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Outbreak of Histoplasmosis Among Travelers Returning From El Salvador — Pennsylvania and Virginia, 2008

Histoplasmosis is a fungal disease caused by infection with *Histoplasma capsulatum*. Histoplasmosis, which can be acquired from soil contaminated with bird or bat droppings, occurs worldwide and is one of the most common pulmonary and systemic mycoses in the United States (1). However, among international travelers returning from areas in which histoplasmosis is endemic, histoplasmosis is rare, accounting for <0.5% of all diseases diagnosed in this group (1,2). During February–March 2008, the Pennsylvania and Virginia departments of health investigated a cluster of respiratory illness among three mission groups that had traveled separately to El Salvador to renovate a church. This report summarizes the results of the investigation. Of 33 travelers in the three mission groups for whom information was available, 20 (61%) met the case definition for histoplasmosis. Persons who reported sweeping and cleaning outdoors (relative risk [RR] = 2.1, 95% confidence interval [CI] = 1.3–3.6), digging (RR = 2.6, CI = 1.1–6.1), or working in a bird or bat roosting area (RR = 1.8, CI = 1.3–2.4) had a greater risk for illness. The findings emphasize the need for travelers and persons involved in construction activities to use personal protective equipment and decrease dust-generation when working in areas where histoplasmosis is endemic. Clinicians should consider histoplasmosis as a possible cause of acute respiratory or influenza-like illness in travelers returning from areas in which histoplasmosis is endemic.

On February 13, 2008, the Pennsylvania Department of Health (PADOH) notified the Virginia Department of Health (VDH) of a cluster of nine persons with respiratory illness. The nine persons were among 11 members of a Pennsylvania-based mission group who had been renovating a church in Nueva San Salvador, El Salvador, during January 20–27, 2008. Two other mission groups, one from Virginia (16 members) and one from Pennsylvania (eight members), had traveled separately to assist with renovations of the same church during January 3–10,

2008 and February 2–10, 2008, respectively. After arrival, mission members immediately began renovation activities at the church. Renovation projects varied among the mission groups and included cleaning of indoor and outdoor renovation sites, electrical and plumbing installation, construction of additional rooms, roof replacement, and septic tank excavation. Mission members remained in El Salvador for the entire trip, but also visited local markets and churches and took a 1-day trip to either a beach or lake.

The initial report from PADOH indicated that all nine persons from the initial cluster, upon returning from El Salvador, had presented to their health-care providers with respiratory symptoms. One of these persons was diagnosed with suspected histoplasmosis based on physical exam and a chest radiograph. To search for additional cases of illness among the mission groups, PADOH and VDH contacted the trip organizers and leaders.

A case of histoplasmosis was defined as 1) a laboratory-confirmed *H. capsulatum* infection or 2) self-reported fever and two additional symptoms (i.e., headache, cough, chest pain, or difficulty breathing) beginning at least 24 hours after arrival in El Salvador, in any mission group member who traveled to El Salvador during January 3–February 10, 2008. Laboratory-confirmation was defined as either a urine or serum *Histoplasma* antigen enzyme immunoassay (EIA) test result of ≥ 0.6 ng/mL.

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All participants from each mission group were administered a standard questionnaire through their church pastors or through telephone interviews. Information collected included demographics, illness, underlying health conditions, protective measures used, and potential exposures. Medical records of hospitalized patients also were reviewed, and a retrospective cohort study of the mission members was conducted.

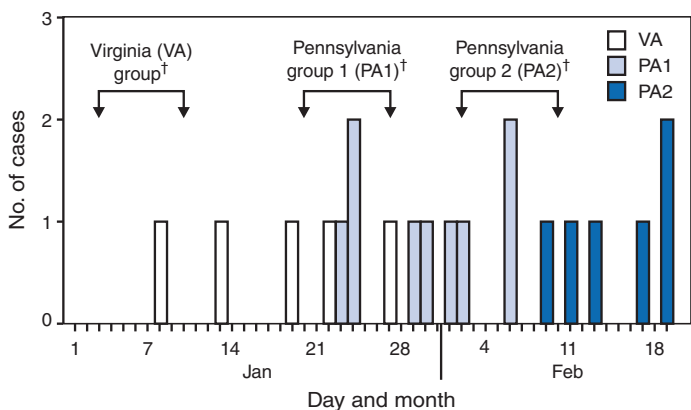
Statistical differences between proportions were assessed using chi-square and Fisher's exact tests of significance, when appropriate. Mean ages were compared using a t-test. Relative risk and 95% confidence interval estimates were calculated using Poisson regression analysis with robust variance.

Information was collected from 33 (94%) of the 35 mission group participants. Twenty persons (12 males and eight females) met the case definition for histoplasmosis, for an overall attack rate of 61%. The 20 cases included histoplasmosis in five (36%) of 14 persons from the Virginia mission group, nine (82%) of 11 persons from the first Pennsylvania mission group, and six (75%) of eight persons from the second Pennsylvania mission group (Figure). Seven (35%) of the 20 ill persons met the case definition through laboratory-confirmed histoplasmosis based on urine specimens tested by EIA. The other 13 (65%) ill persons met the case definition through the symptom criteria, but eight of these 13 persons had urine specimens that tested negative by EIA. No participants had paired serologic antibody test results available. Median time from symptom onset to specimen collection date was 6 days (range: 1–28 days).

Incubation periods could not be calculated because exact dates of exposure were not available; however, the median number of days between arriving in El Salvador and onset of symptoms was 12 (range: 3–25 days). Primary symptoms reported among the 20 ill persons meeting the case definition included fatigue (100%), fever or chills (95%), and headache (95%) (Table 1). Nineteen (95%) of the 20 ill persons visited a health-care provider, and six (30%) required hospitalization for their illness; all subsequently recovered. Because the clinical manifestation of histoplasmosis partly depends on the underlying health and immune status of the host, mission members were asked about their underlying medical conditions. Three ill persons reported a history of cancer, none reported a history of chronic lung disease, and none were current smokers.

Differences in age ($p=0.13$), sex ($p=0.44$), and membership in mission group ($p=0.06$) were not statistically significant. Digging (RR = 2.6), sweeping or cleaning outdoors (RR = 2.1), and septic tank excavation (RR = 1.7) were associated with increased risk for illness (Table 2). For those persons who reported two or three high-risk exposures, defined as digging, sweeping indoors, or sweeping outdoors, the relative risk for illness was elevated (RR = 2.6), compared with those

FIGURE. Number of cases of histoplasmosis* among travelers returning from El Salvador, by date of symptom onset — Pennsylvania and Virginia, 2008



* A histoplasmosis case was defined as a laboratory-confirmed infection (i.e., a urine or serum *Histoplasma* antigen enzyme immunoassay test result of ≥ 0.6 ng/mL) or self-reported fever and two additional symptoms, including headache, cough, chest pain, or difficulty breathing, associated with travel to El Salvador during January 3–February 10, 2008.

† Interval of stay in El Salvador.

who reported no such high-risk exposures. In addition, those persons who worked in an area where bird or bat excrement was observed or where birds or bats were roosting had a higher attack rate than those who did not work in such areas. Sample size was not sufficient to stratify the analysis by mission group. None of the participants reported wearing a mask as personal protective equipment while working at the church site.

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Editorial Note: *H. capsulatum*, the fungal causative agent of histoplasmosis, is endemic in the midwestern and central United States, Mexico, Central and South America, parts of eastern and southern Europe, parts of Africa, eastern Asia, and Australia (1). The fungus grows in the soil and its growth is thought to be enhanced by bird and bat excrement. Disruption of soil that contains bird or bat excrement is the primary means of aerosolization of and exposure to spores. Several reports have documented occupationally acquired outbreaks specifically associated with construction or renovation activities (4,5). However, persons not directly involved in the soil-disruption process, including travelers in the area, also are at increased risk because airborne spores can travel hundreds of feet (6). A histoplasmosis outbreak involving approximately 250 college students visiting a resort hotel in Mexico was associated with ongoing construction at the hotel (6).

This is the first report of an outbreak of histoplasmosis among volunteer workers performing construction activities abroad. Evidence gathered during this investigation is consistent

TABLE 1. Number and percentage of histoplasmosis cases (N = 20) with clinical symptoms and positive laboratory tests among participants in three separate mission trips to El Salvador, by symptom — United States, January–March 2008

Symptom	No.	(%)
Fatigue	20	(100)
Fever or chills	19	(95)
Headache	19	(95)
Cough	16	(80)
Diarrhea	14	(70)
Muscle/Chest pain	13	(65)
Weight loss	10	(50)
Joint pain	9	(45)
Difficulty breathing	7	(35)
Laboratory confirmed†	7	(35)

* A histoplasmosis case was defined as a laboratory-confirmed infection (i.e., a urine or serum *Histoplasma* antigen enzyme immunoassay (EIA) test result of ≥ 0.6 ng/mL) or self-reported fever and two additional symptoms, including headache, cough, chest pain, or difficulty breathing, associated with travel to El Salvador during January 3–February 10, 2008.

† Defined as urine or serum *Histoplasma* antigen EIA test of ≥ 0.6 ng/mL.

with previous research and revealed that performing outdoor activities, particularly those that cause soil disruption and spore aerosolization, increased the risk for acquiring histoplasmosis. Specifically, the two activities with the highest relative risk for illness were digging and sweeping outdoors.

Histoplasmosis infections typically are asymptomatic or cause mild symptoms from which persons recover without antifungal or other treatment; persons with more severe forms of the infection (i.e., acute pulmonary, chronic pulmonary, and progressive disseminated histoplasmosis) are recommended for treatment with antifungal agents, such as amphotericin B (7). In this outbreak, the high overall attack rate among an otherwise healthy cohort, along with illness severe enough to require health-care services (including hospitalization), suggests substantial exposure to fungal spores during the renovation activities. In addition, working in an environment harboring bird or bat excrement likely increased the risk for acquiring histoplasmosis.

Ultimately, the cause of this outbreak might be that the volunteers were not aware of the risk for histoplasmosis and therefore took no precautions, such as using personal protective equipment or taking care to decrease dust generation when working in this area of endemic disease. Although persons living or working in areas of endemic histoplasmosis might have previous health education and training about the risk and prevention of this disease, volunteers who travel to and work in these areas are likely to have limited, if any, training on disease risk and prevention.

Multiple laboratory tests, including culture, histopathology, serology, and EIA antigen tests, can be used to diagnose histoplasmosis. The sensitivity and specificity of these tests depend on factors that include the patient's clinical syndrome, type and

TABLE 2. Number of histoplasmosis* cases among participants in three separate mission trips to El Salvador, by exposure status and type of exposure — United States, January–March 2008

Type of exposure	Exposed			Not Exposed			Relative risk [§]	95% CI [¶]	p value
	Ill	Total [†]	% Ill	Ill	Total [§]	% Ill			
Sweeping/cleaning indoors	7	10	70	12	22	55	1.3	0.7–2.2	0.38
Sweeping/cleaning outdoors	11	12	92	9	21	43	2.1	1.3–3.6	<0.01
Digging	16	20	80	4	13	31	2.6	1.1–6.1	0.03
Septic tank excavation	9	11	82	10	21	48	1.7	1.0–2.9	0.04
Constructing steps**	2	3	67	3	11	27	2.4	0.7–8.6	0.16
Working in an area where bird or bat droppings were observed	1	1	100	19	32	59	1.7	1.3–2.2	<0.01
Working in or around mission building while birds or bats were roosting	4	4	100	16	28	57	1.8	1.3–2.4	<0.01
A combination of two or more types of exposure (digging, sweeping/cleaning indoors, or sweeping/cleaning outdoors)	6	7	86	14	26	54	2.6	1.1–6.1	0.03

* A histoplasmosis case was defined as a laboratory-confirmed infection (i.e., a urine or serum *Histoplasma* antigen enzyme immunoassay test result of ≥ 0.6 ng/mL) or self-reported fever and two additional symptoms, including headache, cough, chest pain, or difficulty breathing, associated with travel to El Salvador during January 3–February 10, 2008. Based on responses from 33 of 35 participants; total number responding to each question varied.

[†] Persons who reported participating in specified activity while in El Salvador.

[§] Persons who reported not participating in specified activity while in El Salvador.

[¶] Relative risk and 95% confidence intervals estimates calculated using Poisson regression analysis with robust variance.

** Information about exposure ascertained from Virginia mission participants (n = 14) only.

timing of specimen collection, fungal burden, and the host's immune status (8). In general, testing of convalescent serum samples offers the highest sensitivity for subacute and chronic pulmonary disease, and antigen testing (i.e., a quantitative, second-generation EIA), appears to be one of the most sensitive tests for acute pulmonary histoplasmosis (8). However, the EIA antigen test is less sensitive in milder infections when the fungal burden is lower (8,9). In this outbreak, five of seven patients with a positive urine EIA test required hospitalization.

The findings in this report are subject to at least three limitations. First, information about exposures and illness were ascertained via self-report, which might be associated with recall bias and subsequent exposure and disease misclassification. Second, misclassification of disease status is possible, given the negative antigen test results and given that infection with other respiratory pathogens (e.g., influenza virus) could not be ruled out for all ill persons. Finally, the majority of diagnostic specimens were tested by *Histoplasma* EIA only. Because EIA test sensitivity increases with increasing illness severity (8,9), specimens collected from persons with less severe disease might have tested falsely negative.

Persons in areas of endemic histoplasmosis who perform certain jobs or activities, such as construction and farming, are at risk for acquiring histoplasmosis (10). Travel clinics and organizers of group travel to areas of endemic histoplasmosis should be informed about the risk for histoplasmosis among travelers with potential exposure to *H. capsulatum*. Clinicians should consider a diagnosis of histoplasmosis when evaluating a patient who has acute febrile respiratory illness and has traveled to an area in which histoplasmosis is endemic.

Clinicians also should inquire about the patient's activities in the area of endemic disease. If histoplasmosis is suspected, consultation with laboratory experts is recommended to ensure the proper collection and referral of blood and urine specimens. Depending on the patient's clinical presentation, antigen testing for *Histoplasma*, convalescent serologic testing to detect antibodies, or culture might be performed to diagnose histoplasmosis. Travelers to areas of endemic histoplasmosis who visit caves or areas with high concentrations of bird or bat excrement, or who perform dust-generating activities, should consider using personal protective equipment (e.g., respirators) and dust-suppression strategies (e.g., keeping surfaces wet) to reduce their potential exposure to *H. capsulatum*.

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References

1. Panackal AA, Hajjeh RA, Cetron MS, Warnock DW. Fungal infections among returning travelers. *Clin Infect Dis* 2002;35:1088–95.
2. Freedman DO, Weld LH, Kozarsky PE, et al.; GeoSentinel Surveillance Network. Spectrum of disease and relation to place of exposure among ill returned travelers. *N Engl J Med* 2006;354:119–30.

3. Wheat LJ. Histoplasmosis: a review for clinicians from non-endemic areas. *Mycoses* 2006;49:274–82.
4. Huhn GD, Austin C, Carr M, et al. Two outbreaks of occupationally acquired histoplasmosis: more than workers at risk. *Environ Health Perspect* 2005;113:585–9.
5. CDC. Outbreak of histoplasmosis among industrial plant workers—Nebraska, 2004. *MMWR* 2004;53:1020–2.
6. Morgan J, Cano MV, Feikin DR, et al. A large outbreak of histoplasmosis among American travelers associated with a hotel in Acapulco, Mexico, spring 2001. *Am J Trop Med Hyg* 2003;69:663–9.
7. Kauffman CA. Histoplasmosis: a clinical and laboratory update. *Clin Micro Rev* 2007;20:115–32.
8. Wheat LJ. Improvements in diagnosis of histoplasmosis. *Expert Opin Biol Ther* 2006;6:1207–21.
9. Wheat LJ, Conces D, Allen SD, Blue-Hnidy D, Loyd J. Pulmonary histoplasmosis syndromes: recognition, diagnosis, and management. *Semin Respir Crit Care Med* 2004;25:129–44.
10. CDC. Histoplasmosis: protecting workers at risk, revised edition. Cincinnati, OH: US Department of Health and Human Services, CDC, National Institute for Occupational Safety and Health; 2004. Available at <http://www.cdc.gov/niosh/docs/2005-109>.

Effects of New Penicillin Susceptibility Breakpoints for *Streptococcus pneumoniae* – United States, 2006–2007

Streptococcus pneumoniae (pneumococcus) is a common cause of pneumonia and meningitis in the United States. Antimicrobial resistance, which can result in pneumococcal infection treatment failure, is identified by measuring the minimum inhibitory concentration (MIC) of an antimicrobial that will inhibit pneumococcal growth. Breakpoints are MICs that define infections as susceptible (treatable), intermediate (possibly treatable with higher doses), and resistant (not treatable) to certain antimicrobials. In January 2008, after a reevaluation that included more recent clinical studies, the Clinical and Laboratory Standards Institute (CLSI) published new *S. pneumoniae* breakpoints for penicillin (the preferred antimicrobial for susceptible *S. pneumoniae* infections). To assess the potential effects of the new breakpoints on susceptibility categorization, CDC applied them to MICs of invasive pneumococcal disease (IPD) isolates collected by the Active Bacterial Core surveillance (ABCs) system* at sites in 10 states during 2006–2007. This report summarizes the results of that analysis, which found that the percentage of IPD nonmeningitis *S. pneumoniae* isolates categorized as susceptible, intermediate, and resistant to penicillin changed from 74.7%, 15.0%, and 10.3% under the former breakpoints

to 93.2%, 5.6%, and 1.2%, respectively, under the new breakpoints. Microbiology laboratories should be aware of the new breakpoints to interpret pneumococcal susceptibility accurately, and clinicians should be aware of the breakpoints to prescribe antimicrobials appropriately for pneumococcal infections. State and local health departments also should be aware of the new breakpoints because they might result in a decrease in the number of reported cases of penicillin-resistant pneumococcus.

Antimicrobial susceptibility breakpoints are established based on 1) the pharmacokinetic and pharmacodynamic properties of an antimicrobial agent and 2) data correlating individual MIC results with patient outcomes. Under the former criteria, susceptible, intermediate, and resistant MIC breakpoints for penicillin were ≤ 0.06 , 0.12–1, and ≥ 2 $\mu\text{g}/\text{mL}$, respectively, for all pneumococcal isolates, regardless of clinical syndrome or route of penicillin administration. Those breakpoints remain unchanged for patients without meningitis who can be treated with oral penicillin (e.g., for outpatient pneumonia). However, for patients without meningitis who are treated with intravenous penicillin, the new breakpoints are ≤ 2 , 4, and ≥ 8 $\mu\text{g}/\text{mL}$, respectively. In addition, isolates from patients with meningitis are now categorized as either susceptible or resistant, with intravenous penicillin breakpoints of ≤ 0.06 or ≥ 0.12 $\mu\text{g}/\text{mL}$, respectively (Table). Because the blood-brain barrier limits penetration of penicillin into the cerebrospinal fluid (CSF), no intermediate category for meningitis exists.

To conduct this analysis, cases of IPD were identified through ABCs. Cases of IPD were defined by isolation of *S. pneumoniae* from a normally sterile site, such as blood or CSF. *S. pneumoniae* infections in persons with noninvasive isolates (e.g., from sputum) were not considered IPD cases. Cases were categorized as meningitis or nonmeningitis based on medical record review (e.g., clinical presentation) and source of the isolate. If a case was classified as meningitis on the basis of the patient's clinical presentation but pneumococcus was isolated from blood rather than CSF, the new meningitis breakpoints were applied to the blood isolate (1). Isolates were tested for susceptibility at reference laboratories, using CLSI methods (1). Because 88% of persons with nonmeningitis IPD are hospitalized and oral penicillin is not used for treatment of hospitalized persons with IPD, the oral penicillin route was not considered in this analysis, and only the new intravenous penicillin breakpoints were applied to the MICs.

During 2006–2007, ABCs identified 7,903 cases of IPD. Isolates were available for 6,845 (87%) cases. Of the available isolates, 6,423 (94%) were associated with nonmeningitis syndromes, and 422 (6%) were associated with meningitis. Among isolates from patients without meningitis, the number of penicillin-susceptible isolates increased from 4,797 (74.7%)

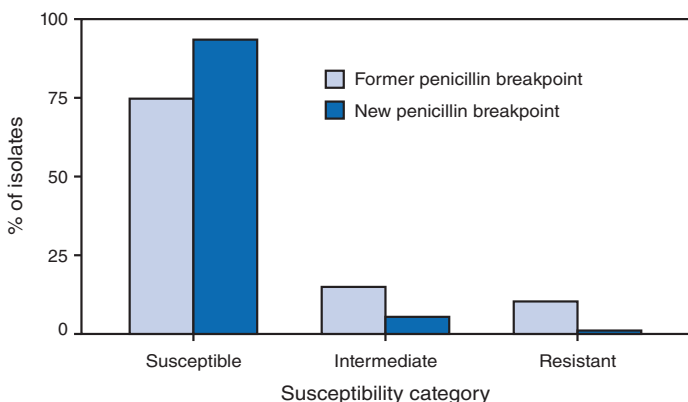
*ABCs is a collaboration between CDC, state health departments, and universities and conducts active, population-based, laboratory-based surveillance for invasive bacterial diseases in all or parts of 10 states. Additional information is available at <http://www.cdc.gov/ncidod/dbmd/abc/index.htm>.

TABLE. Comparison of former and new penicillin breakpoints (minimum inhibitory concentrations [MIC]) for *Streptococcus pneumoniae*, by susceptibility category — Clinical and Laboratory Standards Institute, 2008

Standard	Susceptibility category MIC ($\mu\text{g/mL}$)		
	Susceptible	Intermediate	Resistant
Former (all clinical syndromes and penicillin routes)	≤ 0.06	0.12–1	≥ 2
New (by clinical syndrome and penicillin route)			
Meningitis, intravenous penicillin	≤ 0.06	—*	≥ 0.12
Nonmeningitis, intravenous penicillin	≤ 2	4	≥ 8
Nonmeningitis, oral penicillin	≤ 0.06	0.12–1	≥ 2

* No intermediate category for meningitis under new penicillin breakpoints.

FIGURE 1. Percentage of isolates for *Streptococcus pneumoniae* from patients with nonmeningitis-associated invasive pneumococcal disease* that were categorized as susceptible, intermediate, or resistant under former and new penicillin breakpoints† — Active Bacterial Core surveillance, 2006–2007



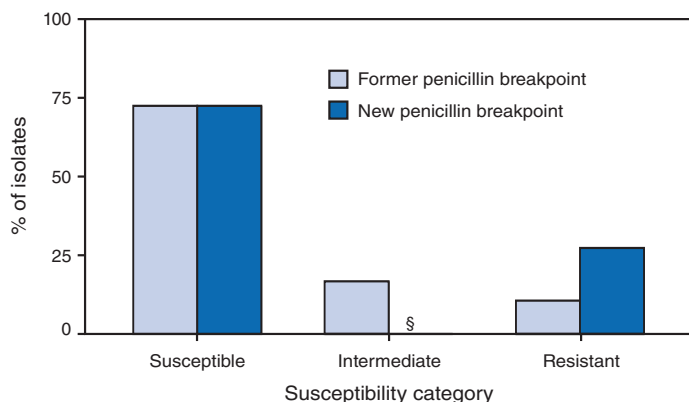
* N = 6,423.

† Under the former criteria, susceptible, intermediate, and resistant breakpoints for penicillin were ≤ 0.06 , 0.12–1, and ≥ 2 $\mu\text{g/mL}$, respectively, for all pneumococcal isolates. Under the new criteria, for isolates from patients without meningitis who are treated with intravenous penicillin, the breakpoints are ≤ 2 , 4, and ≥ 8 $\mu\text{g/mL}$, respectively. Isolates from patients with meningitis are now categorized as either susceptible or resistant, with intravenous penicillin breakpoints of ≤ 0.06 or ≥ 0.12 $\mu\text{g/mL}$, respectively.

under the former breakpoints to 5,989 (93.2%) using the new breakpoints for intravenous treatment (Figure 1). The number of isolates associated with nonmeningitis syndromes with intermediate susceptibility to penicillin decreased from 962 (15.0%) under the former breakpoints to 357 (5.6%) under the new intravenous breakpoints; the number of penicillin-resistant isolates decreased from 664 (10.3%) under the former breakpoints to 77 (1.2%) under the new intravenous breakpoints.

The number of penicillin-susceptible isolates associated with meningitis remained unchanged at 306 (73%). All isolates associated with meningitis that had been categorized under the former breakpoints as having intermediate susceptibility to penicillin were recategorized as penicillin resistant under the new breakpoints, increasing the number of resistant isolates from 45 (10.7%) to 116 (27.5%) (Figure 2).

FIGURE 2. Percentage of isolates for *Streptococcus pneumoniae* from patients with meningitis-associated invasive pneumococcal disease* that were categorized as susceptible, intermediate, or resistant under former and new penicillin breakpoints† — Active Bacterial Core surveillance, 2006–2007



* N = 422.

† Under the former criteria, susceptible, intermediate, and resistant breakpoints for penicillin were ≤ 0.06 , 0.12–1, and ≥ 2 $\mu\text{g/mL}$, respectively, for all pneumococcal isolates. Under the new criteria, for isolates from patients without meningitis who are treated with intravenous penicillin, the breakpoints are ≤ 2 , 4, and ≥ 8 $\mu\text{g/mL}$, respectively. Isolates from patients with meningitis are now categorized as either susceptible or resistant, with intravenous penicillin breakpoints of ≤ 0.06 or ≥ 0.12 $\mu\text{g/mL}$, respectively.

§ No intermediate category for meningitis isolates under new penicillin breakpoints.

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Editorial Note: The new susceptibility breakpoints for *S. pneumoniae*, published by CLSI in January 2008, were the result of a reevaluation that showed clinical response to penicillin was being preserved in clinical studies of pneumococcal infection, despite reduced susceptibility response in vitro. CLSI took a similar approach in 2003, when third-generation cephalosporin breakpoints for *S. pneumoniae* were redefined for isolates from patients with and without meningitis (2). The former penicillin breakpoints for *S. pneumoniae* were based on attainable concentrations of penicillin in CSF and the MIC at which meningitis treatment was thought to fail. However, published studies evaluating penicillin as monotherapy for treatment during the first 48 hours of nonmeningitis pneumococcal infections have not shown increased case-fatality rates associated with penicillin MICs ≤ 2 $\mu\text{g}/\text{mL}$ (3–5). These studies provide evidence that the former CLSI breakpoints for penicillin underestimated the clinical utility of that agent for intravenous therapy of nonmeningitis pneumococcal infections.

Because most antimicrobial reports from clinical laboratories have included only one set of susceptibility breakpoints, the use of multiple sets of breakpoints has the potential to cause confusion among clinicians. Some patients with clinical signs and symptoms of pneumococcal meningitis have negative cultures from CSF but positive cultures from blood. Therefore, CLSI recommends that both sets of breakpoints for intravenous therapy (i.e., for meningitis and nonmeningitis syndromes) be reported for all pneumococcal isolates not collected from CSF (1). Professional society guidelines state that, after patients have received empiric therapy and culture and susceptibility results are available, penicillin should be used to treat infections caused by penicillin-susceptible *S. pneumoniae* (6). Clinicians should review all susceptibility results, decide which set of breakpoints to use, based on the patient's clinical presentation and the planned route of drug administration, and then decide whether penicillin or some other antimicrobial is most appropriate for treatment. If a third-generation cephalosporin is considered as an alternative for treatment, clinicians also should evaluate both susceptibility breakpoints provided for third-generation cephalosporins (2). Clinical laboratory reports should include sufficient information regarding the susceptibility results, so that clinicians can apply the appropriate breakpoints to their patients.

Use of narrow-spectrum agents, such as penicillin, is encouraged to prevent the spread of antimicrobial-resistant *S. pneumoniae* and also the spread of methicillin-resistant *Staphylococcus aureus* and *Clostridium difficile*, which can result from use of broader-spectrum antimicrobials (7,8). The changes in penicillin breakpoints for *S. pneumoniae* have the potential to allow clinicians to increase use of penicillin to treat

penicillin-susceptible nonmeningitis pneumococcal infections, instead of using broader-spectrum antimicrobials.

Some state and local health departments conduct surveillance for antimicrobial-resistant pneumococcal infections. Because of the breakpoint changes described in this report, those health departments might observe decreases in reported cases of antimicrobial-resistant IPD during 2008. Health departments should take these breakpoint changes into consideration when interpreting trends in antimicrobial resistance.

References

1. Clinical and Laboratory Standards Institute. Performance standards for antimicrobial susceptibility testing; eighteenth informational supplement. CLSI document M100-S18. Wayne, PA: Clinical and Laboratory Standards Institute; 2008.
2. CDC. Effect of new susceptibility breakpoints on reporting of resistance in *Streptococcus pneumoniae*—United States, 2003. MMWR 2004;53:152–4.
3. Pallares R, Linares J, Vadillo M, et al. Resistance to penicillin and cephalosporin and mortality from severe pneumococcal pneumonia in Barcelona, Spain. N Engl J Med 1995;333:474–80.
4. Yu VL, Chiou CC, Feldman C, et al. An international prospective study of pneumococcal bacteremia: correlation with in vitro resistance, antibiotics administered, and clinical outcome. Clin Infect Dis 2003;37:230–7.
5. Song JH, Jung SI, Ki HK, et al. Clinical outcomes of pneumococcal pneumonia caused by antibiotic-resistant strains in Asian countries: a study by the Asian Network for Surveillance of Resistant Pathogens. Clin Infect Dis 2004;38:1570–8.
6. Mandell LA, Wunderink RG, Anzueto A, et al. Infectious Diseases Society of America/American Thoracic Society consensus guidelines on the management of community-acquired pneumonia in adults. Clin Infect Dis 2007;44:S27–72.
7. Schneider-Lindner V, Delaney JA, Dial S, Dascal A, Suissa S. Antimicrobial drugs and community-acquired methicillin-resistant *Staphylococcus aureus*, United Kingdom. Emerg Infect Dis 2007;13:994–1000.
8. Baxter R, Ray GT, Fireman BH. Case-control study of antibiotic use and subsequent *Clostridium difficile*-associated diarrhea in hospitalized patients. Infect Control Hosp Epidemiol 2008;29:44–50.

Brief Report

Respiratory Syncytial Virus Activity — United States, July 2007–December 2008

Respiratory syncytial virus (RSV) is the most common cause of bronchiolitis and pneumonia in children aged <1 year and is a major cause of respiratory illness in older adults (1,2). RSV is transmitted person-to-person via close contact, droplets, and fomites. Each year in the United States, an estimated 75,000–125,000 children aged <1 year are hospitalized with RSV (1). Those at increased risk for hospitalization include premature infants meeting certain criteria and persons of any age with compromised respiratory, cardiac, and immune systems (3,4). RSV incidence follows a seasonal pattern. In temperate climates, the RSV season generally occurs during the fall, winter, and spring months. However, the timing of RSV

circulation can vary by location and year (5). CDC analyzed laboratory data from the National Respiratory and Enteric Virus Surveillance System (NREVSS) to summarize RSV temporal and geographic trends in the United States during the weeks ending July 7, 2007–June 28, 2008, and for the first 5 months of the current reporting season (the weeks ending July 5–December 6, 2008). This report describes the results of that analysis, which indicated that the 2007–08 RSV season onset* for the 10 U.S. Department of Health and Human Services (HHS) regions† and Florida ranged from early July to mid-December, and the season offset ranged from late January to mid-April; the current 2008–09 season onset occurred in eight of the 10 HHS regions by December 6, 2008. These findings support previous observations that the RSV season not only varies by location, but can vary by year.

NREVSS is a passive surveillance system that relies on a voluntary network of laboratories that report weekly the number of specimens submitted to that laboratory and the number of positive results for various pathogens, including RSV. During July 2007–June 2008, a total of 636 laboratories reported at least 1 week of RSV testing data using antigen detection methods, virus culture, or polymerase chain reaction.§ For this analysis, CDC included 217 laboratories (34.0%) from 44 states that met the following criteria: reported ≥ 30 weeks and averaged ≥ 10 antigen detection tests per week. The analysis was restricted to antigen detection methods to provide consistency because this method is used by 98.0% of NREVSS laboratories.

Data are presented for each of the 10 HHS regions, allowing greater characterization of geographic variability in RSV detections than the four U.S. Census regions used in previous *MMWR* reports (6); the findings can be used to determine the

optimal timing of RSV prophylaxis for infants and children at high risk in each region. The HHS regions (listed by region number and headquarter city) include Region 1 (Boston), Region 2 (New York), Region 3 (Philadelphia), Region 4 (Atlanta), Region 5 (Chicago), Region 6 (Dallas), Region 7 (Kansas City), Region 8 (Denver), Region 9 (San Francisco), and Region 10 (Seattle). Florida is summarized separately because, historically, the RSV season in Florida has been distinct from the remainder of Region 4 (Atlanta) (6) (Table and Figure).

During the 2007–08 season, the 217 laboratories reported a total of 369,944 tests, of which 58,957 (15.9%) were positive. The national RSV season onset occurred in the week ending October 20, 2007, and continued for 22 weeks until the season offset in the week ending March 15, 2008. When data from Florida were excluded, the national RSV season onset began 2 weeks later (week ending November 3, 2007); the season offset was not affected.

The season onset date for all 10 HHS regions ranged from mid-October (week ending October 13, 2007) to mid-December (week ending December 15, 2007); however, in Florida, the season onset occurred in early July (week ending July 7, 2007). After Florida, the RSV season began the earliest in Region 6 (Dallas) and Region 2 (New York) (mid-October), followed by Region 4 (Atlanta) (late October). The RSV season started in Region 3 (Philadelphia) in early November, followed by Region 5 (Chicago) in mid-November, and Region 7 (Kansas City) and Region 9 (San Francisco) in late November. The RSV season began in Region 1 (Boston) and Region 10 (Seattle) in early December and started the latest in Region 8 (Denver) (mid-December).

The season offset for all 10 HHS regions and Florida ranged from late January (week ending January 26, 2008) to mid-April (week ending April 12, 2008). The season offset occurred the earliest in Florida (late January), followed by Region 2 (New York) and Region 6 (Dallas) (early February), Region 1 (Boston) and Region 3 (Philadelphia) (mid-February), and Region 4 (Atlanta) (late February). The RSV season ended in Region 7 (Kansas City) in early March, followed by Region 8 (Denver) and Region 9 (San Francisco) in late March. The RSV season ended the latest in Region 5 (Chicago) (early April) and Region 10 (Seattle) (mid-April).

The median RSV season duration among the 10 HHS regions was 17 weeks (range: 12–21 weeks). The regions with the shortest seasons were Region 1 (Boston) (12 weeks), followed by Region 3 (Philadelphia) and Region 7 (Kansas City) (15 weeks). The regions with the longest seasons were Region 5 (Chicago) (21 weeks), followed by Region 9 (San Francisco) (19 weeks) and Region 10 (Seattle) (19 weeks). The season in Florida lasted 30 weeks.

* As defined by NREVSS, RSV national and regional season onset is the first of 2 consecutive weeks during which the mean percentage of specimens testing positive for RSV antigen is $\geq 10\%$. RSV season offset is the last of 2 consecutive weeks during which the mean percentage of positive specimens is $\geq 10\%$.

† Listed by region number and headquarter city. Region 1 (Boston): Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Region 2 (New York): New Jersey and New York. Region 3 (Philadelphia): Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia. Region 4 (Atlanta): Alabama, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. Region 5 (Chicago): Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. Region 6 (Dallas): Arkansas, Louisiana, New Mexico, Oklahoma, and Texas. Region 7 (Kansas City): Iowa, Kansas, Missouri, and Nebraska. Region 8 (Denver): Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming. Region 9 (San Francisco): Arizona, California, Hawaii, and Nevada. Region 10 (Seattle): Alaska, Idaho, Oregon, and Washington. District of Columbia, Idaho, Maine, Montana, Nebraska, New Hampshire, and New Mexico did not have any participating laboratories in the 2007–08 season analysis.

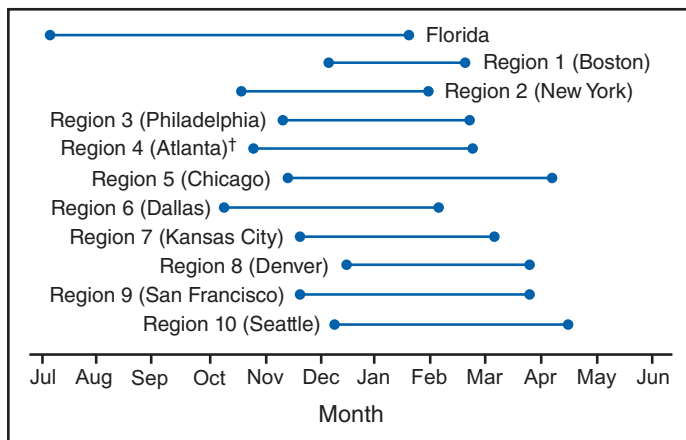
§ Surveillance Data, Inc. (SDI), a private company that conducts RSV surveillance with support from MedImmune, Inc. (Gaithersburg, Maryland), contributes laboratory data to NREVSS. CDC does not make recommendations regarding the administration of RSV immune prophylaxis. Additional information is available from NREVSS by e-mail (nrevss@cdc.gov).

TABLE. Summary of 2007–08 and 2008–09 respiratory syncytial virus seasons, by U.S. Department of Health and Human Services (HHS) Region* or state — United States, July 7, 2007–December 6, 2008

HHS Region or state	States	2007–08 season				2008–09 season†	
		No. of laboratories reporting	Onset week ending (month/day)	Offset week ending (month/day)	Season duration (wks)	No. of laboratories reporting	Onset week ending (month/day)
Florida	FL	16	7/7	1/26	30	33	7/12
Region 6 (Dallas)	AR, LA, NM,§ OK, TX	27	10/13	2/9	18	65	10/25
Region 2 (New York)	NJ, NY	23	10/20	2/2	16	55	11/15
Region 4 (Atlanta)¶	AL, GA, KY, MS, NC, SC, TN	23	10/27	2/23	18	69	10/11
Region 3 (Philadelphia)	DE, DC,§ MD, PA, VA, WV	25	11/10	2/16	15	59	11/22
Region 5 (Chicago)	IL, IN, MI, MN, OH, WI	39	11/17	4/5	21	97	12/6
Region 7 (Kansas City)	IA, KS, MO, NE§	11	11/24	3/1	15	33	—**
Region 9 (San Francisco)	AZ, CA, HI, NV	26	11/24	3/29	19	63	11/29
Region 1 (Boston)	CT, ME,§ MA, NH,§ RI, VT	6	12/1	2/16	12	28	11/22
Region 10 (Seattle)	AK, ID,§ OR, WA	11	12/8	4/12	19	21	11/29
Region 8 (Denver)	CO, MT,§ ND, SD, UT, WY	10	12/15	3/29	16	25	—**

* Listed by region number and headquarter city.
 † 2008–09 data are preliminary.
 § No participating laboratories in 2007–08 season analysis.
 ¶ Data for Region 4 (Atlanta) exclude Florida.
 ** As of December 6, 2008, the 2008–09 season onset had not occurred.

FIGURE. Duration of respiratory syncytial virus season, by U.S. Department of Health and Human Services Region* and Florida — National Respiratory and Enteric Virus Surveillance System, July 7, 2007–June 28, 2008



* Listed by region number and headquarter city. Region 1 (Boston): Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Region 2 (New York): New Jersey and New York. Region 3 (Philadelphia): Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia. Region 4 (Atlanta)†: Alabama, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. Region 5 (Chicago): Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. Region 6 (Dallas): Arkansas, Louisiana, New Mexico, Oklahoma, and Texas. Region 7 (Kansas City): Iowa, Kansas, Missouri, and Nebraska. Region 8 (Denver): Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming. Region 9 (San Francisco): Arizona, California, Hawaii, and Nevada. Region 10 (Seattle): Alaska, Idaho, Oregon, and Washington. District of Columbia, Idaho, Maine, Montana, Nebraska, New Hampshire, and New Mexico did not have any participating laboratories in the 2007–08 season analysis.
 † Excludes data from Florida.

Preliminary data for the current 2008–09 RSV season are available from the week ending July 5, 2008, through the week ending December 6, 2008. A total of 548 laboratories from all 50 states and the District of Columbia reported 94,180 RSV antigen detection tests and 10,410 (11.1%) positive results to NREVSS. Reports received through December 6, 2008, indicated that the RSV season onset had begun in mid-October in Region 4 (Atlanta) (excluding Florida [week ending October 11, 2008]) and in late October in Region 6 (Dallas) (week ending October 25, 2008). The season had begun in Region 1 (Boston) and Region 2 (New York) in mid-November (week ending November 15, 2008), followed by Region 3 (Philadelphia) (week ending November 22, 2008), and Region 9 (San Francisco) and Region 10 (Seattle) (week ending November 29, 2008). The Region 5 (Chicago) season onset occurred in early December (week ending December 6, 2008). As of December 6, 2008, the RSV season onset had not started in Region 7 (Kansas City) and Region 8 (Denver). In Florida, reports indicate that the season onset occurred in mid-July (week ending July 12, 2008), 1 week later than in 2007. Nationally, the 2008–09 RSV season onset occurred the week ending November 1, 2008; however, when data from Florida are excluded, the national season onset occurred 2 weeks later (week ending November 15, 2008). Weekly updates showing RSV national, regional, and state trends are available from the NREVSS website at <http://www.cdc.gov/surveillance/nrevss>. Additional information about Florida RSV trends is available from the Florida Department of Health website at http://www.doh.state.fl.us/disease_ctrl/epi/rsv/rsv.htm.

Although no RSV vaccine exists, infants and children at risk for severe RSV infection can receive monthly doses of palivizumab, a humanized murine anti-RSV monoclonal antibody, during the RSV season. The most recent edition of the American Academy of Pediatrics *Red Book* should be consulted for specific recommendations (3).

Reported by: *National Respiratory and Enteric Virus Surveillance System laboratories. CA Panozzo, MPH, AL Fowlkes, MPH, GE Fischer, MD, EE Schneider, MD, LJ Anderson, MD, Div of Viral Diseases, National Center for Immunization and Respiratory Diseases, CDC.*

References

1. Shay DK, Holman RC, Newman RD, Liu LL, Stout JW, Anderson LJ. Bronchiolitis-associated hospitalizations among U.S. children, 1980–1996. *JAMA* 1999;282:1440–6.
2. Falsey AR, Hennessey PA, Formica MA, Cox C, Walsh EE. Respiratory syncytial virus infection in elderly and high-risk adults. *N Engl J Med* 2005;352:1749–59.
3. American Academy of Pediatrics. Respiratory syncytial virus. In: Pickering LK, Baker CJ, Long SS, McMillan JA, eds. *Red book: 2006 report of the Committee on Infectious Diseases*. 27th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2006:560–6.
4. Welliver RC. Review of epidemiology and clinical risk factors for severe respiratory syncytial virus (RSV) infection. *J Pediatr* 2003;143 (5 Suppl):S112–7.
5. Mullins JA, LaMonte AC, Bresee JS, Anderson LJ. Substantial variability in community RSV season timing. *Pediatr Infect Dis J* 2003;22:857–62.
6. CDC. Respiratory syncytial virus activity—United States, July 2006–November 2007. *MMWR* 2007;56:1263–5.

Errata: Vol. 57, No. 33

In Vol. 57, No. 33 (August 22, 2008), in “Final 2007 Reports of Nationally Notifiable Infectious Diseases,” errors occurred in Table 2, “Reported cases of notifiable diseases, by geographic division and area — United States, 2007.” On page 903, under “AIDS,” the number of reported cases, by geographic division and area should have read as follows.

TABLE 2. Reported cases of notifiable diseases,* by geographic division and area — United States, 2007

Area	AIDS†	Area	AIDS
United States	37,503¶		
New England	1,309	South Carolina	742
Connecticut	528	Virginia	634
Maine	46	West Virginia	76
Massachusetts	612	E.S. Central	1,693
New Hampshire	51	Alabama	391
Rhode Island	66	Kentucky	292
Vermont	6	Mississippi	352
Mid. Atlantic	7,724	Tennessee	658
New Jersey	1,164	W.S. Central	4,303
New York (Upstate)	1,548	Arkansas	196
New York City	3,262	Louisiana	879
Pennsylvania	1,750	Oklahoma	264
E.N. Central	3,207	Texas	2,964
Illinois	1,348	Mountain	1,517
Indiana	329	Arizona	585
Michigan	628	Colorado	355
Ohio	703	Idaho	23
Wisconsin	199	Montana	25
W.N. Central	1,050	Nevada	335
Iowa	76	New Mexico	113
Kansas	132	Utah	68
Minnesota	197	Wyoming	13
Missouri	542	Pacific	5,728
Nebraska	80	Alaska	32
North Dakota	8	California	4,952
South Dakota	15	Hawaii	78
S. Atlantic	10,750	Oregon	239
Delaware	171	Washington	427
District of Columbia	871	American Samoa	—
Florida	3,961	C.N.M.I.	—
Georgia	1,877	Guam	—
Maryland	1,394	Puerto Rico	847
North Carolina	1,024	U.S. Virgin Islands	34

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

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

* No cases of diphtheria; neuroinvasive or non-neuroinvasive western equine encephalitis virus disease, poliomyelitis, paralytic, poliovirus infection, nonparalytic, rubella, congenital syndrome, severe acute respiratory syndrome-associated coronavirus syndrome, smallpox and yellow fever were reported in 2007. Data on chronic hepatitis B and hepatitis C virus infection (past or present) are not included because they are undergoing data quality review. Data on human immunodeficiency virus (HIV) infections are not included because HIV infection reporting has been implemented on different dates and using different methods than for AIDS case reporting.

† Total number of acquired immunodeficiency syndrome (AIDS) cases reported to the Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), through December 31, 2007.

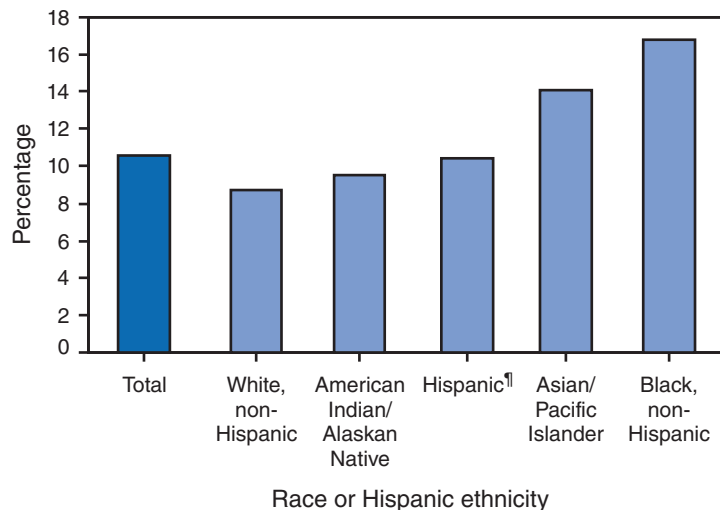
§ Includes cases reported as wound and unspecified botulism.

¶ Includes 222 cases of AIDS in persons with unknown state or area of residence that were reported in 2007.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Small-for-Gestational-Age* Births,† by Race and Hispanic Ethnicity§—United States, 2005



* Birthweight at or below the 10th percentile for a given gestational age.

† Includes only singleton live births.

§ Percentages are based on standards for all 2005 births; SGA levels might differ if race and Hispanic ethnicity-specific standards were used.

¶ Might be of any race.

Infants born small for their gestational age (SGA) are at increased risk for neonatal distress, permanent deficits in growth and neurocognitive development, and mortality. Information from U.S. birth certificates for 2005 (the most recent year for which such information is available) shows that a greater percentage of non-Hispanic black women gave birth to an SGA infant (17%), followed by Asian/Pacific Islander women (14%). Hispanic, American Indian/Alaska Native, and non-Hispanic white women were the least likely to have given birth to an SGA infant (9%–10%).

SOURCES: National Vital Statistics System. Annual natality files. Available at: <http://www.cdc.gov/nchs/births.htm>.

Oken E, Kleinman KP, Rich-Edwards J, Gillman MW. A nearly continuous measure of birth weight for gestational age using a United States national reference. *BMC Pediatr* 2003;3:6. Available at <http://www.biomedcentral.com/content/pdf/1471-2431-3-6.pdf>.

TABLE 1. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending December 13, 2008 (50th week)*

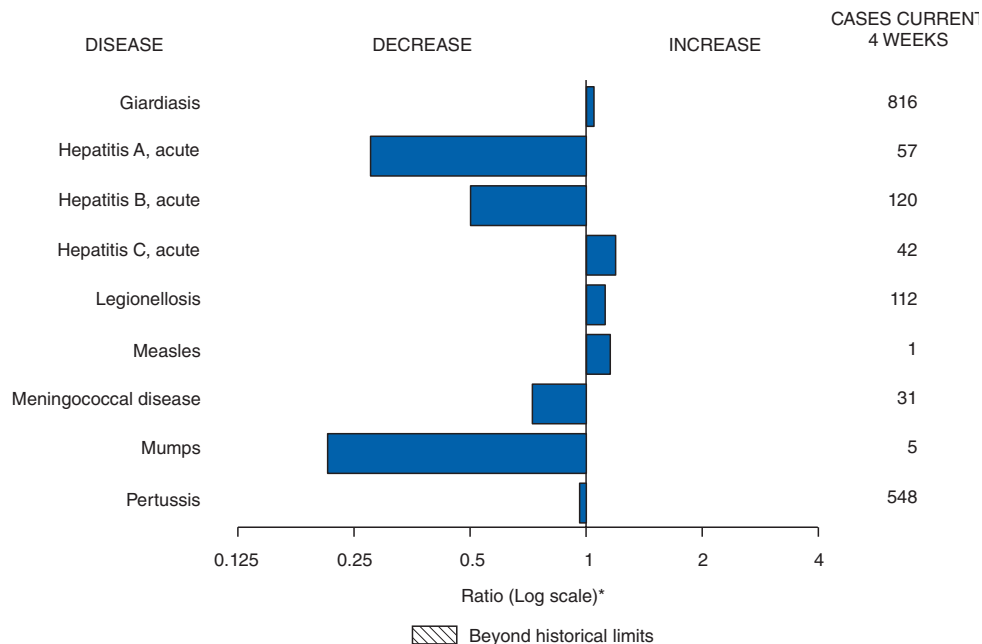
Disease	Current week	Cum 2008	5-year weekly average†	Total cases reported for previous years					States reporting cases during current week (No.)
				2007	2006	2005	2004	2003	
Anthrax	—	—	—	1	1	—	—	—	
Botulism:									
foodborne	—	12	1	32	20	19	16	20	
infant	—	94	2	85	97	85	87	76	
other (wound & unspecified)	1	22	1	27	48	31	30	33	CA (1)
Brucellosis	1	83	3	131	121	120	114	104	CA (1)
Chancroid	—	31	1	23	33	17	30	54	
Cholera	—	2	0	7	9	8	6	2	
Cyclosporiasis§	1	122	2	93	137	543	160	75	MD (1)
Diphtheria	—	—	—	—	—	—	—	1	
Domestic arboviral diseases§,¶:									
California serogroup	—	43	0	55	67	80	112	108	
eastern equine	—	2	0	4	8	21	6	14	
Powassan	—	1	—	7	1	1	1	—	
St. Louis	—	8	—	9	10	13	12	41	
western equine	—	—	—	—	—	—	—	—	
Ehrlichiosis/Anaplasmosis§,**:									
<i>Ehrlichia chaffeensis</i>	5	826	20	828	578	506	338	321	OH (1), MD (3), OK (1)
<i>Ehrlichia ewingii</i>	—	9	—	—	—	—	—	—	
<i>Anaplasma phagocytophilum</i>	3	439	33	834	646	786	537	362	NY (1), MN (2)
undetermined	—	64	2	337	231	112	59	44	
<i>Haemophilus influenzae</i> ,††									
invasive disease (age <5 yrs):									
serotype b	—	26	1	22	29	9	19	32	
nonserotype b	1	159	5	199	175	135	135	117	OK (1)
unknown serotype	3	174	5	180	179	217	177	227	NY (1), OH (1), NC (1)
Hansen disease§	—	68	3	101	66	87	105	95	
Hantavirus pulmonary syndrome§	—	14	1	32	40	26	24	26	
Hemolytic uremic syndrome, postdiarrheal§	5	219	8	292	288	221	200	178	OH (1), NC (1), AR (1), CA (2)
Hepatitis C viral, acute	4	781	28	849	766	652	720	1,102	OH (1), MO (1), CA (2)
HIV infection, pediatric (age <13 years)§§	—	—	5	—	—	380	436	504	
Influenza-associated pediatric mortality§,¶¶	1	91	0	77	43	45	—	N	FL (1)
Listeriosis	9	619	19	808	884	896	753	696	PA (1), NC (2), FL (1), KY (1), WA (1), CA (3)
Measles***	—	131	1	43	55	66	37	56	
Meningococcal disease, invasive†††:									
A, C, Y, & W-135	3	257	8	325	318	297	—	—	IN (1), OK (1), CO (1)
serogroup B	1	145	6	167	193	156	—	—	FL (1)
other serogroup	—	30	1	35	32	27	—	—	
unknown serogroup	5	574	18	550	651	765	—	—	NY (2), OH (1), OR (1), CA (1)
Mumps	2	355	21	800	6,584	314	258	231	NY (1), CA (1)
Novel influenza A virus infections	—	1	—	4	N	N	N	N	
Plague	—	1	0	7	17	8	3	1	
Poliomyelitis, paralytic	—	—	—	—	—	1	—	—	
Polio virus infection, nonparalytic§	—	—	—	—	N	N	N	N	
Psittacosis§	1	12	0	12	21	16	12	12	CA (1)
Qfever total§,§§§:	—	111	3	171	169	136	70	71	
acute	—	99	—	—	—	—	—	—	
chronic	—	12	—	—	—	—	—	—	
Rabies, human	—	1	0	1	3	2	7	2	
Rubella¶¶¶	—	16	0	12	11	11	10	7	
Rubella, congenital syndrome	—	—	—	—	1	1	—	1	
SARS-CoV§,****	—	—	—	—	—	—	—	8	
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	—	125	3	132	125	129	132	161	
Syphilis, congenital (age <1 yr)	—	212	9	430	349	329	353	413	
Tetanus	2	15	1	28	41	27	34	20	FL (1), CA (1)
Toxic-shock syndrome (staphylococcal)§	3	66	3	92	101	90	95	133	OH (1), CA (2)
Trichinellosis	—	6	0	5	15	16	5	6	
Tularemia	—	102	3	137	95	154	134	129	
Typhoid fever	1	369	8	434	353	324	322	356	TN (1)
Vancomycin-intermediate <i>Staphylococcus aureus</i> §	1	33	0	37	6	2	—	N	NY (1)
Vancomycin-resistant <i>Staphylococcus aureus</i> §	—	—	0	2	1	3	1	N	
Vibriosis (noncholera <i>Vibrio</i> species infections)§	4	427	5	447	N	N	N	N	GA (1), FL (1), OK (1), CA (1)
Yellow fever	—	—	—	—	—	—	—	—	

See Table 1 footnotes on next page.

TABLE 1. (Continued) Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending December 13, 2008 (50th week)*

—: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts.
 * Incidence data for reporting year 2008 are provisional, whereas data for 2003, 2004, 2005, 2006, and 2007 are finalized.
 † Calculated by summing the incidence counts for the current week, the 2 weeks preceding the current week, and the 2 weeks following the current week, for a total of 5 preceding years. Additional information is available at <http://www.cdc.gov/epo/dphsi/phs/files/5yearweeklyaverage.pdf>.
 § Not notifiable in all states. Data from states where the condition is not notifiable are excluded from this table, except in 2007 and 2008 for the domestic arboviral diseases and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at <http://www.cdc.gov/epo/dphsi/phs/infdis.htm>.
 ¶ Includes both neuroinvasive and nonneuroinvasive. Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for West Nile virus are available in Table II.
 ** The names of the reporting categories changed in 2008 as a result of revisions to the case definitions. Cases reported prior to 2008 were reported in the categories: Ehrlichiosis, human monocytic (analogous to *E. chaffeensis*); Ehrlichiosis, human granulocytic (analogous to *Anaplasma phagocytophilum*), and Ehrlichiosis, unspecified, or other agent (which included cases unable to be clearly placed in other categories, as well as possible cases of *E. ewingii*).
 †† Data for *H. influenzae* (all ages, all serotypes) are available in Table II.
 §§ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. Implementation of HIV reporting influences the number of cases reported. Updates of pediatric HIV data have been temporarily suspended until upgrading of the national HIV/AIDS surveillance data management system is completed. Data for HIV/AIDS, when available, are displayed in Table IV, which appears quarterly.
 ¶¶ Updated weekly from reports to the Influenza Division, National Center for Immunization and Respiratory Diseases. One confirmed influenza-associated pediatric death was reported for the current 2008-09 season.
 *** No measles cases were reported for the current week.
 ††† Data for meningococcal disease (all serogroups) are available in Table II.
 §§§ In 2008, Q fever acute and chronic reporting categories were recognized as a result of revisions to the Q fever case definition. Prior to that time, case counts were not differentiated with respect to acute and chronic Q fever cases.
 ¶¶¶ No rubella cases were reported for the current week.
 **** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals December 13, 2008, 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
 Patsy A. Hall
 Deborah A. Adams Rosaline Dhara
 Willie J. Anderson Michael S. Wodajo
 Lenee Blanton Pearl C. Sharp

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending December 13, 2008, and December 15, 2007 (50th week)*

Reporting area	Giardiasis					Gonorrhea					Haemophilus influenzae, invasive All ages, all serotypes†				
	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007
		Med	Max				Med	Max				Med	Max		
United States	190	308	1,158	16,405	17,755	3,090	5,969	8,913	285,831	340,364	27	47	173	2,407	2,317
New England	1	24	49	1,204	1,423	63	100	227	4,975	5,414	1	3	12	145	176
Connecticut	—	6	11	291	359	39	50	199	2,422	2,064	1	0	9	42	45
Maine§	—	3	12	179	188	1	2	6	92	117	—	0	2	16	13
Massachusetts	—	9	17	343	594	19	39	69	2,037	2,648	—	1	5	57	87
New Hampshire	—	2	11	142	33	1	2	6	97	136	—	0	1	9	18
Rhode Island§	—	1	8	87	80	1	6	13	296	388	—	0	7	13	9
Vermont§	1	3	13	162	169	2	0	3	31	61	—	0	3	8	4
Mid. Atlantic	32	60	131	3,053	3,098	340	621	1,028	31,099	34,840	6	9	31	473	451
New Jersey	—	7	14	302	395	—	93	167	4,676	5,893	—	1	7	71	68
New York (Upstate)	21	23	111	1,164	1,132	114	119	545	5,767	6,724	4	3	22	147	128
New York City	4	15	29	775	831	136	180	633	10,225	10,027	—	1	6	83	101
Pennsylvania	7	15	45	812	740	90	213	394	10,431	12,196	2	4	8	172	154
E.N. Central	16	45	79	2,378	2,789	537	1,233	1,648	59,644	70,075	6	7	28	351	362
Illinois	—	10	24	519	847	—	365	589	16,779	19,743	—	2	7	105	117
Indiana	N	0	0	N	N	116	148	284	7,857	8,556	2	1	20	68	58
Michigan	2	11	22	557	600	373	327	657	16,131	14,852	—	0	2	21	30
Ohio	12	16	31	861	796	6	293	531	14,493	20,387	4	2	6	130	101
Wisconsin	2	8	19	441	546	42	89	176	4,384	6,537	—	1	2	27	56
W.N. Central	5	29	621	1,931	1,427	171	316	425	15,640	18,815	1	3	24	186	135
Iowa	1	6	18	309	294	14	29	48	1,500	1,864	—	0	1	2	1
Kansas	1	3	11	157	181	41	41	130	2,210	2,216	—	0	3	16	11
Minnesota	—	0	575	666	168	—	55	92	2,648	3,372	—	0	21	57	60
Missouri	2	8	22	447	504	104	149	199	7,591	9,605	1	1	6	70	39
Nebraska§	1	4	10	202	154	—	25	47	1,252	1,394	—	0	2	28	18
North Dakota	—	0	36	23	24	—	2	6	91	114	—	0	3	13	6
South Dakota	—	2	10	127	102	12	7	15	348	250	—	0	0	—	—
S. Atlantic	51	54	87	2,738	2,952	819	1,175	3,072	60,860	80,947	8	12	29	644	573
Delaware	1	1	3	40	41	17	19	44	989	1,268	—	0	2	7	8
District of Columbia	—	1	5	56	74	—	48	101	2,449	2,302	—	0	2	11	3
Florida	38	24	57	1,297	1,221	433	448	522	21,997	22,542	5	3	10	182	154
Georgia	5	9	27	557	662	1	111	560	7,301	16,752	—	2	9	135	118
Maryland§	4	5	12	244	258	125	116	206	5,990	6,517	1	2	6	91	85
North Carolina	N	0	0	N	N	—	0	1,949	2,638	14,439	1	1	9	74	51
South Carolina§	2	2	6	127	119	239	180	830	9,103	10,074	1	1	7	49	51
Virginia§	1	8	39	361	529	—	177	486	9,697	6,152	—	1	6	74	75
West Virginia	—	1	5	56	48	4	14	26	696	901	—	0	3	21	28
E.S. Central	—	8	21	445	553	377	552	837	27,932	30,983	1	2	8	124	133
Alabama§	—	5	12	248	258	—	174	250	7,967	10,520	—	0	2	21	28
Kentucky	N	0	0	N	N	67	90	153	4,405	3,266	—	0	1	2	9
Mississippi	N	0	0	N	N	145	132	401	7,090	7,910	—	0	2	13	10
Tennessee§	—	4	13	197	295	165	162	297	8,470	9,287	1	2	6	88	86
W.S. Central	7	7	41	412	423	452	950	1,355	46,391	49,946	1	2	29	98	98
Arkansas§	1	3	8	133	148	—	86	167	4,267	4,049	—	0	3	10	9
Louisiana	—	2	10	120	138	114	167	317	8,666	10,893	—	0	2	8	10
Oklahoma	6	2	35	159	137	—	60	124	2,903	4,683	1	1	21	72	69
Texas§	N	0	0	N	N	338	636	1,102	30,555	30,321	—	0	3	8	10
Mountain	24	27	62	1,479	1,801	47	209	338	10,054	13,344	2	5	14	271	250
Arizona	3	3	8	133	189	23	63	109	3,142	4,882	1	2	11	106	87
Colorado	4	10	27	532	562	—	58	100	2,900	3,255	1	1	4	54	56
Idaho§	2	3	14	191	206	2	3	13	173	256	—	0	4	12	8
Montana§	4	1	9	84	109	—	2	10	103	112	—	0	1	2	2
Nevada§	—	1	8	89	139	21	39	130	1,997	2,307	—	0	2	14	12
New Mexico§	—	1	7	85	115	—	24	104	1,200	1,664	—	0	4	36	40
Utah	11	6	22	341	435	—	10	36	426	791	—	1	5	43	39
Wyoming§	—	0	3	24	46	1	2	9	113	77	—	0	2	4	6
Pacific	54	53	185	2,765	3,289	284	601	759	29,236	36,000	1	2	7	115	139
Alaska	3	2	10	99	78	13	10	24	493	545	—	0	2	16	15
California	19	35	91	1,792	2,202	218	501	657	24,320	30,101	—	0	3	24	46
Hawaii	—	1	4	40	74	—	11	22	540	641	—	0	2	19	11
Oregon§	1	8	18	434	448	17	23	48	1,196	1,189	1	1	4	53	64
Washington	31	8	87	400	487	36	54	90	2,687	3,524	—	0	3	3	3
American Samoa	—	0	0	—	—	—	0	1	3	3	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	2	—	1	15	73	134	—	0	0	—	1
Puerto Rico	—	2	13	150	365	7	5	25	268	310	—	0	0	—	2
U.S. Virgin Islands	—	0	0	—	—	—	2	6	93	39	N	0	0	N	N

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

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

* Incidence data for reporting year 2008 are provisional.

† Data for *H. influenzae* (age <5 yrs for serotype b, nonserotype b, and unknown serotype) are available in Table I.

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending December 13, 2008, and December 15, 2007 (50th week)*

Reporting area	Hepatitis (viral, acute), by type†										Legionellosis				
	A				B				Legionellosis						
	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007
	Med	Max				Med	Max				Med	Max			
United States	20	48	171	2,265	2,755	32	68	259	3,273	4,194	30	44	144	2,644	2,542
New England	—	2	7	101	129	—	1	7	60	122	4	2	16	139	155
Connecticut	—	0	4	26	26	—	0	7	23	38	4	0	5	45	38
Maine§	—	0	2	11	5	—	0	2	11	16	—	0	2	9	9
Massachusetts	—	0	5	38	65	—	0	1	9	42	—	0	3	13	47
New Hampshire	—	0	2	12	12	—	0	2	11	5	—	0	5	27	8
Rhode Island§	—	0	2	12	13	—	0	1	4	16	—	0	14	40	44
Vermont§	—	0	1	2	8	—	0	1	2	5	—	0	1	5	9
Mid. Atlantic	2	6	12	286	438	5	9	14	408	546	6	13	58	883	815
New Jersey	—	1	4	57	120	—	2	7	111	160	—	1	7	79	113
New York (Upstate)	1	1	6	61	72	2	1	4	63	86	2	5	19	317	224
New York City	—	2	6	102	155	—	2	6	90	115	—	1	12	110	180
Pennsylvania	1	1	6	66	91	3	2	8	144	185	4	6	33	377	298
E.N. Central	2	6	16	295	328	2	8	13	376	437	4	10	40	545	572
Illinois	—	1	10	85	113	—	2	5	92	126	—	1	7	66	108
Indiana	—	0	4	21	27	—	1	6	47	56	1	1	7	50	62
Michigan	1	2	7	110	92	—	2	6	122	115	—	2	16	151	165
Ohio	1	1	4	49	67	2	2	8	109	120	3	4	18	260	203
Wisconsin	—	0	2	30	29	—	0	1	6	20	—	0	3	18	34
W.N. Central	1	4	29	242	168	—	1	9	92	111	1	2	9	130	111
Iowa	—	1	7	105	44	—	0	2	14	25	—	0	2	15	11
Kansas	—	0	3	14	11	—	0	3	7	8	—	0	1	2	10
Minnesota	—	0	23	36	68	—	0	5	10	20	—	0	4	23	28
Missouri	1	1	3	43	21	—	1	4	51	38	—	1	7	66	44
Nebraska§	—	0	5	40	18	—	0	2	9	12	1	0	4	21	14
North Dakota	—	0	2	—	—	—	0	1	1	1	—	0	2	—	—
South Dakota	—	0	1	4	6	—	0	0	—	7	—	0	1	3	4
S. Atlantic	6	7	15	364	464	10	17	60	849	965	7	8	28	450	427
Delaware	—	0	1	7	8	—	0	3	10	15	—	0	2	13	11
District of Columbia	U	0	0	U	U	U	0	0	U	U	—	0	2	15	16
Florida	4	2	8	143	147	8	6	12	326	328	3	3	7	143	145
Georgia	—	1	4	45	67	—	3	6	131	150	—	0	4	32	41
Maryland§	—	1	3	39	71	—	2	4	78	109	3	2	10	118	83
North Carolina	1	0	9	61	62	—	0	17	78	124	1	0	7	37	44
South Carolina§	1	0	3	18	18	—	1	6	57	62	—	0	2	12	17
Virginia§	—	1	5	46	82	2	2	16	105	126	—	1	6	59	52
West Virginia	—	0	2	5	9	—	1	30	64	51	—	0	3	21	18
E.S. Central	—	1	9	77	107	3	7	13	358	372	—	2	10	108	99
Alabama§	—	0	4	12	24	—	2	6	97	126	—	0	2	15	11
Kentucky	—	0	3	29	20	1	2	5	90	75	—	1	4	53	49
Mississippi	—	0	2	5	8	—	1	3	44	37	—	0	1	1	—
Tennessee§	—	0	6	31	55	2	3	8	127	134	—	1	5	39	39
W.S. Central	—	4	55	186	258	2	12	131	592	919	1	1	23	84	130
Arkansas§	—	0	1	5	13	—	0	4	30	71	—	0	2	11	15
Louisiana	—	0	1	10	27	—	1	4	73	97	—	0	2	9	6
Oklahoma	—	0	3	7	10	2	2	22	111	128	—	0	6	10	6
Texas§	—	3	53	164	208	—	7	107	378	623	1	1	18	54	103
Mountain	3	4	12	199	222	—	4	12	187	210	2	2	7	84	107
Arizona	3	2	11	104	147	—	1	5	68	81	—	0	2	19	37
Colorado	—	0	3	35	25	—	0	3	30	35	—	0	2	10	21
Idaho§	—	0	3	18	8	—	0	2	8	14	—	0	1	3	6
Montana§	—	0	1	1	9	—	0	1	2	1	—	0	1	4	3
Nevada§	—	0	3	9	12	—	1	3	33	48	—	0	2	10	9
New Mexico§	—	0	3	17	12	—	0	2	11	12	—	0	1	7	10
Utah	—	0	2	12	6	—	0	3	31	14	2	0	2	31	18
Wyoming§	—	0	1	3	3	—	0	1	4	5	—	0	0	—	3
Pacific	6	10	51	515	641	10	7	30	351	512	5	4	18	221	126
Alaska	—	0	1	3	4	—	0	2	9	9	—	0	1	3	—
California	6	8	42	424	549	8	5	19	252	374	5	3	14	177	91
Hawaii	—	0	2	17	7	—	0	1	7	17	—	0	1	8	2
Oregon§	—	0	3	25	29	—	1	3	39	57	—	0	2	16	13
Washington	—	1	7	46	52	2	1	9	44	55	—	0	3	17	20
American Samoa	—	0	0	—	—	—	0	0	—	14	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	1	—	2	—	0	0	—	—
Puerto Rico	—	0	2	17	62	—	0	5	39	87	—	0	1	1	4
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 notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.

* Incidence data for reporting year 2008 are provisional.

† Data for acute hepatitis C, viral are available in Table I.

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending December 13, 2008, and December 15, 2007 (50th week)*

Reporting area	Lyme disease				Malaria				Meningococcal disease, invasive† All serotypes						
	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007
		Med	Max				Med	Max				Med	Max		
United States	419	383	1,444	25,450	25,932	10	21	136	1,010	1,247	9	20	53	1,006	1,005
New England	29	45	259	3,612	7,750	—	0	35	35	58	—	0	3	22	43
Connecticut	—	0	10	—	3,046	—	0	27	11	3	—	0	1	1	6
Maine§	29	2	73	844	522	—	0	1	1	8	—	0	1	6	7
Massachusetts	—	12	114	1,039	2,978	—	0	2	14	34	—	0	3	15	20
New Hampshire	—	11	139	1,381	891	—	0	1	4	9	—	0	0	—	3
Rhode Island§	—	0	0	—	177	—	0	8	1	—	—	0	0	—	3
Vermont§	—	3	40	348	136	—	0	1	4	4	—	0	1	—	4
Mid. Atlantic	287	233	1,002	14,822	10,730	—	4	14	234	384	2	2	6	114	120
New Jersey	—	32	209	2,743	3,106	—	0	2	—	70	—	0	2	10	18
New York (Upstate)	249	83	453	5,293	3,270	—	0	7	30	70	2	0	3	31	35
New York City	—	0	3	31	416	—	3	10	165	203	—	0	2	26	20
Pennsylvania	38	79	531	6,755	3,938	—	1	3	39	41	—	1	5	47	47
E.N. Central	6	9	141	1,326	2,089	—	2	7	126	135	2	3	9	164	159
Illinois	—	0	10	79	149	—	1	6	57	61	—	1	4	54	59
Indiana	1	0	8	41	52	—	0	2	5	10	1	0	4	27	28
Michigan	—	1	10	95	51	—	0	2	17	20	—	0	3	29	25
Ohio	—	1	5	48	32	—	0	3	29	27	1	1	4	40	35
Wisconsin	5	8	127	1,063	1,805	—	0	3	18	17	—	0	2	14	12
W.N. Central	69	6	740	1,268	658	3	1	10	67	56	—	2	8	92	69
Iowa	—	1	8	86	123	—	0	3	8	3	—	0	3	19	15
Kansas	—	0	1	5	8	—	0	2	9	4	—	0	1	5	5
Minnesota	69	1	731	1,152	507	3	0	8	28	29	—	0	7	24	22
Missouri	—	0	1	8	10	—	0	3	14	8	—	0	3	26	17
Nebraska§	—	0	2	13	7	—	0	2	8	7	—	0	1	12	5
North Dakota	—	0	9	1	3	—	0	1	—	4	—	0	1	3	2
South Dakota	—	0	1	3	—	—	0	0	—	1	—	0	1	3	3
S. Atlantic	24	66	215	3,981	4,433	3	5	15	259	251	1	3	10	147	172
Delaware	4	12	37	746	705	—	0	1	3	4	—	0	1	2	1
District of Columbia	—	2	11	158	116	—	0	2	4	2	—	0	0	—	—
Florida	6	1	10	112	28	—	1	7	58	53	1	1	3	50	64
Georgia	—	0	3	23	11	1	1	5	51	37	—	0	2	16	24
Maryland§	6	30	156	2,020	2,532	1	1	6	66	71	—	0	4	17	21
North Carolina	2	0	7	50	49	1	0	7	28	21	—	0	3	13	22
South Carolina§	—	0	2	22	30	—	0	1	9	7	—	0	3	22	16
Virginia§	6	11	68	776	883	—	1	7	40	55	—	0	2	22	22
West Virginia	—	1	11	74	79	—	0	0	—	1	—	0	1	5	2
E.S. Central	—	0	5	46	51	1	0	2	21	38	—	1	6	52	50
Alabama§	—	0	3	10	13	—	0	1	4	7	—	0	2	10	9
Kentucky	—	0	2	5	6	—	0	1	5	9	—	0	2	9	13
Mississippi	—	0	1	1	1	—	0	1	1	2	—	0	2	12	11
Tennessee§	—	0	3	30	31	1	0	2	11	20	—	0	3	21	17
W.S. Central	—	2	11	97	79	—	1	64	76	89	1	2	13	109	99
Arkansas§	—	0	0	—	1	—	0	0	—	2	—	0	2	14	9
Louisiana	—	0	1	3	2	—	0	1	3	14	—	0	3	22	26
Oklahoma	—	0	1	—	—	—	0	4	4	5	1	0	5	18	17
Texas§	—	2	10	94	76	—	1	60	69	68	—	1	7	55	47
Mountain	—	0	4	43	45	1	1	3	32	64	1	1	4	55	65
Arizona	—	0	2	8	2	—	0	2	14	12	—	0	2	9	12
Colorado	—	0	2	7	—	—	0	1	4	23	1	0	1	15	21
Idaho§	—	0	2	9	9	—	0	1	3	5	—	0	1	4	7
Montana§	—	0	1	4	4	—	0	0	—	3	—	0	1	5	2
Nevada§	—	0	2	4	15	—	0	3	3	3	—	0	1	4	6
New Mexico§	—	0	2	6	5	—	0	1	3	5	—	0	1	7	3
Utah	—	0	1	3	7	1	0	1	5	13	—	0	3	9	12
Wyoming§	—	0	1	2	3	—	0	0	—	—	—	0	1	2	2
Pacific	4	5	10	255	97	2	3	10	160	172	2	5	19	251	228
Alaska	—	0	2	5	10	—	0	2	6	2	—	0	2	5	1
California	4	3	10	195	71	1	2	8	120	122	1	3	19	179	165
Hawaii	N	0	0	N	N	—	0	1	3	2	—	0	1	5	10
Oregon§	—	1	4	44	6	—	0	2	4	18	1	1	3	38	30
Washington	—	0	7	11	10	1	0	3	27	28	—	0	5	24	22
American Samoa	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	2	3	1	—	0	0	—	—
Puerto Rico	N	0	0	N	N	—	0	1	1	3	—	0	1	3	8
U.S. Virgin Islands	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—

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

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

* Incidence data for reporting year 2008 are provisional.

† Data for meningococcal disease, invasive caused by serogroups A, C, Y, & W-135; serogroup B; other serogroup; and unknown serogroup are available in Table I.

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending December 13, 2008, and December 15, 2007 (50th week)*

Reporting area	Salmonellosis					Shiga toxin-producing <i>E. coli</i> (STEC)†					Shigellosis				
	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007
		Med	Max				Med	Max				Med	Max		
United States	613	803	2,110	43,013	45,182	36	85	250	4,938	4,653	289	430	1,227	19,235	18,005
New England	—	19	502	1,676	2,208	—	3	47	217	309	—	2	39	157	242
Connecticut	—	0	473	473	431	—	0	44	44	71	—	0	38	38	44
Maine§	—	2	8	142	135	—	0	3	23	40	—	0	6	21	14
Massachusetts	—	14	52	741	1,288	—	1	11	80	141	—	1	5	78	152
New Hampshire	—	3	10	138	168	—	0	3	34	35	—	0	1	3	6
Rhode Island§	—	2	8	104	106	—	0	3	9	7	—	0	1	12	23
Vermont§	—	1	7	78	80	—	0	3	27	15	—	0	2	5	3
Mid. Atlantic	45	88	177	4,930	5,758	3	6	192	579	515	23	44	96	2,247	882
New Jersey	—	14	30	636	1,199	—	0	3	26	116	—	12	38	754	177
New York (Upstate)	20	26	73	1,401	1,384	3	3	188	404	200	11	10	35	563	157
New York City	3	21	53	1,225	1,273	—	1	5	58	47	—	13	35	691	274
Pennsylvania	22	27	78	1,668	1,902	—	1	8	91	152	12	3	23	239	274
E.N. Central	43	88	181	4,595	5,796	2	11	67	860	728	65	73	145	3,676	2,959
Illinois	—	23	67	1,088	1,920	—	1	8	89	131	—	16	29	742	727
Indiana	—	9	53	578	647	—	1	14	93	102	—	10	83	582	194
Michigan	—	17	38	866	948	—	2	39	213	123	1	3	15	168	81
Ohio	43	25	65	1,298	1,302	2	3	17	189	153	64	28	80	1,765	1,216
Wisconsin	—	15	50	765	979	—	4	20	276	219	—	8	32	419	741
W.N. Central	16	49	151	2,689	2,748	2	12	58	790	746	5	16	39	874	1,772
Iowa	—	8	15	397	463	—	2	21	196	173	—	3	11	171	104
Kansas	3	7	31	452	400	—	0	7	51	51	—	1	5	62	25
Minnesota	2	13	70	688	661	—	3	21	200	224	2	5	25	296	229
Missouri	9	13	48	735	741	—	2	11	145	151	3	4	14	217	1,259
Nebraska§	2	4	13	229	268	2	1	29	146	91	—	0	3	15	27
North Dakota	—	0	35	45	46	—	0	20	3	9	—	0	15	37	6
South Dakota	—	2	11	143	169	—	1	4	49	47	—	0	9	76	122
S. Atlantic	245	250	457	11,845	11,986	5	13	50	759	681	45	58	149	2,974	4,479
Delaware	—	2	9	143	138	—	0	2	12	16	1	0	1	11	11
District of Columbia	—	1	4	52	63	—	0	1	12	—	—	0	3	19	18
Florida	115	100	174	5,069	4,822	1	2	18	142	158	4	15	75	780	2,190
Georgia	30	38	86	2,171	1,971	—	1	7	87	93	14	21	48	1,063	1,577
Maryland§	13	13	36	756	887	—	2	9	115	82	5	2	7	103	111
North Carolina	79	22	228	1,461	1,616	4	1	12	119	142	14	3	27	244	103
South Carolina§	6	20	55	1,074	1,124	—	1	4	40	14	3	8	32	516	205
Virginia§	2	19	49	962	1,166	—	3	25	203	157	4	4	13	222	184
West Virginia	—	3	25	157	199	—	0	3	29	19	—	0	61	16	80
E.S. Central	17	57	137	3,261	3,390	1	5	21	270	315	11	38	77	1,812	2,916
Alabama§	1	15	47	909	946	1	1	17	58	65	1	8	20	381	713
Kentucky	10	9	18	466	563	—	1	7	98	123	—	4	24	256	489
Mississippi	—	13	57	1,027	1,034	—	0	2	6	7	—	5	45	288	1,377
Tennessee§	6	15	57	859	847	—	2	7	108	120	10	18	43	887	337
W.S. Central	92	105	894	5,600	5,089	5	6	27	317	267	87	91	748	4,650	2,284
Arkansas§	15	11	40	754	814	2	1	3	43	43	7	11	27	558	88
Louisiana	—	13	49	916	964	—	0	1	2	11	—	10	25	549	483
Oklahoma	12	15	72	784	628	1	1	19	52	19	4	3	32	171	128
Texas§	65	50	794	3,146	2,683	2	5	11	220	194	76	62	702	3,372	1,585
Mountain	42	58	110	3,082	2,667	2	10	38	580	576	21	18	53	1,133	945
Arizona	23	19	45	1,079	976	1	1	5	67	105	8	9	34	607	540
Colorado	10	12	43	667	552	—	3	17	187	152	11	2	9	133	120
Idaho§	1	3	14	184	152	1	2	15	144	129	—	0	2	14	13
Montana§	—	2	10	117	110	—	0	3	31	—	—	0	1	8	26
Nevada§	—	3	9	171	252	—	0	2	10	31	—	4	13	216	71
New Mexico§	—	6	33	467	282	—	1	6	49	40	—	1	10	110	104
Utah	8	6	19	353	272	—	1	9	87	97	2	1	4	40	38
Wyoming§	—	1	4	44	71	—	0	1	5	22	—	0	1	5	33
Pacific	113	108	399	5,335	5,540	16	8	49	566	516	32	28	82	1,712	1,526
Alaska	—	1	4	54	87	—	0	1	7	4	—	0	1	1	8
California	94	78	286	3,914	4,187	11	5	39	305	269	29	26	74	1,481	1,229
Hawaii	—	5	15	244	300	—	0	5	13	36	—	1	3	40	70
Oregon§	—	7	20	409	322	—	1	8	65	76	—	2	10	90	79
Washington	19	12	103	714	644	5	2	16	176	131	3	2	13	100	140
American Samoa	—	0	1	2	—	—	0	0	—	—	—	0	1	1	5
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	2	13	19	—	0	0	—	—	—	0	3	15	19
Puerto Rico	1	10	41	512	902	—	0	1	2	1	—	0	4	19	24
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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

* Incidence data for reporting year 2008 are provisional.

† Includes *E. coli* O157:H7; Shiga toxin-positive, serogroup non-O157; and Shiga toxin-positive, not serogrouped.

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending December 13, 2008, and December 15, 2007 (50th week)*

Reporting area	Streptococcal diseases, invasive, group A					<i>Streptococcus pneumoniae</i> , invasive disease, nondrug resistant† Age <5 years				
	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007
		Med	Max				Med	Max		
United States	61	95	259	4,902	4,935	17	34	166	1,561	1,797
New England	1	6	31	321	371	—	1	14	71	124
Connecticut	1	0	26	100	113	—	0	11	11	13
Maine§	—	0	3	26	26	—	0	1	2	4
Massachusetts	—	3	8	138	179	—	0	5	39	84
New Hampshire	—	0	2	27	27	—	0	1	11	13
Rhode Island§	—	0	9	18	8	—	0	2	7	8
Vermont§	—	0	2	12	18	—	0	1	1	2
Mid. Atlantic	12	18	43	960	898	—	4	19	202	314
New Jersey	—	3	11	138	164	—	1	6	62	66
New York (Upstate)	6	6	17	316	271	—	2	14	99	104
New York City	—	3	10	181	220	—	0	8	41	144
Pennsylvania	6	6	16	325	243	N	0	0	N	N
E.N. Central	9	17	42	883	929	1	6	23	254	303
Illinois	—	4	16	232	279	—	0	5	48	81
Indiana	3	2	11	127	115	—	0	14	35	22
Michigan	—	3	10	164	196	—	1	5	75	79
Ohio	5	5	14	253	218	1	1	5	59	62
Wisconsin	1	1	10	107	121	—	1	4	37	59
W.N. Central	3	5	39	367	322	1	2	16	150	99
Iowa	—	0	0	—	—	—	0	0	—	—
Kansas	—	0	5	36	32	—	0	3	19	2
Minnesota	—	0	35	166	153	—	0	13	69	53
Missouri	2	2	10	89	81	—	1	2	35	26
Nebraska§	1	1	3	41	25	1	0	2	9	17
North Dakota	—	0	5	12	19	—	0	2	8	1
South Dakota	—	0	2	23	12	—	0	1	10	—
S. Atlantic	11	21	37	1,056	1,208	3	6	16	286	326
Delaware	—	0	2	9	10	—	0	0	—	—
District of Columbia	—	0	4	23	17	—	0	1	2	3
Florida	4	5	10	259	301	2	1	4	66	65
Georgia	1	4	14	230	248	—	1	5	66	78
Maryland§	1	4	8	171	205	—	1	5	57	68
North Carolina	4	2	10	134	157	N	0	0	N	N
South Carolina§	1	1	5	71	99	—	1	4	48	55
Virginia§	—	3	12	126	145	1	0	6	39	50
West Virginia	—	0	3	33	26	—	0	1	8	7
E.S. Central	1	4	9	167	204	1	2	11	96	102
Alabama§	N	0	0	N	N	N	0	0	N	N
Kentucky	—	1	3	39	38	N	0	0	N	N
Mississippi	N	0	0	N	N	—	0	3	20	10
Tennessee§	1	3	6	128	166	1	1	9	76	92
W.S. Central	14	9	85	456	309	8	5	66	263	276
Arkansas§	—	0	2	5	17	—	0	2	7	18
Louisiana	—	0	2	16	16	—	0	2	10	36
Oklahoma	4	2	19	114	66	1	1	7	61	57
Texas§	10	6	65	321	210	7	3	58	185	165
Mountain	9	10	22	528	551	3	4	13	222	240
Arizona	5	3	9	190	202	2	2	8	109	117
Colorado	3	3	8	144	139	1	1	4	57	49
Idaho§	—	0	2	15	18	—	0	1	5	2
Montana§	N	0	0	N	N	—	0	1	4	1
Nevada§	—	0	1	12	2	N	0	0	N	N
New Mexico§	—	1	8	94	101	—	0	3	18	40
Utah	1	1	5	67	84	—	0	4	28	31
Wyoming§	—	0	2	6	5	—	0	1	1	—
Pacific	1	3	8	164	143	—	0	2	17	13
Alaska	1	1	4	40	25	N	0	0	N	N
California	—	0	0	—	—	N	0	0	N	N
Hawaii	—	2	8	124	118	—	0	2	17	13
Oregon§	N	0	0	N	N	N	0	0	N	N
Washington	N	0	0	N	N	N	0	0	N	N
American Samoa	—	0	12	30	4	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	14	—	0	0	—	—
Puerto Rico	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	N	0	0	N	N

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

* Incidence data for reporting year 2008 are provisional.

† Includes cases of invasive pneumococcal disease, in children aged <5 years, caused by *S. pneumoniae*, which is susceptible or for which susceptibility testing is not available (NNDSS event code 11717).

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending December 13, 2008, and December 15, 2007 (50th week)*

Reporting area	Streptococcus pneumoniae, invasive disease, drug resistant†										Syphilis, primary and secondary				
	All ages				Age < 5 years										
	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007	Current week	Previous 52 weeks		Cum 2008	Cum 2007
	Med	Max				Med	Max				Med	Max			
United States	77	56	307	2,793	2,952	7	9	43	417	508	133	240	351	11,533	10,817
New England	—	1	49	100	107	—	0	8	13	13	2	5	13	287	261
Connecticut	—	0	48	55	55	—	0	7	5	4	—	0	6	31	33
Maine§	—	0	2	16	12	—	0	1	2	2	—	0	2	10	9
Massachusetts	—	0	0	—	2	—	0	0	—	2	2	4	11	207	152
New Hampshire	—	0	0	—	—	—	0	0	—	—	—	0	2	19	29
Rhode Island§	—	0	3	16	21	—	0	1	4	3	—	0	5	13	34
Vermont§	—	0	2	13	17	—	0	1	2	2	—	0	5	7	4
Mid. Atlantic	3	4	13	227	158	—	0	2	22	29	31	33	50	1,611	1,489
New Jersey	—	0	0	—	—	—	0	0	—	—	—	4	10	195	218
New York (Upstate)	1	1	6	61	51	—	0	2	7	10	5	3	13	135	137
New York City	—	1	5	68	—	—	0	0	—	—	24	20	36	1,029	875
Pennsylvania	2	2	9	98	107	—	0	2	15	19	2	5	12	252	259
E.N. Central	21	12	64	665	758	2	1	14	90	124	30	20	34	990	859
Illinois	—	0	17	71	198	—	0	3	14	46	—	5	14	251	445
Indiana	11	2	39	199	163	—	0	11	21	25	3	2	10	132	52
Michigan	—	0	3	16	3	—	0	1	2	2	21	3	19	225	113
Ohio	10	8	17	379	394	2	1	4	53	51	5	6	15	326	187
Wisconsin	—	0	0	—	—	—	0	0	—	—	1	1	4	56	62
W.N. Central	—	3	115	150	240	—	0	9	10	44	1	8	14	371	348
Iowa	—	0	0	—	—	—	0	0	—	—	—	0	2	15	20
Kansas	—	1	5	59	87	—	0	1	4	10	1	0	5	30	28
Minnesota	—	0	114	—	72	—	0	9	—	26	—	2	5	100	57
Missouri	—	2	8	84	64	—	0	1	3	3	—	4	10	218	231
Nebraska§	—	0	0	—	2	—	0	0	—	—	—	0	1	7	4
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	1
South Dakota	—	0	2	7	15	—	0	1	3	5	—	0	1	1	7
S. Atlantic	35	21	53	1,196	1,275	3	4	12	210	233	23	52	215	2,621	2,483
Delaware	—	0	1	3	11	—	0	0	—	2	—	0	4	15	17
District of Columbia	1	0	3	19	21	—	0	1	1	1	—	2	8	125	171
Florida	27	13	30	720	695	3	3	12	142	125	10	20	37	970	877
Georgia	7	7	23	360	478	—	1	5	56	97	—	13	175	581	483
Maryland§	—	0	2	5	1	—	0	1	1	—	5	7	14	320	324
North Carolina	N	0	0	N	N	N	0	0	N	N	6	5	19	269	305
South Carolina§	—	0	0	—	—	—	0	0	—	—	2	2	6	87	90
Virginia§	N	0	0	N	N	N	0	0	N	N	—	5	17	252	210
West Virginia	—	1	9	89	69	—	0	2	10	8	—	0	1	2	6
E.S. Central	1	5	15	258	263	—	1	4	42	36	15	21	37	1,077	881
Alabama§	N	0	0	N	N	N	0	0	N	N	—	8	17	424	367
Kentucky	—	1	6	72	28	—	0	2	11	3	1	1	7	80	56
Mississippi	—	0	2	4	58	—	0	1	1	—	9	3	19	170	108
Tennessee§	1	3	13	182	177	—	0	3	30	33	5	8	19	403	350
W.S. Central	3	2	7	85	87	1	0	2	13	12	23	41	60	2,083	1,814
Arkansas§	3	0	2	19	6	1	0	1	4	2	—	2	19	163	116
Louisiana	—	1	6	66	81	—	0	2	9	10	—	10	30	530	514
Oklahoma	N	0	0	N	N	N	0	0	N	N	—	1	5	54	64
Texas§	—	0	0	—	—	—	0	0	—	—	23	26	47	1,336	1,120
Mountain	14	2	9	110	61	1	0	4	15	14	2	9	17	412	520
Arizona	—	0	0	—	—	—	0	0	—	—	—	4	12	200	286
Colorado	—	0	0	—	—	—	0	0	—	—	—	2	7	91	55
Idaho§	N	0	0	N	N	N	0	0	N	N	—	0	2	6	1
Montana§	—	0	1	1	—	—	0	0	—	—	—	0	3	—	8
Nevada§	N	0	0	N	N	N	0	0	N	N	2	1	6	71	104
New Mexico§	—	0	1	2	—	—	0	0	—	—	—	1	4	40	44
Utah	14	1	9	104	44	1	0	4	15	11	—	0	2	1	18
Wyoming§	—	0	1	3	17	—	0	0	—	3	—	0	1	3	4
Pacific	—	0	1	2	3	—	0	1	2	3	6	44	64	2,081	2,162
Alaska	N	0	0	N	N	N	0	0	N	N	—	0	1	—	7
California	N	0	0	N	N	N	0	0	N	N	2	39	58	1,877	1,980
Hawaii	—	0	1	2	3	—	0	1	2	3	—	0	2	19	8
Oregon§	N	0	0	N	N	N	0	0	N	N	—	0	3	24	17
Washington	N	0	0	N	N	N	0	0	N	N	4	3	9	160	150
American Samoa	N	0	0	N	N	N	0	0	N	N	—	0	0	—	4
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—	4	3	11	157	159
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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† Includes cases of invasive pneumococcal disease caused by drug-resistant *S. pneumoniae* (DRSP) (NNDSS event code 11720).

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