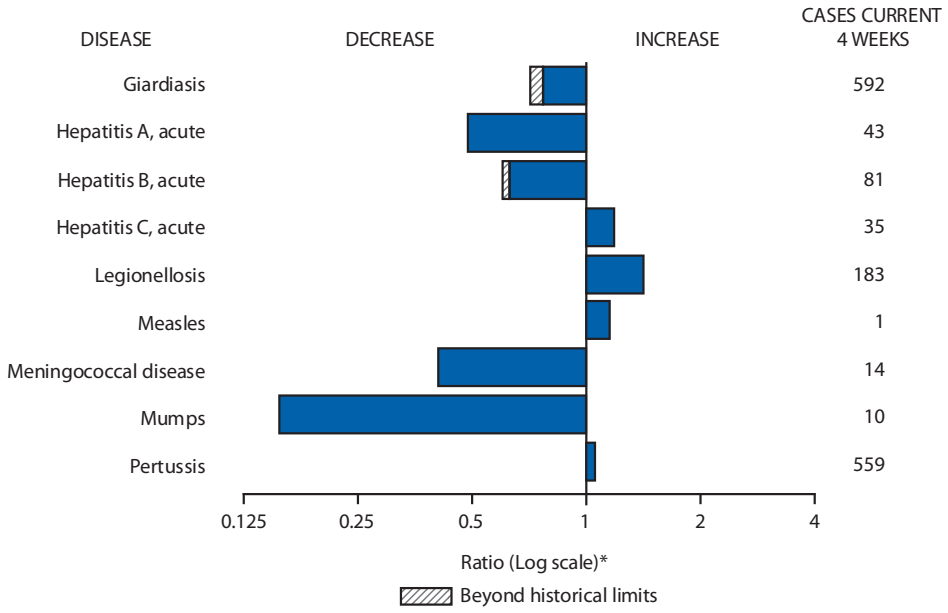
*** CDC discontinued reporting of individual confirmed and probable cases of 2009 pandemic influenza A (H1N1) virus infections on July 24, 2009. During 2009, four cases of human infection with novel influenza A viruses, different from the 2009 pandemic influenza A (H1N1) strain, were reported to CDC. The four cases of novel influenza A virus infection reported to CDC during 2010, and the eight cases reported during 2011, were identified as swine influenza A (H3N2) virus and are unrelated to the 2009 pandemic influenza A (H1N1) virus. Total case counts are provided by the Influenza Division, National Center for Immunization and Respiratory Diseases (NCIRD).

††† No rubella cases were reported for the current week.

§§§ Updated weekly from reports to the Division of STD Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.

¶¶¶ There was one case of viral hemorrhagic fever reported during week 12 of 2010. The one case report was confirmed as lassa fever. See Table II for dengue hemorrhagic fever.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals November 26, 2011, with historical data



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

Notifiable Disease Data Team and 122 Cities Mortality Data Team

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TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending November 26, 2011, and November 27, 2010 (47th week)*

Reporting area	*Chlamydia trachomatis* infection					Coccidioidomycosis					Cryptosporidiosis				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	6,921	25,571	31,142	1,158,750	1,170,503	96	375	572	17,418	NN	38	129	368	7,477	8,322
New England	490	859	2,043	39,645	37,928	—	0	1	1	NN	1	7	22	354	459
Connecticut	177	216	1,557	9,545	10,184	—	0	0	—	NN	—	1	9	64	77
Maine†	37	58	100	2,741	2,310	—	0	0	—	NN	—	1	4	44	92
Massachusetts	258	427	860	19,983	19,003	—	0	0	—	NN	1	3	8	150	154
New Hampshire	—	56	91	2,443	2,192	—	0	1	1	NN	—	1	5	55	53
Rhode Island†	—	80	154	3,617	3,094	—	0	0	—	NN	—	0	1	1	17
Vermont†	18	27	84	1,316	1,145	—	0	0	—	NN	—	1	5	40	66
Mid. Atlantic	970	3,391	4,031	151,001	156,176	—	0	1	5	NN	4	15	41	787	801
New Jersey	82	544	1,071	27,075	23,748	—	0	0	—	NN	—	0	3	22	51
New York (Upstate)	506	711	2,099	32,411	31,169	—	0	0	—	NN	3	4	15	204	201
New York City	1	1,129	1,689	46,454	58,166	—	0	0	—	NN	—	1	6	77	93
Pennsylvania	381	971	1,245	45,061	43,093	—	0	1	5	NN	1	9	26	484	456
E.N. Central	595	4,044	7,039	180,750	185,548	—	0	5	44	NN	16	32	143	2,309	2,285
Illinois	8	1,094	1,320	47,197	54,944	—	0	0	—	NN	—	3	26	190	318
Indiana	125	504	3,376	24,385	18,158	—	0	0	—	NN	—	4	14	180	264
Michigan	259	941	1,429	43,922	44,873	—	0	3	27	NN	1	6	14	310	305
Ohio	103	995	1,124	44,875	46,501	—	0	3	17	NN	15	11	95	1,056	441
Wisconsin	100	458	558	20,371	21,072	—	0	0	—	NN	—	8	61	573	957
W.N. Central	30	1,467	1,755	66,314	65,740	—	0	2	6	NN	5	18	87	1,212	1,787
Iowa	15	212	253	9,643	9,612	—	0	0	—	NN	1	6	19	335	378
Kansas	—	202	288	9,247	8,782	—	0	0	—	NN	—	0	10	39	103
Minnesota	—	284	369	12,377	14,055	—	0	0	—	NN	—	0	4	—	384
Missouri	—	529	759	24,718	23,705	—	0	0	—	NN	1	5	63	499	538
Nebraska†	—	113	216	5,622	4,574	—	0	2	6	NN	2	3	12	172	250
North Dakota	—	40	77	1,739	2,129	—	0	0	—	NN	—	0	12	28	30
South Dakota	15	63	93	2,968	2,883	—	0	0	—	NN	1	2	13	139	104
S. Atlantic	1,986	5,381	6,701	253,145	232,173	—	0	2	4	NN	4	21	37	1,002	978
Delaware	32	87	134	3,916	3,995	—	0	0	—	NN	—	0	1	7	7
District of Columbia	—	107	191	4,937	5,044	—	0	0	—	NN	—	0	1	5	8
Florida	341	1,494	1,698	68,308	68,180	—	0	0	—	NN	4	8	17	401	365
Georgia	410	1,012	2,384	46,122	39,472	—	0	0	—	NN	—	5	11	247	249
Maryland†	261	473	1,125	22,037	21,952	—	0	2	4	NN	—	1	6	60	37
North Carolina	—	971	1,688	46,603	38,283	—	0	0	—	NN	—	0	13	36	86
South Carolina†	415	524	946	25,764	23,865	—	0	0	—	NN	—	2	8	120	113
Virginia†	480	661	1,590	31,669	27,851	—	0	0	—	NN	—	2	8	110	96
West Virginia	47	80	121	3,789	3,531	—	0	0	—	NN	—	0	5	16	17
E.S. Central	857	1,896	3,314	86,942	82,728	—	0	0	—	NN	—	6	13	277	325
Alabama†	473	546	1,566	26,718	24,393	—	0	0	—	NN	—	2	7	122	170
Kentucky	249	301	2,352	14,722	13,043	—	0	0	—	NN	—	0	2	30	80
Mississippi	—	403	696	17,939	19,432	—	0	0	—	NN	—	1	4	44	24
Tennessee†	135	599	757	27,563	25,860	—	0	0	—	NN	—	1	6	81	51
W.S. Central	838	3,567	4,639	164,379	160,866	—	0	1	5	NN	4	7	62	500	488
Arkansas†	79	309	440	14,294	14,087	—	0	0	—	NN	—	0	2	23	32
Louisiana	94	432	1,071	20,274	25,145	—	0	1	5	NN	—	0	9	45	64
Oklahoma	13	319	1,340	16,472	12,863	—	0	0	—	NN	—	2	34	79	81
Texas†	652	2,436	3,048	113,339	108,771	—	0	0	—	NN	4	5	37	353	311
Mountain	564	1,748	2,155	80,785	75,355	91	292	459	13,639	NN	3	10	30	540	575
Arizona	342	545	757	26,346	24,418	88	288	456	13,486	NN	—	1	4	39	38
Colorado	—	412	847	20,937	18,033	—	0	0	—	NN	2	2	12	144	130
Idaho†	16	81	235	3,647	3,568	—	0	0	—	NN	1	2	9	100	99
Montana†	51	62	87	3,029	2,802	—	0	2	5	NN	—	1	6	71	47
Nevada†	112	203	380	9,494	8,848	3	2	5	90	NN	—	0	2	11	38
New Mexico†	43	209	1,183	9,834	9,755	—	0	4	44	NN	—	2	8	114	127
Utah	—	126	186	5,833	6,045	—	0	2	11	NN	—	0	5	38	68
Wyoming†	—	38	67	1,665	1,886	—	0	2	3	NN	—	0	5	23	28
Pacific	591	3,121	6,559	135,789	173,989	5	81	143	3,714	NN	1	11	29	496	624
Alaska	8	113	157	5,154	5,501	—	0	0	—	NN	—	0	3	14	6
California	131	2,242	5,763	94,107	133,407	5	81	143	3,707	NN	1	6	19	297	338
Hawaii	—	100	135	4,360	5,482	—	0	0	—	NN	—	0	0	—	1
Oregon	225	279	524	12,524	10,327	—	0	1	7	NN	—	2	8	116	203
Washington	227	436	672	19,644	19,272	—	0	0	—	NN	—	1	9	69	76
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	NN	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	NN	—	—	—	—	—
Guam	—	13	62	189	843	—	0	0	—	NN	—	0	0	—	—
Puerto Rico	57	104	349	4,836	5,552	—	0	0	—	NN	N	0	0	N	N
U.S. Virgin Islands	—	16	27	642	528	—	0	0	—	NN	—	0	0	—	—

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 26, 2011, and November 27, 2010 (47th week)*

Reporting area	Dengue Virus Infection†									
	Dengue Fever§					Dengue Hemorrhagic Fever¶				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max		
United States	—	3	16	186	671	—	0	1	2	10
New England	—	0	1	2	10	—	0	0	—	—
Connecticut	—	0	0	—	—	—	0	0	—	—
Maine**	—	0	1	—	6	—	0	0	—	—
Massachusetts	—	0	0	—	—	—	0	0	—	—
New Hampshire	—	0	0	—	—	—	0	0	—	—
Rhode Island**	—	0	0	—	1	—	0	0	—	—
Vermont**	—	0	1	2	3	—	0	0	—	—
Mid. Atlantic	—	1	6	55	219	—	0	0	—	5
New Jersey	—	0	0	—	29	—	0	0	—	—
New York (Upstate)	—	0	1	—	30	—	0	0	—	2
New York City	—	0	4	40	139	—	0	0	—	3
Pennsylvania	—	0	2	15	21	—	0	0	—	—
E.N. Central	—	0	2	12	66	—	0	1	1	1
Illinois	—	0	2	2	21	—	0	1	1	—
Indiana	—	0	1	2	14	—	0	0	—	—
Michigan	—	0	1	2	9	—	0	0	—	—
Ohio	—	0	1	2	16	—	0	0	—	—
Wisconsin	—	0	2	4	6	—	0	0	—	1
W.N. Central	—	0	2	11	32	—	0	0	—	1
Iowa	—	0	1	3	2	—	0	0	—	—
Kansas	—	0	1	1	4	—	0	0	—	—
Minnesota	—	0	1	5	14	—	0	0	—	—
Missouri	—	0	1	1	4	—	0	0	—	—
Nebraska**	—	0	0	—	7	—	0	0	—	—
North Dakota	—	0	1	1	1	—	0	0	—	—
South Dakota	—	0	0	—	—	—	0	0	—	1
S. Atlantic	—	1	8	72	233	—	0	1	1	2
Delaware	—	0	2	2	—	—	0	0	—	—
District of Columbia	—	0	0	—	—	—	0	0	—	—
Florida	—	1	7	52	185	—	0	0	—	2
Georgia	—	0	1	3	11	—	0	0	—	—
Maryland**	—	0	2	5	—	—	0	0	—	—
North Carolina	—	0	1	2	8	—	0	0	—	—
South Carolina**	—	0	1	1	13	—	0	0	—	—
Virginia**	—	0	1	7	14	—	0	1	1	—
West Virginia	—	0	0	—	2	—	0	0	—	—
E.S. Central	—	0	3	5	7	—	0	0	—	—
Alabama**	—	0	1	2	4	—	0	0	—	—
Kentucky	—	0	1	1	2	—	0	0	—	—
Mississippi	—	0	0	—	—	—	0	0	—	—
Tennessee**	—	0	2	2	1	—	0	0	—	—
W.S. Central	—	0	2	9	28	—	0	0	—	1
Arkansas**	—	0	0	—	—	—	0	0	—	1
Louisiana	—	0	1	3	4	—	0	0	—	—
Oklahoma	—	0	0	—	5	—	0	0	—	—
Texas**	—	0	1	6	19	—	0	0	—	—
Mountain	—	0	2	4	22	—	0	0	—	—
Arizona	—	0	2	2	10	—	0	0	—	—
Colorado	—	0	0	—	—	—	0	0	—	—
Idaho**	—	0	0	—	3	—	0	0	—	—
Montana**	—	0	0	—	4	—	0	0	—	—
Nevada**	—	0	1	1	4	—	0	0	—	—
New Mexico**	—	0	0	—	1	—	0	0	—	—
Utah	—	0	1	1	—	—	0	0	—	—
Wyoming**	—	0	0	—	—	—	0	0	—	—
Pacific	—	0	4	16	54	—	0	0	—	—
Alaska	—	0	0	—	1	—	0	0	—	—
California	—	0	2	5	36	—	0	0	—	—
Hawaii	—	0	4	5	—	—	0	0	—	—
Oregon	—	0	0	—	—	—	0	0	—	—
Washington	—	0	1	6	17	—	0	0	—	—
Territories										
American Samoa	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	26	80	1,233	10,436	—	0	3	19	236
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

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† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance).
§ Dengue Fever includes cases that meet criteria for Dengue Fever with hemorrhage, other clinical and unknown case classifications.
¶ DHF includes cases that meet criteria for dengue shock syndrome (DSS), a more severe form of DHF.
** Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 26, 2011, and November 27, 2010 (47th week)*

Reporting area	Ehrlichiosis/Anaplasmosis†														
	Ehrlichia chaffeensis					*Anaplasma phagocytophilum*					Undetermined				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	2	7	109	654	615	11	15	56	699	1,671	2	2	13	100	86
New England	—	0	1	4	7	2	2	27	238	104	—	0	1	1	2
Connecticut	—	0	0	—	—	—	0	5	—	32	—	0	0	—	—
Maine§	—	0	1	1	4	2	0	2	18	17	—	0	0	—	—
Massachusetts	—	0	0	—	—	—	1	18	160	—	—	0	0	—	—
New Hampshire	—	0	1	2	2	—	0	4	15	19	—	0	1	1	2
Rhode Island§	—	0	1	1	1	—	0	15	40	34	—	0	0	—	—
Vermont§	—	0	0	—	—	—	0	1	5	2	—	0	0	—	—
Mid. Atlantic	1	1	7	57	83	7	6	31	316	251	1	0	2	10	12
New Jersey	—	0	1	—	50	—	0	3	—	67	—	0	0	—	1
New York (Upstate)	1	0	7	46	26	7	3	27	267	172	1	0	2	10	8
New York City	—	0	2	11	5	—	0	5	45	11	—	0	0	—	—
Pennsylvania	—	0	0	—	2	—	0	1	4	1	—	0	0	—	3
E.N. Central	—	0	3	28	44	—	0	4	19	504	—	0	5	41	44
Illinois	—	0	2	18	16	—	0	2	9	9	—	0	1	2	3
Indiana	—	0	0	—	—	—	0	0	—	—	—	0	3	32	15
Michigan	—	0	2	4	2	—	0	0	—	4	—	0	2	5	—
Ohio	—	0	1	6	7	—	0	1	7	2	—	0	1	1	—
Wisconsin	—	0	1	—	19	—	0	4	3	489	—	0	1	1	26
W.N. Central	—	1	19	156	119	—	0	8	35	728	—	0	11	14	10
Iowa	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Kansas	—	0	1	3	6	—	0	1	2	1	—	0	0	—	—
Minnesota	—	0	12	—	—	—	0	4	1	715	—	0	11	—	—
Missouri	—	1	19	151	111	—	0	7	29	12	—	0	7	13	10
Nebraska§	—	0	1	1	2	—	0	1	1	—	—	0	1	1	—
North Dakota	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
South Dakota	—	0	1	1	—	—	0	1	2	—	—	0	0	—	—
S. Atlantic	1	2	33	230	244	2	1	8	65	58	1	0	2	13	6
Delaware	—	0	2	15	17	—	0	1	1	4	—	0	0	—	—
District of Columbia	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Florida	—	0	3	15	8	—	0	3	10	3	—	0	0	—	—
Georgia	—	0	3	18	20	1	0	2	9	1	1	0	1	2	1
Maryland§	—	0	3	28	21	—	0	2	7	14	—	0	1	1	2
North Carolina	—	0	17	59	96	—	0	6	20	24	—	0	0	—	—
South Carolina§	—	0	1	2	4	—	0	0	—	1	—	0	1	1	—
Virginia§	1	1	13	93	75	1	0	3	18	11	—	0	1	8	3
West Virginia	—	0	0	—	3	—	0	0	—	—	—	0	1	1	—
E.S. Central	—	1	8	71	87	—	0	2	15	20	—	0	3	14	9
Alabama§	—	0	2	4	11	—	0	1	4	7	N	0	0	N	N
Kentucky	—	0	3	13	16	—	0	0	—	—	—	0	0	—	1
Mississippi	—	0	1	3	3	—	0	1	1	2	—	0	0	—	1
Tennessee§	—	0	5	51	57	—	0	2	10	11	—	0	3	14	7
W.S. Central	—	0	87	108	30	—	0	9	8	6	—	0	0	—	1
Arkansas§	—	0	13	49	11	—	0	3	6	3	—	0	0	—	—
Louisiana	—	0	0	—	1	—	0	0	—	—	—	0	0	—	—
Oklahoma	—	0	82	57	15	—	0	7	2	2	—	0	0	—	—
Texas§	—	0	1	2	3	—	0	1	—	1	—	0	0	—	1
Mountain	—	0	0	—	—	—	0	0	—	—	—	0	1	5	—
Arizona	—	0	0	—	—	—	0	0	—	—	—	0	1	4	—
Colorado	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Idaho§	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Montana§	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Nevada§	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
New Mexico§	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Utah	—	0	0	—	—	—	0	0	—	—	—	0	1	1	—
Wyoming§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Pacific	—	0	1	—	1	—	0	1	3	—	—	0	1	2	2
Alaska	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
California	—	0	1	—	1	—	0	0	—	—	—	0	1	2	2
Hawaii	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Oregon	—	0	0	—	—	—	0	1	3	—	—	0	0	—	—
Washington	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Territories															
American Samoa	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
Puerto Rico	N	0	0	N	N	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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† Cumulative total *E. ewingii* cases reported for year 2011 = 13.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 26, 2011, and November 27, 2010 (47th week)*

Reporting area	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive† All ages, all serotypes				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	102	287	445	13,615	18,039	1,733	5,908	7,484	267,985	276,582	26	65	141	2,798	2,723
New England	7	28	65	1,422	1,534	91	107	206	4,915	4,969	—	4	12	201	170
Connecticut	1	4	9	207	268	39	45	150	2,104	2,164	—	1	5	50	40
Maine§	—	3	10	163	203	6	4	17	226	147	—	0	2	24	11
Massachusetts	4	14	29	677	663	46	47	80	2,137	2,204	—	2	6	99	87
New Hampshire	—	2	8	105	150	—	2	7	112	141	—	0	2	13	11
Rhode Island§	—	1	10	65	76	—	6	16	293	265	—	0	2	9	12
Vermont§	2	3	19	205	174	—	0	8	43	48	—	0	3	6	9
Mid. Atlantic	27	57	103	2,696	3,078	225	763	910	35,003	33,195	4	14	32	636	527
New Jersey	—	2	14	135	442	40	155	258	7,472	5,282	—	2	7	91	99
New York (Upstate)	17	20	72	1,065	1,068	102	114	271	5,250	5,188	1	3	18	160	140
New York City	3	16	29	773	857	1	244	333	10,646	11,179	—	3	7	151	88
Pennsylvania	7	16	29	723	711	82	251	362	11,635	11,546	3	5	11	234	200
E.N. Central	10	47	73	2,139	3,024	194	1,028	2,091	47,598	51,208	5	11	22	489	451
Illinois	—	9	19	389	644	1	278	362	12,181	14,195	—	3	10	132	158
Indiana	—	5	11	189	369	54	121	1,018	5,892	5,137	—	2	7	84	94
Michigan	2	10	20	462	643	91	241	499	11,392	12,369	1	1	4	64	32
Ohio	8	16	30	721	783	25	310	398	14,099	14,929	4	3	7	148	105
Wisconsin	—	8	17	378	585	23	91	119	4,034	4,578	—	1	5	61	62
W.N. Central	5	22	50	1,037	1,964	9	305	365	13,979	13,497	3	3	10	140	201
Iowa	1	4	15	250	269	9	36	53	1,725	1,623	—	0	1	2	1
Kansas	1	2	8	92	198	—	42	57	1,859	1,860	—	0	2	18	23
Minnesota	—	0	16	—	785	—	38	53	1,716	1,947	—	0	5	—	71
Missouri	1	8	23	394	390	—	149	187	6,858	6,401	—	1	5	79	76
Nebraska§	—	3	11	164	201	—	24	50	1,152	1,061	—	0	3	26	20
North Dakota	2	0	12	38	28	—	4	8	174	180	3	0	6	14	10
South Dakota	—	2	8	99	93	—	10	20	495	425	—	0	1	1	—
S. Atlantic	30	50	98	2,453	3,636	479	1,487	1,862	68,039	68,813	5	14	31	647	684
Delaware	1	0	3	31	31	5	16	31	724	899	—	0	2	4	5
District of Columbia	—	0	3	29	53	—	38	68	1,758	1,912	—	0	1	—	6
Florida	21	23	50	1,122	1,935	93	377	465	17,697	18,393	3	5	12	206	169
Georgia	—	11	51	631	750	122	311	874	13,999	13,796	—	2	7	115	152
Maryland§	7	5	13	271	245	57	118	246	5,211	6,451	1	2	5	83	61
North Carolina	N	0	0	N	N	—	323	548	14,938	12,850	1	1	7	71	115
South Carolina§	—	2	8	106	132	111	148	257	7,348	7,200	—	1	5	67	74
Virginia§	1	5	32	241	448	81	111	355	5,636	6,798	—	2	8	84	76
West Virginia	—	0	8	22	42	10	16	29	728	514	—	0	9	17	26
E.S. Central	1	3	9	157	206	254	518	1,007	23,822	22,540	3	3	11	170	161
Alabama§	1	3	9	157	206	153	162	408	8,182	7,083	—	1	4	47	26
Kentucky	N	0	0	N	N	64	76	712	4,032	3,405	1	0	4	23	34
Mississippi	N	0	0	N	N	—	117	197	4,903	5,568	—	0	3	18	13
Tennessee§	N	0	0	N	N	37	143	224	6,705	6,484	2	1	5	82	88
W.S. Central	—	5	15	234	372	276	922	1,319	42,821	44,558	4	2	26	129	123
Arkansas§	—	2	9	113	123	23	89	138	4,217	4,289	—	0	3	30	18
Louisiana	—	2	10	121	187	66	126	372	5,884	7,664	1	0	4	41	27
Oklahoma	—	0	0	—	62	1	94	384	4,748	3,917	3	1	19	57	70
Texas§	N	0	0	N	N	186	594	813	27,972	28,688	—	0	4	1	8
Mountain	11	24	43	1,201	1,645	98	207	273	9,828	8,578	2	5	12	232	272
Arizona	—	3	6	115	152	72	79	131	4,031	2,906	—	1	6	80	99
Colorado	10	11	25	579	657	—	41	89	1,992	2,516	2	1	5	58	76
Idaho§	1	3	9	137	197	4	2	15	125	106	—	0	2	19	17
Montana§	—	2	5	72	102	2	1	4	73	96	—	0	1	3	2
Nevada§	—	1	7	69	99	20	38	103	1,793	1,579	—	0	2	17	8
New Mexico§	—	1	6	84	98	—	33	98	1,553	1,053	—	1	4	37	37
Utah	—	3	9	124	289	—	4	10	222	289	—	0	3	17	27
Wyoming§	—	0	5	21	51	—	1	3	39	33	—	0	1	1	6
Pacific	11	48	128	2,276	2,580	107	497	791	21,980	29,224	—	3	9	154	134
Alaska	—	2	7	93	91	2	20	31	889	1,189	—	0	3	23	22
California	7	33	67	1,504	1,566	51	388	695	16,908	23,814	—	0	5	37	24
Hawaii	—	0	4	32	54	—	13	24	560	684	—	0	3	24	19
Oregon	4	7	20	319	450	35	27	58	1,300	943	—	1	6	67	62
Washington	—	7	57	328	419	19	50	79	2,323	2,594	—	0	2	3	7
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	3	—	0	8	6	91	—	0	0	—	—
Puerto Rico	—	1	4	38	87	12	6	14	302	290	—	0	0	—	1
U.S. Virgin Islands	—	0	0	—	—	—	2	10	113	125	—	0	0	—	—

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† Data for H. influenzae (age <5 yrs for serotype b, nonserotype b, and unknown serotype) are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 26, 2011, and November 27, 2010 (47th week)*

Reporting area	Hepatitis (viral, acute), by type														
	A					B					C				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	9	22	74	1,059	1,487	15	48	167	2,259	2,953	5	18	39	884	761
New England	—	1	5	65	91	—	1	8	70	52	—	1	5	45	51
Connecticut	—	0	3	17	27	—	0	4	10	20	—	0	3	25	34
Maine†	—	0	2	6	7	—	0	2	8	13	—	0	2	4	2
Massachusetts	—	0	3	31	47	—	1	6	50	12	—	0	2	11	13
New Hampshire	—	0	1	—	1	—	0	1	2	5	N	0	0	N	N
Rhode Island†	—	0	1	5	9	U	0	0	U	U	U	0	0	U	U
Vermont†	—	0	2	6	—	—	0	0	—	2	—	0	1	5	2
Mid. Atlantic	—	4	8	185	257	2	5	12	250	257	1	1	5	84	99
New Jersey	—	1	3	29	71	—	1	4	57	72	—	0	2	4	27
New York (Upstate)	—	1	4	44	53	1	1	9	47	45	1	1	4	48	44
New York City	—	1	5	61	82	—	1	5	73	75	—	0	2	2	3
Pennsylvania	—	1	3	51	51	1	2	4	73	65	—	0	4	30	25
E.N. Central	1	3	8	165	192	—	6	37	300	439	—	3	11	159	89
Illinois	—	1	4	50	45	—	1	6	59	119	—	0	2	6	1
Indiana	—	0	3	12	11	—	1	3	51	68	—	1	5	55	27
Michigan	—	1	6	61	70	—	1	6	74	113	—	2	6	90	43
Ohio	1	1	3	36	45	—	1	30	89	89	—	0	1	6	8
Wisconsin	—	0	1	6	21	—	0	3	27	50	—	0	1	2	10
W.N. Central	1	1	25	38	72	1	2	16	118	107	—	0	6	8	20
Iowa	—	0	1	7	11	—	0	1	10	13	—	0	0	—	—
Kansas	—	0	2	3	11	—	0	2	11	10	—	0	1	3	2
Minnesota	—	0	22	9	15	—	0	15	9	8	—	0	6	2	10
Missouri	1	0	1	12	20	1	2	5	75	62	—	0	0	—	6
Nebraska†	—	0	1	5	14	—	0	3	12	12	—	0	1	3	2
North Dakota	—	0	3	—	—	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	2	2	1	—	0	1	1	2	—	0	0	—	—
S. Atlantic	5	4	12	215	315	8	12	56	615	810	4	4	11	211	173
Delaware	—	0	1	2	7	—	0	2	11	24	U	0	0	U	U
District of Columbia	—	0	0	—	1	—	0	0	—	3	—	0	0	—	2
Florida	4	1	7	75	129	4	4	7	182	274	—	1	3	52	53
Georgia	1	1	5	44	35	—	2	8	103	148	—	1	3	33	30
Maryland†	—	0	4	24	21	—	1	4	50	64	—	0	3	30	21
North Carolina	—	0	3	25	43	—	2	12	99	93	4	1	7	54	37
South Carolina†	—	0	2	10	25	—	1	3	31	55	—	0	1	1	1
Virginia†	—	1	3	27	46	—	1	6	60	87	—	0	3	16	12
West Virginia	—	0	5	8	8	4	0	43	79	62	—	0	6	25	17
E.S. Central	1	0	6	44	42	4	9	14	401	339	—	4	8	164	152
Alabama†	—	0	2	7	6	1	2	6	104	61	—	0	3	16	6
Kentucky	—	0	2	9	22	2	2	6	101	123	—	2	7	76	102
Mississippi	—	0	1	7	2	—	1	3	42	31	U	0	0	U	U
Tennessee†	1	0	5	21	12	1	4	8	154	124	—	1	5	72	44
W.S. Central	1	3	15	119	132	—	6	67	274	522	—	2	11	79	61
Arkansas†	—	0	0	—	2	—	1	4	43	58	—	0	0	—	1
Louisiana	—	0	2	4	11	—	1	4	28	47	—	0	2	5	3
Oklahoma	—	0	4	3	2	—	1	16	80	90	—	1	10	44	26
Texas†	1	2	11	112	117	—	3	45	123	327	—	0	3	30	31
Mountain	—	1	5	55	136	—	1	4	67	126	—	1	4	55	57
Arizona	—	0	2	16	58	—	0	3	15	24	U	0	0	U	U
Colorado	—	0	2	18	34	—	0	2	15	42	—	0	3	17	16
Idaho†	—	0	1	6	7	—	0	1	2	6	—	0	2	10	9
Montana†	—	0	1	2	4	—	0	0	—	—	—	0	1	3	2
Nevada†	—	0	3	5	14	—	0	3	23	38	—	0	2	10	7
New Mexico†	—	0	1	5	5	—	0	2	7	5	—	0	2	12	13
Utah	—	0	2	1	10	—	0	1	5	8	—	0	1	1	10
Wyoming†	—	0	1	2	4	—	0	0	—	3	—	0	1	2	—
Pacific	—	3	13	173	250	—	3	25	164	301	—	2	12	79	59
Alaska	—	0	1	2	3	—	0	1	4	4	U	0	0	U	U
California	—	3	12	131	206	—	2	22	101	211	—	1	4	37	26
Hawaii	—	0	2	8	7	—	0	1	6	6	U	0	0	U	U
Oregon	—	0	2	8	16	—	0	4	29	38	—	0	3	12	14
Washington	—	0	4	24	18	—	0	4	24	42	—	0	5	30	19
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	5	8	7	—	2	8	28	71	—	0	4	10	57
Puerto Rico	—	0	2	7	17	—	0	2	8	25	N	0	0	N	N
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 November 26, 2011, and November 27, 2010 (47th week)*

Reporting area	Legionellosis					Lyme disease					Malaria				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	37	54	166	3,484	3,053	182	383	1,952	29,436	28,744	5	26	114	1,231	1,554
New England	5	4	39	367	249	4	73	475	6,184	8,586	—	2	20	81	97
Connecticut	—	1	10	72	47	—	29	226	2,436	2,950	—	0	20	10	2
Maine†	—	0	2	17	11	—	14	66	863	648	—	0	2	6	5
Massachusetts	5	3	24	223	119	—	20	106	1,345	3,212	—	1	6	54	68
New Hampshire	—	0	3	20	22	—	9	77	846	1,264	—	0	1	2	4
Rhode Island†	—	0	7	24	41	3	1	31	131	177	—	0	1	3	15
Vermont†	—	0	2	11	9	1	6	67	563	335	—	0	1	6	3
Mid. Atlantic	13	15	82	1,168	862	158	209	1,211	18,373	10,345	—	7	12	300	482
New Jersey	—	2	16	166	142	36	85	591	7,974	3,553	—	0	6	8	99
New York (Upstate)	11	5	27	352	264	46	37	214	3,451	2,440	—	1	4	48	70
New York City	—	3	14	190	154	—	1	16	107	690	—	4	10	191	257
Pennsylvania	2	5	37	460	302	76	69	509	6,841	3,662	—	1	5	53	56
E.N. Central	4	12	51	754	635	—	15	132	1,379	3,759	—	3	10	142	153
Illinois	—	2	11	117	142	—	1	18	160	135	—	1	5	53	57
Indiana	1	2	6	102	55	—	1	15	99	78	—	0	2	9	15
Michigan	—	3	15	181	166	—	1	13	104	92	—	0	4	29	29
Ohio	3	5	34	353	213	—	1	9	45	29	—	1	4	39	38
Wisconsin	—	0	2	1	59	—	13	91	971	3,425	—	0	2	12	14
W.N. Central	—	1	8	77	116	—	1	13	124	2,072	—	1	45	34	66
Iowa	—	0	2	11	15	—	0	11	79	85	—	0	3	21	13
Kansas	—	0	2	10	11	—	0	2	12	10	—	0	2	8	11
Minnesota	—	0	4	—	35	—	0	10	—	1,946	—	0	45	—	3
Missouri	—	1	5	46	33	—	0	0	—	4	—	0	1	—	20
Nebraska†	—	0	1	6	9	—	0	2	8	8	—	0	1	4	15
North Dakota	—	0	1	2	4	—	0	10	21	18	—	0	1	—	1
South Dakota	—	0	1	2	9	—	0	2	4	1	—	0	1	1	3
S. Atlantic	10	10	29	512	509	19	50	172	3,140	3,634	2	8	24	404	416
Delaware	—	0	4	21	15	—	12	48	769	620	—	0	3	7	2
District of Columbia	—	0	3	9	17	—	0	3	29	40	—	0	1	5	11
Florida	4	4	13	171	155	3	2	7	109	77	—	2	7	93	121
Georgia	—	1	3	33	59	—	0	5	24	10	1	1	5	73	67
Maryland†	—	1	14	116	107	12	17	113	1,145	1,569	1	2	14	118	95
North Carolina	3	1	7	62	57	—	0	12	66	73	—	0	6	35	49
South Carolina†	—	0	5	20	14	—	0	6	33	29	—	0	1	5	5
Virginia†	3	1	6	74	71	4	15	76	888	1,096	—	1	8	68	63
West Virginia	—	0	2	6	14	—	0	14	77	120	—	0	0	—	3
E.S. Central	—	2	10	139	128	—	1	5	53	42	—	0	4	31	30
Alabama†	—	0	2	24	19	—	0	2	17	2	—	0	3	6	9
Kentucky	—	0	3	32	27	—	0	1	2	5	—	0	1	7	7
Mississippi	—	0	3	13	12	—	0	1	3	—	—	0	1	1	2
Tennessee†	—	1	8	70	70	—	0	3	31	35	—	0	3	17	12
W.S. Central	1	2	13	122	159	—	1	29	44	105	—	0	18	28	90
Arkansas†	—	0	2	13	18	—	0	0	—	—	—	0	1	5	4
Louisiana	—	0	3	15	10	—	0	1	1	3	—	0	1	1	5
Oklahoma	—	0	3	9	13	—	0	0	—	—	—	0	1	5	5
Texas†	1	2	11	85	118	—	1	29	43	102	—	0	17	17	76
Mountain	—	2	8	94	159	—	0	4	35	27	1	1	4	59	58
Arizona	—	1	4	36	61	—	0	2	10	2	—	0	4	22	23
Colorado	—	0	1	6	29	—	0	1	1	3	1	0	3	21	20
Idaho†	—	0	1	8	6	—	0	2	4	9	—	0	1	2	3
Montana†	—	0	1	1	4	—	0	3	9	4	—	0	1	2	2
Nevada†	—	0	2	14	19	—	0	1	4	1	—	0	2	8	6
New Mexico†	—	0	2	10	9	—	0	2	5	5	—	0	1	3	1
Utah	—	0	2	15	23	—	0	1	1	3	—	0	1	1	3
Wyoming†	—	0	2	4	8	—	0	1	1	—	—	0	0	—	—
Pacific	4	5	21	251	236	1	2	11	104	174	2	3	11	152	162
Alaska	—	0	0	—	2	—	0	2	11	7	—	0	2	5	4
California	4	4	15	210	193	1	1	9	68	115	2	2	8	104	107
Hawaii	—	0	1	2	2	N	0	0	N	N	—	0	1	7	4
Oregon	—	0	3	19	15	—	0	2	12	39	—	0	4	15	14
Washington	—	0	6	20	24	—	0	6	13	13	—	0	3	21	33
Territories															
American Samoa	N	0	0	N	N	N	0	0	N	N	—	0	1	1	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	1	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	1	—	1	N	0	0	N	N	—	0	0	—	5
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 November 26, 2011, and November 27, 2010 (47th week)*

Reporting area	Meningococcal disease, invasive† All serogroups					Mumps					Pertussis				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	2	13	53	607	716	—	7	47	302	2,517	87	278	2,925	12,852	21,801
New England	—	0	3	28	19	—	0	2	11	25	—	12	30	602	483
Connecticut	—	0	1	3	3	—	0	0	—	11	—	1	5	54	104
Maine§	—	0	1	5	4	—	0	2	2	2	—	2	19	185	44
Massachusetts	—	0	2	14	6	—	0	1	4	9	—	4	10	207	260
New Hampshire	—	0	1	1	—	—	0	0	—	3	—	2	9	107	20
Rhode Island§	—	0	0	—	1	—	0	2	4	—	—	0	4	24	38
Vermont§	—	0	3	5	5	—	0	1	1	—	—	0	4	25	17
Mid. Atlantic	—	1	6	69	73	—	1	23	34	2,108	14	30	125	1,469	1,524
New Jersey	—	0	1	5	20	—	0	2	10	349	—	3	10	155	154
New York (Upstate)	—	0	4	21	11	—	0	3	11	663	6	13	81	641	490
New York City	—	0	3	26	18	—	0	22	10	1,039	—	0	36	74	78
Pennsylvania	—	0	2	17	24	—	0	8	3	57	8	12	67	599	802
E.N. Central	1	2	6	91	123	—	2	7	80	69	25	61	198	2,729	5,033
Illinois	—	0	3	26	22	—	1	5	54	26	—	16	46	743	919
Indiana	—	0	2	18	27	—	0	0	—	4	—	4	23	214	685
Michigan	—	0	2	11	22	—	0	2	10	18	3	12	43	596	1,386
Ohio	1	0	2	23	31	—	0	5	13	17	22	13	80	678	1,546
Wisconsin	—	0	2	13	21	—	0	1	3	4	—	11	24	498	497
W.N. Central	1	1	4	47	51	—	0	4	32	81	17	21	501	1,073	2,232
Iowa	—	0	1	12	10	—	0	1	5	38	—	4	22	170	642
Kansas	—	0	1	2	6	—	0	1	4	4	—	2	10	102	164
Minnesota	—	0	2	—	6	—	0	4	1	4	—	0	469	326	648
Missouri	—	0	3	18	22	—	0	3	12	10	7	7	37	344	498
Nebraska§	1	0	2	11	5	—	0	1	6	23	—	1	7	51	201
North Dakota	—	0	1	1	2	—	0	3	4	—	10	0	10	51	50
South Dakota	—	0	1	3	—	—	0	0	—	2	—	0	7	29	29
S. Atlantic	—	2	8	118	125	—	0	4	32	55	9	27	106	1,240	1,676
Delaware	—	0	1	1	1	—	0	0	—	—	—	0	5	22	14
District of Columbia	—	0	1	1	1	—	0	0	—	3	—	0	2	3	12
Florida	—	1	5	46	56	—	0	2	8	8	2	6	17	291	288
Georgia	—	0	1	14	12	—	0	2	5	5	1	3	8	155	229
Maryland§	—	0	1	11	9	—	0	1	1	11	2	1	7	91	126
North Carolina	—	0	3	13	13	—	0	2	9	9	—	2	35	158	316
South Carolina§	—	0	1	9	12	—	0	0	—	4	—	2	25	133	334
Virginia§	—	0	2	16	19	—	0	4	9	13	4	7	41	327	243
West Virginia	—	0	3	7	2	—	0	0	—	2	—	0	41	60	114
E.S. Central	—	0	2	21	40	—	0	1	4	10	2	7	28	330	750
Alabama§	—	0	2	9	7	—	0	1	1	6	—	2	11	124	190
Kentucky	—	0	2	2	17	—	0	0	—	1	—	1	16	74	255
Mississippi	—	0	1	3	5	—	0	1	3	—	—	0	5	37	98
Tennessee§	—	0	2	7	11	—	0	0	—	3	2	2	10	95	207
W.S. Central	—	1	12	53	83	—	1	15	61	111	1	21	297	837	2,722
Arkansas§	—	0	2	11	6	—	0	2	3	5	—	1	16	54	195
Louisiana	—	0	2	11	14	—	0	0	—	8	—	0	3	17	43
Oklahoma	—	0	2	10	15	—	0	2	4	—	—	0	92	52	66
Texas§	—	0	10	21	48	—	1	14	54	98	1	18	187	714	2,418
Mountain	—	1	4	43	50	—	0	2	7	18	18	38	100	1,781	1,568
Arizona	—	0	1	11	13	—	0	0	—	5	2	13	29	622	446
Colorado	—	0	1	9	19	—	0	1	3	7	2	9	63	379	371
Idaho§	—	0	1	5	5	—	0	1	1	1	5	2	11	146	182
Montana§	—	0	2	4	1	—	0	0	—	—	—	2	32	130	84
Nevada§	—	0	1	4	8	—	0	0	—	1	—	0	5	30	32
New Mexico§	—	0	1	2	3	—	0	2	2	—	9	3	22	238	133
Utah	—	0	2	8	1	—	0	0	—	3	—	5	16	227	308
Wyoming§	—	0	1	—	—	—	0	1	1	1	—	0	1	9	12
Pacific	—	3	26	137	152	—	0	11	41	40	1	60	1,710	2,791	5,813
Alaska	—	0	1	2	1	—	0	1	1	1	—	0	4	25	39
California	—	2	17	96	99	—	0	11	33	26	—	43	1,569	1,850	5,058
Hawaii	—	0	1	4	1	—	0	1	2	4	1	1	9	78	62
Oregon	—	0	3	21	30	—	0	1	4	3	—	5	23	281	258
Washington	—	0	8	14	21	—	0	1	1	6	—	11	131	557	396
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	1	3	12	482	—	1	14	31	3
Puerto Rico	—	0	0	—	2	—	0	1	1	1	—	0	1	2	4
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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† Data for meningococcal disease, invasive caused by serogroups A, C, Y, and W-135; serogroup B; other serogroup; and unknown serogroup are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 26, 2011, and November 27, 2010 (47th week)*

Reporting area	Rabies, animal					Salmonellosis					Shiga toxin-producing *E. coli* (STEC)†				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	10	58	119	2,755	4,026	312	860	1,848	42,775	49,768	34	88	264	4,596	4,867
New England	2	4	16	232	287	5	34	107	1,934	2,216	—	3	13	193	204
Connecticut	—	2	10	110	134	—	8	30	425	491	—	1	4	48	60
Maine§	—	1	6	59	58	—	2	8	117	119	—	0	3	28	20
Massachusetts	—	0	0	—	—	4	20	45	1,001	1,215	—	1	9	75	79
New Hampshire	—	0	3	17	16	—	3	8	148	162	—	0	3	23	21
Rhode Island§	1	0	6	22	29	1	1	62	170	154	—	0	2	4	3
Vermont§	1	0	2	24	50	—	1	8	73	75	—	0	3	15	21
Mid. Atlantic	2	16	35	793	988	24	86	205	4,868	5,491	5	11	36	562	528
New Jersey	—	0	0	—	—	—	15	48	825	1,132	—	2	7	109	117
New York (Upstate)	2	7	20	344	468	20	26	67	1,301	1,329	4	3	12	192	185
New York City	—	0	3	9	144	—	19	42	1,043	1,245	—	1	6	86	71
Pennsylvania	—	8	21	440	376	4	32	111	1,699	1,785	1	3	18	175	155
E.N. Central	—	2	17	175	226	16	86	157	4,053	5,454	5	12	48	790	763
Illinois	—	0	6	49	114	—	30	80	1,462	1,842	—	3	14	180	146
Indiana	—	0	7	26	—	—	7	19	350	716	—	2	8	86	132
Michigan	—	1	6	56	66	4	13	42	762	876	—	3	19	167	141
Ohio	—	1	5	44	46	12	22	46	1,125	1,217	5	3	10	174	132
Wisconsin	N	0	0	N	N	—	7	45	354	803	—	2	20	183	212
W.N. Central	1	1	40	76	239	17	41	103	2,162	2,796	4	12	39	714	849
Iowa	—	0	1	—	26	1	9	19	415	505	—	2	15	179	168
Kansas	—	0	4	30	59	—	8	28	426	412	—	2	8	100	71
Minnesota	—	0	34	—	25	—	0	16	—	668	—	0	7	—	274
Missouri	—	0	1	—	63	10	17	46	902	751	3	5	32	281	216
Nebraska§	1	0	3	33	50	2	4	13	229	236	—	2	7	94	71
North Dakota	—	0	6	13	16	4	0	15	41	49	1	0	4	13	17
South Dakota	—	0	0	—	—	—	3	10	149	175	—	1	4	47	32
S. Atlantic	2	17	93	990	1,063	161	278	721	13,260	14,612	4	12	27	590	666
Delaware	—	0	0	—	—	—	3	11	163	166	—	0	2	15	6
District of Columbia	—	0	0	—	—	—	1	5	47	88	—	0	1	3	9
Florida	—	0	84	108	121	96	107	203	5,329	5,792	3	3	15	134	202
Georgia	—	0	0	—	—	5	41	127	2,259	2,664	—	2	8	109	96
Maryland§	—	5	13	247	349	8	19	42	879	991	—	1	6	53	95
North Carolina	—	0	0	—	—	43	30	251	2,062	2,124	—	2	11	104	86
South Carolina§	N	0	0	N	N	4	29	70	1,411	1,568	—	0	4	15	22
Virginia§	—	12	27	555	519	5	22	68	1,065	1,056	1	3	9	154	127
West Virginia	2	0	30	80	74	—	0	14	45	163	—	0	4	3	23
E.S. Central	—	3	11	164	166	6	57	187	3,727	3,698	1	4	17	235	261
Alabama§	—	1	7	75	69	4	17	70	1,131	988	—	1	15	75	52
Kentucky	—	0	2	16	21	1	9	20	433	539	—	1	5	42	68
Mississippi	—	0	1	1	—	—	19	66	1,237	1,158	—	0	4	20	30
Tennessee§	—	1	6	72	76	1	16	51	926	1,013	1	1	11	98	111
W.S. Central	3	1	31	107	793	37	134	515	5,892	6,774	1	7	151	369	334
Arkansas§	3	0	10	52	33	16	13	53	802	739	—	1	6	55	47
Louisiana	—	0	0	—	—	1	14	44	896	1,278	—	0	1	10	20
Oklahoma	—	0	21	55	41	9	11	95	671	629	—	1	55	63	41
Texas§	—	0	15	—	719	11	85	381	3,523	4,128	1	5	95	241	226
Mountain	—	0	4	39	66	13	44	92	2,227	2,706	6	9	26	516	640
Arizona	N	0	0	N	N	2	14	33	695	934	1	1	7	79	93
Colorado	—	0	0	—	—	6	10	24	503	533	3	2	7	103	214
Idaho§	—	0	1	6	11	—	3	8	135	153	1	2	8	113	98
Montana§	N	0	0	N	N	—	2	10	121	89	1	0	5	38	39
Nevada§	—	0	2	16	8	5	3	8	152	284	—	1	7	39	38
New Mexico§	—	0	2	10	13	—	5	22	290	321	—	1	3	39	47
Utah	—	0	2	7	10	—	5	15	278	334	—	1	7	80	92
Wyoming§	—	0	0	—	24	—	1	9	53	58	—	0	7	25	19
Pacific	—	3	15	179	198	33	100	288	4,652	6,021	8	13	46	627	622
Alaska	—	0	2	12	12	—	1	6	48	79	1	0	1	4	2
California	—	3	11	153	169	29	74	232	3,564	4,470	5	7	36	381	286
Hawaii	—	0	0	—	—	3	7	14	311	307	1	0	1	7	28
Oregon	—	0	1	14	17	1	5	12	235	490	1	1	11	94	109
Washington	—	0	14	—	—	—	11	42	494	675	—	2	13	141	197
Territories															
American Samoa	N	0	0	N	N	—	0	0	—	2	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	3	6	11	—	0	0	—	—
Puerto Rico	—	0	6	34	40	—	4	16	188	568	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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† Includes E. coli O157:H7; Shiga toxin-positive, serogroup non-O157; 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 November 26, 2011, and November 27, 2010 (47th week)*

Reporting area	Shigellosis					Spotted Fever Rickettsiosis (including RMSF)†									
						Confirmed					Probable				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	137	245	742	10,383	12,959	1	3	15	190	133	3	27	245	1,855	1,505
New England	1	4	20	248	311	—	0	1	1	—	1	0	1	8	5
Connecticut	—	0	4	36	69	—	0	0	—	—	—	0	0	—	—
Maine§	—	0	8	29	8	—	0	0	—	—	1	0	0	1	2
Massachusetts	1	3	19	166	207	—	0	0	—	—	—	0	1	4	—
New Hampshire	—	0	1	3	14	—	0	1	1	—	—	0	1	1	1
Rhode Island§	—	0	4	8	12	—	0	0	—	—	—	0	1	2	2
Vermont§	—	0	1	6	1	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	17	16	74	895	1,512	—	0	2	17	2	—	1	4	54	99
New Jersey	—	3	16	172	353	—	0	0	—	1	—	0	1	—	59
New York (Upstate)	17	4	20	282	211	—	0	1	3	1	—	0	1	7	15
New York City	—	5	24	329	286	—	0	0	—	—	—	0	3	29	11
Pennsylvania	—	3	56	112	662	—	0	2	14	—	—	0	3	18	14
E.N. Central	3	15	40	695	1,458	—	0	2	9	3	—	2	8	108	77
Illinois	—	5	16	204	803	—	0	1	2	2	—	1	4	44	34
Indiana§	—	1	4	45	59	—	0	1	2	1	—	0	4	46	20
Michigan	1	3	10	161	238	—	0	1	2	—	—	0	1	1	1
Ohio	2	4	27	285	286	—	0	2	3	—	—	0	2	17	15
Wisconsin	—	0	4	—	72	—	0	0	—	—	—	0	1	—	7
W.N. Central	6	6	22	282	1,990	—	0	4	27	13	—	4	29	340	272
Iowa	—	0	4	19	49	—	0	0	—	—	—	0	2	5	5
Kansas§	1	1	7	58	278	—	0	0	—	—	—	0	0	—	—
Minnesota	—	0	2	—	62	—	0	0	—	—	—	0	2	—	—
Missouri	5	4	17	186	1,539	—	0	3	19	10	—	4	29	330	264
Nebraska§	—	0	2	14	55	—	0	3	5	3	—	0	1	5	2
North Dakota	—	0	0	—	—	—	0	1	2	—	—	0	0	—	1
South Dakota	—	0	2	5	7	—	0	1	1	—	—	0	0	—	—
S. Atlantic	71	70	134	3,442	2,473	1	1	8	101	80	1	6	55	519	470
Delaware§	—	0	2	6	38	—	0	1	1	1	—	0	4	18	20
District of Columbia	—	0	2	12	31	—	0	1	1	1	—	0	1	2	—
Florida§	60	48	98	2,415	1,037	—	0	1	3	3	—	0	2	12	10
Georgia	4	11	24	529	730	—	0	6	63	57	—	0	0	—	—
Maryland§	—	2	7	92	123	—	0	1	3	—	—	0	2	29	49
North Carolina	7	3	19	190	217	—	0	4	14	13	—	0	49	249	240
South Carolina§	—	1	51	101	67	—	0	2	12	1	—	0	2	21	18
Virginia§	—	2	8	93	128	1	0	1	4	4	1	3	14	184	133
West Virginia	—	0	66	4	102	—	0	0	—	—	—	0	1	4	—
E.S. Central	10	14	42	656	719	—	0	2	10	20	1	4	24	319	397
Alabama§	7	5	21	253	207	—	0	1	4	5	1	1	8	70	77
Kentucky	—	0	6	38	213	—	0	1	1	6	—	0	0	—	—
Mississippi	—	3	23	199	52	—	0	0	—	1	—	0	2	12	23
Tennessee§	3	4	11	166	247	—	0	2	5	8	—	3	18	237	297
W.S. Central	24	52	503	2,453	2,596	—	0	8	11	6	—	2	235	462	171
Arkansas§	—	2	7	73	70	—	0	3	6	2	—	0	50	393	117
Louisiana	—	4	21	250	268	—	0	0	—	—	—	0	2	7	2
Oklahoma	5	2	161	178	249	—	0	5	3	3	—	0	202	43	26
Texas§	19	40	338	1,952	2,009	—	0	1	2	1	—	0	5	19	26
Mountain	3	15	42	749	785	—	0	5	13	3	—	0	6	45	13
Arizona	1	5	27	346	432	—	0	4	12	1	—	0	6	29	1
Colorado§	2	1	8	92	90	—	0	1	—	—	—	0	1	2	1
Idaho§	—	0	3	16	23	—	0	1	1	—	—	0	1	1	5
Montana§	—	1	15	121	7	—	0	0	—	2	—	0	1	1	1
Nevada§	—	0	4	31	47	—	0	0	—	—	—	0	1	2	—
New Mexico§	—	2	7	97	142	—	0	0	—	—	—	0	1	1	1
Utah	—	1	4	44	44	—	0	0	—	—	—	0	1	1	3
Wyoming§	—	0	1	2	—	—	0	0	—	—	—	0	2	8	1
Pacific	2	21	63	963	1,115	—	0	2	1	6	—	0	0	—	1
Alaska	—	0	2	5	2	N	0	0	N	N	N	0	0	N	N
California	2	17	59	797	910	—	0	1	1	6	—	0	0	—	—
Hawaii	—	1	3	42	43	N	0	0	N	N	N	0	0	N	N
Oregon	—	1	4	40	57	—	0	0	—	—	—	0	0	—	1
Washington	—	1	6	79	103	—	0	1	—	—	—	0	0	—	—
Territories															
American Samoa	—	0	1	1	4	N	0	0	N	N	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	1	5	N	0	0	N	N	N	0	0	N	N
Puerto Rico	—	0	1	—	6	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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† Illnesses with similar clinical presentation that result from Spotted fever group rickettsia infections are reported as Spotted fever rickettsioses. Rocky Mountain spotted fever (RMSF) caused by Rickettsia rickettsii, is the most common and well-known spotted fever.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 26, 2011, and November 27, 2010 (47th week)*

Reporting area	*Streptococcus pneumoniae*,† invasive disease										Syphilis, primary and secondary				
	All ages					Age <5									
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	131	271	937	11,875	13,720	12	26	118	1,083	1,894	48	261	363	11,514	12,405
New England	1	14	79	652	766	—	1	5	42	94	2	7	16	332	438
Connecticut	—	6	49	282	312	—	0	3	10	26	—	1	5	41	86
Maine§	1	2	13	115	104	—	0	1	4	9	—	0	2	12	29
Massachusetts	—	0	4	32	62	—	0	2	15	42	2	4	10	216	267
New Hampshire	—	2	8	87	113	—	0	1	5	5	—	0	3	17	22
Rhode Island§	—	2	8	73	102	—	0	1	2	7	—	0	7	38	32
Vermont§	—	1	6	63	73	—	0	2	6	5	—	0	2	8	2
Mid. Atlantic	5	26	81	1,195	1,443	—	2	27	97	213	2	29	53	1,357	1,562
New Jersey	—	13	35	546	644	—	0	4	33	54	—	4	13	197	220
New York (Upstate)	1	1	10	74	136	—	1	9	40	103	2	3	20	163	120
New York City	4	12	42	575	663	—	0	14	24	56	—	14	31	688	887
Pennsylvania	N	0	0	N	N	N	0	0	N	N	—	6	14	309	335
E.N. Central	36	61	114	2,652	2,836	2	5	13	209	337	4	30	48	1,354	1,731
Illinois	N	0	0	N	N	—	1	6	65	90	2	12	24	557	830
Indiana	—	15	33	588	664	—	0	4	28	50	1	3	8	143	162
Michigan	3	14	29	586	646	—	1	3	29	76	—	5	12	233	217
Ohio	32	26	45	1,100	1,068	2	2	7	72	89	1	8	21	371	475
Wisconsin	1	8	24	378	458	—	0	3	15	32	—	1	5	50	47
W.N. Central	12	2	33	161	772	2	1	4	63	148	—	6	13	262	331
Iowa	N	0	0	N	N	N	0	0	N	N	—	0	3	17	18
Kansas	N	0	0	N	N	N	0	0	N	N	—	0	4	24	18
Minnesota	—	0	17	—	584	—	0	3	—	81	—	2	8	103	138
Missouri	N	0	0	N	N	1	0	4	36	39	—	2	6	109	142
Nebraska§	2	2	9	107	121	—	0	2	12	15	—	0	2	8	9
North Dakota	10	0	25	54	67	1	0	1	2	2	—	0	1	1	2
South Dakota	N	0	0	N	N	—	0	2	13	11	—	0	0	—	4
S. Atlantic	37	66	170	3,283	3,676	7	6	25	294	508	20	67	178	3,044	2,873
Delaware	—	1	6	41	38	—	0	1	—	—	—	0	4	18	4
District of Columbia	—	1	4	43	70	—	0	1	5	8	—	3	8	139	124
Florida	22	23	68	1,191	1,300	4	3	13	118	175	2	24	36	1,067	1,075
Georgia	6	20	54	877	1,243	1	2	5	69	151	5	14	130	679	617
Maryland§	5	10	33	483	473	1	1	3	35	51	1	8	20	390	286
North Carolina	N	0	0	N	N	N	0	0	N	N	4	8	19	346	365
South Carolina§	4	8	25	393	438	1	0	3	27	50	3	4	11	205	134
Virginia§	N	0	0	N	N	—	0	3	26	51	5	4	12	198	262
West Virginia	—	0	48	255	114	—	0	6	14	22	—	0	1	2	6
E.S. Central	10	17	36	781	941	—	1	4	63	107	—	15	34	674	796
Alabama§	N	0	0	N	N	N	0	0	N	N	—	4	11	196	225
Kentucky	N	0	0	N	N	N	0	0	N	N	—	2	16	105	119
Mississippi	N	0	0	N	N	—	0	2	11	17	—	3	14	163	198
Tennessee§	10	17	36	781	941	—	1	4	52	90	—	5	11	210	254
W.S. Central	22	30	368	1,586	1,656	1	4	38	183	264	6	36	50	1,640	1,920
Arkansas§	5	3	26	196	154	1	0	3	13	17	—	3	10	169	198
Louisiana	—	2	11	138	119	—	0	2	14	25	—	6	25	338	506
Oklahoma	N	0	0	N	N	—	1	8	32	42	1	2	8	87	84
Texas§	17	24	333	1,252	1,383	—	2	27	124	180	5	23	33	1,046	1,132
Mountain	8	29	72	1,426	1,529	—	3	8	117	206	2	11	20	506	558
Arizona	4	12	45	664	697	—	1	5	53	90	—	5	10	210	206
Colorado	4	9	23	459	478	—	0	4	33	60	—	2	6	96	132
Idaho§	N	0	0	N	N	—	0	1	4	8	—	0	4	11	2
Montana§	N	0	0	N	N	N	0	0	N	N	—	0	1	4	3
Nevada§	N	0	0	N	N	N	0	0	N	N	2	2	9	120	109
New Mexico§	—	4	13	209	143	—	0	2	15	16	—	1	4	56	47
Utah	—	1	8	74	198	—	0	3	12	29	—	0	2	9	59
Wyoming§	—	0	15	20	13	—	0	1	—	3	—	0	0	—	—
Pacific	—	3	11	139	101	—	0	2	15	17	12	54	73	2,345	2,196
Alaska	—	2	11	133	101	—	0	1	11	17	—	0	1	1	3
California	N	0	0	N	N	N	0	0	N	N	5	42	60	1,906	1,858
Hawaii	—	0	3	6	—	—	0	1	4	—	—	0	2	11	35
Oregon	N	0	0	N	N	N	0	0	N	N	—	3	13	165	62
Washington	N	0	0	N	N	N	0	0	N	N	7	5	11	262	238
Territories															
American Samoa	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—	4	4	14	215	205
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 reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/osels/ph_surveillance/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Includes drug resistant and susceptible cases of invasive Streptococcus pneumoniae disease among children <5 years and among all ages. Case definition: Isolation of S. pneumoniae from a normally sterile body site (e.g., blood or cerebrospinal fluid).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 26, 2011, and November 27, 2010 (47th week)*

Reporting area	Varicella (chickenpox)					West Nile virus disease†									
						Neuroinvasive					Nonneuroinvasive§				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	104	267	367	11,810	13,883	—	0	59	452	627	—	0	28	206	392
New England	5	23	50	1,109	1,062	—	0	3	14	14	—	0	1	2	5
Connecticut	4	5	16	251	307	—	0	2	8	7	—	0	1	1	4
Maine¶	—	4	11	201	216	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	9	18	429	242	—	0	2	4	6	—	0	1	1	1
New Hampshire	—	2	7	102	149	—	0	0	—	1	—	0	0	—	—
Rhode Island¶	—	0	6	33	45	—	0	1	1	—	—	0	0	—	—
Vermont¶	1	1	10	93	103	—	0	1	1	—	—	0	0	—	—
Mid. Atlantic	22	42	78	2,229	1,560	—	0	11	34	123	—	0	6	22	63
New Jersey	12	21	68	1,329	539	—	0	1	2	15	—	0	2	5	15
New York (Upstate)	N	0	0	N	N	—	0	5	18	56	—	0	4	14	30
New York City	—	0	0	—	—	—	0	4	9	33	—	0	1	2	9
Pennsylvania	10	20	40	900	1,021	—	0	2	5	19	—	0	1	1	9
E.N. Central	43	64	115	2,688	4,478	—	0	13	72	80	—	0	5	26	30
Illinois	—	15	31	657	1,120	—	0	6	22	45	—	0	4	11	16
Indiana¶	8	4	18	226	324	—	0	2	7	6	—	0	1	2	7
Michigan	12	19	41	884	1,331	—	0	7	32	25	—	0	1	1	4
Ohio	23	21	58	919	1,234	—	0	3	10	4	—	0	3	11	1
Wisconsin	—	0	15	2	469	—	0	1	1	—	—	0	1	1	2
W.N. Central	—	7	42	374	883	—	0	9	30	32	—	0	7	28	75
Iowa	N	0	0	N	N	—	0	2	5	5	—	0	2	4	4
Kansas¶	—	2	15	97	339	—	0	1	4	4	—	0	0	—	15
Minnesota	—	0	1	1	—	—	0	1	1	4	—	0	1	1	4
Missouri	—	3	24	182	427	—	0	2	5	3	—	0	2	4	—
Nebraska¶	—	0	4	7	21	—	0	4	14	10	—	0	3	14	29
North Dakota	—	0	10	36	39	—	0	1	1	2	—	0	1	3	7
South Dakota	—	1	6	51	57	—	0	0	—	4	—	0	1	2	16
S. Atlantic	10	33	64	1,574	1,969	—	0	10	51	38	—	0	4	18	22
Delaware¶	—	0	3	6	39	—	0	1	1	—	—	0	0	—	—
District of Columbia	—	0	2	12	19	—	0	1	3	3	—	0	1	1	3
Florida¶	9	16	38	785	905	—	0	5	19	9	—	0	2	2	3
Georgia	N	0	0	N	N	—	0	2	7	4	—	0	1	5	9
Maryland¶	N	0	0	N	N	—	0	5	10	17	—	0	3	10	6
North Carolina	N	0	0	N	N	—	0	1	2	—	—	0	0	—	—
South Carolina¶	—	0	9	12	77	—	0	0	—	1	—	0	0	—	—
Virginia¶	1	7	25	391	508	—	0	2	8	4	—	0	0	—	1
West Virginia	—	6	32	368	421	—	0	1	1	—	—	0	0	—	—
E.S. Central	2	5	15	239	279	—	0	11	54	8	—	0	5	25	10
Alabama¶	2	5	14	227	271	—	0	2	5	1	—	0	0	—	2
Kentucky	N	0	0	N	N	—	0	2	4	2	—	0	1	1	1
Mississippi	—	0	3	12	8	—	0	5	29	3	—	0	4	22	5
Tennessee¶	N	0	0	N	N	—	0	3	16	2	—	0	1	2	2
W.S. Central	16	50	258	2,476	2,563	—	0	4	26	102	—	0	3	11	20
Arkansas¶	2	4	20	263	179	—	0	1	1	6	—	0	0	—	1
Louisiana	—	1	6	71	82	—	0	2	6	18	—	0	2	4	7
Oklahoma	N	0	0	N	N	—	0	0	—	1	—	0	0	—	—
Texas¶	14	44	247	2,142	2,302	—	0	3	19	77	—	0	3	7	12
Mountain	6	17	65	1,009	980	—	0	10	64	157	—	0	4	30	127
Arizona	—	4	50	409	—	—	0	6	42	107	—	0	3	16	60
Colorado¶	6	4	31	250	370	—	0	2	2	26	—	0	2	5	55
Idaho¶	N	0	0	N	N	—	0	1	1	—	—	0	1	1	1
Montana¶	—	2	28	127	182	—	0	1	1	—	—	0	0	—	—
Nevada¶	N	0	0	N	N	—	0	4	12	—	—	0	2	4	2
New Mexico¶	—	1	4	38	92	—	0	1	4	21	—	0	0	—	4
Utah	—	3	26	177	316	—	0	1	1	1	—	0	1	2	1
Wyoming¶	—	0	1	8	20	—	0	1	1	2	—	0	1	2	4
Pacific	—	2	9	112	109	—	0	17	107	73	—	0	7	44	40
Alaska	—	1	4	59	41	—	0	0	—	—	—	0	0	—	—
California	—	0	4	13	34	—	0	17	107	72	—	0	7	44	39
Hawaii	—	1	4	40	34	—	0	0	—	—	—	0	0	—	—
Oregon	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
Washington	N	0	0	N	N	—	0	0	—	1	—	0	0	—	1
Territories															
American Samoa	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	1	4	16	25	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	4	14	174	584	—	0	0	—	—	—	0	0	—	—
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 reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/osels/ph_surveillance/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for California serogroup, eastern equine, Powassan, St. Louis, and western equine diseases are available in Table I.
§ Not reportable in all states. Data from states where the condition is not reportable are excluded from this table, except starting in 2007 for the domestic arboviral diseases and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/osels/ph_surveillance/nndss/phs/infdis.htm.
¶ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE III. Deaths in 122 U.S. cities,* week ending November 26, 2011 (47th week)

Reporting area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
New England	398	283	71	24	13	7	41
Boston, MA	113	70	27	8	6	2	16
Bridgeport, CT	18	14	3	1	—	—	2
Cambridge, MA	11	9	1	1	—	—	2
Fall River, MA	15	14	1	—	—	—	1
Hartford, CT	40	31	5	2	2	—	4
Lowell, MA	25	16	5	2	1	1	—
Lynn, MA	8	6	—	2	—	—	—
New Bedford, MA	10	8	2	—	—	—	—
New Haven, CT	U	U	U	U	U	U	U
Providence, RI	48	38	5	3	2	—	—
Somerville, MA	1	1	—	—	—	—	—
Springfield, MA	42	22	13	3	1	3	2
Waterbury, CT	21	16	4	1	—	—	4
Worcester, MA	46	38	5	1	1	1	10
Mid. Atlantic	1,885	1,297	415	112	23	37	95
Albany, NY	46	30	9	4	1	2	1
Allentown, PA	21	16	5	—	—	—	—
Buffalo, NY	86	62	16	3	—	5	8
Camden, NJ	31	17	4	5	2	3	2
Elizabeth, NJ	14	9	3	2	—	—	2
Erie, PA	33	25	5	2	—	1	—
Jersey City, NJ	23	19	4	—	—	—	5
New York City, NY	918	661	192	46	7	12	43
Newark, NJ	18	14	4	—	—	—	2
Paterson, NJ	9	5	4	—	—	—	—
Philadelphia, PA	391	223	116	38	8	6	12
Pittsburgh, PA§	42	26	9	4	—	3	1
Reading, PA	32	23	5	2	—	1	4
Rochester, NY	56	39	10	2	3	2	2
Schenectady, NY	15	14	1	—	—	—	1
Scranton, PA	23	19	4	—	—	—	2
Syracuse, NY	84	62	18	1	2	1	6
Trenton, NJ	17	12	1	3	—	1	—
Utica, NY	16	12	4	—	—	—	3
Yonkers, NY	10	9	1	—	—	—	1
E.N. Central	1,640	1,115	374	75	29	47	94
Akron, OH	34	24	6	2	—	2	5
Canton, OH	45	31	12	1	1	—	5
Chicago, IL	296	187	82	13	8	6	6
Cincinnati, OH	63	47	6	4	1	5	3
Cleveland, OH	214	146	52	8	3	5	17
Columbus, OH	149	98	35	8	1	7	8
Dayton, OH	80	52	22	2	1	3	1
Detroit, MI	86	46	30	7	2	1	4
Evansville, IN	33	22	8	1	—	2	—
Fort Wayne, IN	67	51	13	2	—	1	4
Gary, IN	9	9	—	—	—	—	3
Grand Rapids, MI	58	37	14	3	—	4	3
Indianapolis, IN	163	113	30	8	6	6	14
Lansing, MI	25	18	6	—	1	—	3
Milwaukee, WI	57	36	11	4	3	3	1
Peoria, IL	45	34	8	2	1	—	1
Rockford, IL	42	29	10	2	1	—	4
South Bend, IN	39	32	5	—	—	2	3
Toledo, OH	82	56	18	8	—	—	1
Youngstown, OH	53	47	6	—	—	—	8
W.N. Central	437	279	111	25	15	7	27
Des Moines, IA	71	50	13	5	2	1	2
Duluth, MN	30	21	9	—	—	—	1
Kansas City, KS	22	9	9	1	3	—	—
Kansas City, MO	54	32	15	4	2	1	4
Lincoln, NE	28	20	5	2	1	—	—
Minneapolis, MN	39	17	15	3	2	2	2
Omaha, NE	78	52	19	4	1	2	16
St. Louis, MO	26	14	4	4	3	1	1
St. Paul, MN	35	25	9	—	1	—	—
Wichita, KS	54	39	13	2	—	—	1
S. Atlantic	717	428	206	46	22	15	43
Atlanta, GA	70	41	23	4	1	1	3
Baltimore, MD	124	69	39	13	1	2	11
Charlotte, NC	87	52	30	3	1	1	6
Jacksonville, FL	9	5	4	—	—	—	—
Miami, FL	72	46	14	4	6	2	1
Norfolk, VA	40	27	10	2	1	—	2
Richmond, VA	40	27	8	3	2	—	1
Savannah, GA	43	25	16	2	—	—	3
St. Petersburg, FL	33	13	13	3	1	3	2
Tampa, FL	113	75	24	5	6	3	6
Washington, D.C.	77	41	25	5	3	3	6
Wilmington, DE	9	7	—	2	—	—	2
E.S. Central	603	397	154	30	14	8	46
Birmingham, AL	108	69	27	6	5	1	14
Chattanooga, TN	63	42	16	3	—	2	3
Knoxville, TN	77	45	21	9	1	1	4
Lexington, KY	66	43	18	3	2	—	2
Memphis, TN	98	64	22	8	4	—	9
Mobile, AL	55	44	11	—	—	—	7
Montgomery, AL	34	24	9	—	—	1	4
Nashville, TN	102	66	30	1	2	3	3
W.S. Central	646	422	149	55	9	11	41
Austin, TX	61	38	15	5	3	—	6
Baton Rouge, LA	31	18	10	3	—	—	—
Corpus Christi, TX	41	28	11	2	—	—	—
Dallas, TX	114	62	37	9	2	4	8
El Paso, TX	40	25	10	4	—	1	—
Fort Worth, TX	U	U	U	U	U	U	U
Houston, TX	90	64	11	13	—	2	7
Little Rock, AR	U	U	U	U	U	U	U
New Orleans, LA	U	U	U	U	U	U	U
San Antonio, TX	171	117	36	10	4	4	17
Shreveport, LA	U	U	U	U	U	U	U
Tulsa, OK	98	70	19	9	—	—	3
Mountain	956	618	215	84	19	19	57
Albuquerque, NM	72	57	11	2	1	1	3
Boise, ID	57	44	11	1	1	—	4
Colorado Springs, CO	46	34	7	4	1	—	3
Denver, CO	85	43	28	10	2	2	5
Las Vegas, NV	340	210	85	32	8	5	30
Ogden, UT	22	12	6	4	—	—	—
Phoenix, AZ	101	58	25	8	2	8	1
Pueblo, CO	30	17	11	2	—	—	1
Salt Lake City, UT	97	67	15	8	4	3	6
Tucson, AZ	106	76	16	13	—	—	4
Pacific	1,130	793	236	66	10	15	92
Berkeley, CA	5	4	1	—	—	—	—
Fresno, CA	83	61	16	4	2	—	7
Glendale, CA	28	25	3	—	—	—	2
Honolulu, HI	62	51	8	2	1	—	8
Long Beach, CA	42	30	9	1	1	1	9
Los Angeles, CA	184	114	47	13	1	9	20
Pasadena, CA	19	15	4	—	—	—	—
Portland, OR	113	65	24	14	1	—	7
Sacramento, CA	145	106	21	11	3	3	9
San Diego, CA	11	8	2	1	—	—	1
San Francisco, CA	82	60	16	4	1	1	6
San Jose, CA	120	86	30	4	—	—	8
Santa Cruz, CA	19	17	—	2	—	—	4
Seattle, WA	89	63	18	7	—	1	3
Spokane, WA	44	32	10	2	—	—	3
Tacoma, WA	84	56	27	1	—	—	5
Total¶	**8,412**	**5,632**	**1,931**	**517**	**154**	**166**	**536**

U: Unavailable. —: No reported cases.

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

† Pneumonia and influenza.

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

¶ Total includes unknown ages.

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