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Perinatal Group B Streptococcal Disease After Universal Screening Recommendations — United States, 2003–2005

Group B streptococcus (GBS) is a leading cause of neonatal morbidity and mortality in the United States. In 2002, CDC, the American College of Obstetricians and Gynecologists (ACOG), and the American Academy of Pediatrics (AAP) issued revised guidelines for the prevention of perinatal GBS disease. These guidelines recommend universal screening of pregnant women by culture for rectovaginal GBS colonization at 35–37 weeks' gestation and the use of intrapartum antibiotic prophylaxis for GBS carriers (*1*). To examine rates of neonatal and pregnancy-associated GBS disease after the revised guidelines were issued, CDC analyzed surveillance data from the Active Bacterial Core surveillance (ABCs) system from the period 2003–2005 and compared them with data from 2000–2001, the period immediately preceding the universal screening recommendations. This report describes the results of that analysis, which indicated that annual incidence of early onset GBS disease (i.e., in infants aged 0–6 days) was 33% lower during 2003–2005 than during 2000–2001. However, although incidence among white infants decreased steadily during 2003–2005, incidence increased 70% among black infants. Incidence of GBS disease among infants aged 7–89 days (i.e., late-onset disease) and pregnant women remained stable after revised universal screening guidelines were issued. Continued surveillance is needed to monitor the impact of the guidelines on perinatal GBS disease and trends in racial disparities and to guide interventions to reduce disparities.

ABCs, part of CDC's Emerging Infections Program (EIP) network, conducts active, laboratory- and population-based surveillance in selected counties of 10 states for invasive GBS disease,* defined as isolation of GBS from a normally sterile site or from the placenta or amniotic fluid in cases of fetal death. In 2004, the surveillance area represented approximately 455,000 live births; 72% of the infants were white, 19% were black, and 9% were of other race. Surveillance areas used standardized case-report forms to collect demographic, neonatal, and obstetric data from medical records. Race and ethnicity were determined from medical records or birth certificates. Multiple imputations were used to account for missing race data (*2*). Live-birth data from state vital records and national vital statistics reports were used as denominators for incidence calculations. Incidence for 2005 was calculated using 2004 natality data. The Cochran-Armitage test was conducted to determine linear trend significance. Average incidence during 2000–2001, designated as the baseline period, was compared with incidence during 2003–2005.

During 2000–2005, a total of 1,020 cases of early-onset GBS disease (EOD) were reported from the surveillance areas (202 in 2000, 193 in 2001, 175 in 2002, 131 in 2003, 152 in 2004, and 167 in 2005). The number of surveillance areas was stable during 2000–2005; however, surveillance started in Colorado in 2001 and in New Mexico in 2004. New Mexico cases are not included in comparison of incidence over time.

* Information available at http://www.cdc.gov/ncidod/dbmd/abcs/index.htm.

INSIDE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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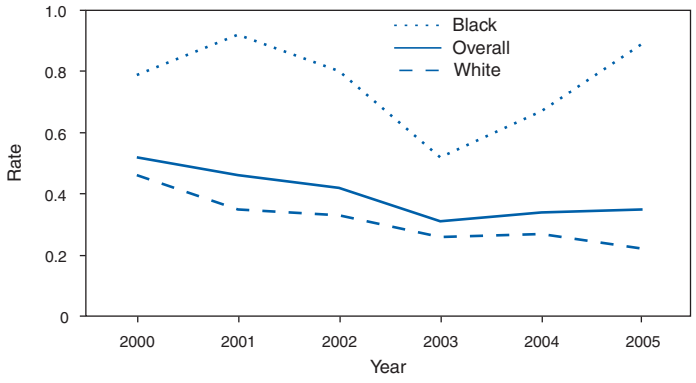
Average EOD incidence during 2003–2005 (0.33 cases per 1,000 live births), after the revised guidelines were issued, was 33% lower than during the baseline period (0.49). Incidence after the revised guidelines was 0.31 cases per 1,000 live births in 2003 and increased to 0.35 in 2005. Stratified by race, rates increased significantly ($p<0.05$) from 2003 to 2005 among black infants (0.52 to 0.89 cases per 1,000 live births) and decreased among white infants (0.26 to 0.22 cases per 1,000 live births) (Figure 1). When further stratified by gestational age, incidence increased among full-term (i.e., ≥37 weeks' gestation) black infants from 2003 to 2005 (0.31 to 0.50 per 1,000 live births), but incidence decreased among full-term white infants during the same period. Incidence among preterm infants, although higher among black infants, fluctuated in both racial groups and demonstrated no trend (Figure 2).

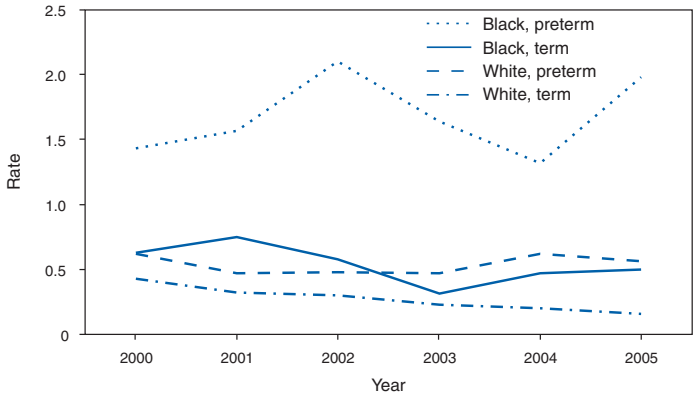
A total of 167 EOD cases were reported for 2005, the year when racial disparities were largest. Incidence of EOD in 2005 was 0.37 cases per 1,000 live births and varied by surveillance area (Table). By race, 44% were white, 39% were black, 4% were of other race, and 12% were of unknown race. Of GBS isolates from EOD cases, 97.6% were from blood only, 1.8% were from blood and cerebrospinal fluid (CSF), and 0.6% were from CSF only. The case-fatality ratio was 5%. Among EOD cases for which gestational age data were available (164 of 167), 29% occurred in infants born preterm (i.e., at <37 weeks' gestation). Among black infants with EOD, 40% of cases occurred in infants born preterm, compared with 24% of

FIGURE 1. Rate* of early-onset† invasive group B streptococcal disease, by race and year — Active Bacterial Core surveillance system, United States, 2000–2005§



*Per 1,000 live births.
†Occurring in infants aged 0–6 days.
§Rates for 2000–2005 correspond to surveillance areas participating since 2000, with the addition of Colorado in 2001. New Mexico, where surveillance began in 2004, is not included in comparison of incidence over time.

FIGURE 2. Rate* of early-onset† invasive group B streptococcal disease, by race, prematurity status, and year — Active Bacterial Core surveillance system, United States, 2000–2005§



* Per 1,000 live births.
† Occurring in infants aged 0–6 days.
§ Rates for 2000–2005 correspond to surveillance areas participating since 2000, with the addition of Colorado in 2001. New Mexico, where surveillance began in 2004, is not included in comparison of incidence over time.

TABLE. Number and rate* of perinatal group B streptococcal disease cases, by disease type and state of surveillance area — Active Bacterial Core surveillance system, United States, 2005

State	Early-onset disease†		Late-onset disease§		Pregnancy-associated disease	
	No.	Rate	No.	Rate	No.	Rate
California	7	0.16	7	0.16	5	0.12
Colorado	10	0.28	11	0.30	0	0.00
Connecticut	10	0.24	18	0.43	0	0.00
Georgia	30	0.40	44	0.59	12	0.16
Maryland	33	0.44	29	0.39	15	0.20
Minnesota	15	0.22	18	0.26	12	0.17
New Mexico	17	0.60	5	0.18	0	0.00
New York	7	0.30	8	0.34	7	0.30
Oregon	8	0.38	4	0.19	0	0.00
Tennessee	30	0.70	21	0.49	2	0.05
Total	**167**	**0.37**	**165**	**0.36**	**53**	**0.12**

* Per 1,000 live births.
† Occurring in infants aged 0–6 days.
§ Occurring in infants aged 7–89 days.

cases in white infants (p=0.05, by chi-square test). Among cases in preterm infants, 60% of cases in white infants were in those born at 35–36 weeks' gestation, and 40% were in those born at <35 weeks, compared with 16% of cases in black infants born at 35–36 weeks and 84% born at <35 weeks. Approximately 88% of cases in white infants born full term and 81% of cases in black infants born full term were in infants born to mothers who received prenatal GBS screening.

A total of 165 cases of late-onset GBS disease (LOD) were reported from the surveillance areas in 2005, resulting in an incidence of 0.36 per 1,000 live births. Incidence of LOD varied by surveillance area (Table). Rates of LOD were similar before and after the revised guidelines (0.36 per 1,000 live births for the baseline period, compared with 0.38 cases per 1,000 live births for 2003–2005).

During 2003–2005, the annual incidence of GBS infection among pregnant women remained stable (averaging 0.12 cases per 1,000 live births) and was similar to the baseline incidence (0.15 cases per 1,000 live births). In 2005, a total of 53 cases of pregnancy-associated GBS invasive infections in women were reported. Incidence varied by surveillance area (Table). Of those pregnancies with known outcomes (50 of 53), 31 (62%) resulted in abortion or stillbirth, 15 (30%) resulted in delivery of healthy infants, one (2%) resulted in delivery of an infant who had clinical infection but survived, and three (6%) resulted in neonatal death.

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Editorial Note: Clinical trials conducted in the 1980s demonstrated that intrapartum antibiotic prophylaxis (IAP) was effective at preventing EOD by interrupting transmission of GBS from mothers who are colonized with the bacteria to their newborns (*3*). However, IAP use was not widely adopted, and national standards for IAP administration were not implemented until 1996, when ACOG, AAP, and CDC issued consensus guidelines recommending that health-care providers use either risk-based or culture-based screening to identify candidates for IAP (*4*). In 2002, a population-based study, demonstrating that routine screening of all pregnant women at 35–37 weeks' gestation and IAP for carriers prevented more cases of EOD than the risk-based approach, led to the universal prenatal screening recommendation in 2002 (*5*). The study predicted that universal screening could decrease incidence of EOD in the United States to 0.32 cases per 1,000 live births. Although this level was achieved in 2003, the rate of overall EOD increased during 2003–2005, reflecting increases in incidence among black infants. This report highlights the need for strategies to reduce the rate of neonatal GBS disease among black infants, to evaluate missed opportunities for prevention, and to continue monitoring disease trends.

Disparities between black and white infants in incidence of GBS disease have been observed since the disease emerged

as a leading cause of neonatal sepsis (*6*). Factors that might contribute to this disparity include higher maternal colonization rates in blacks (*7*), higher rates of preterm deliveries (a risk factor for neonatal GBS disease) among blacks, and less access to prenatal care among black women compared with white women. However, a study that controlled for these factors indicated that black race remained an independent risk factor for disease (*8*). *Healthy People 2010* objectives include achieving rates of EOD below 0.5 cases per 1,000 live births for all racial populations. Rates of EOD among white infants reached this target in 1998 and have remained below this level since the universal screening recommendations were issued. In 2003, the year after the recommendations were issued, incidence among black infants reached a record low (0.52 per 1,000 live births) and suggested that national health objectives might also be met for black infants (*9;* CDC, unpublished data, 2007). However, during the following 2 years, incidence of EOD among black infants returned to levels observed before the recommendations were issued. Continued surveillance is needed to determine whether this trend persists and to identify possible barriers to universal screening for pregnant black women.

The findings in this report are subject to at least two limitations. First, although the surveillance system describes trends in disease, these results alone are not sufficient to determine causes of increases or decreases in GBS disease rates. Second, these results alone do not measure health-care–provider compliance with the guidelines; therefore, changes in incidence of GBS cannot be attributed directly to compliance with prevention guidelines. Although increases in rates of EOD among black infants were reported, whether these increases are attributed to barriers in implementation of the guidelines is not known. To overcome these two limitations, CDC is collaborating with the EIP network to conduct Birthnet, a review of maternal labor and delivery records of live births in 10 ABCs states during 2003–2004. The purpose of the study is to characterize provider compliance to universal screening guidelines, identify barriers to implementation, detect missed prevention opportunities, and increase understanding of racial disparities.

Universal screening and IAP are the most effective measures available for EOD prevention. Rates of EOD were lower after the universal screening recommendations were issued, compared with the baseline period. However, even optimal implementation of the recommendations is unlikely to eliminate EOD because neither screening for GBS carriers nor IAP is 100% effective. When the guidelines were issued, the potential impact of screening and IAP on LOD was unknown; the exact modes of transmission for LOD were not well understood, and vertical transmission might have only a limited role. This report indicates minimal change in rates of LOD and infections in pregnancy since the universal screening recommendations were issued.

The use of a GBS vaccine could be effective in preventing perinatal GBS disease, possibly also preventing stillbirths and premature deliveries attributed to GBS. Vaccination might also help reduce racial disparities in disease. Several potential vaccines are under consideration, some of which have completed Phase II trials (*10*).

Information for patients, health-care providers, and public health practitioners regarding GBS is available from CDC at http://www.cdc.gov/groupbstrep. Brochures are available in both English and Spanish by telephone (404-639-2215); information regarding bulk orders is available through the CDC Foundation by telephone (877-252-1200).

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References

1. CDC. Prevention of perinatal group B streptococcal disease: revised recommendations from CDC. MMWR 2002;51(No. RR-11).
2. Little RJ, Rubin DB. Statistical analysis with missing data. 2nd ed. Wiley series in probability and statistics. Hoboken, NJ: Wiley & Sons; 2002.
3. Boyer KM, Gotoff SP. Prevention of early-onset neonatal group B streptococcal disease with selective intrapartum chemoprophylaxis. N Engl J Med 1986;314:1665–9.
4. CDC. Prevention of perinatal group B streptococcal disease: a public health perspective. MMWR 1996;45(No. RR-7).
5. Schrag SJ, Zell ER, Lynfield R, et al. A population-based comparison of strategies to prevent early-onset group B streptococcal disease in neonates. N Engl J Med 2002;347:233–9.
6. 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.
7. Stapleton RD, Kahn JM, Evans LE, et al. Risk factors for group B streptococcal genitourinary tract colonization in pregnant women. Obstet Gynecol 2005;106:1246–52.
8. Schuchat A, Oxtoby M, Cochi S, et al. Population-based risk factors for neonatal group B streptococcal disease: results of a cohort study in metropolitan Atlanta. J Infect Dis 1990;162:672–7.

9. CDC. Diminishing racial disparities in early-onset neonatal group B streptococcal disease—United States, 2002–2003. MMWR 2004;53:502–5.
10. Heath PT, Feldman RG. Vaccination against group B streptococcus. Expert Rev Vaccines 2005;4:207–18.

Reduced Secondhand Smoke Exposure After Implementation of a Comprehensive Statewide Smoking Ban — New York, June 26, 2003–June 30, 2004

Secondhand smoke (SHS) causes premature disease and death in nonsmokers, including heart disease and lung cancer (*1*). The Surgeon General has concluded that no risk-free level of SHS exposure exists; the only way to fully protect nonsmokers is to completely eliminate smoking in indoor spaces (*1*). Studies have determined that levels of airborne particulate matter in restaurants, bars, and other hospitality venues and levels of SHS exposure among nonsmoking hospitality employees decrease substantially and rapidly after implementation of laws that prohibit smoking in indoor workplaces and public places (*1–5*). To assess changes in indoor SHS exposure in a general population, the New York State Department of Health analyzed data on observations of indoor smoking by respondents to the New York Adult Tobacco Survey (NYATS) and measured levels of cotinine* in saliva among nonsmoking NYATS respondents before and after implementation of the 2003 New York state ban on smoking in indoor workplaces and public places. This report describes the results of that analysis, which determined that reports of indoor smoking among restaurant and bar patrons decreased significantly after the law took effect; moreover, saliva cotinine levels in nonsmoking NYATS participants decreased by 47.4% over the same period. These findings suggest that comprehensive smoking bans can reduce SHS exposure among nonsmokers.

NYATS is an ongoing, quarterly, random-digit–dialed telephone survey of approximately 2,000 state residents aged ≥18 years designed to generate state and regional estimates of tobacco-use behaviors and related attitudes and beliefs among adults living in residential households. Initial NYATS data collection began on June 26, 2003, less than 1 month before implementation of the statewide law on July 24, 2003.

To assess levels of indoor smoking in restaurants, bars, and workplaces, all NYATS participants were asked three questions: "The last time you went to a restaurant in your community in the past 30 days, did you see someone smoking indoors?" "The last time you went to a bar in your community in the past 30 days, did you see someone smoking indoors?" and "In the past 7 days, has anyone smoked in your work area?" To assess smoking status, NYATS participants were asked, "Do you now smoke cigarettes every day, some days, or not at all?" Nonsmokers were defined as those who answered "not at all."

All nonsmokers who participated in NYATS during June 26, 2003–June 30, 2004, and who lived outside New York City and Nassau County were eligible to participate in a saliva cotinine study and were invited to submit a saliva sample through the mail for cotinine analysis. Saliva cotinine has been determined to be an accurate and reliable measure of SHS exposure (*1*), and saliva cotinine samples remain stable when submitted by mail (*6*). Residents of New York City and Nassau County were excluded because those jurisdictions had implemented comprehensive local smoking bans in March 2003; as a result, their residents might have already experienced declines in SHS exposure. Participants who agreed to provide a saliva sample were mailed a packet that included a consent form, a vial, instructions for providing the sample, a $10 incentive check, and a postage-paid return mailer. Eligible NYATS participants who did not submit a sample within 2 weeks were mailed postcard reminders. The 296 respondents whose samples were too small for analysis were not asked to provide an additional sample. The 96 respondents whose samples yielded cotinine values ≥15 ng/mL were excluded from the analysis because those values are associated with active smoking (*1*).

The concentration of cotinine in the saliva samples was determined using liquid chromatography with tandem mass spectrometry. This method has a limit of detection (LOD) of 0.05 ng/mL. For participants with a cotinine level below the LOD, values were imputed by applying an expectation-maximization regression model to the log-transformed cotinine levels that were above the LOD (*7*). This method generates estimates of values below the LOD to replicate the true distribution of the sample (i.e., the distribution that would have been observed had there been no LOD). The method is recommended when the proportion of samples with values below the LOD exceeds 40% to provide the best estimate of the true shape of the distribution while avoiding distortions that result from assigning a single value to samples with cotinine levels below the LOD (*7,8*).

Response rates for NYATS, calculated according to the Council of American Survey Research Organizations for-

*Cotinine, which can be measured in serum, urine, or saliva, is a metabolite of nicotine and a biomarker for both active smoking and SHS exposure.

mula, averaged 22% (range: 21%–24%) for the quarterly surveys conducted during June 26, 2003–June 30, 2004. Response rates for the cotinine study, calculated as the number of participants submitting saliva samples divided by the number of eligible participants, averaged 33% (range: 27%–41%). NYATS data regarding both reported indoor smoking and cotinine levels were weighted to account for nonresponse, demographics, and geographic location. Participants in the cotinine study were similar to all nonsmoking NYATS participants in terms of age group, education level, race/ethnicity, and self-reported health status, with two exceptions. A greater proportion of participants in the cotinine study had college degrees and were non-Hispanic white than the nonsmoking NYATS participant population overall (Table 1).

Reports of Indoor Smoking

The percentages of NYATS respondents reporting exposure to SHS in restaurants and bars decreased significantly after the law took effect, from 19.8% (during June 26–July 23, 2003) to 3.1% (during April 1–June 30, 2004) among restaurant patrons and from 52.4% to 13.4% among bar patrons over the same period (Table 2). The percentage of respondents reporting exposure to SHS in workplaces, which had been 13.6% before implementation of the smoking ban, did not change significantly after implementation of the law. This finding likely is attributable to local smoke-free air laws and voluntary workplace smoking restrictions that were in place before implementation of the state law.

TABLE 1. Comparison of all nonsmoking respondents to the New York Adult Tobacco Survey (NYATS) with nonsmoking respondents to the NYATS saliva study component, by selected characteristics — New York, June 26, 2003–June 30, 2004*

Characteristic	All NYATS nonsmoking respondents who submitted a saliva sample %	(95% CI†)	All NYATS nonsmoking respondents %	(95% CI)
Age group (yrs)				
18–24	10.1	(7.7–12.5)	11.2	(9.9–12.6)
25–39	25.8	(22.4–29.1)	27.6	(25.9–29.3)
40–64	43.3	(39.8–46.9)	40.6	(38.9–42.4)
≥65	20.3	(17.4–23.2)	19.1	(17.7–20.4)
Education				
Less than high school	3.7	(2.5–5.0)	7.0	(6.0–8.0)
High school	21.3	(18.3–24.3)	25.4	(23.8–27.1)
Some college	23.8	(20.7–26.9)	24.3	(22.7–25.9)
College graduate	51.1	(47.5–54.7)	42.9	(41.1–44.7)
Race/Ethnicity				
White, non-Hispanic	76.8	(73.3–80.2)	63.9	(62.0–65.7)
Black, non-Hispanic	8.8	(6.5–11.1)	13.8	(12.4–15.1)
Hispanic	10.0	(7.2–12.8)	14.0	(12.4–15.5)
Other	4.5	(2.9–6.0)	8.4	(7.4–9.5)

* All data are unweighted.
† Confidence interval.

Nonsmoker Levels of Cotinine

Of the 6,152 NYATS participants who were eligible to submit saliva samples, 3,053 agreed, and 2,008 (33%) submitted samples. The analysis described in this report is based on the 1,594 saliva samples that contained sufficient saliva to test for cotinine, had a cotinine level of <15 ng/mL, and were accompanied by a signed consent form. Saliva samples were analyzed at the New York Department of Health Wadsworth Laboratory.

The geometric mean level of salivary cotinine among nonsmoking NYATS participants who submitted saliva samples decreased by 47.4%, from 0.078 ng/mL during June 26–July 23, 2003, before the state law took effect, to 0.041 ng/mL during April 1–June 30, 2004 (Table 3). The proportion of respondents with cotinine levels below the LOD (0.05 ng/mL) increased from 32.5% to 52.4% when comparing the same periods.

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Editorial Note: Revised *Healthy People 2010* objectives call for reducing the proportion of nonsmokers aged ≥4 years who are exposed to SHS to 63% (objective 27-10), increasing the proportion of indoor workers covered by smoke-free air workplace policies to 100% (objective 27-12), and implementing laws making indoor workplaces and public places smoke-free in all 50 states (objective 27-13). The proportion of the U.S. population exposed to SHS has decreased substantially during the past 20 years as the prevalence and strength of local and state smoke-free air laws and voluntary workplace smoking restrictions have increased and adult smoking prevalence has decreased (*1,9,10*). However, approximately 126 million nonsmokers in the United States remain exposed to SHS (*1*).

Studies have determined that laws prohibiting smoking in hospitality venues such as restaurants and bars are associated with rapid reductions in self-reported respiratory and sensory symptoms and improvements in objective measures of pulmonary function among nonsmoking hospitality workers (*1,3–5*). However, this is the first report of a biologically validated population-level reduction in SHS exposure among nonsmokers after implementation of a com-

TABLE 2. Reports of seeing someone smoking* in an indoor work area, inside a restaurant, or inside a bar, before and after implementation of a comprehensive statewide smoking ban — New York Adult Tobacco Survey, June 26, 2003–June 30, 2004†

Survey period	Indoor workers who reported seeing someone smoking in a work area			Restaurant patrons who reported seeing someone smoking inside a restaurant§			Bar patrons who reported seeing someone smoking inside a bar§		
	No. in sample	%	(95% CI¶)	No. in sample	%	(95% CI)	No. in sample	%	(95% CI)
Before July 24, 2003 smoking ban									
June 26–July 23, 2003	443**	13.6	(8.1–19.1)	856**	19.8	(15.6–24.1)	203**	52.4	(41.5–63.4)
After July 24, 2003 smoking ban									
July 24–September 30, 2003	379	10.2	(5.4–15.0)	743	9.9	(6.6–13.3)	161	37.6	(25.7–49.6)
October 1–December 31, 2003	938	10.2	(7.0–13.3)	1,735	4.0	(2.6–5.3)	384	21.7	(15.1–28.3)
January 1–March 31, 2004	828	13.6	(9.8–17.3)	1,536	4.3	(2.9–5.6)	363	21.4	(15.6–27.2)
April 1–June 30, 2004	990	7.6	(5.1–10.2)	1,812	3.1	(2.0–4.2)	417	13.4	(9.5–17.3)

* Determined by answers to the following questions: "In the past 7 days, has anyone smoked in your work area?" "The last time you went to a restaurant in your community in the past 30 days, did you see someone smoking indoors?" "The last time you went to a bar in your community in the past 30 days, did you see someone smoking indoors?" Respondents who answered "yes" were considered to have reported seeing someone smoking in the specific venue.
† Data were weighted to adjust for probability of selection, for nonresponse, and to match the most recent census projections for New York state reported by the U.S. Census Bureau.
§ *t* test for trend; p<0.001.
¶ Confidence interval.
** Sample sizes before the smoking ban were smaller because less time (<1 month) was available for data collection during that survey period than during the periods after the smoking ban went into effect.

TABLE 3. Geometric mean cotinine levels in saliva and percentage of persons with cotinine levels below the limit of detection among nonsmoking* New York adults, before and after implementation of a comprehensive statewide smoking ban — New York Adult Tobacco Survey, June 26, 2003–June 30, 2004†

Survey period	No. in sample	Geometric mean cotinine level		Sample with cotinine level below the limit of detection (0.05 ng/mL)	
		ng/mL	(95% CI§)	%	(95% CI)
Before July 24, 2003 smoking ban					
June 26–July 23, 2003	80¶	0.078**	(0.054–0.111)	32.5	(22.0–43.0)
After July 24, 2003 smoking ban					
July 24–September 30, 2003	425	0.060	(0.051–0.070)	41.9	(37.2–46.6)
October 1–December 31, 2003	338	0.047	(0.041–0.055)	47.0	(41.8–52.4)
January 1–March 31, 2004	337	0.047	(0.040–0.055)	47.2	(41.8–52.5)
April 1–June 30, 2004	414	0.041**	(0.036–0.047)	52.4	(47.6–57.2)

* Determined by the answer to the following question: "Do you now smoke cigarettes every day, some days, or not at all?" Respondents who answered "not at all" were considered nonsmokers. Respondents with cotinine levels ≥15 ng/mL (consistent with active smoking) were excluded from the analysis.
† Data were weighted to adjust for probability of selection, for nonresponse, and to match the most recent census projections for New York state reported by the U.S. Census Bureau.
§ Confidence interval.
¶ Sample size before the smoking ban was smaller because less time (<1 month) was available for data collection during that survey period than during the periods after the smoking ban went into effect.
** Statistically significant difference in geometric means, indicated by nonoverlapping confidence intervals.

prehensive state smoke-free air law. The substantial reduction in saliva cotinine levels observed in this study likely indicates a substantial reduction in SHS exposure, which should result in reductions in morbidity and mortality from heart disease and lung cancer among nonsmoking adults over time (*1*).

The findings in this report are subject to at least two limitations. First, the average quarterly response rates for both NYATS (22%) and the saliva cotinine study (33%, for a cumulative rate of 7%) were low; in addition, the number of preban respondents in the cotinine study (80) was approximately one fourth to one fifth the number of respondents in each of the postban samples (range: 337–425). Although respondents in NYATS and the cotinine study might not be representative of the state's general populations of adults and adult nonsmokers, respectively, 2004 NYATS participants were similar to respondents in the 2004 New York state Behavioral Risk Factor Surveillance System survey in age group, education level, race/ethnicity, and self-reported health status. Moreover, an examination of age

group, education level, and race/ethnicity demonstrated that cotinine study participants were similar to all nonsmoking NYATS participants, with two exceptions. Neither of these differences should negate the findings described in this report, although the low response rates do increase the possibility for error resulting from response bias. Second, a substantial proportion of respondent cotinine levels were below the LOD, and this proportion increased over time (likely because of the protection from SHS afforded by the new law). This required estimation of the values below the LOD to calculate the geometric means; although validated, this estimation is subject to error.

Additional research is needed to confirm the findings of this study. However, the results suggest that comprehensive smoke-free air laws can substantially reduce SHS exposure to nonsmokers, even in jurisdictions with a high prevalence of existing smoking restrictions. Even greater reductions in SHS exposure might be expected in jurisdictions that had fewer smoking restrictions in place before implementing a statewide smoke-free air law.

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References

1. US Department of Health and Human Services. The health consequences of involuntary exposure to tobacco smoke: a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, CDC; 2006. Available at http://www.surgeongeneral.gov/library/secondhandsmoke/report/fullreport.pdf.
2. CDC. Indoor air quality in hospitality venues before and after implementation of a clean indoor air law—western New York, 2003. MMWR 2004;53:1038–41.
3. Farrelly MC, Nonnemaker JM, Chou R, Hyland A, Peterson KK, Bauer UE. Changes in hospitality workers' exposure to secondhand smoke following the implementation of New York's smoke-free law. Tob Control 2005;14:236–41.
4. Eisner MD, Smith AK, Blanc PD. Bartenders' respiratory health after establishment of smoke-free bars and taverns. JAMA 1998;280:1909–14.
5. Menzies D, Nair A, Williamson PA, et al. Respiratory symptoms, pulmonary function, and markers of inflammation among bar workers before and after a legislative ban on smoking in public places. JAMA 2006;296:1742–8.
6. Bernert JT, McGuffey JE, Morrison MA, Pirkle JL. Comparison of serum and salivary cotinine measurements by a sensitive high-performance liquid chromatography-tandem mass spectrometry method as an indicator of exposure to tobacco smoke among smokers and nonsmokers. J Anal Toxicol 2000;24:333–9.
7. Lynn H. Maximum likelihood inference for left-censored HIV RNA data. Stat Med 2001;20:33–45.
8. Lubin JH, Colt JS, Camann D, et al. Epidemiologic evaluation of measurement data in the presence of detection limits. Environ Health Perspect 2004;112:1691–6.
9. Pirkle JL, Bernert JT, Caudill SP, Sosnoff CS, Pechacek TF. Trends in the exposure of nonsmokers in the U.S. population to secondhand smoke: 1988–2002. Environ Health Perspect 2006;114:853–8.
10. Pickett MS, Schober SE, Brody DJ, Curtin LR, Giovino GA. Smoke-free laws and secondhand smoke exposure in US non-smoking adults, 1999–2002. Tob Control 2006;15:302–7.

Smoking-Cessation Advice from Health-Care Providers — Canada, 2005

Tobacco use is the most preventable cause of premature death and disease in Canada. In 2002, an estimated 37,209 Canadians died from illnesses related to tobacco use, accounting for 16.6% of all deaths in Canada (*1*). One of the objectives of the Canadian Federal Tobacco Control Strategy (FTCS) 2001–2011 is to reduce smoking prevalence in Canada from 25% to 20%. Although evidence indicates that an effective and efficient way of providing smoking-cessation information to smokers is through contact with health-care providers (*2,3*), little data in Canada exist regarding smoking-cessation advice from this group. In 2005, the Canadian Tobacco Use Monitoring Survey (CTUMS) included questions to assess self-reported provision of cessation advice by health-care providers. This report summarizes the results of that survey, which indicate that only half of persons who visited health-care providers in the preceding 12 months received smoking-cessation advice, suggesting that health-care providers need to take greater advantage of opportunities to provide such advice to smokers.

CTUMS was developed to provide Canada's federal health department (Health Canada) and its partners with timely, reliable data on tobacco use and related topics. The 2005 CTUMS collected data from approximately 20,800 respondents during February–December 2005. The target population was residents of all provinces of Canada aged ≥15 years; residents of the three territories (Yukon, Northwest Territories, and Nunavut) were excluded because of poor telephone coverage, as were institutionalized persons. The sample design was a two-phase stratified random sample of telephone numbers. In the first phase, households were selected using a random-digit–dialing method. In the second phase, one or two persons (or none) from the household were selected according to household composition. Data were collected using computer-assisted telephone interviewing, which ensured that only valid responses were entered and that all the correct procedures were followed. Data were weighted to provide national estimates.

CTUMS respondents who identified themselves as current smokers* were asked about their visits to various types of health-care providers, including physicians, dentists or dental hygienists, and pharmacists, in the 12 months before the survey.† For each health-care provider visited in the preceding 12 months, respondents were asked whether they were advised by the provider to reduce or quit smoking.§ Those who said they had received advice were then asked whether they received any information on smoking-cessation aids such as nicotine patches, a product such as Zyban®, or counseling programs.¶

According to the 2005 CTUMS, approximately 5 million residents in Canada (weighted data), representing 19% of the population aged ≥15 years, were current smokers, of whom 88% reported visiting one or more of the specified health-care providers (physician, dentist or dental hygienist, and pharmacist) in the 12 months before the survey (Table 1). A greater proportion of female smokers (94%) visited a health-care provider in the preceding 12 months than male smokers (83%). Among female smokers, the highest rate of visiting a health-care provider was among respondents aged 25–34 years (97%), and the lowest was among those aged 15–19 years (91%). In contrast, among male smokers, the highest rate of visiting a health-care provider was among respondents aged 15–19 years (87%), and the lowest was among those aged 25–34 years (79%). Among the current smokers who reported visiting a health-care provider in the preceding 12 months, 54% said that they were advised to reduce or quit smoking. Rates of advice to reduce or quit smoking were lowest among smokers aged 15–19 years (36%) and increased by age group (Table 1).

Regarding types of health-care providers, 73% of current smokers reported visiting a physician in the preceding 12 months, whereas a smaller proportion reported visiting a dentist or dental hygienist (60%) or a pharmacist (38%) (Table 2). A greater portion of female smokers visited a physician (85%), dentist or dental hygienist (64%), or a pharmacist (44%) compared with male smokers (65%, 57%, and 33%, respectively). The highest rate of visiting a physician was among respondents aged ≥45 years (81%), visiting a dentist or dental hygienist was highest among those aged 15–19 years (71%), and visiting a pharmacist was highest among those aged ≥45 years (42%) (Table 2).

Among the current smokers who reported visiting a physician in the preceding 12 months, approximately half (51%) said that they were advised to reduce or quit smoking. Rates of advice to reduce or quit smoking by a physician were lowest among the youngest smokers (i.e., aged 15–19 years) (38%) and increased by age group (Table 2). The prevalence of being advised to reduce or quit smoking by a physician among young adult (aged 20–24 years) males and females was significantly different: 33% among males and 50% among females. Approximately 36% of respondents were advised to reduce or quit smoking by dentists or dental hygienists, whereas 16% of respondents received this advice from pharmacists. Overall, respondents reported a greater prevalence of pharmacists providing information on smoking-cessation aids (84%) compared with the other two categories of health-care providers (physician, 57%, and dentist or dental hygienist, 31%).

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Editorial Note: Although 88% of current smokers in Canada reported visiting a health-care provider in the preceding 12 months, only half of these smokers reported being advised to reduce or quit smoking. Health-care providers are in a unique position to offer smoking-cessation advice and provide information on smoking-cessation aids to their patients; however, the results of this analysis indicate that many of these opportunities are being missed.

In 2001, several Canadian health associations, including the Canadian Medical Association, Canadian Dental Association, and Canadian Pharmacists Association, prepared a joint statement outlining the role of the health-care provider in smoking cessation (*4*). The statement focused on smoking cessation as part of a comprehensive strategy, specifically on the role of health-care providers in helping Canadians to stop smoking. The strategy highlighted the need for a collaborative, multidisciplinary approach to smoking cessation, requiring members to be prepared to discuss counseling, pharmacotherapy, ongoing support mechanisms, and relapse-prevention strategies with patients.

Although the need for smoking-cessation counseling has been recognized, barriers exist among health-care providers, including a need for additional training regarding smoking-cessation counseling, lack of time, low priority for tobacco-related matters, and a perceived lack of interest in

* Determined by response to the question: "At the present time, do you smoke every day, occasionally, or not at all?" Respondents who answered "every day" or "occasionally" were classified as current smokers.

† "In the past 12 months, did you see a doctor?" "In the past 12 months, did you see a dentist or dental hygienist?" "In the past 12 months, did you talk with a pharmacist?"

§ "Did the doctor advise you to reduce or quit smoking?" "Did the dentist or dental hygienist advise you to reduce or quit smoking?" "Did the pharmacist advise you to reduce or quit smoking?"

¶ "Did the doctor provide you with information on quit-smoking aids such as the patch, a product like Zyban, or counseling programs?" "Did the dentist or dental hygienist provide you with information on quit-smoking aids such as the patch, a product like Zyban, or counseling programs?" "Did the pharmacist provide you with information on quit smoking aids such as the patch, a product like Zyban, or counseling programs?"

TABLE 1. Prevalence of visits to a health-care provider* in preceding 12 months among current smokers† and of receiving smoking-cessation advice and information about smoking-cessation aids, by age and sex — Canadian Tobacco Use Monitoring Survey, Canada, 2005

	Visit to a health-care provider in preceding 12 months		Received advice to reduce or quit smoking§		Provided with information on smoking-cessation aids¶	
Age and sex	%	(95% CI**)	%	(95% CI)	%	(95% CI)
15–19 yrs	89	(85.6–91.9)	36	(29.6–41.7)	38	(27.9–47.2)
Male	87	(81.4–91.8)	33	(23.7–41.8)	44	(27.9–59.7)
Female	91	(87.0–94.9)	38	(30.7–46.3)	32	(21.5–43.0)
20–24 yrs	87	(83.7–90.5)	45	(38.9–50.1)	46	(38.8–53.9)
Male	81	(75.2–86.3)	36	(28.5–44.3)	48	(35.2–60.9)
Female	96	(93.2–98.1)	54	(46.8–60.6)	45	(35.9–54.1)
25–34 yrs	85	(78.0–92.3)	48	(39.8–56.8)	56	(44.0–68.1)
Male	79	(68.2–89.0)	47	(34.4–59.1)	59	(40.2–78.1)
Female	97	(94.2–99.3)	51	(38.8–62.2)	52	(36.5–67.2)
35–44 yrs	88	(82.6–93.9)	59	(51.4–67.2)	52	(41.3–63.3)
Male	84	(75.3–93.4)	60	(50.3–70.7)	49	(32.5–65.3)
Female	94	(89.7–98.0)	58	(47.7–67.9)	57	(45.1–68.7)
≥45 yrs	89	(85.1–92.5)	61	(55.6–66.5)	61	(54.8–67.8)
Male	84	(78.3–90.0)	68	(61.6–74.5)	61	(51.6–70.7)
Female	94	(90.4–97.6)	54	(45.8–62.7)	61	(51.5–71.4)
Overall (≥15 yrs)	**88**	**(85.2–90.1)**	**54**	**(50.5–57.5)**	**55**	**(50.6–59.8)**
Male	83	(78.6–86.6)	55	(49.9–59.9)	56	(48.4–62.7)
Female	94	(92.6–96.2)	53	(48.5–57.4)	55	(49.1–60.5)

* Respondents were asked in separate questions whether they had visited a physician, dentist or dental hygienist, and pharmacist; responses were combined to derive the overall health-care provider variable.

† Determined by response to the question: "At the present time, do you smoke every day, occasionally, or not at all?" Respondents who answered "every day" or "occasionally" were classified as current smokers.

§ Respondents who said they had visited a health-care provider in the preceding 12 months were asked whether the provider gave advice to reduce or quit smoking.

¶ Respondents who said they were advised to reduce or quit were asked if the health-care provider provided them with information on smoking-cessation aids such as nicotine patches, a product such as Zyban®, or counseling services.

** Confidence interval.

quitting among patients (*5,6*). Certain clinicians simply might not know how to identify smokers quickly or know which treatments are effective and how these treatments can be provided (*7*). Health-care–provider associations need to develop innovative approaches to support and motivate health-care providers to counsel patients who smoke (*8*).

The medical, dental, and pharmacist associations in Canada endorse the need to educate members regarding their role in smoking cessation, provide members with current training and tools that will motivate and assist them in their roles as counselors and referral agents, and increase public awareness that health-care providers can offer support and resources to help persons stop smoking (*4*). Continuing education programs have been shown to substantially change the way health-care providers counsel smokers, resulting in higher quit rates (*3*). In addition, evidence-based studies have documented that health-care–provider advice alone can increase smoking-cessation rates from approximately 5% to 10%, and following up with patients who are trying to quit can double smoking-cessation rates (*2,3,9*). Even brief interventions by health-care providers can help adult smokers to quit (*10*). In addition, use of smoking-cessation drugs has been documented to increase the cessation rate for many patients (*2*).

Despite missed opportunities in smoking-cessation consultation among health-care providers, progress has been made in decreasing smoking prevalence overall in Canada. In 2001, the Canadian government established FTCS, with the goal of reducing the prevalence of smokers to 20% by 2011. CTUMS demonstrated a reduction in smoking prevalence during 2001–2006 from 25% to 20% and achievement of the original 2011 goal. FTCS was recently renewed, and new targets for 2007–2011 include further reducing smoking rates from 19% to 12%.

The findings in this report are subject to at least five limitations. First, CTUMS does not sample households without landline telephones. Second, the survey methodology did not determine the frequency, timing, and nature of respondent visits to health-care providers or health-care–provider advice to reduce or quit smoking or offers of information on smoking-cessation aids. The variation in results by age might be explained, in part, by the number of visits to health-care providers by respondents during the preceding 12 months because the frequency of visits increases with age. In addition, the survey did not determine whether the respondents told their health-care providers that they smoked, which would affect the prevalence of providers offering advice. For example, pharmacists might have been less likely to ask patients whether they were smokers and might therefore have had a lower prevalence of giving cessation advice. Likewise, the type of encounter (e.g., emergency treatment versus routine or preventive care) would affect the likelihood that a provider would ask about smoking status and offer advice about smoking. The higher prevalence of advice to quit or reduce smoking among females aged 20–24 years compared with males of the same age might be a result of the nature of the visit, which was not assessed; for example, more females might have been

TABLE 2. Prevalence of visits to a health-care provider* in preceding 12 months among current smokers† and of receiving smoking-cessation advice and information about smoking-cessation aids, by type of health-care provider, age, and sex — Canadian Tobacco Use Monitoring Survey, Canada, 2005

Type of provider/ Patient characteristics	Visit to a health-care provider in preceding 12 months		Received advice to reduce or quit smoking§		Provided with information on smoking-cessation aids¶	
	%	(95% CI**)	%	(95% CI)	%	(95% CI)
Physician						
15–19 yrs	67	(61.5–72.3)	38	(31.5–45.1)	36	(24.5–47.8)
Male	58	(50.0–65.5)	35	(23.5–46.2)	41	(19.2–62.8)
Female	76	(68.7–84.0)	41	(32.6–49.6)	33	(21.2–44.7)
20–24 yrs	70	(64.9–74.8)	42	(36.4–47.6)	48	(39.8–56.9)
Male	58	(50.3–65.2)	33	(24.4–41.0)	60	(45.7–74.3)
Female	86	(81.4–90.8)	50	(43.3–57.4)	42	(32.1–51.2)
25–34 yrs	66	(57.7–74.3)	47	(37.6–56.2)	58	(43.0–72.1)
Male	56	(44.2–66.8)	46	(31.8–60.5)	59	(34.8–83.1)
Female	84	(76.6–92.3)	48	(35.5–60.1)	56	(39.3–72.7)
35–44 yrs	73	(65.9–80.0)	51	(42.3–59.7)	52	(38.6–65.0)
Male	65	(53.8–75.6)	50	(36.9–62.7)	42	(20.6–64.1)
Female	85	(78.5–90.8)	52	(42.0–62.5)	62	(49.1–74.1)
≥45 yrs	81	(75.8–85.3)	59	(53.3–65.1)	64	(56.4–70.4)
Male	75	(68.7–81.7)	64	(56.0–71.3)	62	(52.0–72.3)
Female	86	(79.6–93.2)	55	(46.3–63.6)	65	(54.6–74.8)
Overall (≥15 yrs)	**73**	**(70.0–76.5)**	**51**	**(47.5–55.3)**	**57**	**(51.6–61.9)**
Male	65	(59.5–69.5)	51	(45.4–57.5)	56	(47.5–63.9)
Female	85	(81.4–88.1)	51	(46.8–56.0)	58	(51.8–63.7)
Dentist or dental hygienist						
15–19 yrs	71	(66.1–75.9)	19	(14.1–24.1)	31	(19.0–43.3)
Male	67	(59.5–74.8)	22	(14.2–30.8)		—††
Female	75	(69.2–80.9)	16	(9.8–22.5)		—
20–24 yrs	62	(57.7–66.6)	29	(22.4–34.9)	31	(19.3–42.7)
Male	58	(52.0–64.6)	27	(19.1–35.8)	33	(15.6–50.2)
Female	67	(61.2–73.5)	30	(21.3–38.9)		—
25–34 yrs	59	(51.2–67.6)	35	(25.2–45.4)		—
Male	53	(41.9–64.8)	39	(23.4–53.8)		—
Female	70	(60.2–80.1)	31	(18.7–43.1)		—
35–44 yrs	67	(59.9–74.2)	46	(36.8–55.0)	34	(20.7–46.7)
Male	65	(54.1–76.3)	50	(38.6–61.3)		—
Female	70	(61.5–78.0)	40	(28.3–52.7)		—
≥45 yrs	52	(46.3–57.4)	36	(28.2–43.6)	23	(10.5–35.8)
Male	51	(43.1–58.2)	42	(31.0–53.1)		—
Female	53	(44.7–61.6)	29	(19.1–39.3)		—
Overall (≥15 yrs)	**60**	**(56.8–63.0)**	**36**	**(31.7–40.4)**	**31**	**(23.9–38.5)**
Male	57	(52.3–61.7)	40	(33.9–46.5)	32	(21.6–41.9)
Female	64	(59.3–68.2)	31	(25.9–36.4)	30	(20.8–40.0)
Pharmacist						
15–19 yrs	29	(23.2–34.6)	10	(3.9–15.1)		—
Male	21	(14.0–27.7)		—		—
Female	37	(28.9–45.2)		—		—
20–24 yrs	35	(30.9–40.0)	12	(6.9–16.1)	64	(39.6–88.6)
Male	22	(17.1–27.7)		—		—
Female	53	(46.2–59.8)	13	(6.6–19.7)	56	(26.3–86.2)
25–34 yrs	37	(29.7–44.9)	21	(10.2–31.0)	93	(87.1–99.0)
Male	34	(23.4–44.4)		—		—
Female	43	(33.1–53.6)		—		—
35–44 yrs	36	(29.8–42.9)	17	(7.9–25.2)		—
Male	35	(25.7–45.2)		—		—
Female	38	(28.9–46.3)		—		—
≥45 yrs	42	(36.5–47.6)	15	(8.8–21.3)	81	(66.0–95.2)
Male	38	(31.0–45.2)	23	(10.6–34.6)	83	(64.8–99.7)
Female	46	(38.4–54.5)	8	(3.6–12.3)		—
Overall (≥15 yrs)	**38**	**(34.9–40.7)**	**16**	**(12.3–19.4)**	**84**	**(76.7–90.9)**
Male	33	(29.4–37.3)	19	(12.6–24.6)	88	(79.2–96.5)
Female	44	(39.3–48.1)	13	(9.1–17.0)	78	(66.3–89.7)

* Respondents were asked in separate questions whether they had visited a physician, dentist or dental hygienist, and pharmacist.
† Determined by response to the question: "At the present time, do you smoke every day, occasionally, or not at all?" Respondents who answered "every day" or "occasionally" were classified as current smokers.
§ Respondents who said they had visited a physician, dentist or dental hygienist, or pharmacist in the preceding 12 months were asked whether that provider gave advice to reduce or quit smoking.
¶ Respondents who said they were advised to reduce or quit were asked if that physician, dentist or dental hygienist, or pharmacist provided them with information on smoking-cessation aids such as nicotine patches, a product such as Zyban®, or counseling services.
** Confidence interval.
†† Data are unreliable because of high sampling variability.

advised to reduce or quit as they entered their childbearing and rearing years because of 1) the health effects of smoking during pregnancy and on children and 2) the contraindications of certain forms of birth control (i.e., pills or patches). Third, information on visits with health-care providers is self-reported and might be influenced by social-desirability bias or recall bias. Fourth, although CTUMS describes the association between smoking behaviors and selected variables, conclusions regarding causation cannot be drawn from CTUMS cross-sectional data. Finally, the presented estimates of health-care–provider provision of smoking cessation advice to reduce or quit smoking and the provision of information on cessation aids might be an underestimate because the survey questions were only asked of current smokers. No information was collected from persons who had recently quit smoking but who might also have visited health-care providers and received cessation advice and information on cessation aids.

A smoker's chance of quitting increases after receiving smoking-cessation information and support from various health-care providers in different disciplines (*2,10*). Although certain health-care providers have included smoking-cessation activities in their practices, the results indicate that either many health professionals are missing this opportunity to provide smoking-cessation advice or that smokers are not seeking this advice from their health-care providers. Practice guidelines to identify smokers and encourage cessation could help increase the number of smokers who receive smoking-cessation counseling from their health-care providers.

References

1. Canadian Centre on Substance Abuse. The costs of substance abuse in Canada 2002: highlights. Ottawa, Ontario: Canadian Centre on Substance Abuse; 2006.
2. Prochazka A. New developments in smoking cessation. Chest 2000;117:169–75.
3. Cummings SR, Coates TJ, Richard RJ, et al. Training physicians in counselling about smoking cessation. A randomized trial of the "Quit for Life" program. Ann Intern Med 1989;110:640–7.
4. Canadian Pharmacists Association. Joint statement on smoking cessation. Tobacco—the role of health professionals in smoking cessation. Ottawa, Ontario: Canadian Pharmacists Association; 2001. Available at http://www.pharmacists.ca/content/about_cpha/who_we_are/policy_position/pdf/smoking_cessation_joint_stat.pdf.
5. Campbell HS, Macdonald JM. Tobacco counselling among Alberta dentists. J Can Dent Assoc 1994;60:218–26.
6. Goldberg R, Ockene I, Ockene J. Physicians' attitudes and reported practices toward smoking intervention. J Cancer Educ 1993;8:133–9.
7. Orleans CT. Treating nicotine dependence in medical settings: a stepped-care model. In: Orleans CT, Slade J, eds. Nicotine addiction: principles and management. New York, NY: Oxford University Press; 1993.
8. Goldstein MG, DePue JD, Monroe AD, et al. A population-based survey of physician smoking cessation counseling practices. Prev Med 1998;27(5 Pt 1):720–9.
9. Strecher VJ, O'Malley MS, Villagra VG, et al. Can residents be trained to counsel patients about quitting smoking? J Gen Intern Med 1991;6:9–17.
10. Fiore MC, Bailey WC, Cohen SJ, et al. Treating tobacco use and dependence: clinical practice guideline. Rockville, MD: US Department of Health and Human Services, Public Health Service; 2000.

Notice to Readers

Satellite Broadcast and Webcast: Immunization Update 2007

CDC and the Public Health Training Network will present a satellite broadcast and webcast, Immunization Update 2007, on August 9, 2007. The 2½-hour broadcast will occur live during 9:00–11:30 a.m. EST and will be rebroadcast the same day during 12:00–2:30 p.m. EST. Both broadcasts will feature a live question-and-answer session in which participants nationwide can interact with the course instructors via a toll-free telephone number. Anticipated topics include influenza, rotavirus, varicella, and zoster vaccines and other emerging vaccine topics. Continuing education (CE) credits will be provided. Additional information about the program is available at http://www2a.cdc.gov/phtn/immup-2007.

Information for site administrators about establishing and registering a viewing location is available at http://www.cdc.gov/phtnonline. This website also provides information for individual participants who would like to register to view the satellite broadcast from a specific location or for those seeking CE credit.

No registration is necessary to view the webcasts via the Internet; the link to the live webcast is available at http://www2a.cdc.gov/phtn/webcast/immup-2007. The webcast will be accessible via the Internet connection until September 11, 2007. The program will become available as a self-study DVD and Internet-based program in September 2007.

Notice to Readers

Revised International Health Regulations Effective for the United States

On July 18, 2007, the revised International Health Regulations (IHRs) entered into effect for the United States. IHRs are an international legal framework designed to help contain or prevent serious risks to public health while discouraging unnecessary or excessive restrictions on travel or trade. The revised IHRs 1) describe the obligations of World Health Organization (WHO) member states to assess and manage serious health threats that have the potential to

spread beyond their borders and 2) provide guidance for meeting those obligations.

Under the revised IHRs, member states must report to WHO cases of smallpox, poliomyelitis caused by wild-type poliovirus, human influenza caused by a new virus subtype, and severe acute respiratory syndrome. In addition, member states must notify WHO in a timely way of any threat that qualifies as a public health emergency of international concern, whether that threat is associated with an infectious, chemical, biologic, or radiologic agent.

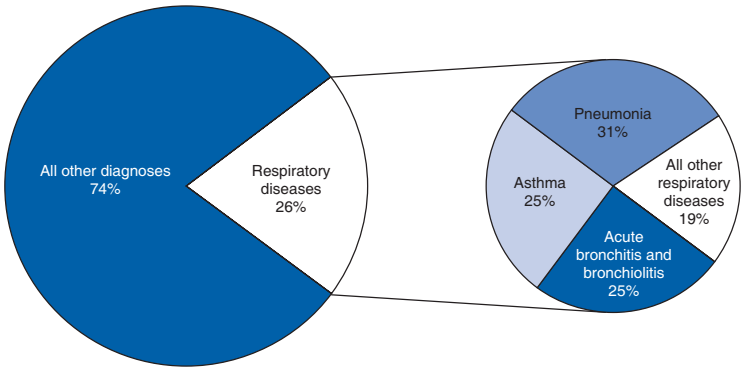
Several federal agencies are working to implement the revised IHRs. The U.S. Department of Health and Human Services (DHHS) has assumed the lead role in carrying out the reporting requirements. The DHHS Operations Center is the central body responsible for reporting events to WHO. The United States will build upon existing state and local reporting and response networks, including the National Notifiable Diseases Surveillance System, to receive information at the federal level. After briefings from CDC on the need for state and local support to implement the revised IHRs, the Council of State and Territorial Epidemiologists on June 28, 2007, approved a resolution that the organization will support the new regulations (available at http://www.cste.org/ps/2007ps/2007psfinal/id/07-id-06.pdf).

Additional information regarding the revised IHRs is available from WHO at http://www.who.int/csr/ihr/en/index.html. Information is also available from DHHS at http://www.globalhealth.gov/ihr.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage Distribution of Hospitalizations for Types of Respiratory Diseases* Among Children Aged <15 Years — National Hospital Discharge Survey, United States, 2005



* Respiratory disease classifications according to the *International Classification of Diseases, Ninth Revision, Clinical Modification* codes 460–519.

In 2005, approximately one fourth of the 2.4 million hospitalizations for children aged <15 years were for respiratory diseases, the largest category of hospitalization diagnoses in this age group. Of these, 31% were for pneumonia, 25% for asthma, 25% for acute bronchitis and bronchiolitis, and 19% for other respiratory diseases, including croup and chronic disease of tonsils and adenoids.

SOURCE: DeFrances CJ, Hall MJ. 2005 National Hospital Discharge Survey. Advance data from vital and health statistics, no. 385, Hyattsville, MD: US Department of Health and Human Services, CDC, National Center for Health Statistics; 2007. Available at http://www.cdc.gov/nchs/data/ad/ad385.pdf, p 15.

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending July 14, 2007 (28th Week)*

Disease	Current week	Cum 2007	5-year weekly average†	Total cases reported for previous years 2006	2005	2004	2003	2002	States reporting cases during current week (No.)
Anthrax	—	—	0	1	—	—	—	2	
Botulism:									
foodborne	—	3	1	20	19	16	20	28	
infant	1	44	2	97	85	87	76	69	PA (1)
other (wound & unspecified)	—	12	1	48	31	30	33	21	
Brucellosis	2	58	2	121	120	114	104	125	NC (1), GA (1)
Chancroid	—	14	1	33	17	30	54	67	
Cholera	—	—	0	9	8	5	2	2	
Cyclosporiasis§	6	49	10	136	543	171	75	156	NY (1), NC (1), FL (4)
Diphtheria	—	—	0	—	—	—	1	1	
Domestic arboviral diseases§,¶:									
California serogroup	—	—	5	67	80	112	108	164	
eastern equine	—	—	1	8	21	6	14	10	
Powassan	—	—	0	1	1	1	—	1	
St. Louis	—	—	0	10	13	12	41	28	
western equine	—	—	—	—	—	—	—	—	
Ehrlichiosis§:									
human granulocytic	22	86	21	646	786	537	362	511	NY (7), MN (13), MO (1), OK (1)
human monocytic	17	132	14	578	506	338	321	216	NY (5), OH (1), MN (2), MO (2), AR (6), OK (1)
human (other & unspecified)	2	46	5	231	112	59	44	23	MO (1), AR (1)
Haemophilus influenzae,**									
invasive disease (age <5 yrs):									
serotype b	—	6	0	27	9	19	32	34	
nonserotype b	1	53	2	142	135	135	117	144	AZ (1)
unknown serotype	3	146	3	214	217	177	227	153	NY (1), KS (1), AK (1)
Hansen disease§	—	26	2	66	87	105	95	96	
Hantavirus pulmonary syndrome§	1	13	1	40	26	24	26	19	CA (1)
Hemolytic uremic syndrome, postdiarrheal§	6	79	6	288	221	200	178	216	NY (1), MO (1), FL (1), AL (1), ID (1), CA (1)
Hepatitis C viral, acute	2	342	19	802	652	713	1,102	1,835	NY (1), WV (1)
HIV infection, pediatric (age <13 yrs)††	—	—	6	52	380	436	504	420	
Influenza-associated pediatric mortality§,§§	1	67	0	41	45	—	N	N	TX (1)
Listeriosis	4	271	19	875	896	753	696	665	NY (2), MO (1), CA (1)
Measles¶¶	—	19	2	55	66	37	56	44	
Meningococcal disease, invasive***:									
A, C, Y, & W-135	3	151	4	311	297	—	—	—	NY (1), OH (1), UT (1)
serogroup B	—	70	3	190	156	—	—	—	
other serogroup	—	11	0	31	27	—	—	—	
unknown serogroup	7	365	10	648	765	—	—	—	PA (2), OH (1), IN (2), NC (1), CA (1)
Mumps	4	479	14	6,584	314	258	231	270	NY (1), CO (1), WA (1), CA (1)
Novel influenza A virus infections	—	—	—	N	N	N	N	N	
Plague	—	4	0	17	8	3	1	2	
Poliomyelitis, paralytic	—	—	—	—	1	—	—	—	
Poliovirus infection, nonparalytic§	—	—	—	N	N	N	N	N	
Psittacosis§	—	2	0	21	16	12	12	18	
Q fever§	2	101	3	169	136	70	71	61	MO (1), FL (1)
Rabies, human	—	—	0	3	2	7	2	3	
Rubella†††	—	10	0	11	11	10	7	18	
Rubella, congenital syndrome	—	—	—	1	1	—	1	1	
SARS-CoV§,§§§	—	—	—	—	—	—	8	N	
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	2	64	1	125	129	132	161	118	MN (1), KY (1)
Syphilis, congenital (age <1 yr)	—	148	8	380	329	353	413	412	
Tetanus	—	6	1	41	27	34	20	25	
Toxic-shock syndrome (staphylococcal)§	—	42	1	101	90	95	133	109	
Trichinellosis	—	4	0	15	16	5	6	14	
Tularemia	1	37	4	95	154	134	129	90	OK (1)
Typhoid fever	2	138	7	353	324	322	356	321	NY (2)
Vancomycin-intermediate *Staphylococcus aureus*§	—	5	0	6	2	—	N	N	
Vancomycin-resistant *Staphylococcus aureus*§	—	—	—	1	3	1	N	N	
Vibriosis (noncholera *Vibrio* species infections)§	3	95	3	N	N	N	N	N	OH (1), FL (2)
Yellow fever	—	—	—	—	—	—	—	1	

—: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts.

* Incidence data for reporting years 2006 and 2007 are provisional, whereas data for 2002, 2003, 2004, and 2005 are finalized.

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

§ Not notifiable in all states. Data from states where the condition is not notifiable are excluded from this table, except in 2007 for the domestic arboviral diseases and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/epo/dphsi/phs/infdis.htm.

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

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

†† Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. Implementation of HIV reporting influences the number of cases reported. Updates of pediatric HIV data have been temporarily suspended until upgrading of the national HIV/AIDS surveillance data management system is completed. Data for HIV/AIDS, when available, are displayed in Table IV, which appears quarterly.

§§ Updated weekly from reports to the Influenza Division, National Center for Immunization and Respiratory Diseases. A total of 66 cases were reported for the 2006–07 flu season.

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

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

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

§§§ Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending July 14, 2007, and July 15, 2006 (28th Week)*

Reporting area	Chlamydia†					Coccidioidomycosis					Cryptosporidiosis				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	10,867	20,592	25,327	530,950	534,708	89	153	658	4,383	4,551	29	69	319	1,490	1,566
New England	733	673	1,357	18,326	17,096	—	0	1	1	—	—	4	27	82	120
Connecticut	275	206	829	5,360	5,107	N	0	0	N	N	—	0	12	12	38
Maine§	35	50	74	1,367	1,148	—	0	0	—	—	—	1	6	14	13
Massachusetts	304	310	600	8,446	7,422	—	0	0	—	—	—	1	19	26	43
New Hampshire	16	39	70	1,051	985	—	0	1	1	—	—	1	4	13	14
Rhode Island§	86	63	108	1,653	1,778	—	0	0	—	—	—	0	5	5	3
Vermont§	17	20	45	449	656	N	0	0	N	N	—	1	4	12	9
Mid. Atlantic	2,204	2,671	4,284	76,541	64,920	—	0	0	—	—	6	10	37	197	242
New Jersey	254	420	541	11,249	10,274	N	0	0	N	N	—	0	5	9	13
New York (Upstate)	449	509	2,758	13,240	12,239	N	0	0	N	N	1	3	14	62	51
New York City	1,158	840	1,567	24,402	21,615	N	0	0	N	N	—	1	10	28	72
Pennsylvania	343	832	1,795	27,650	20,792	N	0	0	N	N	5	4	18	98	106
E.N. Central	502	3,180	6,292	88,004	90,655	—	1	3	15	24	4	15	110	327	367
Illinois	—	1,014	1,323	24,975	28,541	—	0	0	—	—	—	2	22	28	51
Indiana	231	382	644	10,958	10,900	—	0	0	—	—	1	1	18	30	29
Michigan	—	742	1,225	18,611	17,528	—	0	3	11	20	—	2	10	69	60
Ohio	45	646	3,654	23,398	22,320	—	0	2	4	4	3	4	33	92	105
Wisconsin	226	372	528	10,062	11,366	N	0	0	N	N	—	5	53	108	122
W.N. Central	796	1,201	1,448	30,901	32,378	—	0	54	3	—	6	11	77	223	238
Iowa	207	165	243	4,597	4,388	N	0	0	N	N	1	2	28	45	30
Kansas	239	149	294	4,395	4,288	N	0	0	N	N	2	1	8	34	30
Minnesota	—	243	314	5,247	6,759	—	0	54	—	—	—	2	25	48	80
Missouri	287	453	628	12,199	11,950	—	0	1	3	—	—	2	21	34	45
Nebraska§	—	105	184	2,504	2,703	N	0	0	N	N	3	1	16	13	17
North Dakota	—	31	69	624	921	N	0	0	N	N	—	0	11	1	5
South Dakota	63	49	84	1,335	1,369	N	0	0	N	N	—	1	7	48	31
S. Atlantic	3,416	3,905	6,760	104,155	102,081	—	0	1	1	2	6	19	70	367	335
Delaware	122	69	115	1,866	1,893	N	0	0	N	N	—	0	3	3	1
District of Columbia	—	83	167	2,790	1,611	—	0	0	—	—	—	0	2	3	8
Florida	1,413	1,051	1,651	28,573	25,729	N	0	0	N	N	3	9	32	168	132
Georgia	10	691	3,822	12,222	18,541	N	0	0	N	N	1	3	17	76	107
Maryland§	258	412	697	10,401	10,829	—	0	1	1	2	—	0	2	15	11
North Carolina	211	624	1,233	15,779	18,528	—	0	0	—	—	—	1	11	43	37
South Carolina§	816	451	3,030	17,504	10,696	N	0	0	N	N	1	1	14	28	18
Virginia§	573	495	685	13,514	12,696	N	0	0	N	N	1	1	5	27	18
West Virginia	13	54	85	1,506	1,558	N	0	0	N	N	—	0	3	4	3
E.S. Central	524	1,392	2,044	34,657	40,786	—	0	0	—	—	3	3	15	70	59
Alabama§	—	348	539	4,654	12,682	N	0	0	N	N	2	0	12	24	22
Kentucky	82	130	691	4,097	5,180	N	0	0	N	N	1	1	3	21	16
Mississippi	—	381	959	11,016	9,781	N	0	0	N	N	—	0	8	11	7
Tennessee§	442	531	695	14,890	13,143	N	0	0	N	N	—	1	5	14	14
W.S. Central	980	2,208	3,028	58,372	59,696	—	0	1	—	—	1	5	45	71	93
Arkansas§	219	168	337	4,464	4,100	N	0	0	N	N	—	0	3	4	8
Louisiana	468	323	610	8,794	9,190	—	0	1	—	—	—	1	9	17	19
Oklahoma	293	258	471	6,729	6,194	N	0	0	N	N	1	0	9	17	20
Texas§	—	1,463	1,911	38,385	40,212	N	0	0	N	N	—	2	36	33	46
Mountain	86	1,327	2,026	29,127	35,363	53	98	293	2,814	3,206	3	5	40	114	70
Arizona	45	477	993	9,061	10,826	53	97	293	2,741	3,117	1	0	6	19	12
Colorado	—	284	416	5,085	8,573	N	0	0	N	N	1	1	7	36	18
Idaho§	6	38	253	1,453	1,744	N	0	0	N	N	—	0	5	7	5
Montana§	—	52	144	1,352	1,361	N	0	0	N	N	—	1	26	11	8
Nevada§	35	175	397	4,484	4,068	—	1	5	29	38	—	0	3	5	4
New Mexico§	—	165	396	4,334	5,473	—	0	2	11	11	—	1	6	25	13
Utah	—	102	209	2,732	2,535	—	1	4	33	38	1	0	3	4	6
Wyoming§	—	26	45	626	783	—	0	0	—	2	—	0	11	7	4
Pacific	1,626	3,378	4,362	90,867	91,733	36	57	311	1,549	1,319	—	1	5	39	42
Alaska	57	85	157	2,290	2,290	N	0	0	N	N	—	0	1	1	2
California	1,270	2,674	3,627	71,511	71,527	36	57	311	1,549	1,319	—	0	0	—	—
Hawaii	—	105	129	2,655	3,087	N	0	0	N	N	—	0	1	—	2
Oregon§	181	166	394	4,996	5,084	N	0	0	N	N	—	1	5	38	38
Washington	118	342	621	9,415	9,745	N	0	0	N	N	—	0	0	—	—
American Samoa	U	0	32	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	16	18	—	491	—	0	0	—	—	—	0	0	—	—
Puerto Rico	124	122	233	3,905	2,630	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	U	3	7	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional. Data for HIV/AIDS, AIDS, and TB, when available, are displayed in Table IV, which appears quarterly.
† Chlamydia refers to genital infections caused by *Chlamydia trachomatis*.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 14, 2007, and July 15, 2006 (28th Week)*

Reporting area	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive All ages, all serotypes†				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	150	299	1,513	6,998	8,123	3,383	6,944	8,941	170,877	184,109	15	47	184	1,284	1,287
New England	1	23	67	484	602	131	111	259	2,966	2,945	—	3	19	95	86
Connecticut	—	5	25	129	139	60	43	204	1,105	1,194	—	0	6	29	24
Maine§	—	4	14	68	43	3	2	8	63	69	—	0	4	7	7
Massachusetts	—	9	26	194	285	53	49	96	1,450	1,276	—	2	5	48	40
New Hampshire	—	0	3	5	14	3	2	8	87	120	—	0	2	6	6
Rhode Island§	—	0	17	28	45	10	9	19	231	251	—	0	10	4	2
Vermont§	1	3	12	60	76	2	1	5	30	35	—	0	1	1	7
Mid. Atlantic	35	60	127	1,295	1,653	508	715	1,537	19,887	17,182	3	10	27	271	269
New Jersey	—	7	17	142	251	96	120	169	3,271	2,799	—	2	5	36	47
New York (Upstate)	19	24	108	465	546	77	115	1,035	3,047	3,229	2	3	15	75	81
New York City	5	16	32	388	501	224	186	376	5,158	5,261	—	2	6	52	50
Pennsylvania	11	14	34	300	355	111	251	613	8,411	5,893	1	3	10	108	91
E.N. Central	8	46	100	970	1,272	233	1,276	2,608	34,852	36,748	—	6	15	143	219
Illinois	—	11	30	186	326	—	363	500	9,020	10,493	—	2	6	29	69
Indiana	N	0	0	N	N	103	157	293	4,532	4,739	—	1	10	31	37
Michigan	—	14	38	294	340	—	280	880	7,567	7,081	—	0	5	14	20
Ohio	8	15	32	345	358	25	316	1,569	10,235	10,700	—	2	5	61	48
Wisconsin	—	8	27	145	248	105	131	181	3,498	3,735	—	0	4	8	45
W.N. Central	12	20	553	420	956	182	386	514	9,948	9,994	3	3	24	73	69
Iowa	1	5	16	99	128	24	39	62	966	948	—	0	1	1	—
Kansas	3	3	11	68	93	51	42	86	1,207	1,194	1	0	2	8	13
Minnesota	—	0	514	12	402	—	64	87	1,397	1,659	1	1	17	27	33
Missouri	4	8	28	166	240	103	204	268	5,528	5,268	—	1	5	25	18
Nebraska§	2	2	9	43	46	—	27	57	679	670	1	0	2	11	4
North Dakota	2	0	16	8	8	—	2	7	35	59	—	0	2	1	1
South Dakota	—	1	6	24	39	4	6	15	136	196	—	0	0	—	—
S. Atlantic	33	56	106	1,276	1,223	1,252	1,678	3,209	40,559	44,944	4	11	34	329	328
Delaware	—	1	3	18	18	34	27	44	736	789	—	0	3	5	1
District of Columbia	—	1	7	34	36	—	42	63	1,129	929	—	0	2	3	2
Florida	21	24	44	596	495	557	474	717	12,106	12,638	1	3	8	95	99
Georgia	9	12	31	256	277	2	339	2,068	5,086	8,701	1	2	7	68	72
Maryland§	—	5	12	114	105	49	131	228	3,240	3,767	—	2	5	50	41
North Carolina	—	0	0	—	—	138	314	676	7,182	9,412	2	1	9	41	37
South Carolina§	1	1	8	40	57	387	193	1,361	7,426	4,884	—	1	4	32	24
Virginia§	2	9	28	203	223	75	124	236	3,216	3,413	—	1	3	21	40
West Virginia	—	0	21	15	12	10	19	44	438	411	—	0	6	14	12
E.S. Central	1	9	34	212	189	197	545	879	12,972	16,339	—	2	9	78	70
Alabama§	1	4	22	115	86	—	148	271	2,120	5,862	—	0	3	18	14
Kentucky	N	0	0	N	N	33	52	268	1,541	1,783	—	0	1	2	4
Mississippi	N	0	0	N	N	—	152	434	4,069	3,692	—	0	1	6	10
Tennessee§	—	4	12	97	103	164	194	240	5,242	5,002	—	2	6	52	42
W.S. Central	6	7	55	155	140	439	944	1,490	24,183	25,908	3	2	34	65	54
Arkansas§	2	3	13	63	42	87	79	142	2,120	2,268	—	0	2	5	6
Louisiana	—	1	6	29	47	254	211	366	5,334	5,447	—	0	3	4	11
Oklahoma	4	2	42	63	51	98	91	236	2,557	2,291	3	1	29	53	34
Texas§	N	0	0	N	N	—	561	938	14,172	15,902	—	0	3	3	3
Mountain	11	30	67	686	737	23	253	454	5,572	7,839	1	4	11	156	134
Arizona	1	3	11	90	74	20	106	220	1,957	2,657	1	2	6	64	53
Colorado	4	10	26	229	239	—	62	93	1,204	1,981	—	1	4	35	35
Idaho§	—	3	12	58	82	1	2	20	94	99	—	0	1	4	3
Montana§	—	2	10	39	34	—	2	20	47	111	—	0	0	—	—
Nevada§	1	2	8	60	66	2	48	135	1,095	1,479	—	0	2	7	9
New Mexico§	—	2	6	50	32	—	29	64	726	972	—	0	4	21	19
Utah	5	6	27	141	200	—	17	33	408	466	—	0	3	23	13
Wyoming§	—	1	4	19	10	—	2	5	41	74	—	0	1	2	2
Pacific	43	59	558	1,500	1,351	418	750	935	19,938	22,210	1	2	16	74	58
Alaska	—	1	17	31	24	14	10	27	242	299	1	0	2	6	7
California	27	43	93	1,022	1,099	352	633	804	16,931	18,268	—	0	10	20	19
Hawaii	—	1	4	39	29	—	14	26	324	542	—	0	2	6	10
Oregon§	6	8	14	198	199	32	25	46	579	777	—	1	6	41	22
Washington	10	1	449	210	—	20	70	142	1,862	2,324	—	0	5	1	—
American Samoa	U	0	0	U	U	U	0	4	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	0	0	—	—	—	1	6	—	52	—	0	0	—	1
Puerto Rico	—	6	19	114	81	6	6	16	178	165	—	0	2	2	1
U.S. Virgin Islands	U	0	0	U	U	U	0	3	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Data for *H. influenzae* (age <5 yrs for serotype b, nonserotype b, and unknown serotype) are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 14, 2007, and July 15, 2006 (28th Week)*

Reporting area	Hepatitis (viral, acute), by type† A: Current week	A: Previous 52 weeks Med	A: Previous 52 weeks Max	A: Cum 2007	A: Cum 2006	B: Current week	B: Previous 52 weeks Med	B: Previous 52 weeks Max	B: Cum 2007	B: Cum 2006	Legionellosis: Current week	Legionellosis: Previous 52 weeks Med	Legionellosis: Previous 52 weeks Max	Legionellosis: Cum 2007	Legionellosis: Cum 2006
United States	35	55	201	1,331	1,891	41	78	405	1,965	2,271	43	40	113	824	1,022
New England	—	2	6	37	108	—	2	5	33	63	2	2	13	37	65
Connecticut	—	0	3	8	21	—	0	5	18	27	2	0	9	10	15
Maine§	—	0	2	1	5	—	0	2	2	12	—	0	2	1	3
Massachusetts	—	1	4	14	53	—	0	2	2	12	—	1	5	13	34
New Hampshire	—	0	2	7	18	—	0	1	5	7	—	0	2	—	4
Rhode Island§	—	0	2	5	5	—	0	4	5	4	—	0	6	10	7
Vermont§	—	0	1	2	6	—	0	1	1	1	—	0	2	3	2
Mid. Atlantic	5	7	20	187	202	2	9	21	231	282	17	12	55	232	326
New Jersey	—	2	5	42	64	—	2	7	49	89	—	1	10	21	50
New York (Upstate)	4	1	11	39	43	1	1	13	44	36	8	5	30	79	106
New York City	1	2	10	63	59	—	2	6	48	66	—	2	24	29	59
Pennsylvania	—	1	5	43	36	1	3	8	90	91	9	5	19	103	111
E.N. Central	4	6	17	121	163	3	9	23	215	270	5	8	31	150	216
Illinois	—	2	7	38	38	—	2	6	47	84	—	0	13	1	43
Indiana	2	0	7	7	15	2	0	21	22	22	2	1	6	13	15
Michigan	—	2	8	32	53	—	2	8	57	78	—	3	10	53	47
Ohio	2	1	4	37	39	1	2	10	78	64	3	3	19	75	86
Wisconsin	—	0	4	7	18	—	0	3	11	22	—	0	3	8	25
W.N. Central	1	2	18	83	75	1	2	15	65	77	8	1	16	38	27
Iowa	—	0	4	17	7	—	0	3	11	12	—	0	3	4	4
Kansas	1	0	1	3	21	—	0	1	5	8	1	0	3	2	1
Minnesota	—	0	17	42	6	—	0	13	9	10	6	0	11	11	—
Missouri	—	0	2	12	24	—	1	5	31	39	1	0	2	16	12
Nebraska§	—	0	2	5	10	1	0	3	7	6	—	0	1	3	6
North Dakota	—	0	3	—	—	—	0	1	—	—	—	0	1	—	—
South Dakota	—	0	1	4	7	—	0	1	2	2	—	0	1	2	4
S. Atlantic	9	11	27	257	252	16	20	56	528	642	3	8	25	174	200
Delaware	—	0	1	3	9	—	0	3	7	27	—	0	2	5	4
District of Columbia	—	0	5	14	2	—	0	2	1	4	—	0	5	1	8
Florida	3	3	13	75	92	14	7	14	196	224	2	3	9	72	77
Georgia	—	1	4	37	26	—	3	10	57	105	—	1	3	14	12
Maryland§	—	1	6	37	31	—	2	7	49	87	—	1	8	30	46
North Carolina	4	0	11	29	50	—	0	16	75	90	—	1	4	22	20
South Carolina§	—	0	3	5	11	—	2	5	37	44	—	0	2	8	3
Virginia§	1	2	5	53	27	2	2	8	77	21	1	1	4	19	26
West Virginia	1	0	1	4	4	—	0	23	29	40	—	0	4	3	4
E.S. Central	1	2	7	49	66	1	6	17	160	176	1	2	7	44	45
Alabama§	1	0	2	8	7	—	2	10	59	54	—	0	1	5	7
Kentucky	—	0	2	9	24	1	1	6	25	41	1	1	6	21	13
Mississippi	—	0	4	6	5	—	0	8	12	8	—	0	2	—	1
Tennessee§	—	1	5	26	30	—	3	8	64	73	—	1	3	18	24
W.S. Central	—	5	43	81	186	3	17	169	359	418	—	1	16	39	39
Arkansas§	—	0	2	5	36	—	1	7	15	36	—	0	2	3	2
Louisiana	—	0	4	13	10	—	1	4	21	36	—	0	2	1	6
Oklahoma	—	0	3	3	4	—	1	24	17	13	—	0	6	1	1
Texas§	—	4	39	60	136	3	15	135	306	333	—	1	13	34	30
Mountain	1	5	17	157	159	2	4	9	112	73	3	2	8	49	54
Arizona	1	4	13	123	88	1	0	6	47	—	1	0	4	15	19
Colorado	—	1	3	16	26	—	0	2	18	22	1	0	2	9	7
Idaho§	—	0	1	2	7	1	0	2	7	7	—	0	3	4	6
Montana§	—	0	3	4	6	—	0	3	—	—	—	0	1	1	3
Nevada§	—	0	2	7	8	—	1	5	23	19	1	0	2	6	4
New Mexico§	—	0	2	2	12	—	0	2	5	9	—	0	2	3	2
Utah	—	0	1	2	11	—	0	4	12	16	—	0	2	8	13
Wyoming§	—	0	1	1	1	—	0	1	—	—	—	0	1	3	—
Pacific	14	12	92	359	680	13	10	106	262	270	4	1	11	61	50
Alaska	—	0	1	2	1	—	0	3	4	2	—	0	1	—	—
California	12	10	40	317	648	9	7	31	195	219	3	1	11	47	50
Hawaii	—	0	1	3	8	—	0	1	—	5	—	0	1	1	—
Oregon§	—	1	3	16	23	—	1	5	36	44	—	0	1	3	—
Washington	2	0	52	21	—	4	0	74	27	—	1	0	2	10	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	2	1	10	35	26	3	1	9	36	30	—	0	2	3	1
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Data for acute hepatitis C, viral are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 14, 2007, and July 15, 2006 (28th Week)*

Reporting area	Lyme disease					Malaria					Meningococcal disease, invasive† All serogroups				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	511	226	1,150	5,436	8,078	13	22	105	468	677	10	19	87	597	708
New England	221	36	339	817	1,843	—	1	5	19	38	—	1	3	28	24
Connecticut	214	12	184	567	544	—	0	3	1	10	—	0	1	5	8
Maine§	—	2	38	47	39	—	0	1	3	3	—	0	3	5	2
Massachusetts	—	1	145	7	902	—	0	3	14	17	—	0	2	14	11
New Hampshire	—	6	70	141	337	—	0	1	1	7	—	0	1	—	1
Rhode Island§	—	0	93	1	1	—	0	1	—	—	—	0	1	1	—
Vermont§	7	1	16	54	20	—	0	0	—	1	—	0	1	3	2
Mid. Atlantic	224	113	560	2,868	3,985	4	5	18	110	164	3	2	8	77	115
New Jersey	9	26	152	578	1,451	—	0	7	—	48	—	0	2	1	12
New York (Upstate)	142	50	426	899	1,023	3	1	7	30	18	1	1	2	24	26
New York City	—	1	23	11	117	—	3	9	66	81	—	0	4	21	42
Pennsylvania	73	44	223	1,380	1,394	1	1	4	14	17	2	1	5	31	35
E.N. Central	2	5	137	91	1,120	1	2	10	50	79	4	3	9	80	103
Illinois	—	0	16	6	67	—	1	6	18	37	—	0	3	21	29
Indiana	2	0	4	13	9	—	0	2	5	7	2	0	4	16	14
Michigan	—	1	5	14	15	—	0	2	7	11	—	0	3	14	17
Ohio	—	0	5	6	22	1	0	2	13	18	2	1	3	23	28
Wisconsin	—	3	113	52	1,007	—	0	3	7	6	—	0	3	6	15
W.N. Central	15	4	195	132	191	1	0	12	21	26	—	1	5	37	40
Iowa	—	1	8	34	68	—	0	1	2	1	—	0	3	9	9
Kansas	—	0	2	7	3	—	0	2	1	3	—	0	1	1	1
Minnesota	12	1	188	75	111	—	0	12	11	14	—	0	3	10	10
Missouri	3	0	4	13	2	—	0	1	2	4	—	0	3	10	12
Nebraska§	—	0	2	3	6	1	0	1	4	2	—	0	1	2	6
North Dakota	—	0	7	—	—	—	0	1	—	1	—	0	3	2	1
South Dakota	—	0	0	—	1	—	0	1	1	1	—	0	1	3	1
S. Atlantic	39	47	134	1,389	883	3	5	14	111	176	1	3	11	96	122
Delaware	15	9	27	333	277	—	0	1	3	5	—	0	1	2	4
District of Columbia	—	0	7	13	11	—	0	2	3	2	—	0	1	—	—
Florida	2	1	3	23	8	—	1	4	22	23	—	1	7	34	48
Georgia	—	0	1	1	5	1	0	5	12	59	—	0	3	9	10
Maryland§	—	23	108	675	501	—	1	4	28	40	—	0	2	16	7
North Carolina	1	0	6	21	15	—	0	4	13	13	1	0	6	13	22
South Carolina§	—	0	2	10	5	1	0	2	5	5	—	0	2	10	13
Virginia§	21	9	36	303	58	1	1	4	24	28	—	0	2	12	14
West Virginia	—	0	14	10	3	—	0	1	1	1	—	0	2	—	4
E.S. Central	—	1	4	26	9	—	0	3	19	12	—	1	4	31	27
Alabama§	—	0	3	7	3	—	0	2	4	6	—	0	2	6	4
Kentucky	—	0	2	1	—	—	0	1	4	1	—	0	2	6	7
Mississippi	—	0	1	—	1	—	0	1	1	3	—	0	4	7	2
Tennessee§	—	0	3	18	5	—	0	2	10	2	—	0	2	12	14
W.S. Central	—	1	5	30	7	1	1	29	37	43	—	2	15	57	67
Arkansas§	—	0	0	—	—	—	0	2	—	1	—	0	2	7	6
Louisiana	—	0	1	2	—	—	0	2	12	3	—	0	4	15	28
Oklahoma	—	0	0	—	—	1	0	3	4	3	—	0	4	14	8
Texas§	—	1	5	28	7	—	1	25	21	36	—	0	11	21	25
Mountain	—	1	3	12	7	—	1	6	30	34	1	1	5	47	42
Arizona	—	0	1	—	4	—	0	3	5	12	—	0	3	13	11
Colorado	—	0	1	1	—	—	0	2	11	10	—	0	2	15	14
Idaho§	—	0	2	4	—	—	0	1	—	—	—	0	1	3	1
Montana§	—	0	1	1	—	—	0	1	2	1	—	0	1	1	3
Nevada§	—	0	2	5	1	—	0	1	2	1	—	0	1	3	4
New Mexico§	—	0	1	—	2	—	0	1	1	3	—	0	1	2	2
Utah	—	0	1	1	—	—	0	3	9	7	1	0	2	8	5
Wyoming§	—	0	1	—	—	—	0	0	—	—	—	0	2	2	2
Pacific	10	2	16	71	33	3	3	45	71	105	1	4	48	144	168
Alaska	—	0	1	2	1	—	0	4	2	14	—	0	1	1	2
California	10	2	8	68	30	2	2	6	46	79	1	3	10	104	133
Hawaii	N	0	0	N	N	—	0	1	2	5	—	0	1	2	4
Oregon§	—	0	1	1	2	—	0	3	12	7	—	0	3	23	29
Washington	—	0	8	—	—	1	0	43	9	—	—	0	43	14	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	—	—
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	N	0	0	N	N	—	0	1	1	—	1	0	1	6	4
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Data for meningococcal disease, invasive caused by serogroups A, C, Y, & W-135; serogroup B; other serogroup; and unknown serogroup are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 14, 2007, and July 15, 2006 (28th Week)*

Reporting area	Pertussis					Rabies, animal					Rocky Mountain spotted fever				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	74	220	1,479	4,099	7,080	71	96	171	2,322	2,707	62	29	211	691	837
New England	—	32	77	587	825	8	12	22	299	195	—	0	10	—	8
Connecticut	—	2	10	18	40	2	5	14	120	80	—	0	0	—	—
Maine†	—	2	15	37	25	—	2	8	39	47	N	0	1	N	N
Massachusetts	—	22	46	476	528	—	0	0	—	—	—	0	1	—	7
New Hampshire	—	2	9	32	129	—	1	4	20	17	—	0	0	—	1
Rhode Island†	—	0	31	4	25	—	0	3	18	15	—	0	9	—	—
Vermont†	—	1	9	20	78	6	2	13	102	36	—	0	0	—	—
Mid. Atlantic	20	32	155	608	881	—	13	44	420	239	—	1	6	26	37
New Jersey	—	3	16	63	163	—	0	0	—	—	—	0	4	1	20
New York (Upstate)	12	18	146	329	339	—	—	—	—	—	—	0	1	1	—
New York City	—	2	6	51	47	—	1	5	28	8	—	0	3	11	9
Pennsylvania	8	8	20	165	332	—	12	44	392	231	—	0	3	13	8
E.N. Central	6	41	80	806	1,036	4	2	18	88	55	—	0	9	8	32
Illinois	—	7	23	78	266	—	1	7	26	12	—	0	4	1	16
Indiana	—	2	45	30	110	—	0	2	6	4	—	0	1	2	3
Michigan	—	9	39	127	214	—	0	5	21	24	—	0	1	2	1
Ohio	6	15	54	418	317	4	0	12	35	15	—	0	4	3	11
Wisconsin	—	4	24	153	129	—	0	0	—	—	—	0	0	—	1
W.N. Central	3	15	151	264	707	7	6	17	144	158	6	3	13	99	81
Iowa	—	4	16	75	184	3	0	7	19	26	—	0	1	4	2
Kansas	—	3	14	83	144	2	2	8	79	44	1	0	1	2	—
Minnesota	—	0	119	—	104	—	0	4	10	24	—	0	2	1	1
Missouri	2	3	10	44	189	2	1	6	16	25	5	3	12	86	68
Nebraska†	1	1	4	19	66	—	0	0	—	—	—	0	5	4	10
North Dakota	—	0	18	4	4	—	0	6	11	13	—	0	0	—	—
South Dakota	—	0	6	39	16	—	0	2	9	26	—	0	1	2	—
S. Atlantic	6	19	163	491	579	47	40	65	1,067	1,248	36	14	67	374	506
Delaware	—	0	2	6	3	—	0	0	—	—	—	0	2	7	12
District of Columbia	—	0	2	2	3	—	0	0	—	—	—	0	1	1	—
Florida	5	4	18	124	117	—	0	27	71	176	—	0	4	10	8
Georgia	—	1	5	14	53	16	4	9	97	138	—	0	5	10	21
Maryland†	—	2	8	63	84	—	6	17	145	228	—	1	7	24	39
North Carolina	—	3	112	180	105	8	11	21	270	240	33	6	61	246	383
South Carolina†	—	2	11	44	83	—	3	11	46	80	—	1	6	25	15
Virginia†	—	2	17	48	109	23	12	31	400	333	3	2	12	49	27
West Virginia	1	0	19	10	22	—	1	8	38	53	—	0	2	2	1
E.S. Central	—	5	24	104	165	—	3	11	62	139	2	6	27	113	124
Alabama†	—	1	18	31	34	—	0	8	—	47	2	1	9	29	30
Kentucky	—	0	5	2	32	—	0	4	10	7	—	0	1	3	1
Mississippi	—	0	10	17	19	—	0	0	—	4	—	0	1	2	2
Tennessee†	—	3	9	54	80	—	2	8	52	81	—	4	22	79	91
W.S. Central	17	18	226	355	382	1	8	35	60	481	18	1	168	54	31
Arkansas†	17	2	17	92	40	1	0	5	15	19	7	0	53	14	21
Louisiana	—	0	2	6	17	—	0	1	—	2	—	0	1	—	—
Oklahoma	—	0	36	2	10	—	0	22	45	44	11	0	108	32	5
Texas†	—	15	174	255	315	—	0	34	—	416	—	0	7	8	5
Mountain	11	27	61	614	1,660	—	3	28	69	86	—	0	4	15	16
Arizona	—	6	17	150	349	—	2	10	50	66	—	0	2	—	5
Colorado	3	6	17	166	531	—	0	0	—	—	—	0	1	1	1
Idaho†	1	1	6	23	44	—	0	24	—	—	—	0	3	2	1
Montana†	—	1	7	30	74	—	0	2	4	7	—	0	1	1	2
Nevada†	—	0	9	3	53	—	0	2	1	2	—	0	0	—	—
New Mexico†	—	2	8	25	55	—	0	2	4	6	—	0	1	3	4
Utah	7	8	47	203	509	—	0	1	5	3	—	0	0	—	—
Wyoming†	—	1	5	14	45	—	0	2	5	2	—	0	2	8	3
Pacific	11	19	547	270	845	4	4	13	113	106	—	0	1	2	2
Alaska	3	1	8	22	37	—	0	6	34	14	N	0	0	N	N
California	—	15	225	99	661	4	3	12	75	89	—	0	0	—	—
Hawaii	—	0	5	11	70	N	0	0	N	N	N	0	0	N	N
Oregon†	—	1	11	58	77	—	0	4	4	3	—	0	1	2	2
Washington	8	0	377	80	—	—	0	0	—	—	N	0	0	N	N
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	1	7	—	20	—	0	0	—	—	N	0	0	N	N
Puerto Rico	—	0	1	—	—	—	1	5	26	56	N	0	0	N	N
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 14, 2007, and July 15, 2006 (28th Week)*

Reporting area	Salmonellosis					Shiga toxin-producing *E. coli* (STEC)†					Shigellosis				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2007	Cum 2006
United States	507	807	2,338	17,486	18,321	52	75	336	1,458	1,430	236	311	1,287	7,007	5,646
New England	3	34	199	927	1,254	—	3	25	87	143	—	4	16	97	167
Connecticut	—	0	185	185	503	—	0	20	20	75	—	0	13	13	67
Maine§	—	2	14	53	42	—	1	8	17	6	—	0	5	12	2
Massachusetts	—	22	60	542	550	—	1	6	37	45	—	3	11	63	86
New Hampshire	—	3	15	55	97	—	0	3	5	11	—	0	2	3	4
Rhode Island§	—	1	20	51	41	—	0	2	2	2	—	0	3	4	5
Vermont§	3	2	6	41	21	—	0	4	6	4	—	0	2	2	3
Mid. Atlantic	71	94	189	2,293	2,251	5	7	63	146	184	22	11	47	276	506
New Jersey	—	14	50	201	492	—	1	20	11	48	—	2	12	24	216
New York (Upstate)	42	29	112	650	474	4	3	15	62	70	1	3	42	55	110
New York City	3	24	45	586	579	—	0	4	14	22	1	5	12	118	134
Pennsylvania	26	33	66	856	706	1	3	47	59	44	20	1	17	79	46
E.N. Central	51	97	203	2,410	2,603	4	9	63	182	216	61	31	80	812	566
Illinois	—	30	65	669	780	—	1	8	18	36	—	13	53	220	203
Indiana	33	15	55	321	297	—	1	8	22	27	2	2	17	34	73
Michigan	—	18	35	373	494	—	1	6	32	37	—	1	5	19	94
Ohio	18	25	56	610	572	4	3	18	62	62	59	5	68	428	89
Wisconsin	—	17	49	437	460	—	2	41	48	54	—	4	14	111	107
W.N. Central	24	49	104	1,241	1,202	7	11	45	231	252	30	41	156	1,050	740
Iowa	1	9	26	205	206	—	2	38	48	56	—	2	14	38	38
Kansas	5	7	20	199	174	1	0	4	28	12	—	1	10	16	63
Minnesota	—	13	44	290	317	—	4	26	76	60	—	5	24	122	50
Missouri	15	15	35	341	332	5	2	12	41	79	26	16	72	826	422
Nebraska§	2	3	11	105	96	1	1	11	24	26	—	1	14	11	40
North Dakota	1	0	23	18	9	—	0	12	1	2	—	0	127	4	4
South Dakota	—	3	11	83	68	—	0	5	13	17	4	4	24	33	123
S. Atlantic	180	209	401	4,461	4,366	5	15	32	285	223	77	82	167	2,502	1,346
Delaware	4	3	10	62	57	—	0	3	10	2	—	0	1	4	4
District of Columbia	—	1	4	16	32	—	0	1	1	1	—	0	5	4	6
Florida	74	94	176	1,856	1,861	2	2	8	79	44	42	46	76	1,412	612
Georgia	17	29	73	719	675	—	1	7	31	38	28	28	89	898	489
Maryland§	—	14	31	321	301	—	3	10	43	34	—	2	10	45	42
North Carolina	28	30	130	625	632	1	2	11	46	39	1	1	14	36	95
South Carolina§	37	18	47	377	378	1	0	3	8	4	4	1	5	45	66
Virginia§	14	20	58	415	386	1	3	11	64	60	2	2	9	57	32
West Virginia	6	1	31	70	44	—	0	5	3	1	—	0	2	1	—
E.S. Central	26	54	140	1,162	1,070	17	4	21	97	107	17	18	89	700	340
Alabama§	7	14	78	329	307	17	0	7	37	12	6	7	67	261	93
Kentucky	19	9	23	244	199	—	1	12	23	24	11	2	32	167	153
Mississippi	—	12	101	234	262	—	0	3	2	2	—	2	76	178	36
Tennessee§	—	17	32	355	302	—	2	9	35	69	—	4	14	94	58
W.S. Central	15	78	595	1,321	1,937	—	4	73	82	84	8	37	655	656	822
Arkansas§	3	13	45	234	379	—	1	7	17	12	3	2	10	53	43
Louisiana	—	14	48	191	414	—	0	2	—	11	—	6	25	145	77
Oklahoma	12	9	103	197	184	—	0	17	12	7	4	2	63	55	52
Texas§	—	43	470	699	960	—	2	68	53	54	1	23	580	403	650
Mountain	30	48	90	1,180	1,326	9	8	34	186	183	11	20	84	384	446
Arizona	16	17	44	420	379	1	2	9	59	39	7	10	37	202	245
Colorado	6	10	21	282	367	—	1	7	30	39	1	3	15	56	69
Idaho§	—	3	8	59	84	8	2	10	42	36	1	0	3	6	6
Montana§	—	2	6	45	76	—	0	0	—	—	—	0	13	13	4
Nevada§	4	4	10	97	113	—	0	5	11	15	1	1	20	16	47
New Mexico§	—	5	15	101	123	—	1	5	19	18	—	2	15	51	46
Utah	4	4	13	136	151	—	1	14	25	30	1	1	4	15	26
Wyoming§	—	1	4	40	33	—	0	3	—	6	—	0	19	25	3
Pacific	107	109	890	2,491	2,312	5	5	164	162	38	10	32	256	530	713
Alaska	1	1	5	42	39	N	0	0	N	N	—	0	2	6	5
California	92	89	260	1,868	1,945	4	0	15	96	N	7	25	84	416	611
Hawaii	1	5	16	121	116	—	0	3	8	6	—	1	3	16	24
Oregon§	2	7	17	162	210	—	1	9	20	32	—	1	6	35	73
Washington	11	1	625	298	2	1	0	162	38	—	3	0	170	57	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	0	0	—	—	N	0	0	N	N	—	0	0	—	—
Puerto Rico	5	14	66	306	233	—	0	0	—	—	1	0	6	16	16
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Includes *E. coli* O157:H7; Shiga toxin-positive, serogroup non-O157; and Shiga toxin-positive, not serogrouped.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 14, 2007, and July 15, 2006 (28th Week)*

Reporting area	Streptococcal disease, invasive, group A					*Streptococcus pneumoniae*, invasive disease, nondrug resistant† Age <5 years				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max		
United States	77	89	261	3,130	3,435	4	30	108	882	778
New England	—	6	29	262	221	—	2	11	67	68
Connecticut	—	0	23	84	59	—	0	6	—	23
Maine§	—	0	3	18	10	—	0	1	1	—
Massachusetts	—	3	12	121	115	—	2	6	50	39
New Hampshire	—	0	5	24	24	—	0	2	7	6
Rhode Island§	—	0	12	—	4	—	0	3	7	—
Vermont§	—	0	2	15	9	—	0	1	2	—
Mid. Atlantic	9	15	41	588	650	—	3	20	102	116
New Jersey	—	2	9	80	115	—	1	4	16	43
New York (Upstate)	9	5	27	196	207	—	2	15	63	63
New York City	—	3	12	133	118	—	1	3	23	10
Pennsylvania	—	6	11	179	210	N	0	0	N	N
E.N. Central	21	16	32	546	677	—	5	14	143	206
Illinois	—	5	13	135	205	—	1	6	32	58
Indiana	18	2	12	88	80	—	0	10	14	25
Michigan	—	3	10	130	138	—	1	4	50	51
Ohio	3	4	14	167	175	—	1	7	39	43
Wisconsin	—	1	6	26	79	—	0	2	8	29
W.N. Central	7	5	32	219	231	—	2	8	67	59
Iowa	—	0	0	—	—	—	0	0	—	—
Kansas	2	0	3	27	43	—	0	1	2	10
Minnesota	3	0	29	110	107	—	1	6	46	32
Missouri	1	2	6	51	44	—	0	2	13	11
Nebraska§	—	0	3	15	21	—	0	2	5	4
North Dakota	1	0	2	10	8	—	0	2	1	2
South Dakota	—	0	2	6	8	—	0	0	—	—
S. Atlantic	19	22	51	759	739	2	3	14	179	49
Delaware	1	0	2	6	7	—	0	0	—	—
District of Columbia	—	0	3	8	9	—	0	1	—	—
Florida	4	6	16	182	157	1	0	5	40	—
Georgia	5	5	12	143	162	—	0	5	44	—
Maryland§	—	4	9	134	144	—	1	6	42	40
North Carolina	6	0	22	105	106	—	0	0	—	—
South Carolina§	1	1	7	69	50	1	0	3	21	—
Virginia§	2	2	11	94	84	—	0	3	27	—
West Virginia	—	0	3	18	20	—	0	4	5	9
E.S. Central	1	4	9	124	145	—	1	6	51	14
Alabama§	N	0	0	N	N	N	0	0	N	N
Kentucky	1	1	3	30	34	—	0	0	—	—
Mississippi	N	0	0	N	N	—	0	2	3	14
Tennessee§	—	3	8	94	111	—	0	6	48	—
W.S. Central	5	6	90	185	253	—	4	43	130	123
Arkansas§	1	0	2	16	18	—	0	2	7	16
Louisiana	—	0	1	6	12	—	0	4	25	16
Oklahoma	4	1	23	49	67	—	1	13	33	23
Texas§	—	3	64	114	156	—	1	27	65	68
Mountain	13	10	23	369	460	1	4	12	121	129
Arizona	5	5	11	150	235	1	2	7	69	73
Colorado	3	3	9	106	81	—	1	4	32	32
Idaho§	—	0	2	8	7	—	0	1	2	1
Montana§	N	0	0	N	N	N	0	0	N	N
Nevada§	—	0	1	2	—	—	0	1	1	2
New Mexico§	—	1	5	34	88	—	0	4	17	21
Utah	5	1	7	64	46	—	0	0	—	—
Wyoming§	—	0	1	5	3	—	0	0	—	—
Pacific	2	3	9	78	59	1	1	4	22	14
Alaska	2	0	3	20	N	1	0	2	20	—
California	N	0	0	N	N	N	0	0	N	N
Hawaii	—	2	9	58	59	—	0	2	2	14
Oregon§	N	0	0	N	N	N	0	0	N	N
Washington	N	0	0	N	N	N	0	0	N	N
American Samoa	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U
Guam	—	0	0	—	—	N	0	0	N	N
Puerto Rico	—	0	0	—	—	N	0	0	N	N
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U

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U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Includes cases of invasive pneumococcal disease, in children aged <5 years, caused by *S. pneumoniae*, which is susceptible or for which susceptibility testing is not available (NNDSS event code 11717).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 14, 2007, and July 15, 2006 (28th Week)*

Reporting area	*Streptococcus pneumoniae*, invasive disease, drug resistant†										Syphilis, primary and secondary				
	All ages					Age <5 years									
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	23	47	256	1,424	1,557	2	8	35	250	239	119	198	310	5,080	4,845
New England	—	1	12	31	88	—	0	3	5	2	7	4	13	120	110
Connecticut	—	0	5	—	68	—	0	0	—	—	—	0	10	15	22
Maine§	—	0	2	7	5	—	0	2	1	1	—	0	1	2	7
Massachusetts	—	0	0	—	—	—	0	0	—	—	6	2	8	77	66
New Hampshire	—	0	0	—	—	—	0	0	—	—	1	0	2	13	6
Rhode Island§	—	0	4	13	6	—	0	1	2	—	—	0	5	12	7
Vermont§	—	0	2	11	9	—	0	1	2	1	—	0	1	1	2
Mid. Atlantic	2	3	9	86	95	—	0	5	21	12	30	26	45	855	607
New Jersey	—	0	0	—	—	—	0	0	—	—	3	3	8	93	89
New York (Upstate)	—	1	5	28	31	—	0	4	7	6	1	3	14	69	81
New York City	—	0	0	—	—	—	0	0	—	—	24	16	35	554	293
Pennsylvania	2	2	6	58	64	—	0	2	14	6	2	5	12	139	144
E.N. Central	4	9	40	365	344	—	1	7	46	53	3	15	27	378	490
Illinois	—	0	3	10	18	—	0	1	2	5	—	7	13	166	255
Indiana	4	2	31	97	87	—	0	5	10	14	1	1	5	24	43
Michigan	—	0	1	2	15	—	0	1	1	2	—	2	8	58	60
Ohio	—	5	38	256	224	—	1	5	33	32	1	4	9	98	102
Wisconsin	N	0	0	N	N	—	0	0	—	—	1	1	4	32	30
W.N. Central	2	1	124	95	28	—	0	15	6	1	1	6	16	167	147
Iowa	—	0	0	—	—	—	0	0	—	—	—	0	3	5	8
Kansas	—	0	10	48	—	—	0	2	2	—	—	0	3	9	12
Minnesota	—	0	123	—	—	—	0	15	—	—	—	1	5	40	29
Missouri	2	1	5	39	28	—	0	1	—	1	1	3	14	108	95
Nebraska§	—	0	1	2	—	—	0	0	—	—	—	0	2	1	2
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	1
South Dakota	—	0	3	6	—	—	0	1	4	—	—	0	3	4	—
S. Atlantic	15	21	59	640	742	2	4	15	131	114	48	45	180	1,174	1,040
Delaware	—	0	1	5	—	—	0	1	1	—	—	0	3	6	14
District of Columbia	—	0	2	5	18	—	0	0	—	2	—	2	12	93	57
Florida	10	12	29	371	385	—	2	8	72	74	19	15	25	415	381
Georgia	5	7	17	216	253	2	1	10	50	38	—	7	153	146	140
Maryland§	—	0	1	1	—	—	0	0	—	—	6	5	15	156	171
North Carolina	—	0	0	—	—	—	0	0	—	—	11	5	23	188	160
South Carolina§	—	0	0	—	—	—	0	0	—	—	1	1	10	52	39
Virginia§	N	0	0	N	N	—	0	0	—	—	11	4	17	114	76
West Virginia	—	1	17	42	86	—	0	1	8	—	—	0	2	4	2
E.S. Central	—	3	9	92	130	—	0	3	18	22	5	16	29	407	331
Alabama§	N	0	0	N	N	—	0	0	—	—	—	6	17	144	135
Kentucky	—	0	2	17	26	—	0	1	2	5	1	1	7	37	36
Mississippi	—	0	2	—	16	—	0	0	—	—	—	2	9	56	32
Tennessee§	—	2	8	75	88	—	0	3	16	17	4	6	14	170	128
W.S. Central	—	1	9	76	62	—	0	2	11	6	15	32	55	869	756
Arkansas§	—	0	1	1	9	—	0	0	—	2	5	1	7	59	38
Louisiana	—	1	3	31	53	—	0	1	3	4	8	7	29	196	124
Oklahoma	—	0	8	44	—	—	0	2	8	—	2	1	5	40	38
Texas§	—	0	0	—	—	—	0	0	—	—	—	21	35	574	556
Mountain	—	1	5	39	68	—	0	3	12	29	—	7	27	138	261
Arizona	—	0	0	—	—	—	0	0	—	—	—	2	16	48	99
Colorado	—	0	0	—	—	—	0	0	—	—	—	1	5	15	43
Idaho§	N	0	0	N	N	—	0	0	—	—	—	0	1	1	2
Montana§	—	0	0	—	—	—	0	0	—	—	—	0	1	1	1
Nevada§	—	0	3	16	15	—	0	2	5	1	—	2	12	42	74
New Mexico§	—	0	0	—	—	—	0	0	—	—	—	1	7	26	35
Utah	—	0	5	13	28	—	0	3	6	20	—	0	2	4	7
Wyoming§	—	0	2	10	25	—	0	1	1	8	—	0	1	1	—
Pacific	—	0	0	—	—	—	0	0	—	—	10	38	57	972	1,103
Alaska	—	0	0	—	—	—	0	0	—	—	—	0	2	5	5
California	N	0	0	N	N	—	0	0	—	—	1	36	54	888	968
Hawaii	—	0	0	—	—	—	0	0	—	—	—	0	1	5	13
Oregon§	N	0	0	N	N	—	0	0	—	—	—	0	6	8	9
Washington	N	0	0	N	N	—	0	0	—	—	9	2	11	66	108
American Samoa	U	0	0	U	U	U	0	1	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
Puerto Rico	N	0	0	N	N	—	0	0	—	—	1	3	11	77	81
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Includes cases of invasive pneumococcal disease caused by drug-resistant *S. pneumoniae* (DRSP) (NNDSS event code 11720).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 14, 2007, and July 15, 2006 (28th Week)*

Reporting area	Varicella (chickenpox)					West Nile virus disease†									
						Neuroinvasive					Nonneuroinvasive§				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	104	792	2,813	23,581	30,417	—	0	178	3	122	—	1	417	3	158
New England	9	21	124	435	3,048	—	0	3	—	—	—	0	2	—	1
Connecticut	—	1	76	1	1,067	—	0	3	—	—	—	0	1	—	1
Maine¶	—	0	7	—	167	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	16	—	1,105	—	0	1	—	—	—	0	1	—	—
New Hampshire	—	7	17	169	230	—	0	0	—	—	—	0	0	—	—
Rhode Island¶	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Vermont¶	9	9	66	265	479	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	31	109	195	2,944	3,179	—	0	11	—	2	—	0	4	—	1
New Jersey	N	0	0	N	N	—	0	2	—	—	—	0	1	—	—
New York (Upstate)	N	0	0	N	N	—	0	5	—	—	—	0	1	—	—
New York City	—	0	0	—	—	—	0	4	—	—	—	0	2	—	—
Pennsylvania	31	109	195	2,944	3,179	—	0	2	—	2	—	0	0	—	1
E.N. Central	11	227	568	6,723	10,129	—	0	42	—	4	—	0	33	—	4
Illinois	—	2	11	87	82	—	0	24	—	2	—	0	22	—	—
Indiana	—	0	0	—	—	—	0	5	—	1	—	0	12	—	1
Michigan	—	93	258	2,719	3,001	—	0	10	—	—	—	0	4	—	1
Ohio	11	107	449	3,242	6,309	—	0	11	—	—	—	0	3	—	—
Wisconsin	—	17	72	675	737	—	0	2	—	1	—	0	2	—	2
W.N. Central	6	32	136	1,189	1,218	—	0	37	—	23	—	0	78	2	35
Iowa	N	0	0	N	N	—	0	3	—	2	—	0	4	1	4
Kansas	2	9	52	426	234	—	0	3	—	4	—	0	3	—	1
Minnesota	—	0	0	—	—	—	0	7	—	5	—	0	7	—	6
Missouri	4	16	78	619	927	—	0	14	—	4	—	0	2	—	—
Nebraska¶	N	0	0	N	N	—	0	9	—	4	—	0	38	—	12
North Dakota	—	0	60	84	25	—	0	5	—	—	—	0	28	—	7
South Dakota	—	2	15	60	32	—	0	7	—	4	—	0	22	1	5
S. Atlantic	21	96	239	3,152	2,886	—	0	2	—	1	—	0	7	—	—
Delaware	—	1	6	22	44	—	0	0	—	—	—	0	0	—	—
District of Columbia	—	0	8	14	21	—	0	0	—	—	—	0	1	—	—
Florida	15	16	85	783	N	—	0	1	—	1	—	0	0	—	—
Georgia	N	0	0	N	N	—	0	1	—	—	—	0	4	—	—
Maryland¶	N	0	0	N	N	—	0	2	—	—	—	0	1	—	—
North Carolina	—	0	0	—	—	—	0	1	—	—	—	0	0	—	—
South Carolina¶	1	18	72	668	784	—	0	1	—	—	—	0	0	—	—
Virginia¶	1	28	190	961	1,037	—	0	0	—	—	—	0	2	—	—
West Virginia	4	23	50	704	1,000	—	0	1	—	—	—	0	0	—	—
E.S. Central	3	2	571	322	25	—	0	15	3	16	—	0	17	1	5
Alabama¶	3	2	571	320	25	—	0	2	—	2	—	0	0	—	—
Kentucky	N	0	0	N	N	—	0	2	—	—	—	0	1	—	—
Mississippi	—	0	2	2	—	—	0	10	3	14	—	0	16	1	5
Tennessee¶	N	0	0	N	N	—	0	5	—	—	—	0	2	—	—
W.S. Central	19	190	1,640	7,009	8,116	—	0	59	—	53	—	0	27	—	24
Arkansas¶	15	10	105	304	578	—	0	5	—	4	—	0	2	—	1
Louisiana	—	1	11	68	177	—	0	13	—	9	—	0	10	—	9
Oklahoma	—	0	0	—	—	—	0	6	—	1	—	0	4	—	2
Texas¶	4	168	1,534	6,637	7,361	—	0	39	—	39	—	0	16	—	12
Mountain	3	56	133	1,782	1,816	—	0	63	—	17	—	0	245	—	64
Arizona	—	0	0	—	—	—	0	10	—	1	—	0	14	—	3
Colorado	3	22	62	688	945	—	0	11	—	2	—	0	51	—	11
Idaho¶	N	0	0	N	N	—	0	32	—	10	—	0	174	—	37
Montana¶	—	4	40	271	N	—	0	3	—	—	—	0	8	—	—
Nevada¶	—	0	1	1	9	—	0	9	—	3	—	0	17	—	11
New Mexico¶	—	5	39	272	297	—	0	1	—	—	—	0	1	—	—
Utah	—	15	73	532	534	—	0	8	—	1	—	0	17	—	1
Wyoming¶	—	0	11	18	31	—	0	7	—	—	—	0	10	—	1
Pacific	1	0	9	25	—	—	0	15	—	6	—	0	51	—	24
Alaska	1	0	9	25	N	—	0	0	—	—	—	0	0	—	—
California	—	0	0	—	N	—	0	15	—	6	—	0	37	—	21
Hawaii	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Oregon¶	N	0	0	N	N	—	0	2	—	—	—	0	14	—	3
Washington	N	0	0	N	N	—	0	0	—	—	—	0	2	—	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	5	14	—	151	—	0	0	—	—	—	0	0	—	—
Puerto Rico	4	12	27	374	327	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2006 and 2007 are provisional.
† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for California serogroup, eastern equine, Powassan, St. Louis, and western equine diseases are available in Table I.
§ Not notifiable in all states. Data from states where the condition is not notifiable are excluded from this table, except in 2007 for the domestic arboviral diseases and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/epo/dphsi/phs/infdis.htm.
¶ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE III. Deaths in 122 U.S. cities,* week ending July 14, 2007 (28th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
New England	553	355	131	40	15	12	37
Boston, MA	138	88	35	11	1	3	13
Bridgeport, CT	47	31	9	1	5	1	4
Cambridge, MA	16	11	4	—	1	—	1
Fall River, MA	17	12	3	2	—	—	1
Hartford, CT	53	32	9	7	4	1	5
Lowell, MA	11	9	2	—	—	—	—
Lynn, MA	5	2	2	1	—	—	—
New Bedford, MA	21	16	3	2	—	—	2
New Haven, CT	27	13	9	4	—	1	2
Providence, RI	74	52	15	3	2	2	—
Somerville, MA	7	4	3	—	—	—	—
Springfield, MA	44	22	13	3	2	4	3
Waterbury, CT	21	14	6	1	—	—	—
Worcester, MA	72	49	18	5	—	—	6
Mid. Atlantic	2,203	1,504	493	122	41	42	122
Albany, NY	58	43	10	4	1	—	5
Allentown, PA	16	10	5	1	—	—	—
Buffalo, NY	78	57	17	2	1	1	8
Camden, NJ	25	19	3	1	—	2	1
Elizabeth, NJ	20	11	6	3	—	—	1
Erie, PA	34	23	9	1	1	—	3
Jersey City, NJ	23	13	6	4	—	—	4
New York City, NY	1,005	719	211	46	18	10	41
Newark, NJ	72	28	25	6	3	10	3
Paterson, NJ	14	7	2	3	—	2	—
Philadelphia, PA	431	257	124	30	13	7	27
Pittsburgh, PA§	34	21	7	3	—	3	4
Reading, PA	22	14	4	2	—	2	1
Rochester, NY	138	104	24	5	2	3	12
Schenectady, NY	24	19	4	1	—	—	1
Scranton, PA	28	19	8	1	—	—	—
Syracuse, NY	131	100	21	6	2	2	7
Trenton, NJ	19	14	3	2	—	—	1
Utica, NY	16	13	3	—	—	—	1
Yonkers, NY	15	13	1	1	—	—	2
E.N. Central	1,780	1,177	406	110	48	38	100
Akron, OH	45	25	11	5	2	2	2
Canton, OH	37	23	12	2	—	—	3
Chicago, IL	233	122	71	21	12	6	16
Cincinnati, OH	78	45	20	5	6	2	7
Cleveland, OH	232	161	50	13	3	5	10
Columbus, OH	190	124	44	13	5	4	7
Dayton, OH	133	101	25	6	1	—	10
Detroit, MI	U	U	U	U	U	U	U
Evansville, IN	55	40	11	3	1	—	6
Fort Wayne, IN	56	37	15	2	1	1	4
Gary, IN	20	13	3	3	1	—	1
Grand Rapids, MI	61	43	8	2	2	6	5
Indianapolis, IN	195	135	33	11	8	8	8
Lansing, MI	35	24	10	1	—	—	1
Milwaukee, WI	98	64	24	8	2	—	7
Peoria, IL	45	31	12	1	1	—	3
Rockford, IL	53	43	7	1	—	2	4
South Bend, IN	40	25	11	3	1	—	2
Toledo, OH	114	72	29	9	2	2	3
Youngstown, OH	60	49	10	1	—	—	1
W.N. Central	485	317	122	24	13	9	31
Des Moines, IA	—	—	—	—	—	—	—
Duluth, MN	28	26	2	—	—	—	3
Kansas City, KS	22	14	5	3	—	—	—
Kansas City, MO	91	52	28	6	3	2	4
Lincoln, NE	33	23	9	—	1	—	2
Minneapolis, MN	44	28	11	2	2	1	5
Omaha, NE	94	64	26	1	—	3	5
St. Louis, MO	78	42	25	6	3	2	6
St. Paul, MN	35	24	6	3	2	—	3
Wichita, KS	60	44	10	3	2	1	3
S. Atlantic	1,176	685	312	97	32	49	69
Atlanta, GA	108	57	31	13	4	3	6
Baltimore, MD	149	76	46	17	5	5	13
Charlotte, NC	140	82	37	15	3	3	15
Jacksonville, FL	182	112	44	7	8	10	6
Miami, FL	95	60	26	6	3	—	7
Norfolk, VA	49	30	12	4	—	3	1
Richmond, VA	39	19	16	4	—	—	3
Savannah, GA	76	53	15	4	1	3	6
St. Petersburg, FL	38	26	9	3	—	—	2
Tampa, FL	174	110	41	14	4	5	9
Washington, D.C.	113	50	33	9	4	17	—
Wilmington, DE	13	10	2	1	—	—	1
E.S. Central	869	559	211	54	26	19	59
Birmingham, AL	167	102	47	8	6	4	17
Chattanooga, TN	85	55	22	4	2	2	5
Knoxville, TN	106	77	18	6	4	1	3
Lexington, KY	63	39	12	7	3	2	—
Memphis, TN	157	93	41	10	5	8	10
Mobile, AL	104	74	23	6	1	—	8
Montgomery, AL	43	29	8	5	1	—	3
Nashville, TN	144	90	40	8	4	2	13
W.S. Central	1,455	914	353	103	44	41	74
Austin, TX	94	58	22	6	5	3	9
Baton Rouge, LA	98	59	22	11	3	3	—
Corpus Christi, TX	53	40	4	3	1	5	4
Dallas, TX	174	106	35	19	3	11	8
El Paso, TX	35	27	6	—	1	1	—
Fort Worth, TX	142	95	41	1	2	3	9
Houston, TX	357	204	100	35	10	8	18
Little Rock, AR	70	44	18	5	1	2	1
New Orleans, LA¶	U	U	U	U	U	U	U
San Antonio, TX	237	147	59	17	11	3	13
Shreveport, LA	70	51	13	3	2	1	7
Tulsa, OK	125	83	33	3	5	1	5
Mountain	1,057	648	262	87	20	40	67
Albuquerque, NM	125	72	35	13	1	4	6
Boise, ID	57	45	9	1	—	2	5
Colorado Springs, CO	68	42	19	6	—	1	—
Denver, CO	76	44	17	7	4	4	3
Las Vegas, NV	240	148	71	14	2	5	20
Ogden, UT	39	25	7	5	1	1	4
Phoenix, AZ	166	85	45	19	6	11	10
Pueblo, CO	33	26	6	1	—	—	3
Salt Lake City, UT	117	67	25	12	4	9	6
Tucson, AZ	136	94	28	9	2	3	10
Pacific	1,515	1,020	337	91	33	32	104
Berkeley, CA	12	8	4	—	—	—	1
Fresno, CA	85	55	24	2	3	1	9
Glendale, CA	U	U	U	U	U	U	U
Honolulu, HI	92	66	19	2	—	5	6
Long Beach, CA	76	48	18	5	3	2	8
Los Angeles, CA	U	U	U	U	U	U	U
Pasadena, CA	22	12	7	3	—	—	2
Portland, OR	137	97	25	5	5	4	7
Sacramento, CA	196	126	51	14	3	2	8
San Diego, CA	157	105	32	10	4	5	14
San Francisco, CA	134	85	34	11	2	2	10
San Jose, CA	277	190	52	19	7	9	18
Santa Cruz, CA	27	18	5	2	2	—	—
Seattle, WA	135	85	35	10	4	1	5
Spokane, WA	61	46	12	2	—	1	9
Tacoma, WA	104	79	19	6	—	—	7
Total	11,093**	7,179	2,627	728	272	282	663

U: Unavailable. —:No reported cases.

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

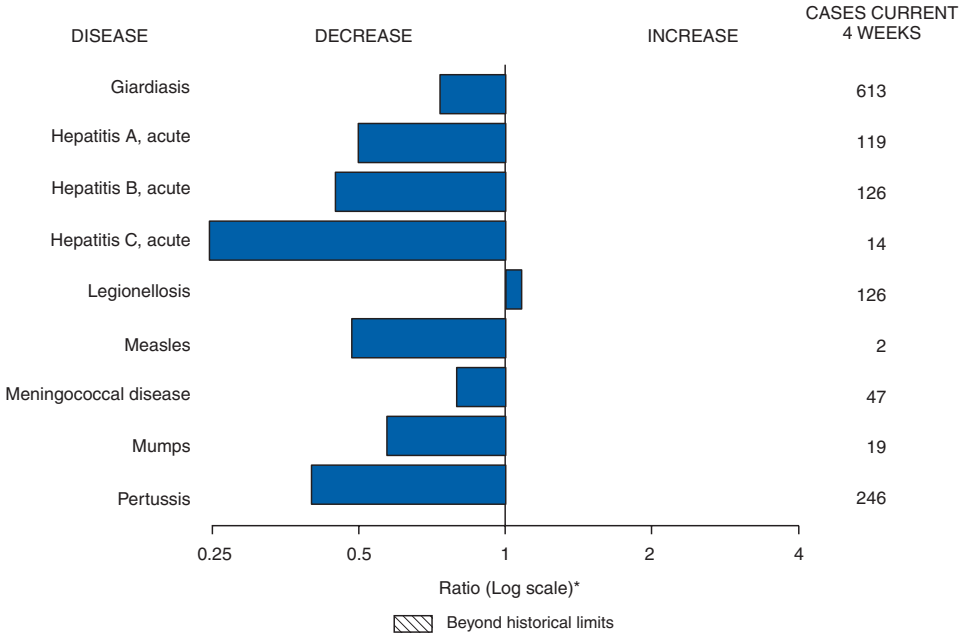
† Pneumonia and influenza.

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

¶ Because of Hurricane Katrina, weekly reporting of deaths has been temporarily disrupted.

** Total includes unknown ages.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals July 14, 2007, 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.

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