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MORBIDITY AND MORTALITY WEEKLY REPORT

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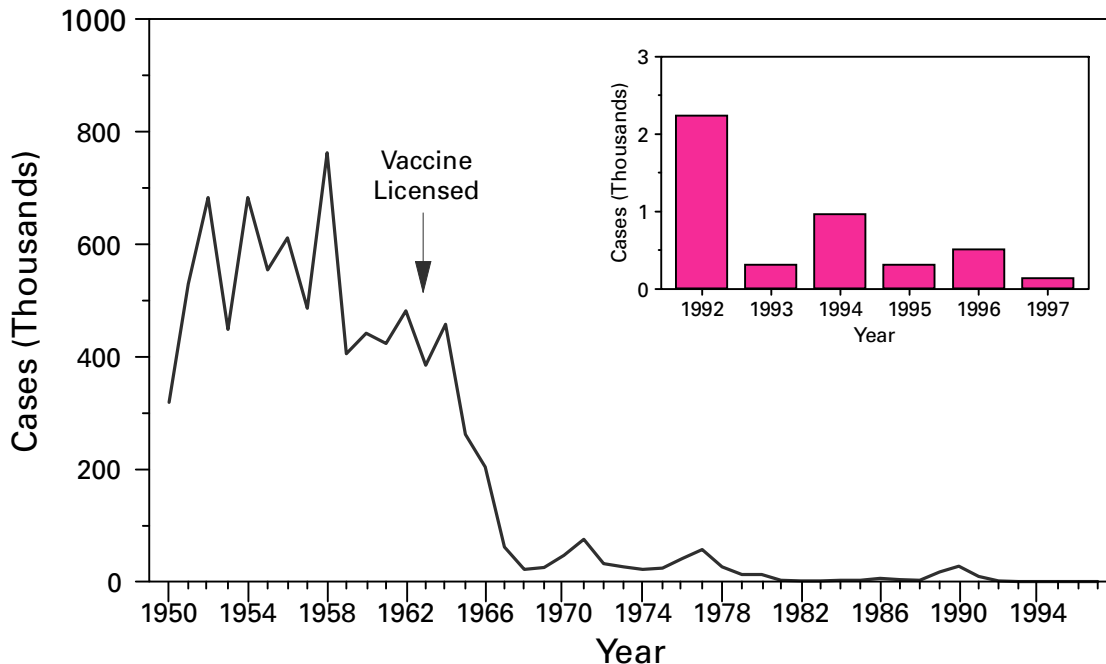
Measles — United States, 1997

During 1997, a provisional total of 138 confirmed measles cases was reported to CDC by local and state health departments, the lowest number of measles cases ever reported in 1 year and a 55% decrease from the previous record low of 309 cases reported in 1995 (Figure 1). This report describes the epidemiology of measles in the United States in 1997, which suggests that no endemic measles virus is circulating in the United States.

Case Classification

Reported measles cases are classified as imported or indigenous based on where transmission of measles virus is likely to have occurred. Cases in persons who traveled outside the United States within 18 days before rash onset are classified as international importations. Indigenous measles cases are classified into three groups:

FIGURE 1. Reported measles cases, by year — United States, 1950–1997



Measles — Continued

1) cases linked epidemiologically to a known international importation, 2) cases in which a measles virus strain is isolated that has been associated with other countries (1), and 3) all other cases in which no association to an importation was detected.

Of the 138 cases reported in 1997, a total of 57 (41%) were international importations. Thirty-six (63%) occurred in visitors traveling to the United States from other countries. The remaining 21 imported cases occurred in U.S. residents who were abroad during the exposure period. The countries from which measles was most frequently imported were Germany (nine cases), Italy (nine), Switzerland (five), Brazil (five), and Japan (four).

Of the 81 indigenous cases, 17 (21%) cases were linked epidemiologically to international importations. The maximum number of cases epidemiologically linked to a single imported case was four. The longest reported chain of measles transmission following an imported case lasted 5 weeks. Measles virus was isolated from two chains of transmission that included seven (9%) of the 81 indigenous cases; the isolated measles strains have been associated with disease in other countries (1). There was no epidemiologic link or virologic evidence suggesting importation for the remaining 57 (70%) of the 81 indigenous cases. In 1997, there was epidemiologic or virologic evidence of an international source for 81 (59%) of the 138 cases reported to CDC, compared with 15% in 1995 and 28% in 1996.

Geographic Distribution

In 21 states, no measles cases were reported for 1997, and in 20 states and the District of Columbia, fewer than five cases were reported. Nine states (Arizona, California, Florida, Massachusetts, Minnesota, New York, Pennsylvania, South Dakota, and Texas) accounted for 64% of total cases and 56% of imported cases.

Temporal Patterns of Transmission

The maximum number of reported cases occurring in a single week was 11, and the median number of cases per week was two. In 9 weeks, no reported cases occurred, and in 21 weeks, all reported cases were associated with imported cases (Figure 2).

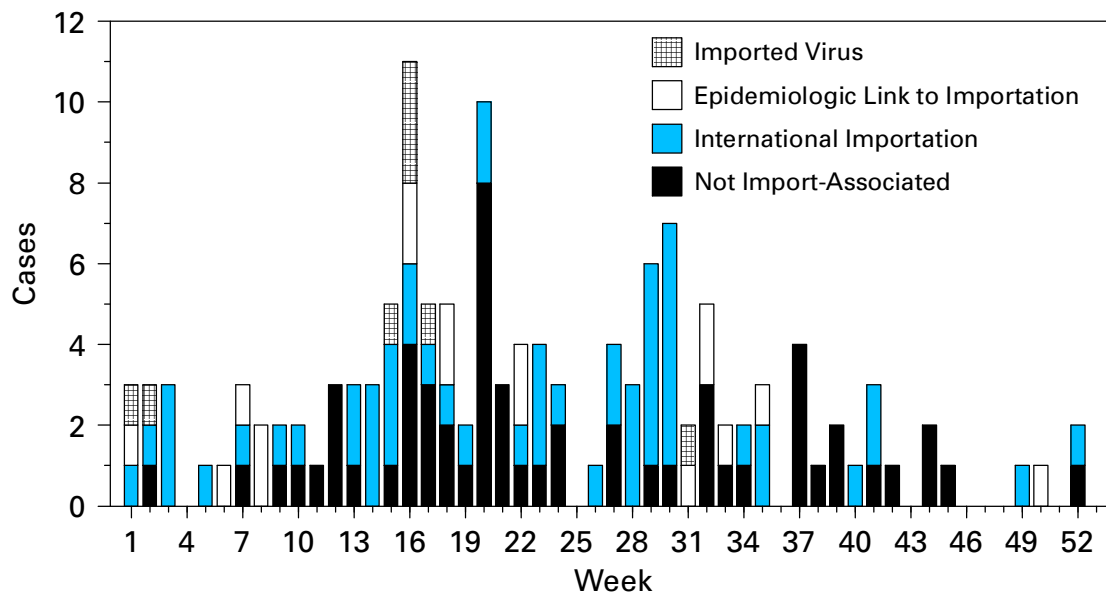
Age and Vaccination Status

The predominant age groups with confirmed measles were preschool-aged children (1–4 years) (40 [29%] cases), followed by persons aged 5–19 years (39 [28%] cases), and persons aged 20–39 years (36 [26%] cases). Of the 138 patients, 32 (23%) had a documented history of vaccination with measles-containing vaccine (MCV): 25 (18%) patients had received one dose of MCV, and seven (5%) had received two doses of MCV. The remaining 106 (77%) patients reported being unvaccinated. For all persons with reported measles in age groups for which vaccine is recommended, 62% were unvaccinated.

Outbreaks

A total of 13 outbreaks, defined as three or more epidemiologically linked cases, were reported to CDC by 11 states. Outbreak-related cases accounted for 44% of all cases. The largest outbreak involved eight cases (median: four; range: three to eight cases). Adult/postschool-related and preschool-related outbreaks were the most common, with four outbreaks each, and three outbreaks involved persons with philosophical or religious objections to vaccination. One school-related and one

Measles — Continued

FIGURE 2. Reported measles cases*, by importation status and week of rash onset — United States, 1997

*n=138.

college-related outbreak also were reported. Five (38%) of the 13 outbreaks had known international sources.

Reported by: State and local health depts. Measles Virus Section, Respiratory and Enteric Viruses Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; Measles Elimination Activity, Child Vaccine Preventable Disease Br, Epidemiology and Surveillance Div, National Immunization Program, CDC.

Editorial Note: The 138 confirmed measles cases in 1997 represent a record low since measles became a nationally reportable disease in 1912. Since the 1989–1991 measles resurgence, the number of reported measles cases has declined substantially, with record low numbers reported during 1993–1997 and <500 cases reported during 1993, 1995, and 1997.

The isolated geographic distribution of measles cases, the small number of reported measles cases, and the lack of a recurrent viral strain suggest that there is no endemic circulation of measles virus in the United States (1). The current pattern of reported measles cases suggests continual importations of measles virus resulting in short chains of secondary transmission in the United States. Some of the indigenous cases that were not associated with importation may have resulted from incomplete reporting and undetected transmission in these chains. Others may have been associated with exposure to undetected importations, or may have been misclassified resulting from false-positive laboratory tests.

Limited secondary transmission following international importation demonstrates the success of vaccination efforts in the United States in increasing population immunity. The measles vaccine coverage rate among children aged 19–35 months was 91% in 1996 (2), and second-dose coverage is increasing among school children through expanding implementation of school requirements for two doses of measles vaccine.

Measles — Continued

However, there are still groups in the population with low measles immunity. The groups most likely to be vulnerable to measles include those with religious or philosophic objections to vaccination, students in grades not required to have two doses of measles vaccine, health-care workers, and preschool-aged children in areas with low vaccination coverage (3,4). The exposure of such groups to an imported case could result in large outbreaks. Continued promotion of vaccination, better implementation of the two-dose vaccination requirement, and improved vaccination of health-care workers should decrease the risk for potential outbreaks among these groups.

Permanent elimination of indigenous transmission of measles in the United States will require strong surveillance and high levels of population immunity. Cooperation with other countries to enhance control of measles can reduce the burden of measles in those countries and the risk for importations to the United States. The decrease in importations to the United States from other countries in the Americas following measles elimination efforts underscores the benefits of coordinated measles elimination efforts in the region (5). For example, only five importations from elsewhere in the Americas were detected in 1997 (compared with 242 cases in 1990) after increased efforts in measles control (6).

The Pan American Health Organization established the goal of eliminating measles from the Western Hemisphere by 2000, and the Eastern Mediterranean Regional Office of the World Health Organization (WHO) established a regional goal of measles elimination by 2010. The European Regional Office of WHO is considering establishing a measles elimination goal. Elimination of measles from other regions of the world greatly reduces the risk for importation and spread of measles in the United States. The goal of global elimination is being considered but has not yet been established.

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Demographic Characteristics of Persons Without a Regular Source of Medical Care — Selected States, 1995

Having a regular source of medical care (i.e., a regular provider or site) is one of the strongest predictors of access to health-care services (1,2), which has been associated with greater use of preventive health services (3,4). This report summarizes state-specific data from the 1995 Behavioral Risk Factor Surveillance System (BRFSS) and examines demographic factors associated with not having a regular source of medical care among adults in the 10 states for which this information was available. The findings indicate that certain demographic characteristics are associated with lack of a regular source of medical care.

The BRFSS is a state-based, random-digit-dialed telephone survey of the noninstitutionalized U.S. population aged ≥ 18 years (5). The 1995 BRFSS collected information about source of medical care from 15,989 survey respondents in 10 states (Alaska, Arizona, Illinois, Kansas, Louisiana, Mississippi, New Jersey, North Carolina, Oklahoma, and Virginia). Participants were asked, "Is there one particular clinic, health center, doctor's office, or other place that you usually go to if you are sick or need advice about your health?" Prevalence estimates were calculated for persons who reported not having a regular source of medical care, and the reasons given for not having a regular source of medical care were examined. Sample estimates were weighted to represent the civilian population of each state, and SUDAAN[®] (Software for the Statistical Analysis of Correlated Data) was used to calculate 95% confidence intervals (6). Response rates ranged from 61.6% in Illinois to 76.2% in Oklahoma (7) (overall response rate: 68.4%).

State-specific estimates of persons who lacked a regular source of medical care ranged from 11.0% in Oklahoma to 20.4% in Arizona (median: 14.4%) (Table 1). Among men, the prevalence of not having a regular source of medical care ranged from 13.5% in Oklahoma and New Jersey to 25.1% in Alaska (median: 20.3%). Among women, the prevalence of not having a regular source of medical care was lower and ranged from 8.5% in Illinois and North Carolina to 16.2% in Arizona (median: 9.5%). In most states,

TABLE 1. Percentage of persons without a regular source of medical care, by state and sex — selected states, Behavioral Risk Factor Surveillance System, 1995

State	Men		Women		Total	
	%	(95% CI*)	%	(95% CI)	%	(95% CI)
Alaska	25.1	(20.1%–30.1%)	9.9	(6.9%–12.9%)	18.0	(14.9%–21.1%)
Arizona	24.7	(20.3%–29.1%)	16.2	(13.4%–19.0%)	20.4	(17.9%–22.9%)
Illinois	22.4	(18.5%–26.3%)	8.5	(6.3%–10.7%)	15.0	(12.7%–17.3%)
Kansas	20.7	(17.6%–23.8%)	8.8	(7.0%–10.6%)	14.3	(12.5%–16.1%)
Louisiana	19.1	(15.7%–22.5%)	10.4	(8.3%–12.5%)	14.5	(12.5%–16.5%)
Mississippi	19.9	(16.3%–23.5%)	9.0	(6.9%–11.1%)	14.1	(12.1%–16.1%)
New Jersey	13.5	(9.9%–17.1%)	10.3	(8.1%–12.5%)	11.9	(9.8%–14.0%)
North Carolina	15.5	(12.0%–19.0%)	8.5	(6.5%–10.5%)	11.9	(9.9%–13.9%)
Oklahoma	13.5	(9.8%–17.2%)	8.6	(6.6%–10.6%)	11.0	(9.3%–12.7%)
Virginia	21.9	(18.5%–25.3%)	13.0	(10.8%–15.2%)	17.3	(15.3%–19.3%)
<i>Median</i>	<i>20.3</i>		<i>9.5</i>		<i>14.4</i>	

*Confidence interval.

Persons Without Regular Source of Medical Care — Continued

both white and black adults were more likely than Hispanics to have a regular source of medical care.

In all states, as age increased, the likelihood of having a regular source of medical care also increased. The prevalence of not having a regular source of medical care was highest among persons aged 18–29 years (range: 16.6%–31.4%; median: 25.5%), and lowest among persons aged ≥65 years (range: 2.0%–10.2%; median: 4.1%). In all states except North Carolina, persons with annual household incomes <\$15,000 were more likely to not have a regular source of medical care than those with incomes ≥\$50,000.

Persons without health-care insurance were more likely to not have a regular source of care than those who did have health-care coverage (Table 2). Among persons who were uninsured, the prevalence of not having a regular source of medical care ranged from 24.7% in Louisiana to 55.4% in Arizona (median: 34.7%); and for those who were insured, from 6.6% in Oklahoma to 14.8% in Virginia (median: 12.0%).

When persons who did not have a regular source of health care were asked why, most (43.2%) reported that they did not need a doctor (range: 38.5% in New Jersey to 55.2% in Mississippi). More than 18% reported that they either had no health-care insurance or could not afford to visit a doctor.

Reported by the following BRFSS coordinators: P Owen, Alaska; B Bender, Arizona; B Steiner, MS, Illinois; M Perry, Kansas; R Meriwether, MD, Louisiana; P Arbuthnot, Mississippi; G Boeslager, MS, New Jersey; K Passaro, PhD, North Carolina; N Hann, MPH, Oklahoma; L Redman, Virginia. S Bland, MS, TRW Inc., Atlanta, Georgia. Behavioral Surveillance Br, Div of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: The findings in this report indicate that persons without a regular source of medical care are more likely to be young, male, Hispanic, and uninsured and to have a low household income. Most persons who did not have a regular source of medical care did not think they needed a regular source. The results suggest the need for education about the health benefits of having a primary source of medical care, including early identification of health problems and increased access to and use of preventive health services. In addition, the results provided information about factors,

TABLE 2. Percentage of persons without a regular source of medical care, by state and health insurance status — selected states, Behavioral Risk Factor Surveillance System, 1995

State	Insured		Uninsured		Total	
	%	(95% CI*)	%	(95% CI)	%	(95% CI)
Alaska	14.1	(11.0%–17.2%)	39.5	(30.3%–48.7%)	18.0	(14.9%–21.1%)
Arizona	14.1	(11.6%–16.6%)	55.4	(47.2%–63.6%)	20.4	(17.9%–22.9%)
Illinois	12.2	(10.0%–14.4%)	38.3	(28.0%–48.6%)	15.0	(12.7%–17.3%)
Kansas	11.4	(9.7%–13.4%)	33.2	(25.8%–40.6%)	13.9	(12.9%–15.7%)
Louisiana	11.8	(9.9%–13.7%)	24.7	(19.1%–30.3%)	14.5	(12.5%–16.5%)
Mississippi	12.2	(10.2%–14.2%)	25.9	(18.6%–33.2%)	14.2	(12.2%–16.2%)
New Jersey	9.5	(7.2%–11.5%)	33.5	(22.7%–44.3%)	11.4	(9.4%–13.4%)
North Carolina	8.6	(6.2%–10.4%)	35.2	(26.3%–44.1%)	11.8	(9.8%–13.8%)
Oklahoma	6.6	(5.1%– 8.1%)	35.4	(28.6%–42.2%)	10.9	(9.2%–12.6%)
Virginia	14.8	(12.8%–16.8%)	34.1	(26.7%–41.5%)	17.1	(15.1%–19.1%)
<i>Median</i>	<i>12.0</i>		<i>34.7</i>		<i>14.3</i>	

*Confidence interval.

Persons Without Regular Source of Medical Care — Continued

such as lack of health-care coverage and cost considerations, that might prevent access to preventive care and other appropriate health services.

The findings in this report are subject to at least two limitations. First, because households without telephones were not surveyed, the findings might underrepresent persons who have less education, have a lower annual household income, or are unemployed—all of which have been associated with increased likelihood of not having a regular source of health care (8). Second, because the estimates were based on self-reported data, they may be subject to recall bias.

Having a regular source of medical care is one of the strongest predictors of access to health services (2). Persons who lack a regular source for medical care have less access to primary care (2) and are more likely to experience a delay in seeking preventive health care and services (4); such persons, therefore, are at greater risk for chronic health conditions. Identification of subgroups at increased risk (i.e., young adults, males, Hispanics, persons with low incomes, and uninsured persons) is important in targeting prevention strategies to ensure greater access to and use of preventive health services. These results suggest that a policy of promoting a regular source of medical care is likely to facilitate access to health-care services for adults. At the state level, information about regular source of medical care can be used to develop policies promoting better access to health-care services, thereby lowering the prevalence of chronic health problems and associated economic costs.

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Update: Influenza Activity — United States and Worldwide, 1997–98 Season, and Composition of the 1998–99 Influenza Vaccine

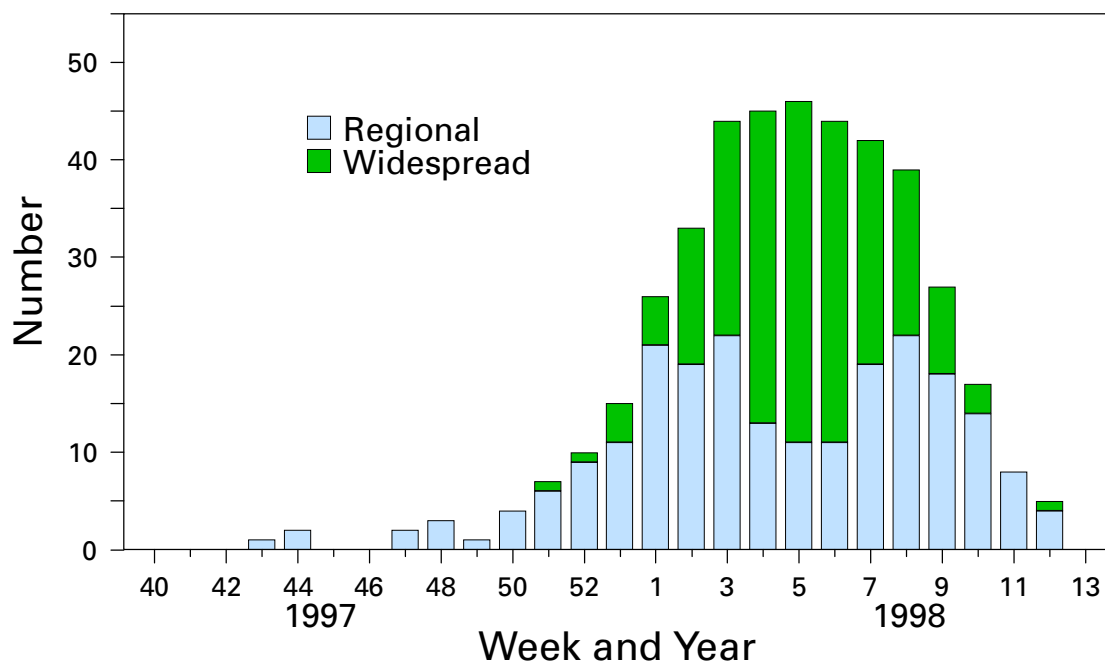
In collaboration with the World Health Organization (WHO), the WHO international network of collaborating laboratories, and state and local health departments, CDC conducts surveillance to monitor influenza activity and to detect antigenic changes in the circulating strains of influenza viruses. This report summarizes surveillance for influenza in the United States and worldwide during the 1997–98 influenza season and describes the composition of the 1998–99 influenza vaccine.

United States

Influenza activity began to increase in early December 1997 and peaked during late January through early February 1998. The predominant virus was influenza A(H3N2); few influenza type B and influenza A(H1N1) isolates were reported. Each week during the weeks ending January 24 through February 21, 1998, >40 state and territorial epidemiologists reported widespread or regional activity* with peak activity occurring during the week ending February 7 (Figure 1).

*Levels of activity are 1) *no activity*; 2) *sporadic*—sporadically occurring influenza-like illness (ILI) or culture-confirmed influenza, with no outbreaks detected; 3) *regional*—outbreaks of ILI or culture-confirmed influenza in counties with a combined population of <50% of the state's total population; and 4) *widespread*—outbreaks of ILI or culture-confirmed influenza in counties with a combined population of \geq 50% of the state's total population.

FIGURE 1. Number of state and territorial epidemiologists reporting widespread or regional influenza activity*, by week and year — United States, September 28, 1997, through March 28, 1998



*Levels of activity are 1) *no activity*; 2) *sporadic*—sporadically occurring influenza-like illness (ILI) or culture-confirmed influenza, with no outbreaks detected; 3) *regional*—outbreaks of ILI or culture-confirmed influenza in counties with a combined population of <50% of the state's total population; and 4) *widespread*—outbreaks of ILI or culture-confirmed influenza in counties with a combined population of \geq 50% of the state's total population.

Influenza Activity — Continued

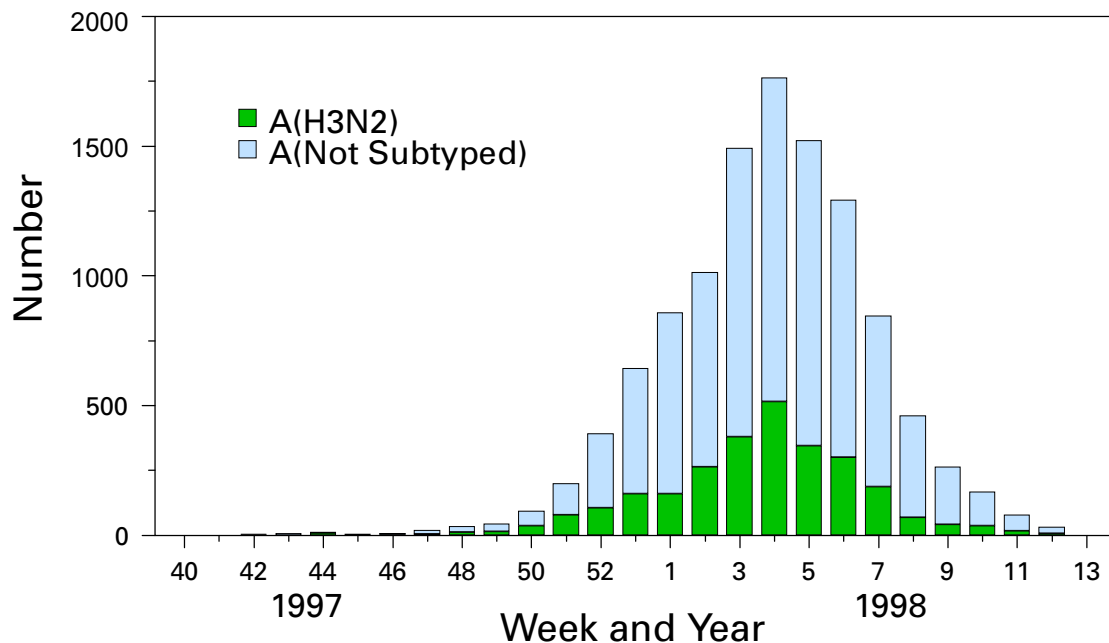
From September 28, 1997, through March 28, 1998, WHO collaborating laboratories in the United States tested 73,940 specimens for respiratory viruses, and 11,439 (15.5%) were positive for influenza (Figure 2). Of these, 11,407 (99.7%) were influenza type A, and 32 (0.3%) were type B. Among 2799 subtyped influenza type A isolates, 2793 (99.8%) were type A(H3N2), and six (0.2%) were type A(H1N1).

Beginning the week ending January 3, the proportion of deaths attributed to pneumonia and influenza (P&I) reported by 122 U.S. cities exceeded the epidemic threshold† for 10 consecutive weeks. During the week ending March 21, the proportion of deaths attributed to P&I decreased below the threshold, but increased slightly above the threshold for the week ending March 28 (Figure 3).

Two related groups of influenza A(H3N2) viruses circulated in the United States this influenza season: A/Wuhan/359/95-like viruses, similar to the strain included in the 1997–98 influenza vaccine, and A/Sydney/5/97-like viruses, a drifted variant of A/Wuhan/359/95. Results from laboratory-confirmed influenza A outbreaks associated with A/Sydney/5/97-like viruses suggest that vaccine containing A/Wuhan/359/95-like virus provided only limited protection (1). Of the 272 influenza A(H3N2) isolates antigenically characterized by CDC, 52 (19%) were similar to A/Wuhan/359/95, and 220 (81%) were similar to A/Sydney/5/97. Among influenza A(H3N2) viruses, the proportion that were A/Sydney/5/97-like increased from 20% (three of 15) in October, to 46% (11 of 24) in November, to 86% (97 of 113) in December, and to 91% (101 of 111)

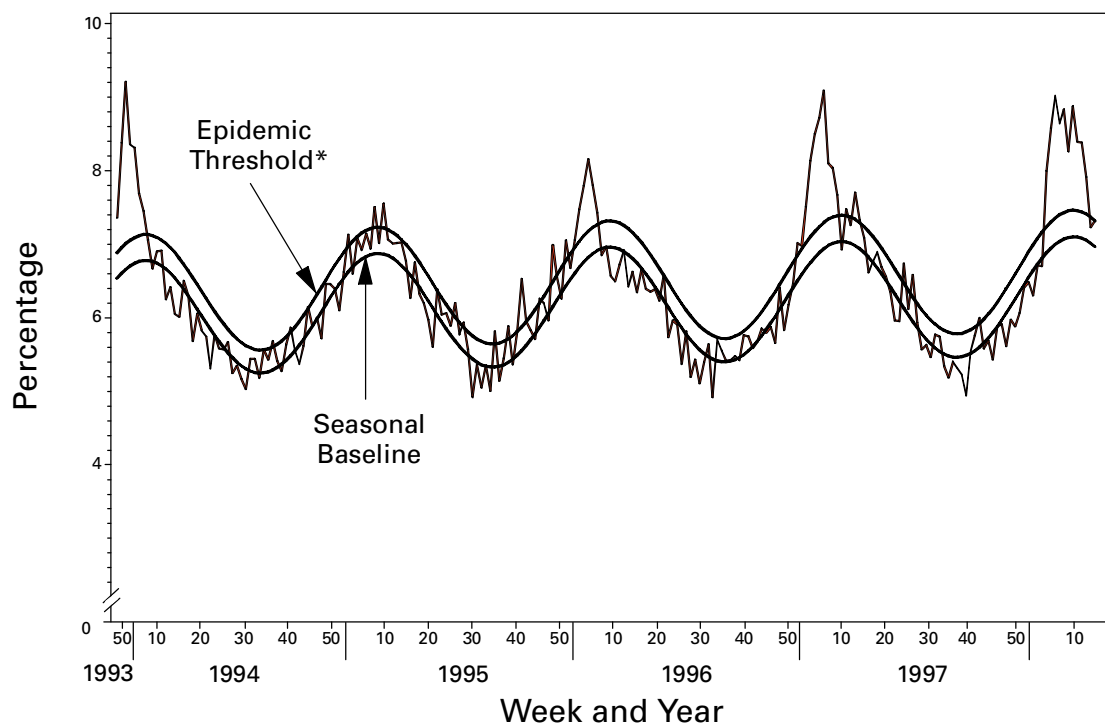
†The epidemic threshold is 1.645 standard deviations above the seasonal baseline. The expected seasonal baseline is projected using a robust regression procedure in which a periodic regression model is applied to observed percentages of deaths from P&I since 1983.

FIGURE 2. Number of influenza virus isolates* reported by the World Health Organization collaborating laboratories, by week and year — United States, September 28, 1997, through March 28, 1998†



* n=11,439.

†Six influenza A (H1N1) and 32 influenza type B isolates also were reported, but are not shown in the figure.

*Influenza Activity — Continued***FIGURE 3. Weekly pneumonia and influenza (P&I) mortality as a percentage of all deaths in 122 cities — United States, December 7, 1993, through March 28, 1998**

*The epidemic threshold is 1.645 standard deviations above the seasonal baseline. The expected seasonal baseline is projected using a robust regression procedure in which a periodic regression model is applied to observed percentages of deaths from P&I since 1983.

in January. Of the nine characterized influenza A(H3N2) viruses collected in February, eight (78%) were A/Sydney/5/97-like.

Eight influenza type B isolates characterized by CDC were similar to the vaccine strain B/Harbin/7/94 and B/Beijing/184/93, and six of seven influenza A(H1N1) isolates were similar to the vaccine strain A/Johannesburg/82/96 and A/Bayern/7/96. One A(H1N1) isolate was characterized as A/Beijing/262/95-like, which is antigenically different from the vaccine strain.

Worldwide

In the northern hemisphere, during October 1997–March 1998, influenza A(H3N2) predominated in Austria, Canada, Croatia, Denmark, Finland, France, Germany, Greece, Iran, Israel, Italy, Japan, Morocco, Russian Federation, Spain, Sweden, Switzerland, United Kingdom, and the Federal Republic of Yugoslavia. Influenza A(H3N2) also was isolated in Czech Republic, Egypt, Hong Kong, Iceland, Korea, Netherlands, Norway, Poland, Portugal, Romania, Saudi Arabia, and Taiwan. Influenza A(H3N2) activity increased in Iran, Israel, and Japan in early January and in Canada and Europe from late January through February. In the southern hemisphere, during October–December, influenza A(H3N2) viruses were isolated from outbreaks in Argentina, Chile, and Fiji and from sporadic cases in Australia, French Polynesia, and South Africa (2–4).

Influenza Activity — Continued

Influenza A(H1N1) isolates were reported less often than influenza A(H3N2) isolates. Outbreaks of influenza A(H1N1) were reported from Belarus, Russian Federation, and United Kingdom. Sporadic cases of influenza A(H1N1) were reported in Argentina, Canada, Croatia, Czech Republic, Denmark, Egypt, France, Germany, Hong Kong, Israel, Italy, Japan, Netherlands, Norway, People's Republic of China, Poland, Portugal, Saudi Arabia, South Africa, Sweden, Switzerland, and Taiwan. Russian Federation and United Kingdom reported increases in influenza A(H1N1) isolates in February, and Germany and Italy reported increases in March (2–4).

Outbreaks of influenza B were reported in Japan and People's Republic of China; sporadic cases were reported in Algeria, Argentina, Austria, Belarus, Belgium, Brazil, Canada, Finland, France, Germany, Greece, Hong Kong, Italy, Netherlands, Norway, Portugal, Russian Federation, Senegal, Slovakia, South Africa, Spain, Sweden, Switzerland, United Kingdom, the Federal Republic of Yugoslavia, and Zambia.

In May 1997, the first case of influenza A(H5N1) in a human occurred in Hong Kong (5). Seventeen additional cases occurred in Hong Kong in November and December. Despite enhanced surveillance, no new cases have been detected since the end of December.

Composition of the 1998–99 Vaccine

The Food and Drug Administration's Vaccines and Related Biologic Products Advisory Committee (VRBPAC) recommended that the 1998–99 trivalent vaccine for the United States contain A/Sydney/5/97-like(H3N2), A/Beijing/262/95-like(H1N1), and B/Beijing/184/93-like viruses. This recommendation was based on antigenic analyses of recently isolated influenza viruses.

Influenza A(H3N2) isolates were either A/Wuhan/359/95-like or A/Sydney/5/97-like viruses. The proportion of influenza A(H3N2) viruses that were A/Sydney/5/97-like increased from October through March and became predominant in many countries. Vaccine containing an A/Wuhan/359/95-like virus induced a lower antibody response against A/Sydney/5/97 than against A/Wuhan/359/95. Therefore, VRBPAC recommended including A/Sydney/5/97 in the 1998–99 vaccine.

A/Bayern/7/95-like viruses, similar to the 1997–98 influenza A(H1N1) vaccine strain, have been the predominant influenza A(H1N1) viruses isolated during the previous year. However, A/Beijing/262/95-like viruses, which have been detected in Asia during the previous 3 years, were identified recently in France, Senegal, South Africa, and the United States. Persons who were vaccinated in an experimental vaccine trial with A/Beijing/262/95 developed equivalent antibody levels against A/Bayern/7/95 and A/Beijing/262/95. However, persons vaccinated with A/Bayern/7/95 had lower antibody levels against A/Beijing/262/95 than A/Bayern/7/95. Because A/Beijing/262/95-like viruses were detected on four continents and because the antibody response to this antigen was more heterogeneous than to A/Bayern/7/95, VRBPAC recommended including A/Beijing/262/95 in the 1998–99 vaccine.

Influenza type B isolates from all continents (except Asia) were similar to B/Beijing/184/93 and the 1997–98 vaccine strain B/Harbin/7/94. Viruses antigenically related to the B/Victoria/2/87 reference strain were isolated in Japan and People's Republic of China. Since vaccine containing the B/Harbin/7/94 strain induced antibody to recently isolated B/Beijing/184/93-like strains, VRBPAC recommended retaining B/Harbin/7/94 in the 1998–99 vaccine.

Influenza Activity — Continued

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Editorial Note: During the 1997–98 influenza season, influenza A(H3N2) viruses predominated worldwide. This is the second consecutive year in which influenza A(H3N2) viruses have predominated in the United States and the third consecutive year in which the proportion of deaths caused by P&I reported by 122 U.S. cities was elevated for several consecutive weeks. Influenza A(H1N1) and influenza B were isolated only sporadically during the 1997–98 influenza season in most countries, including the United States. However, outbreaks of influenza B were reported in Japan and People's Republic of China. Identification of the A/Sydney/5/97-like(H3N2) and A/Beijing/262/95-like (H1N1) strains and, in Hong Kong, identification of the 18 cases of influenza A(H5N1) illustrate the need for continued international virologic surveillance for influenza and the timely subtyping of influenza A isolates.

The production of a vaccine against influenza A(H5N1) for general use was not recommended. However, efforts continue at several laboratories worldwide to develop a vaccine candidate should the need arise, and plans are being developed to test an experimental influenza A(H5N1) vaccine for safety and immunogenicity.

Strains to be included in the influenza vaccine usually are selected during the preceding January through February because of scheduling requirements for production, quality control, packaging, distribution, and vaccine administration before onset of the next influenza season. Recommendations of the Advisory Committee on Immunization Practices for the use of vaccine and antiviral agents for prevention and control of influenza will be published in an *MMWR Recommendations and Reports* on May 1, 1998 (6).

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Nosocomial *Ralstonia pickettii* Colonization Associated with Intrinsically Contaminated Saline Solution — Los Angeles, California, 1998

From February 24 through March 15, 1998, a total of 22 respiratory tract cultures from 13 patients at Childrens Hospital Los Angeles (CHLA), California, were culture-positive for *Ralstonia pickettii*. Because of this unusual cluster of colonization, on March 16 the Los Angeles County Department of Health Services initiated an investigation. This report summarizes the findings of the investigation, which resulted in a recall of sterile sodium chloride solution that was contaminated with *R. pickettii*.

A case of *R. pickettii* colonization was defined as isolation of *R. pickettii* from any clinical site in a CHLA patient during February 1–March 27, 1998 (epidemic period). To determine the background rate, CHLA microbiology records were reviewed, and all cultures positive for *R. pickettii* from July 1, 1997, through February 1, 1998 (pre-epidemic period), were identified. Colonized patients' medical records, hospital laboratory culture methods, and respiratory therapy procedures were reviewed. Selected opened and unopened vials of solutions used in respiratory therapy were cultured.

R. pickettii was isolated significantly more frequently from respiratory specimens submitted to the microbiology laboratory during the epidemic than during the pre-epidemic period (36 [7.2%] of 498 compared with three [0.1%] of 2200; relative risk=53, 95% confidence interval=16–171). Seventeen patients had isolates meeting the case definition. Colonized patients ranged in age from 4 days to 17 years (median: 2 months), nine (53%) were female, all had been hospitalized in an intensive-care unit, and all had received respiratory therapy.

Of the 17 patients, 16 (94%) were mechanically ventilated, and one had a tracheostomy. The endotracheal suctioning protocol in this hospital included the pre-suctioning instillation of sterile saline. All colonized patients received endotracheal suctioning after instillation of 0.9% sterile sodium chloride solution (Modudose[®], manufactured by Kendall Corporation, Mainsfield, Massachusetts*); no infections or deaths were attributed to *R. pickettii*.

Cultures of pooled unopened 3-mL vials of Modudose[®], lot number 718315, by the Los Angeles County Public Health Laboratory and the Food and Drug Administration (FDA) grew *R. pickettii*. Patient and product *R. pickettii* isolates had closely related pulsed-field gel electrophoresis patterns. Since March 30, 1998, when the use of this product was discontinued at CHLA, no further *R. pickettii* colonization has been detected.

Modudose[®] is a sterile 0.9% sodium chloride solution for use in respiratory therapy distributed by Kendall Corporation; Umeco Corporation, San Juan, Puerto Rico; and Westmed Corporation, Tucson, Arizona. On confirmation of Modudose[®] contamination with *R. pickettii*, the manufacturer voluntarily issued a recall that FDA designated as Class I (defined as having a reasonable probability that the use of, or exposure to, a product will cause serious adverse health consequences or death). All lots of the following Modudose[®] labels and product codes were recalled: Kendall product codes 5251 (3 mL) and 5257 (5 mL), Umeco product code PR5251 (3 mL), and Westmed product code 0454 (1.5 mL).

*Use of trade names and commercial sources is for identification only and does not imply endorsement by CDC or the Department of Health and Human Services.

Ralstonia pickettii Colonization — Continued

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Editorial Note: *R. pickettii* is a nonfermentative gram-negative bacillus formerly known as *Pseudomonas pickettii* and *Burkholderia pickettii* (1). In 1995, a new genus, *Ralstonia*, was proposed on the basis of phenotypic characterization, cellular lipid and fatty acid analyses, phylogenetic analysis of 16S rDNA nucleotide sequences, and rRNA-DNA hybridization. The type species of the new genus is *R. pickettii*.

Since 1972, *R. pickettii* has been detected as a contaminate of several solutions (e.g., saline, deionized water, "sterile" water, and intravenous ranitidine) (2–7). These intrinsically contaminated solutions have been associated with outbreaks of respiratory colonization, bloodstream infections, or catheter-related infections.

Modudose[®] is filter sterilized. Previous laboratory studies have shown that low numbers (1–10 colony-forming units) of *R. pickettii* inoculated into 0.9% sodium chloride solution can proliferate over a wide range of temperatures (59 F–108 F [15 C–42 C]) (8). Although the filter size used to terminally sterilize this product is not known (proprietary information), previous studies have shown that *R. pickettii* can pass through a 0.2 µ filter (8).

Clinicians detecting patients with *R. pickettii* colonization or infection associated with use of Modudose[®] are encouraged to report these episodes through local and state health departments to CDC's Hospital Infections Program, National Center for Infectious Diseases (telephone [404] 639-6413; fax [404] 639-6459) and to MedWatch, the FDA Medical Products Reporting Program, telephone (800) 332-1088.

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Notice to Readers

1999 CDC and ATSDR Symposium on Statistical Methods

CDC and the Agency for Toxic Substances and Disease Registry (ATSDR) will co-sponsor a statistical methods symposium, "Emerging Statistical Issues in Public Health for the 21st Century," January 28–29, 1999, in Atlanta. A short course, "Privacy, Confidentiality, and the Protection of Health Data—A Statistical Perspective," will be offered January 27, 1999, in conjunction with the symposium. The symposium and course are open to the public.

Abstracts will be considered in the following areas: 1) data collection and storage, including questionnaire and survey design, the use of data registries, and issues related to patients' rights and data privacy and confidentiality; 2) modeling and analysis of complex and/or dependent data structures, including techniques and software for spatial, clustered, longitudinal, survey, and genetic data, hierarchical and causal modeling, and data mining; 3) modeling and analysis of sparse data structures, including issues related to missing values, limits of detection, low dosages or exposures, and rare conditions; 4) design, modeling, and evaluation of public health interventions; and 5) applications of statistical methods in public health arenas including infectious and chronic disease prevention, injury and violence prevention, occupational and environmental exposures, and immunization.

Abstracts should be postmarked no later than July 1, 1998. Authors of papers accepted for presentations or posters will be notified by September 30, 1998. Registration and abstract information and additional information regarding scientific content of the symposium is available from CDC's Epidemiology Program Office, 1999 CDC and ATSDR Symposium on Statistical Methods, 1600 Clifton Road, NE, Mailstop D-01, Atlanta GA 30333; telephone (404) 639-3806; fax (404) 639-4463; or e-mail bam6@cdc.gov.

Erratum: Vol. 47, No. RR-2

In the *MMWR Recommendations and Reports*, "Public Health Service Task Force Recommendations for the Use of Antiretroviral Drugs in Pregnant Women Infected with HIV-1 for Maternal Health and for Reducing Perinatal HIV-1 Transmission in the United States," on page 10, second paragraph, the correct reference after line nine should be 31.

Erratum: Vol. 46, No. 48

In the report, "Use of Clinical Preventive Services by Medicare Beneficiaries Aged ≥ 65 Years—United States, 1995," on page 1139, the percentages in the first sentence of the first paragraph were incorrect. The sentence should read: "The percentage of women aged ≥ 65 years who had received a mammogram during the 2 years preceding the survey ranged from 52.8% (95% CI=44.2%–61.3%) (New Jersey) to 80.8% (95% CI=69.4%–92.2%) (Alaska) (median: 65.5%), and prevalences did not vary by region."

In the same report, in Table 1 on pages 1140–1, the mammography prevalence estimates and confidence intervals were incorrect. Following is the corrected table.

TABLE 1. Estimated prevalence of use of four clinical preventive services by Medicare beneficiaries* aged ≥65 years, by service and state — United States, Behavioral Risk Factor Surveillance System (BRFSS), 1995

State	Influenza vaccination [†]		Pneumococcal vaccination [§]		Mammography [¶]		Papanicolaou smear ^{**}	
	%	(95% CI ^{††})	%	(95% CI)	%	(95% CI)	%	(95% CI)
Alabama	46.2	(40.3%–52.1%)	33.4	(27.9%–38.9%)	66.3	(59.2%–73.4%)	64.3	(55.1%–73.5%)
Alaska	49.8	(33.9%–65.7%)	46.3	(29.8%–62.8%)	80.8	(69.4%–92.2%)	86.5	(74.3%–98.7%)
Arizona	65.0	(59.1%–70.9%)	49.3	(43.0%–55.6%)	80.5	(73.9%–87.1%)	88.5	(83.4%–93.6%)
Arkansas	62.1	(57.0%–67.2%)	37.6	(32.1%–43.1%)	63.7	(57.3%–70.0%)	68.7	(59.9%–77.5%)
California	60.9	(56.0%–65.8%)	44.8	(39.9%–49.7%)	NA ^{§§}		NA	
Colorado	66.9	(61.4%–72.4%)	46.7	(40.6%–52.8%)	65.5	(58.9%–72.0%)	70.2	(61.6%–78.8%)
Connecticut	63.2	(57.5%–68.9%)	38.3	(32.6%–44.0%)	79.0	(73.2%–84.8%)	70.0	(61.8%–78.2%)
Delaware	57.3	(52.2%–62.4%)	41.7	(36.8%–46.6%)	70.2	(64.2%–76.2%)	69.1	(61.1%–77.1%)
Florida	62.4	(58.7%–66.1%)	39.9	(36.2%–43.6%)	78.5	(74.6%–82.4%)	82.3	(77.2%–87.4%)
Georgia	47.6	(42.7%–52.5%)	40.5	(35.6%–45.4%)	75.4	(69.6%–81.3%)	73.9	(65.7%–82.1%)
Hawaii	62.4	(56.9%–67.9%)	42.9	(37.2%–48.6%)	74.4	(68.3%–80.4%)	78.7	(70.7%–86.7%)
Idaho	64.4	(59.9%–68.9%)	40.1	(35.4%–44.8%)	64.4	(58.9%–69.8%)	67.3	(59.7%–74.9%)
Illinois	57.7	(51.4%–64.0%)	29.0	(23.3%–34.7%)	70.4	(65.5%–75.2%)	71.7	(65.6%–77.8%)
Indiana	59.7	(55.0%–64.4%)	34.5	(30.0%–39.0%)	65.5	(59.9%–71.1%)	68.3	(61.6%–75.0%)
Iowa	63.7	(60.2%–67.2%)	44.8	(40.9%–48.7%)	63.6	(59.1%–68.0%)	67.9	(62.4%–73.4%)
Kansas	62.3	(57.0%–67.6%)	45.1	(39.8%–50.4%)	69.4	(63.4%–75.5%)	71.6	(63.8%–79.4%)
Kentucky	53.6	(49.1%–58.1%)	25.6	(21.7%–29.5%)	59.4	(54.2%–64.7%)	52.2	(44.9%–59.5%)
Louisiana	52.8	(46.5%–59.1%)	25.7	(20.6%–30.8%)	61.0	(53.9%–68.1%)	54.6	(43.6%–65.6%)
Maine	65.9	(59.6%–72.2%)	36.5	(29.8%–43.2%)	69.7	(61.9%–77.5%)	74.3	(65.7%–82.9%)
Maryland	58.4	(54.7%–62.1%)	33.6	(30.1%–37.1%)	76.9	(73.0%–80.8%)	69.1	(63.6%–74.6%)
Massachusetts	60.3	(54.4%–66.2%)	33.1	(27.2%–39.0%)	77.6	(71.3%–83.9%)	75.2	(67.2%–83.2%)
Michigan	57.2	(52.3%–62.1%)	40.0	(35.1%–44.9%)	77.4	(72.5%–82.4%)	71.4	(64.3%–78.5%)
Minnesota	63.6	(59.9%–67.3%)	40.5	(36.8%–44.2%)	69.7	(65.2%–74.1%)	73.2	(68.1%–78.3%)
Mississippi	57.1	(51.2%–63.0%)	40.0	(34.1%–45.9%)	54.0	(47.0%–61.0%)	63.9	(54.9%–72.9%)
Missouri	66.7	(60.6%–72.8%)	32.9	(26.6%–39.2%)	69.7	(62.9%–76.6%)	66.4	(56.2%–76.6%)
Montana	64.9	(58.6%–71.2%)	35.6	(29.1%–42.1%)	62.0	(53.9%–70.1%)	69.4	(58.6%–80.2%)
Nebraska	64.1	(59.4%–68.8%)	36.3	(31.6%–41.0%)	60.7	(54.7%–66.6%)	66.0	(58.4%–73.6%)
Nevada	52.4	(46.5%–58.3%)	40.4	(34.5%–46.3%)	63.6	(56.2%–70.9%)	70.4	(60.2%–80.6%)
New Hampshire	56.1	(49.4%–62.8%)	40.6	(33.7%–47.5%)	75.8	(68.0%–83.6%)	74.0	(63.2%–84.8%)
New Jersey	48.4	(40.8%–56.0%)	13.1	(8.0%–18.2%)	52.8	(44.2%–61.3%)	63.2	(52.2%–74.2%)
New Mexico	69.4	(62.3%–76.5%)	40.3	(32.9%–47.7%)	68.0	(58.8%–77.1%)	80.1	(69.9%–90.3%)

New York	56.6	(51.3%–61.9%)	26.9	(22.0%–31.8%)	64.8	(58.3%–71.3%)	64.2	(56.8%–71.6%)
North Carolina	52.9	(49.0%–56.8%)	31.7	(28.2%–35.2%)	65.5	(61.0%–70.0%)	73.2	(67.7%–78.7%)
North Dakota	57.4	(52.5%–62.3%)	33.3	(28.4%–38.2%)	62.9	(57.0%–68.9%)	66.2	(58.6%–73.8%)
Ohio	62.7	(56.0%–69.4%)	40.4	(33.3%–47.5%)	64.6	(56.9%–72.3%)	66.4	(56.2%–76.6%)
Oklahoma	61.0	(56.3%–65.7%)	36.9	(32.2%–41.6%)	58.5	(52.3%–64.6%)	71.4	(62.0%–80.8%)
Oregon	67.3	(63.2%–71.4%)	46.1	(41.6%–50.6%)	76.9	(72.2%–81.6%)	80.7	(74.4%–87.0%)
Pennsylvania	58.7	(54.2%–63.2%)	38.7	(33.8%–43.6%)	60.5	(55.4%–65.6%)	61.7	(55.0%–68.4%)
Rhode Island	66.8	(61.3%–72.3%)	31.0	(25.5%–36.5%)	70.1	(63.3%–76.8%)	59.3	(50.3%–68.3%)
South Carolina	51.7	(46.0%–57.4%)	26.8	(21.9%–31.7%)	70.6	(63.8%–77.4%)	77.6	(68.6%–86.6%)
South Dakota	60.1	(55.2%–65.0%)	31.2	(26.3%–36.1%)	60.7	(54.1%–67.3%)	69.1	(61.3%–76.9%)
Tennessee	63.6	(58.1%–69.1%)	29.5	(24.6%–34.4%)	64.7	(58.5%–71.0%)	66.9	(58.7%–75.1%)
Texas	57.3	(50.4%–64.2%)	45.6	(38.3%–52.9%)	63.8	(56.1%–71.4%)	64.9	(54.1%–75.7%)
Utah	70.3	(65.4%–75.2%)	42.9	(37.4%–48.4%)	67.2	(61.3%–73.1%)	72.0	(64.2%–79.8%)
Vermont	64.0	(59.1%–68.9%)	36.0	(31.1%–40.9%)	65.9	(59.7%–72.0%)	77.5	(70.8%–84.2%)
Virginia	53.2	(46.3%–60.1%)	40.2	(32.9%–47.5%)	72.1	(63.9%–80.4%)	79.5	(70.5%–88.5%)
Washington	67.5	(63.0%–72.0%)	46.7	(41.8%–51.6%)	75.3	(70.2%–80.4%)	77.0	(69.6%–84.4%)
West Virginia	53.6	(49.3%–57.9%)	37.1	(32.6%–41.6%)	61.7	(56.6%–66.9%)	65.7	(59.2%–72.2%)
Wisconsin	56.7	(50.8%–62.6%)	35.8	(30.1%–41.5%)	59.6	(52.2%–67.0%)	71.7	(63.1%–80.3%)
Wyoming	66.5	(61.4%–71.6%)	44.4	(39.1%–49.7%)	59.6	(52.1%–67.0%)	63.5	(54.7%–72.3%)

*All persons responding to the BRFSS questionnaire were asked “Do you have any kind of health-care coverage, including health insurance, prepaid plans such as HMOs [health-maintenance organizations], or government plans such as Medicare?” A “yes” response was used as a proxy for Medicare coverage.

† Vaccination received during the 12 months preceding the survey.

§ Vaccination received during their lifetime.

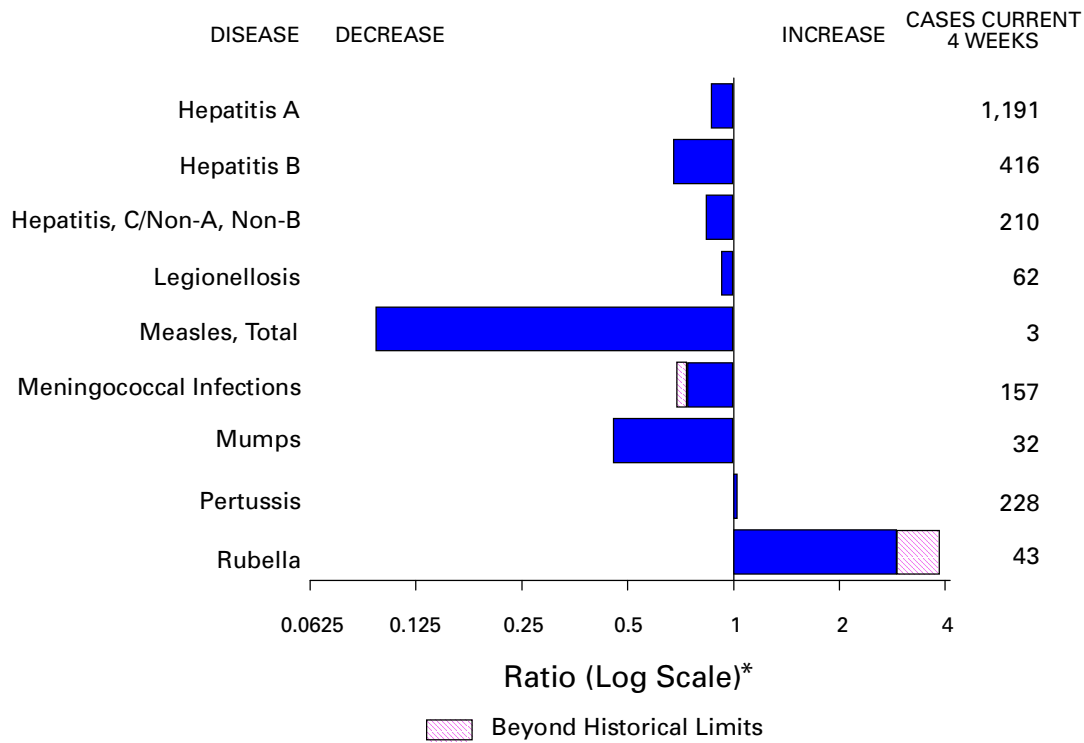
¶ Service received during the previous 2 years.

** Service received during the previous 3 years. Excludes women with no uterine cervix.

†† Confidence interval.

§§ Female respondents from California were excluded from these estimates because of the different wording of the survey questions in that state.

FIGURE I. Selected notifiable disease reports, comparison of provisional 4-week totals ending April 11, 1998, with historical data — United States



*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 — provisional cases of selected notifiable diseases, United States, cumulative, week ending April 11, 1998 (14th Week)

	Cum. 1998		Cum. 1998
Anthrax	-	Plague	-
Brucellosis	4	Poliomyelitis, paralytic [¶]	-
Cholera	-	Psittacosis	11
Congenital rubella syndrome	1	Rabies, human	-
Cryptosporidiosis*	474	Rocky Mountain spotted fever (RMSF)	15
Diphtheria	-	Streptococcal disease, invasive Group A	500
Encephalitis: California*	-	Streptococcal toxic-shock syndrome*	18
eastern equine*	-	Syphilis, congenital**	10
St. Louis*	-	Tetanus	3
western equine*	-	Toxic-shock syndrome	30
Hansen Disease	28	Trichinosis	1
Hantavirus pulmonary syndrome* [†]	-	Typhoid fever	75
Hemolytic uremic syndrome, post-diarrheal*	4	Yellow fever	-
HIV infection, pediatric* [§]	72		

-:no reported cases

*Not notifiable in all states.

[†] Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID).

[§] Updated monthly to the Division of HIV/AIDS Prevention—Surveillance and Epidemiology, National Center for HIV, STD, and

[¶] TB Prevention (NCHSTP), last update March 29, 1998.

[¶] One suspected case of polio with onset in 1998 has also been reported to date.

**Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending April 11, 1998, and April 5, 1997 (14th Week)

Reporting Area	AIDS		Chlamydia		<i>Escherichia coli</i> O157:H7		Gonorrhea		Hepatitis C/NA,NB	
	Cum. 1998*	Cum. 1997	Cum. 1998	Cum. 1997	NETSS [†]	PHLIS [§]	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997
					Cum. 1998	Cum. 1998				
UNITED STATES	12,103	16,345	130,526	119,480	196	82	79,081	73,891	839	734
NEW ENGLAND	320	461	4,982	4,731	23	11	1,277	1,630	10	20
Maine	8	18	249	252	1	-	13	13	-	-
N.H.	13	4	253	208	5	2	27	43	-	2
Vt.	8	10	92	117	-	-	2	15	-	1
Mass.	98	217	2,380	1,943	9	9	571	630	10	17
R.I.	32	43	662	573	3	-	88	145	-	-
Conn.	161	169	1,346	1,638	5	-	576	784	-	-
MID. ATLANTIC	3,425	5,157	16,404	15,003	14	5	9,332	9,500	106	68
Upstate N.Y.	425	845	N	N	11	-	1,271	1,625	90	50
N.Y. City	1,936	2,636	8,925	8,039	-	3	4,074	3,852	-	-
N.J.	580	1,109	1,971	2,794	3	2	1,527	1,914	-	-
Pa.	484	567	5,508	4,170	N	-	2,460	2,109	16	18
E.N. CENTRAL	995	1,213	22,002	19,224	34	9	15,446	11,304	118	182
Ohio	169	251	6,429	6,045	12	-	3,867	3,796	5	5
Ind.	261	283	2,499	2,368	6	3	1,630	1,660	3	3
Ill.	376	369	6,154	2,982	10	-	5,095	1,551	5	24
Mich.	143	248	5,392	4,855	6	2	4,294	3,091	105	140
Wis.	46	62	1,528	2,974	N	4	560	1,206	-	10
W.N. CENTRAL	215	367	8,411	8,343	24	12	3,784	3,425	83	37
Minn.	32	54	1,521	2,021	9	6	526	675	-	-
Iowa	11	51	1,088	1,245	2	-	306	314	8	8
Mo.	101	194	3,213	3,059	4	5	2,023	1,750	73	21
N. Dak.	3	3	215	264	1	1	18	17	-	2
S. Dak.	7	2	442	291	-	-	75	31	-	-
Nebr.	26	28	789	441	3	-	314	157	-	1
Kans.	35	35	1,143	1,022	5	-	522	481	2	5
S. ATLANTIC	3,235	4,175	27,813	22,196	23	9	22,657	22,237	44	51
Del.	40	51	664	-	-	1	380	286	-	-
Md.	334	435	2,252	1,849	9	4	2,489	3,407	3	5
D.C.	266	244	N	N	-	-	958	1,234	-	-
Va.	231	325	2,945	2,988	N	4	1,947	2,317	1	4
W. Va.	30	21	757	902	N	-	193	264	2	1
N.C.	217	218	6,164	4,804	7	-	5,160	4,393	7	17
S.C.	187	211	4,876	3,331	1	-	3,142	2,961	-	12
Ga.	371	529	5,768	2,070	2	-	4,919	2,939	8	-
Fla.	1,559	2,141	4,387	6,252	4	-	3,469	4,436	23	12
E.S. CENTRAL	444	472	10,706	8,695	15	3	10,255	8,936	28	89
Ky.	65	48	1,693	1,703	2	-	987	1,149	-	5
Tenn.	144	200	3,488	3,145	9	3	2,952	2,725	25	47
Ala.	119	129	2,794	2,148	4	-	3,543	2,988	3	5
Miss.	116	95	2,731	1,699	-	-	2,773	2,074	-	32
W.S. CENTRAL	1,370	1,463	15,785	14,516	2	-	10,009	9,820	9	62
Ark.	52	58	979	648	1	-	1,087	1,151	-	1
La.	212	239	3,144	1,798	-	-	2,702	1,781	-	44
Okla.	71	86	2,425	2,061	1	-	1,352	1,351	-	2
Tex.	1,035	1,080	9,237	10,009	-	-	4,868	5,537	9	15
MOUNTAIN	389	461	5,010	6,461	15	9	1,884	2,058	225	85
Mont.	10	12	256	212	1	-	15	13	4	3
Idaho	8	8	486	417	2	-	42	33	68	14
Wyo.	1	9	197	121	-	-	11	16	101	29
Colo.	65	128	-	906	2	1	699	548	10	13
N. Mex.	55	35	1,095	1,051	5	3	192	346	20	14
Ariz.	128	122	2,427	2,577	N	2	833	832	-	7
Utah	35	35	409	399	3	1	44	47	11	2
Nev.	87	112	140	778	2	2	48	223	11	3
PACIFIC	1,710	2,576	19,413	20,311	46	24	4,437	4,981	216	140
Wash.	137	175	2,975	2,503	11	11	504	585	5	7
Oreg.	40	97	1,543	1,291	10	8	228	183	2	1
Calif.	1,499	2,269	13,961	15,741	25	3	3,540	3,964	174	86
Alaska	11	18	553	364	-	-	84	131	1	-
Hawaii	23	17	381	412	N	2	81	118	34	46
Guam	-	2	8	123	N	-	2	15	-	-
P.R.	460	419	U	U	1	U	85	165	1	20
V.I.	13	16	N	N	N	U	-	-	-	-
Amer. Samoa	-	-	-	-	N	U	-	-	-	-
C.N.M.I.	-	-	N	N	N	U	7	10	-	2

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

*Updated monthly to the Division of HIV/AIDS Prevention—Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention, last update March 29, 1998.

†National Electronic Telecommunications System for Surveillance.

§Public Health Laboratory Information System.

TABLE II. (Cont'd.) Provisional cases of selected notifiable diseases, United States, weeks ending April 11, 1998, and April 5, 1997 (14th Week)

Reporting Area	Legionellosis		Lyme Disease		Malaria		Syphilis (Primary & Secondary)		Tuberculosis		Rabies, Animal
	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997	Cum. 1998*	Cum. 1997	Cum. 1998
UNITED STATES	252	227	884	832	262	327	1,805	2,338	1,419	3,854	1,840
NEW ENGLAND	11	18	140	176	11	12	20	40	58	93	349
Maine	1	1	-	1	1	-	1	-	U	10	58
N.H.	2	2	5	4	1	1	-	-	2	1	32
Vt.	1	3	2	2	-	1	-	-	1	-	15
Mass.	3	7	40	30	9	9	17	18	43	46	98
R.I.	4	1	16	24	-	1	-	-	12	7	27
Conn.	-	4	77	115	-	-	2	22	U	29	119
MID. ATLANTIC	56	37	561	539	71	78	60	106	118	652	420
Upstate N.Y.	16	7	328	55	23	11	3	14	U	73	283
N.Y. City	6	1	-	40	32	46	9	18	U	356	U
N.J.	2	5	3	126	8	15	14	53	118	142	55
Pa.	32	24	230	318	8	6	34	21	U	81	82
E.N. CENTRAL	85	96	22	10	16	31	255	203	74	409	14
Ohio	43	47	21	5	1	2	52	69	5	90	14
Ind.	15	12	1	4	1	4	49	47	U	37	-
Ill.	5	4	-	1	5	12	104	18	69	200	-
Mich.	17	24	-	-	8	11	38	22	U	56	-
Wis.	5	9	U	U	1	2	12	47	U	26	-
W.N. CENTRAL	18	17	6	2	15	8	44	54	52	108	147
Minn.	1	-	1	-	8	3	-	13	U	34	29
Iowa	1	1	4	-	2	2	-	2	U	10	33
Mo.	8	7	-	1	3	3	34	26	47	40	9
N. Dak.	-	1	-	-	-	-	-	-	U	2	39
S. Dak.	-	1	-	-	-	-	-	-	4	2	14
Nebr.	6	5	-	1	-	-	4	-	-	-	-
Kans.	2	2	1	-	2	-	6	13	U	20	23
S. ATLANTIC	44	23	112	74	68	69	746	926	260	612	646
Del.	6	3	-	13	1	2	7	7	-	8	17
Md.	8	10	94	51	23	23	174	270	65	57	144
D.C.	3	1	4	4	3	5	26	32	27	21	-
Va.	3	1	3	-	7	16	52	81	53	86	182
W. Va.	N	N	2	-	-	-	-	2	17	13	25
N.C.	4	3	1	2	7	5	218	194	98	89	136
S.C.	4	2	-	1	-	3	85	106	U	64	34
Ga.	-	-	2	1	12	9	122	167	U	112	43
Fla.	16	3	6	2	15	6	62	67	U	162	65
E.S. CENTRAL	4	8	10	17	7	7	335	524	-	288	68
Ky.	1	-	-	1	-	1	38	43	U	42	12
Tenn.	3	3	5	3	4	2	163	212	U	108	37
Ala.	-	2	5	2	3	1	73	134	U	89	19
Miss.	-	3	-	11	-	3	61	135	U	49	-
W.S. CENTRAL	-	1	-	2	3	5	193	353	22	567	52
Ark.	-	-	-	-	-	1	38	43	22	45	1
La.	-	-	-	1	3	3	87	119	-	22	-
Okla.	-	1	-	-	-	1	13	32	U	44	51
Tex.	-	-	-	1	-	-	55	159	U	456	-
MOUNTAIN	15	15	1	-	15	17	57	40	68	110	41
Mont.	1	1	-	-	-	1	-	-	2	2	15
Idaho	-	1	-	-	1	-	-	-	2	1	-
Wyo.	1	1	-	-	-	1	-	-	1	1	25
Colo.	4	4	-	-	5	9	4	-	U	20	-
N. Mex.	1	-	-	-	6	2	-	-	7	5	-
Ariz.	1	3	-	-	2	1	50	33	39	49	1
Utah	6	4	-	-	1	-	2	1	17	4	-
Nev.	1	1	1	-	-	3	1	6	U	28	-
PACIFIC	19	12	32	12	56	100	95	92	767	1,015	103
Wash.	1	2	1	-	1	2	4	5	U	75	-
Oreg.	-	-	1	5	6	7	2	1	U	31	-
Calif.	18	9	30	7	49	90	89	85	715	826	93
Alaska	-	-	-	-	-	1	-	-	11	26	10
Hawaii	-	1	-	-	-	-	-	1	41	57	-
Guam	-	-	-	-	-	-	-	2	-	13	-
P.R.	-	-	-	-	-	3	75	59	-	-	20
V.I.	-	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-	-	-
C.N.M.I.	-	-	-	-	-	-	1	2	8	-	-

N: Not notifiable U: Unavailable -: no reported cases

*Additional information about areas displaying "U" for cumulative 1998 Tuberculosis cases can be found in Notice to Readers, *MMWR* Vol. 47, No. 2, p. 39.

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending April 11, 1998, and April 5, 1997 (14th Week)

Reporting Area	<i>H. influenzae</i> , invasive		Hepatitis (Viral), by type				Measles (Rubeola)					
	Cum. 1998*	Cum. 1997	A		B		Indigenous		Imported†		Total	
			Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997	1998	Cum. 1998	1998	Cum. 1998	Cum. 1998	Cum. 1997
UNITED STATES	286	322	4,566	7,147	1,686	2,301	-	1	-	7	8	21
NEW ENGLAND	15	19	85	170	13	52	-	-	-	1	1	-
Maine	2	2	10	12	-	3	-	-	-	-	-	-
N.H.	1	2	6	8	4	4	-	-	-	-	-	-
Vt.	2	-	6	4	-	1	-	-	-	-	-	-
Mass.	10	14	17	94	6	29	-	-	-	1	1	-
R.I.	-	1	6	11	3	4	-	-	-	-	-	-
Conn.	-	-	40	41	-	11	-	-	-	-	-	-
MID. ATLANTIC	39	43	250	643	226	356	-	-	-	1	1	9
Upstate N.Y.	16	1	94	50	82	54	-	-	-	-	-	3
N.Y. City	7	18	67	336	51	152	U	-	U	-	-	4
N.J.	15	14	2	102	-	72	-	-	-	-	-	1
Pa.	1	10	87	155	93	78	-	-	-	1	1	1
E.N. CENTRAL	44	49	650	931	199	469	-	-	-	1	1	4
Ohio	22	24	105	131	22	28	-	-	-	-	-	-
Ind.	5	4	66	82	20	29	-	-	-	-	-	-
Ill.	16	15	92	252	29	94	-	-	-	-	-	3
Mich.	-	6	361	404	124	146	-	-	-	1	1	1
Wis.	1	-	26	62	4	172	-	-	-	-	-	-
W.N. CENTRAL	14	9	510	501	101	152	-	-	-	-	-	1
Minn.	5	2	20	27	7	3	-	-	-	-	-	-
Iowa	1	2	237	70	14	7	-	-	-	-	-	-
Mo.	4	2	199	290	65	126	-	-	-	-	-	1
N. Dak.	-	-	2	5	1	-	-	-	-	-	-	-
S. Dak.	-	2	2	6	1	-	-	-	-	-	-	-
Nebr.	-	-	11	17	2	7	-	-	-	-	-	-
Kans.	4	1	39	86	11	9	U	-	U	-	-	-
S. ATLANTIC	73	63	493	393	277	259	-	1	-	4	5	-
Del.	-	-	-	10	-	1	-	-	-	-	-	-
Md.	17	24	107	99	38	45	-	-	-	1	1	-
D.C.	-	-	15	11	3	18	-	-	-	-	-	-
Va.	9	4	78	47	28	27	-	-	-	2	2	-
W. Va.	2	2	-	5	1	6	-	-	-	-	-	-
N.C.	8	10	28	56	69	63	-	-	-	-	-	-
S.C.	1	3	8	31	-	20	-	-	-	-	-	-
Ga.	17	15	111	39	59	14	-	-	-	1	1	-
Fla.	19	5	146	95	79	65	-	1	-	-	1	-
E.S. CENTRAL	15	16	107	168	126	164	-	-	-	-	-	1
Ky.	-	3	-	25	-	10	-	-	-	-	-	-
Tenn.	10	10	76	80	101	104	-	-	-	-	-	-
Ala.	5	3	31	35	25	21	-	-	-	-	-	1
Miss.	-	-	-	28	-	29	-	-	-	-	-	-
W.S. CENTRAL	16	15	257	1,053	90	149	-	-	-	-	-	-
Ark.	-	1	14	62	19	17	-	-	-	-	-	-
La.	7	1	8	54	8	34	U	-	U	-	-	-
Okla.	8	11	126	460	14	9	-	-	-	-	-	-
Tex.	1	2	109	477	49	89	-	-	-	-	-	-
MOUNTAIN	48	38	913	1,127	225	231	-	-	-	-	-	-
Mont.	-	-	9	34	2	1	-	-	-	-	-	-
Idaho	-	-	60	53	9	7	-	-	-	-	-	-
Wyo.	-	1	16	14	5	6	-	-	-	-	-	-
Colo.	10	5	72	136	30	47	-	-	-	-	-	-
N. Mex.	-	2	50	71	89	79	-	-	-	-	-	-
Ariz.	30	12	602	492	55	46	-	-	-	-	-	-
Utah	4	3	55	238	19	30	-	-	-	-	-	-
Nev.	4	15	49	89	16	15	U	-	U	-	-	-
PACIFIC	22	70	1,301	2,161	429	469	-	-	-	-	-	6
Wash.	1	1	193	151	35	16	-	-	-	-	-	-
Oreg.	19	13	103	118	35	35	-	-	-	-	-	-
Calif.	-	53	995	1,835	354	406	-	-	-	-	-	3
Alaska	1	1	2	12	2	8	-	-	-	-	-	-
Hawaii	1	2	8	45	3	4	U	-	U	-	-	3
Guam	-	-	-	-	-	1	U	-	U	-	-	-
P.R.	-	-	9	106	156	366	-	-	-	-	-	-
V.I.	-	-	-	-	-	-	U	-	U	-	-	-
Amer. Samoa	-	-	-	-	-	-	U	-	U	-	-	-
C.N.M.I.	-	4	-	1	7	16	U	-	U	-	-	1

N: Not notifiable U: Unavailable -: no reported cases

*Of 64 cases among children aged <5 years, serotype was reported for 26 and of those, 14 were type b.

†For imported measles, cases include only those resulting from importation from other countries.

TABLE III. (Cont'd.) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending April 11, 1998, and April 5, 1997 (14th Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 1998	Cum. 1997	1998	Cum. 1998	Cum. 1997	1998	Cum. 1998	Cum. 1997	1998	Cum. 1998	Cum. 1997
UNITED STATES	855	1,183	11	118	155	37	938	1,364	4	121	13
NEW ENGLAND	51	71	-	-	6	4	168	376	-	21	-
Maine	4	8	-	-	-	1	5	6	-	-	-
N.H.	1	6	-	-	-	2	18	40	-	-	-
Vt.	1	2	-	-	-	-	22	127	-	-	-
Mass.	24	43	-	-	1	1	118	187	-	2	-
R.I.	3	2	-	-	4	-	-	11	-	-	-
Conn.	18	10	-	-	1	-	5	5	-	19	-
MID. ATLANTIC	92	115	-	5	19	2	137	124	2	66	5
Upstate N.Y.	24	24	-	2	4	2	80	53	2	66	1
N.Y. City	8	20	U	-	1	U	-	28	U	-	4
N.J.	24	22	-	-	3	-	-	7	-	-	-
Pa.	36	49	-	3	11	-	57	36	-	-	-
E.N. CENTRAL	126	161	1	18	23	4	102	158	-	-	3
Ohio	53	59	1	10	7	2	38	53	-	-	-
Ind.	23	17	-	-	4	-	34	11	-	-	-
Ill.	25	51	-	-	7	2	7	18	-	-	-
Mich.	12	14	-	8	4	-	13	24	-	-	-
Wis.	13	20	-	-	1	-	10	52	-	-	3
W.N. CENTRAL	71	87	5	15	7	9	76	74	-	1	-
Minn.	6	2	4	8	3	9	50	45	-	-	-
Iowa	11	21	1	5	3	-	13	7	-	-	-
Mo.	31	47	-	1	-	-	9	9	-	1	-
N. Dak.	-	-	-	1	-	-	-	1	-	-	-
S. Dak.	5	3	-	-	-	-	2	1	-	-	-
Nebr.	3	4	-	-	1	-	2	2	-	-	-
Kans.	15	10	U	-	-	U	-	9	U	-	-
S. ATLANTIC	161	204	2	20	19	2	83	120	1	3	-
Del.	1	4	-	-	-	-	-	-	-	-	-
Md.	16	25	-	2	2	1	16	56	1	1	-
D.C.	-	5	-	-	-	-	-	2	-	-	-
Va.	15	14	1	4	1	-	6	17	-	-	-
W. Va.	4	6	-	-	-	-	1	3	-	-	-
N.C.	22	39	-	6	5	-	38	25	-	1	-
S.C.	20	31	-	3	1	1	7	4	-	1	-
Ga.	37	34	-	-	2	-	-	2	-	-	-
Fla.	46	46	1	5	8	-	15	11	-	-	-
E.S. CENTRAL	56	86	-	-	11	1	16	32	-	-	-
Ky.	-	20	-	-	-	-	1	9	-	-	-
Tenn.	29	27	-	-	3	1	6	10	-	-	-
Ala.	27	27	-	-	4	-	9	7	-	-	-
Miss.	-	12	-	-	4	-	-	6	-	-	-
W.S. CENTRAL	44	105	1	21	16	4	46	23	1	24	-
Ark.	10	19	-	-	-	-	5	2	-	-	-
La.	16	21	U	-	5	U	-	6	U	-	-
Okla.	18	13	-	-	-	-	6	-	-	-	-
Tex.	-	52	1	21	11	4	35	15	1	24	-
MOUNTAIN	60	77	1	9	7	6	221	247	-	5	-
Mont.	2	4	-	-	-	-	1	2	-	-	-
Idaho	2	5	-	-	2	3	113	140	-	-	-
Wyo.	3	-	-	1	-	-	-	3	-	-	-
Colo.	14	21	-	1	2	1	30	77	-	-	-
N. Mex.	12	13	N	N	N	-	47	12	-	1	-
Ariz.	21	16	-	2	-	1	18	9	-	1	-
Utah	5	9	1	1	1	1	9	1	-	2	-
Nev.	1	9	U	4	2	U	3	3	U	1	-
PACIFIC	194	277	1	30	47	5	89	210	-	1	5
Wash.	24	27	-	4	3	5	78	98	-	-	-
Oreg.	41	61	N	N	N	-	8	5	-	-	-
Calif.	126	186	1	16	32	-	-	101	-	-	1
Alaska	1	1	-	2	2	-	-	2	-	-	-
Hawaii	2	2	U	8	10	U	3	4	U	1	4
Guam	-	1	U	-	1	U	-	-	U	-	-
P.R.	1	6	-	2	4	-	2	-	-	-	-
V.I.	-	-	U	-	-	U	-	-	U	-	-
Amer. Samoa	-	-	U	-	-	U	-	-	U	-	-
C.N.M.I.	-	-	U	-	-	U	-	-	U	-	-

N: Not notifiable

U: Unavailable

-: no reported cases

TABLE IV. Deaths in 122 U.S. cities,* week ending April 11, 1998 (14th Week)

Reporting Area	All Causes, By Age (Years)						P&J†	Total	Reporting Area	All Causes, By Age (Years)						P&J†	Total
	All Ages	>65	45-64	25-44	1-24	<1				All Ages	>65	45-64	25-44	1-24	<1		
NEW ENGLAND	482	378	65	20	4	14	37	S. ATLANTIC	1,304	835	285	127	34	22	60		
Boston, Mass.	122	85	22	5	2	7	15	Atlanta, Ga.	U	U	U	U	U	U	U		
Bridgeport, Conn.	53	40	11	1	1	-	2	Baltimore, Md.	205	113	57	24	6	5	11		
Cambridge, Mass.	11	8	2	1	-	-	2	Charlotte, N.C.	66	43	15	6	1	1	1		
Fall River, Mass.	20	20	-	-	-	-	-	Jacksonville, Fla.	136	93	28	11	1	2	-		
Hartford, Conn.	51	45	4	1	-	1	2	Miami, Fla.	104	60	25	17	1	1	-		
Lowell, Mass.	26	21	3	1	-	1	2	Norfolk, Va.	61	38	12	5	2	4	6		
Lynn, Mass.	13	12	1	-	-	-	1	Richmond, Va.	77	55	13	7	2	-	2		
New Bedford, Mass.	25	22	2	1	-	-	-	Savannah, Ga.	45	35	3	5	1	1	5		
New Haven, Conn.	41	31	4	1	1	4	3	St. Petersburg, Fla.	61	48	6	3	2	2	3		
Providence, R.I.	U	U	U	U	U	U	U	Tampa, Fla.	188	123	37	20	5	3	14		
Somerville, Mass.	2	1	1	-	-	-	-	Washington, D.C.	353	222	86	29	13	3	18		
Springfield, Mass.	48	33	8	6	-	1	5	Wilmington, Del.	8	5	3	-	-	-	-		
Waterbury, Conn.	20	18	2	-	-	-	1	E.S. CENTRAL	818	562	164	54	21	15	50		
Worcester, Mass.	50	42	5	3	-	-	4	Birmingham, Ala.	181	118	35	13	7	6	10		
MID. ATLANTIC	2,240	1,587	430	153	24	36	111	Chattanooga, Tenn.	52	33	12	4	1	2	3		
Albany, N.Y.	38	31	3	2	1	1	2	Knoxville, Tenn.	70	48	12	5	3	2	8		
Allentown, Pa.	27	23	3	1	-	-	-	Lexington, Ky.	57	36	16	2	2	1	2		
Buffalo, N.Y.	62	49	9	2	1	1	1	Memphis, Tenn.	193	137	40	13	1	2	19		
Camden, N.J.	27	15	7	2	1	2	1	Mobile, Ala.	111	87	9	11	3	1	2		
Elizabeth, N.J.	20	15	5	-	-	-	-	Montgomery, Ala.	31	25	4	1	-	1	4		
Erie, Pa.	41	35	5	1	-	-	5	Nashville, Tenn.	123	78	36	5	4	-	2		
Jersey City, N.J.	25	14	8	2	-	1	-	W.S. CENTRAL	1,446	962	280	123	41	40	88		
New York City, N.Y.	1,147	791	243	81	12	20	42	Austin, Tex.	86	56	13	10	2	5	6		
Newark, N.J.	69	45	11	2	-	1	2	Baton Rouge, La.	22	16	2	2	1	1	-		
Paterson, N.J.	10	4	2	4	-	-	-	Corpus Christi, Tex.	43	21	11	6	3	2	1		
Philadelphia, Pa.	400	276	89	30	3	2	24	Dallas, Tex.	209	143	42	17	4	3	3		
Pittsburgh, Pa.‡	45	33	8	2	-	2	3	El Paso, Tex.	84	58	18	7	1	-	6		
Reading, Pa.	22	20	2	-	-	-	1	Ft. Worth, Tex.	113	74	16	14	4	5	10		
Rochester, N.Y.	112	91	10	7	3	1	8	Houston, Tex.	378	246	76	31	13	12	26		
Schenectady, N.Y.	29	20	5	4	-	-	4	Little Rock, Ark.	82	49	20	6	2	5	2		
Scranton, Pa.	32	25	4	2	1	-	-	New Orleans, La.	74	47	20	6	1	-	-		
Syracuse, N.Y.	90	67	11	5	2	5	11	San Antonio, Tex.	210	148	40	16	4	2	24		
Trenton, N.J.	27	19	4	4	-	-	7	Shreveport, La.	58	43	9	2	3	1	5		
Utica, N.Y.	17	14	1	2	-	-	-	Tulsa, Okla.	87	61	13	6	3	4	5		
Yonkers, N.Y.	U	U	U	U	U	U	U	MOUNTAIN	883	619	160	58	19	26	54		
E.N. CENTRAL	2,165	1,465	399	176	50	59	131	Albuquerque, N.M.	86	62	11	7	4	2	1		
Akron, Ohio	49	32	11	4	-	2	-	Boise, Idaho	32	20	8	1	-	3	2		
Canton, Ohio	37	27	7	3	-	-	5	Colo. Springs, Colo.	56	37	10	4	2	3	4		
Chicago, Ill.	513	319	92	54	23	23	52	Denver, Colo.	U	U	U	U	U	U	U		
Cincinnati, Ohio	101	75	20	3	1	2	1	Las Vegas, Nev.	209	147	45	12	4	1	8		
Cleveland, Ohio	119	74	26	12	2	5	4	Ogden, Utah	26	18	6	1	1	-	4		
Columbus, Ohio	185	129	37	14	3	2	18	Phoenix, Ariz.	202	128	38	20	5	10	13		
Dayton, Ohio	123	96	21	5	-	1	6	Pueblo, Colo.	29	22	4	2	1	-	2		
Detroit, Mich.	201	113	50	26	5	7	7	Salt Lake City, Utah	99	71	21	3	-	4	10		
Evansville, Ind.	44	38	5	1	-	-	1	Tucson, Ariz.	144	114	17	8	2	3	10		
Fort Wayne, Ind.	66	42	13	7	1	3	-	PACIFIC	1,451	994	283	106	31	36	131		
Gary, Ind.	18	13	2	3	-	-	1	Berkeley, Calif.	9	6	1	1	-	1	-		
Grand Rapids, Mich.	84	64	9	1	3	7	9	Fresno, Calif.	139	101	16	12	3	7	8		
Indianapolis, Ind.	225	147	43	24	7	4	-	Glendale, Calif.	18	17	1	-	-	-	2		
Lansing, Mich.	24	19	3	2	-	-	3	Honolulu, Hawaii	65	45	15	3	1	1	4		
Milwaukee, Wis.	90	63	18	6	2	1	8	Long Beach, Calif.	77	56	17	2	1	1	14		
Peoria, Ill.	20	16	3	-	1	-	1	Los Angeles, Calif.	296	196	70	19	5	6	28		
Rockford, Ill.	45	30	9	4	1	1	2	Pasadena, Calif.	23	18	3	2	-	-	3		
South Bend, Ind.	38	33	3	1	-	1	4	Portland, Oreg.	105	80	14	5	6	-	5		
Toledo, Ohio	109	89	16	3	1	-	7	Sacramento, Calif.	U	U	U	U	U	U	U		
Youngstown, Ohio	74	46	11	3	-	-	2	San Diego, Calif.	116	81	21	7	3	3	12		
W.N. CENTRAL	901	630	167	57	18	20	61	San Francisco, Calif.	116	67	30	15	2	2	16		
Des Moines, Iowa	104	77	17	6	1	3	9	San Jose, Calif.	221	158	40	16	4	3	22		
Duluth, Minn.	29	22	2	4	1	-	3	Santa Cruz, Calif.	22	16	3	2	1	-	3		
Kansas City, Kans.	32	19	6	3	3	1	1	Seattle, Wash.	140	79	33	19	3	6	6		
Kansas City, Mo.	109	56	28	11	3	2	2	Spokane, Wash.	40	28	7	1	2	2	8		
Lincoln, Nebr.	34	26	8	-	-	-	4	Tacoma, Wash.	64	46	12	2	-	4	-		
Minneapolis, Minn.	206	147	37	11	4	7	17	TOTAL	11,690 [§]	8,032	2,233	874	242	268	723		
Omaha, Nebr.	126	92	24	6	2	2	9										
St. Louis, Mo.	101	72	19	7	1	2	5										
St. Paul, Minn.	83	62	16	4	-	1	10										
Wichita, Kans.	77	57	10	5	3	2	1										

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 or more. 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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