

National Diabetes Month — November 2011

November is National Diabetes Month. In 2010, nearly 26 million persons in the United States had diabetes, a leading cause of blindness, kidney failure, and nontraumatic lower-limb amputations, and 79 million adults were at increased risk for developing type 2 diabetes (1). Persons with diabetes can take steps to control the disease and prevent complications, and persons at increased risk can prevent or delay the onset of type 2 diabetes through weight loss and physical activity (1,2).

CDC and state and territorial diabetes prevention and control programs are working with public and private partners to improve outcomes for persons with diabetes and to reduce new cases of type 2 diabetes. The National Diabetes Prevention Program, led by CDC, is designed to bring communities evidence-based lifestyle interventions for preventing type 2 diabetes (3,4). CDC's Native Diabetes Wellness Program has established cooperative agreements with 17 American Indian and Alaska Native communities to increase access to traditional local foods and increase physical activity. Resources on diabetes control and prevention are available at <http://www.yourdiabetesinfo.org>. Information about diabetes, including the importance of a yearly influenza vaccine, is available at <http://www.cdc.gov/diabetes>.

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Self-Reported Visual Impairment Among Persons with Diagnosed Diabetes — United States, 1997–2010

Diabetes can lead to visual impairment (VI) and blindness (1). However, early detection and treatment of many common eye diseases, such as diabetic retinopathy and glaucoma, can reduce the risk for developing VI (1). Surveillance of VI among persons with diabetes is important for evaluating the effectiveness of efforts to reduce VI and other complications of diabetes. To examine trends in the prevalence of self-reported VI among adults (persons aged ≥ 18 years) with diagnosed diabetes in the United States and to assess reported access to eye-care providers, CDC analyzed 1997–2010 data from the National Health Interview Survey (NHIS). This report describes the results of that analysis, which indicated that although the number of adults with diagnosed diabetes reporting VI increased, the age-adjusted percentage of adults with diagnosed diabetes who reported VI declined significantly, from 23.7% in 1997 to 16.7% in 2010. During this 14-year period, age-adjusted VI prevalence declined significantly among most categories of adults with diabetes: men, women, whites, Hispanics, those with some college or higher education, and those diagnosed with diabetes for ≥ 3 years. Prevalence also declined among those aged ≥ 45 years. The percentage of adults with diagnosed diabetes and self-reported VI who reported having consulted an eye-care provider in the past year remained constant at approximately 63%. Continued efforts are needed to sustain and improve the declining trends in self-reported VI and to increase rates of recommended eye examinations in the population with diabetes.

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NHIS is a survey of the civilian, noninstitutionalized population of the United States (2). Adult respondents were asked whether a health professional had ever told them they had diabetes. Women who responded that they had been told they had diabetes during pregnancy only were not considered to have diabetes. Respondents who answer “yes” to the question, “Do you have any trouble seeing even with glasses or contacts?” were considered to have VI. Respondents who answered “yes” to the question, “During the past 12 months, have you seen or talked to an optometrist, ophthalmologist, or eye doctor (someone who prescribes eyeglasses) about your own health?” were considered to have had contact with an eye-care provider in the past year. Prevalence of self-reported VI in persons with diabetes was estimated by age, sex, race, ethnicity, education level, time since diagnosis of diabetes, current insulin use, contact with an eye-care provider in the past year, and health insurance coverage in the past year. The racial groups (i.e., whites and blacks) included persons of both Hispanic and non-Hispanic ethnicity, and the ethnic group (i.e., Hispanics) included persons of any race. Annual prevalences were calculated using 3-year moving averages to improve the precision and reliability of the estimates, and these averaged annual estimates were age-adjusted on the basis of the 2000 U.S. standard population. Joinpoint regression based on single years of data was used to analyze trends. Joinpoint regression uses permutation tests to identify points (i.e., joinpoints) where linear trends change significantly in direction or

magnitude (e.g., zero joinpoints indicates a straight line).^{*} The rate of change for each trend is tested to determine whether it is significantly different from zero, and each trend in the final model is described by an annual percentage change with a 95% confidence interval. Results were considered significant if $p < 0.05$. The NHIS response rate for adult respondents over the entire 14-year period averaged 70.5% but ranged from 80.4% in 1997 to 60.8% in 2010.

From 1997 to 2010, the number of adults with self-reported diabetes and VI increased from 2.7 million to 3.9 million ($p < 0.001$) (Figure 1). However, the crude percentage of adults with diabetes who reported VI decreased from 26.0% in 1997 to 18.6% in 2010 ($p < 0.001$). The age-adjusted prevalence of self-reported VI among persons with diagnosed diabetes decreased from 23.7% to 16.7% ($p < 0.001$). During this period, prevalence of self-reported VI declined significantly in all age groups examined except those aged 18–44 years. The age-adjusted prevalence declined significantly in all groups except blacks and persons diagnosed with diabetes <3 years before (Table). The age-adjusted VI prevalence declined significantly among adults with self-reported diabetes regardless of current insulin use or whether in the past 12 months they had had health insurance coverage or had seen an eye-care provider. Among those with a high school education or less, the age-adjusted VI prevalence declined significantly, from 26.4%

^{*} Additional information available at <http://srab.cancer.gov/joinpoint>.

The *MMWR* series of publications is published by the Office of Surveillance, Epidemiology, and Laboratory Services, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

Suggested citation: Centers for Disease Control and Prevention. [Article title]. *MMWR* 2011;60:[inclusive page numbers].

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in 1997 to 18.2% in 2005 (p=0.008) and then increased (but not significantly) to 20.7% in 2010 (p=0.17).

The percentage of adults with self-reported diabetes who reported annual contact with an eye-care provider remained constant throughout the period, regardless of VI status (Figure 2). During 1997–2010, reported annual contact with an eye-care provider was approximately 63% among persons with self-reported diabetes and VI, and approximately 57% among those with self-reported diabetes but no self-reported VI (63.1% versus 56.8% in 2010; p=0.21).

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Editorial Note

This report highlights encouraging trends in the prevalence of self-reported VI among persons with diagnosed diabetes. From 1997 to 2010, although the number of adults with self-reported diabetes and VI increased, the percentage of adults who reported VI among those with self-reported diabetes declined. Similar declines in the age-adjusted prevalence of self-reported VI suggest that aging of the population had

What is already known on this topic?

Diabetes can lead to visual impairment (VI) and blindness. Early detection and treatment of eye diseases, such as diabetic retinopathy and glaucoma, can reduce the risk for developing VI.

What is added by this report?

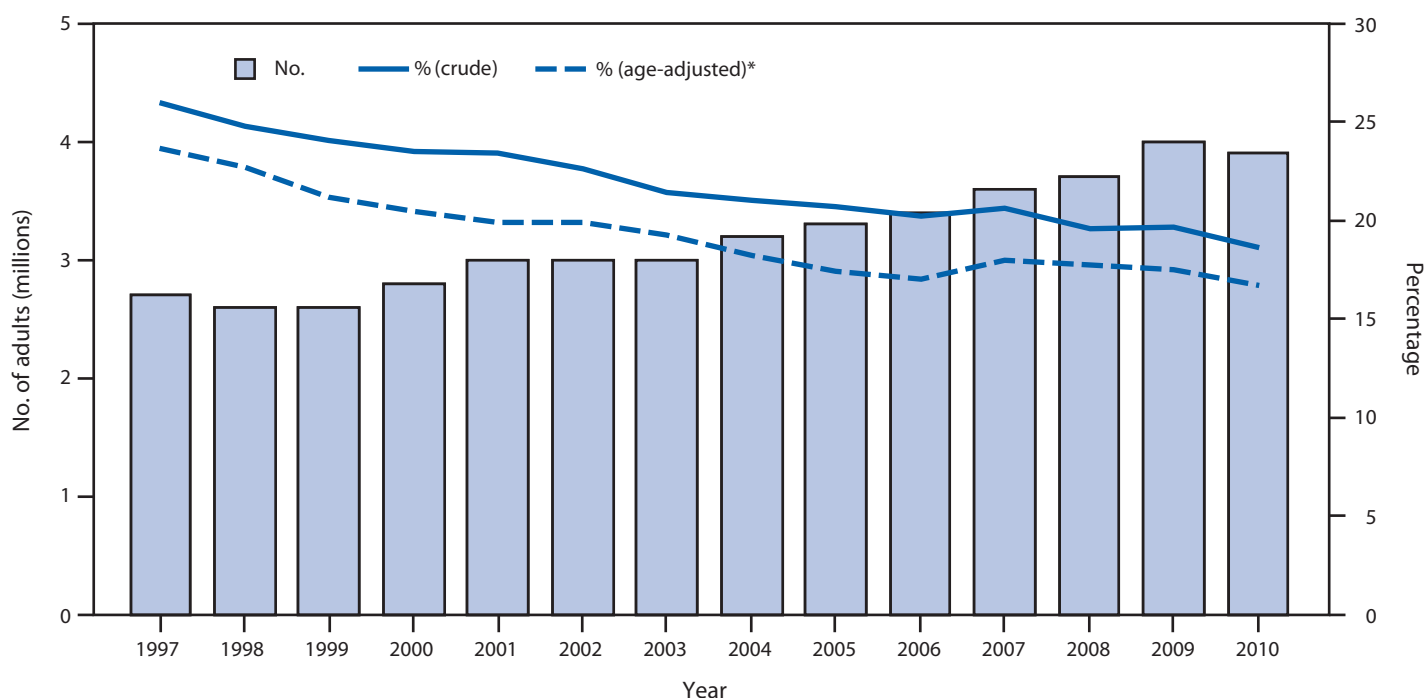
The prevalence of self-reported VI among adults with diagnosed diabetes has declined significantly, with age-adjusted rates decreasing from 23.7% in 1997 to 16.7% in 2010. However, throughout this period, reported annual contact with eye-care providers did not change and remained at approximately 63% among persons with self-reported diabetes and VI.

What are the implications for public health practice?

Surveillance of VI among persons with diabetes is important for evaluating the success of efforts to reduce diabetes complications. Continued awareness of the risk factors for diabetic eye diseases and interventions to improve eye care are needed to sustain and improve the declining trends in self-reported VI among persons with diabetes.

little effect on trends. Consistent with this finding, declining trends in severe diabetic retinopathy have been seen in patients with type 1 diabetes (3,4). The decline in self-reported VI prevalence among persons with diagnosed diabetes during 1997–2010 might be attributable, in part, to better control of VI risk factors (e.g., better blood glucose, blood pressure, and lipid control) (5), improved detection and treatment of eye problems, or other factors. An alternative explanation for

FIGURE 1. Number of adults aged ≥18 years with self-reported diabetes and visual impairment and percentage of adults aged ≥18 years with self-reported diabetes who also reported visual impairment — National Health Interview Survey, United States, 1997–2010



* Based on the 2000 U.S. standard population.

TABLE. Prevalence and trends of self-reported visual impairment (VI) among adults aged ≥ 18 years with self-reported diabetes, by selected characteristics — National Health Interview Survey, United States, 1997–2010

Characteristic	Percentage*		Trend analysis†			
	1997	2010	Period	APC	(95% CI)	p value
Total						
Crude	26.0	18.6	1997–2010	-2.4	(-3.1– -1.7)	<0.001
Age-adjusted [§]	23.7	16.7	1997–2010	-2.3	(-3.4– -1.2)	<0.001
Age group (yrs)						
18–44	20.7	15.0	1997–2010	-2.1	(-4.4– 0.2)	0.06
45–64	26.3	19.9	1997–2010	-2.1	(-3.4– -0.8)	0.005
65–74	24.8	17.7	1997–2010	-2.0	(-3.6– -0.3)	0.02
≥ 75	32.4	19.5	1997–2010	-3.5	(-5.0– -2.0)	<0.001
Sex[§]						
Men	20.7	15.7	1997–2010	-2.2	(-3.6– -0.8)	0.005
Women	26.4	18.6	1997–2010	-2.6	(-4.1– -1.1)	0.003
Race[¶]						
White	22.8	16.3	1997–2010	-2.3	(-3.3– -1.4)	<0.001
Black	25.2	21.6	1997–2010	-1.1	(-3.7– 1.6)	0.38
Hispanic ethnicity^{§**}	21.9	14.0	1997–2010	-2.4	(-4.5– -0.4)	0.02
Education level[§]						
High school or less	26.5	20.7	1997–2005	-4.1	(-6.8– -1.4)	0.008
Some college or more	19.6	13.4	2005–2010	4.0	(-2.0– 10.5)	0.17
			1997–2010	-2.8	(-4.4– -1.1)	0.003
Duration of diabetes (yrs)[§]						
<3	18.8	16.2	1997–2010	-1.8	(-4.4– 0.9)	0.17
3–5	23.3	14.9	1997–2010	-2.5	(-4.5– -0.5)	0.02
6–10	24.3	13.6	1997–2010	-3.3	(-6.0– -0.6)	0.02
≥ 11	27.5	20.9	1997–2010	-2.4	(-3.6– -1.3)	<0.001
Current insulin use[§]						
Yes	27.9	19.7	1997–2010	-2.3	(-3.7– -0.8)	0.007
No	21.4	16.1	1997–2010	-1.9	(-3.3– -0.6)	0.009
Saw eye-care provider in the past 12 mos[§]						
Yes	25.8	19.9	1997–2010	-2.5	(-3.9– -1.2)	0.002
No	21.1	14.1	1997–2010	-2.2	(-4.2– -0.2)	0.03
Health insurance coverage in the past 12 mos[§]						
Yes	22.5	16.8	1997–2010	-2.3	(-3.2– -0.6)	<0.001
No	25.6	20.8	1997–2010	-2.7	(-5.0– -0.5)	0.02

Abbreviations: APC = annual percentage change; CI = confidence interval.

* Annual prevalences were calculated using a 3-year moving average.

† Joinpoint regression based on single years of data was used to analyze trends. Joinpoint regression uses permutation tests to identify points (i.e., joinpoints) where linear trends change significantly in direction or magnitude (e.g., zero joinpoints indicates a straight line). The rate of change for each trend is tested to determine whether it is significantly different from zero, and each trend in the final model is described by an annual percentage change with 95% CI. Results were considered significant if $p < 0.05$.

§ Based on the 2000 U.S. standard population, using age groups 18–44, 45–64, 65–74, and ≥ 75 years.

¶ Whites and blacks include persons of both Hispanic and non-Hispanic ethnicity.

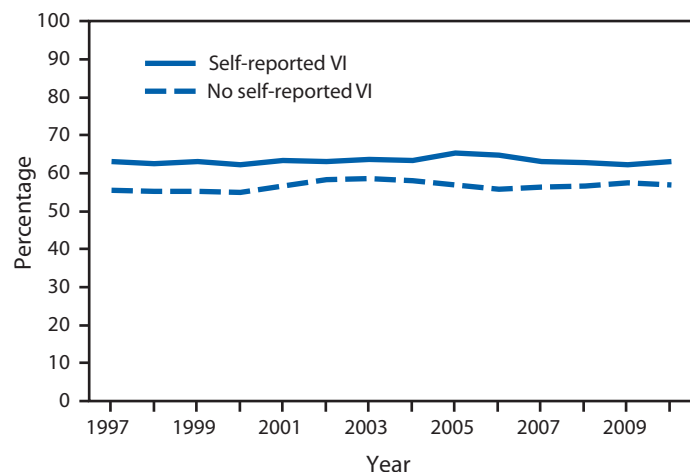
** Persons of Hispanic ethnicity can be of any race.

the declining trend in self-reported VI is that the large and sustained increase of new cases of diabetes since the 1990s (6) might have led to a large number of persons who have not had diabetes long enough to develop VI. Once these patients have had diabetes long enough, the encouraging trends in self-reported VI prevalence might reverse. In addition, reported annual contact with eye-care providers among persons with self-reported diabetes and VI remained constant at approximately 63% during 1997–2010. This finding is consistent with previous studies and surveillance data, which indicate suboptimal levels of eye examination among persons with diabetes (6,7). An annual dilated eye examination is recommended for

persons with diabetes (8). Continued efforts are needed to sustain and improve the declining trends in self-reported VI among persons with diagnosed diabetes, and effective strategies are needed to increase awareness about eye health and improve rates of recommended eye examinations in this population.

In 2010, nearly 26 million persons in the United States had diabetes, and 79 million adults were at high risk for developing type 2 diabetes (1). By 2050, given the current increasing trend in the number of persons with diagnosed diabetes (6), 16.0 million persons aged ≥ 40 years are projected to have diabetic retinopathy, 9.9 million will have cataracts, 3.4 million will have vision-threatening diabetic retinopathy,

FIGURE 2. Age-adjusted* percentage of adults aged ≥ 18 years with self-reported diabetes who reported annual contact with an eye-care provider, by visual impairment (VI) status — National Health Interview Survey, United States, 1997–2010



* Based on the 2000 U.S. standard population.

and 1.4 million will have glaucoma (8). However, persons with diabetes can take steps to control the disease and lower the risk for complications, and persons at high risk for diabetes can prevent or delay the onset of type 2 diabetes with weight loss and physical activity (1).

The findings in this report are subject to at least five limitations. First, NHIS excludes military personnel and persons in nursing homes and other institutions and does not include information on persons with undiagnosed diabetes. Second, NHIS data were self-reported. The validity of self-reported diagnosed diabetes is high (9). However, the validity of self-reported VI and access to eye-care providers among persons with diagnosed diabetes remains unclear. Third, NHIS data about access to eye-care providers does not capture recent advances in screening for diabetic retinopathy, such as digital fundus photography (or telemedicine), and thus might underestimate the level of recommended eye-care received by persons with diabetes (10). Fourth, VI severity could not be assessed. Finally, NHIS response rates averaged 70% but declined during 1997–2010. The potential impact this decline might have had on the trend analysis is unknown.

Although this report highlights encouraging trends in the prevalence of self-reported VI among persons with diagnosed

diabetes, declines were not observed across all population subgroups, and the reported annual contact with eye-care providers remained suboptimal. Continued surveillance of VI among persons with diagnosed diabetes, risk factors for VI, and the level of care received by patients with diabetes, will help public health officials monitor and assess progress toward *Healthy People 2020* national objectives for improving vision health.†

† Additional information available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=42>.

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Paralytic Shellfish Poisoning — Southeast Alaska, May–June 2011

On June 6, 2011, the Section of Epidemiology (SOE) of the Alaska Division of Public Health was notified of a case of paralytic shellfish poisoning (PSP) in southeast Alaska. In collaboration with local partners, SOE investigated and identified a total of eight confirmed and 13 probable PSP cases that occurred during May–June 2011. Warnings to avoid noncommercially harvested shellfish were broadcast on local radio and television and displayed at beaches and in post offices, government offices, and businesses throughout the region. Commercially harvested shellfish, which are tested for the presence of PSP-causing toxins, were safe. Because the risk for PSP is unpredictable, persons who consume noncommercially harvested Alaskan shellfish should know that they are at risk for PSP, and suspected cases should be reported promptly to SOE to initiate control measures in the affected area.

On June 3, 2011, a man aged 52 years residing in Metlakatla, on Annette Island in southeast Alaska, awoke from a nap with numbness around his mouth, tingling in his hands, and slight dyspnea. He was taken to the Annette Island Service Unit, the community's health center, where a clinician inquired about recent seafood consumption. After the man reported eating a meal of steamed cockles shortly before his nap, the clinician diagnosed PSP. The man was transported to Ketchikan where, having become weak and unable to sit up in bed without assistance, he was admitted to the intensive-care unit.

PSP primarily results from ingestion of saxitoxins, toxins produced by marine dinoflagellate algae that accumulate in bivalve mollusks (e.g., butter clams, cockles, geoducks, and mussels) (1). PSP is a potentially fatal neuroparalytic condition. Signs and symptoms of PSP range from mild, short-lived paresthesias of the mouth or extremities to severe, life-threatening paralysis (1). Because PSP is such a serious condition and because a case indicates widespread risk to the shellfish-consuming population of the affected area, immediate reporting of PSP cases to SOE by health-care providers is mandatory in Alaska.

When SOE was notified of the probable case of PSP (in patient A) (Table) on June 6, they also were informed by a nurse in Metlakatla that other community members had eaten cockles and had experienced PSP symptoms. That afternoon, two SOE epidemiologists traveled to Metlakatla (population: 1,460 persons) to investigate. The epidemiologists met with a visiting public health nurse onsite and conducted active case finding by broadcasting messages on local television and radio and through word-of-mouth among community members.

For this investigation, a probable case of PSP was defined as a compatible illness, including paresthesias, in a person shortly after consumption of noncommercially harvested shellfish from Alaska waters during spring 2011. A confirmed case also met this case definition and had detectable saxitoxins in urine or levels ≥ 80 μg saxitoxins/100 g of meat (the level at which product is considered unsafe) in the shellfish that had been consumed before illness onset.

SOE identified an additional 12 probable cases in Metlakatla and used a structured questionnaire for patient interviews. The team collected shellfish from two beaches where shellfish associated with PSP had been harvested. They also collected frozen cockles from a community member who harvested them with the index patient (patient A) before that patient became ill.

While conducting the investigation in Metlakatla, SOE was notified of two men working in Ketchikan (population: 8,050 persons) who had been examined in the hospital's emergency department on June 8 and subsequently were admitted with symptoms consistent with PSP, including paresthesias (patients F and G). Both patients were severely ill; one had required intubation and assisted ventilation and was admitted to the intensive-care unit. The men had shared a meal of boiled, noncommercially harvested mussels. The hospital shipped leftover mussels brought in by the men to the Alaska Department of Environmental Conservation's Environmental Health Laboratory. Urine specimens from the two hospitalized men and two persons who had accompanied them to the hospital and had eaten the same meal of mussels, but who had no symptoms themselves, were sent to CDC for analysis (2). SOE requests that clinicians collect the first available urine, freeze it immediately, and ship as soon as possible.

On June 9, the two SOE epidemiologists in Metlakatla traveled to Ketchikan to interview patients F and G and conduct additional case finding. While at the hospital in Ketchikan, the epidemiologists were informed of two additional patients who had been examined in the emergency department in May 2011 and who had been diagnosed with shellfish allergies but who had symptoms consistent with PSP hours after consuming a clam and cockle chowder. Active case finding in Ketchikan identified three additional probable cases.

Overall, eight probable and five confirmed PSP cases were identified in Metlakatla, and five probable and two confirmed cases of PSP were identified in Ketchikan during this outbreak. Another confirmed case of PSP (in patient H) in Ketchikan had

TABLE. Characteristics of laboratory-confirmed cases of paralytic shellfish poisoning — southeast Alaska, May–June 2011

Patient	Location	Date of onset	Symptoms	Time from consumption to symptom onset	Type of shellfish consumed	Toxin level in shellfish consumed (μg saxitoxins/100 g of meat*)	Toxin level in urine (ng/mL)	Hospitalized
A	Metlakatla	6/3/2011	Ataxia, difficulty swallowing, dizziness, difficulty moving, floating sensation, nausea, paresthesia, shortness of breath, weakness	3.5–4 hrs	Cockles	528	N/A	Yes (ICU)
B	Metlakatla	6/3/2011	Paresthesia	10–15 min	Cockles	528	N/A	No
C	Metlakatla	6/3/2011	Paresthesia	2.5–3 hrs	Cockles	528	N/A	No
D	Metlakatla	6/3/2011	Ataxia, dysphagia, floating sensation, paresthesia, weakness	<1 min	Cockles	528	N/A	No
E	Metlakatla	6/3/2011	Paresthesia	<1 min	Cockles	528	N/A	No
F	Ketchikan	6/8/2011	Ataxia, dysphagia, floating sensation, paresthesia, shortness of breath, weakness	<1 min	Blue mussels	5,037	118	Yes (ICU)
G	Ketchikan	6/8/2011	Dizziness, dysphagia, floating sensation, nausea, weakness	1 hr	Blue mussels	5,037	15	Yes
H	Ketchikan	5/22/2011	Ataxia, dizziness, floating sensation, paresthesia, vomiting, weakness	45 min	Butter/Little neck clams	1,321	N/A	Yes

Abbreviations: N/A = not available; ICU = Intensive-care unit.

*The international regulatory action level set by the U.S. Food and Drug Administration for paralytic shellfish toxins in shellfish is $\geq 80 \mu\text{g}$ saxitoxins/100 g of meat.

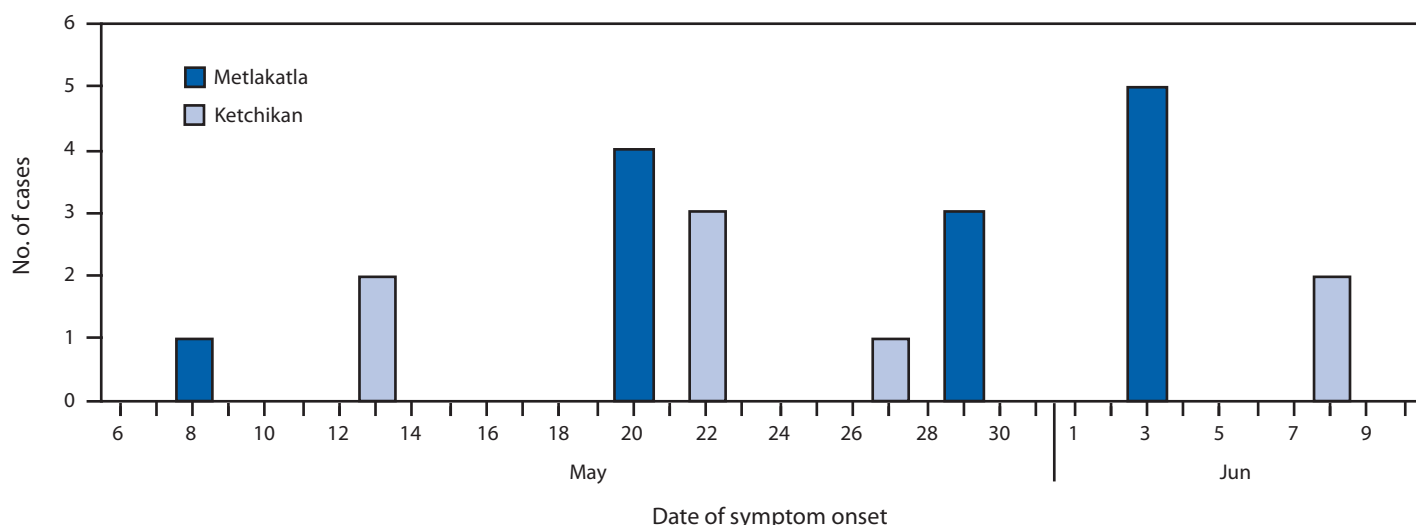
been reported to SOE in May, for a total of eight confirmed cases (Table). In all, 21 cases of PSP were identified in southeast Alaska during May–June 2011 (Figure). All 21 patients reported experiencing paresthesias, with incubation periods for all cases ranging from 0 to 3.75 hours (median: 30 minutes). Four of the 21 (19%) patients were hospitalized (Table); none died. Of the 21 patients, 15 (71%) had consumed cockles; four (19%) had consumed blue mussels; one (5%) had consumed butter clams and cockles; and one (5%) had consumed clams that were otherwise unspecified. Four of the cases were reported to SOE, one after a delay of 3 days.

The cockles collected from the community member in Metlakatla and the mussels collected from the hospital in Ketchikan tested positive for high levels of saxitoxins (Table). Mussels collected from implicated beaches in Metlakatla also tested positive for saxitoxin (range: 4,602–5,429 $\mu\text{g}/100 \text{ g}$ of meat).

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FIGURE. Number of paralytic shellfish poisoning cases (N = 21), by location and date of symptom onset — southeast Alaska, May–June 2011



What is already known on this topic?

Paralytic shellfish poisoning (PSP) is a potentially fatal yet preventable condition that results from ingestion of saxitoxins, a family of neurotoxins produced in certain marine algae and sometimes found in bivalve mollusks. PSP is considered a rare condition and is reportable in Alaska.

What is added by this report?

Of the 21 cases of PSP that were identified in southeast Alaska during May–June 2011, a total of 17 were unreported to the Alaska Section of Epidemiology, indicating that PSP might be underreported in Alaska.

What are the implications for public health practice?

Public health authorities should respond immediately to suspected cases of PSP so that warnings can be provided to the community. Enhanced surveillance during public health responses might increase the number of cases identified, allowing better characterization of the magnitude of the problem. Effective public information campaigns on the risks of noncommercially harvested shellfish and the need to seek medical care if symptoms of PSP develop are an important public health practice in PSP-affected regions.

Editorial Note

The 21 cases of PSP identified in southeast Alaska during May–June 2011 represent a considerable increase in the numbers reported in recent years (≤ 10 cases annually in Alaska since 1998). However, this was not the first time an increase occurred in the annual number of PSP cases in Alaska (3). Active case finding during this outbreak enabled epidemiologists to identify persons with PSP symptoms who had not sought care and thus would never have been reported. This demonstrates that the overall burden of PSP in Alaska likely is underestimated through standard reporting. However, saxitoxin levels were reported to have been higher in shellfish in the region during spring 2011 than in previous years (Kate Sullivan, University of Alaska Southeast, personal communication, 2011), indicating that the increase in the number of cases might not have been a surveillance artifact.

PSP is a preventable condition. Avoidance of noncommercially harvested Alaskan shellfish not tested for saxitoxins is the best way to prevent PSP. Commercially harvested shellfish are tested for saxitoxin in Alaska* and considered safe for human consumption but shellfish collected by persons for their own use are not. Because shellfish harvesting is an important cultural tradition and shellfish are an important subsistence food source for many Alaska Natives and other Alaska residents, not everyone follows the public health recommendation to avoid eating shellfish from noncommercial sources. Furthermore, transient fish-processing workers in Alaska might be unaware

*Food safety requirements for commercial harvesting of shellfish in Alaska are available at http://www.dec.alaska.gov/eh/fss/seafood/shellfish_home.html.

of the potential danger of eating untested Alaskan shellfish because they are unfamiliar with PSP and might have limited English literacy.

During the investigation, SOE epidemiologists posted signs at beaches on Metlakatla and within the community to warn residents about the PSP risks associated with consuming non-commercially harvested shellfish. The warnings were printed in English, Tagalog, Russian, Spanish, and Korean. The Ketchikan Public Health Center and the Alaska Department of Fish and Game posted similar signs throughout Ketchikan and surrounding areas. Additionally, the Alaska Department of Health and Social Services issued press releases and conducted media interviews to inform the public about the outbreak and the need to avoid noncommercial harvesting of shellfish. No additional cases of PSP have been reported in Alaska since this investigation.

Because Alaskan shellfish can have high levels of PSP saxitoxins at any time of year and neither cooking nor freezing destroys the toxin, development of a widely available, inexpensive, and easy-to-use test kit to measure toxin concentrations in noncommercial shellfish would be beneficial. Symptoms of PSP occur within minutes to hours of shellfish consumption (1), and because the course of the illness is unpredictable, immediate medical assessment is strongly recommended. The roles of state and local governments, clinicians, and community leaders include 1) identifying cases so that investigations and control measures (e.g., posting warning signs) can be initiated promptly, 2) educating persons who choose to continue to consume noncommercially harvested shellfish about the signs and symptoms of PSP, and 3) recommending that medical care be sought immediately if symptoms develop. Clinicians should report suspected cases of PSP to local health authorities immediately and promptly collect and freeze samples of patient urine and any uneaten shellfish for PSP toxin testing.

Acknowledgments

Metlakatla Dept of Fish and Wildlife; Annette Island Service Unit staff members; community of Metlakatla; Ketchikan Public Health Center staff members; Karen A. Martinek, Barbara J. Smith, and Eileen L. Nickoloff, Alaska Div of Public Health; Alaska Dept of Environmental Conservation; Kate Sullivan, Univ of Alaska Southeast; Raymond RaLonde, Alaska Sea Grant Marine Advisory Program. Div of Laboratory Sciences, National Center for Environmental Health; Diana M. Bensyl, EIS Field Assignments Br, Scientific Education and Professional Development Program Office, CDC.

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Announcements

National Alzheimer's Disease Awareness Month — November 2011

November is National Alzheimer's Disease Awareness Month. Alzheimer's disease (AD), the most common cause of dementia, is a major cause of morbidity and mortality worldwide. An estimated 2.4–5.2 million persons in the United States currently have AD (1,2). Although AD is not a normal part of aging, the risk for developing it increases with age; approximately half of persons aged ≥85 years are estimated to have AD (3). In the United States, AD is the sixth leading cause of death for all adults and the fifth leading cause of death for adults aged ≥65 years (4).

AD is an important issue for the public health system and is included as a new topic area (dementias, including Alzheimer's disease) in *Healthy People 2020* (5). *The Healthy Brain Initiative: A National Public Health Road Map to Maintaining Cognitive Health* provides a framework for a coordinated public health response across agencies and organizations to address cognitive health, including AD (6). CDC's Health Brain Initiative works to achieve the desired objectives described in the road map that fall under the purview of CDC's mission and vision. Included are efforts to provide state-level surveillance regarding the impact of perceived cognitive impairment through population-based systems. In 2009, five states (California, Florida, Iowa, Louisiana, and Michigan) piloted a new cognitive impairment module in their Behavioral Risk Factor Surveillance System (BRFSS) survey, and 22 states included the module in 2011. Additional information about CDC's Healthy Brain Initiative, including reports highlighting the 2009 BRFSS cognitive impairment pilot data, is available at <http://www.cdc.gov/aging>.

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Rabies Postexposure Prophylaxis Online Course

Rabies Postexposure Prophylaxis (PEP) Basics: Case Illustrations of the 2010 Advisory Committee on Immunization Practices (ACIP) Guidelines is a free online course developed by the Maryland Department of Health and Mental Hygiene (DHMH) in collaboration with CDC. It is designed to educate health-care and public health professionals about rabies, the approach used in assessing rabies virus exposure, and administration of rabies PEP based on ACIP recommendations. Continuing Education credits are available to any physician, nurse, pharmacist, or veterinarian who takes the training. The course can be accessed at the Maryland DHMH website at <http://ideha.dhmf.maryland.gov/training/rabies/default.aspx>.

Announcements

World Day of Remembrance for Road Traffic Victims — November 20, 2011

Road traffic crashes kill nearly 1.3 million persons every year and injure or disable as many as 50 million more (1). Road trauma is the leading cause of death among persons aged 10–24 years worldwide and the leading cause of death to those aged 5–34 years in the United States. CDC has declared road traffic injuries a “winnable battle” and supports efforts at the United Nations (UN) and World Health Organization (WHO) to celebrate 2011–2020 as the Decade of Action for Road Safety (2).

In October 2005, the UN General Assembly adopted a resolution* calling for governments to mark the third Sunday in November each year as World Day of Remembrance for

Road Traffic Victims. The day was created as a means to give recognition to persons injured or killed in road traffic crashes and the plight of relatives and others who must cope with the emotional and practical consequences of these events.

WHO and the UN Road Safety Collaboration encourage governments and nongovernmental organizations worldwide to commemorate this day as a means of drawing the public's attention to road traffic crashes, their consequences and costs, and prevention measures. Additional information about the remembrance day is available at <http://www.worlddayofremembrance.org>. Additional information about motor vehicle injuries and prevention is available at <http://www.cdc.gov/winnablebattles/motorvehicleinjury>.

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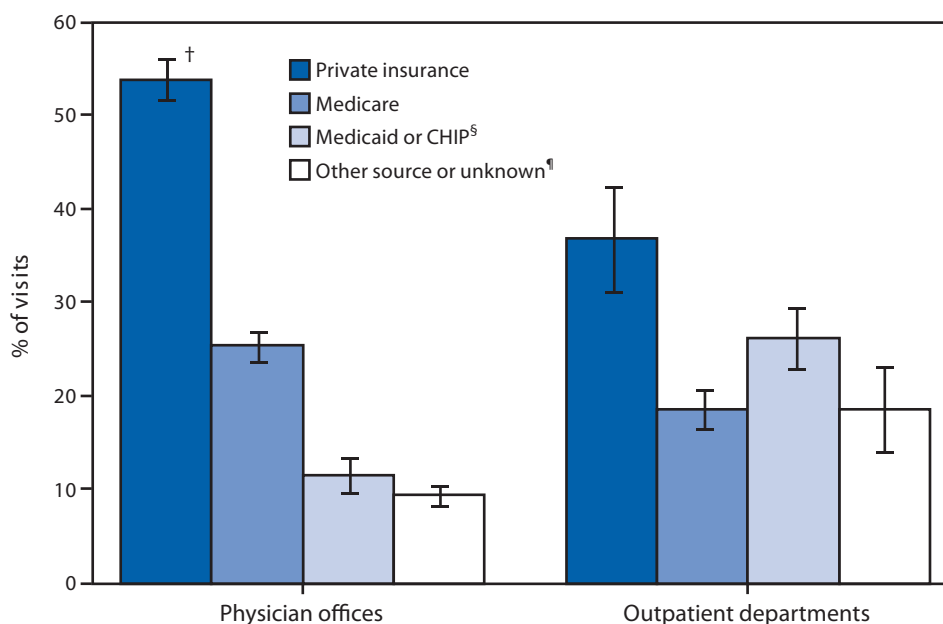
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QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Patient Visits* to Physician Offices and Outpatient Departments, by Payment Source — United States, 2009



* Estimates based on sampled visits to office-based physicians and hospital outpatient department clinics.

[†] 95% confidence interval.

[§] Children's Health Insurance Program.

[¶] Includes self-pay, workers' compensation, and all other insurance types.

In 2009, an estimated 1,038 million visits were made to physician offices and 96 million visits to hospital outpatient department clinics for ambulatory care. Visits by patients to a doctor in a physician's office were more likely (54%) to be covered by private insurance than by Medicare (25%) or Medicaid (12%). Visits to outpatient departments showed a different payment source pattern: 37% of patients were covered by private insurance, 19% by Medicare, and 26% by Medicaid.

Sources: CDC's National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey.

Notifiable Diseases and Mortality Tables

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending November 12, 2011 (45th week)*

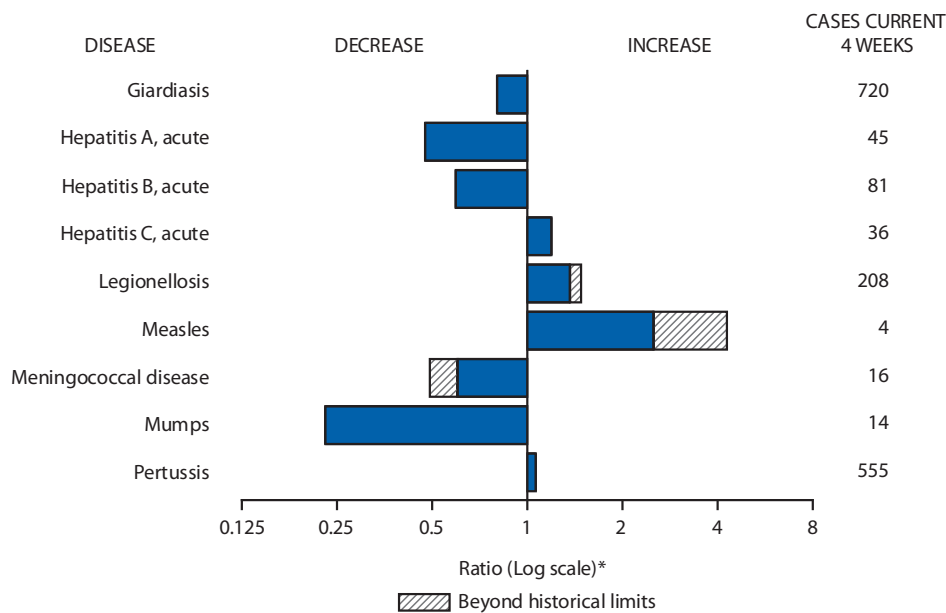
Disease	Current week	Cum 2011	5-year weekly average [†]	Total cases reported for previous years					States reporting cases during current week (No.)
				2010	2009	2008	2007	2006	
Anthrax	—	1	—	—	1	—	1	1	
Arboviral diseases ^{§, ¶} :									
California serogroup virus disease	—	111	0	75	55	62	55	67	
Eastern equine encephalitis virus disease	—	3	—	10	4	4	4	8	
Powassan virus disease	—	14	0	8	6	2	7	1	
St. Louis encephalitis virus disease	—	3	0	10	12	13	9	10	
Western equine encephalitis virus disease	—	—	—	—	—	—	—	—	
Babesiosis	5	618	0	NN	NN	NN	NN	NN	NH (1), NY (3), AZ (1)
Botulism, total	1	102	2	112	118	145	144	165	
foodborne	—	8	0	7	10	17	32	20	
infant	1	66	1	80	83	109	85	97	PA (1)
other (wound and unspecified)	—	28	1	25	25	19	27	48	
Brucellosis	2	67	2	115	115	80	131	121	FL (2)
Chancroid	—	26	0	24	28	25	23	33	
Cholera	—	29	0	13	10	5	7	9	
Cyclosporiasis [§]	—	140	1	179	141	139	93	137	
Diphtheria	—	—	—	—	—	—	—	—	
<i>Haemophilus influenzae</i> ,** invasive disease (age <5 yrs):									
serotype b	—	6	0	23	35	30	22	29	
nonsensory type b	—	90	3	200	236	244	199	175	
unknown serotype	4	201	4	223	178	163	180	179	NC (1), ID (1), AZ (1), HI (1)
Hansen disease [§]	—	40	2	98	103	80	101	66	
Hantavirus pulmonary syndrome [§]	—	19	0	20	20	18	32	40	
Hemolytic uremic syndrome, postdiarrheal [§]	3	159	5	266	242	330	292	288	OH (1), AR (1), CA (1)
Influenza-associated pediatric mortality ^{§, ††}	—	112	5	61	358	90	77	43	
Listeriosis	4	640	16	821	851	759	808	884	MD (1), NC (1), TX (1), WA (1)
Measles ^{§§}	—	204	0	63	71	140	43	55	
Meningococcal disease, invasive ^{¶¶} :									
A, C, Y, and W-135 serogroup B	1	163	5	280	301	330	325	318	AR (1)
other serogroup	—	86	3	135	174	188	167	193	
unknown serogroup	4	328	9	406	482	616	550	651	ME (1), NY (1), OR (1), CA (1)
Novel influenza A virus infections ^{***}	—	8	0	4	43,774	2	4	NN	
Plague	—	2	0	2	8	3	7	17	
Poliomyelitis, paralytic	—	—	—	—	1	—	—	—	
Polio virus Infection, nonparalytic [§]	—	—	—	—	—	—	—	NN	
Psittacosis [§]	—	2	0	4	9	8	12	21	
Q fever, total [§]	1	93	2	131	113	120	171	169	
acute	1	70	1	106	93	106	—	—	NC (1)
chronic	—	23	0	25	20	14	—	—	
Rabies, human	—	2	0	2	4	2	1	3	
Rubella ^{†††}	—	4	0	5	3	16	12	11	
Rubella, congenital syndrome	—	—	—	—	2	—	—	1	
SARS-CoV [§]	—	—	—	—	—	—	—	—	
Smallpox [§]	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome [§]	—	95	1	142	161	157	132	125	
Syphilis, congenital (age <1 yr) ^{§§§}	1	200	7	377	423	431	430	349	NY (1)
Tetanus	—	8	0	26	18	19	28	41	
Toxic-shock syndrome (staphylococcal) [§]	—	62	2	82	74	71	92	101	
Trichinellosis	—	9	0	7	13	39	5	15	
Tularemia	2	127	1	124	93	123	137	95	OK (2)
Typhoid fever	—	315	5	467	397	449	434	353	
Vancomycin-intermediate <i>Staphylococcus aureus</i> [§]	1	56	1	91	78	63	37	6	FL (1)
Vancomycin-resistant <i>Staphylococcus aureus</i> [§]	—	—	0	2	1	—	2	1	
Vibriosis (noncholera <i>Vibrio</i> species infections) [§]	4	632	10	846	789	588	549	NN	FL (4)
Viral hemorrhagic fever ^{¶¶¶}	—	—	—	1	NN	NN	NN	NN	
Yellow fever	—	—	—	—	—	—	—	—	

See Table 1 footnotes on next page.

TABLE I. (Continued) Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending November 12, 2011 (45th week)*

—: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts.
 * Case counts for reporting year 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/osels/ph_surveillance/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf.
 † Calculated by summing the incidence counts for the current week, the 2 weeks preceding the current week, and the 2 weeks following the current week, for a total of 5 preceding years. Additional information is available at http://www.cdc.gov/osels/ph_surveillance/nndss/phs/files/5yearweeklyaverage.pdf.
 ‡ Not reportable in all states. Data from states where the condition is not reportable are excluded from this table except starting in 2007 for the arboviral diseases, STD data, TB data, and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/osels/ph_surveillance/nndss/phs/infdis.htm.
 ¶ Includes both neuroinvasive and nonneuroinvasive. Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for West Nile virus are available in Table II.
 ** Data for H. influenzae (all ages, all serotypes) are available in Table II.
 †† Updated weekly from reports to the Influenza Division, National Center for Immunization and Respiratory Diseases. Since October 2, 2011, no influenza-associated pediatric deaths occurring during the 2011-12 influenza season have been reported.
 ‡‡ No measles cases were reported for the current week.
 ¶¶ Data for meningococcal disease (all serogroups) are available in Table II.
 *** CDC discontinued reporting of individual confirmed and probable cases of 2009 pandemic influenza A (H1N1) virus infections on July 24, 2009. During 2009, four cases of human infection with novel influenza A viruses, different from the 2009 pandemic influenza A (H1N1) strain, were reported to CDC. The four cases of novel influenza A virus infection reported to CDC during 2010, and the eight cases reported during 2011, were identified as swine influenza A (H3N2) virus and are unrelated to the 2009 pandemic influenza A (H1N1) virus. Total case counts are provided by the Influenza Division, National Center for Immunization and Respiratory Diseases (NCIRD).
 ††† No rubella cases were reported for the current week.
 §§§ Updated weekly from reports to the Division of STD Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
 ¶¶¶ There was one case of viral hemorrhagic fever reported during week 12 of 2010. The one case report was confirmed as lassa fever. See Table II for dengue hemorrhagic fever.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals November 12, 2011, with historical data



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

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Morbidity and Mortality Weekly Report

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending November 12, 2011, and November 13, 2010 (45th week)*

Reporting area	Dengue Virus Infection†									
	Dengue Fever§					Dengue Hemorrhagic Fever¶				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
	Med	Max				Med	Max			
United States	—	3	16	182	660	—	0	1	1	9
New England	—	0	1	2	9	—	0	0	—	—
Connecticut	—	0	0	—	—	—	0	0	—	—
Maine**	—	0	1	—	5	—	0	0	—	—
Massachusetts	—	0	0	—	—	—	0	0	—	—
New Hampshire	—	0	0	—	—	—	0	0	—	—
Rhode Island**	—	0	0	—	1	—	0	0	—	—
Vermont**	—	0	1	2	3	—	0	0	—	—
Mid. Atlantic	—	1	6	55	217	—	0	0	—	5
New Jersey	—	0	1	—	28	—	0	0	—	—
New York (Upstate)	—	0	1	—	30	—	0	0	—	2
New York City	—	1	4	40	138	—	0	0	—	3
Pennsylvania	—	0	2	15	21	—	0	0	—	—
E.N. Central	—	0	2	12	66	—	0	0	—	1
Illinois	—	0	2	2	21	—	0	0	—	—
Indiana	—	0	1	2	14	—	0	0	—	—
Michigan	—	0	1	2	9	—	0	0	—	—
Ohio	—	0	1	2	16	—	0	0	—	—
Wisconsin	—	0	2	4	6	—	0	0	—	1
W.N. Central	—	0	2	11	32	—	0	1	—	—
Iowa	—	0	1	3	2	—	0	0	—	—
Kansas	—	0	1	1	4	—	0	0	—	—
Minnesota	—	0	1	5	14	—	0	0	—	—
Missouri	—	0	1	1	4	—	0	0	—	—
Nebraska**	—	0	0	—	7	—	0	0	—	—
North Dakota	—	0	1	1	1	—	0	0	—	—
South Dakota	—	0	0	—	—	—	0	1	—	—
S. Atlantic	—	1	8	69	228	—	0	1	1	2
Delaware	—	0	2	2	—	—	0	0	—	—
District of Columbia	—	0	0	—	—	—	0	0	—	—
Florida	—	1	7	50	180	—	0	0	—	2
Georgia	—	0	1	3	11	—	0	0	—	—
Maryland**	—	0	2	4	—	—	0	0	—	—
North Carolina	—	0	1	2	8	—	0	0	—	—
South Carolina**	—	0	1	1	13	—	0	0	—	—
Virginia**	—	0	1	7	14	—	0	1	1	—
West Virginia	—	0	0	—	2	—	0	0	—	—
E.S. Central	—	0	3	4	7	—	0	0	—	—
Alabama**	—	0	1	2	4	—	0	0	—	—
Kentucky	—	0	0	—	2	—	0	0	—	—
Mississippi	—	0	0	—	—	—	0	0	—	—
Tennessee**	—	0	2	2	1	—	0	0	—	—
W.S. Central	—	0	2	9	27	—	0	0	—	1
Arkansas**	—	0	0	—	—	—	0	0	—	1
Louisiana	—	0	1	3	4	—	0	0	—	—
Oklahoma	—	0	1	—	4	—	0	0	—	—
Texas**	—	0	1	6	19	—	0	0	—	—
Mountain	—	0	2	4	22	—	0	0	—	—
Arizona	—	0	2	2	10	—	0	0	—	—
Colorado	—	0	0	—	—	—	0	0	—	—
Idaho**	—	0	0	—	3	—	0	0	—	—
Montana**	—	0	0	—	4	—	0	0	—	—
Nevada**	—	0	1	1	4	—	0	0	—	—
New Mexico**	—	0	0	—	1	—	0	0	—	—
Utah	—	0	1	1	—	—	0	0	—	—
Wyoming**	—	0	0	—	—	—	0	0	—	—
Pacific	—	0	4	16	52	—	0	0	—	—
Alaska	—	0	0	—	1	—	0	0	—	—
California	—	0	2	5	35	—	0	0	—	—
Hawaii	—	0	4	5	—	—	0	0	—	—
Oregon	—	0	0	—	—	—	0	0	—	—
Washington	—	0	1	6	16	—	0	0	—	—
Territories										
American Samoa	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	26	101	1,107	10,293	—	0	3	17	232
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.

U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.

* Case counts for reporting year 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/osels/ph_surveillance/nndss/phps/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.

† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance).

§ Dengue Fever includes cases that meet criteria for Dengue Fever with hemorrhage, other clinical and unknown case classifications.

¶ DHF includes cases that meet criteria for dengue shock syndrome (DSS), a more severe form of DHF.

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

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TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending November 12, 2011, and November 13, 2010 (45th week)*

Reporting area	Hepatitis (viral, acute), by type														
	A					B					C				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
	Med	Max				Med	Max				Med	Max			
United States	10	21	74	993	1,434	15	47	167	2,092	2,845	16	18	39	858	719
New England	—	1	5	59	89	—	1	8	66	50	—	1	5	44	49
Connecticut	—	0	3	17	27	—	0	4	10	20	—	0	3	25	33
Maine†	—	0	2	6	7	—	0	2	8	13	—	0	2	4	2
Massachusetts	—	0	3	27	45	—	1	6	46	10	—	0	2	11	13
New Hampshire	—	0	1	—	1	—	0	1	2	5	N	0	0	N	N
Rhode Island†	—	0	1	3	9	U	0	0	U	U	U	0	0	U	U
Vermont†	—	0	2	6	—	—	0	0	—	2	—	0	1	4	1
Mid. Atlantic	1	4	8	182	249	5	5	12	238	249	2	1	6	76	93
New Jersey	—	1	3	29	69	—	1	4	53	71	—	0	4	1	25
New York (Upstate)	1	1	4	43	51	4	1	9	46	41	2	1	4	44	41
New York City	—	1	5	60	79	—	1	5	68	73	—	0	2	2	3
Pennsylvania	—	1	3	50	50	1	2	4	71	64	—	0	4	29	24
E.N. Central	—	4	8	162	189	—	6	37	290	429	2	3	12	162	80
Illinois	—	1	4	49	45	—	1	6	56	114	—	0	2	6	1
Indiana	—	0	3	12	11	—	1	3	49	66	—	1	5	53	25
Michigan	—	1	6	60	69	—	1	6	71	111	1	2	7	96	37
Ohio	—	1	3	35	44	—	1	30	87	89	1	0	1	6	8
Wisconsin	—	0	2	6	20	—	0	3	27	49	—	0	1	1	9
W.N. Central	—	1	25	36	71	—	2	16	113	106	—	0	6	8	20
Iowa	—	0	1	7	11	—	0	1	10	13	—	0	0	—	—
Kansas	—	0	2	3	11	—	0	2	11	10	—	0	1	3	2
Minnesota	—	0	22	9	15	—	0	15	9	8	—	0	6	2	10
Missouri	—	0	1	10	19	—	2	5	70	61	—	0	1	—	6
Nebraska†	—	0	1	5	14	—	0	3	12	12	—	0	1	3	2
North Dakota	—	0	3	—	—	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	2	2	1	—	0	1	1	2	—	0	0	—	—
S. Atlantic	4	5	12	204	301	7	12	56	576	779	2	4	11	203	164
Delaware	—	0	1	2	7	—	0	2	11	24	U	0	0	U	U
District of Columbia	—	0	0	—	1	—	0	0	—	3	—	0	0	—	2
Florida	2	1	7	70	123	3	4	8	177	262	1	1	3	50	50
Georgia	—	1	4	40	35	—	2	8	90	145	—	1	3	32	28
Maryland†	—	0	4	24	18	2	1	4	47	61	—	0	3	29	20
North Carolina	1	0	3	25	43	—	2	12	99	89	1	1	7	50	35
South Carolina†	—	0	2	9	23	—	1	3	28	53	—	0	1	1	1
Virginia†	1	1	3	26	44	1	1	6	55	82	—	0	3	16	11
West Virginia	—	0	5	8	7	1	0	43	69	60	—	0	6	25	17
E.S. Central	—	1	6	43	36	2	9	14	374	328	5	4	8	161	139
Alabama†	—	0	2	7	6	—	2	6	101	61	—	0	3	16	6
Kentucky	—	0	6	9	16	—	2	6	86	117	5	2	7	74	96
Mississippi	—	0	1	7	2	—	1	3	39	30	U	0	0	U	U
Tennessee†	—	0	5	20	12	2	4	8	148	120	—	1	5	71	37
W.S. Central	1	3	15	114	128	1	7	67	260	502	1	2	11	79	61
Arkansas†	—	0	0	—	2	—	1	4	43	55	—	0	0	—	1
Louisiana	—	0	1	2	11	—	1	4	27	46	—	0	2	5	3
Oklahoma	—	0	4	3	2	—	1	16	71	85	1	1	10	44	26
Texas†	1	2	11	109	113	1	3	45	119	316	—	0	3	30	31
Mountain	1	1	5	54	133	—	1	4	63	122	1	1	4	53	56
Arizona	—	0	2	15	57	—	0	3	13	23	U	0	0	U	U
Colorado	1	0	2	18	34	—	0	2	15	42	—	0	3	16	15
Idaho†	—	0	1	6	6	—	0	1	2	6	1	0	2	9	9
Montana†	—	0	1	2	4	—	0	0	—	—	—	0	1	3	2
Nevada†	—	0	3	5	14	—	0	3	22	36	—	0	2	10	7
New Mexico†	—	0	1	5	5	—	0	2	6	5	—	0	2	12	13
Utah	—	0	2	1	9	—	0	1	5	8	—	0	1	1	10
Wyoming†	—	0	1	2	4	—	0	1	—	2	—	0	1	2	—
Pacific	3	3	13	139	238	—	3	25	112	280	3	1	12	72	57
Alaska	—	0	1	2	2	—	0	1	4	3	U	0	0	U	U
California	—	2	12	98	196	—	1	22	51	195	1	1	4	31	24
Hawaii	—	0	2	7	7	—	0	1	6	6	U	0	0	U	U
Oregon	—	0	2	8	16	—	0	4	29	35	—	0	3	12	14
Washington	3	0	4	24	17	—	0	4	22	41	2	0	5	29	19
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	5	8	7	—	2	8	28	71	—	0	4	10	57
Puerto Rico	—	0	2	6	16	—	0	2	8	24	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.

U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.

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

Morbidity and Mortality Weekly Report

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending November 12, 2011, and November 13, 2010 (45th week)*

Reporting area	Shigellosis					Spotted Fever Rickettsiosis (including RMSF)†									
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Confirmed					Probable				
		Med	Max			Current week	Med	Max	Cum 2011	Cum 2010	Current week	Med	Max	Cum 2011	Cum 2010
United States	176	241	742	9,835	12,328	—	3	15	186	133	5	27	245	1,784	1,452
New England	—	4	19	228	304	—	0	1	1	—	—	0	1	6	5
Connecticut	—	0	4	36	69	—	0	0	—	—	—	0	0	—	—
Maine [§]	—	0	8	29	6	—	0	0	—	—	—	0	0	—	2
Massachusetts	—	3	18	150	202	—	0	0	—	—	—	0	1	4	—
New Hampshire	—	0	1	3	14	—	0	1	1	—	—	0	1	1	1
Rhode Island [§]	—	0	4	6	12	—	0	0	—	—	—	0	1	1	2
Vermont [§]	—	0	1	4	1	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	7	15	74	830	1,489	—	0	2	15	2	—	1	4	47	97
New Jersey	—	3	16	172	347	—	0	0	—	1	—	0	1	—	58
New York (Upstate)	5	4	20	257	209	—	0	1	3	1	—	0	1	7	15
New York City	2	5	21	295	279	—	0	0	—	—	—	0	3	24	11
Pennsylvania	—	3	56	106	654	—	0	2	12	—	—	0	3	16	13
E.N. Central	3	15	40	668	1,415	—	0	2	9	3	—	1	8	105	75
Illinois	—	5	16	198	788	—	0	1	2	2	—	0	4	43	34
Indiana [§]	—	1	4	43	57	—	0	1	2	1	—	0	4	44	20
Michigan	—	3	10	148	229	—	0	1	2	—	—	0	1	1	1
Ohio	3	5	27	279	275	—	0	2	3	—	—	0	2	17	14
Wisconsin	—	0	4	—	66	—	0	0	—	—	—	0	1	—	6
W.N. Central	3	6	22	266	1,956	—	0	5	27	13	1	4	29	334	270
Iowa	—	0	5	19	47	—	0	0	—	—	—	0	2	5	5
Kansas [§]	1	1	12	54	265	—	0	0	—	—	—	0	0	—	—
Minnesota	—	0	2	—	59	—	0	0	—	—	—	0	2	—	—
Missouri	2	4	17	175	1,523	—	0	3	20	10	1	3	29	323	262
Nebraska [§]	—	0	2	14	55	—	0	3	5	3	—	0	1	5	2
North Dakota	—	0	0	—	—	—	0	1	2	—	—	0	0	—	1
South Dakota	—	0	2	4	7	—	0	0	—	—	—	0	1	1	—
S. Atlantic	87	69	134	3,260	2,254	—	1	8	98	80	2	6	54	502	454
Delaware [§]	—	0	2	6	38	—	0	1	1	1	—	0	4	18	19
District of Columbia	—	0	2	12	29	—	0	1	1	1	—	0	1	2	—
Florida [§]	56	45	98	2,293	973	—	0	1	3	3	—	0	2	11	8
Georgia	5	11	24	509	706	—	0	6	62	57	—	0	0	—	—
Maryland [§]	1	2	7	92	116	—	0	1	3	—	—	0	2	29	48
North Carolina	2	3	36	182	169	—	0	4	14	13	—	0	49	249	232
South Carolina [§]	23	1	4	73	63	—	0	2	11	1	—	0	2	20	18
Virginia [§]	—	2	8	89	124	—	0	1	3	4	2	3	14	169	129
West Virginia	—	0	66	4	36	—	0	0	—	—	—	0	1	4	—
E.S. Central	13	14	28	578	683	—	0	2	10	20	—	4	24	313	393
Alabama [§]	11	5	14	219	182	—	0	1	4	5	—	1	8	67	77
Kentucky	1	1	6	40	211	—	0	1	1	6	—	0	0	—	—
Mississippi	—	3	10	161	49	—	0	0	—	1	—	0	2	12	23
Tennessee [§]	1	4	11	158	241	—	0	2	5	8	—	3	18	234	293
W.S. Central	48	56	503	2,343	2,431	—	0	8	11	6	1	2	235	432	144
Arkansas [§]	3	2	7	72	63	—	0	3	6	2	1	0	50	370	95
Louisiana	—	4	21	234	257	—	0	0	—	—	—	0	2	7	2
Oklahoma	28	2	161	167	241	—	0	5	3	3	—	0	202	42	22
Texas [§]	17	42	338	1,870	1,870	—	0	1	2	1	—	0	5	13	25
Mountain	6	15	42	727	751	—	0	5	14	3	1	0	6	45	13
Arizona	2	6	27	333	414	—	0	4	13	1	1	0	6	29	1
Colorado [§]	3	1	8	86	88	—	0	1	—	—	—	0	1	2	1
Idaho [§]	—	0	3	16	23	—	0	1	1	—	—	0	1	1	5
Montana [§]	—	1	15	121	7	—	0	0	—	2	—	0	1	1	1
Nevada [§]	1	0	4	31	47	—	0	0	—	—	—	0	1	2	—
New Mexico [§]	—	2	9	94	129	—	0	0	—	—	—	0	1	1	1
Utah	—	1	4	44	43	—	0	0	—	—	—	0	1	1	3
Wyoming [§]	—	0	1	2	—	—	0	0	—	—	—	0	2	8	1
Pacific	9	21	63	935	1,045	—	0	2	1	6	—	0	0	—	1
Alaska	—	0	2	5	2	N	0	0	N	N	N	0	0	N	N
California	8	17	59	773	843	—	0	1	1	6	—	0	0	—	—
Hawaii	—	1	3	42	42	N	0	0	N	N	N	0	0	N	N
Oregon	—	1	4	39	57	—	0	0	—	—	—	0	0	—	1
Washington	1	1	6	76	101	—	0	1	—	—	—	0	0	—	—
Territories															
American Samoa	—	0	1	1	4	N	0	0	N	N	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	1	5	N	0	0	N	N	N	0	0	N	N
Puerto Rico	—	0	1	—	4	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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† Illnesses with similar clinical presentation that result from Spotted fever group rickettsia infections are reported as Spotted fever rickettsioses. Rocky Mountain spotted fever (RMSF) caused by Rickettsia rickettsii, is the most common and well-known spotted fever.

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending November 12, 2011, and November 13, 2010 (45th week)*

Reporting area	<i>Streptococcus pneumoniae</i> , [†] invasive disease														
	All ages					Age <5					Syphilis, primary and secondary				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	96	292	937	11,400	13,029	3	26	118	1,028	1,825	43	260	363	11,018	11,955
New England	1	15	79	640	721	—	1	5	42	91	2	7	16	316	420
Connecticut	—	6	49	278	286	—	0	3	10	26	—	1	5	39	82
Maine [§]	—	2	13	110	102	—	0	1	4	8	—	0	2	12	27
Massachusetts	—	0	4	31	59	—	0	2	15	41	2	4	9	202	259
New Hampshire	—	2	8	86	109	—	0	1	5	5	—	0	3	17	22
Rhode Island [§]	—	2	8	73	96	—	0	1	2	6	—	0	7	38	28
Vermont [§]	1	1	6	62	69	—	0	2	6	5	—	0	2	8	2
Mid. Atlantic	4	26	81	1,128	1,384	—	2	27	92	204	8	29	53	1,310	1,489
New Jersey	—	13	35	517	614	—	0	4	30	51	—	4	13	189	211
New York (Upstate)	1	1	10	71	129	—	1	9	38	97	2	3	20	154	113
New York City	3	12	42	540	641	—	0	14	24	56	—	15	31	663	845
Pennsylvania	N	0	0	N	N	N	0	0	N	N	6	6	14	304	320
E.N. Central	26	65	114	2,522	2,688	—	5	13	204	328	—	30	48	1,289	1,683
Illinois	N	0	0	N	N	—	1	6	65	84	—	12	24	520	804
Indiana	—	15	33	566	617	—	0	4	26	50	—	3	8	134	158
Michigan	4	14	29	554	615	—	1	3	29	74	—	5	12	224	213
Ohio	19	26	45	1,041	1,019	—	2	7	70	89	—	8	21	362	463
Wisconsin	3	8	24	361	437	—	0	3	14	31	—	1	5	49	45
W.N. Central	2	2	33	143	740	—	1	6	56	140	1	6	13	250	321
Iowa	N	0	0	N	N	N	0	0	N	N	—	0	2	16	18
Kansas	N	0	0	N	N	N	0	0	N	N	—	0	3	21	18
Minnesota	—	0	17	—	567	—	0	3	—	80	—	2	8	102	131
Missouri	N	0	0	N	N	—	0	4	32	34	—	2	6	103	140
Nebraska [§]	2	2	9	99	111	—	0	2	10	14	1	0	2	7	9
North Dakota	—	0	25	44	62	—	0	1	1	2	—	0	1	1	1
South Dakota	N	0	0	N	N	—	0	2	13	10	—	0	0	—	4
S. Atlantic	19	72	170	3,160	3,478	1	6	25	273	487	22	67	178	2,905	2,765
Delaware	—	1	6	40	35	—	0	1	—	—	1	0	4	18	4
District of Columbia	—	1	4	43	65	—	0	1	5	8	—	3	8	132	122
Florida	8	23	68	1,142	1,250	1	3	13	109	171	2	24	36	1,013	1,029
Georgia	8	20	54	844	1,155	—	2	7	64	143	6	14	130	641	593
Maryland [§]	3	10	33	468	447	—	1	4	32	47	1	9	20	385	277
North Carolina	N	0	0	N	N	N	0	0	N	N	4	8	19	325	351
South Carolina [§]	—	7	25	368	425	—	0	3	23	50	1	4	11	197	128
Virginia [§]	N	0	0	N	N	—	0	3	26	49	7	4	12	192	255
West Virginia	—	0	48	255	101	—	0	6	14	19	—	0	1	2	6
E.S. Central	11	18	36	762	881	—	1	4	59	101	—	15	34	660	777
Alabama [§]	N	0	0	N	N	N	0	0	N	N	—	4	11	188	221
Kentucky	N	0	0	N	N	N	0	0	N	N	—	2	16	105	116
Mississippi	N	0	0	N	N	—	0	2	9	15	—	3	14	163	191
Tennessee [§]	11	18	36	762	881	—	1	4	50	86	—	5	11	204	249
W.S. Central	20	30	368	1,519	1,574	—	4	38	173	258	4	37	50	1,549	1,855
Arkansas [§]	—	3	26	188	150	—	0	3	11	17	3	3	10	167	193
Louisiana	—	3	11	134	106	—	0	2	12	24	—	6	25	332	494
Oklahoma	N	0	0	N	N	—	1	8	31	40	1	2	8	86	82
Texas [§]	20	24	333	1,197	1,318	—	2	27	119	177	—	23	31	964	1,086
Mountain	13	30	72	1,390	1,467	2	3	8	115	199	1	11	20	476	536
Arizona	2	12	45	645	671	—	1	5	52	85	1	4	10	197	197
Colorado	11	9	23	449	460	2	0	4	32	58	—	2	6	89	126
Idaho [§]	N	0	0	N	N	—	0	1	4	8	—	0	4	11	2
Montana [§]	N	0	0	N	N	N	0	0	N	N	—	0	1	4	3
Nevada [§]	N	0	0	N	N	N	0	0	N	N	—	2	9	115	103
New Mexico [§]	—	4	13	202	134	—	0	2	15	16	—	1	4	51	46
Utah	—	1	8	74	189	—	0	3	12	29	—	0	2	9	59
Wyoming [§]	—	0	15	20	13	—	0	1	—	3	—	0	0	—	—
Pacific	—	3	11	136	96	—	0	2	14	17	5	54	72	2,263	2,109
Alaska	—	2	11	131	96	—	0	1	11	17	—	0	1	1	3
California	N	0	0	N	N	N	0	0	N	N	3	43	59	1,840	1,790
Hawaii	—	0	3	5	—	—	0	1	3	—	—	0	5	10	30
Oregon	N	0	0	N	N	N	0	0	N	N	1	3	13	157	56
Washington	N	0	0	N	N	N	0	0	N	N	1	5	11	255	230
Territories															
American Samoa	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—	3	4	14	203	199
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending November 12, 2011, and November 13, 2010 (45th week)*

Reporting area	Varicella (chickenpox)					West Nile virus disease [†]									
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Neuroinvasive					Nonneuroinvasive [§]				
		Med	Max			Current week	Previous 52 weeks Med	Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Max	Cum 2011	Cum 2010
United States	155	267	367	11,124	13,409	—	0	55	426	625	—	0	25	195	392
New England	1	21	50	1,013	1,031	—	0	3	14	14	—	0	1	2	5
Connecticut	—	5	16	229	301	—	0	2	8	7	—	0	1	1	4
Maine [¶]	—	4	10	170	211	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	7	18	389	235	—	0	2	4	6	—	0	1	1	1
New Hampshire	—	2	7	102	144	—	0	0	—	1	—	0	0	—	—
Rhode Island [¶]	—	0	6	33	43	—	0	1	1	—	—	0	0	—	—
Vermont [¶]	1	1	10	90	97	—	0	1	1	—	—	0	0	—	—
Mid. Atlantic	24	43	78	2,127	1,511	—	0	11	33	123	—	0	6	21	63
New Jersey	11	16	68	1,265	519	—	0	1	2	15	—	0	2	4	15
New York (Upstate)	N	0	0	N	N	—	0	5	18	56	—	0	4	14	30
New York City	—	0	0	—	—	—	0	4	9	33	—	0	1	2	9
Pennsylvania	13	19	40	862	992	—	0	1	4	19	—	0	1	1	9
E.N. Central	38	64	115	2,539	4,303	—	0	13	71	80	—	0	5	25	30
Illinois	—	15	31	645	1,086	—	0	6	21	45	—	0	4	10	16
Indiana [¶]	1	5	18	218	315	—	0	2	7	6	—	0	1	2	7
Michigan	10	19	38	810	1,266	—	0	7	32	25	—	0	1	1	4
Ohio	27	21	58	865	1,183	—	0	3	10	4	—	0	3	11	1
Wisconsin	—	0	22	1	453	—	0	1	1	—	—	0	1	1	2
W.N. Central	—	7	42	346	841	—	0	8	28	32	—	0	6	27	75
Iowa	N	0	0	N	N	—	0	2	5	5	—	0	2	4	4
Kansas [¶]	—	2	15	93	328	—	0	1	4	4	—	0	0	—	15
Minnesota	—	0	0	—	—	—	0	1	1	4	—	0	1	1	4
Missouri	—	3	24	173	400	—	0	1	4	3	—	0	1	3	—
Nebraska [¶]	—	0	4	7	21	—	0	4	13	10	—	0	3	14	29
North Dakota	—	0	10	36	39	—	0	1	1	2	—	0	1	3	7
South Dakota	—	1	5	37	53	—	0	0	—	4	—	0	1	2	16
S. Atlantic	30	32	64	1,537	1,901	—	0	9	49	38	—	0	4	17	22
Delaware [¶]	—	0	3	6	34	—	0	1	1	—	—	0	0	—	—
District of Columbia	—	0	2	12	19	—	0	1	1	3	—	0	0	—	3
Florida [¶]	28	16	38	761	876	—	0	5	19	9	—	0	2	2	3
Georgia	N	0	0	N	N	—	0	2	7	4	—	0	1	5	9
Maryland [¶]	N	0	0	N	N	—	0	5	10	17	—	0	3	10	6
North Carolina	N	0	0	N	N	—	0	1	2	—	—	0	0	—	—
South Carolina [¶]	—	0	9	12	75	—	0	0	—	1	—	0	0	—	—
Virginia [¶]	2	7	25	378	495	—	0	2	8	4	—	0	0	—	1
West Virginia	—	6	32	368	402	—	0	1	1	—	—	0	0	—	—
E.S. Central	2	5	15	233	267	—	0	8	47	8	—	0	5	25	10
Alabama [¶]	2	4	14	221	259	—	0	1	3	1	—	0	0	—	2
Kentucky	N	0	0	N	N	—	0	1	2	2	—	0	1	1	1
Mississippi	—	0	3	12	8	—	0	4	26	3	—	0	4	22	5
Tennessee [¶]	N	0	0	N	N	—	0	3	16	2	—	0	1	2	2
W.S. Central	50	44	258	2,250	2,508	—	0	4	25	101	—	0	3	11	20
Arkansas [¶]	5	4	20	257	177	—	0	1	1	6	—	0	0	—	1
Louisiana	—	1	6	68	77	—	0	2	6	18	—	0	2	4	7
Oklahoma	N	0	0	N	N	—	0	1	—	—	—	0	0	—	—
Texas [¶]	45	39	247	1,925	2,254	—	0	3	18	77	—	0	3	7	12
Mountain	10	18	65	981	943	—	0	10	57	156	—	0	4	25	127
Arizona	—	4	50	409	—	—	0	6	35	106	—	0	2	11	60
Colorado [¶]	10	4	31	233	360	—	0	2	2	26	—	0	2	5	55
Idaho [¶]	N	0	0	N	N	—	0	1	1	—	—	0	1	1	1
Montana [¶]	—	2	28	123	177	—	0	1	1	—	—	0	0	—	—
Nevada [¶]	N	0	0	N	N	—	0	4	12	—	—	0	2	4	2
New Mexico [¶]	—	1	4	38	92	—	0	1	4	21	—	0	0	—	4
Utah	—	3	26	170	298	—	0	1	1	1	—	0	1	2	1
Wyoming [¶]	—	0	3	8	16	—	0	1	1	2	—	0	1	2	4
Pacific	—	2	6	98	104	—	0	17	102	73	—	0	7	42	40
Alaska	—	1	4	50	39	—	0	0	—	—	—	0	0	—	—
California	—	0	2	9	32	—	0	17	102	72	—	0	7	42	39
Hawaii	—	1	4	39	33	—	0	0	—	—	—	0	0	—	—
Oregon	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
Washington	N	0	0	N	N	—	0	0	—	1	—	0	0	—	1
Territories															
American Samoa	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	1	4	16	25	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	4	14	166	570	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.

U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.

* Case counts for reporting year 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/osels/ph_surveillance/nndss/phys/files/ProvisionalNationalNotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.

[†] Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for California serogroup, eastern equine, Powassan, St. Louis, and western equine diseases are available in Table I.

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

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

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TABLE III. Deaths in 122 U.S. cities,* week ending November 12, 2011 (45th week)

Reporting area	All causes, by age (years)						P&I†	Reporting area (Continued)	All causes, by age (years)						P&I†
	All Ages	≥65	45-64	25-44	1-24	<1			All Ages	≥65	45-64	25-44	1-24	<1	
New England	552	399	112	26	9	6	47	S. Atlantic	905	588	209	61	14	33	51
Boston, MA	135	94	29	7	3	2	16	Atlanta, GA	133	96	23	6	4	4	3
Bridgeport, CT	33	24	6	2	—	1	6	Baltimore, MD	114	70	29	11	2	2	9
Cambridge, MA	9	8	—	1	—	—	1	Charlotte, NC	118	81	29	7	—	1	7
Fall River, MA	19	16	1	2	—	—	1	Jacksonville, FL	34	23	5	5	—	1	4
Hartford, CT	60	45	14	—	1	—	6	Miami, FL	57	42	5	6	1	3	1
Lowell, MA	29	23	4	1	1	—	3	Norfolk, VA	41	26	10	2	—	3	—
Lynn, MA	10	5	3	2	—	—	2	Richmond, VA	47	24	13	5	4	1	4
New Bedford, MA	20	15	3	2	—	—	3	Savannah, GA	40	29	7	4	—	—	6
New Haven, CT	32	19	11	—	2	—	2	St. Petersburg, FL	33	24	8	—	1	—	2
Providence, RI	71	50	17	4	—	—	1	Tampa, FL	157	93	47	11	—	6	5
Somerville, MA	4	3	—	—	1	—	—	Washington, D.C.	125	75	32	4	2	12	10
Springfield, MA	44	31	6	4	1	2	3	Wilmington, DE	6	5	1	—	—	—	—
Waterbury, CT	24	15	8	1	—	—	2	E.S. Central	723	467	175	50	14	17	47
Worcester, MA	62	51	10	—	—	1	1	Birmingham, AL	122	79	28	7	6	2	8
Mid. Atlantic	1,801	1,269	377	89	21	45	83	Chattanooga, TN	99	74	18	5	2	—	3
Albany, NY	47	34	10	1	—	2	1	Knoxville, TN	106	75	27	2	1	1	11
Allentown, PA	30	23	6	1	—	—	4	Lexington, KY	53	36	11	2	—	4	1
Buffalo, NY	130	73	20	6	1	30	8	Memphis, TN	126	74	37	9	3	3	13
Camden, NJ	25	13	7	3	—	2	—	Mobile, AL	57	33	14	6	1	3	—
Elizabeth, NJ	9	6	3	—	—	—	—	Montgomery, AL	11	9	2	—	—	—	—
Erie, PA	53	44	7	2	—	—	—	Nashville, TN	149	87	38	19	1	4	11
Jersey City, NJ	17	15	2	—	—	—	2	W.S. Central	1,007	619	263	67	34	24	42
New York City, NY	1,004	710	227	45	17	5	43	Austin, TX	76	45	19	6	5	1	4
Newark, NJ	15	8	3	1	—	3	1	Baton Rouge, LA	61	35	9	11	4	2	—
Paterson, NJ	17	12	2	3	—	—	—	Corpus Christi, TX	64	40	19	3	2	—	4
Philadelphia, PA	141	88	35	14	2	2	6	Dallas, TX	213	125	58	16	5	9	11
Pittsburgh, PA§	37	20	12	5	—	—	1	El Paso, TX	78	53	21	3	1	—	5
Reading, PA	31	26	4	1	—	—	1	Fort Worth, TX	U	U	U	U	U	U	U
Rochester, NY	69	46	18	5	—	—	3	Houston, TX	105	61	25	10	7	2	5
Schenectady, NY	22	19	3	—	—	—	1	Little Rock, AR	42	26	15	1	—	—	—
Scranton, PA	29	25	3	—	1	—	2	New Orleans, LA	U	U	U	U	U	U	U
Syracuse, NY	81	68	11	1	—	1	6	San Antonio, TX	207	131	53	12	7	4	6
Trenton, NJ	13	10	2	1	—	—	—	Shreveport, LA	69	44	16	4	1	4	3
Utica, NY	15	15	—	—	—	—	2	Tulsa, OK	92	59	28	1	2	2	4
Yonkers, NY	16	14	2	—	—	—	2	Mountain	1,014	656	219	68	23	17	58
E.N. Central	1,872	1,250	437	100	44	41	125	Albuquerque, NM	103	68	27	6	—	2	10
Akron, OH	48	29	14	3	—	2	5	Boise, ID	56	35	19	—	1	1	3
Canton, OH	36	26	10	—	—	—	1	Colorado Springs, CO	52	41	9	—	1	1	2
Chicago, IL	226	148	53	18	6	1	15	Denver, CO	104	56	38	9	1	—	4
Cincinnati, OH	70	38	18	6	3	5	7	Las Vegas, NV	285	187	63	26	7	2	20
Cleveland, OH	266	187	62	7	8	2	16	Ogden, UT	29	20	7	2	—	—	1
Columbus, OH	219	139	54	15	5	6	13	Phoenix, AZ	125	67	30	12	6	8	5
Dayton, OH	98	66	22	4	3	3	7	Pueblo, CO	31	20	9	2	—	—	2
Detroit, MI	129	69	38	12	6	4	7	Salt Lake City, UT	104	74	17	7	4	2	6
Evansville, IN	37	25	9	3	—	—	1	Tucson, AZ	125	88	—	4	3	1	5
Fort Wayne, IN	69	45	18	2	3	1	4	Pacific	1,510	1,057	332	61	35	24	118
Gary, IN	14	8	5	1	—	—	—	Berkeley, CA	11	7	3	1	—	—	3
Grand Rapids, MI	51	35	10	4	1	1	8	Fresno, CA	103	75	19	7	2	—	6
Indianapolis, IN	186	121	44	11	4	6	13	Glendale, CA	32	20	10	2	—	—	3
Lansing, MI	31	20	11	—	—	—	1	Honolulu, HI	70	54	9	2	2	3	9
Milwaukee, WI	83	61	16	3	1	2	2	Long Beach, CA	71	48	18	3	1	1	10
Peoria, IL	53	40	11	1	—	1	6	Los Angeles, CA	220	139	50	15	10	6	17
Rockford, IL	61	45	14	1	1	—	4	Pasadena, CA	21	18	3	—	—	—	2
South Bend, IN	43	35	6	—	—	2	2	Portland, OR	90	63	23	1	1	1	1
Toledo, OH	89	62	13	7	2	5	8	Sacramento, CA	185	133	42	6	4	—	19
Youngstown, OH	63	51	9	2	1	—	5	San Diego, CA	142	104	26	5	3	4	8
W.N. Central	525	328	134	42	14	7	36	San Francisco, CA	122	83	29	3	2	5	7
Des Moines, IA	62	43	13	6	—	—	6	San Jose, CA	166	119	40	1	4	2	6
Duluth, MN	30	21	6	1	2	—	2	Santa Cruz, CA	29	24	3	2	—	—	1
Kansas City, KS	23	10	11	2	—	—	—	Seattle, WA	70	45	21	3	1	—	7
Kansas City, MO	108	63	29	11	5	—	4	Spokane, WA	60	41	14	3	—	2	7
Lincoln, NE	25	19	6	—	—	—	2	Tacoma, WA	118	84	22	7	5	—	12
Minneapolis, MN	52	27	16	3	4	2	4	Total¶	9,909	6,633	2,258	564	208	214	607
Omaha, NE	74	46	20	4	2	2	10								
St. Louis, MO	26	13	5	8	—	—	—								
St. Paul, MN	58	41	14	2	—	1	4								
Wichita, KS	67	45	14	5	1	2	4								

U: Unavailable. —: No reported cases.

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

† Pneumonia and influenza.

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

¶ Total includes unknown ages.

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Data presented by the Notifiable Disease Data Team and 122 Cities Mortality Data Team in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. Address all inquiries about the *MMWR* Series, including material to be considered for publication, to Editor, *MMWR* Series, Mailstop E-90, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333 or to mmwrq@cdc.gov.

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U.S. Government Printing Office: 2012-523-043/21090 Region IV ISSN: 0149-2195