



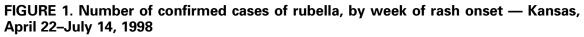
- 225 Rubella Among Hispanic Adults Kansas, 1998, and Nebraska, 1999
- 228 Adoption of Perinatal Group B Streptococcal Disease Prevention Recommendations by Prenatal-Care Providers — Connecticut and Minnesota, 1998
- 232 National Public Health Week April 3–9, 2000
- 233 Notices to Readers

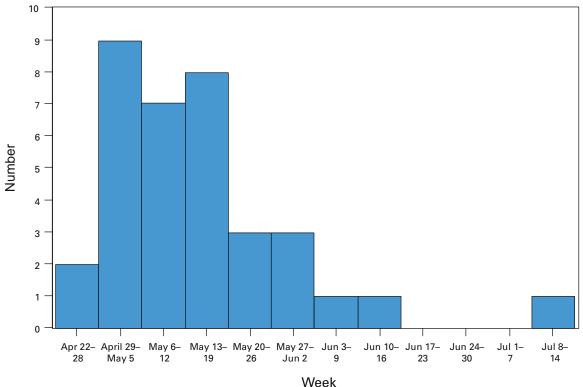
# Rubella Among Hispanic Adults — Kansas, 1998, and Nebraska, 1999

Since 1994, the incidence of rubella has been low; most reported rubella cases have been associated with outbreaks (1,2). Recent outbreaks have occurred primarily among adult Hispanics, many of whom are natives of countries where rubella vaccination is not routine or has been implemented recently (1). This report describes two workplace-associated outbreaks of rubella and summarizes the characteristics of the recent outbreaks in the United States.

## Kansas

During April 22–July 14, 1998, 35 confirmed cases of rubella were reported to the Kansas Department of Health and Environment (Figure 1), compared with one case in





U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

#### Rubella — Continued

1997 and no cases during January–April 1998. The first case was identified in a 45-yearold Hispanic female employee of a meat-packing plant who developed the characteristic rubella rash on April 22. Of the 35 confirmed cases, 28 (80%) occurred in employees in meat-packing plants in the same region. The median age was 29 years (range: 3 months– 47 years); 27 (77%) were men. Of the eight cases among females, four occurred among women of childbearing age; two were infected during pregnancy (one in the second and one in the third trimester). Both women delivered full-term, healthy infants who had no clinical findings suggestive of rubella and had negative rubella IgM antibodies. Of the 35 confirmed cases, 28 (80%) occurred among Hispanics. Of the 32 case-patients with known place of birth, 20 (63%) were born outside the United States in Latin American countries (15 in Mexico, four in El Salvador, and one in Guatemala). Of these, the median length of residence in the United States was 9.5 years. The median age of U.S.-born casepatients during the Kansas outbreak was 34.5 years, compared with 26.5 years in foreign-born case-patients.

Active surveillance for rubella was established in counties where cases had been reported and in adjacent counties. From May 8 to June 19, 1998, worksite vaccination clinics were established in six Kansas meat-packing plants. Clinic activities included 1) screening for persons who presented with rash or who had a history of rash illness during the previous 2 months; 2) vaccination with measles, mumps, and rubella vaccine (MMR) for every consenting employee without contraindications and without proof of rubella immunity; and 3) serologic testing of pregnant women. At these clinics, 7334 doses of vaccine were administered, and 64% of plant employees were vaccinated. An additional 1210 doses of MMR were administered in clinics established in county health departments, associated workplaces (e.g., cattle-feeding farms), and Spanish-language churches. The last confirmed case of rubella associated with this outbreak was reported in Kansas on July 11, 1998.

#### Nebraska

On April 1, 1999, a 29-year-old Hispanic man residing in Omaha sought treatment at a local sexually transmitted diseases clinic. He had a rash, low grade fever, and lymphadenopathy and tested positive for rubella-specific IgM. He worked in a meat-packing plant. Seven additional cases subsequently were detected in the same plant.

Rubella surveillance was enhanced and, during March 21–May 29, the Douglas County Health Department identified 53 confirmed cases of rubella (Figure 2), compared with none for the previous 8 years. Of these, 44 (83%) occurred among Hispanics born outside the United States, and 45 (85%) occurred either among workers in a meat-packing plant or who resided in the same household with a meat-packing–plant worker. Four cases occurred among pregnant women; two were in the first trimester.

Outbreak control measures included mass vaccination campaigns in the community, encouragement by health-care providers to receive vaccination (e.g., assuring that missed opportunities were minimized and vaccinating all family members with no contraindications at the health-care visit), collaboration with the Special Supplemental Food Program for Women, Infants and Children (WIC) to reach potentially undervaccinated populations, and efforts to increase community awareness. Rash onset for the last reported case-patient was July 27, 1999. A total of 95 cases of rubella associated with this outbreak have been reported to the Nebraska Health and Human Services System. Rubella — Continued

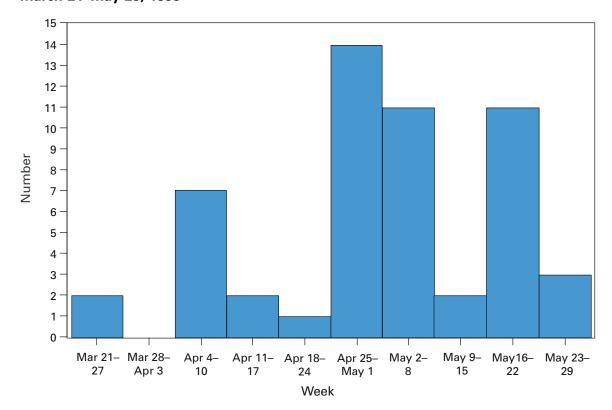


FIGURE 2. Number of confirmed cases of rubella, by week of rash onset — Nebraska, March 21–May 29, 1999

Reported by: D Langvardt, G Pezzino, M Mayer, C Miller, Kansas Dept of Health and Environment. J Weston, C Allensworth, Douglas County Health Dept, Omaha; R Raymond, Nebraska Health and Human Svcs System. RC Jones, Rollins School of Public Health, Emory Univ, Atlanta, Georgia. Child Vaccine Preventable Diseases Br, Vaccine Safety and Development Br, Epidemiology and Surveillance Div, National Immunization Program; Measles Virus Section, Respiratory and Enteric Viruses Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; and an EIS Officer, CDC.

**Editorial Note**: During 1969–1989, the annual number of reported cases of rubella in the United States decreased 99.6% as a result of a successful childhood vaccination program (1). Indigenous rubella is targeted for elimination in the United States by the end of 2000 (3). However, approximately two thirds of other countries did not routinely vaccinate against rubella before 1997 (2). Rubella remains endemic in many Latin American countries, and large epidemics of rubella occur periodically. For example, during January–June 1998, approximately 25,000 cases of rubella were reported to the Ministry of Health in Mexico.

During 1996–1998, 14 rubella outbreaks were reported in the United States (median number of reported cases: 21; range: eight–95). Seven outbreaks were workplace associated and most occurred among workers at food-processing plants or other industries employing predominantly foreign-born workers. Most cases reported in these outbreaks occurred among persons of Hispanic origin (median: 92.5%; range: 32%–100%). No case-patients in the Kansas or Nebraska outbreaks reported having received rubella vaccination.

#### Rubella — Continued

Although rubella is near record low levels in the United States, epidemics continue to occur among susceptible foreign-born adults. Workers born outside the United States are a potentially susceptible population in which outbreaks may occur after importation of the virus from areas outside the United States where rubella is endemic. Vaccinating against rubella in workplaces is a strategy to reach this susceptible population and can be a critical step in eliminating indigenous rubella. Public health professionals, other health-care professionals, and industrial health-care services should design appropriate programs to assure high coverage of foreign-born employees with rubella vaccine.

#### References

- 1. CDC. Rubella and congenital rubella syndrome—United States, 1994–1997. MMWR 1997;46:350–4.
- Robertson SE, Cutts FT, Samuel R, Diaz-Ortega JL. Control of rubella and congenital rubella syndrome in developing countries, part 2: vaccination against rubella. Bull World Health Organ 1997;75:68–90.
- 3. Public Health Service. Healthy people 2000: national health promotion and disease prevention objectives—full report, with commentary. Washington, DC: US Department of Health and Human Services, Public Health Service, 1991; DHHS publication no. (PHS)91-50212.

## Adoption of Perinatal Group B Streptococcal Disease Prevention Recommendations by Prenatal-Care Providers — Connecticut and Minnesota, 1998

Group B streptococcal (GBS) infections are the leading bacterial cause of serious neonatal disease in the United States (1). In 1996, in collaboration with the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, CDC issued consensus guidelines for preventing perinatal GBS disease (2–4). These guidelines recommend using either a screening-based or a risk-based strategy to identify women who should receive intrapartum antimicrobial prophylaxis. To assess adoption of the GBS disease prevention guidelines, the Connecticut and Minnesota state health departments surveyed prenatal-care providers during January–April 1998. This report presents the survey findings, which indicate that most prenatal-care providers in Connecticut and Minnesota have adopted perinatal GBS disease prevention policies and that strategy choice may vary by state and provider type.

In Connecticut, surveys were mailed to all (n=576) licensed obstetricians/ gynecologists (OBs). Group practices were allowed to submit a single response for all members. A second mailing was sent to nonrespondents. A sample of nonrespondents was then contacted by telephone to determine reasons for nonresponse. After eliminating providers from the sample who did not deliver prenatal care and those who were represented by a response from another provider in their practice, the final response rate was 77% (250 of 323). In Minnesota, surveys were mailed to a random sample of approximately 50% of practicing OBs, a random sample of approximately 25% of family physicians (FPs) who indicated on their licensure application they provided prenatal care, and all certified nurse midwives (CNMs). After three mailings, 431 (77%) of those sampled responded. The response rate was similar for all three provider groups.

In 1998, most prenatal-care providers in Connecticut and Minnesota reported that their practices had a perinatal GBS disease prevention policy, although most practices did not have a written policy (Table 1). Practices in Connecticut were more likely than

Group B Streptococcal Disease — Continued

	Connec	ticut	Minnes	sota	
Policy	No.	(%)	No.	(%)	
Policies at the practice level	(n=250)		(n=431)		
Written policy	114	(46)	199	(46)	
Any GBS disease prevention policy*	237	(95)	348	(81)	
No policy*	5	(2)	74	(17)	
Not reported	8	(3)	9	(2)	
GBS disease prevention strategy					
used by individual physicians	(n=250)		(n=431)		
Screening-based <sup>+</sup>	181	(72)	143	(33)	
Risk-based <sup>+</sup>	62	(25)	236	(55)	
Other	3	(1)	28	(6)	
None/Unknown	4	(2)	24	(6)	
Culture sites					
(screening-based strategy only)	(n=181)		(n=143)		
Vagina and rectum	128	(71)	108	(76)	
Vagina only	37	(20)	23	(16)	
Cervix only	7	(4)	4	(3)	
Other/Unknown	9	(5)	8	(6)	
Timing of culture					
(screening-based strategy only)	(n=181)		(n=143)		
34–38 weeks	148	(82)	114	(80)	
First trimester	12	(7)	3	(2)	

TABLE 1. Number and percentage of prenatal-care providers with group B streptococcal (GBS) disease prevention policies, by type of policy — Connecticut and Minnesota, 1998

\*p<0.001 for the presence of any GBS disease prevention policy, Connecticut compared with Minnesota.

<sup>†</sup> p<0.001 for screening-based vs. risk-based strategy, Connecticut compared with Minnesota.

those in Minnesota (p<0.001) to have a GBS disease prevention policy, primarily because of the relatively low percentage of Minnesota family practices with a policy. More than 90% of individual providers from both states reported having a GBS disease prevention policy. Most providers in Connecticut chose a screening-based strategy (72%), and most in Minnesota chose a risk-based strategy (55%). When the analysis was limited to OBs in both states, OBs in Connecticut were more likely than OBs in Minnesota to choose a screening-based strategy (p<0.001).

Of providers who used a screening-based strategy, 71% from Connecticut and 76% from Minnesota collected specimens from both the vagina and rectum, as recommended by the consensus guidelines. Providers using the screening-based strategy from Connecticut (82%) and Minnesota (80%) obtained cultures within 1 week of the recommended 35–37 weeks' gestation. Of providers who used a risk-based strategy in Minnesota, 80% indicated that they would administer intrapartum prophylaxis for all five of the high-risk criteria (i.e., previous infant with invasive GBS disease, GBS bacteriuria during the current pregnancy, delivery at <37 weeks' gestation, duration of rupture of membranes  $\geq$ 18 hours, and intrapartum fever  $\geq$ 100.4 F [ $\geq$ 38 C]) as specified in the consensus guidelines. Questions about indications for prophylaxis under the risk-based strategy were not asked in the Connecticut survey.

#### Group B Streptococcal Disease — Continued

In Minnesota, differences were observed between the responses of FPs compared with OBs or CNMs (Table 2). OBs and CNMs were more likely than FPs (p<0.001) to report that their practices had a GBS disease prevention policy. Individual FPs were less likely to choose a risk-based strategy or to use penicillin for intrapartum prophylaxis (p<0.001 for all comparisons except strategy choice between FPs and OBs). OBs were significantly more likely than either CNMs (91% vs. 46%, p=0.001) or FPs (91% vs. 73%, p=0.03) to report collecting specimens from both the vagina and rectum. FPs were less likely to respond that they would follow all five recommended indications than either OBs (69% vs. 89%, p=0.004) or CNMs (69% vs. 84%, p=0.04).

Reported by: R Lynfield, MD, K White, MPH, R Danila, PhD, Acting State Epidemiologist, Minnesota Dept of Health. A Roome, PhD, H Linardos, J Hadler, MD, State Epidemiologist, Connecticut Dept of Public Health. Respiratory Diseases Br, Div of Bacterial and Mycotic Diseases and Emerging Infections Program Network, National Center for Infectious Diseases; and an EIS Officer, CDC.

**Editorial Note**: Perinatal GBS disease is largely preventable through targeted use of intrapartum antibiotic prophylaxis (2). Since the release of the 1996 consensus prevention guidelines, the incidence of perinatal GBS disease has declined in the United States (5). Prenatal-care providers play a critical role in preventing GBS disease. The findings in this report suggest that most prenatal-care providers in Connecticut and Minnesota have adopted one of the two GBS disease prevention strategies recom-

	Gynec	ricians/ ologists 127)	Certifie midv (n=1	vives	Family physicians (n=200)		
Policy	No.	(%)	No.	(%)	No.	(%)	
Policies at the practice level							
Written policy	63	(50)	57	(55)	79	(40)	
Any GBS disease							
prevention policy*	120	(94)	93	(89)	135	(68)	
No policy*	7	(6)	11	(11)	56	(28)	
Not reported	0	_	0	_	9	(4)	
GBS disease prevention strategy							
used by individual physicians							
Screening-based <sup>+</sup>	46	(36)	13	(12)	84	(42)	
Risk-based <sup>+</sup>	74	(58)	75	(72)	87	(44)	
Other	6	(5)	10	(10)	12	(6)	
None/Unknown	1	(1)	6	(6)	17	(8)	
Antibiotic for							
intrapartum prophylaxis							
Penicillin*	91	(72)	72	(69)	81	(40)	
Ampicillin*	35	(28)	28	(27)	112	(56)	
Other	0	_	1	(1)	2	(1)	
Not reported	1	(1)	3	(3)	5	(2)	

TABLE 2. Number and percentage of prenatal-care providers with group Bstreptococcal (GBS) disease prevention policies, by type of policy and providerspecialty — Minnesota, 1998

\*p<0.001 for comparison of family physicians with obstetricians/gynecologists and family physicians with certified nurse midwives.

<sup>†</sup> p=0.09 for comparison of family physicians with obstetricians/gynecologists and p<0.001 for comparison of family physicians with certified nurse midwives.

#### Group B Streptococcal Disease — Continued

mended in the consensus guidelines and that strategy choice may vary by state and provider type. Pregnant women should discuss GBS disease prevention with their prenatal-care providers to optimize GBS disease prevention opportunities.

In Minnesota, FPs providing prenatal care were less likely than OBs or CNMs to report that their practices have a GBS disease prevention policy and to report following all the guidelines within either the risk-based or screening-based strategy. These findings suggest that additional efforts are needed to inform FPs in Minnesota about GBS disease prevention recommendations. FPs also were less likely to use penicillin, the recommended intrapartum antibiotic. Although ampicillin is an acceptable alternative (2), penicillin is preferred because it has a narrower spectrum of activity and is therefore less likely to promote antimicrobial resistance. This study was conducted before the recent shortage of penicillin G for intravenous administration. A new supplier has been identified, and penicillin G should be more available for intrapartum prophylaxis (6).

In 1997, hospital obstetric departments were surveyed in both Connecticut and Minnesota about perinatal GBS disease prevention policies (7). In both states, the percentage of OBs providing prenatal care who reported adopting a perinatal GBS disease prevention policy was higher than the percentage of hospitals with a policy. Hospitals may leave decisions about GBS disease prevention activities to prenatal-care providers. Efforts to expand perinatal GBS disease prevention activities should be directed at both hospitals and prenatal-care providers (8).

Although the surveys presented in this report were not designed to measure provider practices, the results suggest that prenatal-care providers are aware of the recommendations outlined in the consensus guidelines. The screening-based strategy relies on appropriate and accurate specimen collection by prenatal-care providers. Most providers in Connecticut and in Minnesota using the screening-based strategy reported collecting specimens from both the vagina and rectum. Collection site is important because vaginal/rectal specimens improve group B *Streptococcus* isolation rates by 40% over vaginal specimens alone (*9, 10*). At least 80% of prenatal-care providers using the screening-based strategy in both states also reported collecting specimens at appropriate times. The risk-based strategy depends on prenatal-care providers identifying and administering prophylaxis to women at increased risk for delivering an affected infant. In Minnesota, 80% of prenatal-care providers using the risk-based strategy reported following the recommended indications for intrapartum antibiotic prophylaxis.

The findings in this report are subject to at least two limitations. First, because the surveys were conducted in only two states, the results might not be generalizable to other states. Second, the surveys measured only the reported practices of prenatal-care providers and not the services actually rendered.

GBS disease prevention guidelines and order forms for other information for prenatal-care providers and patients are available on the World-Wide Web at http:// www.cdc.gov/ncidod/dbmd/gbs or from CDC's National Center for Infectious Diseases, Division of Bacterial and Mycotic Diseases, Respiratory Diseases Branch, Mailstop C-23, 1600 Clifton Road, N.E., Atlanta, GA 30333.

#### References

- Schuchat A, Wenger JD. Epidemiology of group B streptococcal disease. Epidemiol Rev 1994;16:374–402.
- CDC. Prevention of perinatal group B streptococcal disease: a public health perspective. MMWR 1996:45(no. RR-7).

#### Group B Streptococcal Disease — Continued

- Committee on Obstetric Practice, American College of Obstetricians and Gynecologists. Prevention of early-onset group B streptococcal disease in newborns. Washington, DC: American College of Obstetricians and Gynecologists, 1996; ACOG committee opinion no. 173.
- Committee on Infectious Diseases/Committee on Fetus and Newborn, American Academy of Pediatrics. Revised guidelines for prevention of early-onset group B streptococcal infection. Pediatrics 1997;99:289–96.
- 5. Schrag SJ, Zywicki S, Farley MM, et al. Group B streptococcal disease in the era of intrapartum antibiotic prophylaxis. N Engl J Med 2000;342:15–20.
- 6. CDC. Update: penicillin G availability. MMWR 2000;49:61.
- 7. CDC. Adoption of hospital policies for prevention of perinatal group B streptococcal disease—United States, 1997. MMWR 1998;47:665–70.
- Factor SH, Whitney CG, Zywicki SS, Schuchat A. Effects of hospital policies based on 1996 group B streptococcal disease consensus guidelines. Obstet Gynecol 2000;95: 377–82.
- 9. Philipson EH, Palermino DA, Robinson A. Enhanced antenatal detection of group B *Streptococcus* colonization. Obstet Gynecol 1995;85:437–9.
- 10. CDC. Laboratory practices for prenatal group B streptococcal screening and reporting— Connecticut, Georgia, and Minnesota, 1997–1998. MMWR 1999;48:426–8.

## National Public Health Week — April 3–9, 2000

"Healthy People in Healthy Communities" is the focus of this year's National Public Health Week, April 3–9, 2000. U.S. residents are living 30 years longer than they did in 1900; at least 25 years are attributable to advances in public health (1). Among the most notable achievements are control of infectious diseases; fewer deaths from heart disease and stroke; healthier mothers and babies; family planning; higher rates of vaccination; safer foods, motor vehicles, and workplaces; fluoridated water; and recognizing tobacco as a health hazard. As part of public health week, the U.S. Department of Health and Human Services and the Surgeon General will release *Healthy People 2010*, health promotion and disease prevention objectives for the next decade. Additional information on National Public Health Week is available from the American Public Health Association, telephone (202) 777-2434, World-Wide Web site at http://www.apha.org\*; or from the CDC Office of Communications, telephone (404) 639-3286, World-Wide Web site at http://www.cdc.gov. *Healthy People 2010* is available at http://www.health.gov/healthypeople.

Reference

1. CDC. Ten great public health achievements—United States, 1900–1999. MMWR 1999;48:241–3.

<sup>\*</sup>References to sites of non-CDC organizations on the Internet are provided as a service to *MMWR* readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of pages found at these sites.

## Notice to Readers

### Availability of Work-Related Lung Disease Surveillance Report, 1999

CDC's National Institute for Occupational Safety and Health (NIOSH) has released the Work-Related Lung Disease (WoRLD) Surveillance Report for 1999 (1). This report is the fifth in a series of WoRLD reports presenting summary tables and figures concerning various occupationally relevant respiratory diseases, including pneumoconioses, occupational asthma, other airway diseases, and other respiratory conditions. The report has three major sections: 1) summary highlights and limitations; 2) disease-specific tables and figures; and 3) appendices describing data sources, methods, and supplementary information.

The WoRLD report presents national and state summary statistics such as counts, crude and age-adjusted mortality rates, and years of potential life lost to age 65 years and to life expectancy; U.S. maps showing the geographic distribution of mortality by state; and tables and figures summarizing selected occupational exposure data for asbestos, coal and coal mine dust, silica dust, cotton dust, and other substances. Proportionate mortality ratios by industry and occupation are based on the most recent decade of data from a subset of states for which usual industry and occupation have been coded for decedents. Also included are tables summarizing silicosis and asthma surveillance data collected by states funded by the Sentinel Event Notification Systems for Occupational Risks Program.

The 1999 WoRLD Surveillance Report is available from Surveillance Branch, Division of Respiratory Disease Studies, NIOSH, CDC, 1095 Willowdale Road, Morgantown, WV 26505-2888; fax (304) 285-6111; or e-mail WoRLD@cdc.gov.

#### Reference

 National Institute for Occupational Safety and Health. Work-related lung disease surveillance report, 1999. Cincinnati, Ohio: US Department of Health and Human Services, Public Health Service, CDC, National Institute for Occupational Safety and Health, December 1999; DHHS(NIOSH) publication no. 2000-105.

## Notice to Readers

## Satellite Broadcast on HIV Prevention

"HIV Prevention with Incarcerated Persons," a satellite broadcast, is scheduled for Thursday, April 27, 2000, at 1–3 p.m. eastern time. Co-sponsors are CDC and the Public Health Training Network. This forum will focus on activities and resources for human immunodeficiency virus (HIV) infection prevention within correctional facilities. Viewers will hear about CDC activities and programs throughout the country.

This broadcast is designed for organizations and persons involved in providing health care and HIV prevention for incarcerated persons and their partners. This audience includes administrators and other staff in correctional facilities, public health programs,

#### Notices to Readers — Continued

community-based organizations, legislative staffs, and managed care. Speakers will discuss why incarceration is a critical opportunity for HIV prevention, benefits of HIV prevention for correctional programs and public health, specific programs in HIV prevention at correctional facilities, and resources and technical assistance for corrections and public health. Viewers can fax questions and comments before and during the satellite broadcast.

Additional information for organizations and potential viewers is available through the World-Wide Web site for this broadcast, http://www.cdcnpin.org/broadcast, and CDC's Fax Information System, telephone (888) 232-3299 ([888] CDC-FAXX), by entering document number 130026 and a return fax number. Organizations setting up viewing sites can register online or by fax as early as possible so that potential viewers may access information about viewing locations when visiting the web site or calling the information line.

## Erratum: Vol. 49, No. 10

In the article "Hantavirus Pulmonary Syndrome—Panama, 1999–2000," on page 205, the year given in the first sentence of the second paragraph was incorrect. The sentence should read: "In mid-January *2000*...."

DISEASE	DECREASE			INCREASE		CURRENT VEEKS
Hepatitis A						571
Hepatitis B						269
Hepatitis, C/Non-A, Non-B						79
Legionellosis						42
Measles, Total						2
Meningococcal Infections						136
Mumps						20
Pertussis						217
Rubella						2
0.125	0.25	0.5	1	2	4	
	0.20		Log Scale)		·	
		Beyond H	istorical Limi	ts		

#### FIGURE I. Selected notifiable disease reports, comparison of provisional 4-week totals ending March 18, 2000, with historical data - United States

\*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 — provisional cases of selected notifiable diseases,United States, cumulative, week ending March 18, 2000 (11th Week)

		Cum. 2000		Cum. 2000
Anthrax		-	HIV infection, pediatric* <sup>§</sup>	34
Brucellosis*		4	Plague	2
Cholera		-	Poliomyelitis, paralytic	-
Congenital ru	bella syndrome	1	Psittacosis*	4
Cyclosporiasi	s*	2	Rabies, human	-
Diphtheria		-	Rocky Mountain spotted fever (RMSF)	24
Encephalitis:	California* serogroup viral	1	Streptococcal disease, invasive Group A	606
•	eastern equine*	-	Streptococcal toxic-shock syndrome*	30
	St. Louis*	-	Syphilis, congenital <sup>¶</sup>	-
	western equine*	-	Tetanus	2
Ehrlichiosis	human granulocytic (HGE)*	14	Toxic-shock syndrome	29
	human monocytic (HME)*	1	Trichinosis	1
Hansen Disea	se*	8	Typhoid fever	59
Hantavirus pu	ulmonary syndrome*†.	-	Yellow fever	-
Hemolytic ure	emic syndrome, post-diarrheal*	14		

-: no reported cases

\*Not notifiable in all states. \*Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID). \*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 February 27, 2000.

<sup>1</sup>Updated from reports to the Division of STD Prevention, NCHSTP.

	AIE	<b>.</b>	Ohlen	avdia§	Conneter	oridicala	N 1		<i>coli</i> O157:H7 PH	
	Cum.	Cum.	Cum.	nydia <sup>s</sup> Cum.	Cum.	ooridiosis Cum.	NET Cum.	Cum.	Cum.	Cum.
Reporting Area UNITED STATES	2000 <sup>†</sup> 6,288	<b>1999</b> 6,945	<b>2000</b> 99,460	<b>1999</b> 140,011	2000 220	<b>1999</b> 285	2000 271	<b>1999</b> 240	<b>2000</b> 154	<b>1999</b> 194
NEW ENGLAND	511	352	4,261	4,378	10	14	21	38	22	34
Maine	6 5	5	247 216	146 224	2	1	2	2	2	2
N.H. /t.	5 1	13 4	118	224 91	- 5	1	4	23	4 2	2 -
Mass. R.I.	370 17	238 20	1,657 477	1,889 459	1 2	8	6	18 1	6	16 1
Conn.	112	72	1,546	1,569	-	3	8	12	8	15
MID. ATLANTIC	1,592	1,492	4,032	16,434	19	56	25	13	37	2
Jpstate N.Y. N.Y. City	65 986	76 835	N -	N 7,966	12 4	20 28	25	9 1	31	- 1
N.J. Pa.	387 154	370 211	668 3,364	2,715 5,753	- 3	3 5	Ň	3 N	1 5	1
E.N. CENTRAL	590	489	18,024	21,933	30	53	37	45	8	- 28
Ohio	92	97	4,569	7,041	13	7	10	20	3	20 9 7
Ind. III.	56 353	52 231	2,256 5,061	2,414 5,814	3	3 6	5 11	9 8	1	7 5
Mich.	67	81	4,629	4,226	6	8	10	8	2	4
Wis.	22	28	1,509	2,438	8	29	N	N	2	3
W.N. CENTRAL Minn.	151 32	161 28	5,138 1,238	8,986 1,659	16 4	21 10	66 16	52 11	29 10	53 12
owa Mo.	10 70	13 84	605 902	481 4,142	2 6	1 4	11 31	5 4	4 10	2 3
N. Dak.	-	3	-	195	1	-	2	2	1	1
S. Dak. Nebr.	2 7	3 10	371 667	451 807	1 2	2 2	- 2	- 16	2	1 34
Kans.	30	20	1,355	1,251	-	2	4	14	2	-
S. ATLANTIC Del.	1,531 26	1,832 31	18,454 607	29,119 653	37	43	24	22 1	15	12
Md.	153	252	1,303	2,802	3	4	5	1	1	-
D.C. Va.	112 115	69 102	628 2,968	N 3,375	- 1	3	- 5	- 6	U 5	U 2
W. Va.	6	14 125	400 4,000	465	- 3	- 1	2	- 5	1	1 4
N.C. S.C.	75 156	128	669	4,750 4,813	-	-	-	1	-	1
Ga. Fla.	183 705	207 904	3,442 4,437	5,943 6,318	22 8	30 5	2 4	1 7	3 4	U 4
E.S. CENTRAL	281	300	9,702	9,728	7	3	13	18	8	11
ζy. Tenn.	37 105	37 130	1,683 2,956	1,655 2,919	- 1	1 1	5 5	5 7	3 5	4
Ala.	92	69	2,810	3,051	6	1	1	3	-	3
Miss.	47	64	2,253	2,103	-	-	2	3	-	1
W.S. CENTRAL Ark.	542 20	980 34	17,098 939	18,034 1,241	7 1	15	10 4	7 2	12 1	12 2
La. Okla.	92 16	67 19	3,442 1,517	2,037 1,737	- 1	12 1	- 3	3 1	7 3	2 1
Tex.	414	860	11,200	13,019	5	2	3	1	1	7
MOUNTAIN	213	207	4,416	7,238	16	23	28	14	9	11
Vont. daho	3	3 5	64	225 399	1 1	1 2	8 4	-	-	- 2
Nyo. Colo.	1 52	- 56	168 747	164 1,651	1 4	- 3	2 8	1 4	2 3	1 1
N. Mex.	26	9	416	933	1	10	-	1	-	-
Ariz. Utah	56 28	86 27	1,930 468	2,836 370	2 6	7 N	3 2	3 5	3 1	1 5
Nev.	44	21	623	660	-	-	1	-	-	1
PACIFIC	877	1,132	18,335	24,161	78 N	57 N	47	31 3	14 7	31 12
Wash. Oreg.	102 22	58 32	2,670 1,005	2,573 1,263	N 1	N 3	5 5	12	4	12 10
Calif. Alaska	727	1,021 5	13,531 496	19,221 424	77	54	34	16	-	9
Hawaii	26	16	633	680	-	-	3	-	3	-
Guam	9	1	-	98	-	-	Ν	N	U	U
P.R. /.l.	153 6	215 3	142	U U	-	Ū	-	1 U	U U	U U
Amer. Samoa C.N.M.I.	-	-	-	U U	-	U U	-	U U	U U	U U

TABLE II. Provisional cases of selected notifiable diseases, United States,weeks ending March 18, 2000, and March 20, 1999 (11th Week)

N: Not notifiable U: Unavailable -: no reported cases C.N.M.I.: Commonwealth of Northern Mariana Islands \* Individual cases may be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS). \* Updated monthly from reports to the Division of HIV/AIDS Prevention–Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention, last update February 27, 2000. \* Chlamydia refers to genital infections caused by *C. trachomatis.* Totals reported to the Division of STD Prevention, NCHSTP.

	Gono	rrhea		oatitis IA,NB	Legior	nellosis		/me sease
Reporting Area	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	52,130	76,133	413	739	124	189	593	915
NEW ENGLAND Maine N.H.	1,253 15 19	1,545 10 18	-	2	9 2 2	12 2 1	87 - 15	225 1 -
Vt. Mass.	10 463	13 604	-	1 1	- 3	3 3	- 44	- 95
R.I. Conn.	111 635	115 785	-	-	- 2	1 2	28	2 127
MID. ATLANTIC Upstate N.Y. N.Y. City	3,100 1,077 - 321	9,231 1,163 3,825 1,588	10 10 -	30 18 -	20 11	52 12 8 5	396 176 2	490 112 16
N.J. Pa.	1,702	2,655	-	12	9	27	218	114 248
E.N. CENTRAL Ohio Ind. III.	11,282 2,656 1,036 3,281	13,113 3,504 1,450 4,183	57 - - 3	393 - - 7	31 17 5 1	58 15 4 10	4 4 -	33 9 1 2
Mich. Wis.	3,377 932	2,934 1,042	54	109 277	7 1	17 12	Ū	1 20
W.N. CENTRAL Minn.	1,797 484	4,227 608	53	45	7 1	7	22 6	13 2
lowa Mo.	133 367	179 2,520	- 48	- 40	2 4	3 2	- 5	2 3
N. Dak. S. Dak.	54	14 35	-	-	-	- 1	-	1
Nebr. Kans.	211 548	388 483	1 4	1 4	-	1 -	- 11	- 5
S. ATLANTIC Del.	13,155 321	22,429 376	19	46	28 2	23 2	61 1	107 5
Md. D.C.	604 503	3,251 1,522	2	19	8	4	44	85 1
Va. W. Va.	1,870 105	2,259 130	- 1	6 4	3 N	4 N	5 4	- 1
N.C. S.C.	3,625	4,201 2,264	7	10 6	3	4	4	13
Ga. Fla.	574 2,345 3,208	2,264 3,948 4,478	- - 9	в 1	2 - 10	4 - 5	- - 3	1 - 1
E.S. CENTRAL	3,208 7,026	4,478 7,712	83	47	3	11	-	12
Ky. Tenn.	682 2,286	792 2,367	9 20	5 22	1 1	5 5	-	- 4
Ala. Miss.	2,244 1,814	2,785 1,768	3 51	1 19	1 -	1	-	5 3
W.S. CENTRAL Ark.	9,119 486	10,372 585	94 3	83 3	-	1	-	-
La. Okla.	2,558	2,158 905	36	61 2	-	1	-	-
Tex.	697 5,378	6,724	55	17	-	-	-	-
MOUNTAIN Mont.	1,829	2,083 4	58	58 4	9	12	1	2
ldaho Wyo.	4 17	25 8	- 42	4 21	1 1	-	-	- 1
Colo. N. Mex.	775 77	454 187	8	8 7	4	1 1	-	- 1
Ariz.	646	1,076	4	11	-	1	1	-
Utah Nev.	69 241	40 289	-	1 2	3	5 4	-	-
PACIFIC Wash.	3,569 492	5,421 456	39 4	35 2	17 5	13 2	22	33
Oreg.	110	200	8	4	N	N	1	1
Calif. Alaska	2,828 62	4,569 80	27	29	12	11 -	21	32
Hawaii	77	116	-	-	-	-	Ν	Ν
Guam P.R.	30	16 67	- 1	-	-	-	Ň	Ň
V.I. Amer. Samoa	-	U U	-	U U	-	U U	-	U U
C.N.M.I.	-	U	-	U	-	U	-	U

# TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States,<br/>weeks ending March 18, 2000, and March 20, 1999 (11th Week)

N: Not notifiable U: Unavailable

- : no reported cases

			,,				nellosis*	
	Ma	laria	Rabie	s, Animal	NE	TSS		ILIS
Reporting Area	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	138	250	759	1,037	4,127	5,083	2,464	4,671
NEW ENGLAND Maine N.H. Vt.	1 1 -	4 - -	93 17 2 6	156 23 14 30	275 29 20 12	280 26 9 11	242 12 15 4	300 16 11 13
Mass. R.I. Conn.	-	4 - -	31 - 37	37 15 37	159 6 49	164 13 57	149 12 50	159 28 73
MID. ATLANTIC Upstate N.Y. N.Y. City N.J. Pa.	14 9 2 - 3	81 18 35 21 7	165 131 U 22 12	210 130 U 47 33	338 109 129 100	768 144 244 198 182	540 124 194 51 171	572 175 229 163 5
E.N. CENTRAL Ohio Ind. III. Mich. Wis.	11 2 1 2 6	24 2 4 10 5 3	8 2 - 6 -	1 - - 1 -	550 162 61 179 98 50	790 173 44 243 190 140	249 70 46 1 88 44	679 132 50 243 174 80
W.N. CENTRAL Minn. Iowa Mo. N. Dak. S. Dak. Nebr. Kans.	6 4 - - 1 1	10 - 2 6 - - - 2	72 22 8 2 9 18 - 13	156 18 20 5 28 35 1 49	221 42 25 76 2 11 27 38	294 80 37 65 2 8 26 26 76	184 48 19 64 10 13 7 23	320 110 32 96 11 17 24 30
S. ATLANTIC Del. Md. D.C. Va. W. Va. N.C. S.C. Ga. Fla.	40 19 12 4 - 5	57 20 6 9 1 4 - 6 11	321 10 71 81 22 64 23 28 22	357 7 88 - 15 79 24 33 28	796 10 134 - 81 22 159 76 124 190	916 17 107 20 106 17 194 56 183 216	437 7 103 U 66 14 69 41 137	838 18 112 U 104 20 171 58 245 110
E.S. CENTRAL Ky. Tenn. Ala. Miss.	6 2 - 4 -	5 1 2 2	32 5 23 4	53 17 19 17	221 41 56 83 41	315 67 85 93 70	99 19 54 23 3	191 41 82 55 13
W.S. CENTRAL Ark. La. Okla. Tex.	1 - 1 -	9 1 6 1 1	8 - - 8 -	24 - - 24 -	239 43 26 28 142	366 54 57 43 212	244 22 72 18 132	489 44 69 29 347
MOUNTAIN Mont. Idaho Wyo. Colo. N. Mex. Ariz. Utah Nev.	12 - - 6 - 2 2 1	10 1 3 1 3 1 3	31 9 16 - 2 4 -	27 12 7 1 - 7 -	416 18 24 6 93 41 135 63 36	365 4 14 3 105 50 113 43 33	270 - - - - - - - - - - - - - - - - - - -	360 1 19 6 112 45 103 49 25
PACIFIC Wash. Oreg. Calif. Alaska Hawaii	47 2 5 39 - 1	50 3 7 36 - 4	29 - 22 7 -	53 - 50 3 -	1,071 53 52 908 12 46	989 57 72 790 7 63	199 99 58 - 8 34	922 136 98 623 5 60
Guam P.R. V.I. Amer. Samoa C.N.M.I. N: Not potifiable	- - - - -	- - U U U	- 6 - -	- 14 U U U	10 - - -	14 61 U U U		U U U U U

# TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States,<br/>weeks ending March 11, 2000, and March 20, 1999 (11th Week)

N: Not notifiable U: Unavailable -: no reported cases \*Individual cases may be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

		Shige			sy	philis			
L L	NET			HLIS	· · ·	Secondary)		culosis	
Reporting Area	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999 <sup>†</sup>	
UNITED STATES	2,506	2,562	1,015	1,396	1,106	1,391	1,569	2,501	
NEW ENGLAND Maine N.H. Vt. Mass. R.I.	60 2 1 41 7	64 1 4 3 42 9	43 - 1 - 31 4	61 5 3 38 7	14 - - 12 1	13 - - 1 8 1	47 - 1 35 2	72 3 - 35 15	
Conn.	8	5	7	8	1	3	9	19	
MID. ATLANTIC Upstate N.Y. N.Y. City N.J. Pa.	122 70 39 - 13	212 39 71 67 35	138 31 60 15 32	128 19 57 52	22 1 6 4 11	61 7 22 14 18	312 20 187 79 26	432 35 222 101 74	
E.N. CENTRAL Ohio Ind. III. Mich. Wis.	380 26 60 115 170 9	457 159 18 171 52 57	119 4 9 2 99 5	210 16 8 159 13 14	244 13 92 68 56 15	210 18 56 103 26 7	179 34 15 111 13 6	249 64 23 113 37 12	
W.N. CENTRAL Minn. Iowa Mo. N. Dak.	173 42 25 85	130 19 2 81 1	92 38 21 25	116 22 3 79 1	16 2 6 5	59 5 2 48	83 31 7 34	83 33 - 38 1	
S. Dak. Nebr. Kans.	1 14 6	- 9 18	- 4 4	1 4 6	- 2 1	- 1 3	3 2 6	3 1 7	
S. ATLANTIC Del. Md. D.C. Va. W. Va. N.C. S.C.	293 1 24 - 12 1 18 3	394 5 24 19 16 3 53 24	66 - 8 U 12 1 5 1	105 1 5 0 5 1 33 10	343 2 64 15 25 1 111 11	511 1 111 33 34 1 120 47	253 - - 8 43 18	382 4 44 10 17 7 60 75	
Ga. Fla. E.S. CENTRAL	25 209 121	42 208 292	18 21 70	17 33 176	59 55 188	94 70 244	99 47 109	74 91 133	
Ky. Tenn. Ala. Miss.	28 58 9 26	27 214 28 23	16 51 1 2	20 145 11	18 123 24 23	26 122 59 37	48 61	15 42 59 17	
W.S. CENTRAL Ark. La. Okla. Tex.	238 45 19 9 165	401 30 30 111 230	192 3 34 4 151	456 20 26 26 384	167 12 45 36 74	202 20 29 51 102	27 20 7	406 14 U 20 372	
MOUNTAIN Mont. Idaho Wyo.	210  1	156 3 2 2	63 - 1	87 - 2 1	36 - - -	32 - -	67 - - -	64 - -	
Colo. N. Mex. Ariz. Utah Nev.	29 25 79 5 49	31 18 83 11 6	15 13 28 6	20 12 38 12 2	3 3 28 - 2	- 32 -	6 15 22 7 17	U 11 27 11 15	
PACIFIC Wash. Oreg. Calif. Alaska Hawaii	909 162 75 660 2 10	456 13 12 419 - 12	232 182 43 - 1 6	57 27 15 - 15	76 11 2 63	59 5 1 51 1 1	492 35 428 12 17	680 29 19 590 8 34	
Guam P.R. V.I. Amer. Samoa C.N.M.I.	- 1 - -	3 7 U U U			20	52 U U U	- - - -	- - - U U U	
N: Not notifiable	[]·]]nav	a tha be to		ted cases					

# TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 18, 2000, and March 20, 1999 (11th Week)

N: Not notifiable U: Unavailable -: no reported cases \*Individual cases may be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS). <sup>†</sup>Cumulative reports of provisional tuberculosis cases for 1999 are unavailable ("U") for some areas using the Tuberculosis Information System (TIMS).

	11 - 6		T				(TITH VVEEK) Measles (Rubeola)					
	<i>H. influ</i> inva		A	epatitis (V	iral), by typ B	e	Indiger	10115	IVIeas		la) Total	
Demention Arres	Cum.	Cum.	Cum.	Cum.	Cum.	Cum.		Cum.		Cum.	Cum.	Cum.
Reporting Area	<b>2000</b> <sup>†</sup> 244	<b>1999</b> 267	2,337	<b>1999</b> 3,786	2000 895	<b>1999</b> 1,200	2000	<u>2000</u> 3	2000	2000	2000 3	1999 21
NEW ENGLAND	20	18	44	42	11	39	-	-	-	-	-	1
Maine N.H.	1 3	2 2	1 7	2 5	1 6	- 2	-	-	-	-	-	- 1
Vt.	2	3	2	-	2	1	-	-	-	-	-	-
Mass. R.I.	11 -	10 -	11 -	17	2	21 2	-	-	-	-	-	-
Conn.	3	1	23	18	-	13	-	-	-	-	-	-
MID. ATLANTIC Upstate N.Y.	33 17	42 19	97 51	245 56	78 21	178 31	-	-	-	-	-	-
N.Y. City N.J.	5 10	10 12	46	77 34	57	54 24	-	-	-	-	-	-
Pa.	1	1	-	78	-	69	-	-	-	-	-	-
E.N. CENTRAL Ohio	31 16	37 15	287 90	848 170	113 24	118 22	-	3 2	-	-	3 2	-
Ind.	3	3	5	17	5	4	-	-	-	-	-	-
III. Mich.	9 3	16 3	75 111	166 477	- 84	- 85	-	- 1	-	-	- 1	-
Wis.	-	-	6	18	-	7	-	-	-	-	-	-
W.N. CENTRAL Minn.	12 5	17 5	247 21	190 6	50 3	59 4	-	-	-	-	-	-
lowa Mo.	- 3	3 3	28 135	28 115	9 25	10 32	-	-	-	-	-	-
N. Dak.	1	- 1	-	- 2	-	-	U	-	U	-	-	-
S. Dak. Nebr.	- 1	1	8	19	5	- 8	-	-	-	-	-	-
Kans.	2	4	55	20	8	5	-	-	-	-	-	-
S. ATLANTIC Del.	62	57	254	278	186 -	168	-	-	-	-	-	-
Md. D.C.	20	19 2	33	87 15	26	46 6	-	-	-	-	-	-
Va. W. Va.	13 1	7 1	42 22	25 2	28	14	-	-	-	-	-	-
N.C.	5	9	56	36	73	44	-	-	-	-	-	-
S.C. Ga.	1 17	2 13	3 33	4 86	2 10	24 27	-	-	-	-	-	-
Fla.	5	4	65	23	47	7	U	-	U	-	-	-
E.S. CENTRAL Ky.	13 7	20 5	78 7	101 18	61 13	98 7	-	-	-	-	-	-
Ténn. Ala.	4 2	7 6	21 14	46 24	28 5	46 25	-	-	-	-	-	-
Miss.	-	2	36	13	15	20	-	-	-	-	-	-
W.S. CENTRAL Ark.	14	18	362	742	37	155	-	-	-	-	-	2
La.	2	6	40 8	8 37	11 17	12 45	-	-	-	-	-	-
Okla. Tex.	12	10 2	71 243	127 570	9	29 69	-	-	-	-	-	2
MOUNTAIN	36	34	167	367	79	99	-	-	-	-	-	-
Mont. Idaho	- 2	1 1	1 8	4 9	3 4	1 4	-	-	-	-	-	-
Wyo. Colo.	10	1	5	1	20	1 22	-	-	-	-	-	-
N. Mex.	10	9	38 20	69 7	20 17	30	-	-	-	-	-	-
Ariz. Utah	12 2	18 3	68 13	224 16	28 3	21 7	-	-	-	-	-	-
Nev.	-	-	14	37	4	13	-	-	-	-	-	-
PACIFIC Wash.	23 2	24	801 40	973 61	280 7	286 5	-	-	-	-	-	18 3 8 7
Oreg. Calif.	7	8 14	49 709	58 849	19 250	22 249	-	-	-	-	-	87
Alaska	1	2	3	3	3	6	-	-	-	-	-	-
Hawaii	9	-	-	2	1	4	-	-	-	-	-	-
Guam P.R.	-	-	- 15	2 17	- 8	2 25 U	U U	-	U	-	-	-
V.I. Amer. Samoa	-	U U	-	U U	-	U U	U U	-	U U	-	-	U U
C.N.M.I.	-	Ŭ	-	Ŭ	-	Ŭ	Ŭ	-	Ŭ	-	-	Ŭ

# TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending March 18, 2000, and March 20, 1999 (11th Week)

N: Not notifiable U: Unavailable - : no reported cases \*For imported measles, cases include only those resulting from importation from other countries. \*Of 61 cases among children aged <5 years, serotype was reported for 26 and of those, 5 were type b.

		jococcal ease		Mumps			Pertussis			Rubella	
- Reporting Area	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999
UNITED STATES	<u>2000</u> 528	601	<u>2000</u> 9	<u>2000</u> 84	88	<u>2000</u> 49	758	1,086	- 2000	<u>2000</u> 5	8
NEW ENGLAND	28	33	1	1	3	9	190	118	-	1	2
Maine N.H.	3	3 3	-	-	- 1	-7	7 42	- 18	-	- 1	-
Vt. Mass.	1 18	2 22	-	-	2	2	45 86	9 85	-	-	- 2
R.I.	-	2	- 1	1	-	-	6	2	-	-	-
Conn.	6	1	-	- 5	-	-	4	4	-	-	-
MID. ATLANTIC Upstate N.Y.	39 9	61 9	1 1	5	13 2	7 7	66 45	137 95	-	2 2	-
N.Y. City N.J.	10 10	22 14	-	-	3	-	-	10 3	-	-	-
Pa.	10	16	-	2	8	-	21	29	-	-	-
E.N. CENTRAL Ohio	77 18	94 35	2	11 3	10 3	3	140 108	135 79	-	-	-
Ind.	17	6	-	-	-	-	8	8	-	-	-
III. Mich.	18 20	34 10	2	3 5	3 4	3	8 6	20 14	-	-	-
Wis.	4	9	-	-	-	-	10	14	-	-	-
W.N. CENTRAL Minn.	52 3	78 18	-	10	2	2	27 9	32	-	2	-
lowa	9	13	-	3	2	-	7	6	-	-	-
Mo. N. Dak.	35 1	27	Ū	1 -	-	Ū	3 1	7	Ū	-	-
S. Dak. Nebr.	2 1	5 3	-	- 4	-	2	1 2	1 1	-	-	-
Kans.	1	12	-	2	-	-	4	17	-	2	-
S. ATLANTIC	93	80	1	10	12	8	53	61	-	-	1
Del. Md.	- 9	1 16	- 1	- 3	- 3	-	1 14	23	-	-	- 1
D.C. Va.	- 16	1 10	-	- 1	1 2	-	- 3	-7	-	-	-
W. Va. N.C.	2 17	1 13	-	2	-	-	15	21	-	-	-
S.C.	6	15	-	4	2	1	11	5	-	-	-
Ga. Fla.	18 25	14 9	Ū	-	- 3	7 U	9	4 1	Ū	-	-
E.S. CENTRAL	33	51	-	1	1	1	19	24	-	-	-
Ky. Tenn.	8 14	10 16	-	-	-	-	12 1	5 12	-	-	-
Ala.	10 1	15 10	-	1	1	1	6	6	-	-	-
Miss. W.S. CENTRAL		55	-	-	-	-	- 3	30	-	-	-
Ark.	23 3	12	-	-	12	-	3	2	-	-	4
La. Okla.	12 8	29 11	-	-	2 1	-	-	2 3	-	-	-
Tex.	-	3	-	-	9	-	-	23	-	-	4
MOUNTAIN Mont.	35 1	54	-	3	7	12	182 1	181 1	-	-	1
ldaho	4	6	-	-	-	3	31	74	-	-	-
Wyo. Colo.	- 8	2 16	-	-	2	- 4	- 96	1 37	-	-	-
N. Mex. Ariz.	4 11	7 18	-	1	N	2 3	31 17	9 39	-	-	-
Utah Nev.	6 1	3	-	- 2	4 1	-	4 2	18 2	-	-	1
PACIFIC	148	2 95	- 4	43	28	- 7		368	-	-	-
Wash.	10	14	-	2	-	7	27	129	-	-	-
Oreg. Calif.	13 122	23 50	N 4	N 40	N 23	-	16 32	3 224	-	-	-
Alaska Hawaii	1 2	4	-	- 1	1 4	-	2 1	1 11	-	-	-
Guam	-	-	U	-	1	U	-	-	U	-	-
P.R. V.I.	-	2 U	Ŭ U	-	U	Ŭ U	-	- U	Ŭ U	-	Ū
Amer. Samoa	-	Ŭ	Ŭ	-	U	Ŭ	-	U	U	-	U
C.N.M.I. N: Not notifiable	-	U available	U	- no reporter	U	U	-	U	U	-	U

# TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending March 18, 2000, and March 20, 1999 (11th Week)

N: Not notifiable U: Unavailable

- : no reported cases

		All Cau	ises, By	Age (Ye	ears)		P&I <sup>†</sup>			All Cau	ises, By	Age (Y	'ears)		P&I⁺
Reporting Area	All Ages	≥65	45-64	25-44	1-24	<1	Total	Reporting Area	All Ages	≥65	45-64	25-44	1-24	<1	Total
NEW ENGLAND Boston, Mass. Bridgeport, Conn Cambridge, Mass Fall River, Mass. Hartford, Conn. Lowell, Mass. New Bedford, Ma New Haven, Conn Providence, R.I. Somerville, Mass Springfield, Mass Waterbury, Conn. Worcester, Mass. MID. ATLANTIC Albany, N.Y. Allentown, Pa. Buffalo, N.Y. Camden, N.J. Elizabeth, N.J.	. 8 U 23 16 ss. 25 . 44 . 37 . 37 . 9 89 2,411 44 U 130 30 19	299 91 26 6 U 16 11 22 31 5 49 1,729 30 U 8 8 6 1,729 30 1,729 30 1,729	25 7 2 U U 6 4 3 4 U - 2 3 13 461 9 U 310 3	25 13 1 U U 1 1 - 4 U - - 1 4 152 2 U 3 1 2	8 4 - - - - - 1 U - - - 1 0 - - 1 36 - - - - - - - - - - - - - - - - - -	16 8 - UU 2 2 31 3 U 4 3 0 4 3	38 14 2 2 U U 3 - 1 7 U - 1 4 4 3 U 15 - - - - - - - - - - - - - - - - - -	S. ATLANTIC Atlanta, Ga. Baltimore, Md. Charlotte, N.C. Jacksonville, Fla Miami, Fla. Norfolk, Va. Richmond, Va. Savannah, Ga. St. Petersburg, I Tampa, Fla. Washington, D.C. Wilmington, De E.S. CENTRAL Birmingham, Al Chattanooga, Te Knoxville, Tenn Mobile, Ala. Montgomery, A	U 72 53 51a. 71 188 C. 100 I. 29 937 a. 207 2010. 80 104 60 . 181 93 1a. 53	645 U 127 56 79 U 43 35 34 60 130 139 57 75 37 127 60 22	211 49 19 31 U 18 13 9 4 35 26 7 185 47 185 47 16 19 19 520 67	88 U 37 42 U 4 3 6 3 12 7 66 15 3 9 3 19 8 3 3	34 U 8 1 4 U 2 2 3 4 7 3 - 21 2 2 3 1 1 4 2 2	28U544U5-1-45-153163-0	85 U 21 110 U 4 6 10 6 6 10 6 10 7 1 89 17 7 1 82 3 5 11
Erie, Pa.§ Jersey City, N.J. New York City, N.Y. Paterson, N.J. Philadelphia, Pa. Pittsburgh, Pa.§ Reading, Pa. Rochester, N.Y. Schenectady, N.Y. Scranton, Pa.§ Syracuse, N.Y. Trenton, N.J. Utica, N.Y. Yonkers, N.Y.	U 14 462 85 31 135	42 16 826 0 325 67 28 103 25 31 73 17 20 U	6 237 U 3 96 14 2 20 7 2 11 2	2 92 U 2 32 4 - 1 4 2 1 U	2 18 U 1 4 - 3 - U	1 10 5 - 4 - 1 - U	5 31 U 3 43 8 3 20 1 5 7 3 2 U	Nashville, Tenn. W.S. CENTRAL Austin, Tex. Baton Rouge, La Corpus Christi, Dallas, Tex. El Paso, Tex. Ft. Worth, Tex. Houston, Tex. Little Rock, Ark. New Orleans, La San Antonio, Te Shreveport, La. Tulsa, Okla.	Tex. 71 203 64 135 461 76 . U x. 192 57 148	39 60 45 119 45 88 262 52 U 139 48 103	33 331 14 20 18 48 16 30 103 12 U 34 8 28	6 126 3 5 4 20 2 8 59 59 5 0 10 - 10	6 50 2 2 2 2 8 - 4 21 2 0 7 1 1	2 49 1 3 2 8 1 5 16 5 U 2 - 6	17 137 1 6 4 14 2 12 61 5 U 9 7 16
E.N. CENTRAL Akron, Ohio Canton, Ohio Chicago, III. Cincinnati, Ohio Columbus, Ohio Dayton, Ohio Detroit, Mich. Evansville, Ind. Fort Wayne, Ind. Grand Rapids, Mi Indianapolis, Ind. Lansing, Mich. Milwaukee, Wis. Peoria, III. Rockford, III. South Bend, Ind. Toledo, Ohio Youngstown, Ohi W.N. CENTRAL Des Moines, Iowa Duluth, Minn. Kansas City, Kans Kansas City, Kans Kansas City, Kans Kansas City, Mo. Lincoln, Nebr. Minneapolis, Min Omaha, Nebr. St. Paul, Minn.	178 39 104 43 56 112 0 82 854 121 33 . 42 114 38	$\begin{array}{c} 1,473\\ 50\\ 28\\ 3100\\ 81\\ 132\\ 99\\ 362\\ 513\\ 28\\ 121\\ 32\\ 741\\ 432\\ 44\\ 75\\ 8\\ 307\\ 81\\ 31\\ 153\\ 57\\ 0\\ 8\\ 9\\ 307\\ 81\\ 31\\ 153\\ 57\\ 0\\ 0\\ 8\\ 9\\ 9\\ 307\\ 81\\ 31\\ 153\\ 57\\ 0\\ 0\\ 0\\ 8\\ 9\\ 9\\ 9\\ 9\\ 9\\ 9\\ 9\\ 9\\ 9\\ 9\\ 9\\ 9\\ 9\\$	10 9 7 14 32 3 19 37 11 10 4 8 33 5 20 1 7 8 22 12 14 9 20 2 9 23 4 36 18 16 U	142 6 2 3 5 9 13 8 19 3 2 - 2 15 2 6 1 2 3 9 2 73 7 1 12 5 - 14 2 10 U 22	46 1 - 17 5 7 1 1 - 23 - 21 1 - 36 2 - 43 24 - 5 U 16	54 2 1 6 3 2 6 4 9 4 6 - 2 1 2 1 5 - 12 3 2 1 4 1 - U 1	19 <sup>8</sup> 5 8 7 3 2 <sup>8</sup> 1 2 3 , ១ 2 3 , ១ 3 4 2 8 4 5 1 1 5 7 3 4 , U 8	MOUNTAIN Albuquerque, N Boise, Idaho Colo. Springs, C Denver, Colo. Las Vegas, Nev. Ogden, Utah Phoenix, Ariz. Pueblo, Colo. Salt Lake City, U Tucson, Ariz. PACIFIC Berkeley, Calif. Fresno, Calif. Glendale, Calif. Honolulu, Hawa Long Beach, Cal Los Angeles, Ca Pasadena, Calif. Portland, Oreg. Sacramento, Ca San Jose, Calif. Sant Cruz, Calif San Francisco, C San Jose, Calif. Santa Cruz, Cali Seattle, Wash. Spokane, Wash. Tacoma, Wash. TOTAL	47 colo. 57 126 215 25 175 33 14ah 89 157 2,847 2,847 21 203 92 117 2,847 21 203 92 117 113 113 115 116 117 113 115 115 115 115 115 115 115	735 106 35 39 24 109 28 54 109 2,142 16 155 79 56 60 933 20 84 129 137 110 128 36 85 48 66 9,256	$\begin{array}{c} 211\\ 27\\ 7\\ 9\\ 28\\ 46\\ 1\\ 36\\ 4\\ 228\\ 473\\ 4\\ 31\\ 9\\ 16\\ 21\\ 168\\ 5\\ 21\\ 431\\ 300\\ 38\\ 5\\ 20\\ 147\\ 2,465\end{array}$	76 7 2 8 6 77 - 17 1 5 13 14 5 10 4 2 5 56 1 4 8 15 11 6 1 8 4 9 893	25 3 4 6 7 4 51 4 51 1 22 3 1 5 3 2 6 3 307	23 3 3 - 1 3 - 5 2 35 - 7 5 1 5 9 1 2 2 - 1 - 2 2 3 5 - 2 2 3 5 - 2 2 2 3 5 - 2 2 3 5 - 2 2 3 5 - 2 2 - 3 - 3 - - 5 2 - 3 - - 5 2 - - - - - - - - - - - - - - - -	93 14 5 1 20 21 3 9 3 8 9 302 4 24 9 4 117 4 13 300 25 3 8 9 4 1,129

# TABLE IV. Deaths in 122 U.S. cities,\* week ending March 18, 2000 (11th Week)

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 or more. 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.

# Contributors to the Production of the *MMWR* (Weekly) Weekly Notifiable Disease Morbidity Data and 122 Cities Mortality Data

Samuel L. Groseclose, D.V.M., M.P.H.

**State Support Team** Robert Fagan Jose Aponte Paul Gangarosa, M.P.H. Gerald Jones David Nitschke Carol A. Worsham

**CDC Operations Team** Carol M. Knowles Deborah A. Adams Willie J. Anderson Patsy A. Hall Kathryn Snavely Sara Zywicki

The Morbidity and Mortality Weekly Report (MMWR) Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format and on a paid subscription basis for paper copy. To receive an electronic copy on Friday of each week, send an e-mail message to *listserv@listserv.cdc.gov*. The body content should read *SUBscribe mmwr-toc*. Electronic copy also is available from CDC's World-Wide Web server at *http://www.cdc.gov/* or from CDC's file transfer protocol server at *ftp.cdc.gov*. To subscribe for paper copy, contact Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone (202) 512-1800.

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Address inquiries about the *MMWR* Series, including material to be considered for publication, to: Editor, *MMWR* Series, Mailstop C-08, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone (888) 232-3228.

All material in the *MMWR* Series is in the public domain and may be used and reprinted without permission; citation as to source, however, is appreciated.

Director, Centers for Disease Control and Prevention Jeffrey P. Koplan, M.D., M.P.H. Acting Deputy Director for Science and Public Health, Centers for Disease Control and Prevention Lynne S. Wilcox, M.D., M.P.H.	Acting Director, Epidemiology Program Office Barbara R. Holloway, M.P.H. Editor, <i>MMWR</i> Series John W. Ward, M.D. Acting Managing Editor, <i>MMWR</i> (weekly) Caran R. Wilbanks	Writers-Editors, MMWR (weekly) Jill Crane David C. Johnson Teresa F. Rutledge Desktop Publishing Lynda G. Cupell Morie M. Higgins Cheryle R. Reynolds				
☆U.S. Government Printing Office: 2000-533-206/08061 Region IV						