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Rapid Increase in HIV Rates — Orel Oblast, Russian Federation, 1999–2001

During 1999–2001, the estimated number of cases of human immunodeficiency virus (HIV) reported officially in the Russian Federation increased approximately 16-fold, from 11,000 to 177,000 (1). In 2001, of 49,434 HIV-infected persons for whom a risk factor was identified, 46,274 (94%) were injection-drug users (IDUs) (1). However, the actual number of HIV-infected persons in Russia is estimated to be four to 10 times higher than reported (2; Russian Federal Center for Prevention of AIDS, unpublished data, 2002). Rapid increases in HIV have been reported in urban areas (e.g., Kaliningrad, Moscow, and St. Petersburg) (3) and also might be occurring in rural areas. During 1997–2000, HIV seroprevalence reportedly increased 33-fold in Orel Oblast, a predominantly rural, agricultural province (1999 population: 900,000) in central European Russia (Figure) (4). To confirm and describe this increase and evaluate the risk for continued rapid increase of HIV, CDC collaborated with the Orel Oblast AIDS and Infectious Diseases Prevention Center (AIDS Center) to assess recent HIV trends and the prevalence of risk behaviors among IDUs in Orel Oblast. This report summarizes the results of that assessment, which indicate continued increases in HIV rates and underscore the need for interventions directed at IDUs and their sex partners to limit further spread of HIV.

During 1987–2001, the AIDS Center recorded results of all HIV tests (annual range: 140,000–170,000) and confirmed all HIV-positive tests for Orel Oblast residents and nonresidents. Voluntary routine HIV testing was offered to patients at drug-treatment, sexually transmitted disease (STD), tuberculosis (TB), and prenatal clinics; HIV testing was mandatory for prisoners. Because HIV reporting was name-based and confidential, persons testing positive were included only once. The AIDS Center collected clinical, HIV-risk, and contact histories for HIV-positive residents of Orel Oblast and offered HIV testing to recent sex and injection-drug using

FIGURE. Location of Orel Oblast, Russian Federation



contacts of HIV-positive residents. During spring 2001, HIV-negative IDUs attending the drug-treatment clinic in Orel City were asked by clinic staff to complete an anonymous, self-administered survey on injection and drug-use practices.

During 1998–2001, the annual rate of new positive HIV test results increased from five per 100,000 tests performed to 202 (Table). Testing patterns (i.e., populations tested and number of tests performed) remained stable during this time.

INSIDE

- 660 Fetal Alcohol Syndrome — South Africa, 2001
- 662 Homemade Chemical Bomb Events and Resulting Injuries — Selected States, January 1996–March 2003
- 664 Update: Severe Acute Respiratory Syndrome — Worldwide and United States, 2003
- 665 Weekly Update: West Nile Virus Activity — United States, July 10–16, 2003

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Rates of prevalence of HIV infection were highest in Orel City and Mtsensk (64 and 181 per 100,000 population, respectively). The majority of IDUs were males aged 15–29 years; the combined age-adjusted prevalence of HIV among males aged 15–29 years in these two cities was <1%.

During 1987–1998, eight Orel Oblast residents were identified as HIV-positive. During January 1999–September 2001, a total of 380 Orel Oblast residents were identified as HIV-positive; 312 (82%) were male, 341 (90%) were aged <30 years, and 313 (82%) were IDUs. A total of 62 (16%) were identified through contact investigation. During January 1999–September 2001, the number of new cases among women increased from 15 (12%) of 125 cases in January 1999 to 42 (22%) of 190 cases in September 2001. During January 1987–September 2001, a total of 33 (47%) of 70 women and 30 (9%) of 318 men probably were infected through having heterosexual sex. Of the 63 persons probably infected through heterosexual sex, 31 (49%) had sexual contact with persons known by the AIDS Center to be IDUs. Although precise data were not available, the majority of these cases occurred during 1999–2001.

During January–September 2001, among 802 tests performed on IDUs at the main drug-treatment center, 52 (6%) persons were HIV-positive. As of September 2001, of an estimated 2,700 IDUs (one third of the estimated number of IDUs residing in Orel Oblast) tested through either the drug-treatment or penal system, 313 (12%) were HIV-positive (AIDS Center, unpublished data, 2001).

All HIV care and treatment for Orel Oblast residents is provided at the AIDS Center clinic. As of September 2001, none of the 331 persons followed at the clinic who were HIV-positive had signs or symptoms consistent with CDC's case definition of AIDS (5). During January 1987–September 2001, three persons who were HIV-positive were identified with active TB despite a high community TB prevalence (211 cases per 100,000 population) in Orel Oblast (Orel Tuberculosis Dispensary, unpublished data, 2000) and routine HIV screening for all TB patients.

Orel City drug-treatment clinic staff surveyed HIV-negative IDUs to assess their risk for contracting HIV. Of 110 HIV-negative IDUs who were surveyed about their drug use and injection practices, 88 (80%) were male, 97 (88%) were aged <30 years, and 105 (95%) injected heroin. Reported high-risk injection behaviors were frequent: 65 (59%) shared needles at least occasionally, and 68 (62%) purchased drugs already mixed in solution and thus potentially contaminated with HIV during mixing or sale. Of the 110 IDUs surveyed, 102 (93%) reported no difficulty acquiring unused needles, which are available legally without prescription at local pharmacies.

TABLE. Number and rate* of Orel Oblast residents and nonresidents testing positive for human immunodeficiency virus (HIV) and number of tests performed, by year — Orel Oblast, Russian Federation, 1998–2001

Category	1998	1999	2000	2001†
No. residents testing HIV-positive	1	125	65	190
No. nonresidents testing HIV-positive	6	34	74	51
Total	7	159	139	241
No. tests performed	145,500	160,462	171,903	119,581
Rate of new HIV reports‡	5	99	81	202

* Per 100,000 tests performed.

† As of September 2001.

‡ Persons testing positive for the first time.

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Editorial Note: The findings in this report confirm recent increases in HIV in Orel Oblast, affecting primarily young male IDUs. The high prevalence of needle sharing and other unsafe injection practices among HIV-negative IDUs suggests continued rapid spread of HIV among this population. Continued spread of HIV from IDUs to their sex partners who do not inject drugs also is likely to continue in Orel Oblast unless further interventions to reduce transmission succeed. Since 2001, when this investigation was completed, approximately one fourth of new HIV cases reported in Orel Oblast have occurred in women whose infections resulted reportedly from heterosexual transmission (AIDS Center, unpublished data, 2003), indicating that an epidemiologic transition to transmission of HIV among heterosexual non-IDUs might be under way.

Rates of injection-drug use, STDs, and TB in Russia are high (2,4,6). An estimated 1%–2% of the population inject drugs (2). The majority of IDUs are young men, and an estimated 5%–8% of men aged <30 years have injected drugs. Infection of a substantial proportion of young IDUs and their sex partners could have a substantial impact on social and economic conditions in the Russian Federation. The high rates of STDs (e.g., syphilis, which peaked in 1997 at 277 cases per 100,000 population) suggest that HIV could spread rapidly within sexual networks (6). In addition, in other countries with high endemic rates of TB, rising HIV rates have led to explosive growth in TB despite TB-control efforts (7).

The findings in this report are subject to at least two limitations. First, although the total number of tests was known, the total number of IDUs tested was not available. As a result, HIV prevalence rates could only be estimated. Second, the number of tests among IDUs tested at the main drug-treatment center during 2001 who were HIV-negative included

tests for persons who had multiple HIV-negative tests, some of whom were tested three to four times per year. As a result, HIV prevalence estimates in this report probably are underestimated.

All HIV testing information is centralized at the AIDS Center. Although standard surveillance data do not routinely record the number of persons tested, minimal supplemental surveillance activities (e.g., computerization of testing information from all or sentinel sites to

identify repeat HIV-negative testers) would allow routine calculation of true prevalence. Additional outreach to assess prevalence among IDUs and to identify interventions for IDUs not in contact with treatment or penal systems (“out-of-system IDUs”) also might be useful.

HIV-prevention interventions targeted at IDUs are needed that encourage cessation of drug use and build skills for safer injection and sex practices. In some communities, needle exchange programs have provided access to out-of-system IDUs, serving to deliver information on HIV prevention and drug treatment and to reduce risk behaviors (8,9). However, because unused needles can be acquired without difficulty in Orel Oblast, the AIDS Center and CDC are exploring other approaches to enhance access to out-of-system IDUs, including initiation of street-based peer outreach to IDUs and community-based “12-step” programs that encourage cessation of drug use and increase IDUs’ understanding of safer injection and sex practices.

The review of clinical data indicated that as of September 2001, few HIV-infected persons in Orel Oblast had signs of symptomatic HIV disease, and none were living with AIDS. However, clinical care needs will necessarily increase with disease progression. A well-established infrastructure exists for delivering care through the AIDS Center, providing a strong basis for additional interventions. Because community TB rates are high, isoniazid preventive TB therapy for HIV-infected persons should be considered; this strategy reduces morbidity and might limit the impact of HIV on local TB-control efforts (10). In addition, funding and partnerships should be pursued to support increased availability of monitoring tests, prophylactic medications for opportunistic infections, and affordable antiretroviral medications.

To limit further increases of HIV in Orel Oblast, particularly among IDUs and their sex partners, local HIV-prevention activities should be enhanced. Because Orel Oblast is typical of many predominantly rural provinces in central European Russia (e.g., comparable population distribution, recent increase in injection-drug use and HIV reports, and

the existence of a centralized AIDS center coordinating a network of services for the entire oblast), successful interventions in Orel might provide a model for interventions elsewhere in Russia.

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Fetal Alcohol Syndrome — South Africa, 2001

Fetal alcohol syndrome (FAS) is caused by maternal alcohol use during pregnancy and is one of the leading causes of preventable birth defects and developmental disabilities (1). The FAS phenotype is characterized by a combination of facial dysmorphic features, growth retardation, and central nervous system (CNS) abnormalities. State-based estimates of the prevalence of FAS in the United States vary from 0.3 to 1.5 per 1,000 live-born infants (2). Recently, the highest prevalence of FAS worldwide was reported among first-grade children in a wine-growing region in the Western Cape province of South Africa (3). Investigators for the National Institutes of Alcoholism and Alcohol Abuse (NIAAA) reported a FAS prevalence of 40.5 to 46.4 per 1,000 children aged 5–9 years

in one community in Western Cape. To determine whether FAS was associated exclusively with the wine-growing region in Western Cape or was more endemic in other areas of the country, CDC, in collaboration with the University of Witwatersrand and the Foundation for Alcohol Related Research in Johannesburg, South Africa, conducted a prevalence study in Gauteng province and is developing ongoing surveillance and prevention activities. This report summarizes the findings of the study, which indicate a high prevalence of FAS among first-grade children in four nonwine-growing communities around Johannesburg. Because South Africa has limited resources and many competing health problems (e.g., human immunodeficiency virus/acquired immunodeficiency syndrome, tuberculosis, and sexually transmitted diseases), integrating prenatal alcohol-exposure prevention activities with existing prevention programs should be explored.

Four communities were selected on the basis of their willingness to participate and ability to represent the various racial/ethnic groups in Gauteng province. Human subjects approval was obtained through the University of Witwatersrand's Institutional Review Board. A two-stage screening and case-finding method, similar to methods implemented in the Western Cape communities, was used to identify children with FAS (3). Because growth retardation is a cardinal feature of FAS, in the first stage (screening), the weights, heights, and head circumferences of all children in first grade in selected schools were measured. Because standard growth curves are not available for children in South Africa, the World Health Organization (WHO) international growth reference curves were used for weight and height (4,5). Head circumference growth reference curves developed from the Fels Longitudinal Study were used to determine 10th-percentile cut points by age and sex (6). Children were classified as screen-positive if they were below the 10th percentile for weight and height or head circumference for age and sex. The sensitivity of the screening procedures in this study was 96%; however, the positive predictive value was only 8%.

In the second stage (case ascertainment), all screen-positive children and, whenever possible, screen-negative children who were matched by age, sex, and classroom received a physical evaluation by two teams of physicians. The physicians were trained in clinical genetics and FAS diagnosis and were unaware of the screening team's findings during the clinical evaluation of the children. Physical signs of FAS (e.g., facial dysmorphism, joint and bone abnormalities, CNS anomalies, and skin and other abnormalities) and other measurements (e.g., palpebral fissures and inner canthal and interpupillary distances) were recorded, and a diagnosis of "FAS," "deferred,"

or “not FAS” was determined. The physicians diagnosed FAS on the basis of clinical judgment and the presence of abnormalities in three major case-definition categories: growth retardation (i.e., <10th percentile for weight and height); facial dysmorphic features (e.g., hypoplastic midface, smooth philtrum, thin narrow upper lip, flat nasal bridge, and small palpebral fissures); and head circumference below the 10th percentile (1). A deferred diagnosis was made when a child had FAS characteristics, but the clinicians requested either more information about CNS functions from neuropsychologic testing or evidence of maternal alcohol exposure to confirm an FAS diagnosis. A “not FAS” diagnosis was indicated when a child did not appear to have the phenotype associated with prenatal alcohol exposure. All children with an FAS or deferred diagnosis received a follow-up neuropsychologic assessment to measure CNS-related disabilities and cognitive functioning to make appropriate referrals and recommendations for services. After completion of all examinations, clinicians held a case conference for each child to determine a final diagnosis. Six children with physical signs of FAS remained in the deferred case category pending further neuropsychologic assessments.

Among 19 participating schools from the four communities, 830 children in first grade were screened for growth retardation (Table). The median age of children screened was 6.5 years (range: 5–10 years). A total of 306 (37%) children screened positive for weight and height or for head circumference below the 10th percentile. The percentage of screen-positive children varied among the four communities from 27% to 43%. Of the 306 screen-positive children, 275 (90%) were available for the FAS clinical evaluations. For purposes of comparison, another 207 children from the screen-negative group were included; for three schools, >50% of children screened positive, limiting the pool of screen-negative children available for comparison. A total of 482 children received clinical evaluations.

Of the 275 screen-positive children examined, 21 (8%) received an FAS (n = 16) or deferred (n = five) diagnosis. A deferred diagnosis was made on one child from the screen-negative group; however, none from the screen-negative group had FAS diagnosed. The median prevalence for FAS alone among first-grade children in the four communities was 19 per 1,000 children (range: 0–37.5). When FAS and deferred diagnoses were combined, the median prevalence was 26.5 per 1,000 children (range: 11.8–41.7) in the four communities (Table).

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Editorial Note: The findings of this report are comparable to an earlier report of high prevalence of FAS in the Western Cape province (3) and confirm that FAS is a serious public health problem in South Africa. This report extends the initial findings (3), indicating that the unusually high prevalence of FAS among first-grade children is not a function of the availability of alcohol in the wine-growing regions of South Africa. Although rates of FAS in all four communities described in this report were high, the rates varied by community and probably reflect differences in local drinking patterns, alcohol availability, poverty, unemployment, health problems, and other risk factors.

In the absence of national standard anthropometric references for growth, WHO recommends the use of growth curves by using data from the Fels Research Institute and U.S. Health Examination Surveys for international studies (4,7). In the study described in this report, which used these growth references, a high proportion of children screened positive either for weight and height or for head circumference below the 10th percentile for sex and age. Growth retardation is a cardinal feature of the FAS phenotype and appears to be an

TABLE. Number and percentage of first-grade children screened for growth retardation and examined for fetal alcohol syndrome (FAS), and rate* in four communities — Gauteng province, South Africa, 2001

Area	Growth retardation screening			Children examined for FAS				Total	
	No. screened	No. positive	(%) positive	No. examined	No. screened positive examined [†]	No. with FAS	No. deferred [§]	No. with FAS and deferred combined	Rate
A	176	48	(27.3)	72	39	0	4	4	22.7
B	253	94	(37.2)	150	86	3	0	3	11.8
C	161	61	(37.9)	103	51	4	1	5	31.1
D	240	103	(42.9)	157	99	9	1	10	41.7
Total	830	306	(36.9)	482	275	16	6[¶]	22	26.5

* Per 1,000 children.

[†] A total of 31 children who screened positive for growth retardation were not available for the clinical examinations.

[§] A deferred diagnosis was made when a child had FAS characteristics, but the clinicians requested either more information about central nervous system functions from neuropsychologic testing or evidence of maternal alcohol exposure to confirm an FAS diagnosis.

[¶] Includes one child who originally screened negative.

important tool for screening in this population. Although the sensitivity of the screening procedures was high (96%), the positive predictive value was only 8%, indicating a large number of children without FAS were examined. Because measuring weight and height is relatively easy, can be performed by local staff, and can be cost-effective by eliminating unnecessary clinical examinations of children who do not meet the growth retardation criteria for FAS, using growth measures for FAS screening in a high-prevalence population is advantageous. However, staff time and clinical examinations are completed on many children who do not have FAS. The population-based growth data collected on all first graders in the four communities can be used to refine the screening tool and improve the positive predictive value by adjusting the screen-positive percentile cut points for future FAS screening, case-finding, and surveillance activities in South Africa.

The findings in this report are subject to at least two limitations. First, the number of children in South Africa affected adversely by in-utero alcohol exposure is probably underestimated. Many children with severe FAS might not attend public schools, or, because of the increased health problems associated with this birth defect, might have died before school-entry age. In addition, the programs for children with developmental disabilities that exist in the study areas were not used for case-finding. Second, because children were not identified until school entry, they missed opportunities for early education interventions that could improve overall developmental outcome. The late age at identification represents missed opportunities to intervene with high-risk mothers who might have given birth to additional children with FAS. Ideally, case-finding should be conducted at birth to maximize the opportunity for prevention and early intervention with the family.

With limited resources and many health problems in South Africa, prenatal alcohol-exposure prevention activities for women and intervention programs for children with FAS are virtually nonexistent. The screening and case-finding approach described in this report can be useful for identifying high-risk communities and targeting scarce prevention resources. As resources become available for prevention and intervention activities, an ongoing cost-effective surveillance system that maximizes case-finding in a child's first year of life is crucial to evaluate prevention strategies and programs targeted toward South Africa's multiple racial/ethnic groups. CDC will work with investigators in South Africa to improve the screening criteria, evaluate strategies to identify children earlier in life, and develop and evaluate prevention and intervention strategies.

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Homemade Chemical Bomb Events and Resulting Injuries — Selected States, January 1996–March 2003

Homemade chemical bombs (HCBs), also known as acid bombs, bottle bombs, and MacGyver bombs, are explosive devices that can be made easily from volatile household chemicals (e.g., toilet bowl, drain, and driveway cleaners) purchased at a local hardware or grocery store. When these and other ingredients are combined and shaken in a capped container, the internal gas pressure generated from the chemical reaction causes the container to expand and explode. The subsequent explosion can cause injuries or death to persons in the immediate vicinity of the detonation. Since 1996, some of the states participating in the Agency for Toxic Substances and Disease Registry (ATSDR)'s Hazardous Substances Emergency Events Surveillance (HSEES) system have been documenting HCB events. This report describes examples of HCB events, summarizes all reported HCB events, discusses associated injuries*, and suggests injury-prevention methods.

HSEES is an active multistate health department surveillance system for tracking acute morbidity and mortality resulting from the release of hazardous substances during emergency events†. To determine the frequency of HCB events, ATSDR searched the HSEES database for all years for which

*Includes illnesses and other adverse health effects.

†An event is the release or threatened release of a hazardous substance(s) into the environment in an amount that requires (or would have required) removal, clean-up, or neutralization according to federal, state, or local law (1). A hazardous substance is one that can reasonably be expected to cause an adverse health effect.

data were available (January 1, 1993–March 31, 2003)[§] from 17 participating states[¶]. An HCB event is defined as one that involves the release or threatened release of a hazardous substance(s) from any homemade chemical explosive device that requires (or would have required) removal, clean-up, or neutralization according to federal, state, or local law. Events at which nonexplosive devices (i.e., homemade smoke bombs) involving releases or threatened releases of hazardous substances were excluded from the analysis because the potential for injury is minimal.

Case Reports

Rhode Island. In May 2000, two students were making bottle bombs on an elementary school playground by using hydrochloric acid. The two sustained eye irritation from detonation of one of the bombs. Both were transported to a hospital for treatment and released. The school was evacuated for 1 hour while a hazardous materials (HazMat) team conducted decontamination and debris removal.

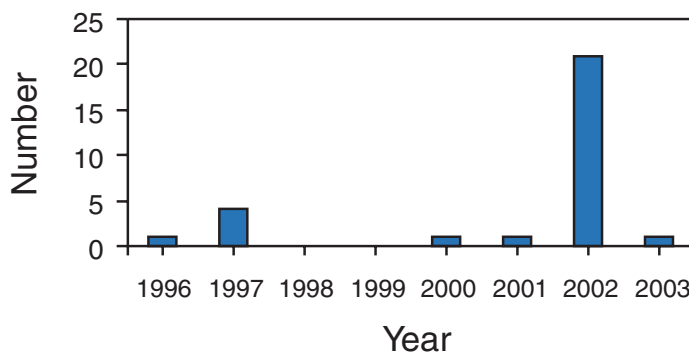
Rhode Island. In October 2001, a high school student placed a chemical bomb in a vacant classroom. The bomb, made with sodium hypochlorite, released chlorine gas on explosion. A total of 23 persons (five teachers and 18 students) in the vicinity of the explosion sustained respiratory irritation and were transported to a hospital for treatment and released. The school was evacuated, and a HazMat team conducted decontamination and debris removal.

New York. In June 2002, a person aged 16 years sustained chemical burns after detonating a bottle bomb made of sodium hypochlorite in a friend's front yard. The juvenile was transported to a hospital for treatment and released.

Summary of Surveillance Data

During January 1, 1993–March 31, 2003, a total of 29 HCB events were reported to HSEES. All 29 events occurred during 1996–2003; a total of 24 (83%) of these occurred during 2000–2003 (Figure). The 29 HCB events were reported from six states (Alabama [one], Iowa [one], New York [six], Rhode Island [two], Washington [14], and Wisconsin [five]). Explosions occurred in 24 (83%) of these events; five (17%) involved failed explosions. Three (10%) of the 29 HCB events

FIGURE. Number of homemade chemical bomb events, by year — Hazardous Substances Emergency Events Surveillance (HSEES) system, United States, January 1, 1996–March 31, 2003



resulted in injury to 26 persons. The injuries sustained included eye irritation, respiratory irritation, and chemical burns. No fatalities were reported. The chemicals involved in HCB events reported most frequently were sodium hypochlorite (17), sodium hydroxide (15), hydrochloric acid (five), and acid not otherwise specified (five). A total of 18 of these HCB events occurred on school property (college/university [14], high school [three], and elementary school [one]), 10 occurred in residential areas, and one occurred in a grocery store parking lot. In at least 22 (76%) of the 29 HCB events, bombs were made by juveniles (aged <18 years) or college/university students. The majority of events occurred during the summer (19) or immediately after school (three).

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Editorial Note: The HSEES data indicate that the number of HCB events has increased during the last several years. This increase might be attributed to enhanced surveillance from the participating HSEES states and/or to an actual increase in the number of events because bottle bomb recipes have become more available on the Internet. The results of this analysis suggest that HCBs are a rare cause of injury. However, the chemical reactions that occur within an HCB makes these devices highly unstable and unpredictable, which increases the risk for injury. Two of the three HCB events with injuries reported resulted in the person making the bomb becoming the unintended victim. Once the ingredients are combined, no timers or fuses are installed that could signal when detonation will occur. HCBs can detonate within

[§]Data for 2003 are preliminary.

[¶]During 1993–2003, a total of 17 state health departments participated in HSEES. State health departments in Alabama, Colorado, Iowa, New York, North Carolina, Oregon, Texas, Washington, and Wisconsin participated during the entire reporting period. Eight state health departments participated during portions of this period: Louisiana (2001–2003), Minnesota (1995–2003), Mississippi (1995–2003), Missouri (1994–2003), New Hampshire (1993–1996), New Jersey (2000–2003), Rhode Island (1993–2001), and Utah (2000–2003).

seconds to hours after initial mixing. Sodium hypochlorite was the chemical used most frequently in the making of these bombs; however, other hazardous substances (e.g., ammonia, liquid nitrogen, and dry ice) also have been used to create explosive pressure devices (CDC, unpublished data, 2003). Because these devices are potentially deadly, the detonation of HCBs is a felony offense in several states.

Low to medium exposure to sodium hypochlorite, such as that found in bleach, can cause irritation of the eyes, skin, and respiratory and gastrointestinal tract. High levels can result in severe corrosive damage to the eyes, skin, and respiratory and gastrointestinal tissues and can be fatal (2). Exposure to other bottle bomb chemicals such as hydrochloric acid can cause irritation to the nose, throat, and larynx; cough; choking; dermatitis; eye and skin burns; laryngeal spasm; and pulmonary edema (3,4).

The findings in this report are subject to at least three limitations. First, reporting of any event to HSEES is not mandatory; for this reason, participating state health departments might not be informed about every event. Second, these data were reported events from 17 participating states and do not reflect data from non-HSEES states. Finally, the HSEES system does not have a category specific to HCB events; for this reason, some events might have been omitted inadvertently from the analysis.

HSEES data illustrate the potential dangers associated with HCBs. Public health strategies to prevent injuries resulting from bottle bombs include making communities aware of bottle bombs and educating juveniles about the dangers and legal ramifications of manufacturing and detonating these devices. Parents should be particularly vigilant about monitoring the activities of their children during nonschool hours.

Persons who observe suspicious activity or an unusual item, such as a bottle filled with a white or gray liquid with a possible cloudy appearance, should notify school officials or law enforcement officers. If a suspected or actual bottle bomb is discovered, the surrounding area should be evacuated immediately (to a minimum of 200 feet from the device), and local law enforcement should be notified (5). Only trained bomb squad personnel should approach, handle, or attempt to neutralize these devices.

Persons who come into contact with the contents of a detonated bomb should remove contaminated clothing immediately. If dermal contact with the contents occurs, the affected area should be rinsed with large amounts of water (5). If severe adverse health effects (e.g., trauma, chemical burns, or respiratory irritation) occur, medical attention should be sought immediately.

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Update: Severe Acute Respiratory Syndrome — Worldwide and United States, 2003

This report updates reported cases of severe acute respiratory syndrome (SARS) worldwide and in the United States, describes a change in the recommended timing of collection of a convalescent-phase serum specimen to test for antibody to SARS-associated coronavirus (SARS-CoV), and introduces a new case exclusion criterion based on negative SARS-CoV serology (1). In addition, this report also summarizes changes in travel alerts for Beijing and mainland China, Hong Kong, Toronto, and Taiwan.

During November 1, 2002–July 11, 2003, a total of 8,427 probable SARS cases were reported to the World Health Organization (WHO) from 29 countries; 813 deaths (case fatality rate: 9.6%) have been reported, with no SARS-related deaths in the United States (2). On July 5, WHO announced that all known person-to-person transmission of SARS-CoV had ceased (3).

CDC has revised the laboratory criteria in the SARS case definition to require that convalescent serum be collected >28 days after symptom onset, instead of >21 days after symptom onset. This change reflects data that some persons with SARS-CoV infection might not mount a detectable antibody response until >28 days after illness onset (4). Because most persons without immune-compromising conditions are thought to mount an immune response within 28 days, test results from

serum collected previously 22–28 days after symptom onset will be considered definitive. However, state and local health officials can choose to collect a later specimen on a case-by-case basis if they consider it to be indicated clinically.

On June 26, the Council of State and Territorial Epidemiologists changed the U.S. SARS case definition to allow exclusion of cases with a negative convalescent serum specimen. This change

reflects data indicating that >95% of patients with SARS mount a detectable convalescent antibody response (4,5). The U.S. case numbers in this report reflect this exclusion criterion.

As of July 15, a total of 418 SARS cases were reported in the United States, with 344 (82%) classified as suspect SARS and 74 (18%) classified as probable SARS (i.e., more severe illnesses characterized by the presence of pneumonia or acute respiratory distress syndrome). A total of 169 reported suspect cases and 38 reported probable cases were excluded because the convalescent serum specimen was negative for SARS-CoV antibodies (Table). None of the reported suspect cases and eight reported probable SARS cases had a convalescent serum specimen that was positive for SARS-CoV antibodies; these eight laboratory-confirmed SARS cases have been reported previously (6–8). Convalescent serum specimens have not been obtained for the other 28 reported probable cases and 175 reported suspect cases; therefore, it is not known whether these persons had SARS.

Serologic testing results suggest that a small proportion of persons who had illness consistent with the clinical and epidemiologic criteria for a U.S. case of suspect or probable SARS actually had SARS. The case definition captures an array of respiratory illnesses that cannot be easily distinguished from SARS until laboratory testing results for SARS and other agents are performed. However, this sensitive case definition allowed for rapid investigation of persons who might have had SARS and for public health intervention to prevent person-to-person transmission.

CDC lifted the travel alerts for Beijing and mainland China, Hong Kong, Toronto, and Taiwan during July 1–15, 2003 (9); CDC's criteria for lifting an alert for SARS include the absence of new cases for three incubation periods (i.e., 30 days) after the date of onset of symptoms for the last reported case (http://www.cdc.gov/ncidod/sars/travel_alertadvisory.htm). For traveler's illness to meet the case definition for SARS, the travel should have occurred on or before the last date the travel alert was in place. In addition, the last date for illness onset is 10 days (i.e., one incubation period) after removal of a CDC travel alert (1). With removal of all SARS travel alerts and

TABLE. Number of reported suspect and probable severe acute respiratory syndrome (SARS) cases, by results of serologic tests for SARS-associated coronavirus (SARS-CoV) infection — United States, July 15, 2003

Case status	Convalescent serum negative for SARS-CoV antibodies	Convalescent serum specimen not obtained	SARS-CoV infection confirmed by serology	Total
Suspect	169	175	0	344
Probable	38	28	8	74
Total	207	203	8	418

completion of an incubation period, U.S. travelers with respiratory illness will no longer meet the case definition for SARS; reports of suspect or probable cases are expected to end by the end of July 2003.

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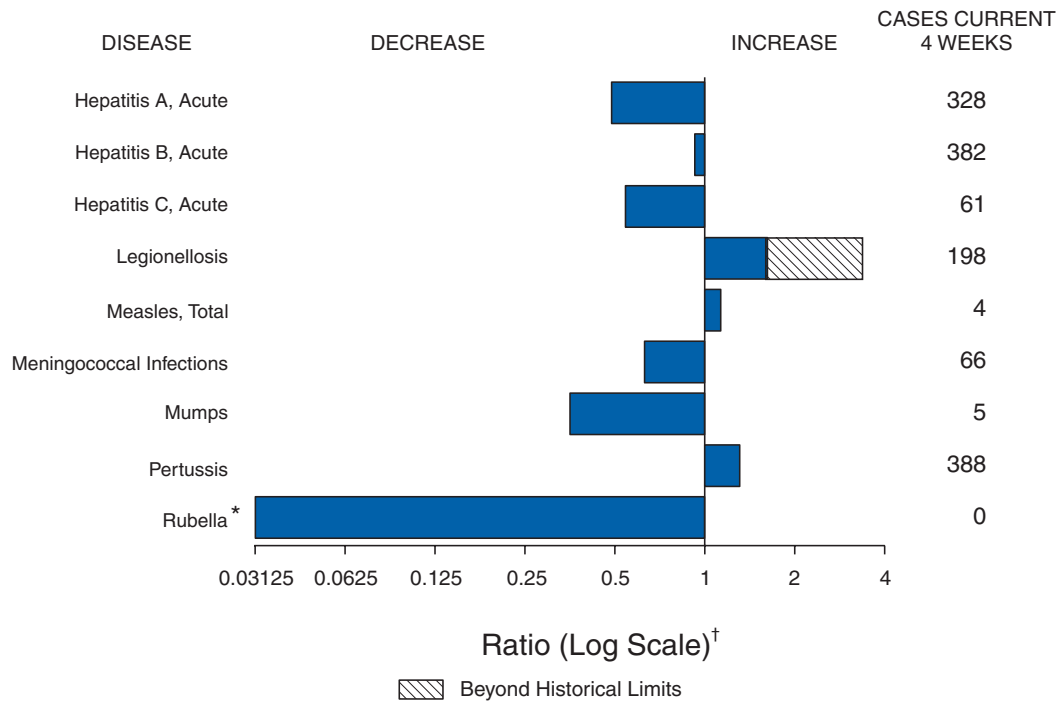
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Weekly Update: West Nile Virus Activity — United States, July 10–16, 2003

This report summarizes West Nile virus (WNV) surveillance data reported to CDC through ArboNET as of 7 a.m. Mountain Daylight Time, July 16, 2003.

During the reporting week of July 10–16, four human cases of WNV infection were reported from two states (Alabama and Texas). During the same period, WNV infections were reported in 112 dead corvids (crows and related species), 18 other dead birds, 20 horses, and 130 mosquito pools.

During 2003, a total of five human cases of WNV infection have been reported from Texas (n = three), Alabama (n = one), and South Carolina (n = one) (Figure). Among these

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals July 12, 2003, with historical data

* No rubella cases were reported for the current 4-week period yielding a ratio for week 28 of zero (0).

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

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending July 12, 2003 (28th Week)*

	Cum. 2003	Cum. 2002		Cum. 2003	Cum. 2002
Anthrax	-	2	Hansen disease (leprosy) [†]	27	54
Botulism:	-	-	Hantavirus pulmonary syndrome [†]	10	12
foodborne	7	8	Hemolytic uremic syndrome, postdiarrheal [†]	53	89
infant	32	39	HIV infection, pediatric ^{‡§}	108	89
other (wound & unspecified)	12	8	Measles, total	21 [¶]	16 ^{**}
Brucellosis [†]	36	62	Mumps	112	156
Chancroid	22	42	Plague	1	-
Cholera	1	1	Poliomyelitis, paralytic	-	-
Cyclosporiasis [†]	28	93	Psittacosis [†]	8	12
Diphtheria	-	1	Q fever [†]	37	29
Ehrlichiosis:	-	-	Rabies, human	-	1
human granulocytic (HGE) [†]	72	101	Rubella	5	9
human monocytic (HME) [†]	38	63	Rubella, congenital	-	1
other and unspecified	5	9	Streptococcal toxic-shock syndrome [†]	112	76
Encephalitis/Meningitis:	-	-	Tetanus	4	15
California serogroup viral [†]	-	-	Toxic-shock syndrome	69	66
eastern equine [†]	-	-	Trichinosis	1	10
Powassan [†]	-	-	Tularemia [†]	30	34
St. Louis [†]	-	-	Yellow fever	-	-
western equine [†]	-	-			

-: No reported cases.

* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

[†] Not notifiable in all states.

[§] Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update May 25, 2003.

[¶] Of 21 cases reported, 19 were indigenous and two were imported from another country.

** Of 16 cases reported, eight were indigenous and eight were imported from another country.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending July 12, 2003, and July 13, 2002 (28th Week)*

Reporting area	AIDS		Chlamydia†		Coccidiomycosis		Cryptosporidiosis		Encephalitis/Meningitis West Nile	
	Cum. 2003§	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	19,482	20,774	421,450	431,411	1,743	2,302	980	1,138	-	-
NEW ENGLAND	654	795	14,226	14,372	-	-	59	71	-	-
Maine	27	19	929	789	N	N	6	2	-	-
N.H.	15	19	815	841	-	-	6	14	-	-
Vt.	6	8	532	418	-	-	13	15	-	-
Mass.	277	373	5,722	5,718	-	-	22	22	-	-
R.I.	51	61	1,420	1,486	-	-	9	13	-	-
Conn.	278	315	4,808	5,120	N	N	3	5	-	-
MID. ATLANTIC	4,098	4,738	45,158	47,786	-	-	135	162	-	-
Upstate N.Y.	274	421	10,158	8,536	N	N	39	34	-	-
N.Y. City	1,976	2,545	17,067	16,383	-	-	43	68	-	-
N.J.	787	809	7,448	6,569	-	-	4	12	-	-
Pa.	1,061	963	10,485	16,298	N	N	49	48	-	-
E.N. CENTRAL	1,982	2,238	73,218	79,286	3	15	228	323	-	-
Ohio	303	428	19,625	20,390	-	-	38	70	-	-
Ind.	259	304	8,799	8,782	N	N	27	24	-	-
Ill.	959	1,028	20,486	25,224	-	2	26	59	-	-
Mich.	359	369	16,280	15,999	3	13	47	56	-	-
Wis.	102	109	8,028	8,891	-	-	90	114	-	-
W.N. CENTRAL	358	328	24,159	24,063	1	1	120	116	-	-
Minn.	74	72	5,251	5,616	N	N	47	40	-	-
Iowa	41	46	2,676	2,825	N	N	22	13	-	-
Mo.	177	135	8,522	7,850	-	-	10	15	-	-
N. Dak.	-	1	700	657	N	N	10	10	-	-
S. Dak.	7	2	1,336	1,132	-	-	20	5	-	-
Nebr.¶	25	31	2,076	2,280	1	1	4	24	-	-
Kans.	34	41	3,598	3,703	N	N	7	9	-	-
S. ATLANTIC	5,488	6,359	83,619	81,210	3	2	153	150	-	-
Del.	106	113	1,631	1,426	N	N	3	1	-	-
Md.	558	954	8,819	8,087	3	2	8	7	-	-
D.C.	595	321	1,427	1,736	-	-	6	3	-	-
Va.	481	482	10,063	8,758	-	-	15	4	-	-
W. Va.	42	48	1,315	1,282	N	N	3	2	-	-
N.C.	581	438	13,806	12,797	N	N	19	23	-	-
S.C.	330	440	7,852	7,713	-	-	2	2	-	-
Ga.	736	1,087	17,494	16,983	-	-	57	56	-	-
Fla.	2,059	2,476	21,212	22,428	N	N	40	52	-	-
E.S. CENTRAL	841	903	28,317	27,750	N	N	55	70	-	-
Ky.	79	150	4,377	4,578	N	N	13	1	-	-
Tenn.	374	388	10,122	8,529	N	N	17	38	-	-
Ala.	185	172	7,484	8,735	-	-	22	27	-	-
Miss.	203	193	6,334	5,908	N	N	3	4	-	-
W.S. CENTRAL	2,125	2,164	54,338	57,293	-	5	12	34	-	-
Ark.	65	150	3,972	3,901	-	-	3	5	-	-
La.	368	498	9,275	9,932	N	N	1	8	-	-
Okla.	92	118	5,642	5,474	N	N	5	6	-	-
Tex.	1,600	1,398	35,449	37,986	-	5	3	15	-	-
MOUNTAIN	722	666	24,825	26,680	1,248	1,546	53	72	-	-
Mont.	10	6	1,004	1,127	N	N	12	4	-	-
Idaho	13	15	1,301	1,323	N	N	8	17	-	-
Wyo.	4	5	523	476	-	-	2	6	-	-
Colo.	159	132	5,559	7,490	N	N	11	19	-	-
N. Mex.	52	51	3,691	4,072	4	5	3	9	-	-
Ariz.	341	272	7,691	7,756	1,219	1,516	3	9	-	-
Utah	31	35	2,287	1,222	5	8	11	5	-	-
Nev.	112	150	2,769	3,214	20	17	3	3	-	-
PACIFIC	3,214	2,583	73,590	72,971	487	732	165	140	-	-
Wash.	214	256	8,274	7,758	N	N	14	9	-	-
Oreg.	126	193	3,872	3,604	-	-	24	21	-	-
Calif.	2,815	2,074	58,374	57,311	487	732	127	109	-	-
Alaska	12	12	2,002	1,927	-	-	-	-	-	-
Hawaii	47	48	1,068	2,371	-	-	-	1	-	-
Guam	2	1	-	345	-	-	-	-	-	-
P.R.	514	600	985	1,517	N	N	N	N	-	-
V.I.	15	56	-	103	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	-	U	-	U	-	U	-	U

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

* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

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

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update May 25, 2003.

¶ For Nebraska, data for hepatitis A, B, and C; meningococcal disease; pertussis; streptococcal disease (invasive, group A); and *Streptococcus pneumoniae* (invasive) were collected by using the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending July 12, 2003, and July 13, 2002 (28th Week)*

Reporting area	<i>Escherichia coli</i> , Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	720	1,131	86	64	59	17	7,686	9,244	160,132	182,756
NEW ENGLAND	40	86	17	14	7	2	536	827	3,508	4,115
Maine	4	4	1	-	-	-	65	82	105	62
N.H.	6	9	1	-	-	-	17	26	56	64
Vt.	2	3	-	-	-	-	44	62	41	53
Mass.	16	44	2	10	7	2	243	431	1,396	1,781
R.I.	1	5	-	-	-	-	55	68	424	471
Conn.	11	21	13	4	-	-	112	158	1,486	1,684
MID. ATLANTIC	83	133	3	-	18	2	1,550	2,000	18,891	21,743
Upstate N.Y.	37	58	1	-	9	-	432	551	3,891	4,386
N.Y. City	3	7	-	-	-	-	545	753	6,614	6,583
N.J.	5	21	-	-	-	-	154	237	4,739	3,836
Pa.	38	47	2	-	9	2	419	459	3,647	6,938
E.N. CENTRAL	175	283	10	17	10	2	1,246	1,533	32,847	38,153
Ohio	43	55	10	5	9	2	424	407	10,944	11,213
Ind.	33	24	-	-	-	-	-	-	3,348	3,798
Ill.	26	91	-	6	-	-	280	456	9,092	12,751
Mich.	34	39	-	2	-	-	328	403	6,722	7,265
Wis.	39	74	-	4	1	-	214	267	2,741	3,126
W.N. CENTRAL	121	152	14	8	13	2	807	869	8,049	9,267
Minn.	42	48	8	5	-	-	307	309	1,314	1,618
Iowa	20	39	-	-	-	-	113	119	607	629
Mo.	31	22	2	-	1	-	223	237	4,006	4,540
N. Dak.	5	4	-	-	5	-	18	13	30	34
S. Dak.	8	16	3	1	-	-	23	35	108	139
Nebr.	6	16	1	2	-	-	57	72	678	805
Kans.	9	7	-	-	7	2	66	84	1,306	1,502
S. ATLANTIC	63	101	29	13	-	-	1,287	1,370	40,852	46,934
Del.	1	5	N	N	N	N	18	28	621	859
Md.	2	7	-	-	-	-	57	52	4,137	4,584
D.C.	1	-	-	-	-	-	18	20	1,103	1,426
Va.	18	24	5	1	-	-	187	110	4,618	5,309
W. Va.	2	2	-	-	-	-	16	20	458	539
N.C.	5	17	9	-	-	-	N	N	7,718	8,535
S.C.	-	1	-	-	-	-	59	38	4,262	4,819
Ga.	13	30	1	7	-	-	479	428	8,617	9,159
Fla.	21	15	14	5	-	-	453	674	9,318	11,704
E.S. CENTRAL	33	48	-	-	4	5	167	173	13,699	15,825
Ky.	11	13	-	-	4	5	N	N	1,848	1,822
Tenn.	14	23	-	-	-	-	74	79	4,071	4,841
Ala.	6	6	-	-	-	-	93	94	4,577	5,603
Miss.	2	6	-	-	-	-	-	-	3,203	3,559
W.S. CENTRAL	21	52	1	-	3	2	137	91	22,345	25,481
Ark.	4	3	-	-	-	-	75	66	2,139	2,409
La.	1	1	-	-	-	-	4	1	5,791	6,148
Okla.	9	10	-	-	-	-	58	23	2,186	2,341
Tex.	7	38	1	-	3	2	-	1	12,229	14,583
MOUNTAIN	87	104	10	8	4	2	672	676	5,188	5,760
Mont.	3	9	-	-	-	-	35	35	55	54
Idaho	18	7	5	2	-	-	75	46	39	39
Wyo.	2	3	-	1	-	-	10	12	26	31
Colo.	26	38	1	4	4	2	190	229	1,315	1,826
N. Mex.	2	4	3	1	-	-	21	77	615	785
Ariz.	16	14	N	N	N	N	129	83	2,016	1,879
Utah	14	19	1	-	-	-	149	125	214	120
Nev.	6	10	-	-	-	-	63	69	908	1,026
PACIFIC	97	172	2	4	-	-	1,284	1,705	14,753	15,478
Wash.	25	21	1	-	-	-	116	208	1,480	1,539
Oreg.	21	42	1	4	-	-	171	190	511	435
Calif.	50	84	-	-	-	-	935	1,209	12,212	12,827
Alaska	1	4	-	-	-	-	40	48	290	340
Hawaii	-	21	-	-	-	-	22	50	260	337
Guam	N	N	-	-	-	-	-	6	-	32
P.R.	-	1	-	-	-	-	29	26	106	224
V.I.	-	-	-	-	-	-	-	-	-	26
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.

* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending July 12, 2003, and July 13, 2002 (28th Week)*

Reporting area	<i>Haemophilus influenzae</i> , invasive [†]								Hepatitis (viral, acute), by type	
	All ages		Age <5 years						A	
	All serotypes		Serotype b		Non-serotype b		Unknown serotype		Cum.	Cum.
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	2003	2002
UNITED STATES	911	1,000	8	18	53	78	102	93	2,943	5,086
NEW ENGLAND	68	67	-	-	6	7	5	1	131	185
Maine	2	1	-	-	-	-	1	-	6	6
N.H.	9	5	-	-	-	-	-	-	8	10
Vt.	6	5	-	-	-	-	-	-	4	1
Mass.	36	29	-	-	6	3	3	1	69	81
R.I.	4	9	-	-	-	-	1	-	11	27
Conn.	11	18	-	-	-	4	-	-	33	60
MID. ATLANTIC	192	180	-	2	1	8	28	19	585	651
Upstate N.Y.	73	68	-	2	1	2	9	6	65	105
N.Y. City	28	42	-	-	-	-	6	8	176	226
N.J.	38	38	-	-	-	-	6	5	82	104
Pa.	53	32	-	-	-	6	7	-	262	216
E.N. CENTRAL	121	207	1	2	4	8	17	26	323	615
Ohio	43	54	-	-	-	1	7	4	65	174
Ind.	27	31	-	1	2	7	-	-	32	32
Ill.	34	77	-	-	-	-	8	14	92	165
Mich.	12	8	1	1	2	-	1	-	110	126
Wis.	5	37	-	-	-	-	1	8	24	118
W.N. CENTRAL	68	38	-	-	6	2	6	3	106	184
Minn.	25	20	-	-	6	2	1	1	32	26
Iowa	-	1	-	-	-	-	-	-	18	39
Mo.	27	9	-	-	-	-	5	2	34	54
N. Dak.	1	4	-	-	-	-	-	-	-	1
S. Dak.	1	1	-	-	-	-	-	-	-	3
Nebr.	2	-	-	-	-	-	-	-	5	9
Kans.	12	3	-	-	-	-	-	-	17	52
S. ATLANTIC	212	222	-	3	7	11	14	17	746	1,419
Del.	-	-	-	-	-	-	-	-	4	10
Md.	47	58	-	1	4	1	-	-	72	160
D.C.	-	-	-	-	-	-	-	-	24	49
Va.	31	17	-	-	-	-	5	2	46	50
W. Va.	7	7	-	-	-	-	-	1	11	10
N.C.	17	21	-	-	1	3	1	-	35	131
S.C.	3	8	-	-	-	-	-	2	18	42
Ga.	46	51	-	-	-	-	5	9	315	292
Fla.	61	60	-	2	2	7	3	3	221	675
E.S. CENTRAL	47	37	1	1	-	3	6	7	88	165
Ky.	2	3	-	-	-	-	-	-	16	38
Tenn.	27	19	-	-	-	-	4	5	48	65
Ala.	16	9	1	1	-	3	1	1	11	23
Miss.	2	6	-	-	-	-	1	1	13	39
W.S. CENTRAL	39	35	1	2	5	5	2	2	74	514
Ark.	5	1	-	-	1	-	-	-	15	25
La.	7	4	-	-	-	-	2	2	27	48
Okla.	25	28	-	-	4	5	-	-	8	24
Tex.	2	2	1	2	-	-	-	-	24	417
MOUNTAIN	112	118	4	4	14	19	18	9	255	310
Mont.	-	-	-	-	-	-	-	-	2	9
Idaho	3	2	-	-	-	-	1	1	-	20
Wyo.	1	2	-	-	-	-	-	-	1	2
Colo.	19	21	-	-	-	-	4	2	35	47
N. Mex.	13	19	-	-	3	4	2	1	9	9
Ariz.	60	53	4	2	6	12	7	3	155	169
Utah	10	14	-	1	2	3	4	-	20	24
Nev.	6	7	-	1	3	-	-	2	33	30
PACIFIC	52	96	1	4	10	15	6	9	635	1,043
Wash.	6	2	-	1	4	1	1	-	32	98
Oreg.	30	37	-	-	-	-	3	3	36	43
Calif.	11	31	1	3	6	14	2	2	559	880
Alaska	-	1	-	-	-	-	-	1	6	7
Hawaii	5	25	-	-	-	-	-	3	2	15
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	1	-	-	-	-	-	-	20	116
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

[†] Non-serotype b: nontypeable and type other than b; Unknown serotype: type unknown or not reported. Previously, cases reported without type information were counted as non-serotype b.

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending July 12, 2003, and July 13, 2002 (28th Week)*

Reporting area	Hepatitis (viral, acute), by type				Legionellosis		Listeriosis		Lyme disease	
	B		C		Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002						
UNITED STATES	3,205	3,847	702	976	682	450	227	254	4,165	6,494
NEW ENGLAND	129	145	-	17	23	30	13	24	471	1,113
Maine	1	4	-	-	1	2	2	2	-	-
N.H.	11	12	-	-	4	4	2	2	19	62
Vt.	2	3	-	12	1	3	-	1	8	11
Mass.	103	80	-	5	7	17	6	14	57	949
R.I.	4	17	-	-	2	-	-	1	119	46
Conn.	8	29	U	U	8	4	3	4	268	45
MID. ATLANTIC	495	849	91	54	138	120	46	52	3,060	4,011
Upstate N.Y.	54	68	30	26	39	29	11	17	1,343	1,445
N.Y. City	205	445	-	-	10	21	9	14	2	45
N.J.	103	152	-	4	2	19	7	7	442	1,351
Pa.	133	184	61	24	87	51	19	14	1,273	1,170
E.N. CENTRAL	225	308	119	59	149	110	29	35	94	611
Ohio	80	49	6	-	89	39	9	9	24	23
Ind.	15	18	-	-	8	5	1	4	6	6
Ill.	1	56	7	12	3	14	5	9	-	25
Mich.	107	154	106	45	40	32	11	9	1	10
Wis.	22	31	-	2	9	20	3	4	63	547
W.N. CENTRAL	160	115	122	453	30	25	6	8	92	90
Minn.	21	8	4	1	3	2	2	-	60	48
Iowa	4	11	-	1	5	6	-	1	11	15
Mo.	105	63	117	443	15	8	1	5	15	21
N. Dak.	-	4	-	-	1	-	-	1	-	-
S. Dak.	2	-	-	-	1	2	-	-	-	-
Nebr.	14	16	1	8	2	7	3	-	2	2
Kans.	14	13	-	-	3	-	-	1	4	4
S. ATLANTIC	1,013	919	102	102	211	96	55	39	355	504
Del.	5	8	-	-	7	5	N	N	60	73
Md.	64	78	10	6	45	17	8	5	206	300
D.C.	1	9	-	-	1	5	-	-	5	12
Va.	84	114	2	1	44	8	7	3	27	26
W. Va.	10	13	1	1	3	-	2	-	3	5
N.C.	96	133	6	14	16	5	10	3	28	52
S.C.	73	66	26	4	4	6	1	5	1	5
Ga.	345	237	3	44	14	7	16	8	10	1
Fla.	335	261	54	32	77	43	11	15	15	30
E.S. CENTRAL	212	201	44	67	46	13	10	8	23	32
Ky.	40	32	7	2	19	7	1	2	5	13
Tenn.	98	78	9	16	17	1	1	3	9	7
Ala.	37	44	5	3	9	5	6	3	1	6
Miss.	37	47	23	46	1	-	2	-	8	6
W.S. CENTRAL	158	580	141	126	10	12	6	17	16	79
Ark.	29	70	3	10	1	-	1	-	-	-
La.	32	68	27	52	-	4	-	1	3	3
Okla.	26	23	1	4	4	2	1	4	-	-
Tex.	71	419	110	60	5	6	4	12	13	76
MOUNTAIN	343	270	35	33	37	15	16	19	7	8
Mont.	8	3	1	-	2	1	1	-	-	-
Idaho	-	5	-	-	3	-	-	2	2	2
Wyo.	22	12	-	5	2	1	-	-	-	-
Colo.	46	41	21	4	8	3	7	2	1	-
N. Mex.	18	63	-	2	2	1	2	2	-	1
Ariz.	177	89	4	3	9	3	5	9	-	2
Utah	31	22	-	2	7	5	-	3	2	2
Nev.	41	35	9	17	4	1	1	1	2	1
PACIFIC	470	460	48	65	38	29	46	52	47	46
Wash.	31	35	8	13	4	1	2	4	-	-
Oreg.	69	81	8	9	N	N	2	4	12	7
Calif.	359	334	31	43	34	28	40	39	34	38
Alaska	7	6	1	-	-	-	-	-	1	1
Hawaii	4	4	-	-	-	-	2	5	N	N
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	34	97	-	-	-	-	-	2	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending July 12, 2003, and July 13, 2002 (28th Week)*

Reporting area	Malaria		Meningococcal disease		Pertussis		Rabies, animal		Rocky Mountain spotted fever	
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	427	640	930	1,129	2,951	3,818	2,528	3,804	224	401
NEW ENGLAND	11	38	48	65	275	343	238	423	-	2
Maine	1	1	5	2	9	5	22	23	-	-
N.H.	1	5	3	8	23	7	5	18	-	-
Vt.	-	1	-	4	30	63	18	61	-	-
Mass.	9	16	31	34	206	246	93	140	-	2
R.I.	-	3	2	4	6	4	26	32	-	-
Conn.	-	12	7	13	1	18	74	149	-	-
MID. ATLANTIC	100	162	120	150	284	165	233	582	11	37
Upstate N.Y.	29	21	28	34	148	112	170	316	1	-
N.Y. City	45	100	24	23	-	9	1	10	4	8
N.J.	9	23	19	23	23	-	62	84	3	14
Pa.	17	18	49	70	113	44	-	172	3	15
E.N. CENTRAL	44	94	150	171	209	448	45	45	6	12
Ohio	11	12	45	54	120	225	17	10	4	4
Ind.	1	5	28	22	29	22	5	8	-	1
Ill.	15	42	33	39	-	72	6	8	-	6
Mich.	15	27	30	26	25	33	15	12	2	1
Wis.	2	8	14	30	35	96	2	7	-	-
W.N. CENTRAL	25	41	87	89	170	310	356	262	16	61
Minn.	13	14	18	21	59	109	17	16	1	-
Iowa	3	2	16	13	41	98	50	36	2	1
Mo.	2	11	38	35	38	62	6	19	11	57
N. Dak.	1	1	1	-	2	5	35	23	-	-
S. Dak.	1	-	1	2	3	5	67	53	-	-
Nebr.	-	5	6	13	2	3	60	-	1	3
Kans.	5	8	7	5	25	28	121	115	1	-
S. ATLANTIC	123	129	169	171	246	223	1,290	1,355	151	185
Del.	-	1	7	6	1	2	23	24	-	-
Md.	34	45	16	4	34	28	147	223	45	22
D.C.	7	8	-	-	-	1	-	-	-	-
Va.	14	12	18	27	58	90	290	290	4	12
W. Va.	4	2	1	-	5	12	47	95	3	1
N.C.	8	9	19	19	75	20	412	354	67	101
S.C.	3	5	9	16	13	28	109	47	10	31
Ga.	21	17	20	20	23	18	199	228	17	15
Fla.	32	30	79	79	37	24	63	94	5	3
E.S. CENTRAL	7	9	46	63	69	114	33	147	32	60
Ky.	1	2	8	11	19	47	21	16	-	2
Tenn.	4	2	12	23	35	40	-	108	24	29
Ala.	2	3	12	15	12	20	12	23	3	9
Miss.	-	2	14	14	3	7	-	-	5	20
W.S. CENTRAL	13	25	65	135	237	892	157	696	3	35
Ark.	4	1	10	20	7	414	25	-	-	-
La.	2	3	24	27	6	5	-	-	-	-
Okla.	3	-	10	16	12	34	132	64	2	28
Tex.	4	21	21	72	212	439	-	632	1	7
MOUNTAIN	17	28	47	63	550	461	73	142	5	8
Mont.	-	-	2	2	1	2	11	7	1	1
Idaho	1	-	6	3	33	46	3	8	1	-
Wyo.	1	-	2	-	118	7	1	13	2	2
Colo.	11	15	12	21	191	183	11	20	-	1
N. Mex.	-	1	6	3	29	87	5	5	-	-
Ariz.	2	5	14	19	106	90	36	85	1	-
Utah	1	4	1	1	55	27	5	2	-	-
Nev.	1	3	4	14	17	19	1	2	-	4
PACIFIC	87	114	198	222	911	862	103	152	-	1
Wash.	13	12	16	42	258	276	-	-	-	-
Oreg.	7	5	35	34	233	98	4	3	-	1
Calif.	63	89	142	139	412	471	96	123	-	-
Alaska	-	2	1	1	-	4	3	26	-	-
Hawaii	4	6	4	6	8	13	-	-	-	-
Guam	-	-	-	1	-	2	-	-	-	-
P.R.	-	1	2	5	-	2	38	46	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
 * Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending July 12, 2003, and July 13, 2002 (28th Week)*

Reporting area	Salmonellosis		Shigellosis		Streptococcal disease, invasive, group A		<i>Streptococcus pneumoniae</i> , invasive			
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Drug resistant, all ages		Age <5 years	
							Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	15,081	17,966	9,756	8,400	3,203	2,948	1,329	1,631	245	190
NEW ENGLAND	839	980	137	137	189	227	16	72	5	1
Maine	55	71	6	3	19	16	-	-	-	-
N.H.	60	62	4	5	19	26	-	-	N	N
Vt.	31	36	5	-	16	9	6	3	2	1
Mass.	474	569	84	99	130	79	N	N	N	N
R.I.	39	55	4	6	5	13	10	6	3	-
Conn.	180	187	34	24	-	84	-	63	U	U
MID. ATLANTIC	1,759	2,555	1,091	692	564	502	84	77	62	52
Upstate N.Y.	440	682	163	94	261	206	43	68	49	42
N.Y. City	469	639	174	226	78	122	U	U	U	U
N.J.	196	549	157	253	41	102	N	N	N	N
Pa.	654	685	597	119	184	72	41	9	13	10
E.N. CENTRAL	2,130	2,787	929	883	765	638	301	138	96	66
Ohio	677	670	194	355	226	143	199	18	70	-
Ind.	261	210	73	39	76	36	102	118	21	27
Ill.	592	1,014	452	331	178	194	-	2	-	-
Mich.	348	453	145	79	268	191	N	N	N	N
Wis.	252	440	65	79	17	74	N	N	5	39
W.N. CENTRAL	1,130	1,139	404	634	222	171	118	320	40	37
Minn.	278	261	46	124	111	87	-	220	34	33
Iowa	175	188	24	65	N	N	N	N	N	N
Mo.	411	391	200	86	44	37	8	5	2	1
N. Dak.	23	24	3	16	9	-	3	1	4	3
S. Dak.	38	45	9	150	17	9	-	1	-	-
Nebr.	71	71	85	137	20	14	-	25	N	N
Kans.	134	159	37	56	21	24	107	68	N	N
S. ATLANTIC	4,028	4,040	3,957	2,716	598	478	667	754	8	16
Del.	35	35	136	11	6	1	1	3	N	N
Md.	395	377	299	477	185	74	-	-	-	13
D.C.	16	40	30	36	10	5	2	-	4	1
Va.	428	396	219	488	79	51	N	N	N	N
W. Va.	49	47	-	4	27	11	41	34	4	2
N.C.	533	528	470	154	66	93	N	N	U	U
S.C.	203	243	234	58	24	29	74	130	N	N
Ga.	782	727	1,138	664	78	93	183	192	N	N
Fla.	1,587	1,647	1,431	824	123	121	366	395	N	N
E.S. CENTRAL	1,010	1,140	488	696	130	70	91	95	-	-
Ky.	188	161	60	76	31	12	11	12	N	N
Tenn.	323	287	164	33	99	58	80	83	N	N
Ala.	261	303	162	345	-	-	-	-	N	N
Miss.	238	389	102	242	-	-	-	-	-	-
W.S. CENTRAL	944	1,786	1,230	1,316	109	190	30	143	30	15
Ark.	259	313	52	106	4	5	7	5	-	-
La.	137	375	113	278	1	1	23	138	10	4
Okla.	181	182	476	237	55	33	N	N	20	1
Tex.	367	916	589	695	49	151	N	N	-	10
MOUNTAIN	1,032	1,036	495	292	319	357	19	32	4	3
Mont.	49	48	2	2	2	-	-	-	-	-
Idaho	93	60	11	2	12	5	N	N	N	N
Wyo.	49	30	1	3	1	7	4	10	-	-
Colo.	247	280	78	61	87	76	-	-	-	-
N. Mex.	88	141	94	55	79	70	15	22	-	-
Ariz.	322	276	255	135	129	175	-	-	N	N
Utah	104	83	27	18	8	24	-	-	4	3
Nev.	80	118	27	16	1	-	-	-	-	-
PACIFIC	2,209	2,503	1,025	1,034	307	315	3	-	-	-
Wash.	261	234	82	70	26	18	-	-	N	N
Oreg.	201	196	53	45	N	N	N	N	N	N
Calif.	1,632	1,904	878	884	240	263	N	N	N	N
Alaska	48	35	4	2	-	-	-	-	N	N
Hawaii	67	134	8	33	41	34	3	-	-	-
Guam	-	27	-	18	-	-	-	3	-	-
P.R.	124	211	1	18	N	N	N	N	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	U	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.

* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending July 12, 2003, and July 13, 2002 (28th Week)*

Reporting area	Syphilis				Tuberculosis		Typhoid fever		Varicella (Chickenpox)
	Primary & secondary		Congenital		Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002					
UNITED STATES	3,520	3,470	185	220	5,135	6,524	124	166	7,516
NEW ENGLAND	113	65	1	-	151	219	12	8	1,223
Maine	4	1	1	-	5	9	-	-	628
N.H.	12	-	-	-	7	7	1	-	-
Vt.	-	1	-	-	3	4	-	-	487
Mass.	75	48	-	-	94	103	4	6	105
R.I.	10	1	-	-	19	32	2	-	3
Conn.	12	14	-	-	23	64	5	2	-
MID. ATLANTIC	409	387	35	29	1,065	1,124	16	46	13
Upstate N.Y.	17	19	7	1	133	156	3	3	N
N.Y. City	241	230	21	12	613	550	7	23	-
N.J.	81	72	7	15	201	250	5	13	-
Pa.	70	66	-	1	118	168	1	7	13
E.N. CENTRAL	486	667	38	33	568	623	10	17	3,591
Ohio	119	76	2	-	100	102	-	4	886
Ind.	25	36	7	1	67	60	4	2	-
Ill.	178	253	13	26	267	287	-	6	-
Mich.	155	290	16	6	112	135	6	3	2,218
Wis.	9	12	-	-	22	39	-	2	487
W.N. CENTRAL	82	70	2	-	192	287	2	6	37
Minn.	26	32	-	-	89	123	-	3	N
Iowa	4	2	-	-	11	17	1	-	N
Mo.	30	16	2	-	18	84	1	1	-
N. Dak.	-	-	-	-	-	4	-	-	37
S. Dak.	1	-	-	-	16	10	-	-	-
Nebr.	1	5	-	-	9	9	-	2	-
Kans.	20	15	-	-	49	40	-	-	-
S. ATLANTIC	942	848	35	54	1,015	1,326	28	18	1,473
Del.	4	8	-	-	-	7	-	-	16
Md.	160	102	6	10	117	148	7	4	-
D.C.	28	26	1	1	-	-	-	-	18
Va.	47	40	1	1	92	135	10	-	402
W. Va.	-	-	-	-	10	12	-	-	881
N.C.	90	158	9	14	148	166	5	-	N
S.C.	59	69	4	6	85	102	-	-	156
Ga.	214	168	3	9	152	257	3	4	-
Fla.	340	277	11	13	411	499	3	10	N
E.S. CENTRAL	167	287	12	15	342	414	3	4	-
Ky.	22	52	1	2	62	70	-	4	N
Tenn.	72	110	6	5	112	158	1	-	N
Ala.	61	94	4	5	124	120	2	-	-
Miss.	12	31	1	3	44	66	-	-	-
W.S. CENTRAL	435	431	29	50	599	1,023	1	19	823
Ark.	25	17	-	3	52	71	-	-	-
La.	56	66	-	-	-	-	-	-	3
Okla.	31	34	1	1	71	88	-	-	N
Tex.	323	314	28	46	476	864	1	19	820
MOUNTAIN	147	171	19	8	174	210	3	7	356
Mont.	-	-	-	-	-	6	-	-	N
Idaho	6	1	-	-	3	10	-	-	N
Wyo.	-	-	-	-	2	2	-	-	35
Colo.	12	34	3	1	42	38	3	3	-
N. Mex.	28	19	-	-	6	22	-	-	-
Ariz.	91	108	16	7	83	103	-	-	3
Utah	4	2	-	-	17	16	-	2	318
Nev.	6	7	-	-	21	13	-	2	-
PACIFIC	739	544	14	31	1,029	1,298	49	41	-
Wash.	40	26	-	1	113	125	2	4	-
Oreg.	23	7	-	-	69	55	3	2	-
Calif.	675	506	14	29	796	1,016	44	35	-
Alaska	-	-	-	-	29	30	-	-	-
Hawaii	1	5	-	1	22	72	-	-	-
Guam	-	6	-	-	-	36	-	-	-
P.R.	110	147	1	18	33	57	-	-	245
V.I.	-	1	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,* week ending July 12, 2003 (28th Week)

Reporting Area	All causes, by age (years)							P&I [†] Total	Reporting Area	All causes, by age (years)							P&I [†] Total
	All Ages	≥65	45-64	25-44	1-24	<1	All Ages			≥65	45-64	25-44	1-24	<1			
NEW ENGLAND	636	440	133	38	10	15	65	S. ATLANTIC	1,247	770	286	114	39	37	82		
Boston, Mass.	155	99	37	9	4	6	14	Atlanta, Ga.	123	71	29	17	3	3	7		
Bridgeport, Conn.	45	31	10	1	2	1	4	Baltimore, Md.	133	88	24	13	3	4	15		
Cambridge, Mass.	21	16	4	1	-	-	1	Charlotte, N.C.	98	63	24	5	3	3	9		
Fall River, Mass.	44	31	7	5	1	-	8	Jacksonville, Fla.	163	101	36	16	4	6	5		
Hartford, Conn.	49	32	14	2	-	1	4	Miami, Fla.	137	75	38	13	7	4	9		
Lowell, Mass.	15	10	2	2	-	1	-	Norfolk, Va.	42	26	10	4	1	1	1		
Lynn, Mass.	10	7	3	-	-	-	-	Richmond, Va.	76	42	19	5	7	3	5		
New Bedford, Mass.	37	30	3	3	-	1	2	Savannah, Ga.	78	56	12	5	1	4	8		
New Haven, Conn.	53	36	10	4	-	3	9	St. Petersburg, Fla.	56	41	10	4	-	1	6		
Providence, R.I.	26	19	6	1	-	-	2	Tampa, Fla.	162	103	38	15	4	2	9		
Somerville, Mass.	5	3	2	-	-	-	1	Washington, D.C.	163	91	44	16	6	6	5		
Springfield, Mass.	64	40	17	5	2	-	11	Wilmington, Del.	16	13	2	1	-	-	3		
Waterbury, Conn.	51	40	6	3	1	1	3	E.S. CENTRAL	714	443	190	50	18	12	54		
Worcester, Mass.	61	46	12	2	-	1	6	Birmingham, Ala.	124	77	26	9	5	6	12		
MID. ATLANTIC	2,293	1,623	453	146	38	31	120	Chattanooga, Tenn.	60	38	13	6	2	1	4		
Albany, N.Y.	41	31	7	3	-	-	3	Knoxville, Tenn.	89	56	23	7	2	1	5		
Allentown, Pa.	24	22	2	-	-	-	4	Lexington, Ky.	55	31	20	3	1	-	7		
Buffalo, N.Y.	75	42	24	6	1	2	4	Memphis, Tenn.	138	87	39	10	2	-	10		
Camden, N.J.	22	13	5	3	1	-	1	Mobile, Ala.	40	25	14	-	-	1	3		
Elizabeth, N.J.	35	18	8	6	3	-	-	Montgomery, Ala.	20	12	5	3	-	-	1		
Erie, Pa.	41	28	11	2	-	-	2	Nashville, Tenn.	188	117	50	12	6	3	12		
Jersey City, N.J.	36	29	5	1	-	1	-	W.S. CENTRAL	1,139	696	234	111	65	33	59		
New York City, N.Y.	1,253	882	241	92	21	16	52	Austin, Tex.	75	46	16	8	4	1	1		
Newark, N.J.	45	22	14	5	2	1	6	Baton Rouge, La.	41	27	9	4	1	-	-		
Paterson, N.J.	25	10	9	2	2	2	1	Corpus Christi, Tex.	32	25	5	1	-	1	2		
Philadelphia, Pa.	281	208	53	12	4	4	15	Dallas, Tex.	195	107	52	23	10	3	13		
Pittsburgh, Pa. [‡]	22	16	4	2	-	-	2	El Paso, Tex.	79	58	14	6	-	1	-		
Reading, Pa.	24	16	7	1	-	-	3	Ft. Worth, Tex.	116	83	20	7	2	4	6		
Rochester, N.Y.	150	111	28	8	2	1	10	Houston, Tex.	331	173	65	38	39	16	28		
Schenectady, N.Y.	31	24	7	-	-	-	4	Little Rock, Ark.	72	38	20	8	4	2	1		
Scranton, Pa.	34	29	5	-	-	-	4	New Orleans, La.	U	U	U	U	U	U	U		
Syracuse, N.Y.	82	70	9	1	1	1	6	San Antonio, Tex.	161	114	25	14	3	5	6		
Trenton, N.J.	31	19	7	1	1	3	1	Shreveport, La.	37	25	8	2	2	-	2		
Utica, N.Y.	16	13	3	-	-	-	1	Tulsa, Okla.	U	U	U	U	U	U	U		
Yonkers, N.Y.	25	20	4	1	-	-	1	MOUNTAIN	831	561	179	51	23	17	43		
E.N. CENTRAL	1,956	1,284	415	162	52	42	125	Albuquerque, N.M.	91	58	19	12	2	-	6		
Akron, Ohio	48	41	3	2	1	1	6	Boise, Idaho	54	34	14	4	2	-	3		
Canton, Ohio	34	25	8	1	-	-	4	Colo. Springs, Colo.	67	46	15	2	2	2	1		
Chicago, Ill.	393	221	90	47	22	12	16	Denver, Colo.	90	59	16	5	5	5	5		
Cincinnati, Ohio	101	71	23	3	3	1	11	Las Vegas, Nev.	236	164	49	14	6	3	9		
Cleveland, Ohio	97	61	26	6	-	4	3	Ogden, Utah	30	16	11	1	2	-	-		
Columbus, Ohio	217	133	55	23	3	3	10	Phoenix, Ariz.	U	U	U	U	U	U	U		
Dayton, Ohio	134	96	26	8	3	1	7	Pueblo, Colo.	39	29	8	1	1	-	3		
Detroit, Mich.	220	126	50	28	9	7	12	Salt Lake City, Utah	89	60	20	4	-	5	6		
Evansville, Ind.	40	29	6	5	-	-	5	Tucson, Ariz.	135	95	27	8	3	2	10		
Fort Wayne, Ind.	50	30	15	3	1	1	3	PACIFIC	1,200	807	244	94	30	25	93		
Gary, Ind.	U	U	U	U	U	U	U	Berkeley, Calif.	U	U	U	U	U	U	U		
Grand Rapids, Mich.	44	29	10	1	1	3	5	Fresno, Calif.	116	79	19	10	4	4	9		
Indianapolis, Ind.	137	95	26	10	5	1	9	Glendale, Calif.	12	10	1	1	-	-	1		
Lansing, Mich.	41	27	9	1	3	1	3	Honolulu, Hawaii	94	64	23	2	3	2	8		
Milwaukee, Wis.	110	83	18	7	1	1	12	Long Beach, Calif.	61	44	12	4	1	-	7		
Peoria, Ill.	37	31	4	2	-	-	6	Los Angeles, Calif.	194	125	40	23	3	3	14		
Rockford, Ill.	62	44	13	4	-	1	5	Pasadena, Calif.	U	U	U	U	U	U	U		
South Bend, Ind.	50	35	10	4	-	1	2	Portland, Oreg.	181	118	42	14	6	1	9		
Toledo, Ohio	87	63	15	6	-	3	5	Sacramento, Calif.	U	U	U	U	U	U	U		
Youngstown, Ohio	54	44	8	1	-	1	1	San Diego, Calif.	175	121	37	8	2	7	13		
W.N. CENTRAL	364	250	64	33	7	10	30	San Francisco, Calif.	U	U	U	U	U	U	U		
Des Moines, Iowa	29	22	6	-	-	1	1	San Jose, Calif.	149	103	32	8	4	2	12		
Duluth, Minn.	38	27	6	4	-	1	4	Santa Cruz, Calif.	45	36	3	6	-	-	11		
Kansas City, Kans.	3	1	1	-	1	-	1	Seattle, Wash.	106	58	26	13	3	6	5		
Kansas City, Mo.	84	56	12	11	1	4	6	Spokane, Wash.	67	49	9	5	4	-	4		
Lincoln, Nebr.	38	32	1	5	-	-	3	Tacoma, Wash.	U	U	U	U	U	U	U		
Minneapolis, Minn.	62	38	15	6	2	1	7	TOTAL	10,380 [¶]	6,874	2,198	799	282	222	671		
Omaha, Nebr.	59	43	9	4	2	1	6										
St. Louis, Mo.	U	U	U	U	U	U	U										
St. Paul, Minn.	48	30	12	3	1	2	2										
Wichita, Kans.	3	1	2	-	-	-	-										

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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