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Iron Deficiency — United States, 1999–2000

Iron deficiency, the most common nutritional deficiency worldwide, has negative effects on work capacity and on motor and mental development in infants, children, and adolescents, and maternal iron deficiency anemia might cause low birthweight and preterm delivery (*1*–*3*). Although iron deficiency is more common in developing countries, a significant prevalence was observed in the United States during the early 1990s among certain populations, such as toddlers and females of childbearing age (*4*). One of the national health objectives for 2010 is to reduce iron deficiency in these vulnerable populations by 3–4 percentage points (objective no. 19-12) (*5*). CDC has published recommendations to prevent iron deficiency in the United States (*6*). To characterize the iron status of persons in the United States, CDC calculated the prevalence of iron deficiency and iron deficiency anemia by applying a multiple-indicator model to data from the 1999–2000 National Health and Nutrition Examination Survey (NHANES 1999–2000). These values were compared with those observed in the third National Health and Nutrition Examination Survey (NHANES III [1988–1994]) using the same multiple-indicator model. This report summarizes the results of this analysis, which indicate that iron deficiency remains 2–5 percentage points above the 2010 national health objectives. To prevent iron deficiency, vulnerable populations should be encouraged to eat iron-rich foods and breast-feed or use iron-fortified formula for infants.

Both NHANES surveys sampled the U.S. civilian, noninstitutionalized population and collected data through household interviews and physical examinations. In both surveys, blood was collected by venipuncture from all persons aged ≥1 year. Four biochemical measures of iron status were included in the analysis: hemoglobin, serum ferritin, transferrin saturation, and free erythrocyte protoporphyrin. Hemoglobin was measured in mobile examination centers in both surveys as part of a complete blood count by using an automated electronic counter: Coulter S-Plus Jr in NHANES III and Coulter MAXM in NHANES 1999–2000 (Coulter Electronics, Hialeah, Florida). In both surveys, the remaining three iron indicators were measured at CDC by using the same assay methods and comparable quality-control materials. Serum ferritin was measured with the Bio-Rad QuantImune Ferritin IRMA™ (Bio-Rad Laboratories, Hercules, California); transferrin saturation was calculated from serum iron and total iron-binding capacity, which were measured by a modification of the automated AAII-25 colorimetric method; and free erythrocyte protoporphyrin was measured by a modification of the Sassa method (*7*). Because abnormal values for these iron status indicators might be caused by inflammatory conditions rather than by poor iron status (*8*), a serum indicator of inflammation (C-reactive protein) also was used. This indicator was measured on participants aged ≥3 years by latex-enhanced nephelometry at the University of Washington (*7*).

The definition of iron deficiency was an abnormal value for at least two of the following three indicators: serum ferritin, transferrin saturation, and free erythrocyte protoporphyrin. Persons with iron deficiency and a low hemoglobin value were considered to have iron deficiency anemia (*4*). The same threshold values to define abnormality for the four iron

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indicators were applied to both surveys. These thresholds were derived from NHANES III (*4*).

The estimated prevalence of iron deficiency was greatest among toddlers aged 1–2 years (7%) and adolescent and adult females aged 12–49 years (9%–16%) (Table 1). The prevalence of iron deficiency was approximately two times higher among non-Hispanic black and Mexican-American females (19%–22%) than among non-Hispanic white females (10%). Excluding persons aged ≥3 years with elevated C-reactive protein levels (>1 mg/dL) from the analysis did not change prevalence estimates.

The prevalence of iron deficiency was similar in NHANES III and NHANES 1999–2000 in most age and sex groups (Table 1). Exceptions included males aged 12–69 years and women aged 50–69 years; in these groups, the prevalence was substantially higher in NHANES 1999–2000 than in NHANES III as determined by a t-test (Table 1).

The prevalence of iron deficiency anemia was examined for the populations in which iron deficiency was most common in NHANES 1999–2000 (Table 2). In these groups, the prevalence was <5%, which is similar to that observed in NHANES III (Table 2).

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Editorial Note: Data from NHANES 1999–2000 indicate that iron deficiency anemia is uncommon in the United States, but iron deficiency remains above the 2010 objectives of 5%, 1%, and 7% for toddlers, preschool children, and females aged 12–49 years, respectively (*5*). Among minority females aged 12–49 years, the prevalence of iron deficiency was approximately three times greater than the 2010 national health objectives. Multiple factors, including dietary intake, parity, and socioeconomic status (*4,6*), might explain the continued prevalence of iron deficiency in these groups. These factors were not included in this assessment of iron status.

The findings in this report are subject to at least two limitations. First, because abnormal values for iron status indicators might reflect inflammation rather than poor iron status (*8*), confounding by inflammation might have affected results in some age groups. The confounding could not be addressed in toddlers because data on inflammation in this age group were not available. The confounding might have been only partially addressed in middle-aged and older adults because C-reactive protein is less sensitive for detecting chronic inflammatory conditions common in older persons than it is

TABLE 1. Prevalence of iron deficiency — United States, National Health and Nutrition Examination surveys, 1988–1994 and 1999–2000*

Sex/Age group (yrs)	1988–1994 No.	%	(95% CI†)	1999–2000 No.	%	(95% CI)
Both sexes						
1– 2	1,339	9	(6 –11)	319	7	(3 –11)
3– 5	2,334	3	(2 – 4)	363	5	(2 – 7)
6–11	2,813	2	(1 – 3)	882	4	(1 – 7)
Males						
12–15	691	1§¶	(0.1 – 2)	547	5¶	(2 – 8)
16–69	6,635	1¶	(0.6 – 1)	2,084	2¶	(1 – 3)
≥70	1,437	4	(2 – 3)	381	3§	(2 – 7)
Females**						
12–49	5,982	11	(10 –12)	1,950	12	(10 –14)
12–15	*786*	*9*	*(6 –12)*	*535*	*9*	*(5 –12)*
16–19	*700*	*11*	*(7 –14)*	*466*	*16*	*(10 –22)*
20–49	*4,495*	*11*	*(10 –13)*	*949*	*12*	*(10 –16)*
White, non-Hispanic	*1,827*	*8*	*(7 – 9)*	*573*	*10*	*(7 –13)*
Black, non-Hispanic	*2,021*	*15*	*(13 –17)*	*498*	*19*	*(14 –24)*
Mexican American	*1,845*	*19*	*(17 –21)*	*709*	*22*	*(17 –27)*
50–69	2,034	5¶	(4 – 7)	611	9¶	(5 –12)
≥70	1,630	7	(5 – 8)	394	6	(4 – 9)

* All racial/ethnic groups except where noted.
† Confidence interval.
§ Unreliable; relative standard error (i.e., standard error/prevalence estimate) is >30%.
¶ p<0.05 for comparison between surveys within age and sex category.
** Nonpregnant only.

TABLE 2. Prevalence of iron deficiency anemia in selected populations — United States, National Health and Nutrition Examination surveys, 1988–1994 and 1999–2000*

Sex/Age group (yrs)	1988–1994 No.	%	(95% CI†)	1999–2000 No.	%	(95% CI)
Both sexes						
1–2	1,339	3	(2–4)	319	2§	(0 –4)
Females¶						
12–49	5,982	4	(3–5)	1,950	3	(2 –4)
12–19	*1,486*	*2*	*(1–3)*	*1,001*	*2*	*(1 –3)*
20–49	*4,495*	*5*	*(4–6)*	*949*	*4*	*(2 –5)*
50–69	2,034	2	(1–3)	611	3§	(0.5 –5)
≥70	1,630	2	(1–3)	394	1§	(0 –2)

* All racial/ethnic groups.
† Confidence interval.
§ Unreliable; relative standard error (i.e., standard error/prevalence estimate) is >30%.
¶ Nonpregnant only.

in detecting inflammation from acute infections (*9*). Second, insufficient sample size also might have limited the ability to detect trends in iron deficiency over time. Data from the Pediatric Nutrition Surveillance System (PNSS) indicated that anemia continued to decline among toddlers in low-income households during the 1990s (*10*). Anemia is not always caused by iron deficiency, but the PNSS data suggest progress in improving iron status among children. However, the prevalence of iron deficiency did not differ substantially between the two NHANES surveys among toddlers, adolescents, or females aged 12–49 years, possibly because of limited study power resulting from the smaller sample size in NHANES 1999–2000. For example, power calculations revealed that a sample size of approximately 1,300 would be needed in each survey to demonstrate that the difference in prevalence among females aged 16–19 years (11% versus 16%) was statistically significant. Thus, additional years of data will be needed to ascertain whether progress has been made in achieving the 2010 national health objectives for reducing iron deficiency in vulnerable populations.

Many of the adverse consequences of iron deficiency are associated with its most severe form, iron deficiency anemia (*1,3*). However, iron deficiency without anemia has been linked to negative impacts on cognitive development in children and adolescents (*2*). Continued monitoring of iron status of the U.S. population is warranted because the prevalence of iron deficiency in vulnerable populations exceeds the 2010 national health objectives.

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Usual Sources of Cigarettes for Middle and High School Students — Texas, 1998–1999

Persons often begin smoking when they are minors (aged <18 years) (*1,2*), and easy access to cigarettes might contribute to this behavior (*3*). Laws and regulations were in place in Texas during 1998–1999 to reduce minors' access to cigarettes by 1) prohibiting the sale and distribution of tobacco products to minors; 2) imposing fines against retailers caught selling cigarettes to minors; 3) prohibiting minors from purchasing, possessing, or using tobacco products; 4) limiting vending machines to adult-only locations; and 5) requiring tobacco retailers to ask for proof of identification from anyone attempting to purchase tobacco who appeared to be aged <27 years (*4*). To measure progress in reducing access to cigarettes among middle and high school students in Texas, CDC analyzed self-reported data from the 1998 and 1999 Texas Youth Tobacco Survey (TYTS). This report summarizes the results of that survey, which indicate that during 1998–1999, reported access to cigarettes from stores and vending machines (commercial sources) decreased among middle school students from 13.2% to 5.3% and from 7.6% to 1.7%, respectively, but access from noncommercial and other sources (e.g., stealing cigarettes and "getting them some other way") increased from 8.3% to 12.3% and from 16.6% to 23.3%, respectively. Among high school students, most sources did not change. Educating retailers and actively enforcing laws governing youth access to tobacco as part of a comprehensive tobacco-control approach are required to reduce youth access to cigarettes.

The Texas Department of Health conducted the statewide TYTS in spring 1998 and spring 1999. TYTS uses a two-stage cluster sample design to produce representative samples of public middle and high school students in Texas. The first-stage sampling included all public schools containing any grades 6–12. The probability of a school being selected depended on its enrollment size. A total of 214 schools were sampled in 1998 and 276 in 1999. At the second stage of sampling, second-period classes were selected randomly, and all students in these classes were eligible to participate. The overall response rate* was 71.2% in 1998 and 61.0% in 1999. School participation rates decreased from a combined (middle and high school) response rate of 84.6% in 1998 to 73% for middle schools and 69.1% for high schools in 1999. Students completed an anonymous, self-administered questionnaire that included questions on demographics, cigarette-smoking status, and sources of tobacco products. Students who reported having smoked during the 30 days preceding the survey were asked, "During the past 30 days, how did you usually get your own cigarettes?" Data were weighted to provide estimates that could be generalized to all public school students in grades 6–12 in the state. SUDAAN 7 was used to calculate standard errors for determining 95% confidence intervals (CIs).

During 1998–1999, the percentage of middle school students who smoked during the preceding 30 days and who reported buying cigarettes from a store decreased from 13.2% (95% CI=±1.0) to 5.3% (95% CI=±1.0), and the percentage of those who reported buying from vending machines decreased from 7.6% (95% CI=±1.0) to 1.7% (95% CI=±0.4) (Table). A significant increase was reported among those who reported stealing cigarettes (8.3% [95% CI=±0.9] in 1998 and 12.3% [95% CI=±1.9] in 1999) or getting them in "some other way" (16.6% [95% CI=±1.2] in 1998 versus 23.3% [95% CI=±2.4] in 1999). Among high school students, no significant change was observed during 1998–1999 in the percentage who bought cigarettes from a store (33.0% [95% CI=±1.7] in 1998 and 31.1% [95% CI=±1.6] in 1999). A small but statistically significant decrease was observed in the percentage who reported buying cigarettes from vending

TABLE. Sources of cigarettes for public middle and high school students who smoked during the 30 days preceding the survey, by category and year — Texas Youth Tobacco Survey, 1998 and 1999

	Middle school students		High school students	
Category	%	(95% CI*)	%	(95% CI)
Bought in a store				
1998	13.2	(±1.0)	33.0	(±1.7)
1999	5.3	(±1.0)	31.1	(±1.6)
Bought in a vending machine				
1998	7.6	(±1.0)	1.8	(±0.4)
1999	1.7	(±0.4)	1.0	(±0.3)
Someone else bought for them				
1998	19.5	(±1.2)	23.8	(±1.1)
1999	17.8	(±1.7)	22.3	(±1.3)
Borrowed from someone else				
1998	23.7	(±1.4)	21.4	(±1.3)
1999	26.7	(±2.5)	22.6	(±1.2)
Stole them				
1998	8.3	(±0.9)	3.8	(±0.6)
1999	12.3	(±1.9)	3.3	(±0.5)
Older person gave it to them				
1998	11.1	(±1.0)	8.0	(±0.8)
1999	12.9	(±1.6)	10.5	(±1.3)
Got them some other way				
1998	16.6	(±1.2)	8.3	(±0.8)
1999	23.3	(±2.4)	9.2	(±1.1)

* Confidence interval.

* Derived by multiplying the number of schools participating divided by the number of schools sampled by the number of completed surveys divided by the total number of students who would have been surveyed if all had participated.

machines (1.8% [95% CI=±0.4] versus 1.0% [95% CI=±0.3]) in 1999. A small but statistically significant increase also was observed in the percentage who reported that "an older person" gave them cigarettes (8.0% [95% CI=±0.8] in 1998 and 10.5% [95% CI=±1.3] in 1999).

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Editorial Note: The findings in this report document a decrease in access to cigarettes from stores for middle school students in Texas and a decrease in access to cigarettes from vending machines for both middle and high school students. However, the percentages of middle school students who reported stealing cigarettes or getting them "in some other way" increased. The percentage of high school students who reported getting cigarettes from an older person also increased. These findings suggest an increase in the use of alternative sources for acquiring cigarettes (e.g., stealing or getting them from other adolescents, parents, and older friends) (*5*).

The findings in this report are subject to at least three limitations. First, these data apply only to youth who attend public schools in Texas and might not be representative of all persons in this age group. The average dropout rate for Texas middle and high school students during school years 1997–98 and 1998–99 was 16%, and approximately 10% of middle and high school students are enrolled in private schools (*6–8*). Second, the decline in school participation rates could have affected the validity of the 1998-1999 comparisons if the nonrespondents in 1999 differed from the respondents. However, given the size of some of the changes in access patterns, it is unlikely that the decrease in response rates would account for all of the changes observed. Finally, a substantial proportion of middle school students responded that they obtained tobacco products "in some other way." Future surveys should include an open-ended category to learn how students obtained tobacco products.

Studies designed to determine if reducing illegal cigarette sales to minors can reduce youth smoking prevalence suggest that substantial decreases (to as low as 3%) in illegal sales will be needed to decrease youth smoking prevalence (*9*). In Texas, the illegal sale rate to minors decreased from 24.0% in 1998 to 13.0% in 1999; a reduction in cigarette smoking prevalence for those years among middle school students (20.0% to 14.8%) also was observed, but not among high school students (33.0% and 32.7%, respectively). However, it is impossible to know if the reduction in smoking prevalence among middle school students is linked directly to reductions in self-reported access to cigarettes in stores or from vending machines.

To reduce youth access to cigarettes, stricter policies prohibiting the sale of tobacco to minors are needed, and retailer and community education should be intensified. In addition, a comprehensive approach to prevent both minors and adults from using tobacco should include 1) local community programs, 2) evidence-based school programs, 3) tobacco counter marketing, 4) tobacco-use cessation programs, and 5) surveillance and evaluation systems to monitor progress in reducing the use of tobacco (*10*).

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Public Health Dispatch

Vancomycin-Resistant *Staphylococcus aureus* — Pennsylvania, 2002

Staphylococcus aureus is one of the most common causes of hospital- and community-acquired infections (*1,2*). Since the recognition of vancomycin-resistant enterococci in 1988, the emergence of vancomycin-resistant *S. aureus* (VRSA) (minimum inhibitory concentration [MIC] ≥32 µg/mL [*3*]) has been anticipated. The transfer of the genetic element containing the *vanA* vancomycin resistance gene from *Enterococcus faecalis* to *S. aureus* was demonstrated in the laboratory in 1992 (*4*); the first clinical infection with VRSA was reported in July 2002 (*5*). This report describes the second documented clinical isolate of VRSA from a patient.

On September 20, the patient was admitted to a hospital in Pennsylvania and evaluated for a chronic foot ulcer and possible osteomyelitis. A culture of the ulcer grew *S. aureus.* This isolate was tested for antimicrobial susceptibility by disk diffusion; a vancomycin-agar screen plate (brain heart infusion agar containing 6 µg/mL vancomycin) also was inoculated. Growth on the vancomycin screen plate and a 12 mm zone of inhibition around the vancomycin disk suggested that the isolate had decreased susceptibility to vancomycin. Further testing by Etest® confirmed that the isolate was resistant to vancomycin (MIC=64 µg/mL). Following notification of the Pennsylvania Department of Health (PDH), the isolate was forwarded to CDC, where it was confirmed to be VRSA (vancomycin MIC=32 µg/mL by broth microdilution testing). The isolate contained both the *mecA* and *vanA* genes mediating oxacillin and vancomycin resistance, respectively. The isolate was susceptible to chloramphenicol, linezolid, minocycline, quinupristin-dalfopristin, rifampin, and trimethoprim-sulfamethoxazole.

The patient has been discharged from the hospital and is responding to antimicrobial treatment. The patient is receiving home-health care. PDH and CDC are assisting health-care providers investigating this case of VRSA. The goals of this investigation include assessment of infection-control practices in the hospital and home setting and the possibility of transmission of the organism to other patients, health-care providers, and family or social contacts. Previous investigations of VRSA and vancomycin-intermediate *S. aureus* in the home setting demonstrated no transmission among family or home health-care contacts (*5,6*).

The presence of *vanA* in this VRSA suggests that the resistance determinate was acquired from a vancomycin-resistant enterococcus. Development of this VRSA appears to be unrelated to the previous VRSA identified in Michigan (*5*). However, because both were probably the result of conjugation events, additional VRSA infections are likely to occur. Therefore, clinical microbiology laboratories must ensure that they are using susceptibility testing methods that will detect VRSA and that they are saving potential VRSA for confirmatory testing. In addition, more systematic surveillance for VRSA will enhance the ability of the public health system and the health-care system to rapidly address this resistant pathogen.

The public health response to this VRSA occurrence is ongoing. Using proper infection-control practices and good antimicrobial agent management will help limit the emergence and spread of antimicrobial-resistant microorganisms, including VRSA. CDC recommends contact precautions when caring for patients with these infections, including placing the patient in a private room, wearing gloves and a gown during patient contact, washing hands after contact with the patient and infectious body tissues or fluids, and not sharing patient-care items with other patients. CDC guidelines for preventing spread of VRSA are available at http://www.cdc.gov/ncidod/hip/10_20.pdf.

The isolation of *S. aureus* with confirmed or "presumptive" vancomycin resistance should be saved and reported through state and local health departments to CDC's Division of Healthcare Quality Promotion, National Center for Infectious Diseases, telephone 800-893-0485.

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West Nile Virus Activity — United States, October 3–9, 2002

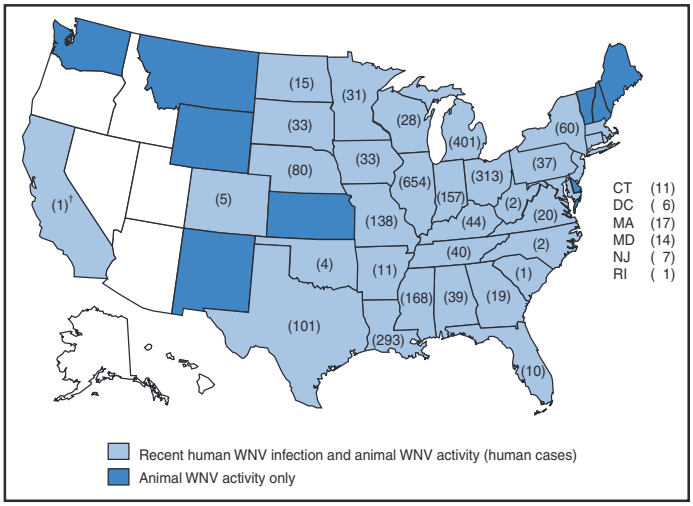
This report summarizes West Nile virus (WNV) surveillance data reported to CDC through ArboNET and by states and other jurisdictions as of 8 a.m. Mountain Daylight Time, October 9, 2002.

During the reporting period of October 3–9, a total of 266 laboratory-positive human cases of WNV-associated illness were reported from Michigan (n=58), Illinois (n=55), Ohio (n=25), Pennsylvania (n=11), Alabama (n=nine), New York (n=nine), South Dakota (n=nine), Tennessee (n=nine), Texas (n=nine), Wisconsin (n=nine), Iowa (n=eight), Massachusetts (n=seven), Missouri (n=seven), Louisiana (n=six), Minnesota (n=five), Mississippi (n=five), Connecticut (n=four), Kentucky (n=four), Maryland (n=four), Virginia (n=four), Colorado (n=two), Florida (n=two), West Virginia (n=two), New Jersey (n=one), North Carolina (n=one), and Rhode Island (n=one). During this period, West Virginia and Rhode Island reported their first human WNV cases ever. Also during this time period, WNV infections were reported in 438 dead crows and 298 other dead birds. A total of 915 veterinary cases (all equine) were reported. During the same period, 136 WNV-positive mosquito pools were reported.

During 2002, a total of 2,796 human cases with laboratory evidence of recent WNV infection have been reported from Illinois (n=654), Michigan (n=401), Ohio (n=313), Louisiana (n=293), Mississippi (n=168), Indiana (n=157), Missouri (n=138), Texas (n=101), Nebraska (n=80), New York (n=60), Kentucky (n=44), Tennessee (n=40), Alabama (n=39), Pennsylvania (n=37), Iowa (n=33), South Dakota (n=33), Minnesota (n=31), Wisconsin (n=28), Virginia (n=20), Georgia (n=19), Massachusetts (n=17), North Dakota (n=15), Maryland (n=14), Arkansas (n=11), Connecticut (n=11), Florida (n=10), New Jersey (n=seven), the District of Columbia (n=six), Colorado (n=five), Oklahoma (n=four), North Carolina (n=two), West Virginia (n=two), California (n=one), Rhode Island (n=one), and South Carolina (n=one) (Figure). Among the 2,496 patients for whom data were available, the median age was 56 years (range: 1 month–99 years); 1,348 (54%) were male, and the dates of illness onset ranged from June 10 to September 26. A total of 138 human deaths have been reported. The median age of decedents was 79 years (range: 27–99 years); 82 (59%) deaths were among men. In addition, 6,071 dead crows and 4,514 other dead birds with WNV infection were reported from 43 states and the District of Columbia; 5,292 WNV infections in mammals (5,284 equines, three canines, and five other species) have been reported from 35 states (Alabama, Arkansas, Colorado, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Wisconsin, and Wyoming). During 2002, WNV seroconversions have been reported in 342 sentinel chicken flocks from Florida, Iowa, Nebraska, Pennsylvania, and New York City; 4,010 WNV-positive mosquito pools have been reported from 26 states (Alabama, Arkansas, Connecticut, Delaware, Georgia, Illinois, Indiana, Iowa, Kentucky, Maryland, Massachusetts, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Vermont, and Virginia), New York City, and the District of Columbia.

Additional information about WNV activity is available from CDC at http://www.cdc.gov/ncidod/dvbid/westnile/index.htm and http://www.cindi.usgs.gov/hazard/event/west_nile/west_nile.html.

FIGURE. Areas reporting West Nile virus (WNV) activity — United States, 2002*



* As of 8 a.m. Mountain Daylight Time, October 9, 2002.
† California has reported human WNV activity only.

Notice to Readers

Recommended Adult Immunization Schedule — United States, 2002–2003

Although the childhood immunization program in the United States has reduced the burden of vaccine-preventable disease substantially among children, substantial vaccine-preventable morbidity and mortality from diseases such as hepatitis A, hepatitis B, influenza, and pneumococcal infections continue to occur among adults. In February 2002, the Advisory Committee on Immunization Practices (ACIP) approved for the first time a schedule for the routine vaccination of persons aged ≥19 years. The Adult Immunization Schedule has been accepted by the American Academy of Family Physicians (AAFP) and the American College of Obstetricians and Gynecologists (ACOG). ACIP will review and approve annually both the recommended adult and childhood immunization schedules. Together, these schedules provide a comprehensive summary of recommendations for prevention of vaccine-preventable diseases during the life span of persons in the United States.

The Adult Immunization Schedule is based on published recommendations of ACIP (*1*), AAFP (*2*), ACOG (*3*), and the American College of Physicians–American Society of Internal Medicine (ACP-ASIM) with the Infectious Diseases Society of America (*4*) and was developed by members of these organizations and CDC. The schedule presents a tabular, color-coded summary of vaccine indications by age group (Figure 1) and medical condition (Figure 2). Footnotes included in Figure 1 are summaries of the ACIP recommendations for specific vaccines since 1991. Figure 2 includes special considerations or contraindications for vaccinating persons with specific medical conditions. Licensed combination vaccines can be used whenever any components of the combination are indicated and the vaccine's other components are not contraindicated. Providers should consult manufacturers' package inserts for detailed recommendations. CDC and ACIP will update the schedule annually through collaboration with members of AAFP, ACOG, and ACP-ASIM.

Providers should report all postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS), telephone 800-822-7967. Reporting forms and instructions on filing a VAERS report are available at http://www.vaers.org. Tetanus-diphtheria (Td); hepatitis B; measles, mumps, and rubella (MMR); and varicella vaccines are covered by the Vaccine Injury Compensation Program (VICP). Health-care providers are required to give adult patients copies of the Vaccine Information Statements developed by CDC before administering each dose of the vaccines covered by VICP. Information on how to file a claim with VICP is available at 800-338-2382.

The schedule provides an up-to-date tool for family physicians, gynecologists, internists, and other health-care providers to assess the vaccine needs of patients during office visits and to administer the appropriate vaccines. Providers can use the schedule to promote the use of standing orders, patient-reminder/recall systems, provider-reminder systems, and other strategies that reduce missed opportunities to vaccinate their patients. The notes accompanying the age-based table and the footnotes for highlighting issues unique to chronic disease groups provide information for providers who might be unfamiliar with the dosage or contraindications of a particular vaccine.

Because adult vaccination requires the participation of health-care providers in three medical specialties (internal medicine, family practice, and obstetrics and gynecology) that do not include vaccinations in clinical training, tools such as the adult immunization schedule could play an important role in educating health-care providers who want to vaccinate their adult patients.

A printable, annotated, color version of the schedule will be available at http://www.cdc.gov/nip. Additional information on adult immunization and ordering instructions for *Increasing Adult Vaccination Rates: What Works*, a CD-ROM–based continuing education program offering primary-care providers strategies for increasing vaccination rates among their adult patients, also will be available at this website.

References

1. CDC. Update on adult immunization: recommendations of the Immunization Practices Advisory Committee (ACIP). MMWR 1991;40(No. RR-12).
2. American Academy of Family Physicians. Age charts for periodic health examinations. Available at http://www.aafp.org/exam/table2.html and http://www.aafp.org/exam/table4.html.
3. American College of Obstetricians and Gynecologists. Immunization during pregnancy. ACOG Technical bulletin 160, October 1991. Washington, DC: American College of Obstetricians and Gynecologists, 1991.
4. American College of Physicians. Guide for adult immunization. 3rd ed. Philadelphia, Pennsylvania: American College of Physicians, 1994.

FIGURE 1. Recommended adult immunization schedule — United States, 2002–2003

Vaccine	Age group (yrs) 19–49	50–64	≥65
Tetanus, diphtheria (Td)*	1 dose booster every 10 years†		
Influenza	1 dose annually for persons with medical or occupational indications or household contacts of persons with indications§	1 annual dose	
Pneumococcal (polysaccharide)	1 dose for persons with medical or other indications (1 dose revacinnation for immunosuppressive conditions)¶**		1 dose for unvaccinated persons¶ 1 dose revaccination**
Hepatitis B*	3 doses (0, 1–2, 4–6 months) for persons with medical, behavioral, occupational, or other indications††		
Hepatitis A	2 doses (0, 6–12 months) for persons with medical, behavioral, occupational, or other indications§§		
Measles, mumps, rubella (MMR)*	1 dose if MMR vaccination history is unreliable; 2 doses for persons with occupational, geographic, or other indications¶¶		
Varicella*	2 doses (0, 4–8 weeks) for persons who are susceptible***		
Meningococcal (polysaccharide)	1 dose for persons with medical or other indications†††		

For all persons in this age group

For persons with medical/exposure indications

Catch-up on childhood vaccinations

* Covered by the Vaccine Injury Compensation Program.

† A primary series for adults is 3 doses: the first 2 doses administered ≥4 weeks apart and the third dose administered 6–12 months after the second dose. Administer 1 dose if the person had received the primary series and the last vaccination was ≥10 years ago. The American College of Physicians Task Force on Adult Immunization supports a second option: a single Td booster at age 50 years for persons who have completed the full pediatric series, including the teenage/young-adult booster (*1*).

§ *Medical indications*: chronic disorders of the cardiovascular or pulmonary systems including asthma; chronic metabolic diseases, including diabetes mellitus, renal dysfunction, hemoglobinopathies, immunosuppression (including immunosuppression caused by medications or by human immunodeficiency virus [HIV]), requiring regular medical followup or hospitalization during the preceding year; or women who will be in the second or third trimester of pregnancy during the influenza season. *Occupational indications*: health-care workers. *Other indications*: residents of nursing homes and other long-term–care facilities; persons likely to transmit influenza to persons at high risk (in-home caregivers to persons with medical indications, household contacts and out-of-home caregivers of children aged ≤23 months or children with asthma or other indicator conditions for influenza vaccination, and household members and caregivers of elderly persons and adults with high-risk conditions); and anyone who wishes to be vaccinated (*2*).

¶ *Medical indications*: chronic disorders of the pulmonary system (excluding asthma), cardiovascular diseases, diabetes mellitus, chronic liver diseases including liver disease as a result of alcohol abuse (e.g., cirrhosis), chronic renal failure or nephrotic syndrome, functional or anatomic asplenia (e.g., sickle cell disease or splenectomy), immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection, leukemia, lymphoma, multiple myeloma, Hodgkin's disease, generalized malignancy, and organ or bone marrow transplantation), chemotherapy with alkylating agents, antimetabolites, or long-term systemic corticosteroids. *Geographic/other indications*: American Indian/Alaska Native. *Other indications*: residents of nursing homes and other long-term–care facilities (*3*).

** Revaccination with pneumococcal polysaccharide vaccine: one-time revaccination after 5 years for persons with chronic renal failure or nephrotic syndrome, functional or anatomic asplenia (e.g., sickle cell disease or splenectomy), immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection, leukemia, lymphoma, multiple myeloma, Hodgkin's disease, generalized malignancy, and organ or bone marrow transplantation), chemotherapy with alkylating agents, antimetabolites, or long-term systemic corticosteroids. For persons aged ≥65 years, one-time revaccination if they were vaccinated ≥5 years previously and were aged <65 years at the time of primary vaccination (*3*).

†† *Medical indications*: hemodialysis patients and patients who receive clotting-factor concentrates. *Occupational indications*: health-care workers and public-safety workers who are exposed to blood in the workplace; persons in training in schools of medicine, dentistry, nursing, laboratory technology; and other allied health professions. *Behavioral indications*: injection-drug users, persons with more than one sex partner during the preceding 6 months, persons with a recently acquired sexually transmitted disease (STD), all clients in STD clinics, and men who have sex with men (MSM). *Other indications*: household contacts and sex partners of persons with chronic hepatitis B virus (HBV) infection, clients and staff of institutions for the developmentally disabled, international travelers who will be located for >6 months in countries with high or intermediate prevalence of chronic HBV infection, and inmates of correctional facilities (*4*).

§§ For the combined hepatitis A–hepatitis B vaccine, use 3 doses at 0, 1, and 6 months. *Medical indications*: persons with clotting-factor disorders or chronic liver disease. *Behavioral indications*: MSM and users of injection-drug and noninjecting illegal drugs. *Occupational indications*: persons working with hepatitis A virus (HAV)–infected primates or with HAV in a research laboratory setting. *Other indications*: persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A (*5*).

¶¶ *Measles component*: Adults born before 1957 might be considered to be immune to measles. Administer 2 doses of MMR for adults with at least one of the following conditions and without vaccination history:

- adults born after 1956
- persons vaccinated with killed-measles–virus vaccine during 1963–1969
- students in postsecondary education institutions
- health-care workers
- susceptible international travelers to countries in which measles is endemic.

Mumps component: 1 dose of MMR should be adequate for protection. *Rubella component*: Administer 1 dose of MMR to women whose rubella vaccination history is unreliable and counsel women to avoid becoming pregnant for 4 weeks after vaccination. For women of childbearing age, regardless of birth year, determine rubella immunity and counsel women routinely regarding congenital rubella syndrome. Do not vaccinate pregnant women or those planning to become pregnant during the next 4 weeks. If pregnant and susceptible, vaccinate as early in postpartum period as possible (*6*).

*** Recommended for all persons who do not have reliable clinical history of varicella infection or serologic evidence of varicella zoster virus (VZV) infection; health-care workers and family contacts of immunocompromised persons; those who live or work in environments in which transmission is likely (e.g., teachers of young children, day care employees, and residents and staff members in institutional settings); persons who live or work in environments in which VZV transmission can occur (e.g., college students, inmates and staff members of correctional institutions, and military personnel); adolescents and adults living in households with children; women who are not pregnant but who might become pregnant in the future; and international travelers who are not immune to infection. Do not vaccinate pregnant women or those planning to become pregnant during the next 4 weeks. If pregnant and susceptible, vaccinate as early in postpartum period as possible (*7,8*).

††† Meningococcal vaccine (quadrivalent polysaccharide for serogroups A, C, Y, and W-135). *Medical indications*: consider vaccination for adults with terminal complement-component deficiencies or with anatomic or functional asplenia. *Other indications*: travelers to countries in which disease is hyperendemic or epidemic (e.g., the "meningitis belt" of sub-Saharan Africa and Mecca [Saudi Arabia] during Hajj). Revaccination at 3–5 years might be indicated for persons at high risk for infection (e.g., persons residing in areas in which disease is epidemic). Counsel college freshmen, especially those who live in dormitories, about meningococcal disease and the vaccine so that they can make an educated decision about receiving the vaccination (*9*). AAFP recommends that colleges should take the lead in providing education about meningococcal infection and vaccination and offer it to those who are interested. Health-care providers need not initiate discussion of the meningococcal quadravalent polysaccharide vaccine as part of routine medical care.

FIGURE 2. Recommended immunizations for adults with medical conditions — United States, 2002–2003

Medical condition	Vaccine						
	Tetanus-diphtheria (Td)*	Influenza	Pneumo-coccal (poly-saccharide)	Hepatitis B*	Hepatitis A	Measles, mumps, rubella (MMR)*	Varicella*
Pregnancy		A					
Diabetes, heart disease, chronic pulmonary disease, and chronic liver disease, including chronic alcoholism		B	C		D		
Congenital immunodeficiency, leukemia, lymphoma, generalized malignancy, therapy with alkylating agents, antimetabolites, radiation, or large amounts of corticosteroids			E				F
Renal failure/end stage renal disease and recipients of hemodialysis or clotting factor concentrates			E	G			
Asplenia including elective sphlenectomy and terminal complement-component deficiencies			E,H,I				
Human immunodeficiency virus (HIV) infection			E,J			K	

For all persons in this age group; For persons with medical/exposure indications; Catch-up on childhood vaccinations; Contraindicated

* Covered by the Vaccine Injury Compensation Program.

A. If pregnancy is at second or third trimester during influenza season.

B. Although chronic liver disease and alcoholism are not indicator conditions for influenza vaccination, administer 1 dose annually if the patient is aged ≥50 years, has other indications for influenza vaccine, or if patient requests vaccination.

C. Asthma is an indicator condition for influenza but not for pneumococcal vaccination.

D. For all persons with chronic liver disease.

E. Revaccinate once if ≥5 years have elapsed since initial vaccination.

F. Persons with impaired humoral but not cellular immunity might be vaccinated (*8*).

G. Hemodialysis patients: Use special formulation of vaccine (40 μg/mL) or two 1.0 mL 20 μg doses administered at one site. Vaccinate early in the course of renal disease. Assess antibody titers to hepatitis B surface antigen (anti-HBs) levels annually. Administer additional doses if anti-HBs levels decline to <10 milliinternational units (mIU)/mL.

H. Also administer meningococcal vaccine.

I. Elective splenectomy: Vaccinate ≥2 weeks before surgery.

J. Vaccinate as close to diagnosis as possible when CD4 cell counts are highest.

K. Withhold MMR or other measles-containing vaccines from HIV-infected persons with evidence of severe immunosuppression (*10*).

References

1. American College of Physicians. Guide for adult immunization. 3rd ed. Philadelphia, Pennsylvania: American College of Physicians, 1994.
2. CDC. Prevention of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2002;51 (No. RR-3).
3. CDC. Prevention of pneumococcal disease: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1997;46(No. RR-8).
4. CDC. Hepatitis B virus: a comprehensive strategy for eliminating transmission in the United States through universal childhood vaccination: recommendations of the Immunization Practices Advisory Committee (ACIP). MMWR 1991;40(No. RR-13).
5. CDC. Prevention of hepatitis A through active or passive immunization: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1999;48(No. RR-12).
6. CDC. Measles, mumps, and rubella—vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1998;47(No. RR-8).
7. CDC. Prevention of varicella: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1996;45 (No. RR-11).
8. CDC. Prevention of varicella: updated recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1999;48(No. RR-6).
9. CDC. Control and prevention of meningococcal disease and control and prevention of serogroup C meningococcal disease: evaluation and management of suspected outbreaks: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1997;46(No. RR-5).
10. CDC. Measles pneumonitis following measles-mumps-rubella vaccination of a patient with HIV infection, 1993. MMWR 1996;45:603–6.

Notice to Readers

National Lead Poisoning Prevention Week

October 20–26, 2002, is National Lead Poisoning Prevention Week. Childhood lead poisoning is the most preventable environmental disease in young children, but approximately 1 million children still have elevated blood lead levels. One of the national health objectives for 2010 is to eliminate childhood lead poisoning in the United States (objective 8-11) (*1*). The aim of National Lead Poisoning Prevention Week is 1) to raise awareness about the importance of screening at-risk children aged 1–2 years and those aged 3–6 years who have not been previously screened and 2) to urge persons to take precautions to eliminate children's exposure to lead.

This year's theme is "Discover the Rewards of Lead-Safe Living." As part of National Lead Poisoning Prevention Week, events such as state proclamations, free lead screenings, lead-awareness community events, and educational campaigns will be conducted nationwide. CDC, the U.S. Environmental Protection Agency, and the U.S. Department of Housing and Urban Development are collaborating to coordinate activities and offer aid to local lead poisoning prevention campaigns.

Information about National Lead Poisoning Prevention Week activities is available through state or local health departments. Additional information about preventing childhood lead poisoning is available at http://cdc.gov/nceh/lead or by telephone, 800-424-5323.

Reference

1. U.S. Department of Health and Human Services. Healthy people 2010, 2nd ed. With understanding and improving health and objectives for improving health (2 vols). Washington, DC: U.S. Department of Health and Human Services, 2000.

Notice to Readers

First World Report on Violence and Health

On October 3, 2002, the World Health Organization announced the release of the World Report on Violence and Health (WRVH) (*1*). The report is the first comprehensive review of the problem of violence on a global scale. The goals of the report are to highlight the crucial role that public health has to play in addressing the causes and consequences of violence, to make the case that violence is preventable, and to raise awareness about the problem of violence globally. The report is available at http://www5.who.int/violence_injury_prevention.

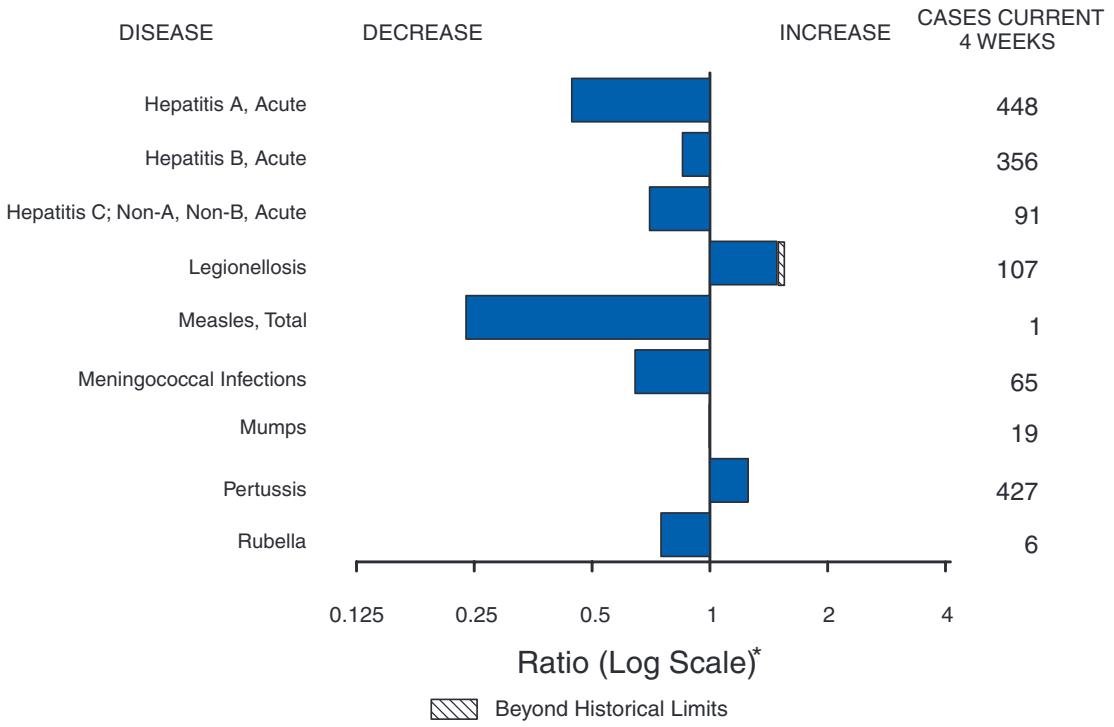
Each year, approximately 1.6 million persons die as a result of violence, and many more are injured and suffer from a range of physical, sexual, reproductive, and mental health problems. Violence is among the leading causes of death for persons aged 15–44 years worldwide, accounting for 14% of deaths among males and 7% of deaths among females (*1*). In the United States, violent deaths (i.e., homicide and suicide combined) are the second leading cause of death among persons in the same age group (*2*).

The report indicates that a science-based public health approach focused on prevention can contribute to reducing violence. The report encourages governments to develop and implement a national plan of action for violence prevention, to enhance data collection and research capacity, to promote primary prevention responses, and to strengthen emergency response systems and services for victims of violence. The report also calls for the integration of violence prevention into social and educational policies and highlights the need for mechanisms to facilitate collaboration and exchange of information on violence and its prevention among international agencies, governments, ministries of health, researchers, and civil society.

WRVH examines a broad spectrum of violence including child abuse and neglect, elder abuse, intimate partner

(*Continued on page 919*)

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending October 5, 2002, 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.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending October 5, 2002 (40th Week)*

		Cum. 2002	Cum. 2001		Cum. 2002	Cum. 2001
Anthrax		2	3	Encephalitis: West Nile†	782	46
Botulism:	foodborne	11	33	Hansen disease (leprosy)†	58	50
	infant	43	75	Hantavirus pulmonary syndrome†	11	7
	other (wound & unspecified)	18	13	Hemolytic uremic syndrome, postdiarrheal†	154	130
Brucellosis†		61	100	HIV infection, pediatric†§	137	147
Chancroid		57	28	Plague	-	2
Cholera		4	4	Poliomyelitis, paralytic	-	-
Cyclosporiasis†		160	125	Psittacosis†	17	11
Diphtheria		1	2	Q fever†	32	21
Ehrlichiosis:	human granulocytic (HGE)†	252	185	Rabies, human	2	1
	human monocytic (HME)†	125	96	Streptococcal toxic-shock syndrome†	63	60
	other and unspecified	6	5	Tetanus	18	26
Encephalitis:	California serogroup viral†	89	80	Toxic-shock syndrome	87	93
	eastern equine†	2	8	Trichinosis	12	18
	Powassan†	-	-	Tularemia†	51	111
	St. Louis†	-	75	Yellow fever	1	-
	western equine†	-	-			

-:No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update September 29, 2002.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending October 5, 2002, and October 6, 2001 (40th Week)*

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli, Enterohemorrhagic*			
							O157:H7		Shiga Toxin Positive, Serogroup non-O157	
	Cum. 2002§	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	31,555	30,610	580,653	589,626	2,040	3,025	2,652	2,455	127	109
NEW ENGLAND	1,236	1,116	20,258	18,523	139	119	215	210	29	34
Maine	27	36	1,258	1,021	9	14	31	24	5	1
N.H.	25	27	1,213	1,069	26	10	27	28	-	3
Vt.	12	13	698	469	27	30	6	13	1	1
Mass.	629	595	8,367	7,939	47	46	101	106	9	9
R.I.	82	76	2,095	2,263	16	3	12	10	-	-
Conn.	461	369	6,627	5,762	14	16	38	29	14	20
MID. ATLANTIC	7,170	7,965	67,087	63,872	237	267	178	186	-	-
Upstate N.Y.	482	1,079	12,876	10,256	91	81	139	121	-	-
N.Y. City	4,225	4,361	22,042	23,028	100	100	10	15	-	-
N.J.	1,117	1,345	9,824	10,559	8	14	29	50	-	-
Pa.	1,346	1,180	22,345	20,029	38	72	N	N	-	-
E.N. CENTRAL	3,291	2,223	98,667	108,614	571	1,401	657	623	13	7
Ohio	663	424	22,739	28,218	102	143	118	141	11	5
Ind.	422	264	12,314	11,992	34	68	51	69	-	-
Ill.	1,556	989	26,595	32,871	66	463	139	153	-	-
Mich.	500	411	24,838	22,932	82	152	106	78	2	2
Wis.	150	135	12,181	12,601	287	575	243	182	-	-
W.N. CENTRAL	507	636	32,721	30,099	334	403	402	394	28	28
Minn.	113	105	7,314	6,285	176	120	141	152	24	25
Iowa	67	73	4,086	3,783	37	73	99	69	-	-
Mo.	229	302	11,583	10,745	32	38	51	50	N	N
N. Dak.	1	2	740	791	6	12	3	16	-	1
S. Dak.	4	22	1,621	1,378	27	6	35	36	1	1
Nebr.	44	61	2,362	2,500	43	151	44	54	3	1
Kans.	49	71	5,015	4,617	13	3	29	17	-	-
S. ATLANTIC	9,368	9,405	109,669	114,441	265	292	230	189	35	22
Del.	155	202	2,030	2,168	3	5	7	4	-	1
Md.	1,412	1,494	12,335	11,613	19	32	22	26	-	-
D.C.	453	639	2,576	2,490	4	11	-	-	-	-
Va.	612	763	11,805	13,992	10	20	44	46	8	2
W. Va.	72	59	1,859	1,814	2	2	7	9	-	-
N.C.	782	699	18,930	17,347	28	24	36	38	-	-
S.C.	649	565	8,974	12,082	6	7	5	12	-	-
Ga.	1,356	1,027	21,882	24,538	120	126	51	29	10	9
Fla.	3,877	3,957	29,278	28,397	73	65	58	25	17	10
E.S. CENTRAL	1,469	1,401	36,478	38,178	102	41	88	115	-	-
Ky.	253	278	6,557	6,875	5	4	27	59	-	-
Tenn.	620	438	12,314	11,320	50	12	37	33	-	-
Ala.	298	347	9,841	10,560	41	13	17	15	-	-
Miss.	298	338	7,766	9,423	6	12	7	8	-	-
W.S. CENTRAL	3,336	3,087	81,415	82,411	31	109	55	159	-	-
Ark.	190	156	5,133	5,826	7	6	9	12	-	-
La.	815	652	14,786	14,038	5	7	2	7	-	-
Okla.	156	187	8,461	7,995	14	11	19	25	-	-
Tex.	2,175	2,092	53,035	54,552	5	85	25	115	-	-
MOUNTAIN	1,043	1,068	36,046	35,268	130	178	292	231	16	12
Mont.	9	14	1,698	1,475	4	28	25	16	-	-
Idaho	24	17	1,838	1,462	25	19	37	52	7	2
Wyo.	8	3	706	615	9	5	12	8	2	1
Colo.	212	244	10,664	10,028	46	37	81	81	3	6
N. Mex.	65	107	4,708	4,779	18	20	8	11	3	3
Ariz.	444	417	11,724	11,100	12	7	32	21	1	-
Utah	53	87	1,982	1,869	12	57	73	28	-	-
Nev.	228	179	2,726	3,940	4	5	24	14	-	-
PACIFIC	4,134	3,709	98,312	98,220	231	215	535	348	6	6
Wash.	386	385	11,194	10,417	43	U	129	96	-	-
Oreg.	260	154	5,102	5,577	31	40	186	60	6	6
Calif.	3,379	3,098	75,952	77,125	155	171	178	171	-	-
Alaska	22	17	2,741	2,035	-	1	6	4	-	-
Hawaii	87	55	3,323	3,066	2	3	36	17	-	-
Guam	2	9	-	315	-	-	N	N	-	-
P.R.	915	932	1,828	1,998	-	-	-	2	-	-
V.I.	67	2	125	122	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	138	U	-	U	-	U	-	U

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

* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

† Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update September 29, 2002.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 5, 2002, and October 6, 2001 (40th Week)*

Reporting Area	*Escherichia coli Enterohemorrhagic* Shiga Toxin Positive, Not Serogrouped		Giardiasis	Gonorrhea		*Haemophilus influenzae*, Invasive All Ages, All Serotypes		*Haemophilus influenzae*, Invasive Age <5 Years Serotype B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	29	11	12,471	245,209	272,471	1,168	1,146	16	20
NEW ENGLAND	-	1	1,282	5,696	5,211	81	86	-	1
Maine	-	-	163	107	106	1	1	-	-
N.H.	-	-	32	100	142	7	4	-	-
Vt.	-	1	102	80	51	7	3	-	-
Mass.	-	-	644	2,533	2,427	41	39	-	1
R.I.	-	-	124	678	634	10	3	-	-
Conn.	-	-	217	2,198	1,851	15	36	-	-
MID. ATLANTIC	-	1	2,681	30,683	31,406	212	171	3	3
Upstate N.Y.	-	-	919	6,623	6,221	95	56	2	-
N.Y. City	-	-	1,019	9,128	9,645	51	43	-	-
N.J.	-	-	244	5,465	5,484	45	39	-	-
Pa.	-	1	499	9,467	10,056	21	33	1	3
E.N. CENTRAL	11	5	2,276	47,628	57,242	175	214	3	2
Ohio	10	5	707	12,572	15,736	65	56	-	1
Ind.	-	-	-	5,284	5,191	35	43	1	-
Ill.	-	-	528	14,171	18,264	57	74	-	-
Mich.	1	-	654	11,188	13,429	11	12	2	-
Wis.	-	-	387	4,413	4,622	7	29	-	1
W.N. CENTRAL	-	2	1,545	12,783	12,825	51	55	1	1
Minn.	-	-	620	2,218	2,000	37	30	1	-
Iowa	-	-	243	944	998	1	-	-	-
Mo.	N	N	364	6,631	6,631	10	16	-	-
N. Dak.	-	2	11	42	37	-	6	-	-
S. Dak.	-	-	58	197	221	-	-	-	-
Nebr.	-	-	122	711	904	-	2	-	1
Kans.	-	-	127	2,040	2,034	3	1	-	-
S. ATLANTIC	-	-	2,213	62,811	71,035	304	281	2	1
Del.	-	-	41	1,217	1,283	-	-	-	-
Md.	-	-	97	6,618	6,926	71	71	2	-
D.C.	-	-	31	2,126	2,230	-	-	-	-
Va.	-	-	204	7,034	8,217	26	21	-	-
W. Va.	-	-	44	737	512	14	14	-	1
N.C.	-	-	-	12,407	13,385	30	42	-	-
S.C.	-	-	111	5,418	8,621	11	4	-	-
Ga.	-	-	705	12,070	13,547	78	71	-	-
Fla.	-	-	980	15,184	16,314	74	58	-	-
E.S. CENTRAL	7	1	292	21,004	24,608	50	63	1	-
Ky.	7	1	-	2,792	2,698	4	2	-	-
Tenn.	-	-	130	7,170	7,622	26	33	-	-
Ala.	-	-	162	6,391	8,141	15	26	1	-
Miss.	-	-	-	4,651	6,147	5	2	-	-
W.S. CENTRAL	-	-	183	36,260	40,582	50	42	2	1
Ark.	-	-	130	3,044	3,633	2	-	-	-
La.	-	-	3	9,175	9,690	7	7	-	-
Okla.	-	-	50	3,631	3,674	36	34	-	-
Tex.	-	-	-	20,410	23,585	5	1	2	1
MOUNTAIN	11	1	1,237	7,692	8,028	139	124	2	7
Mont.	-	-	74	75	84	-	-	-	-
Idaho	-	-	94	67	61	2	1	-	-
Wyo.	-	-	25	49	63	1	1	-	-
Colo.	11	1	404	2,646	2,431	26	34	-	-
N. Mex.	-	-	129	958	774	21	19	-	1
Ariz.	-	-	153	2,887	3,023	64	52	1	4
Utah	-	-	246	198	143	16	6	-	-
Nev.	-	-	112	812	1,449	9	11	1	2
PACIFIC	-	-	762	20,652	21,534	106	110	2	4
Wash.	-	-	289	2,217	2,307	2	2	1	-
Oreg.	-	-	324	658	861	51	32	-	-
Calif.	-	-	-	16,802	17,571	22	49	1	4
Alaska	-	-	78	452	321	1	6	-	-
Hawaii	-	-	71	523	474	30	21	-	-
Guam	-	-	-	-	38	-	-	-	-
P.R.	-	-	32	273	453	1	1	-	-
V.I.	-	-	-	31	21	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	1	13	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 5, 2002, and October 6, 2001 (40th Week)*

Reporting Area	*Haemophilus influenzae*, Invasive, Age <5 Years, Non-Serotype B		*Haemophilus influenzae*, Invasive, Age <5 Years, Unknown Serotype		Hepatitis (Viral, Acute), By Type, A		B		C; Non-A, Non-B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	189	186	14	24	6,407	7,655	5,166	5,485	11,936	3,115
NEW ENGLAND	8	15	-	-	243	510	196	103	20	31
Maine	-	-	-	-	8	10	8	5	-	-
N.H.	-	1	-	-	11	15	16	11	-	-
Vt.	-	-	-	-	1	12	4	5	12	6
Mass.	5	7	-	-	108	238	108	22	8	25
R.I.	-	-	-	-	30	38	24	22	-	-
Conn.	3	7	-	-	85	197	36	38	-	-
MID. ATLANTIC	26	25	-	3	732	965	1,048	1,043	1,184	1,022
Upstate N.Y.	10	7	-	1	148	190	105	95	54	24
N.Y. City	8	7	-	-	315	344	521	490	-	-
N.J.	5	4	-	-	89	234	247	224	1,104	944
Pa.	3	7	-	2	180	197	175	234	26	54
E.N. CENTRAL	27	32	1	2	832	957	626	732	77	138
Ohio	7	9	1	-	272	181	81	85	7	8
Ind.	7	6	-	1	39	87	38	42	-	1
Ill.	11	11	-	-	216	362	104	116	11	9
Mich.	1	-	-	1	181	264	403	453	59	120
Wis.	1	6	-	-	124	63	-	36	-	-
W.N. CENTRAL	3	2	3	6	254	305	170	164	676	914
Minn.	3	1	1	2	36	32	21	17	-	8
Iowa	-	-	-	-	67	29	12	18	1	-
Mo.	-	-	2	4	70	69	92	94	661	894
N. Dak.	-	1	-	-	1	2	4	-	-	-
S. Dak.	-	-	-	-	3	2	1	1	1	-
Nebr.	-	-	-	-	17	31	22	23	9	5
Kans.	-	-	-	-	60	140	18	11	4	7
S. ATLANTIC	46	40	1	6	1,950	1,681	1,333	1,121	139	77
Del.	-	-	-	-	9	13	7	21	5	6
Md.	3	7	-	1	243	188	96	112	6	6
D.C.	-	-	-	-	65	43	16	11	-	-
Va.	4	5	-	-	96	104	154	132	9	-
W. Va.	1	1	1	1	17	14	18	20	2	9
N.C.	3	2	-	4	190	165	187	171	22	18
S.C.	2	1	-	-	55	64	95	26	4	6
Ga.	17	16	-	-	385	759	338	323	29	-
Fla.	16	8	-	-	890	331	422	305	62	32
E.S. CENTRAL	10	12	1	3	202	320	273	370	159	172
Ky.	1	-	-	1	41	114	44	47	3	8
Tenn.	6	6	-	1	83	115	104	180	24	59
Ala.	3	5	1	1	32	68	60	75	5	3
Miss.	-	1	-	-	46	23	65	68	127	102
W.S. CENTRAL	12	6	-	-	417	715	418	614	9,538	607
Ark.	1	-	-	-	31	60	68	76	5	8
La.	2	1	-	-	39	77	64	99	31	128
Okla.	7	5	-	-	40	99	42	83	5	4
Tex.	2	-	-	-	307	479	244	356	9,497	467
MOUNTAIN	34	20	7	1	471	596	488	372	54	45
Mont.	-	-	-	-	13	10	8	3	-	1
Idaho	1	-	-	-	24	50	6	10	-	2
Wyo.	-	-	-	-	3	7	16	2	5	5
Colo.	2	2	-	-	70	75	62	80	17	6
N. Mex.	6	8	1	1	22	34	122	106	1	11
Ariz.	16	8	5	-	251	304	185	115	4	9
Utah	5	2	-	-	50	59	45	19	4	3
Nev.	4	-	1	-	38	57	44	37	23	8
PACIFIC	23	34	1	3	1,306	1,606	614	966	89	109
Wash.	1	1	-	1	133	108	53	111	17	18
Oreg.	5	5	-	-	55	89	99	129	15	13
Calif.	13	26	1	1	1,108	1,379	453	701	57	78
Alaska	1	1	-	-	8	14	3	9	-	-
Hawaii	3	1	-	1	2	16	6	16	-	-
Guam	-	-	-	-	-	1	-	-	-	-
P.R.	-	1	-	-	87	168	75	211	-	1
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	37	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 5, 2002, and October 6, 2001 (40th Week)*

Reporting Area	Legionellosis		Listeriosis		Lyme Disease		Malaria		Measles Total	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	762	811	409	464	11,133	12,094	944	1,184	22†	105§
NEW ENGLAND	66	53	47	42	3,301	3,517	49	76	-	5
Maine	2	6	5	-	53	-	5	4	-	-
N.H.	4	8	4	4	193	70	7	2	-	-
Vt.	28	5	3	2	26	14	3	1	-	1
Mass.	23	19	23	21	941	1,021	15	40	-	3
R.I.	1	6	1	1	261	393	5	7	-	-
Conn.	8	9	11	14	1,827	2,019	14	22	-	1
MID. ATLANTIC	197	186	115	86	6,359	6,534	212	358	7	18
Upstate N.Y.	64	50	47	24	3,853	2,619	33	52	1	4
N.Y. City	41	34	25	19	109	61	138	213	6	6
N.J.	18	20	20	16	578	1,878	20	54	-	1
Pa.	74	82	23	27	1,819	1,976	21	39	-	7
E.N. CENTRAL	191	224	41	69	68	667	107	146	3	10
Ohio	87	93	16	12	50	33	17	21	1	3
Ind.	16	17	6	5	18	20	11	15	2	4
Ill.	-	23	1	21	-	30	26	60	-	3
Mich.	65	54	14	22	-	5	42	32	-	-
Wis.	23	37	4	9	U	579	11	18	-	-
W.N. CENTRAL	39	43	14	15	196	327	51	31	3	4
Minn.	10	9	3	-	119	266	16	6	1	2
Iowa	9	8	1	2	31	27	4	5	-	-
Mo.	9	17	6	8	34	28	14	12	2	2
N. Dak.	-	1	1	-	-	-	1	-	-	-
S. Dak.	2	3	1	-	1	-	1	-	-	-
Nebr.	9	4	1	1	5	4	5	2	-	-
Kans.	-	1	1	4	6	2	10	6	-	-
S. ATLANTIC	149	138	62	57	1,025	821	284	243	2	5
Del.	7	7	-	2	132	144	3	2	-	-
Md.	28	30	14	11	551	500	95	100	-	3
D.C.	5	7	-	-	18	10	17	13	-	-
Va.	17	19	4	9	123	104	23	43	-	1
W. Va.	N	N	-	5	16	10	3	1	-	-
N.C.	9	7	6	4	103	35	19	13	-	-
S.C.	6	10	8	4	16	5	7	6	-	-
Ga.	11	10	10	11	2	-	59	39	-	1
Fla.	66	48	20	11	64	13	58	26	2	-
E.S. CENTRAL	27	52	13	20	37	56	19	33	-	2
Ky.	11	12	2	7	19	22	7	13	-	2
Tenn.	10	24	7	7	18	19	3	11	-	-
Ala.	6	12	4	6	-	8	4	5	-	-
Miss.	-	4	-	-	-	7	5	4	-	-
W.S. CENTRAL	8	20	12	31	18	76	14	72	2	1
Ark.	-	-	-	1	3	-	2	3	-	-
La.	1	6	-	-	2	6	4	5	-	-
Okla.	3	3	7	2	-	-	8	2	-	-
Tex.	4	11	5	28	13	70	-	62	2	1
MOUNTAIN	34	42	25	31	17	9	39	45	1	2
Mont.	3	-	-	-	-	-	2	2	-	-
Idaho	1	2	2	1	3	4	-	3	-	1
Wyo.	1	2	-	1	1	1	-	-	-	-
Colo.	6	13	6	9	3	-	21	21	-	-
N. Mex.	2	2	2	6	1	-	2	3	-	-
Ariz.	8	15	11	6	2	-	6	6	-	1
Utah	10	5	3	2	6	1	5	3	-	-
Nev.	3	3	1	6	1	3	3	7	1	-
PACIFIC	51	53	80	113	112	87	169	180	4	58
Wash.	5	7	8	7	9	7	15	7	-	15
Oreg.	N	N	8	9	14	9	9	13	-	3
Calif.	46	41	56	91	86	69	137	148	3	33
Alaska	-	1	-	-	3	2	2	1	-	-
Hawaii	-	4	8	6	N	N	6	11	1	7
Guam	-	-	-	-	-	-	-	1	-	-
P.R.	-	2	1	-	N	N	-	5	-	1
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Of 22 cases reported, 10 were indigenous and 12 were imported from another country.
§ Of 105 cases reported, 53 were indigenous and 52 were imported from another country.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 5, 2002, and October 6, 2001 (40th Week)*

Reporting Area	Meningococcal Disease		Mumps		Pertussis		Rabies, Animal	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	1,323	1,832	204	184	5,616	4,084	4,689	5,662
NEW ENGLAND	79	83	6	1	475	372	728	588
Maine	7	3	-	-	12	21	48	55
N.H.	11	11	4	-	14	15	40	19
Vt.	4	5	-	-	93	27	85	54
Mass.	39	46	1	1	318	287	229	215
R.I.	5	3	-	-	13	5	61	52
Conn.	13	15	1	-	25	17	265	193
MID. ATLANTIC	125	199	20	22	312	264	886	1,055
Upstate N.Y.	37	51	3	3	232	115	565	636
N.Y. City	21	33	1	11	10	46	10	26
N.J.	24	34	-	3	3	18	138	160
Pa.	43	81	16	5	67	85	173	233
E.N. CENTRAL	173	283	25	23	676	656	130	128
Ohio	65	75	8	1	340	253	31	42
Ind.	26	33	2	1	94	67	30	2
Ill.	36	70	7	16	102	71	28	24
Mich.	34	62	7	3	41	100	41	42
Wis.	12	43	1	2	99	165	-	18
W.N. CENTRAL	120	119	15	7	553	206	308	309
Minn.	29	16	3	3	258	70	36	40
Iowa	18	23	1	-	127	20	62	72
Mo.	39	43	5	-	111	84	42	37
N. Dak.	-	5	1	-	-	4	12	33
S. Dak.	2	5	-	-	6	4	47	43
Nebr.	25	13	-	1	6	4	-	4
Kans.	7	14	5	3	45	20	109	80
S. ATLANTIC	239	284	23	30	343	198	1,916	1,943
Del.	7	3	-	-	2	-	24	30
Md.	7	37	5	4	53	33	199	400
D.C.	-	-	-	-	1	1	-	-
Va.	33	33	3	6	117	35	397	360
W. Va.	4	12	-	-	30	2	144	118
N.C.	29	59	1	4	38	58	571	465
S.C.	25	29	2	3	38	31	109	90
Ga.	29	41	4	8	18	20	303	332
Fla.	105	70	8	5	46	18	169	148
E.S. CENTRAL	75	118	12	7	200	128	130	191
Ky.	11	20	4	1	79	36	22	25
Tenn.	32	52	2	1	84	54	90	106
Ala.	20	30	3	-	30	34	18	56
Miss.	12	16	3	5	7	4	-	4
W.S. CENTRAL	164	273	16	9	1,358	398	103	904
Ark.	23	19	-	-	439	22	3	-
La.	28	66	1	2	7	6	-	7
Okla.	17	26	-	-	66	23	100	55
Tex.	96	162	15	7	846	347	-	842
MOUNTAIN	73	83	15	14	723	1,159	248	233
Mont.	2	4	-	1	5	30	16	31
Idaho	3	7	2	1	56	169	32	28
Wyo.	-	5	-	1	10	1	18	28
Colo.	21	31	2	3	289	253	57	-
N. Mex.	4	10	1	2	146	126	7	14
Ariz.	23	13	1	1	106	492	103	117
Utah	4	7	5	1	68	73	10	14
Nev.	16	6	4	4	43	15	5	1
PACIFIC	275	390	72	71	976	703	240	311
Wash.	51	56	-	1	357	127	-	-
Oreg.	38	50	N	N	166	46	13	3
Calif.	176	271	59	32	432	494	203	270
Alaska	4	2	-	1	4	6	24	38
Hawaii	6	11	13	37	17	30	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	5	5	-	1	2	-	49	74
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	1	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 5, 2002, and October 6, 2001 (40th Week)*

Reporting Area	Rocky Mountain Spotted Fever		Rubella				Salmonellosis	
			Rubella		Congenital Rubella			
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	735	468	13	19	2	-	29,496	30,538
NEW ENGLAND	3	3	-	-	-	-	1,686	1,957
Maine	-	-	-	-	-	-	112	151
N.H.	-	1	-	-	-	-	107	143
Vt.	-	-	-	-	-	-	65	66
Mass.	-	2	-	-	-	-	941	1,124
R.I.	3	-	-	-	-	-	126	107
Conn.	-	-	-	-	-	-	335	366
MID. ATLANTIC	36	27	1	8	-	-	3,624	4,059
Upstate N.Y.	7	2	1	1	-	-	1,195	920
N.Y. City	8	1	-	6	-	-	1,016	1,024
N.J.	9	7	-	1	-	-	512	980
Pa.	12	17	-	-	-	-	901	1,135
E.N. CENTRAL	14	15	1	2	-	-	4,056	4,020
Ohio	10	1	-	-	-	-	1,093	1,080
Ind.	2	1	-	-	-	-	353	419
Ill.	-	12	-	2	-	-	1,248	1,148
Mich.	2	1	1	-	-	-	686	698
Wis.	-	-	-	-	-	-	676	675
W.N. CENTRAL	89	61	-	3	-	-	1,999	1,799
Minn.	-	-	-	-	-	-	453	514
Iowa	3	2	-	1	-	-	390	270
Mo.	81	57	-	1	-	-	674	471
N. Dak.	-	-	-	-	-	-	25	53
S. Dak.	1	2	-	-	-	-	88	120
Nebr.	4	-	-	-	-	-	126	130
Kans.	-	-	-	1	-	-	243	241
S. ATLANTIC	384	226	5	4	-	-	7,941	6,978
Del.	4	8	-	-	-	-	70	81
Md.	45	36	-	1	-	-	748	638
D.C.	-	-	-	-	-	-	57	68
Va.	28	17	-	-	-	-	806	1,090
W. Va.	2	-	-	-	-	-	102	97
N.C.	231	125	-	-	-	-	1,052	1,023
S.C.	45	27	-	2	-	-	566	652
Ga.	18	9	-	-	-	-	1,436	1,330
Fla.	11	4	5	1	-	-	3,104	1,999
E.S. CENTRAL	84	92	-	-	1	-	2,237	2,085
Ky.	5	2	-	-	-	-	276	293
Tenn.	63	64	-	-	1	-	601	497
Ala.	16	13	-	-	-	-	634	561
Miss.	-	13	-	-	-	-	726	734
W.S. CENTRAL	106	34	2	-	-	-	2,288	3,894
Ark.	45	5	-	-	-	-	764	699
La.	-	2	-	-	-	-	318	681
Okla.	61	27	-	-	-	-	383	368
Tex.	-	-	2	-	-	-	823	2,146
MOUNTAIN	13	9	1	-	-	-	1,723	1,710
Mont.	2	1	-	-	-	-	75	60
Idaho	-	1	-	-	-	-	108	113
Wyo.	3	2	-	-	-	-	57	53
Colo.	2	1	-	-	-	-	468	469
N. Mex.	1	1	-	-	-	-	246	225
Ariz.	-	-	-	-	-	-	460	467
Utah	-	3	1	-	-	-	153	179
Nev.	5	-	-	-	-	-	156	144
PACIFIC	6	1	3	2	1	-	3,942	4,036
Wash.	-	-	-	-	-	-	381	405
Oreg.	2	1	-	-	-	-	283	224
Calif.	4	-	3	1	-	-	3,008	3,091
Alaska	-	-	-	-	-	-	47	33
Hawaii	-	-	-	1	1	-	223	283
Guam	-	-	-	-	-	-	-	19
P.R.	-	-	-	3	-	-	170	741
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	25	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 5, 2002, and October 6, 2001 (40th Week)*

Reporting Area	Shigellosis		Streptococcal Disease, Invasive, Group A		*Streptococcus pneumoniae*, Drug Resistant, Invasive		*Streptococcus pneumoniae*, Invasive (<5 Years)	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	12,787	14,389	3,270	2,937	1,690	2,119	184	328
NEW ENGLAND	257	253	154	186	17	101	2	35
Maine	5	6	20	10	-	-	-	-
N.H.	9	6	30	N	-	-	N	N
Vt.	1	7	9	12	4	7	1	-
Mass.	161	177	80	57	N	N	N	N
R.I.	14	17	15	11	13	4	1	3
Conn.	67	40	-	96	-	90	-	32
MID. ATLANTIC	984	1,203	532	534	91	137	51	84
Upstate N.Y.	220	400	252	220	79	131	51	84
N.Y. City	319	338	130	148	U	U	U	U
N.J.	276	236	103	108	N	N	N	N
Pa.	169	229	47	58	12	6	-	-
E.N. CENTRAL	1,314	3,453	571	674	171	146	80	94
Ohio	493	2,298	180	171	34	-	10	-
Ind.	72	174	42	53	132	146	45	46
Ill.	486	469	105	218	2	-	-	48
Mich.	136	253	244	181	3	-	N	N
Wis.	127	259	-	51	N	N	25	-
W.N. CENTRAL	803	1,345	199	297	150	119	39	49
Minn.	173	345	101	131	36	51	39	40
Iowa	101	331	-	-	N	N	N	N
Mo.	127	257	41	63	5	9	-	-
N. Dak.	15	20	-	11	1	6	-	9
S. Dak.	150	265	12	11	1	3	-	-
Nebr.	166	64	16	34	29	16	N	N
Kans.	71	63	29	47	78	34	N	N
S. ATLANTIC	4,793	1,964	683	487	1,060	1,135	5	5
Del.	160	13	2	2	3	6	N	N
Md.	897	123	114	N	N	N	N	N
D.C.	46	49	6	20	48	5	1	3
Va.	700	245	65	65	N	N	N	N
W. Va.	9	8	17	18	37	37	4	2
N.C.	301	286	107	125	N	N	U	U
S.C.	93	220	31	9	150	232	N	N
Ga.	1,205	301	147	154	260	335	N	N
Fla.	1,382	719	194	94	562	520	N	N
E.S. CENTRAL	1,032	1,247	89	93	115	204	-	-
Ky.	115	546	18	33	13	24	N	N
Tenn.	72	79	71	60	102	179	N	N
Ala.	565	182	-	-	-	1	N	N
Miss.	280	440	-	-	-	-	-	-
W.S. CENTRAL	996	2,264	106	269	48	239	3	61
Ark.	155	471	5	-	6	14	-	-
La.	154	194	-	1	42	225	1	61
Okla.	422	50	38	37	N	N	2	-
Tex.	265	1,549	63	231	N	N	-	-
MOUNTAIN	660	752	466	333	38	34	4	-
Mont.	3	4	-	-	-	-	-	-
Idaho	14	31	9	7	N	N	N	N
Wyo.	7	7	7	10	9	5	-	-
Colo.	141	192	117	127	-	-	-	-
N. Mex.	133	103	87	68	29	27	-	-
Ariz.	294	300	217	118	-	-	N	N
Utah	27	48	29	3	-	-	4	-
Nev.	41	67	-	-	-	2	-	-
PACIFIC	1,948	1,908	470	64	-	4	-	-
Wash.	122	159	65	-	-	-	N	N
Oreg.	83	87	N	N	N	N	N	N
Calif.	1,690	1,605	343	-	N	N	N	N
Alaska	6	6	-	-	-	-	N	N
Hawaii	47	51	62	64	-	4	-	-
Guam	-	37	-	1	-	-	-	-
P.R.	7	15	N	N	-	-	N	N
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	-	-	U	U
C.N.M.I.	17	U	-	U	-	-	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 5, 2002, and October 6, 2001 (40th Week)*

Reporting Area	Syphilis				Tuberculosis		Typhoid Fever	
	Primary & Secondary		Congenital					
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	4,746	4,578	244	392	8,819	10,475	197	279
NEW ENGLAND	107	47	-	3	277	351	15	12
Maine	2	-	-	-	10	15	-	1
N.H.	3	1	-	-	10	13	-	1
Vt.	1	2	-	-	-	4	-	-
Mass.	75	26	-	2	155	183	9	9
R.I.	6	8	-	-	29	48	-	-
Conn.	20	10	-	1	73	88	6	1
MID. ATLANTIC	526	397	44	62	1,604	1,747	46	97
Upstate N.Y.	26	15	5	4	227	269	8	15
N.Y. City	320	215	18	29	823	866	23	41
N.J.	105	98	20	29	374	385	12	34
Pa.	75	69	1	-	180	227	3	7
E.N. CENTRAL	821	787	36	54	916	1,052	17	30
Ohio	117	65	1	2	148	210	6	3
Ind.	54	127	-	8	83	75	2	2
Ill.	240	266	26	35	449	485	1	16
Mich.	391	309	9	5	195	221	3	5
Wis.	19	20	-	4	41	61	5	4
W.N. CENTRAL	80	79	-	9	423	412	8	13
Minn.	38	30	-	2	177	166	3	6
Iowa	2	4	-	-	24	34	-	-
Mo.	22	20	-	5	110	107	1	7
N. Dak.	-	-	-	-	1	3	-	-
S. Dak.	-	-	-	-	9	10	-	-
Nebr.	3	6	-	-	20	29	4	-
Kans.	15	19	-	2	82	63	-	-
S. ATLANTIC	1,232	1,579	58	95	1,741	1,960	32	34
Del.	10	11	-	-	13	15	-	-
Md.	148	200	11	3	215	172	7	9
D.C.	48	30	1	2	-	51	-	-
Va.	50	82	1	4	134	197	1	9
W. Va.	2	-	-	-	27	25	-	-
N.C.	222	367	18	11	259	263	1	2
S.C.	93	196	5	20	136	140	-	-
Ga.	261	298	8	20	306	349	8	9
Fla.	398	395	14	35	651	748	15	5
E.S. CENTRAL	379	503	12	26	570	639	4	1
Ky.	77	37	3	-	105	95	4	-
Tenn.	136	261	3	16	227	238	-	1
Ala.	132	93	4	4	158	205	-	-
Miss.	34	112	2	6	80	101	-	-
W.S. CENTRAL	654	555	53	66	1,195	1,593	4	15
Ark.	25	30	2	6	101	116	-	-
La.	119	130	-	-	-	100	-	-
Okla.	51	48	3	5	106	112	-	-
Tex.	459	347	48	55	988	1,265	4	15
MOUNTAIN	217	175	12	26	270	417	10	8
Mont.	-	-	-	-	6	6	-	1
Idaho	1	1	-	-	9	7	-	-
Wyo.	-	1	-	-	3	3	-	-
Colo.	33	20	1	1	48	100	5	1
N. Mex.	23	15	-	2	21	44	1	-
Ariz.	147	124	11	23	149	164	-	1
Utah	6	8	-	-	21	29	2	1
Nev.	7	6	-	-	13	64	2	4
PACIFIC	730	456	29	51	1,823	2,304	61	69
Wash.	48	37	1	-	177	188	4	4
Oreg.	12	13	1	-	86	82	2	7
Calif.	662	395	26	51	1,405	1,885	52	55
Alaska	-	-	-	-	40	40	-	1
Hawaii	8	11	1	-	115	109	3	2
Guam	-	5	-	1	-	47	-	2
P.R.	185	208	13	9	33	95	-	-
V.I.	1	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	15	U	-	U	32	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,* week ending October 5, 2002 (40th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	379	289	63	16	7	4	29
Boston, Mass.	U	U	U	U	U	U	U
Bridgeport, Conn.	35	30	3	2	-	-	8
Cambridge, Mass.	12	10	2	-	-	-	4
Fall River, Mass.	19	14	4	1	-	-	1
Hartford, Conn.	U	U	U	U	U	U	U
Lowell, Mass.	25	19	5	-	1	-	1
Lynn, Mass.	10	10	-	-	-	-	2
New Bedford, Mass.	29	23	4	2	-	-	2
New Haven, Conn.	33	24	6	1	2	-	4
Providence, R.I.	69	53	11	3	2	-	1
Somerville, Mass.	6	6	-	-	-	-	-
Springfield, Mass.	44	31	9	3	1	-	3
Waterbury, Conn.	29	20	6	1	-	2	-
Worcester, Mass.	68	49	13	3	1	2	3
MID. ATLANTIC	2,047	1,416	403	152	44	31	100
Albany, N.Y.	41	33	7	-	1	-	2
Allentown, Pa.	21	18	3	-	-	-	2
Buffalo, N.Y.	98	67	27	1	2	1	10
Camden, N.J.	34	15	8	4	3	4	3
Elizabeth, N.J.	41	27	7	5	2	-	-
Erie, Pa.	42	31	9	1	-	1	1
Jersey City, N.J.	31	21	5	5	-	-	-
New York City, N.Y.	1,020	712	204	77	14	13	36
Newark, N.J.	48	26	8	13	-	1	1
Paterson, N.J.	30	17	6	5	2	-	3
Philadelphia, Pa.	265	166	63	20	11	4	15
Pittsburgh, Pa.§	26	18	4	4	-	-	3
Reading, Pa.	27	19	5	2	-	1	3
Rochester, N.Y.	108	84	16	6	2	-	9
Schenectady, N.Y.	16	13	3	-	-	-	-
Scranton, Pa.	29	23	4	-	2	-	1
Syracuse, N.Y.	106	81	14	3	4	4	10
Trenton, N.J.	40	23	8	6	1	2	1
Utica, N.Y.	24	22	2	-	-	-	-
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,412	960	312	80	27	33	85
Akron, Ohio	36	25	6	1	2	2	4
Canton, Ohio	34	31	2	-	-	1	2
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	85	57	18	5	-	5	4
Cleveland, Ohio	120	80	31	6	1	2	3
Columbus, Ohio	219	135	57	16	6	5	19
Dayton, Ohio	128	72	33	14	7	2	11
Detroit, Mich.	U	U	U	U	U	U	U
Evansville, Ind.	43	34	7	2	-	-	3
Fort Wayne, Ind.	63	47	12	1	3	-	1
Gary, Ind.	15	6	5	4	-	-	1
Grand Rapids, Mich.	74	53	15	4	-	2	9
Indianapolis, Ind.	199	126	52	11	4	6	7
Lansing, Mich.	45	33	10	1	-	1	2
Milwaukee, Wis.	107	81	16	7	2	1	9
Peoria, Ill.	46	39	4	-	-	3	4
Rockford, Ill.	53	37	11	2	1	2	1
South Bend, Ind.	34	26	5	3	-	-	1
Toledo, Ohio	67	47	16	3	-	1	4
Youngstown, Ohio	44	31	12	-	1	-	-
W.N. CENTRAL	536	362	103	38	20	13	40
Des Moines, Iowa	78	55	14	3	4	2	7
Duluth, Minn.	29	25	4	-	-	-	1
Kansas City, Kans.	40	20	11	4	5	-	3
Kansas City, Mo.	83	61	15	6	1	-	6
Lincoln, Nebr.	26	23	2	1	-	-	1
Minneapolis, Minn.	73	44	15	10	4	-	10
Omaha, Nebr.	82	52	15	6	2	7	6
St. Louis, Mo.	U	U	U	U	U	U	U
St. Paul, Minn.	48	32	9	4	1	2	3
Wichita, Kans.	77	50	18	4	3	2	3
S. ATLANTIC	1,528	886	386	158	56	42	64
Atlanta, Ga.	467	262	117	59	16	13	8
Baltimore, Md.	191	96	60	23	9	3	19
Charlotte, N.C.	89	61	20	3	3	2	9
Jacksonville, Fla.	121	71	30	11	7	2	8
Miami, Fla.	111	66	21	14	6	4	5
Norfolk, Va.	68	40	12	10	1	5	1
Richmond, Va.	46	27	13	4	-	2	3
Savannah, Ga.	U	U	U	U	U	U	U
St. Petersburg, Fla.	68	45	18	-	5	-	-
Tampa, Fla.	157	96	36	17	3	5	9
Washington, D.C.	200	112	59	17	6	6	1
Wilmington, Del.	10	10	-	-	-	-	1
E.S. CENTRAL	691	452	145	48	28	18	42
Birmingham, Ala.	149	96	26	14	8	5	12
Chattanooga, Tenn.	66	44	14	5	3	-	1
Knoxville, Tenn.	107	66	25	9	6	1	-
Lexington, Ky.	73	46	16	4	4	3	4
Memphis, Tenn.	U	U	U	U	U	U	U
Mobile, Ala.	79	52	19	4	1	3	5
Montgomery, Ala.	63	54	6	1	2	-	7
Nashville, Tenn.	154	94	39	11	4	6	13
W.S. CENTRAL	1,236	772	272	97	62	32	89
Austin, Tex.	90	59	21	3	5	2	9
Baton Rouge, La.	46	29	13	3	1	-	1
Corpus Christi, Tex.	56	36	11	6	2	1	4
Dallas, Tex.	190	110	46	18	9	7	15
El Paso, Tex.	64	47	9	6	1	1	4
Ft. Worth, Tex.	111	64	27	12	7	1	9
Houston, Tex.	290	161	61	32	23	13	18
Little Rock, Ark.	65	39	16	2	6	2	-
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	192	141	33	9	6	2	17
Shreveport, La.	43	28	14	-	-	1	5
Tulsa, Okla.	89	58	21	6	2	2	7
MOUNTAIN	857	577	161	72	23	24	49
Albuquerque, N.M.	152	95	32	17	5	3	4
Boise, Idaho	36	27	6	3	-	-	4
Colo. Springs, Colo.	60	37	16	4	1	2	3
Denver, Colo.	110	68	21	10	3	8	7
Las Vegas, Nev.	230	157	42	25	5	1	10
Ogden, Utah	24	23	1	-	-	-	2
Phoenix, Ariz.	U	U	U	U	U	U	U
Pueblo, Colo.	27	22	4	1	-	-	-
Salt Lake City, Utah	92	54	18	7	6	7	8
Tucson, Ariz.	126	94	21	5	3	3	11
PACIFIC	2,048	1,373	431	151	50	40	110
Berkeley, Calif.	10	6	3	-	1	-	-
Fresno, Calif.	467	262	117	59	16	13	8
Glendale, Calif.	27	25	2	-	-	-	-
Honolulu, Hawaii	72	58	11	2	-	1	9
Long Beach, Calif.	74	49	20	4	1	-	7
Los Angeles, Calif.	428	313	70	31	10	4	1
Pasadena, Calif.	18	11	7	-	-	-	1
Portland, Oreg.	173	119	34	10	7	3	11
Sacramento, Calif.	203	137	39	13	7	6	24
San Diego, Calif.	144	96	32	8	1	6	16
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	157	117	31	6	2	1	11
Santa Cruz, Calif.	25	17	5	2	-	1	5
Seattle, Wash.	117	65	34	12	4	2	6
Spokane, Wash.	54	42	10	1	-	1	7
Tacoma, Wash.	79	56	16	3	1	2	4
TOTAL	10,734¶	7,087	2,276	812	317	237	608

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.

(*Continued from page 908*)

violence, sexual violence, suicide, youth violence, and collective violence (i.e., primarily armed conflict within and between states and the complex emergencies that result from such conflicts).

Additional information about child maltreatment, intimate partner violence, sexual violence, suicide, and youth violence risk factors, prevention, and new research is available at http://www.cdc.gov/ncipc.

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1. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R. World report on violence and health. Geneva, Switzerland: World Health Organization, 2002.
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Erratum: Vol. 51, No. 39

In the article, "Increase in African Immigrants and Refugees with Tuberculosis—Seattle-King County, Washington, 1998–2001," on page 883, the data for the community-based TB prevention project of Seattle-King County Public Health were incorrectly attributed to the Institute of Medicine Report on TB (reference 6). The data were contributed directly from the Seattle TB prevention project.

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