MMWR™
Morbidity and Mortality Weekly Report
Weekly January 25, 2002 / Vol. 51 / No. 3

Recent Trends in Mortality Rates for Four Major Cancers, by Sex and Race/Ethnicity — United States, 1990–1998

In 1998, 53% of all cancer-related deaths in the United States were associated with four sites: lung/bronchus, colon/rectum, prostate, and female breast (*1*). Cancer-related death does not affect racial/ethnic populations similarly. In 1996, the National Cancer Institute (NCI) published cancer incidence and death rates during 1988–1992 in 10 categories of race/ethnicity (*2*). To examine trends during 1990–1998 in annual death rates for the four major cancers by sex and race/ethnicity (i.e., blacks, whites, Hispanics, American Indians/Alaska Natives [AI/ANs], and Asians/Pacific Islanders [APIs]), CDC analyzed data from the National Center for Health Statistics' National Vital Statistics System (*3*). This report summarizes the results of that analysis, which indicated that, except for lung cancer in women and lung, colorectal, and breast cancer in AI/ANs, trends in death rates from these cancers have generally declined. But the rates remained high for blacks, have not decreased equally among all populations, and have increased in certain instances. Continuing research and prevention efforts are needed to reach high-risk and underserved populations and to understand the reasons for differences in cancer mortality among racial/ethnic populations.

In each state, attending physicians report and file causes of death on death certificates, which then are consolidated into the National Vital Statistics System. For this analysis, the *International Classification of Diseases, Ninth Revision,* (*ICD-9*) codes* for cause of death from these cancers and NCI software were used to compute death rates as the number of deaths per 100,000 population, age-adjusted to the 1970 U.S. population by using 5-year age intervals. Deaths and death rates were presented for 1990–1998 for whites, blacks, Hispanics, AI/ANs, and APIs. To test for significant trends in death rates during 1990–1998, linear regression was used to estimate the annual percentage change for this period.

Data from 1998 indicated that death rates for lung and bronchus cancer were higher for blacks and whites than for other races/ethnicities (Table 1). Death rates for black men were higher than for white men. Among men, death rates from lung and bronchus cancer decreased 1% to 2% per year for each race/ethnicity except AI/ANs. Among AI/ANs, death rates increased 1.7% per year among men and 2.9% per year among women. Death rates also increased for white and black women.

For 1998, death rates for colorectal cancer for each race/ethnicity were approximately 40% higher among men than women (Table 1). Blacks had the highest death rate for colorectal cancer, followed by whites. Death rates for colorectal cancer decreased 2.2% per year for white men and 1.8% per year for white women. Declines in death rates among black men and women were approximately 50% less than that for whites. Death rates for colorectal cancer increased 4.5% per year for AI/AN men, although the increase was not significant because of year-to-year variations in rates.

* Codes: lung and bronchus 162.2–162.5, 162.8–162.9; colon and rectum 153, 154.0–154.1, 159.0; prostate 185; breast 174.

INSIDE

The *MMWR* series of publications is published by the Epidemiology Program Office, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

SUGGESTED CITATION
Centers for Disease Control and Prevention. [Article Title]. MMWR 2002;51:[inclusive page numbers].

Death rates for prostate cancer were more than twice as high for blacks than for whites (Table 1). Rates were lowest among APIs. Death rates decreased for men of each race/ethnicity except AI/ANs (Table 1, Figure 1). The declines in death rates for whites (2.8% per year) and APIs (3.4% per year) were approximately twice the decreases for blacks, Hispanics, and AI/ANs.

Female breast cancer death rates were highest for blacks, followed by whites, Hispanics, AI/ANs, and APIs (Table 1). During 1990–1998, breast cancer-related death rates decreased for white (2.5% per year) and Hispanic (1.2% per year) women and were unchanged for black, AI/AN, and API women (Table 1, Figure 2).

Reported by: *P Gargiullo, PhD, PA Wingo, PhD, RJ Coates, PhD, TD Thompson, Div of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

Editorial Note: The findings in this report indicate that death rates have declined for lung and bronchus, colorectal, prostate, and female breast cancers among most racial/ethnic populations; however, death rates remained high for certain cancers among blacks and are generally increasing among AI/ANs. Trends in cancer death rates might reflect changes in cancer risk behaviors, new screening modalities, and the development and use of new and more effective treatments (*1*).

Lung and bronchus cancer was the most important cause of cancer mortality in the 1990s, accounting for approximately 28% of all cancer-related deaths (*1*). Approximately 90% of these deaths have been attributed to smoking (*4,5*). Changes in death rates reflect substantial decreases in smoking during 1965–1985 among men (51.9% to 32.6%) and smaller decreases among women (33.9% to 27.9%) (*5*). Increases in death rates for AI/ANs probably reflect increases in smoking rates. AI/ANs have among the highest smoking rates in the United States (*6*).

Incidence of colorectal cancer among whites has been decreasing since approximately 1985 and has remained virtually unchanged for blacks, AI/ANs, APIs, and Hispanics. In the 1990s, decreases in death rates might relate to the increased use of chemotherapy and to screening and early detection (*7*). During 1987–1998, the percentage of persons aged ≥50 years who ever had sigmoidoscopy/proctoscopy increased from 24% to 38%. During 1992–1998, the percentage of persons in this age group who had had fecal occult blood testing within a 2-year period increased from 30% to 33% (*7*).

Prostate cancer is second to lung cancer as a cause of cancer-related death among men. The gradual decreases in death rates for all the reported races/ethnicities during the study period might reflect aggressive treatment of advanced

TABLE 1. Number of deaths and death rate* among persons with cancer and annual percentage change from 1990 to 1998, by type of cancer, sex, and race/ethnicity — United States, 1990–1998

Type of cancer	No. of deaths		Age–adjusted rates		Annual % change
	1990	1998	1990	1998	1990–1998
Lung and bronchus					
Men	91,012	91,397	75.2	65.4	–1.8†
Whites	79,420	79,608	73.2	64.2	–1.7†
Blacks	10,621	10,280	107.0	88.8	–2.3†
American Indians/Alaska Natives	205	325	37.5	45.3	1.7†
Asians/Pacific Islanders	756	1,184	34.1	33.5	–1.2†
Hispanics§	1,813	2,245	34.7	28.6	–2.1†
Women	50,134	63,075	31.6	34.6	1.1†
Whites	45,112	56,342	32.0	35.3	1.2†
Blacks	4,503	5,813	31.8	34.7	1.0†
American Indians/Alaska Natives	117	202	16.5	22.5	2.9†
Asians/Pacific Islanders	397	718	14.5	15.4	0.9
Hispanics	780	1,104	11.2	10.6	–0.2
Colorectal cancer					
Men	28,481	28,023	23.4	19.6	–2.1†
Whites	25,233	24,381	23.1	19.2	–2.2†
Blacks	2,879	3,074	29.2	26.2	–0.9†
American Indians/Alaska Natives	52	94	9.6	12.7	4.5
Asians/Pacific Islanders	314	474	13.9	12.9	–1.5†
Hispanics	744	1,051	14.2	13.0	–0.5
Women	28,673	28,950	15.6	13.7	–1.7†
Whites	25,213	24,936	15.2	13.2	–1.8†
Blacks	3,158	3,506	20.7	19.4	–0.8†
American Indians/Alaska Natives	61	93	8.3	9.2	1.2
Asians/Pacific Islanders	238	415	8.7	8.7	–0.5
Hispanics	653	842	9.1	7.7	–1.9†
Prostate	32,376	32,203	26.4	21.5	–2.6†
Whites	26,915	26,416	24.3	19.6	–2.8†
Blacks	5,181	5,436	54.8	48.7	–1.5†
American Indians/Alaska Natives	59	80	12.4	11.3	–1.5
Asians/Pacific Islanders	220	271	11.1	8.0	–3.4†
Hispanics	724	1,089	15.6	14.7	–1.7
Breast (Women)	43,389	41,736	27.4	22.7	–2.3†
Whites	38,284	35,758	27.3	22.2	–2.5†
Blacks	4,659	5,281	31.6	29.6	–0.5
American Indians/Alaska Natives	89	120	11.5	12.0	1.4
Asians/Pacific Islanders	354	577	11.2	11.2	–1.0
Hispanics	1,244	1,591	16.4	14.2	–1.2†

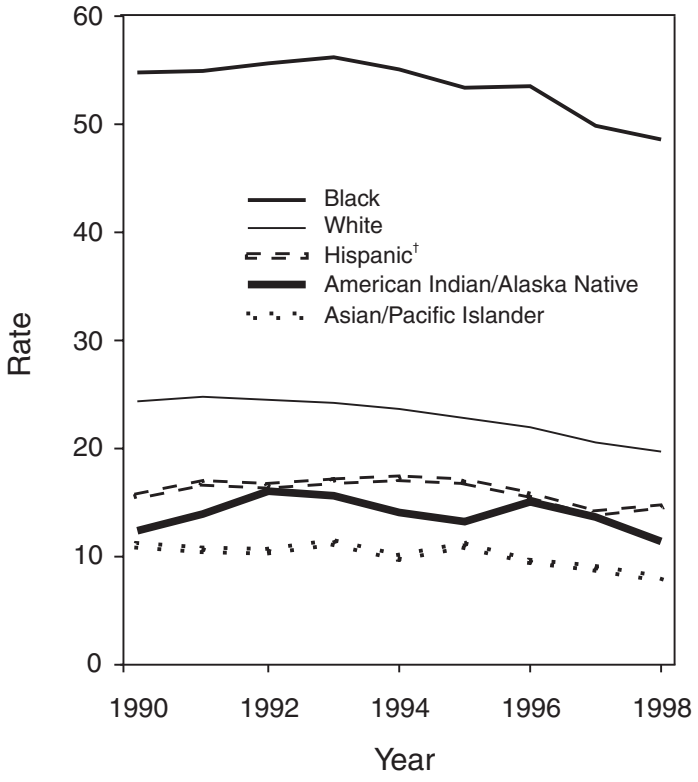
* Per 100,000 population; rates age-adjusted to the 1970 U.S. standard million population.
† Significantly different from zero ($p \leq 0.05$).
§ Deaths among Hispanics are not mutually exclusive of deaths among the four race/ethnicity categories. Deaths and death rates for Hispanics do not include data from Connecticut, Louisiana, New Hampshire, and Oklahoma because data on Hispanic origin were not available for certain years.

cancer and use of serum prostate-specific antigen (PSA) testing (*1*). However, the effectiveness of PSA screening and early-stage treatment in reducing mortality is unknown.

Breast cancer accounts for the second largest proportion of cancer-related deaths among women (*1*). The recent increase in the incidence of breast cancer probably reflects greater use of screening and early detection because the increase has occurred mostly among women diagnosed with early-stage disease (*1*). By 1997, the percentage of women aged ≥40 years who reported having had a mammogram during the preceding 2 years was 72.9% for blacks, 72.5% for APIs, 71.4% for whites, 67% for Hispanics, and 59.9% for AI/ANs (*8*).

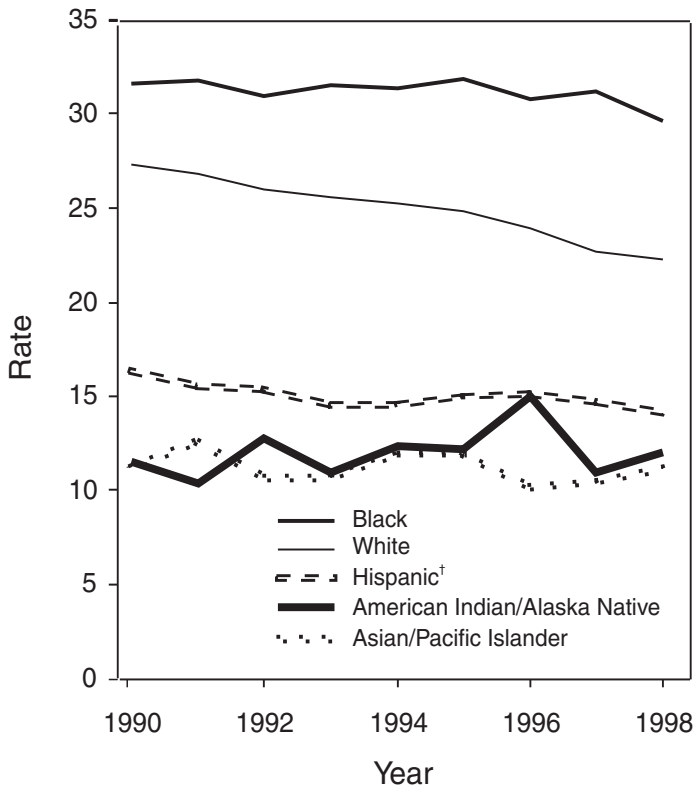
The findings in this report are subject to at least two limitations. First, the reporting of race/ethnicity to the U.S. Bureau of the Census and on death certificates usually is reliable for blacks and whites (*9*); however, underreporting for other races/ethnicities can understate death rates from 2% among Hispanics to 21% among AI/ANs. Second, because this study was a description of national trends and not an evaluation of cancer intervention studies, the findings should be interpreted with caution.

FIGURE 1. Rate* of prostate cancer deaths, by race/ethnicity — United States, 1990–1998



* Per 100,000 population; rates age-adjusted to the 1970 U.S. standard million population.
† Deaths among Hispanics are not mutually exclusive of deaths among the four race/ethnicity categories. Death rates for Hispanics do not include data from Connecticut, Louisiana, New Hampshire, and Oklahoma because data on Hispanic origin were not available for certain years.

FIGURE 2. Rate* of female breast cancer deaths, by race/ethnicity — United States, 1990–1998



* Per 100,000 population; rates age-adjusted to the 1970 U.S. standard million population.
† Deaths among Hispanics are not mutually exclusive of deaths among the four race/ethnicity categories. Death rates for Hispanics do not include data from Connecticut, Louisiana, New Hampshire, and Oklahoma because data on Hispanic origin were not available for certain years.

One of the goals of the national health objectives for 2010 is to eliminate health disparities among racial/ethnic populations. CDC supports several initiatives that address the four major cancers: national tobacco-control efforts; *Screen for Life*, a multimedia campaign promoting prevention and early detection of colorectal cancer; and Racial and Ethnic Approaches to Community Health (REACH 2010). CDC also funds research on the high death rates from prostate cancer among blacks and the National Breast and Cervical Cancer Early Detection Program, which provides screening to underserved women. Additional information about CDC's cancer prevention and control programs is available at http://www.cdc.gov/tobacco; http://www.cdc.gov/cancer; and http://www.cdc.gov/cancer/minorityawareness.htm.

Differences in cancer death rates result from a combination of factors such as behaviors (e.g. smoking and nutrition); access to preventive, diagnostic, therapeutic, and screening services; and aggressiveness of treatment. If these factors were modified, more than half of the cancer deaths could be prevented and most racial/ethnic disparities in cancer death rates could be eliminated.

References

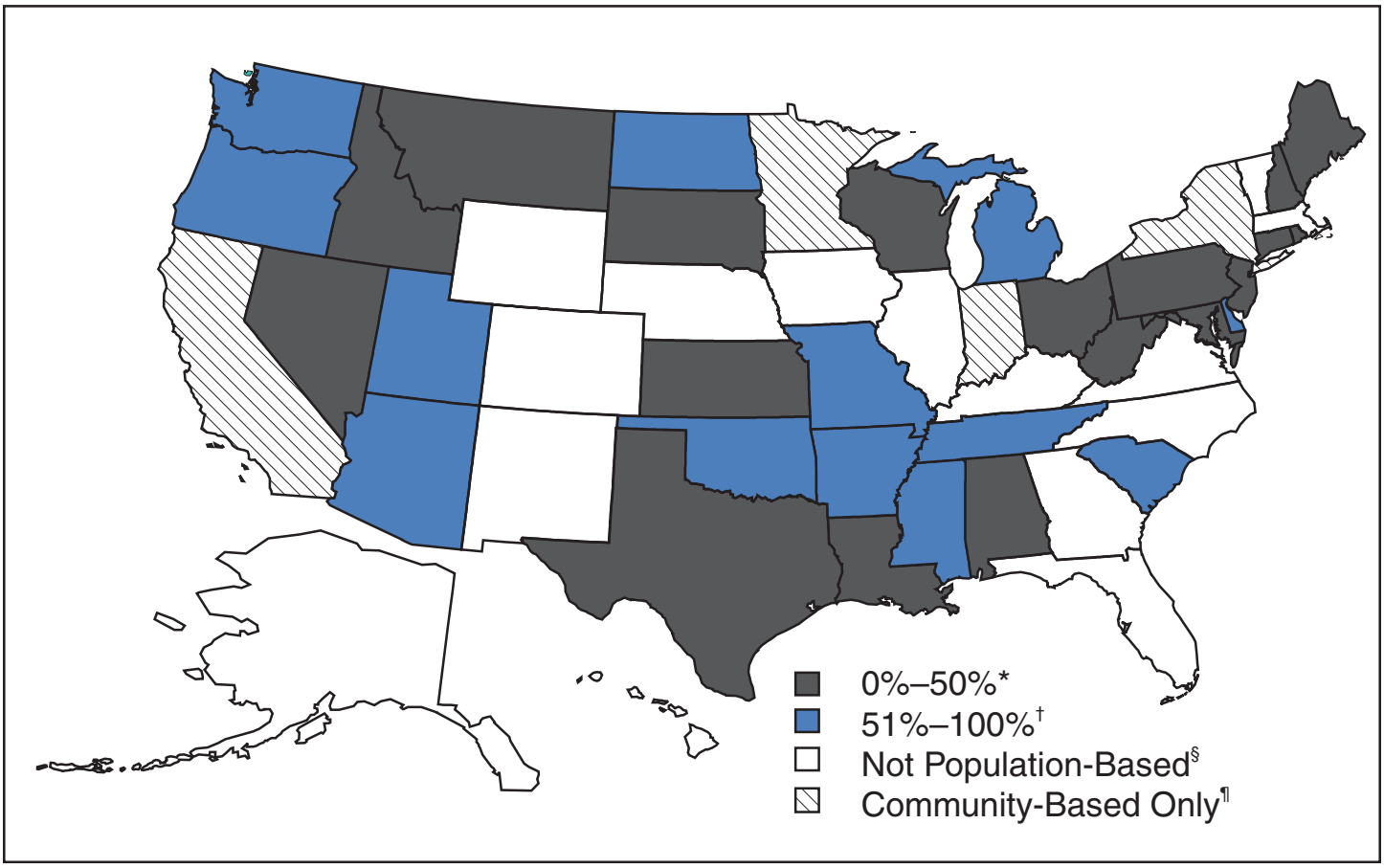
1. Howe HL, Wingo PA, Thun MJ, et al. Annual report to the nation on the status of cancer (1973 through 1998), featuring cancers with recent increasing trends. J Natl Cancer Inst 2001;93:824–42.
2. Miller BA, Kolonel LN, Bernstein L, et al. Racial/ethnic patterns of cancer in the United States 1988–1992. Bethesda, Maryland: National Cancer Institute; 1996. National Institutes of Health publication no. 96-4104.
3. Murphy SL. Deaths: final data for 1998. National Vital Statistics Reports; vol. 48, no. 11. Hyattsville, Maryland: National Center for Health Statistics, July 24, 2000.
4. Harras A, Edwards BK, Blot WJ, Ries LAG, eds. Cancer rates and risks, 4th ed. Bethesda, Maryland: National Cancer Institute, 1996; National Institutes of Health publication no. 96-691.
5. Wingo PA, Ries LAG, Giovino GA, et al. Annual report to the nation on the status of cancer, 1973–1996, with a special section on lung cancer and tobacco smoking. J Natl Cancer Inst 1999;91:675–90.
6. CDC. Cigarette smoking among adults—United States, 1998. MMWR 2000;49:881–4.
7. Ries LAG, Wingo PA, Miller DS, et al. The annual report to the nation on the status of cancer, 1973–1997, with a special section on colorectal cancer. Cancer 2000;88:2398–424.

8. Blackman DK, Bennett EM, Miller DS. Trends in self-reported use of mammograms (1989–1997) and Papanicolaou tests (1991–1997)—Behavioral Risk Factor Surveillance System. MMWR 1999;48(No. SS-6).
9. Rosenberg HM, Maurer JD, Sorlie PD, et al. Quality of death rates by race and Hispanic origin: a summary of current research, 1999. Hyattsville, Maryland: US Department of Health and Human Services, CDC, National Center for Health Statistics, 1999; Vital and Health Statistics, Series 2, No. 128.

Immunization Registry Use and Progress — United States, 2001

Immunization registries are confidential, population-based, computerized information systems that collect vaccination data about all children within a geographic area (*1*). Registries are key tools used to increase and sustain high vaccination coverage by providing complete and accurate information on which to base vaccination decisions. Registries consolidate vaccination records of children from multiple healthcare providers, identify children who are due or late for vaccinations, generate reminder and recall notices to ensure that children are appropriately vaccinated, and identify provider sites and geographic areas with low vaccination coverage. One of the national health objectives for 2010 is to increase to 95% the proportion of children aged <6 years who participate in fully operational population-based immunization registries (objective 14-26) (*2*). CDC analyzed data from 50 states and the District of Columbia (DC) from the calendar year 2000 Immunization Registry Annual Report (CY 2000 IRAR) to assess current registry activity. This report summarizes the results of those analyses, which indicate that 32 (63%) of the 51 grantees are operating population-based immunization registries (Figure 1). These 32 projects represent 49% of the U.S. population aged <6 years (*3*).

FIGURE 1. Percentage of children with ≥2 immunizations listed in a population-based registry — United States, 2000



* Eighteen states.
† Thirteen states and the District of Columbia.
§ Fifteen states.
¶ Four states.

The CY 2000 IRAR was a self-administered questionnaire distributed to immunization program managers as part of the yearly reporting requirement for Public Health Service Act § 317b grantees. Responses were received from all 50 states and DC. A total of 32 (63%) of the 51 grantees reported operating population-based registries that targeted their entire catchment areas. Of the remaining 19 (37%) grantees, four (21%) reported operating population-based registries in regions or counties as demonstration or pilot projects, and 15 (79%) were planning or developing population-based registries. The CY 2000 IRAR requested information about the percentage of children and vaccination providers in the registry's catchment area who participated and progress in implementing the 13 functional standards for immunization registry operation (*3*).

Data from the 32 grantees operating population-based registries indicated that approximately 49% of the estimated 11.4 million children aged <6 years, based on the U.S. Census, in these catchment areas had ≥2 vaccinations recorded in the registry. The 32 grantees also reported that an average of 56% of public vaccination provider sites and 41% of private provider sites in their catchment areas participated in the registry during the 6 months preceding completion of the CY 2000 IRAR. All 51 grantees were working to meet key elements of the 13 functional standards established for immunization registries (Table 1). Although no registry has met all key elements of all standards, 14 of the 51 grantees have met all key elements of ≥11 of the standards (*3*).

Reported by: *T Boyd, MS, and RW Linkins, PhD, Data Management Div, National Immunization Program, CDC.*

Editorial Note: In 2000, the Institute of Medicine noted, "with the increasing importance of population-based approaches to health system planning and evaluation, immunization registries offer one of the most useful instruments for assessing population-specific effectiveness of health and medical care programs" (*4*). Projects use their registries for program decision support as exemplified by San Antonio's use of registry data to examine the implementation of new vaccines through the Vaccines for Children (VFC) entitlement program. San Antonio's data demonstrated that, although non-VFC providers began using heptavalent pneumococcal conjugate vaccine (PCV7) soon after licensure, delay in VFC reimbursement might have caused slower PCV7 uptake among VFC-eligible children (*5*). Other projects have used their registry data to measure reminder/recall system effectiveness (*6*), identify sources of delayed immunizations (*7*), and track the implementation of immunization schedule changes (*8*).

Oregon registry data were used to assess the impact on hepatitis B (HepB) vaccine administration after issuance of the Joint Statement of the American Academy of Pediatrics (AAP) and the U.S. Public Health Service (USPHS) (*9*) about using thimerosal as a vaccine preservative. Their joint statement recommended reducing infant exposure to thimerosal; specific recommendations were made to postpone the first HepB vaccine dose until age 2–6 months for infants born to hepatitis B surface antigen-negative mothers. Oregon's registry data (which include 88% of the state's population of children aged <6 years) indicated that the average proportion of children participating in the registry per week who were administered

TABLE 1. Number and percentage of the 32 population-based immunization registries that implemented key elements of the 13 functional standards — United States, December 2000

Functional standard	Registries meeting all key elements		Registries meeting ≥1 key elements	
	No.	(%)	No.	(%)
Electronically store data regarding all National Vaccine Advisory Committee-approved core data elements	15	(46.9)	32	(100.0)
Establish a registry record within 6 weeks of birth for each child born in the catchment area	27	(84.4)	27	(84.4)
Enable access to vaccine information from the registry at the time of encounter	32	(100.0)	32	(100.0)
Receive and process vaccine information within 1 month of vaccine administration	31	(96.9)	31	(96.9)
Protect the confidentiality of medical information	23	(71.9)	27	(84.4)
Recover lost data (i.e., disaster recovery)	16	(50.0)	32	(100.0)
Ensure the security of medical information	24	(75.0)	32	(100.0)
Exchange vaccination records by using Health Level Seven standards*	2	(6.3)	7	(21.9)
Automatically determine the immunization(s) needed when a person is seen by the health-care provider for a scheduled vaccination	29	(90.1)	29	(90.1)
Automatically identify persons due or late for vaccinations to enable the production of reminder and recall notifications	27	(84.4)	29	(90.1)
Automatically produce vaccination coverage reports by providers, age groups, and geographic areas	26	(81.3)	28	(87.5)
Produce authorized immunization records	28	(87.5)	28	(87.5)
Consolidate all vaccination records from multiple providers, using deduplication and edit-checking procedures to optimize accuracy and completeness	15	(46.9)	32	(100.0)

* **Source:** Health Level Seven, Inc. Health level seven. Ann Arbor, Michigan: Health Level Seven, Inc., 2001. Available at http://www.hl7.org. Accessed January 16, 2002.

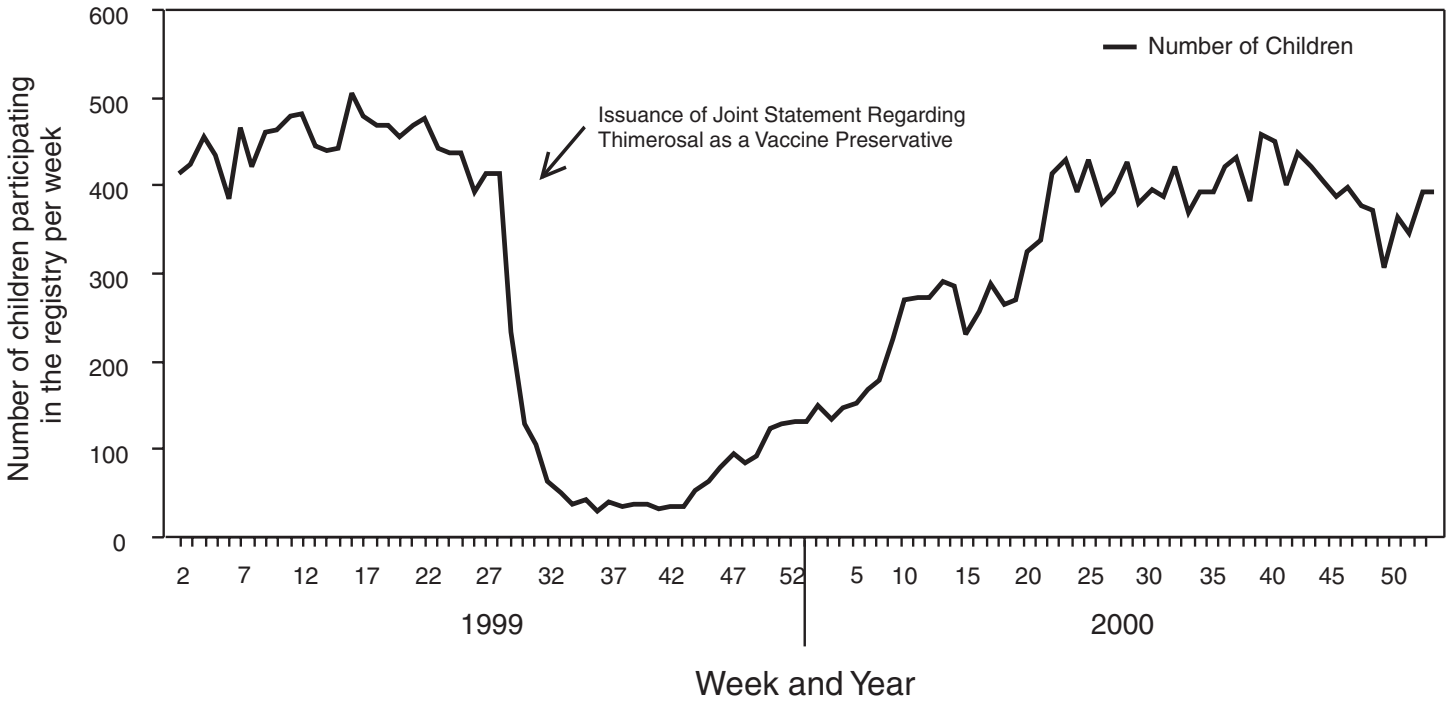
HepB vaccine ≤5 days after birth decreased 93% during the 6 weeks after the report's release (Figure 2). On the basis of these data, Oregon officials contacted health plans, health-care providers, and local health departments to ensure that the report's recommendations were being followed (i.e., that the first dose of HepB be delayed only for infants born to hepatitis B surface antigen-negative mothers and that providers return to previous infant HepB vaccination practices after a thimerosal-free alternative became available). Continued monitoring of registry data indicated that, despite the availability of thimerosal-free vaccine in August 1999, by the end of 2000, administration rates had reached only 88% of pre-report levels for HepB vaccination (*8*). These data assist education efforts for providers who have not reinstated HepB vaccine recommendations.

CDC recently identified for grantees eight core program attributes in the Immunizations Program Operations Manual released in 2001: population assessment, surveillance, consumer information, service delivery, provider quality assurance, vaccine management, registry development, and program management (*10*). CY 2000 IRAR data indicate that certain grantees might have the capacity to use registry data to support these program attributes. For example, 42 grantees use registry data to determine vaccine coverage among different segments of the population, and 32 grantees track VFC participant eligibility by using their registries. CDC is collecting data to monitor projects' use of registries and registry data to support each of these program attributes beginning with the CY 2001 IRAR.

The findings in this report are subject to at least three limitations. First, because the annual report relied on self-reported information, bias in reporting could have occurred. However, on-site verification through record reviews and observation of registry operations during the 20 site visits performed in 2000 indicated that 98.3% of the answers provided by those sites in response to the previous year's annual report were accurate. Second, because only information from these 51 immunization grantees was included in the analyses, any immunization registry development performed by other entities (e.g., city immunization grantees, hospitals, local health departments, and managed care plans) would not be included in these findings. This could result in an underestimation of the degree of registry development in the United States. Finally, the CY 2000 IRAR did not collect information about the completeness or accuracy of immunization data recorded in a registry. Tools are under development at CDC to assist with registry data quality assessment.

Immunization registries continue to develop to improve vaccination coverage and reach the 2010 national health objective of 95% participation for children aged <6 years. Additional information about immunization registries is available from CDC at http://www.cdc.gov/nip/registry; by telephone at 800-799-7062; or by e-mail at siisclear@cdc.gov.

FIGURE 2. Number of children who received first dose of Hepatitis B vaccine ≤5 days after birth — United States, 1999–2000



References

1. National Vaccine Advisory Committee (NVAC). Development of community and state-based immunization registries; approved January 12, 1999. Atlanta, GA: US Department of Health and Human Services, CDC, 1999. Available at http://www.cdc.gov/nip/registry/nvac.htm. Accessed January 16, 2002.
2. US Department of Health and Human Services. Immunizations and infectious diseases. In: Healthy people 2010 (conference ed, vol 1). Washington, DC: US Department of Health and Human Services, 2000:14-41–2. Available at http://www.health.gov/healthypeople. Accessed January 16, 2002.
3. Linkins, R. Current status of registry development. Presented at the 2001 Registry Conference, Little Rock, Arkansas, July 9–11, 2001. Available at http://www.cdc.gov/nip/registry/irc2001plen.htm. Accessed January 16, 2002.
4. Institute of Medicine. Calling the shots: immunization finance policies and practice. Washington, DC: National Academy Press, 2000. Available at http://www.nap.edu/catalog/9836.html. Accessed January 16, 2002.
5. Poydence, K. Utilization of a metropolitan immunization registry to examine implementation of heptavalent pneumococcal conjugate vaccine. Presented at the 2001 Registry Conference, Little Rock, Arkansas, July 9–11, 2001. Available at http://www.cdc.gov/nip/registry/irc2001e.htm. Accessed January 16, 2002.
6. Romey, K. Working with private sector to implement a registry reminder recall system. Presented at the 2001 Registry Conference, Little Rock, Arkansas, July 9–11, 2001.
7. Canavan, B. Using registry data to identify delayed immunization (late starts) for children covered by Medicaid. Presented at the 2001 Registry Conference, Little Rock, Arkansas, July 9–11, 2001.
8. Canavan, B. Using registry data to assess the impact of changes in the vaccine schedule. Presented at the 2001 Registry Conference, Little Rock, Arkansas, July 9–11, 2002. Available at http://www.cdc.gov/nip/registry/irc2001e.htm. Accessed January 16, 2002.
9. American Academy of Pediatrics. Joint statement of the American Academy of Pediatrics (AAP) and the United States Public Health Service (USPHS) (RE9937). Elk Grove Village, IL: American Academy of Pediatrics, 1999:568–9. Available at http://www.aap.org/policy/re9937.html. Accessed January 16, 2002.
10. National Immunization Program. Immunization program operations manual. Atlanta, GA: US Department of Health and Human Services, CDC, National Immunization Program, 2001.

Emergency Medical System Responses to Suicide-Related Calls — Maine, November 1999–October 2000

Suicidal acts are morbid and potentially lethal events that are risks for subsequent completed suicide and possibly other health problems (e.g., substance abuse and depression) (*1,2*). Suicidal behavior also can have negative consequences on family members, friends, and caregivers (*3*). In 1996, the cost of health care and lost wages for suicide attempts in Maine was approximately $115 million (*4*). In 1999, a total of 1,079 persons were hospitalized in Maine for self-injurious behavior. Although Maine has no injury-related surveillance systems, the Maine Bureau of Health (MBOH) assessed the use of Emergency Medical Service (EMS) response data to estimate incidence of EMS responses to suicide-related calls in Maine and to summarize the distribution of these responses by patient and event characteristics. This report describes EMS suicide-related responses during November 1999–October 2000 and indicates that EMS data would be a useful component of an integrated statewide suicidal behavior surveillance system.

Maine EMS responders complete a run report form (RRF) for each emergency assistance call. RRF contains a check box titled "concern suicide," which is selected "for patients who have, relevant to this call/run, expressed or displayed any suicidal tendencies or attempts." For any RRF on which "concern suicide" is selected, personal identifiers are removed and the form is sent to the MBOH Injury Prevention Program (MIPP). RRF has defined fields for sex, age, date of birth, incident date, incident location, incident site*, town of residence, insurance payor, and EMS service number. EMS responders can provide additional information in a free text field, from which MIPP extracts data on method of attempt or threat and circumstances surrounding the event.

Inclusion criteria for this analysis were 1) "concern suicide" box checked on the RRF, 2) confirmed Maine residency, 3) aged >10 years†, and 4) presence of a unique RRF number. If RRFs were duplicated, only one was counted as a case. Of the 2,152 RRFs received during November 1999–October 2000, a total of 2,036 (95%) were eligible for inclusion in the analysis, of which 967 (47.5%) were made for the intra- or interinstitutional transportation of suicidal residents from nursing homes, psychiatric, correctional, or medical facilities§. Data were evaluated separately for all responses and for the 1,069 noninstitutional (NI) responses. All age-adjusted rates were standardized to the 2000 U.S. standard population and included both completed suicides and nonlethal attempts.

For all calls, age-adjusted EMS response rates to "concern suicide" in Maine were 179.2 per 100,000 females and 142.3 per 100,000 for males. For females, age-specific rates were highest among those aged 15–19 years (384.8); for males, rates were highest for those aged 20–24 year (258.1). Because geographic and event data are limited for the institutionalized subgroup, the remainder of the descriptive analysis was limited to the NI cases.

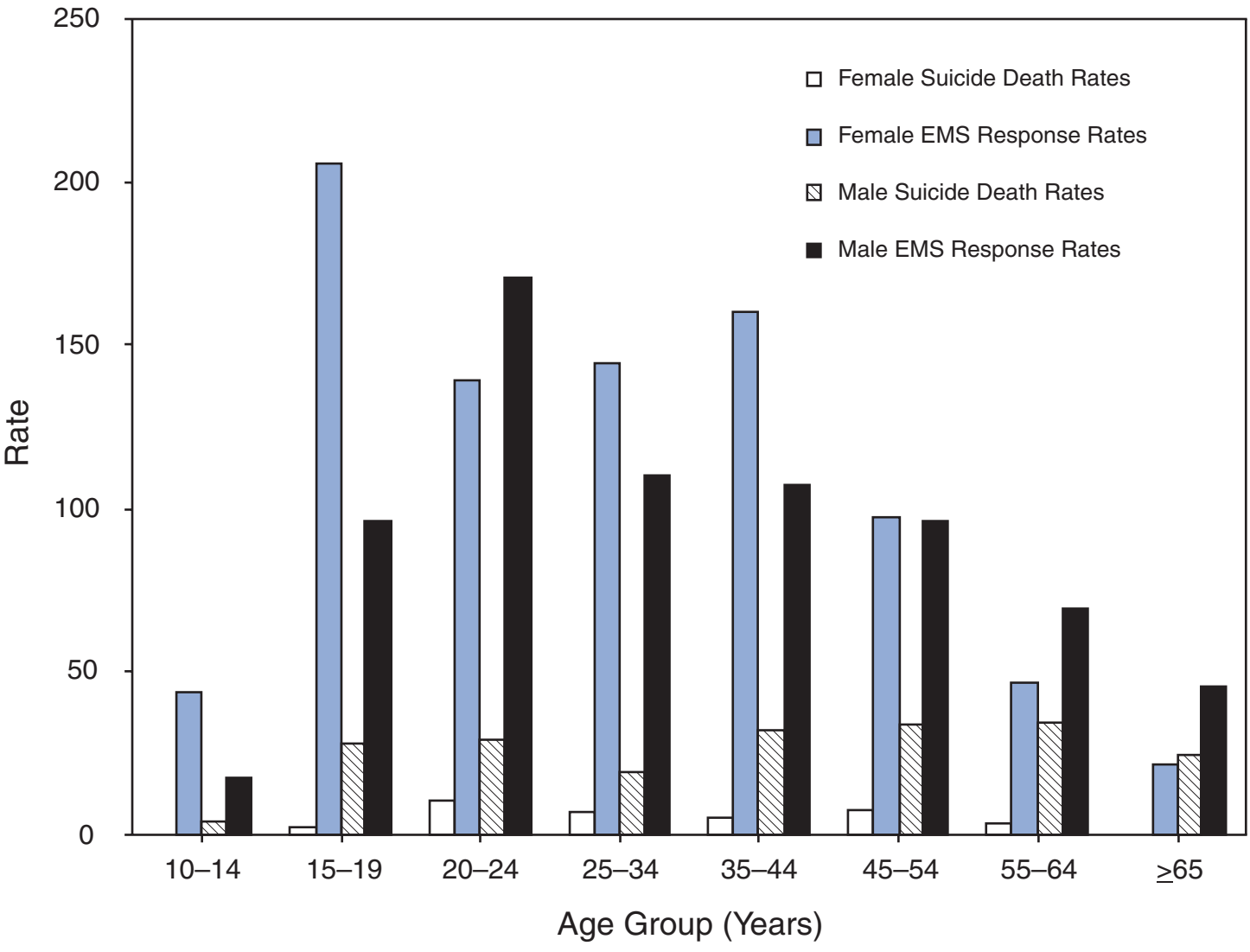
* Location is town and state of the incident; site is the type of location (e.g., home, office, school, or highway).
† Age cutoff was set at age 10 years because only three RRFs were submitted for children aged <10 years, and suicidal behavior in this age group is sufficiently different than the 10–14 year age group to make comparing them problematic.
§ The current data entry system does not allow for distinctions between persons being transported from nursing homes and residential facilities versus from correctional facilities.

For the 1,069 NI cases, age-adjusted EMS response rates were 92.5 and 76.5 among females and males, respectively. Female rates of suicide-related EMS calls were highest among those aged 15–19 years (206.2), but were generally high among females aged 20–44 years (range: 138.8–160.2). Male rates of suicide-related EMS calls were highest among those aged 20–24 years (170.3) and high among those aged 15–19 and 25–34 years (range: 96.0–110.4). Age-specific rates were statistically similar for females aged 20–34 years and >55 years and for males aged 25–54 years. All other age-specific rate differences were statistically significant ($p < 0.05$). In comparison, suicide completion rates (derived from medical examiner data) were uniform across all female age groups (range: 0–10.7) and were highest among males aged ≥45 years (range: 25.0–34.8) (Figure 1).

Among the 1,069 NI responses, 761 (72.0%) were to the residence of the attempter. EMS calls were most frequent in the summer (27.1%) and least frequent in the winter and spring (23.5% and 23.3%, respectively).

Among the 963 (90.1%) NI cases for which method was documented, overdose (29.9%), "suicidal ideation only" (27.0%), and laceration (17.7%) were the most commonly documented methods. Attempts with firearms comprised 3.7%.

FIGURE 1. Rate* of suicide deaths and emergency medical service response to noninstitutionalized residents, by sex and age group — Maine, November 1999–October 2000



* Per 100,000 population.

The case-fatality ratio for EMS calls was 3.8% (1.3% for females and 6.9% for males). Case-fatality ratios were highest among males aged ≥65 years (15.2%). Method employed also was related to fatality ratios, even in the minority of completions[¶] receiving EMS response. Of the 36 EMS responses to firearm-related suicidal behavior, 21 (58.3%) were lethal by the time of RRF completion. Compared with drug overdoses (1.0% lethal), attempts by firearm and hanging receiving EMS response were 58 and 60 times more lethal, respectively.

Of the 1,069 events, circumstance was reported for 636 (59.5%); a total of 695 circumstances were reported. The most commonly reported circumstances were drug/substance abuse at the time of the incident (220 [31.7%] of all reported circumstances), patient-reported psychiatric illness (200 [28.8%]), domestic discord or violence (117 [16.8%]), and medical illness/pain (49 [7.1%]).

Reported by: *N Sonnenfeld, Div of Community Health, Maine Bureau of Health; D Bailey, C DiCara, Injury Prevention Program; J Bradshaw, Maine Emergency Medical Svc. A Crosby, MD, Div of Violence Prevention, National Center for Injury Prevention and Control; K Askland, MD, EIS Officer, CDC.*

Editorial Note: Among all states, Maine ranks 14th in rate of suicide deaths (13.4 per 100,000 population); this rate is 25% higher than the national rate (*5*). Despite the magnitude of the problem, no surveillance system exists in Maine to monitor suicidal behavior. The findings in this report indicate that EMS NI responses to suicide-related calls in Maine identified characteristics similar to those in community- and population-based studies of nonlethal suicidal behaviors (*6–8*) and might be an important component of a suicide surveillance system. Virtually all (99%) EMS response data in Maine from state-, municipal-, volunteer-, and fire-department–based and private services are compiled in a centralized database. In addition, Maine is developing an electronic reporting form and a mobile data input system for use across all 141 EMS services.

The findings in this report are similar to other population- and community-based studies of the distribution of injuries associated with nonfatal suicidal behavior. Findings were similar for age, sex, location, method, and circumstances of suicide-related injuries. Other findings, such as seasonality of the suicidal act and a description of the institutionalized population, might be important for prevention efforts and require further analysis.

Although this approach demonstrates the value of existing EMS response data for injury surveillance, the findings are subject to several limitations. First, no systematic mechanism exists to ensure that only one RRF is filed for each event or for systematically identifying repeat attempters. Second, the dataset contains only those events for which an RRF is completed. Many persons who contemplate or attempt suicide will not seek assistance and no surveillance instrument, except possibly population-based surveys, will detect these events (*1*). Despite the lack of prevalence data, demographic and event characteristic profiles parallel those previously documented *(1,6–9)*. Moreover, incidence estimates (i.e., estimates of the total societal burden of attempts) may be most valuable in determining health services needs. Third, because unique record linkages with other health service data systems cannot currently be made, the sensitivity of EMS data, even to those who will eventually visit the emergency department or be admitted to the hospital, is unknown. Finally, this analysis includes data for only 12 months; as a result, the sample size is relatively small, which precludes description of temporal trends over several years. However, analysis at the early stage of development provides opportunities for improving the data collection system and preparing for its use in public health surveillance.

Prevention of suicidal behaviors and attempts might preclude more life-threatening health problems (*1*). EMS data provide information about suicidal acts and might be useful in early prevention efforts. In addition, EMS data provide event detail unavailable in other health information systems. Data about the circumstances surrounding violent injuries are critical to understand attempt risk and to develop age- and sex-specific prevention strategies. Although refinements are needed, EMS data, together with medical examiner, hospital discharge, and emergency department data, would be a useful component of an integrated statewide suicidal behavior surveillance system (*10*).

[¶]Medical examiner data for November 1999–October 2000 indicated 102 suicides completed by firearm. Therefore, 66 (65%) of firearm-related suicides were completed without an EMS response.

References

1. Diekstra RFW. Suicide and attempted suicide: an international perspective. Acta Psychiatrica Scandinavica 1989;80:1–24.
2. Moscicki EK. Identification of suicide risk factors using epidemiologic studies. The Psychiatric Clinics of North America 1997;20:499–517.
3. United Nations/World Health Organization. Prevention of suicide: guidelines for the formulation and implementation of national strategies. Geneva, Switzerland: World Health Organization, 1996 (publication no.ST/ESA/245).
4. Educational Development, Inc. Northeast injury prevention network suicide databook. Children's Safety Network Injury Data Technical Assistance Center, San Diego, California: 2000.
5. Spicer RS, Miller TR. Suicide acts in 8 states: incidence and case fatality rates by demographics and method. Am J Public Health 2000;90:1885–91.

6. Eisele JW, Frigino J, Haglund W, Reay DT. Teenage suicide in King County, Washington: comparison with adult suicides. Am J Forensic Med Pathol 1987;8:214.
7. CDC. Fatal and nonfatal suicide attempts among adolescents—Oregon, 1988-1993. MMWR 1995;48:312–5.
8. Rausch TK, Sanddal ND, Sanddal TL, Esposito TJ. Changing epidemiology of injury-related pediatric mortality in a rural state: implications for injury control. Pediatr Emerg Care 1998;14:390–1.
9. Hsaio AK, Hedges JR. Role of the emergency medical services system in regionwide health monitoring and referral. Ann Emerg Med 1993;22:1696–702.
10. Hoyert DL, Arias E, Smith BL, Murphy SL, Kochanek KD. Deaths: final data for 1999. National vital statistics report. Hyattsville, Maryland: National Center for Health Statistics; vol 49, no. 8.

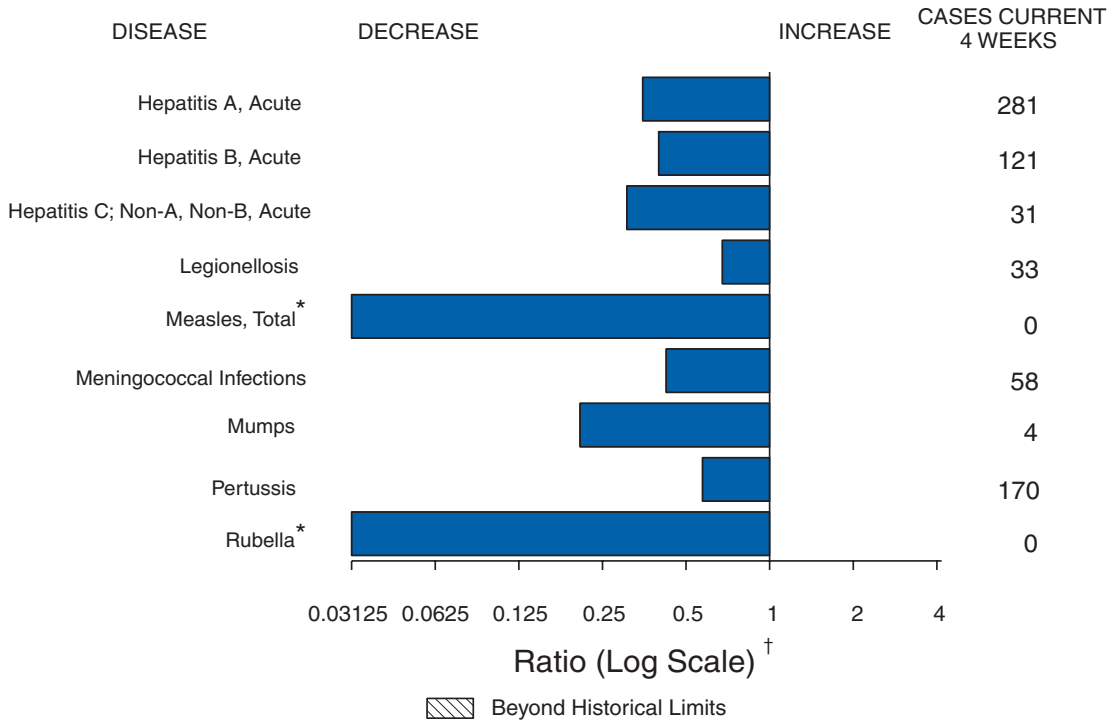
Notice to Readers

Evaluation of Postexposure Antibiotic Prophylaxis to Prevent Anthrax

In response to the recent bioterrorist attacks associated with intentional release of *Bacillus anthracis*, approximately 10,000 persons potentially exposed to anthrax in Connecticut, Florida, New Jersey, New York City, and Washington, D.C., were recommended to take at least 60 days of postexposure antibiotic prophylaxis. Surveillance for adverse events and adherence to antibiotics has been conducted through surveillance and cross-sectional studies. CDC is evaluating the program to distribute antimicrobial agents and assessing adverse events and adherence. The objectives of this evaluation are to assess the provision of antimicrobial agents and educational materials to affected persons, to determine adverse events associated with the antimicrobial agents, and to characterize adherence to the recommended regimen. The information from this evaluation will be critical to CDC's effort to improve the technical assistance and supplies needed with future anthrax postexposure prophylaxis campaigns and to comply with Food and Drug Administration regulations for monitoring for adverse events.

CDC has contracted RTI International to conduct brief telephone interviews of all persons for whom postexposure antibiotic prophylaxis was recommended. Interviews are scheduled to begin in late January 2002 and will continue for approximately 8 weeks. Additional information about the program evaluation is available from CDC, telephone 404-639-3158.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending January 19, 2002, with historical data



* No measles or rubella cases were reported for the current 4-week period yielding a ratio for week 3 of zero (0).
† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending January 19, 2002 (3rd Week)*

		Cum. 2002	Cum. 2001		Cum. 2002	Cum. 2001
Anthrax		-	-	Encephalitis: West Nile†	3	-
Botulism:	foodborne	1	1	Hansen disease (leprosy)†	1	2
	infant	3	3	Hantavirus pulmonary syndrome†	-	-
	other (wound & unspecified)	1	-	Hemolytic uremic syndrome, postdiarrheal†	6	4
Brucellosis†		2	2	HIV infection, pediatric †§	-	-
Chancroid		2	4	Plague	-	-
Cholera		-	-	Poliomyelitis, paralytic	-	-
Cyclosporiasis†		3	-	Psittacosis†	-	-
Diphtheria		-	-	Q fever†	2	-
Ehrlichiosis:	human granulocytic (HGE)†	3	2	Rabies, human	-	-
	human monocytic (HME)†	1	2	Streptococcal toxic-shock syndrome†	1	4
	other and unspecified	-	-	Tetanus	-	4
Encephalitis:	California serogroup viral†	6	1	Toxic-shock syndrome	5	8
	eastern equine†	-	-	Trichinosis	-	2
	Powassan†	-	-	Tularemia†	3	1
	St. Louis†	-	-	Yellow fever	-	-
	western equine†	-	-			

-:No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update December 25, 2001.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending January 19, 2002, and January 20, 2001 (3rd Week)*

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7		*Escherichia coli* Shiga Toxin Positive, Serogroup non-O157	
	Cum. 2002§	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	-	-	21,567	34,730	60	80	45	38	3	2
NEW ENGLAND	-	-	693	770	-	2	7	5	-	-
Maine	-	-	64	57	-	-	-	-	-	-
N.H.	-	-	39	60	-	-	-	-	-	-
Vt.	-	-	51	24	-	2	-	-	-	-
Mass.	-	-	382	126	-	-	4	5	-	-
R.I.	-	-	157	136	-	-	-	-	-	-
Conn.	-	-	-	367	-	-	3	-	-	-
MID. ATLANTIC	-	-	1,867	2,388	7	9	4	4	-	-
Upstate N.Y.	-	-	168	143	2	-	4	4	-	-
N.Y. City	-	-	1,034	1,215	1	7	-	-	-	-
N.J.	-	-	-	322	-	2	-	-	-	-
Pa.	-	-	665	708	4	-	N	N	-	-
E.N. CENTRAL	-	-	3,173	6,891	10	31	7	5	-	-
Ohio	-	-	196	2,249	3	4	5	1	-	-
Ind.	-	-	174	633	-	1	1	-	-	-
Ill.	-	-	950	2,190	-	3	1	3	-	-
Mich.	-	-	1,664	903	4	4	-	-	-	-
Wis.	-	-	189	916	3	19	-	1	-	-
W.N. CENTRAL	-	-	306	1,793	4	3	8	2	2	-
Minn.	-	-	169	480	1	-	2	1	2	-
Iowa	-	-	-	73	1	1	3	-	-	-
Mo.	-	-	29	656	2	-	1	-	-	-
N. Dak.	-	-	13	46	-	-	-	-	-	-
S. Dak.	-	-	95	106	-	-	-	1	-	-
Nebr.	-	-	-	122	-	2	-	-	-	-
Kans.	-	-	-	310	-	-	2	-	-	-
S. ATLANTIC	-	-	4,145	6,353	23	6	11	4	1	1
Del.	-	-	131	165	-	-	-	-	-	-
Md.	-	-	748	712	1	1	-	-	-	-
D.C.	-	-	77	175	1	1	1	-	-	-
Va.	-	-	648	740	-	1	-	-	-	1
W. Va.	-	-	106	110	-	-	-	-	-	-
N.C.	-	-	457	739	2	-	1	2	-	-
S.C.	-	-	292	1,359	-	-	-	1	-	-
Ga.	-	-	353	1,000	19	2	9	1	1	-
Fla.	-	-	1,333	1,353	-	1	-	-	-	-
E.S. CENTRAL	-	-	2,527	2,321	1	2	-	2	-	-
Ky.	-	-	417	343	1	-	-	-	-	-
Tenn.	-	-	1,013	662	-	-	-	2	-	-
Ala.	-	-	837	640	-	1	-	-	-	-
Miss.	-	-	260	676	-	1	-	-	-	-
W.S. CENTRAL	-	-	4,358	5,799	1	2	-	3	-	-
Ark.	-	-	-	540	1	-	-	-	-	-
La.	-	-	837	970	-	1	-	-	-	-
Okla.	-	-	577	498	-	1	-	-	-	-
Tex.	-	-	2,944	3,791	-	-	-	3	-	-
MOUNTAIN	-	-	1,304	1,900	3	7	-	4	-	1
Mont.	-	-	63	13	-	-	-	-	-	-
Idaho	-	-	114	113	1	-	-	2	-	-
Wyo.	-	-	31	45	-	-	-	-	-	-
Colo.	-	-	262	658	-	3	-	1	-	1
N. Mex.	-	-	135	262	-	2	-	-	-	-
Ariz.	-	-	563	501	-	1	-	1	-	-
Utah	-	-	136	33	2	1	-	-	-	-
Nev.	-	-	-	275	-	-	-	-	-	-
PACIFIC	-	-	3,194	6,515	11	18	8	9	-	-
Wash.	-	-	704	756	-	U	-	-	-	-
Oreg.	-	-	-	285	5	1	5	-	-	-
Calif.	-	-	2,330	5,172	6	17	3	7	-	-
Alaska	-	-	98	76	-	-	-	-	-	-
Hawaii	-	-	62	226	-	-	-	2	-	-
Guam	-	-	-	-	-	-	N	N	-	-
P.R.	-	-	-	147	-	-	-	-	-	-
V.I.	-	-	-	7	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	11	U	-	U	-	U	-	U

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

* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

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

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update December 25, 2001.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending January 19, 2002, and January 20, 2001 (3rd Week)*

Reporting Area	*Escherichia coli* Shiga Toxin Positive, Not Serogrouped		Giardiasis	Gonorrhea		*Haemophilus influenzae*, Invasive			
						All Ages, All Serotypes		Age <5 years Serotype B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	-	1	329	10,521	17,888	42	53	-	-
NEW ENGLAND	-	-	23	213	210	-	2	-	-
Maine	-	-	10	5	1	-	-	-	-
N.H.	-	-	1	4	4	-	-	-	-
Vt.	-	-	6	5	10	-	-	-	-
Mass.	-	-	4	155	40	-	2	-	-
R.I.	-	-	-	44	38	-	-	-	-
Conn.	-	-	2	-	117	-	-	-	-
MID. ATLANTIC	-	-	55	860	1,441	13	16	-	-
Upstate N.Y.	-	-	16	107	119	6	4	-	-
N.Y. City	-	-	7	491	585	5	4	-	-
N.J.	-	-	-	-	274	-	8	-	-
Pa.	-	-	32	262	463	2	-	-	-
E.N. CENTRAL	-	-	83	1,643	3,605	10	11	-	-
Ohio	-	-	41	151	1,265	10	4	-	-
Ind.	-	-	-	84	325	-	-	-	-
Ill.	-	-	11	547	1,218	-	4	-	-
Mich.	-	-	27	818	439	-	1	-	-
Wis.	-	-	4	43	358	-	2	-	-
W.N. CENTRAL	-	-	32	98	834	-	1	-	-
Minn.	-	-	4	70	167	-	-	-	-
Iowa	-	-	7	-	12	-	-	-	-
Mo.	-	-	12	15	419	-	1	-	-
N. Dak.	-	-	-	-	1	-	-	-	-
S. Dak.	-	-	3	13	14	-	-	-	-
Nebr.	-	-	-	-	59	-	-	-	-
Kans.	-	-	6	-	162	-	-	-	-
S. ATLANTIC	-	-	51	2,756	4,735	13	17	-	-
Del.	-	-	4	114	73	-	-	-	-
Md.	-	-	8	436	509	3	-	-	-
D.C.	-	-	5	92	187	-	-	-	-
Va.	-	-	-	414	332	-	1	-	-
W. Va.	-	-	-	40	21	-	1	-	-
N.C.	-	-	-	378	796	3	5	-	-
S.C.	-	-	-	252	1,377	-	-	-	-
Ga.	-	-	34	269	625	7	7	-	-
Fla.	-	-	-	761	815	-	3	-	-
E.S. CENTRAL	-	1	11	1,590	1,820	-	1	-	-
Ky.	-	1	-	187	172	-	-	-	-
Tenn.	-	-	3	628	554	-	-	-	-
Ala.	-	-	8	592	625	-	1	-	-
Miss.	-	-	-	183	469	-	-	-	-
W.S. CENTRAL	-	-	4	2,212	3,025	-	-	-	-
Ark.	-	-	4	-	380	-	-	-	-
La.	-	-	-	626	703	-	-	-	-
Okla.	-	-	-	252	245	-	-	-	-
Tex.	-	-	-	1,334	1,697	-	-	-	-
MOUNTAIN	-	-	30	369	599	1	4	-	-
Mont.	-	-	1	5	1	-	-	-	-
Idaho	-	-	1	6	7	-	-	-	-
Wyo.	-	-	-	3	7	-	-	-	-
Colo.	-	-	22	124	254	1	2	-	-
N. Mex.	-	-	5	25	63	-	2	-	-
Ariz.	-	-	-	198	162	-	-	-	-
Utah	-	-	1	8	2	-	-	-	-
Nev.	-	-	-	-	103	-	-	-	-
PACIFIC	-	-	40	780	1,619	5	1	-	-
Wash.	-	-	4	180	164	-	-	-	-
Oreg.	-	-	31	-	52	3	-	-	-
Calif.	-	-	-	571	1,357	-	1	-	-
Alaska	-	-	1	16	13	-	-	-	-
Hawaii	-	-	4	13	33	2	-	-	-
Guam	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	61	-	-	-	-
V.I.	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending January 19, 2002, and January 20, 2001 (3rd Week)*

Reporting Area	*Haemophilus influenzae*, Invasive, Age <5 years, Non-Serotype B		*Haemophilus influenzae*, Invasive, Age <5 years, Unknown Serotype		Hepatitis (Viral, Acute), by Type, A		Hepatitis (Viral, Acute), by Type, B		Hepatitis (Viral, Acute), by Type, C; Non-A, Non-B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	2	16	-	1	235	602	96	242	24	301
NEW ENGLAND	-	1	-	-	7	27	2	4	-	4
Maine	-	-	-	-	1	-	-	-	-	-
N.H.	-	-	-	-	-	1	-	-	-	-
Vt.	-	-	-	-	-	-	1	1	-	1
Mass.	-	1	-	-	1	14	-	-	-	3
R.I.	-	-	-	-	-	-	1	-	-	-
Conn.	-	-	-	-	5	12	-	3	-	-
MID. ATLANTIC	-	1	-	-	18	65	7	61	2	119
Upstate N.Y.	-	-	-	-	1	5	1	-	1	-
N.Y. City	-	1	-	-	2	25	1	26	-	-
N.J.	-	-	-	-	-	32	-	30	-	118
Pa.	-	-	-	-	15	3	5	5	1	1
E.N. CENTRAL	-	3	-	-	17	142	23	30	2	19
Ohio	-	-	-	-	7	9	5	6	1	-
Ind.	-	-	-	-	-	-	-	-	-	-
Ill.	-	2	-	-	3	99	-	-	-	8
Mich.	-	-	-	-	7	30	18	24	1	11
Wis.	-	1	-	-	-	4	-	-	-	-
W.N. CENTRAL	-	-	-	-	15	37	3	10	13	64
Minn.	-	-	-	-	-	-	1	-	-	-
Iowa	-	-	-	-	5	1	1	-	-	-
Mo.	-	-	-	-	2	11	-	8	13	63
N. Dak.	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	1	-	-	1	-	-
Nebr.	-	-	-	-	-	13	-	1	-	-
Kans.	-	-	-	-	7	12	1	-	-	1
S. ATLANTIC	-	2	-	-	84	55	31	37	2	-
Del.	-	-	-	-	-	-	-	-	1	-
Md.	-	-	-	-	25	15	6	4	-	-
D.C.	-	-	-	-	7	1	1	1	-	-
Va.	-	-	-	-	-	3	-	2	-	-
W. Va.	-	-	-	-	-	-	-	-	-	-
N.C.	-	-	-	-	20	4	11	8	1	-
S.C.	-	-	-	-	1	-	2	-	-	-
Ga.	-	2	-	-	31	28	11	20	-	-
Fla.	-	-	-	-	-	4	-	2	-	-
E.S. CENTRAL	-	-	-	-	5	14	2	12	1	14
Ky.	-	-	-	-	-	1	-	3	-	-
Tenn.	-	-	-	-	-	4	-	1	-	1
Ala.	-	-	-	-	3	9	2	2	-	-
Miss.	-	-	-	-	2	-	-	6	1	13
W.S. CENTRAL	-	-	-	-	5	138	7	12	-	77
Ark.	-	-	-	-	4	3	6	2	-	-
La.	-	-	-	-	-	7	-	10	-	19
Okla.	-	-	-	-	-	3	-	-	-	-
Tex.	-	-	-	-	1	125	1	-	-	58
MOUNTAIN	1	2	-	1	13	29	6	18	2	2
Mont.	-	-	-	-	1	2	-	-	-	-
Idaho	-	-	-	-	-	2	-	1	-	-
Wyo.	-	-	-	-	-	1	-	-	-	2
Colo.	-	-	-	-	6	11	3	8	2	-
N. Mex.	1	2	-	1	3	1	1	6	-	-
Ariz.	-	-	-	-	1	6	-	1	-	-
Utah	-	-	-	-	2	1	2	-	-	-
Nev.	-	-	-	-	-	5	-	2	-	-
PACIFIC	1	7	-	-	71	95	15	58	2	2
Wash.	-	-	-	-	-	-	-	-	-	-
Oreg.	1	-	-	-	10	-	8	2	2	-
Calif.	-	6	-	-	61	86	7	53	-	2
Alaska	-	-	-	-	-	8	-	1	-	-
Hawaii	-	1	-	-	-	1	-	2	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	-	1	-	-
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	4	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending January 19, 2002, and January 20, 2001 (3rd Week)*

Reporting Area	Legionellosis		Listeriosis		Lyme Disease		Malaria		Measles Total	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	26	31	9	19	127	131	24	46	-	6†
NEW ENGLAND	-	1	1	2	3	7	2	2	-	-
Maine	-	-	-	-	-	-	-	-	-	-
N.H.	-	-	-	-	-	-	1	-	-	-
Vt.	-	1	-	-	-	-	-	-	-	-
Mass.	-	-	-	2	3	7	-	2	-	-
R.I.	-	-	-	-	-	-	-	-	-	-
Conn.	-	-	1	-	-	-	1	-	-	-
MID. ATLANTIC	3	2	2	2	85	73	-	13	-	-
Upstate N.Y.	-	-	2	1	66	21	-	1	-	-
N.Y. City	-	-	-	1	-	2	-	8	-	-
N.J.	-	2	-	-	-	39	-	2	-	-
Pa.	3	-	-	-	19	11	-	2	-	-
E.N. CENTRAL	18	17	2	4	2	17	4	5	-	-
Ohio	13	9	2	-	2	7	2	1	-	-
Ind.	-	1	-	-	-	-	-	1	-	-
Ill.	-	3	-	1	-	2	-	3	-	-
Mich.	5	2	-	2	-	-	2	-	-	-
Wis.	-	2	-	1	U	8	-	-	-	-
W.N. CENTRAL	-	3	-	1	3	-	3	1	-	-
Minn.	-	-	-	-	1	-	-	-	-	-
Iowa	-	-	-	-	-	-	1	-	-	-
Mo.	-	1	-	-	2	-	2	1	-	-
N. Dak.	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	-	-	-	-
Nebr.	-	1	-	-	-	-	-	-	-	-
Kans.	-	1	-	1	-	-	-	-	-	-
S. ATLANTIC	3	1	-	2	28	21	7	8	-	-
Del.	1	-	-	-	-	1	-	-	-	-
Md.	2	1	-	1	26	19	4	4	-	-
D.C.	-	-	-	-	2	1	1	1	-	-
Va.	-	-	-	1	-	-	-	2	-	-
W. Va.	N	N	-	-	-	-	-	-	-	-
N.C.	-	-	-	-	-	-	2	1	-	-
S.C.	-	-	-	-	-	-	-	-	-	-
Ga.	-	-	-	-	-	-	-	-	-	-
Fla.	-	-	-	-	-	-	-	-	-	-
E.S. CENTRAL	-	1	-	1	-	1	-	-	-	-
Ky.	-	-	-	1	-	1	-	-	-	-
Tenn.	-	-	-	-	-	-	-	-	-	-
Ala.	-	1	-	-	-	-	-	-	-	-
Miss.	-	-	-	-	-	-	-	-	-	-
W.S. CENTRAL	-	1	-	-	1	8	-	2	-	-
Ark.	-	-	-	-	-	-	-	-	-	-
La.	-	1	-	-	-	-	-	1	-	-
Okla.	-	-	-	-	-	-	-	-	-	-
Tex.	-	-	-	-	1	8	-	1	-	-
MOUNTAIN	1	1	1	-	1	-	-	2	-	-
Mont.	-	-	-	-	-	-	-	-	-	-
Idaho	-	-	-	-	-	-	-	1	-	-
Wyo.	-	-	-	-	-	-	-	-	-	-
Colo.	-	1	1	-	1	-	-	1	-	-
N. Mex.	-	-	-	-	-	-	-	-	-	-
Ariz.	-	-	-	-	-	-	-	-	-	-
Utah	1	-	-	-	-	-	-	-	-	-
Nev.	-	-	-	-	-	-	-	-	-	-
PACIFIC	1	4	3	7	4	4	8	13	-	6
Wash.	-	-	-	-	-	-	-	-	-	5
Oreg.	N	N	-	-	-	-	-	2	-	-
Calif.	1	4	3	7	4	4	6	11	-	-
Alaska	-	-	-	-	-	-	-	-	-	-
Hawaii	-	-	-	-	N	N	2	-	-	1
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	N	N	-	-	-	-
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Of six cases reported, five were indigenous and one was imported from another country.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending January 19, 2002, and January 20, 2001 (3rd Week)*

Reporting Area	Meningococcal Disease		Mumps		Pertussis		Rabies, Animal	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	51	164	2	7	106	171	101	299
NEW ENGLAND	2	11	-	-	39	57	18	21
Maine	1	-	-	-	2	-	2	3
N.H.	-	1	-	-	-	-	-	-
Vt.	1	-	-	-	11	11	3	6
Mass.	-	6	-	-	26	46	4	7
R.I.	-	-	-	-	-	-	2	3
Conn.	-	4	-	-	-	-	7	2
MID. ATLANTIC	9	25	-	-	1	5	27	22
Upstate N.Y.	3	3	-	-	1	2	22	13
N.Y. City	1	5	-	-	-	3	-	-
N.J.	-	14	-	-	-	-	-	7
Pa.	5	3	-	-	-	-	5	2
E.N. CENTRAL	12	20	-	-	21	29	1	3
Ohio	11	5	-	-	18	19	-	-
Ind.	-	-	-	-	-	-	1	-
Ill.	-	5	-	-	-	-	-	-
Mich.	1	6	-	-	3	2	-	1
Wis.	-	4	-	-	-	8	-	2
W.N. CENTRAL	2	5	-	-	11	12	2	15
Minn.	-	-	-	-	-	-	-	4
Iowa	-	2	-	-	2	2	2	4
Mo.	1	3	-	-	9	6	-	1
N. Dak.	-	-	-	-	-	-	-	-
S. Dak.	1	-	-	-	-	-	-	5
Nebr.	-	-	-	-	-	-	-	-
Kans.	-	-	-	-	-	4	-	1
S. ATLANTIC	6	22	-	-	5	6	39	53
Del.	-	-	-	-	1	-	-	-
Md.	1	4	-	-	2	3	-	8
D.C.	-	-	-	-	-	-	-	-
Va.	-	1	-	-	-	-	12	6
W. Va.	-	-	-	-	-	-	3	5
N.C.	1	6	-	-	-	1	21	12
S.C.	-	2	-	-	2	2	3	3
Ga.	4	6	-	-	-	-	-	15
Fla.	-	3	-	-	-	-	-	4
E.S. CENTRAL	1	4	-	-	2	4	2	106
Ky.	-	-	-	-	1	-	-	-
Tenn.	-	1	-	-	1	2	1	106
Ala.	1	3	-	-	-	1	1	-
Miss.	-	-	-	-	-	1	-	-
W.S. CENTRAL	4	47	-	-	2	-	5	45
Ark.	2	-	-	-	2	-	-	-
La.	1	5	-	-	-	-	-	-
Okla.	-	3	-	-	-	-	5	4
Tex.	1	39	-	-	-	-	-	41
MOUNTAIN	2	9	-	-	20	34	5	15
Mont.	-	-	-	-	-	-	-	1
Idaho	-	3	-	-	4	3	-	-
Wyo.	-	-	-	-	-	-	-	5
Colo.	2	3	-	-	10	30	-	-
N. Mex.	-	2	-	-	5	-	-	-
Ariz.	-	-	-	-	-	1	5	9
Utah	-	1	-	-	1	-	-	-
Nev.	-	-	-	-	-	-	-	-
PACIFIC	13	21	2	7	5	24	2	19
Wash.	1	-	-	-	-	-	-	-
Oreg.	6	1	N	N	4	1	-	-
Calif.	6	16	2	5	-	19	-	9
Alaska	-	-	-	-	1	-	2	10
Hawaii	-	4	-	2	-	4	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	-	6
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending January 19, 2002, and January 20, 2001 (3rd Week)*

Reporting Area	Rocky Mountain spotted fever		Rubella				Salmonellosis	
			Rubella		Congenital Rubella			
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	10	4	-	-	-	-	757	1,159
NEW ENGLAND	-	-	-	-	-	-	54	75
Maine	-	-	-	-	-	-	5	7
N.H.	-	-	-	-	-	-	1	4
Vt.	-	-	-	-	-	-	2	5
Mass.	-	-	-	-	-	-	36	57
R.I.	-	-	-	-	-	-	2	-
Conn.	-	-	-	-	-	-	8	2
MID. ATLANTIC	1	-	-	-	-	-	49	172
Upstate N.Y.	-	-	-	-	-	-	8	13
N.Y. City	-	-	-	-	-	-	11	42
N.J.	-	-	-	-	-	-	-	84
Pa.	1	-	-	-	-	-	30	33
E.N. CENTRAL	1	1	-	-	-	-	96	189
Ohio	1	-	-	-	-	-	39	54
Ind.	-	-	-	-	-	-	6	4
Ill.	-	1	-	-	-	-	14	70
Mich.	-	-	-	-	-	-	36	23
Wis.	-	-	-	-	-	-	1	38
W.N. CENTRAL	-	-	-	-	-	-	74	62
Minn.	-	-	-	-	-	-	9	13
Iowa	-	-	-	-	-	-	10	5
Mo.	-	-	-	-	-	-	47	27
N. Dak.	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	3	5
Nebr.	-	-	-	-	-	-	-	6
Kans.	-	-	-	-	-	-	5	6
S. ATLANTIC	8	3	-	-	-	-	235	226
Del.	-	-	-	-	-	-	-	3
Md.	2	1	-	-	-	-	38	20
D.C.	-	-	-	-	-	-	6	6
Va.	-	-	-	-	-	-	-	10
W. Va.	-	-	-	-	-	-	-	-
N.C.	6	2	-	-	-	-	53	60
S.C.	-	-	-	-	-	-	7	14
Ga.	-	-	-	-	-	-	131	86
Fla.	-	-	-	-	-	-	-	27
E.S. CENTRAL	-	-	-	-	-	-	49	55
Ky.	-	-	-	-	-	-	3	8
Tenn.	-	-	-	-	-	-	8	5
Ala.	-	-	-	-	-	-	36	24
Miss.	-	-	-	-	-	-	2	18
W.S. CENTRAL	-	-	-	-	-	-	28	167
Ark.	-	-	-	-	-	-	13	16
La.	-	-	-	-	-	-	-	31
Okla.	-	-	-	-	-	-	13	2
Tex.	-	-	-	-	-	-	2	118
MOUNTAIN	-	-	-	-	-	-	40	51
Mont.	-	-	-	-	-	-	-	2
Idaho	-	-	-	-	-	-	5	3
Wyo.	-	-	-	-	-	-	-	3
Colo.	-	-	-	-	-	-	28	18
N. Mex.	-	-	-	-	-	-	2	11
Ariz.	-	-	-	-	-	-	-	4
Utah	-	-	-	-	-	-	5	5
Nev.	-	-	-	-	-	-	-	5
PACIFIC	-	-	-	-	-	-	132	162
Wash.	-	-	-	-	-	-	1	-
Oreg.	-	-	-	-	-	-	18	-
Calif.	-	-	-	-	-	-	105	152
Alaska	-	-	-	-	-	-	2	1
Hawaii	-	-	-	-	-	-	6	9
Guam	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	-	14
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	1	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending January 19, 2002, and January 20, 2001 (3rd Week)*

Reporting Area	Shigellosis		Streptococcal Disease, Invasive, Group A		*Streptococcus pneumoniae*, Invasive (<5 years)		*Streptococcus pneumoniae*, Drug Resistant, Invasive	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	324	664	124	205	18	3	61	80
NEW ENGLAND	8	11	4	6	5	-	-	2
Maine	-	-	2	2	-	-	-	-
N.H.	-	-	1	-	-	-	-	-
Vt.	-	-	1	1	5	-	-	2
Mass.	7	10	-	3	-	-	-	-
R.I.	-	-	-	-	-	-	-	-
Conn.	1	1	-	-	-	-	-	-
MID. ATLANTIC	10	102	15	50	-	1	2	3
Upstate N.Y.	3	40	10	6	-	1	2	3
N.Y. City	1	29	2	26	-	-	-	-
N.J.	-	18	-	18	-	-	-	-
Pa.	6	15	3	-	-	-	-	-
E.N. CENTRAL	84	97	26	54	12	2	3	1
Ohio	57	18	14	5	1	-	1	-
Ind.	3	4	-	-	11	2	2	1
Ill.	12	44	1	19	-	-	-	-
Mich.	12	24	11	28	-	-	-	-
Wis.	-	7	-	2	-	-	-	-
W.N. CENTRAL	71	95	2	12	-	-	6	1
Minn.	13	43	-	-	-	-	-	-
Iowa	5	6	-	-	-	-	-	-
Mo.	5	30	1	6	-	-	1	-
N. Dak.	-	-	-	-	-	-	-	-
S. Dak.	45	1	-	2	-	-	-	-
Nebr.	-	5	-	-	-	-	-	-
Kans.	3	10	1	4	-	-	5	1
S. ATLANTIC	60	54	39	18	1	-	45	55
Del.	2	-	-	-	-	-	-	-
Md.	18	3	5	4	-	-	-	-
D.C.	3	3	2	-	1	-	2	-
Va.	-	3	-	2	-	-	-	-
W. Va.	-	-	-	-	-	-	-	-
N.C.	14	16	6	6	-	-	-	-
S.C.	-	6	-	1	-	-	9	7
Ga.	23	14	26	3	-	-	34	26
Fla.	-	9	-	2	-	-	-	22
E.S. CENTRAL	26	43	1	3	-	-	2	3
Ky.	3	18	-	-	-	-	-	1
Tenn.	-	-	1	3	-	-	2	2
Ala.	20	12	-	-	-	-	-	-
Miss.	3	13	-	-	-	-	-	-
W.S. CENTRAL	9	135	3	25	-	-	1	13
Ark.	6	7	-	-	-	-	1	3
La.	-	8	-	-	-	-	-	10
Okla.	2	-	2	2	-	-	-	-
Tex.	1	120	1	23	-	-	-	-
MOUNTAIN	13	29	18	29	-	-	2	2
Mont.	-	-	-	-	-	-	-	-
Idaho	-	1	-	-	-	-	-	-
Wyo.	-	-	-	-	-	-	-	-
Colo.	7	6	11	19	-	-	-	-
N. Mex.	1	11	7	10	-	-	2	2
Ariz.	-	10	-	-	-	-	-	-
Utah	5	-	-	-	-	-	-	-
Nev.	-	1	-	-	-	-	-	-
PACIFIC	43	98	16	8	-	-	-	-
Wash.	-	-	-	-	-	-	-	-
Oreg.	8	-	-	-	-	-	-	-
Calif.	33	98	16	8	-	-	-	-
Alaska	-	-	-	-	-	-	-	-
Hawaii	2	-	-	-	-	-	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	-	1	-	-	-	-	-	-
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	-	-
C.N.M.I.	-	U	-	U	-	U	-	-

N: Not notifiable. U: Unavailable. - : No reported cases.
*Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending January 19, 2002, and January 20, 2001 (3rd Week)*

Reporting Area	Syphilis				Tuberculosis		Typhoid fever	
	Primary & Secondary		Congenital†					
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	191	199	-	25	111	227	3	6
NEW ENGLAND	-	2	-	-	8	2	2	1
Maine	-	-	-	-	-	-	-	-
N.H.	-	-	-	-	-	-	-	-
Vt.	-	-	-	-	-	1	-	-
Mass.	-	-	-	-	-	-	1	1
R.I.	-	-	-	-	3	-	-	-
Conn.	-	2	-	-	5	1	1	-
MID. ATLANTIC	5	16	-	3	21	11	-	-
Upstate N.Y.	-	-	-	1	-	-	-	-
N.Y. City	4	8	-	-	7	4	-	-
N.J.	-	2	-	2	-	5	-	-
Pa.	1	6	-	-	14	2	-	-
E.N. CENTRAL	27	21	-	2	9	14	-	1
Ohio	5	3	-	-	2	4	-	-
Ind.	1	5	-	-	6	4	-	-
Ill.	3	12	-	2	1	6	-	1
Mich.	18	-	-	-	-	-	-	-
Wis.	-	1	-	-	-	-	-	-
W.N. CENTRAL	-	3	-	1	19	4	-	1
Minn.	-	2	-	-	1	4	-	-
Iowa	-	-	-	-	-	-	-	-
Mo.	-	1	-	-	18	-	-	1
N. Dak.	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	-	-
Nebr.	-	-	-	-	-	-	-	-
Kans.	-	-	-	1	-	-	-	-
S. ATLANTIC	52	78	-	8	3	21	1	1
Del.	-	-	-	-	-	-	-	-
Md.	5	10	-	1	-	-	-	1
D.C.	3	-	-	-	-	3	-	-
Va.	3	6	-	-	-	-	-	-
W. Va.	-	-	-	-	1	1	-	-
N.C.	19	17	-	-	2	-	-	-
S.C.	5	9	-	2	-	5	-	-
Ga.	9	15	-	2	-	12	1	-
Fla.	8	21	-	3	-	-	-	-
E.S. CENTRAL	39	19	-	-	7	10	-	-
Ky.	1	2	-	-	-	-	-	-
Tenn.	16	8	-	-	-	-	-	-
Ala.	20	4	-	-	7	10	-	-
Miss.	2	5	-	-	-	-	-	-
W.S. CENTRAL	40	35	-	4	1	82	-	1
Ark.	-	5	-	2	-	8	-	-
La.	14	8	-	-	-	-	-	-
Okla.	7	3	-	-	1	-	-	-
Tex.	19	19	-	2	-	74	-	1
MOUNTAIN	18	3	-	1	2	8	-	-
Mont.	-	-	-	-	-	-	-	-
Idaho	1	-	-	-	-	-	-	-
Wyo.	-	-	-	-	-	-	-	-
Colo.	-	-	-	-	-	1	-	-
N. Mex.	3	-	-	-	-	2	-	-
Ariz.	14	2	-	1	2	2	-	-
Utah	-	1	-	-	-	-	-	-
Nev.	-	-	-	-	-	3	-	-
PACIFIC	10	22	-	6	41	75	-	1
Wash.	1	3	-	-	4	9	-	-
Oreg.	-	2	-	-	-	3	-	-
Calif.	9	16	-	6	30	52	-	1
Alaska	-	-	-	-	1	3	-	-
Hawaii	-	1	-	-	6	8	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	-	21	-	-	-	-	-	-
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	1	U	-	U	2	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE III. Deaths in 122 U.S. cities,* week ending January 19, 2002 (3rd Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	611	455	94	30	9	23	77
Boston, Mass.	193	138	32	5	4	14	29
Bridgeport, Conn.	29	21	5	3	-	-	1
Cambridge, Mass.	18	15	3	-	-	-	4
Fall River, Mass.	32	29	2	-	1	-	1
Hartford, Conn.	48	34	6	5	2	1	6
Lowell, Mass.	19	15	3	1	-	-	8
Lynn, Mass.	3	2	1	-	-	-	1
New Bedford, Mass.	24	21	1	2	-	-	4
New Haven, Conn.	43	34	8	1	-	-	6
Providence, R.I.	68	46	12	4	1	5	1
Somerville, Mass.	5	4	-	1	-	-	1
Springfield, Mass.	47	30	10	4	1	2	5
Waterbury, Conn.	14	8	4	1	-	1	-
Worcester, Mass.	68	58	7	3	-	-	10
MID. ATLANTIC	2,501	1,741	524	158	30	44	144
Albany, N.Y.	54	38	13	3	-	-	-
Allentown, Pa.	15	13	2	-	-	-	1
Buffalo, N.Y.	62	54	7	1	-	-	4
Camden, N.J.	24	16	6	1	-	1	3
Elizabeth, N.J.	33	21	11	1	-	-	-
Erie, Pa.	59	45	8	3	1	2	3
Jersey City, N.J.	59	41	11	5	2	-	-
New York City, N.Y.	1,372	921	304	98	15	31	72
Newark, N.J.	U	U	U	U	U	U	U
Paterson, N.J.	25	12	6	5	2	-	3
Philadelphia, Pa.	321	199	85	26	6	4	14
Pittsburgh, Pa.§	36	26	9	-	1	-	3
Reading, Pa.	30	23	3	4	-	-	4
Rochester, N.Y.	129	104	21	2	-	2	13
Schenectady, N.Y.	23	20	2	1	-	-	2
Scranton, Pa.	26	22	3	1	-	-	-
Syracuse, N.Y.	164	133	25	4	1	1	20
Trenton, N.J.	44	31	8	1	1	3	1
Utica, N.Y.	25	22	-	2	1	-	1
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,922	1,350	380	113	33	46	159
Akron, Ohio	60	42	11	3	1	3	7
Canton, Ohio	40	27	9	2	-	2	5
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	103	76	13	10	2	2	15
Cleveland, Ohio	147	81	46	12	5	3	8
Columbus, Ohio	237	155	49	25	-	8	11
Dayton, Ohio	174	130	24	15	3	2	24
Detroit, Mich.	214	122	62	13	8	9	19
Evansville, Ind.	47	39	6	1	-	1	1
Fort Wayne, Ind.	89	71	11	5	1	1	6
Gary, Ind.	18	7	9	2	-	-	1
Grand Rapids, Mich.	82	68	10	1	2	1	6
Indianapolis, Ind.	214	151	49	7	4	3	18
Lansing, Mich.	49	41	6	2	-	-	7
Milwaukee, Wis.	135	99	25	5	2	4	4
Peoria, Ill.	52	36	8	4	1	3	4
Rockford, Ill.	47	32	10	2	2	1	6
South Bend, Ind.	46	36	9	-	1	-	7
Toledo, Ohio	97	76	17	1	-	3	7
Youngstown, Ohio	71	61	6	3	1	-	3
W.N. CENTRAL	746	517	145	49	22	13	53
Des Moines, Iowa	99	68	25	5	1	-	10
Duluth, Minn.	9	8	1	-	-	-	-
Kansas City, Kans.	30	16	8	5	1	-	3
Kansas City, Mo.	113	67	28	9	7	2	4
Lincoln, Nebr.	39	30	6	-	2	1	3
Minneapolis, Minn.	99	75	15	6	2	1	9
Omaha, Nebr.	117	82	23	6	5	1	11
St. Louis, Mo.	53	39	7	4	2	1	-
St. Paul, Minn.	74	58	11	2	-	3	5
Wichita, Kans.	113	74	21	12	2	4	8
S. ATLANTIC	1,293	833	280	102	31	46	98
Atlanta, Ga.	211	138	45	12	7	9	6
Baltimore, Md.	192	97	60	28	3	4	26
Charlotte, N.C.	128	97	23	6	-	2	15
Jacksonville, Fla.	164	111	34	9	3	6	18
Miami, Fla.	23	13	6	2	-	2	2
Norfolk, Va.	74	45	14	6	4	5	5
Richmond, Va.	101	57	25	14	2	3	9
Savannah, Ga.	45	34	11	-	-	-	3
St. Petersburg, Fla.	71	55	7	5	1	3	3
Tampa, Fla.	184	125	35	10	6	8	9
Washington, D.C.	100	61	20	10	5	4	2
Wilmington, Del.	U	U	U	U	U	U	U
E.S. CENTRAL	1,088	757	208	75	28	19	97
Birmingham, Ala.	258	188	41	13	10	5	27
Chattanooga, Tenn.	73	54	14	4	1	-	9
Knoxville, Tenn.	135	92	29	10	3	1	3
Lexington, Ky.	98	62	20	12	1	3	8
Memphis, Tenn.	201	138	41	14	6	2	22
Mobile, Ala.	109	72	19	11	1	6	5
Montgomery, Ala.	48	34	11	2	1	-	5
Nashville, Tenn.	166	117	33	9	5	2	18
W.S. CENTRAL	983	660	213	68	16	26	64
Austin, Tex.	124	81	31	9	1	2	9
Baton Rouge, La.	80	49	21	8	2	-	1
Corpus Christi, Tex.	74	54	16	3	1	-	4
Dallas, Tex.	U	U	U	U	U	U	U
El Paso, Tex.	U	U	U	U	U	U	U
Ft. Worth, Tex.	160	88	50	14	4	4	6
Houston, Tex.	U	U	U	U	U	U	U
Little Rock, Ark.	70	41	17	4	2	6	2
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	257	191	40	17	2	7	23
Shreveport, La.	65	46	10	5	2	2	5
Tulsa, Okla.	153	110	28	8	2	5	14
MOUNTAIN	949	649	187	64	21	24	87
Albuquerque, N.M.	151	108	28	12	2	1	14
Boise, Idaho	54	40	12	1	-	1	3
Colo. Springs, Colo.	67	48	13	4	-	2	5
Denver, Colo.	102	56	26	11	3	6	13
Las Vegas, Nev.	243	165	46	19	4	8	16
Ogden, Utah	32	22	5	4	-	1	3
Phoenix, Ariz.	151	102	33	7	6	-	13
Pueblo, Colo.	39	32	4	-	3	-	4
Salt Lake City, Utah	110	76	20	6	3	5	16
Tucson, Ariz.	U	U	U	U	U	U	U
PACIFIC	2,034	1,437	383	132	52	27	161
Berkeley, Calif.	19	11	8	-	-	-	-
Fresno, Calif.	171	129	27	11	4	-	13
Glendale, Calif.	22	19	-	3	-	-	4
Honolulu, Hawaii	109	84	15	8	1	1	11
Long Beach, Calif.	100	70	17	10	-	3	13
Los Angeles, Calif.	382	246	77	32	19	8	21
Pasadena, Calif.	40	33	6	1	-	-	8
Portland, Oreg.	260	193	51	9	5	2	24
Sacramento, Calif.	229	155	53	10	8	3	7
San Diego, Calif.	176	112	43	12	6	3	13
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	237	166	49	13	5	1	24
Santa Cruz, Calif.	31	25	5	1	-	-	5
Seattle, Wash.	154	109	20	17	3	5	12
Spokane, Wash.	U	U	U	U	U	U	U
Tacoma, Wash.	104	85	12	5	1	1	6
TOTAL	12,127¶	8,399	2,414	791	242	268	940

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.

All *MMWR* references are available on the Internet at http://www.cdc.gov/mmwr. Use the search function to find specific articles.

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

References to non-CDC sites on the Internet are provided as a service to *MMWR* readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of pages found at these sites.

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: 2002-733-100/69006 Region IV