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Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses — United States, 1997–2001

Smoking harms nearly every organ of the body, causing many diseases and reducing quality of life and life expectancy (*1*). This report assesses the health consequences and productivity losses attributable to smoking in the United States during 1997–2001. CDC calculated national estimates of annual smoking-attributable mortality (SAM), years of potential life lost (YPLL) for adults and infants, and productivity losses for adults. The findings indicated that, during 1997–2001, cigarette smoking and exposure to tobacco smoke resulted in approximately 438,000 premature deaths in the United States, 5.5 million YPLL, and $92 billion in productivity losses annually. Implementation of comprehensive tobacco-control programs as recommended by CDC can reduce smoking prevalence and related mortality and health-care costs (*1*).

The Adult and Maternal and Child Health Smoking-Attributable Mortality, Morbidity and Economic Cost (SAMMEC) software (*2*) was revised on the basis of findings from the 2004 Surgeon General's report on diseases caused by smoking (*1*). The list of smoking-attributable diseases now includes stomach cancer and acute myeloid leukemia and excludes hypertension. Sex- and age-specific smoking-attributable deaths were calculated by multiplying the total number of deaths for 19 adult and four infant disease categories by estimates of the smoking-attributable fraction (SAF) of preventable deaths. The attributable fractions provide estimates of the public health burden of each risk factor and the relative importance of risk factors for multifactorial diseases. Because of the effect of interactions between various risk factors, attributable fractions for a given disease can add up to more than 100%. For adults, SAFs were derived by using sex-specific relative risk (RR) estimates (*2*) for current and former smokers for each cause of death from the American Cancer Society's Cancer Prevention Study-II (CPS-II) for the period 1982–1988 (*2*). For ischemic heart disease and cerebrovascular disease deaths, RR estimates were also stratified by age (35–64 years and ≥65 years). SAFs also used sex- and age-specific (35–64 years and ≥65 years) current and former cigarette smoking–prevalence estimates from the National Health Interview Survey.* For infants, SAFs were calculated by using pediatric RR estimates (*2*) and maternal smoking prevalence estimates from birth certificates (*2*). Smoking-attributable YPLL and productivity losses were estimated by multiplying sex- and age-specific SAM by remaining life expectancy (*3*) and lifetime earnings data (*4*). In addition, smoking-attributable fire-related deaths (*5*) and lung cancer and heart disease deaths attributable to exposure to secondhand smoke (*6,7*) were included in the SAM estimates.

During 1997–2001, smoking resulted in an estimated annual average of 259,494 deaths among men and 178,408 deaths among women in the United States (Table). Among adults, 158,529 (39.8%) of these deaths were attributed to cancer, 137,979 (34.7%) to cardiovascular diseases, and 101,454 (25.5%) to respiratory diseases. The three leading specific causes of smoking-attributable death were lung

* SAFs for each disease are calculated by using the following equation: $SAF = [(p_1(RR_1 - 1) + p_2(RR_2 - 1)] / [p_1(RR_1 - 1) + p_2(RR_2 - 1) + 1]$ where p_1 = percentage of current smokers (persons who have smoked ≥100 cigarettes and now smoke every day or some days), p_2 = percentage of former smokers (persons who have smoked ≥100 cigarettes and do not currently smoke), RR_1 = relative risk for current smokers relative to never smokers, and RR_2 = relative risk for former smokers relative to never smokers.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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cancer (123,836), chronic obstructive pulmonary disease (COPD)† (90,582), and ischemic heart disease (86,801). Smoking during pregnancy resulted in an estimated 910 infant deaths annually during 1997–2001. An estimated 38,112 lung cancer and heart disease deaths annually were attributable to exposure to secondhand smoke. The average annual SAM estimates also included 918 deaths from smoking-attributable fires.

During 1997–2001, on average, smoking accounted for an estimated 3.3 million YPLL for men and 2.2 million YPLL for women annually, excluding burn deaths and adult deaths from secondhand smoke. Estimates for average annual smoking-attributable productivity losses were approximately $61.9 billion for men and $30.5 billion for women during this period (Table).

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Editorial Note: During 1997–2001, an estimated 438,000 persons in the United States died prematurely each year as a result of smoking or exposure to secondhand smoke. This figure is lower than the average annual estimate of approximately 440,000 deaths during 1995–1999 (*8*) because of changes in the list of smoking-attributable diseases and declines in the prevalence of smoking. Accelerated reductions in the prevalence of smoking could prevent millions of premature deaths (*1*).

The findings in this report are subject to at least six limitations. First, the estimates understate deaths attributable to tobacco use because estimates of deaths attributable to cigar smoking, pipe smoking, and smokeless tobacco use were excluded. Second, RRs were based on deaths during 1982–1988 among birth cohorts who might have had different smoking histories than current or former smokers (e.g., age of initiation and duration of smoking before quitting). Third, this report used a death certificate–based definition of COPD, including codes for bronchitis/emphysema and chronic airway obstruction (ICD-10 J44) (*1*). Therefore, the COPD SAM estimate used for this report might differ from other estimates that use other definitions of COPD (*1*). Fourth, RRs were adjusted for the effects of age but not for other potential confounders. However, research suggests that education, alcohol, and other confounders had negligible additional impact on SAM estimates for lung cancer, COPD, ischemic heart disease, and cerebrovascular disease in CPS-II (*2*). Fifth, productivity losses understate the total costs of

† COPD includes bronchitis/emphysema (*International Classification of Diseases, Tenth Revision* [ICD-10] codes J40–J42 and J43) and chronic airway obstruction (ICD-10 J44) (*1*).

TABLE. Annual deaths and estimates of smoking-attributable mortality (SAM), years of potential life lost (YPLL), and productivity losses (PLoss), by sex and cause of death — United States, 1997–2001

	Male				Female			
Cause of death (ICD-10* code)	**Deaths**	**SAM**	**YPLL**	**PLoss†**	**Deaths**	**SAM**	**YPLL**	**PLoss**
Malignant neoplasms								
Lip, oral cavity, pharynx (C00–C14)	4,973	3,686	63,153	1,407,108	2,525	1,182	19,710	329,290
Esophagus (C15)	9,037	6,533	101,057	2,075,079	2,854	1,625	25,002	377,256
Stomach (C16)	7,403	2,052	29,435	576,855	5,223	600	9,163	142,908
Pancreas (C25)	13,984	3,078	48,337	1,011,388	14,774	3,431	51,555	766,122
Larynx (C32)	3,017	2,499	38,241	775,821	816	596	10,375	172,820
Trachea, lung, bronchus (C33–C34)	89,912	79,026	1,113,644	20,950,648	63,181	44,810	740,221	11,796,204
Cervix uteri (C53)	—	—	—	—	3,989	491	12,959	300,078
Kidney, other urinary (C64–65)	7,169	2,790	43,091	891,392	4,454	222	3,861	66,482
Urinary bladder (C67)	8,025	3,764	42,204	637,445	3,841	1,054	12,958	150,902
Acute myeloid leukemia (C92.0)	3,447	791	11,664	233,255	2,919	299	4,989	83,554
Total	**146,967**	**104,219**	**1,490,826**	**28,558,991**	**104,576**	**54,310**	**890,793**	**14,185,616**
Cardiovascular diseases								
Ischemic heart disease (I20–I25)	262,968	54,629	848,560	17,962,696	256,871	32,172	426,108	5,758,053
Other heart disease (I00–I09, I26–I51)	70,368	13,006	169,552	3,148,168	92,173	7,937	95,948	1,168,287
Cerebrovascular disease (I60–I69)	64,074	8,543	135,609	2,942,167	101,873	8,893	151,945	2,715,092
Atherosclerosis (I70–I71)	5,444	1,439	13,394	158,581	9,276	759	6,822	41,664
Aortic aneurysm (I71)	9,635	6,203	75,640	1,263,516	6,185	3,046	37,129	423,261
Other arterial disease (I72–I78)	4,188	547	7,200	132,202	5,585	805	10,246	131,435
Total	**416,677**	**84,367**	**1,249,955**	**25,607,330**	**471,963**	**53,612**	**728,198**	**10,237,792**
Respiratory diseases								
Pneumonia, influenza (J10–J18)	27,389	6,170	60,862	814,279	34,748	4,702	49,577	483,219
Bronchitis, emphysema (J40–J42, J43)	9,455	8,586	97,003	1,442,012	8,594	6,922	90,537	1,085,109
Chronic airway obstruction (J44)	48,644	39,563	411,713	5,515,658	47,769	35,511	427,097	4,588,079
Total	**85,488**	**54,319**	**569,578**	**7,771,949**	**91,111**	**47,135**	**567,211**	**6,156,407**
Perinatal conditions								
Short gestation/low birthweight (P07)	2,435	230	17,024	—	1,980	187	14,870	—
Respiratory distress syndrome (P22)	688	25	1,863	—	468	17	1,368	—
Other respiratory (newborn) (P23–28)	891	44	3,239	—	640	31	2,481	—
Sudden infant death syndrome (R95)	1,603	224	16,587	—	1,082	152	12,053	—
Total	**5,617**	**523**	**38,713**	—	**4,170**	**387**	**30,772**	—
Burn deaths	—	**530**	—	—	—	**388**	—	—
Secondhand smoke deaths								
Lung cancer	—	1,130	—	—	—	1,930	—	—
Ischemic heart disease	—	14,406	—	—	—	20,646	—	—
Total	—	**15,536**	—	—	—	**22,576**	—	—
Total	—	**259,494**	**3,349,072**	**61,938,270**	—	**178,408**	**2,216,974**	**30,579,815**

* *International Classification of Diseases, Tenth Revision.*
† Productivity loss estimates are in thousands of dollars.

smoking because costs associated with smoking-attributable health-care expenditures, smoking-related disability, employee absenteeism, and secondhand smoke–attributable disease morbidity and mortality were not included. Finally, the estimates do not account for the sampling variability in smoking prevalence estimates or in RRs.

Cigarette smoking continues to impose substantial health and financial costs on society. In 1998, smoking-attributable health-care expenditures were estimated at $75.5 billion (*2*). During 1997–2001, these expenditures plus the productivity losses ($92 billion) exceeded $167 billion per year. By comparison, investments in comprehensive, state-based tobacco prevention and control programs in 2002 were approximately 200-fold smaller than those costs (*9*). Because investments in evidence-based prevention programs have produced larger and faster reductions in cigarette consumption (*10*), increased investments to the levels recommended by CDC are needed to achieve a greater health impact.

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Heat-Related Mortality — Arizona, 1993–2002, and United States, 1979–2002

Hyperthermia is the elevation of body temperature resulting from the body's inability to dissipate heat (*1*). Continued exposure to ambient heat close to body temperature (98.6°F [37.0°C]) contributes to a substantial number of deaths from hyperthermia, especially among elderly persons (*2*). To assess the health risk from hyperthermia, Arizona health practitioners and CDC researched cases of heat-related death and illness in Arizona, used U.S. death certificate data to summarize trends in heat-related deaths, and compared age-specific, heat-related death rates in Arizona with those in the United States overall. Findings indicated that, during 1979–2002, a total of 4,780 heat-related deaths in the United States were attributable to weather conditions and that, during 1993–2002, the incidence of such deaths was three to seven times greater in Arizona than in the United States overall. Public health agencies in communities affected by periods of extreme heat should educate populations at risk (e.g., persons aged ≥65 years) and consider designing and implementing location-specific heat response plans (HRPs).

Case Reports — Arizona

Case 1. In July 2001, a boy aged 14 years was participating in a youth boot camp west of Phoenix when he began hallucinating and eating dirt. He had been in direct sunlight for 1–5 hours in an outside temperature of 111°F (44°C). When the boy became unresponsive, camp supervisors placed him in a bathtub with a running shower. The tub drain reportedly became blocked with dirt and other material. The camp supervisors returned to find the boy with his face in the water. The supervisors telephoned 911, but the boy never regained consciousness and was pronounced dead later that night. The office of the medical examiner (ME) attributed the boy's death to complications of near-drowning and dehydration from heat exposure. The ME did not document a core body temperature.

Case 2. In August 2004, at 5:50 p.m, two sisters aged 2 and 4 years were found unresponsive in the locked family car by their mother in a Phoenix suburb. The children had been locked in the car for more than 15 minutes. Temperatures inside and outside the automobile were not recorded; however, high temperatures in the area on that day and at that time ranged from the mid-90s (~32°C) to 101°F (38°C). When emergency medical services (EMS) personnel arrived, both children were asystolic. During helicopter transport to the hospital, EMS personnel administered multiple doses of intraosseous epinephrine and atropine. At the emergency department (ED), rectal temperatures were 106.4°F (41.3°C) for the younger girl and 105.0°F (40.6°C) for the older girl. Both children were pronounced dead within 10 minutes of arrival at the ED. The ME found severe cerebral edema in both children and declared hyperthermia as the cause of death.

Case 3. In May 2004, at approximately 4 p.m. in Phoenix, a man aged 35 years with a history of schizophrenia suddenly collapsed after working in a garden for 1 hour in 98°F (37°C) heat. EMS personnel found him unresponsive, with a heart rate of 170 beats per minute (bpm). At the ED, his rectal temperature was 105.4°F (40.8°C). Primary diagnosis was heat stroke with nonepileptic convulsions, with a secondary diagnosis of burn blisters with epidermal loss on limbs and trunk. The patient was intubated, rapidly cooled with fans and ice baths, and started on ceftriaxone and vancomycin; however, subsequent cultures and imaging studies were within normal limits. The man's hospital course was complicated by rhabdomyolysis, but he recovered and was discharged on the third day.

Case 4. In September 2004, at approximately 11 a.m. in a Phoenix suburb, a woman aged 59 years who had been riding her bicycle was found lying on the ground with altered mental status. The ambient temperature was 95°F (35°C). EMS personnel recorded a blood pressure of 130/72 mm/Hg, a heart rate of 174 bpm, and a respiratory rate of 28 breaths per minute. Serial examinations, multiple radiographs, and computerized tomography scans did not locate any trauma. The patient had an oral temperature of 101.4°F (38.8°C) 1 hour after arriving at the ED. Primary diagnosis was heat stroke; schizophrenia (not otherwise specified), gastric hemorrhage, and acute renal failure were secondary diagnoses. The woman's mental status returned to baseline when she was externally cooled with water misters and fans. She was observed overnight and discharged the next day after improvement of her clinical status.

Heat-Related Mortality — United States, 1979–2002

During 1979–2002, the most recent years for which national data are available, 4,780 deaths were classified as heat related because of weather conditions.* Of the 4,686 (98%) heat-related deaths attributed to weather for which age of the decedent was reported, 260 (6%) occurred among children aged <15 years, 2,356 (50%) among persons aged 15–64 years, and 2,070 (44%) among persons aged ≥65 years (*3*). During 1979–2002, heat waves with high mortality occurred in 1980 (St. Louis and Kansas City, Missouri), 1995 (Chicago, Illinois), and 1999 (Cincinnati, Ohio, and Chicago). During that period, the annual rate of heat-related deaths from weather conditions was highest among persons aged ≥65 years (Figure 1).

Heat-Related Mortality — Arizona, 1993–2002

Arizona experiences intense and prolonged summer heat. Normal daily maximum temperature reaches ≥100°F (≥38°C) in early June and can remain at that level until mid-September (*4*). During 1993–2002, a total of 253 deaths in Arizona were attributable to heat exposure. During this period, Arizona had the highest average annual age-adjusted† rate of death from heat exposure (five deaths per million) among U.S. states. Within the state, the highest average annual age-adjusted death rates (>10 per million population) occurred in the western counties of Mohave, La Paz, and Yuma. Combining data from the period 1993–2002, the rate of death from heat exposure in Arizona for persons aged ≥25 years was three to seven times higher than that for the United States overall and ranged from two deaths per million persons aged 25–34 years to 42 deaths per million persons aged ≥85 years (Figure 2).

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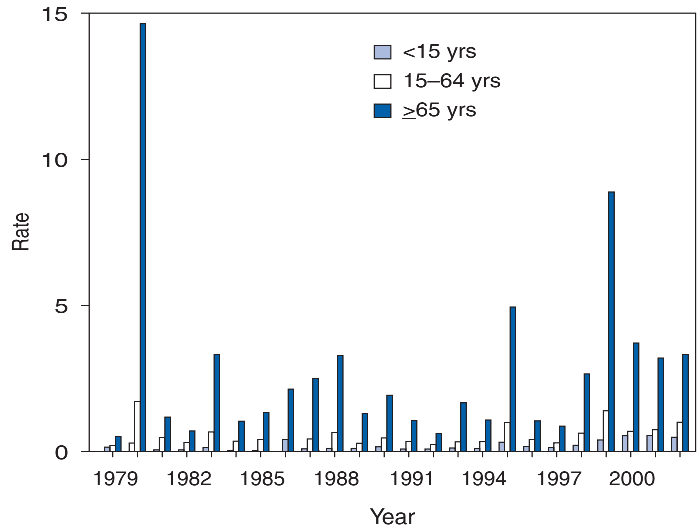
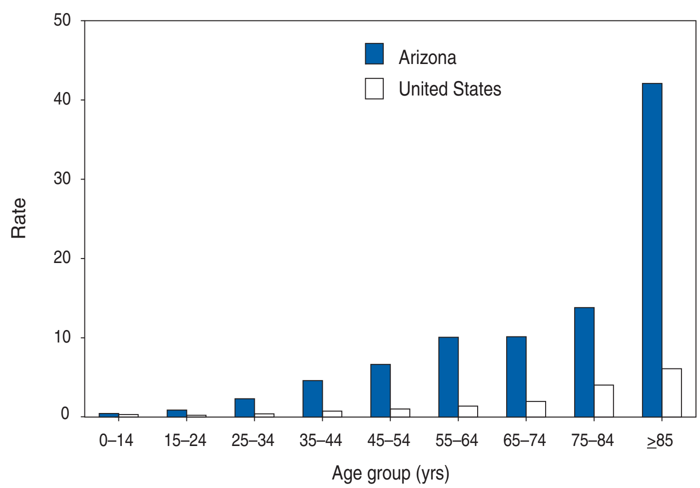
* For the period 1979–1998, deaths were classified according to *International Classification of Diseases, Ninth Revision* (ICD-9), code E900.0, "due to weather conditions." For the period 1999–2002, deaths were classified according to ICD-10, code X30, "exposure to excessive natural heat."
† Rates age-adjusted to the 2000 U.S. standard population.

FIGURE 1. Annual rate* of heat-related deaths attributed to weather conditions† or exposure to excessive natural heat,§ by age group and year — United States, 1979–2002



* Per 1,000,000 population.
† *International Classification of Diseases, Ninth Revision* (ICD-9), code E900.0.
§ ICD-10, code X30.

FIGURE 2. Average annual rate* of heat-related deaths attributed to weather conditions† or exposure to excessive natural heat,§ by age group — United States, 1979–2002



* Per 1,000,000 population.
† *International Classification of Diseases, Ninth Revision* (ICD-9), code E900.0.
§ ICD-10, code X30.

Editorial Note: The Arizona cases described in this report highlight the spectrum of disease caused by exposure to excessive heat. Exposure to prolonged periods of high temperature can cause heat-related illnesses, including heat cramps, heat syncope, heat exhaustion, heat stroke, and death (*5*). Heat exhaustion is the most common heat-related illness (*6*). Signs and symptoms include intense thirst, heavy sweating, weakness, paleness, discomfort, anxiety, dizziness, fatigue, fainting, nausea or vomiting, and headache. Core body temperature can be normal, below normal, or slightly elevated, and the skin can be cool and moist (*5,7,8*). If unrecognized and untreated, these mild to moderate signs and symptoms can progress to heat stroke (*6*), a severe illness clinically defined as core body temperature ≥105.0°F (≥40.6°C), accompanied by hot, dry skin and central nervous system abnormalities, such as delirium, convulsions, or coma (*5,7,8*).

To prevent heat-related illness and death, public health agencies should identify susceptible populations and risk behaviors. Children, elderly persons, and persons without access to air conditioning are at increased risk for heat-related illness and death. In addition, persons with chronic mental disorders or cardiopulmonary disease and those receiving medications that interfere with salt and water balance, such as diuretics, anticholergic agents, and tranquilizers that impair sweating, are at greater risk for heat-related illness and death. Drinking alcoholic beverages, ingesting illicit drugs (e.g., cocaine or amphetamines), and participating in strenuous outdoor physical activities (e.g., sports or manual labor) in hot weather also are risk behaviors associated with heat-related illness (*7,9,10*).

Periodic heat waves highlight the need for public health interventions to prevent excess morbidity and mortality; written HRPs are central to those interventions. HRPs detail actions that local government agencies and nongovernment organizations can take in the event of a forecast of extremely hot weather to reduce heat-related mortality (Box).

All heat-related deaths and illnesses are preventable. In hot weather, persons can take precautions, including rescheduling strenuous outdoor activities to cooler times of the day, reducing the level of physical activity, drinking additional water, wearing lightweight and light-colored clothing, and increasing the amount of time spent in air-conditioned environments (*7*). Indoors, persons can prevent sunlight from coming through windows and minimize cooking; sprinkling water on clothing also can reduce heat stress. Parents should never leave young children in parked cars and should keep cars locked when not in use. Relatives, neighbors, and caretakers of persons at risk for heat-related illness and death (e.g., elderly, disabled, and homebound persons) should frequently check on these persons, recognize symptoms of heat-related morbidity, and take appropriate action (*5*).

BOX. Criteria for development of an effective heat response plan (HRP)

- Identify a lead agency and other participating agencies and nongovernment organizations, describing roles and responsibilities in detail.
- Review plans annually, before onset of warm weather, to review response protocols and confirm participation of lead personnel.
- Identify activation and deactivation thresholds for the HRP by using community-specific factors affecting mortality (e.g., extremes in daytime high and nighttime low temperatures and deviation from local norms).
- Before a heat emergency, use preexisting communication plans and public education tools to define a clear communications strategy and pathway from the lead agency to first responders, the public, and the media.
- Define risk factors, populations at high risk, and methods to reach them (e.g., daily checks on the elderly by social service agency personnel and provision for transportation to air-conditioned public centers).
- Establish a method to evaluate and revise the HRP, including post-emergency meetings with participating agencies to review response activities, activation and deactivation thresholds, communication plans, outreach activities, and the association between weather data and heat-related morbidity and mortality.

SOURCE: Bernard SM, McGeehin MA. Municipal heat wave response plans. Am J Public Health 2004;94:1520–2.

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Update: Influenza Activity — United States and Worldwide, 2004–05 Season

During the 2004–05 influenza season, influenza A (H1),* A (H3N2), and B viruses cocirculated worldwide, and influenza A (H3N2) viruses predominated. In addition, several Asian countries continued to report widespread outbreaks of avian influenza A (H5N1) among poultry; in Vietnam, Thailand, and Cambodia, these outbreaks were associated with severe illnesses and deaths among humans. In the United States, the 2004–05 influenza season peaked in February, was moderate, and was associated predominantly with influenza A (H3N2) viruses. This report summarizes influenza activity in the United States and worldwide during the 2004–05 influenza season.

United States Influenza Activity

Influenza activity occurred at low levels from October to mid-December, steadily increased during January, and peaked in mid-February. Influenza A (H3N2) viruses predominated overall, but influenza B viruses were more frequently identified than influenza A viruses during late March through May. A small number of A (H1) viruses were also identified.

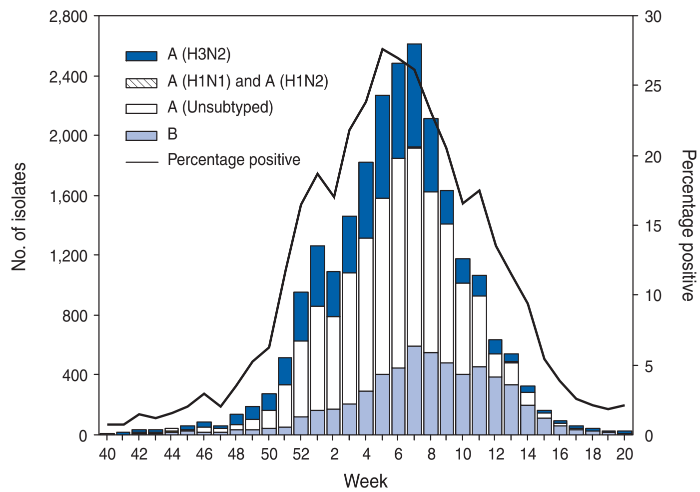
Viral Surveillance

During October 3, 2004–May 21, 2005, World Health Organization (WHO) and National Respiratory and Enteric Virus Surveillance System (NREVSS) collaborating laboratories in the United States tested 157,759 respiratory specimens for influenza viruses (Figure 1); 23,549 (14.9%) were positive.

Among the 23,549 identified influenza viruses, 17,750 (75.4%) were influenza A viruses, and 5,799 (24.6%) were influenza B viruses. A total of 5,819 (32.8%) of the 17,750 influenza A viruses were subtyped; 5,801 (99.7%) were influenza A (H3N2), and 18 (0.3%) were influenza A (H1) viruses. The proportion of specimens testing positive for influenza first exceeded 10% during the week ending December 25, 2004 (week 51), peaked at 27.0% during the week ending February 5, 2005 (week 5), and declined to <10% during the week ending April 9, 2005 (week 14). The peak percentage of specimens testing positive for influenza during the previous three seasons had ranged from 24.9% to 34.7% and peaked during late November to late February (*1*; CDC, unpublished data, 2005).

* Includes both the A (H1N1) and A (H1N2) influenza virus types.

FIGURE 1. Number* and percentage of respiratory specimens testing positive for influenza reported by World Health Organization and National Respiratory and Enteric Virus Surveillance System collaborating laboratories, by week — United States, 2004–05 influenza season†



* N = 23,549.
† As of June 18, 2005.

Antigenic Characterization

CDC antigenically characterized 1,075 influenza viruses collected by U.S. laboratories since October 1, 2004: a total of 11 influenza A (H1N1) viruses, 709 influenza A (H3N2) viruses, and 355 influenza B viruses. All 11 of the influenza A (H1N1) viruses were similar antigenically to A/New Caledonia/20/99, the 2004–05 and 2005–06 vaccine component. A total of 156 (22.0%) of the 709 influenza A (H3N2) isolates were characterized as antigenically similar to A/Wyoming/3/2003, which is the A/Fujian/411/2002-like (H3N2) component of the 2004–05 influenza vaccine, and 553 (78.0%) were characterized as A/California/7/2004-like. An A/California/07/2004-like virus was recommended as the H3 component for the 2005–06 Northern Hemisphere vaccine.

Influenza B viruses circulating worldwide can be divided into two antigenically distinct lineages: B/Yamagata/16/88 and B/Victoria/2/87. The type-B component of the 2004–05 and 2005–06 influenza vaccines (B/Shanghai/361/2002-like) belongs to the B/Yamagata lineage. A total of 264 (74.4%) of the influenza B viruses characterized in the 2004–05 season belong to the B/Yamagata/16/88 lineage. Of these, 219 (83.0%) were B/Shanghai/361/2002-like, and 45 (17.0%) had reduced titers to ferret antisera produced against B/Shanghai/361/2002. Ninety-one (25.6%) influenza B viruses belong to the B/Victoria/2/87 lineage.

Influenza-Like Illness (ILI)† Surveillance

The weekly percentage of patient visits to U.S. influenza sentinel providers for ILI first exceeded the national baseline of 2.5%§ during the week ending January 1, 2005, and again for 13 consecutive weeks during the weeks ending January 15–March 26, 2005. ILI peaked at 5.4% during the week ending February 19, 2005. During the previous three influenza seasons, the peak percentage of patient visits for ILI ranged from 3.2% to 7.6% and occurred during late December through early February (*1*; CDC, unpublished data, 2005).

State-Specific Activity Levels

Influenza activity, as reported by state and territorial epidemiologists, peaked during the week ending February 19, 2005 (week 7), when 30 states reported widespread influenza activity and 13 states reported regional activity.¶ A total of 42 states and New York City reported widespread influenza activity for at least 1 week. No states reported widespread, regional, or local influenza activity during the weeks ending May 7–21, 2005 (weeks 18–20). The peak number of states reporting widespread or regional activity during the previous three seasons ranged from 35 to 50 states (*1*; CDC, unpublished data, 2005).

Influenza-Associated Pediatric Hospitalizations

Laboratory-confirmed, influenza-associated, pediatric hospitalizations are monitored in two population-based surveillance networks: the Emerging Infections Program (EIP) and the New Vaccine Surveillance Network (NVSN). During October 1, 2004–April 30, 2005,** the preliminary influenza-associated hospitalization rates for children aged 0–4 years reported by NVSN and EIP were 7.0 and 3.1 per 10,000, respectively. EIP also monitors hospitalizations in children aged 5–17 years; the preliminary influenza-associated hospitalization rate for this age group was 0.6 per 10,000. The overall hospitalization rate reported by EIP for children aged 0–17 years was 1.3 per 10,000.

During 2000–2004, the end-of-season hospitalization rate for NVSN ranged from 3.7 (2002–03) to 12.0 (2003–04) per 10,000 children. The 2003–04 end-of-season hospitalization rate for EIP was 8.9 per 10,000 children aged 0–4 years and 0.8 per 10,000 for children aged 5–17 years. The difference in rates between NVSN and EIP is likely attributable to different case-finding methods and the different populations monitored.††

Pneumonia and Influenza-Related Mortality

As measured by the 122 Cities Mortality Reporting System, the percentage of deaths in the United States attributed to pneumonia and influenza (P&I) exceeded the epidemic threshold§§ during 8 consecutive weeks ending February 14–April 9, 2005, and peaked at 8.9% during the week ending March 5, 2005 (Figure 2). The percentage of P&I deaths remained below the threshold through the weeks ending April 30–May 21, 2005. During the previous three influenza seasons, the peak percentage of P&I deaths ranged from 8.5% to 10.4% (*1*; CDC, unpublished data, 2005).

Influenza-Associated Pediatric Mortality

In October 2004, pediatric deaths (i.e., deaths in children aged <18 years) associated with laboratory-confirmed influenza infection became a nationally notifiable condition. For the 2004–05 influenza season, 36 pediatric deaths have been reported to CDC from 16 states (California, Colorado, Florida, Georgia, Iowa, Maine, Maryland, Massachusetts, Michigan, Mississippi, Nevada, New Jersey, New York, Ohio, Pennsylvania, and Vermont) and New York City; all deaths were reported during January–June 2005.

† Defined as temperature of ≥100.0° F (≥37.8° C) and either cough or sore throat in the absence of a known cause other than influenza.

§ The national baseline was calculated as the mean percentage of patient visits for ILI during non-influenza weeks plus two standard deviations. Wide variability in regional data precludes calculating region-specific baselines and makes it inappropriate to apply the national baseline to regional data. National and regional percentages of patient visits for ILI are weighted on the basis of state population.

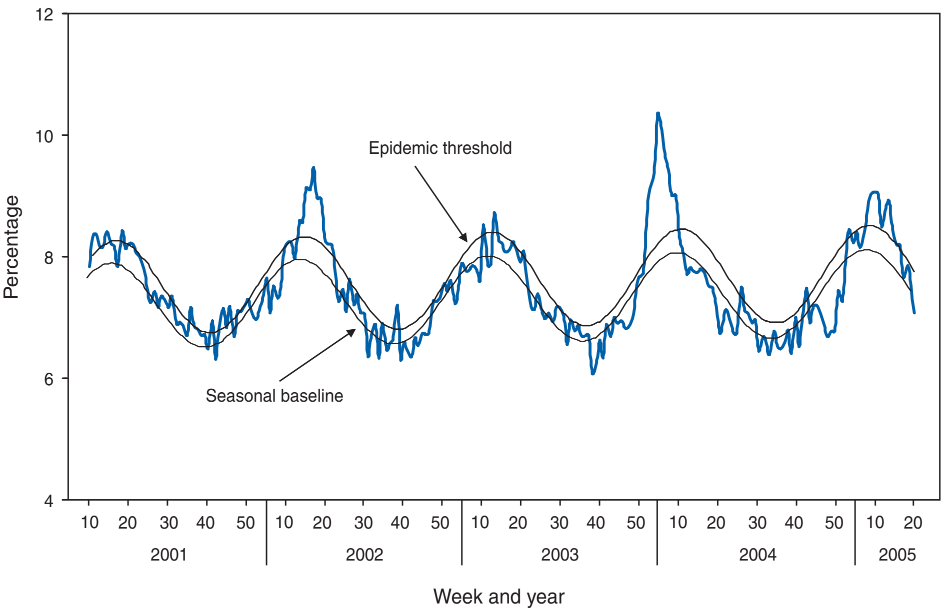
¶ Levels of activity are 1) *no activity*; 2) *sporadic*: isolated laboratory-confirmed influenza cases or laboratory-confirmed outbreak in one institution, with no increase in activity; 3) *local*: increased ILI in one region, or at least two institutional outbreaks (ILI or laboratory-confirmed influenza) in one region; virus activity no greater than sporadic in other regions; 4) *regional*: increased ILI activity or outbreaks (ILI or laboratory-confirmed influenza) in at least two but fewer than half of the regions in the state; and 5) *widespread*: increased ILI activity or outbreaks (ILI or laboratory-confirmed influenza) in at least half the regions in the state.

** Active prospective surveillance in EIP and NVSN for the 2004–05 influenza season ended as of April 30, 2005.

†† NVSN provides population-based estimates of laboratory-confirmed influenza hospitalization rates in children aged <5 years admitted to NVSN hospitals with fever or respiratory symptoms. Children are prospectively enrolled, and respiratory samples are collected and tested by viral culture and reverse transcriptase-polymerase chain reaction (PCR). EIP conducts surveillance for laboratory-confirmed, influenza-related hospitalizations in person aged <18 years. Hospital laboratory and admission databases and infection-control logs are reviewed to identify children with a positive influenza test result (i.e., culture, direct or indirect fluorescent antibody assays, PCR, or a rapid test) from testing conducted as a part of their routine care.

§§ The expected seasonal baseline proportion of P&I deaths reported by the 122 Cities Mortality Reporting System is projected by using a robust regression procedure in which a periodic regression model is applied to the observed percentage of deaths from P&I during the previous 5 years. The epidemic threshold is 1.654 standard deviations above the seasonal baseline.

FIGURE 2. Percentage of all deaths attributed to pneumonia and influenza mortality, by week and year — 122 U.S. cities, week ending May 21, 2005



Worldwide Influenza Activity

During October 2004–May 2005, influenza A viruses circulated widely worldwide. Influenza A (H3N2) viruses predominated in most countries, whereas influenza A (H1) and B viruses circulated at low levels in most parts of the world. Influenza A (H3N2) viruses predominated and were associated with outbreaks in Asia (Hong Kong, Indonesia, Israel, and South Korea), Europe (Belgium, Finland, France, Germany, Italy, Latvia, Norway, Portugal, Romania, the Russian Federation, Spain, Sweden, Switzerland, Turkey, Ukraine, and the United Kingdom), and North America (Canada). Influenza A (H3N2) viruses also were reported in Africa (Egypt, Madagascar, Morocco, Senegal, South Africa, and Tunisia), Asia (China, India, Iraq, Iran, Japan, Kyrgyzstan, Malaysia, the Philippines, Singapore, Taiwan, and Thailand), Europe (Austria, Belarus, Bulgaria, Czech Republic, Denmark, Greece, Hungary, Iceland, Ireland, the Netherlands, Poland, Serbia and Montenegro, and Slovenia), South America and the Caribbean (Argentina, Brazil, Chile, Dominica, Guyana, Peru, Saint Lucia, and Venezuela), North America (Canada and Mexico), and Oceania (Australia, Guam, New Caledonia, and New Zealand).

Influenza A (H1) viruses circulated at low levels in most parts of the world. Influenza A (H1) viruses were isolated in Africa (Senegal, South Africa, and Tunisia), Asia (China, Hong Kong, Indonesia, Iran, Israel, Japan, Kazakhstan, Kyrgyzstan, Malaysia, Singapore, South Korea, Taiwan, and Thailand), Europe (Austria, Belgium, Bulgaria, Czech Republic, Denmark, France, Germany, Greece, Ireland, Italy, Latvia, Norway, Poland, Portugal, Romania, Russian Federation, Slovakia, Sweden, Switzerland, Turkey, Ukraine, and the United Kingdom), and South America (Brazil and Peru).

Influenza B viruses were reported in association with outbreaks in Asia (China, Hong Kong, Japan, and Taiwan) and Europe (Denmark, Ireland, and the Netherlands). Influenza B viruses also were isolated in Africa (Egypt, Madagascar, Morocco, Senegal, South Africa, and Tunisia), Asia (Bangladesh, India, Indonesia, Israel, Malaysia, South Korea, Singapore, and Thailand), the Caribbean (Jamaica and Saint Lucia), Europe (Austria, Belarus, Belgium, Czech Republic, Finland, France, Germany, Greece, Iceland, Italy, Latvia, Norway, Portugal, Romania, Russia, Spain, Sweden, Switzerland, Turkey, Ukraine, and the United Kingdom), South America (Argentina, Brazil, Chile, Colombia, Guyana, Paraguay, Peru, and Uruguay), North America (Canada and Mexico), and Oceania (Australia, New Caledonia, and New Zealand).

Human Infections with Avian Influenza A (H5N1) Viruses

During January 2004–June 28, 2005, a total of 108 human cases of avian influenza A (H5N1) infection resulting in 54 deaths were reported in Vietnam (87 cases and 38 deaths), Thailand (17 cases and 12 deaths), and Cambodia (four cases and four deaths) (*2*). From mid-December 2004 through June 28, 2005, a total of 60 cases (18 deaths) were reported in Vietnam, and four cases (four deaths) were reported in Cambodia (*2*).

Reported by: *WHO Collaborating Center for Surveillance, Epidemiology, and Control of Influenza. R Dhara, MPH, K Teates, MPH, L Brammer, MPH, T Wallis, MS, A Postema, MPH, T Uyeki, MD, A Klimov, PhD, K Fukuda, MD, N Cox, PhD, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases, CDC.*

Editorial Note: During the 2004–05 influenza season, influenza A (H3N2) viruses predominated in most countries in Asia, Europe, and North America, but influenza A (H1) and B viruses were also identified. In the United States, influenza activity peaked in February and was less severe than during the previous season.

Human infections with avian influenza A (H5N1) viruses continue to be identified in Southeast Asia. To date, the majority of cases have been associated with direct exposure to A (H5N1)-infected poultry. Probable, limited, person-to-person transmission of A (H5N1) viruses during 2004 occurred in Thailand (*3*) and is one of several possible explanations for the observed increase in clusters of A (H5N1) cases in northern Vietnam during 2005 (*4*). Limited, person-to-person transmission of A (H5N1) was also identified during the 1997 outbreak in Hong Kong (*5*). However, efficient, sustained, person-to-person transmission of influenza A (H5N1) viruses has not been reported to date. Genetic analysis of influenza A (H5N1) viruses isolated from humans in 2004 and 2005 revealed that all genes were of avian origin.

CDC continues to recommend enhanced surveillance for influenza A (H5N1) infection among travelers with severe unexplained respiratory illness returning from A (H5N1)-affected countries. Additional information is available at http://www.phppo.cdc.gov/HAN/ArchiveSys/ViewMsgV.asp?AlertNum=00221.

Additional information on influenza, including avian influenza, is available at http://www.cdc.gov/flu. Updates on human infections with avian influenza are available from the World Health Organization at http://www.who.int/csr/disease/avian_influenza/en.

Acknowledgments

This report is based on data contributed by participating state and territorial health departments and state public health laboratories, WHO collaborating laboratories, National Respiratory and Enteric Virus Surveillance System collaborating laboratories, the U.S. Influenza Sentinel Provider Surveillance System, the New Vaccine Surveillance Network, the Emerging Infections Program, and the 122 Cities Mortality Reporting System. WHO National Influenza Centers, WHO Global Influenza Programme, Geneva, Switzerland. I Gust, MD, A Hampson, WHO Collaborating Center for Reference and Research on Influenza, Parkville, Australia. A Hay, PhD, WHO Collaborating Center for Reference and Research on Influenza, National Institute for Medical Research, London, England. M Tashiro, MD, WHO Collaborating Center for Reference and Research on Influenza, National Institute of Infectious Diseases, Tokyo, Japan. Bur of Epidemiology and Field Epidemiology Training Program, Thai Ministry of Public Health. National Center for Public Health Informatics; National Immunization Program, CDC.

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Notice to Readers

Beginning and Intermediate/Advanced Courses in Epi Info

Emory University's Rollins School of Public Health and CDC's Office of Workforce and Career Development will cosponsor Epi Info training August 10–12, 2005, for beginning level students and August 15–17, 2005, for intermediate/advanced level students. Courses will be held at Emory University; tuition is charged.

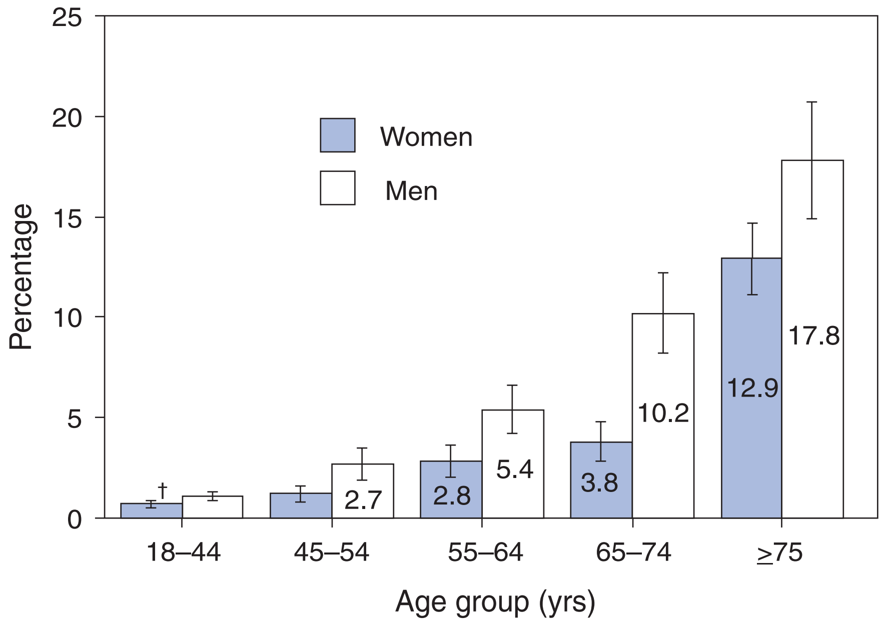
These courses are designed for practitioners of epidemiology and computing who wish to develop software applications using Epi Info for Windows. The beginning level course will cover MakeView, Analysis, Enter, Epi Map and Epi Report. The intermediate/advanced level course will cover importing and converting other data formats; creating relational databases; advanced check-coding and use of Epi Info functions; advanced analysis (e.g., linear regression, logistic regression, Kaplan-Meier method, Cox proportional hazards, complex sample frequencies, tables and means); special topics regarding Epi Map and Epi Report; and issues related to students' own projects.

Additional information and applications are available from Emory University, Rollins School of Public Health, International Health Department, 1518 Clifton Road, N.E., Room 746, Atlanta, Georgia, 30322; fax 404-727-4590; website http://www.sph.emory.edu/epicourses; e-mailpvaleri@sph.emory.edu.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Adults* Who Reported Being Deaf or Having a Lot of Trouble Hearing Without a Hearing Aid, by Sex and Age Group — United States, 2003



* The civilian, noninstitutionalized population aged ≥18 years.
† 95% confidence interval.

In 2003, the percentage of adults aged ≥18 years who reported being deaf or having a lot of trouble hearing increased with age, from 1% in persons aged 18–44 years to 15% in persons aged ≥75 years. In every age group, more men than women reported hearing limitations; among persons aged 65–74 years, men were more than twice as likely as women to have hearing limitations.

SOURCE: National Health Interview Survey, 2003. Available at http://www.cdc.gov/nchs/nhis.htm.

Notice to Readers

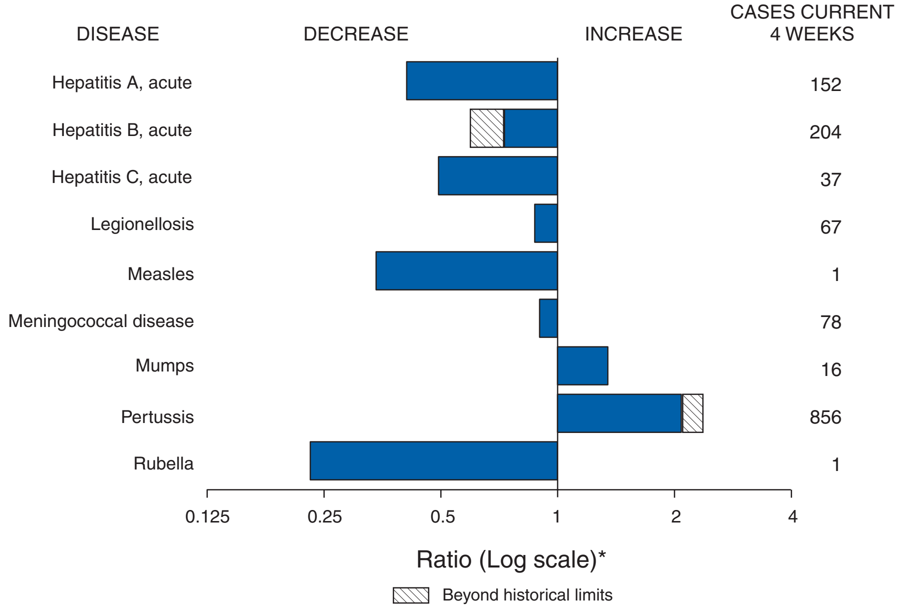
Satellite Broadcast on Immunization Update 2005

CDC's National Immunization Program and the Public Health Training Network will present a live satellite broadcast, "Immunization Update 2005," on July 28, 2005, from 9:00 to 11:30 a.m. EDT, and a rebroadcast of the same program that day from 12:00 to 2:30 p.m. EDT. Both broadcasts will include a live question-and-answer session, during which participants nationwide can interact with course instructors via toll-free telephone lines.

This program is intended for physicians, nurses, nurse practitioners, physician assistants, pharmacists, residents, medical and nursing students, and their colleagues who either administer vaccinations or set policy in the workplace. Anticipated topics include recommendations for influenza vaccination and an update of the influenza vaccine supply, meningococcal conjugate vaccine, acellular pertussis vaccine for adolescents, and revised varicella vaccination recommendations. Continuing education credit (2.5 hours of instruction) will be offered for various professions.

The program can be viewed via live webcast and will also be available for viewing for 30 days after the broadcast at http://www.phppo.cdc.gov/phtn/webcast/immup2005. Information about the satellite broadcast, webcast, and continuing education registration is available at http://www.phppo.cdc.gov/phtn/immup2005/default.asp. Information on locations for viewing the satellite broadcast can be obtained from state distance-learning coordinators (http://www.cdc.gov/nip/ed/coordinators.htm).

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals June 25, 2005, 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 June 25, 2005 (25th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	61	50
Botulism:			HIV infection, pediatric†¶	150	170
foodborne	6	6	Influenza-associated pediatric mortality†**	36	—
infant	28	37	Measles	22††	18§§
other (wound & unspecified)	12	5	Mumps	125	106
Brucellosis	40	45	Plague	2	—
Chancroid	11	23	Poliomyelitis, paralytic	—	—
Cholera	1	4	Psittacosis†	9	6
Cyclosporiasis†	525	100	Q fever†	44	33
Diphtheria	—	—	Rabies, human	1	—
Domestic arboviral diseases			Rubella	6	9
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	1	—
California serogroup†§	—	7	SARS†**	—	—
eastern equine†§	—	—	Smallpox†	—	—
Powassan†§	—	—	*Staphylococcus aureus*:		
St. Louis†§	—	1	Vancomycin-intermediate (VISA)†	—	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	—	1
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome†	78	87
human granulocytic (HGE)†	72	87	Tetanus	10	9
human monocytic (HME)†	52	62	Toxic-shock syndrome	46	43
human, other and unspecified †	15	11	Trichinellosis¶¶	5	—
Hansen disease†	35	48	Tularemia†	38	31
Hantavirus pulmonary syndrome†	8	8	Yellow fever	—	—

—: No reported cases.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
¶ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update May 29, 2005.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of 22 cases reported, 14 were indigenous and eight were imported from another country.
§§ Of 18 cases reported, six were indigenous and 12 were imported from another country.
¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending June 25, 2005, and June 26, 2004 (25th Week)*

Reporting area	AIDS		Chlamydia†		Coccidioidomycosis		Cryptosporidiosis	
	Cum. 2005§	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	16,504	19,333	423,967	438,780	1,978	2,576	872	1,146
NEW ENGLAND	673	671	14,961	14,598	—	—	49	68
Maine	8	5	994	927	N	N	7	13
N.H.	10	26	882	805	—	—	7	14
Vt.¶	4	13	479	560	—	—	11	7
Mass.	331	185	6,783	6,404	—	—	17	23
R.I.	68	70	1,544	1,661	—	—	1	2
Conn.	252	372	4,279	4,241	N	N	6	9
MID. ATLANTIC	3,059	4,379	50,986	54,233	—	—	123	184
Upstate N.Y.	318	587	10,568	10,654	N	N	32	38
N.Y. City	1,725	2,326	17,386	16,658	—	—	29	56
N.J.	472	741	5,526	8,650	N	N	8	14
Pa.	544	725	17,506	18,271	N	N	54	76
E.N. CENTRAL	1,387	1,701	66,819	79,016	4	5	185	294
Ohio	209	229	18,689	20,345	N	N	66	65
Ind.	198	215	9,493	8,723	N	N	11	31
Ill.	664	846	19,605	22,395	—	—	12	46
Mich.	246	322	11,374	18,734	4	5	28	57
Wis.	70	89	7,658	8,819	N	N	68	95
W.N. CENTRAL	394	384	25,104	26,698	3	5	133	135
Minn.	104	92	3,962	5,631	3	N	38	52
Iowa	48	26	2,951	3,213	N	N	22	19
Mo.	163	168	10,793	9,698	—	3	50	21
N. Dak.	5	13	501	918	N	N	—	7
S. Dak.	9	6	1,328	1,156	—	—	11	16
Nebr.¶	18	21	2,393	2,500	—	2	1	8
Kans.	47	58	3,176	3,582	N	N	11	12
S. ATLANTIC	5,315	5,729	82,385	82,021	—	—	174	202
Del.	81	80	1,560	1,396	N	N	—	—
Md.	637	686	8,684	8,978	—	—	12	10
D.C.	407	354	1,727	1,736	—	—	2	4
Va.¶	273	283	9,713	10,292	—	—	14	23
W. Va.	30	30	1,263	1,340	N	N	4	3
N.C.	399	334	16,477	13,686	N	N	25	37
S.C.¶	287	375	9,964	8,855	—	—	7	9
Ga.	896	779	12,485	15,426	—	—	43	61
Fla.	2,305	2,808	20,512	20,312	N	N	67	55
E.S. CENTRAL	896	862	29,704	27,478	—	3	23	48
Ky.	118	68	4,941	2,649	N	N	8	16
Tenn.¶	369	386	10,677	10,759	N	N	4	13
Ala.¶	244	227	4,691	6,592	—	—	10	11
Miss.	165	181	9,395	7,478	—	3	1	8
W.S. CENTRAL	1,896	2,356	53,154	55,887	1	2	25	45
Ark.	71	88	4,197	3,923	—	1	1	8
La.	370	444	9,334	12,370	1	1	3	—
Okla.	113	87	5,224	5,177	N	N	13	11
Tex.¶	1,342	1,737	34,399	34,417	N	N	8	26
MOUNTAIN	643	713	25,173	24,335	1,288	1,584	54	50
Mont.	4	1	998	1,252	N	N	9	10
Idaho¶	7	11	1,054	1,407	N	N	4	5
Wyo.	1	6	518	512	2	—	2	2
Colo.	127	134	6,703	6,309	N	N	18	23
N. Mex.	60	106	1,945	4,170	3	10	2	2
Ariz.	258	278	9,112	6,572	1,250	1,536	5	6
Utah	33	31	1,864	1,653	2	7	7	1
Nev.¶	153	146	2,979	2,460	31	31	7	1
PACIFIC	2,241	2,538	75,681	74,514	682	977	106	120
Wash.	196	213	9,241	8,454	N	N	5	—
Oreg.¶	117	131	4,096	3,877	—	—	19	17
Calif.	1,865	2,134	58,266	57,614	682	977	82	101
Alaska	10	14	1,853	1,851	—	—	—	—
Hawaii	53	46	2,225	2,718	—	—	—	2
Guam	1	1	—	667	—	—	—	—
P.R.	335	208	2,029	1,803	N	N	N	N
V.I.	8	6	32	181	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	—	U	—	U	—	U

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

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

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

§ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update May 29, 2005.

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 25, 2005, and June 26, 2004 (25th Week)*

	Escherichia coli, Enterohemorrhagic (EHEC)									
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped		Giardiasis		Gonorrhea	
Reporting area	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	603	688	81	112	77	62	6,843	7,697	141,724	152,221
NEW ENGLAND	47	49	23	26	9	7	623	730	2,879	3,393
Maine	7	2	5	—	—	—	71	64	61	122
N.H.	4	9	1	5	—	—	28	19	76	60
Vt.	5	2	—	—	—	—	71	59	25	43
Mass.	18	25	6	8	9	7	262	324	1,300	1,447
R.I.	2	5	—	1	—	—	40	54	242	427
Conn.	11	6	11	12	—	—	151	210	1,175	1,294
MID. ATLANTIC	70	88	4	15	9	12	1,291	1,702	14,569	17,249
Upstate N.Y.	30	36	4	6	3	4	449	526	3,005	3,483
N.Y. City	2	13	—	—	—	—	335	523	4,459	5,343
N.J.	14	17	—	3	—	4	171	224	2,066	3,236
Pa.	24	22	—	6	6	4	336	429	5,039	5,187
E.N. CENTRAL	111	137	8	20	4	7	1,007	1,159	26,578	32,504
Ohio	39	30	1	4	2	6	287	339	8,635	10,330
Ind.	21	15	—	—	—	—	N	N	3,706	3,004
Ill.	14	31	1	1	—	1	183	368	7,868	9,466
Mich.	19	26	—	4	2	—	290	272	4,341	7,499
Wis.	18	35	6	11	—	—	247	180	2,028	2,205
W.N. CENTRAL	87	110	18	16	10	14	847	832	8,034	7,879
Minn.	12	28	6	7	2	2	423	276	1,125	1,404
Iowa	20	28	—	—	—	—	95	113	643	576
Mo.	28	19	8	7	3	4	176	240	4,392	3,977
N. Dak.	1	4	—	—	—	5	1	12	26	63
S. Dak.	3	5	1	—	—	—	36	28	182	124
Nebr.	7	13	3	2	3	—	43	60	576	521
Kans.	16	13	—	—	2	3	73	103	1,090	1,214
S. ATLANTIC	85	64	12	11	36	10	1,005	1,194	34,609	36,587
Del.	—	1	N	N	N	N	16	24	382	442
Md.	15	16	2	2	—	2	74	44	3,232	3,802
D.C.	—	1	—	—	—	—	21	35	924	1,190
Va.	10	6	6	6	8	—	229	170	3,360	4,131
W. Va.	1	1	—	—	—	—	13	12	353	394
N.C.	—	—	—	—	19	6	N	N	7,719	7,414
S.C.	1	5	—	—	—	—	31	41	4,228	4,316
Ga.	12	14	2	1	—	—	227	383	5,411	6,598
Fla.	46	20	2	2	9	2	394	485	9,000	8,300
E.S. CENTRAL	35	46	—	3	5	8	165	167	11,061	11,892
Ky.	8	11	—	1	4	5	N	N	1,557	1,148
Tenn.	15	15	—	—	1	3	82	82	3,786	3,852
Ala.	11	12	—	—	—	—	83	85	2,819	3,849
Miss.	1	8	—	2	—	—	—	—	2,899	3,043
W.S. CENTRAL	19	39	3	1	3	4	106	127	21,010	20,944
Ark.	3	8	—	—	—	—	37	53	2,152	1,974
La.	3	2	3	—	2	—	17	22	5,033	5,607
Okla.	6	7	—	—	—	—	52	52	2,135	2,174
Tex.	7	22	—	1	1	4	N	N	11,690	11,189
MOUNTAIN	55	65	11	19	1	—	504	568	5,175	5,231
Mont.	3	3	—	—	—	—	18	19	54	48
Idaho	7	18	5	3	—	—	39	77	40	38
Wyo.	—	1	2	1	—	—	11	8	30	26
Colo.	15	16	1	1	—	—	186	189	1,322	1,507
N. Mex.	2	6	3	3	—	—	16	34	349	494
Ariz.	12	6	N	N	N	N	69	80	1,958	1,774
Utah	8	7	—	10	—	—	132	116	294	247
Nev.	8	8	—	1	1	—	33	45	1,128	1,097
PACIFIC	94	90	2	1	—	—	1,295	1,218	17,809	16,542
Wash.	21	28	—	—	—	—	116	120	1,681	1,249
Oreg.	25	12	2	1	—	—	117	186	732	488
Calif.	39	46	—	—	—	—	994	841	14,736	13,842
Alaska	6	1	—	—	—	—	35	29	252	306
Hawaii	3	3	—	—	—	—	33	42	408	657
Guam	N	N	—	—	—	—	—	2	—	108
P.R.	—	—	—	—	—	—	25	84	192	138
V.I.	—	—	—	—	—	—	—	—	2	63
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 25, 2005, and June 26, 2004 (25th Week)*

Reporting area	*Haemophilus influenzae*, invasive							
	All ages		Age <5 years					
	All serotypes		Serotype b		Non-serotype b		Unknown serotype	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,130	1,095	3	8	58	61	116	103
NEW ENGLAND	79	108	—	1	6	7	4	1
Maine	4	7	—	—	—	—	1	—
N.H.	3	13	—	—	—	2	—	—
Vt.	6	5	—	—	—	—	2	1
Mass.	33	54	—	1	1	2	1	—
R.I.	7	3	—	—	2	—	—	—
Conn.	26	26	—	—	3	3	—	—
MID. ATLANTIC	220	224	—	1	—	3	28	27
Upstate N.Y.	61	77	—	1	—	3	5	4
N.Y. City	38	47	—	—	—	—	9	9
N.J.	44	40	—	—	—	—	7	2
Pa.	77	60	—	—	—	—	7	12
E.N. CENTRAL	147	203	1	—	1	8	9	28
Ohio	77	65	—	—	—	2	7	10
Ind.	39	30	—	—	1	4	1	1
Ill.	13	65	—	—	—	—	1	14
Mich.	11	12	1	—	—	2	—	3
Wis.	7	31	—	—	—	—	—	—
W.N. CENTRAL	62	56	—	2	3	3	9	5
Minn.	21	24	—	1	3	3	—	—
Iowa	—	1	—	1	—	—	—	—
Mo.	30	20	—	—	—	—	7	4
N. Dak.	1	3	—	—	—	—	1	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	5	2	—	—	—	—	1	—
Kans.	5	6	—	—	—	—	—	1
S. ATLANTIC	270	251	1	—	16	17	14	17
Del.	—	—	—	—	—	—	—	—
Md.	39	43	—	—	4	4	—	—
D.C.	—	2	—	—	—	—	—	1
Va.	26	21	—	—	—	—	—	1
W. Va.	14	10	—	—	1	3	2	—
N.C.	52	35	1	—	5	5	—	—
S.C.	10	7	—	—	—	—	1	1
Ga.	56	72	—	—	—	—	7	14
Fla.	73	61	—	—	6	5	4	—
E.S. CENTRAL	68	42	—	—	1	—	12	7
Ky.	6	3	—	—	1	—	1	—
Tenn.	46	28	—	—	—	—	7	5
Ala.	16	11	—	—	—	—	4	2
Miss.	—	—	—	—	—	—	—	—
W.S. CENTRAL	70	41	1	1	4	5	7	1
Ark.	4	1	—	—	—	—	1	—
La.	27	9	1	—	2	—	6	1
Okla.	39	30	—	—	2	5	—	—
Tex.	—	1	—	1	—	—	—	—
MOUNTAIN	160	120	—	3	15	13	27	12
Mont.	—	—	—	—	—	—	—	—
Idaho	3	5	—	—	—	—	1	2
Wyo.	3	—	—	—	—	—	1	—
Colo.	29	29	—	—	—	—	6	3
N. Mex.	13	25	—	—	4	4	1	4
Ariz.	88	43	—	—	9	6	10	1
Utah	11	9	—	2	—	1	6	1
Nev.	13	9	—	1	2	2	2	1
PACIFIC	54	50	—	—	12	5	6	5
Wash.	—	1	—	—	—	—	—	1
Oreg.	20	25	—	—	—	—	4	2
Calif.	25	16	—	—	12	5	1	1
Alaska	4	4	—	—	—	—	1	1
Hawaii	5	4	—	—	—	—	—	—
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	—	—	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 25, 2005, and June 26, 2004 (25th Week)*

Reporting area	Hepatitis (viral, acute), by type A Cum. 2005	A Cum. 2004	B Cum. 2005	B Cum. 2004	C Cum. 2005	C Cum. 2004
UNITED STATES	1,743	2,736	2,679	2,773	368	340
NEW ENGLAND	227	400	143	178	6	6
Maine	—	8	8	1	—	—
N.H.	33	11	6	22	—	—
Vt.	2	7	2	2	6	1
Mass.	161	333	105	87	—	5
R.I.	5	10	1	3	—	—
Conn.	26	31	21	63	U	—
MID. ATLANTIC	275	335	569	363	50	62
Upstate N.Y.	42	39	46	35	12	2
N.Y. City	137	128	47	74	—	—
N.J.	47	75	371	98	—	—
Pa.	49	93	105	156	38	60
E.N. CENTRAL	171	224	175	259	63	40
Ohio	27	26	68	64	1	3
Ind.	22	23	11	16	15	3
Ill.	37	72	15	33	—	12
Mich.	71	79	81	122	47	22
Wis.	14	24	—	24	—	—
W.N. CENTRAL	57	77	185	171	20	5
Minn.	3	23	10	20	3	4
Iowa	17	24	67	11	—	—
Mo.	27	11	80	111	15	1
N. Dak.	—	1	—	2	1	—
S. Dak.	—	2	—	—	—	—
Nebr.	3	9	14	15	1	—
Kans.	7	7	14	12	—	—
S. ATLANTIC	257	497	698	898	127	87
Del.	1	5	34	25	59	4
Md.	26	64	85	77	17	2
D.C.	2	4	4	13	—	1
Va.	43	42	84	99	8	8
W. Va.	3	1	19	2	5	14
N.C.	38	32	81	91	9	6
S.C.	8	28	41	66	1	8
Ga.	42	191	93	268	4	7
Fla.	94	130	257	257	24	37
E.S. CENTRAL	116	79	181	229	43	36
Ky.	6	11	36	25	3	16
Tenn.	83	54	68	109	9	9
Ala.	14	6	40	38	8	2
Miss.	13	8	37	57	23	9
W.S. CENTRAL	106	373	180	132	18	54
Ark.	3	48	20	57	—	1
La.	36	19	27	27	8	3
Okla.	3	17	20	34	—	2
Tex.	64	289	113	14	10	48
MOUNTAIN	168	211	259	209	17	19
Mont.	7	4	3	1	—	2
Idaho	15	10	5	6	—	1
Wyo.	—	2	1	6	—	—
Colo.	19	20	22	23	8	4
N. Mex.	8	10	7	10	—	U
Ariz.	100	137	177	105	—	2
Utah	13	22	26	18	6	2
Nev.	6	6	18	40	3	8
PACIFIC	366	540	289	334	24	31
Wash.	21	31	33	26	4	9
Oreg.	26	39	46	55	9	9
Calif.	306	454	202	241	11	12
Alaska	3	3	6	8	—	—
Hawaii	10	13	2	4	—	1
Guam	—	1	—	10	—	8
P.R.	8	21	6	37	—	—
V.I.	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 25, 2005, and June 26, 2004 (25th Week)*

Reporting area	Legionellosis		Listeriosis		Lyme disease		Malaria	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	538	672	224	261	3,218	5,585	474	598
NEW ENGLAND	33	19	8	11	201	897	24	53
Maine	1	—	—	2	15	29	3	4
N.H.	4	—	1	1	23	40	3	—
Vt.	—	1	—	—	5	13	—	3
Mass.	19	11	4	3	110	559	16	31
R.I.	3	2	1	1	3	60	2	2
Conn.	6	5	2	4	45	196	—	13
MID. ATLANTIC	154	153	47	58	2,236	3,700	129	152
Upstate N.Y.	38	30	13	17	502	1,103	23	18
N.Y. City	18	18	7	9	—	120	58	74
N.J.	34	22	9	16	945	1,092	31	34
Pa.	64	83	18	16	789	1,385	17	26
E.N. CENTRAL	104	155	23	45	45	383	33	52
Ohio	48	72	10	15	30	21	10	12
Ind.	6	13	1	8	4	4	—	6
Ill.	12	23	—	8	—	42	9	17
Mich.	30	40	7	12	3	4	11	10
Wis.	8	7	5	2	8	312	3	7
W.N. CENTRAL	15	16	11	5	116	63	24	37
Minn.	1	1	2	1	90	25	11	16
Iowa	2	3	4	1	13	13	2	1
Mo.	9	8	2	2	11	19	10	10
N. Dak.	1	1	2	—	—	—	—	2
S. Dak.	—	1	—	—	—	—	—	1
Nebr.	—	1	—	1	—	4	—	2
Kans.	2	1	1	—	2	2	1	5
S. ATLANTIC	127	147	53	36	529	470	97	140
Del.	8	3	N	N	174	58	—	3
Md.	34	25	8	5	252	308	34	29
D.C.	2	7	—	—	3	2	2	7
Va.	12	9	5	4	40	24	11	11
W. Va.	4	2	1	1	4	2	1	—
N.C.	13	15	10	8	22	45	14	9
S.C.	2	4	1	1	7	5	3	7
Ga.	8	23	10	8	—	8	14	28
Fla.	44	59	18	9	27	18	18	46
E.S. CENTRAL	21	32	11	15	15	22	12	18
Ky.	7	8	1	4	1	10	3	1
Tenn.	7	12	5	7	14	9	6	3
Ala.	7	11	4	2	—	3	3	11
Miss.	—	1	1	2	—	—	—	3
W.S. CENTRAL	10	87	10	23	32	14	33	60
Ark.	1	—	—	2	2	2	2	6
La.	4	5	4	2	4	1	2	3
Okla.	2	2	—	—	—	—	2	2
Tex.	3	80	6	19	26	11	27	49
MOUNTAIN	44	35	2	11	3	5	25	20
Mont.	3	1	—	—	—	—	—	—
Idaho	1	4	—	1	1	2	—	1
Wyo.	3	4	—	—	—	2	1	—
Colo.	11	6	1	3	—	—	14	7
N. Mex.	1	1	—	—	—	—	—	1
Ariz.	13	5	—	—	—	1	5	5
Utah	5	11	—	1	2	—	4	3
Nev.	7	3	1	6	—	—	1	3
PACIFIC	30	28	59	57	41	31	97	66
Wash.	—	4	4	6	—	2	7	3
Oreg.	N	N	4	4	5	14	3	10
Calif.	30	24	51	47	35	15	80	51
Alaska	—	—	—	—	1	—	3	—
Hawaii	—	—	—	—	N	N	4	2
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 25, 2005, and June 26, 2004 (25th Week)*

Reporting area	Meningococcal disease: All serogroups Cum. 2005	All serogroups Cum. 2004	Serogroup A, C, Y, and W-135 Cum. 2005	Serogroup A, C, Y, and W-135 Cum. 2004	Serogroup B Cum. 2005	Serogroup B Cum. 2004	Other serogroup Cum. 2005	Other serogroup Cum. 2004	Serogroup unknown Cum. 2005	Serogroup unknown Cum. 2004
UNITED STATES	674	715	51	54	33	29	—	1	590	631
NEW ENGLAND	48	38	1	4	—	5	—	1	47	28
Maine	2	8	—	—	—	1	—	—	2	7
N.H.	6	3	—	—	—	—	—	—	6	3
Vt.	4	1	—	—	—	—	—	—	4	1
Mass.	24	22	—	4	—	4	—	—	24	14
R.I.	2	1	—	—	—	—	—	—	2	1
Conn.	10	3	1	—	—	—	—	1	9	2
MID. ATLANTIC	90	106	26	31	4	5	—	—	60	70
Upstate N.Y.	22	30	3	5	3	3	—	—	16	22
N.Y. City	12	19	—	—	—	—	—	—	12	19
N.J.	26	20	—	—	—	—	—	—	26	20
Pa.	30	37	23	26	1	2	—	—	6	9
E.N. CENTRAL	60	75	15	13	5	5	—	—	40	57
Ohio	28	41	—	3	5	4	—	—	23	34
Ind.	9	11	—	—	—	1	—	—	9	10
Ill.	3	1	—	—	—	—	—	—	3	1
Mich.	15	10	15	10	—	—	—	—	—	—
Wis.	5	12	—	—	—	—	—	—	5	12
W.N. CENTRAL	44	46	2	—	1	3	—	—	41	43
Minn.	6	13	1	—	—	—	—	—	5	13
Iowa	12	10	—	—	1	2	—	—	11	8
Mo.	15	14	1	—	—	1	—	—	14	13
N. Dak.	—	1	—	—	—	—	—	—	—	1
S. Dak.	2	1	—	—	—	—	—	—	2	1
Nebr.	3	2	—	—	—	—	—	—	3	2
Kans.	6	5	—	—	—	—	—	—	6	5
S. ATLANTIC	126	141	3	2	5	2	—	—	118	137
Del.	2	2	—	—	—	—	—	—	2	2
Md.	12	7	1	—	2	—	—	—	9	7
D.C.	—	5	—	2	—	—	—	—	—	3
Va.	16	9	—	—	—	—	—	—	16	9
W. Va.	5	4	1	—	—	—	—	—	4	4
N.C.	17	21	1	—	3	2	—	—	13	19
S.C.	11	13	—	—	—	—	—	—	11	13
Ga.	12	9	—	—	—	—	—	—	12	9
Fla.	51	71	—	—	—	—	—	—	51	71
E.S. CENTRAL	34	34	—	—	3	—	—	—	31	34
Ky.	11	4	—	—	3	—	—	—	8	4
Tenn.	15	11	—	—	—	—	—	—	15	11
Ala.	4	9	—	—	—	—	—	—	4	9
Miss.	4	10	—	—	—	—	—	—	4	10
W.S. CENTRAL	53	41	1	1	5	1	—	—	47	39
Ark.	9	10	—	—	—	—	—	—	9	10
La.	22	24	—	1	2	—	—	—	20	23
Okla.	12	4	1	—	3	1	—	—	8	3
Tex.	10	3	—	—	—	—	—	—	10	3
MOUNTAIN	59	40	2	1	5	4	—	—	52	35
Mont.	—	3	—	—	—	—	—	—	—	3
Idaho	1	4	—	—	—	—	—	—	1	4
Wyo.	—	3	—	—	—	—	—	—	—	3
Colo.	13	11	2	—	—	—	—	—	11	11
N. Mex.	1	6	—	1	—	3	—	—	1	2
Ariz.	32	6	—	—	2	—	—	—	30	6
Utah	7	2	—	—	2	—	—	—	5	2
Nev.	5	5	—	—	1	1	—	—	4	4
PACIFIC	160	194	1	2	5	4	—	—	154	188
Wash.	29	16	1	2	4	4	—	—	24	10
Oreg.	25	38	—	—	—	—	—	—	25	38
Calif.	99	133	—	—	—	—	—	—	99	133
Alaska	1	2	—	—	—	—	—	—	1	2
Hawaii	6	5	—	—	1	—	—	—	5	5
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	4	9	—	—	—	—	—	—	4	9
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	—	—	—	—	—	—	—	—	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 25, 2005, and June 26, 2004 (25th Week)*

Reporting area	Pertussis		Rabies, animal		Rocky Mountain spotted fever		Salmonellosis		Shigellosis	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	7,950	5,591	2,323	2,917	376	391	12,724	14,160	4,645	5,671
NEW ENGLAND	475	748	341	244	1	8	833	698	104	118
Maine	13	3	26	28	N	N	63	35	4	2
N.H.	19	24	4	10	—	—	56	45	4	5
Vt.	55	40	27	10	—	—	46	21	6	2
Mass.	359	640	199	98	—	7	451	406	60	76
R.I.	11	16	8	15	1	1	32	48	7	8
Conn.	18	25	77	83	—	—	185	143	23	25
MID. ATLANTIC	705	1,114	279	363	24	34	1,621	1,847	488	596
Upstate N.Y.	250	808	222	186	—	1	448	421	122	276
N.Y. City	44	75	14	9	1	12	355	536	191	172
N.J.	126	78	N	N	8	8	260	332	140	95
Pa.	285	153	43	168	15	13	558	558	35	53
E.N. CENTRAL	1,660	1,484	52	28	6	14	1,532	2,029	313	428
Ohio	663	201	25	8	4	5	464	472	34	77
Ind.	146	40	4	4	—	3	147	191	33	92
Ill.	190	303	15	9	1	5	274	680	55	157
Mich.	109	53	8	5	1	1	340	350	124	50
Wis.	552	887	—	2	—	—	307	336	67	52
W.N. CENTRAL	1,141	344	170	289	54	43	945	938	491	173
Minn.	316	72	35	23	—	—	223	226	29	23
Iowa	324	42	32	34	—	—	134	194	41	35
Mo.	215	184	27	12	51	38	315	257	346	75
N. Dak.	48	10	6	30	—	—	11	16	2	1
S. Dak.	1	11	27	59	2	—	60	35	15	6
Nebr.	107	5	—	66	—	5	72	59	28	7
Kans.	130	20	43	65	1	—	130	151	30	26
S. ATLANTIC	521	296	789	1,163	202	176	3,370	3,105	809	1,371
Del.	13	—	—	9	1	2	27	24	4	3
Md.	90	57	141	136	22	14	279	259	30	51
D.C.	4	6	—	—	—	—	20	17	8	21
Va.	91	73	273	220	9	2	364	321	43	49
W. Va.	28	4	19	32	3	1	52	62	—	—
N.C.	41	46	243	321	142	103	536	364	84	137
S.C.	161	49	5	77	6	20	161	242	35	246
Ga.	15	14	102	163	9	28	482	585	204	327
Fla.	78	47	6	205	10	6	1,449	1,231	401	537
E.S. CENTRAL	225	71	65	64	43	54	715	881	638	315
Ky.	63	11	7	11	—	—	142	134	105	36
Tenn.	104	39	21	22	31	29	255	244	345	140
Ala.	40	11	37	25	11	13	230	240	152	109
Miss.	18	10	—	6	1	12	88	263	36	30
W.S. CENTRAL	227	261	465	613	19	52	894	1,508	820	1,635
Ark.	122	19	18	27	12	22	271	188	29	26
La.	20	9	—	—	2	3	254	288	55	168
Okla.	—	17	50	69	5	27	140	134	357	247
Tex.	85	216	397	517	—	—	229	898	379	1,194
MOUNTAIN	1,947	510	99	56	22	7	843	930	271	343
Mont.	371	13	—	6	1	2	36	64	4	4
Idaho	64	18	—	—	1	1	49	70	2	6
Wyo.	18	3	12	—	1	1	21	22	—	1
Colo.	703	264	9	7	2	1	212	223	43	57
N. Mex.	62	70	—	2	—	1	62	101	31	64
Ariz.	515	99	78	41	13	1	286	277	147	175
Utah	189	33	—	—	4	—	117	93	19	16
Nev.	25	10	—	—	—	—	60	80	25	20
PACIFIC	1,049	763	63	97	5	3	1,971	2,224	711	692
Wash.	234	224	—	—	—	—	176	185	35	53
Oreg.	348	231	2	2	—	2	143	190	34	32
Calif.	390	289	60	84	5	1	1,502	1,642	624	579
Alaska	20	10	1	11	—	—	21	31	5	5
Hawaii	57	9	—	—	—	—	129	176	13	23
Guam	—	—	—	—	—	—	—	42	—	34
P.R.	1	—	29	25	N	N	79	154	1	12
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 25, 2005, and June 26, 2004 (25th Week)*

Reporting area	Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive disease: Drug resistant, all ages		*Streptococcus pneumoniae*, invasive disease: Age <5 years		Syphilis: Primary & secondary		Syphilis: Congenital	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	2,389	2,673	1,314	1,310	463	440	3,538	3,613	113	201
NEW ENGLAND	89	193	14	79	48	67	110	88	—	—
Maine	5	5	N	N	—	2	1	2	—	—
N.H.	7	13	—	—	3	N	6	3	—	—
Vt.	8	7	8	6	3	1	—	—	—	—
Mass.	62	90	—	21	42	39	80	52	—	—
R.I.	7	17	6	7	—	5	2	9	—	—
Conn.	—	61	U	45	U	20	21	22	—	—
MID. ATLANTIC	556	469	132	99	92	65	466	462	12	22
Upstate N.Y.	179	145	50	44	43	43	35	39	6	1
N.Y. City	95	76	U	U	17	U	300	275	5	9
N.J.	116	102	N	N	14	5	63	83	1	11
Pa.	166	146	82	55	18	17	68	65	—	1
E.N. CENTRAL	462	628	355	309	122	111	325	432	19	27
Ohio	122	152	230	223	53	54	99	117	2	1
Ind.	49	69	118	86	31	22	33	27	1	1
Ill.	100	175	7	—	34	1	148	170	5	3
Mich.	183	182	—	N	—	N	35	98	9	22
Wis.	8	50	N	N	4	34	10	20	2	—
W.N. CENTRAL	156	190	32	13	51	42	120	91	1	2
Minn.	58	89	—	—	29	25	30	16	—	1
Iowa	N	N	N	N	—	N	1	4	—	—
Mo.	46	42	27	10	5	8	74	52	1	1
N. Dak.	2	9	—	—	1	1	—	—	—	—
S. Dak.	16	8	3	3	—	—	—	—	—	—
Nebr.	11	14	2	—	6	5	3	5	—	—
Kans.	23	28	N	N	10	3	12	14	—	—
S. ATLANTIC	491	529	536	667	55	31	899	888	24	36
Del.	—	2	1	4	—	N	6	3	—	1
Md.	125	82	—	—	36	20	171	169	8	5
D.C.	6	5	14	5	2	4	56	25	—	1
Va.	44	41	N	N	—	N	50	49	3	1
W. Va.	11	16	69	66	17	7	2	3	—	—
N.C.	79	80	N	N	U	U	109	79	7	4
S.C.	11	43	—	76	—	N	30	61	1	9
Ga.	83	134	109	165	—	N	121	153	—	2
Fla.	132	126	343	351	—	N	354	346	5	13
E.S. CENTRAL	108	139	114	86	5	9	202	193	12	9
Ky.	23	44	21	20	N	N	17	23	—	1
Tenn.	85	95	93	64	—	N	89	67	8	1
Ala.	—	—	—	—	—	N	80	83	3	5
Miss.	—	—	—	2	5	9	16	20	1	2
W.S. CENTRAL	97	203	87	42	56	87	594	557	27	41
Ark.	8	7	12	6	13	7	26	17	—	3
La.	6	2	75	36	18	20	123	134	3	3
Okla.	69	39	N	N	16	26	21	13	1	2
Tex.	14	155	N	N	9	34	424	393	23	33
MOUNTAIN	377	277	44	14	33	28	183	193	14	27
Mont.	—	—	—	—	—	—	5	1	—	—
Idaho	1	5	N	N	—	N	19	13	1	2
Wyo.	2	6	18	5	—	—	—	1	—	—
Colo.	140	61	N	N	32	28	19	36	—	—
N. Mex.	23	64	—	N	—	—	23	49	1	2
Ariz.	162	116	N	N	—	N	68	80	12	23
Utah	48	24	25	7	1	—	4	3	—	—
Nev.	1	1	1	2	—	—	45	10	—	—
PACIFIC	53	45	—	1	1	—	639	709	4	37
Wash.	N	N	N	N	N	N	64	42	—	—
Oreg.	N	N	N	N	—	N	16	16	—	—
Calif.	—	—	N	N	N	N	553	648	4	37
Alaska	—	—	—	—	—	N	4	—	—	—
Hawaii	53	45	—	1	1	—	2	3	—	—
Guam	—	—	—	—	—	—	—	1	—	—
P.R.	N	N	N	N	—	N	91	69	6	3
V.I.	—	—	—	—	—	—	—	4	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 25, 2005, and June 26, 2004 (25th Week)*

Reporting area	Tuberculosis Cum. 2005	Tuberculosis Cum. 2004	Typhoid fever Cum. 2005	Typhoid fever Cum. 2004	Varicella (chickenpox) Cum. 2005	Varicella (chickenpox) Cum. 2004	West Nile virus disease† Neuroinvasive Cum. 2005	West Nile virus disease† Neuroinvasive Cum. 2004	West Nile virus disease† Non-neuroinvasive§ Cum. 2005
UNITED STATES	4,501	6,087	97	127	12,795	12,359	—	63	—
NEW ENGLAND	146	199	11	14	920	1,774	—	—	—
Maine	8	11	1	—	200	177	—	—	—
N.H.	4	7	—	—	151	—	—	—	—
Vt.	—	—	—	—	31	399	—	—	—
Mass.	97	114	7	12	538	41	—	—	—
R.I.	14	23	—	1	—	—	—	—	—
Conn.	23	44	3	1	U	1,157	—	—	—
MID. ATLANTIC	946	893	25	34	2,804	58	—	2	—
Upstate N.Y.	117	114	4	2	—	—	—	—	—
N.Y. City	483	454	6	13	—	—	—	1	—
N.J.	221	192	8	11	—	—	—	—	—
Pa.	125	133	7	8	2,804	58	—	1	—
E.N. CENTRAL	599	533	5	13	3,833	3,890	—	1	—
Ohio	122	97	—	2	862	962	—	—	—
Ind.	64	66	—	—	120	N	—	—	—
Ill.	283	240	1	6	24	1	—	—	—
Mich.	92	94	2	4	2,572	2,459	—	1	—
Wis.	38	36	2	1	255	468	—	—	—
W.N. CENTRAL	209	204	2	3	199	128	—	2	—
Minn.	87	75	2	2	—	—	—	—	—
Iowa	17	19	—	—	N	N	—	—	—
Mo.	56	58	—	1	125	2	—	1	—
N. Dak.	2	3	—	—	10	71	—	—	—
S. Dak.	6	5	—	—	64	55	—	1	—
Nebr.	13	11	—	—	—	—	—	—	—
Kans.	28	33	—	—	—	—	—	—	N
S. ATLANTIC	996	1,240	13	14	1,040	1,444	—	1	—
Del.	2	12	—	—	10	4	—	—	—
Md.	112	118	3	5	—	—	—	—	—
D.C.	28	4	—	—	16	17	—	—	—
Va.	122	91	3	3	209	343	—	—	—
W. Va.	10	11	—	—	628	804	—	—	N
N.C.	98	126	2	3	—	N	—	—	—
S.C.	100	98	—	—	177	276	—	—	—
Ga.	149	310	2	1	—	—	—	—	—
Fla.	375	470	3	2	—	—	—	1	—
E.S. CENTRAL	247	272	1	5	—	—	—	1	—
Ky.	52	47	1	2	N	N	—	—	—
Tenn.	106	100	—	3	—	—	—	—	—
Ala.	89	92	—	—	—	—	—	1	—
Miss.	—	33	—	—	—	—	—	—	—
W.S. CENTRAL	424	1,014	3	9	2,379	3,579	—	2	—
Ark.	49	61	—	—	—	—	—	—	—
La.	—	—	—	—	101	45	—	—	—
Okla.	65	77	—	—	—	—	—	—	—
Tex.	310	876	3	9	2,278	3,534	—	2	—
MOUNTAIN	156	254	3	6	1,620	1,486	—	52	—
Mont.	6	4	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—	—
Wyo.	—	1	—	—	43	22	—	—	—
Colo.	27	66	—	1	1,157	1,170	—	1	—
N. Mex.	8	18	—	—	97	U	—	—	—
Ariz.	104	103	1	2	—	—	—	51	—
Utah	11	20	1	1	323	294	—	—	—
Nev.	—	42	1	2	—	—	—	—	—
PACIFIC	778	1,478	34	29	—	—	—	2	—
Wash.	98	115	2	2	N	N	—	—	—
Oreg.	50	39	2	—	—	—	—	—	—
Calif.	564	1,257	24	21	—	—	—	2	—
Alaska	13	15	—	—	—	—	—	—	—
Hawaii	53	52	6	6	—	—	—	—	—
Guam	—	36	—	—	—	82	—	—	—
P.R.	—	21	—	—	96	242	—	—	—
V.I.	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	—
C.N.M.I.	—	U	—	U	—	U	—	U	—

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* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).
† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
§ Not previously notifiable.

TABLE III. Deaths in 122 U.S. cities,[*] week ending June 25, 2005 (25th Week)

Reporting Area	All causes, by age (years)						P&I[†]
	All Ages	≥65	45–64	25–44	1–24	<1	Total
NEW ENGLAND	403	272	74	29	15	13	21
Boston, Mass.	127	82	23	8	9	5	7
Bridgeport, Conn.	26	14	6	2	3	1	2
Cambridge, Mass.	13	12	1	—	—	—	—
Fall River, Mass.	21	17	1	3	—	—	—
Hartford, Conn.	49	34	11	1	—	3	3
Lowell, Mass.	17	12	3	2	—	—	—
Lynn, Mass.	8	4	2	2	—	—	1
New Bedford, Mass.	25	19	3	3	—	—	2
New Haven, Conn.	17	10	1	5	1	—	2
Providence, R.I.	55	40	11	1	2	1	2
Somerville, Mass.	U	U	U	U	U	U	U
Springfield, Mass.	U	U	U	U	U	U	U
Waterbury, Conn.	U	U	U	U	U	U	U
Worcester, Mass.	45	28	12	2	—	3	2
MID. ATLANTIC	1,883	1,254	439	106	42	39	94
Albany, N.Y.	38	30	3	1	2	2	3
Allentown, Pa.	32	23	6	1	2	—	2
Buffalo, N.Y.	78	57	14	4	2	1	6
Camden, N.J.	25	11	6	4	3	1	—
Elizabeth, N.J.	19	15	3	1	—	—	2
Erie, Pa.	50	36	10	2	2	—	1
Jersey City, N.J.	44	28	15	1	—	—	—
New York City, N.Y.	1,094	750	248	57	14	22	47
Newark, N.J.	48	21	16	5	5	1	2
Paterson, N.J.	U	U	U	U	U	U	U
Philadelphia, Pa.	264	159	71	16	11	7	17
Pittsburgh, Pa.[§]	23	13	7	1	1	1	1
Reading, Pa.	23	12	7	3	—	1	3
Rochester, N.Y.	U	U	U	U	U	U	U
Schenectady, N.Y.	13	9	3	1	—	—	1
Scranton, Pa.	U	U	U	U	U	U	U
Syracuse, N.Y.	72	51	13	5	—	3	9
Trenton, N.J.	34	18	13	3	—	—	—
Utica, N.Y.	12	7	4	1	—	—	—
Yonkers, N.Y.	14	14	—	—	—	—	—
E.N. CENTRAL	1,886	1,207	460	131	37	47	124
Akron, Ohio	45	30	14	1	—	—	7
Canton, Ohio	32	23	7	1	—	1	3
Chicago, Ill.	365	191	108	44	9	9	25
Cincinnati, Ohio	109	63	29	6	5	6	8
Cleveland, Ohio	243	178	44	10	3	8	10
Columbus, Ohio	223	148	57	10	3	5	22
Dayton, Ohio	139	97	34	6	2	—	5
Detroit, Mich.	140	70	46	17	5	2	5
Evansville, Ind.	49	38	10	—	1	—	1
Fort Wayne, Ind.	65	39	16	8	2	—	3
Gary, Ind.	8	3	3	1	1	—	—
Grand Rapids, Mich.	50	36	6	3	3	2	5
Indianapolis, Ind.	182	122	40	12	1	7	14
Lansing, Mich.	43	33	6	4	—	—	6
Milwaukee, Wis.	U	U	U	U	U	U	U
Peoria, Ill.	52	30	15	4	—	3	3
Rockford, Ill.	46	28	13	1	2	2	—
South Bend, Ind.	46	38	6	1	—	1	2
Toledo, Ohio	U	U	U	U	U	U	U
Youngstown, Ohio	49	40	6	2	—	1	5
W.N. CENTRAL	680	452	152	37	17	20	32
Des Moines, Iowa	159	112	35	3	6	3	8
Duluth, Minn.	30	21	6	1	1	1	2
Kansas City, Kans.	32	22	9	—	—	1	—
Kansas City, Mo.	69	47	14	3	4	1	2
Lincoln, Nebr.	34	25	7	1	1	—	3
Minneapolis, Minn.	57	30	12	8	2	5	2
Omaha, Nebr.	64	43	10	8	1	2	7
St. Louis, Mo.	90	47	26	8	1	6	6
St. Paul, Minn.	42	26	12	2	1	1	2
Wichita, Kans.	103	79	21	3	—	—	—
S. ATLANTIC	984	610	240	83	30	21	42
Atlanta, Ga.	U	U	U	U	U	U	U
Baltimore, Md.	147	86	41	13	3	4	13
Charlotte, N.C.	81	55	15	8	2	1	4
Jacksonville, Fla.	148	96	30	12	5	5	1
Miami, Fla.	120	76	19	17	7	1	5
Norfolk, Va.	55	34	18	2	1	—	—
Richmond, Va.	43	25	11	5	2	—	1
Savannah, Ga.	55	34	13	3	2	3	3
St. Petersburg, Fla.	53	38	8	5	1	1	2
Tampa, Fla.	158	87	51	12	2	6	10
Washington, D.C.	100	63	29	4	4	—	2
Wilmington, Del.	24	16	5	2	1	—	1
E.S. CENTRAL	884	585	205	56	22	16	60
Birmingham, Ala.	228	154	52	14	6	2	18
Chattanooga, Tenn.	85	61	16	5	1	2	6
Knoxville, Tenn.	98	69	20	6	2	1	6
Lexington, Ky.	83	54	21	4	1	3	4
Memphis, Tenn.	140	88	35	7	7	3	6
Mobile, Ala.	55	32	15	5	2	1	2
Montgomery, Ala.	65	51	11	3	—	—	6
Nashville, Tenn.	130	76	35	12	3	4	12
W.S. CENTRAL	1,488	925	365	102	52	44	65
Austin, Tex.	36	28	5	1	1	1	1
Baton Rouge, La.	30	22	7	1	—	—	—
Corpus Christi, Tex.	48	37	9	1	—	1	3
Dallas, Tex.	188	105	54	17	6	6	8
El Paso, Tex.	96	64	20	4	6	2	1
Ft. Worth, Tex.	126	75	26	12	7	6	1
Houston, Tex.	303	181	81	27	8	6	16
Little Rock, Ark.	79	48	24	3	2	2	3
New Orleans, La.	148	76	46	15	6	5	4
San Antonio, Tex.	237	155	52	14	8	8	16
Shreveport, La.	68	47	12	4	3	2	6
Tulsa, Okla.	129	87	29	3	5	5	6
MOUNTAIN	1,081	700	242	81	46	12	67
Albuquerque, N.M.	134	82	33	12	6	1	11
Boise, Idaho	46	39	4	3	—	—	2
Colo. Springs, Colo.	52	31	10	5	6	—	1
Denver, Colo.	102	61	21	8	7	5	2
Las Vegas, Nev.	243	150	63	16	13	1	10
Ogden, Utah	21	17	1	1	1	1	1
Phoenix, Ariz.	185	104	59	15	4	3	11
Pueblo, Colo.	30	24	4	1	1	—	1
Salt Lake City, Utah	112	83	18	7	4	—	14
Tucson, Ariz.	156	109	29	13	4	1	14
PACIFIC	1,571	1,086	323	105	38	19	113
Berkeley, Calif.	12	7	3	—	—	2	3
Fresno, Calif.	161	112	32	10	4	3	6
Glendale, Calif.	17	15	—	2	—	—	1
Honolulu, Hawaii	85	58	19	3	4	1	3
Long Beach, Calif.	55	40	12	3	—	—	5
Los Angeles, Calif.	223	144	54	14	9	2	31
Pasadena, Calif.	21	14	5	2	—	—	—
Portland, Oreg.	129	87	25	12	2	3	6
Sacramento, Calif.	203	133	50	18	2	—	12
San Diego, Calif.	123	93	19	3	4	4	7
San Francisco, Calif.	103	73	21	5	3	1	8
San Jose, Calif.	151	117	23	8	2	1	15
Santa Cruz, Calif.	32	23	7	1	1	—	3
Seattle, Wash.	101	58	27	10	4	2	5
Spokane, Wash.	57	44	10	3	—	—	6
Tacoma, Wash.	98	68	16	11	3	—	2
TOTAL	10,860[¶]	7,091	2,500	730	299	231	618

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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