CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

October 27, 2000 / Vol. 49 / No. 42

MMWR™
MORBIDITY AND MORTALITY
WEEKLY REPORT

National Diabetes Awareness Month — November 2000

November is National Diabetes Awareness Month. In the United States, an estimated 15.7 million persons have diabetes (*1*). During 1990–1998, the prevalence of diagnosed diabetes among adults, including gestational diabetes, increased 33% (*2*). During November, CDC, in collaboration with 59 state and territorial diabetes control programs and other partners, will highlight activities that increase awareness of the need for persons with diabetes to receive influenza vaccine and of the growing public health problem of type 2 diabetes in children and adolescents.

Persons with diabetes should receive pneumococcal and annual influenza vaccinations because they are more likely than persons without diabetes to die with complications of influenza and pneumonia (*3*). In 1997, only approximately half of persons with diabetes received an annual influenza vaccination, and only one third received pneumococcal vaccine (*4*).

Type 2 diabetes among children and adolescents appears to be a growing public health problem among American Indians/Alaska Natives and other North American ethnic populations (*5*). Although diabetes in children has typically been assumed to be type 1 diabetes, recent clinical case series have indicated that type 2 diabetes is emerging among black, Asian/Pacific Islander, Hispanic, and white children and may account for 8%–45% of the new cases of childhood diabetes (*6*).

CDC is developing population-based registries of childhood diabetes to study prevalence, incidence, natural history, and quality of care. The study will help identify future program and intervention activities.

Information about diabetes is available from CDC, by telephone (877) 232-3422; e-mail, diabetes@cdc.gov; or the World-Wide Web, http://www.cdc.gov/diabetes.

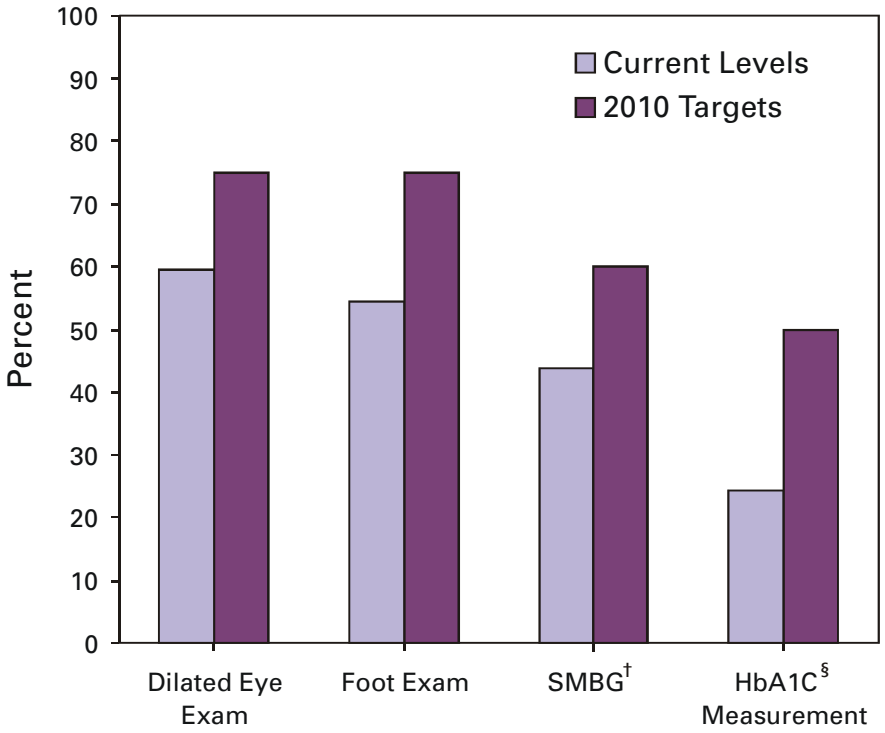
References

1. CDC. National diabetes fact sheet: national estimates and general information on diabetes in the United States. Atlanta, Georgia: US Department of Health and Human Services, CDC, 1998.
2. Mokdad AH, Ford ES, Bowman BA, et al. Diabetes trends in the U.S.: 1990–1998. Diabetes Care 2000;23:1278–83.
3. Geiss LS, Thompson TJ. Are persons with diabetes more likely to die from influenza and pneumonia? Diabetes 1995;44:124.
4. CDC. Influenza and pneumococcal vaccination rates among persons with diabetes mellitus—United States, 1997. MMWR 1999;48:961–7.
5. Fagot-Campagna A, Pettitt DJ, Engelgau MM, et al. Type 2 diabetes among North American children and adolescents: an epidemiological review and a public health perspective. J Pediatr 2000;136:664–72.
6. American Diabetes Association. Type 2 diabetes in children: consensus conference. Diabetes Care 2000;23:381–9.

Levels of Diabetes-Related Preventive-Care Practices — United States, 1997–1999

Persons with diabetes are at increased risk for serious complications (e.g., blindness, kidney failure, nontraumatic lower-extremity amputations, and cardiovascular disease) (*1*). Preventive-care practices, such as annual dilated eye and foot examinations, self-monitoring of blood glucose, and glycemic control, are effective in reducing both the incidence and progression of diabetes-specific complications (*2–6*). Despite the benefits of preventive-care practices, many persons with diabetes in the United States do not receive these services (*7*). The national health objectives for 2010 include increasing the proportion of persons with diabetes who 1) have an annual dilated eye examination to 75%, 2) have an annual foot examination to 75%, 3) perform self-monitoring of their blood glucose (SMBG) at least once daily to 60%, and 4) have a glycosylated hemoglobin (HbA1C) measurement at least once a year to 50%. To measure levels of preventive-care practices, CDC analyzed data from the 1997–1999 Behavioral Risk Factor Surveillance System (BRFSS). This report summarizes the results of that analysis, which indicate that levels of preventive-care practices among persons with diabetes are lower than the national health objectives for 2010 (Figure 1).

FIGURE 1. Percentage of persons with diabetes who receive preventive-care practices and national health objectives for 2010 for each practice — Behavioral Risk Factor Surveillance System, United States, 1997–1999*



* Estimates are age-adjusted to the 2000 U.S. adult population, 3-year averages. Data from the following states and territories were not included in the analysis: Delaware, Illinois, Indiana, Maryland, Missouri, New York, Oklahoma, Oregon, South Carolina, South Dakota, Washington, Puerto Rico, Guam, and the U.S. Virgin Islands.

† Self-monitoring of blood glucose.

§ Glycosylated hemoglobin.

Diabetes-Related Preventive-Care Practices — Continued

BRFSS is an ongoing, state-based, random-digit–dialed telephone survey of the noninstitutionalized U.S. population aged ≥18 years. BRFSS is conducted in 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. This analysis was restricted to respondents who answered "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who were told they had diabetes only during pregnancy were excluded from this analysis. Persons with self-reported diabetes were asked, "When was the last time you had an eye exam in which the pupils were dilated?", "About how many times in the last year has a health professional checked your feet for any sores or irritations?", "About how often do you check your blood for glucose or sugar?", and "About how many times in the last year has a doctor, nurse, or other health professional checked you for glycosylated hemoglobin or hemoglobin 'A one C'?" Only persons who reported having seen a health professional for their diabetes during the preceding year were asked if they had their feet examined, and only patients who had seen a health professional for their diabetes during the preceding year and heard of the term "glycosylated hemoglobin" or "hemoglobin A one C" were asked if they had received a HbA1C measurement. Persons who were not asked the questions were considered not to have received the services. Data were analyzed to determine the level of use of each preventive-care practice, by state, in the 40 states that had at least 2 years of data during 1997–1999. In addition, sociodemographic characteristics associated with use of each preventive-care practice were examined. Data were weighted to reflect the age, sex, and racial distribution of the adult, noninstitutionalized population of each state, and all estimates were age-adjusted to the 2000 U.S. adult population. Data were analyzed using SAS software, with SUDAAN to calculate point estimates and 95% confidence intervals.

Among adults with diabetes in the 40 states, substantial gaps exist between current levels of preventive-care practices and the 2010 targets (Figure 1). Sociodemographic characteristics associated with each preventive-care practice varied by practice (Table 1). Men were more likely than women to have their feet examined. Persons aged ≥45 years were more likely to report having a dilated eye examination, persons aged ≥75 years were less likely to perform SMBG, and persons aged <45 years were more likely to have their HbA1C measured. Non-Hispanic whites were more likely to perform SMBG than were persons from other racial/ethnic groups. Persons with at least a high school education and with health insurance were more likely to receive each of the four preventive-care practices.

Levels of preventive-care practices varied by state for each practice (Table 2). The proportion of persons who received an annual dilated eye examination ranged from 47.0 to 81.0, who received an annual foot examination ranged from 42.4 to 69.4, who self-monitored their blood glucose ranged from 29.7 to 65.5, and who received a HbA1C measurement ranged from 16.9 to 42.4. Three states (Alaska, Maine, and Massachusetts) met the dilated eye examination target, and one state (Montana) met the self-monitoring of blood glucose target; no state met the annual foot examination or HbA1C measurement target.

Reported by the following BRFSS coordinators: S Reese, MPH, Alabama, MBA; P Owen, Alaska; B Bender, MBA, Arizona; G Potts, MBA, Arkansas; B Davis, PhD, California; M Leff, MSPH, Colorado; M Adams, MPH, Connecticut; F Breukelman, Delaware; I Bullo, District of Columbia; S Hoecherl, Florida; L Martin, MS, Georgia; F Reyes-Salvail, MS, Hawaii; J Aydelotte, MA, Idaho; B Steiner, MS, Illinois; L Stemnock, Indiana; J Igbokwe, PhD, Iowa; C Hunt, MPH, Kansas; T Sparks, Kentucky; B Bates, MSPH, Louisiana; D Maines, Maine; A Weinstein, MA, Maryland; D Brooks, MPH, Massachusetts; H McGee, MPH, Michigan; N Salem, PhD, Minnesota;

Diabetes-Related Preventive-Care Practices — Continued

TABLE 1. Age-adjusted proportion of persons with diabetes who received preventive care, by selected sociodemographic characteristics — Behavioral Risk Factor Surveillance System, United States, 1997–1999*

Characteristic	Dilated eye examination		Foot examination		SMBG†		HbA1C§	
	%	(95% CI¶)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Sex								
Men	60.5	(± 2.8)	58.2	(± 2.8)	43.0	(± 2.8)	24.3	(± 2.5)
Women	58.1	(± 2.2)	50.8	(± 2.2)	44.2	(± 2.2)	23.8	(± 2.0)
Age group (yrs)								
18–44	53.2	(± 3.1)	51.2	(± 3.1)	44.1	(± 3.1)	28.4	(± 2.8)
45–64	62.9	(± 1.9)	59.1	(± 1.9)	44.6	(± 1.9)	21.8	(± 1.7)
65–74	72.1	(± 2.0)	57.3	(± 2.3)	43.4	(± 2.3)	15.9	(± 1.7)
≥75	71.2	(± 2.5)	52.6	(± 2.8)	37.2	(± 2.7)	12.5	(± 2.0)
Race/Ethnicity								
White, non-Hispanic	59.6	(± 2.1)	56.2	(± 2.1)	48.1	(± 2.1)	26.5	(± 1.9)
Black, non-Hispanic	64.3	(± 3.9)	56.9	(± 4.1)	42.4	(± 4.1)	20.3	(± 3.9)
Hispanic	54.1	(± 5.0)	46.8	(± 4.9)	34.8	(± 4.5)	17.6	(± 3.9)
Asian/Pacific Islander	61.0	(±12.0)	55.1	(±12.0)	30.6	(±11.3)	36.1	(±11.7)
American Indian/ Alaska Native	56.2	(±11.8)	48.9	(±11.1)	35.7	(±10.2)	23.1	(± 9.4)
Education level								
<High school	52.5	(± 4.5)	44.6	(± 4.6)	35.1	(± 4.0)	13.8	(± 3.3)
High school	60.2	(± 3.0)	54.6	(± 3.0)	43.4	(± 3.0)	20.5	(± 2.4)
>High school	62.1	(± 2.4)	58.5	(± 2.4)	47.7	(± 2.5)	31.7	(± 2.4)
Health insurance								
Yes	61.9	(± 1.9)	56.5	(± 1.9)	46.6	(± 1.9)	25.6	(± 1.7)
No	48.0	(± 4.6)	42.1	(± 4.7)	31.3	(± 4.1)	17.4	(± 3.8)

* Estimates are age-adjusted to the 2000 U.S. adult population, 3-year averages. Data from the following states and territories were not included in the analysis: Delaware, Illinois, Indiana, Maryland, Missouri, New York, Oklahoma, Oregon, South Carolina, South Dakota, Washington, Puerto Rico, Guam, and the U.S. Virgin Islands.
† Self-monitoring of blood glucose.
§ Glycosylated hemoglobin.
¶ Confidence interval.

D Johnson, MS, Mississippi; J Jackson-Thompson, PhD, Missouri; P Feigley, PhD, Montana; L Andelt, PhD, Nebraska; E DeJan, MPH, Nevada; L Powers, MA, New Hampshire; G Boeselager, MS, New Jersey; W Honey, MPH, New Mexico; C Baker, New York; Z Gizlice, PhD, North Carolina; L Shireley, MPH, North Dakota; P Pullen, Ohio; K Baker, MPH, Oklahoma; K Pickle, MS, Oregon; L Mann, Pennsylvania; Y Cintron, MPH, Puerto Rico; J Hesser, PhD, Rhode Island; M Wu, MD, South Carolina; M Gildemaster, South Dakota; D Ridings, Tennessee; K Condon, Texas; K Marti, Utah; C Roe, MS, Vermont; K Carswell, MPH, Virginia; K Wynkoop-Simmons, PhD, Washington; F King, West Virginia; K Pearson, Wisconsin; M Futa, MA, Wyoming. Epidemiology and Statistics Br, Div of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: The findings in this report indicate low levels of preventive-care practices and a wide gap between current state levels and the 2010 targets. States with the lowest levels were approximately 30 percentage points from reaching the target. Increasing the proportion of persons with diabetes who receive each preventive-care practice could minimize diabetes-related complications and would reduce the morbidity, mortality, and costs associated with diabetes (*1*). Collaborative efforts among health-care systems, health-care providers, public health officials, members of community-based organizations, and patients are needed to identify effective mechanisms for delivering improved quality care to persons with diabetes.

Diabetes-Related Preventive-Care Practices — Continued

TABLE 2. Age-adjusted proportion of persons with diabetes who received preventive care, by state — Behavioral Risk Factor Surveillance System, United States, 1997–1999*

State	Dilated eye examination		Foot examination		SMBG†		HbA1C§	
	%	(95% CI¶)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Alabama	53.6	(± 8.0)	42.4	(± 7.6)	41.0	(± 8.0)	16.9	(± 5.7)
Alaska	76.8	(± 8.0)	59.9	(±11.3)	49.5	(±11.1)	37.7	(±11.6)
Arizona	60.5	(±12.5)	45.3	(±11.0)	42.2	(±10.9)	20.8	(± 9.0)
Arkansas	47.0	(± 7.4)	49.0	(± 8.5)	38.4	(± 8.7)	21.0	(± 8.6)
California	58.2	(± 5.7)	51.1	(± 5.7)	37.2	(± 5.2)	29.0	(± 5.2)
Colorado	56.0	(±10.2)	59.6	(±10.0)	49.8	(±10.6)	40.8	(± 9.8)
Connecticut	72.5	(± 8.8)	65.2	(± 8.6)	58.5	(± 9.4)	31.3	(± 9.7)
District of Columbia	68.1	(±12.8)	57.9	(±13.6)	33.5	(±11.2)	20.7	(±12.4)
Florida	53.5	(± 6.1)	51.7	(± 6.2)	48.1	(± 6.1)	18.8	(± 4.9)
Georgia	57.6	(± 9.0)	52.6	(± 9.1)	41.4	(± 8.8)	18.3	(± 6.9)
Hawaii	70.2	(±10.3)	61.8	(±10.1)	29.7	(± 9.9)	25.5	(±10.6)
Idaho	59.6	(± 8.5)	51.4	(± 8.5)	52.7	(± 8.6)	27.8	(± 8.1)
Iowa	63.8	(± 7.4)	55.0	(± 7.7)	45.2	(± 7.6)	26.2	(± 6.8)
Kansas	57.4	(±10.3)	49.8	(±10.6)	39.3	(±10.0)	17.1	(± 7.0)
Kentucky	58.6	(± 6.0)	60.1	(± 5.6)	45.7	(± 6.0)	24.1	(± 5.6)
Louisiana	66.9	(± 9.2)	52.7	(±11.1)	41.2	(±10.8)	22.0	(± 9.2)
Maine	76.0	(± 8.9)	69.4	(±10.2)	47.9	(±11.0)	42.4	(±11.0)
Massachusetts	81.0	(± 5.0)	65.4	(± 8.0)	51.8	(± 8.8)	27.9	(± 7.6)
Michigan	58.0	(± 7.0)	45.8	(± 7.2)	36.3	(± 7.0)	22.1	(± 5.9)
Minnesota	61.8	(± 5.9)	58.0	(± 5.9)	58.3	(± 5.9)	31.6	(± 5.4)
Mississippi	52.5	(± 9.9)	52.9	(±10.2)	34.1	(± 9.1)	18.1	(± 7.8)
Montana	66.4	(±10.2)	63.3	(±10.1)	65.5	(± 9.4)	39.9	(±10.0)
Nebraska	55.9	(± 8.4)	58.4	(± 8.3)	55.1	(± 8.2)	38.2	(± 8.3)
Nevada	63.5	(±10.9)	51.8	(±11.2)	35.8	(±10.3)	20.8	(± 8.3)
New Hampshire	60.5	(±12.1)	53.6	(±12.1)	47.2	(±12.3)	31.1	(±11.4)
New Jersey	63.6	(± 9.1)	58.6	(± 9.1)	47.5	(± 9.1)	25.6	(± 8.3)
New Mexico	62.3	(± 7.1)	59.3	(± 7.0)	45.2	(± 7.1)	25.1	(± 6.3)
North Carolina	67.3	(± 6.8)	54.6	(± 7.0)	42.9	(± 6.9)	23.8	(± 6.2)
North Dakota	71.5	(±10.8)	67.8	(±10.6)	53.7	(±10.9)	35.7	(±11.2)
Ohio	61.7	(± 9.2)	62.1	(± 9.2)	49.2	(± 9.5)	21.7	(± 8.7)
Pennsylvania	62.4	(± 6.3)	58.3	(± 6.3)	46.6	(± 6.4)	27.8	(± 6.1)
Rhode Island	68.4	(± 7.9)	58.7	(± 8.0)	45.4	(± 8.0)	30.2	(± 7.9)
Tennessee	51.7	(± 7.0)	53.2	(± 7.2)	57.4	(± 7.0)	17.2	(± 5.6)
Texas	55.3	(± 5.9)	53.1	(± 5.8)	41.7	(± 5.6)	17.9	(± 4.2)
Utah	63.9	(± 8.6)	65.4	(± 8.1)	54.3	(± 8.7)	31.4	(± 8.7)
Vermont	71.9	(± 9.2)	50.8	(±11.5)	36.2	(± 9.4)	35.8	(±13.1)
Virginia	64.2	(± 8.2)	59.3	(± 7.3)	46.5	(± 9.0)	24.2	(±11.1)
West Virginia	55.0	(± 8.4)	63.7	(± 7.8)	50.5	(± 8.3)	24.1	(± 7.7)
Wisconsin	64.6	(±11.2)	62.9	(±10.4)	55.3	(±10.4)	27.7	(± 9.9)
Wyoming	56.5	(± 8.8)	48.0	(± 8.7)	50.8	(± 8.8)	30.2	(± 8.4)

* Estimates are age-adjusted to the 2000 U.S. adult population, 3-year averages. Data from the following states and territories were not included in the analysis: Delaware, Illinois, Indiana, Maryland, Missouri, New York, Oklahoma, Oregon, South Carolina, South Dakota, Washington, Puerto Rico, Guam, and the U.S. Virgin Islands.
† Self-monitoring of blood glucose.
§ Glycosylated hemoglobin.
¶ Confidence interval.

Diabetes-Related Preventive-Care Practices — Continued

The only characteristics that were consistent across each preventive-care practice were education level and health insurance status. These findings suggest that socioeconomic status and access to health care have an effect on the receipt of diabetes-related preventive-care practices. Further examination is needed to determine the role of sex, age, and race on receipt of preventive care. The variation by state in receipt of preventive care may, in part, result from differences in demographic distribution, physician practice patterns, health-care system characteristics, and patient attitudes.

The findings in this analysis are subject to at least two limitations. First, persons who live in nursing homes and in households without telephones are not included in this survey; therefore, these results cannot be generalized to these segments of the population. Second, because the data were self reported, they are subject to recall bias and may be underreported or overreported.

CDC, in collaboration with 59 state and territorial diabetes control programs, provides leadership for a coordinated, multifaceted approach to increasing awareness and education about diabetes, improving the quality of diabetes care, promoting early detection of diabetic complications, and monitoring trends in the quality of care received by persons with diabetes. CDC and the National Institutes of Health will cosponsor the National Diabetes Education Program, which develops educational tools and community-based interventions and establishes public and private partnerships to address the needs of persons with diabetes and raise general awareness about the disease. CDC also supports Diabetes Today, a program that provides health professionals and community leaders with the skills needed to mobilize communities and improve diabetes care. CDC also is working with managed-care partners to determine how to improve care for persons with diabetes. Project TRIAD (Translating Research into Action for Diabetes) is a multicenter study that includes several managed-care organizations. Information on these prevention programs is available on the World-Wide Web at http://www.cdc.gov/diabetes/projects/index.htm.

References

1. Harris MI. Diabetes in America: epidemiology and scope of the problem. Diabetes Care 1998;21:11C–4C.
2. Allen TB, DeLong ER, Feussner JR. Impact of glucose self-monitoring on non-insulin treated patients with type II diabetes mellitus. Diabetes Care 1990;13:1044–50.
3. The Diabetes Control and Complications Trial Research Group. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. N Engl J Med 1993;329:977–86.
4. The UK Diabetes Study Group. Intensive blood-glucose control with sulphonlylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33). Lancet 1998;352:837–53.
5. Litzelman DK, Slemenda CW, Langefeld CD, et al. Reduction of lower extremity clinical abnormalities in patients with non-insulin dependent diabetes mellitus. Ann Intern Med 1993;119:36–41.
6. Ferris FL. How effective are treatments for diabetic retinopathy? JAMA 1993;269:1290–1.
7. Beckles GLA, Engelgau MM, Venkat Narayan KM, Herman WH, Aubert RE, Williamson DF. Population-based assessment of the level of care among adults with diabetes in the U.S. Diabetes Care 1998;21:1432–8.

End-Stage Renal Disease Attributed to Diabetes Among American Indians/Alaska Natives With Diabetes — United States, 1990–1996

Diabetes is the leading cause of end-stage renal disease (ESRD) (i.e., kidney failure requiring dialysis or kidney transplantation), and ESRD treatment has increased among American Indians/Alaska Natives (AI/ANs) (*1,2*). To assess trends in the incidence of ESRD attributable to diabetes mellitus (ESRD-DM) treatment among AI/ANs with diabetes, CDC and the Indian Health Service (IHS) analyzed data from the U.S. Renal Data System (USRDS). This report summarizes the findings of the analysis, which indicate that the incidence of ESRD-DM treatment is increasing among AI/ANs with diabetes, particularly young AI/ANs.

USRDS is a surveillance system for ESRD supported by the Health Care Financing Administration (HCFA), the federal agency that administers the Medicare program which reimburses >90% of the ESRD treatment in the United States (*1*). USRDS collects, analyzes, and distributes information about the incidence, prevalence, treatment, and costs of ESRD (*1*), including demographic (e.g., age, sex, and race) and ESRD-related information (e.g., first date of treatment and primary cause of renal failure), ESRD-DM* (i.e., listed in USRDS as the primary cause of renal failure), and first treatment (e.g., kidney dialysis, peritoneal dialysis, or kidney transplantation) in each year during 1990–1996. The incidence of ESRD-DM treatment was calculated using annual age-specific and sex-specific diabetes prevalence estimates from the IHS outpatient database (*3*) and annual estimates of the AI/AN population from the U.S. Bureau of the Census. Incidence of ESRD-DM treatment was age-adjusted by the direct method based on the 1980 U.S. population with diabetes (*4*).

In 1990, 394 AIs/ANs with diabetes began treatment for ESRD-DM; in 1996, 719 began treatment (Table 1). During 1990–1996, of 3884 AI/ANs with diabetes who began treatment for ESRD-DM, 2221 (57%) were women. During this period, the age-adjusted incidence of ESRD-DM treatment increased 24%, from 472 to 584 per 100,000 persons with diabetes (Table 1). The relative increase in the age-adjusted incidence was 32% among women and 14% among men. In 1996, the age-adjusted incidence of ESRD-DM treatment among AI/ANs with diabetes was 584 per 100,000 persons with diabetes compared with 378 among the entire U.S. population with diabetes (*4*). Incidence of ESRD-DM treatment among AI/ANs with diabetes increased with age (Figure 1). In 1996, incidence ranged from 278 per 100,000 persons with diabetes among AI/ANs aged <45 years to 723 among those aged ≥65 years. During 1990–1996, incidence increased 58% among AI/ANs aged <45 years, 9% among those aged 45–64 years, and 34% among those aged ≥65 years.

Reported by: National Diabetes Program Headquarters, Indian Health Svc. Epidemiology and Statistics Br, Div of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: ESRD-DM is a disabling and costly condition that disproportionately affects AI/ANs and is associated with high mortality (*1*). The data analyzed in this report suggest that the incidence of ESRD-DM treatment among the AI/AN population with

*Diabetes as the primary disease causing renal failure is determined by ESRD treatment providers and reported on the Medical Evidence Form of HCFA using a detailed code from a list of diseases.

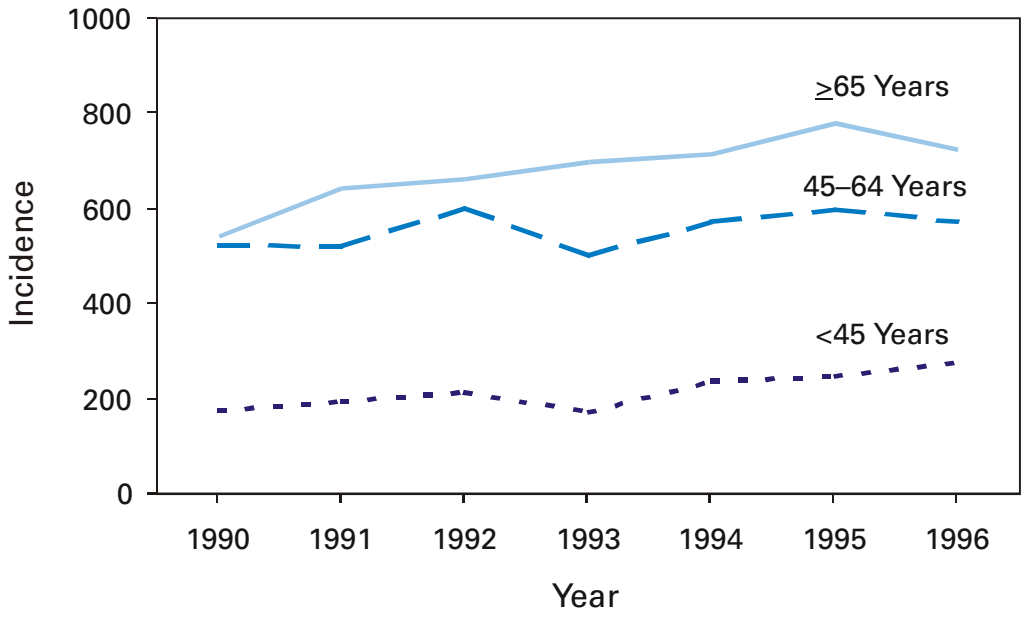
End-Stage Renal Disease — Continued

TABLE 1. Number and incidence* of American Indians/Alaska Natives with diabetes who initiated treatment for diabetes-related end-stage renal disease, by year and sex — United States, 1990–1996

	Men		Women		Total	
Year	No.	Incidence	No.	Incidence	No.	Incidence
1990	182	516.9	212	439.0	**394**	**472.4**
1991	190	549.9	249	489.9	**439**	**514.7**
1992	229	601.2	294	533.0	**523**	**561.1**
1993	207	515.5	298	527.3	**505**	**524.3**
1994	260	571.6	356	569.7	**616**	**573.0**
1995	286	611.9	402	608.1	**688**	**610.9**
1996	309	589.0	410	577.5	**719**	**584.3**

* Per 100,000 persons with diabetes. Incidence of treatment was age-adjusted based on the 1980 U.S. population with diabetes.

FIGURE 1. Incidence* of treatment for end-stage renal disease attributed to diabetes among American Indians/Alaska Natives with diabetes, by age and year — United States, 1990–1996



* Per 100,000 persons with diabetes.

diabetes is increasing. The increase in treatment, especially among those aged <45 years, contributes further to the large and growing public health problem of diabetes among AI/ANs (*3,5*).

Reasons for the increased incidence of ESRD-DM treatment need further research; however, possible factors include higher incidence of ESRD-DM, changes in treatment and care practices, greater recognition of the etiologic role of diabetes in ESRD, better access to or acceptance of treatment, or a combination of these factors. Risk factors for

End-Stage Renal Disease — Continued

developing ESRD-DM include familial and genetic factors, duration of diabetes, hypertension, and hyperglycemia (*2*).

The findings in this report are subject to at least four limitations. First, the data are for persons receiving ESRD treatment as reported to HCFA and do not include patients who die of ESRD before receiving treatment and those who are not reported to HCFA. Second, racial/ethnic misclassification of AI/ANs in USRDS data may result in an underestimation of incidence (*6*). Third, underreporting of AI/ANs in U.S. census counts may result in an overestimation of incidence. Finally, IHS data may not account for the total AI/AN population and may result in overestimation or underestimation of the number of AI/ANs with diabetes and, therefore, the incidence of ESRD-DM. Although these biases may have affected the magnitude of incidence estimates, trends in incidence would not be affected if the biases remained constant over time.

The increased incidence of ESRD-DM treatment poses a public health challenge for AI/AN communities. Moreover, during 1990–1996, the age-adjusted prevalence of diabetes among AI/ANs increased by 24% compared with 14% among the U.S. general population (*3*). Interventions are needed to prevent both diabetes and diabetes-related renal disease among AI/ANs. Regular exercise, improved nutrition, and reduced body weight may prevent or delay the onset of diabetes (*7*). Among persons with diabetes, aggressive blood sugar and hypertension control and the use of angiotensin-converting enzyme inhibitors may prevent or delay the development of ESRD-DM (*8–10*).

In 1998, IHS granted $30 million to tribal governments to help develop and implement interventions to prevent diabetes and its complications. In 1999, CDC, IHS, and other organizations established the National Diabetes Prevention Center in Gallup, New Mexico, to provide guidance and technical support to AI/AN communities throughout the United States and to develop, evaluate, and disseminate culturally appropriate interventions. CDC and the National Institutes of Health cosponsor the National Diabetes Education Program (NDEP) to promote early diagnosis and improve the treatment and outcomes of persons with diabetes. In 1999, in collaboration with IHS and other partners, NDEP launched a diabetes awareness campaign focused on the importance of controlling diabetes. Additional information about NDEP is available from the World-Wide Web, http://ndep.nih.gov/; http://www.cdc.gov/diabetes; or by telephone (800) 438-5383. CDC assists the National IHS Diabetes Program by providing technical assistance on the surveillance of diabetes and its complications among AIs/ANs. The continued surveillance of diabetes and its complications will be an important tool for monitoring the effectiveness of ongoing and future prevention strategies.

References

1. US Renal Data System. USRDS 1999 annual data report. Bethesda, Maryland: US Department of Health and Human Services, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, 1999. Available at http://www.usrds.org. Accessed October 2000.
2. Nelson RG, Knowler WC, Pettitt DJ, Bennett PH. Kidney diseases in diabetes. In: Harris MI, Cowie CC, Stern MP, Boyko EJ, Reiber GE, Bennett PH, eds. Diabetes in America. 2nd ed. Washington, DC: US Department of Health and Human Services, National Institutes of Health, 1995; DHHS publication no. (NIH)95-1468.
3. Burrows NR, Geiss LS, Engelgau MM, Acton KJ. Prevalence of diabetes among American Indians and Alaska Natives, 1990–1997: an increasing burden. Diabetes Care, December 2000(in press).

End-Stage Renal Disease — Continued

4. CDC. 1999 Diabetes surveillance report. Atlanta, Georgia: US Department of Health and Human Services, CDC, 1999. Available at http://www.cdc.gov/diabetes/statistics/index.htm. Accessed October 2000.
5. CDC. Prevalence of diagnosed diabetes among American Indians/Alaska Natives—United States, 1996. MMWR 1998;47:901–4.
6. Sugarman JR, Lawson L. The effect of racial misclassification on estimates of end-stage renal disease among American Indians and Alaska Natives in the Pacific Northwest, 1988 through 1990. Am J Kidney Dis 1993;21:383–6.
7. Pan XR, Li GW, Hu YH, et al. Effects of diet and exercise in preventing NIDDM in people with impaired glucose tolerance: the Da Qing IGT and diabetes study. Diabetes Care 1997;20:537–44.
8. Pahor M, Psaty BM, Alderman MH, Applegate WB, Williamson JD, Furberg CD. Therapeutic benefits of ACE inhibitors and other antihypertensive drugs in patients with type 2 diabetes. Diabetes Care 2000;23:888–92.
9. UK Prospective Diabetes Study Group. Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33). Lancet 1998;352:839–55.
10. UK Prospective Diabetes Study Group. Tight blood pressure control and risk of macrovascular and microvascular complications in type 2 diabetes (UKPDS 38). BMJ 1998;317:703–13.

Folate Status in Women of Childbearing Age — United States, 1999

In 1992, the U.S. Public Health Service (PHS) recommended that women of childbearing age increase consumption of the vitamin folic acid to reduce spina bifida and anencephaly (neural tube defects [NTD]) cases (*1*). Since then, national efforts have been implemented to increase the use of dietary supplements containing folic acid (*2*). In 1996, the U.S. Food and Drug Administration (FDA) mandated that all enriched cereal grain products be fortified with folic acid (*3*). To assess levels of folic acid among childbearing-aged women, CDC compared serum and red blood cell (RBC) folate concentrations for childbearing-aged women who participated in the 1999 National Health and Nutrition Examination Survey (NHANES 1999) to childbearing-aged women who participated in the Third National Health and Nutrition Examination Survey (NHANES III, 1988–1994). The findings indicate substantial increases in serum and RBC folate concentrations among women of childbearing age.

Both NHANES III and NHANES 1999 used a stratified, multistage probability sample of the civilian, U.S. noninstitutionalized population. NHANES III surveyed persons aged ≥2 months. NHANES 1999 surveyed persons of all ages. A household interview and a physical examination were conducted for each survey participant. During the physical examination, blood was collected by venipuncture for all persons aged ≥1 year. Serum and RBC folate were measured by the same analyst in the NHANES Central Laboratory for both NHANES III and NHANES 1999. For Phase 2 (1991–1994) of NHANES III and for NHANES 1999, the Bio-Rad Quantaphase II™ simultaneous folate/vitamin B12 radioassay (Bio-Rad Laboratories, Hercules, California) was used; the Quantaphase™ assay (folate alone) was used for Phase 1 of NHANES III (1988–1991) (*4*). Longterm quality-control data for these assays, including "bridge" control materials that were used in both surveys, indicated no analytical drift; results of all external proficiency testing challenges

Folic Acid — Continued

were graded as satisfactory. The overall ≥6 year mean coefficient of variation for serum and RBC folate was 5%.

From NHANES III to NHANES 1999, mean serum folate concentrations for all women aged 15–44 years increased from 6.3 to 16.2 ng/mL, and the 75th percentile increased from 7.8 to 19.5 ng/mL (Table 1). Increases in the mean serum folate concentration were of comparable magnitude for nonpregnant women (6.0 to 15.9 ng/mL), a group less likely to use folic acid-containing supplements, for women who had used a vitamin/mineral supplement at least once during the preceding 30 days (8.4 to 20.0 ng/mL), and for women who had not used supplements (4.7 to 12.6 ng/mL). Similar results were obtained for RBC folate, a better measure of longterm folate status. Mean RBC folate concentrations for all women aged 15–44 years increased from 181 to 315 ng/mL (Table 1).

Reported by: National Center for Health Statistics, National Center for Chronic Disease Prevention and Health Promotion, and National Center for Environmental Health, CDC.

Editorial Note: Results from NHANES 1999, which was conducted after implementation of food fortification and educational efforts to increase folate consumption, suggest that these public health actions have been effective in increasing folate status among U.S. women of childbearing age. These findings are consistent with reports of improved folate status in selected subsets of the U.S. population (*5,6*).

One of the national health objectives for 2010 is to increase the proportion of pregnancies begun with an optimum folic acid level by increasing the median RBC folate level to 220 ng/mL among nonpregnant women aged 15–44 years (objective 16-6b) (*7*). On the basis of NHANES 1999, this objective has been met.

Women of childbearing age in the United States who are capable of becoming pregnant should consume 0.4 mg of folic acid per day to reduce their risk for having a pregnancy affected with spina bifida or other NTDs (*1*). The use of vitamin supplements containing folic acid before and during early pregnancy reduces the risk for NTD (*1*). In addition, PHS recommended and FDA subsequently mandated fortification of the food supply to deliver folic acid to the general population. Because up to half of pregnancies are unplanned and NTDs occur early in pregnancy, before many women are aware that they are pregnant, food fortification is a particularly important approach to folic acid delivery.

The increase in blood folate levels among women of childbearing age participating in NHANES 1999 is probably the result of the fortification of enriched cereal grain products, although some of the increase may be attributable to educational efforts and an increase in women using vitamin supplements containing folic acid. Preliminary analyses indicate that the prevalence of supplement use was similar in the two surveys. Other studies have documented relatively small increases in the proportion of childbearing-aged women who regularly consume supplements containing folic acid (*8,9*). In addition, blood folate concentrations in women who did not use vitamin supplements also were higher in NHANES 1999 than in NHANES III.

Because the sample size in NHANES 1999 is smaller than that of the multiyear NHANES III, more data will be necessary to confirm these findings and to allow more detailed analyses of trends in biochemical folate status in all population subgroups, particularly in young women of different race/ethnicity and socioeconomic status.

If all women of childbearing age followed the PHS recommendation of daily folic acid consumption, the number of pregnancies affected by NTD would be reduced by half (*1*). Despite the substantial increase in blood folate concentrations documented for U.S.

TABLE 1. Mean and selected percentiles of serum and red blood cell (RBC) folate concentrations (in ng/mL) for U.S. women aged 15–44 years — National Health and Nutrition Examination Surveys, United States, 1988–1994 and 1999

Folate	Sample size	Mean		10th		25th		50th		75th		90th	
		No.	(95% CI*)	No.	(95% CI)	No.	(95% CI)	No.	(95%CI)	No.	(95% CI)	No.	(95% CI)
Serum													
1988–1994	5261	6.3	(6.1– 6.5)	2.3	(2.2–2.3)	3.1	(3.1– 3.3)	4.8	(4.6– 5.0)	7.8	(7.4– 8.1)	11.7	(11.0–12.5)
1999	658	16.2	(14.2–18.2)	6.7	(6.3–7.5)	9.6	(8.1–11.3)	14.5	(11.9–17.0)	19.5	(17.8–24.6)	28.6	(24.6–34.4)
RBC													
1988–1994	5254	181	(177–185)	92	(90– 94)	120	(116–122)	160	(156–164)	223	(216–231)	296	(286–309)
1999	663	315	(289–341)	174	(161–185)	216	(201–232)	293	(240–338)	381	(341–419)	474	(434–540)

*Confidence interval.

Folic Acid — Continued

women of childbearing age, full evaluation of the health impact of folic acid fortification on NTD occurrence will require additional information. Data on NTD occurrence derived from the birth certificates of babies born in 1999 (conceived in 1998, after fortification became mandatory) are scheduled to be released in 2000. These national data, along with other NTD data collected by CDC and additional analyses of data from the continuous and ongoing NHANES, will provide data to evaluate fully the impact of folic acid fortification in the United States.

References

1. CDC. Recommendations for the use of folic acid to reduce the number of cases of spina bifida and other neural tube defects. MMWR 1992;41(no. RR-14).
2. CDC. Preventing neural tube defects: A prevention model and resource guide. Atlanta, Georgia: US Department of Health and Human Services, CDC, 1998.
3. Food and Drug Administration. Food standards: amendment of standards of identity for enriched grain products to require addition of folic acid. Federal Register 1996;61:8781–97.
4. Wright JD, Bialstosky K, Gunter EW, et al. Blood folate and vitamin B12: United States, 1988–1994. US Department of Health and Human Services, CDC, National Center for Health Statistics. Vital Health Stat 11(243). March 1999.
5. Jacques PF, Selhub J, Bostom AG, Wilson PW, Rosenberg IH. The effect of folic acid fortification on plasma folate and total homocysteine concentrations. N Engl J Med 1999;340:1449–54.
6. Lawrence JM, Petitti DB, Watkins M, Umekubo MA. Trends in serum folate after food fortification. Lancet 1999;354:915–6.
7. US Department of Health and Human Services. Healthy people 2010 (conference ed, 2 vols). Washington, DC: US Department of Health and Human Services, 2000.
8. CDC. Knowledge and use of folic acid by women of childbearing age—United States, 1995 and 1998. MMWR 1999;48:325–7.
9. CDC. Folic acid campaign and evaluation—Southwestern Virginia, 1997–1999. MMWR 1999;40:914–7.

Notice to Readers

National Epilepsy Month — November 2000

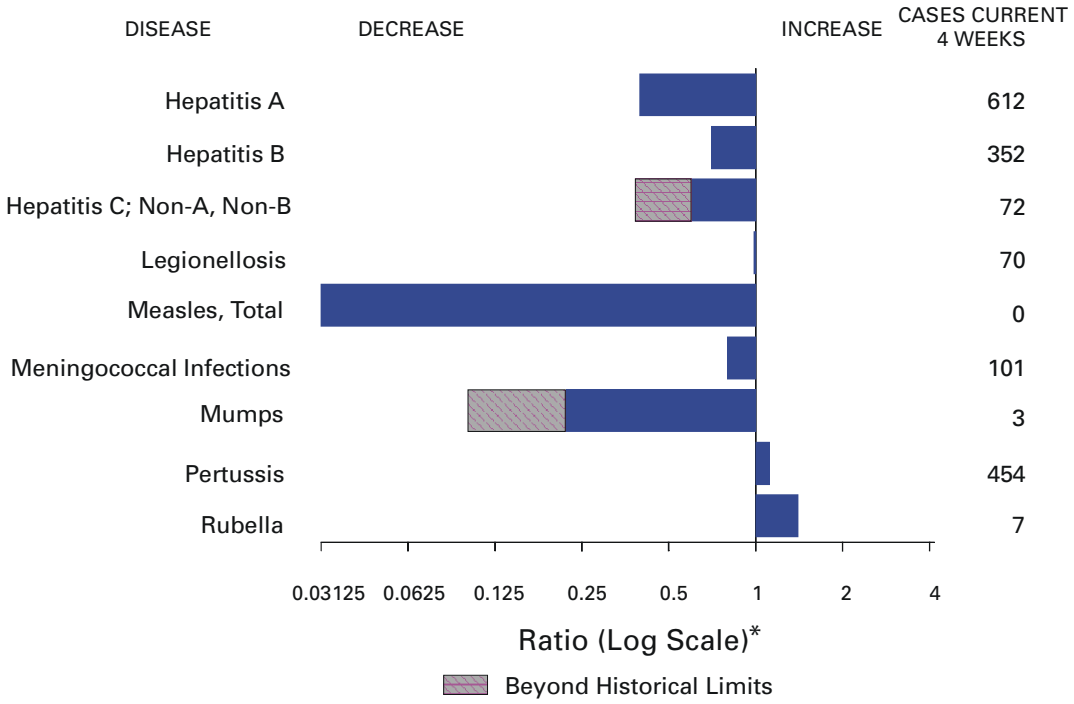
November is National Epilepsy Month. Epilepsy, a central nervous system disorder characterized by unprovoked recurrent seizures, affects approximately 2.3 million persons in the United States. Of these, approximately 316,000 are children aged <15 years. It is common for a child to daydream or, when first awakened from sleep, to appear sleepy and irritable. It also is common for a toddler to fall suddenly when learning to walk. When these behaviors occur often or in patterns, however, they actually may be signs that a child is having a seizure. To address this concern, the Epilepsy Foundation and its affiliates have launched the "Kids & Seizures: Know the Hidden Signs" campaign as the focus of this year's National Epilepsy Month activities. The activities will be directed at parents, daycare workers, and other care givers to help them recognize the common and little-known signs of epilepsy.

Additional information about epilepsy or the "Kids & Seizures: Know the Hidden Signs" campaign is available from the National Epilepsy Foundation, telephone (800) EFA-1000, or the World-Wide Web, http://www.epilepsyfoundation.org.

Erratum: Vol 49, No. 41

In the article, "Hospital-Based Policies for Prevention of Perinatal Group B Streptococcal Disease United States, 1999," on page 938 in Table 2, the denominator in 1997 for "Hepatitis B" should be *170* hospitals and the denominator for "Standing Orders for GBS prophylaxis" should be *176* hospitals.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending October 21, 2000, 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.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending October 21, 2000 (42nd Week)

	Cum. 2000		Cum. 2000
Anthrax	-	Poliomyelitis, paralytic	0
Brucellosis*	55	Psittacosis*	10
Cholera	2	Q fever*	17
Cyclosporiasis*	37	Rabies, human	1
Diphtheria	1	Rocky Mountain spotted fever (RMSF)	382
Ehrlichiosis: human granulocytic (HGE)*	146	Rubella, congenital syndrome	6
human monocytic (HME)*	83	Streptococcal disease, invasive, group A	2,318
Encephalitis: California serogroup viral*	92	Streptococcal toxic-shock syndrome*	64
eastern equine*	1	Syphilis, congenital¶	173
St. Louis*	2	Tetanus	20
western equine*	-	Toxic-shock syndrome	125
Hansen disease (leprosy)*	55	Trichinosis	16
Hantavirus pulmonary syndrome*†	22	Tularemia*	106
Hemolytic uremic syndrome, postdiarrheal*	155	Typhoid fever	271
HIV infection, pediatric*§	170	Yellow fever	-
Plague	6		

-: 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 from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update September 24, 2000.
¶ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending October 21, 2000, and October 23, 1999 (42nd Week)

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7*			
							NETSS		PHLIS	
	Cum. 2000§	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	30,346	35,529	517,486	529,425	2,039	2,196	3,775	3,056	2,579	2,348
NEW ENGLAND	1,599	1,797	16,732	17,018	94	161	340	367	332	336
Maine	27	55	1,163	818	18	24	25	34	26	-
N.H.	28	40	851	789	21	17	32	30	28	29
Vt.	22	15	428	387	26	34	31	32	33	20
Mass.	1,006	1,210	7,040	7,268	26	61	147	161	151	173
R.I.	78	78	2,048	1,857	3	4	18	26	16	26
Conn.	438	399	5,202	5,899	-	21	87	84	78	88
MID. ATLANTIC	6,780	9,051	45,544	53,662	145	462	344	270	201	111
Upstate N.Y.	692	958	N	N	99	129	249	206	43	-
N.Y. City	3,619	4,835	20,533	22,194	9	211	10	17	9	17
N.J.	1,336	1,666	6,762	9,963	9	36	85	47	89	56
Pa.	1,133	1,592	18,249	21,505	28	86	N	N	60	38
E.N. CENTRAL	2,871	2,397	83,566	88,649	658	562	831	863	474	455
Ohio	427	413	21,841	24,049	221	54	229	196	169	181
Ind.	286	257	10,041	9,793	56	34	118	76	71	59
Ill.	1,569	1,106	22,738	26,166	7	81	167	482	-	81
Mich.	437	502	19,948	17,773	86	43	124	109	97	75
Wis.	152	119	8,998	10,868	288	350	193	N	137	59
W.N. CENTRAL	681	815	28,869	30,258	263	177	621	462	438	497
Minn.	130	138	5,693	6,096	58	66	178	152	160	169
Iowa	70	68	3,805	3,595	71	51	173	99	76	72
Mo.	316	407	9,384	10,826	29	21	121	36	83	57
N. Dak.	2	6	577	743	9	16	15	16	18	16
S. Dak.	7	13	1,459	1,276	15	7	53	42	55	59
Nebr.	53	57	3,036	2,796	72	14	57	89	32	111
Kans.	103	126	4,915	4,926	9	2	24	28	14	13
S. ATLANTIC	8,394	9,895	103,576	112,292	396	323	317	275	221	168
Del.	156	129	2,328	2,207	5	-	1	6	1	3
Md.	1,060	1,215	10,960	10,502	10	15	27	33	1	4
D.C.	570	409	2,603	N	15	7	1	-	U	U
Va.	574	676	12,375	11,733	16	21	61	65	55	54
W. Va.	47	53	1,379	1,453	3	3	14	11	11	8
N.C.	529	690	18,185	18,284	21	20	77	61	64	50
S.C.	660	842	8,376	15,044	-	-	21	18	14	14
Ga.	983	1,377	20,872	27,359	147	121	37	27	26	1
Fla.	3,815	4,504	26,498	25,710	179	136	78	54	49	34
E.S. CENTRAL	1,533	1,612	39,276	37,437	42	29	114	123	88	92
Ky.	160	240	6,394	6,083	5	6	40	42	31	29
Tenn.	657	612	11,908	11,701	11	10	49	52	42	39
Ala.	397	398	12,284	10,334	15	10	8	21	7	20
Miss.	319	362	8,690	9,319	11	3	17	8	8	4
W.S. CENTRAL	3,049	3,763	81,282	74,479	84	76	167	108	205	134
Ark.	150	155	4,809	4,909	10	1	55	13	30	12
La.	510	720	14,928	13,434	10	23	9	13	44	13
Okla.	257	102	7,092	6,472	16	8	17	23	14	25
Tex.	2,132	2,786	54,453	49,664	48	44	86	59	117	84
MOUNTAIN	1,131	1,399	29,503	27,160	146	86	382	254	219	208
Mont.	12	11	1,094	1,262	10	10	30	22	-	-
Idaho	19	19	1,467	1,397	19	7	61	39	-	28
Wyo.	7	10	646	629	5	1	15	14	9	15
Colo.	258	271	8,340	5,439	62	11	147	95	97	83
N. Mex.	116	74	3,685	4,049	15	37	20	11	15	5
Ariz.	367	694	9,527	10,010	11	12	45	27	34	19
Utah	112	116	1,626	1,752	20	N	51	30	64	43
Nev.	240	204	3,118	2,622	4	8	13	16	-	15
PACIFIC	4,308	4,800	89,138	88,470	211	320	659	334	401	347
Wash.	394	281	10,066	9,526	N	N	197	133	173	161
Oreg.	113	152	3,754	4,966	16	87	144	64	109	68
Calif.	3,693	4,276	71,012	69,846	195	233	279	124	108	107
Alaska	15	13	1,951	1,541	-	-	25	1	1	1
Hawaii	93	78	2,355	2,591	-	-	14	12	10	10
Guam	15	11	-	393	-	-	N	N	U	U
P.R.	1,028	1,013	3,188	U	-	-	6	5	U	U
V.I.	27	25	U	U	U	U	U	U	U	U
Amer. Samoa	-	-	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	U	U	U	U	U	U	U	U

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

* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

† Chlamydia refers to genital infections caused by *C. trachomatis*. Totals reported to the Division of STD Prevention, NCHSTP.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update September 24, 2000.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending October 21, 2000, and October 23, 1999 (42nd Week)

Reporting Area	Gonorrhea		Hepatitis C; Non-A, Non-B		Legionellosis		Listeriosis	Lyme Disease	
	Cum. 2000[§]	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 2000	Cum. 1999
UNITED STATES	271,456	290,466	2,546	2,308	772	811	570	10,997	12,868
NEW ENGLAND	4,667	5,382	14	14	47	67	43	3,646	3,797
Maine	72	67	2	2	2	3	2	-	41
N.H.	86	91	-	-	2	8	2	59	18
Vt.	54	37	4	6	5	13	3	22	18
Mass.	1,911	2,021	3	3	13	25	22	922	701
R.I.	509	478	5	3	8	7	1	417	408
Conn.	2,035	2,688	-	-	17	11	13	2,226	2,611
MID. ATLANTIC	27,727	32,335	543	107	158	199	134	5,677	6,865
Upstate N.Y.	5,548	5,560	58	50	65	50	72	3,106	3,211
N.Y. City	8,859	10,164	-	-	-	40	25	17	131
N.J.	4,795	6,283	450	-	12	15	19	1,368	1,519
Pa.	8,525	10,328	35	57	81	94	18	1,186	2,004
E.N. CENTRAL	51,216	55,895	181	803	200	225	94	300	557
Ohio	13,155	14,737	10	3	94	64	48	76	41
Ind.	4,749	5,213	1	1	33	34	7	32	17
Ill.	15,340	18,529	13	43	9	29	11	11	17
Mich.	14,309	12,625	157	740	41	58	25	-	11
Wis.	3,663	4,791	-	16	23	40	3	181	471
W.N. CENTRAL	12,897	13,188	491	211	58	47	13	276	274
Minn.	2,247	2,303	5	7	7	9	5	187	168
Iowa	879	951	1	-	13	12	3	25	21
Mo.	6,074	6,396	470	201	28	16	4	43	60
N. Dak.	35	71	-	-	-	1	1	1	1
S. Dak.	253	151	-	-	2	3	-	-	-
Nebr.	1,181	1,210	6	3	4	6	-	4	11
Kans.	2,228	2,106	9	-	4	-	-	16	13
S. ATLANTIC	76,901	85,030	107	143	159	111	94	866	1,104
Del.	1,392	1,372	-	-	8	14	1	140	105
Md.	7,589	7,876	18	19	52	26	21	478	780
D.C.	2,129	3,013	3	1	4	3	-	5	4
Va.	8,156	7,717	3	10	31	28	7	130	109
W. Va.	451	469	14	17	N	N	3	26	16
N.C.	14,849	16,265	14	32	13	13	-	42	63
S.C.	10,575	11,533	2	22	4	7	9	7	4
Ga.	13,452	18,498	3	1	6	1	21	-	-
Fla.	18,308	18,287	50	41	41	19	32	38	23
E.S. CENTRAL	28,551	29,896	350	239	29	44	17	44	89
Ky.	2,839	2,759	31	17	17	17	3	10	16
Tenn.	9,501	9,392	80	89	10	21	10	28	50
Ala.	9,560	9,197	7	1	2	4	4	6	19
Miss.	6,651	8,548	232	132	-	2	-	-	4
W.S. CENTRAL	43,013	42,857	405	449	15	10	14	36	46
Ark.	2,600	2,649	9	25	-	1	1	4	4
La.	11,052	10,818	290	267	6	5	-	3	8
Okla.	3,146	3,185	8	15	2	3	6	-	7
Tex.	26,215	26,205	98	142	7	1	7	29	27
MOUNTAIN	8,030	7,855	281	157	35	40	28	27	13
Mont.	38	43	4	5	1	-	-	-	-
Idaho	69	69	3	7	5	2	-	3	3
Wyo.	41	25	210	41	2	-	1	9	3
Colo.	2,474	2,022	21	29	12	11	5	10	2
N. Mex.	820	802	13	28	1	1	2	-	1
Ariz.	3,193	3,632	17	33	7	6	12	-	-
Utah	166	174	1	6	7	14	4	2	2
Nev.	1,229	1,088	12	8	-	6	4	3	2
PACIFIC	18,454	18,028	174	185	71	68	133	125	123
Wash.	1,797	1,624	28	17	16	15	5	7	7
Oreg.	525	724	27	14	N	N	5	11	12
Calif.	15,549	15,064	117	154	55	52	120	105	104
Alaska	278	249	-	-	-	1	-	2	-
Hawaii	305	367	2	-	-	-	3	N	N
Guam	-	43	-	1	-	-	-	-	-
P.R.	547	272	1	-	1	-	-	N	N
V.I.	U	U	U	U	U	U	-	U	U
Amer. Samoa	U	U	U	U	U	U	-	U	U
C.N.M.I.	U	U	U	U	U	U	-	U	U

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

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending October 21, 2000, and October 23, 1999 (42nd Week)

Reporting Area	Malaria		Rabies, Animal		Salmonellosis*			
					NETSS		PHLIS	
	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	984	1,191	4,879	5,499	29,335	31,402	24,606	27,834
NEW ENGLAND	55	54	680	734	1,858	1,864	1,835	1,879
Maine	6	3	110	142	108	119	83	95
N.H.	1	2	19	44	119	118	119	112
Vt.	2	4	52	86	99	82	108	71
Mass.	21	19	220	177	1,046	995	1,022	1,012
R.I.	8	4	54	78	117	109	128	140
Conn.	17	22	225	207	369	441	375	449
MID. ATLANTIC	195	343	899	1,058	3,294	4,228	3,357	4,398
Upstate N.Y.	64	57	623	754	990	1,073	1,046	1,141
N.Y. City	72	198	U	U	750	1,238	723	1,270
N.J.	33	48	162	158	725	859	444	954
Pa.	26	40	114	146	829	1,058	1,144	1,033
E.N. CENTRAL	102	141	138	152	4,172	4,596	2,619	4,014
Ohio	17	18	48	32	1,194	1,098	1,022	919
Ind.	4	19	-	12	527	444	473	407
Ill.	46	63	21	10	1,176	1,393	1	1,349
Mich.	25	34	61	79	745	847	788	837
Wis.	10	7	8	19	530	814	335	502
W.N. CENTRAL	41	64	464	632	2,068	1,912	1,997	2,082
Minn.	13	33	74	90	473	503	560	619
Iowa	3	13	70	133	314	210	185	199
Mo.	9	13	48	28	642	613	754	755
N. Dak.	2	-	106	127	48	40	67	54
S. Dak.	1	-	80	158	84	83	93	107
Nebr.	7	1	2	4	191	167	83	143
Kans.	6	4	84	92	316	296	255	205
S. ATLANTIC	267	294	1,977	1,784	6,602	6,966	4,341	5,518
Del.	4	1	42	50	96	135	116	132
Md.	84	86	338	337	689	722	643	769
D.C.	15	17	-	-	52	68	U	U
Va.	47	62	473	466	828	1,102	746	906
W. Va.	3	2	101	95	141	145	125	136
N.C.	31	26	475	377	910	1,070	916	1,151
S.C.	2	14	142	129	628	537	457	426
Ga.	19	21	272	178	1,193	1,129	1,168	1,421
Fla.	62	65	134	152	2,065	2,058	170	577
E.S. CENTRAL	42	23	172	222	1,798	1,787	1,292	1,231
Ky.	17	7	19	33	322	334	216	228
Tenn.	11	8	88	79	512	483	583	508
Ala.	13	7	65	109	547	502	423	414
Miss.	1	1	-	1	417	468	70	81
W.S. CENTRAL	18	15	70	399	2,600	3,051	3,478	2,314
Ark.	3	3	20	14	607	551	508	191
La.	7	10	-	-	248	635	551	488
Okla.	8	2	50	82	334	379	233	298
Tex.	-	-	-	303	1,411	1,486	2,186	1,337
MOUNTAIN	42	39	221	189	2,384	2,502	1,817	2,221
Mont.	1	4	60	52	79	50	-	1
Idaho	3	3	9	-	103	90	-	90
Wyo.	-	1	47	41	53	56	37	53
Colo.	21	16	-	1	627	628	589	622
N. Mex.	-	2	19	9	199	332	167	257
Ariz.	7	6	68	71	655	739	608	687
Utah	5	4	10	7	434	438	416	462
Nev.	5	3	8	8	234	169	-	49
PACIFIC	222	218	258	329	4,559	4,496	3,870	4,177
Wash.	24	22	-	-	481	531	547	719
Oreg.	36	19	7	3	265	373	318	408
Calif.	157	165	230	319	3,560	3,252	2,783	2,779
Alaska	-	1	21	7	55	51	23	31
Hawaii	5	11	-	-	198	289	199	240
Guam	-	-	-	-	-	34	U	U
P.R.	4	-	67	67	466	480	U	U
V.I.	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending October 21, 2000, and October 23, 1999 (42nd Week)

Reporting Area	Shigellosis* NETSS Cum. 2000	Shigellosis* NETSS Cum. 1999	Shigellosis* PHLIS Cum. 2000	Shigellosis* PHLIS Cum. 1999	Syphilis (Primary & Secondary) Cum. 2000	Syphilis (Primary & Secondary) Cum. 1999	Tuberculosis Cum. 2000	Tuberculosis Cum. 1999
UNITED STATES	16,225	13,191	8,498	8,015	4,837	5,460	9,877	12,517
NEW ENGLAND	330	717	320	689	61	50	329	345
Maine	10	5	12	-	1	-	12	16
N.H.	6	16	8	14	1	1	15	10
Vt.	4	6	-	4	-	3	4	2
Mass.	230	614	218	596	40	28	193	193
R.I.	24	22	28	18	4	2	27	35
Conn.	56	54	54	57	15	16	78	89
MID. ATLANTIC	1,697	873	1,032	614	217	240	1,828	2,103
Upstate N.Y.	624	238	180	63	12	17	235	259
N.Y. City	627	293	426	205	101	102	998	1,082
N.J.	270	204	235	191	41	57	432	433
Pa.	176	138	191	155	63	64	163	329
E.N. CENTRAL	3,261	2,496	925	1,333	938	997	1,029	1,341
Ohio	314	363	215	121	66	72	205	212
Ind.	1,340	252	133	92	300	354	80	111
Ill.	828	1,014	2	768	279	349	516	668
Mich.	583	365	527	292	255	185	160	265
Wis.	196	502	48	60	38	37	68	85
W.N. CENTRAL	1,971	993	1,536	667	52	111	379	419
Minn.	612	197	706	213	12	9	124	156
Iowa	445	46	217	42	10	9	32	37
Mo.	605	614	414	310	23	77	151	155
N. Dak.	16	3	49	2	-	-	2	6
S. Dak.	7	13	4	6	-	-	14	17
Nebr.	107	72	49	58	2	6	19	15
Kans.	179	48	97	36	5	10	37	33
S. ATLANTIC	2,472	1,966	894	453	1,606	1,765	2,003	2,495
Del.	19	13	20	8	8	8	-	25
Md.	172	136	96	47	236	313	199	218
D.C.	67	46	U	U	43	43	24	38
Va.	375	113	304	54	107	131	216	221
W. Va.	4	8	3	5	2	4	24	37
N.C.	298	168	242	77	405	412	233	369
S.C.	111	104	78	55	171	220	104	207
Ga.	209	193	80	74	309	353	456	487
Fla.	1,217	1,185	71	133	325	281	747	893
E.S. CENTRAL	873	1,029	414	607	729	949	747	843
Ky.	361	215	70	138	67	85	99	149
Tenn.	306	596	305	401	438	531	280	287
Ala.	62	100	36	58	101	185	247	251
Miss.	144	118	3	10	123	148	121	156
W.S. CENTRAL	1,819	2,161	2,343	956	675	860	867	1,611
Ark.	174	72	44	24	79	57	148	135
La.	134	174	141	105	184	252	74	148
Okla.	99	465	35	149	107	157	111	149
Tex.	1,412	1,450	2,123	678	305	394	534	1,179
MOUNTAIN	1,003	866	571	618	193	196	397	426
Mont.	7	7	-	-	-	1	14	10
Idaho	43	23	-	10	1	1	10	12
Wyo.	5	3	2	1	1	-	2	3
Colo.	216	158	156	123	10	2	57	58
N. Mex.	124	111	67	83	20	11	36	49
Ariz.	425	427	273	337	155	175	166	180
Utah	71	54	73	58	1	2	41	34
Nev.	112	83	-	6	5	4	71	80
PACIFIC	2,799	2,090	463	2,078	366	292	2,298	2,934
Wash.	397	95	339	93	53	57	187	207
Oreg.	154	75	94	68	5	6	25	89
Calif.	2,206	1,892	-	1,888	307	225	1,901	2,449
Alaska	8	2	3	3	-	1	82	45
Hawaii	34	26	27	26	1	3	103	144
Guam	-	15	U	U	-	-	-	56
P.R.	23	125	U	U	122	131	238	161
V.I.	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.
*Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending October 21, 2000, and October 23, 1999 (42nd Week)

Reporting Area	*H. influenzae*, Invasive		Hepatitis (Viral), By Type				Measles (Rubeola)					
			A		B		Indigenous		Imported*		Total	
	Cum. 2000†	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	2000	Cum. 2000	2000	Cum. 2000	Cum. 2000	Cum. 1999
UNITED STATES	925	969	9,768	13,242	5,457	5,580	-	54	-	18	72	83
NEW ENGLAND	82	76	291	273	84	124	-	2	-	4	6	11
Maine	1	5	17	11	5	1	-	-	-	-	-	-
N.H.	12	15	18	14	15	13	-	2	-	1	3	1
Vt.	6	5	8	18	6	3	-	-	-	3	3	-
Mass.	36	29	107	102	12	41	-	-	-	-	-	8
R.I.	4	5	22	16	18	28	-	-	-	-	-	-
Conn.	23	17	119	112	28	38	-	-	-	-	-	2
MID. ATLANTIC	146	167	937	997	719	714	-	14	-	5	19	5
Upstate N.Y.	79	67	189	220	114	153	-	9	-	-	9	2
N.Y. City	30	53	277	334	357	217	-	5	-	4	9	3
N.J.	28	42	154	128	57	110	-	-	-	-	-	-
Pa.	9	5	317	315	191	234	-	-	-	1	1	-
E.N. CENTRAL	118	159	1,137	2,480	576	603	-	8	-	-	8	2
Ohio	45	52	224	554	93	81	-	2	-	-	2	-
Ind.	26	21	90	89	41	35	-	-	-	-	-	1
Ill.	40	65	417	641	106	52	-	4	-	-	4	-
Mich.	7	16	393	1,129	335	407	-	2	-	-	2	1
Wis.	-	5	13	67	1	28	U	-	U	-	-	-
W.N. CENTRAL	59	59	700	649	572	224	-	2	-	1	3	1
Minn.	32	38	173	63	35	40	-	-	-	1	1	1
Iowa	1	2	65	116	28	36	-	2	-	-	2	-
Mo.	17	6	335	391	450	123	-	-	-	-	-	-
N. Dak.	1	1	3	2	2	-	-	-	-	-	-	-
S. Dak.	1	2	1	9	1	1	-	-	-	-	-	-
Nebr.	3	4	30	43	34	17	-	-	-	-	-	-
Kans.	4	6	93	25	22	7	-	-	-	-	-	-
S. ATLANTIC	250	205	1,223	1,533	1,032	915	-	3	-	-	3	15
Del.	-	-	-	2	-	1	-	-	-	-	-	-
Md.	68	53	189	257	100	126	-	-	-	-	-	-
D.C.	-	4	23	54	27	22	-	-	-	-	-	-
Va.	35	16	129	142	137	75	-	2	-	-	2	13
W. Va.	9	7	52	33	11	22	-	-	-	-	-	-
N.C.	20	29	121	134	205	194	-	-	-	-	-	-
S.C.	15	5	69	40	13	61	-	-	-	-	-	-
Ga.	57	55	224	407	162	136	-	-	-	-	-	-
Fla.	46	36	416	464	377	278	-	1	-	-	1	2
E.S. CENTRAL	39	53	324	331	365	395	-	-	-	-	-	2
Ky.	12	6	41	63	60	39	-	-	-	-	-	2
Tenn.	18	29	119	128	177	190	-	-	-	-	-	-
Ala.	8	15	52	48	47	78	-	-	-	-	-	-
Miss.	1	3	112	92	81	88	-	-	-	-	-	-
W.S. CENTRAL	56	54	1,551	2,574	626	961	-	-	-	-	-	11
Ark.	2	2	104	46	72	64	-	-	-	-	-	4
La.	11	12	55	191	87	156	-	-	-	-	-	-
Okla.	41	36	227	426	133	121	-	-	-	-	-	-
Tex.	2	4	1,165	1,911	334	620	-	-	-	-	-	7
MOUNTAIN	88	92	801	1,046	435	481	-	11	-	1	12	1
Mont.	1	2	7	17	7	17	-	-	-	-	-	-
Idaho	4	1	22	36	7	25	-	-	-	-	-	-
Wyo.	1	1	39	8	25	12	-	-	-	-	-	-
Colo.	14	13	173	193	81	83	-	1	-	1	2	-
N. Mex.	19	18	62	43	91	150	-	-	-	-	-	-
Ariz.	37	48	396	579	164	119	-	-	-	-	-	1
Utah	10	6	46	45	19	28	-	3	-	-	3	-
Nev.	2	3	56	125	41	47	-	7	-	-	7	-
PACIFIC	87	104	2,804	3,359	1,048	1,163	-	14	-	7	21	35
Wash.	5	5	241	279	91	58	-	2	-	1	3	5
Oreg.	25	35	146	213	90	92	-	-	-	-	-	12
Calif.	28	50	2,395	2,837	849	985	-	11	-	3	14	17
Alaska	6	6	9	10	8	15	-	1	-	-	1	-
Hawaii	23	8	13	20	10	13	-	-	-	3	3	1
Guam	-	-	-	1	-	2	U	-	U	-	-	1
P.R.	4	2	197	261	213	193	-	-	-	-	-	-
V.I.	U	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. - : No reported cases.
*For imported measles, cases include only those resulting from importation from other countries.
†Of 188 cases among children aged <5 years, serotype was reported for 79 and of those, 20 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending October 21, 2000, and October 23, 1999 (42nd Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999
UNITED STATES	1,702	1,978	-	274	299	78	5,101	5,097	4	127	239
NEW ENGLAND	112	94	-	4	8	18	1,206	612	-	12	7
Maine	8	5	-	-	-	6	41	-	-	-	-
N.H.	11	12	-	-	1	5	102	81	-	2	-
Vt.	3	4	-	-	1	5	199	57	-	-	-
Mass.	64	54	-	1	4	2	808	425	-	8	7
R.I.	9	4	-	1	2	-	16	33	-	1	-
Conn.	17	15	-	2	-	-	40	16	-	1	-
MID. ATLANTIC	158	188	-	20	37	1	505	786	-	9	31
Upstate N.Y.	54	57	-	9	8	1	252	602	-	2	18
N.Y. City	32	51	-	4	11	-	44	48	-	7	6
N.J.	33	41	-	3	1	-	35	22	-	-	4
Pa.	39	39	-	4	17	-	174	114	-	-	3
E.N. CENTRAL	288	354	-	28	39	4	536	452	-	1	2
Ohio	77	119	-	7	14	-	265	177	-	-	-
Ind.	41	53	-	1	4	1	86	58	-	-	1
Ill.	64	95	-	6	9	2	64	75	-	1	1
Mich.	86	54	-	14	8	1	66	48	-	-	-
Wis.	20	33	U	-	4	U	55	94	U	-	-
W.N. CENTRAL	155	196	-	19	11	16	464	367	-	2	127
Minn.	18	45	-	-	1	15	285	187	-	-	5
Iowa	28	34	-	7	6	-	46	53	-	-	30
Mo.	88	73	-	5	1	-	64	60	-	1	2
N. Dak.	2	3	-	-	-	-	6	4	-	-	-
S. Dak.	5	11	-	-	-	-	4	5	-	-	-
Nebr.	7	10	-	4	-	-	25	6	-	1	90
Kans.	7	20	-	3	3	1	34	52	-	-	-
S. ATLANTIC	271	333	-	41	43	6	397	349	4	74	35
Del.	1	10	-	-	-	-	8	5	-	1	-
Md.	25	48	-	10	4	6	97	108	-	-	1
D.C.	-	3	-	-	2	-	3	-	-	-	-
Va.	37	45	-	9	10	-	90	19	-	-	-
W. Va.	12	6	-	-	-	-	1	3	-	-	-
N.C.	34	38	-	5	8	-	77	88	-	64	34
S.C.	20	42	-	10	4	-	27	15	4	7	-
Ga.	42	54	-	2	4	-	35	35	-	-	-
Fla.	100	87	-	5	11	-	59	76	-	2	-
E.S. CENTRAL	113	137	-	7	11	-	96	82	-	5	2
Ky.	24	27	-	1	-	-	49	25	-	1	-
Tenn.	47	56	-	2	-	-	28	34	-	1	-
Ala.	32	33	-	2	8	-	18	20	-	3	2
Miss.	10	21	-	2	3	-	1	3	-	-	-
W.S. CENTRAL	114	189	-	24	38	-	285	185	-	5	14
Ark.	12	31	-	2	-	-	31	23	-	-	5
La.	35	59	-	4	10	-	12	9	-	1	-
Okla.	25	28	-	-	1	-	19	33	-	-	1
Tex.	42	71	-	18	27	-	223	120	-	4	8
MOUNTAIN	121	122	-	19	22	16	661	639	-	2	16
Mont.	4	2	-	1	-	-	35	2	-	-	-
Idaho	7	9	-	-	1	-	58	138	-	-	-
Wyo.	-	4	-	2	-	-	6	2	-	-	-
Colo.	30	32	-	1	6	15	383	242	-	1	1
N. Mex.	8	14	-	1	N	-	79	99	-	-	-
Ariz.	62	40	-	4	7	-	70	95	-	1	13
Utah	7	14	-	4	3	1	18	55	-	-	1
Nev.	3	7	-	6	5	-	12	6	-	-	1
PACIFIC	370	365	-	112	90	17	951	1,625	-	17	5
Wash.	49	59	-	10	2	15	341	617	-	7	-
Oreg.	59	65	N	N	N	2	105	46	-	-	-
Calif.	246	229	-	81	73	-	456	924	-	10	5
Alaska	8	6	-	7	2	-	20	4	-	-	-
Hawaii	8	6	-	14	13	-	29	34	-	-	-
Guam	-	1	U	-	3	U	-	2	U	-	-
P.R.	9	10	-	-	-	-	5	21	-	-	-
V.I.	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U	U	U	U

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

TABLE IV. Deaths in 122 U.S. cities,* week ending October 21, 2000 (42nd Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	640	458	114	44	13	11	50
Boston, Mass.	166	105	34	16	6	5	8
Bridgeport, Conn.	51	35	8	5	2	1	5
Cambridge, Mass.	12	11	-	1	-	-	1
Fall River, Mass.	23	20	2	1	-	-	3
Hartford, Conn.	58	37	15	5	1	-	5
Lowell, Mass.	31	23	4	3	1	-	2
Lynn, Mass.	12	11	1	-	-	-	1
New Bedford, Mass.	25	19	3	3	-	-	2
New Haven, Conn.	42	29	9	1	1	2	1
Providence, R.I.	55	44	9	1	-	1	7
Somerville, Mass.	3	2	1	-	-	-	-
Springfield, Mass.	60	46	13	-	1	-	4
Waterbury, Conn.	39	25	6	6	1	1	4
Worcester, Mass.	63	51	9	2	-	1	7
MID. ATLANTIC	2,256	1,565	460	153	32	45	110
Albany, N.Y.	54	43	5	5	-	1	6
Allentown, Pa.	23	14	7	-	2	-	-
Buffalo, N.Y.	75	59	11	1	3	1	7
Camden, N.J.	38	24	10	4	-	-	-
Elizabeth, N.J.	16	11	3	2	-	-	-
Erie, Pa.§	43	36	7	-	-	-	1
Jersey City, N.J.	48	35	10	2	-	1	-
New York City, N.Y.	1,227	850	253	90	14	19	51
Newark, N.J.	46	15	19	9	-	3	1
Paterson, N.J.	26	20	3	3	-	-	-
Philadelphia, Pa.	252	149	62	24	5	12	11
Pittsburgh, Pa.§	71	47	17	4	1	2	3
Reading, Pa.	35	30	3	1	1	-	2
Rochester, N.Y.	139	108	19	5	5	2	14
Schenectady, N.Y.	30	23	7	-	-	-	-
Scranton, Pa.§	31	22	8	-	-	1	4
Syracuse, N.Y.	68	53	10	2	1	2	8
Trenton, N.J.	18	12	4	1	-	1	1
Utica, N.Y.	16	14	2	-	-	-	1
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,985	1,335	398	131	49	58	150
Akron, Ohio	41	23	3	1	-	3	3
Canton, Ohio	39	34	5	-	-	-	5
Chicago, Ill.	339	204	75	38	9	10	34
Cincinnati, Ohio	97	63	20	5	6	3	9
Cleveland, Ohio	130	86	22	11	5	6	2
Columbus, Ohio	175	120	44	7	3	1	9
Dayton, Ohio	135	90	32	8	2	3	12
Detroit, Mich.	177	92	56	16	6	7	13
Evansville, Ind.	33	26	6	1	-	-	3
Fort Wayne, Ind.	62	43	12	5	1	1	5
Gary, Ind.	20	10	5	3	2	-	1
Grand Rapids, Mich.	60	45	9	2	-	4	5
Indianapolis, Ind.	201	153	28	6	7	7	10
Lansing, Mich.	39	27	11	-	1	-	2
Milwaukee, Wis.	139	96	29	8	2	4	16
Peoria, Ill.	58	39	12	2	3	2	3
Rockford, Ill.	54	47	3	4	-	-	7
South Bend, Ind.	43	38	2	3	-	-	6
Toledo, Ohio	94	62	17	8	2	5	4
Youngstown, Ohio	49	37	7	3	-	2	1
W.N. CENTRAL	700	494	122	48	25	11	61
Des Moines, Iowa	39	28	8	1	1	1	6
Duluth, Minn.	14	12	1	1	-	-	-
Kansas City, Kans.	33	15	11	6	1	-	1
Kansas City, Mo.	87	61	13	10	3	-	5
Lincoln, Nebr.	50	41	6	2	1	-	10
Minneapolis, Minn.	160	120	24	9	5	2	17
Omaha, Nebr.	89	68	10	7	3	1	8
St. Louis, Mo.	83	41	24	9	8	1	-
St. Paul, Minn.	76	62	12	-	1	1	8
Wichita, Kans.	69	46	13	3	2	5	6
S. ATLANTIC	1,217	818	225	100	49	25	74
Atlanta, Ga.	168	93	36	24	9	6	4
Baltimore, Md.	165	108	25	18	11	3	15
Charlotte, N.C.	98	63	20	8	3	4	10
Jacksonville, Fla.	166	122	28	10	5	1	12
Miami, Fla.	71	48	15	4	3	1	8
Norfolk, Va.	50	31	10	6	1	2	1
Richmond, Va.	72	47	18	6	-	1	2
Savannah, Ga.	53	38	10	3	2	-	3
St. Petersburg, Fla.	73	57	11	1	3	1	2
Tampa, Fla.	182	129	32	11	7	3	13
Washington, D.C.	100	63	20	9	5	3	4
Wilmington, Del.	19	19	-	-	-	-	-
E.S. CENTRAL	851	567	191	48	27	18	49
Birmingham, Ala.	185	131	35	9	7	3	14
Chattanooga, Tenn.	82	57	16	7	1	1	5
Knoxville, Tenn.	109	78	21	6	4	-	3
Lexington, Ky.	71	40	23	4	-	4	3
Memphis, Tenn.	164	105	44	10	3	2	7
Mobile, Ala.	75	45	15	5	4	6	2
Montgomery, Ala.	42	32	6	1	3	-	7
Nashville, Tenn.	123	79	31	6	5	2	8
W.S. CENTRAL	1,471	910	322	149	72	18	99
Austin, Tex.	88	54	21	6	5	2	3
Baton Rouge, La.	64	42	13	6	3	-	4
Corpus Christi, Tex.	72	51	13	4	2	2	5
Dallas, Tex.	205	125	49	24	5	2	13
El Paso, Tex.	88	61	15	9	1	2	7
Ft. Worth, Tex.	104	66	22	7	6	3	5
Houston, Tex.	370	199	83	59	28	1	40
Little Rock, Ark.	81	49	22	4	2	4	3
New Orleans, La.	49	17	8	12	12	-	-
San Antonio, Tex.	187	131	43	11	1	1	8
Shreveport, La.	58	41	14	1	2	-	5
Tulsa, Okla.	105	74	19	6	5	1	6
MOUNTAIN	1,028	710	189	79	26	23	85
Albuquerque, N.M.	124	94	14	13	2	1	12
Boise, Idaho	35	24	8	-	2	1	1
Colo. Springs, Colo.	60	45	7	4	4	-	4
Denver, Colo.	106	63	25	5	3	10	11
Las Vegas, Nev.	205	142	46	10	4	3	15
Ogden, Utah	30	21	6	3	-	-	6
Phoenix, Ariz.	176	118	33	19	2	4	16
Pueblo, Colo.	26	20	3	3	-	-	2
Salt Lake City, Utah	114	79	14	13	4	3	10
Tucson, Ariz.	152	104	33	9	5	1	8
PACIFIC	1,581	1,116	296	105	33	30	121
Berkeley, Calif.	21	12	7	1	-	1	3
Fresno, Calif.	93	65	20	5	2	1	4
Glendale, Calif.	14	11	1	2	-	-	-
Honolulu, Hawaii	78	55	16	4	-	3	9
Long Beach, Calif.	53	37	11	1	3	1	8
Los Angeles, Calif.	291	201	52	24	7	7	15
Pasadena, Calif.	20	14	3	3	-	-	3
Portland, Oreg.	160	123	24	9	1	3	8
Sacramento, Calif.	221	159	46	8	4	4	23
San Diego, Calif.	148	100	24	11	7	6	12
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	152	101	34	10	5	2	11
Santa Cruz, Calif.	28	17	9	2	-	-	4
Seattle, Wash.	122	83	24	13	2	-	3
Spokane, Wash.	59	41	11	5	-	2	8
Tacoma, Wash.	121	97	14	7	2	-	10
TOTAL	11,729¶	7,973	2,317	857	326	239	799

U: Unavailable. -:No reported cases.

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

†Pneumonia and influenza.

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

¶Total includes unknown ages.

Contributors to the Production of the *MMWR* (Weekly)

Weekly Notifiable Disease Morbidity Data and 122 Cities Mortality Data

Samuel L. Groseclose, D.V.M., M.P.H.

State Support Team
Robert Fagan
Jose Aponte
Gerald Jones
David Nitschke
Scott Noldy
Carol A. Worsham

CDC Operations Team
Carol M. Knowles
Deborah A. Adams
Willie J. Anderson
Patsy A. Hall
Suzette A. Park
Felicia J. Perry
Pearl Sharp

Informatics

T. Demetri Vacalis, Ph.D.

Michele D. Renshaw
Erica R. Shaver

The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format and on a paid subscription basis for paper copy. To receive an electronic copy on Friday of each week, send an e-mail message to *listserv@listserv.cdc.gov*. The body content should read *SUBscribe mmwr-toc*. Electronic copy also is available from CDC's World-Wide Web server at *http://www.cdc.gov/mmwr* or from CDC's file transfer protocol server at *ftp://ftp.cdc.gov/pub/Publications/mmwr*. To subscribe for paper copy, contact Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone (202) 512-1800.

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Address inquiries about the *MMWR* Series, including material to be considered for publication, to: Editor, *MMWR* Series, Mailstop C-08, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone (888) 232-3228.

☆U.S. Government Printing Office: 2001-633-173/48007 Region IV