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Fatal Laboratory-Acquired Infection with an Attenuated *Yersinia pestis* Strain — Chicago, Illinois, 2009

On September 18, 2009, the Chicago Department of Public Health (CDPH) was notified by a local hospital of a suspected case of fatal laboratory-acquired infection with *Yersinia pestis*, the causative agent of plague. The patient, a researcher in a university laboratory, had been working along with other members of the laboratory group with a pigmentation-negative (pgm-) attenuated *Y. pestis* strain (KIM D27). The strain had not been known to have caused laboratory-acquired infections or human fatalities. Other researchers in a separate university laboratory facility in the same building had contact with a virulent *Y. pestis* strain (CO92) that is considered a select biologic agent; however, the pgm- attenuated KIM D27 is excluded from the National Select Agent Registry (*1*). The university, CDPH, the Illinois Department of Public Health (IDPH), and CDC conducted an investigation to ascertain the cause of death. This report summarizes the results of that investigation, which determined that the cause of death likely was an unrecognized occupational exposure (route unknown) to *Y. pestis,* leading to septic shock. *Y. pestis* was isolated from premortem blood cultures. Polymerase chain reaction (PCR) identified the clinical isolate as a pgm- strain of *Y. pestis*. Postmortem examination revealed no evidence of pneumonic plague. A postmortem diagnosis of hereditary hemochromatosis was made on the basis of histopathologic, laboratory, and genetic testing. One possible explanation for the unexpected fatal outcome in this patient is that hemochromatosis-induced iron overload might have provided the infecting KIM D27 strain, which is attenuated as a result of defects in its ability to acquire iron, with sufficient iron to overcome its iron-acquisition defects and become virulent (*2*). Researchers should adhere to recommended biosafety practices when handling any live bacterial cultures, even attenuated strains, and institutional biosafety committees should implement and maintain effective surveillance systems to detect and monitor unexpected acute illness in laboratory workers.

Case Report

On September 10, 2009, the researcher, a man aged 60 years with insulin-dependent diabetes mellitus, was evaluated at an outpatient clinic for fever, body aches, and cough of approximately 3 days duration. A clinic physician suspected influenza or other acute respiratory infection and referred the patient to an emergency department (ED) for further evaluation; however, the patient did not seek further care at that time. On September 13, the patient was brought by ambulance to a Chicago hospital ED because of fever, cough, and worsening shortness of breath. Paramedics recorded an oxygen saturation level of 92%, and oxygen was administered via mask.

Upon arrival at the ED, the patient was noted to be alert and able to converse, with a temperature of 100.9ºF (38.3ºC), pulse of 106 beats per minute, respiratory rate of 42 breaths per minute, and blood pressure of 106/75 mm/Hg. Examination revealed distant breath sounds, abdominal distention, peripheral cyanosis, and trace pedal edema; no lymphadenopathy, rash, or jaundice was noted. A chest radiograph revealed normal lung fields; however, the patient continued to have labored breathing and required supplemental oxygen. Blood chemistries showed

INSIDE

206 Use of a Registry to Improve Acute Stroke Care — Seven States, 2005–2009
211 Maternal, Pregnancy, and Birth Characteristics of Asians and Native Hawaiians/Pacific Islanders — King County, Washington, 2003–2008
214 Notes from the Field: Two Cases of Human Plague — Oregon, 2010
215 Announcements
216 QuickStats

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renal failure (creatinine: 6.5 mg/dL; blood urea nitrogen: 73 mg/dL), incipient acidosis (bicarbonate: 17 mEq/L; $PaCO_2$: 31mmHg; pH: 7.36), and elevated liver function enzymes (aspartate aminotransaminase [AST]: 794 IU/L; alanine aminotransaminase [ALT]: 160 IU/L). Complete blood count showed severe leukocytosis (white blood cells: 79.2 10^3/mL) with a left shift (22% band forms) and hemoglobin level and platelet count within normal limits. Extracellular bacteria were noted on a peripheral blood smear.

The patient initially was treated with diuretics for suspected congestive heart failure and later with intravenous antibiotics (vancomycin and piperacillin/tazobactam) once infection was suspected. At approximately 12 hours after presentation, the patient had worsening respiratory distress and was intubated. He died 1 hour later of cardiac arrest, despite resuscitation attempts.

The patient had last worked in the laboratory on September 4. On September 10, he notified his supervisor about his illness to explain his absence from work. Whether the patient himself suspected his symptoms were consistent with plague is not known; however, existing laboratory policy called for laboratory workers with illness consistent with plague to report to the university's occupational health clinic (or to the ED). The patient's occupation was not documented in the records of either the outpatient clinic he visited or the hospital ED.

On September 14, blood cultures drawn the previous day yielded gram-negative bacilli (four of four bottles), gram-positive cocci (three of four bottles), and yeast (one of four bottles and presumed to be a contaminant). On September 15, the clinical laboratory identified the gram-positive cocci as nutritionally variant streptococci (NVS). An autopsy performed the same day identified no signs of pneumonia, bowel perforation, or endocarditis, which is often associated with NVS infection. Efforts to identify the slow-growing, gram-negative organism were under way when, on September 16, an ED physician learned that the patient had worked in a laboratory that conducted research on select biologic agents and notified the hospital clinical laboratory. On the morning of September 18, 16S ribosomal DNA sequencing performed by the hospital clinical laboratory narrowed the identity of the gram-negative bacilli to either *Y. pestis* or *Y. pseudotuberculosis*. That same day, hospital infection control staff members notified CDPH of the suspected *Y. pestis* case.

Epidemiologic and Environmental Investigation

On September 18, CDPH, IDPH, CDC, and the university initiated a joint investigation to determine the source of *Y. pestis* infection, identify any potential additional infections, and implement prevention and control measures. Because inhalation exposure could not be excluded, antimicrobial prophylaxis was offered to all staff members at the research laboratory in which the patient worked and to his close contacts. A close contact was defined as a person who had been within 6 feet of the patient or who had handled his blood or tissue samples during September 7–18, 2009. Unless contraindications existed, a 7-day course of doxycycline was

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prescribed for prophylaxis. All 30 coworkers were prescribed prophylaxis during September 19–20. One household contact and 64 other close contacts, including medical, laboratory, and pathology personnel, were identified, and 61 (94%) accepted prophylaxis during September 18–20. No additional *Y. pestis* infections have been identified.

An assessment of the laboratory environment identified no major deficiencies in laboratory engineering controls. A review of Occupational Safety and Health Administration Form 300 logs identified no recent work-related injuries or illnesses among workers in this laboratory. A review of attendance records for university biosafety training identified deficiencies in staff attendance (including the patient) at a number of required biosafety courses. The patient's family members and coworkers were asked about knowledge of any possible exposure events, such as a needle puncture or splash of liquid to the face, and none were reported. Interviews with laboratory coworkers revealed that the patient inconsistently complied with the laboratory policy to wear gloves while handling *Y. pestis* KIM D27 bacterial cultures.

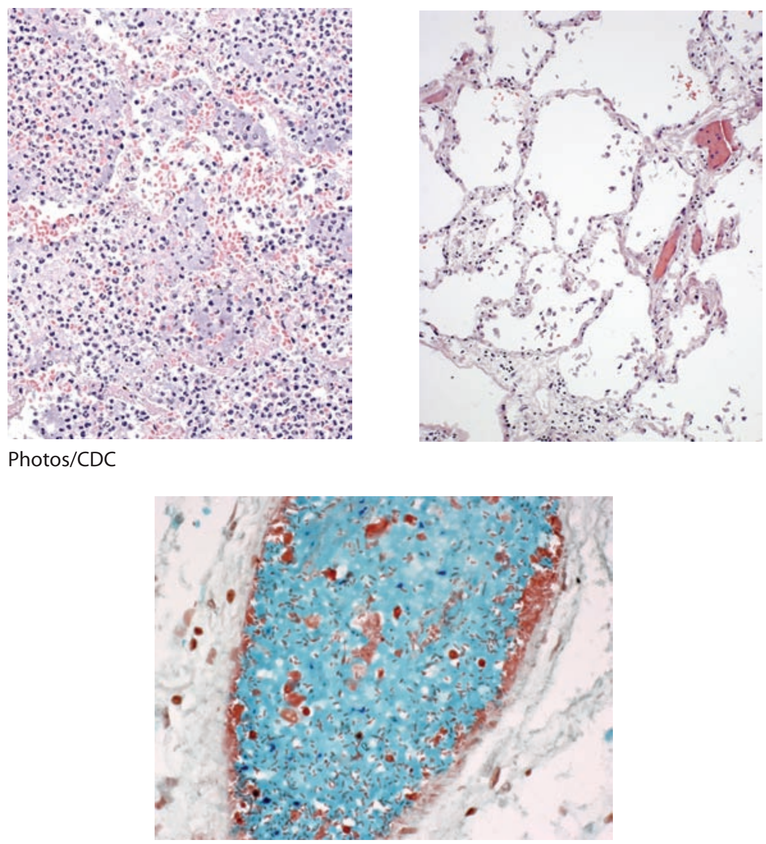
Laboratory and Pathologic Testing

Preliminary PCR and microbiologic analyses conducted by the university research laboratory identified the organism isolated from the patient as a pgm- attenuated strain of *Y. pestis* (*3*), consistent with the KIM D27 strain with which the patient worked, and not the virulent *Y. pestis* strain CO92, which was used in a separate laboratory facility on another floor. The IDPH Division of Laboratories confirmed the infecting organism as *Y. pestis.* CDC independently isolated *Y. pestis* from an aliquot of one of the original blood culture bottles and confirmed the absence of the pgm locus. CDC also identified a chloramphenicol resistance gene (a common, laboratory-based resistance marker) that was not in the original laboratory stock strain, suggesting that the infecting strain had been modified as part of routine laboratory research.

To determine whether new virulence mechanisms had been acquired or genetically inserted into the infecting strain, CDC compared the virulence of the infecting strain with that of CO92 from CDC culture archives and the original, attenuated KIM D27 stock strain from the patient's laboratory. Male Swiss Webster mice were inoculated subcutaneously with varying doses of bacteria ranging from 10^3 to 10^8 colony-forming units (CFUs) for the infecting strain and the parental KIM D27 strain, and from 10^2 to 10^3 for CO92. Virulence was measured by determining the median lethal dose (LD_{50}). The LD_{50} of CO92 was ≤100 CFUs. In contrast, an LD_{50} was not achieved for either the infecting strain or KIM D27; <3% of the mice died after injection with doses as high as 10^8 CFUs. Such findings suggest that the strain with which the patient was infected was attenuated and that no new virulence mechanisms were acquired by or engineered into the infecting strain.

Histopathologic examination of the patient's lung tissue at CDC revealed preserved alveolar structure without inflammatory infiltrates that would have indicated pneumonic processes consistent with plague (Figure). Immunohistochemical tests using an anti–*Y. pestis* mouse monoclonal antibody revealed abundant staining of *Y. pestis* in blood vessels of multiple organs, consistent with septicemic plague. Histologic staining revealed abnormal iron deposits in the liver, but not

FIGURE. Pathologic findings indicating that a deceased researcher had septicemic plague, not pneumonic plague* — Chicago, Illinois, 2009



Photos/CDC

* Investigators compared lung pathology images of a patient with primary pneumonic plague (*top, left*), with that of the deceased researcher (*top, right*). Lung tissue of the patient with primary pneumonic plague shows extensive inflammation and no open air space. Postmortem lung tissue from the deceased researcher shows open air spaces and preserved alveolar structure, indicating the deceased did not have pneumonic processes consistent with plague. Magnification of postmortem lung tissue (*bottom*) revealed gram-negative bacteria (red, rod-shaped) in the lumen of a pulmonary blood vessel. Subsequent immunostaining with a *Yersinia pestis* antibody confirmed *Y. pestis* only in blood vessels of numerous tissues, consistent with septicemic plague.

What is already known on this topic?

The last known laboratory-acquired infection with *Yersinia pestis* in the United States occurred in 1959.

What is added by this report?

This case report describes the first reported fatality from a laboratory-acquired infection with an attenuated strain of *Y. pestis*.

What are the implications for public health practice?

Under certain environmental and host conditions, infection with attenuated bacteria might result in severe disease. Researchers always should adhere to recommended use of personal protective equipment. Unexpected acute illness in a laboratory worker should be reported to the institution and health-care providers so that the differential diagnosis can be expanded to include diseases occurring as a result of occupational exposures.

in pancreatic or cardiac tissues. Postmortem testing of blood samples revealed a total serum iron of 541 mcg/dL (reference range: 40–160 mcg/dL), iron saturation of 83.5% (reference range: 14%–50%), and total iron binding capacity of 648 mcg/dL (reference range: 230–430 mcg/dL). Genetic testing revealed that the patient was homozygous for the C282Y mutation of the HFE gene, confirming a postmortem diagnosis of hereditary hemochromatosis (*4*). Investigators found no evidence that the researcher knew he had hemochromatosis or that he exhibited any symptoms of this condition.

Reported by

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Editorial Note

This report describes the first known fatality from a laboratory-acquired infection with attenuated *Y. pestis*. The last known laboratory-acquired infection with *Y. pestis* in the United States occurred in 1959 and was caused by inhalation of a virulent strain (*5*). Pathology findings for the case described in this report are consistent with septicemic plague and inconsistent with pneumonic plague, suggesting a transdermal or mucosal route of infection. However, a recent study (*6*) demonstrated that intranasal infection of mice with KIM D27 can result in persistent colonization of the lung vasculature, subsequent dissemination of infection, and eventual death without classic pathologic signs of pneumonic plague. Consequently, a respiratory route of infection cannot be ruled out definitively. Although the route of transmission for the infection remains unclear, deficiencies in biosafety practices, including inconsistent use of gloves, could have resulted in inadvertent transdermal exposure. The severe outcome experienced by the patient was unexpected, given that he had worked with an attenuated *Y. pestis* strain that 1) is widely used by laboratory researchers, 2) has not been associated with previous laboratory-acquired infections or fatalities, and 3) is excluded from select biologic agent requirements (*1*). Although NVS bacteremia cannot be excluded as a contributing factor in the patient's death, the clinical course, lack of endocarditis, and the visualization of *Y. pestis* in blood vessels throughout the body strongly support gram-negative sepsis as the cause of death.

Hemochromatosis, an iron-overload disease (*7*), is characterized by increased iron absorption and progressive iron storage in multiple organs. Persons with hemochromatosis are especially susceptible to infection with *Vibrio vulnificus*, *Listeria monocytogenes, Yersinia enterocolitica,* and *Yersinia pseudotuberculosis* (*7*). Animal studies have shown that the virulence of pgm- *Y. pestis* strains can be enhanced by the simultaneous injection of iron into experimental animals (*2*). Conceivably, hemochromatosis-induced iron overload might have a similar effect, enhancing the virulence of the infecting KIM D27 strain by compensating for its iron-acquisition defects (*2*). Although iron deposition in pancreatic tissue is known to cause bronze diabetes, pathologic examination ruled out iron deposition as the cause of this patient's diabetes. Nonetheless, diabetes is a known risk factor for increased severity and complications from bacterial infections (*8*).

Research using animal models of hemochromatosis (*9*) is under way to better understand susceptibility to infection with bacteria attenuated as a result of defects in iron acquisition. Researchers working with attenuated *Y. pestis* and other potentially infectious material should always use at least biosafety level 2 practices (*10*), and laboratory managers should ensure that staff adheres to recommended biosafety practices. Institutional safety committees should implement and maintain effective surveillance programs to identify and monitor acute illness among laboratory workers, and health-care providers should routinely inquire about occupational exposures when evaluating patients.

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Use of a Registry to Improve Acute Stroke Care — Seven States, 2005–2009

Each year, an estimated 795,000 persons in the United States experience a stroke. In all, an estimated 7 million U.S. residents have had a stroke, and the cost of cerebrovascular disease in 2007 was estimated at $41 billion (*1*). During 2004–2009, CDC funded seven state health departments for different periods to implement stroke care improvement registries. As part of the quality-improvement activities conducted by the Paul Coverdell National Acute Stroke Registry (PCNASR), CDC monitors adherence to 10 quality-of-care measures. This report documents the status of adherence to these 10 performance measures of stroke care through these seven state health departments for the period 2005–2009. The number of participating hospitals in the seven states ranged from 112 to 229 per year, with a total of 303 participating hospitals during the 5-year period. Average annual improvement in adherence to stroke care measures ranged from zero in one measure (prescription of antithrombotic at discharge) to 11% (use of intravenous tissue plasminogen activator [IV tPA]); five measures showed average annual improvements of at least 6%. The proportion of patients receiving "defect-free care" (a descriptor that indicates whether patients received all of the quality-of-care measures for which they were eligible) also improved. These results demonstrate the ability of state health departments to collaborate with hospitals to monitor and improve the delivery of high-quality care for acute stroke patients. This role for public health and state health departments in hospital quality improvement for acute stroke care is a viable approach to improving the quality of stroke care in the United States.

PCNASR was established by Congress in 2001. Its goals are to 1) measure, track, and improve the quality of care and access to care for stroke patients from the onset of symptoms through rehabilitation and recovery; 2) decrease rates of premature death and disability from acute stroke; 3) eliminate disparities in care; 4) support the development of systems of stroke care that emphasize quality of care; and 5) improve access to rehabilitation and opportunities for recovery after stroke. PCNASR is funded by CDC through a cooperative agreement with state health departments. It requires state health departments to recruit hospitals that are representative of all hospitals within a state in terms of size, status as an academic teaching hospital, rural or urban setting, geographic location, and racial/ethnic populations served. The state health departments work with participating hospitals to track the care of hospitalized stroke patients to improve the quality of acute stroke care from the onset of stroke through hospital discharge. Specifically, the health departments provide hospitals with an interactive program of quality-improvement activities through conference calls, in-person meetings, and individual hospital site visits. Topics include education on data-driven quality-improvement methodology and overcoming barriers to improving stroke care. The methods for data collection and the types of data collected on patients and hospitals have been described previously (*2*).

In 2008, CDC, the American Heart Association, and the Joint Commission (an independent organization that accredits and certifies health-care organizations and programs) developed a set of 10 performance measures of acute stroke care (Box) (*3*). These measures are derived from published care guidelines and clinical trials; eight of the 10 measures are endorsed by the National Quality Forum as important measures of care (*4*). Nine of the measures were bundled into groups that define defect-free care* (*5*).

CDC examined 2005–2009 data on all patients aged ≥18 years who were admitted to a participating hospital with any of four clinical diagnoses†: 1) acute hemorrhagic stroke (intracerebral hemorrhage or subarachnoid hemorrhage); 2) ischemic stroke; 3) ill-defined stroke (not classified as hemorrhagic or ischemic); or 4) transient ischemic attack (TIA). In-hospital mortality was calculated for each stroke type as the percentage of patients who died during admission for acute stroke. Cochran-Armitage tests were used to test for a trend in improvement over time.

During the 5-year period, 139,260 patients with one of the four diagnoses were admitted to a participating hospital in the seven states. Overall, 18,921 (13.6%) patients had hemorrhagic stroke; 82,066 (58.9%) had ischemic stroke; 8,236 (5.9%) had ill-defined stroke; and 30,037 (21.6%) had TIA. Median age of patients was 72 years (range: 18–108 years); 53% were female, and 74% were non-Hispanic white.

In-hospital mortality for hemorrhagic stroke (intracerebral or subarachnoid hemorrhage) increased from 21.0% in 2005

* *Ischemic stroke inpatient:* dysphagia screening, early antithrombotic medication, deep venous thrombosis/venous thromboembolism (DVT/VTE) prophylaxis, and lipid testing and/or treatment. *Ischemic stroke discharge:* antithrombotic medication, anticoagulation for atrial fibrillation, rehabilitation assessment, smoking cessation counseling, and education on stroke. *Hemorrhagic stroke and ill-defined stroke:* screening for dysphagia, DVT/VTE prophylaxis, rehabilitation assessment, smoking cessation counseling, and education on stroke. *Transient ischemic attack:* early antithrombotic medication, lipid testing and/or treatment, antithrombotic medication at discharge, anticoagulation for atrial fibrillation, smoking cessation counseling, and education.

† In PCNASR, the clinical diagnosis is the diagnosis that the physician wrote in the medical record rather than the *International Classification of Diseases, Ninth Revision, Clinical Modification* code.

BOX. Performance measures for acute stroke care*

1. **Screening for dysphagia (ischemic and hemorrhagic stroke).** Patients with acute ischemic stroke or acute hemorrhagic stroke who received dysphagia screening (swallow screening) before being given anything by mouth (including food, fluid, or medication) were included in the numerator of this performance measure. In the registry, patients who were on NPO (*nil per os*) orders (i.e., no food, fluid, or medication by mouth) throughout the entire hospitalization were excluded from the measure. If dysphagia screening was not documented or the status was unknown, then the screening was assumed not to have been performed.
2. **Education on stroke (all stroke and transient ischemic attack).†** Patients with acute ischemic stroke, hemorrhagic stroke, or transient ischemic attack (TIA) who were given stroke education before discharge were included in the numerator of this performance measure. Patients who were transferred to another acute-care facility, left against medical advice, were transferred to hospice, or died were excluded.
3. **Receipt of intravenous tissue plasminogen activator (IV tPA) (ischemic stroke).†** Patients with acute ischemic stroke who arrived at the hospital within 2 hours of onset of stroke signs and symptoms or time last known to be well and received IV tPA within 3 hours of onset unless contraindicated were included in the numerator of this performance measure. Patients who received IV tPA at a hospital before being transferred to the current hospital were excluded, as were patients undergoing thrombolytic experimental protocols and patients receiving intra-arterial (IA) tPA, unless the IA tPA was given after IV tPA. If patients did not receive IV tPA because of in-hospital delays, they were included in the denominator.
4. **Lipid measurement and/or lipid-lowering medication prescribed at discharge (ischemic stroke and TIA).†**
   - 2005–2007: Acute ischemic stroke or TIA patients who had a lipid profile performed during their hospital admission or had documentation in the medical record that a lipid profile was performed in the 30 days before the event, with results also recorded in the medical record, were included in the numerator of this performance measure. Patients were included in the analysis if they had a low-density lipoprotein (LDL) level recorded or if they had all three of the following recorded: total cholesterol, high-density lipoprotein, and triglycerides.
   - 2008–2009: Acute ischemic stroke or TIA patients who were admitted on lipid lowering therapy or who had an LDL ≥100, who were discharged on lipid-lowering therapy (2008), or who were discharged on statins (2009). Patients were excluded in the analysis if they were not admitted on lipid-lowering therapy and their LDL was <100. Patients who were not admitted on lipid-lowering therapy and who did not have LDL measured were included in the denominator but not the numerator.
5. **Nonambulatory patients given deep venous thrombosis/venous thromboembolism (DVT/VTE) prophylaxis by end of second hospital day (ischemic and hemorrhagic stroke).†** Patients with acute ischemic stroke or acute hemorrhagic stroke who were nonambulatory and who began receiving DVT prophylaxis within 48 hours of admission (2005–2007) or by the end of the second hospital day (2008–2009) were included in the numerator of this performance measure. Patients who were discharged or transferred to another short-term facility, left against medical advice, or died within 48 hours of admission were excluded.
6. **Assessment for rehabilitation (ischemic and hemorrhagic stroke).†** Patients with acute ischemic stroke or hemorrhagic stroke who were assessed for rehabilitation services or who received rehabilitation services were included in the numerator of this performance measure. Patients who were transferred to a rehabilitation facility at discharge were assumed to have been assessed for or to have received rehabilitation services. Patients who were transferred to another acute-care facility, left against medical advice, were transferred to hospice, or died were excluded.
7. **Anticoagulation medication prescribed at discharge for patients with atrial fibrillation (ischemic stroke and TIA).†** Patients with acute ischemic stroke or TIA who had atrial fibrillation during this hospitalization who were discharged on anticoagulation therapy unless contraindicated were included in the numerator of this performance measure. Contraindications had to be documented in the medical record for exclusion from the measure. Patients who were transferred to another acute-care facility, left against medical advice, were transferred to hospice, or died were excluded.
8. **Antithrombotic medication within 48 hours or by the end of the second hospital day (ischemic stroke and TIA).†** Patients with acute ischemic stroke or TIA who received antithrombotic medication within 48 hours of admission or by the end of the second hospital day unless contraindicated were included in the numerator of this performance measure. Contraindications to antithrombotic therapy had to be documented in the medical record for exclusion from the measure. Patients discharged within 48 hours but who received antithrombotic medication were included.
9. **Antithrombotic medication provided at discharge (ischemic stroke and TIA).†** Patients with acute ischemic stroke or TIA who were discharged on antithrombotic therapy unless contraindicated were included in the numerator of this performance measure. Contraindications had to be documented in the medical record for exclusion from the measure. Patients who were transferred to another acute-care facility, left against medical advice, were transferred to hospice, or died were excluded.
10. **Counseling on smoking cessation (all stroke and TIA).** Patients with acute ischemic stroke, hemorrhagic stroke, or TIA who had smoked one or more cigarettes in the past year and who were given smoking-cessation counseling before discharge were included in the numerator of this performance measure. Patients who were transferred to another acute-care facility, left against medical advice, were transferred to hospice, or died were excluded.

* Developed by CDC, the American Heart Association, and the Joint Commission in 2008.
† Endorsed by the National Quality Forum.

to 23.7% in 2009 (p=0.02). However, in-hospital mortality for ischemic stroke decreased significantly, from 6.2% in 2005 to 5.1% in 2009 (p<0.001). The in-hospital mortality for ill-defined stroke declined (but not significantly), from 6.2% to 4.9%, and the in-hospitality mortality rate for TIA ranged from 0.1% to 0.3% with no significant trend.

Adherence to nine of the 10 performance measures increased significantly during 2005–2009 (Table). The one measure that did not show improvement was provision of antithrombotic therapy at discharge, but this measure was at 98% in 2005 and remained at 98% in 2009. The greatest overall improvements during the 5-year period were adherence to the use of thrombolytic therapy (IV tPA) (average annual improvement of 11%), counseling on smoking cessation (9.2%), and lipid testing and/or treatment (7.6%).

Defect-free care improved significantly (p<0.001) for patients in each of the four categories: adherence to measures for patients with TIA showed the greatest average annual improvement (21%, from 28% to 57%), followed by inpatient measures for patients with ischemic stroke (17%, from 37% to 69%), measures for patients with hemorrhagic stroke or ill-defined stroke (17%, from 31% to 57%), and discharge measures for patients with ischemic stroke (8%, from 51% to 72%) (Table).

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Editorial Note

Results from the initial (prototype) phase of PCNASR (i.e., from the period 2001–2004) indicated a range of adherence to recommended guidelines for care of stroke patients: 45% adherence to screening for dysphagia, 34% adherence to lipid profile measurement, 21% adherence to smoking-cessation counseling, 91% for providing antithrombotic medication at discharge, and 74% for anticoagulation for atrial fibrillation (*6*). The results described in this report for 2005–2009 document substantial and significant progress in performance, and compare favorably with those of other major stroke care quality-improvement programs involving predominantly academic hospitals. One such program, Get with the Guidelines — Stroke (GWTG-Stroke) (*7*), documented improvement in hospitals participating during the same period as PCNASR (i.e., 2005–2009). Improvements in the PCNASR measures were similar to GWTG-Stroke for seven identical performance measures reported (lipid testing and/or treatment, deep venous thrombosis/venous thromboembolism prophylaxis, antithrombotics at discharge, antithrombotics at 48 hours, anticoagulation for atrial fibrillation, and use of IV tPA) (*7*). The progress shown for PCNASR is especially encouraging considering that the majority of PCNASR hospitals are small and/or nonacademic and have fewer resources to devote to stroke care quality-improvement programs.

The decrease demonstrated in ischemic stroke in-hospital mortality might be a result of improvement in defect-free care and increased use of IV tPA, although other factors, such as increased use of discharge to hospice, shortened length of stay,

TABLE. Number and percentage of hospitals reporting adherence to 10 performance measures for acute stroke care and those reporting defect-free care, by year — seven states, 2005–2009

Characteristic	2005 No.	2005 (%)	2006 No.	2006 (%)	2007 No.	2007 (%)	2008 No.	2008 (%)	2009 No.	2009 (%)	Improvement from 2005 to 2009 (%)	Average annual improvement (%)
Performance measure												
Screening for dysphagia*	3,546	(55)	9,329	(57)	8,959	(57)	16,221	(66)	22,392	(73)	33	6.6
Education on stroke*†	4,378	(54)	11,818	(57)	12,552	(63)	17,767	(55)	27,354	(70)	30	6.0
Counseling on smoking cessation*	965	(66)	2,836	(76)	3,215	(86)	5,592	(92)	7,487	(96)	46	9.2
Lipid testing and/or treatment*†	4,473	(64)	12,815	(69)	13,677	(73)	15,814	(75)	12,981	(88)	38	7.6
DVT/VTE prophylaxis*†	3,249	(81)	9,323	(85)	9,137	(88)	12,631	(91)	15,653	(93)	15	3.0
Antithrombotic at discharge†	6,017	(98)	15,875	(97)	15,929	(98)	26,018	(97)	32,221	(98)	0	0
Antithrombotic at 48 hrs*†	4,745	(92)	12,842	(95)	12,882	(95)	22,108	(96)	26,552	(96)	4	0.8
Anticoagulation for atrial fibrillation*†	514	(82)	1,460	(80)	1,496	(85)	3,766	(89)	4,140	(87)	7	1.4
Assessment for rehabilitation*†	5,437	(88)	14,191	(90)	13,664	(92)	23,025	(94)	29,057	(97)	10	2.0
IV tPA*†	161	(37)	485	(39)	489	(45)	842	(57)	1,166	(57)	55	11.0
Defect-free care												
Ischemic in-patient*	1,803	(37)	5,615	(42)	5,937	(44)	11,733	(55)	18,516	(69)	85	17.0
Ischemic discharge*	2,485	(51)	7,339	(55)	8,502	(64)	12,370	(58)	19,314	(72)	41	8.0
Hemorrhagic stroke*	405	(31)	1,225	(39)	1,193	(47)	1,761	(46)	2,716	(57)	85	17.0
Transient ischemic attack *	565	(28)	1,785	(35)	2,209	(43)	3,258	(40)	5,325	(57)	105	21.0

Abbreviations: DVT/VTE = deep venous thrombosis/venous thromboembolism; IV tPA = intravenous tissue plasminogen activator.
* Trend on yearly result using Cochran-Armitage test for trend was statistically significant (p<0.001).
† Endorsed by the National Quality Forum.

or increased use of stroke-prevention medications also might have affected mortality rates. Although a small increase was observed in mortality for hemorrhagic stroke, this unadjusted rate is consistent with previous reports documenting 7-day mortality rates >30% (*9*). The increase might also reflect changes in characteristics of participating hospitals over time, and this finding warrants further study. Measures of acute-phase care (exclusive of discharge measures) for hemorrhagic stroke patients in this registry include only dysphagia screening and deep venous thrombosis/venous thromboembolism prophylaxis. These patients often develop complex neurologic and hemodynamic conditions associated with their stroke that are not addressed by current performance measures. The GWTG-Stroke program reported comparable rates of in-hospital mortality for ischemic stroke (5.5%) and hemorrhagic stroke (20%–25%) (*7*).

Little improvement was observed in three of the defect-free care measures through 2008, but in 2009 the three showed substantial improvement. For stroke education, improvement was observed during 2005–2007, declining in 2008 and improving in 2009. The stroke education measure changed in 2008, when stricter requirements were established for reporting adherence; this change likely explains the decline observed in 2008. Dysphagia screening and lipid testing and/or treatment showed little improvement until 2008 and 2009. PCNASR programs worked with hospitals to improve adherence to dysphagia screening and lipid management guidelines. Although use of anticoagulation for atrial fibrillation has improved modestly over time, further improvement is warranted.

The findings in this report are subject to at least four limitations. First, improvement in the quality of care over time most likely is multifactorial, and thus establishing a causal relationship between participation in PCNASR and improvement in quality of care is difficult. Dysphagia screening and provision of stroke education are complex processes. Improvement in stroke education and dysphagia screening has been the focus of intensive quality-improvement efforts recommended to hospitals by state health departments. Because hospital recruitment occurs on a different schedule for each state, this study assessed overall improvement of the program by calendar year rather than assessing improvement over time by length of hospital participation in the program. Second, although state health departments are encouraged to recruit hospitals that are representative of hospitals throughout their state by size, geographic location, and teaching status, participation by hospitals is voluntary, which limits generalizability of these results to other states and hospitals. Third, this report did not include modeling to assess trends in stroke care during the study period. Missing data excluded cases from entering into a performance measure, and this might lead to bias in performance measure estimates. Finally, although PCNASR is intended to include all stroke cases, the completeness of case abstraction varies by hospital and state (state registries report abstraction of 75%–100% of eligible cases). Sampling of cases at the hospital level might lead to biased estimates of performance measures.

Additional efforts in primary prevention, including prevention and control of hypertension and hypercholesterolemia, smoking-cessation counseling, provision of smoke-free environments, and promotion of healthy lifestyle behaviors (e.g., regular physical activity and a healthy diet), are needed to reduce the substantial burden of stroke. PCNASR addresses secondary prevention to reduce the recurrence of stroke. The importance of initiating secondary prevention among ischemic stroke patients at the time of discharge from the hospital was shown by the Preventing Recurrence of Thromboembolic Events through Coordinated Treatment (PROTECT) program. PROTECT was designed to improve early initiation of secondary prevention and resulted in significantly fewer adverse vascular events and improved clinical outcomes through better adherence to the use of medications for secondary prevention (*8*). The Joint Commission recently added stroke care measures to its core hospital quality measures; in 2009, the Centers for Medicare & Medicaid Services added participation in a stroke care quality-improvement registry as a quality indicator and has added stroke care measures to its core quality measures for reporting on meaningful use of electronic health records. These efforts will assist in improving care for stroke throughout the United States. PCNASR provides a strong model for state

What is already known on this topic?

The estimated cost of stroke in 2007 in the United States was $40.9 billion. During the prototype phase of the Paul Coverdell National Acute Stroke Registry (PCNASR), assessment of the quality of care for acute stroke revealed major gaps in adherence to evidence-based guidelines of care.

What is added by this report?

This study documents the improvement in the quality of stroke care over time among hospitals participating in PCNASR. State health departments have collaborated with hospitals to improve the quality of acute care for stroke, demonstrating significant and steady improvements in the overall quality of stroke care during the past 5 years associated with a voluntary, nonregulatory quality-improvement program. Despite this progress, further improvement in defect-free care is needed.

What are the implications for public health practice?

This role for public health and state health departments in hospital quality improvement for acute stroke is a viable approach to improving the quality of stroke care in the United States and in instituting secondary prevention of stroke.

health departments as they work to develop a comprehensive, coordinated approach to responding to the challenge of stroke care from prevention, through prehospitalization emergency services and acute care, to rehabilitation and recovery.

Improving the quality of stroke care requires a multidisciplinary, systems-focused effort that engages both public and private entities. State health departments perform a vital role by providing leadership in elevating the level of stroke care and promoting access to high-quality, organized care for stroke through policy development and quality assurance (*10*).

Acknowledgments

This report is based, in part, on data provided by the Paul Coverdell National Acute Stroke Registry in seven U.S. states (Georgia, Illinois, Massachusetts, Michigan, Minnesota, North Carolina, and Ohio).

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Maternal, Pregnancy, and Birth Characteristics of Asians and Native Hawaiians/Pacific Islanders — King County, Washington, 2003–2008

In 1997, the Office of Management and Budget issued revised standards for reporting race and ethnicity in federal datasets (*1*). In addition to permitting the reporting of two or more races for each record, the revised standards separated the "Asian or Pacific Islander" category into two categories: "Asian" and "Native Hawaiian or other Pacific Islander" (NHPI). To quantify the health status of NHPI mothers and infants in King County, Washington, 2003–2008 vital statistics for NHPI disaggregated from Asians were used to assess several key maternal and birth outcome indicators. This analysis determined that, compared with Asians in King County, NHPI mothers were significantly more likely to be adolescents, overweight or obese before pregnancy, or to have smoked during pregnancy, and their infants were more likely to be born preterm, weigh >4,500 g, or receive either third trimester only or no prenatal care. These results identify important differences and support routine presentation of health data separately for Asians and NHPIs.

To conform to the federal standards for collecting and reporting data on race and ethnicity (*1*), the Washington State Department of Health (DOH) adopted the 2003 revision of the U.S. Standard Certificate of Live Birth (*2*). Using the new reporting categories, the person completing the data collection form can check one or more races to indicate which the mother considers herself to be. Following the standards, DOH reports data for Asians and NHPIs separately. Under federal guidelines (*1*), Asian refers to a person having ancestral origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, or Vietnam). NHPI refers to a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands (including Fiji, Tonga, Micronesia, Melanesia, French Polynesia, Palau, the Northern Mariana Islands, and the Marshall Islands). Information on birth weight, length of gestation, maternal prepregnancy height and weight, initiation of prenatal care, maternal age, and smoking status during pregnancy are collected on the birth certificate.

The DOH birth certificate statistical file was used to calculate population health measures of maternal characteristics and birth risk factors for Asians and NHPIs in King County. Comparisons were made using a Pearson chi-square test. All persons identified as only Asian race or as multiple races that included Asian as one of the races were included in the Asian category. Similarly, single and multiracial persons identified as only NHPI or as NHPI in combination with another race were included in the NHPI reporting category. Prevalences are presented for single race and multiracial persons combined because of identification as a single community. However, multiracial persons reporting both Asian and NHPI race were excluded from this analysis. Self-reported height and weight data were used to calculate prepregnancy body mass index (BMI) (weight [kg] / height [m^2]). Respondents were considered overweight if their BMI was 25.0–29.9 and obese if their BMI was ≥30.0. Infants were considered preterm if born at <37 completed weeks of gestation. Prenatal care initiation in the third trimester was considered to be late initiation.

Washington had the third-largest NHPI community in the United States (43,000 single or multiracial NHPI persons), after Hawaii (283,000) and California (221,000), according to U.S. Census counts for 2000 (*3*). Approximately 22,000 NHPI and 303,000 Asian single race and multiracial persons lived in King County in 2009, based on U.S. Census Bureau estimates.*

Combining data from 2003–2008, King County recorded 142,350 births, of which 2,442 were to NHPI mothers (79.2% NHPI only and 20.8% NHPI in combination with another race). During that period, 26,229 births in the county were to Asian mothers (92.4% Asian only and 7.6% Asian in combination with another race). A total of 242 births were to multiracial women who considered themselves to be both Asian and NHPI and were excluded from further analyses.

In King County, NHPI mothers were significantly more likely than Asian mothers to be overweight (23.9% versus 19.5%; p<0.001) or obese (49.9% versus 7.6%; p<0.001) before pregnancy. NHPI mothers also were more likely than Asian mothers to smoke during pregnancy (9.8% versus 1.4%; p<0.001) or to be adolescents (aged 15–17 years) (2.4% versus 0.6%; p<0.001). Infants born to NHPI mothers were significantly more likely than infants of Asian mothers to be born preterm (12.6% versus 9.7%; p<0.001), at high birth weight (>4,500 g) (3.0% versus 0.6%; p<0.001), or to have received either late or no prenatal care (15.8% versus 4.2%; p<0.001). No significant differences were observed for very low birth weight (<1,500 g; p=0.2), and infants of Asian mothers were more likely to be born at low birth weight (<2,500 g; p<0.001) (Table).

* Data available at http://www.census.gov/popest/counties/asrh/files/cc-est2009-5race-53.csv.

TABLE. Maternal, pregnancy, and birth characteristics among Asians and Native Hawaiians/Pacific Islanders (NHPIs)* — King County, Washington, 2003–2008

Characteristic	Asian %	Asian (95% CI)	NHPI %	NHPI (95% CI)
Maternal				
Overweight (BMI 25.0–29.9)	19.5	(18.9–20.1)	23.9	(21.6–26.4)
Obese (BMI ≥30.0)	7.6	(7.2–7.9)	49.9	(46.6–53.4)
Smoked during pregnancy	1.4	(1.3–1.6)	9.8	(8.5–11.2)
Adolescent (aged 15–17 yrs)	0.6	(0.5–0.7)	2.4	(1.8–3.1)
Pregnancy/Birth				
Very low birth weight (<1,500 g)†	1.0	(0.9–1.1)	1.3	(0.9–1.9)
Low birth weight (<2,500 g)	7.5	(7.2–7.9)	5.5	(4.6–6.6)
High birth weight (>4,500 g)	0.6	(0.5–0.7)	3.0	(2.3–3.8)
Premature birth (<37 wks)	9.7	(9.3–10.1)	12.6	(11.1–14.2)
Late or no prenatal care	4.2	(4.0–4.5)	15.8	(14.0–17.7)

Abbreviations: BMI = body mass index (weight [kg] / height [m^2]) based on prepregnancy weight; CI = confidence interval.

* Asian and NHPI categories include both single race and multiple race persons (in combination with another race). N = 25,987 Asians and 2,200 NHPIs; comparison excludes 242 births to multiracial Asian-NHPI women.

† p=0.2, from Pearson chi-square test comparing Asians and NHPIs, excluding 242 births to multiracial Asian-NHPI women; p<0.001 for all other characteristics.

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Editorial Note

Although the 1997 revised federal guidelines on collection of race/ethnicity data separated the "Asian or Pacific Islander" race categories, many published analyses have continued to present data for the combined Asian/Pacific Islander group rather than present data separately for Asians and NHPIs. Differences between NHPIs and Asians resulting from cultural heterogeneity between these groups, variations in income and poverty, and historical discrimination and immigration patterns support routine disaggregation of health data for these racial groups in public health planning and reporting of data (*4*). The results of this analysis quantify important health concerns among the NHPI population in King County and support wider reporting of the new race categories for population-level health indicators.

Because the King County Asian population is approximately 10 times larger than the NHPI population, separate reporting categories are critical to accurately assess local NHPI population health and identify disparities. In King County, the prevalence of high infant birth weight, preterm births, and late or no initiation of prenatal care was higher among NHPI mothers than Asian mothers. NHPI mothers also were more likely to be overweight or obese before pregnancy, to be adolescents, or to have smoked during pregnancy. Identification of such health disparities in the local NHPI population is critical for validating community concerns and developing local programs to address health problems.

NHPI maternal and child health indicators differ from those for Asians, not only in King County, but also in other geographic areas. A limited number of prior studies, mainly from Hawaii and California, have identified elevated risks for preterm birth (*5,6*), low birth weight (*5,6*), high birth weight (*5*), smoking during pregnancy (*5*), and teen births (*5,7*) among Pacific Islanders. High birth weight might be influenced by high rates of obesity and diabetes (*8*). A high prevalence of either third trimester initiation or a complete lack of prenatal care during pregnancy might be caused by more frequent logistical, financial, and personal barriers to early prenatal care access (*9*).

Although this report focused on maternal and child health indicators, important health disparities among NHPIs can be identified for other vital statistics (e.g., deaths), adverse health outcomes, and health risk behaviors (e.g., smoking and unhealthy weight) (*8*). Data for these other population health measures are of high interest, but are outside the scope of this report.

The findings in this report are subject to at least four limitations. First, differences in maternal and child health indicators have been identified not only between Asians and NHPIs, but also within Asian and NHPI reporting categories (*6,7,9*) and among single and multiple race persons (*6*). Further analyses by subgroup will be needed to design appropriate programs and to describe disparities accurately. Second, this report presents data combined for the 2003–2008 period to provide precise prevalence estimates. Any underlying trends during this period might be masked by using combined data. Third, these

What is already known on this topic?

Revised federal standards for collecting race and ethnicity information disaggregate the Native Hawaiian and Pacific Islander (NHPI) category from Asians, but reported data often aggregate the two categories.

What is added by this report?

Disaggregated maternal and child health assessment data for King County, Washington, show high percentages of maternal overweight and obesity before pregnancy, maternal smoking, younger maternal age, late or no prenatal care, preterm birth, and high birth weight in the local Native Hawaiian and Pacific Islander population, compared with the local Asian population, leading to the identification of important health concerns in the NHPI community.

What are the implications for public health practice?

Routine reporting of health data for NHPIs separately from Asians will help identify and quantify differences in the distribution of health concerns in these two populations.

analyses did not consider the role of potential confounders, which might affect the differences in maternal, pregnancy, and birth characteristics reported between Asian and NHPI women. Finally, the heterogeneity of local populations might affect the generalizability of these findings to other areas and nationally.

At the end of 2009, a total of 32 states and the District of Columbia reported birth certificate data with disaggregated race information (*2*). The findings in this report support the use of separate Asian and NHPI data collection categories by other states. This would allow federal and local agencies to report disaggregated data. Without key assessment data describing health disparities between racial groups, public health agencies and community partners cannot accurately and efficiently design and implement policies and programs to address national public health priorities.

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Notes from the Field

Two Cases of Human Plague — Oregon, 2010

Plague, caused by *Yersinia pestis,* is enzootic among rodents in the western United States. Humans can be infected through 1) the bite of an infected flea carried by a rodent or, rarely, other animals, 2) direct contact with contaminated tissues, or 3) in rare cases, inhalation of respiratory secretions from infected persons or animals. In September 2010, the Oregon Health Authority reported the first two cases of human plague in Oregon since 1995 and the only two U.S. cases in 2010.

Both illnesses began on August 21. The patients, aged 17 and 42 years, lived in the same household and might have been exposed to plague by infected fleas from one of their dogs; that dog was found to be seropositive for *Y. pestis* by the passive hemagglutination-inhibition assay (dilution of 1:64). One patient acknowledged sleeping in the same bed with the dog during the 2 weeks before illness onset. Both patients had high fever and multiple bilateral inguinal buboes; one patient had hypotension, tachycardia, and acute renal failure and was hospitalized. A gram-negative rod with bipolar staining was isolated from a specimen of that patient's blood.

Four different clinical laboratories attempted to identify the isolate. Three different commercial automated systems identified the organism as *Acinetobacter lwoffii, Pseudomonas luteola*, and *Yersinia pseudotuberculosis*, respectively. However, 25 days after specimen collection, the isolate was identified as *Y. pestis* by direct fluorescent antibody to F1 antigen, polymerase chain reaction, and bacteriophage lysis at the Spokane (Washington) Regional Health District Laboratory, prompting notification of the Oregon Health Authority. The second patient was identified retrospectively on the basis of a single positive serology (passive hemagglutination-inhibition [dilution of 1:32]). Plague was not suspected initially. Both patients recovered uneventfully after empiric therapy with doxycycline and amoxicillin clavulanate potassium, respectively, although the latter is not considered effective in treating plague.

Automated bacterial identification systems can misidentify *Y. pestis* (*1,2*). Automated identification of *Yersinia* spp. in blood should prompt further clinical evaluation of the patient to determine whether symptoms are compatible with plague. When plague is suspected, treatment should be started immediately, and both the state public health laboratory and public health authorities should be notified promptly.

Plague is a Category A potential bioterrorism agent. Human infections are rare but can be life-threatening. The plague case-fatality rate depends on the clinical presentation (i.e., bubonic, septicemic, or pneumonic) and timing of antibiotic therapy initiation; if untreated, the case-fatality rate is >50% for bubonic plague and approaches 100% for pneumonic plague (*3*). Rapid laboratory identification can help guide therapy.

Sleeping in the same bed with dogs has been associated with plague in enzootic areas (*4*). Plague patients with no history of exposure to rodents can be infected by *Y. pestis* if their pets carry infected rodent fleas into the home. Veterinarians always should recommend flea control to dog and cat owners.

Reported by

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Announcements

Introduction to Public Health Surveillance Course

CDC and the Rollins School of Public Health at Emory University will cosponsor the course, Introduction to Public Health Surveillance, May 2–6, 2011, at Emory University in Atlanta, Georgia. The course is designed for state and local public health professionals.

The course will provide theoretical and practical knowledge to enable participants to design, implement, and evaluate effective public health surveillance programs. Topics scheduled for presentation include an overview and history of surveillance systems; planning considerations; sources and collection of data; analysis, interpretation, and communication of data; surveillance systems technology; ethics and legalities; state and local concerns; and future considerations. Tuition is charged.

Additional information and applications are available by mail (Emory University, Hubert Department of Global Health [Attn: Pia], 1518 Clifton Rd. NE, CNR Bldg., Rm. 7038, Atlanta, GA 30322); telephone (404-727-3485); fax (404-727-4590); Internet (http://www.sph.emory.edu/epicourses); or e-mail (pvaleri@emory.edu).

Release of New WISQARS Cost of Injury Reports

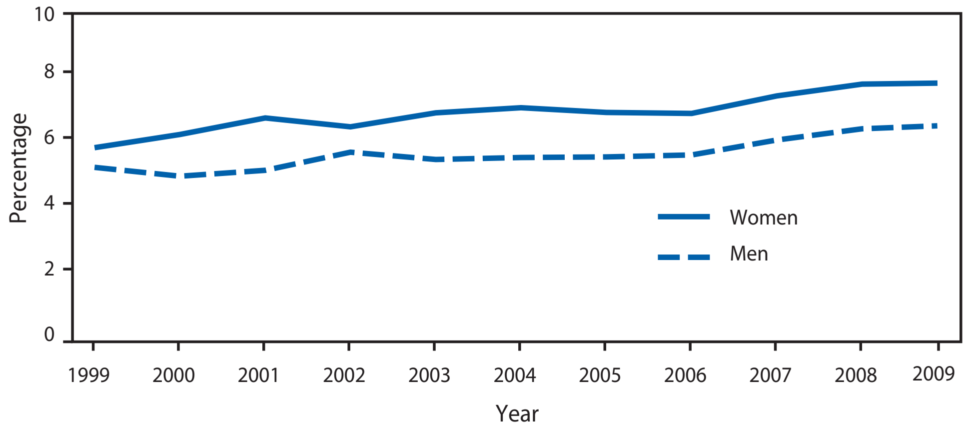
CDC's Web-based Injury Statistics Query and Reporting System (WISQARS) is a leading source of injury statistics in the United States. WISQARS is an interactive, web-based query system that provides data on injury deaths, violent deaths, and nonfatal injuries. CDC's National Center for Injury Prevention and Control (NCIPC) is introducing a new WISQARS Cost of Injury Reports module that provide cost estimates for injury deaths, hospitalizations, and emergency department visits in which the patient was treated and released.

Users can use the query system to create tables with medical (e.g., treatment and rehabilitation), work loss (e.g., lost wages, benefits, and self-reported household services), and combined (medical plus work loss) costs based on a number of variables, including intent and mechanism (cause) of injury, body region and diagnosis of injury, geographic location (for deaths only), sex, and age. The WISQARS Cost of Injury Reports module is a valuable tool to help raise awareness of the economic impact of fatal and nonfatal injuries in the United States. Additional information is available at http://www.cdc.gov/injury/wisqars.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Adults Aged 25–44 Years Reporting Fair or Poor Health,* by Sex — National Health Interview Survey, United States, 1999–2009†



* Respondents were asked to assess their own health and that of family members living in the same household as excellent, very good, good, fair, or poor. Data are presented only for respondents aged 25–44 years.

† Estimates are based on household interviews of a sample of the U.S. civilian noninstitutionalized population. Denominators for each category exclude persons for whom data were missing.

From 1999 to 2009, the percentage of adults aged 25–44 years whose health status was reported as fair or poor increased from 5.6% to 7.2%. During this period, the percentage reported to be in fair or poor health increased for men (from 5.3% to 6.6%) and for women (from 5.9% to 7.9%). For each year during 1999–2009, women in this age group were more likely to report fair or poor health than men in this age group.

Source: National Health Interview Survey 1999–2009 data. Available at http://www.cdc.gov/nchs/nhis.htm.

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 February 19, 2011 (7th week)*

Disease	Current week	Cum 2011	5-year weekly average[†]	Total cases reported for previous years 2010	2009	2008	2007	2006	States reporting cases during current week (No.)
Anthrax	—	—	—	—	1	—	1	1	
Arboviral diseases[§, ¶]:									
California serogroup virus disease	—	—	0	74	55	62	55	67	
Eastern equine encephalitis virus disease	—	—	—	10	4	4	4	8	
Powassan virus disease	—	—	—	8	6	2	7	1	
St. Louis encephalitis virus disease	—	—	0	8	12	13	9	10	
Western equine encephalitis virus disease	—	—	—	—	—	—	—	—	
Babesiosis	—	2	1	NN	NN	NN	NN	NN	
Botulism, total	1	8	2	108	118	145	144	165	
foodborne	1	1	0	7	10	17	32	20	OH (1)
infant	—	5	2	76	83	109	85	97	
other (wound and unspecified)	—	2	1	25	25	19	27	48	
Brucellosis	2	5	1	128	115	80	131	121	FL (2)
Chancroid	1	4	1	36	28	25	23	33	NY (1)
Cholera	—	7	—	12	10	5	7	9	
Cyclosporiasis[§]	4	14	2	172	141	139	93	137	FL (4)
Diphtheria	—	—	—	—	—	—	—	—	
Haemophilus influenzae,[**] invasive disease (age <5 yrs):									
serotype b	1	1	1	17	35	30	22	29	NE (1)
nonserotype b	—	9	5	160	236	244	199	175	
unknown serotype	4	31	4	266	178	163	180	179	PA (1), OH (1), NC (1), FL (1)
Hansen disease[§]	1	5	2	65	103	80	101	66	CA (1)
Hantavirus pulmonary syndrome[§]	—	1	0	17	20	18	32	40	
Hemolytic uremic syndrome, postdiarrheal[§]	—	5	2	229	242	330	292	288	
Influenza-associated pediatric mortality[§,††]	6	37	3	61	358	90	77	43	PA (1), IL (1), NC (3), NM (1)
Listeriosis	3	39	9	777	851	759	808	884	NY (1), OH (1), TX (1)
Measles[§§]	1	12	1	61	71	140	43	55	PA (1)
Meningococcal disease, invasive[¶¶]:									
A, C, Y, and W-135	2	14	8	244	301	330	325	318	NY (1), NC (1)
serogroup B	—	9	4	112	174	188	167	193	
other serogroup	—	—	1	9	23	38	35	32	
unknown serogroup	11	77	13	427	482	616	550	651	MO (1), FL (2), TN (1), AZ (1), CA (6)
Novel influenza A virus infections***	—	1	0	4	43,774	2	4	NN	
Plague	—	—	0	1	8	3	7	17	
Poliomyelitis, paralytic	—	—	—	—	1	—	—	—	
Polio virus Infection, nonparalytic[§]	—	—	—	—	—	—	—	NN	
Psittacosis[§]	—	—	0	4	9	8	12	21	
Q fever, total[§]	—	5	2	122	113	120	171	169	
acute	—	3	1	93	93	106	—	—	
chronic	—	2	0	29	20	14	—	—	
Rabies, human	—	—	—	1	4	2	1	3	
Rubella[†††]	—	—	0	6	3	16	12	11	
Rubella, congenital syndrome	—	—	0	—	2	—	—	1	
SARS-CoV[§]	—	—	—	—	—	—	—	—	
Smallpox[§]	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome[§]	3	13	4	168	161	157	132	125	OH (2), NC (1)
Syphilis, congenital (age <1 yr)[§§§]	—	8	7	258	423	431	430	349	
Tetanus	—	—	0	10	18	19	28	41	
Toxic-shock syndrome (staphylococcal)[§]	—	8	2	79	74	71	92	101	
Trichinellosis	1	3	0	4	13	39	5	15	VA (1)
Tularemia	—	1	0	113	93	123	137	95	
Typhoid fever	2	24	8	428	397	449	434	353	PA (1), WA (1)
Vancomycin-intermediate *Staphylococcus aureus*[§]	1	5	1	91	78	63	37	6	AZ (1)
Vancomycin-resistant *Staphylococcus aureus*[§]	—	—	—	2	1	—	2	1	
Vibriosis (noncholera *Vibrio* species infections)[§]	1	18	3	785	789	588	549	NN	FL (1)
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 February 19, 2011 (7th week)*

—: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts.

* Case counts for reporting years 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/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/ncphi/disss/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/ncphi/disss/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 3, 2010, 41 influenza-associated pediatric deaths occurring during the 2010-11 influenza season have been reported.

§§ The one measles case reported for the current week was indigenous.

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

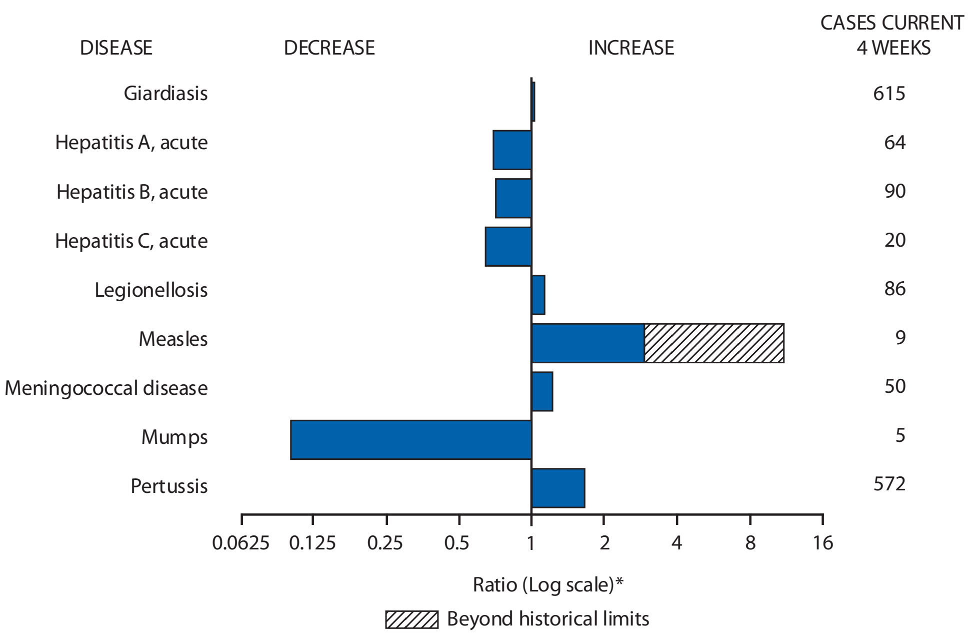
*** CDC discontinued reporting of individual confirmed and probable cases of 2009 pandemic influenza A (H1N1) virus infections on July 24, 2009. During 2009, four cases of human infection with novel influenza A viruses, different from the 2009 pandemic influenza A (H1N1) strain, were reported to CDC. The four cases of novel influenza A virus infection reported to CDC during 2010, and the one case 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 for 2009 were 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 February 19, 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.

Notifiable Disease Data Team and 122 Cities Mortality Data Team

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TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending February 19, 2011, and February 20, 2010 (7th week)*

Reporting area	*Chlamydia trachomatis* infection					Coccidioidomycosis					Cryptosporidiosis				
	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	12,957	24,019	26,582	139,061	162,906	148	0	372	1,554	NN	54	119	352	433	760
New England	724	804	1,962	4,234	4,493	—	0	0	—	NN	—	7	19	6	110
Connecticut	10	177	1,474	120	728	N	0	0	N	NN	—	0	4	4	71
Maine†	—	48	100	—	340	N	0	0	N	NN	—	1	7	—	11
Massachusetts	496	403	694	2,896	2,569	N	0	0	N	NN	—	3	9	—	14
New Hampshire	43	51	113	406	260	—	0	0	—	NN	—	1	5	—	7
Rhode Island†	94	67	143	597	444	—	0	0	—	NN	—	0	2	—	1
Vermont†	81	23	51	215	152	N	0	0	N	NN	—	1	5	2	6
Mid. Atlantic	1,579	3,363	5,199	19,795	20,592	—	0	0	—	NN	9	15	38	58	63
New Jersey	—	509	709	2,789	3,278	N	0	0	N	NN	—	0	4	—	4
New York (Upstate)	798	701	1,723	4,178	3,544	N	0	0	N	NN	6	4	13	16	9
New York City	183	1,219	2,772	6,597	7,636	N	0	0	N	NN	—	2	6	6	6
Pennsylvania	598	946	1,187	6,231	6,134	N	0	0	N	NN	3	8	26	36	44
E.N. Central	872	3,589	4,013	18,753	26,376	1	0	3	5	NN	12	30	128	117	183
Illinois	27	830	1,027	3,113	6,924	N	0	0	N	NN	—	4	21	4	33
Indiana	—	414	798	1,990	1,597	N	0	0	N	NN	—	4	10	15	26
Michigan	552	941	1,417	6,326	7,777	—	0	1	1	NN	1	5	18	25	46
Ohio	156	995	1,131	4,972	6,926	1	0	3	4	NN	9	8	24	58	33
Wisconsin	137	428	517	2,352	3,152	N	0	0	N	NN	2	10	63	15	45
W.N. Central	62	1,360	1,559	6,065	9,865	—	0	0	—	NN	7	20	83	49	79
Iowa	24	205	237	1,187	1,478	N	0	0	N	NN	—	4	24	9	19
Kansas	—	188	265	878	1,346	N	0	0	N	NN	—	2	9	4	9
Minnesota	—	285	351	947	2,173	—	0	0	—	NN	—	0	16	—	22
Missouri	—	503	619	2,052	3,435	—	0	0	—	NN	4	4	30	17	12
Nebraska†	17	92	185	468	727	N	0	0	N	NN	3	3	26	16	11
North Dakota	—	35	81	114	265	N	0	0	N	NN	—	0	9	—	—
South Dakota	21	61	90	419	441	N	0	0	N	NN	—	1	6	3	6
S. Atlantic	3,778	4,785	5,457	31,664	32,059	—	0	0	—	NN	15	18	47	103	135
Delaware	60	84	220	516	508	—	0	0	—	NN	—	0	1	2	1
District of Columbia	—	90	161	265	639	—	0	0	—	NN	—	0	1	—	1
Florida	668	1,456	1,705	8,975	9,786	N	0	0	N	NN	8	7	19	40	48
Georgia	597	663	1,220	4,960	4,408	N	0	0	N	NN	5	5	16	34	65
Maryland†	—	482	994	1,575	2,156	—	0	0	—	NN	1	1	3	6	3
North Carolina	1,063	750	1,436	5,967	6,822	N	0	0	N	NN	—	0	12	3	3
South Carolina†	641	530	847	3,195	3,376	N	0	0	N	NN	—	2	8	14	4
Virginia†	749	649	971	5,645	3,883	N	0	0	N	NN	1	2	8	4	8
West Virginia	—	75	123	566	481	N	0	0	N	NN	—	0	3	—	2
E.S. Central	838	1,769	2,414	10,070	10,531	—	0	0	—	NN	1	4	19	11	28
Alabama†	—	536	780	2,926	3,065	N	0	0	N	NN	—	2	13	5	7
Kentucky	208	271	614	1,306	1,264	N	0	0	N	NN	1	1	6	5	8
Mississippi	413	375	780	2,399	2,495	N	0	0	N	NN	—	0	2	—	4
Tennessee†	217	578	800	3,439	3,707	N	0	0	N	NN	—	1	5	1	9
W.S. Central	2,600	3,073	4,234	20,678	24,617	1	0	0	1	NN	1	7	29	13	25
Arkansas†	361	273	391	1,879	1,854	N	0	0	N	NN	—	0	3	—	6
Louisiana	334	323	742	2,862	4,214	1	0	0	1	NN	1	1	6	2	6
Oklahoma	297	254	1,374	1,481	1,541	N	0	0	N	NN	—	1	8	—	4
Texas†	1,608	2,285	3,110	14,456	17,008	N	0	0	N	NN	—	4	22	11	9
Mountain	832	1,436	1,916	8,353	9,858	48	0	318	1,144	NN	4	10	30	42	68
Arizona	168	489	706	1,872	3,179	48	0	314	1,134	NN	—	0	3	3	4
Colorado	478	338	628	2,868	2,621	N	0	0	N	NN	2	3	6	20	15
Idaho†	44	68	199	399	516	N	0	0	N	NN	1	2	7	7	13
Montana†	—	62	81	362	366	N	0	0	N	NN	1	1	4	4	7
Nevada†	—	175	329	961	1,165	—	0	4	8	NN	—	0	7	1	1
New Mexico†	142	171	386	1,249	807	—	0	0	—	NN	—	2	12	6	12
Utah	—	120	156	642	892	—	0	0	—	NN	—	1	5	—	10
Wyoming†	—	37	90	—	312	—	0	2	2	NN	—	0	2	1	6
Pacific	1,672	3,678	4,919	19,449	24,515	98	0	82	404	NN	5	12	29	34	69
Alaska	—	111	148	707	842	N	0	0	N	NN	—	0	1	—	2
California	1,534	2,797	4,250	15,380	18,239	98	0	82	404	NN	5	6	18	22	37
Hawaii	—	108	158	—	841	N	0	0	N	NN	—	0	0	—	1
Oregon	138	212	496	1,448	1,712	N	0	0	N	NN	—	3	13	12	20
Washington	—	399	505	1,914	2,881	N	0	0	N	NN	—	1	7	—	9
Territories															
American Samoa	—	0	0	—	—	N	0	0	N	NN	N	0	0	N	NN
C.N.M.I.	—	—	—	—	—	—	—	—	—	NN	—	—	—	—	—
Guam	—	8	31	50	3	—	0	0	—	NN	—	0	0	—	—
Puerto Rico	172	103	265	803	635	N	0	0	N	NN	N	0	0	N	NN
U.S. Virgin Islands	—	12	29	—	71	—	0	0	—	NN	—	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).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 19, 2011, and February 20, 2010 (7th week)*

	Dengue Virus Infection									
	Dengue Fever†					Dengue Hemorrhagic Fever§				
	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum
Reporting area	week	Med	Max	2011	2010	week	Med	Max	2011	2010
United States	—	6	48	2	41	—	0	2	—	—
New England	—	0	3	—	1	—	0	0	—	—
Connecticut	—	0	0	—	—	—	0	0	—	—
Maine¶	—	0	2	—	1	—	0	0	—	—
Massachusetts	—	0	0	—	—	—	0	0	—	—
New Hampshire	—	0	0	—	—	—	0	0	—	—
Rhode Island¶	—	0	1	—	—	—	0	0	—	—
Vermont¶	—	0	1	—	—	—	0	0	—	—
Mid. Atlantic	—	2	23	—	17	—	0	1	—	—
New Jersey	—	0	3	—	—	—	0	0	—	—
New York (Upstate)	—	0	5	—	1	—	0	1	—	—
New York City	—	1	17	—	11	—	0	1	—	—
Pennsylvania	—	0	3	—	5	—	0	0	—	—
E.N. Central	—	1	7	2	7	—	0	1	—	—
Illinois	—	0	2	—	1	—	0	0	—	—
Indiana	—	0	2	1	1	—	0	0	—	—
Michigan	—	0	2	—	—	—	0	0	—	—
Ohio	—	0	2	—	5	—	0	0	—	—
Wisconsin	—	0	2	1	—	—	0	1	—	—
W.N. Central	—	0	6	—	3	—	0	1	—	—
Iowa	—	0	1	—	—	—	0	0	—	—
Kansas	—	0	1	—	—	—	0	0	—	—
Minnesota	—	0	2	—	3	—	0	0	—	—
Missouri	—	0	0	—	—	—	0	0	—	—
Nebraska¶	—	0	6	—	—	—	0	0	—	—
North Dakota	—	0	1	—	—	—	0	0	—	—
South Dakota	—	0	0	—	—	—	0	1	—	—
S. Atlantic	—	2	17	—	8	—	0	1	—	—
Delaware	—	0	0	—	—	—	0	0	—	—
District of Columbia	—	0	0	—	—	—	0	0	—	—
Florida	—	2	14	—	6	—	0	1	—	—
Georgia	—	0	2	—	1	—	0	0	—	—
Maryland¶	—	0	0	—	—	—	0	0	—	—
North Carolina	—	0	2	—	—	—	0	0	—	—
South Carolina¶	—	0	3	—	—	—	0	0	—	—
Virginia¶	—	0	3	—	1	—	0	0	—	—
West Virginia	—	0	1	—	—	—	0	0	—	—
E.S. Central	—	0	2	—	—	—	0	0	—	—
Alabama¶	—	0	2	—	—	—	0	0	—	—
Kentucky	—	0	1	—	—	—	0	0	—	—
Mississippi	—	0	0	—	—	—	0	0	—	—
Tennessee¶	—	0	1	—	—	—	0	0	—	—
W.S. Central	—	0	1	—	—	—	0	1	—	—
Arkansas¶	—	0	0	—	—	—	0	1	—	—
Louisiana	—	0	0	—	—	—	0	0	—	—
Oklahoma	—	0	1	—	—	—	0	0	—	—
Texas¶	—	0	1	—	—	—	0	0	—	—
Mountain	—	0	2	—	2	—	0	0	—	—
Arizona	—	0	1	—	—	—	0	0	—	—
Colorado	—	0	0	—	—	—	0	0	—	—
Idaho¶	—	0	1	—	—	—	0	0	—	—
Montana¶	—	0	1	—	—	—	0	0	—	—
Nevada¶	—	0	1	—	1	—	0	0	—	—
New Mexico¶	—	0	0	—	1	—	0	0	—	—
Utah	—	0	0	—	—	—	0	0	—	—
Wyoming¶	—	0	0	—	—	—	0	0	—	—
Pacific	—	0	6	—	3	—	0	0	—	—
Alaska	—	0	1	—	—	—	0	0	—	—
California	—	0	5	—	1	—	0	0	—	—
Hawaii	—	0	0	—	—	—	0	0	—	—
Oregon	—	0	0	—	—	—	0	0	—	—
Washington	—	0	2	—	2	—	0	0	—	—
Territories										
American Samoa	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	108	524	88	626	—	1	16	—	12
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

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* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† 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).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 19, 2011, and February 20, 2010 (7th week)*

	Ehrlichiosis/Anaplasmosis[†]														
	Ehrlichia chaffeensis					*Anaplasma phagocytophilum*					Undetermined				
	Current week	Previous 52 weeks		Cum	Cum	Current week	Previous 52 weeks		Cum	Cum	Current week	Previous 52 weeks		Cum	Cum
Reporting area		Med	Max	2011	2010		Med	Max	2011	2010		Med	Max	2011	2010
United States	1	8	48	7	15	—	12	58	5	10	—	1	10	1	—
New England	—	0	1	—	1	—	1	8	1	4	—	0	2	—	—
Connecticut	—	0	0	—	—	—	0	5	—	—	—	0	2	—	—
Maine[§]	—	0	1	—	1	—	0	2	1	2	—	0	0	—	—
Massachusetts	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
New Hampshire	—	0	1	—	—	—	0	3	—	—	—	0	1	—	—
Rhode Island[§]	—	0	0	—	—	—	0	5	—	2	—	0	0	—	—
Vermont[§]	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	—	1	6	—	1	—	4	14	2	1	—	0	1	—	—
New Jersey	—	0	0	—	—	—	0	1	—	—	—	0	0	—	—
New York (Upstate)	—	0	6	—	—	—	4	14	2	1	—	0	1	—	—
New York City	—	0	3	—	—	—	0	1	—	—	—	0	0	—	—
Pennsylvania	—	0	0	—	1	—	0	0	—	—	—	0	0	—	—
E.N. Central	—	0	4	1	1	—	4	40	—	3	—	1	7	1	—
Illinois	—	0	2	—	—	—	0	2	—	—	—	0	2	—	—
Indiana	—	0	0	—	—	—	0	0	—	—	—	0	3	1	—
Michigan	—	0	1	—	—	—	0	0	—	—	—	0	1	—	—
Ohio	—	0	3	1	—	—	0	1	—	—	—	0	0	—	—
Wisconsin	—	0	1	—	1	—	4	40	—	3	—	0	4	—	—
W.N. Central	—	1	13	—	1	—	0	3	—	—	—	0	3	—	—
Iowa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Kansas	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
Minnesota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Missouri	—	1	13	—	1	—	0	3	—	—	—	0	3	—	—
Nebraska[§]	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
S. Atlantic	1	4	19	6	10	—	1	7	1	2	—	0	1	—	—
Delaware	—	0	3	1	1	—	0	1	—	—	—	0	0	—	—
District of Columbia	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Florida	—	0	2	1	1	—	0	1	—	—	—	0	0	—	—
Georgia	—	0	4	1	2	—	0	1	—	1	—	0	1	—	—
Maryland[§]	1	0	3	2	3	—	0	2	—	1	—	0	1	—	—
North Carolina	—	1	13	1	3	—	0	4	1	—	—	0	0	—	—
South Carolina[§]	—	0	2	—	—	—	0	1	—	—	—	0	0	—	—
Virginia[§]	—	1	8	—	—	—	0	2	—	—	—	0	1	—	—
West Virginia	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
E.S. Central	—	1	11	—	—	—	0	2	1	—	—	0	1	—	—
Alabama[§]	—	0	3	—	—	—	0	2	1	—	—	0	0	—	—
Kentucky	—	0	2	—	—	—	0	0	—	—	—	0	0	—	—
Mississippi	—	0	1	—	—	—	0	1	—	—	—	0	0	—	—
Tennessee[§]	—	0	7	—	—	—	0	2	—	—	—	0	1	—	—
W.S. Central	—	0	6	—	1	—	0	2	—	—	—	0	1	—	—
Arkansas[§]	—	0	5	—	—	—	0	2	—	—	—	0	0	—	—
Louisiana	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
Oklahoma	—	0	6	—	—	—	0	2	—	—	—	0	0	—	—
Texas[§]	—	0	1	—	1	—	0	1	—	—	—	0	1	—	—
Mountain	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Arizona	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Colorado	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Idaho[§]	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Montana[§]	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Nevada[§]	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
New Mexico[§]	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Utah	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Wyoming[§]	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Pacific	—	0	1	—	—	—	0	0	—	—	—	0	1	—	—
Alaska	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
California	—	0	1	—	—	—	0	0	—	—	—	0	1	—	—
Hawaii	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Oregon	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Washington	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	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 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Cumulative total *E. ewingii* cases reported for year 2010 = 10, and 1 case report for 2011.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 19, 2011, and February 20, 2010 (7th week)*

Reporting area	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive† All ages, all serotypes				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010
United States	136	339	502	1,312	2,202	2,952	5,607	6,446	33,131	38,277	30	58	96	362	463
New England	7	30	54	27	208	90	100	197	545	575	—	3	9	7	23
Connecticut	—	5	12	—	54	16	38	169	179	208	—	0	6	—	—
Maine§	5	4	12	13	23	—	2	7	—	39	—	0	2	5	1
Massachusetts	—	13	25	—	85	58	47	80	308	264	—	2	5	—	16
New Hampshire	—	2	8	3	20	5	3	7	14	20	—	0	1	1	4
Rhode Island§	—	0	7	—	4	11	4	15	39	37	—	0	2	—	2
Vermont§	2	3	10	11	22	—	0	17	5	7	—	0	3	1	—
Mid. Atlantic	28	60	106	292	384	355	706	1,170	4,462	4,233	7	11	25	77	109
New Jersey	—	5	18	—	54	—	116	175	767	721	—	2	5	10	13
New York (Upstate)	13	22	54	103	124	113	109	227	637	568	3	3	14	18	25
New York City	5	17	33	107	103	51	232	534	1,423	1,494	—	2	6	14	21
Pennsylvania	10	14	27	82	103	191	259	366	1,635	1,450	4	3	11	35	50
E.N. Central	12	54	90	181	406	200	989	1,210	5,122	7,244	5	10	20	52	80
Illinois	—	12	32	16	88	10	205	256	834	1,597	—	3	7	2	17
Indiana	—	5	12	10	58	—	104	222	538	488	—	1	6	3	12
Michigan	1	12	25	44	80	103	251	471	1,725	2,253	1	1	3	9	3
Ohio	10	16	29	86	118	54	317	383	1,557	2,255	4	2	6	28	23
Wisconsin	1	8	33	25	62	33	93	156	468	651	—	2	5	10	25
W.N. Central	5	24	101	114	151	7	287	357	1,249	1,836	2	3	14	13	17
Iowa	—	5	11	27	37	4	34	57	191	217	—	0	1	—	—
Kansas	1	4	10	20	33	—	40	62	156	249	—	0	2	—	4
Minnesota	—	0	75	—	—	—	37	61	115	317	—	0	9	—	—
Missouri	3	8	26	41	44	—	142	181	611	833	1	2	4	7	10
Nebraska§	1	4	9	21	25	3	22	50	120	141	1	0	3	6	1
North Dakota	—	0	5	—	—	—	2	8	6	19	—	0	2	—	2
South Dakota	—	1	7	5	12	—	7	20	50	60	—	0	0	—	—
S. Atlantic	42	74	108	300	433	1,024	1,347	1,798	8,489	9,554	7	14	26	102	108
Delaware	1	0	5	3	4	10	18	48	121	116	—	0	1	—	1
District of Columbia	—	0	5	—	5	—	34	66	94	255	—	0	1	—	—
Florida	22	41	75	177	222	190	382	486	2,356	2,727	2	4	9	38	22
Georgia	6	13	51	50	81	172	226	392	1,506	1,386	4	3	6	26	39
Maryland§	9	5	11	33	36	—	136	224	463	616	—	1	5	8	7
North Carolina	N	0	0	N	N	401	242	596	2,082	2,243	1	2	9	9	12
South Carolina§	—	2	9	6	14	166	151	261	925	1,031	—	1	5	4	18
Virginia§	4	9	29	31	67	85	145	223	830	1,127	—	2	6	17	8
West Virginia	—	0	6	—	4	—	13	26	112	53	—	0	3	—	1
E.S. Central	1	5	12	13	36	179	479	697	2,718	2,959	2	3	10	23	29
Alabama§	1	4	11	12	16	—	158	236	904	913	1	0	4	8	2
Kentucky	N	0	0	N	N	52	73	160	337	370	—	1	3	6	5
Mississippi	N	0	0	N	N	85	109	216	653	705	—	0	2	—	3
Tennessee§	—	0	4	1	20	42	137	195	824	971	1	2	5	9	19
W.S. Central	2	6	14	22	48	649	840	1,165	5,574	6,718	3	3	21	26	13
Arkansas§	2	2	7	9	13	105	79	133	585	550	1	0	3	5	2
Louisiana	—	3	8	13	22	86	93	238	822	1,307	—	0	4	10	5
Oklahoma	—	0	5	—	13	87	76	332	471	468	2	2	17	11	6
Texas§	N	0	0	N	N	371	599	866	3,696	4,393	—	0	1	—	—
Mountain	15	31	51	113	210	101	178	235	1,077	1,154	4	5	15	42	66
Arizona	—	3	8	10	22	32	55	87	315	389	—	2	7	17	26
Colorado	13	13	27	66	87	33	56	93	336	367	4	1	5	15	13
Idaho§	1	4	9	19	25	3	2	14	8	20	—	0	2	2	2
Montana§	1	2	7	2	13	—	2	6	10	16	—	0	1	1	—
Nevada§	—	2	11	6	6	—	29	94	170	210	—	0	1	1	4
New Mexico§	—	2	6	4	10	33	22	39	215	101	—	1	3	6	9
Utah	—	4	11	—	33	—	5	15	23	44	—	0	3	—	7
Wyoming§	—	0	4	6	14	—	0	4	—	7	—	0	1	—	5
Pacific	24	52	120	250	326	347	613	815	3,895	4,004	—	3	20	20	18
Alaska	—	2	6	6	9	—	21	37	113	191	—	0	2	5	6
California	19	32	57	186	222	338	506	691	3,404	3,237	—	0	17	5	—
Hawaii	—	1	4	—	9	—	14	26	—	106	—	0	2	—	3
Oregon	—	9	20	38	62	9	19	34	141	131	—	1	5	10	7
Washington	5	8	65	20	24	—	53	86	237	339	—	0	2	—	2
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	—	—	—	0	5	1	—	—	0	0	—	—
Puerto Rico	1	1	8	4	3	9	6	14	45	32	—	0	0	—	1
U.S. Virgin Islands	—	0	0	—	—	—	3	7	—	14	—	0	0	—	—

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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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† 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 February 19, 2011, and February 20, 2010 (7th week)*

	Hepatitis (viral, acute), by type														
	A					B					C				
	Current week	Previous 52 weeks		Cum	Cum	Current week	Previous 52 weeks		Cum	Cum	Current week	Previous 52 weeks		Cum	Cum
Reporting area		Med	Max	2011	2010		Med	Max	2011	2010		Med	Max	2011	2010
United States	19	29	44	144	212	15	63	90	217	382	7	14	26	69	79
New England	—	1	5	6	21	—	1	4	2	10	—	0	4	—	9
Connecticut	—	0	3	4	7	—	0	2	—	3	—	0	4	—	5
Maine†	—	0	1	—	1	—	0	1	1	3	—	0	0	—	—
Massachusetts	—	0	5	—	13	—	0	2	—	4	—	0	1	—	4
New Hampshire	—	0	1	—	—	—	0	2	1	—	N	0	0	N	N
Rhode Island†	—	0	4	—	—	U	0	0	U	U	U	0	0	U	U
Vermont†	—	0	1	2	—	—	0	1	—	—	—	0	1	—	—
Mid. Atlantic	3	4	10	21	27	2	5	10	22	33	1	2	6	5	7
New Jersey	—	0	2	—	4	—	1	5	—	6	—	0	2	—	—
New York (Upstate)	1	1	4	4	3	1	1	7	8	6	1	1	4	4	5
New York City	—	1	7	8	12	—	1	3	4	13	—	0	1	—	—
Pennsylvania	2	1	3	9	8	1	1	5	10	8	—	0	3	1	2
E.N. Central	2	4	9	23	38	1	9	20	37	80	—	2	7	16	10
Illinois	—	1	3	1	8	—	2	6	3	14	—	0	0	—	—
Indiana	—	0	2	3	2	—	1	5	3	12	—	0	4	8	3
Michigan	—	1	5	7	8	1	2	5	12	22	—	1	6	8	6
Ohio	2	1	5	11	8	—	2	16	17	15	—	0	1	—	—
Wisconsin	—	0	2	1	12	—	1	8	2	17	—	0	2	—	1
W.N. Central	1	1	13	6	8	1	2	7	14	20	—	0	8	—	—
Iowa	—	0	3	1	4	—	0	1	—	4	—	0	0	—	—
Kansas	—	0	2	—	2	—	0	2	2	2	—	0	1	—	—
Minnesota	—	0	12	—	—	—	0	4	—	—	—	0	6	—	—
Missouri	—	0	2	2	1	1	1	3	8	10	—	0	2	—	—
Nebraska†	1	0	4	1	1	—	0	3	4	4	—	0	1	—	—
North Dakota	—	0	3	—	—	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	2	2	—	—	0	1	—	—	—	0	0	—	—
S. Atlantic	2	6	14	30	41	4	16	32	69	106	2	2	6	14	11
Delaware	—	0	1	1	2	—	0	2	—	3	U	0	0	U	U
District of Columbia	—	0	0	—	1	—	0	1	—	1	—	0	1	—	1
Florida	2	3	7	12	17	3	5	11	29	43	1	0	3	5	—
Georgia	—	1	3	6	6	—	3	7	16	30	—	0	2	—	1
Maryland†	—	0	3	4	2	—	1	6	8	4	—	0	3	3	3
North Carolina	—	1	5	2	1	1	1	16	9	10	1	1	3	4	4
South Carolina†	—	0	3	1	8	—	1	4	2	3	—	0	1	—	—
Virginia†	—	1	6	4	4	—	1	6	5	8	—	0	2	2	2
West Virginia	—	0	5	—	—	—	0	12	—	4	—	0	5	—	—
E.S. Central	1	0	5	3	5	2	8	13	41	52	1	3	8	15	17
Alabama†	—	0	2	—	2	1	1	4	6	13	—	0	1	—	1
Kentucky	—	0	5	2	1	—	2	8	17	18	1	2	6	9	15
Mississippi	—	0	1	—	—	—	0	3	1	4	U	0	0	U	U
Tennessee†	1	0	2	1	2	1	2	8	17	17	—	1	4	6	1
W.S. Central	1	2	10	4	10	3	9	31	19	32	1	2	6	10	5
Arkansas†	—	0	1	—	—	—	1	4	1	5	—	0	0	—	—
Louisiana	—	0	2	—	2	—	1	3	6	10	—	0	2	4	—
Oklahoma	—	0	4	—	—	—	2	8	2	3	—	0	6	3	1
Texas†	1	2	7	4	8	3	5	25	10	14	1	0	3	3	4
Mountain	1	2	8	11	25	—	2	8	7	18	1	1	5	4	6
Arizona	1	1	4	5	12	—	0	2	1	4	U	0	0	U	U
Colorado	—	1	2	4	7	—	0	5	—	6	—	0	2	1	2
Idaho†	—	0	2	—	2	—	0	1	1	1	1	0	2	3	1
Montana†	—	0	1	1	1	—	0	0	—	—	—	0	1	—	—
Nevada†	—	0	2	—	1	—	1	3	5	4	—	0	1	—	—
New Mexico†	—	0	1	1	1	—	0	1	—	—	—	0	2	—	2
Utah	—	0	1	—	1	—	0	1	—	3	—	0	2	—	1
Wyoming†	—	0	3	—	—	—	0	1	—	—	—	0	0	—	—
Pacific	8	5	16	40	37	2	6	20	6	31	1	1	7	5	14
Alaska	—	0	1	—	—	—	0	1	—	1	U	0	0	U	U
California	6	4	16	34	30	1	3	16	2	24	—	0	2	—	7
Hawaii	—	0	1	—	3	—	0	1	—	1	U	0	0	U	U
Oregon	—	0	2	3	2	—	1	3	3	5	—	0	3	3	7
Washington	2	0	2	3	2	1	1	5	1	—	1	0	5	2	—
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	6	1	—	—	1	6	7	6	—	0	7	3	2
Puerto Rico	—	0	2	—	2	—	0	2	—	2	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 19, 2011, and February 20, 2010 (7th week)*

Reporting area	Legionellosis					Lyme disease					Malaria				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010
United States	23	55	117	193	298	41	403	1,674	533	1,636	5	26	80	124	161
New England	1	4	15	2	14	—	126	504	26	522	—	1	5	2	8
Connecticut	—	0	6	—	3	—	47	213	—	230	—	0	1	—	—
Maine†	1	0	4	1	—	—	12	65	7	16	—	0	1	—	—
Massachusetts	—	2	10	—	7	—	41	223	—	170	—	1	4	—	8
New Hampshire	—	0	5	—	1	—	24	68	14	94	—	0	2	—	—
Rhode Island†	—	0	4	—	2	—	1	40	1	2	—	0	1	—	—
Vermont†	—	0	2	1	1	—	4	27	4	10	—	0	1	2	—
Mid. Atlantic	5	14	48	50	63	29	179	738	343	763	1	7	17	37	49
New Jersey	—	1	11	—	9	—	49	220	—	219	—	0	1	—	—
New York (Upstate)	4	5	19	18	19	18	38	200	58	81	1	1	6	5	11
New York City	—	2	17	13	13	—	1	7	—	20	—	4	14	27	28
Pennsylvania	1	6	19	19	22	11	92	387	285	443	—	1	3	5	10
E.N. Central	3	12	44	30	68	—	26	325	4	62	—	3	9	9	12
Illinois	—	2	15	—	8	—	1	18	—	3	—	0	7	—	7
Indiana	—	2	7	3	9	—	1	7	—	6	—	0	2	—	1
Michigan	—	3	20	6	9	—	1	14	1	—	—	0	4	1	2
Ohio	3	4	15	21	26	—	0	9	2	3	—	1	5	7	2
Wisconsin	—	1	5	—	16	—	21	297	1	50	—	0	1	1	—
W.N. Central	—	2	9	4	7	—	1	11	—	3	—	1	4	1	10
Iowa	—	0	2	—	—	—	0	10	—	2	—	0	2	—	2
Kansas	—	0	2	—	2	—	0	1	—	1	—	0	2	—	3
Minnesota	—	0	8	—	1	—	0	0	—	—	—	0	3	—	—
Missouri	—	1	4	3	2	—	0	1	—	—	—	0	3	—	2
Nebraska†	—	0	2	—	2	—	0	2	—	—	—	0	1	1	3
North Dakota	—	0	1	—	—	—	0	5	—	—	—	0	1	—	—
South Dakota	—	0	2	1	—	—	0	1	—	—	—	0	2	—	—
S. Atlantic	6	10	28	35	53	11	57	176	141	258	4	7	44	50	46
Delaware	—	0	3	—	3	—	10	33	35	73	—	0	1	—	1
District of Columbia	—	0	4	—	—	—	0	4	2	1	—	0	2	1	1
Florida	3	3	9	20	20	3	2	10	8	7	3	2	7	13	19
Georgia	—	1	4	1	6	—	0	2	1	1	—	1	6	9	2
Maryland†	2	2	6	5	13	6	23	105	49	118	—	1	24	10	10
North Carolina	1	1	7	5	2	—	1	9	6	5	1	0	13	5	3
South Carolina†	—	0	2	—	1	—	0	3	—	2	—	0	1	—	—
Virginia†	—	1	10	4	7	2	18	83	40	48	—	1	5	12	10
West Virginia	—	0	3	—	1	—	0	29	—	3	—	0	1	—	—
E.S. Central	1	2	10	9	16	—	0	4	—	5	—	0	3	1	3
Alabama†	—	0	2	1	2	—	0	1	—	—	—	0	1	—	1
Kentucky	1	0	4	4	5	—	0	1	—	1	—	0	1	—	2
Mississippi	—	0	3	1	2	—	0	0	—	—	—	0	2	—	—
Tennessee†	—	1	6	3	7	—	0	4	—	4	—	0	2	1	—
W.S. Central	—	3	8	6	8	—	2	9	—	1	—	1	11	3	10
Arkansas†	—	0	2	—	1	—	0	0	—	—	—	0	1	—	1
Louisiana	—	0	2	1	1	—	0	1	—	—	—	0	1	—	1
Oklahoma	—	0	3	1	—	—	0	0	—	—	—	0	1	1	1
Texas†	—	2	7	4	6	—	2	9	—	1	—	1	10	2	7
Mountain	—	3	10	7	21	—	0	3	1	2	—	1	4	8	8
Arizona	—	1	7	4	5	—	0	1	—	—	—	0	3	3	1
Colorado	—	0	2	1	7	—	0	1	—	—	—	0	3	2	2
Idaho†	—	0	1	1	—	—	0	2	—	1	—	0	1	—	—
Montana†	—	0	1	—	1	—	0	1	—	—	—	0	1	—	—
Nevada†	—	0	2	1	4	—	0	1	—	—	—	0	2	2	2
New Mexico†	—	0	2	—	1	—	0	2	1	—	—	0	1	1	—
Utah	—	0	2	—	3	—	0	1	—	1	—	0	1	—	3
Wyoming†	—	0	2	—	—	—	0	0	—	—	—	0	0	—	—
Pacific	7	5	15	50	48	1	4	10	18	20	—	3	10	13	15
Alaska	—	0	2	—	—	—	0	1	—	1	—	0	2	2	—
California	6	4	14	44	48	1	3	8	16	13	—	2	9	6	12
Hawaii	—	0	1	—	—	N	0	0	N	N	—	0	1	—	—
Oregon	—	0	3	1	—	—	1	4	2	6	—	0	3	3	1
Washington	1	0	5	5	—	—	0	3	—	—	—	0	5	2	2
Territories															
American Samoa	—	0	0	—	—	N	0	0	N	N	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	N	0	0	N	N	—	0	1	—	3
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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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).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 19, 2011, and February 20, 2010 (7th week)*

Reporting area	Meningococcal disease, invasive† All serogroups					Mumps					Pertussis				
	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	13	15	31	100	126	—	17	221	25	529	106	518	1,234	1,461	1,351
New England	—	0	3	1	1	—	0	2	—	11	—	9	24	8	27
Connecticut	—	0	1	1	—	—	0	2	—	6	—	1	8	—	5
Maine§	—	0	1	—	—	—	0	1	—	1	—	1	5	4	1
Massachusetts	—	0	2	—	1	—	0	2	—	4	—	5	13	—	17
New Hampshire	—	0	0	—	—	—	0	1	—	—	—	0	2	4	2
Rhode Island§	—	0	0	—	—	—	0	0	—	—	—	0	9	—	—
Vermont§	—	0	1	—	—	—	0	0	—	—	—	0	4	—	2
Mid. Atlantic	1	1	5	12	14	—	7	209	1	490	17	37	123	174	74
New Jersey	—	0	2	—	3	—	2	16	1	121	—	2	9	1	17
New York (Upstate)	1	0	2	2	2	—	1	75	—	339	7	11	85	60	16
New York City	—	0	3	6	5	—	0	201	—	30	—	0	12	—	—
Pennsylvania	—	0	2	4	4	—	0	16	—	—	10	15	70	113	41
E.N. Central	—	2	9	9	26	—	1	7	7	11	25	112	193	440	407
Illinois	—	0	3	1	4	—	0	2	1	3	—	22	51	48	52
Indiana	—	0	2	2	9	—	0	1	—	2	—	12	26	14	35
Michigan	—	0	4	1	2	—	0	2	1	4	6	29	57	128	115
Ohio	—	1	2	4	5	—	0	5	5	—	17	34	80	208	153
Wisconsin	—	0	3	1	6	—	0	2	—	2	2	9	22	42	52
W.N. Central	1	1	5	10	6	—	1	14	6	3	9	35	193	87	120
Iowa	—	0	3	1	1	—	0	7	—	1	—	12	34	13	24
Kansas	—	0	2	1	1	—	0	1	1	1	—	3	9	5	25
Minnesota	—	0	1	—	—	—	0	1	—	—	—	0	144	—	—
Missouri	1	0	4	5	3	—	0	3	4	1	9	8	44	49	52
Nebraska§	—	0	2	3	1	—	0	10	1	—	—	4	13	16	10
North Dakota	—	0	1	—	—	—	0	1	—	—	—	0	30	3	—
South Dakota	—	0	0	—	—	—	0	1	—	—	—	0	2	1	9
S. Atlantic	3	2	7	15	29	—	0	5	—	8	10	35	78	221	172
Delaware	—	0	1	—	1	—	0	0	—	—	—	0	4	3	—
District of Columbia	—	0	0	—	—	—	0	1	—	—	—	0	2	1	1
Florida	2	1	5	6	12	—	0	3	—	1	4	6	28	38	25
Georgia	—	0	2	—	3	—	0	1	—	—	2	5	18	34	25
Maryland§	—	0	1	1	—	—	0	1	—	3	1	3	6	15	26
North Carolina	1	0	2	4	4	—	0	2	—	—	3	2	34	61	61
South Carolina§	—	0	1	2	2	—	0	2	—	1	—	6	25	23	21
Virginia§	—	0	2	2	6	—	0	2	—	2	—	6	39	46	12
West Virginia	—	0	1	—	1	—	0	1	—	1	—	1	21	—	1
E.S. Central	1	1	3	6	4	—	0	2	1	—	2	15	35	64	99
Alabama§	—	0	1	5	1	—	0	2	1	—	—	4	8	12	25
Kentucky	—	0	2	—	2	—	0	1	—	—	1	5	16	34	36
Mississippi	—	0	1	—	1	—	0	0	—	—	—	1	8	—	9
Tennessee§	1	0	2	1	—	—	0	1	—	—	1	4	11	18	29
W.S. Central	—	1	9	5	15	—	2	12	7	3	11	59	189	73	224
Arkansas§	—	0	1	1	2	—	0	1	—	—	—	2	14	—	13
Louisiana	—	0	2	2	6	—	0	2	—	—	1	1	3	3	6
Oklahoma	—	0	7	1	3	—	0	1	—	—	—	1	63	2	—
Texas§	—	1	7	1	4	—	1	11	7	3	10	48	121	68	205
Mountain	1	1	6	5	5	—	0	4	1	1	18	32	106	237	141
Arizona	1	0	2	3	2	—	0	1	—	1	1	9	28	49	45
Colorado	—	0	4	—	1	—	0	1	—	—	15	8	76	128	14
Idaho§	—	0	1	2	—	—	0	1	—	—	1	2	15	18	32
Montana§	—	0	1	—	—	—	0	0	—	—	1	1	16	21	4
Nevada§	—	0	1	—	1	—	0	1	—	—	—	0	7	3	1
New Mexico§	—	0	1	—	1	—	0	2	1	—	—	1	11	2	22
Utah	—	0	1	—	—	—	0	1	—	—	—	5	13	16	23
Wyoming§	—	0	1	—	—	—	0	1	—	—	—	0	2	—	—
Pacific	6	3	14	37	26	—	0	18	2	2	14	124	579	157	87
Alaska	—	0	1	—	—	—	0	1	—	—	—	0	6	12	3
California	6	2	10	31	17	—	0	18	—	—	7	108	450	103	29
Hawaii	—	0	1	—	—	—	0	1	—	1	—	1	6	—	9
Oregon	—	0	2	4	8	—	0	1	2	1	—	6	15	13	42
Washington	—	0	4	2	1	—	0	2	—	—	7	7	121	29	4
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	1	15	4	—	—	0	3	4	—
Puerto Rico	—	0	0	—	—	—	0	1	—	—	—	0	1	1	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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† Data for meningococcal disease, invasive caused by serogroups A, C, Y, and 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 February 19, 2011, and February 20, 2010 (7th week)*

Reporting area	Rabies, animal					Salmonellosis					Shiga toxin-producing *E. coli* (STEC)[†]				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010
United States	19	60	143	148	333	284	918	1,746	2,572	4,093	21	92	214	269	322
New England	1	4	13	9	23	4	31	68	51	629	—	2	13	4	70
Connecticut	—	0	9	—	5	—	0	25	25	480	—	0	2	2	57
Maine[§]	1	1	4	3	8	4	2	7	12	8	—	0	3	—	—
Massachusetts	—	0	0	—	—	—	23	52	—	109	—	1	9	—	10
New Hampshire	—	0	5	1	2	—	3	12	11	15	—	0	2	2	3
Rhode Island[§]	—	0	4	—	—	—	1	17	—	15	—	0	1	—	—
Vermont[§]	—	1	3	5	8	—	2	5	3	2	—	0	2	—	—
Mid. Atlantic	3	19	41	30	91	19	95	218	243	443	1	9	32	31	31
New Jersey	—	0	0	—	—	—	16	57	8	85	—	1	9	—	6
New York (Upstate)	3	9	19	30	41	10	25	63	65	86	1	4	13	12	10
New York City	—	1	12	—	22	—	23	56	70	121	—	1	7	2	7
Pennsylvania	—	8	24	—	28	9	31	81	100	151	—	3	13	17	8
E.N. Central	—	2	27	4	5	11	91	252	231	431	4	13	43	37	48
Illinois	—	1	11	3	1	—	33	123	53	148	—	2	9	1	13
Indiana	—	0	0	—	—	—	13	62	12	54	—	2	10	8	3
Michigan	—	1	5	1	2	2	16	49	50	79	2	2	16	13	12
Ohio	—	0	12	—	2	9	24	47	103	108	2	2	11	12	4
Wisconsin	—	0	0	—	—	—	10	47	13	42	—	3	17	3	16
W.N. Central	2	4	14	3	18	13	45	97	134	193	1	11	39	17	38
Iowa	—	0	3	—	—	2	9	34	34	19	—	2	16	3	5
Kansas	—	1	4	1	9	1	7	18	19	28	—	1	5	3	4
Minnesota	—	0	4	—	5	—	0	32	—	45	—	0	7	—	10
Missouri	—	1	6	—	1	9	13	44	64	65	1	4	27	6	13
Nebraska[§]	2	1	4	2	3	1	4	13	12	19	—	1	6	5	4
North Dakota	—	0	3	—	—	—	0	13	—	2	—	0	10	—	—
South Dakota	—	0	0	—	—	—	2	17	5	15	—	0	4	—	2
S. Atlantic	13	20	36	92	168	130	262	617	899	1,185	8	14	31	89	45
Delaware	—	0	0	—	—	—	3	11	12	7	—	0	2	—	—
District of Columbia	—	0	0	—	—	—	1	6	—	6	—	0	1	1	1
Florida	3	0	5	9	96	58	108	226	382	514	5	5	23	38	14
Georgia	—	0	0	—	—	39	45	133	173	208	—	2	16	7	7
Maryland[§]	—	7	14	17	32	7	18	56	67	78	2	2	9	16	8
North Carolina	—	0	0	—	—	13	29	240	123	205	1	2	10	14	1
South Carolina[§]	—	0	0	—	—	5	25	99	58	65	—	0	2	—	1
Virginia[§]	10	12	25	66	32	8	20	66	84	89	—	3	9	13	13
West Virginia	—	1	7	—	8	—	2	13	—	13	—	0	3	—	—
E.S. Central	—	3	7	6	10	9	55	177	196	199	—	5	22	16	10
Alabama[§]	—	1	4	5	—	—	19	52	65	60	—	1	4	2	5
Kentucky	—	0	4	1	—	3	11	32	32	41	—	1	6	4	1
Mississippi	—	0	1	—	—	—	18	67	30	34	—	0	12	—	1
Tennessee[§]	—	1	4	—	10	6	17	53	69	64	—	2	7	10	3
W.S. Central	—	0	30	—	—	7	123	290	183	236	2	6	67	15	14
Arkansas[§]	—	0	7	—	—	3	12	43	37	17	—	0	5	1	4
Louisiana	—	0	0	—	—	—	20	49	41	75	—	0	2	—	3
Oklahoma	—	0	30	—	—	3	12	39	26	27	—	0	24	4	1
Texas[§]	—	0	0	—	—	1	78	242	79	117	2	4	43	10	6
Mountain	—	1	7	1	5	14	49	108	205	296	—	11	34	15	35
Arizona	—	0	0	—	—	—	16	42	63	111	—	1	13	2	6
Colorado	—	0	0	—	—	10	10	24	63	64	—	3	21	5	9
Idaho[§]	—	0	2	—	—	2	3	9	25	20	—	2	7	4	6
Montana[§]	—	0	3	1	—	2	1	5	6	19	—	1	5	1	2
Nevada[§]	—	0	2	—	—	—	5	22	13	19	—	0	5	1	1
New Mexico[§]	—	0	2	—	2	—	6	19	21	31	—	0	6	2	6
Utah	—	0	2	—	—	—	5	17	11	25	—	1	7	—	5
Wyoming[§]	—	0	4	—	3	—	1	8	3	7	—	0	3	—	—
Pacific	—	2	12	3	13	77	116	268	430	481	5	12	46	45	31
Alaska	—	0	2	1	4	—	1	5	8	14	—	0	1	—	1
California	—	1	12	—	5	69	79	217	368	366	1	6	28	35	22
Hawaii	—	0	0	—	—	—	6	14	—	33	—	0	4	—	3
Oregon	—	0	2	2	4	—	8	48	31	48	—	2	12	4	4
Washington	—	0	0	—	—	8	14	71	23	20	4	3	17	6	1
Territories															
American Samoa	N	0	0	N	N	—	0	1	—	1	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	3	3	—	—	0	0	—	—
Puerto Rico	2	1	3	4	7	—	9	21	5	71	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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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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† Includes E. coli O157:H7; Shiga toxin-positive, serogroup non-O157; and Shiga toxin-positive, not serogrouped.
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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 19, 2011, and February 20, 2010 (7th week)*

	Shigellosis					Spotted Fever Rickettsiosis (including RMSF)†									
						Confirmed					Probable				
	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum
Reporting area	week	Med	Max	2011	2010	week	Med	Max	2011	2010	week	Med	Max	2011	2010
United States	88	275	453	903	1,566	—	2	11	8	5	2	24	91	30	27
New England	—	4	17	4	92	—	0	0	—	—	—	0	1	—	—
Connecticut	—	0	2	2	63	—	0	0	—	—	—	0	0	—	—
Maine§	—	0	1	1	1	—	0	0	—	—	—	0	1	—	—
Massachusetts	—	3	16	—	24	—	0	0	—	—	—	0	0	—	—
New Hampshire	—	0	2	—	2	—	0	0	—	—	—	0	1	—	—
Rhode Island§	—	0	2	—	1	—	0	0	—	—	—	0	1	—	—
Vermont§	—	0	1	1	1	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	2	29	69	56	277	—	0	1	—	—	—	1	4	2	—
New Jersey	—	5	16	5	41	—	0	0	—	—	—	0	0	—	—
New York (Upstate)	2	3	15	17	20	—	0	1	—	—	—	0	3	—	—
New York City	—	5	14	24	45	—	0	1	—	—	—	0	4	2	—
Pennsylvania	—	11	55	10	171	—	0	0	—	—	—	0	3	—	—
E.N. Central	4	25	239	73	195	—	0	1	—	—	—	1	10	2	1
Illinois	—	8	229	20	79	—	0	1	—	—	—	0	5	—	—
Indiana§	—	1	4	6	5	—	0	1	—	—	—	0	5	—	1
Michigan	1	5	10	14	28	—	0	0	—	—	—	0	1	1	—
Ohio	3	5	18	33	46	—	0	0	—	—	—	0	2	1	—
Wisconsin	—	3	21	—	37	—	0	0	—	—	—	0	1	—	—
W.N. Central	1	28	81	59	361	—	0	4	—	—	—	4	21	2	3
Iowa	—	1	4	4	7	—	0	0	—	—	—	0	1	—	—
Kansas§	—	5	13	13	18	—	0	1	—	—	—	0	0	—	—
Minnesota	—	0	3	—	5	—	0	0	—	—	—	0	0	—	—
Missouri	1	18	66	40	326	—	0	4	—	—	—	4	20	2	3
Nebraska§	—	1	10	1	3	—	0	1	—	—	—	0	1	—	—
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	1	—	—
South Dakota	—	0	2	1	2	—	0	0	—	—	—	0	0	—	—
S. Atlantic	48	53	134	331	211	—	1	9	4	4	2	7	60	14	21
Delaware§	—	0	3	—	17	—	0	1	—	—	—	0	3	—	—
District of Columbia	—	0	4	2	3	—	0	1	—	—	—	0	0	—	—
Florida§	30	25	53	211	68	—	0	1	1	—	—	0	2	2	—
Georgia	11	14	40	60	74	—	1	6	1	4	—	0	0	—	—
Maryland§	1	2	8	12	9	—	0	1	1	—	—	0	5	1	1
North Carolina	6	3	36	32	19	—	0	3	1	—	1	2	48	7	18
South Carolina§	—	1	5	3	11	—	0	1	—	—	—	0	3	1	2
Virginia§	—	3	9	11	10	—	0	2	—	—	1	2	12	3	—
West Virginia	—	0	66	—	—	—	0	0	—	—	—	0	0	—	—
E.S. Central	8	14	40	50	57	—	0	3	—	—	—	5	29	3	—
Alabama§	5	5	14	26	9	—	0	1	—	—	—	1	8	2	—
Kentucky	1	3	28	5	25	—	0	2	—	—	—	0	0	—	—
Mississippi	—	1	4	5	2	—	0	0	—	—	—	0	3	—	—
Tennessee§	2	5	14	14	21	—	0	2	—	—	—	4	20	1	—
W.S. Central	12	53	115	133	170	—	0	3	—	—	—	1	18	—	1
Arkansas§	1	1	6	4	7	—	0	2	—	—	—	0	17	—	—
Louisiana	—	6	13	11	17	—	0	0	—	—	—	0	1	—	—
Oklahoma	2	5	13	9	24	—	0	3	—	—	—	0	11	—	—
Texas§	9	43	98	109	122	—	0	1	—	—	—	0	3	—	1
Mountain	2	15	32	69	81	—	0	5	4	—	—	0	3	7	1
Arizona	—	8	18	32	49	—	0	5	4	—	—	0	3	7	—
Colorado§	2	2	8	18	16	—	0	1	—	—	—	0	1	—	—
Idaho§	—	0	3	3	1	—	0	0	—	—	—	0	1	—	—
Montana§	—	0	3	4	1	—	0	1	—	—	—	0	1	—	—
Nevada§	—	0	6	1	2	—	0	0	—	—	—	0	0	—	—
New Mexico§	—	3	10	10	9	—	0	0	—	—	—	0	0	—	1
Utah	—	1	4	1	3	—	0	0	—	—	—	0	1	—	—
Wyoming§	—	0	0	—	—	—	0	0	—	—	—	0	1	—	—
Pacific	11	22	71	128	122	—	0	2	—	1	—	0	0	—	—
Alaska	—	0	1	—	—	N	0	0	N	N	N	0	0	N	N
California	10	18	57	117	107	—	0	2	—	1	—	0	0	—	—
Hawaii	—	1	4	—	6	N	0	0	N	N	N	0	0	N	N
Oregon	—	1	4	6	6	—	0	1	—	—	—	0	0	—	—
Washington	1	2	17	5	3	—	0	0	—	—	—	0	0	—	—
Territories															
American Samoa	—	1	1	1	—	N	0	0	N	N	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	—	—	N	0	0	N	N	N	0	0	N	N
Puerto Rico	—	0	1	—	—	N	0	0	N	N	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.
* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† 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 February 19, 2011, and February 20, 2010 (7th week)*

Reporting area	*Streptococcus pneumoniae*,† invasive disease — All ages: Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Age <5: Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010	Syphilis, primary and secondary: Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2011	Cum 2010
United States	183	279	689	2,075	2,403	14	33	84	153	381	107	246	328	1,000	1,582
New England	1	9	99	30	83	—	1	14	—	17	7	9	20	39	52
Connecticut	—	0	91	—	—	—	0	12	—	—	2	1	8	5	7
Maine§	1	2	13	25	19	—	0	1	—	3	—	0	3	—	6
Massachusetts	—	1	5	—	18	—	0	4	—	12	2	5	15	22	30
New Hampshire	—	0	7	—	29	—	0	1	—	2	—	0	2	3	2
Rhode Island§	—	0	36	1	—	—	0	3	—	—	2	1	4	8	5
Vermont§	—	1	6	4	17	—	0	1	—	—	1	0	2	1	2
Mid. Atlantic	19	30	57	252	176	5	7	19	20	56	11	32	45	120	215
New Jersey	—	1	8	7	17	—	1	5	5	10	—	4	12	21	24
New York (Upstate)	3	3	11	15	30	3	2	9	8	22	4	2	12	18	7
New York City	4	14	32	121	51	—	2	14	—	9	—	18	31	36	131
Pennsylvania	12	11	22	109	78	2	1	5	7	15	7	7	16	45	53
E.N. Central	34	59	100	395	529	2	6	18	31	68	3	27	49	59	228
Illinois	—	2	7	10	18	—	2	5	10	16	—	7	26	6	113
Indiana	—	8	24	23	114	—	0	6	—	12	—	3	14	11	3
Michigan	3	13	29	78	111	—	1	6	6	15	—	4	9	11	46
Ohio	27	25	45	226	211	2	2	6	12	13	1	9	19	28	59
Wisconsin	4	7	22	58	75	—	0	4	3	12	2	1	3	3	7
W.N. Central	13	10	61	74	109	2	1	12	10	24	—	6	18	27	32
Iowa	—	0	0	—	—	—	0	0	—	—	—	0	3	—	2
Kansas	1	2	7	16	11	1	0	2	1	3	—	0	3	1	1
Minnesota	—	0	46	—	38	—	0	8	—	9	—	3	9	15	5
Missouri	4	2	10	33	27	1	0	4	8	9	—	2	9	11	23
Nebraska§	8	2	9	25	30	—	0	2	1	2	—	0	2	—	1
North Dakota	—	0	11	—	—	—	0	1	—	—	—	0	0	—	—
South Dakota	—	0	3	—	3	—	0	2	—	1	—	0	1	—	—
S. Atlantic	66	59	144	606	620	5	8	27	45	93	36	58	103	276	325
Delaware	3	1	4	16	3	—	0	1	—	—	—	0	4	3	—
District of Columbia	—	0	3	2	6	—	0	2	—	3	—	2	20	9	15
Florida	44	26	89	329	247	5	3	18	23	24	1	22	44	106	125
Georgia	8	11	26	85	122	—	2	9	11	33	11	11	34	33	30
Maryland§	6	8	32	91	97	—	1	6	4	9	—	6	15	32	15
North Carolina	—	0	0	—	—	—	0	0	—	—	14	5	19	40	80
South Carolina§	5	7	25	78	113	—	1	4	2	12	—	3	10	24	21
Virginia§	—	1	4	5	11	—	1	4	5	9	10	4	22	29	36
West Virginia	—	1	9	—	21	—	0	4	—	3	—	0	2	—	3
E.S. Central	16	25	48	185	226	—	2	7	14	23	10	16	39	64	100
Alabama§	—	0	0	—	—	—	0	0	—	—	—	4	11	20	38
Kentucky	2	4	16	35	12	—	0	3	4	2	5	2	12	21	12
Mississippi	—	1	8	1	19	—	0	2	—	5	4	4	16	9	14
Tennessee§	14	20	43	149	195	—	2	6	10	16	1	5	17	14	36
W.S. Central	6	35	289	175	225	—	5	22	10	43	31	36	68	184	263
Arkansas§	1	3	23	29	18	—	0	3	1	4	5	3	10	16	39
Louisiana	2	2	7	29	26	—	0	2	—	9	2	8	33	21	59
Oklahoma	—	1	4	5	12	—	1	4	5	12	2	2	6	7	9
Texas§	3	27	260	112	169	—	3	17	4	18	22	23	33	140	156
Mountain	24	35	74	311	394	—	4	12	21	51	4	10	26	36	60
Arizona	8	13	36	159	205	—	1	7	10	24	1	3	8	3	21
Colorado	12	11	22	76	93	—	1	4	4	10	1	2	8	11	21
Idaho§	—	0	2	2	2	—	0	2	1	1	—	0	2	2	1
Montana§	—	0	2	1	2	—	0	1	—	—	—	0	2	1	—
Nevada§	—	2	4	14	18	—	0	1	2	2	—	2	9	11	8
New Mexico§	4	3	12	42	30	—	0	4	2	6	2	1	4	6	6
Utah	—	3	8	12	41	—	0	3	2	8	—	1	5	2	3
Wyoming§	—	0	15	5	3	—	0	1	—	—	—	0	0	—	—
Pacific	4	5	23	47	41	—	0	7	2	6	5	45	63	195	307
Alaska	—	2	9	20	22	—	0	5	1	4	—	0	1	—	—
California	4	3	22	27	19	—	0	5	1	2	5	38	52	176	260
Hawaii	—	0	3	—	—	—	0	0	—	—	—	0	5	—	5
Oregon	—	0	0	—	—	—	0	0	—	—	—	1	7	6	7
Washington	—	0	0	—	—	—	0	0	—	—	—	4	11	13	35
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—	3	4	15	24	32
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 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Includes drug resistant and susceptible cases of invasive Streptococcus pneumoniae disease among children <5 years and among all ages. Case definition: Isolation of S. pneumoniae from a normally sterile body site (e.g., blood or cerebrospinal fluid).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 19, 2011, and February 20, 2010 (7th week)*

	Varicella (chickenpox)					West Nile virus disease†									
						Neuroinvasive					Nonneuroinvasive§				
	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum	Current	Previous 52 weeks		Cum	Cum
Reporting area	week	Med	Max	2011	2010	week	Med	Max	2011	2010	week	Med	Max	2011	2010
United States	123	261	563	1,261	2,051	—	1	71	—	1	—	1	53	—	—
New England	—	20	45	60	126	—	0	3	—	—	—	0	2	—	—
Connecticut	—	5	20	—	27	—	0	2	—	—	—	0	2	—	—
Maine¶	—	4	16	28	39	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	4	12	—	26	—	0	2	—	—	—	0	1	—	—
New Hampshire	—	2	9	9	22	—	0	1	—	—	—	0	0	—	—
Rhode Island¶	—	0	3	1	1	—	0	0	—	—	—	0	0	—	—
Vermont¶	—	0	10	22	11	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	8	30	62	98	238	—	0	19	—	—	—	0	13	—	—
New Jersey	—	7	30	7	73	—	0	3	—	—	—	0	6	—	—
New York (Upstate)	N	0	0	N	N	—	0	9	—	—	—	0	7	—	—
New York City	—	0	1	—	—	—	0	7	—	—	—	0	4	—	—
Pennsylvania	8	20	41	91	165	—	0	3	—	—	—	0	3	—	—
E.N. Central	33	93	176	447	794	—	0	15	—	—	—	0	8	—	—
Illinois	1	19	45	80	194	—	0	10	—	—	—	0	5	—	—
Indiana¶	—	5	30	26	87	—	0	2	—	—	—	0	2	—	—
Michigan	11	29	62	147	259	—	0	6	—	—	—	0	1	—	—
Ohio	21	26	58	194	203	—	0	1	—	—	—	0	1	—	—
Wisconsin	—	6	22	—	51	—	0	0	—	—	—	0	1	—	—
W.N. Central	3	15	32	35	114	—	0	7	—	—	—	0	11	—	—
Iowa	N	0	0	N	N	—	0	1	—	—	—	0	2	—	—
Kansas¶	3	3	22	23	46	—	0	1	—	—	—	0	3	—	—
Minnesota	—	0	0	—	—	—	0	1	—	—	—	0	3	—	—
Missouri	—	7	23	10	59	—	0	1	—	—	—	0	0	—	—
Nebraska¶	N	0	0	N	N	—	0	3	—	—	—	0	7	—	—
North Dakota	—	0	10	—	7	—	0	2	—	—	—	0	2	—	—
South Dakota	—	1	7	2	2	—	0	2	—	—	—	0	3	—	—
S. Atlantic	15	35	100	159	245	—	0	4	—	—	—	0	4	—	—
Delaware¶	—	0	3	1	—	—	0	0	—	—	—	0	0	—	—
District of Columbia	—	0	4	2	—	—	0	1	—	—	—	0	1	—	—
Florida¶	15	16	57	126	125	—	0	3	—	—	—	0	1	—	—
Georgia	N	0	0	N	N	—	0	1	—	—	—	0	3	—	—
Maryland¶	N	0	0	N	N	—	0	3	—	—	—	0	2	—	—
North Carolina	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
South Carolina¶	—	0	35	—	7	—	0	1	—	—	—	0	0	—	—
Virginia¶	—	10	29	30	48	—	0	1	—	—	—	0	1	—	—
West Virginia	—	7	26	—	65	—	0	0	—	—	—	0	0	—	—
E.S. Central	3	5	22	28	26	—	0	1	—	1	—	0	3	—	—
Alabama¶	3	5	22	28	26	—	0	1	—	—	—	0	1	—	—
Kentucky	N	0	0	N	N	—	0	1	—	—	—	0	1	—	—
Mississippi	—	0	2	—	—	—	0	1	—	1	—	0	2	—	—
Tennessee¶	N	0	0	N	N	—	0	1	—	—	—	0	2	—	—
W.S. Central	39	43	177	224	287	—	0	16	—	—	—	0	3	—	—
Arkansas¶	5	2	32	12	16	—	0	3	—	—	—	0	1	—	—
Louisiana	—	1	4	5	14	—	0	3	—	—	—	0	1	—	—
Oklahoma	N	0	0	N	N	—	0	1	—	—	—	0	0	—	—
Texas¶	34	39	171	207	257	—	0	15	—	—	—	0	2	—	—
Mountain	9	19	48	177	214	—	0	18	—	—	—	0	15	—	—
Arizona	—	0	0	—	—	—	0	13	—	—	—	0	9	—	—
Colorado¶	6	8	31	86	75	—	0	5	—	—	—	0	11	—	—
Idaho¶	N	0	0	N	N	—	0	0	—	—	—	0	1	—	—
Montana¶	3	3	28	64	36	—	0	0	—	—	—	0	0	—	—
Nevada¶	N	0	0	N	N	—	0	0	—	—	—	0	1	—	—
New Mexico¶	—	1	8	6	17	—	0	5	—	—	—	0	2	—	—
Utah	—	4	17	21	85	—	0	1	—	—	—	0	1	—	—
Wyoming¶	—	0	3	—	1	—	0	1	—	—	—	0	1	—	—
Pacific	13	2	9	33	7	—	0	8	—	—	—	0	6	—	—
Alaska	—	1	5	10	4	—	0	0	—	—	—	0	0	—	—
California	13	0	9	23	2	—	0	8	—	—	—	0	6	—	—
Hawaii	—	0	7	—	1	—	0	0	—	—	—	0	0	—	—
Oregon	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
Washington	N	0	0	N	N	—	0	1	—	—	—	0	1	—	—
Territories															
American Samoa	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	2	1	1	—	0	0	—	—	—	0	0	—	—
Puerto Rico	4	9	30	29	50	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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† 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/ncphi/disss/nndss/phs/infdis.htm.
¶ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE III. Deaths in 122 U.S. cities,* week ending February 19, 2011 (7th week)

Reporting area	All causes, by age (years)						P&I†
	All Ages	≥65	45–64	25–44	1–24	<1	Total
New England	614	445	123	30	9	7	68
Boston, MA	132	87	28	15	1	1	20
Bridgeport, CT	26	20	6	—	—	—	5
Cambridge, MA	17	14	1	1	1	—	1
Fall River, MA	29	24	5	—	—	—	3
Hartford, CT	84	60	18	3	2	1	10
Lowell, MA	26	21	4	1	—	—	3
Lynn, MA	11	8	2	1	—	—	2
New Bedford, MA	26	20	4	2	—	—	2
New Haven, CT	41	27	8	3	1	2	2
Providence, RI	73	52	18	2	1	—	5
Somerville, MA	3	1	2	—	—	—	—
Springfield, MA	45	34	8	—	1	2	2
Waterbury, CT	34	28	3	1	1	1	5
Worcester, MA	67	49	16	1	1	—	8
Mid. Atlantic	2,051	1,459	437	103	30	22	143
Albany, NY	44	26	14	2	2	—	2
Allentown, PA	25	17	6	2	—	—	—
Buffalo, NY	92	70	15	3	2	2	12
Camden, NJ	53	38	11	2	—	2	2
Elizabeth, NJ	19	16	3	—	—	—	1
Erie, PA	63	55	5	3	—	—	5
Jersey City, NJ	25	19	6	—	—	—	2
New York City, NY	1,118	814	231	57	7	9	76
Newark, NJ	42	20	13	7	2	—	1
Paterson, NJ	28	18	9	—	1	—	2
Philadelphia, PA	202	120	56	13	10	3	9
Pittsburgh, PA§	39	26	12	1	—	—	5
Reading, PA	34	27	5	2	—	—	5
Rochester, NY	69	47	14	3	3	2	5
Schenectady, NY	22	14	5	3	—	—	2
Scranton, PA	25	20	3	2	—	—	2
Syracuse, NY	79	63	9	—	3	4	6
Trenton, NJ	29	19	7	3	—	—	—
Utica, NY	9	7	2	—	—	—	1
Yonkers, NY	34	23	11	—	—	—	5
E.N. Central	2,277	1,516	561	132	41	27	184
Akron, OH	45	32	8	1	2	2	2
Canton, OH	44	35	8	1	—	—	7
Chicago, IL	275	176	70	21	8	—	26
Cincinnati, OH	93	59	18	4	5	7	9
Cleveland, OH	284	199	64	16	2	3	20
Columbus, OH	293	198	68	18	6	3	21
Dayton, OH	136	93	31	8	3	1	12
Detroit, MI	141	73	49	15	3	1	9
Evansville, IN	36	26	8	—	2	—	4
Fort Wayne, IN	71	52	15	2	1	1	3
Gary, IN	21	11	7	3	—	—	1
Grand Rapids, MI	62	41	14	6	1	—	7
Indianapolis, IN	269	178	63	20	3	5	23
Lansing, MI	56	38	16	—	2	—	6
Milwaukee, WI	133	81	44	6	1	1	4
Peoria, IL	60	40	15	3	—	2	5
Rockford, IL	62	44	15	3	—	—	3
South Bend, IN	50	42	5	2	1	—	5
Toledo, OH	95	58	33	2	1	1	11
Youngstown, OH	51	40	10	1	—	—	6
W.N. Central	761	510	182	30	15	24	60
Des Moines, IA	64	50	10	3	—	1	6
Duluth, MN	24	19	4	—	1	—	4
Kansas City, KS	52	34	16	2	—	—	6
Kansas City, MO	114	76	30	1	2	5	8
Lincoln, NE	80	57	16	5	—	2	5
Minneapolis, MN	63	44	14	3	—	2	6
Omaha, NE	85	63	14	3	2	3	8
St. Louis, MO	134	59	50	10	5	10	5
St. Paul, MN	59	44	12	1	2	—	8
Wichita, KS	86	64	16	2	3	1	4
S. Atlantic	1,315	814	374	73	30	23	109
Atlanta, GA	172	102	46	14	6	4	9
Baltimore, MD	150	89	48	9	2	2	14
Charlotte, NC	103	60	35	5	2	1	8
Jacksonville, FL	187	113	59	9	5	1	15
Miami, FL	123	88	27	4	4	—	10
Norfolk, VA	56	31	19	4	—	2	3
Richmond, VA	73	36	28	2	3	3	4
Savannah, GA	69	46	18	1	2	2	7
St. Petersburg, FL	51	31	16	3	—	1	7
Tampa, FL	217	145	50	15	2	5	17
Washington, D.C.	110	71	26	7	4	2	15
Wilmington, DE	4	2	2	—	—	—	—
E.S. Central	1,153	782	254	73	22	22	103
Birmingham, AL	240	158	57	12	6	7	30
Chattanooga, TN	123	95	16	7	4	1	5
Knoxville, TN	110	76	28	6	—	—	10
Lexington, KY	83	52	21	7	1	2	9
Memphis, TN	218	142	52	14	5	5	17
Mobile, AL	174	121	32	14	4	3	14
Montgomery, AL	51	43	5	3	—	—	6
Nashville, TN	154	95	43	10	2	4	12
W.S. Central	1,296	866	289	80	35	25	87
Austin, TX	118	83	27	4	2	2	4
Baton Rouge, LA	77	42	10	13	12	—	—
Corpus Christi, TX	89	58	24	5	2	—	7
Dallas, TX	210	123	52	18	6	10	18
El Paso, TX	45	35	7	2	1	—	1
Fort Worth, TX	U	U	U	U	U	U	U
Houston, TX	100	61	26	3	1	9	5
Little Rock, AR	81	52	21	5	1	2	3
New Orleans, LA	U	U	U	U	U	U	U
San Antonio, TX	287	199	66	14	6	2	24
Shreveport, LA	106	70	27	8	1	—	8
Tulsa, OK	183	143	29	8	3	—	17
Mountain	990	694	205	61	13	16	70
Albuquerque, NM	136	105	21	8	1	1	14
Boise, ID	60	48	7	3	1	1	4
Colorado Springs, CO	78	59	14	3	—	2	4
Denver, CO	84	56	22	4	1	1	6
Las Vegas, NV	273	168	73	24	3	5	20
Ogden, UT	35	26	4	3	1	—	5
Phoenix, AZ	U	U	U	U	U	U	U
Pueblo, CO	42	33	8	1	—	—	5
Salt Lake City, UT	119	77	27	4	5	6	7
Tucson, AZ	163	122	29	11	1	—	5
Pacific	1,810	1,241	416	85	28	40	188
Berkeley, CA	8	8	—	—	—	—	1
Fresno, CA	151	102	32	7	3	7	18
Glendale, CA	44	36	7	1	—	—	11
Honolulu, HI	62	45	13	2	1	1	8
Long Beach, CA	78	50	21	4	2	1	15
Los Angeles, CA	282	178	75	18	6	5	25
Pasadena, CA	31	26	3	1	1	—	5
Portland, OR	101	70	22	4	3	2	7
Sacramento, CA	219	136	54	19	4	6	17
San Diego, CA	167	115	40	6	1	5	14
San Francisco, CA	130	93	23	8	4	2	16
San Jose, CA	219	153	54	7	1	4	24
Santa Cruz, CA	42	32	9	1	—	—	4
Seattle, WA	105	74	25	1	1	4	8
Spokane, WA	68	48	14	4	—	2	7
Tacoma, WA	103	75	24	2	1	1	8
Total¶	**12,267**	**8,327**	**2,841**	**667**	**223**	**206**	**1,012**

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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